OND SCHEDULE (r. 13 (c), 15 (1) and 17).

PART A—MINIMUM REQUIREMENTS FOR A GENERAL PRACTITIONER

1. PREMISES: (1) Premises should contain the following accommodation— (a) waiting room; (b) a consulting room which should be reasonably sound-proofed so that conversations taking place therein are not easily audible outside the consulting room; (c) an examination room which should be either separate room or a curtained- off part of a consulting room; (d) a treatment room in which such procedures as the giving of medications and the carrying out of minor surgical operations can be done; (e) adequate toilet facilities. (2) These rooms should be adequately furnished and cleaned and— (a) there shall be sufficient sitting accommodation in the waiting room for the size of the practice; (b) the consulting room shall have a desk and a chair for the doctor and two or three chairs for the patient(s); and a consulting room should also have a facility for the practitioner to wash his hands, for example, where there is no running water there shall be a washing basin with a jug of water which is periodically topped up; (c) there shall be an examination couch in the consulting or examination room and another couch in the treatment room and the couches shall be designed so that it is easy for an infirm patient to get on to them, and there shall be adequate lighting, either daylight or artificial light, to enable the practitioner to see his patient fully.

2. EQUIPMENT: The practitioner shall have the following equipment available at his place of work— (a) diagnostic instruments such as stethoscope, syphygmomanometer, foetal stethoscope, torch, patella hammer, auroscope, opthalmoscope, proctoscope,, virginal speculum, disposable tongue depressors; (b) instruments for carrying out certain procedures, for example, opening abcesses and stitching wounds; (c) sterilizers for surgical instruments and containers, etc; (d) a

facility to examine urine on the premises, for example, by the use of “labstix” or equivalent reagents; (e) a cabinet for patients’ records. [Issue 1] [Issue 1] Kenya Subsidiary Legislation, 2014 1208 1208 1208 1208 1208 1208 1208 1208 Kenya Subsidiary Legislation, 2014

3. STOCKING OF DRUGS: (1) The practitioner should attempt to keep in his premises a stock of those essential drugs which he considers should be administered in his premises and especially if his practice is not in a location where there may be a dispensing pharmacy. The range of drugs that he should have is wide, but he ought to have at least the following— (a) Injections of analgesics (for example, pethidine, morphine, etc.); (b) Antibiotics, antihistamines, brochodilators, antiemetics, antispamodics, local anaesthetics and corticosteroids; (c) For the purpose of administering injections, he should have disposable syringes and needles and surgical spirit. (2) Further the doctor should provide himself with a bag which he can carry with him when visiting patients, when travelling or to be available for him to use whenever his services may be needed. This bag should contain as a minimum the following— (a) Such drugs as injections of analgesics, antibiotics, bronchodilators, tranquilisers, local anaesthetics, antipasmodics, antiemetics; (b) oral preparations such as antipyretics, analgesics,gastrointestinal sedatives, antidiarrhoeals, antihistamines, brochodilators, antibiotics, muscle relaxants, etc. (3) For the purpose of the doctor’s bag it should be the practice to carry disposable syringes and needles rather than steel and glass syringes which require sterilization. The bag will be adequately furnished if it carries a supply of 2ml disposable syringes and 25g (1 in) and 21g (1½in) disposable needles. It is also convenient to carry strips of spirit swabs rather than carrying a supply of surgical spirit and pieces of cotton wool. Practitioners shall take steps to destroy all disposable equipment to avoid their possible use.

4. APPROVED DESCRIPTION OF NAME: Dr./Mr……..MBchB, BDS* Medical Practitioner/Dentist/Clinical Laboratory/Clinical Radiological Laboratory*. Dr./Mrs…….MBchB,DCH,MRCP,FRCS, M.MED, FRCR*, etc. Specialist* Physician, Paediatrician, Dermatologist*, Anaesthetist, Radiologist, Psychiatrist, Pathologist, Obstetrician and Gynaecologist, Surgeon (Orthopaedic, Urologist, Neurosurgeon, Thoracic, Plastic, Opthalmology*), etc. *Delete where not applicable. [Issue 1] [Issue 1] Kenya Subsidiary Legislation, 2014 1209 1209 1209 1209 1209 1209 1209 1209 Kenya Subsidiary Legislation, 2014

PART B—MINIMUM REQUIRMENTS FOR A DENTAL SURGERY

1. WAITING ROOM: with basic furniture, telephone etc.

2. LABORATORY/WORKSHOP: (a) Basic Laboratory RequirementInvesting flasks; Press and clamp; Polishing motor; Laboratory motor and hand piece; Bunsen burner; Pliers, wax knife etc; Denture materials; Plaster for models; Model trimmer; Polishing brushes, cone felt etc. (c) Basic Requirements in filling materials 1. Amalgams; 2. Dental cements; (i) Zinc oxide Engenel; (ii) Zinc and copper phosphates; (iii) Calcium hydroxides; (iv) Silicate and silicophosphate cements; (v) Filling resins.

3. TOILET—with wash basin and water borne sanitation.

4. SURGERY - composed of the following basic essentials— (i) Dental unit with low and high speed drills which are water cooled; (ii) Wash-basin with running water; (iii) Sterilizer unit (iv) Cabinet with basic dental instruments; (v) Basic drugs and medicaments used in dentistry including antimicrobials, corticosteroids, analgesics, haemostatic and anesthetic drugs, in addition to antiseptics disinfectants; (vi) Lockable

cabinet, containing essential emergency drugs; (vii) Emergency oxygen cylinder; (viii) Cabinet for patients' records and card system.

5. INTRA-ORAL RADIOLOGICAL UNIT. [Issue 1] [Issue 1] Kenya Subsidiary Legislation, 2014 1210 1210 1210 1210 1210 1210 1210 1210 Kenya Subsidiary Legislation, 2014 THIRD SCHEDULE (r.18) RETURN OF NOTIFIABLE INFECTIOUS DISEASES The following diseases are notified on Med. 25 Forms.

These forms are obtainable from Kenya Medical Supplies Agency or any Government medical institution Acute poliomyelitis Anthrax Cerebro-spinal fever (meningococcal meningitis) Cholera Diphtheria Infective hepatitis Malaria S.T. (in high altitude areas) Plague (human) Plague (rodent) Rabies Severe diarrhoeal diseases Sexually transmitted diseases, including HIV Smallpox (variola major) Smallpox (variola minor) Trypanosomiasis Tuberculosis (all forms) Yellow fever ———————————

FOURTH SCHEDULE (r. 26) MINIMUM STANDARDS FOR A CLINICAL LABORATORY 1. CATEGORIES AND RESPONSIBILITIES OF PATHOLOGISTS

(a) General Pathologist: (i) This is a specialist whose basic training has covered all the disciplines of clinical laboratory medicine and who ultimately has attained a recognizable higher qualification in any one or all other disciplines. (ii) General pathologists shall run laboratories that carry out the following investigations— 1. Morbid anatomy, histopathology and cytology; 2. Haematology and blood transfusion; 3. Clinical chemistry; 4. Medical microbiology and parasitology; 5. Immunopathology; 6. Forensic pathology; 7. Other allied laboratory investigations

(b) Single Discipline Pathologist: This is a medically qualified person whose training shall not have covered all the disciplines of clinical laboratory medicine but who shall be a holder of a postgraduate qualification in only one discipline. He shall practise only

in his particular discipline of specialization. [Issue 1] [Issue 1] Kenya Subsidiary Legislation, 2014 1211 1211 1211 1211 1211 1211 1211 1211 Kenya Subsidiary Legislation, 2014

(c) Categories of Pathology Laboratories: For purposes of the practice of clinical laboratory medicine, the following categories of laboratories shall be recognized— (i) Government hospitals and County laboratories; (ii) Non-profit making missionary hospital laboratories; (iii) Non-governmental or private hospital laboratories which charge economical fees; (iv) Private clinical laboratories not attached to hospitals; (v) Nursing home laboratories; (vi) Other non-profit making laboratories.

4. MINIMUM FACILITIES FOR A PRIVATE CLINICAL LABORATORY

(a) A minimum of any three of the following disciplines should be offered— (i) Haematology and blood transfusion; (ii) Medical microbiology and parasitology; (iii) Clinical chemistry; (iv)Morbid anatomy, histopathology and cytology.

(b) STAFF: (i) At least one pathologist; (ii) At least one qualified technologist for each of the disciplines.

(c) PHYSICAL FACILITIES: (i) Waiting room; (ii) Specimen collection room with a couch; (iii) Adequate laboratory space dictated by activities.

(d) SAFETY REQUIREMENTS: (i) Autoclave for sterilization of specimens before disposal; (ii) Fire-fighting equipment; (iii) Sinks with both cold and hot water.

(e) EQUIPMENT: (i) At least one microscope; (ii) Refrigerator; (iii) Incubator; (iv) Centrifuge; (v) Haemoglobinometer; (vi) Counting chamber; (vii) E.S.R. tube; (viii) Disposable syringes and needles; (ix) Calorimeter; (x) Water bath; (xi) Still; (xii) Burners; [Issue 1] [Issue 1] Kenya Subsidiary Legislation, 2014 1212 1212 1212 1212

1212 1212 1212 1212 Kenya Subsidiary Legislation, 2014 (xiii) Electrophoresis tank; (xiv) Necessary laboratory glassware; (xv) Chemical balance;

(f) REAGENTS AND CHEMICALS: There should be minimum reagents and chemicals to enable a confirmatory diagnosis to be reached in each of the disciplines offered.

(g) DOCUMENTATION: All specimens must be recorded in a register. Such registration should show the following— (i) date; (ii) patient's name; (iii) attending doctor's name; (iv) nature of the specimen; and (v) tests required. ——————————

FIFTH SCHEDULE (r. 33) 1. MINIMUM REQUIREMENTS FOR A CLINICAL RADIOLOGICAL LABORATORY

For the purpose of considering radiological protection facilities, the following should be adopted as a general guide— Level 0 - Clinics and health stations operated by a nurse or medical assistant without any direct medical supervision – no radiological facility required.

Level 1 - Small clinics, health stations or general practices under supervision of a general practitioner who can undertake emergency work and refer patients to other levels – radiography only for chest, fractures (mainly extremities), and in exceptional cases plain abdomen necessary. No fluoroscopy should be undertaken.

Level 2 - Sub-county hospitals, or rural hospitals staffed by a small number of doctors and undertaking general medical care and minor surgery, some private hospitals, clinics and non-profit making hospitals may be included in this group – radiographic examinations required include chest, simple abdomen, fractures and possibly some fluoroscopic examinations.

Level 3 - Medium sized County hospital that undertakes routine hospital work such as general medical care and routine surgery including abdominal surgery. The medical staff should include specialists in main fields as defines in these Rules. All general radiographic work is needed which would include some special examinations e.g. tomography, angiography, urography etc.

Level 4 & 5-National referral, County and private referral hospitals including teaching hospitals where all types of radiological procedures are required.

2. For a properly organized radiation protected programme to succeed, it is strongly recommended that— [Issue 1] [Issue 1] Kenya Subsidiary Legislation, 2014 1213 1213 1213 1213 1213 1213 1213 1213 1213 1213 Kenya Subsidiary Legislation, 2014

(a) In hospitals at levels 3, 4 and 5, all x-ray diagnostic examinations should be carried out by the diagnostic radiology department;

(b) Even when an x-ray equipment is installed in other departments the head of the radiology department should have responsibility for radiological aspects of any examination performed;

(c) Level 1 refers to a rural or remote area where no other radiological service is available and the supervision is that of a general practitioner with limited skill in radiology. A fully qualified radiographer may not be available at this level and the x-ray equipment may be operated by a nurse or laboratory technician. Such a nurse or technician should have had additional training in radiography;

(d) In areas where a more comprehensive radiological service is available, no attempt should be made to provide a level 1 radiological service.

5. PREMISES: (a) The x-ray room should provide adequate radiation protection for people outside the room, who may have no knowledge of radiation or radiation requirements; (b) The basic x-ray room for general purposes should be about 6 x 4 x 3 metres in size, with wall thickness in all directions of 2mm. lead equivalent; (c) The doors, the darkroom hatch, and covers for services and other instructions through the wall should have the same lead equivalent protection; (e) Windows should be at least 2 metres from the ground outside the x-ray room and 1.6 metres from the floor level of the room; (f) If the control panel is within the x-ray room, the protective shield should be positioned such that neither “once scattered” radiation nor direct radiation can pass round the edge of the shield from any part of the room where x-ray procedures are carried out; (g) The darkroom should be at least 6sq. meters in area; (h) There should be at least two protected changing cubicles of 1.5sq metres minimum size, preferably outside the x-ray room; (i) If ordinary building materials are used, they should be thick enough e.g. in the range 70.25 KV, 15cm of concrete or 25cm of brick with plaster is sufficient; (j) However, if a prefabricated wood or metal building is being planned, it will need lead lining, preferably supported by plywood to prevent sagging (2mm. lead sheet is adequate); (k) Converting an old building for an x-ray room will need a review by a radiation protec tion expert.

6. CHOICE OF X-RAY EQUIPMENT: (a) The x-ray equipment should be adequate for its purposes e.g. at level 1 of radiological care, a good stationery x-ray tube and generator should be [Issue 1] [Issue 1] Kenya Subsidiary Legislation, 2014 1214 1214 1214 1214 1214 1214 1214 1214 1214 Kenya Subsidiary Legislation, 2014 employed. Improvisation of a mobile machine in an old room used for other purposes should not be tolerated under any circumstances; (b) For routine general radiography, necessary ancillary apparatus should be provided e.g. chest stand and a stationary couch with

grid and film x-ray; (c) To avoid mains voltage drops, the power supply to an x-ray unit should be separated from, say, that for lifts, etc; (d) Where power supplies are particularly unreliable, battery operated or condenser discharge equipment should be used; (e) An x-ray tube head of lower rating than that of generator should be installed; (f) For exposure controls, meters giving clear indication of voltage, current and milliampere-seconds at all times are required; (h) The timing device must be capable of making sufficiently short exposures (say down to 0.04 sec) must terminate a present exposure, and must be “dead man” type; (i) All x-ray, fluoroscopic and dental equipment must further meet the protection standards as laid down by the International Commission on Radiation Protection; (j) The normal output for radiographic units should lie from 60 KV and above with preferably not less than 50mA. For fluoroscopic units without image intensifiers, 75 KV and 2-3mA is the normal order. 3mA should not be exceeded at 100 KV.

7. SAFETY PROCEDURES: RADIOGRAPHY (a) Staff positions should be behind protective shields preferably outside the x-ray room providing there is adequate view through a lead glass and communication device for speaking to the patient during exposure; (b) During special techniques, where staff need be in the x-ray room, protective aprons and gloves should be worn; (c) Films should be supported mechanically. Beam size should be reduced to cover by means of light beam diaphragms or variable cones only areas under investigation.

FLUOROSCOPY (a) Only essential persons who must wear protective aprons, should be present in the room during fluoroscopy; (b) The fluoroscopy switch should be spring loaded so that it is not left on unnecessarily or accidentally; (c) A cumulative timing device that gives an audible warning and finally switches off after a few minutes to restrict the total switch-on time of the equipment; (d) A properly darkened room; [Issue

1] [Issue 1] Kenya Subsidiary Legislation, 2014 1215 1215 1215 1215 1215 1215 1215 1215 Kenya Subsidiary Legislation, 2014 (e) A fluoroscopy switch coupled with the rooms red light; (f) If sufficient information can be obtained from radiography alone (e.g. as in chest examinations) then fluoroscopy should not be done; (g) There should be effective coning devices; (h) With conventional equipment, adequate dark adaptation of at least 15 minutes prior to screening is necessary.

ROOM LAYOUT (a) Primary x-ray beam should not fall on the darkroom wall and should not routinely point towards doors or windows; (b) Where there is more than one piece of equipment in the same room— (i) only one generator per room should be installed; (ii) a warning device should be mounted on each x-ray tube and control panel of the generator; (iii) an adequate protective screen should be provided between each x-ray tube area; (c) For special techniques such as tomography, angiography, etc a special room should be provided; (d) Record room, office and waiting room should be provided outside the main x-ray room at all levels; (e) Protective screens should be provided for all the positions in which staff are required to be during exposure in the x-ray room; (f) Persons required to assist during fluoroscopic procedures should wear a protective apron of at least 0.25mm. lead equivalent; (g) The physician performing the fluoroscopic procedures should wear a protective apron of at least 0.25mm lead equivalent; (h) When a new x-ray facility goes into operation, all staff members who at any time may enter the department should be issued with radiation monitoring badges; (i) Site monitoring during the radiation surveys should be done before commissioning the unit; (j) Persons likely to receive three tenths (3/10) of the annual maximum permissible dose should be monitored regularly; (k) Radiation personnel should be medically examined on initial appointment and at any time when the exposure levels as indicated by personnel monitoring are sufficiently high. [Issue 1] Kenya Subsidiary

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PROTECTION OF THE GENERAL PUBLIC (a) Careful attention must be paid to the protection of all areas around, above and below x-ray rooms; (b) Apart from adequate protective thickness of walls, floors, ceilings and doors, unprotected windows should not allow the public outside to be irradiated; (c) Stray radiation should not reach the waiting rooms or other occupied areas; (d) One patient must not use a curtained corner of an x-ray room to change clothing while another is being radiographed in the same room; (e) Separate protected cubicles should be provided preferably outside x-ray room; (f) Lead protected doors must always be closed during x-ray examinations; (g) Particular care should be taken to avoid irradiating patients in adjacent beds during mobile radiography; and (h) Protective clothing should be sworn by parents holding children undergoing x- ray examinations. They should not stand in the path of a primary bea.

Ministry of Health

2015 Annual Report

Introduction

The 2015 deadline for the Millennium Development Goals has come and gone. The scorecard for Seychelles' shows great successes in most areas and qualified failures in some areas. Specifically, most of the development targets have been achieved except for target 5 in goal 4 relating to under five mortality reduction, target 6 in goal five relating to maternal mortality reduction and target 7 in goal six relating to reduction in HIV infections and deaths.

These missed targets need however to be qualified. Target 5 of goal 4 required countries to reduce by two thirds, between 1990 and 2015, their under-five mortality. This target has three main indicators.

Proportion of children immunized against measles.

Infant mortality rate

Under five mortality rate,

The proportion of children immunised against measles has remained consistently over 99%. Infant mortality rate in Seychelles is one of the lowest in the African Region and in developing countries. It stood at around 12 per 1000 live births in 1990 and remained at 11 per 1000 live births in 2015. Evidence suggests that the perinatal period and the neonatal period account for most of the infant deaths. The number of still births is also quite alarming.

In order to further reduce infant mortality rate in Seychelles to below 10 per 1000 live births consistently, (which is now the national target) and also to reduce the number

of stillbirths, a substantial amount of both professional focus and investment need to happen both in the hospital care setting and in the community care setting to address both antenatal care and neonatal care.

The paediatric services talk of a lack of adequately trained medical and nursing personnel to address the care needs of new-born babies with severe medical conditions. They refer also to the need to upgrade the quality of medical technology for the care of severely compromised infants.

On the other hand, in focus group discussions, the midwifery and obstetric services in the hospital refer to the need to the need for midwives and doctors in the community to better risk assessment during the antenatal period. The prenatal risk assessment system that assesses women and refers them from primary care to secondary and tertiary care services are known to have failed to work as intended in certain instances with deleterious consequences on child survival. Also, preconception counselling services are not available in Seychelles.

Midwives talk of an increase in the number of pregnant women who use drugs, especially the hard intravenous drugs, and associate the use of these drugs to the increase in the number of babies born prematurely and to some of those who fail to survive. Use of hard intravenous drugs is indeed on the increase in Seychelles but use of these drugs in in pregnancy is not adequately documented or adequately researched for the Ministry of Health to suggest a causal relationship.

Any weakness or failure in the chain of events from conception to the post-natal period that directly or indirectly affects the survival outcome, will have a major bearing on that all important indicator.

In 2015, the Ministry of Health and its operational agency, the Health Care Agency, took decisive steps to address some of the gaps mentioned above. A basic midwifery training course started at the National Institute of Health and Social Studies. Fifteen student midwives enrolled on the programme. Such a training programme had not been on offer for over five years. In addition, experts in neonatal resuscitation from the Island of Reunion began training medical and nursing teams on the resuscitation of new-borns. Training on staff of simulators that are able to reproduce real-life condition was a first for Seychelles.

The Ministry of Health has argued that there are major policy implications in trying to save every single baby that is born alive no matter what the age of gestation is and no matter what the co-morbidities are. Babies born below 28 weeks of gestation and much below 800 g of body weight could end up with frighteningly severe complications as a result of heavy oxygen use and invasive manoeuvres to save their lives. Investment in the expertise and technology to achieve to save every single one of these lives, no matter what, represents massive opportunity costs for other areas of health care. The right balance needs to be struck.

Another Millennium Development Goal that caught Seychelles on the back foot was Millennium Development Goal Six. Seychelles was unable to reduce the number of new HIV infections and the number of AIDS related death by 2015.

Governance of the Health Sector

In 2015, the Ministry of Health continued to implement the recommendations of the Health Task Force Report, 2013. Special attention was paid to drafting the national health policy, the national strategic plan and the monitoring and evaluation framework. Local and international consultants were hired to move the process forward initially. Work on these overarching documents went on for the most part of 2015. The work was informed by wide ranging consultation with public and private sector leaders, members of the public, health workers and non-governmental organizations. In June 2015, the Cabinet of Ministers approved the proposed national health policy document. Work immediately started on the drafting of the National Strategic Plan.

The Ministry of Health submitted proposed contractual agreement framework to the Health Care Agency and to the Public Health Authority for their consideration. This framework was based on what the Ministry of Health considers as achievable national targets for these two operational entities. It was not apparent to what extent these two agencies were willing or able to work towards the targets contained in the proposed document.

Health Service Delivery

Medicine, Vaccine and Technology

Human Resource for Health

Health Information System

Health Financing