Managing programmes on reproductive, maternal, newborn, child and adolescent health

Module 1: Introduction
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Module 1: Introduction

Adapted for the South-East Asia Region based on the WHO publication on “Managing Programmes to Improve Child Health (2009)”
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Foreword

The WHO South-East Asia Region has in recent years accelerated reductions in maternal, newborn and child mortality. Between 1990 and 2018 the Region’s estimated decline in under-five and neonatal mortality was around 72% and 62%, respectively. Between 2000 and 2017 the Region achieved a decline in the maternal mortality ratio of more than 57%, and between 2000 and 2019 reduced the stillbirth rate by 50%.

Member States are to be commended on the path-breaking change they have achieved. Progressive improvements in the coverage of evidence-based interventions for reproductive, maternal, newborn, child and adolescent health (RMNCAH) are responsible for the Region’s progress and must continue to be strengthened to ensure that no person or community is left behind.

To fill remaining gaps, well planned and managed programmes are needed. Such programmes will improve the population-based coverage of evidence-based interventions and thus reduce maternal, newborn and child morbidity and mortality. This will in turn facilitate the fulfillment of the Region’s Flagship Priorities and the achievement of the Sustainable Development Goal targets.

The technical programme planning and management cycle required to strengthen RMNCAH services has two parts: first, the strategic planning cycle at the national level; and second, the implementation planning cycle at the sub-national level. The training materials contained herein address the second part of the cycle – implementation planning – and include an introductory module which is followed by modules on planning and managing implementation, as well as a guide for facilitators. The draft materials have been pilot tested in countries in the South-East Asia Region, as well as some countries in African Region, and reflect the wisdom and input of participants from all countries and regions.
I am certain that these modules will help build the skills of programme managers at national and sub-national level across the Region, and will scale-up the provision of evidence-based interventions that will achieve lasting gains, in line with the Region’s Flagship Priority on accelerating reduction of maternal, newborn and child mortality. I urge all stakeholders to make full use of these modules as together we continue to drive real change in the lives of women and children across the Region, for a healthier, more equitable and sustainable future for all.

Dr Poonam Khetrapal Singh
Regional Director
Abbreviations

AARR    average annual rate of reduction
AIDS    acquired immunodeficiency syndrome
ANC     antenatal care
ARH     adolescent reproductive health
ART     antiretroviral therapy
BEmONC  basic emergency obstetric and newborn care
CAH     child and adolescent health
CEDAW   Convention on Elimination of all forms of Discrimination Against Women
CEmONC  comprehensive emergency obstetric and newborn care
CHW     community health worker
CPAP    continuous positive airway pressure
CRC     Convention on the Rights of the Child
DHS     demographic and health survey
EPI     Expanded Programme on Immunization
EPMM    ending preventable maternal mortality
ENAP    Every Newborn Action Plan
FP      family planning
FP 2020 Family Planning 2020
HIV     human immunodeficiency virus
HMIS    health management information system
ICPD    International Conference on Population and Development
IFA  iron and folic acid
IMCI  Integrated Management of Childhood Illness
IMR  infant mortality rate
IPT  intermittent preventive therapy (for malaria)
IPV  intimate partner violence
ITN  insecticide-treated bednet
IYCF  infant and young child feeding
LBW  low birth weight
mCPR  modern contraceptive prevalence rate
MDGs  Millennium Development Goals
MICS  multiple indicator cluster survey
MMR  maternal mortality ratio
MoH  ministry of health
MPDSR  maternal and perinatal death surveillance and response
NGO  nongovernmental organization
ORT  oral rehydration therapy
PCPNC  pregnancy, childbirth, postpartum and newborn care
PHC  primary health care
PMTCT  prevention of mother-to-child transmission (of HIV)
PNC  postnatal care
PPH  post-partum haemorrhage
PSBI  possible severe bacterial infection
RMNCH  reproductive, maternal, newborn and child health
RMNCAH  reproductive, maternal, newborn, child and adolescent health
SBA  skilled birth attendant
SDGs  Sustainable Development Goals
STI  sexually transmitted infections
TFR  total fertility rate
ToT  training of trainers
UHC  universal health coverage
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
Acknowledgements

The South-East Asia Regional Office of World Health Organization (WHO-SEARO) would like to thank all the experts, reviewers, partners and facilitators who have contributed in developing and piloting this training package on programme management on Reproductive, Maternal, Newborn, Child and Adolescent Health. This training package has been developed under the overall guidance of Dr Neena Raina, Senior Advisor, Maternal, Newborn, Child, Adolescent and Ageing (MCA). This effort was coordinated by Dr Anoma Jayathilaka, Medical Officer, Maternal and Reproductive Health, and contributions of Dr Rajesh Mehta, Regional Adviser, Child and Adolescent Health, WHO-SEARO, Dr Deepthi Agrawal, WHO Country Office India; Dr Pooja Pradhan, WHO Country Office Nepal and Dr Shwe Sin Yu, WHO Country Office Myanmar are appreciated.

WHO-SEARO would like to acknowledge the contributions of Dr Chandani Galwaduge (Sri Lanka); Dr Harish Kumar (India); Dr Hiranya S. Jayawickrama (Sri Lanka); Dr Nethmini Thenuwara (Sri Lanka); Dr Nanthini Arumugam (India) in preparing the package and refining after pilot testing.

WHO-SEARO would like to thank all the experts who participated in the Regional pilot training including the programme officers from the ministries of health of South-East Asia Region: Dr Kazi Golam Ahsan, Bangladesh; Mr Samten, Mr Pema Lethro, Bhutan; Dr Sumita Ghosh, Dr Ajay Kumar Khera, India; Dr Nida Rohmawati, Dr Victorino, Dr Wilda Hayati., Indonesia; Ms Aishath Hamdha Ahmed, Dr Hussain Juman Jaleel, Maldives; Dr Saroja Karki Pande, Ms Sita Pokharel, Mr Pradip Giri, Nepal; Dr Kaushalya Kasturiaratchi, Dr Dimuth Peiris, Sri Lanka; Dr Pimolphan Tangwiwat, Dr Manus Ramkiattisak, Thailand; Dr Jose Felix Correia Freitas, Ms Madalena F.S. Gomes, Ms Perpetua Ana Mery Estela Laot, Timor-Leste; and experts from WHO: Dr Lobzang Dorji, WHO Country Office Bhutan; Mr Jermias da Cruz, WHO Country Office, Timor-Leste and partner agencies: Dr Nilesh Deshpande, UNFPA, India; Dr Aung Thu Tun, UNFPA, Myanmar; Dr S.M Nazmul Ahsan, UNICEF, Bangladesh; Dr Apurva Chaturvedi, UNICEF, India, Ms Jonia Lourenca Nunes Brites da Cruz, UNICEF, Timor-Leste. This package was field tested by the WHO Regional Office for Africa (WHO-AFRO) in Uganda with six countries and feedback provided by Dr Teshome Desta Woldehanna (RA in WHO-AFRO) and team is duly acknowledged.
Managing programmes on reproductive, maternal, newborn, child and adolescent health
Implementing evidence-based interventions in a population is a key to reducing mortality, morbidity, fertility and improving nutritional status. Simple low-cost interventions are available for the prevention and treatment of all the most common causes of maternal, newborn, child and adolescent mortality and morbidity, as well as for reducing fertility and improving nutritional status. An effective Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Programme must focus on achieving a high level of coverage, with evidence-based interventions that have the greatest potential to reduce maternal, newborn, child and adolescent mortality and morbidity, to improve nutritional status in a country and to achieve the desired fertility intentions of individual couples.

RMNCAH interventions are treatments, technologies and key family practices, that prevent or treat illness, reduce deaths, morbidities, fertility and improve the nutrition status among women, newborns, children and adolescents.

At the national level, RMNCAH programme managers and partners should select high-impact interventions to implement in the country. This selection should be based on consideration of the primary causes of morbidity and mortality, high fertility and low nutritional status in the country. It should also be based on the feasibility of implementing different interventions within the existing health system.

RMNCAH programme managers at the subnational level, such as the state, provincial and regional/district level, must understand the RMNCAH issues in their respective areas and the strategies specified in the country’s strategic plan/s for RMNCAH. They must then plan to implement the selected, evidence-based RMNCAH interventions in a way that will be effective

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1 These modules are based on the generic guidelines on programme planning for child health (2009) as the same principles and concepts could be applied for any area of the RMNCAH programmes.
in their administrative areas, manage implementation on an ongoing basis and periodically review and evaluate the programmes, to understand what has been achieved.

1.2 Programme planning and management cycles

Programme management to improve RMNCAH is an ongoing process and has two components (Fig. 1):

A. Strategic planning cycle
B. Implementation cycle

A. Strategic planning cycle:

The boxes in the dotted lines in Fig. 1 show the strategic planning cycle.

The strategic planning cycle ideally begins with an evaluation of the programme efforts of the previous years. A strategic plan will be developed to guide the RMNCAH programmes in the next five to 10 years. The strategic plan will set goals and objectives, specify the priority evidence-based interventions, and outline how they should be packaged and delivered.

Strategic planning is usually done at the national level and, sometimes, at subnational levels. Strategic plans are used to ensure the commitment of stakeholders and to advocate for programme resources. They provide overall guidance for implementation and financing to ensure the achievement of the goals and objectives. A strategic plan provides the framework for developing an implementation plan.

B. Implementation cycle:

The implementation cycle comprises three main steps:

a. Planning implementation
b. Managing implementation
c. Reviewing implementation.

Then the cycle repeats, beginning with using the results of the review, to inform planning for the next year or two.

The shaded boxes in Fig. 1 describe the implementation cycle.

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2 Strategic planning is not discussed in detail in these guidelines.
Planning implementation: Planning implementation (i.e. developing an implementation plan), is usually done every 1–2 years. Planning implementation helps managers at the national and subnational levels to work out how interventions can be effectively delivered and what activities and resources will be required. If a strategic plan is available, it states the objectives for the RMNCAH programme and the priority evidence-based interventions to be implemented. The strategic plan thus provides the framework for the implementation (operational) plan. If a strategic plan has not been developed, it is still necessary to do implementation planning in order to manage the RMNCAH programme in the short term.

**Managing implementation**: Managing implementation is the process of getting activities and tasks done according to the implementation plan.

**Reviewing implementation**: Reviewing implementation is a rigorous, systematic, objective, impartial review, or a self-evaluation. It indicates how effectively the activities of the implementation plan have been implemented, as part of the ongoing pursuit of higher levels of achievement. The review usually uses data from different sources to assess the strengths and weaknesses of previous implementation.

A comprehensive WHO methodology is available for reviewing RMNCAH programmes. However, it is not discussed in these training modules.
1.3 Comparison of strategic and implementation plan

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<td>● Prepared at national level (or sometimes at subnational level), to guide the country’s reproductive, maternal, newborn, child and adolescent health efforts.</td>
<td>● Prepared for a geographical area, to guide the RMNCAH programme implementation in that area (a state/region or a district).</td>
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<td>● Reflects a broad perspective of progress needed for women, child and adolescent survival and health, and how progress should be achieved in the future.</td>
<td>● Reflects specific knowledge of how interventions can be implemented in the home and community, field health services, at first-level health facilities and at referral facilities; what the programme can do or provide to enable successful implementation; and the resources required to carry out activities.</td>
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<tr>
<td>● Usually for 5–10 years</td>
<td>● Usually for 1 or 2 years.</td>
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<td>● The country’s major partners in reproductive, maternal, newborn, child and adolescent health should be involved in its development.</td>
<td>● Stakeholders and implementing partners in the geographical area should be involved in its development.</td>
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<tr>
<td>● Provides framework, defines goals, objectives and coverage targets.</td>
<td>● Defines activity-related (input and output) targets.</td>
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<td>● Specifies priority evidence-based interventions to be implemented to address major causes of morbidity and mortality; Specifies priority strategies to implement and scale up evidence-based interventions.</td>
<td>● Specifies activities to be implemented to deliver priority interventions in the geographical area.</td>
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<tr>
<td>● Includes impact and coverage indicators that will be evaluated every 3–5 years.</td>
<td>● Includes activity-related indicators (input, process and output) that will be monitored and reviewed at year-end.</td>
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<tr>
<td>● Includes overall guidance on financing and health systems support that is needed.</td>
<td>● Includes budget for the year, based on activities planned to meet the needs of women, newborns, children and adolescents in the geographical area.</td>
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Where can a programme enter these cycles?

A subnational area may start planning at almost any point in these cycles. To **develop an implementation plan (planning implementation)**, programme managers should get together and use the best available review findings on what has been done so far and the results of the work. If the available data are limited, the implementation plan should focus on activities that generate data so that better data will be available for the next planning cycle.

If the country has a strategic plan, it will provide some direction for planning implementation, such as the objectives for reproductive, maternal, newborn, child and adolescent health and the priority evidence-based interventions. It may also provide strategies that should be implemented. If a country does not have a national strategic plan/plans, a strategic planning cycle should begin with an evaluation of the RMNCAH status and coverage of these evidence-based interventions.

### 1.4 Learning objectives

On completion of Module 1, you will understand:

- the global and national RMNCAH situation, and the importance of epidemiology for planning effective health programmes;
- recommended RMNCAH interventions and packages;
- principles for the delivery of interventions: the continuum of care (across the life-cycle and health systems), packaging of interventions, coverage, equity and quality;
- definitions of important terms in planning and managing the implementation of RMNCAH programmes such as goal, objective, indicator, activity, coverage, impact and targets.

You will practise:

- interpreting RMNCAH data;
- selecting an intervention package and the most important level at which to implement it;
- using terms important for planning and managing RMNCAH programmes including goal, objective, indicator, activity, coverage, impact, target, etc.
Managing programmes to improve RMNCAH is designed to give programme managers the essential knowledge and skills that they require to manage a programme. Many RMNCAH managers have training in medicine or nursing, but have rarely received training in programme management. Therefore, training in key management concepts is essential for programme managers.

Better planning and management of RMNCAH programmes are urgently needed. Although simple and effective interventions to reduce maternal, newborn and child mortality and morbidity are available, these interventions often do not reach those who need them most. Well planned and managed programmes are more likely to improve population-based intervention coverage and, therefore, reduce maternal, newborn, child and adolescent mortality, morbidity and fertility and improve nutritional status. These programmes are more likely to achieve the relevant targets identified for RMNCAH in the Sustainable Development Goals (SDGs) by 2030.

2.1 Who is the target audience?

These training modules are designed primarily for programme managers related to RMNCAH at the national, subnational, state, regional, provincial and district levels. These programme managers must take the vision for RMNCAH as described by national-level planners in the strategic plans, and turn it into action on the ground.

Managers responsible for RMNCAH programmes can apply the skills described in these training modules. In addition, the training will broaden perspectives on how RMNCAH activities should link with other departments, or programmes directed at the same goals.

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Coverage is the proportion of the target population that receives the intervention. It is a population-based indicator, usually measured in a community/household survey.
2.2 What is taught?

*Managing programmes on* RMNCAH describes in detail how to perform two major steps in the **implementation cycle** (Fig. 2). Those steps are:

- Planning implementation (developing an implementation plan)
- Managing implementation.

This training course teaches the concept of public health programme planning and how to carry out these steps at the national or subnational levels.

**Fig. 2. The implementation cycle**

Below is a brief description of the steps addressed in this course.

**Planning implementation (developing an implementation plan): Module 2**

An implementation plan specifies in detail how evidence-based interventions (identified in the national strategic plan/plans) will be delivered. It includes activities, tasks, budgets and monitoring. An implementation plan is usually developed every 1–2 years, based on the strategic decisions for RMNCAH made at the national level.

Key steps in developing an implementation plan (Fig. 3) include:

1. **Prepare for planning** - forming a planning team, involving stakeholders and deciding on the timing and resources needed.

2. **Review implementation status** - using data from different sources, assessing the level of implementation, and strengths and weaknesses of previous implementation.
3. **Decide on programme activities** - planning activities to implement interventions in the home and community, field health services, first-level health facilities and referral facilities, and setting activity-related targets.

4. **Plan monitoring of implementation of activities** - selecting monitoring indicators and planning how to monitor them.

5. **Plan for the next review of implementation status** - planning what will be assessed, how data will be collected, and who will conduct the review.

6. **Write a workplan and budget.**

Fig. 3. Flow chart: planning implementation (developing an implementation plan)
Managing implementation: Module 3

Managing implementation is the process of getting activities and tasks done according to the implementation plan. Important management skills are often general skills that cut across several technical areas.

Steps involved in managing implementation are listed below, with key skills needed to perform them (Fig. 4).

1. **Advocate** for RMNCAH
   - To prepare and give a presentation on advocacy

2. **Mobilize resources**
   - To prepare a presentation to ask for support from (a) strategic partner(s)
   - To prepare a letter of intent to a donor

3. **Manage resources**
   - To calculate quantities of medicines, other supplies and equipment needed
   - To monitor expenditure

4. **Manage supervision**
   - To analyse common problems found during supervision
   - To give feedback during supervision

5. **Monitor progress**
   - To analyse monitoring indicators to identify successes and problem areas.

These training materials are not a comprehensive guide to programme management. More detailed information on all aspects of programme management is available from many sources, including WHO reference documents, textbooks, journal articles and other publications. Useful references have been listed at the end of each module.

These materials focus on **improving coverage with effective RMNCAH interventions**. They also address the important concepts of **quality of care** (providing services of good quality), and equity (ensuring that all women, mothers, newborns, children and adolescents receive services, and not just those who are closer, economically better off, or members of the majority social groups), and **accountability**.

The planning should be **client-centred, needs-based and rights-based**. This means plans should be written for delivering specific interventions in a way that will **reach as many mothers, newborns, children, adolescents and women in the reproductive age group** as possible, to ensure that they survive, thrive and transform.\(^4\) Sufficient funding is then sought to implement the plans.

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**Resource-based planning is not recommended**, because it is carried out only to use the available resources to implement activities that are easily funded, or to continue activities of the previous year, or to use limited resources to help geographical areas or social groups that are easiest to reach or politically favoured. **Resource-based planning is unlikely to help achieve RMNCAH outcomes and impact.**

**Fig. 4. Flow chart: managing implementation**

1. **Advocate for RMNCH**
   1.1. Review policy and programme changes needed;
   1.2. Identify the target audience;
   1.3. Decide on advocacy messages;
   1.4. Decide how best to deliver messages;
   1.5. Develop a plan to monitor effectiveness of advocacy.

2. **Mobilize resources**
   2.1. Form strategic partnerships;
   2.2. Mobilize donor funds.

3. **Manage human, material and financial resources**
   3.1. Manage human resources;
   3.2. Manage material resources;
   3.3. Manage financial resources.

4. **Manage supervision**
   4.1. Review and improve the organization of supervision;
   4.2. Ensure that supervisors are well prepared;
   4.3. Ensure sufficient management of transportation and funding for supervision;
   4.4. Supervise the supervisors.

5. **Monitor progress and use results**
   5.1. Analyse monitoring data;
   5.2. Use monitoring data to improve the programme.

Steps do not need to follow any direction. Can enter the cycle at any point, based on the needs.
### 2.3 What materials and learning methods are used?

There are three modules. These are summarized below.

#### Table 2. Materials and learning methods

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<td>Validate the learning methods</td>
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<td></td>
</tr>
<tr>
<td>2: Planning implementation</td>
<td>- Prepare for planning</td>
<td>Reading/presentations/interpretation of local data/ written exercises/group discussion.</td>
<td>Use of available data to review implementation status or use case study (Annex 7)</td>
</tr>
<tr>
<td></td>
<td>- Review implementation status</td>
<td></td>
<td>Planning activities for implementation of an intervention package</td>
</tr>
<tr>
<td></td>
<td>- Decide on programme activities</td>
<td></td>
<td>Practice of skills through exercises about fictional country.</td>
</tr>
<tr>
<td></td>
<td>- Plan monitoring of implementation of activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Plan for a review of implementation status</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Write a workplan and budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3: Managing implementation</td>
<td>- Advocate for RMNCAH</td>
<td>Reading/written exercises/role play/group discussions.</td>
<td>Role play presentations</td>
</tr>
<tr>
<td></td>
<td>- Mobilize resources</td>
<td></td>
<td>Application of management skills to your implementation plan</td>
</tr>
<tr>
<td></td>
<td>- Manage human, material and financial resources</td>
<td></td>
<td>Application of skills to exercises about fictional country.</td>
</tr>
<tr>
<td></td>
<td>- Manage supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Monitor progress and use results.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

5 The terms effective interventions and essential interventions are used interchangeably.
2.4 How are the materials to be used?

These materials are designed to be used as guidelines for a facilitated workshop.

Background data needed for this workshop:

- You will use policy and programme information from your own setting to help develop your skills (also refer to the findings of RMNCAH policy survey 2018)\(^6\).
- A copy of the country report will be made available at the workshop venue.
- You should have received a list of the information needed in advance of the workshop.

If possible, regional and district managers should bring data/plans of the last year from their own regions or districts. A case study on a district in a fictional country will be used in several exercises to practice skills (Annex 7).

If these training materials can be adapted appropriately, they may be used in other ways, such as a reference guide for self-learning, for on-the-job training, or as part of pre-service training.

\(^6\) Reproductive, maternal, new-born, child, and adolescent health policy survey. Geneva: WHO; 2018
RMNCAH programme managers at the national and subnational (state/regional/provincial and district) levels must understand the mortality, morbidity and nutrition status of women, newborns, children and adolescents, and the fertility status of women in their respective geographical/administrative areas, along with problems related to their ability to survive, thrive and transform.

Programme managers at all these levels should be knowledgeable about the framework specified in the country's strategic plan/s for RMNCAH. They must then plan to implement the selected interventions in a way that will be effective in their areas, manage that implementation on an ongoing basis, and periodically review what has been achieved.

3.1 What are the target populations for RMNCAH programmes?

The target populations for RMNCAH programmes are:

- Women who are pregnant or in childbirth (intrapartum and postpartum periods).
- Newborns or neonates (from birth up to 28 days of life)
- Infants (from birth up to the age of 1 year)
- Children aged from 1 year to 5 years (12 months to 60 months)
- Children aged from 5 years to 10 years
- Adolescents (10 to 19 years)
- Women of reproductive age (15–49 years, who are not covered under pregnancy and postpartum period)
3.2 What are the problems?

This section will briefly discuss the following thematic areas:

A. Maternal mortality
B. Child mortality (including neonatal mortality)
C. Stillbirths
D. High fertility
E. Child undernutrition
F. Adolescent health issues
G. Emerging priorities
   - Birth defects
   - Early childhood care and development
   - Cervical cancer
H. Underlying factors
   - Water, sanitation and environmental health
   - Indoor air pollution.

A. Maternal mortality

Maternal mortality remains unacceptably high in many developing countries. The United Nations Maternal Mortality Estimation Inter-Agency Group (UN MMEIG) estimated that 295,000 (unit interface [UI] 279,000 to 340,000) maternal deaths occurred globally in 2017, yielding an overall MMR of 211 (UI 199 to 243) maternal deaths per 100,000 live births.\(^7\)

The South-East Asia Region observed the highest decline (by 71%) of MMR between 1990 and 2017, compared with a global reduction of 44%. MMR was 525/100,000 live births (LB) in 1990 in the SEA Region, and declined to 152/100,000 LB\(^7\) by 2017.

Fig. 5A. Trends in maternal mortality ratio by WHO regions 1990–2017

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The MDG 5A target to reduce maternal mortality by three quarters by the end of 2015 was achieved by only nine countries globally, including three countries from the SEA Region: Bhutan, Maldives and Timor-Leste. All countries in the Region reduced the MMR significantly during 2000–2017; yet, maternal mortality remains a significant public health problem in most countries.

Direct causes, such as severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), hypertensive disorders during pregnancy (pre-eclampsia and eclampsia) and unsafe abortions, account for nearly 75% of all maternal deaths that are due to direct causes.

**Fig. 5C. Main causes of maternal deaths in the South-East Asia Region 2015**

B. Child mortality

As per the United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME), *Levels & Trends in Child Mortality: Report 2019*, it is estimated that in 2018, 5.3 million under-5 children died globally before their fifth birthday. Around 1.2 million of these deaths occurred in the 11 Member States of the World Health Organization’s South-East Asia Region.

According to the same report, the estimates of child mortality in the SEA Region suggest a 71.4% reduction in under-5 mortality in 2018, as compared with 1990 estimates. This means that an additional 3.4 million children’s lives were saved in the Region, compared with 1990 (Fig. 6A).

![Fig. 6A. Child mortality reduction (1990–2018)](image)

The main direct causes of under-5 deaths in South-East Asia are neonatal causes (59%), and common illnesses like pneumonia (15%) and diarrhoea (9%). With countries at different levels of mortality, an epidemiological transition in the causes of under-five deaths is evident in the SEA Region. Birth defects are now a leading cause of under-5 deaths (9%).

Neonatal mortality in the SEA Region has reduced by 62% as per 2018 data compared with the level in 1990. This indicates that about 1.4 million additional newborn lives were saved in the Region, as compared with 1990. Complications of preterm care are responsible for most child deaths. About 41% of newborn mortality is caused by complications of preterm births. Reduction in NMR has been the slowest, but the SEA Region’s performance is better than the global performance.
Managing programmes on reproductive, maternal, newborn, child and adolescent health

**C. Stillbirths**

An estimated 2.6 million third trimester stillbirths\(^9\) occurred globally, and almost 800,000 stillbirths occurred in the SEA Region in 2015.\(^{10}\) Globally almost all stillbirths occur in 10 countries; three are in the SEA Region, namely India, Bangladesh and Indonesia (Fig. 7). These deaths mostly happen to babies who are delivered at term and who would have been expected to survive.

**Fig. 7.** The countries with the highest stillbirth rates in 2015 and those with the largest numbers

Source: Ending preventable stillbirths: Lancet series 2016 (blue circles are proportionate to the number of stillbirths).

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\(^9\) Definition of stillbirth: a baby born with no signs of life at, or after, 28 weeks’ gestation

\(^{10}\) Ending preventable stillbirths: Lancet series 2016
Fetal survival is intimately linked to effective maternal care, throughout the continuum of pregnancy and labour. There are proven evidence-based interventions with estimated effect size (effect of percentage reduction of still births at universal coverage at population level) available for the prevention of stillbirth, as given in Table 3.\textsuperscript{11}

**Table 3. Estimated effect size of interventions on antepartum and intrapartum stillbirths**

<table>
<thead>
<tr>
<th>Timing</th>
<th>S.N.</th>
<th>Intervention</th>
<th>Effect size on antepartum stillbirths</th>
<th>Effect size on intrapartum stillbirths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before pregnancy and basic antenatal care</td>
<td>1</td>
<td>Peri-conceptional folic acid fortification</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Insecticide-treated bed nets or intermittent preventive treatment for malaria prevention during pregnancy</td>
<td>22%</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Syphilis screening and treatment</td>
<td>80%</td>
<td>NA</td>
</tr>
<tr>
<td>Advanced antenatal care</td>
<td>4</td>
<td>Detection and management of hypertensive disease of pregnancy</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Detection and management of diabetes of pregnancy</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Detection and management of fetal growth restriction</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Identification and induction of mothers with \geq 41 weeks of gestation</td>
<td>69%</td>
<td>69%</td>
</tr>
<tr>
<td>Obstetric care</td>
<td>8</td>
<td>Skilled care at birth and immediate care for neonates</td>
<td>NA</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Basic emergency obstetric care</td>
<td>NA</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Comprehensive emergency obstetric care</td>
<td>NA</td>
<td>75%</td>
</tr>
</tbody>
</table>

\textsuperscript{11} Ending preventable stillbirths - Lancet series 2016.

**D. High fertility**

As shown in Fig. 8 there is a remarkable decline in the total fertility rate (TFR) in the SEA Region. Although contraceptive prevalence has increased, there is an unmet need for family planning (FP) both for spacing and for limiting in several countries. Met demand for FP also remains low in some Member States.
E. Child undernutrition

Child undernutrition is a major contributor to child mortality. It increases the risk of children dying from pneumonia, diarrhoea and other infections. It is also a major factor in preventing children from reaching their full human potential. Under-5 stunting and wasting, are common in the countries of the SEA Region. The period from pregnancy until 24 months of a child’s life is the window in which there is an opportunity to reduce undernutrition, and its adverse effects. In addition, the prevalence of babies born with low birth weight (LBW) and preterm births is also significant, for which maternal health and nutrition are major contributory factors. Child undernutrition and LBW are proven risk factors for noncommunicable diseases in later life.

Countries in the SEA Region have endorsed global nutrition targets for improving maternal, infant and young child nutrition, and are committed to monitoring progress by 2025. Achieving substantial improvements in nutrition is within SDG Goal 2 as well. This will be instrumental in boosting child survival rates across countries of the Region.

The graphs in Fig. 9 show regional trends (1990–2018) in child malnutrition indicators for stunting and overweight, as well as the latest (2018) estimates of wasting and severe wasting. These estimates are presented by various regional and income group country classifications.
F. Adolescent health issues

Although adolescents are generally considered healthy, there is significant mortality and morbidity in this age group. In 2015, there were 362 million adolescents (10–19 years) in the Region, which was 30% of the global population of adolescents. With an overall mortality rate of 102/100 000 adolescents, there are an estimated 1.7 million deaths in this age group in a year: that is, 27% of global deaths among adolescents12 occur in the SEA Region.

Leading causes of mortality include self-harm (suicide), road injury and maternal mortality (among women aged 15–19 years). In addition, significant morbidity is reported among adolescents in the SEA Region: a loss of 21 783 disability-adjusted life years (DALYs) per 100 000 adolescents owing to self-harm, iron deficiency anemia, depressive disorders, road traffic injuries and diarrhoeal diseases.13

About 6 million adolescent girls between 15 and 19 years of age give birth each year in the SEA Region. The adolescent birth rate among 15–19-year-old girls in the Region is 33.9/1000, just below the global average of 44.1.14

It is observed that children aged 10–14 share the burden of some diseases that are also common among under-5 children, such as diarrhoea and iron deficiency (Fig. 10). Significant disability-adjusted life years are lost among 10–14-year-olds, because of mental depression and injuries. Availability of dependable data for the age groups 5–9 years and 10–14 years is, however, limited. Nonetheless, there are important public health measures that can be taken to improve survival, health and the well-being of older children (5–9 years age group) and adolescents (10–19 years age group).

Fig. 10. South-East Asia Region: Causes of DALYs lost (DALY rate per 100 000 population) among 10–14-year-olds disaggregated by sex, 2015

Source: WHO Global Accelerated Action for the Health of Adolescents (AA-HA!), 2016

G. Emerging priorities

Birth defects

Birth defects are a major cause of death, especially neonatal mortality, and of long-term disability among infants and children. These diminish productivity and quality of life, and cause significant social stigma, discrimination and economic burden.
Early childhood care and development

Globally, about 250 million under-5 children are at the risk of poor development on account of malnutrition and poverty. Of this about 70 million in the SEA Region are stunted, and at the risk of poor development. The Sustainable Development Goals and the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health, have embraced young children's development, seeing it as key to the transformation that the world seeks to achieve by 2030.

In response, the Nurturing Care Framework, developed by WHO, UNICEF and the World Bank with support from the Partnership for Maternal, Newborn and Child Health (PMNCH) and the ECD Action Network (ECDAN), was launched in May 2018. The Framework provides guidance action, with particular focus on the period from pregnancy to age of three years. As is known, in these earliest years, the health sector is uniquely positioned to provide support for nurturing care. Trained health workers would provide counselling to mothers and family members for providing age-appropriate responsive care to children to ensure comprehensive development.
Cervical cancer

Cervical cancer accounts for 15% of all female cancers in the WHO South-East Asia Region (second highest after breast cancer). During the year 2018, in WHO South-East Asia Region, there were an estimated 158,692 (27.2% of the total in the world) new cases of cervical cancer and 95,766 (37% of the total in the world) deaths due to it in the SEA Region.

Cervical cancer has been identified as an emerging priority in the SEA Region. The Region is leading the way towards the elimination of cervical cancer as a preventable public health concern, which is a priority focus area of the WHO Director-General as well as the Regional Director of the WHO South-East Asia Region. The WHO elimination target for cervical cancer is to bring down incidence to 4/100,000 women at the end of the century (i.e. 2030).

**Fig. 12. Number of new cases of cancers among females of all ages in the SEA Region**

![Cancer Cases Chart](source: Globocan 2018)

**H. Underlying factors**

**Water, sanitation and environmental health**

Inadequate access to potable drinking water and poor sanitary provisions are obvious risk factors for diarrhoeal diseases and other infections. Improvements in water and sanitation require multisectoral cooperation and will be carried out in conjunction with national, regional and district-level government departments. In addition to long-term changes in infrastructure for increasing access to clean drinking water and improved sanitation, a multipronged effort is needed to educate communities to demand such provisions and utilize them.

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Indoor air pollution

Exposure of children to indoor and outdoor air pollution (secondhand tobacco and biofuels used for cooking) contributes to respiratory illnesses, such as life-threatening pneumonia and debilitating asthma. In some settings, children are also exposed to environmental hazards such as lead, industrial and community waste and agricultural chemicals, to which there is increased vulnerability at this age. Legislation and policy change to restrict use and exposure, community awareness as well as appropriate services need to be strengthened.

These are clear examples of multisectoral actions for child health that are so important in the SDG phase. It is good to include such intersectoral actions in the district plans, such as advocacy meetings, joint planning and joint monitoring activities with these sectors.

Fig. 13. Key points: RMNCAH epidemiology

<table>
<thead>
<tr>
<th>RMNCAH epidemiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sound epidemiological data are essential for planning.</td>
</tr>
<tr>
<td>Most maternal, newborn, child and adolescent deaths including stillbirths, and adverse health and nutrition outcomes are still preventable.</td>
</tr>
<tr>
<td>Primary causes of mortality and morbidity vary between and within countries.</td>
</tr>
<tr>
<td>Programme planners need to identify and understand the epidemiology of mortality and morbidity, nutrition status and fertility patterns in their countries/geographic areas.</td>
</tr>
<tr>
<td>Emerging problems also need attention.</td>
</tr>
</tbody>
</table>

3.3 Sustainable Development Goals (SDGs)

The Sustainable Development Goals, launched in 2016, aim to address the unfinished agenda of unachieved MDGs while maintaining the significant progress made.

The SDGs build upon, and extend, the MDGs by adding the dimensions of economic and environmental sustainability, all held together by the glue of “peaceful and inclusive societies for sustainable development”. They will address the three pillars of development: economic, social and environmental issues for sustainable development, while ensuring that no one is left behind.
The SDGs also emphasize the need to address uneven progress across and within countries, that was observed during the MDG phase. The SDGs consist of 17 goals and 169 targets, including one specific goal for health (SDG 3) that has 13 targets, which are framed in broad terms relevant to all countries and all populations: “Ensure healthy lives and promote well-being for all at all ages”. The health goal is interlinked with many of the non-health goals, reflecting the fact that health affects, and is in turn affected by, many economic, social and environmental determinants.

Monitoring of SDG target 3.8 tracks two aspects of universal health coverage (UHC): financial protection and coverage of essential health services. The momentum around the SDGs and UHC has created new demands and opportunities for strengthening primary health care.\textsuperscript{16}

### Table 4. SDG Goals, targets and indicators to be achieved by 2030, that have a direct relevance to RMNCAH

<table>
<thead>
<tr>
<th>SDG goal</th>
<th>Targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture</td>
<td>Target 2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons. The intermediate target is a reduction in the prevalence of stunting by 40% by 2025 (from 2012 levels).\textsuperscript{17}</td>
<td>2.2.1 Prevalence of stunting among children under 5 years of age. 2.2.2 Prevalence of wasting and overweight among children under 5 years of age.</td>
</tr>
<tr>
<td>Goal 3. Ensure healthy lives and promote well-being for all at all ages</td>
<td>3.1 Reduce the global maternal mortality ratio to less than 70 per 100 000 live births. No country should have an MMR greater than 140/100 000 LB. Country target is: Reduce the MMR by at least two thirds from the 2010 baseline by 2030.\textsuperscript{18}</td>
<td>3.1.1 Maternal mortality ratio 3.1.2 Proportion of births attended by skilled health personnel</td>
</tr>
</tbody>
</table>

\textsuperscript{16} Primary health care at forty: reflections from South-East Asia. WHO; 2018.

\textsuperscript{17} Global targets 2025 to improve maternal, infant and young child nutrition (MIYCN), WHO.

\textsuperscript{18} Strategies toward finding preventable maternal mortality (EPMM). Geneva: WHO & HRP ; 2015 - Target on MMR.
<table>
<thead>
<tr>
<th>SDG goal</th>
<th>Targets</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| 3.2 End preventable newborn and under-5 child deaths:  
  - Reduce neonatal mortality to at least 12 per 1000 live births.  
  - Reduce under-5 mortality to 25 per 1000 live births. | 3.2.1 Under-five mortality rate.  
  3.2.2 Neonatal mortality rate. |
| 3.7 Ensure universal access to sexual and reproductive health-care services including for family planning, information and education and the integration of reproductive health into national strategies and programmes. | 3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods.  
  3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group. |
| 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all. | 3.8.1 Coverage of essential health services that include RMNCH, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged populations.  
  3.8.2 Number of people covered by health insurance or a public health system per 1000 population. |
| Goal 5. Achieve gender equality and empower all women and girls | 5.6 Ensure universal access to sexual and reproductive health and reproductive rights, as agreed in accordance with the Programme of Action of the International Conference on Population and Development, and the Beijing Platform for Action, and the outcome documents of their review conferences. | 5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.  
  5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and services. |
3.4 Strategic documents that serve as roadmaps to achieve targets in RMNCAH

There are important strategic documents that serve as roadmaps to achieve the SDG targets on RMNCAH. The Global Strategy for Women’s, Children’s and Adolescent’s Health (2016–2030), Strategies towards Ending Preventable Maternal Mortality (EPMM), Every Newborn Action Plan, Global Strategy towards the Elimination of Cervical Cancer as a Public Health Problem, and Maternal, Infant and Young Child Nutrition (MIYCN) targets for 2025, are some of them.

3.4.1 The Global Strategy for Women’s, Children’s and Adolescents' health (2016–2030)

The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030), launched by the UN Secretary-General, provides a roadmap to end all preventable deaths of women, children and adolescents and ensure that they not only survive, but also every woman, child and adolescent can thrive to realize their full potential, resulting in enormous social, demographic and economic benefits (refer to Annex 1).

3.4.2 Strategies towards ending preventable maternal mortality (EPMM)

The Strategy for EPMM serves as a roadmap towards the SDGs and provides directions and cross-cutting actions to achieve the specific target of reducing maternal mortality. The EPMM Strategy focuses on high impact interventions to address major gaps in the continuum of care for mothers. EPMM provides the country SDG target for MMR (refer to Table 4).

---

3.4.3 Every Newborn Action Plan (ENAP)

ENAP, launched in 2014, provides a roadmap of strategic actions for ending preventable newborn mortality and stillbirth, and contributing to reducing maternal mortality and morbidity. Many countries have adopted and developed country-specific ENAPs.

**Table 5. Strategic objectives: ending preventable maternal mortality and Every Newborn Action Plan**

<table>
<thead>
<tr>
<th>EPMM</th>
<th>ENAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Address inequities in access and quality of sexual, reproductive, maternal and newborn health care</td>
<td>- Strengthen and invest in care during labour, birth, and the first day and first week of life</td>
</tr>
<tr>
<td>- Ensure universal coverage for sexual, reproductive, maternal and newborn health care</td>
<td>- Improve the quality of maternal and newborn care</td>
</tr>
<tr>
<td>- Address all causes of maternal mortality, reproductive and maternal morbidities and related disabilities</td>
<td>- Reach every woman and every newborn, reduce inequities</td>
</tr>
<tr>
<td>- Strengthen health systems to respond to the needs and priorities of women and girls</td>
<td>- Harness the power of parents, families and communities</td>
</tr>
<tr>
<td>- Ensure accountability to improve quality of care and equity.</td>
<td>- Count every newborn: measurement, tracking and accountability.</td>
</tr>
</tbody>
</table>

3.4.4 Global Strategy towards the Elimination of Cervical Cancer as a Public Health Problem; achieving the 90-70-90 targets towards elimination

Global Strategy towards elimination of cervical cancer (published 2020) has three main pillars: prevent, screen and treat, that capture a comprehensive approach that includes prevention, effective screening and treatment of pre-cancerous lesions, early cancer diagnosis and programmes for the management of invasive cancer.

To eliminate cervical cancer as a public health problem within a century, these 90-70-90 targets must be reached by 2030:

- 90% of girls are fully vaccinated with the HPV vaccine by 15 years of age;
- 70% of women are screened with a high-precision test at 35 and 45 years of age; and
- 90% of women identified with cervical disease receive treatment and care.
3.4.5 Regional Strategy documents

Based on the Global Strategy documents, several Regional Strategy documents have been developed including the Newborn and Child Health Strategy, Adolescent Health Strategy, Sexual and Reproductive Health Strategy, Strategic Action Plan to reduce double burden of malnutrition, etc., which will provide regional strategic directions to the Member States.

3.5 Rights of women and children

Women's rights and children's rights are interrelated. There are two important United Nations treaties that have great relevance to the rights of women and children: the Convention on Elimination of all forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC) (refer to Annex 2).
Evidence-based interventions on RMNCAH

Relatively simple, low-cost evidence-based interventions are available for the prevention and treatment of almost all the most common causes of maternal, newborn, infant and child mortality (including stillbirths) and morbidity, as well as for the reduction of fertility and improvement of nutritional status.

4.1 Definitions

Evidence-based Interventions: In programmatic language, interventions are defined as treatments, technologies and key health behaviours that prevent or treat illness and reduce deaths, or improve health status (morbidity, mortality, nutritional status and fertility) among target groups.

Therefore, an intervention is not a simple act of "intervening" or an activity.

Fig. 14. Key points: RMNCAH evidence-based interventions

Reproductive, maternal, newborn, child and adolescent health interventions

RMNCAH interventions can prevent or manage health problems, reduce deaths, stillbirths and promote the well-being of mothers, children, adolescents and women of reproductive age.

- Examples of preventive interventions include family planning using modern contraceptive methods, exclusive breastfeeding, iron and folic acid supplementation, tetanus toxoid immunization.
- Examples of treatment interventions include emergency obstetric care, treatment of severe hypertension in pregnancy, active management of the third stage of labour, induction and augmentation of labour, newborn resuscitation, antibiotics for diarrhoea and pneumonia in children, and management of severe acute malnutrition.

(Continued)
Interventions are usually delivered using a combination:

a) services (to provide preventive and treatment interventions)
b) health education (to improve knowledge and practices)
c) distribution of essential commodities (such as contraceptives)
d) infrastructure (such as birthing rooms that provide privacy, potable water and latrines).

An intervention is **efficacious** if it has been demonstrated to reduce maternal, newborn, child and reproductive age death and morbidity, and improve health status, under controlled (research) conditions.

An intervention is **effective** if it has been demonstrated to reduce maternal, newborn and child and reproductive age deaths and morbidity, and improve health status, under real-life (programme) conditions.

International agencies such as WHO and partners from time to time publish lists of essential/effective interventions relevant for each programme area based on the review of the newest scientific evidence. Effective/essential interventions to improve the health of mothers, newborns, children and women of reproductive age should form the basis for all RMNCAH programmes.

Global coverage with most of these effective interventions, however, is still low and is sometimes well below 50%. In most regions of the world with high maternal, newborn and child mortality, effective interventions are not reaching enough women in the reproductive age, mothers, newborns, children and adolescents who need them.

### 4.2 Effective interventions for improving RMNCAH and survival

Please refer to Annex 3 for the list of effective interventions for improving RMNCAH goals of **survive, thrive and transform**, that were adopted from the Global Strategy for Women’s Children’s and Adolescent Health (2016–2030), essential nutrition actions such as mainstreaming nutrition through the life-course, and packages of interventions for family planning, safe abortion care, maternal, newborn and child health. These lists are updated from time to time by technical agencies such as WHO.
Essential RMNCAH evidence-based interventions:24

- Demonstrated to be effective in improving maternal, newborn, child and adolescent health and survival by addressing the main causes of mortality.
- Delivered along the continuum of care for women and children – from the reproductive years, through pregnancy, birth, the newborn period, infancy and childhood, and adolescence (continuum of care through life-cycle).
- Suitable for implementation in low- and middle-income countries.
- Delivered at all levels of the health system: community/home, first-level, and outreach and referral-level services.
- Selected based on systematic data reviews and meta-analyses, WHO recommendations are derived from these evidence-based interventions.

4.3 How well are effective interventions reaching mothers, newborns, children, adolescents and women of the reproductive age group?

4.3.1 Intervention coverage

Intervention coverage is the proportion of the target group receiving the intervention. It reflects the extent to which an intervention reaches the target population. This, in turn, decides its effect on morbidity and mortality reduction. As shown in Table 6 below, the effect varies according to the intervention coverage, and universal coverage of 99% has the maximum effect. Therefore, all health care planning should drive at achieving high levels of intervention coverage (universal coverage). The table shows that if intervention coverage is low, the effect on impact will be low.

Table 6. Estimated effects of individual interventions on stillbirths according to coverage in 2015

<table>
<thead>
<tr>
<th>Stillbirths</th>
<th>60% coverage</th>
<th>90% coverage</th>
<th>99% coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline estimate for 2015</td>
<td>2 499 000</td>
<td>2 499 000</td>
<td>2 499 000</td>
</tr>
<tr>
<td>Preconception folic acid fortification</td>
<td>2 481 000</td>
<td>2 472 000</td>
<td>2 470 000</td>
</tr>
</tbody>
</table>

(Continued)
### Stillbirths

<table>
<thead>
<tr>
<th>Intervention</th>
<th>60% coverage</th>
<th>90% coverage</th>
<th>99% coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent treatment (ITN) for malaria prevention during pregnancy</td>
<td>2 457 000</td>
<td>2 433 000</td>
<td>2 425 000</td>
</tr>
<tr>
<td>Syphilis detection and treatment</td>
<td>2 425 000</td>
<td>2 396 000</td>
<td>2 350 000</td>
</tr>
<tr>
<td>Detection and management of hypertensive disease of pregnancy</td>
<td>2 463 000</td>
<td>2 472 000</td>
<td>2 430 000</td>
</tr>
<tr>
<td>Detection and management of diabetes of pregnancy</td>
<td>2 484 000</td>
<td>2 475 000</td>
<td>2 473 000</td>
</tr>
<tr>
<td>Detection and management of fetal growth restriction</td>
<td>2 430 000</td>
<td>2 391 000</td>
<td>2 380 000</td>
</tr>
<tr>
<td>Identification and induction of mothers with &gt;41 weeks of gestation</td>
<td>2 467 000</td>
<td>2 448 000</td>
<td>2 442 000</td>
</tr>
<tr>
<td>Skilled care at birth and immediate care for neonates</td>
<td>2 443 000</td>
<td>2 355 000</td>
<td>2 326 000</td>
</tr>
<tr>
<td>Basic emergency obstetric care</td>
<td>2 313 000</td>
<td>2 147 000</td>
<td>2 088 000</td>
</tr>
<tr>
<td>Comprehensive emergency obstetric care</td>
<td>2 146 000</td>
<td>1 824 000</td>
<td>1 723 000</td>
</tr>
</tbody>
</table>

Numbers of stillbirths have been rounded off to the nearest thousand, but percentages of stillbirths averted, are based on actual numbers.

Source: Lancet Stillbirth series 2016

Although global coverage with the measles vaccine is relatively high, coverage with most of the other effective preventive and treatment interventions, remains low, or very low.

In Fig. 15, the bars show the median coverage of essential interventions for the South-East Asia Region across the life-course, and the dots show country-specific data. Regional coverage for essential interventions is also quite low, except for immunization coverage.
**Fig. 15.** Median coverage of all essential interventions for survival of women and children: South-East Asia Region across RMNCAH continuum

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand satisfied by modern methods FP</td>
<td>73</td>
</tr>
<tr>
<td>At least one visit</td>
<td>77</td>
</tr>
<tr>
<td>At least four visits</td>
<td>55</td>
</tr>
<tr>
<td>SBA (birth attended by skilled birth attendant)</td>
<td>72</td>
</tr>
<tr>
<td>Institutional delivery</td>
<td>74</td>
</tr>
<tr>
<td>Birth registration (2010-2018)</td>
<td>66</td>
</tr>
<tr>
<td>Postnatal health check by mothers</td>
<td>38</td>
</tr>
<tr>
<td>Postnatal health check for newborns</td>
<td>47</td>
</tr>
<tr>
<td>Early initiation of ORS treatment (within 1 hr)</td>
<td>55</td>
</tr>
<tr>
<td>Exclusively breastfed milk</td>
<td>53</td>
</tr>
<tr>
<td>ORS treatment</td>
<td>73</td>
</tr>
<tr>
<td>ARI taken to facility</td>
<td>89</td>
</tr>
<tr>
<td>Full immunization</td>
<td></td>
</tr>
</tbody>
</table>

Source: Countdown to 2030 – maternal, newborn and child survival 2017 (UNICEF and WHO)

As shown in the above graph, none of the essential interventions has achieved 90% coverage across the RMNCAH continuum in the SEA Region.

**Fig. 16.** Key points on effective interventions

**Key points**

- Effective interventions that are feasible for implementation in countries are available. These include strategies to both prevent diseases and treat diseases when they occur.

- Interventions that have been proven to be effective for RMNCAH should form the basis of all RMNCAH programmes.

- In resource-low settings, it is important to select high-impact, effective/essential interventions.

- Population-based coverage of most of the effective RMNCAH interventions still remains low in the SEA Region.
EXERCISE A: Review RMNCAH situation and effective interventions

In this exercise, you will answer questions about maternal, newborn and child health epidemiology globally, and maternal and reproductive health planning in your country, or area of work.

1. Enter "T" for the statements that are true. Enter "F" for the statements that are false.

   a. ____ SDG 3.1 on the health target on maternal mortality is to reduce the global maternal mortality ratio to less than 70/100 000 LB, and to ensure that no country has an MMR greater 140/100 000 LB.

   b. ____ Home delivery without a skilled birth attendant is an important contributor to maternal deaths.

   c. ____ In the WHO SEA Region, coverage with 4+ antenatal visits is high, because these interventions have been promoted for a long time.

   d. ____ Women's rights and children's rights are not interrelated, as they belong to two distinct age groups.

2. What are the major causes of maternal mortality in your country/area?

   Is maternal mortality uniform in your country, or are there state and regional differences? What are the differences?

3. What are the major causes of newborn mortality in your country/area?

4. Name three interventions that would have the greatest impact on maternal mortality in your country:

   a) 

   b) 

   c)
5. Does your country have (a) national strategic plan/s or national policy/policies on RMNCAH? If available, list them. If yes, are you using them in your implementation plans?

6. In the following, tick whether each is an intervention or an activity. If it is an intervention, of what type?

<table>
<thead>
<tr>
<th></th>
<th>Intervention</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treatment</td>
<td>Technology</td>
</tr>
<tr>
<td>a</td>
<td>Kangaroo mother care for small babies</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Early initiation of breastfeeding</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Training on IYCF</td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>Prevention and treatment of maternal anaemia</td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>Advocacy meeting for fund allocation for printing of health records</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Procurement of essential medicines</td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>Development of BCC material on immunization</td>
<td></td>
</tr>
<tr>
<td>h</td>
<td>Active management of third stage of labour</td>
<td></td>
</tr>
<tr>
<td>i</td>
<td>Labour room supervision</td>
<td></td>
</tr>
<tr>
<td>j</td>
<td>Care for children with development delays</td>
<td></td>
</tr>
</tbody>
</table>

When you have completed this exercise, tell your facilitator that you are ready for the group discussion.
5.1 The continua of care for RMNCAH

The two guiding principles for planning maternal and reproductive health programmes are:

(1) Continuum of care across the life-cycle (Fig. 17)
(2) Continuum of care across the health system (Fig. 18).

The continuum of care across the life-cycle includes the life stages from adolescent and youth, pre-pregnancy, pregnancy, through birth, the postnatal period, newborn period, infancy and childhood, and the inter-pregnant period for women. Appropriate interventions should be targeted at all of these stages in order to maximize impact. The interventions that are implemented in one stage of the life-cycle may have an impact in another stage (e.g. tetanus toxoid vaccination in pregnancy).

The continuum of care across the health system includes the levels at which interventions are delivered: home and community, first-level health facilities and referral facilities. Implementation must occur at each of these levels as appropriate for interventions to get high coverage. Facility-based interventions should be balanced with those in the home and community, since the prevention and management of reproductive, maternal, newborn, child and adolescent health problems and mortality begins in the home.

Good understanding of two types of continua of care in your settings will allow decisions to be made more easily about:

- what interventions to implement
- where interventions should be implemented.

See Fig. 17, 18 and Table 7 on examples of interventions along the two continua of care.
5.1.1 The continuum of care across the life-cycle

Interventions should be delivered at different stages of the life-cycle. Interventions delivered at one stage may contribute to reduction in morbidity and mortality in another stage of the life-cycle, e.g.:

- Congenital rubella among newborns could be prevented by immunizing children under five years, adolescents and pre-pregnant women.

- Maternal mortality due to heart disease complicating pregnancy, could be prevented, by screening girl children at school and pre-pregnant women of reproductive age for morbidities, and by appropriate management of identified cases.

- Folic acid supplementation for pregnant women will prevent neural tube defects of newborns.

Adopted from the WHO working document on analysis and use of health facility data; guidance for RMNCAH managers October 2019.
Where to implement which interventions will be guided by several factors, including technical complexity, availability of trained staff, acceptability to community members, access to health facilities, demand for service and equity.

Levels for delivery of interventions include:

- **Home and the community**: In order to achieve equity of coverage, many interventions need to be directed at the level of home and community. The community-based health staff or health volunteers (if there are no defined health staff to provide care at home) can be trained to provide care at home. They can also be trained to recognize the signs they need to take the women/mothers/children to the next level of the health system for care. Home and community care could be provided for many interventions such as postnatal/newborn care. Even self-care interventions (e.g. handwashing) are practised in homes and the community. A number of issues are important when developing programmes at this level, including how to deliver key messages, how to support sustained changes in behaviour, and how to train and support community health workers. Community-level interventions could be implemented by conducting outreach clinics (e.g. antenatal, FP, child welfare). When planning community interventions, it is important to involve the community in a meaningful manner.

- **First-level health facilities**: In most settings, this level is required in order to provide additional preventive and treatment services, which cannot be provided or managed at the home and community levels, such as ANC, care during birth and the postpartum period, newborn care, family planning, child care and standard case management and immunization, as well as counselling and referral. Key implementation issues include how to train and supervise health staff, how to manage staff turnover, how to provide medicines and supplies, how to maintain quality of care, and how to better link facilities with communities. This level is very important in achieving universal health coverage.
- Referral health facilities: These are required in order to provide high-level clinical care, such as the management of obstetric and newborn complications, reproductive health problems such as the management of cervical cancer, and for the management of severely ill mothers and children. This level also provides preventive and promotive services such as FP services (most referral hospitals conduct FP clinics and provide post-partum and post-abortion FP services).

All levels have a role in implementation, but the balance between them should be appropriate for local conditions. For example, in areas where access to health facilities is limited, most childbirths may happen at home. In such settings, interventions to improve postnatal care for mother and newborn care (early and exclusive breastfeeding, thermal care, hygienic cord care, extra care for LBW infants, and prompt care-seeking for illness), need to be directed to the home and community in addition to health facilities. At the same time, health facilities need to be strengthened to provide appropriate care for women and children and appropriate RH services, such as screening for cervical cancers.

**Table 7. Selected interventions for improvement of RMNCAH along the continua of care across the health system**

<table>
<thead>
<tr>
<th>Life-cycle</th>
<th>Home and community</th>
<th>First-level health facility</th>
<th>Referral facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>- Promote and support antenatal care</td>
<td>- Tetanus toxoid immunization</td>
<td>Manage complications of pregnancy.</td>
</tr>
<tr>
<td></td>
<td>- Inform and counsel on self-care, nutrition, safer sex, breastfeeding, family planning and danger signs during pregnancy</td>
<td>- Undertake birth and emergency planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Undertake birth and emergency planning, promote sleeping under insecticide-treated bednets (ITN).</td>
<td>- Detect and treat syphilis</td>
<td></td>
</tr>
<tr>
<td>Birth and 1–2 hours after birth</td>
<td>- Promote and support skilled care at birth</td>
<td>- Intermittent preventive therapy (IPT) for malaria</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Promote and support key practices, e.g., clean delivery, social support (companion) during birth, early initiation of breastfeeding, Skin-to-skin contact, Newborn thermal care.</td>
<td>- Prevent mother-to-child transmission of HIV (PMTCT)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Detect complications of pregnancy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Monitor progress during labour</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Encourage social support (companion) during birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provide immediate newborn care (resuscitation if required, thermal care, hygienic cord care, early initiation of breastfeeding)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Prevent mother-to-child transmission of HIV</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Detect obstetric complications, appropriate care and referral.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensure clinical management of obstetric complications</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Life-cycle</th>
<th>Home and community</th>
<th>First-level health facility</th>
<th>Referral facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newborn period</strong></td>
<td>• Promote and support key practices, e.g.</td>
<td>• Provide vitamin K injection soon after birth</td>
<td>Manage severe newborn illness.</td>
</tr>
<tr>
<td></td>
<td>• Exclusive breastfeeding</td>
<td>• Promote exclusive breastfeeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Thermal care</td>
<td>• Ensure thermal care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hygienic cord care</td>
<td>• Ensure hygienic cord care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Extra care of LBW infants including Kangaroo mother care</td>
<td>• Provide extra care for LBW infants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prompt care seeking for illness</td>
<td>• Prevent mother-to-child transmission of HIV</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Manage newborn illness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Continued)</td>
<td></td>
</tr>
<tr>
<td><strong>Infancy and childhood</strong></td>
<td>• Promote and support key practices, e.g.</td>
<td>• Provide immunizations.</td>
<td>Manage severe infant and childhood illness.</td>
</tr>
<tr>
<td></td>
<td>• exclusive breastfeeding</td>
<td>• Provide vitamin A supplementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• complementary feeding and continued breastfeeding</td>
<td>• Ensure standard case management including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• sleeping under ITN</td>
<td>• ORT and zinc for diarrhoea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• handwashing and proper disposal of faeces</td>
<td>• antibiotics for dysentery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• care-seeking for preventive interventions (e.g. immunization)</td>
<td>• antibiotics for pneumonia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• care-seeking for illness</td>
<td>• ART for HIV-exposed and HIV-infected children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• responsive caregiving and opportunities for early learning</td>
<td>• co-trimoxazole prophylaxis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community case management of diarrhoea, pneumonia, malaria and malnutrition.</td>
<td>• antimalarials.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Continued)</td>
<td></td>
</tr>
</tbody>
</table>
5.2 Packaging of interventions

The most cost-effective strategy for implementing RMNCAH interventions is as "packages" of several interventions together. Packaging can be done at the facility level, or at the health worker level. The intervention packages that can be delivered at each level of facility, and those that can be delivered by health workers based on their training and skills, need to be defined.

**Fig. 19. Cost-effective MNH intervention packages**

<table>
<thead>
<tr>
<th>Life-cycle</th>
<th>Home and community</th>
<th>First-level health facility</th>
<th>Referral facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescence</td>
<td>● Promotion of healthy behaviour (e.g. nutrition, physical activity, no tobacco, alcohol or drugs).</td>
<td>● Routine vaccinations (e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles)</td>
<td>● Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury.</td>
</tr>
</tbody>
</table>

Intersectoral: improved living and working conditions including housing, water and sanitation, food security, education and empowerment, especially of girls, folic fortification, safe and healthy work environments for women and pregnant women.

**CARE AT BIRTH, TRIPLE RETURN**
Highest impact, highly cost-effective, benefits women, stillbirths, newborns.

**3 MILLION LIVES SAVED PER YEAR:** running cost US$1.15 per person.

Source: Lancet Every Newborn series, Paper 5
Several RMNCAH intervention packages already exist. Most new interventions can be added, or linked to existing intervention packages. This is not difficult as it is the same health staff who are involved in different tasks. For example, postnatal family planning could be linked with the immunization programme of infants, or with intra-partum and post-partum care. However, evidence-based interventions may be packaged in different ways, depending on the country context.

**Packaging of interventions can reduce programme costs and increase programme effectiveness by:**

- Minimizing programme start-up costs
- Promoting or implementing more than one intervention at the same time
- Reducing the costs of training
- Making monitoring/supervision and disease surveillance more efficient
- Maximizing the impact.

*Example:* Proper training on a package of interventions will potentially reduce maternal and newborn mortality due to obstetric and newborn complications. For this, health staff caring for women during childbirth need to be competent and confident of using a partograph, conducting a clean and safe delivery, performing signal functions of basic emergency obstetric and newborn care (BEmONC) as described in duty lists, and providing essential newborn care. They must also be able to recognize danger signs and make appropriate referrals.
Family planning is relevant not only in pre-pregnancy but also in ANC, postpartum, inter-pregnancy periods. Therefore, some services of family planning will be delivered in other packages as well.

<table>
<thead>
<tr>
<th>Intervention package</th>
<th>Interventions in universal packages (recommended in all settings)</th>
<th>Interventions in situational packages (where warranted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning&lt;sup&gt;26&lt;/sup&gt;</td>
<td>● Health education to women, men, adolescents, families and the community</td>
<td>Prevention of HIV</td>
</tr>
<tr>
<td></td>
<td>● Information on safe sex, family planning, birth spacing, the availability of services including for safe abortion</td>
<td>Screening for cervical cancer.</td>
</tr>
<tr>
<td></td>
<td>● Counselling on, and distribution of contraceptive methods, including emergency contraception</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Screening and prevention of STIs (including HIV)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Appropriate management of the infertile couples</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Appropriate management of methods of choices for family planning (tubal ligation/vasectomy/insertion and removal of implants, difficult removal of devices etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Information, counselling and services for comprehensive SRH, including awareness, screening for, and management of signs of domestic and sexual violence, and contraception (including postpartum FP) for birth spacing.</td>
<td></td>
</tr>
<tr>
<td>Comprehensive abortion care</td>
<td>● Access to, and provision of, safe abortion care, where it is legal</td>
<td>Folic acid supplementation as required.</td>
</tr>
<tr>
<td></td>
<td>● Access to treatment for complications of spontaneous and unsafe abortion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Contraceptive information, counselling and methods</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Screening, treatment and referral for other sexual and reproductive health needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Management of miscarriages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Management of complications of abortion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Pain relief and infection prevention.</td>
<td></td>
</tr>
</tbody>
</table>
### Intervention package

#### Pregnancy care

- Confirmation of pregnancy
- Accurate determination of gestational age
- Monitoring of progress of pregnancy and assessment of maternal and fetal well-being, including nutritional status
- Tetanus immunization, anaemia prevention and control (iron and folic acid supplementation)
- Counselling on family planning, birth and emergency planning
- Detection and management of risk factors, genetic conditions and complications (chronic medical conditions, gestational diabetes, eclampsia and pre-eclampsia)
- Prevention, detection and treatment of communicable and noncommunicable disease, and sexually transmitted and reproductive tract infections, including HIV, TB and syphilis
- Information and counselling on self-care, nutrition, safer sex, breastfeeding, and healthy lifestyle, including harmful effects of smoking and alcohol use
- Recognize and respond to IPV
- Management/referral of mal-presentation, premature rupture of membranes, macrosomia,

#### Childbirth care

- Respectful and skilled birth attendant
- Respectful care at birth
- Monitoring progress during labour
- Social support (companion) during birth
- Infection prevention
- Induction and augmentation of labour
- Active management of third stage of labour
- Immediate newborn care (resuscitation if required, thermal care, hygienic cord care, early initiation of breastfeeding)
- Emergency obstetric and newborn care
- Detection and clinical management of obstetric and newborn complications.

### Interventions in universal packages (recommended in all settings)

- Sleeping under insecticide-treated bed nets (only in malaria endemic area)
- Prevention of mother-to-child transmission of HIV
- Deworming
- Assessment of female genital mutilation.

### Interventions in situational packages (where warranted)

- Prevention of mother-to-child transmission of HIV
- Pain relief
- Postpartum family planning.

(Continued)
<table>
<thead>
<tr>
<th>Intervention package</th>
<th>Interventions in universal packages (recommended in all settings)</th>
<th>Interventions in situational packages (where warranted)</th>
</tr>
</thead>
</table>
| Postpartum care      | ● Counselling on self-care, recognition of danger signs and key health practices  
● Assessment of maternal well-being, including maternal nutrition  
● Prevention and management of postnatal complications  
● Family planning (including postpartum FP)/birth spacing information and counselling  
● Reporting birth and death (vital registration)  
● Detection of maternal morbidities such as fistula, depression, etc.                                                                                                                                                                                                 | Prevention of mother-to-child transmission of HIV  
Prevention and management of intimate partner violence.                                                                                                                                                                                                  |
| Newborn care         | ● Rooming in  
● Vitamin K injection soon after birth  
● Promotion, protection and support for exclusive breastfeeding  
● Thermal care  
● Infection prevention: general hygiene, hand washing, cord care and safe disposal of baby’s faeces  
● Immunization (e.g. BCG and hepatitis B)  
● Extra care for LBW babies, including kangaroo care  
● Prevention of indoor air pollution  
● Newborn stimulation and play  
● Recognition of problems, illness and timely care-seeking  
● Treatment of local infections (skin, cord, eye, mouth)  
● Management/referral of a newborn with any sign of severe illness (prematurity/PSBI/asphyxia), injury, jaundice, feeding problem or malformation  
● CPAP to manage respiratory distress  
● Prophylactic ART for babies exposed to HIV.                                                                                                                                                                                                 |
### Interventions in universal packages (recommended in all settings)

**Infancy and childhood care**
- Promotion and support for:
  - Exclusive breastfeeding (exclusive for six months and continued)
  - Appropriate complementary feeding
  - Child stimulation and play
  - Handwashing
  - Sanitation and appropriate disposal of faeces
  - Recognition of signs of illness and timely care-seeking
  - Home care during illness

- Identification and management/referral of children with signs of severe illness, diarrhoea, pneumonia, febrile illness, malnutrition
- Immunization
- Vitamin A/iron supplementation where appropriate
- Assessment of nutritional status and feeding counselling
- Micronutrient supplementation
- Prevention and response to child maltreatment
- Care of children with development delays
- Management of children with congenital abnormalities and disabilities.

### Interventions in situational packages (where warranted)

- Care of children infected with/exposed to HIV
- Provision and promotion of insecticide-treated bednets.

(Continued)
<table>
<thead>
<tr>
<th>Intervention package</th>
<th>Interventions in universal packages (recommended in all settings)</th>
<th>Interventions in situational packages (where warranted)</th>
</tr>
</thead>
</table>
| Adolescent health    | • Routine vaccinations (e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles)  
  • Promotion of healthy behaviour (e.g. nutrition, physical activity, no tobacco, alcohol or drugs)  
  • Prevention, detection and management of anaemia, especially for adolescent girls  
  • Comprehensive sexuality education  
  • Information, counselling and services for comprehensive sexual and reproductive health including contraception  
  • Psychosocial support and related services for adolescent mental health and well-being  
  • Prevention of, and response to, sexual and other forms of gender-based violence  
  • Prevention of, and response to, harmful practices such as female genital mutilation and early and forced marriage  
  • Prevention, detection and treatment of communicable and noncommunicable diseases, and sexually transmitted and reproductive tract infections, including HIV, TB and syphilis  
  • Detection and management of hazardous and harmful substance use  
  • Parent skill training, as appropriate, for managing behavioural disorders in adolescents  
  • Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury  
  • Prevention of suicide and management of self-harm/suicide risks. | Voluntary medical male circumcision in countries with HIV generalized epidemics |

Packaging is a way of combining RMNCAH interventions, and is essential for making programmes feasible, as it reduces programme costs and improves programme effectiveness and sustainability.
5.3 Coverage, equity and quality

5.3.1 Coverage

The coverage of an intervention is the proportion of the target group receiving the intervention. The extent to which an intervention reaches the target group determines the magnitude of the impact. An intervention coverage of 99% – “universal coverage” – is expected to bring about the maximum impact possible from an evidence-based intervention (refer to Table 6).

5.3.2 Equity

Equity in health care means "leaving no one behind" by ensuring that there should be no avoidable or remediable health-related differences among populations or groups defined socially, economically, demographically or geographically. There should be no differences in health status, coverage, or access to the resources\(^{27}\) needed to improve and maintain health. Women and children who are most likely to experience health inequities include those of poor or marginalized groups, and those of racial and ethnic minorities. RMNCAH programmes must plan activities to remedy and prevent inequities in implementing interventions.

5.3.3 Quality

Quality means that the health services are provided according to technical standards and in a way that is appropriate for that target population. Increasing the quality of services often increases the demand for them. WHO has prepared standards for the quality of care for maternal and newborn health, paediatric care and adolescent health.

For instance, in a case where tetanus toxoid immunization is received by all the pregnant women in an area, but there are issues in the cold chain maintenance. In this situation, although the intervention coverage can be 100% or universal, the coverage will not be 100% effective due to issues of quality of vaccines. Similarly weighing of children alone is not sufficient without giving counselling on feeding, food security and care practices.

5.3.4 Effective coverage

"Effective coverage" is defined as high and equitable coverage of quality care for all in order to reduce and eliminate preventable mortality and morbidity, improve nutrition status and achieve desired fertility. When an intervention reaches the total target population including vulnerable populations (equity) while maintaining quality, then that intervention coverage will be effective.

Therefore, to achieve the desired impacts, you need to choose appropriate interventions and also need to ensure effective coverage by addressing equity and quality, during the implementation of selected interventions.

5.4 Integration and coordination with other programmes bring opportunities

RMNCAH programmes need to work in collaboration and coordination with other health programmes such as the Expanded Programme of Immunization, the National Malaria Control Programme, the National STD AIDS Programme, and the national nutritional programmes, which address the same target groups and have activities in common. Some of these programmes may be able to prepare an implementation plan together and integrate some activities. Even if separate plans are written, it is important to communicate with other health programmes to understand what they have accomplished and what is planned, so that your plan can avoid conflicts or duplication, and better meet the needs of the target population.

Coordinating with programmes beyond the Ministry of Health can also bring opportunities, such as providing information to families and communities. For example, programmes involved in food security and distribution and income-generation programmes, may have contact with community members, and may be willing to address RMNCAH-related topics that complement their purposes. Similarly, sectors dealing with water, sanitation and environment health, indoor air pollution will significantly contribute to improving RMNCAH as important determinants.

EXERCISE B - Review intervention packages and the continua of care


- For each intervention, specify the package in which the intervention could logically be implemented (refer to Tables 7 and 8). Place a tick to indicate the levels at which implementation of the package could logically take place (home and community, first-level health facility or referral facility). The first intervention has been done as an example.

2. Are there groups or populations that experience inequities in health in your country? Give some examples.
### Table 9: Checklist of interventions, packages and levels of implementation

<table>
<thead>
<tr>
<th>Intervention(s)</th>
<th>Intervention package(s)</th>
<th>Level/s for implementation of the package</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Iron and folic acid supplementation for pregnant women</td>
<td>Care during pregnancy or ANC</td>
<td>✔</td>
</tr>
<tr>
<td>b) Tetanus immunization of pregnant women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Treatment of eclampsia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Screening for syphilis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Routine monitoring of labour with partograph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Counselling and support for proper complementary feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Immediate newborn care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Counselling and services for birth spacing/family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Provision of immediate postpartum contraceptive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Management of obstetric complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Give zinc and oral rehydration solution (ORS) to children with diarrhoea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) Extra care for LBW infants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) Screening for cervical cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Definitions of terms

In order to plan and manage programmes, you need to understand some terms that are commonly used,

1. Goals and objectives
2. Results framework for monitoring and evaluation of the programme
3. Indicators:
   - activity-related indicators
   - population-based coverage indicators
   - impact indicators
4. Targets

The ultimate goal of any public health programme is to reduce mortality and morbidity and improve the well-being of the people. To achieve this goal, programmes must implement evidence-based interventions with adequate coverage, while ensuring equity and quality to achieve the desired effect of the interventions.

### 6.1 Goals and objectives

Programmes must define their ultimate goals clearly (what the programme is going to achieve in the long term), and their objectives (what the programme is going to achieve in the shorter term, in order to reach the goals).
6.1.1 Goals

Goals are long-term improvements in health status (impact) that are expected by a programme. Goals reflect the desired changes in nutritional status, morbidity, mortality and fertility, and may take 5–10 years or longer, to achieve. An ideal goal will have a time frame and a measurable value. Countries may write goals in different ways. Given below are a few examples.

- To reduce neonatal mortality to 12/1000 LB by 2030.
- To reduce maternal mortality by two thirds from the 2010 value by 2030.
- To reduce the stillbirth rate to 9/1000 total births by 2030.
- To reduce low birth weight by 30% from the current level by 2030.
- To reduce TFR to 2.5 by 2025.
- To reduce incidence of cervical cancer by 20% from the current value by 2030.

All RMNCAH evidence-based interventions implemented by the programme, are directed at achieving the programme’s goals.

6.1.2 Objectives

Objectives are what the programme is going to achieve in the shorter term in order to reach the goals.

The objective of any RMNCAH programme is to:

- increase population-based coverage of the intervention
- increase quality
- reduce inequity.

Ideally, an objective should be quantified and have a time frame.

Examples:

- To increase the proportion of women of reproductive age who are using (or whose partners are using) a contraceptive method, to 55% by 2022 (coverage).
- To increase the proportion of infants under six months who are exclusively breastfed, to 85% by 2022 (coverage).
- To increase the proportion of children under five with pneumonia who receive an appropriate antibiotic, to 75% by 2022 (quality).
- To increase the proportion of women from rural areas receiving skilled attendance at delivery, to 60% by 2022 (equity).
If objectives are not met, it is unlikely that goals for reductions in maternal and child morbidity and mortality and improvement in nutritional status, will be achieved.

6.2 Results framework for monitoring implementation of the programme

Fig. 20. Framework for monitoring implementation of the programme

Programme starts with utilizing the inputs received.

**Inputs** are resources that are needed to implement activities. These can be in terms of human resources, funds, supportive policies, logistic support, etc. With the support of inputs, activities will be implemented. In implementation plans we focus on first three columns and in strategic plans the last two columns.

Activities are planned and conducted to achieve the **outputs**, such as to:

- increase the **availability** of services to the target population and their access to the services;
- improve the **demand** for the services;
- improve the **quality** of the services provided for the target population;
- improve the **knowledge and key family practices** in RMNCAH.

Most activities will affect one or more of these aspects. Therefore, the successful implementation of activities will result in expected outputs, e.g. the training of community health workers on modern contraceptive methods will improve the availability of and access to family planning methods.
These programme outputs will lead to increased population coverage of interventions, i.e., programme **outcome**. For example, the improved availability and accessibility of family planning services will increase the uptake of contraceptives, thereby improving the contraceptive prevalence rate (population-based intervention coverage).

Programme **outcomes**, in turn, contribute to a change in morbidity, mortality, malnutrition and fertility levels in the population, i.e. programme **impact**. For example, increased CRP will reduce TFR and maternal mortality (the lifetime risk of maternal death).

Fig. 20 shows the application of results framework in programme planning.

### 6.3 Indicators

Indicators are used to measure and quantify what a programme is accomplishing. An indicator has two components: the numerator and denominator. The numerator is the top part, which represents the actual number of people/events that exhibit a certain trait. The denominator is the bottom number, which shows the total number possible of people/events expected to exhibit that trait.

Indicators are measured repeatedly over time to track the programme’s progress. Different steps in the implementation would be measured using different indicators. It is the responsibility of the planning team to decide on the appropriate indicators for each step along with targets, and on the data sources for each, during the planning itself. A series of possible indicators can be listed, and most appropriate and feasible indicator/s can be selected, after obtaining consensus from the planning team.

**An indicator is a measurement that is repeated over time to track progress**

Different programmes use different terminology, as shown in Fig. 21.

**Fig. 21. Results framework for the measurement of health**
6.3.1 Activity-related indicators

Programme activities are the work done to implement the interventions and focus of the implementation plan. Activities are planned and implemented for various reasons, such as to increase the availability, or access of services for the target population, to improve the demand for the services, to improve the quality of the services provided, or to increase the knowledge of families and communities, regarding RMNCAH.28

Most activities will affect one or more of these aims. Indicators that measure the inputs, the process of implementation and the results of the activities, are called activity-related indicators in this course. The results of activities are called outputs.

The activity-related indicators will track the progress of the implementation of planned activities. These indicators will measure whether planned activities were implemented, and the extent of completion. They may track the number completed, or, the proportion of the planned activities that were completed.

For example:
- The proportion of planned IMNCI training courses for first-level health facility workers that were conducted.
- The proportion of the planned number of CHWs that were recruited and trained on basic ANC and child care, during the last six months.
- The proportion of planned supervisory visits that were completed last year.

Output indicators (results of activities):
These are indicators that describe the results of activities. That is, whether there is an improvement (or a decline) in the availability of, or access to, a service, the demand for the service, the quality of the service or, in the knowledge of families and communities, regarding RMNCAH. For example:
- The proportion of health facilities that have at least 80% of staff caring for women during childbirth, who are trained in BEmONC.
- The proportion of villages in the district that have an active “mother support group”,
- The proportion of BEmONC facilities that provide 24/7 services.
- The proportion of newly-trained primary health care workers who conducted 10 or more household visits to promote key family and community practices, in the previous month.

Many of the above indicators may be collected from programme records as a part of monitoring. Most of the programmes do not have data on these areas and may consider only resources used such as money spent.

---

28 Specific definitions of availability, access, demand, quality and knowledge of families and community are provided in the glossary at the end of this module and are described in more detail in Module 2: Planning Implementation.
However, indicators of the quality of care provided at health facilities, are measured by a special health facility survey. A health facility survey measures whether health workers provide a service correctly to the target population, when they are seen at health facilities. For example, it can measure indicators such as:

- The proportion of sick children attending health facilities who need an antibiotic and/or an antimalarial, and are prescribed the medicine correctly.
- The proportion of women who have complications during childbirth, are managed correctly and referred to higher level institutions in time.
- The proportion of caregivers of sick children prescribed ORS, and/or an antibiotic and/or antimalarial at a health facility, who can describe correctly how to give the treatment.
- The proportion of children who need immunization and leave the facility with all needed immunization.
- The proportion of mothers/caregivers at the 9-month vaccination session for children, who received accurate instructions on immunization.

6.3.2 Population-based coverage indicators (outcome indicators)

Population-based coverage is the proportion of the target population (pregnant women, mothers, children and their caregivers) that needs an intervention in a given geographical area, and receives that intervention. The denominator of a coverage indicator is the size of the target population living in the geographical area. Coverage indicators are mainly considered in strategic planning. These materials emphasize that programme activities should be directed towards providing interventions to as many mothers, newborns, children and adolescents as possible, including all geographical and social subgroups in an area. High levels of population coverage will be key indicators of an effective programme. Examples of population-based coverage indicators (in a given geographical area) include:

- The proportion of children with suspected pneumonia who received an antibiotic = the number of children with suspected pneumonia who received an antibiotic / total number of children with suspected pneumonia x 100.
- The proportion of children under six months of age who are exclusively breastfed.
- The proportion of children aged 12–23 months who are fully immunized.
- The proportion of deliveries (pregnant women giving birth), attended by a skilled birth attendant.
- The proportion of women aged 15–49 years using modern contraceptive methods.
- The proportion of women aged 35 and 45 years, who were screened for cervical cancer.

29 Some organizations also use the word “coverage” to describe the proportion of health facilities that provide a particular service, or the proportion of the population that lives within a specific distance of a health facility, that provides a particular service. These are not coverage indicators. They are output indicators, which give the idea of availability and accessibility of services. This material limits the definition of coverage to the proportion of the target population that receives the service/intervention.
6.3.3 Impact indicators

The impact of a programme is the change in reproductive, maternal, newborn, child and adolescent health, or the survival and improvement of nutritional status and reduction of fertility, that results from improved coverage of the population with effective interventions.

Impact is the ultimate purpose of an RMNCAH programme; it is what you hope to achieve in the long term. Expected impact changes are programme goals. An impact indicator is stated as a measurement of morbidity, mortality, nutritional status or fertility and has, as its denominator, the target population in the country, region or province, etc. For example, impact indicators would be:

- under-5 mortality
- maternal mortality
- neonatal mortality (stillbirth) rate
- cause-specific child/maternal mortality
- the proportion of under-5 children that is underweight (low weight for age)
- total fertility rate/adolescent fertility rate
- mortality/incidence due to cervical cancer
- case-fatality rate due to PPH.

Significant and measurable changes in such indicators are expected over periods of 5–10 years or longer, and mainly focused in strategic plans of the country.

Impact indicators are measured using large-sample household surveys, which allow mortality rates/ratios to be calculated. Mortality rates can also be derived from civil registration and vital statistics (CRVS) systems.
Fig. 22. Example of indicators for programme monitoring

**Example of indicators**

**Population-based coverage indicator (Outcome indicator):**

- Proportion of pregnant mothers in the district who received skilled care during childbirth
- Proportion of pregnant women who have had four antenatal clinic visits
- Proportion of mothers who received postnatal care within 24 hours of childbirth.

**Output indicators: (results achieved)**

- Proportion of staff in health facilities who received competency-based training on BEmONC
- Proportion of first level (BEmONC) health facilities in the district that provide basic emergency obstetric and newborn care (24 hours/day, 7 days/week)
- Proportion of health staff who were trained on insertion and removal of contraceptive implants practicing the methods as per the checklist
- Proportion of health facilities that received a supervisory visit in the previous six months.

**Activity-related indicators**

**Process indicators: (completion of activity)**

- Number of supervisors who conducted two supervisory visits each month during the last quarter
- Number of BEmONC training programmes held in the last quarter out of the total number planned
- Number of community education programmes held last quarter
- Number of meetings held with community leaders against the planned number.

### 6.4 Targets

A target is a quantified statement of **desired change** in a key indicator over a given **time period** in a **specified geographical area**. Review/evaluation compares the target and the actual level of achievement after the given period of time, to determine whether or not the programme is being implemented effectively.
A programme will revise and add to its targets, as it adds new activities. However, the list of targets should never be too long. A limited number of targets should be selected and kept simple. The selected targets must be useful for planning activities, identifying resource needs and for evaluation. Usually, impact and outcome targets are defined in strategic plans at the national level.
EXERCISE C: Review planning terms and concepts

1. Decide whether each indicator given in Table 10 is activity-related, coverage or impact indicator, and place a tick in the appropriate column.

Table 10: Checklist of indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Activity-related indicator (completion of activities or, results of activities)</th>
<th>Coverage indicator (target population receiving the intervention)</th>
<th>Impact indicator (health status)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Proportion of health workers scheduled to be trained in IMNCI, who received the training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Proportion of births attended to by skilled health personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Proportion of children under five years who are wasted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Proportion of health facilities with at least 60% of midwives, trained and competent in performing BEmONC signal functions</td>
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<td></td>
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</tr>
<tr>
<td>e) Contraceptive prevalence rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Percentage of women receiving at least four antenatal visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Proportion of facilities conducting maternal and perinatal death surveillance and response (MPDSR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Proportion of facilities with all essential vaccines available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Proportion of planned CHW training sessions completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Proportion of villages with a trained CHW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Proportion of children under six months of age who are exclusively breastfed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) Maternal mortality ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Read the phrase in the left column of the box. Then choose the phrase from the right column of the box that will best complete the sentence. Draw a line to connect them.

| A | ● A population-based coverage indicator | ● is measured with a health facility survey |
| B | ● An indicator of population-based coverage with ANC | ● has the planned activities as the denominator |
|   | ● An indicator of the quality of ANC for pregnant women at facilities | ● has the number of pregnant women in the geographical area as the denominator |
|   | ● An indicator of planned activities completed | ● has the number of pregnant women who came to a health facility for ANC as the denominator |
| C | ● An example of a target for improvement in population-based coverage with an intervention is: | ● in 20XX, 75% of villages will have a trained CHW to identify and provide ORS/ORT for children’s diarrhoea and refer all who need treatment |
|   | ● An example of a target for improving quality is: | ● in 20XX, 85% of the trained midwives will follow guidelines on BEmONC |
|   | ● An example of a target for improving access is: | ● in 20XX, 80% of women will be making four antenatal clinic visits |

When you have completed this exercise, discuss your work with a facilitator.
Global Strategy for women's, children's and adolescents' health (2016-2030)

SURVIVE: End preventable deaths

- Reduce global maternal mortality to less than 70 per 100,000 live births
- Reduce newborn mortality to at least as low as 12 per 1000 live births in every country
- Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country
- Reduce global stillbirth rate to 9 per 1000 total birth and individual countries to not more than 12 per total births*
- End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
- Reduce by one third premature mortality from noncommunicable diseases and promote mental health and well-being
THRIVE: Ensure health and well-being

- End all forms of malnutrition and address the nutritional needs of adolescent girls, pregnant and lactating women, and children
- Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights
- Ensure that all girls and boys have access to good quality early childhood development
- Substantially reduce pollution-related deaths and illnesses
- Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines

TRANSFORM: Expand enabling environments

- Eradicate extreme poverty
- Ensure that all girls and boys complete free, equitable and good quality primary and secondary education
- Eliminate all harmful practices and all discrimination and violence against women and girls
- Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene
- Enhance scientific research, upgrade technological capabilities and encourage innovation
- Provide legal identity for all, including birth registration
- Enhance the global partnership for sustainable development

*Targets on stillbirth are not identified in SDG or Every Newborn Action Plan (ENAP)
Sexual and reproductive health and rights & rights of women and children

What is sexual and reproductive health?

Sexual and reproductive health (SRH) is an essential component of the universal right to the highest attainable standard of physical and mental health, as enshrined in the Universal Declaration of Human Rights (1948) and other international human rights conventions, declarations and consensual agreements.

SRH needs must be met for both men and women. Human rights standards require states to respect, protect, and fulfil the right to SRH. States must also ensure that individuals have the opportunity to actively participate in the development of a health-care policy and in individual care decisions, including determining whether and when to have children; and in protecting the rights of others to SRH, including through ensuring violence-free relationships and homes, and in seeking information, education and care for children.

What are sexual and reproductive rights?

SRH rights, including access to SRH care and information, as well as autonomy in sexual and reproductive decision-making, are human rights; they are universal, indivisible and undeniable.

Such rights are grounded in other essential human rights, including the right to health, the right to be free from discrimination, the right to privacy, the right not to be subjected to torture or ill treatment, the right to determine the number and spacing of one's children, and the right to be free from sexual violence.

Sexual and reproductive rights (SRR) are most clearly defined in the 1994 International Conference on Population and Development’s (ICPD) Programme of Action, which took place in Cairo, Egypt. Among the elements of comprehensive SRR outlined in the Programme of Action are:
• voluntary, informed, and affordable family planning services;
• prenatal care, safe motherhood services, assisted childbirth from a trained attendant (e.g. a physician or midwife), and comprehensive infant health care;
• prevention and treatment of sexually transmitted infections (STIs), including HIV and AIDS, and cervical cancer;
• prevention and treatment of violence against women and girls, including torture;
• safe and accessible post-abortion care and, where legal, access to safe abortion services;
• sexual health information, education and counselling to enhance personal relationships and quality of life.

Rights of women and children

There are two important United Nations (UN) treaties that have great relevance to the rights of women and children. These are the Convention on Elimination of all Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC). CEDAW was adopted by the UN General Assembly in 1979, and entered into force in 1981. CRC was adopted by the UN General Assembly in 1989, and entered into force in 1990. CEDAW has been ratified by 163 countries and the CRC by 191 countries.

The rights of women and children are interrelated; a significant percentage of infant deaths are attributable to the poor health and nutrition of the mother during pregnancy, and in the immediate postpartum period.

CRC and CEDAW recognize that women and children have specific needs that have been historically neglected or overlooked by societies; neglect that is both a cause and a result of the specific forms of discrimination that these groups suffer from.

Rights are not luxuries. Although rights cannot be realized if needs are not met, simply meeting needs is not enough.

The problems facing vulnerable women and children have immediate, underlying and structural causes and many have common roots. These could be discrimination in various forms, including gender bias, unsafe environments or chronic poverty. The root causes of preventable death and illness, for example, are often a violation of civil and political rights. The CRC specifically mentions the child's right to life, survival, development, and the best interests of the child.
Some principles shared by CEDAW and CRC are:

- **Accountability**: Duty bearers (primarily the State, but also parents, teachers and others) need to be held accountable for their obligations and responsibilities. Systems of accountability may include legal redress but can also be promoted more broadly by fostering transparency and a free media.

- **Universality**: All people, by virtue of being human, are holders of human rights.

- **Indivisibility**: All rights have equal status and are interdependent. The promotion of one right does not justify the violation of another.

- **Non-discrimination**: All individuals are entitled to human rights without discrimination of any kind on the basis of race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status.

- **Participation**: All individuals are entitled to active, free and meaningful participation in the fulfilment of their rights.
ANNEX 3

List of effective RMNCAH interventions

Examples of effective interventions for improving RMNCAH and survival

The interventions included in this list are not static. This list will be periodically updated, based on emerging evidence. Regional and national strategic plans also contain updated interventions.

Adapted from the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030): Evidence-based health interventions for women’s, children’s and adolescents’ health, essential nutrition actions: mainstreaming nutrition through the life-course and packages of interventions for family planning, safe abortion care, and maternal, newborn and child health.

REPRODUCTIVE AGE (including pre-pregnancy)

- Information, counselling and services for comprehensive SRH, including contraception.
- Prevention, detection and treatment of communicable and noncommunicable diseases and sexually transmitted and reproductive tract infections, including HIV, TB and syphilis.
- Iron/folic acid supplementation (pre-pregnancy).
- Screening for, and management of, cervical and breast cancer.
- HPV vaccination.
- Safe abortion (wherever legal), post-abortion care.
- Prevention of, and response to, sexual and other forms of gender-based violence.
- Pre-pregnancy detection and management of risk factors (nutrition, obesity, tobacco, alcohol, mental health, environmental toxins) and genetic conditions.
• Early and appropriate antenatal care, including identification and management of gender-based violence.

• Accurate determination of gestational age.

• Screening for maternal illness.

• Screening for hypertensive disorders.

• Iron and folic acid supplementation.

• Tetanus immunization.

• Counselling on family planning, birth and emergency preparedness.

• Prevention of mother-to-child transmission of HIV, including with antiretrovirals.

• Prevention and treatment of malaria including through the use of insecticide-treated bednets, and intermittent preventive treatment in pregnancy.

• Cessation of smoking.

• Screening for and prevention and management of STIs (syphilis and hepatitis B).

• Identification and response to intimate partner violence.

• Dietary counselling for healthy weight gain and adequate nutrition.

• Detection of risk factors for, and the management of, genetic conditions.

• Management of chronic medical conditions (e.g. hypertension, pre-existing diabetes mellitus).

• Prevention, screening and treatment of gestational diabetes, eclampsia and pre-eclampsia (including timely delivery); screening and treatment of heart diseases, etc.

• Management of obstetric complications (preterm, premature rupture of membranes, macrosomia, etc.).

• Antenatal corticosteroids for women at risk of birth from 24–34 weeks of gestation, when appropriate conditions are met.

• Management of malpresentation at term.

• Community participation in quality improvement processes for maternity care, to improve the quality of care from the perspectives of women, communities and health-care providers.

• Management of abortion, and post-abortion family planning counselling and services (including threatened or complete abortion, incomplete abortion with manual vacuum aspiration, complicated abortion).

• Management of ectopic pregnancy.

• Birth and emergency preparedness.
LABOUR AND CHILDBIRTH

- Facility-based childbirth with a skilled birth attendant.
- Birth companion of choice.
- Pain relief during labour.
- Routine monitoring with partograph with timely and appropriate care.
- Active management of third stage of labour.
- Management of prolonged or obstructed labour, including instrumental delivery and caesarean section.
- Caesarean section for maternal/ fetal indications.
- Induction of labour with appropriate medical indications.
- Management of postpartum haemorrhage.
- Prevention and management of eclampsia (including with magnesium sulphate).
- Detection and management of women with, or at risk of, infections (including the prophylactic use of antibiotics for caesarean sections).
- Screening for HIV (if not already tested), and prevention of mother-to-child transmission.
- Hygienic management of the cord at birth, including the use of chlorhexidine where appropriate.
- Safe blood transfusion.

POSTNATAL PERIOD (mother)

- Management of postpartum haemorrhage.
- Prevention and management of eclampsia.
- Prevention and treatment of maternal anaemia.
- Detection and management of postpartum sepsis.
- Family planning advice and contraceptives, routine postpartum examination and screening, and services for cervical cancer in the appropriate age group.
- Screening for HIV and the initiation or continuation of antiretroviral therapy.
- Identification of, and response to intimate partner violence.
- Early detection of maternal morbidities (e.g. fistula).
- Screening and management for postpartum depression.
- Nutrition and lifestyle counselling, management of inter-partum weight.
NEWBORN PERIOD

- Vitamin K injection soon after the birth.
- Immediate drying and thermal care.
- Neonatal resuscitation with bag and mask.
- Early initiation of breastfeeding (within the first hour).
- Optimal timing of umbilical cord clamping.
- Hygienic cord and skin care.
- Initiation of prophylactic antiretroviral therapy for babies exposed to HIV.
- Kangaroo mother care for small babies.
- Extra support for feeding small and preterm babies with breast milk.
- Presumptive antibiotic therapy for newborns at risk of bacterial infection.
- Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome.
- Detection and case management of possible severe bacterial infection.
- Management of newborns with jaundice.
- Detection and management of genetic conditions.

INFANCY AND CHILDHOOD

- Exclusive breastfeeding for six months; continued breastfeeding and complementary feeding from six months.
- Dietary counselling for prevention of undernutrition, overweight and obesity.
- Responsive caregiving and stimulation.80
- Routine immunization (including haemophilus influenzae, pneumococcal, meningococcal and rotavirus vaccines).
- Periodic vitamin A supplementation where appropriate.
- Iron supplementation where appropriate.
- Prevention and management of childhood illnesses including malaria, pneumonia, meningitis and diarrhoea.
- Weight and height or length assessments for children under five years of age.
- Case management of severe acute malnutrition and treatment for wasting.
- Management of moderate acute malnutrition (appropriate breastfeeding, complementary feeding, and supplementary feeding where necessary).

● Zinc supplementation with increased fluids, and continued feeding for management of diarrhoea in children.

● Comprehensive care of children infected with, or exposed to, HIV.

● Case management of meningitis.

● Prevention and response to child maltreatment.

● Prevention of harmful practices including female genital mutilation.

● Care for children with developmental delays.

● Treatment and rehabilitation of children with congenital abnormalities and disabilities.

**ADOLESCENCE**

● Routine vaccinations (e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles).

● Promotion of healthy behaviours (e.g. nutrition, physical activity, no tobacco, alcohol or drugs).

● Prevention, detection and management of anaemia, especially for adolescent girls.

● Comprehensive sexuality education.

● Information, counselling and services for comprehensive sexual and reproductive health including contraception.

● Psychosocial support and related services for adolescent mental health and well-being.

● Prevention of, and response to, sexual and other forms of gender-based violence.

● Prevention of, and response to, harmful practices such as female genital mutilation, and early and forced marriage.

● Prevention, detection and treatment of communicable and noncommunicable diseases and sexually transmitted and reproductive tract infections, including HIV, TB and syphilis.

● Detection and management of hazardous and harmful substance use.

● Parent skill training, as appropriate, for managing behavioural disorders in adolescents.

● Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury.


(Note: Categorization of the effective interventions for the maternal and reproductive health is made on the principle of continuum of care.)
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### Glossary

(defined as used in these modules)

<table>
<thead>
<tr>
<th>term</th>
<th>definition</th>
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</thead>
<tbody>
<tr>
<td>access</td>
<td>the extent of the population’s ability to reach and use health services, when they are available. Possible barriers to access include distance, finances (unable to afford costs of transport, goods or services), culture (husband opposing the woman using family planning/ institutional care during pregnancy and childbirth, husband or other family members may not agree for women to go/ take their sick children to a health facility on their own), or time limitations.</td>
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<tr>
<td>activity</td>
<td>work (a group of tasks) that is done to implement interventions.</td>
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<tr>
<td>activity-related indicator</td>
<td>a measurement of completion of an activity or the result of activities that is repeated over time to assess progress.</td>
</tr>
<tr>
<td>availability</td>
<td>the extent that the health services (preventive and treatment) are available to those who need them. For example, the availability of counselling on breastfeeding (preventive service) can be improved by training health workers on breastfeeding counselling. The availability of treatment services can be improved by increasing the opening hours of the clinic, by increasing the number of health workers available to run the clinic, and by ensuring regular supplies of necessary medicines.</td>
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<tr>
<td>continuum of care</td>
<td>uninterrupted sequence of care. The continuum of care for mother and child includes care during pre-pregnancy, pregnancy, through birth, and postnatal/newborn period, infancy and childhood. The continuum of care across the health system includes care in the home and community, first-level health facilities and referral facilities.</td>
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(Continued)
| **coverage** | proportion of the target population in a geographical area that receives an intervention. Intervention coverage is the proportion of the target group in the population who needed the intervention and have received it. Coverage is a population-based indicator, usually measured in a community/household survey. |
| **coverage indicator** | a measurement of how well interventions are reaching the target population that is repeated over time to assess progress. The denominator of a coverage indicator is the target population in a geographical area. |
| **demand** | motivation to seek and make use of the health services. Improved demand indicates that clients have knowledge of the availability and benefits of the services and are motivated to use them. |
| **effective** | proven to have impact on health status (morbidity, mortality or nutritional status) when used under programme conditions. |
| **efficacious** | proven to have impact in controlled research settings. |
| **equity** | In health care, no health-related differences among populations or groups to be defined socially, economically, demographically or geographically; specifically, there should be no differences in health status, coverage or access to the resources needed, to improve and maintain health. |
| **evaluation** | The process of assessing a programme's status, achievements and impact, in order to detect and solve problems, and plan future emphases. |
| **first-level health facility** | A facility that provides basic preventive and treatment services, such as standard case management and immunization for children, family planning, ANC, (perhaps) services to conduct clean delivery, as well as counselling and referral. Such a service is considered the first facility within the health system, where the population of an area seeks care. A first-level health facility may be a health centre, clinic, rural health post, dispensary or the outpatient department of a small hospital. |
| **goal** | Long-term improvements in health and survival that a programme aims to achieve. For example, SDG aims to reduce the global maternal mortality ratio to less than 70/100 000 LB, by 2030. |
| **health facility survey** | A method of data-collection. Surveyors visit a representative sample of health facilities to ask a series of standard questions, and make observations to investigate the quality of care received by well and sick children, pregnant mothers or women of reproductive age attending first-level health facilities. For the WHO Health Facility Survey, health workers are observed and their practices compared with immunization, family planning, and IMCI and PCPNC clinical standards, to determine whether the clients (patients) are managed correctly. The survey measures key indicators of the quality of health worker practices, and the availability of facility support required for quality practices, such as supervision, essential medicines, equipment, vaccines and supplies. Interviews with caregivers and health workers are often included. |
**household or community survey**

A method of data collection. Surveyors visit a representative sample of households to ask a standard series of questions to measure intervention coverage (such as the treatment of diarrhoea or pneumonia, appropriate complementary feeding, feeding sick children, or exclusive breastfeeding) and other indicators of family and community practices (such as action taken by families when children are sick).

Small-sample household surveys can also measure activity-related indicators among the population, such as the availability of antenatal care, immunization and the knowledge among families about reproductive, maternal newborn and child health-related practices.

Large-scale household surveys, usually undertaken at the national level, are required to calculate mortality rates. Commonly conducted large-scale surveys include the DHS survey (http://www.measuredhs.com) and the UNICEF MICS3 survey (http://www.childinfo.org/mics/mics3), which require extensive resources.

**impact**

A change in mortality, morbidity or nutritional status because of programme(s) activities.

**impact indicator**

A measurement of morbidity, mortality or nutritional status that is repeated over time, to track progress.

**implementation plan**

An operational plan that describes how priority interventions will be delivered, and what activities and resources will be required in the next 1–2 years.

**indicator**

A measurable number, proportion, percentage or rate that suggests or indicates the extent of a programme's achievements or the level of some condition among the population; a measurement that is repeated over time to track progress.

**infant**

Child from birth to age of one year.

**intervention**

Treatments, technologies and key family practices that prevent, or treat illness and reduce death. RMNCAH interventions are treatments, technologies and key family practices that prevent or treat illness, and reduce deaths in children and mothers.

**intervention package**

Several interventions that are implemented together. For example, the routine postnatal care of mother and newborn is a package that includes the following interventions: exclusive breastfeeding, thermal care, postpartum care for the mother, essential immunizations, extra care for LBW infants and prompt care-seeking for illness.

**knowledge (among families and communities) of RMNCAH)**

Information that caregivers/family members have about appropriate home-care practices during health and illness, as well as when and where to seek care outside the home. Educational, communication and counselling activities aim to improve this knowledge.

(Continued)
maternal mortality
This is defined by WHO as 'the death of a woman while pregnant, or within 42 days of a termination of pregnancy irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy, or its management, but not from accidental or incidental causes'.

monitoring
Regular checking to see that programme activities are being carried out as planned. Programmes monitor implementation to identify and solve problems, so that activities can be implemented effectively.

newborn
A child from birth up to 28 days; same as neonate.

objective
The result that a programme aims to get in the shorter term, in order to achieve its goals. For example, the objectives of an RMNCAH programme would be to increase coverage of specified interventions. It may also have additional objectives, such as to increase the quality of care, or to increase equity (e.g. to increase coverage among the poor).

percentage
A part of a whole expressed in hundredths. If 50% of a population is female, it means that 50 out of 100 people are females. The following examples show different ways of expressing the same value as a percentage, a decimal fraction and a fraction: 50% = 0.50 = 50/100; 4% = 0.04 = 4/100.

population-based
An indicator in which the denominator is the entire population, or all of the members of a subgroup of the population in the geographical area, such as all children under five, women of reproductive age and pregnant mothers in the district.

proportion
The relation of one part to a whole. When written as a fraction, the numerator signifies the part, and the denominator signifies the whole, for example: 2/3, 1/2. Proportions also can be expressed as a decimal fraction, or percentage, if the whole is expressed in hundredths, for example, 0.17 or 17%.

quality
A standard for how health services are provided. Good quality services are provided according to technical standards and in a way that is appropriate for the target population. Improving the quality of a service, often increases demand for it.

referral facility
A health facility that provides high-level care, such as the management of obstetric complications and of severely-ill children.

results framework
A results framework has three main components: clear objectives that lead to achieving the goals of a programme, a set of indicators that clearly track progress, and the monitoring arrangement.
| **stakeholders** | Those who have a stake, or an interest in RMNCAH programmes. They can be individuals, organizations or unorganized groups. Stakeholders may include: international actors (e.g. donors, cooperating partners), national or political figures (e.g. legislators, governors), local governments (e.g. mayor, city council), public sector agencies, local community and traditional leaders, medical/nursing associations, academic institutions, commercial/private for-profit organization (e.g. pharmacies), non-profit organizations (e.g. NGOs, foundations), community-based organizations (women's groups, mother's groups), faith-based organizations, schools and teachers, health-care workers, users of health services, and community members. |
| **stillbirth** | Birth of a baby that does not show any signs of life, with a birth weight $\geq 1000g$ or if missing, $\geq 28$ completed weeks gestation, or if missing, of body length $\geq 35$ cm. |
| **strategic plan** | A plan that provides a framework to guide a programme for the next 5–10 years. It usually specifies goals and objectives, targets and priority interventions, and provides overall guidance for implementation and financing to achieve the programme's goals. |
| **supervision** | Overseeing or watching over an activity or task being carried out by someone, and ensuring that it is performed correctly. The supervision of health staff includes the observation of practices, the assessment of conditions in the health facility, the provision of feedback with guidance or training, if needed, and of support. |
| **target** | A quantified statement of desired change in a key indicator of programme implementation over a given period of time, in a specified geographical area. Targets can be set for impact, coverage and completion, or results of activities. |
| **target population** | The group that an intervention is designed to help. The target population for antenatal care is pregnant women. The target population for IMNCI is children under five years. |