Gilgit Baltistan

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 GILGIT BALTISTAN

CONTENTS

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-Short Course
ENAP	Every Newborn Action Plan
ENC	Essential Newborn Care
EmONC	Emergency Obstetric & Newborn Care
EPI	Expanded Program on Immunization
GB	Gilgit-Baltistan
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 Neonatal and 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 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
MPDSR	Maternal and Perinatal Death Surveillance & Response
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
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, GILGIT BALTISTAN

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 and newborn 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 provinces and regions 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 and nutrition services at all levels of health care, while keeping the principle of continuum of care in sight, the Department of Health Gilgit-Baltistan 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 Gilgit-Baltistan. Moreover, the costing of the Action Plan was done through a process of consultation with the vertical programs of the region assisted by a consultant hired for the purpose.

While GB 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 some regions including Health and Population Welfare. This provides the regions, including Gilgit-Baltistan, 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 regions such as Gilgit-Baltistan. Communicable diseases, maternal and newborn health issues and under-nutrition dominate and constitute a major portion of the burden of disease in such cases.

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

Core components of the Gilgit-Baltistan RMNCAH&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). 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 to malnourished children.

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

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. This 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 incorporating 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.

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

f) A Monitoring & Supervision framework will be developed including ToRs, plans, reporting formats and checklists at regional, divisional, district and facility level. The overall responsibility of M&E will rest with the Regional 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

This 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 additional support for the program. The medium-term, 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. 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.

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 Government of Gilgit-Baltistan has been a keen participant in these consultations through the involvement of The Department of Health and has endorsed the National Vision wholeheartedly.

SITUATIONAL ANALYSIS

[2] *PDHS 2012-13*

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

Previously known as the 'Northern Areas' of Pakistan, the area's name was changed to Gilgit-Baltistan after Pakistan's cabinet signed the Gilgit-Baltistan Empowerment and Self-Governance Order (ESGO) in 2009. With an area of 72,496 Km and a population of 1.301m[4], the region is divided into two administrative divisions; Gilgit Division – consisting of five districts: Gilgit, Ghizer, Diamer, Astore, and Hunza-Nagar - and Baltistan Division having four districts: Skardu, Ghanche, Shigar, and Kharmang.

The Department of Health Gilgit-Baltistan has the responsibility of providing a multi-layered health care system over difficult terrain and sparse population. The department operates around 499 health facilities with the help of 248 medical officers and specialists[5].

The health status of the people of the region as a whole is below the desired level as is revealed from the key health indicators described in table 1. However 60% percent of the population has access to improved drinking water sources while 82 percent of the population has access to sanitation facilities. Similarly, projected data estimates the average literacy rate to be around 60%[4].

Table 1: Key Indicators of Gilgit-Baltistan

Total population	1.301m
Population Growth Rate	2.56
% Illiterate married women	36.2
Neonatal mortality rate/1,000 live births	39
Infant mortality rate/1,000 live births	71
Under 5 mortality rate/1,000 live births	117[5]
Maternal mortality ratio/100,000 live births	450-500[5]
%age delivered by a skilled provider	43.7
%age delivered in health facility	42.6
%age receiving antenatal care from a skilled provider	64
%age of women with a postnatal checkup in the first 2 days after birth	19.9
%age Under nutrition < 5 years	15.2
Fully immunization (12-23 m based on recall and record)	47
Tetanus toxoid (%age receiving two or more injections during last pregnancy)	45.3
Total fertility rate (15-49 yrs)	3.8
Contraceptive prevalence rate	33.6

Source: PSLM 2014-15, PDHS 2012-13, pwd.Gilgit-Baltistan.gov.pk/population profile, http://health.Gilgit-Baltistan.gov.pk

According to PDHS 2012, about seventy percent of all pregnant women in Gilgit-Baltistan are estimated to have iron deficiency anemia. Over 36 percent of children under the age of five years are short for their age while over 12.6 percent are under weight for their age[6].

Poor health status in Pakistan is partly explained by poverty, low levels of education especially for women, low status of women in large segments of society, and inadequate sanitation potable water facilities and a low spending/expenditure on health (0.7% as compared to 1.3% - World Bank report). It is also strongly related to serious deficiencies in health services; both in public and private sectors.

CHALLENGES & CONSTRAINTS

Like other regions, GB faces a double burden of communicable and non-communicable diseases in addition to nutritional deficiencies. Human resource is insufficient and services at facilities are not uniform and of poor quality. 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. Information systems relating to logistics, finances, human resource and health are limited in opera-

4 *http://www.gilgitbaltistan.gov.pk/DownloadFiles/GBFinancilCurve.pdf*

5 *http://health.Gilgit-Baltistan.gov.pk*

6 PDHS 2012-13, PSPU website, Gilgit-Baltistan Health Sector Strategy 2012-2020, IRMNCAH&N PC1 2016-17

tion, while duplication of efforts by public and private entities (NGOs/INGOs) is also an issue. Logistical supplies are poorly handled with no procurement cell in the region.

The region is endeavoring to evolve local mechanisms and capacity to handle management and service delivery. Patchy and sporadic data coverage and major issues in data validity and reliability hamper decision making and management. Maternal and child health services have been underemphasized 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 is generally poor especially for the children, women of reproductive age and the elderly. Similarly, micronutrient deficiencies are also frequent and there is widespread lack of awareness about malnutrition. Furthermore, the coordination amongst various departments such as education, finance, labor and industry and water and sanitation also need to be strengthened.

The salient challenges faced by the Gilgit-Baltistan Health Sector are as follows:

1. Service delivery – Issues of access and quality of healthcare
2. Governance and accountability – Weak system of health sector governance, management and regulation. Lack of regulatory framework for service delivery
3. Health workforce – Lack of policy guidelines for HRM / HRD. Inadequate and lack of skilled workforce available to fulfill population health needs.
4. Health information system - Lack of comprehensive, timely, accurate and functional 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. Weak regulation of quality of medicines procured.
6. Health Financing - 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

Following the Empowerment and Self-Governance Order (ESGO) 2009 and devolution of legislative authority in GB, the situation is conducive to change towards the better as governance structures are evolving and more attention is being given to health and education services. 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. The area has a relatively clean environment and is free from pollution and there is a growing awareness of health care which is strongly highlighted in public gatherings.

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 has been fully extended to GB although the EPI program is yet to be fully extended to region.

A restructuring and reform process has been initiated by the DoH GB 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 medical college at Gilgit and also setup CMW training schools at each of the Administrative divisions if the region from where trained and deployed community mid-wives (CMWs) have been deployed both through their own resources but also in collaboration with Agha Khan Rural Support Programme (AKRSP). Other pertinent initiatives aimed at strengthening the health system are the construction of regional a blood center and the introduction of a broad based DHIS in the region.

The Directorate of Health GB has been collaborating with a number of international and local organizations such as the AKRSP and KFW as affiliates in the effort to provide quality health care services to the people of the region. The Health Development Program as well as the Social Health Protection Initiative by KFW is a good example of such collaboration.

With the help of such 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, GB covering the period 2013 to 2018. The strategy lays out the roadmap to address key health sector reforms such as human resources, management, information systems, logistics and financing etc.

Salient features of GB Health Sector strategy are:

1. Governance and Accountability;
   Strengthen the stewardship role of the department in the context of new roles and challenges faced.

2. Human Resource Management;
   Strengthen human resource management functions of the department.

3. Service Delivery;
   Increase the coverage and utilization of quality services at primary and secondary health care level, Introduce quality assurance mechanism to ensure safety of patient /client.

4. Health Management Information Systems:
   Develop an integrated health information system giving reliable information for decision making and policy formulation processes. It will also assist in monitoring and evaluation of ongoing programs and projects.

5. Pharmaceutical and Medical Supplies Management:
   Improve the availability of quality essential medicines in health facilities based on standardized services at each level.

6. Health Financing:
   Formulate a financial system, which is equitable, efficient, self-sustainable and pro-poor which will assist in the economic uplift of the population and is also important for improving the overall health situation in GB.

IMPLEMENTATION APPROACH FOR RMNCAH&N STRATEGY

The regional RMNCAH&N strategy 2016 -2020 follows the vision and goal of the National Strategic 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. 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 of mapping will be carried out to identify uncovered areas of both CMWs and LHWs in Gilgit-Baltistan region. It will be ensured that 85% population is 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 Gilgit-Baltistan 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 malnourished children at community level through outpatient therapeutic program (OTP) and facility level through Nutrition Stabilization Centers (NSCs) is another focused area of intervention. Provision of micro nutrient supplements to the children, pregnant ladies; adolescents to overcome the nutritional deficiencies, address the exposure to 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 Care and Postnatal Care (PCPNC), helping babies breathe (HBB), infant and young child feeding (IYCF) practices. Moreover, trainings on HIV/STI, TB, DOTS, Hepatitis, referral and reporting of MNC mortality, family planning methods: hormonal, long term FP methods, IUCD, PPIUCD, etc. will also be undertaken.

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 high-

light 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-sectoral 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 modern methods as well as male and female contraceptive surgery facilities in static units and in extension service camps under safe and sterile circumsstance. 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 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:

ToRs, plans, reporting formats and checklists for monitoring and supervision 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 GB 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 RMNCAH&N services by LHWs in LHWs covered areas. - % of LHWs and CMWs involved in routine immunization - % increase in uptake of IRMNCAH&N services from CMWs and LHWs.
Objective 2: Improved quality of care at primary & secondary level care facilities.	- % of HCF in target districts with full complement of HR, supplies and functional infrastructure for IRMNCAH&N services including referral mechanisms. - % of HCF with health care providers trained on key RMNCAH&N topics (PCPNC, IMNCI etc). - % of HCF in target districts implementing the WHO Quality of

	Care standards for RMNCAH&N services.
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions.	- % of institutions implementing new social security regulations to develop linkages between various public sector institutions for social security. - % of coverage of beneficiary population under the conditional cash transfer schemes -
Objective 4: Increase in funding and allocation for advocacy, awareness and research for RMNCAH & Nutrition	- % increase in annual funding for RMNCAH and Nutrition programs by Government of Sindh. - % of Awareness campaigns and programs conducted - % utilization of funds designated for advocacy, awareness and research activities in target districts. -
Objective 5: Improve reproductive health including family planning.	- % of HCF with required supplies and appropriately trained HR for management and outreach of RH services. - % of CMWs; with enhanced skills and competencies, involved in family planning -
Objective 6: Investing in nutrition especially of adolescent girls, pregnant and lactating women, children under 5	- % of HCF providing nutrition specific services (static and outreach) to MAM and SAM children, adolescent girls and PLWs in target districts. - % of districts regularly conducting supervision, monitoring and evaluation of RMNCAH&N interventions and sharing quarterly reports at provincial level. - % of total population of adolescent girls, PLWs, MAM and normal children, provided with micronutrients -
Objective 7: Investing in addressing social determinants of health.	- % of districts adopting multi-sectorial approach for addressing social determinants of poor RMNCAH&N - Regulation formulated and implemented for mandatory

	female enrollment in schools. -
Objective 8: Measurement and action at district level.	- % of districts with Integrated DHIS i.e. includes all RMNCAH & Nutrition indicators% of districts with required supplies, appropriate trained HR implementing integrated DHIS - % of districts implementing MNDSR protocols in target districts -
Objective 9: -Regional accountability and oversight.	- % of planned quarterly progress review meetings of the National RMNCAH&N program oversight committee conducted per year - % of districts implementing the accountability framework related to RMNCAH&N program. -
Objective 10: Generation of political will to support MNCH as a key priority within sustainable development goals.	- ToRs for SDG Cell approved and cell established under P & D and DGHS - % increase in 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

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 Gilgit Balitistan 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/modifications were made. The unit costs were determined on the basis of unit costs finalized for Sindh, Gilgit-Baltistan, Balochistan and KHYBER Pakhtunkhwa, and available documents like RMNCAH&N action plan of GB, 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

The 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

Resource requirements by component/ objective

S.#	Component/Objective	Total PKR	%
1	Improving Access and Quality of MNCH Community Based Primary Care Services	1,901,918,950	34.92
2	Improved quality of care at primary and secondary level care facilities	926,857,000	17.02
3	Overcoming financial barriers to care seeking and uptake of interventions	1,200,000,000	22.03
4	Increased Funding and allocation for MNCH	8,450,000	0.16
5	Reproductive health including Family planning	13,200,000	0.24

6	Investing in nutrition especially of adolescent girls , mothers and children	1,093,111,301	20.07
7	Investing in addressing social determinants of health	14,680,000	0.27
8	Measurement and action at district level	272,585,000	5.00
9	National Accountability and Oversight	11,290,000	0.21
10	Generation of the political will to support MNCH	4,200,000	0.08
Total		**5,446,292,251**	**100**

As shown in the above table, total amount of PKR 5,446,292,251 will be required over a period of five years (2016-2020) for implementing the RMNCAH plan in Gilgit Baltistan. The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (34.92%) 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 (22.03%) and (20.07%) have been costed under objectives 3 & 6 respectively.

The objective 3 is focusing on "Overcoming financial barriers to care seeking and uptake of interventions, and objective 6 will be "Investing in nutrition especially of adolescent girls, mothers and children".

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	57,777,500	401,050,650	697,977,000	360,430,200	384,683,600
2.	Improved quality of care at primary and secondary level care facilities	44,700,000	200,596,000	281,208,000	198,627,000	201,726,000
3.	Overcoming financial barriers to care seeking and uptake of interventions	200,000,000	220,000,000	240,000,000	260,000,000	280,000,000
4.	Increased Funding and allocation for MNCH	1,800,000	2,750,000	1,200,000	1,300,000	1,400,000
5.	Reproductive health including Family planning	2,200,000	2,420,000	2,640,000	2,860,000	3,080,000
6.	Investing in nutrition especially of adolescent girls , mothers and children	155,050,090	188,266,476	236,610,151	245,366,555	267,818,028
7.	Investing in addressing social determinants of health	1,800,000	3,520,000	2,880,000	3,120,000	3,360,000
8.	Measurement and action at district level	14,000,000	80,355,000	57,480,000	59,150,000	61,600,000
9.	National Accountability and Oversight	-	5,830,000	1,680,000	1,820,000	1,960,000
10.	Generation of the political will to support MNCH	-	2,640,000	480,000	520,000	560,000
Total		**477,327,590**	**1,107,428,126**	**1,522,155,151**	**1,133,193,755**	**1,206,187,628**

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

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	1,901,918,950	137,905,500	1,764,013,450	92.75
2.	Improved quality of care at primary and secondary level care facilities	926,857,000	89,100,000	837,757,000	90.39
3.	Overcoming financial barriers to care seeking and uptake of interventions	1,200,000,000	-	1,200,000,000	100.00
4.	Increased funding and allocation for MNCH	8,450,000	800,000	7,650,000	90.53
5.	Reproductive health including Family planning	13,200,000	1,000,000	12,200,000	92.42
6.	Investing in nutrition especially of adolescent girls , mothers and children	1,093,111,301	108,800,000	984,311,301	90.05
7.	Investing in addressing social determinants of health	14,680,000	1,300,000	13,380,000	91.14
8.	Measurement and action at district level	272,585,000	19,900,000	252,685,000	92.70
9.	National Accountability and Oversight	11,290,000	1,200,000	10,090,000	89.37
10.	Generation of the political will to support MNCH	4,200,000	400,000	3,800,000	90.48
Total		**5,446,292,251**	**360,405,500**	**5,085,886,751**	**93.38**

As seen in the above table, the available funding is approximately 7% of the total resource requirement for implementing RMNCAH plan. Mainly, these funds will be provided by the regional government. The remaining 93% of the total resources requirement is a funding gap, for which Government of Gilgit Baltistan will mobilize resources through allocating funds from their own budget, and by approaching potential donors through the MoNHSR&C.

ACTION PLAN FOR GILGIT-BALTISTAN IRMNCAH&N STRATEGY

Action Plan GB for National RMNCH & 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: improved, access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted Agencies	**50% coverage (subject to condition)**							
	Baseline	**Target**						
1.1.1 Mapping of outreach staff (CMWs,FWAs, Male Mobilizers, vaccinators, LHWs)	NA	100%		100% Mapping				
1.1.2 Recruitment of outreach staf (CMWs,FWAs, Male Mobilizers, vaccinators, LHWs)	CMWs 158(60 under training), 125 Vaccinator ,LHWs 1385 , FWAs 77	CMWs 48 , 225 Vaccinator/ LHWs 600, FWAs 52	Recuirment of 105 Vaccinators under GAVI Project	CMWs 39, Vaccinators 165 , LHWs 480 , FWAs 42	CMWs 9, Vaccinator 60, LHWs 120 , FWAs 10			MNCH Program/National Program/EPI/PWD
1.1.3 Salary of exisiting and newly recuirted CMWs, vaccinators, LHWs and FWAs	CMWs 158(60 under training), 125Vaccinator ,LHWs 1385 , FWAs 77 , Male Mobilizers 55	CMWs 206 , 350 Vaccinator , LHWs 1985, FWAs 129	CMWs 158(60 under training), 125 Vaccinator ,LHWs 1385 , FWAs 77 , Male Mobilizers 55	CMWs 197, 230 Vaccinator , LHWs 1865 , FWAs 119	CMWs 206 , 350 Vaccinator , LHWs 1985, FWAs 129	CMWs 206 , 350 Vaccinator , LHWs 1985, FWAs 129	CMWs 206 , 350 Vaccinator , LHWs 1985, FWAs 129	MNCH Program/National Program/EPI/PWD
1.1.4 Training of more outreach workers from uncovered areas as per mapping	CMWs 158(60 under training), Vaccinator 125 ,LHWs 1385 , FWAs 77 , Male Mobilizers 55	CMWs 48 , Vaccinator 350 , LHWs 600, FWAs 52	60 CMWs under training	CMWs 39, 165 vaccinators, 87 , LHWs 300 , FWAs 42	CMWs 9, 60 Vaccinators , LHWs 300 , FWAs 10			MNCH Program/National Program/EPI/PWD
1.1.5 15 Days Training of Master Trainers in Family Planning (LHVs, LMOs, CMW Tuto	0	4 LHVs/ FWWs, gynaecologists 2, 5 LMOs, 4 CMW Tutors (16= 1 Batch)		Training of 1 Batch (100%)	Refresher Trainings	Refresher Trainings		MNCH Program, DoH, PWD
1.1.5. Trainings on Standard Clinical outlook, procedure and Record keeping of New Contraceptives Methods 11 Gynaecologists, 55 LMOs, 18 FWWs/ 3FWC/ 24 LHVs over 5 years	0	11 Gynaecologist, 55 LMOs, 21 staff Nurses, 18 FWWs/ 3 FWC/ 24 LHVs (Total= 132 (7 batches)		3 batches	4 batches			DoH, MNCH Program, PWD
1.1.6 Training of Officers (Field & Provincial) on Monitoring & Supervision on Manual Developemd by TRF for 4 Days (10 Provincial Officers, 10 DHOs, 10 District Coordinators, 10 PHS, 5 District Population Welfare Officers, 6 District Nutriiton Assistant, 76 LHSs)	0	10 Provincial Officers, 10 DHOs, 10 District Coordinators, 10 PHS, 5 District Population Welfare Officers, 6 District Nutriiton Assistant, 76 LHSs (7 Batches)	0	50 % in 2017	50 % in 2018			DoH, MNCH Program, LHW Program

1.1.7 Refresher Training of LHVs/LHSs on technical and administrative monitoring of CMWs (in Facility and Field on avialble checklist)	0	76 LHSs, 20 LHVs (5 Batches)		76 LHSs, 20 LHVs (5 Batches)				MNCH Program and LHW Program
1.1.8. Construction of Warehouse with all allied facilities	2 EPI Warehouses are under construction	3 (1 for Gilgit, 1 Skardu and 1 for Diamir region)		Need Assessment	100%			DoH and PWD
1.1.9. Provision of Solar Pannels with inverter for insertion lamps for Insertion rooms of Family Welfare center/ RHCs/ BHUs, DHQs and Civil Hospital	0	37 FW center/ 3 RHCs/ 17 BHUs / 5 DHQs/ 28 Civil Hospitals	Assessment of all Health Facilities	Procurement	100%			DoH and PWD
1.1.9. Establishment of RTIs in exsisting HRDCs of Gilgit and Skardu	No RTIs in GB	2	Need Assessment	Established	Functional	Functional	Functional	DoH and PWD
1.1.10. Recruitment of Staff (2 Tutors, 1 Support Staff and 1 Sweeper)	0	2 Tutors, 1 Support Staff and 1 Sweeper		2 Tutors, 1 Support Staff and 1 Sweeper				DoH and PWD
1.1.11. Strengthening of RTIs through Provision of Teaching Aids (Dummies, Menniquin, Demonstration material, multimedia , desk compurters, scanner, lap top etc)	0	2 Set of Teaching Aid		100%	Functional	Functional	Functional	DoH and PWD
1.1.12. Procurment of essential supplies and equipments (As per standard equipment list for MSUs, FWCs and RHS Centers) to Family Planning Service Delivery Project	Partially Equipped	37 FWCs 3 MSUs & 3 RHS centers		37 FWCs 3 MSUs & 3 RHS centers				DoH and PWD
1.1.13. Furnishing of 2 newly established RTI centers in HRDCs (Conference table, Chairs, Curtains, Paint and renovation)	0	2	0	2				DoH and PWD
1.1.14.Upgrading 3 FWCs and 2RHSAs as Model Units	0	3 FWCs and 2 RHSAs	0	3 FWCs	2 RHSAs			DoH and PWD
1.1.15. Repair, Renovation of 10 FWCs	0	10 FWCs (2 Astore, 2 Ghanche, 2 Ghizer, 2 Diamer, 2 Gilgit)	0	5 FWCs	5 FWCs	0	0	DoH and PWD
1.1.16. Establishment of a midwifery training centre in DHQ Chilas	0	1		Needs assesment in 1st Qtr	Established & Functional			DoH and PWD
1.1.17.Printing of recording and reporting tools, Contraceptives Logistic manual and Counselling Material on FP	0	1000	0	1000	0	0	0	PWD
1.1.18 Incraese the incentive for the deployed CMWs	2000	7000	0	158 CMWs	197 CMWs	206 CMWs	206 CMWs	MNCH
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)	**Baseline**	**Target**						
1.2.1 Capacity Building of existing CMWs (refresher courses/short term) Duration One Month	158 (60 under training)	98 CMWs (5 batches) 60 CMWs (3 Batches)	0	2 Batches of deployed CMWs	3 Batches of deployed CMWs	3 batches of CMWs trained in 2016/17	0	MNCH Program

1.2.2 Increase capacity of existing CMW tutors by enhancing technical/clinical skills (10 days)	8	8 (1 batch)	0	8 (1 batch)	0	8 (same batch)	0	MNCH Program
1.2.3 Recruitment of LHSs	76	30	0	15 LHSs	15 LHSs			LHW Program
1.2.4 Salary of LHSs	76	106	76	100	106	106	106	LHW Program
1.2.5 Basic Training of LHS	0	30 (2 Batches)		1 Batch	1 Batch			LHW Program
1.2.6 Vehicles and Drivers for Newly recruited LHSs	0	30		15 Vehicles and Drivers	15 Vehicles and Drivers			LHW Program
1.2.7 Repaire and maintenance of LHSs Vehicles	76			50% Repair	50% Repair			LHW Program
1.2.8 Repair and refurbishing of MSU vehicles	3	3		100.00%				DoH and PWD
1.2.9. Recruitment of LHVs	103	50	32	18				DoH
1.2.10 Salary of LHVs	103	50	135	185	185	185	185	DoH
1.2.11. POL for LHSs Vehicles	76	106	76	91	106	106	106	LHW Program
1.2.12. POL for MSU Camps	5 camps/ district/ month (50 camps)	5 camps/ district/ month (50 camps)	5 camps/ district/ month (50 camps)	5 camps/ district/ month (50 camps)	5 camps/ district/ month (50 camps)	5 camps/ district/ month (50 camps)	5 camps/ district/ month (50 camps)	DoH and PWD
1.2.13. POL for technical supervision of CMWs	0	POL for 20 Vehicles		POL for 20 Vehicles	POL for 20 Vehicles	POL for 20 Vehicles	POL for 20 Vehicles	MNCH Program
1.2.14 Refresher trainings of CMWs on HTSP (3 Days), Nutrition (IYCF (5 Days), CMAM (3 Days)), ENC/HBB (5 Days), Use of Chlorhexidine and misoprostol (2 Days), cIMNCI (6 Days)	158	158 (8 Batches/ Training)	0	Nutrition, ENC/HBB, Use of Chlorhexidine and misoprostol	cIMNCI and HTSP			MNCH Program & Nutrition Cell
1.2.15 Provision of logisitics for cIMNCI, nutrition and contrceptives to the CMWs	0	100%	As per requirement	As per requirement	As per requirement	As per requirement	As per requirement	MNCH Program & Nutrition Cell
Expected outcome 1.3: Improved community routine immunization through involvement of vaccinators with coordination of LHWs/ catchment area	**Routine Immunization coverage by LHWs in LHWs covered areas**		**70%**	**75%**	**80%**	**85%**	**90%**	**EPI Program**
	Baseline	**target**						**EPI Program**
1.3.1 Training/ awareness of LHWs on Routine immunization and referral (6 days class room training)	0%	1385	0	6 Districts	4 Districts			EPI Program
1.3.2 Coordination among Vaccinator and LHWs in routine immunization activities through proper micro planning at catchment area level	**All facilities linked through referral system**		100%	100%	100%	100%	100%	EPI Program/LHW Program
1.3.3 Deployment of trained LHWs as Vaccinators in the respective catchment areas	0	100%		Trained LHWs of 6 Districts	Trained LHWs of 4 Districts			

Expected outcome 1.4: Improved linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI/NBC	**Baseline**	**Target**						
	Fragmented	**Integrated and in place**						
1.4.1 Development of referral network/ Districts and MDSR	not in place	Developed and displayed		100%	100%	100%	100%	DoH and all concerned program
1.4.1a. Notification of Committee of all concerened Programs to develop linkages network			Notification will be done in by end of 2016	Will be Developed in 2017	Functional	Functional	Functional	DoH
1.4.2 Orientation to LHWs, CMWs and HCF staff on referal pathways	0	100%		50%	50%			All concerned program and HFs
1.4.3 Development/printing/provision of referral slips and record keeping formats to the CMWs and LHWs	0	100%		100%				MNCH and LHW Programs
1.4.4 Display of referal linkages pathways in CMWs birth stations, LHWs Health Houses and Health Care facilities	0	100%		50%	50%			All concerned program and HFs
1.4.5 Strengthening linkage between referral unit/LHS/ LHW/ CMW by ensuring supervisory visit of LHS and monthly meeting at Refferal unit.	0	100%		22 visits by LHSs/ Month= 240	22 visits by LHSs/ Month= 240	22 visits by LHSs/ Month= 240	22 visits by LHSs/ Month= 240	MNCH & LHW Program
Expected outcome 1.5: Increase in community demand for RMNCAH and Nutrition services	**% of ANC coverage**							
	Baseline	**Target**						
	73% (PDHS 12-13)	**90%**						**PPHI/ MCHIP**
1.5.1 Development of integrated communication strategy	0	1		Strategy Developed				DoH and Development Partners
1.5.2 Community mobilization and health services awareness on RMNCH and Nutrition through utilization of Local Support Organizations/CBOs	0	8 M			Biannual Meetings	Biannual Meetings	Biannual Meetings	DoH, MNCH, LHW Program and PWD
1.5.2. a. Conduct effective health education and awareness sessions at community (LHWs/CMWs/Health staff/ EPI Vaccinator) in the catchment area of the HCF	Inadequate	1	month in LHWs/ CMWs area/ during outreach and mobile activities	month in LHWs/ CMWs area/ during outreach and mobile activities	Once a month in LHWs/ CMWs area/ during outreach and mobile activities	Once a month in LHWs/ CMWs area/ during outreach and mobile activities	Once a month in LHWs/ CMWs area/ during outreach and mobile activities	MNCH/LHW Program, EPI Program
1.5.2.b. Involment of community elders, relegious leaders, print and electronic media for BCC on RMNCH and Nutrition **(specific days & week)**	Inadequate	Strengthen	100%	100%	100%	100%	100%	MNCH/LHW/Nutrition Program
1.5.3 Provision of E- communication (mobile projectors) IEC material on MNCH, FP and Nutrition to CMWs for health educations sessions	0	100%		To be developed in 2017	100 % Available	100 % Available	100 % Available	MNCH Program
Objective 2: Improve access to and quality of RMNCH care at Primary and Secondary level care facilities								

Anum Rafiq: Number to be added

Anum Rafiq: Number of target to be given

Expected outcome 2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ENC/HBB/NBC/ RH/ CMAM/ IYCF etc (training package) at Primary and Secodnary HCFs	**75% of the HCPs at PHC are trained on PCPNC/IMNCI/ENC skills**							
	Baseline	**Target**						
2.1.1. Capacity building of health care providers at PHC facilities (Pediatrcians/MOs/WMOs/MTs/Paramedics etc) on IMNCI skills	0	15 Pediatrcians/263 MOs & LMOs/01 Paramedic per health facility (Total 278 Pediatrician/ Mos/LMOs -14 Batches) 103 LHVs + 50 Paramedic- 8 Batches **(Total 22 Batches required)**		9 Batches in 2017 (3 Batches per quarter/ region)	9 Batches in 2018 (3 Batches per quarter/ region)	4 Batches in 2019		DoH
2.1.2 Create pool of IMNCI facilitators in GB	14 Master trainers	15 Master trainers (1 Batch)		1 batch				DoH
2.1.3 Conduct follow-up visits 4 – 6 weeks after IMNCI training (2nd part of training) for the trained providers for all components.	0	100%		100%	100%	100%	100%	MNCH Program
2.1.4 Conduct training of Health care provides (Gynecologists/Obstetricians/LMOs/LHVs/Staff Nurses) on PCPNC (7 Days Training)	0	1			50%			MNCH Program
2.1.5 Create pool of PCPNC facilitators in GB (11-14 Days Training)	0							WHO
2.1.6 Conduct training of the HCPs (Gyne &Obs, WMO, MO, Pediatricians, LHVs, staff nurses) on Essential Newborn Care (ENC) (5 Days training) (PLEASE INDICATE NUMBER)		1						WHO/UNICEF
2.1.7 Increase the pool of ENC facilitators at GB level	0							MNCH Program
2.1.8 Conduct training of the HCPs (Gyne/Obs, LMO, MO, Pediatricians, LHVs, staff nurses) on CMAM/ IYCF	20 Trained in IYCF (master Trainers)	1 M P facility (Total 278 Pediatrician/ Mos/LMOs -14 Batches) 103 LHVs + 50 Paramedic- 8 Batches **(Total 22 Batches required)**	Master ainers MAM	6 Batches	6 Batches	6 Batches		MNCH Program
2.1.9 Conduct the training of HCPs (Pediatrician/ MO/WMO/Staff Nurses) on inpatient neonatal care.	3	57 (3 batches)	2 batches of 15 days by UNICEF	1 batch				WH0/UNICEF
Expected outcome 2.2: Strenthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs and provision of supplies	**Availibility of 24/7 cEMONC**							
	Baseline	**Target**						
2.2.1 Provision of essential IMNCI/PCPNC/ENC equipment to all DHQ/THQ/RHCs for establishment of under 5 and Basic EMOC clinics	patchy	100%	Assessment of all Health Facilities for Equipments through Checklist	100%	100%	100%	100%	DoH/MNCH Program/Development Partners
2.2.2 Provision of essential IMNCI/PCPNC/ENC drugs to all DHQ/THQ/RHCs and their inclusion in routine Drug list	patchy	100%	Assessment of all Health Facilities for drug list through Checklist	100%	100%	100%	100%	DHS/MNCH Program/UNICEF
2.2.3 Establish sick newborn care units through provision of equipment and supplies at DHQs	0	6	3	2	1	Functional	Functional	DoH/MNCH Program

Anum Rafiq:
Baseline numbers to b given

Anum Rafiq:
numbrs to be given

Anum Rafiq:
Numbers to be given

Anum Rafiq:
Indicate baseline

Expected outcome 2.3: Improved referral mechanism involving all health care levels to ensure continuum of care	**All level health care facilities linked**							
	Baseline	**Target**						
2.3.1a. Provision of ambulances to HCFs for referral of cases.	**47**	**4**			4			DoH
2.3.1b. Repair & Maintanace of Ambulances								DoH
2.3.2 Establish Web based data base at DHQ/Civil Hospital/RHCs	0	5 DHQ/28 Civil Hospital/2 RHCs		5 DHQs	28 Civil Hospitals & 2 RHCs			DoH & Development Partners
2.3.3 Provision of IT support to establish referral desks and data base	0	1 per DHQ/1 per 28 Civil Hospital/ 1 per 2 RHCs		5 IT support 1 for each DHQs	28 IT support 1 for each 28 Civil Hospital and 1 for each 2 RHCs	Functional	Functional	DoH & Development Partners
2.3.4 Training of the HCPs on maternal and child health referral data recording and dissemination	0	1 per DHQ/1 per 28 Civil Hospital/ 1 per 2 RHCs		5 (1 for each DHQs)	28 (1 for each 28 Civil Hospital) and (1 for each 2 RHCs)			DoH & Development Partners
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**							
	Baseline	**Target**						
2.4.1 Develop/strengthen provincial, District and facility level M&E supervsion plans, ToRs and reporting formats/Checklists	0	Development of Plans, TORs and Reporting format checklist		Plans, TORs and Tools will be developed by Mid of 2017	Implemented	Implemented	Implemented	DoH and all concerned program
2.4.2 Capacity buidling of the M&E and supervsiory tiers on M&E tools	0	All tiers			100% Training			DoH and all concerned program
2.4.3 Review of the M&E feedback reports and reccomendation.	Quarterly review meeting in Place	Strengthen Quarterly review meeting	2 quaterly review meeting held	quaterly review meeting	quaterly review meeting	quaterly review meeting	quaterly review meeting	DoH and all concerned program
2.5. Availibility of comprehensive quality EPI services as part of RMNCAH/Nutirtion services package at all PHC level facilities	**Increase in EPI coverage in the**							
	Baseline	**Target**						
2.5.1 Ensuring required resources for EPI programme as per PC1 and cMYP	PC-1 approved and cMYP endoresed	Persue and Ensure implementation		100% Implementation as per plan	100% Implementation as per plan	100% Implementation as per plan	100% Implementation as per plan	EPI Program
2.5.2 Establish new EPI fixed centers in selective Health Facilities	111	60	PC-1 Approved	30 centers	30 Centers	Functional	Functional	EPI Program

2.5.3 Hiring of Vaccinators and training	125	120 (2 per fixed center) (1 for each fixed center and one for out reach activities)		60 Vaccinators	60 Vaccinators			EPI Program
2.5.4 Hiring of cold chain technician and their training	2	1 Technician per district, 2 for 3 regions (Total 16)		Hiring and training completed				EPI Program
2.5.4 Provision of solar ILRs and cold chain equipments to all PHC facilities	Solar ILRs in 2 districts and inadequate cold chain equipment in all districts	To cover all 10 Districts		Will be provided in phase manner		100% Functional	100% Functional	EPI Program
2.5.5 Ensuring timely availability of EPI vaccines as per updated schedule	100%	100%	100%	100%	100%	100%	100%	EPI Program
2.5.6 Strengthen periodic review of EPI performance at various levels	Inadequate	Strengthen		quaterly review meetings at regional level and monthly review meetings at district level				EPI Program
2.5.7 Development of the training plan and Refresher trainings (enhacement of skills and data recording and reporting) of the staff (3 days)	0	125 (6 batches)		6 batches				EPI Program
2.5.8 Ensure printing and availabilityof all reporting and recording tools	Inadequate	all Tools available		100%	100%	100%	100%	EPI Program & development partners
2.5.9 Vehicles/Motor bikes for mobility of Vaccinators	0 (Vaccinators are using their personnel transport)	350		164 Bikes will be provided under NISP	186 Bikes	100%	100%	EPI Program & development partners
2.5.10 POL requirement for mobility of Vaccinators	Claiming TA	35 Liters/ bike		Implemented	Implemented	Implemented	Implemented	EPI Program
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions								
	Establishment of institutionalized							
	Baseline	**Target**						
3.1.1. Food supplementation for preganant and lactating mothers visiting health facility for ANC	0	Pilot in 2 under previledged districts		Develop Proposal and share with line department and development partners	Implemented	Implemented	Implemented	Nutrition Cell, Line departments and development Partners

3.1.2. National Health Insurance Program	1 districts supported by KfW and 4 by Prime Minister Program	1 districts supported by KfW and 4 by Prime Minister Program		100%	100%	100%	100%	Prime Mister Program and KfW
Objective 4: Increase in funding and allocation for RMNCAH								
Expected outcome 4.1: Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	**Increase in the government fund**							
	Baseline	**Target**						
4.1.1.Establish Coordination Committee & conduct Quarterly Meetings of Coordination Committee of all Stake Holders	0	Establish 1 Coordination Committee		Establishment and notification of coordiantion committee in first quarter				DoH and PW
4.1.2.Bi annual advocacy/Consultative Meetings with stakeholders and partners on Financial & Implementation Strategy	0	2 Meetings per year		2	2	2	2	DoH and PW
Expected outcome 4.2: Improve in mechanism and capacity of the GB to absorb and utilize the available resources	**Timely release of the funds to the**							
	Baseline	**Target**						
4.3.1 Development and reconcilliation of the annual Budgeted Work Plan/ Cash Plan for the RMNCAH/EPI/LHW/Nutrition Programs with the strategic plan for timely implementation	Already in place	Continue (Reconcillation with the strategic plan)						DoH and PW
4.3.2 Development/ Adaptation of manuals for Account Management (DDOs and Account Officers)	0	1 Manaul comprising of portions of DDOs and Account officers/account supervisors/casheirs		Develop Manual by first half of 2017				DoH and PW, Development Partners
4.3.2 Capacity buidling of the DDOs and their Account Officers on efficient uitlization of available funds, monitoring of resources and audits (5 Days Training)	0	**DDOs:** DHOs 10, DDOs of PW 7, MS 7, Programs 5. 3 in Directorate (Total 34) **Accounts Officers:** PW 6, 10 Districts, 7 MSs, 7 Programs, 8 Civil Hospitals, 3 Directorates (Total 41) (Grand Total: 75)		in Second half of 2017 (3 Batches)				DoH and PW
Objective 5: Improve Reproductive Health including family Planning								
Expected Outcomes 5.1: Enhanced coordination of Population Welfare and Health department and functional intergartion of RH/FP and RMNCAH sevices	**Integration of the FP and**							
	Baseline	**Target**						
5.1.1 Bianuual meetings of steering committee for Health & Population Welfare to oversight/review for better coordination in planning, procurements and service delivery (health mnagement committee)	0	2 Meetings per year		2	2	2	2	DoH and PW
5.1.2 Integration of the family planning and RMNCH & N services and MIS at service delivery levels (RHS and FWC integration with Health Care Facilities in the catchment areas) i.e. provision under one roof in Health facilities								
5.1.3 Provision of FP supplies for RH and FP to all level integrated FP/RMNCAH	0	Integrated forcasting for provision of FP		Integrated forcasting for provision of FP supplies				DoH and PW

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) practices in GB	**% increase in coverage of IYCN**							**FATA Nutrition Cell**
	Baseline	**Target**						
6.1.1.Annual celebration of Breast Feeding Week (August)	1 Regional & 10 Districts	1 Regional & 10 Districts	1 Regional & 10 Districts	1 Regional & 10 Districts	1 Regional & 10 Districts	1 Regional & 10 Districts	1 Regional & 10 Districts	MNCH, LHW Program, Nutrition Cell and DoH GB
6.1.2. Notification of Regional Infant Feeding Board and conduction of Annual Meeting	0	1	1	1	1	1	1	
6.1.3. Implement National IYCF communication Strategy	Strategy in place	Implementation	Endorsed	Initaite implementation Startegy				
6.1.4. Implement GB Multisectoral Nutrition Stategy	Nutrition Strategy Approved	Strategy to be implemented		Implemented				
Expected Outcome 6.2: Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade 1-5), adolescent girls and pregnant/lactating women(PLW) in GB	**Baseline**	**Target**						**GB Nutrition Cell**
6.2.1: Provision of multiple micronutrient powder for home fortification for all children 6-59 months thorugh LHW	0							DoH/LHW Program/Nutrition Cell
6.2.2 Training of LHWs on usage of Mutilmicronutriteint powder all children 6-59 months and Iron/Folic Acid for PLWs and adolescent girls (2 Days Training)								
6.2.3: Biannual deworming of all children 2-5 years of age through mother and child week	In all 10 Districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	
6.2.4: Biannual Vitamin-A supplementation with NIDs for all children < 5 years	In all 10 Districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	Continue in all 10 districts	
6.2.5: Promoting use of Iodized Salt through awarness campaign	Celebrate International IDD Day per Year	Celebrate International IDD Day per Year		Celebrate International IDD Day per Year	Celebrate International IDD Day per Year	Celebrate International IDD Day per Year	Celebrate International IDD Day per Year	
6.2.6 Regular Market analysis to ensure Iodized Salt availability	Monthly in all 10 districts	Strengthen and continue	Strengthen and continue					
6.2.7: Intermittent iron/folic acid (IFA) supplementation for adolescent girls through LHWs	Patchy	In all 10 districts		100%	100%	100%	100%	
6.2.8: Zinc supplementation for children of age 6-59 months through LHWs	inadequate supply of Zinc supplementation to LHWs	ensure regular supply to all LHWs through Nutriiton Cell		100%	100%	100%	100%	
6.2.9 Updating and Printing of "Sehat ki Dastak" for all LHWs (trainers and trainee manual)	0	2500		Updating and Printing				
6.2.10: Refresher training on "Sehat ki Dastak" for all LHWs of GB (3 Days)	0	1385 LHWs + 76 LHSs (Total 1500 = 60 Batches)			100%			

Expected Outcome 6.3: Enhanced assess of local community to life saving nutrition services for acute malnourished children in GB	**% decrease in Global Acute**							**GB Nutrition Cell**
	Baseline	**Target**						
6.3.1: Establishment and Fuctionalization of inpatient nutrition services (Stabilization Centers) in DHQs	0	5 SC	1 SC(with the support of WHO in Gilgit)	Establish 2 SC in DHQs Skardu & Diamer	Establish 2 SC in DHQs Ghizer & Ghanche	Functional	Functional	DoH and development partners
6.3.2: Establishment and Fuctionalization of outpatient nutrition services (SFP and OTP Centers)	0	28 Civil Hospitals and 3 RHCs		50%	50%	Functional	Functional	
6.3.3 Establishment and Fuctionalization of Breast Feeding Corners	0	5 DHQs, 3 RHCs, 28 Civil Hospitals and 17 BHUs		50%	50%	Functional	Functional	
6.3.3. HR at Provincial/Reginal and District level	1 Nutrition Officer at Provincial Level, 2 Nutrition Officers at district level, 6 Nutrition Assitants	Director and Deputy Director and 1 Training Coordinator at Provincial Level, 8 District Nutrition Officers, 36 Nutrition Assitants at DHQs, Civil			100%			DoH/Nutrition Cell
6.3.4. Nutrition Supplements for SFP/OTP Centers/NSC (RUSF,WSB/FBF,OIL/RUTF,F-75, F-100,ResoMal,MM Tabs,MM Sachets, Iron/Folic ACID)	0	31 Health Facilities		8 Health Facilities	15 Health Facilities	8 Health Facilities		DoH/Nutrition Cell
6.3.4a.Costing and Procurment of Nutrition Supplements (RUSF,WSB/FBF,/RUTF,F-75, F-100,ResoMal,MM Tabs,MM Sachets, Iron/Folic ACID)	0	100%	100% Costing	Procurement		100% available		DoH/Nutrition Cell
6.3.5. Procurement of Equipments/Instruments for SFP/OTP Centers (Uniscale, Height/Length Board, MUAC Tapes for Children/PLWs)	0	31 Heath Facilities		8 Health Facilities	15 Health Facilities	8 Health Facilities	Functional	DoH/Nutrition Cell
6.3.6. Equipments/Instruments for NSC (Complete NSC Kit)	0	5 SC	Maintain 5 SC	1 SC	2 SC	2 SC	Functional	DoH/Nutrition Cell
objective 7: Investing in addressing in social determinants of Health								
Expected Outcome 7.1: Health Friendly Multi Sectoral Policies and Practices adopted (Health, education, public health engineering, social walfare, Women Development Deparment, Agriculture Department, Food Department, NGOs, civil society and PPP).	**Integrated mechism to address the**							
	Baseline	**Target**						
7.1.1.Establish Multi Sectoral Coordination Committee at GB Level with well defined TORs (biannual Meeting)	0	8 Meetings		2	2	2	2	Initiation by DoH under approval of Chief Secretary Health

7.1.2. Involvement of parlimentarians, politicians/ religious leaders, human rights activists, teachers and other civil society through seminars/ official meetings to link RMNCAH & Nutrition/Mental Health issues in their slogans and campaigns to address social determinants in Health	0	1 Meeting/Year	1	1	1	1	1	DoH and PW
7.1.3 Establish Health/education Promotion cell at Directorate Level	0	1		Functional	Functional	Functional	Functional	DoH and PW and Nutrition Cell
Expected outcome 7.2: Laws inplace supporting mandatory female education, Birth/Death registration and marriage registration	**Baseline**	**Target**						
7.2.1 Advocacy and registration of each and every birth/Death	0	1 advocacy seminar/year	1	1	1	1	1	DoH and PW
7.2.2 Advocacy for Female education and marriage registration	0	1 advocacy seminar/year	1	1	1	1	1	DoH and PW
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 establish DHIS system inclusive of all indicators on RMNCAH, Nutrition and other programs	0	1 Committee		Need based meetings to develop/adopt DHIS system	Review and updating DHIS	Review and updating DHIS	Review and updating DHIS	DoH and HMIS cell
8.1.2. Training of Master Trainer District wise (DHIS) (4 Days)	0	5 Person at provincial level and 2 per district (1 Batch)		1 Batch trained		refresher training of 1 batch		DoH and HMIS cell
8.1.3. Training of Facility staff (DHIS) (3 days)	0	2 Staff per 5 DHQs, 1 staff per 28 CH, 1 staff per 3 RHCs, 1 staff per 17 BHUs, 1 staff per 169 rural dispensaries, 1 Staff per 90 MCH centers, 1 staff per 134 FAP (Total=451= 23 Batches, 20 participant per batch)		23 Batches complete		Refresher Training		DoH/HMIS cell
8.1.4 Quarterly performance Review meetings on DHIS at District level	0	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	DoH/HMIS cell
8.1.5 Monitoring of health facilities in regard with DHIS reporting	0	Develop Plan	As per plan	As per plan	As per plan	As per plan	As per plan	DoH/HMIS cell
8.1.6 Establish E-Reporting system	0	1 No		By mid 0f 2017				DoH/HMIS cell
8.1.7 Provision of Printed Material i.e DHIS Tools and instruments for		Ensure 100%						DoH/HMIS cell

8.1.5 Monitoring of health facilities in regard with DHIS reporting	0	Develop Plan	As per plan	As per plan	As per plan	As per plan	As per plan	DoH/HMIS cell
8.1.6 Establish E-Reporting system	0	1 No		By mid 0f 2017				DoH/HMIS cell
8.1.7 Provision of Printed Material i.e DHIS Tools and instruments for routine reporting	Patchy	Ensure 100% availability		On Going				DoH/HMIS cell
8.1.8. Adapt WHO Maternal and New Born Death Audit Guidelines, Protocols,Refrrals SOPs,Recording & Reporting Tools (2 Selected Districts)	0	Pilot in 2 Districts			2 Districts			DoH/WHO
8.1.9. One day orientation/Sensitization meetings with stake holders on Maternal and New Born death Audit (Local Councelors, Religious Leaders, Media, Teachers, Mothers Support Group etc)	0	Pilot in 2 Districts			2 Districts			DoH/WHO
8.1.10. 3 Days trainings of Health Care Providers (Gynacologist, M/F Medical Officers, LHVs, LHSs,CMWs) in Maternal and Newborn death	0	Pilot in 2 Districts			2 Districts			DoH/WHO
8.1.11. Develop Policy brief on Maternal & Newborn Death Audit	0	Pilot in 2			2 Districts			DoH/WHO
Objective 9: National accountability and oversight								
Expected Outcome 9.1: Effective oversight mechanism of the RMNCAH/N Program in place.	**Monitoring and supervision**							
	Baseline	**Target**						
Expected Outcome 9.1. Improve Governeness and Accountibility	0							
9.1.1. Formulation of oversight Committee Chaired by Secretary Health and PW to review Performance and outcomes (Bi Annual Meetings)	0	Formulate Oversight Committee and conduct meetings		Formulate Oversight Committee	Biannual Meetings	Biannual Meetings	Biannual Meetings	DoH and PW
9.1.2.Development of accountibility Framework	0	Frame Work Develop		Frame Work Develop				DoH and PW
9.1.3.Link the Monitoring and Evaluation reports for accountiblity framework	0	Quarterly Reports		Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	DoH and PW
9.1.4. Implementation of Quality assurance tools at all level	0	Development of Tools		Development of Tools	Implemented	Implemented	Implemented	DoH and PW
Objective 10.Generation of the Political will to support RMNCAH & Nutrition as a key prority within sustainible develpoment goals								
Expected Outcome: 10.1. Awareness about SDGs on Health and Population among Policy Makers and Parlimentarian								
10.1.1. Establish SDG Unit and SUN unit under P&D GB	0	1 SDG Unit and 1 SUN unit		Notify Committee	Functional	Functional	Functional	P & DD
10.1.2. Establish SDGs goal 2 & 3 Health Cell under DoH and PW GB	0	1 (Quartrly Review Meetings		Notify Cell + 4 Meeting	4	4	4	DoH and PW
10.1.3. Advocacy and Awareness oreientation of Policy Makers and Parlimentarian on Health, Population and Nutrition Issues	0	1 advocacy seminar/year/ region	0	3 Seminars	3 Seminars	3 Seminars	3 Seminars	DoH and PW
10.1.4.Engagemnt of religiuos scholors, Media to address Myths and Misconception on Health RMNCAH & Nutrition Population Issues	0	1 advocacy seminar/year	0	1	1	1	1	DoH and PW

8.1.9 Provision of Printed Material i.e DHIS Tools and instruments for routine reporting	100% availabl e	Ensure 100% availability	On going					
8.1.10 Training for Managers at each level on use of information (5 Persons/Agency/FRs + 10 from Regional Level)	0	75 (18/Batch) 4 Batches	0	2 Batches	2 Batches			DHS
8.1.11. Equipment/Furniture required for Agency Headquarter Hospitals/Agency Sugreons and DHIS Cell DHS FATA		23 offices/DHIS cells		Available as per need				DHS
8.1.12. Adapt WHO Maternal and New Born Death Audit Guidelines, Protocols,Refrrals SOPs,Recording & Reporting Tools (2 Selected Agencies AHQ Hospitals of Bajaur and Khyber)	0	2 Agencies in FATA	1 AHQ in 2016	1 AHQ in 2017				WHO/DHS
8.1.13. One day orientation/Sensitization meetings with stake holders on Maternal and New Born death Audit (Local Councelors, Religious Leaders, Media, Teachers, Mothers Support Group etc)	0	2 Agencies in FATA	100%					WHO/DHS
8.1.14. 3 Days trainings of Health Care Providers (Gynacologist, M/F Medical Officers, LHVs, LHSs,CMWs) in Maternal and Newborn	0	26	50%	50%				WHO/DHS
8.1.15. Develop Policy brief on Maternal & Newborn Death Audit	0	100%	100%					WHO/DHS
Objective 9: National accountability and oversight								
Expected Outcome 9.1: Effective oversight mechanism of the RMNCAH/N Program in place.	**Monitoring and supervision**							
	Baseline	**Target**						
Expected Outcome 9.1. Improve Governeness and Accountibility	0							
9.1.1. Formulation of oversight Committee Chaired by Sectory Socail Sector 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 Develop					
9.1.3.Link the Monitoring and Evaluation reports for accountiblity framework	0	Quarterly Reports	Quarterly Reports					
9.1.4. Implementation of Quality assurance tools at all level	0	Development of Tools	Development of Tools					
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 P&D FATA	0	1	Notify Committee					
10.1.2. Establish SDGs goal 2 & 3 Health Cell under DHS FATA	0	1 (Quartrly Review Meetings	Notify Cell + 1 Meeting	4	4	4	4	
10.1.3. Advocacy and Awairness oreientation of Policy Makers and Parlimentarian on Health and Population Issues	0	1 advocacy seminar/year	0	1	1	1	1	
10.1.4.Engagemnt of religiuos scholors, Media to address Myths and Misconception on Health RMNCAH & Nutrition Population Issues	0	1 advocacy seminar/year	0	1	1	1	1	