USAID ASSIST Project

Botswana Country Report FY16

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USAID ASSIST Project

Applying Science to Strengthen and Improve Systems

Botswana Country Report FY16

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DISCLAIMER
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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

Recommended citation
# Table of Contents

List of Figures .......................................................................................................................... i
Abbreviations .......................................................................................................................... ii

1 INTRODUCTION .................................................................................................................... 1

2 PROGRAM OVERVIEW ......................................................................................................... 2

3 KEY ACTIVITIES, ACCOMPLISHMENTS, AND RESULTS .................................................. 2

Activity 1. Strengthen the community health system response to HIV and AIDS to contribute to HIV epidemic control in Botswana ............................................................................................... 2

4 SUSTAINABILITY AND INSTITUTIONALIZATION ............................................................. 10

5 KNOWLEDGE MANAGEMENT PRODUCTS AND ACTIVITIES ..................................... 11

6 GENDER INTEGRATION ....................................................................................................... 11

7 DIRECTIONS FOR FY17 ....................................................................................................... 12

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## List of Figures

- Figure 1: High-level project objectives along the four system dimensions under ASSIST Botswana ............... 4
- Figure 2: Overview of ASSIST’s community health system approach ......................................................... 6
- Figure 3: Community-led improvement applied to the acute loss of patients from ART treatment (Feb – April 2016) .................................................................................................................. 7
- Figure 4: Community-directed testing modality with NGO providers to address low testing numbers in Gamodubu Village, Kweneng East (Jan-Aug 2016) ................................................................. 8
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>APC</td>
<td>USAID Advancing Partners and Communities Project</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ASSIST</td>
<td>USAID Applying Science to Strengthen and Improve Systems Project</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<tr>
<td>CIT</td>
<td>Community improvement team</td>
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<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
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<td>FY</td>
<td>Fiscal year</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>LTFU</td>
<td>Lost to follow-up</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MLGRD</td>
<td>Ministry of Local Government and Rural Development</td>
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<tr>
<td>MOHW</td>
<td>Ministry of Health and Wellness (renamed in 2016)</td>
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<tr>
<td>NACA</td>
<td>National AIDS Coordinating Agency</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>PDSA cycle</td>
<td>Plan-Do-Study-Act cycle</td>
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<tr>
<td>PEPFAR</td>
<td>U.S. President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<td>QI</td>
<td>Quality improvement</td>
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<td>URC</td>
<td>University Research Co., LLC</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VHC</td>
<td>Village Health Committee</td>
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<td>WHC</td>
<td>Ward Health Committee</td>
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1 Introduction

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project has been providing support to the Botswana Ministry of Health (renamed the Ministry of Health and Wellness in 2016) since 2012, with an initial focus on supporting the national Maternal Mortality Reduction Initiative to achieve the Millennium Development Goal of improved maternal health. At the request of the USAID Mission in Botswana, ASSIST shifted its focus at the beginning of fiscal year (FY) 2016 to support the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) Botswana strategy for epidemic control of HIV. Based on its previous experience with the Ministry of Health and Wellness (MOHW) and other partners, ASSIST quickly adapted its quality improvement (QI) approaches to strengthen the role of community platforms in priority districts particularly affected by HIV, in order to complement the efforts of clinical platforms under an enhanced national HIV response.

Under PEPFAR’s strategy to achieve epidemic control in Botswana, a reinforced role of community-based care was recognized as an important element to strengthen: the identification of remaining HIV-positive people; their enrollment into treatment (especially under the new Treat All Initiative); and effective retention and HIV suppression through life-long adherence to ART. While Botswana nominally never stopped following a Primary Health Care approach that emphasized the active involvement of communities, the country’s decade-long HIV emergency response resulted in delivery models that were dominated by biomedical and hospital-based interventions that focused on the immediate saving of lives. In 2015, the political decision to finally reach an effective ‘AIDS transition’ to bring the epidemic under control coincided with revitalizing a Primary Health Care approach meant to emphasize quality care and strong community involvement to achieve Universal Health Coverage.

It is against this background that the USAID ASSIST Project designed its activities in Botswana to implement and institutionalize QI to achieve refined and more effective differentiated care models at scale that are better positioned to achieve and sustain 90-90-90 targets in the long term in the context of a stronger, community-based health system. This is done with a focus on:

- Addressing acute quality and service gaps along the existing HIV care and treatment cascade;
- Working with existing community structures to generate change ideas to address these gaps systemically – by, among other things, enhancing community collaboration with health facilities and other service providers; and
- Mainstreaming and spreading successful improvements and process innovations in coordination with District Health Management Teams (DHMTs).
Scale of USAID ASSIST's Work in Botswana

Coordinated PEPFAR Botswana efforts to achieve epidemic control started in October 2015

2 Program Overview

<table>
<thead>
<tr>
<th>What are we trying to accomplish?</th>
<th>At what scale?</th>
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| 1. Strengthen the community health system response to HIV and AIDS to contribute to HIV epidemic control in Botswana | • Communities linked to high-volume facilities in the 7 PEPFAR priority districts in Botswana  
• ASSIST is working with community improvement teams; service providers under USAID; DHMTs and other district officials; departments and programs under the national MOHW |

Improvement Activity

3 Key Activities, Accomplishments, and Results

Activity 1. Strengthen the community health system response to HIV and AIDS to contribute to HIV epidemic control in Botswana

BACKGROUND

Working with existing community structures, district administration, and tribal chiefs, as well as the central ministries of health and local government in project districts, ASSIST’s efforts under this activity are targeted at reinforcing community health systems and informal networks as platforms to expand and effectively coordinate HIV services with facilities and the formal health system. By developing simple but functional ways to ensure regular two-way communication and community/provider collaboration, practical improvement work led by community QI teams can – and has begun to – directly address some of the most acute gaps and quality concerns limiting the current HIV response.
ASSIST’s work to strengthen the role of community platforms as integral parts of the health system, through the targeted application of quality improvement methods and the evidence it generates, is closely aligned with stated policy priorities by the Government of Botswana. Project efforts are further coordinated with complementary activities by other PEPFAR Botswana implementers – in particular the USAID-funded Advancing Partners and Communities (APC) Project managed by FHI 360 – to expand testing, treatment, and adherence under the national Treat All initiative. Delivering services to people living with HIV (PLHIV) outside of government facilities in the communities (and even at home) is seen as a major component of the strategy to achieve epidemic control in Botswana. ASSIST-supported community improvement teams are playing a major role in designing, adapting, and differentiating relevant services, based on their closer understanding and direct involvement in community affairs, under the mandate of local chiefs.

While ASSIST activities in year 1 of its new focus on HIV continues to be dominated by direct support to community-led quality improvement, the growing involvement and appreciation by district-level actors has opened the door for complementary targeted technical assistance to integrate and institutionalize improvement mechanisms at district and national levels. Based on expressions of interest by the MOHW in FY16, ASSIST will support the Government and its partners in FY17 to look closely at existing service delivery models for more quality-oriented and patient-centred differentiated care in (and beyond) HIV. In addition, the project will look at the implications of such new models of delivering quality care for human resources and their organization, including the integration of improvement mechanisms. These efforts are also regarded as critical to ensure long-term sustainability of any improvement gains made during the project’s direct assistance. Sustainability is a shared concern of both PEPFAR Botswana and the Government of Botswana – and constitutes a core objective of ASSIST.

KEY ACCOMPLISHMENTS AND RESULTS

Introduction

When the ASSIST team was asked to shift its focus in Botswana for FY16 from working with facility staff to reduce maternal mortality, to facilitating community involvement in scaling up quality HIV care, there was no previous experience or blueprint in the country to follow. ASSIST’s role was also unique in the context of PEPFAR’s new strategy – tasking a range of different implementing partners to each address a specific aspect for achieving epidemic control. Working primarily with and alongside the USAID APC Project on the ‘community side’ of this strategy, ASSIST focused its initial activities on ensuring a clear project design that did not duplicate the work of others but added value at a system level to support an effective and sustainable scale-up of services. As the single implementer not mandated to provide direct services, ASSIST’s technical assistance depended from the start on strong working relationships with a wide range of other partners. These include community-based service providers funded by PEPFAR – but also Government as the dominant provider of health care in Botswana and as the ‘owner’ of key system functions at central and district levels.

Based on a wide range of consultations across government partners during the first quarter of FY16, ASSIST clarified its role in community-based rather than facility-based quality improvement. As a result, government and community leaders across districts invited ASSIST throughout the second quarter to form dedicated community improvement teams, drawing from a range of community committees and groups. During the third and fourth quarters, the project saw the rapid expansion of community-led improvement work, primarily to explore and confirm more effective and community-friendly HIV testing approaches to identify PLHIV and to enhance community/facility collaboration on tracing and returning patients who were previously deemed ‘lost to follow-up’ by ‘the system’.

Overall, the key accomplishment of ASSIST in Botswana in FY16 was the effective combination of hands-on improvement work in a range of communities across the country, with the integration of broader quality and delivery concerns across the system as a whole. At the same time, the project experienced considerable transaction costs associated with the effective coordination with government stakeholders across multiple levels – as well as with other PEPFAR partners and their separate but shifting activities implementing PEPFAR’s strategy to achieve the 90-90-90 targets.

ASSIST’s position at the end of FY16

As a result of accomplishments and developments throughout FY16, ASSIST’s work has become more multidimensional, now affecting several system angles simultaneously. While the application of focused
Improvement techniques at the community level still constitutes the core of ASSIST’s work in Botswana, it now also serves as the foundation for other key engagements to strengthen the HIV response and broader health system from the bottom up. These include:

1) **At the district level**, with DHMTs to refine service delivery mechanisms to both de-congest government facilities, especially HIV and TB clinics, and to ‘outsource’ services for direct delivery in communities by nongovernmental partners;

2) **At the national level**, with a range of national MOHW programs dedicated to the expanded treatment of HIV, TB, and related acute and chronic conditions – but also with general ministry leadership and lead system functions to drive the revitalization of prevention-focused primary health care.

As part of the growing collaboration with the USAID APC Project and because of identified service weaknesses in the important district of Gaborone, ASSIST also began working directly with key service providers under PEPFAR to improve internal programming for more effective and client-friendly services at scale. This form of provider-based improvement work is adding an important dimension to ASSIST’s work: for the first time, the project will have a relatively direct influence on the services that will be provided and scaled up in communities. This will be subject to rigorous monitoring and evaluation (M&E) through the provider-based QI team facilitated by ASSIST to determine what works best in the context of urgent pressures to achieve epidemic control.

At the end of FY16, ASSIST has established itself as a leading voice and partner along four system dimensions that are key for strengthening both the HIV response and broader Botswana health system (see Figure 1). These are as follows:

1) **Re-activating community health structures** and informal networks as the backbone for the community-coordinated delivery of patient-centered quality services;

2) **Reconnecting dormant community/facility collaboration** to strengthen district coordination for consistent delivery at scale across public and private service providers;

3) **Refining delivery models for quality differentiated care** along the entire HIV continuum of care in facilities, communities, and at home, integrated with other chronic condition where possible

4) **Reviving and adapting Primary Health Care** for community-based, patient-centered care delivery that emphasizes prevention through a combination of delivery models and providers.

Figure 1: High-level project objectives along the four system dimensions under ASSIST Botswana
Overview of results in FY16

Due to the nature of ASSIST’s technical assistance at different levels of the system without a direct role in service delivery, the result graphs included in this section are drawn from partner data (as acknowledged) and serve as illustrations for the practical community-led improvement facilitated by ASSIST. As a systems project, ASSIST’s primary impact to date is mostly at a systems level in the context of what are still predominantly fragmented vertical disease and service programs. While service numbers of key partners like the APC Project have been increasing throughout FY16 and thus constitute promising signs of improved access and uptake of key services, there is little indication to date that these developments are indeed sustainable – or even adequate to bring about epidemic control and the ‘AIDS transition’ that the country truly deserves. There are also obvious difficulties in establishing clear attribution of effects across multiple partners, government, and other providers.

The following results areas provide an overview of ASSIST’s work and efforts during FY16:

**Result area 1: Community health system structures and informal networks**

- **Designed a focused community health system approach to strengthen the national HIV response on the basis of thorough consultations and dialogue at national and district levels, implemented in seven priority districts alongside related efforts to scale up HIV services in the community (Oct-Dec 2015).**
- **Established dedicated improvement teams in 32 distinct communities across six districts (except in Southeast District where Government asked ASSIST to support the implementation of its own CATCH approach, see below) at the invitation of local chiefs and community leaders (Jan-Sept 2016).**
- **Oriented, trained, and actively facilitated community improvement teams (CITs) formed by local chiefs. Against initial expectations, all of them remain operational, meeting twice monthly to focus on specific steps along Plan-Do-Study-Act (PDSA) cycles to improve access and quality of services (Feb-Sept 2016).**
- **Supported District Health Management Teams (DHMTs) in the revitalization of Village and Ward Health Communities (VHCs/WHCs) in selected districts and communities, drawing from the experience of ASSIST-supported CITs to improve community/facility collaboration and coordination (July-Sept 2016).**
- **Secured active support from all relevant local actors, including public service staff at facilities and community-based organizations (CBOs) (Jan-Sept 2016). In many cases, Health Education Assistants and Nurses-in-Charge were active team members or assured their support to the CIT. This is an important milestone given the competing demands and initial reservations by individual health care workers, as well as the fact that there are no formal reporting lines between communities and these health care workers (and certainly no leverage of ASSIST as an external project).**
- **Integrated community-based service providers (predominately funded by PEPFAR under the USAID APC Project) in existing community platforms and teams to scale up delivery and access to quality services in communities and households (Feb-Sept 2016).**
- **Transformed community/facility relationships with health care workers becoming vocal advocates within facilities and DHMTs for more active roles of community platforms – as confirmed by Dikgosi (local tribal chiefs) who report on a transformed relationship of the community with government facilities, as well as NGO providers who originally reported strong concerns regarding the isolated functioning of both, and the frustrations this caused in communities. (Jan-Sept 2016).**

ASSIST’s approach to work with existing community structures and networks is outlined in **Figure 2**, illustrating the involvement of facility and CBO staff in the local application of QI methods to improve the quality, reach, and scale of HIV and related health services at the community level.
Result area 2: Acute quality and service gaps through focused quality improvement

- Facilitated the work of more than 30 community-based improvement teams with a focus on problem analysis and development of change ideas to address acute critical bottlenecks and quality concerns as experienced by communities (Feb-Sept 2016).
- Guided teams on the focused development, testing, and evaluation of specific change ideas to improve the effective delivery, linkage, reach, and scale of key services along the HIV continuum of care (Mar-Sept 2016). Initial CIT efforts focused on community-directed HIV testing and counselling approaches and innovative ways to collaborate around tracing, return, and retention in treatment.
- Improved relationships and functional collaboration between communities, facilities, and community-based non-governmental providers around testing campaigns and patient follow-up (Mar-Sept 2016).
- Directly coached a provider-based QI team in Gaborone charged with a central role under the USAID APC Project to scale up a wide range of HIV services to achieve ambitious service targets under APC and PEPFAR Botswana (Aug-Sept 2016).

Figure 3 illustrates the outcomes of a community-generated and tested change idea in Palla Road village in Mahalapye Sub-District. There the CIT found a creative solution to collaborate with their local facility for the quick recovery and return to ART treatment of patients the facility had deemed “lost to follow-up” (LTFU).
Result area 3: Community mobilization and collaboration with public and NGO providers

- Mobilized community members, in particular in hard-to-reach areas, as part of ASSIST support to community-based teams to scale up community-directed testing campaigns in several districts (Feb-Sept 2016).

- Improved the immediate communication and collaboration of community leaders and community platforms with government health facilities, including by directly involving clinic personnel in the CITs to guide the identification of immediate high-value areas for collaboration, the joint analysis of service data, and generation of concrete local change ideas (Jan-Sept 2016).

- Supported the clarification and circulation of information related to services provided by PEPFAR-funded community service providers through the community improvement mechanisms established by ASSIST – leading to increased community awareness and uptake of services (Jan-Sept 2016).

- Facilitated innovative ways for key providers under the APC Project to test and implement improved approaches for community- and home-based HIV testing campaigns in Gaborone (June-Aug 2016).

Figure 4 shows the result of a community-directed testing approach developed and tested by a CIT in the rural-area Gamodubu village in Kweneng East Sub-District. The team felt strongly that low testing rates in the community were caused by a general lack of trust in facility practices around the confidentiality of people’s HIV status. The change idea they tested brought independent outside testers to offer testing services in the community at various events mobilized by the CIT.
Figure 4: Community-directed testing modality with NGO providers to address low testing numbers in Gamodubu Village, Kweneng East (Jan-Aug 2016)

Similarly, Figure 5 illustrates the impact of a CIT-directed testing campaign that involved personal introductions of external service providers by CIT members during a door-to-door testing campaign in the streets of Bontleng Ward, Gaborone. Members of the CIT accompanied NGO HIV testing counselors to visit households and recreational places, introducing and encouraging household members to test with a special focus on improving the identification of HIV-infected men who are untested. Compared with previous campaigns conducted without the CIT involvement in March 2016, the enhanced collaboration under the change idea yielded much higher positivity rates amongst men.
Figure 5: Community-directed testing innovation with NGO providers to improve provider acceptance and testing uptake among men unaware of their status in Gaborone (June 2016)

### Result area 4: Community connections with district health system management

- **Agreed with the Mahalapye sub-district DHMT leadership on a strategic partnership with ASSIST to provide technical assistance to (re)establish and strengthen all Village Health Committees across the district as central community platforms to liaise and collaborate with facility platforms** (June-Sept 2016). This represents a set performance targets for the DHMT under the formal MOH Annual Performance Plan. The DHMT further asked ASSIST to support the potential institutionalization of service delivery innovations developed and tested by ASSIST-supported CITs in Mahalapye (as showcased during the August learning session in Mahalapye).

- **Achieved sufficient QI proficiency with more experienced community improvement teams formed earlier in 2016 for ASSIST to work with DHMTs on beginning to shift coaching and mentorship functions from the project to relevant district managers** (Aug-Sept 2016).

- **Introduced DHMTs to QI tools and opportunities under the broader trend of differentiated care and fine-tuning delivery models to better address service bottlenecks and facility congestion in the context of expanded treatment for HIV** (July-Sept 2016).

- **Established a close and firm working relationship with the central level DHMT Coordination Unit at the MOHW, responsible for the coordinated support to service delivery across programs under the new priority of revitalizing Primary Health Care** (Aug-Sept 2016).

- **Brought together district health managers and facility staff with ASSIST-supported CITs to learn together about potential areas for collaboration – with a focus on decongesting infectious disease clinics and other government facilities and the improvement of service quality as reflected in linkage and retention numbers in the coming months and years** (Aug-Sept 2016).

- **Intensified dialogue with district actors within and beyond health to include broader District Administration and District Council stakeholders around pathways to improve the functioning of service delivery and the institutionalization of change ideas at district level** (Aug-Sept 2016).

### Result area 5: Move toward the ‘how of’ differentiated care and service delivery

- **Presented to the Botswana International HIV/AIDS Conference in August 2016 on “HIV and the system” about the challenges of integration and quality improvement in the Botswana health and HIV context** (Aug 2016).

- **Explored with central MOHW departments broader regional developments around differentiated care and delivery models for integrated services, including overviews of guidelines and standard operating procedures as developed and implemented in other high-
prevalence settings (South Africa, Swaziland, Zimbabwe, Zambia) (Sept 2016).

- Accepted requests by MOHW to advise HIV and broader clinical services departments on service delivery innovation and adaptation in the Botswana context (Sept 2016).

- Collaborated with the USAID Mission on identifying a way forward for fast-tracking discussions on differentiated care in Botswana, with ASSIST taking the lead in liaising with IAS, WHO, UNAIDS, and other partners for the organization of a national stakeholder workshop planned for Q1 FY17 (Aug-Sept 2016).

**SPREAD OF IMPROVEMENT**

Much has changed since ASSIST was invited by the first local chiefs and community leaders to introduce improvement work to address local problems around HIV and health. Expanding from the first community-led improvement teams in February 2016, ASSIST quickly increased the number of teams to 32 at the end of FY16 (with an estimated expected total of between 40-50 by end of FY17) and with it, the involvement of additional community, district, and national level government counterparts directly exposed to improvement methods and results. Furthermore, facility staff in the public health system who were initially reticent and undecided about what to think and expect from community-based efforts to identify problems around facility-based services, quickly came around to recognize the opportunities for improved collaboration and communication. Wherever local community leaders and teams took on an active coordination role, both facilities and NGO service providers realized their complementary roles in providing services – thereby pointing to the opportunities for spreading improvement efforts not only to new communities and across districts, but also from across public and private service sectors.

In response to requests from several DHMTs for technical assistance, ASSIST is planning to expand its efforts to integrate quality improvement work in their work, as well as district administration more broadly in order to spread a shared understanding of issues of quality, and of QI as a practical, system-focused approach. This support will also involve local government officials beyond the DHMTs as they are charged with improving the delivery of other government services. These actors are at the center of broader government-led efforts coordinated by the Office of the President under the Government Implementation Coordination Office with which ASSIST began collaborating in the final quarter of FY16. Overall, at this stage of Botswana’s development and political constellation, the improvement and gradual decentralization of service delivery across all sectors (health, education, social affairs, and agriculture) provides a very conducive environment for quality improvement approaches. While there is increasing recognition of QI, it continues to be confused with more superficial and limited quality assurance (QA) approaches that don’t entail direct improvement roles for communities and service providers.

4 **Sustainability and Institutionalization**

Close coordination and continuous dialogue with relevant government counterparts at different levels has been a key feature of the ASSIST work program design in Botswana. At the central level, this particularly involved the MOHW (including the now integrated National AIDS Coordinating Authority) and the Ministry of Local Government and Rural Development (MLGRD). At the district level, ASSIST went out of its way to continuously inform and consult with the equivalent sub-national structures, namely the DHMTs and District AIDS Coordinators working with District Multisectoral AIDS Committees. In Botswana’s unique hybrid governance system of both traditional and Western legal and political institutions, ASSIST also engages with Tribal Administration offices for the effective involvement of tribal leaders who are critical for any efforts to institutionalize improvement practices at local level in the long term.

Increasingly, and in particular following ASSIST-organized learning sessions and regular update presentations at district meetings, the project has received requests for focused technical support to train and coach district-level government officers and staff in applied improvement. Recognizing the growing relevance of decentralized government, the active involvement and empowerment of district actors – both from within the portfolios of health and HIV and more broadly around social welfare – was central to ASSIST’s underlying institutionalization strategy to make a strong sustainable contribution to Botswana’s efforts to re-align and strengthen its community-based health system under primary health care. As illustrated by recent political statements from the President and Minister of Health, the need for quality services has finally arrived at the top of the government’s agenda. Through ASSIST’s close collaboration with the government in recent years – including the involvement in senior public servants in QI training,
learning sessions and seminars – its efforts to institutionalize QI in a public service context are fully appreciated.

5 Knowledge Management Products and Activities

- District learning sessions on community improvement
  
  1st learning session for Mahalapye Sub-District (Aug 2-3 2016) involving six operational community improvement teams across the district, in addition to community leaders from five prospective communities. A draft report of the learning session was circulated among primary participants to be finalized in Q1 FY17 for wider circulation. ASSIST conducted a first major district-wide learning session in close coordination with district and national partners in August 2016. The two-day session brought together community leaders and improvement teams from all ASSIST-supported villages and wards across the large Sub-District of Mahalapye, including relevant district and national government stakeholders and service providers. The objectives were to:

  (i) Ensure horizontal learning about improvement and its practical challenges across communities that have been applying QI methods for several months at that time;

  (ii) Allow district level officials, including from DHMTs and facility staff in the district, to understand what quality improvement means in practice and to discuss how this approach and the strengthened role of community platforms might contribute to district-wide plans to adjust and improve service delivery; and

  (iii) Begin to explore practical opportunities to integrate improved processes and service innovations across the district.

  Another related objective of the learning session was to effectively connect community-led improvement with district-level coordination mechanisms to prepare the institutionalization of QI teams and their practices in the context of broader trends for decentralized service delivery across sectors.

- Case study on the experience with community-led quality improvement in Botswana
  
  “Strengthening HIV Linkage and Retention through improved community/facility collaboration in Pallaroad, Botswana” (August 2016). Available at: https://www.usaidassist.org/resources/strengthening-hiv-linkage-and-retention-through-improved-communityfacility-collaboration

  This four-page case study summarizes the background, approach, and results of specific community-led efforts in one of the ASSIST-supported communities to reconnect ‘lost’ HIV patients with care and treatment. The CIT was coached by ASSIST in their application of QI processes to find innovative approaches to this prioritized problem, specifically by strengthening their collaboration with local facility personnel. Under these approaches, they tested and monitored the effects of change ideas that involved community support to facility staff in reconnecting with and ultimately returning patients that were deemed lost-to-follow-up. Community resources like local knowledge, trust, legitimacy, and access to the larger village complemented the technical expertise of facility staff, thereby also reinforcing their mandate to ensure effective patient follow-up. Within existing public service guidelines and policies to preserve patient confidentiality, the community effectively enabled the recovery of over 90% of the patients previously deemed ‘lost’.

6 Gender Integration

Like in other countries, gender plays a major role in Botswana in terms of risks, access, and other aspects around HIV and health. Significant room remains for a better understanding – and thus for the practical improvement of how services and support are programmed and delivered, especially to those at higher risk. Through its direct work with communities to analyze local problems and the ways in which women and men access services and/or change relevant behaviors, communities (and the ASSIST team) have managed to gain a better understanding around key issues – including around how ‘men’ and ‘women’ seek care – that challenge conventional wisdom and stereotypes. Important differences in behaviors and experiences around HIV certainly exist, but in particular QI-generated data is proving to be very helpful in moving toward more a solid evidence base and understanding of what works for whom and under what conditions. In the second half of FY16, ASSIST was particularly involved in highlighting the
importance of differentiating care delivery models according to key patient preferences and needs, specifically women and young girls – but also men. Communities supported by ASSIST have quickly learned that in order to improve, they must better understand what are the underlying problems and reasons for certain behaviors, obstacles, and bottle necks.

The collection, review, and improvement of data from across different relevant sources to support community-led QI work in Botswana has been identified both as a key objective and requirement for the project from the start. While the project doesn’t provide any services directly or have direct access to clinical facilities, and thus doesn’t generate any original service data on its own, the disaggregation and analysis of any available data has been a continuous aspect of ASSIST’s work. Unfortunately, the quality of available data – including sufficient reliable information on how men and women are differently accessing (or not accessing) HIV and other health services – remains a major problem in Botswana. From the project start in October, many interactions with partners have highlighted the need for constructive dialogue and openness on the quality of care, and with it on data. The quality of data also involves access to disaggregated data, ideally by sex and age, as well as the use of gender-sensitive indicators. Under PEPFAR Botswana, considerable efforts were made to improve the quality and management of data and patient information; however, much more needs to be done to systematically capture and understand the various cultural and other gender-related factors that affect access, uptake and other behaviors in the area of HIV and health more broadly.

In May 2016, Ms. Julia Holtemeyer of WI-HER, LLC provided onsite training and technical support in gender integration. She facilitated staff discussions around gender issues in the community HIV work, including gender-based violence, gendered caregiving burden, gendered fear of disclosure, gendered stigma and discrimination, confidentiality of the health system, and QI team composition. These important discussions led to staff thinking critically and explicitly about gender issues affecting their work. This led to changing the ASSIST coaching guides to include gender considerations, including asking QI teams about sex-disaggregated data and how gender may impact whatever aim they are working on. Additional efforts in this area will be focused on informing the development of new service delivery models that differentiate care packages to specific key sub-populations, including under gender considerations.

7 Directions for FY17

In line with ASSIST’s general emphasis on contextual adaptation, the project is constantly re-assessing its approach and improvement strategy to ensure “best fit” and value added to the broader PEPFAR and government strategies. The overall goal remains to ensure both maximum short-term impact by supporting ongoing Government and PEPFAR efforts to scale up treatment and related services and sustainable long-term impact by institutionalizing improvement mechanisms and practices in Public Service and other providers under the national health system and HIV response.

In recent interactions, the MOHW expressed additional interest in ASSIST’s technical assistance in helping the system gradually shift from its current approach to one that is more firmly organized around patient interests and community resources. This position matches well with the project’s interests in long-term sustainability and commitments under USAID and PEPFAR Botswana.

For FY17, ASSIST Botswana sees a range of potential entry points to reinforce the existing focus on institutionalizing community-led and district-coordinated quality services. This section presents them according to the primary governance level (see Figure 6).
I. Project implementation at community level

The project will continue to form additional community improvement teams, on the basis of joint analysis of community hotspots and achieving a representative set to advance the learning objectives of the project to inform systemic changes at all levels. Overall, however, the project aims to not add many new teams but rather to focus on deepening the work of the existing teams.

In addition to ASSIST’s work with community-based improvement teams, the project sees great importance and potential in its direct work with service providers under the APC Project in Gaborone. Results from the work of the QI team are expected from Q1 FY17 and have the potential to show multiplied effects for the innovation of models for differentiated care delivery on the basis of close monitoring and QI data evaluation. This work is important not only because of the relative importance of Gaborone as the district with the largest gap in identified, linked, and retained PLHIV, but also for the combination of QI teams at both ends of the service spectrum – in ‘hotspot’ wards across Gaborone communities and with the main community-based provider.

II. Dialogue and technical assistance at district level

ASSIST’s strategic partnership with DHMTs involves technical assistance to (re)establish and strengthen all Village Health Committees across the district to liaise and collaborate with facility platforms. ASSIST is pursuing similar partnership models with other project districts, involving APC partners in exploring improved community-based, patient-centred service delivery models, especially around ART delivery and the enhanced support to linkage and adherence beyond facility platforms into the community.

III. Alignment and dialogue at national level

ASSIST’s engagement with the Botswana Government intensified in the context of clear government policy priorities for a transformation of the health system under a revitalized Primary Health Care approach with an emphasis of quality services. Among counterparts at the MOHW, ASSIST is most directly engaged with the Department of HIV/AIDS Prevention and Care, specifically in advising on the implementation of Treat All and the adaptation of differentiated models of care. With the Department of Clinical Services as the department responsible for many of the system functions and the actual organization of program implementation across facilities, ASSIST was asked to collaborate directly with DHMTs through the DHMT coordination unit in the context of the Ministry’s overall policy directive of revitalized Primary Health Care. Furthermore, ASSIST is working with the Directorate of Health Services responsible for regulating and ensuring service quality standards across the system, both public and private.

Outside of the MOHW, the project continues to closely engage and coordinate with the Ministry of Local Governance and Rural Development as the Government ministry responsible for overseeing the work of District Administrations, including the work of District AIDS Coordinators and District Multisectoral AIDS
Committees, as well as the work of Village Development Committees and District Council support. ASSIST’s primary interface at MLGRD is the Department of Primary Health Care.

Finally, ASSIST has responded to requests by the Government Implementation Coordination Office (under the Office of the President) to advise on quality improvement approaches to strengthen ‘community-based monitoring’ of decentralized government service delivery.

Planned activities for FY17

- Update project implementation strategies and implementation plans for Year 2 implementation and realignment of ASSIST strategies and activities with partners and Government
- Conduct improvement workshops to review/adjust improvement aims and measures in light of project-internal and external developments, partner requests, and evolving policy context
- Provide assistance to central MOHW and DHMTs in the development, implementation, and continuous monitoring and evaluation of new service delivery models (under strategic partnerships)
- Jointly organize seminars with DHMT managers on operational aspects of applying QI methods in the refinement of delivery and coordination mechanisms across facilities/CBOs
- Facilitate a national stakeholder workshop on patient-centred differentiated care adaptations to the Botswana context
- Organize and facilitate inter-community learning sessions across districts:
  - Southern District (Kanye, Moshupa, Goodhope): October 2016
  - Greater Gaborone District: December 2016
  - Kweneng East Sub-District: January 2017
- Conduct a national quality improvement learning session: March 2017
- Intensify technical assistance to institutionalize QI with main community service providers under APC (BOCAIP) in Gaborone
- Train and coach organizational coaches and other personnel (BOCAIP)
- Orient wider circles of district-level coaches and other relevant government personnel in the interest of preparing the institutionalization of QI and handover of ASSIST-supported teams
- Support to stakeholders in gender analysis to inform the development of gender-sensitive, differentiated care packages around HIV and chronic care
- Conduct focused documentation, reporting, and development of additional case studies
  - Q2: Community-directed implementation of HIV service modalities
  - Q3: Adapting differentiated care under the Botswana Treat All strategy
USAID APPLYING SCIENCE TO STRENGTHEN AND IMPROVE SYSTEMS PROJECT

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