

BEST PRACTICE REPORT FOR SRHR & HIV LINKAGES PROJECT IN BOTSWANA: MOCHUDI CLINIC 1, KGATLENG DISTRICT, BOTSWANA



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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Medicines
BONELA	Botswana Network of Ethics, Law and HIV and AIDS
BONEPWA	Botswana Network of People Living with HIV/AIDS
BOFWA	Botswana Family Welfare Association
BP	Best Practice
CBO	Community-Based Organisation
DHMT	District Health Management Team
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
LEGABIBO	Lesbians, Gays and Bisexuals of Botswana
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MoH	Ministry of Health
NGO	Non-Governmental Organisation
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme On HIV/AIDS
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHC	Village Health Committee

1. BACKGROUND

1.1 OVERVIEW OF THE HEALTH SECTOR IN BOTSWANA

The overall aim of the Ministry of Health (MoH) is to improve the physical, mental, and social well-being of every Mbotswana so that they can fully contribute to the development of Botswana as a healthy nation. The MoH is responsible for co-ordinating and leading the health sector in Botswana, including formulating policies, setting standards and regulations, as well as ensuring that quality and affordable health services are delivered to all.

Healthcare in Botswana is delivered through a decentralised model, with primary healthcare being the pillar of the delivery system. According to the MoH, Botswana has an extensive network of health facilities (referral hospitals, hospitals, clinics, health posts, mobile stops) in its 27 health districts. In addition to an extensive network of 111 clinics with beds, 175 clinics without beds, 343 health posts and 1,052 mobile stops, Botswana has 7 private hospitals (including 3 mine hospitals) 3 referral hospitals, 8 General Hospitals and 17 primary hospitals.

Primary Health Care (PHC) services in Botswana are integrated within overall hospital services and are provided through outpatient services. This enables the provision of preventive, promotive and rehabilitative health services as well as treatment and care of common problems. Today, citizens are always within eight kilometres of the nearest health facility.

1.1.1 HIV AND AIDS IN BOTSWANA

In 2002, Botswana became the first country to offer free antiretroviral medicines (ARVs) to its citizens. It also became one of the first nations in sub-Saharan Africa to curb the transfer of HIV from mothers to their babies through its prevention of mother-to-child transmission (PMTCT) programme. In 2013, it saw more than 95% of pregnant women living with HIV receiving antiretroviral therapy (ART). However, despite good progress, the estimated prevalence of HIV remains high amongst the general adult population, standing at 23%, with three in every ten pregnant women tested being HIV positive. This clearly demonstrates a discord between provision of HIV and sexual and reproductive health (SRH) services.

The EU-supported 2008 review of the linkages between HIV and sexual and reproductive health services resulted in the development of a sexual and reproductive health rights (SRHR) and HIV linkages strategy that defined actions needed to advocate for – and achieve – comprehensive services that can be systematically and proactively deployed to all clients/users in one location by skilled service-providers in order to avoid missed opportunities. The Government of Botswana is thus cognizant of the benefits of integrating health services where there is a policy environment in place to support practice.

1.2 THE LINKAGES PROJECT AND INTEGRATED HEALTH SERVICE PROVISION

A focus on strengthening SRHR and HIV linkages in the Southern African Development Community, SADC, ran between 2011 and 2014 and was driven by a seven-country pilot project in partnership with the European Union (EU), the United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

In Botswana, this project was implemented in the sub-districts of Letlhakeng, Kgatleng and Mahalapye. The aim was to strengthen bi-directional linkages between SRH and HIV and in doing so, to draw lessons from operations across a diversity of sites (remote, rural and urban). As the country employs a diversity of health delivery models, three approaches were included to offer integrated SRHR and HIV services, namely:

The Kiosk Model: Applicable to health posts and smaller clinics where a number of services are offered to clients within the same room by one health care facility.

The Supermarket Model: Applicable to clinics with or without maternity wards/wings, where the larger space allows use of a number of rooms as entry points to health care, and where at each point of service, a number of options can be offered to the client. Referrals within and to other facilities may or may not be common, helping streamline referrals for improved efficiency of delivery.

The Mall Model: Applicable to hospitals, whether primary, general or referral. Here, services are internally disaggregated and referrals are expected and routinised to support service integration.

In total, there were ten pilot sites across Botswana: Mahalapye Hospital Youth Centre, Sefhare Primary Hospital, Shoshong Clinic, Otse Health Post, Letlhakeng Clinic (with a maternity wing), Khudumelapye Clinic, Sesung Health Post, Mochuidi 1, Sikwane Clinics and Odi Health Post. Several independent studies informed implementation, key amongst them being:

- [A baseline study to identify pilot sites and assess their capacity to integrate services](#)
- [A progress report assessing the situation on linkages at each pilot site.](#)

Following a review of all information, Mochudi Clinic 1 in Kgatleng District was identified as a potential best practice site by MoH and UNFPA and thus worthy of follow-up documentation.

2. THE RELEVANCE OF BEST PRACTICES TO INTEGRATION OF SRHR AND HIV SERVICES

Over the past decade, SADC Member States have shown increased commitment to, and recognition of, the value of best practice documentation in the health sector. This has been especially evident in the context of efforts to control HIV and the Maseru Declaration on the Fight against HIV and AIDS, which declared that:

“Within the SADC region there have been successes and best practices in changing behaviour, reducing new infections and mitigating the impact of the HIV and AIDS pandemic, and that these successes need to be rapidly scaled up and emulated across the SADC region.”

Both the SADC Strategic Plan and the Business Plan on HIV and AIDS advocate the sharing of best practices between Member States. To this end, Member States have signed and ratified a number of regional and international declarations that heighten the added value of best practice documentation and sharing. These include:

- 1999 – SADC Protocol on health, which prioritises the control of communicable diseases and calls for harmonising policies and strategies aimed at disease prevention and control
- 2000 – Millennium Development Goals (MDGs), especially MDG 4 (Reduce child mortality) and MDG 6 (Combat HIV, malaria and other diseases)
- 2003 – Maseru Declaration on the Fight against HIV and AIDS in the SADC Region
- 2006 – Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, TB and Malaria Services
- 2006 – The 55th WHO Regional Committee for Africa, which declared TB an emergency
- 2011–2015 – Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.

It remains important for SADC Member States to continually improve on documenting and sharing of working models, strategies and approaches in the response to the three main communicable diseases (HIV, TB and malaria), including integration with health service response. This will help to boost a culture of learning based on examples of success and facilitate the investment of resources in proven programmes across the various regional policy, service delivery and resource mobilisation agendas.

To assist this process, in 2006, SADC developed its own framework for documenting Best Practices in the region.

2.1 A BEST PRACTICE CONCEPTUAL FRAMEWORK

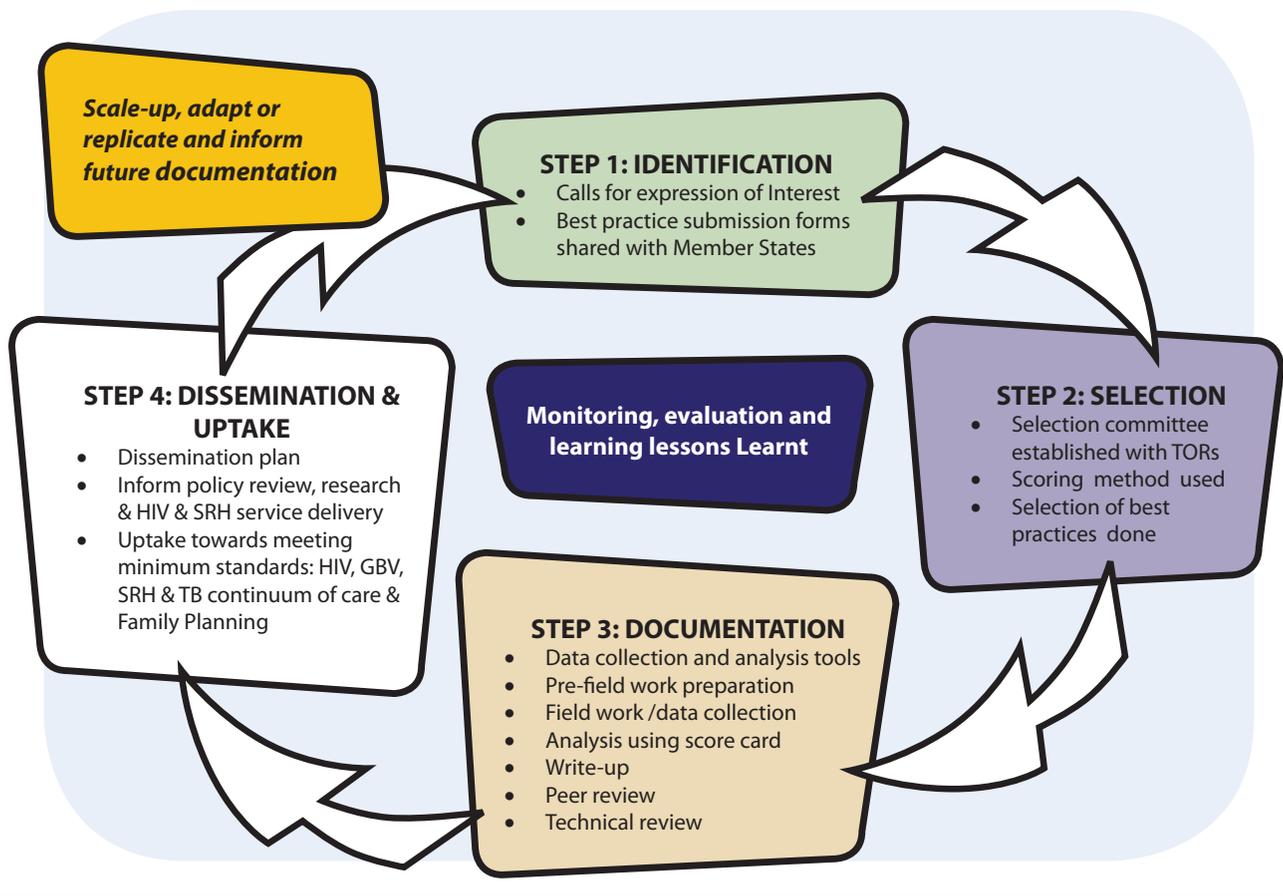
The SADC Framework for HIV BPs defines the primary purposes of a BP as being a practical instrument that facilitates sharing within and between Member States in order to assist local authorities to scale-up interventions based on what is known to work. There are seven criteria for measuring best practices in HIV related programmes and these served as the guiding framework for the methodology and design used in documenting the health facilities described herein.

The seven core criteria elements of best practices are:

1. Effectiveness.
2. Cost-effectiveness.
3. Ethical soundness.
4. Relevance.
5. Replicability.
6. Innovativeness.
7. Sustainability.

These criteria were reviewed and adapted to incorporate the context of HIV, TB and malaria in child and adolescent interventions. The diagram below outlines the four-step model of best practice documentation that was applied within the conceptual frame of this publication.

The four basic steps in systematic SRHR and HIV linkages best practice documentation



2.2 KGATLENG DISTRICT PROFILE

Kgatlang District is located in southern Botswana. Its administrative capital is Mochudi village, while its northern boundary is with Central District, with Dibete Cordon Fence being the physical demarcation. To the west, it is bordered by the Kweneng District and in the south by the Greater Gaborone Area, South-East District. Its eastern boundary is with South Africa.

The district, which has 22 villages and two settlements, occupies an area of around 7,600 kilometres and has a population size of 91,660 of whom 49% are male and 51% female (CSO, 2011). There are 29 health facilities – one Hospital, 14 clinics, 14 health posts, plus five private practitioners. The HIV prevalence is 19% (BAIS IV 2013).



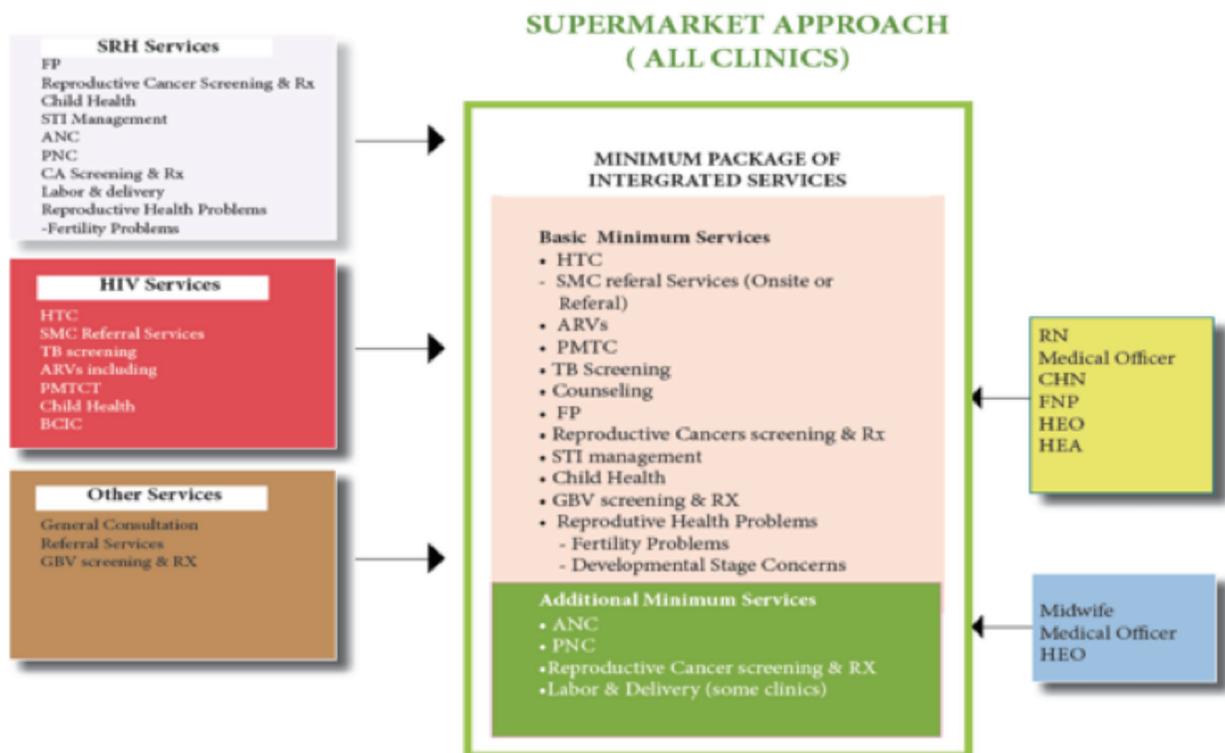
Entrance Signage

2.3 MOCHUDI CLINIC 1

Mochudi Clinic 1 is a peri-urban facility, situated close to Mochudi village, which is 37 km north-east of Gaborone, Botswana's capital.

Prior to the site's induction into the SRHR and HIV Linkages Pilot Programme, Mochudi Clinic 1 ran as a clinic with maternity services. It had a complement of nurse-midwives and general nurses, lay counsellors, auxiliary nurses and a health education assistant. Doctors were available for consultation on Mondays and Fridays. An unserviced caravan in the grounds was used for meetings by Gaonosi, a PLHIV group.

Induction into the programme resulted in the improvement of the clinic's infrastructure, its staff and overall capacity through training and partnership. Under the SRHR and HIV Linkages Pilot Programme, Mochudi Clinic 1 operationalised the Supermarket Model, as outlined below.



After induction into the linkages programme, Mochudi Clinic 1 was provided with additional space through provision of a new SRH linkages caravan by UNFPA, which is fully reticulated and used for SRH consultations, including ante and postnatal care. It now has a visiting pharmacist and a nurse-prescriber for HIV treatment, while the number of doctors' visits has been increased to three.

Mochudi 1 clinic continues to offer family planning, cancer screening, maternal and newborn care, prevention and management of STIs, HIV Testing (HTS) and TB screening. It also has integrated ARV and PMTCT support with gender-based violence (GBV) prevention and management.

This report focuses on evaluating Mochudi Clinic 1 as a best practice in the 'Supermarket Model' of primary health care service delivery, using the SADC best practice criteria as the main reference framework.

2.4 DOCUMENTATION METHODOLOGY

The methodology applied for a best practice documentation process is based on the SADC Framework for HIV and AIDS Best Practice (BP). This applies a mixed-method approach, including a literature review and observation, centred around a set of four tools, three main data-gathering tools and a data analysis scorecard. Applied together, these can determine and confirm the following:

- The contribution to the body of knowledge in the area of providing a sustainable source of local financing and support towards national or regional efforts.
- The ability to offer practical experience and lessons learned from implementation.
- The extent of intra-national, national, regional and international replicability in other structures and organisations.
- The contribution to mitigating the impact of HIV and AIDS and reducing the spread of HIV.

The field methodology comprised a literature review, focus group discussions (FGDs), semi-structured interviews, on-site observations and a peer review of findings. The fieldwork was carried out by a team of three SAfAIDS documentalists, with logistical assistance from UNFPA and MoH staff.

Document review: The literature review included the pilot project documents, the baseline study, evaluation reports, national data sources from MoH, work plans, and strategic and related guiding documents from UNFPA, MOH and Mochudi Clinic 1.

FGDs: Six FGDs were conducted in Mochudi Clinic 1 with community leaders (chiefs, headmen, religious leaders and a village development committee (VDC) chairperson), and project beneficiaries who were divided into men, women, CBOs and youth. Sampling was random and by appointment.

Key Informant Interviews: These were conducted with implementers at Mochudi Clinic 1, Mochudi District Health Team and policy makers at the MoH in the departments of HIV prevention and SRH.

Observations: Data was collected by sitting in during service delivery activities and observing the environment in general, including the beneficiaries accessing the services at Clinic 1. Cameras and voice recorders were used to collect data.

Peer Review: Whilst the data collection and analysis process is tried and tested, every aspect of documentation is subject to review by technical experts in order to provide an additional level of endorsement.

A scoring system in line with SADC standards guided the review process. In the final analysis, criteria with data available and collected that rated 75% or higher were deemed best practices, with those rated between 60 and 74% being categorised as promising practices. Data scoring less than 60% indicated areas that require strengthening before they could be considered as promising.

An in-country peer review process of the draft reports was carried out prior to the report being finalised.

3. FINDINGS FROM THE BEST PRACTICE REVIEW OF MOCHUDI CLINIC 1

3.1 EFFECTIVENESS

To be considered effective, a project or programme must meet the following: It must have clear objectives, be guided by identified community needs established through a baseline study and must show that it is achieving these objectives. The community participates from project inception, to implementation, monitoring and evaluation.

Three key variables are used to measure effectiveness using the BP Scorecard, namely: programme design; community involvement; and programme monitoring and evaluation. The following section outlines key feedback from the main data sources.

3.1.1 PROGRAMME DESIGN

Almost everyone who was interviewed was able to articulate the purpose of the project, clearly stating that it was supposed to provide comprehensive healthcare and offer multiple services in one place. One female beneficiary from a women's FGD said:

"I can bring my four-year-old, weigh her and also get SRH services."

Implementers and community members alike spoke about reducing repeat visits, discrimination, and stigma. People reported customer satisfaction and time saved – for beneficiaries and staff – thanks to the reduction in repeat visits facilitated by having access to a variety of services at one point (District Health Management Team (DHMT)).

With regard to HIV-related stigma and discrimination, respondents compared the new arrangement with the previous one, which saw them having to go to the infectious disease care clinic where there were designated queues and rooms for people living with HIV (PLHIV). They were very appreciative of more than one service being offered at a time because:

"No one can say this person is here for this or that; I saw them go into this or that door. It has reduced stigma; we live in harmony." (VDC Chairperson)



Mochudi Clinic Staff and Local Leadership meet regularly

3.1.2 COMMUNITY INVOLVEMENT

The clinic falls under Moshawana VDC's catchment area and they work closely and well together. Talking about their contributions, the VDC chairperson said:

"We built a waiting area shelter, we are building an office for a social worker and we are going to construct a coughing spot at the clinic."

The VDC brings the community and government together; clinic representatives are invited to attend community meetings organised by the VDC; they read the minutes and are informed of any issues or people needing special care. The VDC also carries out assessments and often gives the clinic feedback regarding the services the community receives at the clinic.



Local Leaders from Moshwana Village

The clinic has strong partnerships with a range of non-governmental organisations (NGOs) in the community such as the Botswana Family Welfare Association (BOFWA), Stepping Stones. Who We Are, Botswana Network of People Living with HIV/AIDS (BONEPWA), Botswana Network of Ethics, law and HIV and AIDS (BONELA), Centre for Youth of Hope (CEYOHO) and more. BOFWA offers services related to youth and HIV and supports young people living with HIV by keeping registers of those who attend the clinic and through activities every Tuesday and Thursday.

"We are part of demand-creation and community mobilisation for the clinic." (BOFWA)

Stepping Stones mobilises men and encourage them to be active parents. It visits the clinic on Mondays and Tuesdays. A representative said:

"There are more couples and men using this facility now, because, through us, they know about the services. Also HTS, we see more men using HTS because they no longer need to go to the IDCC for their medicines."



Young people happy to be accessing their SRHR!

A YOUTH PARTNER

'Who are We' engages with youth to inform them about the clinic's services and encourage them to visit and learn more.

PLHIV PARTNERS

Botswana Network of People Living with HIV/AIDS (BONEPWA) offers counselling, helps people to accept their HIV positive status and encourages them to go to the clinic for treatment. It also follows up with those who miss appointments and sends them to the Centre for Youth of Hope (CEYOHO), which works with PLHIV. Trained counsellors at CEYOHO focus on antiretroviral therapy (ART) and likewise encourage people to attend the clinic. They also teach and conduct motivational talks at the clinic. Gaonosi is another HIV support group that falls under BONEPWA.

BONELA, the Botswana Network of Ethics, Law and HIV and AIDS, connects the community to departments like the police, health workers and teachers, especially in cases of sexual or other rights abuses:

“We can teach people things they cannot learn in the clinic, regarding patients’ rights”

Finally, ‘Plight for Teen Mothers’ started working with the clinic in March 2016 – the month of youth against HIV and AIDS. Empowering these young mothers can reduce intergenerational relationships and the risk of contracting HIV risk.

All these groups provide regular feedback to the clinic concerning their target populations.

3.1.3 MONITORING AND EVALUATION

Paperwork for the programme and systems needed to implement linkages are in place at Mochudi 1. Hard copies of the linkages forms and service tally forms are available in every room and the tally forms are regularly updated and filed. However, supervisory visits have been affected by workload at the DHMT and by the multiple responsibilities of the Linkages Co-ordinator.



All staff at Mochudi Clinic 1 get involved

3.2 ETHICAL SOUNDNESS

An ethical practice is defined by the SADC Best Practice criteria as one that upholds social principles and professional conduct. An intervention is a Best Practice if it does not violate human rights, respects confidentiality as a principle, embraces the concept of informed consent, applies the 'do no harm' principle, and works towards the protection of interests of various vulnerable groups.

The variables for ethical soundness listed on the BP Scorecard are evaluated by means of a document review, discussions around processes at the clinic and, more critically, through clients' experiences. MoH core values are listed as botho, equity, timeliness, customer focus, teamwork and accountability.

Mochudi Clinic 1 does not break principles of social and professional conduct. Determining whether the rights of those attending at the clinic were being respected was effortless, since almost everyone confirmed there was a good culture of confidentiality among the staff:

"We feel that the service providers keep our information private and confidential. I had an issue I couldn't tell anyone about and they did not share it with anyone." (Women's FGD).

"Even though it was hard for youth to trust the Clinic 1 staff, after a while they realised that their information was kept safe without any judgmental approach. We are the mediators as well." (BOFWA)

There was a strong consensus regarding the issue of fairness in distributing services to various age groups, gender orientation, economic status and marital status. Almost everyone confirmed that the services are offered equally, with no discrimination and vulnerable groups such as young people, women, and children living with disabilities and living with HIV are included.

"Everyone is treated well because we have not heard of any complaints from our clients." (NGO partners)

However, there is a language barrier that makes communication between clients and doctors slightly difficult, especially when a doctor is not competent in Setswana. The women's FGD also shared this sentiment, and raised the issue of their opinions being listened to by staff. They said:

"The staff is friendly and people feel comfortable. But we need to interact with them and share our concerns especially when they are doing Wednesday talks."

Despite good community linkages, outreach has been curtailed due to transport constraints. This is an area the staff would like to support to ensure the most vulnerable in the community can access their services.

A key contributor to the clinic's ethical soundness is teamwork, which in turn improves the quality service and ensures the equal treatment of all clients. Here, the head nurse said:

"We ensure a team approach to our health delivery. Every morning, we review what needs do[ing] and assign someone to support clients to go to where they need to go. Everyone has a project or a thematic area to work on. Even the General Duty Assistants, when they finish early can help direct the clients."

The community and beneficiaries of this project also strongly believe that they receive excellent service and treatment. One community leader said:

"Clinic 1 is number 1 in the way they treat people".

From the same group, one woman said:

"The service is good; I am pleased with it."

At district level, it was commented that:

“Because we have skilled personnel, one service provider can provide a client with all the services, and that leads to effective implementation. Personnel who come in as nurses are trained in midwifery (family planning, maternal health), and for HIV services, staff get trained in Kitso (testing, prescribing etc.).”



DHMT staff and the Charge Nurse working together to ensure quality service standards

And one woman from women FGD said:

“The clinic is doing all it can to reduce stigma and discrimination, it’s up to us to accept our situation and not to be self-conscious when we leave with our pills or milk.”

Yet another stated that she considered the clinic staff to be like family:

“I can call Berlinah, nurse-in-charge, any time.”

Young people appreciate the service so much that one young person said:

“It would be great if one of the nurses from other clinics could come here to observe how things are done and learn from the friendliness and openness of the nurses here.” (Youth FGD)

Individual beneficiaries and community members also contribute by sharing the news of the clinic with their families, friends, and neighbours:

“We encourage people close to us to come to the clinic, telling them about the single line and lack of discrimination and we contribute by encouraging others to come to the clinic and test for HIV so that they can know their status and start treatment before its too late.” (Women FGD)

Likewise, a male beneficiary said:

“I encourage my friends to come to the clinic.” (Men’s FGD)

The staff have tried to ensure that every entry point (nurse, HTS, doctor consultation, immunisation, child welfare, or ante-/post-natal clinic) is an opportunity to offer as many services as possible and to provide health education.

The clinic takes into cognizance the needs of different age groups and abilities. It allows schoolchildren, the elderly, those living with disability and those who are very sick to be given priority. Given how busy the clinic is, people are not always happy about this, but the staff try to enforce it.



General nursing staff in the dispensary with the pharmacist/prescriber

3.3 COST-EFFECTIVENESS

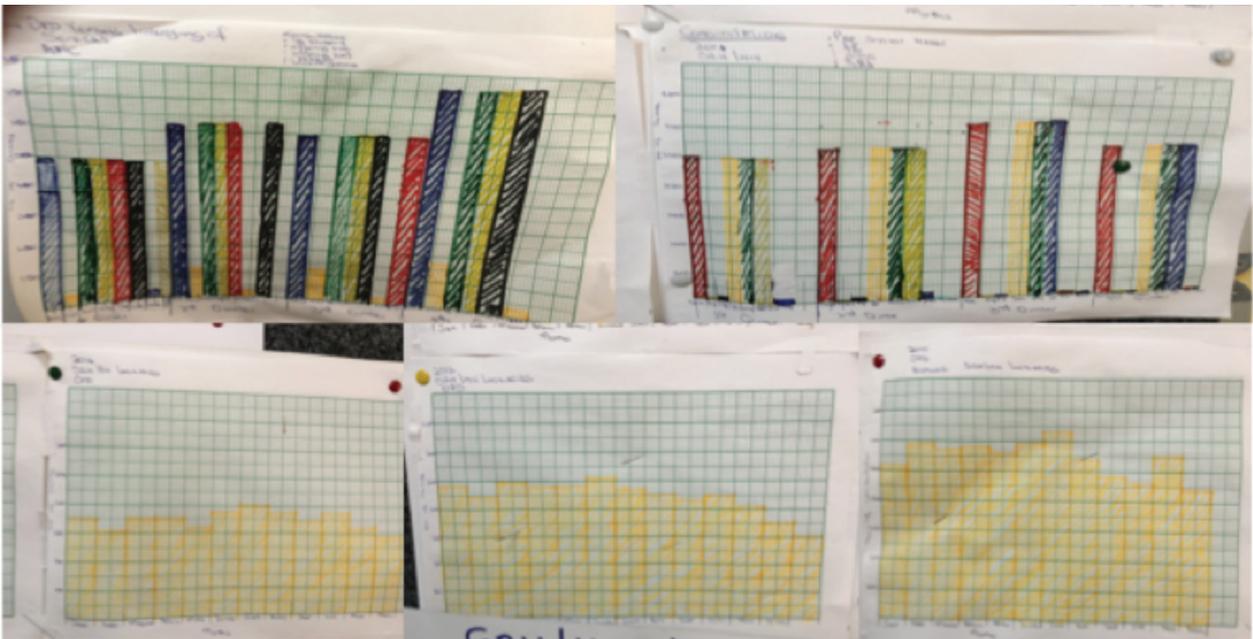
The definition of cost-effectiveness used is that the cost of delivery for a cost effective programme is proportionate to available resources, i.e. "the capacity to produce desired results with a minimum expenditure of energy, time or resources." The intervention should have in place cost saving and reduction systems. The programme should provide a standard package of HIV prevention, treatment or care products and services, at a reasonable cost. This should result in an increased number of community members whose quality of life has improved through programme products and services.

Of the MoH core values, timeliness and accountability apply in this section, as does a keen eye to the affordability of services and adequate resourcing, supplies and staffing within the given context.

The linkages project was rigorous in its planning and implementation. A baseline study informed and shaped the project design and regular progress reports are available. Most notable was the development of a costed scale-up plan for Botswana. The plan has two phases: Year One aiming to expand integrated services to 227 sites across Botswana, and Year Two, during which an additional 415 government facilities will be provided. Botswana currently has 286 clinic facilities, 111 with maternity and 175 without maternity support. The estimated cost for a supermarket model is BWP 24,000.

The scale-up plan report reveals an increased uptake of SRHR and HIV services, with demonstrable upsurges in HIV-testing by adults and youths, dual contraception and screening for cervical cancer. Although costs could not be disaggregated to individual clinics, it is clear that the investment at Mochudi Clinic 1 has yielded tangible results towards the rationale behind the national goal of improving the SRH of all people living in Botswana.

Mochudi 1 Clinic charts on display showing increase of uptake over time



Both service-providers and policy makers posit that service integration services augers well for saving both time and money. The DHMT feels that meeting all healthcare needs at once is saving the government money. Integrating SRH and HIV improves how supplies are ordered; they don't just order an infinite amount:

"We have seen use of certain commodities go down, because everything is addressed in one visit and that prevents further/other issues."

BOFWA noted that block-booking also reduces the amount of time young people spend waiting at the clinic.

The beneficiaries and communities see that the staff is doing its best to provide services in a timely and efficient manner. They also reported a reduction in repeat visits, saving them time and transport expenses. 'Who are We' participants volunteer at the clinic and boost the clinic's capacity. Of this, they said:

"We work from 7:30 to 12:45, so when we leave the nurses have to do everything – screen and register patients, consult with them, and give them medication." (Youth FGD)

The biggest asset for the project as regards cost-effectiveness appears to be the level of community involvement – there is evidence of community support at all levels. Concrete examples include the VDC building the waiting area, an office for the social worker and a coughing spot. This augmentation of the physical structure goes a long way to supporting the clinic's own efforts.



The new waiting area at Mochudi Clinic 1, built with community funds



The community constructed a coughing spot at Mochudi Clinic 1. The bricks left over from building the waiting room will be used to make this structure more permanent.

3.4 RELEVANCE

In order to be relevant, all HIV interventions need to take cognizance of the specific context in which they take place, and to take into account cultural, religious and other norms, political systems and socio-economic environments insofar as they affect vulnerability, risk behaviour, or the successful implementation of a response.

The BP Scorecard focuses on social and cultural relevance, together with evidence of needed services.

Concerns were voiced when exploring the views of traditional and religious leaders. These pertained to the fact that traditional healers/doctors tried to dissuade people from accessing certain services, for example, by giving people with HIV herbal remedies that don't work. This led to the formation of the Dingaka Association, whose mandate is to urge traditional doctors to work with the clinics and to accept the use of western medicine. However, the contributions made by religious leaders were appreciated, as they have encouraged people to visit the clinic and take medication, also boosting their faith and beliefs.

"We are discouraged to mix western medicine and traditional medicine. I would like to see the law of Botswana allowing western and traditional medicine to work together. I have seen that traditional healers can heal broken bones faster than western medicine can. But when it comes to HIV, traditional healers discourage patients to take their ARVs." (Men's FGD).

The women also shared their experiences, also highlighting the importance of religious leaders and traditional healers. Some appreciated the help of traditional doctors, for example them providing massages when they were pregnant. One such beneficiary said:

"The religious leader who comes every Wednesday morning is okay, her contribution is helpful, it gives people hope and faith."

Another had a slightly different view:

"We think religious leaders are important but should not take too much time, taking the focus off health information."

Being close to an urban centre, the clinic has a young population to care for, many of whom are being raised by elderly guardians. The Charge Nurse and the local primary school teacher noted that cases of abuse were not uncommon and that many young people in the area take drugs and abuse alcohol. It is critical to ensure that this age group feels welcomed by the clinic.

"This is the most youth-friendly clinic in Mochudi." Says the 'Who are We' representative.

"Young people prefer to come to this clinic over other clinics because of the friendly service and treatment by the nurses." (Youth FGD)



Some young women from the community FGD

3.5 REPLICABILITY

Inherent in a Best Practice, according to the SADC criteria is that it can be copied, and that it acknowledges the need to discover interventions that set an example.

How relevant is the approach at Mochudi Clinic 1 to other facilities' at all levels, from local, national and regional?

The supermarket model at Mochudi Clinic 1 is highly dependent on good organisation and teamwork. Each week, staff members are assigned duties and responsibilities, often rotated to ensure everyone participates. After 8 a.m. even the cleaners are asked to help direct clients as they arrive.



Mochudi Clinic 1 Staff

The Charge Nurse further indicated that they ensure the consistency of the following tools in place; handover reports when staff change or on leave; community meeting reports (Wednesday reports); asset registers; and the clients' register template. The clinic has also assigned a staff member as a community partner co-ordination focal person.

"Each entry point has a linkages form, each client is offered a feedback form. Monthly reports are generated." (Linkages Co-ordinator)

There was a strong consensus from the implementers' interviews on one major problem. This is the lack of transport, which compromises most of the referral services. The second issue they raised was the attitude of the staff:

"The biggest issue can be the attitude of the health staff – they are not motivated to change the way they do things. Linkages needs a new energy and an open mind." (Charge Nurse)

"We have included all staff across the district in linkages training, so they do have the skills to implement. However, [their] attitude holds us back." (Linkages Co-ordinator).

3.6 INNOVATIVENESS

A Best Practice may show a unique way of implementing a programme that is more effective or saves resources. This is how innovativeness is defined in the SADC BP criteria.

In terms of innovativeness, the BP Scorecard focuses on the creativity of the programme and how health practitioners localise and implement the programme on the ground.

Throughout the duration of the site visit, a steady stream of men, young and old, was seen at this clinic, either with their partners or on their own. The services the clinic offers are relevant and confidential.

"I had TB and was very ill, and the clinic staff really took care of me and would check on me at home." (Men's FGD)

"I am happy with the services provided here. I always leave satisfied." (Men's FGD)

The clinic has also worked hard to include everyone in the community with their services. They take health for all very seriously. The clinic works with LEGABIBO to ensure young people of diverse sexual orientation receive the services they need. LEGABIBO refers clients who need SRH services to the clinic and vice versa; staff from both organisations are included in any training programmes the other holds and LEGABIBO's representative is also included in clinic meetings and provided with feedback reports. The NGO also supplies the clinic with HIV prevention packs.



A new father proudly carrying his baby into and out of the clinic premises. Not all fathers in the community want to be seen doing this.



Men awaiting consultation



A male client at the clinic waiting for HTCS was happy to be pictured doing so!

3.7 SUSTAINABILITY

Sustainability is the ability of a programme or project to continue effectively over the medium to long term. This is strengthened through community ownership of the project, and when skills transfer takes place. Sustainability should take into cognizance the project's financial sustainability, marketing and awareness building.

The second largest component on the BP Scorecard, this is measured through three main variables: programme sustainability, financial sustainability and the efforts to market and build awareness.

3.7.1 PROGRAMME SUSTAINABILITY

There is a much evidence of sustained support for the project by community members and other stakeholders. Those community members that were consulted felt that they could contribute in some way. A teacher from Brigade said:

"We can contribute skills. For example, Brigade is building a coughing spot. Brigade also does a blood donation day and has people come and teach about HIV at the school" (Men's FGD).

To this, the women's FGD added:

"We will encourage others to access the services, while also maintaining their confidentiality and not spreading their information all over the village. We will assist the nurses who are already overworked with this increased demand."

Will linkages continue here beyond the pilot?

"Heelang, tthe mma re ka tswelela!" (VDC Chairperson)

"We don't blame others for our problems; we discuss amongst ourselves, we approach businesses and the council for any assistance. We have to develop our own projects and everyone should contribute, do what they can for their community and country." (Community Leaders' FGD)



This clinic is its own success!

3.7.2 FINANCIAL SUSTAINABILITY

There is commitment for integrating services at policy level, and a scale-up plan has been costed and shared with MoH for review. At local level, the community is prepared to give their time and resources to support the project. The new waiting area, coughing spot and support requested from local organisations are excellent examples of on going assistance where available funds are limited.

The MoH National Focal Person also expressed confidence about the sustainability of the project beyond UNFPA's tenure of support, and investment in the two-year scale-up plan has been a boost:

"We are currently working on roll-out plans, and this will happen with or without funding from UNFPA."

3.7.3 MARKETING AND AWARENESS-BUILDING

In terms of marketing, the clinic did note constraints in terms of transport but said that opportunities for expanding reach were still presenting themselves. The quality of the service itself is also acting as a marketing tool, as clients have been attracted by word of mouth, while the volunteers help spread the message about the linkages approach at the clinic.

"People learn from one another about the services here." (Women's FGD)

"The facility can do campaigns in the community to sensitise people about the services offered; this worked very well for the male mobilisation campaign." (Men's FGD)

Efforts have been made to ensure that the linkages services are known and understood within the clinic. Signage at the gate is clear, doors are labelled and the staff make efforts to direct visitors to the appropriate area. New signage has been ordered and should be installed soon. Such signage can also be used in outreach campaigns and carried through villages to raise awareness.



One of the banners describing the services at Mochudi Clinic!

The biggest eye-catcher is the new linkages caravan, which provides space for nurse consultations. It adds a splash of colour and its clear labelling explains the linkages between SRH services and HIV.

The staff hopes to extend this visibility to the original caravan, which they are hoping to fully service so that it can also be used as a consultation space. It will continue to also be used as a meeting room for community groups. At present, although it is still labelled as a meeting space for PLHIV, it is in fact used by all community groups attending the clinic.

4. CONCLUSIONS, LESSONS LEARNED AND RECOMMENDATIONS

4.1 CONCLUSIONS

Mochudi Clinic 1 has shown some clear successes in integrating SRHR and HIV through this pilot programme, most especially in the areas of applying the supermarket model across the facility, speeding up service provision and attracting new clients – especially those infected with and affected by HIV – to use their services regularly.

Men in particular have been attracted to this site and use a range of services. Additional support through community groups has seen them increase their attendance as well as accompany their partners. The issue of clinic visits by key populations such as the LGBTI community is further testimony to the impact linkages can have in terms of supporting better health outcomes at community level.

The BP Scorecard recorded an admirable 76.5%, rating Mochudi 1 as a 'Best Practice that needs minor improvements in certain areas'. The scores are summarised in the following table:

Best Practice Elements and Scores

Scorecard variable	Maximum points achievable	Points received (rounded-off)	Comments
Effectiveness	25 points	19.25 points	Good as community involvement is high. Dropped points on M & E component.
Sustainability	20 points	14	Good as support does not rely on government alone. Lost points on visibility and outreach.
Relevance	12 points	10.25	Good as HIV testing and ARV treatment was needed but some areas to improve were the Wednesday morning sessions and more tailored support for the young people.
Cost-effectiveness	12 points	6	Gained points by getting all staff involved, improving motivation and ensuring a good floor plan in place for visiting doctors and pharmacist.
Replicability	11 points	10	The clinic moved smoothly to integrating PLHIV and showcases the role of good planning and communication.
Ethical soundness	10 points	8	Gained points due to strong element of trust and confidentiality and ongoing staff training support.
Innovativeness	10 points	9	Gained points as services were reaching out to all members of the community.
Total	100 Points	76.5	

4.2 KEY SUCCESSES

Support from local leadership: The Kgosi and his assistants use the Kgotla as a platform for the dissemination of project information. Healthcare workers have regular meetings with traditional structures. The support is there when it is needed.

Male involvement: It was clear that men were regular and comfortable visitors at the clinic, feeling free to test for HIV, collect medicines and accompany their partners to consultations and child welfare support.

“I work across clinics in this district, and it is rare to see a couple in this community, but here at Mochudi Clinic 1 there are many who come to the clinic!” (Pharmacy technician)

Partnerships for Health: Whilst Mochudi Clinic 1 continues to lobby for more resources, especially transport, it has not stopped it from progressing. The clinic has used a partnership approach to do so, leveraging both private philanthropy and the technical capacity and reach of community based organisations and national agencies alike.

Building a strong committed team is critical: The Charge Nurse at this clinic had a clear vision and understood that she could only implement the supermarket approach if she had the buy-in of all her staff, to the extent that even the non-medical staff were also involved.

Ongoing training support and supervision: Here, training has been a critical component, with regular district training boosting skills, confidence and capacity. This has been provided by partner organisations such as LEGIBIBO and Stepping Stones and has led to quality and consistent service provision. At the end of the day, this is what keeps bringing and clients in and ensures they remain happy and healthy.

4.3 RECOMMENDATIONS

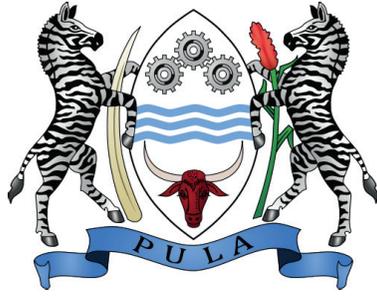
Workload with integrated service provision: The project has increased demand for services and as a result the current staff is highly overloaded, especially in the afternoons and when volunteers are not present. The clinic should continue to use volunteers to boost their capacity and be encouraged to request extra help from willing organisations.

Building skills in and for integrated services: The clinic must continue to build and refresh the skills of all its staff to ensure that referrals are kept to a minimum and that every entry point is a true one-stop-shop. This includes training staff on rapid HIV testing, including dried blood spot testing for infants. This will alleviate many problems, including follow up losses and patients not returning for results after weeks of anxiety. The good news is that plans for this training were already underway during the documentation exercise. Given the increasing number of PLHIV users, it is also important that the good work in reducing stigma be continued.

Augmented space and improved visibility: The linkages caravan has enlarged service space and has helped the site meet its targets. However, the older caravan has not been connected to reticulated services such as water and waste and thus is under-utilised, being used as a community meeting space rather than as a consultative one. In addition it is still clearly labelled as an area for HIV interventions, which goes against the integrated approach this pilot programme encourages. Fully repurposing this area is crucial.

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