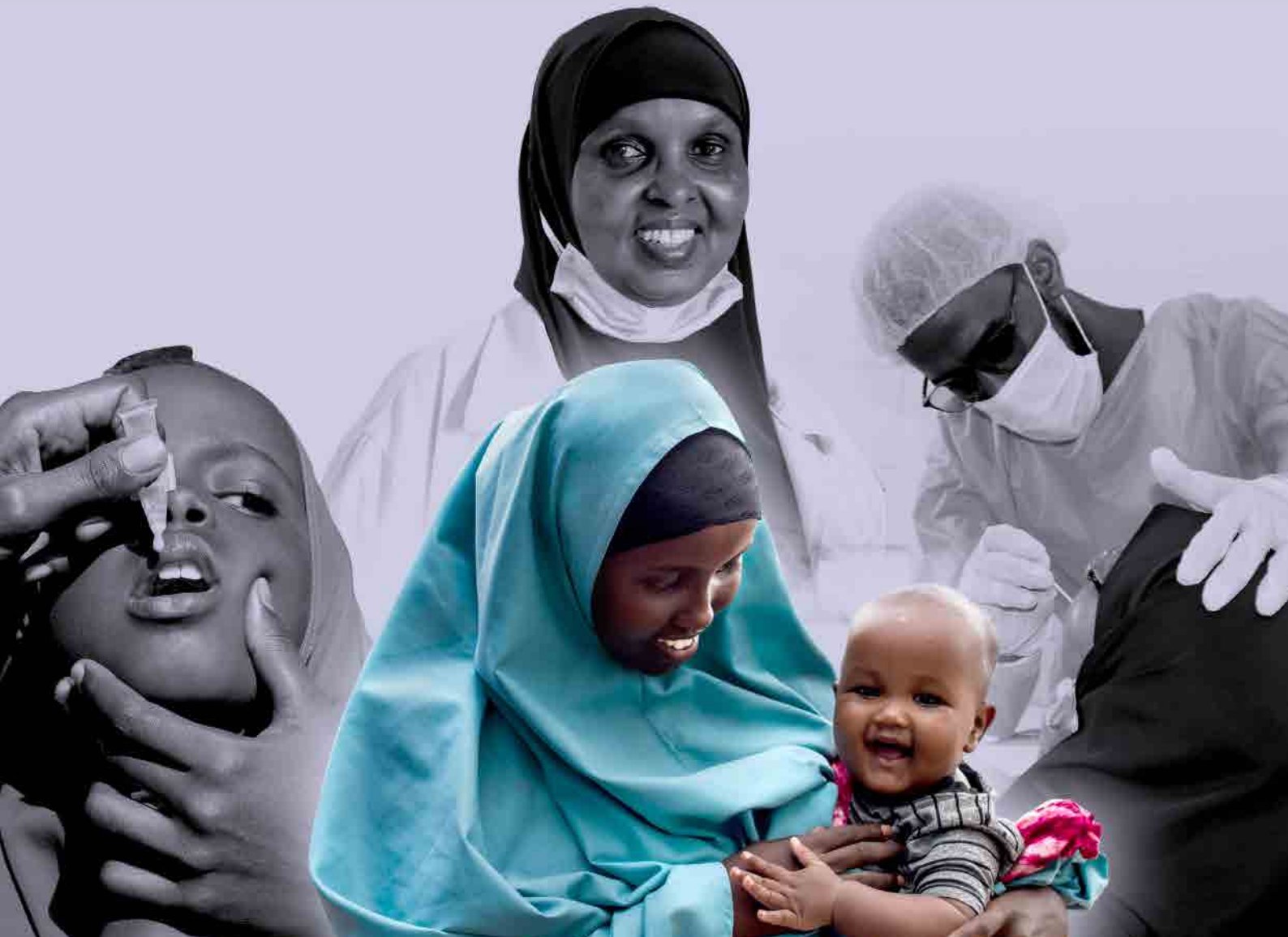
Ministry of Health and Human Services
Federal Republic of Somalia

Executive Action Document

Essential Package of Health Services (EPHS) Somalia, 2020



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Human Services
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Executive summary

The implementation of EPHS 2020 marks a milestone in Somalia's efforts to improve health and will lay the foundation for a resilient health system that can prevent, detect and respond to disease outbreaks and improve health outcomes as the country strives to improve health security and to achieve the global universal health coverage (UHC) goal of 80% by 2030.

Taking into account the vision statement of Somalia's Ministry of Health (MoH), that an essential requirement for a productive nation is that all citizens have the best possible health, the 2020 EPHS builds on experiences and learning from the implementation of the earlier version of EPHS developed in 2009, as well as the lessons learned from countries in the continent and around the world who are facing similar social, political and economic circumstances while emerging from decades of protracted conflict as Somalia.

The aims of the revised EPHS are in line with the mission of the MoH of Somalia to achieve UHC by ensuring the provision of equitable, accessible, efficient, affordable and quality essential health and nutrition services as close to the communities and families as possible, particularly to the mothers and children in nomadic communities, rural areas and internally displaced persons (IDPs). Further values of the MoH include ownership and leadership, transparency and accountability, equity, effective collaboration and partnership, participation and engagement of communities, and gender sensitivity and women's empowerment.

The design of the package was guided by:

- the government's vision;
- Somali Roadmap towards Achieving UHC (2020-2023);
- Health Sector Strategic Plan (HSSP) 2017-2021;
- Ninth National Development Plan 2020-2024; and
- the experiences and lessons learned from the implementation of the 2009 EPHS.

This effort was undertaken by a task force consisting of a core team from the Ministries of Health at the federal and state level, the World Bank, the World Health Organization (WHO), UNICEF and the Department for International Development, under the leadership of the MoH, and with a full participation of all stakeholders. The EPHS task force aims to:

- revise and design and an EPHS that can improve health outcomes and progress towards UHC;
- deliver health services that are cost-effective, equitable, accessible and affordable, addressing immediate needs of the Somali people;
- address the high morbidity, mortality and disability afflicting the Somali people, particularly the most vulnerable segments of our population, women, children, the IDPs and the elderly; and
- ensure the delivery of 412 interventions across the five health service delivery channels.

Background

Current context

Demographics

Somalia is emerging from a long period of conflict that has brought public health infrastructure to a state of near collapse. Over the past decade, the Federal MoH, in collaboration with health partners, has embarked on a process of health system rehabilitation with the goal of ensuring access to essential health services for all.

The goal of the EPHS is to put the country onto a path towards achievement of equity in health service delivery, and to lay the foundation for progress towards UHC by 2030. Core health indicators suggest some early successes, though much work remains to be done. Somalia is in the initial stages of an epidemiological transition, characterized by declining maternal, infant and child mortality and increasing life expectancy at birth. In 2019, the population of Somalia was estimated to be 15.6 million [1], total fertility rate at 6.4 children per woman on average [2] and life expectancy at birth estimated at 58 years [1]. An estimated 45.6% of the population is under 15 years of age, and 75% is under 30 years of age [2]. The majority of the young – including neonates, infants, children under the age of five, adolescents and youths – are users of health services. A significant proportion of children under the age of five suffer acute malnutrition every year, and child stunting and wasting is identified as one of the major impediments to healthy growth and development.

In addition, the country has an estimated 2.6 million IDPs [3], a number that fluctuates frequently due to recurring natural disasters, especially drought and famine.

Population uptake of health services

Since the ratification of the SDGs in 2015, Somalia, considered one of the least developed countries, has increasingly emphasized the strategic importance of SDG target 3.8 on UHC with a focus on access, quality and financial protection.

As part of the effort to progress towards UHC and following a UHC index assessment showing only 22% of Somali population having access to essential services [4], Somalia launched the HSSP-II 2017-2021, and the Somali Roadmap towards Achieving UHC 2019-2023, demonstrating strong political commitment and paving the way for the roll out of UHC in the country. The current EPHS revision process is fundamentally driven by and oriented to the goals, principles and targets outlined in these strategic documents. The 2020 update of the EPHS aims to optimize the balance among the three dimensions of UHC, i) services coverage; ii) population coverage; and iii) financial protection, and to align with the strategic direction set out in the Somali Roadmap towards Achieving UHC 2030.

Lessons learned from EPHS 2009

In 2009, Somalia developed its first EPHS built upon the first edition of Disease Control Priorities and the experiences of and lessons learned from this is the primary driver behind the revised EPHS 2020. Though all services included in the 2009 EPHS document were deemed essential for the Somali people, its implementation was partial and fragmented with limited consistency throughout the country partly due to challenges related to coordination, health financing, health system capacity, security and access, and weak stewardship and oversight by health authorities.

While the EPHS programme has improved the quality and capacity of service delivery, the shortage of qualified staff, limited bed capacity, lack of specialists and poorly managed referrals remain key implementation challenges.

In a recent desk review of the EPHS, regarding the content and structure of the package, the following gaps were identified:

programmatic limitations in high-burden health areas, including family planning, nutrition, noncommunicable diseases (NCDs) (respiratory,

cardiovascular and neoplastic conditions, as well as diabetes, mental health, oral health and injury);

- lack of services associated with the core continuity and coordination functions of primary care;
- lack of explicit services for common symptomatic presentations in primary care and emergency care, such as cough, pain or difficulty breathing;
- absence of some specific priority interventions (based on a comparison with the essential UHC and highest priority packages of the updated DCP3);
- lack of intersectoral interventions;
- package organization inadequate to support coordinated referral and movement across the health system; and
- package design unsuited to guide progressive realization and dynamic adaptation to variable contexts across the country.

While the EPHS programme has improved the quality and capacity of service delivery, the shortage of qualified staff, limited bed capacity, lack of specialists and poorly managed referrals remain key implementation challenges.

Development

Revising the EPHS

The revised EPHS 2020 aims to address all high-burden conditions through simple, low-cost, high-impact interventions, establish demand-driven services to facilitate more accurate costing, facilitate integrated service delivery and link services to level of care/platform of delivery. The current effort to revise the Somalia EPHS was motivated by the driving factors described above, including the evolving health needs of the Somali population, the gaps identified through review of the 2009 EPHS, and the increasing strategic emphasis on progress towards UHC and other SDGs. The overall objective is to develop a sustainable service delivery strategy that responds to the priority health needs of the Somali people, building on the lessons learned from experience with the EPHS 2009 and incorporating the most recent evidence-based tools.

the EPHS 2020 aims to prioritize services that are

- likely to have the greatest impact on major health problems of the Somali people;
- cost-effective in addressing the problems faced by the majority of the population; and
- scalable to offer equal access to nomadic, rural and urban populations.

The design of the EPHS 2020 supports a range of use cases and aims to:

address high-burden conditions through simple, low-cost interventions, such as pain control;

explicitly account for common symptomatic presentations at the primary level of the health system (demand-driven services) to facilitate more accurate costing;

- formulate and organize content to facilitate integrated service delivery;
- link services to level of care (platform of delivery) to support effective referral and ensure coordination of services across lower to higher-level platforms;
- easily communicate what services are covered and where they are delivered;
- allow dynamic adaptation to operationalize the package in variable contexts with distinct delivery platforms;
- formulate content to provide a foundation for service planning, workforce mapping and training competencies and ensure enough detail to provide a foundation for contracting, monitoring and evaluation;
- support progressive realization and account for the need to increase service delivery capacity over time (for example, by introducing newly added services initially at higher levels of the health system with later expansion to lower levels once capacity increases); and
- support expansion to additional services (and/or further dissemination of included services) when additional resources become available.

Health needs assessment

Though declining, Somalia is still faced with communicable diseases and maternal, neonatal and nutritional conditions. With increasing life expectancy, NCDs will play a prominent role in Somalia's health. The revised EPHS responds to the real needs of the Somali people with attention to the social determinants of health and the key components of health security, therefore reviewing the health needs versus existing services is a crucial step in revisiting this service package.

The health needs of Somalia are defined by three components:

1. **High burden diseases**
2. **Public health concerns**
3. **Hazards as consequences of emergencies**

Developmental process

To facilitate integrated service delivery, address

high-burden conditions and support progressive realization and expansion of the EPHS, the task force undertook a systematic process that included the following steps:

1. The EPHS 2009 was reviewed and gaps identified.
2. Additional services were proposed to address gaps in the 2009 package.
3. A burden of disease analysis and a health needs assessment were utilized to further guide the selection of the essential services.
4. Evidence on the cost-effectiveness of key interventions was reviewed and utilized to shape the package.
5. Selected services were assigned to initial and optimal service delivery platforms.
6. Core services were identified and a mechanism to allow for progressive realization and dynamic adaptation of services was developed.

Programmatic areas in the EPHS 2020

What follows are the categories of care in which the EPHS will offer. At the end of this document, key interventions will be listed.

Access to care

- Continuity, care planning and coordination
- Emergency care
- Approach to common signs and symptoms

Reproductive, maternal and newborn health

- Maternal and newborn care
- Sexual and reproductive health
- Life course, growth and development
- Childhood and adolescence, including nutrition
- Older age and adults

NCDs

- Health promotion and disease prevention
- Cardiovascular and pulmonary diseases
- Diabetes
- Cancer
- Mental health and substance use disorders
- Injuries
- Other NCDs

Communicable diseases

- Immunization
- Management of HIV, tuberculosis (TB), malaria, hepatitis
- Neglected tropical diseases
- Respiratory infections
- Gastrointestinal infections
- Other infections
- Outbreak surveillance

Core and extended services

The EPHS 2020 interventions are divided into a core and extended package to support progressive realization and future expansion of the service package. The core package constitutes a minimum service entitlement to be made available to most Somali people, while the extended package contains the additional interventions to be progressively implemented when suitable resources become available.

Core scenario

- foundation for priority implementation
- includes all services to be made available to all Somali people in the short term
- new services assigned to platforms where there is likely to be short-term capacity for successful delivery

Extended option

- supports expansion of select services
- shifts to lower-level delivery platform as capacities increase
- identifies priority services for medium to long term implementation

	District in rural context	District in urban context	Nomadic populations	Insecure and/or inaccessible areas
Context characteristics	Lower population per health district, with lower population density	Larger population per health district, with higher population density	Populations that move across administrative boundaries of health districts	Boundaries based on accessibility and security; areas served through humanitarian hubs
Assumption for adaptation	Local differences in population density need to be considered when planning locations for the facilities for upgrading the health network to progressively increase coverage of service availability (based on with 5 km distance and/or 1 hr travel time)	More efficient to increase the capacity of One Health Centre (HC) or rural health clinic (RHC)/district hospital (DH) to serve the catchment population within 5 km/1 hr travel, rather than rigidly adhering to the standards for rural contexts	For smaller nomadic populations it will be more efficient to invest in first aid and stabilization capacities of the community health worker, and transport for referral	Referral pathways need to be defined for each hub, whereby it may be desirable to upgrade a HC to DH, or DH to regional hospital (RH). Special considerations should be given to support transport to referral facilities
Community services	1 community health worker per 600-1000 population	1 community health worker per 600-1000 population	1 community health worker per 600-1000 population	1 community health worker per 600-1000 population in accessible areas
Primary health unit (PHU)	1 PHU per 1000-10 000 population	1 PHU per 1000-10 000 population	1 PHU per 1000-10 000 population	1 PHU per 1000-10 000 population in accessible areas
Health centres	1 HC per 20-30 000 population	1 HC per 20-30 000 population, with capacity adapted to catchment population within 5 km/1hr	Mobile HC that follows the population, or flexible referral pathways to nearest HC with investment in transport capacities within nomadic population	Where not possible to support fixed HCs: mobile health and nutrition teams that provide HC services
District hospitals	1 DH 120 000-150 000 per population	1 DH per 120 000-150 000 population, with capacity adapted to catchment population within 5 km/1 hr	Flexible referral pathways to nearest RHC/DH, with investment in transport capacities within nomadic population	Where not possible to support the planned DH in an administrative district: 1 DH in a town that services as the humanitarian hub for a geographical area or upgrade to DH in the accessible area.
Regional/ national hospital	Existing national, regional or specialized hospitals			
Surge capacity or specialized treatment centres linked to acute or chronic emergencies	Temporary treatment centres, e.g., when there are epidemics, floods or nutrition rehabilitation units when there is increased food insecurity phase. Additional temporary staff can be recruited for the duration of the increased health needs, but in other cases, existing staff may be repurposed to these treatment centres. When this happens, there is an inevitable effect on the capacity to maintain services as per the EPHS, and further reprioritization needs to be anticipated in contingency plans to suspend temporarily noncritical services.			

The revised EPHS includes intersectoral actions, which are mostly cost-effective and have long lasting impact on the health outcomes. These intersectoral interventions, not included in the costing, are as follows:

- advocate and promote the ban of smoking in public places and indoor environments;
- create a mass education and awareness campaign of the harmful effects of indoor air pollution;
- advocate policies and legislation imposing high taxes on tobacco and other addictive substances;
- advocacy and enforcement of regulations against advertising and promoting tobacco use;
- promote handwashing and general hygiene through mass media and in schools;
- promote food fortification with, iodine, iron and folic acid;
- provide consumer education about the harmful effects on the consumption of food with high salt content and beverage with excess sugar;
- promote the use of seat bels in vehicles; and
- provide consumer education about the harmful effects on the consumption of food with high salt content and beverage with excess sugar.

Costing

It is estimated that the initial, baseline cost of implementing the EPHS will be about US$ 105 million (per capita expenditure of US$ 7.4), with the largest share of this being attributed as follows; human resources (46%), medicines and other supplies (34%), infrastructure development (10%) and logistics costs (9%).

This cost is expected to gradually increase to reach an estimated per capita expenditure of US$ 33 by 2030, with the largest proportion of cost increase being attributed to the expansion of priority intervention coverage to cover a bigger population with essential health services.

The cost analysis of EPHS 2020 examines key required resources and suggests a gradual scale up of the implementation of a set of essential health interventions through the community, primary health units, health centre, district hospital and regional hospital levels across Somalia. Specifically, resources required include drugs and other supplies, infrastructure facilities, human resources, logistics and programme support activities. In order to achieve the objective of implementing EPHS 2020, a coordinated financial support effort will be required to ensure the delivery of 412 interventions across the five delivery channels/platforms.

The cost of EPHS 2020 was estimated using the One Health Tool [5], software which estimates various resources used in a health programme.

The resources considered were:

- drugs, vaccines, medical supplies, diagnostic materials;
- running and rehabilitation costs of existing health infrastructure – buildings, medical equipment, furniture, vehicles and IT equipment;
- employing health staff;
- logistics services; and
- programme activities related to EPHS implementation.
- Cost estimates indicate that EPHS 2020 implementation over the next decade would require sufficient and predictable financial resources. However, the impact analysis attributes significantly positive health benefits to these investments.

Cost type	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total
Total human resources (salaries) cost	48.22	54.09	60.22	66.59	73.20	80.04	87.19	94.59	102.30	110.30	118.58	895.34
Total infrastructure cost of all facilities	10.49	10.72	10.95	11.19	11.44	11.69	11.95	12.21	12.48	12.76	13.04	128.93
Rehabilitation costs	4.36	4.46	4.56	4.66	4.76	4.86	4.97	5.08	5.19	5.31	5.42	53.63
Maintenance and operating cost of all existing facilities	6.12	6.26	6.40	6.54	6.68	6.83	6.98	7.13	7.29	7.45	7.61	75.29
Total medicines, and supplies cost	36.03	43.33	54.32	68.16	85.69	107.82	136.65	174.43	223.86	288.90	375.06	1594.26
Total logistics cost	9.63	11.70	14.83	18.85	24.05	30.74	39.63	51.51	67.35	88.60	117.33	474.22
Total warehouse costs	0.09	0.09	0.09	0.10	0.10	0.10	0.10	0.10	0.11	0.11	0.11	1.11
Total worker costs	0.53	0.54	0.55	0.56	0.58	0.59	0.60	0.62	0.63	0.64	0.66	6.51
Drug transport costs	9.01	11.07	14.18	18.19	23.37	30.05	38.93	50.78	66.61	87.85	116.56	466.61
Total programme costs	0.18	1.50	1.14	1.30	1.19	1.27	1.25	1.32	1.30	1.38	1.46	13.29
Grand total	**104.54**	**121.35**	**141.47**	**166.09**	**195.57**	**231.56**	**276.66**	**334.07**	**407.30**	**501.94**	**625.47**	**3106.03**

Considerations for implementation

A clear investment plan and modalities for implementation will be required to optimize the impact of the EPHS 2020. Mechanisms to monitor implementation progress in and to empower and hold accountable national, regional and district authorities will be established. The public also will be informed about their right to access to defined essential services via community leaders and civil society organizations.

An implementation plan for the EPHS 2020 will need to be fully developed. Such a plan will ensure that the EPHS does not remain aspirational and will seek alignment with all health system functions and include:

- governance mechanisms and regulations to increase accountability and transparency;
- quality assurance programmes for services;
- financing systems and revisions of purchasing mechanisms;
- expanded training to ensure sufficient competent health workforce and management;
- information systems to track implementation progress; and
- community health needs and asset assessments to inform service planning.

Rights-based approach

Adopting a right-to-health approach means actively pursuing the progressive realization of universal access to essential services, with an emphasis on ensuring access for the most vulnerable. A well-defined EPHS sets the direction and an implementation plan ensures that progressively more services, of increased quality, are made available to more people. The Somalia EPHS will set measurable objectives that are monitored with a well-established information system. Special attention will be given to sex-disaggregated data as well as data related to vulnerable populations. Mechanisms to enhance access to the services in the EPHS will be designed and could include community-led surveillance systems, a patient charter, complaint mechanisms or ombudsman services.

Management

Subnational health authorities

District and regional health management teams will need to ensure that services in the EPHS are available and are effectively delivered. These management teams also play a key role in informing policymakers on the need for package adjustments and delivery modalities, as well as providing input on resource allocations and, when required, take corrective action or communicate the need for policy adaptations to the national level.

Local authorities can also interface with the community to generate demand and can provide crucial oversight of resources to optimize service delivery. In particular, they can determine what services are to be delivered where in order to increase equity and efficiency and improve how patients access and move through the health system.

Information systems

Various facility- and population-based information systems or tools exist to monitor and assess different dimensions of EPHS implementation. These provide data on the availability and quality of services, outputs and population coverage, utilization trends and barriers for access, and provider performance. These systems ideally also provide feedback on financial protection for access for the most vulnerable and on the shifting burden of disease. Purpose-designed systems, for example, are needed for disaster risk management, including epidemic preparedness.

Routine data collection systems complemented by surveys and community based surveillance systems and mechanisms to collect qualitative information (e.g., focus group interviews on a regular basis) constitute the basis of an integrated health information system.

Mechanisms for collecting data:

- Routine health information system – collects information on services provided by the different types of delivery platforms.
- Integrated disease surveillance and response system – manages alerts, investigates and responds to potential epidemics.
- Facility mapping – a national master list aids mapping of all public and private health facilities.
- Somalia Demographic and Health Survey – a comprehensive survey with optional modules survey released in 2020 to improve data availability.

Tools and resources

WHO has created a suite of tools and resources that are useful in supporting the development of effective emergency care systems. These include resources for use at the system level and in-service delivery settings. Additionally, there are a range of clinical process guidance tools, which can be implemented at facilities to ensure that no life-threatening conditions are missed, and that timely, life-saving interventions are performed.

Some relevant tools include:

- Clinical care training tools
- WHO International Committee of the Red Cross Basic Emergency Care course – an open-access training course for frontline health care providers
- WHO Emergency Unit Management course – teaches a systematic approach to management to improve quality of care in emergency units for senior clinical providers including nurses, clinical officers and specialists
- Clinical process tools
- Checklists – simple tools, designed for use in emergency units
- WHO standardized clinical forms – ensures a systematic and structured approach to every injured or acutely ill person

- Mechanisms to sustain EPHS
- Regional and district dashboards – informs service organization and planning
- Integrated quality assessment tool – supports quality management processes in facilities
- Independent complaint and resolution mechanism – encourages accountability and transparency to the population
- Public reporting – monitors/evaluates EPHS implementation plan
- Third party monitoring – supports contracting systems, provides validation to the state and federal ministry
- Certification – ensures high level of quality standards

Plan of action – Interventions

In Somalia there are five levels of health service delivery platforms, community, primary health care units, health centres, district hospitals and regional hospitals. Various interventions will be offered at the different levels of health care system. What follows is a brief look at key interventions included in the 2020 EPHS at Somalia's five different health care platforms. For a complete listing of interventions offered in the revised 2020 EPHS, please refer to the table at the end of the full EPHS 2020 document. Several services currently offered at particular facilities would optimally be delivered at a lower level and will be shifted once resources and capacity become available.

At the community level, the revised EPHS keeps active interventions from the 2009 package (community based first aid, the promotion of safe motherhood, family planning and women's health services, nutritional counselling and screening and supplementation for food insecure households, HIV prevention and social support for those living with HIV, management of common upper respiratory tract infections and treatment for pneumonia, etc.) and adds further interventions including, but not limited to, referrals for neonates born at home, immunization uptake and conduct defaulter tracing, treatment for malaria, and the promotion of good hygienic and oral health practices.

Included in the EPHS, primary health units offer the same care as community health centres with the addition of detecting sepsis (offered in the 2009 EPHS) and expanded postnatal care compared to the 2009 EPHS. Maintained from the 2009 EPHS, primary health units continue to offer interventions such as, contact tracing for sexually transmitted infections, supplementary feeding for moderate acute malnutrition, support to families coping with mental health and substance use issues, immunization services, the provision of life support, malaria prevention and treatment, de-worming campaigns, treatment of gastrointestinal infections, and treatment of common illnesses including skin infections. Added in the 2020 EPHS are interventions such as additional family planning counselling, healthy behavioural modification counselling, harm reduction services such as safe injection, treatment of basic injuries and active case-finding during epidemics.

At health centres, many interventions are included, both already offered under the 2009 EPHS and new interventions included in the revised EPHS (2020). Further services will be offered in the continuity, care planning and coordination category, such as assessments to inform care plans, and targeted care coordinated with public health and social service programmes. Emergency care is maintained as was offered in the 2009 EPHS (initial assessments and management of difficulty in breathing, mental health conditions, shock, injury, etc.) with the addition of detection and early referral of metabolic emergencies. The bulk of uncomplicated maternal and newborn care occurs at health centres and EPHS coverage includes additional screenings, assessments, vaccination services and treatments, management of low-risk labour and delivery, additional postpartum care and counselling, and newborn care. Programmes added to the revised package at health centres includes parenting programmes for early childhood developmental disorders.

The 2020 EPHS includes enhanced screening, and support and treatment for NCDs as well as management of chronic skin conditions. The treatment of injury remains the same as in the 2009 package – provision of basic wound care and initial management. Concerning communicable diseases, many of the same interventions included in the 2009 EPHS are present in the revised package, such as vaccinations, support for people living with HIV, testing and treatment for TB, treatment of malaria, but this is expanded upon to include communicable disease screening for high-risk groups, enhanced treatment for respiratory, central nervous system and other infections. To monitor outbreaks, the health centre is responsible for responding to and being prepared for epidemics as well as promoting public awareness and providing targeted vaccinations, much as what was offered in the existing EPHS with the addition of the capacity to coordinate and provide rapid surges of service delivery when needed.

The district hospital has the capacity to take on the same functions as the health centre but with enhanced services, the ability to manage complications, perform triage upon arrival and provide advance initial assessments in emergency care. Many of the interventions offered in care planning and emergency care were present in the 2009 EPHS, but the revised EPHS takes a better managed approach and adds additional interventions. District hospitals have the capacity to manage complicated pregnancies and deliveries, and in the revised EPHS, additional interventions for deliveries have been added (induction, spinal anaesthesia, full supportive care for preterm neonates, etc.). Treatment of NCDs has expanded to include management of heart failure, ischaemic heart disease, acute coronary syndromes, stroke and additional management of diabetes, as well as management of polytrauma, wound and burn care, fractures.

The revised EPHS implements WHO checklist for the management of critically ill and injured patients and now offers further light surgical interventions (removal of foreign body, cataract extraction, trachomatous trichiasis, etc.). Enhanced treatment of HIV/AIDS, TB and hepatitis B and C are now available through the 2020 EPHS at district hospitals as well as management of bronchiolitis and complicated measles. Additionally, emergency dental work is now offered under the 2020 EPHS. The district hospital is now more involved in outbreak surveillance and is responsible for the implementation of mass casualty management protocols and to provide comprehensive facility outbreak preparedness plans among other new services.

The regional hospital offers the same services as district hospitals, but like the district to the local health centre, the regional hospital offers advanced services and much like the lower levels, many of the interventions offered in the 2020 EPHS were in the existing package. New services unique to regional hospitals offered in the 2020 EPHS include detection and management of fetal growth restriction, specialized follow-up of high-risk infants, management of severe acute malnutrition associated with serious infection, diagnosis of childhood mental disorders, management of acute stroke and management of substance abuse withdrawal.

The revised package offers surgeries such as trauma laparotomy, amputations, basic skin grafting, surgical intervention for gastrointestinal bleeding, appendectomy and surgical intervention for TB. With the new package, outbreak surveillance has been ramped up to include outbreak preparedness, surveillance and response, and to provide health worker training and simulation exercises for outbreak events.

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