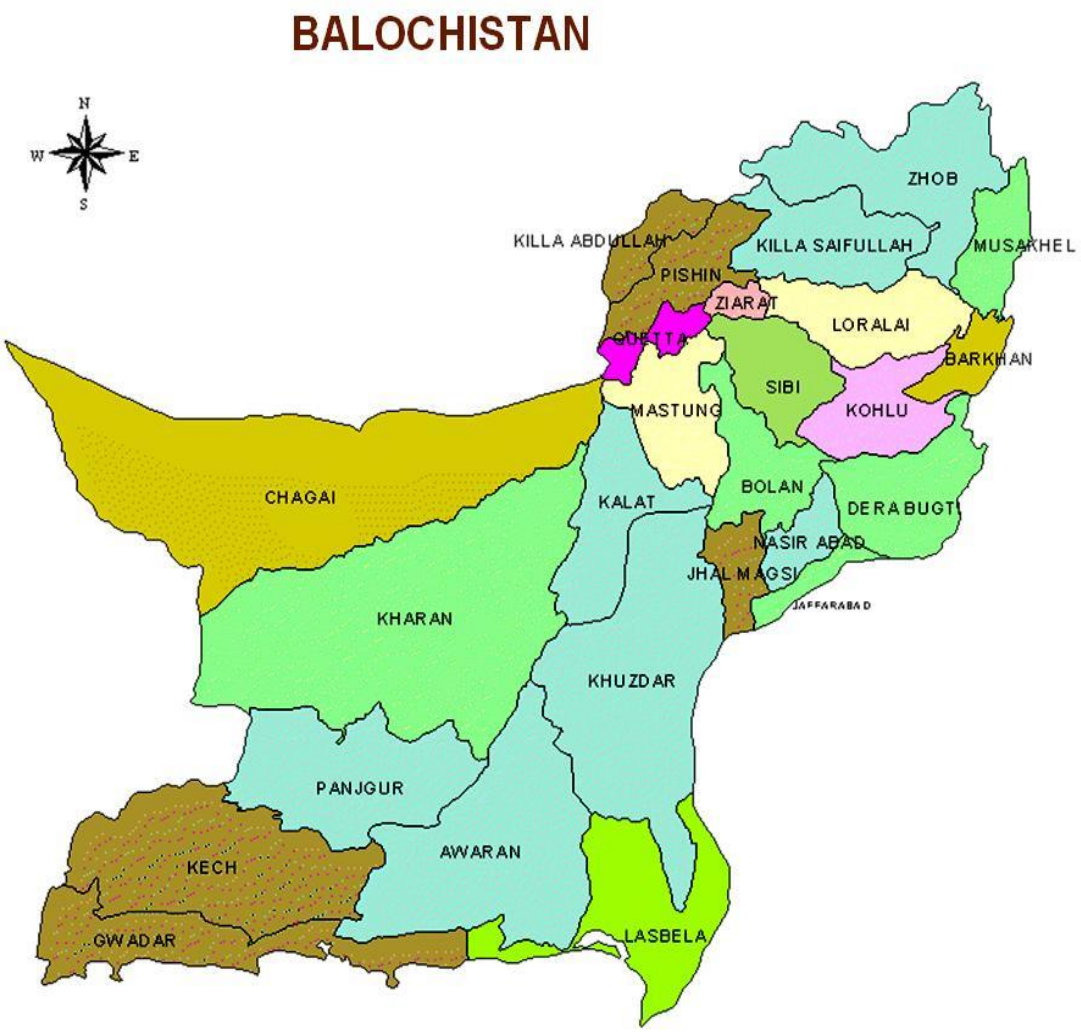
Balochistan

Provincial IRMNCAH&N Strategy (2016-2020)

Baluchistan provincial vision

for ten priority actions to address challenges of reproductive, maternal, newborn, child, adolescent health and nutrition

MAP OF BALOCHISTAN



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ACRONYMS

BHU	Basic Health Unit
CCT	Conditional Cash Transfer
CDK	Clean Delivery Kits
CMAM	Community-based Management of Acute Malnutrition
CMW	Community Midwife
CoIA	Commission on Information and Accountability (for Women & Children's health)
DDO	Drawing and Disbursement Officer
DHIS	District Health Information System
DHO	District Health Officer
DHQ	District Headquarter (Hospital)
DHRT	District Health Response Team
DoH	Department of Health
DOTS	Directly Observed Treatment System
ENAP	Every Newborn Action Plan
ENC	Essential Newborn Care
EmONC	Emergency Obstetric & Newborn Care
EPI	Expanded Program on Immunization
FATA	Federally Administered Tribal Areas
FP	Family Planning
GIS	Geographic Information System
HCF	Health Care Facility
HCP	Health Care Provider
HIV	Human Immuno-virus
IMR	Infant Mortality Rate
IMNCI	Integrated Management of Newborn Care
IRMNCAH&N	Integrated Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition
IUCD	Intra-Uterine Contraceptive Device
KPI	Key Performance Indicator
LHs	Lady Health Supervisor

LHV	Lady Health Visitor
LHW	Lady Health Workers
LMIS	Logistics Management and Information System
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MIS	Management Information System
MNCH	Maternal Neonatal and Child Health
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MNDSR	Maternal Neonatal Death Surveillance & Response
MPDR	Maternal and Perinatal Death Review
MNH	Maternal and Newborn Health
MoH	Ministry of Health
M/oNHSR&C	Ministry of National Health Services, Regulation and Coordination
MPI	Multidimensional Poverty Index
MUAC	Mean Upper Arm Circumference
NMR	Neonatal Mortality Rate
NSC	Nutrition Stabilization Center
ODF	Open defecation free
OTP	Outpatient Therapeutic-Feeding Program
PCPNC	Pregnancy Care and Post Natal Care
PHC	Primary Health Care
PHED	Public Health Engineering Department
PPIUCD	Post-Partum Intra-uterine Contraceptive Device
RHC	Rural Health Centre
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health Package
RTI	Reproductive Tract Infection
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection
THQ	Taluka/Tehsil Headquarter (Hospital)

UNICEF	United Nations Children's Fund
UNFPA	United States Agency for International Development
WHO	World Health Organization

MESSAGE:

SECRETARY HEALTH, BALOCHISTAN

PREAMBLE

Pakistan is a country beset by several economic, social and cross border challenges compounded by repeated natural catastrophes and political instability. These factors are considered to have contributed to a vicious cycle of poverty and rapid population growth as well as a high rate of maternal and child mortality in the country. Communicable diseases, maternal health issues and under-nutrition dominate and constitute a major portion of the burden of disease in the country. Maternal deaths due to preventable causes like sepsis, hemorrhage and hypertensive crises are unacceptably high while in children, diarrhea and respiratory illness remain as the major causes of morbidity and mortality. Many of these conditions are controllable through relatively low cost interventions and best practices at the primary and secondary care levels.

Improving coverage for RMNCAH services is a high priority for the Government of Pakistan and the *National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child & Adolescent Health, and Nutrition*, containing a list of ten priority actions, is a confirmation of the governments' commitment; made towards global movements and strategies such as 'A Promise Renewed' and "Every Woman Every Child" and is aligned with the overall National Health Strategy of Pakistan. The National Action Plan also serves as a guide for all regions and provinces of Pakistan to formulate each of these area's own RMNCAH&N Action Plans. These consequent action plans have been developed through a process of detailed intradepartmental discourse and consensus in the four provinces and three regions of the country and are designed to be an integral part of National action plan.

In order to ensure and sustain standard maternal, newborn and child health care services at all levels of health care, while keeping the principle of continuum of care in sight, the Department of Health Balochistan MNCH Program; in coordination with the WHO, UNICEF and UNFPA, came up with a comprehensive five year Action Plan for the province in line with the "Ten Point Agenda" on RMNCAH and Nutrition 2016-2020 by the National Ministry for Health Services Coordination and Regulation. This Action Plan chalks out the activities needed in the province for betterment of the RMNCAH services through multisectorial approach in the light of the guiding principles in the National Ten Points Agenda elaborated in the document.

The development process was supervised and guided by the Secretary Health and Director General Health services Balochistan. Moreover, the costing of the Action Plan was done through consultation with the vertical programs of the province through consultant hired for the purpose.

While the province will endeavor to implement the plans through use of own resources, securing additional health care financing will be imperative to the success of this RMNCAH&N strategy as a medium term Investment Plan for the province.

EXECUTIVE SUMMARY

In Pakistan Health care provision is traditionally the responsibility of the government. Under the 18th amendment to the constitution, the government has devolved a number of ministries to the provinces including Health and Population Welfare. This provides the provinces, including Balochistan, with opportunities for strategic planning as well as resource generation and management at the local level.

The Poor health status is in part explained by poverty, low levels of education especially for women, low status of women in large segments of society, and inadequate sanitation and potable water facilities, low spending/expenditure on health even by Asian standards (0.9% of GDP in Pakistan as compared to 1.4%[1]; World Bank report). These factors combine to develop and exacerbate the prevailing conditions of inadequate and low quality primary health care services in the country This has in turn put intense pressure on an already over-burdened health care system; leading to high rates of maternal and child mortality; especially so in the resource strapped provinces such as Balochistan. Communicable diseases, maternal health issues and under-nutrition dominate and constitute a major portion of the burden of disease in such cases.

Presently, in a reiteration of the commitment made towards global initiatives for addressing the key challenges in providing optimal care to mothers, adolescents and children, a comprehensive National Action Plan - with identified priority areas - has been developed on the direction of the national leadership. *The National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child & Adolescent Health, and Nutrition* (RMNCAH&N) also served as a guide for the formulation of the Balochistan provincial RMNCAH&N strategic action plan.

The provincial Integrated RMNCAH&N strategy 2016 - 2020 builds on the vision of improving the health of women and children through universal access to affordable quality essential health services; delivered through a resilient and responsive health system aimed at attaining the Sustainable Development Goals and fulfilling other global health responsibilities of the country.

The provincial strategy follows the ten priority action areas; identified in the National vision, as its objectives and lays out a comprehensive 5-year plan of action for implementing and achieving the strategic objectives and expected outcomes through minute detailing of the activities to be undertaken at various levels of the provincial health care system.

Core components of the Balochistan provincial strategy include:

a) Improving accessibility to quality primary health care at the community level by ensuring maximum coverage of rural areas, slums and other identified pockets of high need through induction

[1] http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS?end=2014&start=2014

of new community level health staff i.e. Lady Health Workers (LHWs) and Community Mid Wives (CMWs). Additional LHWs and CMWs will be recruited and equipped for the areas; left uncovered by existing health workers. Micro-nutrient supplementation as well as therapeutic treatment will also be provided.

b) Improving quality of care at primary & secondary level care facilities will be achieved by enhancing the relevant knowledge base and skills of the different cadres of health care staff including, field staff such as LHWs, CMWs, LHVs, LHSs and other supervisory staff, Teaching and clinical staff such as midwifery tutors and clinical supervisors etc. Improving the referral system and provision of essential drugs, vaccines and equipment is also part of the strategy for effective and quality health care. To ensure availability of well furbished essential infrastructure for additional HR induction and capacity building, new midwifery schools, hostels and residences will be built

c) Improving financial accessibility to reduce barriers to care seeking by the most vulnerable segments of the community will be achieved through developing forums for advocacy and orientation to politicians, policy makers and members of standing committees. Support groups for maternal and child health amongst the parliamentarians will also be established.

d) Health system strengthening will be achieved through expansion in essential health related infrastructure, provision of up-to-date equipment and latest technological enhancements to the health system. Construction and repair/renovation of essential infrastructure, vehicles and equipment and provision of comprehensive family planning services is a core theme. Strengthening referral linkages and feedback mechanisms are essential parts of the strategy.

An integrated DHIS incorporating IRMNCAH&N indicators will enhance oversight and coordination between provincial and district management levels. Governance, oversight and accountability will be achieved through implementation of investigative and response mechanisms (MPDSR), development and implementation of accountability frameworks such as the oversight committee on IRMNCAH&N and the Commission on Information and Accountability for Women & Children's health (CoIA), development and implementation of quality assurance tools (KPIs) and protocols as well as developing and linking of the M&E tools to these frameworks.

5: Social mobilization and political will be achieved through advocacy seminars, symposium, international conferences and orientation sessions to raise awareness regarding RMNCAH&N interventions at provincial and district level as well as SDGs amongst Politicians and the legislature. health education interventions will be utilized to disseminate public health issues like family planning promotion and demand creation. Community based organizations, community elders, local influential, professionals, religious leaders etc. will be engaged using Volunteers and peer support groups for demand creation.

6: A Monitoring & Supervision framework will be developed including ToRs, plans, reporting formats and checklists at provincial, divisional, district and facility level. The overall responsibility of M&E will rest with the Provincial Department of Health whereas the MNCH programs will be responsible for compiling

their respective M&E reports on quarterly basis and submit regularly to the DOH to be consolidated on annual basis

The strategy also includes a detailed Financial Action Plan which serves as a resource mobilization tool which could be used comprehensively for mobilizing political commitment and financial resources at the national level or for garnering donor support. The plan envisages that an amount of PKR 31,695,589,898will be required over a period of five years (2016-2020) for implementing the RMNCAH plan in the Balochistan province. The available funding (**10,993,053,926)** is approximately 35% of the total resource requirement for implementing RMNCAH plan whereas Rs. 20,702,535,972 would need to be be funded from alternate sources.

The medium-term, IRMNCAH&N strategy is aimed at reducing maternal, child and neonatal mortality through localized interventions and solutions that are culturally amenable as well as financially viable. The accompanying action plan is designed to utilize existing resources and contributing towards achieving the SDG targets of Pakistan.

BACKGROUND

Pakistan is an agricultural country with 64% of its population living in rural areas.[2] Every year, approximately 476,000 children under five years of age die of preventable causes, and 14,000 women die from preventable complications related to pregnancy and childbirth[3]. These unacceptable deaths are potentially avoidable by ensuring that all women and children get the prevention, treatment and care they need. Access to reproductive, maternal, newborn, child health and nutrition services is a high priority need.

The Prime Minister of Pakistan, Mian Muhammad Nawaz Sharif, during a meeting in February 2015 with international and national leaders in public health expressed his concern over the slow progress in RMNCAH and nutrition related aspects in Pakistan over the last decades. He directed the national leadership to take stock of the situation and carve a comprehensive action plan with identified priority areas at national level taking along the provincial counterparts and all partners in development sector addressing the key problems in a comprehensive manner. The Prime Minster of Pakistan reiterated that mother and child safety through proper immunization and better nutrition are also a major priority for the government. He further added that best practices should be replicated in Pakistan to achieve better results.

The National Vision Action Plan, developed on directions of the Prime Minister with ten priority areas, is a dynamic document and is leading to a mechanism for national consensus on important issues around RMNCAH and Nutrition. The objectives of the plan are also in line with global commitments for reproductive, maternal, newborn, child, and adolescent health such as the updated 'Global Strategy for Women's Children and Adolescent Health 2016 -30' and the SDGs.

Subsequently a consultative process was initiated between all stakeholders to identify priority areas and identify clear strategic directions for MNCH and Nutrition for the next ten years with tangible results/outcomes and a mechanism for oversight in order to ensure priority and visibility for the cause of mothers and children of the country.

All provinces, regions, partners, line ministries, academics and international experts in Pakistan have contributed to and endorsed the action plan in order to take the process forward. The 'Ten Point Agenda' was launched on 13th May, 2015 aiming to identify priority areas of health interventions that would enhance action for mothers and children of Pakistan.

The Government of Balochistan has been a keen participant in these consultations through the involvement of The Department of Health and has endorsed the National Vision wholeheartedly with the understanding that together we must:

1. Strengthen and invest in care during pregnancy, labor, birth, first day, week, year of life along continuum of care approach.

[2] *PDHS 2012-13*

[3] *National vision for coordinated priority actions – RMNCAH Ten point agenda*

2. Improve quality of maternal, newborn and child care.
3. Reach every mother, newborn and child to reduce in equities.
4. Harness the power of parents, families and communities
5. Count every mother, newborn and child through measurement, program tracking and accountability

The province of Balochistan has developed concrete action plans to further operationalize the ten priority actions of the National Vision into a comprehensive strategy to serve the purpose of advocacy, resource mobilization and provide guidance in implementation during 2016-2020.

SITUATIONAL ANALYSIS

The province of Balochistan has 32 administrative districts, clustered in 6 administrative divisions. It constitutes 44% of the land mass of Pakistan. Moreover, the population density in the province is lowest in the country i.e. 25/KM Sq., implying scattered population settlements. The urban and rural distribution is 24:76 respectively. The overall literacy rate of Balochistan is 28% (male: 39%, female: 16%). Health status of the people of the province as a whole is below the desired level as is revealed from the key health indicators described in table 1 below. Moreover, Moreover, 73 percent of the population uses improved drinking water sources while 61.4 percent of the population have access to improved sanitation facilities[4]. The salient demographic and health related indicators of the province are shown in Table 1.

Table 1: Key Indicators of Punjab Province

Total population	**6,566m**
Population – Urban : Rural	24:76
Annual growth rate	2.47
Adult literacy rate – Aged 15 yrs. & older	38
Neonatal mortality rate/1,000 live births	63
Infant mortality rate/1,000 live births	97
Under 5 mortality rate/1,000 live births	111
Maternal mortality ratio/100,000 live births	785
%age delivered by a skilled provider	17.8
%age delivered in health facility	15.8
%age receiving antenatal care from a skilled provider	30.6
%age of women with a postnatal checkup in the first 2 days after birth	37.2
All basic vaccinations	16.4
Tetanus toxoid (%age receiving two or more injections during last pregnancy)	20.9
Total fertility rate (15-49 yrs)	4.2
Contraceptive prevalence rate	19.5

Source: PSLM 2014-15, PDHS 2012-13

In the public sector, the MNCH services are part and package of the regular health services delivery system. The health systems comprise of three tiers i.e. 1) primary healthcare facilities comprising of Basic Health Units (BHUs) and Rural Health Centers (RHCs), 2) secondary healthcare facilities including Tehsil Headquarters Hospitals (THQs) and District Headquarters Hospitals (DHQs), and 3) tertiary level healthcare facilities (provincial level teaching hospitals).

[4] *MICS Baluchistan 2011*

Moreover the BHUs are contracted out to the People's Primary Healthcare Initiative (PPHI). Whereas, the DoH provides the facility infrastructure, administrative and operational staff as well as basic equipment and supplies, whereas the PPHI provides technical staff, training and overall management and supervision to the BHU.

Other than the public RMNCAH service delivery system, private sector also provides RMNCH services mostly in the provincial and district headquarters through general practitioners and specialists.

Table 2: Sanctioned and filled positions DoH Balochistan

BHUs	642
RHCs	102
THQs	13
DHQs	28
Teaching hospitals	5
Sanctioned medical doctor positions	2,342
Filled medical doctor positions	2,231
Sanctioned female medical doctor positions	516
Filled female medical doctor positions	491
Filled LHV positions	829

Source: Provincial Department of Health, Balochistan

CHALLENGES & CONSTRAINTS `

According to the midterm evaluation of the National MNCH Program, the following gaps and challenges were identified:

1. Financial constraints:
Inadequate and slow releases of funds had been the major issue for program progress.

2. Facility-based RMNCH service delivery:
Availability of skilled human resource in the far flung remote districts to provide comprehensive reproductive health MNCH is serious issue for the program. In adequate resources for in-service training of the RMNCH staff on the updated protocols is a major gap to improve the service delivery.

3.Community Midwives component:
The issues and challenges related to expanding skilled birth attendance through the CMWs includes issues pertaining to the selection process (i.e. low literacy rate for selection according to the PNC criteria), retention of the CMWs in their areas of deployment and training quality issues. Inadequate supportive supervision resulted in compromise on quality of service delivery.

4. Communication and community mobilization:
Effective communications strategy is needed to bring change in behavior and demand creation for the RMNCH services.

5. Coordination:
There is need for inter-departmental (DoH and PWD) and intra departmental (LHW, Nutrition, EPI, MNCH and DHIS programs) coordination for tangible achievement and long term impact.

OPPORTUNITIES

In addition to curative services the Department of Health Balochistan also implements a number of preventive programs such as EPI, MCP, TB Control Program, HIV/AID controls program, Leprosy Control Program, MCH Program, National Program for FP&PHC, Polio Eradication Initiatives (PEI) etc. The DoH also has a functional Health Management Information System (HMIS) which retrieves and stores data from various reports and surveys in addition to regular DHIS data. The department has also taken steps to eradicate polio through the polio eradication initiative (PEI), which started in 1994, and total NIDs to date are 49[5].

The Health Department has also initiated special programs and projects with international agencies such as the women health project in collaboration with ADB, the Reproductive Health Project with the support of ADB and UNFPA and the HIV / AIDS Control Program with the assistance of the World Bank[5].

After the 18th amendment and devolution of health to the provinces, all the vertical programs are owned by the provincial Department of Health in terms of planning, budgeting and implementation. The MNCH service delivery depends upon the following vertical programs:

- Lady Health Workers (LHW) Program
- Nutrition Program
- MNCH Program (reporting to Secretary Health)
- MCH Program (MCH centers)
- Expanded Program On Immunization (EPI)

The National MNCH Program was established in 2006. Its goal was to improve maternal, newborn and child health status of the province. It had five main components:

1) Integrated Delivery of MNCH Services at District Level
2) Training and Deployment of Community Midwives
3) Provision of Comprehensive Family Planning Services
4) Strategic Communication for MNCH Care
5) Strengthening Program Management

The Program strategies include:

1) Strengthening district health systems through improvement in technical and managerial capacity at all levels, and upgrading institutions and facilities
2) Streamlining and strengthening services for provision of basic and comprehensive emergency obstetric and newborn care.
3) Integrating all services related with MNCH at the district level
4) Introducing a cadre of community-based skilled birth attendants
5) Increasing demand for health services through targeted, socially acceptable communication strategies.

The National Program was funded by the federal government and DFID from April 2007 to 2012, which was extended up to June, 2015 by the federal government. The deployment of community midwives as a substitute to traditional birth attendants had been the main stay for improving

[5] http://www.balochistan.gov.pk/health/

RMNCH services in the province by the National MNCH Program. In 2015 the provincial government approved the MNCH Program new PC1 of worth 1791/- million rupees for 2015-2020[6].

The Prime Minister's National Health Insurance Program was launched in Balochistan in 2016. In the first phase, four districts i.e. Quetta, Lasbela, Loralai and Kech are included in the Scheme. The scheme ensures the identification of under-privileged citizens across the country to gives access to their entitled medical health care.

IMPLEMENTATION APPROACH FOR RMNCAH&N STRATEGY

The provincial Integrated RMNCAH&N strategy 2016 -2020 follows the vision and goal of the of The National Action Plan for RMNCAH&N and pursues the ten priority action areas; identified in the national vision document, as its objectives to be achieved during the next five years

VISION

To improve the health, particularly women and children, through universal access to affordable quality essential health services, and delivered through resilient and responsive health system, ready to attain Sustainable Development Goals and fulfill its other global health responsibilities.

GOAL

Provision of quality and affordable maternal, newborn, child, adolescent and nutrition health care in accountable and equitable manner through evidence based operational planning.

OBJECTIVE

1. Improving the access and quality of MNCH community based primary care services ensuring continuum of care including newborn care in rural districts and urban slums
2. Improved quality of care at primary and secondary level care facilities
3. Overcoming financial barriers to care seeking and uptake of interventions.
4. Increased funding and allocation for MNCH
5. Reproductive health including family planning
6. Investing in nutrition especially of adolescent girls, mothers and children.
7. Investing in addressing social determinants of health
8. Measurement and action at district level.
9. National accountability and oversight
10. Generation of the political will to support MNCH as a key priority within the sustainable development goals.

[6] DoH: Government of Balochistan (write-up for IRMNCAH&N Strategy)

CORE COMPONENTS OF THE IMPLEMENTATION APPROACH

1: Improving accessibility:

An exercise in mapping will be carried out to identify uncovered areas of both CMWs and LHWs in Balochistan province. It will ensure that 85% population will be covered through LHWs and 100% population covered through CMWs in the targeted districts to provide outreach services by these community health workers; in a phased manner till 2020, especially in rural areas and urban slums of the province.

Additional LHWs and CMWs will be recruited for the areas; left uncovered by existing health workers in Balochistan province, to address the issues of access to RMNCAH&N services. The new recruits will also be provided with furniture, equipment, kits, CMW & LHW supplies, logistics and transportation cost to facilitate the establishment of CMW birthing station and LHW Health House.

Provision of comprehensive services for Malnourished children at community level (CMAM, OTP) and Facility level through Nutrition Stabilization Centers (NSCs) is another focused area of intervention. Provision of micro nutrient supplements to the children, pregnant ladies; adolescents to overcome the nutritional deficiencies, address the exposure drug abuse among adolescents and awareness for health life style to deal with the long term health factors.

2: Capacity building

The technical teaching and clinical skills of additional midwifery tutors will be enhanced to impart quality midwifery training and LHSs will receive training in MDSR to contribute in preventing maternal deaths in their respective districts. The capacity building of pre-service training will focus on clinical, hands on skills and mandatory roaster for shift duties.

Emphasis will be laid on integration of IMNCI, PCPNC & ENC in pre-service education at medical schools to provide knowledge, develop skills and attitudes among students as part of their learning process and enable them to think through a differential diagnostic process before formulating a diagnosis and prescribing treatment. Similarly, in-service trainings for facility and community health workers will focus on topics like use of Chlorhexidine, use of Misoprostol, healthy timing and spacing of pregnancy (HTSP), essential newborn care (ENC), kangaroo mother care (KMC), Pregnancy Care and Postnatal Care (PCPNC), helping babies breathe (HBB), infant and young child feeding (IYCF) practices. Moreover, trainings on HIV/STI, TB, DOTS, Hepatitis, referral and reporting of MNC mortality, family planning methods: hormonal, long term FP methods, IUCD, PPIUCD, etc. will also be undertaken.

3: Improving financial accessibility & provision of safety nets

The strategy envisages developing forums for advocacy and orientation to politicians, policy makers and members of standing committees of the parliament on health and population issues through short in-session briefings on health programs to generate political will and ownership. Efforts will also be made to establish support groups for maternal and child health amongst the parliamentarians. These initiatives will be supplemented by conducting inter-provincial observational visits to highlight best practices and deepen learning and understanding regarding the issues and solutions there-of.

4: Health system strengthening

The strategy envisages expansion in essential health related infrastructure, provision of up-to-date equipment and latest technological enhancements to the health system for optimizing health care delivery. Residences for female health providers, new midwifery schools and hostels will be constructed and/or refurbished with necessary equipment and material to ensure availability of essential infrastructure for additional HR induction and capacity building. Likewise, new provincial population houses, district population houses and regional training institutes will also be constructed to further strengthen the services offered by population welfare department

Measures will be adopted to improve and strengthen referral linkages and feedback mechanism between various cadres of community health workers and health care referral facilities by ensuring supervisory visit of LHS/LHV and monthly meetings at referral units. The referral slips, record keeping formats and network will be developed and displayed in CMWs birth station, LHWs health house and health facility. The CMWs and LHWs will receive orientation on referral pathways and will also be provided with referral slips and record keeping formats.

Implementing of an integrated DHIS dash board incorporating IRMNCAH&N indicators will enhance oversight and coordination between provincial and district management levels and procurement units and ensure continued availability of services and supplies. A multi-spectral approach will be adopted to achieve coordination improved between the nutrition and MNCH program and other complimentary public service structures such as PHED, Agriculture, Local Government as well as social welfare department for effective planning and utilization of resources. Management and oversight of the activities of the RMNCAH&N action plan will be achieved through the implementation of an M&E framework, supported by development of plans, ToRs, reporting formats and checklists. Field supervisory tiers will be strengthened and supported at multiple administrative levels. The supervisory staff will be provided mobility and supplies as well as appropriate training for the monitoring protocols and reporting procedures.

Comprehensive family planning services will be offered which include conventional and clinical methods as well as male and female contraceptive surgery facilities in static units and in extension service camps under safe and sterile circumstance. Regular means of transportation will be ensured for contraceptive procurement, distribution and provision from provincial to district to service delivery level. In order to confirm the availability of contraceptives at service delivery point, even outsourcing of distribution mechanisms at various levels can be taken into account.

Governance, oversight and accountability will be achieved through implementation of investigative and response mechanisms (MPDSR), development and implementation of accountability frameworks such as the oversight committee on IRMNCAH&N and the Commission on Information and Accountability for Women & Children's health (CoIA), development and implementation of quality assurance tools (KPIs) and protocols as well as developing and linking of the M&E tools to these frameworks. Capacity building of various cadres of the health staff on these protocols will be an essential part of the strategy. Regular awareness, advocacy and orientation of the politicians and parliamentarians on the one hand and demand creation at the community level will support the effective streamlining of RMNCAH&N strategy as a priority agenda in achieving the SDG goals.

The use of new technologies i.e. GIS, CLMIS, smart phone apps for EPI, m-Health and smart phones for data recording and reporting will be utilized for analysis and decision making. Research will also

be carried out; encompassing the issues such as malnutrition, effective utilization of MNCH services, anemia, newborn care, CMWs, LHWs services and utilization, etc. to aid in evidence-based decision making, policy formulation, planning and consequent advocacy.

5: Social mobilization

Advocacy seminars, symposium, conferences and orientation sessions will be organized to raise awareness regarding RMNCAH&N interventions at provincial and district level. The internationally recognized days, such as; midwifery day, world health day, mother's day, children day, hepatitis, TB, HIV, etc. will be celebrated to emphasize and highlight the importance of various aspects and life-styles affecting health.

The health education interventions will enable the mothers to understand that how their health seeking behaviors can promote health and well-being of the newborn and children with simple accessible and affordable interventions.

Volunteers and peer support groups will be involved for demand creation by engaging community based organizations, community elders, local influential, professionals, religious leaders, etc.

6: Monitoring & Supervision:

Monitoring and supervision ToRs, plans, reporting formats and checklists will be developed at provincial, divisional, district and facility level. The monitoring and evaluation framework will be endorsed at various supervisory tiers at various levels including; provincial, divisional, district through deputy directors at DGHS office, provincial coordinators, divisional directors, district team and health care facility teams.

Coordination, program management, improving data quality, data routine monitoring & reporting, and oversight will be an integral component for improved monitoring system.

OUTLINE OF MONITORING & EVALUATION PLAN

This section provides an outline of the monitoring and evaluation plan for the IRMNCAH & N strategy implementation. A detailed M&E framework will be developed for tracking progress of the activities during 2016 to 2020 in Pakistan. This framework will clearly define the baselines, targets, data sources, frequency of data collection and responsibility. As part of the M&E plan, both qualitative and quantitative indicators will be added and multiple data sources will be used to provide strategic information and guidance for IRMNCAH & N monitoring and evaluation plans. The overall responsibility of M&E will rest with the Provincial Department of Health whereas relevant vertical programs will be responsible for compiling their respective M&E reports on quarterly basis and submit regularly to the DOH to be consolidated on annual basis. The DOH will be developing monitoring tools based on quality benchmarks and ensure regular field monitoring of all the activities. In addition, information from all available surveys and studies will also be used to inform the M&E plan. Using the regularly updated M&E reports, an action plan tracker will be maintained. This tracker will be regularly reviewed in annual progress review meetings to follow the progress and agree on course correction as well as follow up on agreed action from previous meetings.

The following table presents a list of core indicators for measuring the progress in achieving the key objectives of the strategy.

Table 2: Strategic objectives with key indicators of achievement.

Strategic Objectives	Core Indicators of achievement
Objective1: Improving access and quality of IRMNCAH primary care community based services ensuring continuum of care including newborn care in rural districts and urban slums	- Routine Immunization outreach coverage by LHWs in LHWs covered areas. - % increase in deliveries by SBA in the province - % of community health workers linked to referral system. - % increase in ANC coverage in the province
Objective 2: Improved quality of care at primary & secondary level care facilities.	- % of designated HCF where 24/7 CEmONC Available. - % Health facilities that received at least one supervisory visit during the past 6 month. - % of selected HCPs at PHC trained on PCPNC/IMNCI/ENC skills - % Increase in Penta III coverage in the province.
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions.	- Institutionalized and integrated social-welfare network Established - % increase in Districts piloted with PM Insurance Scheme
Objective 4: Increase in funding and allocation for advocacy, awareness and research for RMNCAH & Nutrition	- Increase in the government fund allocation and donor support for RMNCAH & N programs - Timely release of the funds to the programs.
Objective 5: Improve reproductive health including family planning.	- Integration of the FP and RMNCAH services at the PHC level - Reduction in Unmet need for contraception
Objective 6: Investing in nutrition especially of adolescent girls,	- % decrease in Maternal and Adolescent Anemia

pregnant and lactating women, children under 5	- % increase in IYCF practices
Objective 7: Investing in addressing social determinants of health.	- % Decrease in wasting, anemia and Zinc deficiency - Integrated mechanism to address the social determinants in place - Laws pertaining to mandatory female school enrollment and early girl marriages passed and in place
Objective 8: Measurement and action at district level.	- Integrated DHIS in place and scaled up to all districts - % of health facilities with two-way feedback mechanism in place - Maternal and child mortality audit systems in place - All policies formulated are evidence based
Objective 9: National accountability and oversight.	- **Monitoring and supervision mechanism in place and practice** - Accountability framework in place and practiced
Objective 10: Generation of political will to support MNCH as a key priority within sustainable development goals.	- Increase in % of allocation in PSDP for Health development including RMNCAH and Nutrition Program

FINANCIAL ACTION PLAN

BACKGROUND AND COSTING METHODOLOGY

In order to operationalize the ten priority RMNCAH&N actions into concrete action plans that would enable implementation over the coming five years (2016-2020), the action plans need to be costed to serve the purpose of advocacy, resource mobilization, and providing guidance in implementation

The exercise was built upon the existing costed IRMNCAH&N action plans, which had documented the baselines where available, and clearly set targets with milestones over the 5 years duration. In circumstances where additional information required, the consultant referred to the concerned provincial and federating areas program managers. To initiate the process, inception meetings were

held with the Ministry of National Health Services Regulation and Coordination, and with World Health Organization team, to discuss and approve the costing tool template. The costing tool template was discussed in detail and approved by the WHO and the MoNHSR&C.

The costing tool utilized in this process was a simplified costing developed in Microsoft Excel. The tool comprises 11 sheets (one for each of the 10 objectives in alignment to the ten objectives of the strategy, and one for overall summary). The tool was prepared in a way to calculate the total cost per activity, required for implementation of the activity/intervention each year, and summed up to provide the total cost per activity required for five years along with the available resources with funding sources and the funding gap.

For costing of RMNCAH and Nutrition action plan of Balochistan province, an initial meeting was held with the Director General, Health Services Balochistan on February 27, 2017 in his office. The meeting was also attended by the Deputy Provincial Program Manager MNCH and WHO MNCH Officer. Afterwards, individual meetings/discussions were held with all the relevant Program Managers. The main objective of these meetings was to determine the unit costs and number of units per year for all the activities under each of 10 objectives of the RMNCAH plan. The unit costs were determined on the basis of discussions with the relevant program stakeholders and available documents like RMNCAH&N action plan of Balochistan province, PC-1s, Comprehensive Multi-Year Plans of EPI, project concept notes, etc. The numbering of units were mainly taken from the RMNCAH&N action plan. Where necessary, the number of units has been changed for some of the activities, as suggested by the relevant program managers during the costing process. In consultation with the concerned stakeholders, an inflationary increment of 10% every year was applied to the unit costs, due to a periodic increase in the prices of goods and services.

DETAILS ON RESOURCE REQUIREMENTS

The already developed RMNCAH and Nutrition action plan has been costed under the ten priority objectives, using the costing tool, especially developed for this task. For each objective, corresponding activities have been costed.

Component-wise total resource requirements

Resource requirements by component/ objective

S.#	Component/Objective	Total PKR	%
1	Improving Access and Quality of MNCH Community Based Primary Care Services	7,017,724,800	22.14
2	Improved quality of care at primary and secondary level care facilities	12,842,524,304	40.52
3	Overcoming financial barriers to care seeking and uptake of interventions	68,250,000	0.22
4	Increased Funding and allocation for MNCH	16,200,000	0.05
5	Reproductive health including Family planning	336,455,000	1.06
6	Investing in nutrition especially of adolescent girls , mothers and children	10,665,697,694	33.65
7	Investing in addressing social determinants of health	449,724,000	1.42
8	Measurement and action at district level	262,314,100	0.83
9	National Accountability and Oversight	25,300,000	0.08
10	Generation of the political will to support MNCH	11,400,000	0.04
Total		31,695,589,898	100

As shown in the above table, total amount of PKR 31,695,589,898will be required over a period of five years (2016-2020) for implementing the RMNCAH plan in the Balochistan province. The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (40.52%) have been costed under objective 2 i-e “Improved quality of care at primary and secondary level care facilities”. After this, the majority of funds (33.65%) and (22.14%) have been costed under objectives 6 & 1 respectively. The objective 6 is focusing on “Investing in nutrition especially of adolescent girls, mothers and children, and objective 1 will Improve Access and Quality of MNCH Community Based Primary Care Services in the province.

Component-wise yearly resource requirements

Yearly resource requirements by component/obejctive

S.#	Component/ Objective	2016	2017	2018	2019	2020
		PKR	PKR	PKR	PKR	PKR
1	Improving Access and Quality of MNCH Community Based Primary Care Services	969,433,400	1,083,481,740	1,450,372,080	1,596,690,420	1,917,747,160
2	Improved quality of care at primary and secondary level care facilities	1,569,960,537	2,062,180,018	2,812,371,528	2,978,487,782	3,419,524,439
3	Overcoming financial barriers to care seeking and uptake of interventions	7,200,000	8,910,000	13,920,000	16,380,000	21,840,000
4	Increased Funding and allocation for MNCH	2,700,000	2,970,000	3,240,000	3,510,000	3,780,000
5	Reproductive health including Family planning	61,910,000	102,448,500	55,632,000	56,075,500	60,389,000
6	Investing in nutrition especially of adolescent girls , mothers and children	2,343,161,120	1,614,105,280	2,498,785,886	2,001,269,772	2,208,375,636
7	Investing in addressing social determinants of health	88,804,000	79,310,000	86,520,000	93,730,000	101,360,000
8	Measurement and action at district level	82,151,600	27,900,070	13,948,440	68,280,810	70,033,180
9	National Accountability and Oversight	6,300,000	4,180,000	4,560,000	4,940,000	5,320,000
10	Generation of the political will to support MNCH	1,900,000	2,090,000	2,280,000	2,470,000	2,660,000
Total		**5,133,520,657**	**4,987,575,607**	**6,941,629,934**	**6,821,834,284**	**7,811,029,415**

Yearly resource requirements by each of 10 components/ objectives are given in the above table. Yearly resources requirement has some variation in the cost from year 1 to 5. This may be due to the i) different activities and or change in number of units during various years.

FINANCING AND FUNDING GAP

COMPONENT-WISE FUNDING GAP

Funding Gap

S.#	Component/ Objective	Total Cost	Available Funds	Funding Gap	Funding Gap %
		PKR	PKR	PKR	
1.	Improving Access and Quality of MNCH Community Based Primary Care Services	7,017,724,800	1,408,776,000	5,608,948,800	79.93
2.	Improved quality of care at primary and secondary level care facilities	12,842,524,304	9,292,091,926	3,550,432,378	27.65
3.	Overcoming financial barriers to care seeking and uptake of interventions	68,250,000	-	68,250,000	100.00
4.	Increased funding and allocation for MNCH	16,200,000	1,200,000	15,000,000	92.59
5.	Reproductive health including Family planning	336,455,000	30,000,000	306,455,000	91.08
6.	Investing in nutrition especially of adolescent girls , mothers and children	10,665,697,694	254,586,000	10,411,111,694	97.61
7.	Investing in addressing social determinants of health	449,724,000	3,000,000	446,724,000	99.33
8.	Measurement and action at district level	262,314,100	2,100,000	260,214,100	99.20
9.	National Accountability and Oversight	25,300,000	800,000	24,500,000	96.84
10.	Generation of the political will to support MNCH	11,400,000	500,000	10,900,000	95.61
Total		**31,695,589,898**	**10,993,053,926**	**20,702,535,972**	**65.32**

As seen in the above table, the available funding is approximately 35% of the total resource requirement for implementing RMNCAH plan. Mainly, these funds will be provided by the provincial government, including the approved EPI PC-1. The remaining 65% of the total resources requirement is a funding gap, for which Government of Balochistan will mobilize resources through allocating funds from their own budget, and by approaching potential donors directly or through the MoNHSR&C.

OUTLINE OF BALOCHISTAN ACTION PLAN

The RMNCAH & Nutrition Action Plan 2015-2020 Balochistan is the outcome of consultative process entailing cascade of consultative workshops held at national and provincial levels, with involvement of the highest circles of DoH Balochistan and the political leadership at various stages of development to ensure maximum participation and ownership by the major stakeholders.

Based on the National Ten Points Agenda for RMNCAH and Nutrition for upcoming five years i.e. 2016-2020, the province of Balochistan under high level leadership of Secretary Health and Director General Health Services involving all stakeholders aforementioned, came up with comprehensive Provincial Action Plan. The activities in the Action Plan are based on the critical gaps and huge unmet need for RMNCAH and Nutrition intervention in the province.

The Action Plan 2015-2020 Balochistan is guided by the "Ten Point RMNCAH & Nutrition Vision" adopted through elaborate consultative process, initiated by the Ministry of National Health Services Coordination and Regulation under the directives from the Prime Minister of Pakistan Mian Mohammad Nawaz Sharif in February 2015

The baselines and targets set in the Action Plan have been aligned with the PC1s of the provincial preventive programs (MNCH, LHW, Nutrition, EPI and PWD). In the absence of comprehensive data management system in the province, the PDHS 2012-13, MICs 2010 and NNS 2011, are also used as major resource for RMNCAH and Nutrition baselines and targets. The program MISs (MNCH and LHW Program) is also used to provide information on activities progress and gaps. The detailed action plan is presented below.

Objective 1: Improving access and quality of IRMNCAH primary care community based services ensuring continuum of care including newborn care in rural districts and urban slums.

Expected outcome 1.1: Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs etc.)

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.1.1	1.1.1 Mapping of CMWs uncovered areas	% of uncovered areas mapped	5 districts	32 districts	27					MNCH Program
1.1.2	1.1.2 Training of more CMWs from uncovered areas as per mapping (as per new PC1 2016-2020)	% of CMWs trained	721	1200	200	200	200	300	300	MNCH Program
1.1.3	1.1.3 Deployment of newly trained CMWs (as per new PC1) in the uncovered areas as per mapping and their deployment guidelines (establishment of birthing stations equiped for RMNCH/EPI/FP	% of new CMWs deployed	0	375	0	0	375	0	0	MNCH/LHW Program

	services)									
1.1.4	1.1.4 Deployment of already trained un-deployed CMWs (establishment of birthing stations equiped for RMNCH/EPI/FP services)	% of already trained CMWs deployed	291	430	430	0	0	0	0	MNCH Program
1.1.5	1.1.5 Construction of midwifery schools and hostels (Zhob, Harnai, Pishin, Chaghi, Gwadar) (Currently operating in one room)	% of planned midwifery schools and hostels constructed	0	6	2	2	2	0	0	MNCH Program
1.1.6	1.1.6 Strengthening of the existing midwifery schools through minor repair and renovation work	% of existing midwifery schools repaired/renovated	0	9	2					2
1.1.7	1.1.7 Establishement of new Midwifery schools and hostels (Ziarat, Sherani, Mustung, Kalat, Lasbella, Barkahn, Kohlu, Musakel, Awaran,Kharan, Washuk, Jaffarabad, Dera Bugti, Jhal Magsi, Lasbella, Kachi) 16	% of new Midwifery schools and hostels established	0	16	3	3	3	3	4	MNCH Program
1.1.8	1.1.8 Construction of quarters for tutors in new CMW schools (3/school, total 48)	% of planned quarters for tutors in new CMW schools constructed	0	48	9	9	9	9	12	MNCH Program

1.1.9	Vehicles for new CMW School (16)	% of planned vehicles procured	0	16	3	3	3	3	4	MNCH Program
1.1.10	Provision equipment, furniture and teaching aid to the new CMW schools	% of new CMW schools fully refurbished (as per plan)	0	16	3	3	3	3	4	MNCH Program
1.1.11	Recruitment of tutors for new schools (48 tutors , 3 /school)	% of tutors for new schools recruited (from target)	0	48						
1.1.12	Increasing the number of tutors per school (ones)	% Increase in the tutors for existing school (from target)	27	26	5	5	5	5	6	MNCH Program
1.1.13	Recruitment of new LHWs for LHW uncovered areas (according to programmatic mapping of LHWs)	% of LHWs recruited for uncovered areas	6720	9200	496	496	496	496	496	LHW Program
1.1.14	1.1.14 Annual increase/increment in the incentives for CMWs during initial 2 years of their deployment	Incentives provided (100%)	5000	12000	6000	7000	8000	10000	12000	MNCH Program

Expected outcome 1.2: Improved quality of community based RMNCAH and Nutrition services (through improvement in monitoring and supervision/revision of ToRs/capacity building and supplies) of the CMWs and LHWs.

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.2.1	1.2.1 Recruitment of new LHSs (LHWs and CMWs supervisory staff) for supervision	% of LHSs recruited	255	379	24	24	24	24	28	LHW Program
1.2.2	1.2.2 Refresher trainings of LHVs/LHSs on technical monitoring (in facility and field) of CMWs	% of LHVs/LHSs conducted Refresher Trainings	0	255 LHSs, 456 LHVs	142	142	142	142	143	MNCH Program/LHW Program

1.2.3	1.2.3 Refresher training of Field Program Officers (FPOs) and Provincial Program Implmentation Unit (PPIU) on monitoring and supervsion	% of Field Program & PPIU Officers conducted Refresher Trainings	0	20		20				
1.2.4	Increase in mobility support to the supervsiory staff LHS/LHV	% Increase in mobility support to the super-visory staff (from within Target)	3000	5000	5000	5000	5000	5000	5000	MNCH/LHW Program
1.2.5	Repair of the off-road vehicles of LHW Program (used for monitoring and supervsion)	% of vehicles repaired	0	125	25	25	25	25	25	LHW Program
1.2.6	1.2.6 Integrated monitoring and supervsion plan/rosters for LHSs and LHVs to monitor LHWs and CMWs at the catchment area facilitated through Facility Incharge	% of supervision visits conducted	255	365	73	73	73	73	73	District MNCH and LHW Program

1.2.7	1.2.7 Training of Female Welfare Workers (FWW) on Midwifery (8 months)	% of Female Welfare Workers (FWW) trained	20	170	30	30	30	30	30	Population Walfare Dept.
1.2.8	1.2.8 Implementation of Licence Practicing Midwife (LPM) curriculum in the Midwifery Schools		0	15		5	5	5		MNCH/LHW Program
1.2.9	1.2.9 Develop Newborn survival startegy (in line with ENAP) and implement at community levels through LHWs and CMWs	Newborn survival strategy developed								UNICEF/MNCH Program/LHW Program
1.2.10	1.2.10 In-service training of CMWs on new areas/protocols (HTSP, IYCF, HBB, Use of Chlorhexidine, KMC and misoprostol, cIMNCI, GAPPD etc) contextual to provincial policy	% of CMWs trained	0	721	291	107	107	107	109	MNCH Program
1.2.11	1.2.11 In-service training of LHWs on new areas (HTSP, IYCF, HBB, Use of Chlorhexidine, KMC and misoprostol, cIMNCI, GAPPD etc) con-	% of in-service LHWs trained	0	6720	1344	1344	1344	1344	1344	LHW Program

	textual to provincial policy									
1.2.12	1.2.12 Refresher trainings of Midwifery tutors and CMWs on maternal, newborn and child care, FP, nutrition and reporting of MNC mortalitities	% of in-service CMWs/ tutors trained	0	318	35	63	63	63	66	MNCH Program
1.2.13	1.2.13 Refresher trainings of LHWs on revised protocols on maternal, newborn and child care, FP, nutrition and cIMNCI, revised councelling skills and reporting of MNC mortalities	% of LHWs trained	0	6720	1344	1344	1344	1344	1344	LHW Program
1.2.14	1.2.14 Refresher training for Account Supervisors on LMIS and Account Management of LHW Program		0	31	16	15				LHW Program

Expected outcome 1.3: Improved community outreach routine immunization through involvement of LHWs

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.3.1	Training of LHWs on Routine immunization out reach	% of LHWs trained	2160	6720	600	600	1100	1100	1160	EPI Program
1.3.2	Provision of logistic support to LHWs for routine immunization outreach activities	The % of LHWs provided logistics support	0	for 2160 LHWs that are already trained	432	432	432	432	432	EPI Program

1.3.3	Involvement of LHWs in outreach routine immunization activities through proper micro planning at catchment level	% of LHWs conducted Micro planning	0%	mciro planning done for routine immunization at the catchment area of the LHWs	10%	20%	35%	55%	65%	EPI Program

Expected outcome 1.4: Improved the linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.4.1	1.4.1 Orientation to LHWs, CMWs and HCF staff on referal pathways and MIS	Number of LHWs/CMWs/ HCP staff oriented	0	10224	2044	2044	2044	2044	2048	MNCH/LHW/DoH
1.4.1.1	.4.2 Display of referal linkages pathways in CMWs birth stations, LHWs Health Houses and Health Care facilities	Visibility of referral linkages pathways in HCFs/B.S/HHs	0	8457	1691	1691	1691	1691	1693	MNCH/LHW/PPHI/ DOH
	1.4.3 Scale up e-communication of RMNCAH/N related data/information to more CMWs and connect them with Secondary level health care through provision of		90	430	86	86	86	86	86	MNCH Program

	gadgets for communication and speedy referral in all currently deployed CMWs and awaited for deployment.									
	1.4.4 Piloting referral linkage mechanism at UC level with empowering of LMOs at UC level for referral linkages and technical guidance to CMWs from community to secondary health care level (Gynecologist)		0	5 U Cs						
1.4.2	Provision of IEC material on MNCH, EPI, FP and Nutrition and advocacy kits to LHWs/CMWs for health educations sessions	% of LHWs & CMWs provided IEC material								
	1.4.3 Scale up e-communication of RMNCAH/N related data/information to more CMWs and connect them with Secondary level health care through provision of gadgets for communication and speedy referral in all currently deployed CMWs and awaited for deployment.		90	430	86	86	86	86	86	MNCH Program
	1.4.4 Piloting referral linkage mechanism at UC level with empowering of LMOs at UC level for referral linkages and technical guidance to CMWs from community to secondary health care level (Gynecologist)	% facilities displaying referral linkage pathways	0	5 U Cs						

Expected outcome 1.5: CMWs Increase in community demand for RMNCAH and Nutrition services

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.5.1	1.5.1 Utilization of PPHI social Organizers for community health sessions/ school health sessions and support groups for community mobilization and health services awareness on RMNCH and Nutrition	% community mobili-zation and health ser-vices awareness activi-ties conducted	1870	18720	3744	3744	3744	3744	3744	PPHI
1.5.2	1.5.2 Training and Involvement of LHWs for communication activities & tracing defaulters and non starters (EPI/ANC/PNC/Nutrition)	% LHWs and CMWs trained		6720	1344	1344	1344	1344	1344	LHW Program
1.5.3	1.5.3 Use local print and electronic media for social mobilization and health messages on RMNCAH and Nutrition	% messages printed								
1.5.4	1.5.4 Provision of IEC material on MNCH, EPI, FP and Nutrition and advocacy kits to LHWs/CMWs for health educations sessions	% LHWs and CMWs provided IEC material		2500	500 copies	500 copies	500 copies	500 copies	500 copies	PPHI in collaboration with the DoH

bjective 2: Improve access to and quality of RMNCH care at Primary and Secondary level care facilities

Expected outcome 2.1: Enhanced skills of HCPs on IMNCI/PCPNC/ENC at Primary and Secondary HCFs

S.No	Activities	Indicators			Target by year					Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020	
2.1.1	2.1.1. Capacity building of health care providers at PHC facilities (Pediatricians/MOs/LMOs/MTs/FMTs) on IMNCI and GAPPD skills	% of health care providers capacitated	624	2818	563	563	563	563	566	MNCH Program
2.1.2	2.1.2 Expanding the pool of IMNCI facilitators in province at Center of Excellences	Percentage of IMNCI facilitators recruited	20	50	30	0	0	0	0	MNCH Program
2.1.3	2.1.3 Expanding the pool of follow-up supervisors	% of follow-up supervisors recruited	20	50	30	0	0	0	0	MNCH Program
2.1.4	2.1.4 Conduct of follow-up visits 4 – 6 weeks after training (2nd part of training) for the trained providers.	% of follow-up visits conducted	0	2818						MNCH Program

2.1.5	Conduct training of Health care provides (Gynecologists/Obstetricians/LMOs /LHVs/FMTs/MW Nurses) on PCPNC	% of health care providers trained	0	2317	463	463	463	463	465	MNCH Program
2.1.6	Increase the pool of PCPNC facilitators in the province at the Center of Excellences (Quetta and Gwadar)	% of new PCPNC facilitators recruited	20	50	30	0	0	0	0	MNCH Program
2.1.7	Conduct the training of HCPs (Pediatrician/ MO/WMO/Staff Nurses) on Neonatal care at Neonatal Intensive care Units (total 9 trainings) (4 Weeks Training)	% of health care providers trained	0	180	20	80	80	0	20	MNCH Program
2.1.7	2.1.7 Conduct training of the HCPs (Gyne/Obs, LMO, MO, Pediatricians, LHVs, staff nurses) on Essential Newborn Care (ENC) and Help Baby Breath (HBB)	% of health care providers trained	0	4986	997	997	997	997	998	MNCH Program
2.1.8	2.1.8 Increase the pool of ENC facilitators at district level	% of new ENC facilitators recruited	10	128	25	25	25	25	25	MNCH Program
2.1.9	2.1.9 Conduct the training of HCPs (Pediatrician/ MO/LMO/Staff Nurses) on management of sick newborn at Neonatal care at Neonatal Intensive care Units	% of health care providers trained	0	90	18	18	18	18	18	MNCH Program

Expected Outcome 2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HFs and provision of supplies

S.No	Activities	Indicators			Target by year					Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020	
2.2.1	2.2.1 Provision of essential RMNCAH equipment to all DHQ/THQ/RHCs for under 5 and Basic and comprehensive EMONC clinics	% of C/B EmONC Clinics established		140	140	140	140	140	140	MNCH Program
2.2.2	2.2.2 Provision of Long Lasting Insecticide Nets to all Pregnant women and adolesent girls(Malaria high risk districtrs 11)	% Pregnant women and adolesent girls ProviDED Long Lasting Insecticide Nets			415983 6	415983 6	41598 36	41598 36	415983 6	Malaria Program
2.2.3	2.2.3 Provision of essential RMNCAH drugs to all DHQ/THQ/RHCs.	% of DHQs, THQs and RHCs provided essen-tial medicine		140	140	140	140	140	140	MNCH Program
2.2.4	2.2.4 Establish the NICUs through provision of equipment and supplies at DHQs	% of NCIUs established	4	11	2	2	2	2	3	MNCH Program

2.2.5	2.2.5 Recruitment of the LHVs in Rural Health Centers to ensure 24/7 Basic EmONC services (3/RHC) and atleast for 2 RHCs in every districts	% of required staff inducted		30 LHVs for 30 prioritzed RHCs	10	10	10	0	0	MNCH Program
2.2.6	2.2.6 Induction of HR for providing 24/7 CEmONC services at DHQ/THQ in rural districts as per requirement (gynecologist,pediatrician,anesthetist, WMOs, Nurses, LHVs,OTT, BBT, Lab tech,aya, sweepers)	% of required staff inducted		38	7	7	7	7	10	DoH/MNCH Program
2.2.7	2.2.7 Secure Incentivise (top ups) for the services of the MNCH staff to ensure cEMONC services in rural and hard to reach districts DHQs based on PC1	% of staff provided incentives	0	17 districts						DoH/MNCH Program/
2.2.8	2.2.8 Construction of residence for female staff at DHQ hospitals (Bunglows and Quarters) in district Zhob, Gwadar, Harnai, Panjgoor, Sibi, Nushki, Nasirabad.		0	7 Bunglows and 12 Quarters	2 bunglows 4 quarters	3 bunglows and 4 quarter	2 bunglows and 4 quarters	0	0	MNCH Program
2.2.9	2.2.9 Provision of alternate energy resources (solar penals) for PHC facilities to run labor rooms/OT/gyne/obs wards/Pediatric wards/basic lab equipments			140	28	28	28	28	28	MNCH Program/DoH

Expected Outcome 2.3: Improved referral mechanism involving all health care levels to ensure continuum of care

S.No	Activities	Indicators			Target by year					Responsible
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
2.3.1	Provision ambulances to RHCs for referral of cas-es.		72	102	10	10	10	0	0	MNCH Program
2.3.2	Establish referral desks and data bases at DHQ/THQ/RHCs through provision IT equipment		15	140	20	26	26	26	35	MNCH Program
2.3.3	Training of the staff of DHQ/THQ/RHCs on maternal and child health referral data recording and dissemination		0	140	20	26	26	26	35	MNCH Program

Expected Outcome 2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
2.4.1	Strengthen M&E/supervisory tiers at various level (provincial/divisional/district (through Deputy Directors at DGHS office/Provincial Coordinators/divisional directors/ district team/ HCF teams)			Structure in place						DoH
2.4.2	Develop provincial, divisional, district and facility level M&E supervsion plans, ToRs and reporting formats/Checklists		ToR/Plans not develped	ToRs/Plans in place						DoH
2.4.3	Review of the M&E feedback reports and reccomendation to the DoH for rectification			review meetings held	4	4	4	4	4	DoH

Expected Outcome 2.5: Inclusion of IMNCI/PCPNC/ENC WHO protocols in pre-service training.

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
2.5.1	Inception workshop for medical schools to re-view the IMNCI/PCPNC/ENC pre-service experience in Balochistan. Medical colleges and Public health schools		1 (Bolan Medical College (IMNCI)	1/Bolan Medical Collgeg (PCPNC)/5 pub-lic health schools/3 nursing schools	1	3	5	0	0	MNCH Program
2.5.2	In-depth orienta-tion/planning to strengthen the IMNCI/PCPNC/ENC teaching in all Medical Colleges (Bolan, Loralai, Khuzdar and Turbat medical colleges) and 5 Public health schools			Bolan medical college/5 public health schools/3 nursing schools	1	3	5	0	0	DoH
2.5.3	Training of teaching staff (IMNCI/PCPNC/ENC, One Facilitator Course)			66	30	4	20	12		DoH

2.5.4	Training of teaching staff (IMNCI/PCPNC/ENC (CME or Facilitator Course)	% of staff trained	0	4 Courses Each	1 for Each Course	3 for Each Course				DoH

Expected Outcome 2.6: Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities

S.No	Activities	Indicators			Target by year					Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020	
2.6.1	Provision of solar ILRs to PHC facilities at UC level with no electricty, where electricty is available for more than 8 hrs and where load shading more than <8hrs till 2017. (As per PC1 (EVM IP)		46	201 for Ucx with no electricty 118 for Ucs where electicity shortage is for more than 8 hrs. 172 for UC where at least 8 hrs electricity is available		179 for Ucs where there is no electricity. 118 for Ucs where < 8HRs electricty shortage. 172 for Ucs where shorateg of electricty is > 8 HRs				EPI Program
2.6.2	Ensuring timely availability of funds for EPI vaccines as per updated schedule (PC1)				360.15 million	516 million	817 million	1043 million	1283 million	GoB/GAVI

2.6.3	Ensure resource allocation for Periodic review of EPI performance at various levels as per PC1		0	review meetings held 4/year provinical and 12 /district level	7.2 million, 3.6 million	8 million, 4 million	8.7 million, 4.3 million	9.6 million, 4.8 millio	10.5 million, 5.3 million	EPI Program
2.6.4	Ensure Refresher training for the EPI staff through allocation of funds as per PC1		0	1000 staff	0	0	7.5 million	0	0	EPI Program
2.6.5	Monitoring and supervision mobility support		0	Monthly district visits. Quarterly by provincial level						EPI Program

Objective 3: Overcoming financial barriers to care seeking and uptake of interventions

Expected Outcome 3.1: Improved & strengthened coordination of the existing social safety nets

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
3.1.1	Pilot Social security regulation (Bait-ul Maal, Social welfare									GoB Dept of Social Welfare/Zakat/BISP

	department, Zakat department, BISP etc) to develop linkage of benefits with utilization of primary and secondary healthcare on priority									
3.1.2	3.1.2 Pilot revisit and revise the beneficiaries of the existing public social nets for equitable distribution among the communities and scale up		1 district							GoB Dept of Social Walfare/Zakat/BISP

Expected Outcome 3.2: Provision of equity based health Insurance coverage to the people

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
3.2.1	Introduce voucher scheme for the natal services at community level in 4 districts and rollout to 6 more districts (10 dis-tricts		0	10 districts	4	1	1	2	2	DoH

Objective 4: Increase in funding and allocation for RMNCAH

Expected Outcome 4.1: Increase resource allocation and mobilization for RMNCAH and nutrition programs

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
4.1.1	Advocacy with the Political leadership and relevant Govt. dept.(P&D Finance and Health) on RMNCAH and Nutrition Program adequate fund allocation.									DoH

4.1.2	Advocacy with international donors for redirecting their priority towards RMNCAH and Nutrtition in the province in the light of RMNCAH/N 2016-2020 strategy..			opportunity based						DoH/MNCH Program/Nutrition Program/KHW Program

Expected Outcome 4.2: Improvement in mechanism and capacity of the province to absorb and utilize the available resources

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
4.3.1	Development of the biannual budgeted workplans for the RMNCAH/EPI/LHW/ Nutrition Programs for timely implementation									DoH
4.3.2	4.3.2 Capacity buidling of the DDOs and their Account Officers on efficient uitlization of available funds, monitoring of resources and audits		0	125 Health Managers with DDO authority						DoH

Objective 5: Improve reproductive health including family planning

Expected Outcome 5.1: Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
5.1.1	Strengthen the Provincial and districts coordination committee comprising of Population Development and Health department to oversight/review for better coordination in planning, procurements and service delivery		0	20 meetings in 5 years	4	4	4	4	4	DoH/PWD
5.1.2	Integration of the FP and RMNCAH/N/MH services at service delivery level (RHS and FWC integration with HCFs in the catchment) i.e.provision under one roof in health facilities		0	Integration of 102 RHCs and 79 FWCs (181)	36	36	36	36	36	DoH and PWD

Expected Outcome 5.2: Strengthened systems for FP and RH through regular provision of commodities for all levels/ capacity building of the HCPs/Enhanced funding for FP

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
5.2.1	Provision of FP supplies (contrceptives) to all level integrated FP/RMNCAH PHC facilities and community health workers (LHWs/FWW) including latest techniques like implants									PWD/LHW Program
5.2.2	Capapcity buidling of the HCPs at the RHS (A), MSU and FWCs on latest FP methods i.e. Im-plants (femiplants/D Jars/Jadelle)		0	55 WMOs/ 170 FWCs/ 12 FTO/						PWD dept
5.2.3	Refresher training on RH-FP of th FWWs/FTO		0	225	45	45	45	45	45	PWD
5.2.4	Provision of equipment to the FWCs		0	170	170					PWD
5.2.5	Establishment of Center of Excellences for Balochistan 6 districts Naseeabad, Gwadar, Killa Abdullah, Killa Saifullah, Sibi and Khuz-dar		0	6	2	2	2	2	2	PWD

5.2.6	Refresher training of the HCPs on Reproductive Health/Family Planning at PHC facilities (Gynecologists/LHVs/LMO/FMTs/midwives)		0	969	193	193	193	193	194	MNCH Program/PWD
5.2.7	Strengthening of RTI through: hiring of qualified tutors		0	10						
5.2.8	a through: hiring of qualified tutors		0	10	5	5				
5.2.9	Provision of teaching Aid		0	1						
5.2.10	Construction of Warehouse									

Objective 6: Investing in nutrition especially of adolescent girls, mothers and children

Expected Outcome 6.1: Reduction of Micro Malnutrition among Adolescent girls, Pregnant and Lactating Women(PLW) with more focus on 07 food insecure districts in the province

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
6.1.1	6.1.1 Daily Iron and Folic Acid (IFA) supplementation for Pregnant and Lactating Women and preconception care in Adolescent Girls		49% (NNS 2011)	29%	45%	41%	37%	33%	29%	Provincial Nutrition Cell
6.1.2	6.1.2 Intermittent Folic Acid and Iron supplementation for Adolescent Girls									Provincial Nutrition Cell
6.1.3	6.1.3 Provision of Multiple Vitamins Supplementation to CBAs and adolescent girls									Provincial Nutrition Cell
6.1.4	6.1.4 Training of District Master Trainers on IFA				7	7	7	0	0	

6.1.5	6.1.5 Training of District Master Trainers of NGOs on IFA				7	7	7	0	0	
6.1.6	6.1.6 Training of Health Facility staff on IFA				28	28	28	0	0	
6.1.7	6.1.7 Training of LHWs, CMWs on IFA at district level				70	70	70	0	0	
6.1.8	6.1.8 Training of NGO's CMWs on IFA				14	14	14	0	0	

Expected Outcome 6.2: Promotion of Good IYCF Practices (6-23 months)

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						

6.2.1	6.2.1 Promotion of Early initiation of Breast Feeding		63% (NNS 2011)	78%	66%	69%	72%	75%	78%	Provincial Nutrition Cell
6.2.2	Protection and Promotion of exclusive Breast Feeding		27% (NNS 2011)	52%	32%	37%	42%	47%	52%	Provincial Nutrition Cell
6.2.3	Continued Breast Feeding until upto 6-24 Months		72% (NNS 2011)	87%	75%	78%	81%	84%	87%	Provincial Nutrition Cell
6.2.4	Establishment of Breast feeding cornors in public health facilities (30 DHQs, 102 RHCs and 600 BHUs		0%	100%	30	102	600			Provincial Nutrition Cell
6.2.5	Training of the District Master trainer on IYCF				7	7	7	0	0	Provincial Nutrition Cell
6.2.6	6.2.6 Training of LHWs, CMWs on IYCF component at district level				70	70	70	0	0	Provincial Nutrition Cell
6.2.7	6.2.7 Training of Health Care Facility staff on IYCF component at district level				28	28	28	0	0	Provincial Nutrition Cell

6.2.8	6.2.8 Training of LHS on IYCF and monitoring				14	14	14	0	0	Provincial Nutrition Cell
6.2.9	6.2.9 Training of District Master trainers of NGOs on IYCF for uncovered area				7	7	7			Provincial Nutrition Cell
6.2.10	6.2.10 Training of CHW of NGOs on IYCF				14	14	14	0	0	Provincial Nutrition Cell

Expected Outcome 6.3: Reduction of General and Micro Malnutrition among Infants (0-23 months) and Children(6-59 months) through Out Patient and In Patient management of SAM children

S.No	Activities		Indicators	Target by year	Responsibility

		Description	Baseline	Target	2016	2017	2018	2019	2020	
6.3.1	6.3.1: Out Patient Therapeutic Program(OTP) for SAM Children at Community Level		16.1% (NNS 2011)	11%	15%	14%	13%	12%	11%	Provincial Nutrition Cell
6.3.1.1	6.3.1.a: Establishment of OTP in districts through provision of supply and equipment			42	10	10	10	12	0	Provincial Nutrition Cell
6.3.1.2	6.3.1.b: Procurement and distribution of RUTF				2000	2000	2000	2000	2000	Provincial Nutrition Cell
6.3.2	6.3.2: Stablization Centers			7 DHQ Hospitals	7	0	0	0	0	Provincial Nutrition Cell
6.3.2.1	6.3.2.a: Establishment of Stabilization centers at DHQ hospitals for SAM with complication through supplies and equipment									Provincial Nutrition Cell
6.3.2.2	6.3.2.b: Procurement and distribution of F75				350	350	350	350	350	Provincial Nutrition Cell
6.3.2.3	6.3.2.c: Procurement and distribution of F100				700	700	700	700	700	Provincial Nutrition Cell

6.3.3	6.3.3: Iron Supplementation from 6-23 months for Anaemia through general OPDs and pharmacy		57% (NNS 2011)	32%	52%	47%	42%	37%	32%	Provincial Nutrition Cell
6.3.4	6.3.4:Provision of Micro Nutrients Powder Sachet		40% (NNS 2011)	25%	37%	34%	31%	28%	25%	Provincial Nutrition Cell
6.3.5	6.3.5: Zinc Supplementation									Provincial Nutrition Cell
6.3.5.1	6.3.5.a: Training of master trainer for Zinc during diarrhea for 7 food in secure districts		0	105 master trainers	35	35	35	0	0	Provincial Nutrition Cell
6.3.5.2	6.3.5.b: Training of Health facility staff at district level			420 HCPs	140	140	140	0	0	Provincial Nutrition Cell
6.3.5.3	6.3.5.c: Training of LHWs, CMWs at facility level			1750 LHWs and CMWs	350	350	350	350	350	Provincial Nutrition Cell
6.3.5.4	6.3.5.d: Training of district master trainers of NGOs at district level			84 personels	42	42	0	0	0	Provincial Nutrition Cell

6.3.5.5	6.3.5.e: Training of NGOs CHWs at facility level			350 persons total	116	116	118	0	0	Provincial Nutrition Cell

Objective 7: Investing in addressing social determinants of health

Expected Outcome 7.1: Multispectral approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH/Nutrition/mental health issues in women and adolescent girls at district level

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
7.1.1	7.1.1 Increase coodination with Social Welfare, Education, Public Health Engineering departments, live stock deparments on health and hygeine (WASH, vector borne and disease surveillance, vaccination and reproductive health) issues at the district level			Biannual meetings						DoH/Education/PHE/Live Stock dept
7.1.2	7.1.2 Revise and update health education/Promotion modules (including IPC) for HCPs and community on comprehensive messages on RMNCAH/Nutrition and social determinants like fe-			Health education/Promotion modules revised						DoH

	male literacy and women empowerment.									
7.1.3	7.1.3 Training of the facilitators and HCPs on revised modules		0	5655	1131	1131	1131	1131	1131	DoH
7.1.4	7.1.4 Involvement of human rights and other civil society through seminars/ official meetings to link their slogans and campaigns to RMNCAH/Nutrition/Mental Health issues in women, adolescent girls and children along social determinants like female literacy and economic empowerement at district and provincial level									DoH
7.1.5	7.1.5 Strengthen Health/education Promotion cell in DoH									DoH/Education/PHE/Live Stock dept

Expected Outcome 7.2: Legislation done supporting mandatory female education and abandon early age marriages

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						

7.2.1	7..2.1 Advocacy for legislation in provincial assembly for mandatory female enrollment in schools.									Woman development department
7.2.2	7.2.2 Advocacy for legislation for ban on early age girl marriages (before 18 years) and notifying it as crime and punishable act by law									GoB
7.2.3	7.2.3 Advocacy for legislation for Thalassemia cases blood testing (CBC) testing and Hemoglobin Electrophoresis for confirmation if required.		0	32 districts	6	6	6	6	8	GoB
7.2.4	4 Mass awareness campaigns for awareness on passed laws for mandatory female school enrollment, ban on early girl marriages and mandatory pre-marriage thalassemia screening			biannual campaigns and continuous media advertisements						

Objective 8: Measurement and action at district level

Expected Outcome 8.1: Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH and Nutrition indicators

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						

8.1.1	8.1.1 Formulation of DHIS Review committee to review existing system to eliminate insignificant indicators and include missing indicators on RMNCAH and Nutrition related mortalities and mor-bidities (both Health facility and community based)									DHIS/DOH
8.1.2	8.1.2 Integrate fragemented MISs for various programs into existing DHIS (LHW-MIS, EPI, DHIS, CMW-MIS, NIS, TB MIS, HIV/AIDS MIS, Malaria etc)		0	4		2	2			DHIS/MNCH/ Nutrition/LHW Program
8.1.3	8.1.3 Review and revisit the primary data collection tools and entry protocols to allign with the revised DHIS									DHIS/MNCH/ Nutrition/LHW Program

Expected Outcome 8.2: Improved data quality (Reporting timeliness and completeness and 2 way feedback mechanism)

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
8.2.1	8.2.1 Nomination of the dis-trict focal person for DHIS		0	32						

8.2.2	8.2.2 Capacity buidling of the DHIS focal person, Provincial Coordinators, and IT persons at all levels on the revised RR tools.		0	100						DOH/DHIS
8.2.3	8.2.3 Strengthen two way feedback mechanism through sharing the findings of DHIS cell in monthly re-ports/bulleitins									DOH/DHIS
8.2.4	Capacity building of the facili-ty based and community based health workers on data recording on revised formats.		0	12800		3200	3200	3200	3200	DOH/DHIS

Expected Outcome 8.3: Improved investigation and response mechanism (MNDSR) at provincial level and priority districts (based polio audit model

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
8.3.1	Pilot MDSR in the province and scale up		0	1	1	0	1	1	1	MNCH/ LHW/DHIS Program
8.3.2	Notify maternal, newborn and child mortalities and morbidi-ties as essentially notifiable events through DHO office and eligible for MNDSR at									DOH

	district levels (Polio case audit model can be considered) (benchmarks needs to be developed for various level MNDSR initiation)									
8.3.3	Constitute and support (logisitics) the district health response teams to respond any outbreak/ high maternal, neonatal and child mortality investigation indicated in DHIS/alerts through DHO Office									DoH

Expected outcome 8.4: Data disseminated to support formulation of evidence based policies

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	**Baseline**	**Target**						
8.3.1	8.4.1 Generate and share the monthly reports and annual bulleitins of DHIS with all the districts managers, vertical programs, health response team and policy making circles for evidence based planning		0	1	1	0	1	1	1	DHIS Program

Objective 9: National Accountability and oversight

Expected Outcome 9.1: Effective oversight mechanism of the RMNCAH/N Program in place.

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
9.1.1	9.1.1 Strengthen the oversight/steering committee on RMNCAH/Nutrition for quarterly review of the programs progress in terms of implementation and outcomes			regular quarterly meetings	4	4	4	4	4	GoB
9.1.2	9.1.2 Link the monitoring and evaluation reports to accountibility frameworks in place at all levels in DoH			the progress linked to accountibility and carreer						DoH
9.1.3	9.1.3 Capacity building of the monitoring and evaluation team at all levels in DoH			125 Health Managers and DDOs at avrious level	0	0	60	65	0	DoH

Expected outcome 9.2: Effective accountability framework in place and in vogue

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
9.2.1	Institutionalization of KPIs to improve governance & accountability mechanism at provincial,district and HCF levels			KPI fromulated for posting and transfers						DoH/GoB
9.2.2	Development of Provincial CoIA framework			Framework developed						DoH/GoB
9.2.3	Implementation of COIA framework			Framework implemented at all levels						DoH/GoB

Objective 10: Generation of the political will to support MNCH as a key priority within Sustainable Development Goals

Expected Outcome 10.1: RMNCAH and Nutrition being recognized as priority area in development agenda and increased political will and support for RMNCAH and Nutrition from political leadership in policy making, planning and resource allocation

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
10.1.1	10.1.1 Advocacy and orientation of the politicians, members of standing committees on health and population issues and policy makers through short in-session breifings on health programs (RMNCAH/Nutrition/EPI)	% of awareness meetings conducted	0	Atleast 1 per Quarter	4	4	4	4	4	DoH
10.1.2	Advocacy for creation of support group for health among parliamentarian		0							DoH
10.1.3	Observational inter-provincial visits for parliamentarians on health systems		0	2/year or need based	2	2	2	2	2	DoH