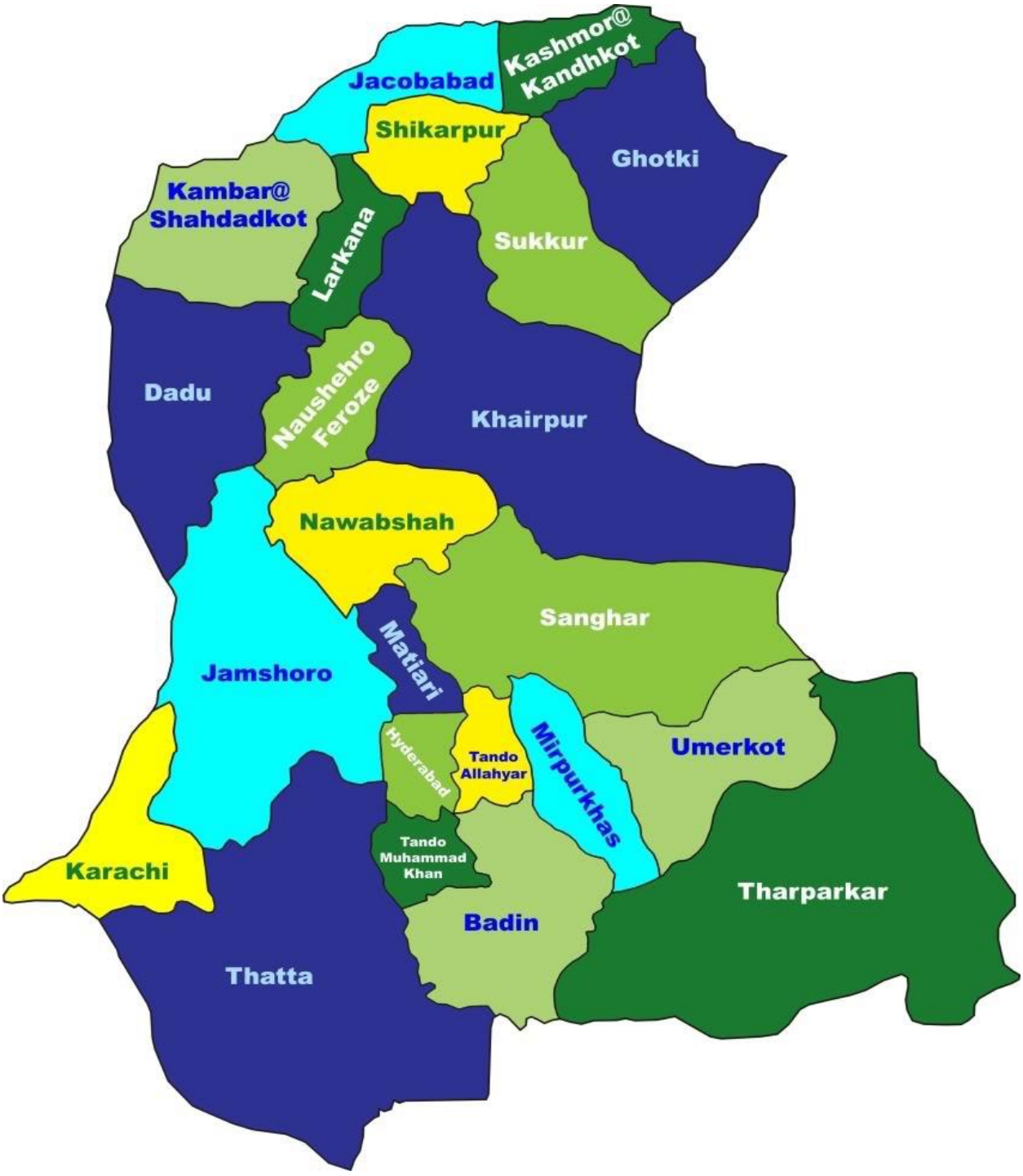
SINDH

Provincial IRMNCAH&N Strategy (2016-2020)

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

MAP OF SINDH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Karachi
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Badin
Tharparkar
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CONTENTS

Acronyms

BHU	Basic Health Unit
CCT	Conditional Cash Transfer
CMW	Community Midwife
DHIS	District Health Information System
DHQ	District Headquarter (Hospital)
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
LHs	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Workers
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MNCH	Maternal Neonatal and Child Health
MoH	Ministry of Health
M/oNHSR&C	Ministry of National Health Services, Regulation and Coordination
MMR	Maternal Mortality Ratio

MPI	Multidimensional Poverty Index
MNCH	Maternal Newborn and Child Health
MNH	Maternal and Newborn Health
NMR	Neonatal Mortality Rate
ODF	Open defecation free
PCPNC	Pregnancy Care and Post Natal Care
PHC	Primary Health Care
PPIUCD	Post-Partum Intra-uterine Contraceptive Device
RHC	Rural Health Centre
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health Package
RTI	Reproductive Tract Infection
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection
THQ	Taluks/Tehsil Headquarter (Hospital)
UNFPA	United Nation's Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

MESSAGE:

SECRETARY HEALTH, SINDH

PREAMBLE

Pakistan is a country beset by 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 alarmingly high while in children, diarrhea and respiratory illness remain as the major causes of morbidity and mortality. Many of these conditions can be managedthrough relatively low cost interventions and best practices at the primary and secondary care levels.

A major strength of the government's health care system in Pakistan is the widespread infrastructure of primary, secondary and tertiary level health facilities complemented by an extensive outreach primary health care, delivered at the community level through Lady Health Workers (LHWs), community midwives (CMWs) and vaccinators. The government's commitment to the devolution process has also capacitated/facilitated the provinces and regions to formulate and implement indigenous solutions to local problems.

The Ministry of National Health Services, Regulation and Coordination, Government of Pakistan has launched the *National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child & Adolescent Health, and Nutrition (RMNCAH&N)*, containing a list of ten priority actions. This 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. It also confirms that improving coverage for RMNCAH&N services is a high priority. The National Vision on RMNCAH&N highlights ten point agenda to guide all regions and provinces of Pakistan to formulate each of these area's own RMNCAH&N Action Plans. The provincial/area 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 consolidated national plan. The Province of Sindh has utilized its Action Plan to devise an area-specific implementation strategy that specifically focuses on how to improve services relevant to their own context for improving maternal, adolescent and child health.

While Sindh province will endeavor to implement the RMNCAH&N action plan through use of indigenous 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

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

However, factors such as illiteracy and poor quality of education (particularly female education), lack of awareness regarding good health-seeking behavior in the community, disproportionate resource availability, chronic systemic problems of healthcare delivery system, low public investment on health and education combine to develop and exacerbate the prevailing conditions of inadequate and low quality health care services in the Province. This has in turn put immense pressure on an already over-burdened health care system; leading to high rates of maternal and child mortality in the Province. Communicable diseases, maternal & neonatal health issues and under-nutrition dominate and constitute a major portion of the burden of disease in Sindh.

The MNCH program of the department of health, Sindh, has made concerted efforts to improve key MNCH indicators of the province. These include a considerable increase in the proportion of women receiving antenatal care from skilled provider (61% in 2006-07 in comparison to 73% in 2012-13); proportion of deliveries assisted by skilled birth attendant (39% in 2006-07 as compared to 52% in 2012-13) and the proportion of facility deliveries (34% in 2006-07 as compared to 48%).

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 Sindh provincial RMNCAH&N strategic action plan.

The provincial Integrated RMNCAH&N strategy 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 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 Sindh 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 of new community level health staff i.e. Lady Health Workers (LHWs) and Community Mid Wives

(CMWs), establishing new midwifery schools and to ensure availability of well furbished essential infrastructure for additional HR induction and capacity building.

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.

c) Improving financial accessibility to reduce barriers to care seeking by the most vulnerable segments of the community will be achieved through developing and strengthening coordination and linkages between various social security institutions and Income Support Programme. This can be achieved through development of comprehensive legal instruments as well as revising the framework for identifying and mapping of beneficiaries of the social safety mechanisms.

d) Health system strengthening will be achieved through upgrading of existing health care facilities and expansion of the essential medicine list enabling health facilities to provide enhanced health care, manage Infertility and reproductive health related issues, RTIs/STIs and HIV/AIDS as well as early detection of breast and cervical cancers. Provision of comprehensive family planning services and strengthening referral linkages and feedback mechanisms are essential parts of the strategy which also envisages the use of new technologies i.e. GIS, smart phone, m-Health etc. for analysis and decision making.

e) Social mobilization and political will can 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. The internationally recognized days will be celebrated to emphasize and highlight the importance of various aspects and life-styles affecting health. Various media channels 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.

f) 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 strategy and accompanying action plan is designed to utilize existing resources towards accelerating progress for achieving the SDG targets for women and children's health in the country. It is aimed at reducing maternal, child and neonatal mortality through localized interventions and solutions that are culturally amenable as well as financially viable.

BACKGROUND

Pakistan is an agricultural country with 64% of its population living in rural areas.[1] 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[2]. 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 notice 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. 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.

During 2015-2016, Sindh province has received considerable technical assistance from Ministry of National Health Services Regulations & Coordination and the development partners (WHO, UNICEF and UNFPA) to further operationalize these ten priority actions into concrete action plans to serve the purpose of advocacy, resource mobilization and provide guidance in implementation during 2017-2020.

[1] *PDHS 2012-13*

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

SITUATIONAL ANALYSIS

Sindh is the second largest province of Pakistan with an estimated population of 42.4 million; geographically it stands as third largest province with an area of 140,914 square Kilometers. The province is composed of 7 divisions, 29 districts, 113 Talukas/Tehsils and 1,400 Union Councils. Sindh has an unusual composition of urban and rural population since 47% of the population resides in urban areas. Karachi; the provincial capital, is the largest cosmopolitan city of Pakistan and has the highest growth rate of 3.2%, mainly driven by in-migration. Furthermore, there are wide inter-district disparities in terms of socio-economic and health indicators. The least developed districts being Thatta, Tharparkar, Jacobabad, Badin, Mirpurkhas, Kambar-Shahdadkot and Kashmore.

Table 1: Key MNCH Indicators of Sindh Province

Key Indicators	Value
Population – Urban : Rural	32:68
Annual growth rate	2.64
Adult literacy rate – Aged 15 yrs. & older	58
Literacy rate – Male:Female	70:46
Neonatal mortality rate/1,000 live births	54
Infant mortality rate /1,000 live births	74
Under 5 mortality rate /1,000 live births	93
Maternal mortality ratio / 100,000 live births	190
Births by skilled birth attendant	60.50
Institutional deliveries	58.6
Proportion of antenatal care (4 visits)	52
Proportion of postnatal care (within 24 hours)	64
Severe malnutrition	17
Under weight (Weight for age)	42
Fully immunization (12 – 23 m based on recall and record)	73
Tetanus Toxoid (%age of married women)	69
Total Fertility Rate (15-49 yrs)	3.9
Contraceptive prevalence rate	29.5

Source: PSLM 2014-15; PDHS 2012-13

The coverage of essential healthcare services is not uniform, mainly due to sub-optimal health system performance combined with limited healthcare demand from communities.

The social and health indicators are particularly poor amongst the rural population of Sindh; falling below the average for rural Pakistan. Coverage of maternal and child health services, contraception, vaccination and communicable disease control is sparse due to poorly functional basic and emergency services. The LHW program coverage ranges from 20-43% in certain districts.[3]This dismal situation has led to a state where only 27%of deliveries take place in health facilities, merely 70% of under 1 year children are immunized for measles, 11% of child-bearing age couples practice contraception.

In Sindh province the maternal death accounts for an average of 314/100,000 live births per year due to pregnancy related complications[4] and likewise, the neonatal mortality is nearly 50% higher in rural areas of Sindh (62/1000 LB in rural and 42/1000 LB in urban). However, despite all the challenges and constraints the concerted efforts from Sindh Department of Health are reflected from encouraging trend of key MNCH indicators as reported by the successive Pakistan Demographic and Health Survey. These include proportion of women receiving antenatal care from skilled provider (61% in 2006-07 in comparison to 73% in 2012-13); proportion of deliveries assisted by skilled birth attendant (39% in 2006-07 as compared to 52% in 2012-13) and the proportion of facility deliveries (34% in 2006-07 as compared to 48%).

[3] *Sindh health sector strategy 2012-2020*
[4] *PDHS 2006-07*

CHALLENGES & CONSTRAINTS

There are various challenges experienced by the MNCH program in Sindh, ranging from political environment, capacity building, service delivery, operational, management and monitoring and supervisory constraints. There is a lack of formal district planning mechanisms which can be linked up with budgetary allocations.

The underlying factors for low performance on key MNCH indicators include poverty and disproportionate resource availability in comparison to the increasing population, lower public investment on health and education, illiteracy and poor quality of education (particularly female education) poor liaison among development partners and lack of community motivation and ownership. These factors combine to develop and exacerbate the prevailing conditions of inadequate and low quality primary health care services, poor coordination among various existing primary health care programs and a lack of awareness and health-seeking behavior in the community,

In far flung Talukas, there are almost non-functional or poorly functional health facilities and even the district headquarter hospitals in remote districts are poorly equipped to provide CEmONC services due to lack of qualified staff, stock-outs of basic commodities and inoperative medical and surgical equipment. Likewise, the average LHW coverage across Sindh is only 45% with weak technical knowledge and poor supervision. The specialist positions mainly remain vacant in remote districts resulting in lack of basic service delivery.

There is acute shortage of female doctors, nurses and female paramedic staff across rural areas in Sindh combined with an unequal distribution of medical and paramedic staff. Furthermore, the already available female nurses and paramedics need skill enhancement for optimal MNCH service delivery[2].

The social determinants of health are a major challenge for Sindh province with its low social indicators, poor sanitation, poor socio-economic conditions and lack of mapping of vulnerable and marginalized populations. There is lack of strategy to implement healthy lifestyle changes in urban population of Sindh.

OPPORTUNITIES

The Sindh health sector strategy 2012-2020 exemplifies the commitment of Sindh Government towards various national and international commitments. It establishes congruence with existing international commitments and goals for child, maternal health, and related areas of poverty and hunger, gender equality and environmental sustainability. It builds upon the key health parameters delineated by the National Health Policy of 2001 and the commitments made in the Sindh Health Policy of 2005 as well as the National Health Strategy 2009.

The Expanded Program on Immunization (EPI) was established in 1978 in Sindh province and provides vaccination coverage to approximately six million children aged 0-11 months against nine target diseases (Childhood Tuberculosis, Poliomyelitis, Diphtheria, Pertussis, Tetanus, Hepatitis B, Haemophilus Influenza Type b, Pneumonia, Measles) and the pregnant ladies against tetanus. Similarly, the Family Planning & Primary Health Care program, popularly known as 'LHWs Program' was launched in 1994 for provision of basic essential primary healthcare and family planning services to communities through lady health workers.

The Ministry of Health commissioned its National MNCH Strategic Framework in April 2005 to achieve the Millennium Development Goals for child and maternal health by 2015. Subsequently, the MNCH program Sindh was formally launched in 2007 as a development initiative to pursue the national maternal & child health frame work. Likewise, the Population Welfare Department was devolved to the provincial authorities in 2010 primarily to improve the contraceptive accessibility at the community level by providing free contraceptives to married couples and ensure healthy timing and spacing in pregnancy (HTSP). Other initiatives of the Department of Health, Sindh include implementing the Nutrition Support Program, the Hepatitis Free Sindh Program, and Tuberculosis Control Program; Roll back Malaria, dengue control program, HIV/AIDS Control Program, CDD program and safe blood transfusion authority.

In Feb 2007, a public private partnership was established between Sindh Rural Support Organization and the Government of Sindh and was known as the Public Private Health Initiative (PPHI). Presently, PPHI (now a private "Company" registered under section 42 of the Companies Ordinance, 1984) is responsible to manage 9 RHCs, 649 BHUs, 35 MCHCs, 435 Dispensaries and 12 others a total of 1140 health facilities in rural Sindh[5]5. Another relevant experience of public-private partnership is the Norway-Pakistan Partnership Initiative (NPPI); managed through the UN agencies in 10 districts of the province. More recently, the Government of Sindh has engaged national NGOs in public-private partnership arrangement for improving performance of the healthcare delivery system. A total of 165 healthcare facilities at primary and secondary levels have been outsourced to local NGOs covering all districts of the province aiming at improved performance of the healthcare delivery system.

In October 2012, the Sindh province launched a Health Sector Strategic Framework (2012-2020) which provides an over-arching strategic framework or roadmap aligned with evidence based prioritized needs; identified to guide the operational plans of medium and long term programs and projects. It also identifies requirements for health systems strengthening (HSS) in Sindh and defines a set of sub strategies for the six main health system building blocks, addressing: service delivery, human resources, health management information, medical products, vaccines and technologies, financing, leadership, governance and stewardship. It also provides strategic directions for resource mobilization from the stakeholders including the public sector, international donors, corporate sector and philanthropic organizations. The eight year strategic framework also guides the DoH in the development of its annual development plans and expenditure forecasting.

Other important strategic opportunities include the development of an operational guideline for newborn health, policy guidance notes for multi-sectorial nutrition strategy, Provincial Multi-sectorial Nutrition Strategy, the Accelerated Action Plan to address Malnutrition in Sindh and related initiatives. The stakeholder coordination is also adequately facilitated by the Sindh Department of Health through notification of relevant coordination platforms e.g. for RMNCH and Nutrition, IYCF Technical Working Group and Family Planning Task Force; as a part of FP 2020, etc.

[5] *http://pphisindh.org/pphiweb/index.php/introduction*

IMPLEMENTATION APPROACH FOR RMNCAH&N STRATEGY

The provincial Integrated RMNCAH&N strategy 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

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.

OBJECTIVES

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.

CORE COMPONENTS OF THE IMPLEMENTATION APPROACH

1: Improving accessibility:

An extensive mapping exercise will be carried out to identify uncovered areas of both CMWs and LHWs in all 29 districts of Sindh province. It will ensure the provision of 100% outreach services by community health workers; in a phased manner till 2020, 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 Sindh 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.

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.

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 MPDSR to contribute in preventing maternal deaths in their respective districts. The capacity building of pre-service training will focus on clinical setup, 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.

The skill enhancement of health care providers will also be undertaken by offering them with scholarship opportunity for BSc.M, MPH, MSc.HPM, MSc.Epi, MSc.Bio, post-graduation in ultrasonography, anesthesia, Gyne/Obs and pediatrics.

3: Improving financial accessibility & provision of safety nets

It is envisaged that coordination and linkages will be established and strengthened between various social security departments; Bait-ul-Maal, Social Welfare department, Zakat department, Benzair Income Support Programme, etc to pilot, revisit and revise the beneficiaries of the existing public

social nets. It will promote equitable distribution among the vulnerable and marginalized communities and scaling up of various planned interventions in a more coordinated manner and with holistic approach. It will also enhance the utilization of primary and secondary health care facilities by marginalized groups and vulnerable population as a priority due to availability of financial support system at health care facilities.

The conditional cash transfers (CCT), social health insurance and voucher schemes will be introduced to provide equity based health insurance coverage to the vulnerable and marginalized groups. CCT programs will aim to enhance both the income of the poor in the short run, and their skills and capabilities in the medium and long run

4: Health system strengthening

The DHQs and THQs will be upgraded to CEmONC or BEmONC facilities, under 5 clinics and NICUS will be established by provision of essential IMNCI equipment and medicine to all DHQ, THQ and RHCs. The IMNCI medicines will also be included in essential medicine list (EML) to ensure its availability.

The mother and child health care, prevention and management of RTIs/STIs and HIV/AIDS, management of reproductive health related issues of adolescent boys and girls, other RH related issues of men and women, management of Infertility and early detection of breast and cervical cancers by promoting self-examination will be addressed by establishment of new RHS-A centers. These will also offer comprehensive family planning services 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 circumstances.

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.

The coordination between provincial and district procurement units will be further enhanced to ensure continued supply and availability of contraceptives. Coordination will also be improved between nutrition and MNCH program 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.

Measures to strengthen the district level health information system include establishment of a DHIS Committee mandated to review existing tools and protocols of data collection related to RMNCAH&N with a view to integrate the MIS of various programs into the existing DHIS to strengthen the M&E dashboard. District DHIS cells will be supported through provision of HR, appropriate equipment, capacity building, mobility support and supplies.

The use of new technologies i.e. GIS, smart phone apps for EPI, m-Health, DHIS integrated dash board and smart phones for data recording and reporting will be utilized for analysis and decision making. Regular means of transportation will be ensured for contraceptive procurement, distribution and provision from provincial to district to SDP level. In order to confirm the availability of contraceptives at service delivery point, even outsourcing of distribution mechanisms at various levels will be taken into account.

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.

Governance and accountability will be achieved through development of accountability framework as well as oversight committees (functioning under supervision of the highest political level), development and implementation of quality assurance tools and protocols, establishing of an SDG cell with effective ToRs. 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.

5: Social mobilization

Advocacy seminars, symposium, international 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, no tobacco, etc will be celebrated to emphasize and highlight the importance of various aspects and lifestyles 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.

The various activities contributing to achievement of sustainable development goals will be branded and meetings will be organized with friends of FWCs for promotional and awareness purposes. Television commercials will be developed, produced and aired through TV, FM radio & video on wheels to raise awareness on family planning. Likewise, thematic dramas will be developed in Sindhi to cover topics such as family planning promotion and demand creation.

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

Awareness campaigns and programs on breast cancer, cervical cancer, pneumonia, diarrhea, health and hygiene will highlight the signs and symptoms and other indications which require urgent medical attention. These campaigns will enable the participants to detect any disease which is preventable and can be cured at an early stage with a prompt diagnosis.

Mobile application and games will be developed to promote healthy life style and encourage positive health seeking behaviors.

The wheat flour fortification program will be expanded focusing on advocacy for flour fortification law and establishing systems for monitoring of fortification processes at the provincial and district production levels.

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, surveillance, 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. (WHO may support this activity)**

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	• %coverage of target districts with IRMNCAH&N services by LHWs and CMWs. • % of CMWs and LHWs involved in routine immunization. • % increase in uptake of IRMNCAH&N services from CMWs and LHWs.
Objective 2: Improved quality of care at primary & secondary level care facilities.	• % of HCF in target districts with full complement of HR, supplies and functional infrastructure for IRMNCAH&N services including referral mechanisms. • % of HCF with health care providers trained on key IRMNCAH&N topics (PCPNC, IMNCI etc). • % of HCF in target districts implementing the WHO Quality of Care standards for IRMNCAH&N services.
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions.	• % of institutions implementing new social security regulations to develop linkages between various public sector institutions for social security. • % of coverage of beneficiary population under the conditional cash transfer schemes
Objective 4: Increase in funding and allocation for advocacy, awareness and research for RMNCAH & Nutrition	• % increase in annual funding for RMNCAH and Nutrition programs by Government of Sindh. • % of Awareness campaigns and programs conducted • % utilization of funds designated for advocacy, awareness and research activities in target districts.
Objective 5: Improve reproductive health including family planning.	• % of HCF with required supplies and appropriately trained HR for management and outreach of RH services. • % of CMWs; with enhanced skills and competencies, involved in family planning
Objective 6: Investing in nutrition especially of adolescent girls, pregnant and lactating women, children under 5	• % of HCF providing nutrition specific services (static and outreach) to MAM and SAM children, adolescent girls and PLWs in target districts. • % of districts regularly conducting supervision, monitoring and evaluation of IRMNCAH&N interventions and sharing quarterly

	reports at provincial level. • % of total population of adolescent girls, PLWs, MAM and normal children, provided with micronutrients
Objective 7: Investing in addressing social determinants of health.	• % of districts adopting multi-sectorial approach for addressing social determinants of poor RMNCAH&N • Regulation formulated and implemented for mandatory female enrollment in schools.
Objective 8: Measurement and action at district level.	• % of districts with Integrated DHIS i.e. includes all RMNCAH & Nutrition indicators% of districts with required supplies, appropriate trained HR implementing integrated DHIS • % of districts implementing MNDSR protocols in target districts
Objective 9: Provincial accountability and oversight.	• % of planned quarterly progress review meetings of the Provincial IRMNCAH&N program oversight committee conducted per year • % of districts implementing the accountability framework related to IRMNCAH&N program.
Objective 10: Generation of political will to support MNCH as a key priority within sustainable development goals.	• ToRs for SDG Cell approved and cell established under P & D and DGHS

FINANCIAL ACTION PLAN

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 plan has been costed to serve the purpose of advocacy, resource mobilization, and providing guidance in implementation . The exercise built upon the existing 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 is required, the consultant is referred to the concerned provincial and federating areas program managers.

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.

To further ensure accuracy in the process of costing of RMNCAH and Nutrition action plan of Sindh province, a joint consultative meeting was organized by the MNCH Program on February 02, 2017 in the office of the Provincial Program Manager MNCH, Karachi. The meeting was attended by the relevant Provincial Program Managers and international partners including the WHO and WFP. The meeting was chaired by the Provincial Manager MNCH program. The main objective of the meeting 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. Afterwards, individual meetings/discussions were held with the Program Managers, as and when needed. The unit costs were determined on the basis of discussions with the relevant program stakeholders and available documents like RMNCAH&N action plan of Sindh province, PC-1s, Comprehensive Multi-Year Plans of EPI, project concept notes, etc. The numbers 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.

COMPONENT-WISE TOTAL RESOURCE REQUIREMENT

Resource requirements by component/ objective

S.#	Component/Objective	Total PKR	%
1	Improving Access and Quality of MNCH Community Based Primary Care Services	27,827,144,530	23.66
2	Improved quality of care at primary and secondary level care facilities	25,148,957,313	21.40
3	Overcoming financial barriers to care seeking and uptake of interventions	2,183,800,000	1.85
4	Increased Funding and allocation for MNCH	409,800,000	0.34
5	Reproductive health including Family planning	4,196,777,800	3.57
6	Investing in nutrition especially of adolescent girls , mothers and children	55,517,392,715	47.22
7	Investing in addressing social determinants of health	107,635,000	0.09
8	Measurement and action at district level	1,791,014,000	1.52
9	Provincial Accountability and Oversight	15,250,000	0.01
10	Generation of the political will to support MNCH	366,250,000	0.31
Total		117,564,021,358	100

As shown in the above table, total amount of PKR 117,564,021,358 will be required over a period of five years (2016-2020) for implementing the RMNCAH and Nutrition plan in the Sindh province. The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (47.22%) have been costed under objective 6 i-e “Investing in nutrition especially of adolescent girls, mothers and children”. After this, the majority of funds (23.66%) and (21.40%) have been costed under objectives 1 & 2 respectively. The objective 1 is focusing on “Improving the access and quality of MNCH community based primary care services, and objective 2 will improve the quality of care at primary and secondary level care facilities 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	4,232,845,937	4,687,260,696	6,033,953,564	6,420,959,544	6,452,124,790
2.	Improved quality of care at primary and secondary level care facilities	4,297,390,940	4,930,027,000	4,906,969,100	5,255,599,360	5,758,970,913
3.	Overcoming financial barriers to care seeking and uptake of interventions	363,600,000	402,160,000	436,320,000	472,680,000	509,040,000
4.	Increased Funding and allocation for MNCH	68,300,000	75,130,000	81,960,000	88,790,000	95,620,000
5.	Reproductive health including Family planning	1,085,290,000	1,167,705,000	783,120,000	558,870,000	601,792,800
6.	Investing in nutrition especially of adolescent girls , mothers and children	9,681,690,000	9,884,466,625	10,925,666,663	11,948,672,806	13,076,896,621
7.	Investing in addressing social determinants of health	25,735,000	17,226,000	22,392,000	20,358,000	21,924,000
8.	Measurement and action at district level	355,469,000	315,819,900	344,530,800	373,241,700	401,952,600
9.	Provinciall Accountability and Oversight	1,200,000	7,810,000	1,920,000	2,080,000	2,240,000
1(	Generation of the political will to support MNCH	60,100,000	68,640,000	73,080,000	79,170,000	85,260,000
Total		**20,171,620,877**	**21,556,245,221**	**23,609,912,127**	**25,220,421,410**	**27,005,821,724**

Yearly resource requirements by each of 10 components/ objectives are given in the above table. There is an increasing trend in the cost from year 1 to 5. This may be due to the i) increasing number of units in coming years and ii) yearly inflation rate of 10% applied to year 2 onwards.

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	27,827,144,530	1,533,315,665	26,293,828,865	94.49
2.	Improved quality of care at primary and secondary level care facilities	25,148,957,313	13,396,717,600	11,752,239,713	53.26
3.	Overcoming financial barriers to care seeking and uptake of interventions	2,183,800,000	0	2,183,800,000	100.00
4.	Increased funding and allocation for MNCH	409,800,000	41,500,000	368,300,000	89.87
5.	Reproductive health including Family planning	4,196,777,800	491,715,000	3,705,062,800	88.28
6.	Investing in nutrition especially of adolescent girls , mothers and children	55,517,392,715	1,729,100,000	53,788,292,715	86.78
7.	Investing in addressing social determinants of health	107,635,000	6,000,000	101,635,000	94.43
8.	Measurement and action at district level	1,791,014,000	105,200,000	1,685,814,000	94.13
9.	Provincial Accountability and Oversight	15,250,000	2,000,000	13,250,000	86.89
10.	Generation of the political will to support MNCH	366,250,000	42,800,000	323,450,000	88.31
Total		**117,564,021,358**	**17,348,348,265**	**100,215,673,093**	**85.24**

As seen in the above table, the available funding is approximately 14.76% of the total resource requirement for implementing RMNCAH plan. 85.24% of the total resources requirement is a funding gap, for which Government of Sindh will take lead towards mobilization of resources through allocating funds from their own budget, and by approaching potential donors directly or through the MoNHSR&C.

OUTLINE OF SINDH ACTION PLAN

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) in the targeted districts

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
1.1.1	Scale up of mapping of LHWs/CMWs uncovered areas		(Subjected to conditions) 60% population covered through LHWs and 100% population covered through CMWs in the targeted districts								MNCH Program, LHWs Program, Partners (USAID-MCHIP)
		% of uncovered areas mapped	No district	29 districts	29	10	19	x	x	x	
1.1.2	Induction of CMWs for training from uncovered areas	% of CMWs inducted	2,086	4,914	7,000	1,457	1,457	667	667	666	MNCH Program Sindh
1.1.3	Training of CMWs from uncovered areas as per mapping	% of CMWs trained	2,086	4,914	7,000	1,457	1,457	667	667	666	MNCH Program Sindh

1.1.4	Deployment of newly trained CMWs in the uncovered areas of rural districts and urban slums of Karachi, as per mapping. (Provision of furniture and equipment, kits, CMW supplies, logistics and transportation cost)	% of newly trained CMWs deployed as per mapping.	2,086	4,914	7,000	1,457	1,457	667	667	666	MNCH Program Sindh
1.1.5	Increase the stipend for CMWs	Stipend increased (100%)	PKR 2,000	PKR 5,000	PKR 5,000	x	x	x	x	X	MNCH Program Sindh
1.1.6	Increase the incentives for deployed CMWs	Incentives provided (100%)	PKR 3,500	PKR 5,000	PKR 5,000	x	x	x	x	x	MNCH Program Sindh
1.1.7	Recruitment of LHWs for the areas uncovered by LHWs in the targeted districts (according to the programmatic mapping of LHWs)	% of LHWs recruited for uncovered areas	21,775 LHWs (43% - covered area)	5,325 new LHWs - 60%	27,100 LHWs	1,332	1,,331	1,331	1,331	x	LHW Program

1.1.8	Training of newly recruited LHWs for the uncovered areas	% of new LHWs trained	0	5,325	5,325	1,332	1,,331	1,331	1,331	x	LHW Program

Expected outcome 1.2: Improved quality of community based services by supporting infrastructure for HR induction/ capacity building

S.No	Activities		Indicators			Targets by Year					Responsibility
			Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
1.2.1	Increase the number of midwifery schools and hostels. (Construction, transport, furniture, fixture, equipment, training material, books etc).	% of new schools& Hostels established (from target No.)	26 Schools	4	30	x	4	x	x	x	MNCH Program
1.2.2	Recruitment of principals, tutors and wardens for	% of new principals, tutors and wardens re-	0	20	20	x	20	x	x	x	MNCH Program

	newly constructed midwifery schools	cruited									
1.2.3	Recruitment of support staff for new midwifery schools: Computer operator, drivers for schools and district focal persons, assistants, Naib Qasid, cook & cleaner	% of support staff for new midwifery schools recruited (category-wise)	0	28	28	x	12	16	x	x	MNCH Program
1.2.4	Recruitment of district focal person	% of district focal persons recruited	0	4	4	x	4	x	x	x	MNCH Program
1.2.5	Recruitment of clinical supervisors (LHVs), 2 per districts	% of Clinical Supervisors recruited (per district)	0	60 LHVs	60	20	20	20	x	x	MNCH Program

1.2.6	Recruitment and hiring of HR for MNCH program (PIU): MIS officers, midwifery specialist, administrative staff, data collection officer, procurement officer, training coordinator & drivers	% of staf-frecruited and hired for MNCH program (category wise)	10	16/4 drivers		20	x	x	x	x	MNCH Program, Development Partners
1.2.7	Recruitment of for existing midwifery schools	% of principals, tutors and wardens recruited (category wise)	45	85		40	45	28	x	x	MNCH Program
1.2.8	Procurement, purchasing, maintenance of vehicles, POL, TA/DA for the district focal person, CMWs schools, PIU unit	% of vehicles procured (from target No.)	23	10	33	2	4	4	x	x	MNCH Program

1.2.9	Recruitment of LHSs as the supervisory staff for supervision and monitoring of LHWs and CMWs.	% of LHSs recruited	758	193	951	49	48	48	48	x	LHW Program
1.2.10	Recruitment of Drivers to support LHS for supervision and monitoring	% of Drivers recruited	758	193	951	49	48	48	48	x	LHW Program, MNCH Program
1.2.11	Induction of new staff for the newly demarked districts (LHW Program) and one account supervisor	% of new staff inducted (category-wise)	27	15	42	15	x	x	x	x	LHW Program

Expected outcome 1.3: Improved quality of community based RMNCAH & Nutrition services (through improvement in monitoring and supervsion/revision of ToRs)

S.No	Activities	Indicators				Targets by Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
1.3.1	Increase in mobility support to the supervisory staff: LHV/CS MNCHP (PKR 15000)	% Increase in mobility support to the supervisory staff (from within Target)	0	60 CS MNCHP	60	20	40	60	60	60	MNCH Program, LHW Program
1.3.2	Integrated monitoring and supervision plan/rosters for LHSs and LHVs to monitor LHWs and CMWs in their respective catchment area through DPIU Field program officer, PIU officers and with facility incharge	% monitoring and supervision visits conducted (by Category of officers involved)	0	16 PIU Officers (1250 visits)		250 visits	250 visits	250 visits	250 visits	250 visits	LHW Program, MNCH Program

1.3.3	Increase in mobility support to LHS as the supervisory staff for 29 districts	% Fuel support to LHS (ltrs) provided in target year	70. liters fuel + 1,500 m*	- 30 liters fuel + 1,000 m* in 21 districts - 80 liters fuel + 2,500 m* in 8 hard to reach d*	- 100 lit f* + 2,500 m* in 21 d* - 150 lit f* + 4,000 m* in 8 hard to reach d*	- 100 lit f* + 2,500 m* in 21 d* - 150 lit f* + 4,000 m* in 8 hard to reach d*	- 100 lit f* + 2,500 m* in 21 d* - 150 lit f* + 4,000 m* in 8 hard to reach d*	- 100 lit f* + 2,500 m* in 21 d* - 150 lit f* + 4,000 m* in 8 hard to reach d*	- 100 lit f* + 2,500 m* in 21 d* - 150 lit f* + 4,000 m* in 8 hard to reach d*	- 100 lit f* + 2,500 m* in 21 d* - 150 lit f* + 4,000 m* in 8 hard to reach d*	MNCH Program, LHW Program

1.3.4	Increase in mobility support to the supervisory staff for monitoring and supervision: District coordinator, field program officers, field monitoring officer, health education officer, training coordinator, assistant provincial coordinator, logistic officer, finance officer, MIS Officer, deputy provincial coordinator, provincial coordinator in	% Fuel support to Supervisory staff (ltrs) provided in target year	50	0	50	x	x	x	x	x	LHW Program
1.3.5	Purchase of vehicles for newly recruited LHSs	% of vehicles purchased	0	951 LHS + 50 Officer = 1001	951 LHS + 50 Officer						LHW Program
1.3.6	Support for 50 office staff and district staff vehicles for M&E: LHSs 770 and 181 to be purchased and its repair & maintenance	% of vehicles purchased& % of costs allocated	391								LHW Program
1.3.7	Support in transportation of goods from PPIU to DPIU to FLCF to LHW	% of costs allocated(other-wise; % of Support provided)	29 districts								

1.3.8	Integrated monitoring and supervision plan/rosters for LHSs and LHVs to monitor LHWs and CMWs at the catchment area through DPIU field program officer/PIU officers with facility in-charge	% of supervision visits conducted									
1.3.9	Training of LHS on MDSR	% of new LHSs trained	0	951	951						
1.3.10	Strengthening of Maternal Mortality Conference of LHSs - (MDSR strengthening)	% of conferences held	758	193	951						

Expected outcome 1.4: Improved quality of community based RMNCAH & Nutrition services (through Capacity building and supplies) of the CMWs and LHWs.

S.No	Activities	Indicators				Targets by Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	

1.4.1	Increase capacity of existing MW tutors by enhancing technical/clinical skills	% of MW tutors capacitated	36	54	90	20	20	14	x	x	MNCH Program
1.4.2	Training of clinical supervisors	% Of clinical supervisors trained	0	60	60	20	20	20	x	x	District MNCH and LHW Program
1.4.3	Training of clinical supervisors on administrative monitoring of CMWs at the facility and in the field	% of clinical supervisors trained	0	60	60	20	20	20	x	x	MNCH Program
1.4.4	Enhancement of skills of CMWs during pre-service training, focusing on clinical, hands on skills, mandatory roaster for shift duties	% of CMWs trained	65	435	500	87	87	87	87	87	
1.4.5	Capacity Building of operational CMWs through intensive CMW clinical refresher course for 28 days	% of CMWs trained	0	500	500	100	100	100	100	100	MNCH Program
1.4.6	In-service training of CMWs in Misoprostol (as PAC and for prevention of PPH)	% of CMWs trained	0	3000	3000	600	600	600	600	600	MNCH Program, Development partners

1.4.7	In-service training of CMWs in HTSP	% of in-service CMWs trained	0	3000	3000	600	600	600	600	600	MNCH Program, Development partners
1.4.8	In-service training of CMWs in IYCF	% of in-service CMWs trained	0	3000	3000	600	600	600	600	600	MNCH Program, Development partners
1.4.9	In-service training of CMWs in ENC, KMC	% of in-service CMWs trained	376	625	1000	125	125	125	125	124	MNCH Program, Development partners
1.4.10	In-service training of CMWs in HBB (Provision of HBB kit)	% of in-service CMWs trained	452	548	1000	108	110	110	110	110	MNCH Program, Development partners
1.4.11	In-service training of CMWs in HIV/STI, TB DOTS, Hepatitis	% of in-service CMWs trained	0	1000	1000	200	200	200	200	200	MNCH Program, Development partners

1.4.12	In-service training of CMWs in Use of Chlorhexidine	% of in-service CMWs trained	0	3000	3000	600	600	600	600	600	MNCH Program, Development partners
1.4.13	In-service training of CMWs in family planning methods: Hormonal, long term FP methods, IUCD, PPIUCD, etc	% of in-service CMWs trained	72	928	1000	128	200	200	200	200	MNCH Program, Development partners
1.4.14	In-service training of CMWs in referral and reporting of MNC mortality	% of in-service CMWs trained	2000	1000	3000	200	200	200	200	200	MNCH Program, Development partners
1.4.15	In-service training of CMWs in PCPNC	% of in-service CMWs trained	380	620	1000	124	124	124	124	124	MNCH Program, Development partners
1.4.16	In-service training of CMWs in post-abortion care (MVA)	% of in-service CMWs trained	24	976	1000	176	200	200	200	200	MNCH Program, Development partners
1.4.17	Capacity Building of existing LHWs (refresher courses/ short term courses for	% of in-service LHWs trained	0	21,775	21,775	10,000	11,775	x	x	x	LHW Program

	1-2 months)										
1.4.18	Training of LHS, LHV, DHOs, DCOs on CRVS	% of STAFF trained	0								District MNCH, LHW Program
1.4.19	Training of LHS & LHV for supervision	% of staff trained	0	193 LHS, 58 LHV	193 LHS, 58 LHV	151	100	x	x	x	District MNCH Program, LHW Program
1.4.20	Refresher trainings of LHSs on technical monitoring of CMWs at the facility and in field	% of LHSs given refresher training	0	758	758	400	358	x	x	x	MNCH Program, LHW Program
1.4.21	Capacity building of supervisory staff district coordinator, FPOs, field monitoring officer, health education officer, training coordinator, assistant provincial coordinator, logistic officer, finance Officer, MIS Officer, deputy provincial coordinator, provincial coordinator in monitoring and supervision	% of Supervisory staff capacitated	50	50	100	50	x	x	x	x	LHW Program

1.4.22	In-service training of LHWs on new areas (HTSP, IYCF, Use of Chlorhexidine, Misoprostol, Community IMNCI, routine vaccination, TB DOTS, Carcinoma Cervix and Breast, GBV, STI/HIV, Hepatitis, mental health, etc; contextual to provincial policy ---- Awareness KMC	% of in-service LHWs trainedon new areas									Population Welfare Department
1.4.23	Revision of Trainer Manual of LHWs, & Refresher Manual and LMIS tools of LHSs	Manuals revised (100%)	0								LHW Program
1.4.24	Refresher training on MIS (LHV/LHS)	% of LHV/LHSs trained	0	193 LHS, 58 LHV	193 LHS, 58 LHV	151	100	x	x	x	LHW Program
1.4.25	Refresher trainings of LHWs on maternal, newborn care, FP, nutrition and reporting of MNC mortality	% Of the LHWs trained	0	22,576	22,576	10,000	12,576	x	x	x	LHW Program
1.4.26	Training/capacity building of provincial officers of LHW Program	% of Provincial officials trained	0	50	50	10	10	10	10	10	LHW Program
1.4.27	ToT of LHW/LHS master trainers	LHW/LHS master trainers trained	0	3000	3000	600	600	600	600	600	LHW Program

Expected outcome 1.5: Improved community outreach routine immunization through involvement of LHWs and CMWs

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
1.5.1	Training of LHWs on Routine immunization out reach	trained	22,576	4,525	27,100						EPI Program
1.5.2	Provision of logistic support to LHWs for outreach activities for routine immunization	The % of LHWs provided logistic support	22,576	4,525	27,100						EPI Program
1.5.3	Involvement of LHWs in outreach routine immunization activities through proper micro planning at the catchment level in target districts	% of LHWs conducted Micro planning	22,576	4,525	27,100						EPI Program
1.5.4	Involvement of CMWs for the outreach activities at the vaccination point for routine immunization activities through proper micro planning at catchment level in target districts	% of CMWs conducted Micro planning	0	2086	2086						EPI Program

Expected Outcome 1.6: Improved Referral linkages between LHW, CMWS and Health care facilities for Nutrition, family planning, antenatal, natal, postnatal care, Skilled birth attendant, routine ePI, HIV, Hepatitis, Malaria, Tuberculosis, Etc

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
1.6.1	Development of referral network at district level	Developed & displayed (100%)	NA	Developed & displayed							MNCH Program
1.6.2	Orientation to LHWs, CMWs and HCF staff on referral pathways	% LHWs orientated	0	5000 CMW 27100 LHWs	5000 CMW 27100 LHWs						MNCH Program, LHW Program
1.6.3	Display of referral linkage pathways in CMWs birth station, LHWs health house and Health care facilities	% facilities displaying referral linkage pathways	186 CMWs	4,184 CMW 27,100 LHWs	5,000 CMW 27,100 LHWs						MNCH Program, LHW Program

1.6.4	Development, printing, provision of referral slips and record keeping formats to the CMWs and LHWs	% of CMW's and LHWs provided referral material	2086		5,000 CMW 27,100 LHWs						MNCH Program, LHW Program
1.6.5	Strengthening linkages and feedback mechanism between referral unit, LHS, LHW, CMW by ensuring supervisory visit of LHS/LHV and monthly meeting at referral unit	% LHWs and CMWs visited for supervisory visits and monthly meetings	2086		5,000 CMW 27,100 LHWs						MNCH Program, LHW Program

Expected outcome 1.7: Increase in community demand through social mobilization for RMNCAH & Nutrition services

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
1.7.1	Utilization of social mobilizers, support groups and CBOs supported by PPHI, MCHIP and other NGOs for on RMNCH and Nutrition	% community mobilization and health services awareness activities conducted	24	5	29	5	29	29	29	29	MNCH Program, LHW Program

1.7.2	Conduct effective health education and awareness sessions at community level (LHWs/CMWs) in the catchment area of the HCF	%health education and awareness sessions conducted									MNCH Program, LHW Program
1.7.3	Training and involvement of LHWs & CMWs for communication activities & tracing defaulters and counseling non-users of EPI, ANC, PNC, Nutrition	% LHWs and CMWs trained									MNCH Program, LHW Program
1.7.4	Use local print and electronic media for social mobilization and health messages on RMNCAH and Nutrition	% messages printed									MNCH, LHW, EPI, Nutrition, Reproductive Health Program, Population Welfare Department

1.7.5	Provision of IEC material on MNCH, EPI, FP, Nutrition, HIV, TB, Malaria, Hepatitis etc and advocacy kits to LHWs & CMWs for health educations sessions	% of LHWs & CMWs provided IEC material									MNCH, LHW, EPI, Nutrition, Reproductive Health Program, Population Welfare Department

Expected outcome 1.8: Enhanced equitable access, coverage & utilization of quality RMNCAH & Nutrition services by provision of supplies, equipments for LHWs & CMWs

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
1.8.1	Provision of logistics & supplies: Medicines & Contraceptives for CMWs	% of CMW's and LHWs provided logistic and supplies	0	5000	5000						MNCH Program

1.8.2	Provision of equipment for CMWs	% of CMW's provided equipment	2086	2914	5000						MNCH Program
1.8.3	Provision of LHW Kit (Printing material and stationary, etc, for LHWs)	% of LHWs provided with Kit	21,775	5,325	27,100						LHW Program
1.8.4	Provision of medicines, FP commodities and non-drug items for LHWs	% of LHWs provided with all items	0	27,100	27,100						LHW Program
1.8.5	Provision of bill boards for LHW Health House	% of LHWs provided with bill boards	21,775	5,325	27,100						LHW Program

Objective 2: Improved quality of care at primary & secondary level care facilities

Expected Outcome 2.1: Enhanced skills of health care providers of Primary and Secodnary health care facilities in IMNCI, PCPNC, ENC, RH, CMAM & IYCF training packages

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
2.1.1	Capacity building of health care providers (Pediatricians, MOs, WMOs, MTs, FMTs) at PHC facilities in IMNCI	% of health care providers capacitated	2000	1000	3000	200	200	200	200	200	MNCH Program
2.1.2	Expanding the pool of IMNCI facilitators at provincial Center of Excellences	Percentage of IMNCI facilitators recruited	140	60	200	20	20	20	x	x	MNCH Program
2.1.3	Conducting follow-up visits (as a second part of the training), 4-6 weeks after training of the trained health care providers for all components	0% of follow-up visits conducted	0	3000	3000	600	600	600	600	600	MNCH Program
2.1.4	Conduct training of health care provides (Gynecologists, Obstetricians, MOs, WMOs, LHVs, MW, Nurses) on PCPNC	% of health care providers trained	236	1000	1236	200	200	200	200	200	MNCH Program
2.1.5	Increase the pool of PCPNC facilitators at provincial Center of Ex-	% of new PCPNC facilitators recruited	18	42	60	22	20	x	x	x	MNCH Program

	cellences										
2.1.6	Conduct training of health care provides (Gynecologists, Obstetricians, WMOs, LHVs, MW, Nurses) on Post-Abortion Care (MVA)	% of health care providers trained	36	964	1000	164	200	200	200	200	MNCH Program
2.1.7	Conduct training of health care provides (Gynecologists, Obstetricians, Pediatricians, MOs, WMOs, LHVs, Staff Nurses) on Essential Newborn Care	% of health care providers trained	603	1000	1603	200	200	200	200	200	MNCH Program
2.1.8	Increase the pool of ENC facilitators at district level	% of new ENC facilitators recruited	38	22	60	22	x	x	x	x	MNCH Program
2.1.9	Capacity building of health care providers (Gynecologists, MOs, WMOs, LHVs, FMTs) at PHC facilities in reproductive health & family planning	% of health care providers trained	NA	1000	1000	200	200	200	200	200	MNCH Program, Population Welfare Department
2.1.10	Conduct training of health care provides (Gynecologists, Obstetricians, Pediatricians, MOs, LMOs, LHVs, Staff Nurses) on CMAM, IYCF	% of health care providers trained	0	1000	1000	200	200	200	200	200	MNCH Program, Nutrition Program

2.1.11	Conduct training of health care providers (Pediatricians, MOs, LMOs, Staff Nurses) on neonatal care at neonatal intensive care units	% of health care providers trained	0	100	100	20	20	20	20	20	MNCH Program
2.1.12	Skill enhancement of health care providers through scholarship for BSc.M, MPH, MSc.HPM, MSc.Epi, MSc.Bio, post-graduation in Ultrasonography, Anesthesia, Gyne/Obs, Pediatrics)	% of health care providers given scholarships	10	20	30	4	4	4	4	4	MNCH Program

Expected outcome 2.2: Health systems strengthening for RMNCAH & Nutrition services through filling gaps of human resource, repair, renovation, upgradation of health care facilities & provision of supplies

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
2.2.1	Establishment of BEmONC clinics by provision of essential PCPNC, ENC equipment to all DHQ, THQ,	% of BEmONC Clinics established	60	THQ, DHQ 60	THQ, DHQ 60						MNCH Program

	RHCs			RHC 126	RHC 126						
2.2.2	Establishment, up-gradation of CEmONC clinics by provision of essential PCPNC, ENC equipment to all DHQ, THQ	% of CEmONC Clinics established	20	40	60						MNCH Program
2.2.3	Establishment of under 5 clinics by provision of essential IMNCI equipment to all DHQ, THQ, RHCs	% of under-five Clinics established	0	60	60						MNCH Program
2.2.4	Provision of essential PCPNC, ENC medicine to DHQ, THQ, RHCs and its inclusion in routine medicine standard drug list	% of DHQs, RHCs and THQs provided essential medicine	0	60	60						MNCH Program
2.2.5	Provision of essential IMNCI medicine to DHQ, THQ, RHCs and its inclusion in routine medicine standard drug list	% of DHQs, THQs and RHCs provided essential medicine	0	60	60						MNCH Program
2.2.6	Establish NICUs by providing , equipment supplies at DHQs	% of NCIUs established	2	20	22	4	4	4	4	4	MNCH Program
2.2.7	Basic Health Units are providing 24/7 services	% of BHUs providing 24/7 service	778								PPHI
2.2.8	Induction of Human Resource (WMOs, Nurses, LHVs, Lab Technician, Aya, Sweepers) for providing 24/7 Basic EmONC services at RHCs as per requirement	% ofrequired staff inducted	60	66	126						MNCH Program

2.2.9	Induction of Human Resource (Gynecologist, Pediatrician, Anesthetist, WMOs, Nurses, LHVs, OT Technician, BBT, Lab Technician, Aya, Sweepers) for providing 24/7 CEmONC services at DHQ, THQ as per requirement	% of required staff inducted	20	40	60						MNCH Program
2.2.10	Incentive for the RMNCAH related staff in rural and hard to reach districts	% of staff provided incentives	0	8	8	2	6	8	8	8	DoH, MNCH Program
2.2.11	Strengthening of CMWs school skills lab by provision of equipment, teaching-training material, audio-visual teaching aids, mannequins etc	% of CMW skill Labs established	8	22	30	10	20	x	x	x	MNCH Program
2.2.12	Repair, renovation, upgradation of OT, labor rooms, gynae, pediatric wards in RHCs, THQs, DHQs	% of facilities upgraded	61	125	186	25	25	25	25	25	MNCH Program
2.2.13	Repair, renovation of residence of WMO, LHV and other staff in the RHCs, THQ, DHQ	% of residences renovated	97	89	186	18	18	18	18	17	MNCH Program
2.2.14	Construction of CMWs schools & hostels	% of CMW's Schools and hostels constructed	26	2	28	x	2	x	x	x	MNCH Program
2.2.15	Repair, renovation of CMWs schools & hostels	% of CMW's Schools and hostels repaired	7	14	21	x	4	5	5	x	MNCH Program

2.2.16	Renovation, repair of Provincial Implementation Unit		1	1	1	x	1	x	x	x	MNCH Program

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

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
2.3.1	Provision of ambulances to health care facilities for referral of cases based on user end fee for PoL generation.	% of ambulances provided to the health care facilities	80	106	186	37	37	37	37	38	MNCH Program, MCHIP, Partners
2.3.2	Provision of PoL for existing and new ambulances	% of ambulances provided POL	80	106	186						MNCH Program
2.3.3	Establish referral desks and data base at DHQ, THQ, RHCs	% of Referral desks and databases established	0	186	186						MNCH Program
2.3.4	Provision of IT support to establish referral desks and data base	% of Facilitiesprovided IT support	0	186	186						MNCH Program

2.3.5	Training of 2 health care providers/facility on maternal and child health referral data recording and dissemination	% of health care providers trained									MNCH Program
2.3.6	Maintenance and repair of equipment in DHQ, THQ, RHC	% of facilities supported	0	186	186						MNCH Program
2.3.7	Maintenance and repair of ambulances in DHQ, THQ, RHC	% offacilities for which ambulances repairED	80	106	186						MNCH Program
2.3.8	Induction of Human Resource (driver, referral desk officer, IT data operator) for referral desk	% of facilities for which staff recruited	80	106	186						MNCH Program

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

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
2.4.1	Develop M&E, supervisory tiers at various levels; provincial, divisional, district through Deputy Directors at DGHS office, Provincial Coordinators, divisional directors, district team, HCF teams	M&E Framework Drafted & Endorsed (100%)	Drafted	Endorsed M&E Framework							DoH
2.4.2	Develop provincial, divisional, district and facility level M&E supervision plans, ToRs, reporting formats and checklists	Provincial, divisional, district and facility level M&E framework established (100%)	NA	Developed							DoH
2.4.3	Capacity building of the M&E and supervisory tiers on M&E tools	% of staff trained									
2.4.4	Review of the M&E feedback reports and recommendations to the DoH for rectification	% of feedback and recommendationsgiven									

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

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
2.5.1	Inception workshop for medical schools to review the IMNCI, PCPNC & ENC pre-service experience in Sindh medical colleges and public health schools	% of workshops conducted	3	24	27	3	6	6	6	6	DoH, MNCH
2.5.2	In-depth orientation & planning to strengthen the IMNCI, PCPNC & ENC teaching in all medical colleges, public health schools, nursing schools	% of orientation & planning events conducted	3	27	30	3	6	6	6	6	DoH, MNCH
2.5.3	Training of faculty in IMNCI, PCPNC, ENC (CME or One Facilitator Course)	% of staff trained				48	57	67	75	85	

Expected Outcome 2.6: Availability of comprehensive quality EPI services as part of RMNCAH &Nutrition service package at all Primary Health Care level facilities

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
2.6.1	Ensuring required resources for EPI Programme as per PC1 (2015-2020)	% of resources provid-ed	NA								EPI Program
2.6.2	Vitamin A supplementation cam-paigns	% of targeted cam-paigns conducted									
2.6.3	Availability of qualified human resources	% of essential staff re-cruited	NA								EPI Program
2.6.4	Uninterrupted supply of vaccines, cold chain equipment and other logistics		NA								EPI Program
2.6.5	Strengthening and optimization of immunization service delivery		NA								EPI Program
2.6.6	Improved oversight, coordination and program management per-formance		NA								EPI Program

2.6.7	Improved surveillance system, data quality, routine monitoring & reporting performance		NA								EPI Program
2.6.8	Demand generation through effective communication and advocacy		NA								EPI Program
2.6.9	Human resource support		3	41	46	13	10	10	10	46	EPI Program
2.6.10	Program management										EPI Program
2.6.11	Procurement of cold chain equipment		NA								EPI Program
2.6.12	Operational vehicles (motorbikes)	% of operational vehicles procured			1400						EPI Program
2.6.13	Office equipment: 70 Computer/laptops (30 PO) 4 Photocopier machines for provincial and 29 for districts, 29 Scanner, digital camera & Faxes for districts	% of office equipment procured									EPI Program
2.6.14	Establishment of Vaccine Preventable Disease surveillance unit at PHQ and district level	% ofVaccine Preventable Disease surveillance units established									EPI Program
2.6.15	Supervision and operational resource										EPI Program
2.6.16	Printing material										EPI Program

2.6.17	IEC material										EPI Program
2.6.18	E-vaccination		0	29	29	5	6	6	6	6	EPI Program
2.6.19	GPRS tracking for vaccinators		0	29	29	5	6	6	6	6	EPI Program
2.6.20	MIS development		0	29	29	5	6	6	6	6	EPI Program
2.6.21	Capacity Building and refresher training of vaccinators, LHWs, CMWs in injection safety, cold chain, vaccine management, communication and routine immunization	% of training is conducted									EPI Program
2.6.22	Training of paramedics of fixed EPI centers in routine immunization	% of staff trained									EPI Program
2.6.23	MIS & data management training, V-LMIS refresher training for vaccinators & provincial office staff	% of staff trained									EPI Program
2.6.24	Mid-level manager refresher training for Districts	% of staff trained									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				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
3.1.1	Pilot social security regulations (Bait ulMaal, Social Welfare department, Zakat department, BISP, etc) to develop linkages for benefit of marginalized for utilization of primary and secondary healthcare facilities on priority	social security regulations formulated and piloted									Dept: of Social Welfare, Zakat, BISP

3.1.2	Pilot, revisit and revise the beneficiaries of the existing public social nets for equitable distribution among the communities and scaling up										

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

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
3.1.1	Introduce voucher scheme for the hospital services at community level	voucher schemeIntroduced									DoH, MNCH Program
3.1.2	Conditional Cash transfers										
3.1.3	Social health insurance										

Objective 4: Increase in funding and allocation for RMNCAH

Expected Outcome 4.1: Increased resource allocation and mobilization for RMNCAH and Nutrition Programs

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
4.1.1	Advocacy with political leadership and relevant Govt. dept. (P&D, Finance and Health) on adequate fund allocation for RMNCAH and Nutrition Programs	% of Advocacy events conducted									DoH
4.1.2	Advocacy with international donors for redirecting their priority towards RMNCAH and Nutrition in the light of RMNCAH & N 2016-2020 strategy	% of Advocacy events conducted									DoH

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

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	

4.2.1	Development of the biannual budgeted work plans for the RMNCAH, EPI, LHW, Nutrition programs for timely implementation	biannual budgeted work plans developed									DoH
4.2.2	Capacity building of the DDOs and their account officers in efficient utilization of available funds, monitoring of resources and audits	% of staff trained									

Expected Outcome 4.3: Resource allocation of funds for advocacy, awareness and research for RMNCAH and Nutrition Programs

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
4.3.1	Celebration of internationally recognized days: Midwifery, World Health Day, Mother's day, Children Day, Hepatitis, TB, HIV, No Tobacco, etc)	% of events conducted	2	6	8	8	8	8	8	8	DoH

4.3.2	Celebration of MNCH, Breast feeding weeks, etc	% ofMNCH, Breast feeding week celebrations conducted	NA	2/29	2/29	2/29	2/29	2/29	2/29	2/29	DoH
4.3.3	Awareness campaigns and programs on breast cancer, cervical cancer, pneumonia, diarrhea, health and hygiene	% ofAwareness campaigns and pro-grams conducted	NA	3/29	3/29	3/29	3/29	3/29	3/29	3/29	DoH
4.3.4	Advocacy seminars, symposium, international conferences	% ofAdvocacy seminars, symposium, international conferences conducted									
4.3.5	Research on malnutrition, effective utilization of MNCH services, anemia, CMWs, LHWs, etc	% ofResearch papers published									

Objective 5: Improve reproductive health including family planning

Expected Outcome 5.1: Enhanced equitable access, coverage to FP services through outreach services and scaling up of services reach

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
5.1.1	Scaling up of MSU services					36	36	0	0	0	PWD
5.1.2	Hiring of medical officers in districts such as Kashmore, Ghotki, Tharparkar, Umerkot and Badin on competitive private sector package	% of required staff hired	0	25	25	25	x	x	x	x	PWD
5.1.3	Enhancing FP services through celebration of family health day	% of family health days celebrated	962	962	962	962	962	962	962	962	PWD
5.1.4	Improved provincial and district management through construction of Provincial Population House and District Population Houses in each district	% of Provincial Population House and District Population Houses established	0	30	30	6	6	6	6	6	PWD
5.1.5	Increase the number of Regional Training Institutes	% of new Regional Training Institutes established	4	2	6	1	1	x	x	x	PWD
5.1.6	Hiring of qualified tutors for RTIs	% of required staff hired	40	60	100	20	20	20	x	x	PWD

5.1.7	Increase capacity of RTI, PWTI tutors by enhancing technical & clinical skills	% of RTI, PWTI tutors trained	40	60	100	20	20	20	x	x	PWD
5.1.8	Capacity building of demographers in research methodology & conducting surveys	% of required staff trained	NA	100	100	29					
5.1.9	Establish new RHS A Centers	% ofnew RHS A Centers established	74	32	106	6	6	6	7	7	PWD
5.1.10	Establishment of new family welfare centers in unserved areas in union councils	% of new family welfare centers established	972	188	1160	37	37	38	38	38	PWFS
5.1.11	Enhanced acceptability of services due to skill development & training of providers at each level	% of required staff trained	972	188	1160	37	37	38	38	38	PWD

Expected Outcome 5.2: Introduction of modern methods of family planning to women and adolescent girls (PPIUCDs, implanons, femiplants, D Jars-PPFP

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	

5.2.1	Promoting LARCs FP technology and infection prevention		614	1386	2000	277	277	277	277	279	DoH, PWD, MNCH, PPHI
5.2.2	Promotion of client centered approach		115	405	520	81	81	81	81	81	DoH, PWD, MNCH, PPHI
5.2.3	Improving skills and competencies of FWWs		120	920	1040	208	208	208	208	208	PWD
5.2.4	Improving quality of 2 year pre-service training course		100	200	300	100	100	100	x	x	PWD
5.2.5	Access to training material: Printing of training material: Manuals on LARCs, client centered counseling, HTSP and Infection Prevention	% of training material printed and distributed	0	2400	2400	600	600	600	600	600	PWD
5.2.6	Enhance involvement of CMWs in FP		204	396	600	80	80	80	80	78	PWD
5.2.7	Training of LHWs in FP at RTIs	% of LHWs trained	0	10,000	10,000	2000	2000	2000	2000	2000	PWD, LHW Program
5.2.8	Improved performance of male mobilizers and other services, JDs revisited for Male Mobilizers, LHVs, and para medics. Performance mechanism developed to assess their performance	Performance assessment mechanism developed JDs revised for Male Mobilizers, LHVs, and para medics.	1250	1250	1250						

5.2.9	Improved performance through use of new technologies i.e. GIS, smart phone, mHealthIntroducing smart phones for data collection and performance of the staff GIS used for geo-mapping of facilities for districts selected to introduce the smart phone initiative -Staff trained on smart phone reporting -Generating report through server based data sent through smart phone -Assessment of the success of the smart phone pilot -GIS use for analysis and decision making	% of required staff trained. Assessment of the success of the smart phone pilot conducted									
5.2.10	Contraceptive procured and made available at sub district level through: Regular means of transportation and outsourcing of distribution to district to SDP level	% of HCFs provided contraceptives									

5.2.11	Strengthening of Provincial Logistic Cell, contraceptive commodity security committee, Develop ownership for Contraceptive Logistic Management Information System (cLMIS) and Sustained reporting through trained staff so as to strengthen supply chain management, 1,Refresher trainings will be conducted on cLMIS .2.Trainings on forecasting and quantification 3 Monitoring the reporting rate at district and provincial level (at provincial level PLC will work and at district level a focal point to be strengthened) No of Trainings	% of required staff trained.									
5.2.12	Refresher trainings on Contraceptive Logistic Management Information System	% of required staff trained.	0	60	60	60	x	x	x	x	
5.2.13	Services more accessible to poorest of the poor through Vouchers Scheme initiated in underserved areas	% of facilities where Vouchers Scheme initiated									PWD
5.2.14	Refurbishing of RTIs libraries	% ofRTI libraries established	4	4	4						PWD

5.2.15	Refurbishing of Population Welfare Training Institutes in Karachi	% of Population Welfare Training InstitutesRefurbished	1	1	1						PWD
5.2.16	Refurbishing of laboratories at RTI	% of laboratories at RTIlaboratories Refurbished	4	4	4						PWD
5.2.17	Involvement of CBOs & community elders, local influential, professionals, religious leaders, etc. to serve as volunteers										PWD
5.2.18	Branding of PWD sustainable development plans and products		0	1307	1407	261	261	261	261	263	PWD
5.2.19	Meeting with friends of FWCs	% of meetings conducted	0	961	961						PWD
5.2.20	Development, production of TVC for enhancing awareness on FP	% of TVC developed	0	2	2	2	2	2	2	2	PWD
5.2.21	Airing of TVCs through TV, FM radio & video on wheels)	% of TVC aired	0	0	5000	5000	5000	5000	5000	5000	PWD
5.2.22	Thematic drama in Sindhi	% of drama theatres conducted	0	5	5	1	1	1	1	1	PWD
5.2.23	Advertising in print media	% of ads given	0	250	250	50	50	50	50	50	PWD
5.2.24	Billboards advertising on designated days	% of ads given	0	300	300	60	60	60	60	60	PWD

5.2.25	Celebration of international days	% of days celebrated	2	723	725	145	145	145	145	145	PWD

Objective 6: Investing in nutrition especially of adolescent girls, pregnant and lactating women, children under 5

Expected Outcome 6.1: Addressing General Malnutrition

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.1.1	Infant and young child feeding practices Counseling for infant and young child feeding practic-es, as per Pakistan guidelines, by LHWs to promote appropriate infant and young child feeding practices	% of Counseling Sessions conducted									
6.1.2	Appropriate infant and young child feeding practices										
6.1.3	Implementation of community based management of severe acute malnutrition - CMAM										
6.1.4	Provision of Therapeutic Food - RUTF										

6.1.5	Treatment of severely acute malnutrition with medical complication through provision of therapeutic food F-75 and F-100	% of SAM cases managed									

Expected Outcome 6.2: Addressing Micronutrient Malnutrition

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.2.1	Provision of iron-folic supplements to pregnant and lactating women	% of pregnant and lactating women given supplements									
6.2.2	Procurement & distribution of micronutrient powder sachet (97% of total population) MAM and normal children	% of total population; of MAM and normal children, covered		97% of total population of MAM and normal children							
6.2.3	Expansion of wheat flour fortification program	% of target population covered									

6.2.4	Advocacy for a flour fortification law	% of advocacy events conducted									
6.2.5	Setting up systems for monitoring of fortification levels at production level	% of nutrition sentinel sites established									
6.2.6	Treatment of diarrhea in children 6-24 months using zinc and ORS	% of total patient-load treated									

Expected Outcome 6.3: Behavior Changes Communication

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.3.1	Introduction of design thinking concept for BCC	Concept for BCC designed and approved									
6.3.2	Mobile cinemas										
6.3.3	Development of tools for mobile such as apps and games to encourage positive behavior change	% of total target apps and games approved for development									

6.3.4	2 days training for all health care providers and CHWs for BCC Communication	% of HCP trained									
6.3.5	E Health introduction and implementation; MIS, E-learning, communication, E-counseling										
6.3.6	Training of health care staff for E-health package	% of HCP 's trainedfor E-health package									
6.3.7	Evaluation for results of BCC implementation	End of project Evaluation completed									

Expected Outcome 6.4: Office strengthening, governance and institutional management

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	

6.4.1	Establish and operationalize institutional structures including human resources at provincial and district levels	% of Institutional structures established and operationalized									
6.4.2	Provision of technical assistance for capacity building										

Expected Outcome 6.5: Office strengthening, research, monitoring & evaluation

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.5.1	Hiring of M&E Specialist for effective monitoring and evaluation systems for the provincial nutrition program	% of M&E specialists (targeted for hiring) recruited	9	20	29						

Expected Outcome 6.6: Service delivery through different programs for outreach activity and treatment

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.6.1	Involvement of National Program and MNCH program for community outreach, establishing mother support groups and community volunteers										
6.6.2	Training for LHW and health facility staff on CMAM, IYCF and multi-micronutrients	% of LHWs & Health Facility Staff trained	6000	30,000	36,000	7200	7200	7200	7200	7200	
6.6.3	Equip health facilities for nutrition activities with treatment protocol, anthropometric tools and furniture	% HF provided with tools and protocols	0	700	700	700	x	x	x	x	
6.6.4	Training of Health care staff for service delivery	% of Health Facility Staff trained									
6.6.5	Supplies management and ware houses		0	20	20	20	x	x	x	x	

Expected Outcome 6.7: Treatment of adolescent girls and boys

S.No	Activities	Indicators			Targets/Year					Responsibility
		Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.7.1	Provision of multi-micronutrient to adolescent girls and boys									

Expected Outcome 6.8: Office, transportation, human resource, community outreach

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.8.1	Provision of vehicles – Toyota 1600 CC	% of vehicles provided	0	22	22	8	8	6	x	x	
6.8.2	PoL expense and vehicle maintenance	% of vehicles provided with POL & maintenance	0	22	22	8	8	6	x	x	

6.8.3	Rental cost of 1000 yards office building	% Rental costs budget-ed	0	1	1	1	1	1	1	1	
6.8.4	Human resource for provincial office Provincial Coordinator	% of staff hired (cate-gory-wise)	4	4	4	4	4	4	4	4	
	Program Officer Technical		1	1	1	1	1	1	1	1	
	Program Officer M&E		1	1	1	1	1	1	1	1	
	Data Analyst		1	1	1	1	1	1	1	1	
	Data Entry Operator		2	2	2	2	2	2	2	2	
	Admin Officer		1	1	1	1	1	1	1	1	
	Finance Officer		1	1	1	1	1	1	1	1	
	Accounts Officer		2	2	2	2	2	2	2	2	
	Warehouse In-charge		1	1	1	1	1	1	1	1	
	Logistics Officer		1	1	1	1	1	1	1	1	
	Watchmen		2	2	2	2	2	2	2	2	
	Peon		2	2	2	2	2	2	2	2	
6.8.5	Human Resource for 19 districts: District Nutrition Officer	% of staff hired	20	20	20	20	20	20	20	20	
	Drivers		20	20	20	20	20	20	20	20	
	Medical Officers for NSC's		87	87	87	87	87	87	87	87	
	Staff Nurse		87	87	87	87	87	87	87	87	

	Aya		87	87	87	87	87	87	87	87	
6.8.6	Provision of IT equipment: Laptops, printers, scanners, landline phone with internet	% of IT equipment provided	0	20	20	20	x	x	x	x	
6.8.7	Provision of stationary: All data collection forms, monitoring check lists, banners, IEC material	% of stationary provided	0								
6.8.8	Inception workshop & seminars on breast feeding day, iodine deficiency disorders day	% of Inception workshops & seminars held	0	1	1	1	1	1	1	1	
6.8.9	Research, academia, scholarships for staff to continue education and capacity building	% of scholarships provided	0	25	25	5	5	5	5	5	
6.8.10	Travel and accommodation cost for meetings	% of meetings conducted	0	5	5	1	1	1	1	1	
6.8.11	Internal evaluation & third party evaluation	% of Internal & 3rd party Evaluation completed	0	5	5	1	1	1	1	1	

Expected Outcome 6.9: WASH Activities

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.9.1	Sector coordination and support to district ODF committees		0								
6.9.2	PM&ER support										
6.9.3	Knowledge management & documentation support										
6.9.4	Media and BCC support										
6.9.5	Sanitation marketing & supply side inter-ventions										
6.9.6	Hiring and mobility support NGO partners										
6.9.7	CLTS training for LHWs, LHS, Sec. UCs and Field Facilitators	% of LHWs trained									
6.9.8	Supportive supervision by district sanitation co-coordinators										
6.9.9	ODF location celebrations, demonstration, publicity										

6.9.10	ODF replication in neighboring villages by natural leaders through incentive based performance contracts										
6.9.11	ODF district celebrations										
6.9.12	Incentives to health centers for sustaining ODF status										

Expected Outcome 6.10: Agriculture activities

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
6.10.1	Awareness raising and evidence generation or advocacy and communication for nutrition promotion and demand creation	% of awareness raising and advocacy events held									
6.10.2	Capacity building and institution-al strengthening										

6.10.3	Monitoring, evaluation, research and reporting										
6.10.4	Capacity building and institution-al strengthening										
6.10.5	Conduct 5 days IYCF training	% of training sessions conducted									
6.10.6	Conduct 5 days CMAM training	% of training sessions conducted									
6.10.7	Conduct 5 days SAM: NSC Strengthening training	% of training sessions conducted									
6.10.8	Conduct training on nutrition in emergencies	% of training sessions conducted									
6.10.9	Conduct 4 days training for insti-tutional strengthening	% of training sessions conducted									
6.10.10	Conduct 3 days training on lo-gistic and supply chain manage-ment	% of training sessions conducted									
6.10.11	Conduct 3 days M&E training	% of training sessions conducted									
6.10.12	Exchange visits & international trainings	% of exchange visits &trainings conducted									
6.10.13	Study courses from AKU	% of study courses conducted									

6.10.14	Conduct orientation training for nutrition program	% of training sessions conducted									
6.10.15	Conduct 2 days MIS training	% of training sessions conducted									
6.10.16	Masters &Ph.D Programs	% of staff completing masters and PhD PROGRAMS									
6.10.17	Provision of MIS tools & NIS										
6.10.18	Printing of MIS tools	% of MIS tools printed									

Objective 7: Investing in addressing social determinants of health

Expected Outcome 7.1: Multi-sectorial 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				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
7.1.1	Increase coordination with social welfare, education, public health engineering departments, livestock departments on health and hygiene, WASH, vector borne and disease surveillance, vaccination and reproductive health issues at the district level	% of coordination meetings held	0								DoH
7.1.2	Revise and update health education modules including IPC for HCPs and community on comprehensive messages on RMNCAH& Nutrition and social determinants like female literacy and women empowerment	% of health education modules revised and updated	0								

7.1.3	Seminars and meetings with parliamentarians, politicians, religious leaders, human rights, teachers and other civil society to link their slogans and campaigns with RMNCAH & Nutrition, mental health issues in women, adolescent girls and children along social determinants like female literacy and economic empowerment at district and provincial level	% of Seminars and meetings held									DoH, Education, PHE, Livestock Deptt:
7.1.4	Multi-sectoral coordination committee at provincial Level		0								
7.1.5	Establish provincial research cell for comparative analysis of health indicators with social determinants	Provincial research cell established	0								
7.1.6	Strengthen health education promotion cell at DoH										

Expected Outcome 7.2: Laws are in place for supporting mandatory female education, birth & marriage registration and abandon early age marriages,

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
7.2.1	Advocacy for legislation in provincial assembly for mandatory female enrollment in schools	% of advocacy meetings held									Women Development Department
7.2.2	Advocacy for implementation and execution of legislation for ban on early age girl marriages (before 18 years) and notifying it as crime and punishable act by law	% of advocacy meetings held									
7.2.3	Advocacy for each birth registration	% of advocacy meetings held									
7.2.4	Advocacy for marriage registration	% of advocacy meetings held									

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 & Nutrition indicators

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
8.1.1	Formulation of DHIS committee to eliminate insignificant indicators and include missing indicators on RMNCAH and Nutrition related mortalities and morbidities (both Health facility and community based) in online DHIS dash board	DHIS Committee formulated									

8.1.2	Integrate fragmented MISs for various programs into existing online DHIS (LHW-MIS, EPI, DHIS, CMW-MIS, NIS, TB MIS etc) M&E Dash board reflects the performance of districts and of HFs by taking the Data from all MISs of vertical programs and DHIS automatically(strengthening of M&E dash board may solve the problem.	MIS integrated									
8.1.3	Review and revisit the primary data collection tools and entry protocols to allign with the revised DHIS + Data & reporting tools for tertiary Hospitals+ Review of DHIS manual , training manual and trainers manual	Primary data collection tools updated									
8.1.4	Provision of IT Equipment for District DHIS cell	% of districts provided with IT tools									

8.1.5	Monitoring, supervision & implementation of DHIS & mobility support for provincial & district DHIS Cells										
8.1.6	Establish, repair & renovation of provincial & district DHIS stores	% of DHIS Stores established, repaired or renovated									
8.1.7	Stationary, maintenance & repair cost of equipment for monitoring & evaluation cell										

Expected Outcome 8.2: Improved data quality (reporting timeliness and completeness and 2 wat feedback mechanism

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	

8.2.1	Placement of required HR in provincial & district DHIS cell & at DHQ, THQH, Civil, Governments General Hospitals & tertiary care hospitals	% of required staff placed at targeted facility									
8.2.2	Additional allowance for Provincial DHIS staff										
8.2.3	Capacity building of DHIS focal person, provincial coordinators and IT persons at all levels on the revised RR tools	% of staff trained									
8.2.4	Capacity building of health care providers to follow the protocols for valid data recording	% of staff trained									
8.2.5	Strengthen two way feedback mechanism through sharing the findings of DHIS cell in monthly reports and bulletins	% of DHIS cells generating monthly reports									
8.2.5	Enhanced coordination among DHIS and vertical programs on reporting										

8.2.6	Capacity building of the facility based and community based health workers on data recording on revised formats	% of staff trained									

Expected Outcome 8.3: improved investigation and response mechanism (MNDSR) at district and provincial level

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
8.3.1	Notify maternal, newborn and child mortalities and morbidities as essentially notifiable events through DHO office, and eligible for MNDSR at district levels (strengthen MMC, benchmarks needs to be developed for various level MNDSR initiation)	% of District offices sending mortality and morbidity reports									

8.3.2	Constitute and support (logistics) the district health response teams to respond any outbreak/ high maternal, neonatal and child mortality investigation indicated in DHIS/alerts through DHO Office	% of DHRT functional									

expected outcome 8.4: formulation of evidence based policies

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
8.4.1	Generate and share monthly reports, quarterly reports and annual bulletins of DHIS with all the districts managers, vertical programs, health response team (Partners and all stakeholders) and policy making circles for evidence based planning	% of DHIS cells generating monthly reports									

Objective 9: Provincial Accountability and oversight

Expected Outcome 9.1: effective oversight mechanism of the RMNCAH/N program in place

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
9.1.1	Formulation of oversight committee on RMNCAH/Nutrition chaired by Minister of Health for quarterly review of the programs progress in terms of implementation and outcomes	% of review meetings conducted by Oversight committee held									
9.1.2	Development of accountability Framework	Accountability Framework developed									
9.1.3	Link the monitoring and evaluation reports to accountability frameworks in place at all levels in DoH										

Expected Outcome 9.2: effective accountability framework in place

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
9.2.1	Implementation of quality assurance tools at all level, KPIs to improve governance & accountability mechanism at provincial, district and HCF levels	% of quality assurance tools(KPIs) developed and implemented at provincial, district and HCF levels									

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

Expected Outcome 10.1: increased political will and support for RMNCAH and nutrition from political leadership at all levels

S.No	Activities	Indicators				Targets/Year					Responsibility
		Description	Baseline	Target for 2016-20	Total Target	2016	2017	2018	2019	2020	
10.1.1	Awareness about SDGs regarding health and population among policy makers and parliamentarian	% of awareness meetings conducted									
10.1.2	Establish SDG Cell under P&D and DGHS, Sindh	ToRs for SDG Cell approved and cell established under P & D and DGHS									
10.1.3	Advocacy, awareness & orientation of policy makers and parliamentarians on health and population Issues										
10.1.4	Engagement of religious scholars, media to address myths and misconception on health & population Issues	% of religious scholars engaged									

10.1.5	Revival of village health committee and women group for improving health seeking behaviors	% of village health committees and women groups developed									
10.1.6	Inter-provincial study tours for parliamentarians on health systems	% of study tours conducted									