COMMUNITIES IN THE LEAD: THE BOTSWANA EXPERIENCE WITH COMMUNITY-LED HEALTH IMPROVEMENT TO ACHIEVE HIV EPIDEMIC CONTROL

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BACKGROUND

Botswana, as one of the countries most affected by the HIV/AIDS epidemic, was among the first to embrace community-centered primary health in the late 1970s. However, despite noteworthy progress in reducing HIV-related mortality and morbidity owing to the spirited antiretroviral therapy (ART) program launched in 2002, the national response has been costly and characterized by intensely vertical disease control efforts. Today, as country and partners are hoping to achieve epidemic control, they recognize the need and urgency to "deliver differently." With more than one in five Botswanans living with the virus, there is a strong call for an integrated community perspective in the design and delivery of quality client-centered integrated HIV/AIDs services.

COMMUNITY HEALTH SYSTEM APPROACH

Under PEPFAR/Botswana, the USAID-funded Applying Science to Strengthen and Improve Systems (ASSIST) project employed a community health system approach for Botswana's unique context. In line with PEPFAR strategies and in collaboration with the USAID-funded Advancing Partners and Communities (APC) project, ASSIST focused on facilitation and coaching of community (quality) improvement teams (CITs), following a systematic approach to analyze barriers along the HIV/AIDS treatment cascade to generate, test, and monitor locally relevant change ideas.

Under the mandate of traditional leaders, community teams drove local improvement in collaboration with facility staff and NGO-employed community health workers under USAID's community platform. The approach generated effective improvement ideas that were adopted by district health management teams.

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METHODS

Under the USAID-funded ASSIST project, University Research Co. worked closely with Botswana government counterparts at the central level (Ministry of Health and Wellness); in districts (district health management teams, district administrations, councils); and community level (di-Kgosi [traditional leaders] and village development committees) across seven districts to revitalize functioning community health system structures.

ASSIST focused on facilitation and coaching of CITs to drive their own improvement by following a systematic approach to analyze barriers along the HIV/AIDS treatment cascade and generate and test and monitor locally relevant change ideas.

CITs were established under the mandate of di-Kgosi and embedded in the local governance context, representing existing community structures and committees, on a volunteer basis — as well as facility staff and other local providers.

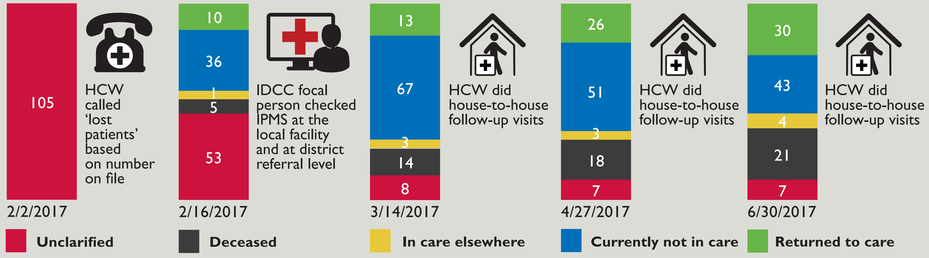
Applying a simple but powerful "quality improvement" methodology strengthened the community HIV response and addressed acute gaps in and barriers to patient-centered quality HIV services in the community.

KEY OUTCOMES

- Tangible improvements in testing, retention, and adherence, and return of unclarified (or "lost") patients to ART at rates between 38 percent and 100 percent, once communities and providers coordinated their activities around community preferences and "rewired" local accountability loops
- Practical application of quality improvement methods at the community level by volunteers and a team approach to finding local solutions by identifying and testing change ideas
- Establishment of 40 community improvement teams, which were integrated into the existing system context to generate practical local solutions to acute service gaps and barriers
- Generation of evidence for new community-based service delivery strategies, which is critical in the broader context of differentiating models of care across the continuum of HIV/TB care

SPREADING WHAT WORKS:
ADDRESSING ACUTE GAPS IN COMMUNITY ART RETENTION ACROSS 5 DISTRICTS

Community/facility collaboration to clarify status of 'lost-to-follow-up' patients and return them to care:
Illustration from Molepolole (February to June 2017)



Replication and Spread

Results of variations with joint community/provider teams

KWENENG: MOLEPOLOLE
- 93% reconnected and clarified
- 38% returned to ART (ongoing)
- 20% already deceased

GABARONE: BLOCK 9
- 100% reconnected and clarified
- 100% returned to care and ART
- 6% already deceased

KGATLENG: BOKAA
- 91% reconnected and clarified
- 71% returned to care and ART
- 5% already deceased

GOODHOPE: PITSANE
- 100% reconnected and clarified
- 63% returned to care and ART
- 15% already deceased

MAHALAPYE: PALLA ROAD
- 94% reconnected and clarified
- 57% returned to care and ART
- 44% already deceased

CONCLUSIONS AND LESSONS LEARNED

There were many lessons learned from ASSIST's efforts to apply quality improvement methodologies across seven districts in Botswana via a community health systems approach, which are being applied in the follow-on HRH2030 (Human Resources for Health in 2030) program:

- Well-coordinated community/provider collaboration and rewired accountability loops based on volunteerism and existing governance structures led to demonstrable improvements in reconnecting "lost" ART patients.
- At this stage in Botswana's HIV epidemic, it is critical to find new strategies to connect new HIV-positive patients with care and coordinate these efforts with the community.
- Patient needs, rather than provider interests, should be at the forefront when developing strategies to improve service delivery.
- There are no shortcuts; innovations that work in one place for a particular service and group of people may not be generalizable.
- In Botswana, existing governance structures hold considerable legitimacy and should not be undermined or replaced by NGOs or other provider practices.
- Dedicated support to community structures and generating new service delivery strategies are critical in the broader context of differentiating models of care across the continuum of HIV/TB care.

In Botswana's unique context, traditional structures hold the promise of successfully revitalizing primary health care without undermining HIV control. In fact, they directly help in sustaining epidemic control — if Botswana dedicates the necessary support to institutionalizing new community partnerships. Building on the work done under the ASSIST project, the HRH2030 program will continue to support the realignment and operationalization of health workforce frameworks to innovative models of care to "deliver differently" in Botswana.