Republic of Botswana

MINISTRY OF HEALTH AND WELLNESS

NATIONAL GUIDELINE FOR IMPLEMENTATION OF INTEGRATED COMMUNITY-BASED HEALTH SERVICES

November 2020

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ACRONYMS

ACHAP	African Comprehensive HIV/AIDS Partnership
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal clinic
APC2.0	Accelerating Progress in Communities
ART	Antiretroviral therapy
ASSIST	Applying Science to Strengthen and Improve Systems
BABPS	Botswana Association of the Blind and Partially Sighted
BCC	Behavior change and communication
BOCAIP	Botswana Christian AIDS Intervention Programme
BONASO	Botswana Network of AIDS Service Organizations
BUMMHI	Botswana University of Maryland Health Initiative
CATCH	Communities Acting Together to Control HIV
CBO	Community-based organization
CCE	Community capacity enhancement
CDC	Centers for Disease Control and Prevention
CHBCV	Community health home-based care volunteer
CHV	Community health volunteer
CHW	Community health worker
CLM	Community liaison model
COVID-19	Coronavirus disease of 2019
CSO	Civil society organization
CSS	Community systems strengthening
DHMT	District Health Management Team
DMSAC	District Multisectoral AIDS Committee
DOTS	Directly observed treatment support
EID	Early infant diagnosis
FP	Family planning
FWE	Family welfare educator
GBV	Gender-based violence
HEA	Health education assistants
HIV	Human immunodeficiency virus
HPM	Health promoter model
HSDM	Health service delivery management
IEC	Information, education, and communication
ILI	Influenza-like illnesses
IHSP	Integrated Health Service Plan
IGA	Income-generating activities
ITECH	International Training and Education Centre for Health
LMIS	Logistic Management Information System
MAUC	Mid-upper arm circumference

MBE	Ministry of Basic Education
MELPSD	Ministry of Employment, Labour, Productivity and Skills Development
M&E	Monitoring and evaluation
MLGRD	Ministry of Local Government and Rural Development
MOHW	Ministry of Health and Wellness
MTERST	Ministry of Tertiary Education, Research, Science and Technology
NCDs	Noncommunicable diseases
NDP 11	National Development Plan 11
NIC	Nurse-in-charge
NSP	National Strategic Plan
OP	Office of the President
ORS	Oral rehydration solution
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Research
PCG	Primary care guideline
PCV	Peace Corps volunteer
PHC	Primary health care
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
QI	Quality improvement
QIT	Quality improvement teams
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
RDT	Rapid diagnostic test
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
SCM	Supply chain management
SCHW	Senior community health worker
SMC	Safe male circumcision
SOPs	Standard operating procedures
SRH	Sexual and reproductive health
TB	Tuberculosis
TAC	Technical advisory committee
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund (now United Nations Children's Fund)
VDC	Village Development Committee
VHC	Village Health Committee
VMSAC	Village Multisectoral AIDS Committee
WASH	Water, Sanitation, and Hygiene project
WHO	World Health Organization

FOREWORD

Community health workers (CHWs) are a vital component of the primary health care strategy toward delivering people-centered care. CHWs enable the delivery of health services to everybody, including the poorest and most vulnerable, making them part of the national workforce that is key in supporting healthy populations and prosperous economies.

The role of CHWs in Botswana's health care service delivery is not new. Indeed, Botswana was one of the first countries to embrace the vision of community-centered primary health care and health for all in the late 1970s.

With a focus on community participation and overall community development, CHWs were instrumental in the improvement of health in the new independent Botswana. However, the advent of HIV/AIDS and the two-decade emergency response has been dominated by highly medicalized vertical programs. The current COVID-19 pandemic poses a similar scenario. While CHWs have remained critical in this response as part of the health workforce, they have remained largely uncoordinated and under-developed within the broader health system. This document seeks to address this deficiency.

Determined to re-vitalize primary health care and to refocus on local communities, the adoption and launch of the Harmonization of Botswana's Community Health Workers Groups: Primary Health Care-Community Health Worker (PHC-CHW) Coordination Strategy of 2017 reflects a critical commitment by the Botswana Government to institutionalize CHWs as part of the health sector.

This guideline operationalizes the Harmonization Strategy of 2017 and is pivotal in supporting the aforementioned commitment. It provides clear guidance for ensuring that CHWs are well coordinated, monitored, and incentivized to deliver integrated community-based health services for optimal community health outcomes.

It is, therefore, expected that all organizations and ministries implementing community-based health services will maximally use this guideline to provide quality integrated community-based health interventions, thus strengthening primary health care delivery across Botswana.

Let us all be the change we desire.

Sincerely,

Mr. Kabelo A. Ebineng
Permanent Secretary

ACKNOWLEDGMENTS

The Ministry of Health and Wellness thanks all those who have generously volunteered their time, effort, resources, and expertise in contributing to the planning and development of this guideline.

The National Guideline for Implementation of Integrated Community-Based Health Services was developed by a multidisciplinary team through an extended collaborative process. The development was led by the Ministry of Health and Wellness task team and supported by the United States Agency for International Development (USAID) and PEPFAR-funded FHI 360 APC 2.0 Project.

The guideline was made possible by the technical support of the Ministry of Local Government and Rural Development, PEPFAR, USAID, Centers for Disease Control and Prevention and Business Botswana, whose participation is critical for ownership and implementation.

The guideline draws from and reflects current and future health sector reforms aimed at provision of quality health care for all in line with achieving universal health coverage. We continue to appreciate the World Health Organization (WHO) and United Nations Children's Fund (UNICEF), who are always there to provide the government with normative guidance and support in the re-structuring and re-orientation of Botswana's health services to address the needs of all communities.

In addition, the Ministry of Health and Wellness acknowledges key experts from a range of different departments, programs, and District Health Management Teams. The guideline is a success because of consultation with representatives from other sectors, partners, civil society organizations (ACHAP, BONASO, BOCAIP, and Tebelopele) as well as other health services providers.

Le kamoso!

Mr. Samuel Kolane
Community Health Services Advisor

EXECUTIVE SUMMARY

The *National Guideline for Implementation of Integrated Community-Based Health Services* has been developed by the Ministry of Health and Wellness–Department of Health Services Management as a technical tool. This guideline is a reflection of the Ministry's commitment to strengthening primary health care and implementation of the *Harmonization of Botswana's Community Health Workers Groups: Primary Health Care–Community Health Workers (PHC-CHW) Coordination Strategy* launched in 2017.

Seeking to promote an integrated approach to community-based health service delivery and standardize a minimum package of community-based health interventions, the guideline also reflects the country's commitment to local and global health sector goals. The specific objectives are to provide technical and programmatic guidance including:

- Improving the delivery of integrated community-based health interventions through provision of a standardized minimum package
- Strengthening coordination and management of community-based health services through harmonized community health workers groups, leadership and governance
- Strengthening CHWs competencies and skill mix for delivery of integrated community-based health services
- Strengthening information management for integrated community-based health services

The guideline will benefit various actors and stakeholders including policymakers, managers, Ministries, and CHWs who are responsible for managing and implementing community-based health services. A multidisciplinary team developed the initial concept for the guideline and engaged in an interactive and extended collaborative process of reviewing and refining the scope and content. The guideline is the first publication on community health services and mirrors the primary health care guideline in the way the minimum package is developed. The guideline is intended to be easy to read and user friendly, and will be placed in all facilities for reference. It also includes a curriculum for CHWs in the era of COVID-19.

DEFINITIONS OF KEY TERMS

These definitions will enable users to have a common understanding of terms used.

Community-Based Health Services: One aspect of achieving universal health coverage is ensuring availability of health services in the community. Community-based health services have been a critical part of addressing health challenges in Botswana, especially improving access to HIV and tuberculosis (TB) care services. For this guideline, community-based health services means all services provided by trained health workers who spend a substantial part of their working time outside a health facility, discharging their services at the individual, family, and community level and linking clients with facilities for continuity of care.

Community Health Worker (CHW): Community health worker is widely used internationally to describe the cadre who provide health services at the community level. For purposes of this guideline, a CHW is primarily based and works in the community and has undergone formal (although limited) training to carry out a series of specified roles and functions, which are provided by the health system or health program. Recruitment of CHWs should be based on a pre-defined set of criteria or qualifications that each should meet to be considered for the program (see **Annex A.1.1**).

Epidemic: As per WHO, the occurrence in a community or region of cases of an illness, specific health-related behavior, or other health-related events clearly in excess of normal expectancy. The community or region and the period in which the cases occur are specified precisely. The number of cases indicating the presence of an epidemic varies according to the agent, size, and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence.

Health care systems: A health system includes all the actors and activities that work together to promote, improve, or maintain the health of the citizens (WHO). Organized health services, i.e., the health care system, are only one of the many factors for maintaining good health, recovering from ill health, or making a life with chronic illness easier. Health is influenced by many external factors such as environmental, social, and economic, and by factors related to lifestyles and other sectors within society. Botswana has a mixed health care system composed of public, private for-profit, private nonprofit, and traditional medicine practice. A significant 96 percent of Botswana urban residents live within a 5 km radius of the nearest health facility compared to 72 percent of rural residents (Statistics Botswana, 2017).

Health sector: The health sector is a collection of public, private for-profit, private nonprofit, and traditional health care providers working together to improve the health status of its citizens.

Health sector reforms: A transformation that focuses on the delivery of quality health care that is financially sustainable and incorporates a revitalization of primary health care as well as increased private sector and community participation. In 2010, the Ministry of Health in Botswana developed the strategy for changing the health sector for a healthy Botswana 2010–2020, which serves as a road map on how Botswana, through the MOH and partners, will improve the health status and health care of the population.

Integrated health service approach: Integrated health services means different things to different people. In this context, the approach refers to the vertical integration of different levels of health service provided through a network of service providers at public, private, community, and traditional settings to allow clients to receive a continuum of preventive and curative services that meet their needs over time.

Pandemic: As per WHO, the worldwide spread of a new disease. An influenza pandemic occurs when a new influenza virus emerges and spreads around the world, and most people do not have immunity. Viruses that have caused past pandemics typically originated from animal influenza viruses.

Primary health care: WHO defines primary health care as a whole-of-society approach to health and well-being centered on the needs and preferences of individuals, families, and communities. It is ensuring that people receive comprehensive care ranging from promotion and prevention to treatment, rehabilitation, and palliative care as close as feasible to their everyday environment. Primary health care (PHC) services in Botswana are integrated within overall hospital services, being provided in the outpatient sections of all levels of hospitals. Through these structures a complement of preventive, promotive, and rehabilitative health services as well as treatment and care of common problems are provided.

Stakeholders: People and organizations who have interest in the guideline at the district and national level. District level stakeholders include District Health Management Teams; health service providers and professionals; civil society organizations (CSOs); various community-based organizations, networks, and support groups; community committees; and community and religious leaders. National level stakeholders include government ministries and departments, and development partners and donors.

Sustainability: The ability to continue to deliver affordable and quality health services that are cost effective and meet client's expectations over time.

Universal health coverage: WHO defines universal health coverage as ensuring that all people have access to needed and affordable health services including prevention, promotion, treatment, rehabilitation, and palliation of sufficient quality to be effective while also ensuring the use of these services does not expose the user to financial hardship and push households into poverty. It requires health care system strengthening, particularly the re-orientation and up-skilling of human resources for health to ensure quality PHC services.

PART 1:
Introduction and purpose

1.1 Introduction

National Guideline for Implementation of Integrated Community-Based Health Services represents Botswana's health sector vision for a healthy and productive nation in line with Vision 2036. It is the result of a collaborative and consultative process led by the Ministry of Health and Wellness (MOHW) with stakeholder representatives of the health sector. The guideline identifies a minimum package of integrated community-based health interventions and how they should be delivered to provide comprehensive care to people in their communities across a number of areas, including prevention, treatment, care and support for HIV infection and tuberculosis (TB); selected noncommunicable diseases (NCDs); selected aspects of reproductive, maternal, newborn, child, and adolescent health (RMNCAH); malaria; nutrition; aging and audiology; palliative care; alcohol and substance abuse, rehabilitation, mental health; eye health; and other community-based services. A COVID-19 Training Curriculum for Community Health Workers (see **Annex D**) has also been included to address knowledge, attitudes, and practices during the current pandemic. The minimum package of health services is aligned to the country's and communities' epidemiological priorities and supports a human rights approach to service delivery.

The main thrust for implementation is anchored on the continuing application by the MOHW of the WHO concept for PHC and a people-centered approach, which emphasizes the importance of a comprehensive and integrated model—as opposed to a vertical approach toward health services delivery—that prioritizes the needs and expectations of individuals, families, and communities, rather than diseases. This guideline will, for the first time, provide a harmonized and integrated approach to household needs through home visits and community review. The health of a nation or society is a good barometer to judge how well run and structured its health and social services departments are, the nucleus of which is the local communities as conceived in the social-upliftment pillar of NDP11. Consequently, the guideline will strengthen patient feedback mechanisms and accountability of our health system from individual, household, and community levels to the facility level.

One of the four PHC principles is community and individual involvement and promotion of self-reliance, which can only be realized through having, a well-trained and well-motivated team of CHWs at the grassroots. CHWs, inclusive of volunteers, are the gears for the smooth delivery of a comprehensive and integrated community-based package of health care services. This is part of a holistic approach to health care delivery that guarantees a product that is not only patient-centered but ensures sustainability as well as continuity of care. For example, TB treatment remains one of the most cost-effective interventions in the world, being far cheaper than many preventive services. According to (MOHW, 2007), the cost of ignoring community care would be extremely high as TB kills more than 50 percent of its victims if they are not effectively treated, so creating

a demand for services through education as well as early detection and active case finding and screening at the household level will have a comparative advantage compared to facility-based passive surveillance and treatment.

PHC is about putting communities at the center as the reference or starting point for any development program, including health care delivery. It means not just working for the communities but WITH them, helping them get meaningfully involved in the planning, decision-making, and implementation processes, including—but not limited to—resource mobilization, partnership-building, monitoring, and evaluation. Such bottom-up approaches help build communities' confidence in health systems, strengthen community leadership and governance structures, create a sense of community ownership, and provide the foundation for creating sustainability. A pivotal role can be played by CHWs and volunteers, with this guideline offering a template on how to incorporate them to effectively deliver quality community-based health care services.

Communities are at the center of the notion of PHC and the idea of providing patient-centered quality services closer to the people for them to take charge of their own health. In Botswana, **traditional community structures** played a very prominent and critical role in the health sector prior to the advent of the HIV epidemic. Community leaders and health workers communicated, connected, and collaborated closely, thereby integrating clinics and their staff with the community they served.

With shifting disease burdens, longer life spans, and increasingly complex interventions, Botswana's future health depends on a **renewed focus on communities** and a health system tailored to serve them to prevent all forms of ill health. This emphasis is recognized in the 2016 WHO framework on **integrated people-centered health services** as a call for a fundamental shift in the way health services are funded, managed, and delivered. Its strategies include the determined empowerment and engagement of communities through existing governance structures.

The **effective coordination of health interventions at the community level** is a critical function under the community health system to ensure that health interventions are designed and delivered around the needs of patients, their families, and communities, acknowledging local context and resources. Established mandates of **Village and Ward Health Committees** under both the traditional Kgotla system and decentralized government have fulfilled critical coordination and communication functions in the past; they are also critical under this guideline to provide the **effective community-centered delivery** of integrated quality services.

All service providers, whether under the public health system or those funded by nongovernmental or external partners, are expected to explore and seize any opportunity to seek the **active involvement of existing community structures** wherever they operate. While local capacity and circumstances vary from community to community, the imperative to strengthen and revitalize these structures to join in the transformation of the health system is a shared responsibility of all partners.

1.2 Goal, objectives, and target audience

1.2.1 GOAL

To guide and standardize implementation of community-based health services in Botswana

1.2.2 OBJECTIVES

This guideline provides technical and programmatic guidance on the implementation of the minimum package of community-based health interventions to better meet the needs and expectations of communities.

Specifically, the guideline will:

- Improve coordination, management and alignment of community-based health services through harmonized CHW groups – leadership and governance
- Strengthen the delivery of integrated community-based health interventions through provision of a standardized minimum package of community-based health services
- Strengthen CHWs competencies and skill mix for delivery of integrated community-based health services
- Strengthen information management for integrated community-based health services

1.2.3 TARGET AUDIENCE

This guideline is intended for use by all stakeholders involved in implementation of community-based health services at national, district, and community levels.

The target audience includes government ministries, civil society organizations (CSOs), nongovernmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations, funding agencies, business entities, researchers, and community members.

1.2.4 ADOPTION AND ADAPTATION

This guideline was prepared as a national guiding framework with the understanding that most of the approaches and interventions described are expected to be adopted. Occasionally, some limited portions of the guideline (e.g., individual elements in the package of integrated services) may require adaption to better address community or district specific needs. For example, in a district where malaria is not prevalent, interventions aimed at malaria prevention will be seen as a low priority and thus, functions aimed at malaria prevention may be excluded from the essential package of integrated services in that district.

In other cases, the proximity and ease of access to higher level of care in some districts may affect the referral structure and degree of task shifting. In any case, the adaptation process should include district and local level consultations among community governance structures, NGOs and other CSOs, and direct beneficiaries of the community health services.

In rural and urban settings, the comparative advantage of community-based health services may be different to achieve optimal health outcomes. Currently transportation and poor terrain have been a limiting factor for CHWs in sparsely populated areas, exacerbated in 2010 when clinics moved to central government and programs no longer had earmarked vehicles for fieldwork (i.e., domiciliary, mobile, and outreach services). There is a need for structured, scheduled, and regular integrated community-based health fieldwork or outreach services to optimize current practices. The involvement of all sectors, including the private sector and civil society, in health sector planning is critical at the community level, especially in education for prevention and early detection for the control and elimination of communicable and noncommunicable diseases.

Part 2:
Policy frameworks and context

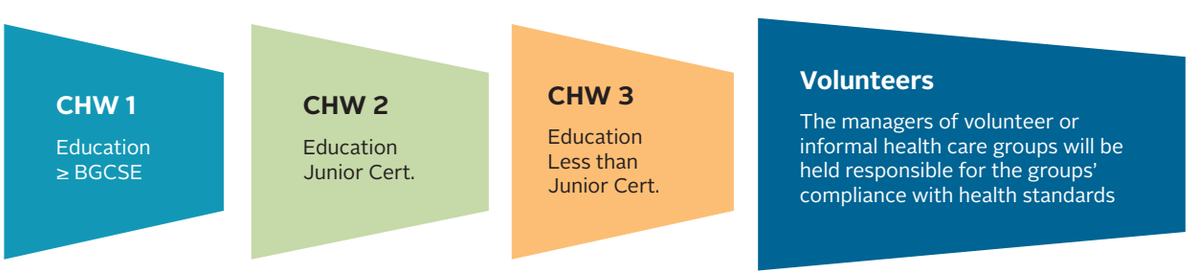
2.1 Policy frameworks and context

Botswana has embarked on reforming its health system, envisioning attainment of universal health care coverage through a transformation agenda. This process is guided by the principles of revitalization of a PHC approach to service delivery and sustainable quality health care services. The reform is aligned with the Health Systems Framework set by the WHO comprised of six building blocks: leadership and governance/organization and management; health information; health financing; health workforce; infrastructure, medicines, vaccines and technology; and health services delivery. It is operationalized through the Integrated Health Services Plan (IHSP) that provides a platform to facilitate the desired transformation.

The reform safeguards a more strategic and efficient response to the health needs of Botswana necessitated by a desired paradigm shift from curative to preventive services and a shift from a vertical disease-orientated approach to an integrated approach. It affords continuum of care, rooted in the PHC approach, and integrated health service delivery that also strengthens community linkages and collaboration within districts and regions.

In pursuit of universal health coverage, the Government of Botswana has committed to providing quality health services closer to the people in a manner that encourages a holistic continuum of care approach that strengthens community engagement and cost effectiveness. A community support strategy (*Harmonization of Botswana's Community Health Worker Groups*) has been developed to guide the establishment of a unified and coordinated community health work program approach. CHWs will be institutionalized through an administrative structure of four levels (**Figure 1**), categorized by education level and type of services rendered.

Figure 1. CHW Categories



Source: Harmonization of Botswana's Community Health Workers Groups: Primary Health Care-Community Health Worker (PHC-CHW) Coordination Strategy, 2017

CHW I: The education level for this category is Form 5 (BGCSE) or above. A certificate in a health-related field accredited by BQA will also suffice, for example, some earlier family welfare educators (FWEs) have certificates but no Form 5. In Government this category corresponds to health education assistants (HEAs) who are full-time employees on a predetermined Government salary scale. Some HEAs who were trained as FWEs after being nominated by their communities in earlier years, may not have a Form 5 certificate but have requisite years of work experience to qualify for CHW I or a post as an HEA and have progressed through the ranks with on-the-job training, workshops, and seminars.

CHW II: The minimum entry level of education for this category is Form 3 (Junior Certificate) but less than Form 5.

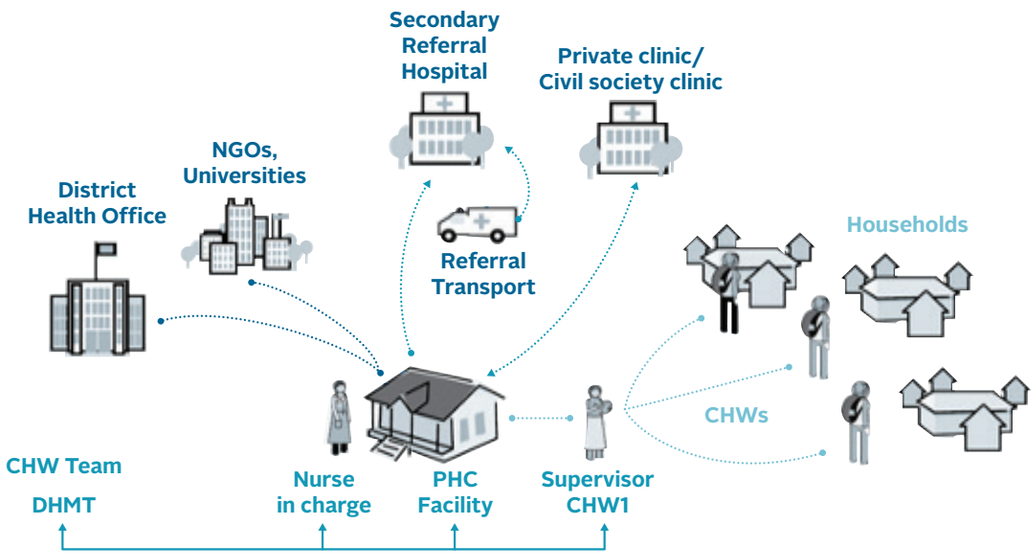
CHW III: The level of education is less than Form 3.

Volunteers: Some CHWs (mainly volunteers) may not easily be classified according to category I, II, or III; they are included in the fourth category. Volunteers may include individuals without educational qualification on the one hand, and those with professional qualifications on the other.

For ALL categories, the conveners or managers of these groups will be required to ensure their adherence to relevant MOHW guidelines and policies.

CHW II, III, and volunteers will be linked to the formal health system at district level through CHW 1 (HEA) category. The CHW I will supervise CHW II, III, and volunteers, and report to an established CHW Team of the District Health Management Team (DHMT) on a monthly basis, but for routine activities the CHW I will report directly to the nurse in charge of the facility for support with health services. Continuity of care will therefore be achieved through the linkages between the CHW group and PHC facilities under the DHMT as well as through an effective multidirectional referral network (See **Figure 2**).

Figure 2. CHW group as part of the broader health system



2.2 Revitalization of primary health care (PHC) approach

According to the WHO, the PHC concept offers a comprehensive guide on equity, what to prioritize, technology to be applied, sociocultural aspects, target groups, full involvement of the community, and cost-effectiveness and efficiency. PHC encompasses personal health care (medical care) and public health care. The medical care focuses on treatment, rehabilitation, and palliative care of individuals while public health focuses on prevention of diseases or ill health and promotion of health of the community. PHC gives higher priority to primary level of care and to public health compared to medical care. The application of the PHC concept in community settings requires an integrated and comprehensive approach. WHO identifies four principles of PHC:

1. **Universal access and coverage.** This translates into the task of fulfilling needs of vulnerable populations, such as women and children, as well as those living in remote areas and the poor. This principle also implies that equity, or social justice, is a driving force for addressing the health needs of the whole population. Botswana embodies this ideology in Vision 2036-Prosperity for All.
2. **Community and individual involvement and self-reliance.** Health should not be the sole responsibility of the government. Each individual and the community should be held responsible as well by involving them from the planning stage through implementation and monitoring and evaluation of health programs.
3. **Intersectoral action for health.** The causes of ill health include health risks, health determinants, outbreaks, and pandemics. Health risks emerge from people's lifestyles while the determinants of health include several factors, such as social, educational, economic, gender, political, security, and physical environment (e.g., water and sanitation). The implication is that successful implementation of PHC requires intersectoral action, as well as the ability to coordinate with other sectors.
4. **Appropriate technology and cost-effectiveness.** Right choice of technology will ensure better efficiency of the health system, for example, the use of global positioning systems (GPS) in disease surveillance. Cost-effectiveness alone should not be used as the determining criterion for developing policy and priorities. It has to be coupled with feasibility for implementation and acceptability by the people at large. The focus on prevention and promotion in PHC, without neglecting curative, rehabilitative, and palliative care, is derived from this principle.

The focus on a revitalized PHC system requires a paradigm shift from curative to preventative services. It also requires an investment in International Health Regulations, Public Health Security, and epidemic preparedness and response. Preventive care aims to mobilize communities for health interventions such as immunization, malaria control, sanitation, and promoting health seeking behavior; promote a culture of healthy lifestyles; target high-risk groups; and strengthen community-based and multisectoral interventions. When communities have a good health status and functional surveillance structures, outbreaks and pandemics are easier to prevent and control.

Inherent Resilience

Selected community health worker roles that promote inherent resilience

- Increase the access to health services and products within communities to improve population health and reduce the likelihood of an outbreak
- Communicate important public health concepts in a culturally appropriate fashion
- Reduce the burden felt by formal health care systems and improve the quality of clinical care

Adaptive Resilience

Selected community health worker roles that promote adaptive resilience

- Act as community-level educators, organizers, and mobilizers during infectious disease outbreaks
- Contribute to syndromic disease surveillance systems while completing routine activities
- Complete medical tasks unrelated to the infectious disease outbreak to fill health service gaps during or following the outbreak

Source: Matthew R. Boyce and Rebecca Katz (2019) Community Health Workers and Pandemics Preparedness: Current and Prospective Roles.

2.2.1 THE ROLE OF COMMUNITY HEALTH WORKERS IN EPIDEMICS AND PANDEMICS

Epidemic and pandemic preparedness are vital in PHC systems. CHWs are an inevitable resource in prevention of outbreaks because the link the health systems with the community. Their protection and safety during pandemics should be prioritized along with other HCWs in manpower planning and resource mobilization. CHWs as the voice and eyes of the community have an inherent and adaptive role in building resilient health systems (Boyce & Kartz, 2019).

2.3 Integrated health service approach

"Integrated health services" means different things to different people. The WHO defines integrated services as the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system. While vertically organized programs are successful in addressing individual health issues, such as childhood immunizations, HIV, or malaria, integration of health services derive greater overall impact from health resources and systems. As the population ages, cancer, diabetes, and other noncommunicable diseases become more common, with a growing need for screening, information, and services to help them combat these illnesses. An integrated approach strengthens the health system by integrating prevention, treatment, and care for clients with chronic conditions at the PHC level in order to ensure a seamless transition to assisted management and self-management within the community.

In this guideline, "integrated" refers to a health service delivery model. From the health worker perspective, integration of services enables them to address the health of their clients more holistically. From a health care system and program perspective, integrated services can be more efficient by avoiding duplication of effort and serving more people at the same or similar cost. Health care providers need assistance to inform and screen individuals with behavioral and general health care needs. Integration that uses a single encounter with a client to address multiple health or social concerns is an important tool that better meets the needs of individuals in a timely and efficient manner.

In addition, integration in this guideline refers to a minimum package of preventive and curative health interventions for a particular population or community. The package addresses chronic communicable diseases including HIV and TB, and chronic noncommunicable diseases (NCDs) such as diabetes and cardiovascular issues. It also addresses certain aspects of reproductive, maternal, and child health; eye diseases such as cataracts, glaucoma, and diabetic retinopathy; substance abuse; and mental health illness. People with chronic health conditions often face earlier mortality due to poor health habits (e.g., inadequate physical activity, poor nutrition, smoking, and nonadherence to medication) and challenges in navigating a complex health care system.

2.4 Leadership and governance: community health worker system strengthening

All players in the community have a prerogative to follow existing and agreed on channels of communication of local governance structures and to be acquainted with the different idiosyncrasies of the various communities and cultures in which they work. No one is above the law, and this guideline will add to the order and guidance in moving resources and services in a manner agreed on by the community, for the community, and with the community for maximum utility in delivering the best possible health outcomes.

Leadership and governance are critical building blocks of any health system. The role of government involves overseeing and guiding the whole health system to protect the public interest. This includes reconciling competing demands for limited resources in changing circumstances, thus requiring both political and technical action. This section focuses on how the integrated model will be operationalized from the national and district level and how bottom-up approaches may improve the acceptance and uptake of services provided. Social accountability mechanisms and engagement of communities through activism, lobbying, and advocacy play a critical role in ensuring equity and implementation of national policies and guidelines.

At the community level, various structures exist to support health activities. Delivery of the minimum package of community health services should take into consideration and optimize functions of the existing community structures in the country. Successful implementation relies on the synergistic efforts of both formal and informal structures in the community. Formal structures include CSOs, various CBOs, network support groups, and community committees such as the

Village Development Committee (VDC), Village Health Committee (VHC), Village Multisectoral AIDS Committee (VMSAC), as well as chieftaincy (Bogosi). Informal structures include support and peer groups.

The VDC's function is to identify and prioritize village needs as well as to liaise between the villagers, politicians, and local authorities. The VHCs focus on matters directly related to health and may be involved in the identification of health needs in their communities. They can also facilitate the selection of CHWs, provide motivation to them, and promote cooperation and respect between CHWs and the community. Bogosi will facilitate open community fora (Dikgotla) where community members can make health decisions and have the chiefs pass them on to the local authorities. Concerns, needs, and feedback on community health services can be discussed and communicated to decision-making bodies at facility and district levels, through the Community Health Worker Administration structure.

At the district level, community-based activities are currently guided by the Community Health Nurse and the Health Education Officer under the management of the DHMT, which supports the different health care programs and activities. The DHMT reports to the district development committee (DDC) which in turn reports to the full council. A Community Health Worker Coordination Team will be established at the DHMT to coordinate and oversee community health programs.

At the national level, the community health system in Botswana is governed by the Health Services Management Department with the guidance of the Community Health Services Advisor at the MOHW.

2.5 Coordination of community-centered service delivery

Communities function within a wide variety of community networks, linkages, and partnerships. These are critical for enabling effective delivery of activities and services. Strong ties of informal and formal relationships between communities, community actors, and other stakeholders enable them to work in harmony and in a complementary way. This recognition and consideration will maximize the use of resources, avoid unnecessary duplication or overlap, further encourage mutual reinforcement, and minimize competition.

Coordination bottlenecks will be addressed by:

1. Including crucial health partners from the beginning, which will improve implementation and collaboration of service delivery in the long run
2. Ensuring proper communication between different levels to avoid isolation and reduce duplication or waste of resources
3. Improving linkages between community and health facility through community support and good community relations to promote uptake and acceptability by community.

2.6 Sustainability

Sustainability of community health services is rooted in a fully integrated approach, creating and building momentum to maintain community-wide change by organizing and maximizing community assets and resources. It means institutionalizing policies and practices within communities and organizations. It also means involving a multiplicity of stakeholders to ensure long-term buy-in and support. These elements are crucial to ensure lasting change and make a difference in people's lives.

The adoption of the PHC-CHW coordination strategy provides an enabling ground to facilitate needed budgetary support for the establishment of a cadre of CHWs in the health sector. The strategy recognizes the effective role played by CHWs and their efficiency in providing a range of preventive, promotive, rehabilitative, and palliative services to help reduce inequalities in access to essential health services. This growing recognition also provides an enabling environment and momentum for this guideline to be carried forward, including the current transitions in development health assistance and health financing at the community level. This guideline can therefore help promote sustenance in community-based health interventions through aligned efforts that also have better chances for continuity beyond assisted programs.

Part 3:
Implementation guide

3.1 Guiding principles

3.1.1 PEOPLE-CENTERED HEALTH SERVICES

Botswana has very strong and vibrant communities, supported by the traditional leadership and existing community structures caring for the well-being and functioning. Within this conducive environment, community-led approaches and service delivery at community-level will be well received and accommodated.

Guiding principles

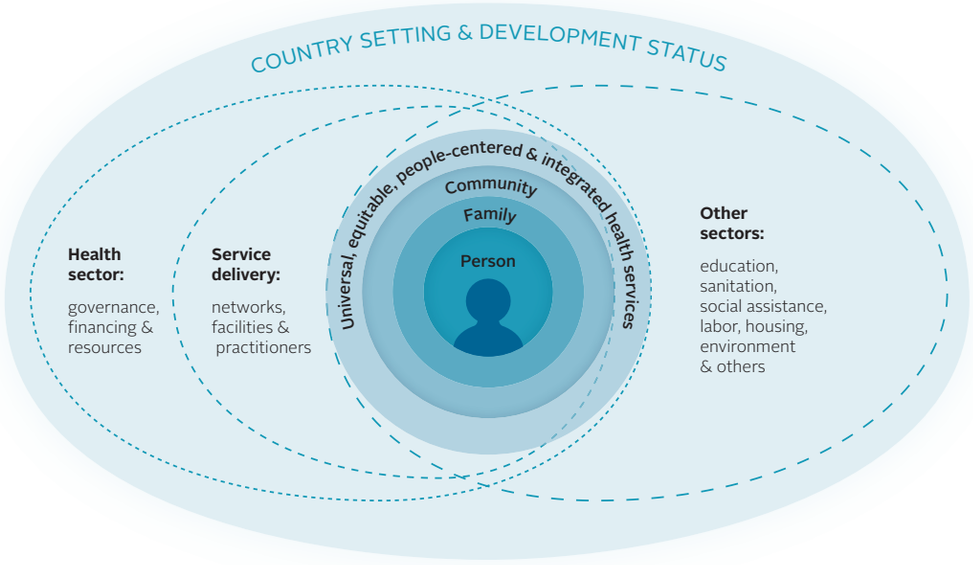
- People centeredness
- Community involvement, participation, and collaboration
- Universal health coverage
- Sustainable development
- Health systems strengthening
- Quality health care
- Affordable health care

People-centered health services is an approach built around health needs and expectations of people rather than diseases, putting people, not diseases at the center of health services. The approach prioritizes health services that consciously adopt the perspectives of individuals, families, and communities, and sees them as participants as well beneficiaries of trusted health systems that respond to their needs and preferences in human and holistic ways. People-centered health services require that people have the education and support they need to make decisions and participate in their own care.

Working with communities assists implementers in understanding and appreciating structural challenges they face with regard to the services and initiatives brought to them. Putting the community at the center of the health response asks for meaningful community involvement, innovative bottom-up approaches, and respecting existing structures and community voices within the planning, implementation/delivery, and monitoring and evaluation phases.

People-centered services strengthen community ownership, which in turn ensures (1) buy-in by traditional leadership and recognized community groups to ensure acceptability of services, (2) high demand and uptake of quality services, (3) improved feedback loop, and (4) sustainability through local ownership, understanding, partnerships for resources, and strengthened linkages between community and health care providers/facilities.

Diagram 3.1. People-centered health services model (WHO, 2015)



3.1.2 COMMUNITY RESOURCES, PARTNERSHIPS, AND COLLABORATION

Working at the community level also brings the opportunity to tap into various community resources (material, financial, and manpower). These internal resources will be considered and used in accordance with and led by the community to improve the cost-effectiveness and sustainability of community-based interventions.

Partnerships and improved collaboration at the community level is crucial to achieve positive health outcomes. Existing structures for partnerships, collaboration, and coordination between recognized community groups, traditional leadership, and health care providers and facilities need to be taken into account and strengthened.

3.1.3 COMMUNITY-LED IMPROVEMENT, MONITORING, AND EVALUATION

There should be a single national monitoring and evaluation (M&E) system that recognizes all the players in the health sector system. Monitoring at the village structures will be linked to the health facility. The VHC and the VDC through the office of the Kgosi and community leaders will contribute to the improvement of health activities on behalf of the community as gatekeepers and development agents. The volunteers should also assist in the M&E processes.

Traditionally, M&E are normally left for experts to determine, however, people-centered services demand that communities be involved at the program planning stage where key performance indicators (KPIs) are determined and how evaluation will be structured. This requires innovative ways of engaging communities to inform KPIs and structuring of M&E frameworks. M&E techniques such as theory of change can be used to meaningfully engage communities in program planning, monitoring, and evaluation. This can result in robust M&E systems that monitor

CHW supplies, activities, and performance, serving as early warnings for under-performing districts, identifying CHWs for targeted follow-up, and supporting the implementation of a performance-based incentive structure to reward good performance. This is outlined in the Harmonization Strategy and in the M&E section, Part 4 of this guideline.

3.1.4 HEALTH SYSTEM SUPPORT

A community health work program depends entirely on the capacity of the health system to ensure that CHW functions are expedited across different contexts of the system. Understanding the health system's capacity is necessary to effectively support the CHW program at national, district, and local levels. CHWs support will leverage on available policy guidance; supervision and accountability (at all levels of service implementation) structures; curriculum development and training, community data management, M&E; community leadership engagement, trust, and acceptance; community supply chain commodity management; community health care waste management; quality improvement; and sustainability programs.

3.1.5 ETHICAL AND LABOR ISSUES

CHW initiatives and programs should be aligned with and be part of broader national health workforce policies. The program should be linked with educational, labor, and community development policies and frameworks including labor laws that promote decent working conditions. CHWs will be trained in ethical and legal issues including, but not limited to:

- Client confidentiality: not to be discussed with anyone with the exception of health care professionals at the health center or hospital.
- Distribution of medication: to be provided to the patient only, never to intermediaries, with the exception of custodians if the patient is under the age of consent or clients who are unable to get their medication at the facility.
- Solicitation and acceptance of gifts: never ask clients for money or gifts; receiving gifts should be according to the gift policy of the organization engaging the CHW.
- Disclosure: provide necessary information about patients' health to health professionals to facilitate service provision and quality of care.
- Authority: never abuse authority;
- Conduct themselves with proper etiquette and ethics within the bounds of the law at all times.

3.2 Service delivery models

Community service delivery in Botswana relies mostly on a combination of two models: the Community Liaison Model (CLM) and Health Promoter Model (HPM). The CLM is disease oriented. This may be disease prevention and ongoing disease management, such as directly observed therapy (DOTS) for patients with tuberculosis, or referral and screening for HIV, TB, and NCDs. The HPM focuses on education and counselling activities, including immunization campaigns, Water, Sanitation and Hygiene (WASH) project, family planning education, etc.

3.3 Approaches of service delivery models

3.3.1 TARGETED HOME VISITS BY CHWs

Targeted home visits can be initiated by a health facility when it refers a patient for follow-up and support by CHWs. The visit can also be initiated by CHWs when they identify an unmet need within a household through some other community channels. Depending on the situation, targeted home visits may involve health education and demand creation, conducting needs/risk assessment of household members and linking to appropriate services where necessary, providing screening for certain health conditions, or providing counselling and adherence support. Targeted home visits also provide an opportunity for social support by making CHWs available to listen and talk through problems that patients or household members experience.

3.3.2 PEER-TO-PEER COMMUNICATION IN HEALTH PROMOTION AT COMMUNITY LEVEL

Peer-to-peer is an approach to health promotion in which community members are supported to promote health-enhancing change among their peers. It involves teaching or sharing of health information, values, and behaviors with other community members who share similar social backgrounds or life experiences. Peer-to-peer approach helps to reduce communication barriers and improve support mechanisms and social connections. Research suggests that people are more likely to accept the message when they believe the messenger has similar experiences to them and shares similar concerns and pressures. Thus, they are more likely to change their attitudes and behaviors.

Peer-to-peer communication can complement integrated community-based prevention, treatment, care, and support services by emphasizing healthy, preventive behaviors and supporting adherence to treatment.

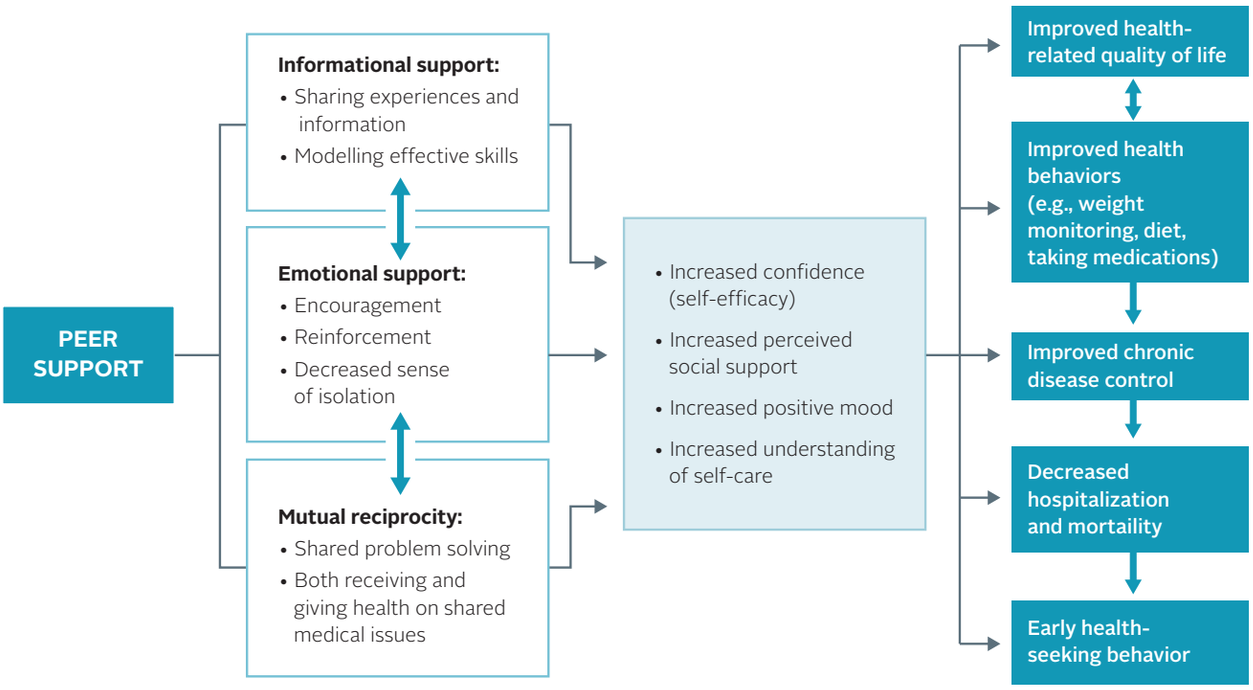
Deliberate efforts will be made to ensure that CHWs are recruited from the same community or target audience (e.g., age, sex, behavioral traits) that they are to serve. This will facilitate effective communication and enhance positive change in the community. Communities will be engaged throughout the recruitment and deployment of the CHWs.

3.3.3 SUPPORT GROUPS

Support groups are voluntary gatherings of people who share common experiences, situations, or problems, and who offer each other emotional and practical support. Most effective support groups are largely run by and for group members, even though CHWs or other professionals may initiate and provide some structure for the group. Meetings usually include discussions, sharing of information and experiences, and other activities that promote mutual support and empowerment. The groups are open to any community member who has shared in the experience. Participation in support groups often leads to better treatment adherence, symptom control, coping skills, and greater improvement in general well-being; it also gives members an opportunity to develop friendships, build social networks, boost self-esteem, enhance confidence, and promote early health care seeking behavior (**Figure III**).

This approach will also be applied in the implementation of this guideline.

Figure 3. Peer support and social groups for improved health outcomes



3.3.4 HEALTH INFORMATION/COMMUNICATION CAMPAIGNS

Community-based information campaigns involve dissemination of health messages that seek to increase community knowledge and awareness of health issues, influence health behaviors and attitudes, demonstrate healthy practices, demonstrate benefits of behavior change, advocate a position on a health issue or policy, argue against misconceptions about health, and increase demand and support for health services. These campaigns can rely on community meetings (Kgotla meetings and other social gatherings), theater performances, and mass media (both printed materials such as newspaper adverts, posters, pamphlets, brochures, and broadcast media such as television, radio, and internet) to deliver health messages.

Health information/communication campaigns are effective for spreading public health messages, especially endorsing disease prevention (e.g., TB, HIV/AIDS, diabetes) and general health promotion and wellness (e.g., smoking cessation, physical activity, family planning, reproductive health).

The following three components should be present regardless of service delivery model:

1. Cross referrals/multidirectional referrals between service points and different providers. All prevention, treatment, care, and support services are linked by a referral system within the community and between the community and other elements of PHC system.
2. CHWs and volunteers ensure the referral points are reached as soon as possible, preferably the same day.
3. Essential package of health interventions offered by individual CHW (the package may vary based on the level of the CHW and may be tailored to the specific needs of the community).

3.4 Overview of the minimum package of community-based health services

Table 1 summarizes interventions provided within the minimum package of community health services. While most interventions should be available in all communities, certain activities may be less relevant in communities with low prevalence/low risk of a disease (e.g., if malaria is not a problem in a particular district, the package should be tailored to reflect that).

Table 1. Overview of the Minimum Package of Community-Based Health Services per the Community Health Worker Structure

DESCRIPTION	PREVENTION, SCREENING, AND EDUCATION	TREATMENT, CARE, AND SUPPORT	QUALIFICATIONS
Community Health Volunteer (e.g., CHBCV-community home-based care volunteer)			
Volunteers: a member of the community who volunteers their time and is supported by the community and the health system but is not necessarily a part of its formal organization; undergone informal training to carry out a series of specific functions predominantly in health promotion and prevention area. CHBCV will become a part of this workforce with a different package of services as defined in home-based care guideline and SOPs.	**Basic health education** (as part of BCC, they will employ IEC materials and job aids) **Interpersonal communication training** • HIV-specific education: prevention, transmission, frequency of testing, safe male circumcision (SMC), "treat all" approach, PMTCT, PrEP • TB-specific education: transmission, infection control messages • Education about overall STI symptoms and prevention • Education on NCDs, including major risk factors (lifestyle, physical activity, diet/nutrition, impact of smoking) • Education on diabetic retinopathy screening centers and cataract services • Reproductive health education: creating awareness about availability of services for family planning, youth-friendly services, early antenatal registration, hospital delivery, cervical cancer screening, male involvement in SRH (in terms of importance of health-seeking behavior, HIV testing, and partner support), safer-sex negotiation, preventing early pregnancy, and gender-based violence • Messages on malaria prevention • Messages on risks associated with alcohol/substance abuse • WASH education (sanitation and hygiene, proper waste disposal, clean and safe water) **Screening and referral:** • Basic/initial assessment to identify need for HIV testing; referral to CHW based on need.	**Adherence support:** • Provide adherence follow-up and positive reinforcement, including support for TB adherence (family DOT), ART adherence, and treatment adherence for NCDs conditions) **Tracking treatment interrupters (HIV, TB, diabetes, hypertension):** • In collaboration with health facility, identify and track patients with HIV, TB, diabetes, and hypertension who were lost to follow-up; also those in need of early infant diagnosis (EID) of HIV **Psychosocial support:** • Identifying those in need of psychosocial support and referring to the higher level of care	**Education and age:** • Ability to read and write is desirable but non-ability is not excluding (although will limit tasks); age 18 years or older **Supervision** • Supervised by CHW1 who will report to the facility and organization they work for. Organizations engaging CHVs will develop clear supervisory structures that facilitate accountability of CHV performance **Reporting structure:** • Report will follow the district and organization reporting structures. All CHV reports will be submitted to CHW1. **Compensation:** • May be incentivized and volunteering part-time

DESCRIPTION	PREVENTION, SCREENING, AND EDUCATION	TREATMENT, CARE, AND SUPPORT	QUALIFICATIONS
Community Health Volunteer *(continued)*			
	• Basic/initial assessment to identify need for STI testing/treatment; referral to CHW or primary care clinic based on need • Identifying unmet FP needs (women who want to prevent pregnancy, but not using contraception) and referral as needed • Identify unmet needs related to visual impairment and blindness • Identify unmet needs related to pregnancy, such as early entry into antenatal care and referral to HIV testing and PMTCT services • Growth monitoring for children under age 5 • Checking immunization cards/ schedule **Provision of tools for prevention:** • For malaria: check mosquito nets and indoor residual sprays; assist with distribution of mosquito nets • For HIV/STIs: condom education, demonstration, and distribution (offered to everyone, but also targeted to high-risk groups within the community)		
Community Health Worker 3 (CHWIII)			
Community Health Worker III: • CHW who is based and works in the community; undergone limited training provided by the health system to carry out a series of specified roles and functions	*In addition to the tasks listed in the Community Health Volunteer section, Community Health Worker III can also provide the following tasks:* **Extended health education (as part of BCC):** • More in-depth information about STI, HIV, TB, NCDs • Life skills and comprehensive sexuality education for in- and out-of-school youth (referral to youth clubs as needed) **Screening, counselling, and referral** • Screening for TB, including for children under age 5: by asking four questions or through contact tracing	**Adherence support:** • Encourage creation of support groups for chronic diseases and assist with facilitation (examples are PLHIV groups, TB groups, diabetes support groups, or mixed groups for people with chronic conditions) **Tracking treatment interrupters (HIV, TB, diabetes, hypertension):** • Follow up directly or by phone and refer or accompany the patient to the support group or health facility for additional support	**Education and age:** • Form 3; age 18–60 years **Supervision** • Supervised by CHW1 who will report to the facility and organization they work for. Organizations engaging CHW III will develop clear supervisory structures that facilitate accountability of CHW III performance

DESCRIPTION	PREVENTION, SCREENING, AND EDUCATION	TREATMENT, CARE, AND SUPPORT	QUALIFICATIONS
Community Health Worker 3 *(continued)*			
	• Facilitating sputum collection • Linkage to care for those who tested positive for HIV • Ensuring risk/needs assessment done consistently and adequately in community (when shifted to CHVs) and conducting more in-depth assessment as needed • Breast cancer self-examination • Counsel about FP methods and refer as appropriate for method provision • Identify and refer clients with medication side effects • Identify and refer clients at risk of GBV to social worker and inform them about their rights and support structures • Household hunger scale **RMNCAH** • Growth monitoring • Mid-upper arm circumference (MUAC) for malnutrition in children under age 5 • Diarrhoea prevention and control: ORS and zinc distribution to children under 5	**Adherence support:** • Refill for TB DOT • Monitoring treatment adherence, checking on side effects **Psychosocial support:** • Identifying those in need of psychosocial support and referring to the higher level of care	**Reporting structure:** • Report will follow the district and organization reporting structures. All CHW III reports will be submitted to CHW1. **Compensation:** • Paid and working part-time
Community Health Worker 2 (CHWII)			
Community Health Worker II: • CHW who is primarily based and works in the community; undergone formal training provided by the health system or health program to carry out a series of specified roles and functions	*In addition to the tasks listed in the Community Health Volunteer section, Community Health Worker II can also provide the following tasks:* **Screening, counselling, and referral** • HIV testing and counselling (HTC) *(note: importance on policy issue, only if form 5* • STI screening for symptoms • Screen for diabetes, heart disease, hypertension (glucose blood level, dipstick urine test, blood pressure, BMI) and refer as needed *(note: needs policy change and logistical issues to be addressed)*	**Adherence support:** • SMS reminders TB DOT *(note: needs logistics, budget implications, question on sustainability)* • Refill and distribution of medication for stable patients (for ART and treatment of other chronic conditions) – *(note: needs policy change)*	**Education and age:** • Form 5; age 18–60 years **Supervision** • Supervised by CHW1 who will report to the facility and organization they work for. Organizations engaging CHW II will develop clear supervisory structures that facilitate accountability of CHW II performance

DESCRIPTION	PREVENTION, SCREENING, AND EDUCATION	TREATMENT, CARE, AND SUPPORT	QUALIFICATIONS
Community Health Worker 2 *(continued)*			
	• Identify and refer those eligible for cervical cancer screening • Follow up for borderline diabetes/ pre-diabetes for clients who have been assessed at facility level **RMNCAH** • Mother and newborn care (critical in first month after delivery, including information on breastfeeding) • Growth monitoring • Nutrition: identification of malnourished children (0–18 years); minimum dietary package/ dietary diversity (child receiving four or more food groups); meal frequency (2 times for breastfed infants 6–8 months; 3 times for breastfed children 9–23 months; 4 times for non-breastfed children 6–23 months) **Coordination, collaboration, and managerial issues:** • Supportive supervision of CHVs and CHW II • Mentoring and coaching for CHW II and CHVs	**Home-based care:** • Providing palliative care, minor wound care and cleaning *(note: needs provision and inclusion of CHBC supply: diapers, powder, spray, etc.)*	**Reporting structure:** • Report will follow the district and organization reporting structures. All CHW II reports will be submitted to CHW1. **Compensation:** • Paid and working full-time
Community Health Worker 1 (CHWI)			
Community Health Worker I: • a CHW based at the clinic, but working within the community; received limited standardized training outside the formal nursing or medical curricular to deliver a range of basic health promotional, educational, mobilization, and basic clinical services, and has a defined role within	*In addition to the tasks listed in the Community Health Volunteer section and Community Health Worker section, Senior CHW can also provide the following tasks:* **Screening and counselling:** • **Human-centered demand for health services training (UNICEF tool kit)** • Identify and refer people with mental health problems • Provide health education on compliance to treatment • Reinforce family support • Identify adults and children with hearing loss • Identifying adults and children with vision loss and refer	**Treatment:** • Point-of-care viral load testing **Rehabilitation** **Dealing with complex cases** **Follow up on use of hearing aids and supply of accessories such as batteries**	**Education and age:** • Minimum qualification: certificate in health-related field; accredited by BQA; age 18–60 years **Additional desired qualities/skills:** • Coaching and mentoring • Writing and reporting skills • Basic supervisory skills

DESCRIPTION	PREVENTION, SCREENING, AND EDUCATION	TREATMENT, CARE, AND SUPPORT	QUALIFICATIONS
Community Health Worker 1 *(continued)*			
the community system and larger health system (HEAs will become a part of this workforce.)	**Coordination, collaboration, and managerial issues:** • Ensuring linkage between facility and community • Coordination of services across different levels of care • Supportive supervision of CHWs • In-service training, mentoring, and coaching for CHWs and CHVs		**Reporting structure:** • If MOHW employee supervised by/ reports to the NIC; if part of the CBO/ NGO, supervision and performance supervised by program manager but reports should be shared with NIC **Compensation:** • Paid and working full-time

3.5 Description of interventions within the minimum package of community-based health services: health education tasks

3.5.1 SYSTEMATIC SCREENING FOR UNMET NEEDS FOR KEY HEALTH SERVICES

CHVs and CHWs will conduct systematic screening for unmet needs for key health services during the first contact with the client and subsequent contacts as appropriate (refer to **Annex C**).

3.5.2 HEALTH EDUCATION TASKS

EDUCATION ABOUT HIV

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Explanation of HIV and AIDS
- The ways one can acquire and transmit HIV
- Behaviors that put people at risk of HIV infection
- How HIV is diagnosed
- Importance of testing for HIV, disclosure, partner notification, including frequency of testing
- Ways to reduce the risk of acquiring HIV, including safer behaviors (abstinence, consistent condom use, reducing number of sexual partners, mutual monogamy, delaying first sexual intercourse, testing, avoiding needle sharing), safe male circumcision, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), reduce alcohol consumption and substance use, and stop GBV
- Ways to reduce the risk of transmitting HIV to uninfected partner or from mother to child, including consistent condom use, treatment as prevention, and use of elimination of mother-to-child transmission (EMTCT) services with emphasis on primary prevention of HIV, prevention of unwanted pregnancies through the use of family planning (FP), use of ART to prevent vertical transmission and treatment care and support
- Availability of treatment and support services within the community including community medication refills, tracking back of legacy patients, missed appointments, defaulters, and lost-to-follow-up and linking them back to care and treatment.
- Need to be screened for TB, STIs, reproductive cancers, and NCDs
- Education on the prevention of hepatitis and syphilis

EDUCATION ABOUT TB

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Explain TB and the different types of TB
- The way TB is transmitted and who may be at risk of infection
- Signs and symptoms of TB
- What to do if one was exposed to TB
- How TB is diagnosed
- Ways to prevent TB/reduced risk of infection (both exposure and progression from latent TB to TB disease)
- Infection control measures by an individual at the household and community level
- Availability of TB treatment, support services, and importance of adherence
- HIV testing for TB presumptive and confirmed cases
- Need to be screened for STIs, reproductive cancers, diabetes, and other NCDs; and FP services

EDUCATION ABOUT SEXUALLY TRANSMITTED INFECTIONS

WHO CAN PROVIDE: Volunteers and CHWs

WHAT SHOULD BE INCLUDED:

- Explanation of the most common STIs and how they are transmitted
- Signs and symptoms of STIs
- Behaviors that put people at risk of STIs
- How STIs are diagnosed (testing or based on symptoms and signs)
- Ways to reduce the risk of acquiring/transmitting STIs
- Availability of treatment and importance of being treated in a timely manner to avoid complications
- HIV testing, TB, STIs, reproductive cancers, and NCDs screenings

EDUCATION ABOUT NONCOMMUNICABLE DISEASES

WHO CAN PROVIDE: Volunteers and CHWs

WHAT SHOULD BE INCLUDED:

- Explanation of the most common NCDs (cancer, cardiovascular disease, diabetes, and chronic respiratory disease)
- Explanation of NCD risk factors
- Ways to reduce risks of NCDs (address healthy lifestyle/physical activity, diet/nutrition, minimizing alcohol and tobacco use)
- Screening for and diagnosis of NCDs
- Availability of treatment, care, and support for people with chronic health conditions
- Importance of continuous treatment adherence
- Need to be screened for TB, STIs, reproductive cancers, and FP

EDUCATION ABOUT EYE DISEASES/CONDITIONS

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Explanation of the most common eye diseases (cataract, red eye, glaucoma, diabetic retinopathy, and uncorrected refractive errors)
- Awareness creation on effects of blindness on families, communities, and the nation
- Availability of treatment, care, and support for people living with vision impairment and blindness
- Importance of continuous follow-up and treatment adherence
- Need to be screened for eye diseases with familial tendencies (e.g., glaucoma)

REPRODUCTIVE HEALTH EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Importance of using prenatal services and FP to ensure individuals/couples have children by choice, not chance (when they are ready physically, socially, mentally, spiritually, and economically)
- Brief description of available contraceptive methods and where to get them and accessing emergency contraception in case of a mishap
- Importance of dual protection from both unplanned pregnancy and STIs
- Availability of antenatal care services and importance of early antenatal registration
- Benefits of hospital delivery
- Need for cervical cancer screening, including frequency by age and HIV status
  - **For youth:** benefits of delaying sexual activity and/or abstaining until in long-term relationships, delaying first pregnancy until at least 18 years old, use of contraception, condoms, HIV/STI testing, negotiating safer sex, and availability of youth-friendly services (adolescent girls and young women and key populations; key populations include sex workers, men who have sex with men, people who use drugs, and transgender people)
  - **For men:** benefits of male involvement in terms of supporting their partners in reproductive health decisions; safer sex practices; access to services (erectile dysfunction, infertility, andropause, screening for prostate cancer); HIV testing and disclosure; importance of good health seeking behavior
- Preventing all forms of gender-based violence (GBV) in both men and women, reporting and getting help when GBV takes place.
- Emphasis for older persons
  - Educate on issues of libido associated with body physiological changes related to the aging process
  - Educated on issues associated with menopause
  - Refer if client admits to having the problem

MALARIA EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- How malaria is transmitted and what are the symptoms
- Malaria control approaches, including insecticide-treated nets, indoor residual spraying, and clean and safe environments
- Importance of seeking timely diagnosis and treatment, especially for pregnant women and children under age 5

EDUCATION ON RISKS ASSOCIATED WITH ALCOHOL/SUBSTANCE ABUSE

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Prevention and treatment of alcohol and substance abuse
- Risk factors
- Signs and symptoms of alcohol/substance abuse
- The difference between abuse and addiction
- Negative effects and risks (including risky sexual behaviors and practices, anxiety and depression, short concentration span, sleep disturbances, damage to liver and other organs, cancer, death)
- Where to get help, including community support groups
- Community rehabilitation – referrals for psychological and physical support
- Non-use of prescribed and over-the-counter medicine

WASH EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- How to wash hands (good practices for children from infant to 5 years), benefits of WASH
- How to make unsafe water safe to drink (household water treatment)
- Safe water storage, keeping treated water safe from recontamination
- What constitutes safe and unsafe sanitation facilities
- Behavior change messages to help people improve their hygiene and safe water use
- *Sekupu* hand wash
- Water safety teams
  - Community-led total sanitation

REHABILITATION AND EYE EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- What is rehabilitation and what are its benefits?
- Who provides different types of rehabilitation (ophthalmic personnel, low vision therapists, low vision centers and associations (e.g., BABPS, Pudulogong Rehabilitation Centre, Lephoi Centre), physiotherapists, occupational therapists, speech and language therapists, prosthetics and orthotics, psychologists, audiologists, and specialist rehabilitation medicine doctors and nurses/community mental health nurse)
- Basic knowledge on disease (acute or chronic), disorders, injuries, or trauma and disabilities needing rehabilitation for identification purposes
- Importance of continuous rehabilitation interventions as a way to reduce the risk of complications
- Facts and myths about eye health
- Family education on living with a person with visual impairment and blindness
- Where to get help, directory for all rehabilitation, eye health, and mental health centers within a particular community, including community support groups and government health facilities offering rehabilitation, eye health, and mental health services
- Integration with other services, e.g., SRH, HIV, social welfare department
- Assist in the early identification and rehabilitation intervention for people in urban and rural areas
- Identify the needs for provision of all necessary assistive products in the community

MENTAL HEALTH

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Facts and myths about mental illness
- Education on depression and schizophrenia
- Family education on living with a person with mental illness, a disabled person, someone with visual impairment or blindness

HEALTHY AGING

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Education on healthy aging
- Education on common illnesses for the aged
- Facts and myths about aging
- Where to get help, information on old-age friendly facilities and services

HEARING HEALTH

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- What is hearing loss
- What causes hearing loss
- How can it be prevented
- What is tinnitus
- What is hearing health conservation

CHILD HEALTH CARE EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Promotion of appropriate child care
- Illness prevention
- Illness recognition
- Home management
- Care seeking and treatment compliance practices
- Immunizations
- Low concentration oral rehydration salts (ORS) and zinc (purpose of use)
- High impact interventions
- Early childhood development
- Early infant diagnosis
- Early infant circumcision

NUTRITION EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Basic information on nutrition
- Importance of breastfeeding
  - Breastfeeding initiation
  - Exclusive breastfeeding
  - Continued breastfeeding to 2 years or beyond
- Infant formula, storage, and preparations
- Complementary feeding
- Minimum dietary package
- Dietary diversity (child receiving four or more of the food groups)
- Supplementary feeding
- Healthy eating, exercise
- Food handling, storage, and preparations
- Importance of using iodized salt
- Handwashing

ORAL HEALTH EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Explanation of the most common oral diseases and conditions
- Signs and symptoms of common oral diseases and conditions
- Behaviors that put people at risk of common oral diseases and conditions
- Prevention/ways to reduce the risk for oral diseases including reduction and amount of sugary food intake, healthy diet, brushing with fluoride toothpaste, and importance of early detection through regular dental checkups
- Available treatment options
- Where to get help

EPIDEMIC AND PANDEMIC PREPAREDNESS EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Prevention approaches specific to disease
- Case identification and contact tracing
- Mitigation strategies and response to specific diseases
- Note: specific strategies will be provided when an epidemic or pandemic occurs.

COMMUNITY FIRST AID EDUCATION

WHO CAN PROVIDE: Volunteers and CHWs

WHAT TO BE INCLUDED:

- Prevention of accidents in the home
- First respondents for road accidents
- Snake bites and where and how to get help
- Management of minor injuries in the home

PART 4:
Monitoring and evaluation

4.1 Monitoring and evaluation

This section explains the internal monitoring and evaluation (M&E) plan for the community health care workforce and describes how the health facility and DHMT will manage health information. It is important to emphasize the value added by CHWs at all levels to the facility M&E system.

4.2 Coordination, roles, and responsibilities

The **District Health Management Team** (DHMT), with central oversight of level of service delivery in all districts, will work with all partners and providers to identify entry points into communities through local DiKgosi and established committee structures. **All providers of health services** have responsibility to undertake meaningful efforts to operate and coordinate their work through these structures, gradually building their capacity and immediately benefiting from their local knowledge, resources, and networks to optimize the impact of prevention and care services across the country.

4.2.1 KEY PERSONNEL AND RESPONSIBILITIES

Table 2. Key Personnel in Data Management Roles and Responsibilities

KEY PERSONNEL IN DATA MANAGEMENT AND THEIR ROLES AND RESPONSIBILITIES	
Community Health Worker/ Volunteer	• Record data in individual registers • Record required data elements in line with the variables provided on each collection sheet and in accordance with the guidance document provided • Ensure that all the correct data elements are placed in the correct columns for each session and for each service provided • Close the data collection sheets once the reporting month is closed • Maintain confidentiality of data at all times • File and store individual client registers and summary forms in the dedicated locked facility • Identify barriers to effective data collection procedures and communicate these to the supervisor/program manager • Submit records/registers to the senior community health worker (SCHW) every month to prepare for collation

KEY PERSONNEL IN DATA MANAGEMENT AND THEIR ROLES AND RESPONSIBILITIES	
CHW I	• Coordinate the data collection process • Enter individual registers into an Excel spreadsheet, verify and record the monthly totals for each register onto a monthly form • Ensure that the data entry verification process is conducted by a second individual who is not entering the data • Resolve discrepancies in data before reports are forwarded to the next level • Complete summary forms and submit to the community nurse on an agreed day of the month • Oversee, lead, and support effective and efficient data collection, management, and use • Provide monthly feedback to team members about: – Data quality: timeliness, completeness, and accuracy – Program-related indicators, highlighting good performance and service delivery shortcomings • In collaboration with team members, analyze, interpret, and use information for remedial interventions to optimize performance and develop action plans for indicators that reflect poor performance • Submit reports/compiled summaries to the community health nurse on an agreed day of every month • Optimize data quality and use by means of: – Weekly spot checks on individual performance by means of supervisory site visits – Verifying that data on registers and on summary forms correlate – Filing records and data collection tools as required for data verification and audit
Community Health Nurse	• Ensure that a data quality report is received from CHWI • Ensure that there is a written procedure to address late, incomplete, inaccurate, and missing reports; including follow-up on data quality issues • Submit monthly and quarterly reports to the DHMT Head • Conduct data quality audits for improving overall data quality. Focus is mainly on verifying the quality of reported data and assessing the underlying data management and reporting systems for standard program level output indicators • Provide monthly feedback to the team about: – Data quality (timeliness, completeness, and accuracy, etc.) – Performance-related indicators highlighting good performance and service delivery shortcomings • Provide enough resources for routine health information management: – Data collection tools (standardized registers, summary forms, etc.) – Office supplies such as pens, calculators, and staplers – Filing cabinets, files, and an effective filing system – Cell phones – Up-to-date tables, graphs, and reports on data quality and program performance – Definitions of data elements and indicators • Analyze, interpret, and use information for remedial interventions to optimize performance

KEY PERSONNEL IN DATA MANAGEMENT AND THEIR ROLES AND RESPONSIBILITIES	
District Health Management Team M&E Officer	• Management of the M&E team and providing M&E leadership • Program management support • Data management and analysis • Communication and reporting
MOHW	• M&E system development • Provide leadership and governance

4.3 Data management and process

Data management involves the following components:

- Data management process
- Key personnel in data management and their roles
- Program indicators
- Data flow
- Key considerations for data management
- Information dissemination and use

4.3.1 DATA COLLECTION

Data will be collected on point, in contact with client. All data will be collected using standardized data collection tools agreed upon. The data collectors should have an extended and common understanding in completing the prescribed tools. CHWs and CHVs will be regarded as primary data collectors. Data will be collected on a daily basis from the first day to the last day of every month, as they come in contact with the clients to offer services. No client information should be completed in the absence of the client. They will use the Daily Activity Sheets to collect client information, and this tool should be completed/signed for every actual session, i.e., no client signing in advance or signed by a friend. Data will be collected by the supervisor CHW1 routinely and will be submitted to the Community Health Nurse for further analysis and use at the DHMT monthly for compilation of the district report, which will be submitted to the national level. Ideally, a real-time reporting system will be in place to collect community health data once all systems are in place.

The CHWs will also collect data on community health interventions. Data will be collected daily using the Botswana community health programs tools. Data collected will be submitted to the senior community health worker (SCHW) monthly for compilation of the monthly district report, using the monthly summary tool.

4.3.2 DATA COLLATION

After submission of the completed data collection tools by the primary data collectors, every district and subrecipient will aggregate data for the different program areas and services provided. The SCHW will have five days subsequent to the last day of the month to compile their reports. This will be done in close communication with the CHWs to guard against errors. The SCHW and the Nurse-in-Charge will have to review the data, cross check for errors, document and fix the inconsistencies using a different color ink, and sign the data received.

4.3.3 REPORTING SYSTEMS

The CHW will report to the SCHW on the last day of every month. Data reported at this point will be facility data. The SCHW will report to the community health care nurse on the fifth of every month using the TB&HIV Monthly Reporting Tool as well as the tools developed for other types of community services, while the Nurse-in-Charge will report using the Daily Activities Summary Tool. All reports should be submitted in an electronic format, while hard copies should be printed and filled in the reporting office. The Nurse-in-Charge will compile all the reports submitted to his/her office by the facility. The monthly report will be submitted to DHMT on the agreed day of each month.

Quarterly reports will be prepared by the M&E officer, using the monthly submissions, and then submitted to MOH on the agreed day of the month following the last month of the quarter.

4.3.4 ANALYSIS

Data presented in the narrative reports should be analyzed to show the performance for each indicator against its target, monthly trends (especially quarterly and biannual reports), and district performance. Data should be disaggregated by sex and age as per the requirements of the indicator. Graphs and tables should be used to present data.

Table 3. GOAL: Promote an integrated approach to implementing community-based health interventions; standardize and strengthen delivery of community-based health services

SPECIFIC OBJECTIVE 1: Improve the delivery of integrated community-based health interventions through provision of a standardized minimum package of community-based health services by 2025				
INPUT	**ACTIVITY**	**OUTPUT**	**OUTCOME**	**IMPACT**
Human resources, financial	• Stakeholder's alignment with standardized minimum package	• Number of stakeholders aligned to standardized minimum package	• Improved delivery of integrated community-based health services	• Positive health outcomes in the communities
	• Provision of services as per the standard minimum service package	• Proportion of services provided as per the standard minimum service package		
	• Develop community health service quality standards and protocol	• Availability of community- based health organizations standards and protocols	• Improved community health care services (access and demand) • Compliance with quality health care and standards • Improved delivery of integrated community-based health services	
	• Standardize referral tools	• Availability and use of standardized referral tools	• Improve community health referral systems • Increased community health completed referrals (access and coverage)	

SPECIFIC OBJECTIVE 2: Strengthen coordination and management of community-based health services through harmonized community health worker groups by 2025 – leadership and governance				
INPUT	**ACTIVITY**	**OUTPUT**	**OUTCOME**	**IMPACT**
Human resources, financial	• Sensitize the health sector organization on the Harmonization Strategy for ownership	• Number of health sector organizations sensitized	• Increase in implementation of the harmonization strategy by health sectors • Increased leadership and governance in management of community-based health services in all levels	• Positive health outcomes in the communities • Improved health sector response
	• Strengthen the existing or establish PHC-CHW coordination and community participation structures	• Availability of functional and efficient coordinating structures	• Strengthened support from all levels to CHWs through national, district, and local PHC-CHW structures for integrated community-based health services	
	• Develop MOU with key/ strategic stakeholders	• Availability of signed MOUs	• Increase in key/strategic stakeholder involvement	
	• Align CHWs to Human Resource for Health Strategy	• Community Human Resource for Health Strategy developed • Availability of CHWs Job Effective and Description (JEDs)	• Increased range of skill sets rendering integrated community-based health services • CHW development	
	• Develop and sign a formal agreement that binds community-based organizations to National Guideline for Implementation of Community-Based Health Services	• Signed agreement developed between MOHW and other stakeholders	• Increase in community-based organizations abiding to the National Guideline	

SPECIFIC OBJECTIVE 3: Strengthen CHW competencies and skill mix for delivery of integrated community-based health services				
INPUT	**ACTIVITY**	**OUTPUT**	**OUTCOME**	**IMPACT**
Human resources, financial	• Develop pre- and in-service training curriculum for CHWs in collaboration with training institutions	• Availability of training curriculum developed (pre- and in-service)	• Increase in knowledge of people • Increase in skilled CHWs	• Strengthened competencies and skills of CHWs in the delivery of integrated community-based health services • Positive health outcomes in the communities
	• In-service training for CHWs • Conduct pre-service training for CHWs (in collaboration with training institutions)	• In-service training reports • Pre-service training reports • CHWs trained	• Improved knowledge and skills for CHWs • Improved community health service delivery	
	• Develop community health services field handbook/user manual	• Availability of CHWs handbook/user manual	• Improved community health service delivery	
	• Provide on-site mentorship and supervisory visits for CHWs	• Mentorship reports • Supervisory support reports	• Improved CHWs performance • Improved quality of community health services	

SPECIFIC OBJECTIVE 4: Strengthen information management for integrated community-based health services				
INPUT	**ACTIVITY**	**OUTPUT**	**OUTCOME**	**IMPACT**
Human resources, financial	• Establish community-based health sector M&E (in line with the national health sector M&E framework)	• Availability of community-based health M&E system at all levels	• Improved planning, programming, and implementation • Improved data collection, analysis, use, and feedback at community level	• Effective and sustainable community health M&E services
	• Indicator mapping (global and national health indicators)	• List of all community-based health indicators that will be incorporated into the tools		
	• Review and harmonize tools for data collection by CHWs – based on existing program tools and minimum service package	• Availability of harmonized community-based health tools	• Integrated data collection processes • Integrated reporting	
	• Develop a community-based services electronic data management system that will facilitate real-time reporting and accessibility of information by all stakeholders	• Availability of community-based electronic data collection and reporting tool	• Real-time reporting system using DHIS2 • Community-based health reporting rates improved • Data quality of community-based health services improved	

4.4 Indicators selection table/matrix

INDICATOR TYPE	INDICATOR	TARGET	DEFINITION	DATA SOURCE	FREQUENCY	WHO WILL ANALYZE AND REPORT DATA?
SPECIFIC OBJECTIVE 1: Improve the delivery of integrated community-based health interventions through provision of a standardized minimum package of community-based health services by 2025						
Output	Number of stakeholders implementing standard minimum service package	100%	Quantifies/ measures all stakeholders implementing standard minimum service package	Stakeholders assessment	Annually	MOHW
Outcome	Number of services provided as per the standard minimum service package	100%	Measures the number of services provided in line or compliant with standard minimum service package	CHW tools, registers	Quarterly	PHC Teams
Outcome	Proportion of completed referrals within community health sectors in the district	TBC	Measures the proportion of completed referrals out of total referrals among stakeholders in the community(district) in a reporting period	Referral forms	Quarterly	PHC Teams
	Number of people accessing integrated community-based health services	TBD	Measures overall access and coverage of community-based health services by program/service received in a reporting period	Community-based program/ service registers	Monthly	MOHW
SPECIFIC OBJECTIVE 2: Strengthen coordination and management of community-based health services through harmonized community health worker groups by 2025 – leadership and governance						
Outcome	Community-based health services expenditures per annum		Measures expenditures on community health services, CHWs remuneration, incentives, and financial packages per annum	National Health accounts	Annually	MOHW/ DPSM
Output	Scheme of services reviewed for CHWs		Assessment of the scheme of services reviewed	CHW scheme of services CHWs HR assessment report	Annually	MOHW

INDICATOR TYPE	INDICATOR	TARGET	DEFINITION	DATA SOURCE	FREQUENCY	WHO WILL ANALYZE AND REPORT DATA?
Outcome	Stakeholders compliance to community-based health national guideline/strategy	100%	Measures implementing partners compliance to community-based health national guideline	MOU assessment report	Annually	PHC Teams
Output	Percentage compliance to service quality standards and protocols	TBC	Proportion of community health services implemented in accordance with quality standards and protocol developed	Standards and protocol assessment forms	Annually	MOHW
SPECIFIC OBJECTIVE 3: Strengthen CHW competencies and skill mix for delivery of integrated community-based health services						
Output	Number of CHWs trained in a reporting period		Measures the number of CHWs trained (pre- and in-service)	Training register, training reports	Quarterly	PHC Teams
Output	Number of CHWs recruited in a reporting period	TBD	Quantifies the number of newly recruited CHWs in a reporting period	HR recruitment reports	Semi-annually	PHC teams
	Proportion of CHWs with in-service training needs	TBD	Measures the proportion of training requirements for CHWs out of total of all CHWs	HR recruitment reports CHWs training needs assessment report	Annually	PHC teams
	Number of CHWs per community (per 10,000 people)	TBD	Measures CHWs population density per community served	Community health services annual reports	Annually	MOH

INDICATOR TYPE	INDICATOR	TARGET	DEFINITION	DATA SOURCE	FREQUENCY	WHO WILL ANALYZE AND REPORT DATA?
SPECIFIC OBJECTIVE 4: Strengthen information management for integrated community-based health services						
Output	Number of community-based health service providers trained on information management		Count of service providers trained on information management	Training report, attendance registers	Quarterly	M&E team
	Number of community-based health providers reporting		Count of all community-based health providers reporting	Program/ service reports	Monthly and quarterly	
Outcome	Percentage access to electronic community health information management system		Proportion of access and use of community health electronic data management systems (DHIS, openMRS, etc.)	Community HIS utilization reports	Quarterly	M&E team
Outcomes	Number of community-based service providers who conduct routine data quality assessment (RDQA) in a reporting period	TBD	Count of RDQA conducted by each service provider	RDQA reports	Semi-annually	M&E team
Outcomes	Number of community-based surveys conducted	TBD	Count of total community surveys conducted	Annual reports	Annually	M&E team
Outcomes	Availability of community-based health services/ programs data	TBD	Measures the availability of community-based health services/ programs data	Monthly, quarterly reports	Monthly, quarterly	
Outcome	Percentage of community-based health stakeholders compliant to a community-based M&E system	TBD	Proportion of stakeholders complying to a community-based M&E system	Checklist and assessment	Annually	M&E teams
Impact						
Impact	Improved health outcomes of communities	TBD	Measure of quality of life of the community	Survey	End term	Evaluating team

4.5 Evaluation plan

4.5.1 PROCESS EVALUATION

QUESTIONS	INDICATORS	METHOD OF INVESTIGATION	TIME LINE
Are all the activities planned for implemented within time frame?	Number of activities implemented within time frame	Review monthly, quarterly, and annual reports	By end of year 2
Are we providing the outcome expected?	Knowledge and understanding of integrated community-based health services	Focus groups	By end of year 2
Are resources and inputs being used efficiently?	Number of resources used against target	Budget assessment, HR assessments	By end of year 2

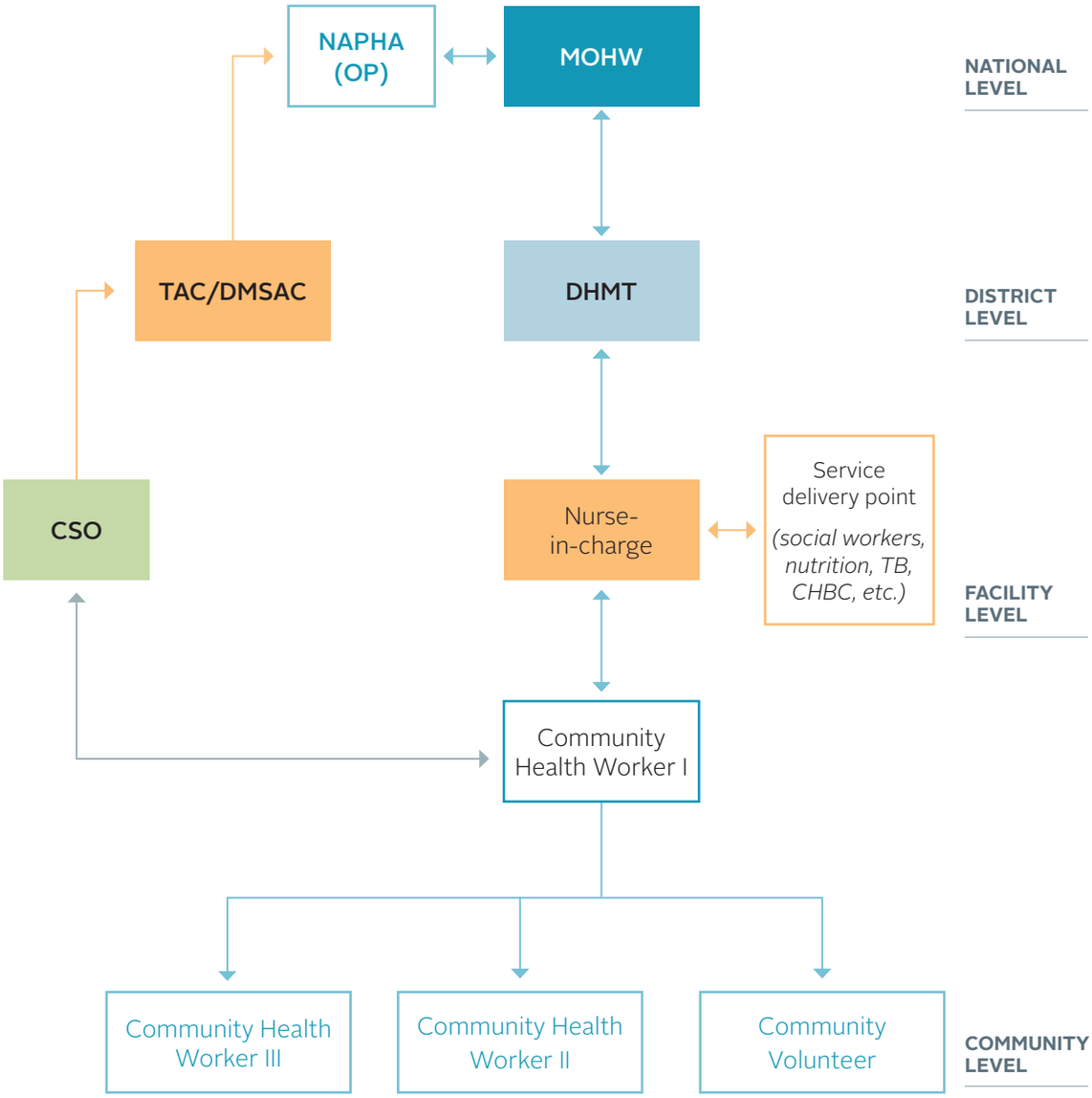
4.5.2 OUTCOME EVALUATION

QUESTIONS	INDICATORS	METHOD OF INVESTIGATION	TIME LINE
Is the information management strategy working?	% increase in planning, programming, and implementation through M&E	Review monthly, quarterly, and annual reports	
Do the CHWs have competencies and skill mix for delivery of integrated community-based health services?	% increase in knowledge of people and existing staff	Focus groups, survey, review of reports	
Is there coordination, leadership, and management at all levels?	% increase in leadership and governance in management of community-based health services at all levels	Desk review, focus groups, survey, review of reports	

4.5.3 IMPACT EVALUATION

QUESTIONS	INDICATORS	METHOD OF INVESTIGATION	TIME LINE
Was there an increase of delivery of integrated community-based health services?	% increase in quality of delivery of integrated community-based health services	Survey, document review	End term
Was there improved leadership and governance in management of community-based health services at all levels?	% improved leadership and governance in management of community-based health services at all levels	Survey, document review	End term
Has CHW literacy in delivery of integrated community-based health services increased?	% increase in CHW literacy in delivery of integrated community-based health services	Survey, document review	End term

Figure IV. Organization and Structure



4.6 Stakeholder matrix

Stakeholder	Audience background (knowledge, experience, etc.)	Audience characteristics	What information is required? (audience needs and interests)	Why is the information required?	When is the information required?	How will the information be communicated? (format)
EXTERNAL AUDIENCE						
Donors	Technical, decision-makers	Funders, capacity-building contribution	Lessons and best practices from the program—evaluation results	• For sharing lessons and best practices • To assess value for money and global impact measuring	Quarterly	• Comprehensive report • Publications
CSOs	Professional and non-professional	Service providers	• Individual and service level data • Service provision reports and statistics • Challenges, lessons, and best practices • Recommendations from the programs	• For accountability and reporting purposes • To determine service reach • To share information and coordinated client support, • To determine program effectiveness • To determine and provide remedial/ corrective actions • For program M&E	Monthly	• Meetings, presentations, • reports, • raw data, • data collection tools (paper based/ electronic)
Private sector	Different experts	Profit makers, corporate social responsibility, business sector	• Resource mobilization • Program resource adequacy • Existing gaps and program effectiveness	• To help plan for sustainability of the community programs • To contribute toward community development	Quarterly	• Media reports, high-level reports, summary report
Community leaders	Non-technical	Decision-makers	Information on program coverage and effectiveness	• For policy decisions • To be informed and empowered • To access and utilize the services	Quarterly	• Presentations • Summary report
Community members	Non-technical	Community members	• Sensitization on program services availability, accessibility, and quality	• To gain knowledge • To access and utilize the services	Ongoing	IEC materials, public campaigns and meetings, media reports

4.7 Capacity requirements for community M&E plan implementation guide

4.7.1 BUDGET

A key function of planning for M&E is to estimate the costs, staffing, and other resources needed.

- **Tasks and activity cost estimates:** List all M&E tasks and overall responsibilities, analyze the necessary items associated with each task, and determine their cost.
- **Human resources:** Budget for staffing, including external consultants, capacity building/ training, and other human resource expenses.
- **Capital expenses:** Ensure that the budget includes all facility costs, office equipment and supplies, travel and lodging, computer hardware and software, and other expenses.
- Incorporate M&E costs into the project/program budget:
- Determine whether all tasks are included in the overall project budget, such as support for an information management system, field transportation and vehicle maintenance, translation, and printing and publishing M&E documents/tools.
- Review any budget requirements and contributions:
- Determine whether there are any extra items that need to be budgeted, or conversely, items such as an external evaluation that will be funded.
- Plan for cost contingency

4.7.2 HR REQUIREMENTS

An effective M&E system requires capable people to support it.

- Assess the human resources capacity for M&E:
- Determine the available M&E experience within the project/program team and all relevant stakeholders that participate in the M&E system.
- Determine the extent of local participation:
- Participation can happen at multiple levels in the M&E system.
- Determine the extent of outside expertise:
  Outside specialists (consultants) are usually employed for technical expertise, objectivity, and credibility; and to save time.

It is important to have well-defined roles and responsibilities at each level of the M&E system. Plan to manage project team's M&E activities:

- Develop tools and mechanisms to manage their time and performance
- Identify M&E capacity-building requirements and opportunities
- Define the roles and responsibilities for M&E

Annex A:
Toward a harmonized community health workforce

A.1 Selection Criteria for Community Health Workers

In the new community health worker (CHW) structure, the current cadres are expected to be merged into newly created levels of CHWs (see table below).

Recruitment of CHWs should be based on a pre-defined set of criteria or qualifications that each individual CHW should meet to be considered for the program. The selection criteria may include demographic elements, such as gender, age, and place of residence, as well as education level and ability to successfully complete training on standard competencies. Residency is an important criterion in the selection of CHWs and recruiting from within the communities that they serve is considered a best practice. Another important criterion for CHW selection is language skills. Language differences may distinguish socioeconomic or ethnic groups, and efforts should be made whenever possible to recruit CHWs who can communicate with as many subgroups of the catchment population as possible. Alternatively, several CHWs with complementary language skills to serve the same catchment population can be recruited. Desired qualities/skills for all levels of CHWs include:

- Committed to serving the community
- Shares values and experiences of the people served
- Cares for others
- Respected by peers
- Trustworthy
- Responsible
- Good attitude
- Ability to grow, change, and learn
- Good communication skills
- Ability to maintain confidentiality
- Good facilitation skills
- Team player

A.2 New Community Health Worker Structure

Compensation and Career Path

Having a career path can be a strong motivating factor, and CHWs should be exposed to opportunities that enable them to grow and eventually move into new jobs and/or assume new responsibilities. Maintaining records of training received and offering new training opportunities to CHWs can help them with career prospects, both paid and unpaid.

Compensation and incentives were shown to play a role in CHWs' job satisfaction and retention. Monetary factors that motivate individual CHWs include satisfactory remuneration/financial incentives; possibility of future paid employment. However, there are also nonmonetary factors, including community recognition and respect for CHW work, acquisition of valued skills, personal growth and development, and status among peers and within the community. An identifying government dress code will apply. Protective clothing is required for clinical work and for protection from climate conditions.

Table A1. CHW Selection Criteria, Reporting System, and Compensation

PROPOSED CHW CATEGORIES	
Community Health Worker I:	A CHW based at the clinic, but working within the community; received limited standardized training outside formal nursing or medical curricula to deliver a range of basic health promotional, educational, mobilization, and clinical services and has a defined role within the community system and larger health system. HEAs will become a part of this workforce. CHWs recruited and trained by CBOs or NGOs to work as a link between facilities and other CHWs listed below will also fall under this cadre. CBOs/NGOs have these workers supervised by the Senior Community Health Worker (SCHW), same qualifications but with additional training and experience.
	Education and age: • Minimum qualification BGSE (Form 5): certificate in health-related field; accredited by BQA, age 18–60 **Additional desired qualities/skills:** • Coaching and mentoring **Reporting structure:** • If a MOH employee, supervised by/reports to the NIC; if part of the CBO/NGO, operational supervision by NIC and performance supervision by program manager **Compensation:** • Paid and working full-time

PROPOSED CHW CATEGORIES	
Community Health Worker II:	CHW who is primarily based and works in the community; has formal training to carry out a series of specified roles and functions, which was provided by the health system or health program.
	Education and age: • Junior Certificate (Form 3); age 18–60 **Reporting structure:** • Supervised and supported by CHWI; if part of the CBO/NGO, operational supervision by CHW I and performance supervision by program manager **Compensation:** • Likely to be paid and working either part-time or full-time
Community Health Worker III:	CHW who is based and works in the community; has undergone limited training to carry out a series of specified roles and functions, which was provided by the health system
	Education and age: • Less than Junior certificate (Form 3); age 18–60 **Reporting structure:** • Supervised and supported by CHWII; if part of the CBO/NGO, operational supervision by CHWII and performance supervision by program manager **Compensation:** • Likely to be paid and working part-time
Volunteers:	Member of the community who volunteers their time and is supported by the community and the health system but is not necessarily a part of its formal organization; has undergone informal training to carry out a series of specific functions predominantly in health promotion and prevention. CHBCV will become a part of this workforce.
	Education and age: • Ability to read and write is desirable but non-ability is not excluding (although will limit tasks); age 18 or older **Reporting structure:** • Accountability to community structure through Dikgosi and VDC/VHC; from DHMT side, supervised and supported by CHW **Compensation:** • May be incentivized and volunteering part-time

A.3 Training of Community Health Workers

CHWs will have pre-service and in-service training. The in-service curriculum will be rolled out to all CHWs and volunteers through the KITSO training. The program will comprise theoretical training as well as practical experience at selected health facilities and communities under the supervision of CHW lectures at the training schools and selected MOHW staff members at health facilities and community-based localities.

A.4 Protection and Wellness of Community Health Workers

Providing health care services at home and within the community can present health and safety challenges. CHWs perform a variety of different tasks with some of these tasks putting them at risk of injury or/and infection, thus community health programs should address the occupational health of CHWs. Policies and practices should be in place to help educate CHWs about occupational health and safety.

CHWs need a system that caters to their own health, e.g., offers periodic medical exams. Wellness activities may also include social activities such as retreats and stress management events. CHWs should be encouraged to participate in existing wellness activities. Peer counselling, support groups/network, and use of stress-management techniques can help CHWs alleviate work-related stress. CHWs and their supervisors should be trained on how to recognize signs of burnout and stress in themselves and others.

CHWs should also be provided with protective gear (see Waste Management section) and know what to do if they are exposed to infection (e.g., where to access PEP and other types of treatment).

Annex B:
Standard operating procedures

B.1 Standard Operating Procedures

SOPs at community level

- Hand washing
- Wound care
- Infection control
- Waste management
- Sputum collection
- Specimen transportation (cold chain)
- Lifting techniques
- Referral system
- Data collection and M&E
- Others

B.2 Community-Based Waste Management

Community health work produces hazardous medical waste that needs to be properly managed and disposed of for safety of both the CHWs and the community. Establishing good practices for proper handling and disposal of health care waste is an important part of the health care delivery system, including at the community level.

Hazardous waste can be divided in two categories:

- Infectious hazardous waste that may be contaminated with blood or other bodily fluids. It includes sharps (e.g., needles, syringes) and nonsharps (e.g., contaminated gloves, swabs, cotton, bandages, and dressing materials; sputum cups and slides, used test kits).
- Noninfectious hazardous waste, which includes damaged or expired pharmaceuticals, vaccines, or rapid diagnostic tests (RDTs).

CHWs should have clear procedures in place for segregating hazardous waste into sharps/nonsharps and infectious/noninfectious waste, and for disposing of it safely. All CHWs involved in the delivery of health services that generate hazardous waste should be provided with:

- Sharps containers and training on how to dispose of sharps safely (e.g., always wear gloves while handling sharps or other infectious waste, never overfill sharps containers, never recap syringes, never empty or reuse sharps container)

- Leak-resistant plastic bags for segregating/collecting nonsharp infectious and noninfectious waste.
- Instructions where to return the filled sharps containers and other hazardous waste. This usually means bringing hazardous waste to a health facility that has an incinerator and/or ash pit for disinfection and final disposal.
- Instructions on where to return any damaged/expired drugs and other supplies.
- Protective gear, which, depending on the type of tasks the CHW performs, may include gloves, masks, aprons, heavy-duty plastic bags, disinfectants, umbrellas, and hats.

Appropriate handling and disposing of hazardous wastes should protect the workers and the community against potential health risks and be done in accordance with the established system for safe, environmentally sound practices, following the national health care waste management guideline and/or policies.

B.3 Community-Based Supply Chain

Meeting a demand for health services at the community level requires effective community-based distribution and supply chain management (SCM). Five supply chain functions should be considered essential for the success of community service delivery:

Product availability: Without commodities, CHWs will not be able to deliver some of the interventions that are part of the package of essential integrated services and fulfill their mandates to reach communities with preventive and screening services. Responsibilities for product availability should be clearly defined for all levels: national supply chain, DHMTs, primary care facility, and CHWs themselves. CHWs will receive their supplies from the primary care facility, which will receive supplies from DHMT. Proper forecasting is required to ensure that stockouts are avoided. In addition, implementing partners might support product availability through direct procurement.

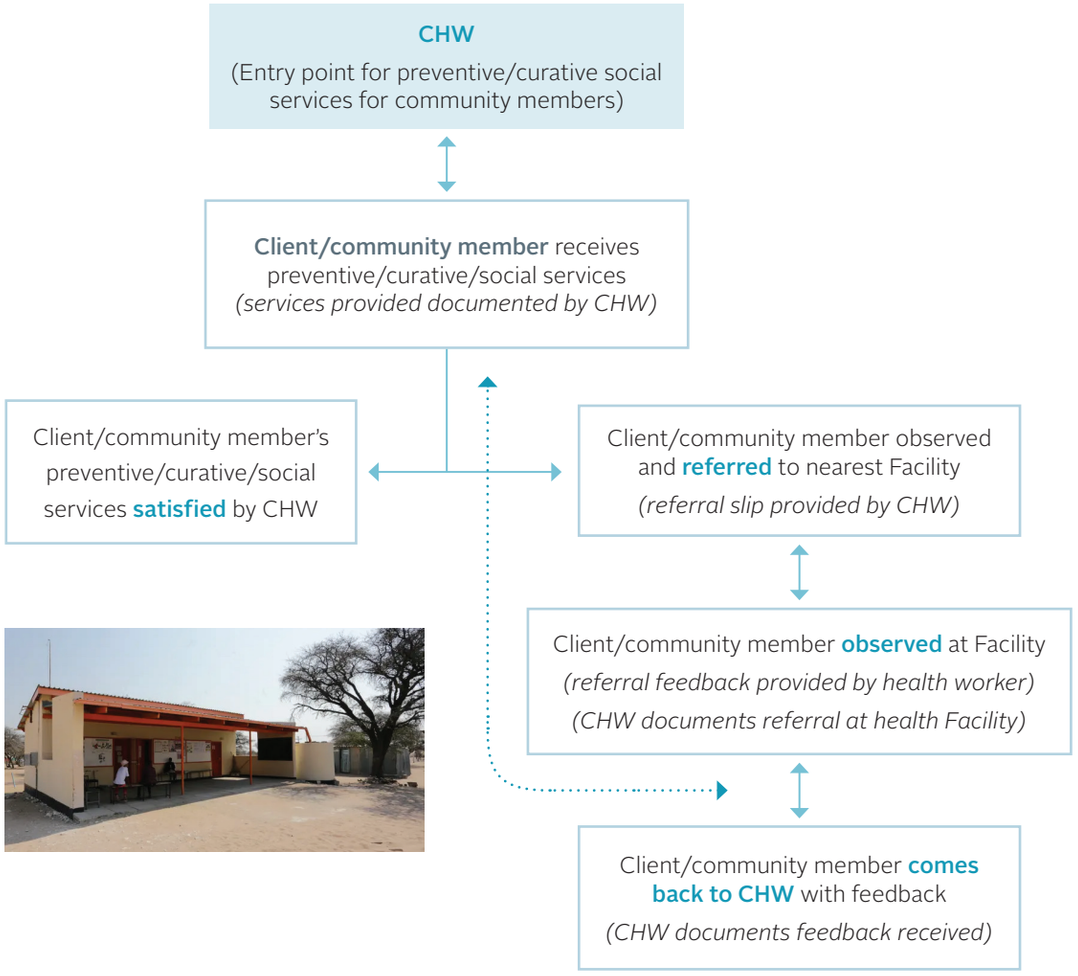
Storage and Distribution: This involves the storage and transportation of products. In large part, the types and quantities of commodities needed for essential services delivered by CHWs will dictate storage and transportation requirements. Some commodities, such as malaria bed nets and condoms, are bulkier and require additional storage and transportation space. Storage mechanisms and volume of products must consider the primary transportation means of the CBD agent. For example, transporting multiple boxes might be difficult on foot or on a bicycle. At a minimum, CHWs should be provided with a bag or backpack to transport their products and a box in which to store them. While at the district level commodities and supplies are stored in warehouses or dedicated storerooms, CHWs must keep their commodities safe at local facilities.

It is important for CHWs to track some type of basic logistics management information such as current stock on hand and quantity dispensed. Collecting these data assists program managers in calculating resupply quantities, monitoring stock status of CHWs, and reporting CHW dispensed-to-user data in the logistics system.

B.4 Referral

A policy on referral is essential for improving service delivery and customer satisfaction. The CHW will refer all cases that require procedures outside of the approved scope of work to the nearest health facility, depending on the gravity of the case (see **Figure B1**).

Figure B1. Referral Flow Chart



Annex C:
Minimum package of community-based health services

C.1 Systematic Screening for Unmet Needs for Key Health Services (Household Profiling)

Prior to the screening, the purpose should be explained (e.g., "I am asking these questions to see how I can address your health needs best") and a safe, private environment ensured. If not specified, screening applies to both male and female clients.

		SCREENING QUESTIONS FOR THE CLIENT	ACTION
TB	Unmet need for TB screening in 13-year-olds and above, adolescents	1. Do you have any of the following • Cough ≥2 weeks (any duration for HIV +) • Fever ≥2 weeks • Night sweats ≥2 weeks • Weight loss? 2. Have you ever worked or lived in the mines?	• If the answer is YES to one or more, refer for further evaluation • If the answer is YES to question 2, refer to the nearest facility
	Unmet need for TB testing in children 12 years old and younger	1. Does the child have cough, fever, and night sweats ≥2 weeks, enlarged lymph nodes, and/or reduced playfulness? Weight loss (failure to thrive)? 2. Does the child have contact with someone known to have TB (e.g., household member, caregiver)?	• If the answer is YES to one or more questions, refer for further evaluation
HIV	Unmet need for HIV testing	1. Do you know your HIV status? 2. If HIV negative, when was the last time you were tested for HIV? 3. If HIV negative, what will you do to ensure you continue being negative? 4. If HIV positive, have your family members been tested (children and sexual partner) 5. If HIV positive, have you disclosed to sexual partner and other caretakers?	• Question 1: If the answer is NO, refer for testing. • Question 2: If it has been more than a year since last HIV test, refer for testing. • Question 4: If the answer is NO, refer family for testing. • If HIV positive, ensure linkage to care, treatment adherence and compliance to the 3/12 or 6/12 viral load and CD4 monitoring. • If the answer to question 5 is NO, support to disclose status and support them to test themselves, too.

		SCREENING QUESTIONS FOR THE CLIENT	ACTION
STI	Unmet need for STI testing and/or syndromic treatment	**1.** Do you currently have any of the following symptoms? • **For men & boys:** painful urination, unusual discharge from penis, a rash, lesions, or blisters on the genitals • **For women & girls:** Painful urination, lower abdominal pain, unusual vaginal discharge, pain during sexual intercourse, bleeding between menstrual periods, a rash, lesions, or blisters on the genitals • **Pregnant women:** Have you been tested for syphilis at registration and at 36 weeks?	• If YES, refer for STI testing or syndromic approach management, contact tracing, and treatment • If NO, reinforce positive behavior • If not tested for syphilis, link to care (testing, treatment, and contact tracing and treatment).
MENTAL HEALTH		Emphasis on older persons, age 60 or older **1.** Do you have problems with loss of memory? **2.** Do you experience severe sadness? **3.** Do you happen to get lost in your neighbourhood? **4.** Are you diagnosed with a mental condition or do you have signs and symptoms of one? **5.** Also confirm with caregivers the above problems?	• Emphasis on older persons, age 60 or older • If answer is YES for questions 1–5, then refer to health care worker.
CHILD HEALTH	Unmet need for child health and ECD	**1.** Do you have a child under age 5? **2.** Is child under 6 months exclusively breastfed? **3.** Is the immunization schedule up to date? **4.** Did you introduce your child to soft foods from 6 months of age? **5.** Does your child have Oral Rehydration Salt (ORS) and Zinc Sulphate for diarrhea? **6.** Did your child receive Vitamin A supplementation? **7.** Do you feed your child after washing hands with soap and clean water? **8.** Does your child sleep under insecticide-treated nets (Malaria Endemic Areas)? **9.** Does your child receive timely medical attention? **10.** Did you, talk, sing, and play with your child from an early age? **11.** Did your child receive deworming treatment (November)? **12.** Does your child have any of the following signs? • child not able to drink or breastfeed • child vomits everything • child had convulsions • child convulsing now • child is lethargic or unconscious	• If the answer to question 1 is YES, ask for under 5 card and review (age of child, feeding methods, immunization, growth monitoring, developmental milestones, exposure to HIV, TB, & circumcision (if boy). • In the absence of relevant cards, establish reasons and refer the mother as necessary. • If the answers to questions 4–11 are NO, provide education and counselling or refer • Check availability of ORS and Zinc • If the answer to question 12 is YES, refer to the nearest facility immediately. • Assess for risk factors for childhood illnesses • Check for childhood illnesses and refer if there are any

		SCREENING QUESTIONS FOR THE CLIENT	ACTION
SRH/FP	Unmet need for SRH/FP services	**1.** Have you ever been pregnant? **2.** Are you planning to get pregnant within the next year? **3.** Are you currently using a reliable contraceptive method? **4.** Do you know your HIV status and that of your sexual partner? **5.** Why are you not using any FP method? **6.** Does your sexual partner consent and support you in SRH/FP services? **7.** Do you get support to use SRH/FP services from friends and relatives? **8.** Emphasis with older persons **a.** Do you have problems associated with loss of libido? **b.** Do you have difficulty coping with menopausal symptoms?	• If the answer to **questions 1 and 2** is NO, provide education on FP methods to couple, provide a method you are allowed to give, and refer to family planning provider for further FP counselling and method provision. • If the answer to question 3 is NO, refer couple for counselling, HIV testing, planning pregnancy in HIV positive or discontent couples • Address the reason for not using contraceptive in question 4 or refer. • If the partner does not consent and support FP use, establish the reason and manage or refer as necessary. • If next of kin and friends are not supportive, establish reasons and intervene as per need. • Emphasis with older persons **a.** If s/he has problems associated with loss of libido, then refer. • If she has difficulty coping with menopausal symptoms, then refer.
REPRODUCTIVE CANCER SCREENING	Unmet need for cancer screening	Ask women who are 25 years or older: **1.** Have you been screened for cervical cancer? If yes, when was the last time you were screened for cervical cancer? **2.** Are you experiencing abnormal vaginal bleeding, foul-smelling discharge, or pain during vaginal intercourse? **3.** Ask men and women if they have screened themselves for breast cancer (both) and testicular and penile cancer (men) monthly. **4.** Do you know how to do self-screening of these cancers (breast and prostate)?	• If the answer to question 1 is No, or if it's been more than 5 (for the HIV negative and 2years for the HIV positive since last screening, refer for cervical cancer screening. • If the answer to question 2 is YES, refer urgently to facility. • If the answer to question 3 is NO, explore reasons. • If the answer to question 4 is NO, demonstrate to them or refer to health facility.

		SCREENING QUESTIONS FOR THE CLIENT	ACTION
ANC/PMTCT	Unmet need related to pregnancy care	**1.** Are you pregnant or is there anyone who is pregnant in the family? **2.** Did you enroll in antenatal care (ANC) program? **3.** Do you know the benefits of registering early for ANC? **4.** Was the pregnancy planned or not? **5.** Do you know your HIV status? **6.** Do you know the HIV status of your partner? **7.** If HIV negative, do you test every 3 months? **8.** If HIV-positive, did you enroll in the PMTCT program? **9.** HIV positive and on PMTCT, does your partner and other caretakers know your status? Have you done your viral load check? **10.** Do you experience any danger signs of pregnancy: **a.** Persistent headache, swollen face and hands on waking up, pitting swelling of feet and legs, epigastric pain, blurred vision, ringing or buzzing in the years? (high blood pressure in pregnancy) **b.** Do you experience any vaginal bleeding during pregnancy? (possible spontaneous abortion) **c.** Do you experience any abdominal pains or lower backache in your pregnancy? (premature labor) **d.** Do you have any water/fluid coming from the vagina, smelly or not smelly? (premature rupture of membrane) **e.** Do you experience frequent urination, excessive frequent hunger and thirst? (diabetes)	• If the answer to question 1 is YES establish if they have registered for ANC services. • If the answer to question 2 is NO, refer to question 3. • If the answer to 3 is NO, educate the client/family. • If the answer to question 3 is YES but they are not attending ANC, establish if pregnancy was planned and if partner is supportive; test or refer for HIV testing. • If the answer to question 5 & 6 is NO, refer to PMTCT services. • If on PMTCT, evaluate and support for adherence. • If the answer to question 9 is NO, support to disclose status and support partner and family to test themselves too, refer for viral load testing (should be done every 3 months (from pregnancy to until end of breast feeding) • If the answer to any points listed under question 10 is YES, refer urgently to health worker.
PNC/PMTCT	Unmet needs related to post-natal care	**1.** Have you recently delivered, or has anyone recently delivered in the family? **2.** Are you breastfeeding or formula feeding? **3.** Are you HIV positive? **4.** Do you experience any of the following: **5.** Excessive bleeding **6.** Engorgement of breasts/abscess **7.** High temperature (both mother and baby)	• If yes to question 11, go to question 12. • If breastfeeding, check for proper attachment and breast problems, refer appropriately; if formula feeding, check for proper preparation of formula and encourage cleanness of feeding utensils and hand washing. • If yes to question 13 and breastfeeding, check the last V/L test and refer to the clinic if more than 3 months. • Check if the baby has been tested for HIV, if not, refer for testing. • If yes to any of the items under question 14, refer immediately to the health facility.

		SCREENING QUESTIONS FOR THE CLIENT	ACTION
HEALTHY AGING	Unmet need related to healthy aging	The Healthy and Active Aging program is being integrated in all different programs hence each program is being encouraged to cater to the specific needs of this population. Emphasis on older persons, age 60 and older • Do you have sight problem? • Do you have hearing problems? • Are you able to perform activities of daily living? • Do you experience musculoskeletal pain? • Do you have problems associated with bladder control? • Also confirm with caregivers the above problems?	• If answer is YES for any question, refer to health care worker.
NCD SCREENING	Unmet need for NCD screening (diabetes, cardiovascular conditions, cancers, respiratory, nutrition problems, oral health, and eye health)	1. **Diabetes:** Do you experience frequent urination, excessive frequent hunger and thirst? 2. **Cardiovascular:** Do you experience persistent headache, swollen face and hands on waking up, pitting swelling of feet and legs, epigastric pain, blurred vision, ringing or buzzing in the ears or palpitations/pounding in the chest or chest pains? 3. **Respiratory:** Are you coughing, have difficulty breathing and chest pains when coughing 4. **Lifestyle risk assessment:** Do you use any form of tobacco and or take alcohol or any other substance (marijuana, glue, benzene, cocaine, etc.? Do you have a desire to quit the habit? 5. How often do you brush your teeth? 6. Nutrition: How many meals do you have a day and what is predominant composition of your meals? (You can ask about the last three meals and analyze the composition for nutritional value.) 7. How often do you take sugary foods? 8. Do you regularly exercise or do moderate manual work? 9. Are you having any chronic illness? (review outpatient card) 10. Do you have a toothache, bleeding gums? 11. Do you go for dental checkups every six months? 12. Do you have sight problems? 13. Do you have painful eye/eyes? 14. Do you have any history of blindness in your family? 15. Have you ever gone for an eye checkup/ screening?	• If the answer to 1 is YES, refer urgently to health worker. • If the answer to 2 is YES, refer urgently to health worker. • If the answer to 3 is YES, refer urgently to health worker. • If the answer to 4 is YES, refer urgently to health worker. • For question 5, emphasize importance of oral hygiene (recommend 2 times a day). • If the answer to 6 and 7 reveal inadequate or unbalanced nutrition, provide practical nutrition education and if there are signs of nutrition problems (underweight, overweight) refer to health worker. • If the answer to 8 is NO, encourage to do moderate intensity exercise, like brisk walking for 30 minutes, 5 times a week. • If YES to 9 and 10, refer to health care worker. • If NO to 11, emphasize importance of dental checkups. • If YES to 12, 13, and 14, refer for health care worker. • If YES to 15, emphasize the importance of eye screening.

		SCREENING QUESTIONS FOR THE CLIENT	ACTION
REHABILITATION	Unmet need for rehabilitation interventions	**1.** Do you have anyone in the family with any condition needing rehabilitation? **2.** Are they enrolled in any program/service to address their condition? **3.** Are they able to perform activities of daily living? **4.** Are they enrolled in any school or day-care program or employment? **5.** Have you been issued with a hearing aid? **6.** Do you use it most of the day? **7.** Does your hearing aid help you with communication? **8.** Identify adults and children with hearing loss. **9.** Identify adults and children with loss of vision and blindness. **10.** If there are there: Are they involved in any school or employment? **11.** If they are there: Are they involved in any association for the blind? **12.** If they are there: Have they been issued with vision impairment assistive device (e.g., white cane/ magnifiers) **13.** If they are there: Do they use the devices often? **14.** If they are there: Are the assistive devices useful?	• If the answer to question 1 is YES, refer to the rehabilitation officer. • If the answer to question 2 is NO, refer to rehabilitation officer. • If the answer to question 3 is NO, refer to rehabilitation officer. • If the answer to question 4 is NO, refer to rehabilitation officer. • Follow up on use of hearing aids and supply of accessories such as batteries, otherwise refer to the nearest audiology clinic. • If YES to 9, refer to ophthalmic personnel with skills for low vision. • If NO to 10, refer to social welfare department. • If NO to 11, refer to Association for the Blind, e.g., BABPS. • For 14, follow up on supply and use of assistive devices and refer accordingly.
MALARIA	Unmet need for malaria screening	**1.** Do you stay in a malaria endemic area? **2.** Have you visited a malaria endemic area? **3.** Do you experience high temperature, headache, shivering, nausea, and vomiting?	• If the answer to all these questions is YES, do a rapid test and/or refer to health worker.
WASH	Unmet need for WASH	**1.** Do you have a toilet? **2.** Do you have running water and soap for hand washing in the toilet area/room or hand washing *sekupu* outside the toilet? **3.** Where do you collect your water? **a.** Tap **b.** Well **c.** Dam/pond **d.** Other **4.** Do you purify unclean water? **5.** Where do you keep your household water? **a.** Open bucket **b.** Closed bucket **c.** Jojo **d.** Other **6.** How do you dispose of household waste?	• If the answer is NO to question 1, establish the alternative. • If answer to question 2 is NO, educate and demonstrate it to family. • Emphasize teaching children under age 5 how to wash hands with soap and water. • If answer for question 2 is b. or c, purify the water. • If answer to question 3 is NO, teach domestic water purification. • If answer to question 4 reveals unsafe water storage, teach and demonstrate how to store water safely.

		SCREENING QUESTIONS FOR THE CLIENT	ACTION
NUTRITION	Unmet need for nutrition	**1.** Is child under 6 months exclusively breastfeed? **2.** How old is the baby? **3.** Check the child's growth chart Emphasis for the elderly, **1.** How many fruits/Vegetables per serving do you have in a week? **2.** Is client being monitored for nutritional needs?	• If no to question 1, establish what the baby is being fed. If the milk is not enough: **a.** Assess breastfeed and assist the mother to position and attach the baby to the breast • If the child is 6 months and above, establish if the baby has been started on complementary feeding. If not counsel and educate on importance of introducing solid foods from six months • If the child's weight is stagnant or dropping, assess to find out how the child is being fed • Measure MUAC, if yellow or red refer to the health facility for further assessment • Also establish if the child is receiving food from four or more food groups **(dietary diversity)** • Assess the socio-economic status of the household • For elderly 1. if answer is taking 3 or less servings of vegetables or fruits per week, then refer • If client is not being monitored for nutritional needs, then refer.

ANNEX D:
COVID-19 Training Curriculum for Community Health Workers

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Foreword

Coronavirus disease 2019 (COVID-19) was first identified during an investigation into an outbreak in Wuhan, China, in 2019. Since then, the virus has spread to many countries, including Botswana. The country is one of the few that has reported significantly lower cases since the World Health Organization declared the outbreak a pandemic on March 12, 2020.

The role of community health workers in Botswana's health care service delivery is not new. They have been significantly important in ensuring a person-centered approach and have long been embraced in the Primary Health Care and Health for All approach since the late 1970s. It is therefore crucial that they are equally empowered on COVID-19 to be able to mobilize communities into action for their health and well-being. It is through the community-based approach that behavior change will be realized.

This curriculum is designed to be used by those who do cultural or population-specific work in the community (community health workers, home visitors, home-based care volunteers, peer educators, etc.). Community health worker training requires full engagement of trainers through provision of real-life scenarios as well as real-life practical situations to utilize all the domains of learning.

Thanks to all organizations, workplaces, and businesses for showing interest in educating your community about coronavirus.

Ms. Baile Moagi
Acting Permanent Secretary
Ministry of Health and Wellness

Introduction

The workshop should be participant-centered and as interactive as possible. It needs to instill the basic principles of justice, equity, and decision-making in community work. An atmosphere needs to be created in which people are comfortable sharing ideas and experiences, and transferring knowledge with a solution-oriented mentality.

The curriculum is divided into seven topics; theoretical and practical knowledge will be shared with emphasis on the background of COVID-19, prevention, signs and symptoms, legal and ethical responsibilities and roles, advocacy, and outreach.

Target: The workshop is intended for community health education assistants, community health workers, peer support personnel, and patient navigators.

Methodologies: The curriculum uses interactive activities in which participants move around the room. The space should be large enough for group discussions, demonstrations, and role-play.

Materials Required: Toolkit, PowerPoint slides, flip charts, markers, hand-outs
Reference materials: charts, posters, leaflets

Learning Objectives: By the end of the workshop, the participants will be able to:

- Identify ways to share the information back with their community members
- Respond to misinformation or stigmatizing comments or behavior related to the virus
- Discuss prevention measures for COVID-19
- Explain roles and responsibilities when responding to the COVID-19 outbreak
- Discuss legal and ethical responsibilities when dealing with community members

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TOPIC 1:
Introduction to coronavirus disease (COVID-19)

1.1 What is COVID-19?

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The virus was first identified during an investigation into an outbreak in Wuhan, China, in 2019. Since then, the virus has spread to more than 100 countries, including neighboring countries in the southern part of Africa.

Naming the coronavirus disease (COVID-19)

Official names have been announced for the virus responsible for COVID-19 (previously known as "2019 novel coronavirus") and the disease it causes. The official names are:

Disease: Coronavirus disease (COVID-19)
Virus: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

COVID-19 is highly contagious and affects people of all ages. The majority of cases are mild, however people with cardiovascular disease or other underlying conditions may have more severe response.

Diseases are named to enable discussion on disease prevention, spread, transmissibility, severity, and treatment. Human disease preparedness and response is one of the roles of the World Health Organization, so diseases are officially named by WHO in the International Classification of Diseases (ICD).

1.2 Situation report

The novel coronavirus originated in Wuhan, China, in late December 2019. As of April 1, 2020, according to WHO, the trend is as follows:

Globally: 823,626 cases confirmed (72,736); 40,598 deaths (4,193)
Western Pacific Region: 106,422 confirmed (1,554); 3,701 deaths (30)
European Region: 464,212 confirmed (40,266); 30,089 deaths (3,395)
South-East Asia Region: 5,175 confirmed (960); 195 deaths (29)
Eastern Mediterranean Region: 54,281 confirmed (3,932); 3115 deaths (161)
Region of the Americas: 188,751 confirmed (25 737); 3,400 deaths (564)
African Region: 4,073 confirmed (287); 91 deaths (14)
NB: Botswana has 15 confirmed cases and 1 death as of April 17, 2020

1.3 What are the symptoms?

The COVID-19 virus affects different people in different ways. It typically cause respiratory symptoms, and most infected people will develop mild to severe symptoms. Symptoms can take from two to 14 days to appear. Typically, symptoms appear four to five days after exposure (may differ from person to person). A person is contagious two to three days after exposure, even if they do not show any symptoms.

Common symptoms include:

- Fever
- Tiredness
- Difficulty breathing

Other symptoms include:

- Dry cough
- Aches and pains
- Sore throat
- Some report diarrhea, nausea, or runny nose

1.4 How is it transmitted?

1. **The virus is spread mainly from person to person through**
    - Close contact with one another (less than 2 metres apart)
    - Respiratory droplets produced when an infected person coughs or sneezes
2. **Spread from contact with contaminated surfaces or objects**
    - Touching a surface or object that has the virus on it and then touching the mouth, nose, or, possibly, the eyes

1.5 Who is at risk?

Everyone is at risk of contracting the virus if they have had contact with the infected person or have travelled to affected places and countries where there is transmission.

Most people infected with COVID-19 will experience mild to moderate respiratory illness and recover without requiring special treatment.

Health care workers, people who have underlying medical conditions, and those older than 60 years have a higher risk of developing severe disease and death.

Groups at higher risk:

- Older adults
- People with HIV
- People with asthma
- Pregnant women

Republic of Botswana

Ministry of Health and Wellness

ALWAYS
WASH YOUR HANDS
WITH SOAP AND CLEAN WATER

Steps on washing your hands to kill germs.

1. Wet hands with clean running water.

2. Apply enough soap and rub your hands palm to palm.

3. Rub your hands in and around fingers.

4. Rub back of each hand with palm of other hand.

5. Rub fingertips of each hand in opposite palm.

6. Rub each thumb clasped in opposite hand and vice versa.

7. Rinse hands with running water.

8. Use paper towel or tissue to turn off the tap and dispose it off.

9. Use a clean paper towel or tissue to dry your hands.

10. Dispose the paper towels in the dustbin.

11. Your hands are now clean.

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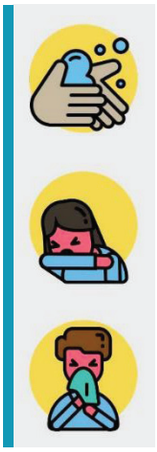
Vision: A Healthy Nation by 2023
Values: Customer Focus, Botho, Timeliness, Equity, Teamwork, Accountability.

TOPIC 2:
Prevention of COVID-19

2.1 How to prevent COVID-19?

To prevent infection and to slow transmission of COVID-19, do the following:



- Wash your hands regularly with soap and water or clean them with alcohol-based hand rub/sanitizer.
- Cover your mouth and nose when coughing or sneezing (use a tissue or flexed elbow). Then throw the tissue in the bin.
- Maintain at least 2 metres distance between you and other people.
- Avoid touching your face.
- Stay home if you feel unwell.
- Refrain from smoking and other activities that weaken the lungs.
- Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people.
- Clean and disinfect frequently touched objects and surfaces.

2.2 Use of masks

Steps when using a mask/how to use a mask

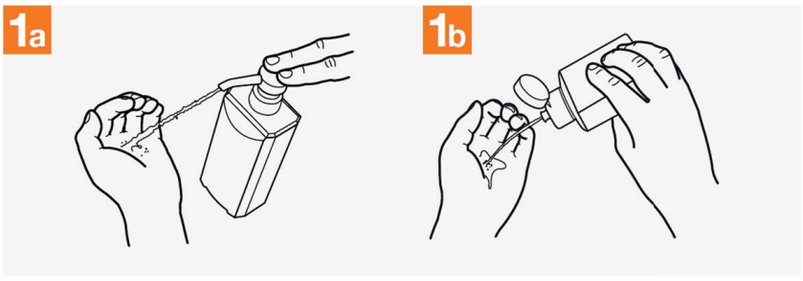
1. Before putting on a mask, clean hands with soap and water or alcohol-based hand rub.
2. Cover mouth and nose with mask and make sure there are no gaps between the face and the mask.
3. Avoid touching the mask while using it; if you do, clean your hands with soap and water or alcohol-based hand rub.
4. Replace the mask with a new one as soon as it is damp and do not re-use.
5. To remove the mask: remove it from behind (do not touch the front of the mask).
6. Discard it immediately in a closed bin.
7. Clean hands with soap and water or alcohol-based hand rub.

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a 1b

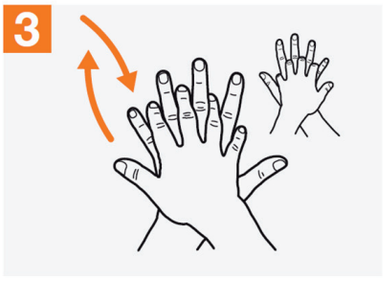


Apply a palmful of the product in a cupped hand, covering all surfaces;

2

Rub hands palm to palm;

3

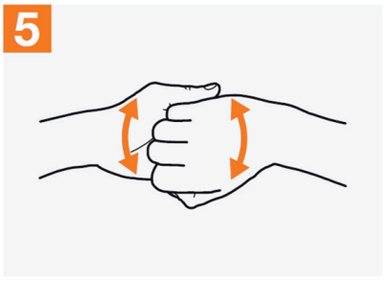


Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5



Backs of fingers to opposing palms with fingers interlocked;

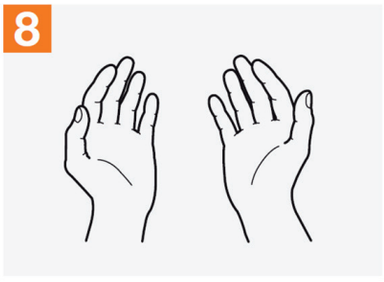
6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Once dry, your hands are safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

Settings for use of masks

Health care facility

- Individuals with respiratory symptoms
- Health care workers during screening of patients, when caring for someone suspected to have COVID-19, or when caring for a confirmed COVID-19 patient

Community setting

- Individuals with respiratory symptoms
- Use in highly populated areas such as malls

Home care

- Individuals caring for a family member with suspected COVID-19 infection
- When one has respiratory symptoms
- Health worker providing routine home visits

Hand washing and hand rub techniques

Activity

Go through the proper hand washing and hand rub technique pictured below.
Explain why it is important to wash hands using the outlined steps.

2.3 Prevention interventions

The country adopted the following prevention and control strategies as of February 2020:

- Public education through the use of mass media and other forms of education
- Port health-screening at all points of entry for early detection, diagnosis, and treatment
- Quarantine: advised self-quarantine or institutional quarantine for suspected cases as well as rapid specimen collection for testing
- Isolation for suspected cases or symptomatic individuals following screening at designated health facilities followed by contact tracing instituted to ensure that the virus does not spread
- Social distancing where the public is advised to take measures to reduce contact in malls, shops, workplaces, gyms, places of worship, etc.
- Community lockdown/extreme social distancing for training institutions and other places where large numbers of people gather or there is restricted movement. This includes restricting and preventing travel within or outside the country.

2.4 How is COVID-19 treated?

Currently there is no known cure; treatment is supportive, for example, providing oxygen for patients with shortness of breath or treating a fever or other symptoms.

TOPIC 3:
Myths and misconceptions

3.1 Defining myths and misconceptions

Misconceptions are false impressions and misapprehensions.

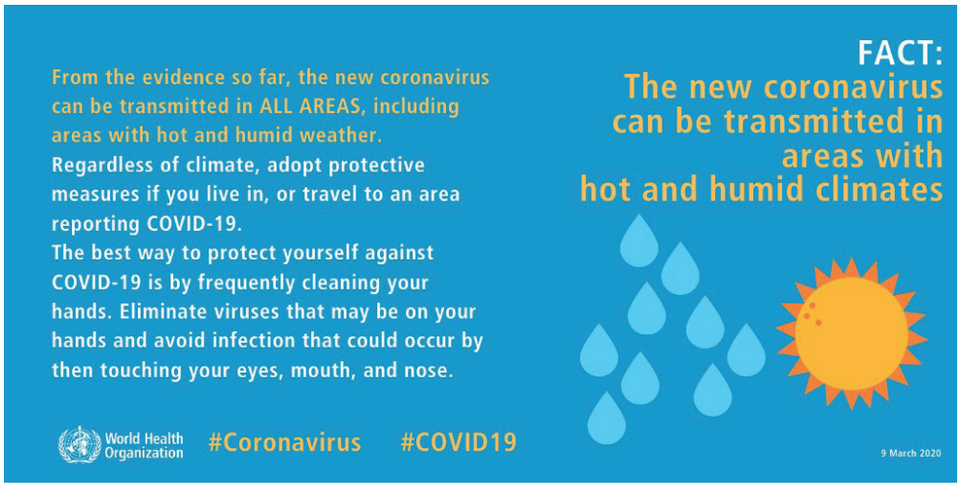
Myth is a widely held but false belief or idea.

These could be mistaken thoughts, ideas, or notions that develop and prosper in societies, mostly leading to malpractice in terms of health beliefs and health-seeking behaviors. Such myths and fallacies hinder the logical approach to seek appropriate health care, resulting in various health problems (Wambua 1997; Amankwaa 2003). Currently, there are many myths regarding COVID-19; the role of such myths in governing the health and health-seeking behavior of people is quite explicit. These myths could have a negative implication; therefore, it is the duty of community health workers to set the record straight.

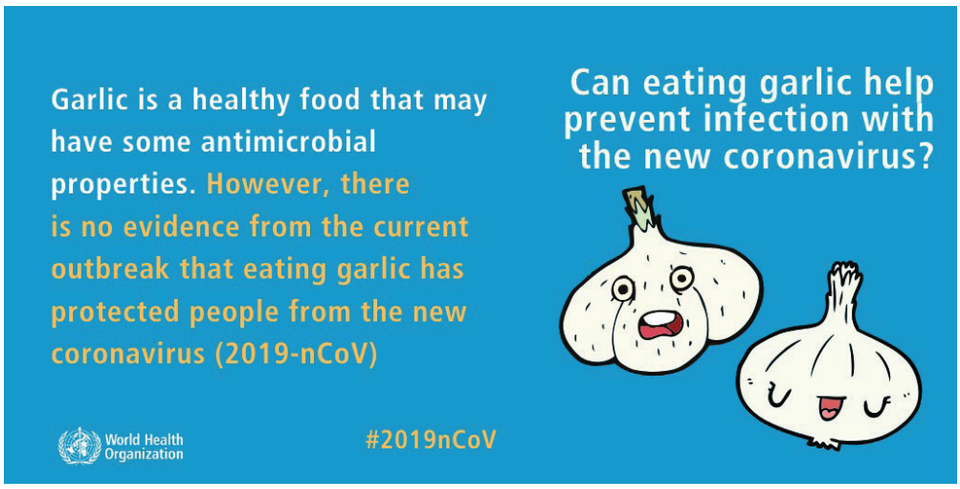
3.2 Common myths on COVID-19

Below are examples of myths that have emerged in relation to COVID-19 and the corrections.

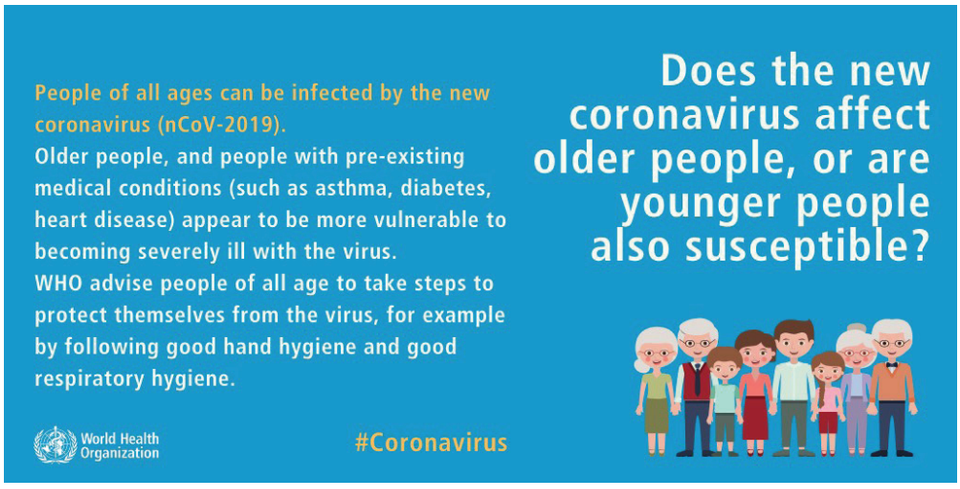
Myth: Exposing myself to the sun or being hot conditions will prevent me from having COVID-19.



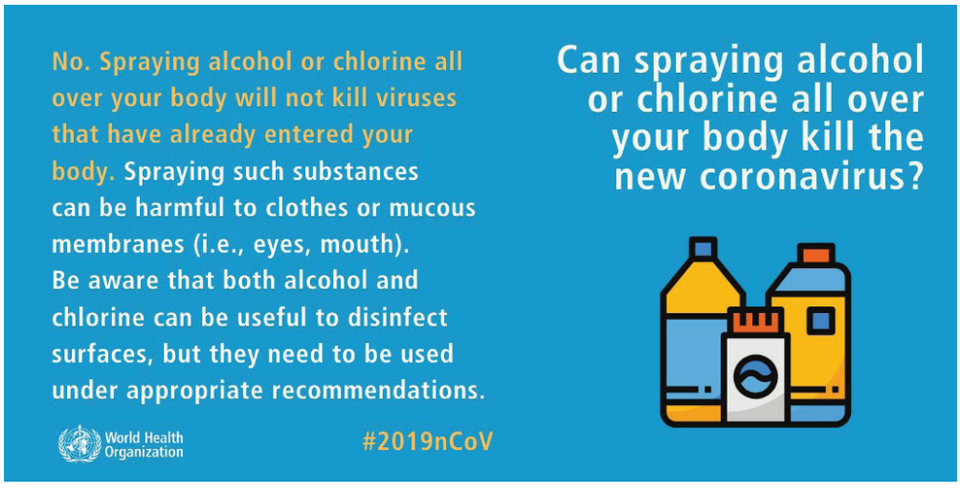
Myth: Eating garlic will protect me from COVID-19.



Myth: COVID-19 only affects older people.



Myth: I am protected if I apply alcohol or sanitizer to my body.



It is important for community health workers to identify myths that exist in relation to COVID-19, and come up with counteracting measures to dismiss them to help the community stay informed, which leads to change in behavior and perceptions.

3.2.1 ACTIVITY

List any other COVID-19 myths and come up with ways to address them.

_____

_____

TOPIC 4: Social stigma

4.1 What is social stigma?

Social stigma in the context of health is the negative association between a person or group of people who share certain characteristics and a specific disease. In an outbreak, this may mean people are labelled, stereotyped, discriminated against, treated separately, and/or experience loss of status because of a perceived link with a disease.

Such treatment can negatively affect those with the disease, as well as their caregivers, family, friends, and communities. People who do not have the disease but share other characteristics with this group may also suffer from stigma.

The current COVID-19 outbreak has provoked social stigma and discriminatory behavior against people of certain ethnic backgrounds as well as anyone perceived to be in contact with the virus.

4.2 Why is COVID-19 causing so much stigma?

The level of stigma associated with COVID-19 is based on four main factors: (1) it is a disease that is new and for which there are still many unknowns; (2) we are often afraid of the unknown; (3) it is easy to associate that fear with 'others'; (4) it instills fear associated with the other person.

4.3 What is the impact of stigma?

Stigma can:

- Drive people to hide the illness to avoid discrimination
- Prevent people from seeking health care immediately
- Discourage people from adopting healthy behavior

Stigma can undermine social cohesion and prompt possible social isolation of groups, which might contribute to a situation where the virus is more, not less, likely to spread. This can result in more severe health problems and difficulties controlling a disease outbreak.

4.4 How to address social stigma

DO:
Talk about the new coronavirus disease (COVID-19).

DO NOT:
Attach locations or ethnicity to the disease, this is not a "Wuhan Virus," "Chinese Virus," or "Asian Virus."

DO:
Talk positively and emphasize the effectiveness of prevention and measures

DON'T:
Emphasize or dwell on the negative, or messages of threat. We need to work together to help keep everyone safe.

FACTS, not fear, will stop the spread of novel coronavirus (COVID-19)

- Share facts and accurate information about the disease.
- Correct myths and misconceptions.
- Choose words carefully. The way we communicate can affect the attitudes of others (see do's and don'ts above).

4.4.1 ACTIVITY

Come up with other ways to tackle social stigma in relation to COVID-19 among your community.

TOPIC 5:
Role, advocacy and outreach

5.1 Community-based strategy

Community-based strategy is critical once again in our global response to COVID-19. As cases grow exponentially, so does work to prevent, detect, and respond to the pandemic. Here is what the job description of a COVID-19 community health worker looks like:

5.1.1 PREVENT

- Assess community risk and mapping of high-risk populations for targeted intervention
- Engage District and community structures
- Organize and carry out community education campaigns to promote social distancing and advocate for timely policies
- Encourage strategies in the district and online to promote mental and physical health and resilience
- Provide capacity building and training for community structures

5.1.2 DETECT

- Learn the signs and symptoms of COVID-19, and help hospitals and public health departments to answer questions from the public
- Refer possible COVID-19 patients to their nearest testing center and organize transportation
- Enforce self-quarantine of potential cases
- Implement community education

5.1.3 RESPOND

- Support MOHW to implement community-based surveillance, through screening and contact tracing for COVID-19.
- Call people with COVID-19 who are in self-isolation with mild symptoms and monitor them for worsening symptoms.
- Provide moral support for people with COVID-19 at home.

- With nurse supervision, monitor patients for worsening symptoms and support rapid referral of people who require hospitalization.
- With public health officers, support contact tracing, symptom reporting, and monitoring of contacts of COVID-19 patients to ensure access to testing and treatment for people who develop signs and symptoms.

5.1.4 DATA COLLECTION AND REPORTING

- Use checklist for house visits and gather information arising at household level.
- Compile a report on visits conducted at the end of the week and submit to the supervisor.

5.2 Contact tracing

Contact tracing is an integral component of the overall strategy for controlling an outbreak of coronavirus (COVID-19). Contact tracing is defined as the identification and follow-up of persons who may have had contact with an infected person.

5.2.1 ELEMENTS OF CONTACT TRACING

5.2.1.1 CONTACT IDENTIFICATION

Contact identification therefore begins from a case. Identification of contacts is done by asking about the activities of that person (whether alive or dead) and the activities and roles of the people around him/her (alive/dead) since onset of illness.

5.2.1.2 CONTACT LISTING

All persons considered to have had significant exposure should be listed as contacts, using the contact listing form. Efforts should be made to physically identify every listed contact and inform them of their contact status, what it means, the actions that will follow, and the importance of receiving early care if they develop symptoms.

5.2.1.3 CONTACT FOLLOW-UP

Responsible for contact tracing. It should be a competent team comprised of local surveillance and appropriate community members to follow-up all the listed contacts. This could include surveillance staff/health workers from health facilities, community health workers, or volunteers.

5.2.2 ROLE OF COMMUNITY HEALTH WORKERS IN CONTACT TRACING

Contact identification: Conduct active and passive contact tracing.

Contact listing: Any person considered to have had a potential COVID-19 exposure and meeting the contact definition criteria should be listed as a contact.

Contact follow-up: Perform contact follow-up through daily visits with the contact at a predetermined location and time, or by telephone. Daily monitoring of temperature and symptoms of clients on home care.

Contact tracing: Conduct contact tracing if there is a suspect identified from the institutional quarantine sites.

Education: Provide education on prevention of COVID-19 while in quarantine.

Record keeping: Keep records of the contact tracing data and reports.

Report: Compile contact list forms and report to the district contact tracing team or supervisor in charge.

TOPIC 6:
Lockdown/extreme social distancing effects

6.1 Gender-based violence (GBV)

An unsettling amount of information is available about GBV occurring against the backdrop of the COVID-19 outbreak. Many of the measures deemed necessary to control the spread of the disease (e.g., restriction of movement, reduction in community interaction, closure of businesses and services, etc.) are not only increasing GBV-related risks and violence against women and girls, but also limiting survivors' ability to distance themselves from their abusers as well as reducing their ability to access external support.

6.1.1 HOW CAN WE ADDRESS GBV?

- Provide information about COVID-19, and the risk of GBV through different media and forums
- Involve key community leaders, law enforcement officers, social workers, and GBV service providers
- Work in close collaboration with GBV actors to identify alternative shelter options where possible
- Develop age appropriate awareness-raising messages on GBV risks (e.g., child friendly messages)

6.2 Psychosocial issues

People who are quarantined or under movement restrictions are very likely to develop a wide range of symptoms of psychological stress and disorder, including low mood, insomnia, stress, anxiety, anger, irritability, emotional exhaustion, depression, and post-traumatic stress symptoms.

It goes without saying that there is a risk of worsening or relapse in persons with existing mental illness. The stress can also tip vulnerable persons into alcohol and illicit substance abuse.

6.2.1 HOW CAN WE ADDRESS PSYCHOSOCIAL ISSUES?

- Make sure community-based interventions are in place that can address the needs of large groups of affected populations
- Educate people about the expected psychological impact and reactions to trauma if they are interested in receiving it
- Make sure people understand that a psychological reaction is normal
- Engage NGOs/CSOs to address psychosocial issues

6.2.1 ACTIVITY

Explain any other health effects that may be a result of extreme social distancing.

TOPIC 7:
Legal and ethical responsibilities

7.1 Introduction

The ethical principles of autonomy, non-maleficence, beneficence, justice, and veracity should remain your touchstones. Be aware that balancing the sometime competing application of these principles during a pandemic may lead to new or different conclusions. Currently, they may require different steps than you are used to taking; however, the underlying premises are the same.

7.2 ETHICAL PRINCIPLES

Autonomy: People have the right to decide what they want. However, with COVID-19 it is important that decisions be made not only in the best interest of self but also of the next person. Autonomy also emphasizes "duty to respect the patient's rights to self-determination and confidentiality." Health workers are "obliged to safeguard the confidentiality of patient records." You may not be able to meet this obligation if contact tracing and/or reporting becomes necessary to reduce the spread of COVID-19.

Non-maleficence: Health workers have a "duty to refrain from causing harm." This ethical principle applies not just to an individual patient undergoing treatment, but also to the whole community. As a community health worker, you have a responsibility to assess community risk and enforce self-quarantine of potential cases and promote compliance with social distancing to make sure no one is put in harm's way.

Beneficence: Health workers have "a duty to promote the patient's welfare." Under this principle, "your primary obligation is service to the public-at-large." This duty obligates community health workers to use their "skills, knowledge, and experience for the improvement of the health of the public." It also means "doing good," balancing risks versus benefits.

Justice: Health workers have a "duty to treat people fairly." You cannot refuse to accept or deny anyone service "because of their race, faith, nationality, or origin." COVID-19 is not unique to any one race, faith, or nationality and, as always, ethically inappropriate to base decisions on any of those factors. A community health worker is linked to social justice precisely because their work focuses on ensuring that individuals and communities share equally in the benefits society has to offer.

Veracity: Health workers have a "duty to communicate truthfully." This is very important given the uncertainty surrounding COVID-19. Trust, especially in the time of a pandemic, cannot and should not be compromised. Having all the facts results in informed decision-making; therefore, providing all the information needed helps enable changes in behavior.

7.2.1 ACTIVITY

Give example(s) on how you can implement one of the mentioned principles in real-life scenarios.

_____

_____

7.3 Individual responsibility and vigilance

- Treat all clients with respect, compassion, and dignity.
- Maintain patient confidentiality.
- Swiftly follow established public health reporting procedures of suspected and confirmed cases.
- Provide or reinforce accurate infection prevention, control, and public health information.
- Put on, use, take off, and dispose of personal protective equipment properly.
- Self-monitor for signs of illness, and self-isolate or report illness to supervisors if it occurs.
- Advise management on communication and community engagement principles.
- Report to the immediate supervisor any situation that you have reasonable justification to believe presents an imminent and serious danger to life or health.

SUBANNEXES

SUBANNEX D1:
Training plan

The plan provides a guide for facilitation. The facilitator may customize the lesson plan or decide on the mode of transmission most appropriate.

TOPIC	CONTENT	MATERIAL	TEACHING METHOD	DURATION
Introduction and Welcome	• Welcome remarks • Housekeeping • Interactive introductions • Objectives of the workshop • Participants expectations • Review group agreements/ ground rules	• Flip charts		15 mins
Introduction to COVID-19	• What is COVID-19? • COVID-19 situation report • Signs and symptoms • Transmission • Who is at risk?	• Hand-out • PowerPoint • Pictorial presentations	• Lecture-discussion	30 mins
Prevention of COVID-19	• Prevention of COVID-19 • Use of Masks • Hand hygiene technique • Hand rub technique • Prevention intervention *Break participants into small groups/pairs. Provide the groups with the different settings in the community. Ask them to discuss the interventions or mitigating strategies that may be put in place to prevent the spread of COVID-19 in those settings.*	• Pictorials • Poster • PowerPoint • Toolkits	• Lecture • Demonstration • Group discussions	2 hrs

TOPIC	CONTENT	MATERIAL	TEACHING METHOD	DURATION
Myths and misconceptions	• What are myths? • Common myths, rumors, and misinformation *Give the participants an opportunity to share myths they are aware of and how best they can address them.*	• PowerPoint • Flip charts	• Lecture • Discussion	30 mins
Social stigma	• Define social stigma • Why the stigma • Impact of the stigma • How to address it *Ask participants in their groups to come up with interventions to deal with stigma.*	• PowerPoint	• Lecture	1 hr
Role, advocacy, and outreach	• Roles of community health workers before, during, and after outbreak • Role during contact tracing • Reporting *Using the same grouping criteria as before, ask the participants to come up with initiatives to tackle community empowerment in relation to COVID-19.*	• PowerPoint • Flip chart	• Group discussions and plenary	1 hr 30 mins
Lockdown/ extreme social distancing effects	• GBV • Psychosocial issues *Ask participants to discuss other known effects.*	• Newspaper articles	• Discussion	30 Mins
Legal and ethical responsibilities	• Definition of ethical principles (autonomy, beneficence, non-maleficence, and justice) • Individual responsibility and vigilance	• PowerPoint	• Lecture	1hr

TOPIC	CONTENT	MATERIAL	TEACHING METHOD	DURATION
Evaluation and closure	• Determine the most appropriate way to evaluate participants' understanding in line with set objectives • Provide a summary of the workshop and emphasize roles and responsibilities in COVID-19 prevention and control • Distribution of packages (identifiers, tools, bag packs, etc.) *Thank participants for their time and efforts.*	• Flip chart • Quiz	• Discussion	30 mins

SUBANNEX D2:
Developing a planner (Weekly)

Below is the template that facilitators need to take the trainees through to assist them in planning for their activities. The template may be customized to meet the needs depending on the nature of assignment.

DATE: 01-08 MARCH 2020

OBJECTIVE	ACTIVITY	DATE	EXPECTED OUTCOME
To conduct contact tracing in at least 20 clients for index case **#40 by end of 8 March 2020**	• Conduct home visits • Provide family education on importance of quarantine	• 1–4 March 2020	
Conduct at least 3 clinic health talks by end of the week	• Clinic X • Clinic Y • Clinic Z	• 2–6 March 2020 • 07:30–08:00	

ANNEX E:
List of Contributors

Contributors to development of the National Guideline for the Implementation of Community-Based Health Services in Botswana

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