Khyber PakhtunKhwa

Provincial RMNCAH&N Strategy (2016-2020)

Khyber

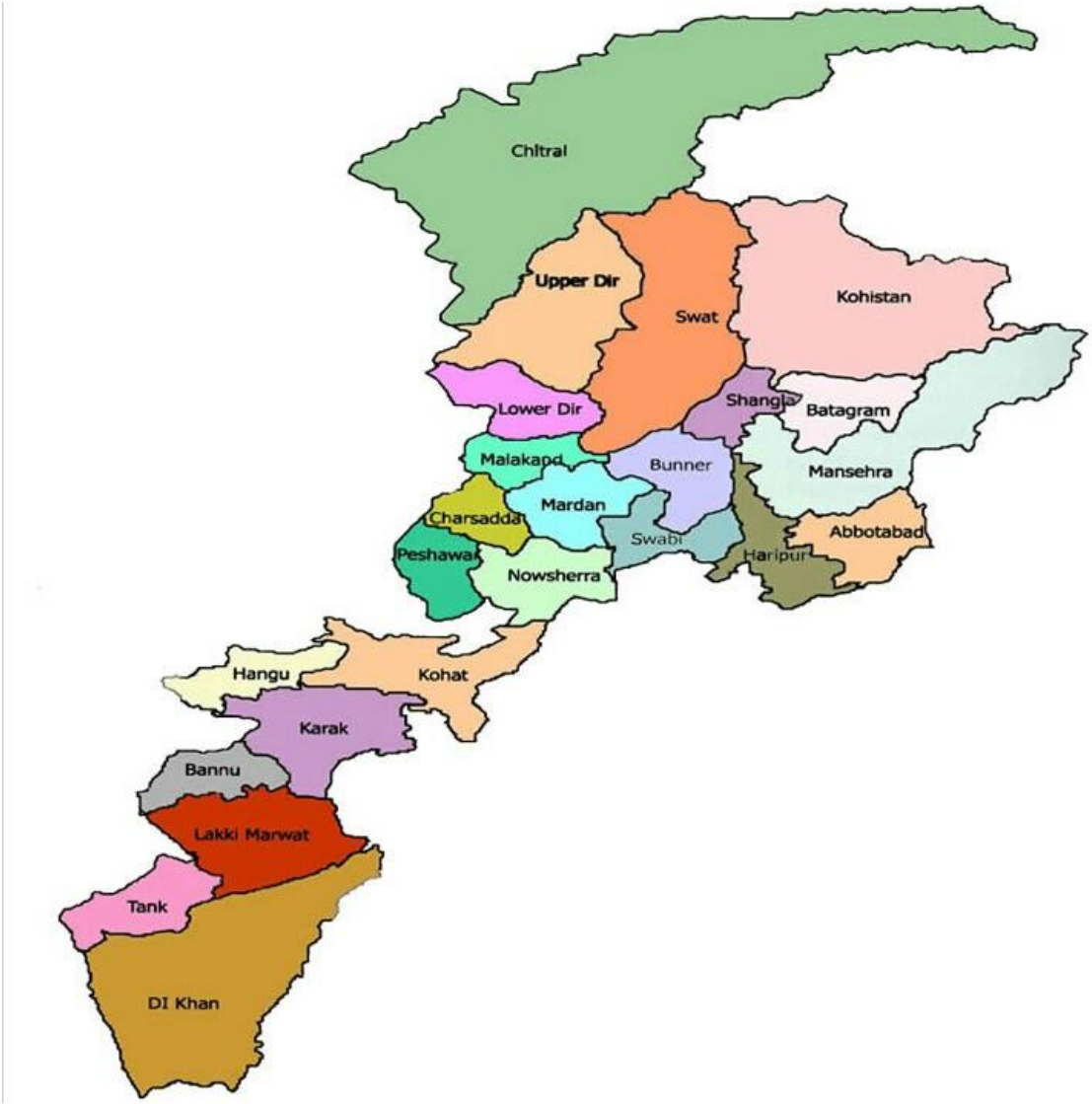
PakhtunKhwa provincial vision

for ten priority actions to address challenges of

reproductive, maternal, newborn, child, adolescent

health and nutrition

MAP OF KHYBER PAKHTUNKHWA



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 System
ENAP	Every Newborn Action Plan
ENC	Essential Newborn Care
EmONC	Emergency Obstetric & Newborn Care
EPI	Expanded Program on Immunization
FATA	Federally Administered Tribal Areas
FP	Family Planning
GIS	Geographic Information System
HCF	Health Care Facility
HCP	Health Care Provider
HIV	Human Immuno-virus
IMR	Infant Mortality Rate
IMNCI	Integrated Management of Newborn Care
IRMNCAH&N	Integrated Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition
IUCD	Intra-Uterine Contraceptive Device
KPI	Key Performance Indicator
LHs	Lady Health Supervisor

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

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

MESSAGE: SECRETARY HEALTH,

KHYBER PAKHTUNKHWA

I am pleased to express my gratitude towards the department of Health, Khyber Pakhtunkhwa, Population Welfare Department Khyber Pakhtunkhwa and UN Partner (WHO, UNICEF and UNFPA) for playing their role in the development of RMNCAH and Nutrition Action Plan 2016-2020. I also thank the Ministry of National Health Services Regulation and Coordination, for its pivotal constitutional role of regulation and coordination, needed to carry out effective consultation during the development processes. Moreover, the efforts of the two consultants Dr. Riaz Solangi and Dr. Mohammad Ishaq Khan Mohmand are also highly appreciated in the development of the RMNCAH and Nutrition Strategy 2016-2020 for the province.

The Department of Health Khyber Pakhtunkhwa is looking forward to own the RMNCAH and Nutrition Strategy 2016-2020 for bringing improvement in RMNCAH and Nutrition services delivery at all levels of health care in the province. I am hopeful that the RMNCAH and Nutrition Strategy 2016-2020 Khyber Pakhtunkhwa would help us in resource mobilization for RMNCAH and Nutrition programs. This document also holds strategic position for guidance to the Department of Health in planning, programming, implementation and monitoring and evaluation of the programs. The strategy is practical example of integration and multi-sectoral approaches adopted at the policy and programming level in the province.

Abid Majeed

Secretary Health, Department of Health, Khyber Pakhtunkhwa

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.

Despite the fore-mentioned hurdles, the health indicators of Pakistan have shown encouraging improvement over the last decade. A major strength of the government's health care system in Pakistan is an outreach primary health care, delivered at the community level through Lady Health Workers (LHWs) and community midwives (CMWs). The government's commitment to the devolution process has also capacitated the provinces and regions to formulate and implement indigenous solutions to local problems.

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

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

EXECUTIVE SUMMARY

In Pakistan Health care provision is traditionally the responsibility of the government. Under the 18th amendment to the constitution, the government has devolved a number of ministries to the provinces including Health and Population Welfare. This provides the provinces, including Khyber Pakhtunkhwa, 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 Province This has in turn put intense pressure on an already over-burdened health care system; leading to high rates of maternal and child mortality in the Province. Communicable diseases, maternal health issues and under-nutrition dominate and constitute a major portion of the burden of disease in Khyber Pakhtunkhwa.

The MNCH program of the department of health, Khyber Pakhtunkhwa has made concerted efforts to strengthen the health system through improvements in institutional arrangements and integration of various programs; especially at the district level by, implementing an integrated essential health services package which is the cornerstone of this process. The Integration of the MNCH, Nutrition and Family planning into an IRMNCAH&N program, Integration Health Information System, implementation of a health insurance scheme and the chief ministers conditional cash transfer scheme for pregnant women major successes amongst other achievements. These efforts have brought about a considerable betterment in the health of Khyber Pakhtunkhwa.

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 Khyber Pakhtunkhwa provincial RMNCAH&N strategic action plan.

The provincial Integrated 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.

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

The provincial 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 provincial health care system.

Core components of the Khyber Pakhtunkhwa provincial strategy include:

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

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

c) Improving financial accessibility to reduce barriers to care seeking by the most vulnerable segments of the community will be achieved through developing and strengthening the government's conditional cash transfer scheme called 'the Chief Minister's Initiative for women and children' and the Social health insurance scheme to provide safety nets for the most vulnerable community members and households.

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

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

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

The strategy also includes a detailed Financial Action Plan which serves as a resource mobilization tool which could be used comprehensively for mobilizing political commitment and financial resources at the national level or for garnering donor support. It is estimated that for implementing the RMNCAH plan in the Khyber Pakhtunkhwa province an amount of PKR 32,686,114,889 will be required over a period of five years (2016-2020).

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

BACKGROUND

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

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

The National Vision Action Plan, developed on directions of the Prime Minister with ten priority areas, is a dynamic document and is leading to a mechanism for national consensus on important issues around RMNCAH and Nutrition. The objectives of the plan are also in line with global commitments for reproductive, maternal, newborn, child, and adolescent health such as the updated 'Global Strategy for Women's Children and Adolescent Health 2016 -30' and the SDGs. All provinces, regions, partners, line ministries, academics and international experts in Pakistan have contributed to and endorsed the action plan in order to take the process forward. The 'Ten Point Agenda' was launched on 13th May, 2015 aiming to identify priority areas of health interventions that would enhance action for mothers and children of Pakistan.

Khyber Pakhtunkhwa province have developed concrete action plans to further operationalize these ten priority actions into a comprehensive strategy to serve the purpose of advocacy, resource mobilization and provide guidance in implementation during 2016-2020.

[2] *PDHS 2012-13*

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

SITUATIONAL ANALYSIS

Khyber Pakhtunkhawa is comprised of 74,521 sq km and the population has increased from 17.7 million in 1998 to 22.2 million in 2009. The average household size is 8. In addition it is [4]estimated that there are more than 3 million Afghan refugees living in the province. Over half the population is illiterate and 31 percent of the population is living below the poverty line with the highest levels of poverty in Shangla, Upper Dir, Buner, Kohistan and Battagram. There is also a wide variation between districts in resource allocation, disease prevalence, malnutrition, gender inequality and illiteracy. Only 47% of the households have tap water and 61% have safe sanitation10 leading to a high prevalence of water borne diseases.[5]

Despite the adverse conditions in the province, child mortality rates are better than the national average. The neonatal mortality rate is 41 per 1000 live births, while the infant mortality rate is 58 and under-five mortality rate is 70. The attendance of skilled birth attendants (SBAs) at delivery has increased significantly from 28 % in the MICS 2001 to 41% in the MICS 2008. At present only 60% of women in the province receive any form of ante-natal care and only 37% are receiving any form of post-natal care from a SBA (MICS 2008). The new community midwife scheme will require ongoing support from the DoH for the training, deployment and establishment of community midwives (CMWs) in their communities. In 2008 there were 737 CMWs students training under the Maternal and Neonatal, Child Health (MNCH) program and 22 graduated CMWs had been deployed to their villages in the province. A survey showed that emergency obstetric care (EmOC) services are available at only 34% of hospitals.

Table 1: Key Indicators of Khyber Pakhtunkhwa

Total population	17,7m
Population – Urban : Rural	16.9 : 83.1
Annual growth rate (1981-1998)	2.82
Adult literacy rate – Aged 15 yrs. & older	66 :29
Neonatal mortality rate/1,000 live births	41
Infant mortality rate/1,000 live births	58
Under 5 mortality rate/1,000 live births	70
Maternal mortality ratio/100,000 live births	275
%age delivered by a skilled provider	48.3
%age delivered in health facility	40.5
%age receiving antenatal care from a skilled provider	60.5
%age of women with a postnatal checkup in the first 2 days after birth	37.7
Fully immunization (12-23 m based on recall and record)	39.7
Tetanus toxoid (%age receiving two or more injections during last pregnancy)	51
Total fertility rate (15-49 yrs)	3.9
Contraceptive prevalence rate	28.1

Source: PSLM 2014-15, PDHS 2012-13

There is a lack of public awareness, health seeking behavior and availability of treatments for conditions such as cancer, mental illness, ophthalmologic disease, obesity and related illnesses, hypertension and cardiac conditions. There is also low level of service provision, equipment, and availability of staff to address NCDs including a lack of laboratory services at the district level for routine investigations. There is also no radiation machine for the treatment of cancer in the public facilities of the province.

4 http://www.pbs.gov.pk/

[5] Khyber Pakhtunkhwa Health Sector Strategy 2010-2017

CHALLENGES & CONSTRAINTS `

There are several challenges experienced by the health sector in Khyber Pakhtunkhwa. The issue of regulating the private health sector and stewardship of the whole system are concerns that need special attention. Women and children are particularly disadvantaged by socioeconomic and cultural barriers with estimates of only 30% of them having access to medical care[6]. Public as well as private services focus on curative care, with little attention to promotive, preventive or rehabilitative care. In addition, there is little known about the community's priorities in relation to primary health care services. Chronic staff shortages and non-availability of essential medicines is common and leads to health facilities being underutilized due to shortages of staff and supplies.

Recently the DoH has faced multiple challenges due to the law and order situation in the province. The DoH has had to respond to the manmade or natural disasters; maintain routine services at the district level and provide services to internally displaced persons (IDPs).

At the peak of the insurgency in the past three years around 2.7 million civilians were displaced due to militancy. There is a lack of capacity both at the provincial and the district level to respond to emergencies, epidemics and disasters appropriately. There are only a small number of ambulances available, often without trained staff. In affected areas, nearly a third of health facilities including hospitals, Rural Health Centers (RHCs) and Basic Health Units (BHUs) are damaged. Provision of emergency services is hampered by 44% of the provincial roads and 78% of district roads being in poor or bad condition. Demand for emergency services has increased after the 2005 earthquake, bomb blasts resulting in mass casualties, and the increase in road traffic accidents. While services for rehabilitation, including the provision of orthotics and artificial limbs have improved, demand is far from being met.

Where there is no local facility within the community, the average distance to a health facility is about 10 kilometers in rural areas, roughly three times the distance in urban areas. Given the size of the rural population in Khyber Pakhtunkhwa, there should be over 380 RHCs and over 1280 BHUs. There are however, only 86 RHCs and 784 BHUs, in the province.[7]

The failure of the referral system contributes to the underutilization of primary healthcare facilities, resulting in high unit costs. This failure can be attributed to health worker attitudes in addition to social, economic and organizational factors which need to be understood. Weak organizational and functional linkages between the district health officers and the medical superintendents of District Headquarter

(DHQ) hospitals, contributes to a lack of integration between primary and secondary level health services.

[6] *KPK Health Sector Strategy2010- 17*

[7] *DHIS KPK, 2010*

OPPORTUNITIES

After devolution, Khyber Pakhtunkhwa is the first province to develop a Health Sector Strategy (2010-2017) entailing a responsive health system to improve the health status of the population. High priority is also given to dealing with emergency situations and disaster risk reduction and management. Its approach focuses on enhancing coverage, improving human resource management, governance and regulating the health sector. Implementation of the Minimum Health Services Delivery Package for primary and secondary level is of prime focus.

The Health Sector Reform Unit (HSRU) of the province is taking the lead on these reforms. A robust monitoring mechanism, headed by the Health Secretary, is already operational; development of an integrated PC-1 and other pilot interventions undertaken indicate good progress in the implementation of the Strategy which is aligned with the overall Comprehensive Development Strategy (CDS 2010-2017).

The National MNCH Program, KPK, was initiated in 2007 with a life-span of 6 years, and was aimed at improving the delivery of better health care facilities to women and children of NWFP and ensure progress toward achieving the Millennium Development Goals in maternal and child health.[8]

Chief Minister of KPK's initiative for women and children whereby cash incentives are offered to pregnant mothers for attending anti-natal clinics, birthing at a government health facility as well as for post natal visits. Similarly, The Government of Khyber Pakhtunkhwa, committed to improving the access of the people to quality Healthcare Services, has launched a Social Health Protection Scheme which will enable the people of the province to have improved access to quality health care services. It covers costs for hospitalization including child birth; common diseases of childhood; injuries and accidents; common surgeries and medical ailments. The Micro Health Insurance Scheme, administered by the State Life Insurance Corporation of Pakistan is a step towards providing social safety net to the most vulnerable segments of the community. The scheme has been launched initially in the Districts of Mardan, Malakand, Kohat and Chitral.[9]

[8] http://health.kp.gov.pk/page/national_maternal_newborn_child_health_program_nwfp
[9] http://health.kp.gov.pk/page/social_health_protection_initiative

IMPLEMENTATION APPROACH FOR RMNCAH&N STRATEGY

The provincial Integrated RMNCAH&N strategy 2016 -2020 follows the vision and goal of the of The National Action Plan for RMNCAH&N and pursues the ten priority action areas; identified in the national vision document, as its objectives 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 of mapping will be carried out to identify uncovered areas of both CMWs and LHWs in Khyber Pakhtunkhwa province. It will ensure that 80% population will be covered through LHWs in the targeted districts to provide outreach services by these community health workers; in a phased manner till 2020.

To address the issues of access to RMNCAH&N services, additional outreach staff such as LHWs, FMWs, MMWs, Vaccinators and CMWs will be recruited for the areas left uncovered by existing health workers in the province. The new recruits will also be provided with necessary training, furniture, equipment, kits, CMW & LHW supplies, logistics and transportation cost to facilitate the establishment of CMW birthing station and LHW Health House.

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

Provision of comprehensive services for Malnourished at community level (CMAM, 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 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 Government of KPK has initiated the conditional cash transfers (CCT) initiative of the Chief Minister of KPK whereby cash incentives are offered to pregnant mothers for attending anti-natal clinics, birthing at a government health facility as well as for post natal visits. Similarly, the social health insurance schemes; a Micro Health Insurance Scheme, administered by the State Life Insurance Corporation of Pakistan is a step towards providing social safety net to the most vulnerable segments of the community. The scheme has been launched initially in the Districts of Mardan, Malakand, Kohat and Chitral where the poorest 21% population will be served. The scheme will be expanded to provide equity based health insurance coverage to the vulnerable and marginalized groups in other dis-

tricts as well. The strategy also envisages developing forums for consultations with potential support structures such as donor agencies and stakeholders.

4: Health system strengthening

The mother and child health care, prevention and management of RTIs/STIs and HIV/AIDS, management of reproductive health related issues of adolescent boys and girls, other RH related issues of men and women, management of Infertility and early detection of breast and cervical cancers by promoting self-examination. 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 circumstances.

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

The coordination between provincial and district procurement units will be further enhanced to ensure continued supply and availability of contraceptives. Coordination will also be improved between nutrition and MNCH program for effective planning and utilization of resources. Management and oversight of the activities of the RMNCAH&N action plan will be achieved through the implementation of an M&E framework, supported by development of plans, ToRs, reporting formats and checklists. Field supervisory tiers will be strengthened and supported at multiple administrative levels. The supervisory staff will be provided mobility and supplies as well as appropriate training for the monitoring protocols and reporting procedures.

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

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

Governance and accountability will be achieved through development of accountability framework as well as oversight committees (functioning under supervision of the highest political level), development and implementation of quality assurance tools and protocols, establishing of an SDG cell with effective ToRs. Regular awareness, advocacy and orientation of the politicians and parliamentarians on the one hand and demand creation at the community level will support the effective streamlining of RMNCAH&N strategy as a priority agenda in achieving the SDG goals.

5: Social mobilization

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

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

The various activities contributing to achievement of sustainable development goals will be branded and meetings will be organized with friends of FWCs for promotional and awareness purposes. Television commercials will be developed, produced and aired through TV, FM radio & video on wheels to raise awareness on family planning.

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

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

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

6: Monitoring & Supervision:

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

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

OUTLINE OF MONITORING & EVALUATION PLAN

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

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

Table 2: Strategic objectives with key indicators of achievement.

Strategic Objectives	Core Indicators of achievement
Objective1: Improving access and quality of IRMNCAH primary care community based services ensuring continuum of care including newborn care in rural districts and urban slums	• % coverage of target districts with IRMNCAH&N services by LHWs and CMWs. • % LHWs involved in routine immunization. • % increase in uptake of IRMNCAH&N services from CMWs and LHWs.
Objective 2: Improved quality of care at primary & secondary level care facilities.	• % of HCF providing essential health care package on RMNCAH &N services including referral mechanisms. • % of HCF with health care providers trained on key IRMNCAH&N topics (PCPNC, IMNCI etc). • % of HCF implementing the WHO Quality of Care standards for

	IRMNCAH&N services.
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions.	• Number of social protection schemes/programs linked with promotion of utilization of health care services • % of coverage of beneficiary population under the conditional cash transfer schemes
Objective 4: Increase in funding and allocation for RMNCAH & Nutrition	• % increase in funding for RMNCAH and Nutrition programs reflected in PSDP/ADP. • % utilization of funds allocated for advocacy on RMNCAH & N.
Objective 5: Improve reproductive health including family planning.	• % of HCF providing integrated service delivery for RH & MNCH services. • % of HCP with enhanced skills and competencies regarding 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 • % of adolescent girls, PLWs, MAM and normal children, provided with micronutrients
Objective 7: Investing in addressing social determinants of health.	• Number of sectors incorporating social determinants of health into their respective sectoral plans
Objective 8: Measurement and action at district level.	• % of districts reporting to integrated DHIS i.e. includes all RMNCAH & Nutrition indicators
Objective 9: National 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	• Number of in-parliamentary sessions focusing on RMNCAH & N issues • Number of mass media products focusing on RMNCAH & N

FINANCIAL ACTION PLAN

BACKGROUND AND COSTING METHODOLOGY

Background and Costing Methodology

In order to operationalize the ten priority RMNCAH&N actions into concrete action plans that would enable implementation over the coming five years (2016-2020), the action plans need to be costed to serve the purpose of advocacy, resource mobilization, and providing guidance in implementation This was undertaken through the support of a short term consultant (Dr. Riaz Hussain Solangi).

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

The costing tool utilized in this process was a simplified costing developed in Microsoft Excel. The tool comprises 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.

For costing of RMNCAH and Nutrition action plan of Khyber Pakhtunkhwa province, a joint consultative meeting was organized by the MNCH program on February 23, 2017 in their conference room, Peshawar. The meeting was attended by the relevant Provincial Program Managers including the Population Welfare Department, and international partners WHO and UNFPA. The meeting was chaired by the Provincial Manager MNCH program. The main objective of the meeting was to determine the unit costs and number of units per year for all the activities under each of 10 objectives of the RMNCAH plan. Afterwards, individual meetings/discussions were held with the Program Managers, as and when needed. The unit costs were determined on the basis of discussions with the relevant program stakeholders and available documents like RMNCAH&N action plan of Khyber Pakhtunkhwa province, 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 relevant program managers during the costing process. In consultation with the concerned stakeholders, an inflationary increment of 10% every year was applied to the unit costs, due to a periodic increase in the prices of goods and services.

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	12,877,232,128	39.40
2	Improved quality of care at primary and secondary level care facilities	4,240,264,296	12.97
3	Overcoming financial barriers to care seeking and uptake of interventions	45,000,000	0.14
4	Increased Funding and allocation for MNCH	6,600,000	0.02
5	Reproductive health including Family planning	941,090,139	2.88
6	Investing in nutrition especially of adolescent girls , mothers and children	14,337,528,327	43.86
7	Investing in addressing social determinants of health	8,200,000	0.03
8	Measurement and action at district level	160,000,000	0.49
9	National Accountability and Oversight	9,900,000	0.03
10	Generation of the political will to support MNCH	60,300,000	0.18
Total		32,686,114,889	100

As shown in the above table, total amount of PKR 32,686,114,889 will be required over a period of five years (2016-2020) for implementing the RMNCAH plan in the Khyber Pakhtunkhwa province. The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (43.86%) have been costed under objective 6 i-e "Investing in nutrition especially of adolescent girls, mothers and children". After this, the majority of funds (39.40%) and (12.97%) have been costed under objectives 1 & 2 respectively. The objective 1 is focusing on "Improving Access and Quality of MNCH Community Based Primary Care Services, and objective 2 will Improved quality of care at primary and secondary level care facilities in the province.

Component-wise yearly resource requirements

Yearly resource requirements by component/obejctive

S.#	Component/ Objective	2016	2017	2018	2019	2020
		PKR	PKR	PKR	PKR	PKR
1	Improving Access and Quality of MNCH Community Based Primary Care Services	1,235,968,310	3,902,284,221	3,606,858,132	2,017,916,631	2,114,204,834
2	Improved quality of care at primary and secondary level care facilities	563,983,680	1,494,593,320	1,058,284,800	616,316,896	507,085,600
3	Overcoming financial barriers to care seeking and uptake of interventions	7,500,000	8,250,000	9,000,000	9,750,000	10,500,000
4	Increased Funding and allocation for MNCH	600,000	1,320,000	1,440,000	1,560,000	1,680,000
5	Reproductive health including Family planning	78,823,855	123,267,268	202,185,711	227,342,363	309,470,942
6	Investing in nutrition especially of adolescent girls , mothers and children	2,370,141,765	2,597,046,715	2,810,250,418	3,118,956,401	3,441,133,028
7	Investing in addressing social determinants of health	2,300,000	4,730,000	360,000	390,000	420,000
8	Measurement and action at district level	52,400,000	84,920,000	19,440,000	1,560,000	1,680,000
9	National Accountability and Oversight	6,900,000	660,000	720,000	780,000	840,000
10	Generation of the political will to support MNCH	22,300,000	22,880,000	12,960,000	1,040,000	1,120,000
Total		**4,340,917,610**	**8,239,951,524**	**7,721,499,060**	**5,995,612,291**	**6,388,134,404**

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	12,877,232,128	1,545,900,000	11,331,332,128	88.00
2.	Improved quality of care at primary and secondary level care facilities	4,240,264,296	324,500,000	3,915,764,296	92.35
3.	Overcoming financial barriers to care seeking and uptake of interventions	45,000,000	5,000,000	40,000,000	88.89
4.	Increased funding and allocation for MNCH	6,600,000	700,000	5,900,000	89.39
5.	Reproductive health including Family planning	941,090,139	104,525,939	836,564,200	88.89
6.	Investing in nutrition especially of adolescent girls , mothers and children	14,337,528,327	1,691,600,000	12,645,928,327	88.20
7.	Investing in addressing social determinants of health	8,200,000	900,000	7,300,000	89.02
8.	Measurement and action at district level	160,000,000	21,000,000	139,000,000	86.88
9.	National Accountability and Oversight	9,900,000	1,100,000	8,800,000	88.89
10.	Generation of the political will to support MNCH	60,300,000	6,700,000	53,600,000	88.89
Total		**32,686,114,889**	**3,701,925,939**	**28,984,188,950**	**88.67**

As seen in the above table, the available funding is approximately 11% of the total resource requirement for implementing RMNCAH plan. Mainly, these funds will be provided by the provincial government. The remaining 89% of the total resources requirement is a funding gap, for which Government of Khyber Pakhtunkhwa will mobilize resources through allocating funds from their own budget, and by approaching potential donors directly or through the MoNHSR&C.

OUTLINE OF KHYBER PAKHTUNKHWA ACTION PLAN

Objective 1: Improving access and quality of IRMNCAH primary care community based services ensuring continuum of care including newborn care in rural districts and urban slums.

Expected outcome 1.1: Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs etc.)

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.1.1	Mapping of outreach staf (CMWs,FMWs, MMWs, vaccinators, LHWs)	% of uncovered areas mapped	TBD	100%	10 Dis-tricts	15 Dis-tricts				MNCH Program
1.1.2	Recruitment of out-reach staf (CMWs,FMWs, MMWs, vaccinators, LHWs)	% of CMWs, FMWs, MMWs, vaccinators, LHWs inducted	CMWs 1410, Vaccinator 2888,LHWs 14922, FWWs 632, MSMs 0	CMWs 2920, Vaccina-tor 300, LHWs 5328, FMWs 1050,MS M,1050						

1.1.3	Training of more outreach workers from uncovered areas as per mapping	% of outreach workers trained	CMWs 1410, Vaccinator 2888,LHWs 14922, FWWs,632, MSMs 632	CMWs 2920, Vaccinator 300, LHWs 5328, FMWs ,1050,MSWs,1050	CMWs 200, Vaccinator, LHWs 2000	CMWs 1360,Vaccinator 300, LHWs 2000	CMWs 1360, LHWs 1328,	0	0	MNCH Program
1.1.4.	Trainings on Standard Clinical outlook, procedure and Record keeping 50 WMOs, FWWs/FWC/FTO over 5 years	% of Trainings conducted	0	50 WMOs, 1141 FWWs/FWC/FTO	10 WMOs, 228 FWWs/FWC/FTO	10 WMOs , 228 FWWs /FWC /FTO	10 WMOs , 228 FWWs /FWC /FTO	10 WMOs , 228 FWWs /FWC /FTO	10 WMOs , 228 FWWs /FWC /FTO	PWD
1.1.5	Training of Officers (Field & Provincial) on Monitoring & Supervision (total 120)	% of Officers trained	0	120	24	24	24	24	24	UNFPA
1.1.6	. Capicity Building of the HCP of Directorate of Health & PWD in Long Acting Reversible Contraceptives(180 WMO/Mos & 180 FWW/LHVs)	% of HCP of Directorate of Health & PWD trained	34	180 WMO/Mos & 180 FWW/LHVs	36 WMO/Mos & 36 FWW/LHVs	36 WMO/ Mos & 36 FWW/ LHVs	36 WMO/ Mos & 36 FWW/ LHVs	36 WMO/ Mos & 36 FWW/ LHVs	36 WMO/ Mos & 36 FWW/ LHVs	PWD
1.1.7	Construction of Warehouse 5000 sq. ft. with all allied facilities	% of Warehouses Constructed	0	1	0	1	0	0	0	PWD
1.1.8	Provision of Solar Panels with inverter for insertion lamps for Insertion rooms of Fw center.	% of Solar Panels with inverter provided	0	1050	225	225	225	225	225	PWD/UNFPA
1.1.9	Recruitment and Hiring of qualified midwifery tutors	% of midwifery tutors hired	40	60	50	10	0	0	0	MNCH Program

1.1.10	Recruitment and hiring for MNCH Program (MIS, HR , Midwifery advisor,admin, procurement, training coordinator)	% of MIS, HR , Midwifery advisor hired	10	15	6	9	0	0	0	MNCH Program
1.1.11	Recruitment of clinical Supervisors (LHVs) 2 per districts (58)	% of clinical Supervisors (LHVs) recruited	0	58	58	0	0	0	0	MNCH Program
1.1.12	Increase the stipend for CMWs	Stipend in-creased (100%)	5000	7000	increase in stipend (if any Govt. policy)					
1.1.13	Enumeration of union council based existing service delivery infrastructure of all stake holders involved in delivering of Health Care services.	% of districts where enumeration completed	0%	100%	25 districts					Population Welfare Department
1.1.14	Expansion of Family Welfare Centers	% of new Family Welfare Centers established (from target)	632	1050	0	200	200	18	0	Population Welfare Department
1.1.15	Increase in the number of Mobile Service Units.	% of new Mobile Service Units.	34	58	12	12	0	0	0	Population Welfare Department
1.1.16	Increase in the number of Reproductive Health Services Centers Type A	% of new Reproductive Health Services Centers Type A established (from target)	29	33	4	0	0	0	0	Population Welfare Department

1.1.17	Increase in the Number of Regional Training Institutes	% of new RTIs established (from target)	3	4	1	0	0	0	0	Population Welfare Department
1.1. 18	Enrollment of Religious Scholars as Social Mobilisers	% of Religious Scholars enrolled as Social Mobilisers	0	1050	500	500	50	0	0	Population Welfare Department
1.1.19	Establishment of KP Population and Research Institute	KP Population and Research Institute Established	nil	1	1	0	0	0	0	Population Welfare Department
1.1.20	Awareness and Advocacy Campaign (Communication Strategy)	Communication Strategy developed	19.47	66.47	47	0	0	0	0	Population Welfare Department

Expected outcome 1.2: Improved quality of community based RMNCAH and Nutrition services (through improvement in monitoring and supervision/revision of ToRs/capacity building and supplies) of the CMWs and LHWs.

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.2.1	Increase capacity of existing CMW tutors by enhancing technical / clinical skills	% of new CMW tutors trained	40	60	60	0	0	0	0	MNCH Program
1.2.2	Training of LHS/ LHV for supervision / technical monitoring (in facility and field) of CMWs	% of LHS/ LHVs trained	0	864 (LHS)/ 864 (LHV)	216(LHS)216 LHV	216(LHS)216 LHV	216(LHS)216 LHV	216(LHS)216 LHV		District MNCH /LHW Program
1.2.3	Enhancement of skills of CMWs focusing on clinical (hands on), mendatory roaster for shift duties (pre service)	% of CMW trained on clinical mandatory roaster	0	1500	500	400	400	200	0	MNCH Program
1.2.4	Refresher training of LHWs on new areas (HTSP (2 days) , IYCF(5 days), Use of Chlorhexidine (1	% of LHWs trained	Existing LHWs	14228	0	14228	0	0	650	MNCH

	Day) , cIMNCI (5days), MDSR (1 Day), Home Based Care New Born (3 Days) etc) contextual to provincial policy									
1.2.5	In Service Refresher trainings of CMWs on maternal, FP, nutrition and cIMNCI, clinical PC/PNC and reporting of MNC mortalitities ENC (HBB/HBS/KMC) (5 days), MDSR (1 Day), Use of Chlorhexidine & Mesoprostol (2 Day)	% of CMW trained	Existing CMWs	1410	200	1210	0	0	100	1.2.6 In Service Refresher trainings of CMWs on maternal, FP, nutrition and cIMNCI, clinical PC/PNC and reporting of MNC mortalitities ENC (HBB/HBS/KMC) (5 days), MDSR (1 Day), Use of Chlorhexidine & Mesoprostol (2 Day)
1.2.6	Provision of logisitics for training/Awareness material of all community based interventions for LHWs		0	100%						1.2.7 Provision of logisitics for training/Awareness material of all community based interventions for LHWs

1.2.6.1	Provision of logisitics for training/Awareness material of all community based interventions for CMWs		0	100%						1.2.7 Provision of logisitics for training/Awareness material of all community based interventions for CMWs
1.2.6.2	Provision of logistics for training /Awareness material of all community based interventions for FWWs		0	100%						1.2.7 Provision of logisitics for training /Awareness material of all community based interventions for FWWs

Expected outcome 1.3: Improved community outreach routine immunization through involvement of LHWs

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.3.1	Development of referral network from Community up to Provincial / district Level	Developed & displayed (100%)	not in place	Developed and displayed						MNCH Program
1.3.2	Orientation to LHWs, CMWs and HCF staff / Provincial /Distriict level Staff on referal pathways	% LHWs orientated	0	100%	15%	50%	35%			MNCH Program

1.3.3	Display of referal linkages pathways in CMWs birth stations, LHWs Health Houses and Health Care facilities	% facilities displaying referral linkage pathways	0	100%						MNCH Program
1.3.4	Development/printing/provision of referral slips and record keeping formats to the CMWs and LHWs	% of CMW's and LHWs provided referral material		100%						
1.3.5	strengthening linkage between referral unit/ LHS/ LHW/ CMW by ensuring supervisory visit of LHS and monthly meeting at Refferal unit.	% LHWs and CMWs visited for supervi-sory visits and monthly meetings		100%						MNCH/LHW
1.3.5	Scale up e-communication of RMNCAH/N related data/information to more CMWs/ FWW/ LHW (online data base? E- monitoring)?					100%				

Expected outcome 1.4: Improved the linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.4.1	Utilization of NGOs social mobilizers/support groups/ CBOs for community mobilization and health services awareness on RMNCH and Nutrition	% community mobilization and health services awareness activities conducted								MNCH/ LHW
1.4.1.1	Conduct effective health education and awareness sessions at community (LHWs/CMWs) in the catchment area of the HCF	% health education and awareness sessions conducted								
1.4.1.2	Training and Involvement of LHWs & CMWs for communication activities & tracing defaulters and non starters (EPI/ANC/PNC/Nutrition)	% LHWs and CMWs trained								MNCH/LHW
1.4.1.3	Use local print and electronic media for social mobilization and health messages on RMNCAH and Nutrition	% messages printed								
1.4.2	Provision of IEC material on MNCH, EPI, FP and Nutrition and advocacy kits to LHWs/CMWs for health educations sessions	% of LHWs & CMWs provided IEC material								

Expected outcome 1.5: CMWs Increase in community demand for RMNCAH and Nutrition services

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
1.5.1	Development of Integrated Primary Healthcare and RMNCAH &N Communication Strategy	Integrated Communication Strategy developed	Communication Strategy not available	Approved Communication Strategy available						IRMNCH
1.5.2	Development of a costed Operational Plan (Including IEC material, Advocacy Kit) for Communication strategy	Comprehensive Communication Plan developed	Not available	Comprehensive Communication Plan along with Approved /adopted IEC material available		*				IRMNCH
1.5.2.1	Training on newly developed IEC material of community based (LHWs-CMWs, Vaccinators, SHNS etc.) and relevant facility based staff	% of staff trained (per staff category)	NA	All Facility + Outreach staff			*	*	*	IRMNCH
1.5.3	Re-Vitalization of LHW Support Groups with effective participation of CMWs & SH&NS	% LHWs, CHWs and other relevant staff participating in meetings (per district)	NA	All LHWs		*	*	*	*	IRMNCH

1.5.3.1	Involvement of UCMO/Health Officers in monitoring of support group activities (FTA allowance)	% of meetings attended by UCMO/Health Officers	NA	All Health Facilities		*	*	*	*	IRMNCH
1.5.4	Printing and Provision of newly developed IEC material on MNCH, EPI, FP and Nutrition and advocacy kits to LHWs/CMWs for health educations sessions	% of LHWs and CMWs and Health Facilities provided with IEC material and Kits	NA	Available for all LHWs and CMWs and Health Facilities		*	*	*	*	IRMNCH
1.5.5	Use local print and electronic media for social mobilization and health messages on RMNCAH and Nutrition (refer to PC_I as well)	--	Need based	As per Communication Strategy Action Plan	*	*	*	*	*	IRMNCH

Objective 2: Improve access to and quality of RMNCH care at Primary and Secondary level care facilities

Expected outcome 2.1: Enhanced skills of HCPs on IMNCI/PCPNC/ENC at Primary and Secondary HCFs

S.No	Activities	Indicators			Target by year					Responsi-bility
		Description	Baseline	Target	2016	2017	2018	2019	2020	
2.1.1	Conduct training of Health care provides (Gynecol-ogists/Obstetricians/WMOs/LHVs/MW Nurses) on PCPNC (7 days)	% of health care providers capacitated	130	370	100	100	100	70	0	MNCH Program
2.1.2	Increase the pool of PCPNC facilitators in the province at the Center of Excellences	Percentage of PCPNC facilitators recruited	18	42	22	20	0	0	0	MNCH Program
2.1.3	Conduct training of the HCPs (Gyne &Obs, WMO, MO, Pediatricians, LHVs, staff nurses) on Essential Newborn Care (ENC) (5 Days)	% of health care providers trained	360	640	40	200	200	200	0	MNCH Program
2.1.4	Increase the pool of ENC facilitators at district level	% of new ENC facilitators recruited	38	22	22	0	0	0	0	MNCH Program

2.1.5	Capacity building of the HCPs on Reproductive Health/Family Planning Counseling at PHC facilities (LHVs/CMWs/FMTs etc) (5 days)	% of health care providers trained	336	704	104	200	200	200	200	PWD/MNCH Program
2.1.6	Capacity building of the HCPs on Reproductive Health/Family Planning Surgical Trainings at PHC facilities (CMWs/LHVs etc) (14 days)	% of health care providers trained	0	500	24	200	200	76	200	PWD/MNCH Program
2.1.7	Conduct the training of HCPs (Pediatrician/ MO/WMO/Staff Nurses) on Neonatal care at Neonatal Intensive care Units (total 9 trainings) (4 Weeks Training)	% of health care providers trained	0	180	20	80	80	0	20	MNCH Program

Expected Outcome 2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/up gradation of HFs and provision of supplies

S.No	Activities	Indicators			Target by year					Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020	
2.2.1	Provision of essential IMNCI/PCPNC/ENC equipment to all DHQ/THQ/RHCs for establishment of under 5 and Basic EMOC clinics	% of BEmONC Clinics established	0	129	50	50	29	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	% of DHQs, THQs and RHCs provided essen-tial medicine	0	180 (DHQ 23 , Type- D 45 , RHC 94, THQ 18)	20	60	60	40	0	MNCH Program
2.2.3	Establish the Sick New Born Care Unit through provision of equipment and supplies at DHQs	% of Sick New Born Care Unit established	5	10	2	4	4	0	0	MNCH Program
2.2.4	Induction of HR for providing 24/7 CEmONC services at DHQ/THQ and Basic EMONC services at RHCs in rural districts as per requirement (gyne-co-logist,pediatrician,anesthetist, WMOs, Nurses, LHVs,OTT, BBT, Lab tech,aya, sweepers)	% of required staff in-ducted	16 (CEmONC) 58 (BE-mONC)	7 (CEmONC) 48 (BE-mONC)	0	2 (CEmONC) 15 (BE-mONC)	2 (CEmONC) 16 (BE-mONC)	3 (CEmONC) 16 (BE-mONC)		MNCH Program
2.2.7	Incentivise (top ups) the services of the RMNCAH related staff in rural and hard to reach districts (20/ District) in 8 Dis-trict.(Paediatrician, Gyna-co-logist/WMO/Anesthetic, Staff Nurse/LHV/OT Techinician)	% of staff provided in-centives	0	8 districts (Tank, Laki, Hangu, Ko-histan, Shangla, Thor Ghar, Chitral, Batagram) =160 Persons	8 Dis-trict	8 Dis-trict	8 Dis-trict	8 Dis-trict	8 Dis-trict	DoH/MNCH Program/
2.2.8	Repair/renovate/upgrade the OT/labor rooms/ gyne wards/pediatric wards in the DHQ/THQ	% of facilities upgraded	56	164	20	70	50	24	0	MNCH Program

2.2.9	Repair/Renovation of CMWs School and hostels	% of facilities Repair/Renovated	25	25	10	15				
2.2.10	construction of CMWs School and hostels	% of CMW's Schools and hostels constructed	10	4	0	4	0	0	0	MNCH Programme

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
2.3.1	Provision ambulances to HCFs for referral of cases based on user end fee for PoL generation.	% of ambulances provided to the health care facilities	80	140	0	70	70	0	0	MNCH Program	2.3.1 Provision ambulances to HCFs for referral of cases based on user end fee for PoL generation.

2.3.2	Establish referral desks and data base at DHQ/THQ/Type-D Hospital/RHCs	% of Referral desks and databases established	0	220	0	220	0	0	0	MNCH Program	2.3.2 Establish referral desks and data base at DHQ/THQ/Type-D Hospital/RHCs
2.3.3	Provision of IT support to establish referral desks and data base	% of Facilities provided IT support	0	220	0	220	0	0	0	MNCH Program	2.3.3 Provision of IT support to establish referral desks and data base
2.3.4	Training of the HCPs on maternal and child health referral data recording and dissemination (5 days)	% of health care providers trained	0	440	0	440	0	0	0	MNCH Program	2.3.4 Training of the HCPs on maternal and child health referral data recording and dissemination (5 days)

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

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
2.4.1	Establish Steering Committe for IRMNCAH-N Committee at Provincial Level	Steering Committe for IRMNCAH-N established	0	1	1	0	0	0	0	DoH

2.4.2	Establish M&E Cell at Provincial Level under Directorate of MNCH, EPI, DHIS, Nutrition, LHW Programme	M&E Cell Established	0	1	1	0	0	0	0	
2.4.3	Develop Organogram & TORs of HRs at all Levels									
2.4.4	Capacity Building of Provincial and District Managers on M&E for IRMNCAH-N related activities (3 Days)	% of Managers providers trained	**0**	**440**	50	390	0	0	0	
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 Monitoring Cell	% of vehi-cles procured	0	10	0	10	0	0	0	

2.4.9	Provision/Procurement of Three Vehicle for Each 25 District (Suzuki Jimny Jeep)	% of vehicles procured	0	75	0	75	0	0	0	

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

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
2.5.1	Revitalization of Technical working group on Pre Service IMNCI	TWG Functional	1	1	1	0	0	0	0	
2.5.2	Inception workshop for medical schools to review the IMNCI/PCPNC/ENC pre-service experience in KP (Medical colleges)	% of workshops conducted	4	6 Public Medical Colleges and 2 Private Medical Colleges in KP		3 Public & 1 Private	3 Public & 1 Private			MNCH Program
2.5.3	In-depth orientation/planning to strengthen the IMNCI/PCPNC/ENC teaching in all Medical Colleges)	% of orientation & planning events conducted	3 centre of excellence-WMC Abbottabad KMC/KMU, KICH	2 Public Medical Colleges and 2 Private Medical Colleges		1 Public & 1 Private	1 Public & 1 Private			DoH

2.5.4	Training of teaching staff (IMNCI/PCPNC/ENC (CME or Facilitator Course)	% of staff trained	0	4 Courses Each	1 for Each Course	3 for Each Course				DoH

Expected Outcome 2.6: Strengthening EPI

S.No	Activities	Indicators			Target by year					Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020	
2.6.1	Advocacy,Policy and planning meetings with stakeholders		0	2	1	1				EPI Program
2.6.2	.Development Regulation on VPDs (Vaccine Preventable Diseases) Regulation on manadatory immunization of all antigens and dealing with refusals		0	1		1				EPI Program
2.6.3	. Periodical planning reviews/meetings regarding EPI at Provincial level (Quarterly/Bi Annualy)		0	18	2	4	4	4	4	EPI Program
2.6.4	Periodical planning reviews/meetings at districts/Divisional levels (Peshawar, Mardan, Swat, Abbottabad, Bannu, DiKhan)		0	450 Meetings	50	100	100	100	100	EPI Program

2.6.5	Planning and orientation of managers on EPI related MoRES (all DHOs/EPI Coordinator)		0	2	1	1	0	0	0	EPI Program
2.6.6	MLM training for the managers		0	2	0	2				EPI Program
2.6.7	Training of managers and field staff on RED/REUC (1600 field staff) 64 sessions in 25 distts (1600/25 participants)		10	54	0	25	20	9	0	EPI Program
2.6.8	Training on EVM and vLMIS for rest of the 20 Districts (300 field staff) = 15 sessions		4	11	0	5	4	2	0	EPI Program
2.6.9	Refresher/Training on Cold Chain and equipment for storekeepers and cold chain staff (50 store keepers and CC staff, 12-16 grade) refresher for 25 & training for 25 = 2 sessions		1	2 (one training one refresher)	0	2	0	0	0	EPI Program
2.6.10	Trainings on EPI/MIS Soft ware/reporting system - 2/distt, Computer operators x 25 distts = 2 sessions		0	2	0	2	0	0	0	EPI Program

2.6.11	Networking of EPI-MIS Soft Ware with in all the 25 Districts with Province +repair of the outdated ones		0	25	0	25	0	5	5	EPI Program
2.6.12	Technical support on RED stretegy (hiring RED Consultant for implementation of RED/REUC in the province and 07 divisions) cost per person 150-200 thousands per month + mobility		0	8	8	0	0	0	0	EPI Program
2.6.13	Support on stablishment of 250 fixed/static EPI centers (125 UCs/selected Health houses)		915	250	0	100	100	50	0	EPI Program
2.6.14	Support on establishment of 50 private hospitals/clinics		10	40	10	20	10	0	0	EPI Program
2.6.15	Support on strengthening reporting and moitoring system e.g. HR provision of computor opertaors/analysts for 25 distrcts + relvant IT equipment (Computers, Printers,Scanners,Multi-media and office equipment fx machine, photocopier, laptops with accessories		5	20	5	15	0	5	0	EPI Program
2.6.16	Motorcycles for outreach routine immunization. 500 - 70cc		0	500	0	500	0	0	0	EPI Program

2.6.17	mobility + PoL for field staff/vaccinators + mobile teams 600/team x 2900 vaccinators		1300	1600	500	1000	100	0	0	EPI Program
2.6.18	Support on technician for repair and maintenance of CC equipment - 1000/ILR x /year for 1600		500	1100	550	1100	1100	1100	1100	EPI Program
2.6.19	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		35%	65% cost	33%	65%	65%	65%	65%	EPI Program
2.6.20	Establishment of VPD suviellance system at Provincial and Distt levels -		0	26	5	21	0	0	0	EPI Program
2.6.21	Technical support on surviellance/HR support - 01 provincial surviellance officer and 25 distt surviellance officers.		0	26	0	26	0	0	0	EPI Program
2.6.22	Support on operational research and EPI related MoRES promotion for evidence based monitoring -		0	1 (yearly)	0	1	1	1	1	EPI Program

2.6.23	11.4.5 Suport on periodical evaluations on yearly basis and end project		0	5	1	1	1	1	1	EPI Program
2.6.24	11.5.1 Development of provincial EPI communication strategy - Consultant 01		0	1 (Continue)	0	1	1	1	1	EPI Program
2.6.25	11.5.2 Orientation on EPI communication strategy		0	1	0	1	0	0	0	EPI Program
2.6.26	11.5.3 Development of updated messages on VPDs and Polio new introduction of vaccines		0	1	0	1	0	1	0	EPI Program
2.6.27	11.5.4 Printing of tools on EPI Information, registration and reportings		33% existing	66% needed	0	66%	66%	66%	66%	EPI Program
2.6.28	11.5.5 Education and awareness material for communities, school , religious leaders, public representatives, media etc		15%existing	85% needed	0	85%	85%	85%	85%	EPI Program
2.6.29	11.5.6 Support on awareness sessions by LHWs among the women groups at house hold level etc, on routine immunization		0%	100% Needed	25%	100%	100%	100%	100%	EPI Program

2.6.30	11.5.7 Visibility through banners, bill boards/Panaflex, posters etc		0%	100% Needed	50%	100%	100%	100%	100%	EPI Program
2.6.31	11.5.8 Media sessions with social media/print and electronic media			100% Needed	20%	20%	20%	20%	20%	EPI Program
2.6.32	11.5.9 Supprot on printing MIS tools and stationary		15% existing	85% Needed	25%	85%	85%	85%	85%	EPI Program
2.6.33	11.5.10 Seminars, Talk shows, walks, and other sessions etc		0%	100%	50%	100%	100%	100%	100%	EPI Program
2.6.34	11.6. Improve data quality reporting/data quality audit (DQA) timeline and completenes and 2 way feed back mechanism		0%	100%	50%	100%	100%	100%	100%	EPI Program
2.6.35	11.7 HR/Equipment/Furniture required for those EPI offices, static centers etc.			100%	20%	20%	20%	20%	20%	EPI Program

Objective 3: Overcoming financial barriers to care seeking and uptake of interventions

Expected Outcome 3.1: Improved & strengthened coordination of the existing social safety nets

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
3.1.1	Continue & Sustain CM Special Initiative (CCT)for Moth-er and Child		24 Dis-trict	25 District	24 Dis-trict	24 Dis-trict	25 Dis-trict	25 Dis-trict	25 Dis-trict	
3.1.2	Social Health Protection Scheme		3	10						

Objective 4: Increase in funding and allocation for RMNCAH

Expected Outcome 4.1: Increase resource allocation and mobilization for RMNCAH and nutrition programs

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
4.1.1	Establish Coordination Committee & conduct Quarterly Meetings of Coordination Committee of all Stake Holders	% of meetings conducted	0	18	2	4	4	4	4	4.1.1.Establish Coordination Committee & conduct Quarterly Meetings of Coordination Committee of all Stake Holders
4.1.2	Bi annual advocacy/Consultative Meetings with stakeholders and partners on Financial & Implementation Strategy	% of events conducted	0	9	1	2	2	2	2	4.1.2.Bi annual advocacy/Consultative Meetings with stakeholders and partners on Financial & Implementation Strategy

Objective 5: Improve reproductive health including family planning

Expected Outcome 5.1: Linkages between existing forums established from Federal to District Level (NATPOW, Provincail Technical Committee)

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
5.1.1	5.1.1.Coordination Meetings for Data Sharing, Avoid duplication of services and strengthing of Reffrals and sharing of future planning (Man, Money, Material)									
5.1.2	5.1.2. Scaling Up ASRH Centers in Public Health Facilities (Councelling/Refrral)	% of ASRH Centers established	0	7	1	6	0	0	0	
	5.1.3.Procurement of Contraceptives (Rs in millions)	% of Contraceptives procured	170	1596	1000	426	0	0	0	Population Welfare Department
	5.1.4. Comodity security of Implanon and Hormonal IUCDs (1 Million/Year USD)		0							

	5.1.5. Cntraceptive Commodity for DOH KP (Estimated 1035 Million PKR for Con-taceptives-)		0	POP=5635 /Year ,COC=1648064/Year ,CTs=34779/Year ,Injection=611236/Year ,Implant=2860/Year ,Condom=27884698/Year						DoH KP

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

Expected Outcome 6.1: Improved infant and young child nutrition (children < 24 months) practices in all districts of KP (CMAM/IYCN/SUN/IDD/Food Fortification/)

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
6.1.1	.Annual celebra-tion of Breast Feeding Week (August)	% of campaigns con-ducted		1 Provin-cail & 25 Districts	1 Provin-cail & 25 Districts	1 Provin-cail & 25 Districts	1 Provin-cail & 25 Districts	1 Provin-cail & 25 Districts	1 Provin-cail & 25 Districts	MNCH, LHW Program, Nutri-tion Program and DoH KP
6.1.2	Notification of Provincail Infant Feeding Board and conduction of Annual Meeting	Annual Meeting of Provincial Infant Feed-ing Board held	0	1	1	1	1	1	1	
6.1.3	Notification of Provincail Food Fortification Alli-ance conduction of BI Annual Meeting		1	1	1	1	1	1	1	

6.1.4.	Implementation of Provincail Nutritional Stategy		Stretegy Developed to be implemented	25	4	10	11	0	0	

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 all districts of KP

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	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	% of pregnant and lac-tating women given s multiple micronutrient powder	0	25	4	10	11	0	0	MNCH, LHW Program, Nutrition Program and DoH KP	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
6.2.2	Biannual deworming of all children 2-5 years of age	% of target population covered	0	>80% children							5.2.2: Biannual deworming of all children 2-5 years of age

6.2.3	: Biannual deworming of all primary scholl aged children (Grade 1-5)	% of target population covered		> 80% children							5.2.3: Biannual deworming of all primary scholl aged children (Grade 1-5)
6.2.4	Biannual Vitamin-A supplementation with NIDs for all children < 5 years	% of target population covered		> 90% coverage							5.2.4: Biannual Vitamin-A supplementation with NIDs for all children < 5 years
6.2.5	Promoting use of Iodized Salt through Schools and Community Health Workers and salt processors	% of target population covered		> 80% HH use iodized salt							5.2.5: Promoting use of Iodized Salt through Schools and Community Health Workers and salt processors
6.2.6	Intermittent iron/folic acid (IFA) supplementation for adolescent girls	% of target population covered		> 60% adolescent girls							6.2.6: Intermittent iron/folic acid (IFA) supplementation for adolescent girls
6.2.7	Promotion of healthy/appropriate eating for pregnant ladies and lactating mothers including provision of supplementary food ?	% of target population covered	0	> 60% PLW							6.2.8: Promotion of healthy/appropriate eating for pregnant ladies and lactating mothers including provision of supplementary food ?
6.2.8	: Zinc supplementation for children of age 6-59 months	% of target population covered	0	> 60% Children							6.2.9: Zinc supplementation for children of age 6-59 months

Expected Outcome 6.3: Enhanced access of local community to life saving nutrition services for acute malnourished children in all districts of KP

S.No	Activities		Indicators		Target by year					Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020	
6.3.1	Establishment and Functionalization of inpatient nutrition services (Stabilization Centers) in secondary health care facilities	% of Stabilization Centers established and operationalized	SC 14	SC 26	SC 4	SC 8	0	0	0	MNCH, LHW Program, Nutrition Program and DoH KP
6.3.2	Establishment and Functionaliza-tion` of outpatient nutrition services (SFP and OTP Centers/Breast Feeding Corners)	% of S SFP and OTP Centers/Breast Feeding Corners established and operationalized		SFP/OTP in each RHC (92) and in selected BHUs (408)		All RHC will have SFP/OTP				
6.3.3	HR/Nutritionist at each District level and Provincial level (BPS 17)	% of staff (targeted for hiring) recruited	0	1 Provincial + 25 Districts		All 25 Districts will have 1 Nutritionist				
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							

6.3.5	Equipments/Instruments for SFP/OTP Centers (Uniscale, Height/Length Board, MUAC Tapes for Children/PLWs)	% of Equipments provided	0	500 Health facilities						
6.3.6	Equipments/Instruments for NSC (Complete NSC Kit)	% of Equipment provided	0	26						
6.3.7	IT Equipments/ Soft Ware /Networking /Cameras	% of IT Equipment provided	0	25						

Objective 7: Investing in addressing social determinants of health

Expected Outcome 7.1: Health Friendly, Multi-sectorial Policies and Practices adopted

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
7.1.1	Multi Sectoral Coordi-nation Committee at Provincial Level	% of meetings con-ducted								

7.1.2	Establish Provincail Research cell to analyse Health with Social Determinents	Provincail Research cell Established	0	0	0	Functional	Functional	Functional	Functional	
7.1.3	Revival of School Health Services (Piloting 4 Schools in a selected District)Deploy 1 School Nurse with Necessary eqipements and Health Care Provider of 58elevant Health Facility visit each school Monthly	% of schools operationalized	0			Piloting				

Objective 8: Measurement and action at district level

Expected Outcome 8.1: Generation of Valid, Timely, Complete, Reliable routine Data

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
8.1.1	Formulation of DHIS review committee to review existing system and include missing indicators on RMNCAH and Nutrition	DHIS Committee formulated	0	1 Committee	Notify	Quarterly Review Meeting	Quarterly Review Meeting	Quarterly Review Meeting	Quarterly Review Meeting	

8.1.2	Develop and Implement routine HMIS for Tertiary Level Care Hospitals		0	4		2	2			
8.1.3	.A.Develop Reporting Formats and 3 Days training of MIS staff of Tertiary Level Care Hospitals (5 Persons/ Hospital)	% of staff trained	0	1 Batch	Develop Tool	Training				
8.1.4	Training of staff (DHIS) (5 days)	% of staff trained		2000	1000	700	300			
8.1.5	Training of Master Trainer district wise (DHIS)	% of staff trained		40	40					
8.1.6	Adapt WHO Maternal and New Born Daeth Audit Guidelines,Protocols,Refrrals SOPs,Recording & Reporting Tools (2 Selected Disticts Nowshehra & Abbottabad-Pilot)		0	2 Districts in KP	Adaptation	Implemented				
8.1.7	A 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))	Orientation Meeting Conducted	0	2 Districts in KP		Orientation Meeting Conducted				

8.1.8	.3 Days trainings of Health Care Providers (Gynacologist, M/F Medical Officers, LHVs, LHSs,CMWs) in Maternal and Newborn death Audit.	% of staff trained	0	160		160 Trained				
8.1.9	Develop Policy brief on Maternal & Newborn Death Audit									

Objective 9: National Accountability and oversight

Expected Outcome 9.1: Improve Governance And Accountability

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
9.1.1	Formulation of oversight Committee Chaired by Minister of Health KP to review Performance and outcomes (Bi Annual Meetings)	% of review meetings conducted by Oversight committee held	0	Formulate Oversight Committee	Formulate Oversight Committee					
9.1.2	9.1.2.Development of accountability Framework	Accountability Framework developed	0	Frame Work Develop	Frame Work Develop					

9.1.3	.Link the Monitoring and Evaluation reports for accountability framework		0	Quarterly Reports	Quarterly Reports					
9.1.4	Implementation of Quality assurance tools at all level	% of quality assurance tools (KPIs) developed and implemented at provincial, district and HCF levels	0	Development of Tools	Development of Tools					

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

Expected Outcome 10.1: Awareness about SDGs on Health and Population among Policy Makers and Parliamentarians

S.No	Activities	Indicators			Target by year					Responsibility
					2016	2017	2018	2019	2020	
		Description	Baseline	Target						
10.1.1	Expected Outcome: 10.1. Awareness about SDGs on Health and Population among Policy Makers and Parliamentarian	% of awareness meetings conducted								
10.1.2	Establish SDG Cell under DGHS KPs	ToRs for SDG Cell approved and cell established under P & D and DGHS								

10.1.3	Advocacy and Awareness orientation of Policy Makers and Parliamentarian on Health and Population Issues	% of awareness meetings conducted								
10.1.4	Engagement of religious scholars, Media to address Myths and Misconception on Health & Population Issues	% of religious scholars engaged								