Islamic Republic of Afghanistan
Ministry of Public Health

A Basic Package of Health Services for Afghanistan – 2010/1389

Revised July 2010

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Acronyms and Abbreviations

AFB	Acid-Fast Bacilli
ANDS	Afghanistan National Development Strategy
ARI	Acute Respiratory Infection
ART	Antiretroviral Treatment (HIV)
BCG	Bacillus Calmette Guerin
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CB	Cold Box (EPI)
CBHC	Community-Based Health Care
CGHN	Consultative Group on Health and Nutrition
CHC	Comprehensive Health Center
CHS	Community Health Supervisor
CITC	Client Initiated Testing and Counseling (HIV)
CTC	Community Based Therapeutic Care
CHW	Community Health Worker
DDH	Developmental Dysplasia of the Hip
DEWS	Disease Early Warning System
DH	District Hospital
DMPA	Depot Medroxyprogesterone Acetate
DOTS	Directly Observed Treatment Short-course (TB)
DPT	Diphtheria, Pertussis, Tetanus vaccine
EC	European Commission
EOC	Emergency Obstetric Care
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
FHA group	Family Health Action Group
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GMS	Gender Main Streaming
GMP	Growth Monitoring and Promotion
GOA	Government of Afghanistan
GRR	Gender and Reproductive Rights
HB	Hepatitis B
HMIS	Health Management Information System
HNS	Health and Nutrition Sector
HNSS	Health and Nutrition Sector Strategy
HCS	Health Care Services
HP	Health Post
HR	Human Resources
HSC	Health Sub-Centers
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses
IUD	Intrauterine Device
IV	Intravenous
M&E	Monitoring and Evaluation
MDD	Micronutrient Deficiency Diseases
MDR-TB	Multidrug-Resistant Tuberculosis
MoPH	Ministry of Public Health
MICS	Multiple indicator cluster survey
MVA	Manual Vacuum Aspiration
NHCS	National Health Care System
NID	National Immunization Day
NGO	Non Governmental Organization
OPD	Outpatient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHC	Primary Health Care

PHCC	Provincial Health Coordination Committee
PITC	Provider Initiated Testing and Counseling (HIV)
PMTCT	Preventing Mother-To-Child Transmission (HIV)
PPHD	Provincial Public Health Director
PPHO	Provincial Public Health Office
RC	Rehabilitation Center
RH	Reproductive Health
SFP	Supplemental Feeding Program
SFC-TFC	Supplementary Feeding Center-Therapeutic Feeding Center
SMZ-TMP	Sulfamethoxazole-Trimethoprim (Co-trimoxazole)
STD	Sexually Transmitted Disease
TAG	Technical Advisory Group
TB	Tuberculosis
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency
VA	Visual Acuity
VCCT	Voluntary Confidential Counseling and Testing (HIV)
VPD	Vaccine Preventable Disease
WB	World Bank
WHO	World Health Organization

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Foreword

The Ministry of Public Health (MoPH) of the Islamic Republic of Afghanistan is very pleased to present this newly revised Third Edition of the Basic Package of Health Services (BPHS) 2010/1389. This version reflects the evolution in the health system since 2005 and includes new approaches to improve both the access to and the quality of the basic health services. The MoPH believes that by continuing to focus on a Basic Package of Health Services, it will be able to concentrate its resources on reducing mortality among its most vulnerable citizens, especially women of reproductive age and children under five.

The BPHS continues to serve as the foundation of the Afghan health system and remains the key instrument in making sure that the most important and effective health interventions are made accessible to all Afghans. This edition of the BPHS continues the format used in previous editions. It clearly identifies what services need to be available at each level of the primary health care system -health posts, health sub centers, basic health centers, mobile health teams, comprehensive health centers, district hospitals- and lists the staff, equipment, diagnostic services, and medications required to provide the services at each level. More attention is given to the wide range of actual conditions experienced in the field in Afghanistan, due to geographical, cultural and security factors, allowing flexibility in implementation in order achieve maximum impact given the local conditions.

The BPHS itself is completely consistent with and based upon the principles contained in the Afghan National Development Strategy (ANDS) 2008 -2013 and the Health and Nutrition Sector Strategy (HNSS) 2008 – 2013, which reflect the collective aspirations of the Afghan government and people. The BPHS in conjunction with the Essential Package of Hospital Services remains the cornerstone of health service delivery in Afghanistan.

Some services already included in the 2005 edition of the BPHS, like mental health and disabilities, have been given more attention in this edition, clearly listing recommended interventions, staffing and equipment. Likewise, more specific recommendations are included on how increase access to services for difficult to reach populations, including nomads (Kochis) and prisoners. We invite all our partners to cooperate, under the stewardship of the MoPH, to make sure that all Afghans, rich or poor, living in towns or remote villages or in prisons will be able to receive quality services through this newly revised BPHS. Meanwhile, the MoPH will monitor and evaluate what works best, and based on observed best practices, we will continue updating and improving the BPHS.

We would like to express our appreciation for the tremendous effort provided by the members of the BPHS Revision Core Group, and the members of the five sub-groups, who have preserved the spirit of the original BPHS throughout the process of revision and improvement. The MoPH appreciates the continued financial

support for the BPHS implementation, and is especially grateful to European Commission and EPOS for providing funding and technical assistance for the elaboration of this version of the BPHS, and to USAID and MSH/TechServe for the assistance in the finalization of this version of the BPHS.

The joint effort of the staff of MoPH, the World Bank, UN and donor agencies, NGOs and other MoPH partners has resulted in a document that will provide valuable guidance for further increasing access to quality basic health services for all Afghans. Now we need to dedicate ourselves to make sure that this BPHS is actually provided to all Afghans and that the quality of the provided services continues to improve. The people of Afghanistan have the right to high quality basic health services.

Dr. Suraya Dalil
Acting Minister of Public Health
Kabul, Afghanistan
July 2010

1. The Process for the Development of the Second Revised Basic Package of Health Services

After the establishment of the Islamic Transitional Government of Afghanistan in 2002, fourteen separate development programs were created within the new government's National Development Framework. It was decided that in each development program there would be a consultative group to provide advice on developing policies, laws, regulations, strategies, plans and guidelines. In response to this directive, the Ministry of Public Health (MoPH) formed the Consultative Group on Health and Nutrition (CGHN) whose members included important stakeholders such as donors, line ministries, NGOs, UN agencies, Embassies and International Assistance Forces. In 2002 the CGHN proposed developing a Basic Package of Health Services to address the highest priority health problems with services and interventions that would be available to all Afghans. The CGHN determined that it was especially important for the BPHS to be provided to those living in remote and underserved areas. In March 2003 the MoPH ratified the first version of the BPHS which had been developed collaboratively with partner agencies. The purpose of developing the BPHS was to provide a standardized package of basic services that would form the core service delivery package in all primary health care facilities.

The first revision of BPHS was completed in 2005 and implemented by NGOs and the MoPH Strengthening Mechanism from 2005 until 2009. In developing the original BPHS in 2002 and the revised BPHS in 2005, the MoPH established a set of criteria which determined how the revision was conducted.

In the first BPHS revision the MoPH focused on obtaining better responses to emerging priority health problems with essential services. To accommodate new policy and strategic directions, as well as including evidence-based updates, the BPHS will be reviewed every 3-4 years.

The Government of Afghanistan (GOA) has developed a medium term strategic plan, the Afghanistan National Development Strategy (ANDS), along with the Health and Nutrition Sector Strategy (HNSS). Within these two umbrella strategies a number of important public health considerations were recognized as falling within the GOA/MoPH mandate to address; namely the previously neglected areas within population health.

Additionally, a number of health concerns have recently been identified as priorities for the government as a result of broader enquiry into areas such as mental health, disability, dental health, and renal disease. National health strategies for these and other priority health issues have identified areas for intervention that fall outside the current framework of the BPHS such as the public health and non-BPHS primary health care interventions that go beyond service provision. These are currently unplanned for and have no commitment for funding. Private providers are also being encouraged to contribute to better health outcomes for Afghans by delivering services that complement the scope of the BPHS and the GOA commitment to provision of free essential health care to all.

The MoPH has commenced the process of developing provincial level strategic plans which will address population health, primary care and secondary/tertiary care. It is therefore essential to differentiate between what is included within the BPHS package and what will fall outside that package or within other levels of intervention or care.

Given the significance of these new developments and the dynamics of the health sector at this point in time, it was decided to instigate a full review of the BPHS.

The process began in May 2008 after receiving the approval of the MoPH leadership. First of all, the idea of revision was communicated to the relevant stakeholders in the health sector and they were requested to share their comments on the revision of this very important document over a period of one and half months. Once all comments had been compiled, a core group of members from various relevant partners and departments in MoPH was selected to start the revision. The core group came up with the specific TOR and timeline for the revision. In common with the first revision, the core group came up with a short list of essential criteria need to be considered for any interventions proposed for inclusion in the revised BPHS:

1) Is the intervention **relevant** to BPHS?
2) Does the intervention have proven **effectiveness**?
3) Can the intervention be **scaled-up** to be implemented on a national scale?
4) Is the intervention **affordable** in the long term? (Sustainability)
5) Who will have **access** to and **benefit from** the intervention so as to be fair to all? (Equity)
6) Is the set of proposed new services **kept basic and essential**?
7) Is the intervention **acceptable** to most Afghans?
8) Do the proposed new services have a significant **impact** on priority health problems?

After consolidating all the comments received from MoPH colleagues and partners, the core group established sub-groups for reviewing the different categories of comments that had been received. The sub-groups then came up with recommendations to the core group regarding which suggested changes in the BPHS should be accepted and which rejected. After extensive work and deliberation regarding the sub-groups' recommendations, the core group, with the support of the technical adviser, produced a list of draft recommendations for change.

These recommendations were presented to the CGHN in January 2009 and after incorporating inputs from both the CGHN and the Technical Advisory Group (TAG), the final recommendations were submitted to the MoPH Executive Board for endorsement. Delay in printing the document led to a quick updating with regards to new policies and strategies in June 2010.

2. The Success of the BPHS

Five years of BPHS implementation have witnessed enormous progress in the health sector. The BPHS was not only successful in achieving its direct objectives regarding the availability, coverage and quality of health care, but in addition the package has had tremendous influence on the organizational and managerial attributes of health care in Afghanistan.

Bringing coherence and unified priorities to the Afghan health system, the BPHS provided the health sector with uniform standards found in the core package of preventive and curative health services. In addition to being a vehicle to provide widely available basic health care to the Afghan population, it also provided the MoPH with tools to effectively assume its stewardship role to coordinate and monitor the implementation of health care activities.

The BPHS represented a roadmap that provided policymakers with a clear sense of direction and emphasized essential primary health care as the basis of the health system. As a result, the BPHS has been the catalyst behind the establishment of strong understandings between the MoPH and its major partners; namely the BPHS implementing NGOs and the donors.

As experience with BPHS implementation has progressed, the standardized package of health services has expanded to respond to newly identified priority needs and to embrace additional services. In the first revision of 2005, mental health and disability services were included in first tier of implementation. Eye care services, however, were considered in detail, for the first time, in the second revision of the BPHS. Similarly, the basic package, which managed to install a standardized uniform structure of health facilities in its first version, now recognizes new types of facilities to increase the accessibility of health care to people living in remote and isolated areas. The standardized classifications of health facilities that provide the basic services now include the following:

- Health Posts (HPs)
- Health Sub-centers (HSCs)
- Basic Health Centers (BHCs)
- Mobile Health Teams (MHTs)
- Comprehensive Health Centers (CHCs)
- District Hospitals (DHs)

This standardized classification establishes a common language used by the MoPH and its partners. Being based on measurable considerations such as population size and the locations of the target areas, the standardized classification of facilities emphasizes the equitable distribution of health care all over the country. In addition, the standardized classification has increased the ability of the MoPH to oversee, monitor and manage the health system. It has been particularly important when one considers the number of key donors of financial resources for provision of the BPHS with whom the MoPH has had to deal.

Soon after completion of the initial BPHS in 2003, the MoPH identified the need to address the hospital sector of the health system in a similar manner in order to ensure a complete and integrated health system in which a functioning hospital system existed that could accept referrals of complicated cases and conditions from health posts, basic health centers, and comprehensive health centers. The Essential Package of Hospital Services (EPHS) was endorsed by the MoPH in July 2005. For each of the three levels of hospitals—district, provincial, and regional and specialty—the EPHS identifies[1]:

- The hospital services provided

[1] Essential Package of Hospital Services, MoPH, 2005.

- The diagnostic services that should be available
- The equipment necessary for providing the services in the hospital
- The elements of the Afghanistan Essential Drug List needed at each type of hospital
- The minimum and recommended staffing levels needed.

While BPHS 2005/1384 included the services provided by district hospitals as part of the BPHS, the EPHS provides a complete and comprehensive list of services beyond the BPHS based services

The BPHS and EPHS together represent the basic and essential elements of the health system.
Increased availability and accessibility of basic health services is another profound success achieved through the implementation of the BPHS. Six years of BPHS implementation have led to a significant increase in the proportion of the population with access to basic health services. BPHS is implemented currently in districts where 85% of population resides[2]. The increased access of population to the BPHS facilities has resulted in very significant increase in the utilization of the various services of the package. The MoPH plans to expand BPHS coverage to 90% by the year 2010. It is expected that the MHTs and HSCs, endorsed in this new revision, will be instrumental in reaching this target.
The success of the BPHS is demonstrated in the significant improvement in key Afghan health indicators compared with 2003. The following table displays the improvements achieved in some important indicators:

Table 1: Key Indicators of the Afghan Health System

	INDICATOR	Value	Year	Value	Year
1	Outpatient visits per capita per year	0.6[1]	2003	1.04[1]	2008
2	DPT3 immunization coverage	29.9%[2]	2003	82.9%[2]	2007
3	Skilled birth attendance at deliveries	6.0%[3]	2003	18.9%[4]	2006
4	Infant mortality rate (per 1,000 live births)	165[3]	2000	129[4]	2006
5	Under 5 mortality rate (per 1,000 live births)	257[3]	2000	191[4]	2006
6	Number of health facilities	1241	2003	1688[1]	2009
7	Skilled Antenatal Care (at least 1 visit, excluding TT) (%)	4.6%[3]	2003	32.3 %[4]	2006

[1] HMIS
[2] Expanded Program on Immunization, MoPH
[3] MICS
[4] Afghanistan Health Survey 2006

3. Future Challenges to the BPHS Strategy

While the achievements of the MoPH under the BPHS framework have been significant, the future holds a number of challenges:

First, further expansion of the BPHS, as measured by the percentage of the population with access to BPHS services, will become increasingly difficult. Extending access will require the MoPH to reach all remote areas in the country plus 23% of urban dwellers. For the rural population coverage, increasing levels of access will require a great amount of effort; however, the MoPH is committed to the issue of equity and will strive to increase the proportion of the population that has access to the BPHS.

The MoPH remains committed to building a sustainable nationwide health system that is appropriate for Afghanistan. However, this will prove a challenge since current services are primarily provided through funding from three major donors plus significant contributions by other donor agencies. The MoPH remains dedicated to the principle of equity and to care being based upon need rather than ability to pay for services. This commitment is reiterated in two of the six principles stated in the MoPH's draft "National Policy on Cost-Sharing and Sustainability":

- Everyone who needs care must receive care, regardless of ability to pay
- Quality of care must be the same for paying and nonpaying patients

Ensuring quality is essential to maintaining and expanding the BPHS. If the quality of services is inadequate, the population will not continue to support BPHS, and the foundation of the health system will crumble. The MoPH is working on establishing quality standards for BPHS service delivery and assessing compliance with those standards. In this effort, the tools it is using include the HMIS, the National Monitoring Checklist and the Balanced Score Card. In addition, other tools may become national tools, such as the Quality Assurance

[2] Grants and Contract Management Unit, MoPH, 2008.

Standards for BPHS, which are being used by health providers in certain provinces to ensure and monitor the quality of health service delivery.

Insecurity is still another challenge which reduces population access to health care services. It also limits monitoring visits to the provinces where BPHS is being implemented. This may result in a compromise of the quality and possibly a lack of transparency in terms of quality service provision.

Location of the construction of health facilities in the provinces on the basis of political influence brings the risk of mal-distribution of the health facilities. This is an ongoing and serious concern in developing an appropriate infrastructure for BPHS delivery.

An additional challenge is to align the BPHS with the EPHS to develop a single, unified, and community-based health system with appropriate linkages for referrals throughout the system. The BPHS rests on the concept that all services in the package should be available as integrated whole, rather than piecemeal or as individual services, or only through vertical programs. Integration also means that hospitals will not only provide secondary services but also provide BPHS services, and that they will reach out to their communities to ensure that basic health services are being provided. Further, hospitals need linkages to CHCs and BHCs, not only to receive referred patients but also to provide clinical supervision of the health centers and much needed in-service education on a regular basis to staff in health posts, health sub centers, BHCs, Mobile Health Teams and CHCs.

Finally, retaining the commitment to the BPHS will be a challenge. As the emergency situation that the health system faced in 2002 has diminished, increasing attention is being paid to the hospital elements of the health system. Typically, hospitals primarily benefit the urban population, yet Afghanistan's population is over 80 percent rural. It is the BPHS that will provide the foundation for an equitable health system that can improve the health of the country's population. The MoPH remains committed to the BPHS as the foundation for an equitable and sustainable health system. A commitment to primary health care is internationally recognized as a sensible and appropriate approach, as stated in *The Lancet* editorial of March 5, 2005:

… it is important that the Ministry of Health's current sensible course of prioritizing and strengthening basic primary health care is strongly advocated within government and maintained despite a lack of immediately visible results and overt outside recognition. Only then will these remarkable efforts and achievements benefit the Afghan people and make Afghanistan the blue-print country for post-conflict health reconstruction.

4. BPHS 2010/1389—Changes made to the 2010/1389 BPHS (as compared with the 2005/1384 version)

The following is a summary of the major changes introduced to the BPHS through a consultative process:

1. The Disability and Mental Health elements of the 2005 edition of the BPHS have not had any funds or staff allocated to either program. In this new edition indicates required staffing, training, services, supplies and equipment. Over the next three years these two services will be gradually implemented, as funding becomes available. Different implementation mechanisms will be document and reviewed for efficiency for the next edition of the BPHS.
2. Primary eye care has been newly introduced as a BPHS component to be gradually implemented in the form of more training, primary eye care services and referral services.
3. Two new categories of health facilities or delivery mechanisms—Health Sub Centers and Mobile Health Teams—which have already been established based on need in different parts of Afghanistan, have been integrated into the BPHS. It is anticipated that these will improve access and quality of services for the people
4. Privacy for psychosocial counseling and for labor rooms is now recognized in CHCs and BHCs
5. More essential drugs and equipment have been added to all categories of health facilities, from health posts to district hospitals.
6. Updated Intervention Tables regarding EPI, Malaria, Nutrition, Disability, Mental Health and HIV/AIDS have been included
7. Introductory and explanatory notes to clarify different sections of the new BPHS document have been added.
8. Creation of a linkage between the ANDS, HNSS and other program-specific strategies, policies and the BPHS has been established
9. A "flexibility clause" has been added to the BPHS document—it has been introduced to allow implementers to address variations between localities, local demand, and other local conditions requiring flexibility

10. A table providing specifications for medical supplies and another for physiotherapy equipment and supplies have been added
11. The need to extend BPHS services to internally displaced persons, nomads and persons residing in prisons is now explicitly mentioned.
12. A monitoring and evaluation framework and an indicator fact sheet have been introduced
13. Community Based Therapeutic Centers (CTCs) and Family Health Action (FHA) Groups have been added to the BPHS. Modalities for establishing FHA groups in different parts of the country are being testes, and, after evaluation, will guide the gradual establishment of FHA Groups throughout the country.
14. Additional staff that are newly required at health facilities for this BPHS include one physiotherapist in each DH, as well as the addition of a second physiotherapist where there is no physiotherapy center in the vicinity of the DH. One psychosocial counselor (nurse) may now be added to a CHC if required by a sufficiently funded mental health intervention. One of the existing MDs of the DH will be trained and serve as psychosocial focal point. One driver will be added to those CHCs which have their own ambulance. The addition of other staff categories will be governed by the "flexibility clause".
15. A Table on training needed for implementation of the BPHS has also been added
16. Restrictions on the use of antibiotics for the management of IMCI at BHCs have been reduced
17. Transportation cost for the community health workers have been taken into consideration.
18. The National Salary Policy has been revised.

5. Types of Health Facilities Used by the BPHS

The BPHS will be offered at six standard types of health facilities, ranging from community outreach provided by CHWs at health posts, through outpatient care at health sub centers and basic health centers and provided by mobile health teams, to inpatient services at comprehensive health centers and district hospitals. The section below summarizes the services available at each type of facility.

Health Posts (HP) : At the community level, basic health services are delivered by CHWs from their own homes, which function as community health posts. A health post, ideally staffed by one female and one male CHW, cover a catchments area of 1,000– 1,500 people, which is equivalent to 100–150 families. CHWs offer limited curative care, including diagnosis and treatment of malaria, diarrhea, and acute respiratory infections such as pneumonia; distribution of condoms, oral contraceptives, and depot medroxy progesterone acetate (DMPA) injections; community DOTS; growth promotion nutrition counseling; and micronutrient supplementation., CHWs are responsible for treating minor illnesses and conditions common in children and adults, for awareness-raising on disability and mental health, and for identification of persons with disabilities and mental conditions (for a fuller explanation of CHW tasks, see the CHW job description in Annex A). The routine management of normal deliveries is not part of the CHW's job description, but female CHWs focus on promoting birth preparedness, safe home deliveries with a skilled birth attendant (when possible), awareness of the danger signs of pregnancy, the need for urgent referral when delivery complications occur, and basic essential newborn care.

Health Sub-Centers (HSC) : An important lesson learned from BPHS implementation has been that it is often impossible to precisely follow the criteria for establishing the location of different types of health facilities. The extremely challenging geography, especially in some parts of the country, the scattered pockets of population, the absence of basic infrastructure such as roads and bridges, ethnic and security issues, etc. all pose difficult questions regarding the establishment of BPHS health facilities based on the number of people covered.

Many health facilities have been established for small pockets of population that do not meet the criteria recommended for locating health facilities under the BPHS. For example, there are Comprehensive Health Centers (CHCs) for less than 15,000 people and Basic Health Centers (BHCs) for fewer than 10,000 people or sometimes much less, depending upon the population distribution. Consequently, according to HMIS data, about 8-10% of CHCs are underutilized, as defined by low patient volume levels.

The Health Sub-Center (HSC) is an intermediate health delivery facility to bridge the services gap between Health Posts and other BPHS levels of service delivery. The MoPH has agreed to establish a number of HSCs with financial support from the World Bank, European Commission (EC), USAID and the Global Alliance for Vaccines and Immunizations (GAVI) to benefit a total of 600,000 people who are currently not served by

the healthcare system. The HSCs are additional inputs to the BPHS and are integrated into the overall BPHS system rather than serving as a vertical program.

The overall objective of establishing HSCs is to increase access to health services for underserved populations residing in remote areas. A HSC is intended to cover a population of about 3,000-7,000. The maximum walking distance to a HSC is two hours for the consumer of health services living in remote areas. HSCs are initially being established in private houses. This is a precondition before construction of a permanent facility and requires commitment from the surrounding community. Priority HSC locations need to be determined, with the ultimate location approved by the PHCC.

The HSC will provide most of the BPHS services that are available in BHCs including health education, immunization, antenatal care, family planning, TB case detection and referral, and follow up of TB cases in coordination with community DOTS. In addition, HSCs will be able to treat infectious diseases such as diarrhea and pneumonia. HSCs will refer severe and complicated cases to higher level facilities. Where feasible, HSCs will support health posts and CHWs, CHWs will provide a copy of their monthly reports to the HSC or the mobile team in their areas. In addition, the DHOs should supervise the heath posts in their relevant districts. The HSC will be staffed by two technical staff (a male nurse and a community midwife), as well as a cleaner/guard.

Mobile Health Team (MHT) : Another way to ensure access to basic health services in remote areas is the provision of health care services through mobile health teams. While the provision of mobile health services is often perceived to be costly, establishing more (fixed) health facilities within current available financial and human resources appears to be a less feasible option at this stage. The principal idea of mobile health services is to establish a limited number of mobile health teams in each province by dividing the province into clusters of districts .1) to ensure the provision of essential and basic health services in remote villages located in geographically hard to access areas; 2) to expand and strengthen community-based health care (CBHC) through the identification of additional CHWs in hard to access areas and to link community level interventions with BPHS facility-based services; and 3) to encourage greater community participation and community ownership of health services.

Given all the challenges coupled with the scarcity of trained health workers (particularly females), it may not be feasible to establish staffed fixed centers in some remote areas, where the population is scattered and live in small communities. Furthermore, establishing more basic health centers (BHCs) in remote areas raises the risk of the creation of more underutilized health facilities. The alternative, the creation mobile health teams, is therefore anticipated to be more effective in many cases in terms of increasing access to health services as well as being more feasible.

It is expected that the work of mobile health teams will facilitate the further strengthening and expansion of CBHC, by enhancing community participation and community ownership of their health services, particularly as they will be involved in the monitoring and evaluating of the mobile health team's work and the work of the CHWs.

The implementation strategy of mobile health services was partly based on recommendations from Provincial Health Coordination Committees (PHCCs). One recommendation was that MHTs should have a clear understanding of the main reasons for the frequency of their visits to remote villages. Intervals between visits should be based on security, remoteness, and the needs of the population. MHT visits to remote villages should occur at least once every two months (For more information refers to MoPH MHT concept paper). Based on the experience of the MHTs, the PHCC can revise the frequency of the visits. Planning for mobile health services needs to be done together with community leaders to gain their support and guidance. Their assistance in providing secure accommodations for overnight stays of the mobile team staff will be very important for their success. EPI teams will assist the PHCC in determining the appropriate sites for mobile health services.

Mobile health services are an extension of BHC services; therefore, the services they provide are in most cases those recommended for a BHC. The MHT ideally has the following staff, male health provider (doctor or nurse), female health provider (community midwife or nurse), vaccinator and driver.

Basic Health Center (BHC) : The BHC is a facility offering primary outpatient care, immunizations and Maternal and Newborn care. Services offered include antenatal, delivery, and postpartum care; newborn Care ,nonpermanent contraceptive methods; routine immunizations; integrated management of childhood illnesses; treatment of malaria and tuberculosis, including DOTS; and identification, referral, and follow-up care for mental health patients and persons with disabilities including awareness-raising. The BHC supervises the

activities of the health posts in its catchment area. The services of the BHC cover a population of about 15,000–30,000, depending on the local geographic conditions and the population density. In circumstances where the population is very isolated, the catchment population for a BHC can be less than 15,000. The minimal staffing requirements for a BHC are a nurse, a community midwife, and two vaccinators. Depending upon the scope of services provided and the workload of the BHC, up to two additional health care workers may need to be added to perform well-defined tasks (e.g., supervision of community health workers and outreach activities).

A male/female ratio of 1/1 is recommended, and at least one female health worker should be part of the BHC staff. The MoPH will allow a physician to be at a BHC only to replace a midwife or a nurse, when those positions are not filled, and a physician is available and there is sufficient physician staffing at CHCs and district hospitals. The doctors can be given the salary of the physician if they work in the BHCs. Hospital physiotherapist should visit BHCs on an outreach basis from the district level.

Comprehensive Health Center (CHC): The CHC covers a catchment area of about 30,000–60,000 people and offers a wider range of services than does the BHC. In addition to assisting normal deliveries, the CHC can handle certain complications, grave cases of childhood illness, treatment of complicated cases of malaria, and outpatient care for mental health patients. Persons with disabilities and persons requiring physiotherapy services will be screened, given advice and referred to appropriate services in the area. The facility usually has limited space for inpatient care, but has a laboratory. The staff of a CHC is larger than that of a BHC; it includes both male and female doctors, male and female nurses, midwives, one (male or female) psychosocial counsellor when mental health activities are implemented, and laboratory and pharmacy technicians. Physiotherapists will visit CHCs on an outreach basis from the district hospital.

District Hospital (DH): At the district level, the district hospital handles all services in the BPHS, including the most complicated patients. Patients referred to the district hospital level include those requiring major surgery under general anesthesia, X-rays, comprehensive emergency obstetric care, and male and female sterilizations. It offers comprehensive outpatient and inpatient care for mental health patients and rehabilitation for persons requiring physiotherapy with referral for specialized treatment when needed. The district hospital also provides a wider range of essential drugs, treatment of severe malnutrition renewable supplies and laboratory services than do the health centers. The district hospital is staffed with a number of doctors, including female obstetricians/gynecologists; a surgeon, an anesthetist, a pediatrician, a doctor who serves as a focal point for mental health: psychosocial counsellors/supervisors; midwives; laboratory and X-ray technicians; a pharmacist; a dentist and dental technician; and one to two physiotherapists (male and female). Each district hospital covers a population of about 100,000–300,000.

A summary of all the services, staffing, equipment, and essential drugs for health post, SHC, BHC, MHT, CHC, and district hospital is provided in Tables 11, 12, 13, 14, 15 and 16, respectively.

6. BPHS: The Foundation of the Health System and Its Relationship to Hospitals

Health services in Afghanistan operate at three levels: 1) Primary Care Services i.e. at the community or village level as represented by health posts, CHWs, SHCs, BHCs and MHTs; 2) Secondary Care Services i.e. at the district level, as represented by CHCs and District Hospitals operating in the larger villages or communities of a province; and 3) tertiary care services at the provincial and national levels, as represented by provincial, regional, national, and specialty hospitals.

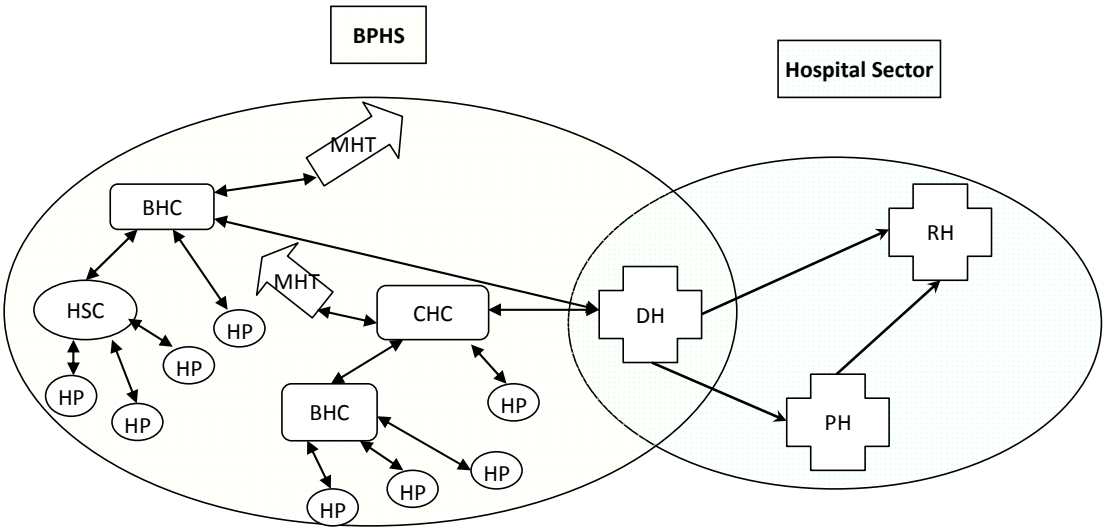
BPHS is complemented by the EPHS which defines essential elements of hospital services and promotes a referral system in synergy with the BPHS. Together, the BPHS and the EPHS represent a number of key elements of the health system being built by the MoPH in Afghanistan. At the planning stage they have illustrated where essential primary care and hospital services will be provided and have explained the referral hospital system necessary to support the BPHS.

However the EPHS which was developed at a later phase cannot attain the coverage nor achieve the mortality impact of the BPHS. The hospital sector is generally a less cost effective service of the MoPH, but provides high profile and highly desired services to the population.

The initial expectation that the referral system will complete the synergy between BPHS and EPHS has not materialized to the extent expected. This can be attributed to the sometimes inappropriate utilization of hospital services and an unstructured referral system.

Figure 1 illustrates the critically important role played by Health Posts, Health Sub Centers, BHCs, Mobile

Health Teams, CHCs, as well as the key role the District Hospitals play in linking the BPHS and the hospital sector.



BPHS		**Hospitals**
HP	Health Post	DH = District Hospital
HSC	Health Sub-Center	PH = Provincial Hospital
BHC	Basic Health Center	RH = Regional Hospital
MHT	Mobile Health Team	
CHC	Comprehensive Health Team	
DH	District Hospital	

Figure 1: The Link between BPHS and Hospital Sector

Who is responsible for supervising Health Posts located near Health Sub-Centers? The MoPH has concluded that NGOs can have flexibility in supervising Health Posts. Health Posts can be supervised either from a nearby BHC or from a Health Sub-Center.

7. Flexibility in implementation

Flexibility in the implementation of BPHS was among the most important recommendations of the Health Sector Strategic Planning Retreat of December 2008. Adopting the principle of flexibility in implementation is meant to allow alternative solutions when the BPHS implementing agency faces local situations or problems that require innovation, modifications, or alternative approaches. Those include, *inter alia*, staff patterns, types of staff training, selection of brands and manufacturers of medical supplies, levels of health facilities, incentive schemes and on-call arrangements for relevant staff members. The implementing agency can also be flexible in response to changes in population growth or unusual population distribution.

Flexible adjustments in BPHS implementation must observe the following principles:

1. Each adjustment should have a strong justification (such as gender equity, geography, security) and lead to tangible improvements in specific aspects of service delivery
2. Modifications should promote the availability and equitable access of BPHS
3. They should not undermine the quality of the BPHS services
4. They should be cost effective
5. They should be of limited nature, implemented only when and where necessary, to maintain the consistency of BPHS implementation

8. Health Care for difficult to reach populations

Every BPHS implementer has to cover the nomadic population and the internally displaced population living for even part of the year in their catchment area. Vaccinators must provide outreach services for them and clinics for these groups must be integrated into the BPHS. Coverage must be based on accurate population data and implemented according to their primary health care needs. There is the possibility of obtaining hardship allowances for provision of health services for difficult populations by the implementing agency over and above the provision of regular services. The Nomad Health Unit of the MoPH, through the PPHD, will supervise these activities according to agreed-upon indicators.

Due to the limitations of the current health services provided by the Ministry of Justice, the Prison Health Services reform currently underway includes the transfer of the provision of services from the Ministry of Justice to the Ministry of Public Health, or NGOs as its agents, under the stewardship of the MoPH. Detainees are a part of the target population of the BPHS who are temporarily found in a special location and while they reflect the epidemiological pattern of the general population, for certain diseases and behavior patterns (such as tuberculosis and drug use), detention can actually be an aggravating factor. The referral of these detained population groups for illness or wounds to a hospital is notoriously difficult, owing to constraints of logistics and security. Therefore, establishing access to solid primary care services for detainees in Afghanistan's 34 provincial central prisons by the BPHS implementers is also a pre-condition for the implementation of disease- and problem-specific activities for which special funding is available (such as activities related to HIV/AIDS and drug use). Special services requiring inputs beyond those normally provided by the BPHS, such as activities related to HIV/AIDS and drug use are the responsibility of the MoPH through implementation of the Prison Health Package but not the responsibility of NGOs or others who are providing the BPHS.

9. The Seven Elements of the BPHS and their Components

The BPHS has seven primary elements. Six involve basic services but the seventh element is necessary for the six service elements to succeed: the seventh element is the regular and dependable supply and availability of essential drugs.

Before going into the details of these elements it is expected that the BPHS implementing partners will be familiar with the specific policies and strategies of the various priority health streams of MoPH. The Afghanistan National Development Strategy (ANDS), the Health and Nutrition Sector Strategy (HNSS) are umbrella strategies supported by the specific service strategies with each supported by a service department for implementation purposes. The BPHS, and to an extent EPHS, are service delivery packages which identify only the essential, most cost effective and high impact interventions for priority service delivery (these documents can all be obtained from the MoPH Resource Center, the Policy and Planning Department or related departments). Similarly, support strategies (HR, M&E, HMIS, and DEWS), their procedures and all relevant administrative procedures should be known to the relevant staff of implementing partners.

Dissemination trainings on these strategies and procedures will be provided to staff. Meanwhile, it is the responsibility of the contracting NGOs, the Policy and Planning and the individual MoPH departments to disseminate the information contained in all these documents in a logical sequence so that the implementation is done in unison and in an integrated manner rather than in isolation. NGOs are required to follow MoPH standards.
The seven elements of the BPHS and the relevant sub-elements are listed in Table 2. The number of the table listing services provided at various levels is given in parentheses.

The HSC and MHT have been added to the BPHS but they are to be regarded as temporary facilities which may be abolished or changed to other permanent types of facilities if the need arises.

Table 2 : The Seven Elements of the BPHS and their Components

1. Maternal and Newborn Care (Table 2.1 – 2.5)	a. Antenatal care (Table 2.1) b. Delivery care (Table 2.2) c. Postpartum care (Table 2.3) d. Family planning (Table 2.4) e. Care of the newborn (Table 2.5)
2. Child Health and Immunization (Table 2.6 – 2.7)	a. Expanded Program on Immunization (EPI) (Table 2.6) b. Integrated Management of Childhood Illness (IMCI) (Table 2.7)
3. Public Nutrition (Table 2.8)	a. Prevention of malnutrition b. Assessment of malnutrition
4. Communicable Disease Treatment and Control (Table 2.9 – 2.11)	a. Control of tuberculosis (Table 2.9) b. Control of malaria (Table 2.10) c. Prevention of HIV and AIDS (Table 2.11)
5. Mental Health (Table 2.12)	a. Mental health education and awareness b. Case identification, diagnosis and treatment
6. Disability and Physical Rehabilitation Services (Table 2.13)	a. Disability awareness, prevention, and education b. Provision of physical rehabilitation services c. Case identification, referral and follow-up
7. Regular Supply of Essential Drugs (Table 2.14)	Listing of all essential drugs needed

Blood transfusion and blood bank services are not one of the seven basic elements of BPHS but are an important element of health services at CHCs and district hospitals. Table 3 on blood transfusion and blood-bank services has been added to this version of the BPHS.

Table 4, detailing primary **eye care** services has been added to BPHS 2009.

Training pertaining to all the BPHS components and management issues e.g. maintenance of equipment or training needed for building staff capacity should be provided to the relevant staff. Gender training up to the BHC level should be conducted and training on blood transfusion, physiotherapy, nutrition and mental health should be conducted and budgeted for in the proposals submitted by the implementing organizations.

For all the elements of the BPHS, implementers will adhere to certain principles of and requirements for appropriate implementation:

a. **Routine reporting** using the standard formats and reporting intervals as required by the HMIS and M&E of the MoPH;
b. Strict adherence at all levels and for all services to the MoPH recommendations for **infection control, safe injection practices, and proper waste disposal**;
c. **Regular and supportive supervision** of lower levels by higher levels, according to the recommendations and requirements of the concerned MoPH departments and national programs.

9.1 Maternal and Newborn Health

9.1.a Antenatal Care

(A part of Component 1 of the BPHS, "Maternal and Newborn Health")

Table 2.1. Antenatal Care Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
Information, education, and communication (IEC)	Yes	Yes	Yes	Yes	Yes	Yes
Diagnosis of pregnancy	Presumptive	Yes	Yes	Yes	Yes	Yes
Antenatal visits—weight, height measurement	No—referral	Yes	Yes	Yes	Yes	Yes
Tetanus immunization	Outreach	Yes	Yes	Yes	Yes	Yes
Iron and folic acid supplementation to pregnant women	Yes	Yes	Yes	Yes	Yes	Yes
Multi-micronutrient supplementation	Yes	Yes	Yes	Yes	Yes	Yes
Blood pressure measurement	No—referral	Yes	Yes	Yes	Yes	Yes
Simplified urinalysis	No	No	No	No	Yes	Yes
Diagnosis of anemia	Yes—clinical	Yes—clinical	Yes—clinical	Yes—clinical	Yes—blood test	Yes—blood test
Treatment of intestinal worms	Yes	Yes	Yes	Yes	Yes	Yes
Treatment of malaria	Yes	Yes	Yes	Yes	Yes based on lab findings	Yes based on lab findings
Treatment of asymptomatic urinary tract infections	No	Yes	Yes	Yes	Yes - urinalysis	Yes - urinalysis
Treatment of symptomatic urinary tract infections	No—referral	Yes	Yes	Yes	Yes	Yes
Treatment of anemia	Yes—iron folate	Yes—iron folate	Yes—iron folate	Yes—iron folate	Yes—iron folate/blood transfusion	Yes—iron folate/blood transfusion
Screening for and management of sexually transmitted diseases	No—referral	Yes—clinical	Yes—clinical	Yes—clinical	Yes—based on laboratory findings	Yes—based on laboratory findings
Treatment of hypertensive disorders of pregnancy	No—referral	Yes and refer	Yes and refer	Yes and refer	Yes	Yes
Treatment of pre-eclampsia/eclampsia	No—referral	Yes and refer	Yes and refer	Yes and refer	Yes and refer	Yes
Treatment of incomplete miscarriage/abortion	No	Yes—MVA	Yes—MVA	Yes – MVA	Yes – MVA	Yes –MVA MVA
Treatment of ectopic pregnancy	No—referral	Stabilize and refer	Stabilize and refer	Stabilize and refer	Stabilize and refer	Yes
Infection control, safe injection practices, and proper waste disposal	Yes	Yes	Yes	Yes	Yes	Yes
Reporting	Yes	Yes	Yes	Yes	Yes	Yes
Supervision and monitoring	No—referral	Yes	Yes	Yes	Yes	Yes

Note: An infrastructure requirement is to ensure the privacy of clients before, during and after delivery by making partitions or making small changes in the delivery room e.g. separate entry way, waiting area plus appropriate location of bathrooms in proximity to the delivery room, etc.

9.1.b Delivery Care

(A part of Component 1 of the BPSH, "Maternal and Newborn Health")

Table 2.2. Delivery Care Services by Type of Facility

Interventions and Services Provided	Health Facility Level					
	Health Post	Health Sub-Center	BHC	MHT	CHC	Dist. Hospital
Information, education, and communication	Yes	Yes	Yes	Yes	Yes	Yes
Monitor progression of labor	No	Yes—partograph	Yes—partograph	Assess—refer	Yes—partograph	Yes—partograph
Identify fetal malpositions	No	Yes and refer	Yes and refer	Yes and refer	Yes and refer	Yes
Assist normal delivery (ONLY emergency cases at home)	No	Yes	Yes	Yes	Yes	Yes
Vaginal delivery requiring additional procedures/equipment	No	Yes and refer	Yes and refer	Assess—refer	Yes	Yes
Provide mini delivery kit (see Annex C for kit contents)	Yes	No	No	Yes	No	No
Parenteral administration of oxytocin	No	Yes	Yes	Yes if called to a delivery	Yes	Yes
Parenteral administration of anticonvulsants	No	Yes and refer	Yes and refer	Yes and refer	Yes and refer	Yes
Bimanual compression of the uterus	No	Yes	Yes	Yes	Yes	Yes
Controlled cord traction	No	Yes	Yes	Yes	Yes	Yes
Suturing tears (Emergency cases at home)	No	Yes—vaginal	Yes—vaginal	Yes	Yes—vaginal/cervical	Yes—vaginal/cervical
Provision of intravenous fluids	No	Yes	Yes	Yes	Yes	Yes
Safe blood transfusion	No	No	No	No	Yes	Yes
Manual removal of placenta	No	Yes—manual	Yes—manual	Yes	Yes	Yes
Removal of retained products (e.g. MVA)	No	Yes MVA	Yes MVA	Yes MVA	Yes MVA	Yes
Curettage	No	No	No	No	MVA	Yes
Hysterectomy	No	No	No	No	No	Yes
Management of prolapsed cord	No	No	No	Assess & refer	Yes	Yes
Management of shoulder dystocia	No	Yes	Yes	No	Yes	Yes
Vacuum extraction(assisted vaginal delivery)	No	Yes	Yes	No	Yes	Yes
External cephalic version	No	No	No	No	Yes	Yes
Symphysiotomy	No	No	No	No	No	Yes
Caesarean section	No	No	No	No	No	Yes
Craniotomy	No	No	No	No	No	Yes
Parenteral administration of antibiotics (first dose)	No	Yes	Yes	Yes	Yes	Yes

9.1.c Postpartum Care

(A part of Component 1 BPHS, "Maternal and Newborn Health")

Table 2.3: Postpartum Care Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
Information, education, and communication	Yes	Yes	Yes	Yes	Yes	Yes
Vitamin A supplementation to mother	Yes	Yes	Yes	within 40 days of delivery	Yes	Yes
Treatment of anemia	To be referred	Yes—clinical	Yes—clinical	Yes—clinical	Yes—based on lab findings	Yes—based on lab findings
Treatment of puerperal infection	To be referred	Yes	Yes	Yes	Yes	Yes
Antibiotics	Yes—oral	Yes—oral/IV	Yes—oral/IV	Yes—oral/IV	Yes—oral/IV	Yes—oral/IV
Breast examination (if privacy is not an issue)	To be referred	Yes	Yes	Yes	Yes	Yes
Counseling on birth spacing and exclusive breastfeeding	Yes	Yes	Yes	Yes	Yes	Yes
Provide birth spacing methods	Yes—condom or inject able progesterone	Condom/Oral or injectable progesterone	Condom/Oral or injectable progesterone	Condom/Oral or injectable progesterone	Condom/Oral or injectable progesterone	Condom/Oral or injectable progesterone
Case definition and referral of infertility cases to provincial hospital	Yes	Yes	Yes	Yes	Yes	Yes

9.1.d Family Planning

(A part of Component 1 of the BPHS, "Maternal and Newborn Health")

Table 2.4. Family Planning Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
Counseling on family planning methods	Yes	Yes	Yes	Yes	Yes	Yes
Clinical examination	No	Yes	Yes	Yes	Yes	Yes
Screening for STD	To be referred	Yes - clinical	Yes - clinical	Yes - clinical	Yes - lab	Yes - lab
Treatment of STD	No	Yes - oral/IM	Yes - oral/IM	Yes - oral/IM	Yes - oral/IV	Yes - oral/IV
Promotion of LAM	Yes	Yes	Yes	Yes	Yes	Yes
Distribute condoms	Yes	Yes	Yes	Yes	Yes	Yes
Distribute oral contraceptives	Yes	Yes	Yes	Yes	Yes	Yes
DMPA injection	Yes, including first injection	Yes	Yes	Yes	Yes	Yes
Intrauterine devices (IUDs)	No	Yes –if trained person available	Yes –if trained person available	Yes –if trained person available	Yes –if trained person available	Yes –if trained person available
Female sterilization	No	No	No	No	No	Yes
Male sterilization	No	No	No	No	No	Yes

9.1.e Care of the Newborn

(A part of Component 1 of the BPHS, "Maternal and Newborn Health")

Table 2.5. Care of the Newborn Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
Information, education, and communication	Yes	Yes	Yes	Yes	Yes	Yes
Stimulate, clean airway; clean, clamp, and cut cord; establish early breastfeeding	Yes	Yes	Yes	Only emergency/ counseling	Yes	Yes
Prevention of ophthalmia of the newborn	No	Yes	Yes	Yes	Yes	Yes
Resuscitation of the newborn	No	Yes	Yes	Yes	Yes	Yes
Newborn immunizations	No	Yes	Yes	Yes	Yes	Yes
Kangaroo care	No	Yes	Yes	Yes	Yes	Yes
Incubator	No	No	No	No	Yes	Yes
Manage neonatal infections (omphalitis)	Prereferral treatment, refer	Prereferral treatment, refer	Prereferral treatment, refer	Prereferral treatment, refer	Yes	Yes
Manage neonatal sepsis	Prereferral treatment, refer	Prereferral treatment, refer	Prereferral treatment, refer	Prereferral treatment, refer	Yes	Yes
Manage neonatal jaundice	Counseling	Counseling	Counseling	Counseling	Counseling	Yes
Manage neonatal tetanus	Refer	Refer	Refer	Refer	Refer	Yes

9.2 Child Health and Immunization

9.2.a Expanded Programme on Immunization

(A part of Component 2 of the BPHS, "Child Health and Immunization"),

The EPI guidelines, as described in the National EPI Policy, must be observed during the implementation of the EPI program.

Table 2.6. EPI Services by Type of Facility

Interventions and Services Provided	Health Facility Level					
	Health Post	Health Sub-Center	BHC	MHT	CHC	Dist. Hospital
IEC	Yes	Yes	Yes	Yes	Yes	Yes
Storage of vaccines	No	Yes (CB and VC)	Yes	Yes (CB and VC)	Yes	Yes
EPI routine (all antigens)	Yes—support	Yes	Yes	Yes	Yes	Yes
Outreach immunization service	Yes—support	Yes (catchment area)	Yes	Yes	Yes	Yes
EPI-plus (ORS+ De-worming)	Yes—support	Yes	Yes	Yes	Yes	Yes
Supplementary Immunization Activities	Yes—support	Yes	Yes	Yes	Yes	Yes
Disease surveillance and case reporting	Yes	Yes	Yes	Yes	Yes	Yes
VPD outbreak response	Yes	Yes	Yes	Yes	Yes	Yes
Vitamin A supplementation	Yes	Yes	Yes	Yes	Yes	Yes

Health Sub-centers will be linked with their related health facilities for referral and supply/logistics

Health Sub-centers will submit an EPI report to the health facility where they obtain vaccine supplies

9.2.b Integrated Management of Childhood Illness (IMCI)

(A part of Component 2 of the BPHS, "Child Health and Immunization") IMCI targets all children under the age of 5 (0-59 months)
The IMCI and C-IMCI guidelines of the MoPH need to be observed during the implementation.

Table 2.7. Integrated Management of Childhood Illness (IMCI) Services by Type of Facility

Interventions and Services Provided	Health Facility Level					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
Counsel mother what to do at home and follow-up	Yes	Yes	Yes	Yes	Yes	Yes
Counsel mother when to return immediately for assessment of the child.	Yes	Yes	Yes	Yes	Yes	Yes
a. Case Management of ARI						
No pneumonia (cough or cold)	Yes	Yes	Yes	Yes	Yes	Yes
Pneumonia	Yes	Yes	Yes	Yes	Yes	Yes
Severe pneumonia or very severe diseases	Refer to CHC or DH	Pre-referral treatment and refer to CHC or DH	Pre-referral treatment and refer to CHC or DH	Pre-referral treatment and refer to CHC or DH	Treatment and refer if necessary to DH	Treatment and refer if necessary to PH or RH
b. Case management of diarrhea						
No dehydration	Yes	Yes	Yes	Yes	Yes	Yes
Some dehydration (ORS and Zinc)	Yes	Yes	Yes	Yes	Yes	Yes
Severe dehydration (ORS and Zinc)	ORS and refer	Yes	Yes	Yes and refer	Yes	Yes
Severe persistent diarrhea	ORS and refer	Yes	Yes	Refer	Yes	Yes
Persistent diarrhea	ORS and Zinc	Yes	Yes	Yes	Yes	Yes
Dysentery	Yes	Yes	Yes	Yes	Yes	Yes
c. Ear problems						
Mastoiditis	Refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Yes
Acute ear infection	Yes	Yes	Yes	Yes	Yes	Yes
Chronic ear infection	Yes and follow	Yes	Yes	Yes and refer	Yes	Yes
d. Fevers and Malaria						
Very severe febrile diseases	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Assess and refer	Pre-referral treatment and refer	Yes
Malaria	Yes	Yes	Yes	Yes	Yes	Yes
Fever malaria unlikely	Yes	Yes	Yes	Yes - refer	Yes	Yes
e. Measles						
Severe, complicated measles	Pre-referral	Pre-referral	Pre-referral	Pre-referral	Pre-referral	Yes

Table 2.7. Integrated Management of Childhood Illness (IMCI) Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
	treatment and refer	treatment and refer	treatment and refer	treatment and refer	treatment and refer	
Measles with eye or mouth complications	Yes and refer	Yes	Yes	Yes	Yes	Yes
Measles	Yes	Yes	Yes	Yes	Yes	Yes
Severe malnutrition and anemia, a secondary entry point for HIV testing for infants and children	No, Refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Yes
f. Malnutrition and Anemia						
Severe malnutrition or severe anemia	refer	Yes-refer	Yes-refer	Yes-refer	Yes-refer	Yes
Anemia or very low weight	Refer	Yes	Yes	Yes-refer	Yes	Yes
No anemia and not very low weight	Yes	Yes	Yes	Yes	Yes	Yes
Vitamin A supplementation	Yes (NID)	Yes if not given by HP	Yes, if not given by previous levels	Yes, if not given by previous levels	Yes, if not given by previous levels	Yes, if not given by previous levels
Mebendazole (periodic)	Yes	Yes, if not given by HP	Yes, if not given by HP	Yes	Yes, if not given by previous levels	Yes, if not given by previous levels
h. Immunization						
See table 4.1. for details	Yes (assist)	Yes	Yes	Yes	Yes	Yes
i. Additional services for children under 2 months of age						
Possible serious bacterial infection, possible secondary entry point for HIV screening	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Yes
Skin infection	Yes	Yes	Yes	Yes	Yes	Yes
Blood in stool	Refer	Yes and refer	Yes and refer	Yes and refer	Yes and refer	Yes
Not able to feed, possible serious bacterial infection	Refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Yes
Feeding problem	Refer	Yes	Yes	Counseling-refer	Yes	Yes

9.3 Public Nutrition

(The Public Nutrition Policy and Strategy and the Infant and Young Child Feeding strategic plan need to guide implementation)

Table 2.8. Public Nutrition Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
a. Assessment of Malnutrition (Population Level)						
Nutritional status	*Estimate prevalence of malnutrition (z-score using indices of weight for height [wasting], weight for age [underweight], and height for age [stunting] as well as the underlying causes. Surveys conducted at district or provincial level for purposes of **baseline**, **monitoring,** and **evaluation** or in case of **obvious deterioration** in nutritional situation.*					
b. Prevention of Malnutrition						
Vitamin A supplementation: To all children 6 months to 59 months	Yes during NIDs	No, except yes after NIDs stop	No, except yes after NIDs stop	No, except yes after NIDs stop	No, except yes after NIDs stop	No, except yes after NIDs stop
Promotion of iodized salt	Yes	Yes	Yes	Yes	Yes	Yes
Promotion of balanced micronutrient-rich foods	Yes	Yes	Yes	Yes	Yes	Yes
Support and promote exclusive breastfeeding	Yes	Yes	Yes	Yes	Yes	Yes
Promotion of appropriate complementary feeding for young children with behavior changes	Yes	Yes	Yes	Yes	Yes	Yes
Community food demonstration	Yes	Yes	Yes	Yes	Yes	Yes
Growth monitoring and promotion for less than 2 years[1] (Where applicable and linked with IMCI)	Yes	Yes	Yes	Yes	Yes	Yes
Iron/folic acid supplementation for pregnant, lactating women	Yes	Yes	Yes	Yes	Yes	Yes
Vitamin A supplementation post-partum	Yes	Yes	Yes	Yes	Yes	Yes
Promotion of maternal nutritional status[2]	Yes	Yes	Yes	Yes	Yes	Yes
Control and prevent diarrheal disease and parasitic infections	Yes	Yes	Yes	Yes	Yes	Yes
Underlying causes: based on analysis of causes of malnutrition, support, and advocate for interventions to address underlying causes.	BPHS NGO will demonstrate understanding of underlying causes and outline appropriate interventions to prevent and address malnutrition including, in areas of food security, social and care environment and health (including water and sanitation (see Conceptual Model of Causes of Malnutrition).					
e. Treatment of Malnutrition						
Micronutrient deficiency diseases diagnosis and treatment	Identify and refer	Yes	Yes	Yes	Yes	Yes
Treatment of severe malnutrition based on MoPH protocols for 24-hour care for Phase I; day care/home-treatment for Phase II[3] and follow-up	No—refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Yes

Table 2.8. Public Nutrition Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
Treatment of severe malnutrition at community-based Community Therapeutic Centers (CTCs)[5]: Community mobilization and screening	Yes Refer	(Pre- referral treatment and refer)	Yes	Yes	Yes	Yes
Out patient management (OPM)	No	Yes	Yes	Yes	Yes	Yes
Inpatient care /Stabilization Center (SC)	No	No	No	No	No	Yes
Moderate malnutrition: only where acute malnutrition levels higher than 10% with additional risk factors.	No	Where applicable				
d. Surveillance and Referral						
Clinic-based surveillance: all children under 5 years measured for weight for height (using HMIS forms), monitor trends and children showing developmental delay referred to physiotherapy services	No	Yes	Yes	Yes	Yes	No
Screening: Screening and referral of at risk using mid-upper-arm circumference (MUAC), or weight/height, or clinical signs of micronutrient deficiency diseases (MDDs)	Yes	Yes	Yes	Yes	Yes	Yes to (H2)

1. Growth monitoring and promotion (GM and P): During 2004 or 2005, The MoPH in collaboration with WHO carried out an assessment to identify what needs (resources, training, skills, and adaptation) should be in place for GM and P to be effective in Afghanistan. As indicated in the IYCF strategic plan and the Public Nutrition Policy and Strategy, approaches to growth promotion proven successful elsewhere will be adapted for each level and tested in the Afghan situation before careful scaling up.
2. Maternal nutrition: Improving the nutritional status of women remains a priority, but a strategy for addressing the poor nutritional status of women is still being developed.
3. Treatment of severe malnutrition: The MoPH currently has guidelines and a strategy to support hospital-based (24-hour/day care) treatment, which are implemented in hospitals
4. Supplementary feeding points (SFPs): Emergency SFPs will only be implemented in those identified districts which have a prevalence of acute malnutrition > 10% and/or high risk (see MoPH Guidelines for Supplementary Feeding).
5. Community Therapeutic Centers (CTC) with its components will be implemented where vertical input is provided by UNICEF in agreement with the Public Nutrition Department.

9.4 Communicable Diseases

9.4.a Control of Tuberculosis primary entry point for VCCT

(A part of Component 4 of the BPHS, "Communicable Disease Treatment and Control")

Table 2.9. Control of Tuberculosis primary entry point for VCCT Services by Type of Facility						
Interventions and Services Provided	**Health facility Level**					
	Health Post	**Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
IEC	Yes	Yes	Yes	Yes	Yes	Yes
Case detection among self-reporting patients using sputum smear	Refer suspect cases	Refer suspect cases	Refer suspect cases	Refer suspect cases	Yes	Yes
Short course chemotherapy, including DOTS	Yes—follow-up	Yes—follow-up	Yes—follow-up	Yes—follow-up	Yes—diagnose and treat	Yes—diagnose and treat
Surveillance of cases of interrupted treatment	Yes	Yes	Yes	Yes	Yes	Yes
BCG vaccination	Assist in outreach	Yes	Yes	Yes	Yes	Yes
X-ray for smear-negative patients	No	No	No	No	No	Yes
Algorithms of treatment for AFB(-)	No	No	No	No	Yes	Yes
Active case finding in OPD/community	Yes and refer	Yes and refer	Yes and refer	Yes and refer	Yes	
Preventive therapy for child contacts of TB patients	To be referred	Yes – chemo-prophylaxis	Yes – chemo-prophylaxis	Yes - Counseling	Yes	Yes
DOTS-plus in multi-drug-resistant TB	No	Yes-follow-up	Yes-follow-up	Yes follow up	Yes-if culture is available	Yes
Inpatient management of severe cases	No	No	No	No	Yes and refer	Yes and refer
Management of complicated severe cases	No	No	No	No	No	Yes and refer

9.4.b Control of Malaria

(A part of Component 4 of the BPHS, "Communicable Disease and Control")
(For children under 5, see Table 2.2, IMCI)

Table 2.9. Control of Tuberculosis primary entry point for VCCT Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Sub-Center**	**BHC**	**MHT**	**CHC**	**Dist. Hospital**
Information, education, communication	Yes	Yes	Yes	Yes	Yes	Yes
Clinical diagnosis	Yes	Yes	Yes	Yes	Yes	Yes
Microscopic diagnosis	No	No	No	No	Yes	Yes
Treatment of uncomplicated cases—first line treatment	Yes	Yes	Yes	Yes	Yes	Yes
Treatment of uncomplicated cases not responding to first line treatment	Refer	Yes	Yes	Assess -refer	Yes	Yes
Treatment of severe and complicated cases	Pre-referral management and refer	Pre-referral management and refer	Pre-referral management and refer	Pre-referral management and refer	Yes and refer	Yes
Insecticide-treated mosquito nets (based on availability and seasonal variations)	Yes	Yes	Yes	Yes	Yes	Yes
Intermittent presumptive therapy (since the prevalence of Malaria is low in Afghanistan, intermittent presumptive therapy is not recommended by National Treatment Guidelines, and is therefore removed)	No	No	No	No	No	No

9.4.c Control of HIV

(A part of Component 4 of the BPHS, "Communicable Disease and Control")

Table 2.11. Control of HIV by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**DH**
Information, education, and communication	Yes	Yes	Yes	Yes	Yes	Yes
Referral to HIV counseling (and testing where indicated)	Yes	Yes	Yes	Yes	Yes	Yes
HIV testing for TB (PITC)	No	No	No	Yes	Yes	Yes
HIV testing for STI (PITC)	No	No	No	Yes	Yes	Yes
HIV testing for ANC (PITC)	No	No	No	Yes	Yes	Yes
HIV testing for diagnosis (CITC)	No	No	No	Yes	Yes	Yes
HIV testing for injecting drug use (PICT)	No	No	No	Yes	Yes	Yes
HIV testing for blood safety (PITC)	No	No	No	Yes	Yes	Yes
CTX (co-trimoxazole) prophylaxis	No	No	Yes	Yes	Yes	Yes
OI (opportunistic infections) and TB	No	No	No	Yes	Yes	Yes
Monitoring, supervision and support for ARV prophylaxis for PMTCT	Subject to training and orientation?	Subject to training and orientation?	Subject to training and orientation?	Subject to training and orientation?	Yes	Yes
Monitoring, supervision and support for ART (antiretroviral treatment)	Subject to training and orientation?	Subject to training and orientation?	Subject to training and orientation?	Subject to training and orientation?	Yes	Yes
Staff safety through vaccination for Hepatitis B	Yes	Yes	Yes	Yes	Yes	Yes
Referral to physical rehabilitation services (exercise training) if required	Yes	Yes	Yes	Yes	Yes	Yes

Many CHCs and DHs are using rapid HIV testing now. A national protocol for VCCT is to be developed.

1. All HIV testing will respect confidentiality, informed consent, and voluntary action.
2. Provider initiated testing and counseling (PITC) is by recommendation of physician for improved medical care, to be performed on advice of physician and with consent of patient fully respecting confidentiality.
3. Client initiated testing and counseling (CITC) is by voluntary request of patient fully respecting confidentiality.
4. HIV prevention, treatment, care and diagnosis in BPHS is based on 6 entry points-1) all blood donors, 2) TB positive patients, 3) STI patients, 4) injecting drug users, 5) clients seeking HIV diagnosis, and 6) ANC patients who have blood samples taken (to be confirmed).
5. HIV testing requires HIV rapid tests with 3 tests of different assays for HIV positive diagnoses. First rapid test will be used for blood screening. Second (but different assay) rapid test will be used for HIV positive results from the first test. Third (but different assay) rapid test will be used for HIV positive results from the second test. Positive results on the 3rd test yields HIV diagnosis.

9.5 Mental Health

(BPSM = biopsychosocial management; PSM= psychosocial management)

Table 2.12. Mental Health Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**District Hospital**
Mental health awareness	Yes	Yes	Yes	Yes	Yes	Yes
Mental health education	No	No	Yes	Yes	Yes	Yes
Identification of suspected cases	Yes	Yes	Yes	Yes	Yes	Yes
Diagnosis and classification	No	No	Yes	Yes	Yes	Yes
Psychosocial problems/stresses	PSM	PSM	PSM	PSM	PSM	PSM
Common Mental Disorders (mild-moderate depression, anxiety disorders, unexplained somatic complaints):	Refer suspected cases	PSM	BPSM	BPSM	BPSM	BPSM
Severe Mental Disorders (psychosis, severe depression, bipolar disorder, schizophrenia):	Refer suspected cases	Refer suspected cases	BPSM *	Referral	BPSM	BPSM
Substance Abuse:	Refer suspected cases	Motivation, referral, follow up	Motivation, referral, follow up	Motivation, referral, follow up	Motivation, referral, follow up	Detoxification, Referral to specialized services
Childhood mental disorders (including enuresis)	Refer suspected cases	Referral	BPSM *	BPSM	BPSM	BPSM
Learning difficulties : Identification and education for parents and teachers	No	Yes	Yes	Yes	Yes	Yes
Epilepsy	To be referred	Referral	Yes *	Yes	Yes	Yes
Self harm	Identify, and referral	Identify and referral	Identify and referral	Identify and referral	BPSM	BPSM
Community based rehabilitation (linked to disability component)	Yes	Yes	Yes	Yes	Yes	Yes
Inpatient treatment	No	No	No	No	To be referred	Yes
Monitoring and follow up	Yes (treatment compliance)	Yes	Yes	Yes	Yes	Yes

* BHC staffed by doctor, otherwise only follows up

Funds will be provided for mental health training, drugs and psychosocial counselling in a phased manner

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9.6 Disability and Physical Rehabilitation

Table 2.13. Physical Rehabilitation (including Persons with Disabilities) Services						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**District Hospital**
Information, education, communication[1]	Yes	Yes	Yes	Yes	Yes	Yes
Identification of people with disabilities and referral to nearest services for physical rehabilitation	Yes	Yes	Yes	Yes	Yes	Yes
Early identification and referral to physical rehabilitation services at DH level for children with physical, sensory and intellectual impairments.	Yes	Yes	Yes	Yes	Yes	Yes refer on as needed
Assess and treat persons with musculoskeletal conditions such as: developmental dysplasia of the hip, clubfoot, low back pain; neurological conditions such as cerebral palsy and sequels of poliomyelitis and traumatic injuries from burns, accidents, explosive devices, war	No	No	No	No	No[2]	Yes
Provision of crutches, walking aids at CHC and DH[3]. Physical rehabilitation staff at DH can measure for wheelchairs and assistive devices for children with cerebral palsy and refer to Orthopedic Workshops centers for prostheses, orthoses, assistive devices, special seating, wheelchairs and management of club foot and DDH	Refer to nearest rehabilitation centre (RC)	Refer to nearest RC	Refer to nearest RC	Refer to nearest RC	Refer to nearest RC	Yes

1. Awareness and information package available with Disability and Rehabilitation Department of MoPH.
2. Physical rehabilitation staff can assess physical needs and advice on outreach visits from DH to CHCs subject to staff availability
3. Wooden auxiliary crutches and walking sticks can be made locally for low cost as an income generation project for persons with disability or low income families or purchased. Measurement of correct height can be easily taught to staff in CHC.

Note: Disability services will be implemented gradually

9.7 Regular Supply of Essential Drugs

Table 2.14. Essential Drugs for BPHS by Type of Facility

Drug	Dosage Form and Strength	Health Post	HS-C	BHC	MHT	CHC	Dist Hos
√=drug permitted at this level ★= drug permitted at BHC only if physician is present							
1. Anesthetics							
1.1 General Anesthetics and Oxygen							
Ketamine	Injection 50gms (as hydrochloride)/ml in 10-ml ampoule	--	--	--	--	✓If anes-thetist	✓
Oxygen	Inhalation (medical gas)	--	✓	✓	✓	✓	✓
1.2 Local Anesthetics							
Lidocaine	injection solution 1% in vial	--	✓	✓	✓	✓	✓
Lidocaine	injection solution 2% in vial	--	✓	✓	✓	✓	✓
Lidocaine	Injection solution for spinal anesthesia 5% in 2-ml ampoule to be mixed with 7.5% glucose solution	--	--	--	--	--	✓
Lidocaine	Topical forms 2% (hydrochloride)	--	✓	✓	✓	✓	✓
Lidocaine	Topical forms 4% (hydrochloride)	--	✓	✓	✓	✓	✓
Lidocaine + Adrenaline	injection solution 1% + epinephrine 1:200,000 in vial	--	--	--	✓	✓	✓
Lidocaine + Adrenaline	injection solution 2% + epinephrine 1:200,000 in vial	--	--	--	✓	✓	✓
2. Analgesics, Antipyretics, Non-steroidal Anti-Inflammatory Drugs							
2.1 Non-Opioid Analgesics/Antipyretics/ NSAID							
Paracetamol (acetaminophen)	Tablet 500 mg	✓	✓	✓	✓	✓	✓
Paracetamol (acetaminophen)	Syrup 120 mg/5 ml	--	✓	✓	✓	✓	✓
Paracetamol (acetaminophen)	Tablet 100 mg	✓	✓	✓	✓	✓	✓
Acetyl Salicylic Acid	Tablet 500 mg	--	✓	✓	✓	✓	✓
Ibuprofen	Tablet 200 mg	--	✓	✓	✓	✓	✓
Diclofenac	injection 25mg per ml in 3 ml ampoule	--	✓	✓	✓	✓	✓
Tramadol	injection 100 mg per 2 ml Ampoule	--	--	--	--	✓	✓
Morphine	injection Morphine 10mg per ml in 2ml ampoule	--	--	--	--	--	✓
3. Anticonvulsants/Anti-Epileptics							
Carbamazepine	Tablet 200 mg	--	--	--	--	✓	✓
Diazepam	injection 5 mg/ml in 2-ml ampoule	--	✓	✓	✓	✓	✓
Magnesium Sulfate	injection 500 mg/ml in 20-ml ampoule	--	✓	✓	✓	✓	✓
Phenobarbital	Tablet 15 mg	--	--	✓	✓	✓	✓
Phenobarbital	Tablet 100 mg	--	--	✓	✓	✓	✓

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
Sodium Valproate	Tablet 200 mg	--	---	--	--	--	✓
4. Antidotes							
4.1 Nonspecific Antidotes							
Activated charcoal	Tablet 500 mg	✓	✓	✓	✓	✓	✓
Neostigmine	Injection 0.5 mg per ml	--	--	--	--	--	✓
Naloxone Hydrochloride	Injection 0.4mg per ml	--	--	--	--	--	✓
5. Antihistamines							
5.1 H1-Receptor Antagonists							
Chlorpheniramine Maleate (Chlorphenamine)	Tablet 4 mg	✓	✓	✓	✓	✓	✓
Chlorpheniramine Maleate (Chlorphenamine)	injection 10 mg/ml in 1-ml ampoule	--	✓	✓	✓	✓	✓
6. Anti-infective Medicine							
6.1 Anti-helminthics							
Mebendazole	chewable tablet 100 mg	--	✓	✓	✓	✓	✓
6.2 Antibacterials							
6.2.1 Beta Lactam Medicines							
Amoxicillin	capsules/tablet 500 mg (anhydrous)	--	✓	✓	✓	✓	✓
Amoxicillin	capsules/tablet 250 mg (anhydrous)	--	✓	✓	✓	✓	✓
Amoxicillin	powder for oral suspension 125 mg/5 ml (anhydrous)	--	✓	✓	✓	✓	✓
Ampicillin	powder for injection 1g (as sodium salt)	--	✓	✓	✓	✓	✓
Ampicillin	powder for injection 500 mg (as sodium salt)	--	✓	✓	✓	✓	✓
Benzathine Benzyl Penicillin	powder for injection, 1.2 million IU in 5-ml vial	--	★	★	★	✓	✓
Benzathine Benzyl Penicillin	powder for injection, 2.4 million IU in 5-ml vial	--	★	★	★	✓	✓
Phenoxy Methyl Penicillin (Penicillin V)	Tablet 250 mg (as potassium-salt)	--	✓	✓	✓	✓	✓
Phenoxy Methyl Penicillin (Penicillin V)	Tablet 500 mg (as potassium-salt)	--	✓	✓	✓	✓	✓
Phenoxy Methyl Penicillin (Penicillin V)	powder for oral suspension 250 mg/5 ml (as potassium salt)	--	✓	✓	✓	✓	✓
Procaine Penicillin	powder for injection 2 million IU	--	--	★	★	✓	✓
Procaine Penicillin	powder for injection 4 million IU	--	--	★	★	✓	✓
Erythromycin(Ethyl succinate)	Suspension 100 mg per ml 100 ml bottles	--	✓	✓	✓	✓	✓
Cloxacillin	Injection 500 mg per vial						✓
Cloxacillin	Capsule 500 mg					✓	✓
6.2.2 Other Antibacterials							
Silver sulfadiazine cream	Cream	✓	✓	✓	✓	✓	✓
Chloramphenicol	capsule/tablet 250 mg	--	✓	✓	✓	✓	✓

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
Chloramphenicol	powder for injection, 1-g vial	--	✓	✓	✓	✓	✓
Chloramphenicol	suspension 125 mg/5 ml	--	✓	✓	✓	✓	✓
Doxycycline	capsule/tablet 100 mg (hydrochloride)	--	✓	✓	✓	✓	✓
Gentamicin	injection 10 mg (as sulfate)/ml in 2-ml vial	--	✓	✓	✓	✓	✓
Gentamicin	injection 40 mg (as sulfate)/ml in 2-ml vial	--	✓	✓	✓	✓	✓
Ciprofloxacin	Tablet 250 mg	--	--	--	--	✓	✓
Ceftriaxone	Injection 500 mg vial	--	--	--	--	--	✓
6.2.3 Tuberculosis drugs							
Ethambutol	Tablet 400 mg	--	✓	✓	--	✓	✓
Ethambutol/Isoniazide (EH)	Tablet 400/150mg	--	✓	✓	--	✓	✓
INH	Tablet 100 mg	--	✓	✓	--	✓	✓
INH	Tablet 300 mg	--	✓	✓	--	✓	✓
Isoniazide (H)	Tablet 100 mg	--	✓	✓	--	✓	✓
Pyrazinamide(Z)	Tablet 500 mg	--	✓	✓	--	✓	✓
Pyrazinamide (Z)	Tablet 400mg	--	✓	✓	--	✓	✓
Rifampicin (Rifampin)	capsule/tablet 150 mg	--	✓	✓	--	✓	✓
Rifampicin (Rifampin)	capsule/tablet 300 mg	--	✓	✓	✓	✓	✓
Rifampicin/Isoniazide (RH)	Tablet 150/75mg	--	✓	✓	--	✓	✓
Rifampicin/Isoniazide (RH)	Tablet 60/30mg (Child)	--	✓	✓	--	✓	✓
Rifampicin/Isoniazide/Ethambutol (RHE)	Tablet 150/75/275mg	--	✓	✓	--	✓	✓
Rifampicin/Isoniazide/Pyrazinamide (RHZ)	Tablet 60/30/150mg	--	✓	✓	--	✓	✓
Rifampicin/Isoniazide/Pyrazinamide/Ethambutol (RHZE)	Tablet 150/75/400/275mg	--	✓	✓	--	✓	✓
Streptomycin (S)	powder for injection 1g (as sulfate) in vial	--	✓	✓	✓	✓	✓
6.3 Antifungal							
Nystatin	drop 100,000 IU/ml	--	✓	✓	✓	✓	✓
Nystatin	coated tablet 100,000 IU	--	✓	✓	✓	✓	✓
Nystatin	coated tablet 500,000 IU	--	✓	✓	✓	✓	✓
6.4 Anti-protozoal Medicine							
6.4.1 Anti-amoebic and Anti-giardiasis							
Metronidazole	Tablet 250 mg, 200mg	--	✓	✓	✓	✓	✓
Metronidazole	Tablet 400 mg, 500mg	--	✓	✓	✓	✓	✓
Metronidazole	injection 500 mg in 100 ml vial	--	--	--	--	✓	✓

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
Metronidazole	oral suspension 200 mg (as benzoate)/5 ml	--	✓	✓	✓	✓	✓
6.4.2 Antimalarial							
Chloroquine	Tablet 150 mg (as phosphate or sulfate)	✓	✓	✓	✓	✓	✓
Chloroquine	Syrup 50 mg (as phosphate or sulfate)/5 ml	✓	✓	✓	✓	✓	✓
Primaquine	Tablet 15mg	--	--	--	--	✓	--
Pyrimethamine + Sulfadoxine (Fansidar)	Tablet 25 mg + 500 mg	✓[1]	✓	✓	✓	✓	✓
Quinine	Tablet 300 mg (as bisulfate or sulfate),		✓[2]	✓[2]	✓	✓	✓
Quinine	injection 300 mg (as dihydrochloride)/ml in 2-ml ampoule	--	--	--	--	✓	✓
Artesunate + Sulfadoxine +Pyrimethamine[3]	Artesunate 100mg (6 tabs) + Sulfadoxine 500mg/Pyrimethamine 25mg (3 tabs)		✓[4]	✓[4]	✓	✓	✓
Artesunate + Sulfadoxine +Pyrimethamine[3]	Artesunate 50mg (6 tabs) + Sulfadoxine 500mg/Pyrimethamine 25mg (2 tabs)		✓[4]	✓[4]	✓	✓	✓
Artesunate + Sulfadoxine +Pyrimethamine[3]	Artesunate 50mg (3 tabs) + Sulfadoxine 500mg/Pyrimethamine 25mg (1 tabs)		✓[4]	✓[4]	✓	✓	✓
Artemether for pre-referral treatment of suspected and confirmed severe or complicated malaria	Injection 20 & 80 mg in oil for intramuscular injection		✓	✓	✓	✓	✓
1Presumptive treatment for unconfirmed malaria is chloroquine *and* sulfadoxine / pyrimethamine, before referral to CHC for confirmatory diagnosis. 2 Quinine – 2nd line treatment and treatment for severe / complicated malaria require *laboratory confirmation* 3 Artemesinin combination therapy: Artesunate + SP (fansidar) as first line treatment for *laboratory confirmed* Falciparum malaria... 4 In BHCs where diagnostic services are available.							
6.4.3 Antileishmania							
Sodium Stibogluconate	Injection 100 mg per ml.					✓[5]	✓[5]
Meglumine antimonate	Injection 85mg per ml					✓[5]	✓[5]
5. Either Stibogluconate or Meglumine antimonate to be supplied							
6.5 Sulfonamide/Related							
Co-trimoxazole (Sulfamethoxazole + Trimethoprim)	Tablet 100 mg + 20 mg	✓	✓	✓	✓	✓	✓
Co-trimoxazole (Sulfamethoxazole + Trimethoprim)	Tablet 400 mg + 80 mg	✓	✓	✓	✓	✓	✓
Co-trimoxazole (Sulfamethoxazole + Trimethoprim)	suspension 200 mg + 40 mg/5 ml	✓	✓	✓	✓	✓	✓
Note: Co-trimoxazole is given to HIV-positive patients at CHC and DH							
6.6 Urinary Antiseptics							
Nitrofurantoin	Tablet 100 mg	--	--	--	✓	✓	✓
7. Medicines affecting the Autonomic system							

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
7.1 Sympathomimetics and |Anticholinergics							
Adrenaline	injection 1 mg (as hydrochloride or hydrogen tartrate) in 1-ml ampoule	--	✓	✓	✓	✓	✓
Salbutamol	Tablet 4 mg (as sulfate)	--	✓	✓	✓	✓	✓
Salbutamol	Syrup 2 mg/5 ml (as sulfate)	--	✓	✓	✓	✓	✓
Alcuronium Bromide	Injection 5mg per ml in two ml ampoule	--	--	--	--	--	✓
Atropine	Injection 1mg per ml .	-	-	-	-	✓	✓
Trihexyphenidyl Tab 2 mg	Tab 2 mg					✓	✓
8. Drugs Affecting the Blood							
8.1 Drugs Used in Anemia							
Ferrous Sulfate	Tablet equivalent to 60 mg iron	--	✓	✓	✓	✓	✓
Ferrous Sulfate	oral solution equivalent 25 mg iron (as sulfate)/ml	--	✓	✓	✓	✓	✓
Ferrous Sulfate + Folic Acid	Tablet equivalent to 60 mg iron + 400 mcg folic acid	✓	✓	✓	✓	✓	✓
Folic Acid	Tablet 5 mg	--	✓	✓	✓	✓	✓
9. Cardiovascular medicines							
9.1 Antihypertensive Agents							
Atenolol	Tablet 50 mg	--	--	--	✓	✓	✓
Atenolol	Tablet 100 mg	--	--	--	✓	✓	✓
Methyl Dopa	Tablet 250 mg	--	✓	✓	✓	✓	✓
Nifedipine	capsule/tablet 10 mg	--	--	★	★	✓	✓
Hydralazine	Injection 20mg per ml	-	-	-	-	-	✓
9.2 Antithrombotic Agent							
Acetyl salicylic acid (Acetylsalicylic Acid)	Tablet 100 mg	--	--	✓	✓	✓	✓
10. Dermatological Topical medicines							
10.1 Anti-Infective, Topical							
Gentian Violet (Methyl Rosanilinium Chloride)	aqueous solution 0.5% (or crystals)	✓	✓	✓	✓	✓	✓
Gentian Violet (Methyl Rosanilinium Chloride)	aqueous solution 1% (or crystals)	✓	✓	✓	✓	✓	✓
Silver Sulfadiazine	Cream 1%	--	✓	✓	✓	✓	✓
10.2 Antifungal, Topical							
Benzoic Acid + Salicylic Acid	cream or ointment 6% + 3%	--	✓	✓	✓	✓	✓
Nystatin	ointment 100,000 IU, vaginal	--	✓	✓	✓	✓	✓
Nystatin	tablet 100,000 IU, vaginal	--	✓	✓	✓	✓	✓
10.3 Scabicides/Pediculocides							

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
Lindane	lotion 1%	--	✓	✓	✓	✓	✓
11. Disinfectants and antiseptics							
Chlorhexidine	solution 5% (digluconate) for dilution	✓	✓	✓	✓	✓	✓
Chlorhexidine+Cetrimide	solution chlorhexidine gluconate 1.5% +Cetrimide 15%	--	✓	✓	✓	✓	✓
Chlorine releasing comp.,	Powder for solution	✓	✓	✓	✓	✓	✓
12. Diuretics							
Hydrochlorothiazide	tablet 50 mg	--	✓	✓	✓	✓	✓
Furosemide	Tablet 20 mg	--	--	--	--	✓	✓
Furosemide	Injection, 20 mg in 2-ml Ampoule	-	-	--	--	--	✓
13. Gastro-intestinal medicines							
13.1 Antacids							
Aluminum Hydroxide	tablet 500 mg	--	✓	✓	✓	✓	✓
Aluminum Hydroxide + Magnesium Hydroxide	chewable tablet aluminum hydroxide 200 mg + magnesium hydroxide 200 mg	✓	✓	✓	✓	✓	✓
Aluminum Hydroxide + Magnesium Hydroxide	suspension aluminum hydroxide 225 mg + magnesium hydroxide 200 mg/5 ml	--	✓	✓	✓	✓	✓
Ranitidine	Tablet 150 mg	--	--	--	--	✓	✓
13.2 Anti-Emetics							
Metoclopramide	tablet 10 mg (hydrochloride)	--	✓	✓	✓	✓	✓
Metoclopramide	injection 5 mg (hydrochloride)/ml in 2-ml ampoule	--	✓	✓	✓	✓	✓
13.3 Oral Rehydration Solution							
Low Osmolarity ORS 20.5gr/liter	Glucose anhydrous 13.5g, Sodium chloride 2.6g, Trisodium citrate dihydrate 2.9 gm, Potatium chloride 1.5g for one liter	✓	✓	✓	✓	✓	✓
Note: Existing stocks of ORS 29.7gr/liter can be used till depletion							
14. Hormones, other endocrine and contraceptives							
14.1 Adrenal Hormones and Synthetic Substitutes							
Hydrocortisone	powder for injection 100 mg (as sodium succinate) in vial	--	✓	✓	✓	✓	✓
Betamethasone + Neomycin	Cream 1% + 0.5 %	--	✓	✓	✓	✓	✓
14.2 Contraceptives							
Ethinylestradiol + Levonorgestrel	tablet 30 microgram +150 microgram	✓	✓	✓	✓	✓	✓
Ethinylestradiol + Levonorgestrel	tablet 50 microgram + 250 microgram	✓	✓	✓	✓	✓	✓
Ethinylestradiol + Norgestrel	tablet 30 microgram + 300 microgram	✓	✓	✓	✓	✓	✓

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
Ethinylestradiol + Norethisterone	tablet 35 microgram + 1mg	✓	✓	✓	✓	✓	✓
Depot Medroxy Progestrone Acetate (DMPA)	depot injection 150 mg/ml in 1-ml vial	✓	✓	✓	✓	✓	✓
Progesterone Only Pills (POP)	Tablet Norgestrel 75microgram	✓	✓	✓	✓	✓	✓
Progesterone Only Pills (POP)	Pill Norethindrone 0.35 mg	✓	✓	✓	✓	✓	✓
Condoms		✓	✓	✓	✓	✓	✓
IUD		--	✓	✓	✓	✓	✓
15. Immunologicals							
15.1 Vaccines							
BCG	0.05 ml given subcutaneously to children between birth and 1 year old (single dose)	--	✓	✓	✓	✓	✓
DPT (diphtheria, pertussis, tetanus)	0.5 ml given intramuscularly to children between 6 weeks and 1 year old	--	✓	✓	✓	✓	✓
DPT/Hepatitis-B vaccine	0.5 ml given intramuscularly	--	✓	✓	✓	✓	✓
Pentavalent DPTw-HB/Hib	0.5 ml given intramuscularly to children between 6 weeks and 1 year old	--	✓	✓	✓	✓	✓
Measles	0.5 ml given intramuscularly to children between 9 months and 1 year old	--	✓	✓	✓	✓	✓
OPV (oral polio vaccine)	2 drop PO for children under 1 year old, supplemental doses given to all children under 5 years during NIDs	--	✓	✓	✓	✓	✓
Tetanus Toxoid	0.5 ml given intramuscularly to women 15–45 years old	--	✓	✓	✓	✓	✓
15.1 Antisera							
Anti Tetanus Serum(ATS)	Injection 1500 IU ampoule	--	--	--	--	--	✓
16. Ophthalmological Preparations							
16.1 Anti-Infective Topical							
Tetracycline	eye ointment 1% hydrochloride	✓	✓	✓	✓	✓	✓
Tetracaine Hydrochloride	Eye drop 0.5%	--	--	--	--	✓	✓
Fluoresceine		--	--	--	--	--	✓
17. Oxytocics and anti-oxytocics							
17.1 Oxytocics							
Ergometrine	tablet 200 microgram (hydrogen maleate)	--	✓	✓	✓	✓	✓
Ergometrine	injection 200 microgram (hydrogen maleate)	--	✓	✓	--	✓	✓
Oxytocin	injection 10 IU in 1-ml ampoule	--	✓	✓	✓	✓	✓
17.2 Antioxytocics							

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
Salbutamol	tablet 4 mg (as sulfate)	--	✓	✓	✓	✓	✓
Salbutamol	injection 50 microgram (as sulfate)/ml in 5-ml ampoule	--	✓	✓	--	✓	✓
18. Psychotherapeutic Medicines							
18.1 Medicines Used in Psychotic Disorders							
Chlorpromazine	100 mg tablet (hydrochloride)	--	--	--	--	--	✓
Chlorpromazine	injection 25 mg (hydrochloride)/ml in 2-ml ampoule	--	--	--	--	--	✓
Haloperidol	tablet 5 mg	--	--	--	--	--	✓
Haloperidol	injection 5 mg in 1-ml ampoule	--	--	--	--	--	✓
Thioridazine	tablet 25 mg	--	--	--	--	--	✓
18.2 Medicines Used in Depressive Disorders							
Amitriptyline	tablet 25 mg (hydrochloride)	--	--	✓	--	✓	✓
Fluoxetine	Tablet 20 mg					✓	✓
18.3 Medicines Used in Generalized Anxiety and Sleep Disorders							
Diazepam	tablet 5 mg	--	✓	✓	✓	✓	✓
Diazepam	tablet 10 mg	--	✓	✓	✓	✓	✓
19. Medicines acting on the Respiratory tract							
19.1 Anti-Asthmatic Medicines							
Aminophylline	injection 25 mg/ml in 10-ml ampoule	--	✓	✓	✓	✓	✓
Aminophylline	tablet 100 mg	--	✓	✓	✓	✓	✓
Epinephrine (Adrenaline)	injection 1 mg (as hydrochloride or hydrogen tartrate) in 1-ml ampoule	--	★	★	★	✓	✓
Salbutamol	tablet 4 mg	--	✓	✓	✓	✓	✓
Salbutamol	inhalation (aerosol) 100 microgram (as sulfate) per dose	--	✓	✓	✓	✓	✓
Salbutamol	syrup 2 mg (as sulfate)/5 ml	--	✓	✓	✓	✓	✓
Salbutamol	respirator solution for use in nebulizers 5 mg (as sulfate)/ml	--	✓	✓	✓	✓	✓
20. Solutions Correcting Water, Electrolyte and Acid-base Disturbances							
20.2 Parenteral							
Sodium Chloride	injectable solution 0.9% isotonic (equivalent to Na^+ 154 mmol/1, Cl^-154 mmol/1)	--	✓	✓	✓	✓	✓
Compound solution of Sodium Lactate	injectable solution	--	✓	✓	✓	✓	✓
Glucose	injectable solution 10% isotonic 5% isotonic	--	✓	✓	✓	✓	✓
Glucose	injectable solution 50% hypertonic	--	--	--	--	✓	✓

Table 2.14. Essential Drugs for BPHS by Type of Facility							
Drug	**Dosage Form and Strength**	**Health Post**	**HS-C**	**BHC**	**MHT**	**CHC**	**Dist Hos**
Glucose with Sodium Chloride	injectable solution 4% glucose, 0.18% NaCl (equivalent to Na^+, 30 mmol/l, Cl-, 30 mmol/l)	--	✓	✓	✓	✓	✓
Potassium Chloride	injectable solution 11.2% (112 mg) in 20-ml ampoule (equivalent to K^+, 1.5 mmol/ml, Cl^-, 1.5 mmol/ml)	--	★	★	✓	✓	✓
Sodium Hydrogen Carbonate (Sodium Bicarbonate)	injectable solution 8.4% (840 mg), in 10-ml ampoule, equivalent to Na^+, 1,000 mmol/l, HCO_3^- 1,000 mmol/l)	--	--	--	✓	✓	✓
Calcium Gluconate	Injection 10% 10ml solution	--	✓	✓	✓	✓	✓
20.3 Miscellaneous							
Water for injection	5 ml	✓	✓	✓	✓	✓	✓
Water for injection	10 ml	✓	✓	✓	✓	✓	✓
21. Vitamins and Minerals							
Iodine	0.57 ml (308 mg iodine) in dispenser bottle	--	✓	✓	✓	✓	✓
Iodine	capsule 200 mg	--	✓	✓	✓	✓	✓
Retinol (vitamin A)	sugarcoated tablet 100,000 IU (as palmitate) (55 mg)	✓	✓	✓	✓	✓	✓
Retinol (vitamin A)	capsule 200,000 IU (as palmitate) (110mg)	✓	✓	✓	✓	✓	✓
Multi-micronutrients		✓	✓	✓	✓	✓	✓
Zinc	Zinc Dispersable Tablet 20mg strip of ten	✓	✓	✓	✓	✓	✓
Vitamin K	Injection 10mg per ml ampoule	--	✓	✓	✓	✓	✓

10. Blood Transfusion Services to Support BPHS

Table 3. Blood Transfusion Services by Type of Facility						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**District Hospital**
Fresh blood donations	No	No	No	No	Yes	Yes
Immuno-hematology testing	No	No	No	No	Yes	Yes
Screen blood for transmissible diseases	No	No	No	No	Yes	Yes
Perform transfusion	No	No	No	No	Yes	Yes
Provide transfusion counseling	No	No	No	No	Yes	Yes
Infection control, safe injection practices, and waste	Yes	Yes	Yes	Yes	Yes	Yes

It is essential that WHO-qualified blood safety test kits are used.

The Central Blood Bank guidelines on blood transfusion should be followed.

HMIS must be updated to show blood safety screening of HIV, HBV, HCV, and syphilis.(Both Central Blood Bank and HMIS are to take coordinated action)

Note: Due to the low prevalence of syphilis within the general population close attention will be paid to the quantities and expiry dates of the reagents (kits).

11. Primary Eye Care Services

(*Primary Eye Care = Eye care education, prevention and awareness, common eye diseases detection and referral, and simple treatment)*

Table 4. Primary Eye Care Services by Type of Facility

Interventions and Services Provided	Health Facility Level					
	Health Post	Health Sub-Center	BHC	MHT	CHC	District Hospital
Eye Care education and awareness	Yes	Yes	Yes	Yes	Yes	Yes
Recognition of common blinding eye diseases in the community	Yes	Yes	Yes	Yes	Yes	Yes
Recording Visual Acuity	No	No	Yes	Yes	Yes	Yes
Simple and early treatment of common eye diseases (Trachoma, VAD, Conjunctivitis, Sty and Blepharitis)	Yes	Yes	Yes	Yes	Yes	Yes
Eye wash and removal of superficial conjunctiva foreign body	Yes	Yes	Yes	Yes	Yes	Yes
Remove superficial corneal foreign body	No	Yes	Yes	Yes	Yes	Yes
Timely referral of eye patients with significant eye symptoms and visual impairment (VA <6/18)	Yes	Yes	Yes	Yes	Yes	Yes
Advice and counseling for people who require operation sand glasses	Refer	Yes	Yes	Yes	Yes	Yes
Provide capacity building of each level of BPHS staff	No	Yes	Yes	Yes	Yes	Yes

Note: Primary Eye care will be implemented gradually

12. The Recommended Staffing Patterns for BPHS Facilities

Table 5. Type and Number of Health Workers by Type of Facility							
Type of Health Workers and Professionals		**Number of Health Workers in the Health Facility**					
		Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**District Hospital**
Outreach Workers							
	Community health worker (male)	1					
	Community health worker (female)	1					
	Community health supervisor	-	-	1	-	1	1
	Vaccinator	-	-	2	1	2	2
Health Providers							
	Nurse (male)	-	1	1	-	1	5
	Nurse (female)					1	5
	Psychosocial counselor (nurse)	--	--	--	--	(1)	-
	Community midwife		1	1	1	2	
	Midwife	--	--	--	-	-	4
	Physician MD general (male)	--	--	--	1	1	2
	Physician MD general (female)	--	--	(1)	-	1	2
	Surgeon Male			--	-		1
	Surgeon Female	--	--	-	-	-	--
	Anesthetist	--	--	--	--	--	1
	Pediatrician	--	--	--	--	--	1
	Dentist	--	--	--	--	--	1
	Pharmacist	--	--	--	--	--	1
	Physiotherapist	--	--	--	--	--	2
Paramedics, Ancillary Services Staff							
	Laboratory technician	-	-	-	-	1	2
	Pharmacy technician	-	-	-	-	1	-
	X-ray technician	-	-	-	-	-	1
	Dental Technician	-	-	-	-	-	1
Support staff							
	Administrator	-	-	-	-	1	1
	Cleaners, guards	-	1	2	-	4	6
	Driver				1	1	1

Notes:

Compliance with all MoPH HRD policies, strategies and procedures is required by the implementing NGOs. These policies and procedures will be provided by the PPHD to the NGOs and the NGOs will disseminate the relevant documents to their staff at all levels.

1. At Health Post level:
    a. The implementing NGOs will develop processes to ensure supervision of female CHWs. Female CHWs must be appropriately supported in accordance with local circumstances, gender, geography, security, culture etc.
2. At BHC level:
    a. **Incentives** are provided to the BHC staff in case they are asked to work over time or need to work during the night.
    b. **A second midwife or community midwife and/or a pharmacy assistant** in the BHC or any other staff will be included only if the workload of the health facility is too much for one person to perform the duties properly and the resources are available (available extra resources) (Covered by the Flexibility Clause).
    c. **Physicians** may be added to BHCs only to replace a midwife or nurse when those positions are not filled and a physician is available and the CHCs and District Hospital are adequately staffed. In no case is there to be more than one physician per BHC. Physicians employed in such a manner can receive the salary and hardship allowance of physicians.
    d. While appointing **CHSs** priority should be given to those candidates who have some health/medical background and are local residents. CHSs should supervise up to 15 HPs. If a health facility has more than 15 HPs to supervise, there should be more than one CHS.

e. **Female CHSs**, if available, will be trained and appointed as CHSs (if CHSs are couples, it is preferable). Consideration will be given for couples (each one appointed to different but nearby facilities) to work for 15 days in one facility and for the remaining 15 days in another facility located nearby.

3. At CHC level:

   a. One of the 2 nurses of the CHC will be trained to work for Community Therapeutic Care (**CTC**) besides his/her other nursing duties. UNICEF will provide food and training.
   b. One driver at a CHC is to be included and budgeted for in 10% of the CHCs
   c. Where a sufficiently-funded mental health intervention requires it, a psycho-social counselor (nurse)will be added.

4. At DH level:

   a. Two of the DH nurses will be specified to work in the Therapeutic Feeding Center (**TFU**). The psychosocial counselor nurse can also provide counseling on nutrition.
   b. It is recognized that there are insufficient **physiotherapists** in Afghanistan currently to fill all positions in hospitals as well as provincial and regional hospital levels. More physiotherapists need to be trained.

Table 6. Descriptions of the Duties of Specific Categories of Health Workers

Type of Health Worker	General description of duties
Skilled birth attendant	These are health workers with midwifery skills, such as midwives, doctors, and nurses, who have proficiency in the skills necessary to manage normal deliveries and diagnose, and manage or refer, obstetric complications. These workers must be competent to manage normal childbirth and able to provide emergency obstetric care. Not all skilled attendants can provide comprehensive emergency obstetric care, although they should have the skills to determine when such interventions are needed and the capacity to refer women to a higher level of care. Traditional birth attendants (TBAs), whether or not trained, are not considered to be skilled birth attendants. ***Note**: Skilled birth attendance refers to the process by which a pregnant woman is provided with adequate care during labor, birth, and the postpartum and immediate newborn periods. In order for this process to take place, the attendant must have the necessary skills and must be supported by an enabling environment at the household, primary health care, or district hospital level. This includes adequate supplies, equipment, and infrastructure, as well as an efficient and effective system of communication and referral/transport*. (Inter-Agency Group for Safe Motherhood, Nov. 2000)
Midwife	Works in the country's hospitals (district, provincial, and central) and CHCs, primarily to deliver reproductive health care services to women. She assumes responsibility and accountability for her practice, applying up-to-date knowledge and skills in caring for each woman and family. She works as a member of a team that includes doctors (including obstetric/gynecology specialists), nurses, paramedics, and CHWs. The team offers comprehensive emergency obstetric care.
Community midwife	Works in the country's CHCs, MHTs, BHCs, and HSCs primarily to deliver reproductive health care services to women. She assumes responsibility and accountability for her practice, applying up-to-date knowledge and skills in caring for each woman and family. Depending on the presence of the skills of the other HWs, she offers assistance with normal deliveries, and when skill permits, basic emergency obstetric care.
Psychosocial Counselor	These are midlevel health workers (for example nurses) with training in psychosocial counselling according to the approved and standardized training manuals of the Mental Health Department of MoPH. The training consists of 3 months intensive training and 9 months follow up training/supervision. They have knowledge and skills necessary to do psychosocial interventions and counselling for patients with mental disorders and patients who suffer from mental distress but do not have a formal disorder. They work closely together with the MDs and are part of the referral system within BPHS

	Their duties include the supervision of the basic psychosocial interventions to be implemented by the staff of the BHCs and Health Posts
Mental Health Focal Point (District Hospital)	These are health workers, usually doctors, with additional training in mental health care. They function as a reference person in a District Hospital. Apart from seeing patients with mental disorders they also supervise the health workers in the BHCs and CHCs ***Note**: Several NGOs, mainly within urban areas, have good experiences with this type of staff. The introduction of this type of health worker (psychosocial counsellor) will be gradually, based on evaluation of pilots*

13. Equipment and supplies for BPHS by type of facility

13.1. Equipment

Table 7. Equipment for BPHS Facilities by Type of Health Facility

Type of Equipment and Supplies		Health Post	HSC	BHC	MHT	CHC	District Hospital
1. Basic Equipment							
1	Scissors	√	√	√	√	√	√
2	Forceps	√	√	√	√	√	√
3	Thermometer	√	√	√	√	√	√
4	Clean delivery kit (mini delivery kit for health post—see Annex C for kit contents)	√	√	√	√	√	√
5	ORS measuring jug/container	√	√	√	√	√	√
6	Tape measure for ANC	√	√	√	√	√	√
2. Simple Equipment and Supplies							
7	Stethoscope	-	√	√	√	√	√
8	Sputum and blood specimen bottles	-	√	√	-	√	√
9	Vision testing chart	-	√	√	√	√	√
10	Sphygmomanometer	-	√	√	√	√	√
11	Dispensing counting tray	-	√	√	√	√	√
12	Pediatric(Salter) and adult scales	-	√	√	√	√	√
13	Cold box/refrigerator for EPI	-	√	√	√	√	√
14	Vaccine carrier and ice pack	-	√	√	√	√	√
15	Patella hammer	-	√	√	√	√	√
16	Diagnostic set or otoscope	-	√	√	√	√	√
17	Drip stand	-	√	√	√	√	√
18	Flashlight	-	√	√	√	√	√
19	Minor surgery kit (see Annex B for contents)	-	√	√	√	√	√
20	Stretcher	-	√	√	Portable√	√	√
21	Specula	-	√	√	√	√	√
22	Lamp	-	√	√	√	√	√
23	Suction	-	√	√	-	√	√
24	Midwifery kit	-	√	√	-	√	√
25	Sterilizer	√Steam	√	√	√	√	√
26	Examining table	-	√	√	Portable√	√	√
3. Anthropometric Equipment							
27	MUAC Tape (Mid Upper Arm Circumference Tape) tool for measuring nutritional status	√	√	√	√	√	√
28	Height measuring board,	--	√	√	Portable√	√	√
29	Growth monitoring chart	--	--	√	√	√	√
4. More Complex Equipment and Supplies							
30	Oxygen gauge and cylinder	-	-	-	-	√	√
31	Neonatal resuscitation trolley	-	√	√	-	√	√
32	Hearing screening equipment	-	-	-	-	√	√
33	Basic emergency obstetric care kit	-	-	-	-	√	√
34	Sterilization equipment	-	-	-	-	√	√

Table 7. Equipment for BPHS Facilities by Type of Health Facility							
Type of Equipment and Supplies		Health Post	HSC	BHC	MHT	CHC	District Hospital
35	Hemoglobin meter	-	-	-	-	√	√
36	Hand crank centrifuge	-	-	-	-	√	√
37	Microscope	-	-	-	-	√	√
38	Nebulizer	-	-	-	-	√	√
39	Cervical collar and oxygen in ambulances	-	-	-	-	√	√
40	Hysterectomy set (already present but not mentioned)	-	-	-	-	-	√
41	ECG Machine	-	-	-	-	-	√
42	MVA (Manual Vacuum Aspiration) set	-	√	√		√	√
43	Resuscitation Trolley	-	-	-	-	-	√
44	Ambubag for infant, child, and adult	-	√	√	-	√	√
45	Pedal suction machine	-	-	√	-	√	√
46	Torches	-	√	√	-	-	-
47	Wheel Stretcher	-	-	-	-	-	√
48	Folding stretcher	-	√	√	√	√	√
49	Water bath	-	-	-	-	-	√
50	Wheel chair	-	-	-	-	-	√
51	Coagulating Cautery	-	-	-	-	-	√
52	Laparatomy set (already present but not mentioned)	-	-	-	-	-	√
53	Loop and lid retractor	-	-	-	-	√	√
54	Cupboards for CHWs	√	-	-	-	-	-
55	All Physiotherapy Equipment	-	-	-	-	-	√

13.2. Physiotherapy equipment

Table 8. Physiotherapy Equipment
Cervical Traction
Desk/chair/store cupboard
Exercise Bicycle
Floor mat for children
Toys to stimulate children
Goniometer
Gas bottle and double boiler
Heat Packs
Pillow round
Pulleys/weights
Reflex hammer
Saw for cutting POP
Scale for weight measurement
Scale for traction
Sphygmomanometer
Stethoscope
Timer
Towels for hot pack
Traction table
Treatment table

13.3. Renewable supplies

Table 9. Renewable Supplies	
Cotton, Gauze and Bandages	
1	Absorbent cotton wool, 500 g { (a) 500 g, roll, non sterile. b) Surgical hydrophilic cotton, c) Hospital quality }

Table 9. Renewable Supplies	
2	Crepe elastic bandage 7.5cm x 5m, per (roll) { (a) 100% cotton, unbleached, b) Washable and autoclavable, c) Elasticity; minimum of 150%, unstretched 3m, stretched 5m) }
3	Gauze pad / compress 10cm x 10cm, 12 ply sterile, pack of 20, Absorbent gauze 100% cotton
4	Gauze bandage 5cmx10m, absorbent wow, pack of 10 rolls
5	Gauze roll 90cm x 100M non-sterile, with selvedges, absorbent 100% cotton { (a) Gauze roll width 22.5cm after 4 folds, b) Weight 23 gm/m2, type 17 threads/cm2) }
6	Bandage, elastic cotton crepe, 7.5cm x 5m, roll (100 % cotton, unbleached, gauze bandage with selvedge, washable and autoclavable, Elasticity: Minimum of 150% length unstretched 3m,stretched 5m)
7	Bandage gauze cotton, 10cm x 4m, with selvedge, pack of 10 (Absorbent gauze, 100% cotton, ii) Material: Warp 12 threads/cm, weft 8 threads/cm)
8	Crepe elastic bandage, cotton (crepe) 5cm x 5 meter, roll { (a) 100% cotton, unbleached, b) Washable and autoclavable, c) Elasticity: Minimum of 150%, unstretched 3m, stretched 5m) }
Catheters and Tubes	
9	a) Airway Guedel, rubber, adult, L 82mm, autoclavable with plastic insert
10	b) Airway Guedel, rubber, large adult L 110mm, autoclavable with plastic insert
11	c) Airway Guedel, rubber adolescent L 77mm, autoclavable with plastic insert
12	d) Airway Guedel, rubber child, L 67mm, autoclavable with plastic insert
13	e) Airway Guedel, rubber, infant L 54mm, autoclavable
14	f) Airway Guedel, rubber neonate, L 43mm, autoclavable
15	a) Chest catheters with flexible introducer, 24, 28, 32 Fg x L280mm, sterile, pack 10 (i) Material: PVC smooth, with radio-opaque line and markings)
16	b) Chest catheters with blunt tip trocar, sizes 8fg to 32fg, L280mm, sterile pack of 10 (i) Material: PVC soft, with radio-opaque line and markings)
17	a] Chest drainage kit, sealed unit when suction not required for ambulatory use, pack of 5 (i) Complete with 1700ml graduated drainage bag and flexible introducer , ii) Integral flutter valve to prevent re-entry of air / fluid)
18	b) Chest drainage system, underwater seal type for use with or without suction (i) Complete with 2000ml drainage chamber, tubing and floor stand (reusable))
19	c) Chest drainage kit, sealed unit when suction not required for ambulatory use, pack of 5
20	a) Feeding tube CH 5, 40cm, luer, sterile disposable, for neonates/infants, pack 100 ((i) PVC, with cap, rounded tip with side holes, marking for first 20cm)
21	b) Feeding tube CH 6, 40cm, luer, sterile disposable, for neonates/infants, pack 100 ((i) PVC, with cap, rounded tip with side holes, marking for first 20cm)
22	a) Foley catheter, sterile CH 10, 40cm, balloon 3-5 ml latex silicone coated
23	b) Foley catheter, sterile CH 12, 40cm, balloon 10ml latex silicone coated
24	c) Foley catheter, sterile CH 14, 40 cm, balloon 10ml, latex silicone coated
25	d) Foley catheter, sterile CH 16, 40 cm, balloon 10ml, latex silicone coated
26	e) Foley catheter sterile, CH 18, 40cm, balloon 10ml, latex, silicone coated
27	a) Endotracheal tube 4mm (D),cuffed oral, red rubber, non-disposable
28	b) Endotracheal tube 5mm (D), cuffed oral, red rubber, non-disposable
29	c) Endotracheal tube 6mm (D), cuffed oral, red rubber, non-disposable
30	a) Tubes, nasogastric CH 12, length 125cm, sterile disp, box of 50 ((i) Material: Polyvinyl chloride (PVC) with marking and 4 side windows, (ii) For aspiration and feeding)
31	b) Tube, nasogastric CH 16, length 125cm, sterile disposable, box of 50 ((i) Material: Polyvinyl chloride (PVE) with marking and 4 side windows, (ii) For aspiration and feeding)
32	c) Tube nasogastric, child, CH 8, length 125cm sterile disposable, box of 50 ((i) Material: Polyvinyl chloride (PVC) with marking and 4 side windows, (ii) For aspiration and feeding in children)
33	d) Tube nasogastric, CH 6, length 125cm, sterile disposable, box of 50 ((i) Material: Polyvinyl chloride (PVC) with marking and 4 side windows,
34	Rectal tube CH 20, length 30cm, polyvinyl sterile disposable, box of 50 { (i) With central opening and eye/window on one side) }
35	Tube rectal CH 24, L30cm, polyvinyl sterile disposable, box of 50 (i) With central opening and

Table 9. Renewable Supplies	
	eye/window on one side)
36	a) Suction tube CH 8, 50cm, sterile, disp, PVC, box of 50 (i) Open distal end with side windows and connector,)
37	b) Suction tube CH 10, 50cm, sterile, disp, PVC, box of 50 (i) Open distal end with side windows and connector)
38	c) Suction tube CH 14, 50cm, sterile, disp, PVC, box of 50 (i) Open distal end with side windows and connector)
39	d) Suction tube CH 16, 50cm, sterile, disp, PVC, box of 50 (i) Open distal end with side windows and connector)
Sutures (Chromic, Dexon and Silks)	
40	Chromic catgut1, 75cm with half circle taper cut 40mm needle, sterile, box of 12
41	Chromic catgut 0, 75cm, with half circle RB 35mm needle, sterile, box of 12
42	Chromic catgut 2/0, 75cm, with half circle taper cut 35mm needle, sterile, box 12
43	Chromic catgut 3/0, 75cm, with curved cutting 16mm needle, sterile, box of 12
44	Dexon 0 needled Suture synthetic absorbable 0.75cm, needle 3/8 triangular end, 36mm. Box of 36
45	Silk braided 1, 75cm with 60mm curved cutting needle, sterile, box of 12
46	Silk braided 2, 75cm with 40mm half circle RB heavy Mayo No 3 needle, box of 12
47	Silk braided 3/0, 45cm with 26mm 3/8 reverse cutting needle, sterile, box of 12
48	Silk braided 0, 75cm with 35mm curved reverse cutting needle, sterile, box of 12
49	Vicryl, 1 - 75cm with 35mm half circle taper cut needle, sterile, box of 12 (a) Absorbable braided suture, color violet)
50	Vicryl 2-0 needled 75cm with 30mm 1/2 circle round bodied needle, pack of 12 (a) Absorbable braided suture, color violet)
51	Vicryl, 0-75cm with 35mm half circle RB needle, sterile, box of 12 (a) Absorbable braided suture, color violet)
52	Vicryl, 3-75cm with 45mm half circle RB needle, sterile, box of 12 (a) Absorbable braided suture, color violet)
Syringes , Cannula and Needles	
53	Syringe Luer disposable, 2 ml, with needle 22G, sterile, box of 100 (Two piece syringe (P/P or PEF) with central luer nozzle, Needle: 23G (0.6mm x 25mm), bi-packed with syringe)
54	IV Cannula, short, 20G (1.1x32mm) { (a) Sterile, disposable, b) Trocar: Stainless steel, c) Injection port, d) Cannula: Polypropylene or Teflon) }
55	IV Cannula, short, 22G (1.1x32mm) (a) Sterile, disposable, b) Trocar: Stainless steel, c) Injection port, d) Cannula: Polypropylene or Teflon)
56	IV Cannula, short, 24 G (1.1x32mm) (a) Sterile, disposable, b) Trocar: Stainless steel, c) Injection port, d) Cannula: Polypropylene or Teflon)
57	Needle Luer, IM, disposable, 21G (0.8x38mm) sterile, stainless steel, box 100
58	a) Needle disp 19G (1.1x40mm), sterile, stainless steel, box of 100
59	b) Needle disp 21G (0.8x40mm), sterile, stainless steel, box of 100
60	c) Needle disp 22G (0.7x30mm), sterile, stainless steel, box of 100
61	d) Needle disp 23G (0.6x25mm), sterile, stainless steel, box of 100
62	e) Needle disp 25G (0.5x16mm), sterile. stainless steel, box of 100
63	Needle, scalp vein infusion set, disposable, 25 G (0.5x19mm) color orange, box of 50 (Materials: Stainless steel needle, PVC tubing (200mm) and wings)
64	Needle, scalp vein infusion set, disposable, 21 G (0.8x19mm),color green, box of 50 (Materials: Stainless steel needle, PVC tubing (200mm) and wings)
65	a) Spinal needle 20g (0.9x90mm) sterile disposable, box of 50 (i) Cannula and stylet stainless steel with Quincke type point)
66	b) Spinal needle 22g (0.7x90mm) sterile disposable, box of 50 (i) Cannula and stylet stainless steel with Quincke type point)
67	IV placement cannula, short, sterile disposable, 18 G, unit, pack of 50 (Trocar stainless steel, Cannula: Polypropylene or teflon with injection port)
68	Syringe 10cc, Luer, sterile disposable, two piece, (P/P or PEF) box of 100
69	Syringe, 20cc Luer, sterile disposable, two piece, (P/P or PEF), box of 100
70	Syringe 5cc, Luer, sterile disposable, two piece (P/P or PEF), box of 100
71	Syringe 50/60cc, Luer lock sterile disp, concentric tip, box of 100

Table 9. Renewable Supplies	
Gloves	
72	Glove, examination, latex, non sterile, small, box of 100 (Disposable, pre-powdered)
73	a) Gloves, examination latex, large, non sterile, powdered, box of 100
74	b) Gloves, examination latex, medium, non-sterile, powdered, box of 100
75	C. Gloves, plastic examination non-sterile, disposable, box of 100
76	a) Gloves surgical 6.5 sterile latex powdered, box of 50 pairs
77	b) Gloves surgical 7.0 sterile latex powdered, box of 50 pairs
78	c) Gloves surgical 7.5, sterile, latex powdered, box of 50 pairs
79	d) Gloves surgical 8.0, sterile, latex powdered, box of 50 pairs
80	e) Gloves surgical 8.5, sterile, latex powdered, box of 50 pairs
Surgical Adhesive Tapes	
81	Sterilization / autoclave test tape for steam sterilization, width 18mm x 50m roll
82	a) Tape surgical, adhesive hypoallergenic, fabric, 5cm x 10m, box of 5
83	b) Tape surgical Leucoplast Zinc oxide, tanned 5cm x 9.2M, box of 12
84	Tape adhesive, Zinc Oxide, 2.5 cm x 5 meter, roll (Color white, non-stretch, Aerated textile strip impregnated with adhesive. Storage: dry conditions and at less than 25 degrees C if possible)
85	c) Tape surgical, Zinc oxide, perforated, 10cm x 5m, box of 10
Bags	
86	Colostomy bag/pouch closed unit opaque, 13mm starter hole, set. Box of 30 (a. Supplied complete with adhesive, skin protector and integral filter, b) Small starter hole for cutting to required size)
87	Drain: Corrugated rubber drainage sheet, 30.5xx15cm (12 x 6 inches)
88	Urine collecting bag with valve, 2000 ml, plastic, graduated with 90mm tube, box of 10 (Supplied complete with connector and suspension eyelets.)
89	a) Blood collection bag, adult for 450ml including 63ml of CPD and blood taking set
90	b) Blood collection bag, child for 250ml including 35ml of CPD and blood taking set
Blade and Razor	
91	Razor safety, stainless steel, 3 piece unit (handle and blade holder), reusable (Razor blades, double edged, steel, disposable, pack of 5. Box of 10 packs)
92	Scalpel blade No 10, sterile disposable small (for handle No 3). Box of 100 (i) Material: Magnetic / Martensitic steel)
93	Scalpel blade No 22, sterile disposable, large (for handle No. 4). Box of 100 (i) Material: Magnetic / Martensitic steel)
Others	
94	Spare bulb for Heine otoscope
95	Battery dry cell alkaline AA size 1.5V or LR6 (for otoscope), single unit
96	Tablet bag, plastic size 10cmx15cm, self sealing with 3 white writing panels, (100 x 5) per 500 (Self sealing minigrip type zip lock, moisture resistant closure, Material: Virgin polyethylene, thickness 0.05 mm
97	Tongue depressor (wooden), disposable, box of 100
98	Apron, utility plastic reusable, unit (Straight apron with bib and neckband back fastening, Moisture proof and blood, water, chemical and stain resistant. Able to withstand extreme temperature, Length 120cm, width 90cm, Re-usable and able to withstand disinfection. Material: Opaque/transparent plastic, PVC, vinyl or polypropylene)
99	Bucket, plastic, approximately 12 liters, with lid. Unit
100	Infant coat
101	Resuscitator, adult, hand operated set with bag 1500-2000ml (balloon for oxygen)
X-Ray Radiology	
102	a) X- ray film, blue sensitive, interleaved, 18 x 24 cm, box of 100
103	b) X- ray film, blue sensitive, interleaved, 24 x 30 cm, box of 100
104	c) X- ray film, blue sensitive, interleaved, 30 x 40 cm, box of 100
105	a) X-ray developer powder for 25 liters, 2.6Kg
106	b) X-ray fixer for 22.5 L, 3.3kg

14. Diagnostic Services for BPHS by Type of Facility

Diagnostic services, such as laboratory and radiology services, support health workers in their diagnoses of patient conditions. As the BPHS comprises the most critical services and interventions, the primary role of diagnostic services is to provide confirmation of a diagnosis. The services available for the BPHS are very basic, as the more sophisticated diagnostic services are located in the provincial and regional hospitals. The radiology, laboratory, and other diagnostic services available in the referral system at higher-level hospitals are outlined in Table 10, "Diagnostic Services by Hospital Level," in the EPHS.

Table 10. Diagnostic Services by Type of Facility

Diagnostic Test	Health Post	HSC	BHC	MHT	CHC	District Hospital
1. Laboratory Services						
1.1 Hematology						
Hemoglobin	-	-	-	-	√	√
Red and white blood cell count	-	-	-	-	√	√
ESR and differential cell count	-	-	-	-	√	√
Hematocrit	-	-	-	-		√
Bleeding time and coagulation time	-	-	-	-		√
Blood grouping and Rh factors	-	-	-	-	√	√
Hepatitis B and C and syphilis tests	-	-	-	-	√	√
HIV test	-	-	-	-	√	√
White blood count (WBC and differential) manual	-	-	-	-	√	√
Erythrocyte sedimentation rate (ESR)	-	-	-	-	√	√
Malaria parasite smear (MPS)	-	-	-	-	√	√
1.2 Bacteriology						
Ziehl-Nielsen staining for acid fast bacilli (AFB)	-	-	-	-	√	-
Direct smear for AFB	-	-	-	-	-	√
Albert's staining for diphtheria	-	-	-	-	√	√
Gram's staining	-	-	-	-	√	√
1.3 Serology						
Widal test	-	-	-	-	-	√
1.4 Clinical Pathology						
Urine analysis: physical exam	-	-	-	-	√	√
Chemical exam: Albumin (qualitative)	-	-	-	-	√	√
Chemical exam: Albumin (quantitative)	-	-	-	-	-	√
Chemical exam: Glucose (qualitative)	-	-	-	-	√	√
Chemical exam: Glucose (quantitative)	-	-	-	-	-	√
Microscopic (stool test)	-	-	-	-	√	√
Macroscopic (stool test)	-	-	-	-	-	√
Pregnancy test	-	-	-	-	√	√
1.5 Biochemistry						
Blood-sugar test	-	-	-	-	-	√
Urea test	-	-	-	-	-	√
Creatinine test	-	-	-	-	-	√
Total protein test	-	-	-	-	-	√
Simple liver-function test	-	-	-	-	-	√
1.6. Gram Stain						
Body fluids	-	-	-	-	-	√
2. Imaging Services						
2.1. X-Rays						
Chest	-	-	-	-	-	√
Abdomen	-	-	-	-	-	√
Skeletal	-	-	-	-	-	√

15. Summary of Services, Staffing, Equipment, Diagnostic Services, Essential Drugs by Facility Type

A summary of each type of BPHS health facility is provided in six tables, as outlined below. Each table catalogs the catchment population, all the services and interventions provided, the type and number of health worker staff, an illustrative list of equipment, and a list of essential drugs at each type of facility. These are provided in the following tables:

- Table 11. Health Post: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs
- Table 12. Health Sub Center: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs
- Table 13. Basic Health Center: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs
- Table 14. Mobile Health Team: Summary of BPHS Services, Staffing, Facility Features, and Essential Drug
- Table 15. Comprehensive Health Center: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs
- Table 16. District Hospital: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs

For all the services listed, implementers will adhere to the principles of and requirements for appropriate implementation as formulated by the MoPH:

1. Routine reporting using the standard formats and reporting intervals as required by the HMIS and M&E of the MoPH;
2. Strict adherence at all levels and for all services to the MoPH recommendations for infection control, safe injection practices, and proper waste disposal;
3. Regular and supportive supervision of lower levels by higher levels, according to the recommendations and requirements of the concerned MoPH departments and national programs.

15.1. Health Post

Population Catchment Area Served: 1,000–1,500 (100–200 families)

Table 11. Health Post: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs

BPHS Core Area	Interventions/Conditions Treated/Services Provided	Type and Number of Staff	Illustrative Facility Features	Illustrative Equipment and Supplies	Essential Drugs
1. Maternal and Newborn Health	• Provide antenatal and postnatal care; refer complicated cases • Promote birth preparedness & safe home delivery; refer complicated cases • Identify sick newborns and refer after first aid • Provide micronutrient supplementation • Identify and refer babies with physical anomalies such as club foot • Provide counseling on family	CHW (male) 1 CHW (female) 1	Private home of CHW	Scissors Forceps Thermometer Mini delivery kit *(see Annex C for kit contents)* ORS Measurement jug Tape measure for nutrition	**Analgesics:** Acetaminophen **Antidotes:** Activated charcoal **Antihistamines:** Chlorpheniramine Maleate **Anti-bacterial:** Co-trimoxazole

Table 11. Health Post: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	planning and exclusive breastfeeding			assessment	
	• Distribute condoms and oral contraceptives, and provide DMPA, including first injection of DMPA			Health education teaching materials	**Anti-malarials:** Chloroquine Fansidar
2. Child Health and Immunization	• Promote routine immunization at the facility and support EPI outreach			Disability awareness materials (visual and written)	**Antenatal Supplements:** Ferrous Sulfate + Folic Acid
	• Disease surveillance and case reporting			Updated referral list of physical rehabilitation service providers in region Sterilizer,	
	• VPD outbreak response				**Anti-infectives:** Gentian Violet
	• Vitamin A supplementation			MUAC Tape (Mid Upper Arm Circumference Tap)	
	• Infection control, safe injection practices, and waste disposal				**Disinfectants:** Chlorhexidine Chlorine releasing comp
	• Reporting			Cupboards for CHWs	
	• Support campaigns				**Oral Rehydration Salts:** ORS and Zinc tablets
	• Manage cases of ARI, pneumonia, diarrhea, fever, malaria, provide ORT, refer complicated cases.				
	• Support case management of measles				**Contraceptives:** Oral, condoms, DMPA
	• Identify gravely ill children and refer				
3. Public Nutrition	• Support for exclusive breastfeeding				**Anti-infectives:** Tetracycline
	• Community-based malnutrition management				
	• Multi-micronutrient Vitamin A and iron Folic supplementation				**Vitamins and Minerals:** Retinol Zinc
	• Community food demonstration				
	• Community-based growth promotion				**Antacid** Aluminum Hydroxide + Magnesium
	• Community Mobilization and screening				
4. Communicable disease Treatment and Control	• DOTS—For identified TB patients, recommend for HIV test encourage compliance with DOTS determined treatment				
	• Referral of self-reporting suspected				

Table 11. Health Post: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	TB patient				Hydroxide **Anti Helminthes:** Mebendazole
	• Surveillance of cases of interrupted TB treatment, active case-finding				
	• Clinical diagnosis of malaria and treatment of uncomplicated cases				
	• Provision of insecticide-treated mosquito nets				
	• Information, education, and communication				
	• Referral to HIV counseling (and testing where indicated)				
	• Monitoring, supervision and support for ARV prophylaxis for PMTCT				
	• Monitoring, supervision and support for ART (antiretroviral treatment)				
	• Infection control, safe injection practices, and waste				
	• Referral to physical rehabilitation services (exercise training) if required				
5. Mental Health	• Mental health awareness				
	• Case detection (self-reporting) and follow-up of chronic cases				
	• Support community-based self-help groups for drug addiction including harm reduction				
6. Disability Services	• Refer patients to nearest physiotherapy and orthopedic workshop services if required				
	• Refer disabled children with physical anomalies to nearest physiotherapy services				
7. Regular Supply of Essential drugs	*(See last column)*				

Table 11. Health Post: Summary of BPHS Services, Staffing, Facility Features, and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
8.General-Information, Education and Communication	• Promotion of healthy lifestyles and care-seeking behavior • Work with Family Health Action Groups in order to spread important messages and healthy behaviors throughout the community				

15.2. Health Sub-Center

Population Catchments Area served served 3000-7000

Table 12. Health Sub-Center: Summary of BPHS Services, Staffing, Facility Features and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
1. Maternal and Newborn Health	• Provide antenatal care; refer complicated cases • Refer all deliveries, if no referral possible attend normal deliveries • Identify sick newborns and refer after first aid • Provide micronutrient supplementation • Provide counseling on family planning and exclusive breastfeeding • Distribute condoms and oral contraceptives, and provide follow-up DMPA	**The sub-center will be staffed as follows:** Male nurse 1 Community midwife 1 Cleaner/Guard 1	Private house provided by the community Examination room Delivery room Wound dressing area Pharmacy Patient registration room	Stethoscope Sputum and blood specimen bottles Vision testing charts Sphygmomanometer Dispensing counting tray Pediatric and adult scales Cold box/refrigerator(flexible) for EPI	**Anesthetics:** Oxygen, Lidocaine **Analgesics:** Acetaminophen, Acetyl, Salicylic Acid, Ibuprofen Diclofenac **Anticonvulsants:** Diazepam, Magnesium Sulfate, Phenobarbital, **Antidotes:** Activated charcoal, Calcium Gluconate **Antihistamines**: Chlorpheniramine Maleate **Anthelminthics**: Mebendazole **Antibacterials**: Amoxicillin, Benzathine Benzyl Penicillin, Phenoxy
2. Child Health and Immunization	• EPI routine (All antigens) • Outreach immunization service • EPI-plus (ORS+ De-worming) • Supplementary Immunization Activities • Disease surveillance and case reporting • VPD outbreak response				

Table 12. Health Sub-Center: Summary of BPHS Services, Staffing, Facility Features and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	• Vitamin A supplementation		Waiting room (area) Medical records area Health Education area Disability materials (Visual and written) Updated referral list of physical rehabilitation services providers in regions	Vaccine carrier and ice pack Patella hammer Diagnostic set or Otoscope Drip stand Flashlight Minor surgery kit *(see Annex B for kit contents)* Stretcher Specula Lamp Suction Midwifery kit *(see Annex C for kit contents)* Sterilizer Examination table Scissors Forceps	Methyl Penicillin (Penicillin V), Procaine Penicillin, Chloramphenicol, Doxycycline, Ampicillin, Gentamycin, Erythromycin **Anti-TB drugs**: Ethambutol, INH, Pyrazinamide, Rifampicin, Streptomycin, **Antifungals:** Nystatin **Anti-amoebic**: Metronidazole **Antimalarials:** Chloroquine, Fansidar, Quinine **Sulfonamide:** Co-trimoxazole **Sympathomimetics:** Salbutamol, Adrenaline **Antenatal Supplements:** Ferrous Sulfate + Folic Acid **Antihypertensives:** Methyldopa, Nifedipine **Anti-infectives**: Gentian Violet, Silver Sulphadiazine **Anti-fungal**: Benzoic Acid + Salicylic Acid, Nystatin, **Scabicides/ Pediculocides:** Lindane **Disinfectants**: Chlorhexidine Chlorine releasing comp., **Diuretics**: Hydrochlorothiazide **Antacids**: aluminium
	• Manage cases of ARI, pneumonia, diarrhea, fever, malaria, provide ORT, refer complicated cases				
	• Support case management of measles				
	• Identify gravely ill children and refer				
3. Public Nutrition	• Support for exclusive breastfeeding				
	• Community-based malnutrition management				
	• Multi-micronutrient and iron supplementation				
	• School feeding & Community food demonstration				
4. Communicable disease Treatment and Control	• TB case detection using sputum smear				
	• Short course Chemotherapy , including DOTS—For identified TB patients, encourage compliance with DOTS determined treatment and HIV testing				
	• Referral of self-reporting TB patient				
	• Surveillance of cases of interrupted TB treatment, active case-finding				
	• Clinical diagnosis of malaria and treatment of uncomplicated cases				
	• Promotion and distribution of insecticide-treated mosquito nets				
	• Referral for VCCT by HIV prevention education				
5. Mental Health	• Awareness raising & psycho-education				
	• Case identification and referral				
	• Basic psychosocial support for individuals, families and groups				
	• Follow up of chronic patients (Treatment compliance				
	• Support community-based self-help for				

Table 12. Health Sub-Center: Summary of BPHS Services, Staffing, Facility Features and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	drug addiction-harm reduction and referral of IDUs for testing			Thermometer Clean delivery kit *(see Annex C for kit contents)* ORS measuring jug/container Tape measure for nutrition assessment Height measuring Board, Growth monitoring chart MVA (Manual Vacuum Aspiration) Ambu bag for child, adult and infant Torches Folding stretcher Neonatal Resuscitation trolley	Hydroxide + magnesium Hydroxide **Anti-emetics**: Metoclopramide **Oral Rehydration Salts**: Low Osmolarity (ORS) **Adrenal Hormones** Hydrocortisone Betamethasone + Neomycin **Oxytocics:** Oxytocin **Contraceptives:** Oral, POP, Condoms, IUD (if person trained), DMPA injections **Vaccines:** BCG, DPT, Hepatitis B, Measles, OPV, Tetanus toxoid, Pentavalent DTPw-HB Hib **Ophthalmological Preparation Anti-infectives:** Tetracycline **Anti-asthmatic:** Aminophylline, Epinephrine, Salbutamol **Parenteral:** Sodium chloride, sodium lactate, glucose with sodium chloride, Potassium chloride **Miscellaneous:** Water for injection **Vitamins and Minerals:** Iodine, Retinol, Multi-micronutrients, Zinc, Vitamin K
	• Mental health training for staff and health workers				
6. Disability Services	• Disability and Physical rehabilitation awareness, prevention and education				
	• Home visit program for paraplegic patients (in urban setting)				
	• Refer patients to nearest Physiotherapy and Orthopedic rehabilitation services as required				
	• Refer disabled children with physical anomalies to nearest Physiotherapy services				
7. Regular Supply of Essential drugs	*(See last column)*				
General-Information, Education and Communication	• Promotion of healthy lifestyles and care-seeking behavior				

15.3. Basic Health Center

Population Catchment Area Served: 15,000-30,000

Table 13. Basic Health Center: Summary of BPHS Services, Staffing Facility Features and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
1. Maternal and Newborn Health	• Antenatal care; refer complicated cases • Assist with normal deliveries, identification of danger signs and referral • Detection of postpartum anemia, puerperal infections • Identification of sick newborns and referral after first aid • Promoting exclusive breastfeeding • Micronutrient supplementation • Counseling on family planning • Screening for and treatment of STDs, HIV testing, condom promotion and supply • Contraceptive services: DMPA injections, distribution of condoms and oral contraceptives, IUDs if trained person available	Nurse (male) 1 Community midwife 1 Community health supervisor 1 Vaccinator 2 Physician (male or female) 1 Cleaners, guards 2	Examination room Delivery room Wound dressing area Pharmacy Patient registration room Waiting room Medical records area Health Education area Disability materials (Visual and written)	Stethoscope Sputum and blood specimen bottles Vision testing charts Sphygmomanometer Dispensing counting tray Pediatric and adult scales Cold box/refrigerator for EPI Vaccine carrier and ice pack Patella hammer Diagnostic set or Otoscope Drip stand Flashlight Minor surgery kit	**Anesthetics:** Oxygen, Lidocaine **Analgesics:** Acetaminophen, Acetylsalicylic Acid, Ibuprofen Diclofenac **Anticonvulsants/Anti-Epileptics:** Diazepam, Magnesium Sulfate, Phenobarbital **Antidotes:** Activated charcoal, Calcium Gluconate **Antihistamines**: Chlorpheniramine Maleate **Anthelminthics**: Mebendazole **Antibacterials**: Amoxicillin, Benzathine Benzyl Penicillin, Phenoxy Methyl Penicillin (Penicillin V), Procaine Penicillin, Chloramphenicol, Doxycycline, Co-trimoxazole, Ampicillin, Gentamycin, Erythromycin(Ethyl succinate) **Anti-TB drugs**: Ethambutol, INH, Pyrazinamide, Rifampicin, Streptomycin, **Antifungals:** Nystatin **Anti-Amoebic**:
2. Child Health and Immunization	• EPI routine (All antigens) • Outreach immunization service • EPI-plus (ORS+ De-worming • Supplementary Immunization Activities • Disease surveillance and case reporting • VPD outbreak response • Vitamin A supplementation • Supervision and monitoring • Case management of ARI, pneumonia, diarrhea, measles, fever/malaria;				

Table 13. Basic Health Center: Summary of BPHS Services, Staffing Facility Features and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	provision of ORT, referral of complicated cases (as per IMCI)		Updated referral list of physical rehabilitation services providers in regions	*(see Annex B for kit contents)* Stretcher Specula Lamp Suction Midwifery kit *(see Annex C for kit contents)* Sterilizer Examination table Scissors Forceps Thermometer Clean delivery kit *(see Annex C for kit contents)* ORS measuring jug/container Tape measure for nutrition assessment Height measuring	Metronidazole **Antimalarials:** Chloroquine, Fansidar, Quinine **Sulfonamide:** Co-trimoxazole **Sympathomimetics:** Salbutamol, Adrenaline **Antenatal Supplements:** Ferrous Sulphate + Folic Acid **Antihypertensives:** Methyldopa, Nifedipine **Anti-infectives**: Gentian Violet, Silver Sulfadiazine **Anti-fungal**: Benzoic Acid + Salicylic Acid, Nystatin **Scabicides/Pediculocides:** Lindane **Disinfectants**: Chlorhexidine, Chlorine releasing comp **Diuretics**: Hydrochlorothiazide **Antacids**: aluminium Hydroxide + magnesium Hydroxide **Anti-emetics**: Metoclopramide **Oral Rehydration Salts**: Low Osmolarity ORS **Adrenal Hormones** Hydrocortisone Betamethasone+Neomycin **Oxytocics:** Oxytocin **Contraceptives:** Oral, POP, Condoms, IUD (if person trained), DMPA injections
	• Identification of gravely ill children and referrals				
3. Public Nutrition	• Support exclusive breastfeeding				
	• Growth monitoring and promotion				
	• Diagnosis and treatment of malnutrition				
	• Multi-micronutrient and iron supplementation				
	• School feeding				
	• Improvement of sanitation				
	• Community food demonstration				
	• Treatment of severe malnutrition at community level (CTC): Community Mobilization and screening				
	• Out patient management (OTP)				
4. Communicable disease Treatment and Control	• TB cases detection using sputum smear (if lab available), HIV testing for TB patients w				
	• Short-course chemotherapy, including DOTS				
	• Surveillance of cases of interrupted TB treatment, active case-finding				
	• Preventive therapy for children contacts of TB patients				
	• Clinical diagnosis of malaria and treatment of uncomplicated cases				
	• Promotion and distribution of insecticide treated mosquito nets				
	• Referral for VCCT for suspected HIV/AIDS patients HIV prevention education, NTDC or non test dependent counseling and referral for V CCT				
5. Mental Health	• Awareness raising & psycho-education				

Table 13. Basic Health Center: Summary of BPHS Services, Staffing Facility Features and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	• Case identification & diagnosis • Psychosocial assessment and basic psychosocial interventions • Basic treatment and referral of mental disorders • Support groups for people with substance abuse, mental disorders and their family members • Substance abuse: identification and education • Community-based rehabilitation and harm reduction • Support group for drug addicts, psychiatry patients/families and women •			Board, Growth monitoring chart MVA (Manual Vacuum Aspiration) Ambu bag for child, adult and infant Pedal suction machine Torches Folding stretcher Neonatal Resuscitation trolley	**Vaccines:** BCG, DPT, Hepatitis B, Measles, OPV, Tetanus toxoid, Pentavalent DTPw-HB Hib **Ophthalmological Preparation Anti-infectives:** Tetracycline **Antioxytocics:** Salbutamol **Anti-asthmatic:** Aminophylline Salbutamol, Epinephrine (Adrenaline) **Medicine Used in Depression:** Amitriptyline **Parenteral:** Sodium Chloride, Sodium Lactate, Glucose with sodium chloride, Potassium Chloride, Calcium Gluconate **Miscellaneous:** Water for injection **Vitamins and Minerals:** Iodine, Retinol, Multi-micronutrients, Zinc, Vitamin K
6. Disability Services	• Disability and Physical rehabilitation awareness, prevention and education • Refer patients to nearest physiotherapy or orthopedic rehabilitation services as required • Identify and refer newborn and young children (i.e. Club foot, DDH) with physical anomalies to nearest physiotherapy services				
7. Regular Supply of Essential drugs	*(See last column)*				
General-Information, Education and Communication	• Promotion of healthy lifestyles and care-seeking behavior				

15.4. Mobile Health Teams

Population catchments area served: depends upon the local situation

Table 14. Mobile Health Team: Summary of BPHS Services, Staffing, Facilities and Essential Drugs

BPHS Core Area	Interventions/Conditions Treated/Services Provided	Type and Number of Staff	Illustrative Facility Features	Illustrative Equipment and Supplies	Essential Drugs
1. Maternal and Newborn Health	• Antenatal care; refer complicated cases • Assist with normal deliveries, identification of danger signs and referral • Detection of postpartum anemia, puerperal infections • Identification of sick newborns and referral after first aid • Promoting exclusive breastfeeding • Micronutrient supplementation • Counseling on family planning • Screening for and treatment of STDs, HIV testing, condom promotion and supply • Contraceptive services: DMPA injections, distribution of condoms and oral contraceptives, IUDs if trained person available	Female Health Provider (Community Midwife or , Nurse) 1 Male Health Provider (Doctor or Nurse) 1 Vaccinator 1 Driver 1	Examination rooms Delivery Room Wound dressing area Pharmacy Patient registration area Waiting area Medical records Table Health Education area ((Disability awareness) Disability materials (Visual and written) Updated referral list of physical rehabilitation services providers in regions))	Stethoscope Sputum and blood specimen bottles Vision testing chart Sphygmomanometer Dispensing counting tray Pediatric and adult scales Cold box for EPI Vaccine carrier and ice pack Patella hammer Diagnostic set or otoscope Drip stand Flashlight Minor surgery kit *(see Annex B for kit contents)*	**Anesthetics:** Oxygen, Lidocaine, Lidocaine + Adrenaline **Analgesics, Antipyretics, Nonsterodial Anti-Inflammatory Drugs:** Acetaminophen (Paracetamol), Acetylsalicylic Acid, Ibuprofen **Anticonvulsants/Anti-Epileptics:** Diazepam, Magnesium Sulphate, Phenobarbital **Antidotes:** Activated charcoal **Antihistamines:** Chlorpheniramine Maleate (Chlorphenamine) **Anti-Infective Medicines:** Mebendazole, **Antibacterials:** Amoxicillin, Benzathine Benzyl Penicillin, Procaine Penicillin, Chloramphenicol, Doxycycline, Gentamicin, Erythromicine, Silver sulfadiazine **Anti-tuberculosis:** Rifampicin (Rifampin), **Antifungal:** Nystatin **Anti-protozoal Medicine**: Metronidazole **Antimalarial:** Chloroquine, Pyrimethamine + Sulfadoxine (Fansidar), Quinine **Sulfonamide/Related:** Co-
2. Child Health and Immunization	• EPI routine (All antigens) • Outreach immunization service • EPI-plus (ORS+ De-worming • Supplementary Immunization Activities • Disease surveillance and case reporting • VPD outbreak response • Vitamin A supplementation • Case management of ARI, pneumonia, diarrhea, measles, fever/malaria; provision of ORT, referral of complicated cases				

Table 14. Mobile Health Team: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	• Identification of gravely ill children and referrals			Stretcher	trimoxazole (Sulfamethoxazole +Trimethoprime)
3.Public Nutrition	Support exclusive breastfeeding			Specula	**Urinary Antiseptics:** Nitrofurantoin
	• Growth monitoring			Lamp	**Sympathomimetics:** Adrenaline, Salbutamol,
	• Diagnosis and treatment of malnutrition			Suction	Atropine
	• Multi-micronutrient and iron supplementation			Midwifery kit *(see Annex C for kit contents)*	**Drugs Used in Anemia:**, Ferrous Sulphate + Folic Acid, **Antihypertensive Agents:** Atenolol, Methyl Dopa, Nifedipine
	• School feeding			Sterilizer	**Antithrombotic Agent:** Acetyl salicylic acid (Acetylsalicylic Acid),
	• Improvement of sanitation				**Anti-Infective, Topical:** Gentian Violet (Methyl Rosanilinium Chloride), Silver sulfadiazine
	• Community food demonstration			Examination table	**Antifungal, Topical:** Benzoic Acid + Salicylic Acid, Nystatin
	• Treatment of severe malnutrition at community level (CTC): Community Mobilization and screening			Scissors	**Scabicides/Pediculocides:** Lindane
	• Out patient management (OTP)			Forceps	**Disinfectants and Antiseptics:** Chlorhexidine, Chlorine releasing compound
4. Communicable Diseases	• TB cases detection using sputum smear (if lab available), HIV testing for TB patients			Thermometer	**Diuretics:** Hydrochlorothiazide
	• Short-course chemotherapy, including DOTS			Clean delivery kit *(see Annex C for kit contents)*	**Antacids:** Aluminum Hydroxide, Aluminum Hydroxide + Magnesium Hydroxide,
	• Surveillance of cases of interrupted TB treatment, active case-finding			ORS measuring jug/container	**Anti-Emetics:** Metoclopramide
	• Preventive therapy for children contacts of TB patients			Tape measure for nutrition assessment	**Oral Rehydration Solution:** low-osmolarity ORS
	• Clinical diagnosis of malaria and treatment of uncomplicated cases				**Adrenal Hormones and Synthetic Substitutes:**
	• Promotion and distribution of insecticide treated mosquito nets				
	• Referral for VCCT for suspected HIV/AIDS patients, HIV prevention education, NTDC or non test dependent counseling and referral for V CCT				
5. Mental Health	• Awareness raising & psycho-education				
	• Case identification				
	• Psychosocial assessment and basic				

Table 14. Mobile Health Team: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	psychosocial interventions				Hydrocortisone, Betamethsone+Neomycin **Contraceptives:** Ethinylestradiol + Levonorgestrel, Ethinylestradiol + Norethisterone, Medroxy Progestrone (DMPA), Condoms, IUD **Vaccines:** BCG, DPT (diphtheria, pertussis, tetanus), DPT/Hepatitis-B vaccine, Measles, OPV (oral polio vaccine), Tetanus Toxoid(Pentavalent DPTPW-HP/Hib) **Anti-Infective Topical:** Tetracycline, **Oxytocics:** Ergometrine **Antioxytocics:**Salbutamol **Sleep Disorder:** Diazepam **Anti-Asthmatic medicines:** Aminophylline, Epinephrine (Adrenaline), Salbutamol, **Parenteral:** Sodium Chloride, Compound solution of Sodium Lactate, Glucose, Glucose with Sodium Chloride, Potassium Chloride, Sodium Bicarbonate **Miscellaneous:** Water for injection **Vitamins and Minerals:** Iodine, Retinol, Multi-micronutrients, Zinc, Vitamin K
	• Basic treatment and referral of mental disorders			MUAC Tap (Mid Upper Arm Circumference Tap) tool for measuring nutritional status Height measuring Board, Portable Salter scale 25kg Portable, Baby scale, Portable Growth monitoring chart MVA (Manual Vacuum Aspiration) set Ambu bag for child, adult and infant Pedal suction machine Lamps and torches Folding stretcher	
	• Support groups for people with substance abuse, mental disorders and their family members				
	• Substance abuse: identification and education				
	• Community-based rehabilitation and harm reduction				
	• Support group for drug addicts, psychiatry patients/families and women				
6.Disability	• Disability and Physical rehabilitation awareness, prevention and education				
	• Refer patients to nearest physiotherapy or orthopedic rehabilitation services as required				
	• Identify and refer newborn and young children (i.e. Club foot, DDH) with physical anomalies to nearest physiotherapy services				
	• Disability and Physical rehabilitation awareness, prevention and education				
7. Essential Supply of Essential Drugs	(See last Column)				
General-Information, Education, and communication	• Promotion of healthy lifestyles and care-seeking behavior				

15.5. Comprehensive Health Center

Population Catchments Area served: 30,000 – 60,000

Table 15. Comprehensive Health Center: Summary of BPHS Services, Staffing, Facilities and Essential Drugs

BPHS Core Area	Interventions/Conditions Treated/Services Provided	Type and Number of Staff	Illustrative Facility Features	Illustrative Equipment and Supplies	Essential Drugs
1. Maternal and Newborn Health	• Antenatal care, treatment of mild pre-eclampsia/eclampsia, incomplete miscarriage/abortion, if blood drawn for any reason to be tested for HIV • Assistance with normal deliveries, provision of basic emergency obstetric care • Detection of postpartum anemia, puerperal infection • Care for new born; management of neonatal infections and sepsis • Promoting exclusive breastfeeding • Micronutrient `supplementation • Counseling on family planning • Screening for and • treatment of STDs, if present then HIV testing condom promotion and supply • Contraceptive services: DMPA injections, distribution of condoms and oral contraceptives, IUDs if trained person available • Gender training • Privacy for delivery rooms	Nurse (male) 1 Nurse (female) 1 Community midwife 2 Community health Supervisor 1 Vaccinator 2 Physician (male) 1 Physician (female) 1 Laboratory technician 1 Pharmacy technician 1 Psychosocial Counselor (if required for funded mental	Inpatient beds Minor surgery room Holding beds Exam rooms Delivery room Wound dressing area Pharmacy Laboratory area	Oxygen gauge and cylinder Neonatal resuscitation trolley Hearing screening equipment EOC supplies and kit Sterilization equipment Hemoglobinometer Hand crank centrifuge Microscope Stethoscope Sputum and blood specimen bottles Vision testing chart Sphygmomanometer Dispensing counting tray	**Anesthetics:** Ketamine (if anesthetist), Oxygen, Lidocaine, Lidocaine + Adrenaline **Analgesics:** Acetaminophen, Acetyl, Salicylic Acid, Ibuprofen Diclofenac Tramadol **Anticonvulsants:** Carbamazepine, Diazepam, Magnesium Sulphate, Phenobarbital **Antidotes:** Activated charcoal, Atropine Calcium Gluconate **Antihistamines**: Chlorpheniramine Maleate **Anthelminthics**: Mebendazole **Antibacterials**: Amoxicillin, Ampicillin, Benzathine Benzyl Penicillin, Phenoxy Methyl Penicillin, Procaine penicillin, Co-trimoxazole, Chloramphemicol, Doxycycline, Gentamicin,
2. Child Health and Immunization	• EPI routine (All antigens) • Outreach immunization services • EPI-plus (ORS+ De-worming) • Supplementary Immunization Activities • Disease surveillance and case reporting • VPD outbreak response • Vitamin A supplementation				

Table 15. Comprehensive Health Center: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	• Infection control, safe injection practices, and waste management	health activities) 1 Administrator 1 Cleaners, Guards 4 Driver (If ambulance available) 1	Patient registration room Waiting room Medical Records area Health Education Area Physiotherapy room Compartments or rooms for psychosocial consultations	Pediatric and adult scales Cold box/refrigerator for EPI Vaccine carrier and ice pack Patella hammer Diagnostic set or Otoscope Drip stand Flashlight Minor surgery kit (*see Annex B for kit contents)* Stretcher Specula Lamp Suction Midwifery *kit (see Annex C for kit contents)*	Erythromycin(Ethyl succinate) Cloxacillin, Ciprofloxacin, **Anti-TB drugs**: Ethambutol, INH, Pyrazinamide, Rifampicin, Streptomycin, **Antifungals:** Nystatin **Anti-Amoebic**: Metronidazole **Antimalarials:** Chloroquine, Fansidar, Quinine, Primaquine, Artesunate **Leishmaniasis:** Sodium Stibogluconate, Meglumine antimonate **Sulfonamide:** Co-trimoxazole **Urinary Antiseptics:** Nitrofurantoin **Sympathomimetics:** Adrenaline, Salbutamol **Antenatal Supplements:** Ferrous Sulfate + Folic Acid **Antihypertensives:** Methyl Dopa, Atenolol, Nifedipine **Antithrombotic:** Acetyl Salicylic Acid **Anti-infectives**: Gentian Violet, Silver Sulphadiazine **Anti-fungal**: Benzoic Acid + Salicylic Acid, Nystatin **Scabicides:** Lindane **Disinfectants**: Chlorhexidine Chlorine releasing comp.,
	• Reporting				
	• Supervision and monitoring				
	• Case management of ARI, pneumonia, diarrhea, measles, fever/malaria; provision of ORT, referral of complicated cases				
	• Identification of gravely ill children and referrals				
3. Public Nutrition	• Support exclusive breastfeeding				
	• Growth monitoring				
	• Diagnosis and treatment of malnutrition				
	• Multi-micronutrient and iron supplementation				
	• School feeding				
	• Improvement of sanitation				
	• Community food demonstration				
	• Treatment of severe malnutrition at community level (CTC): Community Mobilization and screening				
4. Communicable disease Treatment and Control	• TB cases detection using sputum smear (if lab available) if TB positive then HIV testing				
	• Short-course chemotherapy, including DOTS, DOTS + in multi-drug resistant (MDR) TB				
	• Surveillance of cases of interrupted TB treatment, active case-finding				
	• Preventive therapy for children and contacts of TB patients				
	• Clinical and microscopic diagnosis of malaria and treatment of complicated				

Table 15. Comprehensive Health Center: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	cases • Promotion of insecticide treated mosquito nets • Information, education, and communication • Referral to HIV counseling (and testing where indicated) • HIV testing (PITC) for TB, STI, ANC, injection drug use, blood safety • HIV testing (PITC) for diagnosis • CTX (co-trimoxazole) prophylaxis • OI (opportunistic infections) and TB • Monitoring, supervision and support for ARV prophylaxis for PMTCT • Monitoring, supervision and support for ART (antiretroviral treatment) • Infection control, safe injection practices, and waste management • Referral to physical rehabilitation services (exercise training) if required			Sterilizer Examination table Scissors Forceps Thermometer Clean delivery kit *(see Annex C for kit contents)* ORS measuring jug/container Tape measure for nutrition assessment Disability awareness and prevention materials (Visual and written) Updated referral list of physical rehabilitation service providers in the regions Basic physiotherapy equipment list (see annex)	**Diuretics**: Hydrochlorothiazide **Antacids**: aluminum Hydroxide + magnesium Hydroxide Ranitidine **Anti-emetics**: Metoclopramide **Oral Rehydration Salts**: Low Osmolarity (ORS) **Adrenal Hormones:** Hydrocortisone Betamethasone + Neomycin **Contraceptives:** Oral, Condoms, IUD, DMPA injections. Progesterone Only Pills (POP) **Vaccines:** BCG, DPT, Hepatitis B, Measles, OPV, Tetanus toxoid, Pentavalent DTPw-HP Hib **Ophthalmological Preparation** **Anti-infectives:** Tetracycline Tetracaine Hydrochloride **Oxytocics and Antioxytocics:** Ergometrine, Oxytocin, Salbutamol **Depressive disorders medicine:** Amitriptyline **Anxiety and sleep disorders medicine:** Diazepam **Psychotherapeutic drugs:** amitriptyline, fluoxetine, chlorpromazine, haloperidol, Trihexyphenedyl **Anti-asthmatic:** Aminophylline Epinephrine, Salbutamol Ephedrine Hydrochloride
5. Mental Health	• Awareness raising & psycho-education • Case identification & diagnosis • Biopsychosocial treatment of severe mental disorders, common mental disorders, epilepsy, childhood mental disorders, substance abuse disorders • Psychosocial counseling services • Support groups for people with substance abuse, mental disorders and their family members • Community-based rehabilitation • Follow-up of patients with mental				

Table 15. Comprehensive Health Center: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	disorders				
	• Teamwork on Mental Health and Psychosocial Support with staff of DH and BHC			MUAC Tape (Mid Upper Arm Circumference Tape) tool for measuring nutritional status Height measuring Board, Growth monitoring chart Nebulizer Cervical collar and oxygen in ambulances, MVA (Manual Vacuum Aspiration) set Ambu bag for infant child, adult Pedal suction machine Wheel Stretcher Folding stretcher Water bath Loop and lid retractor	**Parenteral:** Sodium chloride, Glucose, Potassium chloride, sodium hydrogen carbonate **Vitamins and Minerals:** Iodine, Retinol, Multi-micronutrients Zinc, Vitamin K **Miscellaneous:** Water for injection
	• Mental Health Training and supervision of BHC and HP staff				
	• Reporting & documentation				
6. Disability Services	• Disability and physical rehabilitation awareness, prevention and education				
	• Physiotherapy assessment and treatment for patients including those with disability				
	• Providing home visits to patients as needed				
	• Refer patients for corrective surgery, prostheses, Orthoses and mobility aids to orthopedic surgeon and orthopedic workshops in the regions				
	• Promote early identification of children with physicals anomalies that is club foot, developmental Dysplasia of the Hip Joint for treatment				
	• Inpatient and outpatient physiotherapy, orthopedics diagnosis				
	• Referral for fitting and training in use of orthotics and prosthesis				
7. Regular Supply of Essential drugs	• (See last column)				
8. Blood Transfusion	• Collect, test and screen blood				
	• Perform transfusion				
General-Information, Education and Communication	• Promotion of healthy life-styles and care seeking behavior				
	• Community outreach and promotion of radio health dramas, messages and spots				

15.6. District Hospital

Population Catchments Area served: 100,000 – 300,000

Table 16. District Hospital: Summary of BPHS Services, Staffing, Facilities and Essential Drugs

BPHS Core Area	Interventions/Conditions Treated/Services Provided	Type and Number of Staff	Illustrative Facility Features	Illustrative Equipment and Supplies	Essential Drugs
1. Maternal and Newborn Health	• Antenatal care, treatment of mild pre-eclampsia/eclampsia, incomplete miscarriage/abortion. if blood drawn for any reason to be tested for HIV • Assistance with normal deliveries, provision of comprehensive emergency obstetric care • Detection and treatment of postpartum anemia, puerperal infection • Care for newborns; management of neonatal infections and sepsis, newborn incubator • Promoting exclusive breastfeeding • Micronutrient supplementation • Counseling on family planning • Screening for and treatment of STDs if present then HIV testing condom promotion and supply • Contraceptive services: DMPA injections, distribution of condoms and oral contraceptives, IUDs if trained person available • Female and male sterilization • Gender training • Privacy for delivery rooms	Physician-general (male) 2 Physician—general (female) 2 Surgeon 1 Anesthetist 1 Pediatrician 1 Dentist 1 Nurse (male) 5 Nurse (female) 5 (Out of five female nurses 2 specified for TFU) Midwife 4 Community health Supervisor 1	Operating theatre Recovery room Emergency (Trauma) room Nursery Inpatient beds Minor surgery room Holding beds Examination room Delivery room Wound dressing room Pharmacy Laboratory Area Patient registration room Waiting room	Oxygen gauge and cylinder Neonatal resuscitation trolley EmOC supplies Hearing screening equipment Basic emergency obstetric care kit Sterilization equipment Hemoglobin meter Hand crank centrifuge Microscope Stethoscope Vision testing chart Sphygmomanometer Dispensing counting tray	**Anesthetics and related drugs :** Ketamine, Oxygen, Lidocaine, Lidocaine + Adrenaline, Pancuronium Bromide, Atropine **Analgesics:** Acetaminophen, Acetyl, Salicylic Acid, Ibuprofen, Diclofenac, Tramadol, Morphine **Anticonvulsants:** Carbamazepine, Diazepam, Magnesium Sulphate, Phenobarbital *Sodium Valproate, **Antidotes:** Activated charcoal Neostigmine, Naloxone, Anti Tetanus Serum(ATS), Calcium Gluconate **Antihistamines**: Chlorpheniramine Maleate **Anthelminthics**: Mebendazole **Antibacterials**: Amoxicillin, Ampicillin, Benzathine Benzyl Penicillin, Phenoxy Methyl Penicillin, Procaine penicillin, Chloramphemicol, Doxycycline, Gentamicin, Erythromycin, Cloxacillin, Ciprofloxacin, Ceftriaxone **Anti-TB drugs**: Ethambutol, INH, Pyrazinamide, Rifampicin, Streptomycin, **Antifungals:** Nystatin **Anti-Amoebic**: Metronidazole
2. Child Health and Immunization	• Delivery of EPI Services • Case management of ARI, pneumonia, diarrhea, measles, fever/malaria; provision of ORT, referral of complicated cases • Identification and treatment of gravely ill children				

Table 16. District Hospital: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
3. Public Nutrition	• Support exclusive breastfeeding • Growth monitoring and promotion • Diagnosis and treatment of malnutrition • Multi-micronutrient and iron supplementation • Coordinate school feeding programs • Improvement of sanitation • Running of TFC • Inpatient care /Stabilization	Pharmacist 1 Vaccinator 2 Laboratory technician 2 Dental Technician 1 X-ray technician 1 Physiotherapist 1 (or 2 if no physiotherapy center near) Administrator 1 Cleaners, Guards 6 Driver 1	Medical Records Area Health Education Area Space for Mental Health OPD and Psychosocial Counselling	Pediatric and adult scales Cold box/refrigerator for EPI Vaccine carrier and ice packs Patella hammer Diagnostic set or Otoscope Drip stand Flashlight Minor surgery kit (see Annex B for kit contents) Stretcher Specula Lamp Suction Midwifery kit (see Annex C for kit contents)	**Antimaterials:** Chloroquine, Fansidar, Quinine, **Artesunate** For Leishmaniasis Stibogluconate Meglumine antimonite **Sulfonamide:** Co-trimoxazole **Urinary Anteseptics:** Nitrofurantoin **Sympathomimetics:** Adrenaline, Salbutamol Ephedrine Hydrochloride **Antenatal Supplements:** Ferrous Sulfate + Folic Acid **Antihypertensives:** Methyl Dopa, Atenolol, Nifedipine Hydralazine **Antithrombotic:** Acetyl Salicylic Acid **Anti-infectives**: Gentian Violet Silver Sulfadiazine **Anti-fungal**: Benzoic Acid + Salicylic Acid, Nystatin **Scabicides:** Lindane **Disinfectants**: Chlorhexidine Chlorine releasing comp., **Diuretics**: Hydrochlorothiazide Furosemide **Antacids**: aluminium Hydroxide + magnesium Hydroxide Ranitidine
4. Communicable disease Treatment and Control	• TB cases detection using sputum smear • X-ray for smear negative patients • Short-course chemotherapy, including DOTS, DOTS + in multi-drug resistant (MDR) TB • Surveillance of cases of interrupted TB treatment, active case-finding • Preventive therapy for children and contacts of TB patients • Clinical and microscopic diagnosis of malaria and treatment of complicated cases • Promotion of insecticide treated mosquito nets • Counseling for HIV/AIDS Information, education, and communication • Referral to HIV counseling (and testing where indicated • HIV testing (PICT) for TB, STI, ANC injection drug us, and blood safety • HIV testing for diagnosis (CITC) • CTX (Co-trimoxazole) prophylaxis • OI (opportunistic infections) and TB				

Table 16. District Hospital: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	• Monitoring, supervision and support for ARV prophylaxis for PMTCT			Sterilizer Examination table Scissors Forceps Thermometer Clean delivery kit (see Annex C for kit contents) ORS measuring jug/container Tape measure for nutrition assessment Disability awareness and prevention materials (Visual and written) Updated referral list of physical rehabilitation services providers in the regions Physiotherapy materials and equipment (see separate list in	**Anti-emetics**: Metoclopramide **Oral Rehydration Salts**: ORS **Adrenal Hormones:** Hydrocortisone Betamethasone **Contraceptives:** Oral, Condoms, IUD, DMPA injections Progesterone Only Pills (POP) **Vaccines:** BCG, DPT, Hepatitis B, Measles, OPV, Tetanus toxoid, Hib **Ophthalmological Preparation** **Anti-infective:** Tetracycline Tetracaine Hydrochloride Flourosceine **Oxytocics and Antioxytocics:** Ergometrine, Oxytocin, Salbutamol **Psychotherapeutics for psychotic disorders:** amitriptyline, fluoxetine, chlorpromazine, haloperidol, thioridazine Anxiety and sleep disorders medicine: Diazepam Trihexyphenedyl **Anti-asthmatics:** Aminophylline, Epinephrine, Salbutamol **Parenteral:** Sodium chloride, Glucose, Potassium chloride, Sodium hydrogen carbonate
	• Monitoring, supervision and support for ART (antiretroviral treatment)				
	• Infection control, safe injection practices, and proper waste disposal				
	• Referral to physical rehabilitation services (exercise training) if required				
5. Mental health	• Awareness raising & psycho-education				
	• Diagnosis and bio psychosocial treatment of severe mental disorders, common mental disorders, epilepsy, childhood mental disorders, substance abuse disorders				
	• Psychosocial counseling				
	• Brief hospitalization of patients with severe acute symptoms of mental illness				
	• Back referral to lower levels of health care system for follow up				
	• Training and supervision in mental health and psychosocial support for staff of CHC and BHC				
	• Support groups for people with substance abuse, mental disorders and their family members				
6. Disability Services	• Provide physiotherapy assessment and treatment for patients including those with disabilities				
	• Awareness raising and education about disability and physical rehabilitation				
	• Providing home visits to patients as needed				
	• Refer patients for corrective surgery, Prostheses, Orthoses and mobility aids to				

Table 16. District Hospital: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
	orthopedic surgeons and Orthopedic workshop in the regions			annexes) Growth monitoring chart Nebulizer Cervical collar and oxygen in ambulances, ECG Machine MVA (Manual Vacuum Aspiration) set Resuscitation Trolley Caesarian section/Hysterectomy set (see Annex D for set contents) Ambu bag for child, adult and infant Pedal suction machine Wheel Stretcher Folding stretcher Water bath Wheel chair	**Vitamins and Minerals:** Iodine, Retinol, Multi-micronutrients Zinc Vitamin K **Miscellaneous:** water for injections
	• Promote early identification of children with physical anomalies (i.e. Club foot, Developmental Dysplasia of the Hip) for treatment				
7. Regular Supply of Essential drugs	• (See last column in this table)				
8. Blood Transfusion	• Collect, test and screen blood				
	• Perform transfusion				
General-Information, Education and Communication	• Promotion of healthy life-styles and care seeking behavior				
	• Community outreach and promotion of radio health dramas, messages and spots				

Table 16. District Hospital: Summary of BPHS Services, Staffing, Facilities and Essential Drugs					
BPHS Core Area	**Interventions/Conditions Treated/Services Provided**	**Type and Number of Staff**	**Illustrative Facility Features**	**Illustrative Equipment and Supplies**	**Essential Drugs**
				Coagulating Cautery Laparatomy set (see Annex E for set contents) Loop and lid retractor All Physiotherapy Equipment Height measuring Board,	

Annex A: Community-Based Health Care and Community Health Worker

1. Background

Community-based health care (CBHC) is the cornerstone of successful implementation of the BPHS. It provides the context for the most comprehensive interaction between the health system and the communities it serves. Its success depends upon community participation and a partnership between community and health staff.

The implementation of CBHC recognizes first that families and communities have always looked after their own health. Religion and cultural norms and beliefs play an important part in health practices, and families are making decisions to maintain health or care for illness every day. In addition, community members understand and have better information on local needs, priorities, and dynamics. The partnership of health services with communities, therefore, has two aspects:

- To persuade families and communities to make appropriate use of scientific health services, and to change certain behaviors and social norms for more healthy ones,
- To accept the guidance and collaboration of communities in the implementation of health programs and the acceptable provision of health care, and encourage them to identify and solve their own problems.

While there is no universally accepted definition of CBHC, global experience has identified three consistent components of CBHC:

- Partnership between the community and the health facility staff,
- Appropriate and good quality care by community-based providers,
- Promotion of healthy practices and life styles.

Community-based Integrated Management of Childhood Illness (C-IMCI) is a very large and important component of CBHC; it consists of the same three components.

Experience of the implementation of these components has produced a set of global principles of CBHC:

- CBHC focuses on major health problems for which solutions exist.
- The lowest-level health worker can provide the service at a reasonable standard of quality.
- Health workers are locally identified and recruited.
- Health workers are trained incrementally, one skill at a time.
- An established list of drugs and supplies is used.
- Supervision is regular and supportive.
- The health worker is accountable to the community.
- The community makes a financial or in-kind contribution for the services.

CBHC is not new to Afghanistan; it existed prior to the many years of war and conflict. However, in this post conflict period, Afghanistan has reviewed the international concepts and developed an Afghanistan-specific form of CBHC, which was adopted by the Ministry of Health following a national conference on CBHC in September 2002. That policy on CBHC in Afghanistan is as follows:

1. The community must play the prime role; its participation is required to ensure both viability and sustainability. CBHC and related CHWs are a community-based and community-owned program, with essential technical and material support from both NGO and MoPH health services channeled through community structures. These channels are often formalized by the establishment of a community health committee made up of representatives from various parts of the community.
2. All levels of the health care system should receive orientation to the principles of CBHC and be trained in responsiveness to referrals and other responsibilities.
3. The community must fundamentally agree with the adopted standardized CHW job description (see below), including agreement to both preventive and first-level curative activities.
4. Quality training using sequential tasks will take place as close to the community as possible, with national CHW standard curriculum guidelines defining needed competencies but methods being locally determined.
5. Adequate supervision is to be assured before recruitment and training, preferably provided by the person who does the training.
6. The closest health facility will regularly provide CHWs with a standardized drug kit adapted to the local situation and approved for CHW activities.
7. Compensation must be sustainable, with full-time work to be paid and part-time work compensated only by incentives. When possible, traditional compensation and in-kind contributions will be maintained.
8. Community mechanisms for identifying needs are to include private-sector providers, both traditional and modern.

2. The Backbone of the BPHS

The Afghan CBHC system is shown in Figure 2, which illustrates the dynamic nature of this system.

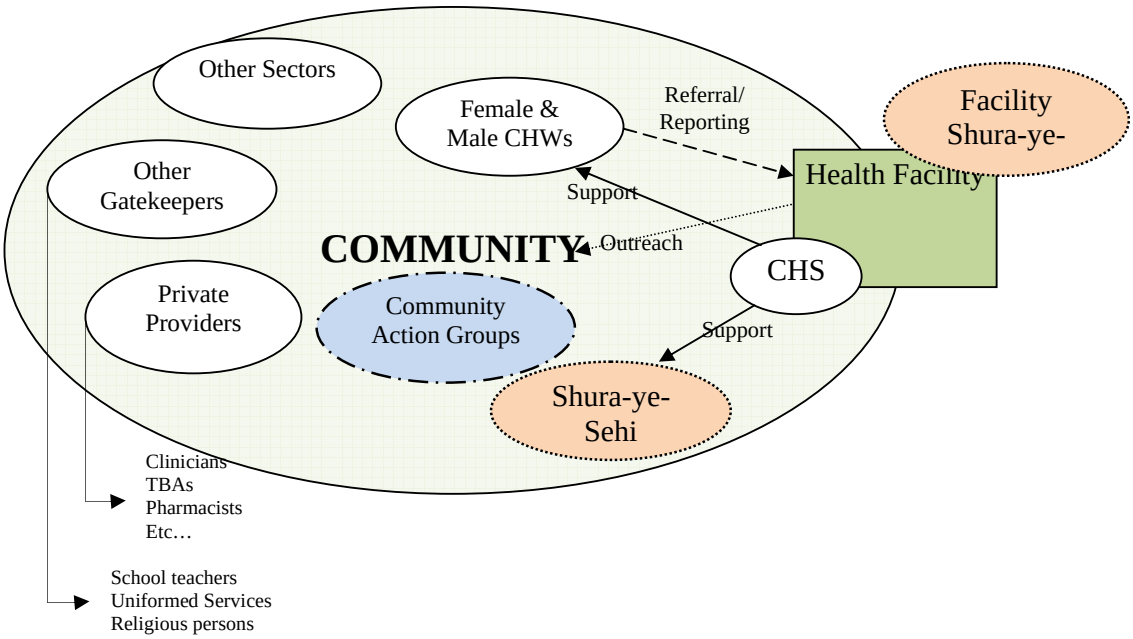

Figure 2: Community-based Health Care: the Backbone of the BPHS

The components of the Afghan CBHC system include:

1. Health facility
The facility provides many case management, midwifery and preventive services that are not available at the HP. Facility staff should work with community leaders and CHWs to optimize use of these services by the community. Many facilities also provide outreach services to communities with poor access to the facility. EPI is the main program delivered in this way because of the importance of achieving herd immunity.

2. Facility Shura (See details in section 4.)
The facility shura works with facility staff to assure the relevance of services to community needs, and good quality of care and patient satisfaction at the facility.

3. Community Health Workers. (See section 3 for Job Description.)
CHWs are community volunteers. A health post has one male and one female CHW to serve a population of 100-150 families. The MoPH encourages the training of couples assigned to the same health post. At least 40% of CHWs should be female. A health post serves a population of between 1000 and 1500 people, but in sparsely populated areas the population served may be as small as 400. Health program managers should give special attention to the coverage of communities by CHWs and train more if required to give access to the whole population. CHWs are trained to provide high impact primary care in the community, and to refer severely sick patients and those needing preventive services or delivery care. They also promote healthy behaviors and lifestyles in the community. CHWs maintain records of their activities and provide monthly reports to the HMIS system.

4. Community Shura-e-sehie (See details in section 4.)
The community shura provides leadership and support to all health-related activities in their community. They select, support and supervise the CHWs in the community; they monitor the community map with the CHWs to be able to encourage families to make full use of preventive health services including outreach services; they provide leadership in the adoption and promotion of new behaviors and social norms.

5. Community Health Supervisor (See job description in section 5.)

Community Health Supervisors are members of the health facility staff. They are the main links between the facility and the communities around the facility. They support and supervise all the CHWs, collect and process all monthly reports from CHWs, meet regularly with Shura, and manage all community-based health programs.

3. The Community Health Worker Job Description

No major changes are introduced to the job description of the CHW in this revision. Some changes are introduced to the provision of birth spacing services and the management of diarrheal diseases. These are being supported by in-service training programs and changes to the pre-service training.

- After appropriate training, CHWs will be allowed to counsel women on the use of DMPA and give the first injection as well as follow-up injections
- CHWs are encouraged to promote the Lactation Amenorrhea Method (LAM) of birth spacing in the first six months after a child is born, and then counsel women on the transition to another appropriate birth spacing method.
- Adding Zinc therapy to ORS is introduced into the management of all diarrheal diseases.
- Cases of dysentery will need to be referred for treatment with Ciprofloxacin.
- CHWs will also be taught to be more aware of mental health and disability problems that can be helped, and how to refer those patients.

Figure 3: Community Health Worker Job Description

Job Description for the Community Health Worker (CHW)

Adapted from the job description revised by the MoPH Community-Based Health Care Task Force, March 2005

The community health worker (CHW) is a person (female or male) selected by the community according to selection criteria reflected in the Policy on Community Health Workers (June 2003). The CHW promotes healthy lifestyles in the community, encourages appropriate use of health services, and treats and refers common illnesses.

The CHW is accountable to the local *Shura* for performance and community satisfaction and technically accountable to the community health supervisor (CHS) assigned by authorities from the nearest health facility.

A. Community Collaboration and Health Promotion

1. Actively participate in community meetings and major community events.
2. Actively work with mother's groups (and Family Health Action Groups) to promote healthier homes and maternal and child health.
3. Encourage and mobilize family/community participation in the immunization of children and women of child-bearing age.
4. Support national initiatives at the village level and actively participate in all campaigns/activities (e.g. National Immunization Days and surveillance for acute flaccid paralysis).
5. Promote good nutrition practices, encourage early and exclusive breastfeeding of children under six months of age, encourage appropriate complementary feeding for children more than 6 months old and continued breastfeeding for children till the age of two.
6. Promote use of Oral Rehydration Salt (ORS) and Zinc, and other homemade rehydration fluids for home management of diarrhea and dehydration.
7. Promote hygiene and sanitation, and the preparation and use of safe drinking water.
8. Encourage couples to practice birth-spacing and receive family planning services.
9. Promote psychosocial well-being and mental health in the community and raise awareness about prevention identification of disability.
10. Create awareness within the community and provide information on the dangers of addictive substances such as tobacco, *naswar*, opium, hashish, and alcohol.

B. Direct Services

1. Identify and manage acute respiratory infections, diarrhea, malaria, and other common communicable diseases according to national protocols. Treat mild to moderate cases and refer complicated cases to the nearest health center.
2. Implement Community-based IMCI.
3. Implement community-based growth promotion where FHA groups exist.

4. Counsel patients on correct use of medications included in the CHW kit.
5. The CHW should create awareness among the community on how to prevent TB and should refer or accompany suspected cases to a health facility. Following completion by a tuberculosis patient of the first phase of treatment at the health facility, the CHW should ensure compliance of TB patients with the second phase treatment course in the community, based on DOTS.
6. Communicate the importance of antenatal and postnatal care. Distribute micronutrients and antimalarials to pregnant women according to national policy. Encourage the community to make regular and timely use of Maternal Child Health (MCH) services.
7. Encourage the use of skilled birth attendants, where possible, and help families to make birth plans. Provide and teach the use of a mini delivery kit (see Annex C for kit contents). Teach family members to recognize the danger signs of complications of pregnancy and childbirth, and assist them in making preparations for emergency referral.
8. Distribute oral contraceptives and condoms to willing members of the target population according to national policy. Promote LAM together with exclusive breastfeeding for the child's health during the first six months of a child's life. Administer first and follow-up injections of Depo-Provera. Encourage interested families to seek long-term family planning methods at a health facility.
9. Provide first-aid services for common accidents at the family and community level.
10. Ensure administration of vitamin A to children aged six months to five years during NIDs.

C. Management

1. Meet regularly with the *Shura* to develop, implement, and monitor community action plans for health improvement.
2. Meet regularly with the community health supervisor to review reports and action plans, receive supplies, and for in-service training.
3. Collaborate with and support community midwife activities in the catchment area, including health promotion and pregnancy-related referrals.
4. Regularly complete and submit the monthly Tally Sheets to the CHS for the HMIS.
5. Know the members of the community, and develop a community map of the eligible families in the catchment area and the services they have used.
6. Report all deaths and other activities included in the report form of the health post. Inform the health facility of any disease outbreaks.
7. Manage the health post, maintaining supplies and drugs given to CHWs and reporting utilization of drugs and supplies.
8. The establishment of Shurai Sehi at the HP level.

D. Compensation for CHWs

CHWs should be compensated for legitimately incurred expenses (transport and food) when working outside their community. Specifically, approved under this BPHS revision:

- Afs100 per month for routine work travel;
- Additional expenses (Afs50) for approved tasks like accompanying a suspected TB patient to a facility with a laboratory.

The MoPH will not make regular payments to Community Health Workers (CHWs) from the MoPH budget and does not recommend donors' resources be allocated for regular payment to CHWs because such a policy is financially unsustainable. Communities are encouraged to support and compensate CHWs in traditional ways.

4. The Community Health Supervisor Job Description

The post of the CHS was created in 2005 and adopted into the BPHS in the 2005 and 2009 revision. All BPHS facilities that are supervising Health Posts should have at least one CHS, and preferably a male and a female CHS (a couple is preferable). Currently, the supervision of female CHWs is poor because only about 10% of CHSs are females. BPHS implementers are encouraged to work out ways to improve the supervision of female CHWs by increasing the number of female CHSs, sharing existing female CHSs between neighboring facilities, or making time in the job of other female technical staff to support the CHWs.

Effective coverage of all health posts by male CHSs should also be considered. Many CHCs and DHs have 20, 30 or more health posts in their catchment areas. In general, CHSs can provide adequate supervision to

about 15 health posts depending upon travel conditions. Deployment of additional CHSs to cover larger numbers of health posts around health facilities should be considered.

Figure 4 : The Job Description of the Community Health Supervisor

A. Qualifications:

- Graduate of high school. Professional qualification in health is preferred (a male or female).
- Respected, self-motivated resident of the local community
- Strong communication skills.
- Experience in community development, health care or management experience will be an advantage.
- Working knowledge of Pashto or Dari and fluent in local language if not Dari or Pashto
- Able and willing to travel to all parts of the area extensively

B. Overall Responsibility:

A Community Health Supervisor will be posted at all BPHS health facilities that supervise CHWs.
The CHS will supervise all community health activities, not only CHW activities. He or she will assist in training, supporting and supervising CHWs and will also supervise public health programs and promote collaboration between the facility and the community. He or she also assists in the formation and linkage of community health committees (Shura-e-Sehie) with the CHW program and health facilities. He or she is responsible for supporting the community in identifying and addressing their health problems. He or she reports to the head of the facility.

C. Training:

- Assists in practical training during CHW training courses, including supervising the practical experience of the CHWs in the community during their training
- Provides on-the-job and monthly in-service training to CHWs
- Reviews and evaluates the performance of the CHWs and identifies need for further training

D. Support and supervision:

- Assists the staff of the health facility in making plans for the community health programs in the facility and its catchment area.
- Implements, supervises and evaluates the community health program activities in the catchment area of the health facility.
- Identifies and reports immediately to the head of the health facility any problems that may interfere in achieving program objectives
- Guides the CHWs in the development and implementation of their action plans.
- Conducts monthly supervisory meetings with CHWs.
- Ensures regular replacement of supplies in the CHW kits.
- Conducts regular visits to the CHWs in their communities to assess and assist their work.
- Encourages team work among CHWs, especially when they are working in the same catchment population
- Provides regular reports on the CHWs to the head of facility

E. Health Management Information System:

- Supervises the quality of the pictorial registers and Community Maps maintained by the CHWs and assists the CHWs where needed.
- Supervises completion of the MARs by CHWs and the completion of the facility MAAR.
- Consolidates the MAARs and assists the head of the health facility in preparing consolidated monthly reports and assists in maintaining graphs to monitor the facility health programs.
- Assists in supervising any required community health survey
- Uses the reporting system and information received from village health committees (Shura-e-Sehie) to monitor health conditions and submits findings to the person in charge of the health facility.

F. Facility-community collaboration:

- Assists formation of community health committees (Shura-e-Sehie)
- Provides orientation session on BPHS and on health topics of concern to the community Shura
- Guides information & implementation of community-based health activities
- Promotes support for CHWs
- Provides feedback from community to head of the health facility

5. The Community Health Shura at Health Post level

The MoPH has defined guidelines for the formation and roles and responsibilities of the Community Health Shura.

Figure 5: MoPH Guidelines for the Community Health Shura

Composition and selection of the Community/health post level shura

The existing shura in the community will be considered for making up the community health shura for BPHS activities. However, the existing shura may be reorganized to ensure more responsive to community health needs. The decision of selection/election of the shura members will be depending on community opinion. Health Facility/Health post will facilitate dialogue with different levels of people and beneficiaries of BPHS programs to select/elect community health shura members. Members for the shura may vary from 6-9 depending on community size and opinion. The shura composition will be:

- Chairperson: 1
- Members: 5 – 8
- One third of the members should be women

The concern Trainer or supervisor will act as member secretary of the shura. The member secretary will be responsible for recording and maintaining meeting minutes. At least attendance of two-third members is essential for meeting quorum taking any decision.

The shura members will be selected /elected on the basis of the following criteria:

- Resident in the community that corresponds with the health post catchment area;
- Well known/reputed/influential/authentic formal and informal leaders from community (i.e. like malik, mullah, teacher, etc.) and members from other development program (i.e. credit program, Water Sanitation program, etc.)
- Ensure representation from all cucha (neighborhood)/mosque/corners/section/ of the community
- Beneficiaries of the health program
- Ensure female representation in the shura

Depending on local custom and culture, a separate female shura may be considered, if this more easily ensures female participation in the decision processes regarding the community's health. The same criteria for selection/election of members will be followed in case of separate female shura.

Roles and responsibilities

- Be knowledgeable on selected BPHS, CBHC policies and CHW's job description
- Review monthly progress/performance of CHWs' activities including his/her updating community maps, completion of the monthly Tally Sheet, and referral clients to health facilities, and give feedback to the CHS or CHWs regarding their performance.
- Develop, implement and review progress of annual action plan for popularizing BPHS activities,
- Support the CHWs in the promotion of healthy behaviors and appropriate use of health services at community and facility level,
- Support outreach activities from the facility and mobilize the community to participate,
- Mobilize local resources for strengthening and sustaining BPHS activities
- Conduct monthly meetings and ad hoc emergency meetings
- Giving ideas and active participation in selection/election of CHWs
- Giving ideas and active participation in selection/election of Community Action Groups

6. The Health Shura at Health Facility level

The MoPH has defined guidelines for the formation and roles and responsibilities of the Health Shura at Facility level.

Figure 6 : MoPH Guidelines for the Facility Health Shura

Facility Shura-e-Sehee formation:

The staff of each level health facility will facilitate the establishment of facility level "Shura-e-Sehee". The Shura-e-Sehee involves different users groups in the management of the health facility and also promotes community-based activities which aim to improve the health status of the population living in the catchments area of the health facility. The Shura-e-Sehee members will be selected /elected from the community health shura at health post level as well as the catchment's area of respective facility. Members for the shura may vary from 13-15 depending on community size (population and geographical distribution) and opinion. The

shura composition will be:

- Chairperson: 1
- Member 12 – 14
- One third of the members should be women if possible.

The shura members will be selected /elected on the basis of the above mentioned criteria for HP Shura

Roles and responsibilities:

- Be knowledgeable on selected BPHS, CBHC policies and CHW's job description
- Write and sign a constitution of the facility level shura. The constitution will record the names and gender of the members and their location of origin (to ensure equitable representation of the communities within the catchments area), the name of the elected chairperson and member secretary. The facility in-charge will act as member secretary of the shura. The member secretary will be responsible for recording and maintaining meeting minutes.
- Facilitate a health need assessment with the facility level shura members. The need assessment should focus on the major health related problems perceived to be faced by the community.
- Based on BPHS and the health problems perceived by the communities they represent, they will develop an annual action plan.
- In case of possibility organize an "open door event" (a specific day like Bazaar day, for visiting the health facility to know about services provided and getting an idea of ownership and trust to people) at the health facility for public in every 6 month
- Mobilize local resources for strengthening and sustaining BPHS activities
- Support facilities and community health shura in performing their responsibilities
- Conduct monthly meetings and maintain meeting minutes
- Monitor monthly performance of the facility and satisfaction of clients
- Review implementation status of annual action plan

Discontinuation of shura membership:

- A member will notify the respective shura if she/he wants to discontinue as a member of the shura. The shura will replace her/him in consultation with people under catchments area.
- The shura may cease any member for the following reasons:
  - Absent from 3 consecutive meetings
  - Mentally/physically unable to perform his/her responsibilities
  - Involved in activities, which may cause harm or against the BPHS activities.

7. Note on Traditional Birth Attendants

International experience has shown that trained TBAs have made no impact on maternal mortality without very close integration into a health system. Since the 2005 edition of the BPHS, the MoPH recommends that:

- Traditional birth attendants (TBAs) will be replaced by female CHWs at all health posts.
- All existing TBAs should be encouraged to become CHWs.
- Training of all TBAs as female CHWs should be promoted.
- Eligibility criteria should be set for TBAs to become community midwives (CMW)/Community Health Workers.
- Supervision of remaining TBAs should be performed by BHCs and CHCs.
- Female CHWs should partner with TBAs to deliver important health messages to families, in particular those related to new born care.

Annex B: Contents of Minor Surgery Kit by type of Facility

Table 17. Contents of Minor Surgery Kit by type of Facility

Item Description	HSC	BHC	MHT	CHC	District Hospital
Forceps, artery	√	√	√	√	√
Forceps, dressing	√	√	√	√	√
Needle holder	√	√	√	√	√
Syringes and disposable needles	√	√	√	√	√
Scissors	√	√	√	√	√
Scalpel handle and blades	√	√	√	√	√
Tourniquet	√	√	√	√	√

Stethoscope	√	√	√	√	√
Suturing silk	√	√	√	√	√
Antiseptic solution	√	√	√	√	√
Detergent	√	√	√	√	√
Thermometer	√	√	√	√	√
Kidney Trays	√	√	√	√	√

Annex C: Detailed List of Contents of Mini Delivery, Clean Delivery, and Midwifery kits

Table 18. Detailed List of Contents of Mini Delivery, Clean Delivery, and Midwifery kits

Item Description	Mini Delivery Kit	Clean Delivery Kit	Midwifery Kit
Present at Health Post	√		
Present at Health Sub- center		√	√
Present at BHC		√	√
Present at MHT		√	
Present at CHC		√	√
Present at DH		√	√
Scissor	√	√	√
One umbilical cord clamp or sterile tape or sterile tie	√	√	√
Suturing material	√	√	√
Clean towels	√		
Clean razor blade	√	√	√
Examination gloves	√	√	√
Sterile cotton or gauze (to clean baby's mouth and nose	√	√	√
Hand soap or detergent	√	√	√
Hand scrubbing brush		√	√
Sterile tray		√	√
Plastic container with a plastic liner for to dispose the placenta		√	√
Plastic container with a plastic liner for medical waste (gauze, etc)		√	√
Stethoscope, adult		√	√
Stethoscope, Pinard fetal		√	√
Sphygmomanometer		√	√
Kidney basin		√	√
Steel bowl		√	√
Protective apron and plastic draw sheet		√	√
Tourniquet		√	√
Two sterile towels (one to receive the baby, one for active management)		√	√
Baby scale (infant weighing scale)		√	√
Forceps, artery		√	√
Forceps, dressing		√	√
Forceps, uterine			√
Needle holder		√	√
Syringes and disposable needles		√	√
16-or 18 gauge needles		√	√
Speculum, vaginal		√	√
Clamps (hemostats)		√	√
Suction pump, hand or foot operated	√	√	√
Vacuum extractor			√
Uterine dilator			√
Curette, uterine			√
Vaginal retractor			√

Ambu bag			√
Guedel airways – neonatal, child and adult			√

Annex D: Caesarean/hysterectomy set

(National Standards for Reproductive Health Services Intra-partum and Emergency Obstetric Care Standards, Reproductive Health Task Force, Department of Women and Reproductive Health, Ministry of Health, Transitional Islamic Government of Afghanistan, 2004)

Abdominal retractors, double-ended (Richardson)	2
Curved operating scissors, blunt-pointed (Mayo), 17 cm	1
Hysterectomy forceps, straight, 22.5 cm	4
Mosquito forceps, 12.5 cm	6
Needle holder, straight, 17.5 cm	1
Round-bodied needles, No. 12, size 6	2
Sponge forceps, 22.5 cm	6
Stainless steel instrument tray with cover	1
Straight artery forceps, 16 cm	4
Straight operating scissors, blunt-pointed (Mayo), 17 cm	1
Surgical knife blades	4
Surgical knife handle, No. 3	1
Surgical knife handle, No. 4	1
Tissue forceps, 19 cm	6
Towel clips	5
Triangular-point suture needles, 7.3 cm, size 6	2
Uterine hemostasis forceps, 20 cm	8

Annex E: Laparatomy set

(WHO/FHE/MSM/94.1)

Curved dissecting scissors,	1 pair
Scalpel handle and blade,	1
Short dissecting scissors,	1 pair
Long dissecting scissors,	1 pair
Stitch scissors,	1 pair
Small, curved artery forceps,	6 pairs
Small, straight artery forceps,	6 pairs
Large, curved artery forceps,	6 pairs
Small, straight artery forceps,	6 pairs
Needle holder, long,	1
Needle holder, short,	1
Retractors (Langenbeck), medium,	1
Retractors (Langenbeck), narrow	1
Retractors (Deaver), medium,	1
Retractors (Deaver), narrow	1
Self-retaining retractor,	1
Dissecting forceps, toothed,	1 pair
Long dissecting forceps, non-toothed,	1 pair
Tissue forceps (Allis),	2 pairs
Tissue forceps (Duval),	2 pairs
Tissue forceps (Babcock),	2 pairs
Sponge forceps,	4 pairs
Malleable copper retractors (spatulae),	2
Occlusion clamps, straight,	2
Occlusion clamps, curved	2
Crushing clamps, large, 2; small	2
Syringe, 10 ml with needle,	1
Syringe, 20 ml with needle,	1
Sutures, No. 1, 0, and 2/0 chromic catgut and 2/0 plain catgut, ties and with needles	
Sutures, No. 1, 0, 2/0, and 3/0 thread, ties and with needles	
Sutures, No. 1, 0, and 2/0 nylon, ties and with needles	
Suction nozzle,	1
Diathermy electrode,	1

Flexible probe, with round point,	1
Grooved director,	1
Nasogastric tube,	1
Towel clips,	6
Stainless steel bowls,	2
Kidney dishes,	2
Gallipots,	2
Linen tape	
Gauze swabs	
Abdominal packs,	5
Dissecting gauze rolls,	10
Antiseptic solution	
Adhesive tape	
Tubing for tension sutures	
Drainage tubes	
Safety pin,	1
Colostomy bags (optional)	
Sterile drapes	
Sterile gloves,	at least 3 pairs

Annex F: Job Description of Physiotherapist

Position: Physiotherapist
Responsible to: Head of Department/Medical Supervisor or; Senior Physiotherapist

Responsibilities

1. Assess the patient, taking care to write detailed assessment cards with history, problem list, long and short term goals and treatment plan
2. Undertake suitable treatments and follow up as appropriate; treatment may include patient education, use of exercises, mobilization and other physical modalities such as electrotherapy.
3. Undertake in-patient treatment and participate in ward rounds as appropriate[3]
4. Refer patients to other specialties such as orthopedic services as appropriate
5. Prescribe and measure suitable walking aids and wheelchairs as appropriate
6. Use all physiotherapy equipment, supplies and machinery properly and safely, take care of them and keep them clean
7. Be punctual and professional in working practice and follow the requirements of the administration on time-keeping, report writing and preparation of any necessary documents
8. Follow up patients in home based visits or outreach programs as appropriate
9. Cooperate with relevant medical and health personnel in the best interest of the patient
10. Educate medical doctors, other healthcare workers and local communities on the benefit of physiotherapy
11. Provide training to families, and community health workers on basic exercises as appropriate
12. Supervise PTAs in the treatment and follow-up of patients
13. Prepare monthly statistical reports
14. Any other duties commensurate with level as instructed by line manager

Professional qualification:
Have completed a recognized training course. In Afghanistan this will mean the person has followed the curriculum set out by PTI at PTI, IAM, SCA, SGAA, PARSA, SERVE and ICRC.

Personal Qualification:

- Should be motivated to work in the profession and desire to help people, particularly the disabled
- Calm approach and good communicator with patients and staff
- Likes to work in a team and demonstrate professional appearance and honesty

Participation:

[3] Physiotherapists working at District Hospitals

Will be required to participate in physiotherapy section meetings and general meetings, Commitment to continued professional development.

Annex G: Monitoring and Evaluating of the BPHS

In order to effectively monitor and evaluate BPHS, the ministry focuses on results defined by the Health and Nutrition Sector Strategy (HNSS) and Millennium Development Goals. National targets have been defined in the HNSS to be achieved by 2013. However, specific targets should be set at the provincial level based on the results of provincial household surveys.

Information and reports produced by the MoPH, other ministries, and agencies that are used to gather information on performance and implementation of BPHS include:

1. Health Management Information System (HMIS) providing information in facility-based estimates for select process indicators;
2. National Health Services Performance Assessment providing information on process and outcome indicators;
3. Census figures provided by the Central Statistics Office provide population estimates at village, district, province and national levels;
4. Household surveys such as the Afghanistan Health Survey (AHS), Multiple Indicator Cluster Surveys (MICS) and National Risk and Vulnerability Assessment (NRVA) providing information on selected primary health and nutrition indicators at population level;
5. Other special studies, like qualitative surveys, measurement of maternal mortality, etc.

The following table provides the framework linking the various aspects of M&E with what needs to be measured and which tool provides the relevant information for effective M&E of BPHS implementation:

Table 19: Monitoring and Evaluation of BPHS

Terminology used						What is Measured	Available Data sources
Program evaluation	Monitoring and Evaluation		Formative			Existing knowledge, beliefs, attitudes and practices; target groups and subgroups; barriers to action; levels of access to services, information, social support groups and a variety of resource channels	Existing epidemiologic and demographic reports (CSO, HHS); special studies using focus groups, in-depth interviews, direct observation, etc… (Qualitative Survey; Mortality Survey)
		Program Performance monitoring	Process evaluation	Monitoring inputs	**Inputs**	Funding, personnel, equipment, supplies, infrastructure	HMIS, HRD, NHSPA
				Monitoring outputs	**Process**	Activities completed, units produced: number of newly trained personnel, number of personnel refresher trained, of community meetings held, of immunization campaigns	HMIS, HRD, NHSPA
					Service outputs	Quality of care, accessibility of services: number BPHS facilities per 10000 people, number of BPHS facilities with certified personnel, percentage of BPHS facilities implementing DOTS, number of trained CHWs per 1000 people	HMIS, NHSPA
			Evaluation		**Utilization outputs**	Utilization of services: number of patients seen, cases diagnosed, number of specific tests performed, number of contraceptives sold/distributed, number of ANC/PNC visits, number of deliveries by trained attendants	HMIS, NHSPA
				Monitoring outcomes	**Initial**	Knowledge, attitudes, beliefs	Household surveys
					Intermediate	Behavior and practice	Household surveys
				Impact assessment	**Long-term**	Health status: mortality, fertility, morbidity	Mortality, fertility, morbidity studies (MICS, DHS, Census, Special Studies)

Outcome indicators

The BPHS focuses on improving the targets derived from the HNSS. The following set of illustrative indicators can be followed to monitor and evaluate the implementation of BPHS.

1. Contraceptive Prevalence Rate
2. TB treatment success rate
3. Proportion of newborns who were breastfed immediately /within one hour after birth
4. DPT3 coverage among children 12-23 months
5. Number of consultations per person per year
6. Proportion of births attended by skilled attendants
7. Proportion of caregivers of under-5 Y children who can identify at least 2 signs for seeking care immediately
8. Coverage of antenatal care
9. Proportion of the lowest income quintile using BPHS services when sick in the last month

In addition, the ministry has adopted the Balanced Scorecard approach to measure and manage delivery of BPHS in the country. It provides a uniform framework that looks at the principal areas of performance – patients and community; staff; capacity for and of service provision; financial systems; and overall vision of the ministry.

Annex H: Proposed trainings for BPHS Health Service Providers

The table below is only a guideline. The duration and number of participants may change depending on the TNAs. The contractor NGO may do its own training needs assessment before submitting a proposal.

Table 20. Proposed Training for BPHS Health Services Providers

S.N	Training	Duration (days)	Participants	Trainers per training	Remarks
	Clinical Trainings				
1	Rational Use of Drugs/Managing Drug Supply (RUD/MDS)	5	25	3	
2	Laboratory Skills Training	10	14	3	
3	Blood Transfusion	10	14	3	
4	Infection Prevention (IP)	5	25	3	
5	EPI	12	15	3	
6	Community IMCI	6	12	2	
7	Common Diseases (Eye, infectious skin disease)				
8	Nutrition	6	15	3	
9	Disablility	7	15	3	
10	Advanced Newborn Care (ANBC)	10	20	3	
11	Basic Newborn Care (BNBC)	10	20	3	
12	IMCI	11	24	3	
13	Family Planning (FP)	10	20	3	
14	Postpartum Family Planning	4	20	2	
15	Advanced EmOC	5 Weeks	16	4	
16	Basic Essential Obstetric Care	21	16	4	
17	Mental Health	14	20	3	
18	Communicable Diseases (TB, Malaria, HIV)	10	15	3	
	Non-Clinical Trainings				
19	Human Resource Management for Health Facility Staff (Head, Admin/HR)	4	20	2	
20	General Management (Head, Admin/HR)	4	20	2	
21	BCC (Behavior Change Communication)	5	25	3	

Table 20. Proposed Training for BPHS Health Services Providers					
S.N	**Training**	**Duration (days)**	**Participants**	**Trainers per training**	**Remarks**
22	IPCC (Interpersonal Communication and Counseling)	5	25	3	
23	Effective Teaching Skills (ETS) for CHW Trainers and CHW Supervisors	10	20	3	
24	Partnership Defined Quality (PDQ)	5	25	3	
25	Monitoring, Evaluation and Supervision	5	25	3	
26	Gender Awareness Training	5	25	3	
27	HMIS	6	15	3	
28	Equipment maintenance	14	12	4	Estimation
29	Primary Eye Care Training	2 -5	15	2	

Annex I: Potential Weak links in the BPHS

The following potential weaknesses need attention from stakeholders in order to prevent or solve them through practical, effective work planning and implementation:

1. Previous versions of the BPHS were somewhat rigid documents with limited flexibility, unless extra resources were available. This version is more flexible but BPHS implementers need to keep their focus on access and quality to help reduce preventable mortality among women and children. One important focus should be the integration of vertical programs to achieve better coordination.

2. Underutilization of facility-based staff has been a problem during BPHS implementation. This may be due to different reasons, e.g., living far from the HF, low staff capacity, security issues, etc. BPHS implementers need to focus more on utilizing existing staff more effectively and efficiently.

3. Lack of involvement of technical MoPH departments in the contracting out process has sometimes been a constraint, so that program implementation is not as effective as it could be.

4. Other problems with BPHS implementation have included inadequate strategies for implementation and lack of necessary drugs, equipment, and supplies. With the revised BPHS there is an opportunity to correct some of the deficiencies of the past.

5. Absence of proper training needs assessments has been a problem for the BPHS. We hope that BPHS implementers will conduct appropriate and effective training needs assessments.

6. Inadequate dissemination to NGO BPHS implementers of the contents of various MoPH documents and procedures has been a problem that needs to be corrected.

7. Weak feedback and follow up by MoPH departments has also been a problem that needs correction.

8. Weak ownership of BPHS activities by the Provincial Health Directorates (PHDs) needs to change so that provinces feel they are a much more important part of the BPHS.

9. Weak referral systems and inadequate referral practices between levels in the BPHS and between BPHS and EPHS facilities has been a recurring problem and needs focused attention.

Annex J: Estimated Cost of the BPHS

BPHS 2009 Costing the Changes – available as excel file (BPHS issues for costing V31)

An Assessment of the Incremental Costs of the BPHS Afghanistan (FY 1388-1389)

I. Summary of BPHS Advancements

Advancements in the BPHS during the FY 1388/1389 period include updates in services such as physiotherapy, mental health, eye care as well as additional drugs and equipment.

More specifically, the main incremental components of the BPHS encompass a few "Community Based Health Services (CBHS)" items, e.g., provision of food and transport for CHWs. As for "staffing advancements", the highlights include the recruitment of a psychosocial counsellor at CHC level and two physiotherapists at DH level. The new BPHS also includes the provision of "several trainings" in Mental Health, Eye Care and Gender. Further, the new BPHS includes a list of additional "drugs", mainly provided at DH, CHC and BHC. As for "equipment", the additional resource costs mainly focus on DH, CHC and BHC, i.e. construction of privacy Partitions for Delivery Rooms in DH, CHC and BHC and of a psychosocial enclosure in CHC; provision of ECG at DH and CHC and MVA sets at DH, CHC and BHC. Additional "services" mainly encompasses the recurrent costs for physiotherapy at DH level and those related to Sub Centres and Mobile Health Units. Furthermore, following the presentation of the costing of the additional BPHS components during TAG in March 2009, TAG participants agreed to increase the salary of BPHS Staff by 15% as well as their related hardship allowance. TAG participants agreed that this increase is justified, as BPHS Staff had not seen any increase salary since 2005.

II. Cost Methods

Data Collection and Analysis of Incremental BPHS Resource Costs

A team from the Health Economics and Financing Directorate (HEFD), *General Directorate Policy and Planning (GDPP)*, developed a spreadsheet workbook to examine incremental costs of the added BPHS components, i.e. CBHC, Staff, Training, Drugs, Equipment etc. As a result, the workbook presents an excel sheet for each BPHS component, and is further broken down per BPHS facility-type. The last Excel sheet is a summary sheet titled "Grant Total" and represents the total incremental costs of the added BPHS components by facility-type, i.e. DH, CHC, BHC, HP, SC and MHT.

The team initially reviewed the estimated resource costs of the new BPHS components as prepared by the BPHS working group.

As for the salary, the team developed an additional spreadsheet for salary increases in the BPHS workbook. Based upon working group discussions, the team allocated a 15% increase to BPHS staff included in the National Salary Policy (NSP). Likewise an additional spreadsheet for Hardship allowance in the BPHS workbook was added. The team applied the list of staff receiving hardship allowance taken for the NSP. The hardship allowance is proportionally related to the salary increase of 15%. More specifically, the Hardship allowance is attributed based on the following geographic areas; (1) Urban; (2) Semi Urban; (3) Rural; (4) Deep Rural and remote; (5) isolated. The Team, together with the head of HEFD, estimated that 20% of the population lived in one of these 5 geographical areas as it was complex to get the exact repartition of the population among these 5 geographic areas.

As described above, the costing of the additional components of the BPHS was conducted for a 1-year period. At this point in time, the number of BPHS facilities used in the analysis is based on the latest facility census conducted by HMIS department, which is as follows:

BPHS Facilities	DH	CHC	BHC	HP	SC	MHT
Number	59	395	778	10000	260	34

NB: the concept "Comprehensive Health Centre +" is integrated into CHC

Once the cost data pertaining to the newly added components and categories were finalized, summary tables were completed using the Excel spreadsheet workbook.

III. Cost Results

The cost results indicate an estimated total increase of **$ 12.007.628** for delivering BPHS over the FY 1388/1389 period. This amounts to approximately a **10.92%** increase in the current BPHS annual cost estimate (110.000.000 USD). Approx. 27% of this increase stems from an increase in the provision of drugs, while 36% from the salary and hardship allowance increase. The remaining additional costs are incurred by the following additional BPHS components, e.g., CBHC, New Staffing, Training, Services and Others. Furthermore, we estimate the primary costs will be incurred at the BHC, CHC and DH levels, amounting approx. 75% of the Grand Total (1,9 Mio USD for DH, 4.4 Mio USD for CHC and 3.4 Mio USD for BHC). It should be noted that a brief sensitivity analysis was conducted for analyzing the additional BPHS Components in remote and insecure areas, counting 2% of BPHS incremental costs to cover those related costs (see flexibility clause in Table 1).

According to the BPHS working groups, some additional components will be gradually implemented in BPHS facilities and phased-in over a few years. For instance, Primary Eye Care Training will be implemented in 33% of the BPHS Health Facilities while Mental Health Training will be implemented in 50% of the BPHS facilities. Likewise, the privacy room for psychosocial counselling will be built in 33% of the BPHS facilities in year 1. Equipments will also be implemented in 33% of the BPHS facilities in year 1. Such arrangements/proportions are mentioned in the Excel sheet. Generally, we account for the costs only incurred in the first year. Likewise, the BPHS working group assume that the costs of the drugs can be calculated with 10% reduction, as some of the additional drugs will be replacing some of the current BPHS drugs.

IV. Conclusions and Recommendations

Despite the limits and challenges inherent in the costing process, this costing exercise provides a reasonable estimate of the incremental costs of the BPHS as well as the expected donor contribution.

The costing of the new BPHS components is in the scope of the donors' expectations that planned to spend between 10 and 15% increase. With a population estimate of 23.5 million in 2004/2005 (as per household listing estimate), and applying the fixed annual rate of 2 percent increase applied by the CSO, the incremental per capita expenditure of BPHS in one year is 0,46 USD (taking for granted that the population is approx. 25 945 899 inh. in 1388). This amounts to approximately $4.96 per capita expenditure for the entire BPHS.

The cost breakdown by donor was conducted based upon the number of BPHS facilities they cover and based upon the nature of the contracts with NGO as well as the location of the provinces. If we take the strict number of BPHS facilities by donors, USAID would bear 37% of the costs (adding PPA 2), while EC, 19%, WB, 24% and GAVI 1%. The rest being incurred by MoPH and others.

Lastly, it should also be noted that the 3rd review of the BPHS is the first one to be costed in detail. Until now, funding of the BPHS was based on the assumption that it "costs approximately" 4.5USD/ per capita to deliver BPHS services (Newbrander, W., Yoder, R., Debevoise, A.B., Rebuilding Health Systems in Post-Conflict Countries: Estimating the costs of basic services, Int J Health Plann Mgmt 2007; 22: 319–336.). More systematic costing exercises should be conducted so that resources are clearly and efficiently allocated within the primary health care sector. In the future, the MoPH and donors should support economic analyses of BPHS interventions to assess the BPHS components which require additional funds or re-organisation. This activity will ultimately assist the MoPH to improve BPHS implementation and improve the health of the Afghan population overall.

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