REPUBLIC OF BOTSWANA

EVALUATION OF THE SRH/HIV LINKAGES PROJECT IN BOTSWANA 2016

MINISTRY of HEALTH
REPUBLIC OF BOTSWANA

UNFPA

UNAIDS

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANOVA	Analysis of Variance
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral (Medication)
BOFWA	Botswana Family Welfare Association
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
BONEPWA	Botswana Network Of People Living With HIV and AIDS
CES	Client Exit Survey
CSO	Civil Society Organizations
EMs	Evaluation Managers
ESARO	East and Southern Regional Office
EU	European Union
FGDs	Focus Group Discussions
GBV	Gender-Based Violence
GNP+	Global Network of People Living with HIV
HIV	Human Immunodeficiency Virus
ICW	International Community of Women Living with HIV/AIDS
IDU	Injection Drug Users
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
KIIs	Key Informant Interviews
LGBIQ	Lesbian, Gay, Transgender, Bisexual, Intersex, and Questioning
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MSM	Men who Have Sex with Men
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NGO	Non-Governmental Organization
NRG	National Reference Group
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission (Of HIV)
POC	Point of Contact
RRG	Regional Reference Group
Sida	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TOT	Training-of-Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Linking efforts to improve sexual and reproductive health and rights (SRHR) with HIV services is vitally important. HIV is sexually transmitted or associated with pregnancy, childbirth, and breastfeeding, and the presence of certain sexually transmitted infections (STIs) further increases the risk of HIV transmission. Sexual and reproductive ill health and HIV often share root causes, including poverty, gender inequality, and the social marginalization of vulnerable groups. Linking SRHR and HIV is expected to improve health outcomes by improving access to and uptake of services, reducing stigma and discrimination, streamlining services and reducing duplication of efforts, increasing the efficient utilization of human resources, and increasing the cost-effectiveness of efforts.

The United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional SRHR and HIV Linkages in 7 Countries in Southern Africa Project was undertaken in response to this need. The Project, funded by the European Union (EU) and the Governments of Sweden and Norway, has supported seven countries in Southern Africa (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe) to strengthen linkages between SRHR and HIV. The Project focused on three main result areas: provision of support to allow full linking of HIV and SRHR in national health and broader development strategies, plans, and budgets; enabling countries to link SRHR and HIV services better and scale them up effectively; and stimulation of formulation and dissemination of lessons learned, formulation of best practices, and facilitation of South-South cooperation in this field.

In Botswana, the SRHR/HIV Linkages Project was overseen by a national interagency Technical Committee whose role was to coordinate, oversee, and implement the Project. Key members of this Technical Committee in Botswana included representatives from the Ministry of Health (MOH), who led and chaired the group; UNFPA; UNAIDS; the World Health Organization (WHO); the EU; and two local civil society organizations (CSOs) with demonstrated expertise in HIV and SRHR.

ICF International (ICF), with support from a South Africa-based regional partner, OtherWISE Research and Evaluation, worked with the UNFPA East and Southern Africa Regional Office and UNAIDS to conduct an evaluation of the SRHR/HIV Linkages Project using a mixed-methods approach. For Botswana, the quantitative approach included three components: (1) secondary analysis of SRHR/HIV linkages indicator data, (2) secondary analysis of facility-level service-utilization data from select facilities, and (3) client exit interviews at select facilities. The qualitative study complemented the quantitative study and included (1) a desk review, (2) focus group discussions with clients at select facilities, and (3) key informant interviews. The specific objectives of the evaluation of the SRHR/HIV Linkages Project are to assess whether SRHR/HIV linkages are relevant to the country contexts; to assess the effectiveness of the SRHR/HIV linkages; to assess the efficiency of the SRHR/HIV linkages; and to assess the ownership of SRHR/HIV Linkages Project by stakeholders and the sustainability of SRH/HIV linkages beyond the Project tenure.

Findings

Relevance of the Project to Botswana. Provision of integrated SRHR and HIV services is relevant to the Botswanan legal and policy context because of the existing strong focus on integrated primary health care, and because laws and policies that existed prior to the Linkages Project provided a policy environment into which integration and linkages could be incorporated. Client exit interviews suggest that the services provided are relevant to client needs: most clients are receiving the services that they seek. While less than a quarter receive additional services, most of those who do, receive HTC as the additional service.

Three policies have been updated with language on integration, including the Second National Strategic Framework for HIV and AIDS, 2009–2016 (NSF II), the National Development Plan11 (NDP 11), and the National HIV Treatment Guidelines. This inclusion of language on integration in these policies should be shared as examples of how integration can be incorporated into existing policies. Botswana's SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan should also be shared as an example of an overarching integration plan.

Effectiveness of the Project. In Botswana, the Project has been effective in changing the three policies noted above to improve support of integration. Evaluation findings also demonstrate improved availability of and access to integrated services, as well as increased uptake of services and increased awareness of services. Reports of increased uptake of services suggest that both key informants and clients see the benefits of integrated and linked services for clients. However, while increases for some indicators suggest that integration of SRHR and HIV services in Botswana is having a positive impact on clients' knowledge, decreases in condom use suggest that integrated services are not having the desired effect on preventive behaviors.

Efficiency of the Project. Botswana is transitioning to a middle-income country, and will likely receive less donor support over time, there is a need to leverage resources and re-allocate funding for impact. Linkage and integration provide one way to achieve this. In terms of policy, findings regarding efficiency were mixed; while policy gains have been made, the extent to which these have communicated to all stakeholders, especially those in service delivery, has been limited. Findings about service delivery efficiencies from the health care provider side are somewhat mixed, indicating a need for more staff/human resources and capacity-building.

Ownership of the Project by Botswana. The evaluation found mixed but mostly positive indications of ownership, with some challenges in terms of coordination at the national level and some areas where policies still needed work. Findings around sustainability related to policy, and to service delivery and scale up were also mixed, but point to a need for additional external support for scale-up of integration. Documents shared by Botswana resoundingly speak to both a strong sense of country ownership.

Recommendations

We offer the following recommendations.

Since many key informants did not share a common understanding of linkage and integration, and some were unaware of policy changes, there needs to be **better definition and promotion of the concepts of "linkage"** and **"integration" and better understanding of how changes in policies affect stakeholders at all levels.**

To provide better evidence of effectiveness during scale-up of integration, we recommend that specific indicators for monitoring and evaluation of SRHR and HIV be incorporated into the national health management information system.

While MOH trainings effectively prepare providers to deliver integrated services, staff workload, shortages, turnover, and rotation, as well as the timing of training on specific topics all negatively impact efficiency. Thus, more needs to done in terms of staffing facilities with trained providers and preparing health care providers to deliver integrated services.

There is strong political support and local support for integration, but there needs to be better coordination between levels and more support from different departments within the MOH. In addition to local health care providers or district health officers acting as champions, we recommend that the new Project Coordinator at MOH should play a visible role in championing integration.

In conclusion, while from the client perspective, Botswana has made significant gains in the provision of integrated SRHR and HIV services through the implementation of the UNFPA/UNAIDS SRHR/HIV Linkages Project, these have not been without significant growing pains and challenges for health care providers, DHOs, the MOH, and UNFPA and UNAIDS. Thus, to ensure the continued provision of these services and expansion of the Project to other sites, there is still work to be done.

1. BACKGROUND

Overview of the Sexual and Reproductive Health and Rights/HIV Linkages Project

The importance of linking sexual and reproductive health and rights (SRHR) with efforts to reduce transmission of and provide care for individuals with HIV has been widely recognized in key international and regional agreements, including the Maputo Plan of Action. Most HIV infections are sexually transmitted or associated with pregnancy, childbirth, and breastfeeding. The presence of certain sexually transmitted infections (STIs) further increases the risk of HIV transmission.1 Sexual and reproductive ill health and HIV often share root causes, including poverty, gender inequality, and the social marginalization of vulnerable groups.1 Linkages between SRHR and HIV are expected to improve health outcomes by improving access to and uptake of services, reducing stigma and discrimination, streamlining services and reducing duplication of efforts, increasing the efficient utilization of human resources,1 and increasing the cost-effectiveness of efforts.

The United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional SRHR and HIV Linkages in 7 Countries in Southern Africa Project was undertaken (hereafter referred to as the SRHR/HIV Linkages Project) in response to this need. The Project, funded by the European Union (EU) and the Governments of Sweden (via the Swedish International Development Cooperation Agency [Sida]) and Norway, has supported seven countries in Southern Africa (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe) to strengthen linkages between SRHR and HIV. The initial project period was 2011–2015 with a funding level of US $15 million.2 The overall aim of the Project was to (1) promote efficient and effective linkages between SRHR and HIV policies and services as part of strengthening health systems and service delivery and (2) to increase access to and use of quality services to achieve the goals of universal access to reproductive health (Millennium Development Goals [MDGs] 3, 4, and 5) and HIV prevention, treatment, care, and support (MDG 6).

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1 International Planned Parenthood Federation, United Nations Population Fund, World Health Organization, Joint United Nations Programme on HIV/AIDS, Global Network of People Living with HIV, International Community of Women Living with HIV/AIDS, & Young Positives. (2009). Rapid assessment tool for sexual & reproductive health and HIV linkages: A generic guide. Retrieved from http://www.unfpa.org/sites/default/files/pub-pdf/rapidassessmenttoolsrhlinkages_2009_en.pdf
2 All fiscal amounts are listed in U.S. dollars

Within the context of expanding access to SRHR and HIV services, the Project focused on three main result areas:
Provision of support to seven countries in Southern Africa to allow full linking of HIV and SRHR in national health and broader development strategies, plans, and budgets (hereafter referred to as the "policy" result area)
Enabling seven countries in Southern Africa to link SRHR and HIV services better and scale them up effectively (the "service delivery and scale-up" result area)
Stimulation of formulation and dissemination of lessons learned in the Southern Africa region; formulation of best practices; and facilitation of South-South cooperation in this field (the "documentation and dissemination of best practices" result area)
All countries started Project implementation in 2011. In 2011, Lesotho, Namibia, Zambia and Zimbabwe began working on Result Areas 1 and 3; when funding resources were mobilized in 2013, these nations started working on Result Area 2 as well.
Each country conducted a rapid assessment to assess SRHR and HIV bi-directional linkages at the policy, system, and service delivery levels using the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages.1 The rapid assessments were used to shape national plans and frameworks for implementing and scaling up linkages and to inform regional and global agendas. The Project also capitalized in various ways on lessons learned in the Integra Initiative, an earlier project in which four different models of integrated SRHR and HIV services were evaluated in "real-world" settings in Kenya, Malawi, and Swaziland.3
In 2012, the Global Inter-Agency Working Group on SRH and HIV Linkages launched an initiative to identify indicators to measure progress in linking SRHR and HIV. They developed a compendium of indicators for measuring SRH and HIV linkages at the policy, systems, and service delivery levels as well as at output, outcome, and impact levels. The SRHR/HIV Linkages Project field tested two new indicators measuring SRHR/HIV integration which were pilot tested by the countries of this Project.1,4

Background for Implementation of the Project in Botswana

Governance

In Botswana, the SRHR/HIV Linkages Project was overseen by a national interagency Technical Committee whose role was to coordinate, oversee, and implement the Project. Key members of this Technical Committee in Botswana included representatives from the Ministry of Health (MOH), who led and chaired the group; UNFPA; UNAIDS; the World Health Organization (WHO); the EU; and two local civil society organizations (CSOs) with demonstrated expertise in HIV and SRHR. MOH representation included the former Deputy Permanent Secretary, now current Permanent Secretary, who also participated in the UNFPA/UNAIDS Regional Reference Group. As Deputy Permanent Secretary, the current Permanent Secretary had been responsible for oversight of accounting for the Botswana implementation of the SRHR/HIV Linkages Project, and thus was directly involved in the genesis of the Project. She continued this deep level of engagement in her new role as Permanent Secretary, viewing integration and linkage as part of her mandate as Permanent Secretary.

3 Health and Development Africa. (2013). Mid-Term Review of the Project "Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa" Project Report. Johannesburg, South Africa: Author.

4 International Planned Parenthood Federation, United Nations Population Fund, & the World Health Organization on behalf of the Interagency Working Group on Sexual and Reproductive Health and HIV Linkages. (2014). SRH and HIV Linkages Compendium: Indicators & Related Assessment Tools. Retrieved from http://www.unfpa.org/sites/default/files/pub-pdf/SRH%20HIV%20Linkages%20Compendium_rev.pdf

The Technical Committee was supported by an Evaluation Committee whose role focused on monitoring and evaluation (M&E) of the Project in Botswana, including data collection and analysis and documentation and dissemination of best practices and lessons learned to improve Project design and inform decision making. The Evaluation Committee was chaired by the MOH, co-chaired by UNFPA and UNAIDS country representatives, and included national Project Coordinators, M&E Officers from both UNFPA and UNAIDS Country Offices in Botswana, representatives of the relevant MOH SRHR and HIV departments involved in the Project, and representatives of the CSOs described above.

Resources

In Botswana, the Linkages Project received $1,193,928 from the EU over the course of the Project, and $258,731 from Sida in 2014. As shown in Exhibits 1 and 2 below, the largest proportion of EU funding was spent on personnel costs (41.9%), followed by publications, research, and evaluation (16.1%). The largest proportions of Sida funding went to specific activities, including CSO models (or support for CSOs, at 40.4%), health care provider trainings (23.6%), and regional consultation (14.9%).

Exhibit 1. Costs and Distribution of Costs Across Input Types: EU Funding, 2011–2015 (Financial Costs), Botswana

Input Types	Amount	Percentage
Personnel	$562,794	41.9%
Travel	$24,406	1.8%
Purchase or rent of vehicles	$33,128	2.5%
Furniture and computer equipment	$34,208	2.5%
Medical equipment and commodities	$24,244	1.8%
Local office	$148,894	11.1%
Publications, Research, and Evaluations	$215,949	16.1%
Financial reporting support	$81	0.01%
Translation/interpreters	-	-
Banking services	$677	0.1%
Conferences/seminars	$92,599	6.9%
Visibility actions	$77,417	5.8%
Other	$44,598	3.3%
Administrative costs	$85,635	6.4%
Total	**$1,344,629**	**100%**

Exhibit 2. Costs and Distribution of Costs Across Activity Types: Sida Funding, 2014 (Financial Costs), Botswana

Activity Types		Amount	Percentage
Activity Costs	High-level meetings	-	-
	Policy and planning reviews	-	-
	CSO capacity building	-	-
	Health service providers capacity building	$61,077	23.6%
	Review and procurement of reproductive health commodities	$26,030	10.1%
	CSO models/support for CSOs	$104,560	40.4%
	ALL ACTIVITY COSTS	**$191,666**	**74.1%**

Continued

Continued

Monitoring and Evaluation Costs	Assessment of non-health sector contributions to linked/integrated models	-	-
	M&E assessment	-	-
	Support to harmonize health management information systems	$18,338	7.1%
	Pilot compendium of SRHR indicators	-	-
	Operational research	-	-
	Best practice documentation	-	-
	Regional consultations	$38,458	14.9%
	Regional staff	-	-
	ALL MONITORING AND EVALUATION COSTS	**$56,796**	**22.0%**
Indirect Costs		$6,036	4.0%
Total Costs		**$258,731**	**100.00%**

Partnerships

Partners who contributed to the SRHR/HIV Linkages Project in Botswana included the MOH; other government ministries like the Ministry of Education; UN partners, including UNFPA, UNAIDS, and the WHO; other development partners, including the EU, the U.S President's Emergency Plan for AIDS Relief (PEPFAR), and Sida; CSOs including BOFWA, Tebelolpele, BONELA, BONEPWA, Boys and Men; health care providers at all levels; the District office of the National AIDS Coordinating Agency (NACA); client support groups; and community leaders.

The MOH played a key leadership role from the design of the Project onwards. The funders placed the Project directly under MOH leadership to ensure close monitoring and success, interaction and joint planning between SRHR and HIV departments at MOH, and joint efforts to develop trainings to help health care providers to understand linkages and integration. The Ministry of Education was involved because of the need to address school health and through indirect involvement in counselling (via the provision of comprehensive sexuality education). UNFPA played an important role in coordinating the Project at the national level, in procurement of SRHR and HIV prevention commodities, and provision of technical assistance (TA) and capacity building to MOH facility and CSO staff. UNAIDS provided advocacy and M&E support to the Project, and the WHO were vocal advocates of primary health care in Botswana.

Development partners had varying levels of involvement. As funders of the Linkages Project, the EU and Sida played an important role in providing direct financial support to the Project through UNFPA. Though other development partners may not have funded the Project directly, their support of related effort—for instance, HIV funding and M&E support from PEPFAR to the MOH—contributed to the availability and delivery of services to clients in Project-supported facilities.
CSOs were typically involved in the Project, and received commodities, TA, and capacity building support for service delivery; they also contributed to advocacy and social marketing of condoms. CSOs worked with a variety of clients, including mothers, youth, men, LGBTIQ (lesbian, gay, transgender, bisexual, intersex, and questioning) persons, men who have sex with men (MSM), commercial sex workers, expecting fathers, orphaned and vulnerable children, and people living with HIV (PLHIV), as well as traditional and religious leaders, health workers, social workers, and teachers.

Coordination

In Botswana, the Project was coordinated by a National Project Coordinator based at MOH but funded by UNFPA, who worked with a program focal person at MOH and a UNAIDS Strategic Information Advisor. As noted above, these individuals were also members of the national Technical and Evaluation Committees. The Technical Committee met at least twice a month and additionally held a yearly meeting to adopt the work plan and annual report and to set priorities and plan the work for the following year. The Evaluation Committee also met at least twice a month and participated in the Technical Committee annual meeting. Regular monthly meetings were used to ensure effective and functional linkages between HIV and SRHR at the national and service delivery levels, to monitor Project progress, and to provide overall technical guidance for the national implementation of the Project. The Evaluation Committee also supervised the baseline survey for the SRHR/HIV linkages pilot project and the pilot testing of the SRHR/HIV linkages indicators.

High-Level Activities

The draft Final Report Narrative—Phase 1: 2011–2015, which combined the narrative reports for each year of the Project, listed activities conducted in Botswana under the auspices of the Project. Below, these activities are presented by key result areas.

Policy

Review and inclusion of integration in national health development plans

o Development of a full integration plan for Botswana

o Successful development of a costed scale-up plan for integration and the subsequent signing of a Global Fund grant in 2015

This grant is expected to financially support the scale up of SRHR, HIV, tuberculosis (TB) and maternal and child health integration in 16 health districts

This also included conduct of a baseline survey on SRHR/HIV Linkages indicators countrywide in preparation for the scale up (funded by Sida)

Service Delivery and Scale-Up

o Implementation of all three models of integration at nine different pilot facilities in three districts between 2011 and 2015, including implementing the "kiosk" model at health posts and smaller clinics; the "supermarket" model at larger clinics; and the "mall" model at hospitals

o Renaming stand-alone HIV clinics (from Infectious Disease Control Clinics) to Comprehensive Care Centers (CCC) as part of reducing stigma and discrimination towards PLHIV and repurposing those clinics to provide integrated services

o Provision of experience-sharing workshops and training on comprehensive data management for health care providers, and provision of training on life and livelihood skills for Guidance and Counselling teachers at primary and secondary school levels

o Review of family planning registers to integrate HIV and consolidation of four HIV testing and counseling (HTC) registers into a single draft register, as well as the printing of 1,000 revised family planning registers to be disseminated in 2016 (funded by Sida)

o Mobilization of youth through the "Condomize" campaigns, via a clinical services component intended to facilitate access and referral of youth to integrated services (funded by Sida)

o Strengthening the provision of integrated services to young people and launching of youth-friendly clinics for provision of youth-friendly services (funded by the EU)

o Mainstreaming of gender into SRHR and HIV programming to improve male involvement and reduce gender-based violence (GBV), including the development of a GBV/SRHR/HIV clinical management flowchart for health care providers

o Development of "Know Your Rights" posters and cards

o High-level visits by the Botswana MOH and EU to field facilities, which contributed to the evidence-informed decision for scaling up of the Project

o Support to MOH for the development of an integrated SRHR/HIV curriculum, led by the University of Maryland Baltimore in Botswana with financial support from the EU and PEPFAR to consolidate existing SRH/HIV curricula and develop a harmonized curriculum

o Participation in the GPRHCS program,5 which resulted in Botswana achieving a target of "0% of health facilities reporting HIV-SRHR commodities stock-out during the 2015 reporting cycle."

5 UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) Phase II (2013–2020) adopts an integrated approach which addresses national priorities and contexts within 46 target countries

- ***Documentation and Dissemination of Best Practices***
    - o Benchmarking tour to Nairobi, Kenya in 2012, by MOH representatives and the National Coordinator to learn about different integration models that could be adapted for Botswana
    - o Participation of three young people in the youth leadership summit in Dakar, Senegal 2014 (funded by the EU)
    - o Attendance at the international Integration for Impact—Reproductive Health & HIV Services in Sub-Saharan Africa conference in 2012
    - o Participation in the Global Inter-Agency Working Group on SRH and HIV Linkages to develop the compendium of indicators, led by IPPF, in 2012
    - o Collaboration with the Southern African Development Community (SADC) in the development of regional guidelines for integrating SRH and HIV, 2012–2015
    - o Hosting of the Regional Project Steering Committee meeting in 2014 that led to coverage in local newspapers and on national television
    - o Development of Information Education and Communication (IEC) materials, including a new family planning client booklet, a brochure on SRHR and HIV/AIDS programs, three banners, labels, pens, and folders

IEC materials continue to be used during trainings, distributed to pilot sites especially during integrated campaigns, and displayed during program launches and World Population day celebrations. Digital cameras, video and voice recorders have also been procured for dissemination purposes

- o Adaptation of indicators, used to conduct a client satisfaction survey that showed an 82.7% satisfaction rating (both funded by Sida); launch of a cost-efficiency study; and participation in a study on best practice modalities and benefits of CSO involvement in supporting the scale-up of integrated SRHR and HIV (also funded by Sida)
- o Development of a promising service model focused on task shifting, which has been adapted to different levels of health service delivery and is part of a finalized plan for countrywide roll-out of this model
- o Documentation of lessons learned and good practice models from the Otse Health Post's implementation of SRHR/HIV linkages, to be completed in 2016

2. Methodology

2.1 Overview of the Evaluation of the SRHR/HIV Linkages Project

ICF International (ICF), with support from a South Africa-based regional partner, Other WISE Research and Evaluation (hereafter referred to as OtherWISE), worked with the UNFPA East and Southern Africa Regional Office (ESARO) and UNAIDS to conduct an evaluation of the SRHR/HIV Linkages Project. Evaluating the SRHR/HIV Linkages Project after five years of implementation is intended to help UNFPA, UNAIDS, and other key stakeholders more comprehensively assess (1) the relevancy of SRHR/HIV linkages to each country's context; (2) which key strategies and processes optimize effectiveness and efficiency of SRHR/HIV linkages across all seven countries; and (3) the degree of stakeholder ownership and sustainability of SRHR/HIV linkages in each country. The evaluation study explored these criteria for each country at three different levels (policy, systems, and service delivery) in

globally to contribute to universal access to RH commodities and family planning services and information, and to prevention of HIV and other sexually transmitted infections. Botswana is considered a "Strategic Support" country and received targeted support to advance and/or maintain ongoing progress towards reproductive health commodity security. An array of commodities were procured to address prevention, diagnosis, and management of reproductive tract infections and STIs, as well as HIV test kits and condoms (male and female). The two projects worked in close collaboration to ensure synergies and strategic leverage of resources, e.g., GPRHCS procured the commodities and the Linkages Project supported additional equipment needed for delivering integrated services in the demonstration sites.

order to ensure accountability to donors and other stakeholders and to provide an opportunity to derive lessons learned from SRHR and HIV linkages, including integration of sexual and reproductive health and HIV services.

The evaluation is intended to help key stakeholders in each country to better understand barriers and key solutions to strengthening linkages between SRHR and HIV policies, systems, and services; to assess how resources have been used; and to determine how health outcomes have been improved for populations served by linked SRHR and HIV country programs. Findings can be used to (1) inform proposed changes to the overall structure of the initiative; (2) enhance improvements to critical components of the comprehensive package of SRHR and HIV interventions; and (3) provide a basis for developing and sharing best practices with other countries beyond the region to promote more widespread adoption or encourage replication.

The specific objectives of the evaluation of the SRHR/HIV Linkages Project are:

To assess whether SRHR/HIV linkages are relevant to the country context across the seven Project countries

To assess the effectiveness of the SRHR/HIV linkages across the seven Project countries

To assess the efficiency of the SRHR/HIV linkages across the seven Project countries

To assess the ownership of SRHR/HIV Linkages Project by stakeholders and the sustainability of SRH/HIV linkages beyond the Project tenure in the seven Project countries

Exhibit 3 lists the key questions the evaluation addressed along with the relevant area of investigation.

Exhibit 3: Key Questions and Areas of Investigation

Key Question	Area of Investigation
1. Was and is the SRHR/HIV Linkages Project aligned to the priorities or needs of the countries in the 7 Project countries?	**Relevance:** Relates to national priorities and needs, policies, client needs, and how the Project addresses changing national contexts.
2. To what extent did the Project achieve SRHR/HIV linkages at the policy, system, and service delivery levels and other results areas?	**Effectiveness:** The extent to which the results were achieved.
3. To what extent were the Project resources (human, time, financial, etc.) used to achieve the three results areas of SRHR/HIV Linkages Project?	**Efficiency:** How funding, personnel, administrative arrangements, partnerships, governance arrangements, time, and other inputs contributed to or hindered the achievements of results.
4. Have Project stakeholders in the seven Project countries sustained interest and resources to continue with SRHR/HIV integration beyond the tenure of this Project?	**Sustainability:** The extent to which the benefits from the Project are likely to continue after completion, while taking into account the existing partnerships and the capacity required for maintaining consistent levels of delivering SRHR/HIV integration services.

2.2 Evaluation Design

The evaluation of the SRHR/HIV Linkages Project used a mixed-methods approach that combined quantitative and qualitative components to gather information on the context of SRHR and HIV linkages in each country. Both the quantitative and qualitative components sought to provide insights into the relevance, effectiveness, efficiency and sustainability of the UNFPA/UNAIDS SRHR/HIV Linkages Project at all levels. For Botswana, the quantitative approach included three components: (1) secondary analysis of SRHR/HIV linkages indicator data, (2) secondary analysis of facility-level service-utilization data from select facilities, and (3) client exit interviews at select facilities. Indicators were analyzed to identify the extent to which the Project was relevant to national priorities and to client needs; the extent to which the Project effectively achieved specific outcomes like increasing the availability and uptake of SRHR and HIV services; the extent to which these services were provided in an efficient fashion, related to the resources allocated to the Project; and the extent to which the Project was taken on and can be sustained by the Ministry of Health. Where possible, this has been reported in terms of the three result areas. The secondary analysis of facility-level service-utilization data examined effectiveness and efficiency, and the client exit surveys were analyzed for relevance, as well as effectiveness and efficiency.

The qualitative study complemented the quantitative study and included (1) a desk review, (2) focus group discussions (FGDs) with clients at select facilities, and (3) key informant interviews (KIIs). Data from the KIIs were analyzed to identify the relevance, effectiveness, and efficiency of the Project reported by key informants, as well as the extent to which the Project was taken on and can be sustained by the Ministry of Health. Data from the FGDs were analyzed to determine the relevance of SRHR/HIV linkages to client needs, and clients' perceptions of the efficiency and effectiveness of integrated services at a single facility. The following sections describe the study methodology in detail, including the methodology for data collection, the techniques used to analyze the data, and the limitations that arose in gathering the data, as well as a summary of the data that was gathered via each method and a description of how the findings are presented.

2.3 Institutional Review Board Approvals

Given that the proposed research involved gathering data from key informants and clients about SRHR and HIV issues, ICF applied for and received approval to conduct the study from both the ICF internal institutional review board as well as the Health Research and Development Division of the Ministry of Health in Botswana. Approval from MOH was granted on 21 April 2016.

2.4 Quantitative Components

2.4.1 SRHR/HIV Linkages Indicator Data

The main objective of the secondary data analysis was to compare the latest results (2015) for each country to their established targets in order to determine the effectiveness of the Project by the three results areas. The analysis focused on the list of indicators provided for each country by the UNAIDS and UNFPA Evaluation Managers (EMs).

The indicator data provided to ICF by UNFPA and UNAIDS EMs for Botswana (Appendix A) were incomplete, which was a significant limitation to this analysis. Some indicators have targets, an indication of what has been achieved by 2015, and a document or note intended to verify the achievement. In many cases, however, there is either no change or no 2015 achievement cited; no target listed; or the 2015 achievement is listed without a data source is listed to corroborate the 2015 achievement (or vice versa). To minimize this limitation, ICF reviewed documents provided by key informants in Botswana in order to identify whether additional achievements had been made or could be corroborated: ICF reviewed 22 documents that are now reflected in our discussion of the indicator data. A list of the documents reviewed is included in Appendix B

Facility Service Utilization Data (Selected Countries/Facilities)

In Botswana, ICF also sought to conduct a secondary analysis of service utilization data from facilities where the Project was implemented in order to compare utilization before and after integration. These data would provide information on the number of clients who used SRHR services, the number who used HIV services, and the number who used both SRHR and HIV services in the past two years, which could be compared to a similar time period across facilities and countries, to determine the effectiveness of integrated services. However, while ICF requested these data from the Botswana Project Coordinator, the data were not available at the time of request.

Client Exit Survey

ICF surveyed clients' perceptions of the relevance, effectiveness, and efficiency of integrated SRHR/HIV services using short interviews conducted by local ICF data collectors as clients exited three facilities inBotswana. The facilities were selected in consultation with the EMs, the Regional Reference Group, and the National Reference Group. The local data collectors used a questionnaire for each interview that asked clients for demographic information, and about the services they received on the day of their visit to the facility (including services sought and received, whether multiple services were received, and awareness of services), and their overall satisfaction with the individual and integrated services (in terms of quality, cost, and time), using a series of close-ended questions and Likert-type scale items. A draft of the questionnaire in English can be found in Appendix C. The questionnaire was translated into the appropriate local language for the selected facilities in Botswana. To the greatest extent possible, questionnaires were administered by a data collector of the same gender as the client.

As noted in the Inception Report, the data from the client exit interviews represent a snapshot of client perspectives from a subset of clients for one day at each facility, and thus are not generalizable beyond those clients or those facilities. Further, other limitations may have arisen in the implementation of the client exit interviews, primarily in terms of clients' understanding and recall, but also in terms of data collection. First, in Botswana, the questionnaire was translated into Setswana, as directed by the National Reference Group, but clients may still have struggled to understand the questions in cases where they spoke another language at home, such as Sekgalagadi or Sekwena. Second, when asked about wait times, clients may also have inaccurately estimated their wait times if they calculated from the point when they registered for a service to when they received it, rather than calculating from when they arrived at the facility. Third, clients may not have been familiar with the terms "integration" and "linkage," even if these were translated into local languages, regardless of whether they were accustomed to receiving services in an integrated fashion; in addition, clients may not also have been able accurately recall all of the services that they have received. Further, because of the timing of data collection at each facility, clients selected for the client exit surveys were those who received services earlier in the day. As a result, this sample may not have included those who had to travel further and arrived later in the day.

In terms of data collection limitations, we were not always able to match the gender of the local data collector with the gender of the client being interviewed; this may have impacted the clients' willingness to share. Finally, while training was provided to local data collectors, they may not always have followed the same protocol, and because study coordinators did not speak the relevant local language, it was difficult to detect a lack of fidelity.

For the client survey data analysis, ICF ran frequencies for each item and for the scale data. Client exit interviews were conducted with 60 clients at Mochudi Clinic, Khudumelapye Clinic, and Otse Health Post; Demographic information on the clients who completed the client exit interviews is presented in Exhibit 4 below.

Exhibit 4: Botswana Client Exit Interviews: Demographics

		n	%
Sex *(N = 60)*	Female	48	80.0%
	Male	12	20.0%
Marital status *(N = 60)*	Single	39	65.0%
	Married/living together	21	35.0%
Education *(N = 60)*	Did not attend school	10	16.7%
	Primary	13	21.7%
	Secondary	33	55.0%
	More than secondary	4	6.7%
Employment *(N = 60)*	Unemployed	45	75.0%
	I work at home	1	1.7%
	I work part time	6	10.0%
	Employed (full time, outside the home)	8	13.3%
Language spoken at home	Sekgalagadi	6	10.0%

Continued

Continued

(N = 60)	Sekwena	1	1.7%
	Setswana	53	88.3%
Age *(N = 57)*	18–20 years old	2	3.5%
	20–30 years old	16	28.1%
	30–40 years old	19	33.3%
	Older than 40 years of age	20	35.1%
Length of time individual has been using/accessing clinic *(N = 60)*	First visit	2	3.3%
	Less than 1 year	8	13.3%
	1–5 years	23	38.3%
	5–10 years	5	8.3%
	More than 10 years	22	36.7%

2.5 Qualitative Components

2.5.1 Desk Review

A desk review for Botswana was conducted that focused initially on 16 key SRHR/HIV Linkages Project documents, including messaging materials like a "Know Your Rights" poster and card; newspaper articles; Project dissemination materials, like the Project one-pager for Botswana; a "Good or Promising Practices" document and video; and Project planning documents like the Botswana Project Rapid Assessment report, Strategy and Implementation Plan, logical framework (log frame), and a costed scale-up plan (a list of documents reviewed is provided in Appendix B).

Review of these strategic documents provided information on context, strategies, policy, and best practices that are being implemented. This information was used to inform the design for the evaluation of the SRHR/HIV Linkages Project and drafts of data collection instruments and tools, and to inform our interpretation of both quantitative data described above and findings from the KIIs and FGDs described below. We also gathered additional documents as a result of conducting KIIs; we added these documents to the desk review to inform our understanding of the outcomes of the SRHR/HIV Linkages Project. In total ICF, reviewed 22 documents, including 6 additional documents, that are reflected in our discussion of the findings.

Key Informant Interviews

The ICF team conducted a series of in-person KIIs in Botswana to explore key informants' perceptions of the relevance, effectiveness, efficiency, and sustainability of the SRHR/HIV Linkages Project in each of the three results areas. ICF used a semi-structured discussion guide to elicit interviewees' perceptions on these issues, tailored to their role and the level of inquiry. The semi-structured discussion guides used for each type of respondent can be found in Appendix D.

The KIIs were recorded; these recordings were used to supplement or clarify the notes. We conducted a thematic analysis of the qualitative data, employing inductive and deductive analytic coding techniques. We used both pre-determined and emergent codes to identify themes in the data. The themes included key informants' understanding of the relationship between integration and linkages; availability of infrastructure, commodities, and services; the policy environment; clients' access to, knowledge about, and perceptions of the quality of services; related government initiatives and funding; and the availability of trainings on SRHR/HIV linkages.

KIIs were conducted in English by the ICF/OtherWISE study coordinators. This may have been a limitation: while all key informants spoke English, some key informants may not have felt completely comfortable conversing in English and may not have been able to fully express themselves. In addition, we only sent female study coordinators to each country, and in cases where their gender was different from any of the key informants being interviewed, this may have impacted the key informant's willingness to share their complete opinion. Further, key informants may have provided socially desirable responses that spoke primarily to the success of the Project, because the evaluation was perceived to be linked to additional funding. Finally, though key informants were initially identified by the National Reference Group, not all of those initially identified were not available. Some substitutions were made from within invited participants' organizations. As a result, those interviewed may not have had the same level of knowledge as the originally identified key informants.

In Botswana, 16 KIIS were conducted with
Four MOH representatives, including the Permanent Secretary; Public Health Specialist and Acting Director—HIV; Acting Director, Department of Public Health; and the Principal Health Officer HIV, Principal Health Officer SRH

Four District Health Officials, including a Principal Officer; a Nurse and Head of the HIV/AIDS Preventive Department; the Principal/Registered Nurse-Midwife, who served as district Focal Person for PMTCT (prevention of mother-to-child transmission of HIV) and Linkages; and the Head Nurse of Mochudi Clinic

Four representatives from local NGOs (BONEPWA and Ceyoho), interviewed together
Five facility-based health care providers, including a Principal Nursing Officer and Registered Midwife, General Nurse, Chief Registered Nurse, Principal Registered Nurse-Midwife, and a Health Care Assistant
Two UNAIDS/UNFPA representatives, including the Assistant Representative, UNFPA Botswana and the Country Representative/Director, UNAIDS Botswana

In the findings section, findings from the KIIs regarding relevance, effectiveness, efficiency, and country ownership and sustainability are presented as summarized statements from key informants at various levels, and not attributed to a given key informant type to protect the confidentiality of key informants.

Focus Group Discussions (FGDs)

In order to explore clients' perceptions of the relevance of integrated SRHR/HIV services to their circumstances and the effectiveness and the efficiency of those services, ICF conducted FGDs in Botswana with both male and female clients. We used an FGD facilitation guide (Appendix E) that included items that explored perceptions of the utility of integrated services at the facility visited, recent experiences at the facility, and suggestions for improving services.

FGDs were moderated by local data collectors in the language spoken in the area around the facility. One local data collector acted as moderator, and one as note-taker. FGDs were conducted under the supervision of an ICF study coordinator and were audio-recorded. Facilitators and note-takers were of the same gender as the participants for each group to mitigate potential gender power imbalances and taboos that might inhibit both men and women from speaking about SRHR and HIV issues in mixed gender groups, and to encourage participants to share freely about their experiences.

There are several limitations associated with the FGDs. First, FGDs were conducted in a local language in each site. ICF study coordinators did not speak the local language and thus were completely reliant on local data collectors for translation. As a result, they could not accurately monitor clients' participation or detect a lack of fidelity to the FGD guide. Second, focus groups were conducted on the same day as the client exit surveys, because clients could not typically return to the facility on a second day just for the FGD. This led to first time clients at the facility being recruited for the FGD, limiting their ability to respond to some questions. Further, while participants were intended to be randomly selected for the FGDs, in one facility in Botswana they were recruited by the facility and did not also participate in an exit

interview. Finally, when responding to questions in the focus groups, cultural mores may have limited clients' willingness to criticize health care providers.

A similar thematic analysis approach used for the KIIs was used for the FGDs. These data are also presented as aggregate summary statements in the findings section.

The ICF team conducted four FGDs in Botswana with 15 male clients (eight in Khudumelapye Clinic, seven in Otse) and 15 female clients (eight in Khudumelapye Clinic, seven in Otse). FGD participants in Otse were randomly selected based on their participation in the client exit interviews, but FGD participants in Khudumelapye were recruited by the facility beforehand and thus had not completed a client exit interview. No incentive was provided for focus group participation, per the direction of the MOH.

3. SUMMARY OF FINDINGS

The findings from the evaluation for each of the four key areas of investigation are presented below. First, the findings address the main objectives of the Project, to assess (1) the relevance of SRHR/HIV linkages to the Botswana context; (2) which key strategies and processes optimized the effectiveness of SRHR/HIV linkages in Botswana; (3) measures of efficiency of linkages applied in Botswana; and finally (4) the degree of stakeholder ownership and sustainability of SRHR/HIV linkages in Botswana. Finally, the findings conclude with lessons learned by the key stakeholders about implementing the Project. Within each section, where relevant, findings are discussed in terms of the three results areas: policy, service delivery and scale-up, and documentation and dissemination of best practices.

3.1 Relevance of the UNFPA/UNAIDS SRHR/HIV Linkages Project to Botswana

As mentioned earlier, a key area of investigation for the evaluation is (1) understanding the degree to which the SRHR/HIV Linkages Project was and is aligned to national priorities and needs, policies, and client needs in each country and (2) understanding how the Project addresses changes within the national context.

To better understand relevance of the Project to each country's national priorities and needs, the evaluation team looked at the policy environment in which the Project was implemented, including existing policies that pre-dated the Project, prior efforts related to integration, the existence of prior and current projects that also focus on HIV and SRHR issues, and the extent to which clients received the services they sought within a reasonable timeframe.

3.1.1 Policy

National Priorities

Key informants reported that the WHO rapid assessment conducted in 2008, which gauged the degree of integration and the need to strengthen integration and linkages between SRHR and HIV in Botswana, informed the adaptation of the SRHR/HIV Linkages Project to the Botswana context. Key informants described a need to integrate services because of major challenges Botswana had faced in the past, including high teen pregnancy/fertility rates and high HIV prevalence, as well as opportunities to build on Botswana's strong existing primary health care systems. In addition, since Botswana is transitioning to a middle-income country, will likely receive less donor support over time, there is a need to leverage resources and re-allocate funding for impact. Linkage and integration provide one way to achieve this.

Changes to Laws or Policies

As noted above, key informants reported that there was an existing strong focus on integrated primary health care in Botswana; one key informant described it as predating the 1978 Alma Ata Declaration. Key informants cited the National Strategic Framework for HIV and AIDS I, the National Development Plan, the National HIV Treatment Guidelines, the National HIV Policy, and the Public Health Act (which has a section on HIV) as examples of laws and policies that existed prior to the Linkages Project that provided a policy environment into which integration and linkages could be incorporated.

In terms of new laws or policies (i.e., changes to the policy environment) that affect SRHR/HIV linkages and integration, key informants in Botswana reported that there have been addendum reviews of existing policy documents to incorporate integration service guidelines. These have been conducted in order to identify ways to strengthen integration. Three policies have been updated with language on integration, including the Second National Strategic Framework for HIV and AIDS, 2009–2016 (NSF II), the National Development Plan11 (NDP 11), and the National HIV Treatment Guidelines. NSF II specifically describes the SRHR/HIV Linkages Project and the need for integration and future actions to scale-up integration across the country. In addition, Botswana developed an SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan, which provided extensive guidance on integration.

Prior and Existing Projects in Each Country

Key informants reported that STI, PMTCT, and anti-retroviral (ARV) therapy (ART) services were all already provided at health facilities in Botswana and that there had been some linkages between programs by referrals to other units and sections of facilities prior to the launch of the SRHR/HIV Linkages Project in 2011. Specifically, different SRHR services, such as maternal and newborn health and family planning, had been integrated since the mid-1970s because of a long-standing focus on primary health care in Botswana; community health workers were already going from house to house providing family welfare education. According to key informants, in Botswana, HIV was initially introduced into SRHR but split off as donor funding focused on HIV-specific activities with their own objectives/indicators, and as the national HIV program employed people directly. In addition, key informants also reported that some integration was already happening prior to 2011 by default because of staff shortages in small facilities. They noted that there was some integration of condom provision with PMTCT services.

In addition, key informants described a number of prior projects focused on SRHR and/or HIV implemented in the same districts as the SRHR/HIV Linkages Project. These projects may have had a complementary effect, in that they synergistically contributed to the Linkages Project's efforts, but they may also have had a confounding effect. According to key informants at the facility level, this included a PEPFAR campaign, implemented by FHI360, which focused on the UNAIDS 90/90/90 HIV/AIDS targets by offering HIV testing. Key informants reported that this project contributes to linkages; previously, HIV testing was only offered in the HIV services, but now clients are offered an HIV test before any other service at other entry points, which has increased entry points for HIV testing and the referral networks from different entry points into the ART clinics. Thus, this has strengthened HIV testing, and given that the donors work together to prevent overlap in villages, it has done so without confounding the services offered by the Project. Key informants also identified a MOH and PEPFAR-supported National Cervical Cancer Prevention Programme predominantly offered in the SRH units in all health facilities. Because of the fact that cervical cancer is more common among the HIV positives, screening for cervical cancer has been introduced in all IDCC clinics, including those that have been reorganized under the Linkages Project as well as others that have not yet been involved in linkage and integration. The programme has introduced VIA screening, cryotherapy and LEEP treatments. In addition, Botswana has strengthened primary prevention for cervical cancer by introducing an HPV vaccination programme supported by MOH. The latter has been integrated into the expanded programme on immunization and the school health program. Key informants described existing domiciliary care campaigns that involved home visits for women who had recently delivered, as well as a TB screening project initiated by one facility.

3.1.2 Service Delivery

The findings from the client exit interviews conducted as part of this evaluation suggest that clients find integration relevant to their needs and contexts. First, as shown in Exhibit 5 on the following page, most clients (86.4%) receive the services that they seek. The largest group of clients (44.1%) were seeking child welfare care services, followed by ART/ARV services (18.6%) and HIV testing (11.9%). However, slightly less than a quarter (22.8%) of clients reported receipt of additional services. Overall, the largest group of clients who received additional services had received HIV testing (46.2%).

Exhibit 5. Botswana Client Exit Interviews: Services Sought and Received

		n	%
Services sought *(N = 59)*	Child welfare	26	44.1%
	ART/ARVs	11	18.6%
	HIV testing	7	11.9%
	Antenatal	4	6.8%
	Other	6	10.2%
	Family planning	5	8.5%
	STI screening	0	0.0%
Was sough service received? *(N = 59)*	Yes	51	86.4%
	Partially	4	6.8%
	No	4	6.8%
Were other services received? *(N = 57)*	Yes	13	22.8%
Type(s) of other services received *(N = 13; totals may be higher since clients reported receiving multiple other services)*	HIV testing	6	46.2%
	STI screening	3	23.1%
	Child welfare	3	23.1%
	Family planning	2	15.4%
	ART/ARVs	2	15.4%
	Antenatal	1	7.7%
	Other	1	7.7%

These findings align with the results of the Client Satisfaction Survey conducted by MOH in 2015, which showed similar trends: most clients received the services they sought (87.9%).

These findings are supported by the findings from both the male and female FGDs. Typically, clients reported that the availability of SRHR and HIV services benefitted them and was thus relevant to their circumstances. Male and female clients in the FGDs reported they were able to access PMTCT, couples HTC, and voluntary male medical circumcision services, as well as receive prevention commodities like condoms. Female clients in the FGDs highlighted the opportunity to learn about the PMTCT program and family planning issues, which helped to promote family welfare and health. This included learning about safe and unsafe sex including condoms; the influence of alcohol; about other STIs, not just HIV/AIDS; about how protect their babies from being infected with HIV through the PMTCT program; and about how to space their pregnancies. The provision of HTC as part of the PMTCT program also enabled them to determine their status, as well as their children's, immediately.

Key informants also described the relevance of the services provided for clients, focusing on the benefits of colocation of SRHR and HIV services; opportunities to provide comprehensive care to PLHIV, to provide client-centered and not objective-focused care, and to provide clients with all of the services they need at the same time, including dispending of their medications. They also noted that facilities that offered integrated services via a "kiosk" model (typically health posts) could reduce stigma by providing all services in one room.

3.1.3 Documentation/Dissemination of Best Practices

In terms of policy changes, the inclusion of language on integration in the NSF II, the NDP 11 and the National HIV Treatment Guidelines should be shared as examples of how integration can be incorporated into existing policies. These policies are also reflected in an Outcome indicator that specifically looks at the percentage of national health policies and plans incorporating strategies that link SRH and HIV, and in Activity indicator related to an "inventory of policies and guidelines incorporating SRH/HIV linkages," along with an Investment Case Report, which UNAIDS built for the MOH and the NACA by testing different approaches to see what model of integrated family planning was most effective at reducing new HIV infections.

In addition, Botswana's SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan should also be shared as an example of an overarching integration plan. This plan also fulfilled three Outcome indicators: "existence of integrated SRH/HIV strategy," "strategy for the implementation of agreed priorities approved by national stakeholders" and "SRH/HIV linkage and integration strategy including M&E plan developed."

In terms of documenting relevance in terms of service delivery, Botswana published a report in December 2015 on the results of the Client Satisfaction Survey that showed a similar trends of clients receiving the services they sought. The Client Satisfaction Survey is also captured by the Output indicator "number of operational research conducted," as well as the achievement that Botswana reports for "number of research recommendations implemented," and "number of evaluation research conducted," all of which are indicated as 1 in the list of Output indicators.

3.1.4 Discussion

Findings from the KIIs suggest that the provision of integrated SRHR and HIV services is relevant to the Botswanan legal and policy context because of the existing strong focus on integrated primary health care, and because of laws and policies that existed prior to the Linkages Project that provided a policy environment into which integration and linkages could be incorporated. Further, the findings from the client exit interviews suggest that the services provided are relevant to client needs: most clients are receiving the services that they seek. While less than a quarter receive additional services, most of those who do receive HTC as the additional service, which is promising. Finally, the report on the 2015 Client Satisfaction Survey provides similar findings, which corroborate the findings from the client exit interviews. It also provides additional findings that are described in subsequent sections, as well as a model for surveying both clients and providers that could be adopted in other countries that have not yet conducted similar research.

3.2 Effectiveness of the UNFPA/UNAIDS SRHR/HIV Linkages Project

As noted in the overview of the evaluation, the effectiveness of linkages between SRHR and HIV is expected to improve health outcomes by improving access to and uptake of services, reducing stigma and discrimination. The evaluation explored the effectiveness of the SRHR/HIV Linkages Project in the three results areas—policy, service delivery and scale-up, and documentation and dissemination of best practices—in order to determine what had been achieved by the Project.

3.2.1 Policy

As noted in the Relevance section, key informants in Botswana reported that three policies (NSF II, the NDP 11, and the National HIV Treatment Guidelines) have been updated with language on integration, and an SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan had been developed. In addition, key informants notes that an Investment Case Report had been developed with support from UNAIDS, and that both the SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan and the Investment Case Report had been used to inform the development of a costed scale-up plan to support the scaling up of integration in all health facilities in Botswana. This was then presented as a concept note to the Global Fund to apply for funding to support scale-up.
However, key informants at the facility level were not aware of changes to policies, as these were not disseminated to them.

3.2.2 Service Delivery

Botswana implemented all three models of integration at different pilot facilities between 2011 and 2015. This included the "kiosk" model, where services are provided by a single health care provider in the same room, at health posts and smaller clinics; the "supermarket" model, where services are provided in a number of rooms by different health care professionals, at larger clinics; and the "mall" model, where clients are referred to different rooms within the same health facility to be provided different services by different health care professionals, at hospitals.

According the SRHR/HIV Output indicators, Botswana exceeded the target of eight for the number of health facilities providing both SRHR and HIV comprehensive services, with nine facilities providing integrated services. Further, they also achieved the target of three for the "number of districts with NGOs implementing SRHR/HIV and AIDS linkages/integration activities," thus increasing the number of facilities where clients can access integrated services. Similarly, Botswana has also achieved the targets for the "number of programs supporting rights education, access to HIV-SRHR integrated services, or to reduce stigma/discrimination" (1), and for the "number of programs implemented to reduce stigma and discrimination" (1). Finally, although there was no target set for this Output indicator, Botswana reported implementing two "programs implemented involving men or vulnerable groups."

Key informants reported that NGOs' role in linkage and integration of SRHR and HIV programs and services was to promote these integrated services as part of the work they do in terms of youth outreach. Specifically, NGOs focused on providing information on ART initiation and follow-up counseling, as well as recommendations for facilities where services are integrated in an effort to link HIV positive clients to care and prevent default or loss-to-follow-up. In terms of community mobilization, this has included promoting services to sex workers and LGBTI populations, providing counseling to members of these key populations, and encouraging employment alternatives for sex workers.

As shown in Exhibit 5 above, per client exit interviews, efforts to provide integrated services at pilot facilities in Botswana have been effective in increasing the number of services available to clients, and enabling most clients to receive the services they seek. However, this measure of effectiveness is somewhat diminished when we consider that, according to the client exit interviews conducted for this evaluation,6 just less than a quarter of clients receive additional services. Nonetheless, the fact that most report receiving HTC as the additional service is promising.

It is difficult to determine from client exit interviews conducted for this evaluation (and from the Client Satisfaction Survey conducted in 2015) whether there has been an effect on the number of clients seeking services due to integration, because these were single point-in-time surveys of clients. However, both facility-level key informants and documents developed by the Linkages Project provide evidence for increases in uptake of services. Key informants described increased uptake of services including HIV

6 This question was not asked as part of the Client Satisfaction Survey.

testing; family planning, including the provision of Pap smears and intrauterine devices (IUDs); and prenatal care, as well as increases in condom distribution. Botswana has reported a figure of 79 for the Outcome indicator "number of HIV-infected women accessing family planning services," but without a denominator or baseline/target, it is difficult to interpret what this means. Other documents, including a description of "good practice" and a UNFPA one-pager on the Botswana Linkages Project describe increases at facility and national levels in the uptake of services. Specifically, the one-pager describes increases from 2012 to 2013 in the number of clients accessing both HIV and family planning services (63%), the number of female family planning clients accessing both HIV and family planning services (89%), the number of female clients at HIV service delivery points accessing both HIV and family planning services (79%); and the number of female clients at HIV service delivery points screened for cervical cancer (47%). Notably, the latter three figures all increased from 0 in 2012.

According to key informants, increased uptake of services has led to decreases in rates of teen pregnancy, home births, TB, and default on ARVs (the last specifically because adherence counseling can be provided in a private area at the dispensary). Key informants also reported a decrease in the frequency of visits by each patient and fewer missed opportunities for services. Integration has brought successes, but also new challenges. Key informants at the regional level have noted that female clients do not go to the pharmacy at the hospital to collect their STI medications because the line is too long, after they condensed the pharmacy into one location. This happens even though the pharmacy prioritizes clients who have come for SRHR/HIV services.

Indicator data also tell a mixed story. Outcome indicator data show an increase in the percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention from 42.1% (to 47.9% (according to figures cited in the list of SRHR/HIV Indicators cited in the Botswana HIV/AIDS Impact Survey (BAIS) III from 2008 and the BAIS IV from 2013). However, Outcome indicators also show a decrease in the percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months reporting the use of a condom during last sexual intercourse from 89.3% in 2008 to 81.9% in 2013.

Another important measure of effectiveness is whether clients are aware that multiple additional services are available, regardless of whether they receive additional services or not. According to the client exit interviews,7 while less than a quarter of clients reported receiving more than one service, many of them were aware that there were other services they could request beyond the service(s) that they sought and received.

According to indicator data, there are three related Outcome indicators for which Botswana has reported exceeding the targets set. Botswana has developed and disseminated three types of SRHR/HIV Linkages promotional materials and procured three SRHR/HIV Linkages communication and visibility materials. The targets for each of these indicators was two types or examples of materials. Further, Botswana reported meeting their target for the number of IEC activities conducted by three District Health Management teams, and as a result reached the target of three for the number of communities reached with SRHR/HIV messages.

7 This question was not asked as part of the Client Satisfaction Survey.

Exhibit 6. Botswana Client Exit Interviews: Services Sought and Received

		n	%
Other services clients were aware of ***(N = 60)***	HIV testing	49	81.7%
	Child welfare	37	61.7%
	ART/ARVs	35	58.3%
	Family planning	35	58.3%
	Antenatal care	33	55.0%
	STI screening	33	55.0%
	Other	16	26.7%
Source of information on services ***(N = 60)***	Doctor or nurse	42	70.0%
	TV or radio	9	15.0%
	Friend or family member	6	10.0%
	NGO/community-based organization	1	1.7%
	All of the above	1	1.7%
	Other	1	1.7%
Awareness of integrated services ***(N = 60)***	No	21	35.0%
	Yes	39	65.0%
Source of information on integrated services ***(N = 39)***	Doctor or nurse	29	74.4%
	TV or radio	6	15.4%
	Friend or family member	3	7.7%
	All of the above	1	2.6%

As shown in Exhibit 6, above, most clients (81.7%) were aware of HIV testing services, even if they did not seek or were not provided with this service. Many (61.7%) were also aware of child welfare care services, and over half were aware of ART/ARV services, family planning (both 58.3%), antenatal care, and STI screening (both 55%).

Most clients who completed a client exit interview stated that a health care provider was their primary information source for services (70%); television/radio and friends and family were the next most cited sources (15% and10%, respectively). More than two-thirds of the clients (65%) were aware that services were integrated. Similarly, in terms of where they received their information on integrated services, most stated that the health care provider was their primary source (74.4%) followed by television/radio (15.4%). Findings related to awareness of services are supported by the findings of both the male and female FGDs. Male clients reported that couples HTC was available and promoted in all three facilities, encouraging both male and female partners to seek and receive HTC. They were also aware of the promotion of voluntary male medical circumcision as a means of risk reduction. Single male clients reported that the men's sector program promoted male visits to health facilities for free voluntary testing. Male clients also reported on the provision of information on ARVs and reproductive health through the PMTCT program.

Sources of information on services cited in the client exit interviews are supported by the findings from the FGDs. Female clients cited health care providers' morning health talks at each facility as a significant source of information on integrated services, but also reported hearing about integrated services via television/radio and workshops. Male clients in the FGDs reported learning about integrated services via television/radio, conversations with friends and family, and even at the facilities themselves. Male focus groups in one facility reported that there was a support group that educated the community about both SRHR and child welfare issues.

Key informants reported that efforts to increase awareness of integrated services had focused on community mobilization meetings with local politicians and elected officials, and community and traditional leaders as well as village health and development committees as well as via HIV support groups. They also reported that health care providers generated local demand for integrated SRHR/HIV services/programs via daily health education talks at the facilities, and that facilities had received some support from the district level to educate and sensitize local communities about integration and linkage. They also reported working with the Ministry of Education and implementing a "road show" to reach youth, and noted that this often reached entire communities. Key informants also reported that in order to generate demand for integrated services by key populations, health care providers gave in-service presentations to other health care providers on LGBTI populations and how to work with these populations, and are working with certain NGOs to reach these populations.

3.2.3 Documentation/Dissemination of Best Practices

Best practices related to effectiveness are documented in multiple documents provided by Botswana, including the Botswana SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan, the report on the 2015 Client Satisfaction Survey, the Final Inception Report for the Development of a Costed Scale-Up Plan for Sexual and Reproductive Health Rights (SRHR) and HIV Linkages in Botswana, and the concept note to the Global Fund to apply for funding to support scale-up that was developed from the costed scale-up plan.

Best practices are also described in the UNFPA one-pager on the Botswana Linkages Project, the Linkages–Good Practice document, the Botswana SRHR-HIV Linkages Program video, and in a personal story brochure created by the Project that has been shared with other countries via the Regional Project and at the Regional Project Steering Committee meeting which Botswana hosted in 2014.

Along with other countries, Botswana has contributed to overall findings in terms of effectiveness for the Project that have also been shared at regional meetings and international conferences, including the 2012 Integration for Impact—Reproductive Health & HIV Services in Sub-Saharan Africa conference; the 2014 UNFPA ESARO regional knowledge-sharing and capacity building meeting on Sexual and Reproductive Health and Rights (SRHR), including family planning, gender equality and human rights, HIV and gender-based violence (GBV) prevention, and adolescents and youth SRH/HIV; and collaborations between 2012 and 2015 with SADC to assist in the development of regional operation guidelines for integrating SRH and HIV.

In addition to the Client Satisfaction Survey, Botswana also engaged in a study on best-practice modalities and benefits of CSO involvement in supporting the scale up of integrated SRHR and HIV programs (conducted in Botswana, Malawi, and Swaziland). Botswana was also the only country that established a committee on visibility.

3.2.4 Discussion

As noted in the Relevance section, findings from this evaluation suggest that in Botswana the Project has been effective in changing three policies to improve support of integration. These changes have already been described in the Relevance section, as they demonstrate the relevance of the Project to the Botswana context. They are included here under Effectiveness because the Project has played a successful role in advocacy for these changes. However, more could be done to disseminate these policy changes, as key informants at the facility level were not aware of them.

In terms of service delivery and scale up, evaluation findings demonstrate improved availability of and access to integrated services, as well as increased uptake of services and increased awareness of services. Mention of increases in uptake of services suggest that both key informants and clients see the benefits of integrated and linked services for clients. Further, some SRHR/HIV indicators also show that the Project has increased the number of sites offering integrated services and meeting targets for the number of NGOs supporting integrated services and addressing stigma and discrimination. However, while increases for other indicators suggest that integration of SRHR and HIV services in Botswana is having a positive impact on clients' (especially youths') knowledge, decreases in condom use suggest that integrated services are not having the desired effect on preventive behaviors.

Findings on awareness are mixed. While the client exit interviews suggest that health care providers play the most important role in informing clients about services and about the integration of services, FGDs suggest that TV and radio play a key role, and key informants report that community mobilization meetings may also have had some impact. However, key informants also suggested that demand generation for youth through the road show may not be working, as the strategy employed by MOH of giving speeches without any services being offered may not be effectively reaching this population. Key informants at the national level also noted a need to increase community involvement or mobilize communities around integrated services in order to generate demand, and mentioned a related need for technical advice on behavior change communication.

3.3 Efficiency of the UNFPA/UNAIDS SRHR/HIV Linkages Project

A third area of investigation for the evaluation is understanding the extent to which Project resources (human, time, financial, etc.) were used to achieve the three results areas of the SRHR/HIV Linkages Project: policy, service delivery and scale-up, and documentation and dissemination of best practices. Linkages between SRHR and HIV are expected to improve health outcomes, streamlining services and reducing duplication of efforts, increasing the efficient utilization of human resources,1 and increasing cost effectiveness. The effectiveness achievements described in the prior section are examined below in terms of the level of resources expended to make those achievements, including human, time, and financial resources. Where possible, changes in effectiveness are also discussed in relation to funding from the EU and Sida for related activities to identify efficiencies. However, as noted previously, the structuring of budget reporting for EU and Sida funding may limit the inferences that can be made.

3.3.1 Policy

The Linkages Project has successfully contributed to advocacy for changes to three national policies in Botswana, which demonstrates not only the relevance of the Project but also its effectiveness. However, also as noted previously, key informants at the facility level were not always aware of these changes, somewhat limiting the effectiveness of these efforts.

Further, when comparing the achievements of efforts to change policies to line items and activities in the EU and Sida budgets for Botswana (Exhibits 1 and 2), it is difficult to identify which funds have been spent on related activities. No funds were spent on policy and planning reviews in Botswana using Sida funds, but some personnel time and therefore costs (reflected as 41.9.% on EU funding to Botswana) may very well have been spent on advocating for changes to these policies.

However, the fact that the Botswana SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan and the Investment Case Report have been used to inform the development of a costed scale-up plan and a concept note to the Global Fund to successfully apply for funding to support scale-up should be seen a measure of efficiency in the use of data and advocacy for changes at the policy level.

3.3.2 Service Delivery

Findings around service delivery efficiency focused on how physical (infrastructure and equipment), financial, human, and time resources were deployed to implement linkages and integration in Botswana and how clients and providers were affected by the implementation of the Project. Findings from the Client Satisfaction Survey, the client exit interviews and the FGDs conducted for this evaluation, and KIIs all contribute to evidence around clients' reports about changes in the quality of services; reasons for quality ratings or improvements; cost of services to clients; and the time spent seeking and receiving integrated services, as well as whether or not services are provided in a non-stigmatizing, non-discriminatory manner. Findings from the Client Satisfaction Survey (which included a Provider component) and KIIs present evidence from providers about preparation (training), workload, time and efficiency related to the provision of services. Finally, findings from the KIIs and the SRHR/HIV indicators describe challenges in efficiency related to reporting on the Project.
Facilities, Equipment, and Supplies

Key informants and FGD participants had mixed views of the efficiency of the Project related to the physical resources deployed for the Project at the facility level, in terms of the equipment and supplies, and in terms of facilities that were renovated or added to. Key informants at the facility level in select facilities typically reported that the resources provided enhanced the efficiency of service provision, in that health care providers were now assigned to one room which was equipped with all of the necessary supplies to provide integrated services. Further, key informants reported that facilities had been renovated or added onto provide additional rooms. Male clients in FGDs were generally pleased with the availability of integrated services at each site, citing the appealing look of additional portable structures provided by the Project as well as the availability of private space for client-provider consultations. They also reported that the additional facilities had generated a positive response from their community.

Key informants and clients in FGDs acknowledged that while there were additional private consultation rooms, rooms at facilities were small and crowded and more rooms are needed. Clients in FGDs reported that, at one site, the portable structure has apparently replaced the original facility instead of complementing it, and space problems persist. They also described a lack of facilities for labor and delivery. In addition, transportation was cited as a concern by both key informants and clients in FGDs, including transportation for client follow-up and for clients referred to other facilities, as well as transportation of samples. Female clients in a FGD at one facility also reported that their facility shared one ambulance with six other facilities. Key informants also reported that providers must negotiate with other facilities to use their vehicles to transport samples for testing, leading to delays in receiving test results. Key informants at both the national and facility levels also described how cellphones were used to follow-up with ARV defaulters. This was done in order to mitigate the lack of transportation as a challenge for ensuring client follow-up. However, key informants noted that this the use of cellphones for follow up only worked until the client's cellphone line was blocked.

However, in terms facility access, clients in the FGDs reported that transport is not a barrier that impeded them from visiting facilities. Where previously, some clinics offered only certain services like an antenatal clinic and HTC, clients reported that now they can get everything they need without having to travel to other clinics in different places.

Cost data and indicators also provide evidence of the efficiency of procurement of equipment, supplies, and commodities and the addition and renovation of facilities. Indicator data findings are mixed. On the one hand, for the Output indicators that describe the "number of porter cabins procured (SRH/HIV linkages space)" and "flowchart for health care providers in place," Botswana achieved the target of procuring two Portacabin and MOH-printed flowcharts and made them available. However, other related Output indicators ("equipment to support SRHR/HIV Linkage interventions procured," "furniture to support SRHR/HIV Linkage interventions procured," and "consumables to support SRHR/HIV Linkage interventions procured") were not enumerated and cannot be verified. Further, the Provider Component of the Client Satisfaction Survey, which captured provider's concerns about the impact of integration, suggested that 88.9% of providers felt that there was a need for equipment, supplies, and drugs. However, most of the providers who completed that survey felt that integration was not likely to impact space and privacy (72.2%). Nonetheless, procurement was likely successful, as Botswana has reported achieving a target of "0% of health facilities reporting HIV-SRHR commodities stock-out during last reporting cycle," supported in part by the funds spent by the Project and through participation in the GPRHCS program..

As shown in Exhibits 1 and 2, relatively small proportions of both EU and Sida funding were spent on procuring furniture and computer equipment (2.5% of EU funding), purchase or rent of vehicles (2.5% of EU funding), medical equipment and commodities (1.8% of EU funding), and review and procurement of reproductive health commodities (10.1% of Sida funding), included purchasing of furniture and equipment like a Pap smear specimen holder, suctions, trolley, scales, or couches; posters/banners and a car for the District focal person so that they would not have to rely on the ambulance to conduct visits; and providing supplies and informational materials like condoms, flip charts, and educational materials for every consultation room.

A significant proportion of Sida funding (40.4%) was spent on CSO models. CSO model funds were used by civil society Project implementers to refurbish centers or purchase mobile clinic units; conduct advocacy activities; run sensitization campaigns through mass media; print and distribute materials; fund demand-generation activities such as men's forums, community dialogues or teen clubs; and cover conference costs and operations research.

Clients' Views on Quality, Time, and Cost-Efficiency

According to the client exit interviews, as depicted in Exhibit 7 on the following page, most clients who completed client exit interviews rated service quality as either good (28.3%) or very good (55%). Most clients who completed the client exit interview either did not have to wait to receive services (25.4%) or waited less than an hour (47.5%); 25.4% waited more than one hour. In terms of costs, no clients reported paying for services and 78.3% did not have to pay for transport to the facility. Those who did typically reported paying between P4 and P8 (20%). While no clients reported paying other costs, one suggested that clients may have to pay for fuel for transportation. All clients reported that receiving integrated services was either better (28.2%) or much better (71.8%) than receiving non-integrated services, suggesting that the Project's provision of integrated services was effective. Most clients (55.3%) attributed this to reduced wait times, speaking to the efficiency of the integrated services.

Exhibit 7. Botswana Client Exit Interviews: Perceptions of Services

		n	%
Quality of services received *(N = 60)*	Poor	0	0.0%
	Bad	5	8.3%
	Just OK	5	8.3%
	Good	17	28.3%
	Very good	33	55.0%
Wait time *(N = 59)*	Did not have to wait	15	25.4%
	Less than 1/2 hour	7	11.9%
	1/2 hour	1	1.7%
	1/2 hour–1 hour	20	33.9%
	1–2 hours	7	11.9%
	More than 2 hours	8	13.6%
	Don't remember	1	1.7%
Cost of services *(N = 60)*	Free	60	100.0%
Cost of transport	Nothing	47	78.3%
(N = 60)	Less than P10.00	12	20.0%
	More than P10.00	1	1.7%
Other costs *(N = 60)*	None	60	100.0%
Relative value of receiving integrated services in one visit *(N = 39)*	Much worse	0	0.0%
	Worse	0	0.0%
	Neither better nor worse	0	0.0%
	Better	11	28.2%
	Much better	28	71.8%
Reason for rating *(N = 38)*	Reduced wait times	21	55.3%
	Doctor or nurse providing services	8	21.1%
	Reduced costs	9	23.7%

The positive findings about quality and timeliness of services from the client exit interviews conducted for this evaluation conflict with the mixed results of the Botswana Client Satisfaction Survey: the results of the Client Satisfaction Survey also showed that most clients (82.7%) were satisfied with the quality of services they were receiving, that most clients (73.6%) preferred receiving SRHR and HIV services at the same facility, and that reduction in trips to the facility was the most important benefit of integration (57.1%), with the opportunity to receive additional services (41.2) as the second most important benefit. However, the Client Satisfaction Survey revealed some disadvantages clients reported in receiving SRH and HIV services from the same facility at one time, including concerns that the service provider would be overwhelmed (35.2%), and that there would be an increase in wait times (26.9%) and a decrease in the quality of services (10.4%).

Findings from the FGD and KIIs regarding time and quality are also mixed. In general, clients in the FGDs reported shorter wait times for receiving services, being able to receive all of the services they needed in one room, being able to receive drugs in one place at one dispensary, and being able to easily navigate within the facilities. They reported being able to access all the services and satisfaction with client-provider interactions and short turnaround times for HTC results. However, some clients in FGDs also cited concerns about shortages of providers leading to long wait times. Male clients also cited long wait times as a barrier, as this required them to put aside daily work. Further, the time at which services are available was a reported barrier. Male clients typically want to come later in the day or at night so that there were no women to see them at the clinic; the lack of availability of service providers at that time may limit men's ability to access STI screening and treatment.

Key informants reported time and quality benefits for clients similar to those from FGD participants, including reduced patient waiting times and receiving all needed services on one day (as opposed to different days of the week) and at one site (instead of having to visit different facilities).
In addition, the findings from the client exit interviews on costs are also supported by FGD findings. Male clients in FGDs reported no costs for visits, and transport to the clinic was typically not an issue. Similarly, all of the female clients from both FGDs highlighted the fact that getting all their services in one clinic is cost saving because they do not have to travel from one clinic to another and could get all of their drugs in one place.

One specific area of efficiency was the reduction of stigma and discrimination. One Outcome indicator was that 4.3% of clients reporting stigma and discrimination in accessing SRHR/HIV services; this figure is a 2013 baseline, and without a 2015 achievement number it is difficult to interpret. However, both clients in FGDs and key informants reported a decrease in stigma and discrimination. Male clients in FGDs reported that providers are doing a good job sensitizing the community about HIV, such that stigma and discrimination have been reduced within the community as well as within the facility. Female clients in FGDs reported that they could freely consult with their providers with HIV/AIDS and SRHR-related issues because confidentiality is stringent, and since services are integrated, no one would know the type of service they came in for. Female clients highlighted that the health care providers in their facility are very friendly and approachable. In general, this is an important factor in their choice of facility, as is the convenience and availability of integrated services.

Key informants at all levels also reported decreases in stigma and discrimination as a result of integrated services. Key informants at the facility level specifically reported reduced stigma since they were able provide almost all services on all days, and because the health talks provided in integrated facilities dealt with multiple concerns this minimized stigma. Key informants at this level also reported that even in cases where they could not offer a given service (e.g., blood collection) every day, all clients regardless of HIV status came for blood collection on the same day, minimizing stigma.

However, key informants also noted that differences in culture between different ethnic groups within Botswana can be a barrier, as is gender equality around communication about family planning. Some female clients may feel shame and not be able to communicate with their male partners about family planning, and as a result, there is inadequate information about family planning.

Providers' Views of Quality, Time, and Cost Efficiency

Gains in efficiency from the clients' perspective must be balanced with key informants' descriptions of their own gains and the challenges faced in bringing integrated services to the clients. Key informants at the facility level reported that quality has improved since existing clients can be provided with all the services they need in one visit, and consultations simply augment prior discussions with clients. However, while consultation time for existing clients has decreased, new clients take longer in the appointment room. Further, key informants at the facility level reported that in the past three years, clients have complained about computers being used to enter data because it takes time for health care providers to first write down records on paper and then enter the data into computers, because the forms on the computer are not updated.

However, key informants at the facility level reported that integrated services preserved "nurses' energy and movement" because clients and health care providers spent less time moving from one room to another. They also noted that this reduced the number of visits that clients have to make, in turn reducing the number of general consultations that providers have to do. The Provider Component of the Client Satisfaction Survey also captured provider's concerns about the impact of integration on the amount of time spent with clients (94.4% cited this as a concern) and the workload for providers (83.3%).
While key informants did not describe cost savings for clients, they did describe cost savings as a result of early cancer cervical screenings and identification of precancerous lesions early.
In terms of efficiency, key informants at the facility level reported that linkages and integration have helped staff to better use resources dedicated to SRH and HIV programs and services and to package services easily. The provision of SRH/HIV services as a one-stop shop has resulted in better use of already constrained human resources.

Key informants at the national level reported that the HIV and SRH district officials conduct planning together and meet every morning to settle issues, including looking for opportunities to combine trainings; e.g., a TB training might cover family planning, or hypertension, or whatever else was new at the moment. Further, key informants at the national level also report that they are able to collaborate on budgets for integrated services, which allows them to tap into HIV funding, which is generally greater than SRHR funding.

Staffing, Training and Motivation

Findings around training and staffing in terms of the efficiency of service delivery in Botswana are mixed. In general, health care providers have been trained and are therefore better able to provide almost all services required by clients with minimum referral, especially in smaller health care facilities. Key informants at the facility level reported receiving an initial package of training specifically for linkages that included training/mentorship and supportive supervision from the district health office. They also reported receiving family planning trainings and trainings on dried blood spot sampling (but not rapid HIV testing), and Pap smear booster trainings that focused on interpreting results, referrals for follow-up, and IUD insertion skills, as well as trainings on emergency contraception and how to recognize and provide services to MSM. However, since that initial training, they reported that new nurses were receiving ad-hoc, on-the-job, but not formal training. This has not happened without some resistance, for instance, by male nurses who did not initially want to provide Pap smears. However, providing integrated services has become the norm at facilities.

Key informants at multiple levels reported that providers are now more competent, had higher levels of job satisfaction, and had undergone a change of mindset enabling them to see the importance of integrating services for clients. Key informants also reported that health posts have been more successful than other facilities at integrating SRHR and HIV services, because there is usually only one provider there who has to provide all services. They also reported that the 24-hour clinic has been more successful because the health care provider at this facility received training and because of their focus on youth.

As noted previously in Exhibit 1, the largest portion of EU funding for the Project in Botswana (41.9%) went to personnel (though it is difficult to tell to what extent this was spent on salaries as opposed to training activities), and 23.6% of Sida funding went to "health service providers capacity building." Relatedly, key informants described how the initial Rapid Assessment for the Project drove training needs and as a result, training focused more on the general approach to linkages and integration rather than specific services. Further, Output indicator data show that Botswana exceeded targets set for the "number of program managers trained (on SRHR/HIV linkages and integration)," training 40 program managers instead of the target of 30 and for the "number of service providers trained (on SRHR/HIV linkages and integration)," training 77 health care providers instead of the target of 45.

However, Botswana also reported no achievement (0) for Outcome indicators that reported the "number of service providers trained (on stigma and value clarification)" and whether "SRH and HIV/AIDS [have been] harmonized into the in-service curricula for service providers," stating that the "Integrated Curriculum [was] currently be[ing] developed first." In addition, no figures were provided for the "percentage of health care providers trained on SRHR/HIV linkages and integration", for the "number of service providers trained (on stigma and value clarification)," for the "percentage of health care providers who undertook training on Care for Carers program," and the "number of service providers trained on rights-based approach to service delivery." However, this may simply reflect a lack of up-to-date documentation for the indicators, as compiled narrative reports from the Regional Project level describe an integrated SRHR/HIV curriculum that the University of Maryland Botswana was developing with support from the EU and PEPFAR to consolidate existing SRH/HIV curricula and develop a harmonized curriculum. Further, key informants have also reported that lecturers from the University have been involved in the development of integrated FP materials, that 16 lecturers have been introduced to the integration concept, and that some curricula were already integrated because they were primary health care-focused. In addition, the compiled narrative reports also describe two training sessions conducted, one at the beginning of the pilot in 2013 and the second occurring later in the Project that targeted the health workers that work closely with CSOs. In addition, complied narrative reports also show that the Botswana MOH includes staff of relevant CSOs when conducting PMTCT training for its own health workers, in an effort to increase technical knowledge among civil society workers, as well as related work in 2013, to raise the capacity of Guidance and Counselling teachers in primary and secondary levels on life and livelihood skills.

However, while they acknowledge the importance of the initial training package, key informants have said that there have not been enough trainings, for instance, there have not been enough on management of linkages at the district level. Key informants have also described a lack of health care providers trained and certified to provide specific services, e.g., Rapid HIV Testing (RHT). As a result, the lack of rapid results for HIV tests leads to clients being lost to follow-up between testing and provision of results. Certification to provide HTC is also reported as a challenge by key informants at the facility level; due to recent changes in HIV testing kits, everyone has had to be re-certified, and as a result there are not enough health care providers to conduct HTC. Similarly, key informants reported that laboratory standards for HIV testing are a barrier to implementing linkages/integration, because in larger facilities, only laboratory technicians, and not nurses, can perform RHT. Laboratory workers are resistant to giving up their territory, and nurses do not necessarily want the additional work since integration primarily consists of task-shifting to nurses. Similarly, because CD4 testing is done at the hospital, smaller facilities like those visited do not collect blood samples, and patients must be referred. However, there is no mechanism in place to track whether or not patients have had CD4 tests conducted.

Key informants also cited restrictions on health care providers prescribing and dispensing ARVs to the same client as a challenge, along with the need to train more providers to prescribe ARVs. Another health care provider has to check their work as a means of reducing errors, which was perceived as increasing providers' workloads. Further, there are limited numbers of providers who can prescribe ARVs; for some facilities this means infrequent visits by a physician to consult on ART. Finally, key informants report

that clients' preference for being seen by a physician rather than by a nurse for certain services is another compounding factor.

In terms of staffing, key informants at all levels have described staff shortages as a challenge to efficiency. This includes staff transfers outside of the district that take providers trained in linkages without replacing them with providers with the same skillset. According to key informants, staff shortages in terms of service delivery included a lack of midwives to provide antenatal care, a lack of lay counselors to provide HIV testing, and a lack of funding available to hire more staff, as well as staff shortages at both the district level and within the Ministry, especially due to recent staffing changes when staff left MOH. As a result of staff shortages, staff workloads have increased and key informants at the national level also acknowledged that staff motivation was a concern. A key informant at the national level noted that facility staff may have been demotivated by their environment but that the Project has paid attention and given them new structures, which may have improved motivation.

In order to address these concerns, key informants at the district level reported that they had leveraged staff, supported NGOs funded by other bilateral donors, and focused on HTC as a means of addressing the shortage of trained staff. In terms of staff motivation, they reported that they overcame this challenge by offering awards, focusing on staff wellness, sharing feedback from clients, and by nominating a performer of the month. However, staff shortages did not go unnoticed by clients; female clients in FGDs reported that a shortage of nurses leads to multi-tasking, which diminishes effectiveness and efficiency.

A key strategy applied at the facility level to address staff shortages and workload was task shifting, where health care assistants and lay counselors are tasked with providing initial services to relieve the burden on higher-skilled nurses. For instance, in one faculty, antenatal clients go to the lay counselor first for testing/consultation so that the nurse knows their status before they arrive. In another facility, health care assistants provide child welfare care, but refer clients to higher-skilled nurses for family planning and immunizations.

Reporting on Implementation of SRHR/HIV Linkages and Integration

Findings in terms of reporting on implementation of linkages and integration were mixed. On the one hand, key informants reported that UNFPA provided M&E support by improving data and M&E and pushing for integration of systems and tools. This included helping to develop skeletal tools that will be integrated into the M&E system, supporting the Project by documenting the pilot phase, and developing logical frameworks (log frames). However, key informants noted that the log frames were used more for donor reporting than M&E planning. Key informants at the facility level described creating new forms that had checklists for all services and noted that these new tools did not take a long time to complete. In this regard, Sida funds (7.1%) supported harmonization of health management information systems.

An Activity indicator suggests that "SRH/HIV linkage baseline data from the 3 pilot sites [have been] established," indicating that some baseline data have been gathered and included in a report. In addition, another Activity indicator shows that "existing SRHR and HIV policy and protocols [have been] reviewed, in the form of a Family Planning register," and an Output indicator shows that "SRH and HIV and AIDS M&E data tools [have been] harmonized," indicating that at least one draft testing register has been discussed. However, a review of the elements of several other indicators suggests that baseline data are missing for many indicators.

Despite these achievements, key informants said reporting on the SRHR/HIV Linkages was an issue at all levels. While key informants at the national level said that there needed to be a focus on reporting structures and on the mandate to report, other key informants report that government filling processes are difficult; that District Health Officers are not getting reports from NGOs; that M&E indicators were not input to the national system; and that data were being collected at pilot sites for these indicators but not analyzed. Delays in the rollout of M&E systems at the district level were also reported as a challenge by other national level key informants, and they suggested that the delays impacted M&E systems at the country level as a result. These key informants reported that there is not enough manpower to report and analyze data, and described a need to harmonize M&E systems to meet the requirements of multiple donors. They also reported that the Project has actually increased the number of M&E reporting tools and indicators for the pilot sites.

Key informants at the national level also acknowledged that data were reported separately by different departments, depending on the service. They said that the M&E component of the Project lagged behind implementation, and that they were still working to be able to pull data together for use in, for example, the Global AIDS Progress Report.

As a result, while one facility reported using a new tool to capture data on linked and integrated services, this strategy was not applied in all facilities. In the other site, key informants reported that each service had its own tool and own register and that data were compiled at the end of every month. Key informants reported that providers at that facility had five registers that they had to complete and said that it took a lot of time to enter data into each register. Key informants at the facility level also described how having to do everything in the same room and having to complete multiple registers was a burden for them. Further, they stated that in the past three years, clients complained about computers being used to enter data because it took time for health care providers to first write down records on paper and then enter the data into computers, because the forms on the computer are not updated. They also reported a challenge with the data around HIV deaths: data tends to be conflated with any cause of death. For example, if an HIV-positive person dies in a car accident, it is counted as an HIV death. As a result, according to key informants, reporting associated with offering integrated services was perceived as an additional burden by health care providers.

Key informants at the district and facility levels reported that health care providers have employed local means of overcoming challenges associated with reporting, including writing down additional services received in the margins of existing registers.

3.3.3 Documentation/Dissemination of Best Practices

Documentation of best practices in terms of efficiency for clients has been captured in the Client Satisfaction Survey, the UNFPA one-pager, and the SRHR Indicators. For providers this was described in the Provider Component of the Client Satisfaction Survey, and to a lesser extent in the SRHR indicators and the Botswana SRHR-HIV Linkages Program video. As noted previously, these have been shared with other countries via the Regional Project and at the Regional Project Steering Committee meeting which Botswana hosted in 2014. Along with other countries, Botswana has contributed to overall findings in terms of efficiency for the Project that have also been shared at regional meetings and international conferences as noted in the Effectiveness section. In addition to the Client Satisfaction Survey and the study on best-practice modalities and benefits of CSO involvement, Botswana also launched a cost-efficiency study.

Key informants also described how promising/best practices and lessons learned (like focusing on patient flow and block booking) were identified through feedback from the community on quality of care, through analysis of what went wrong, and by looking at how gaps in service were being addressed. These were then shared with stakeholders at the district level via program meetings at the District Health Office, via events like Public Service Day, through workshops, and through visits from other providers to sites like Otse and Mochudi. Partnerships have been strengthened through networking at workshops.

Finally, related to documentation and dissemination of best practices, 16.1% of the EU budget for Botswana was spent on publications, research, and evaluations, and 14.9% of the Sida budget was spent on regional consultations.

3.3.4 Discussion

In terms of policy, findings regarding efficiency were mixed; while it is clear that some gains have been made in terms of policy changes, the extent to which these have communicated to all stakeholders, especially those in service delivery, has been limited.

The findings about service delivery efficiencies from the health care provider side are somewhat mixed, indicating a need for more staff/human resources and capacity-building. However, the findings in this regard from the client side are generally positive, indicating that integration has led to perceived increases in quality and efficiency for client. Findings around shorter wait times are somewhat contradictory; depending on the data collection methodology (client exit surveys and the Client Satisfaction Survey versus the FGDs), clients reported either shorter or longer wait times and providers reported longer consultation times. The shorter wait times for the clients indicate some measure of efficiency, but clients may be due only measuring the amount of time they wait to receive a consultation, may be considering the quality/efficiency of the consultations, or may be focusing the fact that they are receiving all services needed at the same time and thus do not have to return on another day of the week. Clients' view of the cost-effectiveness of services is supported in part by the efficiencies noted at the Project level in terms of funds. This includes the Project's success in leveraging resources from allied programs GPRHCS program to increase efficiency, as well as the Project's efficient use of financial resources. As such, relatively small proportions of EU and Sida funding spent on procuring furniture, computer equipment (2.5% of EU funding), purchase or rent of vehicles (2.5% of EU funding), medical equipment and commodities (1.8% of EU funding), and review and procurement of reproductive health commodities (10.1% of Sida funding). However, these purchases led to significant impacts reported for effectiveness in terms of increased service provision, increased uptake and awareness of services. This suggests that there was considerable efficiency in terms of funding for supplies, equipment and facilities. While a significant proportion of Sida funding (40.4%) were spent on CSO models, which also impacted effectiveness of the Project, it should also be noted that Sida found was only provided for 2014.

In terms of efficiencies for documentation and dissemination, it should also be noted that the second largest proportion of EU funding (16.1%) was spent on publications, research, and evaluations and the third largest proportion of Sida funding (14.9%) was spent on regional consultations, but these relatively small amounts of funding yielding significant gains in visibility and sharing of best practices for the Botswana Project.

3.4 Ownership of the UNFPA/UNAIDS SRHR/HIV Linkages Project by Botswana

The fourth area of investigation looked at the ownership of the SRHR/HIV Linkages Project by stakeholders at various levels in Botswana and the sustainability of the Project beyond 2015. This included exploring the extent to which stakeholders had developed a sense of ownership of integration in terms of policy, service delivery and scale-up, and documentation and dissemination of best practices from the Project. This also included examining the extent to which stakeholders at different levels reported that the benefits from the Project are likely to continue after completion, taking into account existing partnerships and the capacity required to maintain consistent levels of delivering SRHR/HIV integration services.

3.4.1 Policy

Ownership, Policy Development and Coordination

In terms of country ownership, findings from the KIIs speak to mixed perspectives both in terms of MOH ownership and coordination. Findings around country ownership from the KIIs showed high levels of political support for the Project, stemming from the Permanent Secretary's deep level of engagement in the Project. Key informants also reported that the Permanent Secretary visited some of the sites to see what was happening on the ground, suggesting the value of visible high-level support to the Project.

Key informants at the national level saw the MOH as a key stakeholder from the project design process onwards, suggesting a strong sense of country ownership from the beginning. Further, the achievement of an Output indicator associated with the signing of an MOU between MOH, the EU, and UNFPA also speaks to country ownership at the highest level.

Key informants at the facility level reported that the MOH had developed strategic policy documents around integration and revised existing policies to include integration elements. One example of a new strategy, the SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan, clearly defined the MOH's role in governance for integration, including developing, coordinating, and managing integration at all levels during the pilot and subsequent phases, mobilizing and sustaining resources, advocating for inclusion of all relevant stakeholders, reporting to donors, and evaluating the Project. In this document, roles for the Reference Committee, the Technical Advisory Committee, the District Health Medical Team, the District Multi-Sectoral AIDS Committees, the National Coordinator, and District Focal Persons are also clearly defined, all suggesting strong country ownership.

Some key informants at the national level acknowledged that guidelines on integration became stronger during implementation because of an initial mapping exercise that was conducted. They reported that both national SRHR and HIV policies needed to be strengthened in terms of the integration strategy. As an example, the age of access to services still needs to be addressed. In addition, key informants at the national level also noted that while policies in place were strong, implementation was weak and needed to be improved. They also identified the lack of a strategic approach to key populations as a barrier, noting that while there is an NGO in one area that is working with MSM, more needs to be done.

Key informants also reported other broad ownership and leadership challenges, including conflicting views of how integration would be implemented at the national level in the future. Key informants at both national and facility levels also reported there would be future efforts to explore integration at the national level. While these planned efforts suggest a strong level of country ownership, the views from these levels about how integration at the national level could take place differ. Key informants at the facility level reported that the MOH is exploring ways to integrate HIV, SRHR, and TB services, either by establishing an Essential Health Services Department or by merging the HIV and SRH departments. However, key informants at the national level reported that the MOH had initially considered merging the HIV department at the MOH into the SRHR division (which is part of the Preventative Health Department), which would have brought considerable resources to SRHR, but they noted that integrating the departments like this ran the risk of losing focus on HIV. In contrast, key informants at the district level reported that they felt like there were too many resources being directed to HIV and that HIV work, including reporting on HIV, was being privileged. In response, key informants at the national level stated that there needed to be a change of mindset at all levels, including a need to decrease turf wars and encourage patience, and to improve knowledge of the concepts of linkage and integration (and their benefits) at all levels.

Key informants also noted concerns about past coordination of the Project and what this might mean for future institutionalization of integration in Botswana. In terms of coordination, key informants at the national level and facility level reported that having a UNFPA-supported SRHR/HIV Linkages Project Coordinator was beneficial. National level key informants reported that while the Project did not change internal MOH structures, it added on to functions of existing staff, and as a result staff at the MOH were overburdened. However, the Project Coordinator helped relieve this burden. Similarly, key informants at the facility level said the SRHR/HIV Project Coordinator had supported integration and linkage by encouraging officers from different departments to talk to each other in order to reduce duplication of efforts.

Despite these benefits, key informants at the national level expressed concerns about who was responsible for the work of coordinating integration and linkage at the national level. They noted initial difficulties in deciding where the Project Coordinator should be housed, which were exacerbated by personnel changes over the life of the Project, as one Coordinator left and someone else temporarily took on their role. However, they also said that this temporary arrangement did not work because of the existing responsibilities the temporary Coordinator already had. Key informants also reported that the Coordinator had been based first at the MOH and then at UNFPA, but neither placement had yielded significantly different results. Instead, they noted that the most important factor appeared to be the capability and personality of the individual person in that role.

Some national level key informants reported that challenges in terms of who was responsible for coordination had led to a lack of institutionalization by the MOH, including delays in appointing focal persons responsible for integration and a subsequent overreliance on the UNFPA-appointed Project Coordinator. However, key informants also reported that MOH was now involved in hiring a Project Coordinator, and that this would promote the institutionalization of integration at the national level. This investment ultimately also indicated a strong level of country ownership, despite the conflicting perspectives on past coordination efforts.

Sustainability

Findings regarding sustainability were also mixed. While key informants at the national and district levels noted high levels of political support for linkages and integration, they said that this needed to be translated into budget allocations for linkages and integration at the district level to be able to continue SRHR/HIV linkages/integration without external support. While there is support at the Permanent Secretary level, they reported that it has been difficult to pass on this passion to district level managers, which discourages implementers.

In terms of resources, some key informants at the national level noted that inadequate resources in terms of attention and supervision led to poor implementation at the facility level, and that sites with a designated integration focal person performed better. Therefore some key informants recognized the need for financial support to be able to scale-up implement integration of SRHR and HIV services nationwide and thus achieve broader geographic service coverage. However, other key informants at the national level stated that the lack of resources should not be used as an excuse, and that a lack of resources are actually a good justification for integration, motivating providers to find innovative solutions. Part of this perspective was an acknowledgement that as a result of global reductions in funding and the classification of Botswana as a middle-income country that requires TA only, future external resources were likely to be limited and to diminish over time.

3.4.2 Service Delivery and Scale Up

When asked whether they thought that the linkage and integration of SRHR and HIV can continue without the support that UNFPA and UNAIDS provided, some key informants at the service delivery suggested that with a change of attitude in the part of health care providers and innovative uses of available resources and partnerships, that linkage and integration of services could continue without external support.

However, other key informants at this level reported that there was a need for support for implementation and monitoring and training health care providers, as well as for attracting new student nurses to the field of SRHR. Key informants also said that additional training on LGBTI services was needed to reduce discrimination against LGBTI clients. One suggested that these resources for recruiting providers into SRHR and for providing LGBTI training could come from NGOs. They also said that linkage and integration of SRHR and HIV services could not be continued without the physical resources that had already been provided by the Project. As an example, one key informant said that it was not possible to provide integrated services without the Portacabin, the furniture, models, charts, and forms provided through the Project, as clients would have to go somewhere else to another clinic for the services. Further, they also noted that the rollout of linkages and integration to other districts and sites could not occur without external technical support.

This focus on training was echoed by some key informants at the national level, who suggested that pre-service training for health care providers would increase sustainability and that without additional training, sustainability was not possible.

However, the strongest evidence of the need for sustainability comes from the development of a costed scale-up plan and a concept note to the Global Fund to successfully apply for funding to support scale-up, from the Botswana SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan, and the Investment Case Report. Together, these indicate the extent to which Botswana has taken on ownership of integration. The application for funding may be seen as an expressed need for external support and thus a potential lack of sustainability. Key informants reported that scale-up was costed at $1,267,903.09 USD and that the Global Fund award was $1,201,961.00 USD, with the difference will be funded by the Government of Botswana, which suggests a certain level of sustainability and through government support, a high level of country ownership.

3.4.3 Documentation and Dissemination of Best Practices

Examples of how language on integration have been incorporated into existing policies speak to the level of country ownership of linkages and integration in Botswana. As noted previously, these examples include the NSF II, the NDP 11, the National HIV Treatment Guidelines, and especially Botswana's SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan, which defines the MOH's role and the role of other key national and district bodies. The Strategy and Implementation Plan and Botswana's costed scale-up plan also support evidence of country ownership in terms of service delivery and scale-up of integration.

3.4.4 Discussion

Findings in terms of country ownership related to policy show mixed but mostly positive indications of ownership, with some challenges in terms of coordination at the national level and some areas where policies still needed work. Findings around sustainability related to policy, and to service delivery and scale up were also mixed, but point to a need for additional external support for scale-up of integration. However, documents shared by Botswana resoundingly speak to both a strong sense of country ownership. While findings may appear mixed in terms of documentation and dissemination of best practices around sustainability, Botswana's costed scale-up plan and related funding support outcomes suggest that while Botswana sees a need for external support, they also have the political will to supplement that support with their own resources.

4. RECOMMENDATIONS

After interpreting the findings from all components of the evaluation, we suggest the following actions be taken.

In terms of Relevance, the findings suggest that the SRHR/HIV Linkages Project is very relevant to the Botswana context and that positive changes have been made at the policy level. However, given that many key informants did not share a common understanding of linkage and integration, and that key informants at the facility level were not always aware of policy changes, there needs to be better definition and promotion of the concepts of "linkage" and "integration" and better understanding of how changes in policies affect stakeholders at all levels.

In terms of Effectiveness, the finding suggest that the Project has been effective in increasing availability of services, uptake of services, and awareness of services. However, to provide better evidence of effectiveness during scale-up of integration, we recommend that specific indicators for monitoring and evaluation of SRHR and HIV be incorporated into the national health management information system. This may include integrating some of the indicators from The SRH and HIV Linkages Compendium developed by UNFPA, the WHO, and IPPF.4 The sparseness of the SRHR and HIV indicator data, along with the data reporting challenges reported by key informants, speak to the importance of gathering data from different streams in a consolidated fashion that does not overburden health care providers, but is ultimately reported back to them (as well as upwards) and can be used for program planning and improvement. This is a major area of recommended change, and external technical consultation may be required to resolve and move forward, but it will ultimately yield significant benefits, not only for health care providers, but also at every other level, for district health officers, for the MOH, and for donors like UNFPA and UNAIDS, as well as for other donors.

In terms of Efficiencies, the findings are mixed. The Project has been efficient in terms of provision of physical resources, and to a certain extent in terms of time in terms of what is delivered to clients. However, while MOH trainings have been shown to effectively prepare providers to deliver integrated services, staff workload, shortages, turnover, and rotation, as well as the timing of training on specific topics all negatively impact efficiency. Thus, more needs to done in terms of staffing facilities with trained providers and preparing health care providers to deliver integrated services. This includes an initial training of service providers at facilities where the SRHR/HIV Linkages Project will be implemented in the future and ad hoc training of new service providers at those facilities to ensure continuity of operation. These trainings should be provided according to a consolidated training plan for all health care providers that has been informed by a needs assessment or skill mapping. In this regard, a related recommendation is to identify health care providers and/or district health officers who can act as champions of the Project and roving trainers. This is already happening in some areas and should be replicated in any area where the Project will be implemented. This champion can not only conduct training but can also encourage and inform other health care providers from their own experience about the benefits and challenges of and solutions for providing integrated services.

In terms of Country Ownership, the findings suggest that while there is strong political support and local support for integration, there needs to be better coordination of the Project between those levels and more support from different departments within the MOH. The MOH's hiring of a new Project Coordinator in the future is anticipated to further strengthen support for linked and integrated SRHR and HIV services. In addition to local health care providers or district health officers acting as champions, we recommend that the new Project Coordinator at MOH should play a visible role in championing integration. The Permanent Secretary already champions the Project, to great effect for health care providers, but expanding and promoting the role of the Project Coordinator will ensure high-level support, ensure that the MOH is seen as the lead stakeholder in the Project, and make integration seem less like a donor-driven initiative and more like an approach that Botswana has adopted.

Finally, the Relevance of the Project along with the strong sense of Country Ownership contribute to the Sustainability of the Project. While Botswana has recognized the need for supplemental external support in the near term (through their costed scale-up plan and Global Fund concept note) specifically to support scale-up of the Project, they have also recognized the need, as a middle income country, for increases in MOH support for integration and have made a commitment to provide that support.

5. CONCLUSION

In conclusion, while from the client perspective, Botswana has made significant gains in the provision of integrated SRHR and HIV services through the implementation of the UNFPA/UNAIDS SRHR/HIV Linkages Project, these have not been without significant growing pains and challenges for health care providers, DHOs, the MOH, and UNFPA and UNAIDS. Thus, to ensure the continued provision of these services and expansion of the Project to other sites, there is still work to be done: to properly train health care providers, to promote the Project, and to provide much needed resources, as well as to document the Project's successes and challenges with the ultimate goal of institutionalizing linkages and integration of SRHR and HIV services as a national approach to synergistically addressing HIV and other SRHR conditions.