

Report

2-Days Consultative Workshop of “National Child Health Forum”



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Report of

2-Days Consultative Workshop of

National Child Health Forum

Organized by

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In collaboration with

**World Health Organization (WHO) and
UNICEF**

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Background

Infections including pneumonia, sepsis and meningitis in infants below the age of two months (young infants) caused over 560,000 deaths in 2015. An estimated 6.9 million episodes of possible serious bacterial infection (PSBI) occurred in 2012. In many low resource settings inpatient care is neither feasible nor acceptable for many families. To address this issue WHO developed a guideline for the treatment of sick young infants with PSBI when referral is not feasible. WHO supported implementation research (IR) to learn how to scale up the new guideline in selected countries in Africa and Asia including Pakistan. IR was conducted over a period of 15 months in two districts of Sindh. After the IR experience the PPHI leadership in Sindh decided to scale up the management of PSBI when referral is not feasible and decided that it should be done through implementation of IMNCI. They requested WHO for assistance in updating the Pakistan IMNCI materials to include management of PSBI when referral is not feasible.

WHO in consultation with federal and provincial ministry of health supported revision of Pakistan IMNCI materials to include all recent WHO updates including new WHO guideline for management of PSBI when referral is not feasible in the young infant component. Additionally, IMNCI materials were adapted for an abridged/shorter course to facilitate scale up upon request from programme managers/policy makers who found 11 days course more resource intensive (human and financial). A pilot training of IMNCI facilitators was held in August 2017 with end of course evaluation using writing tests. Abridged course will be very useful for achieving IMNCI implementation at large scale as it will place less financial and human resource burden on the health system.

Under the leadership of Federal Ministry of National Health Services, Regulation and Coordination and in close collaboration with Sindh Department of Health, WHO and UNICEF organized 2-day National Child Health Forum on 19-20 September 2017, with the following three objectives.

1. Present PSBI IR preliminary results and implications for policy and scale-up.
2. Present final update on IMNCI for Pakistan and endorsement for nation-wide use.
3. Present results from pilot training of IMNCI abridged course and endorse next steps.

Participants: (Annex-I-List of Participants)

Participants from following departments/institutions attended event;

- Ministry of National Health Services, Regulation and Coordination
- Provincial and Area Health Departments
- MNCH Program Managers from all provinces and areas
- Pediatricians and neonatologist
- Pakistan Pediatric Association
- Partners working on child health both from Islamabad and Sindh offices (e.g. UNICEF, USAID, JSI, Save the Children etc.)

- Academia and medical schools engaged in Pre-service IMNCI
- Members of the IMNCI National Taskforce
- PPHI

Proceedings of the National Health Forum (Annex II-Agenda)

Day 1-Possible Serious Bacterial Infection (PSBI)

Dr. Atiya Aabroo, Deputy Director, National Health Services, Regulation and Coordination inaugurated the workshop by inviting Dr. Khwaja Masoud for recitation of few verses from Holly Qurran. Dr. Sara Salman, Head WHO Sindh office, welcomed the participants to the two day child health forum. Dr. Baseer Khan Achakzai, Director Nutrition, MoNHSR&C Islamabad, appreciated the efforts towards providing a platform to discuss the important issue of children's morbidity and mortality. He emphasized that collaborative efforts by all partners can bring about positive change and government is committed to take actions for health reforms. Dr. Kennedy Ongwae, Health Expert, UNICEF Pakistan shared that they have already started continuum of care in an integrated manner for improving the health of children. He further highlighted that project of GAPPD in Sindh will positively impact the deaths of children under 5 years of age.

Session was chaired by Director General Health Services, Sindh Dr Muhammad Akhlaque Khan, who in his welcome speech reflected the growing concerns over high infant morbidity and mortality. He acknowledged the efforts of WHO for supporting the revision of IMNCI guidelines, introducing the abridged course, inclusion of PSBI component and conducting pilot training in collaboration with Child Survival Program and Government of Sindh in Karachi last month. He further announced that DoH Sindh is committed to initiate under-5 clinics at district headquarter hospitals, by the end of this year.

Dr Shamim Qazi, Medical Officer, MCA/WHO Geneva explained the objectives of the first day of the workshop: (1) share global learning and progress on PSBI implementation research in African and Asian countries ; and (2) share lessons and best practices from the implementation research in Sindh.

Status of newborn and child health in Pakistan

Dr Sabeen Afzal, Deputy Director, National Health Services, Regulation and Coordination gave a presentation on status of newborn and child health in Pakistan. She reminded participants that Pakistan has adopted the UN's Sustainable Development Goals and approved the target for SDG Goal 3. She then presented data from PDHS 2012-13, which showed child mortality rate (CMR) at 89 per 1000 live births, infant mortality rate (IMR) at 74/1000 live births and neonatal mortality rate (NMR) of 55/1000 live births. Both CMR and IMR have shown improvements, however, NMR has remained stagnant over the two decades. Mortality rates in all categories were higher in rural areas than in urban areas. Mother's education was inversely related to child mortality. A strong

relationship was also observed with the length of the previous birth interval. Birth asphyxia (40%), sepsis (20%) and prematurity (17%) constituted 3/4th of all causes of neonatal mortality.

The government of Pakistan has taken various steps to address the child health situation, which includes: establishment of Lady health Worker's program; development of IRMNCAH-N vision in consultation with all stakeholders and budgeted provincial plans; development of Pakistan health information dash board; revision of essential drug list to include RMNCH commodities; successful implementation of RMNCH trust funds; and review and updating of IMNCI guidelines. Several new initiatives under Essential Newborn Action Plan have been taken, which include: introduction of chlorhexidine for umbilical cord care and Kangaroo Mother Care; establishing and equipping of model sick new born care units; and procurement and distribution of baby warmer's, bag and mask for resuscitation of newborn.

Dr Sabeen also presented the constraints faced by the national and provincial health authorities. She noted the financial constraints, i.e. low public sector pending on health; high out of pocket expenses; and delayed releases of funds. She mentioned political challenges, which include weak governance and public accountability, low priority and investment on social sectors, and hasty devolution. Health system challenges highlighted include: shortage and distribution of appropriately qualified staff, weak technical guidance, program management and supervision, inadequate supplies of drugs and medical equipment, poor and unreliable data and reporting mechanisms.

She also highlighted the existing opportunities which include delivery of PHC services at the doorsteps of the community by LHWs; expansion of community mid wives deployment; integration of services, decentralization, introduction of Essential Health Services Package (EHSP), web base dash boards at provincial and federal level and integration of various health information system.

She concluded her presentation with prospective steps/actions for the child health agenda in Pakistan. Finally she put forward steps for moving forward, which include: mobilization of resources for implementation of newborn action plan and scaling up of evidence based interventions, establishment of results based monitoring system for newborn and child health , operationalization of the National and Provincial Technical Working Groups for technical support and capacity building for maternal and perinatal death audits.

WHO Guideline – Management of PSBI when referral is not feasible

Dr Shamim Qazi, Medical Officer, MCA/ WHO/HQ presented the background and basis for simplified management of sick young infants with possible serious bacterial infection (PSBI) when referral is not feasible. He stated that according to regional estimates, 19% of neonatal deaths in South East Asia were caused by neonatal sepsis. However, AMANHI (The Alliance for Maternal and Newborn Health Improvement) study data from 2016 show that neonatal sepsis is responsible for 36% of all deaths in the neonatal period. The 2012 systematic review and meta-analysis published in Lancet in 2014

showed that estimated 6.9 million cases of PSBI occurred annually, of which 3.4 million cases occurred in South Asia, 2.6 million in sub-Saharan Africa and 0.8 million in Latin America.

The WHO PSBI criteria includes: Fast breathing (respiratory rate ≥ 60 breaths/min); Chest in drawing; Fever (temperature ≥ 37.5 C); Hypothermia (temperature < 35.5 C); No movement at all or movement only on stimulation; Feeding poorly or not feeding at all; and Convulsions. The current management of PSBI based on clinical experience and expert opinion is referral to hospital for injectable therapy for 7-10 days with up to five injections /day. It has a single regimen irrespective of severity.

He highlighted the importance of hospital treatment for sick infants with sepsis and the challenges for accessing such treatment. Data from several African and Asian countries show that referral is not accepted by families for 68-98% cases of PSBI. Dr Qazi emphasized that infections are common and recommended treatment is often not available or accessible to many.

WHO sponsored studies in Asia and Africa have shown that health workers at first level facilities can safely treat sick infants with PSBI. The evidence generated from the studies led to the development of the WHO guideline on management of young infants with PSBI where referral is not feasible. The WHO guideline recommends: use of antibiotics for neonates and young infants (0-59 days old) with PSBI to increase access to treatment and to reduce mortality; provides clinical guidance on use of safe and effective simplified antibiotic regimens for outpatient treatment of less severe infections; provides programmatic guidance on the role of CHW and home visits in identifying signs of PSBI.

WHO Guideline Recommendations

- a. During home visits made as part of postnatal care, CHWs should counsel families on recognition of danger signs, assess young infants for danger signs of illness and promote appropriate care seeking.
- b. Young infants 7-59 days old with fast breathing as the only sign of illness should be treated with oral amoxicillin, 50 mg/kg per dose twice daily for 7 days, by an appropriately trained health worker.
- c. Infants 0-6 days with fast breathing as the only sign of illness should be referred to hospital. If referral is not accepted, they should be treated with oral amoxicillin, 50 mg/kg per dose twice daily for 7 days, by an appropriately trained health worker.
- d. Young infants 0-59 days old with clinical severe infection whose families do not accept or cannot access hospital care should be managed in outpatient settings with intramuscular injectable gentamicin 5-7.5 mg/kg per once daily and oral amoxicillin, 50 mg/kg per dose twice daily for 7 days by an appropriately trained health worker
- e. Young infants 0-59 days old who have any sign of critical illness (at presentation or developed during treatment of clinical severe infection) should be hospitalized after pre-referral treatment.

Dr. Qazi stated that although the African Neonatal Sepsis Trial (AFRINEST) and Simplified Antibiotic Therapy Trial (SATT) were quite large (up to 3 million people), they were not at scale. Also, despite availability of policy guideline in India and Ethiopia, experience showed that implementing the policy guidelines was quite challenging. Therefore it is essential to have technical back up and support for scale-up.

To facilitate implementation at scale of the WHO recommendations, implementation research with a partnership between Technical Support Unit (TSU) comprising of technical experts – pediatricians/neonatal units with trained health workers to provide technical support and program implementers (health Centre staff, District Managers, Provincial/State and National Managers) was conducted in selected countries including Pakistan.

Learning from ongoing PSBI implementation research in Asia and Africa

Dr Samira Aboubaker, Medical Officer, MCA/WHO/HQ presented the learning from ongoing PSBI implementation research in Asia and Africa. She stated that the objective of implementation research was to introduce an innovative approach for demonstrating and accelerating the use of simplified management of sick young infants up to two months of age with possible serious bacterial infection for eventual scale up in selected countries. The objective of this innovative approach was to demonstrate that – all health facilities can provide simplified outpatient management of PSBI, with the aim that at least 80% of sick young infants receive treatment and 80% of the treated sick young infants receive adequate quality treatment.

Eleven implementation research demonstration sites have been established in Asia and Africa (Bangladesh – 2 sites; Democratic Republic of Congo – 1 site; Ethiopia – 2 sites; Malawi – 1 site; Nigeria – 2 sites; India – 4 sites; and Pakistan – 1 site). In these sites service providers include physicians, nurses, clinical officers and Health Extension Workers (Ethiopia). The key elements of implementation include: policy dialogue and orientation meetings with Ministry of Health (MOH) and other stakeholders at national and subnational levels; establishment of early implementation sites to demonstrate feasibility of delivering simplified antibiotic regimens to young infants with PSBI where referral is not possible; development of partnership between technical experts running the demonstration site and programme managers; pilot implementation in few health facilities in a programme setting as proof of principle.

In all countries policy dialogue and orientation meetings were key step for adopting early implementation. Policy decisions were made to support implementation at PHC level. In Ethiopia, Nigeria & DRC multiple meetings were held to share preliminary results and to initiate discussions on scaling up.

The policy dialogue was accompanied by establishment of TSUs and partnership between the TSU and the programs in all countries. The TSUs included joint planning and joint action between the MOH and the technical experts. The establishment of TSU

created opportunities for understanding programming and challenges in translating evidence into action – learning experience for technical experts especially from the academia. In Ethiopia, Nigeria and DRC the academia facilitated policy dialogue for national adoption and scaling up and problem solving. The TSUs have engaged in capacity building for scaling up and have contributed to introducing PSBI in countries other than their own.

This early implementation experience has generated local evidence to demonstrate feasibility of implementing PSBI within a programme setting where refusal to referral advice in the majority of cases has been documented. In addition, key health system challenges have been identified and in most cases local solutions have been found. Most significantly, thousands of sick young infants have received lifesaving treatment in settings where referral is not feasible.

The results show that early implementation has generated evidence about the feasibility of implementing PSBI within a programme context and it has been possible to make treatment available to the most vulnerable and save many lives. Also, success depends not only on making simplified treatment available at primary health care first but also on implementing interventions that aim for creating demand for services. However, health system challenges remain, in particular: implementation of post-natal home visits; monitoring /clinical mentoring to sustain skills; availability of essential medicines and other supplies; documentation; care seeking and timely identification of sick young infants; improvement of quality of care at referral facility.

Countries including Pakistan have initiated the process of integrating PSBI management into existing national newborn and child health strategies, IMCI guidelines and tools

Results of the implementation research in Pakistan and its implications

Mr Ali Turab, Senior Instructor, Technical Support Unit (TSU), Aga Khan University (AKU), Karachi presented the design and preliminary results from the PSBI implementation research initiative in Sindh Province. He stated that the process in Sindh started with policy dialogue in October 2015 to facilitate the policy adoption for limited implementation. The People's Primary Health Initiative (PPHI) and the Lady Health Worker's (LHW) program expressed keen interest and promised support for pilot implementation. This was followed by MOU between AKU and PPHI on Feb 12, 2016. The AKU received Ethical Review Committee approval on March 02, 2016. A planning meeting with stakeholders (WHO, PPHI, LHWs Program and Department of Health, Sindh) was held on April 08, 2016, followed by district level planning meeting on April 15, 2016. The project activities were rolled out on 25th May, 2016.

The IR was implemented in Thatta and Sujawal districts. Ten health facilities (catchment population of 2.5 million) participated in the study. The expected number of births per year in this population was 6410 with an estimated 10% (641) of infants developing signs of PSBI.

The implementation design followed the WHO recommendation for management of PSBI in outpatient setting when referral is not possible. The LHWs conducted routine pregnancy surveillance to identify births and conduct postnatal home visits on day 1, 3, and 7. In case of identification of YI with PSBI signs the baby was referred to the health facility for assessment. At Basic Health Unit level (BHU) the facility staffs assessed YI referred by the LHWs and those coming directly to the facility. Those with PSBI were referred to the district hospital. In case referral was not accepted, YI with clinical severe infection (CSI) and 0-6 days with FB as a single sign only are offered treatment at the facility after providing consent for treatment. YI with CSI were given injection gentamicin once daily for 2 days and oral amoxicillin twice a day for 7 days. YI with FB only were given oral amoxicillin twice a day for 7 days.

The roles and responsibilities of LHWs and BHU staff were defined. The LHWs were expected to carry out pregnancy surveillance and registration, postnatal home visits on days 1, 3 and 7 and referral to BHU if danger signs were present: BHU staff (PPHI) assesses sick young infants (YI) for PSBI; refers those needing referral after administering a pre-referral treatment, provides treatment for those whose families refuse referral advice and conducts follow up care.

The roles and responsibilities of Technical Support Unit (AKU) include: trainings of BHU staff involved in case management; training of LHW's on identification of signs of illness, administering consent, filling case recording forms; call reminders to families for follow up at BHU; home visits for missed follow up; validation of case management (20%), monitoring and evaluation and coordination amongst partners.

WHO organized a national level training of Master Trainers (TOT) from 5-7 April 2016, which was followed training of health care providers and LHWs by AKU staff in June and August 2016 respectively. PPHI arranged training of 5 additional BHUs other than PSBI health facilities in January 2017.

A total of 5171 YI were assessed at BHUs (735 referred by LHWs and 4436 coming directly). Of these, 1835 were diagnosed as having PSBI or fast breathing (FB). A total of 531 YI had Clinical Severe Infection (CSI) of which 427 (80.4%) refused referral advice and accepted treatment at the facility. Among the 427 treated at the health facility, only one YI died. Of the 104 who accepted referral, 8 YI died. It is important to note that only 37.5% of the 104 who were referred to the district hospital received pre-referral treatment at the BHU.

Two ninety four YI aged 0-6 days were diagnosed as having only FB, of which 276 (93.8%) accepted treatment at the BHU. No deaths occurred in this group. Of the 18 who accepted referral, 2 YI died. Eight seventy eight YI aged 7-59 days had only FB, of which 860 (97.9%) were treated at the health facility. Among these YI only one death occurred. One thirty two YI had critical illness, of which 125 (94.6%) accepted referral to the district hospital. Among these YI, 13 deaths occurred. Of the YI cases managed at the health facility, 58% completed follow-up at home and 42% completed facility follow-up.

Mr Ali presented the challenges faced during implementation. In the beginning the BHU doctor's adherence to PSBI guideline was very low citing busy OPD. TSU staff provided assistance to the doctors in the case management for initial few months. Their role was phased out once doctors were comfortable with providing management. Also, TSU manager and Deputy Manager PPHI provided rigorous feedback and motivation to doctors periodically to implement the management.

Doctors were reluctant to administer injectable ampicillin and gentamicin to sick young infants who had fever. They believed that injections may worsen YI's condition if administered in presence of fever. The TSU and PPHI staff encouraged the doctors for use of injectable antibiotics. PPHI leadership played a crucial role in getting the message across. AKU faculty conducted a consultative dialogue with all doctors and addressed their concerns and motivated them to administer injections.

During the frequently occurring supplementary immunization activities (SIA) pregnancy surveillance by LHWs suffered. This also affected their scheduled post-natal visits, resulting in missed or delayed visits. To improve pregnancy surveillance and post-natal visitation, the TSU and LHW coordinators organized monitoring visits to LHWs. In addition, the TSU staff arranged joint monitoring visits with the Lady Health Supervisors. During such visits, the number of new pregnant women, their outcomes and findings from newborn assessment form were verified and feedback given to LHWs.

Ali ended the presentation with key messages: LHWs identified significant number (35%) of Young Infants with a danger signs; 85% of the Sick YI presenting at BHU with PSBI (Clinical Severe Infections plus Severe Pneumonia) refused referral to higher level health facility and were treated in accordance with the new WHO PSBI guideline. The management with the new guideline greatly improved survival of sick young infants with clinical severe infections and fast breathing.

PPHI development, programme and IMNCI scale-up plan for health facilities

Dr Chandio, Dr Zaib and Mr Dharejo from PPHI presented comprehensively the priorities for PPHI and services provided in Sindh. They shared the IMNCI scale-up plan for PPHI supported facilities in Sindh. PPHI was formed as an autonomous entity in 2007 by the government of Sindh. In 2014 it was granted an independent section 2 company status. PPHI's mandate is restricted to management of primary health facilities. It is managing 1139 facilities in Sindh. Since 2007 PPHI has been able to greatly improve functioning of health facilities. 250 BHUs have been upgraded to provide 24/7 maternity services. The OPD visits have gone up from 7.5 million to 22 million in 2016. In 2007, there were only 47 deliveries in the BHUs, which have increased to 99,447 in 2016. The family planning visits have gone up from 1636 to 3.9 million. PPHI has trained 756 female health providers in Helping Babies Breathe (HBB) program for management of birth asphyxia and established HBB corners in 630 labour rooms. It has trained 638 providers on infection prevention, 740 providers on antenatal care, delivery and postnatal care and 630 providers on family planning implants. For increasing motivation of health providers it has introduced pay for performance. PPHI's training approach is based on group based

trainings, on the job trainings (low dose high-frequency), supportive supervision and on the job coaching and mentoring.

As PPHI health facilities are managing millions of cases of pneumonia, and diarrhea it was important to improve provider skills through introduction of IMNCI. PPHI has the approval from Minister of Health Sindh to introduce IMNCI, including management of PSBI in outpatient settings when referral is not possible. It has included all medicines and equipment needed for implementation of IMNCI. It has developed operational framework for introducing PSBI in its health facilities, which includes establishment of its own Technical Support Unit. A plan has been developed for including PSBI component in DHIS. PSBI indicators have been included as summary of additional services indicators developed by PPHI Sindh, and changes made in the OPD registers.

To move the IMNCI initiative forward training of trainers for IMNCI was conducted in March 2017 in collaboration with WHO. Six day abridged IMNCI training on IMNCI for trainers is planned for November 2017, with trickle down training for staff from 250 upgraded BHUs between October and November 2017. The remaining BHUs staff will be trained in November-December 2017.

The PPHI's training quality monitoring will include pre and post training assessment, random visits of technical wing/M&E wing to evaluate the sessions; in cases where the post test scores of participants are not satisfactory, on job coaching will be provided on priority basis along with supportive supervision, follow up after training visits and monitoring of progress using DHIS, PSBI recording tool data on monthly and quarterly basis.

Dr. Zaib stated that the going forward challenges faced during implementation research would be addressed. There was lack of ownership by the in-charge MOs and the LHW program, for which PPHI will introduce pay for performance mechanism and build strong coordination with the LHW program. Facility and home follow-up and adherence to gentamycin and ampicillin were also an issue, which will be addressed through defaulter monitoring similar to the one PPHI has instituted for EPI defaulter monitoring, improved caregiver counselling, on job training of facility staff .

Day 2 – Integrated Management of Neonatal and Childhood Illnesses (IMNCI)

Dr Nand Lal from the Child Survival Project presented the process of updating the IMNCI materials and experience with the abridged course. He presented the background of IMNCI, its' successful implementation in several countries and its contribution to reduction in child hood mortality. He described some of the barriers to scaling up implementation in Pakistan, the revision/updated of IMNCI materials, development of 6-days duration abridged IMNCI course for implementation in Pakistan, and experience from pilot training of Master Trainers using the abridged course materials. The current abridged shortened course for 6 days was streamlined into four modules with reduced reading as follows.

Module 1 – Introduction and Assess and Classify

Module 2 – Identify treatment and Treat

Module 3 – Follow- up And Counsel the Mother

Module 4 – Assess, Classify and the Treat the Sick Young Infant (includes management when referral is not possible)

A strong emphasis is put on using the chart booklet and 5 days clinical hands on practice.

The overall feedback from the participants from the first master trainers was positive.

i) In terms of the time it takes to complete this module, most (nearly 70%) participants said it was either adequate or manageable; ii) 10% felt they were rushed; iii) the methods of teaching used were generally appreciated (80%); iv) the clinical practice in under five clinic was most appreciated; and v) 82 % felt homework was adequate or manageable; vi) 93% of the participants felt that they were competent to assess and classify a sick child; vii) up to 30% of the participants felt the modules on treatment, follow up, young infant and counselling were rushed; viii) 70% of the participants scored well at the end of the training; and ix) up to 85% of the candidates were confident they can assess, treat and counsel as taught.

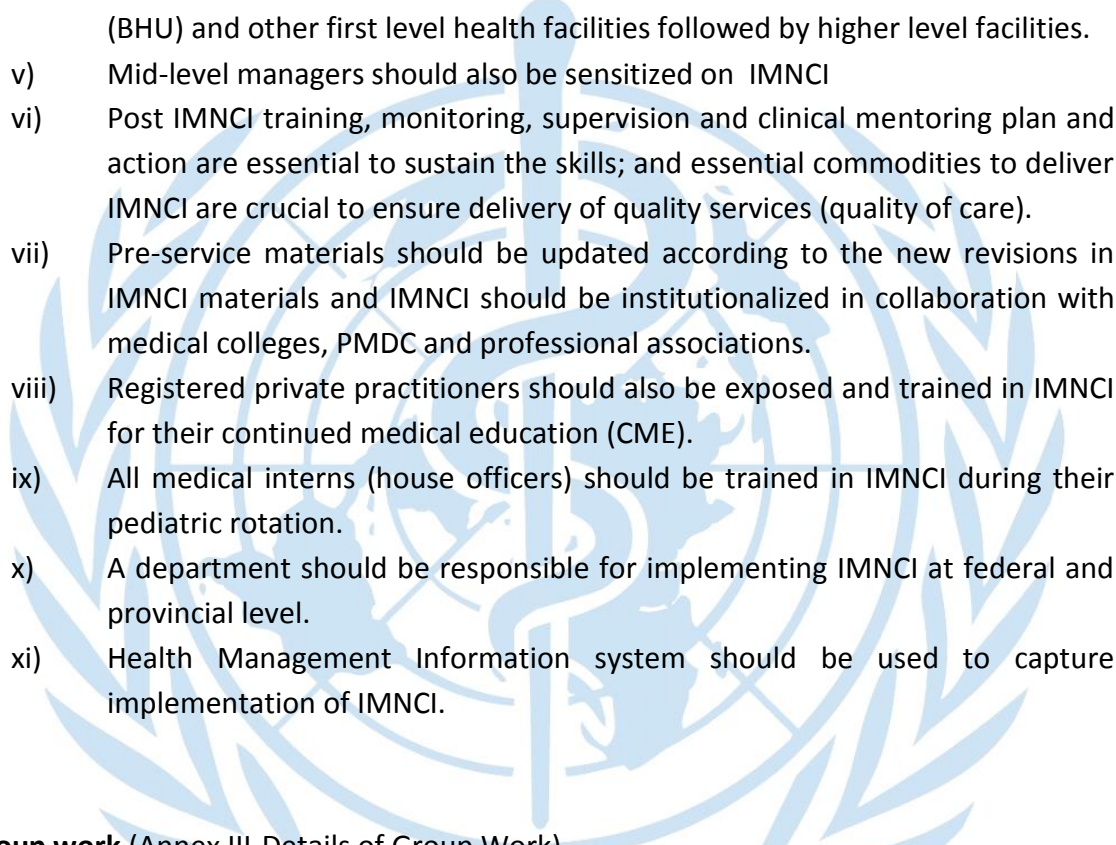
Potential benefits of the abridged course are that i) it is less expensive probably up to 40% as it is only 6 days compared to 11 days standard course; ii) it is as good as the 11 days course as evaluation of other short courses showed similar performance of the trainees and iii) potential of training more health workers, including those in a remote setting. Shorter courses have been developed and used in Afghanistan, Benin, India, Kosovo, Nigeria, Aga Khan Health Services (AKHS) in Northern areas of Pakistan and elsewhere, Sudan, Uganda, Zambia.

Additionally, Dr Lal informed that Sindh province has a pool of more than 2000 health care providers who had received 11-days training during the last decade. However, resource constraints, lack of proper monitoring, non-implementation of IMNCI by trained personnel and lack of sustained supply of essential medicines/equipment remained a challenge.

Dr Lal concluded that i) IMNCI with proper implementation has been successful in contributing to reduction in under five child mortality; ii) there is a dire need of acceleration of IMNCI trainings throughout Pakistan to address relatively slower reduction in U5MR, IMR and NMR by endorsing 6 day training;

Currently in the post pilot phase, the IMNCI materials are being revised and made available for the planned second round of training.

Dr Aboubaker moderated the discussion. Salient discussion points are given below.

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- i) Participants were pleased with revision of IMNCI materials in light of the recent evidence and WHO guidelines.
 - ii) Participants endorsed the revised version of IMNCI training materials and the implementation of abridged course in Pakistan.
 - iii) As PSBI management at outpatient facilities when referral is not feasible is a new area to which most of the health providers have not been exposed, due attention needs to be given to this component in the abridged IMNCI training.
 - iv) Priority for training should be given to the staff working at Basic Health Units (BHU) and other first level health facilities followed by higher level facilities.
 - v) Mid-level managers should also be sensitized on IMNCI
 - vi) Post IMNCI training, monitoring, supervision and clinical mentoring plan and action are essential to sustain the skills; and essential commodities to deliver IMNCI are crucial to ensure delivery of quality services (quality of care).
 - vii) Pre-service materials should be updated according to the new revisions in IMNCI materials and IMNCI should be institutionalized in collaboration with medical colleges, PMDC and professional associations.
 - viii) Registered private practitioners should also be exposed and trained in IMNCI for their continued medical education (CME).
 - ix) All medical interns (house officers) should be trained in IMNCI during their pediatric rotation.
 - x) A department should be responsible for implementing IMNCI at federal and provincial level.
 - xi) Health Management Information system should be used to capture implementation of IMNCI.

Group work (Annex III-Details of Group Work)

The participants were divided into groups to discuss four issues i.e., i) main barriers for implementation and scaling up IMNCI; ii) actions needed to overcome barriers and challenges; iii) steps to be taken to scale up IMNCI and; iv) how to monitor the progress. The groups made following recommendations.

A. Main Barriers for implementation and scaling up IMNCI

1. Political Ownership – there is lack of political ownership for effective implementation across the Health Care System (policy, programming, resource mobilization) financial constraints – there is no allocation within MNCH Programmes for IMNCI and thus it is mostly donor dependent.

2. Human Resource – There are several issues like adequate production of paramedical and nursing personnel, inequity in deployment, poor retention, high turn-overs, gaps in skills and training, ineffective utilization of skilled human resource; poor follow up and monitoring of the post training practices through regular monitoring and linkages with accountability framework (weak accountability all over). Finally there is lack of an appropriate human resource development policy.
3. Health Information System is fragmented with individual programmes having their own management information systems (MIS) and there are multiple data recording tools at service delivery level, making it cumbersome for health care providers. There is lack of integration of existing child-health Programmes such as lady health worker programme (LHW), community midwives (CMW), nutrition, malaria (diarrhea, pneumonia) and EPI. Lot of data is still collected manually from registers.
4. Logistics and supplies are deficient as there is lack of adherence to procurement of IMNCI drugs according to the essential drugs list (EDL) by the provincial departments of health. There is also lack of use and effective integration between logistics management information system (LMIS) and procurement.
5. Leadership/Management - Health managers lack relevant qualifications pertaining to procurement, management and leadership.
Socio-cultural constraints include lack of community mobilization for key family practices through community IMNCI (integrated community case management iCCM) and ineffective social mobilization and community engagement for appropriate and prompt health seeking behavior.

B. Actions needed to overcome barriers and challenges

1. Political Ownership – there is a need for advocacy with the decision/policy makers for effective implementation of IMNCI across the existing health care system; inclusion of IMNCI in Planning Commission document 1 (PC1) and resources from non-development budget (instead of donor dependent development component), and effective translation of the RMNCAH/N Action Plans into Programme PC1s.
2. Financial Constraints - allocation for IMNCI funds should be within the MNCH Programmes (training, supplies and M&E).
3. Human Resource - Development of effective Human Resource Development Plan (focus on production, equitable deployment, retention and accountability);

linking performance appraisals and promotions with IMNCI trainings and practice and development of accountability framework with clear responsibilities; development of IMNCI health care practitioner databases; institutionalization of pre-service through IMNCI abridged courses; effective follow up of IMNCI post training practice through integrated quality of care (QoC) checklists; IMNCI should be a mandatory course for permanent registration from national professional registration councils; and making IMNCI course mandatory as continuing medical education (CME) subject for physician's certification purposes; partnerships of DoH with donors, research organizations and academia.

4. Health Information Management - review demographic health information system (DHIS) indicators for integration of IMNCI indicators; and development of integrated data collection tools; inclusion of IMNCI indicators in the regular progress review meetings at district and provincial levels would be useful for monitoring; and knowledge sharing platform or mechanism to be devised – e.g. website, newsletters – where updated material is made available for which, increased budget should be provided.
5. Logistics and Supplies - earmarking the EDL for procurement at district and provincial level; dedicated procurement units at district and provincial levels are needed where not present; enhance the scope of existing LMIS to include IMNCI commodities; and training of managers on supply chain management, forecasting and PPRA rules.
6. Leadership and Management - reinforcement of Health Management Cadres; and refresher trainings on management.
7. Social and Cultural barriers - implementation of cIMNCI/iCCM; and community engagement activities and plans within MNCH Programmes to improve care seeking.

C. Steps to be taken to scale up IMNCI

1. Policy decision for inclusion of the updated IMNCI in the curriculum of medical (undergraduate and postgraduate education) and allied Institutions; inclusion of IMNCI in pre-service and in-service trainings; professional associations, professional registration bodies (Pakistan Medical and Dental council and Pakistan Nursing Council); college of physicians and surgeons (CPSP) as CME course.
2. Costed action plan and roadmap to be prepared to scale up IMNCI by the Federal government and provincial departments of health (DoH) in consultation with each other.

3. Policy advocacy with the political influencers for appropriate resource allocation
4. All development partners and donors should align with national/provincial government priorities to implement IMNCI in true spirit and synergies their activities for rational use of resources.
5. DoHs should ensure continuous capacity building of all tiers on IMNCI guidelines and protocols; and availability of the equipment and supplies for IMNCI implementation.

D. Monitoring of progress

1. Develop national monitoring and evaluation (M & E) plan for IMNCI implementation; including IMNCI monitoring checklist; integrated provincial M&E framework for IMNCI implementation through provincial DoH; DoH to follow joint monitoring plan to assess IMNCI and other programme implementation.
2. Provincial DoH should develop an IMNCI follow-up mechanism and hold short duration orientations of district managers, master trainers/monitors for IMNCI follow-up
3. All development partners and donors should facilitate the provincial DoHs in joint monitoring
4. Existing Healthcare Commissions (Punjab, Khyber Pakhtunkhwa and Sindh) should be engaged to regulate private practitioners for IMNCI implementation.

UNICEF, Pakistan conducted two studies to analyze gaps in health services delivery system regarding treatment of pneumonia and diarrhea in Pakistan. Two consultants, a financial expert and a supply chain expert presented their findings which showed the gaps that need to be addressed for smooth and effective implementation of service delivery at public health facilities. Most of the gaps were related to procedural delays and lack of capacity on part of managers.

IRD presented the details of pilot eIMNCI introduced at selected health facilities in Karachi and Muzaffargarh. User friendly android based software is designed to record online data of visiting patient. It is translated in Urdu for ease of care providers. Some of the potential benefits of eIMNCI are: i) decreased dependency on quality of training, health workers and supervision ii) better implementation of IMNCI protocols iii) reduced screening and waiting time iv) real time monitoring and v) local adaptation to identify important pediatric diseases. Application has three modes for LHW, Admin and Physician. Using application, LHWs can keep complete track of referrals. Analysis of pilot phase results show that using the application helped in identifying malnourished and unimmunized children.

Concluding session

Dr Aboubaker summarised the key findings and discussions for the chief guest and other esteemed participants.

Federal Director General (DG) Health Dr Assad Hafeez, in his concluding remarks referred to poor MCH indicators for Pakistan. He added that according to latest publication, though Pakistan has shown improvement in vital indicators the pace of improvement is very slow and needs to be enhanced. He appreciated the efforts of partners in organizing such an important workshop and bringing so many experts by providing a platform for discussing child health. He expected that concrete suggestions and actionable recommendations will be presented as a conclusion of this workshop so that MoH may take necessary actions to ensure the implementation of same.

DG Health Sindh, Dr Muhammad Akhlaque Khan thanked all participants for their presence during a very important workshop. He reiterated his commitment towards establishing under 5 clinics at DHQ hospitals of Sindh before end of current year.

Dr Kennedy UNICEF Chief of Health and Nutrition Pakistan mentioned that immunization and child survival will be two key components of the next 5 year plan for UNICEF Pakistan from 2018 to 2022. UNICEF will contribute to implementation of IMNCI in Pakistan. He said that accountability is key to IMNCI implementation success, as it has expanded since its launch in 1998.

Dr Sara Salman Head of Sub Office, Sindh thanked all the participants for spending two days to discuss important issues and recommending valuable action points. Workshop concluded with vote of thanks.

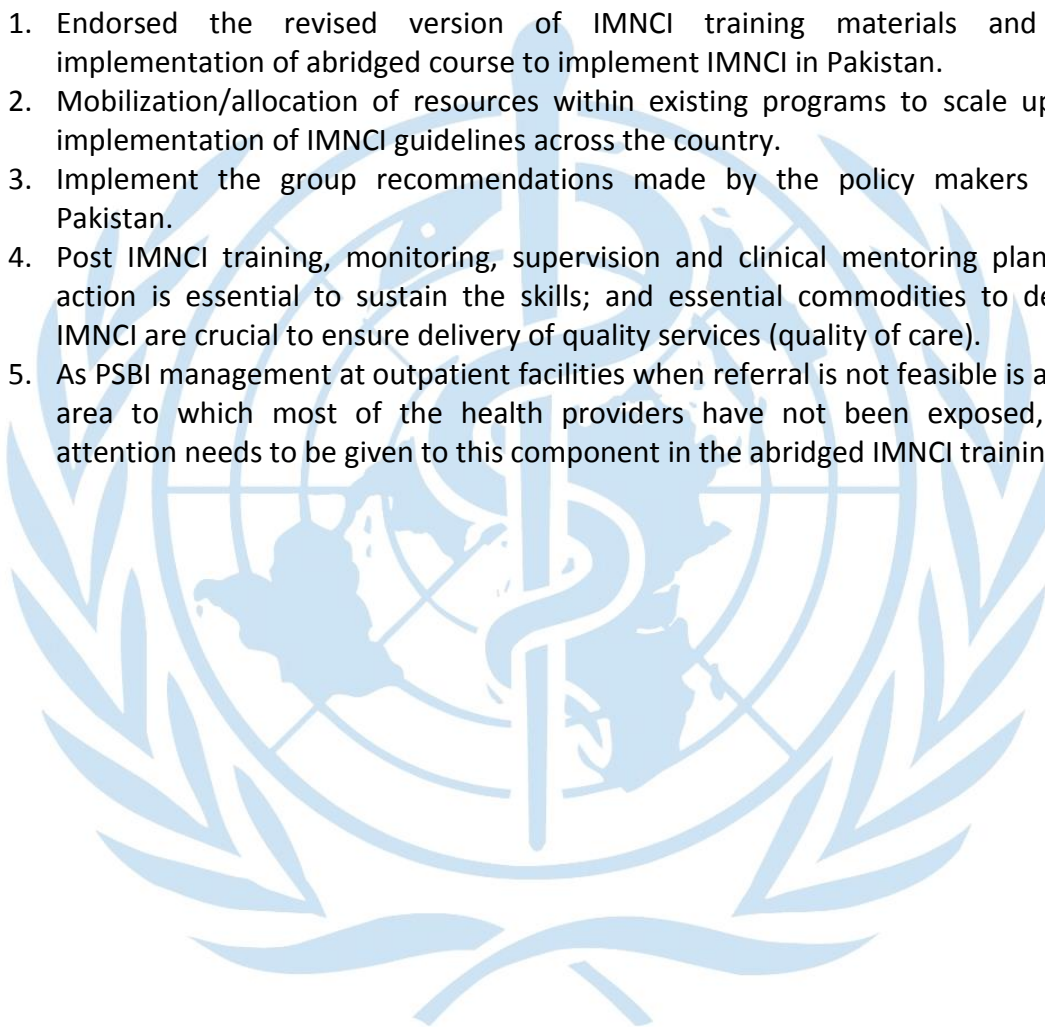
Recommendations/Actions

WHO

1. To provide technical and financial support to finalize the Pakistan specific IMNCI materials and assist in their printing.
2. Collaborate and provide support to other stakeholders such as Federal Ministry and provincial ministries departments of health, Pakistan; UNICEF, PPHI, other NGOs to facilitate and support scale up IMNCI in the country.

Government of Pakistan and other stakeholders

1. Endorsed the revised version of IMNCI training materials and the implementation of abridged course to implement IMNCI in Pakistan.
2. Mobilization/allocation of resources within existing programs to scale up the implementation of IMNCI guidelines across the country.
3. Implement the group recommendations made by the policy makers from Pakistan.
4. Post IMNCI training, monitoring, supervision and clinical mentoring plan and action is essential to sustain the skills; and essential commodities to deliver IMNCI are crucial to ensure delivery of quality services (quality of care).
5. As PSBI management at outpatient facilities when referral is not feasible is a new area to which most of the health providers have not been exposed, due attention needs to be given to this component in the abridged IMNCI training.





Annex-I. Agenda of workshop**DAY 1 - TUESDAY- SEPTEMBER 19, 2017**

Time	Activity	Responsible
8:30	Registration	Participants
9:00	Recitation from Holy Quran	
9:05	Introduction of participants	Participants
Opening Session		
9:15	Welcome remarks	Dr Sara Salman WHO & Dr Ayaz UNICEF
9:25	Objectives of day (PSBI)	Dr Shamim Qazi, WHO HQ
9:35	Opening remarks by UNICEF	Mr. Kennedy Ongwae, UNICEF Pakistan
9:45	Remarks by Federal Ministry	Dr. Baseer Khan Achakzai, Director Nutrition, MoNHSR&C, Islamabad
9:55	Keynote Address by Chairperson of event	Dr. Muhammad Akhlaq, DG Health, DOH, Sindh
10:05	Newborn and Child Health Status in Pakistan	Dr. Sabeen Afzal, MoNHSR&C, Islamabad
10:20	Tea/Coffee	
10:40	Background and basis for management of Sick Young Infants where referral is not possible	Dr Shamim Qazi, WHO HQ
11:00	Discussion	
11:30	Lessons learnt from other countries	Dr Samira Aboubaker, WHO HQ
11:50	PSBI Implementation Research in Sindh Province	AKU Team
	Description of Implementation Research	Dr Sajid Soofi, AKU, Karachi
	Preliminary Results & findings	Dr Shabina Arif, AKU, Karachi
	Lessons learnt	Dr Turab Ali, AKU, Karachi
13:00	Discussion	
13:30	Lunch break	
14:30	Taking lessons learned from Implementation Research, What is the vision for improving quality of care	Dr Shamim Qazi, WHO HQ
15:00	Presentation by PPHI Sindh, Q&A	Dr Zaib Dahar, PPHI, Sindh
15:45	Wrap up of the day	Dr Shamim Qazi, WHO HQ
16:00	Tea/Coffee	

DAY 2 - WEDNESDAY, SEPTEMBER 20, 2017

Time	Activity	Responsible
9:00	Objective of the day-2 (IMCI)	Dr Samira Aboubaker, WHO HQ
9:10	Global IMCI updates adopted at national level- Experience on piloting the abridged course of IMCI in Pakistan-Presentation	Dr M.N Lal, Child Survival Project, Civil Hospital, Karachi.
10:10	Discussion	
10:40	Tea/Coffee	
11:00	Group Work on Scaling Up IMNCI implementation - Introduction to group work	Dr Samira Aboubaker, WHO HQ
11:10	GROUP WORK: Participants to be divided in four group:	Each group
	Group 1 and 2 - From your experience what are the barriers for implementing and scaling up IMCI?	
	Group 1 and 2 - What actions need to be taken to overcome these barriers and challenges?	
	Group 3 and 4 - What steps need to be taken to scale up IMNCI implementation? By decision makers? Programme Implementers? Professional Bodies? Partners?	
	Group 3 and 4 -How do monitor that actions have been taken?	
13:00	Lunch	
14:00	Presentation of groups, Q&A	Group members
14:50	Findings and recommendations of in depth situation analysis and budgetary gap analysis regarding Pneumonia and Diarrhea	Mr Nouman Ishtiaq & Mr Fuad Hamid UNICEF Consultants
15:30	Way forward and conclusions from the 2 days	Dr Shamim Qazi, WHO HQ
	Closing Session	
16:00	Remarks by Federal Ministry	Dr. Asad Hafeez, Director General, MoNHSR&C, Islamabad, Pakistan
16:15	Closing remarks	Dr. Muhammad Akhlaq, DG Health, DOH, Sindh
16:25	Vote of thanks	Dr Qudsia, WHO CO
16:30	Tea/Coffee	

Annex-II. List of participants

Sr. #:	Name	Designation	Organization
1	Abdul Sattar	DHS	PPHI
2	Afzal Ahmed	P/C MNCH	Govt. Of Balochistan
3	Aisha Fatima	Health Specialist	Save The Children
4	Ali Turab	Senior Instructor	AKU
5	Amina Khalid	SWMO	CSP/CHK
6	Ammarah Jawad	Associate Prof. PAED	DMC/CHK
7	Anum Vighio	DS	DHSK
8	Arif Niaz		
9	Asfandiyar Sherani	NPO	WHO
10	Ashok Kumar	M.O	Civil Hospital Karachi
11	Assad Hafeez	Federal DG Health	M/o NHSRC (Federal)
12	Atiya Abroo	Dy. Director	M/o NHSRC (Federal)
13	Ayaz Hussain	H & N Specialist	UNICEF
14	Badar Munir	MNCH	WHO
15	Baseer Khan Achakzai	Dir. Nutrition	M/o NHSRC (Federal)
16	Danya Arif	Prog. Manager	IRD
17	Dr. Nimra	Intern	WHO
18	Dr. Salim Sadruddin	Team Leader CCM/GMP	WHO HQ
19	Dr. Samira Aboubaker	Medical Officer	WHO HQ
20	Dr. Shamim Qazi	Medical Officer	WHO HQ
21	Fatima Saad	PM	NI
22	Farida Memon	Dpty Dir. CSP	Child Survival Project
23	Fuad Hamid	Consultant	UNICEF
24	Ghulam Murtaza	DGHSS	Govt. Of Sindh
25	Ghulam Mustafa	Dir. Child Health	PPHI
26	Haroon Khan	Director Nutrition	DOH KP
27	Ihsan Ullah	Sr. Officer	Save The Children
28	Iqbal Memom	Prof. PAEDS	
29	Ishaq Khan	Dpty Director	Health FATA
30	Jalal Akber	Chairman HOD	BMU
31	Jenifer Yunus	Sr. Prog. Manager	Jhpiego
32	Kamal Asghar	Health Specialist	UNICEF
33	Khwaja Masoud	National Coordinator	M/o NHSRC (Federal)
34	Kishore Khatri	Add. Director	MNCH Sindh
35	Luqman Ali	Dpty Director	DGHS KP
36	M. Akhalque Khan	DG Health	Sindh
37	M. Khalid Shafi	GS	PPA
38	M. Nand Lal	Project Director	Child Survival Project

39	M. Tofique	Dir. Health Karachi	Govt. Of Sindh
40	Mazhar Khan	NPO	WHO
41	MB Dharejo	Director	PPHI
42	Mehwish Mubarik	Asst. Director	PKID
43	Mr. Kennedy Ongwae	Chief of Health	UNICEF
44	Mubeen Memon		Pediatrician
45	Mushtaq Memom	PPA	PPA
46	Naeem Majeed	Add. Director	IRMNCHNP Punjab
47	Nahid Jamali	Dir. Of Malaria	Govt. Of Sindh
48	Naqeeb Ullah	Dpty.Prog. Conductor	Govt. Of Balochistan
49	Nasser Mohiuddin	Director Technical	M/o NHSRC (Federal)
50	Nida Siddiqui	Consultant	WHO
51	Nohman Ishtiaq	Consultant	UNICEF
52	Pir Ghulam Hussain		LHW Prog.
53	Qudsia Uzma	NPO-MNCH	WHO
54	Riaz Ahmed	CEO	PPHI
55	Sabeen Afzal	DDP	M/o NHSRC (Federal)
56	Saeed Gul	Dir. MCH	DOH KP
57	Sahib Gul	PC-MNCH	DOH KP
58	Sahib Jan Badar	Tech. Advisor	Sindh
59	Saima Memon	Prog. Manager	Jhpiego
60	Sajid Sufi	Associate Prof	AKU
61	Sajida Qureshi	Prog. Asst	UNFPA
62	Sara Salman	Head of Office	WHO Sindh
63	Shabina Arif	Associate Prof	AKU
64	Shaista Jabeen	Nutrition Manager	Jhpiego
65	Shankar Lal	Chief M.O	CHK
66	Shujaat Zaidi	Health Advisor	AKU
67	Sohail Bin Saad	DPD	EPI Sindh
68	Suhail Channar	Site Manager	AKU
69	Tahir Zehri	Assistant Prof.	Govt. Of Balochistan
70	Tasleem A. Khamisani	SPM	IRD
71	Umar Khan	Nutrition Specialist	UNICEF
72	Wali Khan	Coordinator MNCH	DHS FATA
73	Waqar Somroo	NPO-EPI	WHO
74	Yahya Gulzar	NPO	WHO
75	Yar Ali Jamali	DPD	LHW Prog.
76	Yasir Hussain	D. Dir. Nutrition	Govt. Of Balochistan
77	Yasir Ihtesham	Nutrition Officer	WFP
78	Zaib Dahar	Sr. Technical Advisor	PPHI

Annex-III. Details of group work

Questions for group work:

Group 1 and 2

- From your experience what are the barriers for implementing and scaling up IMCI?
- What actions need to be taken to overcome these barriers and challenges?

Group 3 and 4

- What steps need to be taken to scale up IMNCI implementation? By decision makers? Programme Implementers? Professional Bodies? Partners?
- How do monitor that actions have been taken?

Group-1

Barriers

Political Ownership:

- Lack of political ownership for effective implementation across the Health Care System (policy, programming, resource mobilization) through Continuum of Care approach

Financial constraints:

- No allocations within MNCH Programs for IMNCI
- Donor dependent

Human Resource:

- Lack of HR (production, inequity in deployment, retention issues, HR high turn-overs)- lack of HRMPs and Policy
- Gaps in skills (lack of training need assessment and mapping of staff)
- In effective utilization of skilled HR (IMNCI training data-bases, retention)
- Follow up and monitoring of the post training practices (through regular monitoring and linkages with accountability framework)

Health Information System

- Fragmented Health Information System (individual program MISs)
- Multiple data recording tools at service delivery (cumbersome for HCPs)

Logistics & Supplies:

- Lack of adherence to procurement of EDL that has the IMNCI drugs by the DoH
- Lack of effective integrated LMIS and capacity on LMIS and procurement

Leadership/Management:

- Health managers lack in relevant qualification resulting in issues to pertaining to procurement, management and leadership

Socio-cultural constraints:

- Lack of community mobilization for key family practices through cIMNCI
- Ineffective social mobilization and community engagement for improvement in health seeking behavior



Actions

Political Ownership:

- Advocacy with the decision/policy makers for effective implementation of IMNCI across the existing health care system
- Inclusion of IMNCI in PC1s and put in non-development budget
- Effective translation of the RMNCAH/N Action Plans into Program PC1s

Financial Constraints:

- Allocation for IMNCI within MNCH Programs(training, supplies and M&E)

Human Resource:

- Development of effective Human Resource Development Plan (focus on production, equitable deployment, retention and accountability)
- Linking performance appraisals and promotions with IMNCI trainings and practice
- Development of IMNCI HCPs databases
- Institutionalization of Pre-service through IMNCI abridged course
- Effective follow up of IMNCI post training practice through integrated QoC checklists
- IMNCI should mandatory course for permanent registration from councils
- Registering IMNCI as CME course for all medical schools

Health Information Management:

- Review and revisit DHIS for integration IMNCI
- Development of integrated data tools

Logistics and Supplies:

- Ear marking of the EDL for procurement at district and provincial level (at 5%)
- Dedicated procurement units at district and provincial levels
- Enhance the scope of existing LMIS to IMNCI commodities
- Training of managers on supply chain management, forecasting and PEPR rules

Leadership and Management:

- Reinforcement of Health Management Cadres
- Refresher trainings on management

Social and Cultural barriers:

- Implementation of cIMNCI
- Community engagement activities and plans within MNCH Programs

Group-2

Barriers

- Limited ownership by the Government
- Limited understanding of the Government on what is IMNCI and how can it be implemented?
- Lack of integration of existing child-health programmes – LHWs, CMWs, Nutrition, Malaria, Diarrhoea, Pneumonia, EPI
- Shortage of government budget, HR and supplies
- Regular capacity building plan & training database not in place (for in-service training) –
- IMNCI pre-service trainings is not part of all medical and para-medical curricula
- Lack of supported supervision and progress tracking

- IMNCI related training materials, job-aides and regular updates are not available at the level of service providers
- Monitoring and reporting is complex and time-consuming – currently largely manual registers – and is not fully reflected in the DHIS
- IMNCI adaptation committee not functional
- Weak accountability at all levels

Actions

- Evidence based persistent advocacy – partnerships with donors, research organisations, academia
- Regular government orientation and sensitisation at different levels
- A clear national / provincial strategy (including articulation of priorities and costing) on implementation of IMNCI to avoid piecemeal programming by partners
- Improved resource allocation for effective implementation of IMNCI – financial and HR
- Use of task-sharing and multi-tasking to address HR deficiency issue
- Institutionalisation of capacity building – with effective planning for training and refreshers
- Maintenance of training database to avoid duplication and wastage of resources
- Inclusion of IMCI medicines and equipment to be ensured in EDL
- As per WHO recommendation, inclusion of IMNCI in pre-service curricula for medical and para-medical institutes by PMDC
- Inclusion of IMNCI monitoring in regular district monitoring plan with capacity building of monitors
- Inclusion of IMNCI indicators in the regular progress review meetings at district and provincial levels
- Knowledge sharing platform or mechanism to be devised – e.g. website, newsletters – where updated material is made available – for this increased budget should be provided
- Simplification of reporting and inclusion of missing indicators in the DHIS
- Revitalisation / activation of IMNCI adaptation committee
- Development of accountability framework with clear responsibilities and incentive / disincentive structure

Group-3

What steps need to be taken

- Policy decision for Inclusion of the updated IMNCI in the curriculum of Medical (undergraduate & Post grade) and Allied Institutions
- Policy decision for inclusion of IMNCI in pre-service and in-service trainings
- Inclusion of institutions; PMDC, Pakistan Pediatric Association (PPA) and CPSP through CME courses
- All development partners and donors should align with National/Provincial Government priorities to implement IMNCI in true spirit

- All UN agencies should synergies their activities for rational use of resources for IMNCI implementation across Pakistan
- It is mandatory for programs to ensure continuous capacity building of all tiers on IMNCI Guidelines and protocols
- The Provincial Program will ensure availability of the equipment and supplies for IMNCI implementation

How do monitor

- Develop National M&E plan for IMNCI implementation; including IMNCI monitoring checklist,
- Integrated Provincial M&E framework for IMNCI implementation is responsibility of the Provincial Program
- Provincial Programs will follow joint monitoring plan to assess IMNCI and other program implementation
- Provincial Programs will develop IMNCI Follow-up mechanism
- Short orientation of District managers, Master trainers/Monitors for IMNCI Follow-up
- All development partners and donors will facilitate the Provincial Programs in Joint Monitoring
- Engagement of Healthcare Commissions (Punjab, KP & Sindh) to regulate private practitioner for IMNCI implementation

Group-4

What steps need to be taken

- Strategy IMNCI by DoH/WHO/partner
- Endorsement by IMNCI Task force / DoH Endorsement from IMNCI Task force to abridge (Involvement of professional Association Like MAP, PNC, PMDC, Institutionalized Capacity building)
- Costed Action Plan by DOH/WHO/Programme and other donor partner (Costed Action Plan and Road Map from Federal with the consultation of Provincial to scale up)
- Resource Allocations by Govt./Donors/Partners (Policy advocacy with the political Influencers for appropriate resource allocation)
- Implementation plan by Provincial/District team/Community level

How do monitor

- Strategy IMNCI by IMNCI Task force/DoH (Provincial and district level)
- Endorsement by DoH/DHOs and team
- Costed Action Plan by MNCH, Finance Dept, Nutrition Prog. AAP, Child Survival and LHW prg (Development Wing because it is a custodian.4As)
- Resource Allocations by all above
- Implementation plan by In Tier Provincial level(DG-M&E cell) District level (DHMPPT) Facility Level(MS/HCP), Quarterly/Annually



