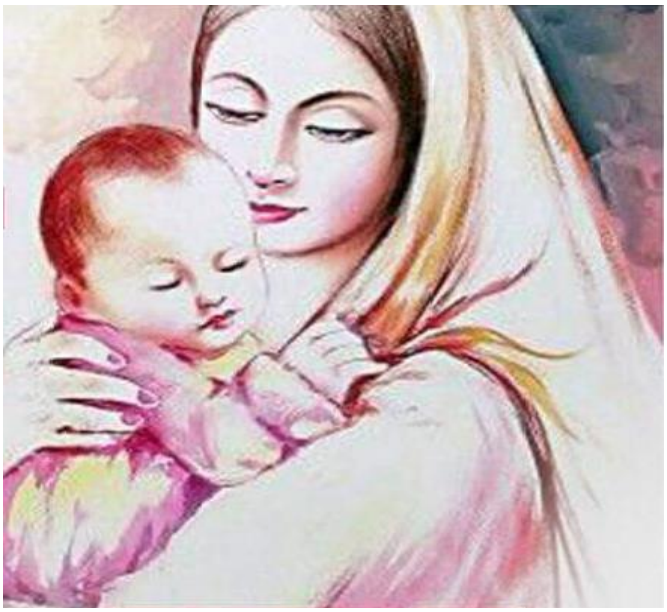
PUNJAB



Punjab RMNCAH&N Action Plan (2016-2020)

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

MAP OF PUNJAB

CONTENTS

ACRONYMS

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

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

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

MESSAGE:
SECRETARY HEALTH, PUNJAB

I am pleased to affirm that improving coverage for RMNCAH&N services is one of the top most priority of the Government of Punjab and the commitment of the department is exhibited through development of Essential Package of Health Services (EPHS) with primary focus on the community based and facility based (both primary and secondary health facilities) package for maternal, neonatal, child and adolescent health and nutrition. The Provincial RMNCAH&N Action Plan for the Punjab has been developed quite in line with the priority areas envisaged in the "Ten Point National Vision on R-MNCAH & Nutrition" formulated by Ministry of National Health Services Regulation & Coordination on the desire of the Honorable Prime Minister of Pakistan Mian Muhammad Nawaz Sharif and its alignment and consistency with our home grown Punjab Health Sector Strategy 2012-2020 have also been ensured.

The provincial action plan has been developed after due consultative process and coordination among all the key relevant stakeholders i.e., IRMNCH and Nutrition Program, Population Welfare Department, Policy & Strategic Planning Unit (PSPU), EPI, HMIS Department and UN partners at provincial level (WHO, UNICEF and UNFPA).

I feel indebted to highly acknowledge the continuous support WHO provincial team in taking this task forward and assisting the department throughout the process till its successful completion.

I wish the objectives of the task are fulfilled in the true spirit and the desired results/outcomes are achieved in a tangible manner quite in accordance with the high aspirations of Premier of Pakistan regarding maternal, neonatal, child and adolescent health and nutrition.

Ali Jan Khan
Secretary Primary & Secondary
Healthcare Department
Punjab

PREAMBLE

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

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

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

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

EXECUTIVE SUMMARY

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

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

The MNCH program of the department of health, Punjab has made concerted efforts to strengthen the health system through improvements in institutional arrangements and integration of various programs; especially at the district level by, implementing an integrated essential health services package which is the cornerstone of this process. The Integration of the MNCH, Nutrition and Family planning into an IRMNCAH&N program, Integration Health Information System, implementation of a health insurance scheme and development of a health care commission are major successes amongst other achievements. These efforts have brought about a considerable increase in the health of Punjab. The province has the highest percentage (in all provinces) of women receiving antenatal care from skilled provider (52.5% in 2012-13); proportion of deliveries assisted by a doctor increased from 26% in 2006-07 to 47% in 2012-13 and the proportion of facility deliveries also saw a considerable rise (25% in 2006-07 as compared to 48.5% in 2013).

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

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

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

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

Core components of the Punjab provincial action plan include:

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

b) Improving quality of care at primary & secondary level care facilities will be achieved by enhancing the relevant knowledge base and skills of the different cadres of health care staff including, field staff such as LHWs, CMWs, LHVs, LHSs and other supervisory staff, Teaching and clinical staff such as midwifery tutors and clinical supervisors etc.

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

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

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

6: A Monitoring & Supervision framework will be developed including ToRs, plans, reporting formats and checklists at provincial, divisional, district and facility level. The overall responsibility of M&E will rest with the Provincial Department of Health whereas the MNCH programs will be responsible for compiling

their respective M&E reports on quarterly basis and submit regularly to the DOH to be consolidated on annual basis

The action plan also includes a detailed Financial Action Plan which serves as a resource mobilization tool which could be used comprehensively for mobilizing political commitment and financial resources at the national level or for garnering donor support.

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

BACKGROUND

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

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

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

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

[2] *PDHS 2012-13*

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

SITUATIONAL ANALYSIS

Punjab is Pakistan's second largest province by area after Baluchistan, and is the most populous province with an estimated population of 103 million. Punjab is known for its relative prosperity and has the lowest rate of poverty amongst all provinces of Pakistan. The province is composed of 9 divisions, 36 districts, 140 tehsils, 3464 Union Councils and 25,914 Mauzas.[4] In spite of extensive network of health care facilities, health status of the people of the province as a whole is below the desired level as is revealed from the key health indicators described in table 1 below. Moreover, 92 percent of the population has access to improved drinking water sources while 58 percent of the population has access to sanitation facilties.

Presently, there are about four million malnourished children in Punjab, and about a third of all pregnant women are estimated to have iron deficiency anemia. Over 34 percent of children under the age of five years are short for their age; over 10 percent are under weight for their age and over half anemic. Malnutrition is a major contributor to infant and maternal deaths[5].

Table 1: Key Indicators of Punjab Province

Total population	103m
Population – Urban : Rural	33m : 70m
Annual growth rate	2.05%
Adult literacy rate – Aged 15 yrs. & older	69 : 51
Neonatal mortality rate/1,000 live births	63
Infant mortality rate/1,000 live births	77
Under 5 mortality rate/1,000 live births	112
Maternal mortality ratio/100,000 live births	300
%age delivered by a skilled provider	52.5
%age delivered in health facility	48.5
%age receiving antenatal care from a skilled provider	77.8
%age of women with a postnatal checkup in the first 2 days after birth	66
%age Under nutrition < 5 years	34
Fully immunization (12-23 m based on recall and record)	90
Tetanus toxoid (%age receiving two or more injections during last pregnancy)	67.9
Total fertility rate (15-49 yrs)	4.7
Contraceptive prevalence rate	40.7

Source: PSLM 2014-15, PDHS 2012-13, pwd.punjab.gov.pk/population pro-

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

CHALLENGES & CONSTRAINTS

The burden of ill health on the population of Punjab is longstanding and well documented. Maternal and child health services have been under-emphasized within the health system resulting in a high rate of maternal and child deaths. From childhood to old age, communicable diseases account for a large proportion of deaths and disability in the province. Among children, the burden of disease is largely associated with diarrhea, pneumonia and vaccine preventable diseases. Nutritional status of the population is generally poor especially for the children, women of reproductive age and the elderly. Similarly, micronutrient deficiencies are also frequent and there is widespread lack of awareness about malnutrition. Furthermore, the role of various departments such as education, finance,

[4] *Bureau of statistics, Punjab*

5 PDHS 2012-13, PSPU website, Punjab Health Sector Strategy 2012-2020, IRMNCAH&N PC1 2016-17

labor and industry and water and sanitation will also need to be strengthened.

The salient challenges faced by the Punjab Health Sector are as follows:

1. Service delivery – Issues of access and quality of healthcare
2. Governance and accountability – Weak system of health sector governance, management and regulation
3. Health workforce - Inadequate and lack of skilled workforce available to fulfill population health needs.
4. Health information system - Lack of comprehensive, timely, accurate and functional information foundation for health policy and planning decisions.
5. Essential drugs and medical technologies – Lack of continued supply of quality essential drugs for healthcare facilities and outreach workers.
6. Healthcare financing – Lack of well-structured health care financing policy with strategy for financial risk protection of disadvantaged and vulnerable households; efficient and effective utilization of budget allocated and increased public private partnership for provision of quality services at larger scale.

OPPORTUNITIES

The Punjab health sector strategy 2012-2020 aims to strengthen the health system through improvements in institutional arrangements and integration of various programs especially at the district level by implementing an integrated essential health services package which is the cornerstone of this process.

Essential health services package for the primary level care services has been developed and formally approved, whereas, packages for secondary and tertiary care level is in progress. An integrated PC-1 mainly focusing on the Maternal and Neonatal Child Health, Nutrition and Family Planning is also available. An integrated Punjab Health Information System and the Punjab Health Care Commission is now operational to regulate the health sector. Department for International Development and World Bank have in principle committed to support the health sector based on the vision and outcomes spelled out in the Punjab Health Sector Strategy. Therefore, a result-based framework has been developed to ensure proper monitoring for implementing the Strategy. Disbursement Linked Insights (DLIs) for the health sector support agreed by the Government of Punjab, World Bank and Department for International Development, has been based on Health Sector Strategy Medium Term Budgetary Framework (MTBF) of Department of Health Punjab is linked with Health Sector Strategy.

The Punjab Health Reforms Roadmap was launched in 2013 and a regular review is carried out at the highest political level in the province. The Roadmap aims to achieve dramatic and fast improvements in the health system. It focuses on a set of four priorities; vaccination, safe deliveries, primary healthcare and district effectiveness. A monthly stock taking is held to update the progress in each priority area.

Health Department has integrated the LHWs Program, MNCH and the Nutrition Programs under the nomenclature of Integrated Reproductive Maternal Child Health Program (IRMNCH). The Program functions in a truly integrated manner.

A Knowledge Management Unit has been established since 2013 under the Policy & Strategic Planning Unit (PSPU). The Knowledge Management Unit produces briefs of reports and provides feedback on different reports/ surveys being conducted under the Health sector within and outside the province of Punjab.

Health watch technology based monitoring and evaluation initiative is spearheaded and coordinated by Policy and Strategic Planning Unit with collaboration of Punjab Information Technology Board (PITB). In Health watch Android-based smartphones have been provided in January 2015 to district supervisory officers (EDOHs, DOHs DDOHs), who have been tasked with the collection of performance related data from Basic Health Units, Rural Health Centers, Tehsil and District Headquarters. The data submitted by these officers through the phones are being recorded on a website, known as the 'Dashboard'.

PSPU has developed a multi-sectorial strategy for addressing malnutrition in Punjab, with the support of UNICEF & other partners. This multi-sectorial nutrition strategy involves all key sectors which collectively have considerable potential for reducing malnutrition in the Province.

The Prime Minister's National Health Insurance Program was launched in Punjab in 2016. In the first phase, four districts i.e. Rahim Yar Khan, Narowal, Khanewal and Sargodha are included in the Scheme. The scheme ensures the identification of under-privileged citizens across the country to gives access to their entitled medical health care.

IMPLEMENTATION APPROACH FOR RMNCAH&N ACTION PLAN

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

VISION

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

GOAL

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

OBJECTIVE

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

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

CORE COMPONENTS OF THE IMPLEMENTATION APPROACH

1: Improving accessibility:

An exercise in scaling-up of mapping will be carried out to identify uncovered areas of both CMWs and LHWs in Punjab province. It will ensure that 60% population will be covered through LHWs and 100% population covered through CMWs in the targeted districts to provide outreach services by these community health workers; in a phased manner till 2020, in rural areas and urban slums of the province.

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

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

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

2: Capacity building

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

Emphasis will be laid on integration of IMNCI, PCPNC & ENC in pre-service education at medical schools to provide knowledge, develop skills and attitudes among students as part of their learning

process and enable them to think through a differential diagnostic process before formulating a diagnosis and prescribing treatment. Similarly, in-service trainings for facility and community health workers will focus on topics like use of Chlorhexidine, use of Misoprostol, healthy timing and spacing of pregnancy (HTSP), essential newborn care (ENC), kangaroo mother care (KMC), Pregnancy Care and Postnatal Care (PCPNC), helping babies breathe (HBB), infant and young child feeding (IYCF) practices. Moreover, trainings on HIV/STI, TB, DOTS, Hepatitis, referral and reporting of MNC mortality, family planning methods: hormonal, long term FP methods, IUCD, PPIUCD, etc. will also be undertaken.

3: Improving financial accessibility & provision of safety nets

It is envisaged that coordination and linkages will be established and strengthened between various social security departments; Bait-ul-Maal, Social Welfare department, Zakat department, Benazir Income Support Program, etc. to pilot, revisit and revise the beneficiaries of the existing public social nets. It will promote equitable distribution among the vulnerable and marginalized communities and scaling up of various planned interventions in a more coordinated manner and with holistic approach. It will also enhance the utilization of primary and secondary health care facilities by marginalized groups and vulnerable population as a priority due to availability of financial support system at health care facilities.

The conditional cash transfers (CCT), social health insurance and voucher schemes will be strengthened and expanded to provide equity based health insurance coverage to the vulnerable and marginalized groups. CCT programs will aim to enhance both the income of the poor in the short run, and their skills and capabilities in the medium and long run

4: Health system strengthening

The mother and child health care, prevention and management of RTIs/STIs and HIV/AIDS, management of reproductive health related issues of adolescent boys and girls, other RH related issues of men and women, management of Infertility and early detection of breast and cervical cancers by promoting self-examination. Comprehensive family planning services will be offered which include conventional and clinical methods as well as male and female contraceptive surgery facilities in static units and in extension service camps under safe and sterile circumstances.

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

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

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

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

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

5: Social mobilization

Advocacy seminars, symposium, international conferences and orientation sessions will be organized to raise awareness regarding RMNCAH&N interventions at provincial and district level. The internationally recognized days, such as; health day, global breast feeding day, hand washing day, midwifery day, world health day, mother's day, children day, hepatitis, TB, HIV, no tobacco, etc will be celebrated to emphasize and highlight the importance of various aspects and lifestyles affecting health.

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

The various activities contributing to achievement of sustainable development goals will be branded and meetings will be organized with friends of FWCs for promotional and awareness purposes. Television commercials will be developed, produced and aired through TV, FM radio & video on wheels to raise awareness on family planning. Likewise, thematic dramas will be developed in Punjabi to cover topics such as family planning promotion and demand creation.

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

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

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

6: Monitoring & Supervision:

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

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

OUTLINE OF MONITORING & EVALUATION PLAN

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

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

Table 2: Strategic objectives with key indicators of achievement.

Strategic Objectives	Core Indicators of achievement
Objective1: Improving access and quality of MNCH community based primary care services ensuring continuum of care including newborn care in rural districts and urban	• % coverage of target districts with IRMNCAH&N services by LHWs and CMWs. • % LHWs involved in routine immunization. • % increase in uptake of IRMNCAH&N services from CMWs and LHWs.

slums	
Objective 2: Improve access to and quality of RMNCH care at Primary and Secondary level care facilities	• % of HCF providing essential health care package on RMNCAH &N services including referral mechanisms. • % of HCF with health care providers trained on key IRMNCAH&N topics (PCPNC, IMNCI etc). • % of HCF implementing the WHO Quality of Care standards for IRMNCAH&N services.
Objective 3: Overcoming financial barriers to care seeking and uptake of interventions	• Number of social protection schemes/programs linked with promotion of utilization of health care services • % of coverage of beneficiary population under the conditional cash transfer schemes
Objective 4: Increase in funding and allocation for RMNCAH & Nutrition	• % increase in funding for RMNCAH and Nutrition programs reflected in PSDP/ADP. • % utilization of funds allocated for advocacy on RMNCAH & N.
Objective 5: Improve reproductive health including Family planning	• % of HCF providing integrated service delivery for RH & MNCH services. • % of HCP with enhanced skills and competencies regarding family planning
Objective 6: Investing in nutrition especially of adolescent girls, mothers and children	• % of HCF providing nutrition specific services (static and outreach) to MAM and SAM children, adolescent girls and PLWs • % of adolescent girls, PLWs, MAM and normal children, provided with micronutrients
Objective 7: Investing in addressing social determinants of health	• Number of sectors incorporating social determinants of health into their respective sectoral plans
Objective 8: Measurement and action at district level	• % of districts reporting to integrated DHIS i.e. includes all RMNCAH & Nutrition indicators
Objective 9: National Accountability and	• % of planned quarterly progress review meetings of the National RMNCAH&N program oversight committee conducted per year

Oversight	• % of districts implementing the accountability framework related to RMNCAH&N program
Objective 10: Generation of the political will to support MNCH as a key priority within Sustainable Development Goals	• Number of in-parliamentary sessions focusing on RMNCAH & N issues • Number of mass media products focusing on RMNCAH & N

FINANCIAL ACTION PLAN

BACKGROUND AND COSTING METHODOLOGY

In order to operationalize the ten priority RMNCAH&N actions into concrete action plans that would enable implementation over the coming five years (2016-2020), the action plan has been costed to serve the purpose of advocacy, resource mobilization, and providing guidance in implementation. The exercise built upon the existing RMNCAH&N action plans, which had documented the baselines where available, and clearly set targets with milestones over the 5 years duration. In circumstances where additional information required, the consultant referred to the concerned provincial and federating areas program managers.

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

To further ensure accuracy in the process of costing of RMNCAH and Nutrition action plan of Punjab province, a joint consultative meeting was organized by the Policy and Strategic Planning Unit (PSPU) on March 02, 2017 in the conference room of PSPU, Lahore. The meeting was attended by the relevant Provincial Program Managers including the Population Welfare Department, PSPU staff, and international partners including the WHO, UNICEF and UNFPA. The meeting was chaired by the Additional Director PSPU. The main objective of the meeting was to determine the unit costs and number of units per year for all the activities under each of 10 objectives of the RMNCAH action plan. Afterwards, individual meetings/discussions were held with the Program Managers, as and when needed. The unit costs were determined on the basis of discussions with the relevant program stakeholders and available documents like RMNCAH&N action plan of Punjab province, PC-1s, Comprehensive Multi-Year Plans of EPI, project concept notes, etc. The numbers of units were mainly taken from the RMNCAH&N action plan. Where necessary, the number of units has been changed for some of the

activities, as suggested by the relevant program managers during the costing process. In consultation with the concerned stakeholders, an inflationary increment of 10% every year was applied to the unit costs, due to a periodic increase in the prices of goods and services.

Component-wise total resource requirements

1 Resource requirements by component/ objective

S.#	Component/Objective	Total PKR	%
1	Improving Access and Quality of MNCH Community Based Primary Care Services	38,489,796,300	26.28
2	Improved quality of care at primary and secondary level care facilities	9,695,916,400	6.62
3	Overcoming financial barriers to care seeking and uptake of interventions	43,050,700,000	29.39
4	Increased Funding and allocation for MNCH	41,040,000	0.03
5	Reproductive health including Family planning	2,677,500,000	1.83
6	Investing in nutrition especially of adolescent girls , mothers and children	52,196,799,162	35.63
7	Investing in addressing social determinants of health	187,030,000	0.13
8	Measurement and action at district level	88,075,000	0.06
9	National Accountability and Oversight	22,950,000	0.02
10	Generation of the political will to support MNCH	32,490,000	0.02
Total		146,482,296,862	100

As shown in the above table, total amount of PKR 146,482,296,682 will be required over a period of five years (2016-2020) for implementing the RMNCAH and Nutrition plan in the Punjab province. The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (35.63%) have been costed under objective 6 i-e “Investing in nutrition especially of adolescent girls, mothers and children”. After this, the majority of funds (26.28%) and (29.39%) have been costed under objectives 1 & 3 respectively. The objective 1 is focusing on “Improving the access and quality of MNCH community based primary care services, and objective 3 will overcome financial barriers to care seeking and uptake of interventions in the province.

Component-wise yearly resource requirements

2 Yearly resource requirements by component/obejctive

S.#	Component/ Objective	2016	2017	2018	2019	2020
		PKR	PKR	PKR	PKR	PKR
1.	Improving Access and Quality of MNCH Community Based Primary Care Services	6,521,698,000	8,433,048,800	6,289,726,800	7,826,570,700	9,418,752,000
2.	Improved quality of care at primary and secondary level care facilities	1,001,242,000	1,953,021,400	2,354,704,800	2,346,518,200	2,040,430,000
3.	Overcoming financial barriers to care seeking and uptake of interventions	5,005,700,000	6,607,260,000	8,409,720,000	10,412,480,000	12,615,540,000
4.	Increased Funding and allocation for MNCH	9,000,000	3,960,000	10,800,000	4,680,000	12,600,000
5.	Reproductive health including Family planning	381,500,000	447,700,000	830,400,000	490,100,000	527,800,000
6.	Investing in nutrition especially of adolescent girls , mothers and children	8,098,195,720	9,770,333,362	10,558,738,448	11,433,046,608	12,336,485,025
7.	Investing in addressing social determinants of health	28,880,000	41,118,000	34,056,000	36,244,000	46,732,000
8.	Measurement and action at district level	21,140,000	32,219,000	15,168,000	9,412,000	10,136,000
9.	National Accountability and Oversight	3,000,000	8,250,000	3,600,000	3,900,000	4,200,000
10.	Generation of the political will to support MNCH	4,500,000	4,620,000	7,440,000	7,670,000	8,260,000
Total		**21,074,855,720**	**27,301,530,562**	**28,514,354,048**	**32,570,621,508**	**37,020,935,025**

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

FINANCING AND FUNDING GAP

Component-wise Funding Gap

3 Funding Gap

S.#	Component/ Objective	Total Cost	Available Funds	Additional Funds Required
		PKR	PKR	PKR
1.	Improving Access and Quality of MNCH Community Based Primary Care Services	38,489,796,300	7,236,688,940	31,253,107,360
2.	Improved quality of care at primary and secondary level care facilities	9,695,916,400	2,641,295,000	7,054,621,400
3.	Overcoming financial barriers to care seeking and uptake of interventions	43,050,700,000	0	43,050,700,000
4.	Increased funding and allocation for MNCH	41,040,000	8,800,000	32,240,000
5.	Reproductive health including Family planning	2,677,500,000	233,300,000	2,444,200,000
6.	Investing in nutrition especially of adolescent girls , mothers and children	52,196,799,162	10,794,700,000	41,402,099,162
7.	Investing in addressing social determinants of health	187,030,000	32,000,000	155,030,000
8.	Measurement and action at district level	88,075,000	12,500,000	75,575,000
9.	National Accountability and Oversight	22,950,000	1,000,000	21,950,000
10.	Generation of the political will to support MNCH	32,490,000	4,500,000	27,990,000
Total		**146,482,296,862**	**20,964,783,940**	**125,517,512,922**

As seen in the above table, the available funding through different sources; PC-1, Provincial Business Plan and Punjab Growth Strategy currently does not meet the total resource requirement to implement this holistic RMNCAH action plan. Mainly, these funds will be channeled by the provincial government to the respective programs upon submission of these plans to the Global Trust Fund by Federal Ministry. In order to further meet the additional resources requirement, the Government of Punjab may mobilize resources through allocating funds from their own development schemes or by approaching potential donors.

OUTLINE OF PUNJAB ACTION PLAN

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

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Base-line	Target							
1.1.1	Increased cover-age of LHWs	% of new population covered (from target)	46000 (71%)	65000	Salary component of existing LHWs may be funded by the federal government till 2017 so provincial government may not be able to enhance the numbers till 2017. For the following years, LHW Program coverage may be increased subject to positions creation for uncovered areas					Govt. Contribution	Policy Decision Government of Pun-jab/IRMNCH Program
1.1.2	Mapping of LHW uncovered area and Re-appropriation to enhance coverage	% of uncovered areas mapped	71% covered	Exact map-ping of un-covered areas population will be available	*	*				RMNCAH&N Action Plan	IRMNCH&N Program

1.1.2.1	Scale up of Mapping of CMWs uncovered areas	% of uncovered areas mapped	No such mapping available	Uncovered areas in all 36 districts	*	*				RMNCAH&N Action Plan	IRMNCH&N Program
1.1.3	Increased coverage of CMWs by training new CMWs and improved retention of already trained CMWs		5700 CMWs	12000 (Deployment as per mapping)	1200	1200	1200	1200	1200	Govt. Contribution	IRMNCH&N Program
1.1.3.1	Deployment of newly trained CMWs in the uncovered areas as per mapping (establishment of birthing stations equipped for RMNCH/EPI/FP services)	% of new CMWs deployed	5700	Baseline Plus 1200 per year	1200	1200	1200	1200	1200	Govt. Contribution/ RMNCAH&N ACTION PLAN	IRMNCH&N Program
1.1.4	Strengthen the existing midwifery schools (Strengthening in terms of renovation and upgradation of class rooms; Provision of AV teaching aids and training material and equipment (including mannequin etc.) as per class strength	% of existing schools strengthened	0	42	6	18	18			RMNCAH&N Action Plan	IRMNCH&N Program

1.1.5	Placement of appropriate number of tutors per school	% of tutors placed (from target)	(29*3)	(42*3)	*	*				Govt. Contribution	IRMNCH&N Program
1.1.6	Establishment of Center of Excellence (CoE) for Midwifery Education	Center of Excellence (CoE) for Midwifery Education established	0	3		1	1	1		RMNCAH&N Action Plan	Department of Health/ IRMNCH&N Program
1.1.7	Training of Tutors at AKU for BS Midwifery course to create a pool of Master Trainers in the Province	% of tutors trained	0	20		10		10		RMNCAH&N Action Plan	IRMNCH&N Program
1.1.8	Couple health workers pilot project		3 (by UNICEF)	Model to be tested in 6 additional districts		6					Subject to Scalability
1.1.8.1	Training of Couple Health Workers	% of districts where Couple Health Workers trained	0	6 Districts		6					Subject to Scalability
1.1.8.2	Adaptation, Printing and Provision of Training Modules and Recording Reporting Tools of Couple Health Workers	% of districts provided with revised Training Modules and Recording/ Reporting Tools	0	6 Districts		6					Subject to Scalability
1.1.8.3	Establish and support Monitoring Mechanism of Couple Health Workers Initia-	% of districts where support Monitoring Mechanism initiated	0	9 (3 UNICEF supported districts)		*					Subject to Scalability

	tive within the program										
1.1.8.4	Transportation & POL support to the Monitoring Supervisors of CHW Model in Pilot Districts	% of districts where Transportation & POL support Provided	0	9 (3 UNICEF supported districts)		*	*	*	*	RMNCAH&N Action Plan	IRMNCH&N Program
1.1.9	Assessment of existing MCH Centers for their possible role in service provision to peri-urban and urban slums	% Assessment Reports developed	NA (280 MCH Centers)	Assessment Reports with Gap Analysis and recommendations		*				RMNCAH&N Action Plan	IRMNCH&N Program
1.1.9.1	Strengthening of MCH Centers based upon Gap analysis	% of MCH Centers strengthened & Operational	NA (280 MCH Centers)	280 Centers strengthened & Operational			100	100	80	RMNCAH&N Action Plan	IRMNCH&N Program / Local Government
1.1.10	Introduction of Public Private Partnership (PPP) Model to enhance MNCH coverage in uncovered areas and urban slums by involving CBOs/NGOs	% of districts where Public Private Partnership (PPP) Model introduced	0	10 districts in uncovered areas and urban/Peri-Urban Slums		*				RMNCAH&N Action Plan	IRMNCH&N Program

1.1.10.1	Implementation of Public Private Partnership (PPP) Model to enhance MNCH coverage in uncovered areas and urban slums by involving CBOs/NGOs	% of districts where Public Private Partnership (PPP) Model implemented	0	10 districts in uncovered areas and urban/Peri-Urban Slums			5	5		RMNCAH&N Action Plan	Government of Punjab/Punjab Health Department
1.1.11	Establishment of Birthing Centers as workable business model for CMWs	% of districts where Birthing Centers established as a business model	0	36 Districts		12	12	12		RMNCAH&N Action Plan	IRMNCH&N Program

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
1.2.1	Recruitment of LHSs (LHWs and CMWs supervisory staff) for supervision	% of new LHSs recruited	1796	3200 (current posting + Additional numbers to match if new LHWs are recruited	-	-	-	-	-	Govt. Contribution	Policy decision Provincial Health Department
1.2.2	Trainings/Refresher of LHSs on administrative monitoring (in facility and field) of CMWs	% of existing LHSs trained	-	1796 (Existing Numbers)		900	896			RMNCAH&N Action Plan	IRMNCH&N Program
1.2.3	Integrated monitoring and supervision plan/rosters for LHSs to monitor LHWs and CMWs at the catchment	% of Integrated monitoring and supervision plans/rosters for LHSs	Not formally exists	1796 (Existing Numbers)		900	896			Govt. Contribution	IRMNCH&N Program

	area facilitated through Facility In charge	Provided /facilitated									
1.2.4	Increase in mobility support to the supervisory staff (LHS)	% Fuel support to LHS (ltrs) provided in target year	70 L/LHS/Month	90 L/LHS/Month	*	*	*	*	*	Govt. Contribution	IRMNCH&N Program
1.2.5	Introduction of Inter-District Monitoring Model	functional Inter-district monitoring system introduced	Not in place	A well functional Inter-district monitoring system within program structure		*	*	*	*	RMNCAH&N Action Plan	IRMNCH&N Program
1.2.6	Improved quality of services of LHWs and CMWs Through:						*	*	*		IRMNCH&N Program
1.2.6.1	Revision of ToRs to eliminate unnecessary ac-	ToRs revised	-	Revised TORs available	*					RMNCAH&N Action Plan	IRMNCH&N Program

	tivities and effective utilization of time										
1.2.6.2	Revision of curriculum to include new initiatives and evidence based best practices for maternal and newborn care	Curriculum revised	In progress	Revised and Approved Curriculum available		*				RMNCAH&N Action Plan	IRMNCH&N Program
1.2.6.3	Printing of Revised Curriculum for the LHWs	% of copies of revised curriculum printed	-	65000			*			RMNCAH&N Action Plan	IRMNCH&N Program
1.2.6.4	Training of LHWs on new modules based on revised curriculum	% of LHWs trained on revised curriculum	-	65000		* (Existing 46000 LHWs)		* (New recruits LHWs)	* (New recruits LHWs)	RMNCAH&N Action Plan	IRMNCH&N Program
1.2.7	Refresher trainings of LHWs and CMWs	% of LHWs and CMWs trained	0	46000 LHWs + 6000 CMWs	*	*				Govt. Contribution	IRMNCH&N Program
1.2.8	Trainings of LHWs on maternal, newborn care (5 days); FP (7 days); Nutrition (5 days) and reporting of MNC mortalities (2 days)	% of LHWs trained (from target)	Baseline available with Program	46000 LHWs	*	*				Govt. Contribution	IRMNCH&N Program

1.2.8.1	Trainings of CMWs on maternal, newborn care (5 days); FP (7 days); Nutrition (5 days) and reporting of MNC mortalities (2 days)	% of CMWs trained (from target)	Baseline available with Program	6000 CMWs	*	*				Govt. Contribution	IRMNCH&N Program
1.2.9	Training of LHWs and CMWs on new areas: HTSP (5 days), PCPNC(7 days), ENC(4 days), IYCF(5 days), HBB (2 days), Use of Chlorhexidine (1 day), cIMNCI (5 days) etc.	% of CMWs and LHWs trained (from target)	Baseline available with Program	46000 + (New Planned) LHWs Plus 6000 + 6000 (Additional) CMWs	13000 + 2400	13000 + 2400	13000 + 2400	13000 + 2400	13000 + 2400	RMNCAH&N Action Plan	IRMNCH&N Program
1.2.9.1	Printing and Provision of Training Modules and Material for each training according to the number of LHWs and CMWs	% of Training Modules and Material provided to LHWs and CMWs for each training	0	46000 + (New Planned) LHWs Plus 6000 + 6000 (Additional CMWs)	13000 + 2400	13000 + 2400	13000 + 2400	13000 + 2400	13000 + 2400	RMNCAH&N Action Plan	IRMNCH&N Program

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
1.3.1	Training of LHWs on Routine immunization	% of LHWs trained on Routine immunization out reach (from Target)	20582 LHWs in 18 Districts	45926 in all 36 Districts PLUS New LHWs if 100% covered areas	6336	6336	6336	6336	19000 (subject to Recruitment)	WHO	IRMNCH&N Program and EPI Program
1.3.1.1	Provision of logistic support to LHWs for routine immunization	The % of LHWs provided logistic support	20582 LHWs in 18 Districts	45926 in all 36 Districts PLUS New LHWs if 100% covered areas	6336	6336	6336	6336	19000 (subject to Recruitment)	WHO	IRMNCH&N Program
1.3.2	Printing and Provision of Training Modules and revised recording and reporting	% of LHWs provided with Training Modules and revised recording and reporting tools	20582 LHWs in 18 Districts	45926 in all 36 Districts PLUS New LHWs if 100%	6336	6336	6336	6336	19000 (subject to Recruitment)	WHO	IRMNCH&N Program

	tools for all LHWs in re-maining dis-tricts			covered areas							

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
1.4.1	Adaptation of Referral Linkage Pathways from Community to Health Facility (Referral Proto-cols developed by TRF+)	Protocols developed and adopt-ed	NA	Referral Proto-cols adopted and availa-ble at all levels in 36 dis-		*	*			RMNCAH&N Action Plan	IRMNCH&N Program

				tricts							
1.4.1.1	Strengthening of referral system / mechanism (Proper Orientation to LHWs, CMWs and HCF staff on referral pathways (1 day Orientation training)	% of relevant staff given orientation training on referral mechanism (by category of staff targeted for training)	NA	All LHWs, CMWs, Incharges and Referral focal points of Primary & Secondary HCF are oriented		*	*			RMNCAH&N Action Plan	IRMNCH&N Program
1.4.1.2	Printing and Display of referral linkages pathways / protocols in CMWs birth stations, LHWs Health Houses and Health Care facilities	% of Referral Protocols available and displayed at health houses etc.	NA	Referral Protocols available and displayed at all levels		*	*			RMNCAH&N Action Plan	IRMNCH&N Program
1.4.1.3	Development/printing/provision of referral slips and record keeping formats to the CMWs and LHWs	% of LHWs and CMWs with whom referral slips and record keeping	NA	Available for all LHWs and CMWs as per average						RMNCAH&N Action Plan	IRMNCH&N Program

		formats are available		referral							
1.4.2	Strengthening linkage and feed-back mechanism between referral unit/ LHS/ LHW/ CMW by quarterly meeting at Referral unit.	% of quarterly meetings held (by /per district)	NA	All 36 Districts		*	*	*	*	RMNCAH&N Action Plan	IRMNCH&N Program

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
1.5.1	Development of Integrated Primary Healthcare and RMNCAH &N Communication Strategy	Integrated Communication Strategy developed	Communication Strategy not available	Approved Communication Strategy available						RMNCAH&N Action Plan	MSNC (P&D) /IRMNCH&N Program
1.5.2	Development of a costed Operational Plan (Including IEC material, Advocacy Kit) for Communication strategy	Comprehensive Communication Plan developed	Not available	Comprehensive Communication Plan along with Approved /adopted IEC material available		*				RMNCAH&N Action Plan	MSNC (P&D) /IRMNCH&N Program
1.5.2.1	Training on newly developed IEC material of community based (LHWs-CMWs, Vaccinators, SHNS etc.) and relevant facility based staff	% of staff trained (per staff category)	NA	All Facility + Outreach staff			*	*	*	MNCAH Action Plan	MSNC (P&D) /IRMNCH&N Program

1.5.3	Re-Vitalization of LHW Support Groups with effective participation of CMWs & SH&NS	% LHWs, CHWs and other relevant staff participating in meetings (per district)	NA	All LHWs		*	*	*	*	MNCAH Action Plan	MSNC (P&D) /IRMNCH&N Program
1.5.3.1	Involvement of UCMO/Health Officers in monitoring of support group activities (FTA allowance)	% of meetings attended by UCMO/Health Officers	NA	All Health Facilities		*	*	*	*	MNCAH Action Plan	MSNC (P&D) /IRMNCH&N Program
1.5.4	Printing and Provision of newly developed IEC material on MNCH, EPI, FP and Nutrition and advocacy kits to LHWs/CMWs for health educations sessions	% of LHWs and CMWs and Health Facilities provided with IEC material and Kits	NA	Available for all LHWs and CMWs and Health Facilities		*	*	*	*	MNCAH Action Plan	MSNC (P&D) /IRMNCH&N Program
1.5.5	Use local print and electronic media for social mobilization and health messages on RMNCAH and Nutrition (refer to PC_I as well)	--	Need based	As per Communication Strategy Action Plan	*	*	*	*	*	Govt. Contribution	MSNC (P&D) /IRMNCH&N Program

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

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020		
2.1.1	Specialized Training institutes at divisional level	% of training institutes developed	4	9	2	2	1	0		RMNCAH&N Action Plan	IRMNCH&N Program
2.1.2	Capacity building of health care providers at PHC & SHC facilities (Pediatricians, MOs/WMOs/LHVs) on IMNCI skills	% of staff trained (by selected category of staff)	360 (MNCH PC-1)	5850	1170	2340	3510	4680	5850	WHO/RMNCAH&N Action Plan	IRMNCH&N Program
2.1.3	Expanding the pool of IMNCI facilitators(5 days Training) in province	% of facilitators trained	70	200	30	50	50	-	-	WHO/RMNCAH&N Action Plan	IRMNCH&N Program
2.1.4	Expanding the pool of follow-up supervisors (3 days Training) in province	% of follow-up supervisors trained	25	100	25	25	25			WHO/RMNCAH&N Action Plan	IRMNCH&N Program

2.1.5	Increase the pool of PCPNC facilitators in Province (7days)	% of PCPNC facilitators trained	42	100	30	30				WHO/RMNCAH&N Action Plan	IRMNCH&N Program
2.1.6	Increase the pool of ENC facilitators (9 days) at district level	% of ENC facilitators trained	Baseline data?	108 (3 per district)	25	50	33			WHO/RMNCAH&N Action Plan	IRMNCH&N Program
2.1.7	Conduct training of Health care provides (Gynecologists/Obstetricians/WMOs/LHVs/Nurses etc.) on PCPNC	% of HCP trained	79	1804	125	250	375	500	630	WHO/RMNCAH&N Action Plan	IRMNCH&N Program
2.1.8	Training of Master Trainers on use of misoprostol, Use of MgSo4, use of partogram and Use of MVA (PPH, & Eclampsia & Pre-Eclampsia) (5 days Training)	% of Master Trainers trained	113 (By UNFPA) but exact database not available	5 Master Trainers Per District + 1 Health Manager/Coordinator (216)	108	108				RMNCAH&N Action Plan	IRMNCH&N Program
2.1.9	Training of HCP on use of misoprostol, Use of Mgso4, use of partogram and Use of MVA (PPH, & Eclampsia & Pre-Eclampsia) (5 days Training)	% of HCP trained	Data Not available	4 HCPs per DHQ & THQ + 3 HCPs per RHC and 24/7 BHUs (5664)	1888	1888	1888			RMNCAH&N Action Plan	IRMNCH&N Program

2.1.10	Conduct training of the HCPs (Gyne/Obs, WMO, MO, Pediatricians, LHVs, staff nurses) on Essential Newborn Care (ENC)	% of HCP trained	97	950	100	200	200	200	153	WHO/RMNCAH&N Action Plan	IRMNCH&N Program
2.1.11	Training of HCPs (Pediatrician/ MO/WMO/Staff Nurses) on Neonatal care at Neonatal Intensive care Units	% of HCP trained	4 UNICEF	36	4 UNICEF	8	12	12		RMNCAH&N Action Plan	IRMNCH&N Program
2.1.12	Piloting of Kangaroo Mother Care Model at Selected Health Facilities	% of district hospitals piloting Kangaroo Mother care model	KMC is being piloted in 1 HF of Lahore by UNICEF	1 Hospital in each District (36);	1 (UNICEF)	12	12	12		RMNCAH&N Action Plan	IRMNCH&N Program
2.1.13	Training of Staff on Kangaroo Mother Care	% of staff trained (per selected hospital)	6 (Services Hospital Lahore)-UNICEF Pilot	6 staff per Hospital (6*36*'n' Days)	6 (UNICEF)	72	72	72		RMNCAH&N Action Plan	IRMNCH&N Program
2.1.14	Adaptation and Provision of Training Materials to the staff involved in Pilot	% of trainee staff provided training material	UNICEF Pilot Training Material	-	-	*	*	*		RMNCAH&N Action Plan	IRMNCH&N Program

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020		
2.2.1	Implementation of Essential Package of Health Services and Minimum Service Delivery Standards at all levels	% of districts implementing EPHS	Approved EPHS available but not implemented	EPHS implemented in all 36 districts		*	*	*	*	Govt. Contribution + RMNCAH&N Action Plan	PHCC/IRM NCH&N Program
2.2.2	Induction and Availability of trained HR for providing 24/7 CEmONC services at DHQ/THQ and Basic EMONC services at PHC centers the districts as per requirement (Gynecologist, Pediatrician, Anesthetist, WMOs, MOs & Para Medics)	% of HCF with appropriately trained staff (by district)	Baseline available with DoH and IRMNCH Program	All DHQs, THQs, RHCs and 24/7 BHUs	*	*				Govt. Contribution	IRM-NCH&N Program

2.2.3	Availability of essential medicines and equipment (As per EPHS/IMNCI/PCPNC Protocols)	% of HCF with availability of essential medicines and equipment (by district)	-	All DHQs, THQs, RHCs and 24/7 BHUs	*	*				Govt. Contribution	IRM-NCH&N Program
2.2.4	Assessment of Health Facility Infrastructure for repair and renovation for MNCAH and FP Service delivery (DHQ/THQ and RHC)	% of HCF Assessed (per district)	NA	Assessment Reports with Gap Analysis and recommendations		*				RMNCAH&N Action Plan	Government of Punjab (Health Councils)/IRMNCH&N Program
2.2.5	Improvement of health facility infrastructure (Repair/renovate/upgrade the OT/Labor rooms/ Gyne wards/Pediatric wards in the DHQ, THQ and RHCs)	% of HCF Repaired/renovated/ upgraded (per district)	Assessment Report and recommendations	DHQ + THQ + RHCs			*	*	*	RMNCAH&N Action Plan	Government of Punjab (Health Councils)/IRMNCH&N Program
2.2.6	Renovation / refurbishment of existing Provincial and District Stores especially in terms of appropriately insulated & air-conditioned section	% of District Stores renovated /refurbished (per district)	0	36		9	9	9	9	MNCAH	Government of Punjab (Health Councils)/IRMNCH&N Program

	etc.										
2.2.7	Establishment of fully equipped Nutrition Stabilization Centers at Secondary Care facilities in Punjab	% of Nutrition Stabilization Centers established (from target)	42 SC's are fully functional, support for establishing remaining SCs will be required	36 Districts (42 NSCs)	*	*				Govt. Contribution + WHO/ RMNCAH&N Action Plan	IRM-NCH&N Program
2.2.8	Printing and Provision of Training Modules on Management of SAM Children with Medical Complications	% of Training Modules printed (from tarhet)	42 SC's are fully functional, support for establishing remaining SCs will be required	500 Sets	*	*				WHO/RMNCAH&N Action Plan	IRM-NCH&N Program
2.2.9	Training of Medical & Paramedical Staff on Management of SAM Children with complications (5 days)	% of staff Trained (by SC)	42 SCs	24 SCs*6 Staff members	*	*				WHO/RMNCAH&N Action Plan	IRM-NCH&N Program H

2.2.10	Establishment of fully equipped Newborn care Unit in all district Headquarter hospitals	% of districts where Newborn care Unit established (from target)	4 Trust Fund Districts (WHO provided trainings and equipment)	27						Govt. Contribution / WHO +UNICEF	Government of Punjab/ IRMNCH&N Program

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
2.3.1	Linkages with medical universities, medical colleges and district health system (Concept of Tele-Medicine: Spe-	% of pilot projects initiated with selected hospitals (from taget)	0 Districts	Pilot Project with 10 Hospitals involving Pediatricians,		*	*	*	*	RMNCAH&N Action Plan	Government of Punjab/IRMNCH&N Program

	cialsits to link up with Secondary Hospitals)			Neonatol-ogists, OB/GY Specialist							
2.3.2	Repair and renova-tion of ambulanc-es/program vehicles	% of ambu-lances re-paired/renov ated	41 Ambu-lances+ 1 vehicle per dis-trict + 6-10 provin-cial pro-gram ve-hicles	All vehicles (85) func-tional and operational		*				RMNCAH&N Action Plan	IRMNCH&N Program
2.3.3	Repair and renova-tion of LHS vehicle	% of vehicles repaired /renovated	?	1862		*				RMNCAH&N Action Plan	IRMNCH&N Program
2.3.4	Establish referral desks and data base at DHQ/THQ/RHCs	% of referral desks and data base established (as per target)	linked with re-ferral mecha-nism	1 for each HF till RHC (412)	36	121	230	330	412	RMNCAH&N Action Plan	IRMNCH&N Program
2.3.5	Provision of IT sup-port to establish referral desks and data base (referral coordinator)	% of HCF pro-vided IT sup-port for refer-ral desks and data base (as per target)	0	1 for each HF till RHC (412)	36	121	230	330	412	RMNCAH&N Action Plan	IRMNCH&N Program
2.3.6	Training of the HCPs on maternal and child health referral data recording and dissemination (one	% of HCPs trained (from target)	0	2 for each HF till RHC (824)	72	242	460	660	824	RMNCAH&N Action Plan	IRMNCH&N Program

	day)										
2.3.7	Referral/ transportation charges by voucher	% of districts implementing Referral/ transportation charges (as per target)	1	10 Districts		3	3	4		For Malnutrition, Government Contribution; similar model may be worked out for other referrals	Government of Punjab/IRMNCH &N Program
2.3.8	Piloting in 4 districts for provision of vouchers to the clients accessing SBA	Of districts piloting Voucher system	0	4 Districts		1	3			Revised Nutrition Stunting Reduction PC-1 for 11 Districts	Policy Decision Government of Punjab

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							

2.4.1	Integration of MNCH/LHW MIS with DHIS/Integrated Dash board	MNCH/LHW MIS Integrated with DHIS	Not in place	Integrated		*				Partners support/RMNCAH&N Action Plan	IRMNCH&N Program/ DHIS
2.4.2	Develop provincial, district and facility level M&E supervision plans, ToRs and reporting formats/Checklists	provincial, district and facility level M&E supervision plans, ToRs and reporting formats/Checklist developed	TORs & Plans not available	Agreed and approved TOR & Plans available in line with SA 3 of PC-1		*				Govt. Contribution, RMNCAH&N Action Plan	IRMNCH&N Program
2.4.3	e Monitoring at the level of LHSs	% of districts implementing e Monitoring	0	1800 (36 Districts)		6	10	20		RMNCAH&N Action Plan	IRMNCH&N Program
2.4.4	Capacity building of the M&E and supervisory tiers on M&E tools (2 days)	% of Supervisory staff trained on M&E Tools	0	60		60				RMNCAH&N Action Plan	IRMNCH&N Program
2.4.5	Review of the M&E feedback reports and recommendation to the DoH/Provincial Level for rectification	% of districts where recommendations given on M&E feedback reports are reviewed	Not in place	Institutionalized in all 36 Districts		*	*	*	*	RMNCAH&N Action Plan	IRMNCH&N Program

2.4.6	Coordination between development partners & NGOs for improved MNCH services and Involvement of private sector in MNCH services; regularized through Health Care Commission	% of coordination meetings held (per district)	0	Institutionalized in all 36 Districts	*	*	*	*	*	MNCAH	IRMNCH&N Program
2.4.7	Maternal and Neonatal Death Review Conferences Bi-annually	Biannual Maternal and Neonatal Death Review Conferences held	0	2/year at Provincial level		*	*	*	*	UNFPA supported till 31st July 2017	IRMNCH&N Program

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							

2.5.1	Inception work-shop for medical colleges and PH schools to review the PCPNC/ENC pre-service expe-rience in Punjab.	% of inception workshops con-ducted	Part of IMNCI	Complete-ly institu-tionalized	*	*				RMNCAH&N Action Plan	IRMNCH&N Program
2.6.2	In-depth orienta-tion/planning to strengthen the IMNCI/PCPNC/EN C teaching in all Medical Colleges & Public health schools	% of orientation & planning events conducted	0	5 Sessions	*	*				RMNCAH&N Action Plan	IRMNCH&N Program
2.5.2	Training of teach-ing staff on IMNCI/PCPNC/EN C and facilitators course	% of staff trained	58 pool of master trainers for PCPNC, 22 for IMNCI	5-10 facili-tators per insti-tute(300 App)		*	*	*	*	RMNCAH&N Action Plan	IRMNCH&N Program

Expected Outcome 2.6: Availability of comprehensive quality EPI services as part of RMNCAH/Nutrition services package at all PHC level facili-ties

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020		

2.6.1	Increase EPI Coverage to/above 80%	EPI Coverage increased to/above 80%	66% (as per PDHS 2012-13)	80%		*	*	*	*	Government Contribution	Provincial EPI Program
2.6.2	Provision of solar systems for facilities where ILRs provided (3500 PHC facilities)	% of solar systems provided to facilities (from Target)	0	3500 PHC facilities		500	1000	1000	1000	cMYP/EPI PC-1/RMNCAH&N Action Plan	Provincial EPI Program
2.6.3	Periodic review of EPI performance at various levels	% of Regular Quarterly reviews of EPI Pro-gram held by EPI managers and staff	District reviews are Part of regular departmental meetings	Regular Quarterly reviews of EPI Program involving EPI Managers and Staff	*	*	*	*	*	cMYP/EPI PC-1/RMNCAH&N Action Plan	Provincial EPI Program
2.6.4	Assessment of Involvement of LHWs in routine immunization (Managerial and Service Delivery)	% of districts where assessment carried out	Assessment in 18 districts is being supported by the WHO through GAVI funding	A repeat assessment is proposed after two years for all districts				*		cMYP/EPI PC-1/RMNCAH&N Action Plan	Provincial EPI Program
2.6.5	Availability of Vitamin A for the management of children re-	% of districts where Vitamin A provided	Not available		*	*	*	*	*	cMYP/EPI PC-1/RMNCAH&N Action Plan	Provincial EPI Program / Micronutrient Initiative

	ported with Measles										

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

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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
3.1.1	Pilot Social security regulation (Bait ul Maal, Social welfare department, Zakat department, BISP etc.) to develop linkage of benefits with utilization of primary and secondary healthcare on priority	social security regulations formulated and piloted	Not in place	The system developed and Piloted	*	*	*	*		Punjab Social Protection Agency / RMNCAH&N Action Plan	MSNC / Punjab Social Protection Agency / IRM-NCH&N Program

3.1.2	Conditional cash transfers on delivery by SBA, birth registration, vaccination completion, nutrition supplementation through LHWs and CMWs	% of districts where CCT being implemented	0	4 Districts (As above under outcome 2.3)		*	*	*		Punjab Social Protection Agency / RMNCAH&N Action Plan	MSNC / Punjab Social Protection Agency / IRM-NCH&N Program
3.1.3	Referral/ transportation charges by voucher	% of districts where Charging-by-voucher method being implemented	1	10 (As above under outcome 2.3)		*	*	*		MSNC / Punjab Social Protection Agency / IRMNCH&N Program	MSNC / Punjab Social Protection Agency / IRM-NCH&N Program

Expected Outcome 3.2: Provision of equity based health insurance coverage to the people

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
3.2.1	Health insurance company: Health insurance schemes for poorest	% of districts where MNCH and Nutrition related services included in health insurance program	4 districts (Under Health Insurance Program)	Inclusion of MNCH and Nutrition related services in Health In-	*	*	*	*	*	Government of Punjab Contribution	Punjab Health Insurance Management Company under SHC&ME

	groups for priority ill-nesses			surance Pro-gram							

Objective 4: Increase in funding and allocation for RMNCAH

Expected Outcome 4.1: Increased resource allocation and mobilization for RMNCAH and Nutrition Programs

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
4.1.1	Advocacy with the Political leadership and relevant Govt. dept.(Health, P&D Finance and) on RMNCAH and Nutri-tion Program ade-quate fund alloca-tion.	% of advocacy meetings con-ducted (from target)	No regular mechanism		*	*	*	*	*		Department of Health / IRM-NCH&N Pro-gram

4.1.2	Increased advocacy for mobilization of resources from federal government For salaries of LHWs, CMWs, vaccinators etc. (to increase coverage) For new trainings For logistics such as CDKs, NBKs, radiant warmers to improve BEmONC and CEmONC services)	% of Advocacy meetings conducted	No regular mechanism		*	*	*	*	*	RMNCAH&N Action Plan	Department of Health / IRM-NCH&N Program
4.1.3	Advocacy and fund mobilization through corporate sector (CSR) Mandatory percentage of health tax on items such as cigarettes, fast food, soft drinks, etc. – should be allocated directly to health Tax paid by pharmaceuticals should be allocated for health	% of advocacy meetings conducted with corporate sector (from target)	No regular mechanism		*	*	*	*	*	RMNCAH&N Action Plan	Department of Health / IRM-NCH&N Program
4.1.4	Advocacy with international partners and donors for redirecting their priority towards RMNCAH and Nutrition in the prov-	% of advocacy events conducted with international partners and donors (from	No regular mechanism		*	*	*	*	*	RMNCAH&N Action Plan	Department of Health / IRM-NCH&N Program

	ince in the light of RMNCAH/N 2016-2020 action plan.	target)									

Expected Outcome 4.2: Improve in mechanism and capacity of the province to absorb and utilize the available resources

S.No	Activities		Indicators		Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
4.2.1	Utilization of National Health Accounting exercises to monitor spending on MNCH and nutrition disaggregated by public and private sector	% of districts where Utilization of National Health Accounting exercises (to			*	*	*	*	*	RMNCAH&N Action Plan	Department of Health / P&D / IRM-NCH&N Program

		monitor spending on MNCH and nutrition) held									
4.2.2	Development of the biannual budgeted work plans for the RMNCAH/EPI/LHW/Nutrition Programs for timely implementation	biannual budgeted work plans developed			*	*	*	*	*	RMNCAH&N Action Plan	Government of Punjab / P&D
4.2.3	Capacity building of the DDOs and their Account Officers on efficient utilization of available funds, monitoring of resources and audits	% of DDOs and their Account Officers trained			*	*	*	*	*	RMNCAH&N Action Plan	Department of Health / P&D

Objective 5: Improve reproductive health including family planning

Expected Outcome 5.1: Enhanced equitable access, coverage to FP services through outreach services and scaling up of services reach

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							

5.1.1	Strengthening of Provincial steering committee comprising of Population Welfare Development and Health department for Coordination and development of synergies between population health and private sector	The role, ToRs and composition of the Provincial Steering Committee revised	PTCC	Strengthening role, Review ToRs and composition.	*	*	*	*	*	RMNCAH&N Action Plan	PTCC / FP Task Force
5.1.2	Integration of the FP and RMNCAH/N/MH, Improved coordination at District and Union council level. (support to monthly DTCs)	% of monthly DTC integrated reports generated (per district)	DTCs	Strengthening of DTC, Review ToRs, Integrated reporting system	*	*	*	*	*	Department of Health / PWD/ RMNCAH&N Action Plan	FP Task Force / DTCC

Expected Outcome 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

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							

5.2.1	Improving CPR through: Focus on RH education among adolescents, both boys and girls in a culturally sensitive manner	% of adolescents boys and girls given RH sessions	35%	55%	*	*	*	*	*	RMNCAH&N Action Plan	Department of Health / PWD / IRMNCH&N Program
5.2.2	Referral of 2 couples per LHW per month for long term contraceptives through Vouchers scheme	% of LHWs achieving target of 2 referrals per month	Not regular	2 couple/LHW/ Month	*	*	*	*	*	RMNCAH&N Action Plan	Department of Health / PWD / IRMNCH&N Program
5.2.3	Provision of logistics for FP supplies for RH and FP to all level integrated FP/RMNCAH PHC facilities and community health workers (LHWs/CMWs/FWW)	% of districts providing timely Commodities to targeted facilities and health workers	-	Timely supply of Commodities to all levels	*	*	*	*	*	Govt. Contribution	Department of Health / PWD / IRMNCH&N Program
5.2.4	Development of Post Partum Family Planning strategy	Post Partum Family Planning strategy approved	Not available	Approved PPFP Strategy available		*				RMNCAH&N Action Plan	Department of Health / PWD / IRMNCH&N Program

5.2.5	Capacity building of the HCPs on latest FP methods (implanons). (5 days)	% of SBAs trained on latest FP methods (per district)	Data Not available	100% facility based SBAs in all districts will be trained		6	10	10	10	Govt. Contribution / RMNCAH&N Action Plan	Department of Health / PWD / IRMNCH&N Program
5.2.6	Training of HCPs on PPIUCD (7 days)	% of HCPs trained on PPIUCD (from Target)	432	2400		1000	1000			Govt. Contribution / RMNCAH&N Action Plan	Department of Health / PWD / IRMNCH&N Program
5.2.7	Trainings/Refreshers of Facility Based and Community Health Workers on Healthy Timing and Spacing of Pregnancy (HTSP) (2 days)	% of SBAs, CMWS and LHWs trained on HTSP (per district)		100% facility based SBAs, & CMWS and LHWs in all 36 districts will be trained		6	10	10	10	RMNCAH&N Action Plan	Department of Health / PWD / IRMNCH&N Program

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

Expected Outcome 6.1: Reduction of Micro Malnutrition among Adolescent girls, Pregnant and Lactating Women (PLW)

S.No	Activities	Indicators	Target by year					Contribution	Responsibility
			2016	2017	2018	2019	2020		

		Description	Baseline	Target							
6.1.1	Provision of Iron and Folic Acid supplementation for Pregnant and Lactating Women and pre-conception care in Adolescent Girls	% of Adolescent Girls and PLWs provided with Folic Acid and Iron supplements			*	*	*	*	*	Government contribution	IRMNCH&N Program
6.1.2	Advocacy for food fortification	% of advocacy events held (per year)			*	*	*	*	*	Government contribution / Partners support	MSNC / Fortification Alliance / IRMNCH&N Program
6.1.3	Advocacy for bio fortification, food safety and control of mycotoxins	% of advocacy events held (per year)			*	*	*	*	*		MSNC / Fortification Alliance

Expected Outcome 6.2: Promotion of Good IYCF Practices (6-23 months)

S.No	Activities	Indicators	Target by year					Contribution	Responsibility
			2016	2017	2018	2019	2020		

		Description	Baseline	Target							
6.2.1	IYCF communication strategy followed by training of IYCF to all health care providers	% of HCPs trained on IYCF	Data Not available	54000	*	*	*	*	*		IRMNCH&N Program
6.2.2	Training of the District Master trainer on IYCF (5 days)	% of District Master trainers trained on IYCF	NA	108 (3 Master Trainers per District)?		18 Districts	18 Districts			Government Contribution / RMNCAH&N Action Plan	IRMNCH&N Program
6.2.3	Training of LHWs, CMWs on IYCF component at district level (5 days)	% of LHWs, CMWs trained on IYCF		77000		18 Districts	18 Districts			Government Contribution / RMNCAH&N Action Plan	IRMNCH&N Program
6.2.4	Training of Health Care Facility staff on IYCF component at district level (5 days)	% of Health Care Facility staff trained on IYCF	1166	5000		18 Districts	18 Districts			Government Contribution / RMNCAH&N Action Plan	IRMNCH&N Program
6.2.5	Training of LHS on IYCF and monitoring	% of LHSs trained on IYCF and monitoring	Data Not available	1800		1800				Government Contribution / RMNCAH&N Action Plan	IRMNCH&N Program
6.2.6	Training of Community Health Workers of NGOs (PPP Model) on IYCF (5 days)	% of Community Health Workers of NGOs trained on IYCF and monitoring	NA	10 Districts (Linked with PPP Model under ob-			(5 Districts *20 CHWs/Dis	(5 Districts *20 CHWs/Dis		Government Contribution / RMNCAH&N Action Plan	IRMNCH&N Program

				jective 1)			tricts)	tricts)			
6.2.7	Early initiation and promotion of Exclusive Breast feeding -Implementation of breast feeding act 2009 -Awareness campaigns, Global Breast Feeding Week	% of districts promoting Exclusive Breast feeding	16%	65%	*	*	*	*	*	Government Contribution / RMNCAH&N Action Plan	IRMNCH&N Program

Expected Outcome 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

S.No	Activities		Indicators		Target by year					Contribution	Responsibility
		Description	Baseline	Target	2016	2017	2018	2019	2020		
6.3.1	Establishment of Screening System for early identification of malnourished children, mothers and adolescent girls (weight machine, MUAC Tape for LHWs)	% of districts supplied with essential equipment & supplies	0%	Through out the Province		18 Districts	18 Districts			Government Contribution / Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program
6.3.2	Establishment of OTP centers in Selected locations across the province	% of OTP centers developed (per district)	589 (22 districts)	remaining 14 districts 30% of BHUs		7 Districts	7 Districts			Government Contribution / Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program
6.3.3	Provision of OTP supply and equipment	% of OTP centers developed (per district)	Baseline as above	36 Districts		*	*	*	*	Government Contribution / Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program
6.3.4	Training of staff facility Based Health Workers on CMAM (5 days)	% of facility Based Health Workers trained on CMAM	589 (22 districts)	remaining 14 districts 30% of BHUs		7 Districts	7 Districts			Government Contribution / Partner Support / RMNCAH&N	IRMNCH&N Program

										Action Plan	
6.3.5	Establishment of fully equipped Nutrition Stabilization Centers for management of Malnourished Children with Medical Complications at Secondary Care level throughout the province	% of fully equipped Nutrition Stabilization Centers established (from target)	18	41 (One per DHQ Plus additional identified locations)	5	10	8			Government Contribution / Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program
6.3.6	Training of staff dedicated for NSCs on Management of Malnourished Children with Medical Complications	% of Pediatrician, MO and staff nurses trained	Baseline provided by program (108) Pediatrician, MO and 4 staff nurses	246 Total (Old + New)	123	123				Government Contribution / Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program
6.3.7	Provision of equipment and supplies for NSCs: F-75, F-100, RUTF, RESOMAL,MMNS (Calcium, Vitamin D, Iron Folic Acid)	% of equipment and supplies for NSCs provided	Govt. Supplies + Partner Support		*	*	*	*	*	Government Contribution / Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program

6.3.8	Establishment of Regular reporting system of NSCs and mechanism for Data Analysis, feedback and use of data by District and Provincial Managers	Regular reporting system of NSCs and mechanism for Data Analysis, feedback established	Nutrition MIS is being developed	Available & Integrated	*	*	*	*	*	Government Contribution	IRMNCH&N Program
6.3.9	Ensure Provision of Zinc Supplement to the Children in the management of Diarrhea through PHC & SHC HCFs and Community Health Workers	% of children receiving zinc supplements	-	Ensured availability of Zinc Plus ORS to the Children		*	*	*	*	Government Contribution / Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program

Objective 7: Investing in addressing social determinants of health

Expected Outcome 7.1: Multi-sectorial approach adopted (health, education, public health engineering, social welfare, women welfare departments, NGOs and civil society) in addressing the social determinants of poor RMNCAH, nutrition, mental health issues in women and adolescent girls at district level

S.No	Activities	Indicators	Target by year					Contribution	Responsibility
			2016	2017	2018	2019	2020		

		Description	Baseline	Target							
7.1.1	Involvement of parliamentarians, politicians/ religious leaders, human rights, teachers and other civil society through seminars/ official meetings to link their slogans and campaigns to RMNCAH/Nutrition/ Mental Health issues in women, adolescent girls and children along social determinants like female literacy and economic empowerment at district and provincial level	% of seminars and meetings held			*	*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program
7.1.2	Establishment/Strengthening of Health/education Promotion cell at Provincial Health Directorate having functional linkages with District Health Offices and other stakeholders	Health education Promotion cell established			*	*				Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program
7.1.3	Regular Health Promotion and disease prevention programs	Health Promotion and disease prevention programs conducted (as per plan)	Need based when situation/demand arise	Institutionalized Health Promotion and Disease	*	*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program

				Prevention Programs							
7.1.4	Increase coordination with Social Welfare, Education, Public Health Engineering departments, livestock departments on health and hygiene (WASH, vector borne and disease surveillance, vaccination and reproductive health) issues at the district level	% of coordination meetings held			*	*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program
7.1.5	Integration with Diseases Surveillance System and PHED for water borne disease prevention				*					Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program
7.1.6	Multi sectoral response involving TMAs, HUD & PHED, Education department, Social Welfare Department for improvement in literacy, women empowerment	% of Multi-sectorial coordination meetings held			*	*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program

7.1.7	Revise and update health education modules (including IPC) for HCPs and community on comprehensive messages on RMNCAH/Nutrition and social determinants like female literacy and women empowerment.	Revised and updated health education modules developed			*	*				Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program
7.1.8	Evidence generation for social determinants of health and health equity; including equity focused research	Research publication on social determinants of health and health equity recieved			*	*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / IRM-NCH&N Program

Expected Outcome 7.2: Legislation done supporting mandatory female education and abandon early age marriages

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
7.2.1	Advocacy for legislation in provincial assembly for mandatory female child en-	Legislation floored in provincial assembly for mandatory female child enrollment in schools.		-	*					Government Contribution / RMNCAH&N Action Plan	Government of Punjab / MSNC / Punjab Health Department

	rollment in schools.										
7.2.2	Advocacy for (implementation and execution) legislation for ban on early age girl marriages (before 18 years) and notifying it as crime and punishable act by law	Legislation floored in provincial assembly for ban on early age girl marriages.		-	*					Government Contribution / RMNCAH&N Action Plan	Government of Punjab / MSNC / Punjab Health Department
7.2.3	Advocacy and Laws for mandatory enrollment of each and every birth (birth registration)	Legislation floored in provincial assembly for mandatory enrollment of each and every birth		-	*	*				Government Contribution / RMNCAH&N Action Plan	Government of Punjab / MSNC / Punjab Health Department
7.2.4	Advocacy and Law for mandatory registration of marriage	Legislation floored in provincial assembly for mandatory registration of marriage		-	*	*	*			Government Contribution / RMNCAH&N Action Plan	Government of Punjab / MSNC / Punjab Health Department

Objective 8: Measurement and action at district level

Expected Outcome 8.1: Strengthened HIS through integration and broaden its scope to comprehensively cover the RMNCAH and Nutrition indicators

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
8.1.1	Consultative meetings involving all stakeholders for developing and strengthening of Integrated Health Information System in the Province	% of Consultative meetings involving all stakeholders held	no-existent integrated system	Periodic Advocacy Meetings conducted	*	*				WHO / Government Contribution / RMNCAH&N Action Plan	Department of Health / MIS Program
8.1.2	Context Analysis and review of existing Health Information Systems including Vertical Program's MIS through a consultative process	% of Consultative meetings involving all stakeholders held	Already started with support of WHO in collaboration with PSPU and TRF+	Context Analysis Report/Recommendations available (2015)	*					WHO / Government Contribution / RMNCAH&N Action Plan	Department of Health / MIS Program
8.1.3	Establishment and operationalize Provincial Core committee and Technical Working Group to review and adoption of recommendations of Context Analysis	% of Provincial Core committee and Technical Working Group meetings held (From MNCH Plan)	Provincial Core Committee notified	TWG established and Quarterly session convened	*					Government Contribution /RMNCAH&N Action Plan	Department of Health / MIS Program

8.1.4	Establishment/strengthening of One Single Online Dashboard of Health Information System in the province	Online Dashboard of Health Information System established	Proposed PHIS conceptual dashboard available	Functional Integrated PHIS established		*				Partners support/RMNCAH &N Action Plan	Department of Health / MIS Program
8.1.5	Review and revisit the primary data collection tools and entry protocols to align with the integrated MIS tools	Integrated MIS tools developed	fragmented reporting tools of respective programs	Integrated MIS Tools established		*				Partners support/RMNCAH &N Action Plan	Department of Health / MIS Program
8.1.6	Strengthening of LMIS					*				Partners support/RMNCAH &N Action Plan	Department of Health / MIS Program
8.1.7	Establishment of integrated DHIS cells at District level	% of integrated DHIS cells established	Parallel MIS in place at district level for each program	District integrated MIS Cell established in 36 Districts		*	*			Partners support/RMNCAH &N Action Plan	Department of Health / MIS Program
8.1.8	Integrated monitoring framework for IRMNCH & Nutrition Program	Integrated Monitoring System implemented	Each component of program has its independent monitors	Integrated Monitoring System in Place in 36 Districts		*	*			Partners support/RMNCAH &N Action Plan	Department of Health / MIS Program

Expected Outcome 8.2: Improved data quality (reporting timeliness and completeness and 2 way feedback mechanism

S.No	Activities	Indicators			Target by year				Contribution		Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
8.2.1	Placement of designated and trained district focal person for DHIS (IRMNCH & N - MIS)	% of designated and trained district focal persons placed	No Designated DHIS focal Person (DPIU Computer Operators)	36		36				Govt. Contribution	IRMNCH&N Program, DHIS Program
8.2.2	Training of Provincial Coordinators, DHIS focal persons, and DEO at Provincial and District levels on the revised integrated MIS tools (3 days)	% of Provincial Coordinators, DHIS focal persons, and DEO trained	0	36		36 Districts staff + Provincial Focal Points				Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program, DHIS Program
8.2.3	Strengthen of Provincial and Districts DHIS cells for generation and dissemination of monthly progress bulletins to appropriate level	Provincial and Districts DHIS cells strengthened	No system in place	36		*	*	*	*	Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program, DHIS Program

8.2.4	Capacity building of the facility based and community based health workers on data recording on integrated MIS tools (2 day)	% of facility based and community based health workers trained		75000		15000	20000	20000	20000	Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program, DHIS Program

Expected Outcome 8.3: improved investigation and response mechanism (MNDSR) at district and provincial level

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							
8.3.1	Notify maternal, newborn and child mortalities and morbidities as essentially notifiable events through DHO office, and eligi-	% of districts implementing Maternal and Infant/Neonatal Death Audit Mechanism	Not in Place	System establishment through enforcement of notification	*					Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program, DHIS Program

	ble for MNDSR at district levels (Introduction of Maternal and Infant/Neonatal Death Audit Mechanism in the Province)										
8.3.2	Constitute and support (logistics) the district health response teams to respond any outbreak/ high maternal, neonatal and child mortality investigation indicated in DHIS/alerts through DHO Office	% of districts with functional DHRTs	Not in Place	System establish and in Place		*	*	*	*	Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program, DHIS Program
8.3.3	Support to Neonatal and Maternal Death Review Committees in the districts (District and Facility)	% of district holding regular NMDR Committee meetings	NMDR Review committees notified in districts	Regular Review meetings		*	*	*	*	Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program, DHIS Program

Expected outcome 8.4: formulation of evidence based policies

S.No	Activities	Indicators	Target by year					Contribution	Responsibility
			2016	2017	2018	2019	2020		

			Baseline	Target							
8.4.1	Generate and share the monthly reports, quarterly reports and annual bulletins of DHIS with all the districts managers, vertical programs, health response team (Partners and all stakeholders) and policy making circles for evidence based planning	% of districts with regular reporting of DHIS	Only Quarterly Reports	Monthly, Quarterly and Annual Consolidated Bulletins	*	*	*	*	*	Partner Support / RMNCAH&N Action Plan	IRMNCH&N Program, DHIS Program

Objective 9: National Accountability and oversight

Expected Outcome 9.1: effective oversight mechanism of the RMNCAH/N program in place

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							

9.1.1	Multi-tiered monitoring and evaluation system linked to accountability forums at all levels; district, province, country -KPIs for each cadre of staff	% of districts with functional accountability forums with KPIs	Fragmented	Institutionalized System in place			*			Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health
9.1.2	Development of Accountability framework for all tiers	Accountability framework for all tiers developed	NA	Established			*			Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health
9.1.3	Development of Mechanisms for monitoring and evaluation reports to accountability frameworks in place at all levels in DoH	Mechanisms for monitoring and evaluation reports to accountability frameworks formulated	NA	Established and Functional			*			Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health

Expected Outcome 9.2: effective accountability framework in place

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
		Description	Baseline	Target							

9.2.1	Institutionalization and re-enforcement of KPIs to improve governance & accountability mechanism at provincial, district and HF levels	% of quality assurance tools (KPIs) developed and implemented at provincial, district and HCF levels	NA	Established			*	*		Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health
9.2.2	Implementation of CoIA framework for Women and Child Health	CoIA framework for Women and Child Health established	NA	Established and Functional			*	*		Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health

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

Expected Outcome 10.1: increased political will and support for RMNCAH and nutrition from political leadership at all levels

S.No	Activities	Indicators			Target by year					Contribution	Responsibility
					2016	2017	2018	2019	2020		
			Baseline	Target							
10.1.1	Early marriages act approval and implementation	Early marriages act Approved and implemented	Approved	Implemented		*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health

10.1.2	Breast feeding act approval and implementation	Breast feeding act Approved and implemented	Approved	Implemented		*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health
10.1.3	Advocacy and orientation of the politicians, members of standing committees on health and population issues and policy makers through short in-session briefings on health programs (RMNCAH/Nutrition /EPI)	% of Advocacy events conducted	NA	Regular Feature		*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health
10.1.4	Advocacy for creation of support group for health among parliamentarian	% of Advocacy events conducted	NA	Support Group Identified and involved		*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health
10.1.5	Observational inter-provincial visits for parliamentarians on health systems	% visits conducted	NA	Documented exchange visits		*	*	*	*	Government Contribution / RMNCAH&N Action Plan	MSNC / Department of Health