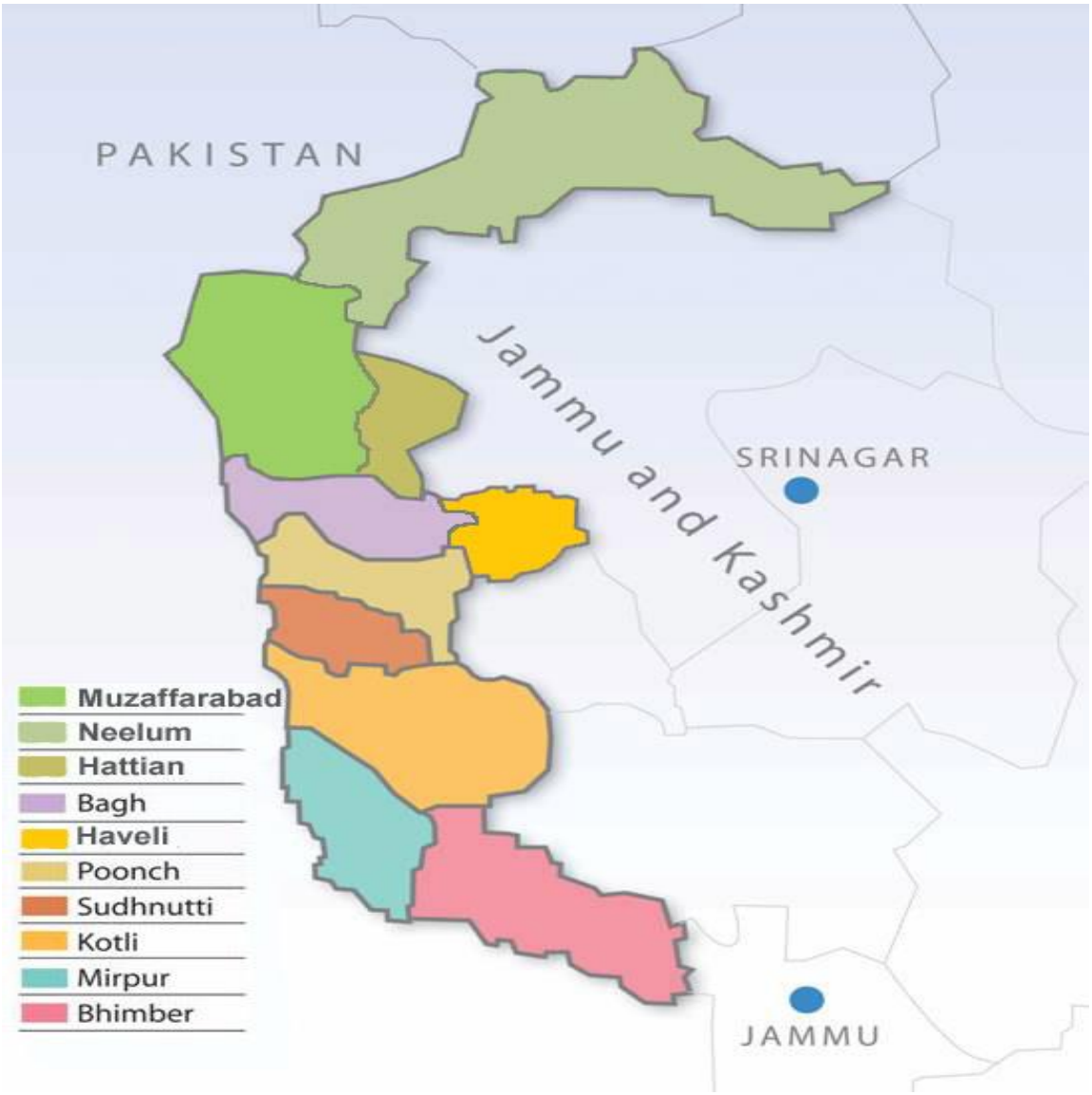
Azad Jammu & Kashmir

Regional RMNCAH&N Strategy (2016-2020)

National vision

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

MAP OF AZAD JAMMU AND KASHMIR



CONTENTS

ACRONYMS

AJK	Azad Jammu & Kashmir
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 Short-Course
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 & Childhood Illnesses
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
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 Program
PCPNC	Pregnancy, Childbirth and Postpartum and Newborn 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 Nations Population Fund
WHO	World Health Organization

MESSAGE:

SECRETARY HEALTH, AZAD JAMMU & KASHMIR

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 corresponding Action Plan at federal level 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 plan.

In order to ensure and sustain standard maternal, newborn and child health care and nutrition services at all levels of health care, while keeping the principle of continuum of care in sight, the Department of Health Azad Jammu & Kashmir MNCH Program; in coordination with the WHO, UNICEF and UNFPA, came up with a comprehensive five year Action Plan for the region in line with the "Ten Point Agenda" on RMNCAH and Nutrition 2016-2020 by the National Ministry for Health Services Coordination and Regulation. This Action Plan chalks out the activities needed in the region 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.

The development process was supervised and guided by the Secretary Health and Director General Health Services Azad Jammu & Kashmir. Moreover, the costing of the Action Plan was done through consultation with the vertical programs of the region through a consultant hired for the purpose.
While the region will endeavor to implement the plans through use of domestic 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 region.

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 regions including Health and Population Welfare. This amendment provides Azad Jammu & Kashmir, with greater autonomy 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 overburdened health care system; leading to high rates of maternal and child mortality; especially so in the resource strapped regions such as Azad Jammu & Kashmir. Communicable diseases, maternal, newborn health issues and under-nutrition dominate and constitute a major portion of the burden of disease in this region.

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 Action Plan - with identified priority areas - has been developed on the direction of the national leadership. The National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child & Adolescent Health, and Nutrition (RMNCAH&N) also served as a guide for the formulation of the Azad Jammu & Kashmir regional RMNCAH&N strategic action plan.

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

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

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

Core components of the Azad Jammu & Kashmir regional 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). Additional LHWs and CMWs will be recruited and equipped for the areas; left uncovered by existing health workers. Micro-nutrient supplementation as well as therapeutic treatment will also be provided.

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

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

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

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

Social mobilization and political will be achieved through advocacy seminars, symposium, international conferences and orientation sessions to raise awareness regarding RMNCAH&N interventions at regional and district level as well as SDGs amongst Politicians and the legislature. Health education interventions will be utilized to disseminate public

health issues like family planning promotion and demand creation. Community based organizations, community elders, local influential, professionals, religious leaders etc. will be engaged using Volunteers and peer support groups for demand creation.

e) A Monitoring & Supervision framework will be developed including ToRs, plans, reporting formats and checklists at regional, divisional, district and facility level. The overall responsibility of M&E will rest with the AJK 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 for mobilizing political commitment and financial resources at the national level or for garnering donor support.

The RMNCAH&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 regional counterparts and all partners in development sector addressing the key problems in a comprehensive manner. The Prime Minster of Pakistan reiterated that mother and child safety through proper immunization and better nutrition are also a major priority for the government. He further added that best practices should be replicated in Pakistan to achieve better results.

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

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

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

The Government of Azad Jammu & Kashmir has been a keen participant in these consultations through the involvement of The Department of Health and has endorsed the National Vision wholeheartedly.

[2] *PDHS 2012-13*

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

SITUATIONAL ANALYSIS

Azad Kashmir has a geographic spread of 13,297,000 square kilometres and is divided into three divisions (Muzaffarabad, Mirpur & Poonch) and ten administrative districts with Muzaffarabad as the capital of the state. These ten districts are further divided into 32 subdivisions with 189 Union Councils.

The Government of Azad Jammu and Kashmir was established on 24th October, 1947. According to the 1998 population census, the State of Azad Jammu & Kashmir had a population of 2.973 million, which has grown to 4.361 million[4]. The Rural to Urban ratio is 88:12. The population density is 336 persons per Sq Km. The region was hit by a mega earthquake in 2005 which caused a huge loss to life and destroyed almost all infrastructure in the region including that of the department of health.

According to the latest estimates, the general literacy rate in AJK is 76%[5].

The region has around 23 hospitals which include 06 District headquarter hospitals. At the sub-district level, there are 11 Tehsil /Civil headquarter hospitals, 50 Rural Health Centers, 225 Basic Health Units, 79 dispensaries, and 201 Mother and Child Health Centers.

The health workforce in AJK has around 8346 members which includes 826 Medical Officers/Specialists; giving an average of 0.18 Per 1000 Population in respect of Medical Officers/Specialists (WHO recommends at least 1 physician per 1000 population).

The health coverage in Azad Jammu & Kashmir is still inadequate with under-5 stunting reported at 32% and wasting at 18% while Anemia (moderate to severe) is prevalent at 46% amongst children. It is encouraging to note that 70% mothers are educated in the region, however, the prevalence of anemia amongst pregnant women was recorded at 43%.

Table 1: Key Indicators of Azad Jammu and Kashmir

Total population	4.466m
Population Growth Rate (%)	2.41
Literacy Rate	77
Infant mortality rate/1,000 live births	58
Under 5 mortality rate/1,000 live births	96
Maternal mortality ratio/100,000 live births	201
%age delivered by a skilled provider	-
%age delivered in health facility	42.6
%age receiving antenatal care from a skilled provider	-
%age of women with a postnatal checkup in the first 2 days after birth	50
%age Under nutrition < 5 years	18
Fully immunization (12-23 m based on recall and record)	94
Tetanus toxoid (%age receiving two or more injections during last pregnancy)	81
Total fertility rate (15-49 yrs)	3.8
Contraceptive prevalence rate	30

Source: http://www.ajk.gov.pk/aboutprofile.php, Health Sector Strategy AJK, 2013 – 2018, http://pndajk.gov.pk/AJKGLANCE/1985-2015/AJkatGlance2015.pdf

Family planning services were introduced in 1983 under the admistrative control of the health department and have been continuing since then. At present family planning services are provided through 55 Family Welfare Centers located in 10 districts namely Muzaffarabad, Hattain Balla, Neelum, Bagh, Havaile, Poonch, Sudhunoti, Kotli, Mirpur and Bhimber, 07 RHSC-A Centers at district

[4] http://pwajk.gok.pk/overview/

[5] http://www.ajk.gov.pk/aboutprofile.php

level, 08 RHSC-"A" Centre at Tehsil level, 07 MSUs, 120 Social Mobilizers and 57 Female Village Based Family Planning Workers[6].

CHALLENGES & CONSTRAINTS

AJK's health infrastructure and health workforce was devastated during the earthquake of 2005. Although large scale reconstruction has replaced the damage, the region is still recovering from the trauma.

Like other regions, AJK faces a double burden of communicable and non-communicable diseases in addition to nutritional deficiencies. Human resource is insufficient and healthcare services at many facilities are not uniform and of poor quality. According to a study, the major issues faced by the facilities were mainly due to the lack of MNCH-related staff at the facilities, like WMOs at RHCs and specialists (Including gynecologists, anesthetists and pediatricians). The availability of staff residences was seen as a major impediment to ensuring 24/7 availability of EmONC services. Infrastructure components required for pediatric care were also deficient at some facilities in the sub-divisions[7].The problem is even further exacerbated by the geographical spread of the population over difficult and inaccessible terrain as well as a deteriorated security environment due to frequent cross border skirmishes.

Maternal and child health services have been under-emphasized within the health system resulting in a high rate of maternal and child deaths. Communicable diseases account for a large proportion of deaths and disability in the region. Among children, diarrhea, pneumonia and vaccine preventable diseases are the main cause of morbidity. Nutritional status of the population, although better than other regions, is still generally poor. Similarly, micronutrient deficiencies are also frequent and there is widespread lack of awareness about malnutrition.

Patchy and sporadic data coverage and major issues in data validity and reliability hamper decision making and management. Information systems relating to logistics, finances, human resource and health are limited in operation. To add to the already challenging situation, a reduction of the federal share in the National Finance Commission (NFC) Award in the post-18th amendment scenario has dire implications for AJK's planning, budgeting and operations. The region is, however, endeavoring to evolve local mechanisms and capacity to handle management and service delivery.

The salient challenges faced by the Azad Jammu & Kashmir Health Sector are as follows:

1. Essential healthcare services need to be strengthened at primary and secondary levels
2. Health Sector Reform and Governance is required to improve the weak system of health sector governance, management and regulation. Lack of regulatory framework for administration, service delivery and finance.

[6] http://pwajk.gok.pk

[7] Health Facility Assessment – Azad Jammu & Kashmir. TRF.

3. Lack of policy guidelines for HRM / HRD. Inadequate and lack of skilled health workforce to fulfill population health needs. Human resource production, retention and development needs to be addressed.
4. Lack of comprehensive, timely, accurate and functional health information system. Inadequate DHIS implementation. Limited data use for decision making.
5. Essential drugs and medical technologies – Lack of continued supply of quality essential drugs for healthcare facilities and outreach workers. Drug regulation needs strengthening for quality of medicines procured.
6. Federal control on financial resources and uncertainty in flow of funds is a major challenge. The prevailing security situation is also hampering service provision and funding of essential projects by non-state actors and donor agencies.

OPPORTUNITIES

The 18th Constitutional Amendment while providing greater autonomy to the region, has posed a unique opportunity to AJK's health system; the Department of Health (DoH), AJK as it could now institute reforms in the health system and also devise a common, integrated and sustainable framework so that all stakeholders could be streamlined and work in congruence. Currently, AJK's health indicators parallel national averages, and in some cases even take the lead.

Considerable opportunities for collaboration and partnerships also exist which could be further strengthened to focus upon available opportunities for synergistic action since NGOs/ INGOs and organized communities are present in many areas and there is a growing awareness and demand for better health care services.

The presence of a widely distributed infrastructure of public sector, strong outreach services and a progressive management cadre are existing strengths. This is complemented by a unified administrative control of health and population welfare services. The National Program for Family Planning & PHC has a strong presence in the community while the National MNCH program and the Population Welfare department have been fully extended to AJK.

A restructuring and reform process has been initiated by the DoH AJK which will help in achieving the goal of providing accessible, affordable, preventive, curative, promotive and rehabilitative health services to the population of the region. A systems approach is being adopted and identified issues and their solutions are being given priority.

In response to the low availability of skilled workers in public health care facilities, the government has initiated the establishment of a teaching hospital and also setup 07 training schools for paramedics and nurses from where trained health care workers could be deployed.

The Prime Minister's National Health Program (social safety net) was launched in February 2016; aimed at providing free-of-cost healthcare to the poorest citizens of Azad Jammu and Kashmir. The program was piloted in Muzaffarabad, Kotli districts in the initial phase and extended to Havelian, Neelum, Bhimber, Mirpur, Hattianbala / Jehlum Velley, Bagh, Poonch and Sadhondi.

Presently, with the help of development partners as well as the federal ministry of National Health Services, Regulation & Coordination, a 5-year, health sector strategy has been drawn up by the Department of Health, AJK covering the period 2013 t0 2018. The strategy lays out the roadmap to address key health sector reforms such as human resources, management, information systems, logistics and financing etc.

IMPLEMENTATION APPROACH FOR RMNCAH&N STRATEGY

The regional 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

VISION

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

GOAL

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

OBJECTIVE

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

CORE COMPONENTS OF THE IMPLEMENTATION APPROACH

1: Improving accessibility:

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

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

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

2: Capacity building

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

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

3: Improving financial accessibility & provision of safety nets

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

4: Health system strengthening

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

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

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

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

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

The use of new technologies i.e. GIS, CLMIS, smart phone apps for EPI, m-Health and smart phones for data recording and reporting will be utilized for analysis and decision making. Research will also be carried out; encompassing the issues such as malnutrition, effective utilization of MNCH services, anemia, newborn care, CMWs, LHWs services and utilization, etc. to aid in evidence-based decision making, policy formulation, planning and consequent advocacy.

5: Social mobilization

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

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

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

6: Monitoring & Supervision:

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

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

OUTLINE OF MONITORING & EVALUATION PLAN

This section provides an outline of the monitoring and evaluation plan for the RMNCAH & 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 RMNCAH & N monitoring and evaluation plans. The overall responsibility of M&E will rest with the Regional 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 RMNCAH primary care community based services ensuring continuum of care including newborn care in rural districts and urban slums	- % coverage of routine Immunization outreach by LHWs in LHWs covered areas. - % increase in deliveries by skilled birth attendants in the region. - % of community health workers linked to referral system. - % increase in ANC coverage in the region
Objective 2: Improved quality of care at primary & secondary level care facilities.	- % of designated health facilities where 24/7 CEmONC is available. - % Health facilities that received at least one supervisory visit during the past 6 month. - % of selected primary level health providers trained on PCPNC/IMNCI/ENC skills - % Increase in Penta III coverage in the region.

Objective 3: Overcoming financial barriers to care seeking and uptake of interventions.	- % of districts with 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 annual 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&N 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 - - Laws pertaining to mandatory female school enrollment and early girl marriages passed and in place
Objective 8: Measurement and action at district level.	- % of districts with integrated DHIS in place. - % of health facilities with two-way feedback mechanism in place - % of districts with maternal and perinatal mortality audit systems in place -
Objective 9: National accountability and oversight.	- % of districts with monitoring and supervision mechanism in place and practiced - % of districts with 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 allocation of PSDP funds for Health development including RMNCAH and Nutrition Program

FINANCIAL ACTION PLAN

BACKGROUND AND COSTING METHODOLOGY

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

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

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

The MNCH program Azad Jammu and Kashmir (AJK) took the lead and facilitated/coordinated the process of costing of RMNCAH and Nutrition action plan. A tentative costing done by the consultant was shared with the MNCH program for the review and inputs by the relevant stakeholders. In the light of feedback received from the MNCH program, the revisions/modification were made. The unit costs were determined on the basis of unit costs finalized for Sindh, Punjab, Balochistan and Khyber Pakhtunkhwa, and available documents like RMNCAH&N action plan of AJK, PC-1s, Comprehensive Multi-Year Plans of EPI, project concept notes, etc. The number of units were mainly taken from the RMNCAH&N action plan. Where necessary, the number of units has been changed for some of the activities, as suggested by the MNCH program during the costing process. In consultation with the concerned stakeholders, an inflationary increment of 10% every year was applied to the unit costs, due to a periodic increase in the prices of goods and services.

DETAILS ON RESOURCE REQUIREMENTS

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

Component-wise total resource requirements

1 Resource requirements by component/ objective

S.#	Component/Objective	Total PKR	%
1	Improving Access and Quality of MNCH Community Based Primary Care Services	4,726,828,200	43.18
2	Improved quality of care at primary and secondary level care facilities	2,997,201,336	27.38
3	Overcoming financial barriers to care seeking and uptake of interventions	21,630,000	0.20
4	Increased Funding and allocation for MNCH	14,360,000	0.13
5	Reproductive health including Family planning	5,150,000	0.05
6	Investing in nutrition especially of adolescent girls , mothers and children	2,904,721,928	26.54
7	Investing in addressing social determinants of health	8,500,000	0.08
8	Measurement and action at district level	180,084,000	1.65
9	National Accountability and Oversight	19,880,000	0.18
10	Generation of the political will to support MNCH	68,100,000	0.62
Total		**10,946,455,464**	**100**

As shown in the above table, total amount of PKR 10,946,455,464 will be required over a period of five years (2016-2020) for implementing the RMNCAH plan in Azad Jammu and Kashmir (AJK). The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (43.18%) have been costed under objective 1 i-e “Improving Access and Quality of MNCH Community Based Primary Care Services”. After this, the majority of funds (27.38%) and (26.54%) have been costed under objectives 2 & 6 respectively. The objective 2 is focusing on “Improved quality of care at primary and secondary level care facilities, and objective 6 will be “Investing in nutrition especially of adolescent girls, mothers and children”.

COMPONENT-WISE YEARLY RESOURCE REQUIREMENTS

2 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	151,753,000	1,063,495,400	1,376,053,200	1,221,690,600	913,836,000
2.	Improved quality of care at primary and secondary level care facilities	147,122,080	1,196,562,400	716,476,800	572,222,456	364,817,600
3.	Overcoming financial barriers to care seeking and uptake of interventions	3,250,000	4,400,000	4,800,000	4,420,000	4,760,000
4.	Increased Funding and allocation for MNCH	1,300,000	3,960,000	2,040,000	4,680,000	2,380,000
5.	Reproductive health including Family planning	400,000	3,190,000	480,000	520,000	560,000
6.	Investing in nutrition especially of adolescent girls , mothers and children	497,269,080	524,132,463	565,160,290	626,891,630	691,268,465
7.	Investing in addressing social determinants of health	1,200,000	1,320,000	1,440,000	2,860,000	1,680,000
8.	Measurement and action at district level	11,000,000	98,384,000	35,592,000	18,252,000	16,856,000
9.	National Accountability and Oversight	2,800,000	6,160,000	3,360,000	3,640,000	3,920,000
10.	Generation of the political will to support MNCH	12,100,000	12,320,000	13,440,000	14,560,000	15,680,000
Total		**828,194,160**	**2,913,924,263**	**2,718,842,290**	**2,469,736,686**	**2,015,758,065**

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

FINANCING AND FUNDING GAP

Component-wise Funding Gap

3 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	4,726,828,200	437,300,000	4,289,528,200	90.75
2.	Improved quality of care at primary and secondary level care facilities	2,997,201,336	248,600,000	2,748,601,336	91.71
3.	Overcoming financial barriers to care seeking and uptake of interventions	21,630,000	1,500,000	20,130,000	93.07
4.	Increased funding and allocation for MNCH	14,360,000	1,300,000	13,060,000	90.95
5.	Reproductive health including Family planning	5,150,000	500,000	4,650,000	90.29
6.	Investing in nutrition especially of adolescent girls , mothers and children	2,904,721,928	205,200,000	2,699,521,928	92.94
7.	Investing in addressing social determinants of health	8,500,000	900,000	7,600,000	89.41
8.	Measurement and action at district level	180,084,000	15,500,000	164,584,000	91.39
9.	National Accountability and Oversight	19,880,000	1,600,000	18,280,000	91.95
10.	Generation of the political will to support MNCH	68,100,000	3,400,000	64,700,000	95.01
Total		**10,946,455,464**	**915,800,000**	**10,030,655,464**	**91.63**

As seen in the above table, the available funding is approximately 8% of the total resource requirement for implementing RMNCAH plan. Mainly, these funds will be provided by the regional government. The remaining 92% of the total resources requirement is a funding gap, for which Government of Azad Jammu and Kashmir will mobilize resources through allocating funds from their own budget, and by approaching potential donors directly or through the MoNHSR&C.

AJK ACTION PLAN FOR NATIONAL IRMNCAH&N STRATEGY 2016 -20

AJK-Action Plan for National IRMNCH & Nutrition Strategy 2016-2020

Activities	Indicators		Target by year					Responsibility
			2016	2017	2018	2019	2020	
Objective 1: Improving access and quality of MNCH community based primary care services ensuring continuum of care including newborn care in rural districts and urban slums								
Expected outcome 1.1: Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in AJK	**80% coverage (subject to condition) population covered through LHWs and 100 % through CMWs in the targeted**							
	Baseline	**Target**						
1.1.1 Mapping of outreach staf (CMWs,LHWs, FMWs, MMWs, vaccinators)	TBD	100%	0	10 districts				MNCH Program
1.1.2 Recruitment of outreach staf (CMWs,FWWs, MMWs, vaccinators, LHWs)	CMWs 305, Vaccinator 362 , LHWs 3007, FWWs 55, SMM 120	CMWs 500, Vaccinator 84, LHWs 2000, FWWs 112, SMM 62	Vaccinators 100,	150 CMWs, 1000 LHWs, FWWs 52, SMM 20	175 CMWs, 1000 LHWs, FWWs 52, SMM 20	175 CMWs, , SMM 42		DoH, MNCH Program, LHWs Program, PWD
1.1.3 Training of more outreach workers from uncovered areas as per mapping	CMWs 305, Vaccinator 342 , LHWs 3007, FWWs 55, SMM 120	CMWs 500, Vaccinator 84, LHWs 2000, FWWs 112, SMM 62	Vaccinator 84,	150 CMWs, 1000 LHWs, FWWs 52, SMM 20	175 CMWs, 1000 LHWs, FWWs 52, SMM 20	175 CMWs, , SMM 42	0	MNCH AJK
1.1.4.Refresher Trainings on Standard Clinical outlook, procedure and Record keeping (10 Days)	305 CMWs, 55 FWWs/FWC over 5s years	305 CMWs, 55 FWWs/FWC over 5s years	0%	305 CMWs, 55 FWWs/FWC over 5s years	0%	0%	0%	MNCH & PWD AJK
1.1.5.Training of Officers (Field & Provincial) on Monitoring & Supervision (2 Refersher trainings with Gap of One Year)	142 LHSs + All PHSs + All District officers	LHWs Prog 142 LHSs,3 Officers/ district=30, 10 Officers from Regional level + 05 Officers from DGH CMW Prog. 142 Admin Sup.,60 LHVs as Tech. Sup., 02 Officers /Disttrict, 06 at DHS Level, PWD 07 Distt. Officers, 15 FMOs of RHSs, 07 FMOs of MSUs,)3 Officers from Regional level		LHWs Prog 142 LHSs,3 Officers/ district=30, 10 Officers from Regional level + 05 Officers from DGH CMW Prog. 142 Admin Sup.,60 LHVs as Tech. Sup., 02 Officers /Disttrict, 06 at DHS Level, PWD 07 Distt. Officers, 15		LHWs Prog 142 LHSs,3 Officers/ district=30, 10 Officers from Regional level + 05 Officers from DGH CMW Prog. 142 Admin Sup.,60 LHVs as Tech. Sup., 02 Officers /Disttrict, 06 at DHS Level, PWD 07 Distt. Officers, 15		DoH

1.1.6. Capicity Building of the HCP of Directorate of Health & PWD in Long Acting Reversible Contraceptives	0	22 FMOs	0%	22				PWD
1.1.7. Construction of Integrated Warehouse with all allied facilities 1 for Each District	0	10	0	2	5	3	0	DoH, EPI(NISP), 1 EPI Warehouse by UNICEF
1.1.8. Provision of Solar Pannels with inverter for insertion lamps for FW Center/ CMW Birthing Stations	0	800 CMWs Workstations ,55FWCs,7 MSUs,	0	139	0	0	0	DoH
1.1.9. Strengthening of RTIs PWD through hiring of tutors (Qualified) 3 English as per Govt Rules (2 Years)	1	1	Hiring of tutors by 12/2016	0	0	0	0	PWD
1.1.10. Strengthening of RTIs PWD through Provision of Teaching Aids (Dummies, Menniquin, Demonstration material, multimedia , desk compurters, scanner, lap top etc)	0	1	1					PWD AJK with support of MNCH
1.1.11. Replacement/Provision of Equipments to Service Delivery Project (IUCD kits,BP Apparatus + Stethoscope)	800 Kits 475 BP Apparatus	300 Kits 500 BP Apparatus		As per requirement	As per requirement	As per requirement		UNFPA/PWD
1.1.15. Repair, Renovation of RHSAs	15	15	0	5	5	5	0	PWD
1.1.16.Printing of booklets on FP Counselling, FP Techiques & Management of Side effects of contraceptives	0	500	0	500	0	0	0	PWD AJK
1.1.18. Upgrade the existing midwifery schools to accommodate the additional requirement (Repairing/Maintanace Operational Cost)	5	5	0	2	3	0	0	MNCH Program
1.1.19. Recruitment and Hiring of qualified midwifery tutors	3 per school=15	6 per School= 30	0	10	20	0	0	MNCH Program
1.1.20. Recruitment and hiring for MNCH Program (training coordinator)	0	1	0	1	0	0	0	MNCH Program
1.1.13 . Expansion of Family Welfare Centres	55	55	11	11	11	11	11	Population Welfare Department
1.1.14 Increase in the number of Mobile Service Units.	7	25	0	10	5	5	5	Population Welfare Department
1.1.15 Procurement of contraceptives for PWD, LHW Prog., MNCH & Health	31% (24000 Users)	50%(45000 Users)						

Expected outcome 1.2: Improved quality of community based RMNCAH and Nutrition services (through improvement in monitoring and supervsion/revision of ToRs/capacity buidling and supplies) of the CMWs and LHWs.	**Baseline**	**Target**						
1.2.2 Increase capacity of existing CMW tutors by enhancing technical / clinical skills (4 Weeks outside	15	15	0	15	0	0	0	MNCH Program
ToT of CMW Tutors on Clinical Skills (07 Days)	15	0	15 (1 Batch)	0	0	0	0	UNFPA/MNCH Prog.
Revision of Basic Training Curriculum of LHWs	Basic CurriculumAvailable	Develop Revised Curriculum	By Mid of 2017					DoH LHW Prog.
1.2.5 Refresher training of LHWs on new areas (HTSP (2 days) , IYCF(5 days), Use of Chlorhexidine (1 Day) , cIMNCI (5days), MDSR (1 Day), Home Based Care New Born (3 Days) etc) contextual to provincial policy								
1.2.5.1 HTSP Training 4 Days	3007	3007	HTSP Training Completed with the Support of UNFPA. y					
1.2.5.2 IYCF Training 5 Days	3007	3007	In 5 Districts with the Support of UNICEF (No. of LHWs)	Remaining 5 Districts No. of LHWs				
1.2.5.3 Use of Chlorhexidine (1 Day)	3007	3007		3007				
1.2.5.4 cIMNCI (5days)	3007	3007		In 5 Districts (No. of LHWs)	In 5 Districts (No. of LHWs)			
1.2.5.5 MDSR (1 Day)	3007	3007			5007	0		MNCH
1.2.5.6 Home Based Care New Born (3 Days)	3007	3007			3007			
1.2.5.7 Training of LHWs as Vaccinator (3 Days)	3007	5007			5007			
1.2.6 In Service Trainings	305	805				0	100	MNCH
1.2.6.1 Refresher trainings of CMWs on FP Techniques(15 days)	305	305	75 CMWs Trained By UNFPA	230				
1.2.6.2 Clinical PCPNC (7 Days)	305	805	0	305 CMWs (3 Batches /Midwifery school) 1 batch of 20 participants		250	250	
1.2.6.3 ENC(HBB,HBS,KMC) (5 Days)	105	700	100 (In 4 Batches)	100 (In 4 Batches)		250	250	MNCH
1.2.6.4 MDSR (01 Day)	305	800			305	250	250	
1.2.6.5 Use of Chlorhexidine & Mesoprostol (2 Days)	305	800		305		250 in Chlorohexadine	250 in Chlorohexadine	
Use of MgSo4 for Eclampsia/Pre Eclampsia (2 Days)	305	305		155	150			

1.2.7 Provision of logisitics for training/Awareness material of all community based interventions for LHWs	0	100%	As per requirement					LHWP
1.2.7 Provision of logisitics for training/Awareness material of all community based interventions for CMWs	0	100%	As per requirement					MNCH
Capacity building of CMWs/LHWs On Mental health treatment gap for PHC physicians and paramedics								
1.2.7 Provision of logisitics for training /Awareness material of all community based interventions for FWWs	0	100%	As per requirement					PWD
Expected outcome 1.4: Improved the linkages (referral) between the LHWs/CMWs and HCFs	**Baseline** **Fragmented**	**Target** **Integrated and in place**						
1.4.1 Development of referral network from Community up to Provincial / district Level	not in place	Developed and displayed		100%				DoH/MNCH/LHWP
1.4.2 Orientation to LHWs, CMWs and HCF staff / Provincial /Distriict level Staff on referal pathways	0	100%						
1.4.3 Display of referal linkages pathways in CMWs birth stations, LHWs Health Houses and Health Care facilities	0	100%						
1.4.4 Development/printing/provision of referral slips and record keeping formats to the CMWs and LHWs		100%						
1.4.5 strengthening linkage between referral unit/ LHS/ LHW/ CMW by ensuring supervisory visit of LHS and monthly meeting at Refferal unit.		100%						
Strengthening DHIS and linking of LHW/CMW MIS with it.		100%						
1.4.6 Scale up e-communication of RMNCAH/N related data/information to more CMWs/ FWW/								
Expected outcome 1.5: Increase in community demand for RMNCAH and Nutrition services	**% of ANC coverage** **Baseline** **73% (PDHS 12-13)**	**Target** **90%**						
1.5.1 Utilization of NGOs social mobilizers/support groups/ CBOs for community mobilization and health services awareness on RMNCH and Nutrition	5 Districts for Nutrition Awareness	Integration and Scaling Up		Initiation	Scaling Up & Strengthening			MNCH/ LHW
1.5.2 Conduct effective health education and awareness sessions at community (LHWs/CMWs) in the catchment area of the HCF								
1.5.3 Training and Involvement of LHWs & CMWs for communication activities & tracing defaulters and non starters (EPI/ANC/PNC/Nutrition)								MNCH/LHW

1.5.3 Training and Involvement of LHWs & CMWs for communication activities & tracing defaulters and non starters (EPI/ANC/PNC/Nutrition)								MNCH/LHW
1.5.4 Use local print and electronic media for social mobilization and health messages on RMNCAH and Nutrition								
1.5.5 Provision of IEC material on MNCH, EPI, FP								
Objective 2: Improve access to and quality of RMNCH care at Primary and Secondary level care facilities								
Expected outcome 2.1 : Enhanced skills of	**75% of the HCPs at PHC are trained on PCPNC/IMNCI/ENC skills**							
	Baseline	**Target**						
2.1.1 Expanding the pool of IMNCI facilitators in province at Center of Excellences	5	1 Batch of 20 Regional Master Trainers, 6 District Trainers per district= 60	1 Batch of 20 Regional Master Trainers	2 Batches of District Trainers	2 Batches of District Trainers			
2.1.2. Capacity building of health care providers at PHC facilities (Pediatrcians/MOs/WMOs/MTs/Paramedics etc) on IMNCI skills (11 days)	385	528 (18 participants per batch=29 batches)		10 Batches	10 Batches	09 Batches		q
2.1.3 Conduct of follow-up visits 4 – 6 weeks after training (2nd part of training) for the trained providers for all components.		As per requirement						DOH/MNCH Program
2.1.4 Conduct training of Health care provides (Gynecologists/Obstetricians/WMOs/LHVs/MW Nurses) on PCPNC (7 days)	196	470	70	150	150	100	0	DOH/MNCH Program
2.1.5 Increase the pool of PCPNC facilitators in the province at the Center of Excellences	18	42	22	20	0	0	0	DOH/MNCH Program
2.1.6 Conduct training of the HCPs (Gyne &Obs, WMO, MO, Pediatricians, LHVs, staff nurses) on Essential Newborn Care (ENC) (5 Days)	297	400	100	100	100	100	0	DOH/MNCH Program
2.1.7 Increase the pool of ENC facilitators at district level	38	22	22	0	0	0	0	DOH/MNCH Program
Training of HCPs in Helping the babies Breathe	186	1000	200	200	200	200	200	DOH/MNCH Program
2.1.8 Capacity buidling of the HCPs on Reproductive Health/Family Planning Councelling at PHC facilities (LHVs/CMWs/FMTs etc) (5 days)	0	528	0	200	200	128	0	DOH/MNCH Program
2.1.8 Capacity buidling of the HCPs on Reproductive Health/Family Planning Surgical Trainings at PHC facilities (CMWs/LHVs etc) (14 days)	0	500	24	200	200	76	200	DOH/MNCH Program

Expected outcome 2.2: Strenthened Health systems for RMNCAH/Nutrition services through filling the HR gaps,	**Availibility of 24/7 cEMONC services at**							
	Baseline	**Target**						
2.2.1 Induction of HR for providing 24/7 CEmONC services at DHQ/THQ and Basic EMONC services at RHCs in rural districts as per requirement (gynecologist,pediatrician,anesthetist, WMOs, Nurses, LHVs,OTT, BBT, Lab tech,aya, sweepers)	11 (CEmONC) 58 (BEmONC)	6 (CEmONC) 50 (BEmONC)	0	2 (CEmONC) 18 (BEmONC)	2 (CEmONC) 16 (BEmONC)	2 (CEmONC) 16 (BEmONC)		DOH/MNCH Program
2.2.2 Incentivise (top ups) the services of the RMNCAH related staff in rural and hard to reachareas (20/ District) in 10 District.(Paediatrician, Gynacologist/WMO/Anesthetic,Staff Nurse/LHV/OT Techinician)	0	10 districts(Athmuqam, Kel,leepa,Kahuta, Khurshidabad,Samahni, Nakyal,Hajira,Trarkhal… .) Total 200 HCPs	10 District	10 District	10District	10 District	10 District	DoH/MNCH Program/
2.3 Repair/renovate/upgrade the OT/labor rooms/ gyne wards/pediatric wards in the DHQ/THQ/RHCs	125	125 facilities (12 CEmONC &113 BEmONC)	0	50	40	35	0	MNCH Program
2.2.9 Repair/Renovation/extention of CMWs School and hostels	5	5	0	3	2			MNCH Program
2.2.10 construction of CMWs Hostels	3	2	0	1	1	0	0	MNCH Programme
Expected outcome 2.3: Improved referral mechanism involving all health care Facility levels to ensure continuum of care	**All level health care facilities linked through**							
	Baseline	**Target**						
2.3.1 Provision ambulances to HCFs for referral of cases based on user end fee for PoL generation.	**80**	**20**	0	20	0	0	0	DoH/MNCH Program
2.3.2 Establish referral desks and data base at DHQ/THQ Hospital/RHCs	0	125	0	125	0	0	0	MNCH Program
2.3.3 Provision of IT support to establish referral desks and data base	0	125	0	125	0	0	0	MNCH Program
2.3.4 Training of the HCPs on maternal and child health referral data recording and dissemination (3 days) 1 Designated IT Person + 1 Senior HCP/ FLCF	0	250	0	250	0	0	0	DoH/MNCH Program
Expected outcome 2.4: Improved monitoring and supervsion of the facility based RMNCAH and Nutrition services	**% Health facilities that received at least one supervisory visit during the past 6 months**							
	Baseline	**Target**						DoH
2.4.1 Operationalization of Steering Committe for IRMNCAH-N at State Level (Bi-Annual Meetings	**1(Non-Functional)**	**1(Functional)**	1 Meeting	2 Meetings	2 Meetings	2 Meetings	2 Meetings	DoH
2.4.2 Establish M&E Cell at State Level to coordinate/collate data from MNCH, EPI, DHIS, Nutrition, LHW Programme (quarterly review meetings)	**0**	**1**	establishing (notification) and development of Tors	4 meetings	4 meetings	4 meetings	4 meetings	

2.4.2.1 Provision of IT & Office Equipment, Printing Material, Stationary & Operational Expenditures for M& E Cell	**0**	**Functional M&E Cell**		**Operating M&E Cell**	**Operating M&E Cell**	**Operating M&E Cell**	**Operating M&E Cell**	DoH
2.4.4 Capacity Building of 5 Provincial and 40 District Managers on M&E for IRMNCAH-N	**0**	**50**		50	0	0	0	DOH/MNCHP
2.4.5 Prepare Supervisory Plan and Conduct (5 Visits/ Manager/Month) at Provincail Level								DoH
2.4.6 Prepare Supervisory Plan and Conduct (5 Visits/ Manager/Month) at District Level								
2.4.7 Review of the M&E feedback reports and reccomendation to the DoH for rectification								DoH
2.4.8 Provision of Two 4x4 Vehicle for MNCH/Nutrition/RH/EPI/LHW Programme and	0	10	0	10	0	0	0	MNCH/DOH
2.4.9 Provision/Procurement of Three Vehicle for Each 10 District (Suzuki Jimny Jeep)	0	30	0	30	0	0	0	
Expected outcome 2.5 Inclusion of IMNCI/PCPNC/ENC WHO protocols in pre-service of Medical Colleges	**All medical colleges/public health and Baseline**	**Target**						
2.5.2 Inception workshop for medical schools for inclusion ofe IMNCI/PCPNC/ENC in pre-service inAJK (Medical colleges) one Day Meeting	**0**	3 Public Medical Colleges and 1 Private Medical College in AJK	Oct-16					MNCH Program
2.5.3 In-depth orientation/planning to strengthen the IMNCI/PCPNC/ENC teaching in all Medical Colleges) One Day Meeting	1 centre of excellance in AIMS	3 centre of excellance in Poonch, MBBS Mirpur and Muzaffarabad Medical College	Oct-16					DoH/MNCH/WHO
2.2.1 Provision of essential IMNCI/PCPNC/ENC equipment to all DHQ/THQ/RHCs for establishment of under 5 and Basic EMOC clinics	0	125		50	(Supply according to trainings of IMNCI)	0	0	MNCH Program
2.2.2 Provision of essential IMNCI/PCPNC/ENC drugs to all DHQ/THQ/RHCs and their inclusion in routine MSD list	0	125	20	125	125	125	0	MNCH Program
2.2.3 Establish the Sick New Born Care Unit through provision of equipment and supplies at DHQs	3	15	3 Established (Supported by UNICEF)	10	5	0	0	DoH
2.2.3.1 HR Support for Sick New Born Care Unit (1 Pediatrician, 3 Mos, 3 Staff Nurses per unit)	Staff Avaialable at 2 Sick Care Units	Staff for 16 Sick Care Units Required (7 Persons per unit)		Staff for 11 Sick Care Units Required (7 Persons per unit)	Staff for 5 Sick Care Units Required (7 Persons per unit)			

2.2.3.2 Training NICU Staff (4 Weeks) (1 Pediatrician, 3 Mos, 3 Staff Nurses per unit)	7	119 (Staff of 17 units to be Trained)		84 (Staff of 12 units to be Trained)	35 (Staff of 5 units to be Trained)			
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions	(No. ofadvocacy sessions /meetings held/research papers)							
	baseline	target						
Advocacy for creation of endowment fund that will be utilized for supporting the poor quantile of health	02 Meetings Held	4 Sessions/Year	1 session	4 Sessions/Year	4 Sessions/Year	4 Sessions/Year	4 Sessions/Year	DoH
3.1 coordination among financial institutions supporting the Poor quintile on health expenditure on user end (Bait ul mal, zakat, BISP, social welfare)	0	4 Meetings/District/Year (40 Meetings)		4 Meetings/District/Year (40 Meetings)	4 Meetings/District/Year (40 Meetings)	4 Meetings/District/Year (40 Meetings)	4 Meetings/District/Year (40 Meetings)	
3.2 Advocacy and materialize the integration of existing social net under the umbrella of National Health Insurance for better coordination and integration.	0	01 Session/ Year at State Level		01 Session/ Year at State Level	01 Session/ Year at State Level	01 Session/ Year at State Level	01 Session/ Year at State Level	DoH
3.4 Advocacy for prioritization of MNCH and nutrition as area for subsidy (Include MNCH and nutritional related mortalities in notifiable domain through health information system to generate evidence to support prioritization of health issues.)	0	05 sessions /District/Year		05 sessions /District/Ye	05 sessions /District/Ye	05 sessions /District/Ye	05 sessions /District/Ye	MNCH Prog.
Objective 4: Increase in funding and allocation for RMNCAH								
4.1 Advocacy for increase budget for Health (RMNCAH&N in particular) (P &D and FD)	On Going	02/Year(Meetings, Press Brief, Seminars with Stake Holders)		02/Year(Meetings, Press Brief, Seminars with Stake Holders)	02/Year(Meetings, Press Brief, Seminars with Stake Holders)	02/Year(Meetings, Press Brief, Seminars with Stake Holders)	02/Year(Meetings, Press Brief, Seminars with Stake Holders)	
4.2 Advocate with the donors and development partners for MNCH related funding	0	1 Donor Conference/Year		1 Donor Conference/ Year	1 Donor Conference/ Year	1 Donor Conference/ Year	1 Donor Conference/ Year	**DoH**
4.3 Advocacy for increasing Share of MNCH/LHW program AJK with the federal government and political leadership through MNCH/LHW Action Committee	4 Meetings/Year	4 Meetings/Year	2 Meetings/Year	4 Meetings/Year	4 Meetings/Year	4 Meetings/Year	4 Meetings/Year	DoH/MNCH/LHW Prog.
4.4 Training of the health managers on financial management(10 DHOs,10 DCs LHW Prog., 10 PHSs MNCH & 04 Provincial Managers and 04 Accounts Staff)	16	38(02 Batches)		38 (02 Batches)		38(02 Batches) Refresher training		**DoH**

Objective 5: Improve Reproductive Health including family Planning								
Expected Outcome: Linkages between existing forums established from Federal to District Level (NATPOW, Provincail Technical Committee)								
5.1 A framework to be developed at State Level (Pop policy 2010 is available including post devolution scenario which needs revision)	Draft Policy Available	Final Policy Document available		Final Policy Document available (05 Meetings)				PWD AJK
5.2 Functional integration of both departments at State Level(Concensus Building, Data Sharing, Joint Monitoring, Accountability)	0	Functional Integration Completed		Functional Integration	Functional Integration	Functional Integration	Functional Integration	DoH/ PWD
5.3 Establish Joint steering committee to address FP issues which may be headed by Chief Secretary/ACS Development to prioritize FP (Biannual Meeting)	0	Joint Steering Committee Establish(Biannual Meeting)		Committee established by 1st Qtr. Of 2017(Bi Annual Meeting)	(Bi Annual Meeting)	(Bi Annual Meeting)	(Bi Annual Meeting)	
5.1.3.Forcasting & costing for Procurement of Contraceptives	Forcasting done	Costing Done	**02 days coordinated costing meeting in Dec.2016(LHWP,MNC**					**PWD AJK**
Objective 6: Investing in nutrition especially of adolescent girls, mother and children								
Expected Outcome 6.1: Improved infant and young child nutrition (children < 24 months)	**% increase in coverage of IYCN practices**							**AJK Nutrition Cell**
	Baseline	**Target**						
6.1.1 Establish Nutrition Cell at State Level in DoH	0	1		Cell Established & functional	functional	functional	functional	
6.1.1.2 Placement of HR at State & District Level as per PC-I (attached)	0	HR In place						
6.1.1.3 IT & Office Equipment for Nutrition Cell								
6.1.2.Annual celebration of Breast Feeding Week (August)	01 State Level	1 State Level & 10 Districts Level per year	1 Provincail & 10 Districts	1 Provincail & 10 Districts	1 Provincail & 10 Districts	1 Provincail & 10 Districts	1 Provincail & 10 Districts	MNCH, LHW Program, Nutrition Program and DoH KP
6.1.3. Notification of Provincail Infant Feeding Board and conduction of Annual Meeting	0	1	1	1	1	1	1	
6.1.4. Notification of Provincail Food Fortification Alliance conduction of biannnual Meeting	1	1	1	1	1	1	1	
6.1.5. Implementation of Provincail Nutritional Stategy	Stretegy Developed to be implemented	10	1	1	1	1	1	

Expected Outcome 6.2: Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade 1-5), adolescent girls and	**% decrease in child, adolescents and**							**AJK Nutrition Cell**
	Baseline	**Target**						
6.2.1: Provision of multiple micronutrient powder for home fortification for all children 6-59 months and Iron/Folic Acid for PLWs and adolescent girls	0	10	4	10	10	0	0	MNCH, LHW Program, Nutrition Program and DoH AJK
5.2.2: Biannual deworming of all children 2-5 years of age	0	>80% children		>80% children	>80% children	>80% children	>80% children	
5.2.3: Biannual deworming of all primary scholl aged children (Grade 1-5)		> 80% children		> 80% children	> 80% children	> 80% children	> 80% children	
5.2.4: Biannual Vitamin-A supplementation with NIDs for all children < 5 years		> 90% coverage		> 90% coverage	> 90% coverage	> 90% coverage	> 90% coverage	
5.2.5: Promoting use of Iodized Salt through Schools and Community Health Workers and salt processors		> 80% HH use iodized salt		> 80% HH use iodized salt	> 80% HH use iodized salt	> 80% HH use iodized salt	> 80% HH use iodized salt	
6.2.6: Intermittent iron/folic acid (IFA) supplementation for adolescent girls		> 60% adolescent girls		> 60% adolescent girls	> 60% adolescent girls	> 60% adolescent girls	> 60% adolescent girls	
6.2.8: Promotion of healthy/appropriate eating for pregnant ladies and lactating mothers including provision of supplementary food ?	0	> 60% PLW		> 60% PLW	> 60% PLW	> 60% PLW	> 60% PLW	
6.2.9: Zinc supplementation for children of age 6-59 months	0	> 60% Children		> 60% Children	> 60% Children	> 60% Children	> 60% Children	
Expected Outcome 6.3: Enhanced access of local community to life saving nutrition services for acute malnourished children in all districts of AJK	**% decrease in Global Acute Malnutrition and Stunting Rates**							**AJK Nutrition Cell**
	Baseline	**Target**						
6.3.1: Establishment and Fuctionalization of inpatient nutrition services (Stabilization Centers) in secondary health care facilities	SC 0	SC3(Muzaffarabad,mirpur and poonch)	0%	SC 3	3	3	3	MNCH, LHW Program, Nutrition Program and DoH
6.3.2: Establishment and Fuctionalization of outpatient nutrition services (SFP and OTP Centers/Breast Feeding Corners)		SFP/OTP in each RHC () and in selected BHUs (408)		SFP/OTP in each RHC 35 and in selected				
6.3.3. HR/Nutritionist at each District level and Provincial level (BPS 17)	0	1 State + 10 Districts		1 Provincial + 10Districts				
6.3.4. Nutrition Supplements for SFP/OTP Centers/NSC (RUSF,WSB/FBF,OIL/RUTF,F-75,	0			Supplement for all ten				

6.3.5. Equipments/Instruments for SFP/OTP Centers (Uniscale, Height/Length Board, MUAC	0	500 Health facilities		270 Health facilities				
6.3.5. Equipments/Instruments for NSC (Complete NSC Kit)	0	26		3				
6.3.4. provision of vehicle for nutrition cell as per attached PC1	0	1	0	3				
6.3.6.IT Equipments/ Soft Ware /Networking /Cameras	0	25		300%				
objective 7: Investing in addressing in social determinants of Health								
Expected Outcome: 7.1. Health Friendly Multi Sectorial Policies and Practices adopted			28					
7.1.1.Multi Sectoral Coordination Committee at Provincial Level	0	1	Notify	Quarterly Meetings	Quarterly Meetings	Quarterly Meetings	Quarterly Meetings	DoH
7.1.2. Revival of School Health Services (Piloting 4 Schools in a selected District)Deploy 1 School Nurse with Necessary equipements and Health Care Provider of relevent Health Facility visit each school Monthly	0	1		Piloting		Assesment	Scaling	
Objective 8: Measurement and action at district level								
Expected Outcome 8.1: Generation of Valid,Timely, Complete, Reliable routine Data								
8.1.1. Formulation of DHIS review committee to review exsisting system and include missing indicators on RMNCAH and Nutrition	0	1 Committee	Notify	Quarterly Review Meeting	Quarterly Review Meeting	Quarterly Review Meeting	Quarterly Review Meeting	
8.1.2.Develop and Implement routine MIS for Tertiary Level Care Hospitals	0	1 MIS Tool		Tool Developed				
8.1.2.A.Develop Reporting Formats and 3 Days training of MIS staff of Tertiary Level Care Hospitals (15 Persons/Hospital x 4 Hospitals)	0	60 (3 batchs of 20)		1 Batch	2 Batches			
8.1.3 Refresher Training of staff (DHIS) on Tools & Instruments(03 days)	1543 (Basic Training)	1543	0	1072	474			
8.1.4 Training of District computer staff on DHIS Software (3 Days)(2 Persons/District)	0	20 (2 Batches)		Training of 2 Batches				
8.1.4. Training of Master Trainer district wise (2/ District + 4 State Level) (DHIS)	24	24		24				

8.1.5. HR required for District Level(HR 1 D Statistical Officersfor districts + 1 SA for 3 DHQs	16 SAs avaialable	10 DAs + 3 SAs(1 for each DHQs)		Induction completed				
8.1.6 IT Equipment/Furniture required for District Level	0	All IT & Furniture Required for all Districts						DoH
8.1.7.Training on Use of Information for Health Managers (3 Days)	0	57 (3 Batches of 20)		Training of 3 Batches				
8.1.8 Printing of recording/reporting tools		No stock out	Partially Available	Printing Done		No stock Out	No stock Out	DoH
8.1.9 provision of supervisory vehicle for DHIS Cell	0	2	0			2		
Objective 9. National Accountibility and Oversight	0							
Expected Outcome 9.1. Improve Governeness and Accountibility	0							
9.1.1. Formulation of oversight Committee Chaired by Minister of Health AJK to review Performance and outcomes (Bi Annual Meetings)	0	Formulate Oversight Committee		Formulate Oversight Committee				
9.1.2.Development of accountibility Framework	0	Frame Work Develop		Frame Work				
9.1.3.Link the Monitoring and Evaluation reports for accountiblity framework	0	Quarterly Reports		Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	
9.1.4								
9.1.5. Implementation of Quality assurance tools at all level	0	Development of Tools		Development of Tools	Tools Implemented	Tools Implemented	Tools Implemented	
Objective 10.Generation of the Political will to support RMNCAH & Nutrition as a key prority within sustainible develpoment goals								
Expected Outcome: 10.1. Awairness about SDGs on Health and Population among Policy Makers and Parlimentarian								
10.1.1. Establish SDG Cell under DGHS AJK	0	1	Notify					
10.1.2. Advocacy and Awairness oreientation of Policy Makers and Parlimentarian on Health and Population Issues	1 Seminar/Year	1 Seminar/Year	Dec.2016	1 Seminar/Year	1 Seminar/Year	1 Seminar/Year	1 Seminar/Year	DoH
10.1.3.Engagemnt of religiuos scholors, Media to address Myths and Misconception on Health & Population Issues	1 State Level + 5 District Level	11 per Year(1 State Level + 10 District Level)		11 per Year(1 State Level + 10 District Level)	11 per Year(1 State Level + 10 District Level)	11 per Year(1 State Level + 10 District Level)	14 per Year(1 State Level + 10 District Level)	
10.1.4.Revival of Village Health Committee and Women Group for improveming Health Seeking Behaviors(1 Day Refresher training in Continouss education class)	3007	5007		3007	5007	5007	5007	LHWs Prog.

Stenghting EPI								
11.1.1. Advocacy,Policy and planning meetings with stakeholders				1				EPI Program
11.1.2.Development Regulation on VPDs (Vaccine Preventable Diseases) Reguation on manadatory immunization of all antigens and dealing with refusals				1				EPI Program
11.1.3. Periodical planning reviews/meetings regarding EPI at state level (Quarterly/Bi Annualy)				4	4	4	4	EPI Program
11.1.4) Periodical planning reviews/meetings at districts/Divisional levels				40	40	40	40	EPI Program
11.1.5) Planning and orientation of managers on EPI related MoRES (all DHOs/EPI Coordinator)				1	0	0	0	EPI Program
11.2 Technical support, logistic support and Capacity building of managers, implementers, field staff, community level health workers								
11.2.1 MLM training for the managers on EPI				1			1	
11.2.2 Training of managers and field staff on RED/REUC (1600 field staff) 64 sessions in10 distts (5000/25 participants 200 sessions)				50	50	50	50	
11.2.3 Training on EVM and vLMIS for rest of the 9 Districts (4000 field staff) = 160 sessions				40	40	40	40	
11.2.4 Refresher/Training on Cold Chain and equipment for storekeepers and cold chain staff (30 store keepers and CC staff, 12-16 grade) refresher for 10 & training for 50 = 2 sessions				2				
11.2.5 Trainings on EPI/MIS Soft ware/reporting system - 2/distt, Computer operators x10 distts + 2 regional office = 1 session				1				
11.2.6 Networking of EPI-MIS Soft Ware with in all the 10 Districts +repair of the outdated ones	0	All 10 Districts	0	10	10	10	10	EPI Program
11.2.7 Technical support on RED stretegy (hiring RED Consultant for implementation of RED/REUC in the province and 02 divisions) cost per person 150-200 thousands per month + mobility	0	2	2	10	10	10	10	EPI Program
11.2.8 Support on stablishment of 500 fixed/static EPI centers (125 UCs/selected Health houses)	500	250	0	100	100	50	0	EPI Program
11.2.9 Support on establishment of 50 private hospitals/clinics	10	50	0	30	20	0	0	EPI Program
11.2.10 Support on strengthening reporting and moitoring system e.g. HR provision of computor opertaors/analysts for 10 distrcts + relvant IT equipment (Computers, Printers,Scanners,Multi-media and office equipment fx machine,	2	0 districts + Reginal office	2	8	0	0	0	EPI Program

11.2.10 Support on strengthening reporting and moitoring system e.g. HR provision of computor opertaors/analysts for 10 distrcts + relvant IT equipment (Computers, Printers,Scanners,Multi-media and office equipment fx machine, photocopier, laptops with accessories	2	0 districts + Reginal office	2	8	0	0	0	EPI Program
11.3 Mobility and field implementation								EPI Program
11.3.1 Motorcycles for outreach routine immunization. 500 - 70cc	6	500		500				
11.3.2 mobility + PoL for field staff/vaccinators + mobile teams 600/team x 2900 vaccinators		as per requirement						
11.3.3) Support on technician for repair and maintenance of CC equipment - 1000/ILR x /year		as per requirement						
11.4 Monitoring, surviellance, reporting and operational research/MoRES on EPI								
11.4.1 Mobility support - vehicle + PoL for Provincial Prog managers, DHO, EPI Coordinator, DSV/FSV… 15000/head x 2 (DHO+EPI Coord) x 50 and 600/head (DSV+TSV) x 125		as per requirement						
11.4.2) Establishment of VPD suviellance system at Provincial and Distt levels -	no surveillance officer	All 10 Districts + regional office		11				
11.4.3 Technical support on surviellance/HR support - 01 provincial surviellance officer and 10 distt surviellance officers.	no surveillance officer	All 10 Districts + regional office						
11.4.4 Support on operational research and EPI related MoRES promotion for evidence based monitoring -	0	research survey done			1			
11.4.5 Suport on periodical evaluations on yearly basis and end project	0	3 yearly and one end of project evaluation report		1	1	1	1	
11.5 ACSM on routine immunization and RED/REUC strategy in 10 Distrct of AJK								
11.5.2 Orientation of managers on EPI communication strategy (two sessions)				2				
11.5.3 Development of updated messages on VPDs and Polio new introduction of vaccines								
11.5.4 Printing of tools on EPI Information, registration and reportings								
11.5.5 Education and awareness material for communities, school , religious leaders, public representatives, media etc								

11.5.5 Education and awareness material for communities, school , religious leaders, public representatives, media etc									
11.5.6 Support on awareness sessions by LHWs among the women groups at house hold level etc, on routine immunization									
11.5.7 Visibility through banners, bill boards/Panaflex, posters etc									
11.5.8 Media sessions with social media/print and electronic media									
11.5.9 Supprot on printing MIS tools and stationary									
11.5.10 Seminars, Talk shows, walks, and other sessions etc									
11.6. Improve data quality reporting/data quality audit (DQA) timeline and completenes and 2 way feed back mechanism									
11.7 HR/Equipment/Furniture required for those EPI offices, static centers etc.									