Pakistan

National IRMNCAH&N Strategy (2016-2020)

National vision

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

MAP OF PAKISTAN

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ACRONYMS

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

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

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

MESSAGE:

SECRETARY HEALTH

PREAMBLE

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

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

In order to ensure and sustain standard maternal, newborn and child health care services at all levels of health care, while keeping the principle of continuum of care in sight, the provincial/regional Departments of Health and MNCH Programs; with the support of the National Ministry for Health Services Coordination and Regulation came up with a comprehensive five year Action Plan for the provinces/regions; in line with the "Ten Point Agenda" on RMNCAH and Nutrition 2016-2020. This Action Plans chalk out the activities needed in the province for betterment of the RMNCAH services through multi-sectorial approach in the light of the guiding principles in the National Ten Points Agenda elaborated in the document.

This National vision necessitates a comprehensive approach which takes into account the structural and social determinants of health; tackling inequity in access to healthcare, and encourages accountability. This National strategy, while consolidating the individual provincial and regional Plans of Actions, ensures conformity with the national vision.

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

EXECUTIVE SUMMARY

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

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

Presently, in a reiteration of the commitment made towards global initiatives for addressing the key challenges in providing optimal care to mothers, adolescents and children, a comprehensive National Vision - with identified priority areas - has been developed on the direction of the national leadership. *The National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child & Adolescent Health, and Nutrition* (RMNCAH&N) 2016 2025. The national vision document served as a guide for the formulation of the National and provincial IRMNCAH&N strategies.

The National strategy 2016 - 2020 builds on the vision of improving the health of women and children through universal access to affordable quality essential health services; delivered through a resilient and responsive health system aimed at attaining the Sustainable Development Goals of zero poverty and hunger, universal access to health services, education, clean water and sanitation and fulfilling other global health responsibilities of the country.

The National strategy follows the ten priority action areas; identified in the National vision, as its objectives and consolidates upon the comprehensive 5-year plans of action; developed by each of the provinces and regions, into an overarching strategic guideline for achieving the objectives set in the National Vision.

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

The core components of the IRMNCAH&N strategy include:

a) Improving accessibility to quality primary health care at the community level by ensuring maximum coverage of rural areas, slums and other identified pockets of high need through induction of new community level health staff i.e. Lady Health Workers (LHWs) and Community Mid Wives (CMWs) New midwifery schools and to ensure availability of well furbished essential infrastructure for additional HR induction and capacity building.

b) Improving quality of care at primary & secondary level care facilities will be achieved by enhancing the relevant knowledge base and skills of the different cadres of health care staff including, field staff such as LHWs, CMWs, LHVs, LHSs and other supervisory staff, Teaching and clinical staff such as midwifery tutors and clinical supervisors etc. Improving the referral system and provision of essential drugs, vaccines and equipment is also part of the strategy for effective and quality health care.

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

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

5: Social mobilization and political will be achieved through advocacy seminars, symposium, international conferences and orientation sessions to raise awareness regarding RMNCAH&N interventions at provincial and district level as well as SDGs amongst Politicians and the legislature. The internationally recognized days will be celebrated to emphasize and highlight the importance of various aspects and lifestyles affecting health. Various media channels will be utilized to disseminate public health issues like family planning promotion and demand creation. Community based organizations, community elders, local influential, professionals, religious leaders etc. will be engaged using Volunteers and peer support groups for demand creation.

6: A Monitoring & Supervision framework will be developed including ToRs, plans, reporting formats and checklists at provincial, divisional, district and facility level. The overall responsibility of M&E will rest with the Provincial Department of Health whereas the MNCH programs will be responsible for compiling their respective M&E reports on quarterly basis and submit regularly to the DOH to be consolidated on annual basis

The strategy also includes a detailed Financial Action Plan which serves as a resource mobilization tool which could be used comprehensively for mobilizing political commitment and financial resources at the national level or for garnering donor support. The financial costing exercise, carried out to assess the financial outlay of each plan, computed the total amount which will be required over a period of five years (2016-2020) for implementing the RMNCAH plans in the country to be PKR 356,633,568,804

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

BACKGROUND

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

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

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

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

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

With the active support of the Ministry of National Health Services, Regulation and Coordination (M/oNHSR&C), each of the four provinces and three regions of Pakistan (Gilgit-Baltistan, FATA and Azad Jammu and Kashmir) have developed concrete action plans for the operationalization of the National vision and the ten priority areas. This have been achieved through an intense and collaborative inter-departmental consensual process which resulted in listing detailed activities aimed

[2] *PDHS 2012-13*

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

at operationalizing the ten priority actions of the National Vision. Each of these operational action plans have been supported with financial costing of the activities and formulated into a comprehensive strategy to serve the purpose of advocacy, resource mobilization and provide guidance in implementation during 2016-2020.

SITUATIONAL ANALYSIS

Pakistan is the 6th most populous country of the world (2015) with a population estimated at over 190 million people. Its annual growth rate of 2.05% implies that, at the current rate of growth, the population will double in the next 34 years[4] and will also comprise a much larger proportion of younger people (63% below the age of 30).

With an area of 796,096 km^2 (340,509 sq mi), it is the 33rd-largest nation of the world (by area, Pakistan has 07 administrative areas comprising of four provinces and three regions. The average population density is around 166.3 per Km^2, with Punjab having the highest density of 358.5 while the lowest (18.9) occurring in Balochistan[5]

The average life expectancy has increased from 59 years by 1990 to 67 years by 2015. The last maternal mortality ratio recorded was 276 per 100,000 live births [2006-07], but it has improved significantly in the past decade, owing to wide outreach of national LHW program, and better skilled birth attendance availability. Similarly, infant and under 5 mortality rates have improved [from 72/1000 to 66/1000 live births]; but neonatal mortality rate has remained stagnant; and so has the rising toll of stillbirths [43/1000 live births][6]

Table 1: Key Indicators, Pakistan

Total population	190m
Population – Urban : Rural[1]	35:51
Annual growth rate	2.9
Adult literacy rate – Aged 15 yrs. & older	57
Neonatal mortality rate/1,000 live births	55
Infant mortality rate/1,000 live births	74
Under 5 mortality rate/1,000 live births	89
Maternal mortality ratio/100,000 live births	276
%age delivered by a skilled provider	52
%age delivered in health facility	48.2
%age receiving antenatal care from a skilled provider	73.1
%age of women with a postnatal checkup in the first 2 days after birth	39
%age of underweight children under 5	30
%age of children stunted under 5	45
Fully immunization	54
Tetanus toxoid (%age receiving two or more injections during last pregnancy)	58.6
Total fertility rate (15-49 yrs)	3.8
Contraceptive prevalence rate	35

[4] Punjab Population Policy 2016, Population Welfare Department; Government of Punjab
[5] http://www.pbscensus.gov.pk/sites/default/files/Files/PAKISTAN.pdf
[6] National Health Vision; 2016 – 2025, Pakistan

CHALLENGES & CONSTRAINTS `

Pakistan's health indicators severely fall short of the required levels. Per capita expenditure on health is very low in Pakistan, and in the last eleven years has not increased significantly. In 2011 for example, public health spending in Pakistan was less than 0.5 percent of the GDP.

Pakistan is facing a double burden of disease (BoD), the burden is higher in the poor, and many of these conditions can be controlled at relatively low cost interventions and best practices through primary and secondary care levels. Communicable diseases, maternal health issues and under-nutrition dominate and constitute about half of the BoD. In young children, diarrhea and respiratory illness remain as the major killers. Maternal deaths due to preventable causes like sepsis, hemorrhage and hypertensive crises are common[6]

Pakistan has one of the lowest doctors, dentists and paramedics to population ratios. Paramedics such as nurses, lady health visitors and midwives play a vital role in keeping a population healthy. The percentage of mothers attended to by skilled health staff during childbirth is 43% in Pakistan..

Pakistan's maternal mortality ratio (MMR), which indicates risk of death per pregnancy, has declined from 521 in 1990 to 332 (range 250–433) in 2012, still far behind the proposed target of 130 by 2015. Under-5 mortality in children born to mothers with no education (112/1000 live births) is two times higher than that of children born to mothers with secondary education (57/1000 live births) and more than three times higher than that of mothers with more than a secondary education (36/1000 live births).

The public health sector is inadequately staffed and also faces an imbalance in the number, skill mix and deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary and tertiary. Multiple other factors such as poverty, access to clean drinking water, food insecurity and poor environmental sanitation contribute to the health of the people. 44% of Pakistani children under the age of five suffer from chronic malnutrition and only 47.4% of the population has access to improved sanitation facilities[7]

The role of social determinants in affecting maternal and child health in Pakistan cannot be underestimated and extensive research needs to be carried out in this very crucial area if the country is to achieve the health related sustainable development goals (SDGs) it has committed to achieve .

OPPORTUNITIES

In addition to curative services the public health sector also implements a number of preventive programs such as EPI, MCP, TB Control Program, HIV/AID controls program, Leprosy Control Program, MCH Program, National Program for FP&PHC, Polio Eradication Initiatives (PEI) etc. The provincial departments of health also have a functional Health Management Information System (HMIS) which retrieves and stores data from various reports and surveys in addition to regular DHIS data. The government has also taken steps to eradicate polio through the polio eradication initiative (PEI), which started in 1994 and is supported by the National Institute of Health (NIH) through laboratory diagnostics

[7] Pakistan Vision 2025, Planning Commission, Ministery for Planning, Development & Reform

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

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

The National MNCH Program was established in 2006. Its goal was to improve maternal, newborn and child health status of the province. It had five main components[8]:

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

The Program strategies include:

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

The National Program for Family Planning & Primary Health Care popularly known as LHWs Program was launched in 1994 for provision of basic essential primary healthcare and family planning services to community through the community-based Lady Health Workers. The program is well established and provides primary health care and family planning services based around the health-house concept.

The Expanded Program on Immunization (EPI) was established in 1978 and aims to vaccinate children aged 0-11 months against nine target diseases (Childhood Tuberculosis, Poliomyelitis, Diphtheria, Pertussis, Tetanus, Hepatitis B, Haemophilus Influenza Type b, Pneumonia, Measles) and the pregnant ladies against Tetanus.

After the devolution of the subject of Health to the provinces, the respective EPI program units are responsible to manage the operational cost of the immunization activities at the provincial and district levels. The Federal EPI cell procures and supplies the vaccines, syringes, safety boxes and other logistics needed by the provinces and areas to vaccinate their target populations.

The Prime Minister's National Health Insurance Program was launched in 2016. In the first phase, the scheme has initiated in the districts of Quetta, Loralai, Lasbela , Kech (Balochistan), Rahim Yar Khan, Khanewal, Narowal, Sargodha (Punjab) Bajour Agency , Khyber Agency (FATA) Muzaffarabad ,

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[8] Excerpts from the Provincial IRMNCAH action plan narrative, Balochistan

Kotli (AJK) Skardu, Diamer and Gilgit (GB). The scheme ensures the identification of under-privileged citizens across the country and gives access to their entitled medical health care. The Program is envisaged to expand to a total of 60 districts in Pakistan.

IMPLEMENTATION APPROACH FOR IRMNCAH&N STRATEGY

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

The following sections details the vision, goal and objectives of the National IRMNCAH&N strategy and lists (as excerpts) some of the actions which the provinces and regions of the country have incorporated in their action plans for achieving each objective in the medium term (2016 – 2020) strategy .[9]

VISION

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

GOAL

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

OBJECTIVE

1. **Improving the access and quality of MNCH community based primary care services ensuring continuum of care including newborn care in rural districts and urban slums**

   Improved accessibility to quality RMNCAH and Nutrition services at the community level will be achieved by ensuring maximum coverage of rural areas, slums and other identified pockets of high need through induction of new community level health staff i.e. Lady Health Workers (LHWs) and Community Mid Wives (CMWs).

   An extensive mapping exercise will be carried out to identify uncovered areas of both CMWs and LHWs. It will be ensure the provision of 100% outreach services

[9] For a comprehensive list of activities, please read the individual provincial/regional Action Plans

by community health workers; in a phased manner till 2020, in rural areas and urban slums of the country.
Additional LHWs and CMWs will be recruited and trained and deployed to the areas left uncovered by existing health workers so as to address the issues of access to RMNCAH&N services. The new recruits will also be provided with furniture, equipment, kits, CMW & LHW supplies, logistics and transportation cost to facilitate the establishment of CMW birthing station and LHW Health House to aid their deployment.

New midwifery schools and hostels will be constructed and/or refurbished with necessary equipment and material to ensure availability of essential infrastructure for additional HR induction and capacity building. Likewise, new provincial population houses, district population houses and regional training institutes will also be constructed to further strengthen the services offered by population welfare department.

Similarly, the provision of community services will be enhanced by improvement M&E protocols, tools and supplies. Supervisory structures will be strengthened by new inductions, revision of ToRs, capacity building and necessary logistics support and supplies. Capacity building of the support staff on issues such as MDSR, administrative monitoring and other necessary protocols will also be a salient feature.

Increased outreach of services to the community will also be extended to routine immunization through involvement of LHWs and CMWs . They will be provided with the latest knowledge, skills, supplies and necessary logics support for routine immunization and nutrition related services.

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

Improved the linkages between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI for referral purposes will be attained through orientation on referral pathways, provision of necessary stationary and supplies etc.

Increase in community demand for utilization of RMNCAH and Nutrition services will be attained through capacity building and supplies such as IEC material to l volunteer community mobilizers and CSOs etc for social mobilization

2. Improved quality of care at primary and secondary level care facilities

Training packages for the health care providers at the Primary and Secondary HCFs will aim at Enhancing skills on IMNCI/PCPNC/ENC/ RH/ CMAM/ IYCF etc. The initiative will be supported by increasing the pool of facilitators for the trainings.

Emphasis will also be laid on integration of IMNCI, PCPNC & ENC in pre-service education at medical schools to provide knowledge and develop skills and attitudes among students as part of their learning process and enable them to think through a differential diagnostic process before formulating a diagnosis and prescribing treatment.

Similarly, in-service trainings for facility and community health workers will focus on topics like use of Chlorhexidine, use of Misoprostol, healthy timing and spacing of pregnancy (HTSP), essential newborn care (ENC), kangaroo mother care (KMC), Pregnancy Care and Postnatal Care (PCPNC), helping babies breathe (HBB), infant and young child feeding (IYCF) practices. Similarly, Inclusion of IMNCI/PCPNC/ENC/HBB/Infection Prevention Protocols in pre-service training institutions will also be ensured.

Moreover, trainings on HIV/STI, TB, DOTS, Hepatitis, referral and reporting of MNC mortality, family planning methods: hormonal, long term FP methods, IUCD, PPIUCD, etc. will also be undertaken.

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

Strengthening of the health care system for RMNCAH & Nutrition services will be ensured through filling of the HR gaps to reduce absenteeism, the repair/renovation or up gradation of Health Care Facilities including residential accommodations and provision of necessary supplies and equipment to all DHQs, RHCs and THQs. Establishment of BEmONC and CEmONC units as well as NICUs will also be undertaken.

Improved referral mechanisms will be established; involving all health care levels, to ensure continuum of care by provision of ambulances and PoL as well as recruitment of drivers for the vehicles. Establishment of referral desks and protocols will also be established. Training of staff and establishment of database for referral are essential requisites of this strategy.

Improving the monitoring and supervision of the facility based RMNCAH and Nutrition services by developing and equipping supervisory tools are a necessity. Inclusion of IMNCI/PCPNC/ENC/HBB/Infection Prevention Protocols in pre-

service training institutions and ensuring the availability of, uninterrupted, comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities are also to be undertaken. Capacity Building, Refresher Training (e.g. on Injection safety, cold chain, vaccine management, communication and routine immunization) by Vaccinators; LHWs; CMWs) will be undertaken

3. **Overcoming financial barriers to care seeking and uptake of interventions.**

Providing social safety nets will promote equitable distribution among the vulnerable and marginalized communities and scaling up of various planned interventions in a more coordinated manner and with holistic approach. It is envisaged that coordination and linkages will be established and strengthened between various social security departments; Bait-ul-Maal, Social Welfare department, Zakat department, Benzair Income Support Program, etc to pilot, revisit and revise the beneficiaries of the existing public social nets..

The conditional cash transfers (CCT), social health insurance and voucher schemes will be introduced to provide equity based health insurance coverage to the vulnerable and marginalized groups. CCT programs will aim to enhance both the income of the poor in the short run and their skills and capabilities in the medium and long run. It will also assist in improving the utilization of primary and secondary health care facilities by marginalized groups and vulnerable population as a priority due to availability of financial support system at health care facilities and possibly even food supplements for the PLWs, adolescent girls and young children.

Advocacy will be undertaken for creation of endowment funds and subsidies for the vulnerable population as well as to declare MNCH and nutrition related mortality as a mandatory notified event.

4. **Increased funding and allocation for MNCH**

Advocacy meetings will be convened with political leadership and relevant Govt. departments; P&D, finance and health for adequate fund allocation for RMNCAH and nutrition programs. The international donors and UN agencies will also be contacted for resource mobilization for the improvement and scaling up of RMNCAH&N services in accordance to RMNCAH & N national vision 2016-2020.

The celebration of MNCH week and breast feeding week in remote districts will enable the program to reach out to the far flung and marginalized communities. The health education sessions during these celebrations will enable the mothers to understand that how their health seeking behaviors can promote health and well-being of the newborn and children with simple accessible and affordable interventions.

Awareness campaigns and programs on breast cancer, cervical cancer, pneumonia, diarrhea, health and hygiene in remote districts will aim to highlight the signs and symptoms and other indications which require urgent medical atten-

tion. These campaigns will enable the participants to detect any disease which is preventable and can be cured at an early stage with a prompt diagnosis.

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

Celebration of special days such as midwifery, World health day, Mothers-day, Children Day, Hep, TB, HIV, No Tobacco etc) will help in keeping alive peoples interest and knowledge regarding maternal and child issues. Similarly, timely Research on malnutrition, effective utilization of MNCH services, anemia, CMWs, LHWs etc will support policy and decision making.

5. Improve Reproductive health including family planning

Reproductive health services will receive a substantial boost through enhanced coordination between Population Welfare and Health department and the functional integration of reproductive health and family planning with RMNCAH services at health facility level. This will be achieved through strengthening of provincial steering structures and improved coordination at the district and lower levels. Steps will be taken to ensure regular supply of essential items to the facilities and health care workers in an integrated manner. The provincial logistic cell, contraceptive commodity security committee will be strengthened. The supply chain management system will be strengthened by capacity building of staff in cLMIS and sustained reporting on contraceptive forecasting and quantification

Improvements in management will be achieved through provision of dedicated infrastructure such as RHS-A centers, population houses, RTI libraries and training institutes. These structures are aimed at supporting the provision of comprehensive family planning services which include conventional and clinical methods as well as male and female contraceptive surgery facilities in static units and in extension service camps under safe and sterile circumstances. Recruitment of qualified managerial, field staff and tutors will be ensured and their skills updated through regular training and assessment.

Services provided at these facilities will include mother and child health care, prevention and management of RTIs/STIs and HIV/AIDS, management of reproductive health related issues of adolescent boys and girls, other RH related issues of man and women, management of Infertility and early detection of breast and cervical cancers by promoting self- examination.

Increased uptake and utilization of the services will be achieved through a focus on RH related education to adolescents and married couples in a coordinated

and synergistic manner between the two departments. IEC and BCC processes and material will be utilized in achieving the objective while introducing modern methods of family planning such as PPIUCDs and Jars-PPFP. Community mobilization and advocacy will be achieved through involvement of CBOs and NGOs, community elders and influential, branding of products, and utilizing the print and electronic media for enhancing awareness.

Improved performance of health providers will be achieved through use of new technologies i.e. GIS, smart phone, GIS, m-Health and Introducing smart phones for data collection and assessing performance of the staff.

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

A Reduction of Micro Malnutrition among Adolescent girls, Pregnant and Lactating Women (PLW) will be achieved through measures aimed at ensuring regular uptake of the recommended daily allowance of micronutrients and multi-vitamins. This includes the regulation of the supply and logistics chain as well as appropriate training of health care providers.

The provincial and district level institutional structures will be established and operationalized, and staffed with qualified human resources. Health facilities will be equipped with malnutrition treatment and referral protocols, guidelines, nutritional anthropometric tools, furniture and fixture required to support nutritional interventions in health facilities.20 warehouses will be strengthened for supply management.

Involvement of LHWs will be further strengthened to promote infant and young child feeding practices and counsel mothers for appropriate infant and young child feeding practices, as per Pakistan guidelines. The children 6-24 months suffering from diarrhea will be treated by using Zinc and ORS. The chronic management of acute malnutrition will be addressed by implementation of community based management of CMAM and provision of therapeutic food – RUTF. Whereas, the severely acute malnutrition cases with medical complication will be treated through provision of therapeutic food F-75 and F-100.

Vitamin A supplementation campaigns will be conducted, the pregnant and lactating women will be provided with iron-folic supplements and the micronutrient powder sachet will be procured & distributed to the moderate acute malnutrition and the normal children to address micronutrient malnutrition. The adolescent girls and boys will also receive multi-micronutrients.
The wheat flour fortification program will be expanded focusing on advocacy for flour fortification law and establishing systems for monitoring of fortification levels at the provincial and district production level.

Technical assistance will be provided for capacity building activities. LHWs and health facility staff will be trained on relevant topics such as CMAM, SAM, IYCF, institutional strengthening, a training on logistic and supply chain management, training in monitoring, evaluation, research and reporting, MIS training, nutrition in emergencies and provision of multi-micronutrients.

Furthermore, all health care providers and CHWs will also be trained for 2 days in behavior change communication and in E-health package. The E-health, E-learning, communication, management information system and E-counseling packages will be introduced, strengthened and implemented.

7. Investing in addressing social determinants of health

Health is impacted by the political, social, economic and developmental environment Factors such as illiteracy, unemployment, gender inequality, food insecurity, rapid urbanization environmental degradation, natural disasters and the lack of access to safe water and sanitation all have the potential to aggravate the state of health of individuals and communities. The most important of these are distribution of income, discrimination on the basis of gender, class, ethnicity, disability, or sexual orientation[10]

The IRMNCAH&N strategy envisages adopting a multi-sectorial approach to tackling the complicated issue of addressing the social determinants of health. Close coordination will be developed between health, education, public health engineering, social welfare and women welfare departments on the public service side while also including the civil society as well as NGO sectors in addressing the social determinants of poor RMNCAH/Nutrition/mental health issues in women and adolescent girls at district level especially focusing on health and hygiene (WASH, vector borne and disease surveillance, vaccination and reproductive health) issues at the district level.

Advocacy and social mobilization involving parliamentarians, politicians/ religious leaders, human rights, teachers and other civil society through seminars or official meetings will be used to link their slogans and campaigns to RMNCAH/Nutrition/Mental Health issues in women, adolescent girls and children along social determinants like female literacy and economic empowerment at district and provincial level

Existing modules on health education/Promotion will be revised and updated for HCPs and community on comprehensive messages on RMNCAH/Nutrition and social determinants like female literacy and women empowerment. Mass awareness campaigns will be conducted for awareness on passed laws for man-

[10] http://www.emro.who.int/images/stories/pakistan/documents/pak_documents/HSS/SDH_Pakistan.pdf

datory female school enrollment, ban on early girl marriages and mandatory pre-marriage thalasemmia screening. While evidence based information will be used to generate action for social determinants of health and health equity; including equity focused research

Advocacy will also be carried out for legislation for ban on early age girl marriages, compulsory female enrollment and mandatory pre-marriage thalassemia screening.

8. Measurement and action at district level.

In order to make vital information on RMNCAH and nutrition related events available to decision makers at the provincial and district level, the plan envisages the development and Implementation of an integrated DHIS dash board incorporating IRMNCAH&N indicators which are of use at management levels and procurement units to ensure continued availability of services and supplies. It will also enhance oversight and coordination between provincial and district and aid in assessment and monitoring of program activities

The Health Information system will be strengthened to improve the quality of data generated through integration and broadening of its scope. The aim will be to comprehensively cover the RMNCAH and Nutrition indicators as well. Context Analysis and review of existing Health Information Systems will be carried out through a consultative process which will also include the MIS of all relevant Vertical Program's as well as logistics management, with a view to integration into the new dash board.

Provincial DHIS Review committees will be formulated to review existing indicators on RMNCAH and Nutrition related mortalities and morbidities (both Health facility and community based). ToRs for the realignment will be developed and all existing tools and protocols will be reviewed. An integrated monitoring framework will be developed and followed to integrate the data into a single online DHIS dashboard.

District Focal persons will be nominated and trained on the new tools and protocols along with District and provincial his staff. Each district will establish a DHIS cell. Facility and community based health workers will also be trained on the relevant tools.

Improved investigation and response mechanisms (MNDSR) at the provincial and district level will be piloted for expansion after refining. A two-way feedback mechanism will be emphasized.

Advocacy will also be done to allow for notification of Maternal, neonatal and child death and creation of Neonatal and Maternal death review committees. A district health response team will also be established, trained and provided with necessary logistics. The generation of integrated monthly and quarterly reports will be supported to aid in the formulation of evidence based policies

9. National accountability and oversight

Governance, oversight and accountability will be achieved through implementation of investigative and response mechanisms (MPDSR), development and implementation of accountability frameworks such as the oversight committee on IRMNCAH&N and the Commission on Information and Accountability for Women & Children's health (CoIA), development and implementation of quality assurance tools (KPIs) and protocols as well as developing and linking of a multi-tiered M&E system to these frameworks. KPIs will be developed for each cadre of staff for performance management.

Capacity building of various cadres of the health staff on these protocols will be an essential part of the strategy. Regular awareness, advocacy and orientation of the politicians and parliamentarians on the one hand and demand creation at the community level will support the effective streamlining of RMNCAH&N strategy as a priority agenda in achieving the SDG goals.

10. Generation of the political will to support MNCH as a key priority within the sustainable development goals.

Advocacy and awareness raising sessions will be conducted with community elders, politicians and parliamentarians for engendering ncreased political will and support for RMNCAH and Nutrition from political leadership at all levels. This will help in developing a critical mass of consensus behind critical social issues that have detrimental effects on their health suchas the abolition of early age marriages of girls and approval of a legal act to abolish the practice. Similar efforts will be carried out in support of a breast feeding act and universal enrolment in school of all girl-child.

A support group to aid in the advocacy will be developed for the purpose; amongst willing and friendly parliamentarians. Learning and exchange visits will be organized for parliamentarians to showcase good practices in other provinces and educate the parliamentarians regarding issues related to RMNCAH&N.

Other efforts in this direction include the engagement of religious scholars and media to address myths and misconception on health & population issues. The establishment of an SDG cell in the DoH or the P&D department would support in the development of policies and plans for the placement of the agenda of maternal and child health as a key component of the Sustainable Development Goals

OUTLINE OF MONITORING & EVALUATION PLAN

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

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

Table 2: Strategic objectives with key indicators of achievement.

Strategic Objectives	Core Indicators of achievement
Objective1: Improving access and quality of IRMNCAH primary care community based services ensuring continuum of care including newborn care in rural districts and urban slums	- Routine Immunization outreach coverage by LHWs in LHWs covered areas. - % increase in deliveries by SBA in the province - % of community health workers linked to referral system. - % increase in ANC coverage in the province
Objective 2: Improved quality of care at primary & secondary level care facilities.	- % of designated HCF where 24/7 CEmONC Available. - % Health facilities that received at least one supervisory visit during the past 6 month.

	- % of selected HCPs at PHC trained on PCPNC/IMNCI/ENC skills - % Increase in Penta III coverage in the province.
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions.	- Institutionalized and integrated social-welfare network Established - % increase in Districts piloted with PM Insurance Scheme
Objective 4: Increase in funding and allocation for advocacy, awareness and research for RMNCAH & Nutrition	- Increase in the government fund allocation and donor support for RMNCAH & N programs - Timely release of the funds to the programs.
Objective 5: Improve reproductive health including family planning.	- Integration of the FP and RMNCAH services at the PHC level - Reduction in Unmet need for contraception
Objective 6: Investing in nutrition especially of adolescent girls, pregnant and lactating women, children under 5	- % decrease in Maternal and Adolescent Anemia - % increase in IYCF practices
Objective 7: Investing in addressing social determinants of health.	- % Decrease in wasting, anemia and Zinc deficiency - Integrated mechanism to address the social determinants in place - Laws pertaining to mandatory female school enrollment and early girl marriages passed and in place
Objective 8: Measurement and action at district level.	- Integrated DHIS in place and scaled up to all districts - % of health facilities with two-way feedback mechanism in place - Maternal and child mortality audit systems in place - All policies formulated are evidence based
Objective 9: National accountability and oversight.	- **Monitoring and supervision mechanism in place and practice**

	- Accountability framework in place and practiced
Objective 10: Generation of political will to support MNCH as a key priority within sustainable development goals.	- Increase in % of allocation in PSDP for Health development including RMNCAH and Nutrition Program

FINANCIAL ACTION PLAN

BACKGROUND AND COSTING METHODOLOGY

In order to operationalize the ten priority RMNCAH&N actions into concrete action plans that would enable implementation over the coming five years (2016-2020), the action plans need to be costed

to serve the purpose of advocacy, resource mobilization, and providing guidance in implementation This was undertaken through the support of a short term consultant (Dr. Riaz Hussain Solangi).

The exercise was built upon the existing costed IRMNCAH&N action plans, which had documented the baselines where available, and clearly set targets with milestones over the 5 years duration. In circumstances where additional information required, the consultant referred to the concerned provincial and federating areas program managers. To initiate the process, inception meetings were held with the Ministry of National Health Services Regulation and Coordination, and with World Health Organization team, to discuss and approve the costing tool template. The costing tool template was discussed in detail and approved by the WHO and the MoNHSR&C.

The costing tool utilized in this process was a simplified costing developed in Microsoft Excel. The tool comprises 8 sheets (one for each of 7 provinces/ areas and one for overall summary - National. The costing at the National level was done by compiling the overall summary sheets of costing of all the provinces and areas. The tool calculates the total cost per objective required for implementation each year, and summed up to provide the total cost per objective required for five years along with the available resources with funding sources and the funding gap.

DETAILS ON RESOURCE REQUIREMENTS

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

Component-wise total resource requirements

Resource requirements by component/ objective

S.#	Component/Objective	Total PKR	%
1	Improving Access and Quality of MNCH Community Based Primary Care Services	98,571,068,023	27.64
2	Improved quality of care at primary and secondary level care facilities	45,077,403,649	12.64
3	Overcoming financial barriers to care seeking and uptake of interventions	48,114,380,000	13.49
4	Increased Funding and allocation for MNCH	505,000,000	0.14
5	Reproductive health including Family planning	8,172,372,939	2.29
6	Investing in nutrition especially of adolescent girls , mothers and children	151,679,195,093	42.53
7	Investing in addressing social determinants of health	789,569,000	0.22
8	Measurement and action at district level	3,063,870,100	0.86
9	National Accountability and Oversight	115,970,000	0.03
10	Generation of the political will to support MNCH	544,740,000	0.15
Total		**356,633,568,804**	**100**

As shown in the above table, total amount of PKR 356,633,568,804 will be required over a period of five years (2016-2020) for implementing the RMNCAH plans in the country. The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (42.53%) have been costed under objective 6 i-e “Investing in nutrition especially of adolescent girls, mothers and children”. After this, the majority of funds (27.64%) and (13.49%) have been costed under objectives 1 & 3 respectively. The objective 1 is focusing on “Improving the access and quality of MNCH community based primary care services, and objective 3 will overcome financial barriers to care seeking and uptake of interventions in the province.

Component-wise yearly resource requirements

Yearly resource requirements by component/obejctive

S.#	Component/Objective	2016	2017	2018	2019	2020
		PKR	PKR	PKR	PKR	PKR
1	Improving Access and Quality of MNCH Community Based Primary Care Services	13,405,420,147	20,484,408,062	20,914,109,636	20,886,721,194	22,880,408,984
2	Improved quality of care at primary and secondary level care facilities	5,760,449,237	10,024,400,138	9,961,987,028	9,596,532,694	9,734,502,552
3	Overcoming financial barriers to care seeking and uptake of interventions	5,844,750,000	7,534,230,000	9,422,760,000	11,510,460,000	13,802,180,000
4	Increased Funding and allocation for MNCH	84,750,000	91,740,000	102,480,000	106,470,000	119,560,000
5	Reproductive health including Family planning	1,610,323,855	1,847,170,768	1,874,937,711	1,336,287,863	1,503,652,742
6	Investing in nutrition especially of adolescent girls , mothers and children	25,900,967,230	27,471,092,906	30,588,841,748	32,487,285,650	35,231,007,559
7	Investing in addressing social determinants of health	151,519,000	149,644,000	150,288,000	159,562,000	178,556,000
8	Measurement and action at district level	636,520,600	715,475,970	537,759,240	585,536,510	588,577,780
9	National Accountability and Oversight	28,600,000	33,550,000	16,560,000	17,940,000	19,320,000
1	Generation of the political will to support MNCH	101,900,000	113,410,000	109,920,000	105,690,000	113,820,000
Total		**53,525,200,069**	**68,465,121,844**	**73,679,643,363**	**76,792,485,911**	**84,171,585,617**

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

Province-wise resource requirements

Province-wise Resource requirements

S.#	Component/ Objective	Punjab	Sindh	KP	Balochistan	FATA	AJK	GB	National
		PKR	PKR	PKR	PKR	PKR	PKR	PKR	PKR
1	Improving Access and Quality of MNCH Community Based Primary Care Services	38,489,796,300	27,827,144,530	12,877,232,128	7,017,724,800	5,730,423,115	4,726,828,200	1,901,918,950	98,612,844,423
2	Improved quality of care at primary and secondary level care facilities	9,695,916,400	13,072,457,313	4,240,264,296	12,842,524,304	1,302,183,000	2,997,201,336	926,857,000	45,077,403,649
3	Overcoming financial barriers to care seeking and uptake of interventions	43,050,700,000	2,183,800,000	45,000,000	68,250,000	1,545,000,000	21,630,000	1,200,000,000	48,114,380,000
4	Increased Funding and allocation for MNCH	41,040,000	409,800,000	6,600,000	16,200,000	8,550,000	14,360,000	8,450,000	505,000,000
5	Reproductive health including Family planning	2,677,500,000	4,196,777,800	941,090,139	336,455,000	2,200,000	5,150,000	13,200,000	8,172,372,939
6	Investing in nutrition especially of adolescent girls , mothers and children	52,196,799,162	67,282,880,000	14,337,528,327	10,665,697,694	3,198,456,682	2,904,721,928	1,093,111,301	151,679,195,093
7	Investing in addressing social determinants of health	187,030,000	107,635,000	8,200,000	449,724,000	13,800,000	8,500,000	14,680,000	789,569,000
8	Measurement and action at district level	88,075,000	1,791,014,000	160,000,000	262,314,100	309,798,000	180,084,000	272,585,000	3,063,870,100
9	National Accountability and Oversight	22,950,000	15,250,000	9,900,000	25,300,000	11,400,000	19,880,000	11,290,000	115,970,000
10	Generation of the political will to support MNCH	32,490,000	366,250,000	60,300,000	11,400,000	2,000,000	68,100,000	4,200,000	544,740,000
Total		**146,482,296,862**	**117,253,008,643**	**32,686,114,889**	**31,695,589,898**	**12,123,810,797**	**10,946,455,464**	**5,446,292,251**	**356,633,568,804**
Province-wise Resource Requirements (%)		**41.07**	**32.88**	**9.17**	**8.89**	**3.40**	**3.07**	**1.53**	**100**

Province-wise yearly resource requirements by each of 10 components/ objectives are given in the above table. Total amount of PKR 356,633,568,804 will be required over a period of five years (2016-2020) for implementing the RMNCAH plans in the country. Maximum funds (41.07%) of the total requirement are required for Punjab province, and 32.88% of the total funds are required by Sindh province. For implementing the plans 9.17% and 8.89% of the total funds are required for Khyber Pakhtunkhwa and Balochistan respectively. 3.40%, 3.07% and 1.53% of the total required funds for the country are needed for implementing the RMNCAH plans in FATA, AJK and GB respectively.

FINANCING AND FUNDING GAP

Component-wise Funding Gap

Funding Gap

S.#	Component/ Objective	Total Cost	Available Funds	Funding Gap	Funding Gap %
		PKR	PKR	PKR	
1.	Improving Access and Quality of MNCH Community Based Primary Care Services	98,571,068,023	12,790,436,105	85,780,631,918	87.02
2.	Improved quality of care at primary and secondary level care facilities	45,077,403,649	14,043,004,526	31,034,399,123	68.85
3.	Overcoming financial barriers to care seeking and uptake of interventions	48,114,380,000	10,100,000	48,104,280,000	99.98
4.	Increased funding and allocation for MNCH	505,000,000	54,800,000	450,200,000	89.15
5.	Reproductive health including Family planning	8,172,372,939	861,540,939	7,310,832,000	89.46
6.	Investing in nutrition especially of adolescent girls , mothers and children	151,679,195,093	25,790,786,000	125,888,409,093	83.00
7.	Investing in addressing social determinants of health	789,569,000	44,100,000	745,469,000	94.41
8.	Measurement and action at district level	3,063,870,100	199,900,000	2,863,970,100	93.48
9.	National Accountability and Oversight	115,970,000	8,800,000	107,170,000	92.41
10.	Generation of the political will to support MNCH	544,740,000	58,300,000	486,440,000	89.30
Total		**356,633,568,804**	**53,861,767,570**	**302,771,801,234**	**84.90**

As seen in the above table, the available funding is approximately 15% of the total resource requirement for implementing RMNCAH plans in Pakistan. Mainly, these funds will be provided by the federal and provincial governments. The remaining 85% of the total resources requirement is a funding gap, for which Government of Pakistan will mobilize resources through allocating funds from federal and provincial governments' budget, and by approaching potential donors.

OBJECTIVES AND OUTCOMES:

A NATIONAL OVERVIEW OF THE PROVINCIAL IRMNCAH ACTION PLANS

The following table lists the expected outcomes that will be attained from implementing the provincial and regional IRMNCAH&N strategies. The matrix presents a visual comparison of commitments of each plan and also lends itself to periodic reviews for monitoring of achievements against each objective

Table 2: comparative list of expected outcomes

Objectives	Expected Outcomes						
	AJK	Balochistan	FATA	GB	KPK	Punjab	Sindh
1: Improving access and quality of MNCH community based primary care services ensuring continuum of care including	1.1: Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in AJK 1.2: Improved quality of community based RMNCAH and Nutrition services (through	1.1: Enhanced equitable access and coverage of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) 1.2: Improved quality of community based RMNCAH and Nutrition services (through	1.1: improved, access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted Agencies 1.2: Improved quality of community based RMNCAH and Nutrition services (through	1.1: improved, access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted Agencies 1.2: Improved quality of community based RMNCAH and Nutrition services (through	1.1: Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in KP 1.2: Improved quality of community based RMNCAH and Nutrition services (through	1.1: Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs etc.) 1.2: Improved quality of community based RMNCAH and Nutrition services (through	1.1: Enhanced equitable access, coverage and utilization of quality RMNCAH and Nutrition services through community based workers (LHWS & CMWS) in the targeted districts. 1.2: Improved quality of community based services by supporting infrastructure

	improvement in monitoring and supervi-sion/revision of ToRs/capacity building and supplies) of the CMWs and LHWs.	improvement in M&S/revision of ToRs/capacity building and supplies)	improvement in monitoring and supervi-sion/revision of ToRs/capacity building and supplies)	improvement in monitoring and supervi-sion/revision of ToRs/capacity building and supplies)	improvement in monitoring and supervi-sion/revision of ToRs/capacity building and supplies) of the CMWs and LHWs.	improvement in monitoring and supervi-sion/revision of ToRs/capacity building and supplies) of the CMWs and LHWs.	for HR induc-tion / capacity building.
	===	1.3: Improved community outreach rou-tine immuniza-tion through involvement of LHWs	1.3: Improved community routine immun-ization through involvement of vaccinators with coordina-tion of LHWs/ catchment area	1.3: Improved community routine immun-ization through involvement of vaccinators with coordina-tion of LHWs/ catchment area	===	1.3: Improved community outreach rou-tine immuniza-tion through involvement of LHWs	1.5: Improved community outreach rou-tine immuniza-tion through involvement of LHWS and CMWs.
	1.4: Improved the linkages (referral) be-tween the LHWs/CMWs and HCFs for Nutri-tion/FP/ANC/N atal care/PNC/SBA/ EPI	1.4: Improved the linkages (referral) be-tween the LHWs/CMWs and HCFs for Nutri-tion/FP/ANC/N atal care/PNC/SBA/ EPI	1.4: Improved linkages (refer-ral) between the LHWs/CMWs and HCFs for Nutri-tion/FP/ANC/N atal care/PNC/SBA/ EPI/NBC	1.4: Improved linkages (refer-ral) between the LHWs/CMWs and HCFs for Nutri-tion/FP/ANC/N atal care/PNC/SBA/ EPI/NBC	1.4: Improved the linkages (referral) be-tween the LHWs/CMWs and HCFs for Nutri-tion/FP/ANC/N atal care/PNC/SBA/ EPI	1.4: Improved the linkages (referral) be-tween the LHWs/CMWs and HCFs for Nutri-tion/FP/ANC/N atal care/PNC/SBA/ EPI	1.6: Improved referral linkag-es between LHWs, CMWs and health care facilities for nutrition, family planning, ante-natal, natal, post-natal care, skilled birth attendant, rou-tine EPI, hepati-tis, malaria, tuberculosis, etc.

	1.5: Increase in community demand for RMNCAH and Nutrition ser-vices	1.5: Increase in community demand for utilization of RMNCAH and Nutrition ser-vices	1.5: Increase in community demand for RMNCAH and Nutrition ser-vices	1.5: Increase in community demand for RMNCAH and Nutrition ser-vices	1.5: Increase in community demand for RMNCAH and Nutrition ser-vices	1.5: Increase in community demand for RMNCAH and Nutrition ser-vices	1.7: Increase in community demand through social mobilization for RMNCAH&N services. 1.3: Improved quality of com-munity based RMNCAH & N services through im-provement in monitoring and supervision / revision of ToRs. 1.8: Enhanced equitable ac-cess, coverage and utilization of quality RMNCAH&N services by provision of supplies, equipment for LHWs and CMWs.
2: Improve ac-cess to and quality of RMNCH care at Primary and Secondary level	2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ ENC/ RH/ CMAM/ IYCF	2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ ENC/HBB/GAPP D at Primary and Secondary	2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ ENC/HBB/NBC / RH/ CMAM/	2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ ENC/HBB/NBC / RH/ CMAM/	2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ ENC/ RH/ CMAM/ IYCF	2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ ENC at Primary and Secondary	2.1: Enhanced skills of HCPs of primary and secondary health care facilities in

care facilities	etc. (training package) at Primary and Secondary HCFs	HCFs	IYCF etc. (training package) at Primary and Secondary HCFs	IYCF etc. (training package) at Primary and Secondary HCFs	etc. (training package) at Primary and Secondary HCFs	HCFs	IMNCI, PCPNC, ENC, RH, CMAM & IYCF training packages.
	2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HCFs and provision of supplies	2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HCFs including residential accommodations and provision of supplies	2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HCFs and provision of supplies	2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HCFs and provision of supplies	2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HCFs and provision of supplies	2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HFs and provision of supplies	2.2: Health systems strengthening for RMNCAH&N services through filling gaps of human resource, repair, Renovation, upgradation of health care facilities & provision of supplies.
	2.3: Improved referral mechanism involving all health care Facility levels to ensure continuum of care	2.3: Improved referral mechanism involving all health care levels to ensure continuum of care	2.3: Improved referral mechanism involving all health care levels to ensure continuum of care	2.3: Improved referral mechanism involving all health care Facility levels to ensure continuum of care	2.3: Improved referral mechanism involving all health care Facility levels to ensure continuum of care	2.3: Improved referral mechanism involving all health care levels to ensure continuum of care	2.3: Improved referral mechanism involving all health care levels to ensure continuum of care.
	2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	2.4: Improved monitoring & supervision of the facility based RMNCAH & Nutrition

	2.5 Inclusion of IMNCI/PCPNC/ ENC WHO protocols in pre-service of Medical Colleges ===	2.5: Inclusion of IMNCI/PCPNC/ ENC/HBB/Infection Prevention Protocols in pre-service training institutions 2.6 Availability of comprehensive quality EPI services as part of RMNCAH /Nutrition services package at all PHC level facilities	=== 2.6 Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities	=== 2.5. Availability of comprehensive quality EPI services as part of RMNCAH /Nutrition services package at all PHC level facilities	2.5 Inclusion of IMNCI/PCPNC/ ENC WHO protocols in pre-service. ===	2.5: Inclusion of IMNCI/PCPNC/ ENC WHO protocols in pre-service. 2..6 Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities	services. 2.5: Inclusion of WHO protocols of IMNCI, PCPNC & ENC in pre-service training. 2.6: Availability of comprehensive quality EPI services as part of RMNCAH & Nutrition service package at all primary health care level facilities.
3: Overcoming financial barriers to care seeking and uptake of interventions	3.1: Expansion and Improved coordination of the existing social safety nets ===	3.1: Expansion and Improved coordination of the existing social safety nets 3.2: Provision of equity based health Insurance coverage to the people	=== 3.2: Provision of equity based health Insurance coverage to the people	3.1: Food supplementation for pregnant and lactating mothers visiting health facility for ANC 3.2: Provision of equity based health Insurance coverage to the people	3.1: Improved and strengthened coordination of the existing social safety nets. 3.2: Provision of equity based health Insurance coverage to the people	3.1: Improved and strengthened coordination of the existing social safety nets. 3.2: Provision of equity based health Insurance coverage to the people.	3.1: Improved & strengthened coordination of the existing social safety nets. 3.2: Provision of equity based health insurance coverage to the people.
4: Increase in funding and allocation for	4.1: Increased resource allocation and mobi-	4.1: Increased resource allocation and mobili-	4.1: Increased resource allocation and mobili-	4.1: Increased resource allocation and mobili-	4.1: Increased resource allocation and mobili-	4.1: Increased resource allocation and mobili-	4.1: Increased resource allocation and mobili-

RMNCAH	lization for RMNCAH and Nutrition Programs ===	zation for RMNCAH and Nutrition Programs 4.2: Improved mechanism and capacity of the province to absorb and utilize the available resources	zation for RMNCAH and Nutrition Programs 4.2: Improved mechanism and capacity of the FATA to absorb and utilize the available resources "	zation for RMNCAH and Nutrition Programs 4.2: Improved mechanism and capacity of the GB to absorb and utilize the available resources	zation for RMNCAH and Nutrition Programs ===	zation for RMNCAH and Nutrition Programs 4.2: Improved mechanism and capacity of the province to absorb and utilize the available resources	zation for RMNCAH and Nutrition programs 4.2: Improved mechanism and capacity of the province to absorb and utilize the available resource. 4.3: Resource allocation of funds for advocacy, awareness and research for RMNCAH and Nutrition programs.
5: Improve Reproductive Health including family Planning	5.1: Linkages between existing forums established from Federal to District Level (NATPOW, Provincial Technical Committee) ===	5.1: Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level 5.2: Strengthened systems for FP and RH	5.1: Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level ===	5.1: Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level ===	5.1: Linkages between existing forums established from Federal to District Level (NATPOW, Provincial Technical Committee) ===	5.1: Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level 5.2: Strengthened systems for FP and RH	5.1: Enhanced equitable access, coverage to FP services through outreach services and scaling up of services reached. 5.2: Introduction of modern methods of

		through regular provision of commodities for all levels/ capacity building of the HCPs/Enhanced funding for FP				through regular provision of commodities for all levels/ capacity building of the HCPs/Enhanced funding for FP 5.3: Increase community demand for reproductive health and family planning service	family planning to women and married adolescent girls (PPIUCDs, implanons, femiplants, D Jars-PPFP).
6: Investing in nutrition especially of adolescent girls, mother and children	6.1: Improved infant and young child nutrition (children < 24 months) practices in all districts of KP (CMAM/IYCN/SUN/IDD/Food Fortification/) 6.2: Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade 1-5), adolescent	6.1: Reduction of Micro Malnutrition among Adolescent girls, Pregnant and Lactating Women(PLW) with more focus on 07 food insecure districts in the province 6.2: Promotion of Good IYCF Practices(6-23 months)	6.1: Improved infant and young child nutrition (children < 24 months) practices in all Agencies (7) and FRs (6) of FATA 6.2: Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade	6.1: Improved infant and young child nutrition (children < 24 months) practices in GB 6.2: Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade	6.1: Improved infant and young child nutrition (children < 24 months) practices in all districts of KP (CMAM/IYCN/SUN/IDD/Food Fortification/) 6.2: Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade 1-5), adolescent	6.1: Reduction of Micro Malnutrition among Adolescent girls, Pregnant and Lactating Women(PLW) 6.2: Promotion of Good IYCF Practices(6-23 months)	6.1: Addressing general malnutrition. 6.2: Addressing micronutrient malnutrition.

	girls and pregnant/lactating women(PLW) in all districts of AJK 6.3: Enhanced access of local community to life saving nutrition services for acute malnourished children in all districts of AJK	6.3: Reduction of General and Micro Malnutrition	1-5), adolescent girls and pregnant/lactating women(PLW) in all Agencies (7) and FRs (6) of FATA 6.3: Enhanced assess of local community to life saving nutrition services for acute malnourished children in all Agencies (7) and FRs (6) of FATA	1-5), adolescent girls and pregnant/lactating women(PLW) in GB 6.3: Enhanced access of local community to life saving nutrition services for acute malnourished children in all districts of KP	girls and pregnant/lactating women(PLW) in all districts of KP 6.3: Enhanced access of local community to life saving nutrition services for acute malnourished children in all districts of KP	6.3: Reduction of General and Micro Malnutrition	6.3: Behavior changes communication. 6.4: Office strengthening, governance and institutional management. 6.5: Office strengthening, research, monitoring & evaluation. 6.6: Service delivery through different programs for outreach activity and treatment. 6.7: Treatment of adolescent

							girls and boys. 6.8: Office, transportation, human resource, community outreach 6.9: WASH activities. 6.10: Agriculture activities.
7: Investing in addressing social determinants of health	7.1. Health Friendly Multi Sectorial Policies and Practices adopted	7.1: Multi-sectorial approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH/Nutrition/mental health issues in women and adolescent girls at district level 7.2: Legislation done supporting	7.1: Health Friendly Multi Sectorial Policies and Practices adopted (health, education, public health engineering, social welfare, and women welfare departments, NGOs, civil society and PPP). 7.2: Laws in place supporting mandatory	7.1: Health Friendly Multi Sectorial Policies and Practices adopted (health, education, public health engineering, social welfare, and women welfare departments, NGOs, civil society and PPP). ===	7.1. Health Friendly Multi Sectorial Policies and Practices adopted ===	7.1: Multi-sectorial approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH/Nutrition/mental health issues in women and adolescent girls at district level 7.2: Legislation done supporting mandatory	7.1: Multi-sectorial approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH & nutrition, mental health issues in women and adolescent girls at district level. 7.2: Laws are in place for supporting manda-

		mandatory female education and abandon early age marriages	female education, Birth/Death registration and marriage registration			female education and abandon early age marriages	tory female education and abandon early age marriages, birth registration and marriage registration.
8: Measurement and action at district level	8.1: Generation of Valid, Timely, Complete, Reliable routine Data ===	8.1: Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH and Nutrition indicators 8.2: Improved data quality (Reporting timeliness and completeness and 2 way feedback mechanism)	8.1: Generation of Valid, Timely, Complete, Reliable routine Data ===	8.1: Generation of Valid, timely, Complete Reliable routine Data ===	8.1: Generation of Valid, timely, Complete Reliable routine Data ===	8.1: Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH and Nutrition indicators 8.2: Improved data quality (Reporting timeliness and completeness and 2 way feedback mechanism)	8.1: Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH & Nutrition indicators. 8.2: Improved data quality (reporting, timeliness, completeness, follow-up and feedback mechanism.

	=== ===	8.3: Improved investigation and response mechanism (MNDSR) at provincial level and priority districts (based polio audit model 8.4: Data disseminated to support formulation of evidence based policies	=== ===	=== ===	=== ===	8.3: Improved investigation and response mechanism (MNDSR) at district and provincial levels 8.4: Formulation of evidence based policies	8.3: Improved maternal and newborn death investigation and response mechanism (MNDSR) at district and provincial level. 8.4: Formulation of evidence based policies.
9: National accountability and oversight	9.1. Improve Governances and Accountability ===	9.1: Effective oversight mechanism of the RMNCAH/N Program in place. 9.2: Effective accountability framework in place and in vogue	9.1: Effective oversight mechanism of the RMNCAH/N Program in place. ===	9.1: Effective oversight mechanism of the RMNCAH/N Program in place ===	9.1: Improve Governance and Accountability ===	9.1: Effective oversight mechanism of the RMNCAH/N Program in place. 9.2: Effective accountability framework in place	9.1: Effective oversight mechanism for the IRMNCAH&N program in place. 9.2: Effective accountability framework in place.
10: Generation of the political will to support MNCH as a key priority within Sustainable Development Goals	10.1. Awareness about SDGs on Health and Population among Policy Makers and Parliamentarian	10.1: RMNCAH and Nutrition being recognized as priority area in development agenda and increased political will and support for	10.1. Awareness about SDGs on Health and Population among Policy Makers and Parliamentarians	10.1. Awareness about SDGs on Health and Population among Policy Makers and Parliamentarian	10.1: Awareness about SDGs on Health and Population among Policy Makers and Parliamentarian	10.1: RMNCAH and Nutrition being recognized as priority area in development agenda and increased political will and support for	10.1: Increased political will and support for IRMNCAH and nutrition from political leadership at all levels.

		RMNCAH and Nutrition from political leadership in policy making, planning and resource allocation				RMNCAH and Nutrition from political leadership in policy making, planning and resource allocation	