CLIENT SATISFACTION SURVEY IN PILOT HEALTH FACILITIES IMPLEMENTING SRHR/HIV LINKAGES PROJECT

MINISTRY OF HEALTH

GOVERNMENT OF BOTSWANA

FINAL REPORT

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Table of Contents

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Last but not least the ministry appreciates the consultant Mr. Peter Punishment Chibatamoto who conducted the whole survey processes of identifying the relevant methodology, data collection, data analysis and report writing.

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CSO	Civil Society Organizations
CSS	Client Satisfaction Survey
DHMT	District Health Management Team
DMSAC	District Multi-sectoral AIDS Committee
GoB	Government of Botswana
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTR	Mid Term Review
PMTCT	Prevention of Mother To Child Transmission
SRHR	Sexual and Reproductive Health Rights
TOR	Terms of Reference
UNAIDS	United Nations Program on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Government of Botswana (GoB) is advocating for implementation of SRHR/HIV linkages at different service delivery points so as to increase the uptake of both SRHR and HIV services. This approach will lead to reduction in missed opportunities, reduction in number of visits to health care facilities and ultimately improved health outcomes and client and health care worker satisfaction. The Government of Botswana's decision is also supported by the goal of the Integrated Health Service Plan and the findings of the Mid Term Review of the Second National Strategic Plan for HIV and AIDS (2010-2016).

In light of this, a Client Satisfaction Survey (CSS) in nine selected pilot health facilities implementing SRH/HIV services was commissioned in order to establish the level of client satisfaction and the quality of service being delivered before rolling out the intervention to all the districts of the country.

A non-experimental, cross-sectional descriptive survey at each of the nine SRHR/HIV health facilities in the three pilot districts (Mahalapye, Kweneng West and Kgatleng) was conducted through user exit surveys at the point of service delivery. Clients were interviewed as they left their final service delivery point at the health facility.

The results indicate that over eighty percent of the clients (82.7%) were satisfied with the services they received at the health facilities. The clients welcomed the approach of integration because they felt it reduced the number of trips to health facility. Although the clients were satisfied with privacy and type of information, education and communication (IEC) materials they found at the facilities, they were concerned with the long waiting time. The service providers were taking more time with clients due to the integrated nature of services provided to clients. The level of satisfaction was not affected by the type of health facility. Clients visiting all the pilot facilities (kiosk, supermarket or mall model) were equally satisfied with services they received. It should also be noted that both clients and service providers identified shortage of staff and ambulances as the major barrier to integration,

Clients are still self-stigmatized as the reported that they would feel embarrassed to talk about HIV with a service provider of the same village/neighborhood. Although clients were concerned with stigma, the service providers felt that integration would decrease stigmatization of HIV and SRH. This finding calls for the need to address issues of self-stigma in the community. One of the most important findings of the study is that both providers and clients appear to welcome integration and appreciate the advantages and convenience to the client of a 'one-stop' service. However, there is need to address issues pertaining to shortages of staff, training, ambulances and stigma in the community and health care workers through education. If these challenges are addressed, issues of workload and waiting time will be resolved.

The lessons learnt from the integration of SRH and HIV services will motivate the Government of Botswana to scale up services nationwide. Through SRH/HIV, it has been demonstrated that goals on increased access to family planning services, prevention of unintended pregnancies in PLHIV, and joint delivery of family planning commodities and ARVs can be achieved. In the long term, health and community systems will be strengthened, and HIV prevention amongst the general population will be realized.

The client satisfaction survey has indicated that for integration to be successful there is need to address the drawbacks of insufficient health facility space, increased staff workload and waiting times. Furthermore, whilst service providers at facility level have demonstrated high knowledge levels and skills to implement integrated SRH and HIV, the shortage of healthcare workers will need to be addressed, together with other factors that motivate them.

The results of the survey are of special interest because Botswana has taken a decision to scale up the provision of integrated SRH and HIV services countrywide within the framework of primary health care. Thus evidence from the pilot sites on the benefits and limitations of integrated services should be of direct relevance to other districts in Botswana and indeed other countries with similar profiles of sexual and reproductive health problems.

1. Introduction

1.2 Background

The world over evidence shows that linking Sexual and Reproductive Health Rights (SRHR) and HIV services prevents duplication and competition for resources thereby increasing effectiveness and efficiency. It is also important to acknowledge that SRHR services attract a greater number of people and a larger cross-section of the population. Therefore, linking services can increase opportunities for broadening key HIV interventions, including increasing voluntary HIV counseling and testing to identify people living with HIV and help them to access treatment, care and support. It has also been shown that linking SRHR and HIV service provision can also broaden the skills of health providers, and reduce stigma and discrimination towards people seeking SRH/HIV services. Reducing discrimination and stigma has been associated with enhanced community involvement and participation in the development, uptake and follow-up of services.

It is in this light that the Government of Botswana has, with support from development partners, embarked on a process of implementing a strategy aimed at increasing access to and use of a broad range of quality sexual reproductive health services and HIV prevention, treatment, care and support, while making relevant linkages with the education, gender and legal sectors in Botswana. The strategy provides a platform for strengthening health systems for attaining the national goal of improving the sexual reproductive health of all people living in Botswana.

Evidence from the review of implementation of the strategy in pilot facilities has revealed that there has been an increase in the uptake of SRHR and HIV services. Based on this evidence, the Ministry of Health made a decision to scale up provision of integrated SRHR and HIV services as a one-stop shop countrywide. The Ministry of Health is advocating for implementation of SRHR/HIV linkages at different service delivery points so as to increase the uptake of both SRHR and HIV services. This approach will lead to reduction in missed opportunities, reduction in number of visits to health care facilities and ultimately improved health outcomes and client satisfaction. The Ministry of Health's decision is also supported by the goal of the Integrated Health Service Plan and the findings of the Mid Term Review of the Second National Strategic Plan for HIV and AIDS (2010-2016).

While linking HIV and SRH services shows immense promise for making progress on universal access to prevention, treatment, care and support, the evidence is yet to be supported through operational research with clients and health care service providers in facilities. Therefore, UNFPA in partnership with UNAIDS and the Government of Botswana commissioned a Client Satisfaction Survey in nine selected pilot health facilities implementing SRH/HIV services in order to establish the level of client satisfaction and the quality of service being delivered.

The focus of the client satisfaction survey was on measuring user satisfaction and perceptions of SRHR/HIV services in the nine pilot health facilities. The survey assessed the performance of the integrated SRHR/HIV pilot project. The client satisfaction survey identified facility attributes or practices that increase satisfaction, hence the willingness to use the integrated SRHR/HIV services offered by health facilities. Whilst measuring client satisfaction does not

measure outcomes, it provides valuable feedback on process measures of the pilot SRHR/HIV integrated programme, such as waiting time, cost, attitudes of staff, treatment received and the physical setting of services.

1.3 Objectives

1.3.1 Broad Objective

To assess the level of client satisfaction and overall quality of SRHR/HIV integration services in nine selected pilot health facilities

1.3.2 Specific Objectives

i. Survey clients 'perceptions, experiences including waiting time and expectations of outpatient services received from the selected health facilities
ii. Seek client feedback to establish whether standards of care were followed
iii. Identify client care issues of concern and opportunities for individual and system quality improvement
iv. Assess perceptions of service providers on SRHR/HIV integration

2. Methodology

2.1 Study Design

To achieve the Client Satisfaction Survey objectives, a non-experimental, cross-sectional descriptive survey at each of the nine SRHR/HIV health facilities in the three pilot districts (Mahalapye, Kweneng West and Kgatleng) was conducted. This was conducted in the form of user exit surveys at the point of service delivery. Clients were interviewed as they left their final service delivery point at the health facility. The nine participating facilities are offering a minimum package of integrated services using a specific model selected according to the type of model as shown in Table 1 below.

Table 1: Type of Models participating in the SRHR/HIV pilot project

Type of Model	Description of the Model
Kiosk Model	- Provision of a number of services within the same room by one health care provider - More applicable to health posts and smaller clinics
Supermarket Model	- Utilizes the same principle as the kiosk but service provision is in a bigger place. - There may be a number of rooms used for provision of services - Services are likely to be provided by different health care professionals - Referrals may/ may not be common - Applicable to clinics with or without maternity wards/wings
Mall Model	- Provision of services in different rooms within the same health facility - Services are provided by different health professionals - Referrals are inevitable - Applicable to hospitals- Primary, General or Referral

2.3 Sampling

The sampling strategy for this survey was adapted from the "*Guidelines for implementing the MSI Client Satisfaction Exit Interview Questionnaire Survey*" developed for Marie Stopes International Partners (http://www.mariestopes.org.uk). The guidelines focus on achieving a representative sample through spreading it over each day of the survey, so that equal numbers of clients are interviewed each day.

For each of the nine pilot health facilities, a sample size of at least 20 clients per health facility per day calculated from the historical health facility registers as shown in Table 2 was used given the limited resources and duration of data collection. The interviews were spread throughout the day so that all respondents were not interviewed in the morning. This is because those who come in the morning earlier may be different to the clients who come later (for example, they may live further away, or be the clients with more children who take longer to prepare before they can leave the house in time to get to the clinic).

Table 2: Sample size for clients and service providers to be interviewed in the pilot districts

District	Health Facility	No. of clients	No. of service providers	Data collection Period (Days)
Kgatleng	Sikwane Health Post	20	2	1
	Mochudi 1 clinic	20	2	1
	Oodi Clinic	25	2	1
Kweneng West	Sesung Health Post	20	2	1
	Khudumelapye Clinic	20	2	1
	Letlhakeng Clinic	25	2	1
Mahalapye	Otse Health Post	20	2	1
	Shoshong Clinic	25	2	1
	Sefhare Primary Hospital	50	2	2
Total		**225**	**18**	**10**

In order to assess the perceptions of service providers on SRHR/HIV integration, two service providers (one at SRH service point and the other at HIV service point) per health facility were interviewed. A total of 18 service providers were interviewed.

2.4 Data collection tools

2.4.1 Client Exit Questionnaire (Annex B and E)

For data collection, a Client Exit Survey questionnaire was administered to assess accessibility to services, confidentiality of services, available options, staff friendliness and friendliness of the service. The questionnaire (Annex B) was translated into Setswana (Annex E), pretested and administered by two experienced Setswana speaking research assistants. Clients were asked to sign consent forms before the interviews. Specifically, the Client Questionnaire addresses the issues:

i. Socio-demographic questions such as gender, age, accessibility, affordability and availability of information.

ii. SRHR and HIV services available to clients at the different pilot health facilities. This was based on the minimum package for the integrated services. This included services sought by clients, received, not received and referrals to other places in cases where the service could not be provided.

iii. Benefits and disadvantages of provision of integrated services.

iv. Levels of satisfaction, issues of confidentiality, trust and privacy. This also covered attitude of service providers in terms of whether staff members were answering all questions to their satisfaction and staff understood clients' concerns on SRHR/HIV.

2.4.2 Service Provider Questionnaire (Annex C)

A questionnaire for service providers at each health facility visited was administered. The questionnaire captured the perceptions of service providers on SRHR/HIV. Some of the overall service provider perspectives on linkages in SRH and HIV Services that were explored include:

- most important enablers/challenges/constraints to strengthening SRHR/HIV linkages
- the likely impact of linking SRH and HIV services on various service dimensions
    - ✓ Costs of services at facility level,
    - ✓ Cost of services at client level,
    - ✓ Efficiency of services,
    - ✓ Stigmatization of HIV clients,
    - ✓ Stigmatization of SRH clients,
    - ✓ Workload for providers,
    - ✓ Time spent per client,
    - ✓ Space and privacy,
    - ✓ Need for equipment, supplies and drugs

2.5 Data Management

Study numbers for respondents were created by numbering the individual forms *before* the survey was conducted. This avoided confusion and duplication of study numbers by the research assistants. This also allowed for inclusion of refusals to be counted and it made the process of enrolling respondents quicker.

The data was entered into a computer using user statistical software (Microsoft Excel). The data was then exported into EPI INFO™ Version 7 for data analysis. The data was

independently double entered so that all differences in data entry were identified and corrected. In order to ensure confidentiality and anonymity for the respondents, being fully aware of the sensitivity and complexity of issues relating to disclosure, consent, use of information and stigma, ethical considerations were taken care of. Participation of the clients was completely voluntary and they were notified of their right to give, withhold consent or withdraw at any stage of the study. The study participants were persons of 18 years and above. The original forms were stored in a locked cabinet and a locked room. Answer sheets were kept separately from the consent forms with signatures on them for ethical reasons. These were handed over to be Ministry of Health after approval of the survey report.

3.0 Findings

3.1 Perspectives of Clients

i. Demographic Characteristics of Clients

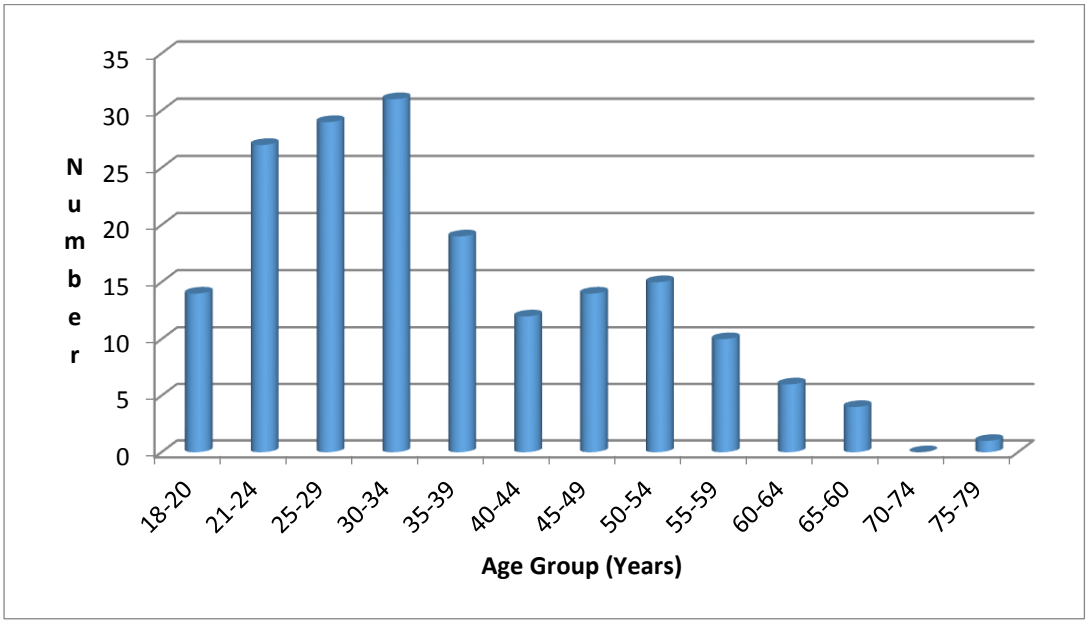
As shown in Table 3 below, total of 182 exit interviews were successfully conducted for this client satisfaction survey. The majority (80.8%) of clients were female.

Table 3: Clients who participated in the Client Exit Interview

District	FACILITY	SEX		TOTAL
		Male	Female	
Kgatleng	Mochudi 1	3	16	19 (10.4%)
	Sikwane Health Post	2	15	17 (9.3%)
	Oodi Clinic	1	20	21 (11.5%)
Kweneng West	Sesung	1	14	15 (8.2%)
	Khudumelapye Clinic	4	14	18 (9.9%)
	Letlhakeng Clinic	6	14	20 (11.0%)
Mahalapye	Shoshong Clinic	6	15	21 (11.5%)
	Otse Health Post	5	17	22(12.1%)
	Sefhare Primary Hospital	7	22	29 (15.9%)
TOTAL		**35 (19.2%)**	**147 (80.8%)**	**182 (100%)**

The average age of the 182 clients was 36.3 years old with the youngest aged 19 years and oldest 77 years (Standard deviation of 13.19). The majority of the respondents were in the 30-34 year age group as shown in Figure 1 below. Only five potential respondents (across all the three districts) refused to participate in the exit interviews, yielding a refusal rate of 2.7%. They cited lack of time as the reason for failure to participate.

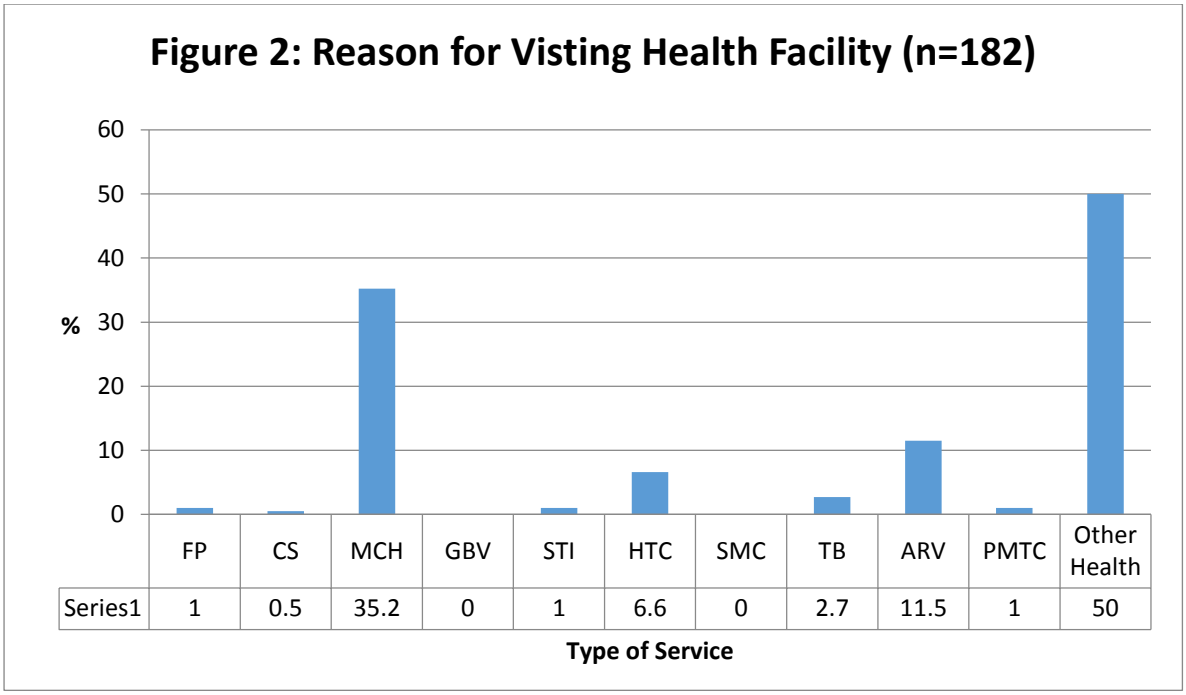
Figure 1: Number of respondents per age group (n =182)



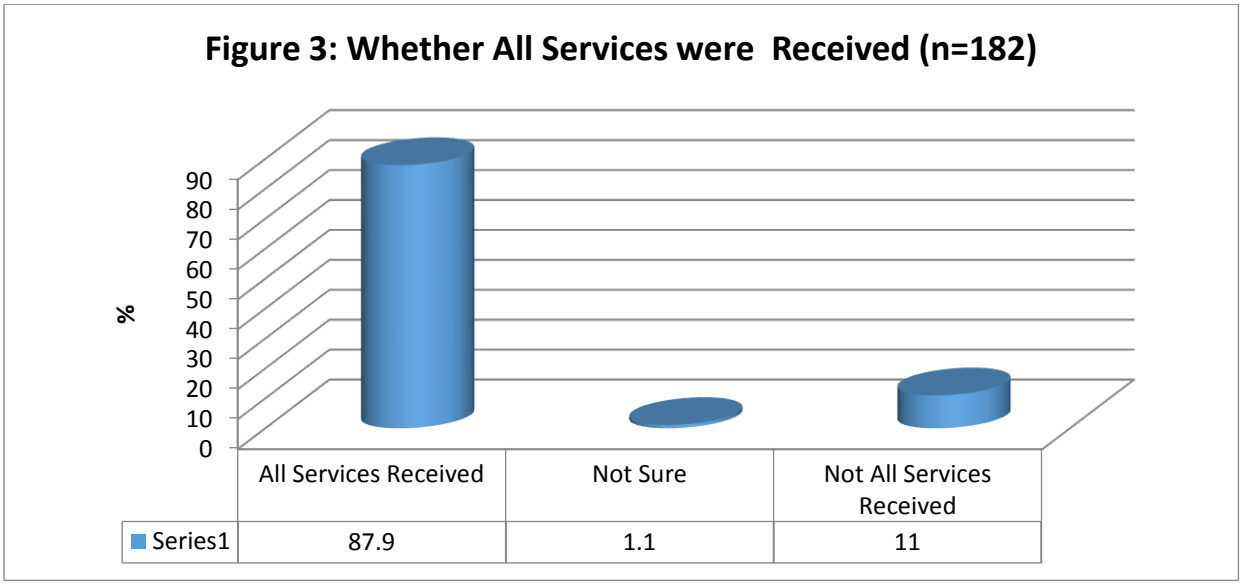
ii. SRH and HIV services received by Clients

The majority of clients who were interviewed were exiting from the dispensary service delivery point (69.1%). Some were exiting form Maternal and Newborn Care (24.3%), ARV service delivery point (5.5%) and Family planning service delivery point (0.6%). There was only one client who did not know the name of the service delivery point where she was exiting from.

Fifty percent (91) of the clients interviewed reported to have visited the health facility for general consultation about their health, 35.2% had visited the health facility for Maternal and newborn care services (MCH), 11.5% for ARV, 6.6% for HTC and 2.7% for TB screening. Only 1% had visited for either family planning, STIs or PMTC. None of the clients had visited the health facility for gender based violence (GBV) or safe male circumcision (SMC) as shown in Figure 2 below.



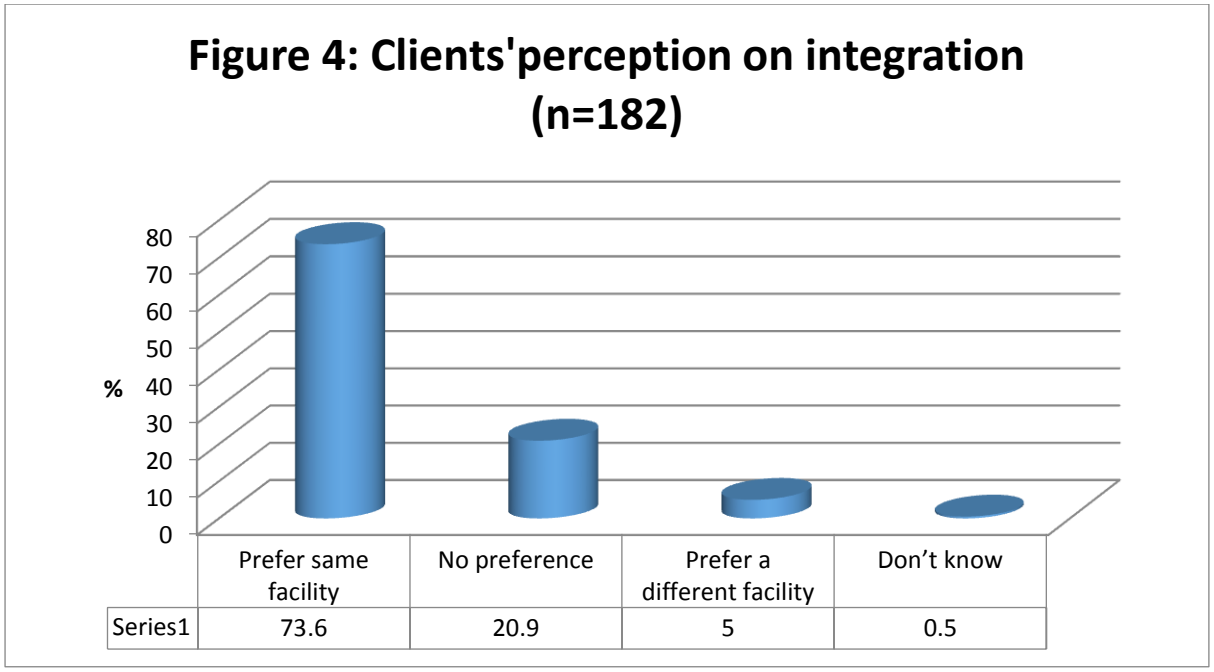
Ninety four percent reported that they were not referred to any other services than those for which they visited the health facility and 87.9% of the clients interviewed indicated that they had received all the services they were seeking from the health facilities. As shown in Figure 3 below, 11% (20 clients) had not received all the services they wanted and 0.6% (1 client) was not sure whether they had received the services they wanted from the health facility on the day of the exit interview.



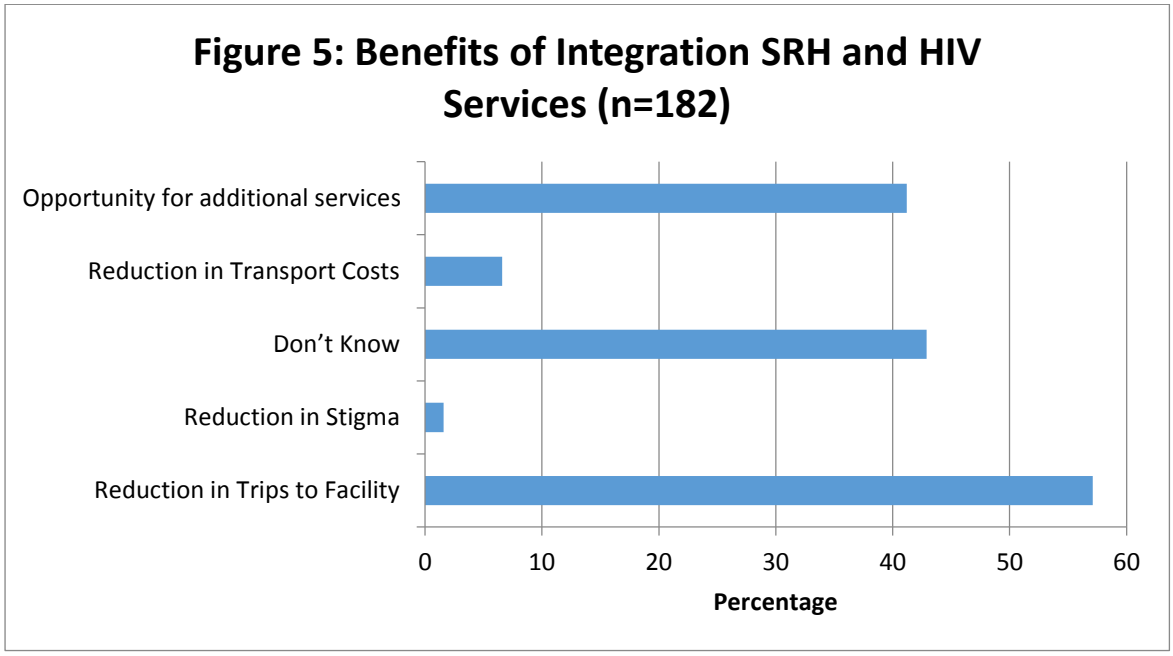
The 20 clients who had not received all the services they wanted indicated that they expected the service providers to have performed routine gynecological examination (3 clients); family planning (1 client); condom services (1 client); and information on prevention of unsafe abortion and management of post-abortion care (1). Fifteen clients could not disclose the services they would have liked to get from the health facility on the day of the interview.

iii. Clients' Perceptions on Integration of SRH and HIV services

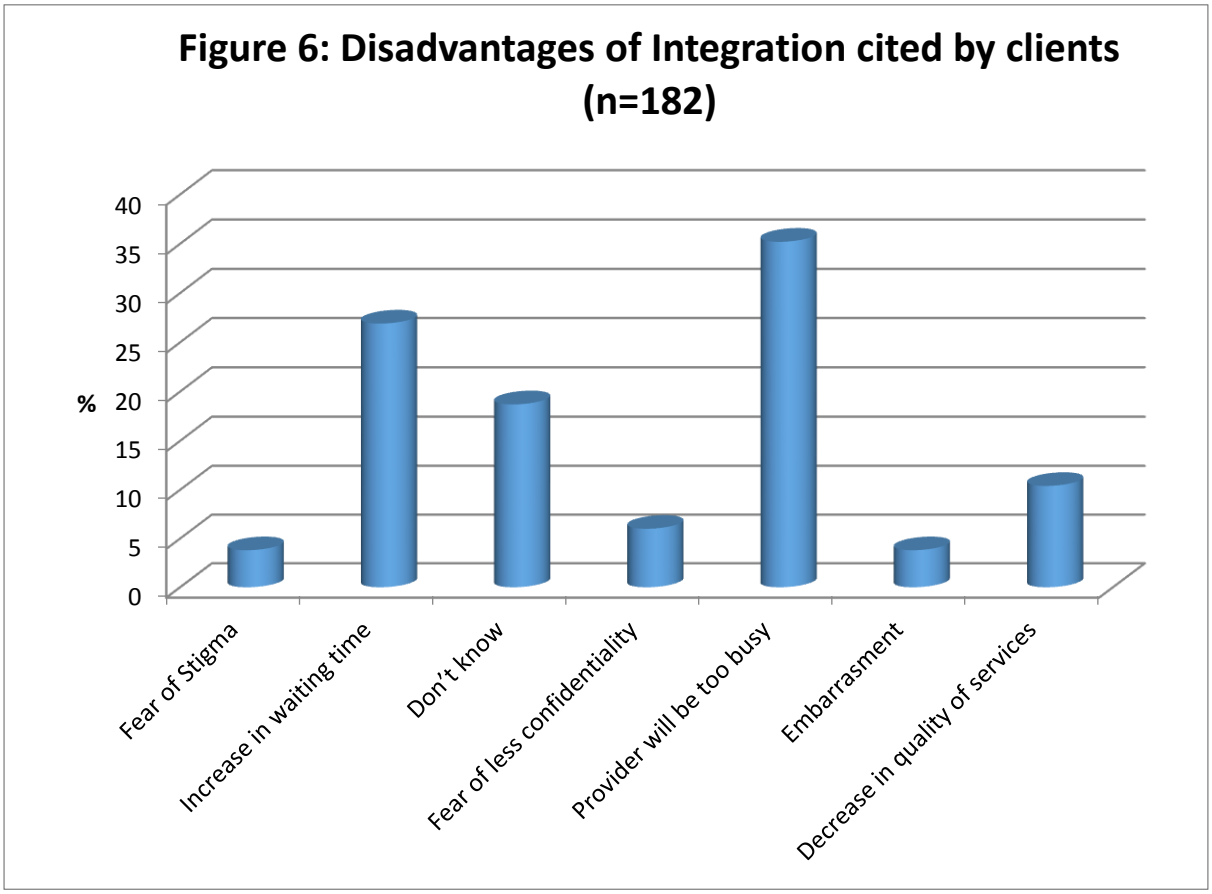
Clients were asked whether they preferred sexual and reproductive health and HIV services at the same facility or different facilities. As shown in Figure 4, the majority (73.6%) of clients reported that they preferred SRH and HIV services to be offered at the same facility and 20.9% indicated that they had no particular preference.



They were also asked about the possible benefits of receiving SRH and HIV services from the same facility at one time. The two major benefits cited were reduction in number of trips to health facility (57.1%) and opportunity for additional services for clients (41.2%) as shown in Figure 5.

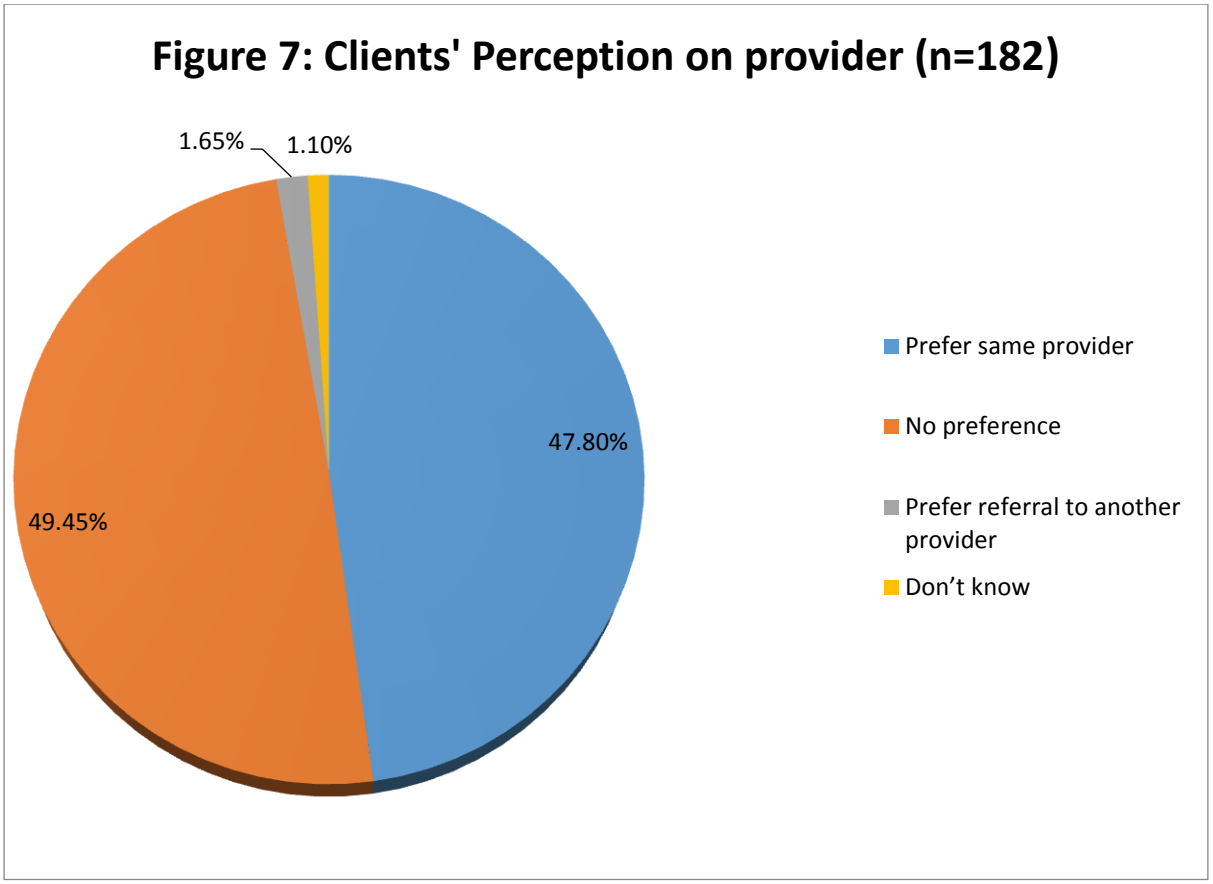


However, they also cited some disadvantages of receiving SRH and HIV services from the same facility at one time. As shown in Figure 6 below, the main disadvantages cited by clients were that the service provider would be overwhelmed (35.2%), there will be increase in waiting time (26.9%) and decrease in quality of services (10.4%).



When asked about their opinions about receiving SRH and HIV services from the same health service provider, the clients had mixed views. As shown in Figure 7 below, about half (49.5%) of the clients indicated that they had no preference about service provider and slightly less (47.8%) preferred to be offered SRH and HIV services by the same service provider.

The benefits of receiving SRH and HIV services from the same provider cited by the clients were reduction in client waiting time (51.1%), reduction in number of trips to health facility (18.1%) and reduction in transport costs (14.3%). However, about half (46.7%) of the clients reported that they would feel embarrassed to talk about HIV with a provider of the same village/neighborhood. Some of the disadvantages mentioned include decrease in quality of services provided (22.0%), service provider being too busy to see all clients (17.6%) and increase in client waiting time (19.2%).



During their consultation with service providers, the clients indicated that service providers mentioned the services described in Table 4 without being prompted. The most common services mentioned include labor and delivery (26.4%), women's rights and health needs of young people.

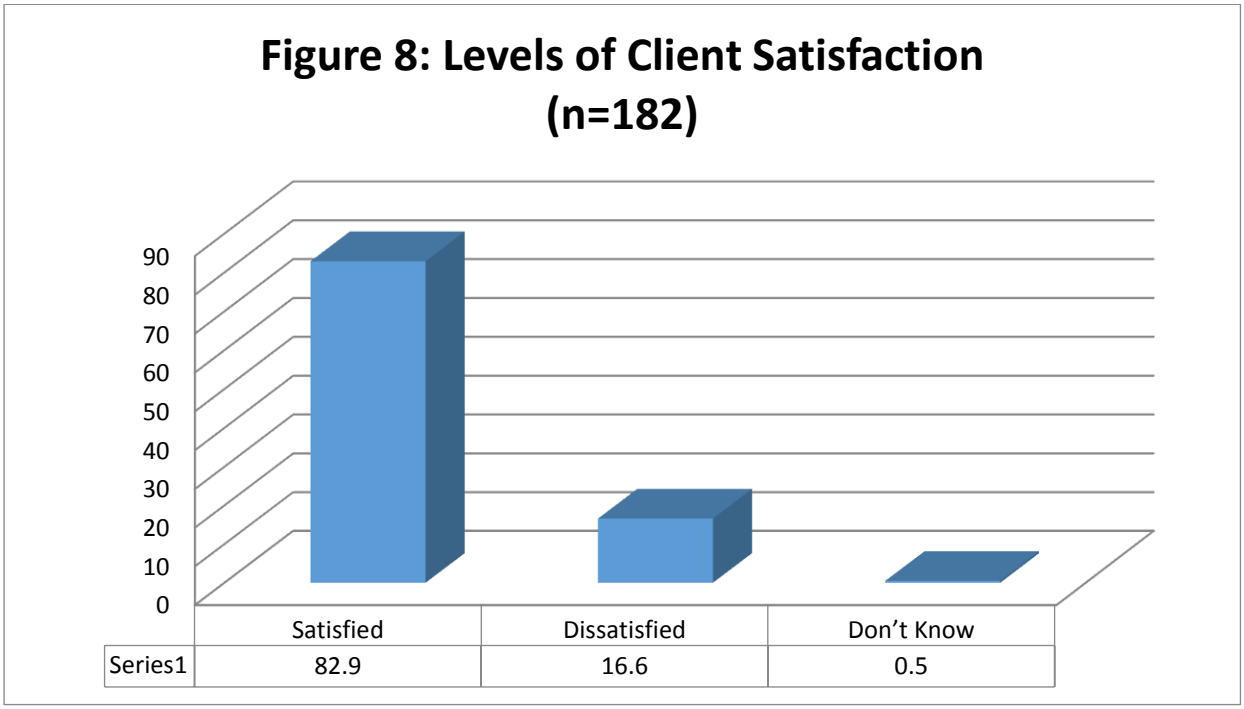
Table 4: Services mentioned by service providers during consultations with clients

Family planning	**13 (7.1%)**	Counselling and testing for HIV	**23 (12.6%)**	Labour and delivery	**48 (26.4%)**
Use of condoms to prevent unintended pregnancy	**12 (6.6%)**	PMTCT	**23 (12.6%)**	Domestic or other violence	**21 (11.5%)**
Use of condoms to prevent HIV /STI	**15 (8.2%)**	Breast cancer screening	**23 (12.6%)**	Women's rights	**37 (20.3%)**
Use of female condoms	**19 (10.4%)**	Cervical cancer screening	**9 (4.9%)**	Men's health	**25 (13.7%)**
STI management	**19 (10.4%)**	HIV is treatable with ART	**18 (9.9%)**	Health needs of young people	**32 (17.6%)**
HIV prevention	**19 (10.4%)**	Care and support for PL HIV	**11 (6.0%)**	Relationships	**2 (1.0%)**
Child health services	**6 (3.3%)**	Sexuality	**14 (7.7%)**	Vaccination	**4 (2.2%)**

It was observed that service providers were also addressing issues pertaining to male involvement, domestic violence, women's rights and youth health services holistically due to the training on SRH and HIV linkages they had received. These integrated services are offered as a minimum package to clients in the pilot districts and is based on the need to have linked services at one point instead of having to make repeated visits for accessing services by clients.

iv. Levels of Satisfaction

Over eighty percent of the clients (82.7%) were satisfied with the services they received at the health facilities at the time of the survey as shown in Figure 8 below. When clients were asked to make suggestions needed to improve services at the facility, they all indicated that there was need for government to avail resources such as staffing and ambulances.



The level of satisfaction is not affected by the type of health facility. Clients visiting all the pilot facilities (kiosk, supermarket or mall model) were equally satisfied with services they received. When broken down by type of facility, the level of satisfaction was the same for all health facilities visited by clients as shown in Table 5 below.

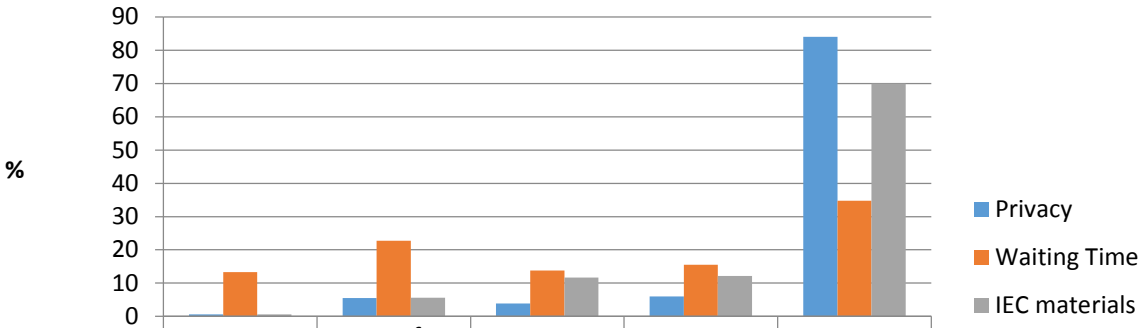
Table 5: Level of Satisfaction by type of facility

FACILITY	**LEVEL OF SATISFACTION (n=182)**			
	Dissatisfied	**Satisfied**	**Don't Know**	**TOTAL**
Mochudi One	0 0.00%	19 26.67%	0 0.00%	19 10.50%
Sikwane Health Post	3 19.62%	14 20.00%	0 0.00%	17 9.39%

Oodi Clinic	10 67.94%	10 14.44%	1 100.00%	21 11.60%
Sesung Health Post	0 0.00%	15 18.33%	0 0.00%	15 8.29%
Khudumelapye Clinic	6 39.23%	12 15.56%	0 0.00%	18 9.94%
Letlhakeng Clinic	4 21.05%	16 21.11%	0 0.00%	20 11.05%
Shoshong Clinic	3 23.44%	18 25.00%	0 0.00%	21 11.60%
Otse Health Post	2 10.53%	19 24.44%	0 0.00%	21 11.60%
Sefhare Hospital	2 18.18%	27 34.44%	0 0.00%	29 16.02%
TOTAL	**30 16.48%**	**150 82.42%**	**2 1.1%**	**182 100%**

The clients were also asked to rate the services they received from the health facility prior to the interview. As shown in Figure 9, clients rated privacy (84%) and type of information, education and communication (IEC) materials (70.0%) as excellent.

Figure 9: Service rating by clients (n=182)



	Poor	Unsatisfactory	Satisfactory	Good	Excellent
Privacy	0.6	5.5	3.9	6	84
Waiting Time	13.3	22.7	13.8	15.5	34.8
IEC materials	0.6	5.6	11.7	12.2	70

However, waiting time was not scored well since only a third (34.8%) rated it as excellent. When broken down by type of facility, the low level of satisfaction with waiting time was the same across the different types of health facilities.

v. Accessibility to Health Facility

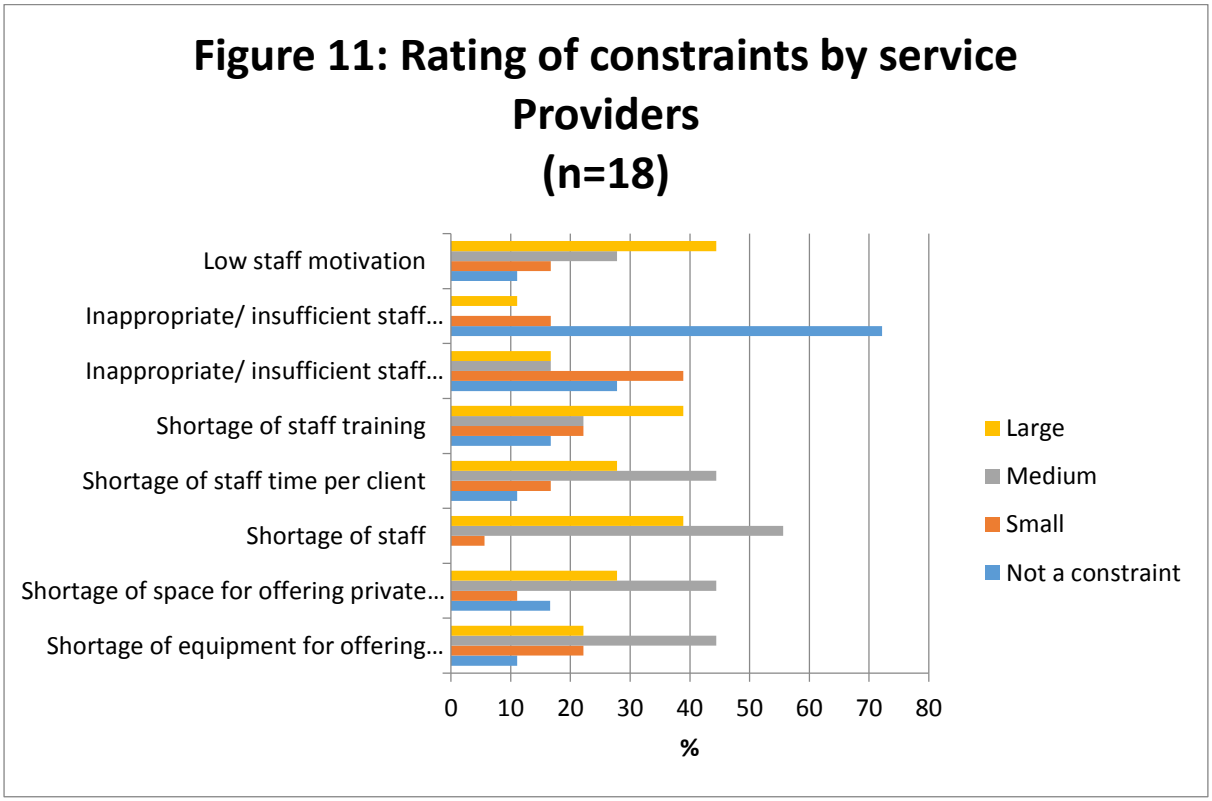
In terms of accessibility to health facilities, clients reported that they had taken an average of 34.1 minutes to get to the health facility. None of the clients had paid for transport to reach

the health facility. However, 92.4% reported that they had walked to the health facility. About seventeen percent (16.7%) of the clients indicated that they had to take time off from work for them to visit the health facilities and about half (51.1%) the clients had to make arrangements for someone else to do house chores or take care of children for them to get to the health facilities.

3.2 Perspectives of Service Providers

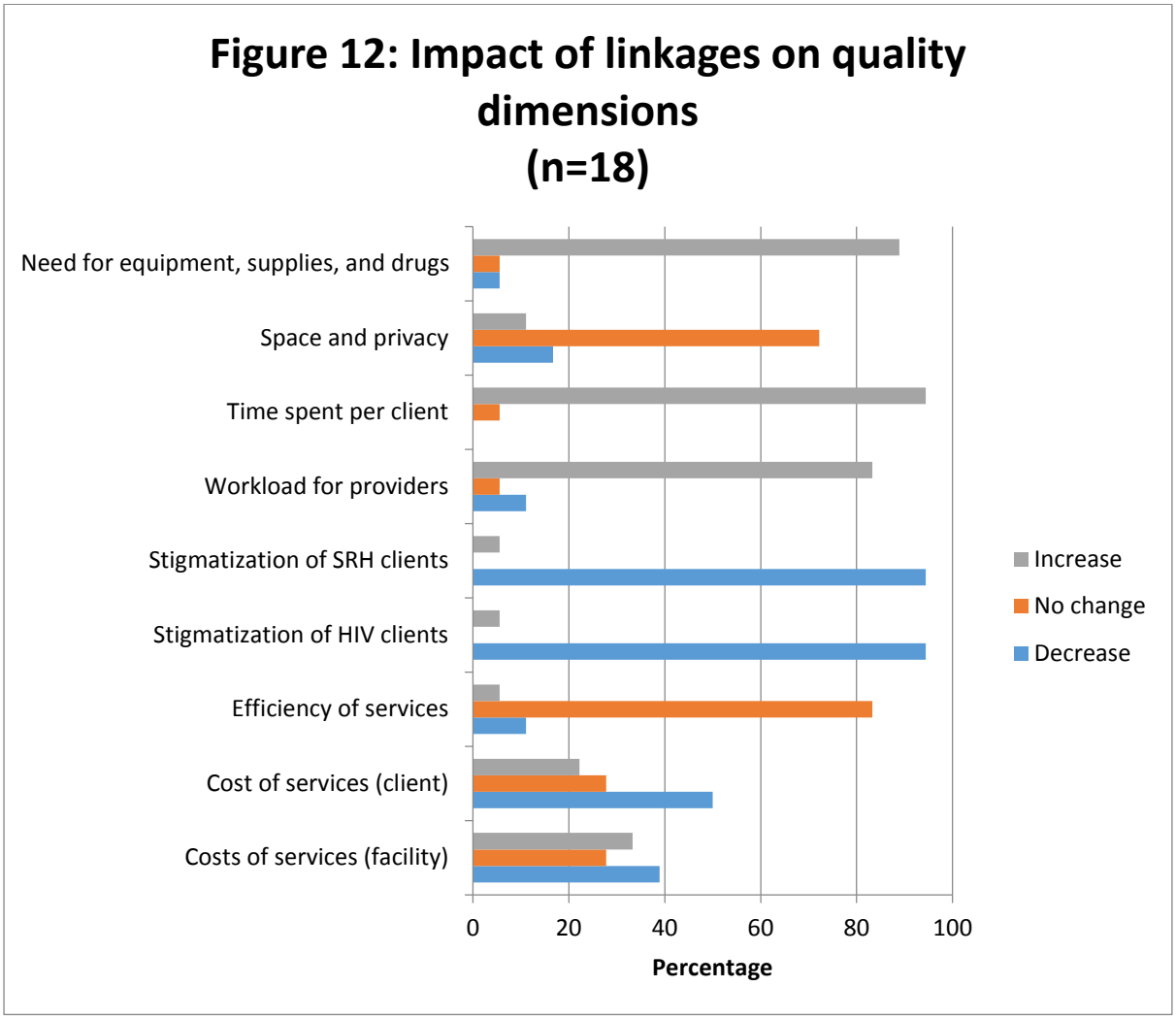
A total of 18 service providers (two from each health facility) were interviewed during the survey. They all reported that their facilities were offering HIV and SRH services. All the service providers indicated that shortage of resources (staff and ambulances), inadequate space, inadequate training and the lack of information on integration by clients were some of the major challenges associated with strengthening linkages between SRH and HIV services.

The service providers were asked to rate some of the challenges as to how large a constraint they are to offering linked SRH and HIV services at the health facilities visited. According to the service providers, as shown in Figure 11, staff supervision was not a constraint. When ranking constraints, staff motivation, shortage of staff, training and shortage of space to offer private and confidential services were rated as the biggest constraints.



The service providers also described the likely impact of linking SRH and HIV services on various quality dimensions. Figure 12 indicates that the service providers feel that linking SRH and HIV services will increase time spent per client (94.4%), need for equipment, supplies and drugs (88.9%) and workload for service providers (83.3%). The majority of service providers felt that integration decreases stigmatization of HIV (94.4%) and SRH

(94.4%). However, most of the service providers thought that integration of SRH and HIV services does not have an impact on efficiency of services (83.3%) and space and privacy (72.2%).



4. Discussion

This client satisfaction survey was conducted in a setting where the case for linking SRH and HIV services has been piloted for at least four years. More females than males (80.8% females and 19.2% males) of the same age group visited the clinics to access HIV and sexual and reproductive health services. The big difference between the two gender groups shows that society is still experiencing serious gender orientation views and perceptions that health services are only meant for females.

The results indicate that clients were receiving all the HIV and SRH services they want from the same facility. The clients were satisfied (82.9%) with the services they received from the pilot sites. The level of satisfaction is not affected by the type of health facility. Clients visiting all the pilot facilities (kiosk, supermarket or mall model) were equally satisfied with services they received. They were also satisfied with privacy and type of information, education and communication materials they found at the facilities. The level of satisfaction

is not different from the results obtained during the survey conducted in 2012 in the same pilot facilities in which 82% were satisfied with services received. The clients welcomed the approach of integration because they felt it reduced the number of trips to health facility.

However, clients were not happy with the waiting time. It should be noted that integration of services tends to increase the waiting since service providers will be offering more services to clients. Nevertheless, clients would prefer to wait for services at the facilities compared to the number of trips they make if services are not integrated. In scaling up integration of SRH and HIV services, efforts should be put in place to ensure that waiting time is not unnecessarily increased. The increase of service providers at the health facilities would reduce the waiting time by increasing staff. It should also be noted that both clients and service providers identified shortage of staff as the major barrier to integration. Although health service providers indicated that training of integration of SRH and HIV was a constraint, all the service providers in the pilot districts were oriented on integration modalities. The orientation was also augmented by the supervision conducted which was rated as excellent. The orientation offered to health service providers on linkages of SRH and HIV enabled service providers to deliver quality integrated services.

Although the SRH and HIV linkages project has been implemented four more than four years in the same facilities, clients are still self-stigmatized as they reported that they would feel embarrassed to talk about HIV with a service provider of the same village/neighborhood. Although clients were concerned about self-stigma, the service providers felt that integration has decreased stigmatization of HIV and SRH. This finding is supported by the baseline survey results of 2012 which showed that the majority of clients (85.6%) surveyed in the same pilot facilities indicated that health service providers did not stigmatize people living with HIV. This finding calls for the need to address issues of self- stigma in the community.

The results of the survey are of special interest because Botswana has taken a decision to scale up the provision of integrated SRH and HIV services countrywide within the framework of primary health care. Thus evidence from the pilot sites on the practical benefits (and limitations) of integrated services should be of direct relevance to other districts in Botswana and indeed other countries with similar profiles of sexual and reproductive health problems.

One of the most important findings of the study is that both providers and clients appear to welcome integration and appreciate the advantages and convenience to the client of a ‘one-stop’ service. However, in scaling up the integration of SRH and HIV services, issues of limited resources (particularly equipment, staffing and commodities) should be taken into consideration across the districts.

5. Lessons Learnt

In Botswana, a pilot intervention targeted at supporting a co-ordinated approach to integration of SRH and HIV services was initiated four years ago. This was in response to the increased need for policy and programming to jointly address SRH and HIV, particularly in the context of the commitment to universal access to health care services and the Maputo Plan of Action. A review of findings from the client satisfaction survey has revealed the following:

- *Client Satisfaction* - With high political and community commitment and support, the SRH/HIV integration project responded to the needs of the community as is demonstrated by improved client satisfaction. The initiative reduced the number of visits that clients make to health facilities.
- *Ownership* - The systematic efforts made by the SRH/HIV linkages project in preparing service providers for the provision of integrated services resulted in greater ownership and appreciation of the services being provided
- *Efficiency* - Integration of SRH and HIV services demonstrated efficiency in both clients, financial and human resource use. Given the acute shortage of health service providers, the intervention has demonstrated that effective utilization of human resources can be achieved through increased integration, since service providers become multi-skilled and competent to deliver both SRH and HIV services.
- *Stigma and discrimination* – Although clients still have self-stigma, community awareness of integrating SRH and HIV services will assist with reduction in stigma in communities.
- *Waiting time* – Due to the provision of integrated services and the shortage of service providers, clients experienced long waiting time. Service providers were spending more time with clients since they were offering more services.
- *Resources* – Equipment, commodities and space for offering confidential services are critical for integration of SRH and HIV services.

6. Conclusions

There is strong evidence that integration of SRH and HIV in Botswana is welcomed by both clients and service providers. Clients are satisfied with the integrated approach to the delivery of SRH and HIV services. The level of satisfaction is not affected by the type of health facility. Clients visiting all the pilot facilities (kiosk, supermarket or mall model) were equally satisfied with services they received. Through integration, the clients were reducing the number of trips required to visit a health facility. However, the clients were concerned with the long waiting time and recommended that the staffing at health facilities should be increased to cater for the time spent on one client during consultation.

The lessons learnt from the integration of SRH and HIV services will motivate the Government of Botswana to scale up services nationwide. Through SRH/HIV, it has been demonstrated that goals on stigma reduction, increased access to family planning services, prevention of unintended pregnancies in PLHIV, and joint delivery of family planning commodities and ARVs can be achieved. In the long term, health and community systems will be strengthened, and HIV prevention amongst the general population will be realized.

However, the client satisfaction survey indicates that for integration to be successful there is need to address the drawbacks of insufficient health facility space, increased staff workload and waiting times. Furthermore, whilst service providers at facility level have demonstrated high knowledge levels and skills to implement integrated SRH and HIV, the shortage of healthcare workers will need to be addressed, together with other factors that motivate them.

References:

1. Ministry of Health, Botswana (2010). Sexual and Reproductive Health Rights and HIV and AIDS Linkages Integration Strategy and Implementation Plan
2. Ministry of Health, Botswana (2014). SRHR HIV Linkages Assessment Report
3. Ministry of Health, Botswana (2014). SRHR and HIV Scale Up Plan
4. Government of Botswana. SRH Policy Guidelines and Service Standards
5. Marie Stopes International Partners *Guidelines for implementing the MSI Client Satisfaction Exit Interview Questionnaire Survey*" (http://www.mariestopes.org.uk).

ANNEXES

A. INFORMED CONSENT FORM

My name is …….. I am here on behalf of Ministry of Health.

The Ministry of Health, in partnership with UNFPA, is conducting an assessment on policies, systems and services related to SRHR and HIV linkages. This information may help to improve policies, programs and services during scale up of the pilot project. We would appreciate it if you could answer some questions. However, your participation in this study is voluntary and if you choose not to participate, you will not be penalized in any way. If you agree to participate and you change your mind later, you can also ask me to stop the interview whenever you want.

If you participate, you will not benefit directly from your participation. But your participation may result in improved future Sexual and Reproductive Health and HIV policies and services. Your opinions and the information you give during the interview will remain confidential. The questionnaire will not have your name. This way, no one will be able to know that I interviewed you or what you said.

Finally, if you have any questions about this study at a later time, you can call the National Coordinator for SRHR/HIV Linkages, Ministry of Health.

May I continue with the Interview?

Yes_____ No _____

Client Signature _____ Date _____

B. CLIENT EXIT QUESTIONNAIRE

1. Preliminary Questionnaire Information

1a	District	
1b	Facility	
1c	Interviewee number	
1d	Date of Interview	
1e	Service from which client is exiting	i. Family planning ii. Cancer Screening (e.g. Pap smear, breast exam, etc.) iii. Maternal and newborn care iv. Prevention and management of gender-based violence v. Prevention & management of STI services vi. HIV Testing and Counseling vii. Safe Male Circumcision viii. TB screening ix. ARV x. PMTC xi. No integration xii. Other, (specify) xiii. Don't know
1f	Sex of client	i. Male ii. Female
1g	Age of client	…… years (at last birthday)

2. Please tell me what services you came for today and what service you received?
(Do not read. Listen and tick all that apply. Probe: Any others?)

Service		**Which one you came for**	**Which one you received**
i.	Family planning		
ii.	Cancer Screening (e.g. Pap smear, breast exam, etc.)		
iii.	Maternal and newborn care		
iv.	Prevention and management of gender-based violence		
v.	Prevention & management of STI services		
vi.	HIV Testing and Counselling		
vii.	Safe Male Circumcision		
viii.	TB screening		
ix.	ARV		
x.	PMTC		
xi.	No integration		
xii.	Other (specify)		
xiii.	Don't know		
xiv.	Refused to answer		

3a.Were you referred to any other services than those for which you came?

i. Yes		ii. No	

3b.Did you get all of the services you wanted today?

i.	Yes			ii. Not sure	
iii.	No **(>Q3c & Q3d**)			iv. Other (specify):	

3c. (If no in 3b). What other services would you have liked to get from this facility today? (Do not read. Listen and tick all that apply. Probe: Any others?)

i.	Family planning		ii.	Treatment preparedness		iii.	Psycho-social support	
iv.	Prevention and management of STIs		v.	HIV monitoring and/or treatment		vi.	Nutrition support	
vii.	Maternal and newborn care		viii.	HIV prevention		ix.	Routine gynecological examination	
x.	Prevention and management of gender-based violence		xi.	Condom services		xii.	Prevention of unsafe abortion and management of post-abortion care	
xiii.	PMTCT		xiv.	HIV counselling and testing		xv.	Economic assistance	
xvi.	Other (specify):		xvii.	Don't know		xviii.	Refused to answer	

3d. (If no in 3b). Why did you not receive all the services you wanted?
(Do not read. Listen and tick all that apply. Probe: Any others?)

i.	Cost		ii.	Nurse/doctor didn't have time		iii.	Don't know	
iv.	Not available		v.	I didn't feel comfortable requesting the service		vi.	Other (specify):	
vii.	I didn't have time		viii.	I didn't know that that service was available to me		ix.	Refused to answer	

4a.Do you prefer sexual and reproductive health and HIV services at the same facility, or do you prefer different facilities?

i.	Prefer same facility/site		ii.	No preference		iii. Other (specify):	
iv.	Prefer a different facility/site		v.	Don't know			
4b. Why?							

5. What do you think may be some of the possible benefits of receiving all these services from the same facility at one time?
(Do not read. Listen and tick all that apply. Probe: Any others?)

i.	Reduce no. of trips to facility		ii.	Reduce fees		iii. Reduce stigma for HIV (If yes) Probe: In what way?	
iv.	Improve efficiency of services		v.	Reduce waiting time		vi. Don’t know	
viii.	Reduce transportation costs		ix.	Good opportunity to access additional services		x. Other (specify):	

6. What do you think may be some of the possible disadvantages of receiving all these services from the same facility at one time?
(Do not read. Listen and tick all that apply. Probe: Any others?)

1. Fear of stigma and discrimination		2. Increase client waiting time		3. Don’t know	
4. Fear of less confidentiality		5. Provider will be too busy		6. Other (specify):	
7. Embarrassment to talk about HIV with provider of same village/ neighborhood				8. Decrease quality of services	

7a.Do you prefer sexual and reproductive health and HIV services from the same provider or do you prefer referral to another provider?

1. Prefer same facility/site		2. No preference		3. Other (specify):	
4. Prefer referral to another provider		5. Don't know			
7b. Why?					

8. What do you think may be some of the possible benefits of receiving all these services from the same provider at one time? (Do not read. Listen and tick all that apply. Probe: Any others?)

i.	Reduce number of trips to facility		ii.	Reduce fees		iii.	Reduce stigma for HIV (If yes) Probe: In what way?	
v.	Improve efficiency of services		vi.	Reduce waiting time		vii.	Don't know	
viii.	Reduce transportation costs		ix.	Good opportunity to access additional services		x.	Other (specify):	

9. What do you think may be some of the possible disadvantages of receiving all these services from the same provider at one time? (Do not read. Listen and tick all that apply. Probe: Any others?)

i.	Fear of stigma and discrimination		ii.	Increase client waiting time		iii.	Decrease quality of services	
iv.	Fear of less confidentiality		v.	Embarrassment to talk about HIV with provider of same village/ neighbourhood				
vi.	Provider will be too busy		vii.	Other (specify):		viii.	Don't know	

10. Please tell me which of the following your provider mentioned today? (Read and tick all that apply.)

i.	Family planning		ii.	Counselling and testing for HIV		iii.	Labour and delivery	
iv.	Use of condoms to prevent unintended pregnancy		v.	Preventing transmission of HIV to your "baby"		vi.	Domestic or other violence	
vii.	Use of condoms to prevent HIV /STI		viii.	Breast cancer screening		ix.	Women's rights	
x.	Use of female condoms		xi.	Cervical cancer screening		xii.	Men's health	
xiii.	STI management		xiv	HIV is treatable with ART		xv.	Health needs of young people	
xvi.	HIV prevention		xvii.	Care and support for PL HIV		xix.		
xx.	Relationships		xxi.	Child health services		xxii.	Sexuality	
xxiii	Vaccination		xxiv.	Anything else that interested you (specify):				

11. If you could make only one suggestion for improving services at this facility, what would you suggest?

_____

12. Do you have any suggestions about the integration of sexual and reproductive health and HIV services?

_____

13a.How satisfied are you with the services you received today?

Very dissatisfied 1	Somewhat dissatisfied 2	Mostly satisfied 3	Very satisfied 4	Don't know 5	Does not wish to answer 6

13b.What might have helped you to be more satisfied with the services you received today?

_____

14a How would you rate the service(s) you received from this health care facility? *(Ask the client about each item individually)*

	ITEM	Poor	Unsatisfactory	Satisfactory	Good	Excellent
i.	Waiting time					
ii.	Privacy/space for consultation					
iii.	Information/education materials					

14b. Explain any items ranked "Unsatisfactory" or "Poor":

C. SERVIVE PROVIDER QUESTIONNAIRE

Preliminary Questionnaire Information

1a. District _____

1b. Name of Health Facility_____

1c. Interviewee number _____

1d. Title and role of respondent _____

1e. Date of Interview _____

2. Type of services provided

Question		Service	Tick
2a.	Which of the following essential HIV services are offered at this facility? [Read all options. Tick all as appropriate]	HTC	
		SMC	
		TB screening	
		ARV	
		PMTC	
		No integration	
		Other (specify) ……..	
2b.	Which of the following essential SRHR services are offered at this facility? [Read all options. Tick all as appropriate]	Family planning	
		Cancer Screening	
		Maternal and new-born care	
		Prevention and management of gender-based violence	
		Prevention & management of STI services	
		Other (specify) ----------	

3. What do you believe are some of the policies and procedures in place that serve as the most important challenges and constraints to strengthening linkages between SRH and HIV services?

_____

_____

_____

4. Please rate each of the following as to how large a constraint it is to offering linked SRH and HIV services at this facility. Would you say it was not a constraint, a small, a medium, or a large constraint?

	Not a constraint 1	Small 2	Medium 3	Large 4	Don't know 5
4a. Shortage of equipment for offering integrated services					
4b. Shortage of space for offering private and confidential services					
4c. shortage of staff					
4d. Shortage of staff time per client					
4e. Shortage of staff training					
4f. Inappropriate/ insufficient staff supervision by district management					

4g. Inappropriate/ insufficient staff supervision by facility management					
4h. Low staff motivation					
4i. Some other constraint? (specify):					

5. What do you believe are some of the most important policies and procedures in place that facilitate the strengthening of linkages between SRH and HIV services?

_____
_____
_____
_____

6. What do you think is or will be the likely impact of linking SRH and HIV services on the following service dimensions. Will they decrease, increase or not change the (read each dimension below)?

	Decrease 1	No change 2	Increase 3	Don't know 4
6a. Costs of services (facility)				
6b. Cost of services (client)				
6c. Efficiency of services				
6d. Stigmatization of HIV clients				
6e. Stigmatization of SRH clients				
6f. Workload for providers				
6g. Time spent per client				
6h. Space and privacy				
6i. Need for equipment, supplies, and drugs				
6j. Other (please specify)				

Thank you very much for your time and assistance!

D. Setswana Version of Client Exit Interview

1a	District	
1b	Facility	
1c	Interviewee number	
1d	Date of Interview	

1e	Service from which client is exiting	xiv. Katologanyo Tsholo xv. Tlhatlhobo ya kankere ya molomo wa popelo le kankere ya lebele xvi. Baimana le Masea xvii. Thibelo ya kgokgontsho ya bong xviii. Taolo ya Malwetsi a tlhakanelo dikobo xix. Tshidilo Maikutlo le Itlhatlhobelo mogare wa HIV xx. Kgaolo ya letlalo la borre mo go sireletsegileng xxi. Tlhatlhobo ya bolwetsi jwa kgotlholo e tona xxii. ARV xxiii. PMTC xxiv. No integration xxv. Tse dingwe,(tlhalosa) xxvi. Ga a itse
1f	Sex of client	iii. Rre iv. Mme
1g	Age of client	…… years (at last birthday)

2.Tswee-tswee ke kopa o mpolelele ditirelo tse o neng o di tletse gompieno le tse o di amogetseng?

Ditirelo	Ye o e tletseng	Ye o e amogetseng
i. Katologanyo Tsholo		
ii. Tlhatlhobo ya kankere ya molomo wa popelo le kankere ya lebele		
iii. Baimana le Masea		
iv. Thibelo ya kgokgontsho ya bong		
v. Taolo ya Malwetsi a tlhakanelo dikobo		
vi. Tshidilo Maikutlo le Itlhatlhobelo mogare wa HIV		
vii. Kgaolo ya letlalo la borre mo go sireletsegileng		
viii. Tlhatlhobo ya bolwetsi jwa kgotlholo e tona		
ix. ARV		
x. PMTC		
xi. No integration		
xii. Tse dingwe,(tlhalosa)		
xiii. Ga a itse		
xvii. O ganne go araba		

3a A o ile wa romelwa go bona ditirelo tse dingwe gona le tse o di tletseng?

1. Yes		2.No	

3b A ditirelo tsotlhe tse o di tletseng o di bone?

1.Ee		2.ga kena bosupi	
3.Nnyaa(>Q3c & Q3d)		4.tse dingwe(tlhalosa)	

3c (Fa ele nnyaa)Ke dife ditirelo tse o neng o eleditse go ka di bona mo kokelong/kokelwana e gompieno?

1.Katologanyo Tsholo		2. Go ipaakanyetsa kalafi		3.Tse di amanang le Tlhaloganyo le tikologo	
4.Thibelo le Taolo ya malwetsi a tlhakanelo dikobo		5.Taolo kgotsa kalafi ya mogare wa HIV		6.Thuso ka tse di otlang mmele	
7.Baimana le Masea		8.Thibelo ya mogare wa HIV		9.Tlhatlhobo ya bomme ee akaretsang)tlhatlhobo ya kankere ya molomo wa Popelo le kankere ya lebele	
10.Thibelo le Taolo ya Kgokgontsho ya bong		11.Tiriso ya sekausu		12.Ga a itse	
13.Thibelo ya tshenyego ya boimana le 14. taolo morago ga tshenyego ya boimana		15.Thibelo mogare go tswa mo go mmangwana go ya ko leseeng		16.Tse dingwe(tlhalosa)	
17.Tshidilo maikutlo le Itlhatlhobelo mogare wa HIV		18.Thuso ka tsa Itsholelo		19.O gana go araba	

3d.(fa ele nnyaa)Ke eng o sa amogela ditirelo tsotlhe tse o neng o di batla?

1.Ditlhwatlhwa		2.Mooki/Ngaka o ne a sena nako		3.Ga ke itse	
4.Ga di yo		5.Ke ne ke sa phuthologa 6.go kopa ditirelo tsa teng		7.Tse dingwe,(tlhalosa	
8.Ke ne ke sena nako		9.Ke ne ke sa itse gore a nka bona ditirelo tsa teng		10.O gana go araba	

4a Ao eletsa go amogela ditirelo tsa tlhakanelo dikobo,thuso ya tsa tsholo le tsa mogare wa HIV mo kokelong/kokelwana e le nosi,kgotsa tse di farologanyeng?

1.Ele nosi		2.Ngwe le ngwe		3.Tse dingwe(tlhalosa)	

4.E e farologaneng		5.Ga ke itse			
4.b Why?					

5.O akanya gore dipoelo tse di molemo e ka nna di fe fa o ne o ka amogela ditirelo tse tsotlhe mo kokelong/kokelwana ele nosi ka nako ele nngwe?

1.Go fokotsega ga maeto a go ya kokelwaneng		2.Dituelo tse di ko tlase		3.go fokotsega ga kgetholoIo ya mogare wa HIV 4.fa ele ee)botsolotsa : Jang?	
5.Go fefosa go amogela ditirelo		6.Nako ya go letela ea fokotsega		7.Ga ke itse	
8.Phokotsego ya dituelo tsa go palama		9.Sebaka se se ntle sa go amogela ditirelo tsa tlaleletso		10.Tse dingwe(tlhalosa)	

6. O akanya gore ditlamorago tse di seng molemo e ka nna dife fa o ne o ka amogela ditirelo tse tsotlhe mo kokelong/kokelwana ele nosi ka nako ele nngwe?

1.Letshogo la kgetholoIo		2.Nako e oketsegileng ya go letela		3.Ga ke itse	
4.Letshogo la go tlhoka go phutologa		5.Mooki/ngaka o pitlagangwa ke tiro		6.Tse dingwe(tlhalosa)	
7.Go tlhajwa ke ditlhong go bua ka mogare wa HIV le mooki wa mo legaeng le le lengwe kgotsa moagisanyi		8.Go fokotsega ga go amogela ditirelo tse di tlhwatlhwa			

7a A o eletsa go amogela ditirelo tsa tlhakanelo dikobo ,thuso ya tsa tsholo le ditirelo ka tsa mogare wa HIV go tswa mo mooki a le mongwe kgotsa yo o farologanyeng?

1.A le nosi		2.Mongwe le mongwe		3.Tse dingwe(tlhalosa	
4.O eletsa go romelwa kwa go o sele		5.Ga ke itse			
7b.Why?					

8. O akanya gore dipoelo tse di molemo e ka nna dife fa o ka amogela ditirelo tse tsotlhe go tswa go mooki a le mongwe?

1.Go fokotsega ga maeto a go ya kokelwaneng		2.Dituelo tse di ko tlase		3.go fokotsega ga kgetholololo ya mogare wa HIV 4.fa ele ee)botsolotsa : Jang?	
5.Go fefosa go amogela ditirelo		6.Nako ya go letela ea fokotsega		7.Ga ke itse	
8.Phokotsego ya dituelo tsa go palama		9.Sebaka se se ntle sa go amogela ditirelo tsa tlaleletso		10.Tse dingwe(tlhalosa)	

9. O akanya gore ditlamorago tse di seng molemo e ka nna di fe, fa o ka amogela ditirelo tse tsotlhe go tswa mo mooki a le mongwe?

1.Letshogo la kgetholololo		2.Nako e oketsegileng ya go letela		3.Ga ke itse
4.Letshogo la go tlhoka go phutologa		5.Mooki/ngaka o pitlagangwa ke tiro		6.Tse dingwe(tlhalosa)
7.Go tlhajwa ke ditlhong go bua ka mogare wa HIV le mooki wa mo legaeng le le lengwe kgotsa moagisanyi		8.Go fokotsega ga go amogela ditirelo tse di tlhwatlhwa		

10. Tswee-tswee ,mpolelele gore ke dife ditirelo tse mooki a buileng ka tsone gompieno?

1	Katologanyo tsholo		9	Tshidilo maikutlo le Itlhatlhobelo mogare wa HIV		17	Tsa pelegi	
2	Tiriso ya sekausu mo go thibeleng boimana jo sa solofelwang		10	Go thibela go fetisediwa ga mogare ko leseeng		18	Kgokgontso ya mo lapeng kgotsa epe fela	
3	Tiriso ya sekausu go thibela go tsenwa ke mogare wa HIV kgotsa malwetsi a tlhakanelo dikobo		11	Tlhatlobo ya kankere ya lebele		19	Ditshwanelo tsa bomme	
4	Tiriso ya sekausu sa bomme		12	Tlhatlhobo ya kankere ya molomo wa popelo		20	Botsogo jwa borre	
5	Taolo ya malwetsi a tlhakanelo dikobo		13	HIV ea laolesega ka ART		21	Ditlhokego tsa botsogo tsa banana	
6	Thibelo ya mogare		14	Tlhokomelo ya molwetsi o tshelang		22	Sengwe fela se se go kgatlhileng(tlhalosa)	

				ka mogare				
7	Botsalano		15	Botsogo jwa Bana				
8	Tsa tlhakanelo dikobo		16	Mekento				

11	Fa o ne o ka ntsha mogopolo o le mongwe ka fa go ka tokafadiwang kamogelo ya ditirelo mo kokelong/kokelwana e,o ne o ka reng?	
12	Aon a le tswhaelo ka go tshwaragana ga ditirelo tsa tlhakanelo dikobo,tsa tsholo lemogare wa HIV?	

13a O kgotsofetse go le kae ka ditirelo tse o di amogetseng gompieno?

Ga kea itumela gotlhelele	Ga kea itumela go se kae	Ke kgotsofetse thata	Ke kgotsofetse	Ga ke itse	Ga a batle go araba

13b	Ke eng se se ka bong se ne sa thusa gore o kgotsofalele ditirelo tse o di amogetseng gompieno?	

14a. O ne o ka kala jang ditirelo tse o di amogetseng mo kokelong/kokelwaneng e ?(Botsa mmotsisiwa ka ditirelo ka g ka bongwe)

	Ga go kgatlhise gotlhelele	Ga go kgatlhise	Go a nametsa	Go botoka	Go a kgatlhisa thata
Nako ya go letela					
Go phuthologa mo phaphosing ya tlhatlhobo					
Didirisiwa tsa dikitsiso kgotsa dithuto					
Go dirisanya le mmereki wa tsa					

botsogo					