Republic of Botswana

The Essential
Health service
Package for Botswana

March 2010

MINISTRY OF HEALTH

GOVERNMENT OF BOTSWANA

The Essential Health Service Package for Botswana

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Acknowledgements

Stakeholders

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Abbreviations

ACSM	Advocacy, Communication, Social Mobilisation
AEFI	Adverse Events Following Immunisation
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Treatment
BOTUSA	US Centers for Disease Control and Prevention, Botswana
CBO	Community Based Organization
CBR	Community Based Rehabilitation
DHMT	District Health Management Team
DOTS	Directly Observed Treatment
DP	Development Partner
DPO	Disabled People's Organisation
EDL	Essential Drug List
EHSP	Essential Health Service Package
FP	Family Planning
GBV	Gender Based Violence
GM	Growth Monitoring
HBC	Home Based Care
HIV/AIDS	Human Immunodeficiency Virus/Auto-Immune Deficiency Syndrome
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorders
IEC	Information, Education and Communication
IHSP	Integrated Health Service Plan
IMCI	Integrated Management of Childhood Illness
IPT	Isoniazid preventive treatment
MOH	Ministry of Health
NGO	Non-Governmental Organisation
OH	Oral Health
ORS	Oral Rehydration Salt
OVC	Orphan and Vulnerable Children
PEP	Perinatal Education Programme
PH	Primary Hospital
PHC	Primary Health Care
PLA	Participatory Learning and Action
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
SRG	Stakeholder Reference Group
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFP	Therapeutic Feeding Programme
TG	Thematic Group
TOP	Termination Of Pregnancy
VPD	Vaccine Preventable Diseases
WHO	World Health Organization

1. INTRODUCTION

As part of harmonizing and aligning health sector planning, the MOH in partnership with the US Centers for Disease Control and Prevention, Botswana (BOTUSA) contracted HLSP – a UK based consultancy firm - to provide support to the Development of an Integrated Health Services Plan (IHSP). This is a 10-year Strategic Plan for the entire health sector of Botswana (Public, Private, and NGOs). Development of a high quality Essential Health Services Package (EHSP) for Botswana is an important deliverable of HLSP's assignment. This document contains the EHSP for Botswana along with norms and standards for key interventions. The EHSP is identified by levels of care and follows the draft revised National Health Policy 2010 (which was also developed with technical support from HLSP).

2. WHAT IS THE EHSP?

The EHSP is a set of Health Interventions - promotive, preventive, curative, and rehabilitative - that are to be available to the entire population of a country. They can be provided through public, private, or a combination of public and private facilities. The connotation or assumption that all health care should be provided by governments is, in many countries, unrealistic; the necessary resources simply do not exist. Several variations of the term "***Essential Health Package***" exist, and may include the words ***basic***, ***minimum***, and also ***health care*** or ***services***.

EHSPs define the health interventions that governments are committed to providing, and making accessible to the entire population. The content will not, however, be comprehensive; not all health needs will be met by the EHSP.

The EHSP is an integrated collection of cost-effective interventions that address the main diseases, injuries and risk factors that affect the population. They include diagnostic and therapeutic services. The range of interventions is dependent upon the financial resources available; that is, the per capita health expenditure government is prepared to commit to the EHSP.

Cost effectiveness is achieved through synergism between treatment and preventive activities, joint production costs and improved use of specialised resources. EHSP ensures that the highest priority services get the highest priority with regards to finance. There is considerable inefficiency in resource allocation in both the developed and developing world between primary health care (PHC), secondary and tertiary care, as well as for Curative and Preventive services. A disproportionate share of resources is usually allocated to the secondary and tertiary sectors, where the costs incurred are often excessive in terms of the benefits achieved. Similarly, low workforce productivity, lack of essential supplies, especially essential drugs, as well as low levels of utilisation, especially at primary health care facilities also result in further inefficiency.

The objective of the EHSP approach is to assist Government and its Development Partners (DPs) to obtain the best possible value for money by allocating their scarce resources using cost effectiveness as the main criteria. This approach is preferable to current approaches which rely on very crude incremental budgeting (i.e. last year's budget plus 10%).

3. WHAT THE EHSP ENTAILS

In order to measure cost effectiveness and allow comparisons to be made between different types of intervention several approaches have been developed e.g., DALY, HALE, HeaLY, and, recently, in a series of articles in Lancet medical journal. In addition to determining the interventions the EHSP also identifies other health system issues required to deliver the package. In Botswana the approach for developing the EHSP involved a combination of cost-effective analysis as well as technical, political and social considerations. The aim is to concentrate scarce resources on the services which provide the best 'value for money'. The EHSP provides a comprehensive list of services to be offered at three/four standard levels of health facilities within the health system: the mobile/health post, health clinics, primary hospitals, and district/tertiary hospital. It allows the creation of a standard set of interventions/services for to be delivered at each level of facility. The types of services offered will determine staffing levels, and define referral mechanisms. It is also required that Botswana determines health overall staff numbers and the skill mix necessary to deliver not only the EHSP but the entire range of services that are required in the country.

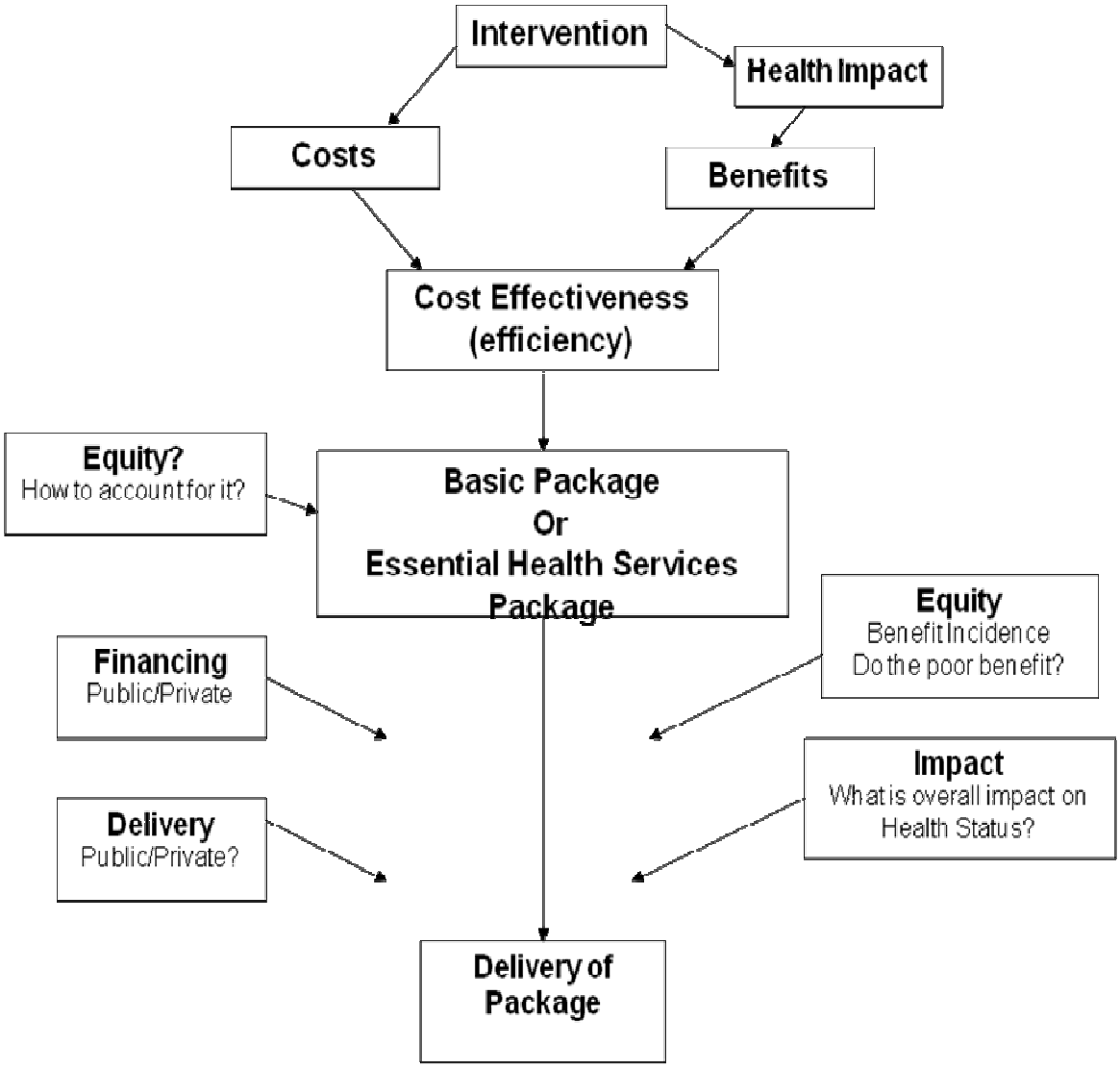
The draft revised National Health Policy 2010 identifies the following five Levels of Care for Botswana as part of standardising the health care service delivery:

- Individual/family/community
- Primary health care clinic/centre
- Primary hospital
- District hospital
- Referral hospital.

The selection criteria that were followed are based on the three ethical principles:

- Principle of need (based on the disease profile of the country)
- Principle of Cost-effectiveness (based on the international literature)
- Principle of human dignity (based on acumen of the stakeholders).

The identification of the contents of EHSP is depicted through the following diagram:



4. THE PROCESS

The concept of the EHSP is that all the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programs. It also entails that all key stakeholders will have an opportunity to contribute their ideas and experience. The key elements to include in the EHSP are:

- those services which would have the greatest impact on the major health problems and also covering up to 80% of the disease burden,
- services and interventions that are cost-effective in addressing the problems faced by many people, and
- services and interventions which could be delivered to ensure equal access to both rural and urban populations.

For oversight and steer the process for the development of IHSP, a Stakeholder Reference Group (SRG) with top management of the MOH, Ministries of Local Government, Finance and Development Planning, and Education was formed. The SRG also included senior members of the Development Partners and other non-government key stakeholders. The EHSP Thematic Group (TG) was one of the six TG established, representing the six building blocks of health system.

Soon after the EHSP TG was convened, it was agreed that four subgroups should be established: Sexual and Reproductive Health; Child Health; Communicable Disease: and Non-communicable disease and conditions.

The initial drafting was done by the four sub-groups and presented to full group. The draft EHSP was presented to stakeholders throughout the country holding 12 workshops. Inputs from these consultative workshops were incorporated and presented to the SRG for their approval which was accorded.

Choice of interventions was based on:

- Technically effective services that can be delivered successfully
- Targeted diseases are those which have imposed a heavy burden on Botswana (at now and in the future), considering the effect on the individual with the illness as well as the social impact of the disease (such as epidemics and adverse economic effects)
- Sustainability of the services in the long-term as donors reduce support in the years ahead, taking into consideration the government's ability to maintain a basic level of health services
- The need for equity in ensuring that critical health services are provided to all, especially the poor.

5. THE GOAL AND PURPOSE OF THE EHSP

The Overall Goal of the EHSP in Botswana is:

- Attainment of universal coverage of high-quality package of essential health services.

The EHSP has two key purposes:

- to provide a standardized package of basic services which forms the core of service delivery in all primary health care facilities and
- to promote a redistribution of health services by providing equitable access, especially in underserved areas, population etc.

Specifically for the targeted population in Botswana the objectives of the contents of EHSP are:

a) For Mothers

- To ensure access to high quality antenatal care, and quality care during and after delivery to mothers and their babies
- To implement a population-based system of service delivery for mothers and their babies which strives to achieve agreed objectives

b) For Children

- To enable each child to reach his/her maximum potential within the resources available, and to enable as many children as possible to reach adulthood with their potential uncompromised by illness, disability, environmental hazard or unhealthy lifestyle.

c) For Adolescents

- To ensure access to relevant and appropriate information, community support and health services, which enable adolescents to cope with the rapid physical and psychological changes that occur during this period, and which expose them to the dangers of aberrant psychological behaviour and disorders.

d) For All Women

- To achieve optimal reproductive and sexual health (mental, physical and social) for all women and men across the life-span of individuals
- To raise the status of women, their safety, health and quality of life.

e) For All Elderly

- To ensure the availability health care support so to live an active life.

f) For All People Living In Botswana

- To enable all people living in Botswana have access to high quality essential health services at the moment they need and within convenient reach
- To raise the status of health of all Batswana through active involvement and access to information of prevention of diseases and promotion of health.

6. CONTENTS OF THE EHSP

The EHSP consists of the following components:

a) Sexual And Reproductive Health (SRH)

- Antenatal Care
- Delivery Care
- Postnatal Care
- Family Planning
- Sexually Transmitted Infections
- Prevention of Mother to Child Transmission (PMTCT)
- Adolescent SRH
- Infertility
- Male Involvement in SRH
- Gender -based violence (includes rape)
- Post Abortion Care
- Reproductive Cancers.

b) Child Health

- Vaccine Preventable Diseases (VPD)
- Integrated Management of Childhood Illness including diarrhoea, respiratory infections, nutrition, Micronutrient supplementation
- HIV/AIDS
- School Health
- Orphan and vulnerable children (OVC)
- Disabilities.

c) Communicable Diseases

- HIV/AIDS
- TB
- Malaria
- Diarrhoeal Diseases
- Respiratory Infection including Pneumonia
- STI
- Meningitis
- Dermatological diseases
- Neglected tropical disease
- Nosocomial infection
- Emerging infectious disease.

d) Non-Communicable Diseases and Conditions

- Mental Health
- Oral Health
- Trauma
- Diabetes

- Hypertension and cardiovascular diseases
- Cancers
- Eye Conditions
- Respiratory Diseases.

6.1 Essential Health Services Package (EHSP) – Interventions/activities by levels of care

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**
Programme: *Sexual and Reproductive Health*	
ANC	Health Education on: ○ Early registration ○ Substance abuse e.g. alcohol ○ STI and HIV testing ○ PMTCT ○ IPT malaria ○ TB screening ○ Nutrition ○ Identification of danger signs e.g. anaemia, swelling feet & face during pregnancy ○ Recognition of early signs of labour (water breaking) and danger signs e.g. bleeding. ○ Referral ○ Compliance and adherence to treatment ○ Preparing community for transportation ○ Community Mobilisation ○ Male involvement ○ Provide counselling services for FP, breast feeding and infant feeding ○ Importance of health facility based delivery and referral ○ Counselling for child circumcision
Delivery	• Health education • Provide transportation • Managing of emergency deliveries • Health promotion on male child circumcision

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**
PNC (post natal care)	• Provide domiciliary nursing within 24 hours of discharge and a second visit within the first week • Provide education and counselling on cord care, hygiene, PNC, congenital syphilis, check up after 6wks, FP, maternal & infant nutrition(feeding options) • Male involvement

Family Planning (FP)	• Education on:
	  ○ Types of FP methods
	  ○ Mode of action
	  ○ Advantages and disadvantages of methods
	  ○ Side-effects
	  ○ Myths and misconceptions
	  ○ Benefits of FP
	  ○ Use of dual methods
	  ○ Male child circumcision
	  ○ Sexually transmitted infections
	• Counselling services including HIV discord and testing
	• Provision of methods e.g. Pills and condoms
	• Distribution of IEC materials on FP
	• Male involvement
	• Education on importance of PAP smears and breast self examination

STI	• Education (signs and symptoms, treatment, complications) and follow up • Prevention education • Male involvement • Education on safe male circumcision • Condom distribution • Contact/partner tracing

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**

PMTCT	• Health Education
	  ○ Early registration
	  ○ Partner involvement
	• Education on importance of HIV testing (including infant testing), what PMTCT is and effectiveness of PMTCT

Adolescent SRH services	• Health Education on availability, importance and types of adolescent services • Education on STI, HIV, family planning, abortion • Life Skills Education
Male Involvement in SRH	• Health promotion and education • Sensitize on issues of gender and MI in SRH/HIV/AIDS /GBV • Advocacy for male involvement and support among community leaders, religious leaders, worker's unions and politicians for utilization of the interventions set out for achieving male involvement in addressing SRH problems, prevention of STI/HIV infections and GBV
Infertility	• Education on causes and treatment, availability of services
Gender -based violence (includes rape) (*requires legal instrument to be reviewed*)	• Health promotion and education • Advocacy and sensitize community leaders, Religious Leaders, Worker's Unions and Politicians • Post exposure at community level

Abortion Care
(requires legal instrument to be reviewed)
	• Health education on:
	  ○ Available contraceptives and use of dual methods
	  ○ Dangers of abortion
	  ○ Danger signs of abortion
	  ○ Complications of post abortion

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**

Cancers of the Reproductive system	• Education on:-
	  ○ Predisposing causes
	  ○ Signs and symptoms of RH cancer
	  ○ Prevention
	  ○ HIV related cancers
	• Distribution of IEC materials on prevention of RH cancer
	• Distribution of condoms

Programme*: Child Health*	
IMCI – Vaccine Preventable Diseases (VPD)	• Social Mobilisation • Health Education • Acute Flaccid Paralysis, measles and tetanus surveillance

IMCI - Diarrhoea	• Health Education on:
	  ○ Safe Water and safe Sanitation
	  ○ Personal hygiene
	  ○ Food safety
	• Social Mobilisation
	• Availability of Oral Rehydration Salt (ORS) + Zinc specially inaccessible terrains
	• Persistent diarrhoea – refer for HIV testing

IMCI – ARI including Pneumonia	• Social Mobilisation
	• Health Education on:
	  ○ early recognition & care,
	  ○ air pollution,
	  ○ temperature control,
	  ○ adequate clothing
	  ○ importance of appropriate shelter

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**

IMCI – Nutrition	• Health Education on:
	  ○ appropriate feeding practices
	  ○ Promotion of BF
	  ○ assist HIV+ mothers to choose feeding option,
	  ○ Complimentary feeding
	• Promotion of back yard gardening
	• Promotion of Growth Monitoring
	• Community based Therapeutic Feeding Programme (TFP)
	• Monitoring Regulation for Marketing Formula Feeding

IMCI – Micronutrients	• Health Education • Social Mobilisation (for Vitamin A supplementation campaign and IDD) • Intra household food security

HIV/AIDS	• Health Education on:
	  ○ screening at 6/52
	  ○ TB screening
	• Social Mobilisation
	• PMTCT
	• Care
	• Prevention

School Health	• Health Education on:
	  ○ reproductive health
	  ○ STI
	  ○ TB
	  ○ safe male circumcision
	  ○ alcohol and substance abuse
	• Screening and identification of problems

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**
	• Referral to clinic

Orphans and Vulnerable Children (OVC)	• Psycho-social support
	• Education on:
	  o Child abuse
	  o Education
	  o Nutrition
	  o Health
	  o Importance of HIV testing
	  o Right to health

Disabilities	• Identify poor eyesight and other disabilities • Referral
Programme*: Communicable Diseases*	

HIV/AIDS	• Public education:
	  o Safe sex,
	  o Abstinence,
	  o faithfulness,
	  o condom promotion
	  o positive living (safe sex, prevention of positives)
	• Palliative care (HBC)
	• Orphan care
	• Provision of social safety net
	• HIV testing
	• Universal infection precaution control

TB	• Advocacy, Communication, Social Mobilisation (ACSM) • Community TB case Management (community based DOT)

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**
	• Contact tracing • Supplementary feeding • Food Safety • Education on infection control • HIV screening

Malaria	• Health Education for
	  ○ diagnosis,
	  ○ risk,
	  ○ prevention and
	  ○ Treatment adherence
	• Spraying (Residual)
	• ITN
	• Environmental control (drainage)

Diarrhoeal Diseases including paratyphi
(for yr 5+)
	• Health Education:
	  ○ hand wash,
	  ○ food hygiene
	  ○ Prevention
	• ORS + Zinc
	• Safe Water and Sanitation
	• Prevention of malnutrition
	• Refer persistent diarrhoea for HIV testing

Respiratory Infection including Pneumonia (for yr 5+)	• Health Education • Infection control
STI (HBV/ HCV/ HPV/ HSV/ Candidiasis/ TV/ Gonorrhoea/	• Health Education • Condom promotion and distribution

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**
Syphilis)	• Contact tracing • Promotion of Safe male circumcision
Meningitis	• Health Education

Dermatological diseases (scabies, tinea, HSV, Varicella zoster)	• Health Education:
	  o personal hygiene
	  o Sanitation

Neglected tropical diseases Bilharziasis, Trypanosmiasis, Intestinal and soil TH	• Health Education:
	  o personal hygiene,
	  o Environmental control
	• Safe Water and sanitation

Zoonotic disease (Rabies, Anthrax, plague)	• Health Education • Sanitation • Control of stray animals
Leprosy	• Health Education • School Health Programme
Emerging infectious disease (VHF, Avian influenza, etc)	• Health Education
Programme*: Non-communicable Diseases and Conditions*	
Mental Health	• Health education and mental health awareness • Case detection (including self-reporting) • Support of chronic patients • Self-help groups e.g. for drug addictions

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**
Oral Health: • Dental caries and Periodontal diseases • Fluorosis	• Health Education and awareness • Early detection and seeking of help
Trauma	• Health Education and awareness • First Aid • Continued support (rehabilitative)
Diabetes	• Health Education: awareness and treatment adherence • Early detection • Home/self management
Hypertension and Cardiovascular	• Health Education and awareness • Early detection • Home /self management
Cancers	• Health Education and awareness • Early detection e.g. breast self examination • Palliative Care and Home Based Care (HBC) • Treatment adherence
Eye Conditions	• Health Education and awareness • Early detection/ identification • Home management • Support
Respiratory Diseases	• Health Education and awareness • Early detection

Level of Care: Individual/ Family/ Community	
Sub-programme	**Description of Service provided (Interventions)**
	• Home/self management

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
Programme: *Sexual and Reproductive Health*	
ANC	• Pregnancy test • Registration • Screening and physical examination for health conditions (BP, Weight, Urine test, TT) • Antenatal classes & exercises • Lab services for blood grouping including RH factor, Hb, RPR • Basic tests for HIV, Malaria, Urine analysis • Provision of Fe-Folate, Anti Malaria-in malarial areas (IPT) • Detection of abnormality and referral • Take home IEC material (develop & distribute) • Provide ultrasound/scanning services • Recommendation for contraception • Management of mild pre-eclampsia • Recommendation for lactation, IEC on PMTCT, and advice on breast deeding HIV+ • Instructions for delivery
Delivery	• Manage emergency deliveries (provide delivery pack) • Referral
PNC	• 6 week check up – mother, baby care, HIV testing infant; • Isoniazid preventive treatment (IPT) • Monitoring of anaemia • Check malnutrition

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
	• Advice on breastfeeding • Evolution of uterus • Referrals for complications, • ART services to mother and baby
Family Planning	• Registration • Health Education • Counselling services for various FP methods • Screening through – History taking, physical examination and laboratory investigations on initial and subsequent visits • Screening and management for STIs • Voluntary Testing for HIV • Screening for prevention of cancer of the cervix • Provision of condoms, oral pills and injectable contraceptives • Referral for surgical methods • Distribution of IEC materials • Follow-up and monitoring of clients on FP methods
STI	• Contact tracing • Education, counselling and provision of treatment services, including ART • Syndromic management of STIs • Referral to ART if not available • Follow-up • Education on safe male circumcision
PMTCT	• Provision of all PMTCT services (testing, counselling, ART, feeding support and supplies, infant testing)
Adolescent SRH services	• Youth Friendly environment/facilities

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
	• Life skills education • Counselling services on sexuality and safer sex • IEC material on ASRH issues • Family Planning Services • Availability of peer education through trained peer educators • Education, counselling, testing for HIV, pregnancy, & treatment of STIs, • ANC services • PNC services • Referrals for HIV treatment, • Referrals for high risk ANC
Male Involvement in SRH	• Screening for STIs, HIV, urinary tract infections, • Counselling for SRH conditions, sexual dysfunction, infertility, family planning • Provide family planning service
Infertility	• Education, screening and referrals
Gender -based violence	• Screening, counselling, primary management and referral
Post Abortion Care *(requires legal instrument to be reviewed)*	• Health education on available contraceptives. • Dangers of abortion • Danger signs of abortion • Offer contraceptives • Counselling
Reproductive Cancers	• Health Education on prevention of cancer • Education as previous • Counselling

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
	• Screening through – History taking, physical examination • Referral for further management
Programme: *Child Health*	
IMCI – Vaccine Preventable Diseases (VPD)	• Outreach (school health) • Vaccination campaign • Routine Immunisation (pentavalent) • Monitoring cold chain • Monitoring of outbreaks • Management of common conditions • Refer major complicated cases
IMCI – Diarrhoea and dysentery	• ORT corner (properly furnished) • Manage according to IMCI guidelines • Preliminary Lab Diagnosis (microscopy , test kits) • Antibiotics • Refer complicated cases
IMCI – ARI including Pneumonia	• Manage Acute Respiratory Infection (ARI) • Early recognition of Pneumonia • Antibiotics • Treatment initiation for Pneumonia • Referral severe pneumonia
IMCI – Nutrition	• Growth monitoring (GM) • Mobile/outreach services for GM and TFP • Manage Mild and Moderate malnutrition • Management of underlying causes

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
	• Food ration to under-fives • Demonstration gardens • Facility based TFP • Referral for severely malnourished children • Promote Baby/Mother friendly initiative
IMCI – Micronutrients	• Routine provision of Vit A • Anaemia preventive intervention (FeSO4, Multivitamin) • Clinical Screening of newborns for Iodine Deficiency Disorders (IDD)
HIV/AIDS	• Screening at 6/12 • Dried Blood Spot (DBS) • Feeding counselling • Follow-up treatment • Supplementary feeding
School Health	• Health Education • Screening for health conditions • Manage minor ailments • Deworming • Refer complicated cases • Identify disabilities through school health
Programme: *Communicable Diseases*	

HIV/AIDS	• Health Education through Video, IEC materials, & Talks
	• Counselling
	  ○ Safe sex
	  ○ Nutrition
	  ○ Hygiene

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
	• HIV-Testing • PMTCT • Clinical Management (ARV) • FP • Referral: Complicated • IPT
TB	• Smear test • Specimen collection for Microscopy, Culture and DST • DOTS • TB/HIV Collaboration (HIV Testing and counselling) • Contact Tracing • Defaulter tracing • Follow up Treatment of MDR cases • Referral
Malaria	• IEC • Distribution of ITNs • Clinical Diagnosis • Rapid Test • Treatment for uncomplicated cases • Initiation of Treatment of complicated cases and refer
Diarrhoeal Diseases including paratyphi (for yr 5+)	• Treatment including dehydration • HIV testing • Collect stool samples for microscopy and CS • Treatment for dysentery • Management of malnutrition

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
	• Initiate Treatment and refer severe dehydration • Refer persistent diarrhoea
Respiratory Infection including Pneumonia For yr 5+	• Treat uncomplicated cases • HIV • Sputum examination
STI (HBV/ HCV/HPV/ HSV/Candidiasis/ TV/Gonorrhea/ Syphilis)	• HIV Testing • Syndromic diagnosis and Treatment • Screening for HPV (Relate to SRH) • Counselling (including partner) • Contact tracing and Treatment
Meningitis	• HIV Testing • Immunization (Hib) Refer
Dermatological diseases (scabies, tinea, HSV, Varicella zoster)	• HIV testing • Clinical Diagnosis • Treatment • Refer chronic cases
Neglected tropical diseases Bilharziasis, Trypanosmiasis, Intestinal and soil TH	• Clinical Diagnosis • Treatment • Specimen collection • Refer
Nosocomial infections (Pseudomonas, TB, Staph aureus etc.)	• Standard Infection Control Programme including UPI • Waste management

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
Leprosy	• Clinical Diagnosis • Treatment follow up • Contact tracing
Emerging infectious disease (VHF, Avian influenza, etc)	• Preparedness (National and district) plan
Programme: *Non-communicable Diseases and Conditions*	
Mental Health	• Health education and mental health awareness • Holistic Patient management • Follow up of chronic patients • Reporting • Referral
Oral Health: • Dental caries and Periodontal diseases • Fluorosis	• Health Education and awareness • Check-ups (dental caries) • Referral • reporting
Trauma	• Holistic patient management • Patient transfer system • Basic life support • Referral • Reporting
Diabetes	• Health Education awareness • Early detection through screening(urine and blood glucose) • Basic management

Level of Care: Primary Health Care Centre/Clinic	
Programme Area	**Description of Service provided (Interventions)**
	• Monitoring for optimal control • Referral
Hypertension and Cardiovascular	• Health Education and awareness • Early detection and screening, incl BP check • Basic management • Monitoring for optimal control • referral
Cancers	• Health Education and awareness • Early detection(pap smears and breast examination) • Supportive care • Reporting and referral
Eye Conditions	• Early detection and basic management • Screening incl visual acuity • Home visits • Reporting and referral
Respiratory Diseases	• Health Education and awareness • Early detection • Screening (risk factors, history) • Basic management(oxygen, nebulisation) • Monitoring for optimal control • referral

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
Programme: *Sexual and Reproductive Health*	
ANC	• Registration • Screening and physical examination for health conditions (BP, Weight, Urine test, PT, TT) • Provide Nutrition Counselling/Management • Lab services • Antenatal classes & exercises • Partner Companion • Collection of samples for blood group, Hb, RPR • Basic tests for HIV, Malaria, Urine analysis • Provision of Fe-Folate, Anti Malaria-in malarial areas (IPT) • Take home IEC material (develop & distribute) • Pregnancy test • Use of Doppler • See referred and complicated cases from the clinic • Provide comprehensive emergency obstetric care • Provide Termination Of Pregnancy (TOP) service
Delivery	• Conduct normal deliveries (BEmOC) (including episiotomy and repair of minor lacerations) • Identification and management of high risk deliveries and refer complicated cases • Provision of services for eclampsia and refer • Provide pre delivery close monitoring for high risks services • Caesarean section • Neonatal Care • Refers complicated cases
PNC	• 6 week check up – mother, baby care, HIV testing infant; • IPT • Referrals for complications,

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• ART services to mother and baby
Family Planning	• Registration • Health Education • Counselling services for various FP methods • Screening through – History taking, physical examination and laboratory investigations on initial and subsequent visits • Screening and management for STIs • Voluntary Testing for HIV • Screening for prevention of cancer of the cervix • Provision of emergency Contraception • Provision of FP methods • Referral for surgical methods • Distribution of IEC materials • Follow-up and monitoring of clients on FP methods
STI	• Contact tracing • Education, counselling and provision of treatment services, including ART • Syndromic management of STIs • Follow-up • Education on safe male circumcision • Provision of safe male circumcision
PMTCT	• Provision of all PMTCT services (testing, counselling, ART, feeding support and supplies, infant testing)
Adolescent SRH services	• Youth Friendly environment/facilities • Life skills education • Counselling services on sexuality and safer sex • IEC material on ASRH issues

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Family Planning Services • Availability of peer education through trained peer educators • Education, counselling, testing for HIV, pregnancy, & treatment of STIs, • ANC, PNC • Referrals for HIV treatment, high risk ANC
Male Involvement in SRH	• Screening for STIs, HIV, urinary tract infections, and male reproductive cancers • Management of STIs, HIV, urinary tract infections, and male reproductive cancers • Counselling for SRH conditions, sexual dysfunction, infertility, family planning • Provide family planning service
Infertility	• Education, screening and referrals
Gender -based violence (includes rape) *(requires legal instrument to be reviewed)*	• Screening, counselling, primary management and referral • Plus legal services – One stop shop
Post Abortion Care *(requires legal instrument to be reviewed)*	• Health education on available contraceptives. • Dangers of abortion • Danger signs of abortion • Offer contraceptives • Counselling • Treat abortion (use MVA) • Refer • Do lab tests
Reproductive Cancers	• Health Education on prevention of cancer • Education as previous

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Counselling • Screening through – History taking, physical examination • Referral for further management
Programme: *Child Health*	
IMCI – Vaccine Preventable Diseases (VPD)	• Management of complications • Refer severe cases
IMCI - Diarrhoea	• Manage complicated cases • Refer severe complicated cases
IMCI – ARI incl Pneumonia	• Manage severe pneumonia • Incubator facilities • MED-pumps • Refer complicated pneumonias
IMCI – Nutrition	• Manage severe malnourished • Refer complicated malnutrition cases
IMCI – Micronutrients	• Screening of newborns for Iodine Deficiency Disorders (IDD) (through Full Blood Count) • Screening for iron deficiency anaemia (IDA) – haemoglobin estimation
HIV/AIDS	• Screening PBS/PCR • Initiation of treatment
School Health	• Health education • Counselling • Prevention : vaccination (BCG, DT & Polio) • Growth Monitoring (nutritional assessment)

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Screening for communicable and non-communicable diseases and conditions, (scabies/ringworm, oral health) • Life skills training • Management of childhood diseases and conditions • Refer
Disabilities related to malnutrition and other disabilities	• Assessment for disability (hearing, sight, speech etc) • Manage-Physiotherapy • Rehabilitation • Out-Reach specialist services • Refer
Programme: *Communicable Diseases*	
HIV/AIDS	• Treatment of OI (uncomplicated)
TB	• AFB • Specimen collection for Culture and DST • Referral of MDR and XDR
Malaria	• Microscopic Diagnosis • Treatment of complicated cases and refer non-responding cases
Diarrhoeal Diseases including paratyphi (for yr 5+)	• Stool Exam (microscopy and Culture/Sensitivity) • Treatment of all complicated and severe dehydration • Refer renal failure cases
Respiratory Infection including Pneumonia For yr 5+	• Treatment of complicated cases • Sputum Exam, • Culture/Sensitivity Chest X-ray

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Refer complicated cases for intensive care management
STI (HBV/ HCV/HPV/ HSV/Candidiasis/ TV/Gonorrhoea/ Syphilis)	• Microscopy • Serology for HPV/HCV/HSV/ Syphilis/HBV • Rapid test TV • Treatment
Meningitis	• Lumbar puncture (Culture/Sensitivity) • Treatment • Refer complicated cases
Dermatological diseases (scabies, tinia, HSV, Varicella zoster)	• Microscopy and staining • Treatment chronic cases
Neglected tropical diseases Bilharziasis, Trypanosmiasis, Intestinal and soil TH	• Laboratory Diagnosis • Treatment • Refer complicated cases
Nosocomial infections	• Isolation and fumigation
Zoonotic disease	• Vaccine – Rabies
Leprosy	• Microscopy + Special stain • Treatment • Refer complicated cases
Emerging infectious disease	• Isolation

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
Programme: *Non-communicable Diseases and Conditions*	
Mental Health	• Health education and mental health awareness • Reporting • Referral • Outreaches
Oral Health: • Dental caries and Periodontal diseases • Fluorosis • Noma	• Health Education • Extractions • Reporting • Referral
Trauma	• Basic life support • ACLS • Life saving procedures • Management of burns and other injuries • Referral • Reporting
Diabetes	• Health Education awareness • Early detection • Screening (fundoscopy, renal, lipids) • Treatment • Monitoring for optimal control • Reporting and referral
Hypertension and cardiovascular	• Health Education and awareness • Early detection & Screening • (BP check, ECG, RFTs)

Level of Care: Primary Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Treatment • Monitoring for optimal control and complications • Reporting and referral
Cancers	• Health Education and awareness • Early detection(biopsies pap smears and breast examination, rectal examinations and PSA for prostate cancer) • Supportive care • Reporting and referral
Eye Conditions	• Early detection and basic management • Screening incl visual acuity and fundoscopy • Home visits • Reporting and referral
Respiratory Diseases	• Health Education and awareness • Early detection and management; steroids, BLS • Screening-peak flow meters, CXRs • Monitoring for optimal control and complications Reporting and referral

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
Programme: *Sexual and Reproductive Health*	
ANC	• Registration • Screening and physical examination for health conditions (BP, Weight, Urine test, PT, TT) • Lab services

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Antenatal classes & exercises • Partner Companion • Collection of samples for blood group, Hb, RPR • Basic tests for HIV, Malaria, Urine analysi • Provision of Fe-Folate, Anti Malaria-in malarial areas • Take home IEC material (develop & distribute) • Pregnancy test • Provide Doppler • See referred and complicated cases from the clinic • Provide comprehensive emergency obstetric care • Provide Termination Of Pregnancy (TOP) service • Specialized obstetric and other services (amniocentesis, etc)
Delivery	• Conduct normal deliveries (BEmOC) • Identification and management of high risk deliveries and refer complicated cases • Provision of services for eclampsia and refer • Provide maternity waiting rooms • Neonatal Care • Referral • Specialised Neo-Natal care • Repair of RVF and VVF
PNC	• 6 week check up – mother, baby care, HIV testing infant • IPT • Referrals for complications • ART services to mother and baby
Family Planning	• Registration

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Health Education • Counselling services for various FP methods • Screening through – History taking, physical examination and laboratory investigations on initial and subsequent visits • Screening and management for STIs • Voluntary Testing for HIV • Screening for prevention of cancer of the cervix • Provision of FP methods • Referral for surgical methods • Distribution of IEC materials • Follow-up and monitoring of clients on FP methods • Provision of surgical methods • Fertility management
STI	• Contact tracing • Education, counselling and provision of treatment services, including ART • Laboratory diagnosis and management of STIs • Follow-up • Education on safe male circumcision • Provision of safe male circumcision • Provision of ART • Management of complication, e.g. urethrolplasty, blocked fallopian tubes
PMTCT	• Provision of all PMTCT services (testing, counselling, ART, feeding support and supplies, infant testing)
Adolescent SRH services	• Youth Friendly environment/facilities • Life skills education • Counselling services on sexuality and safer sex

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• IEC material on ASRH issues • Family Planning Services • Availability of peer education through trained peer educators • Education, counselling, testing for HIV, pregnancy, & treatment of STIs, • ANC, PNC • Referrals for HIV treatment, high risk ANC
Male Involvement in SRH	• Screening for STIs, HIV, urinary tract infections, • Counselling for SRH conditions, sexual dysfunction, infertility, family planning • Provide family planning service • Specialised screening for male fertility problems , male reproductive cancers, and male sexual Dysfunctions • Provide clinical management for above • Male SRH services for advanced conditions and rehabilitation services: • Surgery • Chemotherapy • Radiotherapy • Management of sexual dysfunctions and infertility •
Infertility	• Education, screening • Specialized fertility services •
Gender -based violence (includes rape) *(requires legal instrument to be reviewed)*	• Screening, counselling, primary management and referral • Plus legal services – One stop shop • Reconstructive surgery
Post Abortion Care *(requires legal instrument to be*	• Health education on available contraceptives • Dangers of abortion

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
reviewed)	• Danger signs of abortion • Offer contraceptives • Counselling • Treat abortion (use MVA) • Treat and manage and abortion (do evacuation using MVA or D and C) • Manage complicated cases
Reproductive Cancers	• Health Education on prevention of cancer • Education as previous • Counselling • Screening through – History taking, physical examination • Referral for further management • Management • Chemotherapy and advanced management
Programme: *Child Health*	
IMCI – Vaccine Preventable Diseases (VPD)	• Management of severe cases
IMCI - Diarrhoea	• Manage severe complicated cases • Rx for renal failure
IMCI – ARI incl Pneumonia	• Management of severe complicated pneumonia
IMCI – Nutrition	• Manage complications of severe malnutrition
School Health	• Manage
Disabilities related to malnutrition	• Manage

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
and other disabilities	• Refer
Programme: *Communicable Diseases*	
HIV/AIDS	• Treatment of complicated OI • Treatment of complicated severe malnutrition
TB	• Culture • DST • Treatment of MDR/XDR cases
Malaria	• Treatment of complicated cases
Diarrhoeal Diseases including paratyphi (for yr 5+)	• Management of renal failures
Respiratory Infection including Pneumonia (For yr 5+)	• Intensive care management of complicated cases
STI (HBV/ HCV/HPV/ HSV/Candidiasis/ TV/Gonorrhoea/ Syphilis)	• Treatment complicated cases
Meningitis	• Management of complicated cases
Dermatological diseases (scabies, tinia, HSV, Varicella zoster)	• Clinical and laboratory diagnosis • Treatment
Neglected tropical diseases	• Management of complicated cases

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
Bilharziasis, Trypanosmiasis, Intestinal and soil TH	
Nosocomial infections (Pseudomonas, TB, Staph aureus etc.)	• Hospital infection control programme
Zoonotic disease (Rabies, Anthrax, plague)	• Diagnosis and treatment of Rabies and anthrax
Leprosy	• Management of complicated cases
Emerging infectious disease (VHF, Avian influenza, etc)	• Intensive care management
Programme: *Non-communicable Diseases and Conditions*	
Mental Health	• Inpatient treatment • Occupational therapy • holistic Patient management including rehabilitation • Specialist services and sub specialist services • Specialist outreach services • Monitoring and evaluation
Oral Health: • Dental caries and Periodontal diseases • Fluorosis • Noma	• Health Education and awareness • Extractions • Fillings • Treatment of diseases including Inpatient treatment • Prosthetic services • Specialist and sub specialist services

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Rehabilitation
Trauma	• Holistic patient management • ACLS • Life saving procedures • Rehabilitation • Specialist and sub specialist services • Monitoring and evaluation
Diabetes	• Health Education • Specialised services for complicated cases • Screening • Treatment • Monitoring for optimal control and complications including Hb1ac • Reporting • Monitoring and evaluation
Hypertension and cardiovascular	• Health Education and awareness • Detection & Screening (BP check, ECG, RFTs lipid profile) • Specialised services for complicated conditions
Cancers	• Specialised services for complicated cases • mammograms • chemotherapy • monitoring and evaluation
Eye Conditions	• Cataract operations • Specialised services for complicated conditions

Level of Care: Referral Hospital	
Programme Area	**Description of Service provided (Interventions)**
	• Rehabilitation • Outreach services
Respiratory Diseases	• Specialised services for complicated cases (lung biopsy, bronchoscopy, CT scans)

7. STRATEGIC NORMS AND STANDARDS FOR EHSP BOTSWANA

7.1 The Choice of Norms and Standards

All necessary components of the EHSP are described and the norms and standards for each component are provided. The norms and standards are largely derived from existing national policy documents or, if unavailable, other authoritative sources such as WHO and research work undertaken in the country. All the norms and standards are verifiable (some more easily than others) by staff providing the service. Some of the norms were taken from the existing documents within the MOH. An attempt has been made to ensure that the standards are practical, essential and comprehensive and describe the range of services that should be available to all Batswana.

7.2 Potential Uses

It is hoped that the norms and standards are comprehensive enough to be used:

- By local staff to help assess their own performance and that of their facility (clinic, hospitals, etc)
- By the community who are able to see the range and quality of services to which they are entitled
- As planning guidelines by district health planners to help assess the unmet needs of their population and draw up plans to bring services up to national standards
- By MOH to guide resource allocation.

This wide range of uses requires the document to be available in different formats and selecting particular sections. Once this core document is published, it will be widely distributed to all stakeholders. Components can for example be adapted for use as checklists for local staff.

7.3 A Living Document

Not every primary health care component has been fully documented. National policies will change and service standards will be able to be enhanced, as more resources are made available. The document is the first of its kind. As experience of its use grows, many areas for improvement will become apparent. Feedback from patients and staff is essential. Some programmes have already introduced norms and standards of their own. This is beneficial as the more experience that is gained with their use the more can be shared.

7.4 Definition of Norms and Standards

FOR THE PURPOSE OF THIS DOCUMENT NORMS AND STANDARDS ARE DEFINED THUS:

A **NORM** is defined as a statistical normative rate of provision or measurable target outcome over a specified period of time.

A **STANDARD** is defined as a statement about a desired and acceptable level of health care.

A common framework used to develop these standards addresses health service inputs, processes, outputs and outcomes. This approach has been adopted. Standards are best developed in incremental stages and according to national priorities. These represent the first stage of this process for primary health care.

Standard setting takes place within specific dimensions of quality - acceptability, accessibility, appropriateness, continuity, effectiveness, efficiency, equity, interpersonal relations, technical competence and safety. The most important dimensions have been chosen for each service.

7.5 Interpretation

Two important issues need to be taken into account when interpreting these norms and standards in the local setting. The first relates to the role of national and district health authorities. The second relates to staff competency.

7.6 What Services are Required Not How Services are Provided

The role of MOH is to define **what** services are required to best meet the health needs of the nation. It is for Districts to decide, in the light of local circumstances, **how** these services are to be provided. Because of these different roles this national document is about **what** services at **what** standard are required. The standards do not specify **how** the services are to be provided and at what level the standards will be met. It is for Districts to harden up the standards with verifiable time limited measures based on existing performance and anticipated improvements.

Different kinds of facilities will be required to provide the same services in different situations. Take for instance the use of mobile clinics in remote rural areas compared to polyclinics in high-density urban areas. For this reason national standards about facilities and staffing norms are not offered. In some instances some standards about special facilities are included without which a service would be impossible to provide, for example a confidential room to talk to a sexually abused patient.

7.7 Staffing Norms and Standards

Staffing standards are based on staff-mix by levels of service delivery, where the norms are based number of key staff by levels as well as catchments' population. While it may not be possible for Botswana to fully staff these levels of facilities as per standards and norms at this moment due to shortage of human resources, yet these norms and standards will provide the MOH and the district health systems including facilities to plan for deployment and recruitment of staff. It will also assist the training facilities including schools to develop strategies for the production of optimum human resources.

7.8 Staff Competency

Many standards relate to staff competency. It is to be expected that some staff will not have received training, or if trained, no longer remain competent to provide all the services specified. It is the responsibility of professional staff to seek to rectify the deficit in themselves and their staff by arranging appropriate training. It goes without saying that no members of staff should undertake tasks unless they are competent to do so. The safety of the patient is paramount.

7.9 Content

Part 1 concerns the individual/family/community based services. The section of standards and norms is arranged in a logical order. It deals with community based services, health clinics, primary hospitals and district hospitals. The section on health clinics starts with a chapter on patient rights, which is followed by a chapter on core norms and standards for all clinics whatever services they are providing. For instance all clinics are expected to have stocks of, and to dispense drugs listed in the Essential Drug List. The standard is therefore included as a core standard. It is not repeated in later chapters although its use is essential for most if not all services. Sections succeeding the core standards one do not duplicate core standards.

Then each section follows on interventions starting with sexual and reproductive health, child health, communicable diseases and finally non-communicable diseases.

Each section comprises three paragraphs. The first describes the service to be provided. The second paragraph describes the norms, chosen to represent key measures of what is required. All clinics should be aspiring to measure and reach these norms. The third paragraph describes the standards and norms for the staffing for that level of care. The fourth paragraph describes the standards for each service for sub-programmes. Within the sub-programme, the first three sections describe the essential material, equipment, supplies and medicines required. Successful performance to meet these standards requires good organisation and logistics.

Part 2 considers Primary Health Care Clinic/Centre initiated services. **Part 3** is about Primary Hospital based services. **Part 4 and Part 5** are for services provided at District and Referral Hospitals. The format is similar.

PART 1: NORMS AND STANDARDS FOR:

i) INDIVIUAL/FAMILY/ COMMUNITY BASED SERVICES

INTRODUCTION

Public and private sector resources provide initial training and long-term support to create an environment in which individual/family/community based services can function. Technology is affordable and sustainable. Development activities are demand driven, community based and of a level to provide a healthy environment which is a human right.

NORMS

1. There is access to district health expertise including the services of an environmental health officer.
2. Reduce the under 5 mortality rate by XX%.
3. Reduce the mortality of children under 5 due to diarrhoea by XX%.
4. Ensure Botswana remains poliomyelitis-free.
5. Reduce the prevalence of underweight for age among children under the age of 5 to XX%.
6. Reduce the prevalence of stunting among children under- 5 to XX%.
7. Reduce the prevalence of severe malnutrition in children under 5 to X%.
8. Eliminate micro deficiency disorders.
9. Reduce maternal mortality.

STAFFING STANDARDS AND NORMS

COMMUNITY	**NORM**	**COMMENTS**
FULL TIME	**1 staff per population of**	
Health Education Assistant (HEA)	up to 1500	Number increases with multiple of 1500 pop
Social worker (for social mobilisation)	Up to 1500	
Lay counsellors	up to 500	Number increases with multiple of 500 pop
Community health Volunteers for Home Based Care	Per 5 requiring HBC	Based on number of person requiring HBC
PART TIME	**Source**	**Comments**

HEOs	From District	Numbers for district depends on total population Norms described under DHMT, PHCC and PH/DH
CH Nurse	From PHCC	
Nutrition officer	From District	
Environmental health officers	From District	
Rehabilitation officer	From PH	
Community based NGOs	From Community	Based on special programme need

ii) COMMUNITY LEVEL HOME-BASED CARE

NORMS

1. Every community provides some home-based care and has access to community-based care through partnership of community-based and clinic-based health services.
2. All clinics serving communities in their catchment areas identify home-based carer co-ordinators for formal and informal sector activities.
3. All communities with home-based care have access to a referral system and to comprehensive support services.
4. All clinics have access to home-based care guidelines and palliative care guidelines so that they can assist communities and families.

STANDARDS

1. Home-based care is comprehensive and holistic, person centred, sensitive to culture, religion, values and respects privacy and dignity and maintains self-esteem.
2. It empowers and promotes functional independence of the individual and family.
3. The patient, the carer and the community are provided with appropriate targeted education.
4. Home-based care assists in reducing unnecessary visits and admissions to health facilities.
5. Community groups and individual home-based carers receive training from the nearest competent resource – NGOs or the local clinics or visiting health team.
6. Community groups and clinics maintain records of home-care and it's continuity and consistency.
7. Patients referred from a health facility for home care have the homestead carer prepared and given adequate instruction on medication and daily living care. Referring facilities also provide prescribed medicine and assistive devises.
8. Protocols or manuals of care are provided to home-care patients from the local clinic on palliative care and the management of pain.
9. Community-based training of home-carers is based on adult education principles and practical simple guidelines.
10. Health staff assist in the development of case management plans which consider physical and psychological needs, environment social networks, diet, exercise and rest, personal habits, sexuality, recreation, dressing, washing, feeds, toilet, continence, hearing, seeing and home layout.
11. Community groups, family, neighbours or volunteers assist with continuing home needs.
12. Social workers assist with arranging legal assistance (e.g. wills) and application for disability grants and other social support.
13. Integrated community home-based services have a mosaic of categories, (medical, counselling, pastoral, rehabilitation and traditional) brought together around the individual and family through professional co-ordination.

Home Care for AIDS

14. Home care for AIDS in the community includes access to common drugs, emotional support, consideration of families, help with households, kind relationships from clinic staff and financial support if available through social welfare or self-help groups.
15. The community care of AIDS patients involves a continuum of care, which links all available resources in a community.
16. The continuum of care starts from initial counselling to include care of psychosocial needs, medical and nursing needs and family needs such as care of children, legal advice and assistance.
17. Clinics, hospices, NGOs and community groups are linked in a network and this can be initiated by the clinic, NGOs or community groups.
18. The aims of AIDS home care are the same as for any home-based health care programme:

    18.1 to prevent problems when possible
    18.2 to take care of existing problems
    18.3 to know when and how to get help.

iii) DIRECTLY OBSERVED TREATMENT (SHORT COURSE) STRATEGY "DOTS"

Service description

The national TB control strategy of directly observed treatment short course 5 key elements, are :-

- Directly observed treatment by the clinic or community health volunteers for 6 months.
- Short course chemotherapy and uninterrupted drug supply
- Standard reporting and recording system.
- Diagnosis based on positive sputum microscopy.
- Commitment to the DOTS programme by all.

NORMS

Achieve a minimum community-based directly observed tuberculosis treatment cure rate of new sputum positive TB cases of 90%.

STANDARDS

Accessibility

1. Community health volunteers for DOTS are as near to the home of TB cases as is convenient to ensure regular treatment and periodic clinic supervision.

Equipment

2. Community health volunteers will have:

   2.1 a box in which to store the supply of drugs specific for each patient being supported,
   2.2 a supply of green cards for recording (as a duplicate) the treatment given while the patient keeps the original card issued by the clinic,
   2.3 patient education material in the correct language.

Training

3. All Community health volunteers have received a course of training equivalent to at least one week, either continuous or in sessions.
4. Training covers knowledge, attitude change and skills in communication, simple counselling and problem solving in providing correct continuous directly observed treatment.
5. Suitable training manuals and health learning materials are provided.

Supervision

6. Community health volunteers in the community receive supportive supervision by regular contact with the clinic nurse who will also record continuity of progress in the clinic TB register.

Evaluation

7. Success is measured by recording:

   7.1 The number of missed treatments and
   7.2 The rapidity of re-establishing continuous treatment and sputum conversion at 2 months for new cases and 3 months for re-treatment cases and at 6 months and 8 months for new and re-treatment cases respectively.
   7.3 % of patients on DOT.
   7.4 smear conversion rate at 2/3 months of treatment.
   7.5 % of patients who are cured.

Community Support

8. The community health committee participates in identifying new potential Community health volunteers. This is a partnership between Community health volunteers, patient and clinic with the patient deciding who his Community health volunteers will be.
9. Committees may provide non-financial incentives such as community recognition of outstanding Community health volunteers support.

Referrals and Transfers

10. All referrals and transfers of community based DOTS patients are documented on the correct forms and followed up by the referring or transferring health facility.

iv) NUTRITION PROGRAMME

BASIC CONSIDERATIONS

The vision for nutrition is optimum nutrition for all Batswana. It is recognised that nutrition is multi-sectoral and complex. Nutrition status is improved through a mix of direct and indirect nutrition interventions implemented at various points of service delivery such as clinics, hospital and communities and aimed at specific target groups.

NORMS

1. Ensure that all health facilities are baby friendly.
2. Increase the proportion of mothers who breastfeed their babies exclusively for at least six months of age and who breastfeed their babies for at least 12 months of age.
3. Contribute to the reduction of mortality due to infectious diseases particularly diarrhoea, measles, and acute respiratory infections in children 5 years of age through nutritional support and counselling.
4. Contribute to the reduction in the prevalence of low birth weight to 5% of all live births.
5. Increase regular growth monitoring to reach 90% of children 2 years of age.
6. Reduce the prevalence of under weight (weight-for-age) among children 5 years of age to 5%.
7. Reduce the prevalence of severe underweight (weight-for-age) among children 5 years of age to 1%.
8. Reduce the prevalence of stunting (height-for-weight) among children 5 years to 10%.
9. Reduce the prevalence of wasting (weight-for-height) among children 5 years of age to 1%.
10. Eliminate micro nutrient malnutrition:

    - Reduction of Vitamin A deficiency in children under 5 years of age with serum retinol 20ug/dl,
    - Reduction of Iron deficiency anaemia rates in children and women.
    - Reduction of Iodine deficiency rates.

11. Reduce disease of lifestyle related to over-nutrition.

STANDARDS

1. References, prints and educational materials

1.1 The Breastfeeding Guidelines for Health Workers.
1.2 Guidelines and Protocols on Vitamin A Supplementation.
1.3 Vitamin A Brochures for Health Workers.
1.4 Guidelines for Health Facility Based Nutrition Interventions to Prevent Malnutrition.
1.5 Integrated Management of Childhood Illnesses Manual.
1.6 National Guidelines on Nutrition for People Living with HIV/AIDS

1.7 Growth Monitoring and promotion guidelines and manuals

2. Equipment

2.1 Growth monitoring Charts
2.2 Weighing scales
2.3 Non-stretch tape measures
2.4 Dolls for demonstration purposes.
2.5 Nutrition Education tools.

3. Medicine and Supplies:

3.1 Vitamin A capsules.
3.2 Iron and folate capsules
3.3 Nutrition supplements. ("PEM" scheme)

4. Competencies:

4.1 Staff working at the district level have the following competencies, particularly applied to community- based, integrated nutrition (the competencies listed below are applicable to health workers other than dieticians and nutritionist):

4.1.1 An understanding of the principles of nutrition.
4.1.2 An understanding of the conceptual framework for the analysis of nutrition problems in communities.
4.1.3 The ability to design, implement and evaluate inter-sectoral programmes.
4.1.4 The capacity for project management and application of innovative approaches to nutrition issues.
4.1.5 The ability to communicate with a target group, analyse its needs and make appropriate choices of communication media and materials.
4.1.6 The ability to train at community and other levels using good educational practice.
4.1.7.The ability to follow-up and monitor the growth of children using the Growth Monitoring Chart
4.1.8.The ability to recognise under-nutrition, micronutrients deficiency and obesity, and appropriately counsel and advise clients.

4.2. The ability to give basic nutrition advise and counselling particularly on the following:

- Nutrition during pregnancy, breast feeding and complementary feeding
- Infant feeding options for HIV positive mothers
- Feeding during illness such as diarrhoea and other infections
- Young child feeding practices
- Importance of micro-nutrients and choice of micro-nutrient rich foods
- Food hygiene

4.3.The ability to recognise severe signs of malnutrition and take appropriate action

5. Referrals:

There is effective and efficient referral and counter referral system between health

facilities and community based services.

5.1. Mothers are referred to breastfeeding support groups
5.2. Clients on the Supplementation Programme are referred to the next level of care.
5.3. Severe cases of malnutrition are referred to the next level of care.
5.4. Patients with a need for additional health and social services are referred as appropriate.

6. Patient Education:

6.1 Appropriately counsel and advise clients on under-nutrition, micronutrient deficiency and over-nutrition.
6.2 Appropriately counsel and advise clients on breastfeeding and complementary feeding.
6.3 Appropriately counsel and advise clients on infant feeding options for HIV positive mothers.
6.4 Counselling and support of current coping strategies.
6.5 Counselling on growth promotion
6.6 Counselling on nutrition during the life cycle as appropriate.

7. Records:

7.1 Children's weight and height is recorded and graphed accurately on the Growth monitoring Chart.
7.2 Charting of weight and other appropriate parameters by the client on a home monitoring programme.
7.3 Supplement provided recorded on statistical returns

8. Community and Home Based Activity:

8.1 The active participation of households, community leaders and structures, NGOs, CBOs and other community role players are mobilised in the district.
8.2 Household coping strategies already in place are supported.
8.3 Communities are empowered with the necessary skills and knowledge to become self-reliant with regard to their food and nutrition needs and to be in control of factors affecting their nutritional well being.
8.4 Community health workers are utilised to initiate community growth monitoring and identification of nutrition problems.

9. Collaboration:

9.1 Intersectoral collaboration of line departments and other sectors are mobilised at all levels to ensure joint action to ensure nutrition problems are addressed
9.2 Collaboration between health-facilities and community-based programmes to implement the community component of the Integrated Management of Childhood Illness.

v) SCHOOL HEALTH SERVICES

Basic Considerations

The School Health Service is expected to provide a health promoting services by acting in a co-ordinating role, making use of the skills and capacity in different sectors of society, including the community, the learners themselves, educators and NGOs.

Standards set for the School Health Service need to take into account the diverse situation of schools and school health services at present and the changing philosophy introduced by the education sector, including outcomes based education and inclusive education. The introduction of the philosophy of inclusive education means that children with barriers to learning will be included in ordinary schools and that these schools and communities will have to be develop to provide acceptable services for these children. Teachers generally do not have the capacity to deal with these children and the school health services can play a role in enabling teachers to identify and integrate these children into the classroom. School Health personnel may not have the capacity to implement their new role so a transformation-training programme is required. New resources for school health promotion need to be developed and funded.

These recommended standards are based on the assumption that the EHSP is built on the clinic catchment area approach to service delivery.

Service Description

The school health service is a health promotive service dealing with the individual in the context of the family and community and with the school environment. The service encourages the school to seek to develop and implement school policies that promote and sustain health, improve the physical and social environment within which children learn and develop and improve children's capacity to become and stay healthy.

Norms:

1. Each catchment area has a minimum of one School Health Promoting Team.
2. Every clinic will be able to access a specially trained nurse on school health within the district
3. District School Health Promoting Teams are supported from central level with an appropriate, effective transformation training programme, and the development of standardised resource packs and the training occurs during those times of the year when schools are closed.
4. Screening Programmes are provided to give adequate coverage to identify all children at risk of barriers to learning and are not limited to certain age groups.
5. The School Health Promoting Service creates a positive learning environment, by identifying barriers to learning, and developing ways to remove these barriers in a community inclusive way.
6. School Health Promotion Programmes promote acceptance and celebration

of diversity among individuals through a learner centred approach.
7. An accessible, healthy physical and social environment in which children can learn is promoted.

Standards

1. References prints and Educational Material

1.1 A standardised questionnaire for use by teachers to screen for the presence of factors causing barriers to learning in the individual.
1.2 A standardised questionnaire for use by school health promoting teams to assist them detecting barriers to learning in the environment of the learner.
1.3 A resource register for the district for use by School Health Promotive Teams and Educators, by which available health services can be identified, and how they can be accessed, to be compiled by each district and regularly updated.
1.4 Health promoting educational materials in the local language and accessible to people with disabilities, including films, videos, posters, booklets, visual aids and audiotapes.

2. Equipment

2.1 As for mobile teams

2.2 Projector, video recorder, slide projector, white boards and audiotapes.
2.3 Access to administrative support, including typing services, telephone and fax, photocopying services, stationary and appropriate transport for the environment.

3. Medicines, supplies and assistive devices

3.1 Access to medication for control of specific disease conditions identified at district level, e.g. prevention of blindness, treatment of scabies outbreak.
3.2 Assistive devices for daily living for people with disabilities.

4. Competencies

4.1 The School Health Promoting Team is able to:

4.1.1 Function as an effective and efficient team.
4.1.2 Promote the whole person and life-style skills development of pupils and educators.
4.1.3 Identify resource people and involve them to promote the transformation.
4.1.4 Promote community participation and the participation of all stakeholders in programmes e.g. Participatory Learning and Action (PLA) skills.
4.1.5 Plan and implement health promoting programmes.
4.1.6 Apply and interpret the screening questionnaires for individuals and schools and transfer these skills to the teachers.
4.1.7 Identify gaps in the service and barriers to learning.
4.1.8 Promote healthy nutrition, mental health and reproductive health.
4.1.9 Counsel for substance abuse and victims of violence including rape.
4.1.10 Identify and seek to reduce stress.
4.1.11 Promote healthy sexuality and deal with the results of unhealthy sexual

behaviour.
5. Patient Education 5.1 Address health risk behaviours with the provision of behaviour specific knowledge and opportunities to practice knowledge and skills.
6. Referrals 6.1 Refer to nearest clinical service, the students that require more intense clinical assessment and management.
7. Records 7.1 An information system at all levels of the service, which informs the different sectors to make effective use of existing services, identifies gaps in the service and monitors the progress toward the development of Health Promoting Schools.
8. Community based activities 8.1 Promote the development of child–to–child programmes as an important resource. 8.2 Work with school boards to promote activities in the community such as libraries and sport activities.
9. Collaboration 9.1 Clinic staff collaborate with and involve officials from health, welfare, education, agriculture sectors, educators, learners, parents, community leaders CBOs and NGOs, 9.2 School Health Promoting Teams are intra- and intersectoral.

vi) COMMUNITY BASED REHABILITATION

Service description

The philosophy of Community Based Rehabilitation (CBR) is to promote the concept of shared governance, namely the active participation of people with disabilities and their family members in:

- Developing of a vision for their lives within the society in which they live,
- Identifying the needs and resources of people with disabilities within the community,
- Planning and implementing the vision and
- Monitoring and evaluating its implementation.
-

This participatory approach to governance and service implementation takes place at all levels of society from central government down to community groups and home based care. This chapter describes what happens in the community and at home, after listing the norms and standards that apply at all levels in society.

NORMS

STANDARDS

1. References, prints and educational materials:

1.1 WHO Manual on Community based Rehabilitation.

2. Equipment:

2.1 As when necessary

3. Medicine and Supplies:

3.1 Medical and surgical supplies and assistive devices are accessed from the nearest health facility.

4. Competencies:

4.1 Community groups skills are available:

4.1.1 To organise and run regular, focused and functional meetings.
4.1.2 In record keeping and minutes taking.
4.1.3 To run committees and resolve conflicts.
4.1.4 In bookkeeping, financial reporting and operating a bank accounts.
4.1.5 In writing proposals and fund-raising.
4.1.6 In developing job descriptions and monitoring the services of employees like cooks, day-care providers, drivers, etc.

4.2 Day caretakers have:

4.2.1 Basic training in early education and can carry out a basic rehabilitation programme under the guidance of a therapist or therapy assistant.

4.2.2 The ability to

4.2.2.1 do a basic assessment of the rehabilitation needs of the children in their care, and record this in the local vernacular in a standardised format.
4.2.2.2 keep a progress record of a child in his/her care in the local vernacular.
4.2.2.3 keep a daily journal of their activities, attendance and incident registers and write half-yearly reports of the child's progress to the parents.
4.2.2.4 construct toys from locally available material and plan stimulation programmes for a group of children.
4.2.2.5 counsel parents on handling of the child.
4.2.2.6 Identify children who are not adequately cared for by their families, even with support from community services, and refer these to welfare services.
4.2.2.7 Know which social grants are available to people with disabilities and how to apply for such assistance.
4.2.3 Self-help and Income Generating Groups have skills are available in financial management and marketing products made.

Organising the service at all levels

4.3 Districts have a community-based level of service for rehabilitation, which is provided in partnership with people with disabilities and their caregivers.
4.4 Councils are in place at district and community level, based on the shared governance structure described as the model in the white paper on disability.
4.5 DHMT representatives at these levels participate in, and actively promote, the shared governance structures, in an empowering way, putting the leadership into the hands of the people with disabilities.
4.6 Health forums, and community health committees have at least one member with a disability.
4.7 Meetings of the committees are conducted in barrier free circumstances.
4.8 Services for people with disabilities are given priority.
4.9 The Health Sector gives technical support to shared governance structures and community-based services.
4.10 People with disabilities are involved in setting up and implementing disability information systems at all levels of service provision, and this information is used to prioritise and plan services.

Organising the service at community level

4.11 Opportunities are developed for care givers of disabled children, or people with disabilities to be involved in providing community based services.
4.12 Community based services include day care facilities for children with multiple severe disabilities, support groups, self help groups, protected workshops, home based care, sport opportunities and instruction for people with disabilities.
4.13 Each sub-district has a centre for rehabilitation with, as a minimum, facilities for day care and a workshop.
4.14 Community based service points are visited by a therapist or therapy assistant.
4.15 Suitable space is available for these services to be provided on or within health service facilities, if needed.

5. Referrals:

5.1 There is effective and efficient referral and counter referral system between district health facilities and community based and owned facilities.

6. Patient Education:

6.1 Assist in empowering people by them recognising their self-worth.
6.2 Handling of behavioural problems.

7. Records:

7.1 A progress record of a child in his/her care in the local vernacular.
7.2 Daily journal of day care centres, their activities, attendance and incident register.
7.3 Regular reports on the child's progress to the parents.
7.4 Record of a basic assessment of the rehabilitation needs of the children in their care in the local vernacular in a standardised format

8. Community and Home Based Activity:

8.1 Needs driven community training, counselling and awareness raising programmes to address issues concerning people with disabilities operate from these centres.
8.2 Community groups are actively involved in awareness raising activities within the district, especially the International Day of Disabled and other special days with related topics.

9. Collaboration:

9.1 People with disabilities are involved in the planning, setting of standards and monitoring of the services of which they are the main benefactors.
9.2 Issues pertaining to disability are addressed, through intersectoral collaboration, with the community at community based service points.
9.3 Community based services are provided within a framework of accountability to a committee made up of stakeholders, which receives technical support from a service provider.
9.4 Rehabilitation centres are further developed to provide contact/service points with other sectors, e.g. welfare, labour, education, agriculture, as well as community gardens and adapted gardens for people with disabilities, sports facilities for disabled persons, and short term half way house boarding facilities.
9.5 Therapists and therapy assistants assist community-based groups to contact services from other sectors, NGOs and Disabled People's Organisations (DPO's).
9.6 District maintenance personnel provide technical support for these services e.g. construction of aids for daily living for individual clients.
9.7 Opportunities to contract the provision of services for the health sector to people with disabilities are developed e.g. making of pressure garments, sewing or repair of hospital linen, making of special chairs from Appropriate Paper Technology, garden services.
9.8 The education sector makes use of the resources within the Community Based Rehabilitation service to cater for the educational needs of children and adults with barriers to learning, and provides technical support to the groups.
9.9 Community Groups remain in contact with the Department of Labour, and are

given priority in suitable skills training programmes.

PART 2. NORMS AND STANDARDS FOR:

i) PRIMARY HEALTH CLINICS/CENTRES

INTRODUCTION

Access to decent public services is the rightful expectation of all citizens especially those previously disadvantaged. Communities are encouraged to participate in planning services to improve and optimize service delivery for the benefit of the people who come first.

STANDARDS

All communities will know from displayed posters about the following:

CONSULTATION
Communities will be consulted about the level and quality of public services they receive and where possible will be given a choice about the services offered.

SERVICE STANDARDS
Citizens would know the level and quality of public service they are to receive and know what to expect

ACCESS
All citizens have equal access to the services to which they are entitled

COURTESY
Citizens should be treated with courtesy and consideration.

INFORMATION
Citizens should be given full accurate information about the public service they are entitled to receive.

OPENNESS and TRANSPARENCY
Citizens should be told how national and provisional departments are run, how much they cost and who is in charge.

REDRESS
If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy, when complaints are made, citizens should receive a sympathetic positive response.

VALUE FOR MONEY
Public services should be provided economically and efficiently in order to give citizens and communities the best possible value for money.

Implications for health staff

In line with these principles the local health services for a community will provide:

- services with a high standard of professional ethics
- a missions statement for service delivery
- services which are measured with performance indicators displayed, so community can understand the level of achievement
- services which are in partnership with or complement other sectors e.g. the private sector and non-government organizations and community based organizations
- services which are customer friendly and confidential
- opportunities for community consultation
- types of outreach which can reach to all communities and to families in greatest need
- easily accessible and effective ways of dealing with complaints or suggestions for improvement
- current information on services available and hours of service, staff changes of movements and extra activities such as health days.

ii) POPULATION HEALTH RIGHTS CHARTER

SERVICE DESCRIPTION

The purpose and expected outcome of the population health rights charter and complaints procedure is to deal effectively with complaints and rectify service delivery problems and so improve the quality of care, raise awareness of rights and responsibilities, raise expectations and empowerment of users, change attitudes by strengthening the relationship between providers and users, improve the use of services and develop a mechanism for enforcing and measuring the quality of health services.

STANDARDS

1. Each clinic displays the population health rights charter and responsibilities at the entrance in local languages.
2. Every person has the right to:

    - a healthy and safe environment
    - access to health care
    - confidentiality and privacy
    - informed consent
    - be referred for a second opinion
    - exercise choice in health care
    - continuity of care
    - participation in decision making that affect his/her health
    - be treated by a named health care provider
    - refuse treatment and
    - knowledge of their health insurance/medical aid scheme policies
    - complain about the health service they receive.

3. Every person has the responsibilities for:

    - Living a healthy lifestyle
    - Care and protect the environment
    - Respect the rights of other patients and health staff
    - Utilise the health system optimally without abuse
    - Know the health services available locally and what they offer
    - Provide health staff with accurate information for diagnosis, treatment, counselling and rehabilitation purposes
    - Advise health staff on his or her wishes with regard to death
    - Comply with the prescribed treatment and rehabilitation procedures
    - Ask about management costs and arrange for payment
    - Take care of the patient carried health cards and records.

4. There is provision for the special needs of people such as a woman in labour, a blind person or a person in pain.
5. Services are provided with courtesy, kindness, empathy, tolerance and dignity.

6. Information about a patient is confidential and is only disclosed after informed and appropriate consent.
7. Informed consent for clinical procedures is based on a patient being fully informed of the state of the illness, the diagnostic procedures, the treatment and its side effects, the possible costs and how lifestyle might be affected. If a patient is unable to give informed consent the family is consulted.
8. When there is a problem the health care user is informed verbally of the health rights charter with emphasis on the right to complain and the complaints procedure is explained and handed over.
9. The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints.
10. All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic.
11. A register of complaints and how they were addressed is maintained.
12. The name, address, telephone number of the person in charge of the clinic is displayed.

STAFFING STANDARDS AND NORMS		
Full-time Posts	**Norm Per PHCC**	**Comments**
Medical Officer	1 per Clinic serving up to 3000 pop	
Midwife	3 per clinic serving 3000 pop	
General Nurse	6 per clinic serving 3000 pop	
Community Health Nurse	2 per clinic serving 3000 Additional number will depend on catchment pop (1 per 3000)	CHN will also support community based services
Radiography Officer	1 per clinic up to 5000 pop	
Lab Technician	1 per clinic up to 5000 pop	
Pharmacy Technician	1 per clinic up to 5000 pop	
Health Education Technician (HET)	1 per clinic serving 2000 pop	Health Education, promotion, social mobilisation
Data Clerk	1 per clinic up to 5000 pop	
Lay Counsellor	3 per clinic serving 3000 pop	
Social worker	2 per clinic serving 3000	Social mobilisation, counselling
Support staff		**Some services can be outsourced**
Administrator	1	
Messenger	1	
Cleaners	3	Up to a size of 500 sqm

iii) CORE NORMS AND STANDARDS FOR HEALTH CLINICS

CORE NORMS

1. The clinic renders comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week.
2. Access, as measured by the proportion of people living within 5km of a clinic, is improved.
3. The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
4. The clinic has at least one member of staff who has completed a recognised PHC course.
5. Doctors and other specialised professionals are accessible for consultation, support and referral and provide periodic visits.
6. Clinic managers receive training in facilitation skills and primary health care management.
7. There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.
8. There is annual plan based on this evaluation.
9. The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
10. Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

CORE STANDARDS

1. References, prints and educational materials

1.1 Standard treatment guidelines and the essential drug list (EDL) manual.
1.2 A library of useful health, medical and nursing reference books kept up to date.
1.3 All relevant national and provincial health related circulars, policy documents, acts and protocols that impact on service delivery.
1.4 Copies of the Patients Charter and Batho Pele documents available.
1.5 Supplies of appropriate health learning materials in local languages.

2. Equipment

2.1 Diagnostic set.
2.2 Blood pressure machines with appropriate cuffs and stethoscope.
2.3 Scales for adults and young children and measuring tapes for height and circumference.
2.4 Haemoglobinometer, glucometer, pregnancy test, and urine test strips.
2.5 Speculums of different sizes
2.6 A reliable means of communication (two-way radio or telephone).
2.7 Emergency transport available reliably when needed.
2.8 An oxygen cylinder and mask of various sizes.
2.9 Two working refrigerators one for vaccines with a thermometer and another for

medicines. If no electricity, gas fridge with a spare cylinder is always available.
2.10 Condom dispensers are placed where condoms can be obtained with ease.
2.11 A sharps disposal system and sterilisation system.
2.12 Equipment and containers for taking blood and other samples.
2.13 Adequate number of toilets for staff and users in working order and accessible to wheelchairs.
2.14 A sluice room and a suitable storeroom or cupboard for cleaning solutions, and linen.
2.15 Suitable dressing/procedure room with washable surfaces.
2.16 A space with a table and ORT equipment and needs
2.17 Adequate number of consulting rooms with wash basins, diagnostic light (one for each professional nurse and medical officer working on the same shift).

2.18 Ultrasound machine

2.19 Partograph

2.20 Delivery set (emergency)

3. Medicines and Supplies

3.1 Suitable medicine room and medicine cupboards that are kept locked with burglar bars.
3.2 Medicines and Supplies as per the essential drug list for Primary Health Care, with a mechanism in place for stock control and ordering of stock.
3.3 Medicines and Supplies always in stock, with a mechanism for obtaining emergency supplies when needed.
3.4 A battery and spare globes for auroscopes and other equipment.
3.5 Available electricity, cold and warm water.

4. Competence of Health Staff

Organising the clinic

4.1 Staff are able to

4.1.1 map the clinic catchment area and draw specific and achievable EHSP objectives set using district goals and objectives as a framework.
4.1.2 Organise outreach services for the clinic catchment area.
4.1.3 Organise the clinic to reduce waiting times to a minimum and initiate an appointment system when necessary.
4.1.4 Train community health care promoters to educate caretakers and facilitate community action.
4.1.5 Plan and implement a district focused and community based activities, where health workers are familiar with their catchment area population profile, health problems and needs and use data collected at clinic level for this purpose.

Caring for patients

4.2 Staff are able to follow the disease management protocols and standard

treatment guidelines, and provide compassionate counselling that is sensitive to culture and the social circumstances of patients.
4.3 Staff are positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.
4.4 Patients are treated with courtesy in a client-oriented manner to reduce the emotional barriers to access of health facilities and prevent the breakdown in communication between patients and staff.
4.5 The rights of patients are observed.

Running the clinic

4.6 A clear system for referrals and feedback on referrals is in place.
4.7 All personnel wear uniforms and insignia in accordance with the MOH specifications.
4.8 The clinic has a strong link with the community, civic organisations, schools and workplaces in the catchment area.
4.9 The clinic is clean, organised and convenient and accommodates the needs of patients' confidentiality and easy access for older persons and people with disability.
4.10 Every clinic has a house keeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse.
4.11 Every clinic provides comprehensive security services to protect property and ensure safety of all people at all times.
4.12 The clinic has a supply of electricity, running water and proper sanitation.
4.13 The clinic has a written infection control policy, which is followed and monitored, on protective clothing, handling of sharps, incineration, cleaning, hand hygiene, wound care, patient isolation and infection control data.

5. Patient Education

5.1 Staff are able to approach the health problems of the catchment area hand in hand with the clinic health committee and community civic organisations to identify needs, maintain surveillance of cases, reduce common risk factors and give appropriate education to improve health awareness.
5.2 Culturally and linguistically appropriate patients' educational pamphlets are available on different health issues for free distribution.
5.3 Appropriate educational posters are posted on the wall for information and education of patients.
5.4 Educational videos in those clinics with audio-visual equipment are on show while patients are waiting for services.

6. Records

6.1 The clinic utilises an integrated standard health information system that enables and assists in collecting and using data.
6.2 The clinic has daily service registers, road to health charts, patient treatment cards, notification forms, and all needed laboratory request and transfer forms.
6.3 All information on cases seen and discharged or referred is correctly recorded on the registers.
6.4 All notifiable medical conditions are reported according to protocol.
6.5 All registers and monthly reports are kept up to date.

6.6 The clinic has a patient carry card or filing system that allows continuity of health care.

7. Community and Home Based Activity

7.1 There is a functioning community health committee in the clinic catchment area.
7.2 The clinic has links with the community health committee, civic organisations, schools, workplaces, political leaders and ward councillors in the catchment area.
7.3 The clinic has sensitised, and receives support from, the community health committee.
7.4 Staff conduct regular home visits using a home visit checklist.

8. Referral

8.1 All patients are referred to the next level of care when their needs fall beyond the scope of clinic staff competence.
8.2 Patients with a need for additional health or social services are referred as appropriate.
8.3 Every clinic is able to arrange transport for an emergency within one hour.
8.4 Referrals within and outside the clinic are recorded appropriately in the registers.
8.5 Merits of referrals are assessed and discussed as part of the continuing education of the referring health professional to improve outcomes of referrals.

9. Collaboration

9.1 Clinic staff collaborate with social welfare for social assistance and with other health related public sectors as appropriate.
9.2 Clinic staff collaborate with health orientated civic organisations and workplaces in the catchment area to enhance the promotion of health.

CORE MANAGEMENT STANDARDS

10. Leadership and planning

10.1 Each clinic has a vision/mission statement developed and posted in the clinic.
10.2 Core values are developed by the clinic staff and posted.
10.3 An operational plan or business plan is written each year.

11. Staff

11.1 New clinic staff are oriented.
11.2 District personnel policies on recruitment, grievance and disciplinary procedures are available in the clinic for staff to refer to.
11.3 The staff establishment for all categories is known and vacancies discussed with the supervisor.
11.4 Job descriptions for each staff category are in the clinic file.
11.5 There is a performance plan/agreement and training plan made and a performance appraisal carried out for each member of staff each year.
11.6 The on-call roster and the clinic task list with appropriate rotation of tasks are posted.
11.7 An attendance register is in use.
11.8 There are regular staff meetings (at least once a month).
11.9 Services and tasks not carried out due to lack of skills are identified and new

training sought.
11.10 In-service training takes place on a regular basis.
11.11 Disciplinary problems are documented and copied to supervisor.

12. Finance

12.1 The clinic, as a cost centre, has a budget divided into main categories.
12.2 The monthly expenditure of each main category is known.
12.3 Under and over spending is identified and dealt with including requests for the transfer of funds between line items where permitted and appropriate.

13. Transport and communication

13.1 A weekly or monthly transport plan is submitted to the supervisor or transport co-ordinator.
13.2 The telephone or radio is working.
13.3 The ambulance are available for urgent patient transport.

14. Visits to clinic by DHMT

14.1 There is a schedule of monthly visits stating date and time of supervisory support visits.
14.2 There is a written record kept of results of visits.

15. Community

15.1 The community is involved in helping with clinic facility needs.
15.2 The community health committee is in place and meets monthly.

16. Facilities and equipment

16.1 There is an up-to-date inventory of clinic equipment and a list of broken equipment.
16.2 There is a list of required repairs (doors, windows, water) and these have been discussed with the supervisor and clinic committee.

17. Drugs and supplies

17.1 Stocks are secure with stock cards used and up-to-date.
17.2 Orders are placed regularly and on time and checked when received against the order.
17.3 Stocks are kept orderly, with FEFO (first expiry, first out) followed and no expired stock.
17.4 The drugs ordered follow EDL principles.

18. Information and documentation

18.1 New patient cards and medico-legal forms are available.
18.2 The laboratory specimen register is kept updated and missing results are followed up.
18.3 Births and deaths are reported on time and on the correct form.
18.4 The monthly PHC statistics report is accurate, done on time and filed/sent.
18.5 Monthly and annual data are checked, graphed, displayed and discussed with staff and the health committee.

18.6 There is a catchment area map showing the important features, location of mobile clinic stops, CHWs and other outreach activities.

iv) SEXUAL AND REPRODUCTIVE HEALTH

SERVICE DESCRIPTION

Reproductive services for women are provided in an integrated comprehensive manner covering preventive, promotive, curative and rehabilitative aspects of care. The focus is on antenatal, delivery, postnatal and family planning care.

NORMS

1. Increase the percentage of pregnant women receiving 4+ antenatal care (ANC) with at least 2 during last trimester from the existing level to at least 90%.
2. Increase the deliveries in institutions by trained birth attendants from the existing level to at least 100%.
3. Reduce the proportion of pre-term deliveries and low birth weight babies by at least 20%.
4. Reduce the proportion of births in women below 16 years and 16-18 years from the existing level.

STANDARDS

1. References, prints and educational materials

1.1 Midwifery protocols
1.2 Contraception protocols
1.3 Policy guideline and service standards
1.4 All circulars and policy guidelines regarding women's health issues
1.6 A library of suitable references and learning material on women's health issues

2. Equipment and special facilities

2.1 Delivery set
2.2 Neonatal resuscitation trolley
2.3 Specula
2.4 Foetoscope
2.5 Women's Health charts

3. Medicines and Supplies

3.1 Ferrous and folic acid tablets
3.2 Oxytocin
3.3 Vit K injections
3.4 Contraceptive barrier methods e.g. condoms
3.5 Vaginal contraceptives e.g. spermicidal jelly
3.6 Intrauterine contraceptive devices
3.7 Injectable hormonal contraceptives
3.8 Oral hormonal contraceptives
3.9 Post-coital contraceptives

4. Competence of Health Staff

4.1 Nurses receive training in the perinatal education programme (PEP), contraception and post-abortion care management.
4.2 Staff are able to take a history and perform a physical examination and tests according to protocols and guidelines.
4.3 Staff provide routine management, observations and service according to the ANC protocol at each step of the pregnancy including at least three visits during pregnancy.
4.4 Staff provide education and counselling to each pregnant woman and partner on monitoring signs of problems (e.g. bleeding), nutrition, child feeding and weaning, STDs / HIV, delivery, newborn and child care, advanced maternal age, family planning and child spacing.
4.5 Staff offer appropriate counselling, advice and service to pregnant women requesting termination of pregnancy.
4.6 At least one member of staff is able to:-

4.6.1 Deliver uncomplicated pregnancies.
4.6.2 Make routine observations according to the postnatal care protocol.
4.6.3 Make usual routine observations and select and prescribe appropriate family planning methods according to national protocol.
4.6.4 Screen, advice and refer infertility cases as per national guidelines.
4.6.5 Conduct breast cancer and cervical screening for women older than 35 years as per protocols.
4.6.6 Conduct home visits to provide support and supervise care.
4.6.7 Provide appropriate adolescent/youth services on family planning, sexuality, health education and counselling.

5. Patient Education

5.1 Information is given to mothers on booking for delivery, child preventive care, education about child feeding and the introduction of solid food.
5.2 Further information is given to mothers on the care of breasts, vaginal bleeding and scars, signs of hypertension, diabetes, anaemia, return to usual physical efforts, labour rights, rights of the child and advice on family planning.
5.3 Patients are given group education.
5.4 Patients' relatives and the community receive continuous, appropriate high quality information on the importance of antenatal care and institutional deliveries.
5.5 Information, education and counselling are offered to adolescents and youth.

6. Records

6.1 All information on cases and outcome of deliveries are correctly recorded on the register.
6.2 All registers and monthly reports are kept up to date.

7. Community and Home Based Activity

7.1 The clinic has sensitised, and receives support from, the community health committee about the positive encouragement of attendance at clinic of all pregnant women.
7.2 Staff conduct regular home visits using a home visit checklist.

8. Referral 8.1 All referrals within and outside the clinic are motivated and indications for referral written clearly on the referral form. 8.2 Patients with need for additional health or social services are referred according to protocols.
9. Collaboration 9.1 Clinic staff collaborate with social welfare for social assistance and other role players. 9.2 Clinic staff collaborate with clinic health committee, the civic organisations and workplaces in the catchment area to enhance health promotion.

v) MANAGEMENT AND PREVENTION OF INFERTILITY

SERVICE DESCRIPTION

Genetic services are forming part of the integrated maternal, child and women's health care. It aims to assist individuals with a genetic disadvantage to live and reproduce as normally and responsibly as possible .The components include clinical diagnostic services, counselling, laboratory support, prevention strategies and public awareness campaigns in collaboration with NGOs, CBOs and other government sectors.

NORMS

1. At least one clinic staff member trained to recognize, counsel, treat manage and refer most common conditions.
2. Clinic staff receive regular genetic training and update from the regional genetic coordinator.
3. Clinic staff receive support from visiting specialist, clinical geneticist and other academic experts.

STANDARDS

1. References, prints and educational materials

1. The clinic has the latest copy of the Human Genetics Guidelines for Management and Prevention of Genetic Disorders, Birth Defects and Disabilities.

2. Equipment

2.1 .

3. Medicines and Supplies

3.1 List of drugs in accordance with the Essential Drugs List

4. Competence of Health Staff

4.1 At least one clinic staff is able to recognize, counsel, treat, manage and refer most common genetic conditions

5. Referral

5.1 Referrals for further support as per guidelines

6. Patient Education

6.1 Provide posters, pamphlets and other educational materials on genetics for patients.
6.2 All patients and caretakers receive health education on genetic disorders, birth defects and disabilities.
6.3 Encourage women to procreate at the ideal reproductive age (25-35 years) to reduce the risk of chromosomal abnormalities.
6.4 Educate women to avoid exposure to teratogens during pregnancy e.g. alcohol, recreational drugs and certain chemical and infecting agents.

7. Records

7.1 Notification forms to notify genetic disorders and birth defects in the immediate post-natal period and later in life.

8. Community Based Services

8.1 Clinic staff to work with NGOs and CBOs to support affected individuals and families at community level.

9. Collaboration

9.1 Clinic staff collaborate with social workers, physiotherapists, speech therapists and other support staff to provide comprehensive care.
9.2 Clinic staff to work with school teachers, and other NGOs and CBOs to provide information and raise awareness on genetic disorders, birth defects and disabilities.

vi) INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

SERVICE DESCRIPTION.

Promotive, preventative (monitoring and promoting growth, immunisations, home care counselling, de-worming and promoting breast feeding), curative (assessing, classifying and treating) and rehabilitative services are given in accordance with IMCI protocols at all times that the clinic is open.

NORMS

1. Reduce the infant and under-5 mortality rate by xx% and reduce disparities in mortality between population groups.
2. Reduce mortality due to diarrhoea, measles and acute respiratory infections in children by xx%, xx% and xx% respectively.
3. Increase full immunisation coverage among children of one year of age against diphtheria, pertussis, Hib, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to 100% in all districts.
4. Continue poliomyelitis free Botswana.
5. Increase regular growth monitoring to reach xx% of children <2 years.
6. Increase the proportion of mothers who breast-feed their babies exclusively for 4-6 months, and who breast-feed their babies at 12 months.
7. Reduce the prevalence of under weight-for-age among children <5 years to xx%.
8. Reduce the prevalence of stunting among children <5 years to xx%.
9. Reduce the prevalence of severe malnutrition among children <5 years to under 1%.
10. Eliminate micro nutrient deficiency disorders.
11. All children treated at the clinic are treated according to IMCI Guidelines.
12. Every clinic has at least two staff members, who have had the locally adapted IMCI training, based on the WHO/UNICEF Guidelines.
13. Every clinic has a rehydration corner.
14. A supervisor, who also evaluates the degree of community involvement in planning and implementing care, undertakes a six monthly assessment of quality of care.

STANDARDS

1. References, Prints and Educational Materials

1.1 Wall charts and booklets.
1.2 A copy of the IMCI Standard Treatment Guidelines.
1.3 Growth Monitoring Charts to supply to new-borns and children without charts.
1.4 Copies of the National Essential Drugs List and Standard Treatment Guidelines.

2. Equipment

2.1 An oral rehydration corner set up for immediate rehydration.
2.2 Emergency equipment available for intravenous resuscitation of severely dehydrated children.

3. Medicines and Supplies

3.1 The clinic has litre measures and teaspoon measures, cups for feeding, sugar and salt (for the child that is not dehydrated) and rehydration powder (for the dehydrated child).

3.2 Drugs, vaccines and other medical supplies as per IMCI protocol

4. Competence of Health Staff

4.1 Every clinic has nurse practitioners able to treat clients in accordance with the IMCI guidelines.
4.2 IMCI trainer makes regular mentoring/supervision visits, initially 6 weeks after training, thereafter every 3 months.
4.3 Each clinic has an annual review of quality of care by IMCI Supervisor.
4.4 At least one member of staff takes overall responsibility for the assessment and management of the child.
4.5 Staff are able to establish trust and credibility through respect, courtesy, responsiveness, confidentiality and empathy, approaching consultations in a patient-centred way.
4.6 Staff are able to organise and implement an effective triage system for clients attending the clinic based on the IMCI protocol.

5. Referrals

5.1 Children with danger signs and/or severe disease are referred as described in the IMCI provincial protocol.

6. Patient Education

6.1 The mother or caregiver is counselled in accordance with the IMCI counselling guidelines.
6.2 Key family/household practices to improve child health are promoted as described in the IMCI community component.

7. Records

7.1 An adequate patient record system is in place, using the child-health chart as the basic tool.
7.2 Patient details are recorded using the IPMS.

8. Community and Home Based Activity.

8.1 This takes place in line with the IMCI Guidelines for the Community Component.
8.2 The clinic works in close co-operation with community-based health programmes like community health worker schemes or care-groups.

9. Collaboration

9.1 Clinic staff collaborate with social workers, NGOs, CBOs, crèches and other sectors to improve child health.

vii) MANAGEMENT OF ARI

SERVICE DESCRIPTION

This service aims at managing chronic asthma in infants, children and adults with treatment schedules for either mild or moderate to severe asthma. The service can also recognize, assess initiate treatment and refer emergency situations of acute bronchospasm associated with asthma and chronic obstructive bronchitis.

NORMS

Reduced incidence of emergency referrals due to asthma.

STANDARDS

1. References, prints and educational materials

1.1 Each clinic has the protocols and policy documents on management of acute and chronic persistent asthma.
1.2 Standard treatment guidelines and essential drugs list manual
1.3 Education materials for patients on allergy and avoidance of allergens and on the use of inhalers with or without spacers

2. Equipment

2.1 See clinic core standards
2.2 Oxygen and nasal catheters for children and masks for adults

3. Medicines and Supplies

3.1 As per the EDL

4. Competence of Health Staff

4.1 The clinic staff are able to diagnose and treat attacks of bronchospasm and give appropriate health education as per EDL.
4.2 The clinic staff able to take complete patient and family histories on episodes o per week, night time or wheeze, number of times inhalers are used per week and identify possible allergens and other irritants.
4.3 Clinic staff are able to optimize treatment using peak expiry flow rates and give psychological support before referral for further care.
4.4 Staff are able to use inhalers with spacers and masks for infants and small children.
4.5 Clinic staff can interact with caretakers and family of patients to ensure improved control of asthma with emphasis on prevention and early management.

5. Referrals

5.1 Refer to assess and confirm diagnosis when in doubt and to optimise therapy.
5.2 Refer severe non-responding attacks of bronchospasm
5.3 Refer pregnant women with worsening asthma

5.4 Refer patients presenting with repeated asthma exacerbations
5.5 Refer patients with previous life threatening exacerbations
5.6 Refer if there are unsatisfactory social and personal factors such as inadequate access to health care, unavailable transport, difficult home conditions or difficulty with the home management plan

6. Patient Education

6.1 All patients and caretakers attending the service receive health education on prevention of exposure to known allergens and inhaled irritants such as cigarette smoke or allergens in animals, nuts or drugs.
6.2 The use and technique of inhalers is taught and demonstrated
6.3 Carers and patients understand the safety of continuous regular therapy and need for follow up

7. Records

7.1 Clinic records are kept up to date with history of episodes, rate of use of drugs and inhalers, identified allergens and periodic PEFR recorded.

8. Community Based Services

8.1 Conduct educational campaigns in school and community during pollen grain seasons
8.2 Community based programmes stress the need for smoke free environment and give guidelines on reducing common household allergens

9. Collaboration

9.1 Staff collaborate with other departments like Environmental health, Education and other sectors to educate and support sufferers and their caretakers.

viii) VACCINE PREVENTABLE DISEASES

SERVICE DESCRIPTION

Immunization is an essential service that is available whenever the clinic is open and based on an uninterrupted and monitored cold chain of constantly available vaccines.

NORMS

1. All clinics provide immunisations at least for 5 days a week and if the community desires additional periods specifically for child health promotion and prevention.
2. Every clinic has a visit from the Child Health Co-ordinator every 3 months to review the EPI coverage, practices, vaccine supply, cold chain and help solve problems and provide information and skills when necessary.
3. Every clinic has a senior member of staff trained in EPI who acts as a focal point for EPI programmes.

STANDARDS

1. References, prints and educational materials

1.1 Copies of the latest editions of EPI Vaccinators Manual.
1.2 Copies of the Cold Chain and Immunisation and Operations Manual.
1.3 Copies of the Technical guidelines on immunisation in Botswana.
1.4 Copies of the EPI Disease Surveillance Guide.
1.5 Copies of the current circulars on particular aspects, e.g. acute flaccid paralysis, flu virus, Haemophilus influenzae type b (HiB surveillance, Adverse Events Following Immunisation (AEFI) investigation and reporting.
1.6 Patient and community information pamphlets in appropriate languages.
1.7 Copies of the EPI Posters and other EPI disease and schedule promotional materials.

2. Equipment

2.1 Correct needles and syringes according to Vaccinators manual.
2.2 A working refrigerator, properly packed, with thermometer and temperature recorded and a spare gas cylinder if gas operated.

3. Medicines and Supplies

3.1 An uninterrupted and monitored cold chain of constantly available vaccines as recommended by EDL.

4. Competence of Health Staff

4.1 Staff are able to :-

4.1.1 Routinely perform correct immunisation practices according to protocol. Vaccines are checked periodically to ensure no frozen DPT, HBV, TT, HIB and none out of date or indicators showing expiry.
4.1.2 Provide mothers with correct knowledge of what is needed for the child, what is given and possible side effect and when to return for the next immunisation.
4.1.3 Provide group education for mothers and antenatal care attendants.
4.1.4 Follow up suspected cases of measles at home to determine the extent of a possible outbreak.
4.1.5 Take steps to increase coverage using the self-generated vaccination coverage graph (available in the Vaccinators manual) to address progress during the year.
4.1.6 Implement correct disposal of sharps.
4.1.7 Initiate post exposure prophylaxis for HIV in case of needle stick.
4.1.8 Ensure all reported and notified AFP, measles, NNT and AEFI cases are reported to Child Health Coordinator and followed up within 48 hours by district investigation team of which the nurse in clinic is a co-opted member.
4.1.9 Organise immunisation service as a daily component of EHSP and to minimise waiting/queuing times.
4.2 Community health committees are given the lay case definitions of acute flaccid paralysis, measles and neonatal tetanus and urged to report suspected cases immediately.
4.3 The clinic has a good relationship with the Environmental Health Officer for assistance in outbreaks investigations.
4.4 Ensure that appropriate laboratory specimens are taken for the investigation of all AFP, NNT, measles and AEFI investigations are taken or else referred to the nearest hospital where specimens can be taken.
4.5 A 24 hour toll free number for notification - is on the clinic wall.
4.6 All HIV positive children must be immunised with all vaccines except for BCG in children with symptomatic AIDS.
4.7 Clinics arrange mass immunisation or mopping up campaigns in their communities as required by the DHMT.
4.8 Remote villages have mobile outreach sessions to provide routine services and to improve coverage where necessary.
4.9 Reduce missed opportunities and ensure that ill children and women in the childbearing age are immunised as appropriate.

5. Referrals

5.1 Children with signs and symptoms of the EPI priority diseases (AFP, measles, NNT and AEFI) are referred as in the IMCI protocol.

6. Patient Education

6.1 All clients attending clinics for immunisation services receive the appropriate health education, information and support.

7. Records 7.1 Patient records and patient notification forms. 7.2 Monthly immunisation statistics. 7.3 Case investigation forms for flaccid paralysis. 7.4 Case investigation forms for measles. 7.5 Case investigation forms for neonatal tetanus. 7.6 Case investigation forms for adverse events following immunisation. 7.7 Supply of child road to health charts.
8. Community Based Services 8.1 Communities participate in campaigns and national health days. 8.2 Clinic staff follow up suspected cases of measles at home to determine extent of outbreak.
9. Collaboration 9.1 Staff collaborate with other departments like education and other sectors to promote immunization and improve coverage.

ix) ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

SERVICE DESCRIPTION

Adolescents are aged between 10-19 years and youths between 15-24 years as defined by the WHO. The services provided to these specific groups are tailored to ensure a holistic approach with emphasis on special needs.

NORMS

1. Regular visits by SRH coordinator to review health services for adolescents and youth.
2. Staff has continuing professional education on needs of youth and adolescents.

STANDARDS

1. References, prints and educational materials

1.1 Clinic has a copy of rights of the child.
1.2 All legislation relevant to youth and adolescents is kept in the clinic.
1.3 List of relevant NGOs, CBOs and community youth organisations in district.
1.4 IEC materials and a library of youth related materials.

2. Equipment

2.1 Adequate equipment suitable for a youth friendly service catering for the health needs of this group.

3. Medicines and Supplies

3.1 Provided according to EDL.
3.2 Condoms are placed in areas where it is not necessary to ask for them and where they can be taken without being watched

4. Competence of Health Staff

4.1 Staff are able to

4.1.1 Map catchment area and if relevant prisons, orphanages, street children shelters, sports fields, schools and NGOs.
4.1.2 Provide accessible youth friendly services with times or days to suit youth.
4.1.3 Encourage youth to ask questions and seek information.
4.1.4 Communicate well and avoid asking intrusive, irrelevant questions.
4.1.5 Know and work well with youth organisations, sports coaches, teachers, and police in the catchment area of clinic.
4.1.6 Educate parents about parenting and provide guidance on improving intra-family and community relationships.

4.2 Clinic have at least one member of the staff competent in counselling and able to assist an individual (or group) to gain an understanding of the situation and make

and implement appropriate decisions.
4.3 Staff ensure no opportunity is missed to assist youth in managing fertility and preventing STDs and HIV/AIDS.
4.4 Staff involves adolescent and youth in planning and implementation of services.

5. Referrals

5.1 Referred according to protocols for the relevant conditions.
5.2 Ensure a mechanism for feedback of referred cases

6. Patient Education

6.1 Assist in organizing and participate in awareness campaigns on relevant adolescent and youth health issues
6.2 Involve youth in peer education and support peer education
6.3 Supply of patient information pamphlet on:

6.3.1 Growth and development
6.3.2 Gender specific needs of adolescents
6.3.3 Oral care
6.3.4 Nutrition
6.3.5 risks to health of alcohol, smoking, drugs
6.3.6 safe sex, condom use
6.3.7 STD, HIV, AIDS, TB

7. Records

7.1 Staff use information system records to analyse conditions affecting youth (e.g. STD, accidents, infected circumcisions, sports injuries, behaviour problems, teenage pregnancy, TOP, rape, sexual abuse, etc).
7.2 There is a register of disabled youth that indicates all dates of efforts to improve rehabilitation and refer to special school.
7.3 Record is kept of occupational problems of youth in the area e.g. sex work, domestic work, agricultural work etc.

8. Community Based Activity

8.1 Staff are aware of community based initiatives aimed to prevent and respond to problems of youth.

9. Collaboration

9.1 Clinic staff work with social workers, social structures, NGOs and CBOs on adolescent and youth health issues including children at risk problems (adolescents and the law, poor hygiene, sexual abuse, glue sniffing, etc).
9.2 Staff collaborate with other sectors to improve youth health especially with teachers in schools in setting up a child-to-child programme.

x) MANAGEMENT OF COMMUNICABLE DISEASES

SERVICE DESCRIPTION

This chapter deals with the management of communicable diseases in general with the emphasis on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death. Separate chapters deal with Tuberculosis, HIV infection and AIDS, sexually transmitted diseases, cholera, rabies, leprosy, shigella dysentery and malaria. These are the diseases, which are either priority national public health diseases or are ones associated with the possibility of causing outbreaks. The communicable diseases, which are included in the Botswanan Expanded Programme of Immunisation, and scabies, are dealt with separately under childhood diseases.

NORMS

1. All clinics are supervised every three months by the DHMT.
2. All clinics send to the local authority or district health office an immediate telephonic report of acute flaccid paralysis or cholera.
3. Cases referred as notifiable diseases to hospital are notified by the hospitals on a weekly basis.
4. All clinics send an individual notification to the DHMT as soon as possible.
5. Monthly report on deaths from a notifiable disease are notified.

STANDARDS

1. References, Prints and Educational Materials

1.1 Each clinic has the protocols and policy documents on communicable Diseases and every 6 months reviews them with the DHMT.

2. Equipment

2.1 See clinic generic equipment

3. Medicines and Supplies

3.1 As per EDL

4. Competence of Health Staff

4.1 All clinics have a book of notifiable disease forms and complete a form for every notifiable disease. Cases confirmed in hospital send a copy back to the clinic.
4.2 When the district office receives a notification the communicable disease control co-ordinator initiates a response, together with the relevant DHMT officer and the local clinic staff. The Infection Control Nurse of the Hospital and in the case of an outbreak, the outbreak teams and the laboratory are also involved.
4.3 The clinic staffs are able to commence action by taking more complete patient and family histories and by visiting the home and environment to identify other cases and causes which can be prevented. Clinic staff are responsible for stabilising cases before hospitalisation and for taking initial specimens for the

laboratory. 4.4 Clinic staff can interact with community health committees to maintain surveillance for cases and to ensure control measures after suitable education. 4.5 The emphasis is always on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death. 4.6 In endemic areas for Malaria, and neglected tropical diseases receive extra protocols on management from the DHMT.
5. Referrals 5.1 All cases
6. Patient Education 6.1 All patients attending the service receive health education.
7. Records 7.1 Clinic records of communicable diseases are kept up to date.
8. Community Based Services 8.1
9. Collaboration 9.1 Staff collaborate with other departments like Environmental health, Education and other sections within health like Health Promotion.

xi) DIARRHOEAL DISEASE CONTROL

SERVICE DESCRIPTION

Diarrhoeal disease control is an essential daily element of clinic services as well as an element in outbreak prevention and control.

NORMS

1. Every clinic considers itself part of the Diarrhoeal Disease Control Programme.
2. All staff are trained in the management of diarrhoeal disease and have continuing education every 6 months or when there are reports of cholera outbreaks in neighbouring countries or regions.
3. Every clinic is able to contact and works with the environmental health officer in whose area it falls.
4. Reduce mortality due to diarrhoea in children by xx%

STANDARDS

1. References, prints and educational materials

1.1 The clinic has the latest copy of Guidelines for Diarrhoeal diseases Control.

2. Equipment

2.1 Lab supplies and protocol for stool collection.

3. Medicines and Supplies

3.1 List of drugs in accordance with the Essential Drugs List
3.2 The clinic maintains a buffer supply of ORS and intravenous fluids.
3.3 Clinic staff know where extra stocks can be obtained quickly in case of emergency

4. Competence of Health Staff

4.1 Staff have knowledge of the clinical presentation of diarrhoeal diseases and cholera and refer severe cases to hospital having first starting rehydration. Less severe cases are managed at clinic level with oral rehydration.
4.2 Clinic staff are able to manage cases of diarrhoea and dehydration daily during epidemics.
4.3 There is always a state of preparedness for an outbreak of cholera by maintaining a buffer supply of ORS with zinc and intravenous fluids.
4.4 Staff are able to recognise the clinical presentation of cholera.
4.5 Suspected cases are reported immediately by phone or other communication method.
4.6 Oral rehydration (with ORS sachets) are used and the patients state of dehydration is monitored while having the ORS.
4.7 Clinic staff encourage use of salt and sugar home-prepared solution when ORS sachets are not available.
4.8 Staff know that cholera infection can be asymptomatic or cases can be mild and

indistinguishable from other diarrhoea.

5. Referrals

5.1 All severely dehydrated cases should be referred to hospital

6. Patient Education

6.1 All patients and caretakers receive health education on oral rehydration therapy, refuse disposal and cleanliness.

7. Records

7.1 Patient's records are kept up to date.
7.2 A weekly chart is kept in clinics showing diarrhoea cases under 5 and cases over five and any undue rise especially of cases over 5 is reported to the DHMT.

8. Community Based Services

8.1 Education is carried out in the community on hygiene, latrine use, hand washing, food safety, boiling of water and milk, chlorination of drinking water if feasible, use of tap water or delivered tanker supplies during an epidemic.
8.2 The value of breast-feeding as a preventive measure is a permanent part of the clinics community health education programme.

9. Collaboration

9.1 Staff collaborate with other departments like Environmental health, Education and other sections within health like SRH, Health Promotion.

xii) SEXUALLY TRANSMITTED INFECTIONS (STI)

SERVICE DESCRIPTION

The prevention and management of STI is a service available daily at a clinic and is a component of services for reproductive health and for control of HIV/AIDS.

NORMS

1. Every clinic has a review of quality of care once a year by a supervisor.
2. Every clinic has at least one member of staff but preferably all professional staff trained in the management of STI using the "Syndromic Management of Sexually Transmitted Infection".
3. Every clinic has at least one member of staff (but preferably all who have been trained for STI) trained as a counsellor for HIV/AIDS/STI.

STANDARDS

1. References, prints and educational materials

1.1 Standard Treatment Guidelines and Essential Drug List, latest edition.
1.2 Syndromic Case Management of Sexually Transmitted Diseases.
1.3 Supplies of patient information pamphlets on STI.
1.5 Posters on STI and condoms.
1.6 Wall charts of the protocols of STI management in consultation rooms.

2. Equipment

2.1 A condom dispenser placed in a prominent place where condoms (with pamphlets on how to use) can be obtained without having to request them.
2.2 Examination light or torch for every room with a screened examination couch.
2.3 Sterile specula (specula plus steriliser).

3. Medicines and Supplies

3.1 List of drugs in accordance with the Essential Drugs List and latest management protocols.
3.2 A supply of male condoms with no period where condoms are out of stock.
3.3 Gloves.
3.4 Dildos – at least one per clinic but preferably one per consulting room.

4. Competence of Health Staff

4.1 Clinic staff provide STI management daily and have extended hours, or on call weekend time, if in an urban or semi-urban area.
4.2 The staff are adolescent friendly with friendly communication so as to be accessible and acceptable to shy patients whether male or female.
4.3 Patients have friendly, non-judgemental, confidential private consultations.
4.4 Staff are able to take a history and examine patients correctly with dignity respected when all patients have skin, mouth, genital and peri-anal areas examined.

4.5 The history is taken correctly and partner change inquired about (the gender of partners is not presumed).
4.6 Syphilis serology is done on all patients with STI - and twice in pregnancy using RPR.
4.7 Pap smears are done on women over 45 or with a history of vulval warts.
4.8 Patients are counselled on safe sex and HIV/AIDS is explained to them.
4.9 Treatment is according to the protocol for each syndrome.
4.10 Condom use is demonstrated and condoms provided.
4.11 Contact cards are given and reasons explained so that at least xx% result in the contact coming for treatment.

5. Referrals

5.1 All patients are referred to the next level of care when their needs fall beyond the scope of competence.
5.2 Conjunctivitis in the newborn is referred after initial treatment.
5.3 The patient is referred if pregnant and has herpes in the last trimester.
5.4 Pelvic inflammatory disease is referred if patient is sick, has pyrexia and tachycardia, or severe tenderness, or is pregnant.
5.5 A painful unilateral scrotal swelling age under 18 is referred immediately for a surgical opinion regarding a possible torsion.

6. Patient Education

6.1 All patients receive health education on asymptomatic STI, misconceptions, rationale of treatment, compliance and return visit.
6.2 Time is given during counselling and discussion after treatment about the need for contacts to be treated.
6.3 If the patient's syndrome is vaginal discharge the possibility of it not being sexually transmitted is discussed.
6.4 If pregnant then implications for the baby are discussed (congenital syphilis, ophthalmia, HIV, chlamydia).
6.5 The importance of condom use is stressed.

7. Records

7.1 Patient's records are kept according to protocol with confidentiality stressed.
7.2 Laboratory registers with return time for laboratory specimens not greater than 3 days.
7.3 A register is kept of contact cards issued and returned.
7.4 Partner notification cards are in local languages.

8. Community Based Services

8.1 Staff Liaise with traditional healers about the care of STIs.

9. Collaboration

9.1 Staff collaborate with different departments such as schools, churches, traditional healers and community organisations implementing health promotion activities leading to the prevention of STI.

xiii) HIV/AIDS

SERVICE DESCRIPTION

A comprehensive range of services is provided including the identification of possible cases, testing with pre-and post-counselling, the treatment of associated infections, referral of appropriate cases, education about the disease to promote better quality of life and promotion of universal precautions with the provision of condoms and the application of occupational exposure policies including needle stick injury.

NORMS

1. The clinic is supervised every three months by the HIV Co-ordinator and a Senior Infection Control Nurse of the hospital.
2. Every three months have a visit by a laboratory technologist for quality control on RPR and Rapid HIV testing.
3. At least one professional nurse will attend an HIV/AIDS/STI/TB workshop or other continuing education event on HIV/AIDS each year.

STANDARDS

1. References, prints and educational materials

1.1 HIV/AIDS Strategic Plan for Botswana current.
1.2 Summary results of the last Serological Survey on women attending public health services in Botswana.
1.3 Management of Occupational Exposure to Human Immunodeficiency Virus (HIV).
1.4 Paediatric HIV/AIDS Guidelines.
1.5 HIV/AIDS Clinical Care Guidelines for Adults.
1.6 Epidemiological Notes - relating to HIV/AIDS.
1.7 Strategies to reduce Mother to Child Transmission of HIV and other infections during Pregnancy and Childbirth.
1.8 HIV/AIDS Guidelines for home based care.
1.9 Policy guidelines and recommendations for feeding of infants of HIV positive mothers.
1.10 AIDS pamphlets in the local language.
1.11 Posters on HIV/AIDS/STI in the local languages and preferably depicting local culture settings.

2. Equipment

2.1 Laboratory equipment for RPR and Rapid HIV.

3. Medicines and Supplies

3.1 Gloves and protective aprons and goggles
3.2 Condoms - male and dildo, female condoms
3.3 Post exposure prophylaxis of occupationally acquired HIV exposure e.g. needle stick injuries with HIV positive blood in accordance with the recommendations of

the Essential Drug List.

4. Competence of Health Staff

Knowledge and attitudes

4.1 Staff know the contents of the guidelines on Management of Occupational Exposure to Human Immunodeficiency Virus.
4.2 Staff relate to patients in a non-discriminatory and non-judgemental manner and maintain strict confidentiality about patient's HIV status.
4.3 Staff are familiar with regulations and mechanisms to deal with confidentiality in notifying patients with AIDS disease or AIDS deaths.
4.4 Staff provide warm, compassionate, counselling on a continuous basis and which is sensitive to culture, language and social circumstances of patients.
4.5 Staff are aware of the effects of factors such as unprotected sexual intercourse, multiple sexual partners, poverty, migrant labour, women's socio-economic conditions, lack of education, the high incidence of STD, lack of recreational facilities, violence and rape, drugs and alcohol, discrimination, lack of relevant knowledge in relation to HIV transmission in the clinics catchment area.
4.6 Staff are aware of the social consequences (orphans, loss of work, family, disruptions, youths schooling and careers) of AIDS.
4.7 Staff seek to reduce fear and stigma of HIV/AIDS.
4.8 Staff provide youth friendly services that help promoting improved health seeking behaviour and adopting safer sex practices

Skills

4.9 Staff are able to

4.9.1 Take a good history including a sexual history, after establishing a trusting relationship.
4.9.2 Undertake a physical examination according to guidelines checklist in good lighting and in privacy.
4.9.3 Do pre and post test counselling after informed consent and take laboratory specimens for HIV (two separate blood specimens), and RPR.
4.9.4 Perform, after training, rapid HIV and RPR tests in those remote clinics where this has been set up.
4.9.5 Continue counselling at suitable times when more time can be allocated.
4.9.6 Promote optimal health and safer sexual practices (wellness management to include mental attitude, nutrition, healthy lifestyle, vitamins, no drugs or alcohol, avoidance of re-infection with HIV and STD by practising safer sex, early treatment if infectious including TB).
4.9.7 Assess the prognosis of HIV to AIDS by recognising and diagnosing the common opportunistic infections.
4.9.8 Diagnose acute pneumonia and start on cotrimoxazole or other antibiotic while arranging referral for admission.
4.9.9 Refer to Tuberculosis and HIV/AIDS clinical guidelines and initiate directly observed tuberculosis treatment after obtaining positive sputum results or send for x-ray when in doubt and also send sputum for culture, while starting INH prophylaxis 300mg daily
4.9.10 Offer periodic check-ups, including weight, to all HIV cases.

4.9.11 Discuss voluntary HIV testing with patients with STD or TB, and get consent forms signed.
4.9.12 Counsel cases of rape and offer HIV test after informed consent and pre- and post test counselling.
4.9.13 Use universal precautions.
4.9.14 Use policy guidelines and recommendations for feeding infants of HIV positive mothers and assess mothers' circumstances and counsel appropriately and abide with mothers' rights to choose after informed counselling.
4.9.15 Know all community structures in the clinic catchment area that can assist HIV positive mothers and infants and be able to differentiate between slow and rapid progressors.
4.9.16 Provide education, counselling and supportive care for child and child carer (including treatment of intercurrent illness, advise about feeding, Road to Health chart, immunisation, Vitamin A) and facilitate access to social services.
4.9.17 Collaborates with traditional healers on HIV/AIDS
4.10 All clinic staff (professional and cleaning/laundry) are immunised against Hepatitis B.

5. Referrals

5.1 Refer cases of Herpes zoster, oesophageal candidiasis and severe persistent diarrhoea (after trial of symptomatic treatment).
5.2 Refer suspected TB cases with negative sputum for further investigation

6. Patient Education

6.1 All education vigorously addresses ignorance, fear and prejudice regarding patients with HIV/AIDS attending clinics.
6.2 Increase acceptance and use of condoms among the youth and other sexually active populations

7. Records

7.1 Patient's records are kept according to protocol with emphasis on confidentiality.

8. Community Based Services

8.1 The clinic has a working relationship with Community Health Committees, political leaders, councillors, NGOs and CBOs in the catchment area of the clinic.
8.2 Clinics keep track of HIV positive patients in their catchment areas while keeping information confidential.
8.3 Staff help in meeting needs of the individual and family - preventing problems, assisting in care and knowing when and where to seek assistance.
8.4 Staff inform and train family and community groups in home-based care.
8.5 Staff seek to de-stigmatise HIV disease in community through education.
8.6 Staff assist in integrating home based care services from industry, traditional organisations, church, NGO, welfare, and provide guidelines to community health committees on situation analysis and needs assessment in the community.
8.7 Staff work with traditional healers on improved advocacy of HIV/AIDS and STIs.
8.8 Staff provide simple home kits if possible.
8.9 Staff undertake home visits to supervise care and provide support.

9. Collaboration

9.1 Staff collaborate with other departments like education and other sectors.
9.2 Staff collaborate with Community Health Committees, political leaders, ward councillors, NGOs and CBOs in the catchment area of the clinic.
9.3 Staff collaborate with traditional healers in the clinic catchment area

xiv) MALARIA

SERVICE DESCRIPTION

Botswana has an effective control programme for malaria although seasonal outbreaks occur in endemic areas. In addition to public health measures treatment of cases aims at preventing mortality and complications and eliminating parasitaemia to minimise transmission.

NORMS

1. Members of the DHMT visit clinics in endemic areas every month during spraying activities throughout the year.
2. During peak transmission times visits are more frequent.

STANDARDS

1. References, prints and educational materials

1.1 Malaria Control Policy in Botswana – Latest version.
1.2 Latest Guidelines for the Prophylaxis of Malaria.
1.3 Latest Guidelines for the Treatment of Malaria.
1.4 Pamphlets on Malaria control Programme.
1.5 Pamphlets on Malaria diagnosis and treatment and prevention.
1.6 Posters in local languages.

2. Equipment

2.1 Laboratory equipment – rapid diagnostic tests on microscopic slides of blood smears.

3. Medicines and Supplies

3.1 List of drugs in accordance with the Essential Drugs List.

4. Competence of Health Staff

4.1 Staff receive training and periodic continuing education on malaria control and malaria clinical management.
4.2 Staff know if the clinic is in an endemic area.
4.3 Staff know the highest transmission period and its relation to rainfall and abnormal seasonal patterns.
4.4 Staff keep a high level of suspicion of fevers, persons coming from other endemic countries and are thus capable of making early diagnosis to offer rapid treatment.
4.5 Staff regard all Batswana as non-immune and prone to severe complications.
4.6 Staff provide information on personal preventive measures and prophylactic treatment to travellers and tourists in high risk areas.
4.7 Staff treat suspected uncomplicated malaria as per malaria protocol.
4.8 Staff refer urgently to hospital all suspected severe cases.
4.9 Staff confirm diagnosis with blood test either by blood smear for microscopy to

laboratory or rapid diagnostic tests.
4.10 Staff repeat blood test if negative and symptoms persist.

5. Referrals

The following are referred:

5.1 All children after initial treatment with tepid sponging and rehydration.
5.2 Patients not responding to treatment within 4 days.
5.3 Patients with symptoms of severe and complicated malaria (recording blood glucose, weight and what treatment if any already given on the referral form).
5.4 Pregnant patients.
5.5 Patients with skin reactions to treatment.

6. Patient Education

6.1 All patients receive in high risk areas health education on preventative measures: use of impregnated bed nets/curtains, use of repellents on skin, aerosols, coils, vaporisers with insecticides, use of prophylactic drugs and about continuing precautions all year.
6.2 Clinic staff discuss the purpose of vector control measures and house spraying and larval control in endemic areas, reasons for active detection of cases and treatment in homes by malaria control field teams.

7. Records

7.1 Patients records are kept up to date.
7.2 All confirmed cases of malaria are notified to the malaria control programme.

8. Community Based Services

8.1 Clinic staff co-operate with the Malaria Control team and Environmental Health Officers by recording community responses to residual insecticide spraying and any social changes (e.g. influx of migrant workers).

9. Collaboration

9.1 Clinic staff collaborate with other departments like environmental health, water affairs and education.

xv) TUBERCULOSIS

DESCRIPTION OF SERVICE

Following national protocols, the clinic staff diagnose TB on clinical suspicion using sputum microscopy, provide IEC and active screening of families of patients with TB, promote voluntary HIV testing, treat, dispense and follow-up using DOT and complete the TB register.

NORMS

1. Achieve a minimum of xx% cure rate of new sputum positive TB cases.
2. Achieve a passive case finding rate per 100,000 population to be defined.
3. Achieve two days turn around times of sputum results in more than 90% of cases.
4. Every clinic has at least one staff member who has or has had opportunities for continuing education in TB management.
5. Receive a six monthly assessment of quality of care by a supervisor who also evaluates the degree of community involvement in planning and implementing care.

STANDARDS

1. References, prints and educational materials

1.1 The latest edition of the TB training manual for health workers.
1.2 The TB control programme guidelines.
1.3 TB register manual, latest edition.
1.4 A resource list of HIV/AIDS services.
1.5 DOTS and training material.
1.6 Leaflets and pamphlets.
1.7 TB posters on the walls.
1.8 Flow charts on TB diagnosis

2. Equipment

2.1 Screw top sputum containers

3. Medicines and Suppliers

3.1 Uninterrupted supply of TB drugs recorded on bin cards.
3.2 Clinic knows how to get emergency supplies of TB drugs.
3.3 Combination and single TB tables as per protocols.
3.4 Sterile syringes and needles and water for injection.

4. Competence of Health Staff

Staff are able to

4.1 Initiate and follow up treatment of patient using the latest recommended TB management regimen and protocol.
4.2 Suspect and identify TB by early symptoms such as chronic cough, loss of weight and tiredness.
4.3 Educate with the emphasis on correcting misinformation and seeking to prevent spread of the disease.
4.4 Start direct observed treatment (DOT) supported by volunteers chosen and accepted by the patient.
4.5 Enter all sputum results on TB register and forms.

5. Referrals

5.1 Only patients sick enough to require hospital care are referred for hospitalisation and then sent with a completed TB register form and proposed discharge plan.
5.2 Patients referred to the clinics after discharge from hospital and with a discharge plan are followed up immediately to ensure the discharge plan is effectively implemented.
5.3 Before being transferred to another area the patient receives a completed transfer form and a sufficient supply of medication and when possible the facility to which he/she is transferred is notified by telephone.
5.4 If HIV positive the patient is given a confidential sealed letter with relevant data to give to the new facility.
5.5 Any severe complication of TB or adverse drug reaction is referred for admission.
5.6 Children with extensive TB or gross lymphadenopathy or not improving on treatment are referred.
5.7 Patient with need for additional health or social services are referred as appropriate.
5.8 All cases of MDR TB are referred to the Referral Hospitals.

6. Patient Education

6.1 Patients, relatives and the community receive high quality information on TB.
6.2 Patients are given group education each month when their situation is reviewed.
6.3 Patients are educated about HIV/AIDS/STDs in addition to TB so that they can recognise predisposing conditions and so prevent them.

7. Records

7.1 As TB is a notifiable disease the cases are correctly classified by location of disease, result of sputum smear and by the treatment regimen.
7.2 All registers, smear conversion rate forms and quarterly reports are kept up to date.

8. Community Based Services

8.1 The clinic has an agreement with resulting support from the community about

the use of DOT. 8.2 The quality of DOT management within the clinic and the community-based health volunteers are monitored and evaluated quarterly. 8.3 Active case finding is done on all chronic cough patients and TB contacts through home visits.
9. Collaboration 9.1 The clinic collaborates with social welfare for social assistance. 9.2 Staff collaborate with NGOs, schools and workplaces in the catchment area to enhance the promotion of TB prevention and care.

xvi) NEGLECTED TROPICAL DISEASES INCLUDING LEPROSY

SERVICE DESCRIPTION

The service provides multi drug treatment to rapidly cure patients, interrupt further transmission and make elimination of the disease a global possibility.

NORMS

1. Decrease the current prevalence of leprosy in order to move towards its eradication.
2. Each clinic has each year at least one staff member who has had some continuing training in Leprosy from a supervisor.

STANDARDS

1. References, prints and educational materials

1.1 The clinic has a copy of Leprosy Control in Botswana and a plasticised copy of Diagnosis of Leprosy, Skin Lesions in Leprosy, and Treatment of Leprosy.

2. Equipment

2.1

3. Medicines and Supplies

3.1 List of drugs in accordance with the Essential Drugs List.

4. Competence of Health Staff

4.1 A supervisor checks progress of each case every 3 months and arranges for hospital review if needed.
4.2 Staff are able to suspect leprosy by testing for sensation and enlarged nerves and to refer to the correct hospital for biopsy diagnosis and notification if positive for leprosy.
4.3 Close contacts are examined and referred.
4.4 Files of patients are kept in related designated hospitals, supplies of combination bubble packs for multi-drug treatment are provided and clinics supervise continuity of care.
4.5 Clinic staff care for ulcers, educate patients to prevent deformity and seek help from the Leprosy Mission for help with rehabilitation, footwear and protection devices.
4.6 Sensation and motor function are tested every 3 months.
4.7 Reactions are recognised and referred to hospital.
4.8 Staff attitudes, both towards patients and in the community, are friendly, caring and help reduce stigmatisation.

5. Referrals

5.1

6. Patient Education 6.1 All patients attending clinics for service receive health education, information and support.
7. Records 7.1 All newly diagnosed cases are notified to the MOH. 7.2 Patient's records are kept up to date. 7.3 All leprosy patients are on a register at the referral centre in each province.
8. Community Based Services 8.1 Clinic staff once a year on International Leprosy Day (3rd Sunday in January) arrange health education about leprosy to reduce stigma and to arouse awareness of early symptoms and of the fact that leprosy can be cured in their communities.
9. Collaboration 9.1 For purposes of rehabilitation (and contact tracing in some areas) the Leprosy Mission is informed of all newly diagnosed cases by telephone or fax.

xvii) TRAUMA AND EMERGENCY

SERVICE DESCRIPTION

Clinics provide emergency and resuscitation service, treatment and referral of patients that have experienced trauma and/or injury and have arrangements to deal with disaster situations.

NORMS

1. All clinics provide trauma and emergency services.
2. Reduce intentional and unintentional injuries among adolescents, including teenage suicide.
3. Increase the proportion of emergency health staff who has basic ambulance assistance qualifications, and who are able to provide emergency care to victims of poisoning, injuries and maternal emergencies.

STANDARDS

1. References, prints and educational materials

1.1 A Training Manual for Trauma.
1.2 Any local protocols as decided by the MOH.

2. Equipment

2.1 There is an "Emergency Box", containing those items which are needed in an emergency, and a system in place for replenishing it when it has been used.

2.2 The following equipment is kept available:

2.2.1 Clean, preferably sterile, instruments for suturing, with adequate replacements or a sterilising system.
2.2.2 Suture materials
2.2.3 Equipment and IV solutions according to the Essential Drug List.
2.2.4 Stretchers, with or without wheeled trolley.
2.2.5 Crutches.
2.2.6 Wheeled chair.
2.2.7 Body bags / shrouds for dead bodies.

NOTE: Even where skills are not routinely available it is still worth having emergency equipment that can be used by visiting staff.

3. Medicines and Supplies:

3.1 The drugs should be kept, as part of an "emergency box" according to EDL

4. Competence of Health Staff

4.1 A clinic has staff capable of dealing with any anticipated trauma in a safe and effective way and to stabilize and refer patients as appropriate.

4.2 Staff have skills to identify the nature of injury, and decide on the management needed and its urgency.
4.3 Assess the significance of possible poisoning and institute appropriate counter-measures
4.4 Understand the psychological implications of attempted suicide and ability to render effective immediate care.

5. Referrals

5.1 Staff have a clear understanding of:

5.1.1 Indications for transfer and degrees of urgency, as outlined in local policy.
5.1.2 The mechanism of transfer and the immediate referral channel.
5.1.3 The management of seriously ill patient during transfer.
5.1.4 The management of less severe injuries without transfer.

5.2 A reliable means of communication and transport is available when required.

6. Patient Education

6.1 A mechanism is in place at District level to identify the significant causes of trauma locally.
6.2 Staff identify possible interventions that might be made, involving the community in discussion of implementation and education both in schools and communities.
6.3 The consultation in the clinic is used as an opportunity for talking about prevention and first aid of burns.

7. Records

7.1 A reliable patient-held record system is available.
7.2 Data is routinely recorded and used to anticipate and prepare for disasters

8. Community and Home Based Activity.

8.1

9. Collaboration

9.1 The clinic staff collaborate with the Police and Social Welfare Departments.
9.2 The clinic have clear guidelines on referral and support from the Hospital.

PART 3. NORMS AND STANDARDS FOR:

i) PRIMARY HOSPITAL

INTRODUCTION

Access to decent public services is the rightful expectation of all citizens especially those previously disadvantaged. Communities are encouraged to participate in planning services to improve and optimize service delivery for the benefit of the people who come first.

STANDARDS

All communities will know from displayed posters about the following:

CONSULTATION
Communities will be consulted about the level and quality of public services they receive and where possible will be given a choice about the services offered.

SERVICE STANDARDS
Citizens would know the level and quality of public service they are to receive and know what to expect

ACCESS
All citizens have equal access to the services to which they are entitled

COURTESY
Citizens should be treated with courtesy and consideration.

INFORMATION
Citizens should be given full accurate information about the public service they are entitled to receive.

OPENNESS AND TRANSPARENCY
Citizens should be told how national and provisional departments are run, how much they cost and who is in charge.

REDRESS
If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy, when complaints are made, citizens should receive a sympathetic positive response.

VALUE FOR MONEY
Public services should be provided economically and efficiently in order to give citizens and communities the best possible value for money.

Implications for health staff

In line with these principles the local health services for a community will provide:

- services with a high standard of professional ethics
- a missions statement for service delivery
- services which are measured with performance indicators displayed, so community can understand the level of achievement
- services which are in partnership with or complement other sectors e.g. the private sector and non-government organizations and community based organizations
- services which are customer friendly and confidential
- opportunities for community consultation
- types of outreach which can reach to all communities and to families in greatest need
- easily accessible and effective ways of dealing with complaints or suggestions for improvement
- current information on services available and hours of service, staff changes of movements and extra activities such as health days.

STAFFING STANDARDS AND NORMS

PERSONNEL	Norm for PH	COMMENTS
Chief Medical Officer	1	Chief Executive supported by Hosp Manager
Specialty Doctor:		
Internal Medicine/ Family Health Practitioner	1	Not Based on Number of beds **but BASED on Service Delivery Model (It is expected that no ward will be larger than 20 beds)**
General Surgery	1	
OBGN	1	
Medical Officer (various)	6	3 to support specialty and 3 for OPD& A/E
Hospital manager	1	For Administration, HR management and procurement
Specialist nurses:		
FNP	2	Numbers based on 50 bed hospitals. If additional beds number will increase
Ophthalmic	1	
Mental health	1	
Anaesthetic	4	
Theatre	6	
Midwives	10	
ENT	1	
A&E	5	
Obs & Gyne	4	
Nurse-managers	3	
Neonatal	2	
Community Health Nurse	2	
School health nurse	2	

PERSONNEL	Norm for PH	COMMENTS
Diabetic Nurse	1	
General Nurse	1 per 4 beds per shift + 1 per 5 beds reserved	Based on three shifts
Physiotherapist	1	
Clinical Psychologist	1	
Occupational therapist	1	
Pharmacists	1	
Audiologist	1	
Pharmacy techs	2	
Ultrasonographer	1	
Lab Technician	2	
Lab scientist	1	
Health Education Officer	1	
Cytotechnologists	1	
Lay Counsellor	2	
Health Care Assistants/Auxiliary	5	
Health Education Technician	1	Support to HEO, Communication with patients and relatives
Health Education Assistant	1	
Social Workers	1	Counselling support
Mortuary Attendant		
X-Ray Attendant		
Medical Record Clerk	3	Existing Data/Record Clerk with main responsible for IPMS
Administration/Support Staff:		Some services can be outsourced – Laundry, Food, Cleaning
Administration Officers	3	1 for HR, 1 for Procurement and 1 for other admin services
Accountant/Accounts Officer	1	
Record Officer	1	
Hospital Orderly	as required	
Storekeeper		
Mental Attendant		
Messenger		
Ambulance drivers	as required	Part of DHMT
Vehicle Repair and Maintenance	as required	if not outsourced
Cleaners	as required	if not outsourced
Food Service (catering officer and others)	as required	if not outsourced
Laundry/Housekeeping (domestic supervisor and others)	as required	if not outsourced
Labourer		if not outsourced

PERSONNEL	Norm for PH	COMMENTS
Gardener/Grounds men		if not outsourced
Maintenance Assistant		if not outsourced
Porter		
Boiler Operator/Plant Operator		
Switch Board Operator		
Seamstress		
Gatekeeper		
Night-watchmen		

ii) ORAL HEALTH

SERVICE DESCRIPTION

The Basic Primary Oral Health Care Services at clinic level should as a minimum consist of promotive and preventive oral health services (oral health education, tooth-brushing programmes, fluoride mouth rinsing programmes, fissure sealant applications, topical fluoride application); and basic treatment services (an oral examination, bitewing radiographs, scaling and polishing of teeth and simple fillings of 1-3 tooth surfaces including atraumatic restorative treatment (ART)) and emergency relief of pain and sepsis (including dental extractions).

NORMS

1. Expose at least xx% of primary schools to organised school preventive programmes.
2. Everybody in the catchment area is covered by basic treatment services.

STANDARDS

1. References, prints and educational materials

1.1 National Norms, Standards and Practise Guidelines
1.2 Oral health educational material (posters, pamphlets etc).

2. Equipment.

2.1 Dental unit complete with chair, light, hand piece unit with hand pieces, suction and compressor
2.2 Aseptic trolley
2.3 Dental Autoclave
2.4 Amalgamator
2.5 Dental X-ray unit
2.6 Intraoral X-ray film processor
2.7 X-ray view box
2.8 Lead apron
2.9 Ultrasonic scaler
2.10 Dental operating stool (2)
2.11 Dental hand instruments (refer 1.2 above)

Portable dental equipment where fixed facilities are not available.

3. Medicines and Supplies

For details of material required, refer to 1.2 above

3.1 Medicine according to the EDL
3.2 Local anaesthetic materials
3.3 Exodontia and oral surgery procedure materials
3.4 Prophylaxis materials
3.5 Conservative procedure materials

4. Competence of Health Staff

4.1 Community health workers offer oral health education to patients.
4.2 The dental assistant is competent to do patient administration, surgery cleanliness and infection control as well as chair-side assisting.
4.3 The oral hygienist is competent to conduct oral examination, apply fissure sealants, topical fluorides, scaling and polishing and taking of intra-oral x-rays.
4.4 The dental therapist is able to carry out oral hygienist competencies as well as tooth extractions and simple 1 to 3 surface filling of teeth.

5. Referrals

5.1 All patients whose needs fall beyond the scope of services provided at the Primary Hospital are referred to the next level of care.

6. Patient Education

6.1 All patients receive oral health education.

7. Records

7.1 Patients records.
7.2 Patient register.
7.3 Statistics.

8. Community Based Services

8.1 School oral health programmes consist of oral health education, tooth brushing and fluoride mouth rinsing and ART.

9. Collaboration

9.1 Collaboration with other departments: Education, Water Affairs, and Forestry and other sections within health such as Child Health, Health Promotion, Environmental Health, Nutrition, Communication etc..

iii) MENTAL HEALTH

SERVICE DESCRIPTION

Mental health services form part of integrated comprehensive Primary Health Care. The service seeks to improve mental health and social wellbeing of individuals and communities. Promotion of community mental health is included in Primary Hospital and community based IEC. Preventive measures for mental disability are included in all services such as antenatal, infant, child, reproductive health and curative care.

NORMS

1. All PH have access (by referral or by periodic visits) to specialist mental health expertise (psychiatrists, psychologists, occupational therapists) at least once a month.
2. In every PH there is a member of staff who has had continuing education in psychiatry or mental health (including community aspects) in the last year.
3. In every PH there is at least one person trained in counselling and the management of victims of violence and rape.

STANDARDS

1. References, prints and educational materials

1.1 Mental health policy document.
1.2 List of visiting psychiatric staff at nearest district hospital, psychiatric specialist hospital.
1.3 Mental health assessment guidelines.
1.4 Psycho-social rehabilitation checklist for community work.
1.5 Checklist for daily living skills for rehabilitated patients.
1.6 Emergency medication protocol.
1.7 Essential drug list.
1.8 Posters and pamphlets on mental health, severe psychiatric conditions, available services and user rights.

2. Equipment

2.1

3. Medicines and Supplies

3.1 Emergency and routine medication provided according to protocol and EDL.

4. Competence of Health Staff

Recognising mental illness

4.1 PH staff consider risk factors for mental health within their catchment area: poverty, social power, unemployment, ill health, homelessness, migrancy, immigrants, isolated persons, HIV positives etc.
4.2 Staff identify and provide appropriate interventions for patients with depression, anxiety, stress related problems, male violence, substance abuse and special

needs of women (childbearing, abortion, sterilisation, disability, malignancy etc.)
4.3 PH staff recognise the expression and signs of emotional distress and mental illness early (especially in young patients or in relapse of a psychiatric condition).
4.4 PH staff participate in the promotion of healthy life style in clinic attendees and the community.

Organising services

4.5 Staff provide prompt help from or at the PH if a patient's condition in the community deteriorates.
4.6 Staff ensure time is allocated for home visits to patients who have returned from mental hospital.
4.7 Staff ensure there is no segregation or stigmatisation at the clinic of patients who have to use other services e.g. family planning, antenatal care, etc.
4.8 Staff arrange access to a consistent member of staff for each consultation.

Managing care

4.9 Specially trained staff are able to

4.9.1 Maintain relationships with patients that are just, caring, and based on the principles of human rights.
4.9.2 Perform an adequate medical examination which:-

4.9.2.1 Identifies the general mental state e.g. psychotic or depressed.
4.9.2.2 Identifies the severity and level of crisis.
4.9.2.3 Rules out systematic illness.
4.9.2.4 Records temperature and blood glucose level.
4.9.3 Take a history that includes previous service use such as admission to hospital.
4.9.4 Take a family history and evaluate support.
4.9.5 Develop a sustained therapeutic relationship with patients and their families.
4.9.6 Know and implement standard treatment guidelines especially the section on delirium with acute confusion and aggression, acute psychosis and depression.

4.10 General nurses are able to:-

4.10.1 Detect and provide services for severe psychiatric conditions as a component of comprehensive Primary Health Care.
4.10.2 Make appropriate and informed referrals to other levels of care.
4.10.3 Provide basic psychiatric care and assess urgency and severity of symptoms.
4.10.4 Provide individual community maintenance and care for stable long-term patients who have severe psychiatric conditions and have been discharged from hospital.
4.10.5 Provide each stable long-term user with individualised comprehensive care which includes:-

4.10.5.1 An ongoing assessment of mental state, functional ability and social circumstances.

4.10.5.2 Familiarity with the internationally recognised diagnostic system.
4.10.5.3 An ability to detect and monitor distress and relapse.
4.10.5.4 An ability to provide basic counselling and support to patient and family.
4.10.5.5 A basic knowledge, criteria and pathways for referral for disability grants.
4.10.5.6 Knowing community referral and support organisations.
4.10.5.7 The follow-up of all cases returned to community after hospitalisation and keeping a register.

4.10.5.8 An ability to use records to facilitate continuity of care, such that:-
4.10.6 The condition of patients in the community is monitored and poor compliance, functional deterioration, substance abuse and family conflict community ridicule are identified.
4.10.7 The onset of mental deterioration in HIV positive patients is recognised.
4.10.8 The prescription of sedation for aggressive of violent patients only as appropriate when other measures fail.
4.10.9 Coping with disturbed, intoxicated, aggressive suicidal behaviour without resorting to violence, abuse of undue physical restraint.

4.11 Clinic staff provide patient and caregiver satisfaction with assistance in alleviating family burden, achieving social integration, improving quality of life and general functioning while improving symptoms.

4.12 Clinic staff conduct consultations in privacy and in a confidential way and informed consent is obtained for communication to others.

5. Referrals

5.1 Referral pathways to other levels or types of care are known and expedited.

6. Patient Education

6.1 Patients, relatives and the community receive high quality information on mental health and mental illness.
6.2 Patients and their supporters are given individualised education when their situation is reviewed.
6.3 Patients and their supporters are educated on how to recognise predisposing factors and conditions to prevent relapse.
6.4 Clinic staff use education in the family and community to address ignorance, fear, and prejudice regarding patients with severe psychiatric conditions attending the clinic.

7. Records

7.1 Records are kept according to protocol with emphasis on confidentiality and accuracy.
7.2 A register of psychiatric patients in the community is maintained.
7.3 Staff record mental health indicators on:-

7.3.1 The number and mix of cases
7.3.2 The frequency of contact

7.4 Staff analyse indicators and develop appropriate action.

8. Community and Based Activity 8.1 Staff participate in community awareness programmes for mental health according to the national and international calendar. 8.2 Staff participate in the training of family and carers of patients to plan an active role in their rehabilitation. 8.3 Staff encourage patient and caregiver support groups in community. 8.4 Staff keep the addresses and phone numbers of people assisting with mental health and social problems (e.g. women's shelters, community self-help groups).
9. Collaboration 9.1 Staff respect and where appropriate seek collaborative association with local traditional healers. 9.2 Staff collaborate with all community services e.g. crisis counselling (lifeline, priests with counselling skills) and mental health groups especially those for youth. 9.3 Staff collaborate with the hospital for planning discharges to the community.

iv) GENDER BASED VIOLENCE

SERVICE DESCRIPTION

The service, requires co-operation between the health sector, the police and the Department of Justice, provides counselling and referral of victims, STI prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence.

NORMS

1. Every PH has established working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year.
2. A member of staff of every clinic has received training in the identification and management of sexual, domestic and gender related violence. The training includes gender sensitivity and counselling.
3. Every PH will be able to provide one-stop services – for health, legal and counselling

STANDARDS

1. References, prints and educational materials

1.1 All relevant guidelines / protocols related to women health issues.
1.2 A suitable library of references and journals on sexual offences, domestic and gender violence.
1.3 The PH has a list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with these cases.
1.4 The PH has a list of names and addresses of NGOs or other organisations (e.g. CBO) which undertake appropriate counselling for violence, child abuse and sexual offences.

2. Equipment

2.1 There is a room available at short notice for private, confidential consultations.

3. Medicines and Supplies

3.1 Emergency contraceptive pills.

4. Competence of Health Staff

4.1 The clinic staff fast track in a confidential manner any rape victim to a private room for appropriate counseling and examination.
4.2 The staff always include a question on gender violence in the history taking from women with depression, headaches, stomach pains or a known abusive partner.
4.3 The staff include diplomatic probing of the domestic situation in taking histories of children with failure to thrive, recurrent episodes of trauma or behavioural

problems.
4.4 All cases of sexually transmitted disease in children are managed as cases of sexual offence or abuse.
4.5 When a person presenting at a clinic alleges to have been raped or sexually assaulted the allegation is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity.
4.6 A detailed medical history is recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted - with an indication that these are not a full account. These notes are kept for 3 years.
4.7 Staff explain that referral is necessary to an accredited health practitioner and arrangements are made expeditiously and while awaiting referral emergency medical treatment is given with the consent of the victim: prophylactic treatment against STD and post-coital contraception.
4.8 The victim is given information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre.
4.9 The staff even though non-accredited are not prohibited from dealing with rape victims but must keep patient records.
4.10 Victims are not allowed to wash before being seen by an accredited health practitioner.
4.11 Women who have been raped or abused are attended to by a female health worker and if this is not possible (e.g. a male district surgeon comes to the clinic) then another women is present during the examination.
4.12 The victim is given brief information about the legal process and the right to lay a charge.
4.13 If the victim now indicates a desire to lay charges the police are called to the clinic.
4.14 Clinic staff inquire if charges will or have been laid with the SA Police Service.
4.15

5. Referrals

5.1 All patients are referred to the next level of care when their needs fall beyond the scope of competence of clinic staff.

6. Patient Education

6.1 All patients, community, and children attending clinic are educated and informed on abuse.

7. Records

7.1 Patients records are kept according to protocol with emphasis on confidentiality and accuracy.
7.2 The clinic keeps a confidential record of all claims of sexual offences, wife battering and child abuse (sexual, physical, emotional and nutritional).

8. Community Based Services

8.1 Clinic staff establish links with relevant organisations already operating and providing services for victims of abuse.
8.2 Staff encourage community participation on health promotion to curb domestic and gender violence.

9. Collaboration

9.1 Staff collaborate with other departments like the police, relevant NGOs and CBOs to reduce the violence and give reassurance and support.

v) DIABETES

Service description
Norms and standards on materials, equipment, supplies and general competencies are dealt with in the chapter on chronic diseases. This chapter deals specifically with competence and referral standards for diabetes.
NORMS
STANDARDS
1. Reference Prints and Educational Material 1.1 See chronic diseases
2. Equipment 2.1 Sphygmomanometer with different size cuffs
3. Medicine and Supplies 3.1 As per EDL list
4. Competence of Health Staff 4.1 Staff know that prevalence of diabetics in Botswana is high (10% in Indian community and 5 – 6% in the black community) and estimate how many cases there are in clinic catchment areas and are alert to identify them early. 4.2 The interrelationship between abdominal obesity, hypertension and cardiovascular disease and initial presentation with complications of diabetics are known. Hypertension patients are investigated for diabetes. 4.3 All pregnant women have urine examined for glycosuria. 4.4 Patients suspected of having diabetes (history and risk factors, clinic blood and urine testing indicating diabetes) are referred to hospital for diagnosis. 4.5 Nurse knows where to phone the nearest hospital/doctor for advice. 4.6 Staff counsel on disease acceptance, continuity of care and compliance. 4.7 On return from diagnosis the patient is further educated in an inter-active problem solving way on: 4.8 Prevention detection and management of complications 4.9 Principles of nutrition, physical activity, hygiene and weight control 4.10 Self-monitoring with urine glucose strips or preferably blood glucose strips and maintaining urine glucose free. 4.11 Maintaining a body mass of (kg/m) for men 20 - 27 and women 19 - 26. 4.12 The drugs used. 4.13 The symptoms and treatment for hypoglycaemia. 4.14 Contraception and pregestational counselling. 4.15 Not smoking. 4.16 Six monthly or annual referral for assessment of progress, depending on the control of diabetes mellitus and complications.
5. Indicators For Referral

5.1 Urgent referral to the nearest hospital :

5.1.1 If nausea and vomiting, dehydration and hypotension, ketonuria (>2+) significant hyperglycaemia with symptoms, stupor, confusion, coma, deterioration in vision, gangrene, severe infections (TB, pneumonia)
5.2 As soon as possible:

5.2.1 Pregnancy
5.2.2 Newly diagnosed cases
5.2.3 Recurring hypoglycaemic symptoms
5.2.4 Foot problems
5.2.5 Recurring hyperglycemia/glycosemia
5.2.6 Persistent infections.

6. Patient Education

6.1 all hypertensive or obese patients or those with a family history of hypertension are given non-pharmacological advice

7. Records

7.1 See chronic diseases

8. Community based services

8.1 See chronic diseases

9. Records

9.1 See chronic diseases

vi) HYPERTENSION

SERVICE DESCRIPTION
The service aims at increasing detection, treatment and control of hypertension and preventing target organ damage, cardiovascular disease and strokes and adverse interaction with diabetes.

NORMS
1. Reduce the incidence of strokes and congestive cardiac failure and renal failure. 2. Reduce the prevalence of overweight and obese clients. 3. The majority of patients are compliant and on continuous treatment.

STANDARDS
1. Reference, Prints and Educational Material: 1.1 Patients health learning materials available on hypertension diet, exercise and weight reduction.
2. Equipment 2.1 Sphygmomanometer with different size cuffs 2.2 Urine test strips (blood, protein and glucose)
3. Medicine and Supplies 3.1
4. Competence of Health Staff 4.1 All adults entering clinic have blood pressure measured routinely every five years. 4.2 All patients with high normal values (135-139/85-89mm Hg) or previous high reading have blood pressure measured yearly. 4.3 At least two measurements of blood pressure are made at each of several visits to determine blood pressure. 4.4 Staff measure blood pressure seated but standing if patient elderly or diabetic. 4.5 Referral is made to a doctor for the start 160mm Hg or≥of treatment for all people with sustained systolic blood pressure sustained diastolic blood pressure > 100mm Hg. 4.6 Patients with a systolic pressure between 140-159mm Hg or sustained diastolic pressure between 90-99 are referred if they are obese, diabetic or have a strong family history. 4.7 The stepwise treatment outlined in the Standard Guidelines and Essential Drug list is followed. 4.8 Target blood pressure during anti-hypertensive treatment is less than 140

systolic and less than 85mm diastolic and is maintained with minimal side effects.

4.9 Combinations of drugs are prescribed by the hospital or visiting doctors.

4.10 Staff identify hypertensive emergencies (neurological signs, pulmonary oedema) and treat with oral nifedipine 5mg and refer.

4.11 Staff check compliance and ensure continuity.

5. Referral

5.1 Patients on treatment are referred if there is no therapeutic response.

5.2 All pregnant women are referred.

5.3 All children with hypertension are referred.

5.4 All hypertensive emergencies are referred.

6. Patient Education

6.1 All hypertensive or obese patients or those with a family history of hypertension are given non-pharmacological advice :

6.1.1 Weight reduction via reduced fat and total caloric intake, regular brisk physical exercise and limited alcohol consumption.

6.1.2 Reduced intake of salt.

6.1.3 Increased consumption of fruit and vegetables.

6.1.4 Stopping smoking.

7. Records

7.1 Blood pressure and weight recorded regularly.

7.2 A chronic disease register maintained showing patient's dates and monitoring monthly returns.

8. Community and Home-based activity

8.1 Community-based education programmes are initiated in all areas with high levels of obesity.

8.2 Community-based life-style improvement programmes are carried out with youth groups.

2 Collaboration

9.1 Staff collaborate with NGO or CBO dealing with obesity, diabetes and heart disease.

vii) REHABILITATION SERVICES

Basic considerations

Rehabilitation services are an integral part of the services provided at the primary level. This constitutes a reorientation of rehabilitation from mainly institution-based services to community oriented and community based services. Communities and particularly people with disabilities should be involved in designing, implementing and monitoring services for people with disabilities. This precludes a disability service from being seen narrowly as a therapy service provided only by a certain category of staff. All health personnel in co-operation with all other sectors and the communities/people themselves are responsible for making society inclusive of all people including people with disabilities.

The clinic is the first point where people with disabilities, their family members or caregivers meet health staff. Clinics need to become creative in their approach to the problems experienced by these patients.

SERVICE DESCRIPTION

The purpose of rehabilitation at clinic level is to provide a service to prevent disabling conditions, to detect disabilities early so to prevent complications and the worsening of the effects of a disability on a person's functional ability, to treat disabling and potentially disabling conditions and to provide access to rehabilitative services for people with disabilities, making them appropriate and acceptable.

The pivotal person at the clinic, through whom people with disabilities will access the rehabilitation service, is the PHC Nurse. The Therapy Assistant (Community) is the person providing the rehabilitation service at this level, in consultation with the visiting Therapist. The visiting generalist doctor is important in providing access to treatment of potentially disabling conditions, which would otherwise be difficult for people to access on a regular affordable basis.

Specific rehabilitative services include a basic assessment of people with disabilities e.g. stroke, spinal injury, cerebral palsy, developmental delay, blindness, communication problems, arthritis, amputations, backache, followed by an appropriate treatment programme, in consultation with the disabled person and his family. Consumable assistive devices e.g. continence devices, rubber ferrules and other aids to daily living are prescribed, provided and people trained in their use. Management of continence problems of patients with spinal cord injury, spina bifida, mental retardation, traumatic conditions and the elderly includes the supply of continence devices and devising continence programmes.

Patients are assessed for disability and care dependency grant applications.

NORMS

1. Improve access to comprehensive health services for the disabled. (National: Year 2000 Goals, Objectives and Indicators.)
2. Have a responsive and area-specific disability information system in place, which will feed into the general information system of the district and clinic.
3. Institute a functional referral system between the community-clinic-district hospital, as well as other relevant sectors.
4. Institute a system of obtaining, repairing and maintaining essential assistive devices for rehabilitation at clinic level.

STANDARDS

1 Reference, Prints and Educational Material

1.1 A register of all local, regional, provincial and national resources for referral for rehabilitation, education and training.
1.2 OT reference pack.
1.3 "Disabled village children" by David Werner, as reference book

2 Equipment

2.1

3 Medicines and Supplies

3.1 Consumables such as axillary rubbers, rubber ferrules and cane tips.
3.2 Ready-made packs on order per specified patient
3.3

4 Competence of Health Staff

Clinic Staff are able to:

4.1 Use of standardised questionnaire for the detection of hearing loss.
4.2 Identify and refer patients requiring rehabilitation.

The Therapy Assistant is able to:

4.3 Teach prevention of pressure sores and pressure sore care.
4.4 Identify and implement techniques in a walking re-education programme.
4.5 Construct simple aids for daily living from locally available materials and teach the patient how to make and use them.
4.6 Teach mobility and daily living skills to a blind person.
4.7 Identify articulation, language and fluency disorders.
4.8 Plan, implement and monitor language stimulation programmes.
4.9 Use augmentative and alternative communication methods with appropriate patients, construction of simple communication boards, and teach the family how to use them.
4.10 Plan, implement and monitor basic programmes for the rehabilitation of people with neurogenic disorders of communication.
4.11 Counsel the family and teachers of a person with hearing impairment on simple measures to improve communication.
4.12 Have knowledge of available resources for rehabilitation.
4.13 Construct and instruct in the making of corner chairs with table, standing frames and walkers out of Appropriate Paper Technology.

4.14 Construct and instruct in the making of toys out of locally available waste materials and plan, implement and monitor play and stimulation activities to facilitate development.
4.15 Teach basic maintenance of wheelchairs, hearing aids, callipers and crutches.
4.16 Teach an exercise programme for the prevention and treatment of backache.
4.17 Instruct on back care and joint protection principles to decrease pain and maintain the range of movement in the treatment of back pain and other conditions involving joints.

Visiting Therapist are able to:
4.18 Design treatment/rehabilitation programmes for people with stroke, spinal injury, spina bifida, cerebral palsy, barriers to learning, sports injuries, backache, arthritis, amputations, blindness, to be implemented by the therapy assistant or family members of the person with a disability.
4.19 Assess people with disabilities for the need for Specialised Assistive Devices, and prescribe and order these from the District, Regional or Tertiary Hospital.
4.20 Assess patients with burn scar tissue, and prescribe and order pressure garments.
4.21 Assess scholars with barriers to learning
4.22 Guide doctor in assessment of degree of disability for applications for disability and care dependency grants.
4.23 Design and direct needs driven awareness raising, education and prevention programmes.
4.24 Assess the need for surgical release of contractures and other corrective procedures.
4.25 Supervise and arrange the continuing education of community therapy assistants.

The visiting PHC doctor is able to:
4.26 Assess continence problems, and advise suitable continence management in consultation with the therapist or therapy assistant, patient and family.
4.27 Manage spasms related to spinal injury with drug treatment and/or detection and treatment of stress factors.
4.28 Assess persons for disability grants and care dependency grants.
4.29 Use a Schiotz Tonometer.
4.30 Diagnose disabilities as early as possible, and develop a system of referral. (National Year 2000 Goals, Objectives and Indicators.)
4.31 Clinics are accessible to wheelchairs and trolleys and have toilet facilities for people on wheelchairs.
4.32 People with disabilities are given preference when queuing for services and, where feasible, appointments are given to patients to reduce waiting times.

5 Referrals
5.1 From district hospital to clinic:
5.1.1 All patients with newly acquired disabilities, who have completed the acute phase of their rehabilitation for follow up by the therapy assistant.
5.1.2 All newly detected patients with disabilities, who have been assessed by a therapist, doctor or specialist, for follow up and rehabilitation at the nearest

clinic.

5.2 In the clinic to the rehabilitation service:
5.2.1 All children detected with a developmental delay for assessment.
5.2.2 Patients with healed burns that cover a joint surface for the prevention of contractures and treatment of scarring.
5.2.3 Patients with disabilities for alleviation programmes and rehabilitation.
5.2.4 All patients with chronic deforming arthritis.

5.3 Referral of patients to doctor or multidisciplinary team:
5.3.1 Patients with spinal chord injury with troublesome spasms.
5.3.2 Patients with continence problems for institution of an adequate continence programme.

5.4 From clinic for specialist assessment or treatment:
5.4.1 Patients with physical disabilities amenable to corrective surgery, assuming that a therapy follow-up service is available.
5.4.2 Patients with chronic disabling rheumatoid arthritis for assessment and monitoring.

5.5 From clinic to hospital:
5.5.1 Patients requiring intensive daily rehabilitative therapy.
5.5.2 Patients with extensive bedsores.
5.5.3 Patients in need of more assistive devices not available at district level.
5.5.4 Complicated burns (facial, perineal, burns involving a joint or over 10% of body surface).
5.5.5 Patients with spinal injury and sudden increase in spasms, temperature and high blood pressure.

5.6 From clinic to other sectors:
5.6.1 Children with sensory loss to LSEN schools.
5.6.2 Patients with disabilities who are capable of working, to department of labour for employment opportunities.
5.6.3 Patients with disabilities for training in suitable occupational skills.
5.6.4 Patients with disabilities that are not suitable for the open labour market, to community groups for disabled people, self-help groups, or protected workshops.
5.6.5 Any other sectors which are deemed useful for the development of social and economic independence of the disabled person e.g. training centres for the blind.
5.6.6 Peer support groups.
5.6.7 Patients with disability who are not acceptably cared for in the community to the welfare department.
5.6.8 Severely disabled children, who are not accepted at schools to community day care centres.

6 Patient Education

6.1 Prevention of bedsores in debilitated patients and patients with sensory loss.

7 Records

7.1 Data collected at clinics to be used for development of a district data base on disability for use for programme planning

7.2 Patient information recorded using the SOAP Format.

7.3 Initial assessment and follow up forms standardised for the district, and kept in the chronic file of the patient at the clinic.

7.4 A summary note of the diagnosis, referral and treatment is in the patient held record.

7.5 The visiting therapist ensures that data and information, and records are accurately and consistently maintained.

7.6 Data fields for clients referred for rehabilitation are included in the clinic register.

8 Community and Home Based Activity

8.1 Refer patients to community monitoring programmes, mobilise community support, where indicated by the patients' social circumstances to ensure compliance with treatment.

8.2 Needs analysis for rehabilitation in the community, to plan appropriate and effective intervention programmes.

8.3 Home visits on patients to gain insight into their social situation.

8.4 Devise home based rehabilitation programmes for people requiring extended rehabilitation, in collaboration with the disabled person, his family, and/or community.

8.5 Maintain contact with clients through follow up visits.

8.6 Identify and mobilise community resources for groups and peer support, skills training and income generation.

8.7 Supervise, advice and assist community therapy assistants.

8.8 Recommend and assist with implementation of adaptations to client's homes, communities, work areas, or schools.

9 Collaboration

9.1 Develop a responsive disability information system and database in consultation with PHC Nurse, Generalist Doctor, Disabled People's Organisations and Community

PART 4. NORMS AND STANDARDS FOR DISTRICT HOSPITAL

INTRODUCTION

This set of norms and standards is intended to support the development of district hospitals as part of the development of an effective District Health System under decentralised health care delivery and provide comprehensive EHSP to all people of the district.

This means that services provided in **district hospitals** will be fully integrated with services provided through primary hospitals, health clinics and community based care. The implication is that the governance, management and functions of district hospitals should relate to the governance, management and functions of the district health system as a whole. District Health Management Teams (DHMT) have the task of finding ways in which the hospital-based resources can be harnessed to strengthen the delivery of all primary care services. This document should help this process. In addition to the norms of human resources for district hospitals, this section also includes the norms of human resources for DHMT.

THE ROLE OF THE DISTRICT HOSPITAL

The district hospital plays a pivotal role in supporting primary health care on the one hand and being a gateway to more specialist care on the other. The district hospital provides services to in-patients and outpatients (ideally on referral from primary hospital, health clinic). The hospital should have between 30 and 200 beds, a 24-hour emergency service and operating theatres. Specialists and Generalists from a range of clinical disciplines provide the services. In some circumstances primary health care services are rendered where there is no alternative source of this care within a reasonable distance.
The hospital also plays a key role in supporting clinical service delivery in the district as a whole. The following are examples:

- Human resource matters
    - Human resource development such as in–service clinical training
    - Sharing scarce human resources such as pharmacists and doctors
- Information management
    - The use of PHC data in hospital service planning and hospital morbidity and mortality information to support PHC service planning
    - Research activities
- Laboratory services
- Transport services
- Pharmaceutical services
- Equipment supplies

- Organising the technical equipment maintenance system

CORE MANAGEMENT STANDARDS

Eight core management standards are listed below. Criteria are then defined for each of them.

Core Management Standards

1. The hospital has a defined vision, which is in line with and draws from the District and National visions.
2. The hospital management works according to an Operational/ Service Plan to achieve the vision.
3. The community acts as a stakeholder in hospital management.
4. Efficient and effective management systems are in place.
5. Hospital resources are used for the benefit of patients and the District Health System.
6. The hospital has clear policies and procedures to guide management and service provision.
7. The hospital has programmes to improve quality.
8. Management encourages teamwork and promotes an enabling environment for staff.

NORMS AND STANDARDS OF SERVICES

Norms and standards common to all parts of the hospital are included in this section. The specific clinical programme norms and standards are not included to reduce duplication

.

CORE NORMS

1. The hospital renders comprehensive services 24 hours a day, seven days a week.
2. Access to emergency care, as measured by the proportion of people transferred from clinic to hospital is improved
3. The hospital receives visits at least once a month from senior managers to support personnel, monitor the quality of service and identify needs and priorities.
4. The hospital has a mechanism for monitoring services and quality assurance and at least one annual service audit in each discipline.
5. Patient satisfaction survey is conducted at least once a year.
6. The hospital has a patient complaints' system in place.
7. The hospital has a disaster plan in place
8. The hospital observes universal precautions

CORE STANDARDS

1 REFERENCES, PRINTS AND EDUCATIONAL MATERIALS

1.1 Standard treatment guidelines and the essential drug list (EDL) manual for

hospitals.

1.2 Standard treatment guidelines and essential drug list (EDL) manual: Primary Health Care.

1.3 Access to a well-run library to information that supports evidence-based practice in the form of paper or electronic journals, Cochrane reviews, up-to-date reference books, national health related circulars, policy documents, protocols and acts that impact on service delivery.

1.4 Copies of the Patients Charter and Providers Charter.

1.5 Supplies of appropriate health education materials.

1.6 Environmental Health and Occupational Hygiene at District Hospitals

1.7 Nursing Act and Regulations

1.8 Access to information about the catchment area, (e.g. demographics, disease profile etc)

1.9 Standard operating procedures on drug management

2 RECORDS

2.1 An adequate, uniform patient record system is in place, ensuring continuity in ward care.

2.2 Patient details are recorded using a medically and legally accepted system

2.3 Patient consent and associated counselling is documented

2.4 Discharge summary or referral letter is completed on discharge.

2.5 Discharge summaries are sent to referring doctors and/or written in patient-retained outpatient records

2.6 The hospital utilises the integrated standard district health information system that enables and assists in collecting and using data.

2.7 All information on patients seen and discharged or referred and on deaths is correctly recorded on the registers and kept, in accordance with legal requirements were appropriate

2.8 All notifiable medical conditions, and births and deaths are reported according to protocol.

2.9 All registers and monthly reports are kept up to date.

3 COMMUNITY AND HOME BASED ACTIVITY

3.1 The hospital has links with the civic organisations, youth groups, women's groups schools, workplaces, political leaders, traditional leaders and ward councillors in the catchment area.

3.2 The hospital has sensitised, and receives support from, the district health development committee.

3.3 The district hospital works in close co-operation with primary hospital, health clinics, mobile teams and community-based health projects like community health worker programmes or care-groups.

3.4 Where new community programmes are implemented works closely with the district hospital.

3.5 Ensure home-based support for patients living with AIDS or HIV infected mothers who have recently given birth through hospital boards and other community structures to improve nutrition status and care of these patients.

4 REFERRAL AND OUTREACH

4.1 A two-way referral system between the hospital and clinics and between the hospital and referral hospital will be maintained

4.2 Staff provide consultations and management of referrals from primary hospitals and clinics.
4.3 Regular feedback on referrals from the primary hospital and clinics is provided with follow up procedures and support written clearly on the referral form or patient held record.
4.4 Transport of an emergency referral will leave the hospital within one hour following request.
4.5 Referrals within and outside the hospital are recorded appropriately in the registers.
4.6 Medical and allied medical staff provide regular outreach visits to offer patient care, supervision and in-service training.

5 COLLABORATION

5.1 Hospital staff collaborate with district staff on the district health planning and implementation.
5.2 The District Hospital works in close co-operation with health centres/clinics, mobile teams and community-based health projects like community health worker programmes or care-groups.
5.3 Hospital staff collaborate with social welfare for social assistance and with other health related public sectors as appropriate e.g. Police, Defence Force, Private sector.
5.4 Hospital staff collaborate with, religious groups, organised labour and health orientated civic organisations in the catchment area to enhance the promotion of health.

STAFFING STANDARDS AND NORMS FOR DHMT

PERSONNEL	Number	COMMENTS
Head of DHMT	1	Public Health and management trained
Coordinator, Clinical services	1	Medical Specialist with QA training
Coordinator, Preventive Services	1	Public Health Specialist
Coordinator, Corporate services	1	Management trained
Managers (CS Unit):		
Medical Services	1	Medical Doctor with QA training
Nursing Services	1	Nurse with QA training
Allied Health professionals	1	AHP with QA training
Managers (PH Unit):		
Sexual & Rep Health	1	Public Health trained
Child Health	1	Public Health trained
HIV/AIDS	1	Public Health trained
TB	1	Public Health trained
Malaria & other CD	1	Public Health trained

PERSONNEL	Number	COMMENTS
Nutrition	1	Public Health nutrition trained
NCD and conditions	1	
HEP	1	Health Educationist
Managers (Corp. Ser. Unit):		
HR	1	HR Management Trained
Finance	1	Financial Management trained
IT	1	IT Trained
Administration officer	1	
Facility Management	1	Biomedical or Maintenance Engineer
Procurement	1	Procurement and Logistics Trained
HIS & ME Coordinator	1	Public Health with Epi and Bio
HIS Officer	1	

STAFFING STANDARDS AND NORMS FOR DISTRICT HOSPITAL

PERSONNEL	Number	COMMENTS
Hospital Superintendent	1	
Deputy Superintendent	1	
Hospital Managers	1+1	1 deputy
Senior Consultants:		
Paediatrician/Neonatologist	1	Based on service delivery
Urologists	1	Based on service delivery
Gynaecologist	1	Based on service delivery
Oncologist	1	Based on service delivery
Cardiologist	1	Based on service delivery
Nephrologists	1	Based on service delivery
Senior Consultant::		
Endocrinologist	1	Based on service delivery
Neurologist	1	Based on service delivery
Intensive care specialist	1	Based on service delivery
Elderly care medicine specialist(Geriatrist)	1	Based on service delivery
Neurosurgeon	1	Based on service delivery
Paediatric Surgeon	1	Based on service delivery
Cardio-Thoracic Surgeon	1	Based on service delivery
Reconstructive surgeon	1	Based on service delivery
Consultants:		
Surgery	1 per ward	Based on service delivery
Paediatrics	1 per ward	Based on service delivery
Medicine	1 per ward	Based on service delivery
OBGYN	1 per ward	Based on service delivery

PERSONNEL	Number	COMMENTS
Orthopaedics	1 per ward	Based on service delivery
Anaesthesiologist	1 per ward	Based on service delivery
Radiologist	1 per ward	Based on service delivery
Ophthalmology	1 per ward	Based on service delivery
Chief Matron	1	
Specialist nurses:		
Midwife	10 per shift + 5 additional	
Neonatal nurse	4 per shift + 2 additional	
Intensive care nurse	1 per bed + 5 additional	
Mental Health Nurse	4	
FNP	8 per shift + 4 additional	
Ophthalmic	4	
Anaesthetic	4 per shift + 2 additional	
Urology	2 per shift + 2 additional	
Specialist nurses:		
Theatre	8 per shift + 4 additional	
ENT	2 per shift + 1 additional	
A&E	6 per shift + 2 additional	
Nurse-managers	1 per ward	
Neonatal	4 per shift + 2 additional	
Community Health Nurse	4 per shift + 2 additional	
Infection Control Nurse	2 per shift + 1 additional	
Diabetic Nurse	4 per shift + 2 additional	
General nurse	1 per every 2 beds + 10 additional	
Nursing assistants	1 per every 2 beds + 10 additional	
Hospital manager	1+2	2 Deputy Managers (HR and Admin)
Psychiatrist	2	
Clinical Psychologist	2	

PERSONNEL	Number	COMMENTS
Occupational therapist	4	
Paramedics	10	
Financial managers	4	
Public relations officer	2	
Occupational assistant	10	
Perfusionist	2	
Orthotics	2	
Medical officer	1per 5 bed + 4 OPD + 6 A&E	
Dentist	2	
Orthodontist	2	
Maxilla-facial surgeons	1	
Dental therapist	10	
Pathologist	2	
Optometrists	5	
Opticians	4	
Cytotechnologists	2	
Physiotherapist	2	

PART 5. NORMS AND STANDARDS FOR REFERRAL HOSPITAL

INTRODUCTION

The referral hospitals are the ultimate facilities for offering complex curative health services for Botswana and possibly the neighbouring countries. The referrals can thus come from the district or other private sector facilities or from the health facilities in the neighbouring countries. They also provide preventive services and run several health programmes within the hospitals and as outreach for the communities. They have extra- mural treatment alternatives to hospitalisation such as day surgery, home care, home hospitalisation and outreach.

The major reason for the establishment of the referral and teaching hospitals is to teach and train critical high skilled manpower required for the provision of health services in the country as well as a centre of excellence. To this end, the three referral hospitals and the medical school hospital are engaged in the teaching and training of manpower both at graduate and post graduate levels. To reduce duplication the service norms and standards are not included. A set of performance indicators and human resource norms and standards are included.

HOSPITAL PERFORMANCE INDICATORS

There are many indicators of performance and only a few are listed below. Some norms (measurable targets) already exist. For some indicators, information will be easy to obtain but others will need specific processes to be put in place.

Criteria	**Performance measures / indicators**
Are clients satisfied with the service provided?	Client satisfaction rate Community satisfaction Waiting time at OPD or pharmacy
Is the hospital doing the right things? (Being effective) Good diagnosis, treatment and care Objectives and targets are met Regulations and protocols are followed	Incidence of hospitalism (infections obtained in hospital) Perinatal case mortality rate Caesarean section rate Referral rate to higher levels of care Reduction in mortality of children due to diarrhoea, measles and acute respiratory infections
Is the hospital cost-effective? (Being efficient) Value for money for • in-patient care • prescribing • use of staff	Cost per Patient Day Equivalent1 In-patient care performance such as bed occupancy rates2, average length of stay, nurse : PDE ratio Absenteeism rate of staff

Criteria	Performance measures / indicators
	Prescribing patterns and drug supply: Average number of drugs per encounter % of drugs prescribed from the EDL % of scripts which contain drug name, strength, dose and duration
Are the services sustainable? The hospital stay within budget The level of services is sustainable	Spending compared to budget Payments collected from patients as a % of total hospital spending % budget spent on maintenance of buildings and equipment

STAFFING STANDARDS AND NORMS FOR REFERRAL HOSPITAL

PERSONNEL	Number	COMMENTS
Hospital Superintendent	1	
Deputy Superintendent	1	
Hospital Managers	1+1	1 deputy
Senior Consultants:		
Paediatrician/Neonatologist	1	Based on service delivery
Urologists	1	Based on service delivery
Gynaecologist	1	Based on service delivery
Oncologist	1	Based on service delivery
Cardiologist	1	Based on service delivery
Nephrologists	1	Based on service delivery
Senior Consultant::		
Endocrinologist	1	Based on service delivery
Neurologist	1	Based on service delivery
Intensive care specialist	1	Based on service delivery
Elderly care medicine specialist(Geriatrist)	1	Based on service delivery
Neurosurgeon	1	Based on service delivery
Paediatric Surgeon	1	Based on service delivery
Cardio-Thoracic Surgeon	1	Based on service delivery
Reconstructive surgeon	1	Based on service delivery
Consultants:		
Surgery	1 per ward	Based on service delivery
Paediatrics	1 per ward	Based on service delivery
Medicine	1 per ward	Based on service delivery
OBGYN	1 per ward	Based on service delivery
Orthopaedics	1 per ward	Based on service delivery
Anaesthesiologist	1 per ward	Based on service delivery
Radiologist	1 per ward	Based on service delivery

PERSONNEL	Number	COMMENTS
Ophthalmology	1 per ward	Based on service delivery
Chief Matron	1	
Specialist nurses:		
Midwife	10 per shift + 5 additional	
Neonatal nurse	4 per shift + 2 additional	
Intensive care nurse	1 per bed + 5 additional	
Mental Health Nurse	4	
FNP	8 per shift + 4 additional	
Ophthalmic	4	
Anaesthetic	4 per shift + 2 additional	
Urology	2 per shift + 2 additional	
Specialist nurses:		
Theatre	8 per shift + 4 additional	
ENT	2 per shift + 1 additional	
A&E	6 per shift + 2 additional	
Nurse-managers	1 per ward	
Neonatal	4 per shift + 2 additional	
Community Health Nurse	4 per shift + 2 additional	
Infection Control Nurse	2 per shift + 1 additional	
Diabetic Nurse	4 per shift + 2 additional	
General nurse	1 per every 2 beds + 10 additional	
Nursing assistants	1 per every 2 beds + 10 additional	
Hospital manager	1+2	2 Deputy Managers (HR and Admin)
Psychiatrist	2	
Clinical Psychologist	2	
Occupational therapist	4	
Paramedics	10	
Financial managers	4	
Public relations officer	2	
Occupational assistant	10	

PERSONNEL	Number	COMMENTS
Perfusionist	2	
Orthotics	2	
Medical officer	1per 5 bed + 4 OPD + 6 A&E	
Dentist	2	
Orthodontist	2	
Maxilla-facial surgeons	1	
Dental therapist	10	
Pathologist	2	
Optometrists	5	
Opticians	4	
Cytotechnologists	2	
Physiotherapist	2	

The Essential

Health service

Package for Botswana