Federal Republic of Somalia

Ministry of Health

Essential Package of Health Services

Implementation Strategic Plan (EPHS-ISP)

June 2021

Content

Acronyms / Abbreviations

BEmONC	Basic Emergency Obstetric and Newborn Care
BOD	Burden of Disease
ANC	Antenatal Care
BSC	Balanced Scorecard
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
DALYs	Disability Adjusted Life-Years
DHMT	District Health Management Team
DHS	The District Health System
DHS	Demographic Health Survey
EPHS	Essential Package for Health Services
EPHS-ISP	Essential Package for Health Services Implementation Strategic Plan
FCDO	The UK Foreign, Commonwealth and Development Office
FHWs	Female Health Workers
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDPs	Internally Displaced People
JAR	Joint Annual Review
JHNP	Joint Health and Nutrition Programme
MoH	Ministry of Health
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Accounts
OOP	Out-of-Pocket Payment
RHMT	Regional Health Management Team
RHS	Regional Health System
RMET	Resource Mapping and Expenditure Tracking
S-HSCC	Somalia Health Sector Coordination Committee
SMC	Standard Monitoring Checklist
TB	Tuberculosis
WHO	World Health Organization

1. Background and Context

The population of Somalia is estimated at 15.6 million with an overall fertility rate of 6.4 children per woman. In Somalia, 45.6 per cent of the population are aged under 15, while 75 per cent are aged under 30[1]. It is estimated that there are nearly 2.6 million internally displaced persons in the country.[2]

Somalia's per capita expenditure on health is approximately US$13 per person per year, which significantly lags behind the average of US$204 in the Sub-Saharan African region. Government expenditure on health as a percentage of per capita health expenditure is 15 per cent. A significant proportion of health spending is financed by donors, constituting 38 per cent of per capita expenditure, a vast amount of which is off-treasury. The proportion of out-of-pocket payments (OOP) from per capita health spending in Somalia is very high at 46 per cent. It is estimated that on average, household OOP payments on healthcare are US$6 from a total of US$13 with significant variations between the richest and poorest quintiles, suggesting that healthcare services are being accessed by households according to their affordability, rather than their healthcare needs, leading to health inequities.[3] One of the significant obstacles preventing health services from being accessed in the country is cost.[4]

Health indicators in Somalia are consistently at the lower end of global rankings, where the average life expectancy is only around 56 years. Although there were improvements in certain health outcomes in the country between 2006 and 2019, others have experienced a decline after 2016 (Table 1). Service delivery indicators are low across the country; for example, skilled staff only attend approximately 32 per cent of births, only 21 per cent of babies are born in health institutions, antenatal care (ANC) visits are only provided to 31 per cent of pregnant women, and complete immunisation is only reached in 11 per cent of children. A large number of children younger than 5 are severely malnourished each year, and being stunted and wasted has been determined to be one of the key obstacles preventing children from growing and developing healthily (Table 2).

Health services are largely under-utilised, specifically those provided by the public sector, as estimations indicate that there are only 0.23 outpatient visits per individual each year and 0.81 hospital discharges per 100 individuals every year.[5]

The COVID-19 pandemic that has impacted the world is becoming a serious crisis in Somalia, worsened by the inadequate primary healthcare, inefficient surveillance and laboratory

[1] United Nations Population Fund, Population Estimation Survey, UNFPA, 2014.
[2] United Nations Office for Coordination of Humanitarian Affairs, Humanitarian Needs Overview 2019, UN-OCHA, 2019.
[3] Micah SR et al, (2020). Health sector spending and spending on HIV/AIDS, TB, and malaria, and development assistance for health: progress towards SDG3 3. *The Lancet*.
[4] EPHS, Somalia, 2021
[5] Somali Service availability and readiness assessment (SARA) Report, 2016.

capacity and the poor healthcare services. As of May 13th, 2021, a total of 14,486 cases have been confirmed in the country along with 753 deaths.[6]

The density of public health workers in Somalia is 0.43/1,000 persons, while it is 0.49/1,000 persons for those in the private sector. The joint health worker density is estimated to be (0.92), which is considerably under the threshold recommended by the World Health Organization (WHO) of 2.28 health workers per 1,000 individuals, indicating that human resource shortages are critical. The vast proportion of qualified medical personnel are located in urban regions, and more significant problems are being experienced in rural regions in terms of recruiting and retaining staff.

Table 1. Somalia's Key Health Indicators

Indicators	2006	2016	2019
Maternal mortality ratio per 100,000 live births	1040	865	692
Neonatal mortality rate per 1,000 live births	45.1	39	N/A
Infant mortality rate per 1,000 live births	103.3	80.4	N/A
Under-five mortality rate per 1,000 live births	170.5	128.4	N/A

Table 2. Somalia's Health Outcome Data

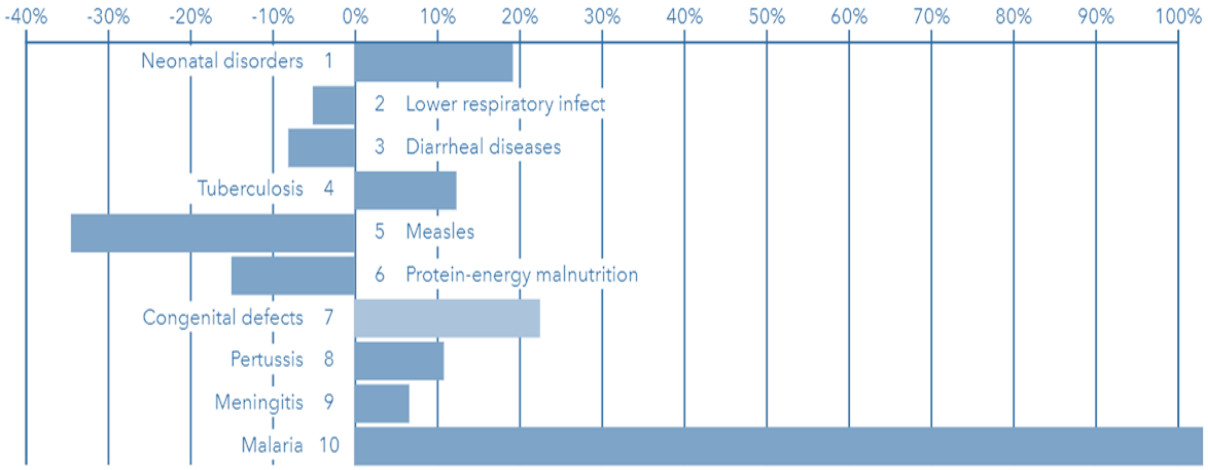
Indicator	Somalia Average	Puntland	Somaliland
Total fertility rate	6.9%	6.8%	5.7%
Stunting	27.8%	25.6%	20.7%
Births attended by skilled personnel	32%	33%	40%
Births at health facilities	21%	19%	33%
Pregnant women receiving at least one ANC visit	31%	26%	47%
Children fully immunised	11%	9%	13%

As shown in Figure 1, the 10 leading causes of disability and death in Somalia in 2019 were reported to be communicable disease, maternal, neonatal, child health and nutrition disorders.[7]

IHME Burden of Disease (BOD) data for Somalia (2019) indicate that the BOD in the country was 58,321 DALYs lost/100,000 population. Communicable disease, maternal and child health and nutrition comprise 44,122 DALYs/100,000 pop (68.8%), whereas non-communicable disease, psychological disorders, and substance abuse lead to 14,879 DALYs/ 100,000 pop (26.3%) and injuries cause 5,069 DALYs/ 100,000 pop (5%).

[6] https://covid19.who.int/region/emro/country/so
[7] See related publication: https://doi.org/10.1016/S0140-6736(20)30925-9

Figure 1. Somalia's top 10 causes of death and disability (DALYs) in 2019 and per cent change 2009–2019, all ages combined



Source: http://www.healthdata.org/somalia

2. The 2009 EPHS content and challenges

Somalia has some of the worst health indicators in the world, with women and children most affected. Even though there has been a small reduction in rates of maternal and child mortality over the last few years, continuing inequities have exposed children and mothers to diseases that could have been treated or avoided. The effects of a clan hierarchy, threats to livelihoods, gender, internal displacement, geography, and stresses arising from shocks and conflicts have also had a deleterious effect on communities in terms of a differential exposure to health promotion, access to services, and the ability of local health authorities to fulfil their duty of care.[8]

The 2009 EPHS began to be implemented in 2013 as result of collaboration between the Joint Health and Nutrition Programme (JHNP) and the Health Consortium for Somali People.[9]

Nevertheless, the delivery of EPHS 2009 was characterised by fragmentation and service duplication. It has not been possible to completely implement EPHS across all regions as a result of insufficiencies in terms of funding and qualified personnel, medical supply shortages and security issues. In the area of essential medicines, donors and NGOs operate their own supply chain system in a parallel manner, largely as a pre-packed kit system with little coordination and integration. Statistics published by the WHO in 2017 indicate that the EPHS partially covered around 47 of 89 districts (population of 5.7 million), which constitutes 41 per cent of the population. After the JHNP was closed when the financing provided by the UK Foreign, Commonwealth and Development Office (FCDO) ceased, the implementation of

[8] Ministry of Health and Human Services, Federal Government of Somalia. Second Phase Health Sector Strategic Plan 2017-2021

[9] JHNP was financed by DFID (currently FCDO), USAID, Finland, Australia, Switzerland, and Sweden; and managed by UNICEF with engagement from WHO and UNFPA.

EPHS began to lack organisation and experienced fragmentation, where only certain regions were covered and different package elements were funded by different partners. For instance, the diversified funding model within the EPHS has been followed to some extent in Puntland and Somaliland, supported by financial contributions from municipalities, health ministries, diaspora, and communities, while in areas affected by conflicts, virtually all funding comes from donors. To take Burao and Odweyne as an example, donors contributed 75% of funding, with the remainder coming from local and central government (14.5%), diaspora (10%), and the private sector (0.5%). Moreover, there were a number of partners offering humanitarian funding who have assisted health and nutrition programmes that did not fall under the remit of EPHS, despite incorporating its 6 core programmes, contributing to the serious fragmentation and unfavourable impact. One reason why such programmes were not deemed part of EPHS delivery might be to avoid having to comply with EPHS standards.[2] Moreover, governments have prioritised programmes for which they needed to meet the performance requirements of donors. The resulting changes in management and other forms of support have created vertical programmes and had a negative impact on routine services.

Coordination structures have lacked institutional capacity and support. Although they have been established with members from a range of sectors, of their roles, responsibilities, and modes of operation need to be assessed and institutionalized to enhance their effectiveness.

In terms of human resources, the vast number of divergent programmes has resulted in a high turnover of Somali staff, especially in southern states, forcing partners to raise salaries in order to retain them. Other than CHW training, pre-service training has not been financed by those implementing EPHS. Consequently, the majority of partners report that the current level of funding is not enough to ensure optimal EPHS staffing and levels of equipment. It has therefore not always been possible to guarantee the 24/7 levels of staffing needed for sufficient basic emergency obstetric and newborn care (BEmONC) and comprehensive emergency obstetric and newborn care (CEmONC).[10]

The Health Information System (HIS) has encountered substantial challenges in maintaining general levels of functioning, performance, effective institutional structures, and the capacity and processes required to facilitate informed levels of decision-making. Although variable, the Health Management Information System (HMIS) is currently operating in the Puntland MOH, Somaliland MOH, and Federal MOH. In the majority of districts, HMIS units are absent. The last national multiple indicator cluster survey in Somalia took place in 2006.[11]

In preference to establishing a referral system, the EPHS has promoted cost-sharing and innovation. Whilst some partners have established a comprehensive ambulance system across all levels, others have employed the cost-sharing model and developed innovations

[10] Ministry of Health and Human Services, Federal Government of Somalia. Second Phase Health Sector Strategic Plan 2017-2021

[11] Pearson N, Blaakman A. Implementation of Somali EPHS 2008 – 2019. 2020

such as donkey carts and Tuk-tuk ambulances run by the community. However, the system faces significant challenges such as unavailability of referral transportation means, bypassing primary care facilities by patients and seeking care directly at referral care hospitals and high cost of transportation.

Over the past twenty years, all levels of the private health sector have grown substantially, ranging from standard not-for-profit and private for-profit health facilities to the specialist care provided by vast chains of general hospitals. Although no data exists to accurately confirm how big the private sector is in Somalia, it is clearly visible in urban regions. This sector has enormous potential to establish a constructive mechanism through which to offer public health services.[2]

In conclusion, the main obstacles confronting the 2009 EPHS implementation in Somalia have included: (i) constrained institutional capacity and stewardship role of the MoH; (ii) inefficiencies, inadequacies, fragmentation and unsustainability in terms of funding; (iii) human resources deficiencies; (iv) insufficient and inequitable availability of services; (v) sub-standard service quality; (vi) lack of coordination and hormonisation among key stakeholders; and (vii) weak health information system and use of information for decision.[12],[13]

3. The 2020 EPHS

The EPHS was modified by the MoH in 2020, leading to the development of a comprehensive package of health services. Programmatic areas in the EPHS 2020 are:[14]

1. Access to care
    a. Continuity, care planning and coordination
    b. Emergency care
    c. Approach to common signs and symptoms
2. Reproductive, maternal and new-born health
    a. Maternal and new-born care
    b. Sexual and reproductive health
3. Life-course, growth and development
    a. Childhood and adolescence including nutrition
    b. Older age and adults
4. Non-communicable diseases
    a. Health promotion and disease prevention
    b. Cardiovascular and pulmonary diseases
    c. Diabetes

[12] Somali Ministry of Health, EPHS, 2020

[13] Nigel Pearson & Aaron Blaakman, February 2019, Development and Implementation of Somali EPHS 2008-2019

[14] Somali Ministry of Health, EPHS, 2020

d. Cancer
e. Mental health and substance use disorders
f. Injuries
g. Other NCDs

5. Communicable diseases
    a. Immunization
    b. Management of HIV, TB, Malaria and Hepatitis
    c. Neglected tropical diseases
    d. Respiratory infections
    e. Gastrointestinal infections
    f. Other infections
    g. Outbreak surveillance)
6. Rehabilitation

4. Expanding the coverage of EPHS and sequencing strategy

In the 2020 EPHS, although the MoH aimed to determine which services were required the most in terms of addressing the health needs of Somalis, it was also acknowledged that the MoH may not possess sufficient resources (internal and external) necessary for the simultaneous implementation of all components of EPHS. Along with the problem of limited funding, additional elements include the operational and technical capabilities of the MoH and NGOs, in addition to the staffing necessary for all components of the EPHS to be implemented.

Therefore, based on the existing limitations, using EPHS in a sequential and integrated manner can provide various benefits. The Package can assist with securing funding for a series of interventions aimed at priority disease regions as part of a broader network targeted at expanding health service coverage for the intended groups. Additionally, this strategy will help with protecting financing public health interventions that offer increased cost-effectiveness. Furthermore, it can enable vertical approaches to be potentially integrated into the EPHS. The outcomes of rational sequencing can inform long-term organisational transformation in critical aspects including the development of capacity. It is possible to address capacity limitations and organisational problems, particularly staff availability, in a gradual manner.

The MoH has performed a carefully examination of these aspects. Four criteria were utilised to enable the health services to be expanded in a sequential order to correspond with the complexity and pressure of population health requirements with evidence-based policies based on the underlying concern regarding how the limited resources could be optimised to enhance public health, deal with inequities, and provide sustainability, which are:

1. Services focused on addressing the primary factors causing morbidity and mortality in Somalia.
2. Cost-effective services that can be provided throughout the country.
3. The necessity to have equity in ensuring the provision of key health services to everyone, particularly those living in poverty.
4. Long-term sustainability of the services as the funding provided by donors begins to decrease going forward, considering the government's capacity to sustain a minimum level of health services.

Based on the sequencing criteria, the implementation of the EPHS will occur in two phases, where the first phase commences from XX/XX/2021. This phase may last between four and five years. Subsequent to the first implementation phase, further interventions can be incorporated in second phase based on (i) experiences gained from the preliminary implementation, (ii) full implementation of the first stage interventions, (iii) service coverage of at least 80 per cent, (iv) availability of the required staff and equipment in at least 80 per cent of health facilities, and (v) increasing capacity of the MoH and its implementing partners.

In *Annex 1*, a complete list of the EPHS interventions is provided, which have been coded in two colours, where those coloured blue are interventions provided during the initial stage, whereas interventions coloured in black are those whose implementation is planned in following stage.

5. Geographic harmonisation and expansion

For the purpose of improving both efficiency and accountability, only a single NGO (service provider) will be allocated per region. This will result in a reduction in transaction costs, improved economies of scale, and will ensure that they are held accountable for results. Likewise, the primary EPHS donors will be allocated to particular geographic regions. Only a single EPHS donor will have responsibility for a particular region or wider area. Additional donors and humanitarian partners supporting vertical and emergency programmes associated with EPHS must ensure that their supports are aligned and coordinated with the MoH and relevant donors to prevent services from being fragmented and duplicated as well as to complement the EPHS services in a meaningful way. Donors are expected to support the complete list of the EPHS interventions in the first phase in the assigned area. If any partner would like to finance fewer interventions, they shall work through the main EPHS implementer in the area.

6. Harmonisation of delivery systems

The various implementation modalities and programmes will be integrated by the MoH, who will also be responsible for the harmonisation of delivery systems. This will incorporate the

gradual integration of vertically implemented interventions like TB, HIV, Malaria, Family Planning, Nutrition, among others, into the EPHS platform where the roles and duties of those implementing the EPHS, donors and technical agencies are clearly defined. By ensuring that a single NGO / service provider is assigned to only one region, the MoH will collaborate with development partners for the purpose of implementing all activities and interventions within the region via the designated NGO / service provider. The integration mechanism of three diseases (TB, HIV and Malaria) within the EPHS will be in line with the "Strategic Plan for the Integration of HIV, TB and Malaria Services in the EPHS in Somalia"[15]. With regard to additional vertical services including humanitarian assistance, the MoH will closely cooperate with the relevant development partners to create roadmap. This will predominantly result in improvements to the EPHS delivery efficiency and ensure the accountability of the designated NGOs / service providers to the MoH.

7. Harmonisation and expansion of community-based health system

The community-based health workers programme called the Marwo Caafimaad Female Health Workers (FHWs) is an essential element of the primary healthcare in Somalia. This programme will be strengthened by the MoH and development partners through expanding the number of FHWs, particularly in regions where health facilities are limited by adopting a phased strategy. The rollout plan prepared by the MoH shall take into account the regions in which FHWs are required the most.

Furthermore, in order to strengthen the linkages between community-based health care and other levels of EPHS service delivery to ensure continuity of health care delivery across the service delivery platforms, the MoH shall review and update the Community Health Strategy to guide community-based health systems strengthening including community governance, coordination, and information system for decision making.

8. Harmonisation of referral system

It is essential that an effective referral system is in place to ensure women can access basic and comprehensive emergency obstetric and newborn care. Therefore, analysis will be conducted on current referral models utilised by certain partners (complete ambulance system, sharing of costs with the community, donkey carts, TukTuk ambulances, conditional cash transfer to local transports, etc.) to facilitate the development of a referral system with increased sustainability. Meanwhile, NGOs / service providers shall be awarded flexible contracts to enable them to suggest innovative solutions and interventions to reinforce the system of referrals.

[15] Ministry of Health, Draft Strategic Plan for the Integration of Human Immunodeficiency Virus Infection (HIV), Tuberculosis (TB) and Malaria Services in the Essential Package of Health Services in Somalia.

9. Rationalisation of EPHS services at urban, nomadic and IDP settings

The EPHS enables the interventions delivered in urban, rural, nomadic and IDP environments to be potentially different. It is designed in such a manner that offers sufficient flexibility to adapt the operations for varying contexts.

The MoH shall offer services to rural and urban settings through a contracting mechanism to NGOs / service providers and possibly public institutions. Meanwhile, the MoH shall explore the possibility of collaborating with the private sector in the provision of EPHS especially to urban areas. A project aimed at engaging the private sector has been piloted by SHINE within 17 private healthcare establishments (7 in Sahil and 10 in Maroodijeex) on the basis of a social franchising model. The MoH may review and decide to scale up the project. Social franchising is aimed at addressing the problems related to fragmentation, access, quality and the availability of services within the private health sector by creating networks in which smaller, independent healthcare institutions can provide quality-assured health services. This is a specific type of model utilised for the purpose of leveraging extant infrastructure in the private sector to enable increased access to higher quality services. Likewise, the MoH shall investigate the potential to expand the MoH "Urban Immunisation Strategy" to reach especially mothers and children in slums and IDP camps. The aim of the existing immunisation strategy is to: perform household enumeration with Open Data Kits, implement district and facility micro plans; engage in outreach activities focused on poor areas, IDP camps, markets and residential districts; implement interventions aimed at stimulating demand such as public announcements in market locations and sensitisation within educational facilities; supervise activities; arrange periodical meetings so that progress can be monitored; and provide training to health professionals on effective vaccine management.

By collaborating with development partners, particularly humanitarian partners, the MoH shall map the existing services to IDP and nomadic groups, and amalgamate the extant support so that it can be aligned via an integrated approach through the EPHS main implementing partner. EPHS services will be provided to IDP and nomadic groups via a community-based programme (use of FHWs) as well as mobile clinics and outreach activities by the closest health facilities. Recognising that it is not possible to provide full EPHS services to IDP and nomadic groups, the types and amounts of interventions shall be standardised by the MoH to allow IDPs and nomads to receive essential services.

At the same time, flexible contracts will be awarded to implementing partners to encourage them to develop creative solutions and interventions to facilitate the provision of EPHS services to rural, urban, nomadic, and IDP settings.

10. Standardisation of essential medicines and equipment

To increase the range and availability of medicines for the population, particular for those in rural areas, essential drugs should be standardised for health facilities covered by the EPHS.

A standard core list of minimum needs of medicines, supplies and equipment of the EPHS for different level of services shall be developed taking into account the epidemiological requirements of the different regions.

11. Rationalisation of human resources

The 2020 EPHS provides details on the staffing levels needed for the provision of service packages at all service delivery levels. Nevertheless, staffing levels in some health facilities do not conform to the guidelines, and there is a likelihood that health facilities may not be fully staffed in line with the EPHS staffing recommendations in the short term as a result of staffing shortage. Therefore, to ensure access to services and improve efficiency, the recommended staffing has to be driven by the utilisation of services at each health facility level.

NGOs / service providers will be authorised to hire (and redistribute) a minimum number of staff for every facility according to the utilisation of services and the specific requirements of the area, whereas the category of staff (mix of skills) should rigidly adhere to the EPHS recommendations. Staffing levels can be progressively increased in line with the growth in the utilisation of services. It should be noted that this approach is not intended to be restrictive. It may be necessary to deploy more staff than it is recommended by the EPHS in certain health facilities, or a category of staff not stipulated in the EPHS may be assigned based on need to improve utilisation and coverage essential services.

The MoH promotes the approach of providing midwifery and nursing training programmes in rural areas. The implementing NGO / service providers in an assigned region in collaboration with the MoH is responsible for identifying the particular training requirements of that area. The proposed programmes for training midwives and nurses will be supported by the EPHS donors. Other development partners will be tasked with aligning their financing for the purpose of supporting training activities in regions where funding cannot be provided by the EPHS donors.

12. Funding and contractual arrangement

The MoH will collaborate with donors to ensure that resources required to implement 2020 EPHS are aligned. To improve efficiency and accountability, financers shall be assigned to take responsibility of funding the EPHS in a specific region or larger.

The MoH will adopt a strategic purchasing approach that incorporates a purchaser-provider split model. The MoH will provide stewardship for the purchasing activities of EPHS, whereas

NGOs, private sector and possibly public institutions will assume the responsibility of providing health services through a contracting mechanism. Recognising that a strategic purchasing approach in purchaser-provider split models can be hindered by inadequate systems and substandard implementation, development partners will closely cooperate with the MoH to strengthen the MoH systems in term of contract management, financial management, health management information system, monitoring, and coordination.

With the assistance of development partners, the MoH shall perform resource mapping and expenditure tracking (RMET) as well as activity mapping for identifying financial gaps and improving efficiency on yearly basis.

Furthermore, in collaboration with the development partners, National Health Accounts (NHA) will be established to develop a framework for the collection, compilation and analysis of data on all aspects of health expenditures in Somalia incorporating overall spending levels, the origins of health spending, as well as the utilisation of funds with regard to the types of services that are purchased and who buys them.

In addition, various economic analyses and evaluations will be deployed within the development projects to enhance evidences to improve health economics and health financing mechanisms.

13. Improving quality of EPHS interventions

The MoH shall adopt the following strategies to improve quality of the EPHS interventions:

Quality improvement strategy: A strategy for improving quality through the application of an implementation-informed approach will be established to facilitate the process of improving the health system from its current status to the targeted level of quality that Somalia hopes to achieve. As part of this strategy, quality will be defined for the specific context of Somalia, key stakeholders will be engaged, interdependent interventions will be selected to enhance health outcomes, governance and organisational structure for quality will be described, and a core group of indicators of quality will be identified to assess whether activities are producing higher quality, make the process more transparent, and allow comparative benchmarking which will enable best practices to be identified for future learning.

Health facility performance and quality assessment tool: The overall strategy for improving quality will include the development of a *health facility performance and quality assessment tool*, which can be utilised by the managers of health facilities for assessing and monitoring the application of health standards, in addition to the enabling environment. In collaboration with the managers of health facilities, the findings will be utilised for the purpose of developing a plan for improving quality, determining what can be achieved within the facility in addition to the level of support that the implementing NGO / service provider and the MoH may need to

provide. In conjunction with the NGO / service provider assigned to assist the facility, the District Health Management can also use the tool to conduct an external assessment as an aspect of supportive supervision.

Culture of quality: The MoH will establish an organisational culture of quality, with a particular focus on health facilities, by demonstrating effective leadership and best practices in daily work. Under strict supervision, the MoH will be responsible for developing and utilising quality standards. The initial goal will be to enhance the organisational culture within health facilities in the public sector as well as those operated by NGOs. Activities will primarily concentrate on enhancing staff attitudes towards clients/patients as well as on the development of customer friendly quality management and quality clinical instruments and encouraging their usage.

14. Enhancing coordination and engagement of stakeholders

The *Somalia Health Sector Coordination Committee (S-HSCC)* will act as a comprehensive coordination framework according to the policies of the MoH. The Committee includes representatives from the MoH, other ministries, donors, United Nation agencies, and selected service providers. The MoH will ensure that the S-HSCC will serve as a core platform for maximising the process of coordinating and integrating all associated EPHS activities to foster a shared approach to evaluating EPHS issues, as well as to offer direction, guidance and general leadership.

State level Coordination Mechanism shall also be utilized to ensure planning, management and monitoring of delivery of essential health care package to the respective population and linked to the national S-HSCC and Social Development Working Group of the national development plan (NDP9) coordination architecture.

A Regional Health System (RHS) is arranged by the health sector according to the Regional Health Office (RHO), which is the core of the RHS. RHO personnel offer support services to every health facility within a given region on policy, planning, financial supervisory, staffing, and technical matters. A Regional Health Management Team (RHMT) will be responsible for directing and managing the RHS, comprising critical technical/professional personnel working in the office. The MoH and development partners shall provide assistance to RHS to optimise the process of coordinating and integrating the EPHS activities among all stakeholders at the regional level with the primary goal of making the EPHS more effective, equitable and efficient.

The District Health System (DHS) is the core of the health sector and is responsible for supporting the management, planning and decision-making associated with the delivery of health care at the local level. The District Health Management Team (DHMT) will direct and manage the DHS. The DHS is a critical actor in the implementation of the national health policies of the MoH, and has direct responsibility for applying such policies. DHMTs are empowered to formulate their own implementation strategies and suggest approaches for

strengthening the delivery of services on a local level according to national guidelines as well as existing resources. Additionally, the DHMTs work to engage the community and offer feedback that can guide new programmes and policies at the national level. Together with its development partners, the MoH will offer help with expanding DHMTs throughout the regions as well as building their capacity to make their performance more effective.

The MoH will organise *quarterly review meetings with NGOs* / service providers aimed at monitoring the EPHS progress. This forum will be beneficial for monitoring progress in terms of health and nutrition indicators, sharing best practices among implementation partners, evaluating problems that emerge and developing solutions to overcome such problems. These review meetings will be conducted at state level and will involve representatives from the Federal and State MoHs, RHMTs, DHMTs, NGOs and development partners.

A Joint Annual Review (JAR) will be conducted on an annual basis by the MoH in collaboration with its development partners. This review will concentrate on the extent to which the EPHS objectives have been achieved as a whole and will accordingly make recommendations regarding how the EPHS implementation can be improved.

15. Health Information System (HIS)

The MoH shall strengthen the HIS capacity in health information system as highlighted below. Particular focus will be on age and sex-disaggregated data and data pertaining to vulnerable populations.

15.1. DHIS2

In order to improve coverage of essential health and nutrition services, particularly for population groups who are neglected, it is necessary to examine both the quality and quantity of services. The MoH shall ensure that the health management information system routinely records personal data on daily basis and collects data regarding service quantities every week and/or monthly that the data are utilised at facility, regional and national levels, a mechanism is implemented via which feedback can be provided to healthcare workers to enable them to evaluate and modify their performance. Besides, the variety of different information systems currently being used will be harmonised to ensure that efforts are not duplicated and that they work collectively. Development partners will offer resources for the purpose of strengthening the HMIS in the MoH and at the lower levels.

15.2. Monitoring

Annual Health Facility Survey: A third-party firm will conduct surveys on health facilities on an annual basis utilising a balanced scorecard (BSC). This will establish a platform that can be used to standardise the monitoring of results by various donors, NGOs, as well as public sector healthcare providers, enabling the MoH to act as an effective steward of the health sector.

The MoH and stakeholders can use the BSC for the purpose of benchmarking over time, which will reveal performance trends in the health system, enable information to be shared on best practices in particular contexts, and mutually address areas of deficiency, thus promoting the objectives of the MoH. Data and indicators from the various information systems at the district level will be integrated by the BSC.

Standard Monitoring Checklist: The MoH establish a standard monitoring checklist (SMC), which will facilitate the process of conducting monitoring visits of EPHS health facilities. All health facilities will be visited on a quarterly basis at a minimum. The data from each SMC will be entered at the subnational level after the visit has been completed and subsequently distributed to the federal MoH every quarter.

The measurement of EPHS services will be based on the indicators described below:

- Percentage of pregnant women attending their first ANC visit
- Percentage of births attended by skilled health worker
- Percentage of children under the age of one who receive a Penta-3 vaccination
- Number of females utilising modern contraceptives (Two Years of Protection)
- Percentage of children between the ages of 6 and 23 months benefiting from micronutrient supplementation
- More indicators might be added by MoH

15.3. Evaluations

This evaluation will review the EPHS performance over a three-year period. The aim of the evaluation will be to determine the degree to which the EPHS is actually helping to improve equity, quality, efficiency, financial sustainability, and community participation in health service systems in Somalia.

The EPHS performance shall be evaluated by a *third-party firm* by conducting household surveys. The survey shall also include a qualitative component to evaluate other key dimensions such as financing, human resources, and overall programme management.

The MoH shall explore the option to invest in the institutionalisation of the Somalia *Demographic Health Survey* (DHS) that can be conducted on regular basis (e.g. every five years).

Annex 1. List of the EPHS interventions colour coded in a sequencing order

Community	Primary health unit	Health Centre	District Hospital	Regional Hospital/ National Hospital
Access to Care				
Continuity, care planning and coordination				
✧3 Recognition and referral for higher-level management	✧ Recognition and referral for higher-level management	✧ Maintenance of care continuity through longitudinal provider relationship	✧ Management of complications, including structured communication with primary care practitioner on specialized and referral visits	✧ Management of complex multi morbidity and complications, including structured communication with primary care practitioner on specialized and referral visits
		✧ Care coordination including referral and counter-referral		✧ Management of complications, including structured communication with primary care practitioner on specialized and referral visits
✧Household Data recording and collection as outline in FHW compendium		✧ Review and monitoring of chronic therapeutic regimens for complications and adherence		
		✧ Assessment of individual characteristics (age, gender, chronic conditions) to determine screening and behavioural/environmental modification and care plans throughout life course		

		✧ Targeted care coordinated with public health and social service programmes to address needs related to social determinants of health		
Emergency care				
✧ Recognition and referral for danger signs in children and adults [DCP-P	✧ Recognition and referral for danger signs in children and adults [DCP-P]	◉ Recognition and management of danger signs in children and adults [DCP-P]	✧ Triage on arrival at facility with validated instrument [DCP-P]	✧ Triage on arrival at facility with validated instrument [DCP-P]
◉ Community based first aid danger signs in children and adults [DCP-P]	◉ Community based first aid danger signs in children and adults [DCP-P]	← ◉ WHO BEC	◉ Resuscitation with advanced life support measures, including surgical airway [DCP-H]	◉ Resuscitation with advanced life support measures, including surgical airway [DCP-H]
Awarenwss creation and accidents		◉ WHO BEC: Initial assessment and management difficulty in breathing	◉ Advanced initial assessment and management of difficulty breathing	◉ Advanced initial assessment and management of difficulty breathing
		◉ WHO BEC: Initial assessment and management of altered mental status	◉ Advanced initial assessment and management of altered mental status	◉ Advanced initial assessment and management of altered mental status
		◉ WHO BEC: Initial assessment and management of shock	◉ Advanced initial assessment and management of shock	◉ Advanced initial assessment and management of shock
		◉ WHO BEC: Initial assessment and management of acute injury		
			◉ Advanced initial assessment and management of injury	◉ Advanced initial assessment and management of injury
		✧ Detection and early referral of metabolic emergencies [WHO-UHC]	✧ Initial management of metabolic emergencies [WHO-UHC]	✧Advanced management of metabolic emergencies [WHO-UHC]

	⟵ ◉ Detection of sepsis [DCP-H]	◉ WHO BEC: Initial assessment and management of septic shock	◉ Advanced initial assessment and management of sepsis	◉ Advanced initial assessmentand management of sepsis
Approach to common signs and symptoms				
		⟵ ✧ **Initial approach to common signs and symptoms:** fever, diarrhoea, headache, cough and dyspnoea, skin lesions and rash, weakness or fatigue, chest pain and palpitations, genitourinary complaints, red eye and visual disturbance, ear pain and hearing disturbance, mood complaints, sleep disturbances, musculoskeletal pain, abdominal pain and GI bleeding, sinus, mouth and throat complaints, syncope, vomiting, gynaecologic complaints, memory loss or attention problem, dizziness or vertigo, weight change, swelling, lump or mass, and general pain symptoms		✧ Advanced assessment and management of common signs and symptoms encountered in frontline care
✧ Initial assessment and recognition of need for referral for common signs and symptoms			✧ Advanced assessment and management of common signs and symptoms encountered in frontline care	✧ Advanced assessment and management of common signs and symptoms encountered in frontline care
Reproductive, maternal and new-born health				
Maternal and newborn				

◉ Promotion of safe motherhood:	◉ Promotion of safe motherhood:	All promotion of safe motherhood activities plus:	◉ All promotion of safe motherhood activities	◉ All promotion of safe motherhood activities◉ Coordinated antenatal visits for pregnancy with complications, including provision relevant preventive therapies◉Transfusion in pregnancy◉Surgery for ectopic pregnancy◉ Repair of FGM prior to delivery⟵ ✧ Detection and management of fetal growth restriction [DCP-E]
⟵ Identification, counselling and referral of all pregnant women	⟵ Identification, counselling and referral of all pregnant women	◉ Coordinated antenatal visits (including four focused visits):	◉ Coordinated antenatal visits for pregnancy with complications, including provision relevant preventive therapies	◉ Advanced management of premature rupture of membranes◉ Advanced management of preterm labour [DCP-H]◉ Management of labour and delivery in high-risk women, including surgical and assisted delivery techniques (comprehensive emergency newborn and obstetric care) [DCP-H]✧ Spinal anaesthesia◉ Hysterectomy for uterine rupture or intractable postpartum haemorrha ◉ Advanced management of postpartum complications◉ Transfusion◉ Repair of perineal tears◉ Dilation and curettage◉ Advanced management of postpartum sepsis ◉ Comprehensive emergency newborn care, including all immediate essential newborn care plus neonatal resuscitation✧ Full supportive care for preterm neonates [WHO

				– UHC][DCP-E]◉ Nutritional care of babies without a mother✧ Recognition and management of neonatal sepsis, meningitis, pneumonia, and other Serious bacterial infections, including use of IV antimicrobial agents [DCP-H]◉ Management of neonatal encephalopathy and seizures [WHO-UHC]✧ Provide specialized follow-up of high-risk infants✧ Surgical treatment of birth defects and congenital anomalies [WHO-UHC]◉ Jaundice management with phototherapy [DCP-E]Sexual and reproductive health
		← Tetanus toxoid vaccination	← ◉ Prevention of mother-to-child transmission through antiretroviral therapy (ART) and safer infant feeding practices [in targeted areas]	◉ Repair of perineal tears◉ Dilation and curettage◉ Advanced management of postpartum sepsis◉ Comprehensive emergency newborn care, including all immediate essential newborn care plus neonatal resuscitation✧ Full supportive care for preterm neonates [WHO – UHC][DCP-E]◉ Nutritional care of babies without a mother✧ Recognition and management of neonatal sepsis, meningitis, pneumonia, and other Serious bacterial infections, including use of IV antimicrobial agents [DCP-H]◉ Management of neonatal encephalopathy and seizures

				[WHO-UHC]✧ Provide specialized follow-up of high-risk infants✧ Surgical treatment of birth defects and congenital anomalies [WHO-UHC]◉ Jaundice management with phototherapy [DCP-E]
⟵ Promotion of facility-based delivery assisted by skilled birth attendants	⟵ Promotion of facility-based delivery assisted by skilled birth attendants	⟵ Promotion of postpartum family planning	◉ Immediate initiation of ART for newly diagnosed HIV cases	⟵ ◉ Prevention of mother-to-child transmission through antiretroviral therapy (ART) and safer infant feeding practices [in targeted areas]
⟵ Maternal nutrition assessment,counselling and provision of micro- nutritional supplements during pregnancy	⟵ Maternal nutrition assessment,counselling and provision of micro- nutritional supplements during pregnancy	⟵ Maternal nutrition counselling with provision of micronutrient supplements and specialized nutritious food if available	◉ Transfusion in pregnancy	◉ Immediate initiation of ART for newly diagnosed HIV cases
	◉ Provision of insecticide-treatedbednets (ITNs) in endemic areas	⟵ Assessment of fetal growth	◉ Surgery for ectopic pregnancy	◉ Advanced management of diabetes in pregnancy
[◉ Provision of specialized nutritious food and/or cash transfers as feasible in food insecure households]	[◉ Provision of specialized nutritious food and/or cash transfers as feasible in food insecure households.]	⟵ HIV and TB screening of pregnant women following national guidelines	◉ Advanced management of diabetes in pregnancy	
		⟵ ✧ Early identification and referral of women at high risk for complications	◉ Advanced management of pre- eclampsia	
		⟵ ✧ Screening for hyperglycaemia and gestational diabetes	◉ Advanced management of antepartum haemorrhage	◉ Advanced management of pre- eclampsia
		⟵ ✧ Screening for anaemia		◉ Advanced management of antepartum haemorrhage
		⟵ Treatment of worms		◉Routine postpartum care of mother

		⟵ Screening and treatment for genitourinary infections, including sexually transmitted infections (STIs)		✧ Provide counselling on danger signs and hygiene practices [WHO-UHC]
		⟵ Intermittent preventive treatment for malaria in pregnancy and provision of ITNs in endemic areas		✧ Provide counselling on contraception [WHO-UHC]
		⟵ Screening for hypertension in pregnancy and pre-eclampsia, antepartum haemorrhage and premature rupture of membranes		◉ Diagnosis of postpartum complications
✧Early recognition and referral for antenatal complications and emergencies	✧Early recognition and referral for antenatal complications and emergencies	◉ Initial management of pre-eclampsia		◉ Management of postpartum haemorrhage (with parenteral uterotonic agents, anti-fibrinolytic agents and IV fluids)
		◉ Initial management of antepartum haemorrhage		◉ Provide support for early initiation of exclusive breastfeeding and rooming in [DCP-P]
◉ Early detection of preterm labour and premature rupture of membranes [DCP-H]	◉ Early detection of preterm labour and premature rupture of membranes [DCP-H]	◉ Initial management of preterm labour and premature rupture of membranes, including administration of antibiotics [DCP-H]	◉ Advanced management of premature rupture of membranes	◉ Advanced management of premature rupture of membranes
			⟵ ✧ Management of preterm labour with corticosteroids [DCP-H]	◉ Advanced management of preterm labour [DCP-H]
		◉ Identification and incorporation of maternal birth preferences into birth plan	⟵ ✧ Induction of labour post-term [DCP-E]	◉ Management of labour anddelivery in high-risk women,including surgical and assisteddelivery techniques

				(comprehensiveemergency newborn and obstetriccare) [DCP-H]
		◉ Management of labour and delivery in low-risk women by skilled attendants in facilities	✧ ◉ Management of labour and delivery in high-risk women, including surgical and assisted delivery techniques (comprehensive emergency newborn and obstetric care) [DCP-H]	✧ Spinal anaesthesia
			✧ Spinal anaesthesia	◉ Hysterectomy for uterine rupture or intractable postpartum haemorrhage
			✧ Hysterectomy for uterine rupture or intractable postpartum haemorrhage	
	Postpartum iron and folate supplements	◉Routine postpartum care of mother	◉Routine postpartum care of mother	
		◉Provide support for early initiation of exclusive breastfeeding and rooming in	◉ Provide support for early initiation of exclusive breastfeeding and rooming in [DCP-P]	◉ Advanced management ofpostpartum complications
		⟵ ✧ Provide counselling on danger signs, hygiene practices and nutrition [WHO-UHC]	✧ Provide counselling on danger signs and hygiene practices [WHO-UHC]	◉ Transfusion
		⟵ ✧ Provide counselling on contraception [WHO-UHC]	✧ Provide counselling on contraception [WHO-UHC]	◉ Repair of perineal tears
		◉ Recognition and initial management of postpartum complications, including sepsis and haemorrhage	◉ Diagnosis of postpartum complications	◉ Dilation and curettage

			◉ Management of postpartum haemorrhage (with parenteral uterotonic agents, anti-fibrinolytic agents and IV fluids)	◉ Advanced management of postpartum sepsis
			◉ Transfusion	
			◉ Repair of perineal tears	
			◉ Dilation and curettage	
			◉ Management of postpartum sepsis	
✧ Referral for babies delivered at home to nearest health facility for evaluation, vaccinations, weighing and registration	✧ Referral for babies delivered at home to nearest health facility for evaluation, vaccinations, weighing and registration	◉ Routine assessment and immediate essential newborn care	◉ Comprehensive emergency newborn care, including all immediate essential newborn care plus neonatal resuscitation	◉ Comprehensive emergency newborn care, including all immediate essential newborn care plus neonatal resuscitation
	✧ Postnatal monitoring and follow-up at days 1, 3 and 7 after birth	⟵ Prevention of hypothermia including immediate drying after birth, skin-to-skin care and wrapping	✧ Full supportive care for preterm neonates [WHO – UHC][DCP-E]	✧ Full supportive care for pretermneonates [WHO UHC][DCP-E]
	◉ Provide support for early and exclusive breastfeeding	⟵ Provide support for early and exclusive breastfeeding	◉ Nutritional care of babies without a mother	◉ Nutritional care of babies without a mother
	◉Administer routine birth vaccinations per national guidelines	⟵ Administer routine birth vaccinations per national guidelines	✧ Recognition and management of neonatal sepsis, meningitis, pneumonia, and other serious bacterial infections, including use of IV antimicrobial agents [DCP-H]	✧ Recognition and management of neonatal sepsis, meningitis, pneumonia, and other Serious bacterial infections, including use of IV antimicrobial agents [DCP-H]
	◉ Perform counselling and support for newborn care, including parental recognition	⟵ Perform counselling and support for newborn care, including parental recognition		◉ Management of neonatal encephalopathy and seizures [WHOUHC]

	of danger signs, responsive caregiving and follow-up	of danger signs, responsive caregiving and follow-up		
				✧ Provide specialized follow-up of highrisk infants
				✧ Surgical treatment of birth defects and congenital anomalies [WHO-UHC]
			◉ Management of neonatal encephalopathy and seizures [WHO-UHC]	◉ Jaundice management withphototherapy [DCP-E]
	◉ Early recognition of danger signs and illness with early referral	◉ Early recognition of danger signs and illness with early referral		
		✧ Provision of co-trimoxazole to children born to HIV – positive mothers [DCP-E]	◉ Jaundice management with phototherapy [DCP-E]	
		◉ Neonatal resuscitation		
Sexual and reproductive health				
			◉ Surgical management of ovarian cysts	◉ Repair of complicated perineal tears ◉ Repair of damage associated with FGM ◉ Repair of obstetric fistula (WHO-UHC) ✧ Interventions to address uterine prolapse [WHO-UHC]
				◉ Surgical management of ovarian cysts

			◉ Repair of FGM induced damage	⟵ ✧ Management of septic abortion [WHO-UHC] ⟵ ✧ Management of injury to the genital tract and internal organs [WHO-UHC] ◉ Provide manual vacuum aspiration ◉ Provide dilation and curettage
				◉ Repair of obstetric fistula (WHOUHC)
◉ Promote safe sex practices [DCP-E]	◉ Promote safe sex practices [DCP-E]	◉ Promote safe sex practices [DCP-E]		◉ Surgical management of ovarian cysts
	✧ Provide vaginal lubricants to address vaginal dryness and dyspareunia [WHO-UHC]	✧ Provide vaginal lubricants to address vaginal dryness and dyspareunia [WHO-UHC]		✧ Interventions to address uterine fibroids [WHO-UHC]
				✧ Interventions to address endometriosis [WHO-UHC]
	◉ Provide contact tracing for STIs	⟵ ◉ Provide syndromic management of STIs		⟵ ✧ Insertion and removal of long acting reversible contraceptives [DCP-H]
		◉ Provide counselling and testing for those with STIs		
		⟵ ✧ Provide partner notification and expedited treatment for common STIs[DCP-H]		
		◉ Provide outpatient treatment for UTIs		
◉ Provide confidential reproductive health education, including for adolescents	◉ Provide confidential reproductive health education, including for adolescents	◉ Provide confidential reproductive health education, including for adolescents		✧ Medical management of incomplete abortion (first and second trimester) [WHO-UHC]

◉ Promote the avoidance of early marriage and early pregnancy and promote birth spacing	◉ Promote the avoidance of early marriage and early pregnancy and promote birth spacing	◉ Promote the avoidance of early marriage and early pregnancy and promote birth spacing		✧ Provide pharmacological termination of pregnancy [WHO-UHC]
◉ Improve cleanliness, comfort and dignity of women during menstruation with free and publicly available sanitary towels	◉ Improve cleanliness, comfort and dignity of women during menstruation with free and publicly available sanitary towels		⟵ ✧ Insertion and removal of long acting reversible contraceptives [DCP-H]	
		◉ Provide counselling on family planning and contraceptive options		✧ Insertion and removal of long acting reversible contraceptives [DCP-H]
	◉ Provide counselling on family planning and contraceptive options	◉Provide short-acting hormonal contraceptives		⟵ ✧ Tubal ligation [DCP-H]
	◉Provide short-acting hormonal contraceptives	✧ Provide emergency contraceptives [DCP-H]		⟵ ✧ Vasectomy [DCP-H]
		◉ Provide initial management for miscarriage or incomplete abortion	✧ Medical management of incomplete abortion (first and second trimester) [WHO-UHC]	⟵ ✧ Management of septic abortion [WHO-UHC]
			✧ Provide pharmacological termination of pregnancy [WHO-UHC]	⟵ ✧ Management of injury to the genital tract and internal organs [WHO-UHC]
			◉ Provide manual vacuum aspiration	◉ Provide manual vacuum aspiration
			◉ Provide dilation and curettage	◉ Provide dilation and curettage
Life course, growth and development				

✧ Parent support and training as part of comprehensive programmes		✧ Parent training and home visitation for high-risk families, for child maltreatment [DCP-E] ✧ Parenting programmes for early and middle childhood [DCP-P]	◉ Inpatient management of SAM associated with complications or serious infection	◉ Inpatient management of SAM associated with complications or serious infection ✧ Management of SAM associated with serious infection (WHO-UHC)
◉Provide growth monitoring and arrange referrals as needed	◉Provide growth monitoring and arrange referrals as needed	◉Provide growth monitoring and arrange referrals as needed		
✧ Counselling of essential new born care as outlined in the FHW compendium	◉ Promotion of complementary child feeding and diversification of foods	◉ Nutrition counselling and targeted supplementary feeding		
✧ Identification and referral of small and preterm babies	◉ Nutrition counselling and targeted supplementary feeding			
◉ Promotion of complementary child feeding and diversification of foods	◉ Referral of children with pallor	◉ Nutritional support for acutely malnourished pregnant and lactating women		
◉ Nutrition counselling and screening	◉Targeted population-based intermittent iron and folic acid per national/WHO guidelines			
		◉ Screening and referral for therapeutic care for severely malnourished children	◉ Inpatient management of SAM associated with complications or serious infection	
◉Targeted population-based intermittent iron and folic acid per national/WHO guidelines	◉Micronutrient supplementation per national/WHO guidelines	◉ Outpatient therapeutic programme for children with severe acute malnutrition (SAM) and no complications	◉ Supplementary feeding for moderate acute malnutrition	
◉Targeted population-based intermittent iron and folic acid per national/WHO guidelines	[◉ Provide food supplementation for food insecure households]			◉ Inpatient management of SAMassociated with complications or seriousinfection
◉Micronutrient supplementation per national/WHO guidelines	✧ Provide cash assistance to women and children in food insecure households	◉ Supplementary feeding for moderate acute malnutrition		✧ Management of SAM associated with serious infection (WHO-UHC)

[◉ Provide food supplementation for food insecure households]				
◉ Routine nutritional screening and referral with mid-upper arm circumference (MUAC) screening and evaluation for oedema	◉ Routine nutritional screening and referral with MUAC screening and evaluation for oedema	✧ Screening for developmental disorders in children [DCP-P] ✧ ✧Provide parenting skills training for developmental disorders [DCP-P]		
✧ Vitamin A supplementation	◉ Supplementary feeding for moderate acute malnutrition			
✧ Deworming (intestinal treatment)				
✧ Assessment of Anaemia and Jaundice				
✧ Weekly iron folic acid supplementation for adolescent girls, pregnant and lactating women.				
✧ Life skills training in schools to build social and emotional competencies [DCP-P]				
Older Adult				
✧ Home-based assistance for activities of daily living				
✧ Nutrition counselling, social care and support for older people				✧ Management of SAM associated with serious infection (WHO-UHC)
NCDs				
Health promotion and disease prevention				

✧Education on prevention and management of non-communicable diseases (cardiovascular disease,cancer, high blood pressure, diabetes)		✧ Integrated screening for NCDs based on individual characteristics through the life course [WHO-UHC]		
✧Referral of suspected cases	✧ Counselling and behavioural modification on nutrition, healthy diet, and physical activity [WHO-UHC]	✧ Counselling and behavioural modification on nutrition, healthy diet, and physical activity [WHO-UHC]	✧Counselling and behavioural modification on nutrition, healthy diet, and physical activity [WHO- UHC]	✧Counselling and behavioural modification on nutrition, healthy diet, and physical activity [WHO-UHC]
		⟵ ✧ Education on tobacco hazards, value of human papillomavirus (HPV) and hepatitis B virus (HBV) vaccina tion, and importance of seeking early treatment for common cancers (DCP-P)	✧ Education on tobacco hazards, value of HPV and HBV vaccination, and importance of seeking early treatment for common cancers (DCP-P)	✧ Education on tobacco hazards, value of HPV and HBV vaccination, and importance of seeking early treatment for common cancers (DCP-P)
Cardiovascular and pulmonary diseases				
		◉ Perform periodic screening of adults and children for hypertension [WHO-UHC]	◉ Initiate regimen for oral anti-hypertensive agents [WHO-UHC]	◉ Management of complications of hypertension
		✧ Monitor oral anti-hypertensive regimen	◉ Perform ECG (electrocardiogram) [WHO-UHC]	✧ Administer parenteral anti-hypertensive agents for hypertensive emergencies
		✧ Monitor oral regimen for long-term medical management of heart failure and ischaemic heart disease	✧ Initiate oral agents for medical management of heart failure and ischaemic heart disease	
		⟵ ✧ Provide aspirin for all suspected cases of acute myocardial infarction [DCP-H]	✧ Management of acute coronary syndromes with aspirin and unfractionated heparin [DCP-E]	◉ Initiate oral agents for medical management of heart failure and ischaemic heart disease {replaces Provide a Heart Failure Special Programme}
		✧ Monitor oral regimen for chronic management of stroke [DCP-H]	✧ Initiate oral regimen for chronic management of stroke [DCP-H]	

				⟵ ✧ Management of acute coronary syndromes with aspirin, unfractionated heparin, and generic thrombolytics [DCP-E]
		◉ Treatment of asthma and COPD with inhaled agents	◉ Treatment of asthma and COPD with inhaled agents	✧ Management of acute stroke
Diabetes				
		⟵ ✧ Screening for diabetes among at-risk adults, [DCP-H]	◉ Management of type 1 diabetes, including treatment with insulin [WHO-UHC]	◉Advanced management of diabetes and complications of diabetes
		✧ Management of type 1 diabetes, including treatment with insulin [WHO-UHC]	◉ Management of type 2 diabetes with oral agents and insulin [WHO- UHC]	
		✧ Management of type 2 diabetes with oral agents and insulin [WHO- UHC]	◉Advanced management of diabetes and complications of diabetes	
		⟵ ✧ Screening for diabetes complications		
Cancer				
		⟵ ✧ Essential palliative care and pain control including oral immediate release morphine and medicines for associated symptoms [DCP-H]	✧ Expanded palliative care and pain control [DCP-H]	✧Expanded palliative care and pain control [DCP-H]
			⟵ ✧ Psychosocial support and counselling services for individuals with serious, complex, or life-limiting health problems, and their caregivers [DCP-E]	⟵ ✧ Psychosocial support and counselling services for individuals with serious, complex, or life-limiting health problems, and their caregivers [DCP-E]

			⟵ ✧ Early detection by visual inspection of early-stage cervical cancer [DCP-H]	⟵ ✧ Treatment by cryotherapy and colposcopy of early-stage cervical cancer [DCP-H]
Mental health and substance use disorders				
✧Education on mental health				
✧Referral of people needing care	◉ Support for families	⟵ ✧ Detection and referral for depressive disorders with validated interview based tools [WHO-UHC]	◉ Provide psychological interventions for depression [WHO-UHC]	◉ Provide psychological interventions for depression [WHO-UHC]
		⟵ ◉ Monitor oral regimen for depression [DCP-H]	◉ Initiate oral agents for depression [DCP-H]	◉Initiate oral agents for depressive disorders [DCP-H]
			◉Provide outpatient psychiatric treatment by mental health nurses	◉ Inpatient psychiatric care for depression
		⟵ ✧ Detection and referral for anxiety disorders for all age groups using validated interview based tools	◉Provide outpatient psychiatric treatment by mental health nurses	◉Provide outpatient psychiatric treatment by mental health nurses
		⟵ ✧ Monitor oral therapy for anxiety disorders [DCP-H]	✧ Initiate oral agents for anxiety [DCP-H]	✧ Initiate oral agents for anxiety [DCP-H]
			✧ Initiate oral agents for psychotic disorders [DCP-H]	✧ Manage refractory psychosis with advanced oral agents [DCP-P]
	Provide harm reduction services such as safe injection equipment [DCP-H]	Provide screening and brief interventions for alcohol use disorders [DCP-E]	Psychosocial support, including supportive communication and problem solving [DCP-E]*	⟵ ✧ Manage alcohol withdrawal [WHO- UHC]
		Provide tobacco and khat cessation counselling and nicotine replacement therapy when relevant	✧Clinical assessment for survivors of violence, including documentation and evidence collection as appropriate	⟵ ✧ Manage opiate withdrawal [WHO- UHC]

◉ Promotion of avoidance of FGM ✧ Community based prevention programmes for gender-based violence [DCP-H]	Promotion of avoidance of FGM	◉ Psychosocial support, including supportive communication and problem solving [DCP-E]*	◉ Provide medical and psychological care for victims of sexual violence, including PEP	◉ Psychosocial support, including supportive communication and problem solving [DCP-E]*
		✧Clinical assessment for survivors of violence, including documentation and evidence collection as appropriate	◉ Special programme for violence mitigation	✧ Clinical assessment for survivors of violence, including documentation and evidence collection as appropriate
				◉ Provide medical and psychological care for victims of sexual violence, including PEP
				◉ Special programme for violence mitigation
				✧ Management of complications following FGM [DCP-E]
Injury				
	◉Basic life support, plus protocol based administration of oral fluids with adjustment for age and condition including malnutrition	◉ Initial management and immediate referral for polytrauma (WHO BEC)	◉Basic initial management off polytrauma (WHO BEC	◉Basicinitial assessment andmanagement of polytrauma [WHOUHC]
	◉ Early recognition and immediate referral for injury	◉ Basic wound care, including suturing of simple lacerations	✧ Implementation of WHO checklists for management of critically ill and injured patients	✧ Implementation of WHO checklists for management of critically ill and injured patients

	✧Initial wound care including cleaning and application of dressing	◉ Initial management of burns	◉ Advanced wound care, including suturing of complex lacerations	✧Trauma laparotomy
		◉ Analgesia, immobilization and referral for musculoskeletal injuries	◉ Management of burns with fluids and nutritional support including therapeutic feeding	◉ Nutritional support for those with major injury
			◉ Analgesia, immobilization, referral for musculoskeletal injuries	✧Basic skin grafting and release of contractures, including for burns
		◉ Initial management of human and animal bites, including snake and dog bites	◉ Management of non-displaced fractures with closed reduction	⟵ ✧ Fracture reduction, external fixation and traction [DCP-H]
			✧ Administer antivenin [DCP-E]	⟵ ✧ Irrigation and debridement of open fractures [DCP-H] ✧ Open reduction and internal fixation for fractures [DCP-P]
				✧Trauma related amputations
		◉ Initial management of human and animal bites, including snake and dog bites	◉ Management of human and animal bites, including snake and dog bites	✧ Burr hole to relieve acute elevated intracranial pressure [DCP-P]
		◉ Referral for rabies vaccine and anti-rabies	✧ Administer antivenin [DCP-E]	◉ Advanced management and surgical debridement of human and animal bites, including snake bites
				✧ Administer antivenin [DCP-E]

		◉ Early recognition and management of poisoning, intoxication and withdrawal syndromes	◉ Early recognition and management of poisoning, intoxication and withdrawal syndromes	✧ Full supportive care for snake-bite envenomation [WHO-UHC]
				◉ Early recognition and management of poisoning, intoxication and withdrawal syndromes
Other NCDs				
				✧ Newborn screening for sickle celldisease [DCP-H]⟵ ✧ Retrospective identification ofcarriers of single-gene disorders (i.e.,thalassemia) plus prospective(premarital) screening and counselling[DCP-E]
	◉ Early recognition and immediate referral for injury			✧ Management of bowel obstruction [DCP-P] ✧ Perform repair of perforations [DCP-P] ✧ Perform colostomy [DCP-P] ✧ Perform hernia repair [DCP-P] ✧ Perform surgical intervention for GI bleeding [DCP-P] ⟵ ✧ Perform appendectomy [DCP-P] ⟵ ✧ Perform surgery for gallbladder disease [DCP-P]
		✧ Perform intervention for relief of urinary obstruction (catheterization) [DCP-P]	✧ Perform intervention for relief of urinary obstruction (catheterization or suprapubic cystostomy) [DCP-P]	✧ Perform intervention for relief of urinary obstruction (catheterization or suprapubic cystostomy) [DCP-P]

◉ Screening of visual acuity	◉ Screening of visual acuity	◉ Screening of visual acuity	◉ Mobile eye camps (free treatment)	⟵ ✧ Prescribe oral generic disease modifying anti-rheumatic drugs (including methotrexate) for moderate to severe rheumatoid arthritis [DCP-H]
◉ School based eye education	◉ Referral to ophthalmic assistants	◉ Referral to ophthalmic assistants	◉ Surgical camps with visiting ophthalmologists (free cataract and other surgery)	
			◉ Community based trachoma treatment in areas of high prevalence	
			◉ Treatment of refractive problems ts (NB Fees are charged)	
			✧ Cataract extraction and insertion of intraocular lens [DCP-H]	
			✧ Surgery for trachomatous trichiasis [DCP-H]	
		✧ Epistaxis management [WHO-UHC]	✧ Audiological testing and monitoring (audiometry) [WHO-UHC]	✧ Audiological testing and monitoring (audiometry) [WHO-UHC]
			✧ Hearing aid trial and fitting [WHO- UHC]	
			✧ Epistaxis management [WHO-UHC]	✧ Hearing aid trial and fitting [WHO-UHC]
			✧ Epistaxis management [WHO-UHC]	✧ Epistaxis management [WHO-UHC]
		✧ Removal of foreign body [WHO- UHC]	✧ Removal of foreign body [WHO-UHC]	✧ Epistaxis management [WHO-UHC]

		✧Monitor oral regimen for convulsive epilepsy therapy [DCP-H]	✧ Initiate oral regimen for convulsive epilepsy [WHO-UHC]	✧ Removal of foreign body [WHO-UHC]
			◉ Provide post-stroke care, including care for those with paralysis	✧ Initiate oral regimen for convulsive epilepsy [WHO-UHC]
				◉ Provide post-stroke care, including care for those with paralysis
		✧ Monitor oral regimen used for headache disorders [WHO-UHC] ✧ Teach self-management treatments for migraine [DCP-E]	✧ Initiate oral regimen for headache disorders [WHO-UHC]	◉ Manage medication-resistant convulsive epilepsy
		✧ Management of chronic skin conditions (WHO-UHC)		
Communicable diseases				
✧ Promote immunization uptake and conduct defaulter tracing	✧ Promote immunization uptake and conduct defaulter tracing	◉ Provide routine age appropriate immunizations, as per national EPI policy and guidelines	◉ Provide routine age appropriate immunizations, as per national EPI policy and guidelines	◉ Provide routine age appropriate immunization, as per national EPI policy and guidelines
	◉ Provide routine age appropriate immunizations, as per national expanded programme for immunization (EPI) policy and guidelines	✧/◉ Targeted age-based and risk- based vaccinations for adults	✧/◉ Targeted age-based and risk- based vaccinations for adults	✧/◉ Targeted age-based and risk- based vaccinations for adults
Management of HIV, TB, malaria, hepatitis				

◉ HIV prevention and promotion activities at the family and community levels	◉ HIV prevention and promotion activities at the family and community levels	<--✧ confirmatory HIV testing, counselling and referral [DCP-E]	<--✧ Provider-initiated testing and counselling for HIV, STIs, and hepatitis [DCP-H]	◉ CD4 testing and clinical monitoring
◉ Promote activities to decrease stigma for people living with HIV (PLHIV)	◉ Promote activities to decrease stigma for PLHIV	✧HIV testing in high-risk groups, including for new diagnoses of TB and STI	◉ CD4 testing and clinical monitoring	◉ Provision of PrEP for high-risk groups [DCP-E]
◉ Promote of safe sex practices	◉ Promote safe sex practices	✧ Referral for pre-exposure prophylaxis (PrEP) for high-risk groups	✧ Provision of PrEP for high-risk groups [DCP-E]	◉ Immediate initiation of ART for newly diagnosed HIV cases
◉ Social support for PLHIV		◉ Co-trimoxazole prophylaxis for P carinii infection	◉ Immediate initiation of ART for newly diagnosed HIV cases	◉ Management of side-effects and toxicity of ARVs
		✧Early recognition and referral opportunistic infections in PLHIV	◉ Management of side-effects and toxicity of ARVs	◉ Co-trimoxazole prophylaxis for P carinii infection
		◉ Nutritional support for PLHIV including screening for malnutrition	◉ Co-trimoxazole prophylaxis for P carinii infection	◉ Screening and treatment of opportunistic infections
		✧HIV Treatment adherence support	◉ Screening and treatment of opportunistic infections	◉ Management of HIV in pregnant women
			◉ Screening and treatment for HIV in at-risk neonates	◉ Screening and treatment for HIV in at- risk neonates
◉ Provide community based TB education	◉ Provide community based TB education	✧ Screen for TB in high-risk groups, including children and PLHIV	◉ Screening and treatment for HIV in at-risk neonates	
✧ Perform active case-finding for TB [DCP-H]	✧ Perform contact tracing [DCP-E]	◉ Provide isoniazid preventive therapy to high-risk groups according to current WHO guidelines [DCP-H]	✧ Advanced management of TB treatment failures	
✧ TB Treatment Adherence support		◉ Perform sputum acid-fast bacillus testing		

✧ Perform contact tracing [DCP-E]		◉ Prescribe first-line treatment for drug-susceptible TB per current WHO guidelines		
		◉ Refer treatment failures for assessment of drug resistant TB		⟵ ✧ Manage MDR-TB and XDR TB as per WHO guidelines [DCP-H]
		◉ Arrange for DOTS (directly observed treatment short course) therapy, including administration by responsible caregivers		✧ Perform surgical intervention for TB [WHO – UHC]
✧ Distribute and promote use of ITNs in high prevalence areas [DCP-P]	◉ Distribute and promote use of ITNs in high prevalence areas [DCP- P]	◉ Diagnose malaria with rapid diagnostic testing or microscopy [DCP-P]	◉ Diagnose malaria with rapid diagnostic testing or microscopy [DCP-P]	
✧Treat malaria with artemisinin- based combination treatments or other first-line combination [DCP-P]	◉ Provide active case-finding during epidemics	◉ Treat malaria with ACTs or other first-line combination [DCP-P]	◉ Treat malaria with ACTs or other first-line combination [DCP-P]	◉ Manage severe malaria
	◉ Treat malaria with artemisinin- based combination therapy (ACT) or other first-line combination [DCP-P]	✧ Early detection of severe malaria and referral [DCP – H]	◉ Manage severe malaria	
	◉ Utilize national protocols for malaria prevention and treatment	✧ Hepatitis B vaccination for high-risk populations including health workers	✧ Hepatitis B vaccination for high- risk populations including health workers	✧ Hepatitis B vaccination for high-risk populations including health workers ✧ Screening for Hepatitis B/C among clinical at-risk group and vulnerable populations (WHO-UHC)

		✧ Screening for Hepatitis B/C among clinical at-risk group and vulnerable populations (WHO-UHC)	✧ Screening for Hepatitis B/C among clinical at-risk group and vulnerable populations (WHO-UHC)	
Neglected tropical diseases				
	◉ Provide treatment for scabies	◉ Provide control programmes for leishmaniasis, schistosomiasis and elephantiasis in endemic areas		
	◉ Provide de-worming campaigns	◉ Provide community based trachoma treatment in areas of high prevalence		
		◉ Treatment of helminthic infections (deworming)	◉ Treatment of helminthic infections (deworming)	◉ Treatment of helminthic infections (deworming)
Respiratory infections				
◉ Manage common upper respiratory tract infections	◉ Manage common upper respiratory tract infections	◉ Empirical treatment for non-severe and severe pneumonia [WHO-UHC]	◉ Treatment for non-severe and severe pneumonia [WHO-UHC]	⟵✧ Management of acute ventilatory failure[DCP-E]
◉ Early recognition and treatment for pneumonia, with referral for danger signs[WHO-UHC]	◉ Early recognition and treatment for pneumonia, with referral for danger signs [WHO-UHC]	✧ Diagnosis and initial management of bronchiolitis [WHO-UHC]	✧ Management of bronchiolitis [WHO-UHC]	◉ Treatment for non-severe and severe pneumonia [WHO-UHC]
		✧ Diagnosis and management of measles without complications [WHO-UHC]	✧ Management of measles with complications [WHO – UHC]	✧ Management of bronchiolitis [WHO-UHC]
◉ Provide supportive treatment for common colds	◉ Provide supportive treatment for common colds	✧ Treat acute pharyngitis to prevent rheumatic fever [DCP-E]		✧ Management of measles with complications [WHO – UHC]
GI infections				

✧ Promote hand washing, safe disposal of faeces, safe water, household sanitation practices	◉ Promote effective sanitation practices	◉ Provide antiprotozoal therapies	◉ Provide antiprotozoal therapies	◉ Provide antiprotozoal therapies
✧ Provide rehydration with Oral Rehydration salts	◉ Provide rehydration with oral rehydration salts for uncomplicated gastroenteritis	◉ Provide antibiotics for complicated gastroenteritis	◉ Provide antibiotics for complicated gastroenteritis	◉ Provide antibiotics for complicated gastroenteritis
	◉ Refer severe cases of dehydration for inpatient management	◉ Provide case management and reporting for acute watery diarrhoea [WHO-UHC]	◉ Provide case management and reporting for acute watery diarrhoea [WHO-UHC]	◉ Provide case management and reporting for acute watery diarrhoea [WHO-UHC]
	◉ Treat with zinc for 10–14 days			
✧ Treat with zinc for 10–14 days				
Other infections				
	✧ Early recognition and referral of common infections	✧ Early recognition, empirical management and referral of central nervous system (CNS) infections	◉ Management of CNS infections	◉ Management of CNS infections (Bacterial meningitis Only)
		✧ Manage ear infections [WHO-UHC]	◉ Management of eye infections (WHO-UHC)	◉ Management of eye infections (WHO-UHC)
		◉ Management of eye infections (WHO-UHC)		
✧ Oral health promotion [DCP-P]	◉ Referral of dental problems	✧ Oral health promotion and treatment [DCP-P]	✧ Dental extraction [DCP-E]	
		✧ Dental extraction [DCP-E]	✧ Drainage of dental abscess [DCP- E]	✧ Drainage of dental abscess [DCP- E]
		◉ Drainage of dental abscess [DCP-E]	✧ Manage dental emergencies	
		◉ Referral of dental problems		

✧ Provide early recognition and referral for urgent soft tissue infections	◉ Provide treatment for common skin infections	✧ Provide early recognition and initial management for urgent soft tissue conditions	✧ Management of urgent soft tissue conditions, including necrotizing infections	✧ Management of urgent soft tissue conditions, including necrotizing infections
	✧ Provide early recognition and referral for urgent soft tissue conditions	✧ Provide incision and drainage of superficial abscess [DCP-E]		
Outbreak surveillance				
✧ Provide public information programmes for infectious disease outbreaks [DCP-E]	✧ Identify high-risk individuals in infectious disease outbreaks (case-finding) [DCP-E]	✧ Provide rapid surge of service delivery capacity under provincial/regional coordination [WHO-UHC]	✧ Provide rapid surge of service delivery capacity under provincial/regional coordination [WHO-UHC]	✧ Provide outbreak preparedness, surveillance, and response [WHO- UHC]
✧ Identify high-risk individuals in infectious disease outbreaks (case- finding) [DCP-E]	◉ Provide weekly reporting (and daily during outbreaks) of suspect cases by health facilities as per WHO protocol	◉ Utilize standardized response to epidemics for diseases of public health concern	✧ Provide and implement Mass Casualty Management protocols [WHO-UHC]	⟵ ✧ Provide health worker training and simulation exercises for outbreak events
		◉ Ensure epidemic preparedness with training, stocks, networks and supply lines	✧ Utilize surge triage with validated instrument [WHO-UHC]	
		◉ Utilize communication and coordination plans	✧ Provide case-based syndromic surveillance in emergency units [WHO-UHC]	
		◉ Utilize preparedness plans that include isolation areas in health facilities with dedicated latrines, water supply and waste disposal	✧ Provide comprehensive facility outbreak preparedness plans [DCP- E]	
		◉ Provide public awareness campaigns		
		◉ Provide targeted vaccination for select diseases		

Rehabilitation				
✧Education on disabilities		✧ Provide and train patients in the use of basic assistive products [DCP- E]	✧ Provide and train patients in the use of basic assistive products [DCP- E]	◉ Provide rehabilitation for motor functions [WHO-UHC]
✧Referral of people needing care			✧ Provide exercise programmes for common musculoskeletal disorders [DCP-E]	◉ Provide rehabilitation for voice and speech functions [WHO-UHC]
				◉ Provide rehabilitation for swallowing [WHO-UHC]
				◉ Provide rehabilitation for self care [WHO-UHC]

Annex 2. The EPHS implementation strategic plan timeline

Please refer to the concerned Excel sheet. Once the timeline is finalized, it will be inserted here.