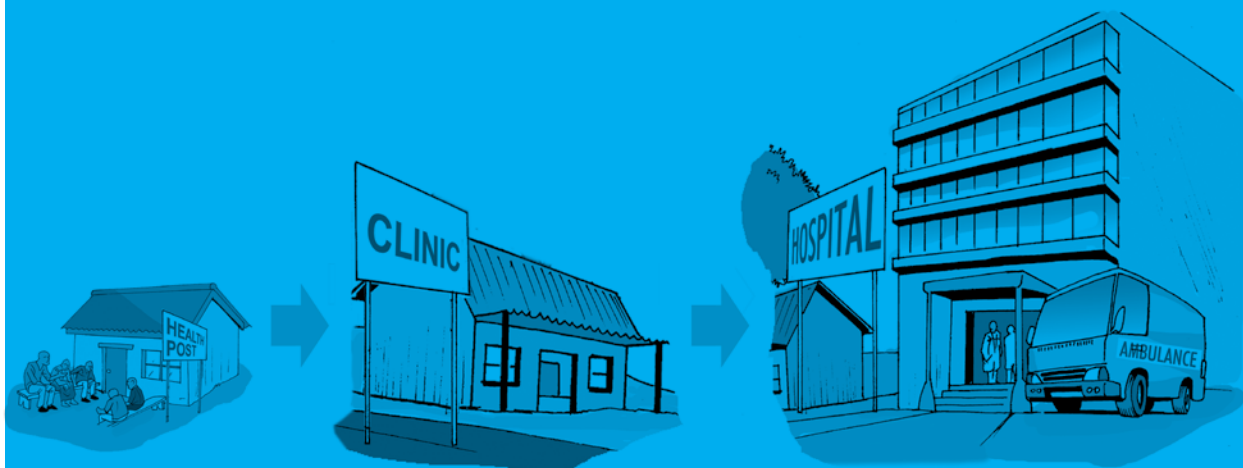


Report 3



ESSENTIAL PACKAGE OF HEALTH SERVICES

Somaliland 2009



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Acronyms

ACT	Artemisinin Combination Therapy (against malaria)
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
ARV	Anti Retro Viral
CHC	Community Health Committee
CHP	Community Health Promoter
CHW	Community health Worker
CS	Caesarian Section
DH	District Hospital
EmONC	Emergency Obstetric and Neonatal Care
EC	European Commission
EPHS	Essential Package of Health Services
EPI	Expanded Programme of Immunization
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
H	Hospital
HC	Health Centre
HF	High Frequency
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HP	Health Post
HR	Human Resources
IPT	Intermittent Preventive Therapy
ITN	Insecticide Treated Net
MBA	Masters in Business Administration
MCH	Maternal and Child Health (clinics)
MD	Medical Doctor
MNH	Maternal and neonatal Health
MoHL	Ministry of Health and Labour
MoH	Ministry of Health
NGO	Non Governmental Organization
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PHU	Primary Health Unit
PHW	Primary Health Worker
PMTCT	Prevention of Mother To Child Transmission
PNC	Post Natal Care
RH	Reproductive Health
RHC	Referral Health Centre
SRCS	Somali Red Crescent Society

STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNFPA	United Nations Population Fund
UNICEFU	nited Nations Children’s Fund
UTI	Urinary Tract Infection
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Endorsement

The EPHS was developed through a series of consultative workshops involving hundreds of representatives from the Somali health sector and NGOs, UN agencies and donors.

It has been officially endorsed by the Somalia MoHL (see foreword)

It has been officially endorsed by the Health Sector Coordination Committee

Foreword by the Minister for Health and Labour

The Ministry of Health and Labour is pleased to present this first edition of the ***Somaliland Essential Package of Health Services***.

The Republic of Somaliland has struggled for over 15 years to establish itself as an independent nation. Upon declaration of independence in 1991, the nation was left with nothing in terms of institutions or infrastructure. Today, through the dedication and largest of many, we have a rudimentary health care system consisting of: a central ministry; regional health offices (although no district health management structures); volunteer Regional Health Boards (primarily concerned with the financing and management of larger referral hospitals); 1 national referral hospital; 1 national mental hospital; 5 regional referral hospitals; 3 district hospitals; 7 tuberculosis treatment centers; 73 maternal and Child Health Clinics (MCHs) and 200 Health Posts. In addition, we have medical and nurse/midwifery associations, medical personnel training institutes and a vibrant private market providing services through private hospitals and pharmacies.

This system is largely staffed by under-trained, under-supervised and under-paid staff, struggling to provide some services to their people. The system functions on donations from international agencies (such as the UN, NGOs and Islamic charity funds). Given the low levels of financing and management, the fact that the public health system exists is a triumph. Nevertheless, we know from surveys that less than 15% of the rural population is able to use the public system for regular complaints and that there are major barriers to access and utilization in rural and urban areas. The public system contributes only marginally to improved health status of the general population and equity of access for the poor. It is imperative that the public system be developed to be of greater utility to the people of Somaliland. This means providing better quality care, a better range of services the people need and demand, more accessible services, open for longer hours, and at a cost all can afford – especially the poor. This imperative requires organization and increased financing.

Delegates from the MoHL to the September 2007 Health Systems Strengthening workshop in Nairobi, financed by the EC and organized by UNICEF, stressed the urgent need for investment in human resources, institutional development of the Ministry of Health and Labour but first and foremost the development of an *Essential Package of Health Services*.

The EPHS has been developed with an awareness that we do not want to re-build systems of the past – we need to build for the future and according to projections of what we can afford and manage. This means any health system will need to be modest and simple yet achieve its aims – to provide essential services to all citizens at an acceptable level of quality.

The EPHS therefore is the basis of the primary health care system and represents an important tool for health systems planning, investment planning, human resource development planning,

service delivery standard setting and systems management. As such, it is the most critical tool to promote coherent investment and activities in the future development of the public health system through:

- Establishing a vision for health sector reform and progressive investment and development.
- Establishing choices made by the MoHL to focus on increasing quality of services currently provided as opposed to increasing numbers of facilities.
- Providing a practical tool for the coordination of the various actors in the health sector – concentrating investment, guiding planners, and aligning service providers.
- Establishing a basic set of standards to which all service providers should subscribe
- Establishing a framework for production of resources (buildings, training etc) to predict future needs and plan and produce accordingly.

This “Essential Package of Health Services” is aspirational – we must work towards it and together. It is fully in line with national policies and strategies developed in previous years. It has been exhaustively developed through a series of consultations and meetings with service providers, medical practitioners and MoHL authorities in Somaliland. It provides us with a path for health system reform.

The EPHS is not set in stone – it is not final. We do not know all the answers now and must learn along the way and change as we go along. The document is grounded in international and local evidence about what works, what is affordable and efficient. Nevertheless, built into the package is the need for operational research to test and fine tune how services should be produced and delivered to the different people of Somaliland¹.

In recognition of the chronic poverty of much of the population, this EPHS recommends free maternal and child health care services. This Ministry fully supports this choice - but again it is an aspiration. The Ministry of Finance has committed to gradually increasing the budget allocation to social services in general and in particular to national health services. But we still face a major financing shortfall. In the absence of adequate financing we have to rely on cost-sharing mechanisms despite the inefficiencies and inequities these produce. We are committed to tackling this problem gradually and as partnerships and international financing allows.

In short we fully endorse this document and thank all the Somalilanders, NGOs and UN agencies who participated in the development of this tool. In particular we would like to thank UNICEF and the EC for their assistance in supporting this process. We commit to trying to implement this tool and sincerely beseech all partners to follow suit and work with us according to these standards to assist in the construction and reformation of an effective and equitable public health system in Somaliland.

Best Regards

Hon. Abdi Haibe Mohamed
Minister of Health and Labour



Introduction

In a workshop in September 2007 – to mark the beginning of the UNICEF/EC health sector development programme – the assembled community of actors called for action to develop standards on training and staffing, costing, drugs and facilities – but all of these depended on first defining an **essential package of health services**.

This Essential Package of Health Services was drafted with those developed for other countries – notably Afghanistan, Liberia, South Sudan and the Democratic Republic of the Congo to name but a few. The principle difference with the examples upon which we drew was that all these EPHS proposals were drawn up immediately after conflict in order to assist with comprehensive nation wide reform and reconstruction of public health infra-structure.

We are not in the same position in Somalia, Puntland and Somaliland. While some zones have managed to secure a modicum of peace, there is no international consensus on the form of state – nor is there a comprehensive peace and political process of transformation. The international community has not come in with significant increases of funds targeted towards harmonized and aligned common strategic agendas. Financing of the health sector in Somalia remains insufficient, piecemeal, fragmented and unstrategic (not driven towards key priorities).

The EPHS and its costing tool have been carefully developed to represent standards of care at each tier or level of the health service in order to be able to meet the basic needs for Somalis of all ages. The EPHS does not define how many of each facility level should exist. These decisions are for the public health authority and donors to decide and are based on demographic considerations, public health needs and available sustainable resources.

What the EPHS *DOES* do is focus on **4** operational principles:

1. If facilities are operating at a level (range of services and drugs) as well as **quality** level below a basic minimum, the public will not use them. Today in Somalia and Somaliland we have a network of health Posts and MCHs which demonstrate extremely low levels of performance and utilization. The EPHS sets basic minimum operating standards for each tier. Each proposed level is far higher than the current levels of operation and exposes the urgent need to improve the quality of facility functioning before expansion of the public health network (despite insufficient public health facilities to cover all needs). This will require sustained and committed collective effort to finance staff and manage services to ensure they function and are used sufficiently to demonstrate efficiency and effectiveness.
2. The utility and performance of each tier of the public health system can be amplified through effective **management and referral**. Lower levels of the systems are available, accessible and affordable. They can deal with the bulk of immediate health concerns. However more serious health concerns requiring higher levels of technical intervention and management can only be provided at a few carefully selected facilities. In a land as large and lowly populated as Somalia, the inter-relation between tiers of services is critical. Performance will depend on inputs (drugs, staffing, salaries) but also supervision and management. The lower tiers of service are obviously the most difficult to supervise effectively. In order to enhance performance through referral, and this focuses needed attention on lower levels of care having the capacity to define cases requiring referral and being able to assist patients to access services to which they are referred.
3. **Maternal and neonatal** mortality rates in Somalia are extremely high. Little can be done about maternal mortality without universal access to

family planning (allowing families to maximize the overall well being of their families) AND a well functioning health system that ensures rapid access to reproductive health services and specifically emergency obstetric care. The current failings of the Somali public health system are best illustrated by the lack of services available to women and the devastating consequences in terms of death and suffering. While much can be done on other areas of health outside of the health system – this EPHS places particular focus on the provision of essential levels of service to women and neonates – and again reinforces need for effective referral between tiers of service.

4. Finally not all services need to be offered through the public sector. The **private sector** in Somalia is vibrant, accessible and well trusted by users – it *can be* a major provider of services to the benefit of public welfare. The public sector does have some specific responsibilities (for example promotion of uptake of public goods like vaccination), as well as some real advantages. This EPHS seeks to encourage the public sector to play to its advantages in which it can outperform the private sector and protect and promote the health and welfare of the people of Somalia.

The EPHS is aspirational – but it is not set in stone. It can be used to define what drug, staff, management, transport and facility needs are required. As operational experience grows – the definitions of inputs and costs will change.

Nor does the design of service systems need to be the same across the entire country. Health seeking behaviour is vastly different across urban and rural populations and between sedentary and nomadic rural populations. The structure of health services will need to reflect these different demands from the public (and different financial possibilities). Urban centers may have fewer Primary Health Units (Health Posts) and fewer referral health centers. Sparsely populated areas may depend more heavily on referral health centers and PHUs – densely populated rural areas may depend more heavily on health centers (MCHs).

While there may be some regional differences (i.e. malaria and schistosomiasis prevalence rates in South Vs North Somalia are very different – justifying IPT or treatment of schistosomiasis in the south but not in the North) the overall package remains largely the same.

The EPHS has already allowed the health community in Somalia to start envisaging the scope of reforms needed and the development of other analyses and tools required to promote change. There are various ways toward reform and reconstruction of the public health sector. They do not need additional investments they can begin now – but they do require decisions to be taken so as not to continue business as usual.

Austen Davis

Health Sector Development Coordinator
UNICEF Somalia

1

ESSENTIAL PACKAGE OF HEALTH SERVICES (EPHS)

1. EPHS overview

The EPHS consists of the following:

- four levels of service provision
- ten health programmes
- six management components

1.1 The four levels of service provision

The essential package is implemented across four levels of service provision, each with a standardised service profile and each supported by a standardised set of management and support components:

- primary health unit (PHU)
- health centre (HC)
- referral health centre (RHC)
- hospital (H)

There is no well-established district health system at present, which is why referral health centres will be established where there are no district hospitals. Most of the management and supervision operate at the regional level, as it is not envisaged that district capacity can be built up during the first two phases of this essential package. The priority is on enabling the regional health system, and in future phases of health systems development a district management structure could then be created. Tuberculosis and mental

hospitals are at the fourth (hospital) level, but would preferably become better-integrated into the hospitals in the future.

1.2 The 10 health programmes

The EPHS is divided into 10 programmes. There are six core programmes which are found at all four levels and four additional programmes that are found only at the referral levels. The programmes are divided into sub-programmes with standardised interventions. Details of programmes with activities and lists of essential drugs and equipment are presented in the annexes. Nutritional interventions are integrated across the programmes.

The six core programmes are:

- 1 Maternal, reproductive and neonatal health
- 2 Child health
- 3 Communicable disease surveillance and control, including watsan promotion
- 4 First aid and care of critically ill and injured
- 5 Treatment of common illness
- 6 HIV, STIs and TB

The four additional programmes are:

- 7 Management of chronic disease and other diseases, care of the elderly and palliative care
- 8 Mental health and mental disability
- 9 Dental health
- 10 Eye health

Medical specialities are included at hospital level. Each programme has promotional, preventive and curative aspects and includes activities for individuals, as well as at community and population levels. Mental health should be streamlined across all levels of the health system. This is a desired aim, but there is currently not the financial or technical capacity to do this. A combined approach may be needed with all Community Health Workers (CHW) and nurses trained in psychosocial support skills, while psychiatrists and psychiatric nurses conduct outreach clinics in Referral Health Centres (RHC) and eventually health centres. This requires agencies to develop and champion mainstreaming of mental health care.

1.3 The six management and support components

The EPHS will require a full range of health systems management inputs and logistical support components, specifically:

- finance
- human resource management and development
- EPHS coordination, development and supervision
- community participation
- health systems support components
- health management information system

Three groups are involved in running the health system, each with its own set of specific management roles and responsibilities:

- Health facility staff (direct facility management)
- Regional health office (supervision and quality of care)
- Community health committee (oversight, ownership and support)

The roles and responsibilities of each group are defined in formal contracts which will be signed between community representatives, the MoH and the implementing agent.

2

EPHS – BACKGROUND AND CONTEXT

2.1 Purpose of the EPHS

The EPHS is the prime mechanism for strategic service provision of the public sector health service. It helps to clarify health priorities and directs resource allocation. It defines MoH responsibilities and activities at central and regional levels, particularly in coordination, management and supervision of services. It clarifies the role communities play in creating a sustainable and accountable health system. It aims to address current poor access to health and inequalities in health service provision. It provides a road map for action and is costed to enable detailed budgetary planning for advocacy purposes and for government, donors, municipalities, districts and communities to plan on how to increase their contributions.

The EPHS helps define health systems standards for the government, UN and NGO agencies and private service providers. It standardises and improves upon existing logistical and supply systems, and adopts essential drugs and equipment lists for each level of provision.

While taking into account existing constraints, the EPHS acts as a blueprint for health sector development

and future resource investments. Details of service needs for district and regional hospitals are limited and it is envisaged that a separate document will be produced in the future, outlining specific needs of hospitals in more detail. However, the EPHS should be fully applied at hospital level to raise standards for all PHC activities, including comprehensive emergency obstetric and newborn care.

2.2 Implementing the EPHS

2.2.1 Services coverage and catchment populations

The four levels of service are distributed with the aim of improving coverage of health services. The primary health unit directly serves communities. Health centres serve the catchment populations of several primary health units, and referral health centres cover the populations of several health centres. There is overlap between populations covered by regional hospitals and referral health centres, but the latter will still refer to the hospitals.

3

DETAILS OF THE ESSENTIAL PACKAGE

3.1 The four service levels

3.1.1 Primary Health Unit

The primary health unit is staffed by at least one trained Community Health Worker (CHW) supported by an elected, representative Community Health Committee that participates in responses to the common causes of ill health affecting the community. The emphasis is on prevention of disease and promotion of health through nutrition education, health-seeking behaviour, vaccination, mosquito nets and improvements in water and sanitation. The CHWs are not nurses, but they are trained to diagnose and treat a few common sicknesses such as malaria, diarrhoea and ARI, particularly in children. They do not do maternal care such as deliveries or conduct antenatal clinics, but they do promote family planning and distribute pills and condoms.

Immunisation clinics and therapeutic nutrition programmes are carried out as an outreach service by nurses from health centres assisted by CHWs, but CHWs also routinely screen under-fives and pregnant women for malnutrition with Mid-upper Arm Circumference bands. Community health workers are responsible for surveillance of epidemic disease and are obliged to record their activities at this first level of the HMIS. As employed personnel, CHWs must fulfil contractual obligations and meet performance targets.

No fees are charged at Primary Health Units (PHU). Health posts can be considered for inclusion as PHUs, but many very poorly functioning HPs *will not be supported until they can fulfil PHU criteria* and will not initially qualify for drugs, equipment and supervision. Community health workers carry out certain promotional, preventive and curative interventions from **core programmes one to six** as specified in the annexes. Once CHW training is established and CHWs are properly supervised, some regions may additionally pilot Community Health Promoter (CHP) training (see annexes). Community health promoters would not be employed within the health system and would be volunteers with a purely promotional and mobilising role within communities. Their point of contact would be the PHUs.

3.1.2 Health Centre

The health centre is the key unit of the essential package, at which all core programmes are carried out. It is the first level at which obstetric services are provided, including ANC and facility-based deliveries with qualified midwives. Minimum staff consist of a qualified midwife, qualified nurse, qualified auxiliary nurse and a community midwife. As well as maternity beds there are a minimum of six beds for 24-hour observation of sick patients. A Primary Health Officer is a qualified nurse responsible for nutritional and EPI activities in the health centre, as well as at outreach

clinics at the PHUs. A Community Health Committee is involved in the management of the health centre with the health team, and they are involved in raising funds at community level. No user fees are charged at the health centre level. All health centres have fridges to guarantee the cold chain. **Core programmes one to six** are all applied in their entirety at the health centre, except for a few interventions (marked in italics) that only take place at referral health centre level. Additional programmes seven to 10 are not operational at health centre level during the first two phases, unless MoH and partners have the additional capacity to introduce these.

3.1.3 Referral Health Centre

Referral Health Centres and district hospitals carry out all **core programmes one to six** and add **additional programmes seven to 10** for treating people with mental illness, chronic disease and dental and eye disease via outreach visits by specialists from the regional level. They carry out comprehensive emergency obstetric and newborn care, with the capacity for carrying out caesarean sections and safe blood transfusions. The surgical facilities also allow tubal ligations to be carried out, as well as IUDs and implants to be fitted. They have at least eight bed maternity wards and an inpatient facility for at least 20 patients. Staff include at least two midwives, two qualified nurses and a health/clinical officer. They have a Primary Health Officer (nurse) for EPI and nutrition, and a laboratory technician. Referral health centres have fridges and freezers, acting as EPI depots.

Health Centre Committees ensure community support for the health facility, as well as leading community-based responses to health challenges. They also are responsible for mobilising funds from the community, local businesses, diaspora populations and other potential resources. The Regional Health Office is responsible for supervision of HCs and RHCs. There is potential for the RHCs to become district hospitals in future phases, but in these first two phases of EPHS

development the priority is on establishing quality health centres, RHCs and a few key referral hospitals from the existing health facilities, and on strengthening supervisory capabilities at Regional Health Offices.

3.1.4 Hospital

The hospital ensures 24-hour quality inpatient referral health care, with qualified nurses, midwives and doctors permanently in the hospital. Core and additional programmes are expanded in hospital departments, each often run by specialist medical and nursing practitioners who may also conduct outreach clinics to RHCs. Management is the task of a hospital administrator (MBA level) overseen by the hospital director and the Regional Health Office. Health Boards are responsible for mobilising funds from the community, business enterprises, the diaspora and other sources. Ministry of Health and municipal authorities also contribute to hospital fixed and variable costs. Regional EPI depots ensure regular vaccine supplies to the districts. A regional medical store is sited separate from the hospital, and eventually the EPI depot would be at the same location.

3.2 The six management components

- 3.2.1 finance
- 3.2.2 human resource management and development
- 3.2.3 EPHS coordination, development and supervision
- 3.2.4 community participation
- 3.2.4 health systems support components
- 3.2.5 health management information system

3.2.1 Finance

The EPHS is funded through five primary sources: (1) donor financing (via contracts with implementing agencies); (2) contributions from the regular budget of the central Ministry of Health; (3) contributions from municipal or district authorities; (4) community health

funds; and (5) user fees (at hospital level only, and only for specific services). During both phases I and II of EPHS implementation, donor financing will comprise the majority of funding for the public sector health services (see table below), but with an increasing percentage from the other sources, namely national government, local government and community.

Most elements of the EPHS, including prescribed drugs, will be provided free of charge at the point of service contact. User fees will be applied to a selection of services provided only at the hospital level, including second line consultations by doctors, elective surgery (not including elective caesarean sections, which are free), ultrasound services, x-rays and laboratory tests that are not part of the essential package. Drugs and consumables will only be charged for in hospitals, but not for children under five, for family planning and/or for women during birth and pregnant and lactating mothers. Caesarean sections will be free, including drugs and consumables. Hospitals will continue to run local exemption from user fees schemes for very poor people. Small-scale studies will be conducted on health financing and utilisation of the health service.

Local communities contribute to the costs of health facility operations through the implementation of Community Health Funds, a model of community financing pioneered by the Somali Red Crescent Society (SRCS). In this model, local Community Health Committees raise up to 15% of the costs of their communities' health facilities, resources which are allocated to, for example, infrastructure construction, renovation and upgrading, purchase of fixtures and certain supplies, basic infrastructure maintenance and minor repairs, and routine cleaning. Different models will be piloted as to how communities raise contributions in kind and funds, but could include voluntary work for upkeep, *Zakat* () and other voluntary contributions, donations from businesses and the diaspora.

MoH budgets will contribute between 5% (Phase I) and 20% (Phase II) of the costs of implementing the EPHS. Donor financing will constitute the bulk of EPHS funding as shown in the table. Although the percentage contribution of donors to the overall costs of the EPHS is likely to decline over time as both community and MoH sources increase, the absolute level of funding from donors will increase as coverage and quality of care improve.

Financing contributions from five primary sources

Financing mechanism	Phase I			Phase II		
	Primary health unit	Health centre/ RHC	Hospital	Primary health unit	Health centre/ RCH	Hospital
Community Health Fund	5%	5%	10%	15%	15%	15%
User fees	0	0	20%	0	0	20%
Ministries of Health regular budgets	5%	5%	10%	15%	15%	20%
Municipal/ district contributions	5%	5%	10%	5%	5%	10%
Donor financing of agencies contracted to provide health services	85%	85%	50%	65%	65%	35%

3.2.2 Human resource management and development

3.2.2.1 *Human resource management*

The emphasis of the first phases of the EPHS will be to improve the quality of existing services and not to create yet more poorly functioning health facilities. One key aspect of human resource management within the EPHS will be classification and clarification of the work force, to clarify whether or not a nurse or midwife has the prerequisite training and qualifications.

The Primary Health Units will be staffed by qualified, salaried CHWs who are civil servants employed by the MoH and who have received specified training. Community health workers conduct promotional, preventive and curative activities and are properly supervised. Existing community health workers may apply for consideration as CHWs during Phase I, but the requirement is that they have already completed training equivalent to CHW training, with further mandatory modular training including IMCI, family planning, health promotion, and HMIS (see annexes).

The current MCH-OPDs will either be upgraded to health centres if they fulfil given criteria, or will become primary health units. Health centres will have at least one qualified nurse and midwife. The outreach team will consist of one EPI officer and one nutrition officer, whose duties will be to conduct EPI and outpatient therapeutic nutrition programmes in the health centres and outreach clinics in the primary health units.

Management and clinical supervision of hospitals, referral health centres, health centres and the primary health units is conducted by the supervisory health team preferably based at a Regional Health Office and which includes, amongst others, a Medical Officer, a HMIS officer, a PHC coordinator and a Pharmacy Technician responsible for the drug supply system in the area.

The term 'auxiliary' applies to someone who has had, or can be sent for, formal auxiliary nurse or auxiliary midwife training (at least one year in a health institute). They can apply for further two-year trainings at institutes, to become registered nurses.

Traditional birth attendants have not been included in this staffing plan. While it is acknowledged that TBAs will continue to assist home deliveries over the next few years, the aim is the professionalisation of maternal care with all pregnant women attending antenatal clinics with trained midwives, delivering in health facilities assisted by skilled birth attendants. Traditional birth attendants fall outside of this structure as they will not be paid by or formalised into the human resources of the health plan. The aim will be to transform TBAs into other roles such as CHWs or health promoters, or to give them small incentives for bringing women to health centres for antenatal care and delivery. Traditional birth attendants with the necessary prerequisites can apply for auxiliary midwife training.

Professionalising the work force: reinforcing a culture of professional conscience, work ethic and standards. Standard human resource systems will be put in place or reinforced. These include contracts which specify a working code of conduct, uniforms, performance indicators, regular supervision and appraisal and time sheets. Staff will undergo competency testing via evaluations with written and practical components. A standard seven-hour working day at PHU, HC and RHC levels will operate from 07h30 to 12h30 and 15h30 to 17h30 for five and a half days a week.

Hospitals will operate eight-hour nursing shifts, with one doctor always on call at a hospital. On call commitments will be reinforced in PHUs, with CHWs available at home for acute IMCI diseases and a permanent qualified staff member on call at HC level and at least two qualified staff at RHCs. A key HR management component of Phase I is the classification and clarification of the work force, creating personnel

files on all staff with criteria for inclusion at each level of the health professional spectrum. Unqualified assistants will be reclassified as “health aides” and will no longer be called ‘auxiliaries’. They will not be allowed to give injections or to carry out any invasive medical procedures. There will be an emphasis on employing fewer unqualified staff in favour of qualified staff, and decreasing the total size of the workforce in favour of a leaner professional team. Health staff are obliged to adhere to standard medical and nursing authority directives. Staff are appraised yearly.

Each HC, RHC and hospital draws up a yearly workplan outlining how it will meet target indicators and fulfil criteria for each EPHS phase, and will produce an annual report. The plan and report should include a summary of HMIS data to show evidence based prioritisation of actions and how far progress was made in reaching objectives. Health facilities also produce graphs of key health indicators and vaccine coverage that are posted on facility walls.

3.2.2.2 *Human resource development*

Pre-service training - The following are key workers in the health system:

Community health workers are trained for six months following the standard curriculum. Community/auxiliary midwives are trained for 18 months. *See annex for CHW curriculum.*

In-service training - There are also post-basic diplomas, including an emergency obstetrics surgical diploma, mental health nurse diploma (see annex). Staff will be offered Continuous Professional Development and will build up a portfolio in their personal file, showing their training hours.

3.2.3 **EPHS coordination, development and supervision**

3.2.3.1 *EPHS coordination and development at central level*

A full time EPHS manager works within the Department of Planning of the central MoH to direct EPHS implementation and ongoing development. The principal job of the EPHS manager is to define all existing health facilities as PHU, HC, RHC or hospital, and to visit and help facilities develop plans to meet criteria for inclusion in phases I and II. The EPHS manager rolls out managerial components of the EPHS at the central MoH level and trains the supervisory team at the Regional Health Office. A database of

Community Health Workers Primary health officers (qualified nurses for nutrition and EPI) Auxiliary nurses Community or auxiliary midwives Registered Nurses Registered midwives	EPI managers Laboratory assistants X-ray technicians Laboratory technicians Pharmacy technicians Pharmacists Physiotherapists Health/Clinical officers Doctors
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facilities is developed, with lists of criteria showing progress made by each health facility. The manager also participates in some supervision conducted by the supervisory team, both to inspect facilities and to provide in-service training for health facility staff and supervisors.

The EPHS undergoes continuous development and refinement, taking into account and highlighting best practices developed in the field with the EPHS manager liaising closely with MoH and partner agencies. The results of pilot projects will be diffused via the EPHS coordinating mechanism within the Department of Planning. The EPHS manager coordinates the standardisation of health care provision by different agencies via the EPHS. All new initiatives in the health sector are seen by the EPHS manager, who also aims to improve equitable distribution of resources. The manager liaises closely with the HMIS, PHC and human resource managers within the MoH, aiming for sustained and standardised improvements in quality of PHC management, data collection and interpretation and human resource performance.

The EPHS manager will coordinate donor interventions, to harmonise and align them. The manager is also responsible for the overall M&E of the EPHS, writing six-monthly reports on achievements, failures and challenges in the implementation of the EPHS, and contributes to the annual health systems performance assessment.

A major review of the EPHS will take place three to four years after quality services have been achieved at PHU, HC, RHC and hospital level, and after Phase I and II criteria have been largely met. The EPHS will then be redrafted for phases III and IV, taking into account changed needs and challenges. If, at the end of Phase II, the regional supervisory system is well established, there could then be further decentralisation to create a district supervisory system and RHCs could potentially be upgraded to district hospitals in phases III and IV.

3.2.3.2 EPHS supervision from the regional level

Supervision will be required for clinical aspects as well as for management and support components. Each member of the regional supervisory team will be able to carry out a complete supervision, but will be focused on concentrating on specific aspects such as drug management, EPI, HMIS, etc. Supervision also functions as a tool for in-service, on the job training. No region will have a regional health office in phases I and II. Some offices will have to supervise two regions as capacity is built up. Some better-resourced regions will pilot district health management, but the priority is to establish at least a regional supervisory capacity.

Supervisory visits are carried out by the Regional Health Office with support from the consortium agencies. Monthly supervisions of hospitals, RHCs, HCs and PHUs are carried out by medical officers, PHC coordinators (for EPI – including polio, quality of diagnosis and treatment, prevention/promotion and nutrition), HMIS managers, finance and medical stores managers. They supervise clinical care via controlling registers and conduct mini ward rounds and on the spot inspections of all rooms and wards, observing nursing care, consultations, operating theatres and delivery rooms (see annex for supervision checklists).

Drug supply supervision consists of support and on-site training for stock taking and stock control, ensuring that consumption of specific tracer drugs are appropriate at each supervised facility. A pharmacy technician based at each hospital provides drug supply supervision, using a motorbike for this purpose.

HMIS supervision and monitoring throughout the health system are conducted by designated health information managers from the supervision team. Each health information manager is responsible for ensuring that data are captured properly, that summary forms are accurate, and that validity checks are clean.

The finance manager is responsible for transport supervision, ensuring that proper transportation records are kept (e.g. transportation logs and maintenance registers), that fuel costs are properly recorded and that vehicles are used appropriately.

3.2.4 Community participation

Representative community committees play an integral role in managing and overseeing health facilities, as one of three groups involved in the health system.

- Health facility staff (direct facility management)
- Regional health office (supervision and ensuring quality of care)
- Community representation (oversight, ownership and support)

These committees vary according to their level.

regional PHC coordinators and health centre staff.

Communities are facilitated to become more aware of their right to health and their responsibility in contributing via community health funds and voluntary in-kind contributions. They are also involved in selecting CHWs for training and in electing members of the CHCs. The views of the community are sought via surveys of clients using health facilities.

3.2.5 Health systems support components

Health systems support components are designed to maximise efficiency throughout the health care system, ensuring that sufficient resources are available for actual service delivery.

	Community representation	Health facility management	Supervision
Primary health unit	Community health committee	Community health worker	MoH & agency supervision team
Health Centre	Community health committee or health centre committee	Health facility in charge	MoH & agency supervision team
Referral health centre	Health centre committee	Health facility manager	MoH & agency supervision team
Hospital	Health board	Hospital management committee	MoH & agency supervision team

Each group has specific roles and responsibilities defined in formal contracts, to be agreed between the respective community groups, the MoHs and the implementing agents. A formal contract is drawn up between the MoH and the implementing partner, with the community group (health board or community health committee) clearly defining roles and responsibilities with target performance indicators.

Communities are also heavily involved in the process of identifying health priorities and in realising their right to health. Discussion takes place via community committees with the facilitation of CHWs, visiting

Drug supply - The aim is for the drug supply system to be changed from distribution of drug kits to a consumption-based system that ensures appropriate oversight and monitoring of drug-prescribing patterns. PHU, HC and RHC levels use a simple system of stock cards and drug order forms. Guidance and on-site training in ensuring adequate drug supplies and maintaining drug stocks (including buffer drug stocks) are provided through regional level supervision. With the continuing difficult access to Somalia, drug kits are still used as the primary way of supplying PHUs, HCs and RHCs.

At the hospital level, a more advanced stock control system involving stock cards with a standardised software tool is required. Region-wide medical stores based at regional health offices also use a more advanced, software-enabled system. A pharmacy technician is in place at the regional office to manage drug ordering and stock control for all public sector health facilities in the region. Drug supply distribution is outsourced to private sector contractors, who bid for distribution contracts on a competitive basis.

Referral system - The referral system consists of a referral letter with space for comments by the referring clinician. Referring health providers will assist patients with arranging transport to the referral facility if necessary. Patients are encouraged to bring the updated referral letter back to the referring provider at their next visit.

Referral criteria and the protocols to be followed in the case of a referred patient are required at each service level. The referral system will inevitably not work linearly in the first phase, so if a regional hospital is close to a health centre then referrals will likely be there and not at a referral health centre.

Transportation - A transportation system is in place both for referrals throughout the health care system and for supervision. Transport via community-level resources (e.g. camel, donkey cart, vehicle if available) is the most appropriate means of patient transport from communities to PHUs, from PHUs to HCs, and from HCs to RHCs. At the regional hospital level and at the regional office, vehicles are used (and motorbike ambulances piloted) both for emergency transport when feasible and for supervisory support to the lower level facilities throughout the region or district.

Donors support orientation and training meetings for staff responsible for transport, encouraging them to develop transport protocols based upon MoH transport policy. Donors also fund selected small capital expenses and some recurrent expenditure such as

new donkey carts, repair and maintenance of carts, and fuel, maintenance and repair of regional office-based vehicles.

Communications - Mobile phones are the standard communication tool at all health facilities where a network exists, and are used for notification in the case of emergency or urgent referrals as well as for systems support functions, e.g. informing medical stores of unexpected stock outs of key drugs or medical supplies requiring urgent replacement. Health facilities outside of mobile networks have HF radios to communicate to regional and referral health centres. To function, HF radios need antennae, cables, and power sources (solar panels, batteries and cables if no electricity supply).

Health equipment maintenance and repair - Basic maintenance and repair of health equipment are the responsibility of the MoHs and implementing agents, possibly through sub-contracts with domestic or international firms. Cold chain technicians also service other equipment. Equipment across the health service is standardized as much as possible.

Physical infrastructure maintenance and repair - Health Committees have responsibility for physical infrastructure maintenance and repair, using financing drawn from local Community Health Funds. Community committees mobilize volunteers to paint or whitewash health facilities and are responsible for minor repairs and upkeep. Major repairs and renovation of existing facilities are funded as far as is possible from the CHF, supplemented by resources from district authorities, donors and the MoH.

3.2.6 Health management information system

The EPHS utilises a simple, efficient and accurate HMIS with standardised tools and protocols.

Core indicator set - A small, focused set of indicators ensures that sufficient data are available for comparative analyses of health facility outputs,

outcomes and performance. At each level of the health system data 'filters' are in place in the form of summary reports containing only essential data for the next level. Core indicators are listed in the annex.

Tools - At all facilities initially, HMIS tools are paper-based and standardised. Software for analysis and feedback of indicators (calculated from aggregate data) may be used at hospitals and regional and national health offices until such time as a district health system is implemented.

Facility-based registers are used for capturing patient data. Essentially, there are two broad 'categories'

of registers: (a) registers that track specific services provided to individual patients over time, used for ensuring continuity of care for each patient, e.g. EPI, FP, ANC, deliveries, PNC, and chronic disease registers; and (b) general registers for capturing aggregate data for which patient-specific data are not a requirement (e.g. OPD register).

Existing communicable disease surveillance systems, including notifiable diseases, run in parallel to the routine HMIS.

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6 CORE AND 4 ADDITIONAL PROGRAMMES OF THE ESSENTIAL PACKAGE OF HEALTH SERVICES

Annex I Tabulated view of the essential package of health services

Level	Primary health unit		Health centre		Referral health centre		Hospital	
	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Function								
6 Core programmes:								
1. Maternal, reproductive and newborn health	FP & promotion	FP & promotion	X Basic EmONC	X Basic EmONC	X Comprehensive EmONC	X Comprehensive EmONC	X and Obstetrics & Gynaecology	X and Obstetrics and Gynaecology
2. Child health	X (outreach OTP)	X (outreach OTP)	X (OTP)	X (OTP)	X (OTP & stabilisation centre)	X (OTP & stabilisation centre)	X (OTP & stabilisation centre)	X (OTP & stabilisation centre)
3. Communicable disease surveillance and control, including watsan promotion	X	X	X	X	X	X	X	X
4. First aid and care of critically ill and injured	Help organise evacuation	Help organise evacuation	X	X	X	X & mass casualty capacity	X & surgical & orthopaedic departments including mass casualty capacity	X & surgical & orthopaedic departments including mass casualty capacity of physical disability
5. Treatment of common illness	X	X	X	X	X	X	X	X

Level	Primary health unit		Health centre		Referral health centre		Hospital	
	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Function								
6. HIV, STIs & TB	prevention & promote care seeking behaviour	prevention & promote care seeking behaviour	X	X HIV testing of pregnant women	X Increase number of VCT district sites	X VCT site in all districts; PMTCT in all Comp EMONC	X Increase number of ART regional sites	X ART centre in all regions; PMTCT in all regions
4 Additional programmes:								
7. Chronic disease management				X	X	X	X & Internal Medicine	X & Internal Medicine
8. Mental health & mental disability				X			X	X
9. Dental health			Oral health & referral	Oral health & referral	Oral health & referral	X (mobile dental clinic)	X	X
10. Eye health			referral	X (first aid and referral of acute red eye)	referral	X (mobile eye clinic & first aid and referral of acute red eye)	X	X
Finance								
User fees (entire PHC package free, including all nurse consultations, EPI, ANC/PNC, deliveries, caesarean sections, FP)	No	No	No	No	No	No, except dental/eyes/ Elective surgery/ consultation by doctor	Only for activities outside of PHC package	Only for activities outside of PHC package
Community health fund	CHF – 5%	CHF – 15%	CHF – 5%	CHF – 15%	DHB – 5%	DHB – 15%	RHB – 10%	RHB – 15%
Municipal/ District authority	5%	5%	5%	10%	5%	5%	5%	10%
MOH	5%	15%	5%	15%	5%	15%	10%	20%
Donors	85%	65%	85%	65%	85%	65%	50%	35%
Diversification of the revenue base (CHCs, DHBs & RHBs empowered to fund raise)	X	X	X	X	X	X	X	X
Human Resource Management								
Minimum Staffing	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
CHW	1	2						
Auxiliary nurse			1	2	1	2		
Community or aux midwife			1	2	1	2		

Level	Primary health unit		Health centre		Referral health centre		Hospital	
	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Function								
MW			1	2	2	3	3	4
Nurse			1	2	2	4	6	10
Nurse (nutrition and EPI officer)			1	1	1	1	1	1
Health/clinical officer						1	1	2
Doctor						1	2	4
Professional qualified for caesarians					1	1	2	3
Anaesthetic assistant					1	1	1	1
Lab assistant				1	1	2	2	3
Lab technician					1	2	2	3
X-ray technician								1
Pharmacist technician						1	1	2
Pharmacist								1
Dental technician						1	1	2
Dentist								1
Ophthalmic technician						1	1	1
Physiotherapist								1
Hospital administrator (MBA)								1
Health management structure	Community health committee	Community health committee	Health centre committee	HCC	HCC/health board	HCC/health board	Health board	Health board
Classification and clarification of the employed work force, and tests of staff competency	X	X	X	X	X	X	X	X
HR management plan, including personnel documents, service contract, uniforms, staff performance indicators and staff appraisals	X	X	X	X	X	X	X	X
Procedures authorisation for different cadres (eg nurses only injections)	X	X	X	X	X	X	X	X
Hygiene standards for health personnel (eg hand washing between patients)	X	X	X	X	X	X	X	X
Human resource performance indicators	X	X	X	X	X	X	X	X
Outreach programme	X (nutrition and EPI)	X (nutrition and EPI)				X (mental, dental & eye health)		

Level	Primary health unit		Health centre		Referral health centre		Hospital	
	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Function								
Supervision								
MOH personnel carrying out supervision & support	PHC supervisor, HMIS supervisor	PHC supervisor, HMIS supervisor	PHC supervisor, HMIS supervisor	PHC supervisor, HMIS supervisor	Regional medical officer PHC supervisor, HMIS sup	Regional medical officer PHC supervisor, HMIS sup	RMO, PHC supervisor, HMIS supervisor	RMO, PHC supervisor, HMIS supervisor
Regularity of supervision	Monthly; HMIS quarterly	Monthly; HMIS quarterly, X (donkey carts)	Monthly; HMIS quarterly	Monthly; HMIS quarterly, X (donkey carts)	Monthly; HMIS quarterly	Monthly; HMIS quarterly, X (ambulance)	Monthly; HMIS quarterly	Monthly; HMIS quarterly, X (ambulance)
Referral system	X (donkey carts)	X (donkey carts)	X (donkey carts)	X (donkey carts)	X (donkey carts)	X (ambulance)	X (ambulance)	X (ambulance)
Community participation – surveys of client satisfaction with facilities		X		X		X		X
Support components								
Physical infrastructure								
Consultation room (adult and child) and waiting room	X	X	X	X	X	X	X	X
Chronic disease consultation								
TB dept								
Dental unit								
Ophthalmology unit								
EPI & Nutrition room	X	X	X	X	X	X	X	X
Dressing room								
Maternity (includes labour room, delivery room, post natal beds)								
Number of post natal beds			4	8	8	8	12	20
Maternity village (can be piloted)								
Admission beds	N/A	N/A	4 beds -observation	8 beds - observation	8	8	40	60
Number of beds per nurse/MW / 24 hour care	N/A	N/A	8	8	8	14	20	20
Number of beds/ doctor for on-call care	N/A	N/A	N/A	N/A	N/A	14	40	60
Laboratory	RDT & urine dipstick	RDT & urine dipstick	X Lab assistant	X Lab assistant	X Lab technician	X Lab technician	X Lab technician	X Lab technician
VCT-ART consultation						X (some regions)	X (some regions)	X (all regions)

6 CORE AND 4 ADDITIONAL PROGRAMMES OF THE ESSENTIAL PACKAGE OF HEALTH SERVICES

Core programme 1 – Maternal, Reproductive and Neonatal Health

Standardised interventions by sub-programme

Sub-programme	Interventions
Promotion of maternal nutrition	<ul style="list-style-type: none"> – Promotion of appropriate nutrition for pregnant & lactating women, girls & adolescents; MUAC screening and referral – Antenatal - Iron/folate supplements for 6 months & vit A 10,000iu once; or combined multiple micronutrient supplements, 1 RNI per day – Postnatal – Iron.folate supplements for 3 months; Vitamin A 200,000iu once during first 6 weeks for mothers or MMN - 1 RNI¹ each day
Targeted supplementary feeding	<ul style="list-style-type: none"> – Context specific, in liaison with MOH, WFP, UNICEF and agencies for acutely malnourished pregnant and lactating women
Promotion of neonatal nutrition	<ul style="list-style-type: none"> – promotion of immediate and exclusive breast feeding – <i>referral health centres/ hospitals: nutritional care of premature babies and term babies without a mother</i>
Antenatal care	<ul style="list-style-type: none"> – promotion of facility based delivery assisted by skilled birth attendants – CHPs and PHWs encourage bring women to go to health facilities to deliver 4 focused antenatal visits including: <ul style="list-style-type: none"> ▪ At least 2 doses of tetanus toxoid vaccination (TT2+) ▪ Intermittent preventive treatment for malaria in pregnancy (IPTp) and insecticide treated bednets (ITN) in endemic areas ▪ Maternal nutrition counselling during pregnancy, including iron and folate supplements; MUAC screening and referral ▪ Treatment of disease, and mebendazole for worms ▪ Treatment of anaemia ▪ screening for pre-eclampsia with urine protein dipstick and BP and further ANC monitoring ▪ treatment of STIs – Identification of high risk pregnancies and referral with register of at-risk pregnancies and referrals to maternity village (pilot programmes) – Standardised management of pre-eclampsia, antepartum haemorrhage and other antenatal complications – Prevention of mother-to-child transmission of HIV – promotion of family planning for after delivery

¹ RNI = Recommended Nutrient Intake

Care during delivery	<ul style="list-style-type: none"> – Skilled in-facility attendance at birth with EmONC for all deliveries, including management of post-partum sepsis and haemorrhage, use of partogrammes and active management of third stage of labour; Companion of the woman’s choice at birth and flexibility of delivery position – <i>Referral health centres and hospitals only: Comprehensive EmONC for any at risk pregnancies and any women with complications, including caesarean section and blood transfusion</i> • Essential newborn care - resuscitation, drying the baby, warmth, kangaroo care for premature babies • <i>Referral health centres and hospitals: PMTCT through antiretroviral therapy and safer infant feeding practices</i>
Care after birth	<ul style="list-style-type: none"> • Routine postnatal care (PNC) for early identification and referral for illness as well as preventive care: <ul style="list-style-type: none"> – For the baby: Promotion of healthy behaviours – hygiene, warmth, breastfeeding and immunisation; danger sign recognition (eg fever, rapid breathing, poor feeding, floppy babies, colour change); early identification of illness and referral • Extra care for babies with other problems (e.g. mothers with HIV/AIDS) • Extra care of low birthweight (LBW) babies including Kangaroo Mother Care (KMC) • Case management of neonatal illness especially sepsis & jaundice • Early and exclusive breastfeeding for babies
Family planning	<ul style="list-style-type: none"> – Widespread availability of oral contraceptive pill, depo-provera, IUD, condoms, implants, tubal ligation (medically indicated) – Integrated plan for promotion of family planning and birth spacing at all levels
Health of girls & boys	<ul style="list-style-type: none"> – Reproductive health education in schools – Promotion of avoidance of early marriage and early pregnancy
Prevention and treatment of STIs and HIV	<ul style="list-style-type: none"> – Condoms – syndromic management of STIs – free distribution of condoms
Reduction of gender based violence	<ul style="list-style-type: none"> – <i>Referral health centres and hospitals: care of victims of sexual violence , including PEP</i> – Prevention through awareness raising
Gynaecological disorders	<ul style="list-style-type: none"> – <i>Referral health centres and hospitals: decrease unsafe abortion with D&C, MVA etc</i> – raise awareness of the availability of treatment of gynaecological disorders and encourage increased care seeking behaviour

Menstruation	<ul style="list-style-type: none"> – improve cleanliness, comfort and dignity of women during menstruation with free distribution and social marketing of sanitary towels in schools, shops and at certain public places
Neonatal tetanus	<ul style="list-style-type: none"> – 2 doses of tetanus toxoid for non-immunised pregnant women
Tuberculosis & polio prevention	<ul style="list-style-type: none"> – BCG & polio vaccine for newborns
HIV	<ul style="list-style-type: none"> – <i>Referral health centres and hospitals: PMTCT</i> – <i>Referral health centres and hospitals ART with low CD4 counts & nutrition counselling/support for pregnant women</i>
FGM & fistulas	<ul style="list-style-type: none"> – <i>Referral health centres and hospitals: gynaecological care for women with complications of FGM, perineal tears and fistulas</i> – promotion of avoidance of FGM

Core programme 2 - Child Health

Standardised interventions by sub-programme

Sub-programme	Interventions
Control of diarrhoeal disease	<ul style="list-style-type: none"> – Rehydration with ORS; referral severe cases for NG tubes/ IV hydration – Treatment with zinc for 10 – 14 days – Metronidazole for protozoal disease – Antibiotics for bacillary dysentery – Promotion of hand washing, safe disposal of faeces & safe water chain
Control of acute respiratory illness	<ul style="list-style-type: none"> – Treatment with oral antibiotics for pneumonia, ear infection, tonsillitis – Referral of children with pneumonia and danger signs for parenteral AB – Supportive treatment for common colds
Control of malaria	<ul style="list-style-type: none"> – Diagnosis and treatment of malaria (ACTs) – Fever management (with decision flow charts) – ITN distribution – only in certain circumstances – Active case finding during epidemics
Control of measles	<ul style="list-style-type: none"> – Standardised case management, including nutritional assessment & support, Vitamin A, prevention and treatment of complications – Prevention via routine EPI & 6 month campaigns, with vitamin A
Vaccine preventable disease	<ul style="list-style-type: none"> – EPI – routine, accelerated and 6 month vaccination campaigns for measles, polio & vitamin A
Promotion of young child nutrition	<ul style="list-style-type: none"> – Promotion of exclusive and immediate breast feeding for 6 months – Promotion of complementary child feeding and diversification of foods – Nutrition counselling
Nutrition screening	<ul style="list-style-type: none"> – Routine nutritional screening with MUAC and look for oedema and referral to health centre/ selective feeding centre ; – NB No routine wt/ht monitoring or road to health charts; road to health charts replaced by EPI cards.
Nutrition – micronutrient supplements	<ul style="list-style-type: none"> – Vitamin A – 6 – 12months 100,000 iu; then 200,000 iu every 6 months until 5 years with 6 month child health campaigns or MMN (see below) – Iron/folate supplements for anaemia OR multiple micronutrients, 1 RNI² each day children aged 6 – 59 months or 2 RNI each day if fortified foods being used
Outpatient therapeutic feeding	<ul style="list-style-type: none"> – National therapeutic care protocol – with outpatient therapeutic programme for severe acute malnutrition & no complications; monitoring wt/ht and z score and/or MUAC, & oedema; moderate acute malnutrition may be managed with supplementary feeding if resources and programming allow
Inpatient therapeutic feeding	<ul style="list-style-type: none"> – <i>Referral health centres and hospitals – inpatient therapeutic feeding programme/ stabilisation centre - admission for all children with severe acute malnutrition with complications and no appetite following national protocols</i>

Targeted supplementary feeding	<ul style="list-style-type: none"> - Context specific, in liaison with MOH, WFP, UNICEF and agencies for malnourished children aged 6 – 59 months,
Skin disease	<ul style="list-style-type: none"> - treatment of scabies - treatment of fungal disease - treatment of dermatitis/eczema - hygiene promotion
Eye disease	<ul style="list-style-type: none"> - treatment of conjunctivitis - hygiene promotion
Childhood chronic disease	see chronic disease sub-programme (for epilepsy, rheumatic heart disease, diabetes, asthma) & HIV, STI & TB programme
Reduction of anaemia	<ul style="list-style-type: none"> - malaria control and treatment - deworming with 6 monthly campaigns with antihelminthics - iron and folate supplements at age specific doses - referral of severe anaemia for blood transfusion

Core programme 3 - Communicable disease surveillance and control, including water and environmental sanitation promotion

Standardised interventions by sub-programme

Sub-programme	Interventions
Surveillance of notifiable diseases	<ul style="list-style-type: none"> – Weekly reporting (and daily during outbreaks) of suspicious cases by health facility as per WHO protocol and HMIS; clinical diagnosis and laboratory samples sent for confirmation; feedback to facilities
Control of epidemics	<ul style="list-style-type: none"> – Standard response to epidemics as per WHO and MSF guidelines for measles, meningitis, dysentery, cholera and viral haemorrhagic fever. – Epidemic preparedness – training, stocks, networks, supply lines, communication, coordination; development of preparedness plans – Isolation area in health facility with dedicated latrines, water supply and waste disposal; public awareness campaigns – Targeted vaccination for certain diseases
Malaria control	<ul style="list-style-type: none"> – National protocols – IPT, ITN, RDT, ACT; ITN distribution strategy; IEC
Control of neglected tropical infections	<ul style="list-style-type: none"> – control of Leishmaniasis, schistosomiasis, elephantiasis, in endemic areas with support of WHO control programme and NGOs
Long term improvements in water supplies	<ul style="list-style-type: none"> – CHC/DHB with health staff advocate for and plan with municipal/district authorities, government ministries and international partners for improved water supplies, testing and supervision; improved water supplies for health facilities – CHC/DHB with health staff advocate for and plan with municipal/district authorities, government ministries and international partners for on-going water chlorination
Long term improvements in sanitation	<ul style="list-style-type: none"> – CHC/DHB with health staff advocate for and plan with municipal/district authorities, government ministries and international partners for latrine construction for schools and public places, and creation of sanitation promotion centres for promoting safe waste disposal; sanitation for health facilities including safe disposal of medical waste
Emergency Watsan response for cholera epidemics	<ul style="list-style-type: none"> – chlorination of local water supplies – free home distribution of water treatment sachets – IEC campaign – Watsan facilities for isolation areas in health facilities

<p>Routine Watsan promotion for families</p>	<ul style="list-style-type: none"> - Promotion of hand washing with soap and safe disposal of faeces and safe water chain - Family latrines - Home water treatment (via social marketing) - PHAST (participatory hygiene and sanitation transformation) & CHAP (community hygiene awareness promotion) techniques to promote: <ul style="list-style-type: none"> ▪ Personal hygiene ▪ Safe disposal of human excreta hygiene ▪ Environmental and domestic hygiene ▪ Water hygiene; separation of drinking and washing water; home water treatment and storage ▪ Food hygiene ▪ Garbage disposal - And promotes improved sanitation facilities & home treatment of diarrhoea with ORS - 6 month child health days – promote hand washing, household water treatment, diarrhoea treatment and safe faeces disposal
<p>Routine Watsan promotion for populations</p>	<ul style="list-style-type: none"> - Hygiene promotion with mass media and campaigns - Improved water supplies - Distribution of water treatment sachets - Social marketing of home water treatment (strategy being developed)

Core programme 4 – First aid and care of critically ill and injured

Standardised interventions for each sub-programme

Sub-programme	Interventions
Life saving support	<ul style="list-style-type: none"> – Immediate care with surveillance of “ABCD” - airway, breathing, circulation, coma, convulsion and dehydration – Treatment of hypovolaemic, anaphylactic, septicaemic shock – Emergency triage, assessment and treatment (ETAT) – Triage of out-patients into routine and emergency cases for immediate care
Minor wound management	<ul style="list-style-type: none"> – first line principals with wound toilet, either delayed primary closure or immediate closure – management of tropical ulcers – referral to appropriate level
Major wound management	<ul style="list-style-type: none"> – first line principals with wound toilet, TT, either delayed primary closure and referral – triage – <i>Referral health centres and hospitals: mass casualty response including anti-tetanus serum</i> – Preparedness – Nutritional support for victims of major trauma
Poisoning	<ul style="list-style-type: none"> – first line care with rehydration, ? emetics and referral
Bites	<ul style="list-style-type: none"> – management of human and animal bites and injuries, including snake and dog bites; referral for rabies vaccine and anti-rabies serum
Fractures	<ul style="list-style-type: none"> – analgesia, immobilisation, referral – <i>Hospitals: reduction, POP</i>
Burns	<ul style="list-style-type: none"> – first line care, fluids, nutritional support including therapeutic feeding
Surgical infection	<ul style="list-style-type: none"> – abscesses and cellulitis – Incision & Drainage, antibiotics, elevation, referral as appropriate
Promotion of accident prevention	<ul style="list-style-type: none"> – promotion of reduction of road accidents – promotion of reduction of burns

Core programme 5 – Treatment of common illness

Standardised interventions for each level of sub-programme

Sub-programme	Interventions
Skin disease	– Out-patient treatment of scabies, eczema, dermatitis, impetigo, ulcers
Gastro-intestinal disease	– Out-patient treatment of gastritis, reflux, worms, haemorrhoids – <i>Referral of acute abdomen to surgical centre</i>
Mouth and throat	– Out-patient treatment of candidiasis, gingivitis, tonsillitis – Promotion of oral hygiene – <i>Referral of dental problems</i>
Ear disease	– Out-patient of otitis media and otitis externa – Out-patient removal of foreign bodies
Eye disease	– Out-patient treatment of acute, chronic & neonatal conjunctivitis – Immediate care & referral of acute painful red eye and all eye trauma – Trachoma management
Respiratory disease	– Management of ARI (upper and lower airway)
Menstrual problems	– <i>Referral health centre and hospitals: out-patient management by GP/ gynaecologist</i>
Surgical problems	– Referral of hernias, hydroceles, swellings,
Musculo-skeletal problems	– Out-patient management of backache – Out-patient management of painful joints; <i>Referral of joint swellings</i>
Physical disability	– <i>Referral to orthopaedic rehabilitation units in hospitals</i>
Urinary problems	– Out-patient treatment of UTI – referral of renal colic, haematuria and urinary retention

Core programme 6 – HIV, STIs and TB

Standardised interventions by sub-programme

Sub-programme	Interventions
Promotion of HIV prevention and decreasing stigma	<ul style="list-style-type: none"> – Promotion at family & community level – Promotion to decrease stigma – Prevention services through behaviour change communication, display and dissemination of educational materials, provision of condoms, post-test clubs and community mobilization
Prevention of sexual spread of HIV and STIs	<ul style="list-style-type: none"> – Promotion of use of condoms – Abstinence, faithfulness education – Prompt treatment of STIs
Prevention of blood borne spread of HIV	<ul style="list-style-type: none"> – <i>Referral health centres and hospitals: Safe blood transfusion, with testing for HIV, Hep B & C, syphilis</i> – Sharps disposal; PEP for needle stick injury – Single needle & syringe use policy
Prevention of maternal to child transmission	<ul style="list-style-type: none"> – HIV testing of pregnant women following national guidelines – <i>Regional hospitals: triple ART for HIV+ve pregnant women; Safe and quick delivery; HIV test & ART for at risk newborns;</i>
Prompt treatment of STIs	<ul style="list-style-type: none"> – Syndromic management of STIs – VCT encouraged for those with STIs – Contact tracing – [advice, prevention and care for high risk groups]
Voluntary Counselling and Testing centres for HIV	<ul style="list-style-type: none"> – <i>Referral health centres and hospitals: Counselling and testing;</i> – <i>PEP for health workers. PEP for victims of sexual violence</i>
Treatment of people with HIV	<ul style="list-style-type: none"> – Social support – <i>Regional hospitals: - close collaboration between ART & TB centres</i> – <i>CD4 testing and clinical monitoring (frozen samples sent to CD4 site</i> – <i>Co-trimoxazole prophylaxis of P carinii infection</i> – <i>Treatment of opportunistic infections (e.g. antibiotics for pneumonia, oral re-hydration for diarrhoea, treatment of skin disorders, protozoa and fungal disease)</i> – <i>Clinical assessment for TB</i> – <i>Appropriate treatment of TB in line with national TB guidelines</i> – <i>Manage severe HIV associated conditions</i> – <i>ART centres for people with HIV needing treatment, with adherence counselling and home-based care</i> – <i>Manage severe side effects and toxicity of ARVs</i> – <i>Support adherence with responsible care-givers</i> – <i>Evaluate for treatment failure</i> – <i>In-patient care as necessary</i>

Nutritional support for PLWHA	<ul style="list-style-type: none"> – promotion of appropriate foods – screening & referral for therapeutic care for severely malnourished – Supplementary food for moderately malnourished
Promotion of early detection and diagnosis of TB	<ul style="list-style-type: none"> – mass education and community education on signs and symptoms of TB – sputum testing – contact tracing – aim for > 70% case detection rate
TB prevention	– see EPI programme and HIV prevention
Management of TB – HIV co-infection	<i>Referral health centres and hospitals</i> <ul style="list-style-type: none"> – appropriate out-patient care following co-infection guidelines.
Multi-drug therapy for TB & leprosy	<i>Referral health centres and hospitals:</i> <ul style="list-style-type: none"> – appropriate out-patient and in-patient care. DOTS and responsible care-givers – aim for 85% treatment success rate
Management of chronic respiratory illness	<i>Referral health centres and hospitals:</i> <ul style="list-style-type: none"> – appropriate out-patient and in-patient care by TB teams of chronic bronchitis, bronchiectasis, pulmonary fibrosis, asthma

Additional programme 7 – Management of chronic disease and other diseases, care of the elderly and palliative care

Standardised interventions by sub-programme

Sub-programme	Interventions Referral health centres and hospitals only
Epilepsy	<ul style="list-style-type: none"> – Special programme at RH, DH/RHC level with monthly out-patient visit for medication, review history and examination and individual care – Promotion of burns prevention
Hypertension	<ul style="list-style-type: none"> – Special programme at RH, DH/RHC level with monthly out-patient visit for medication, review history and examination and individual care
Rheumatic & congenital heart disease	<ul style="list-style-type: none"> – Special programme at RH, DH/RHC level with monthly out-patient visit for medication, review history and examination and individual care
Heart failure	<ul style="list-style-type: none"> – Special programme at RH, DH/RHC level with monthly out-patient visit for medication, review history and examination and individual care
Asthma and chronic respiratory disease	<ul style="list-style-type: none"> – Special programme at RH, DH/RHC level with monthly out-patient visit for medication, review history and examination and individual care – integrated with TB programme
Diabetes	<ul style="list-style-type: none"> – Special programme at RH, DH/RHC level with monthly out-patient visit for medication, review history and examination and individual care including dietetic advice
Neurological illness	<ul style="list-style-type: none"> – Care of paralysed people – Care of elderly after strokes
Health and nutritional problems of the elderly	<ul style="list-style-type: none"> – Nutritional and medical support
Palliative care	<ul style="list-style-type: none"> – Palliative support for those with incurable disease. See Palliative care toolkit.
Nutritional support for adults and children with chronic disease	<ul style="list-style-type: none"> – promotion of appropriate foods – Therapeutic care for severely malnourished – Supplementary food for moderately malnourished cases

Additional programme 8 – Mental health and mental disability

Standardised interventions for each level of sub-programme

Sub-programme	Interventions Referral health centres and hospitals:
Mental disability	– Support for families
Neurotic mental illness	– Out-patient treatment by mental health nurse – Referral to mental health ward
Psychotic mental illness	– Out-patient treatment and support by mental health nurse – Referral to mental health ward
Substance abuse/ addiction	– promotion of reduction of use of cigarettes, qat, illicit drugs and alcohol
Psychosocial support for victims of violence and trauma	– special programme at RH, DH/RHC level – PHU & HC – staff trained in psychosocial support skills, including supportive communication and problem solving

Additional programme 9 – Dental health

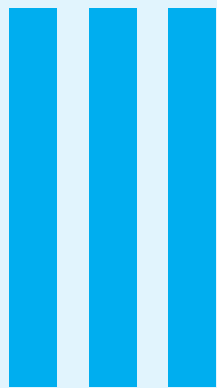
Standardised interventions for each level of sub-programme

Sub-programme	Interventions Referral health centres and hospitals
Promotion of oral hygiene	– Dental assistants teach oral hygiene in schools by dental assistants
Dental extraction	– Dental assistants/dentists in regional hospitals. They conduct mobile clinics to RHC/ DH and HC level. Clients are charged fees.
Dental filling	– Dental assistants/dentists in regional hospitals. They conduct mobile clinics to RHC/ DH and HC level. Clients are charged fees.
De-scaling	– Dental assistants/dentists in regional hospitals. They conduct mobile clinics to RHC/ DH and HC level. Clients are charged fees.

Additional programme 10 – Eye health

Standardised interventions for each level of sub-programme

Sub-programme	Interventions Referral health centres and hospitals
Promotion of eye health	<ul style="list-style-type: none"> – Ophthalmic assistants teach eye health in schools & screen visual acuity – Ophthalmic assistants train HC staff in acute first aid and referral for the acute red eye and eye trauma
Treatment of acute eye problems	<ul style="list-style-type: none"> – Management of acute eye problems at RH level, including removal of foreign body <i>[NB free treatment]</i>
Treatment of chronic eye problems	<ul style="list-style-type: none"> – Referral to ophthalmic assistants at RH level – Mobile eye camps <i>[free treatment]</i> – Eye clinic at RH level – Surgical camps with visiting ophthalmologists <i>[free cataract and other surgery]</i> – Community based trachoma treatment in areas of high prevalence
Correction of refractive errors	<ul style="list-style-type: none"> – Treatment of refractive problems by ophthalmic assistants at RH level and by visiting ophthalmologists <i>[NB Fees are charged]</i>



ESSENTIAL PACKAGE OF HEALTH SERVICE - THE FOUR SERVICE LEVELS

EPHS Programmes at primary health unit level

Core programme 1 – Maternal, Reproductive and Neonatal Health

Sub-programme	Interventions
Promotion of maternal nutrition	<ul style="list-style-type: none"> – Promotion of appropriate nutrition for pregnant & lactating women, girls & adolescents; MUAC screening and referral – Antenatal - Iron/folate supplements for 6 months & vit A 10,000iu once; or combined multiple micronutrient supplements, 1 RNI per day – Postnatal – Iron.folate supplements for 3 months; Vitamin A 200,000iu once during first 6 weeks for mothers or MMN - 1 RNI³ each day
Targeted supplementary feeding	<ul style="list-style-type: none"> – Context specific, in liaison with MOH, WFP, UNICEF and agencies for acutely malnourished pregnant and lactating women
Promotion of neonatal nutrition	<ul style="list-style-type: none"> – promotion of immediate and exclusive breast feeding
Care after birth	<ul style="list-style-type: none"> – For the baby: Promotion of healthy behaviours – hygiene, warmth, breastfeeding and promotion of immunisation; – Early and exclusive breastfeeding for babies
Family planning	<ul style="list-style-type: none"> – Widespread availability of oral contraceptive pill, condoms,
Health of girls & boys	<ul style="list-style-type: none"> – Promotion of avoidance of early marriage and early pregnancy
Prevention and treatment of STIs and HIV	<ul style="list-style-type: none"> – Condoms
Reduction of gender based violence	<ul style="list-style-type: none"> – Prevention through awareness raising
Menstruation	<ul style="list-style-type: none"> – improve cleanliness, comfort and dignity of women during menstruation with free distribution and social marketing of sanitary towels in schools, shops and at certain public places
Neonatal tetanus	<ul style="list-style-type: none"> – 2 doses of tetanus toxoid for non-immunised pregnant women – assist immunisation clinic
Tuberculosis & polio prevention	<ul style="list-style-type: none"> – BCG & polio vaccine for newborns – assist immunisation clinic
FGM & fistulas	<ul style="list-style-type: none"> – promotion of avoidance of FGM & prevention of fistulas with deliver in facilities

3 RNI = Recommended nutrient intake

Core programme 2 - Child Health

Sub-programme	Interventions
Control of diarrhoeal disease	<ul style="list-style-type: none"> – Rehydration with ORS; referral severe cases – Treatment with zinc for 10 – 14 days – Promotion of hand washing, safe disposal of faeces & safe water chain
Control of acute respiratory illness	<ul style="list-style-type: none"> – Treatment with oral antibiotics for pneumonia, ear infection, tonsillitis – Referral of children with pneumonia and danger signs – Supportive treatment for common colds
Control of malaria	<ul style="list-style-type: none"> – Diagnosis and treatment of malaria (ACTs) – Fever management (with decision flow charts) – ITN distribution – only in certain circumstances – Active case finding during epidemics
Control of measles	<ul style="list-style-type: none"> – Standardised case management, including MUAC screening, Vitamin A, prevention of complications & referral – Prevention via assistance at routine EPI & 6 month campaigns
Vaccine preventable disease	<ul style="list-style-type: none"> – EPI – assist at routine, accelerated and 6 month vaccination campaigns for measles, polio & vitamin A
Promotion of young child nutrition	<ul style="list-style-type: none"> – Promotion of exclusive and immediate breast feeding for 6 months – Promotion of complementary child feeding and diversification of foods – Nutrition counselling
Nutrition screening	<ul style="list-style-type: none"> – Routine nutritional screening with MUAC and look for oedema and referral to health centre/ selective feeding centre ; – NB No routine wt/ht monitoring or road to health charts; road to health charts replaced by EPI cards.
Nutrition – micronutrient supplements	<ul style="list-style-type: none"> – Vitamin A – 6 – 12months 100,000 iu; then 200,000 iu every 6 months until 5 years with 6 month child health campaigns or MMN (see below) – Iron/folate supplements for anaemia OR multiple micronutrients, 1 RNI⁴ each day children aged 6 – 59 months or 2 RNI each day if fortified foods being used
Community based management of acute malnutrition (CMAM) – outpatient feeding	<ul style="list-style-type: none"> – May assist at OTP therapeutic outreach clinic in PHU; moderate acute malnutrition may be managed with supplementary feeding if resources and programming allow
Targeted supplementary feeding	<ul style="list-style-type: none"> – Context specific, in liaison with MOH, WFP, UNICEF and agencies for malnourished children aged 6 – 59 months,
Skin disease	<ul style="list-style-type: none"> – treatment of scabies – treatment of fungal disease – treatment of dermatitis/eczema – hygiene promotion
Eye disease	<ul style="list-style-type: none"> – treatment of conjunctivitis – hygiene promotion
Reduction of anaemia	<ul style="list-style-type: none"> – malaria control and treatment – deworming with 6 monthly campaigns with antihelminthics – iron and folate supplements at age specific doses – referral of children with pallor to HC

4

RNI = Recommended nutrient intake

Core programme 3 - Communicable disease surveillance and control, including water and environmental sanitation promotion

Sub-programme	Interventions
Surveillance of notifiable diseases	<ul style="list-style-type: none"> – Weekly reporting (and daily during outbreaks) of suspicious cases by health facility as per WHO protocol and HMIS; feedback to facilities
Control of epidemics	<ul style="list-style-type: none"> – Standard response to epidemics as per WHO and MSF guidelines for measles, meningitis, dysentery, cholera and viral haemorrhagic fever appropriate to PHU level – rapid referral of cases. – Epidemic preparedness – training, communication, public awareness campaigns – Assist Targeted vaccination for certain diseases
Malaria control	<ul style="list-style-type: none"> – National protocols – IPT, ITN, RDT, ACT; ITN distribution strategy; IEC
Long term improvements in water supplies	<ul style="list-style-type: none"> – CHC with CHW advocate for and plan with municipal/district authorities and international partners for improved water supplies, testing and supervision; improved water supplies for health facilities – CHC with CHW advocate for and plan with municipal/district authorities, and international partners for on-going water chlorination
Long term improvements in sanitation	<ul style="list-style-type: none"> – CHC with CHW advocate for and plan with municipal/district authorities, international partners for latrine construction for schools and public places, and creation of sanitation promotion centres for promoting safe waste disposal; sanitation for health facilities including safe disposal of medical waste
Emergency Watsan response for cholera epidemics	<ul style="list-style-type: none"> – chlorination of local water supplies – free home distribution of water treatment sachets – IEC campaign
Routine Watsan promotion for families	<ul style="list-style-type: none"> – Promotion of hand washing with soap and safe disposal of faeces and safe water chain – Family latrines – Home water treatment (via social marketing) – PHAST (participatory hygiene and sanitation transformation) & CHAP (community hygiene awareness promotion) techniques to promote: <ul style="list-style-type: none"> ▪ Personal hygiene ▪ Safe disposal of human excreta hygiene ▪ Environmental and domestic hygiene ▪ Water hygiene; separation of drinking and washing water; home water treatment and storage ▪ Food hygiene ▪ Garbage disposal – And promotes improved sanitation facilities & home treatment of diarrhoea with ORS – 6 month child health days – promote hand washing, household water treatment, diarrhoea treatment and safe faeces disposal
Routine Watsan promotion for populations	<ul style="list-style-type: none"> – Hygiene promotion with mass media and campaigns – Improved water supplies – Distribution of water treatment sachets – Social marketing of home water treatment (strategy being developed)

Core programme 4 – First aid and care of critically ill and injured

Sub-programme	Interventions
Life saving support	– Immediate referral
Minor & major wound management	– referral to appropriate level
Promotion of accident prevention	– promotion of reduction of road accidents – promotion of reduction of burns

Core programme 5 – Treatment of common illness

Sub-programme	Interventions
Skin disease	– treatment of scabies, eczema
Mouth and throat	– treatment of candidiasis, tonsillitis in children – Promotion of oral hygiene – <i>Referral of dental problems</i>
Gastro-intestinal system	– Treatment of upper abdo pain with antacids/ referral
Ear disease	– Otitis media in children
Eye disease	– treatment of acute conjunctivitis – Immediate referral of acute painful red eye and all eye trauma
Respiratory disease	– Management of ARI (upper and lower airway) in children
Urinary tract disease	– Treatment of simple UTI
Musculo-skeletal problems	– Analgesia and referral

Core programme 6 – HIV, STIs and TB

Sub-programme	Interventions
Promotion of HIV prevention and decreasing stigma	– Promotion at family & community level – Promotion to decrease stigma – Prevention services through behaviour change communication, display and dissemination of educational materials, provision of condoms, post-test clubs and community mobilization
Prevention of sexual spread of HIV and STIs	– Promotion of use of condoms – Abstinence, faithfulness education
Prevention of blood borne spread of HIV	– Sharps disposal; – Single needle & syringe use policy
Promotion of early detection and diagnosis of TB	– mass education and community education on signs and symptoms of TB
TB prevention	– see EPI programme and HIV prevention

CHWs carry out the following investigations:

RDT

Urine dipstick – nitrite and leucocyte

EPHS Programmes at health centre level

Core Programmes 1 to 6 are all applied at health centre in their entirety except for a few interventions that are marked in italics that only take place at referral health centre/ district hospital level. Additional programmes 7 to 10 are not operational at health centre level.

Laboratory assistants carry out the following investigations:

RDT

Hb

Stool microscopy

Urine dipstick – glucose, protein (two parameter)

- nitrites, leucocytes (two parameter or multiparameter)

water quality testing – Hydrogen sulphite for contaminants and bacteriology for choliforms

EPHS Programmes at referral health centres

Core Programmes 1 to 6 and **additional programmes 7 to 10** are all applied in their entirety including those interventions that are marked in italics that only take place at referral health centre/ district hospitals or regional hospitals.

Laboratory technicians carry out the following investigations:

RDT

Hb

Stool microscopy

Urine dipstick – glucose, protein (two parameter)

- nitrites, leucocytes (two parameter or multiparameter)

water quality testing – Hydrogen sulphite for contaminants and bacteriology for choliforms

Blood transfusion - ABO group and rhesus, VDRL, Hepatitis B & C, HIV

HIV test in VCT – to expand from 21 sites to all districts.

Carrie blair transport medium for suspected cholera stools

Pregnancy test

Ziehl Neelson for AFBs

Blood sugar

EPHS Programmes at regional hospitals and national hospital

Core Programmes 1 to 6 and **additional programmes 7 to 10** are all applied in their entirety including those interventions that are marked in italics that only take place at referral health centre/ district hospitals or regional hospitals.

In addition, there are further interventions that take place in hospital departments as follows:

Hospital departments

Child health

Management of severe malaria, sepsis, asthma, convulsion, pneumonia, dehydration, coma and acute malnutrition with medical complications.

Intensive care of newborns – phototherapy for jaundice, kangaroo care for low birth weight and premature babies.

Obstetrics

Referral EmONC as well as emergency EmONC.

Gynaecology

Tubal ligation

Ectopic pregnancy

Fistula, perineal tears and repair of FGM induced damage either by resident gynaecologist or visiting specialist.

Tubal pathology

Ovarian cysts (indications protocol)
Hysterectomy (indications protocol)
(Colposcopy)
Care of victims of sexual assault (PEP⁵ and care)

Mental health

1 nurse with 3 month training in psychiatry with outreach at 3 sites in each region (hospital or referral health centre), treating psychosis, depression, anxiety and panic, post-traumatic stress, and addiction counselling.

Mental health ward with psychiatrist, mental health nurses, and social workers.

Surgery

Incision & drainage

Emergency room admission care and CPR

Trauma from road traffic accident

Fractures – POP

Elective orthopaedic care and rehabilitation of physical disability. Orthopaedic departments have the potential of also establishing rehabilitation workshops at referral health centres for people with physical disability, who are referred to the hospital when they need surgery.

Weapon wounds

Amputation (indications protocol, including preserving limbs)

Hernia – elective and emergency

Peritonitis (indications protocol)

Haemorrhoids (indications protocol), Anal stenosis and atresia

Tubal ligation and vasectomy

Male Circumcision

Management of severe burns

Dental care

Extraction, filling, de-scaling

Ophthalmology

Management of the acute eye

Eye surgery – cataracts, lid surgery, trauma, glaucoma

Correction of refraction errors

Internal medicine

Management of life threatening complications - severe malaria, asthma, convulsion, pneumonia, dehydration, coma

TB

TB diagnostic and treatment programme

HIV

VCT – see guidelines⁶

PMTCT – expand from current 8 sites to all 17 regions, with 2 sites in regions with higher populations

ART

Support for PLWHA

Comprehensive HIV/AIDS care⁷:

1. Develop treatment plans for PLWAs
2. Initiate ART
3. Follow-up patients on ART with both clinical and laboratory monitoring; CD4 in lab or samples frozen and sent to CD4 reference site.
4. Manage severe HIV associated conditions (e.g. severe pneumonia, severe dehydration, Kaposi's sarcoma etc) as well as treatment of OI
5. Manage severe side effects and toxicity related to antiretroviral agents
6. Evaluate for treatment failure
7. Supervise clinical teams at first level facilities
8. Offer in-patient care
9. Prevention services through behaviour change communication, display and dissemination of information and educational materials, provision of condoms, post-test clubs, and community mobilization.
10. Conduct drug resistance surveillance and operational research

⁵ Reference guidelines for the clinical management of HIV/AIDS among Somali populations – UNDP 2006 p 112

⁶ Reference guidelines for the clinical management of HIV/AIDS among Somali populations – UNDP 2006 p. 14 – Recommendations for counselling – steps for pre-test counselling and testing.

⁷ Reference guidelines for the clinical management of HIV/AIDS among Somali populations – UNDP 2006

11. Home based kits for all people with critical illness on ARV programme, nutritional surveillance, and supplementary and therapeutic feeding.

Epidemic preparedness

Isolation ward
100 litre stock of perfusion and basic supplies
Protocols for epidemic response – meningitis, cholera, measles, dysentery, viral haemorrhagic fever

Handling of dead bodies

Mortuary
Protocol for safe handling of cadaver

Diagnostic services

Laboratory tests

Free laboratory tests:
RDT & blood slide
Hb
Stool microscopy
Urine dipstick – glucose, protein (two parameter) - nitrites, leucocytes (two parameter or multiparameter)
water quality testing – Hydrogen sulphite for contaminants and bacteriology for choliforms
Blood transfusion - ABO group and rhesus, VDRL,

Hepatitis B & C, HIV
HIV test in VCT & PMTCT
Carrie blair transport medium for suspected cholera stools
Pregnancy test
Ziehl Neelson for AFBs
Ground glass microscopy for vibrio
Vaginal and urethral smear
Sputum – microscopy – gram and ZN
Brucella test
Kala Azar test
Blood sugar
Sickling test

Fee-paying laboratory tests:

Hepatic enzymes
WCC
Red cell count
ESR
Rheumatoid factor
Urine microscopy
Pregnancy test

Fee-paying investigations

x-ray
ultrasound
ECG

Annex IV

REGIONAL HEALTH OFFICE

The Regional Health System

The health sector is organised on the basis of a Regional Health System (RHS)⁸. The RHS includes a full range of health care services, from health promotion activities at community level to sub-specialty services at hospitals. All health systems support components – drug supply, transportation, maintenance and repair of infrastructure and equipment – operate regionally. Information flow is regionally focused.

The Regional Health Office (RHO) is the “hub” of the Regional Health System. RHO staff provide policy, planning, financial, supervisory, personnel and technical support services for all health facilities in a region. The RHO will maintain a Regional Medical Stores (RMS) for drug supply stocking and distribution to health facilities within the region.

Regional (Health) Supervisory Team

The RHS is directed and managed by a Regional Supervisory Team (RTS),⁹ consisting of key professional/technical staff based at the office. The RTS is directly responsible for implementing the health policies of the national Ministries of Health, and provides policy and

planning inputs to the national level. A critical role of the RST is to conduct routine supervision visits to all health facilities throughout the region, to ensure that quality of care and continuity of care are priorities at all sites. The roles and responsibilities of the RST are calibrated specifically to fulfill these objectives.

Functional Roles of the Regional Supervisory Team

The composition of the Regional Supervisory Team may vary from one region to another, depending on the availability of qualified staff. In some cases, a single individual may be responsible for fulfilling more than one functional role. Key functions of the regional supervisory team are listed below:

Clinical supervision (Regional Medical Officer)

The RMO provides clinical oversight to health care providers at primary and secondary levels. Most of the RMO’s supervisory support is focused on the Referral Health Centres and Health Centres, but periodic oversight is also provided to health workers at the Primary Health Units, in concert with the PHC Coordinator. The RMO may serve as Regional CEO in the absence of an appropriate administrative officer.

8 Eventually, the RHS will decentralise into District Health Systems.

9 Alternatively, “Regional Health Management Team” (RHMT)

Supervision of primary health care activities (PHC Coordinator)

The PHC Coordinator ensures that primary care throughout the region is comprehensive, appropriate, adequate and of high quality. A key focus of the PHC Coordinator is monthly supervision and support of all Primary Health Units, Health Centres and Referral Health Centres. The PHC Coordinator also meets with Community Health Promoters to ensure that their activities are compliant with MoH policies and practices.

EPI Coordination (EPI Coordinator, a registered nurse)

The EPI Coordinator ensures that immunisation programmes are adequately supported technically and administratively. The EPI Coordinator is responsible for maintaining the cold chain, and for organising and monitoring immunisation days and mop-up campaigns.

Nutrition Coordination (Nutrition Coordinator, a registered nurse)

The Nutrition Coordinator ensures that outpatient therapeutic nutrition programmes and micronutrient supplementation are in place at all facilities, and ensures that referral procedures for inpatient therapeutic nutrition are functional at Referral Health Centres and Regional Hospitals. The coordinator also helps organise the six monthly accelerate child survival days.

Financing (Regional Finance Officer, preferably trained in accountancy)

The Regional Finance Officer is responsible for ensuring that all health facilities are adequately funded and that disruptions in regional financial flows are minimised.

Health information (HMIS Officer/Health Information Manager, computer literate, preferably with some basic training in epidemiology and statistics)

The regional HMIS Officer is responsible for compiling and analysing all summary reports sent from all of the health facilities in the district. Key tasks include maintaining and updating HMIS analysis software, developing feedback reports for regional health facilities, and providing analytic inputs into RHO management meetings (i.e., the HMIS Officer must be a member of the Regional Supervisory/Management Team). The HMIS officer also regularly supervises HMIS activity at health facility level (HMIS work at PHUs and HCs will be a collateral duty).

Transportation (Transportation Officer/ Manager, preferably with financial management skills)

The regional Transportation Manager is responsible for all vehicular transport operations throughout the region, including allocation, operation and maintenance of RHS vehicles.

Drug supply management (Regional Medical Stores Manager, preferably a Pharmacy Assistant, with financial management skills)

The Stores Manager plays a key role in the RHS, responsible for managing drug and medical supply and distribution for all regional health facilities, and for providing oversight on contractual arrangements with private sector distribution agents. The Stores Manager also provides supervision, oversight and training for facility staff responsible for maintaining adequate drug stocks at facility level.

Training curriculum for Community Health Workers (CHW)

- certified in a 6 month training course that encompassing the following training areas:

The criteria for CHW selection for training include:

- completed primary education and to have literacy and numeracy skills

Suggested key topics for training	Length of time (1 week = 5 days)
Disease, health, communities, environment & the health system - core training	2 weeks
Community mobilisation, behavioural change communication – core training	1 week
Water & environmental sanitation – PHAST & CHAP training & water treatment	1 week 3 days
Management of key childhood illness (fever, malaria, ARI, diarrhoea, anaemia & worms)	2 weeks
Other illnesses diagnosed and treated in the PHU – includes simple UTI, thrush, oral candidiasis, conjunctivitis, mild gastritis, mild allergy, simple skin diseases	1 week
First aid and simple dressings; accident risk reduction	3 days
Mental health and counselling skills	1 week
Physical disability	2 days
Understanding HIV & HIV & STI prevention; TB detection	3 days
Communicable disease surveillance & reporting	1 week
Immunisation	1 week
Maternal health and family planning (CHWs trained to give condoms & pills to clients after initial health check at health centre); reduction of gender violence	1 week
Nutrition promotion, screening and community based rehabilitation; micronutrients; promotion of appropriate food for young children	1 week
Reduction of harmful substance abuse (tobacco, qat, alcohol)	3 days
Data collection, HMIS	4 days
Management of the primary health unit	3 days
Referral systems	2 days

Essential drug management	1 week
Working with community health committees	2 days
Raising resources (human, financial and material) in the community for health, water and sanitation improvements, and building, upkeep & maintenance of PHU	2 days
Community & household mapping	3 days
Disaster preparedness, mitigation and response	3 days
Practical placements	5 weeks
Assessments – oral and written tests, practical procedures tests. Qualifying certificate Code of conduct for CHWs	2 days
TOTAL TRAINING	25 Weeks

Optional: **Short trainings for Community Health Promoters (CHP)**

Some regions may want to pioneer the use of Community Health Promoters who would be volunteers with a role to promote nutrition, clean water and sanitation, hygiene and health seeking behaviour. They could also be used for the six-monthly Child Health Days, and for nutritional screening with MUAC. But the priority for Phase I & II is to establish the role of the CHW. CHPs would work in the communities, but their point of contact is the PHU. CHPs would not be employed within the health system, and hence not salaried, but could be given incentives for certain activities.

Watsan – PHAST & CHAP training	1 week
Nutrition promotion & screening with MUAC	1 week
FP promotion	2 days
Promotion of health seeking behaviour	1 week
Oral assessments and T-shirts awarded	

Community midwife

Community midwives have been trained for at least one year in a certified nursing institute, and have previously completed primary education and have at least years two years of secondary education, with proven numeracy and literacy skills.

Auxillary nurse

Auxillary nurses have been trained for at least one year in a certified nursing institute, and have previously completed primary education and have at least years two years of secondary education, with proven numeracy and literacy skills.

Registered nurse

Registered nurse have had twelve plus years of primary and secondary education and have completed a certified nurse training course at an accredited nursing institution.

Registered midwife

Registered midwives have had twelve plus years of primary and secondary education and have completed a certified nurse training course at an accredited nursing institution.

Anaesthetic assistants

Anaesthetic assistants are nurses or health officers who have undergone six months of post-basic training in the use of simple and safe anaesthesia.

Health/ Clinical officer training

Health/clinical officers are registered nurses or midwives who have completed 18 months on certified post-basic training.

Emergency obstetrics surgery diploma

(9 months)

An emergency obstetrics surgery diploma will be developed for training experienced general doctors, clinical officers and midwives, to do comprehensive emergency obstetrics and gynaecology such as caesarean sections, D&Cs, MVA, ectopic pregnancies, tubal ligation, as well as interventions for APH, PPH and retained placentas. The completed training enables them to carry out comprehensive EmONC at referral health centre level and hospitals.

ICRC training in trauma surgery

(6 months)

ICRC currently training general doctors in Central South Zone for 1 year in trauma surgery.

Mental health nurse diploma

3 months post-basic WHO training

Training for mental health needs to be standardised, with post-basic qualification for nurses to become mental health nurses. This could combine WHO training and GRT/UNA training (Bosaso hospital).

Assistant laboratory training

(WHO training)

Laboratory technician training

Pharmacist training.

Drug prescribing training

Training for health staff in essential drug list and treatment guidelines applicable at each level:

- 1 primary health unit level
- 2 health centre level
- 3 referral health centre level
- 4 hospital level
- 5 specialist drugs (eg TB, ARV, cardiac drugs, chronic disease management, tropical infections, anaesthesia)

Key training references include WHO Somali treatment guidelines, MSF Essential drugs and MSF Treatment Guidelines, WHO TB and Leprosy treatment guidelines, Global Fund Somali HIV guidelines, WHO Mental health manual, WHO Anaesthesia manuals and chronic disease manuals.

SUPERVISION TOOLS FOR MEASURING HEALTH FACILITY QUALITY

User guide for supervision checklist

Introduction

Supervision is a vital tool to improve performance of the health sector. These checklists will help to improve the quality of the work of health staff in facilities.

The supervision provides on-the-job training. These checklists are NOT designed to capture data – that is the role of the HMIS forms. Supervision is primarily a qualitative process. The only data that is collected relates to the criteria of the EPHS, and will be used to assess if a health facility should be supported, and at what level it should be classified – as a Primary Health Unit, a Health Centre, a Referral Health Centre or a Hospital. One key concept embedded in the EPHS was the idea of supporting fewer quality health facilities in which there are measured quality indicators. The EPHS has a list of criteria for facilities, by which a facility is assessed and then a decision made as to:

1. will it be supported?
2. if supported, will it be categorised as a PHU, HC, RHC or Hospital according to its capacity and outputs?
3. does it meet Phase I or Phase II criteria?
4. a supported facility should get:

- I regular deliveries of drugs, supplies and equipment from UNICEF
- II will produce monthly HMIS data
- III appropriate support from communities, MOH, regional authorities and municipalities
- IV support from WHO and UNFPA
may get support from an NGO contracted to improve health service performance.
- VI Regular supervision by the MOH Regional Health Management Team

A database is then kept with facilities that meet EPHS Phase I or Phase II criteria.

An integrated supervisory system will not replace the need to a technical EPI officer to conduct an in-depth supervision of the EPI facilities, or a nutrition officer to do a detailed supervision of an OTP. But particularly at PHU & HC level it is not conceivable that separate people will be supervising different aspects of health service delivery. Much combined supervision can be done by the Primary Health Care Coordinators proposed in the EPHS, or by the Regional Medical Officer. These forms are also designed to be used by UN and NGO health programme managers.

The key component of the supervision will be the Supervision Checklist, which has been produced to *enhance performance management* via:

- Assessing the facility against the EPHS list of inclusion criteria
- Quality indicators
- Promoting discussion around key managerial tasks, with comments given on how to improve performance
- Promoting on-the-job training via appreciation of current performance, with targets set for future supervisions.

The following comments should be used in conjunction with the supervision checklists. The commentary is for appreciating quality of services. As the comments are made with health staff, ways of improving performance are discussed. Thus the supervision is as much a tool to empower health staff to understand their work better and to become more motivated to improve. They will help set their own targets.

During the supervision, the supervisor will need:

- 1 The supervision checklist for either hospital, health centre or primary health unit.
- 2 This user guide
- 3 The Score card for phased evaluation of health facilities
- 4 A summary of health programmes from the EPHS, as appropriate to each level
- 5 A calculator

Some of the information will be gathered BEFORE the supervision visit from the Regional Health Office or the NGO office. Where there is a small star - * - this means that this is one of the criteria for evaluation, and this information will be filled into the Score Card. Where the facility has fulfilled the relevant criteria, a circle is put around the X or number on the score card. If it has not fulfilled the criteria, the X is struck out with a horizontal line. The number of circled Xs and numbers are added together. This figure is put over the total available points and the percentage calculated. To be included, the facility needs to gain 80% of correct points for its level.

1/ Essential information

The boxes are filled in as instructed. Don't forget to fill in the date at the top and each supervisor needs to sign the form, as well as the senior staff member in charge on the day of the supervision.

2/ Physical infrastructure

The commentary on the state of the buildings and cleanliness is important. This will give health staff encouragement to ensure better appearance of rooms, and remind the supervision team that some of the buildings may need renovating. Without an equipped delivery suite, the health facility can not be authorised to conduct normal deliveries. In a similar way, a facility cannot be authorised for Comprehensive Emergency Obstetric and Neonatal Care unless it has an operating theatre equipped for caesarean section with facilities for safe blood transfusion and an operating light.

They also need to have a set number of beds for post-natal women, and the list of criteria gives the number for each level, as well as the 6 beds for 24 hour observation that a health centre should have. All facilities needs clean water, and latrines.

3/ Personnel

3.1 Health facility staff The list of criteria sets the minimum number of each grade of staff that the facility must have to qualify at a particular level. For primary health units this is only 1 CHW in phase I but the CHW must be qualified (minimum 2 months training, ideally 6 months) and supervised!.

3.2 Staff management tools It is for facilities to designate a staff member in charge of the facility. This can be a hospital director, or senior midwife or nurse for health centres. A hospital also needs a Director of Nursing (or matron) and a qualified administrator. The human resource management plan needs to be made by the person in charge. It will include the points listed in the checklist such as personnel files and staff annual appraisals, opening hours and staff presence and duty rosters.

4/ Health system management components

4.1 Drug management This section mainly looks at stock outs as a guide to management of pharmacies. The supervisors can make more detailed observation in the commentary sections. They should identify drugs that are not authorised at that level.

4.2 Finance The EPHS guide on financing is consulted. It consists of the following table against which financing targets are assessed:

Financing contributions from 5 primary sources

Financing mechanism	Phase I			Phase II		
	Primary health unit	Health centre/ RHC	Hospital	Primary health unit	Health centre/ RHC	Hospital
Community Health Fund	5%	5%	10%	15%	15%	15%
User fees	0	0	20%	0	0	20%
Ministries of Health regular budgets	5%	5%	10%	15%	15%	20%
Municipal/ district contributions	5%	5%	10%	5%	5%	10%
Donor financing of agencies contracted to provide health services	85%	85%	50%	65%	65%	35%

This table reminds central government, municipal authorities and communities that health care needs to be funded from different levels, and that their contributions need to increase. At the same time it abolishes user fees for the primary health care package for children under five and pregnant and lactating women, and for family planning and the treatment of sexually transmitted diseases. Caesarian sections and all obstetric care is also free of charge to the client. During the supervision, ways of further diversifying the funding base of the facility are discussed.

4.3 HMIS No HMIS data is collected, but this is a way of appreciating how up to date the facility is on completing the forms, and the quality of the data that is sent. The supervisors check if any of this data is presented visually through graphs or tables that are put up on the walls.

5/ Health programme activities

5.1 Summary of health programmes

Health centres should have all components of all 6 core programmes operational. Primary health units have some components of 5 core programmes, but do not do maternal health care apart from advice on nutrition, breast feeding, family planning. Referral health centres and hospitals have all 6 core programmes and 4 additional programmes running, with higher expectations for Phase II. All facilities should have a

map of the catchment area. Staff can be encouraged to make one if there is not one already in the facility.

5.2 EPI The EPI targets can be collected from the regional health office before the supervision visit and verified and discussed during the visit. The cold chain is checked.

5.3 Nutrition There is no routine weight and height surveillance carried out as part of the EPHS , but all PHUs will be screening under-fives and pregnant women with mid-upper arm circumference bands. Any children then referred to the out-patient therapeutic programme then have weights and heights measured. In-patient care of malnourished children with complications only happens in some hospitals.

5.4 Communicable disease surveillance and infection control The supervisors ensure that the

facility is reporting communicable diseases in line with WHO Early Warning systems and that there is both communication in place for rapidly notifying authorities of an outbreak and some capacity in the facility to make an initial response. Basic hygiene standards need to be in place.

5.5 Out-patient care The numbers of consultations should have increased by 10% in the past year. This indicates both increased satisfaction with the facility and increased health seeking behaviour/ increased accessibility. It might also indicate that either the health care is free or more affordable.

5.6 In-patient care It is important that the staff understand the Case Fatality Rate as this is a very important indicator of quality of care. Supervisors can ask the staff about clients who died in the facility and discuss if there were ways that care could have been improved to avoid the death. Patients should have files, with detailed admissions including history and examination. There should be 3 separate forms – the medical admissions forms with daily clinical observations, the nursing record, including the vital signs chart and a separate prescription chart. There should be at least one clinical entry a day, monitoring the patient's progress and vital signs should be filled in.

5.7 Operating theatre This section is left open for supervisors to observe the theatre and point out good and bad practices. The operation register is consulted and discussed, and any intra-operative deaths looked into.

5.8 Maternity The quality of care in the maternity is appreciated. Are women with complications being rapidly identified and treated appropriately. Is there a referral system in place for women in late pregnancy and during labour? How are women being encouraged to deliver in the facility? The maternal and perinatal mortality rates are very important and a good indicator of the quality of care in the facility. It is important to check if the facility has an ambu bag for neonatal

resuscitation and that it is working and staff know how to use it.

5.9 Laboratory This is left open for observations, and depends on the knowledge of the supervisor as to how much they can observe and comment, but more time can be spent here if they are experienced.

6/ Community participation

This section looks at the involvement on communities via the community health committee or health board. It also looks how the staff go out into the community. The supervisors also interview beneficiaries (clients/ patients and other community members that they may want to see).

7/ Summary of key observations from supervision

The key observations are a summary of what has been assessed with the most important points highlighted that need to change. The supervisors agree with the staff and community committee on action points that can be implemented by them in the weeks following the supervision.

Score card

The score card is based on key criteria from the EPHS. A facility needs to score at least 80% to qualify for that level of facility in either phase I or phase II. On the score card are either numbers or "X"s. The supervision team will put a circle around an X if the criteria is satisfied, or will put a line – through it if it is not. The number of circles is then counted, which gives the score that the facility has gained. This number is then divided by the total available for that facility for that phase using a calculator, and this is multiplied by 100 to give the percentage. The RMO, UN or NGO team can then build up a league table of scores and percentages for the facilities that they supervise, and can review this every 6 months to appreciate the progress that is being made. A simple written database is kept at regional and central level, as well as with NGOs and UN organisations, and with EPHS managers.

Score card for phased evaluation of health facilities

Health facility	Primary health unit		Health centre		Referral health centre		Hospital	
Phase	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
2/ Physical infrastructure	<i>For scoring, the correct facility and phase is chosen. A circle is put around every X or number that is correct. The number of circles is added up.</i>							
Equipped delivery suite			X	X	X	X	X	X
Post-natal beds			4	8	8	14	12	20
Number of admission beds/ 24 observation beds				6	8	14	40	60
Operating theatre equipped for C/S					X	X	X	X
Safe blood						X	X	X
Functioning vaccine fridge			X	X	X	X		
Functioning weight and height measures			X	X	X	X	X	X
Autoclave/ sterilizer		X	X	X	X	X	X	X
Communication (mobile or HF)		X	X	X	X	X	X	X
Light(operating & maternity)			X	X	X	X	X	X
clean water supply		X	X	X	X	X	X	X
Water filter		X		X		X		X
Well maintained latrines	X	X	X	X	X	X	X	X
patient wash area				X	X	X	X	X
hand washing facilities for staff	X	X	X	X	X	X	X	X
Incinerator				X	X	X	X	X
3/ Staff								
3.1 Minimum staff numbers								
CHW	1	2						
MW			1	2	2	3	3	4
Nurse			1	2	2	4	6	10
Doctor						1	2	4
Professional qualified for C/S					1	1	2	3
Anaesthetic assistant					1	1	2	3
Lab assistant				1	1	2	2	3
Lab technician					1	2	2	3

Qualified hospital administrator						X		X
3.2 management tools								
CHW trained > 2 months	X	X						
Staff management plan written				X		X	X	X
Staff contracts?		X		X		X	X	X
Staff have files		X		X	X	X	X	X
Health facility	Primary health unit		Health centre		Referral health centre		Hospital	
Phase	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
weekly staff meetings held		X	X	X	X	X	X	X
staff have annual appraisals		X		X		X		X
All staff have job descriptions		X		X	X	X	X	X
Are there routine consultations in the afternoons?		X		X	X	X	X	
All staff have daily attendance sheets		X	X	X	X	X	X	X
Is there a 24 hour staff duty roster in place?				X	X	X	X	X
4 integrated supervisions per year with feedback	X		X		X		X	
8 integrated supervisions per year with feedback		X		X		X		X
Referral form used for referrals			X	X	X	X	X	X
Transport system for referrals organised		X		X	X	X	X	X
Does the facility received feedback on referrals?				X		X		X
4/ Health system support components								
Drugs – stock-out indicators monitored		X		X	X	X	X	X

Is funding diversified from different sources including community, local and central government?		X		X		X		X
Is there a yearly financial audit?								X
Are at least 10% of resources from a community fund?		X		X		X		X
HMIS monthly forms returned		X	X	X	X	X	X	X
5/ Health programme activities	Primary health unit		Health centre		Referral health centre		Hospital	
80% of programme interventions operational in line with EPHS 6 core & 4 additional programmes	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
1. Maternal, reproductive & newborn health	X	X	X	X	X	X	X	X
2. Child health	X	X	X	X	X	X	X	X
3. Communicable disease surveillance & control & watsan	X	X	X	X	X	X		X
4. First Aid and care of critically injured			X	X	X	X	X	X
5. Treatment of common illness	X	X	X	X	X	X	X	X
6.HIV, STIs & TB		X		X	X	X	X	X
7. Chronic disease management						X	X	X
8. Mental health & mental disability						X	X	X
9. Dental health						X	X	X
10.Eye health						X	X	X
The following EPI data can be obtained from regional office before supervision visit:								
EPI – DPT I to III drop out rate < 40%			X		X			

EPI – DPT I to III drop out rate < 20%				X		X		
Measles coverage rate > 40%			X		X			
Measles coverage rate > 60%				X		X		
Does the facility participate in child health days?	X	X	X	X				
Is outreach EPI conducted in PHU?		X						
> 40% of under-fives screened with MUAC	X		X		X			
> 60% of under-fives screened with MUAC		X		X		X		
OTP % fatality rate < 6%			X		X			
OTP % fatality rate < 3%				X		X		
Health facility	Primary health unit		Health centre		Referral health centre		Hospital	
Phase	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Stabilisation centre fatality rate < 10%							X	
Stabilisation centre fatality rate < 5%								X
Epidemic warning in place?	X	X	X	X	X	X	X	X
Good epidemic preparedness?		X		X	X	X	X	X
Utilisation – numbers of consultations increased by 10%?	X	X	X	X	X	X	X	X
Is the consultation register correctly filled?	X	X	X	X	X	X	X	X
Has the number of admissions increased by 10% in last year?						X	X	X
In-patient case fatality < 4% of admissions			X		X		X	
In-patient case fatality < 2% of admissions				X		X		X
Is there a patient file for each bed?						X	X	X

Is there medical admission form?					X	X	X	X
Is the medical admission complete?						X	X	X
Is there a nursing observation form with vital signs?						X	X	X
Is there a prescription form?						X	X	X
Is the inter-operative death rate < 3% in last 3 months?					X		X	
Is the inter-operative death rate < 1% in last 3 months?						X		X
Is there 24 hour post operative nursing care?						X	X	X
Have numbers of ANC increased by >10% in last year?						X	X	X
Proportion of deliveries referred > 5 %				X				
Proportion of C/S of deliveries > 5%						X	X	X
Health facility	Primary health unit		Health centre		Referral health centre		Hospital	
Phase	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Are partogrammes used for all women in labour?				X		X	X	X
Is there a working ambu bag for cases of neonatal asphyxia?								
Is the Apgar score measured at 1 & 10 minutes?				X		X	X	X
In-facility MMR < 700/100,000			X		X		X	
In-facility MMR < 400/100,000				X		X		X
In-facility perinatal MR < 50/1000			X		X		X	
In-facility perinatal MR < 40/1000				X		X		X

6/ Community participation								
6 community health meetings/ health board held per year	X		X		X		X	
10 community health meetings held per year		X		X		X		X
Are minutes kept of these meetings?		X		X		X	X	X
> 20% of committee are women	X		X		X		X	
> 40% committee are women		X		X		X		X
Is there any planning for improving water and sanitation in the community?	X	X	X	X	X	X	X	X
Health facility	Primary health unit		Health centre		Referral health centre		Hospital	
Phase	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Maximum points available	14	37	36	59	53	78	68	74
Add up total of points (1 point for every circled X or number)								
Total of points as percentage of maximum (must score minimum of 80%)								

Supervision checklist for referral health centres and hospitals

1/ Essential information

Date of supervision: ___/___/200__

Name of facility		Name of in-charge/ hospital director	
District		Supporting agency	
Region		GPS coordinates	
Hospital or RHC?			

Supervision Team

Name	Job Title/ organisation	Signature
Name of person in charge supervised and signature		

2/ Physical infrastructure

	Yes / No/ number	Commentary
Physical state of buildings		
State of cleanliness of wards/ rooms – good ,satisfactory or poor		
* Equipped delivery suite		
* Number of post-natal beds		
* Number of admission beds		
* Operating theatre equipped for caesarians		
* is safe blood transfusion available?		
* Functioning Fridge/ cold chain		
* Autoclave/ sterilizers in working order (in Theatre		
* Communication (mobile or HF)		
* operating Light (for operating and for maternity)		
Is there electricity/ generator/ solar power?		
- is there a water supply on site?		
- is filtered water available?		
- latrines/ flush toilets		
- patient shower area		
- hand washing facilities in every ward?		

- incinerator?		
Equipment inventory checked in last 6 months?		
24 hour system for security of staff, buildings and equipment?		
Other observations of physical infrastructure		

3/ Staff

3.1 Health facility staff

Staff grade	Numbers in facility	Numbers in facility
Nursing aides		X-ray technician
Auxillary nurse (qualified)		Pharmacist technician
Auxillary midwife		Pharmacist
* MW		Dental technician
* Nurse		Dentist
* Doctor		Ophthalmic technician
* Professional qualified for caesarian sections		Physiotherapist
*Anaesthetic assistant		*qualified Hospital administrator (at least degree level)
*Lab assistant		Social worker
*Lab technician		counsellor
What support staff are there?		Administrative clerks

3.2 Staff management tools

	Yes - No - %	Commentary
Is it clear who is in charge of facility? Do they understand their role? Do they have a job description?		
It there a clear director of nursing/matron? Do they understand their role? Do they have a job description?		
* is there a staff management plan written and used?		
Are staff classified correctly according to training diploma/ certificate?		
* do staff have written contracts?		
* do all staff have files?		
* are weekly staff meetings are held?		
* do all staff have annual appraisals?		

* do all staff have clear and detailed job descriptions?		
Are there clear opening hours? Are these long enough? Do they serve the community adequately?		
*are there routine consultations in the afternoon?		
Are ward rounds conducted every day?		
* do all staff fill in daily attendance sheets?		
Are qualified staff present in the afternoon, evening and at night?		
*Is there a 24 hour duty roster in place – permanent rota		
Are there staff performance indicators?		
Have staff had any training recently? What are the training needs? Is there continual professional development?		
* Number of supervision visits in last year by regional medical team. Is feedback given? Are action points written in the supervision book?		
* is a referral form filled in for referrals?		
Is there a transport system organized for referrals? What recommendations can be made?		
* does the facility receive feedback on referrals?		
Are treatment/ management guidelines available? (MOH/WHO national treatment guidelines, protocols, safe motherhood, IMCI, malaria, STIs, family planning etc)		

4/ Health system support components

4.1 Drug management

Is drug usage properly monitored		
* are drug stock-out indicators monitored correctly? Are there buffer stocks?		
Commentary on layout of pharmacy		
Any drugs in pharmacy inappropriate for level of facility, or not generic or essential?		
Are there vaccine stock outs?		
Are there plumpy nut stock outs?		

4.2 Finance

* Is income diversified from: 1. Community health fund 2. Municipality/ regional authority 3. MoH 4. Partner agencies 5. User fees 6. Private donors/ diaspora		
*Are at least 10% of resources from a community health fund?		
Commentary on sources of financing		
Commentary on financial management. Is there a yearly financial audit? Is the cash sheet in order?		

4.3 Health information

* Are HMIS forms completed and returned monthly?		
quality of filling in of HMIS forms – suggestions for improvements		
quality of care in facility as represented by HMIS information – targets for improvement		
Are graphs, charts or posters used made from HMIS data?		

5/ Health programme activities

5.1 Summary of health programmes

Are 80% of programme interventions operational compared with EPHS 6 core & 4 additional programmes:		
1. Maternal, reproductive & newborn health		
2. Child health		
3. Communicable disease surveillance & control & watsan		
4. First Aid and care of critically injured		
5. Treatment of common illness		
6. HIV, STIs & TB		
7 .-Chronic disease management		

8. Mental health & mental disability		
9. Dental health		
10. Eye health		
Is there a map of the catchment area of the hospital/ referral health centre?		

5.2 EPI

EPI – is there a clear outreach plan?		
Are updated monitoring charts on wall? Are annual coverage targets being met?		
Are EPI coverage reports completed correctly and sent on time via HMIS forms?		
* what is the DPT I to III drop out rate (DPT I measures access; DPT II measures quality/ utilization)		
* what is the measles coverage rate?		
What is the TT2 coverage rate		
Are all newborns vaccinated before leaving the maternity?		
Did the facility participate in the last Child Health Day including polio vaccination?		
EPI – is the cold chain maintained? (fridge temperature checked twice daily and temp remained between 2 & 8 degrees C and temp verified during supervision?)		

5.3 Nutrition

* what % of under-fives screened with MUAC (children aged 9 to 59 months are 17% of population)		
* OTP – what is the % fatality rate of children in OTP programme		
What is the OTP % cure rate		
In-patient therapeutic care in nutrition Stabilisation Centre- what is the % fatality rate of children		

Comment on ht/wt monitoring for children on OTP	
Comment on quality of care of malnourished children	

5.4 Communicable disease surveillance & infection control

*Is there an early warning system in place with weekly epidemiological reports?	
*Is there adequate epidemic preparedness?	
Is hand cleansing practice routinely between consultations?	
How is the quality of instrument sterilisation guaranteed?	
Observation: what are hygiene conditions like in the facility?	
Are there sharps boxes for the safe disposal of needles?	
Is malaria properly diagnosed with RDT?	
Is malaria properly treated with ACT?	
Is reporting on malaria cases in line with GF guidelines?	

5.5 Out-patient care

* Utilisation rates – has the total number of consultations increased by > 10% in the last year?	
*Is the out-patient register filled in with mention of history, examination, diagnosis, treatment and advice?	
Is the prescription appropriate to the diagnosis?	
Are too many drugs prescribed?	
Do the staff give health promotion advice during the consultation?	
Is family planning promoted during the consultation?	
Are out-patient health promotion sessions carried out? Where are they carried out?	
Is VCT available?	

5.6 In-patient care

*Has then number of admissions in last year increased by > 10%?		
* what is the case fatality rate of in-patients in the last 3 months?		
*Is there a patient file for each bed?		
*Is there a medical admission form in each file?		
*Does the medical admission include: a full history, a full physical examination, vital signs, differential diagnosis, treatment and daily observation?		
*Is there a form for nursing observation and vital signs chart in each file?		
*Is there a prescription chart in each file?		

5.7 Operating theatres

Does the operating theatre have all the necessary rooms?		
Is the operating theatre properly equipped? What does it lack?		
Are aseptic techniques used correctly?		
*What is the intraoperative death rate? (ie what % of patients died in the theatre of all operated cases?) is it < 1%		
*How is post-op care carried out? Is there a qualified nurse caring for the post-op patients for 24 hours after the operation?		

5.8 Maternities

*Has the number of women at the ANC increased by > 10% in the last year?		
*Has the number of women delivering in the facility increased by > 10% in the last year?		
Is the ANC register filled in properly?		
Is the birth register filled in properly?		
*Is the % of deliveries by caesarian section > 5%?		
*Are partogrammes used for all women in labour?		
*Is there a working newborn ambu bag for cases of asphyxia?		

*Is the appgar score measured for each newborn baby?	
Are there blankets or clothes and hats for newborn babies on the maternity ward?	
*What is the mortality rate of women who give birth in the facility (expressed over 100,000 live births)? Is it < 500/ 100,000?	
*What is the perinatal mortality (still births + deaths of newborns in the first week of life) rate? Is it < 50/ 1000?	
Make at least 2 action points at the end of this form on how maternal and perinatal mortality can be decreased.	
Is there a maternity village for women to wait in before they deliver?	
Is exclusive breastfeeding promoted immediately after birth?	
Is the woman advised about family planning methods before she leaves the maternity?	

5.9 Laboratory

Commentary on quality of laboratory techniques and management	
Commentary on radiography & ultrasonography	

6/ Community participation

* number of meetings of Health Board in last year	
*are minutes kept of the meetings?	
*What % of board members are women?	
How does the committee participate in the hospital or referral health centre? Do staff meet with the Board?	
*Is there any planning for improving water and sanitation in the surrounding communities? How is hygiene and clean water and sanitation promoted in the community?	

How many home visits were carried out by health staff in the past month?	
Discussion with beneficiaries (supervision team discuss with clients, health board members, local authorities). Views of beneficiaries written here.	

7/ Summary of key observations from supervision (also written in health facility Supervision Book) and agreed action points

	Key observation	Agreed action point
1		
2		
3		
4		
5		
6		
7		
8		

Supervision checklist for health centres

1/ Essential information

Date of supervision: ___/___/200__

Name of facility		Name of in-charge	
District		Supporting agency	
Region		GPS coordinates	
Type of facility		Is there a map of the catchment area?	

Supervision Team

Name	Job Title/ organisation	Signature
Name of person in charge supervised and signature		

2/ Physical infrastructure

	Yes / No/ number	Commentary
Physical state of buildings		
Cleanliness of wards/ rooms		
* Equipped delivery suite		
* Number of post-natal beds		
* Number of admission/ 24 observation beds		
* Functioning Fridge/ cold chain		
* Autoclave/ sterilizers in working order		
* Communication (mobile or HF)		
* spot light for maternity		
Water and Sanitation		
- water supply on site?		
- is filtered water available?		
- latrines/ flush toilets		
- patient shower area		
- hand washing facilities in every ward?		
- incinerator?		
Equipment inventory checked in last 6 months?		
24 hour system for security of staff, buildings and equipment?		
Other observations of physical infrastructure		

3/ Personnel

3.1 Health facility staff

Staff grade	Numbers in facility
Nursing aides	
Auxillary nurses (qualified)	
Community midwife	
* MW	
* Nurse	
*Lab assistant	
What support staff are there?	

3.2 Staff management tools

	Yes - No - %	Commentary
Is it clear who is in charge of facility? Do they understand their role? Do they have a job description?		
* is there a staff management plan written and used?		
Are personnel classified correctly according to training diploma/ certificate?		
Do staff have a written contract?		
* what % of personnel have files?		
* what % of monthly staff meetings are held?		
* what % of staff have annual appraisals?		
* what % staff have clear and detailed job descriptions?		
Are there clear opening hours? Are these long enough? Do they serve the community adequately?		
*are there routine consultations in the afternoon?		
Are ward rounds conducted every day?		
* what % staff fill in daily attendance sheets?		
*Is there a 24 hour duty roster in place for emergencies?		
Are there staff performance indicators?		

Have staff had any training recently? What are the training needs? Is there continuous professional development?		
* number of supervision visits in last year by regional medical team. Is feedback given? Are action points written in the supervision book?		
* is a referral form filled in for referrals?		
Is there a transport system organized for referrals? What recommendations can be made?		
* does the facility receive feedback on referrals?		
Are treatment/ management guidelines available? (MOH/WHO national treatment guidelines, protocols, safe motherhood, IMCI, malaria, STIs, family planning etc)		

4/ Health system support components

4.1 Drug management

Is drug usage properly monitored		
* are drug stock-out indicators monitored correctly?		
Commentary on layout of pharmacy		
Any drugs in pharmacy inappropriate for level of facility, or not generic or essential?		
Are there vaccine stock outs?		
Are there plumpy nut stock outs?		

4.2 Finance

* Is income diversified from: <ol style="list-style-type: none"> 1. Community health fund 2. Municipality/ regional authority 3. MoH 4. Partner agencies 5. Private donors/ diaspora 		
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* % of resources are from a community health fund?		
Commentary on sources of financing		
Commentary on financial management		

4.3 Health information

* are HMIS forms completed and returned monthly?		
quality of filling in of HMIS forms – suggestions for improvements		
quality of care in facility as represented by HMIS information – targets for improvement		
Are graphs, charts or posters used made from HMIS data?		

5/ Health programme activities

5.1 Summary of health programmes

Are 80% of programme interventions operational compared with EPHS 6 core programmes:		
1. Maternal, reproductive & newborn health		
2. Child health		
3. Communicable disease surveillance & control & watsan		
4. First Aid and care of critically injured		
5. Treatment of common illness		
6. HIV, STIs & TB		
Is there a map of the catchment area of the health centre?		

5.2 EPI

EPI – is there a clear outreach plan? Are updated monitoring charts on wall? Are annual coverage targets being met?		
Are EPI coverage reports completed correctly and sent on time via HMIS forms?		

* what is the DPT I to III drop out rate (DPT I measures access; DPT II measures quality/ utilization)		
* what is the measles coverage rate?		
What is the TT2 coverage rate		
Are all newborns vaccinated before leaving the maternity?		
*Did the facility participate in the last Child Health Day & polio vaccination?		
EPI – is the cold chain maintained? (fridge temperature checked twice daily and temp remained between 2 & 8 degrees C and temp verified during supervision?)		

5.3 Nutrition

* what % of under-fives screened with MUAC (children aged 9 to 59 months are 17% of population)		
* OTP – what is the % fatality rate of children in OTP programme		
What is the OTP % cure rate		
Comment on ht/wt monitoring for children on OTP		
Comment on quality of care of malnourished children		

5.4 Communicable disease surveillance & infection control

Is there an early warning system in place with weekly epidemiological reports?		
Is there adequate epidemic preparedness?		
Is hand cleansing practice routinely between consultations?		
How is the quality of instrument sterilisation guaranteed?		
Observation: what are hygiene conditions like in the facility?		
Are there sharps boxes for the safe disposal of needles?		
Is malaria properly diagnosed with RDT?		
Is malaria properly treated with ACT?		

Is reporting on malaria cases in line with GF guidelines?	
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5.5 Out-patient care

* Utilisation rates – has the total number of consultations increased by > 10% in the last year?	
*Is the out-patient register filled in with mention of history, examination, diagnosis, treatment and advice?	
Is the prescription appropriate to the diagnosis?	
Are too many drugs prescribed?	
Do the staff give health promotion advice during the consultation?	
Is family planning promoted during the consultation?	
Are out-patient health promotion sessions carried out?	

5.6 In-patient care

Is there an observation form for patients observed for 24 hours?	
Are regular observations made on the delivery for women in the post-natal ward?	

5.7 Maternities

*Has the number of women at the ANC increased by > 10% in the last year?	
*Has the number of women delivering in the facility increased by > 10% in the last year?	
Is the ANC register filled in properly?	
Is the birth register filled in properly?	
*Is the % of women successfully referred > 5%?	
*Are partogrammes used for all women in labour?	
*Is there a working newborn ambubag for cases of asphyxia?	
*Is the appgar score measured for each newborn baby?	

Are there blankets or clothes and hats for newborn babies on the maternity ward?	
*What is the mortality rate of women who give birth in the facility (expressed over 100,000 live births)? Is it < 200/100,000?	
*What is the perinatal mortality (still births + deaths of newborns in the first week of life) rate? Is it < 50/1000?	
Make at least 2 action points at the end of this form on how maternal and perinatal mortality can be decreased.	
Is exclusive breastfeeding promoted immediately after birth?	
Is the woman advised about family planning methods before she leaves the maternity?	

5.8 Laboratory

Commentary on quality of laboratory techniques and management	
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6/ Community participation

* number of meetings of community health committee (CHC) in last year	
*are minutes kept of the meetings?	
*What % of committee members are women?	
How does the committee participate in the health centre? Do staff join in the CHC meetings?	
*Is there any planning for improving water and sanitation in the surrounding communities? How is hygiene and clean water and sanitation promoted in the community?	
*How many home visits were carried out by health staff in the past month?	
Discussion with beneficiaries (supervision team discuss with clients, committee members, local authorities). Views of beneficiaries written here.	

7/ Summary of key observations from supervision (also written in health facility Supervision Book) and agreed action points

	Key observation	Agreed action point
1		
2		
3		
4		
5		
6		
7		
8		

Supervision checklist for primary health units

1/ Essential information

Date of supervision: ___/___/200__

Name of facility		Name of in-charge	
District		Supporting agency	
Region		GPS coordinates	
Type of facility			

Supervision Team

Name	Job Title/ organisation	Signature
Name of person to be supervised and signature		

2/ Physical infrastructure

	Yes / No/ number	Commentary
Physical state of buildings		
Cleanliness of rooms		
* Autoclave in working order		

* Communication (mobile or HF)		
Water and Sanitation - water supply on site?		
- is filtered water available?		
- latrines		
- hand washing facilities?		
Equipment inventory checked in last 6 months?		
Is there security for buildings and equipment?		
Other observations of physical infrastructure		

3/ Staff

3.1 Health facility staff

Staff grade	Numbers in facility
*Community health worker	
Auxillary nurse	
nurse	

3.2 Staff management tools

	Yes - No - %	Commentary
*Has the CHW been trained for more than 2 months?		
Is it clear who is in charge of facility? Do they understand their role? Do they have a job description?		
Are personnel classified correctly according to training diploma/certificate?		
Do staff have a written contract?		
* do personnel have files in the PHU or kept at the health centre?		
* do staff have annual appraisals?		
*do staff have clear and detailed job descriptions?		
Are there clear opening hours? Are these long enough? Do they serve the community adequately?		
*are there routine consultations in the afternoon?		
* do the staff fill in daily attendance sheets?		
*are the staff available to be called for an emergency consultation?		

Are there staff performance indicators?		
Have staff had any training recently? What are the training needs?		
* number of supervision visits in last year by regional medical team. Is feedback received? Are action plans written in the supervision book?		
Is there a transport system organized for referrals by the community? What recommendations can be made?		
Are treatment/ management guidelines available? (CHW treatment guidelines, protocols, , IMCI, malaria, family planning etc)		

4/ Health system support components

4.1 Drug management

Is drug usage properly monitored		
* are drug stock-out indicators monitored correctly?		
Commentary on layout of pharmacy		
Any drugs in pharmacy inappropriate for level of facility, or not generic or essential?		

4.2 Finance

* Is income diversified from: Community health fund <ul style="list-style-type: none"> 1. Municipality/ regional authority 2. MoH 3. Partner agencies 4. Private donors/ diaspora 		
*% of resources are from a community health fund?		
Commentary on sources of financing		
Commentary on financial management		

4.3 Health information

* monthly HMIS forms completed and returned?		
quality of filling in of HMIS forms – suggestions for improvements		
quality of care in facility as represented by HMIS information – targets for improvement		
Are graphs, charts or posters used made from HMIS data?		

5/ Health programme activities

5.1 Summary of health programmes

Are 80% of programme interventions operational compared with EPHS 5 core programmes:		
1. Maternal, reproductive & newborn health		
2. Child health		
3. Communicable disease surveillance & control & watsan		
5. Treatment of common illness		
6. HIV, STIs & TB		
Is there a map of the catchment area of the PHU?		

5.2 EPI

*Did the facility participate in the last Child Health Day including polio vaccination?		
*Is outreach EPI carried out at the PHU from the health centre?		

5.3 Nutrition

* what % of under-fives screened with MUAC (children aged 9 to 59 months are 17% of population)		
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5.4 Communicable disease surveillance & infection control

*Is there a notification system in place for informing the nearest health centre of a possible epidemic disease?		
Is there any epidemic preparedness? (ORS stocks, antibiotics, plan)		

Is hand cleansing practice routinely between consultations?	
How is the quality of instrument sterilisation guaranteed?	
Observation: what are hygiene conditions like in the facility?	
Is malaria properly diagnosed with RDT?	
Is malaria properly treated with ACT?	
Is reporting on malaria cases in line with GF guidelines?	

5.5 Out-patient care

* Utilisation rates – has the total number of consultations increased by > 10% in the last year?	
*Is the out-patient register filled in with mention of history, diagnosis, treatment and advice?	
Is the prescription appropriate to the diagnosis?	
Are too many drugs prescribed?	
Do the staff give health promotion advice during the consultation?	
Is family planning promoted during the consultation?	
Are out-patient health promotion sessions carried out?	

6/ Community participation

* number of meetings of community health committee in last year	
*are minutes kept of the meetings?	
*What % of committee members are women?	
How does the committee participate in the PHU? Does the CHW join in the CHC meetings?	
*Is there any planning for improving water and sanitation in the surrounding communities? How is hygiene and clean water and sanitation promoted in the community?	

*How many home visits were carried out by health staff in the past month?		
Discussion with beneficiaries (supervision team discuss with clients, committee members, local authorities). Views of beneficiaries written here.		

7/ Summary of key observations from supervision (also written in health facility Supervision Book) and agreed action points

	Key observation	Agreed action point
1		
2		
3		
4		
5		
6		

Annex VII

A PRACTICAL GUIDE TO REFERRAL

The priority is not to create a complex list of medical problems needing referral, but an understanding of - the **principles** of referral **who** needs referral **when**, **how** and **to where**. **Priority 1** should be on ensuring women can deliver safely in adequate facilities. **Priority 2** is sick children. **Priority 3** is sick adults. Referral systems need to be kept simple and very clear. Key is in understanding principles of the health system and how referral relates to that, rather than in creating an over-elaborate, complex, unsustainable resource consuming referral system. More effort needs to be put into improving the quality of the health facilities rather than on complex referral networks. This guide suggests certain ideas that can be piloted by MOH and agencies. It does not advocate a country wide referral system. Referral will not be a linear process, will not work in as a “referral pyramid”, and will depend on the quality and reputation of health facilities available and will include private service providers. Someone with an emergency or serious illness would not go to a health centre but should go directly to facility equipped and staffed to deal with emergencies. CHWs in Primary Health Units **do not have the clinical competence** to “make referrals” but are involved in promoting care seeking behaviour, not do they have the competence to stabilise seriously ill clients. Health centre staff however should be trained to both stabilise clients and to “make referrals”.

Who needs referral?

Priority 1 - Pregnant women – need to be referred before they go into labour if there are any risk factors picked up at ANC. For this maternity waiting homes need to be built next to hospitals with Comprehensive Emergency Obstetric and Neonatal Care. For this, partners and MOH should concentrate primarily on ensuring that there are quality CEMONC facilities, and maternity homes and then a referral system.

Priority 1 - Women in labour with complications – the first priority is to ensure that MCHs become health centres with Basic Emergency Obstetric and Neonatal Care. They need partogrammes for monitoring labour, and resuscitation facilities for newborns. They need training to know when to refer. If CEMONC and BEMONC facilities are not in place then referral is pointless.

Priority 2 - Sick children – this includes children with high fever who cannot be managed in the health centre, or dehydrated children who have already received ORS, or unconscious children. They should receive some life saving care in the health centre.

Priority 3 - Sick adults – includes adults with high fever, dehydration, acute medical and surgical emergency and trauma cases. Many of these can be stabilised and receive initial treatment in the health centre (but not the health post) before transfer.

When do they need referral?

Pregnant women who are likely to experience complications in labour, or who have complications of pregnancy like pre-eclampsia need to be near facilities with CEMONC. Referral health centres and hospitals need simple maternity waiting homes where women can wait for 1 – 3 weeks before the expected delivery date, or where they can be closely monitored. In this case, the priority is not on transport or communication, but on the physical place for women to wait, and some kind of provision (food or cash) that enables them to wait away from their homes and for transport.

Women in labour with complications need IMMEDIATE referral. This is ideally in reliable vehicles.

Children with serious illness need stabilisation and IMMEDIATE referral.

Adults with medical or surgical emergencies and **victims of trauma** need stabilisation and IMMEDIATE referral.

How can they be referred? – referral mechanisms at different levels.

From home (village or town home) to health post or health centre

A person coming from their home or community is **not being referred**. They are being facilitated to seek care. The MOH and agencies will not be able to sustain a complex referral transport system. CHWs or TBAs do not have the competence to make referral decisions, but can be involved in advocating that clients go to health centres or hospitals. In the future CHWs may have more competence to refer but this assumes: 1/ that they have been trained for several months (including in IMCI) and 2/ they are given incentives and work set hours in PHUs/ communities. The EPHS does not promote home deliveries conducted by TBAs, but rather facility based deliveries by qualified midwives or auxiliary midwives. The following are suggested as possible alternative actions of MOH/ agencies: Cash payments/ vouchers to certain categories (see

Priority 1,2 & 3) of people needing referral to enable them to pay for commercial transport

Support via community health committees for transport – eg provision of a donkey cart (but community maintain the donkeys), fuel or cash to enable use of commercial vehicles or Revolving Referral Fund that clients pay back into to ensure sustainability.

TBAs could receive a simple incentive (eg bar of soap, chicken, token cash payment) for encouraging a woman in late pregnancy or labour to go to a health centre with BEMONC facilities to deliver. She might also accompany the woman. This would need piloting. There may not be mobile network coverage in small villages. It is unlikely that agencies will have the resources to provide communication means to every village. If however there is a network, small inputs could be given to community health committees so that they can communicate to health centres or hospitals that a person is coming to the facility for care.

The client seeking care will not necessarily go to a health centre, but may choose to go to a hospital directly, especially if the hospital is nearer. Community mobilisation techniques will help people to understand the kind of health facility they need for different problems. Health facilities need to establish reputations based on the quality of care that they provide.

From health centre to hospital

NGOs that support health centres and/ or hospitals are well placed to enable a communication and transport scheme for referral between health centres and hospitals/ RHCs. The following are key components: Communication – mobile phones if there is network (with some financial input) or VHF radios if permitted by the authorities.

Transport – an agency provides vehicle that picks up clients in response to a request. Either this is provided free or clients are means tested to contribute. Or an agency meets some of the costs of the use of private vehicles. The former is needed in remote rural areas where there is no commercial transport infrastructure, the latter in towns or more populated areas. The priority here is on the speed and safety of the transport

and an effective communication system, and not on sophisticated medical equipment inside vehicles.

From IDP site to hospital

This is similar to from health centre to hospitals, with NGOs making key initiatives.

Community mobilisation and referral

Any referral scheme needs to be combined with a community mobilisation scheme (Behaviour Change and Communication) that helps people understand the importance of seeking care early, especially in serious disease. Promoting early health seeking behaviour should be an integral part of CHW and nurse training.

Key components of referral

Communication Existing communication networks are built on – especially mobile phones where there is a network. Small financial inputs/ reimbursements may be needed such as phone cards or occasionally mobile phones.

Transport The priority is NOT on providing expensive highly equipped ambulances that are difficult to sustain. The priority is on improving the transport between home and health centre and between health centre and hospital/ RHC. Existing commercial transport networks should be used where possible.

Finance The emphasis must be on small cash inputs and sustainability. Where possible communities should contribute and revolving funds can be piloted. The NGO should not primarily be responsible for creating the referral network, but communities, regional authorities, municipal authorities and MOH and national authorities. NGOs should concentrate on inputs that promote simplicity, sustainability, and ownership. Voucher schemes may be piloted instead of cash payments. MSF run a workable voucher scheme in Central Southern Zone, although inputs are high. Other successful models can also be copied. The client will be involved in the decision of which health facility they are going, and may chose a health centre, or a hospital or a private facility. Health professionals should help clients in making that decision based on the quality of the facilities that they are available.

The 2 way referral form A simple form is needed that documents: the diagnosis; how the patient presented; any treatment given; the reason for the referral. A second part of the form can be filled in and sent back to the referring facility so that they have feedback on the outcome. Key information on the form is entered into a referral register in both referring and receiving health facilities to permit audit of referrals.

LIST OF ESSENTIAL DRUGS FOR HOSPITALS AND REFERRAL HEALTH CENTRES (MODIFIED FROM WHO SOMALI STANDARD TREATMENT GUIDELINES 2006)

NB the asterisk symbol *, is used against drugs that require specialist training in their use.

ORAL DRUGS Drug name and dose	Referral health centre	Hospital
Acetazolamide tablets, 250mg		X*
Acetylsalicylic acid tablet, 300 mg	X	X
Activated charcoal tablets, 250mg	X*	X*
Aciclovir tablet, 200mg		X
Albendazole tablet, 400mg	X	X
Aluminium hydroxide tablet, 500 mg	X	X
Aminophylline tablet, 100 mg	X	X
Amitryptilline tablet, 25 mg		X*
Amoxicillin tablet, 250 mg	X	X
Amoxicillin powder for oral suspension, 125mg/5ml	X	X
Artesunate combination treatment	X	X
Ascorbic acid tablet, 50 mg	X	X
Atenolol tablet 40 mg	X	X
Beclometasone inhaler, 100 microgram/dose		X
Cefixime 200mg	X	X
Chloramphenicol capsule, 250 mg	X	X
Chlorpheniramine tablets, 4 mg	X	X
Chlorpromazine tablet, 100 mg	X	X
Ciprofloxacin capsule 500mg		X
Clofazimine capsule, 100 mg (leprosy)		X*
Cloxacillin capsule, 500 mg	X	X
Codeine phosphate tablets 30mg	X	X
Dapsone tablet, 100 mg (leprosy)		X*
Diethylcarbamazine tablet, 50 mg (filariasis)		X*
Digoxin tablet, 0.25 mg		X*
Doxycycline tablet, 100 mg	X	X
Enalapril tablet, 2.5mg & 20mg		X*
Erythromycin tablet, 250 mg	X	X
Ethambutol tablet, 400 mg (tuberculosis)	X	X*

Ethinylestradiol + Levonorgestrel tablet 30 mcg + 150 mcg 21 tablet pack	X	X
Ethinylestradiol + Levonorgestrel tablet 30 mcg + 150 mcg 28 tablet pack (7 inactive tablets)	X	X
Ethinylestradiol + Norethisterone 30mcg + 1 mg 21 tablet pack	X	X
Ethinylestradiol + Norethisterone 30mcg + 1 mg 28 tablet pack (7 inactive tablets)	X	X
Ferrous salt + folic acid, 200mg ferrous sulphate tablet + 0.40 mg folic acid	X	X
Fluconazole capsule, 50mg		X
Fluoxetine tablets, 20mg		X*
Folic acid tablet, 5 mg	X	X
Furosemide tablet, 40 mg		X
Glibenclamide tablet, 5 mg		X*
Glyceryl Trinitrate sub-lingual tablet, 0.5mg		X*
Griseofulvin tablet, 125 mg		X
Haloperidol tablet, 5mg		X*
Hydrochlorothiazide tablet, 25 mg		X*
Hyoscine butylbromide tablet, 10 mg	X	X
Ibuprofen tablet, 400 mg	X	X
Isosorbide dinitrate		X*
Levonorgestrel 30 micrograms 28 tablet pack	X	X
Levonorgestrel 1500 micrograms, single dose	X	X
Mebendazole tabs, 100 mg, 500 mg	X	X
Methyldopa tablets, 250 mg	X	X
Metronidazole tablet, 250 mg	X	X
Misoprostol tablets, 200 micrograms	X*	X*
Morphine tablets 10mg		X
Multi-micronutrients RNI	X	X
Niclosamide tablet, 500 mg		X
Nicotinamide tablets, 50 mg		X
Nifedipine prolonged release tablet, 20mg		X*
Nitrofurantoin 100mg	X	X
Norethisterone 5mg		X*
Nystatin 100,000 IU/ml oral suspension	X	X
Nystatin 100,000 IU lozenge	X	X
Omeprazole capsules 10mg		X
Oral rehydration salt (ORS)	X	X
Paracetamol tablet, 100 mg	X	X
Paracetamol syrup 120mg/5ml	X	X
Paracetamol tablet, 500 mg	X	X
Pethidine tablet, 50 mg	X	X
Phenobarbital tablet, 50 mg	X	X*
Phenytoin tablet, 100mg		X*
Phenoxymethylpenicillin tablet, 250 mg	X	X

Praziquantel tablet, 600 mg	X	X
Prednisolone tablet, 5 mg		X*
Promethazine tablet, 25mg	X	X
Pyrazinamide tablet, 500 mg (tuberculosis)	X*	X*
Pyridoxine (vitamin B6) tablet, 250 mg		X
Quinine tablet, 300 mg	X	X
Ranitidine tablet, 150 mg (as hydrochloride)	X	X
Resomal ORS sachets for children with severe malnutrition and dehydration	X	X
Retinol (vitamin A) capsules, 100,000 & 200,000units	X	X
Retinol (vitamin A) capsules, 10,000 units	X	X
Rifampicin + isoniazid (150 mg/100 mg) Tabs (tuberculosis)	X*	X*
Rifampicin + isoniazid (150 mg/150 mg) Tabs (tuberculosis)	X*	X*
Rifampicin tablet, 300 mg		X
Rifater (Rifampicin 120 mg+ isoniazid 50 mg + pyrazinamide 300–400 mg) tablet	X*	X*
Salbutamol tablet, 4 mg	X	X
Salbutamol syrup 2mg (as sulfate)/ 5ml	X	X
Salbutamol inhaler, 100 micrograms/inhalation	X	X
Salbutamol nebuliser solution 5mg/ml	X	X
Spirolactone tablet, 25 mg		X
Sulfadoxine/pyrimethamine tablet (500 mg + 25 mg) for IPT for pregnant women	X	X
Sulfamethoxazole + trimethoprim tablet (100 mg + 20 mg)		X
Sulfamethoxazole + trimethoprim tablet (400 + 80 mg)		X
Thiamine (vitamin B1) hydrochloride, tab 50 mg		X
Zinc sulphate tablet 20mg	X	X
INJECTABLE DRUGS	Referral health centre	Hospital
Drug name and dose		
Aminophylline injection, 25 mg/ml	X*	X*
Ampicillin powder injection, 1 g vial	X	X
Atropine injection 1mg/ml	X*	X*
Benzylpenicillin injection, 600mg vial	X	X
Benzathine benzylpenicillin inj, 2.4 MIU, 5 ml	X	X
Ceftriaxone injection 1g		X*
Chloramphenicol powder injection, 1 g	X	X
Chlorpromazine injection, 25 mg/ml, 2 ml	X	X
Dexamethasone injection. 4 mg/ml, 1 ml		X*
Diazepam injection, 5 mg/ml, 2 ml	X*	X*

Epinephrine (adrenaline) inj, 1 mg/ml, 1 Ampoule	X*	X*
Ergometrine inj, 0.2mg/ml ampoule	X	X
Hyoscine butylbromide, injection 20 mg/ml, 1 ml		X
Furosemide injection, 10 mg/ml, 2 ml		X*
Gentamycin injection, 40 mg/ml, 2 ml	X	X
Hydralazine injection, 20 mg/ml amp	X*	X*
Hydrocortisone powder injection, 100 mg	X*	X*
Insulin medium-acting 100 IU/ml, 10 vials		X*
Insulin short-acting 100 IU/ml, 10 ml vials		X*
Ketamine injection, 50 mg/ml	X*	X*
Lidocaine 2%, 20ml		X*
Lidocaine 2%, 20 ml + adrenaline injection, 2.2 ml		X*
Lidocaine 1%, 20 ml		X*
Lidocaine 1%, 20 ml + adrenaline		X*
Lidocaine 5% in 7.5% glucose for spinal		X*
Magnesium sulfate injection, 500 mg/ml, in 10-ml ampoule	X*	X*
Medroxy Progesterone (DMPA) depot injection 150mg/ml 1ml vial	X	X
Metronidazole injection, 5 mg/ml, 100 ml	X	X
Oxytocin injection, 10 IU/ml, 1 ml	X*	X*
Pethidine injection, 50 mg/ml	X	X
Procaine benzylpenicillin 3 million IU + benzylpenicillin 1 million IU, vials	X	X
Promethazine injection, 25 mg/ml, 2 ml		X
Quinine injection, 300 mg/ml, 2 ml vial	X	X
Rabies vaccine		X*
Rabies immunoglobulin		X*
Ranitidine injection, injection, 25 mg/ml in 2-ml ampoule		X
Streptomycin 1 g vial (tuberculosis)	X*	X*
Tetanus immunoglobulin 250 IU/ml		X*
Tramadol injection 100mg		X
Water for injection 5ml	X	X
Water for injection 10ml	X	X
Perfusions	Referral health centre	Hospital
Drug name and dose		
Dextrose injection, 5%, 500 ml	X	X
Dextrose injection, 50%, 20 ml	X	X
Ringer lactate sol (bottle), 500 ml	X	X
Sodium chloride sol. 0.9%, 500 ml	X	X
Plasma expander 500ml	X	X*

Topical drugs Drug name and dose	Referral health centre	Hospital
Atropine 1% eye drops, 10mls		X*
Benzoic acid + salicylic acid, ointment, 6%+3%, 500 g	X	X
Benzyl benzoate lotion, 25%, 1 L	X	X
Calamine lotion 1.5%, 1L	X	X
Cetrimide + chlorhexidine (savlon) 1L	X	X
Chloramphenicol 5% ear drops, 10mls	X	X
Chlorhexidine 5% solution for dilution	X	X
Clotrimazole 2%, cream	X	X
Clotrimazole vaginal pessary, 500mg	X	X
Condoms	X	X
Dexamethasone ear drops, 5mls		X
Gentamicin 0.3% eye drops, 7.5ml		X*
Gentian violet 0.5% solution	X	X
Hydrocortisone acetate ointment, 1%, 15 g	X	X
IUD	X*	X*
IUD, Mirena	X*	X*
Lidocaine gel 2%, 30 g tube		X
Nystatin pessary, 100 000 IU (vaginal)	X	X
Polyvidone iodine solution, 10%, 5 L	X	X
Pilocarpine 2% eye drops, 5ml		X*
Silver sulfadiazine 1% topical cream, 500 g	X	X
Tetracycline 1% eye ointment, 5 g	X	X
Zinc oxide 10%	X	X

List of equipment for referral health centres and hospitals

FURNITURE & EQUIPMENT	Referral health centre	Hospital
Chairs	X	X
Tables	X	X
Examination beds	X	X
Beds	X	X
Shelves	X	X
Cupboards	X	X
Waste bins	X	X
Drip stands	X	X
Metal box for sharps & disposal	X	X
Bin for clinical waste	X	X
Office equipment	X	X
Reference library	X	X
Trays		

Tablet cutter	X	X
Tablet counter	X	X
Bed pans	X	X
Urinals	X	X
Monkey bar for bed		X
Dressing trolley	X	X
ITN	X	X
Splints	X	X
Stretcher	X	X
Trolleys	X	X
Hand washing bowls and trolleys	X	X
Mattresses	X	X
Sheets	X	X
Blankets	X	X
Draw sheets	X	X
Screens	X	X
Simple Dressing sets	X	X
Suture set	X	X
Autoclave, Steam, pressure	X	X
Electric sterilizer	X	X
Sterilisation drums	X	X
Suture pack	X	X
Timer, 60 minutes	X	X
Manual centrifuge	X	X
Electric centrifuge		X
Haematocrit centrifuge		X
Monocular light microscope	X	X
Binocular electric microscope		X
Balance, single pan, 31g		X
Heat source (bunsen etc)	X	X
Reagent and wash bottles	X	X
Volumetric flasks	X	X
ESR rack		X
Sahi haemoglobinometer	X	X
Haemocue photometer		X
Haemocue glucose tester	X	X
Water filter	X	
Fridge	X	X
ABO testing trays	X	X
Blood donor bed and equipment	X	X
Pipettes and stand	X	X

White cell counter		X
Timer	X	X
Spirit lamp	X	X
Slide box	X	X
Electronic adult scales	X	X
Infant scales, spring	X	X
Weighing trousers	X	X
Height meter	X	X
Height board for children	X	X
Stethoscope	X	X
Anaeroid sphygmo-manometer	X	X
Battery operated sphygmo-manometer		X
Torch	X	X
Otoscope	X	X
Ophthalmoscope		X
X-Ray machine		X
Ultrasound		X
X-Ray equipment		X
Voltage stabiliser		X
ECG unit, portable		X
Visual acuity testing chart	X	X
Tendon hammer	X	X
Respiration timer (for ARI)	X	X
Nebuliser, atomiser, electric		X
Nebuliser, manual, foot pump	X	
Delivery bed	X	X
Ambu bag for newborns	X	X
Guedel airway for newborns	X	X
Ambu bag for mothers	X	X
Geudel airway for mothers	X	X
Foot operated suction for mothers	X	X
Food operated suction for newborns	X	X
Mucus extractors for newborns	X	X
Baby scales	X	X
Neonatal resuscitation trolley	X	X
Fetoscope	X	X
Doppler battery fetoscope	X	X
Basin	X	X
Clock	X	X
Instrument table		

Bucket		
Midwife delivery set	X	X
Forceps jars	X	X
Vacuum extractor	X	X
Speculum	X	X
Baby cots	X	X
Draw sheets	X	X
screens	X	X
Operating table	X	X
Portable foot suction	X	X
Electric suction	X	X
Basin	X	X
Bowl stand	X	X
Clock	X	X
Instrument table, Mayo	X	X
Instrument table, large	X	X
Instrument trolley	X	X
Bucket	X	X
Patient trolley	X	X
X-Ray viewing box		X
Instrument cupboard	X	X
Spinal set		X
Inhalation anaesthesia trolley/ machine		X
Anaesthetic kit	X	X
Basic surgery set	X	X
Abdominal set		X
Hernia set	X	X
Orthopaedic set		X
Fixator set		X
Prostatectomy set		X
Urethral dilatation set		X
D & C set	X	X
MVA set	X	X
Obstetrical surgical set	X	X
Tubal ligation set	X	X
IUD set	X	X
Implant contraception set	X	X
Traction set		X
Dental extraction set		X
Dental equipment		X
Foreign body extraction set	X	X

Ophthalmology equipment		X
Neonate resuscitation trolley		X
Neonate ambubag, mask and airway	X	X
Adult ambubag, masks and airways	X	X
Drip stand	X	X
Crutches	X	X
Stools, adjustable	X	X
Oxygen concentrator set		X
Forceps jars	X	X
BCC kits	X	X
BCC equipment	X	X
Multimedia players	X	X
Fridge	X	X
Freezer	X	X
Cold box 25L	X	X
Cold box 7.2L	X	X
Spot light for maternity	X	X
Operating light	X	X
Examination light	X	X
Solar panel (if not electricity)	X	X
Battery (if no electricity)	X	X
Air conditioning (theatres and maternities)	X	X
Generator	X	X
Lantern, kerosene, non-pressure	X	X
Mobile phone (if net available)	X	X
HF radio (if no mobile net)	X	X
Antenna	X	X
Cable	X	X
Lightning conductor	X	X
Bicycle	X	
Motorbike	X	
Ambulance – 4x4	X	
FURNITURE FOR REGIONAL OFFICES		
Tables		

Chairs		
Desks		
Shelves		
Filing cabinets		
Office equipment		
Computer		
Printer		
Flash disk and external hard drive		
Electric installations		
Internet installations		
Photocopier		
Vehicle 4x4		
Motorbike		
Waste bins		
Reference library		
Communication equipment		

List of supplies for hospitals and referral health centres

SUPPLIES FOR WARDS AND OPDs	Referral health centre	Hospital
Electric thermometers	X	X
Tape measures	X	X
Tongue depressors	X	X
Safety pins	X	X
Single use Needles, 21, 22, 23, 25, guage	X	X
Single use Syringes, 2ml, 5ml, 10ml, 20ml	X	X
Scalpel blades	X	X
Sutures – non-absorbable	X	X
Foley catheters	X	X
Urethral catheters	X	X
Urine collecting bags	X	X
NG tubes	X	X
Gloves, latex, examination, small, medium, large	X	X
Drawsheet, plastic	X	X
Apron, plastic	X	X
Tourniquet, latex	X	X
IV catheters, 18, 20, 22, 24 guage	X	X
IV needle, scalp vein, 21 & 25 guage	X	X
IV giving sets	X	X
Safety box, used syringes & needles	X	X
Bandage elastic	X	X

Bandage guaze	X	X
Bandage tubular	X	X
Compress, guaze	X	X
Compress, paraffin		X
Guaze, roll	X	X
Tape, adhesive, perforated	X	X
Tape, adhesive	X	X
Indicator, TST, control spot for sterilization	X	X
Plastic envelopes (drug dispensing)	X	X
Bed sheets	X	X
Blankets	X	X
Pillows	X	X
Pillow cases	X	X
Mattresses	X	X
PVC Mattress covers	X	X
Examination screens	X	X
Cotton wool rolls	X	X
Plaster of Paris rolls	X	X
Soap	X	X
Towels	X	X
MUAC tapes	X	X
SUPPLIES FOR MATERNITIES		
Hand scrubbing brushes	X	X
Scalpel blades	X	X
Sutures – absorbable	X	X
Sutures – non-absorbable	X	X
Urethral catheters	X	X
Urine collecting bags	X	X
Gloves, latex, examination, small, medium, large	X	X
Surgical sterile gloves, 6.5, 7.5, 8.5	X	X
Gynaeco gloves, sterile 6.5, 7.5, 8.5	X	X
Drawsheet, plastic	X	X
Apron, plastic	X	X
Extractor, mucus	X	X
Shield, nipple, silicone	X	X
Tourniquet, latex	X	X
IV catheters, 18, 20, 22, 24 guage	X	X
IV needle, scalp vein, 21 & 25 guage	X	X
IV giving sets	X	X
Single use Needles, 21, 22, 23, 25 guage	X	X
Single use Syringes, 2ml, 5ml, 10ml, 20ml	X	X

Safety box, used syringes & needles	X	X
Bandage elastic	X	X
Bandage guaze	X	X
Bandage tubular	X	X
Compress, guaze	X	X
Tape, umbilical	X	X
Tape, adhesive, perforated	X	X
Tape, adhesive	X	X
Towels	X	X
SUPPLIES FOR OPERATING THEATRES		
Hand scrubbing brushes	X	X
Scalpel blades	X	X
Sutures – absorbable	X	X
Sutures – non-absorbable	X	X
Foley catheters	X	X
3 way foley catheters		X
Urethral catheters	X	X
Urine collecting bags	X	X
Gloves, latex, examination, small, medium, large	X	X
Surgical sterile gloves, 6.5, 7.5, 8.5	X	X
Gynaeco gloves, sterile 6.5, 7.5, 8.5	X	X
Apron, plastic	X	X
Tourniquet, latex	X	X
IV catheters, 18, 20, 22, 24 guage	X	X
IV needle, scalp vein, 21 & 25 guage	X	X
IV giving sets	X	X
Needle, spinal, 20 & 22 guage		X
Single use Needles, 21, 22, 23, 25 guage	X	X
Single use Syringes, 2ml, 5ml, 10ml, 20ml	X	X
Safety box, used syringes & needles	X	X
Bandage elastic	X	X
Bandage guaze	X	X
Bandage tubular	X	X
Compress, guaze	X	X
Compress, paraffin		X
Guaze, roll	X	X
Tape, adhesive, perforated	X	X
Tape, adhesive	X	X
Towels	X	X
Plaster of paris	X	X

Supplies for laboratories & diagnostics		
Laboratory reagents	X	X
Lancets	X	X
Slides	X	X
Cover slips	X	X
Neuber chamber		X
Urine dipstick – 2 parameter (protein, glucose)	X	X
Urine dipstick – 2 parameter (white cells/ nitrites)	X	X
HIV tests	X	X
VDRL tests	X	X
TPHA tests		X
RPR tests		X
Hep B tests	X	X
Hep C tests	X	X
ABO & Rh antigens	X	X
Blood bags with anticoagulant	X	X
Blood donor sets	X	X
Blood giving sets	X	X
RDT	X	X
Glucometer strips	X	X
Pregnancy tests	X	X
Carrie blair transport medium	X	X
Sample pots, urine, stool, blood	X	X
Widal tests		X
OptLeish test (Leishmaniasis)		X
Brucella test	X	X
Safety box, used syringes & needles	X	X
towels	X	X
Supplies for nutrition programmes		
RUTF ⁵	X	X
RUSF ⁶	X	X
F100	X	X
F75	X	X
Plastic cups 500ml	X	X
Feeding syringes, 50ml	X	X
NG tubes	X	X
NG Feeding tubes	X	X
Supplies for administration		
Patient registers	X	X
EPI & MUAC cards & plastic sachets	X	X
Stationary	X	X

Tally sheets	X	X
Supplies for supervisory health offices		
Office supplies		
Stationary		
Supplies for transport, cold chain, lighting, communications, maintenance		
Fuel		
Spare parts		
Mobile scratch cards		

Drug, supply and equipment kits for health centres and primary health units

NB. Primary health units only receive Kits A1 & 2; health centres receive Kits A1 and 2, and B1 & 2 and some will also receive Kit C. Referral health centres and hospitals will receive all kits. Other drugs, equipment and supplies will be needed by referral health centres and hospitals that are not supplies in kit form.

Primary Health Unit – Renewable Kit (A1)

Drug name and dose	PHU kit - renewables
Albendazole tablet, 400mg PAC-100 [Rx of worms]	4
Amoxicillin tablet, 250 mg PAC-1000 [Rx of pneumonia & otitis media]	3
Amoxicillin powder for oral suspension, 125mg/5ml BOT-100ml [pneumonia & OM]	45
Chlorphenamine tabs, 4 mg PAC-500 [Rx of itch and allergy]	1
Chlorphenamine syrup, 2mg/5ml 100ml [Rx of itch and allergy]	10
Ethinylestradiol + Levonorgestrel tablet 30 mcg + 150 mcg 28 tablet pack (7 inactive tablets) [combined oral contraceptive pill]	40
Ferrous salt + folic acid, 60mg ferrous sulphate tablet + 0.40 mg folic acid PAC 1000 [prevention of anaemia]	6
Ibuprofen cap 400mg PAC-1000 [Rx of fever, pain and inflammation]	1
Ibuprofen syrup 100mg/5ml 100ml [Rx of fever, pain and inflammation]	20
Levonorgestrel 30 micrograms 28 tablet pack [mini pill for lactating women and those who cannot take combined pill]	20
Magnesium trisilicate compound tabs 1000 [antacid for gastritis]	1
Multi-micronutrients tabs PAC-1000 [nutritional support for pregnant women]	6
Nitrofurantoin 100mg PAC-100 [Rx of UTI]	2
Nystatin 100,000 IU/ml oral suspension Bot-30mls [Rx of oral thrush in babies]	15
Oral rehydration salt (ORS) – NEW FORMULA (low osmolarity) 1L Car-1000	4
Paracetamol tablet, 100 mg PAC-1000 [Rx of pain & fever]	2
Paracetamol elixir 120mg/5ml bottle 60ml [Rx of pain & fever]	40
Paracetamol tablet, 500 mg PAC-1000 [Rx of pain & fever]	3

Phenoxymethylpenicillin tablet, 250 mg PAC-1000 [Rx of tonsillitis]	1
Retinol (vitamin A) capsules, 200,000units PAC-500	2
Retinol (vitamin A) capsules, 100,000 units PAC-500	1
Zinc sulphate tablet 20mg tabs (only if new ORS with zinc not available for kits) PAC-500 [Rx of diarrhoea]	4
TOPICAL USE	PHU kit - renewables
Drug name and dose	
Chlorhexidine 5% solution for dilution 100ml [disinfectant & antiseptic – for dilution]	2 bottles
Clotrimazole vaginal pessary, 500mg – PAC 20 [Rx of vaginal thrush]	2
Gentian violet pdr 25g [Rx of simple skin infection]	1
Hydrocortisone 1% cream TBE-30g [Rx of dermatitis]	15
Miconazole nitrate 2% TBE-30g [Rx of fungal skin problems]	10
Permethrin shampoo/ solution 1% 100ml [Rx of scabies and head lice]	30
Silver sulfadiazine 1% topical cream, 500 g [first aid Rx of burns]	1
Tetracycline 1% eye ointment, TBE 5 g [Rx of conjunctivitis]	50 TBE
Zinc oxide 10% cream 500g [Rx of nappy rash in babies and other rashes]	1
SUPPLIES	
item name and pack size	
Notebook A6, 100 pages PAC-10	1
Pad note, A4, plain, 100 pages	2
Pen, ball point, black box-10	1
Sachet tablet plastic PAC-500/ minigrip bags for medicines 8x6cm	4
Cotton wool, 500g roll	1
Gloves, exam, latex, medium disp Box-100	3
Compress, guaze 10x10cm PAC 100	2
Soap, toilet, bar 110g x 10	2
Bandage, elastic, stretch, roll 8x4cm roll	20
Tape, adhesive, Z.O. 2.5cmx5m	5
Tongue depressor, wooden, dispos BOX-500	1
Test strips, urinalysis, nitrite & leucocytes (for diagnosing infection). PAC-100	1
Urine sample collecting tube with cap – disposable PAC-50	1
Mid upper arm circumference bands – children PAC-20	1
Mid upper arm circumference bands – women PAC-20	1

Primary Health Unit – Equipment Kit (A2)

EQUIPMENT	PHU Kit - Equipment
Towel, huck, 430 x 500mm	2
Drawsheet plastic 90x180cm	4
Scissors, bandage, 200mm	1
Kidney dish, ss, 25cm	2
Tray, instru, 225x125x50mm	2
Thermometer, clinical, digital 32 -43 C PAC 5	1
Bottle, plastic, 250ml wash bottle	1

Bottle, plastic 1L, w/screw cap	1
Bowl, stainless steel, 180ml or 150ml	2
Drum, sterilizing 156mm diam	1
Water container, collapsible, 10L, 1.8m test or waterbag, foldable 20ltr, strong	2
Plastic jug, 1L graduated (for mixing ORS)	1
Plastic cups (for administering ORS)	4
Brush, hand, scrubbing, plastic	2
Surg instr dressing/SET Contains: 1 Forceps, dressing, standard, 16cm str 1 Forceps, artery, Pean, 14cm, str 1 Scissors, Deaver, 14cm, str 1 instrument box with lid, ss, 20x10x5cm	2
Cheatle forceps	1
Drum for cotton wool and gauze, 15cm x 15cm	2
Pressure cooker, 10 ltr	1
Wire basket + feet + handle for 10ltr pressure cooker	1
Timer, 60 minutes	1
Timer, diagnostic, 60 seconds (respiration for ARI)	2
Calculator, solar	1
Water filter (Berkefeld) 10ltr, SS3 with 3 candles	1
3 spare filters for Berkefeld water filter	1

Health Centre – Renewable kit (Kit B1)

ORAL DRUGS	
Drug name and dose	Health centre
Azithromycin 250mg PAC 34 [Rx of STIs only]	4
Cefixime tab 200mg PAC-100 [Rx of STIs only]	1
Erythromycin tablet, 250 mg tabs PAC-1000 [pneumonia in penicillin allergic individuals and broad spectrum antibiotic]	1
Ferrous Sulphate & Folic Acid (200m, 0.4mg) PAC-1000 [Rx of anaemia]	2
Methyldopa 500mg tabs PAC-500	1
Methylergometrine 0.125mg tabs/ PAC-100 [Rx of uterine bleeding and for third stage of labour]	1
Metronidazole tablet, 250 mg PAC-1000 [Rx of protozoal diarrhoea and pelvic inflammatory disease and gum infections]	1
Misoprostol tablet, 200 micrograms PAC-100	2
Phenobarbitone tabs PAC-500 (only for Rx of people with epilepsy)	2
Promethazine HCL 25mg PAC 500mg [Rx of nausea & antihist.]	1
Quinine tablet, 300 mg PAC-100 [2 nd line Rx of severe malaria]	1
Salbutamol tablet, 4 mg PAC-1000 [Rx of asthma]	1
Salbutamol syrup 2mg (as sulfate)/ 5ml BOT 150ml [Rx of asthma]	15
INJECTABLE DRUGS	Health centre
Drug name and dose	

Adrenaline/ Epinephrine 1mg/1ml 5 amps [Rx of anaphylaxis]	1
Benzathine penicillin, 2.4 MIU, powder for injection 20 vials [Rx of syphilis]	1
Benzylpenicillin pdr/inj 600mg vial BOX-50 [Rx of infection in neonates & meningitis]	1
Diazepam injection, 5 mg/ml, 2 ml BOX-20 amps [may be needed to be supplied separately due to import licensing requirements; Rx of convulsions]	1*
Gentamycin injection, 40 mg/ml, 2 ml BOX-50 [Rx of infection in neonates and severe pelvic inflammatory disease]	1
Hydralazine injection, 20 mg/ml amp BOX-5 [Rx of raised BP in pregnancy before transfert]	2
Hydrocortisone 100mg/1ml amp BOX-5 [Rx of anaphylaxis]	1
Magnesium sulfate injection, 500 mg/ml, in 10-ml ampoule BOX-10 [Rx of pre-eclampsia and eclamptic fits]	1*
Lidocaine HCL 1% 20ml for injection BOX-5 vials [anaesthetic for skin]	1
Medroxy Progesterone (DMPA) depot injection 150mg/ml 1ml vial [injectable contraception]	20
Metronidazole injection, 5 mg/ml, 100 ml [Rx of pelvic inflammatory disease]	30
Water for injection 5ml BOX-50 [for diluting injections]	2
Water for injection 10ml BOX-50	1
TOPICAL USE – drug name and dose	
Diazepam, rectal 5mg/ dose PAC-10 [Rx of febrile convulsions in children]	1
Calamine lotion 1.5%, 200ml [Rx of itch in chicken pox]	5
Chlorhexidine 5% solution for dilution 1000ml [disinfection and antisepsis – must be diluted]	1
Condoms – male Car-1000	2
Obstetric cream, with chlorhexidine 250ml [for vaginal examination during delivery]	2
Polyvidone iodine solution, 10%, 5 L [antisepsis of wounds]	1
SUPPLIES	Health centre
Apron with neckband, opaque, plastic, disp 100	1
Bandage elastic, guaze,	
Bassin, Kidney, 825ml ss	2
Blade, for scalpel No 4; size 22 PAC-100	1
Blanket	2
Catheter, foley, Ch 14, ball, 5-15ml sterile, disp	5
Catheter, urethral, female, Ch 12 disposable	10
Cannula, IV, short 18G, ster, disp	15
Cannula, IV, short 22G, ster, disp	15
Cannula, IV, short 24G, ster, disp	20
Extractor, mucus, 20ml ster, disp	20
Guaze-pad, sterile 12-Ply 10 x 10cm – PAC-5	20
Guaze roll	
Guaze, Vaseline PAC-10	20
Gloves, surgical, 6 ster, disp pair	100

Gloves, surgical, 7 ster, disp pair	200
Gloves, surgical, 8 ster, disp pair	50
Gloves, gynaeco, 7.5, ster, disp, pair	5
Gloves, examination Small, latex BOX-100	2
Gloves, examination Large, latex BOX-100	2
Goggles, protection plastic, 1 pair	2
Hemocue strips PAC-100	2
Needles, scalp vein 25 G	300
Needles scalp vein 21 G	100
Safety box for used syringes, needles 5ltr	2
Safety pin	
Scalpel blade	
Shield, nipple, silicone	
Suture – absorbable, DEC 3 (2/0) needle semi circle - cutting needle PAC – 12	2
Suture – absorbable, DEC 3 (3/0) needle semi circle – round needle PAC 12	2
Suture – non-absorbable, 2/0 needle semi-circle – cutting needle PAC 12	2
Syringe, dispos, 0.05ml w/needle 25G for BCG BOX-100	4
Syringe, dispos, 0.5ml w/needle 25G BOX-100	4
Syringe, dispos, 2ml w/needle 21G BOX-100	4
Syringe, dispos, 5ml, w/needle 21G BOX-100	1
Umbilical cord tie, 3mm, non-sterile, 100m	1
Tourniquet	
Test strips, urinalysis, protein PAC-100	2
Test strips, urinalysis, glucose PAC-100	2
Pregnancy tests hCG strip 2.5mm PAC-50 tests	1
Autoclave tape 18mm x 50m	1
TST (time, steam, temperature) control strips 100 strips	2
Urine collecting bag, 2000ml, with tap and valve 10 bags	1

Health Centre - Equipment kit (Kit B2)

EQUIPMENT (does not include mattresses, pillows and furniture, nor blankets or clothes for newborns)	Health Centre
Surgical instrument suture SET. Contains: 1 x Forceps, artery, Pean, 14cm str 1 x Forceps, tissue, standard, 14.5cm ½ teeth str 1 x forceps, artery, Halstead-Mosquito, 12.5cm, curved 1 x needle holder, Mayo-Hegar, 18cm str 1 x Scalpel handle, No 4 1 x Scissors, Deaver, 14cm, cvd, s/b 1 x probe, double ended, 145mm 1 x instrument box with lid, ss, 20x10x5cm	4
Surgical instrument delivery/ SET. Contains: 2 x forceps, artery, Pean, 14cm str 1 x scissors, Mayo, 14cm, cvd, b/b 1 x scissors, gyneco, 20cm, cvd, b/b 1 x instrument box with lid, ss, 20x10x5cm	4
Speculum, vaginal	1
Measuring tape 1.5m, flexible, vinyl-coated	5
Otoscope "mini Heine" with battery handle, S	1
Bulb for otoscope, "mini Heine" (XHL 056 2.5V)	2
Spare battery R6 alkaline, AA size	12
Torch	2
Batteries for torch Alkalkine	12
Hemocue machine	1
Ht measuring board	2
Baby scale, manual	1
Scale Satler type 25kgx100g, with 5 trowsers	2
Razor, with blade & handle, disposable PAC-100	1
Scale electronic, mother and child, 150kgx100g	1
Sheeting, plastic, clear, 90cmx180cm	2
Sphygmomanometer, anaeroid, simple	2
Stethoscope foetal, metal	2
Stethoscope littman type, with spares	2
Ambu bag, neonatal, with mask and guedel airway	1
Tourniquet, rubber 50x1.8cm	2
Pressure cooker 25L	1
Wire basket + feet + handle for 25ltr pressure cooker	1

Health Centre - Infusion kit (Kit C)

Infusion kit C1	
Ringer lactate infusion, 500 ml	60
Plasma expander 500ml	4
Infusion giving set with airinlet & needle	64

Annex IX

NATIONAL INDICATORS LIST

NATIONAL INDICATORS LIST Health service delivery & health status (biannually - annually)						
OUTPUT		National indicators	Collected at (EPHS level)			
			PHU	HC	RHC	H
1		N. OPD new patients (< 5 Vs > 5)	X	X	X	X
2		N. hospital discharges (IPD) (< 5 Vs > 5)			X	X
3		N. & % attended deliveries		X	X	X
4		N. & % natural Vs assisted deliveries -CS & instrumental			X	X
5		N & % DTP3 < 1	X	X	X	(X)
6		N & % vaccinated against measles < 1	X	X	X	(X)
7		N & % attending IInd ANC		X	X	X
8		N. & % ARV uptake new				X
9		Malaria confirmed cases treated	X	X	X	X
10		# LLITN distributed to pregnant & lactating mothers	?	?	?	?
11		# LLITN distributed to < 5	?	?	?	?
12		N. & TT2 coverage		X	X	X
13		N. & IPT2 coverage (only for CSZ)		X	X	X
14		FP current users by type (contraceptive prevalence rate)	X	X	X	X
15		TB Treatment Success Rate (Sm +ve/DOTS)			X	X
16		% < 5 screened with MUAC	X	X	X	(X)
OUTCOME		National indicators	PHU	HC	RHC	H
17		Top N disease	X	X	X	X
18		Inpatient case-fatality			X	X
19		ANC HIV prevalence @ facility			X	X
20		N. & % complicated deliveries			X	X
21		N. & % low brth weight		X	X	X
22		N. & % of Confirmed Malaria cases by lab & RDT (differentiate)	X	X	X	X
23		% moderate acute and severe acute malnourished	X	X	X	X
24		N. & % smear positive (Tb cases detected)			X	X
HMIS		National indicators	PHU	HC	RHC	H
25		N. & % of reports received per year (completeness)	X	X	X	X

