Lao People's Democratic Republic

Peace Independence Democracy Unity Prosperity

Ministry of Health

National Strategy and Action Plan for integrated service on Reproductive, Maternal, Newborn, Child and Adolescent Health 2016 - 2025

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Foreword

The Lao People's Revolutionary Party and the Lao People's Democratic Republic Government have a policy of providing preventive and curative health services to the whole population of the country. It is well indicated in the newly endorsed Health Care Law 2015 that the government has a duty to ensure that all citizens, societies and communities have access to equal, full, equitable and quality health care services to be able to effectively contribute to the protection and development of the country.

To realize this, the Ministry of Health developed the Reproductive, Maternal, Newborn and Child Health (RMNCH) Strategy and Action Plan 2016-2025 to provide a clear vision and framework for improving RMNCH outcomes in Lao People's Democratic Republic. The strategy shows the direction of RMNCH is the next 10 years, with specific actions to be taken in the next 5 years. Development of this new strategy and Action Plan builds on the experience of the Strategy and Planning Framework for the Integrated Package of MNCH 2009-2015, which has been reviewed through an evaluation process that took place in the end of 2014 and early 2015.

According the findings from the evaluation, Lao PDR has made progress in improving health indicators over the past decade for major service coverage and MDGs 4-6 are on track towards achievement by 2015 despite many geographic and resource challenges. As a result of the previous strategy implementation, demand for essential services such as family planning, vaccinations, antenatal care and facility delivery has increased significantly. Production of community midwives under the SBA Development Plan is a major achievement. Midwives have been trained and dispatched, within 6 years from 2010- 2015, from 88 to 1784 and quality of training has been improved. At the same time, the Government's endorsement of the Free MCH Policy in 2013 initiated the provision of free deliveries and childcare and has currently been scaled up to cover 70 % of the districts of the country. It is also noteworthy that these achievements were result of the commitment of His Excellency Mr. Choumaly Sayasone, the President of the Lao PDR, to the Global Strategy for Women's and Children's Health addressed by the UN Secretary General in 2011.

While the momentum for progress and change for women and children has grown steadily in Lao PDR, more sustained effort will still be required to progress further particularly through establishing and achieving the country's Sustainable Development Goals 2016-2030, which is now under careful discussion both globally and domestically. Issues of recruitment, deployment in the right place, supervision of skilled health workers, further increase of essential RMNCH service coverage, the provision of resourced facilities implementing Free MCH Policy to address inequity and disparity and the empowerment of women and families in the community to use available maternal and newborn health services and to reduce adolescent pregnancy will be paramount for the achievement of these SDGs and the objectives of the Reproductive, Maternal, Newborn and Child Health (RMNCH) Strategy and Action Plan 2016-2025. It also requires major improvement in the drug supply system and consistent and timely data collection available for regular monitoring and process.

The Strategy addresses the critical reproductive, maternal, newborn and child health needs and rights of the Lao people through the continuum of care perspective. However, to assist the implementation both at national and subnational level, the Strategy identified 11 clearly defined specific objectives, including health system areas such as health financing, health information, human resources and drug/equipment that are directly linked to RMNCH activities. Then it showed the essential service to be delivered and priority activities to be implemented at each level of health facilities and communities to deliver the service in integrated manner.

Lastly the Strategy incorporates priorities and principles articulated in Free MCH Policy and the Health Sector Reform Framework and the Eighth Five Year Health Sector Development Plan 2016-2020. The strategy and action plan was also aligned specific programme plans such as the Family Planning Action Plan 2014-2015 and onward, the Midwifery Improvement Plan 2016-2020, the National Emergency Obstetric Care Five Year Action Plan 2013-2017, the Early Essential Newborn Care Action Plan 2014-2020, and the National Immunization Programme Comprehensive Multi-Year Plan 2016-2020.

On behalf of MoH, I would like to express our thanks to all staff within the Ministry of Health and all development partners that have made a great effort and contribution to develop the Reproductive, Maternal, Newborn and Child Health (RMNCH) Strategy and Action Plan 2016-2025. We believe that this Strategy will be used to guide the program operation to deliver the essential health services for women and children nationwide.

Vientiane Capital,

Minister of Health

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Foreword to the Second Edition

Since the National strategy and Action Plan for Integrated Services on Reproductive, Maternal, Newborn and Child Health 2016-2025 was launched in January 2016, there has been evolution in the environment in which the strategy has been implemented. The year 2016 marked the first year of the Phase Two of the Health Sector Reform (HSR) toward universal health coverage (UHC) by 2025. Phase Two of the HSR aims to ensure essential services for all by 2020. The RMNCH committee has defined the essential RMNCH service package drawing from global standards and local context through consultation with relevant departments, all provinces, and development partners. This package is expected to be a foundation for improving the social protection scheme, defining essential medicines and equipment, developing technical guidelines and trainings.

Furthermore, there has been great effort to develop a Monitoring and Evaluation (M&E) framework for RMNCH over the last year. The framework has defined impact, outcome and output indicators to monitor the progress towards strategic objectives and implementation of action plans of each sub-committee. Along with development of the M&E framework, the management and operation of the RMNHC strategy and action plans has also been reconsidered. The RMNCH committee has also clarified the way of communication between the central and provincial RMNCH committees to operate and monitor the RMNCH strategy effectively and efficiently.

After one year of implementation of the strategy, we found that many activities had not been implemented due to limited coordination among departments and sub-committees. To improve the coordination, we have revised membership and defined roles of each committee clearer.

We hope this edition will give clear and useful guidance in implementation of the strategy to all actors in each level.

Vientiane Capital,

Minister of Health

Foreword to the Third Revision

The Third Revision of the National Strategy and Action Plan for Integrated Services on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) 2016-2025 is being endorsed as the final step in the process of Mid Term Review (MTR), a detailed implementation analysis at the mid-point of the Strategy term. The revised Strategy presented in this document is the outcome of an intensive year of collaborative work led by the RMNCAH Secretariat, involving inputs from over 200 RMMCAH stakeholders, over 150 Government Personnel and over 20 Development Partners.

The MTR identified and celebrated achievements, noted challenges and agreed on priority areas for the last 5 years of strategy implementation. The review demonstrated and built capacity in evidence-based strategic planning, and for the first time the country has been able to do this using coverage and equity data as well as quality of care data from the nation-wide Quality of Healthcare Assessments in RMNCAH. This is a huge milestone for the country, and it is hoped that the resulting action plans presented in this Strategy revision will in turn include an increased focus on driving up quality.

Significant progress has been achieved across the RMNCAH technical areas, with 8 of 9 RMNCAH impact level indicators being on track against strategy targets. Findings from the Second Lao Social Indicator Survey (LSIS-II) in 2017 have evidenced this progress. Especially average annual rate of reduction in maternal mortality ratio in Lao PDR has been among the highest in the world. And yet, the child mortality rates and maternal mortality ratio in Lao PDR remain among the highest in South East Asia, with Lao PDR estimated to have the under-5 mortality rate (U5MR) of 47 deaths per 1,000 live births and maternal mortality ratio of 185 deaths per 100,000 live birth. Inequities are still marked: children in the poorest quintile of households are 2.8 times more likely to die than those in the richest quintile. Nutritional status remains poor in Lao PDR with high rates of stunting, underweight and wasting children under 5 (33%, 21% and 9% respectively).

Developments in the policy environment of the RMNCAH sub-sector have been significant since the start of the current strategy in 2016. In 2021, Lao PDR will be in the third phase of Health Sector Reform (HSR) and MCH has spearheaded this reform through a series of policy related initiatives. A revised Primary Healthcare Policy was endorsed in 2019, where MCH has been a strong driving force. The previous stand-alone Reproductive Health Policy was revised as a broader RMNCAH Policy, importantly includes the addition of adolescents as a specific target group. The development of the Essential Health Services Package (EHSP) for RMNCAH serves as a tool to guide the provision of a minimum set of priority public health and clinical services that must be delivered in different types of health facilities and in the community. The Quality of Healthcare Assessments in RMNCAH during the MTR has paved a path towards a broader operational platform for implementing the 5 Good 1 Satisfaction Policy and hospital accreditation in Laos PDR.

RMNCAH stakeholders have also been channelling efforts into improving systems for planning, monitoring and reporting. Since the start of this strategy in 2016, Sub-Committees have been monitoring and reporting their progresses through the indicators under each strategic objective. However, due to lack of clearly defined indicators to monitor quality of health care, there has not been a systematic monitoring of the impact of the implementation of the action plan, which is more geared towards improving quality of health care. It is also important to align the goal, the objectives, the indicators and the action plan to improve logical framework of the Strategy and Action plan for better planning and monitoring towards the goal. Therefore, it is hoped that the revised Monitoring & Evaluation Framework and corresponding

Action Plan presented in this Strategy document address these systematic issues to facilitate greater progress to the 2025 targets.

Going forwards RMNCAH can continue to spearhead new initiatives in the coming years in areas such as the integration of quality assessment and technical supervision; service delivery models to provide continuous and people-centred care; reinvigoration of community health improvement; and data-based planning.

We hope that this Third revision of the RMNCAH Strategy will receive greatest attention for full implementation to improve the health status of the women and children in Lao PDR.

Vientiane Capital 15 MAR 2021

Minister of Health

Assoc. Prof. Dr.Bounkong SYHAVONG

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Acronyms

ANC	Antenatal care
AYFS	Adolescent and youth friendly service
CHAI	Clinton Health Access Initiative
CIMNCI	Community based IMNCI
CPR	Contraceptive prevalence rate
CSO	Civil Society Organizations
CYP	Couple-years of protection
DHHP	Department of Hygiene and Health Promotion
DHIS2	District Health Information System2
DHO	District health office
DHPE	Department of Health Professional Education
DHR	Department of Healthcare and Rehabilitation
DPC	Department for Planning and Cooperation
EENC	Early essential newborn care
EHSP	Essential Health Service Package
EmOC	Emergency obstetric care
EPI	Expanded Programme on Immunization
GAVI	Gavi, the Vaccine Alliance
HMIS	Health and Management Information System
HSDP	Health Sector Development Plan
HSR	Health Sector Reform
HSRF	Health Sector Reform Framework
ICU	Intensive care unit
IEC	Information, education and communication
IFA	Iron and folic acid
IMNCI	Integrated Management of Childhood Illness
IMR	Infant mortality rate
IPC	Intrapartum care
IUD	Intrauterine devices
IYCF	Infant and Young Child Feeding
JICA	Japan International Cooperation Agency
KMC	Kangaroo mother care
LAK	Lao kip
LARC	Long-acting reversible contraceptives
LDC	Least developed country
LMIC	Low and middle-income country
LSIS	Lao Social Indicator Survey
LuxDev	Luxenbourg Development Cooperation Agency
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCHC	Mother and Child Health Centre
mCPR	Modern contraceptive prevalence rate
MDG	Millennium Development Goal
MDSR	Maternal Death Surveillance and Response
MMR	Maternal mortality ratio
MNCH	Maternal Neonatal and Child Health
MoH	Ministry of Health

MR	Measles-Rubella
MTR	Midterm review
MUAC	Mid-upper arm circumference
NGO	Non Governmental Organizations
NHI	National Health Insurance
NSEDP	National Socio-Economic Development Plan
OECD	Organisation for Economic Cooperation and Development
OECD-DAC	OECD-Development Assistance Committee
ORS	Oral rehydration salts
PHC	Primary health care
PHO	Provincial health office
PNC	Postnatal care
PPH	Postpartum haemorrhage
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
RMNCH	Reproductive, maternal, newborn, and child health
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SDG	Sustainable Development Goal
SO	Strategic Objective
SOP	Standard Operating Procedure
SSC	Skin-to-skin contact
STI	Sexually transmitted infections
SWG	Sector Working Group
ToT	Training of Trainers
TWG	Technical Working Group
U5MR	Under-5 mortality rate
UHC	Universal health coverage
UHS	University of Health Science
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHV	Village Health Volunteers
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacif

1. Introduction

Background & Methodology

The Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy and Action Plan 2016-2020 articulates the Government of Lao's vision for improving the reproductive, maternal, newborn, child and adolescent health status of the Lao people over the next five years. It builds on the experience of the previous Strategy and Planning Framework for the Integrated Package of Maternal, Newborn and Child Health (MNCH) 2009-2015, and incorporates RMNCAH related priorities articulated in the Directions and Functions of the Eighth and Ninth Five Year Health Sector Development Plan (2016-2020 & 2021-2025), the Health Sector Reform Framework to 2025 and specific programme strategies and action plans.

Development of the First Edition

In October 2014, MNCH-TWG decided to formulate a taskforce to lead evaluation of the previous strategy and development of the new strategy. The new strategy and action plan was developed using an evidence based, participatory process that started with evaluation of the previous strategy. In late 2014 - early 2015, an internal evaluation, an external evaluation and a gender and equity evaluation of the previous strategy were undertaken. The task force defined the conceptual and delivery frameworks for the 2016-2020 strategy and established sub-task forces for each technical component: reproductive health, safe delivery, emergency obstetric care, newborn care, child curative care, immunization, nutrition, human resources, health financing, health information and commodities.

This process culminated in a two-day RMNCH Strategy and Action Plan workshop on 14 and 15 May 2015, and a presentation of the draft Strategy and Action Plan to the Vice Minister of Health and Ministry of Health (MoH) Department Directors on 19 May 2015. This was followed by the formal establishment of the task force and sub-task forces as the RMNCH Strategy and Action Plan Steering Committee and Sub-Committees and approval of the 2016-2020 Strategy and Action Plan. (The decree formally establishing the Steering Committee, Coordinating Committee and Sub-Committees can be found in Annex 1.)

Development of the Second Edition

One year after the launching of the first edition of the strategy, there were significant changes in management. The second edition went through a rapid revision to reflect the change to align the document to actual management structure in 2017 led by the secretariat in coordination with all sub-committees.

Development of the Third Edition

2020 represents the mid-point in the strategy term (2016-2025) and a detailed review of implementation progress took place in 2019-20, aimed at identifying and celebrating achievements, noting challenges and agreeing on priority areas for the last 5 years of strategy implementation. The First and Second Editions of the Strategy included an RMNCAH Action Plan that was developed up until 2020 and an M&E Framework with annual targets until 2020. Therefore, both parts of the Strategy required review and extension to 2025, drawing on the findings from the MTR to ensure an evidence-based approach.

The MTR process was undertaken with a highly participatory and collaborative approach, involving inputs from over 200 RMMCAH stakeholders: over 150 Government personnel and over 50 Development Partners. It was conducted under the supervision of the minister, vice minister, and directors of relevant

departments in MoH. It was coordinated by the Secretariat of the national RMNCAH committee with all technical sub-committees and provinces.

The principal data source for the MTR was detailed health care quality data from Quality of Healthcare Assessments, a series of nation-wide assessments by all technical sub-committees from reproductive, maternal, newborn, and childcare that were undertaken over the course of 2019 as part of the MTR. This is the first time Lao PDR has had such comprehensive insights into the quality of health care, so it is a huge milestone for the RMNCAH area and more broadly for the health sector in general. Other data utilised in this MTR were health outcomes and service coverage data from the Lao Social Indicator Survey (LSIS) and from routine service statistics (District Health Information System2: DHIS2), a Cross-cutting Assessment of strategy implementation at the sub-national level, a survey of central level stakeholders on RMNCAH Secretariat performance, and an expenditure review at the central level, complemented by document reviews of existing surveys and assessments, and concurrent complementary assessments informed by identified information needs from the interim meeting on the MTR in February 2019.

In 2019 and 2020, a series of participatory strategic planning workshops were run for each of the seven technical areas under the new strategic arrangement (Reproductive & Adolescent, Maternal, Newborn, Sick Child, Well Child, Community and Governance). Within these workshops, MTR data was presented and discussed, M&E framework indicators and targets were revised, and action plans were developed. Subsequent follow-up meetings provided inputs for more detailed planning and costing.

RMNCAH Context

Health Impacts

Lao PDR has made substantial progress in improving its Reproductive, Maternal, Newborn and Child Health (RMNCH) outcomes and service coverage over the last decade, but clear challenges remain. The country achieved MDG4 target of 75% reduction in maternal mortality ratio (MMR), reaching a 77% reduction in MMR over the course of the MDGs, with the latest estimate sitting at 185 maternal deaths per 100,000 live births in 2017 [1].

Child mortality has also seen reductions; however relative to neighbouring countries, the child mortality rates for Lao PDR remain the highest in South East Asia. Under 5 Mortality Rates and Neonatal Mortality Rates have dropped from 79 to 46 (42%) and from 32 to 18 (44%) per 1,000 live births respectively between the two Social Indicator Surveys (2011, 2017). UN Estimates a milder reduction with U5MR and NMR at 47 and 23 deaths per 1,000 live births in 2018. Inequities are still marked: children in the poorest quintile of households are 2.8 times more likely to die than those in the richest quintile. Variation across provinces also needs to be highlighted, with the lowest recorded Infant Mortality Rate (IMR) at 9 per 1,000 live births in Xayabouli and the highest recorded at 68 in Oudomxay in LSIS 2017.

Nutritional status remains poor in Lao PDR with high rates of stunting, wasting and underweight children under 5 (33%, 21% and 9% respectively). One of the key factors contributing to the high under-five mortality rates in Lao PDR is the poor nutritional status of many children, particularly the poorest children. A 25% reduction in stunting between 2011 and 2017 LSIS's indicates that progress is being made in this area of child health however and the country is on track to reach the 2025 target for stunting. Progress has been less remarkable in other nutrition related indicators, with the wasting rates showing no obvious reduction over the same timeframe. Anaemia in women of reproductive age remains high at 40% in 2017.

[1] WHO – UNICEF Joint Estimates on Maternal Mortality for 2017 (published 2019)

There has been a steady decrease in fertility rates in Lao PDR, the latest reported at 2.7 births per woman in 2017[2]. Age specific fertility rates show a particularly high fertility rate amongst adolescents, with almost 1 in 10 adolescents giving birth (83 births per 1,000 women aged 15-19 years). This remains far off the 2025 target of 65 births per 1,000 women aged 15-19 years, indicating that Lao PDR must target family planning interventions at this population group. These figures were even higher for rural adolescents, and those in lower income and educational groups. High levels of adolescent fertility deserve particular attention as young mothers and their babies are at highest risk of complications during pregnancy and birth, and early childbearing limits young women's opportunities for education and employment.

RMNCAH Service Coverage

The increases in the modern contraceptive prevalence rate (mCPR) have been modest, rising from 42% in 2011 to 49% in 2017. When disaggregated by method, the coverage of the long-acting reversible contraceptives (LARCs) is particularly low at only 3.5%. Although LARCs accounted for 6% of all contraceptive dispensed, they provided 79% of the total couple-years of protection (CYP) which is defined as the estimated protection provided by contraceptive methods during a one-year period. This shows significant potential of improving efficient coverage of contraceptives by shifting towards LARCs.

Antenatal care and skilled birth attendance coverage indicators show a marked improvement since 2011, with ANC first and fourth visits reportedly increasing by 46% and 68% respectively. Delivery by SBA has also increased by 55% between 2011 and 2017.

Child preventive services, such as immunization, has shown slow progress, with the proportion of fully vaccinated children only rising from 42.9% to 48.1% between 2011 and 2017. The increase in Measles-Rubella (MR) 1 coverage was the lowest, rising only 4% over this timeframe. The exception is the Hepatitis B birth dose coverage which increased by 64%, coverage trends which correlate with the rising facility delivery and the resulting increased access to newborn care provision. The percentage of children aged 12-23 months who received a Vitamin A dose within their first year of life was 25%.

Child curative services are also lagging behind. There has been slow progress in improving the proportion of children with diarrhea who were treated with oral rehydration therapy, which only rose from 48% in 2012 to 56% and the proportion of children with diarrhoea treated with ORS plus Zinc (at facility) reportedly low at 13% in 2017. The proportion of children with suspected pneumonia who were treated with antibiotics has actually fallen, from 57% in 2012 to 45% in 2017. This is clearly an area that requires attention going forwards.

Early initiation and exclusive breastfeeding to at least 6 months of age are fundamental to preventing malnutrition, reducing child mortality and establishing a strong physical and emotional bond between mother and baby. Slight increase can be seen in the coverage of exclusive breastfeeding practices in the first six months, with an 11% increase between 2011-2017. These trends are similar to other countries in the region, although for this indicator Lao PDR reports higher rates than neighbouring Vietnam and Thailand. In 2017 50% of newborns were breastfed within one hour of birth, an increase on the 2011 value of 39%.

Equity issues mean that ethnic group, urban/rural residence and educational status remain a significant factor in access and utilisation of RMNCAH services. Analysis of key service coverage indicators by wealth quintile shows the equity gaps narrowing for ANC 1, ANC4 and SBA coverage, with the poorest quintiles increasing by two to three times within the 6 years. Immunization (proportion of fully vaccinated children) has 2-fold difference between the richest and poorest, and has not narrowed down between 2011 and

[2] Government of Lao (2018) Lao Social Indicator Survey II (LSIS II)

2017 indicating that resource-intensive efforts through outreach services to improve equity of access to vaccinations has not been effective enough to tackle the issues.

Clinical quality findings highlight three common areas of weakness in quality of care: weak provision and quality of counselling on health behaviours; missed opportunities to provide comprehensive services to patients during their contact with health providers; and a fragmented continuum of care. Lack of continuity in care can lead to undertreatment or even harmful treatment. Trends in quality of care from Early essential newborn care (EENC) annual assessments indicate initial dramatic improvements across areas of measurement when interventions are introduced, with a slowing of progress subsequently. This highlights the need for ongoing quality assessment across all service areas to better inform strategy implementation.

Readiness and health system quality highlighted gaps in: allocation of RMNCAH personnel against requirement for Essential Health Service Pacakge; the lack of functional handwashing equipment at health centre level; availability of key medicines and equipment for RMNCAH services, which is particularly low at health centre level; whether written policies, guidelines and standards related to RMNCAH exist on the wards; whether there is a team or person responsible for each program with a budget.

Clearly Lao PDR is making significant progress in improving the reproductive, maternal, newborn and child health status of its people. However, much remains to be done in the short to medium term for the government to achieve its national health goals and Universal Health Coverage.

Policy & Strategy Context

The 9th National Socio-Economic Development Plan (2021-2025) provides an overarching strategic framework for the development of the nation, with the 9th National Health Sector Development Plan (HSDP) directly providing directions to health sector. The current HSDP aims to strengthen the existing health system, particularly at the primary health care level, to ensure access to quality health services to the poor and vulnerable populations in remote areas.

Complementary to this, the Health Sector Reform (HSR) Framework details a clear architecture for the health system to achieve Universal Health Coverage (UHC) by 2025. This framework places service delivery as the core pillar, with five supporting pillars which include: human resources for health; health financing; governance; service delivery; and health information, monitoring and evaluation. The third phase of HSR runs from 2021-2025 and includes a focus on strengthening primary health care (PHC). Lao PDR has undergone a few health system sub-reforms under HSR. In 2013 program-specific health information systems started being integrated under DHIS2, the integrated online platform used for routine reporting in health in Lao PDR. In 2016, mSupply started to integrate program-run medical supply management systems. In 2016 different financial protection schemes were integrated under NHI, replacing the Free MCH policy. In 2018, EHSP was endorsed. The four major sub-reforms were spearheaded by the RMNCAH program, and expanded across the health sector. Through this MTR process, the RMNCAH program is establishing an integrated quality assessment and improvement mechanism and has started to integrate other programmes beyond RMNCAH, linking to the “Five Good, One Satisfaction” Policy and “Dok Champa” hospital accreditation.

Through the National Assembly, the Government of Lao PDR made maternal and child health a priority programme. Of the 11 indicators identified by the National Assembly to track health sector progress to graduation from Least Development County and UHC / SDGs, 7 of them are RMNCAH-focused indicators. This highlights the importance that RMNCAH holds within the health sector and beyond in terms of contributing to progress in reaching the 2030 national targets.

Figure 1 provides an overview of the key policy and strategies that govern the work around RMNCAH in Lao PDR.

Figure 1: The RMNCAH Policy Environment

Key findings from the Strategy Mid Term Review

The midterm review in 2019 has collected and analysed data from: nation-wide facility-based assessment on quality of health care; DHIS2 on service provision; LSIS on health outcomes and service coverage in population level; related reviews and reports; and key informant interviews in central, provincial, district levels and development partners.

The complete report can be found as a separate document. The below is the summary of key findings. Key recommendations of the midterm review are reflected on Strategic focus and actions

Relevance: HIGH

- Seven out of eleven National Assembly indicators on health are RMNCAH related.
- Health related indicators for Least Development Country graduation are RMNCAH related.
- Disease burden of RMNCAH in Lao PDR is still very high
- The RMNCAH programs have accelerated the Health Sector Reform in several areas such as health information system (DHIS2), service affordability (Free MCH to National Health Insurance), medical supplies (mSupply), Essential Health Service Package and quality of health care

Effectiveness: HIGH

- Eight out of nine goal indicators in the strategy have been "On-track"
- Significant reduction in maternal and child mortality together with increased service coverage
- Effective interventions on positive impacts in coverage and quality of health care have been developed and validated
- There still is a space for improving effectiveness through improving quality of health care including counselling skills. Respectful care increases satisfaction and trust to health care and increases uptake of essential services. (Example: A training focused on respectful antenatal care counselling increased return to facility-based delivery)

Efficiency: LIMITED

- Budget allocation has space for improved efficiency through arranging governance within MoH, funding through Health Sector Development Plan and adjusting external financial arrangement.
- Significant missed opportunities can be reduced through integration at the point of service delivery. In particular, integration of nutrition and immunization under well child care is very limited.
- Limited service readiness in terms of medical supplies and skilled human resources, together with sub-optimal quality of health care, limits efficient interventions (Example: some facilities have equipment but no skilled staff, some vice versa)
- Weak alignment among policy documents for human resource and expected practice hinders efficient service delivery through each cadre (Example: Due to mis-alignment of scope of practice, competency, regulation, curriculums for midwife against national clinical standards, allocation of midwives do not always result in efficient expansion of essential health service provision)
- Weak alignment of allocation of certain cadres against Essential Health Service Package requirements and dependent on repeated in-service trainings limit efficient coverage of EHSP readiness (Example: Dentists assigned for intrapartum care receiving in-service training for intrapartum care while some midwives have very limited experiences in intrapartum care)

Sustainability: MODERATE (limited in terms of integrated efficient service delivery to ensure sustainability; promising in terms of integration and uptake into broader health system)

- Above mentioned limitations in efficiency hinders sustainable service delivery (Example: While nutrition program heavily depends on external funding and not well integrated with other RMNCAH service delivery platforms, immunization is under financial transition towards domestic financing hence needs to establish well integrated service delivery through well child care)
- RMNCAH has spearheaded the Health Sector Reform and integrated into broader health system in areas such as health information system (DHIS2), service affordability (Free MCH to National Health Insurance), medical supplies (mSupply), Essential Health Service Package and quality of health care. This secures sustainable mechanism to support programs in each health system component with less intensive investment on each separate program.

Equity / Gender: LIMITED

- Even with significant improvement, inequity in both health outcomes and essential service coverage is still unacceptable (Example: While U5MR of the wealthiest 20% is 23 per 1,000 livebirths and has already achieved SDG3.2 of 25, the poorest 20% is 63 per 1,000 livebirths; SBA delivery of the wealthiest 20% is 97% while that of the poorest 20% is 33%)

❖ While there are examples of gender-sensitive interventions such as inclusion of husband in antenatal care counselling and inclusion of sex in the criteria for selecting village health volunteer, uptake to policies and upscale of good practices are still limited

2. Components of the Strategy

The components of the strategy comprise Overarching Principles, Goal, Strategic focus, Conceptual Framework, Strategic and Specific Objectives, and Crosscutting health system follow up actions.

Overarching principles set underlining values and basis for setting the Goal and the Objectives. They also guide developing the Action Plan.

Strategic foci are set to tackle key challenges identified in the midterm review of the strategy, namely, suboptimal quality of health care, inefficiency, limited sustainability and inequity.

Conceptual framework aims to shift the overall approach and the governance of the strategy implementation to enhance strategic foci upon achieving the goal and objectives.

Strategic and Specific Objectives are defined by respective sub-committees together with the secretariat to tackle gaps identified through rigorous analysis during the midterm review. Strategic Objectives 1 to 5 are defined for the five target populations, namely reproductive and adolescent, maternal, newborn, well child and sick child. Each sub-committee is primarily accountable for each respective objective. Strategic Objectives 6 and 7 are crosscutting – community health and governance. The secretariat and all sub-committees are accountable for the objectives.

Crosscutting health system follow up actions

The midterm review has identified challenges and priorities that require systematic health system responses beyond RMNCAH. As the RMNCAH committee alone cannot be accountable for the responses, these actions are not included in the objectives nor action plan in this strategy document. They are summarized in this section for the Management Supervisory Committee to follow up and take responsive actions.

Overarching Principles

- Striving for health equity independent from gender, ethnic group, residential area, socio-economic status and educational level
- Building on existing national policies and health system;
- Building on scientific evidence and international consensus;
- Establishing integrated approach and primary health care network
- Strengthening people centred care and respectful care;
- Improving quality of health care and enhancing trust in health system
- Increasing efficiency and sustainability
- Adhering to the Convention of Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC);

Goal

The goal of the RMNCH Strategy and Action Plan 2016-2025 is to:

Improve the reproductive health status and reduce maternal, neonatal and child mortality and morbidity including malnutrition in Lao PDR.

Strategic focus

The midterm review found the strategy implementation in the past five years highly relevant to the priorities and needs of the country and highly effective in progressing towards goals and objectives. On the other hand, suboptimal health care quality, inefficiency and inequity were highlighted as areas for improvement. Each strategic focus below aims to tackle the issues highlighted in the midterm review.

Strategic Focus 1: **Regular monitoring and improvement on health care quality and respectful care**

While previous strategic objectives aimed both service coverage increase and health care quality improvement, indicators to monitor progress towards the objectives were mainly health outcomes and service coverage with minimal indicators to monitor health care quality. Emerging global evidence that that implies more preventable deaths due to low health care quality compared to those due to non-utilization of essential health services shows importance of monitoring and emphasizing improvement on health care quality.[3]

The revised M&E Framework has included indicators on health care quality. In 2019, a nation-wide facility-based assessment and improvement support on quality of health care was conducted as a part of the midterm review. Once this assessment becomes routine, regular monitoring of health care quality will be feasible. The health care quality data is expected to be used also for the *DokChampa* Hospital Accreditation.

The health care quality also emphasizes counselling skills and respectful care. The antenatal care training on counselling skills for birth preparedness showed increase in return to facility-based delivery. This indicates, in the past five years, technical teams have developed effective trainings to improve counselling skills that increase uptake of subsequent services in the continuum of care. Improving counselling skills and respectful care aims to gain trust to the health system and increase effective coverage of essential health services.

Priority actions:

- ❖ The revised M&E framework added health care quality indicators in addition to coverage indicators
- ❖ Strengthen routine monitoring of both service utilization and service quality for national and sub-national levels
- ❖ Establish a regular integrated RMNCAH quality assessment with all 5 sub-committees and link to 5 Good 1 Satisfaction policy and "DokChampa" hospital accreditation
- ❖ Strengthen counseling skills of providers and respectful care

[3] Kruk M, et al. High-quality health systems in the Sustainable Development Goals era. Lancet 2018

<u>Strategic Focus 2</u>: Efficient and sustainable arrangement in service delivery, human resource management, financing and governance.

Financial transition from external support to domestic financing and expected decrease in domestic fund due to the economic impact of the COVID-19 pandemic require more efficient and sustainable domestic financing as well as improving partner's coordination to improve aid effectiveness. The strategy will aim to improve efficiency and sustainability through: (1) service integration, (2) optimizing service delivery model, and (3) improve aid effectiveness.

(1) Service integration

Current missed opportunity highlighted in the midterm review hinders efficient provision of services at the point of service delivery. More efficient and sustainable service delivery model is needed. To support integrated service provision at the point of service delivery, integration in six areas are recommended:

1) **<u>Technical support for integrated service provision</u>**: Standards (guidelines and SOPs) should be integrated. The integrated RMNCAH quality assessment and support that is developed over the past few years is expected to provide technical support to the providers for service integration.
2) **<u>Incentives to hospital managers</u>**: Accreditation of health facilities based on 5 Good 1 Satisfaction standard is an important opportunity to motivate the managers to encourage providers to integrate services (For example, providers receive high score when they can demonstrate integrated care through clinical vignettes)
3) **<u>Human resource planning</u>**: Long-term planning of human resource should take service integration into consideration (Eg. which providers do we target to develop capacity on the provision of Well Child Care?). Reflect the integrated standard on the preservice education.
4) **<u>M&E and reporting</u>**: The revised M&E framework includes indicators to monitor progress towards integration of services (Eg. % of children who come for immunization receive breastfeeding / complementary feeding screening and counselling) Integrated logbooks are being developed. (This enables providers to record and report integrated service provision)
5) **<u>Planning and budgeting</u>**: In a longer term, the domestic financing has to promote integration (Eg. Currently, all three programs in the well child care, immunization / nutrition / child development, have different budget line and different departments and centers to manage, which makes it difficult for providers to integrate.) Likewise, external funding from partners needs to consider potential impact of their financing mechanism towards integration of services.
6) **<u>Governance</u>**: In a longer term, MoH organizational structure and HSDP needs to be reviewed to institutionalize integrated service delivery. Many partners participate in the RMNCAH Technical Working Group (TWG) and collectively developed the action plan with high commitment. The strategy implementation needs further commitment from development partners to collectively fund, implement and monitor the action plan based on Vientiane Declaration on Aid Effectiveness.

(2) Optimizing service delivery model

The strategy aims to improve provision of RMNCAH services based on Essential Health Service Package (EHSP) in an effective and efficient manner. This requires:

1) assessing the current situation on the EHSP provision, readiness and service quality;
2) identifying optimal service delivery model;
3) financing the services based on the model; and
4) robust implementation

For example, even at provincial and district levels, some hospitals are not “ready” to provide essential services defined by availability of tracer medicines and equipment are assessed. Utilization of services from DHIS2 shows that some basic services that are expected to be provided in district hospitals and health centres are still heavily dependent on provision at provincial hospitals, which could be improved through strengthening “gate-keeping” functions of primary care levels. Many districts and health centres reply on outreach services to provide immunization to villages close to health facilities. Shifting service provisions from outreach to fixed sites will save significant operational cost. Both funding of the EHSP and financing mechanism to accelerate optimal service delivery model are crucial. Finally, all sub-committees and partners need to align to the optimal service delivery model when implementing their activities.

(3) Improve aid effectiveness

While many partners have been actively involved in the midterm review and revision of the strategy and development of the action plan 2021-2025, further collaboration from the partners are crucial. The midterm review showed significantly improved collaboration of development partners in technical level. However, it also showed a huge gap between the plan and the implementation. Donors financial support was sometime not aligned to the action plan, and skewed the focus to certain areas. The implementation of the RMNCAH strategy and action plan is monitored through the RMNCAH TWG meeting under Health Sector Working Group (SWG). SWGs were established to accelerate implementation of Vientiane Declaration on Aid Effectiveness, under which collaborating countries and partners have agreed on:

- The country ownership over development policies, planning, implementation and aid coordination
- Better alignment of development partner's support to national policies and plans
- Harmonisation and simplification of development partner's procedures and activities
- Managing for results in order to ensure effective use of resources
- Both government and development partners having mutual accountability for progress

It is crucial that in the next five-year action plan, relevant partners support the government upon implementation of the strategy and action plan with coordination through the national RMNCAH Committee and TWG meetings.

Priority actions:

- ❖ Integrate service delivery by the 5 target populations (“people-centred approach”) - facilitate integration through: technical support through standard and supportive supervision, incentivizing managers through 5 Good 1 Satisfaction, human resource planning, monitoring, planning and budgeting, and governance and partner’s coordination based on Vientiane Declaration on Aid Effectiveness.

- ❖ Optimizing service delivery model for provision of RMNCAH services based on Essential Health Service Package (EHSP) in an effective and efficient manner

- ❖ Review HSDP and organizational efficiency within MoH for improved budget allocation based on priorities and minimize overlap

- ❖ Improve aid effectiveness by aligning relevant partners’ support to the government upon implementation of the strategy and action plan with coordination through the national RMNCAH Committee and TWG meetings

Strategic Focus 3: Disaggregated and monitoring and targeted improvement towards equity of access to quality service

While some interventions contributed to tackle inequity in health in the past five years, progress towards health equity has not been systematically monitored and specifically targeted in the national strategy level. In the next five years, the strategy will focus on monitoring disaggregated data to identify gaps, design and implement interventions to improve equity. The strategy aims health equity independent from gender, ethnic group, residential area, socio-economic status and educational level. The strategy has set indicators to track progress towards equity and encourages to generate evidence on bottlenecks to equity and effective interventions to improve equity.

Global evidence shows that national increase in service coverage have been primarily driven by coverage increase in the poor population.[4] It is expected that the equity focus not only improves equity but contributes to achieving the goal broadly. Equity can be addressed from different angles. While physical accessibility has improved dramatically, affordability needs further monitoring and improvement mainly through National Health Insurance (NHI). Local culture and ethnicity needs to gain special attention upon designing service delivery as inequity across different ethnicities is still significant. While improvement in education is expected to have significant impact on health equity in a long run, service delivery design also needs to specific consideration to population with different levels of education including skills of counselling and respectful care.

Health care quality can also contribute to health equity. For example, integrating intrapartum care training into Emergency Obstetric Care (EmOC) training in 2017 has improved routine monitoring and care, which results in early detection and management of maternal complications: This can improve equity because less people will need higher referral care ("local solutions for local challenges")This Strategic Focus also includes gender mainstreaming: assessing implications of any planned actions, legislation, policies or programmes for all genders. The strategy aims to make concerns and experiences of all genders an integral dimension of the design, implementation, monitoring and evaluation to move towards gender equality.

Health outcomes across provinces vary significantly. For example, under 5 mortality rate (U5MR) in highest and lowest provinces differs more than 6 folds. Xayabouli, the province with the lowest U5MR has been demonstrated exceptionally strong engagement of provincial authority in strengthen primary health care and records highest uptake in many essential health services such as antenatal care and facility-based delivery. Improving equity requires strong leadership and broader engagement beyond health sector. COVID-19 pandemic has gained unprecedented attention to roles of local governance, non-health sectors and community in health of the people. It has accelerated multi-sectoral collaboration and engagement from local government and community. This engagement can be further strengthened to improve primary health care in general beyond COVID-19.

Priority actions:

- Monitor and design service delivery to improve health equity independent from gender, ethnic group, residential area, socio-economic status and educational level
- Monitor disaggregated data to track progress on equity based on the revised M&E framework
- Generate evidences on bottlenecks towards equity, effective interventions for equity

[4] Victora C, et al. How changes in coverage affect equity in maternal and child health interventions in 35 Countdown to 2015 countries. Lancet 2012

- Emphasize very basic, routine care to prevent necessity of higher-level referral care
- Strengthen primary health care through engagement of local government and community

Conceptual Framework

The conceptual framework for the strategy and action plan articulates the Ministry of Health's vision for improving RMNCH outcomes in the country. This third edition of the RMNCAH Strategy provides a revised conceptual framework in response to the recommendations emerging from the Mid Term Review of the strategy. The strategy recommends that the sub-committees are reorganized based on common delivery platform by target population instead of programs to reduce missed opportunity, hence improve efficiency and establish sustainable service delivery.

Rationales of the strategic shift to "People-centred" governance, operation and service delivery

1. While the midterm review of this strategy demonstrated that the strategy implementation has been highly effective in the first five years, efficiency of the implementation has been limited. For example, almost 80% of the children who accessed health facilities for immunization missed opportunity to receive counselling on breastfeeding and/or complementary feeding. Similar findings were also reported in the midterm review of the National Nutrition Strategy and Action Plan. This shows the current limitation and importance of integrated service delivery at the point of delivery.
2. Economic growth of Lao PDR has triggered financial transition process of Gavi, which requires efficient and sustainable domestic financing of immunization program. This is required in addition to the general expected decrease in domestic fund due to the economic impact of the COVID-19 pandemic. This shows the importance of efficient and sustainable financing to ensure service provision of essential health services. While nutrition currently heavily relies its program funding from external donors, immunization is progressing through financial transition towards domestic financing. Early child development is relatively a new area that is expected to be increasingly important and further develop as a new program. Strategic objective 4 on well child and the respective action plan are expected to integrate the three areas to increase efficiency and ensure sustainability of the three programs. The reorganization is expected to increase efficiency and sustainable financing also for other strategic objectives as well.
3. The shift to "people-centred" service delivery also aims to improve respectful care with emphasis on effective counselling. The midterm review highlighted issues around provision and quality of counselling across all technical areas. The perspective shift from "what programs need to provide" to "what users need to receive" also emphasizes practical benefits for the users such as knowledge gain, behavioural changes, enabling environment, empowerment especially of women and trust to health system. The shift is expected to enhance respectful care and effective counselling. The increased emphasis on delivering service from the perspective of users is expected to encourage public health practitioners and health providers to design and provide services with gender lens such as in encouraging female village health volunteers and health centre staff and involvement of husbands and other males in service provision to encourage their involvement, understanding and support.
4. Inequity is another challenge pointed out in the midterm review. Different services have different level of inequity in service uptake as seen in the review. Integrating services into delivery platforms that are relatively available to broader and vulnerable populations, for example integrated outreach services, maximizes opportunities of each contact between users and service providers to increase uptake of broader essential health services.

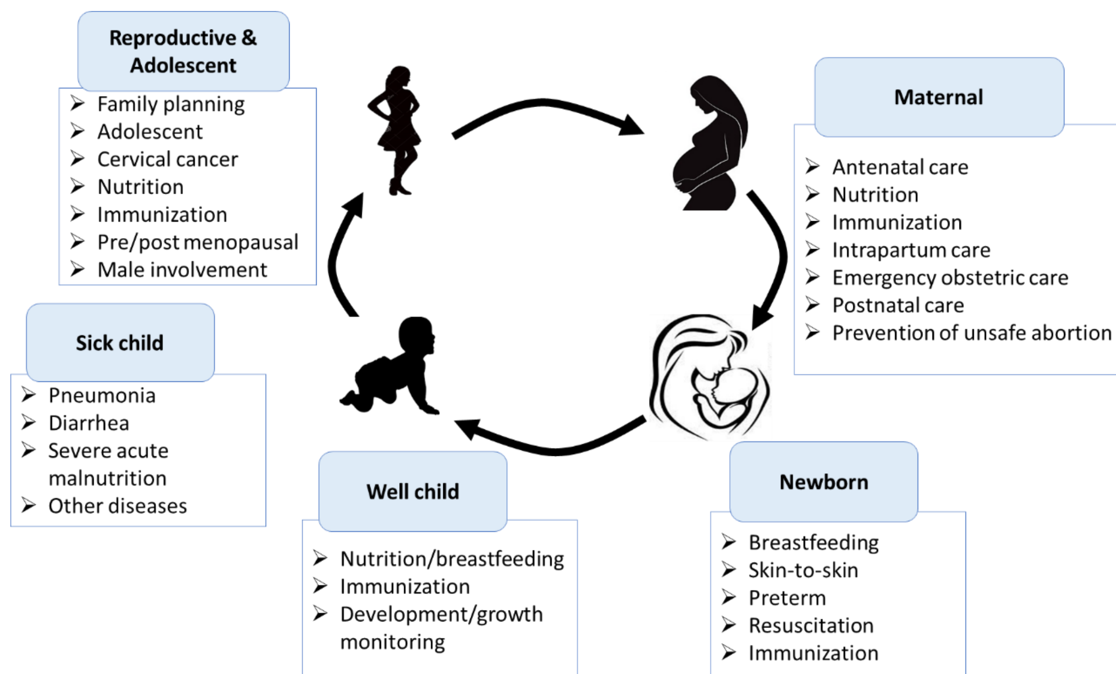
The revised conceptual framework is therefore structured around five common service delivery platforms based on the target population of RMNCAH. It places the patient at its core with the intention of supporting a smoother continuum of quality care. Through an emphasis on these common delivery platforms, essential services are expected to be delivered in a more integrated manner to reduce missed opportunities, increase efficiency, improve respectful care and equity.

Going forwards, this emphasis on integration needs to extend to every aspect of strategy implementation from planning and monitoring, to service delivery, training and supportive supervision. In a long term, a fundamental reorganization in governance and financing may be required for more sustainable arrangement towards integration. The midterm review of this strategy found that majority of the budget for RMNCAH is financed through nutrition program and immunization program, which different national centres are accountable for. While missed opportunities could be solved to a certain extent at the point of service delivery in provincial, district and health centre levels, inefficiency caused by the governance structure needs to be tackled at the higher level. The intended shift to the "people-centred" service delivery is expected to further inform upwards how to design optimal "people-centred" governance in a longer-term reform towards efficient and sustainable service delivery of RMNCAH essential health services.

Health system components (the old Strategic Objectives 8 to 11) will be integrated into management under Health Sector Reform (HSR) pillars. RMNCAH has spearheaded HSR in establishment of various areas such as Essential Health Service Package (EHSP) and quality of health care, DHIS2 and mSupply. Free MCH policy is integrated into National Health Insurance (NHI). Advancement of these reforms to build health system in a crosscutting way has made it more efficient to manage through HSR rather than through RMNCAH Committee.

The approach to Community-based RMNCAH will be aligned to the broader PHC Policy and will be delivered in an integrated manner with oversight from a Community RMNCAH Task Force and implemented in partnership with various stakeholders, especially local authorities, international and local NGOs working at community level.

Figure 2: Revised Conceptual Framework



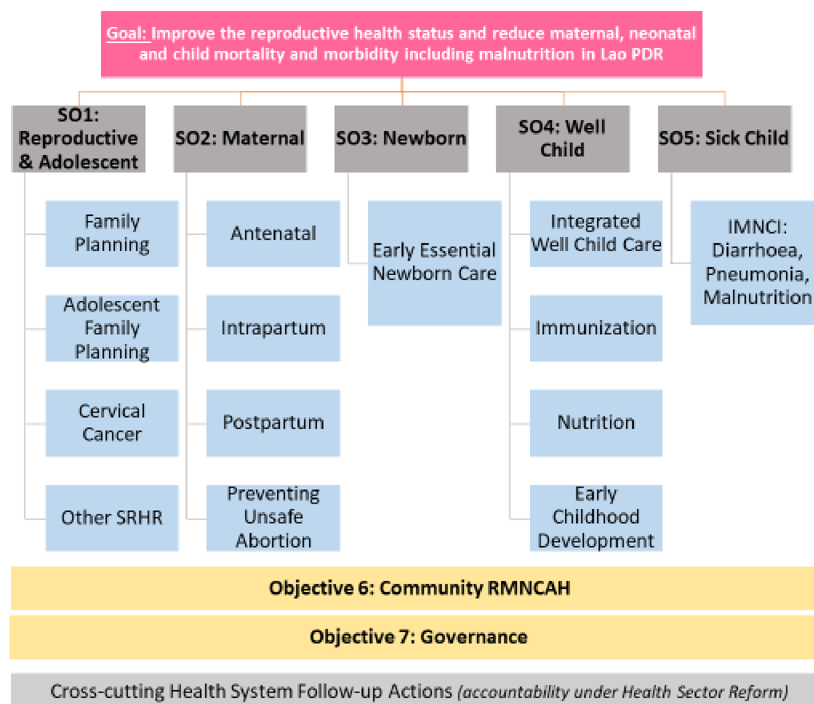
Strategic and Specific Objectives

The structure of Strategic Objectives and their Specific Objectives which operationalises the revised conceptual framework is presented below. This operational framework is comprised of five technical Strategic Objectives aligned to the five delivery platforms and related target groups detailed in the Conceptual Framework: 1) Reproductive & Adolescent; 2) Maternal; 3) Newborn; 4) Well Child; and 5) Sick Child.

These five technical Strategic Objectives are then supported by two cross-cutting Strategic Objectives: 6) Community RMNCAH; and 7) Governance. These cross-cutting Strategic Objectives both have related Specific Objectives and a costed Action Plan. The Strategy Objective 7 on Governance and the respective action plan will be led by the secretariat in collaboration with all sub-committees to aim the overarching strategic shift and monitor progress towards the overall goal.

In line with the recommendations of the MTR, the previous health system sub-committees on human resource, health finance, health information system and medical supplies ("SOs 8-11") will be integrated into the Health Sector Reform Framework's five pillars. Key to this will be maintaining effective communications between HSR committee and RMNCAH management supervisory committee. So as to maintain a high-level focus on the key aspects of health system related RMNCAH improvements, seven Health System Follow-up Actions have been agreed that will underpin this operational framework.

Figure 3: Revised Operational Framework



The table below presents the full wording of the Strategic and Specific Objectives that comprise the Operational Framework. These objectives are linked to the M&E Framework and the Action Plan presented in Section 5 of this document.

Strategic and Specific Objectives
Strategic Objective 1 - Sexual Reproductive Health & Right: Increase SRHR services for all people, without discrimination
Specific Objective 1.1 – Family Planning: By 2025, increase mCPR (modern methods) for all women to 65% and reduce unmet need to 10%
Specific Objective 1.2 – Adolescent FP: By 2025, increase CPR (modern methods) of 15-19-year-olds to 35% by providing youth friendly services to adolescents and youth
Specific Objective 1.3 – Cervical Cancer: By 2025, strengthen capacity of health staff to provide cervical cancer screening services for 40% of women of reproductive age
Specific Objective 1.4 – Other SRHR: By 2025, strengthen the capacity of facilities to provide other SRHR services to all population groups (men/pre-and-post menopausal women) to 30%
Strategic Objective 2 – Maternal: Increase access to quality of ANC, delivery, and PNC services for all women in line with national standards
Specific Objective 2.1 - Antenatal: By 2025, 80% of pregnant women should receive quality ANC service at least 4 times in line with the national standards

Specific Objective 2.2 - Intrapartum: By 2025, 85% of pregnant women delivering with SBA have access to high quality routine or high risk care in line with the national standards

Specific Objective 2.3 - Postpartum: By 2025, 80% of women delivering in a health facility should receive quality postnatal care and complication management within 24 hours of delivery

Specific Objective 2.4 - Safe Abortion: By 2025, to reduce morbidity and mortality amongst women from unsafe abortion

Strategic Objective 3 – Newborn: All newborns receive high quality Early Essential Newborn Care

Specific Objective 3.1 – EENC: By 2025, 70% of newborns initiate breastfeeding within 90 minutes and establish exclusive breastfeeding until discharge

Strategic Objective 4 – Well Child: All Lao children under 5 have access to comprehensive quality services in immunization, nutrition and child development

Specific Objective 4.1 - Integrated Well Child: By 2025, all children attending a health facility or outreach receive a fully integrated Well Child care visit

Specific Objective 4.2 – Fully immunized: By 2025, 85% of two-year old children are fully immunized against Vaccine Preventable Diseases

Specific Objective 4.3 – Immunization Penta 3 & MR2: By 2025, 100% of districts achieve Penta3 and MR2 coverage of 95% or more

Specific Objective 4.4 – Nutrition EHSP: By 2025, ensure children under 5, pregnant/lactating women, and women of reproductive age receive micronutrient supplementation and deworming according to the Essential Health Service Package in line with targets

Specific Objective 4.5 – Nutrition IYCF: By 2025, 65% of caregivers of children less than 5 years receive full screening and counselling on infant and young childcare & feeding practices

Specific Objective 4.6 – Nutrition Breastfeeding: By 2025, ensure that 60% of children under 6 months of age are exclusively breastfed

Specific Objective 4.7 - Early Childhood Development (ECD): By 2025, all children under 5 receive developmental screening through integrated Well Child and Newborn services

Specific Objective 4.8 – ECD Referral Pathways: By 2025, have referral pathways for ECD covering/integrating all levels of health service provision in line with MCH Handbook

Strategic Objective 5 - Sick Child: All children in need of care receive quality curative care at all levels

Specific Objective 5.1 - IMNCI:

By 2025, 80% of children with diarrhoea, pneumonia and acute malnutrition receive quality of care in line with the national guidelines

Strategic Objective 6: By 2025, rural communities, including the most vulnerable and hard to reach, benefit from the implementation of an essential RMNCAH community package

Specific Objective 6.1 – Policy Environment: By 2025, the community health policy environment fosters local authority leadership and facilitates alignment between CHSS and RMNCAH Strategy

Specific Objective 6.2 – Community Package: By 2025, the Community RMNCAH Package is implemented and functional, supported by an operational M&E mechanism

Strategic Objective 7: RMNCAH stakeholders implement the RMNCAH Strategy Action Plan with an integrated and people centred approach supported by strong and efficient governance mechanism

Specific Objective 7.1 – Structural Reform: By 2025, the structural reform to support further integration towards 'people-centred approach' and coordinated planning, implementation and monitoring are established

Crosscutting health system follow up actions

Cross-cutting follow up actions were agreed during the midterm review to address cross-cutting governance and health system challenges beyond RMNCAH. In this strategy, Management Supervisory Committee is responsible to follow up and take responsive actions.

Priority actions specific to each strategic objective are reflected on the Action Plan 2021-2025 (Section 6).

Governance:

- ❖ Shift to “People-centred” governance, financing, operation and service delivery to improve health care quality, respectful care, efficiency and sustainability
- ❖ Strengthen regular joint data-based planning, budgeting and monitoring mechanism with the government and partner stakeholders through the national RMNCAH Committee
- ❖ Integrate health system sub-committees into Health Sector Reform (HSR) governance. Contribute to health system strengthening beyond RMNCAH under HSR
- ❖ Consider optimal arrangement of Health Sector Development Plan (HSDP) and organization of Ministry of Health for efficient and sustainable financing of essential RMNCAH service provision.
- ❖ Assess, monitor, design and implement interventions to promote health of vulnerable populations from the lens of ethnicity, gender and socio-economic status

Human Resources:

- ❖ Strengthen human resource planning through coherent policies, regulations and clinical standards and allocation of relevant cadres based on the Essential Health Service Package (EHSP)
- ❖ Establish regular mechanism to update pre-service curriculum and faculty development based on latest RMNCAH national standards.
- ❖ Link ongoing activities of integrated RMNCAH quality assessment and improvement support to Continuous Professional Development

Service Delivery and Quality:

- ❖ Strengthen regular quality assessment and improvement support in linkage to the 5 Good 1 Satisfaction policy and Dok Champa health facility accreditation
- ❖ Improve availability of medicines, commodities and equipment based on EHSP
- ❖ Improve patient safety, respectful care and counselling
- ❖ Strengthen respectful care, target-specific counselling for behavioural change for improved experience of care and increased trust to health system

Health Financing:

- ❖ Ensure essential operational budget for RMNCAH strategy and Action Plan
- ❖ Improve efficient and sustainable resource allocation and domestic financing under Health Sector Development Plan (HSDP) with a consideration on financial transition and expected decrease of domestic funding from the COVID-19 pandemic
- ❖ Ensure affordability of essential RMNCAH services through financial protection, mainly through National Health Insurance with emphasis on equity

Health Information:

- ❖ Regularly monitor quality of health care in addition to service coverage based on the revised M&E framework and strengthen data-based prioritization
- ❖ Improved quality and use of data through strengthening recording, reporting, monitoring, and data-based planning in health facilities.

Primary Health Care and community health:

- ❖ Strengthen Primary Health Care through engaging local authorities and communities
- ❖ Establish integrated RMNCAH service delivery for community health

3. Management & Accountability

Governance Roles & Responsibilities

The following governance structures have been established with an aim of providing robust mechanisms for monitoring progress, escalating and solving implementation challenges, and sharing lessons learned and developing the evidence base around RMNCAH.

RMNCAH Steering Committee

The RMNCAH Steering Committee will have overall accountability for the National Strategy and Action Plan for Integrated Services on RMNCAH 2016-2025 ("RMNCAH Strategy and Action Plan"). They are responsible for providing enabling environment and comprehensively guiding the implementation of the integrated RMNCAH strategy until 2025.

RMNCAH Management Supervisory Committee

The RMNCAH Management Supervisory Committee leads the development and dissemination of the RMNCAH Strategy and Action Plan. They are responsible for:

- Monitor implementation and facilitate solution to implementation challenges through political dialogue and health system strengthening
- Ensure cohesiveness among RMNCAH Strategy and Action Plan and broader policies and strategies such as Health Sector Reform and Health Sector Development Plan
- Ensure regulations, policies, human resource and financial resource for the implementation of the RMNCAH Strategy and Action Plan
- Give guidance to sub-committee for the ongoing implementation and governance
- Reflect lessons learned through RMNCAH Strategy and Action Plan implementation on broader health sector policies and strategies to further improve enabling environment for implementation of RMNCAH Strategy and Action Plan and other programs beyond RMNCAH
- Encourage directors in provincial health offices and hospitals to facilitate implementation of the RMNCAH Strategy and Action Plan in sub-national levels

RMNCAH Technical Supervisory Committee

The RMNCAH Technical Supervisory Committee provides technical oversight and direction to RMNCAH Strategy and Action Plan implementation. They are responsible for:

- Providing technical guidance to the development, implementation and monitoring of the RMNCAH Strategy and Action Plan
- Facilitate dissemination and implementation of the RMNCAH Strategy and Action Plan by mobilizing technical experts through professional associations and other network with health providers

Sub-Committees

The RMNCAH Sub-Committees are responsible for development, implementation and monitoring of the RMNCAH Strategy Action Plan implementation. They are responsible for:

- Identify strategic objectives, indicators and targets to achieve the overall goal of the RMNCAH Strategy and Action Plan
- Developing five year and annual action plans for their respective sub-committee

- Ensure respective action plans are reflected on the Health Sector Development Plan (HSDP) to ensure effective budgetary flows for their planned work
- Provide technical guidance to provincial level on strategy implementation in their respective areas with collaboration with other sub-committees to ensure coordinated support to provinces
- Monitor progress to respective strategic objectives and report the result of implementation to the steering and supervisory committees
- Monitor budgeting and expenditure against priorities and action plans

Each sub-committee has a head, deputies and a sub-committee secretariat

- The head is responsible to lead the sub-committee to fulfil the responsibilities mentioned above and to represent the sub-committee
- The deputies support the head of the sub-committee and represent the sub-committee on behalf of the head when needed
- The sub-committee secretariat coordination between the sub-committee and the RMNCAH Secretariat for coordinated planning, budgeting, implementation, monitoring and evaluation of the RMNCAH Strategy and Action Plan

<u>RMNCAH Secretariat</u>

The RMNCAH Secretariat is responsible for ensuring good governance and coordination between all stakeholders involved in development, implementation, monitoring and evaluation of the RMNCAH Strategy and Action Plan. The Secretariat is responsible for:

- Facilitate coordinated development, implementation, monitoring, evaluation, and revision as necessary, of the RMNCAH Strategy and Action Plan among all RMNCAH stakeholders to provide targeted and effective inputs to RMNCAH Strategy and Action Plan implementation. These stakeholders include the Steering Committee, The Management Supervisory Committee, The Technical Supervisory Committee, The Sub-Committee and development partners at central level and provincial level.
- Oversight the coordinated work to address challenges and recommendations emerging from the midterm review, including the strategic shift from a program-based approach towards more coordinated and integrated "people-centred approach" in planning, budgeting, service delivery, monitoring, and quality assessment and improvement across strategic objectives.
- Identify outstanding issues beyond particular strategic objective that need attention and support beyond one sub-committee and communicate with relevant stakeholders such as steering and supervisory committees and development partners to facilitate solutions.
- Facilitate sub-national dissemination and oversight of the implementation of RMNCAH Strategy and Action Plan to province and district level. This includes coordination with the provincial RMNCAH focal points to ensure effective implementation of the RMNCAH Strategy and Action Plan at sub-national level.
- Lead the sub-committees in undertaking routine monitoring and reporting, including expenditure, in line with agreed schedule to effectively track progress to strategic objectives, highlight and share lessons learned, and escalate system blockages.
- Convene and facilitate operational and technical review meetings as per the agreed annual schedule of meetings (see table below) to enable formal monitoring of progress.

<u>RMNCAH Community Taskforce</u>

It is agreed that the RMNCAH Community Taskforce will be formulated to ensure that implementation of the RMNCAH Strategy and Action Plan in community level is well coordinated and integrated across the sub-committees as well as with other non-RMNCAH community level interventions. It is a time-bound task force composed from members in the RMNCAH committee and beyond (and as such is not included in the official Ministerial agreement on these committees included in Annex 1 of this document).

This programme of work is led by the Primary Health Care (PHC) Division of the Department of Health and Hygiene Promotion (DHHP), with technical inputs from each of the five technical sub-committees. The RMNCAH Community Taskforce is responsible for:

- Facilitate coordination across the sub-committees in designing, implementation, monitoring and assessment of the RMNCAH Strategy and Action Plan in community level
- Coordinate stakeholder inputs around RMNCAH community health, ensuring an integrated and streamlined approach aimed at reducing missed opportunities to increase service coverage and improve efficiency and sustainability
- Lead a process of reflective lesson learning and evidence-building amongst all relevant stakeholders, both within the health sector and other sectors implementing initiatives at community level
- Ensure alignment between PHC Policy and RMNCAH Strategy and Action Plan by modelling implementation of the policy and providing lessons learned from the implementation to feedback to the policy

The membership of these committees can be found in Annex 1.

Sub-national governance

Implementation of the RMNCAH Strategy and Action Plan at the sub-national level is an area that was highlighted in the midterm review as requiring attention in order to improve coordinated support and effective communication between the central and the sub-national level. In particular, knowledge of key priorities and focal areas from the RMNCAH Strategy at the district level was found to be poor.

The Second Edition of this Strategy included RMNCAH Committees at provincial level to coordinate implementation and monitoring of the RMNCAH Strategy and Action Plan in sub-national level. However, these have only been established in a small number of provinces and the functionality was limited.

Therefore, going forwards from 2021, the RMNCAH Secretariat will work with provinces to identify one Provincial RMNCAH Focal Point in each province to act as the coordinator and liaison point for that province for all matters RMNCAH-related. This will help to streamline communications between central and sub-national. This Focal Person will be responsible for:

- Act as the key coordinator and liaison point both with central RMNCAH stakeholders as well as with district and community level RMNCAH stakeholders to facilitate implementation and monitoring of the RMNCAH Strategy and Action Plan in sub-national levels
- Facilitate understanding of the RMNCAH Strategy and Action Plan and provide briefings, advice, and guidance to those involved in RMNCAH strategy implementation sub-nationally. This includes facilitating the strategic shift toward "people-centred" governance, operation and service delivery in sub-national level.

- Translate RMNCAH Strategy and Action Plan into the local context, identify further priorities of the province based on the local situation, feedback lessons learned to the central RMNCAH Committee to further improve RMNCAH Strategy and Action Plan to meet local needs
- Coordinate with provincial health office managers and relevant units to reflect RMNCAH Strategy and Action Plan on the HSDP of the province and the responsible districts
- Facilitate regular monitoring of service coverage through DHIS2 and quality assessment and improvement to establish regular data-based planning mechanism in the province

4. Monitoring & Evaluation

Central Level Monitoring

The RMNCH Strategy and Action Plan 2016-2025 will be monitored on an on-going basis. At the central level, the sub-committees will report their progress to the Steering Committee and the Technical and Management Supervisory Committees every 6 months using the platform of the RMNCAH Technical Working Group (TWG) meeting, which has been meeting every quarter for the past one decade. Importantly it is through this mechanism that health system follow up actions which need attention beyond RMNCAH program are monitored and discussed, ensuring that issues are escalated to the relevant Department in the Management Supervisory Committee.

On an annual basis, the sub-committees will also report on progress in relation to achievement of their specific objectives, progress against their Action Plans, and progress to their indicator targets. The specific objectives, indicators and targets for each technical area can be found in the Action Plan and Monitoring and Evaluation Framework below, and a complete list of indicators and definitions can be found in Annex 2.

Table 1 below provides an overview of the key central level RMNCAH monitoring meetings scheduled throughout the year. Note that there have been quarterly TWG meeting either with senior managers or by technical sub-committees in the past one decade as under the umbrella of Health Sector Working Group (SWG) and linked to the annual Round Table Meeting. Meetings below are sometimes integrated into one of the TWG meetings.

Table 1: Annual schedule of official Strategy monitoring meetings for RMNCAH

Timing	Meeting	Participants	Agenda	Meeting length	Estimated no. of participants
January / February	**National RMNCAH Annual Meeting**	**Central:** Minister of Health, DGs from all departments, SO Representatives, RMNCAH Secretariat, OBGY, Midwife, Paediatric Associations, central Hospitals **Provincial:** Representatives from all provinces (PHO & PH) **RMNCAH development partners**	- Progress against M&E Framework - Progress against Action Plan - Expenditure reporting - Annual priority setting - Annual planning	2-3 days	100-150 people
May	**RMNCAH Steering Committee Meeting**	**Central**: Minister of Health, DGs, RMNCAH Secretariat	Trouble shooting and decision making on: - Policy issues - Health system issues	2 hours	10 people
August	**Biannual RMNCAH Committee Meeting**	**Central**: Vice Minister, DGs, SO representatives, RMNCAH Secretariat, OBGY, Midwife, Paediatric Associations, central hospitals, development partners	- Summary progress reports from sub-committees - Key issues - Planning revisions	½ day	30 people

November	**RMNCAH Steering Committee Meeting**	**Central**: Minister of Health, DGs, RMNCAH Secretariat	Trouble shooting and decision making on: - Policy issues - Health system issues	2 hours	10 people

Sub-national Monitoring

At the sub-national level, the Provincial RMNCAH Focal Point functions as a coordination point for monitoring: monitoring the progress of implementation of RMNCAH action plans; monitoring and reporting budget expenditure for RMNCAH activities; and evaluating data reported through DHIS2 every month in coordination with the relevant units. The results of monitoring will be shared with relevant sub-national stakeholders at regular PHO meetings and necessary actions taken.

The central RMNCAH Secretariat provides routine supervision support through in-person visits and remote communications to review the progress jointly with the provincial RMNCAH Focal Points and other relevant stakeholders.

Provincial RMNCAH representatives are invited to participate in the National RMNCAH Annual Meeting which takes place at the start of every year. This meeting brings together key central and sub-national stakeholders to review progress and challenges from the past year and to plan for the upcoming year.

The provincial RMNCAH Focal Point monitors progress in districts, health centres and communities.

Strategy Reviews & Evaluations

Routine monitoring will be complemented by interim reviews and a final evaluation of the Strategy and Action Plan. The first interim review over the full course of the Strategy is the Mid Term Review which has taken place in 2019/20 and has informed the revisions that comprise this Third Edition of the RMNCAH Strategy. The midterm review ensures alignment with the 9th Five-year National Socio-economic Development Plan 2021-2025, 9th Health Sector Development Plan 2021-2025 and the third phase of Health Sector Reform Framework to 2025, and makes recommendations for revisions of the strategy and development of the action plan for 2021-2025.

Annual reviews at the start of every year, looking back at progress over the last year are planned to make recommendations for resolving outstanding issues and improving implementation for the remaining period of the strategy.

The final evaluation of the strategy and action plan will take place in 2024/25 and will look at achievement and implementation over the 10 years of implementation. The final evaluation will assess progress in relation to the goal and the strategic and specific objectives and will provide recommendations for the development of the next RMNCAH strategy and action plan.

5. RMNCAH Indicators and targets up to 2025

Development of the revised Monitoring & Evaluation Framework

The revised RMNCAH M&E Framework and Action Plan (AP) to 2025 were developed in 2019-2020 after the findings from the national Quality of Healthcare Assessments in RMNCAH were available. A series of participatory strategic planning workshops by sub-committees and relevant partners were run for each of the technical areas under the new strategic arrangement (Reproductive & Adolescent, Maternal, Newborn, Sick Child, Well Child, Community and Governance). These workshops included the following: midterm review data from the quality assessments, from DHIS2 and from LSIS2 were presented; indicators for which targets were not being reached were highlighted; key gaps in service delivery and quality of care were identified; and implementation bottlenecks and challenges were presented.

M&E guidance from the RMNCAH Secretariat ensured that for each Strategic Objective there was a mixture of coverage and quality indicators. This is to address the fact that quality of health care impacts health outcomes as much as, if not more, the service coverage, and to reflect the emphasis on the quality of health care in the next five years under this revised strategy. As numerous indicators in the previous version of the M&E framework did not have established data collection arrangements and as such were not able to report data against them, a key condition for inclusion in the M&E framework was that there must be already identified systems for data collection either from DHIS2 or the facility-based integrated RMNCAH quality assessment or any other existing source.

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
GOAL: Improve the reproductive health status and reduce maternal, neonatal and child mortality and morbidity including malnutrition in Lao PDR															
Impact 1	Total Fertility Rate (per woman)	Impact	LSIS	2.7 (LSIS, 2017)	3.1	3	3	2.95	2.8	2.7	2.6	2.5	2.4	2.3	Survey (LSIS)
Impact 2	Adolescent Fertility/Birth Rate (per 1,000 women aged 15-19 years)	Impact /Equity	LSIS	83 (LSIS, 2017)	90	85	80	75	70	69	68	67	66	65	Survey (LSIS)
Impact 3	Maternal Mortality Ratio (per 100,000 live births)	Impact	UN Estimate	181 (UN Est 2017)	190	182	175	167	160	150	135	120	115	100	UN estimate
Impact 4	Neonatal Mortality Rate (per 1,000 live births)	Impact	LSIS	18 (LSIS, 2017)	30	27	25	23	20	19	18	17	16	15	Survey (LSIS)
Impact 5	Infant Mortality Rate (per 1,000 live births)	Impact	LSIS	40 (LSIS, 2017)	47	43	38	34	30	28	25	22.5	21	20	Survey (LSIS)
Impact 6	Under Five Mortality Rate (per 1,000 live births)	Impact	LSIS	46 (LSIS, 2017)	62	56	51	42	40	37	35	33	32	30	Survey (LSIS)
Impact 7	Prevalence of Stunting in children < 5 years of age (%)	Impact	LSIS; National Nutrition Survey	33% (LSIS, 2017)	35%	34%	33.2 %	32.5 %	32%	30%	29%	28%	27%	26%	Survey (LSIS)
Impact 8	Rate of underweight among children < 5 years of age (%)	Impact	LSIS	21% (LSIS, 2017)	24.2 %	22%	21%	20.5 %	20%	18%	16%	14.5 %	13%	12%	Survey (LSIS)
Impact 9	Prevalence of Severe Acute Malnutrition < 5 years of age (%)	Impact	LSIS	3% (LSIS, 2017)						2.5%	2.2%	1.8%	1.4%	1%	Survey (LSIS)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
Impact 10	Prevalence of anemia in women of reproductive age (Hb<12g/dL; for pregnant women, less than 11g/dL)) (%)	Impact	LSIS	36% (non-pregnant) (MICS3-NNS 2006)	32%	29%	27%	25%	23%	21%	19%	17%	16%	15%	Survey (LSIS)
Equity: Improve equity of access to essential services on reproductive, maternal, newborn, child and adolescent health in Lao PDR															
Equity 1	Equity ratio of Neonatal Mortality Rate by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	2.2(40/18) (LSIS, 2012) 1.4 (20/14) (LSIS, 2017)							1.2	1.2	1.1	1	Survey (LSIS)
Equity 2	Equity ratio of Under Five Mortality Rate by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	3.6 (120/33) (LSIS, 2012) 2.7 (63/23) (LSIS, 2017)							1.8	1.6	1.4	1.3	Survey (LSIS)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
Equity 3	Equity ratio of stunting prevalence among children under 5 by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	3.1 (60.6/19.7) (LSIS, 2012) 3.5 (48/13.9) (LSIS, 2017)							3	2.8	2.6	2.5	Survey (LSIS)
Equity 4	Equity ratio of coverage of at least 1 ANC visit (ANC1) by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	0.3 (24.5/92.5) (LSIS, 2012) 0.6 (55.6/97.5) (LSIS, 2017)							0.8	0.9	0.9	1	Survey (LSIS)
Equity 5	Equity ratio of coverage of Skilled Birth Attendant (SBA) by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	0.1 (10.8/90.7) (LSIS, 2012) 0.3 (32.6/96.8) (LSIS, 2017)							0.5	0.6	0.7	0.8	Survey (LSIS)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
Equity 6	Equity ratio of coverage of Penta3 (children under 1 year receiving the third dose of Penta vaccine) by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	0.5 (36.8/81.4) (LSIS, 2012) 0.6 (43.1/76.5) (LSIS, 2017)							0.8	0.9	0.9	1	Survey (LSIS)
Strategic Objective 1 - Reproductive & Adolescent - Increase Sexual Reproductive Health and Rights (SRHR) services for all people, without discrimination															
Specific Objective 1.1: By 2025, increase mCPR (modern methods) for all women to 65% and reduce unmet need to 10%.															
1.1.1	Contraceptive Prevalence Rate (married women; all methods) (%)	Coverage	LSIS, Track20	50% (LSIS, 2012) 54.1% (LSIS, 2017)	60%	65%	70%	75%	65%	66%	67%	68%	69%	70%	Survey (LSIS)
1.1.2	Modern Contraceptive Prevalence Rate (all WRA; Modern Methods) (%)	Coverage	LSIS & Track20	49% (LSIS, 2017) 41% (Track20, 2019)					55%	57%	59%	61%	63%	65%	Survey (LSIS)
1.1.3	Percentage of women with an unmet need for contraception (married WRA) (%)	Coverage	LSIS & Track20	18.2% (Track20, 2019) 14.3% (LSIS, 2017)					17.3%	16.4%	15.5%	14.6%	13.8%	13%	Survey (LSIS)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
1.1.4	Number of additional users of modern methods	Coverage	DHIS2, Track20	198,929 (Track20, 2019)				163,444	214,365	229,801	245,237	260,673	276,109	291,550	Service statistics (DHIS2)
1.1.5	Proportion of women using long acting and permanent contraceptives (LARC & sterilization) (%)	Coverage	LSIS, DHIS2, Track20	16.1% (Track20, 2017)				18%	20%	22%	24%	26%	28%	30%	Survey (LSIS) & Service statistics (DHIS2)
1.1.6	Proportion of women accessing services at a health facility using modern contraceptives who received counselling/follow-up on other methods (%)	Quality	Integrated Quality Assessment	43% (QA, 2019)					48%	52%	57%	61%	66%	70%	Facility Assessment: Exit interview
1.1.7	Proportion of women accessing services at a health facility not using any modern contraceptives and not wishing to be pregnant (at least within 2 years) who received counselling on modern methods (%)	Quality	Integrated Quality Assessment	10% (QA, 2019)					12%	14%	18%	25%	30%	40%	Facility Assessment: (Exit interview)
Specific Objective 1.2 - By 2025, increase CPR (modern methods) of 15-19 years old' to 35% by providing youth friendly services to adolescents and youth.															
1.2.1	Modern contraceptive prevalence rate amongst 15-24 years old (all; modern methods) (%)	Coverage	LSIS, DHIS2	38% (LSIS, 2017)					40%	42%	44%	46%	48%	50%	Survey (LSIS) & Service statistics (DHIS2)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
1.2.2	Unmet need for contraception amongst 15-24 years old (all women) (%)	Coverage	LSIS	33.1% (LSIS, 2017)					30%	27%	24%	21%	18%	15%	Survey (LSIS)
1.2.3	Proportion of health facilities (only provincial hospitals) where there is available room for youth friendly service provision (%)	Quality	Integrated Quality Assessment	TBC (next QA)						TBC based on next Quality Assessment					Facility Assessment
Specific Objective 1.3: By 2025, strengthen capacity for health staff to be able to provide cervical cancer screening services to 40% of the population of women of reproductive age															
1.3.1	Proportion of women 25 to 49 years old screened for cervical cancer (%)	Coverage	Clinic Records (LSIS for denominator)	TBC - use 2018 as baseline						10	15	25	35	40%	Service statistics (DHIS2)
1.3.2	Proportion of women 25 to 49 years old diagnosed positive by VIA and treated for cervical cancer (%)	Coverage	Clinic Records (LSIS for denominator)	TBC - use 2018 as baseline					80%	83%	85%	90%	95%	100%	Service statistics (DHIS2)
Specific Objective 1.4 - By 2025 strengthen the capacity of facilities to provide other SRHR services to all population groups (men and pre-and-post menopausal women) to 30%.															

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
1.4.1	Proportion of health facilities (only provincial hospitals) that are ready to provide 'friendly' sexual reproductive health and rights services for all population groups	Quality	Integrated Quality Assessment	TBC (next QA)						TBC based on next Quality Assessment					Facility Assessment
1.4.2	Proportion of health staff who have been trained on sexual reproductive health and rights counselling	Quality	Integrated Quality Assessment	TBC (next QA)						TBC based on next Quality Assessment					Facility Assessment
Strategic Objective 2 – Maternal: All pregnant, laboring and post-partum women receive quality care in line with national standards															
Specific Objective 2.1 - Antenatal: By 2025, 80% of pregnant women should receive at least 4 quality ANC checks in line with the timings advised and national standards															
2.1.1	Proportion of pregnant women receiving at least 1 ANC check	Coverage	LSIS, DHIS2	54% (LSIS, 2012) 82% (LSIS, 2017) 98% (DHIS2, 2019)*	70%	75%	80%	85%	90%	91%	92%	93%	94%	95%	Survey (LSIS)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
2.1.2	Proportion of pregnant women who made first ANC visit before end of 12th gestational week of pregnancy	Quality	LSIS, Integrated Quality Assessment	44% (LSIS, 2017) 40% (QA, 2019)						44%	48%	52%	56%	60%	Survey (LSIS) & Service statistics (DHIS2)
2.1.3	Proportion of pregnant women receiving at least 4 ANC checks	Coverage	LSIS, DHIS2	37% (LSIS, 2012) 71% (DHIS2, 2019)*	50%	55%	65%	70%	75%	76%	77%	78%	79%	80%	Survey (LSIS) & Service statistics (DHIS2)
2.1.4	Proportion of pregnant women attending ANC who were tested for anemia and the result recorded	Quality	Integrated Quality Assessment	35% (QA, 2019)						40%	45%	50%	60%	70%	Facility assessment: Chart review

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
2.1.5	Proportion of women who attended ANC in their third trimester who have a birth preparedness plan written in their MCH handbook	Quality	Integrated Quality Assessment	45% (QA, 2019)						50%	55%	65%	75%	80%	Facility assessment: Chart review
2.1.6	Proportion of pregnant women attending ANC who were counseled on nutrition practices during their current pregnancy	Quality	Integrated Quality Assessment	80% (QA, 2019)						84%	88%	92%	96%	98%	Facility assessment: Chart review
2.1.7	Proportion of pregnant women attending ANC receiving Provider Initiated Counseling and Testing (PICT) for HIV	Coverage	HIVCAM, DHIS2	22% (HIVCAM, 2016) 19% (DHIS2, 2019)*	20%	30%	40%	50%	60%	62%	64%	66%	68%	70%	Service Statistics (DHIS2 & HIVCAM)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
2.1.8	Percentage of pregnant women who receive Iron/Folic acid (> or equal 90 tablets)	Coverage	LSIS, DHIS2	25% (LSIS, 2012) 126% (DHIS2, 2019)*	45%	50%	55%	60%	65%	66%	67%	68%	69%	70%	Survey (LSIS) & Service statistics (DHIS2)
Specific Objective 2.2 - Intrapartum: By 2025, 85% of pregnant women deliver with a skilled birth attendant with access to quality routine or high-risk care in line with national standards.															
2.2.1	Proportion of pregnant women delivering with a trained health professional (SBA)	Coverage	LSIS, DHIS2	42% (LSIS, 2012) 64% (LSIS, 2017) 69% (DHIS2, 2019)*						81%	82%	83%	84%	85%	Survey (LSIS) & Service statistics (DHIS2)
2.2.2	Proportion of births in a health facility (FBD)	Coverage	LSIS, DHIS2	38% (LSIS, 2012) 65% (LSIS, 2017) 67% (DHIS2, 2019)*	45%	50%	55%	60%	65%	70%	73%	76%	78%	80%	Survey (LSIS) & Service statistics (DHIS2)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
2.2.3	Proportion women delivering in a health facility who received routine uterotonic drugs (Oxytocin)	Quality	DHIS2	89% (DHIS2, 2019)*						90%	92%	94%	96%	98%	Service statistics (DHIS2)
2.2.4	Proportion of women with severe preeclampsia or eclampsia who were given the correct dose of MgSO4	Quality	Integrated Quality Assessment	56% (CR, 2019)						40%	44%	50%	55%	60%	Chart review
2.2.5	Proportion of mothers who are monitored for 2 hours after delivery	Quality	Integrated Quality Assessment	TBC (next QA)						TBC once baseline is available (2020)					Facility assessment: Chart review
2.2.6	Proportion of infants born to identified HIV positive mothers receiving ARV prophylaxis for prevention of mother to child transmission	Coverage	HIVCAM	80% (HIVCAM, 2018)	60%	70%	80%	82%	84%	86%	88%	92%	96%	100%	Service Statistics (HIVCAM)
Specific Objective 2.3 - Postpartum: By 2025, 80% of women delivering in a health facility should receive quality post natal care and complication management within 24 hours of delivery															

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
2.3.1	Proportion of women who receive postnatal care for at least 24 hours after delivery	Coverage	LSIS, DHIS2	47% (LSIS, 2017)						50%	55%	60%	65%	70%	Survey (LSIS) & Service statistics (DHIS2)
2.3.2	Proportion of women who receive postnatal care at 6 weeks after delivery	Coverage	DHIS2	TBC						TBC once baseline is available (2020)					Service statistics (DHIS2)
2.3.3	Proportion of women who received a complete PNC check (mother & baby) according to the MCH Handbook	Coverage	DHIS2	TBC						TBC once baseline is available (2020)					Service statistics (DHIS2)
2.3.4	Proportion of postnatal women who received iron/folic acid (> or equal to 90 tablets)	Coverage	DHIS2	89% (DHIS2, 2016)* 77% (DHIS2, 2019)*	45%	50%	55%	60%	65%	68%	70%	74%	78%	80%	Service statistics (DHIS2)
Specific Objective 2.4 - Safe Abortion: By 2025, to reduce morbidity and mortality amongst women from unsafe abortion															
2.4.1	Proportion of induced abortions using MVA or Misoprostol (Misoprostol and/or Misoprostol+ Mifepristone)	Quality	Integrated Quality Assessment	TBC (next QA)						TBC once baseline is available (2020)					Facility assessment: Chart review

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
Strategic Objective 3 - Newborn: All newborns receive high quality Eary Essential Newborn Care (EENC)															
Specific Objective 3.1 - Newborn: By 2025, 70% of newborns initiate breastfeeding within 90 minutes of delivery															
3.1.1	Percentage of last live births in the last 2 years where the newborn was placed on the mother's bare chest after birth	Coverage	LSIS	17% (LSIS, 2017)					37%	39%	41%	43%	45%	47%	Survey (LSIS)
3.1.2	Proportion of newborns born in a health facility who receive immediate and sustained skin-to-skin contact for at least 90min and a complete breastfeed (complete STS)	Quality	Integrated Quality Assessment /DHIS	33% (QA, 2019)					38%	45%	50%	55%	60%	65%	Facility assessment: Interview Service statistics (DHIS2)
3.1.3	Proportion of newborns born in health facilities who were exclusively breastfed from birth until discharge	Quality	Integrated Quality Assessment	80% (QA, 2019) *NB: Baseline is birth-interview (not discharge)*					85%	90%	95%	98%	>99%	>99%	Facility assessment: Interview
Strategic Objective 4 – Well Child: All Lao children under 5 have access to comprehensive quality services in immunization, nutrition and child development															
Specific Objective 4.1 - Integrated Well Child: By 2025, all children attending a health facility receive a fully integrated Well Child care visit															

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
4.1.1	Proportion of children under 5 accessing care at a health facility who have received an integrated Well Child care visit	Quality	Integrated Quality Assessment	TBC (next QA)						TBC once baseline is available (2020)					Facility assessment: Interview and chart review
4.1.2	Proportion of villages in zones 0 and 1 delivering EPI-MCH services at fixed sites	Coverage	DHIS2	26% (DHIS2, 2014)				40%	55%	70%	80%	90%	95%	100%	Service statistics (DHIS2)
Specific Objective 4.2 - Immunization: By 2025, 85% of 2 year-old children are fully immunized against VPD.															
4.2.1	Proportion of HepB birth dose (within 24 hours after birth for hospital births and <7days for outreaches)	Coverage	NIP/DHIS2	50% (NIP, 2014) 71% (NIP/DHIS2, 2019)*	52%	53%	55%	70%	75%	79%	81%	83%	84%	85%	Service statistics (DHIS2)
4.2.2	Proportion of children under 1year received 3 doses of OPV	Coverage	NIP/DHIS2	83% (NIP 2016) 92% (NIP/DHIS2, 2019)*	90%	92%	93%	85%	87%	89%	91%	93%	94%	95%	Service statistics (DHIS2)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
4.2.3	Proportion of under 1 year-old children immunized against DPT-HepB- Hib3	Coverage	NIP/DHIS2	88% (NIP, 2014) 93% (NIP/DHIS2, 2019)*	90%	90%	85%	90%	95%	95%	95%	95%	95%	95%	Service statistics (DHIS2)
4.2.4	Proportion of children aged 12-23 months immunized against measles and rubella (MR2)	Coverage	NIP/DHIS2	TBC					80%	83%	86%	89%	92%	95%	Service statistics (DHIS2)
4.2.5	Proportion of under 2 year-old children fully immunized	Coverage	NIP/DHIS2	76% (<1 years of age - proxy) (NIP, 2019)*				70%	75%	80%	83%	85%	88%	90%	Service statistics (DHIS2)
4.2.6	Proportion of children under 5 accessing services at a health facility who have their vaccination cards filled correctly	Quality	Integrated Quality Assessment	94% (QA, 2019)						95%	96%	97%	98%	99%	Facility assessment: Chart review

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
4.2.7	Proportion of caregivers bringing their children for vaccination at a health facility who know the type of vaccination (s) given to their children under 5 years old	Quality	Integrated Quality Assessment	45% (QA, 2019)						50%	55%	60%	65%	70%	Facility assessment: Interview and chart review
Specific Objective 4.3 - Immunization: By 2025, 100% of districts achieve Penta3 and MR2 coverage of 95% or more															
4.3.1	5.2.1(a): Proportion of districts achieving Penta3 coverage of 95% or more (%)	Coverage	NIP/DHIS2	35% (NIP, 2018)				50%	65%	75%	85%	90%	95%	100%	Service statistics (DHIS2)
4.3.2	5.2.2(a): Proportion of districts achieving MR2 coverage of 95% or more (%)	Coverage	NIP/DHIS2	35% (NIP, 2018)				50%	65%	75%	85%	90%	95%	100%	Service statistics (DHIS2)
Specific Objective 4.4 - Nutrition: By 2025, ensure children under 5, pregnant/lactating women, and womene of reproductive age receive micronutrient supplementation and deworming according to the Essential Health Service Package in line with targets															
4.4.1	Proportion of children 12-59 months who have received deworming twice a year (%)	Coverage	DHIS2	67% (DHIS2, 2018)					70%	72%	74%	76%	78%	80%	Service statistics (DHIS2)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
4.4.2	Proportion of children aged 6-59 months who have received Vitamin A twice a year (%)	Coverage	DHIS2	59% (LSIS 2011/12)					70%	72%	74%	76%	78%	80%	Service statistics (DHIS2)
Specific Objective 4.5 - Nutrition: By 2025, 65% of caregivers of children less than 5 years receive full screening and counseling on infant and young childcare & feeding practices															
4.5.1	Proportion of children 6-59 months who have been screened with MUAC and / or looking for pitting eodema on both feet (%)	Coverage	DHIS2	TBC once added to DHIS2					20%	25%	30%	35%	40%	50%	Service statistics (DHIS2)
4.5.2	Proportion of children 6 - 24 months attending facilities for well child services who have been fully screened for complementary feeding practices (%)	Quality	Integrated Quality Assessment	33% (QA, 2019)					40%	45%	50%	55%	60%	65%	Facility assessment: Interview
4.5.3	Proportion of parents who have children 6 - 24 months attending facilities for well child services who received counselling on complementary feeding (%)	Quality	Integrated Quality Assessment	60% (QA, 2019)					60%	65%	70%	75%	80%	85%	Facility assessment: Interview

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
4.5.4	Proportion of children under 2 attending facilities for well child services whose growth monitoring was recorded correctly in their growth monitoring chart (%)	Quality	Integrated quality assessment	72% (QA, 2019)						75%	80%	86%	90%	95%	Facility assessment: Chart review and re-examination
Specific Objective 4.6 - Nutrition: By 2025, ensure that 60% of children under 6 months of age are exclusively breastfed															
4.6.1	Proportion of infants under 6 months who are exclusively breastfed (%)	Coverage	LSIS	40% (LSIS, 2012) 45% (LSIS, 2017)	42%	44%	46%	48%	50%	52%	54%	56%	58%	60%	Survey (LSIS)
4.6.2	Percentage of children under 6 months attending facilities for well child services who are fully screened on excusive breast feeding (%)	Quality	Integrated Quality Assessment	20% (QA, 2019)					30%	35%	40%	50%	60%	70%	Facility assessment: Interview
4.6.3	Percentage of children under 6 months attending facilities for well child services who received counselling on exclusive breast feeding (%)	Quality	Integrated Quality Assessment *To be included in DHIS2 (TBC)*	58% (QA, 2019)					60%	64%	68%	72%	76%	80%	Facility assessment: Interview

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
Specific Objective 4.7 - Early Childhood Development (ECD): By 2025, all children under 5 receive developmental screening through integrated Well Child and Newborn Services.															
4.7.1	Proportion of children under 5 screened for ECD through fixed site	Coverage	ECD service statistics	1.3% (ECD reporting, 2019)					5%	15%	25%	45%	55%	65%	Service statistics (ECD reporting)
4.7.2	Percentage of parents who have children under 5 attending well child services who received health education using the integrated child development-nutrition-immunization pages within the MCH handbook (%)	Quality	Integrated Quality Assessment	TBC (next QA)						TBC based on next Quality Assessment					Facility assessment: Interview
Specific Objective 4.8 - ECD: By 2025, have referral pathways for ECD covering/integrating all levels of health service provision aligns with MCH Handbook															
4.8.1	Percentage of children under 5 with developmental & physical concerns who have been referred for diagnosis and intervention (%)	Coverage	ECD service statistics / DHIS2	35% (ECD reporting, 2019)					40%	45%	50%	55%	60%	65%	Service statistics (ECD reporting)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
4.8.2	Percentage of children under 5 screened who have received ECD services (%)	Coverage	ECD service statistics / DHIS2	4.3% (ECD reporting, 2019)					10%	20%	30%	40%	50%	60%	Service statistics (ECD reporting)
Strategic Objective 5- Sick Child: All children in need of care receive quality curative care at all levels															
Specific Objective 5.1 - Sick Child: By 2025, 80% of children with diarrhea, pneumonia and acute malnutrition receive quality of care in line with the national Guidelines															
5.1.1	Proportion of children under 5 with diarrhoea for whom advice or treatment was sought from a health facility or provider	Coverage	LSIS	49% (LSIS, 2017)						60%	65%	70%	75%	80%	Survey (LSIS)
5.1.2	Proportion of children under 5 with diarrhoea receiving ORS & Zinc	Coverage	LSIS	1% (LSIS, 2012) 13% (LSIS, 2017)						33%	38%	43%	48%	53%	Survey (LSIS)
5.1.3	Proportion of children under 5 with diarrhoea treated with ORS from health providers (health facility and outreach)	Quality	*To be added to DHIS2*	NA						68%	71%	76%	81%	86%	Service statistics (DHIS2)
5.1.4	Proportion of children under 5 with diarrhoea treated with ORS & Zinc from health providers (health facility and outreach)	Quality	*To be added to DHIS2*	NA						33%	38%	43%	48%	53%	Service statistics (DHIS2)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
5.1.5	Proportion of children under 5 with diarrhoea treated at health facilities with ORS & Zinc in line with IMNCI and Pocket Book guideline	Quality	Integrated Quality Assessment	23% (QA, 2019)						35%	40%	45%	50%	60%	Facility assessment: Chart review
5.1.6	Proportion of children under 5 with acute respiratory infection symptoms (ARI) for whom advice or treatment was sought from a health facility or provider	Coverage	LSIS	54% (LSIS, 2012) 40% (LSIS, 2017)						50%	54%	58%	62%	66%	Survey (LSIS)
5.1.7	Proportion of children under 5 with suspected pneumonia treated with antibiotics	Coverage	LSIS	57% (LSIS, 2012) 45% (LSIS, 2017)						55%	60%	65%	70%	75%	Survey (LSIS)
5.1.8	Proportion of children under 5 with suspected pneumonia treated with antibiotics from health providers (health facility and outreach)	Quality	*To be added to DHIS2*	NA						55%	60%	65%	70%	75%	Service statistics (DHIS2)
5.1.9	Proportion of children under 5 with suspected pneumonia treated with appropriate antibiotics at health facilities in line	Quality	Integrated Quality Assessment	94% (QA, 2019)						95%	96%	97%	98%	99%	Facility assessment: Chart review

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
	with IMNCI and Pocket Book guideline														
5.1.10	Proportion of children aged 6-59 months with Severe Acute Malnutrition (SAM) who are admitted for treatment at health facilities	Coverage	*To be added to DHIS2*	<5% (estimate, 2020)						10%	15%	20%	25%	30%	Service statistics (DHIS2)
5.1.11	Proportion of children aged 6-59 months with Severe Acute Malnutrition (SAM) admitted for treatment at health facilities and discharged as cured	Quality	*To be added to DHIS2*	TBC once added to DHIS2						TBC once baseline is available				75%	Service statistics (DHIS2)
5.1.12	Proportion of children aged 6-59 months with Severe Acute Malnutrition (SAM) admitted for treatment at health facilities and discharged as dead	Quality	*To be added to DHIS2*	TBC once added to DHIS2						TBC once baseline is available				5%	Service statistics (DHIS2)

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
5.1.13	Proportion of children aged 6-59 months with Severe Acute Malnutrition (SAM) admitted for treatment at health facilities and discharged as defaulted	Quality	*To be added to DHIS2*	TBC once added to DHIS2						TBC once baseline is available				15%	Service statistics (DHIS2)
5.1.14	Proportion of children under 5 with severe acute malnutrition (SAM) who received appropriate treatment based on the national guidelines	Quality	Integrated Quality Assessment	TBC (next QA)						65%	70%	75%	80%	85%	Facility assessment: Chart review
Strategic Objective 6: By 2025, rural communities, including the most vulnerable and hard to reach, benefit from the implementation of an essential RMNCAH community package.															
Specific Objective 6.1 - By 2025, the community health policy environment fosters local authority leadership and facilitates alignment between CHSS and RMNCAH Strategy															
6.1.1	Proportion of villages certified as Healthy Model Village (in MOH's 71 priority districts)	Process	Annual report of Hygiene and Health Promotion	77% (Healthy Village Model 2019)						82%	84%	86%	88%	90%	DHHP reporting

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
			Department												
Specific Objective 6.2: By 2025, Community RMNCAH package is implemented and functioning regularly based on the M&E framework.															
6.2.1	Proportion of villages with trained VHV on community based RMNCAH service delivery packages (in MOH's 71 priority districts)	Process	Annual report of Hygiene and Health Promotion Department	Not available						10%	20%	30%	40%	50%	DHHP reporting
6.2.2	Proportion of villages in which the trained VHVs received supportive supervision by health centers at least 2 times/year/village (in 71 priority districts)	Process	Annual report of Hygiene and Health Promotion Department	Not available						30%	50%	70%	80%	90%	DHHP reporting

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
6.2.3	Proportion of villages with trained VHV conducted home visits on RMNCAH at least one visit per month (in MOH's 71 priority districts)	Process	Annual report of Hygiene and Health Promotion Department	Not available						10%	20%	30%	40%	50%	DHHP reporting
Strategic Objective 7: RMNCAH stakeholders implement the RMNCAH Strategy Action Plan with an integrated and people centred approach supported by strong and efficient governance mechanisms															
Specific Objective 7.1: By 2025, the structural reforms to support further integration towards a 'people-centered approach' and coordinated planning, implementation and monitoring are established															
7.1.1	Integrated RMNCAH quality assessment data for all district hospitals are available in a regular basis to be used for 5 Good 1 Satisfaction	Process	Integrated quality assessment	TBC						TBC					
7.1.2	% of children who come for immunization receive breastfeeding / complementary feeding screening and counselling	Quality	Integrated quality assessment	27% (QA, 2019)						45%	54%	63%	71%	80%	Facility assessment: Exit interview

No.	Indicator	Type of Indicator	Data Source	Baseline	Targets										Data collection method
					2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
7.1.3	% of women who visit postnatal care / well child clinic receive family planning counselling	Quality	Integrated quality assessment	4% (QA, 2019)						22%	31%	40%	50%	60%	Facility assessment: Exit interview
7.1.4	Amount of expenditure by central sub-committees spent for promoting (training, monitoring etc.) integrated service delivery that follows national standards of integrated service delivery	Process	Expenditure assessment	TBC						TBC					Expenditure assessment
7.1.5	Proportion of activities in the Action Plan implemented (per Strategic Objective)	Process	Regular implementation monitoring	TBC						TBC					Regular implementation monitoring

6. The national RMNCAH Action Plan for 2021-2025

Development of the revised Action Plan

Once the indicators and targets for a strategic objective had been agreed upon, participants in the Strategic Planning workshops focused on the development of a strategic action plan. This initial action plan focused on high level strategic priorities for driving quality and coverage improvements in order to reach strategy targets. These were then further disaggregated into activities. Priority Areas were agreed by stakeholders for each specific objective focusing on the enabling environment (policies etc.) and supply side priorities (service delivery, training etc.). All demand side priorities were amalgamated under the new RMNCAH Community Strategic Objective (Strategic Object 6) and all health system priorities were streamlined into seven health system follow-up actions. A new action plan for the RMNCAH Secretariat to implement around governance was developed as Strategic Objective 7.

The priority actions need to be operationalized to determine the cost and responsible departments for the actions. The estimated costs includes capital costs, activity costs, and infrastructure costs (activity specific, not included in EHSP) but salary costs or costs for consumables are not included. Responsible departments for actions are listed below.

The national RMNCAH Action Plan for 2021-2025

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
Strategic Objective 1 – Sexual Reproductive Health & Rights: Increase SRHR services for all people, without discrimination											
Specific Objective 1.1 - By 2025, increase mCPR (modern methods) for all women to 65% and reduce unmet need to 10%.											**155,374,054,780**
1.1.1	Strengthen government regulations and collaboration with the private sector providing FP services, including social marketing of FP commodities	SO1 specific, Cross-cutting: private sector	DHHP, MCHC	✓	✓	✓	✓	✓	1.1 1.6	UNFPA, PSI, WHO	822,038,500

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.1.1.1	*Develop government regulations and collaboration with the private sector providing FP services, including social marketing of FP commodities*			✓	✓				*1.6.1*		*4,567,500*
1.1.1.2	*Endorse government regulations and collaboration with the private sector providing FP services, including social marketing of FP commodities*					✓			*1.6.1*		*125,037,600*
1.1.1.3	*Roll out government regulations and collaboration with the private sector providing FP services, including social marketing of FP commodities*						✓	✓	*1.6.2* *1.1.2*		*692,433,400*
1.1.2	Develop guidelines and IEC materials on family planning (especially on long-acting methods, as well as access to FP services by unmarried youth and in times of humanitarian crises)	SO1 specific Links to humanitarian stakeholders	DHHP, DTR, MCHC, CCHE	✓	✓	✓	✓	✓	1.1 1.6	UNFPA, PSI, WHO	9,151,352,000
1.1.2.1	*Review/Develop guideline and IEC materials (especially about long-term method for family planning as well as the family planning services accessibility by unmarried youth and during emergency situation or disaster)*			✓					*1.1.2*		*95,610,000*
1.1.2.2	*Printing guideline and IEC materials (especially about long-term method for family planning as well as the family planning services accessibility by unmarried youth and during emergency situation or disaster)*			✓	✓	✓	✓	✓	*1.6.3*		*2,680,560,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.1.2.3	*Disseminate and distribute guideline and IEC materials (especially about long-term method for family planning as well as the family planning services accessibility by unmarried youth and during emergency situation or disaster)*			✓		✓	✓	✓	*1.6.2* *1.6.3*		*3,117,636,400*
1.1.2.4	*Monitoring and evaluation guideline and IEC materials (especially about long-term method for family planning as well as the family planning services accessibility by unmarried youth and during emergency situation or disaster)*					✓	✓	✓	*1.1.2* *1.6.2*		*3,257,545,600*
1.1.3	Improve quality of health facilities, drug, and equipment to be ready for family planning service	SO1 specific Cross-cutting: counselling	DHHP, DTR, MCHC, CCHE	✓	✓	✓	✓	✓	3.1 5.3	UNFPA, PSI, WHO, CHAI	75,419,466,400
1.1.3.1	*Improve MCH unit to be ready for family planning service (Especially bed for IUD service)*			✓	✓	✓	✓	✓	*3.1.1*		*25,100,800,000*
1.1.3.2	*Ensure the readiness of public and private health facilities for family planning services (equipment, drug)*			✓	✓	✓	✓	✓	*3.1.2* *5.3.3*		*50,318,666,400*
1.1.4	Improve quality of care including counselling focus on long-acting methods family planning and emergency pills	SO1 specific Cross-cutting: counselling	DHHP, DTR, MCHC, CCHE	✓	✓	✓	✓	✓	1.6 5.3	UNFPA, PSI, WHO, CHAI	63,877,427,220
1.1.4.1	*Integrate counselling in the preservice curriculum*			✓	✓				*5.3.3*		*272,114,000*
1.1.4.2	*Ensure the availability of staff who have capacity for family planning service*				✓	✓	✓	✓	*5.3.2* *5.3.3*		*49,424,007,220*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.1.4.3	*Supportive supervision system existed in all public and private health facilities to ensure the quality of family planning youth friendly service*			✓	✓	✓	✓	✓	*1.6.1 1.6.3*		*14,181,306,000*
1.1.5	Strengthen capacity of individual, family and community, and unmarried youth, to encourage clients to access family planning, including emergency contraceptive method	Cross-cutting: community	DHHP, MCHC, CCHE	✓	✓	✓	✓	✓	1.6	UNFPA, PSI	4,441,585,660
1.1.5.1	*Ensure family planning education integrated in fixed site and outreach services*			✓	✓	✓	✓	✓	*1.6.3*		*4,441,585,660*
1.1.6	Support behaviours change among men towards family planning			✓	✓	✓			1.2		1,662,185,000
1.1.6.1	*Mobilize community to engage men in making decision for all family planning methods*			✓	✓	✓			*1.1.2*		*1,662,185,000*
Specific Objective 1.2 - By 2025, increase CPR (modern methods) of 15–19-year-olds to 35% by providing youth friendly services to adolescents and youth.											**61,408,129,710**
1.2.1	Roll out youth Friendly Services (YFS) policies and strategy to health facilities at all levels	SO1 specific	DHHP/DHR	✓	✓	✓	✓	✓	3.1 3.2 3.5	UNFPA,PSI,WHO,CHAI,WB	15,506,556,650
1.2.1.1	*Create an understanding, disseminate youth friendly services policy and strategy in health facility at all level*			✓	✓	✓	✓	✓	*3.2.1*		*310,707,000*
1.2.1.2	*Implement youth friendly services in health facilities at all level*			✓	✓	✓	✓	✓	*3.2.1 3.5.5*		*14,226,524,650*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.2.1.3	*Ensure the quality of youth friendly services in health facilities at all levels*			✓	✓				*3.1.2 3.2.1*		*969,325,000*
1.2.2	Create and Renovate health facilities to be youth friendly services facilities at all levels	SO1 specific	DHHP, DHR, FDD	✓	✓	✓	✓	✓	3.1	UNFPA,PSI,WHO,CHAI,WB, YVC	10,483,200,000
1.2.2.1	*Ensure the availability of youth friendly services in health facilities at all levels*			✓	✓	✓	✓	✓	*3.1.2*		*10,483,200,000*
1.2.2.2	*Establish part time service to increase accessibility to adolescent and youth friendly services in needed health facilities*								*TBD*		*TBD*
1.2.3	Health providers capacity building in youth Friendly Service provision at each health facility	SO1 specific	DHHP, DTR, DHR	✓	✓	✓	✓	✓	1.1 5.3	UNFPA,PSI,WHO,CHAI,WB, VYC	3,155,380,500
1.2.3.1	*Expand training on adolescent and youth friendly services to all public and private health facilities*			✓	✓	✓	✓	✓	*1.1.2*		*3,118,080,500*
1.2.3.2	*Integrate adolescent and youth friendly services in preservice training*			✓					*5.3.4*		*37,300,000*
1.2.4	Ensure availability, monitoring, and evaluation of adolescent and youth services	SO1 specific	DHHP, DHR, FDD, DPI	✓	[illegible]	✓	✓	✓	1.6	UNFPA,PSI,WHO,CHAI,WB, VYC	63,960,000
1.2.4.1	*System for staff supervision available in public and private health facilities to ensure quality of adolescent and youth friendly services*			✓		✓	✓	✓	*1.6.1*		*63,960,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.2.5	Provide information and youth friendly services with involvement of youth, women in village group, men, community leaders, and VHC and VHV	SO1 specific Cross-cutting: community	DHHP, CCHE, Provincial level	✓	✓	✓	✓	✓	1.2 1.6	UNFPA,PSI,WHO,CHAI,WB, VYC, Lao Front, Local authorities, MoE	25,617,368,160
1.2.5.1	*Provide proper information through different channels on family planning to be suitable for youth, including promoting the usage of Noy application*			✓		✓	✓	✓	*1.2.1* *1.6.2*		*13,482,500,000*
1.2.5.2	*Build peer educators*			✓	✓	✓	✓	✓	*1.6.1* *1.6.2* *1.6.3*		*12,134,868,160*
1.2.6	Develop appropriate IEC materials/communication for target group to change their behaviour about ASRH, to provide adolescent and youth with information, and access to health services	Cross-cutting: community, developing IEC materials	DHHP/CCHE	✓	?	✓	?	✓	1.21.6	UNFPA,PSI,WHO,CHAI,WB, VYC, Lao Front, Local authorities	6,581,664,400
1.2.6.1	*Provide proper IEC materials for adolescent and youth to health facilities at all levels (Noy Application)*			✓					*1.2.1*		*2,800,000*
1.2.6.2	*Databased of services that aggregated by age groups in DHIS2 is available*			✓		✓		✓	*1.6.1* *1.6.3*		*6,578,864,400*
Specific Objective 1.3 - By 2025, strengthen capacity of health staff to provide cervical cancer screening services for 40% of women of reproductive age											**6,641,023,300**

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.3.1	Develop strategy, standard guide, and national guideline on cervical cancer screening	SO1 specific	MCHC, FDD, OBGY Association	✓	✓	✓	✓	✓	1.6	UNFPA , WHO	1,698,929,300
1.3.1.1	*Develop and review strategy for cervical cancer screening*			✓			✓		*1.6.1 1.6.2*		*109,990,000*
1.3.1.2	*Develop and review standard guide for cervical cancer screening*			✓	✓	✓	✓	✓	*1.6.1 1.6.2 1.6.3*		*1,588,939,300*
1.3.2	Renovate health facilities to be able to provide cervical cancer screening services	SO1 specific	MCHC, DHHP	?	✓				1.1	UNFPA , WHO	TBD
1.3.2.1	*Develop and improve standard services package for cervical cancer screening*				✓				*1.1.2*		*TBD*
1.3.3	Strengthen capacity of OBGY on cervical cancer service provision	SO1 specific Cross-cutting: training	MCHC, DHHP, OBGY Association	✓	✓	✓	✓	✓	1.6	UNFPA , WHO	4,687,694,000
1.3.3.1	*Develop training plan for health staff*				✓				*1.6.1*		*1,751,000*
1.3.3.2	*Provide training to health staff on cervical cancer screening*			✓	✓	✓	✓	✓	*1.6.3*		*928,517,000*
1.3.3.3	*Monitoring and evaluation*				✓	✓	✓	✓	*1.6.3*		*3,757,426,000*
1.3.4	Improve referral pathways for cervical cancer services	SO1 specific Cross-cutting: referral pathways	MCHC, DHHP, OBGY Association, DHR	✓	?	?	?	?	1.1	UNFPA , WHO	No budget required

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.3.4.1	*Ensure that the referral must be in line with the existing guideline*			✓					*1.1.2*		*No budget required*
1.3.5	Promote women to receive cervical cancer screening service in facility		CCEH, MCHC, OBGYN Association	✓	✓	✓	✓	✓	1.1		254,400,000
1.3.5.1	*Promote women to receive cervical cancer screening service in facility*			✓	✓	✓	✓	✓	*1.1.2*		*254,400,000*
1.3.5.2	*Develop IEC materials on cervical cancer screening service*								*TBD*		*TBD*
Specific Objective 1.4 - By 2025 strengthen the capacity of facilities to provide other SRHR services to all population groups (men and pre-and-post menopausal women) to 30%.											**14,052,928,250**
1.4.1	Disseminate the sexual and reproductive health policy to ensure a strong enabling environment for sexual and reproductive health services in public and private sectors	SO1 specific Cross-cutting: private sector	DHHP, DHR, MCHC	✓	✓	✓	✓	✓	1.6	UNFPA, WHO, CARE INT., CHAI, PSI, PFHA	6,949,578,000
1.4.1.1	*Distribute the sexual and reproductive health policy in the whole country*			✓					*1.6.1*		*No budget required*
1.4.1.2	*Planning together with PHO, DHO, and community levels in sexual and reproductive health services accessibility promotion*			✓					*1.6.2*		*464,180,000*
1.4.1.3	*Conduct the supervision visit for provincial, district, and community levels in SRH policy implementation*			✓	✓	✓	✓	✓	*1.6.3*		*6,485,398,000*

	Priority Areas & Activities	Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.4.2	Revise technical guidelines on RH to cover all aspects of SRHR	SO1 specific	DHHP, DHR, MCHC		✓	✓			1.6	UNFPA, WHO, CARE INT., CHAI, PSI, PFHA	138,136,000
1.4.2.1	*Review and revise the technical guidelines on RH to cover all aspects of SRHR*				✓	✓			*1.6.1*		*138,136,000*
1.4.3	Extend training of service providers to build capacities in SRHR in line with SOPs and counselling guidelines	SO1 specific Cross-cutting: training, counselling	MCHC			✓	✓	✓	1.6	UNFPA, WHO, CARE INT., CHAI, PSI, PFHA	6,810,691,250
1.4.3.1	*Training on SRHR counselling*					✓	✓	✓	*1.6.3*		*6,810,691,250*
1.4.4	Ensure facility preparedness by improving commodity supply relevant to key population groups (men & menopausal women) and IEC materials	SO1 specific Cross-cutting: HSS - commodities & supply chains	MCHC	✓		✓			1.6	UNFPA, WHO, CARE INT., CHAI, PSI, PFHA	154,523,000
1.4.4.1	*Develop SOP for RH services (men, menopause women)*			✓					*1.6.1*		*32,400,000*
1.4.4.2	*Provide training to health providers on RH (men, Pre/menopause women)*			✓		✓			*1.6.3*		*122,123,000*
1.4.5	Disseminate information on SRHR and benefits for clients at central and provincial hospitals	SO1 specific Cross-cutting: community	MCHC, CCHE	?	?	?	?	?	1.2 1.6	UNFPA, WHO, CARE INT., CHAI, PSI, PFHA	TBD

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
1.4.5.1	*Develop IEC materials on RH services*								*1.2.1*		*TBD*
1.4.5.2	*Advertise across multiple channels*								*1.2.1* *1.6.1*		*TBD*
Strategic Objective 2 – Maternal: Increase access to quality of ANC, delivery, and PNC services for all women in line with national standards											
Specific Objective 2.1 - Antenatal: By 2025, 80% of pregnant women should receive quality ANC service at least 4 times in line with the national standards											**87,553,907,850**
2.1.1	Scale up and improve ANC package in all health facilities (training, TOT, supervision visit)	SO2 specific Cross-cutting: training, supervision	DHHP/MCHC	✓	✓	✓	✓	✓	1.1	WHO	87,553,907,850
2.1.1.1	*Strengthen continuous care of individual pregnant women including registry of pregnant women in health facilities and community*			✓	✓	✓	✓	✓	*1.1.3* *1.1.4* *1.1.5*		*63,601,940,000*
2.1.1.2	*Enforce comprehensive ANC package based on the national standard nationwide including PMTCT and maternal nutrition*			✓	✓	✓	✓	✓	*1.1.3*		*11,846,113,000*
2.1.1.3	*Scale up ANC package to all health centres with the emphasize on building continuous quality improvement mechanism*			✓	✓	✓	✓	✓	*1.1.3*		*11,438,104,200*
2.1.1.4	*Develop and scale up high-risk ANC package*			✓	✓	✓			*1.1.3*		*667,750,650*
Specific Objective 2.2 - Intrapartum: by 2025, 85% of pregnant women delivering with SBA have access to high quality routine or high-risk care in line with the national standards											**6,810,383,880**

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
2.2.1	Scale up of routine intrapartum and complication care in all levels across the country	SO2 specific	DHR, DHP, MCHC, OBGY Association, Midwife Association	✓	✓	✓	✓	✓	3.2	WHO, KOFIH, KOICA, JICA, UNFPA, CHAI	4,499,644,630
2.2.1.1	*Strengthen referral arrangement with the emphasis of continuum of care based on the routine intrapartum and complication care package*			✓	✓	✓			*3.2.1*		*328,758,000*
2.2.1.2	*Scale up of routine intrapartum and complication care in health center across the country*			✓	✓	✓	✓		*3.2.1*		*3,650,910,430*
2.2.1.3	*Strengthen intrapartum and complication care for central, provincial, and district levels*			✓	✓	✓	✓	✓	*3.2.1*		*519,976,200*
2.2.2	Strengthen capacity to improve care based on facility based maternal death review and cases with maternal complications	SO2 specific Cross-cutting: health information	DHR, DHP, MCHC, OBGY Association, Midwife Association	✓	✓	✓	✓	✓	3.2	UNFPA, WHO, KOFIH	2,310,739,250
2.2.2.1	*Regular chart review of cases with maternal complications to monitor improvement in quality of care for maternal complications*			✓	✓	✓	✓	✓	*3.2.1 3.2.2*		*312,427,250*
2.2.2.2	*Strengthen response of MDSR and uptake of learnings from review of cases with maternal complications*			✓	✓	✓	✓	✓	*3.2.1*		*1,998,312,000*
Specific Objective 2.3 - Postpartum: By 2025, 80% of women delivering in a health facility should receive quality post-natal care and complication management within 24 hours of delivery											**7,681,269,900**

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
2.3.1	Develop Postnatal Care Package (Assess, develop tool, training, preservice training, supervision)	SO2 specific Cross-cutting: training, pre-service curriculum	DHHP/MCHC, UHS,DHPE	✓					1.1	WHO, UNFPA, UNICEF	948,000,000
2.3.1.1	*Develop a protocol for postnatal care and training materials for postnatal care*			✓	?	?			*1.1.3*		*948,000,000*
2.3.2	Improve and scale up PNC package in all health facilities (training, TOT, supervision)	SO2 specific Cross-cutting: training, supervision	DHHP/MCHC,		✓	✓	✓	✓	1.1	UN/NGOs	4,667,304,900
2.3.2.1	*Scale up postnatal care package nation-wide*			?	✓	✓	✓	✓	*1.1.3*		*4,667,304,900*
2.3.3	Improve the service delivery environment for PNC service in line with the national standards (facility, equipment and drug)	SO2 specific Cross-cutting: service readiness	DHR,FDD/ MPSC		✓	✓			1.1	UN/NGOs	2,065,965,000
2.3.3.1	*Set up private room for PNC service (included in WB costing)*			?	✓	✓	?	?	*1.1.3*		*2,065,965,000*
Specific Objective 2.4 - Safe Abortion: By 2025, to reduce morbidity and mortality amongst women from unsafe abortion											**10,793,344,360**
2.4.1	Finalize & disseminate the regulation on pregnancy and abortion management	SO2 specific	Cabinet, MCHC, OBGY Association	✓	✓	✓	✓	✓	3.2 4.1		7,224,823,360

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
2.4.1.1	*Scale up safe abortion management*			✓	✓	✓	✓	✓	*3.2.1* *4.1.1*		*7,224,823,360*
2.4.2	Conduct supervision and evaluate the implementation of unsafe abortion prevention and care	SO2 specific	DHR, OBGY association, MCHC	✓	✓	✓	✓	✓	3.2	PSI	3,568,521,000
2.4.2.1	*Strengthen the supervision and evaluation system of unsafe abortion*			✓	✓	✓	✓	✓	*3.2.1*		*3,568,521,000*
Strategic Objective 3 – Newborn: All newborns receive high quality Early Essential Newborn Care (EENC)											
Specific Objective 3.1 - By 2025, 70% of newborns initiate breastfeeding within 90 minutes and establish exclusive breastfeeding until discharge											**20,477,967,450**
3.1.1	Strengthen neonatal care after 90mins to discharge	SO3 specific Cross-cutting: pre-service curriculum	DHR, EENC committee, DTR, Nurse faculty, UHS, Paediatric association and OBGY association, EDC	✓	✓	✓		✓	1.1 3.2 3.5 5.2	WHO, UNICEF, SCI and other NGOs	529,706,000
3.1.1.1	*Develop, endorse, disseminate and monitor a policy for birth in facility and newborn care standard*	*SO2*		✓	✓	✓			*3.2.1*		*316,971,000*
3.1.1.2	*Develop a protocol and disseminate, train for newborn care in facility from birth to discharge with emphasis on breastfeeding support*			✓	✓	?			*1.1.3* *3.2.1*		*26,069,000*
3.1.1.3	*Integrate the standard into quality standard and quality assessment of the health facility*			✓	?	?	?		*3.5.1*		*No budget required*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
3.1.1.4	*Recognition of health facilities that achieve the newborn care standard*			✓	⍰	✓	⍰	✓	*5.2.2*		*186,666,000*
3.1.2	Strengthen EENC in a broader target such as preterm babies and babies born through caesarean section	SO3 specific Cross-cutting: supervision & monitoring	DHR, MCHC, EENC committee	✓	✓	✓	✓	✓	1.1 1.6 3.2	WHO, UNICEF, SCI and other NGOs	1,195,450,480
3.1.2.1	*Develop and endorse facility criteria for introducing Kangaroo Mother Care (KMC) and EENC for Caesarean section cases (assessed through the quality assessment of the health facility)*			✓	⍰				*1.1.3* *1.6.1*		*5,200,000*
3.1.2.2	*Expand facilities with Kangaroo Mother Care (KMC)*			✓	✓	✓	✓	✓	*3.2.1*		*614,821,280*
3.1.2.3	*Expand facilities with EENC for Caesarean section cases*			✓	✓	✓	✓	✓	*1.2.1* *3.2.1*		*575,429,200*
3.1.3	Capacity strengthening for EENC service provision in all facilities and community	SO3 specific Cross-cutting: training	DHR, Central hospitals, provincial hospital	✓	✓	✓	✓	✓	1.1 1.6 3.2	WHO, SCI, Lux, KOFIH (XK,HP,PSL), KOICA	6,552,605,090
3.1.3.1	*Strengthen skills of coaching of EENC facilitators through developing coaching skill monitoring tool and integrate into technical supervision*			✓	✓	✓	✓	✓	*1.1.3* *1.6.3* *3.2.1*		*658,058,270*
3.1.3.2	*Expand EENC coaching to all districts and health centres*			✓	✓	✓	✓	✓	*3.2.1* *3.2.2*		*5,894,546,820*
3.1.3.3	*Strengthen EENC supervision through integrated quality assessment and supervision in all levels*			✓	✓	✓	✓	✓	*3.2.1*		*No budget required*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
3.1.4	Establish self-assessment system in all facilities	SO3 specific Cross-cutting: monitoring	DHR, Central hospitals, provincial hospital	✓	✓	✓	✓	✓	1.6	WHO, SCI, Lux, KOFIH (XK,HP,PSL), KOICA	12,200,205,880
3.1.4.1	*Establish regular self-assessment mechanism in central, provincial and district hospitals*			✓	✓	✓	✓	✓	*1.6.3*		*10,049,181,880*
3.1.4.2	*Establish regular self-assessment mechanism in health centres*			⍰	⍰	✓	✓	✓	*1.6.3*		*2,151,024,000*
Strategic Objective 4: All Lao children under 5 have access to comprehensive quality services in immunization, nutrition and child development											
Specific Objective 4.1 - Integrated Well Child: By 2025, all children attending a health facility or outreach receive a fully integrated Well Child care visit											**22,886,678,500**
4.1.1	Revise and disseminate central policy and operational guidelines on service delivery modalities (e.g., fixed sites vs. outreach)	Cross-cutting: MCH integrated activity	MCHC, Nutrition Center	✓					1.6	All Well Child DPs	821,180,000
4.1.1.1	*Integrate existing strategy and guidelines for EPI and nutrition for fixed and outreach*	*Cross-cutting: MCH integrated activity*		✓	⍰				*1.6.1 1.6.2*		*139,690,000*
4.1.1.2	*Disseminate strategy and guidelines to provincial, district and health center level*	*Cross-cutting: MCH integrated activity*		✓	⍰				*1.6.2*		*646,590,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.1.1.3	*Incorporate revised guidelines into supportive supervision and monitoring*	*Cross-cutting: MCH integrated activity*		✓	?				*1.6.1 1.6.2*		*34,900,000*
4.1.2	Budgeting and planning for integration of policy and guidelines into zones 0 and 1 for fixed-site service delivery as also aligned to microplanning guidelines	Well Child integrated activity Cross-cutting: planning	MCHC, PHOs/DHOs, Nutrition Center	✓	✓	✓	✓	✓	1.1 1.6	All Well Child DPs	17,960,163,000
4.1.2.1	*Complete microplanning training in all provinces*	*Well Child integrated activity Cross-cutting: planning*		✓	✓	✓	✓	✓	*1.6.3*		*3,220,015,000*
4.1.2.2	*Conduct bottom-up microplanning from HC to increase fixed service provision (includes sharing plan and engaging with community), review and update quarterly based on performance*	*Well Child integrated activity Cross-cutting: planning*		✓	✓	✓	✓	✓	*1.1.1 1.6.3*		*14,740,148,000*
4.1.2.3	*Include micro plan activities in annual budget*	*Well Child integrated activity Cross-cutting: planning*		✓	✓	✓	✓	✓	*1.1.1*		*No budget required*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.1.3	Ensure the provision of quality well child services across modalities (e.g., fixed sites and outreach)	Well Child integrated activity	MCHC, DHR, PHOs/DHOs, Nutrition Center	✓	✓	✓	✓	✓	1.1 1.6 3.1	All Well Child DPs	4,105,335,500.00
4.1.3.1	*Trial different methods to make fixed site more welcoming (e.g., toys for children, information for parents)*	*Well Child integrated activity*		✓	✓	?	?	?	*1.6.1* *3.1.1*		*1,867,500,000*
4.1.3.2	*Ensure availability of supplies and equipment including vaccines for fixed site and outreach*	*Well Child integrated activity*		✓	✓	✓	✓	✓	*1.1.1*		*602,635,500*
4.1.3.3	*Train at least two providers per facility to do well child check at fixed site or through outreach*	*Well Child integrated activity*		✓	?	?	?	?	*1.6.1* *1.6.3*		*1,635,200,000*
Specific Objective 4.2 - Immunization: By 2025, 85% of two-year old children are fully immunized against VPD											**35,231,898,600**
4.2.1	Continue to disseminate and enforce the Immunization Law down to district and community levels	Immunization specific Cross-cutting: Law	National Assembly, Provincial Govs, community leaders, LWU, Lao Youth, Lao Front	✓		✓		✓	1.5		3,731,793,600
4.2.1.1	*Incorporate messages about immunization law into other training and IEC*	*Immunization specific Cross-cutting: Law*		✓	?	✓		✓	*1.5.2*		*3,731,793,600*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.2.2	Routine pre- and in-service training on EPI management and practice; including surveillance, outbreak response, and supportive supervision, and integration into university curriculum for all health workers	Immunization specific Cross-cutting: pre-service curriculum, training, supervision, monitoring	MCHC, NCLE, DHPE, UHS, and MoE	✓	✓	✓	✓	✓	1.1 5.3		31,500,105,000
4.2.2.1	*Roll out to all provinces and evaluate effectiveness of training for (i) EPI managers training; (ii) IPC (including cultural sensitivity); (iii) using immunization e-learning platform; (iv) cold chain management (districts and health centres)*	*Immunization specific*		✓	✓	✓	✓	✓	*1.1.1*		*4,013,245,000*
4.2.2.2	*Conduct supportive supervision from central to province, province to district (at least twice, more for high risk) and district to health centre (at least once a year, more for high risk)*	*Immunization specific supervision*		✓	✓	✓	✓	✓	*1.1.1*		*27,479,864,000*
4.2.2.3	*Revise and university curricula to include EPI content for all health workers*	*Immunization specific*	*UHS, Nursing colleges, public health schools*	✓	[illegible]	✓		✓	*5.3.4*		*6,996,000*
Specific Objective 4.3 - Immunization: By 2025, 100% of districts achieve Penta3 and MR2 coverage of 95% or more											**7,428,013,600**
4.3.1	Strengthen linkages between EPI and ANC towards increased RI coverage, including the improved delivery of Hep0 via skilled provider at facility and community levels	Integrated activity with SO2 Maternal	MCHC, DHR, UHS	✓	✓	✓	✓	✓	1.51.6 3.2		4,107,833,600

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.3.1.1	*Incorporate information about benefits of vaccination into parenting classes*			✓	⍰	✓		✓	*1.5.2* *1.6.1* *1.6.2*		*1,055,033,600*
4.3.1.2	*Implement enhanced counselling training for HWs to address maternal concerns to facility delivery and encourage HB BD*			✓	✓	✓	✓	✓	*3.2.1*		*3,052,800,000*
4.3.2	Deployment of health staff to deliver services tailored to variety of cultural and linguistic needs	Immunization specific	MCHC, DHP, DHPE, UHS, and MoE; PHO	✓	✓	✓	✓	✓	1.6 3.2 5.2		3,320,180,000
4.3.2.1	*Develop and implement strategies to recruit health and community workers in different ethnic/cultural groups*			✓	✓	✓	✓	✓	*3.2.1*		*3,024,180,000*
4.3.2.2	*Develop and implement tailored strategies to increase service access in different ethnic/cultural groups (e.g., changing time of day)*			✓	⍰				*1.6.1* *1.6.2* *3.2.1* *5.2.2*		*296,000,000*
Specific Objective 4.4 - Nutrition: By 2025, ensure children under 5, pregnant/lactating women, and women of reproductive age receive micronutrient supplementation and deworming according to the Essential Health Service Package in line with targets											**3,946,791,000**
4.4.1	Ensure effective nation-wide implementation of the Micronutrient Supplementation and Deworming Guidelines	Nutrition specific	DHHP + NNC + MCHC	✓	✓	✓	✓	✓	1.4 3.2 5.3	UNICEF	3,946,791,000
4.4.1.1	*Develop micronutrient supplementation job aid for local facility staff*	*Nutrition specific*	*NNC*	✓					*1.4.1*	*UNICEF*	*149,215,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.4.1.2	*Training on guideline to local level facilities led by PHDs*	*Nutrition specific*	*Prov PHDs*	✓					*3.2.1*		*2,690,180,000*
4.4.1.3	*Integrate guideline into all preservice curriculum (med, nurse, MW)*	*Nutrition specific*	*NNC+DHP*	✓	?				*5.3.4*		*5,100,000*
4.4.1.4	*B1 deficiency risk areas and target groups defined, supply plan developed and costed, budget allocated. Develop SBCC materials to support distribution.*	*Nutrition specific*	*NNC+FDD*	✓					*1.4.1*		*45,120,000*
4.4.1.5	*B1 procurement, transport/distribution to facilities in risk areas target groups.*	*Nutrition specific*	*MCHC+NNC (med supply)*	✓	✓	✓	✓	✓	*1.4.4*		*63,600,000*
4.4.1.6	*Weekly IFA for adolescent women (12-25yo) - Identify "risk areas" and identify distribution channels and education campaign*	*Nutrition specific*	*NNC+FDD*	✓					*1.4.1*		*78,600,000*
4.4.1.7	*WIFA procurement, costing, distribution to target group in risk areas*	*Nutrition specific*	*MCHC+NNC (med supply)*	✓	✓	✓	✓	✓	*1.4.1* *1.4.4*		*689,000,000*
4.4.1.8	*Assess coverage and effectiveness of targeted micronutrient supplementation and revise implementation as needed*	*Nutrition specific*	*NNC+MCHC*	✓		✓	✓	✓	*1.4.4* *1.4.5*		*225,976,000*
Specific Objective 4.5 - Nutrition: By 2025, 65% of caregivers of children less than 5 years receive full screening and counselling on infant and young childcare & feeding practices											**7,910,539,440**
4.5.1	Ensure the availability of IYCF screening and counselling services for caregivers of children under 5 in all health facilities in line with the MCH handbook	Nutrition specific	MCHC/NNC/ CCEH	✓	✓	✓	✓	✓	3.2 5.3	UNICEF, SCI, SNV,WVI	7,903,119,440

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.5.1.1	*Roll out integrated MCH Behaviour Change Counselling training for HCP nationally*	*MCH integrated activity*	*DHHP/CCEH/ MCHC/NNC*	?	✓	✓	✓	✓	*3.2.1*	*UNICEF, SCI, SNV, WVI*	*7,898,019,440*
4.5.1.2	*Integrate IYCF screening and counselling skills into preservice curriculum*	*Nutrition specific*	*DHP/DHHP/CCEH/MCHC/NNC*	✓	?				*5.3.4*		*5,100,000*
4.5.2	Ensure the effective and efficient implementation of the nutrition services package (screening, growth monitoring and counselling)	Nutrition specific	MCHC/NNC/ Health facilities	✓	✓	✓	✓	✓	1.6	UNICEF, SCI, SNV	7,420,000
4.5.2.1	*Ensure IYCF Screening guidelines and counselling skills are included in the Integrated Assessment system (for Dok Champa)*	*MCH integrated activity*	*MCHC/NNC*	✓					*1.6.1*	*WHO*	*No budget required*
4.5.2.2	*Include detailed indicators on IYCF screening and counselling in DHIS2, revise GMP indicators as indicated*	*Nutrition specific? Integrated? DHIS2*	*DPIC/DHHP/ NNC*	✓	✓	✓	✓	✓	*1.6.1*	*WHO/UNICEF*	*7,420,000*
Specific Objective 4.6 - Nutrition: By 2025, ensure that 60% of children under 6 months of age are exclusively breastfed											**3,512,873,000**
4.6.1	National initiative for protection, promotion, and support for breastfeeding is established and implemented regularly		NNC, DHR, health facilities (central/provincial hospital)	✓	✓	✓	✓	✓	1.4 1.6	UNICEF, SCI	663,554,500

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.6.1.1	*Establish cross-cutting Breastfeeding Leadership Team at central level as a coordination mechanism for all breastfeeding initiatives.*	*Links to SO3 Newborn*	*NNC +Multi-stakeholder team to reflect BF activities w/in SO2,3,4,5, & LWU*	⍰	✓		✓		*1.6.3*	*UNICEF, SCI*	*11,024,000*
4.6.1.2	*Facility breastfeeding policy disseminated and posted at all facilities providing MCH services*	*Nutrition & Newborn*	*NNC+DHR(SO 3)*	✓	✓				*1.6.1 1.6.2*	*UNICEF, SCI*	*453,173,200*
4.6.1.3	*Improve breastfeeding counselling rooms at health facilities in line with hospital accreditation*	*Links to HSS activities*	*DHR (SO3)+NNC*	✓	✓	⍰			*1.4.4*	*UNICEF, SCI*	*21,537,300*
4.6.1.4	*Review nutrition components of national emergency preparedness plans Inc. IYCF-E and update to reflect current national policy*			✓	✓	✓	✓	✓	*1.4.2*		*21,820,000*
4.6.1.5	*Workplace parental leave & lactation promotion in workplace*			✓	✓	✓	✓	✓	*1.4.3 1.6.1*		*156,000,000*
4.6.2	Lao BMS Code is implemented, monitored, and enforced	Nutrition specific	NNC, FDD, DHHP, MoIC	✓	✓	✓	✓	✓	1.4 1.6 4.1 4.7	EU, UNICEF, SCI	1,855,291,000
4.6.2.1	*Establish Lao BMS Code (PM Decree) monitoring system*	*Nutrition specific*	*NNC, FDD, DHHP, MoIC*	✓					*1.4.2 4.1.1*	*EU, UNICEF, SCI*	*166,660,000*
4.6.2.2	*Develop and disseminate guidance on import, marketing, and sales of BMS products to the private sector*	*Nutrition specific*	*NNC, FDD, DHHP, MoIC*	✓		✓	✓	✓	*4.1.1*	*EU, UNICEF, SCI, WVI*	*25,445,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.6.2.3	*Conduct routine monitoring of Lao BMS Code (PM Decree) and disseminate results to responsible stakeholders across government*	*Nutrition specific*	*NNC, FDD, DHR, health facilities + MoIC*	✓	✓	✓	✓	✓	*1.6.1 1.6.2 4.7.1*	*EU, UNICEF, SCI, WVI*	*1,663,186,000*
4.6.3	Create breastfeeding experts to provide case management in health facilities at each level	Nutrition specific	NNC/MCHC/Faculty of Nursing /health facilities	✓	✓	✓	✓	✓	1.4 3.2 5.3	UNICEF, SCI	994,027,500
4.6.3.1	*Develop and endorse breastfeeding protocols for special care newborns*	*Nutrition specific*	*NNC/DHR (SO3)*	✓	✓	✓	✓		*1.4.2*		*136,170,000*
4.6.3.2	*Develop nationally competency-based certification for Lao breastfeeding expert*	*Links with CME & licensure*	*NNC/DHP/DHR*	✓	⍰				*3.2.1*		*49,500,000*
4.6.3.3	*Establish staffing guidelines to ensure facility can provide required breastfeeding services (# of experts by level/size facility)*	*Links to HSS activities*	*NNC/DHP/DHR*		✓	✓	✓	✓	*3.2.1*		*394,065,000*
4.6.3.4	*Establish & implement standard training programme for breastfeeding experts (endorsed by MOH, funded)*	*Nutrition specific*	*NNC/DHP/DHR*		✓	✓	✓	✓	*3.2.1*		*134,640,000*
4.6.3.5	*Central breastfeeding experts team conducts regular supervision visits and/or review activities with experts in provincial and district facilities*	*Nutrition specific*	*NNC/DHR (SO3)*			✓	✓	✓	*3.2.1 3.2.4 5.3.4*	*SCI, WHO*	*279,652,500*
Specific Objective 4.7 - Early Childhood Development (ECD): By 2025, all children under 5 receive developmental screening through integrated Well Child and Newborn services											**10,347,270,300**

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.7.1	Ensure health facilities are ready for ECD screening for under 5-year-old children	Well Child integrated activity Cross-cutting: service readiness	DHR/DHHP/ MCHC	✓	✓	✓	⍰	⍰	3.1		1,020,850,000
4.7.1.1	*Create/renovate facilities for ECD screening at central, provincial and district hospitals*			✓	✓	⍰	⍰	⍰	*3.1.1*	*Gov.*	*253,000,000*
4.7.1.2	*Provide equipment for ECD screening for central, provincial and district hospitals*			✓	✓				*3.1.1*	*GAVI, SCI*	*227,250,000*
4.7.1.3	*Create/renovate facilities for ECD screening for first 6 hospitals: (Salavan, Sekong, Oudomxay, Phongsaly, Houaphan and Xiengkhouang provincial hospitals)*			⍰	⍰	✓			*3.1.1*	*WB, WVI (Salavan)*	*127,200,000*
4.7.1.4	*Provide equipment for ECD screening for first 6 hospitals: (Salavan, Sekong, Oudomxay, Phongsaly, Houaphan and Xiengkhouang provincial hospitals)*			⍰	⍰	✓			*3.1.1*	*KOICA, SCI, LUX, Gov*	*143,100,000*
4.7.1.5	*Create/renovate facilities for ECD screening for second 6 hospitals: Bolikhamxay, Vientiane, Luangprabang, Luangnamtha, Sayabouly and Saysomboun provincial hospitals)*			⍰	⍰	✓			*3.1.1*		*127,200,000*
4.7.1.6	*Provide equipment for ECD screening for second 6 hospitals: Bolikhamxay, Vientiane, Luangprabang, Luangnamtha, Sayabouly and Saysomboun provincial hospitals)*			⍰	⍰	✓			*3.1.1*		*143,100,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.7.2	Review and revise the guidelines for ECD screening for children under 5	ECD specific	MCHC/Child hospital	✓	✓	✓	✓	✓	1.6		6,526,510,000
4.7.2.1	*Revise, restructure, and publish the manual on ECD screening for children under 5 years old.*			✓	✓	✓	✓	✓	*1.6.1 1.6.2*	*Gov., GAVI, WB*	*6,516,500,000*
4.7.2.2	*Dissemination meeting on ECD screening manual at central and provincial level.*			✓	⍰				*1.6.2*	*UNICEF, WHO*	*10,010,000*
4.7.3	Ensure that health providers have capacity in ECD screening	ECD specific Cross-cutting: pre-service curriculum, training	MCHC/Child hospital	✓	✓	✓	✓	✓	1.1 1.6		271,162,300
4.7.3.1	*Provide training to health providers on how to use the ECD screening manual for children under 5 years old in 22 hospitals .*			✓	✓	✓			*1.6.3*	*Gov*	*271,162,300*
4.7.3.2	*Integrate ECD screening in to outreach service in implemented districts*			✓	✓	✓	✓	✓	*1.1.5*	*WB*	*No budget required*
4.7.4	Improve the quality of ECD management, monitoring and evaluation, and reporting system	ECD specific Cross-cutting: monitoring, health information	MCHC/Child hospital	✓	✓	✓	✓	✓	1.1 1.6 7.2		306,246,000
4.7.4.1	*Develop tool for monitoring, reporting, and evaluation ECD screening*		*Child hospital, MCHC*	✓	⍰				*1.6.1 1.6.2*	*WHO, UNICEF, HI*	*12,000,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.7.4.2	*Integrate data on ECD screening into databased of health facility and DHIS2 (Training at the same time with ECD screening manual)*		*DPIC, Child hospital, MCHC*	✓	?	✓		✓	*1.6.3 7.2.2 7.2.3*	*WHO, UNICEF*	*294,246,000*
4.7.4.3	*Assess and supervise health providers for ECD screening services by central technical team twice a year*			✓	✓	✓	✓	✓	*1.1.5*	*GOV., WB, KOFIH, UNICEF*	*No budget required*
4.7.5	Promote caregivers to use MHC handbook to monitor child development	ECD specific Cross-cutting: MCH Handbook, community	MCHC	✓	?	✓	?	✓			2,222,502,000
4.7.5.1	*Support caregivers to understand about child development monitoring by using MCH handbook through parenting school*		*PHO, DHO*	✓	?	✓	?	✓	*1.6.3*		*2,222,502,000*
4.7.5.2	*Advise parents about child development monitoring and using MCH handbook after receiving ECD screening in health facilities*		*Heath providers at all levels*	✓	?	?	?	?	*1.1.5*		*No budget required*
4.7.6	Engage community to in promoting children to have well child check up	Well Child integrated activity, Saysettha and Nan districts hospital are implementing this activity Cross-cutting: community	MCHC	✓	✓	✓	✓	✓	1.1		No budget required

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.7.6.1	*Engage community in promoting children to have ECD screening though community behaviour change related activities in provinces that implementing the SBCC*		*District hospitals and HC*	✓	✓	✓	✓	✓	*1.1.5*	*WVI (Salavan)*	*No budget required*
4.7.6.2	*Organize dissemination meeting about ECD promotion for village health committee*		*District hospitals and HC*	✓	✓	✓	✓	✓	*1.1.5*	*WVI (Salavan)*	*No budget required*
Specific Objective 4.8 - ECD: By 2025, have referral pathways for ECD covering/integrating all levels of health service provision in line with MCH Handbook											**15,861,412,200**
4.8.1	Strengthen ECD referral system	ECD specific Cross-cutting: referral systems	DHR/Child hospital	✓	✓	✓	✓	✓	1.1 1.6 3.1		2,282,800,000
4.8.1.1	*Establish referral and monitoring system for health facilities*		*DHR, MCHC, Child hospital*	✓	⍰	⍰	⍰	⍰	*1.6.1* *1.6.2*	*HI, WVI (Salavan)*	*No budget required*
4.8.1.2	*Provide equipment for basic practice (walking, standing, and sitting support)*			⍰	✓	✓	✓	⍰	*3.1.1*	*GOV., WB, KOFIH, UNICEF, WVI (Salavan), LUX*	*58,300,000*
4.8.1.3	*Produce relevant IEC materials*			✓	✓	✓	✓	✓	*1.1.5* *1.6.2*	*GOV., WB, KOFIH, UNICEF, WVI (Salavan), LUX*	*2,224,500,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.8.2	Ensure that health care providers are skillful in ECD screening and be able to refer the case to specialists	ECD specific Cross-cutting: training	DHR/Central hospital	✓	✓	✓	✓	✓	1.6		4,784,093,000
4.8.2.1	*Provide technical training on ECD screening (Doctors and Nurses)*			✓	✓	✓	✓	✓	*1.6.3*	*Gov, WB, KOFIH, WVI (Salavan), UNICEF, WHO, HI*	*2,385,000,000*
4.8.2.2	*Training on basic practice (Doctors and Nurses)*		*Together with medical and rehabilitation center*	✓	✓	✓	✓	✓	*1.6.3*	*WVI (Salavan)*	*693,929,000*
4.8.2.3	*Establish specialists in regional hospitals (Champasack, Savannakhet, Luangprabang and Oudomxay 2 years)*			□	✓	□	✓	✓	*1.6.3*	*Gov., WB, WHO, KOFIH, LUX*	*972,000,000*
4.8.2.4	*Exchange visit-sharing lesson learned about ECD implementing and supervision system in Chiangmai*			□	✓	✓	□	✓	*1.6.2*	*Gov., WB, WHO, KOFIH, LUX*	*733,164,000*
4.8.3	Organize lesson learned meeting on ECD implementation	ECD specific Cross-cutting: monitoring, referral systems	Central hospital	✓	✓	✓	✓	✓	1.6		994,810,000
4.8.3.1	*Organize meeting on lesson learned annually*		*MCHC, Child hospital*	✓	✓	✓	✓	✓	*1.6.2*	*HI, WHO*	*994,810,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
4.8.4	Encourage community and village leaders to support caregivers in cases that children needed to be referred for ECD services	ECD specific Cross-cutting: monitoring, referral systems	*MCHC, Child hospital*	✓	✓	✓	✓	✓	1.6	HI, *WVI (Salavan)*	7,799,709,200
4.8.4.1	*Develop and endorse the guidelines of screening and promotion of child development at the community level*			✓	✓	✓	✓	✓	*1.6.1 1.6.2*	*Gov, WVI (Salavan)*	*1,251,700,000*
4.8.4.2	*Empower communities and community leaders to support child care providers in the case that a child needs to be referred for early child development services*			✓	✓	✓	✓	✓	*1.6.1 1.6.3*	*Gov., WB, WHO, KOFIH, LUX, WVI (Salavan)*	*6,533,098,000*
4.8.4.3	*Improve the guidelines of screening and promotion of child development at the community level*			?	?	✓	?	✓	*1.6.1*	*Gov., WB, WHO, KOFIH, LUX, WVI (Salavan)*	*14,911,200*
Strategic Objective 5 - Sick Child: All children in need of care receive quality curative care at all levels											
Specific Objective 5.1: By 2025, 80% of children with diarrhoea, pneumonia and acute malnutrition receive quality of care in line with the national guidelines											**51,854,595,900**
5.1.1	Ensure health facility readiness for managing childhood illnesses at all levels	SO4 specific Cross-cutting: service readiness		✓	✓	✓	✓	✓	3.2 5.4	UNIICEF, WHO	**9,914,108,400**
5.1.1.1	*Print, procure and distribute updated Pocket Book/ IMNCI/ IMAM manuals and tools for health facilities as required*		*DHR/ DHHP*	✓	✓	✓	✓	✓	*3.2.1*	*UNICEF, WVI and other DPs*	*4,317,300,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
5.1.1.2	*Improve health facility infrastructure including provision of equipment and supplies to be suitable with the quality improvement for child health services*	*To be integrated with Health System SO*	*DHR/ DHHP*	✓	✓	✓	✓	✓	*3.2.1 3.2.2*	*UNICEF, Gov, WVI, SCI, LUX Dev, MDM, WB, DPs..*	*2,486,326,400*
5.1.1.3	*Develop training approach, manual, and tools for management of main newborn complications including preterm/ low birth weight and sepsis.*		*DHR, Mother and Newborn hospital*	✓	✓	⍰	⍰	⍰	*3.2.2*	*UNICEF, WHO, other DPs*	*57,682,000*
5.1.1.4	*Conduct the research on sick newborn and child/Conduct the operational research on sick child*		*Paediatric Association, National Tropical and Public Health Institute*	✓	✓	✓	✓	✓	*5.4.1*	*UNICEF, WVI, SCI, LUX Dev, MDM, WB, DPs*	*3,052,800,000*
5.1.2	Strengthen capacity of supervisors and health workers on IMNCI approach	SO4 specific Cross-cutting: monitoring & supervision		✓	✓	✓	✓	✓	1.1 1.4 1.6 3.2	UNICEF, WHO	**34,992,387,500**
5.1.2.1	*Conduct training on IMNCI and Pocket Book for facilitators/ supervisors and HWs*		*DHR/DHHP*	✓	✓	✓	✓	✓	*3.2.1*	*UNICEF, WVI, SCI, LUX Dev, MDM, WB, DPs*	*8,763,577,700*
5.1.2.2	*Provide separate IMAM training and refresher trainings (in addition to IMNCI) to targeted health facilities at all levels based on the IMAM national scale up plan*		*DHR/DHHP, Mahosot hospital*	✓	✓	✓	✓	✓	*1.4.2*	*UNICEF, WVI, SCI, WB, HPA, DPs*	*7,195,068,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
5.1.2.3	*Conduct clinical supportive supervision visit to health facilities on quarterly basis and using standardized checklist including IMAM, IMNCI and pocketbook*		*DHR, all provincial health offices*	✓	✓	✓	✓	✓	*1.1.5 1.6.3 3.2.1*	*UNICEF, WVI, SCI, LUX Dev, MDM, WB, DPs*	*15,471,844,800*
5.1.2.4	*Introduce monitoring system of training by using innovative digital technology*		*DHR/DHHP*	✓	✓	✓	✓	✓	*1.6.1*	*UNICEF and other DPs*	*TBD*
5.1.2.5	*Review, develop guideline and implement on perinatal/ newborn death review and response*	*to be integrated with the MDSR*	*MCHC, Paediatric Association*	✓	✓	✓	✓	✓	*3.2.1*	*UNICEF, WHO and other DPs*	*2,387,152,000*
5.1.2.6	*Conduct Lao paediatric continuing medical education conference annually*		*Paediatric Association*	✓	✓	✓	✓	✓	*3.2.1*		*1,174,745,000*
5.1.3	Increase coverage of services that implement IMNCI, IMAM and Pocket book	SO4 specific Cross-cutting: training		✓	✓	✓	✓	✓	1.1 1.5 3.2 3.2	UNICEF, WHO, WB, WVI, SCI, Lux-Dev, MDM Japan, KOICA, other DPs	***5,077,100,000***
5.1.3.1	*Improved coordination of SO5, planning, implementation and monitoring of activities through quarterly SO5 meetings*		*DHR/DHHP*	✓	✓	✓	✓	✓	*1.6.1*	UNICEF, WHO, WB, WVI , SCI, Lux-Dev, MDM Japan, KOICA, other DPs	*TBD*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
5.1.3.2	*Establish the national IMAM Committee and ensure regular engagement to support IMAM scale up*		*IMAM Community incl. DHR, DHHP (Nutrition Centre)*	✓	✓	✓	✓	✓		UNICEF	*30,000,000*
5.1.3.3	*Develop a national costed scale up plan for IMAM with clear operational guideline*		*IMAM Committee incl. DHR, DHHP (Nutrition Centre)*	✓	✓	?	?	?		UNICEF	*197,600,000*
5.1.3.4	*Integrate sick child service in to outreach service package*		*MCHC, DHR, DHHP, NHIB*	✓	✓	✓	✓	✓	*1.1.5*	*UNICEF, WHO, DPs*	*TBD*
5.1.3.5	*Plan and undertake early case finding and referral at subnational level by leveraging multiple cadres/sectors including communities themselves*	*To be included to quarterly community meeting (QCM) at health centres*	*MCHC, DHR, Nutrition Centre, PHOs, DHOs*	✓	✓	✓	✓	✓	*3.1.3*	*UNICEF, WHO and other DPs*	*4,849,500,000*
5.1.3.6	*Establish centre of excellence on management of sick newborn and childhood illness in selected hospital*			✓	✓	✓	✓	✓	*3.2.1*		*TBD*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
5.1.4	Service delivery in health facilities (improve environment of the facility including equipment and drugs)			✓	✓	✓	✓	✓	*1.1*		***1,871,000,000***
5.1.4.1	*Provide treatment to children in alignment to national guidelines including IMNCI, Pocket Book and IMAM*		*All health facilities*	✓	✓	?	?	?	*1.1.5*	*UNICEF, WVI, SCI, WB, HPA, DPs.*	*TBD*
5.1.4.2	*Ensure referrals to/from inpatient and outpatient care including financial support for caregivers from poor families for inpatient care of SAM in selected areas*	*To be integrated with Health System SO (8.7)*	*All health facilities*	✓	✓	✓	✓	✓	*1.1.5*	*UNICEF, WVI, SCI, WB, HPA, DPs.*	*1,566,000,000*
5.1.4.3	*Undertake defaulter tracing and follow up*		*All health facilities*	✓	✓	✓	✓	✓	*1.1.5*	*UNICEF, WVI, SCI, WB, HPA, DPs.*	*305,000,000*
Strategic Objective 6: By 2025, rural communities, including the most vulnerable and hard to reach, benefit from the implementation of an essential RMNCAH community package.											
Specific Objective 6.1 - By 2025, the community health policy environment fosters local authority leadership and facilitates alignment between CHSS and RMNCAH Strategy											**56,643,502,800**
6.1.1	Strengthen local authorities' leadership and skills in improving the services of RMNCAH strategy			✓	✓	✓	✓	✓	1.6		56,643,502,800

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
6.1.1.1	*Strengthen village health committee capacity and ownership in monitoring and supervision leading and management to improve accessibility to RMNCAH services.*	*with all SOs*	*DHHP, PHO, DHO*	✓	✓	✓	✓	✓	*1.6.2*	*UNICEF, WHO, UNFPA, WB, SCI, WVI, KOFIH, Gavi, Lux-Dev and other DPs*	*24,908,516,000*
6.1.1.2	*Strengthen capacity of health centres to support and supervise VHV in improving accessibility of RMNCAH services.*	*with all SOs*	*DHHP, PHO, DHO*	✓	✓	✓	✓	[illegible]	*1.6.3*	*UNICEF, WHO, UNFPA, WB, SCI, WVI, KOFIH, Gavi, Lux-Dev and other DPs*	*2,995,842,800*
6.1.1.3	*Strengthen cooperation from various sectors at the provincial and district levels in supervision visit for RMNCAH at community level.*	*with all SOs*	*DHHP, PHO, DHO*	✓	✓	✓	✓	✓	*1.6.2*	*UNICEF, WHO, UNFPA, WB, SCI, WVI, KOFIH, Gavi, Lux-Dev and other DPs*	*No budget required*
6.1.1.4	Strengthen linkage between VHC/VHV and HC	*with all SOs*	*DHHP, MCHC, PHO, DHO*	✓	✓	✓	✓	✓	*1.6.2*	*UNICEF, WHO, UNFPA, WB, SCI, WVI, KOFIH, Gavi, Lux-Dev and other DPs*	*28,739,144,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
Specific Objective 6.2 - By 2025, the Community RMNCAH Package is implemented and functional, supported by an operational M&E mechanism											**12,437,748,400**
6.2.1	Develop and expand the implementation of RMNCAH community package for village health volunteers and health centres	*with all SOs*		✓	✓	✓	✓	✓	1.6		4,907,460,000
6.2.1.1	*Develop tools and set up standard on RMNCAH services package for village health volunteer*	*with all SOs*	*DHHP, CCEH, MCHC, NNC, DHR*	✓	⍰				*1.6.1*		*249,800,000*
6.2.1.2	*Develop tools on community RMNCAH services for health centres*	*with all SOs*	*DHHP, DHR and Centres*	✓	⍰				*1.6.1*		*114,400,000*
6.2.1.3	*Train VHV RMNCAH services package including home visit and peer education*	*with all SOs*	*DHHP, PHO, DHO*	✓	✓	✓	✓	✓	*1.6.3*		*4,543,260,000*
6.2.2	Develop and implement monitoring, evaluation and supervision of RMNCAH community implementation	*with all SOs*	*DHHP, CCEH, MCHC, NNC, DHR*	✓	✓	✓	✓	✓	*1.6*		*7,530,288,400*
6.2.2.1	*Health centres conduct the VHV supportive supervision based on the guideline at least 2 times per year per village (614 villages in 71 priority districts)*	*with all SOs*	*DHHP, CCEH, MCHC, NNC, DHR*	⍰	✓	✓	✓	✓	*1.6.1*		*6,195,015,000*
6.2.2.2	*Develop community health information system*	*with all SOs*	*DHHP, DPC, CCEH*	⍰	✓	✓	✓	✓	*1.6.1*	*UNICEF, WB, WHO, KOFIH, WVI, GAVI, LUX, UNFPA*	*1,335,273,400*
Strategic Objective 7: RMNCAH stakeholders implement the RMNCAH Strategy Action Plan with an integrated and people centred approach supported by strong and efficient governance mechanisms											

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
Specific Objective 7.1: By 2025, the structural reform to support further integration towards 'people-centred approach' and coordinated planning, implementation and monitoring are established											**78,630,714,500**
7.1.1	Shifting programme-based approach to people-centred approach in planning, monitoring, service delivery, quality assessment and improvement with emphasis on continuum of care in RMNCAH	Across all technical SOs	RMNCAH Secretariat	✓	✓	✓	✓	✓	1.6	WHO	67,259,894,900
7.1.1.1	*Integrate and rollout quality assessment and improvement module*		*DHHP, DHR, MCHC, Paediatric Association, OBGY Association*	✓	✓	✓	✓	✓	*1.6.1*		*16,023,868,800*
7.1.1.2	*Strengthen integrated people-centred service delivery (Well Child and other sub-committee) and continuum of care*		*DHHP, DHR, MCHC, Paediatric Association, OBGY Association, PHO*	✓	✓	✓	✓	✓	*1.6.1 1.6.3*		*6,337,847,700*
7.1.1.3	*Develop and print SOPs, registers, data collection tools for RMNCAH indicators*		*MCHC, DHHP, DPC, Paediatric Association, OBGYN asso.*	✓	✓	✓	✓	✓	*1.6.2*	*UNICEF, WHO and DPs*	*4,650,000,000*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
7.1.1.4	*Enhance human resource capacity for the collection, analysis, interpretation, dissemination and quality control of RMNCAH data*		*MCHC, DHR, Lao Paediatric Association*	✓	✓	✓	✓	✓	*1.6.3*	*UNICEF, WHO and DPs*	*16,740,000,000*
7.1.1.5	*Provide technical and logistical support (IT equipment, software etc.) for availability of quality and timely RMNCAH data as well as management*		*MCHC, DHR*	✓	✓	✓	✓	✓	*1.6.2*	*UNICEF, WHO and DPs*	*14,787,000,000*
7.1.1.6	*Develop a system for baseline data collection and periodic evaluation of community RMNCAH package implementation (once a year) including survey on RMNCAH service in community (LQAS)*	*with all SOs*	*DHHP, MCHC*	✓	✓	✓	✓	✓	*1.6.1*	*UNICEF, WHO, UNFPA and other DPs*	*6,338,700,000*
7.1.1.7	*Review sick child indicators in DHIS2 including clinical outcomes such as acute malnutrition admission and performance data (cured, defaulting, died, non-responsive)*	*To be integrated with Health System SO*	*NNC,MCHC,DHHP,DHR and IMAM Taskforce*	✓	✓	✓	✓	✓	*1.6.1*	*UNICEF, WHO and DPs*	*1,455,592,000*
7.1.1.8	*Situation analysis on needs and resources for community health including VHV mapping and health volunteer registry*	*with all SOs*	*DHHP, CCEH, MCHC, NNC, DHR*	✓	✓	✓	✓		*1.6.1*		*64,480,000*
7.1.1.9	*Coordinate (and potentially integrate) financial resources for efficient financing of the RMNCAH programmes*			✓	✓	✓	✓	✓	*1.6.1* *1.6.2*		*353,320,000*
7.1.1.10	*Assess efficiency and equity of and further optimize the current service delivery model*		*MCHC*	✓	✓	✓	✓	✓	*1.6.1*	WHO	*509,084,400*

Priority Areas & Activities		Integration & alignment with other activities	Responsible Departments	Timeframe					HSDP Ref.	DP Involvement (List active DPs)	Estimated cost
				21	22	23	24	25			
7.1.2	Strengthen governance and management for joint annual planning and monitoring of expenditure, implementation and outcomes of the strategy and action plan		RMNCAH Secretariat	✓	✓	✓	✓	✓	1.6	WHO	11,370,819,600
7.1.2.1	*Operationalize the revised decree to enforce roles and responsibilities in the RMNCAH strategy management and implementation*			✓	✓	✓	✓	✓	*1.6.2*		*51,000,000*
7.1.2.2	*Establish a regular mechanism on planning and monitoring (E.g., Steering committee, TWG, and sub-committee meetings)*			✓	✓	✓	✓	✓	*1.6.1* *1.6.2* *1.6.3*		*7,966,377,000*
7.1.2.3	*Establish capacity and a regular mechanism on planning, implementing and monitoring priorities in sub-national implementation of the RMNCAH strategy*			✓	✓	✓	✓	✓	*1.6.1* *1.6.2*		*3,353,442,600*

Estimated costs for implementation of the national RMNCAH Action Plan for 5 years (2021-2025)

6.2.1 Estimated costs by strategic objectives and year

Strategic Objective	Y2021	Y2022	Y2023	Y2024	Y2025	Total LAK	Total Bn LAK	Total Mill. US$	Total US$/Cap/Y	%
SO1: RH & AH	25,123,945,000	65,105,106,745	44,050,417,350	65,294,479,825	37,902,187,120	**237,476,136,040**	**237.5**	**24.2**	**0.64**	35.1%
SO2: Maternal	10,246,416,333	33,038,449,263	28,422,897,947	22,414,715,673	18,716,426,773	**112,838,905,990**	**112.8**	**11.5**	**0.30**	16.7%
SO3: Newborn	3,018,470,000	3,659,915,480	4,687,590,300	4,138,192,630	4,973,799,040	**20,477,967,450**	**20.5**	**2.1**	**0.06**	3.0%
SO4: Well Child	24,724,985,000	19,086,169,173	21,773,048,013	18,903,832,213	22,637,442,240	**107,125,476,640**	**107.1**	**10.9**	**0.29**	15.8%
SO5: Sick Child	11,059,147,305	13,424,079,835	8,776,055,095	9,159,070,656	9,436,243,009	**51,854,595,900**	**51.9**	**5.3**	**0.14**	7.7%
SO6: Community	10,706,760,000	13,014,590,750	14,976,464,400	14,752,436,050	15,631,000,000	**69,081,251,200**	**69.1**	**7.0**	**0.19**	10.2%
SO7: Governance	17,484,059,057	14,546,204,928	14,930,427,600	14,074,275,172	17,595,747,743	**78,630,714,500**	**78.6**	**8.0**	**0.21**	11.6%
Total LAK	**102,363,782,695**	**161,874,516,175**	**137,616,900,705**	**148,737,002,220**	**126,892,845,925**	**677,485,047,720**	**677.5**	**69.0**	**1.83**	100%
Total Bn LAK	**102.4**	**161.9**	**137.6**	**148.7**	**126.9**					
Total Mill. US$	**10.4**	**16.5**	**14.0**	**15.2**	**12.9**					
Total US$/Cap/Y	**1.4**	**2.2**	**1.9**	**2.0**	**1.7**					
%	15.1%	23.9%	20.3%	22.0%	18.7%					

Exchange rate: $1= 9,813 LAK
Average estimated population = 7,543,668

6.2.2 Estimated costs by type of activity

Activity	SO1:RH & AH	SO2: Maternal	SO3: Newborn	SO4: Well Child	SO5: Sick Child	SO6: Community	SO7: Governance	Total LAK	Total Bn LAK	%
Training	140,217,655,880	31,318,004,530	10,034,882,470	46,766,140,440	24,939,676,900	7,301,232,800	28,748,296,500	**289,325,889,520**	289.3	42.7%
Operations incl. meetings	35,486,546,100	13,049,248,260	572,485,000	15,656,068,000	4,362,918,200	54,717,631,800	28,698,802,000	**152,543,699,360**	152.5	22.5%
Administration	34,734,585,000	3,323,409,400	-	10,436,605,000	4,485,700,000	111,740,000	2,952,000,000-	**56,044,039,400**	56.0	8.3%
Monitoring &Evaluation	16,554,149,060	65,148,243,800	9,870,599,980	32,571,789,200	18,066,300,800	6,950,646,600	18,231,616,000	**167,393,345,440**	167.4	24.8%
Infrastructure	10,483,200,000	-	-	1,694,874,000	-	-	-	**12,178,074,000**	12.2	1.8%
Total	**237,476,136,040**	**112,838,905,990**	**20,477,967,450**	**107,125,476,640**	**51,854,595,900**	**69,081,251,200**	**78,630,714,500**	**677,485,047,720**	677.5	100.0%
Total Bn LAK	237.5	112.8	20.5	107.1	49.9	69.1	78.6	677.5		

6.2.3 Estimated costs by recurrence of activities

	SO1:RH & AH	SO2: Maternal	SO3: Newborn	SO4: Well Child	SO5: Sick Child	SO6: Community	SO7: Governance	Total LAK	Total Bn LAK	%
Recurrent	31,512,171,360	76,790,517,400	9,763,220,480	83,595,147,300	35,762,451,000	59,842,675,000	61,834,141,000	**359,100,323,540**	359.1	53.0%
Non recurrent	205,963,964,680	36,048,388,590	10,714,746,970	23,530,329,340	16,092,144,900	9,238,576,200	16,796,573,500	**318,384,724,180**	318.4	47.0%
Total LAK	**237,476,136,040**	**112,838,905,990**	**20,477,967,450**	**107,125,476,640**	**51,854,595,900**	**69,081,251,200**	**78,630,714,500**	**677,485,047,720**	**677.5**	**100%**
Total Bn LAK	237.5	112.8	20.5	107.1	51.9	69.1	78.6	677.5		
% recurrent	13.3%	68.1%	47.7%	78.0%	69.0%	86.6%	78.6%	53.0%		

6.2.4 Estimated costs by action level

Action level	SO1:RH & AH	SO2: Maternal	SO3: Newborn	SO4: Well Child	SO5: Sick Child	SO6: Community	SO7: Governance	Total LAK	Total Bn LAK	%
Central	136,515,650,530	36,576,982,260	2,668,231,780	33,460,398,800	17,347,480,700	1,974,443,400	66,786,673,000	**295,329,860,470**	295.3	43.6%
Central & Sub-national	-	-	17,175,004,900	5,219,810,480	8,744,956,000	-	6,105,592,000	**37,245,363,380**	37.2	5.5%
Sub-national	100,960,485,510	76,261,923,730	634,730,770	68,445,267,360	25,762,159,200	67,106,807,800	5,738,449,500	**344,909,823,870**	344.9	50.9%
Total LAK	**237,476,136,040**	**112,838,905,990**	**20,477,967,450**	**107,125,476,640**	**51,854,595,900**	**69,081,251,200**	**78,630,714,500**	**677,485,047,720**	**677.5**	**100%**
Total Bn LAK	237.5	112.8	20.5	107.1	49.9	69.1	78.6	677.5		
% Central level	57.5%	32.4%	13.0%	31.2%	27.9%	2.9%	84.9%	43.6%		

6.2.5 Estimated costs by HSDP programme

HSDP Programme	SO1:RH & AH	SO2: Maternal	SO3: Newborn	SO4: Well Child	SO5: Sick Child	SO6: Community	SO7: Governance	Total LAK	Total Bn LAK	%
HSDP programme 1	86,333,491,770	95,235,177,750	12,767,713,180	86,155,192,700	24,307,168,800	69,081,251,200	78,630,714,500	452,510,709,900	452.5	66.8%
HSDP programme 2	-	-	-	-	-	-	-	-	-	0.0%
HSDP programme 3	51,090,556,650	17,603,728,240	7,523,588,270	19,365,856,940	24,494,627,100	-	-	120,078,357,200	120.1	17.7%
HSDP programme 4	-	-	-	1,202,995,000	-	-	-	1,202,995,000	1.2	0.2%
HSDP programme 5	100,052,087,620	-	186,666,000	116,186,000	3,052,800,000	-	-	103,407,739,620	103.4	15.3%
HSDP programme 6	-	-	-	-	-	-	-	-	-	0.0%
HSDP programme 7	-	-	-	285,246,000	-	-	-	285,246,000	0.3	0.0%
HSDP programme 8	-	-	-	-	-	-	-	-	-	0.0%
Total	**237,476,136,040**	**112,838,905,990**	**20,477,967,450**	**107,125,476,640**	**51,854,595,900**	**69,081,251,200**	**78,630,714,500**	**677,485,047,720**	**677.5**	**100%**
Total Bn LAK	237.5	112.8	20.5	107.1	51.9	69.1	78.6	677.5		

6.2.6 Relation with EHSP

EHSP RMNCAH (Intervention costs excl. salaries & capital costs)				
	Y2021-25	**US$**	**US$/Cap/Y**	**%**
SO1 (FP)	73,881,920,384	7,528,984	0.2	2%
SO2 (Safe Del)	424,938,024,118	43,303,579	1.1	11%
SO3 (EmOC)	293,390,080,858	29,898,103	0.8	8%
SO4 (Newborn)	99,565,595,932	10,146,295	0.3	3%
SO6 (EPI)	569,094,510,224	57,993,938	1.5	15%
SO7 (Nutrition)	504,927,434,595	51,454,951	1.4	13%
		-	-	0%
SO5 (child care)	1,883,753,948,193	191,965,143	5.1	49%
Sub-Total RMNCAH	**3,849,551,514,303**	**392,290,993**	**10.4**	**100%**
		-	-	0%
		-	-	0%
Total RMNCAH package	***3,849,551,514,303***	***392,290,993***	***10.4***	***100%***

MOH 5Y HSDP 2021-25	24,058,000,000,000	**2,451,645,776**	**65**	
% RMNCAH	**16%**	**16%**		

RMNCAH Strategy Action Plan (Programmatic costs excl salaries)				
	Y2021-25	**US$**	**US$/Cap/Y**	**%**
SO1 RHAH	237,476,136,040	24,200,157	0.6	35%
SO2 Maternal	112,838,905,990	11,498,920	0.3	17%
		-	-	0%
SO3 Newborn	20,477,967,450	2,086,820	0.1	3%
SO4 EPI	65,546,590,700	6,679,567	0.2	10%
SO4 Nutrition	15,370,203,440	1,566,310	0.0	2%
SO4 ECD	26,208,682,500	2,670,812	0.1	4%
SO5 Sick	51,854,595,900	5,284,276	0.1	8%
Sub-total Action Plan	**529,773,082,020**	**53,986,863**	**1.4**	**78%**
Community	69,081,251,200	7,039,769	0.2	10%
Governance	78,630,714,500	8,012,913	0.2	12%
Total Action Plan	***677,485,047,720***	***69,039,544***	***1.8***	***100%***

MOH 5Y HSDP 2021-25	24,058,000,000,000	**2,451,645,776**	**65**	
% RMNCAH	**3%**	**3%**		

TOTAL RMNCAH (Total excluding Salaries & Capital costs)						
	EHSP RMNCAH (Intervention costs)	**RMNCAH Strategy Action Plan (Programmatic costs)**	**Total LAK Y2021-25**	**Total US$***	**US$/Cap/Y***	**%**
SO1 RHAH	73,881,920,384	237,476,136,040	311,358,056,424	31,729,141	0.8	7%
SO2 Maternal (Safe delivery)**	424,938,024,118	112,838,905,990	831,167,010,966	84,700,602	2.2	18%
SO2 Maternal (EmOC)**	293,390,080,858	-				
SO3 Newborn	99,565,595,932	20,477,967,450	120,043,563,382	12,233,116	0.3	3%
SO4 EPI	569,094,510,224	65,546,590,700	634,641,100,924	64,673,505	1.7	14%
SO4 Nutrition	504,927,434,595	15,370,203,440	520,297,638,035	53,021,261	1.4	12%
SO4 ECD	-	26,208,682,500	26,208,682,500	2,670,812	0.1	1%
SO5 Sick	1,883,753,948,193	51,854,595,900	1,935,608,544,093	197,249,419	5.2	43%
Sub-Total	**3,849,551,514,303**	**529,773,082,020**	**4,379,324,596,323**	**446,277,856**	**11.8**	**97%**
Community	-	69,081,251,200	69,081,251,200	7,039,769	0.2	2%
Governance	-	78,630,714,500	78,630,714,500	8,012,913	0.2	2%
Total Action Plan	***3,849,551,514,303***	***677,485,047,720***	***4,527,036,562,023***	***461,330,537***	***12.2***	***100%***

MOH 5Y HSDP 2021-25	**24,058,000,000,000**	**2,451,645,776**	**65.0**
% RMNCAH	**19%**	**19%**	

*Exchange rate: $1=9,813 LAK, average estimated population: 7,543,668

**For the Maternal Health service (SO2), the EHSP RMNCAH cost is divided into two sub-services, safe delivery and emergency obstetrics care (EmOC). The cost for SO2 in the RMNCAH strategy action plan and in the total RMNCAH service represent the total cost for SO2.

Annex 1: Ministerial Decision on RMNCAH Committees

Lao People's Democratic Republic
Peace Independence Democracy Unity and Prosperity

Ministry of Health No /MoH

Vientiane Capital, Date

Ministerial Agreement of the Ministry of Health on

Sub-committees Establishing for the Reproductive, Maternal, Newborn, Children and Adolescent Health (RMNCAH) Strategy Implementation

- Pursuing to the Degree of the Prime Minister on the structure and action of the Ministry of Health No. 96/PM, dated 09 March 2017.
- Pursuing to the outcomes of the RMNCH Strategy for 2016 – 2025 mid-term review meeting on 14 – 15 February 2019.
- Pursuing to the proposal of the Department of Hygiene and Health Promotion No. /DHHP, dated: 09 March 2021.
- Pursuing to the exploration and proposal of Department of Health Personnel No. /DHP; dated: April 2021.

Minister of the Ministry of Health agrees to:

Article 1: Appoint committees to implement The RMNCAH Strategy & Action Plan 2021-2025 as follows:

I. **Steering Committee**:

1. PhD. Dr. Bounfeng Phoummalaysith	Minister of Health
2. Mr. Khamphone Phoutthavong	Vice-Minister of Health
3. Assoc. Prof. Dr. Phouthone Meuangpak	Vice-Minister of Health
4. Dr. Phonephaseuth Ounaphom	Director of DHHP

Has role and function to:

1. Comprehensively guide the implementation of the integrated RMNCAH strategy and action plan for 2021-2025.

2. Be the chair of the meeting, give advice and facilitate to the committee, sub-committee.

II. Management Supervisory Committee:

1. Dr. Bounthom Samontry	Rector of University of Health Sciences
2. Dr. Sengchoy Panyavong	Director of DHP
3. Dr. Somphone Phangmanixay	Director of Finance Department
4. Dr. Founkham lattanavong	Director of DPC
5. Dr. Phasouk Vongvichit	Director of DHPE
6. Dr Nikone Vongsavath	Director of National HIB
7. PhD. Dr. Bounxou Keohavong	Deputy Director of FDD
8. Dr. Chandavone Phoxay	Deputy Director of Cabinet of MOH
9. Dr. Sompheng Souvannamethy	Vice director of Inspection Department
10. Mr. Visith Khamleusa	Director of CCEH

Has role and function to:

1. Lead the development and dissemination of the integrated services for RMNCAH and action plan 2016-2025.
2. Meet every 6 months, chaired by the Vice Minister, to monitor implementation and review health system follow-up actions.
3. Give guidance to sub-committee for the ongoing implementation and effective governance
4. Support the RMNCAH sub-committees to implement broader health sector policies and strategies
5. Reflect lessons learned through RMNCAH strategy implementation into broader health sector policies and strategies, including sharing of effective models and good practices.

III. Technical Committee:

1. Dr. Khamphoua Southisombath	Director of DHR
2. Dr. Vanphanom Sychareun	Dean of Faculty of Public Health, University of Health Sciences
3. Dr. Onechan Keosavanh	Deputy Director of DHHP
4. Dr. Chansaly Phommavong	Deputy-Director of DPC
5. Dr. Souphab Panyakeo	Deputy Director of Finance Department
6. Dr. Viengxay Vansilalom	Deputy Director of FDD
7. Ms. Sengmany Khambounheuang	Deputy Director of DHPE
8. Dr. Phouthone Souttalack	Director of CHAS
9. Dr. Manee Thammavong	Director of Medical Equipment Supply
10. Dr. Viengxay Vansilalom	Deputy Director of FDD
11. Dr. Phonesavanh Keonakhone	Acting Director of Nutrition Center
12. Dr. Anan Sackpaseuth	Head of Gynecology-Obstetric Association
13. Assoc. Prof. Dr. Khampae Phongsavath	Head of Pediatric Association
14. Dr. Alongkone Phengsavanh	Vice-Dean of Faculty of Medicine, UHS
15. Dr. Sommanikhone Phangmanixay	Director of Child Hospital

16. Dr. Viengkhan Phixay	Deputy Director of MCHC
17. Dr. Inpong Thongphachanh	Deputy Director of CCEH

Has role and function to:

1. Lead the development and implementation of the National Strategy and Action Plan for RMNCAH to 2025.
2. Call for biannual meetings with sub-committee every 6 months to monitor the implementation of the action plan, track progress to M&E Framework targets, and resolve outstanding implementation issues
3. Give guidance to sub-committees around ongoing implementation of the RMNCAH Strategy & Action Plan to 2025
4. Lead and oversee the ongoing review and periodic evaluation of implementation of the RMNCAH Strategy and Action Plan to 2025, including the end point evaluation
5. Lead and facilitate coordination to sub-committee for the implementation of RMNCAH strategy.

IV. Sub-Committees to Implement the RMNCAH Strategy & Action Plan to 2025

➢ **Sub-Committee for Reproductive Health & Adolescent (SO1):**

1. Dr. Sommana Rattana	Deputy director of DHR
2. Dr. Keokedthong Phongsavanh	Head of Gynecology-Obstetric Division, Setthathirath hospital
3. Dr. Sitthisack Panyavatthanasin	Technical Staff, Gynecology-Obstetric Division, UHS
4. Dr. Kidsada Saenthep	Vice-Director of Medical Equipment Supply
5. Mr. Souksomkouan Chanthamath	Head of management division, FDD
6. Dr. Latsada Phameuang	Vice-Head of Management health promotion Division, DHHP
7. Ms. Soulivanh Keokinnaly	Vice-Head of Drug Management, FDD
8. Ms. Phanthong Phouxay	Vice head of administrative, DHPE
9. Dr. Chansy Dalavong	Vice Head of Gynecology-Obstetric Division, Setthathirath hospital
10. Dr. Sengmany Norchaleun	Head of administrative, Nutrition Center
11. Dr. Chanthavone Louangkhot	Vice-Head of Mother and Child Health Section, MCHC
12. Dr. Souphaxay Khamphanthong	Vice head of surveillance and research, Nutrition Center
13. Dr. Khamphong Kongphaly	Technical Staff, Nutrition Center
14. Ms. Linda Tiphanya	Technical staff of Training and Research, CCEH
15. Dr. Soulivanh Xongvilay	Technical staff, Medical Equipment Supplies
16. Mr. Silisouk Souksavath	Technical Staff of maternal health promotion unit, MCHC
17. Dr. Naly Sayyachack	Technical staff of Management health promotion, DHHP

18. Dr. Sysouvanh Xayyavong	Technical Staff, Gynecology-Obstetric Division, UHS
19. Dr. Sengaloun Chanthavong	Technical Staff, Gynecology-Obstetric Division, UHS

- **Sub-Committee for Maternal (SO2):**

1. Dr. Alongkone Phengsavanh	Vice-Dean of Faculty of Medicine, UHS
2. Dr. Toui Chanthalangsy	Deputy-Director of Mother and Newborn Hospital
3. Dr. Nouansy Keovanpheng	Head of Management-Research, DHPE
4. Dr. Viengsakhone Louangpadith	Heag of Administrative Division, DHR
5. Ms. Phouthone Chanthalangsy	Vice head of Midwife Association, Nursing faculty
6. Dr. Chaimua Xuako	Head of MCH division, Mother and Newborn Hospital
7. Dr. Sengchan Sivilay	Vice head of Gynecology Division, MNH
8. Ms. Phouthone Chanthalangsy	Vice head of Midwife Association, Nursing faculty
9. Ms. Syamphay Khammounneun	Vice-Head of Obstructive Division, MNH
10. Dr. Douangphachanh Xaysomphou	Vice head\ of science research, OBGY, UHS
11. Dr. Sengmany Norchaleun	Head of administrative, National Nutrition Center
12. Dr. Khanthong Keomounkhoun	Head of Mother Health Promotion Section, MCHC
13. Dr. Bounthipphaphone Phouthichai	Technical staff, Nutrition center
14. Ms. Chitsana Thilakoun	Head of OBGY Unit, Mahosot Hospital
15. Dr. Xaysomphone Mouksavanh	Technical staff of management health promotion, DHHP
16. Dr. Vilason Singthong	Technical staff, OBGY Department, MNH
17. Dr. Johnny Vannavong	Technical staff, OBGY Department, Mahosot

- **Sub-Committee for Newborn (SO3):**

1. Dr. Sommana Rattana	Deputy director of DHR
2. Dr. Khamphew Namsena	Head of Gynecology Division, Mother and Newborn Hospital
3. Dr. Viengsakhone Louangpadith	Head of Administrative Division, DHR
4. Dr. Phommady Vetsaphong	Head of Neonatal Division, Mother and Newborn Hospital,
5. Dr. Khamphouvanh Phounsavath	Head of Pediatric Intensive Care Unit, Setthathirath Hospital
6. Dr. Vilaphone Phaymany	Head of Neonatal Intensive Care Unit, Child hospital
7. Dr. Chittaphone Xayyavong	Head of Pediatric Intensive Care Unit, Mother and Newborn Hospital
8. Dr. Douangkham Phommachanh	Vice head of Neonatal Resuscitation Division, Mahosot

9. Dr. Vimonlath Singhalath	Vice Head of Ostretic and Gynegology, Mahosot hospital
10. Dr. Somchanh Souksavanh	Vice Head of Nutrition Division, Mahosot
11. Dr. Vanmaly Sengmeuang	Vice Head of Pediatric Intensive Care Unit, Mahosot hospital
12. Dr. Kongxay Phounphenghak	Head of Vaccine Preventable Disease Division, MCHC
13. Ms. Vanida Chooummaly	Vice head of administrative unit, Nutrition center
14. Dr. Somphathay Bouathong	Vice-Head of Child Health Promotion Section
15. Midwife Phousavath Savanh	Technical staff of NICU, Mahosot Hospital
16. Midwife Vanseng Phongsysay	Head of Obstretic Unit, Mother and Newborn hospital
17. Midwife Keovilay Khemmavong	Head of Gynegology, Mother and Newborn hospital
18. Dr. Latdaphone Vongphakdy	Techniccal staff of training division, Nutrition center
19. Dr. Bounma Latsamy	Techniccal staff of promotion division, Nutrition center
20. Dr. Bouasengniyom Phrasitthideth	Technical staff, Neonatal Intensive Care Unit, Mahosot
21. Dr. Soumounta Phommathep	Technical staff, Obstretic-Gynecology unit, Friendship hospital
22. Midwife Khemkham Phengphet	Technical staff, Obstretic unit, Mahosot hospital
23. Dr. Sitthisong Xaypanya	Technical of newborn division, MNH
24. Dr. Devina Phrasitthideth	Technical staff, Intensive care unit, Children's Hospital

- **Sub-Committee for Well Child (SO4):**

1. Dr. Phonedavanh Donesavanh	Deputy Director of Child Hospital
2. Dr. Phonesavanh Keonakhone	Acting Director of Nutrition Center
3. Dr. Somchan Thounsavath	Head of healthcare and rehabilitation division, DHR
4. Dr. Viengvilay Chanthavong	Head of Primary Health Care Division, DHHP
5. Dr. Latsamy Thammavong	Vice-Head of management Health Promotion Division, DHHP
6. Dr. Souvankham Phommaseng	Vice-Head of management Health Promotion Division, DHHP
7. Dr. Chanthaoloth Soutthivongnorath	Vice-Head of Pediatric Division, Setthathirath Hospital
8. Dr. Chansay Patthammavong	Vice-Head of Vaccine Preventable Disease Division, MCHC
9. Dr. Phouthong Lattanavong	Vice-Head of Child Health Unit, MCHC
10. Dr. Chanthavong Savathcheerang	Vice-Head of Vaccine Preventable Disease Division, MCHC
11. Dr. Khouanheuan Sengkhamyong	Technical staff of training Unit, Nutrition Center
12. Dr. Phonexay Douangnoulack	Technical staff, Children's Hospital

13. Dr. Koulap Bounmixay	Technical staff of ECD division, Children's Hospital
14. Dr Nidaphone Phetdavan	Technical staff, MNH
15. Dr. Phousavanh Meuangpak	Technical staff of management Health Promotion, DHHP
16. Dr. Sonenalin Samonty	Technical staff of Vaccine Preventable Disease Division, MCHC
17. Dr. Bangon Tannavong	Technical staff of Vaccine Preventable Disease Division, MCHC

- **Sub-committee for Sick Child (SO5):**

1. Dr. Sommanikhone Phangmanixay	Director of Child Hospital
2. Dr. Sourideth Sengchanh	Vice-Head of Pediatric Department, UHS
3. Dr. Bandith Soumphonphackdy	Head of Paediatric Infectious Division, Mahosot Hospital
4. Dr. Phengchoy Panyalath	Technical staff, MCHC, Vice-Head
5. Dr. Khaysy Latsavong	Head of Pediatric Intensive Care Unit, Mahosot Hospital
6. Dr. Chanmany Syhaphom	Head of Infection Unit, Child Hospital
7. Dr. Viengsakhone Louangpadith	Head of Administration Division, DHR
8. Dr. Sanyalack Xaysanasongkham	Vice head of emergency division, Children's Hospital
9. Dr. Naly Sayyachack	Technical staff of management Health Promotion, DHHP
10. Dr. Konesanouk Singphouangphet	Technical staff of Child Health Unit, MCHC
11. Dr. Phouphet Sayyalin	Technical staff of Vaccine Preventable Disease Division, MCHC
12. Dr. Khanthaly Philavong	Technical staff of promotion division, Nutrition center
13. MA. Khamphet Louanglath	Technical staff, MCHC
14. Dr. Phoutmany Vongxay	Technical staff of Paediatric division, Setthathirath Hospital
15. Dr. Somying Duangdala	Technical staff of surveillance unit, Nutrition center

Sub-committees have role and function to:

1. **Develop action plan for each sub-committee**
2. **Integrate the plan into the 8 health sector programs.**
3. Provide technical guidance to provincial level according to each strategic objective.
4. Monitoring progress and report the result of implementation periodically.
5. Monitoring the planning and budgeting regularly.

V. RMNCAH Secretariat to Implement the RMNCAH Strategy & Action Plan to 2025

1. PhD. Dr. Bounseuth Keopaseuth	Deputy-Director of the Cabinet, MOH
2. Dr. Viengkhanh Phixay	Vice director of mother and child health center

3. Dr Phonethavy Kodsimeuang — Head of administrative division, DHHP
4. Dr. Latsada Phamuang — Vice-Head of Management health promotion Division, DHHP
5. Mr. Phouthone Souliphone — Technical staff, DHHP
6. Dr. Kommany Phounphenghak — Vice-Head of Administrative-Planning-Statistic Unit, MCHC
7. Dr. Chankham Tengbreachu — Technical staff of Administrative-Planning-Statistic Unit, MCHC
8. Dr. Khammany Phommachanh — Technical staff of Administrative-Planning-Statistic Unit, MCHC
9. Dr. Konesanouk Singphouangphet — Technical staff of Child Health Unit, MCHC
10. Dr. Phetsaphone Thipthilath — Technical staff of Administrative-Planning-Statistic Unit, MCHC
11. Dr. Bannousone Khammavong — Technical staff of Administrative-Planning-Statistic Unit, MCHC
12. MA. Bounsalong Sayyasinh — Technical staff of Administrative-Planning-Statistic Unit, MCHC

- Coordinator for Reproductive Health & Adolescent (SO1):

1. Dr. Sysamone phandanouvong — Technical Staff of maternal health promotion unit, MCHC
2. Dr. Phoumsavath Ounavong — Technical staff, DHR
3. Dr. Inthida Soukkhanouvong — Technical Staff of maternal health promotion unit, MCHC

- Coordinator for Maternal Health (SO2):

1. Dr. Pathoumphone Boulommavong — Technical Staff of maternal health promotion unit, MCHC
2. Dr. Sysomphone Sengdala — Technical Staff, OBGY Department, UHS
3. Dr. Phoumsavath Ounnavong — Technical staff, DHR

- Coordinator for Newborn (SO3):

1. Dr. Viengsakhone Louangpadith — Head of Administration Division, DHR
2. Dr. Souksavanh Sysamay — Technical staff of child health promotion unit, MCHC

- Coordinator for Well Child (SO4):

1. Dr. Fanta Ounkham — Technical staff, MCHC, Coordinator
2. Mr. Phaengpadith Vonglavichit — Technical staff, DHHP, Coordinator

- Coordinator for Sick Child (SO5):

1. Dr. Siamphan Akkhavong — Head of Administration Office, Child Hospital,
2. MA. Viphavanh Syphonesay — Technical staff of Vaccine Preventable Disease Division, MCHC
3. Dr. Phoumsavath Ounnavong — Technical staff, DHR

The RMNCAH Secretariat has role and function to:

1. Oversight of the program of work to address the 10 Strategic Recommendations (see Section 1.4) emerging from the MTR process. This includes facilitating the shift from

a program-based approach to an integrated people-centred approach in planning, monitoring, service delivery, quality assessment and improvement.

2. Coordination of all RMNCAH stakeholders to provide targeted and effective inputs to RMNCAH Strategy and Action Plan implementation. These stakeholders include with the Steering Committee, The Executive Committee, The Technical Committee, the Sub-Committee and Development Partners at central level.
3. Sub-national dissemination and oversight of the RMNCAH Strategy & Action Plan to 2025 to Province and District level. This includes coordination with the Provincial RMNCAH Focal Points to ensure effective implementation of the RMNCAH Strategy & Action Plan at sub-national level.
4. Leading the Sub-Committees in undertaking routine monitoring & reporting, including expenditure reporting, in line with agreed templates and schedule to effectively track progress to Strategy targets, highlight and share lessons learned, and escalate system blockages.
5. Convene and facilitate operational and technical review meetings as per the agreed annual schedule of meetings to enable formal monitoring of progress.

Sub-Committee Coordinators have role and function to:

1. Coordinate with each sub-committee
2. Coordinate with the RMNCAH secretariat
3. Monitor the progress of implementation of each strategic quarterly and semi-annually and annually.

Article 2. Budget for the strategy implementation is from government budget for 2021. The total budget is 500,000,000 LAK (Five hundred million kips).

Article 3. Cabinet of the Ministry of Health, Personnel-Organization Department, Hygiene & Health Promotion Department, Departments, Centers, Hospitals and assigned persons and related organizations shall implement this agreement according to the responsibilities specified in the agreement strictly.

Article 4. This agreement shall become effective from the date of signature.

Minister of the Ministry of Health

Distribute to:

1. Cabinet	01 copy
2. Each relevant department	01 copy
3. Each individual	01 copy
4. Filing	01 copy

Annex 2: List of Indicators & Definitions

No.	Indicator	Type of Indicator	Data Source	Definition	Denominator	Numerator
GOAL: Improve the reproductive health status and reduce maternal, neonatal and child mortality and morbidity including malnutrition in Lao PDR						
Goal 1	Total Fertility Rate (per woman)	Impact	LSIS	The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality		
Goal 2	Adolescent Fertility/Birth Rate (per 1,000 women aged 15-19 years)	Impact	LSIS	The annual number of births to women aged 15–19 years per 1000 women in that age group.		
Goal 3	Maternal Mortality Ratio (per 100,000 live births)	Impact	UN Estimate	The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100,000 live births, for a specified time period.		
Goal 4	Neonatal Mortality Rate (per 1,000 live births)	Impact	LSIS	Number of deaths during the first 28 completed days of life per 1000 live births in a given year or other period		
Goal 5	Infant Mortality Rate (per 1,000 live births)	Impact	LSIS	Probability (expressed as a rate per 1000 live births) of a child born in a specific year or period dying before reaching the age of one, if subject to age-specific mortality rates of that period.		

Goal 6	Under Five Mortality Rate (per 1,000 live births)	Impact	LSIS	Probability (expressed as a rate per 1000 live births) of a child born in a specific year or period dying before reaching the age of five years, if subject to age-specific mortality rates of that period.		
Goal 7	Prevalence of Stunting in children < 5 years of age (%)	Impact	LSIS; National Nutrition Survey	The percentage of stunting (defined as more than two standard deviations below the median height-for-age of the WHO Child Growth Standards) among children aged five years or younger	Total number of children aged five years or younger surveyed.	Number of children aged five years or younger that meet the criteria for stunting (more than two standard deviations below the median height-for-age of the WHO Child Growth Standards) .
Goal 8	Rate of underweight among children < 5 years of age (%)	Impact	LSIS	The percentage of underweight (defined as more than two standard deviations below the median weight-for-age of the WHO Child Growth Standards) among children aged five years or younger	Total number of children aged five years or younger surveyed.	Number of children aged five years or younger that meet the criteria for underweight (more than two standard deviations below the median weight-for-age of the WHO Child Growth Standards)
Goal 9	Prevalence of Severe Acute Malnutrition < 5 years of age (%)	Impact	LSIS	The percentage of severe acute malnutrition (defined as more than three standard deviations below the median weight-for-height of the WHO Child Growth Standards) among children aged five years or younger	Total number of children aged five years or younger surveyed.	Number of children aged five years or younger that meet the criteria for severe acute malnutrition (more than three standard deviations below the median weight-for-height of the WHO Child Growth Standards)

Goal 10	Prevalence of anaemia in women of reproductive age (Hb<12g/dL; for pregnant women, less than 11g/dL)) (%)	Impact	LSIS	Percentage of women aged 15–49 years with a haemoglobin concentration less than 12.0 g/L for non-pregnant women and lactating women, and less than 11.0 g/L for pregnant women	Total number of women of reproductive age surveyed	The number of women of reproductive age surveyed that meet the criteria for anaemia (less than 12.0 g/L for non-pregnant women and lactating women, and less than 11.0 g/L for pregnant women)
Equity: Improve equity of access to essential services on reproductive, maternal, newborn, child and adolescent health in Lao PDR						
Equity 1	Equity ratio of Neonatal Mortality Rate by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	The ratio of NMR in Q1 (the poorest) to NMR in Q5 (the least poor)	NMR in Q1 (the poorest)	NMR in Q5 (the least poor)
Equity 2	Equity ratio of Under Five Mortality Rate by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	The ratio of U5MR in Q1 (the poorest) to NMR in Q5 (the least poor)	U5MR in Q1 (the poorest)	U5MR in Q5 (the least poor)
Equity 3	Equity ratio of stunting prevalence among children under 5 by Socioeconomic Status (SES) (ratio: Q1(the	Equity	LSIS	The ratio of stunting prevalence rate in Q1 (the poorest) to stunting prevalence rate in Q5 (the least poor)	Stunting prevalence rate in Q1 (the poorest)	Stunting prevalence rate in Q5 (the least poor)

	poorest)/Q5(the least poor))					
Equity 4	Equity ratio of coverage of at least 1 ANC visit (ANC1) by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	The ratio of ANC1 in Q1 (the poorest) to ANC1 in Q5 (the least poor)	ANC1 in Q1 (the poorest)	ANC1 in Q5 (the least poor)
Equity 5	Equity ratio of coverage of Skilled Birth Attendant (SBA) by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	The ratio of SBA in Q1 (the poorest) to SBA in Q5 (the least poor)	SBA in Q1 (the poorest)	SBA in Q5 (the least poor)
Equity 6	Equity ratio of coverage of Penta3 (children under 1 year receiving the third dose of Penta vaccine) by Socioeconomic Status (SES) (ratio: Q1(the poorest)/Q5(the least poor))	Equity	LSIS	The ratio of Penta3 coverage in Q1 (the poorest) to Penta3 coverage in Q5 (the least poor)	Penta3 coverage in Q1 (the poorest)	Penta3 coverage in Q5 (the least poor)
Strategic Objective 1 - Reproductive & Adolescent - Increase Sexual Reproductive Health and Rights (SRHR) services for all people, without discrimination						
Specific Objective 1.1: By 2025, increase mCPR (modern methods) for all women to 65% and reduce unmet need to 10%						

1.1.1	Contraceptive Prevalence Rate (married women; all methods) (%)	Coverage	LSIS, Track20	The percentage of women aged 15-49 years, married or in-union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used at a particular point in time	The number of surveyed women aged 15-49 years, married or in union	The number of women aged 15-49 years, married or in-union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used.
1.1.2	Modern Contraceptive Prevalence Rate (all WRA; Modern Methods) (%)	Coverage	LSIS & Track20	The percentage of women aged 15 to 49 who are currently using, or whose sexual partner is using, at least one modern method of contraception at a particular point in time	The number of surveyed women aged 15-49 years	The number of women aged 15 to 49 who are currently using, or whose sexual partner is using, at least one modern method of contraception
1.1.3	Percentage of women with an unmet need for contraception (married WRA) (%)	Coverage	LSIS & Track20	The proportion of women of reproductive age (15-49 years) who are married or in union and who have an unmet need for family planning, i.e. who do not want any more children or want to wait at least two years before having a baby, and yet are not using contraception.	The number of women of reproductive age (15-49 years) who are married or in union	The number of women of reproductive age (15-49 years) who are married or in union and who have an unmet need for family planning
1.1.4	Number of additional users of modern methods	Coverage	DHIS2, Track20	The number of additional users of modern contraceptive method in the reporting year		
1.1.5	Proportion of women using long acting and permanent contraceptives (LARC & sterilisation) (%)	Coverage	LSIS, DHIS2, Track20	The percentage of women aged 15 to 49 who are currently using, or whose sexual partner is using, long acting (implant or IUD) or permanent contraceptive method	The number of women aged 15 to 49	The number of women aged 15 to 49 who are currently using, or whose sexual partner is using, long acting (implant or IUD) or permanent contraceptive method

1.1.6	Proportion of women accessing services at a health facility using modern contraceptives who received counselling/follow-up on other methods (%)	Quality	Integrated Quality Assessment	The proportion of interviewed women accessing services at a health facility on the site visit day currently using any modern contraceptives who received counselling/follow-up on other methods	The proportion of interviewed women accessing services at a health facility on the site visit day currently using any modern contraceptives	The number of interviewed women currently using any modern contraceptives who received counselling/follow-up on other methods
1.1.7	Proportion of women accessing services at a health facility not using any modern contraceptives and not wishing to be pregnant (at least within 2 years) who received counselling on modern methods (%)	Quality	Integrated Quality Assessment	The proportion of interviewed women accessing services at a health facility currently not using any modern contraceptives and not wishing to be pregnant (at least within 2 years) who received counselling/follow-up on at least one modern methods on the site visit day	The proportion of interviewed women accessing services at a health facility on the site visit day currently not using any modern contraceptives and not wishing to be pregnant (at least within 2 years)	The number of interviewed women accessing services at a health facility currently not using any modern contraceptives and not wishing to be pregnant (at least within 2 years) who received counselling/follow-up on at least one modern methods on the site visit day
Specific Objective 1.2: By 2025, increase CPR (modern methods) of 15-24 year-olds to 70% by providing youth friendly service to adolescents and youth.						
1.2.1	Modern contraceptive prevalence rate amongst 15-24 years old (all; modern methods) (%)	Coverage	LSIS, DHIS2	The percentage of women aged 15 to 24 who are currently using, or whose sexual partner is using, at least one modern method of contraception	The number of surveyed women aged 15-24 years	The number of women aged 15 to 24 who are currently using, or whose sexual partner is using, at least one modern method of contraception
1.2.2	Unmet need for contraception amongst 15-24 year olds (all women) (%)	Coverage	LSIS	The proportion of women aged 15-24 years who have an unmet need for family planning, i.e. who do not want any more children or want to wait at least two years before having a baby, and yet are not using contraception.	The number of surveyed women aged 15-24 years in need for family planning	The number of women aged 15-24 years who have an unmet need for family planning

1.2.3	Proportion of health facilities (only provincial hospitals) where there is available room for youth friendly service provision (%)	Quality	Integrated Quality Assessment	The percentage of health facilities (only provincial hospitals) where there is available room for youth friendly service provision	The number of provincial hospitals	The number of health facilities (only provincial hospitals) where there is available room for youth friendly service provision
Specific Objective 1.3: By 2025, strengthen capacity for health staff to be able to provide cervical cancer screening services to 40% of the population of women of reproductive age						
1.3.1	Proportion of women 25 to 49 years old screened for cervical cancer (%)	Coverage	Clinic Records (LSIS for denominator)	The proportion of women 25 to 49 years old screened for cervical cancer	The number of women aged 25-49 years	The number of women aged 25-49 years who received screening for cervical cancer
1.3.2	Proportion of women 25 to 49 years old diagnosed positive by VIA and treated for cervical cancer (%)	Coverage	Clinic Records (LSIS for denominator)	The proportion of women 25 to 49 years old diagnosed positive by VIA and treated for cervical cancer	The number of women aged 25-49 years	The number of women 25 to 49 years old diagnosed positive by VIA and treated for cervical cancer
Specific Objective 1.4: By 2025 strengthen the capacity of facilities to provide other SRHR services to all population groups, focusing on men and pre-and-post menopausal women						
1.4.1	Proportion of health facilities (only provincial hospitals) that are ready to provide 'friendly' sexual reproductive health and rights services for all population groups	Quality	Integrated Quality Assessment	The percentage of provincial hospitals that are ready to provide 'friendly' sexual reproductive health and rights services for all population groups	The number of health facilities (only provincial hospitals)	The number of health facilities (only provincial hospitals) that are ready to provide "sexual reproductive health and rights services for all population groups
1.4.2	Proportion of health staff who have been trained on sexual reproductive health and rights counselling	Quality	Integrated Quality Assessment	The percentage of health staff who have been trained on sexual reproductive health and rights counselling	The number of health staff in all health facilities	The number of health staff who have been trained on sexual reproductive health and rights counselling
Strategic Objective 2 – Maternal: All pregnant, laboring and post-partum women receive quality care in line with national standards						
Specific Objective 2.1 - Antenatal: By 2025, 80% of pregnant women should receive at least 4 quality ANC checks in line with the timings advised and national standards						

2.1.1	Proportion of pregnant women receiving at least 1 ANC check	Coverage	LSIS, DHIS2	The percentage of women with a live birth in a given time period that received antenatal care at least once during pregnancy.	Total number of live births in the same period	The number of women with a live birth in a given time period that received antenatal care at least once during pregnancy
2.1.2	Proportion of pregnant women who made first ANC visit before end of 12th gestational week of pregnancy	Quality	LSIS, DHIS2	LSIS: The proportion of women age 15-49 years with a live birth in the last two years who had the first ANC visit less than 4 months of pregnancy DHIS2: The proportion of pregnant women who had the first ANC visit before end of 12th gestational week of pregnancy	LSIS: The number of surveyed women aged 15-49 years with a live birth in the last two years DHIS2: total number of live births	LSIS: The number of women age 15-49 years with a live birth in the last two years who had the first ANC visit less than 4 months of pregnancy DHIS2: The number of pregnant women who had the first ANC visit before end of 12th gestational week of pregnancy
2.1.3	Proportion of pregnant women receiving at least 4 ANC checks	Coverage	LSIS, DHIS2	The percentage of women with a live birth in a given time period that received antenatal care four or more times.	Total number of live births in the same period	The number of women with a live birth in a given time period that received antenatal care four or more times
2.1.4	Proportion of pregnant women attending ANC who were tested for anaemia and the result recorded	Quality	Integrated Quality Assessment	The percentage of pregnant women at ANC with their charts (MCH handbook) reviewed whose Hb was tested and the result was recorded on the charts (MCH handbook) during their current pregnant period	The number of pregnant women at ANC whose charts (MCH handbook) are reviewed	The number of pregnant women at ANC whose Hb was tested and the result was recorded on their charts (MCH handbook) during their current pregnant period

2.1.5	Proportion of women who attended ANC in their third trimester who have a birth preparedness plan written in their MCH handbook	Quality	Integrated Quality Assessment	The percentage of pregnant women in the third trimester at ANC with their charts (MCH handbook) reviewed who have a birth preparedness plan (facility delivery, transportation, cost and companion) written in their MCH handbook.	The number of pregnant women in the third trimester at ANC whose MCH handbook is reviewed	The number of pregnant women in the third trimester at ANC who have a birth preparedness plan (facility delivery, transportation, cost and companion) written in their MCH handbook
2.1.6	Proportion of pregnant women attending ANC who were counselled on nutrition practices during their current pregnancy	Quality	Integrated Quality Assessment	The percentage of pregnant women at ANC interviewed who received counselling on nutrition during current pregnancy	The number of pregnant women at ANC interviewed	The number of pregnant women at ANC interviewed who received counselling on nutrition during current pregnancy
2.1.7	Proportion of pregnant women attending ANC receiving Provider Initiated Counselling and Testing (PICT) for HIV	Coverage	HIVCAM, DHIS2	The percentage of pregnant women at ANC who received PICT for HIV	Total number of live births in the same period	The number of pregnant women at ANC who received PICT for HIV
2.1.8	Percentage of pregnant women who receive Iron/Folic acid (> or equal 90 tablets)	Coverage	LSIS, DHIS2	The percentage of pregnant women receiving >90 Iron/Folic acid tablets in the reporting year	Total number of live births in the same period	The number of pregnant women who received >90 IFA tablets at ANC
Specific Objective 2.2 - Intrapartum: By 2025, 85% of pregnant women deliver with a skilled birth attendant with access to quality routine or high-risk care in line with national standards						
2.2.1	Proportion of pregnant women delivering with a trained health professional (SBA)	Coverage	LSIS, DHIS2	Percentage of live births attended during delivery by skilled health personnel. Skilled health personnel includes doctors, nurses, midwives and other medically trained personnel	Total number of live births to women occurring in the period prior to the survey	Number of live births to women attended during delivery by skilled health personnel in the period prior to the survey
2.2.2	Proportion of births in a health facility (FBD)	Coverage	LSIS, DHIS2	Percentage of live births delivered in a health facility	Total number of live births to women during a specific time period	The number of women with a live birth attended in a health facility during a specific time period

2.2.3	Proportion women delivering in a health facility who received routine uterotonic drugs (Oxytocin)	Quality	DHIS2	The percentage of live births in a health facility who receive a routine uterotonic drug (Oxytocin) immediately after childbirth	The number of facility delivery during a specific time period	The number of facility delivery receiving oxytocin immediately after delivery
2.2.4	Proportion of women with severe preeclampsia or eclampsia who were given the correct dose of MgSO4	Quality	Integrated Quality Assessment	The percentage of women with severe preeclampsia or eclampsia with their charts reviewed who were given the correct loading dose of MgSO4	The number of women with severe preeclampsia or eclampsia whose charts are reviewed	The number of women with severe preeclampsia or eclampsia who were given the correct loading dose of MgSO4
2.2.5	Proportion of mothers who are monitored for 2 hours after delivery	Quality	Integrated Quality Assessment	The percentage of postpartum women in a health facility with their charts reviewed who are monitored for 2 hours after delivery with following the national standard (monitor vital signs, vaginal bleeding and uterine construction every 15 minutes in the first two hours after delivery)	The number of postpartum women in a health facility whose medical charts are reviewed	The number of postpartum women in a health facility who are monitored for 2 hours after delivery with following the national standard
2.2.6	Proportion of infants born to identified HIV positive mothers receiving ARV prophylaxis for prevention of mother to child transmission	Coverage	HIVCAM	The percentage of infants born from identified HIV positive mothers who received ARV prophylaxis for prevention of mother to child HIV transmission	The number of infants/live births exposed to HIV by identified HIV positive mothers	The number of infants born from identified HIV positive mothers who received ARV prophylaxis for prevention of mother to child HIV transmission
Specific Objective 2.3 - Postpartum: By 2025, 80% of women delivering in a health facility should receive quality post natal care and complication management within 24 hours of delivery						

2.3.1	Proportion of women who receive postnatal care for at least 24 hours after delivery	Coverage	LSIS, DHIS2	LSIS: the percentage of women age 15-49 years with a live birth in the last two years who received health checks at the same day of delivery while in facility or at home following birth DHIS2: the percentage of women with a live birth (including both facility delivery and home delivery) who received the fist postnatal care in health facility within 24 hours after delivery	LSIS: the number of surveyed women age 15-49 years with a live birth in the last two years DHIS2: Total number of live births	LSIS: the number of surveyed women with a live birth who received health checks at the same day of delivery while in facility or at home following birth DHIS2: the number of women with a live birth (including both facility delivery and home delivery) who received the fist postnatal care in health facility within 24 hours after delivery
2.3.2	Proportion of women who receive postnatal care at 6 weeks after delivery	Coverage	DHIS2	The percentage of women with a live birth who received postnatal care at 6 weeks after delivery (both fixed site and outreach)	DHIS2: Total number of live births	The number of women with a live birth who received postnatal care at 6 weeks after delivery (both fixed site and outreach)
2.3.3	Proportion of women who received a complete PNC check (mother & baby) according to the MCH Handbook	Coverage	DHIS2	The percentage of women who received a complete PNC check (mother & baby) according to the MCH handbook (PNC1 <24 hours, PNC2 3 days, PNC3 7-14 days, PNC4 6 weeks after delivery)	Total number of live births	The number of women who received a complete PNC check (mother & baby) according to the MCH handbook
2.3.4	Proportion of postnatal women who received iron/folic acid (> or equal to 90 tablets)	Coverage	DHIS2	The percentage of postpartum women who received >90 iron/folic acid tablets (both fixed site and outreach)	Total number of live births	The number of postpartum women who received >90 iron/folic acid tablets (both fixed site and outreach)
Specific Objective 2.4 - Safe Abortion: By 2025, to reduce morbidity and mortality amongst women from unsafe abortion						

2.4.1	Proportion of induced abortions using MVA or Misoprostol (Misoprostol and/or Misoprostol+ Mifepristol)	Quality	Integrated Quality Assessment	The percentage of induced abortions in a health facility with their charts reviewed that used MVA or Misoprostol (Misoprostol and/or Misoprostol + Mifepristol	The number of induced abortions in a health facility whose charts are reviewed	The number of induced abortions in a health facility that use MVA or Misoprostol (Misoprostol and/or Misoprostol + Mifepristol)
Strategic Objective 3 - Newborn: All newborns receive high quality Eary Essential Newborn Care (EENC)						
Specific Objective 3.1 - Newborn: By 2025, 70% of newborns initiate breastfeeding within 90 minutes of delivery						
3.1.1	Percentage of last live births in the last 2 years where the newborn was placed on the mother's bare chest after birth	Coverage	LSIS	Percentage of last live births in the last 2 years where the newborn was placed on the mother's bare chest after birth	The number of surveyed live birth in the last 2 years	Number of live births receiving skin to skin contact after childbirth
3.1.2	Proportion of newborns born in a health facility who receive immediate and sustained skin-to-skin contact for at least 90min and a complete breastfeed (complete SSC)	Quality	Integrated Quality Assessment	The percentage of newborns born in a health facility who received immediate and sustained skin-to-skin contact for at least 90 minutes and a complete breastfeed	The number of newborns born in a health facility whose mothers are interviewed after delivery	The number of newborns who receive immediate and sustained skin-to-skin contact for at least 90 minutes and a complete breastfeed
3.1.3	Proportion of newborns born in health facilities who were exclusively breastfed from birth until discharge	Quality	Integrated Quality Assessment	The percentage of newborns born in a health facility who are exclusively breastfed from birth until discharge	The number of newborns born in a health facility whose mothers are interviewed after delivery	The number of newborns who are exclusively breastfed from birth until discharge
Strategic Objective 4 – Well Child: All Lao children under 5 have access to comprehensive quality services in immunization, nutrition and child development						
Specific Objective 4.1 - Integrated Well Child: By 2025, all children attending a health facility receive a fully integrated Well Child care visit						

4.1.1	Proportion of children under 5 accessing care at a health facility who have received an integrated Well Child care visit	Quality	Integrated Quality Assessment	The percentage of children under age 5 accessing well child clinic in a health facility who receive an integrated well child care (growth monitoring measurement & recording, child development screening & counselling, breastfeeding/complementary feeding screening & counselling, immunization recording)	The number of children under age 5 whose caregivers receive interview and chart review in a health facility	The number of children under age 5 who receive an integrated well child care(growth monitoring measurement & recording, child development screening & counselling, breastfeeding/complementary feeding screening & counselling, immunization recording) in health facility
4.1.2	Proportion of villages in zones 0 and 1 delivering EPI-MCH services at fixed sites	Coverage	DHIS2	The percentage of villages in zone 0 and 1 delivering EPI-MCH services at fixed sites	The number of villages in zone 0 and 1	The number of villages in zone 0 and 1 delivering EPI-MCH services at fixed sites
Specific Objective 4.2 - Immunization: By 2025, 85% of 2 year-old children are fully immunized against VPD						
4.2.1	Proportion of HepB birth dose (within 24 hours after birth for hospital births and <7days for outreaches)	Coverage	NIP/DHIS2	The percentage of newborn/live births receiving Hepatitis B birth dose vaccine within 24 hours after birth for facility births and <7 days for outreach	Total live births	The number of newborn who received Hepititis B vaccine within 24 hours after delivery at health facilities and <7 days for outreaches
4.2.2	Proportion of children under 1year received 3 doses of OPV	Coverage	NIP/DHIS2	The percentage of children under 1 year receiving 3 doses of OPV	Total number of children under 1 year	The number of children under 1 year who received 3 doses of OPV
4.2.3	Proportion of under 1 year-old children immunized against DPT-HepB- Hib3	Coverage	NIP/DHIS2	The percentage of children under 1 year receiving DPT-HepB-Hib3 (Penta3)	Total number of children under 1 year	The number of children under 1 year who received 3 dosed of DPT-HepB-Hib

4.2.4	Proportion of under 2 year-old children immunized against measles and rubella (MR2)	Coverage	NIP/DHIS2	The percentage of children under 2 years receiving Measles and Rubella2 (MR2)	Total number of children under 2 years	The number of children under 2 years who received two doses of measles and rubella
4.2.5	Proportion of under 2 year-old children fully immunized	Coverage	NIP/DHIS2	The percentage of children under 2 years fully immunized (one dose of BCG, three doses of OPV and Penta, and two doses of measles-rubella vaccine)	Total number of children under 2 years	The number of children under 2 years who have received one dose of BCG, three doses of OPV and Penta, and two doses of measles-rubella vaccine
4.2.6	Proportion of children under 5 accessing services at a health facility who have their vaccination cards filled correctly	Quality	Integrated Quality Assessment	The percentage of children under age 5 accessing immunization services at a health facility with their vaccination record reviewed who have their vaccination record (vaccine card or MCH handbook) filled correctly (date of vaccine, health worker's signature and next appointment)	The number of children under age 5 accessing immunization services at a health facility whose vaccination record (vaccine card or MCH handbook) is reviewed	The number of children under age 5 accessing immunization services at a health facility who have their vaccination record (vaccine card or MCH handbook) filled correctly
4.2.7	Proportion of caregivers bringing their children for vaccination at a health facility who know the type of vaccination (s) given to their children under 5 years old	Quality	Integrated Quality Assessment	The percentage of interviewed caregivers bringing their children for vaccination at a health facility who know the types of vaccination(s) given to their children under 5 years old correctly	The number of interviewed caregivers bringing their children for vaccination at a health facility	The number of interviewed caregivers bringing their children for vaccination at a health facility who know the typed of vaccination(s) given to their children under 5 years old correctly
Specific Objective 4.3 - Immunization: By 2025, 100% of districts achieve Penta3 and MR2 coverage of 95% or more						
4.3.1	Proportion of districts achieving Penta3 coverage of 95% or more (%)	Coverage	NIP/DHIS2	The proportion of districts achieving Penta3 coverage of 95% or more (%)	The number of districts	The number of districts achieving Penta3 coverage of 95% or more

4.3.2	Proportion of districts achieving MR2 coverage of 95% or more (%)	Coverage	NIP/DHIS2	The proportion of districts achieving MR2 coverage of 95% or more (%)	The number of districts	The number of districts achieving MR2 coverage of 95% or more
Specific Objective 4.4 - Nutrition: By 2025, ensure children under 5, receive micronutrient supplementation and deworming according to the Essential Health Service Package in line with targets						
4.4.1	Proportion of children 12-59 months who have received deworming twice a year (%)	Coverage	DHIS2	The percentage of children aged 12-59 months who received deworming tablet twice a year in the reporting year	The number of children aged 12-59 months	The number of children aged 12-59 months who received deworming tablet twice a year
4.4.2	Proportion of children aged 6-59 months who have received Vitamin A twice a year (%)	Coverage	DHIS2	The percentage of children age 6-59 months who received Vitamin A twice a year in the reporting year	The number of children age 6-59 months	The number of children age 6-59 months who received Vitamin A twice a year in the reporting year
Specific Objective 4.5 - Nutrition: By 2025, 65% of caregivers of children less than 5 years receive full screening and counselling on infant and young childcare & feeding practices						
4.5.1	Proportion of children 6-59 months who have been screened with MUAC and / or looking for pitting oedema on both feet (%)	Coverage	DHIS2	The proportion of children 6-59 months who have been screened with MUAC and/or looking for pitting oedema on both feet	The number of children age 6-59 months	The number of children 6-59 months who have been screened with MUAC and/or looking for pitting oedema on both feet
4.5.2	Proportion of children 6 - 24 months attending facilities for well child services who have been fully screened for complementary feeding practices (%)	Quality	Integrated Quality Assessment	The percentage of children aged 6-24 months attending well child clinic in a health facility who have been fully screened for complementary feeding practice	The number of children aged 6-24 months attending well child clinic in a health facility whose caregivers are interviewed	The number of children aged 6-24 months attending well child clinic in a health facility who have been fully screened for complementary feeding practice
4.5.3	Proportion of parents who have children 6 - 24 months attending facilities for well child services who received counselling on complementary feeding (%)	Quality	Integrated Quality Assessment	The percentage of children aged 6-24 months attending well child clinic in a health facility who receive counselling on complementary feeding	The number of children aged 6-24 months attending well child clinic in a health facility whose caregivers are interviewed	The number of children aged 6-24 months attending well child clinic in a health facility who receive counselling on complementary feeding

4.5.4	Proportion of children under 2 attending facilities for well child services whose growth monitoring was recorded correctly in their growth monitoring chart (%)	Quality	Integrated quality assessment	The percentage of children under 2 years attending well child clinic in a health facility whose recorded growth monitoring data on their growth monitoring charts is matching with that data from re-examination by assessors	The number of children under 2 years attending well child clinic in a health facility on the site visit day	The number of children under 2 years attending well child clinic in a health facility whose recorded growth monitoring data on their growth monitoring charts is matching with that data from re-examination by assessors
Specific Objective 4.6 - Nutrition: By 2025, ensure that 60% of children under 6 months of age are exclusively breastfed						
4.6.1	Proportion of infants under 6 months who are exclusively breastfed (%)	Coverage	LSIS	The percentage of infants under 6 months who are exclusively breastfed	The number of children under 6 months old	The number of children under 6 months old who were exclusively breastfed.
4.6.2	Percentage of children under 6 months attending facilities for well child services who are fully screened on excusive breast feeding (%)	Quality	Integrated Quality Assessment	The percentage of children under 6 months attending well child clinic in a health facility who have been fully screened for exclusive breastfeeding practice	The number of children under 6 months attending well child clinic in a health facility whose caregivers are interviewed	The number of children under 6 months attending well child clinic in a health facility who have been fully screened for breastfeeding practice
4.6.3	Percentage of children under 6 months attending facilities for well child services who received counselling on exclusive breast feeding (%)	Quality	Integrated Quality Assessment	The percentage of children under 6 months attending well child clinic in a health facility who receive counselling on exclusive breastfeeding	The number of children under 6 months attending well child clinic in a health facility whose caregivers are interviewed	The number of children under 6 months attending well child clinic in a health facility who receive counselling on breastfeeding
Specific Objective 4.7 - Early Childhood Development (ECD): By 2025, all children under 5 receive developmental screening through integrated Well Child and Newborn Services						
4.7.1	Proportion of children under 5 screened for ECD through fixed site	Coverage	ECD service statistics	The percentage of children under 5 screened for ECD in health facility	The number of children under 5	The number of children under 5 screened for ECD in health facility

4.7.2	Percentage of parents who have children under 5 attending well child services who received health education using the integrated child development-nutrition-immunization pages within the MCH handbook (%)	Quality	Integrated Quality Assessment	The percentage of interviewed caregivers bringing their children under 5 years to well child clinic in a health facility who receive health education on ECD, nutrition and immunization with using the integrated well child care pages in the MCH handbook	The number of interviewed caregivers bringing their children under 5 years to well child clinic in a health facility	The number of interviewed caregivers bringing their children under 5 years to well child clinic in a health facility who receive health education with using the integrated well child care pages in the MCH handbook
Specific Objective 4.8 - ECD: By 2025, have referral pathways for ECD covering/integrating all levels of health service provision aligns with MCH Handbook						
4.8.1	Percentage of children under 5 with developmental & physical concerns who have been referred for diagnosis and intervention (%)	Coverage	ECD service statistics / DHIS2	The percentage of children under 5 with developmental & physical concerns who have been referred for diagnosis and intervention	The number of children under 5 with developmental & physical concerns	The number of children under 5 with developmental & physical concerns who have been referred for diagnosis and intervention
4.8.2	Percentage of children under 5 screened who have received ECD services (%)	Coverage	ECD service statistics / DHIS2	The percentage of children under 5 screened who have received ECD services	The number of children under 5 who received ECD screening	The number of children under 5 screened who have received ECD services
Strategic Objective 5 - Sick Child: All children in need of care receive quality curative care at all levels						
Specific Objective 5.1 - Sick Child: By 2025, 70% of children under 5 with diarrhoea, pneumonia and acute malnutrition receive integrated management in line with the National Guidelines						
5.1.1	Proportion of children under 5 with diarrhoea for whom advice or treatment was sought from a health facility or provider	Coverage	LSIS	The proportion of surveyed children under age 5 with diarrhoea in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	The number of surveyed children under age 5 with diarrhoea in the last 2 weeks	The number of surveyed children under age 5 with diarrhoea in the last 2 weeks for whom advice or treatment was sought from a health facility or provider
5.1.2	Proportion of children under 5 with diarrhoea receiving ORS & Zinc	Coverage	LSIS	The percentage of surveyed children under age 5 with diarrhoea in the last 2 weeks who received ORS and Zinc	The number of surveyed children under age 5 with diarrhoea in the last 2 weeks	The number of surveyed children under age 5 with diarrhoea in the last 2 weeks who received ORS and Zinc

5.1.3	Proportion of children under 5 with diarrhoea treated with ORS from health providers (health facility and outreach)	Quality	*To be added to DHIS2*	The proportion of children under five with diarrhoea treated with ORS from health providers (including IPD, OPD and outreach)	The number of children under five with diarrhoea treated by health providers (including IPD, OPD, and outreach)	The number of children under five with diarrhoea treated with ORS from health providers (including IPD, OPD, and outreach)
5.1.4	Proportion of children under 5 with diarrhoea treated with ORS & Zinc from health providers (health facility and outreach)	Quality	*To be added to DHIS2*	The proportion of children under five with diarrhoea treated with ORS and Zinc from health providers (including IPD, OPD and outreach)	The number of children under five with diarrhoea treated from health providers (including IPD, OPD, and outreach)	The number of children under five with diarrhoea treated with ORS and Zinc from health providers (including IPD, OPD, and outreach)
5.1.5	Proportion of children under 5 with diarrhoea treated at health facilities with ORS & Zinc in line with IMNCI and pocket Book guideline	Quality	Integrated Quality Assessment	The percentage of children under age 5 with diarrhoea with their charts reviewed who were given ORS and Zinc in a health facility in line with IMNCI and Pocket Book guideline	The number of children under age 5 with diarrhoea whose medical charts are reviewed in a health facility	The number of children under age 5 with diarrhoea who were given ORS and Zinc in a health facility in line with IMNCI and Pocket Book guideline
5.1.6	Proportion of children under 5 with acute respiratory infection (ARI) symptoms for whom advice or treatment was sought from a health facility or provider	Coverage	LSIS	The proportion of surveyed children under age 5 with symptoms of ARI in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	The number of surveyed children under age 5 with symptoms of ARI in the last 2 weeks	The number of surveyed children under age 5 with symptoms of ARI in the last 2 weeks for whom advice or treatment was sought from a health facility or provider
5.1.7	Proportion of children under 5 with suspected pneumonia treated with antibiotics	Coverage	LSIS	The percentage of surveyed children under age 5 with ARI symptoms in the last 2 weeks who received antibiotics	The number of surveyed children under age 5 with ARI symptoms in the last 2 weeks	The number of surveyed children under age 5 with ARI symptoms who received antibiotics
5.1.8	Proportion of children under 5 with suspected pneumonia treated with antibiotics from health providers (health facility and outreach)	Quality	*To be added to DHIS2*	The proportion of children under five with suspected pneumonia treated with antibiotics from health providers (including IPD, OPD, and outreach)	The number of children under five with suspected pneumonia treated from health providers (including IPD, OPD, and outreach)	The number of children under five with suspected pneumonia treated with antibiotics from health providers (including IPD, OPD, and outreach)
5.1.9	Proportion of children under 5 with suspected pneumonia treated with appropriate antibiotics at health	Quality	Integrated Quality Assessment	The percentage of children under age 5 with suspected pneumonia with their charts reviewed who were given appropriate antibiotics	The number of children under age 5 with suspected pneumonia whose medical charts were reviewed in a health facility	The number of children under age 5 with suspected pneumonia who were given appropriate antibiotics in a health facility in

	facilities in line with IMNCI and Pocket Book guideline			in a health facility in line with IMNCI and Pocket Book guideline		line with IMNCI and Pocket Book guideline
5.1.10	Proportion of children aged 6-59 months with severe acute malnutrition (SAM) who are admitted for treatment at health facilities	Coverage	*To be added to DHIS2*	The proportion of children age 6-59 months with SAM admitted for treatment at health facilities	Total number of children age 6-59 months affected by SAM	The number of children age 6-59 months with SAM admitted and treated at health facilities
5.1.11	Proportion of children age 6-59 months with severe acute malnutrition admitted for treatment at health facilities and discharged as cured	Quality	*To be added to DHIS2*	The proportion of children age 6-59 months with SAM admitted for treatment who are discharged as cured	Total number of children age 6-59 months with SAM discharged (including cured, defaulted, died and non-recovered) from the programme	The number of children age 6-59 months with SAM admitted for a treatment who are discharged as cured
5.1.12	Proportion of children aged 6-59 months with severe acute malnutrition (SAM) admitted for treatment at health facilities and discharged as dead	Quality	*To be added to DHIS2*	The proportion of children age 6-59 months with SAM admitted for treatment who died while in the program.	Total number of children age 6-59 months with SAM discharged (including cured, defaulted, died and non-recovered) from the programme	The number of children age 6-59 months with SAM admitted for a treatment who died while in the program.
5.1.13	Proportion of children aged 6-59 months with severe acute malnutrition (SAM) admitted for treatment at health facilities and discharged as defaulted	Quality	*To be added to DHIS2*	The proportion of children age 6-59 months with SAM admitted for treatment who are discharged as defaulted	Total number of children age 6-59 months with SAM discharged (including cured, defaulted, died and non-recovered) from the programme	The number of children age 6-59 months with SAM admitted for treatment who are discharged as defaulted
5.1.14	Proportion of children under 5 with severe acute malnutrition (SAM) who received appropriate treatment based on the national guidelines	Quality	Integrated Quality Assessment	The proportion of children under age 5 with severe acute malnutrition (SAM) at health facilities who received appropriate treatment based on national guidelines	The number of children under age 5 with severe acute malnutrition (SAM) at health facilities whose medical charts are reviewed	The number of children under age 5 with severe acute malnutrition (SAM) at health facilities who received appropriate treatment based on national guidelines
Strategic Objective 6: By 2025, rural communities, including the most vulnerable and hard to reach, benefit from the implementation of an essential RMNCAH community package						

Specific Objective 6.1 - By 2025, the community health policy environment fosters local authority leadership and facilitates alignment between CHSS and RMNCAH Strategy						
6.1.1	Proportion of villages certified as Healthy Model Village (in MOH's 71 priority districts)	Process	Annual report of Hygiene and Health Promotion Department	The percentage of stamped villages certified as Healthy Model Village (in MOH's 71 priority districts)	The total number of stamped villages (in MOH's 71 priority districts)	The number of stamped villages certified as Healthy Model Village (in MOH's 71 priority districts)
Specific Objective 6.2: By 2025, Community RMNCAH package is implemented and functioning regularly based on the M&E framework.						
6.2.1	Proportion of villages with trained VHV on community based RMNCAH service delivery packages (in MOH's 71 priority districts)	Process	Annual report of Hygiene and Health Promotion Department	The percentage of stamped villages with trained VHV on community based RMNCAH service delivery package (in MOH's 71 priority districts)	The total number of stamped villages (in MOH's 71 priority districts)	The number of stamped villages with trained VHV on community based RMNCAH service delivery package (in MOH's 71 priority districts)
6.2.2	Proportion of villages in which the trained VHVs received supportive supervision by health centres at least 2 times/year/village (in 71 priority districts)	Process	Annual report of Hygiene and Health Promotion Department	The percentage of stamped villages in which the trained VHV received supportive supervision by health centres at least 2 times/year/village (in MOH's 71 priority districts)	The total number of stamped villages (in MOH's 71 priority districts)	The number of stamped villages in which the trained VHV received supportive supervision by health centers at least 2 time/year/village (in MOH's 71 priority districts)
6.2.3	Proportion of villages with trained VHV conducted home visits on RMNCAH at least one visit per month (in MOH's 71 priority districts)	Process	Annual report of Hygiene and Health Promotion Department	The percentage of stamped villages with trained VHV conducted home visits on RMNCAH at least one visit per month (in MOH's 71 priority districts)	The total number of stamped villages (in MOH's 71 priority districts)	The number of stamped villages with trained VHV conducted home visits on RMNCAH at least one visit per month (in MOH's 71 priority districts)
Strategic Objective 7: RMNCAH stakeholders implement the RMNCAH Strategy Action Plan with an integrated and people centred approach supported by strong and efficient governance mechanisms						
Specific Objective 7.1: By 2025, the structural reforms to support further integration towards a 'people-centered approach' and coordinated planning, implementation and monitoring are established						

7.1.1	Integrated RMNCAH quality assessment data for all district hospitals are available in a regular basis to be used for 5 Good 1 Satisfaction	Process	Integrated quality assessment	The number of district hospitals that received integrated RMNCAH quality assessment	NA	NA
7.1.2	% of children who come for immunization receive breastfeeding / complementary feeding screening and counselling	Quality	Integrated quality assessment	The percentage of children coming to health facilities for immunization who received breastfeeding (for infant younger than 6 months)/ complementary feeding (for children order than 6 months) screening and counselling	The number of children coming to health facilities for immunization during the site visit days whose care givers were interviewed	The number of children coming to health facilities for immunization who received breastfeeding (for infant younger than 6 months)/ complementary feeding (for children order than 6 months) screening and counselling
7.1.3	% of women who visit postnatal care / well child clinic receive family planning counselling	Quality	Integrated quality assessment	The percentage of women visiting postnatal care/well child clinic who received family planning counselling	The number of women visiting postnatal care/well child clinic at health facilities during the site visit days who were interviewed	The number of women visiting postnatal care/well child clinic who received family planning counselling
7.1.4	Amount of expenditure by central sub-committees spent for promoting (training, monitoring etc.) integrated service delivery that follows national standards of integrated service delivery	Process	Expenditure assessment	The amount of expenditure spent by central sub-committees to promote integrated service delivery that follows national standards	NA	NA
7.1.5	Proportion of activities in the Action Plan implemented (per Strategic Objective)	Process	Regular implementati on monitoring	The percentage of planned activities in the Action Plan that are implemented (per Strategic Objective)	The number of planned activities in the Action Plan (per Strategic Objective)	The number of planned activities in the Action Plan that are implemented (per Strategic Objective)

Annex 3: RMNCAH Essential Service Package

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
		Reproductive and Adolescent Health									
1	RMNCAH	health education/promotion for reproductive health and contraceptives: reproductive health information and contraception counselling/generation of demand for contraceptives in particular for modern and long-term methods	x		x	x	x	x			
2	RMNCAH	Short acting contraceptive 1)Condom 2)Oral contraceptives 3)Injectable	x		x	x	x	x		Condoms	Levonorgestrel (Progestin-Only Pill), tablet Ethinylestradiol + levonorgestrel (Combined pill), tablet Depot Medroxyprogesterone Acetate (DMPA)(Progestin-Only Injectable), injection
3	RMNCAH	Long-acting reversible contraceptive 1) Implant 2) IUD (intrauterine device)			x*	x	x	x	* where there is a trained MW/nurse	Implant Blade Forceps mosquitos IUD Speculum vaginal Tenaculum Uterine sound Scissors	lidocaine, injection, 2% (Local anaesthetic) Paracetamol, tablet Amoxycillin, Capsule
4	RMNCAH						x	x			lidocaine, injection, 2% (Local anaesthetic)

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
		Permanent contraceptive 1) Vasectomy 2) Tubal ligation								Minor surgery equipment set Babcock forceps	
5	RMNCAH	Td immunization to Child Bearing Age Women (CBAW) and adolescents to protect neonatal tetanus	x		x	x	x	x		Refrigerator	Tetanus vaccine, infectable solution
6	RMNCAH	Weekly iron & folic acid supplementation for reproductive women	x		x	x	x	x			Iron folic acid tablet (iron 60mg + folic acid 400ug)
		Cervical cancer									
7	RMNCAH	Cervical cancer screening for women (E.g. Visual inspection of cervix with acetic acid (VIA))				x	x	x		Examining table Light for procedure Vaginal speculum	
8	RMNCAH	Treatment of pre cervical cancer condition 1) Cryotherapy				x*	x*	x	*where there is a trained doctor	Cryosurgery unit with adequate gas supply	
9	RMNCAH	Treatment of pre cervical cancer condition 2) Loop electrosurgical excision (LEEP) procedure						x		Electrosurgical generator and electrode handle Wire electrodes of several sizes	
		Prevention of unsafe abortion									
10	RMNCAH	Counselling for women with unplanned, mistimed or unwanted pregnancies, including abortion services			x*	x	x	x	*Where there is a MW who received training	Pregnancy urine rapid test	
11	RMNCAH	Medical abortion management 1) Medical abortion 2) Routine post-abortion follow-up, including post-abortion contraceptives			x*	x	x	x	*Where there is a MW who received training	IUD, Implant, Condom	Misoprostol, tablet Levonorgestrel (Progestin-Only Pill), tablet Ethinylestradiol +

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
											levonorgestrel (Combined pill), tablet
12	RMNCAH	Surgical abortion management 1) Medical abortion 2) Routine post-abortion follow-up, including post-abortion contraceptives				x*	x	x	*Place with trained doctor (or MW/nurse for 1st trimester)	MVA or EVA (Karman Cannula) IUD, Implant, Condom	Oxytocin, injection Ergometrine maleate (Methergine), injection Misoprostol, tablet Levonorgestrel (Progestin-Only Pill), tablet Ethinylestradiol + levonorgestrel (Combined pill), tablet
13	RMNCAH	Complication management followed by abortion 1) Ongoing pregnancy 2) retained products/incomplete abortion 3) Infection 4) Haemorrhage				x*	x	x	*Where there is a trained medical doctor (or MW/nurse for 1st trimester)	MVA or EVA (Karman Cannula) CBC kit & equipment	Oxytocin, injection Ergometrine maleate (Methergine), injection Misoprostol, tablet Ampicillin, powder for injection Gentamicin, injection, vial ceftriaxone, powder for injection, via metronidazole, injection

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
14	RMNCAH	Advanced complication management followed by abortion 1) Uterine perforation					x	x		Surgical equipment General anaesthesia equipment	Operation medicines General anaesthesia medicines
		Pregnancy care									
15	RMNCAH	Basic routine antenatal care (ANC) (refer to Annex service list)			x	x	x	x	*only in strata 2b and 3 districts	Adult sphygmomanometer Foetus stethoscope/Traube/doppler weighing scale for adult MCH handbook Urine test (dipstick) RDT of HIV (Determine) Syphilis rapid test Refrigerator	Ca supplement, tablet Iron folic acid tablet (iron 60mg + folic acid 400ug) Tetanus vaccine, infectable solution
16	RMNCAH	Routine ANC 1) Screening of anaemia (Hb/Hct check) 2) Provide deworming for pregnant women after the first trimester 3) Ultrasound scan at ANC before 24 weeks of gestation to estimate gestational age				x	x	x		Hematometer/CBC kit & equipment Ultrasound	Mebendazole, tablet

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
17	RMNCAH	ANC package in outreach (refer to Annex service list)	x							Adult sphygmomanometer Foetus stethoscope/Traube/doppler weighing scale for adult MCH handbook Vaccine Carriers/Cold box	Ca supplement, tablet Iron folic acid tablet (iron 60mg + folic acid 400ug) Tetanus vaccine, infectable solution
18	RMNCAH	ANC at community Assist pregnant women at community level: Individual health education, detecting antenatal danger signs and refer to health facility, birth and emergency preparedness (ex. Plan for emergency transportation, prepare medical documents, or payment)		x							
19	RMNCAH	Anaemia management at ANC 1) Treatment (double dose of iron & folic acid)			x	x	x	x			Iron folic acid tablet (iron 60mg + folic acid 400ug)

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
20	RMNCAH	Hypertension management at ANC: Antihypertensive drugs to treat high blood pressure * HC: only where there is trained MW/nurse			x*	x	x	x	*Where there is a trained MW/nurse	Adult sphygmomanometer Adult stethoscope	Hydralazine, tablet/injection Nifedipine, tablet Methyldopa (Aldomet), tablet
21	RMNCAH	Low dose aspirin for high-risk women to prevent pre-eclampsia				x	x	x			Low dose Acetylsalicylic acid (aspirin 81 mg)
22	RMNCAH	PMTCT-Syphilis management 1) Treatment of Syphilis for mother 2) Treatment of Syphilis for newborn			x	x	x	x			Ceftriaxone Azithromycin Erythromycin Aqueous benzyl penicillin Procaine benzyl penicillin
23	RMNCAH	PMTCT-HIV management *CH & PH: only ART site 1) Antiretroviral medicine treatment for HIV positive pregnant women 2) Antiretroviral drug Prophylaxis for infants born to identified HIV positive mothers						x*	*Only ART sites		ART drugs Zidovudine (AZT), oral suspension or syrup Nevirapine (NVP), oral suspension

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
24	RMNCAH	Gestational Diabetes mellitus management at ANC 1) Diagnosis: OGTT to diagnose gestational diabetes 2) Medical treatment 3) Counselling						x		Rapid glucose test kit & equipment/blood glucose test kit & equipment	75g OGTT Metformin, tablet Humuline R, injection Intermediate-acting insulin, suspension for injection
		Pre-labour and intrapartum care									
25	RMNCAH	Routine intrapartum care 1) Monitoring vaginal delivery 2) Provide a positive childbirth experience 3) Active management of the third stage of labour: Routine administration of a uterotonic after childbirth to prevent postpartum haemorrhage, controlled cord traction (optional)(should only be performed by a skilled provider), uterine massage (if the uterus is not well contracted)			x	x	x	x		Full delivery sets Delivery bed	Oxytocin, injection(ampoule) Misoprostol, tablet
26	RMNCAH	Assisted vaginal delivery * HC: only where there is trained MW/nurse			x*	x	x	x	*Only where there is a trained MW/nurse	Vacuum extractor (Kiwi ventouse)	Oxytocin, injection Ergometrine maleate (Methergine), injection Misoprostol, tablet

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
27	RMNCAH	Preterm labour management 1) Corticosteroids to prevent respiratory distress syndrome 2) Magnesium sulphate for foetal neuroprotection in preterm babies					x	x			Dexamethasone, injection Magnesium Sulphate, injectable solution
28	RMNCAH	Induction of labour (e.g. to manage prelabour rupture of membrane or prolonged pregnancies)					x	x			Oxytocin, injection(ampoule)
29	RMNCAH	Augmentation for prolonged labour					x	x			Oxytocin, injection
30	RMNCAH	Manual removal of placenta, Remove retained products (MVA) * DH type B: only where there is trained MW/nurse				x*	x	x	*Only where there is a trained MW/nurse	MVA	Ampicillin, powder for injection
31	RMNCAH	Basic Emergency obstetric care (BEmOC): Management of maternal complications * HC: only pre-referral treatment 1) sepsis management (Administer parenteral antibiotics for cases with indication) 2) Postpartum haemorrhage management (uterotonic drugs for management of PPH) 3) pre-eclampsia/eclampsia management (parenteral anticonvulsants for pre-			x*	x	x	x	*For pre-referral	Urine catheter/urine bag IV cannulas 16/18G	Ampicillin, powder for injection Gentamicin, injection, vial metronidazole, injection Oxytocin, injection Ergometrine maleate(Methergine), injection Misoprostol, tablet Tranexamic acid injection, ampule Magnesium Sulphate,

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
		eclampsia and eclampsia (i.e. magnesium sulphate))									injectable solution Hydralazine, tablet/injection Nifedipine, tablet Calcium gluconate, injection
32	RMNCAH	Comprehensive Emergency obstetric care (CEmOC): Management of maternal complications 1) Caesarean section 2) Hysterectomy 3) Blood transfusion* 4) Exploratory operation due to ruptured ectopic pregnancy					x	x	*Blood transfusion, including other purposes	Pre-operation routine examination Surgical equipment General anaesthesia equipment ABO blood type test kit & equipment Blood cross-match test kit & equipment blood transfusion/blood components	Operation medicines General anaesthesia medicines
33	RMNCAH	Care for unplanned home delivery 1) Minimum maternal and newborn care for unplanned home delivery (e.g. cord care, immediate and thorough drying, immediate skin-to-skin contact, initiation of exclusive breastfeeding) 2) Detect danger signs for mother and baby during unplanned home deliveries, and refer to health facility		x							

No	Area	Core service	OR	CMTY	HC	DH Type B	DH Type A	PH&CH	Note	Tracer Equipment	Tracer Medicine
		Newborn care									
34	RMNCAH	Routine newborn care at health facility: 1) Early essential newborn care (immediate and thorough drying, immediate skin-to-skin contact, delayed cord clamping, dry cord care, initiation of exclusive breastfeeding, infection prevention, eye prophylaxis) 2) Routine immunisation for newborns according to the national guidelines (e.g. BCG, Hep B 1st dose)			x	x	x	x		Full delivery sets Refrigerator	Tetracycline eye ointment, 1% Oxytocin, injection(ampoule) Vitamin K1(Phytomenadione), injection, ampoule Hepatitis B vaccine, injectable solution BCG vaccine, injectable solution
35	RMNCAH	Neonatal resuscitation			x	x	x	x		self-inflating bags and masks for newborn	
36	RMNCAH	Kangaroo Mother Care for preterm and low-birth weight infants					x	x		Binder for KMC	
37	RMNCAH	Management of newborn with complications 1) Sepsis management 2) Jaundice management 3) Severe asphyxia management 4) Malformation management (E.g. Club foot, cleft lip or palate, tongue tie) 5) Seizure management				x*	x*	x	*At DH, only pre-referral care	O2 (central supply system/cylinder/concentrator) Light therapy lamp Self inflating bags and masks (size 0 &1) (for premature newborn and newborn)	Ampicillin, powder for injection Cloxacillin, powder for infection(vial) Gentamicin, injection, vial Midazolam Aminophylline,

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
		6) Preterm birth complication management for newborn								Nasogastric tube Incubator/ radiant warmer for newborn	injection(ampoule) Glucose solution
38	RMNCAH	Neonatal respiratory distress syndrome management: CPAP						x		O2 (central supply system/cylinder/concentrator) CPAP	
39	RMNCAH	Routine immunisation for newborns according to the national guidelines (e.g. BCG, Hep B 1st dose) at outreach	x							Vaccine Carriers/Cold box	Hepatitis B vaccine, injectable solution BCG vaccine, injectable solution
		Postpartum and early postnatal care for mother and newborn									
40	RMNCAH	Routine PNC for mothers and babies (refer to Annex service list)			x	x	x	x		Adult stethoscope Adult sphygmomanometer Weighing scale for newborn Height measure (lying down)/measure tape	Iron folic acid tablet (iron 60mg + folic acid 400ug)

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
41	RMNCAH	Community PNC: Detecting postpartum danger signs and refer to health facility		x							
		Child care									
42	RMNCAH	Well child services at health facility 1)Routine immunization of children (BCG, DPT-HepB-Hib, Polio(IPV/OPV), Measles-Rubella, PCV, JE) 2) Vitamin A and deworming for under 5 children 3) Screening and counselling on breastfeeding/complementary feeding 4) Screening and counselling on early childhood development 5) Growth monitoring and counselling			x	x	x	x		Refrigerator weighing scale for adult, weighing scale for newborn height measure (standing) Height measure (lying down)/measure tape	BCG vaccine, injectable solution DPT-HepB-Hib vaccine, injectable solution Polio(IPV/OPV) vaccine Measles-Rubella vaccine PCV vaccine Japanese encephalitis vaccine Vitamin A(Retinol), Sugar-coated tablet(10,000IU)/soft capsule(200,000IU)/Oral solution (100,000IU/ml) Mebendazole, tablet OR Albendazole, tablet
43	RMNCAH	Well child services at outreach 1)Routine immunization of children (BCG, DPT-HepB-Hib, Polio(IPV/OPV), Measles-Rubella, PCV, JE) 2) Vitamin A and deworming for under 5	x							Vaccine Carriers/Cold box MUAC measure tape	BCG vaccine, injectable solution DPT-HepB-Hib vaccine, injectable solution Polio(IPV/OPV) vaccine

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
		children 3) Screening of nutrition status with MUAC for children under 5 years of age									Measles-Rubella vaccine PCV vaccine Japanese encephalitis vaccine Vitamin A(Retinol), Sugar-coated tablet(10,000IU)/soft capsule(200,000IU)/Oral solution (100,000IU/ml) Mebendazole, tablet OR Albendazole, tablet
44	RMNCAH	IMNCI service 1) Infantile very severe disease/local bacterial infection management & sick child with danger sign management 2) Jaundice management 3) Feeding problem/low weight for age management 4) diarrhoea management 5) pneumonia management 6) Fever management 7) Measles management 8) Dengue management 9) Ear problem management 10) sore throat management 11) anaemia management			x	x	x	x		Oxygen oxygen mask or nasal cannula for newborn and child Weighing scale for newborn Height measure (lying down)/measure tape MUAC measure tape Adult stethoscope Aural speculum/auriscope	Ampicillin, powder for injection Amoxycillin, Capsule/ powder for oral suspension Gentamicin, injection, vial Cloxacillin, powder for infection(vial) Gentamicin, injection, vial Glucose solution Oral rehydration salt(ORS) Zinc sulphate, tablet or syrup Paracetamol, tablet/syrup Vitamin A(Retinol), Sugar-coated tablet(10,000IU)/soft capsule(200,000IU)/Oral solution (100,000IU/ml) ferrous salt, oral solution

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
45	RMNCAH	Management of severe acute malnutrition without complication	x		x	x	x	x		Weighing scale for newborn Weighing scale for adult Height measure (standing) Height measure (lying down)/measure tape MUAC measure tape Ready to use therapeutic food (RUTF)	
46	RMNCAH	Management of severe acute malnutrition with complication				x	x	x		Weighing scale for newborn Weighing scale for adult Height measure (standing) Height measure (lying down)/measure tape MUAC measure tape Ready to use therapeutic food (RUTF) F75/F100 ReSoMaL	Ampicillin, powder for injection Gentamicin, injection, vial

No	Area	Core service	OR	CMTY	HC	DH		PH&CH	Note	Tracer Equipment	Tracer Medicine
						Type B	Type A				
47	RMNCAH	Referral level child curative care according to the WHO Pocketbook 1) management of emergency condition (ie. Choking, airway management, unconsciousness, shock, convulsion, common poisoning, drowning, electrocution, common cause of envenoming) 2) cough or difficulty in breathing management 3) diarrhoea management 4) fever management (malaria, meningitis, measles, septicaemia, typhoid fever, ear infection, UTI, septic arthritis/osteomyelitis, dengue, rheumatic fever)				x	x	x		O2 (central supply system/cylinder/concentrator) Self inflating bags and masks(size 0 &1) (for premature newborn and newborn) Self inflating bags and masks (for child and adult) Adult Stethoscope oxygen mask or nasal cannula for newborn and child Inhaler/Nebulisers Hematometer/CBC kit & equipment Lumbar puncture needle	Ampicillin, powder for injection Gentamicin, injection, vial Diazepam, injection, ampoule (DH type A and above) Salbutamol for nebuliser, solution for inhalation(2.5mcg/dose)/ respiratory solution(5mg/ml) Ciprofloxacin, tablet, Oral rehydration salt(ORS) Zinc sulphate, tablet or syrup
48	RMNCAH	Outreach and Community based child curative care 1) Diarrhoea management (ORS and Zinc)* 2) Pneumonia management (antibiotics)* 3) Detect danger signs for severe child illness (e.g. severe acute malnutrition) and refer 4) Screening of nutrition status with MUAC for children under 5 years of age	x	x*					* 1) & 2): Only in hard to reach areas, having a drug kit and trained VHW	MUAC measure tape	Oral rehydration salt (ORS) Zinc sulphate, tablet or syrup Amoxycillin, capsule/powder for oral suspension

Detail Service list	
ES15	Basic routine antenatal care (ANC) 1) Body weight check/2) Blood pressure check/3) History taking/4) Screening of anaemia (check physical anaemia signs)/5) Screening of risk of preterm birth/6) Fundal height check/7) Abdominal palpation (Leopard manoeuvre)/8) Foetal heart check/9) Check oedema and breasts/10) Health education and counselling (Eg. Birth preparedness)/11) Calcium supplement provision/12) Gestational diabetes mellitus risk factor screening with past and family history, BMI (>30kg/m2). When positive in screening, glycosuria on dipstick testing/13) Provide counselling on STI including syphilis and HIV/ AIDS/14) Testing of HIV/ AIDS/15) Testing of STI (syphilis)/16) Daily Iron and folate acid to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth/17) Td immunization to pregnant women at least two doses if no previous Td immunization and one dose for subsequent pregnancies/18) Distribute Long-lasting insecticidal nets (LLIN) to pregnant women at ANC in strata 2b and 3 districts *
ES17	ANC package in outreach 1) Body weight check / 2) History taking/3) Sign of pre-eclampsia/4) Blood pressure check/5) Screening of anaemia (check anaemia signs)/6) Foetal heart check/7) Health education and counselling/8) Calcium supplement provision/9) Daily Iron and folate acid to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth/10) Td immunization to pregnant women at least two doses if no previous Td immunization and one dose for subsequent pregnancies
ES40	Routine PNC for mothers and babies 1) Regular assessment for mothers: general well-being, vital signs (blood pressure, temperature, heart rate), fundal height, uterine contraction, vaginal bleeding, check perineal wound/c-section wound, lochia, uterine involution, urine void, bowel function, breast condition, assessment and counselling on breastfeeding progress, review of emotional well-being, observation for domestic abuse 2) Regular assessment for newborn (weight, feeding, history of convulsions, fast breathing, chest in-drawing, spontaneous movement, fever, low body temperature, jaundice <24hrs, yellow palms and soles, Dry cord care and assessment of signs of cord infection, urination, passing stool, pallor, skin/eye infection) 3) counselling on physiological recover, newborn care, danger signs for mothers and newborns, nutrition, hygiene, malaria protection, mobilisation, family planning, breastfeeding, immunization for newborns 4) Provide Iron and folic acid supplementation for postpartum/ lactating women

Annex 4: List of Contributors

4.1 List of Contributors: 1st Version

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