



# **Informal Meeting on provision of home-based care to mother and child in the first week after birth**

Follow-up to the Joint WHO/UNICEF Statement  
on home visits for the newborn child

---

MEETING REPORT  
8–10 FEBRUARY 2012

---



**World Health  
Organization**



# Informal Meeting on provision of home- based care to mother and child in the first week after birth

---

Follow-up to the Joint WHO/UNICEF Statement  
on home visits for the newborn child

---

MEETING REPORT  
8–10 FEBRUARY 2012



WHO Library Cataloguing-in-Publication Data

Informal meeting on provision of home-based care to mother and child in the first week after birth: follow-up to the Joint WHO/UNICEF statement on home visits for the newborn child, meeting report, 8–10 February 2012.

1. Infant, Newborn, Diseases – prevention and control. 2. Infant mortality – prevention and control. 3. House calls. 4. Home care services, Hospital-based. 5. Infant care. 6. Maternal welfare. I. World Health Organization. II. UNICEF. III. Save the Children. IV. MCHIP. V. USAID

ISBN 978 92 4 150461 4

(NLM classification: WS 421)

**© World Health Organization 2012**

All rights reserved. Publications of the World Health Organization are available on the WHO web site ([www.who.int](http://www.who.int)) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: [bookorders@who.int](mailto:bookorders@who.int)). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press through the WHO web site ([http://www.who.int/about/licensing/copyright\\_form/en/index.html](http://www.who.int/about/licensing/copyright_form/en/index.html)).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Photographs:

UNICEF Country Office India

UNICEF Eastern and Southern Africa Regional Office (ESARO)

WHO/S. v. Xylander

---

# Contents

Acronyms	v
Acknowledgments	vi
Executive Summary	1
Background	5
Introduction and Overview	7
Policy dialogue on PNC home visits	17
Moving from policy to implementation	24
Reaching high levels of coverage with quality care	32
Lessons learnt and next steps	50
Technical updates	54
Annexes	57
1. Summary table on postnatal care in countries	58
2. List of participants	62
3. Proposed agenda	67



---

# Acronyms

ANC	Antenatal care
CBMNC	Community-based maternal and newborn care
CHW	Community health worker
FCHV	Female community health volunteer
HEW	Health extension worker
HMIS	Health management information system
HSA	Health surveillance assistant
IMCI	Integrated management of childhood illness
IMNCI	Integrated management of newborn and childhood illness
MCA	WHO Department of Maternal, Newborn, Child and Adolescent Health
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MoH	Ministry of health
NGO	Nongovernmental organization
NMR	Neonatal mortality rate
PBF	Performance-based funding
PNC	Postnatal care
PPC	Postpartum care
Projahnmo	Project to Advance the Health of Newborns and Mothers
SBA	Skilled birth attendant
SNL	Saving Newborn Lives
TBA	Traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

---

# Acknowledgments

The Department for Maternal, Newborn, Child and Adolescent Health of the World Health Organization gratefully acknowledges the contributions that individuals and organizations made to the informal meeting and this report.

Sam Muziki, Vinod Paul, Antoine Seruflira and Sachiyo Yoshida assisted with the collection and analysis of the rapid survey on implementation of home visits for care of the newborn and postnatal care. John Murray conducted the in-depth review of current status of implementation in five countries.

The meeting was organized in collaboration with Save the Children's Saving Newborn Lives (SNL), the Maternal and Child Health Integrated Program (MCHIP) and UNICEF. Joy Lawn, John Murray, Claudia Morrissey and Deborah Sitrin of Save the Children, Joseph de Graft-Johnson of MCHIP and Renee Van de Weerd of UNICEF were involved in organizing the meeting. WHO staff members included: Rajiv Bahl, Bernadette Daelmans, José Martines and Severin von Xylander. Tania Teninge provided secretarial support. Peggy Henderson assisted in writing the meeting report.

The United States Agency for International Development provided financial support, without which this meeting could not have been held. In addition, SNL and MCHIP supported the participation of a number of participants.



---

# Executive Summary

## Background

In 2009, WHO and UNICEF issued a Joint Statement<sup>1</sup> recommending home visits for care of the newborn infant in the first week of life as a complementary strategy to facility-based postnatal care in order to improve newborn survival. This recommendation was built on evidence showing that home visits by appropriately-trained workers can reduce neonatal mortality even where health systems are weak. Impact has been achieved by the promotion of simple early newborn care practices, such as early and exclusive breastfeeding, appropriate cord care, thermal care, recognition of danger signs and treatment and referral when needed. Ministries of Health (MoHs) in a number of countries, with support from development partners, have moved towards the adoption of the WHO/UNICEF Joint Statement.

In order to review global progress in implementation, the WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA), in collaboration with Save the Children's Saving Newborn Lives (SNL), the United States Agency for International Development (USAID), the Maternal and Child Health Integrated Program (MCHIP) and UNICEF, organized a meeting in Geneva on 8–10 February 2012.

In preparation for this meeting, a rapid survey on the status of policy adoption and implementation in 46 countries in Africa and 12 countries in Asia was undertaken by WHO in December 2011–January 2012. The survey found that most countries have a policy recommending skilled care at childbirth and recommending that childbirth occur in a health facility with discharge not earlier than 24 hours after childbirth. Over half of countries have a policy on home visits for the newborn child, and most include a home visit during pregnancy. However, only 26 countries had very high (>80%) or high (60–80%) coverage by a skilled health provider at birth, and only 12 countries had a high (>75%) proportion of births in health facilities. Reported national coverage of postpartum care for mothers ranged from 5% to 100%, and postnatal care for infants from 6% to 100%. Actual coverage of early home visits for postnatal care was low, with only four countries having over 50%.

Information from the WHO survey was complemented by an in-depth review of the current status of implementation in five countries (Bangladesh, Malawi, Nepal, Nigeria and Rwanda). This review found that policies and strategies for early home visits after childbirth have been implemented in all countries using a community-based package of maternal and newborn interventions with strong MoH ownership and coordination. Community-based packages have been implemented by both government-employed community health workers (CHWs) and volunteers, and performance-based incentive approaches to supporting volunteers have been used widely. In early implementation areas, upward trends are noted in facility-based deliveries, deliveries with a skilled provider and early postnatal contacts. It remains a challenge for CHWs to make household visits in most countries, and early home visits – on the first day after delivery – remain the most difficult to achieve. A number of strategies to improve early household contacts have been used and need to be further investi-

---

<sup>1</sup> WHO, UNICEF. *Home visits for the newborn child: a strategy to improve survival*. Geneva, WHO, 2009, [http://www.who.int/maternal\\_child\\_adolescent/documents/who\\_fch\\_cah\\_09\\_02/en/index.html](http://www.who.int/maternal_child_adolescent/documents/who_fch_cah_09_02/en/index.html), accessed 4 March 2012.

gated in the future. In countries implementing community packages, an increase in demand for facility deliveries and referral care for sick mothers and newborns has placed pressure on health facilities, and the quality of facility-based care is an increasingly important issue. Long-term sustainability will require an increasing shift of human and financial inputs to routine government systems, and refinement of the most effective modes of delivery.

### **Goal, objectives and expected outcomes**

The general goal of the meeting was to share experiences and discuss the way forward for implementing home-based care to mother and child in the first week after birth. The focus was on the countries in Africa and South-East Asia, including Pakistan, and those which had carried out relevant research. The objectives of the meeting were to:

- discuss adoption and implementation of national policies on postnatal care with a particular emphasis on home visits;
- identify enabling factors and barriers for implementation of postnatal care through home visits at scale;
- agree on essential actions to move forward home visitation programmes, including questions for research.

The expected outcomes of the meeting included:

- status of national policy adoption on home visits for postnatal care monitored in high-burden countries of sub-Saharan Africa and South-East Asia;
- status of implementation of home visits for postnatal care in countries with a policy documented;
- models of best practice to facilitate policy adoption and programme implementation of home visits for postnatal care<sup>1</sup> identified;
- next steps for increasing coverage of postnatal care in the context of maternal and child health programmes identified.

Over 60 participants from countries in Asia, sub-Saharan Africa, WHO (Geneva Headquarters, regional and country offices), UNICEF (New York Headquarters and country offices), donors and implementing partners attended.

Over the course of the three days, participants shared current evidence and experiences on the subject of postnatal care in general and through home visits; were informed of the preliminary results of the multi-country rapid survey and also the results of the in-depth review of current status of implementation in five countries; participated in group work on identifying factors leading to successful implementation of postnatal home visits, barriers to progress and how to go forward; and proposed research questions.

### **Summary of deliberations and conclusions**

In various settings, mainly in Asia but also in Africa, it has been demonstrated that it is possible to successfully provide home visits for postnatal care. Community-based home visit packages for newborn and maternal care are currently being implemented in 30 countries. Most implementers are using a continuum of care approach based on pregnancy visits, promoting antenatal care (ANC) visits, giving birth at health facilities, and early postnatal contacts at home. The extent of the maternal health care component included in the packages is more variable than the newborn component.

---

<sup>1</sup> The elements of newborn and maternal care that can be delivered during home visits in the postnatal period may vary from context to context. The 2009 Joint Statement identifies a number of interventions that can be provided at home, but these do not equate to the full package of interventions recommended for comprehensive postnatal care for mother and newborn child. For the purpose of convenience, however, the terminology “home visits for postnatal care” will be used in this report.

The participants concluded that in those countries that have not yet adopted a policy or strategy on early postnatal care, including home visitation programmes, introduction may require several activities to be carried out. These include advocacy and consensus building on maternal and newborn care with policy-makers and other stakeholders; formation of a government and stakeholders' technical working or coordination group including those involved in both maternal and newborn care; a situation analysis on the current status of maternal and newborn health and activities being carried out; a review of the evidence base, including locally-generated evidence where available; adoption and/or adaptation of a standard minimum package of interventions to be delivered during home or health facility visits for the mother and newborn; a careful selection of the health worker cadre to deliver the package; and supporting policies and strategies to facilitate implementation.

As many countries have already adopted a policy or strategy on mother and newborn care, implementation of community-based packages is now their focus. Achieving improved coverage and quality is often the most important issue to be addressed. Many participants felt that coverage at a high level is needed for positive impact, although few countries have achieved it. Even at relatively high coverage levels, there was some concern about equity and how to reach the remaining mothers and infants. Demand creation and community participation appear to be essential for increasing coverage and sustainability.

Improving quality of care at facilities needs to accompany implementation of home visits for postnatal care. Quality of care at first-level health facilities and district hospitals is critical to supporting community mother and neonatal care, since implementation of community packages has been shown to increase attendance at facilities for for antenatal and childbirth care and for sick mother and newborn visits. Work also needs to be done to ensure the quality of programmes overall, not only in health facilities.

Implementation appears to have been most systematic in countries where there is a central coordinating group led by the government. This structure allows a national strategy to be developed and resources allocated where they are needed. Close collaboration between staff with responsibilities for maternal and child health, whichever department or division they are placed in, is required in order to develop a coordinated country approach to implementation.

Different categories of CHWs and volunteers have been used in all settings to carry out home visits for postnatal care, most of which were functioning prior to the introduction of home visits and have additional responsibilities. Experience indicates that a sustainable system of salaries, rewards or incentives is required in order to sustain performance. In many countries, performance-based remuneration is being used to compensate CHWs and other workers, with some success.

Implementation of community mother and newborn packages requires a number of systems issues to be addressed, including:

- A human resources plan should be developed based on the existence of a cadre dedicated to mother and child health, their current and expected additional workload; the density of the population or households; how, where and when workers will be deployed; job description; current regulations; and proposed remuneration.
- An implementation plan needs involvement of all stakeholders to carry out district-based planning, which might include targeting high-risk populations and planning for scaling-up.
- A national and district monitoring plan, including targets, indicators and the use of data for decision-making, needs to be in place to track implementation and outcomes.

In order to ensure that the programme is implemented smoothly and that high coverage of mothers and newborns, including the most vulnerable, can be achieved, essential system supports are needed in key areas:

- mechanisms for birth notification;
- regular contacts between CHWs and health facilities;
- essential equipment and supplies in the facilities and for the CHWs;
- use of alternative methods (such as mobile phones) for connecting families, CHWs and health workers;
- functional referral system.

The meeting focused mainly on neonatal issues. Participants concluded that there is a need to define the maternal component of their programme more clearly, and this would require engagement with other colleagues from the maternal health community in order to achieve improved programme implementation benefiting both.

While the WHO/UNICEF Joint Statement was due for review this year, the consensus of the meeting was that it is still generally acceptable even in the face of rapidly-increasing facility deliveries. However, some participants felt that a brief statement clarifying the evidence and the contexts in which it applies and strengthening the maternal component might be useful. A separate meeting to be convened by WHO in June 2012 will look more specifically at the content of the postnatal package for mother and baby wherever it is provided, and it may be appropriate to issue the clarification after that.

### Recommendations

Given the conclusions reached by the group, the following actions were agreed upon:

- **Advocacy:** UNICEF, WHO and partners should use all avenues, including upcoming global events related to maternal, newborn and child health and the Millennium Development Goals to advocate for increased adoption of postnatal home visit policies and increased resources for implementation.
- **Technical guidance:**
  - WHO should lead the process to:
    - define the optimal package of interventions for mother and baby during the postnatal period regardless of location, including provider profile and skills;
    - define the optimal frequency and timing of early postnatal care and home visits;
    - provide guidance on the cost of delivering the mother and newborn package in different settings;
    - based on the above, update current training packages and related materials.
  - WHO and UNICEF in collaboration with partners should lead the process to:
    - develop a practical implementation guide for community mother-newborn care;
    - define standard indicators for tracking progress at national and district level;
    - consider the establishment of a clearinghouse where technical help could be provided;
    - further develop and support operational research in key areas.
  - Research should be defined and carried out in the following areas:
    - how to link CHWs to health facilities
    - how to initiate and provide post-discharge newborn care in the community
    - how CHWs identify pregnancies and births
    - models for implementing postnatal care in different settings
    - use of technology to support implementation
    - costing and cost-effectiveness studies
    - qualitative research on barriers to improved performance.

---

# Background

In 2009, WHO and UNICEF issued a Joint Statement recommending home visits for care of the newborn infant in the first week of life as a complementary strategy to facility-based postnatal care (PNC) in order to improve newborn survival. This recommendation was built on evidence showing that home visits by appropriately-trained workers can reduce neonatal mortality even where health systems are weak. Impact has been achieved by the promotion of simple early newborn practices, such as early and exclusive breastfeeding, appropriate cord care, thermal care, recognition of danger signs and treatment and referral when needed. Ministries of health (MoH) in a number of countries, with support from development partners, have moved towards the adoption of the WHO/UNICEF Joint Statement.

In order to review global progress in implementation, the WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA), in collaboration with Save the Children's Saving Newborn Lives (SNL), the United States Agency for International Development (USAID), the Maternal and Child Health Integrated Program (MCHIP) and UNICEF, organized a meeting in Geneva on 8–10 February 2012.

In preparation for this meeting, a rapid survey on the status of policy adoption and implementation in 46 countries in Africa and 12 countries in Asia was undertaken by WHO in December 2011–January 2012. The survey found that most countries have a policy recommending skilled care at childbirth and recommending that childbirth occur in a health facility with discharge not earlier than 24 hours after childbirth. Thirty countries have a policy on postnatal home visits, and most include a home visit during pregnancy. However, only 26 countries had very high (>80%) or high (60–80%) coverage by a skilled health provider at birth, and only 12 countries had a high (>75%) proportion of births in health facilities. Reported national coverage of postpartum care for mothers ranged from 5% to 100%, and PNC for infants from 6% to 100%. Actual coverage of early postnatal home visits was low, with only four countries having over 50%.

Information from the WHO survey was complemented by an in-depth review of the current status of implementation in five countries (Bangladesh, Malawi, Nepal, Nigeria and Rwanda). This review found that policies and strategies for early postnatal home visits have been implemented in all countries using a community-based package of maternal and newborn interventions with strong MoH ownership and coordination. Community-based packages have been implemented by both government-employed community health workers (CHWs) and volunteers, and performance-based incentive approaches to supporting volunteers have been used widely. In early implementation areas, upward trends are noted in facility-based childbirth care with the assistance of a skilled provider and early postnatal contacts. It remains a challenge for CHWs to make household visits in most countries, and early home visits – on the first day after delivery – remain the most difficult to achieve. A number of strategies to improve early household contacts have been used and need to be further investigated in the future. In countries implementing community packages, an increase in demand for giving birth at a facility and referral care for sick mothers and newborns has placed pressure on facilities, and the quality of facility-based care is an increasingly important issue. Long-term



sustainability will require an increasing shift of human and financial inputs to routine government systems and refinement of the most effective modes of delivery.

Over 60 participants from countries in Asia, sub-Saharan Africa, WHO (Geneva Headquarters, regional and country offices), UNICEF (New York Headquarters and country offices), donors and implementing partners participated in the meeting. (See **Annex 2** for the list of participants.)

Over the course of the three days, participants shared current evidence and experiences on the subject of postnatal home visits; were informed of the preliminary results of the multi-country rapid survey and also the results of the in-depth review of current status of implementation in five countries participated in group work on identifying factors leading to successful implementation of home visits for PNC, barriers to progress and how to go forward; and proposed research questions. (See **Annex 3** for the proposed agenda.)

This report contains detailed descriptions of the presentations, discussions and group deliberations during the three-day meeting, session by session, as well as the agreed conclusions and recommendations.

---

# Introduction and Overview

## Opening remarks

**Elizabeth Mason, Director, MCA, WHO Headquarters**

Dr Mason welcomed the participants and stressed the importance of the meeting for sharing experiences in the implementation of home-based care for mother and newborn. She noted that there is a gap in care around the immediate post-childbirth period. The norm formerly was to see mothers and newborns at six weeks of age, but many neonatal deaths occur before this time. Dr Mason told the participants that she was very interested to hear their experiences in implementing postnatal visits, and noted that a PNC meeting (to discuss content of the postnatal package) would be in June 2012.

## Words of welcome on behalf of partners

**Joseph de Graft-Johnson, MCHIP, USA**

Dr Johnson explained the work that he and other colleagues had carried out in order to improve the health of newborns, based on research showing that there could be a reduction in neonatal mortality with home visits. Such work included the development of training manuals and supporting countries to introduce and expand home visits for PNC. He said he hoped that this meeting would be a catalyst for further rapid implementation.

## Declarations of interest

**Jose Martines, MCA, WHO Headquarters**

Dr Martines explained the purpose of the conflict of interest forms, and clarified that the intellectual interest that all participants had in the subject had already been factored in to the process. All participants were asked to declare any financial interests, and none were stated.

## Meeting objectives

**Bernadette Daelmans, MCA, WHO Headquarters**

Dr Daelmans presented the objectives of the meeting, in the context of the WHO/UNICEF Joint Statement:

- discuss adoption and implementation of national policies on postnatal care with a particular emphasis on home visits;
- identify enabling factors and barriers for implementation of PNC through home visits at scale;
- agree on essential actions to move forward home visitation programmes, including questions for research.

She also described the expected outcomes:

- status of national policy adoption on home visits for PNC monitored in high-burden countries of Sub-Saharan Africa and South East Asia;
- status of implementation of home visits for PNC in countries with a policy documented;

- models of best practice to facilitate policy adoption and programme implementation of home visits for PNC identified;
- next steps for increasing coverage of PNC in the context of maternal and child health programmes identified.

She reminded participants that a WHO Sharepoint exists (at <https://workspace.who.int/sites/pnc-homevisits/default.aspx>) with the objectives and other relevant information regarding the meeting.

### Impact of home visits: an update of evidence

#### Rajiv Bahl, MCA, WHO Headquarters

Dr Bahl gave a summary of the evidence of the impact of home visits on neonatal health. He began by noting that coverage of the various interventions across the continuum of care from pre-pregnancy to childhood varies considerably, with about 35% of mothers receiving a postnatal visit within 2 days (regardless of the place of delivery).

The WHO/UNICEF Joint Statement details the interventions that can be delivered through home visits:

#### *Pregnancy visits*

- support to seek antenatal care;
- support to plan for childbirth with a skilled birth attendant;
- support for newborn care at birth including immediate drying and skin-to-skin contact, early initiation of breastfeeding, clean cord care.

#### *Postnatal visits*

- support to initiate early and exclusive breastfeeding;
- support for keeping the newborn warm;
- support for hygienic cord care;
- timely recognition and appropriate treatment for danger signs.

A body of published studies from different settings provides the evidence on postnatal visits through various methods. The covered population in the research studies ranged from about 1000 to about 15 000, neonatal mortality was mostly high, home births ranged from 51% to 95%, and coverage of postnatal home visits was about 24% to 93%. Four of the studies showed a clear positive impact on neonatal mortality, while others were less conclusive statistically. The variability appears to be due to study size, underlying neonatal mortality rate (NMR) and the proportion of home births.

Research has also shown an impact on early initiation of breastfeeding when control and intervention areas were compared, ranging from 16% to 55% improvement in rates.

Dr Bahl concluded that:

- home visits in combination with community promotion of good care practices in high-mortality settings reduce NMR by about 21%;
- larger impact is likely in settings with high NMR and where most births occur at home;
- data from India indicate that the impact extends to the post-neonatal period;
- all studies show impressive improvements in newborn care practices.

Discussion centred on the fact that these studies were in different contexts with somewhat different interventions, and little was known about the quality of care. There was a suggestion that more analysis should be carried out looking at the impact according to the number and timing of visits. It appears that where coverage is not at least about 60–70%, little impact can be expected.



## Home-based care to mother and child in the first week after childbirth: PNC policies and practices in priority countries

Severin von Xylander, MCA, WHO Headquarters

Dr von Xylander reported on the preliminary results of a rapid survey on postnatal policies of selected countries in Africa and Asia, done in collaboration with MCHIP and SNL. The purpose of the survey was to provide background information on the state of implementation of national policies on PNC in countries, with a particular emphasis on home visits, including:

- the context in which PNC is being provided;
- adoption and implementation of national policies and strategies on home visits for PNC;
- enabling factors and barriers for policy change and implementation of home visits for PNC.

The target countries for the web-based questionnaire were those in the WHO Regions for Africa (46), South-East Asia (11) and Pakistan (total = 58 countries). The target respondents were the focal points for maternal and newborn health in MoHs in Africa, or in WHO country offices elsewhere. There was active support and facilitation by three consultants to ensure timely and complete responses.

The questionnaire consisted of closed and open questions on background information on respondents, the context in which PNC is being provided, national policies and strategies on home visits for PNC and barriers to policy change. Full responses were received from 47 countries (81%).

Key preliminary results included (see also **Box 1** and Summary Table in **Annex 1**):

- Most countries have a policy recommending skilled care at childbirth and recommending that childbirths occur in a health facility.
- Twenty-six countries had very high (>80%) or high (60–80%) coverage by a skilled health provider at birth, and only one had very low (<20%) coverage.
- Twelve countries had a high (>75%) proportion of births in health facilities, while 3 had less than 25% of births in a facility.
- Most countries have a policy recommending discharge from health facilities 24 hours or more after childbirth.
- Commonly used indicators included: “Proportion of women receiving postpartum care within 7 days after childbirth” and “Proportion of newborn infants receiving health checks while in a health facility or at home following delivery, or a PNC visit within 2 days after birth”.
- Reported national coverage of postpartum care for mothers ranged from 5% to 100%, and PNC for infants from 6% to 100%.
- Over half of countries have a policy on home visits for PNC, and all of these refer to the mother and child. Of these, most include a home visit during pregnancy. Policies differed on the proportion of the population to be covered, and the timing of visits for PNC.





- Actual coverage of early postnatal home visits was low, with only 4 countries having over 50%.
- Twenty-five countries included promotion of appropriate care, identification of danger signs and feeding support in the content of home visits; none included treatment.
- Home visits were carried out by volunteers, CHWs and health professionals – in most countries, by a combination of these workers. In 20 countries, the workforce was only or mainly female.
- Fifteen countries had used the WHO/UNICEF training course.
- Workers covered between less than 100 to more than 1000 households.

A preliminary review of open-ended questions indicated recurrent themes of absence of standard recruitment criteria for CHWs; CHW training too short to cover subjects but too long for this cadre; limits of voluntarism and need for incentives and a formal role; importance of community participation and engagement with local authorities; the difficulty of frequent visits and the extension of post-delivery stays in health facilities as an alternative to early visits; costs and dependence on external funding for training and incentives (including for supervisors); work load for CHW and supervisors; need for broader integration of indicators into health information management systems (HMISs).

After further analysis, a survey report will be produced and widely disseminated.

**BOX I**

## Postnatal care policies and practice in fifty-one countries in Africa and Asia

### Introduction

A web-based questionnaire was sent to Ministries of Health and WHO Country Offices in all countries of the WHO Regions for Africa and South-East Asia as well as in Pakistan to collect information on the context, in which postnatal care to mothers and their newborn infants is provided. The focus was on the adoption and implementation of national policies and strategies on home visits for postnatal care, including enabling factors and barriers for policy change and implementation at scale. Fifty-one country responded of which 47 returned fully completed questionnaires (**Table I**).<sup>1</sup>

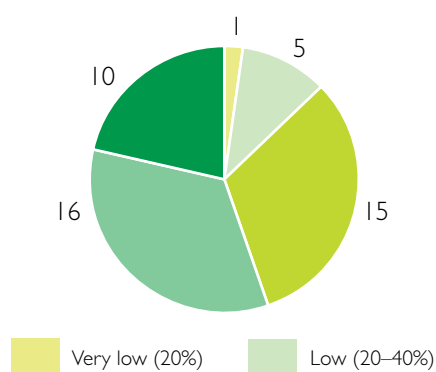
**Table I**

	Number and proportion	African countries		Asian countries		All countries	
	Questionnaire sent	46		12		58	
Response Rate	Country responses	39	85%	12	100%	51	88%
	Full response received	37	95%	10	83%	47	81%
	Primary respondent: Ministry of Health	33	85%	6	50%	39	76%
	Primary respondent: WHO or other partner agency	6	15%	6	50%	12	24%
	Collective response with input from multiple stakeholders	35	90%	10	83%	44	86%

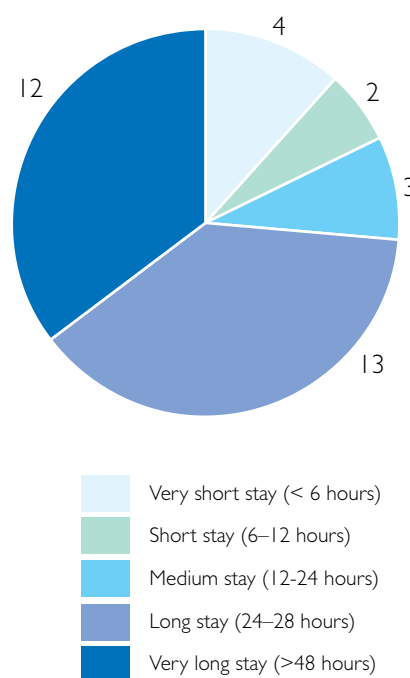
### Results

Most countries have policies for skilled care at birth and recommend mothers to give births in health facilities and not to be discharged before 24 hours after childbirth. The implementation of these policies varies (see **Fig. 1** and **Fig. 2**).

**Figure 1. Coverage of skilled assistance at childbirth in 47 countries**



**Figure 2. Reported practices of discharge after childbirth in 43 countries**

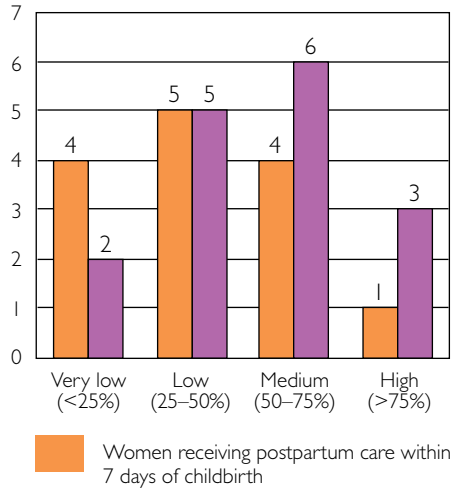


<sup>1</sup> For some countries the questionnaire was also sent to development partners such as SNL. In a number of cases this resulted in discrepant responses to some questions. For this report only the final MoH or WHO country responses were taken into account.

**BOX I**

Countries also reported on postnatal care coverage for mother and child; this information was based on population-based surveys but also routine information systems. Reported coverage varied considerably (see **Fig. 3**).

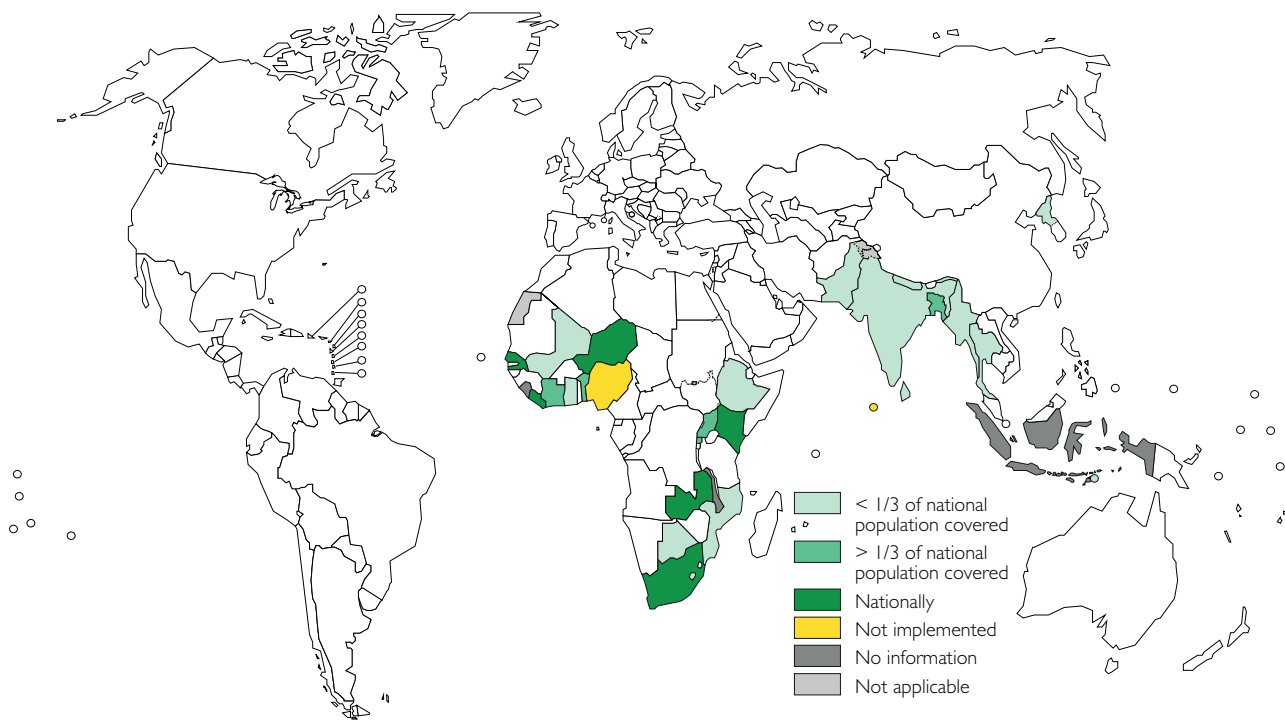
**Figure 3. Reported Coverage of postnatal care for mother and child with sources of information**



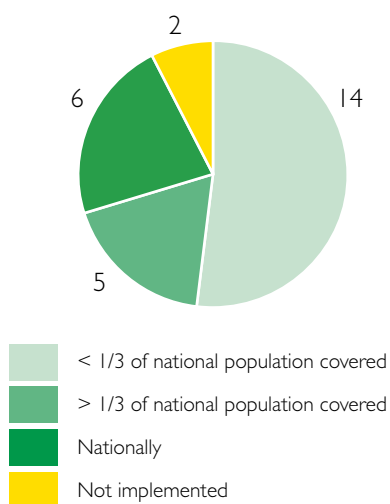
Country (n = 21)	Survey (S), n = 13 Routine (R), n = 7	Year	PPC (%) n = 12	PNC (%) n = 14
Bangladesh	S	2010	5	6
Botswana	R	2010	12	–
Botswana	R	2010	–	12
Burkina Faso	R	2010	46	–
Central African Republic	S	2006	–	32
DPR Korea	R	2010	100	100
Indonesia	S	2010	–	71
Lesotho	n/a	2009	15	–
Liberia	S	2007	–	44
Malawi	S	2010	52	–
Maldives	S	2009	–	94
Niger	R	2010	27	69
Pakistan	S	2011	–	50
Rwanda	S	2007	8	–
Sao Tome and Principe	S	2009	63	82
Tanzania	S	2010	25	–
Timor Leste	R	2011	43	43
Togo	R	2010	32	–
Uganda	S	2006	–	26
Zambia	S	2007	–	39
Zimbabwe	S	2005	–	54

**BOX I**

Thirty countries, 19 in Africa and 11 in Asia, have policies on postnatal home visits but the reach and coverage of these visitation programmes vary (see map, **Fig. 4** and **Fig. 5**).

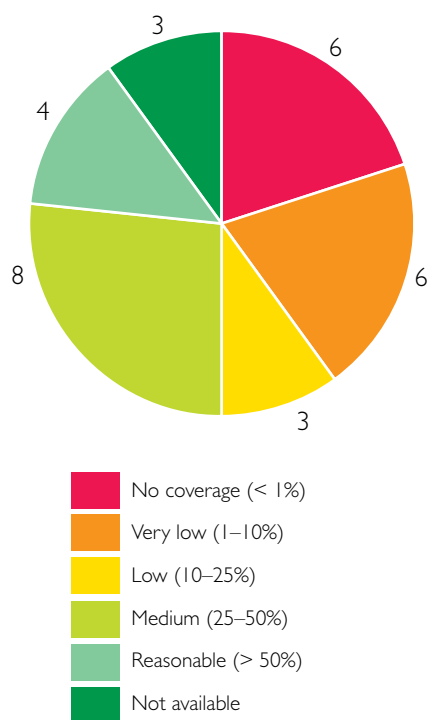


**Figure 4.** Reported reach of postnatal home visitation programmes in 27 countries<sup>a</sup>



<sup>a</sup> Information is missing for three countries.

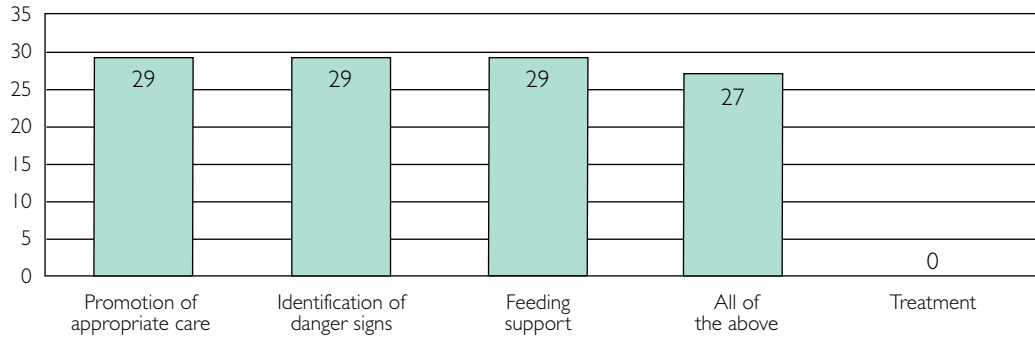
**Figure 5.** Reported coverage of postnatal care home visits in 30 countries



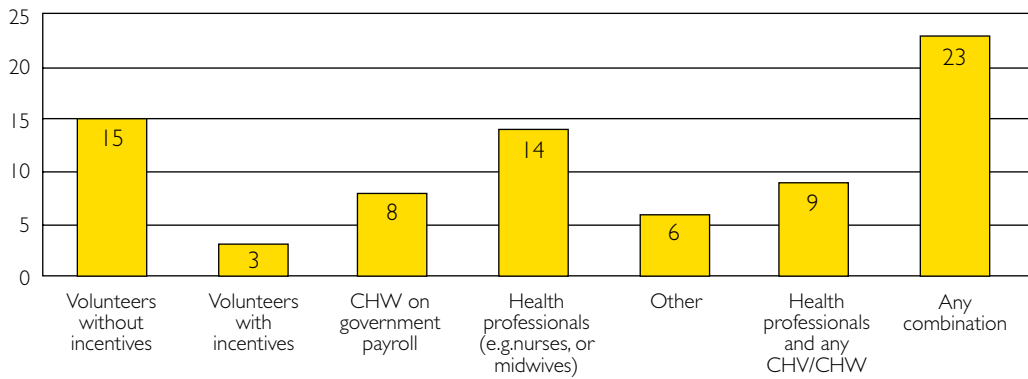
**BOX I**

The content of the postnatal home visits as well as the type of health workers carrying them out are not homogeneous, notably none of the countries reported treatment interventions as part of the postnatal care home visit package (see **Fig. 6** and **Fig. 6b**).

**Figure 6a. Content of PNC home visit package**



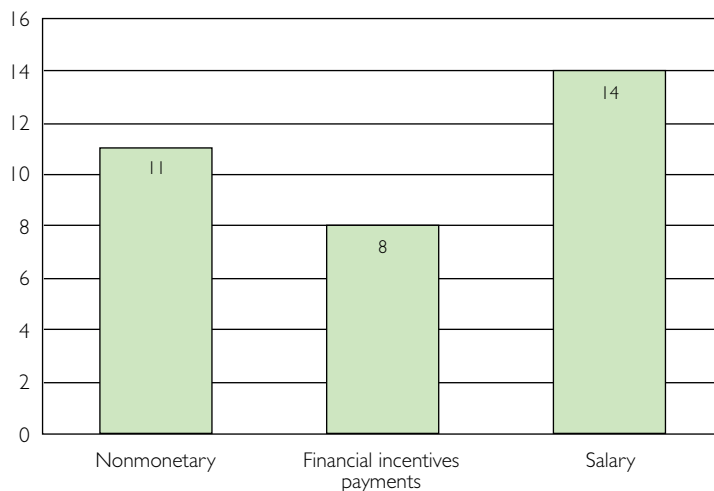
**Figure 6b. Human resources for PNC home visits**



**BOX I**

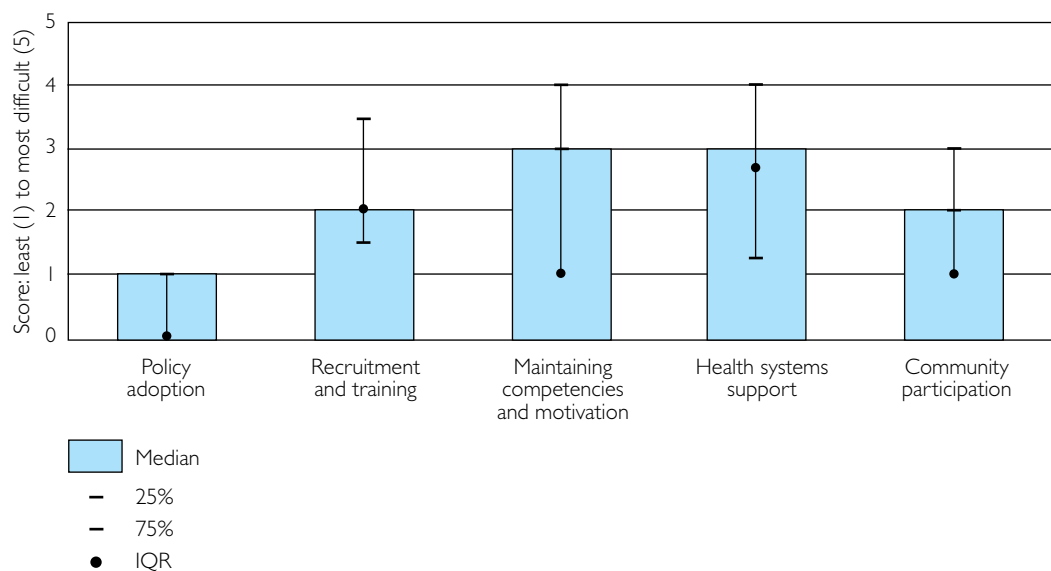
A few countries provided information on incentives for the workforce (see **Fig. 7**).

**Figure 7. Workforce incentives**



Respondents were asked to score their difficulties with the different components of home visitation programmes, which showed that maintaining competencies and motivations of health workers as well as health systems support represented that bigger challenges (see **Fig. 8**)

**Figure 8. Difficulties with Programme Components**

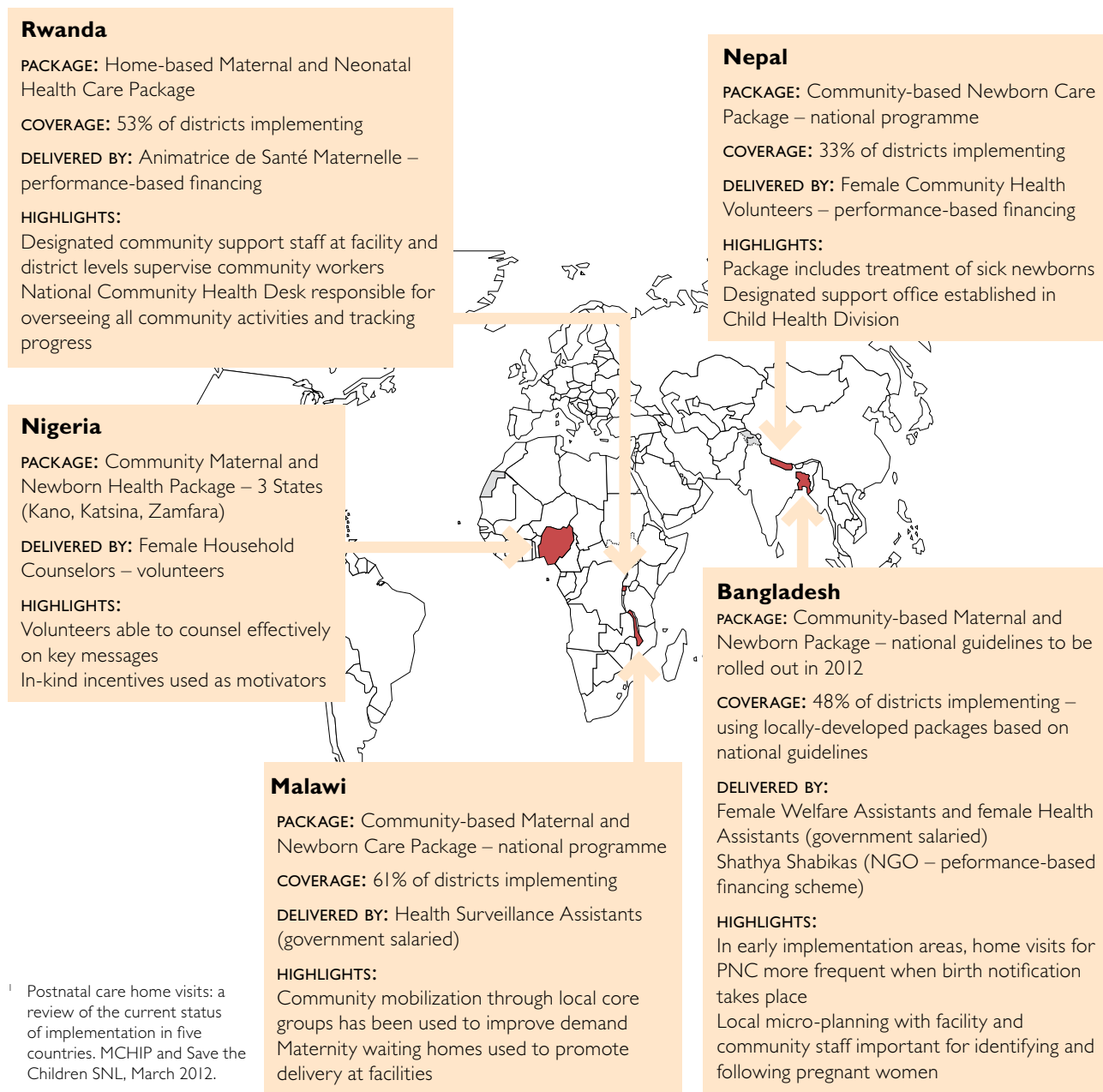


**BOX 2**

**In-depth review of progress in implementation of home visits for pnc in five countries**

September 2011 – January 2012

An in-depth review of progress made with the adoption and implementation of the approach of home visits for PNC was conducted in countries where the MoH is supported by Save the Children's SNL and USAID's MCHIP. Five countries – Bangladesh, Malawi, Nepal, Nigeria and Rwanda – were selected. In each country, documents relevant to home visits for PNC were reviewed, including policies and strategies, programme reports, training and health education documents, and surveys and monitoring data. Interviews were conducted with MoH staff involved with planning and implementation of the maternal, newborn and child health programme at all levels, as well as other local stakeholders and international development partners. Field visits to implementing districts allowed interviews with CHWs and volunteers, community members and mothers of young children. Findings and lessons learnt were synthesized as short country summaries, organized into three areas: 1) policy and strategy adoption; 2) CHW selection and training; and 3) programme implementation and coverage.



<sup>1</sup> Postnatal care home visits: a review of the current status of implementation in five countries. MCHIP and Save the Children SNL, March 2012.



---

# Policy dialogue on PNC home visits

## Panel I: Achieving policy change to establish postnatal home visitation programmes

### Policy adoption process on postnatal home visits in Malawi

*Fannie Kachale, MoH, Malawi*

Ms Kachale gave an overview of the policy environment in Malawi. The country approved a “Road map” to accelerate the reduction of maternal and newborn mortality and morbidity in 2005. A strategy on community empowerment recognizes the importance of community involvement and participation in improving maternal and newborn health. Community participation is also included in the Sexual and Reproductive Health policy. The MoH redefined the role of traditional birth attendants (TBAs) to that of referral and not conducting deliveries. A Human Resource Emergency plan (2004–2010) aims to increase the number of health workers. The number of Health Surveillance Assistants (HSAs), the lowest cadre of health worker, has increased from 5500 to 11 000, each covering a population of 1000.

Malawi adopted community-based maternal and newborn care (CBMNC) after exposure to a programme in India. A task force was formed to plan and lead the implementation of CBMNC, with members including the MoH, District Health Officers, service providers and partners. This task force met monthly for a year. It was agreed to use HSAs to implement CBMNC.

HSAs are meant to conduct three home visits during the antenatal period and another three during the postnatal period (on days 1, 3 and 8). They counsel on birth preparedness, care of the mother and newborn, warmth for the newborn, early breastfeeding initiation and cord care; screen for danger signs for mother and newborn; and refer for health facility services.

It was agreed that community mobilization should be part of the CBMNC package, and a programme was piloted in three districts before being implemented in 19.

The objectives of CBMNC are to increase access and availability of community-based care; improve access, availability and quality of existing facility-based services by strengthening the existing packages; increase community knowledge and mobilization for key maternal and newborn health behaviours and demand for care; and develop, refine, and evaluate an algorithm for diagnosis and referral of neonatal sepsis by HSAs and first level health workers.

Challenges in implementation include that the HSA is not recognized by the regulatory bodies due to the short duration of training; high workload; and inadequate mobility of the HSAs. The MoH hopes to scale up CBMNC to all 29 districts in the country.

In the discussion following the presentation, a participant from Uganda shared experience in implementing home visits for PNC, noting that newborns were brought on to the health agenda there after a *Lancet* supplement.<sup>1</sup> A stakeholders’ meeting was followed by the setting-up of a multi-sectoral steering committee. This group did a situation analysis of newborn health, and actively brought newborn issues into policy discussions and documents. The

---

<sup>1</sup> *Lancet* neonatal survival series, 2005, available at: [http://www.thelancet.com/journal/vol365/iss9465/full/llan.365.9465.neonatal\\_survival\\_series.32704.1](http://www.thelancet.com/journal/vol365/iss9465/full/llan.365.9465.neonatal_survival_series.32704.1)

WHO/UNICEF Joint Statement added impetus to this work, and a technical working group was formed. The MoH has endorsed these efforts, and implementation should follow.

Another Ugandan participant talked about the village health team and volunteers. These volunteers have been trained to refer mothers and mobilize so that they attend health facilities. They are given incentives in kind (e.g. bicycles). It is desirable that they can read and write, but it is not always easy to find someone literate who is willing to be a volunteer. Challenges have included the resistance of professional bodies to the volunteers giving basic treatments; implementing task shifting; and maintaining the enthusiasm of the teams. An innovation is the giving of vouchers to poor women to pay for their health facility care.

A participant from Bangladesh noted that developing a policy on postnatal visits was relatively the easiest part of the implementation process. Implementation has been through government with support from stakeholders. Barriers to be overcome included defining who would do the visits and their job description. In practice, it has been difficult to ensure that what takes place on the ground is based on evidence.

In India, a new type of health worker has been appointed and given special training and supportive supervision. To improve quality, performance-based incentives have been initiated for those who carry out visits. Concerns are the verticality of separate programmes; a large increase in institutional deliveries; and the issue of who can provide antibiotics.

A participant from Kenya noted that WHO had tested the counselling cards on caring for the newborn at home there, and policy-makers have been trained. There is a national communication strategy. CHWs are volunteers, given incentives, and part of their curriculum is on newborn care.

The chair noted that some countries are implementing home visits without a policy, and others are working through a step-wise approach starting with developing policies and strategies before proceeding to implementation.



UNICEF COUNTRY OFFICE INDIA

## Implementing home visits for maternal and newborn health care in Rwanda

*Cathy Mugeni, MoH, Rwanda*

The Government of Rwanda is committed to achieving the Millennium Development Goals (MDGs), particularly MDG 4 on child health, and has made progress on maternal health coverage and child mortality rates. In 2008-2009, strategic policies and plans for child survival and community health were formulated. Implementation began two years ago with support from partners.

Ms Mugeni explained that the health structure includes four CHWs per village of about 60 000 population: one male and one female general worker, one for maternal health, and one for social affairs. Nongovernmental organizations (NGOs) are not allowed to put in place their own CHWs. Many partners support the government CHWs, using a standard curriculum.

The CHW in charge of maternal health has specific duties related to antenatal care. All births are supposed to take place in health facilities. After delivery, the CHW makes an early home visit and identifies women and newborns with danger signs and refers to a health facility for care. She visits again on days 3, 7, 14 and 28.

The programme is gradually being expanded, with the support of various partners, with the intention of covering 13 districts by the end of 2012. Nearly 8000 CHWs have been trained.

The CHW programme has several tools and forms, including a register for all women of child-bearing age, follow-up and referral forms, counselling cards and a manual, a supervision form and a monthly report. They are provided with kits containing items such as drugs and a mobile phone.

Monitoring of the CHWs is done through a set of indicators on maternal and newborn health and community-based nutrition. The information is compiled by the CHWs, and then entered in various registers. Data is digitalized and sent to other levels by mobile phone.

Challenges to the programme include geographic accessibility to health facilities; ensuring health facilities are prepared to receive women and newborns; insufficient staff to implement the long-term core strategy of health centre-based intrapartum care; the huge numbers of CHWs who need training; maintaining high levels of satisfaction of CHWs and providing supportive supervision; and assuring data quality.

Lessons learnt cited by Ms Mugeni involved how to implement performance-based contracts and use them to motivate CHWs.

In the discussion, participants noted that it is hard to have the same model from one setting to another. Ms Mugeni had noted that home deliveries are forbidden in Rwanda, and there were questions about how this was enforced. She explained that any penalty would be for the husband, and that it varies depending on the district and whether the home delivery was intentional.

## Home visiting for PNC of mothers and neonates: insights from a survey in Asia

*Vinod Paul, All India Institute of Medical Sciences, India*

Dr Paul reported on a survey on the status of policy adoption and implementation in 11 countries<sup>1</sup> carried out by the WHO Regional Office for South-East Asia in December 2011–January 2012 as part of a broader survey. Respondents were WHO country staff. Clarifications and additional insights were gathered through teleconferences.

Postnatal home visiting as a policy exists in all 11 countries, and all of them initiated visits before the launch of the WHO/UNICEF Joint Statement. Skilled birth attendants (SBAs) carry out these visits in about half the countries, and CHWs in the other half. Where SBAs

<sup>1</sup> Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Pakistan, Sri Lanka, Thailand, Timor-Leste. (Bhutan was surveyed but did not respond.)



UNICEF COUNTRY OFFICE INDIA

carry out the visits (mostly in older programmes), the focus is more on the mother for CHWs the focus tends to be on the newborn.

Countries reported that they found the easiest component in implementing home visits was adopting a policy, while the most difficult part was strengthening health system support.

Dr Paul identified several issues during the survey:

- How to ensure that policy adoption is followed by operational plans that address other components as well;
- How to develop action plans that encompass all the elements, from district to global level;
- How to ensure that PNC of both mothers and neonates is addressed optimally;
- Are there resource materials on the home-based care of the mother? Are they disseminated?
- What is the most effective home visiting schedule?
- Are some countries aiming at too many visits?
- How to connect facility care with home care? Role for mobile phones?
- Does impact on maternal-neonatal outcomes differ with SBAs versus CHWs?

Another issue is the optimum population size for one worker to cover. The number in the survey varied from 500 to 6500 population. However, geography means that larger numbers are hard to reach in Nepal and the Maldives.

Dr Paul found that supervision is a weak link. The HMIS is good in Sri Lanka and Thailand, but not optimal elsewhere. There were positive examples of referral systems from India, Pakistan, Sri Lanka and Thailand. Tools, community monitoring, standardization and best practices for referral transport were issues.

Recruitment and training of human resources is a huge challenge in Bangladesh, India and Nepal. Community involvement in selection appears to work well in some countries.

Most workers who carry out home visits are salaried, but some countries give only an incentive, and in some places salaries are felt to be inadequate. There were issues around whether incentives are a good practice and sustainable.

Awareness about the WHO/UNICEF Joint Statement appeared to be rather low in some countries, but Dr Paul raised the issue of whether this mattered as long as implementation is taking place.

The way forward should involve policy facilitation and/or reaffirmation, using the WHO/UNICEF Joint Statement as the basis. Help is needed to meet the human resources challenges, including tools, capacity building, innovative training, skills retention and best practices. Financial resources should be leveraged, especially given the US\$ 45 billion recently pledged internationally for women's and children's health.

Implementation research is needed on strategy and interventions. Demand side actions are currently ignored, but there is need for more ideas, best practices, tools and budgets for this. The use of technology, especially mobile phones, could facilitate implementation.

There is a need to develop deeper insights into the barriers, enablers, best practices and needs in the countries, and Dr Paul proposed that this could be achieved through further studies and/or a meeting in the region. Sri Lanka, Thailand and some specific programme sites could be showcased for visits by programme managers. There is need to develop global, regional and country visions, aiming for 90% coverage of high-quality home-based care to mother and child.

### **Selection and training of CHWs: five-country review of early postnatal home visits**

*John Murray, Australia*

Dr Murray reported the results of an in-depth review of early home visits for PNC in five countries (Bangladesh, Malawi, Nigeria, Nepal and Rwanda). This work consisted of a document review and interviews covering three areas: policy and strategy adoption; CHW selection and training; programme implementation and coverage. Box 2 gives further information on the results of the study.

Regarding policy and strategy adoption, Dr Murray noted that the formation of a working group was important to start, with broad membership of stakeholders. There was often not enough dialogue between maternal and child health staff, and this is an opportunity to put them together. Including professional societies can also be important. A local evidence base makes policy shifts easier, and exchange and study visits are useful. The definition of a minimum package of interventions is also critical. Consensus building and advocacy is part of this process, including a review workshop and wide dissemination of documents. Human and



financial sources are needed for meetings, staff time, printing and providing technical expertise. Supporting policies are also important, for example, for performance-based incentives. A technical working group should develop technical standards, ensure a single set of guidelines, develop and coordinate implementation, share resources and secure high level endorsement for changes. Some countries do not have a policy but do have a strategy that enables implementation.

The categories of CHWs conducting home visits differed by country, and could be government or supported by NGOs, and could be salaried, receive incentives (sometimes performance-based), or volunteers. He found that the most common selection criteria for CHWs conducting home visits were that they should be female, married, live in the community they serve, able at least to read, and chosen by the community.

The population served by these workers ranged from 50 to over 1000 households. The time given for basic training was from none to 12 weeks, followed by specific community mother-newborn care training of 5–7 days, with some only receiving a monthly refresher. Government-salaried CHWs have more basic training and tend to serve larger catchment populations.

The tasks of CHWs who conduct home visits varied by country. Community registers have been used widely, and are reported to be useful job-aids. However, registers can be long and complicated, and there may be multiple ones to complete. All CHWs conduct health education and health promotion activities, with one-on-one counselling being the most frequently-used approach. Community mobilization has not yet been implemented widely because of concerns about the time and resources required. CHWs in many countries have multiple programme responsibilities, each with separate training packages, and increased responsibilities can limit their ability to provide home visits.

The training packages used also varied by country. There were positive findings related to the community mother-newborn package, but also challenges, including that standards regarding duration and facilitators were sometimes not complied with in order to reduce costs and save time. Follow-up after training was rarely done and is difficult to sustain. All training costs in early implementation areas have been supported by development partners. A plan outlining who will be trained and when is essential. Sharing training packages from other countries that have already developed, adapted and tested the approach was useful for countries beginning development.

Dr Murray noted some of the characteristics of different CHW programmes, and found that they differed on various measures. For example, government-paid workers appear to have the highest sustainability, but coverage is likely to be higher where volunteers are involved.

Birth notification is essential to ensuring early home visits. Monthly meetings between CHWs and facility supervisors are essential for supporting home visits, supplying CHWs, coordinating CHWs and solving problems. Training for facility supervisors should include





simple guidelines on this process. Mothers' cards can help support demand for key pregnancy, delivery and PNC contacts, by listing all the key contacts needed during pregnancy, delivery and the postnatal period.

Discussion covered various issues. It was noted that Nigeria has three policy documents related to postnatal health visits. This led to a discussion as to what the difference is between a policy and a strategy, whether having a policy caused changes, and whether the WHO/UNICEF Joint Statement had helped. There was some discussion of mapping to help identify where the CHWs are when this wasn't known. It was recognized that female CHWs are needed; in one country males had to train females. In order to retain health workers, it was important to make sure that they receive adequate incentives. Otherwise, there can be high attrition rates. Some issues weren't looked at in the survey (length of training/performance/sustainability). Performance-based finance was very much liked, but in some places CHWs have been in post for a long time with no incentives because of local circumstances. Longer than 5 days for initial training appears to be too much for new recruits with low levels of education. It was better to have sustained follow-up.

The handling of antibiotics by CHWS appears to be a difficult policy issue in many countries. The use of injections by CHWs is a research question, and to understand it better are underway in Africa and Asia. There was discussion on why countries are not including treatment in programmes. CHWs have been shown to be able to treat appropriately in various settings, and this task would be highly relevant for some areas – although referral would be better for others where health facility services are more available. There is need for a solid evidence base on this issue.

Regarding the optimal time for a mother to be discharged after delivery, there is no evidence that later discharge brings better outcomes. However, in research studies early discharge is accompanied by some kind of follow-up support.

---

# Moving from policy to implementation

## Panel 2: Who conducts the postnatal home visits and how are they prepared?

### Neonatal visit implementation in Indonesia

*Erna Mulati, Ministry of Health and Social Welfare, Indonesia*

Dr Mulati gave a brief situation analysis of postnatal health and activities in Indonesia, highlighting death rates and coverage. About 46% of infant mortality is due to neonatal causes, including asphyxia, low birth weight and infections.

She described the activities that are meant to take place at each contact with a mother/infant at birth, between 6 and 48 hours after birth, between 3 and 7 days and at 8 to 28 days (3 visits). A young Infant Integrated Management of Childhood Illness (IMCI) form documents the neonatal visit.

Challenges in implementation of visits have included documenting and increasing coverage of neonatal and maternal visits, ensuring the quality of the visits, and monitoring and evaluation. On the other hand, opportunities are available. Coverage of postnatal visits is an indicator in the MoH's Strategy and Action Plan for 2010–2014, and partnerships are helping to increase it. Efforts to improve quality of neonatal visits are included in orientation and various types of training.

There are future plans to collaborate with the Human Resources Programme in the MoH to strengthen the implementation of mother and child care (especially for the neonate) in the curriculum of midwifery and nursing academies, and include it in the IMCI Computerized Adaptation Training Tools, IMCI training for lecturers and other types of medical training.

### Implementing home visits for newborn care in Ghana: experiences and lessons learnt

*Isabella Sagoe-Moses, Ministry of Health, Ghana*

Dr Sagoe-Moses explained that the policy on home-based newborn care was completed in November 2009 as part of a revised child health policy for under-fives. Before then, community health nurses attended to the needs of newborns at home as part of visits for maternal and child health service delivery. The new policy provides for a first contact within 48 hours of birth, and a second contact on day 6 or 7. Postnatal care is conducted as either home visits or visits to a health facility, and is carried out by a wide range of skilled and trained (volunteer) personnel. According to the Ghana Demographic and Health Survey (DHS) for 2008, 47% of mothers had a postnatal check-up within 4 hours after delivery, 68% had one within 2 days after delivery, and 23% of mothers had none.

In moving from policy to implementation, a need was identified to build the capacity of health workers to provide postnatal care while mobilizing and building the capacity of community-based agents to complement the efforts of health workers. Training materials and job-aids were developed, and training will begin soon. Trained providers go through a 5-day course based on WHO/UNICEF material.

Linkages between health facilities and CHWs are critical. CHWs make referrals to health facilities and receive feed-back. They are supervised by different cadres from the sub-district



facility. CHWs assist health staff during service delivery at outreach points in communities, and assist with health education and community mobilization.

Discussion centred on the links between the health facility and community workers. Volunteers are not paid anything, but are given incentives in kind. There was concern that the health facilities may not be prepared for many referrals, and thus the quality may not be good. In Ghana, an assessment of health facilities has been carried out to identify equipment needs.

### Group work I

The participants were divided into four groups. Two groups discussed the following questions:

1. Identify successful strategies and processes that lead to the adoption of a national policy on home visits for postnatal care.
2. Identify common barriers to the adoption of a policy on home visits for postnatal care and ways to overcome those barriers.
3. Identify enabling factors and challenges for moving from adopted policy to implementation of home visits for postnatal care.

#### ■ Policy adoption group I

All the countries in Group 1 had adopted a policy on newborn health before the WHO/UNICEF Joint Statement was issued. A stagnating NMR was a trigger for countries to adapt a strategy, as was lack of equity in newborn access to services. Nevertheless, the WHO/UNICEF Joint Statement was a useful starting point, and countries adapted it in accordance with their country context.

The group thought that factors facilitating the adoption of a policy included the availability of a convening mechanism to start the process. A review of existing policies, gap analysis and a decision on how to address the gaps was important, as was the ability of the health system to take up home visits. Political support was critical towards policy adoption, as was buy-in from professional associations. At the community level, demand for services and support



UNICEF COUNTRY OFFICE INDIA

from health facilities for maternity care were facilitating factors, as was involvement of communities and stakeholders in the process.

In some countries, developing “strategies” rather than a “policy” made the process go more quickly.

Pilot interventions and documentation related to resources needed, quality control and lessons learnt before scaling-up were useful. Donor coordination and funding was helpful, as was identifying a champion to mobilize resources.

Barriers identified included lack of coordination between communities and facilities, unsupportive professional associations, lack of national ownership, no legal statement from government, poor coordination amongst stakeholders, and lack of agreement on the contents of the package to be delivered.

The group discussed some of the ways to overcome barriers (see **Table 1**).

**Table 1. Ways to overcome barriers to implementation of home visits for PNC**

Barrier	Ways to overcome
Non-resident health workers for delivery of home-based neonatal care	Local recruitment
Retention of health workers	Individual commitment
Lack of proper human resource planning	Revise job description
Contents and quality of delivery of home-based neonatal care	Integrating training courses
Resistance from health workers for additional work	Persistent and patience
Bad experience from previous programme	Build capacities for supervision
Vertical nature at higher level	Outreach services linkages

Enabling factors and challenges for moving from adapted policy to implementation of home visits for PNC identified by the group were having a clear policy/strategy; availability of an operational plan; resource mobilization based on a costed plan; mapping system for special interventions; and an advocacy campaign at all levels. Other factors were the existing health workers and infrastructure; service mapping/situation analysis; motivated traditional leaders; availability of a critical mass of trainers and training facilities; increasing health budget allocation; increasing literacy and cohesive voices for higher allocation; women’s empowerment; global recognition of a country’s efforts; availability of a synthesis of evidence; improved programme management capacity; and a strong volunteer spirit.

Challenges included limited resources for scaling-up; how to rapidly expand without compromising quality; dissemination of policy/tools to all levels; engagement of local officials; lack of clear-cut postnatal maternal guidelines; training load and quality; and volunteers’ and health workers’ remuneration.

**■ Policy adoption group 2**

The group presented a diagram of the strategic ingredients to policy adoption, showing how partnership and advocacy, consensus building, technical leadership and evidence and data generation are all inter-linked.

With regards to advocacy, the key components are global momentum, assisted by the WHO/UNICEF Joint Statement, local evidence (through a situation analysis and DHSs), and scientific publications.

For consensus building, a technical working group and/or other coordination group is a main element, with MoH stewardship. This group should ensure awareness raising, development and designing policy; continued advocacy, partnership and consensus building. Another element is using evidence through operational research, exchange visits and disseminating success stories. These facilitate learning how to deliver services and how to create demand.



UNICEF COUNTRY OFFICE INDIA

Barriers to policy adoption include lack of local evidence on overall programme cost and cost effectiveness; conflict and lack of consensus, because of dissension about leadership between the maternal and child health divisions of MoHs; tensions in the balance between health workers and CHWs, and resistance from professional and regulatory bodies; systems requirements, including human resources and commodities; and institutional instability, where there is a high turnover of senior leadership or on-going restructuring; existing policies lacking neonatal health or contradictory policies; lack of reliable data; unhelpful cultural practices; and lack of social accountability by policy-makers, leading to lack of demand.

Enabling factors include global momentum for neonatal health, such as the MDGs and various WHO/UNICEF statements; existing maternal, newborn and related enabling policies and coordination mechanisms; the catalytic action of organizations and champions of maternal and newborn health; existing local evidence; communication technology advancement; and political stability.

Challenges of moving from policy to implementation include resources (financial, human, commodities), poor support systems (referral, supervision, capacity building); lack of policy dissemination; lack of community involvement; and resistance from skilled professionals and informal health providers).

In the discussion, the issue was raised of whether it is worth going through policy change, if implementation can proceed without it. The importance of a high level champion (in one country, the First Lady) was emphasized. The WHO/UNICEF Joint Statement appears to be useful to articulate what needs to be done, and was an enabling factor for countries. However, some participants thought it was not comprehensive enough, and should be revised to include maternal care, perhaps after the planned WHO consultation on PNC in June 2012. It would be useful to have case studies documenting the process that specific countries have gone through in moving from policy to implementation. Another issue raised was that CHWs appear to be overloaded with tasks. Establishing a reasonable workload for them may be a research question. There is a great deal of knowledge about CHWs, and it would be useful to have a forum to exchange information.

## Group work 2

Two groups discussed the following questions:

- Identify enabling factors, barriers and solutions to recruiting, remunerating and retaining community-based health workers to conduct home visits.
- Identify common enabling factors, barriers and solutions to training community-based health workers to conduct home visits.

### ■ Policy to implementation – Group 1

The group identified the key points in human resources planning, pointing out that they are all part of a process. There should be an overall human resource plan to ensure that home visits for PNC could be carried out. A standard national package to be delivered should be refined through consensus, as well as the number of workers needed, considering a team approach. In the process, data should be used to show the distribution of workers compared to the need. The plan would then need to be costed and subsequently monitored. Coordination mechanisms should be government led, with the MoH coordinating with other ministries, regulatory bodies, professional associations and partners.

Step 1 would normally be recruitment. There are two suggested pathways. One is to use existing workers with redefined/expanded tasks. Considerations for this approach were possible overload of tasks, characteristics may not be suitable (e.g. if they are male), they may not have been selected by the community or may not want to work outside the health post. In some cases, a new cadre of worker may be established, with nationally agreed recruitment criteria.

Step 2 is training, which should not be done until there is a plan for follow-up. Considerations for training design include: national standardization; integration; content and length dependent on tasks and also the literacy of the worker; balancing length of initial training with intensity of ongoing supervision; and whether it should be modular and skills based.

Step 3 involves retaining and incentivizing workers. Possible solutions for incentives include financial (regular and/or performance based); tools for work (bicycle, bag, uniform); commodities; community recognition; supportive supervision; review meetings and technical recognition; peer support; and availability of a career path.

Tracking numbers of workers, their distribution and quality of performance would be Step 4. The group noted that keeping track of human resources is challenging, even for staff working in health facilities. Possible solutions for determining the numbers still active include a payroll list; counting when issuing commodities; and checking coverage and quality.

Refining the plan to improve retention and distribution, and consider more training, would be part of this planning cycle.

### ■ Policy to implementation – Group 2

This group developed principles for selecting CHWs to deliver an essential PNC home visit package, including that criteria for selection must be developed that are appropriate for roles and responsibilities, and that each country will have different requirements depending on the existing system, cultural norms and social differences. A summary of the discussions is presented in **Table 2**.

The group also proposed mechanisms (see **Table 3**) for motivating and providing incentives for CHWs, based on the principle that CHWs should receive some form of fair reward for service.

The group also proposed how to train CHWs to conduct home visits (see **Table 4**).

In the general discussion, participants were concerned that the presentations sounded as though they were proposing a vertical approach, starting from scratch. There should be integration, based on existing systems. Although a general standardized approach was preferred, special situations, such as urban slums, had to be taken into account.

**Table 2. Principles for selecting CHWs to deliver PNC home visit package**

Criteria	Enablers	Barriers	Solutions
<p>Culturally-appropriate gender – usually female</p> <p>Married</p> <p>Age – a range is usually specified (usually 25–45) – but varies with location</p> <p>Schooling – depends on role/skills required (range able to read and write – 8 years of schooling)</p> <p>Be available for work</p> <p>Live in community</p> <p>Be respected</p> <p>Standard household catchment population specified</p>	<p>Women should be accepted in community</p> <p>Women who are daughters-in-law (India)</p> <p>Women from mothers' groups, etc.</p> <p>Catchment population should be small enough to allow regular home visits</p> <p>Community should be involved in the selection themselves – through village health committees and other local bodies – to ensure acceptance</p> <p>Budget line in central budget for government-salaried CHWs – improves sustainability</p> <p>All NGOs should use national CHW cadre if present; and should apply national selection criteria when recruiting for themselves</p> <p>Previous volunteer experience may mean CHW is more likely to remain in post</p>	<p>CHWs selected who do not live in the community – or CHWs with large household catchment population have difficulty making household visits</p> <p>Many CHWs are not as educated as the standard requires – particularly in remote or rural areas; this may limit the quality of their work</p> <p>Caste and other social – norms should be considered in areas where this is important</p> <p>Social/cultural differences – can limit ability of CHW to communicate effectively</p> <p>Politics – may influence who is selected</p> <p>Age – younger women may not be respected</p> <p>NGO projects are time-limited and cease when project over – sometimes train their own CHWs using different standards, and methods of reimbursement</p> <p>Volunteers more likely to leave posts</p>	<ol style="list-style-type: none"> <li>1. Use existing CHW systems when available</li> <li>2. Ensure that CHW mapping is conducted to review coverage and gaps; use data to decide on approaches to filling gaps</li> <li>3. Develop coordination mechanism for all partners implementing activities with CHWs – use this to review criteria for selection, and allocate financial and technical resources to areas where they are needed</li> <li>4. Develop local criteria for selection of CHWs and ensure they are used</li> <li>5. Ensure community involvement in selection process</li> </ol>

**Table 3. Mechanisms for motivating and providing incentives for CHWs**

Method	Enabler	Barrier	Solution
Financial – should be paid as incentive – many models	PBF improves satisfaction and reduces drop-out rates	Different NGOs use different models for different tasks	Existing salaried CHWs should be used when possible
Performance-based financing (PBF)	Salary helps improve retention	Late payments de-motivate	PBF should be explored in all countries implementing – needs high level commitment and systems to manage payments
Salary		Central fund and mechanisms for PBF need to be established	More data needed on progress with PBF generally
Non-monetary – livestock, help with farming, donations of food		Fixed salary may not be as motivating as performance-based	
<b>Equipment and supplies</b>			
Uniform, materials, counselling cards, equipment such as weighing scales and thermometers, badges, bags, bicycles, gum boots, umbrellas	Uninterrupted supplies essential Transportation – such as bicycles – often important Wet-weather gear (boots and umbrella) can make a difference Encourages regular facility visits – often monthly – to receive supplies. This provides an opportunity for problem solving and support	Logistical barriers to getting equipment and supplies to facilities Costs of procurement and distribution	In early implementation areas procurement and costs have been shared with partners Strategies for handing costs to MoH – through district mechanisms needed
<b>Recognition by community</b>			
	Gives status Improves demand Encourages communication with CHW	Requires commitment by local community groups and leaders – this process may take time to establish	Ensure that CHWs are selected by communities Education of community groups and leaders should be a part of the communication plan
<b>Linkage with health facilities</b>			
Regular monthly meetings Regular supervisory visits	Monthly reviews give opportunity for feedback, encouragement and support Use of registers – encourages links Pay for transportation and meals Field visits by supervisors are supportive	Not recognized with respect and dignity by health workers Role not recognized by facility-based staff Logistics costs for supervision – fuel, vehicles, per diems often not available	Facility-based HWs and supervisors should be trained in the Community maternal-newborn package Training in how to manage monthly contacts as part of community maternal-newborn training Develop approaches to improving regular supervisory visits
<b>Other</b>			
Training Free health services Include in other activities	Preferential treatment in facilities Participation in national immunization days and other activities builds status and gives a sense of having a role	Requires the commitment of local planners and managers	Encourage community groups to find alternative methods of rewarding and recognizing CHWs Encourage facility and district managers to include CHWs in activities when appropriate

**Table 4. Training CHWs to conduct home visits**

Element needed	Enabler	Barrier	Solutions
Standardized consistent training materials Linked with supportive supervision Integrated maternal-newborn materials – All elements should be standardized – training materials, facilitators guide, practice time, field work	Reduced duplication Reduced number of trainings required Easier to understand Support and involvement of training section/division	Need close collaboration between vertical programme areas Costs Resistance of vertical programmes Need support of separate training division	Development needs to be coordinated by a technical working group with representation from all key technical areas at the national level – as well as development partners
Materials adapted to country context/different languages within the country/different cultural context – messages should be appropriate for local practices – formative research for adaptation	Development should be overseen by technical working group Adaptation should be a concrete step in development process Qualitative data may already be available from other sources	More time required Requires staff with qualitative data collection skills and guidelines on how and what should be done Funds required	Develop process for training material adaptation – including formative research needs (just as was done for IMCI)
Materials simple and appropriate for level of CHW	Available materials that have been tested can be used to inform process	Need to field test all materials takes time Funds required	Technical working group responsible for training needs to conduct on-going review of training materials and process – and to be responsible for ensuring that all key elements are included
Appropriate amount of knowledge and skills training – video and field work	Liked better by CHWS because they get skills	Field testing required Funds required	
Training materials that support quality and efficiency of training – videos, case-studies, pictorial materials	Make training easier and are well liked	Time and funds required to develop materials	Include tools and guidelines for before and after assessments
Training and practice on counselling skills need to be emphasized	Will increase satisfaction of mothers and families – and CHW will get better feedback	May require more time in training Can be difficult in short time	Alternative methods for post-training follow-up assessment needed – for example, better use of monthly meetings between CHWs and facility supervisors
Training practice should include assessment and feedback on quality of training; pre- and post-training assessments	Allows CHWs to get feedback on progress	Requires time, staff expertise and some resources	
Post-training follow-up after training – use of supervisors to do supervisory visits	Motivates CHWS and improves quality	Lower-level supervisors may not have skills to update skills in all technical areas Logistics barriers to make field visits for supervision Inadequate resources	
Training plan Adequate number of facilitators need to be trained Ensure training for supervisors Supervisors should be practising/working Tracking training coverage and deployment Tracking coverage of workers	Districts given clear guidelines on training coverage and needs Quality is improved Staff better understand roles and responsibilities	Training plan can be difficult to develop when there is pressure to conduct vertical training – with support from development partners Requires district managers to resist ad hoc demands for training – and conduct activities in a more systematic way	Guidelines/training for district and other managers in training plan development – driven by central technical working group or coordinating body
Training structure – institution to do training	Stable group of trainers (competent, trained, well paid, respected)	Costs, political will	Advocacy to higher level

---

# Reaching high levels of coverage with quality care

## Panel 3: Reaching coverage and quality

### Postnatal home visit – reaching coverage and quality: lessons from research in Bangladesh

*Abdullah Baqui, Johns Hopkins Bloomberg School of Public Health, United States of America*

Dr Baqui began by describing the research site in Bangladesh where the Project to Advance the Health of Newborns and Mothers (Projahnmo) is being carried out through a partnership between the Bangladesh Ministry of Health and Family Welfare and local and international institutions. Projahnmo was established in 2001 in Sylhet, a district with a population of 560 000 and a NMR of about 50/1000. The objective is to design and evaluate the effectiveness of a community-based maternal and newborn care intervention package. It is a cluster randomized trial with clusters allocated to home care, community care or comparison. The main study outcomes are knowledge and practices, neonatal mortality and equity.

The intervention package includes antenatal and postnatal visits and community mobilization, with the exact interventions varying by study arm. At the end of 2005, Projahnmo achieved high coverage (91% for first ANC visit, 41% for 3rd PNC visit), although 21% of the target population did not receive any visits at all. Mortality was higher according to when the first postnatal visit was carried out, with a visit on day 1–2 associated with two thirds lower NMR.

CHWs were employed in one arm of the study, and Dr Baqui presented data to show that the assessment of newborn illnesses by CHWs showed good sensitivity and specificity, except for sensitivity for fever. An innovative strategy will be providing incentives to families to phone CHWs to tell them how their infants are.

He concluded that achieving high coverage for postnatal home visits is difficult, but possible if CHW catchment areas are small, existing TBA networks can be used or families actively seek CHW visits. Ideally, families would notify births if they see value in the visits. Widespread availability and use of mobile phones is an important enabling factor.

In the discussion, it was noted that the first postnatal visit should be very early, as half of deaths occurred before a visit in one of the studies. Half of sepsis was identified in the first week and 20% on the first day. It will never be possible to find all cases, but families can be helped to identify danger signs and seek care. Dr Baqui clarified that the CHWs were all recruited through NGO partners, had 6 weeks of training and were women. They received a salary commensurate with government levels, as did supervisors.

### Implementing home visits for newborn care: evaluation of the Indian Integrated Management of Neonatal and Childhood Illness strategy

*Nita Bhandari, Society for Applied Studies, New Delhi, India*

Dr Bhandari described a study in Haryana to determine the effectiveness of implementing the Integrated Management of Newborn and Child Illness (IMNCI) strategy on a district-wide scale in reducing neonatal and infant mortality. Secondary objectives of the study were to determine the effect of IMNCI on newborn and infant care practices, the prevalence of



neonatal and infant illness and care seeking for illness. It was a cluster randomized effectiveness trial in a district with a population of about 1.1 million. The study was in a primarily rural setting, where over half the deliveries occur at home.

There was random allocation of 18 clusters to intervention or control groups after a baseline survey. The intervention consisted of improving CHW skills to promote newborn care practices, improving case management skills of CHWs and other health workers, and strengthening the health system. The impact was a 15% reduction in infant mortality, 14% reduction in neonatal mortality after 24 hours, 20% reduction in neonatal mortality for home births, and a substantial improvement in newborn care practices.

About 60% of neonates were visited in the first day of life, although the CHWs reported a higher proportion than did caregivers. The quality of home visits was considered good based on CHWs' performance in assessment, examination and classification. Incentives to the different types of health workers made a difference in the proportion of young infants referred.

Dr Bhandari described several problems, and the corrective measures put in place to resolve them. She concluded with lessons for programme implementation:

- There is a need to ensure all intervention components are in place after training.
- Workers paid performance-based incentives responded better to new activities than workers with fixed salaries.
- Large programmes need a dedicated team of full-time trainers.
- Supervision is critical.
- Medicines and other supplies need to be easily accessible to CHWs at all times.
- Demand generation through women's group meetings and wall paintings was helpful.
- Adding home visits during pregnancy to postnatal visits would possibly increase impact.

The discussion centred on equity issues, and Dr Bhandari said that an equity analysis was planned. Community-based programmes appear to increase equity. It was suggested that where over 90% coverage is reached, everyone who needs the programme may be accessing it.

#### **Panel 4: Constraints to implementing timely home visits**

##### **Improving newborn survival in Southern Tanzania (INSIST Project)**

*Dr Fatuma Manzi, Ifakara Health Institute, United Republic of Tanzania*

Dr Manzi gave an overview of the Improving Newborn Survival in Southern Tanzania project. Its overall aim was to develop, implement and evaluate the impact and cost of a package of interventions at community level with health system strengthening in an area with a target population of about 1 million. The interventions included home-based counselling visits in pregnancy and the early newborn period and quality improvement for maternal and newborn



UNICEF COUNTRY OFFICE INDIA

care in health facilities. The main outcomes were effects on household behaviours related to newborn health and effects on newborn survival.

An innovative part of the study was using newborn foot size to identify small babies born at home who might be at most risk of death. Sensitivity, specificity and reliability of this measure appeared to be moderate to good.

The programme was carried out by volunteers who received motivational items and a fee for attending scheduled meetings. Extra volunteers were trained to provide for drop-outs. Results from a household survey in 2011 showed that over three quarters of women in intervention areas were visited by a volunteer at least once in pregnancy, and almost half received a postnatal visit at home.

Key implementation challenges and proposed solutions are shown in **Table 5**.

**Table 5. Key implementation challenges and proposed solutions**

Challenge	Solution
Long distances to furthest households	Sharing of village bicycles
Timing of newborn visit – notification of delivery	Postnatal note to link facility to home
Foot size not always measured well	Reinforced training on foot size
Misconception – promoting home birth?	Stakeholders meetings
Supervision of volunteers	Modified to engage Village Executive Officer; meeting supervisor at the facility
Motivation of volunteers – best performers	Certificates

Dr Manzi concluded by suggesting lessons for programmes. She cited innovations, such as using foot size as a surrogate for birth weight and a “bottom-up” approach for improving quality. Scaling-up was facilitated by having training and supervision carried out through existing government health staff and systems, and a collaborative approach involving a core group of agencies was used during development and implementation.

The question of quality of care was a topic of discussion. Dr Manzi noted that quality was not high at the first level. Initiatives were carried out to upgrade facilities, but improvement is difficult. Deliveries in health facilities increased because of the programme, but coverage of



postnatal visits was still low. Since women go home to their mothers to deliver, it is sometimes difficult to track them. Males were involved by leaving an information card for a couple to look at together. The husband is supposed to be present at the first visit to be aware of birth preparations. Trying to standardize a curriculum for many kinds of volunteers was difficult.

### **Panel 5: Linking CHWs with health facilities**

#### **Lessons for programmes from the Democratic Republic of Congo site**

*Antoinette Tshefu, Ecole de Santé Publique, Democratic Republic of Congo*

Professor Tshefu described the overall objective of this study as testing the safety and efficacy of simplified antibiotic regimens for treating possible serious bacterial infection in 0–59 day-old infants. The home visit objectives were identification and follow-up of new pregnancies and promotion of optimal care and identification of danger signs in young infants. The target population was 322 000 in Province Equateur (north-west Congo). The main outcomes of the screening and follow-up were higher coverage of ANC and mortality.

The CHWs involved in the study were literate village volunteers, who were accompanied by TBAs (the majority of whom are illiterate). Most CHWs were male and 18–50 years old. They received a monthly incentive and a bicycle.

CHWs are supervised by project nurses, community coordinators and study physicians with a checklist of activities and direct observation of home visits. The study nurse provides the linkage between CHWs and staff in health facilities, and the health centre nurse collaborates with CHWs in community sensitization and surveillance. CHWs are encouraged to participate in health centre activities (i.e. immunization campaigns).

A strategy for high coverage of infants identified within 24 hours was developed and implemented, building on the linkages between health facilities and CHWs. The close relationship with TBAs (and the stipend provided to them) has also helped. However, there are still difficulties because of frequent population movement.

Professor Tshefu noted several lessons for programmes: identify with the local community and use appropriate criteria for the selection of CHWs; provide incentives for CHWs; establish mechanisms to make CHWs loyal; stress close collaboration between community activities and health centres and the importance of community involvement.





The participants were impressed by the coverage achieved, which was possible because of good communication about births, and having CHWs in contact with women during pregnancy. However, sustainability is an issue. The community could participate more, and income-generating activities are being set up. While motivated volunteers have been used in some settings, the sense of the group was that compensation is needed.

### **Linking CHWs with health facilities – lessons from research in Kenya**

*Peter Gisore, Moi University School of Medicine, Kenya*

Dr Gisore talked about a study on Simplified Regimens for Management of Possible Serious Bacterial Infections in Neonates and Young Infants for Use in Outpatient and Community Settings: a Multi-centre Randomized Controlled Trial in Africa (the AFRINEST study). It is taking place in a rural community in Kenya, where 170 CHWs have been trained in community IMNCI and the use of study tools.

Enrolment nurses in health facilities are also trained in IMNCI, and they meet CHWs weekly to check their work, discuss field experiences, refill supplies, carry out planning and retrain. They also carry out field-based supervision and training for CHWs. Another cadre involved is the cluster coordinator, who attends facility meetings and provides support for CHWs and nurses.

Many lessons have been learnt through the process. To link to health facilities, CHWs need to accept supervision, be motivated, able to access the health facility and have time to complete their work. CHWs accept supervision if well-trained and friendly health facility staff are involved in community entry; and recruitment, training, meetings and joint planning and field-based supervision are carried out appropriately. CHWs need tools that are easy to use, relevant to their work, easy to carry around and link their work to health facility functions.

Dr Gisore noted that about half of the CHWs are self-motivated, about half need supervision to stay motivated, and a few are difficult to work with. CHWs complete their work if they are assisted in planning, plans and work are documented and they have a manageable work load.

Discussion centred on issues around how to remove some of the cultural barriers to creating demand for newborn care and changing behaviours. There was also mention of a pro-

posed national health insurance scheme for Kenya, which may remove some barriers. It was also noted that the CHWs have to carry out many interventions (not just newborn health). It was suggested that there should be operations research on how they can be more effective.

### Translating research into implementation: notes on good practices

*Rajiv Bahl, MCA, WHO Headquarters*

Dr Bahl summarized some of the lessons learnt/conclusions from the studies presented. He noted that these were research studies, but that some of them were very large and therefore the findings were relevant to other types of implementation.

1. High coverage of home-based newborn care is possible, including visits on day one, in diverse and sometimes difficult settings, but there should be realistic expectations about what is achievable. It takes a long time to reach this high coverage. Reported coverage may be different from actual coverage.
2. High quality is also possible.
3. Achieving high quality and coverage requires a high level of inputs that are context specific and not necessarily low cost. The context should help to guide where bicycles, incentives, etc., are needed.
4. Sustainable efforts are needed to achieve sustainable coverage and impact.
5. Identifying births early requires information coming from different sources, and the use of a variety of strategies.
6. Financial incentives to CHWs seemed common to all studies. Whether personnel working strictly as volunteers could do the work is not certain.
7. No matter what the incentive, it was not enough to provide a full salary.
8. All studies required strengthening support systems, for example, providing transport, supervisory check lists, training, etc.
9. Demand generation remains a cornerstone for this type of programme.
10. Training is an important issue. There is need to plan for initial training, follow-up, re-training (or training additional CHWs to replace any who leave).
11. Investment needs to go into the system.

### Panel 6: Creating demand

#### Demand generation – provision of home-based care

*Naresh Pratap, Ministry of Health Planning, Nepal*

Nepal's under-five death rate is decreasing steadily. About 61% of deaths are in the neonatal period, the NMR is 33/1000 live births and 64% of births take place at home. To address this problem the Ministry of Health Planning, in close consultation with partners, has recently developed a Community-based Newborn Care Package.



WHO/S. V. XYLANDER



AFRICA REGIONAL OFFICE (ESARO)



UNICEF COUNTRY OFFICE INDIA

The newborn package builds on training Female Community Health Volunteers (FCHVs) to assist during home deliveries and promote institutional deliveries. The 52000 FCHVs are married women with children. They are not paid, but are sometimes given incentives for assisting with campaigns.

A birth preparedness package is used for generating demand for maternal and newborn care services. It is used for interpersonal and group education through mothers' groups and one-on-one communication by FCHVs, skilled birth attendants and other health staff. A focused social communication campaign has also been initiated. A mass media campaign has been developed for awareness raising of key neonatal messages.

FCHVs encourage the presence of a skilled birth attendant at home deliveries to ensure clean delivery by providing free delivery kits. Social marketing of clean delivery kits has been undertaken for those home deliveries not reached by FCHVs.

Dr Pratap concluded by pointing out that existing platforms have been used in order to ensure demand generation for maternal and newborn services.

### **Models of demand creation and community mobilization**

*Annie Portela, MCA, WHO Headquarters*

WHO currently has guidance on health promotion interventions to increase women, family and community capacity to contribute to improved maternal and newborn health and to increase access and use of the services of the skilled attendant during pregnancy, child-birth and after birth. A major premise of the framework is that is important to systematically address the multiple factors that contribute to women not receiving appropriate care, and emphasizes taking the context into account. Thus community participation in the programme cycle was considered of importance. A number of systematic reviews are under way to review the evidence of health promotion interventions and to update the guidance.

Discussion issues included how to keep the FCHVs motivated. Partners sometimes give additional incentives to FCHVs, but not the government. Hospital services for deliveries are poor and need to improve, while improving the quality of care at the same time. There was further discussion on how to understand what communities want, through talking with them about services. This should be the normal way of working.

## Panel 7: Monitoring the quality of implementation

### Maternal and newborn health situation in Ethiopia

*Gemu Tiru, Federal Ministry of Health, Ethiopia*

Ethiopia is a mostly rural country, with a NMR of 37/1000 and about 10% of births attended by skilled providers. There are about 34 000 rural and 4000 urban Health Extension Workers (HEWs) who provide postnatal services at health posts and during home visits.

The monitoring system is designed as part of the overall policy, planning, monitoring and evaluation process and implemented at all levels of the health system. HMIS data are regularly collected, analysed and used for decision-making at every level. The postnatal care indicator in the HMIS is “at least 1 postnatal visit within 42 days after delivery”. There is one indicator for mother and baby because they are seen together, and it includes home and facility visits. The denominator is estimated deliveries.

Other relevant indicators in the HMIS include:

- number of newborns weighed
- institutional early neonatal deaths
- institutional maternal deaths
- stillbirths
- attendance at birth (skilled, HEW, TBA)
- caesarean sections carried out.

A challenge is that the HMIS is not yet fully implemented, but reforms are in progress. The logistics system is being strengthened, but in the meantime there are still shortages of commodities.

Dr Tiru proposed the way forward for improving delivery and monitoring of PNC services:

- strengthen HMIS and supply chain management systems;
- strengthen the primary health care unit and referral linkages between health facilities;
- carry out community mobilization and behaviour change activities;
- expand integrated community case management to cover >90% of the country in 2012;
- strengthen IMNCI by health workers;
- introduce newborn sepsis treatment by HEWs;
- increase midwifery training capacity;
- strengthen postgraduate training of health officers and midwives in emergency obstetrics and general surgery.

### PNC: national and global tracking

*Deborah Sitrin, Save the Children, Bangladesh*

Dr Sitrin explained the Inter-agency Newborn Indicators Technical Working Group which Save the Children has convened since 2008, with representation from UNICEF, DHSs, USAID, WHO and others. With regards to measurement of postnatal care, the group has accomplished increased consistency of questions; formative research on understanding and recall of questions about PNC; and providing postnatal data for Countdown to 2015 reports. Examples of other newborn health



WHO/S. V. XYLANDER



indicator advances include the Health Facility Assessment modules related to newborn care (working with the Service Provision Assessment).

PNC scale-up needs to be tracked at national level to measure progress towards reaching every mother and newborn, and identifying low coverage groups sub-nationally (by region, socioeconomic status, etc.). Globally, it has been tracked as a Countdown to 2015 core indicator since 2005. It is one of only six coverage indicators for the United Nations Commission on Information and Accountability for Women's and Children's Health.

For global tracking, the indicator is "number of mothers/newborns with a postnatal check within 2 days after birth" (numerator) over "all births" (denominator). Currently there are two separate indicators, one for the mother and one for the infant. Since all 24 countries with a newborn visits policy are visiting both mother and baby, it may be possible to combine this information into one indicator. This indicator

prioritizes early visits as per the WHO/UNICEF Joint Statement, with general agreement that the time should be within 2 days (the initial Countdown indicator was within 3 days).

In 2012, of the 75 Countdown countries, 25 had data available on PNC checks within 2 days for the mother for all births. The same number also had data on PNC checks within 2 days for the baby for home births. Only four countries had data on check-ups for the infant for all births.

There are many remaining PNC data gaps. For postnatal contacts, few countries have data from national surveys consistent with current global indicators. The DHS improved core survey and Multiple Indicator Cluster Surveys detailed module include postnatal information (currently optional). Survey questions do not clearly distinguish intrapartum care from PNC (e.g. a midwife taking blood pressure 1 hour after birth), which leads to an overestimate of true postnatal contacts.

Dr Sitrin expressed a need for more formative research on:

- how to distinguish intrapartum and early postnatal care
- how to track if a pre-discharge check is done in a facility
- whether the mother is aware of postnatal checks on her infant.

Other remaining postnatal data gaps include how to consistently document multiple visits, including the provider and the place. With regard to content, the Newborn Indicators Group reached consensus on four signal functions for a postnatal check for infants: checked cord, counselled on breastfeeding, counselled on danger signs for the newborn and assessed temperature.

PNC tracking in the future can be done with national surveys, but there are limitations, because there are already many questions, they are usually only carried out every five years, and they depend on long recall periods.

Dr Sitrin noted that other data sources are critical, especially for programme management: routine HMIS data from facility and community levels, and quality and process data.



## Indicators and tools for monitoring coverage and quality of PNC

Steve Hodgins, MCHIP, United States

Dr Hodgins talked about measurement. Programme managers need to understand a problem to make a decision, and to do this they need reliable and timely information. Measurement is done in order to understand something, and this is usually in a cycle including implementation, measurement, understanding the results, and deciding what to do about them. Measurement is also done to convince others, such as with the Countdown tool, and to reassure donors or governments.

In general, what is measured gets attention. With regard to maternal and neonatal health, whether there is a skilled birth attendant at delivery, and whether ANC visits took place and how many, are activities often measured. However, it is not always clear what these indicators actually measure. Measuring performance can be problematic, so usually whether a contact took place is recorded, not what happens during a contact.

Many items can be measured. To measure the process, signal functions can be recorded – system requirements (such as management, supervision, commodities), whether services are available (health workers present and motivated), policies and service delivery strategies or approaches, care-seeking and offer of services. Coverage can be measured by the number of contacts at a service delivery opportunity. Coverage combined with quality can be measured by looking at care and the interventions delivered and household practices. These last two together should lead to a measure of impact.

Data can be collected through various sources, such as periodic surveys, special studies, health facility-level quality improvement, routine monitoring systems, and various new hybrids of these items. Surveys are not usually helpful for day-to-day management, but routine HMIS data may not be valid.

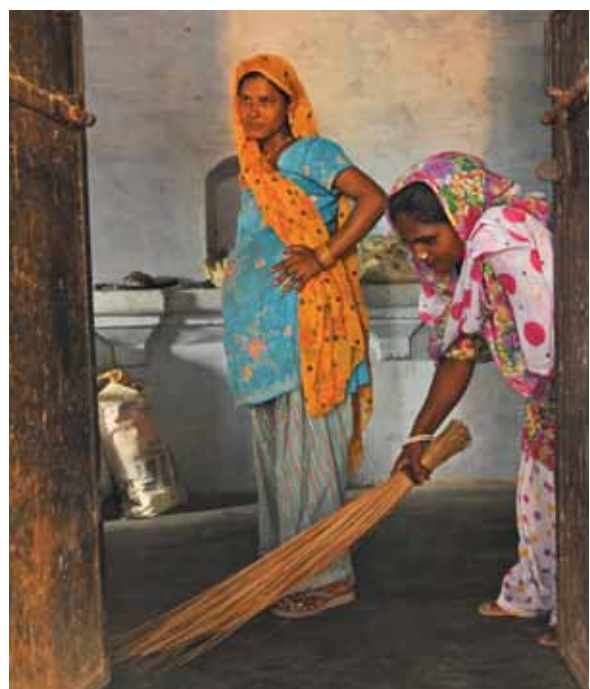
Programme managers need real-time data for getting attention, and for empowering themselves. They should have data not only on the number of contacts with services, but on the actual content and quality of the services delivered. Important criteria for data sources are timeliness, and appropriately approximate key dimensions of interest and validity.

In the discussion, participants wondered if too much is being included in the Multiple Indicator Cluster Surveys, and considered that in general there is a need for less data of better quality. Communities are becoming tired of being surveyed, so there is a need to find answers in other ways. Inconsistencies between national data and that reported globally sometimes occur. The problem of making comparisons over time, for example when different denominators are used, was raised. Participants also questioned the best timing for reporting postpartum and postnatal data. Some felt that the postnatal part of DHS should not be optional for countries.

### Buzz groups

Facilitated by Paul Bloem, MCA, WHO Headquarters

A short exercise was carried out, asking each participant to write on a card the most important action to be taken now to implement home visits for PNC and improve neonatal health. Some actions proposed related to global issues and others were more specific to the participant's own context.



UNICEF COUNTRY OFFICE INDIA

These cards were grouped into subject areas and summarized:

- PNC indicators – global
  - Achieve consensus on key indicators
- Coordination, planning, targets
  - Create a pool of “champions” for moving the agenda forward
  - Invite the country director of medical services to the AFRINEST study, and show the CHW-health facility link as a model for treatment at community level
  - Scale up village health teams to 90% of villages
  - Roll out home-based PNC in 11 districts of 2 regions
  - Make the programme more accessible, equity, and social inclusion
  - Organize maternal and newborn stakeholders’ meeting to plan the way forward
  - Stakeholders’/review meeting
  - Organise working group to draw action plan
  - Facilitate a maternal and newborn health technical working group meeting to outline step-by-step actions for what the country needs to jump-start action
  - Raise the funds for sustainability of implementation and high coverage
  - Mobilize resources
- Guidelines, norms and tools
  - Update PNC guidelines
  - Unified schedule maternal-newborn visits
  - Clear package content for maternal and newborn with context-specific recommendations
  - Change postnatal visit/contact indicator to “a visit within 2 days”, not a visit within less than or equal to 2 days
  - Revise/modify job descriptions of community-based workers to ensure postnatal care for mother and newborns
  - Balance the work of the CHW – to have more time for home visits for postnatal care
  - Provide materials for community-based maternal and newborn care
- Capacity/training
  - Train CHWs on clean delivery and postnatal care
  - Identify service providers and train them on postnatal care
  - Train 100 health workers in rationale of home-based postnatal care
    - Sustaining skills of trained CHWs
    - Train and deploy CHWs to carry out home visits to pregnant and postpartum women and newborns
- Programme management
  - Establish monthly monitoring mechanism to track progress
  - Provide incentive and recognition to maintain motivation
  - Provide data (by name, by address) of target
  - Provide adequate training and follow-up



UNICEF COUNTRY OFFICE INDIA

- Avoid missed opportunities for PNC after facility delivery
- Sustain supportive supervision
- Conduct bi-annual supportive supervision for health surveillance assistants
- Empower communities
  - Orient community action groups to support HSAs with home visits
  - To integrate maternal and neonatal care in PNC, use “Kader” to help the midwife in the village promote mother and neonatal care
  - Make CHWs accountable to the community.

It was noted that mobile phone technology was not mentioned during this exercise.

### **Group work 3: Reaching every mother and every newborn with effective PNC**

Participants were asked to work in groups of two to four countries to discuss the following issues to improve quality and coverage of PNC:

- What are actions you can take now?
- What are actions you can take in the medium term that require additional resources?
- What are actions that are necessary in the long term that require considerable new resources?
- What are new tools you may need?
- What are questions for research?

#### **■ Group 1 (Bangladesh, India, Nepal)**

The group said that it had found commonalities between the three countries. All had a policy adopted, the level of postnatal visit coverage ranged from 10% to 60%, and community workers from both government and NGOs, as well as volunteers.

With regard to human resources, the group felt that the numbers of workers in place were more or less acceptable, although in some places there were many vacancies to be filled. To make maximum use of resources, it was necessary to strategize their utilization (with job descriptions, reallocation, task shifting) through advocacy and negotiation with the government. Volunteers work in some situations, but they are asking for salaries. There is a need to identify an optimal package of compensation, consisting of salary and/or a performance-based incentive. In addition, recognition is needed to motivate workers, such as selection to local government, preference in hospitals, and being made to feel that their work is an honour. Social marketing in this area could help.

The group felt that there is a need to build skills for management. Very brief standard operating procedures for districts and other levels (about four to six pages for managers) would be helpful. Other needs were building skills for management and leadership at district level, and implementation guidelines, both technical and managerial.

Monitoring the programme on a regular basis involves having “Dashboard” indicators at all levels, use of technology and high quality HMIS. Ensuring supplies requires the availability of simple commodities, and linking supplies to programme needs. Supervising well means field visits, engaging in local problem solving, and having training and tools.

There is a need to create demand at the household level, ensuring that the population knows where to go, what to go for and who to contact. The community has its own role in creating demand. Community groups can do local resource mobilization, referral facilitation and monitoring.

The group noted that generic guidelines for training are available. Each country has some innovative job aids, and behaviour change communication materials. Generally, good trainers are available, and training can also be outsourced, for example to universities or NGOs.



There should be exchange learning and wider sharing of lessons learnt.

With regard to the research agenda, routine data can be used to identify programme challenges and low-performing clusters. Suggested research topics included: appropriate use of technology; cost and cost effectiveness; qualitative research on barriers to better performance and bottlenecks for implementation; and the use of antibiotics.

### ■ Group 2 (Ethiopia, Ghana and Malawi)

The group presented an action plan for scaling up:

1. Form an action group from national and other levels, including community representation.
2. Carry out a rapid assessment including current status, lessons learnt, best practices, gaps and recommendations.
3. Develop an action plan with timelines and targets.
4. Identify and mobilize resources – look at partnerships, costs, human resources, materials.
5. Develop a country-specific package – learned from a pilot/initial phase – revise training guides, review the process of training and the training plan.
6. Develop a monitoring and evaluation plan with specific indicators for quality, coverage and supervision.
7. Make a social mobilization and demand creation plan.

To sustain and increase coverage, the group recommended short-term actions within a time frame of up to 2 years:

- Stakeholder meeting for consensus building, resource mobilization, identification of champions at all levels;
- Training:
  - Review the training guidelines and job aids on the basis of a rapid assessment
  - Train facilitators, CHWs, supervisors
  - Follow up after training and supportive supervision;

- Equipment and supplies
  - CHWs and health workers – kits, job-aids
  - Equipment and supplies for facilities;
- Community demand creation:
  - Communication and social mobilization plan implementation, at various levels
  - Develop advocacy and social mobilization materials
  - Mobilization of community groups – traditional, religious leaders, mothers’ support groups.

The group proposed measures to sustain high coverage:

1. Improve referral system:
  - a. See value of referral by families and communities.
  - b. Improve quality of care –human resources, training, supplies and equipment.
  - c. Community safety net for referral – Ghana health insurance makes care free for newborns.
  - d. Team building – link facilities with communities through CHWs, community-based health committees, government budget allocation.
  - e. Removal of barriers – cultural and traditional practices, transport, out-of-pocket expenditure.
2. Mobilize and train existing community groups: women’s, transport and religious.
3. Hold regular review meetings and re-plan if necessary.
4. Use incentives to improve performance of workers, such as recognition, developing career paths, community support system, supportive supervision, supplies and equipment and selective PBF for hard-to-reach areas.

Medium-term actions should include:

- Community programme budget allocation in national and district plans – at all levels.
- Social inclusion and equity of care with a safety net for the hardest-to-reach and bottom quintile.
- Scaling-up at national level.
- Expansion of partnership to religious organizations and others.
- Integration of the maternal and newborn package, including home-based PNC, into pre-service teaching.
- Building capacity of pre-service training institutions, including providing materials and human capacity.
- Improve the HMIS to include key postnatal indicators.



AFRICA REGIONAL OFFICE (ESARO)



AFRICA REGIONAL OFFICE (ESARO)



UNICEF COUNTRY OFFICE INDIA

The group suggested the following research questions:

- Effect of postnatal home visits on both maternal and newborn health outcomes.
- Perceptions (barriers and enablers) of pregnant women, families and communities on postnatal visits during the first week after delivery.
- Affordable and sustainable incentives for CHWs.
- Effect of postnatal visits on family planning and other maternal and newborn services uptake.
- Sociocultural practices that affect health-seeking behaviour and health outcomes during pregnancy, delivery and the first week of life.
- Male involvement in improvement of maternal and newborn care, including home-based postnatal care.
- Innovations and models for the hardest-to-reach and bottom quintiles.

### ■ Group 3 (Indonesia and Myanmar)

The group compared the situation in the two countries as regards midwives and CHWs, timing and implementation of home visits, and other factors, and found that it is quite different. Bottlenecks were also different. In Myanmar, these include the low number and distribution of midwives, skills for visits and content, weak supervision, low coverage and a weak data system. In Indonesia, the issues included who should provide care, standards for integrated PNC, timing of visits, reaching remote and unreached populations, compliance of health workers to standards, and referral pathways and transport issues. There are cash transfers if women go to health facilities, but presumably not for home visits.

With regards to implementation at district level and decentralization issues, both Indonesia and Myanmar have health centres under local government; weak reporting; no good system for rewards and punishment; PBF; and a need to strengthen the capacity of local government. The group proposed follow-up actions for each country:

- Indonesia
  - meeting to integrate maternal and neonatal components of visits, timing (need for guidance from WHO Headquarters)

- incentives for visits, discuss with local government
- discuss better reporting mechanisms with centre for health information
- scaling-up: building on existing system, training locally.
- Myanmar
  - training community health volunteers in newborn care
  - evaluation of programme in ten townships supported by UNICEF
  - scaling-up from five townships with donor support
  - review, revise training to add maternal visits.

The group identified the following research issues:

- timing of visits
- frequency of visits (two or three in the first week?)
- approaches to remote areas
- content of visits, issues with over-sensitivity.

■ **Group 4 (Burkina Faso, Democratic Republic of Congo and Rwanda)**

The group proposed several short-term actions:

- establish protocols and simplified directives at all levels of management of the mother and neonate;
- motivate the mother-child technical working groups, who should analyse the situation with existing protocols, simplify them and establish a follow-up plane
- develop a plan for sensitizing health care workers on the care that prevents neonatal illness, above all those that have a preventive role (cover, put to the breast, etc.);



- sensitize communities on actions to prevent neonatal illness;
- put in place a plan for immediate action and call a meeting of interested parties;
- carry out a situation analysis by the technical group based on a review of existing documents;
- adapt training, data collection and monitoring tools.

Medium-term actions to be carried out included:

- strengthen the link between community actions and the health system (supervision, referral and counter-referral, etc.);
- re-training of health care workers and train CHWs;
- provide equipment for health training and for CHWs;
- create a space for care of the newborn.

Proposals for research included:

- mid-term evaluation and recommendations for improving implementation;
- advocacy for the integration of CHWs into the system of government workers;
- alternatives for motivating CHWs in order to ensure the sustainability of actions.
- the level of education of CHWs in relation to the packet of services offered at community level;
- quality of PNC given by CHWs;
- implications for the community;
- acceptability by the community of the PNC package.

#### ■ Group 5 (Kenya, Nigeria, Tanzania, Uganda)

The group spelled out actions for planning and management:

- Immediate
  - utilizing existing working groups, review road maps, strategies and policies
  - define what needs to be done for both mother and child (i.e. draft Minimum Package)
  - stakeholders' meeting on policy dialogue, mapping, in-service and pre-service training.
- Medium term
  - finalize implementation guidelines for PNC package for all levels of health care
  - dissemination of policy and guidelines
  - district planning
  - implementation.
- Long term
  - implementation
  - review and planning (e.g. curriculum review).

The group proposed several methods of reaching all pregnant women and having notifications of delivery, including:

- register for pregnant women at community level
- register of all women of reproductive age group
- establish a register for all births
- engage the local birth and deaths registration officials
- community participation and mobilization
- involve TBAs
- monitoring and evaluation tool
- incorporate PNC activity in existing health promotion messages.



To improve and ensure availability of essential equipment and supplies, the group suggested the following actions:

- review and define the CHW kit
- mobilize resources to maintain the kit
- cost and procure basic PNC equipment and supplies for health facilities and communities
- include the kit in the essential drugs list
- improve logistics and supplies management (inventory, distribution and storage).

Ideas for the referral of sick mothers and newborns included:

- train CHWs to identify sick mothers and children
- facilitate referral system and care (feedback, transport, ambulance, communication)
- extend the birth preparedness plan to include PNC.

Incentives and other methods of sustaining performance were suggested:

- leverage community funds
- *income-generating activities*
- government to commit financial support.

With regards to monitoring and evaluation and supervision, the group proposed the following actions:

- adopt, adapt or develop PNC indicators
- review or develop monitoring and evaluation tools to include PNC indicators
- utilize m-health/e-health technologies
- appoint “Champions”
- document and disseminate experiences
- follow-up after training, mentorship, supervision (mobilize funds) and specific monitoring and evaluation plans.

Proposed questions for research included:

- best models for monitoring and evaluation of community interventions
- linking CHWs to primary health care facilities
- models for implementing PNC in different contexts (urban, peri-urban, rural)
- knowledge, attitudes and practices of PNC among policy-makers, health workers, communities and CHWs
- best approaches for providing incentives for CHWs
- processes of policy formulation impacting on implementation
- challenges and opportunities for implementing PNC.

Participants discussed new technologies for birth notifications and how these could be used. Some countries have birth registers, and these can be helpful. Some participants wondered whether what most CHWs had was a “kit”, and considered how to supply/re-supply them. Not everyone agreed on the need for more research on the timing and number of postnatal visits, but thought it was better to focus on implementation issues. It was noted that there are already several training packages that relate to PNC, and there was a need to capture linkages. Involving maternal health experts in these discussions would be useful, to look at issues from their perspective.

---

# Lessons learnt and next steps

## Review of lessons learnt and agreed next steps

**Bernadette Daelmans and Joseph de Graft-Johnson**

In summarising the lessons learnt, Dr de Graft-Johnson said that the approach of implementing home visits for PNC has taken off. More emphasis now has to be placed on implementation than on advocacy. A situation analysis doesn't have to be lengthy and formal. For an evidence base, the WHO/UNICEF Joint Statement is adequate.

In light of this, a small working group proposed the following conclusions:

- Community-based home visit packages for maternal and newborn care are currently being implemented in more than 24 countries.
- Most implementing countries are using a continuum of care approach that uses pregnancy visits, referral for delivery at health facilities and early postnatal contacts.
- Mother and newborn are usually included in the community maternal and newborn package (the extent of the maternal health component is variable).
- For those countries who have not yet adopted an early PNC policy or strategy, introduction may require:
  - advocacy and consensus building on maternal and newborn care
  - formation of a government and stakeholders technical working/coordination group
  - situation analysis
  - review of evidence base
  - adoption/adaptation of a minimum package of interventions
  - supporting policies/strategies.
- Implementation to achieve coverage and quality is now the most important issue for many countries.
- Different categories of CHWs have been used in all settings – but a system of rewards or incentives is required in order to sustain performance. In many countries PBF is being used.
- As many countries have adopted a policy/strategy on maternal and newborn care, implementation of community-based packages on the ground is now their focus.
- Implementation has been most systematic in countries where there is a central coordinating group led by the government – which allows a national strategy to be developed and resources allocated where they are needed.
- Close collaboration between maternal and child health staff/divisions is required in order to develop a coordinated country approach to implementation.
- CHWs in all countries require adequate reward for work; financial support (salary, performance-based incentives, or combinations) appears to be important.

Implementation of community mother and newborn packages requires a number of systems issues to be addressed, including:

- A human resources plan should be developed based on the existence of a cadre dedicated to mother and child health; the density of the population or households; how, where and



when workers will be deployed; job description; current regulations; and proposed remuneration.

- An implementation plan needs involvement of all stakeholders to carry out district-based planning, which might include targeting high-risk populations, and planning for scaling-up.
- A national and district monitoring plan, including targets, indicators and the use of data for decision-making needs to be in place to track implementation and outcomes.

In order to ensure that the programme is implemented smoothly, and that high coverage of mothers and newborns, including the most vulnerable, can be achieved, essential system supports are needed in key areas:

- mechanisms for birth notification;
- regular contacts between CHWs and health facilities;
- essential equipment and supplies in the facilities and for the CHWs;
- use of alternative methods for connecting families, CHWs and health workers (such as mobile phones);
- functional referral system.

It was noted that quality of care at first-level health facilities and district hospitals is critical to supporting community maternal and newborn care since implementation of community maternal and newborn packages increases attendance at facilities for ANC, delivery and sick mother and newborn visits; and that demand creation and community participation are essential for increasing coverage and sustainability.

In light of these conclusions, the group proposed the following recommendations, which were generally accepted:

- Advocacy: UNICEF, WHO and partners should use upcoming global meetings to advocate for increased adoption of policies on home visits for PNC and increased resources for implementation.
- Technical guidance:
  - WHO should lead the process to:
    - define the optimal package of interventions for mother and baby during the postnatal period regardless of location, including provider profile and skills;
    - define the optimal frequency and timing of early postnatal visits;
    - provide guidance on the cost of delivering the mother and newborn package in different settings;

- based on the above, update current training packages and related materials.
- WHO and UNICEF in collaboration with partners should lead the process to:
  - develop a practical implementation guide for community mother-newborn care;
  - define standard indicators for tracking progress at national and district level;
  - consider the establishment of a clearinghouse where technical help could be provided;
  - ensure that countries can access support for scaling-up;
  - further develop and support operational research in key areas.
- Research should be defined and carried out in the following areas:
  - how to link CHWs to health facilities
  - how to initiate and provide post-discharge newborn care in the community
  - how CHWs identify pregnancies and births
  - models for implementing postnatal care in different settings
  - use of technology to support implementation
  - costing and cost-effectiveness studies
  - qualitative research on barriers to improved performance.

During the discussion, there was emphasis on the need to improve quality of care at the first level. With regard to costs, it was pointed out that work is going on in this area (led by the London School of Hygiene and Tropical Medicine), so that countries will be able to easily calculate the costs/cost-effectiveness of the community package, taking into account time, pressure on facilities, etc. There was a call to look more at lessons on demand-side initiatives. There is also a need for a practical implementation guide with tools for supply, management and quality assessment.

### Concluding remarks

**Jose Martines, MCA, WHO Headquarters**

Dr Martines noted that the last three years had shown success in implementation of home visits for PNC. Most countries that have a policy have implemented it. However, there is a significant gap in countries that have not yet adopted policies, especially in sub-Saharan Africa.





Low coverage is a challenge, and quality is still far from what is needed for health benefits. A large gap is the engagement with the maternal health community, and the next meeting needs to be more balanced between maternal and newborn experts.

He noted that opportunities for advocacy are increasing, as noted in the list of upcoming major meetings. These also provide for better learning and sharing of lessons. Dr Martines said he hoped that the participants would continue to share experiences, and give feedback to governments and the international community. There were many partnerships represented at this meeting, so it was an internationally supportive moment. He reminded participants of remarks in the meeting about asking and listening before giving advice, and asked everyone to take back inspiration, motivation, and ideas to make a difference.

---

# Technical updates

## Guidelines on newborn health

*Rajiv Bahl, MCA, WHO Headquarters*

Dr Bahl explained the principles of guidelines development followed by WHO. Guidelines should be systematically developed and based on all available evidence. Recommendations should be clear and unambiguous, stating the quality of evidence on which they are based. The strength of a recommendation depends on the balance of benefits and risks, values and preferences, and costs of implementation. Recommendations should take into account the range of circumstances in which they will be used.

The process of guideline development involves several steps:

- establishing a WHO Steering Group and an independent Guidelines Development Group;
- scoping the guidelines, which involves formulating key questions and critical outcomes;
- systematic reviews and synthesis of evidence;
- grading the quality of evidence using GRADE;
- formulation of recommendations by the Guidelines Development Group, taking into account benefits, harms, values and preferences, and costs;
- peer-review and finalization;
- field testing, implementation and evaluation.

Four newborn health guidelines were developed in 2010–11:

- Feeding of low-birth-weight infants (available at: [http://www.who.int/maternal\\_child\\_adolescent/documents/infant\\_feeding\\_low\\_bw/en/index.html](http://www.who.int/maternal_child_adolescent/documents/infant_feeding_low_bw/en/index.html))
- Hospital care for newborns (available at: [http://www.who.int/maternal\\_child\\_adolescent/documents/management\\_childhood\\_conditions/en/index.html](http://www.who.int/maternal_child_adolescent/documents/management_childhood_conditions/en/index.html))
- Management of neonatal seizures (approved – under publication)
- Neonatal resuscitation guidelines (conditionally approved – under publication)

Dr Bahl gave two examples of questions on feeding low-birth-weight infants, formulated according to population, intervention, comparison and outcome (PICO) measures:

- In LBW infants (P), what is the effect of feeding mother's own milk (I) compared with feeding infant formula (C) on critical outcomes – mortality, severe morbidity, neurodevelopment and anthropometric status (O)?
- In LBW infants who cannot be fed mother's own milk (P), what is the effect of feeding donor human milk (I) compared with feeding infant formula (C) on critical outcomes (O)?

He showed how a grade table would be constructed, indicating the number of studies reporting different outcomes, the design, the limitations in methods, precision, consistency between studies, directness, the pooled effect size and a grading of overall quality. Each of these measures receives a score based on agreed criteria.

Dr Bahl gave an example of how the evidence can lead to a recommendation, using moth-

er's milk versus formula. There is evidence of important benefits to using mother's milk for feeding low-birth-weight babies:

- mortality (18% reduction) LOW QUALITY
- severe infections or necrotizing enterocolitis (60% reduction) MODERATE
- mental development scores (5.2 points higher) LOW QUALITY.

At the same time, there was evidence of potential harm (lower length at 9 months), but the evidence for this was graded as VERY LOW QUALITY. Policy-makers, health care providers and parents in developing country settings are likely to give a high value to the benefits, and the observed benefits are clearly worth the costs.

In this case, it was possible to formulate a strong recommendation that low-birth-weight infants, including those with very low birth weight, should be fed mother's own milk, based on moderate quality evidence of reduced severe morbidity and low quality evidence of reduced mortality and improved neurodevelopment. He showed a list of recommendations on choice of milk, supplements and when and how to feed, formulated in this way.

In 2012–2013, WHO expects to produce guidelines on PNC and also on management of sepsis using this approach.

## **New WHO Guidelines on basic newborn resuscitation**

**Severin von Xylander, MCA, WHO Headquarters**

Initiation of breathing/resuscitation is one of eight elements of essential newborn care (the others are cleanliness; thermal protection; early and exclusive breastfeeding; eye care; immunization, management of newborn illness; and care of the preterm and/or low-birth-weight newborn).

The previous WHO guidelines, Basic Newborn Resuscitation: a practical guide, date from 1998. At that time, there were many question unanswered. Newborn resuscitation is included in various WHO documents and in the WHO training course on essential newborn care.

Development of the new guidelines was a process that started in early 2009 with an initial meeting to draft questions. Since then, systematic reviews of the evidence and summaries were developed, a technical consultation was held, and conditional approval to 13 recommendations was given by the Guidelines Review Committee in December 2011.

The new guidelines differ from the previous ones in several ways. The emphasis is now on not clamping the cord too early. There are reduced indications for suctioning, including that no routine suctioning should take place before ventilation, and for babies born through meconium-stained amniotic fluid who do not start breathing on their own. There is now a preference for a bulb syringe in the absence of mechanical equipment, and preference for a self-inflating bag. It is recommended to start PPV within one minute, with measurement of heart rate after 60 seconds. It also recommends stopping resuscitation after 10 minutes, if there is no detectable heart rate.

A summary document providing the background, summarizing the process, the evidence and recommendations, including references, will be published shortly. Other products include a flow chart on basic newborn resuscitation, and a Maternal and Neonatal Care Standard on initiation of breathing and resuscitation. The Integrated Management of Pregnancy and Childbirth, IMCI and other child health documents, including training materials, will be updated based on the new guidelines.

Discussion centred on how these guidelines differed from the guidance from the Helping Babies Breathe initiative of the American Association of Pediatrics. Participants concluded that there were not major technical differences between the two, but rather in the training approach. Countries could consider how Helping Babies Breathe might fit into Essential Newborn Care, and review training methods.





# Annexes

---

# Annex 1

## Summary table on postnatal care in countries

Country			What is the national policy or strategy on the recommended place of childbirth? (tick one or more as appropriate)						Policy on discharge after facility birth
	WHO Region	Primary respondent	Is there a national policy or strategy on skilled care at childbirth?	Any health facility	Health facility with maternity services (labour room, maternity ward)	Home	Home & facility	No recommendation on place of childbirth	Is there a national policy on the recommended timing of discharge of mother and the baby after normal childbirth at a health facility?
Bangladesh	SEAR	MoH	Yes					•	Yes
Benin	AFR	MoH	Yes	•	•				Yes
Bhutan	SEAR	MoH							
Botswana	AFR	MoH	Yes		•				Yes
Burkina Faso	AFR	MoH	Yes		•			•	Yes
Burundi	AFR	MoH	No	•					No
Cameroun	AFR	MoH	Yes		•				No
Comoros	AFR	MoH	Yes	•					Yes
Congo	AFR	MoH	Yes	•	•				Yes
Cote d'Ivoire	AFR	MoH	Yes	•	•				Yes
DPR Korea	SEAR	MoH	Yes		•				Yes
Ethiopia	AFR	WHO or other	Yes	•	•				Yes
Gabon	AFR	MoH	Yes		•				No
Ghana	AFR	WHO or other	Yes		•	•	•		Yes
Guinee	AFR	MoH	Yes	•	•				Yes
Equatorial guinea	AFR	MoH	No	•					No
India	SEAR	WHO or other	Yes	•	•				Yes
Indonesia	SEAR	WHO or other	Yes	•	•				Yes
Kenya	AFR	MoH	Yes		•				Yes
Lesotho	AFR	MoH	Yes		•				Yes
Liberia	AFR	MoH	Yes		•				Yes
Madagascar	AFR	MoH	Yes	•					Yes
Malawi	AFR	MoH	Yes		•				Yes
Maldives	SEAR	MoH	Yes		•				No
Mali	AFR	MoH	Yes	•					Yes
Mauritania	AFR	MoH							

If yes, after what time?		Is there a national policy on home births by skilled birth attendant in the country?	If there is a national policy on home births, please indicate the title of the skilled birth attendant who should conduct home deliveries: (nurse, doctor, mw or else)	If there is a national policy on home births, what is the minimum recommended period that the skilled birth attendant should observe a mother and newborn after birth at home?			Does the country have a national policy/strategy recommending home visits to mother and newborn in the first week after childbirth?				Does the policy/strategy include home visits to pregnant mothers?
Legend: Very short stay (< 6 hours) Short stay (6-12 hours) Medium stay (12-24 hours) Long stay (24-48 hours) Very long stay (>48 hours)	Number of hours:	Policy on home birth	Legend: SBA=1, non-SBA=2	Policy on close observation after home birth	Very short observation time (< 2 hours) Short observation time (2-4 hours) Long observation time (> 4 hours)	Number of hours:	PNC home visits policy/strategy exists	Yes, for both mother and newborn	Yes, for mother only	Yes, for newborn only	Policy on home visits during pregnancy
Medium stay	24	Yes	SBA				yes	•			yes
Very long	72	No					yes	•			
Medium stay	24	No					yes	•			no
Long stay	48	No					no				
Long stay	48	No									
Long stay	48	No					no				
Medium stay	24	No									
Long stay	48	No					no				
Very long	72	No					yes	•			yes
Very long	168	No					yes	•			yes
Short stay	6	No					yes	•			yes
Long stay	48	No					no				
Short stay	6	Yes	Non-SBA	Yes	> 4 hours	6	yes	•			d/k
Short stay	6	No					no				yes
Long stay	48	No					no				
Long stay	48	No	SBA				yes	•			yes
Medium stay	24	No					yes	•			
Long stay	48	Yes	SBA	Yes	2-4 hours	2	yes	•			yes
Long stay	48	No					yes	•			yes
Medium stay	24	Yes	SBA	Yes	> 4 hours	24	yes	•			yes
Very long	72	No									
Long stay	48	No					yes	•			yes
Long stay	48	No					yes	•			yes
Short stay	6						yes	•			yes

Country				What is the national policy or strategy on the recommended place of childbirth? (tick one or more as appropriate)					Policy on discharge after facility birth
	WHO Region	Primary respondent	Is there a national policy or strategy on skilled care at childbirth?	Any health facility	Health facility with maternity services (labour room, maternity ward)	Home	Home & facility	No recommendation on place of childbirth	Is there a national policy on the recommended timing of discharge of mother and the baby after normal childbirth at a health facility?
Mozambique	AFR	MoH	Yes		•				Yes
Myanmar	SEAR	MoH	Yes		•	•	•		Yes
Namibia	AFR	MoH	Yes		•				Yes
Nepal	SEAR	MoH	Yes	•	•				Yes
Niger	AFR	MoH	Yes	•	•				D/K
Nigeria	AFR	MoH	Yes		•				No
Pakistan	EMR	WHO or other	Yes		•				Yes
Democratic Republic of Congo	AFR	MoH	Yes		•				Yes
Central African Republic	AFR	MoH	Yes		•				Yes
Rwanda	AFR	MoH	No		•				Yes
Sao Tome and Principe	AFR	MoH	Yes		•				Yes
Senegal	AFR	WHO or other	Yes		•				Yes
Seychelles	AFR	MoH							
Sierra Leone	AFR	MoH	Yes		•				No
South Africa	AFR	MoH	No		•				Yes
Sri Lanka	SEAR	WHO or other	Yes		•				Yes
Tanzania	AFR	WHO or other	Yes	•					Yes
Chad	AFR	WHO or other	Yes		•				No
Thailand	SEAR	WHO or other							
Gambia	AFR	WHO or other	Yes		•				Yes
Timor Leste	SEAR	WHO or other	Yes		•				Yes
Togo	AFR	MoH	Yes	•					Yes
Uganda	AFR	MoH	Yes		•				Yes
Zambia	AFR	MoH	Yes		•				Yes
Zimbabwe	AFR	MoH	Yes		•				No

FOLLOW-UP TO THE JOINT WHO/UNICEF STATEMENT ON HOME VISITS FOR THE NEWBORN CHILD

If yes, after what time?		Is there a national policy on home births by skilled birth attendant in the country?	If there is a national policy on home births, please indicate the title of the skilled birth attendant who should conduct home deliveries: (nurse, doctor, mw or else)	If there is a national policy on home births, what is the minimum recommended period that the skilled birth attendant should observe a mother and newborn after-birth at home?			Does the country have a national policy/strategy recommending home visits to mother and newborn in the first week after childbirth?				Does the policy/strategy include home visits to pregnant mothers?
Legend: Very short stay (< 6 hours) Short stay (6-12 hours) Medium stay (12-24 hours) Long stay (24-48 hours) Very long stay (>48 hours)	Number of hours:	Policy on home birth	Legend: SBA=1, non-SBA=2	Policy on close observation after home birth	Very short observation time (< 2 hours) Short observation time (2-4 hours) Long observation time (> 4 hours)	Number of hours:	PNC home visits policy/strategy exists	Yes, for both mother and newborn	Yes, for mother only	Yes, for newborn only	Policy on home visits during pregnancy
Medium stay	24	No					yes	•			yes
Very long	72	Yes	SBA	Yes	> 4 hours	2520	yes	•			yes
Very long	168	No					no				
Medium stay	24	Yes	SBA	Yes	> 4 hours	6	yes	•			yes
Very long	72	D/K					yes	•			yes
Long stay	48	No					yes	•			yes
Very long	72	Yes	SBA	Yes	> 4 hours	36	yes	•			yes
Very long	72	No					no				
Long stay	48	No					no				
Very long	72	No					yes	•			yes
		No					no				no
Long stay	48	No					yes	•			yes
		No					yes	•			yes
Short stay	6	No					yes	•			yes
Medium stay	24	Yes	SBA	Yes	> 4 hours	240	yes	•			yes
Medium stay	24	No					d/k				
		No					no				
							yes	•			yes
Medium stay	24	No					no				yes
Medium stay	24						yes	•			yes
Very long	72	No					no				
Medium stay	24	No					yes	•			yes
Long stay	48	No					yes	•			no
Medium stay	24	No					no				

---

# Annex 2

## List of Participants

Dr Gloria Quansah Asare  
Director, Family Health Division  
Ministry of Health  
Accra  
Ghana  
Email: gloasare1@yahoo.com

Dr Abdullah Baqui  
Professor, Department of International Health  
Johns Hopkins University  
615 North Wolfe Street  
Baltimore  
MD 21205  
USA  
Email: abaqui@jhsph.edu

Dr Nita Bhandari  
Society for Applied Studies  
45, Kalu Sarai  
New Delhi 110016  
India  
Email: chrd@sas.org.in

Dr France Donnay\*  
Interim Director, MNCH  
Bill and Melinda Gates Foundation  
USA  
Email: France.Donnay@gatesfoundation.org

Dr Peter Gisore  
Moi University School of Medicine  
Department of Child Health and Paediatrics  
PO Box 4606  
30200 Eldoret  
Kenya  
Email: gisore2007@yahoo.com

Dr Altaf Hossain  
Programme Manager (IMCI)  
Directorate General of Health Services  
Ministry of Health  
Dhaka  
Bangladesh  
Email: altafhossainss@gmail.com

Dr Jean-Fidèle Ilunga\*  
Directeur  
Programme national de prise en charge des  
maladies intégrées de l'enfant  
Ministère de la Santé  
Kinshasa  
D.R. Congo  
Email: jfilungap@yahoo.fr

Mrs Fannie Kachale  
Assistant Director,  
Reproductive Health Unit  
Department of Health  
Ministry of Health  
Lilongwe  
Malawi  
Email: fkachale@yahoo.co.uk

Dr Ahmad Firas Khalid  
University of Ottawa  
Ottawa  
Canada  
Email: feraskhalid@gmail.com

Dr Ajay Khera  
Deputy Commissioner  
Child Health  
Government of India  
New Delhi  
India  
Email: ajaykheramch@gmail.com

Dr Adrien Lokangaka  
P.O. Box 11850  
Université de Kinshasa  
Faculté de Médecine  
Ecole de Santé Publique  
Kinshasa  
D.R. Congo  
Email: adrinloks@yahoo.fr

\* Unable to attend.

Dr Fatuma Manzi Kabanywanyi  
Principal Scientist, Head of Health System  
and Policy Research, Ifakara Health Institute  
P.O. Box 78373  
Plot 463, Kiko Avenue, Mikocheni  
Dar es Salaam  
Tanzania  
Email: fmanzi@ihi.or.tz

Ms Cathy Mugeni  
Head of Community Desk  
Ministry of Health  
Kigali  
Rwanda  
Email: kmugeni@gmail.com

Dr John Murray  
10 Edward Street  
Norwood  
South Australia 5067  
Email: jcsmurray@hotmail.com

Dr Erna Mulati  
Head, Subdirector of Newborn Health  
Directorate of Child Health  
Ministry of Health and Social Welfare  
Jakarta  
Indonesia  
Email: erna\_mlt@yahoo.com

Dr Myint Myint Than (Mrs)  
Deputy Director  
Women and Child Health Development  
Department of Health  
Ministry of Health  
Yangon  
Myanmar  
Email: dr.myint.m.than@gmail.com

Dr Gertrude Namazzi  
Dept of Health Policy, Planning and  
Management  
Makerere University School of Public Health  
and Principal Investigator, Uganda Newborn  
Study, P.O Box 7072  
Kampala  
Uganda  
email: namazzi\_ge@yahoo.co.uk

Dr Vinod Paul  
Head, Department of Pediatrics  
All India Institute of Medical Sciences  
New Delhi 110029  
India  
Email: vinodkpaul@hotmail.com

Dr Naresh Pratap K.C.  
Director  
Family Health Division  
Department of Health Services  
Ministry of Health and Population  
Kathmandu  
Nepal  
Email: npkc@hotmail.com

Dr Riskiyana Sukandhi Putra  
Head of Subdirector of Delivery and  
Postnatal Care  
Directorate of Child Health  
Ministry of Health  
Jakarta, Indonesia  
Email: ariskiyana@yahoo.co.uk

Dr Isabella Sagoe-Moses  
Child Health Coordinator  
Family Health Division  
Ministry of Health  
Accra, Ghana  
Email: i\_sagoemoes@yahoo.com

Dr Gemu Tiru  
Agrarian Health Promotion and Disease  
Prevention Directorate officer  
Ministry of Health  
P.O. Box 1234  
Addis Ababa  
Federal Democratic Republic of Ethiopia  
Email: gemut2010@gmail.com

Professor Antoinette Tshefu  
P.O. Box 11850  
Université de Kinshasa  
Faculté de Médecine  
Ecole de Santé Publique  
Kinshasa  
D.R. Congo  
Email: antotshe@yahoo.com

Dr Collins Tusingwire  
Senior Medical Officer  
Reproductive Health  
Ministry of Health  
Kampala  
Uganda  
Email: drtusingwire@yahoo.com

Dr Annah Wamae  
Head of the Department of Family Health  
Ministry of Public Health and Sanitation  
Nairobi  
Kenya  
Email: awanju2002@yahoo.com

### **Maternal and Child Health Integrated Program (MCHIP)**

Ms Anna Chinombo  
Senior Community Health Advisor  
MCHIP  
Lilongwe  
Malawi  
Email: achinombo@savechildren.org

Dr Joseph de Graft-Johnson  
Newborn Health Team Leader  
MCHIP  
USA  
Email: jjohnson@savechildren.org

Dr Steve Hodgins  
Global Technical Director  
MCHIP  
USA  
Email: shodgins@mchip.org

Dr Ishtiaq Mannan  
MCHIP Programme Manager  
Dhaka  
Bangladesh  
Email: Ishtiaq.mannan@savethechildren.org

Dr Pascal Musoni  
Community health team leader  
MCHIP  
Kigali  
Rwanda  
Email: musonipk@yahoo.fr

### **Saving Newborn Lives**

Dr Joy Lawn  
Director  
Policy and Evidence  
Saving Newborn Lives  
Email: joylawn@yahoo.co.uk

Dr Claudia Morrissey  
Director  
Technical Leadership and Support  
Saving Newborn Lives  
Email: cmorrissey@savechildren.org

Dr Naamala Hanifah Sengendo  
Programme Manager  
Save the Children in Uganda  
Kampala  
Uganda  
Email: h.sengendo@sciug.org

Dr Deborah Sitrin  
Save the Children  
Dhaka  
Bangladesh  
Email: dsitrin@savechildren.org

Dr Steve Wall  
Senior Adviser  
Technical Support  
Saving Newborn Lives  
Email: swall@savechildren.org

### **UNICEF**

Dr Hari Banskota  
UNICEF Ghana Health Manager  
Accra  
Ghana  
Email: hbanskota@unicef.org

Dr Hailemariam Legesse  
Health Unit  
UNICEF Ethiopia  
Addis Ababa  
Ethiopia  
Email: hlegesse@unicef.org

Dr Sarabibi Thuzarwin  
Health Specialist, MNCH  
UNICEF  
Yangon  
Myanmar  
Email: sthuzarwinun@unicef.org



Dr Renée Van de Weerd  
Chief, Maternal, Newborn and Child Health  
UNICEF  
New York  
USA  
Email: rvandeweerd@unicef.org

### **UNFPA**

Ms Laura Laski\*  
Chief, Sexual and Reproductive Health Branch  
Technical Division  
United Nations Population Fund (UNFPA)  
New York  
USA  
Email: laski@unfpa.org

### **USAID**

Dr Neal Brandes  
USAID  
Washington, D.C.  
USA  
Email: nbrandes@usaid.gov

Dr Lily Kak  
USAID  
Washington, D.C.  
USA  
Email: lkak@usaid.gov

### **World Health Organization**

#### **African Region**

Dr Olga Agbodjan-Prince  
Child and Adolescent Health  
Inter-country Support Team, West Africa  
WHO  
Ouagadougou  
Burkina Faso  
Email: agbodjano@bf.afro.who.int

Dr Harriet Chanza  
NPO Making Pregnancy Safer  
WHO  
Lilongwe  
Malawi  
Email: chanzah@mw.afro.who.int

Dr Brigitte Kini  
NPO Child and Adolescent Health  
WHO  
Kinshasa  
D.R. Congo  
Email: kinib@cd.afro.who.int

Dr Andrew Mbewe  
Medical Officer, Child Health  
WHO  
Abuja  
Nigeria  
Email: mbwea@ng.afro.who.int

Dr Seipati Mothebesoane  
Making Pregnancy Safer  
Inter-country Support Team, West Africa  
WHO  
Ouagadougou  
Burkina Faso  
Email: mothesbesoane@bf.afro.who.int

Dr Assumpta Muriithi  
NPO, Child and Adolescent Health  
WHO  
Nairobi  
Kenya  
Email: muriithia@ke.afro.who.int

Dr Olive Sentumbwe  
FHP  
WHO  
Kampala  
Uganda  
Email: sentumbweo@ug.afro.who.int

#### **South-East Asia Region**

Dr Sunanda Gupta  
Focal Point, Maternal Health  
WHO  
New Delhi, India  
Email: guptas@searo.who.int

Dr Tekendra Karki  
Medical Officer  
WHO  
Dhaka  
Bangladesh  
Email: karkit@searo.who.int

\* Unable to attend.

Dr Arvind Mathur  
Medical Officer, Making Pregnancy Safer  
WHO Regional Office  
New Delhi  
India  
Email: mathura@searo.who.int

Dr Neena Raina  
Regional Adviser, Child and Adolescent Health  
WHO Regional Office  
New Delhi  
India  
Email: rainan@searo.who.int

Dr Martin Weber  
Team Leader, Maternal and Child Health  
WHO  
Jakarta  
Indonesia  
Email: weberm@searo.who.int

**WHO Regional Office for the  
Western Pacific**

Dr Emma Manalac  
WHO Regional Office  
Manila  
Philippines  
Email: manalace@wpro.who.int

**WHO HQ secretariat**

Dr Elizabeth Mason  
Director, MCA

Dr Samira Aboubaker, PPP

Dr Rajiv Bahl, MRD

Dr Bernadette Daelmans  
Coordinator, PPP/MCA

Dr Matthews. Mathai  
Coordinator, EME/MCA

Dr Jose Martines  
Coordinator, MRD/MCA

Ms Cathy Wolfheim, PPP

Dr Severin von Xylander, PPP

Kim Ali, Department for Health System  
Governance (HDS)

Director, HSI

Director, HSS

Director, NHD

Director, Partnership for Maternal, Newborn  
and Child Health

Director, RHR

*Rapporteur:*

Dr Peggy Henderson  
La Rippe  
Switzerland  
Email: hendersonpeg@gmail.com

---

# Annex 3

## Provisional Agenda

### Informal Meeting on provision of home-based care to mother and child in the first week after birth: follow-up to the Joint WHO/UNICEF Statement on home visits for the newborn child

8–10 February 2012, Salle D, WHO Headquarters, Geneva

Department of Maternal Newborn Child and Adolescent Health (MCA)  
in collaboration with Saving Newborn Lives, USAID/MCHIP and UNICEF

#### DAY 1: WEDNESDAY, 8 FEBRUARY 2012

##### Session 1: Introduction and Overview

08:30–09:00 Registration

##### Chairperson: Jose Martines

09:00–09:30

Introduction

Opening remarks, Elizabeth Mason

Words of welcome on behalf of partners, Joseph Johnson

Meeting objectives, Bernadette Daelmans

Declarations of interest

09:30–09:45

The importance of postnatal care for newborn survival: evidence and coverage of effective interventions, Rajiv Bahl

09:45–10:10

Presentation of survey results on postnatal care policies and practices in priority countries, Severin von Xylander

10:10–10:30

Discussion

10:30–11:00

COFFEE/TEA

##### Session 2: Policy Dialogue on Postnatal Care Home Visits

11:00–11:10

Introduction by the chairperson

11:15–12:30

**Panel 1:** Achieving policy change to establish postnatal home visitation programmes

Policy adoption process in Malawi, Mrs Fannie Kachale

Policy adoption in Rwanda, Ms Cathy Mugeni

Enabling factors, barriers and solutions to achieving policy change, Dr Vinod Paul

Discussion

12:30–13:30

LUNCH

13:30–15:00

##### Session 3: Moving from Policy to Implementation

**Panel 2:** Who conducts the postnatal home visits and how are they prepared?

	Experience from Indonesia, Dr Erna Mulati
	Experience from Ghana, Dr Gloria Quansah Asare
	Community health worker profiles, remuneration, and training, John Murray
	Discussion
	Introduction of group work by the chairperson
<b>15:15–15:45</b>	<b>COFFEE/TEA</b>
15:45–17:30	<b>Group work 1</b> (2 groups)
	Identify successful strategies and processes that lead to the adoption of a national policy on home visits for postnatal care
	Identify common barriers to the adoption of a policy on home visits for postnatal care and ways to overcome those barriers
	Identify enabling factors and challenges for moving from adopted policy to implementation of home visits for postnatal care
	<b>Group work 2</b> (2 groups)
	Identify enabling factors, barriers and solutions to recruiting, remunerating and retaining community-based health workers to conduct home visits
	Identify common enabling factors, barriers and solutions to training community-based health workers to conduct home visits
<b>18.00</b>	<b>RECEPTION IN WHO RESTAURANT</b>

**DAY 2–THURSDAY, 9 FEBRUARY 2012**

**Chairperson: Claudia Morrissey**

09:00–09:05	Introduction by the chairperson
09:05–10:30	Feedback from the groups
<b>10:30–11:00</b>	<b>COFFEE/TEA</b>

**Session 4: Reaching high levels of coverage with quality care**

11:00–12:15	<b>Panel 3:</b> Reaching coverage and quality
	Lessons from research in Bangladesh, Prof Abdullah Baqui
	Lessons from research in India, Dr Nita Bhandari
	Discussion
<b>12:15–13:30</b>	<b>LUNCH</b>
13:30–14:30	<b>Panel 4:</b> constraints to implementing timely home visits
	Lessons from research in Pakistan, Dr Sajid Bashir Soofi
	Lessons from research in Tanzania, Dr Fatuma Mwanzi
	Discussion
14:30–15:30	<b>Panel 5:</b> Linking CHWs with health facilities
	Lessons from research in the Democratic Republic of Congo, Prof Antoinette Tshetu
	Lessons from research in Kenya, Dr Peter Gisore
	Discussion
15:30–15:40	Translating research into implementation: notes on good practices, Dr Jose Martines
<b>15:40–16:00</b>	<b>COFFEE/TEA</b>

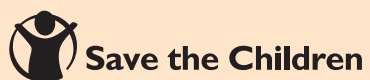
16:00–16.45	<b>Panel 6:</b> Creating demand Experience from Nepal, Dr Naresh Pratap Models of demand creation and community mobilization, Annie Portela Discussion
16.45–17.30	<b>Panel 7:</b> Monitoring the quality of implementation Experience from Ethiopia, Dr Gemu Tiru Indicators and tools for monitoring coverage and quality of postnatal care, Steve Hodgins, Deborah Sitrin Discussion

### DAY 3: FRIDAY, 10 FEBRUARY 2012

#### Chairperson: Renee van de Weerd

08:30–08.45	Welcome by the chairperson Introduction of group work
08.45-10.30	<b>Group work 3:</b> Reaching every mother and every newborn with effective postnatal care Identify key actions for scaling-up of implementation with good quality Identify key actions to sustain implementation and reach high levels of coverage Identify questions that should be addressed by research
<b>10:30–11:00</b>	<b>COFFEE/TEA</b>
11:00–12:30	Feedback from the groups (3)
<b>12:30–14:00</b>	<b>LUNCH</b>
14:00–15:20	Review of lessons learnt and agreed next steps, Bernadette Daelmans
15.20-15.30	Concluding remarks, Elizabeth Mason
<b>15:30–16:00</b>	<b>COFFEE/TEA</b>
16.00–17.00	<b>Technical updates</b> (optional) Newborn indicator working group, Saving Newborn Lives Preliminary results from multi-centre study in India, Vinod Paul Guidelines on feeding low birth weight babies, Rajiv Bahl Guidelines on resuscitation, Severin von Xylander Consultation on postnatal care guidelines, Matthews Mathai

With the support of the following organizations:



ISBN 978 92 4 150461 4

