NATIONAL VISION 2016-2025

for Coordinated Priority Actions

to Address Challenges of Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition

Ministry of
National Health Services
Regulations & Coordination
Government of Pakistan

NATIONAL VISION 2016-2025

for Coordinated Priority Actions

to Address Challenges of Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition

Contents

Foreword

Pakistan is the sixth most populous country of the world and 64% of its population lives in rural areas. Every year approximately 476,000 children under five years of age die of preventable causes, and 14000 women die from preventable complications related to pregnancy and childbirth. These unacceptable deaths can and must be avoided by ensuring that all women and children get the prevention, treatment and care they need. They must have access to family planning services, vaccines, and proper nutrition, as well as prevention of and treatment for pneumonia, diarrhea.

This government gives high priority to RMNCAH and envisages that Mother and child safety through proper immunization and better nutrition should be a major priority while planning healthcare interventions. The international best practices should also be replicated in Pakistan to achieve better results. Significantly, improving and sustaining women's and children's access to an affordable package of life-saving health interventions will require a strengthened health system with sufficient skilled health workers. All the partners involved in health sector need to integrate, and link their work plan to the priorities of the government. Their work also needs to be backed up by a concerted effort to promote human rights, gender equality and poverty reduction.

This National Vision Action Plan developed on directions of the Prime Minister with ten priority areas, is a dynamic document, leading to a mechanism for national consensus on important issues around RMNCAH and Nutrition in the times to come, and is in line with global commitments for reproductive, maternal, newborn, child, and adolescent health. All provinces, regions, partners, line ministries, academics and international experts have contributed and endorsed it in order to take the process forward.

I am confident that working together we can make a real difference. I take this as a sacred duty and a mission and call upon all stakeholders to work with a missionary zeal as it is about saving lives and preserving health of an important segment of our society.

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

Acronyms & Abbreviations

ANC	Ante Natal Care
CCT	Conditional Cash Transfer
CMW	Community Midwife
cMYPs	Comprehensive Multiyear Work Plans
CSOs	Civil Society Organization
DHIS	District Health Information System
EPI	Expanded Programme for Immunization
FP	Family Planning
GDP	Gross Domestic Product
LHW	Lady Health Worker
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
NATPOW	National Trust for Population Welfare
NHA	National Health Accounting
NIPS	National Institute for Population Studies
NRIFC	National Research institute of Fertility Care
PC1	Planning Commission 1
PDHS	Pakistan Demographic Health Survey
PHC	Primary Health Care
RMNCAH	Reproductive, Maternal, New born, Child and Adolescent Health
UNICEF	United Nations Children's Fund

Introduction

Pakistan is the sixth most populous country (185 million) of the world and 64% of its population lives in rural areas. There has been rapid population growth since it came into existence and given current rate of population growth, Pakistan will be the fifth most populous country globally by 2050. Currently, Pakistan is experiencing 32% of adolescents, between 10-24 years which is a biggest cohort in the history. It is a rare demographic opportunity that can be converted into dividend if tapped wisely with concrete social and economic investments in the lives of adolescents.

Pakistan's maternal mortality ratio (MMR), which indicates risk of death per pregnancy, has declined from 521 in 1990 to 332 (range 250–433) in 2012, still far behind the proposed target of 130 by 2015. **An estimated 14000 Pakistani women die every year of pregnancy-related causes. There are also wide variations between provinces, MMR being lowest in Punjab (227) and highest in Baluchistan (785 deaths/100,000 live births). One of the main reason of this High MMR is very low utilization of Family Planning services with current CPR of 35%.**

According to Pakistan demographic Health Survey 2012-2013, Eight percent of adolescent women age 15-19 are already mothers or pregnant with their first child and 35% percent of women age 25-49 were married by age 18. Early pregnancy causes increase in morbidity and mortality in this age bracket. The most common reason of early pregnancy is early/forced/child marriages in Pakistan and it has a correlation with poverty, ilteracy and lack of understanding on sexual and reproductive health matters. Use of any contraception is 10% among married age 15-19 years and only 6.9% use of any modern method. That shows low utilization due to various reasons. Pakistan currently ranks 26th in the world for under-5 child mortality rates. Although Pakistan has reduced its under-5 mortality from 141 in 1990 to 89 in 2012,

64%
of Pakistan's population lives in rural areas.

Pakistan is experiencing
32%
of adolescents, between 10-24 years which is a biggest cohort in the history.

14000
Pakistani women die every year of pregnancy-related causes.

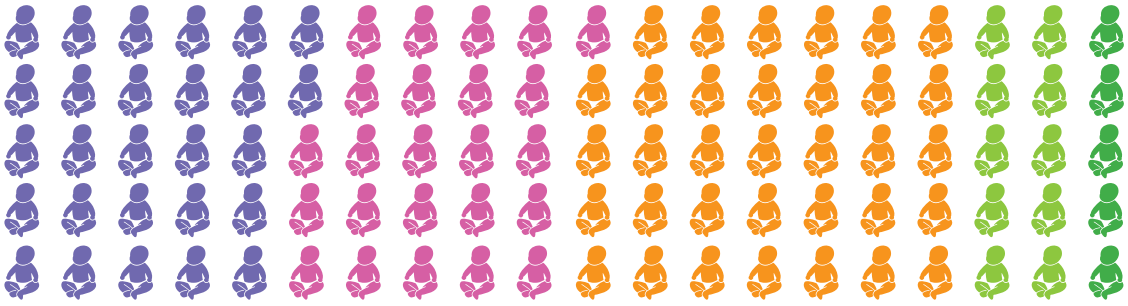
this is much slower than the MDG4 goal of reducing it to 46 by 2015. Newborn deaths are still a major contributor to under five mortality with around half of under-5 deaths occurring in the first month of life (202,000/year); prematurity (27%), birth asphyxia (24%), sepsis (34%), and congenital anomalies (10%) are the major causes, aggravated by low birth weight.

According to PDHS 2006–7 data on child mortality, the leading causes of death during the post-neonatal period are diarrhea (27%) and pneumonia (26%). Deaths from both pneumonia and diarrhoea are closely associated with overlapping risk factors such as those related to poverty, under-nutrition, poor hygiene, sanitation and deprived home environments, making children more prone to the above diseases. **Evidence based cost effective, proven interventions exist to prevent and treat each main cause. Improving quality of care around the time of birth will save most lives, but this requires educated and equipped health work force, including those with midwifery skills, and availability of essential commodities.**

Stillbirths (baby born with no signs of life at or after 28 weeks' gestation-WHO) are one of the most common adverse outcomes of pregnancy. Out of 3.3 million stillbirths worldwide, 97% are occurring in developing countries. South Asia has the world's largest numerical stillbirth burden and reported stillbirth rates. In Pakistan, it varies from 36 per 1000 to 70 or more per 1000 in some rural areas. Stillbirths, newborn survival and health are intrinsically linked with the survival, health and nutrition of women before conception as well as during and between pregnancies. Newborn health and stillbirths are part of the "unfinished agenda" of the

The leading causes of death during the post-neonatal period are diarrhea **27%** & pneumonia **26%.**

In Pakistan, stillbirths varies from **36-70** or **MORE** per 1000 in some rural areas.



27% Prematurity

24% Asphyxia

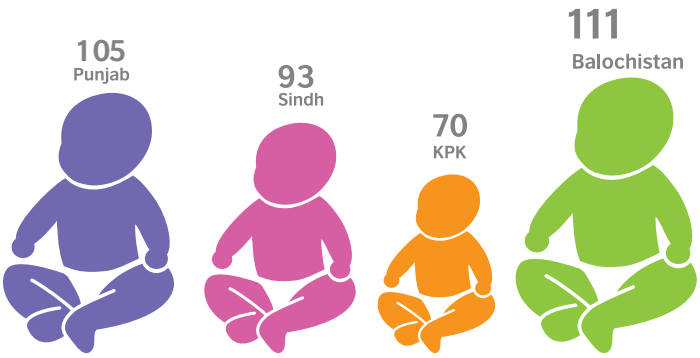
34% Sepsis

10% Congenital Anomalies

Major contributor to under five mortality

1 Projected population estimates, Pakistan Bureau of Statistics, 2014

2 Pakistan Demoghraphic Health Survey, 2012-2013

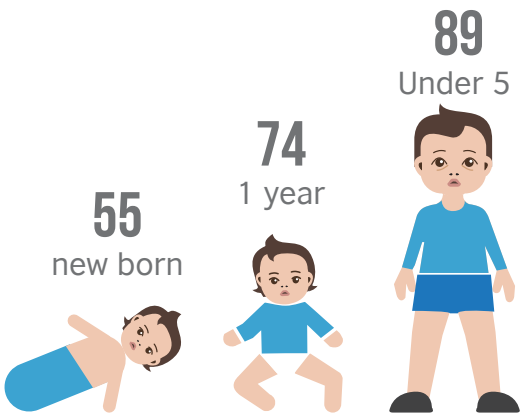


Child Mortality comparison in Provinces

MDGs and require greater visibility in the emerging "post-2015 sustainable development agenda" if the overall under-5 mortality is to be reduced.

The role of social determinants in affecting maternal and child health in Pakistan cannot be underestimated. This is strongly influenced by socio-economic characteristics including place of residence, maternal education and household wealth index. In Pakistan, there are wide disparities, and mortality rates in urban areas are consistently lower than in rural areas. Among the poorest quintiles, under-5 mortality is 2.5 times higher (119/1000 live births) than in the richest (48/1000 live births). There is also disparity amongst provinces: the under-5 mortality rate in Baluchistan is 111 and 70 in Khyber Pakhtunkhwa.

Under-5 mortality in children born to mothers with no education (112/1000 live births) is two times higher than that of children born to mothers with secondary education (57/1000 live births) and more than three times higher than that of mothers with more than a secondary education (36/1000 live births). Maternal demographics also play an important role in child survival:



Child Mortality National comparison

adolescent mothers are inexperienced in child-care and their children therefore are at greater risk of mortality. Birth spacing and size/weight of an infant at birth are also important determinants of child mortality. An increase in the birth interval from 2 to 4 years or more results in better neonatal and child survival by 2.4 times in neonates to 2.9 times in children under 5 years.

An estimated 21% of the population still lives below the poverty line. The poverty

gap ratio (which indicates the average degree of poverty according to distance below the poverty line), has decreased from 23% in 1991 to 4% in 2008. A major measure of this underlying issue is widespread malnutrition with wide disparities between provinces and districts in rates of stunting and wasting among children as well as women of reproductive age who have a body mass index below 18.5. Poor nutritional practices among adolescent mothers, pregnant women, and their children, coupled with the persistently low breast-feeding rates (37%) prevailing in most provinces, are major contributing factors to the overall under-nutrition in Pakistan. Regular house hold surveys and limited research has been carried out in the country to get the baseline and key indicators on maternal, newborn, child, adolescent and nutrition which have helped track the progress made in this context but still MMR estimation needs to be carried out on regular basis to plan for future strategies. Moreover more extensive research needs to be carried out in this very crucial area, which apart from building knowledge, will generate evidence in RMNCAH area for further strengthen the health programs and health care delivery systems in public as well as in private sector with ultimate objective of improving MDG 4 & 5.

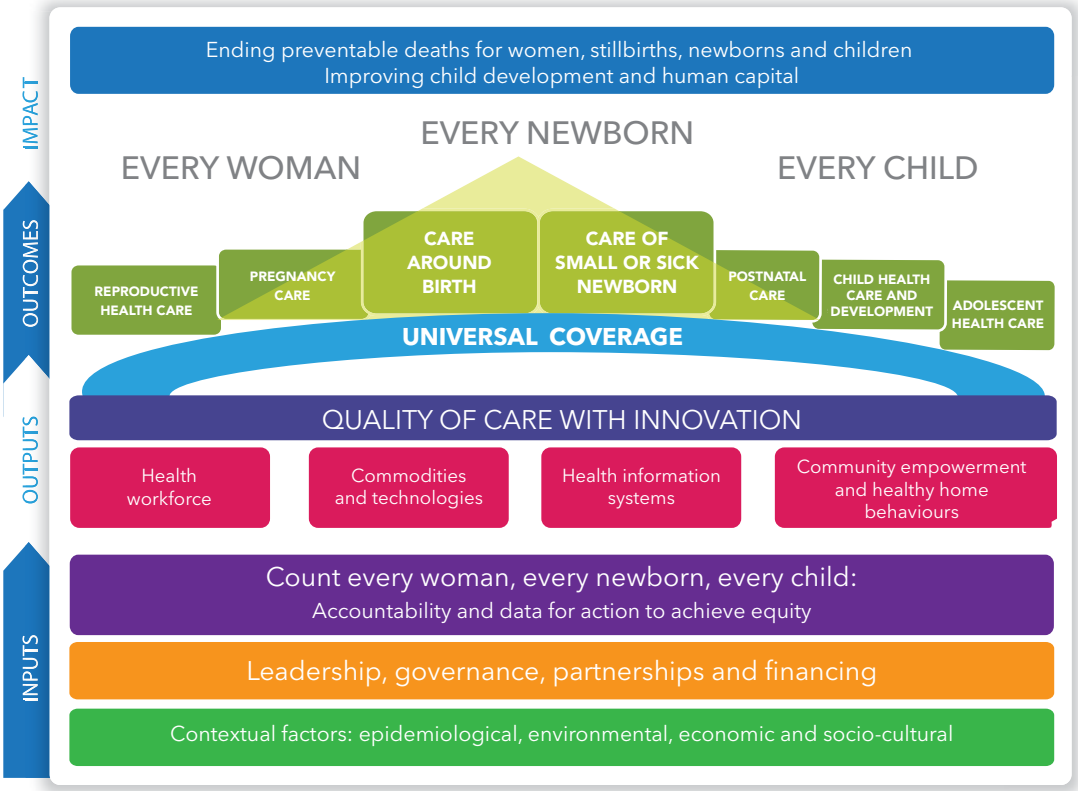
An increase in the birth interval from 2 to 4 years or more results in better neonatal and child survival

by **2.4 TIMES** in neonates

to **2.9 TIMES** in children under 5 years.

Sustainable Development Goals

Every Newborn impact framework



The Commitment

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 on slow progress in R-MNCAH 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 international best practices should be replicated in Pakistan to achieve better results.

Subsequently a consultative process was initiated between all stakeholders to identify priority areas and identify clear strategic directions for R-MNCAH and Nutrition for the next ten years with tangible results/outcomes and a mechanism for oversight in order to ensure priority and visibility for the cause of mothers and children of the country. This document is in line with Pakistan Vision 2025 which was endorsed by all CM of provinces and special areas. The Vision will be realized through strategies and programmes defined in associated five-year and annual plans. A renewed commitment to the founding vision is needed, both to address the current targets for the future—

including ensuring that Pakistan succeeds in achieving the proposed Sustainable Development Goals (SDGs) of zero poverty and hunger, universal access to health services, education, clean water and sanitation, and join the league of Upper Middle Income countries by 2025.

Pakistan's population is projected to increase to over 227 million by 2025. The population will also comprise a much larger proportion of younger people (63% below the age of 30). These demographic projections raise a number of issues for the country which would require appropriate measures in context of their health and wellbeing. The RMNCAH vision document is in line with pillar 1 of vision 2025 document, (developing social and human capital and empowering women) which refer to commitment of Government of Pakistan to MDG (MDG1), access to health and education services (MDGs 2, 4, 5, and 6), and gender empowerment (MDG 3).and SDG goals and targets SDGs 1 (poverty), 3 (health) 4 (education), and 5 (gender) in order to achieve quality health care for all citizen of the country.

TOGETHER WE MUST;

Strengthen and invest in care during pregnancy, labor, birth, first day, week, year of life along continuum of care approach.

Improve quality of maternal, newborn child and adolescent care.

Reach every mother, newborn and child to reduce in equities.

Harness the power of parents, families and communities

Count every mother, newborn child and adolescent through measurement, programme tracking and accountability

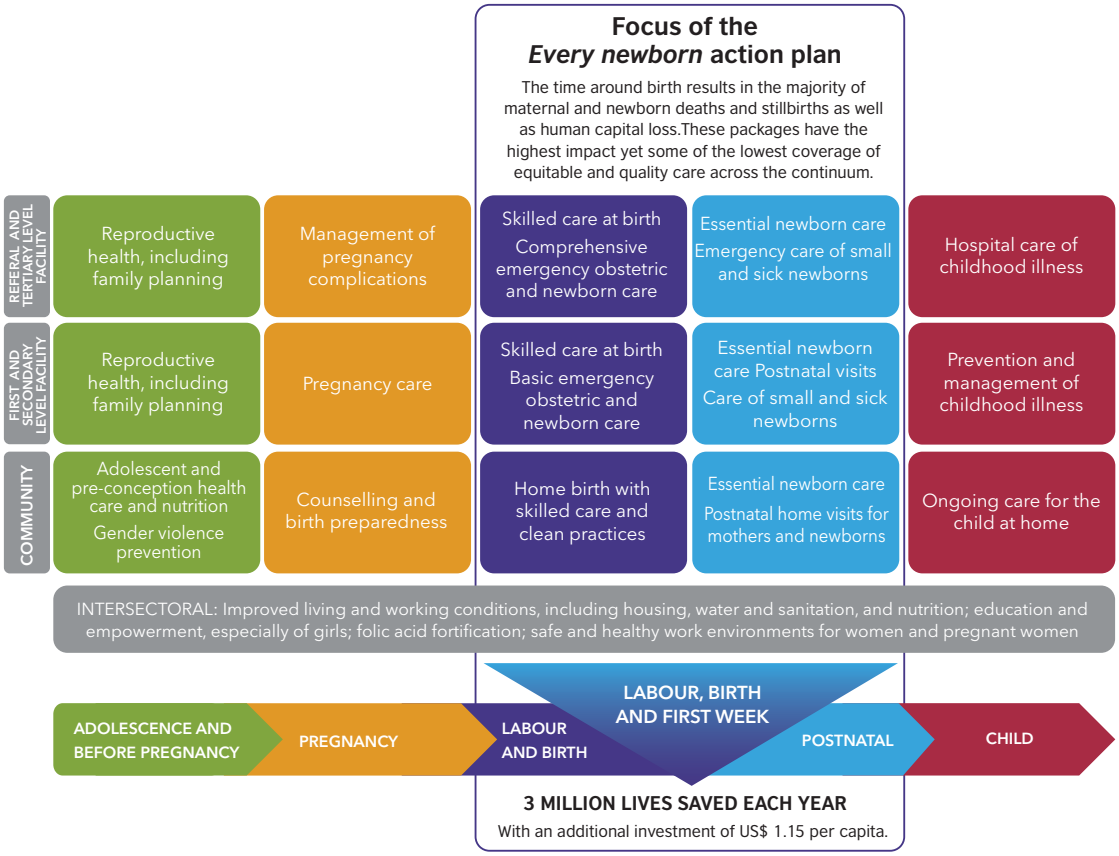
ACCELERATING PROGRESS ON MDG 4 & 5 FOR BUILDING NEW MOMENTUM BEYOND 2015

Government of Pakistan remains committed to support the efforts being undertaken to accelerate improvement in new-born, child and maternal survival, specially focusing on reducing morbidity and mortality linked to common preventable causes.

This goal can be achieved through following ten priority actions:

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 addressing social determinants of health
7. Measurement and action at district level
8. National Accountability and Oversight
9. Generation of the political will to support MNCH as a key priority within the Sustainable Development Goals
10. Generation of the political will to support RMNCAH as a key priority within the Sustainable Development Goals

Packages in the continuum of care



Ten Point Priority Agenda

Urgent action is needed to improve the state of R-MNCAH and nutrition through concerted, direct efforts, rather than wait for economic growth or poverty alleviation alone as the main vehicles for change.

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

Primary care services in rural areas of Pakistan are critically dependent upon the LHWs program and the relatively recent initiative to produce more community midwives. The most recent formal evaluation of the LHW program and a number of informal reports post- devolution have identified several areas of weakness and opportunities for further enhancement of their knowledge and skills specially around standard best practices for maternal, newborn and child survival.

Effective coverage has now become a serious issue given that there are managerial inefficiencies and **between 30-50% of the population in several rural districts, especially the poorest and most remote areas, are without LHW cover.** Similarly the community midwifery program was launched, yet it is still unclear exactly how this has led to their retention and utility in these areas, especially given that they are expected to improve coverage of skilled attendants in these very areas. The quality of services offered by the LHWs and CMWs needs a review and constant monitoring to ensure the trust of clients in these cadres.

There are a number of urgent actions needed to stall the downslide of these national programs. These include:

- An external review of the LHW/MNCH program to evaluate performance and its scope of work in the new settings in order to steer future direction in the post devolution scenario and ensure adequate funding.
- Development of a national strategic vision for LHW/CMW with a renewed focus within these programs for the promotion of evidence based international best practices for maternal newborn care and investing in adolescent health. These include a review of their curriculum and TORs to align more closely with priorities for MNCH, Family Planning& nutrition. This may necessitate elimination of unnecessary activities and appropriate time management.

- Measures for employment, re- recruitment, and retention of LHWs/ CMWs need to be addressed, with appropriate regulatory mechanisms in place.
- Innovative solutions are also needed for areas uncovered by LHWs due to shortage of appropriately qualified and trained young women, including combining an education and training program for young women willing to take on the roles of CHWs, as already piloted in some areas.
- Covering urban slums in larger cities with community volunteer health workers who can be trained in prevention and promotion strategies.
- Utilization of the above cadres for routine immunization through the Reach Every District/Reach Every Community approach, family planning, and nutrition promotion activities to strengthen the outreach arm of health system.
- The limited application of essential newborn care interventions at community level entails review of the Essential Newborn Action Plan with inclusion of Helping Baby Survive technique, identification and modeling of appropriate community- based interventions prior to scale- upTo reduce the burden of still births, especially amongst poorest quintile, the packages of care with greatest impact on ending preventable stillbirths and neonatal deaths include: care before conception, during labor, around birth. The low-cost antenatal care that are effective against the stillbirths relat to infection and malnutrition which could be provided through outreach workers and services.
- To provide extra training and education to community workers to support pregnant women during pregnancy for positive outcomes and thereby preventing still births and neonatal deaths
- Use of appropriate e technologies for monitoring the service delivery at all tiers in remote areas has shown good results and ways to upscale the successful pilots are needed.
- Filling of vacant posts on special pay package at far flung and hard to reach areas.
- Engagement and regulation of CSOs and private sector for involvement in community based MNCH PHC services
- Ensuring provision of essential commodities
- Research to identify gaps in existing community based health programs and coming up with recommendation to strengthen them based on evidence

2. Improved quality of care in district facilities including rural health centers and district hospitals.

This is a key barrier towards the promotion of care seeking in public sector facilities and is dependent upon a range of issues including human resources, infrastructure, essential supplies, medicine, medical technologies, transportation and communication. Poor quality of care (both antenatal and obstetric care), maltreatment or socio cultural insensitivity, absence of a trained attendant at delivery, inadequate referral systems for emergency obstetric care, inadequate or absent transportation facilities, are all key barriers. At district level absence of effective linkages of health centers and management with communities are key barriers to quality improvement and utilization of health facilities, and could in turn be linked with provincial health commissions. Facility based services should be available for mothers, newborns children and adolescents across the continuum of care, from pre-conception through childbirth and postpartum period, through childhood to adolescence, and over the various tiers of service provision.

There is need for targeted supply side actions addressing the quality control of

health facilities:

- Administrative and legal steps to develop linkages between medical colleges / universities with district health systems can act as a game changer.
- Involvement of private and not-for- profit sectors in the provision of RMNCAH and nutrition services with appropriate regulation. Provincial and regional health commissions can play their due part in this area.
- Human resources especially female medical officers, lady health visitors at rural health facilities, need to be staffed with competent cadres capable of delivering quality maternal and newborn care at first contact with formal health services and regular on job training;
- Capacity building for monitoring of quality of services at district and provincial level including maternal, newborn, and child death audits, with adequate focus on civic registration and vital statistics.
- Mechanism to ensure adherence to standard service delivery protocols/ guidelines for RMNCAH should be developed and put in place at all levels to ensure quality of care.
- Expanding service access (24/7) and supporting facility infrastructure; developing referral pathways and linkages
- To prevent stillbirths the interventions at PHC levels included provision of basic emergency obstetric care, facility- based support, use of insecticide-treated bed-nets to prevent malaria and use of folic acid supplementation and management of diabetes in pregnancy.
- Moreover voucher schemes or 10 conditional-cash transfers could be used to encourage births at health facilities
- Provision of adolescent friendly sexual and reproductive health services at the primary health care level for improved health seeking behavior and making informed choices about their wellbeing.
- Strengthening DHIS and M&E component at district level for quality data , reporting and ensuring use of information for decision making.
- Revision of medical and nursing curricula of undergraduate to understand new advances in medical science
- Accountability: count every newborn by institutionalizing civil registration and vital statistics maternal, perinatal and neonatal death surveillance and response.

3. Overcoming financial barriers to care seeking and uptake of interventions

The relationship of poverty with health outcomes is pervasive and a major focus of action must aim at reducing inequities in care. Not only are most deaths clustered among the poorest quintiles, but available evidence suggests that there is much potential for gain by improving quality of care within health systems. These marginalized populations are difficult to ascertain on mere geographic or ethnic grounds. Targeted financial innovations to facilitate RMNCAH, such as cash transfers for promoting skilled care at birth or purchase of health services and nutrition commodities for care, have the potential of overcoming financial barriers of available options, a mixed model of interventions can be proposed.

- Targeted Conditional cash transfers (CCTs); provide direct cash payments to poor households contingent on certain behaviors:
  - i. Routine vaccinations
  - ii. Nutrition supplements
  - iii. Care seeking for high impact high mortality conditions (diarrheal diseases, pneumonias, ANC visits for pregnant women, family planning, delivery and post-partum care).
  - iv. Evidence suggests that all interventions if coupled with health education sessions especially delivered within women's and adolescent groups can have multiplicative benefits. These activities can be ideally conducted or supported by LHWs and community midwives.

- Health Insurance schemes for the identified poorest and marginalized groups for priority illnesses which lead to catastrophic illnesses, funded by government; Third party purchaser contracts with providers on behalf of insured population and reimburses based on outputs.
- Universal health care (UHC) for outreach, primary and secondary care; Government provides subsidies to public providers for staff and supplies. Given the emphasis on UHC in the sustainable development goals, this should be prioritized for consideration and further development.
- Demand side financing especially for provision of family planning services in remote areas with low CPR.

4. Increased Funding and allocation for RMNCAH:

The federal government and all provinces of Pakistan need to substantially increase funding for RMNCAH and to create the ground swell for political support for such measures. Pakistan's current health spending is a mere 0.6% of the GDP. It is critical that investments in health and education and other social determinants increase substantially over the next few years. Civil society needs to be mobilized to play its due role through lobbying for increased public spending on MNCH and nutrition.

Although health has been devolved to the provinces as a principal responsibility, inflation has eroded corresponding increase in resources and support of primary care programs. Much of the existing expenditure within the health sector is also limited to tertiary hospitals and although primary care is supported through the LHW program, there has been limited investment is strengthening district level health services, especially the Rural Health Centers and Basic Health Units. This must change from the current reliance on external assistance for these sectors to much more sustained and enhanced national and provincial funding for such efforts. Pakistan must target phased increase in RMNCAH and nutrition investments over the next decade:

- National Health Accounting (NHA) exercises should be conducted at regular intervals at national, provincial and district level with the power to disaggregate and monitor R-MNCAH and nutrition spending in public and private sectors and across the different service delivery tiers. Results should be analyzed to base policies and strategies
- A realistic and robust plan for phased increase in health spending at PHC level (RMNCAH & Nutrition) for the next 5 years to be prepared jointly by federal and provincial government along with line ministries, based on equity and contextual needs. Including building upon Pakistan's costed 2014- 2018 comprehensive Multi-year plans (cMYPs) for Routine Immunization. The targets set by the WHO for health expenditures to be seen as guiding principles.
- Timely approval of PC1s and release of allocated funds
- These should be coupled with innovative ways of generating finances e.g. imposition of health tax on luxury items, sin tax on tobacco or nutrition levies on soft drinks, tapping private sector resources etc

5. Reproductive Health and Family planning:

Family planning (FP) is one of the most cost effective interventions to reduce maternal and newborn deaths; furthermore, the vicious cycle of continued high rates of population growth and poor RMNCAH outcomes and nutrition in Pakistan needs urgent attention. In the past the two ministries of Population Welfare and of Health worked in parallel and seldom in tandem. While devolution to the provinces has created opportunities for integration, breaking down silos between hitherto parallel initiatives such as the MNCH, EPI, Malaria and Nutrition programs is challenging; it is now clear that the national ministry for health services and regulation will integrate national oversight. Important additional measures in this regards include

- Adoption of a National population policy framework to provide overall guidance and ensure national coordination and development of synergies between population and health sectors, supported by oversight bodies (national and provincial Population Commission),
- There is also an urgent need for declaring population emergency.
- Closing the gap between FP knowledge and practice through comprehensive service that encompasses family planning awareness, options, commodity security with focus on modern methods, as well as innovations, keeping in mind the diversity in the country. Institutions like NIPS, NRIFC and NATPOW along with provincial entities should synergize to provide the guidance to provinces in this area
- Focus on sexual & reproductive health education among adolescents, both boys and girls in school and out of school, is an important step that needs to be taken in a culturally sensitive manner.

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

Although multi-sectoral nutrition strategies may be overseen by the Planning Commission, the role of the health sector in enabling the implementation of

nutrition specific interventions is critical. This is especially true for integrating maternal nutrition and breastfeeding support strategies, ensuring that major causes of micronutrient deficiencies are addressed and that nutrition prevention and promotion is integrated within the primary care programs. There is an emerging role for mass media and communication strategies around this aspect which needs to be energized and implemented. The importance of nutrition as lifecycle approach is mandatory to be recognized.

- Legal interventions followed by mechanisms for enforcement and implementation at appropriate levels are necessary in this area. Concerned sectors need to be engaged, namely trade, economic and legal sectors for close monitoring of the implementation of the adopted legislation to implement the Code. Prominent examples are breastfeeding protection laws, food fortification and iodized salt.
- Given lack of progress in increasing exclusive breastfeeding rates, effective promotion strategies need to be revisited, a task force be established to look at this area on priority
- Fortification of food with micro nutrients by involving industry especially flour and ghee
- Networks under Scaling Up Nutrition (SUN) movement has to be made more effective and proactive
- Biofortification of staple foods, nutrition education, food safety and control of mycotoxins are actions that can improve the nutritional impact of agricultural practices and programs.

- Ensuring that women, adolescent mothers and children get sufficient amounts of key vitamins and minerals are proven strategies that can substantially reduce child mortality and nutrition-related problems.
- Real gains in RMNCAH and Nutrition cannot be achieved by intervening within the health sector alone and hence investments in nutrition- sensitive interventions such as female education, water, sanitation and hygiene and food security through agriculture are urgently needed.

7. Investing in addressing social determinants of health:

There is also the urgent need to tackle social determinants affecting RMNCAH in Pakistan which relate to fundamental issues of the status of women, adolescents girls' education and empowerment. Given the critical role of maternal education in improving child survival and maternal health, investments in integration of health and development messages, in linking RMNCAH to other sectors such as education, prevention of early/forced/ child marriage and gender empowerment is a key task for the federal ministry in tandem with the provinces.

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

- Women and girls empowerment through skill development, women focused micro-financing schemes, creation of job opportunities, and investing in cottage industry
- Generation and sharing of evidence on social determinants of health and health equity, including health equity- focused intervention research
- Addressing all social determinants by engaging line ministries and sectors concerning education, housing, sanitation, safe drinking water, women empowerment for decision making to seek health care and poverty reduction.

8. Measurement and Action at district level:

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

- Agreement on key set of meaningful indicators from facility and community level for MNCAH and nutrition monitoring for inclusion in the

overall framework of monitoring encompassing all health system elements. Executive dashboard having key health indicators be linked up with DHIS and other data reporting sources in order to provide evidence for policy makers and health managers to take evidence based decisions.

- Mechanisms for transparent and robust district level external evaluations at 2-3 yearly intervals that generate population-level estimates.
- Increased alignment and support behind a single national plan and monitoring framework for RMNCAH and nutrition using appropriate logistics and technology.
- Work on implementation throughout the country of civil registration and vital statistics (CRVS) which should have data based on cause specific mortality and morbidity

9. National Accountability and Oversight:

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

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

- This should be coupled with an effective multi-tiered monitoring and evaluation system linked to Accountability forums at district, provincial and national level.
- There is the potential need for a high- level “Inter-ministerial forum for health and population” and an “Inter-agency coordination forum” at national level.
- Institution of key performance indicators and health regulatory measures at provincial & district level aiming to improve governance & accountability mechanism

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

Prioritizing RMNCAH & Nutrition across provinces and establishment of a national oversight body for RMNCAH & Nutrition are only likely to succeed if the federal and provincial leaderships are cognizant of the importance of the area for national development. RMNCAH and Nutrition need to be national priorities clearly understood by ministries of finance, economic affairs division and

the planning commission. Political commitment and investment in sexual and reproductive health services and programs is an integral bottleneck that needs to be addressed.

- Capacity building of policy makers, parliamentarians, and Standing Committees on health & population issues, and media is mandatory to help them understand the linkages of health with development. Concrete actions in this are required.
- Engagements with key stakeholders like Religious scholars, media will be helpful in addressing myths and misconception on family planning etc.
- Actions to ensure a culture of “use of evidence for policy” needs to nurtured at every level. National/provincial forums to develop linkages between politicians, policy makers, scientists and researchers should be created to bridge the gap. Think tanks in very area should be encouraged.
- Local participatory governance mechanisms that enable communities and local government to partner in MNCAH related activities to be encouraged to develop a community base for advocacy.
- Strengthening health system response to adolescent health; capacity building of health care providers, standardization of adolescent friendly service provision protocols, improve easy access to primary health care and family planning services for adolescents
- Establish community mechanism for improve health seeking behavior for adolescents

Way Forward

The vision for action plan was endorsed by all the provinces and development partners on 13 May 2015, in a gathering chaired by Federal Minister of State for Health Mrs Saira Afzal Tarrar. Technical experts from all the provinces gathered on 14 May 2014, to translate the vision into provincial action plans which will be costed and shared with all relevant stakeholders.

The Action plan is envisaged to be a dynamic document leading to a mechanism for national consensus on important issues around RMNCAH and Nutrition in times to come, and will be in line with global commitments for reproductive, maternal, newborn, child, and adolescent health. It will also serve as the guiding framework for the development of Pakistan's RMNCAH strategic action plan 2016-2020. The process is going in tandem with development of National Vision document for Health and population and will feed into that as well. All provinces, regions, partners, line ministries, academics and international experts are participating to take the process forward.

Ministry of National Health Services, Regulations & Coordination,
Goernment of Pakistan
LG&RD Complex, G/5-2, Islamabad. Tel: 051 9245933
Website: www.nhsrc.gov.pk

Printing of document supported by Unicef