

POLICY GUIDELINES AND SERVICE STANDARDS

sexual and reproductive health

Ministry of Health



Policy Guidelines and Service Standards

Sexual and Reproductive Health

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FOREWORD

The formulation and design of the National Sexual and Reproductive Health Programme is an indication of governments' commitment towards the paradigm shift of reorienting the Maternal and Child Health/Family Planning services to Sexual and Reproductive Health approach. This programme takes cognizance of the existing Government policies, in particular the National Population Policy which forms the basis for all population related programmes. The development of the programme involved extensive consultations with stakeholders and opinion leaders at both the national and district level. The team that worked on development of the programme consisted of representatives from: the Ministry of Finance & Development Planning, Ministry of Education, Ministry of Labour & Home Affairs, Ministry of Local Government, Ministry of Health, NGOs, the Private Sector and UN agencies. This was done to ensure that the programme addresses the gaps, needs and concerns of the nation as identified by programme managers, implementers and communities at grassroots level.

The goal of the programme is to improve the sexual and reproductive health of all people living in Botswana. The Sexual and Reproductive Health programme, among other issues focuses on reaching out to adolescents/youth and men, and making health services youth friendly, as well as, gender sensitive. This endeavor to improve the quality of life through provision of comprehensive and quality care is a challenge for the Government, the programme managers and service providers, including non-governmental organisations.

The formulation and design of the National Sexual and Reproductive Health programme is a result of the recognition that improving the quality of life calls for providing comprehensive and quality health care services and making services accessible to the clientele. The challenge is to provide these services, that are gender sensitive, in an environment that is welcoming to the adolescents/youth, men and the elderly through trained and competent health personnel.

In an effort to pursue the Government's commitment to reorient health services, we are pleased to present the following documents:

- National Sexual and Reproductive Health Programme Framework
- Policy Guidelines and Service Standards - National Sexual and Reproductive Health Programme
- Adolescent Sexual and Reproductive Health Implementation Strategy

The National Sexual and Reproductive Health Programme Framework document gives a description of the national sexual and reproductive health issues, outlines the objectives of the programme and provides what could be done to alleviate the problems and address identified needs. The document is expected to guide programme managers, donors and implementers on priority issues and interventions.

The Policy Guidelines and Service Standards for National Sexual and Reproductive Health Programme document outlines the steps on how to offer and deliver services. Improving quality of care is critical to improving clients' health status as well as increasing access to, and utilization of Sexual and Reproductive

Health services. Service standards and guidelines are intended to be used by programme managers, implementers, trainers, supervisors, and service providers as a tool for delivering quality care measures.

The Adolescent Sexual and Reproductive Health Implementation Strategy is meant to guide national and international players on priority needs and problems of adolescents/youth and intervention methodologies as identified by the nation. Both national and international partners are to fit in this framework, as their interest must be complementing the efforts of the government.

The Ministry of Health presents the above as guiding tools in the reorientation of health services to sexual and reproductive health. We urge all programme managers, supervisors and service providers to read these and use them as reference materials in their day-to-day work. It is vital that all recognise that the benefits of having these important documents can only be realised if they are used appropriately.



B. Tafa
Permanent Secretary
Ministry of Health
Republic of Botswana

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Last but not the least, the Ministry wishes to express gratitude to the SRH Task Force and Reference Group Members for their valuable time and sharing their experiences to push forward the process of development of these Service Standards and Guidelines for the National SRH Programme.

LIST OF ACRONYMS

AIDS	Acquired Immuno-deficiency Syndrome
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
AVI	Annual Visual Inspection
BFHS	Botswana Family Health Survey
BMC	Botswana Meat Commission
BNYC	Botswana National Youth Council
BOCONGO	Botswana Council of NGOs
BOFWA	Botswana Family Welfare Association
CBDs	Community Based Distributors
CBOs	Community Based Organisations
CBS	Community Based Services
CHN	Community Health Nurse
CIN	Cervical Infra-epithelial Neoplasia
CIS	Carcinoma in Situ
CMS	Central Medical Stores
COCs	Combined Oral Contraceptives
CPR	Contraceptive Prevalence Rate
CST	Country Support Team
DHS	Demographic Health Surveys
DHT	District Health Team
DMO	District Medical Officer
ECPs	Emergency Contraceptive Pills
EmOC	Emergency Obstetric Care
ENs	Enrolled Nurses
FHD	Family Health Division
FIFO	First In First Out
FLE	Family Life Education
FP	Family Planning
FWEs	Family Welfare Educators
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IHS	Institute of Health Sciences
IUCD	Intra-Uterine Contraceptive Device
MCH	Maternal and Child Health
MI	Male Involvement
MIS	Management Information System
MLG	Ministry of Local Government
MMR	Maternal Mortality Ratio
MOE	Ministry of Education
MFDP	Ministry of Finance and Development Planning

MOH	Ministry of Health
MLHA	Ministry of Labour and Housing Authority
MVA	Manual Vacuum Aspiration
NACA	National AIDS Control Agency
NCPD	National Council for Population and Development
NDP	National Development Plan
NGO	Non-Governmental Organisation
NPPP	National Professional Project Personnel
PAC	Post Abortion Care
PACT	Peer Approach Counselling by Teenagers
PHC	Primary Health Care
PM	Post Menopausal
PMH	Princess Marina Hospital
PNC	Postnatal Care
POCs	Progestrone Oral Contraceptives
RH	Reproductive Health
RNs	Registered Nurses
SDPs	Service Delivery Points
SMI	Safe Motherhood Initiative
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TOR	Terms of Reference
TOT	Training of Trainers
UB	University of Botswana
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VHC	Village Health Committee
VI	Visual Inspection
WHO	World Health Organisation

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BACKGROUND AND USE OF THE GUIDELINES AND SERVICE STANDARDS

Background and Rationale

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, the Government of Botswana joined hands with the rest of the world in signing the Plan of Action which signaled a major paradigm shift from a demographically driven focus on family planning to a health driven focus on sexual and reproductive health (SRH). The SRH approach is comprehensive, integrated and addresses the essential needs of individuals throughout the life cycle.

Post ICPD, the Government of Botswana reaffirmed its commitment by enacting responsive policies such as:

- The National Health Policy (1995) NDP-8 (1997),
- The National Population Policy (1997),
- The National STI/HIV/AIDS Policy (1998), and,
- Sexual and Reproductive Health Programme (Draft, 2001).

The commitment of the Government has borne fruit as it is reflected in several impressive health indices in Botswana, which now has one of the best health services resulting in remarkable indices in the continent; e.g. Contraceptive Prevalence Rate (CPR) stands at 41.7% (*BFHS III, 1996*) while maternal mortality ratio is about 200/100,000 live births.

It is a paradox that while the country has recorded these impressive gains in health care, some worrying SRH indices have emerged; Botswana has one of the highest HIV infection rates in the world, currently 13% for the general population and 30 – 40% in antenatal groups; adolescents/youth who form 25% of the population are at the highest risk of both STI/HIV/AIDS infection, unwanted pregnancy and abortion. HIV infection rates are highest in the age groups 15-29. The average age at first intercourse is 17.5 years and first birth is 18.6 years. Teenage pregnancy rate is 16% while contraceptive use is only 29% among this age group. (*BFHS III, 1996*)

In recognition of the efforts of the Government of Botswana to address the challenges of Adolescent Sexual and Reproductive Health (ASRH), the Bill and Melinda Gates Foundation awarded funds for a 5-year project entitled – African Youth Alliance (AYA): Shared Responsibility for Reproductive Health in Botswana. The project goal is to improve ASRH by increasing access and utilisation of information and high quality cost effective services.

The SRH Guidelines and Service Standards have, therefore, been developed to facilitate the rollout initiative of the National SRH Programme and the implementation of the African Youth Alliance activities.

Use Of These Guidelines

These service standards and guidelines are intended to assist programme managers and providers to expand and improve the quality of services everywhere in the country. Health administrators as well as all providers – i.e. physicians, nurses, counselors and FWEs should use them. They can be used in different ways, including:

- As a guide for upgrading and improving SRH counselling and clinic delivery practices.
- As a reference document for assessing quality of care and compliance with a set of accepted standards.
- As a training tool.
- As a tool for monitoring and supervision of SRH services.

The guidelines will be useful across the board, with critical contribution in reaching out to communities in every corner of the country.

PART I

POLICY FRAMEWORK AND ORGANISATION

Chapter 1

1.0 SEXUAL & REPRODUCTIVE HEALTH IN BOTSWANA: GUIDING PRINCIPLES AND POLICY

1.1 Botswana National Population Policy

- Recognises the fundamental human rights and freedom enshrined in the Constitution of the Republic of Botswana.
- Reaffirms the right of the individual, as the central part of development.
- Emphasises the need to recognise the family as the basic unit of production and reproduction and provides it with the necessary protection and support to enhance this role and the health and welfare of family members.
- Recognises the need for enhancement of child survival and development as well as the child's right to basic needs of life.
- Recognises the impact of religion and cultural beliefs and practices on reproductive health; the dynamic interactions; and the ways to maintain a balance between health and individual rights.
- Reaffirms the principles of gender equality and equity to enhance effective participation at all levels of public and productive life.

1.2 Botswana National Health Policy

- Recognises the enjoyment of a level of health that allows every citizen to lead an economically and socially productive life as a human right.
- Recognises health care as one of the key determinants of health.
- Emphasises the role of the Government as policy maker, professional guide and supervisor of health care in its entirety in Botswana, irrespective of the providers or institutions.
- Commits the Government, through the Ministries of Health (MOH) and Local Government (MOLG), to ensure that all institutions that provide health care are provided with information on recognised standards of care in line with WHO recommendations.
- Commits MOH' and MOLGs services to conform with such recognised standards and through its supervisory activities ensure that districts, cities and town councils and private providers establish appropriate systems for ensuring that recognised standards are complied with.

- Reaffirms the MOH's supervisory role by means of information and systematic and independent audits of, and ensuring that all activities are planned, executed and maintained in accordance with accepted technical and professional standards.

1.3 National Sexual and Reproductive Health Programme

- Reaffirms the steps taken by the Government to shift from MCH/FP to SRH by signing the Reproductive Health Programme Development and Capacity Building Project with UNFPA (BOT/98/P02)
- Sets the goal of improving the sexual and reproductive health of all people living in Botswana through nine specific objectives.

These are to:

- Improve understanding of SRH by parents and children/youth.
 - Improve ASRH and youth health.
 - Reduce maternal and perinatal morbidity and mortality.
 - Enhance gender equality and equity.
 - Control STI's and HIV/AIDS.
 - Meet family planning needs.
 - Prevent and manage infertility, reproductive tract cancers and midlife concerns.
 - Ensure national capacity to conduct operations research and manage functional Health Information System.
- Recognises the critical nature of both management and service delivery issues and their interactions in facilitating the process of expanding SRH services and enhancing quality of care.

1.4 A Right-Based Approach To Sexual Reproductive Health

1.4.1 What are Sexual and Reproductive Rights?

- Sexual and Reproductive Rights derive from fundamental human rights and freedoms that are already enshrined in the Constitution of Botswana and are included in several international agreements and treaties to which the Government of Botswana is a signatory.
- Upholds the basic right of couples and individuals to attain the highest standards of sexual and reproductive health and to decide freely (without discrimination, coercion or violence) and responsibly the number and the spacing of their children and to have access to information and education to make informed choices, and the means to do so.
- Quality of SRH services can lead to increased demand for and acceptability of services. Quality of services should therefore be regarded as the right of the client and everyone in the community who is in need of SRH services.
- Needs of service providers are equally important in ascertaining SRH rights. Providers relate to clients as human beings and have attitudes and skills that are influenced by the working environment.

1.4.2 What Are The Elements Of Client Rights?

- Right to factual and scientific Information on SRH.
- Right of Access to services regardless of social status, economic situation, religious affiliation, ethnic origin, marital status or geographical location.
- Right of Choice to SRH services.
- Right of Safety in the practice of SRH.
- Right of Privacy during discussions or basic examination.
- Right to Confidentiality – information provided must not be communicated to anybody, (including their parents/guardians, spouse and partner) without consent, but counselling should strive for shared confidentiality.
- Right to Dignity – treatment with courtesy consideration, attentiveness and full respect, regardless of level of education, social status, age, etc.
- Right to Comfort when receiving services.
- Right of Continuity of SRH care, services and commodities e.g. contraceptives.
- Right of Opinion to express their views on the type of services they receive.

1.4.3 What Are The Provider Needs?

- Need for training and regular updates in order to access knowledge and skills to perform designated tasks.
- Need for information on issues related to their duties (clear job description).
- Need for infrastructure that is appropriate for provision of acceptable quality of care and observance of client rights to privacy and comfort.
- Need for supplies to ensure quality and continuity of care.
- Need for guidance to reinforce their knowledge and skills for delivering high quality of care.
- Need for back up whenever referral for consultation is needed.
- Need for encouragement in order to stimulate creativity and autonomy commensurate with their capabilities.
- Need for feedback given in a positive and constructive manner.
- Need for self-expression regardless of the level of health care facility in which they are deployed.

1.4.4 Conclusion

Client rights and provider needs anchor the essence of quality of care. Policy makers and SRH Programme managers shall use these principles as a basis for support-supervision and ensuring quality of SRH services.

Special Considerations: Groups with Special Needs

- Adolescents/Youth/The elderly should be treated as individuals and accorded all their due rights.
- Observation of the rights and responsibilities of these special groups, increased demand and accessibility of SRH services.
- Male involvement in SRH issues and services is crucial to improvement of the quality of the sexual and reproductive health of all family members.

- Providers need training; infrastructure, supplies, guidelines and backup are critical to the establishment of user friendly services.
- SRH services for refugees and the migrant population in Botswana

NB: In the early seventies Botswana experienced an influx of refugees from its neighbouring countries of Angola, Namibia, Zambia and Zimbabwe including South Africa. Most of the refugees had left the unrest and political hostilities of their countries. In order to ensure their protection the government, together with the UNCHR agreed to move all refugees to Dukwi camp which is 463 km away from Gaborone in Tutume Sub district, for security and provision of coordinated social and health services.

As any other individuals, the refugees have health needs and experience health problems as well. Therefore comprehensive health services to meet the emerging SRH problems/needs at the camp should be in place and in line with the national SRH services.

The main areas of SRH that will need to be in place are;

- *Adolescents/Youth Sexual and Reproductive Health*
- *Maternal and Newborn Care including Emergency Obstetric Care*
- *Family Planning*
- *STI and HIV/AIDS*
- *Gender, especially gender based violence*
- *Midlife concerns*

PART II

PRIORITY COMPONENTS OF SEXUAL AND REPRODUCTIVE HEALTH IN BOTSWANA

Chapter 2

2.0 ADOLESCENT/YOUTH SEXUAL AND REPRODUCTIVE HEALTH

2.1 Introduction

In view of the youthful population of Botswana and considering that their ASRH needs and problems hitherto have not been given adequate attention, there has been an urgent need to develop policy guidelines and service guideline to cater for them.

2.2 Definition

2.2.1 What Is Adolescence and Youth?

Adolescence is the period of transition from childhood to adulthood characterised by physical, social, psychological and biological changes. WHO defines adolescence as the period ranging from 10-18 years, and youth as the age group 19-29 years, but for purposes of programming in Botswana the period adopted for adolescents and youth ranges from 10-24 years.

2.2.3 What Is The Adolescents/Youth Situation?

Adolescents/Youth are vulnerable to substance abuse, delinquent behaviour, depression, suicide, sexual abuse, and sexual risk-taking, resulting in unplanned pregnancy and STI/HIV/AIDS transmission. Adolescents and youth make up 64.3% of the total population of Botswana. Other demographic facts about the Botswana adolescents and youth are summarised below:

- The 15 - 24 age group constitutes 20.9% of the total population.
- The average age at first intercourse is 17.5 years and first birth is 18.6 years.
- Only 24% of Adolescents/Youth are using contraception.
- Teenage pregnancy rate is approximately 16%.
- HIV infection rate in Botswana is relatively high and the young people are hard hit.

The policy environment for adolescent/youth programmes is highly supportive in Botswana. NGOs (BOFWA & YWCA) have been providing information and services on SRH to young people. Ministries of Education and Health are making efforts to provide FLE in varying arenas including schools. There is a good network system of health facilities at different levels in the country at 15km radius from home (referral hospitals, district hospitals, mine hospitals, private hospitals, clinics, health posts, mobile stops and NGO youth centres).

2.3 The Components

2.3.1 What Adolescent Sexual And Reproductive Health Services Are Provided?

- IEC and advocacy to the general public
- IEC and counselling on ASRH issues and for behaviour change
- Provision of FP services
- Provision of ANC and PMTCT, delivery and PNC
- Provision of Post Abortion Care
- Management of STIs/HIV/AIDS
- Provision of HIV VCT (Pre and Post Test Counselling)
- Family Life Education

All the above stated services are provided according to the Guidelines as stipulated under specific chapters.

2.3.2 Who Is Eligible For ASRH Information And Services?

Different target groups of adolescents/Youth are eligible for ASRH information and services as indicated below:

- Males and females
- In- and out-of-school adolescents /Youth
- adolescents/Youth in poverty
- married and unmarried adolescents/Youth
- Street children
- Teen mothers
- Adolescents/Youth with disabilities, both physical and mental
- Adolescents/Youth living with HIV/AIDS
- Orphaned adolescents /Youth
- Sexually and physically abused children
- Adolescents /Youth with substance abuse problems
- Juvenile delinquents (prisoners)
- Employed/Unemployed Adolescents /Youth
- Adolescent/youth commercial sex workers
- Adolescents /Youth with abortion and other RH complications
- Refugee and displaced adolescents/Youth

It is important that parents, guardians, teachers, community leaders, employers and the general public are also given information on ASRH and their support lobbied for.

2.3.3 Who Are The Providers Of ASRH?

- Trained professional health workers
- Teachers
- Parents/guardians
- Members of Parents Teachers Associations
- Extension workers
- Political, religious and other community leaders
- Social workers
- Youth officers
- Adolescents/Youth themselves/peer educators
- Employers

- Volunteers
- Business community
- Traditional and faith healers
- Traditional midwives

2.3.4 Where Is ASRH Provided?

ASRH shall be provided at all levels of the health care system and other community structures as indicated below:

Hospitals:

- Referral
- District
- Primary
- Mines
- Mission
- Private

Clinics

- Mobile clinics
- Mission clinics
- Private clinics
- NGO clinics
- Health posts
- Pharmacies
- Youth centres, clubs and groups
- Schools
- Churches/places of worship
- Entertainment and recreation places
- Work places

2.3.5 How Are ASRH Services Provided?

Strategies for the provision of ASRH services are:

- Creating an enabling environment for Adolescent Sexual and Reproductive Health
- IEC with emphasis on behaviour change communication.
- Enhancing Life Skills for Adolescents
- Establishing adolescent-friendly health services to include counseling
- Expanding adolescent utilization of quality SRH services
- Building Capacity for ASRH services
- Promoting gender equity in ASRH
- Research

2.3.6 Special Requirements For ASRH Services

- Space – all general health facilities and youth centres should have youth corners – especially designed to provide/promote privacy and confidentiality
- Trained health personnel and teachers
- Equipment and continuous supply of commodities

- Trained peer educators and counsellors
- Supportive environment
- Integrated services
- Easy access
- Affordability
- Acceptability
- Sustainability
- Monitoring and evaluation
- Operations research

2.3.7 What Are The Elements Of Adolescent/Youth Friendly Services?

- Community support:
This support can be assured if members of the community are:
 - Well informed of its existence
 - Acknowledge the value and acceptance of the services by the adolescent/Youth
 - Actively involved
- Adolescents/Youth participation:
This will be achieved if they are:
 - Well informed about the available services and their utilisation
 - Involved in planning and running of services
- Youth friendly policies:
 - Guarantee confidentiality
 - Do not require parental consent
 - Do not withhold provision of information and services
- Youth friendly procedures include:
 - Easy registration /retrieval procedures
 - Short waiting time and convenience
 - “Drop-ins” with or without prior appointments
 - affordable and flexible terms of payment
- Youth friendly staff:
These are those that are:
 - Technically competent
 - Interested and concerned
 - Understanding and considerate
 - Easy to relate to and communicate well
 - Trustworthy
 - Able and willing to devote adequate time
 - Can be contacted at repeat visits
 - Non judgemental

- Adolescent/Youth friendly environment:
Has the following qualities:
 - No stigma
 - Appealing milieu
 - Good facilities
 - Convenient working hours
 - Convenient location
 - Information /education materials available
 - Privacy in the examination/consultation/waiting rooms and in the entrance/exit
 - Entertainment and games available

N.B. These elements need to be considered not just in relation to adolescents /youth as a population segment, but also in relation to groups within the population segment such as male and female adolescents/Youth, older and younger adolescents/Youth, physically and mentally handicapped adolescents/Youth and so on. This approach ensures that services are designed to address group-specific special needs.

ASRH: Special Considerations

Training

Health Workers

- Pre –service curriculum review to incorporate training in ASRH.
- In-service orientation of providers on adolescent/youth friendly services.

Teachers

- Pre-service curriculum review to emphasise ASRH and the role of teachers in the programme.
- FLE to be given more time/prominence as opposed to inclusion only as part of other subjects.
- Improvement of knowledge/skills to counsel adolescent (Guidance and Counselling teachers).
- Guidance and counselling in schools to be provided as a service, not just as a subject.

NGOs

- Special consideration for training NGOs in ASRH issues, service provision and advocacy.

Parents

- Special empowerment programme for parents to enable them to understand ASRH issues and their roles.

Adolescents/Youth

- Setting up of peer education – training/programme with adolescent/youth groups (in-and-out of school), churches, youth clubs etc.
- Training peer educators using national peer education/community based service provision curriculum.
- All these must take into account the service requirements of the adolescents/youth with special needs – as mentioned above in this chapter.

Advocacy

Leaders

- Political, religious, traditional leaders to be oriented on their roles and support for ASRH.

Chapter 3

3.0 FAMILY PLANNING

3.1 Definition

Family Planning means assisting individuals and couples to determine the number of children they would like to have through spacing and timing of their births and also to help the sub-fertile couples to conceive.

It is a basic right of every individual and family to be provided with the service, supplies and information on how to plan their families.

It is therefore, the intension of the Government of Botswana to provide FP services to benefit the health and welfare of the individuals, families and community, and to promote the socio-economic development of the country.

3.2 General Family Planning Policy Guidelines

1. Family planning services in Botswana shall be provided to benefit the health and welfare of individuals and families and to promote the socio-economic development of the country.
2. The SRH/FHD of the Ministry of Health shall plan, coordinate, monitor and evaluate family planning activities in Botswana.
3. All persons of reproductive age regardless of age or marital status shall have the fundamental right to determine for themselves how many children to have and when to have them.
4. Government, private practitioners and pharmacists, mines and mission hospitals, Industries, NGOs and others providing family planning services shall comply with the set family planning service policies and practice standards in Botswana.
5. Family planning policy guidelines, service standards and procedure manuals shall be made available by the SRH/FHD for use at all levels of health facilities and training institutions, government and non government, and shall be reviewed periodically.
6. Since pregnancy before the age of twenty years (20) places the health and welfare of the teenager at risk, individuals and families shall be encouraged to delay the first pregnancy until after that age.
7. Individuals and couples shall be encouraged to plan the spacing and size of families according to the ability to care for them.
8. Other governmental ministries and non-governmental organisations shall be encouraged to participate actively in fertility and family planning related programmes.
9. Health facilities shall provide SRH and FP services as an integral part of basic health services.
10. Family planning services in Botswana shall consist of the following: BCC and IEC at individual and community level; health assessment including screening for selected conditions; provision of a broad range of contraceptive methods; post-natal care; selected services for infertility clients; counselling, follow up and referral.

11. All persons including adolescents and youth shall be given adequate information, education and counselling to enable them to make informed decision concerning their reproductive lives and the means by which to effect their decisions.
12. Post-partum women, irrespective of the place of delivery, shall be provided with post-natal care and Family Planning counselling as an essential service and as an integral part of SRH services.
13. Family planning clients current and potential shall receive information, education and counselling on sexual and reproductive health, family planning, STI/HIV/AIDS infections and on selected health conditions.
14. Women, men, adolescents and youth, in the reproductive age who are sexually active shall be eligible to use family planning methods without the consent of relatives, partner, parents or guardian with the exception of sterilisation.
15. All women regardless of age and for whom there are no contra-indications are eligible to use combined oral contraceptives.
16. All women regardless of age or parity and for whom there are no contra-indications are eligible to use progesterone-only contraceptives e.g. Depo provera, Norplant and progesterone-only pill. Lactating mothers may also use these.
17. All women regardless of parity and for whom there are no contra-indications are eligible to use an IUCD.
18. Sterilisation methods of contraception shall be provided to clients who feel they have achieved their desired family size.
19. The males, adolescents and youth are to be provided with appropriate family planning methods on request after adequate counselling.
20. Non-medical and selected medical methods of contraception shall be made available at all health facilities, work places, community outlets and selected public places.
21. Monitoring and evaluation of family planning services and follow up of clients shall be carried out periodically in accordance with set practice standards.
22. All personnel providing family planning services must be adequately prepared and trained for the duties to which they are assigned, appropriately supervised and receive regular in-service education to update their knowledge and skills.
23. Family planning services shall be provided at all health facilities during regular service hours and speciality designated times.
24. Adequate family planning supplies and equipment shall be made available at all health facilities through the Central Medical Stores.
25. Family planning services shall be provided in an atmosphere that assures privacy and confidentiality of clients.
26. Accurate information on family planning shall be collected and recorded on nationally designed forms

by all family planning providers – public and private (government and non-government, mission, private and industrial), for the purpose of planning and monitoring at all levels.

27. Condoms should be recommended for prevention of STI/HIV/AIDS in addition to other contraceptive methods used by the client.

3.2.1 What FP Services Shall Be Provided?

- BCC and Information, education and communication at individual, family, group, community and national levels.
- Health assessment and provision of contraceptive methods.
- Screening for STIs as per manual for health workers e.g. STI Management for Botswana.
- Screening for cancer of the cervix, breast, prostate and testis, in accordance with the laid down current cancer screening protocol.
- Post-natal care including provision of contraceptives.
- Infertility assessment, STI treatment, HIV testing and cancer screening will also be offered in an integrated approach.
- Counselling as a component of FP.
- Post abortion care and provision of FP commodities.

3.2.2 What FP Methods Are Available In Botswana?

Hormonal methods

- Combined oral contraceptive e.g. Nordette (low dose) and Norinyl (high dose)
- Progesterone only contraceptives:
 - Depo provera
 - Norplant
 - Microval

Non-hormonal methods

- Intra-uterine Contraceptive Device (IUCD)

Barrier methods

- Condoms(female and male)

Natural family planning

- Lactational amenorrhoea
- Abstinence
- Rhythm
- Basal Body Temperature (BBT) method

Voluntary Surgical Contraceptive methods

- Vasectomy
- Tubal ligation

3.2.3 Where Shall FP Services Be Provided?

All health facilities and community Based outlets shall provide FP services.

Note also: Oral contraceptives do not protect against STDs/HIV infections. Dual protection (condoms) is highly recommended.

General instructions to all OC users;

- At the initial visit and each visit thereafter, each pill client shall be informed to contact a health worker right away in the following circumstances:
 - If she forgets instructions about taking the pill.
 - If she experiences any of the early warning signals (see boxes).
 - If she has any concerns about taking the pill whatsoever.

All oral contraceptive users (both combined and progestin-only pill), shall be informed to report the following warning signals to the clinic or health facility at once:

Progestin-Only Pills

Early Warning signals

- Abdominal pain- May be due to an ovarian cyst or ectopic pregnancy (*Don't stop pills but contact the health worker right away*)
- Pills taken late- even if only 3 hours late – use a back up method for the next two days. Be careful to take the mini pill on time

Combined Oral Contraceptive

CAUTION: Early Warning Signals

- Abdominal pain
- Severe chest pain or shortness of breath
- Severe headache
- Eye problems such as blurred vision or loss of vision
- Severe leg pain (calf or thigh)

3.4.2 Depo-Provera

- Depo-Provera is the current progestin injectable contraceptive used for family planning in Botswana. The dose shall be 150 mg every 12 weeks, given as deep intramuscular injection. The procedure shall be in accordance with the procedure manual.
- Every potential client for Depo-Provera shall have an initial thorough health assessment including health history, physical and pelvic examination to rule out the following absolute and relative contra-indications:

Absolute Contra-indications:

- Cancer of breast
- Cancer of reproductive organs
- Pregnancy
- Undiagnosed uterine bleeding.



- Depo Provera shall be provided to eligible clients at all health facilities having resources for initial and periodic health evaluation, aseptic technique for intra-muscular injections and adequately trained MCH/FP service providers.
- Clients on Depo-Provera shall be scheduled for review and provision every 12 weeks. The review visit shall include:
 - Checking blood pressure
 - Checking weight
 - Documentation of side effects or concerns
 - Documentation of any complications
- Lactating women on Depo-Provera need not switch to an alternative contraceptive method on cessation of breastfeeding.

3.4.3 Implants

These consists of different types eg. Jardelle and Norplant.

- * Jardelle consists of a set of two flexible cylindrical implants consisting of a dimethylsiloxane

- * copolymer core enclose in thin walled silicone tubing. Each rod contains 75mg of progestin levonorgestrel. Each rod is approximately 2.5mm in diameter and 43mm in length. The Norplant method consists of six flexible silicone capsules, each containing 36mg of the progestin levonorgestrel within polydimethylsiloxane tubes and is 2.4mm in diameter and 34mm long. This is not a new method since the active ingredient - levonorgestrel is used in the oral contraceptives.

- Clients for implants shall have an initial thorough health assessment including health history, physical and pelvic examination to rule out the following absolute and relative contra-indications.

Absolute contra-indications:

- Suspected or known pregnancy
- Cancer of breast
- Undiagnosed abnormal uterine bleeding.
- Previous ectopic pregnancy
- History or presence of irregular bleeding
- Cancer of reproductive organs

Relative contra-indications:

- Hypertension
 - Diabetes
 - Migraine
 - Epilepsy or seizure disorder
- Every client for implant shall be provided with adequate information and counselling to enable her to make an informed choice and enhance continuation of method use. It shall include the following:
 - The drug mode of action and benefits
 - Duration of effectiveness
 - Pregnancy rate compared to other contraceptive methods
 - Important symptoms to look for and their possible duration – i.e. *Amenorrhoea, menstrual irregularities and local infection of the implant site*
 - Warning signals and complications
 - Importance of follow up care
 - All implants users shall be informed to report the following warning signals to the clinic or health facility. (See box below)

CAUTION: Early Warning Signals

- Severe lower abdominal pain (Ectopic pregnancy is rare but can occur)
- Heavy vaginal bleeding
- Pain in the arm
- Pus or bleeding at insertion site. Caution: these may be signs of infection
- Expulsion of an implant
- Delayed menstrual periods after a long interval of regular periods
- Migraine headaches, repeated very painful headaches or blurred vision

- Implants shall be provided to clients at health facilities where providers have been trained in implant insertion and removal techniques.
- Follow-up/review of implant clients shall be scheduled at 1 week following insertion and then annually thereafter. The review visit will include:
 - Checking blood pressure
 - Checking weight
 - Checking of the implant site (after 1 week)
 - Documentation of side effects or concerns.

All clients should be encouraged to return any time they have any problems.

3.4.4 Intra-Uterine Contraceptive Devices

- Women who desire to use the IUCD shall receive a comprehensive health assessment, which includes medical, obstetrical and gynaecological history, physical and pelvic examination, risk assessment for sexually transmitted diseases/ HIV and pregnancy.
- IUCD shall be provided to a woman after excluding the following: -

Absolute contra-indications:

- Known or suspected pregnancy
- Acute cervicitis or endometritis
- Abnormal vaginal bleeding
- Cancer of the reproductive tract
- Current, recent or recurrent (within the past three months) pelvic inflammatory disease
- Impaired response to infection: diabetes, steroid treatment, HIV disease, leukemia
- Infected abortion within the last three-(3) months.
- Anatomical abnormalities of uterus

Relative contra-indications:

- History of ectopic pregnancy
- High risk for sexually transmitted diseases, especially a woman who has more than one sexual partner or whose partner has more than one sexual partner
- Cervical stenosis
- Moderate or severe anaemia
- Acute vaginitis
- Valvular heart disease
- Painful and/or heavy menstrual periods

Note: Clients with relative contra-indications should be referred for medical assessment.

- Potential clients for IUCD shall be provided with adequate information, education and counselling regarding this method in order to make an informed choice. This must include the following:
 - The mode of action and benefits
 - Duration of effectiveness
 - Pregnancy rate compared to other contraceptive methods
 - Side effects and possible complications
 - Non-contraceptive benefits to health

- Warning signs and complications
- All IUCD users shall be informed to report the following warning signals to the clinic or health facility at once:
- Clients electing to use IUCDs shall be provided with details regarding IUCDs. The details include instructions on:
 - Possible menstruation changes to expect and for how long.
 - How to and how often to check for IUCD strings and what to do if strings are not felt or have lengthened.
 - When to return to the service provider.
 - Follow-up schedule.
 - Possibility of pregnancy.
- IUCD users shall be scheduled for a follow-up after first menses following insertion and annually thereafter. Clients shall be encouraged to return any time they have concerns about the method or side effects.
- Clients electing to use IUCDs following caesarian section must be thoroughly evaluated before IUCD insertion. Midwives, gynaecologists and medical officers may insert the IUCD after the evaluation 6 weeks after the caesarian section.

3.4.5 Voluntary Surgical Contraception (VSC)

- Voluntary Surgical Contraception, which is a permanent method of contraception, shall be provided to clients who feel they have achieved their desired family size. Such clients shall be provided with clear and complete counselling to enable them to make an informed choice.
- Every client for VSC shall be provided with adequate information and counselling to enable her/him make an informed choice. Such information shall include the following:
 - Mechanism of action
 - Benefits and risks of the method

CAUTION:Early Warning Signals

- Late menstrual period
- Period late (Pregnancy) abnormal spotting or bleeding
- Abdominal pain, pain with intercourse
- Infection exposure (any STI'S), abdominal discharge
- Not feeling well, fever, chills
- String missing, shorter or longer

- Pregnancy/failure rate compared to other contraceptive methods
- An encouragement for client to enquire and an offer to answer questions regarding myths, misinformation and rumours
- The clients' freedom to withdraw consent at any time prior to procedure

- Explanation of entire procedure and possible side effects, reversibility, effectiveness and whether or not it will affect libido
- When, after the procedure, is the method effective:

For any of these problems, VSC clients must return to the clinic for medical care without delay.

CAUTION: Early Warning Signals

VASECTOMY:

- Fever
- Bleeding or pus from the site of the incision
- Excessive pain or swelling

TUBAL LIGATION:

- Fever (Greater than 100.4F, 39c)
- Dizziness with fainting
- Acute abdominal pain that is persistent or increasing
- Bleeding or fluid coming from incision

Note: (For both the methods)

Adequate time interval must be allowed after counselling before the actual procedure is carried out. Counselling to be given to both partners irrespective of which partner has the operation

- All clients accepting VSC must exercise informed choice and sign a consent form. The consent form should consist of the following statements: -
 - That other methods are available.
 - That they have been counselled on risks and benefits of the procedure.
 - That there is a slight recognised failure of the method.
 - That the client may withdraw consent for the method at anytime before the procedure and will not be denied other methods.
- A married woman shall be required to have the written consent of the husband for tubal ligation and the husband shall be required to have the written consent of the wife for vasectomy. Where there is conflict/risk, the welfare of the individual/client shall prevail. Single women and men shall give consent for themselves.
- Sterilisation methods of contraception shall be provided at the hospitals and shall be performed by medical practitioners who are qualified in accordance with current national regulations. In addition, medical practitioners operating in any other approved health facilities where these procedures can be performed may provide the service.
- Clients seeking this service from places other than the above named health facilities shall be referred to the appropriate facility and medical practitioner.
- A special programme shall be designed to promote VSC. The programme should include technical training especially VSC under local anaesthesia and IEC.
- After a vasectomy, the method is not completely effective until after 3 months. It is therefore

recommended that the couple should use other back up contraceptive methods until after 3 months.

Note: VSC does not protect against STIs/HIV infection. Dual protection (condom) is highly recommended.

3.5 Emergency Contraception

Emergency contraception refers to methods, which can be used to prevent pregnancy following unprotected coitus (post-coitus) be it consented, rape or method failure. There are two methods:

- Emergency contraceptive pills
- Intra Uterine Contraceptive Devices

3.5.1 Pills

- Emergency contraceptive pills are hormonal methods that can be used to prevent pregnancy following unprotected sexual intercourse.
- There are two emergency contraceptive pills regimens:
 - The standard regimen consists of combined oral pills containing ethinyl estradiol and levonorgestrel. This regimen is known as the Yuzpe method.
 - Alternative hormonal regimen consisting of levonorgestrel only pills is equally effective as the Yuzpe regimen but has a significantly lower incidence of side effects.

Timing

- Ideally she should take levonogestrel only or combined estrogen-progestogen ECPs as early as possible between 72-120 hrs after unprotected sexual intercourse. However she should be advised that the effectiveness of ECP is reduced the longer the interval between having unprotected sexual intercourse and taking ECPs.

Mode of action

See FP procedure Manual.

Contra- indications

- Pregnancy is the only contra-indication for COCs/POCs, do not apply to ECP.

3.5.2 IUCD

IUCDs can be used as emergency method of contraception when inserted within 5 days of unprotected sexual intercourse.

Availability

Refer to section on IUCD above.

Mode of action

Refer to section on IUCD above.

Indications

- IUCD is indicated within 5 days after sexual intercourse.
- When the client is considering using an IUCD for continuous long-term contraception.

Contra-indications

- Will be the same as IUCD in these circumstances.
- In cases of rape, there may be an added risk of STIs. Use of IUCD is therefore not advisable.

Counselling and Information

Counselling is not a prerequisite for providing emergency contraceptives. The client can receive information and counselling at a follow-up appointment at a scheduled more convenient time and if the client wants to continue with either the pill or IUCD as a method of contraception. The following information should be given:

- Explain how to take emergency contraceptive pill correctly as over dose may lead to side effects.
- Describe common side effects to help women know what to expect as this may lead to greater tolerance.
- Advise the client to take the pill with food to reduce nausea, the importance of taking the pill at the stipulated time should be stressed to the client. However, the first dose should not be delayed unnecessarily as efficacy may decline overtime.
- The contraceptive effect of emergency contraception is limited to the unprotected sexual intercourse for which it is immediately used. Subsequent sexual intercourse may not be protected.

Note. The general aspects of counselling for the use of emergency contraceptive pills also apply to counselling for emergency use of IUCD.

3.6 Types of Non-Medical Methods

Non-medical methods of contraception when used do not interfere with normal physiology. These are: condoms (male & female), natural and lactational amenorrhoea methods.

No health assessment shall be required before they are supplied, however, each user must be informed on how the method works, how to use the method correctly and on the advantages and disadvantages of the method.

3.6.1 Condoms (male and female)

Every client for condoms shall be provided with adequate information and counselling to enable him/her make an informed choice and enhance continuation of method use. The information shall include the following:

- The mechanism of action and benefits of method
- Duration of effectiveness
- Pregnancy/failure rate
- That condoms may be particularly useful as a back up method when:
 - The woman has forgotten to take several oral contraceptive pills in a row and needs a back-up method for the rest of that cycle
 - Both men and women are at risk of STIs/HIV, in addition to any other methods of contraception.
 - Maybe used with natural family planning during fertile period.

Note: Used correctly and regularly CONDOMS provide dual protection against both pregnancy and STIs/HIV infection.

3.6.2 Natural Family Planning

- Since natural family planning does not use drugs or devices, it is especially useful for those clients who do not wish to use any of the preceding methods.
- Information, counselling and clear instructions in this method shall be provided only by those who have been trained in the cervical mucus (Billings) method, basal body temperature (BBT) method, calendar (rhythm) method, or sympto-thermal (S-TM) method.

Note: NFP does not protect against STIs/HIV infection. Dual protection (condom) is highly recommended.

3.6.3 Lactational Amenorrhea Method (LAM)

The Lactational Amenorrhea Method is a highly effective but temporary method of contraception. Clients who are breastfeeding shall be provided with information, counselling and clear instructions on use of this method. Additionally they shall be counselled on other methods to be used in case of any of the following conditions:

- When menstruation resumes
- Frequency and duration of breastfeeds are reduced
- If non breastfeeding methods are introduced
- When the baby reaches 5 months of age.

3.7 Family Planning For Special Groups

3.7.1 Males

- To promote male involvement, FP service providers shall make a deliberate effort to educate the male and provide appropriate non-medical methods more freely.
- Condoms, vasectomy as well as FP counselling and education shall be made available to men.
- Clients shall be encouraged to come with their partners for FP sessions and discussions in order to enhance communication between them.
- Family planning providers shall use a variety of educational methods to motivate the males such as providing IEC materials, displaying the various methods available, showing films or slides of the health and social-economic benefits of FP, using 'kgotla' meetings, working places and other suitable places to provide information and identifying male acceptors to assist in motivating others.
- The current service delivery shall be flexible to allow scheduling of family planning sessions and discussions during non-working hours when it is more likely that the male is available. Reaching them from a variety of settings such as vending machines for condoms, work places, through community-based distribution and all health facilities is highly recommended.

- Family planning education and counselling for men shall include the following information, verbally or in IEC materials as appropriate:
 - Explanation of male and female reproductive organs and how FP methods work.
 - How contraception occurs.
 - How to use the condom and spermicides.
 - Where to obtain additional supplies.
- Family planning service providers shall attempt to reach men at their work places during working hours and to arrange for special discussion sessions at their work place or clinic.

3.7.2 Adolescent/Youth

- All health workers including other extension workers and NGOs, shall provide information, education and counselling services to teenagers through:
 - Parent-teacher involvement
 - Individual counselling at home, school, clinic and all other forums
 - Peer group counselling and discussions in youth groups such as Red Cross, Scouts, Church youth groups and work camps, BOFWA, YWCA and other NGOs.
 - Relevant radio programmes such as "*Maokaneng*".
 - Appropriate educational materials.
- In order to make FP more accessible to teenagers, services, supplies and booklets shall be made available not only where SRH services are given but also where general consultations are done. Commodities shall be issued in the privacy of the examination or consultation rooms and not dispensed through the dispensary.
- General Duty Assistants, CBDs, and FWEs trained in the use of non- medical contraceptives shall provide these methods in order to increase accessibility to family planning.
- District Health Teams shall schedule a Responsible Parenthood Seminar for their District at least twice a year. Efforts shall be made to separate old and young teens in these seminars.
- Emergency Contraceptive methods shall be made available for use in case of unprotected sex, for example in case of rape, defilement and incest. (Method of use as in the relevant section).
- Non-medical methods of contraception such as condoms and other appropriate methods shall be promoted among the youth both male and female. These shall be made available on request to members of this group following adequate counselling and instructions on use.
- All methods for female teenagers shall be provided according to the stipulated conditions in this manual.
- Family planning service providers shall promote the use of condoms as a contraceptive method as well as for protection from sexually transmitted infections particularly for this group, which is at high risk as a result of its high sexual activity.
- As with the male population, SRH service providers may have to schedule services for teenagers outside the regular clinic hours or clinic site, as this would enhance anonymity and privacy - two great needs for this group.

- Health workers message to the youth should include the individual's health and welfare benefits of delaying the pregnancy until age 20.

3.7.3 What Needs To Be Done For Individuals with Severe Mental and Physical Disabilities?

- Tubal ligation and hysterectomy for women with severe mental and/or physical disabilities is legally possible if recommended by a psychiatrist/physician and with consent of family members.
- Vasectomy for men with severe mental and/or physical disabilities is legally possible if recommended by a psychiatrist/physician and with consent of family members

3.7.4 Women with Medical Disorders

Appropriate contraceptive methods shall be advised for women with cardiovascular disease, diabetes, epilepsy, migraine, liver disease, haematological and psychiatric disorders.

3.7.5 Post Natal Clients

- The SRH Division shall facilitate the effort by providing relevant information and educational materials carrying accurate messages. These shall be used by other health workers in health teaching and client education on postnatal care and family planning.
- Family planning services for post-partum women shall include family planning information, education and counselling and provision of appropriate contraceptive methods.
- All post-partum women who deliver in health facilities shall be provided with relevant information, education and counselling on family planning before discharge. This shall include but not be limited to the following:
 - The importance of family planning
 - Contraceptive methods which can be used during breast-feeding and how they work including Lactational Amenorrhoea Method (LAM)
 - When after delivery or abortion the various contraceptive methods can be introduced
 - Nutrition and personal hygiene
 - Where and how to obtain the services and supplies.
- Any post-natal woman who desires to use a contraceptive method before the 6-8 week post-natal examination shall be adequately counselled and assessed and provided with the method most appropriate to her.

3.7.6 Post Abortal Client

Refer to section on Post Abortion Care under Maternal and Neonatal Care.

3.8 Privacy and Confidentiality

- In order to assure privacy, FP service providers shall observe the following measures:
 - That privacy is achieved and maintained (e.g. by rearranging furniture if there are no separate rooms to use as examination rooms).
 - That clients are asked to undress only if necessary .

- That any person who has no duty in the examination room leaves during the examination. If outsiders must be present such as nursing, midwifery or medical students, limit their number (preferably to one) and explain the reason for their presence to the client, and ask the client's permission.
- That the client is not asked to undress and then have him or her wait for a long time.
- That a screen is provided if there is no dressing room.
- That they avoid talking to colleagues about clients in their presence, but instead talk to the clients.
- In order to assure confidentiality, FP service providers must observe the following measures:
 - That privacy is provided during individual counselling and during physical examination.
 - That they do not talk about clients in the presence of other clients.
 - That they do not discuss clients when outside the service delivery room.
 - That they always file client records immediately after they are completed.
 - That there is control of unauthorised access to client records.
- In order to provide anonymity, if required, FP service providers:
 - Shall retain clients' FP case cards at the health facility even when others take theirs home.
 - Shall arrange separate consultation times for adolescent/youth and for men or couples.
 - Shall take services to the work places with proper arrangement for privacy.

3.9 Follow up and Referrals for FP Clients

- Follow up visits shall be scheduled by method but in each case shall focus on the following:
 - Management of real or perceived side effects.
 - Management of problems with methods including those requiring a change of method.
 - Problems of how to use the method correctly.
 - Reassurance and support in regard to minor side effects and discomfort.
 - Re-supply of appropriate methods. E.g. condoms, spermicides and pills.
- Each referral health facility shall be required to establish a workable, regular system outlining family planning client referral procedures. These procedures shall be communicated to all referral sources.
- Referral health facilities shall use standard referral forms, which include the following information:
 - Days/times assigned for referrals.
 - Special arrangements for urgently required service.
 - The referral section and the appropriate health provider.
 - What screening and investigations need to be done beforehand and how the client should obtain these.
- Clients requiring referral shall be referred to the next level and/or specialist in accordance with the criteria set out under each contraceptive method in this manual and the clinical procedure manual.

3.10 Preparation and Supervision of FP Providers

- The SRH Division shall work together with all other health-training institutions to ensure that FP is adequately covered in the training curricula.
- All medical methods of contraception, regardless of the setting in which they are offered, shall be

prescribed and monitored by providers who have been trained and prepared and found proficient in client counselling, method prescription and client follow-up in regard to the particular methods.

- Providers for non-medical methods shall have adequate preparation in counselling, giving information on effectiveness, handling misconceptions and rumours, and in providing accurate instructions to the clients on the particular method. Condoms shall be accompanied by clear, simple client instructions regarding their benefits, failure rate and how to use them. Packaging must show manufacture and expiry dates.
- All aspects of FP methods – i.e. knowledge, skills and attitudes - shall continue to be integrated into the pre-service curricula of all health workers in accordance with their post-training duties.
- Institute of Health Sciences pre-service graduates comprising of nurses, midwives, community health nurses, family nurse practitioners and FWEs shall continue to provide facility based FP services with back up from medical officers.
- In order to update the knowledge and skills of the pre-service graduates, the Continuing Education Division of the MOH, as the co-coordinating body, shall establish a regular system of continuing education and in-service training for family planning service providers. In this process the Continuing Education Division shall involve other IHS pre-service departments, the SRH Division and the DHTs and hospitals.
- Institute of Health Sciences shall make efforts towards strengthening and promoting linkages between pre-service training continuing/in-service training, SRH Division and DHTs to ensure continued production of adequate number of competent FP service providers.
- District Health Teams and hospitals shall design a comprehensive supervisory system for FP service delivery and adhere to it. The design must reflect the objectives and the focus of the supervisory system.
- Family planning policy guidelines and practice standards and procedure manuals shall be used as a basis for monitoring and evaluation of family planning service delivery management. Therefore, the comprehensive supervisory system must spell out the department, divisions, units or individuals who shall provide the supervision at specified intervals and the different health facility levels.

3.11 Monitoring And Evaluation Of FP Service Delivery

- Each FP service delivery site including clinics and health posts shall have available a copy of the following:
 - Policy Guidelines and Service Standards For Sexual and Reproductive Health
 - Family Planning Procedures Manual for Service Providers
 - Management of STIs in Botswana – ‘A Manual for Health Workers Management Information Systems for Family Planning
- For any new information systems, policy guidelines or standards formulated, all FP service providers including pre-service trainees and new graduates, shall be provided with information on content to ensure that a high level of competency and uniformity is maintained.
- The SRH Division shall establish a system of periodic review, monitoring and evaluating the family planning service delivery and training. IHS, CMS and DHTs shall be involved in these exercises.

3.12 Standards for basic record keeping and returns for family planning

- All FP service providers shall maintain adequate and accurate records of clients and commodities in order to plan, monitor and evaluate their activities. The primary purpose of these records is to provide quality care to family planning clients and evaluate the attainment of set targets. All information relating to these records shall be strictly confidential.
- Service providers shall use nationally approved forms for recording FP data.
- The Family Planning Case Card (MH 1042) shall provide adequate space for recording the following but not limited to:
 - Findings of the comprehensive health assessment required for initial and annual visits as per this manual.
 - Method-related information particularly method switching and reasons.
 - Findings of follow-up visits.
 - Results of screening for medical conditions such as cancer and STIs.
- The card shall be completed for each client on a medical method of contraception. The MH1042 card shall be a client-retained card. Family planning clients shall be expected to produce it at any visit to any health facility for FP services. Provision shall be made for filing of the records of those clients who do not wish to retain their cards due to personal reasons.
- The Outpatient Register shall be completed daily at health facilities. It shall record the number of FP visits by first or repeat visits and method. This information shall be transferred to the Monthly Summary Form for Outpatient and Preventive Health Statistics.
- The Outpatient and Preventive Health Statistics Monthly Summary Form (MH 1049) shall be completed each month by all FP service providers, including private practitioners, pharmacies, and workplaces, and sent to their DHT who will forward the form to the Medical Statistics Unit.

The SRH Division shall develop an appropriate national mechanism to facilitate decision making and monitoring the type and quality of contraceptives being provided within the service delivery systems in Botswana; monitoring and evaluating the FP service standards from time to time; initiating relevant country specific research with respect to contraceptive practice and effects on users; reviewing existing and determining new FP policy guidelines and service standards; and facilitate dissemination of information to all levels.

Adolescents/Youth: Special Considerations

- Adolescent pregnancy is rising while contraception use remains low.
- Adolescent have not been involved in planning and running of FP services.
- Adolescents/Youth have not been involved in material design and production of IEC material.
- Most FP services are not adolescent friendly in terms of:
 - Timing: Need to allocate convenient timing since majority attend schools and colleges thus 24 hour services recommended
 - Space: Need to provide youth friendly service points

- Staff attitude:- Need to re-orientate service providers to be men/adolescent/youth friendly
 - :- Train peer educators and counsellors
 - :- Ensure privacy/confidentiality
- Special intervention to address adolescent and men participation and uptake of FP programmes.
- Stationing of nurses in schools.
- Focus on integration of FP services with other health

Chapter 4

MATERNAL AND CHILD CARE

4.0 COMPONENTS OF MATERNAL AND NEWBORN CARE

- Pre-conception
- Antenatal care
- Intrapartum (Labour and Delivery) care
- Postnatal care
- Newborn care
- Emergency Obstetric Care
- Post abortion care

4.1 Pre-Conception Care

4.1.1 What is Pre-Conception Care?

Pre-conception care is the health care information and services given to an individual or couple before biologically fathering or mothering a child. It consists of the following services:

- Information on FP, nutrition, responsible parenthood
- STI/HIV/AIDS prevention
- Advice on balanced diet and nutritional supplementation where necessary
- Provision of Family planning methods
- Provision of well woman care
- Screening for STI/HIV/AIDS, anaemia

4.1.2 Where Shall These Services Be Provided?

- Government health facilities
 - Referral, District hospitals (MCH clinics)
 - Clinics with/without maternity
 - Primary hospitals (MCH clinics)
 - Health posts/mobile stops
- Private sector
 - Hospital
 - Private practitioners
 - Private institutions e.g. BMC, Banks etc.
- Non-governmental organisations hospitals and clinics
- Mission hospitals/ clinics
- Mine hospitals
- Parastatal organisations e.g. Botswana telecom, Power Cooperation, BDC etc

- Foetal assessment.
- Identification and management of new risks.
- Counselling on PMTCT programme and provision of antiviral drugs for HIV-positive women.
- Referral in case of complications.
- Teaching on nutrition, avoidance of drugs and alcohol/smoking etc.
- Information and education.

4.2.2 Where Shall Antenatal Care Be Provided?

- Government health facilities
 - Referral hospitals (MCH clinics, ANC High Risk Wards)
 - District hospitals
 - Primary hospitals
 - MCH clinics
 - Maternity wards for ANC/risk clients
 - Clinics with/without maternity
 - Health posts/mobile stops
- Private sector
 - Hospitals
 - Clinics
- Mission Hospitals and clinics (MCH clinics)
- Mine hospitals and clinics
- NGOs hospitals and clinics
- Parastatals - e.g. Botswana telecom, Power Cooperation, BDC clinics etc

4.2.3 Who Can Provide Antenatal Care?

- Obstetricians/Gynaecologists
- Medical officers
- Midwives
- Family Nurse Practitioners
- Traditional Midwives

4.2.4 Who Is Eligible For ANC?

- All pregnant women and their partners
- Pregnant adolescents/Youth

Note! Special attention to be given to adolescents/Youth and women with high-risk pregnancy.

4.2.5 When Shall ANC Be Provided?

- ANC shall start as soon as pregnancy is confirmed.
- Low risk women will be seen as per the protocol on Safe Motherhood.
- High risk women shall be seen as is required.

4.3 Labour and Delivery (Intra partum) Care

4.3.1 What Is Labour And Delivery Care?

It is monitoring interventions and care given to women during labour in order to ensure safety and well being of the mother and the baby. It consists of the following services:

- Review of history and ANC record.
- Evaluation of presenting complaints.
- General physical examination.
- Specific examination to assess the three (4) “Ps”.
- Observation and tests.
- Monitoring of maternal and foetal well-being.
- Monitoring progress of labour by using pantographs.
- Ensuring clean and safe delivery.
- Involvement of father, relatives or friends, according to mother’s wishes.
- Relief of distressing symptoms e.g. pain.
- Counselling and education on birth process etc.

4.3.2 Where Is Labour And Delivery Care Provided?

- Government health facilities
 - Referral hospitals
 - District hospitals
 - Primary hospitals
 - Clinics with MCH facility/wing
- Private hospitals & clinics with maternity facilities
- Mission hospitals & clinics with maternity facilities
- Mine hospitals & clinics with maternity facilities

4.3.3 Who Can Provide Labour And Delivery Services?

Skilled providers such as:

- Obstetricians/gynaecologists
- Medical Officers
- Midwives
- Pediatrician

4.3.4 Who Is Eligible For Labour And Delivery Services?

All women during labour including adolescents /youth.

4.3.5 When Are Labour And Delivery Services Provided?

It is a continuous 24-hour service in all designated facilities

4.4 Postnatal Care

4.4.1 What Is Postnatal Care?

Postnatal care is the health care and follow-up given to a mother immediately following delivery and up to six (6) weeks after delivery. It consists of the following:

- During hospitalisation the following shall be ensured:
 - Immediate examination (during first 24 hrs).
 - Subsequent examination.
 - Prevention of infection in case of caesarian section e.g. wound care, perineum care.
 - Provision of basic needs e.g. nutrition, hygiene, rest/pain relief.
 - Health information on nutrition, FP, 6-8 weeks PNC check up, hygiene.
 - Baby immunisation and care.
 - Growth monitoring.
 - Education on danger signs (warning) for mother and baby.
 - Birth registration.
 - Information and education on postnatal excersises.
- Domiciliary care shall involve:
 - Home visit by health workers within 1st week after delivery.
 - Examination of mother and baby e.g. checking for anaemia, involution of uterus, state of lochia and repaired lacerations on the mother; checking on baby's feeding, bowel movements etc.
 - Dietary advice.
 - Counselling, information and education on individualised personal care.
 - Psychological and emotional support particularly for mothers who had difficult deliveries and or lost their babies.
- 6-8 weeks postnatal visit
 - Examination of the mother and baby.
 - Screening for cervical cancer.
 - Counselling on FP and provision of FP methods.
 - General health education on nutrition, hygiene, care of baby, immunisation, STI and HIV prevention and treatment for HIV positive women or couples
 - Referrals.
 - Medical report.

4.4.2 Where Can Postnatal Care Be Provided?

- Government health facilities
 - Referral hospitals
 - District hospitals
 - Primary hospitals.
 - Clinics with/without maternity wing
- Private sector
 - Private hospitals
 - Clinics with or without maternity facilities
- Mission hospitals and clinics
- Mine hospitals and clinics

- NGOs hospitals and clinics for example YWCA for teenage mothers
- Homes

4.4.3 Who Can Provide Postnatal Care?

- Obstetrician/gynaecologist
- Medical officer
- Midwives
- General nurses
- Family Nurse Practitioners
- Health Educators
- Social workers
- FWEs,
- Adolescent peer educators
- Family members
- Religious/ Community leaders
- Traditional healers and midwives

4.4.4 Who Is Eligible For Postnatal Care?

Any woman and baby within six weeks of delivery (couple counseling for FP and STI/HIV prevention is advisable).

4.4.5 When Shall Post Natal Care Be Provided?

- Daily
- 24 hours in case of emergency

4.4.6 IEC For Postnatal Clients

- All health workers including other extension workers shall provide the community with information and education on the importance and composition of immediate and later postnatal care during the puerperium in regard to the mother and her baby.
- SRH service providers including FWEs shall ensure that antenatal women are given information, education and counselling regarding postnatal care and FP. The education shall include:
 - Description of component of postnatal care and services, including family planning
 - Importance of postnatal care to mother and baby
 - Where and how to obtain the services
 - When after delivery to go for the services.
- Those in-charge of maternity units and SRH clinics or departments (such as senior sisters) shall design a plan to ensure that each client has received the information before discharge.
- Each postnatal client shall be given a return date for post-partum examination at 6 -8 weeks period. This period will depend on whether a medical certificate is required or not. For mothers who do not need a medical certificate, the 8-week return date should as far as possible coincide with the date for the 1st DPT immunisation for the baby currently scheduled at 2 months of age in Botswana.

- Family Welfare Educators (FWEs) and other SRH service providers shall review and give appointments for postnatal follow up during home visits.

For postnatal FP refer to Chapter on Family Planning.

4.5 Emergency Obstetric Care (EmOC)

4.5.1 What Is Emergency Obstetric Care?

Emergency obstetric care refers to urgent life-saving care provided to pregnant women and foetus in response to problems arising during pregnancy, labour, delivery and puerperium.

Common obstetric emergencies include:

- During Pregnancy:
 - Ectopic pregnancy
 - Abortions
 - Severe Pregnancy Induced Hypertension (PIH) and pre-eclampsia
 - Severe anemia
 - Premature rupture of membranes
 - Congestive cardiac failure (CCF)
 - Ante-partum hemorrhage (APH)
- During Labour and delivery:
 - Haemorrhage
 - Pregnancy Induced Hypertension (PIH) and eclampsia
 - Obstructed labour
 - Pre-term labour
 - Delayed 2nd stage of labour
 - Foetal distress
 - Ruptured uterus
 - Malpresentations
 - Impacted shoulders
 - Retained placenta
 - Cervical/extensive tears
- During Puerperium
 - Pre eclampsia
 - Puerperal sepsis
 - Post partum haemorrhage

4.5.2 What Common Activities Are Undertaken In EMoC?

- Anticipation and referral
- Resuscitation and referral
- Manual removal of placenta
- Vacuum extraction
- Repair of tears

- Caesarian section
- Haemostasis
- Blood transfusion
- Management of sepsis
- Induction of labour
- Management of pre eclampsia/eclampsia

4.5.3 Where Can EMOc Be Provided?

- Governmental health facilities
 - Referral hospitals
 - District hospitals
 - Primary hospitals (maternity wards neonatal units)
- Private sector
 - Hospitals
 - Clinics with facilities for maternity
- Mine hospitals
- Mission hospitals

4.5.4 Who Can Provide EMOc?

- Skilled providers such as:
 - Gynaecologist/obstetrician
 - Medical officer
 - Midwife
 - Family Nurse Practitioner
 - Paediatrician
 - Neonatal nurse

4.5.5 Who Is Eligible For EMOc?

Any woman and baby with obstetric emergency including; ectopic pregnancy, and post abortion complications.

4.5.6 When Is Emoc Provided?

Continuous on a 24-hour basis in all designated facilities.

4.6 Neonatal Care

4.6.1 What Is Neonatal Care?

Care of the baby given following delivery to 28 days. It consists of the following services:

- For immediate care:
 - hygiene and cord care
 - Ensure good adaptation to external life e.g. clear airway, maintenance of warmth, resuscitation.
 - Carry out observations.
 - Full examination of baby.

- Prevention of infection by giving tetracycline eye ointment at birth and Vitamin K.
 - Nutrition,.
 - PMTCT protocol followed in case of a baby of HIV-positive woman.
 - Referrals.
 - Prevention of hemorrhage.
- For special baby care:
 - Close observations.
 - Provision of warmth.
 - Prevention of infection.
 - Resuscitation.
 - Provision of appropriate care.
 - Referrals.
 - Information and Education to mothers on continuity of care after discharge.
- Subsequent care for the normal and special baby:
 - Examination.
 - Management of any special condition
 - Immunisations.
 - Growth monitoring.
 - Teaching on child care.
 - Nutrition, hygiene, etc.
 - Education on danger/warning signs, care of cord,
 - Attendance of child welfare clinic.

4.6.2 Where Is Newborn Care Provided?

- Government health facilities:
 - Referral hospital for (specialised care)
 - District hospitals
 - Primary hospitals
 - Clinics with/without maternity wing
 - Mobile stops and health posts
- Private sector
 - Hospitals
 - Private practitioners
- Mine hospitals
- Mission hospitals
- Domicilliary visits

4.6.3 Who Can Provide Newborn Care?

Skilled providers such as:

- Obstetrician
- Pediatrician
- Doctor
- Neonatal nurse
- Midwife

- Registered nurse and enrolled nurse
- FWE

4.6.4 Who Is Eligible For Newborn Care?

- Every newborn irrespective of status at birth.
- High risk newborn need special attention e.g. low birth weight, large for gestational age, congenital abnormalities, asphyxia, baby whose mother dies during childbirth, dumped babies.

4.6.5 When Should Newborn Care Be Provided?

These services shall be provided on a continuous, 24-hour basis in all designated facilities.

4.6.6 Care Of Babies Born Before Arrival

Babies born before arrival should be kept in isolation for observation and necessary care. They should be given tetanus and immediate care as outlined under *What is neonatal care?*

4.7 Post Abortion Care (PAC)

4.7.1 What Is Post Abortion Care (PAC)?

This is a package of services provided to a woman who has had an abortion in order to save her life, prevent and treat complications and prevent recurrence.

- PAC consists of the following elements:
 - Emergency evacuation of the uterus if necessary.
 - Post abortion counselling and FP.
 - Referral/linkage with other SRH services.
 - Partner and family support with consent.

4.7.2 Where Can PAC Be Provided?

- Government health facilities
 - Referral hospitals
 - District hospitals
 - Primary hospitals
 - Clinics
- Private sector
 - Hospitals
 - Clinics
- Mission hospitals and clinics
- Mine hospitals and clinics
- NGO hospitals and clinics

4.7.3 Who Can Provide PAC?

- Obstetrician/gynaecologist
- Medical officer
- Midwife

- Family Nurse Practitioner
- Nurses with relevant training
- Social worker
- Health Educator
- FWEs

4.74 Who Is Eligible For PAC?

Any woman, adolescent/youth who has had abortion(s) and abortion complications and their partners

4.75 When Should PAC Be Provided?

PAC services shall be provided on a continuous 24-hour basis in all hospitals and primary care facilities.

Note: Refer to PAC Manual for details.

Adolescents/Youth Special Considerations

- Adolescent pregnancy is high in Botswana i.e. 16% (BFH III 1996); while the contraceptive prevalence rate (CPR) remains low at 22.1% among 15-19 age group and 48% among those aged 20-24years (BFHS III, 1996).
- Adolescent pregnancy is high-risk pregnancy as it may predispose to
 - Unsafe abortions.
 - Poor/lack/late ANC attendance.
 - Pregnancy and labour complications e.g. anaemia, obstructed labour, operative delivery.
 - Lack/poor social support.
 - Interrupted education.
 - Baby rejection/dumping.
- Special training is needed for health workers to
 - Provide adolescent friendly services.
 - Guidance of peer educators/counselors.
 - Establishing adolescent “corners” within facilities.
 - Post abortion counselling.
 - Continued education to pregnant teenagers adolescents/youth after delivery.
 - Ministry of Education to include Family Life Education in the Curricula and train teachers to empower them with skills to impart (FLE) knowledge.
 Guidance and counselling to adolescents/youth in schools to be offered as a service.

Chapter 5

5.0 STIs AND HIV/AIDS

5.1 Background

HIV/AIDS in Botswana remains a national emergency. STI is the third-most common cause of attendance at public health facilities. Data from the Botswana 2003 second generation HIV/AIDS survey shows that the overall national prevalence was 37.4%, and ranged from 25.7% in the southern districts to 52.2% in Selibe Phikwe district. There is no marked difference in HIV prevalence between the urban and rural population. The highest prevalence was observed among those aged 25-29 years. While the prevalence in the older age groups shows increasing trends, among adolescents 15-19 years the prevalence has remained fairly stable, ranging between 21-22 % between 2002-2003. VCT data showed a significantly higher HIV prevalence among young women than men of similar ages. Trends in HIV prevalence among pregnant women by age group, sentinel surveillance 1992-2003, shows that in age groups 15-19 the prevalence fluctuated from 16.4% in 1992 to a high 32.4% in 1995 and down to 22.8% in 2003. In ages 20-24 the prevalence fluctuated from 20.5% in 1992 to 42.8% in 1998 and down to 38.6 % in 2003. In ages 25-29 the prevalence was between 13.6% and 42.8%.

Although some services are being offered under the SRH services to prevent the transmission of STIs and HIV, a lot of gaps exist in the prevention and management. The SRH programme needs to strengthen the already existing strategies and activities.

The current services have been inadequate because of the following gaps:

- Inadequate staff trained in STI/HIV/AIDS management
- Shortage of staff in health facilities
- Inadequate space for counselling and other services
- Lack of awareness on the part of the clients
- Self-treatment among males and females
- Limited behaviour change towards safer sex
- Negative attitudes of clients towards condom use
- Negative attitudes of health workers

5.2 Service Standards For STI/HIV/AIDS

5.2.1 Information, Education and Communication

- All health workers at all levels of health facilities (hospitals, clinics, health posts, private surgeries, extension workers, voluntary workers, and NGOs shall create awareness on the facts about STI/HIV/AIDS, to individuals, families and communities.
- The national level (SRH/FHD, AIDS/STD Unit) and district level shall develop materials for STI/HIV/AIDS, targeting specific groups.
- All levels shall produce and/or contribute towards the production of and/or, store enough BCC and IEC materials for utilization at all levels.

- Messages for BCC and IEC materials shall be formulated in consultation with the target groups through interviews and focus discussions.
- The FHD, AIDS/STD Unit shall provide support to the districts in material production at district level.
- DHTs shall work hand in hand with the health facility staff during BCC and IEC materials production and distribution.
- Advocacy for change in attitudes and practices of service providers and managers shall be emphasised during support visits and training.
- Testing BCC and IEC materials after production through interviews and focus group discussions.

5.2.2 Counseling

- Counseling services shall be provided to all males, females and adolescent/youth and their partners.
- All DHT staff and health workers at the hospitals, clinics, health posts shall offer counseling on STI, HIV/AIDS to patients irrespective of their age and other attributes.
- Continuous counselling shall be offered to all those known to have repeated STI infections and HIV/AIDS clients.
- Adequate counselling space to be made available at all levels of health facilities by the Government.
- All new health facilities' plans to include enough space for counselling.
- Support shall be provided by the central/district level health care to the NGO carrying out counselling services.

5.2.3 Treatment

- The management of STI/HIV/AIDS shall be integrated into sexual and reproductive health services.
- All health workers at facilities shall offer the treatment to all affected males and females, adolescents and youth irrespective of age, and other attributes.
- All health workers shall offer support to the patients with STI/HIV/AIDS.
- CMS shall procure, store and distribute drugs to the health facilities for use in the management of STI and HIV/AIDS.
- Management of STI/HIV/AIDS shall follow the guidelines as prepared by the AIDS/STD Unit - e.g. NACP 8 (STD), NACP 14 (Adults), and NACP18 (Children).

5.2.4 Training

- The national level (FHD, AIDS/STD Unit, IHS, University of Botswana) shall provide training to all

health workers to equip them with knowledge and skills to counsel and manage patients with STI/HIV/AIDS.

- The district (DHT, Hospitals) shall offer in-service training to all health staff and equip the volunteers with enough knowledge to offer BCC and IEC to the general public.
- The national level (FHD, AIDS/STD Unit) shall give clear guidelines on integration.
- The hospital staff shall be well equipped with the necessary skills to use equipment and supplies for the diagnosis of STI/HIV/AIDS.
- Advocacy for change in attitudes and practices of service providers and managers shall be emphasised during the initial and in-service training.
- The NGOs implementing STI/HIV/AIDS activities shall provide BCC and IEC to create awareness on STI and HIV/AIDS.

5.3 What Tools should be made available?

IEC/training - all levels:

Pamphlets, posters, booklets, audio visuals - e.g., TV, radio, flip charts, power point projections, overhead projector and slide projector.

Adolescents/Youth: Special Considerations

- Not enough IEC materials targeting the adolescents/youth.
- Materials developed without consulting the target group.
- Environment not conducive to cater for adolescents/youth.
- Attitudes/practices of health workers not conducive to adolescents/youth.
- Inadequate outlets/places offering services to adolescents/youth other than health facilities.
- Services offered while some adolescents/youth are in school.
- Correct information not reaching the adolescents/youth.

Interventions

- Develop and disperse appropriate IEC information with their involvement
- Establish adolescent/Youth IEC friendly outlets for IEC and counselling
- Provide adolescent/Youth friendly service by involvement of peer educators.
- Include ASRH in training curriculum for all the health workers
- Integrate ASRH component in FLE in teacher training institutions at all levels.
- Provide enough outlets to cater for the adolescents/youth through strengthening and support to the NGOs.
- Attach qualified nurse to schools to provide treatment and IEC to both teachers and students.

Chapter 6

6.0 GENDER ISSUES IN SEXUAL AND REPRODUCTIVE HEALTH

6.1 What Is Gender?

Gender is the significance a society attaches to the biological categories of female and male i.e. “Masculine and feminine”

Gender is a socially constructed definition and refers to learned behavior and experiences associated with each sex. Gender is used as a sorting device, as a tool to control a portion of population and is a structural feature in society. Sex on the other hand is the biological distinction between males and females.

Gender is a cross cutting issue. Therefore, it is important to mainstream it in all the SRH activities.

6.2 How gender impacts the SRH programme

- Gender and not sex is an important factor in access to health services and quality of life. Many health conditions that affect women and men are similar but most are experienced differently.
- Women have limited control over their health-related decisions because of their subordinate status in the society. Their sexual and reproductive health choice are largely influenced by their male partners, and this puts them at risk.
- Female-headed households are generally poorer than male-headed households, and this feminisation of poverty makes them more vulnerable to diseases.
- The socialisation of females in some society exerts pressure on young women to engage in early sex and early marriages.
- The social and cultural expectations in our society exert pressure on females to engage in high-risk behaviour to accomplish their motherhood role.
- The socialisation of males and females in matters of sexual orientation exacerbates female subordination.
- Limited access to safe water, sanitation and fuel supplies increase the domestic work burden of women and children especially the girl child and this affect their health status directly and indirectly.
- Although both men and women experience gender-based violence, women are more vulnerable which results/or is likely to result in physical, sexual, or psychological harm or suffering. This includes threats of such acts as coercion or deprivation of liberty. Violence against women and particularly the girl child is a problem in Botswana. The study on the “Socio-Economic Implication of Violence Against Women “(1999)” shows that three out of five women have suffered from emotional, psychological or physical abuse, both of which have a bearing on sexual and reproductive health status of women and children.

6.3 What are the Common Manifestations of Gender-Based Violence?

Gender-based violence commonly manifests itself in the form of:

- Domestic violence (spouse battering),
- Oppression and intimidation.
- Rape and defilement.
- Incest.
- Harmful cultural practices.
- Early marriages.
- The belief in large families.
- Wife inheritance

6.4 What are Other Gender-Related SRH Problems?

Some other major gender-related problems that have a bearing on SRH are:

- High maternal death rates
- High incidence of teenage pregnancy and abortions.
- High prevalence rates of STI/HIV/AIDS among young women, as opposed to the male counterparts, due to intergenerational sex.
- Male limited participation and involvement in SRH programmes.

6.5 Who Are At Higher Risk Of Gender-Based Violence?

- Women
- Girl child
- Physically disabled women
- Women with mental health problems
- Commercial sex workers

6.6 What Shall SRH Providers Be Aware of?

The health sector must ensure that gender is mainstreamed in all SRH programmes. This perspective needs to recognise that many health problems:

- Do affect women and men differently.
- Are more prevalent in women.
- Have risk factors that are different for women or groups of women.
- Need different interventions for women and men.
- Men tend to under utilise SRH services.
- Tend to bias attention to women.

6.7 What Services can be provided to Survivors of Gender-Based Violence?

Prevention

- Information of gender-based violence targeted for both men and women.
- Information on gender-based violence should be made available at individual, family and community level.
- Promote multi-sectoral approach to gender-based violence with particular focus on collaboration between health, police, justice, social welfare and counselling services.

Management

- Counselling and rehabilitation.
- Medical treatment of presenting symptoms.
- Screening for STI/HIV/AIDS especially for rape cases.
- Post Exposure Prophylaxis (PEP) sexual violence
- Emergency Contraception in case of sexual violence
- Referral as necessary.
- Legal protection.

6.8 What are the Gaps and Challenges in the Existing Health Facilities in Managing Gender-Based Violence?

Some problems that exist in the health facilities are:

- Inadequate knowledge/skills among health services providers.
- Limited data and statistics on causes and impact of SRH related issues including gender-based violence.
- Inadequate capacity of health facilities to manage gender-based violence.
- Inadequate coordination among key stakeholders in SRH and gender-based violence.
- Inadequate counselling services and follow up.
- Inadequate agencies involved in the prevention and management of gender-based violence.
- Absence of male user-friendly services.

6.9 What More Should the Health Sector Do to Curb Gender Disparity in SRH?

- Orient health system to respond to the prevention and management of gender-based violence, sexual reproductive health issues, promotion of cultural change and improvement of the legal protection of survivors.
- Train health workers to be gender-sensitive in providing health services.
- Increasing men and women's access throughout life cycle to appropriate, affordable and quality health care, information and related services (by improving knowledge, attitudes and skills of health workers).
- Strengthen preventive programmes that address the needs of men and women.
- Undertake gender-sensitive initiatives to address sexual reproductive health issues including gender-based violence.
- Promote gender-based operations research.
- Strengthen gender-sensitive MIS rehabilitation.
- Develop appropriate treatment programmes for survivors of violence and rehabilitation for perpetrators.
- Strengthen national and community response to prevent gender-based violence in SRH.
- Promote male participation and involvement in SRH issues.

- Promote gender-based SRH issues including violence into pre-service and in-services training.
- Priority enrolment of male health workers/male motivators in SRH programmes.
- Health facilities should be equipped with information, examination and laboratory facilities for detection and management of reproductive health related conditions and gender-based violence.
- Establish referral mechanism to create linkages between health system, communities, law enforcement and legal systems. Health facilities should be equipped with laboratory facilities for STI/HIV/AIDS screening, (especially to cater for rape cases).
- Develop gender-sensitive BCC and IEC materials.
- Strengthen the referral mechanism within the health system.
- Guidelines should be made available for health service providers for the provision of:
 - Counselling and support to survivors
 - Records and referral procedures
 - Management procedures (identifying diagnoses and treatment)
- Messages responsive to issues of sexual and reproductive health and gender-based violence should be integrated in health IEC and advocacy activities.

6.10 Who Should Participate in Management and Prevention of Gender-Based Violence?

- Community and Religious Leaders
- Court of arbitration
- General population
- Health workers and managers
- Social workers
- Other stakeholders involved in prevention programmes
- Teachers
- Mass media practitioners
- Police
- Justice systems

6.11 When is Assistance Needed?

Health care should be provided whenever the need arises.

Adolescents/Youth: Special Considerations

- Adolescents/Youth are the most vulnerable group to rape, defilement, incest etc.
- The girl child experiences early arranged marriages mostly to older men and are exposed to early and repeated pregnancies.
- Prevalence rates of STIs including HIV/AIDS are higher among the girl child.
- Abortion and early pregnancy complications are eminent among adolescents/youth.
- ASRH therefore should focus on the following:
 - Advocacy and information on the prevention of gender-based violence, STIs and teenage pregnancy.
 - Adequate management of STIs and incomplete abortions to prevent complications.
 - Advocacy for elimination of early arranged marriages.
 - Advocacy for the review of laws e.g. Law on Abortion, Health Rights for Women

7.1 What Is Infertility?

Infertility is defined as the inability of the woman to conceive and the man to make a woman pregnant after two years of regular unprotected sexual intercourse. Various types of infertility are explained below:

7.1.1 Types

- Primary infertility refers to failure to conceive/ make a woman pregnant in a situation of no previous pregnancy.
- Secondary infertility is inability to conceive/ make a woman pregnant after a previous pregnancy.

7.1.2 Common Causes

- Pelvic inflammatory disease following STI or post abortion infections is the commonest cause of female infertility in Botswana.
- Adhesion following pelvic inflammatory diseases lead to ectopic pregnancies.
- Male factors in infertility are equally important, and must be investigated. Mumps is known to be a common cause of infertility in men.

7.2 Who Is Eligible For Infertility Services?

- Couples or individuals with inability to conceive after two years of regular sexual intercourse without use of contraceptive methods.
- Women with recurrent pregnancy losses.

7.3 What Infertility Services Will Be Provided?

- IEC to the public to inform them about prevention of infertility and treatment options.
- Information/counselling to individuals or couples with fertility concerns.
- Focus on adolescents/youth with information about STIs and abortion and linkage with infertility management services.
- Clinical investigation of individuals/couples.
- Clinical management/treatment of infertility .
- Provision of information on the child adoption services.

7.4 At What Level will Infertility Services be provided?

- At community level – information and referral.
- At health facility level – information, counselling, basic investigation , treatment and referral.
- At district level – information, counselling, basic investigation and treatment and referral.
- At referral hospital level – all the above plus more complex investigations and treatment.
- At Ministry of Local Government level (Social and Community Development Section) – Child adoption Services.

7.5 Who Can Provide Infertility Services?

- Specialist obstetrician/Gynaecologists
- Physicians
- Nurses/midwives
- Social workers
- Community Health workers/FWE
- Religious/Community leaders

7.6 Basic Management Of Infertility

- Manage individuals with emphasis on couples.
- Take careful social, gynaecological/obstetric and medical history.
- Do full clinical examination.
- Investigate both male and female.
- Male factors - e.g. semen analysis.
- Female factors e.g. ovarian, tubal, uterine and others.
- Refer to the appropriate level.
- Administer appropriate medical or surgical intervention.
- Counselling regarding other factors some of which are not available in Botswana e.g. in-vitro fertilisation.
- Provide for adoption options

7.7 When shall infertility services be provided?

- On a daily basis.

Adolescents/Youth: Special Considerations

- Some adolescents/youth, due to early marriage may be eligible for infertility services. In such circumstances, adolescent girls are often married to much older spouses. This creates special dynamics in gender/power relation.
- STIs and unsafe abortion are common among adolescents/youth. Infertility is a common sequelae of inadequately treated STIs, botched abortion or intra-partum sepsis.
- Infertility at this age often leads to divorce which sets off a trail of social disruption in a young girls life. This may force her into having multiple sexual partners and/or prostitution.
ASRH programme should focus on:
 - Advocacy and information to prevent infertility and promote linkage with STIs management services.
 - Risks involved with having multiple sexual partners and unsafe abortion.
 - Advocacy and information on prevention and proper management of STIs/unwanted pregnancy.
 - Advocacy on elimination of early marriages.
 - Special skills in managing infertility in adolescence.
 - Creating a supportive social network to support young women whose social lives are disrupted by infertility.

Chapter 8

8.0 CANCERS OF THE REPRODUCTIVE ORGANS

8.1 What Are The Common Cancers Of Reproductive Organs?

Female

- Cancer of the cervix,
- Cancer of the endometrium
- Ovarian cancer
- Cancer of the breast

Male

- Cancer of the prostate
- Cancer of the testis

8.2 What Services Are Provided For Reproductive Tract Cancers?

- Primary prevention:
 - IEC information on cancer prevention and behaviour change e.g. condom use, discourage smoking and early/illicit sex.
 - Information on early signs/symptoms of cancers.
- Secondary prevention:
 - Screening
 - * Cervix - pap smear, visual inspection
 - * Breast - self examination, clinical examination, and mammosonography
 - * Testis - clinical examination
 - * Prostate – laboratory, rectal examination.
- Early diagnosis and treatment :
 - Physical examination
 - Medical imaging e.g. - ultra sound , X-rays
 - Colposcopy guided biopsy
 - Biopsy - histopathology/cytopathology
 - Surgical intervention - all early cases
 - Chemotherapy - testis/breast/prostate
 - Radiotherapy - cervix/breast
- Palliative care
 - Pain management and emotional support
 - Social support to/by family/community

8.3 Where Shall Cancer Services Be Provided?

- Government health facilities
 - Referral hospitals
 - District hospitals

SERVICE ACTIVITY	CERVIX	BREAST	PROSTATE	TESTIS
Primary Prevention	IEC - Public Risk group	IEC - Public Risk group	IEC - Public Risk group	IEC - Public
Secondary Prevention	Pap-smear - Age 20-65 yrs every 3-5 yrs	BSE - monthly Mammography Mammosonography - as per indications	Rectal examination Age 50 yrs + annually and/or as per indications	Self - examination - Once every year
Early DX and Treatment	As above History/Physical examination Biopsy Surgery and/or Radiotherapy Chemotherapy	As above History/Physical examination Surgery and/or Radiotherapy Chemotherapy	As above History/Physical examination Biopsy Surgery and/or Radiotherapy Chemotherapy	As above History/Physical examination Biopsy Surgery Chemotherapy
Palliative Care	Radiotherapy Pain management Nutritional support	Radiotherapy Pain management Nutritional support	Pain management Urinal and Nutritional support	Pain management Nutritional support

8.8 Type Of Cancer Services By Target Group

TYPE OF SERVICE	TARGET GROUP
IEC/Counselling	Clients attending clinics for SRH and out - patients services Clients met by Community Health Workers Adolescents/Youth
Breast examination	Women over 15 years Women attending clinics for SRH services Women with a feeling history of breast cancer Women whose first conception was after 25 years Women who had menopause before 40 years Women who did not breast feed Nulliparous women
Vaginal examination	Women with abnormal vaginal bleeding Women with abnormal vaginal discharge Sexually active or women of reproductive age
Pap smear	Clients with suspicious lesions Women first seen in a hospital for other SRH services but are of high risk category
Ultrasound	Men with urinary retention Men with enlarged prostates on rectal examination Women with: <ul style="list-style-type: none"> • ovarian cyst • unclear pelvic masses • abnormal PV bleeding
Mammography	<ul style="list-style-type: none"> • Women as per indications
Mammasonography	Breasts with suspicious lesions; especially in every young women
Cervical biopsy	Clients with macroscopically suspicious lesions in the cervix Clients with suspicious Papsmear results
Breast lump removal	Women with breast lumps
Conisation	Clients with CIN II or III
Surgical treatment	Cervical cancer Operable breast cancer Operable prostate cancer Operable endometrium cancer

Chemotherapy/ Radiotherapy	As complimentary therapy following surgery First line therapy for certain cancers
Palliative care	All terminally ill patients

Adolescents/Youth: Special considerations

- Adolescents/youth are susceptible to cancers of the reproductive organs.
- Predisposing factors include high-risk behaviour that begin during adolescence, and especially multiple sexual partners.
- Primary prevention should therefore focus on adolescents/youth.
- Adolescents/Youth often have to provide palliative care for parents or older relatives with terminal cancers of the reproductive organs. They need special psychological , social support and coping skills.
- Adolescents/youth may be forced to drop out of schools in order to look after sick relatives. This interferes with education and limits future options.
- Adolescent programmes need to be sensitive to the needs of young people in these situations.

Chapter 9

9.0 MIDLIFE CONCERNS (MENOPAUSE AND ANDROPAUSE)

9.1 What is Menopause and Andropause?

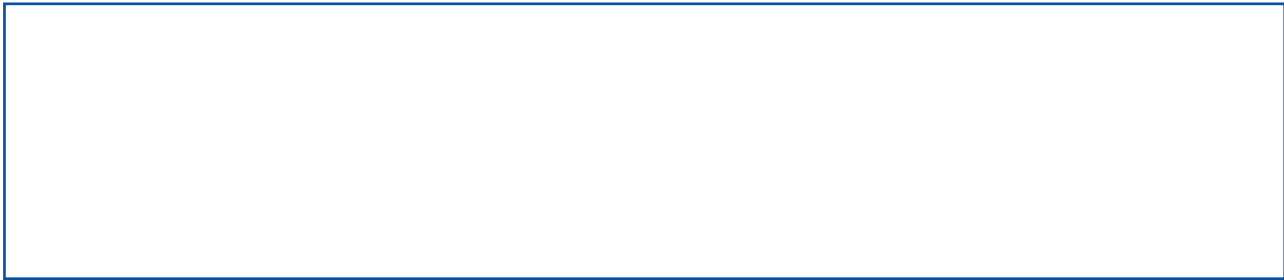
- Midlife is the period between 35-55 years.
- For women the climacteric and menopause have dramatic manifestation in the form of changing ovarian function, e.g irregularity and cessation of ovulation and menses.
- For men there is no clear or dramatic change in normal levels or testicular function. They, however, experience some physiological changes that may impact on their sexual and reproductive behavior.
- Both men and women need support during this period and SRH services have a responsibility to respond to their needs

9.2 What Services Are Provided For Menopause And Andropause?

- IEC – to educate individuals and communities on the issues, symptoms and anticipation.
- Counselling to individuals and couples undergoing midlife changes.
- Management of symptoms and complications of menopause.
 - Psychosocial support.
 - Medical treatment e.g. hormone replacement therapy.
 - (Refer to relevant manuals for details of medical treatment).
 - Screening for disease such as diabetes/hypertension/cancers.

9.3 Where Are These Services Provided?

- At the community level:
 - IEC to all age groups on midlife crisis:
 - Social support
 - Advice on exercise and nutrition
 - Referral for medical intervention
- At facility level:
 - Information/education
 - Advice on exercise and nutrition
 - Individual/couple counselling
 - Clinical/ medical treatment of symptoms and complication (eg. HRT)
 - Screening for non-communicable diseases eg. Hypertension, diabetes, cancers



Chapter 10

10 TRAINING

10.1 Rationale for Training

- Inadequate human resource remains a major constraint to the implementation of health programmes in Botswana. Training is therefore a critical activity in establishing quality of SRH services as it serves the purpose of developing knowledge and skills of providers.
- Establishment of standards and guidelines for service delivery is critical to any national training programme.
- The declining number of nurses opting to join midwifery threatens the gains already made in the area of maternal and newborn care and needs immediate redress.
- Training needs in SRH in Botswana must respond to three specific challenges, namely: -
 - Increasing pre-service training output to respond to the gaps in manpower requirement of the new staffing norms established for various levels of health care delivery systems by the NDP.
 - Enhancing in-service training efforts to update knowledge and skills of providers in response to the shift from MCH/FP to integrated SRH.
 - Using the new SRH standards and guidelines for service delivery to establish consensus in quality of care and expand access.

10.2. Who Are The Trainers?

- Master trainers (staff at national level) to be strengthened first and equipped with knowledge and orientation in SRH.
- Training Of Trainers (TOT) will be conducted by master trainers at national, district and local levels.

10.3 What SRH Training Will Be Offered?

- Training in SRH will be based on training needs assessment by SRH Division in conjunction with MLG at regular intervals.
- Training will address both the needs of the SRH programme and those of providers in the work place.
- Increased pre-service training.

GOLDEN RULES FOR ADULT LEARNING

- Adults learn what they need to know
- Adults learn by doing
- Adults learn in an informal atmosphere
- Adults demand that job-related training be relevant to their real-life situations
- Adults learn most effectively when their status and experience is recognised and accepted
- Motivation is the best credential of an adult learner

- Relevant learning materials will be carefully developed and approved by the SRH Division in collaboration with the Health Education and Promotion Section of the MOH.

10.7 What Are The Components Of SRH Training Needs Assessment?

Training needs assessment will consist of:-

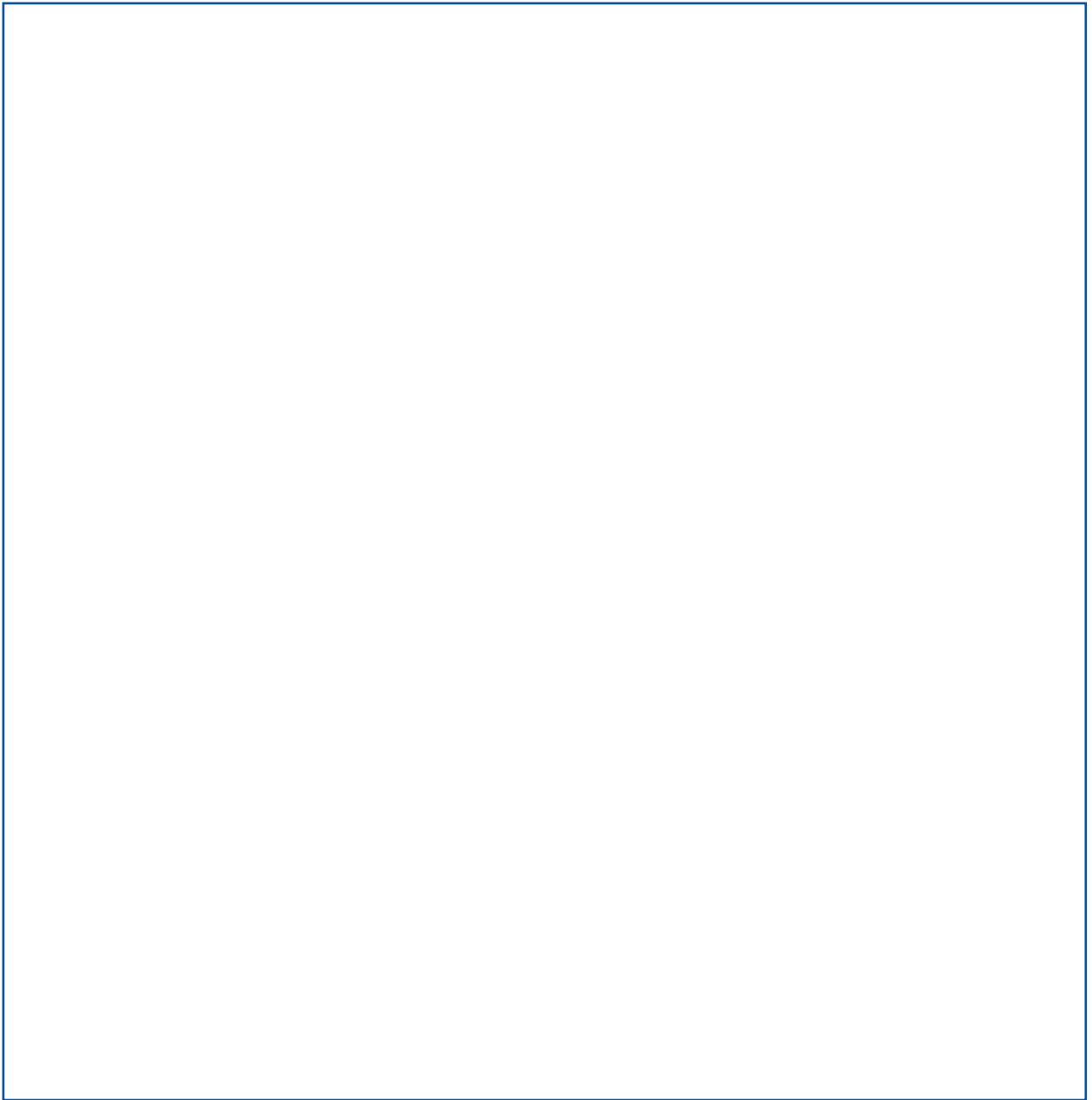
- Analysis of programme objectives in terms of knowledge, skills and attitudes required for achieving those objectives.
- Analysis of monitoring data for deficiencies in quality of care.
- Analysis of providers' own perception of training needs.

10.8 How Will Trainees Be Selected?

- Anyone working in the area of SRH will be a potential trainee for either learning of new skills or improvement of knowledge, attitudes and skills to perform their jobs better.
- Selection of trainees will be based on specific criteria established by SRH Division and the IHS and other stakeholders.
- The experiences individuals bring with them to a training course will be recognised and used for effectiveness.

10.9 How Will Learning And Training Be Evaluated?

- Individual learning will be assessed through formal testing (pre-/post-test), self-assessment, peer assessment and informal feedback between trainers and trainees as specified in the various official curricula.
- All training activities and courses will be subjected to periodic evaluation.
- Feedback from such evaluation will be used to adjust future training, improve quality of training and identify additional training needs.
- Follow-up analysis of trainee performance on the job will also be undertaken by: -
 - Site visits
 - Supervisor reports



11.1 What Is IEC?

- IEC is an intervention that aims to increase knowledge and accomplish positive behaviour change through communication. In these Standards and Guidelines, the aim of IEC is to enhance positive changes in sexual and reproductive health.
- IEC aims to reduce any apprehension and/or misinformation among users, potential clients or beneficiaries and the general public.
- IEC is critical for health development as it set/lay the foundation for individuals and communities to make informed choices and effective implementation of programmes.
- Information provided has to be adequate, relevant and appropriate for the target group to make decisions. On the other hand the provider/trainer has to be well equipped with up to date information to be able to address client's needs. The information must be specific and easy to understand.
- Education in the context of these guidelines should address the client's ability to utilise information for their benefit. The client may require certain skills and capability to use the information. The trainer has to assess the situation and provide the enabling environment to the benefit of the target group.
- Communication plays an important role on our day to day activities, the trainer/provider need to utilise communication skills to reach out to all clients. Appropriate channels have to be selected for different target groups to reduce misinformation and to dispel misconceptions.
- A comprehensive information programme shall include relevant materials and information designed to: -
 - Increase awareness on SRH
 - Enhance the ability of individuals and couples to exercise their basic rights and make decisions freely
 - Change negative attitudes or beliefs toward SRH services
 - Behavioural change
 - Enhance practices and behaviour that will help prevent SRH problems such as STIs/HIV/AIDS, unwanted pregnancy, and high risk pregnancy
 - Encourage action to improve quality and accessibility of SRH services

However, a good programme will result in well-informed clients and will lessen the adverse effects of rumours and ignorance.

11.2 What Are The Possible Barriers To Effective IEC Implementation?

- Socio-cultural attitudes, values, and practices which have been passed on from generation to generation.
- Peer pressure and influence to sustain certain behaviours and beliefs.

- Alcohol and substance abuse and how they affect sexual behaviour
- Cultural beliefs and practices
- Communication between children and their parents on sexuality issues in the home

11.8 Who Is The Target Audience?

- Community Members:
 - Men
 - Women
 - Youth
 - Community leaders
 - Parents
 - Teachers
 - Traditional Healers
 - Traditional Birth Attendants
 - Church leaders/religious leaders
 - Women's organizations
 - Children of 5-12 years
- Health professionals
- Government representatives and politicians
- Media personnel
- Private sector personnel

Note: Mainstreaming gender through IEC process will be critically considered.

11.9 Who Shall Provide IEC Services?

- At community level:
 - Individuals, family members
 - Traditional Birth Attendants
 - Traditional healers
 - Church leaders/Religious leaders
 - Youth leaders
 - Community based organisations
- At facility level:
 - FWEs
 - Nurses, midwives, community health nurses
 - Doctors
 - Health education officers
 - Lay counsellors
- At the national level:
 - Family Health Division
 - Community Health Services
 - AIDS/STD Unit
 - BOFWA
 - YWCA

- PSI
- Botswana National Youth Council (BNYC)

Adolescents/Youth: Special Considerations

- Ensure that there are IEC materials specifically targeted to adolescents/youth.
- Involve adolescents/youth in the development and distribution of materials targeted to them.
- Use multi media approaches appropriate for adolescents/youth.
- Ensure that IEC materials are placed where adolescents/youth have easy access.
- Ensure that there are IEC materials that are gender sensitive- should depict male involvement.)

12.1 Definition

Sexual and Reproductive Health Counselling is a two way process of communication by which one person helps another to identify his/her sexual and reproductive health needs and make informed decisions. It is an important element of SRH services. SRH counselling ensures quality of care and safeguards the client's rights. SRH counselling also helps to dispel myths and misunderstanding and encourages compliance, ensuring continued practice and acceptance.

12.2 Objectives Of Sexual And Reproductive Health Counselling

- To assist client identify SRH problems, concerns or issues.
- To expand SRH knowledge.
- To support clients in need of SRH.
- To assist client in making informed SRH decisions.
- To offer support to client to overcome problems or concerns.
- To maximise the use of services of choice properly.
- To explore choices made by the client.

12.3 Types Of Counselling

- Preventive
- Facilitative
- Developmental
- Therapeutic

12.4 When Is Counselling Done?

Counselling is provided at appropriate time when the client requires it.

12.5 Who Is Eligible For SRH Counselling?

Any individual, couple, or group of people who seek reproductive health services.

12.6 Who Should Provide SRH Counselling?

- Skilled and trained personnel in SRH.
- All health workers with special counselling skills should provide general counselling.
- Staff with extra training will provide special and intensive SRH counselling.
- Teachers, parents, elders and peers should also be provided with exposure to improve their skills and confidence for SRH counselling.

12.7 Where Should SRH Counselling Be Provided?

Wherever SRH counselling is provided, it is very critical that privacy and confidentiality are ensured. Therefore SRH counselling can be provided in:

- Schools
- Clinics
- Health centers
- Hospitals
- Homes
- Youth centres
- Work places.

12.8 Ways Of Providing SRH Counselling?

- One to one
- Group
- Couples
- Bibliotherapy

12.9 What Are The Important Steps In SRH Counselling?

- Establish a helping relationship.
- Establish rapport.
- Establish SRH issues.
- Define and explore the issues broadly.
- Explore the possible choices or alternatives.
- Assess the pros and cons of each choice.
- Select the best option.
- Go and put the choice to test.
- Evaluate.

12.10 Referral System

All SRH counselling providers and social workers should have clearly defined knowledge of referral systems to serve as a back up to ensure that the clients' needs are fully met. This includes psychologists, psychiatrists, psychotherapists, counselors or SRH specialists and social workers.

12.11 Support Services

- Consultation/networking with other stakeholders.
- Use of referral system.
- Follow up.
- Information collection and giving.

12.17 How Will SRH Counselling Be Evaluated?

- Client interviews
- Quality assurance data (Records keeping)
- On-site observation and interaction with counselors
- Surveys through the use of questionnaires

12.18 What Materials Are Needed In Counselling?

- Educational booklet, pamphlets, leaflets, flip charts on SRH
- Video and slides on SRH
- Demonstration equipment
- User friendly, quiet room with furniture to ensure privacy and confidentiality.

Adolescents/Youth: Special Considerations

- Adolescents/Youth have high-level of anxiety.
- Adolescents/youth may need more assurance on confidentiality.
- Adolescents/youth may be more misinformed due to peer influence and peer pressure.
- They may not come back for follow-ups.
- They may feel comfortable if counseled by peer adolescents/youth counselors.
- STIs and HIV/AIDS is a challenge to the adolescents/youth.
- Gender issues.
- Provision of adolescent/youth friendly atmosphere is critical.

Chapter 13

LOGISTICS AND SUPPLIES

Logistics refers to the process of forecasting, procurement, maintenance, storage and distribution of materials, commodities and supplies. Forecasting demands for resources to maintain high quality of services, and is a critical element of any health-related logistics system.

Materials, commodities and supplies needed for the SRH Programme at different levels shall be as follows: -

Type of Service	Target Group	Activity
Disrict hospital	<ul style="list-style-type: none"> • Fp commodities • Equipment (for lab. X-ray, surgical and other procedures) • Drugs • IEC materials • Transport • Storage space 	<ul style="list-style-type: none"> • Making requisition to CMS and FHD • Storage • Monitoring using stock book/inventory • Analyse using data from monthly statistics • Returns to DHT
Primary Hospital	<ul style="list-style-type: none"> • FP commodities • Equipment (for lab. X-ray, and for surgical procedures) • Drugs • IEC materials • Transport • Storage space 	<ul style="list-style-type: none"> • Making orders to CMS and FHD • Storage • Monitoring using stock book/inventory • Analyse using data from monthly statistics
Clinics	<ul style="list-style-type: none"> • FP commodities • Medical and non-medical equipment • Equipment for surgical procedures • Drugs • IEC materials • Storage space • Transport 	<ul style="list-style-type: none"> • Making orders to CMS and FHD • Monitoring using stock book/inventory • Analyse using data from statistics and any observed changes • Distribution

Health post	<ul style="list-style-type: none"> • FP commodities • Medical and non-medical equipment • Drugs • IEC materials • Storage space • Transport 	<ul style="list-style-type: none"> • Making orders to CMS through clinic • Storage • Monitoring using stock book • Analyse using data
Mobile Service	<ul style="list-style-type: none"> • FP commodities (oral contraceptives, injectables, condoms and spermicides) • IEC materials • Drugs 	<ul style="list-style-type: none"> • Making orders to clinic • Distribution • Making monthly returns /reports to DHT
CBD and Volunteers	<ul style="list-style-type: none"> • IEC materials • Non-medical contraceptives 	<ul style="list-style-type: none"> • Distribution • Making monthly returns /reports • Making orders to clinics /primary hospitals • Making referrals
Non-Governmental Organisation (e.g BOFWA, YWCA)	<ul style="list-style-type: none"> • IEC materials • FP commodities 	<ul style="list-style-type: none"> • Making orders to CMS and FHD • Storage • Distribution • Making monthly returns/reports
District Health Team	<ul style="list-style-type: none"> • FP commodities • IEC materials • Storage space • Transport 	<ul style="list-style-type: none"> • Making orders to CMS and FHD • Storage • Analyse demographic data using monthly data and annual statistics • Distribution • Monitoring • Evaluation of the programme • Returns

The SRH Programme shall forecast demand of commodities/supplies by:

- Monitoring consumption at each level using stock book and inventories.
- Analysing user trends and patterns in each programme area.
- Analysing demographic trends in each area.

13.1 Critical Steps In Logistics/Supplies Management

The SRH programme shall ensure that the critical steps in logistics are maintained. Such steps shall include:

13.1.1 Forecasting

- The SRH Programme shall ensure that the Central Medical Stores (CMS) estimates are made through a formalised forecasting process, how many of each commodity shall be needed considering demographic and user trends/patterns. This shall involve: -
 - Collection of historical data
 - Graphing the data
 - Analysing the data to reveal trends
 - Develop and use formulas to project item being forecast into the future

13.1.2 Procurement

- The CMS shall be responsible for the procurement of SRH commodities, medical and non-medical equipment taking into consideration the right quantity, quality, supplier, time and price/cost.
- The FHD/AIDS/STD Unit shall be responsible for the procurement of IEC materials

13.1.3 Storage

- Commodities, equipment and supplies shall be stored at CMS and facility level.
- BCC and IEC materials shall be stored at FHD/AIDS/STD Unit, DHT and facility level. Currently storage at facilities is limited therefore it is important that re-ordering should be placed in time.

13.1.4 Distribution

- CMS shall be responsible for the distribution of its supplies in response to procurement orders from individual facilities.
- Each facility shall place its order at three months minimum stock to allow time between ordering and delivery from CMS.
- Catalogues of available SRH materials shall be sent out quarterly to DHTs by FHD.
- DHTs shall arrange to collect and store requirements for the whole district from FHD.
- DHTs shall arrange distribution to facilities depending on requisition.

- Private hospitals/NGOs shall collect SRH materials free of charge from FHD, AIDS/STD Unit, and DHT.

13.1.5 Monitoring

The SRH Programme shall ensure that enough supplies of commodities/supplies are kept at CMS.

- The activities at the CMS shall be performed by:
 - Pharmacists
 - Pharmacy technicians
- Activities at the FHD and STD Unit shall be performed by:
 - Health Education Officer
 - Programme Coordinator
- Activities at the DHT level shall be performed by;
 - Health Education Officer
 - Community Health Nurse (CHN)
- Activities at the facility level shall be performed by:
 - Nurse in-charge
 - All nurses
 - CHNs
 - Family Welfare Educators

The SRH Programme shall ensure that each level is adequately equipped with knowledge and skills on logistics management which includes acquisition, storage and distribution of commodities/supplies. Each level shall ensure that a minimum of three months stock/supply is kept to allow for a two months lead-time, except in cases of drastic changes where emergency orders should be allowed.

- Standardised stock record cards shall be used to assist in calculating:
 - Consumption
 - Authorised stock level
 - Safety/Buffer stock
 - When to order
 - Amount to order

13.2 Shelf Life/Quality Control

Each level (CMS, FHD, DHT Facility) shall ensure that when storing commodities and supplies the principle of first-in-first-out is maintained.

13.3 Security and Safety

Each level shall protect commodities against:-

- Climate hazards
- Biological hazards
- Criminal hazards – by ensuring safe custody of keys and safety of storehouses.

- Fire
- Physical hazards

13.4 Control and Care of Equipment

Each level shall ensure that the following are maintained:

- Up to date inventories
- Cleaning, inspection and keeping equipment in good order
- Regular maintenance as per manufacturers recommendation
- Adherence to manufacturers' supply handbooks and operating instructions
- Write-off and disposal

Special Considerations

- Logistics and supplies are not easily available.
- Health facilities are not user friendly.
- Inadequate IEC material targeted to adolescents/youth/men.
- Support NGOs to expand community-based service provision.
- Develop programmes for adolescents/youth who are sexually active but uninfected.
- Establish IEC and counselling programmes to those adolescents/youth who are not yet sexually active.
- Equip health workers with counselling skills.
- Lobby and advocate for establishing training slots for SRH at all levels.
- Provide men/adolescent/youth friendly services with involvement of peer educators.
- Counselling and referrals.

14.1 What Is Monitoring And Evaluation?

Monitoring refers to the process of regularly checking on the status of a programme by comparing the actual implementation of activities against work plan, whereas evaluation is directed at measuring progress towards achievement of programme objectives and its impact. Therefore, monitoring and evaluation in terms of adequacy and utilization are critical processes to consider at all levels of the programme.

14.2 Levels of Implementation and Responsibilities

Regular monitoring/evaluation shall be carried out at all levels (i.e. at central, district and facility levels) in an integrated manner.

Central Level

- Develop and clearly indicate the framework to be used by all sectors involved in monitoring and evaluation of SRH programme.
- Provide guidance to the implementers in the execution of the plan especially in terms of who, how and what?
- Assess the scope, effects and impact of training health workers and implementers of services.
- Collect, analyse periodically, interpret and utilize data.
- Monitoring/evaluation shall be budgeted for annually. Therefore, the central level shall formulate annual budgets for the exercise.
- Conduct support visits at regular intervals to the districts.
- Shall receive, compile and utilise data from the districts.
- Provide feedback to the district at earliest possible time (e.g quarterly) following the support visits and data analysis.
- Prepare and produce annual evaluation reports.

District level

- Collect information using checklist and reports from the health facilities and community level.
- Analyse, interpret and utilise data for the benefit of the services.
- Conduct monthly support visits to the facilities.

- Provide timely (i.e. monthly) feedback to the central and facility level.
- Hold regular meetings with the staff at facility level to review and discuss the SRH services implementation and key issues.
- Budget for the monitoring/evaluation activities done at district level.

Facility Level

- Collect, compile, analyse and utilise data locally.
- Forward compiled data to DHT and central levels.
- Conduct monthly meetings to review the implementation of SRH activities at their level.
- Indicate to the DHT/central their training needs in data collection, compilation, analysis and utilisation.

14.3 Who Will Perform Monitoring And Evaluation?

Central Level

- All Programme Officers at the SRH Division
- One officer shall be assigned to coordinate Monitoring and Evaluation (M&E)

District Level

- All DHT members
- CHN shall coordinate the M&E

Facility Level

- All nurses to collect data at the clinic /health post
- All officers in-charge to coordinate the collection of data at clinics and health posts
- Officers in-charge of MCH to coordinate data collection at hospital level (referral, district and primary)
- FWEs/nurses to collect data from community level

14.4 What Will Be The Tools For Monitoring And Evaluation?

- Checklists
- Questionnaires
- Medical records e.g. MH1049, MH1048 at all (facility) levels of health care

Adolescent/Youth: Special Considerations

- Inadequate data on adolescent utilisation of SRH services.
- Adolescent/youth data not disintegrated from other SRH data.
- Prepare M&E checklist for adolescent data collection.
- Redesign existing data collection instruments e.g. MH1049, MH 1048 to capture (separately) SRH services, needs and utilization among adolescents/youth.
- Special efforts during M&E to assess the knowledge, attitude and practice of adolescents/youth towards staff and services at facility level.
- Special efforts during supervision to assess staff attitudes towards adolescents/youth.
- Analyse /youth services provided.

ANNEX 1

SUPPLIES AND EQUIPMENT FOR FAMILY PLANNING

- The SRH Division in consultation with the CMS shall ensure the following with respect to supplies and equipment for FP in Botswana:
 - ensure that a regular stock of appropriate FP commodities and equipment is maintained.
 - ensure that a regular system of distribution of these to health facilities as requested is established and maintained.
 - provide all SRH services providers with up to date information on what commodities and equipment exist at least annually.
 - inform SRH services providers well in advance should a particular type, size, or dosage of family planning commodity be changed. This would ensure both providers and clients are well prepared for the change as need arises.
 - consult with the FP Technical Advisory Committee on FP commodities and introduction of new contraceptives.
 - ensure that instructional leaflets are sent out with the commodities.
- Each facility providing SRH services must keep and use the appropriate supplies and equipment to provide services according to the set standards
- All FP commodities must be stored in spacious, cool and dry rooms and adequately protected from sunlight in order to maintain potency and durability. Expired contraceptives to be removed from shelves.
- SRH services providers must ensure that supplies are off the floor, oldest ones are used before newest and that contraceptives in use are not out-dated.
- Each facility must ensure that contraceptives are available at the service site in sufficient variety, doses and types in order to individualise the choice of method for each client.
- Each health facility shall store a 2-3 month reserve stock to avoid occurrence of shortages, and discourage overstocking of items.
- Ordering of supplies shall be made to CMS in the standard forms according to the need indicated by the SRH service provider.
 - samples of all contraceptive methods available.
- For physical examination to be available at all static and mobile facility providing FP services:
 - one reclining bed or table (in case of mobile stop with a structure, a mattress to be used)
 - adequately lighted room
 - blood pressure apparatus including stethoscope
 - weighing scale
 - sheet for draping client
 - urinalysis apparatus
 - sink or other means of hand-washing.

- For pelvic examination and IUCD insertions the following shall be made available in addition to the above, at clinics, health centres, hospitals and other FP service sites"where medical methods are to be provided:
 - table for the following instruments and supplies: speculi, sponge holding forceps, tenaculi, uterine sounds, scissors, cotton and gauze swabs, gloves, lubricant (e.g. KYjelly), disinfectants antiseptics (e.g. hibitane savlon), IUCDs, torch, receivers, bowls and basin
 - sterilizer
 - equipment for taking pap smear and high vaginal swab
 - stool for client
 - writing desk
 - record forms and registers
 - plain towel

- For injectables and Norplant: A trolley with the following instruments and supplies should be available.
 - For Norplant: Halstead mosquito forcep, straight forceps, carved forceps scapel and blade, instrument tray, inplants, trochers, local anaesthetic, cotton and gauze swabs, plaster, bandage, methylated spirit and sterile drape.
 - For injectables: Syringe and needle, methylated spirit, sharps container, Depo-Provera vial, gali pot and cotton wool swabs.

ANNEX 2

EQUIPMENT/ SUPPLIES FOR MATERNAL AND NEW BORN CARE

1. Pre-Conception Care

- Contraceptives
- Examination coach/bed
- Gloves
- Lab tubes
- Linen – e.g sheets
- Nutritional supplements (e.g folic acid)
- PV packs
- Side lamps
- Solutions (antiseptic)
- Stationery
- Syringes and needles
- Trolleys
- Vital signs equipment

2. Antenatal Care

- Cardio topograph
- Dopplersonicaid
- Examination bed
- Feotoscope
- Gloves
- Immunisation pack
- Injection packs
- Lab stick
- Lab tubes
- Linen
- Measuring tape
- Obstetric chart
- PV packs
- Scale
- Side lamps
- Sonic aid
- Stethoscope
- Syringes/needles
- Trolleys
- Ultrasound
- Vital signs equipment

3 Labour and delivery

- AZT
- Cervical pack
- Cord clamps
- Delivery beds
- Delivery packs
- Dopplersonicaid
- Drugs liquocaine
- Eye ointment
- Foetal monitor
- Gloves
- Identity band
- Infant radiant warmer
- IV fluids
- Lab tubes
- Linen
- Liqnocaine
- Movable overhead lamps
- Narcan
- PV packs
- Resuscitation trolley (mother and baby)
- Scales for placenta
- Solutions (antiseptics)
- Suction machines
- Suture packs
- Suturing materials
- Syntocnon
- Syringes, needles
- Trolley
- Vacuum extraction equipment
- Vit. K
- Vital signs equip
- Wall-mounted O₂ cylinder

4. Newborn care

- Baby cots
- Baby packs
- Cardiac monitor (apnea monitor)
- Glucometer
- Incubators
- Laryngoscope
- Linen
- Mechanical ventilator
- Mosquito net
- N/g tubes
- Oxymeter

- Phototherapy
- Radial warmer (in labour ward and postnatal ward)
- Resuscitation trolley
- Suction machines
- Wall-mounted IV solutions
- Wall-mounted oxygen cylinder

5. Emergency Obstetric care

- Analgesics
- Delivery packs
- Dopplersonicaid
- Drugs
- Eye ointment
- Foetal monitor
- Gloves
- Identity bands
- IV solutions and blood
- Lignocaine
- Measuring tape
- Narcan
- PV packs
- Radiant warmer
- Resuscitation trolleys (mother and baby)
- Scales for mother and baby
- Suction machine
- Suture pack
- Suturing materials
- Syntoconon
- Trolleys
- Vacuum extraction equipment
- Vit K
- Vital signs equipment

6. Post natal care

- Airconditioner
- AZT
- Baby pack
- Drugs; immunisations, antibiotics, analgesics
- Gloves
- Heat lamp
- Incubator
- Linen
- Measuring tape
- PV packs
- Scales for mother and baby
- Side lamps

- Suture packs
- Supportive Rx
- Vital signs equipment
- Wall clock

7. Domiciliary

- Antiseptics
- Gloves
- Measuring tape
- PV packs
- Vital signs equipment

8. 6 – 8 weeks PNC

- Contraceptives
- Gloves
- Immunisation and drugs e.g antibiotics
- Immunisation packs
- Measuring tape
- PV packs
- Scales for baby and mother
- Side lamps
- Supportive Rx
- Vital signs equipment

9. Post abortion Care

- Analgesics
- Antiseptic solutions
- Contraceptives
- Drugs
- Equipment for manual vacuum aspiration
- Gloves
- IV solution
- Resuscitation equipment
- Vital signs equipment

ANNEX 3

FACILITIES FOR MATERNAL/NEWBORN CARE

Hospitals

- Well-equipped theatres
- Adequate staff especially anaesthetists
- Special care baby units with qualified staff e.g. pediatrician and neonatal nurses
- High risk antenatal wards
- Well equipped labour, postnatal and gynae wards
- Ultra scan, foetal monitor
- Counselling rooms
- Single delivery rooms (for privacy) with overhead lamps, wall-mounted and suction machines

Primary Hospitals

- Well-equipped theatres and maternity wards
- Availability of anaesthetists, obstetrician and midwives

Clinics With Maternity

- Adequate delivery beds and linen
- More staff (midwives) and at least an obstetrician responsible for clinics
- Resuscitation equipment, foetal monitor/dopplersonicaid
- Ambulance
- Separate rooms for eg. labour, puerperim, bathing facilities and toilets

Clinics Without Maternity

- Staffed by adequate midwives (MCH/FP Unit)
- Enough equipment to care for a low risk woman and child
- Extra rooms to encourage privacy for pre-conception care, AVC etc.
- Ambulance

Health Posts

- Electrification of facilities
- Adequate e.g. scale, u/signs equipment
- Separate rooms for different services e.g. screening and consultation room, MCH room, injection, dressings, dispensary, storeroom, office for official documents

Mobile Stops

- A structure to be built e.g. 2 roomed house
- Torches to be provided

- Fetoscope/Doppler/Sonicaid
- Gloves
- Intravenous sets (giving sets)
- Masks
- MVA packs
- Needles and syringes
- Pamphlets, posters, booklets etc.
- Pregnancy test kits
- Printed materials/equipments
- Radio
- Rapid testing kits
- Scales for weighing
- Screen
- Sheets
- Specimen bottles
- Steriliser (autoclave)
- Stethoscope
- Suture packs
- Tape measure
- Television
- Video cassettes
- Vital signs tray

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Ministry of Health
Family Health Division
P O Box 992
Gaborone, Botswana