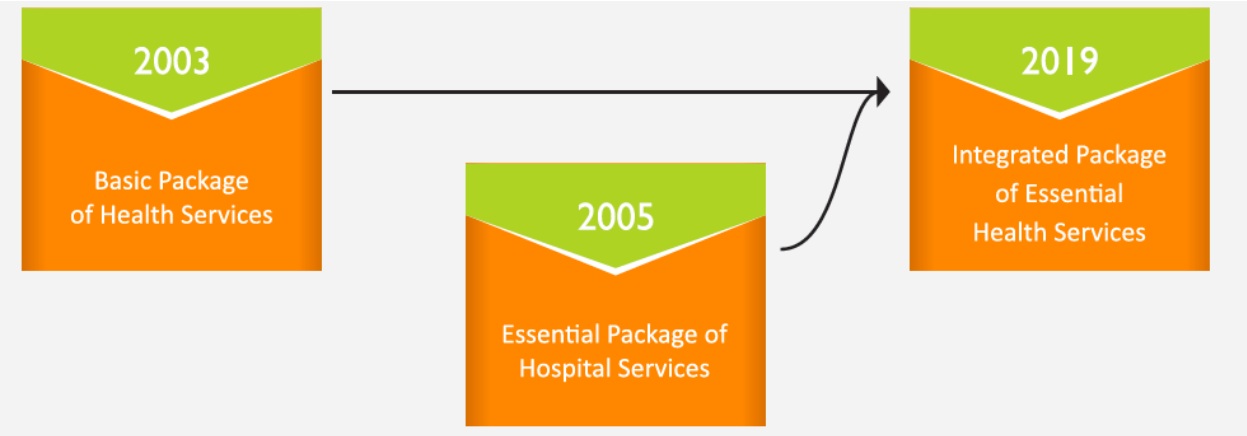
Islamic Republic of Afghanistan
Ministry of Public Health

Integrated Package of Essential Health Services 2019



VISION OF THE MINISTRY OF PUBLIC HEALTH 2015 - 2020

All citizens reach their full potential in health contributing to peace, stability and sustainable development in Afghanistan.

VALUES OF THE MINISTRY OF PUBLIC HEALTH 2015 - 2020

Equity Integrity Right to Health Accountability Trust

MISSION STATEMENT, MINISTRY OF PUBLIC HEALTH 2015 - 2020

The Mission Statement of the Ministry of Public Health of the Government of the Islamic Republic of Afghanistan is to prevent ill health and achieve significant reductions in mortality in line with the national targets and sustainable development goals and to reduce impoverishment due to catastrophic health expenditure. Also to be responsive to the rights of citizens through improving access and utilization of quality, equitable, affordable health and nutrition services among all communities especially mother and children in rural areas, And through changing attitudes and practices, promoting healthy lifestyles and effectively implementing other public health interventions. All in coordination and collaboration with other stakeholders within the framework of strong leadership, sustained political will and commitment, good governance, and effective and efficient management; in its continuous pursuit to become a ministerial ‘institution of excellence’.

TABLE OF CONTENT

FOREWARD

I am very pleased to see this booklet on the Integrated Package of Essential Health Services 2019. Dr Tedros, the World Health Organization Director-General and myself in January this year here in Kabul, officially launched the new package as a policy brief.

Bringing together in this publication, and in one package, health, clinical and surgical interventions, population public health interventions, and inter-sectoral policy interventions, will go a long way towards helping improve the health of all Afghans. Sound, efficient implementation of the whole package will also help make the health system even more resilient, especially to disease and injury shocks. And will also contribute to having a more responsive and inclusive health system.

Of the total of 164 different interventions in the package, 84 are highlighted as the highest priority for implementation. This is a guide to those interventions that will have the most impact should resources be low and/or access difficult. It is hoped that this approach will particularly be of use to other countries with on-going armed conflict or chronic emergencies.

This booklet on the new package is very much a reflection of the sustained commitment and strong leadership that I pledged on my appointment as Minister of Public Health in 2015. I am proud to have the Integrated Package of Essential Health Services 2019 as part of the legacy of my tenure as Minister.

ACKNOWLEDGEMENTS

The Ministry of Public Health is particularly grateful and indebted to the Bill and Melinda Gates Foundation for their funding of the work undertaken. In particular, without the funding we would not have been able to access the quality advice and help that we got through the international members of the Expert Committee. During the process of the development of the package there was added value as a result of the interaction between local and international members of the committee. The Ministry is also very appreciative of the London School of Hygiene and Tropical Medicine for 'housing' the grant and for a staff member, Karl Blanchet, in undertaking the international coordination of the work.

As just hinted the Ministry is very grateful for the advice of members of the Expert Committee – see annex C for the list of members. They gave their time among their busy schedules to attend committee meetings and give useful inputs on ways to move forward. And one member, Teri Reynolds, even came out to Kabul to advise on one of the new health services in the package and help with editing the list of interventions.

Many stakeholders in country have put in hours, days and more of quality work – see for example, annex B for the list of the working group members. Other local stakeholders who have provided a substantial input include the MoPH General Directorate of Monitoring & Evaluation and Health Information System led by Sayad Ataullah Saeedzai, and the MoPH General Directorate of Health Economics and Financing led by Farhad Farewar. They and their staff usefully questioned whether the introduction of any new interventions was relevant, feasible, affordable, and will help improve equitable access to health services.

And last but not least a special thank you to former deputy minister Ahmad Jan Naeem and to Stephanie Simmonds for their oversight from day 1 of, and inputs to, the process to develop the package.

Feroz Ferozuddin MD, MBA, MScPHM
Minister of Public Health
June 2019

EXECUTIVE SUMMARY

Packages of essential health services have been developed in a number of middle and low-income countries. This is with the intention of helping ensure that the population has access to a standard set of priority health services that give emphasis to primary care. This Ministry of Public Health (MoPH) Integrated Package of Essential Health Services 2019 (IPEHS) is a re-design of, and builds upon what is already being done through the 2003 Basic Package of Health Services (BPHS) and the 2005 Essential Package of Hospital Services (EPHS). The re-design has been done to better reflect the current epidemiological profile, and health needs and demands in the country.

This one document, and the package, has health, clinical and surgical interventions - table 1, population public health interventions - table 2, and inter-sectoral policy interventions - table 3. There are a total of 164 different types of interventions of which 84 are highlighted as the highest priority for implementation should resources be low and/or access difficult. It is intended and hoped that this approach will be helpful to other countries with on-going armed conflict or chronic emergencies.

All the interventions are based on international and/or local evidence of effectiveness, cost-efficiency, and feasibility of implementation. If implemented effectively there should be both more equitable access and significant outcomes. If the management of the implementation of the package is sound, it should help improve the quality of health services.

The health, clinical and surgical interventions in table 1 reflect the triple burden of communicable diseases, chronic non-communicable diseases, and injuries due to armed conflict and road traffic accidents. Nine health services are listed, of which just 3 are new. And two of the three, chronic diseases - cancer, hypertension and diabetes - and palliative care, are limited to a very few affordable interventions.

Table 2 formalises 11 population based public health interventions of which two are of the highest priority.

The 15 inter-sectoral inter-ministerial policy interventions in table 3 address the social, environmental, and occupational determinants of health. The ‘package’ of policy interventions has the highest likely magnitude of health effect in the country.

Addressing the health of vulnerable groups such as women and children has always been an important strategy for the ministry. This new package maintains the approach with the highest number of interventions dedicated to reproductive, maternal, newborn, child, and adolescent health. In addition, the integrated package also addresses the vulnerability of urban populations in the country, because of armed conflict, by explicitly including emergency care as one of the essential health services. The increasing numbers of people injured in road traffic accidents in rural and urban areas will also benefit from the service.

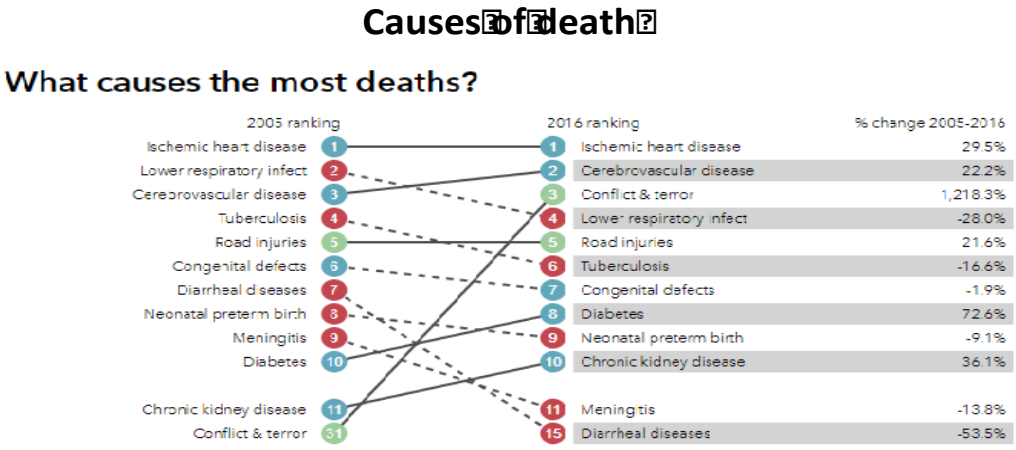
As a step towards universal health coverage, whether urban or rural, the interventions have been streamlined across 7 levels of the health system from the community level through to the provincial hospital level as can be seen in table 1. Among other things this highlights the role and responsibilities of health service providers at each of the 7 levels.

Finally, section 1 of this booklet gives a brief oversight of what is in the IPEHS and why. In section 2 are the 3 tables of interventions. Section 3 gives the method being used to both cost the IPEHS and to estimate the current cost of BPHS and EPHS health services. The data collected has not yet been fully analysed and verified. Stakeholders will be informed in the next few months of the financial costs. And section 4 highlights the work needed to be done to effectively and efficiently monitor and evaluate the IPEHS. At annex A mention is made briefly of the essential medicines and diagnostics needed for the IPEHS.

Office of the Minister of Public Health
June 2019

1. What is in the IPEHS 2019 why and how?

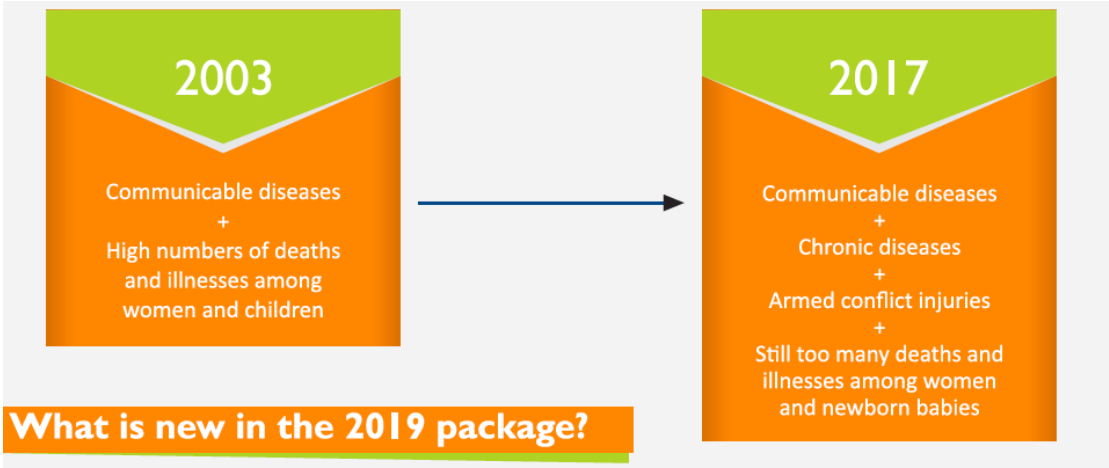
Why change the content of the current packages of health services?
There has been a marked change in the causes of illness and death in Afghanistan since the design by the MoPH of the 2003 BPHS and the 2005 EPHS. The primary focus 2002 onwards was on the control and prevention of communicable diseases and reducing the very high mortality among mothers and children.



Top 10 causes of death in 2016 and percent change, 2005-2016, all ages, number (IHME, 2016)

In 2016 and 2017 the burden of disease analysis showed a triple burden of communicable diseases, chronic diseases and emergencies due to armed conflict and road traffic accidents. In addition, there is the on-going challenge of still too many maternal and neonatal deaths.

Both the BPHS and EPHS helped focus on the priority health services with the BPHS emphasising primary care. The Ministry led the strategy for the effective implementation of both packages. With government contracted health service providers managing the health provision in government owned health facilities. The process has greatly helped reduce levels of mortality and morbidity in the country. But it is more than a decade since the two packages were designed. To meet the changing needs and taking advantage of the publication of Disease Control Priorities 3 (DCP3)[1] [2] a re-design process was initiated in 2018.



What is different about the new IPEHS?

[1] Disease Control Priorities. DCP3. http://dcp-3.org/
[2] Pamela Das, Richard Horton, Disease Control Priorities, 3rd edition – from theory to practice. The Lancet, Volume 391, 17 March 2018

There has been some useful strategic thinking and a series of actions resulting in the combining of the BPHS and the EPHS into one integrated package, the IPEHS. In section 2 the three tables - table 1, population public health interventions - table 2, and inter-sectoral policy interventions - table 3, have a grand total of 164 different types of interventions. Of these 84 are highlighted as the highest priority for implementation. This is a guide to those interventions that will have the most impact should resources be low and/or access difficult. In table 1 there is a sub-total of 304 interventions. This is because some of the same interventions are repeated at some, or in rare cases, all 7 levels of the health system up to provincial level.

The following summarises what is different about the IPEHS. This is followed by a few words about each of the key strategic actions that were determined during the decision making process about the IPEHS:

- Systematically re-structured many of the existing activities and services in the BPHS and EPHS into strategic actions/interventions and added a few new interventions to better match health services to the 2017 epidemiological pattern of disease in the country, and needs and demands. The new interventions are mainly on: emergency care, palliative care, and the prevention and treatment of two chronic non-communicable diseases, diabetes and hypertension.

- Focused on strategic interventions not detailed activities. Activities are for each province to decide upon given the needs and epidemiological context.

- Formalised population based public health interventions such as mass media messages about healthy eating, physical activity, and mental well being.

- Identified priority high impact inter-sectoral, inter-ministerial policy interventions that impact on health.

- Organised the interventions into an integrated health delivery system, reflecting a core value of the Ministry, equity, and the drive towards universal health coverage.

- Streamlined universal health coverage, whether urban or rural, across 7 levels of the health system from the community level through to the provincial hospital level.

- Highlighted those interventions in all 3 tables that are highest priority for implementation.

- Formalised an on-going process to identify the key implications of the IPEHS for the MoPH as the lead governmental institution for health.

Systematic re-structuring

The exercise to identify the most strategic interventions needed highlighted that over the past 10 -15 years some of the government contracted health service implementing partners have been adapting the provision of health services to the on going needs of people. For example, of the 133 different types of health, medical and surgical interventions in table 1 a few are already being provided in health facilities but are not mentioned in the BPHS or the EPHS. Reflecting that some implementing partners are being pro-active about responding to the needs of the people.

The 133 different types of health, medical and surgical interventions are listed under the following 9 health service headings:

1. Reproductive, maternal, and newborn
2. Child and adolescent health development
3. Infectious diseases
4. Chronic, non-communicable diseases
5. Mental, neurological and substance use disorders
6. Emergency care
7. Surgery

8. Palliative care
9. Rehabilitation

Of the 133 interventions, 92 constitute essential universal health care interventions and will contribute to universal health coverage (according to DCP3). The 92 interventions are based on international and/or local evidence of effectiveness, cost-efficiency, and feasibility of implementation. The remaining 41 interventions are country context specific. Table 1 is being costed as is the current BPHS and EPHS.

Formalised population based public health interventions
One of policy initiatives in the National Health Policy 2015-2020[3] aims to ensure that there is a balance between downstream health care services and upstream 'health'. It is stated that 'Quality health care is vital to all of us at some time in our life. To be healthy is vital to all of us all the time.' This is now reflected in table 2 that formalises 11 population based public health interventions, of which two are top priority. To date, most of the public health interventions listed in the table have been undertaken on an ad hoc basis. Flexibility and adaptation will be needed province by province. The costs of the interventions are not included in the cost of the IPEHS.

Identified policy inter-sectoral interventions
There is a list of 15 top priority urgent inter-sectoral policy interventions for early implementation. The interventions address the social, environmental, and occupational determinants of health to reduce behavioural and environmental risks, for the prevention of ill health and to reduce health related poverty – see table 3. The 15 policy interventions are not in order of priority and ideally need to be addressed concurrently as a 'package'.

The policy interventions have the strongest international evidence and the highest likely magnitude of health effect in the country. The interventions are also likely to provide best value for money and be feasible in the low income context of Afghanistan. The costs of the inter-sectoral inter-ministerial policy interventions are not included in the cost of the IPEHS.

Organised the interventions into an integrated health delivery system
The package has been developed bearing in mind a value of the MoPH since 2002, that of equity. Its design has also been within the framework of the principles of universal health coverage including minimising the financial risks to the people of Afghanistan, especially the poor 'leaving no-one behind'. Effective implementation of the package should contribute substantially to helping the country achieve the ambitious health goal in the Sustainable Development Goals 2030.

Streamlined universal health coverage
It can be seen in table 1 of the IPEHS that interventions have been listed across 7 levels of the health system from the community level through to the provincial hospital level, whether urban or rural. At each level there is also the number and type of health personnel allocated as of December 2018. The information is being used at the time of writing this document to identify any staffing gaps given the interventions in the IPEHS.

The interventions that are highest priority
Difficult choices have to be made in a low-income resource poor country such as Afghanistan. And especially so when access can be difficult such as in winter in the mountainous areas of the country or because of armed conflict. For this reason, using as a guide those interventions listed in DCP3 as highest priority, and considering the country context, 84 interventions have been determined as highest priority for implementation. These have been highlighted in bold in all 3 tables.

Focused on strategic essential interventions not detailed activities
All three tables have strategic essential interventions. Table 1 shows which interventions are needed at which level of the health system; from community health posts staffed by community health workers through to the provincial hospital level. Detailed activities have not been given. This allows for flexibility in each province depending on the context and gives the opportunity

[3] National Health Policy 2015 – 2020, Ministry of Public Health, Kabul, Afghanistan

for provincial health offices to decide in consultation with the government contracted health service providers, what the approach should be depending on the epidemiology, and needs and demands of the population.

On-going process to identify key implications of the IPEHS
The IPEHS health, clinical and surgical interventions have been reviewed to determine what essential medicines and diagnostics are needed – see annex A.

MoPH directorates have been asked for their suggestions on the implications for staffing levels and type of health personnel. Some findings, for example on additional senior professional staff needed, once agreed by the ministry top management, may need to be discussed/negotiated with the Afghan Civil Service Commission.

For those interventions that have been added to the list that are new to the health system in Afghanistan, directorates have also been asked if there are any professional continuing education or training implications. This is necessary to help ensure the quality, competent and effective implementation of any new intervention.

Parallel to the development of the 2019 integrated package of health services a new list of essential clinical services[4] has been designed for regional and tertiary hospitals. The quality of care will be improved by standardising the most essential cost-effective evidence based clinical interventions and diagnostics that must be available at these levels of the health system. Packages of care are now being developed for regional and tertiary hospitals e.g. an essential package of cancer control interventions[5].

How was the IPEHS designed?
For the sake of brevity the process described here fails to mention a number of meetings and consultations, other forum, and the coordination mechanisms that took place over about an eighteen-month period. A publication detailing the process will be produced by the LSHTM in consultation with the MoPH sometime in the future. The following brief description is from a MoPH perspective.

The process was MoPH conceived and driven[6]. It involved a number of local and international stakeholders and experts. Nine working groups in the ministry did a major piece of work on the first draft about, and finalisation of, the content of the IPEHS. Led by the director of the relevant directorate or department, the working groups comprised MoPH central level decision makers, provincial level staff, implementers, and some international organisations and agencies – see annex B for both the lead for each working group and their corresponding DCP3 volumes, and the members of each working group. The MoPH Monitoring & Evaluation and Health Information System General Directorate provided any relevant information as requested by the groups.

The task of the working groups was to develop a draft new package of health services through:

- ✓ Identifying and building upon what was already being done through the implementation of the BPHS and EPHS and any work that had been added
- ✓ Using the relevant volume of Disease Control Priorities 3 (DCP3) as a guide as to international cost-effective interventions
- ✓ Using four selection criteria for any intervention that is country context specific and not in DCP3. They are equity, effectiveness, feasibility, and affordability
- ✓ Using the MoPH 2017 epidemiological profile to identify the top priority conditions and causes of premature death

[4] Using DCP3 table 7 as a guideline – see supplement to Jamison DT, Alwan A, Mock CN, et al. Universal health coverage and inter-sectoral action for health: key messages from Disease Control Priorities 3rd edition. Lancet 2017; published online November 24. http://dx.doi.org/10.1016/SO140-6736(17)32906-9
[5] See for example, Hellen Gelband et al, Costs, affordability, and feasibility of an essential package of cancer control interventions in low income and middle income countries: The Lancet, published online, 11 November 2015, http://dx.doi.org/10.1016/
[6] For more on the process see K Blanchet, F Ferozuddin, AJ Naeem, F Farewar, SAA Saeedzai, and S Simmonds, 2019, Perspectives: Priority setting in a context of insecurity, epidemiological transition and low financial risk protection in Afghanistan. Published online 1 April 2019, Bulletin of the World Health Organization

- ✓ Deciding the highest priority interventions in their specific subject

The full list of draft interventions was then sent to the Expert Committee for their suggestions. The committee was formed in early 2018 to provide expert advice during the process of developing a sound, relevant package of health services. It comprised national and international members, two national advisers to the committee, and some observers – see annex C.

The Expert Committee returned a revised draft list of interventions to the ministry for finalisation and at about the same time the ministry received a draft list of essential medicines and diagnostics for the IPEHS from WHO Geneva.

By end December 2018 while the finalisation process was still on going, a two page policy brief on the IPEHS had been written and printed[7]. Minister Feroz and Dr Tedros, the World Health Organization Director-General who was vising Kabul, used the policy brief early January 2019 to launch the package.

Figure 1 From right to left Minister Feroz and Dr Tedros

Between January and May 2019 the finalisation of the process to review both draft lists and the costing of the IPEHS and the current cost of the BPHS was on going. For the draft lists the work needed each working group to comment on the health service interventions relevant to them, and similarly review the essential medicines and diagnostics. The groups sent their comments and suggestions for collation to the MoPH Monitoring & Evaluation and Health Information System General Directorate. The directorate passed them on to the MoPH members of, and advisers to, the Minister for their recommendation.

With these tasks finalised local members of, and advisers to, the Expert Committee were able to finish drafting sections of this booklet ready for approval by the MoPH Executive Committee. Information on the cost of the IPEHS and the current cost of implementing the BPHS is not yet available. It will be released in a few months time.

[7] Policy brief, December 2018, Integrated Package of Essential Health Services, Ministry of Public Health, Kabul, Afghanistan

Ministry of Public Health, Afghanistan

Integrated Package of Essential Health Services 2019: Health, Medical, and Surgical Interventions

Table 1. Health, medical, and surgical interventions

*Please note that both the number of each type of facility and the staffing levels shown listed in first two rows of this table were as of December 2018. The Ministry is now examining the implications of the IPEHS and so the numbers and types of staff may change over time. Updates can be obtained from the MoPH Monitoring & Evaluation and Health Information System General Directorate.

Community health post 16,510*	**Mobile health teams 309***	**Sub-health centre (SHC) 1,001***	**Basic health centre (BHC) 874***	**Comprehensive health centre (CHC) 433***	**District hospital 85***	**Provincial hospital 27***
2 Community health workers (CHWs), one female and one male	Doctor do Doctor (where possible),	*Staff: 1 male nurse; 1 community midwife; 1 cleaner/guard	*Staff: 1 male nurse; 1 community midwife; l laboratory technician; 1 cleaner/guard	*Staff: 1 male nurse; 1 female nurse; 2 community midwives; 1 community health supervisor; 2 vaccinators; 1 male physician; 1 female physician; 1 laboratory technician; 1 pharmacy technician; 1 psychosocial counsellor; 1 administrator; 4 cleaners/guards; 1 driver	*Staff: 2 male physicians general; 2 female physicians; 1 surgeon; 1 anaesthetist; 1 paediatrician; 1 dentist; 5 male nurses; 5 female nurses; 4 midwives; 1 community health supervisor; 1 pharmacist; 2 vaccinators; 2 laboratory technicians; 1 dental technician; 1 x-ray technician; 1 physiotherapist; 6 cleaners/guards; 1 driver	*Staff: 2 surgeons; 1 anaesthetist; 2 obstetrician /gynaecologists; 2 paediatricians; 2 medical specialists; 7 general practitioners); 1 dentist; 5 nurses; 8 midwives; 12 ward nurses; 2 anaesthetic nurses; 4 nurses for emergency room and outpatient department; 1 physiotherapist; 2 pharmacists; 2 x-ray technicians; 4 laboratory technicians; 1 dental technician; 2 vaccinators; 2 technical assistants; driver

A. Reproductive, Maternal and Newborn Health Interventions = 33 of which 20 are MoPH high priority for implementation						
**C1. Family health groups especially for support when there is domestic violence, for newborn care, and nutrition education	*See also mental health section*	*See also mental health section*	*See also mental health section*	*See also mental health section*		
^C2. Provision of appropriate vitamin and mineral supplementation (including vitamin D) to pregnant and lactating women	MHT1. Provision of mineral supplementation (including vitamin D), and **tetanus vaccination**	S1. At least 4 antenatal care visits by pregnant women that includes essential education on maternal health and family planning, support for those experiencing domestic violence, recognition of danger signs for hypertensive disorders and gestational diabetes, promotion of healthy diet and relevant vitamin and mineral supplementation (including vitamin D), HIV education and counselling, and **tetanus vaccination**	B1. At least 4 antenatal care visits by pregnant women that includes essential education on maternal health and family planning, support for those experiencing domestic violence, recognition of danger signs for hypertensive disorders and gestational diabetes, promotion of healthy diet and relevant vitamin and mineral supplementation (including vitamin D), HIV education and counselling, and **tetanus vaccination**	**^CHC1**. Comprehensive antenatal care for complicated pregnancy including management of hypertensive disorders, **gestational diabetes, PMTCT of HIV**, vitamin and mineral supplementation (including vitamin D) and nutrition interventions	**^DH1**. Comprehensive antenatal care for complicated pregnancy, including management of hypertensive disorders, **gestational diabetes, PMTCT of HIV**, vitamin and mineral supplementation (including vitamin D) and relevant nutrition interventions	**^PH1.** Comprehensive antenatal care for complicated pregnancy, including management of hypertensive disorders, **gestational diabetes, PMTCT of HIV**, vitamin and mineral supplementation (including vitamin D) and nutrition interventions
C3. Information on recognition of signs of pre-term labour	**^MHT2**. **Early detection of pre-term labour and premature rupture of membranes with timely referral and first dose of antibiotic if indicated**	**^S2. Early detection of pre-term labour and premature rupture of membranes with timely referral and first dose of antibiotic if indicated**	**^B2. Early detection of pre-term labour and premature rupture of membranes with timely referral and first dose of antibiotic if indicated**	**^CHC2. Early detection of pre-term labour and premature rupture of membranes with timely referral and first dose of antibiotic if indicated**	**^DH2. Management of preterm labour and pre-term pre-labour rupture of membranes with antenatal corticosteroids and antibiotic as indicated**	**^PH2. Management of pre-term labour and pre-term pre-labour rupture of membranes with antenatal corticosteroids and antibiotic as indicated**
	MHT3. Early detection of signs of pre-eclampsia with timely referral	S3. Early detection of signs of pre-eclampsia with timely referral	**^B3. Initial stabilization and management of eclampsia with intra-muscular injection of magnesium sulphate, and transfer to hospital**	**^CHC3. Initial stabilization and management of eclampsia with intra-muscular or intravenous loading dose of magnesium sulphate, and transfer to hos[ital**	**^DH3. Comprehensive management of eclampsia [FLH4]**	**^PH3. Comprehensive management of eclampsia**

	^MHT4 In remote areas, initial treatment of obstetric or delivery complications prior to transfer	**^S4. In remote areas, management of labour and delivery in low risk women and adolescents (BEmNOC), including initial treatment of obstetric or delivery complications prior to transfer**	**^B4. Management of labour and delivery in low risk women and adolescents (BEmNOC), including initial treatment of obstetric or delivery complications prior to transfer**	**^CHC4. Management of labour and delivery in low risk women and adolescents (BEmNOC), including initial treatment of obstetric or delivery complications prior to transfer**	**^DH4. Management of labour and delivery in high risk women and adolescents including caesarean delivery (CEmNOC)**	**^PH4. Management of labour and delivery in high risk women and adolescents including caesarean delivery (CEmNOC)**
^C4. Promotion of Kangaroo care and early breastfeeding		**^S5. Helping babies breathe interventions**	**^B5. Helping babies breathe interventions**	**^CHC5. Management of newborn complications, including jaundice, neonatal meningitis, and other very serious infections requiring continuous supportive care (intravenous fluids, oxygen, etc.)**	*See emergency care section*	
C5. Post-natal home visit within 24 hours	**^MHT5. Referral for clinical signs of pre and post natal maternal and neo-natal danger signs especially maternal sepsis**	**^S6. Early recognition and referral for clinical signs of pre and post natal maternal and neo-natal danger signs especially maternal sepsis**	**^B6. Early recognition and referral for clinical signs of maternal sepsis**	**^CHC6. Early recognition and referral for clinical signs of maternal sepsis**	**^DH5. Management of maternal sepsis, including early detection**	**^PH5. Management of maternal sepsis**
C6. Post-natal reproductive health visit in home or family health house (FHH) that includes distribution of family planning commodities, resumption of sexual activity and pelvic floor exercises	MHT6. Distribution of family planning commodities	S7. Post-natal visit that includes advice about birth spacing, family planning, resumption of sexual activity and pelvic floor exercises	B7. Post-natal visit that includes advice about birth spacing, family planning, resumption of sexual activity, and pelvic floor exercises	CHC7. Post-natal visit that includes advice about birth spacing, family planning, resumption of sexual activity, and pelvic floor exercises		
	MHT7. Counselling and referral for miscarriage or incomplete, or missed abortion	S8. Counselling and referral for miscarriage or incomplete, or missed abortion	**^B8. Management of miscarriage or incomplete or missed abortion and post abortion care [HC2]**	**^CHC8. Termination of pregnancy for medical reasons including by manual vacuum aspiration**	**^DH6. Surgical termination of pregnancy for medical reasons by manual vacuum aspiration and dilation and curettage**	**^PH6. Surgical termination of pregnancy for medical reasons by manual vacuum aspiration and dilation and curettage**
					^DH7. Operative treatment for ectopic pregnancy or ovarian cyst torsion	**^PH7. Operative treatment for ectopic pregnancy or ovarian cyst torsion [**
					^DH8. Hysterectomy for uterine rupture or	**^PH8. Hysterectomy for uterine rupture or**

					intractable postpartum haemorrhage	**intractable postpartum haemorrhage**
C7. Provision of condoms and hormonal contraceptives including emergency contraceptives	**MHT8. Administration of long acting contraceptive methods**	**^S9. Referral for, or where available, administration of, long acting contraceptive methods**	**^B9. Insertion and removal of long-acting contraceptives**	**^CHC9. Insertion and removal of long acting contraceptives**	**^DH9. Surgical methods of contraception including tubal ligation and vasectomy**	**^PH9. Surgical methods of contraception including tubal ligation and vasectomy**
						PH10. Repair of obstetric fistula
				^C10. Post gender based violence care, including provision of emergency contraception, and rape response referral (medical and judicial) [	**^DH10. Post gender based violence care, including provision of emergency contraception, and rape response referral (medical and judicial)**	**^PH11. Post gender based violence care including provision of emergency contraception, and rape response referral (medical and judicial)**
				^CHC11. Early detection by visual inspection of early stage cervical cancer with referral	**^DH11. Early detection by visual inspection and treatment by cryotherapy and colposcopy of early-stage cervical cancer**	**^PH12. Early detection by visual inspection and treatment by cryotherapy and colposcopy of early-stage cervical cancer**
B. Child and Adolescent Health and Development Interventions = 12 of which 7 are MoPH high priority for implementation						
For treatment of acute infections see infectious disease section and emergency care section						
C8. Monthly growth monitoring and health promotion for children under 5 with referral for malnutrition or other complications	MHT9. Referral for malnutrition or other complications	S10. Monthly growth monitoring and health promotion for children under 5 with referral for malnutrition or other complications	B10. Monthly growth monitoring and health promotion for children under 5 with referral for malnutrition or other complications	CHC12. Monthly growth monitoring and health promotion for children under 5 with referral for malnutrition or other complications		
		S11. Routine visits to promote early child development, monitoring for expected developmental milestones and referral for delay in development	B11. Improve early child development through introduction of early child development services	CHC13. Improve early child development through introduction of early child development services	DH12. Targeted therapeutic programmes for children referred with developmental delays including motor, sensory, and language stimulation	

C9. Promotion of relevant childhood nutrition interventions		S12. Promotion of relevant childhood nutrition interventions	**^B12. Management of severe acute malnutrition**	**^CHC14. Management of severe acute malnutrition associated with serious infection**	**^DH13. Management of severe acute malnutrition associated with serious infection**	**^PH13. Management of severe acute malnutrition associated with serious infection**
^C10. Education on hand washing and safe disposal of children's faeces	**^MHT10. Basic treatment of acute diarrhoea including oral fluids and zinc tablet**	**^S13. Basic treatment of acute diarrhoea including oral fluids**	**^B13. Basic treatment of acute diarrhoea including oral fluids**	**^CHC15. Advanced treatment of severe diarrhoea including IV fluids**	*See emergency care section for treatment of severe dehydration and shock*	
C11. Periodic outreach initiatives for age appropriate child vaccination	**^ MHT11. Routine age appropriate immunization**	**^S14. Routine age appropriate immunization**	**^B14. Routine age appropriate immunization**	**^CHC15. Routine age appropriate immunization**	**^DH14. Routine age appropriate immunization**	**^PH14. Routine age appropriate immunization**
C12. Promotion of child safety including prevention of road traffic injury, falls and poisoning		S15. Promotion of child safety including prevention of road traffic injury, falls and poisoning	B15. Promotion of child safety including prevention of road traffic injury, falls and poisoning	CHC16. Promotion of child safety including prevention of road traffic injury, falls and poisoning		
			B16. Early identification of lead poisoning and counselling of families to reduce or prevent exposure to lead in the environment	CHC17. Early identification of lead poisoning and counselling of families to reduce or prevent exposure to lead in the environment	*See emergency care section for management of acute poisoning and toxic exposure*	
C13. Treatment of acute pharyngitis in children to prevent rheumatic fever	MHT 12. Treatment of acute pharyngitis in children to prevent rheumatic fever	S16. Treatment of acute pharyngitis in children to prevent rheumatic fever	B17. Treatment of acute pharyngitis in children to prevent rheumatic fever	CHC18. Treatment of acute pharyngitis in children to prevent rheumatic fever	DH15.Treatment of acute pharyngitis in children to prevent rheumatic fever	
C. Infectious Diseases Interventions = 18 of which 11 are MoPH high priority for implementation						
		S17. Targeted age based and risk based vaccinations for adults including tetanus, pneumococcus, influenza, hepatitis B, and any other relevant vaccinations	B18. Targeted age based and risk based vaccinations for adults including tetanus, pneumococcus, influenza, hepatitis B, and any other relevant vaccinations	CHC19. Targeted age based and risk based vaccinations for adults (including tetanus, pneumococcus, influenza, hepatitis B, and any other relevant vaccinations	DH16. Targeted age based and risk based vaccinations for adults including tetanus, pneumococcus, influenza, hepatitis B, and any other relevant vaccinations	

^C14. Mass helminthiases medicine administration	**^MHT13. Mass helminthiases medicine administration**	**^S18. Mass helminthiases medicine administration**				
		^S19. Early detection and treatment of leishmaniasis				
C15. Contact tracing for tuberculosis						
		^S20. HIV education and counselling, and provision of condoms for high risk individuals	**^B19. Provider initiated testing and counselling for HIV, sexually transmitted infections, and hepatitis, including for adolescents, with rapid treatment of sexually transmitted infections, and referral for the immediate starting of treatment for those testing positive for HIV**	**^CHC20. Provider initiated testing and counselling for HIV, sexually transmitted infections, and hepatitis, including for adolescents, with immediate treatment of sexually transmitted infections, provision of PrEP where relevant, and starting and on-going monitoring of appropriate treatment for those testing positive for HIV**	**^DH17. Provider initiated testing and counselling for HIV, sexually transmitted infections, and hepatitis, including for adolescents, with immediate treatment of sexually transmitted infections, provision of PrEP where relevant, preventive therapies for children born to mothers with HIV, and starting and on-going monitoring of appropriate treatment for those testing positive for**	**^PH15. Provider initiated testing and counselling for HIV, sexually transmitted infections, and hepatitis, including for adolescents, with immediate treatment of sexually transmitted infections, provision of PrEP where relevant, preventive therapies for children born to mothers with HIV, and the starting and on-going monitoring of appropriate treatment for those testing positive for HIV**
				CHC21. Following a new diagnosis of HIV, initial and annual screening for latent tuberculosis infection, initiation of isoniazid preventive therapy among all with positive screen but no evidence of active tuberculosis	DH18. Following a new diagnosis of HIV, initial and annual screening for latent tuberculosis infection, initiation of isoniazid preventive therapy among all with positive screen but no evidence of active TB	PH16. Following a new diagnosis of HIV, initial and annual screening for latent tuberculosis infection, initiation of isoniazid preventive therapy among all with positive screen but no evidence of active tuberculosis
				^CHC22. Provider initiated diagnosis of tuberculosis using sputum smear, and initiation of first line and second line treatment per current WHO guidelines for drug susceptible	**^DH19. Confirmation, further assessment of drug resistance, and treatment of drug resistant tuberculosis**	**^PH17. Drug susceptibility testing for cases of treatment failure and tertiary referral as needed; enrolment of those with MDR-TB for treatment**

				tuberculosis; referral for confirmation, assessment of drug resistance, and treatment of drug resistant tuberculosis		
				CHC23. For PLHIV and children under 5 who are close contacts of individuals with active TB, perform symptom screening, chest x-ray, and preventive therapy	DH20. For PLHIV and children under 5 who are close contacts of individuals with active TB, perform symptom screening, chest x-ray, and preventive therapy	PH18. For PLHIV and children under 5 who are close contacts of individuals with active TB, perform symptom screening, chest x-ray, and preventive therapy
				^CHC24. Screening for HIV in all individuals with a diagnosis of active tuberculosis; if HIV present, initiation of ARV treatment and HIV care	**^DH21. Screening for HIV in all individuals with a diagnosis of active tuberculosis; if HIV present, initiation of ARV treatment and HIV care**	**^PH19. Screening for HIV in all individuals with a diagnosis of active tuberculosis; if HIV present, initiation of ARV treatment and HIV care**
^C16. In high prevalence areas use of rapid diagnostic test for malaria vivax and P. malariae with treatment with relevant anti-malarial medicines	**^MHT14. Treatment of malaria diagnosed by rapid diagnostic test with relevant oral/rectal anti-malarial medicines**	**^S21. In high prevalence areas where rapid tests and microscopy are unavailable, clinically diagnosed uncomplicated malaria with relevant anti-malarial medicines**	**^B20. Treatment of malaria diagnosed by rapid diagnostic test with relevant oral/rectal anti-malarial medicines**	**^CHC25. Treatment of malaria diagnosed by rapid diagnostic test with relevant oral/rectal anti-malarial medicines**	**^DH22. Management of severe malaria including with parenteral artesunate and full course of ACT**	**^PH20. Management of severe malaria including with parenteral artesunate and full course of ACT**
		S22. Provision of insecticide-treated nets to children and pregnant women in high risk areas	B21. Provision of insecticide-treated nets to children and pregnant women in high risk areas	CHC26. Provision of insecticide-treated nets to children and pregnant women in high risk areas		
C17. In the context of an emerging infectious outbreak, disseminate advice and guidance on how to recognise early symptoms and signs and when to seek medical attention	MHT15. Only at time of risk for outbreak, basic case based syndromic surveillance and reporting with contact with bodily fluids precautions	S23. Only at time of risk for outbreak, basic case based syndromic surveillance and reporting with contact precautions	B22. Only at time of risk for outbreak, basic case based syndromic surveillance and reporting with contact precautions	CHC27. Only at time of risk for outbreak, basic case based syndromic surveillance and reporting with contact precautions	DH23. Case based syndromic surveillance in emergency rooms/units and reporting with basic communicable disease isolation	PH21. Case based syndromic surveillance in emergency rooms or units and reporting with advanced communicable disease isolation

D. Chronic Non-Communicable Disease Interventions = 7 of which 3 are MoPH high priority for implementation						
			^B23. Screening for diabetes among at-risk adults, and continuation of prescribed treatment, including for control of glycaemia, blood pressure and lipids, and consistent foot care	**^CHC28. Screening and management of diabetes among at risk adults, including initiation of prescriptions for glycaemic control, and management of blood pressure and lipids**	*See emergency care section for management of acute complications*	*See emergency care section for management of acute complications*
	MHT16. Blood pressure measurement in those aged 40 years and above	S24. Periodic screening for hypertension for all adults and continuation of prescribed treatment	B24. Periodic screening for hypertension for all adults and continuation of prescribed treatment	CHC29. Initiation of treatment among individuals with severe hypertension, evidence of associated end organ changes or other high risk factors	DH24. Initiation of treatment among individuals with severe hypertension, evidence of associated end organ changes or other high risk factors	PH22. Initiation of treatment among individuals with severe hypertension, evidence of associated end organ changes or other high risk factors
				^CHC30. On-going management and monitoring of chronic cardiovascular disease with continuation of prescribed treatment to reduce risk of further events		*See emergency care section for management of acute exacerbations of cardiovascular disease, including ischaemia*
			B25. Chronic management of asthma and chronic obstructive pulmonary disorder with low dose inhaled corticosteroids and long acting bronchodilators	CH31. Chronic management of asthma and chronic obstructive pulmonary disorder with low dose inhaled corticosteroids and long acting bronchodilators.	DH25. Management of acute exacerbations of asthma and chronic obstructive pulmonary disorder *See also emergency care section*	

				^CHC32. Secondary prophylaxis with penicillin for rheumatic fever or established rheumatic heart disease	**^DH26. Secondary prophylaxis with penicillin for rheumatic fever or established rheumatic heart disease**	**^PH23. Secondary prophylaxis with penicillin for rheumatic fever or established rheumatic heart disease**
E. Mental, Neurological, and Substance Use Disorders Intervention = 18 of which 7 are MoPH high priority for implementation						
		S25. Screening for depression and anxiety disorders with interview based tools when possible	B26. Detection and referral for depression for all age groups using validated interview based tools	**^CHC33. Initiation of pharmacological and psychosocial support for depression**	**^DH27. Initiation of pharmacological and psychosocial counselling or psychotherapy for depression**	PH24. Detection and referral to regional hospital of complicated cases e.g. co-morbidity and dual diagnosis needing expert specialized attention, for all age groups using validated interview based tools
			B27. Detection of anxiety disorders for all age groups using validated interview based tools and referral for initiation of pharmacological treatment, referral for psychosocial support.	**^CHC34. Detection and referral for initiation of pharmacological treatment of all mental disorders for all age groups and continuation of psychosocial counselling** *See emergency section for clinically unstable*	**^DH28. Detection of common and severe disorders for all age groups and continuation of psychosocial counselling or psychotherapy with timely referral for initiation of pharmacological treatment** *See emergency section for clinically unstable*	**^PH25. Initiation of pharmacological and psychosocial counselling or psychotherapy for all mental health conditions**
			B28. Detection of substance use disorders for all age groups using validated screening tools, and referral to drug demand reduction programme for pharmacological treatment and referral for psychosocial counselling	CHC35. Detection of substance use disorders for all age groups using validated screening tools, and referral to drug demand reduction programme for pharmacological treatment and psychosocial counselling	DH29. Referral to drug demand reduction treatment facility programme for pharmacological treatment and referral for psychosocial counselling or psychotherapy *See emergency section for clinically unstable or acute e.g. overdose, drug-induced psychosis, suicide, self-harm, and violence*	PH26. Referral to drug demand reduction treatment facility for pharmacological treatment and referral to mental health hospital for psychosocial counselling or psychotherapy *See emergency section for clinically unstable or acute e.g., overdose, drug-induced psychosis, suicide*
			B29. Detection and follow up of psychotic disorders using validated interview based tools	CHC36. Detection, basic counselling and follow up of psychotic disorders	**^DH30. Prescription of pharmacological and psychosocial counselling**	

			with timely referral for management	using validated interview based tools with timely referral for management, and continuation of psychosocial counselling for psychotic disorders	**for psychotic disorders especially bi-polar and schizophrenia conditions** *See emergency section for clinically unstable e.g., severe acute agitation, suicide, self harm, violence*	
C18. Community education to limit exposure to violence, including all domestic violence and conflict	MHT17. Active detection of exposure to domestic and other violence and referral for appropriate care	S26. Active detection of exposure to domestic and other violence and referral for appropriate care	B30. Active detection of exposure to violence and referral for appropriate care	**^CHC37. Psychosocial counselling for those exposed to violence** *See also emergency care section for medical support)*	**^DH31. Advanced management for effects of exposure to violence** *See also treatment for anxiety, depression, and emergency care section for medical support*	**^PH27. Advanced management of effects of exposure to violence** *See also treatment for anxiety, depression, and emergency care section for medical support*
				CHC38. Continuation of prescribed pharmacological medicines and psychosocial counselling for epilepsy *See emergency section for clinically unstable e.g., active seizures*	**^DH32. Prescription and initiation of pharmacological and psychosocial interventions for epilepsy** *Also see emergency section for clinically unstable e.g. active seizures*	**^PH28. Prescription and initiation of pharmacological and psychosocial interventions for epilepsy** *Also see emergency section for clinically unstable e.g. seizures*
				CHC39. Initiation of self managed treatment using migraine protocol		
F. Emergency Care Interventions = 28 of which 13 are MoPH high priority for implementation						
^C19. *Pre-hospital care*: User activated dispatch of basic ambulance services from district level	**^MHT18. *Pre-hospital care*: User activated dispatch of basic ambulance services from district level**	**^S27*. Pre-hospital care*: User activated dispatch of basic ambulance services from district level**	**^B31*. Pre-hospital care*: User activated dispatch of basic ambulance services from district level**	**^CHC40*. Pre-hospital care*: User activated dispatch of basic ambulance services from district level**	**DH33. *Pre-hospital care*: User activated dispatch of basic ambulance services from district level**	**PH 29*. Pre-hospital care*: User activated dispatch of basic ambulance services at provincial level**

* As of December 2018 – the list of staff will be reviewed by the MoPH to determine if there are sufficient types and numbers of staff to implement the IPEHS. Once it is decided if, and what additional staff are needed, the ministry may need to have discussions with the Civil Service Commission as there may be cost and formal recognition of some disciplines of staff

** The letter in capital letters at the beginning of an intervention refers to the level of the health system or type of health facility e.g. C = community, DH = district hospital etc.

^C20. *Pre-hospital care:* WHO basic emergency care - Initial syndrome-based management at scene by pre-hospital providers for difficulty in breathing, shock, altered mental status, and poly trauma	**^MHT19. Pre-*hospital care:* WHO basic emergency care - Initial syndrome-based management at scene by pre-hospital providers for difficulty in breathing, shock, altered mental status, and poly trauma**	**^S28. *Pre-hospital care:* WHO basic emergency care - Initial syndrome-based management at scene by pre-hospital providers for difficulty in breathing, shock, altered mental status, and poly trauma**	**^B32. *Pre-hospital care:* WHO basic emergency care - Initial syndrome-based management at scene by pre-hospital providers for difficulty in breathing, shock, altered mental status, and poly trauma**	**^CHC41. *Pre-hospital care:* WHO basic emergency care - Initial syndrome-based management at scene by pre-hospital providers for difficulty in breathing, shock, altered mental status, and poly trauma**	**^DH34. *Pre-hospital care:* WHO basic emergency care - Initial syndrome-based management at scene by pre-hospital providers for difficulty in breathing, shock, altered mental status, and poly trauma**	**^PH30. *Pre-hospital care:* WHO basic emergency care - Initial syndrome-based management at scene by pre-hospital providers for difficulty in breathing, shock, altered mental status, and poly trauma**
^C21. *Pre-hospital care:* Direct provider monitoring during transport to appropriate health facility and structured handover to hospital personnel	**^MHT20. *Pre-hospital care:* Direct provider monitoring during transport to appropriate health facility and structured handover to hospital personnel**	**^S29. *Pre-hospital care:* Direct provider monitoring during transport to appropriate health facility and structured handover to hospital personnel**	**^B33. *Pre-hospital care:* Direct provider monitoring during transport to appropriate health facility and structured handover to hospital personnel**	**^CHC42. *Pre-hospital care:* Direct provider monitoring during transport to appropriate health facility and structured handover to hospital personnel**	**^DH35. *Pre-hospital care:* Direct provider monitoring during transport to appropriate health facility and structured handover to hospital personnel**	**^PH31. *Pre-hospital care:* Direct provider monitoring during transport to appropriate health facility and structured handover to hospital personnel**
	^MHT21. Recognition of danger signs in neonates, children and adults, including early recognition of signs of serious infection	**^S30. Recognition of danger signs in neonates, children and adults, including early recognition of signs of serious infection**	**^B34. Recognition of danger signs in neonates, children and adults, including early recognition of signs of serious infection**	**^CHC43. Recognition of danger signs in neonates, children and adults, including early recognition of signs of serious infection**	DH36. Triage of children and adults on arrival at facility with validated instrument (e.g. WHO/ICRC triage tool)	PH32. Triage of children and adults on arrival at facility with validated instrument (e.g. WHO/ICRC triage tool)
					DH37. Implementation of checklists for management of critically ill and injured patients in designated resuscitation area (WHO emergency and trauma care checklists)	PH33. Implementation of checklists for management of critically ill and injured patients in designated resuscitation area (WHO emergency and trauma care checklists)

^C22. First aid: Interventions include airway positioning, choking interventions, and basic external haemorrhage control (direct pressure, tourniquet)	**^MHT22. First aid: Interventions include airway positioning, choking interventions, and basic external haemorrhage control (direct pressure, tourniquet)**	**^S31. Basic life support, plus protocol based administration of oral fluids with adjustment for age and condition including malnutrition**	**^B35. Basic syndrome based management of difficulty breathing, shock, altered mental status, and poly trauma in dedicated emergency unit for neonates, children and adults {interventions include manual airway manoeuvres, oral/nasal airway placement, oxygen administration, bag-valve mask ventilation, temperature management, emergency administration of essential medications, including antibiotics for serious infection**	**^CHC44. Basic syndrome based management of difficulty breathing, shock, altered mental status, and poly trauma in emergency unit for neonates, children and adults {interventions include manual airway manoeuvres, oral/nasal airway placement, oxygen administration, bag-valve mask ventilation, temperature management, emergency administration of essential medications, including empiric antibiotics for serious infection**	**^DH38. Advanced syndrome based management of difficulty breathing, shock, altered mental status, and poly trauma in emergency unit, including for neonates, children and adults. (Interventions include intubation, mechanical ventilation, surgical airway, and placement of chest drain, haemorrhage control, defibrillation, administration of intravenous fluids via peripheral and central venous line with adjustment for age and condition, including malnutrition; emergency administration of essential medicines)**	**^PH34. Advanced syndrome based management of difficulty breathing, shock, altered mental status, and poly trauma in emergency unit, including for neonates, children and adults. (Interventions include intubation, mechanical ventilation, surgical airway, and placement of chest drain, haemorrhage control, defibrillation, administration of intravenous fluids via peripheral and central venous line with adjustment for age and condition, including malnutrition; emergency administration of essential medicines**
				CHC45. Management of severe acute exacerbations of asthma and chronic obstructive pulmonary disease {using systemic steroids, inhaled beta-agonists, and, if indicated, oral antibiotic and oxygen therapy	DH39. Management of acute ventilatory failure due to acute exacerbations of asthma and chronic obstructive pulmonary disease with use of bilevel positive airway pressure preferable	PH35. Management of acute ventilatory failure due to acute exacerbations of asthma and chronic obstructive pulmonary disease; in chronic obstructive pulmonary disease use of bilevel positive airway pressure preferable

			B36. Basic management of cardiovascular emergencies, including provision of aspirin for suspected acute myocardial infarction and external defibrillation [	CHC46. Basic management of cardiovascular emergencies, including provision of aspirin for suspected acute myocardial infarction and external defibrillation	**^DH40. Advanced management of cardiovascular emergencies, including myocardial infarction, heart failure, acute arrhythmia, tamponade, and acute critical limb ischemia. {Interventions include aspirin, unfractionated heparin and thrombolytics, pacing and synchronized cardioversion, pericardiocentesis}**	**^PH36. Advanced management of cardiovascular emergencies, including myocardial infarction, heart failure, acute arrhythmia, tamponade, and acute critical limb ischemia. {Interventions include aspirin, unfractionated heparin and thrombolytics, pacing and synchronized cardioversion, pericardiocentesis**
			B37. Recognition of, and referral for, clinical hypoglycaemia	CHC47. Recognition and initial management of hypoglycaemia and hyperglycaemia	DH41. Recognition and management of hypoglycaemia and hyperglycaemia, including treatment of diabetic ketoacidosis	PH37. Recognition and management of hypoglycaemia and hyperglycaemia, including treatment of diabetic ketoacidosis
				CHC48. Recognition of symptoms due e.g. to opioids/narcotics, sedative hypnotics or hallucinogens, including poisoning, acute intoxication and withdrawal symptoms, with referral for management	DH42. Recognition and management of symptoms due e.g. to opioids/narcotics, sedative hypnotics or hallucinogens, including poisoning, acute intoxication and withdrawal symptoms	PH38. Recognition and management of symptoms due e.g. to opioids/narcotics, sedative hypnotics or hallucinogens, including poisoning, acute intoxication and withdrawal symptoms
^C23. Initial wound care, including cleaning and dressing	**^MHT23. Basic wound care, including suturing of simple lacerations**	**^S32. Basic wound care, including suturing of simple lacerations**	**^B38. Basic wound care, including suturing of simple lacerations**	**^CHC49. Advanced wound care, including suturing of complex lacerations**	**^DH43. Advanced wound care, including suturing of complex lacerations**	**^PH39. Advanced wound care, including suturing of complex lacerations**
				^CHC50. Minor soft tissue surgical procedure (drainage of simple abscess and removal of foreign body)	**^DH44. Minor soft tissue surgical procedure (drainage of simple abscess** and removal of foreign body)	**^PH40. Minor soft tissue surgical procedure (drainage of simple abscess** and removal of foreign body

^C24. Splinting of acute fractures and dislocations	**^MHT24. Splinting of acute fractures and dislocations**	**^S33. Splinting of acute fractures and dislocations**	**^B39. Splinting of acute fractures and dislocations**	**^CHC51. Reduction and non-operative management of acute fractures and dislocations**	**^DH45. Reduction and non-operative management of acute fractures and dislocations, including traction**	**^PH41. Reduction and non-operative management of acute fractures and dislocations, including traction**
					DH46. Management of ENT emergencies, including foreign body removal, peritonsillar abscess and epistaxis	
					DH47. Management of acute trauma of the eye, including acid and alkali burns	PH42. Management of acute trauma of the eye, including acid and alkali burns
See also community based first aid and pre-hospital care				CHC52. Rapid scale up of service delivery capacity through provincial coordination	DH48. Protocol based mass casualty management and rapid scale up of service delivery capacity	PH43. Advanced protocol response based on provincial coordination for mass casualty management and rapid scale of service delivery capacity
G. Surgical Interventions (not including obstetric surgery-- see maternal health) = 17 of which 11 are MoPH high priority for implementation						
					^DH49. Burr hole to relieve acute elevated intracranial pressure	**^PH44. Burr hole to relieve acute elevated intracranial pressure**
					^DH50. Debridement and other treatment of soft tissue infection (including diabetic foot) and osteomyelitis	**^PH45. Debridement and other treatment of soft tissue infection (including diabetic foot) and osteomyelitis**
					DH51. Escharotomy or fasciotomy	PH46. Escharotomy or fasciotomy
					^D52. Trauma related amputations	**^PH47. Trauma related amputations**
	See emergency care section above				**^DH53. Reduction of acute fractures and dislocations, placement of external fixator and use of traction for fractures**	**^PH48. Urgent surgical management of orthopaedic injuries (for example, by open reduction and internal fixation)**
					^DH54. Irrigation and debridement of open fractures	**^PH49. Irrigation and debridement of open fractures**

					^DH55. Management of septic arthritis	**^PH50. Management of septic arthritis**
					DH56. Basic skin grafting and release of contractures, including for burns	PH51. Basic skin grafting and release of contractures, including for burns
					^DH57. Relief of urinary obstruction by catheterization or suprapubic cystostomy	**^PH52. Relief of urinary obstruction by catheterization or suprapubic cystostomy**
					^DH58. Abdominal surgery including hernia repair, management of acute abdomen, removal of gallbladder, appendectomy, colostomy, management of hydatic cyst	**^PH53. Abdominal surgery including hernia repair, management of acute abdomen, removal of gallbladder, appendectomy, colostomy, management of hydatic cyst**
					^DH59. Trauma laparotomy	**^PH54. Trauma laparotomy**
			B40. Early recognition and referral for congenital anomalies		DH60. Early recognition and referral for congenital anomalies	**^PH55. Management of cleft lip/palate, club foot**
					DH61. Simple ocular procedures e.g. foreign body removal	PH56. Basic ocular surgery, including cataract removal
					DH62. Basic dental procedures (treatment of caries, extraction, drainage of simple dental abscess)	
H. Palliative Care Interventions = 3						
	MHT25. Oral palliative care and pain control measures with non-opioid agents		B41. Oral palliative care and pain control measures with non-opioid agents	CHC53 Oral and parenteral palliative care and pain control measures with non-opioid agents	DH63. Treatment of severe acute pain including in association with procedures, including with opioid and non-opioid agents	PH57. Treatment of severe acute pain with opioid and non-opioid agents
					DH64. Procedural sedation	PH58. Procedural sedation
I. Rehabilitation Interventions = 2						

	MHT26. Identification of people with disabilities and referral to nearest services for physical rehabilitation or physiotherapy treatment in mobile vehicle	S34. Identification of people with disabilities and referral to nearest services for physical rehabilitation	B42. Identification of people with disabilities and referral to nearest services for physical rehabilitation	CHC54. Identification of people with disabilities and referral to nearest services for physical rehabilitation	DH65. Physical mobilization and strengthening activities following acute injury or illness and guidance in use of rehabilitation equipment e.g. crutches, wheelchair etc.	PH59. Physical mobilization activities and provision of appropriate rehabilitation equipment e.g. crutches, wheelchair etc.
Sub-total number of interventions at the 7 levels of the health system outlined in this table 1 = 304						
24 interventions at community level: 9 = HPI *** 9 = EUHC**** 6 = country context specific	26 interventions by mobile health team: 15 = HPI 5 = EUHC 6 = country context specific	34 interventions at sub-health centre level: 16 = HPI 8 = EUHC 10 = country context specific	42 interventions at basic health centre level: 17 = HPI 10 = EUHC 15 = country context specific	54 interventions at comprehensive health centre level: 27 = HPI 17 = EUHC 10 = country context specific	65 interventions at district hospital level: 36 = HPI 19 = EUHC 10 = country context specific	59 interventions at provincial hospital level: 35 = HPI 15 = EUHC 9 = country context specific
Some of the sub-total of all 304 interventions at the 7 levels of the health system in the above table 1 are repeated at different levels of the health system e.g. see number S1 at the sub-health centre which is also an intervention (B1) at the basic health centre level in section A, the reproductive, maternal and newborn health section. So a total of the different types of interventions is given below.						
TOTAL NUMBER OF DIFFERENT INTERVENTIONS = 144 (133 in table 1 + 11 population based interventions in table 2) many of which were previously in the BPHS and the EPHS. The interventions reflect the epidemiological profile in the country and the fact that there are still too many deaths among mothers and the newborn. Of the 133 different types of interventions in table 1, 92 constitute essential universal health care interventions (EUHC as defined in DCP3), of which 81 are high priority for implementation. The 92 EUHC interventions are based on international and/or local evidence of effectiveness, cost-efficiency, and feasibility of implementation. If implemented effectively there should be an improvement in equitable access and significant outcomes; they will also contribute to adding quality to health services. The remaining 41 interventions are country context specific. **Plus** **14 inter-sectoral inter-ministerial policy interventions to reduce behavioural and environmental risks for early design and implementation - see table 3. The costs of the inter-sectoral inter-ministerial policy interventions are not included in the cost of the IPEHS. Only the interventions in tables 1 and 2 have been costed.**						

^BOLD. Where and/or when there is on-going armed conflict or resources are low those interventions or a component of an intervention in **bold** are **high priority interventions (HPI)** for the Ministry of Public Health – listed as highest priority platform (HPP) in tables 1-4 in DCP3 Annex 3C, 2017, Essential Universal Health Coverage: Interventions and Platforms in Disease Control Priorities. DCP3. World Bank, Washington. http:dcp-3org/

2017, Essential Universal Health Coverage: Interventions and Platforms in Disease Control Priorities. DCP3. World Bank, Washington. http:dcp-3org/

****EUHC = Essential universal health care in Disease Control Priorities (DCP3), World Bank, Washington. http:dcp-3org/

Ministry of Public Health, Afghanistan

Integrated Package of Essential Health Services 2019: Population Based Interventions

Table 2. Population based interventions led by MoPH Provincial Office in collaboration with MoPH headquarters, Kabul*

P1. Mass media messages, especially radio and television, concerning healthy eating, physical activity, and mental well being**
P2. Systematic identification of individuals with TB symptoms among high risk groups
P3. Mass media messages concerning use of tobacco, alcohol, and other addictive products
P4. Mass media messages, concerning awareness about hand washing and health effects of household/indoor air pollution
P5. Conduct simulation exercises with, and awareness raising among, health personnel for disease outbreaks including outbreak investigation, contact tracing, and emergency response
P6. Ensure plan in place to ensure ability to cope with large increase of patients due to infectious diseases e.g. stockpiles of disinfectants, equipment for patient care, and personal protective equipment
P7. Ensure influenza vaccine available at all levels of the health system
P8. In high malaria transmission settings, targeted vector control strategies
P9. Develop plans and legal standards for reducing interactions between infected persons and uninfected population, and implement and evaluate infection control measures
P10. Conduct simulation exercises for response to armed conflict emergencies
P11. Ensure preparedness strategy to have all in place for surge capacity in hospital beds, stockpiles of disinfectants, equipment for supportive care and personal protective equipment

*Costs of the population based public health interventions are not included in the cost of the IPEHS package
The two population based interventions written in bold** are those that where and/or when there is on-going armed conflict and/or resources are low are highest priority interventions (HPI) for the Ministry of Public Health – listed as highest priority platforms (HPP) in annex 3C 1-4 in DCP3 Annex 3C, 2017, Essential Universal Health Coverage: Interventions and Platforms in Disease Control Priorities. DCP3. World Bank, Washington. http:dcp-3org/
Population based interventions numbers 1-9 are also in Table 3 annex 3C, DCP3 2017. Numbers 10 and 11 are country specific because of the extent of emergencies and trauma in the country

Ministry of Public Health, Afghanistan

Integrated Package of Essential Health Services 2019: Top Priority Inter-Sectoral, Inter-Ministerial Policy Interventions

In this table 3 is a list of 15 highest priority urgent inter-sectoral policy interventions for early implementation for the prevention of ill health and to reduce health related poverty. They also address the SDGs. The interventions were decided at inter-ministerial meetings in Kabul during 2018 using DCP3 volume 9 in which table 2.3 has a total of 29 early policy interventions. At the time of the publication of this document policy intervention number 1 below is the highest priority to be addressed based on the high levels of air pollution in the country especially in cities. The remaining policy interventions are not in order of priority and ideally all need to be addressed concurrently.

The policy interventions have the strongest international evidence and the highest likely magnitude of health effect in the country. In some countries the policies have quickly and directly resulted in a measurable decline in mortality. The interventions are also likely to provide best value for money and be feasible in the low income context of Afghanistan.

Table 3. Top priority inter-sectoral, inter-ministerial policy interventions*

1. ***Air pollution*: regulate transport, industrial, power, and household generation emissions**
2. *Public transportation*: build and strengthen affordable public transport systems in urban areas
3. *Substance use:* impose high taxes on tobacco, cigarettes and other addictive substances
4. *Substance use:* impose strict regulation of advertising, promotion, packaging, and availability of tobacco, cigarettes and other addictive substances, with enforcement
5. *Smoking in public places:* ban smoking in public places
6. *Food quality:* ensure that foods have adequate nutritional value
7. *Iron and folic acid:* fortify food
8. *Iodine:* Fortify food
9. *Trans fats:* ban and replace with polyunsaturated fats
10. *Salt:* impose regulations to reduce salt in manufactured food products
11. *Sugar sweetened drinks:* tax to discourage use
12. *Salt and sugar*: provide consumer education against excess use, including product labelling
13. *Vehicle safety:* enact legislation and enforcement of personal safety measures, including seat belts in vehicles and helmets for motorcycle and bicycle users
14. *Pesticides:* enact strict control and ban highly hazardous pesticides
15. *Water and sanitation:* enact standards for safe drinking water, sanitation and hygiene within households, institutions and business companies

*Costs of the inter-sectoral policy interventions are not included in the cost of the IPEHS package

3. Method used to cost the IPEHS

Introduction
Sufficient funding in Afghanistan for the implementation of the IPEHS is a key challenge. To facilitate the implementation of a financially sustainable IPEHS the MoPH is costing current and future services at the 7 different levels of the health system in the IEPHS. This is helping identify areas where greater efficiency might be achieved, as well as informing the quantity of domestic and donor funding that id needed. A key challenge in raising more domestic revenue is that currently investment in health is not seen as a key component of macro-economic policies to foster economic growth.

At the time of going to press the current cost of providing basic health services and the costing of the IPEHS had not yet been fully analysed and verified. The MoPH plans to produce another document sometime mid 2019 fully describing the costing exercise and giving quantitative information on the financial costs.

Objective
The costing analysis estimates the costs of individual services, as well as the total cost of the IPEHS. This is to inform efficiency and support contracting for the IPEHS services, demonstrate value for money, plan the allocation of resources and advocate for government and donor financing.

Method

Data Analysis Tool
The MoPH used the cost and revenue analysis tool, CORE Plus, to undertake the cost analysis of the IPEHS and model the five scenarios give above. CORE Plus is a Microsoft Excel dynamic costing tool developed by Management Sciences for Health. It is specifically for costing primary health care facilities and has been validated by the WHO and used in many countries.

The tool allows users to calculate the total cost of a health facility broken down by service, programme, and resource type. CORE Plus uses a method of bottom-up costing to determine the actual and normative costs under various levels of coverage and staffing for each service - see annex D.

Costs are estimated under five different scenarios: (1) actual services and costs; (2) actual services and normative costs; (3) needed services and normative costs; (4) projected services and normative costs; (5) projected services, normative costs, with the minimum number of staff.

Reclassification of services
Health facility utilization data for the year 2018, obtained from the MoPH data warehouse, DHIS2, was used to do the costing exercise. The list of priority conditions for outpatient and inpatient admissions were retrieved from the monthly integrated activity report and the hospital monthly integrated report. However, while these are useful in indicating morbidity conditions they are not specific enough for costing individual services. A further breakdown of morbidity into specific services was therefore required. In addition, utilization rates were estimated for the newly added health services IPEHS that are not yet implemented in the country. This required assumptions in consultation with relevant MoPH departments and others involved in developing the IPEHS.

In order to agree on reasonable assumptions, a panel was convened. It included doctors, midwives and nurses representing health workers in existing health facilities. The panel helped establish standard treatment guidelines for each disaggregated outpatient intervention. The panel reclassified 31 priority conditions for outpatient morbidity into a total 89 interventions including ‘other unlisted diseases’.

A separate panel was convened to develop standard treatment guidelines for each disaggregated inpatient service. The panel comprised surgeons, general physicians, midwives and nurses representing health personnel in district hospitals The panel reclassified 44 inpatient morbidity conditions included in the hospital monthly integrated report into 75 inpatient services including ‘all other new inpatient cases’. The same approach was applied for the list of new services in consultation with relevant departments,

Development and allocation of costs

The direct costs of services were estimated based on the standard treatment guidelines developed in consultation with the two panels of health personnel. The guidelines for each service are comprised of the quantities of resources required to provide a good quality service. These quantities are then multiplied by the price of each resource to produce a total cost for each service. For each service members of the two panels determined which facility staff member is expected to provide the service and how much of their time is needed.

The two panels also determined which medicines, supplies and laboratory tests are commonly required to diagnose and treat each condition. All the standard guidelines developed for the services are considered established norms for the purposes of the specific application of the data analysis tool CORE Plus.

As required by the data analysis tool the following steps have been taken:

- The classification of each intervention under relevant programmes based on the type of interventions included in the costing;
- The identification of the type of service (curative, preventive, surgical etc.) the target population, and the level of service delivery (primary and secondary) for each intervention;
- The identification of incidence and prevalence rates for each intervention based on various sources;
- The identification of age distribution among health facility catchment population based on national level data held by the Central Statistics Office;
- An 80% target coverage was set for all services needed in the tool.

The costing comprises total costs from the provider perspective which are financial costs incurred by the providers. However, the costs were also estimated in a different scenario, which excluded donations for medicines, medical supplies and laboratory tests. Recurrent costs were included in the modelling since these are directly relate to the on-going costs of service provision. The average annual capital costs by facility type, obtained from the Expenditure Management Information System), were added later on to the health facility total cost. Lastly, the cost of community based services provided by community health workers was added to the total cost produced by CORE Plus.

Sample of health facilities

In consultation with the MoPH Grant and Contract Management Unit, the geographic distribution of provinces and shared borders with other provinces with similar context was considered. This resulted in 15 out of 34 provinces being included in the costing sample. To ensure completeness of data and that selected health facilities represent similar types of health facilities in a province, health facilities were listed based on completeness of their health management information system quarterly report in 2016.

As a second step in getting a sample of health facilities one health facility with history of good reporting was randomly selected from each type to get a total of five health facilities per province. This resulted in a total sample of 67 health facilities, including 15 sub-health centers, 15 basic health centers, 15 comprehensive health centers, 15 district hospitals, and seven mobile health teams. Separate CORE Plus models were established for each facility type to reflect the different package of services that should be provided at each one.

Data collectıon and organızatıon

A semi-structured questionnaire was developed and shared with the government contract health service providers in the sampled provinces. The service providers gave general information on health facilities data on salaries, and average medical supply and laboratory test unit prices. The MoPH team responsible for the expenditure management information system provided the costs of medicines and operating costs. Bulk costs for medical supplies were based on a study from another country. Median scores were used from the pharmaceutical and logistics information system 2016 to allocate each medicine unit price.

4. Brief note on the monitoring and evaluation of the IEPH for its impact on health

Approach to the monitoring and evaluation of the IPEHS
Now that the IEPHS has been finalised the first step that the MoPH has to undertake is a review of all its national systems, tools and indicators to facilitate a revision in order to be able to effectively and efficiently monitor and evaluate (M&E) the IPEHS. Once the implementation of IPEHS is agreed a detailed approach to M&E will be developed. This is with the objective of determining the effectiveness, efficiency and impact of the IPEHS. Operational research on implementation will also be developed.

How will the M&E differ from the current BPHS M&E?
The IPEHS has 3 new health services, the highest priority interventions, formalised populations based interventions, and identified multi-sectoral, inter-ministerial policy interventions. In addition, a few indicators for universal health coverage are needed including for population coverage, service coverage and out-of-pocket expenditure. So a limited number of essential new indicators and their baselines have to be identified.

Current systems and tools
There are a number of different systems and tools that come within the remit and are the responsibility of the MoPH General Directorate of Monitoring & Evaluation and Health Information System. The systems and tools gather health related data from input to impact level at both the health facility and the population level. Currently they are designed to measure the progress of the BPHS and EPHS. This is why there is a need for the revision of all the existing health systems and tools to be in line with the indicators necessary to monitor and evaluate the IPEHS.

These include the:
- ✓ Health management information system (HMIS)
- ✓ Surveillance and response system
- ✓ Vital statistics system
- ✓ National monitoring checklist
- ✓ Health facility assessment/balanced scorecard
- ✓ Surveys

Other tools include indicators, guidelines, forms, questionnaires, standard operating procedures, and terms of reference.

Annex A. Notes about the essential medicines and diagnostics needed

It was intended to print two lists of essential medicines and diagnostics needed for the IPEHS in this annex. But the essential medicines list is too long. So instead the following is a brief description of the process used to develop the lists. Then there is summary of how the lists of both medicines and diagnostics are presented and their content followed by an overview of the next steps.

Process
The list of medicines was developed with the help of the World Health Organization (WHO) Geneva using the 2017 WHO list of essential medicines as a guide. The draft list was then shared with all the 9 MoPH led working groups for their review and completion – see annex B. This was important because there were some gaps concerning what medicines health personnel could offer at the community and sub-health centre levels in particular.

The comments were collated by the MoPH General Directorate of Monitoring & Evaluation and Health Information System and shared with the top management of the Ministry. One of the most useful comments received was that what was originally six levels of the health system from community level to provincial level should become seven. This is because the first level in table 1 had the heading 'Community/Mobile Health Team'. It was pointed out that what a person at a community health post, a community health worker (CHW), could give or prescribe is very different from that of a mobile health team that often includes a doctor.

This change was accepted and a small group within the ministry worked on both the type of intervention in table 1 for the first two levels of the health system. And what community health posts and mobile health teams could and could not have for medicines and diagnostics.

Presentation of both lists
The proposed essential medicines list for the IPEHS is presented by the nine health services in the package:

- ✓ Reproductive, maternal, and newborn
- ✓ Child and adolescent health development
- ✓ Infectious diseases
- ✓ Chronic, non-communicable diseases
- ✓ Mental, neurological and substance use disorders
- ✓ Emergency care
- ✓ Surgery
- ✓ Palliative care
- ✓ Rehabilitation

The category of medicine is given against each health service e.g. for child health - vaccines, with each type of vaccine needed and the route form. In the case of an antibiotic the dose for different ages is given and whether in tablet, oral liquid or injection form.

The essential diagnostics are listed for the seven levels of the health system in the IPEHS, Those in bold are those that are high priority for the MoPH should resources be low and/or access difficult.

Next steps.
Once implementation of the IPEHS has been agreed, the list of IPEHS medicines will be reviewed against the 2014 MoPH list of essential medicines. Should revision of the 2014 list be necessary an updated list will be issued and include a list of essential diagnostics.

The revised MoPH list of essential medicines is unlikely to be as detailed as the list prepared especially for the IPEHS. Therefore, the IPEHS list will be circulated electronically along with the essential diagnostics list to all interested stakeholders, especially the government contracted health service providers.

Annex B. MoPH working group members

MoPH lead of each working group	Relevant DCP3 volume
Mohebullah Zeer	Essential surgery – Volume 1
Zelaikha Anwari	Reproductive, maternal, newborn, child and adolescent health – Volumes 2 and 8
Maihan Abdullah	Cancer – Volume 3
Bashir Sarwari	Mental health – Volume 4
Habib Arwal	Cardiovascular disease – Volume 5
Bashir Hamid	Infectious diseases, and Environmental health – Volumes 6 and 7
Qadir Qadir	Inter-sectoral health – in Volume 9

Surgery – volume 1

Name	Organization
Dr Mohebullah Zeer	GDCM/MoPH
Dr Karima Mayar	GDCM/MoPH
Dr Najiba Yaftali	MoPH
Dr Ahmad shah Wazir	Istiqlal Hospital
Dr Najibullah Zalmai	Istiqlal Hospital
Dr M. Hashim Alakozai	MoPH
Dr Gul Aqa Safi	MoPH
Dr Abdul Wasi Khurami	MoPH
Dr Ghulam Mohammad Mastan	Wazir Akber Khan hospital
Dr Fatima Nawid	Istiqlal Hospital
Dr Naila	RH/MoPH
Dr Safiullah Nadeeb	WHO
Dr Attaullah	102 bed hospital
Dr M. Arif Shinwari	Ibni Sina Ajil
Dr M. Ihsan Ghulban	MoPH
Dr Ajab Ghul Momand	Indragandi Hospital
Dr Khamoush	MoPH
Dr Ahmad Zia Samadi	Attaturk Hospital
Dr Mirwais Jalal	Rabia Balkhi Hospital
Dr Mohammad Haroon	MoPH
Dr Farid Nadir	Ibni sina Ajil Hospital
Dr Rahima Barakzai	Stomatology Hospital
Dr Wahab Abri	Stomatology Hospital
Dr Wali Nadir	Noor Hospital
Dr Mansoor Hamidi	Noor Hospital

Cancer – volume 3

Name	Organization	Name	Organization
Dr. Maihan Abdullah	NCCP/MoPH	Mr. Manocher	NCCP/MoPH
Dr. M. Naser Foshanji	NCCP/MoPH	Dr. Sayed Ikram Hashimi	NCCP/MoPH
Dr. Zabihullah Stanikzai	NCCP/MoPH	Dr. Musa Shukoor	NCD/ MoPH
Dr. Abdullah Bahr	NCCP/MoPH		

Mental Health – volume 4

Name	Organization	Name	Organization
Dr. Zalmai	HNTPO	Dr. M. Ismail	MoPH
Dr. Khalil	IAM	Dr. Sharifullah	HNTPO
Dr. Ab. Sami	HRH	Dr. Sediqullah	HNTPO
Dr. Nasir Ahmad	MoPH	Dr. Najia Tareq	Media-Afghan
Dr. Nazar m. Alami	DDR/MoPH	Dr. Nafisa	MoPH
Dr. Imam Nazar	IPSO	Dr. Ghutai Yaqubi	MoPH
Mohammad Ehsan	GIHS /MoPH	Dr. Taseer	MoPH
Dr. Toorkhan Shirzad	GIHS	Taqi	
Dr. Zahid	MoPH	Azimi	
Shaqayeq	MoPH	Dr. Sarwari	HNTPO
Malika	MoPH		

Cardiovascular Disease – volume 5

Name	Organization
Saib Habib Arwal	MoPH
Musa Shukoor	MoPH
Farhad Farewar	MoPH
Akmal Samsor	JS consultancy
Bashir Ahmad Sarware	MoPH
Rodrigo	MoPH
Ebadullah Hedayat	MoPH
Hassebullah	Wazir Akbar Khan Hospital
Musa Zai	MoPH

Infectious Diseases and Environmental health – volumes 6 and 7

Name	Organization
Mohammad Khaled Seddiq	MoPH
Mir Habibullah Akhgar	MoPH
Zaire Dildar	MoPH
Noor Agha Zahid	MoPH
Nemat	MoPH
Hashim Khan	MoPH
Qader Qader	MSH
Faiz Delawer	MoPH
Akmal	JICA
Reza Aloudal	WHO
Khaled Rahin	MoPH
Shawali Maroofi	MoPH
Naqibullah Hamdard	MoPH
Sami Nazhat	MoPH

Inter-sectoral Policies – volume 9

Name	Organization
Abdul Qadir Qadir	MoPH
Farhad Farewar	MoPH
Jawed	MoPH
Arwal	MoPH GDPM
Bashir Hamid	GDPM
Reshteen	GDPD
Dostyar Dost	
Dayem Kakar	MoPH

Reproductive, Maternal, Child and Adolescent Health – volumes 2 and 8

Name	organization	Name	organization
Zelaikha Anwari	RMNCAH	M. Maseed	HEMAYAT
Lailoma	RMNCAH	Dr. Popal	HEMAYAT
Dr. Yousuf Barialay	RMNCAH	Dr. Kamila Hijran	SCA
Dr. Motawali	CAH/IMNCI	Dr. Murad	UNFPA
Dr. Wassima	MoPH/CAH	Paata	WHO
Najiba Zafari	RMNCAH	Nadia	MoPH
Nezamuddin Jalil	RMNCAH	Dr. Roqia Naser	MoPH
Shekeba	CAH/MoPH	Dr Freba Azizi	HNTPO
Dr. Salim	RMNCAH	Dr. Arwal	MoPH
Dr. Rizwan	RMNCAH	Dr. Salim Saha	Surveillance
Dr. Soroush	RMNCAH	Adela Mubasher	WHO
Dr. Ghutai	RMNCAH	Palwasha Anwari	AHG/Canada
Dr. Noorzad	CAHD	Robaba	MOVE
Dr Hadad	RMNCAH	Zainab	AMA
Dr. Naziha	RMNCAH	Dr. Maria	BDN
Dr. Danesh	RMNCAH	Dr. Seteyi	NRH
Dr. Alawi	RMNCAH	Nadia	BDN
Zohra Shamszai	RMNCAH	Dr. Esmati	HMIS/MoPH
Mr. M. Maher	CAHD	Dr. Hamidullah	IMNCI Trainer
Ahmad Reshad	CAHD	Dr. Khalilullah	MoPH
Sharara	AADA	Dr. Rasoul	MoPH
Dr Farhat Sahak	AADA	Dr. M. Zakir Nassimi	MoPH
Dr. Fatema	AKHS	Dr. S. Masoud	MoPH/CBHC
Dr. Wahida	SCA	Dr. M. Nazir	MoPH/CBHC
Klyh Khishki	ASMO	Faridullah	JHPIEGO
Dr. Ranginaa Aziz	ASMO	Samim Shah	JHPIEGO
Dr. Rita Hashemi	HEMAYAT	A.M. Faize	UNFPA
Dr. Adela Kohistani	HEMAYAT	Dr. Khaksar	UNICEF
Farzana Darkhani	AMA	Malalai	UNICEF
Dr. Zarmina	PND	Habibullah	IMCI
Dr. Roya	MoPH	Hamida	EOC
Dr. M. Zahid	MHD/MoPH	FIda Gul	EOC
Khesraw Parwiz	HEMAYAT	Rohullah	HEMAYAT
Sharifa	MoPH	Dr. Bariq	MSI
Mursal Musawi	MoPH		

Annex C. National and International Expert Committee Members, Advisers, and Observers

Expert committee members

- Minister Ferozuddin Feroz, MoPH – Public health, armed conflict, context
- Former Deputy Minister Ahmad Jan Naeem, MoPH - Public health, armed conflict, context
- Stephanie Simmonds, MoPH – Senior international adviser to the Minister, public health management, armed conflict and health development, context
- Dean Jamison, University of Washington - Health economics, an editor of DCP3
- Charles Mock, DCP3 University of Washington – Surgery, an editor of DCP3
- Ala Alwan, DCP3 University of Washington - NCDs
- Zulfi Bhutta, Aga Khan University – MCH, nutrition
- William Slater, USAID Afghanistan – Representing the donor community
- William Newbrander, NGO Palladium - BPHS, health economics
- Teri Reynolds, WHO Geneva – Emergency care
- Jolene Skordis-Worall, University College London - Health economics
- Ritsuko Kakuma, LSHTM - Mental health
- Susannah Mayhew, LSHTM - Health systems
- Karl Blanchet, LSHTM - Health systems, humanitarian health

Advisers to the committee

- Sayed Ataullah Saeedzai, MoPH - Epidemiology, context
- Farhad Farewar, MoPH - Health financing, context

Observers

Fatima Arifi, MoPH (joined remotely),
Giti Azim, MoPH (joined remotely),
Mohammad Yonus Zawoli, MoPH (joined remotely)
Khwaja Mir Ahad Saeed, MoPH (joined remotely)
Najeebullah Hoshang, MoPH
Najibullah Safi, WHO Country office, Afghanistan
Gerard Abou Jaoude, University College, London
Hassan Haghparast-Bigdoli, University College, London
Neha Singh, London School of Hygiene and Tropical Medicine
Asmae Doukani, London School of Hygiene and Tropical Medicine
Mickey Chopra, World Bank, Washington

Annex D. CORE plus costing scenarios

CORE Plus has the capability to show results from five different scenarios, which vary based on the assumptions used for the utilization and cost data. The following is a brief description of each scenario:

- Scenario A: Actual Services and Actual Costs. This scenario reflects the actual services provided, and actual expenditures made.
- Scenario B: Actual Services and Standard Costs. This scenario reflects the actual services provided, as under Scenario A, but uses the standard costs instead of actual costs. Standard direct costs are based on the data entered in the standard treatment guidelines.
- Scenario C: Needed Services and Standard Costs. This scenario uses the same method of calculating standard costs as described in Scenario B. However, instead of basing the standard costs on the actual number of services, the costs are calculated based on 'needed services'. The needed will be determined based on the incidence of the event in the population for which the population should receive the services.
- Scenario D: Projected Services and Standard Costs. This scenario uses the same method of calculating standard costs as Scenario B. Similarly to Scenario C, this scenario is also based on a standard utilization figure. However, instead of using the total number of 'needed services', a target number of services is selected.
- Scenario E: Projected Services, Standard Costs and Minimum Staff. This scenario uses standard costs and the same numbers of services as Scenario D, but estimates the staff costs based on an 'ideal' or minimum number of staff.