REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH

Ministry of National Health Services,
Regulations and Coordination
Islamic Republic of Pakistan

PAKISTAN RMNCAH INVESTMENT CASE

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Message by the Minister for National Health Services, Regulations and Coordination

The Federal Government will continue supporting and facilitating the provinces in developing and implementing their strategies.

The National Health Vision 2016-2025 provides an overarching national vision, guides national and provincial health departments towards an agreed upon common direction, harmonizes provincial and federal efforts as well as inter-provincical and inter-sectoral efforts for achieving the desired health outcomes to create an impact.

The objectives, expected outcomes and activities presented in this RMNCAH Investment case, are derived from the respective provincial and regional five-year RMNCAH plans. The provincial and regional plans were developed in line with National Health Vision 2016 - 2025 and ten priority actions which were mutually identified by all provincial and regional MNCH, LHWs, EPI, and Nutrition program teams.

This Investment Case is thus stranded in informed evidence, encompasses existing RMNCAH strategies and implementation plans, identifies immediate priorities with least possible financial implications, and provides an integrated planning and implementation approach across the RMNCAH areas. It primarily addresses gaps that are hindering the achievement of sustainable, equitable and accelerated improvements in RMNCAH outcomes.

The delivery of quality health care services is a provincial responsibility, therefore, the priority action are in line with the provincial needs, expectations, and priorities. The national health vision resonates with the ideals and, expectations of provinces.

The Federal Government will continue supporting and facilitating the provinces in developing and implementing their strategies. This support primarily entails in providing the overall vision and by facilitating and advocating for financial and technical resource mobilization. The main purpose is to ensure that essential health services are accessible to all citizens.

I appreciate and thank representatives of Provincial departments of Health, Population welfare Departments, development Partners, International and National Non-Governmental Organizations, for their active participation and contribution to finalize the investment case.

I also acknowledge and thank UNFPA Pakistan for their technical support and collaborative efforts to make it possible

Saira Afzal Tarar
Minister for National Health Services, Regulations and Coordination

ACRONYMS

ANC	Antenatal Care
BoD	Burden of disease
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CMR	Child Mortality Rate
CMW	Community based Midwife
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DHIS	District Health Information System
DGHS	Director General Health services
EmONC	Basic Emergency Obstetric and Newborn Care
FATA	Federally Administered Tribal Area
FMT	Female Medical Technician
FP	Family Planning
FWW	Family Welfare Workers
GB	Gilgit - Baltistan
GFF	Global Financing Facility
HCP	Health Care Provider
KPK	Khyber Pukhtuun Khwa
IMR	Infant Mortality Rate
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDGs	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MO	Medical Officer
MoH	Ministry of Health
MT	Medical Technician
MOV	Means of verification
NGO	Non-Governmental Organization
NHSR & C	Ministry of National Health Services Regulations and Coordination
NMR	Neonatal Mortality Rate
OVI	Objectively Verifiable Indicators
PCPNC	Pregnancy, Childbirth, Postpartum and Newborn Care
PDHS	Pakistan Demographic and Health Survey
PNBS	Pakistan National Bureau of Statistics
PNC	Postnatal Care
PPH	Post-Partum Hemorrhage
PWD	Population Welfare Department
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RTI	Regional Training Institute
SA	Statistical Assistant
SBA	Skilled Birth Attendance
SDG	Sustainable Development Goals
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate

U5MR	Under-Five Mortality Rate
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WMO	Woman Medical Officer

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1 COUNTRY APPROACH

1.1 Background

The Government of Pakistan is committed to ensure Universal Health Coverage (UHC) for the population of Pakistan with specific emphasis on mother and child. It envisions to achieve the health outcomes through improving and accelerating service delivery for Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH). Although most recent Pakistan Demographic and Health Survey (PDHS 2012-13) reveals an improvement in some of the RMNCAH indicators, however, the Millennium Development Goals (MDGs) for maternal and child health could not be reached because of numerous challenges related to service delivery and coverage that continued to exist.

After an amendment in the constitution, in 2011 health was devolved to the provinces which created challenges as well as opportunities for better performance and accomplishment. This scenario has led the provincial health departments and the re-established Ministry of National Health Services, Regulation, and Coordination (NHSR&C) to take up revised roles under the federal legislation[1].

After July 2011, the lack of an agreed national vision was expressively realized that could reflect the shared aspirations for further improving health of population of Pakistan. A need for a national vision document on health that is aligned with the country's vision 2025, international health priorities and based on provincial realities, was identified while remaining within the framework of Amended Constitutional roles /responsibilities[2].

Consequently, this critical need was translated into development of National Vision for Coordinated Priority Actions 2016–2025 by the Ministry of National Health Services, Regulation, and Coordination, Government of Pakistan. The prime aim was to address the challenges in improving Reproductive, Maternal, Newborn, Child and Adolescent Health, and Nutrition.

This vital document was developed in line with the National Health Vision 2016–2025. The 'National Health Vision' offers an overarching national vision, guides national and provincial health departments towards an agreed upon common direction, harmonizes provincial and federal efforts as well as inter-provincial efforts, and inter-sectoral efforts for achieving the desired health outcomes to create an impact. It provides a jointly developed account of strategic directions to achieve the common vision, which gives a guideline of best practices for the provinces/ areas to carve their respective policies and initiatives within their domains[3]. These documents then served as guiding principles to develop seven subnational RMNCAH plans.

During the process of development of provincial subnational plans, the political devolution provided opportunities for healthcare systems to address issues related to systems, planning health care delivery structures, programmes, and services. This assumes greater significance as the targets of health related MDGs were not completely achieved, and far more hard work was essentially required to work towards the even more challenging targets of the Sustainable Development Goals (SDGs)[4].

This document presents a costed investment framework that lays out Pakistan's RMNCAH vision, defines the guiding principles, and gives objectives for ten priority actions to address challenges being faced in improving RMNCAH[5].

1.2 The Process

This RMNCAH Investment Case is the outcome of two-staged consultative process with all the provinces of Pakistan, Federating Areas, and Azad Jammu and Kashmir (AJK), as well as with the Development Partners. This process was led by Ministry of National Health Services Regulations and Coordination (NHSRC), Government of Pakistan. This consultative process has led to two important outcomes:

1. Development of the five-year RMNCAH Costed Plans for the period 2016 to 2020; in view of National Health Vision 2016 – 2025 and in line with priority actions to address challenges of RMNCAH and nutrition.
2. Because of financial constraints, identification and prioritization of vital interventions within the plans, i.e., evidence based and high impact interventions without which the planned objectives are hard to achieve.

This Investment Case is thus stranded in informed evidence, encompasses existing RMNCAH strategies and implementation plans, identifies immediate priorities with least possible financial implications, and provides an integrated planning and implementation approach across the RMNCAH areas. It primarily addresses gaps that are hindering the achievement of sustainable, equitable and accelerated improvements in RMNCAH outcomes.

1.3 The Subnational Plans

The seven subnational multi-year plans are developed in line with these priority actions[6]. These include five provinces plans i.e., Balochistan, Gilgit-Baltistan, KPK, Punjab and Sindh; and Federally Administered Tribal Area (FATA) and Azad Jammu and Kashmir (AJK). These are dynamic plans and the respective entities will periodically revise them according to their changing needs.

Moreover, this national investment case takes into consideration the current programs and initiatives by Ministry of National Health Services, Regulation and Coordination, and the respective provincial Departments of Health, and the development partners.

By prioritizing intervention areas for investment, this Investment Case aims to ensure that affordable evidence-based and high impact interventions are delivered to improve RMNCAH outcomes in Pakistan.

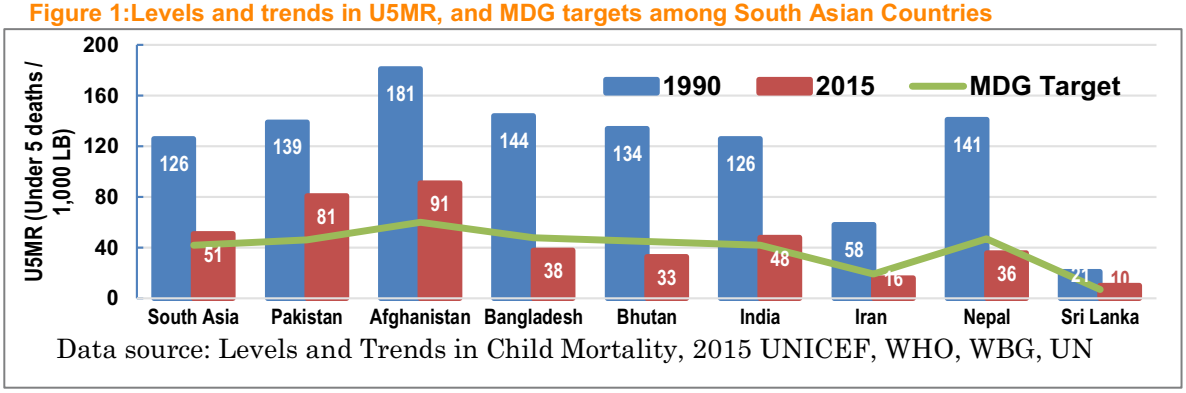
2 COUNTRY CONTEXT

The provisional findings of recent census of 2017 have revealed a 36.3 percent increase in Pakistan population during the last two decades at an average annual growth rate of 2.4. The population has increased from 132.3 million in 1998 to 207.7 million in 2017. During this period, the urban population has increased by 39.8 percent as compared to 34.3 percent rural population. More importantly, there is 2 percent point increase in urban population and a similar decrease is observed in rural population[7].

2.1 MDGs 4 and 5: Efforts and Status

Pakistan is one of the signatories to the MDGs, however despite making loads of efforts Pakistan has not fully achieved its targets for MDG 4 and 5, however WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division have recognized its persistent struggle to improve RMNCAH indicators by placing it in the group of countries

Figure 1:Levels and trends in U5MR, and MDG targets among South Asian Countries



Data source: Levels and Trends in Child Mortality, 2015 UNICEF, WHO, WBG, UN

marked as 'Making Progress'[8 & 9]. However, despite this recognition, much more remains to be achieved.

Figure 1 compares South Asian countries for under five mortality rates in 1990 and 2015 in conjunction with the MDG target set for achievement in 2015. Overall South Asia could not achieve the U5MR target of 42. Three countries in the region i.e., Bangladesh, Iran

Table 1: Levels and trends in IMR, NMR, and MDG targets among South Asian Countries

COUNTRY	IMR (Infant deaths per 1,000 LB)				NMR (Neonatal deaths per 1,000 LB)			
	Status		MDG Target 2015	Decrease (%) 1990-2015	Status		MDG Target 2015	Decrease (%) 1990-2015
	1990	2015			1990	2015		
South Asia	92	42	31	54.3	57	29	19	49.1
Pakistan	106	66	35	37.7	64	46	21	28.1
Afghanistan	123	66	41	46.3	53	36	18	32.1
Bangladesh	100	31	33	69.0	63	23	21	63.5
Bhutan	93	27	31	71.0	44	18	15	59.1
India	88	38	29	56.8	57	28	19	50.9
Iran	45	13	15	71.1	27	10	9	63.0
Nepal	98	29	33	70.4	59	22	20	62.7
Sri Lanka	18	8	6	55.6	14	5	5	64.3

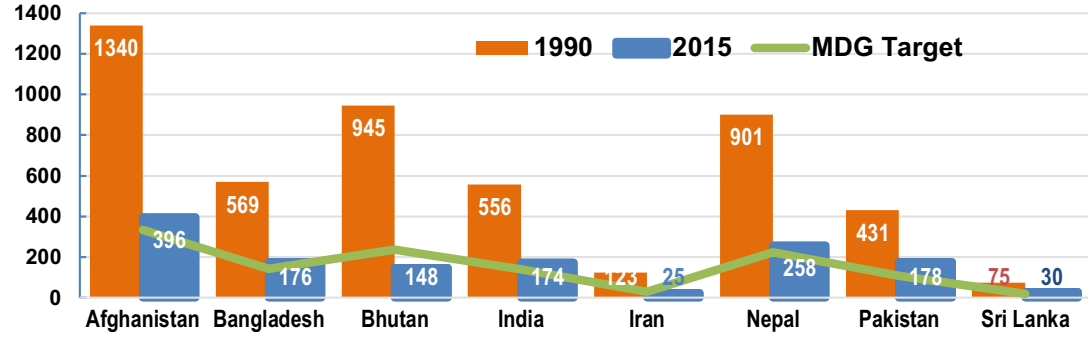
Data Source: Levels and Trends in Child Mortality, 2015 UNICEF, WHO, WBG, UN

and Bhutan could reach to U5MR MDG target. Whereas Pakistan was able to reduce U5MR by 42 percent from 139 in 1990 to 81 in 2005.

Similarly, Pakistan also lags in achieving neonatal and infant mortality related MDGs.

Moreover, the rate of reduction remained the slowest among South Asian regional countries at 28 and 38, respectively. Except Sri Lanka, none of the countries in the region achieved MDG for neonatal mortality whereas Bangladesh, Iran, Bhutan, and Nepal had been successful in achieving MDG targets for IMR (Table 1)[8].

Figure 2: Levels and trends in MMR and MDG targets among South Asian Countries



Data Source: Trends in maternal mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division

Only three countries in the region i.e., Maldives, Nepal and Bhutan had achieved the MDGs for MMR (Figure 2). Regardless of all its targeted efforts, Pakistan had the slowest improvement pace in MMR in the region and could reduce its MMR by 59% as compared to 70%, 69% and 71% respectively by Afghanistan, Bangladesh, and Nepal.

In Pakistan, a high level of political commitment has resulted in inclusion of RMNCH plans in the national health plans with the allocation of budgets. Moreover, maternal and child health were the main components of the joint plans developed with WHO, UNICEF and UNFPA.

Pakistan is among the nine priority countries in the region, for accelerating efforts towards reducing maternal and child mortality under Dubai Declaration. While responding to this, and with the technical support from WHO and other UN agencies, the National Ministry of Health Services Regulation and Coordination in collaboration with provincial health departments had developed a National RMNCH Accelerated Plan (2013-15) to accelerate the progress in further reducing maternal and child deaths.

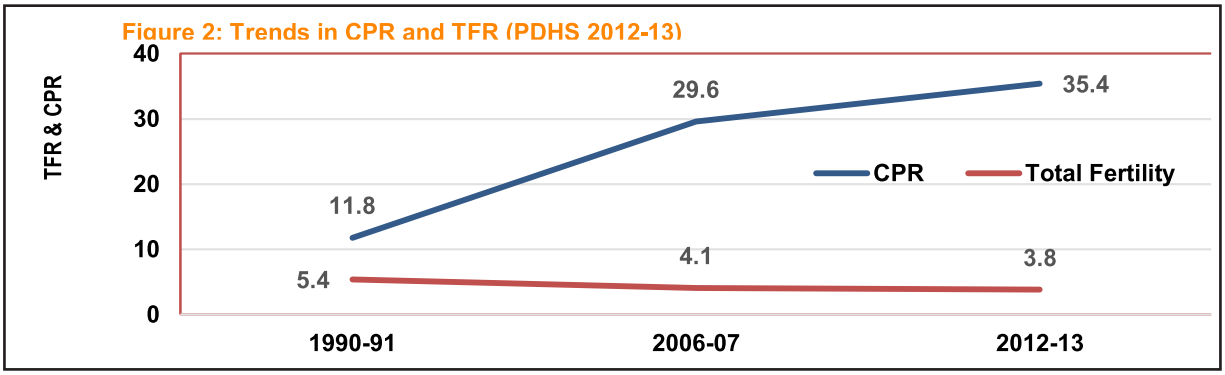
These planned interventions reflected the policy priorities of the provinces collated at federal level, and adapted by the provinces according to their local needs for implementation. All the provinces and other stakeholders had unanimously endorsed the National Accelerated Plan of action for achieving MDGs 4 & 5. Later, the RMNCH Trust Fund was developed to support RMNCH Acceleration Plan, targeting the weakest districts, and filling the gaps in funding to ensure coherence in implementation. Both the National RMNCH Acceleration Plan and RMNCH Trust Fund focused on reducing under-five, newborn, and maternal mortality through targeted interventions, based on the global cost effective and evidence based interventions, delivered in an integrated way.

2.2 Reproductive, Maternal, Newborn, and Child Health

After MDGs, the world has entered the sustainable development era. Despite the progress, much more is required to abolish unnecessary preventable deaths of newborns, children, adolescents, and women in Pakistan.

Pakistan observed a 200% increase in CPR during 1990-91 to 2012-13 and a 30%

Figure 2: Trends in CPR and TFR (PDHS 2012-13)



reduction in TFR for the same period (Figure 3). There is not much disparity in TFR across the provinces however the education status of women seemed to have an impact on TFR reduction. The TFR was reduced by 23 percent from 1990-91 to 2012-13 among uneducated women whereas this reduction was 39 percent for women who were educated to secondary or above levels (Table 2).

Table 2: Trends in fertility by background characteristics (PDHS 2012-13)

Background Characteristics		1990-91	2006-07	2012-13
Residence	Urban	4.9	3.3	3.2
	Rural	5.6	4.5	4.2
Province	Punjab	5.4	3.9	3.8
	Sindh	5.1	4.3	3.9
	KPK	5.5	4.3	3.9
	Balochistan	5.8	4.1	4.2
Education	No education	5.7	4.8	4.4
	Primary	4.9	4.0	4.0
	Middle	4.5	3.2	3.2
	Secondary & above	3.6	2.7	2.2
Total		**5.4**	**4.1**	**3.8**

There is considerable disparity in maternal and child health status across the provinces and regions of Pakistan. Table 3 gives comparison of maternal and child mortality indicators for national, provincial, and regional levels.

Most of the causes that are responsible for this morbidity and mortality in these vulnerable groups are either preventable or easily treatable. This can be achieved through enhanced access to quality health services i.e., antenatal care, delivery by skill birth attendants, improving EmONC services, and by adopting cost effective IMMCI and IYCF strategies.

Table 3: Maternal and Child mortality indicators – National & Provinces

	NMR	IMR	CMR	U5MR	MMR*
Pakistan	55	74	17	89	276
Urban	47	63	11	74	
Rural	62	88	20	106	
Punjab	63	88	18	105	227
Sindh	54	74	20	93	314
KPK	41	58	13	70	275
Balochistan	63	97	15	111	785
ICT Islamabad	26	35	9	43	
Gilgit Baltistan	39	71	19	89	600

* Source for MMR is PDHS 2006-7;
Source for NMR, IMR, CMR and U5MR is PDHS 2012-13

However, the health system is facing many bottlenecks that badly hamper the service provision. These bottlenecks primarily include: lack of qualified human resources especially female health care provider, absence of simple medical technologies, low immunization coverage, ineffective monitoring and evaluation and surveillance systems. Almost all these insufficiencies emerge from deficient resource allocations.

Pakistan has about 33% of the children who need to be immunized in accordance with WHO immunization targets for the Region Unfortunately, in Pakistan routine immunization coverage is far from optimal. It is among 10 countries with at least 60% of children unvaccinated. country remains one of the last with indigenous poliovirus circulation, measles is endemic and deaths due to diphtheria pertussis and neonatal tetanus are reported.

The WHO further reports that in Pakistan there are 31.6 percent tdienneutfu children, 10.5 percent are wasted, 3.3 percent are severely wasted, 45 percent are stunted whereas 4.8 percent are overweight. Around 26 percent of sahsmated reproductivesage suffer from anemia. Around a quarter of newborn have low birth weight, only 18 percent of children are put to breast within first hour of birth, and around 5.3 percent are exclusively breastfed for 6 months.

This situation warrants concerted efforts throughout the country by national and provincial departments of health with a strong advocacy towards policy makers for their continued support to the cause of RMNCAH; this will only be achieved by increasing allocation of resources, to address the issue of equity and access to quality health care services for vulnerable segments of the society.

2.3 Health Service Delivery

In Pakistan, the health care delivery system comprises of two sectors: the public and private sectors. The constitution of Pakistan holds provinces responsible for the provision of health care service delivery, except in the federally administrated areas. Health care delivery has traditionally been jointly administered by the federal and provincial governments with districts mainly responsible for implementation. Service delivery is being organized through preventive, promotive, curative, and rehabilitative services. The curative and rehabilitative services are being provided mainly at the secondary and tertiary care facilities. Preventive and promotive services, on the other hand, are mainly provided through various national programs; and community health workers' interfacing with the communities through primary healthcare facilities and outreach activities[11].

The state provides healthcare through a three-tiered healthcare delivery system and a range of public health interventions.

Some government and semi government organizations like the armed forces, parastatals such as Sui Gas, WAPDA, Railways, Fauji Foundation and the Employees Social Security Institution provide health service to their employees and their dependents through their own system, however, these collectively cover about 10% of the population.

The private health sector constitutes a diverse group of doctors, nurses, pharmacists, traditional healers, drug vendors, as well as laboratory technicians, shopkeepers, and unqualified practitioners.

2.3.1 Public sector

Public sector health care system endeavors to deliver healthcare through a three-level healthcare delivery system and a range of public health interventions. The first level includes Basic Health Units (BHUs) and Rural Health Centers (RHCs) constituting the primary healthcare model, secondary care encompassed first and second referral facilities providing acute, ambulatory, and inpatient care through Tehsil Headquarter Hospitals (THQs) and District Headquarter Hospitals (DHQs) and tertiary care including teaching hospitals.

The public health activities have persistently increased in terms of physical infrastructure and workforce. The national health infrastructure comprises of 1,201 hospitals, 5,518 Basic Health Units, 6,83 Rural Health Centers, 5,802 Dispensaries, 731 Maternity and Child Health Centers and 347 TB centers. The total beds in these health facilities are estimated at 123,394. In addition, more than 103,000 Lady Health Workers are providing primary health care services to the community through the health houses.

The numbers of doctors, dentist, nurses and LHVs have increased and availability of one doctor, dentist, nurse and one hospital bed versus population has gradually improved[12]. A comparison of health man power from 2011-12 to 2016-17 is given in Table 4.

Despite an elaborate and extensive health infrastructure, the health care service delivery faces some key issues like the high population growth, uneven distribution of health professionals, deficient workforce, insufficient funding, and limited access to quality health care services.

Table 4: Health Workforce in Pakistan

HEALTH MANPOWER	2012	2017	PERCENT CHANGE
Registered Doctors	152,368	195,896	28.6
Registered Dentists	11,649	18,333	57.4
Registered Nurses	77,683	99,228	27.7
Population per Doctor	1,162	997	-14.2
Population per Dentist	15,203	10,658	-29.9
Population per Bed	1,647	1,584	-3.8

Data source: http://www.emro.who.int/countries/pak/index.html

2.3.2 Private sector

The rising population pressure on state health institutions and limited public health facilities have encouraged the private sector to bridge the gap between demand and supply. Many private hospitals, clinics and diagnostic labs has increased considerably and is contributing health services in the country. Majority of private sector hospitals has sole proprietorship or a partnership model of organization. Stand-alone clinics across Pakistan are the major providers of out-patient care majority of these clinics falls in the sole proprietorship category. However, the quality services at private hospitals and clinics are expensive and generally inaccessible by most of the population.

2.4 Programs, Policies, and Strategies

Until 2010, before the 18th amendment in the constitution, Pakistan had been implementing health sector reforms through its federal level policy and planning conduits. However, after that constitutional amendment, the subjects of health and population were devolved to Provinces.

The Government of Pakistan comprehends that the health of women and children are crucial to progress on all development goals. There is a dire need to invest more in the health sector to help building a peaceful, stable, and productive society, leading to poverty reduction. With this vision in view, over the time the Government of Pakistan has initiated the following programs:

- National Expanded Program for Immunization – 1979
- National AIDS control program – 1986
- Baby Friendly Initiative – 1989
- Dias Training Program – 1989
- Family Health Project – 1991
- Polio Eradication Initiative – 1994
- National program for Family Planning and Primary Health Care – 1994
- Health Care Development Project – 1997
- Women Health Project – 1999
- National strategy towards MDGs 4 & 5 (R-MNCH Strategic Framework 2005 – 2012)

- National RMNCH program – 2007
- Community Management of Acute Malnutrition – 2010

The National Expanded Program for Immunization provides vaccination services against priority diseases to reduce child mortality from vaccine preventable diseases i.e. childhood tuberculosis, poliomyelitis, diphtheria, pertussis, neonatal tetanus, measles, Hib and Hepatitis B and pneumonia. New vaccines like Rota virus is recently included in EPI to reduce the incidence of diarrhea among children under five. The country has witnessed improvement in reported routine vaccination coverage with DTP – 3 / Penta – 3 coverage, increasing from 43 percent in 1990 to 65 percent in 2012. Moreover, proportion of children who received all vaccination is increased from 35 percent in 1990 to 54 percent in 2012 (Table 5).

Although reported coverage is improving, there are strong indications that the coverage is unevenly distributed with large districts experiencing very low coverage. Official reports indicate that 23% of districts have Penta-3 vaccination coverage of less than 80% in 2011. Unfortunately, progress in implementing the "Reaching Every District" (RED) approach in the priority districts has been very slow.

Table 5: Levels and trends in Immunization coverage of children age 12-23 months (PDHS 2012-13)

YEAR REPORTED	BCG	DPT			POLIO				MEASLES	ALL VACC	NO VACC
		1	2	3	0	1	2	3			
1990-91	69.7	64.1	60	42.7	NA	64.8	60.5	42.9	50.2	35.1	28.3
2006-07	80.3	74.8	66.5	58.5	56.3	93.0	90.6	83.1	59.9	47.3	6.0
2012-13	85.2	78.8	72.7	65.2	69.4	92.3	89.2	85.3	61.4	53.8	5.4

Although the MNCH program has adopted concrete strategies and policies focusing on women and children, their implementation and outcomes have varied greatly. Training and deployment of community midwives is still a great challenge. The availability of 24/7 obstetric and emergency services are again an uphill task under the current circumstances. National health data shows that some of the policies have had a positive impact on few health indicators such as increase in the percentage of deliveries assisted by skilled birth attendants, but much more is needed. Primary health care services were also extended to community level through the lady health worker (LHW) program, which provides services through home visits in rural areas. LHWs contribute directly to improved hygiene and higher levels of contraceptive use, antenatal care, iron supplementation during pregnancy, growth monitoring of children, and vaccination of mothers and children.

2.5 Challenges

Despite several social, economic, political, and cross border challenges compounded by successive natural catastrophes, the health indicators of Pakistan have shown improvement in the last 25 years; however, it still lags some regional countries. The average life expectancy has increased from 59 years by 1990 to 67 years by 2015. The last maternal mortality ratio reported is 178 per 100,000 live births, but it has improved significantly in the past decade, owing to wide outreach of national LHW program, and better skilled birth attendance availability. Similarly, infant and under 5 mortality rates have improved however the neonatal mortality rate has remained almost stagnant.

Pakistan is facing a double burden of disease (BoD), the burden is higher in the poor, and many of these conditions can be controlled at relatively low-cost interventions and best practices through primary and secondary care levels. Communicable diseases, maternal

health issues and under-nutrition dominate and constitute about half of the BoD. In young children, diarrhea and respiratory illness remain as the major killers. Maternal deaths due to preventable causes like sepsis, hemorrhage and hypertensive crises are common. Pakistan is one of the three remaining countries where Polio is still endemic.

Moreover, Pakistan has an endemicity of hepatitis B and C in the general population with 7.6 percent affected individuals; the 5th highest tuberculosis burden in the world[13], has focal geographical area of malaria endemicity, and an established HIV concentration among high risk groups. Other vaccine preventable diseases and new emerging infections call for strengthening disease surveillance and response system uniformly across the country. Pakistan has one of the highest prevalence of under-weight children in South Asia. Similarly stunting, micro nutrient deficiencies and low birth weight babies contribute to already high level of mortality in mothers and children.

Non-Communicable Diseases along with Injuries and Mental health issues, now constitute other half of the BoD, causing far more disabilities and premature deaths among an economically productive adult age group[14]. The common underlying factors for non-communicable diseases including lifestyle, nutrition and smoking have not been addressed adequately. Injuries account for more than 11% of the total BoD, and are likely to rise with increasing road traffic, urbanization, and conflict. Pakistan is ranked 7th highest in the world for diabetes prevalence. One in four adults over 18 years of age is hypertensive, and smoking levels are high (38 percent among men and 7 percent among women). Rising but still un-estimated burden of cancers and COPD remain a largely unaddressed area. Poverty, low literacy, unemployment, gender discrimination, and huge treatment gap have led to an invisible burden of mental health problems in the society. Disability due to blindness or other causes is also high, and services for disabled population are limited, including provision of assist devices to improve their quality of life.

Population Explosion: The BoD is rendered worse by an increasing population. The recent census reveals that Pakistan has a population of almost 217 million. Decline in population growth rate has been slow, and the current population growth rate of 1.9% per annum is driven by increasing age at marriage in urban areas; while contraceptive prevalence of only 35 percent is far below than other regional countries. Unmet need for birth spacing is around 25 percent, and the health system must strategize to address this gap.

Health Access and Inequities: Pakistan has seen progress in access to health care services; however, the gains are uneven across different service areas as out of pocket expenditure is still around 70% despite having network of (primary, secondary, and tertiary) health care system in place. Though skilled birth attendance (SBA) has improved from 18% in late 1990s' to 58% in 2015, but only one third of women make the required minimum number of antenatal visits and the number decreases further for postnatal visits (2% after 1-2 days of delivery). Despite reduction in Polio cases due to high vertical accountability, the rates of routine immunization remain unacceptably low at 54%. Access to and affordability of essential medicines is low. Moreover, there are geographical disparities in coverage between provinces, districts, and rural-urban area. Evidence shows that low income groups are likely to have lower levels of health, nutrition, immunization, and family planning coverage.

Health Systems: Health system faces challenges of vertical service delivery structures

and low performance accountability within the government, creating efficiency and quality issues. Largely unregulated for quality care and pricing, there is also duplication of services by the private sector. Although having the potential, private sector contributes least towards preventive and promotive health services. The public sector is inadequately staffed, and job satisfaction and work environment need improvement. The overall health sector also faces an imbalance in the number, skill mix and deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary, and tertiary. To produce quality workforce for health sector, the quality of medical and allied education both in public and private sector needs to be considered. A range of actions is needed, acting upon the social determinants within the health and social sectors, if a wider impact is to be achieved.

3 THE NATIONAL HEALTH VISION

The National Health Vision 2016–2025 provides an overarching national vision, guides national and provincial health departments towards an agreed upon common direction, harmonizes provincial and federal efforts as well as inter-provincial efforts, and inter-sectoral efforts for achieving the desired health outcomes to create an impact.

Following that visionary document, National Vision for Coordinated Priority Actions 2016–2025 was developed by the Ministry of National Health Services, Regulation, and Coordination, Government of Pakistan. The major aim was to address the challenges in improving Reproductive, Maternal, Newborn, Child and Adolescent Health, and Nutrition.

These proposed interventions are developed in line with these two strategic and planning documents which provided guidance to provinces and regions to develop their respective plans.

The devolution of health to the provinces has created challenges as well as opportunities for action. It is envisaged that the health benefits gained through the federal support can lead to more equitable health system coverage. The provincial health departments and the re-established Ministry of National Health Services, Regulation and Coordination are taking up their new-found roles.

3.1 Vision and Objectives

3.1.1 Vision

To improve the health of all Pakistanis, 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.

3.1.2 Objectives

The National Health Vision has adopted the following objectives to improve the health and well-being of the Pakistani society:

1. Provide a unified vision to improve Health while ensuring provincial autonomy and diversity
2. Build coherence to Federal & Provincial efforts in consolidating the progress, learning from experiences, and moving towards the universal health coverage.

3. Facilitate synchronization for commonality across international reporting and international treaties
4. Facilitate coordination for regulation, information collection, surveillance, and research for improved health systems
5. Provide a foundational basis for charting and implementing SDGs, in partnership with other sectors.

3.2 Guiding Values

While ensuring adherence to Universal Health Coverage as its ultimate goal, the National Health Vision provides an approachable combined national direction to address various health challenges. The principle values include:

- Good governance
- Innovation and Transformation
- Equity and pro-poor approach
- Responsiveness
- Transparency and Accountability
- Integration and cross sectoral synergies

The delivery of quality health care services is a provincial responsibility therefore the priority actions would be in line with the provincial needs, expectations, and priorities. The national health vision resonates with the ideals and expectations of provinces. The Federal government will continue supporting and facilitating the provinces in developing and implementing their strategies. This support primarily entails in providing the overall vision and by facilitating and advocating for financial and technical resource mobilization. The main purpose is to ensure that essential health services are accessible to all citizens.

3.3 Thematic Pillars

National Health Vision builds its narrative on the following thematic pillars. These eight pillars will pave ways for ensuring access, coverage, quality, and safety, which are essential requisites for achieving the ultimate goals of health system: improved health, responsiveness, social protection, and efficiency.

1. Health Financing
2. Health Service Delivery
3. Human Resource for Health
4. Health Information Systems
5. Governance
6. Essential Medicines & Technology
7. Cross-sectoral linkages
8. Global Health Responsibilities

Each thematic pillar or domain is critically analyzed for the challenges as well as for the strategic vision to address the challenges. The federal government will offer and

coordinated the technical support to the provinces.

3.3.1 Health Financing

Challenges

Government spending on health has always been less than optimal (0.6 percent of GDP). Most part of the allocations to health is consumed by the secondary and tertiary care, leaving merely 15 percent for the preventive and primary health care. Furthermore, there are inefficiencies in the public health spending due to weak management systems, resulting in low utilization and eventual lapse of funds. Payments are generally not linked to performance.

Donor funding has been minimal (<2 percent of total national health expenditure). The official donor assistance (ODA) is far less than that committed in the Paris declaration, and that too could be better aligned and coordinated with governments' strategies.

Many population sub-groups lack financial protection, and face risk of catastrophic health expenditure.

Strategies

Government is conscious that adequate, responsive, and efficient health financing is the cornerstone of a country's overall development. The spending on health will be advocated as "investment" with the line ministries, finance departments and international development partners. Federal and Provincial governments will increase allocation to health as pledged in Pakistan vision 2025 to 3 percent of GDP.

Priorities for health allocations will be revisited, and a higher share for essential health service delivery, preventive programs, communication, capacity building of frontline health workers, and governance will be ensured.

Pro-poor social protection initiatives (including the recent national health insurance scheme) will continue to be financed and new initiatives (CCT, vouchers) will be launched, facilitating access to essential primary, secondary health services and priority diseases. There will be a progressive movement towards universal health coverage. RMNCAH and nutrition investments will be increased in a phased manner.

Federal and provincial governments will develop joint strategies aimed to enhance resource mobilization for health from Official Development Assistance (ODA), international development partners, private sectors' engagement, and through taxes.

3.3.2 Packaging Health Services

Challenges

Pakistan now has an established and increasing double burden of disease including non-communicable diseases, mental health, and injuries as well as communicable and infectious diseases such as TB, HIV/AIDS and Hepatitis B and C.

Inadequate infrastructure and inappropriate service delivery standards along with poor quality of services have shaken the trust of the public. This has resulted in underutilizing of the first level care in public sector to merely 20 percent. Progress has been constrained by fragmented delivery of services, inadequate resource commitment to preventive and promotive care, human resource imbalance, and lack of skill mix.

Inequitable access, urban-rural disparities, lack of regulation of private sector, non-conformity of essential services packages have made the healthcare delivery being non – responsive.

Strategies

Governments plan to improve the coverage and functionality of primary and promotive health services, while ensuring the essential service packages by introducing family medicine, newborn survival, birth spacing and contraceptives supply, noncommunicable diseases, mental health, undernutrition, disabilities, problems of ageing population and other issues. Quality of services will be ensured by implementing Minimal Standards for Delivery of Service at all levels.

Provincial Governments will encourage and support the integration of vertical programmes at the provincial level for optimal and efficient utilization of resources and better performance. Moreover, it will enforce the public health laws related to smoking, drug safety, organ donation and transplant, safe blood transfusion, environmental protection, food safety, etc.

Efforts would be geared toward building synergies with the private sector in essential health services delivery (preventive and curative), reporting on key indicators and for understanding its functioning, composition, and possible outreach for the under-privileged.

Entire health care system will be made resilient to disasters (climate change, natural disasters, disease outbreak etc.) in terms of both disaster mitigation response and continued provision of services during acute crisis / emergencies.

3.3.3 Human Resource for Health

Challenges

Human Resource in health is the most critical factor in provision of quality preventive, promotive and curative services. Pakistan has one of the lowest doctors, dentists, nurses, and paramedics to population ratios. Other pressing issues in human resource include their inadequate distribution, retention issues and low work-place satisfaction levels. This results in significant brain drain at all levels.

Professional education in health is run at sub-optimal level without synchronizing the curriculum with modern pedagogic techniques, international standards, and the local requirements.

Licensing and renewal of licensing of health practitioners is weak, and is not linked with improved qualification, competence, performance, and continuous professional development. The institutional capabilities for gauging the performance of health staff are weak. There is an apparent stagnancy in the coverage of community health workers, and their numbers, coverage and quality are far from the required standards.

Strategies

Medical and allied health education will be tailored according to the health needs of the population, focusing on social determinants of health, ethics, and public health laws. Continuous Professional Development will be institutionalized across both public and private sectors in conjunction with associations, and linking up with accreditation of the

health professionals.

Further expansion and strengthening of existing workforce will be done to address challenges of rapidly growing population, disease patterns and the health needs.

Governments will focus towards appropriate and adequate skill mix of human resource production and task shifting, where required. Fields of Public health, Allied health institutions and Family Medicine will be nurtured and institutionalized to increase the cadre of managers, regulators, administrators, specialized allied health staff and family physicians.

Responsive management will be brought in the health departments, and incentives will be given to boost the performance and to make the rural appointments attractive.

HR database at provincial and national level will be formed for forecasting and development. Developing a comprehensive National HR strategy, Nursing strategy and other allied health work force strategies will be considered.

3.3.4 Health Information Systems and Research

Challenges

Health Information Systems currently in use in Pakistan are fragmented and vertical. They respond to or serve primarily the health programs that created them. Consequently, health indicator data collated through various systems sometimes give conflicting results. Moreover, Demographic Health or the Social and Living Measurement Surveys cannot fully compensate for the lack of reliable ongoing systematic data. It is critical to use the information systems for planning, resource allocation, and health care delivery system however, it is unusable because it lacks accuracy, quality, reliability, and absence of linkages with decision makers.

Though research is conducted in Pakistan, it is carried out in silos, does not have relevance to local issues, and quality is often compromised because of capacity and resources. There is a disconnect between researchers, implementers, and policy makers.

Strategies

To support evidence based decision making at the district level through District Health Information System (DHIS), innovative technologies will be incorporated to provide speedy and reliable information. Platforms at provincial and national level for transforming evidence into policy advice will be encouraged including dedicated units at federal and provincial levels.

Governments will be building coherence across health information systems, and will be investing in key missing areas for monitoring the SDGs as well as national health targets, and information on vital events such as births and deaths.

The national health vision calls for a transition from medical research to national health research prioritizing areas as per local requirements. Central hub for information repository, standardization and quality will be developed at national level with the assistance of provinces.

Strengthening of information systems at national, provincial and district levels eventually

leading to an effective, integrated disease surveillance and response system, with a focus on Early Warning System.

3.3.5 Governance

Challenges

Governance has been a constant challenge undermining service delivery and budgetary investments. At times patronage plays a significant role in determining the agenda for health policies and administration in Pakistan, as in other sectors.

The capacity to regulate public and the private sector health market i.e. medical practice, pharmaceutical, and diagnostics is weak.

There is no uniform approach for managing the governance of health institutions and the capacity for contracting in and contracting out of services is not optimal.

Strategies

It appears necessary for federal and provincial health authorities to rebuild their stewardship of the health system through professional independent advice and technical governance of health services planning, and strive to become the forefront provider of essential health services provision and delivery.

A steady and purposeful stewardship role of the provinces should bring about structural changes in the health system. It is envisaged to have sector wide strategic planning, regulation, purchasing and financing and moving towards separation of service provision from its stewardship function. Health services reforms which are already underway should focus more on performance strengthening of government provided services. Innovative management models of PHC are envisaged to be tried out with an emphasis for alignment with preventive health targets.

Private sector should be a partner in healthcare delivery and should be engaged/regulated through appropriate mechanisms. They should also be engaged for meeting national SDG targets.

Increasing share of public sector budgets commitment for governance strengthening, and establishing dedicated structures within provincial and federal ministries. Both government and private service providers will be involved in performance accountability and target oriented service delivery arrangements. Accountability mechanisms at all levels are envisaged to be put in place. Development of key performance indicators and output based measures would be helpful in gradual progression towards performance based models.

3.3.6 Essential Medicines & Technology

Challenges

The current technologies being utilized in the health sector have not evolved through a rigorous needs assessment process, leading to misuse of such equipment/technologies. Current mechanisms to determine the appropriateness of supplies, diagnostics, medicines, and laboratory reagents are not evidence based.

Package of essential services does not identify the type and quantum of equipment,

supplies and medicines needed to deliver the defined services for a specific health facility. This encourages irrational procurements, use and spending on technologies resulting in loss of precious resources.

There are issues related to quality and price of drugs and their prescriptions. Medicines pricing is a contentious issue between the regulators and the industry.

Health Technology Assessment employing multidisciplinary approaches including Pharmaco- economics, Pharmaco-epidemiology and Pharmaco-vigilance remains as un-initiated concepts.

Strategies

Health Technology Assessment (HTA) capacity will be created at federal, provincial and district level. Governments will be vigilantly monitoring the selection, quality, price and use of technologies, equipment and medicine, as per international standards.

More evidence and best practices will be collected regarding medicines related policies, legislations, and operative guidelines; and to translate the same into standard treatment guidelines. Setting up an entity (e.g. NICE-UK) is another need to adherence to the standard treatment guidelines and best practices.

The federal and provincial governments will ensure that appropriate regulations are in place for the control of drugs, devices, diagnostics, and biological reagents across the country, ensuring quality control and patient safety.

Pharmaceutical industry will be encouraged to provide innovative and affordable solutions to the patients. Pharmaco-vigilance program will be introduced at federal level and collection centers at provinces.

Drug pricing policy will be implemented, protecting public interest by regulating prices of essential medicines while allowing long term predictability. Appropriate policies for Orphan Drugs, Alternative medicine and Medical Devices will also be put in place.

Strengthening of DRAP and effective Legislation is required for efficient regulation of drugs, human organs donations, blood transfusions and all therapeutic goods will be revisited and implemented in spirit.

3.3.7 Cross-Sectoral Linkages

Challenges

There is growing awareness amongst public health professionals that their universe is impacted by the political, social, economic, and developmental milieu in which they operate.

Factors such as illiteracy, unemployment, gender inequality, food insecurity, rapid urbanization, environmental degradation, natural disasters, and the lack of access to safe water and sanitation all have the potential to aggravate the state of health of individuals and communities.

Many preventable deaths and disabilities among children, pregnant/ lactating women, young adults, and aging population can be averted but action lies beyond the scope of and mandate of health sector.

Strategic Vision

There will be a renewed and synergistic focus on cross-sectoral action for advancing health, with a focus on communicable and non-communicable disease including mental health and under-nutrition. The concept of “One Health” and “Health in all policies” will be promoted.

Government will be striving to develop a common vision, framework, and a platform with multiple stakeholders from across the sectors to work for health, for instance education, food security, agriculture and livestock, housing, sanitation, water, environment, IT, local government, social protection etc.

To gear up its efforts towards SDGs, Government will embark upon advocacy, planning, legislation, regulation, behavioral change communication, information exchange, and evidence based decision through joint efforts of different sectors.

Efforts will be geared towards recognition of community involvement, women empowerment, and local/ rural development being the key channels for cross-sectoral action, and health will be an inclusive partner.

3.3.8 Global Health Responsibilities

Challenges

Sustainable Development Goals (SDGs) and the broader sustainability agenda, need far more efforts than employed in MDGs, addressing the root causes of poverty and the universal need for development that works for all people.

Achieving international public health security is one of the main challenges arising from the new and complex landscape of public health. Treaties like International Health Regulations (IHR-2005) and Global Health Security Agenda (GHSA) require certain core capacities that are not yet appropriately developed at federal and provincial levels.

Strategies

New global sustainable development agenda will be reflected in all health strategies and plans, for which governments will be provided technical support and appropriate expertise.

Mechanisms will be established for coordination across sectors and between provinces and federal ministry, to prevent, detect, and provide a coordinated response to events that may constitute a public health emergency of both national and international concern, including integrated disease surveillance and response, as laid down by the IHR 2005 and GHSA.

Determining systematically the assets and best practices of polio eradication to be transitioned and mainstreamed over time to support other priorities, particularly immunization and vaccine- preventable disease surveillance. Adherence to other international treaties would warrant a strategic and coordinated approach to achieve the targets of newly adopted SDGs.

4 THE PRIORITY ACTIONS

The Prime Minister of Pakistan during a meeting in February 2015 with international and national leaders in public health expressed his concern on slow progress in RMNCAH and nutrition related aspects in Pakistan over the last decades. On his directions, the national leadership analyzed the situation and carved a comprehensive action plan with identified priority areas at national level, along the provincial counterparts and all partners in development sector.

Subsequently a consultative process was initiated between all stakeholders to identify priority areas and identify clear strategic directions for RMNCAH and Nutrition for the next ten years with tangible results and outcomes. These priority actions provided base for development of objectives and outcomes for the provincial and regional health plans.

The following are the ten priority areas identified by all the stakeholders for action:

1. Improve access and quality of Community based RMNCAH
2. Improve quality of care in district health facilities
3. Overcome financial barriers to care seeking and uptake of interventions
4. Increase funding and allocation for RMNCAH
5. Improve Reproductive Health and Family Planning
6. Invest in nutrition of adolescent girls, mothers, and children
7. Invest in addressing social determinants of health
8. Measure and act at district level
9. Ensure Accountability and Oversight
10. Generate political will for RMNCAH as a key priority within the SDGs

The following paragraphs briefly describe the situation related to these ten priority areas identified for action:

4.1 Improve Access and Quality of Community-based RMNCAH

Primary care services in rural areas of Pakistan are critically dependent upon the LHWs and to some extent on the recently developed community midwives' cadre. After the devolution, the most recent formal evaluation of the LHW program and many informal reports have revealed several areas of weakness in their knowledge and skills specially around standard best practices for maternal, newborn and child survival.

Effective coverage is a serious issue. There are managerial inefficiencies and around 30 to 50 percent of the rural population especially the poorest and most remote areas, are not covered by LHWs.

Similarly, the retention and utility of CMWs is still uncertain, especially when they are expected to improve coverage of skilled attendants in their areas. The quality of services offered by the LHWs and CMWs requires a thorough review and constant monitoring to gain the trust of these workers by the population.

The following are the actions needed for improvement:

i. An external review of the Lady Health Workers and MNCH programs to steer future direction in the post devolution scenario and ensure adequate funding.

ii. Develop national strategic vision for LHWs and CMWs for promotion of evidence based international best practices for maternal newborn care and investing in adolescent health.

iii. Establish regulatory mechanisms for employment, re-recruitment, and retention of LHWs and CMWs.

iv. Innovative solutions for areas uncovered by LHWs, including combining an education and training program for young women willing to take on the roles of CHWs.

v. Train community volunteers in urban slums of larger cities in prevention and promotion strategies.

vi. Review of the Essential Newborn Action Plan and the packages of care on ending preventable stillbirths and neonatal deaths. Provision of low-cost antenatal care to reduce still births related to infection and malnutrition through outreach workers and services.

vii. Use appropriate e-technologies for monitoring service delivery at all tiers in remote areas.

viii. Engage and regulate CSOs and private sector for involvement in community based MNCH PHC services.

ix. Research to identify gaps in existing community based health programs and coming up with recommendation to strengthen them based on evidence

4.2 Improve Quality of Care in District Facilities

This is the key barrier to promote care seeking in public sector facilities due to issues including human resources, infrastructure, essential supplies, medicine, medical technologies, transportation, and communication. Poor quality of care (both antenatal and obstetric care), maltreatment or socio-cultural insensitivity, absence of a trained attendant at delivery, inadequate referral systems for emergency obstetric care, inadequate or absent transportation facilities, are all key barriers.

At district level absence of effective linkages between health services and communities, hamper quality improvement and utilization of health facilities.

The following are the actions needed for improvement:

i. Develop linkages between medical colleges and universities with district health systems.

ii. Involve private and not for profit sectors in the provision of RMNCAH and nutrition services with appropriate regulation.

iii. Ensure human resources especially women medical officers and lady health visitors at rural health facilities.

iv. Build capacities for monitoring of quality of services at district and provincial level.

v. Develop and ensure adherence to standard service delivery protocols and guidelines for RMNCAH.

vi. Expand service access to 24/7 and maintain infrastructure, develop referral pathways and linkages.

vii. Ensure basic emergency obstetric care, facility based support, use of insecticide treated bed-nets to prevent malaria and use of folic acid supplementation and management of diabetes in pregnancy at rural health centers.

viii. Introduce voucher schemes or conditional-cash transfers to encourage births at health facilities.

ix. Provide adolescent friendly sexual and reproductive health services at the primary health care level to improve health seeking behaviors and make informed choices.

x. Strengthen DHIS and M&E component at district level to ensure quality of data, reporting and use of information for decision making.

xi. Revise medical and nursing curricula of undergraduate to include recent advances in medical science

xii. Count every newborn by institutionalizing civil registration and vital statistics maternal, perinatal, and neonatal death surveillance and response.

4.3 Overcome Financial Barriers

The relationship between poverty and health outcomes is unescapable. Hence a major focus of action must aim at reducing inequities in health care as most of the deaths are clustered across the poorest wealth quintiles. Targeted financial innovations to facilitate RMNCAH, such as cash transfers for promoting skilled care at birth or purchase of health services and nutrition commodities for care, have the potential of overcoming financial barriers.

The following are the actions needed to address these issues:

i. Provide direct cash payments to poor households, depending on certain behaviors, like:
   a. Routine vaccinations
   b. Nutrition supplements
   c. Care seeking for high impact high mortality conditions (diarrheal diseases, pneumonias, ANC visits for pregnant women, family planning, delivery, and post-partum Care).
   d. Evidence suggests that all interventions if coupled with health education sessions especially delivered within Women's and adolescent groups can have multiplicative benefits. These activities can be ideally Conducted or supported by LHWs and community midwives.

ii. Ensure Health Insurance schemes for the identified poorest and marginalized groups for priority illnesses which lead to Catastrophic illnesses.

iii. Ensure universal health care (UHC) for outreach, primary and secondary care.

iv. Introduce demand side financing for provision of family planning Services in remote areas with low CPR.

4.4 Increase Funding and Allocation for RMNCAH

The federal government and all provinces of Pakistan need to substantially increase

funding for RMNCAH. Pakistan's current health spending is a mere 0.6 percent of the GDP. It is critical to invest in health and education and other social determinants and to substantially increase the financial allocations.

Although health has been devolved to the provinces as a principal responsibility, inflation has eroded corresponding increase in resources and support of primary care programs. Much of the existing expenditure within the health sector is also limited to tertiary hospitals and although primary care is supported through the LHW program, there has been limited investment is strengthening district level health services, especially the Rural Health Centers and Basic Health Units.

The following are the actions needed for improvement:

i. Conduct of National Health Accounting (NHA) exercise at regular intervals at national, provincial and district level with the power to disaggregate and monitor R MNCAH and nutrition spending in public and private sectors and across the different service delivery tiers. Results should be analyzed to inform polices and strategies.

ii. Plan to increase health spending at PHC level for the next 5 years to be prepared jointly by federal and provincial government along with line ministries, based on equity and contextual needs.

iii. Ensure timely approval of PC1s and release of allocated funds.

iv. Find innovative ways to generate finances like imposing health tax on luxury items, sin tax on tobacco or nutrition levies on soft drinks, tapping private sector resources, etc.

4.5 Improve Reproductive Health and Family Planning

Family planning (FP), being the most cost-effective interventions to reduce maternal and newborn deaths needs urgent attention. This is required to break the vicious cycle of high population growth rate and poor RMNCAH outcomes and nutrition in Pakistan.

While devolution to the provinces has created opportunities for integration however breaking the silos between parallel initiatives like MNCH, EPI, Malaria, and Nutrition programs, is challenging. The national ministry for health services and regulation will integrate national oversight. The following are the actions needed for improvement:

i. Adopt a national population policy framework to provide overall guidance and ensure national coordination and development of synergies between population and health sectors. There is also an urgent need for declaring population emergency.

ii. Reduce the gap between FP knowledge and practice through comprehensive services that comprises of family planning awareness, options, commodity security with focus on modern methods, as well as innovations, keeping in mind the diversity in the country. Institutions like NIPS, NIFRC and NATPOW along with provincial entities should synergize to provide the guidance to provinces in this area

iii. Focus on sexual and reproductive health education among adolescents, both boys and girls in school and out of school in a culturally sensitive manner.

4.6 Invest in Nutrition of Adolescent Girls, Mothers, and Children

The role of health sector in enabling the implementation of nutrition specific interventions is critical. This is especially true for integrating maternal nutrition and breastfeeding support strategies, ensuring that major causes of micronutrient deficiencies are addressed, and that nutrition prevention and promotion is integrated within the primary care programs. There is an emerging role for mass media and communication strategies around this aspect which needs to be planned and implemented. The following are the actions required for improvement:

i. Ensure relative legislation and mechanisms for its enforcement at appropriate levels. Engage concerned sectors like trade, economic and legal sectors for close monitoring of the implementation of the adopted legislation. Prominent examples are breastfeeding protection laws, food fortification, and iodized salt.

ii. Establish a task force to identify reasons for lack of progress in increasing exclusive breastfeeding rates and suggest appropriate measures.

iii. Ensure fortification of food with micro nutrients by involving industry especially flour and ghee.

iv. Support networks under Scaling Up Nutrition (SUN) movement for more effectiveness.

v. Improve nutritional impact of agricultural practices and programs through biofortification of staple foods, nutrition education on food safety, and control of mycotoxins.

vi. Ensure that women, adolescents mothers, and children get sufficient amounts of key Vitamins and minerals which are proven strategies to reduce nutrition-related child mortality.

vii. Invest in nutrition sensitive interventions like female education, WASH, and food security through agriculture.

4.7 Invest to Address Social Determinants of Health

The social determinants affecting RMNCAH in Pakistan like low status of women, compromised adolescent girls' education, and empowerment, need to be addressed. The role of maternal education is critical in improving child survival and maternal health. There is need to integration health information regarding RMNCAH with other sectors such as education. The prevention of early / forced child marriages and ensuring gender empowerment is the key task for the federal ministry along with the provinces.

i. Expand the policy and programs in health promotion, disease prevention, and health care to include social determinants of health approach.

ii. Empower women and adolescents through skill development, women focused micro-financing schemes, creation of job opportunities, and investing in cottage industry.

iii. Generate evidence on social determinants of health and health equity, including health equity focused intervention research.

iv. Address the social determinants by engaging all the relevant line ministries and concerned interventions like education, housing sanitation, safe drinking water, women empowerment for decision making to seek health care and reduce poverty

4.8 Measurement and Action at District Level

One of the key limitations for action is lack of accurate and timely information. Pakistan has for a long time been dependent upon expensive and time-consuming cross-sectional surveys for assessment of progress and to-date key information on important issues of direct causes of mortality and morbidity are not available at provincial and district level. There is a need for strengthening of district information systems such as the DHIS, verbal autopsy and the creation of sentinel information systems for important areas related to RMNCAH, disaggregated by age groups and sex. To operationalize this, there needs to:

i. Agree on key set of meaningful indicators from facility and community level for MNCAH and nutrition monitoring for inclusion in the overall framework of monitoring encompassing all health system elements. Executive dashboard having key health indicators be linked up with DHIS and other data reporting sources to provide evidence for policy makers and health managers to take evidence based decisions.

ii. Ensure mechanisms for transparent and robust district level external evaluations at 2 to 3 yearly intervals that generate population-level estimates.

iii. Increase alignment and support behind a single national plan and monitoring framework for RMNCAH and nutrition using appropriate logistics and technology.

iv. Work on implementation throughout the country of civil registration and vital statistics (CRVS) which should have data based on cause specific mortality and morbidity

4.9 Accountability and Oversight

In addition to the district based measures outlined above, there needs to be a national oversight body for RMNCAH and nutrition in Pakistan linked to respective provincial structures. This national committee should consist of leading technical authorities and civic society representatives. Means should be developed for linking in development partners and creating mechanisms for setting targets, means for implementation and providing independent feedback on progress or lack thereof. A role for the committee needs to be created within the framework of interprovincial coordination and communication. The following is required:

i. Identify and addressed accountability gaps with clear targets/results and indicators to track progress in RMNCAH particularly for newborn survival and nutrition.

ii. Establish an effective multi-tiered monitoring and evaluation system linked to accountability forums at district, provincial and national level.

iii. Establish a high level “inter-ministerial forum for health and population” and an “Inter-agency coordination forum” at national level.

iv. Improve governance and accountability mechanism through institutionalizing key performance indicators and health regulatory measures at provincial and district level.

4.10 Generation of Political Will for RMNCAH

It is vital that the federal and provincial political leaderships are familiar with the importance of RMNCAH and Nutrition in national development. There is dire need that ministries of finance, economic affairs division, and the planning commission understand the national

priorities. Political commitment and investment in sexual and reproductive health services and programs is an integral bottleneck that needs to be addressed. The following are the actions required in this area:

i. Build capacity of policy makers, parliamentarians, and Standing Committees on health and population issues. Media's role could be vital to help them understand the linkages of health with development.

ii. Engage with key stakeholders like religious scholars and media to address myths and misconception on family planning, etc.

iii. Develop a culture of "use of evidence for policy" at every level. National and provincial forums may develop linkages between politicians, policy makers, scientists, and researchers. Think tanks in every area should be encouraged.

iv. Encourage the development of local participatory governance mechanisms to enable communities and local government to collaborate in RMNCAH related activities.

v. Strengthen health system response to adolescent health; capacity building of health care providers, standardization of adolescent friendly service provision protocols, improve easy access to primary health care and family planning services for adolescents.

vi. Establish community mechanism for improve health seeking behavior for adolescents.

5 OBJECTIVES, EXPECTED OUTCOMES, AND ACTIVITIES

The objectives, expected outcomes and activities presented in this RMNCAH Investment Case, are derived from the respective provincial and regional five-year RMNCAH plans. The provincial and regional plans were developed in line with National Health Vision 2016 – 2025 and ten priority actions which were mutually identified by all provincial and regional MNCH, LHWs, EPI, and Nutrition programs teams.

5.1 Objectives and Outcomes

This section of document narrates all objectives, expected outcomes and activities of five-year plan i.e., 2016 to 2020. The next three years priorities of provinces are in the last section along with estimated costs for each objective and expected outcome.

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

Outcome 1.1. Enhanced equitable access, coverage, and utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs)

1.1.1. Map / identify outreach staff (CMWs, LHWs, FMWs, MMWs, vaccinators)

1.1.2. Recruit outreach staff (CMWs, FWWs, MMWs, vaccinators, LHWs)

1.1.3. Train outreach staff after recruitment

1.1.4. Conduct 10 days refresher trainings on Standard clinical outlook, Procedure and Record keeping for CMWs and FWWs

1.1.5. Train Officers (Field and Provincial) in Monitoring and Supervision (2 Refresher trainings on alternate year)

1.1.6. Train Health Care Professionals of health and population welfare directorate in Long Acting Reversible Contraceptives

1.1.7. Construct Integrated Warehouse with all allied facilities, one for Each District

1.1.8. Provide Solar Panels with inverter for insertion lamps for Family Welfare Center / CMW Birthing Stations

1.1.9. Strengthen RTIs of PWD through hiring of qualified tutors

1.1.10. Strengthen RTIs PWD through Provision of Teaching Aids (Dummies, Mannequin, Demonstration material, multimedia, desk computers, scanner, lap tops, etc.)

1.1.11. Replace/Provide equipment to Service Delivery Project (IUCD kits, BP Apparatus, Stethoscopes)

1.1.12. Repair / renovate RHSAs

1.1.13. Print booklets on FP Counselling, FP Techniques & Management of Side effects of contraceptives

1.1.14. Upgrade existing midwifery schools to accommodate additional requirement (Repairing / Maintenance Operational Cost)

1.1.15. Recruit qualified midwifery tutors

1.1.16. Recruit MNCH Program training coordinator

1.1.17. Expand of Family Welfare Centers

1.1.18. Increase number of Mobile Service Units.

1.1.19. Procure contraceptives for PWD, LHW Program, MNCH and Health

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.

1.2.1. Increase capacity of existing CMW tutors by enhancing technical / clinical skills (4 Weeks)

1.2.2. ToT of CMW Tutors on Clinical Skills (07 Days)

1.2.3. Revision of Basic Training Curriculum of LHWs

1.2.4. Refresher training of LHWs on new areas (HTSP (2 days), IYCF (5 days), Use of Chlorhexidine (1 Day), cIMNCI (5days), MDSR (1 Day), Home Based Care New Born (3 Days) etc.) contextual to provincial policy

1.2.5. In Service trainings of CMW on FP Techniques (5 days), Clinical PCPNC (7 Days), ENC (HBB, HBS, KMC) (5 Days), MDSR (01 Day), Use of Chlorhexidine and Misoprostol (2 Days), and Use of $MgSO_4$ for Eclampsia/Pre-Eclampsia (2 Days)

1.2.6. Provision of logistics for training/Awareness material of all community based interventions for LHWs

1.2.7. Provision of logistics for training/Awareness material of all community based interventions for CMWs

1.2.8. Capacity building of CMWs/LHWs On Mental health treatment gap for PHC physicians and paramedics

1.2.9. Provision of logistics for training /Awareness material of all community based interventions for FWWs

Outcome 1.3. Improved the linkages (referral) between LHWs/CMWs and HCFs for Nutrition /FP/ ANC/ Natal care/ PNC/ SBA /EPI

1.3.1. Development of referral network from Community up to Provincial / district Level

1.3.2. Orientation to LHWs, CMWs and HCF staff / Provincial /District level Staff on referral pathways

1.3.3. Display of referral linkages pathways in CMWs birth stations, LHWs Health Houses and Health Care facilities

1.3.4. Development/printing/provision of referral slips and record keeping formats to the CMWs and LHWs

1.3.5. Strengthening linkage between referral unit/ LHS/ LHW/ CMW by ensuring supervisory visit of LHS and monthly meeting at Referral unit.

1.3.6. Strengthening DHIS and linking of LHW/CMW MIS with it.

1.3.7. Scale up e-communication of RMNCAH/N related data/information to more CMWs/ FWW/ LHW (online data base, E- monitoring)

Outcome 1.4. Increased community demand for RMNCAH and Nutrition services

1.4.1. Utilization of NGOs social mobilizers/support groups/ CBOs for community mobilization and health services awareness on RMNCH and Nutrition

1.4.2. Conduct effective health education and awareness sessions at community (LHWs/CMWs) in the catchment area of the HCF

1.4.3. Training and Involvement of LHWs & CMWs for communication activities & tracing defaulters and nonstarters (EPI/ANC/PNC/Nutrition)

1.4.4. Use local print and electronic media for social mobilization and health messages on RMNCAH and Nutrition

1.4.5. Provision of IEC material on MNCH, EPI, FP and Nutrition and advocacy kits to LHWs/CMWs for health educations sessions

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

Outcome 2.1. Enhanced skills of HCPs on IMNCI/PCPNC/ENC/ RH/ CMAM/ IYCF etc. (training package) at Primary and Secondary HCFs

2.1.1. Expanding the pool of IMNCI facilitators in province at Center of Excellences

2.1.2. Capacity building of health care providers at PHC facilities (Pediatricians/MOs/WMOs/MTs/Paramedics etc.) on IMNCI skills (11 days)

2.1.3. Conduct of follow-up visits 4 – 6 weeks after training (2nd part of training) for the trained providers for all components.

2.1.4. Conduct training of Health care provides (Gynecologists/Obstetricians/WMOs/LHVs/MW Nurses) on PCPNC (7 days)

2.1.5. Increase the pool of PCPNC facilitators in the province at the Center of Excellences

2.1.6. Conduct training of the HCPs (Gynae & Obs, WMO, MO, Pediatricians, LHVs, staff nurses) on Essential Newborn Care (ENC) (5 Days)

2.1.7. Increase the pool of ENC facilitators at district level

2.1.8. Training of HCPs in Helping the babies Breathe

2.1.9. Capacity building of the HCPs on Reproductive Health/Family Planning Counselling at PHC facilities (LHVs/CMWs/FMTs etc.) (5 days)

2.1.10. Capacity building of the HCPs on Reproductive Health/Family Planning Surgical Trainings at PHC facilities (CMWs/LHVs etc.) (14 days)

Outcome 2.2. Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs and provision of supplies

2.2.1. Induction of HR for providing 24/7 CEmONC services at DHQ/THQ and Basic EMONC services at RHCs in rural districts as per requirement (gynecologist, pediatrician, anesthetist, WMOs, Nurses, LHVs, OTT, BBT, Lab tech, aya, sweepers)

2.2.2. Incentivize (top ups) the services of the RMNCAH related staff in rural and hard to reach areas (20/ District) in 10 District. (Pediatrician, Gynecologist/ WMO/ Anesthetic, Staff Nurse/ LHV/ OT Technician)

2.2.3. Repair/renovate/upgrade the OT/labor rooms/ gynae wards/ pediatric wards in the DHQ/THQ/RHCs

2.2.4. Repair/Renovation/extension of CMWs School and hostels

2.2.5. Construction of CMWs Hostels

Outcome 2.3. Improved referral mechanism involving all health care Facility levels to ensure continuum of care

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 Hospital/RHCs

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 (3 days) 1 Designated IT Person + 1 Senior HCP/ FLCF

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

2.4.1. Operationalization of Steering Committee for IRMNCAH-N at State Level (Bi-Annual Meetings)

2.4.2. Establish M&E Cell at State Level to coordinate/collate data from MNCH, EPI, DHIS, Nutrition, LHW Programme (quarterly review meetings)

2.4.3. Provision of IT & Office Equipment, Printing Material, Stationary & Operational Expenditures for M& E Cell

2.4.4. Capacity Building of 5 Provincial and 40 District Managers on M&E for IRMNCAH-N related activities (3 Days)

2.4.5. Prepare Supervisory Plan and Conduct (5 Visits/ Manager/Month) at Provincial Level

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 recommendation to the DoH for rectification

2.4.8. Provision of Two 4x4 Vehicle for MNCH/Nutrition/RH/EPI/LHW Programme and Monitoring Cell

2.4.9. Provision/Procurement of Three Vehicle for Each 10 District

Outcome 2.5. Inclusion of IMNCI/ PCPNC/ ENC WHO protocols in pre-service of Medical Colleges

2.5.1. Inception workshop for medical schools for inclusion of IMNCI/PCPNC/ENC in pre-service in AJK (Medical colleges) one Day Meeting

2.5.2. In-depth orientation/planning to strengthen the IMNCI/PCPNC/ENC teaching in all Medical Colleges) One Day Meeting

2.5.3. Provision of essential IMNCI/PCPNC/ENC equipment to all DHQ/THQ/RHCs for establishment of under 5 and Basic EMOC clinics

2.5.4. Provision of essential IMNCI/PCPNC/ENC drugs to all DHQ/THQ/RHCs and their inclusion in routine MSD list

2.5.5. Establish the Sick New Born Care Unit through provision of equipment and supplies at DHQs

2.5.6. HR Support for Sick New Born Care Unit (1 Pediatrician, 3 MOs, 3 Staff Nurses per unit)

2.5.7. Training NICU Staff (4 Weeks) (1 Pediatrician, 3 MOs, 3 Staff Nurses per unit)

Objective 3. Overcome financial barriers to care seeking and uptake of interventions

Outcome 3.1. Improved and strengthened coordination of the existing social safety nets.

3.1.1. Advocacy for creation of endowment fund that will be utilized for supporting the poor quantile of health

3.1.2. Coordination among financial institutions supporting the Poor quintile on health expenditure on user end (Bait ul mal, zakat, BISP, social welfare)

3.1.3. Advocacy and materialize the integration of existing social net under the umbrella of National Health Insurance for better coordination and integration.

3.1.4. Advocacy for prioritization of MNCH and nutrition as area for subsidy (Include MNCH and nutritional related mortalities in notifiable domain through health information system to generate evidence to support prioritization of health issues.)

Objective 4. Increase in funding and allocation for RMNCAH

Outcome 4.1. Increased resource allocation and mobilization for RMNCAH and Nutrition Programs

4.1.1. Advocacy for increase budget for Health (RMNCAH&N in particular) (P &D and FD)

4.1.2. Advocate with the donors and development partners for MNCH related funding

4.1.3. Advocacy for increasing Share of MNCH/LHW program AJK with the federal government and political leadership through MNCH/LHW Action Committee

4.1.4. Training of the health managers on financial management (10 DHOs,10 DCs LHW Prog., 10 PHSs MNCH & 04 Provincial Managers and 04 Accounts Staff)

Objective 5. Improve Reproductive Health including family Planning

Outcome 5.1. Linkages between existing forums established from Federal to District Level (NATPOW, Provincial Technical Committee)

5.1.1. A framework to be developed at State Level (Pop policy 2010 is available including post devolution scenario which needs revision)

5.1.2. Functional integration of both departments at State Level (Consensus Building, Data Sharing, Joint Monitoring, Accountability)

5.1.3. Establish Joint steering committee to address FP issues which may be headed by Chief Secretary/ACS Development to prioritize FP (Biannual Meeting)

5.1.4. Forecasting and costing for Procurement of Contraceptives

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

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

6.1.1. Establish Nutrition Cell at State Level in DoH

6.1.2. IT & Office Equipment for Nutrition Cell

6.1.3. Annual celebration of Breast Feeding Week (August)

6.1.4. Notification of Provincial Infant Feeding Board and conduction of Annual Meeting

6.1.5. Notification of Provincial Food Fortification Alliance conduction of biannual Meeting

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

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. Promoting use of Iodized Salt through Schools and Community Health Workers and salt processors

6.2.3. Promotion of healthy/appropriate eating for pregnant ladies and lactating mothers including provision of supplementary food?

6.2.4. Zinc supplementation for children of age 6-59 months

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

6.3.1. Establishment and Functionalization of inpatient nutrition services (Stabilization Centers) in secondary health care facilities

6.3.2. Establishment and Functionalization of outpatient nutrition services (SFP and OTP Centers/Breast Feeding Corners)

6.3.3. HR/Nutritionist at each District level and Provincial level (BPS 17)

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)

6.3.5. Equipment/Instruments for SFP/OTP Centers (Uni-scale, Height/Length Board, MUAC Tapes for Children/PLWs)

6.3.6. Equipment/Instruments for NSC (Complete NSC Kit)

6.3.7. IT Equipment/ Soft Ware /Networking /Cameras

Objective 7. Investing in addressing social determinants of Health

Outcome 7.1. Health Friendly Multi Sectorial Policies and Practices adopted

7.1.1. Multi Sectoral Coordination Committee at Provincial Level

7.1.2. Revival of School Health Services (Piloting 4 Schools in a selected District) Deploy 1 School Nurse with Necessary equipment and Health Care Provider of relevant Health Facility visit each school Monthly

Objective 8. Measurement and action at district level

Outcome 8.1. Generation of Valid, Timely, Complete, Reliable routine Data

8.1.1. Formulation of DHIS review committee to review existing system and include missing indicators on RMNCAH and Nutrition

8.1.2. Develop and Implement routine MIS for Tertiary Level Care Hospitals

8.1.3. Refresher Training of staff (DHIS) on Tools & Instrument (03 days)

8.1.4. Training of District computer staff on DHIS Software (3 Days) (2 Persons/District)

8.1.5. Training of Master Trainer district wise (2/ District + 4 State Level) (DHIS)

8.1.6. HR required for District Level (1 Statistical Officers for districts + 1 SA for 3 DHQs

8.1.7. IT Equipment/Furniture required for District Level

8.1.8. Training on Use of Information for Health Managers (3 Days)

8.1.9. Printing of recording/reporting tools

8.1.10. Provision of supervisory vehicle for DHIS Cell

Objective 9. National Accountability and Oversight

Outcome 9.1. Improved Governances and Accountability

9.1.1. Formulation of oversight Committee Chaired by Minister of Health AJK to review Performance and outcomes (Bi Annual Meetings)

9.1.2. Development of accountability Framework

9.1.3. Link the Monitoring and Evaluation reports for accountability framework

9.1.4. Implementation of Quality assurance tools at all level

Objective 10. Generation of the Political will to support RMNCAH & Nutrition as a key priority within sustainable development goals

Outcome 10.1. Enhanced awareness among Policy Makers and Parliamentarian about SDGs on Health and Population

10.1.1. Establish SDG Cell under DGHS AJK

10.1.2. Advocacy and Awareness orientation of Policy Makers and Parliamentarian on Health and Population Issues

10.1.3. Engagement of religious scholars, Media to address Myths and Misconception on Health & Population Issues

10.1.4. Revival of Village Health Committee and Women Group for improving Health Seeking Behaviors (1 Day Refresher training in Continuous education class)

6 MONITORING FRAMEWORK

This monitoring framework gives objectives, outcomes, intervention logic, objectively verifiable indicators and means of their verification. It covers the entire program however the prioritized objectives and their expected outcomes with estimated costs are given in the next section for each province and region.

6.1 Objectives, Outcomes, Interventions Logic, OVI and MOV

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
Objective 1. Improve access and quality of MNCH community based primary care services ensuring continuum of care including newborn care in rural districts and urban slums			
Outcome 1.1. Enhanced equitable access, coverage, and utilization of quality RMNCAH and Nutrition services through community based workers	Enhance population coverage through identification, recruitment, and training of community based health workers.	1.1.1. Proportion of coverage increased by newly recruited and trained: a. CMWs b. LHWs c. FMWs d. MMWs e. Vaccinators	1.1.1.1. Respective program records 1.1.1.2. Monitoring reports 1.1.1.3. External evaluation
	Enhance capacity of existing CMWs and FWWs	1.1.2. Proportion of CMWs and FWWs attended refresher trainings on: a. Standard Clinical Outlook Procedure; and b. Record keeping	1.1.2.1. Training records 1.1.2.2. Interviews
	Enhance effectiveness of monitoring supervision of health and PWD interventions	1.1.3. Proportion of HCPs of Health and PWD trained in: a. Monitoring and Supervision every other year: b. Long Acting Reversible Contraceptives	1.1.3.1. Training records 1.1.3.2. Interviews
	Increase district storage and service delivery capacities	1.1.4. Proportion of districts having: a. Constructed Integrated Warehouse with allied facilities b. Increased number of Mobile Service Units.	1.1.4.1. Respective program records 1.1.4.2. Physical verification
	Strengthen FWCs and CMWs birthing stations through provision of continued electricity supply	1.1.5. Proportion of FWCs and CMW birthing stations, having Solar Panels with inverter.	1.1.5.1. Respective program records 1.1.5.2. Physical verification
	Strengthen teaching capacities of RTIs of PWD	1.1.6. Proportion of RTIs of PWD are strengthened and have: a. Qualified tutors b. Teaching Aids (Dummies, Mannequin, Demo material, multimedia, desk computers, scanner, laptops, etc.)	1.1.6.1. Respective program records 1.1.6.2. Physical verification
	Strengthen knowledge base of FP activities	1.1.7. Booklets on FP Counselling, FP Techniques & Management of Side effects of contraceptives are printed	1.1.7.1. Respective program records 1.1.7.2. Physical verification
	Strengthen capacities of existing midwifery schools	1.1.8. Proportion of existing midwifery schools which:	1.1.8.1. Respective program recruitment records

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
		a. are upgraded to accommodate additional requirement through Repairing / Maintenance Operational Cost b. have qualified midwifery tutors.	1.1.8.2. Interviews verification
	Strengthen training component of MNCH program	1.1.9. Training coordinator for MNCH Program is recruited	1.1.9.1. Respective program records 1.1.9.2. Interview
	Expand FWCs services	1.1.10. Proportion of FWCs which are expanded	1.1.10.1. Respective program records 1.1.10.2. Physical verification
	Ensure contraceptive supplies for PWD, LHW Program, MNCH Program, and DoH	1.1.11. Proportion of contraceptives, procured for: a. PWD b. LHW Program c. MNCH Program d. Health Department	1.1.11.1. Respective program procurement records 1.1.11.2. Physical verification
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).	Enhance capacity of existing CMW tutors	1.2.1. Proportion of existing CMW tutors received 4 weeks technical / clinical skills training	1.2.1.1. Training records 1.2.1.2. Interviews
	Enhance clinical skills of trainers of CMW Tutors	1.2.2. Proportion of trainers of CMW Tutors received 7 days ToT of on Clinical Skills	1.2.2.1. Training records 1.2.2.2. Interviews
	Revise Basic Training Curriculum of LHWs	1.2.3. Revised Basic Training Curriculum of LHWs is available	1.2.3.1. Physical verification
	Enhance capacities of LHWs on recently included HTSP, IYCF, Use of Chlorhexidine, cIMNCI, MDSR, Home Based Newborn care	1.2.4. Proportion of LHWs who received refresher training on: a. HTSP (2 days); b. IYCF (5 days); c. Use of Chlorhexidine (1 Day); d. cIMNCI (5days); e. MDSR (1 Day); f. Home Based Newborn Care (3 Days)	1.2.4.1. Training records/reports 1.2.4.2. Interviews
	Enhance capacities of CMWs in FP Techniques, Clinical PCPNC, ENC (HBB, HBS, KMC), MDSR, Use of Chlorhexidine and Misoprostol, and Use of MgSO4 in Eclampsia/Pre-Eclampsia	1.2.5. Proportion of CMW received on-job training in: a. FP Techniques (5 days); b. Clinical PCPNC (7 Days); c. ENC (HBB, HBS, KMC) (5 Days); d. MDSR (01 Day); e. Use of Chlorhexidine and Misoprostol (2 Days); and f. Use of MgSO4 for Eclampsia/Pre-Eclampsia (2 Days)	1.2.5.1. Training records 1.2.5.2. Interviews
	Provide training / awareness materials on community based interventions to LHWs, FWWs and CMWs in the field.	1.2.6. Proportion, received training/awareness material on community based interventions, of: a. CMWs b. LHWs c. FWWs	1.2.6.1. Monitoring reports 1.2.6.2. Progress reports 1.2.6.3. External validation
Outcome 1.3. Improved linkages (referral) between LHWs/CMWs and HCFs for Nutrition	Establish referral network from community level i.e., LHWs / CMWs to health facilities at district and provincial Level	1.3.1. Proportion of community based workers and health facilities in the province are linked to the referral system; a. CMWs b. LHWs c. BHUs	1.3.1.1. Monitoring reports 1.3.1.2. Progress reports 1.3.1.3. External validation

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
/FP/ ANC/ Natal care/ PNC/ SBA /EPI		d. RHCs e. THQs f. DHQs g. Tertiary care health facilities	
	Orientate LHWs, CMWs and HCF staff of provincial and district level facilities on referral pathways	1.3.2. Proportion of LHWs, CMWs, and primary, secondary, and tertiary level health facilities' staff have received orientation on referral pathways	1.3.2.1. Orientation records/reports 1.3.2.2. Interviews
	Display *Referral Linkages Pathways* at CMWs birth stations, LHWs Health Houses and all levels of Health facilities	1.3.3. Proportion of LHWs health houses, CMWs birthing stations, and primary, secondary, and tertiary level health facilities' where referral linkages pathways are displayed	1.3.3.1. Monitoring reports 1.3.3.2. Progress reports 1.3.3.3. External validation
	Provide referral slips and record keeping formats to CMWs and LHWs	1.3.4. Proportion CMWs and LHWs who have referral slips	1.3.4.1. Physical verification 1.3.4.2. Interviews
	Strengthen linkage between referral health facility and LHS/ LHW/ CMW through supervisory visits of LHS and monthly meeting at Referral Facility.	1.3.5. Proportion of LHSs who are: a. Conducting supervisory visits to strengthen referral linkage; b. Holding monthly meetings at Referral unit.	1.3.5.1. Monitoring / visit reports 1.3.5.2. Meeting reports 1.3.5.3. Progress reports 1.3.5.4. External validation
	Strengthen DHIS and link LHW/CMW MIS with it.	1.3.6. Proportion of districts with LHW/CMW MIS integrated into DHIS.	1.3.6.1. DIHS reports 1.3.6.2. External validation
	Scale up e-communication of RMNCAH and Nutrition related data / information to include all CMWs, FWWs, and LHWs in online data base and E- monitoring	1.3.7. Proportion of CMWs, FWWs, and LHWs are included in e-communication of RMNCAH and Nutrition related data/information	1.3.7.1. Monitoring reports 1.3.7.2. DHIS report 1.3.7.3. External evaluation
Outcome 1.4. Increased community demand for RMNCAH and Nutrition services	Enhance community awareness on importance of and availability of RMNCH and Nutrition health services through NGOs, social mobilizers, support groups, and CBOs etc., and health education and awareness sessions at community level by LHWs and CMWs in the catchment area of health facilities	1.4.1. Proportion of health facilities with community awareness activities in the catchment area on importance of and availability RMNCH and Nutrition health services by: a. NGOs and CBOs b. Support groups c. Social mobilizers d. LHWs e. CMWs	1.4.1.1. Monitoring reports 1.4.1.2. Progress reports 1.4.1.3. External evaluation
	Enhance capacities of LHWs and CMWs on communication and identification of defaulters and nonstarters of EPI, ANC, PNC, Nutrition	1.4.2. Proportion of LHWs and CMWs received training on: a. Communication b. Identification of defaulters and nonstarters of EPI, ANC, PNC, Nutrition	1.4.2.1. Monitoring reports 1.4.2.2. Progress reports 1.4.2.3. External evaluation
	Enhance community awareness on importance of and availability of RMNCH and Nutrition health services through use local print and electronic media	1.4.3. Proportion of districts raising community awareness on importance of and availability RMNCH and Nutrition health services through: a. Print media b. Electronic media	1.4.3.1. Monitoring reports 1.4.3.2. Progress reports 1.4.3.3. External evaluation
	Enhance capacities of LHWs and CMWs through providing IEC materials on MNCH, EPI, FP and Nutrition, and advocacy kits for health education sessions	1.4.4. Proportion of LHWs and CMWs are using: a. IEC materials on MNCH, EPI, FP, and Nutrition ; and b. Advocacy kits for health educations sessions	1.4.4.1. Monitoring reports 1.4.4.2. External evaluation

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
Objective 2. Improve access to and quality of RMNCH care at Primary and Secondary level care facilities			
Outcome 2.1. Enhanced skills of HCPs on IMNCI/ PCPNC/ ENC/ RH/ CMAM/ IYCF, etc. at Primary and Secondary HCFs	Expand pool of IMNCI facilitators in the province at Centers of Excellence	2.1.1. Proportion of Centers of Excellence with increased number of IMNCI facilitators	2.1.1.1. Progress reports 2.1.1.2. External evaluation
	Enhance capacity of HCPs, working at PHC facilities, including Pediatricians, MOs, WMOs, MTs, Paramedics, etc.) on IMNCI skills	2.1.2. Proportion of following HCPs working at PHC health facilities received 11 days skills training on IMNCI: a. Pediatricians; b. MOs c. WMOs d. MTs e. Paramedics	2.1.2.1. Training reports 2.1.2.2. Interviews 2.1.2.3. External evaluation
	Provide post training support to trained HCPs through follow up visits 4 – 6 weeks after training.	2.1.3. Proportion of following trained HCPs received post training support: a. Pediatricians; b. MOs c. WMOs d. MTs e. Paramedics	2.1.3.1. Training reports 2.1.3.2. Interviews 2.1.3.3. External evaluation
	Enhance capacity of HCPs on PCPNC including Gynecologists, Obstetricians, WMOs, LHVs, and Nurses	2.1.4. Proportion of following HCPs received 7 days training on PCPNC: a. Gynecologists b. Obstetricians c. WMOs d. LHVs e. Nurses	2.1.4.1. Training reports 2.1.4.2. Interviews 2.1.4.3. External evaluation
	Expand pool of PCPNC facilitators in the province at the Centers of Excellence	2.1.5. Proportion of Centers of Excellence with increased number of PCPNC facilitators	2.1.5.1. Progress reports 2.1.5.2. External evaluation
	Enhance capacity of HCPs on ENC including Gynecologists, Obstetricians, Pediatricians, WMOs, MOs, LHVs, and staff nurses	2.1.6. Proportion of following HCPs received 5 days training on ENC: a. Gynecologists b. Obstetricians c. Pediatricians d. WMOs e. MOs f. LHVs g. Nurses	2.1.6.1. Training reports 2.1.6.2. Progress reports 2.1.6.3. External evaluation
	Expand district pool of ENC facilitators	2.1.7. Proportion of districts with increased number of ENC facilitators	2.1.7.1. Progress reports 2.1.7.2. External evaluation
	Enhance capacity of HCPs in Helping the Babies to Breathe	2.1.8. Proportion of HCPs received training on Helping the Babies to Breathe	2.1.8.1. Training reports 2.1.8.2. Interviews
	Enhance capacity of HCPs working at PHC health facilities on RH/FP counselling, including LHVs, CMWs, FMTs, etc.	2.1.9. Proportion of following HCPs received 5 days training on RH/FP counselling: a. LHVs	2.1.9.1. Training reports 2.1.9.2. Progress reports 2.1.9.3. External evaluation

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
		b. CMWs c. FMTs	
	Enhance capacity of HCPs on RH/FP surgical skills at PHC facilities, including CMWs, LHVs	2.1.10. Proportion of following HCPs received 14 days training on RH/FP surgical skills: a. LHVs b. CMWs	2.1.10.1. Training reports 2.1.10.2. Progress reports 2.1.10.3. External evaluation
Outcome 2.2. Strengthened Health systems for RMNCAH / Nutrition services through filling the HR gaps, repair renovation and upgradation of HCFs and provision of supplies	Provide 24/7 CEmONC services at DHQ and THQ, and Basic EmONC services at RHCs in rural districts through inducting HR as per requirement including gynecologist, pediatrician, anesthetist, WMOs, Nurses, LHVs, OTT, BBT, Lab tech, Aya, sweepers, etc.	2.2.1. Proportion of following health facilities in rural districts where relevant services are provided through induction of relevant HR: a. CEmONC at DHQs and THQs b. EmONC at RHCs	2.2.1.1. Monitoring reports 2.2.1.2. Progress reports 2.2.1.3. External evaluation
	Incentivize the services of the RMNCAH related staff in rural and hard to reach areas including Pediatrician, Gynecologist, WMOs, Anesthetists, Nurses, LHVs, OT Technicians	2.2.2. Proportion of following staff receiving financial incentives for providing RMNCAH services in rural and hard to reach areas: a. Pediatrician b. Gynecologists c. WMOs d. Anesthetists e. Nurses f. LHVs g. OT Technicians	2.2.2.1. Monitoring reports 2.2.2.2. Progress reports 2.2.2.3. External evaluation
	Repair/renovate/upgrade the OT/labor rooms/ gynae wards/ pediatric wards in the DHQ/ THQ/ and RHCs	2.2.3. Proportion of health facilities have repaired / renovated / upgraded OT/ labor rooms/ gynae wards/ pediatric wards in: a. DHQ Hospitals b. THQ Hospitals c. RHCs	2.2.3.1. Monitoring reports 2.2.3.2. Progress reports 2.2.3.3. External evaluation
	Repair/Renovate/extend CMWs School and hostels	2.2.4. Proportion of CMWs schools and hostels Repaired / Renovated / extended	2.2.4.1. Monitoring reports 2.2.4.2. Progress reports 2.2.4.3. Physical verification
	Construction of CMWs Hostels	2.2.5. CMWs Hostels constructed	2.2.5.1. Progress reports 2.2.5.2. Physical verification
Outcome 2.3. Improved referral mechanism involving all health care Facility levels to ensure continuum of care	Provide ambulances to health facilities for referrals, with end-user fee for POL generation.	2.3.1. Proportion of health facilities with ambulances for referrals, with end-user fee for POL generation.	10.1.4.1. Monitoring reports 10.1.4.2. Progress reports 10.1.4.3. Physical verification
	Establish referral desks with IT support and data base at DHQs, THQs, and RHCs	2.3.2. Proportion of health facilities with referral desks established with IT support data base: a. DHQ hospitals b. THQ Hospital c. RHCs	10.1.4.4. Monitoring reports 10.1.4.5. Progress reports 10.1.4.6. Physical verification
	Enhance capacities of HCPs on MNCH referral data recording and dissemination	2.3.3. Proportion of health facilities with at least one HCP trained in MNCH referral data recording and dissemination	10.1.4.7. Training reports 10.1.4.8. Progress reports

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
			10.1.4.9. Interviews
Outcome 2.4. Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	Operationalize Steering Committee for IRMNCAH-N at provincial/regional Level and hold bi-annual meetings	2.4.1. Steering Committee is conducting bi-annual Meetings	Minutes of meeting
	Establish provincial / regional M&E Cell	2.4.2. M&E cell is established and has IT and Office Equipment, Printing Material, Stationary, with allocated Operational Expenditures	10.1.4.10. Notification document
	Manage/collate data, through M&E Cell, from MNCH, EPI, DHIS, Nutrition, LHW Programme on quarterly basis	2.4.3. Provincial / regional M&E Cell is managing/collating data from MNCH, EPI, DHIS, Nutrition, LHW Programme on quarterly basis.	10.1.4.11. Data report 10.1.4.12. External evaluation
	Enhance capacity of Provincial and District Managers on M&E for IRMNCAH-N related activities	2.4.4. Proportion of managers, who have received 3 days training on M&E for IRMNCAH-N: a. Provincial managers b. District managers	10.1.4.13. Training report 10.1.4.14. Interviews
	Prepare Supervisory Plans and conduct at least 5 visits/ Manager/ Month at Provincial and district levels	2.4.5. Proportion of: a. Districts with supervisory visit plan b. Managers who conduct regular supervisory visits as per plan	10.1.4.15. Supervisory plans available 10.1.4.16. Visit reports
	Review M&E feedback reports and give recommendation to DoH for rectification	2.4.6. Proportion of feedback reports reviewed, and recommendations given	10.1.4.17. Feedback reports with recommendations available
	Ensure mobility for MNCH /Nutrition /RH /EPI /LHW Programme, and Monitoring Cell by providing 2 vehicles at provincial and 3 at each district level.	2.4.7. Provincial level and Proportion of districts which have 3 vehicles for MNCH/ Nutrition/ RH/ EPI/ LHW Programme and Monitoring Cell	10.1.4.18. Physical verification
Outcome 2.5. Inclusion of IMNCI/PCPNC/ENC WHO protocols in pre-service of Medical Colleges	Have medical colleges to include WHO's IMNCI /PCPNC/ ENC protocols in pre-service	2.5.1. Proportion of medical colleges in province which attended one-day workshop on inclusion of WHO's IMNCI/ PCPNC /ENC protocols in pre-service	10.1.4.19. Workshop report
	Provide support to strengthen IMNCI/ PCPNC/ ENC teaching in all Medical Colleges	2.5.2. Proportion of medical colleges in province which attended one-day strengthening workshop on IMNCI/ PCPNC /ENC teaching	10.1.4.20. Workshop report 10.1.4.21. Interviews with medical colleges
	Establish under 5 and Basic EMOC clinics at DHQ/ THQ/ RHCs through provision of essential IMNCI/ PCPNC/ ENC equipment	2.5.3. Proportion of health facilities with established under 5 and Basic EMOC clinics at: a. DHQs b. THQs, and c. RHCs	10.1.4.22. Monitoring reports 10.1.4.23. Progress reports 10.1.4.24. External evaluation
	Provide essential IMNCI/ PCPNC/ ENC drugs to DHQ/ THQ/ and RHCs and include them in routine MSD list	2.5.4. Proportion of health facilities receiving essential IMNCI/ PCPNC/ ENC drugs: a. DHQs b. THQs, and c. RHCs 2.5.5. Proportion of essential drugs included in the MSD list	10.1.4.25. Monitoring reports 10.1.4.26. Progress reports 10.1.4.27. External evaluation 10.1.4.28. MSD drug list
	Establish Sick New Born Care Unit through provision of equipment and supplies at DHQs	2.5.6. Proportion of DHQ hospitals with established Sick New Born Care Units	10.1.4.29. Progress reports 10.1.4.30. External evaluation

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
	Provide HR for Sick New Born Care Unit and train them	2.5.7. Proportion of Sick New Born Care Units with all the following staff in place: a. One Pediatrician b. Three MOs c. Three Staff Nurses 2.5.8. Proportion of Sick New Born Care Units staff have received training: a. One Pediatrician b. Three MOs c. Three Staff Nurses	10.1.4.31. Progress reports 10.1.4.32. External evaluation
Objective 3. **Overcome financial barriers to care seeking and uptake of interventions**			
Outcome 3.1. Improved and strengthened coordination of the existing social safety nets.	Advocate for creation of endowment fund to support the poor quantile of health	3.1.1. Proportion of possible support venues identified and contacted for support	10.1.4.33. Minutes of meetings
	Coordinate with financial institutions which support the poor in health expenditure like Bait ul mal, Zakat, BISP, Social Welfare	3.1.2. Proportion of financial institutions with which coordination is established for supporting poor in health expenditure	10.1.4.34. MoUs with respective institution
	Advocate and integrate with existing social net under the umbrella of National Health Insurance	3.1.3. MoU is signed with social net under the umbrella of National Health Insurance for RMNCAH	10.1.4.35. MoU is available
	Generate evidence for advocacy from HIS and advocate with authorities to prioritize MNCH and nutrition as an area for subsidy	3.1.4. Proportion of items for which subsidy is notified by the relevant authorities: a. MNCH items b. Nutrition items	10.1.4.36. Respective notifications
Objective 4. **Increase in funding and allocation for RMNCAH**			
Outcome 4.1. Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	Advocate with P & D and FD for increasing budget for Health (RMNCAH&N in particular)	4.1.1. Number of meetings planned, and proportion of meetings held with: a. P & D department b. Finance department	10.1.4.37. Minutes of meetings
	Advocate with the donors and development partners for MNCH related funding	4.1.2. Number of meetings planned and proportion of them, was held with the donors and development partners for MNCH related funding	10.1.4.38. Minutes of meetings
	Advocate for increasing share of MNCH/LHW program with the federal government and political leadership through MNCH/LHW Action Committee	4.1.3. Meetings planned, and proportion of meetings held for increasing share of MNCH/LHW program, with: a. Federal government b. Political leadership	10.1.4.39. Minutes of meetings
	Enhance capacity of health managers in financial management including EDOH/DHOs, DCs LHW Program, PHSs MNCH, Provincial Managers, and Accounts Staff.	4.1.4. Proportion of following staff have received training in financial management: a. EDOH / DHO b. DCs LHW Program c. PHSs IRMNCH/MNCH program	10.1.4.40. Training reports 10.1.4.41. Interviews

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
		d. Provincial Managers, and e. Accounts Staff	
Objective 5. Improve Reproductive Health including family Planning			
Outcome 5.1. Established linkages between existing forums established from Federal to District Level (NATPOW, Provincial Technical Committee)	Revise population policy and develop framework to establish linkages with existing fora	5.1.1. Population policy is revised, and framework is developed at province level to establish linkages with existing fora	10.1.4.42. Revised population policy is available 10.1.4.43. Framework is available
	Establish functional integration (Consensus Building, Data Sharing, Joint Monitoring, and Accountability) with NATPOW and Provincial Technical Committee at provincial / regional level	5.1.2. MoU is signed to establish functional integration with NATPOW and Provincial Technical Committee at provincial / regional level for Consensus Building, Data Sharing, Joint Monitoring, and Accountability.	10.1.4.44. Signed MoU is available
	Establish Joint steering committee, headed by Chief Secretary / ACS Development / Secretary Health to prioritize FP (Biannual Meeting)	5.1.3. Joint Steering Committee headed by Chief Secretary / ACS Development / Secretary Health to prioritize FP, is: 5.1.4. Notified to address FP issues 5.1.5. holding biannual meetings	10.1.4.45. Notification 10.1.4.46. Minutes of meeting
	Forecast the requirement and estimate costs for procurement of contraceptives	5.1.6. Forecasting and costing for Procurement of Contraceptives is documented	10.1.4.47. Forecasting document 10.1.4.48. Costing document
Objective 6. Invest in nutrition especially of adolescent girls, mothers, and children			
Outcome 6.1. Improved infant and young child nutrition (children < 24 months) practices in all districts of province (CMAM/ IYCN/ SUN/ IDD/ Food Fortification/)	Establish Nutrition Cell at provincial / regional Level in DoH	6.1.1. Establishment of Nutrition Cell at provincial / regional level is notified	10.1.4.49. Notification
	Provide IT and office Equipment for Nutrition Cell	6.1.2. Nutrition Cell has the required IT and office equipment	10.1.4.50. Interviews 10.1.4.51. Records
	Celebrate Annual Breast Feeding Week in August	6.1.3. Breast Feeding Week is celebrated in August	10.1.4.52. Activity report
	Establish Provincial Infant Feeding Board and conduct annual meeting	6.1.4. Notification to establish Provincial Infant Feeding Board is issued and annual meeting of board is held	10.1.4.53. Notification 10.1.4.54. Minutes of meeting
	Establish Provincial Food Fortification Alliance and conduct biannual meeting	6.1.5. Notification to establish Provincial Food Fortification Alliance is issued and biannual meetings of Alliance are held	10.1.4.55. Notification 10.1.4.56. Minutes of meeting
Outcome 6.2. Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade 1-5), adolescent girls and pregnant/ lactating	Provide multiple micronutrient powder for home fortification for children 6-59 months and Iron/Folic Acid for PLWs and adolescent girls	6.2.1. Proportion of households with: a. Children 6-59 months have received multiple micronutrient powder for home fortification b. PLWs and Adolescent Girls have received Iron/Folic Acid	10.1.4.57. Household survey 10.1.4.58. External evaluation 10.1.4.59. Progress & monitoring reports
	Promote use of Iodized Salt through Schools and Community Health Workers, and salt processors	6.2.2. Proportion of Schools, Community Health Workers, and Salt Processors, who are promoting use of Iodized Salt	10.1.4.60. Progress & monitoring reports 10.1.4.61. External evaluation
	Promote healthy/appropriate diet for pregnant women and lactating mothers through health education	6.2.3. Proportion of women received health education on importance of healthy/ appropriate diet for pregnant ladies and lactating mothers	10.1.4.62. Household survey 10.1.4.63. External evaluation 10.1.4.64. Progress & monitoring reports

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
women (PLW) in all districts	Ensure Zinc supplementation for children of age 6-59 months in diarrhea	6.2.4. Proportion of children aged 6-59 months with diarrhea have received Zinc supplementation	10.1.4.65. Household survey 10.1.4.66. External evaluation 10.1.4.67. Progress & monitoring reports
Outcome 6.3. Enhanced access of local community to life saving nutrition services for acute malnourished children	Establish and Functionalize Stabilization Centers in secondary health care facilities	6.3.1. Proportion of secondary health care facilities has: a. Established Stabilization Centers, and b. Functional Stabilization Centers	10.1.4.68. Progress & monitoring reports 10.1.4.69. External evaluation
	Establish and Functionalize outpatient nutrition services (SFP and OTP Centers/Breast Feeding Corners)	6.3.2. Proportion of health facilities has: a. Established SFP, OTP Centers, and Breast Feeding Corners b. Functional SFP, OTP Centers, and Breast Feeding Corners	10.1.4.70. Progress & monitoring reports 10.1.4.71. External evaluation
	Enhance nutritional technical support by appointing a Nutritionist at provincial and at each District level (BPS 17)	6.3.3. Province and Proportion of districts where Nutritionist is working	10.1.4.72. Progress & monitoring reports 10.1.4.73. Interviews
	Ensure regular supply of Nutrition Supplements to SFP/ OTP Centers/ NSC (RUSF, WSB/FBF, OIL/RUTF, F-75, F-100, ResoMal, MM Tabs, MM Sachets, Iron/Folic ACID)	6.3.4. Proportion of nutrition treatment centers with regular supply of nutritional supplements (RUSF, WSB/FBF, OIL/RUTF, F-75, F-100, ResoMal, MM Tabs, MM Sachets, Iron/Folic ACID): a. SFP/OTP Centers b. NSC	10.1.4.74. Progress & monitoring reports 10.1.4.75. External evaluation
	Ensure provision of equipment/Instruments for SFP/OTP Centers (Uni-scale, Height/Length Board, MUAC Tapes for Children/PLWs), NSC (Complete NSC Kit) and IT Equipment / Soft Ware / Networking /Cameras	6.3.5. Proportion of nutrition treatment centers with adequate equipment/Instruments for: a. SFP/OTP Centers - Uni-scale, Height/Length Board, MUAC Tapes for Children/PLWs b. NSC - Complete NSC Kit c. Both - IT Equipment / Soft Ware / Networking /Cameras	10.1.4.76. Progress & monitoring reports 10.1.4.77. External evaluation
Objective 7. Invest in addressing social determinants of Health			
Outcome 7.1. Health Friendly Multi Sectorial Policies and Practices adopted	Establish Multi Sectoral Coordination Committee at Provincial Level	7.1.1. Notification to establish Multi Sectoral Coordination Committee at Provincial Level is issued by the competent authority	10.1.4.78. Notification is available
	Revive School Health Services with piloting 4 Schools in a selected District through deploying one School Nurse with Necessary equipment and Health Care Provider of respective Health Facility visit each school Monthly	7.1.2. School are selected for piloting and staff is ensured with required equipment	10.1.4.79. Progress & monitoring reports 10.1.4.80. External evaluation
Objective 8. Measurement and action at district level			
Outcome 8.1. Generation of Valid, Timely, Complete, Reliable routine Data	Formulate DHIS Review Committee to review existing system and include missing indicators on RMNCAH and Nutrition	8.1.1. DHIS Review Committee is formulated and has: a. Identified missing RMNCAH and nutrition indicators b. Included RMNCAH and nutrition indicators in DHIS	10.1.4.81. Notification 10.1.4.82. DHIS reports 10.1.4.83. External evaluation
	Include information from Tertiary Level Care Hospitals in routine HMIS through	8.1.2. Proportion of Tertiary Level Care Hospitals with: a. Functional MIS b. MIS integrated into the routine HMIS	10.1.4.84. MIS reports 10.1.4.85. HMIS reports 10.1.4.86. External evaluation

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
	developing MIS for Tertiary Level Care Hospitals		
	Enhance capacities of DHIS staff to better understand DHIS Tools and Instrument	8.1.3. Proportion of DHIS staff who has received a 3 days refresher training on DHIS Tools and Instrument	10.1.4.87. Training reports 10.1.4.88. Interviews
	Enhance capacities of District computer staff on DHIS Software	8.1.4. Proportion of districts where computer staff has received 3 days training on DHIS Software	10.1.4.89. Training reports 10.1.4.90. Interviews
	Enhance capacities of Master Trainers at district and provincial level	8.1.5. Proportion of Master Trainer at provincial and district level who have received DHIS training	10.1.4.91. Training reports 10.1.4.92. Interviews
	Enhance capacities at district level in data management and analysis, through appointing statistical officer at district level and Statistical Assistant at each DHQ hospital.	8.1.6. Proportion of districts where: a. Statistical Officer is working b. DHQ hospitals have Statistical Assistant HR	10.1.4.93. District reports 10.1.4.94. Interviews
	Ensure provision of IT Equipment/Furniture required for the district Level	8.1.7. Proportion of districts which have IT Equipment/Furniture	10.1.4.95. Inventory list 10.1.4.96. Interviews 10.1.4.97. Physical verification
	Enhance capacity of health managers in utilizing HMIS information in planning	8.1.8. Proportion of districts where health managers have received 3 days training on Use of Information	10.1.4.98. Training reports 10.1.4.99. Interviews
	Ensure availability of printed recording and reporting tools	8.1.9. Proportion of districts which have enough printed recording and reporting tools	10.1.4.100. Physical verification
	Enhance supervisory and monitoring capacities of DHIS Cell through provision of vehicle	8.1.10. Proportion of districts where DHIS cell has a vehicle for monitoring and supervisory visits	10.1.4.101. Physical verification
Objective 9. National Accountability and Oversight			
Outcome 9.1. Improved Governances and Accountability	Review Performance and Outcomes twice annually by an Oversight Committee Chaired by Minister of Health	9.1.1. Oversight Committee with Minister of Health at Chair, is: a. Formulated b. Reviewing Performance and Outcomes twice in a year	10.1.4.102. Notification 10.1.4.103. Minutes of meetings
	Establish accountability mechanism	9.1.2. Accountability Framework has been developed and approved	10.1.4.104. Notification 10.1.4.105. Accountability Framework is available
	Ensure that Monitoring and Evaluation reports are part of the accountability framework	9.1.3. Monitoring and Evaluation reports are linked with accountability framework	10.1.4.106. Notification 10.1.4.107. Accountability Framework
	Enhance quality of interventions through implementation of Quality assurance tools at all level	9.1.4. Proportion of districts where Quality Assurance Tools are being implemented	10.1.4.108. External evaluation 10.1.4.109. Progress reports
Objective 10. Generate of the Political will to support RMNCAH & Nutrition as a key priority within sustainable development goals			
Outcome 10.1. Increased awareness about	Enhance efforts to achieve SDGs through establishing SDG Cell under Provincial DGHS	10.1.1. SDG Cell is functional with provincial DGHS at chair	10.1.4.110. Notification 10.1.4.111. Progress reports

EXPECTED OUTCOME	INTERVENTION LOGIC	OVI (Objectively Verifiable Indicators)	MOV (Means of Verification)
SDGs on Health and Population among Policy Makers and Parliamentarian	Orientate Policy Makers and Parliamentarian on Health and Population Issues	10.1.2. Proportion of districts where the respective Policy Makers and Parliamentarian have received orientation on Health and Population Issues	10.1.4.112. Meeting reports 10.1.4.113. Progress reports
	Engage religious scholars and Media personnel to address Myths and Misconceptions on Health and Population Issues	10.1.3. Proportion of districts where Myths and Misconceptions on Health and Population Issues are addressed with: a. Religious scholars b. Media personnel	10.1.4.114. Progress reports 10.1.4.115. External evaluation
	Improving Health Seeking Behaviors through revival and training of Village Health Committees and Women Groups	10.1.4. Proportion of districts where: a. At least 80% of Village Health Committees have received 1-day refresher training b. At least 80% of Women Groups have received 1-day refresher training	10.1.4.116. Training reports 10.1.4.117. Progress reports 10.1.4.118. External evaluation

7 ESTIMATED RESOURCE REQUIREMENTS

7.1 Summary

The RMNCAH and Nutrition interventions in all provinces and regions of Pakistan require a total of PKR 72,677 million for the next three years. The total requirement for the first, second and third year is estimated at PKR 25,257, 22,279, and 25,170 million, respectively. The Government of Pakistan and the respective provinces and regions will contribute a sum of PKR 12,512 million whereas an amount of PKR 60,313 million (US$ 564 million) is required to meet the total requirement for the next three years (Table 6).

Table 6: Summary of total costs and gap in funding with cost beneficiary ratio

Sr No	PROVINCE / REGION	YEARLY REQUIREMENT (In Millions)			TOTAL REQUIRED (in millions)	AVAILABLE FUNDS (in millions)	GAP (in millions)		
		YEAR 1	YEAR 2	YEAR 3					
		2018	2019	2020			PKR	US$	PERCENT
1	AJK	2,541.40	1,801.79	1,844.17	6,187.35	674.90	5,512.45	51.52	**89.09**
2	BALOCHISTAN	4,193.34	4,126.26	5,564.79	13,884.39	5,470.66	8,413.73	78.63	**60.60**
3	FATA	2,025.32	1,965.36	1,797.62	5,788.30	513.45	5,274.85	49.30	**91.13**
4	GILGIT BALTISTAN	1,335.84	1,017.75	1,032.75	3,386.35	284.81	3,101.54	28.99	**91.59**
5	KPK	3,752	2,677	2,840	9,277	1,810	7,505	70	**80.91**
6	PUNJAB	2,992.54	1,870.54	2,036.07	6,899.15	1,582.46	5,316.68	49.69	**77.06**
7	SINDH	8,416.78	8,819.57	10,054.65	27,255.20	2,176.47	25,187.92	235.40	**92.42**
GRAND TOTAL		**25,257.46**	**22,278.58**	**25,169.57**	**72,677.36**	**12,512.27**	**60,312.56**	**563.67**	**82.99**
Cost Per Beneficiary[15] PKR		**111.27**	**98.14**	**110.88**	**106.72**				
US$		**1.04**	**0.92**	**1.04**	**1.00**				

7.2 Cost Beneficiary Ratio

The cost per beneficiary per year, for three-year period of RMNCAH and Nutrition interventions is calculated at PKR 107 (US$ 1.00). The CBR for the first, second and third years is calculated at PKR 111, 98 and 111, respectively.

7.3 Provincial and Regional Requirements

The subsequent section gives objectives and outcomes wise total financial requirement, funds available for the next three years with the respective region and province, and the financial gap which need to be filled to effectively achieve RMNCAH and Nutrition objectives.

7.3.1 Resource requirement for AJK (In Millions)

ESTIMATED TOTAL COSTS REQUIREMENT, AVAILABLE FUNDS, AND FINANCIAL GAP (IN PKR & US$) IN MILLIONS

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL REQUIRED	AVAILABLE FUNDS	GAP		
		2018	2019	2020			PKR	US$	PERCENT
1	**Improving Access & Quality of MNCH Community Based Primary Care Services**	**1,289.11**	**821.98**	**816.82**	**2,927.91**	**290.20**	**2,637.71**	**24.65**	**90.09**
1.1	Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in AJK	721.27	808.20	803.69	2,333.16	262.20	2,070.96	**19.35**	**88.76**
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.	193.94	13.78	13.13	220.84	26.10	194.74	**1.82**	**88.18**
1.3	Improved the linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI	238.60	-	-	238.60	-	238.60	**2.23**	**100.00**
1.4	Increase in community demand for RMNCAH and Nutrition services	135.30	0.00	0.00	135.30	1.90	133.40	**1.25**	**98.60**
2	**Improved quality of care at primary and secondary level care facilities**	**554**	**315**	**323**	**1,193**	**160**	**1,032**	**9.65**	**86.56**
2.1	Enhanced skills of HCPs on IMNCI/ PCPNC/ ENC/ RH/ CMAM/ IYCF etc. (training package) at Primary and Secondary HCFs	65.00	43.25	29.66	137.91	13.90	124.01	**1.16**	**89.92**
2.2	Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs and provision of supplies	120.00	104.00	112.00	336.00	33.50	302.50	**2.83**	**90.03**
2.3	Improved referral mechanism involving all health care Facility levels to ensure continuum of care	49.20	-	-	49.20	7.50	41.70	**0.39**	**84.76**
2.4	Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	93.84	5.98	6.44	106.26	14.20	92.06	**0.86**	**86.64**
2.5	Inclusion of IMNCI/PCPNC/ENC WHO protocols in pre-service of Medical Colleges	226.32	162.24	174.72	563.28	91.20	472.08	**4.41**	**83.81**
3	**Overcoming financial barriers to care seeking and uptake of interventions**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	
3.1	Improved and strengthened coordination with the existing social safety nets.	-	-	-	-	-	-	**-**	
4	**Increased Funding and allocation for MNCH**	**2.04**	**4.68**	**2.38**	**9.10**	**1.30**	**7.80**	**0.07**	**85.71**
4.1	Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	2.04	4.68	2.38	9.10	1.30	7.80	**0.07**	**85.71**
5	**Reproductive health including Family Planning**	**3.48**	**0.52**	**0.56**	**4.56**	**0.50**	**4.06**	**0.04**	**89.04**
5.1	Linkages between existing forums established from Federal to District Level (NATPOW, Provincial Technical Committee)	3.48	0.52	0.56	4.56	0.50	4.06	**0.04**	**89.04**
6	**Investing in nutrition especially of adolescent girls, mothers & children**	**602.57**	**623.98**	**666.54**	**1,893.10**	**204.90**	**1,688.20**	**15.78**	**89.18**

ESTIMATED TOTAL COSTS REQUIREMENT, AVAILABLE FUNDS, AND FINANCIAL GAP (IN PKR & US$) IN MILLIONS

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL REQUIRED	AVAILABLE FUNDS	GAP		
		2018	2019	2020			PKR	US$	PERCENT
6.1	Improved infant and young child nutrition (children < 24 months) practices in all districts of AJK (CMAM/ IYCN/ SUN/ IDD/ Food Fortification)	3.00	3.25	3.50	9.75	1.20	8.55	**0.08**	**87.69**
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 AJK	293.00	325.03	358.43	976.46	93.00	883.46	**8.26**	**90.48**
6.3	Enhanced access of local community to life saving nutrition services for acute malnourished children in all districts of AJK	306.57	295.71	304.61	906.89	110.70	796.19	**7.44**	**87.79**
7	**Investing in addressing social determinants of health**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	
7.1	Health Friendly Multi Sectorial Policies and Practices adopted	**-**	**-**	**-**	**-**	**-**	**-**	**-**	
8	**Measurement and action at district level**	**68.47**	**16.95**	**15.46**	**100.88**	**12.70**	**88.18**	**0.82**	**87.41**
8.1	Generation of Valid, Timely, Complete, Reliable routine Data	68.47	16.95	15.46	100.88	12.70	88.18	**0.82**	**87.41**
9	**National Accountability and Oversight**	**6.72**	**3.64**	**3.92**	**14.28**	**1.60**	**12.68**	**0.12**	**88.80**
9.1	Improve Governances and Accountability	6.72	3.64	3.92	14.28	1.60	12.68	**0.12**	**88.80**
10	**Generation of the political will to support MNCH**	**14.64**	**14.56**	**15.68**	**44.88**	**3.40**	**41.48**	**0.39**	**92.42**
10.1	Awareness about SDGs on Health and Population among Policy Makers and Parliamentarian	14.64	14.56	15.68	44.88	3.40	41.48	**0.39**	**92.42**
GRAND TOTAL		**2,541.40**	**1,801.79**	**1,844.17**	**6,187.35**	**674.90**	**5,512.45**	**51.52**	**89.09**

7.3.2 Resource requirement for Balochistan (In Millions))

Sr No	OBJECTIVES / OUTCOMES	YEAR 1 2018	YEAR 2 2019	YEAR 3 2020	TOTAL	AVAILABLE FUNDS	GAP PKR	GAP US$
1	**Improving Access & Quality of MNCH Community Based Primary Care Services**	**593.06**	**528.32**	**697.45**	**1,818.83**	**614.90**	**1,203.93**	**11.25**
1.1	Enhanced equitable access and coverage of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs)	179.65	73.70	188.40	441.75	107.00	334.75	3.13
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.	358.40	394.11	435.84	1,188.36	439.90	748.46	6.99
1.3	Improved community outreach routine immunization through involvement of LHWs	14.20	15.62	24.24	54.05	21.00	33.05	**0.31**
1.4	Improved the linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI	40.81	44.89	48.97	134.66	47.00	87.66	**0.82**
1.5	Increase in community demand for utilization of RMNCAH and Nutrition services	67.92	74.71	81.50	224.14	49.00	175.14	
2	**Improved quality of care at primary and secondary level care facilities**	**1,413.58**	**1,855.12**	**2,563.01**	**5,831.71**	**4,670.03**	**1,161.68**	**10.86**
2.1	Enhanced skills of HCPs on IMNCI/PCPNC/ENC/HBB/GAPPD at Primary and Secondary HCFs	117.90	125.00	136.37	379.27	139.55	239.72	2.24
2.2	Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs including residential accommodations and provision of supplies	290.00	321.20	352.80	964.00	193.00	771.00	7.21
2.3	Improved referral mechanism involving all health care levels to ensure continuum of care	39.40	44.79	48.86	133.06	14.00	119.06	1.11
2.4	Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	1.50	1.65	1.80	4.95	1.00	3.95	0.04
2.5	Inclusion of IMNCI/PCPNC/ENC/HBB/Infection Prevention Protocols in pre-service training institutions	8.60	7.57	17.28	33.45	5.50	27.95	0.26
2.6	Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities	956.18	1,354.90	2,005.90	4,316.98	4,316.98	-	-
3	**Overcoming financial barriers to care seeking and uptake of interventions**	**7.20**	**8.91**	**13.92**	**30.03**	**-**	**30.03**	**0.28**
3.1	Expansion and Improved coordination of the existing social safety nets	1.20	0.66	3.12	4.98	-	4.98	0.05
3.2	Provision of equity based health Insurance coverage to the people	6.00	8.25	10.80	25.05	-	25.05	
4	**Increased Funding and allocation for MNCH**	**2.70**	**2.97**	**3.24**	**8.91**	**1.20**	**7.71**	**0.07**
4.1	Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	2.00	2.20	2.40	6.60	1.20	5.40	0.05
4.2	Improve in mechanism and capacity of the province to absorb and utilize the available resources	0.70	0.77	0.84	2.31	-	2.31	0.02
5	**Reproductive health including Family Planning**	**61.91**	**47.45**	**55.63**	**164.99**	**30.00**	**134.99**	**1.26**

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
5.1	Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level	4.24	4.66	5.09	13.99	-	13.99	0.13
5.2	Strengthened systems for FP and RH through regular provision of commodities for all levels/ capacity building of the HCPs/Enhanced funding for FP	57.67	42.78	50.54	151.00	30.00	121.00	1.13
6	**Investing in nutrition especially of adolescent girls, mothers & children**	**2,024.97**	**1,613.18**	**2,154.83**	**5,792.98**	**148.63**	**5,644.36**	**52.75**
6.1	Reduction of Micro Malnutrition among Adolescent girls, Pregnant and Lactating Women (PLW) with more focus on 07 food insecure districts in the province	537.97	589.26	677.30	1,804.52	37.70	1,766.82	16.51
6.2	Promotion of Good IYCF Practices (6-23 months)	130.95	21.12	157.14	309.21	15.25	293.96	2.75
6.3	Reduction of General and Micro Malnutrition among Infants (0-23 months) and Children (6-59 months) through Out Patient and In-Patient management of SAM children	1,356.05	1,002.80	1,320.39	3,679.25	95.68	3,583.58	33.49
7	**Investing in addressing social determinants of health**	**72.30**	**61.16**	**66.72**	**200.18**	**3.00**	**197.18**	**1.84**
7.1	Multispectral approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH/Nutrition/mental health issues in women and adolescent girls at district level	18.50	1.98	2.16	22.64	3.00	19.64	0.18
7.2	Legislation done supporting mandatory female education and abandon early age marriages	53.80	59.18	64.56	177.54	-	177.54	1.66
8	**Measurement and action at district level**	**10.41**	**3.99**	**4.35**	**18.75**	**1.60**	**17.15**	**0.16**
8.1	Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH and Nutrition indicators	5.15	0.95	1.04	7.14	0.60	6.54	0.06
8.2	Improved data quality (Reporting timeliness and completeness and 2-way feedback mechanism)	-	-	-	-	-	-	-
8.3	Improved investigation and response mechanism (MNDSR) at provincial level and priority districts (based polio audit model	4.26	1.94	2.11	8.31	-	8.31	0.08
8.4	Data disseminated to support formulation of evidence based policies	1.00	1.10	1.20	3.30	1.00	2.30	0.02
9	**National Accountability and Oversight**	**6.30**	**4.18**	**4.56**	**15.04**	**0.80**	**14.24**	**0.13**
9.1	Effective oversight mechanism of the RMNCAH/N Program in place.	0.80	0.88	0.96	2.64	0.80	1.84	0.02
9.2	Effective accountability framework in place and in vogue	5.50	3.30	3.60	12.40	-	12.40	0.12
10	**Generation of the political will to support MNCH**	**0.90**	**0.99**	**1.08**	**2.97**	**0.50**	**2.47**	**0.02**
10.1	RMNCAH and Nutrition being recognized as priority area in development agenda and increased political will and support for RMNCAH and Nutrition from political leadership in policy making, planning and resource allocation	0.90	0.99	1.08	2.97	0.50	2.47	0.02
GRAND TOTAL		**4,193.34**	**4,126.26**	**5,564.79**	**13,884.39**	**5,470.66**	**8,413.73**	**78.63**

7.3.3 Resource requirement for FATA (In Millions)

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
1	**Improving Access & Quality of MNCH Community Based Primary Care Services**	**535.37**	**677.27**	**549.49**	**1,762.13**	**174.25**	**1,587.88**	**14.84**
1.1	Improved, access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted Agencies	243.02	338.70	243.93	825.65	68.40	757.25	**7.08**
1.2	Improved quality of community based RMNCAH and Nutrition services (through improvement in monitoring and supervision/revision of ToRs/capacity building and supplies)	198.92	236.85	279.09	714.86	96.35	618.51	**5.78**
1.3	Improved community routine immunization through involvement of vaccinators with coordination of LHWs/ catchment area	3.96	4.29	4.62	12.87	1.00	11.87	**0.11**
1.4	Improved linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI/NBC	66.54	72.61	-	139.15	-	139.15	**1.30**
1.5	Increase in community demand for RMNCAH and Nutrition services	22.92	24.83	21.84	69.60	8.50	61.10	**0.57**
2	**Improved quality of care at primary and secondary level care facilities**	**395**	**192**	**199**	**787**	**102**	**685**	**6.40**
2.1	Enhanced skills of HCPs on IMNCI/PCPNC/ENC/HBB/NBC/ RH/ CMAM/ IYCF etc. (training package) at Primary and Secondary HCFs	9.24	10.01	-	19.25	2.50	16.75	**0.16**
2.2	Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs and provision of supplies	153.00	161.85	174.30	489.15	73.50	415.65	**3.88**
2.3	Improved referral mechanism involving all health care levels to ensure continuum of care	28.45	-	-	28.45	2.10	26.35	**0.25**
2.4	Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	8.06	6.01	1.57	15.64	1.80	13.84	**0.13**
2.5	Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities	196.68	14.56	23.38	234.62	22.50	212.12	**1.98**
3	**Overcoming financial barriers to care seeking and uptake of interventions**	**309.00**	**334.75**	**360.50**	**1,004.25**	**3.60**	**1,000.65**	**9.35**
3.1	Provision of equity based social health protection initiatives	309.00	334.75	360.50	1,004.25	3.60	1,000.65	**9.35**
4	**Increased Funding and allocation for MNCH**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
4.1	Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	-	-	-	-	-	-	**-**
5	**Reproductive health including Family Planning**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
5.1	Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level	-	-	-	-	-	-	**-**
6	**Investing in nutrition especially of adolescent girls, mothers & children**	**623.21**	**648.48**	**661.65**	**1,933.34**	**209.20**	**1,724.14**	**16.11**

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
6.1	Improved infant and young child nutrition (children < 24 months) practices in all Agencies (7) and FRs (6) of FATA	3.96	4.29	4.62	12.87	2.20	10.67	**0.10**
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 Agencies (7) and FRs (6) of FATA	290.73	322.60	355.84	969.17	89.50	879.67	**8.22**
6.3	Enhanced assess of local community to life saving nutrition services for acute malnourished children in all Agencies (7) and FRs (6) of FATA	328.52	321.60	301.18	951.30	117.50	833.80	**7.79**
7	**Investing in addressing social determinants of health**	**1.32**	**0.39**	**0.42**	**2.13**	**-**	**2.13**	**0.02**
7.1	Health Friendly Multi Sectoral Policies and Practices adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs, civil society, and PPP).	0.96	-	-	0.96	-	0.96	0.01
7.2	Laws in place supporting mandatory female education, Birth/Death registration and marriage registration	0.36	0.39	0.42	1.17	-	1.17	0.01
8	**Measurement and action at district level**	**154.39**	**112.03**	**26.32**	**292.75**	**23.50**	**269.25**	**2.52**
8.1	Generation of Valid, Timely, Complete, Reliable routine Data	154.39	112.03	26.32	292.75	23.50	269.25	**2.52**
9	**National Accountability and Oversight**	**5.40**			**5.40**	**0.50**	**4.90**	**0.05**
9.1	Effective oversight mechanism of the RMNCAH/N Program in place	5.40			5.40	0.50	4.90	**0.05**
10	**Generation of the political will to support MNCH**	**1.20**		**-**	**1.20**	**-**	**1.20**	**0.01**
10.1	Awareness about SDGs on Health and Population among Policy Makers and Parliamentarians	1.20	-	-	1.20	-	1.20	**0.01**
GRAND TOTAL		**2,025.32**	**1,965.36**	**1,797.62**	**5,788.30**	**513.45**	**5,274.85**	**49.30**

7.3.4 Resource requirement for Gilgit Baltistan (In Millions)

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
1	**Improving Access & Quality of MNCH Community Based Primary Care Services**	**662.29**	**383.26**	**364.10**	**1,409.65**	**123.21**	**1,286.45**	**12.02**
1.1	Improved, access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted Agencies	592.36	317.71	308.75	1,218.83	105.30	1,113.53	**10.41**
1.2	Improved quality of community based RMNCAH and Nutrition services (through improvement in monitoring and supervision/revision of ToRs/capacity building and supplies)	32.40	35.10	37.80	105.30	10.00	95.30	**0.89**
1.3	Improved community routine immunization through involvement of vaccinators with coordination of LHWs/ catchment area	4.32	-	-	4.32	1.00	3.32	**0.03**
1.4	Improved linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI/NBC	13.96	14.14	-	28.10	-	28.10	**0.26**
1.5	Increase in community demand for RMNCAH and Nutrition services	19.25	16.30	17.55	53.10	6.91	46.19	**0.43**
2	**Improved quality of care at primary and secondary level care facilities**	**139.81**	**96.06**	**91.83**	**327.70**	**41.50**	**286.20**	**2.67**
2.1	Enhanced skills of HCPs on IMNCI/ PCPNC/ ENC/ HBB/NBC/ RH/ CMAM/ IYCF etc. (training package) at Primary and Secondary HCFs	16.44	13.78	3.22	33.44	3.70	29.74	**0.28**
2.2	Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/ renovation/ upgradation of HCFs and provision of supplies	24.00	26.00	28.00	78.00	13.00	65.00	**0.61**
2.3	Improved referral mechanism involving all health care levels to ensure continuum of care	24.96	-	-	24.96	3.60	21.36	**0.20**
2.4	Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	5.90	1.04	1.12	8.06	0.90	7.16	**0.07**
2.5	Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities	68.51	55.24	59.49	183.23	20.30	162.93	**1.52**
3	**Overcoming financial barriers to care seeking and uptake of interventions**	**240.00**	**260.00**	**280.00**	**780.00**	**-**	**780.00**	**7.29**
3.1	Provision of equity based health Insurance coverage to the people	240.00	260.00	280.00	780.00	-	780.00	**7.29**
4	**Increased Funding and allocation for MNCH**	**3.96**	**1.30**	**1.40**	**6.66**	**0.80**	**5.86**	**0.05**

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
4.1	Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	1.08	1.17	1.26	3.51	0.60	2.91	**0.03**
4.2	Improve in mechanism and capacity of the GB to absorb and utilize the available resources	2.88	0.13	0.14	3.15	0.20	2.95	**0.03**
5	**Reproductive health including Family Planning**	**2.64**	**2.86**	**3.08**	**8.58**	**1.00**	**7.58**	**0.07**
5.1	Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level	2.64	2.86	3.08	8.58	1.00	7.58	**0.07**
6	**Investing in nutrition especially of adolescent girls, mothers & children**	**208.72**	**230.47**	**243.06**	**682.25**	**102.30**	**579.95**	**5.42**
6.1	Improved infant and young child nutrition (children < 24 months) practices in GB	2.64	2.86	3.08	8.58	1.50	7.08	**0.07**
6.2	Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade 1-5), adolescent girls & PLW in GB	81.85	90.64	99.79	272.28	45.00	227.28	**2.12**
6.3	Enhanced assess of local community to life saving nutrition services for acute malnourished children in GB	124.23	136.97	140.19	401.39	55.80	345.59	**3.23**
7	**Investing in addressing social determinants of health**	**1.08**	**1.17**	**1.26**	**3.51**	**0.30**	**3.21**	**0.03**
7.1	Health Friendly Multi Sectoral Policies and Practices adopted (Health, education, public health engineering, social welfare, Women Development Department, Agriculture Department, Food Department, NGOs, civil society, and PPP).	0.72	0.78	0.84	2.34	0.30	2.04	0.02
7.2	Laws in place supporting mandatory female education, Birth/Death registration and marriage registration	0.36	0.39	0.42	1.17	-	1.17	0.01
8	**Measurement and action at district level**	**72.78**	**40.30**	**45.50**	**158.58**	**14.10**	**144.48**	**1.35**
8.1	Generation of valid, Timely, Complete, Reliable routine Data	72.78	40.30	45.50	158.58	14.10	144.48	**1.35**
9	**National Accountability and Oversight**	**1.68**	**1.82**	**1.96**	**5.46**	**1.20**	**4.26**	**0.04**
9.1	Effective oversight mechanism of the RMNCAH/N Program in place.	1.68	1.82	1.96	5.46	1.20	4.26	**0.04**
10	**Generation of the political will to support MNCH**	**2.88**	**0.52**	**0.56**	**3.96**	**0.40**	**3.56**	**0.03**
10.1	Awareness about SDGs on Health and Population among Policy Makers and Parliamentarians	2.88	0.52	0.56	3.96	0.40	3.56	**0.03**
GRAND TOTAL		**1,335.84**	**1,017.75**	**1,032.75**	**3,386.35**	**284.81**	**3,101.54**	**28.99**

7.3.5 Resource requirement for KPK (In Millions)

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
1	**Improving Access & Quality of MNCH Community Based Primary Care Services**	**662.29**	**383.26**	**364.10**	**1,409.65**	**123.21**	**1,286.45**	**12.02**
1.1	Improved, access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted Agencies	592.36	317.71	308.75	1,218.83	105.30	1,113.53	**10.41**
1.2	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)	32.40	35.10	37.80	105.30	10.00	95.30	**0.89**
1.3	Expected outcome 1.3: Improved community routine immunization through involvement of vaccinators with coordination of LHWs/ catchment area	4.32	-	-	4.32	1.00	3.32	**0.03**
1.4	Expected outcome 1.4: Improved linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI/NBC	13.96	14.14	-	28.10	-	28.10	**0.26**
1.5	Expected outcome 1.5: Increase in community demand for RMNCAH and Nutrition services	19.25	16.30	17.55	53.10	6.91	46.19	**0.43**
2	**Improved quality of care at primary and secondary level care facilities**	**140**	**96**	**92**	**328**	**42**	**286**	**2.67**
2.1	Enhanced skills of HCPs on IMNCI/ PCPNC/ ENC/ HBB/ NBC/ RH/ CMAM/ IYCF etc. (training package) at Primary and Secondary HCFs	16.44	13.78	3.22	33.44	3.70	29.74	**0.28**
2.2	Expected outcome 2.2: Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs and provision of supplies	24.00	26.00	28.00	78.00	13.00	65.00	**0.61**
2.3	Expected outcome 2.3: Improved referral mechanism involving all health care levels to ensure continuum of care	24.96	-	-	24.96	3.60	21.36	**0.20**
2.4	Expected outcome 2.4: Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	5.90	1.04	1.12	8.06	0.90	7.16	**0.07**
2.5	Availability of comprehensive quality EPI services as part of RMNCAH/ Nutrition services package at all PHC level facilities	68.51	55.24	59.49	183.23	20.30	162.93	**1.52**
3	**Overcoming financial barriers to care seeking and uptake of interventions**	**240.00**	**260.00**	**280.00**	**780.00**	**-**	**780.00**	**7.29**
3.1	Provision of equity based health Insurance coverage to the people	240.00	260.00	280.00	780.00	-	780.00	**7.29**
4	**Increased Funding and allocation for MNCH**	**3.96**	**1.30**	**1.40**	**6.66**	**0.80**	**5.86**	**0.05**
4.1	Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	1.08	1.17	1.26	3.51	0.60	2.91	**0.03**
4.2	Improve in mechanism and capacity of the GB to absorb and utilize the available resources	2.88	0.13	0.14	3.15	0.20	2.95	**0.03**

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
5	**Reproductive health including Family Planning**	**2.64**	**2.86**	**3.08**	**8.58**	**1.00**	**7.58**	**0.07**
5.1	Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level	2.64	2.86	3.08	8.58	1.00	7.58	**0.07**
6	**Investing in nutrition especially of adolescent girls, mothers & children**	**208.72**	**230.47**	**243.06**	**682.25**	**102.30**	**579.95**	**5.42**
6.1	Improved infant and young child nutrition (children < 24 months) practices in GB	2.64	2.86	3.08	8.58	1.50	7.08	**0.07**
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	81.85	90.64	99.79	272.28	45.00	227.28	**2.12**
6.3	Enhanced assess of local community to life saving nutrition services for acute malnourished children in GB	124.23	136.97	140.19	401.39	55.80	345.59	**3.23**
7	**Investing in addressing social determinants of health**	**1.08**	**1.17**	**1.26**	**3.51**	**0.30**	**3.21**	**0.03**
7.1	Health Friendly Multi Sectoral Policies and Practices adopted (Health, education, public health engineering, social welfare, Women Development Department, Agriculture Department, Food Department, NGOs, civil society, and PPP).	0.72	0.78	0.84	2.34	0.30	2.04	0.02
7.2	Laws in place supporting mandatory female education, Birth/Death registration and marriage registration	0.36	0.39	0.42	1.17	-	1.17	0.01
8	**Measurement and action at district level**	**72.78**	**40.30**	**45.50**	**158.58**	**14.10**	**144.48**	**1.35**
8.1	Generation of Valid, Timely, Complete, Reliable routine Data	72.78	40.30	45.50	158.58	14.10	144.48	**1.35**
9	**National Accountability and Oversight**	**1.68**	**1.82**	**1.96**	**5.46**	**1.20**	**4.26**	**0.04**
9.1	Effective oversight mechanism of the RMNCAH/N Program in place.	1.68	1.82	1.96	5.46	1.20	4.26	**0.04**
10	**Generation of the political will to support MNCH**	**2.88**	**0.52**	**0.56**	**3.96**	**0.40**	**3.56**	**0.03**
10.1	Awareness about SDGs on Health and Population among Policy Makers and Parliamentarians	2.88	0.52	0.56	3.96	0.40	3.56	**0.03**
GRAND TOTAL		**1,335.84**	**1,017.75**	**1,032.75**	**3,386.35**	**284.81**	**3,101.54**	**28.99**

7.3.6 Resource requirement for Punjab (In Millions)

Sr No	OBJECTIVES / OUTCOMES	YEAR 1 2018	YEAR 2 2019	YEAR 3 2020	TOTAL	AVAILABLE FUNDS	GAP PKR	GAP US$
1	**Improving Access & Quality of MNCH Community Based Primary Care Services**	**1,340.19**	**358.57**	**386.32**	**2,085.08**	**444.46**	**1,640.61**	**15.33**
1.1	Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs etc.)	25.20	-	-	25.20	-	25.20	**0.24**
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.	43.10	46.70	50.29	140.09	100.00	40.09	**0.37**
1.3	Improved community outreach routine immunization through involvement of LHWs	173.33	187.77	202.37	563.47	259.00	304.47	**2.85**
1.4	Improved the linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI	984.00	-	-	984.00	-	984.00	**9.20**
1.5	Increase in community demand for RMNCAH and Nutrition services	114.56	124.11	133.66	372.32	85.46	286.86	**2.68**
2	**Improved quality of care at primary and secondary level care facilities**	**179.70**	**2.08**	**2.24**	**184.02**	**32.00**	**152.02**	**1.42**
2.1	Improved referral mechanism involving all health care levels to ensure continuum of care	177.78	-	-	177.78	32.00	145.78	**1.36**
2.2	Improved monitoring and supervision of the facility based RMNCAH and Nutrition services	1.92	2.08	2.24	6.24	-	6.24	**0.06**
3	**Overcoming financial barriers to care seeking and uptake of interventions**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
3.1	Expected outcome 3.1: Improved and strengthened coordination of the existing social safety nets.						-	-
4	**Increased Funding and allocation for MNCH**	**7.92**	**1.56**	**9.24**	**18.72**	**4.00**	**14.72**	**0.14**
4.1	Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	1.44	1.56	1.68	4.68	-	4.68	**0.04**
4.2	Improve in mechanism and capacity of the province to absorb and utilize the available resources	6.48	-	7.56	14.04	4.00	10.04	**0.09**
5	**Reproductive health including Family Planning**	**460.80**	**460.20**	**495.60**	**1,416.60**	**163.30**	**1,253.30**	**11.71**
5.1	Enhanced coordination of Population Welfare and Health department and functional integration of RH/FP and RMNCAH services at HCF level	3.31	3.59	3.86	10.76	3.30	7.46	**0.07**
5.2	Strengthened systems for FP and RH through regular provision of commodities for all levels/ capacity building of the HCPs/Enhanced funding for FP	81.94	49.76	53.59	185.29	65.00	120.29	**1.12**
5.3	Increase community demand for reproductive health and family planning services	375.55	406.85	438.14	1,220.54	95.00	1,125.54	**10.52**
6	**Investing in nutrition especially of adolescent girls, mothers & children**	**942.08**	**997.90**	**1,096.98**	**3,036.95**	**896.20**	**2,140.75**	**20.01**
6.1	Reduction of Micro Malnutrition among Adolescent girls, Pregnant and Lactating Women (PLW)	895.19	993.90	1,096.98	2,986.07	894.70	2,091.37	**19.55**
6.2	Early initiation and promotion of Exclusive Breast feeding -Implementation of breast feeding act 2009 -Awareness campaigns, Global Breast Feeding Week	43.20	-	-	43.20	-	43.20	**0.40**

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
6.3	Reduction of General and Micro Malnutrition among Infants (0-23 months) and Children (6-59 months) through Out Patient and In-Patient management of SAM children	3.69	4.00	-	7.69	1.50	6.19	**0.06**
7	**Investing in addressing social determinants of health**	**29.40**	**31.20**	**34.30**	**94.90**	**30.00**	**4.90**	**0.61**
7.1	Multispectral approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH/Nutrition/mental health issues in women and adolescent girls at district level	29.40	31.20	34.30	94.90	30.00	64.90	**0.61**
8	**Measurement and action at district level**	**31.37**	**17.86**	**10.14**	**59.37**	**11.50**	**47.87**	**0.45**
8.1	Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH and Nutrition indicators	23.28	9.10	0.70	33.08	3.50	29.58	**0.28**
8.2	Improved data quality (Reporting timeliness and completeness and 2-way feedback mechanism)	3.26	3.54	3.81	10.61	4.00	6.61	**0.06**
8.3	Improved investigation and response mechanism (MNDSR) at district and provincial levels	3.02	3.28	3.53	9.83	2.50	7.33	**0.07**
8.4	Formulation of evidence based policies	1.80	1.95	2.10	5.85	1.50	4.35	**0.04**
9	**National Accountability and Oversight**							
9.1	Effective oversight mechanism of the RMNCAH/N Program in place							**-**
10	**Generation of the political will to support MNCH**	**1.08**	**1.17**	**1.26**	**3.51**	**1.00**	**2.51**	**0.02**
10.1	RMNCAH and Nutrition being recognized as priority area in development agenda and increased political will and support for RMNCAH and Nutrition from political leadership in policy making, planning and resource allocation	1.08	1.17	1.26	3.51	1.00	2.51	**0.02**
GRAND TOTAL		**2,992.54**	**1,870.54**	**2,036.07**	**6,899.15**	**1,582.46**	**5,316.68**	**49.69**

7.3.7 Resource requirement for Sindh (In Millions)

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
1	**Improving Access & Quality of MNCH Community Based Primary Care Services**	**3,004.30**	**3,471.91**	**4,173.13**	**10,649.34**	**1,005.49**	**9,643.85**	**90.13**
1.1	Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted districts	632.91	1,197.06	1,839.61	3,669.58	67.00	3,602.57	**33.67**
1.2	Improved quality of community based services by supporting infrastructure for HR induction/ capacity building	32.47	40.37	67.21	140.05	-	140.05	**1.31**
1.3	Improved quality of community based RMNCAH and Nutrition services (through improvement in monitoring and supervision/revision of ToRs)	317.79	344.27	276.35	938.41	-	938.41	**8.77**
1.4	Improved quality of community based RMNCAH and Nutrition services (through Capacity building and supplies) of the CMWs and LHWs	104.10	101.20	108.99	314.29	88.60	225.68	**2.11**
1.5	Improved community outreach routine immunization through involvement of LHWs/CMWs	43.12	46.72	-	89.84	-	89.84	**0.84**
1.6	Improved the linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI/ HIV/ Hep/ MH/ TB etc.	269.64	-	-	269.64	140.04	129.60	**1.21**
1.7	Increase in community demand through social mobilization for RMNCAH and Nutrition services	123.60	133.90	144.20	401.70	119.85	281.85	**2.63**
1.8	Expected outcome 1.8: Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services by provision of supplies / equipment for (LHWs and CMWs)	1,480.67	1,608.39	1,736.78	4,825.84	590.00	4,235.84	**39.59**
2	**Improved quality of care at primary and secondary level care facilities**	**358.66**	**250.82**	**273.22**	**882.70**	**153.42**	**751.28**	**7.02**
2.1	Enhanced skills of HCPs on IMNCI/PCPNC/ENC/ RH/ CMAM/ IYCF (training package) at Primary and Secondary HCFs	114.96	120.64	129.92	365.52	45.77	319.75	**2.99**
2.2	Strengthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs and provision of supplies	4.80	5.20	5.60	15.60	37.60		**-**
2.3	Improved referral mechanism involving all health care levels to ensure continuum of care	0.89	0.96	1.06	2.91	0.50	2.41	**0.02**
2.4	Inclusion of IMNCI/PCPNC/ENC WHO protocols in pre-service	32.09	37.05	42.98	112.12	16.50	95.62	**0.89**
2.5	Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facilities	205.92	86.97	93.66	386.55	53.05	333.50	**3.12**
3	**Overcoming financial barriers to care seeking and uptake of interventions**							
3.1	Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted districts							
4	**Increased Funding and allocation for MNCH**	**17.90**	**19.69**	**21.48**	**23.27**	**25.06**	**107.40**	**1.00**

Sr No	OBJECTIVES / OUTCOMES	YEAR 1	YEAR 2	YEAR 3	TOTAL	AVAILABLE FUNDS	GAP	
		2018	2019	2020			PKR	US$
4.1	Enhanced equitable access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted districts	0.50	0.55	0.60	0.65	0.70	3.00	**0.03**
4.2	Resource allocation of funds for advocacy, awareness, and research for RMNCAH and Nutrition Programs	17.40	19.14	20.88	22.62	24.36	104.40	**0.98**
5	**Reproductive health including Family Planning**	**698.47**	**284.13**	**305.92**	**1,288.52**	**239.00**	**1,049.52**	**9.81**
5.1	Enhanced equitable access, coverage to FP services through outreach services and scaling up of services reach	77.00	48.75	52.50	578.25	117.00	461.25	**4.31**
5.2	Introduction of modern methods of family planning to women and adolescent girls (PPIUCDs implanons/femiplants/D Jars-PPFP)	221.47	235.38	253.42	710.27	122.00	588.27	**5.50**
6	**Investing in nutrition especially of adolescent girls, mothers & children**	**4,224.42**	**4,676.62**	**5,155.54**	**14,056.57**	**699.00**	**13,357.57**	**124.84**
6.1	Addressing General Malnutrition	3,516.25	3,904.50	4,309.97	11,730.71	245.00	11,485.71	**107.34**
6.2	Addressing Micronutrient Malnutrition	470.21	522.13	576.35	1,568.69	454.00	1,114.69	**10.42**
6.3	Service Delivery through different program for outreach activity and treatment	35.52	38.48	41.44	115.44	-	115.44	**1.08**
	Office, Transportation, Human Recourse, Community Outreach	132.48	143.52	154.56	430.56	-	430.56	**4.02**
	Capacity building and institutional strengthening	62.76	67.99	73.22	203.97	-	203.97	**1.91**
	MIS Tools and NIS	7.20	-	-	7.20	-	7.20	**0.07**
7	**Investing in addressing social determinants of health**	**5.52**	**3.82**	**4.12**	**13.46**	**-**	**13.46**	**0.13**
7.1	Multispectral approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH/ Nutrition/mental health issues in women and adolescent girls	5.52	3.82	4.12	13.46	-	13.46	0.13
8	**Measurement and action at district level**	**31.20**	**33.80**	**36.40**	**101.40**	**11.20**	**90.20**	**0.84**
8.1	Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH and Nutrition indicators	21.60	23.40	25.20	70.20	10.00	60.20	**0.56**
8.2	Improved data quality (Reporting timeliness and completeness and 2-way feedback mechanism)	7.80	8.45	9.10	25.35	0.30	25.05	**0.23**
8.3	Formulation of evidence based policies	1.80	1.95	2.10	5.85	0.90	4.95	**0.05**
9	**National Accountability and Oversight**	**5.52**	**2.08**	**2.24**	**9.84**	**1.50**	**8.34**	**0.08**
9.1	Effective oversight mechanism of the RMNCAH/N Program in place	1.92	2.08	2.24	6.24	1.00	5.24	**0.05**
9.2	Effective accountability framework in place and in vogue	3.60	-	-	3.60	0.50	3.10	**0.03**
10	**Generation of political will to support MNCH**	**70.80**	**76.70**	**82.60**	**230.10**	**41.80**	**188.30**	**1.76**
10.1	Increased political will and support for RMNCAH and Nutrition from political leadership at all levels	70.80	76.70	82.60	230.10	41.80	188.30	**1.76**
GRAND TOTAL		**8,416.78**	**8,819.57**	**10,054.65**	**27,255.20**	**2,176.47**	**25,209.92**	**235.61**

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UNFPA

World Health Organization

unicef