Implementation of Home Visits for Mothers and Newborns:

Learning From Three Countries

Photo: Shafiqul Alam Kiron/Save the Children

A Community Health Volunteer examines a baby for danger signs in Bangladesh.

Background

In 2009, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) released a Joint Statement recommending home visits as an important strategy for reducing neonatal deaths, with an emphasis on early postnatal home visits (ideally on days 1, 3, and 7 after birth).[1] The recommendations were based on evidence from a number of research studies showing that home visits by providers trained to deliver simple, effective interventions can improve key newborn care practices, care-seeking and, in high mortality settings, reduce newborn mortality.[2-6] Since the release of the statement, many countries have endorsed policies supporting home visits for newborns and mothers.[7]

Save the Children's Saving Newborn Lives program (SNL) works with ministries of health and partners to develop and strengthen national newborn programs, including the integration of community-based care into existing health systems. There is a need to understand how well health systems are functioning, especially given that service delivery platforms are very different across countries and there are challenges in scaling up services in any resource limited environment.

An analysis of program data was conducted to answer the following implementation questions:

- How many mothers and newborns received home visits from trained community health workers – before and after birth?
- What was done for newborns during early postnatal visits?
- Were mothers visited by a community health worker more likely to use evidence-based newborn care practices?

Program Overview

Data are presented here from three countries – Nepal, Bangladesh, and Malawi – where home visits by community health workers (CHWs) is a program focus. Implementation started in selected districts to demonstrate the feasibility of scaling up community-based maternal and newborn care through existing government health systems. An overview of the services provided during home visits is provided in Box 1. Table 1 compares the characteristics of community workers trained to conduct home visits for women and newborns in areas supported by SNL.

Box 1: Content of home visits in three countries

Newborn

- Promote optimal newborn care practices (breastfeeding, thermal protection, cord care)
- Support care of low birth weight (LBW) infants
- First dose treatment for presumed infection (Nepal only)

Mother

- Promote optimal care for the mother (breastfeeding, nutrition, family planning)

Linking to facility services

- Promote routine antenatal (ANC) and facility delivery
- Promote birth preparedness
- Counsel on danger sign recognition and care seeking for women & newborn
- Identify danger signs in women and newborn and provide referral

Table 1: Community worker characteristics and maternal newborn community package

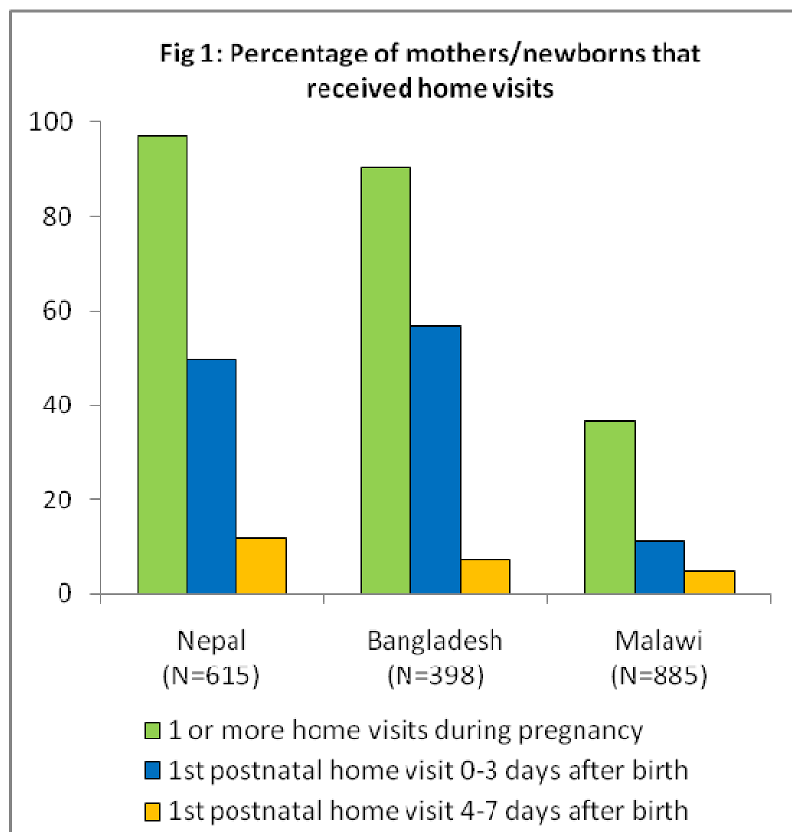
	NEPAL **Bardiya District** **Pop: 460,000**	**BANGLADESH** Faridpur District (4 unions) Pop: 98,000		**MALAWI** **Chitipa, Thyolo, Dowa Dists.** **Pop: 711,000**
Cadre name	Female Community Health Volunteer (FCHV)	Family Welfare Assistant (FWA) Health Assistant (HA) - Females only Community Nutrition Promoter (CNP)		Health Surveillance Assistant (HSA)
Characteristics *Gender* *CHW: pop. ratio* *Education level* *Employment status* *Recruitment* *Pre-service training*	 Female 1: 400 pop.[1] Literate, prefer primary Volunteer (incentives) From communities 18 days	FWA/HA: Female 1: 6000-7000 pop. Secondary Govt. salaried employee From communities 21 days (FWA)/6 wk (HA)	CNP: Female 1: 1250 pop. Primary Volunteer (stipend) From communities 24 days	 Mostly male 1: 1000-2000 pop. Secondary Govt. salaried employee Centrally recruited 12 weeks
Training in MN community package	6 days	5 days		9 days[2]
Pregnancy visits	4 (no specified timing)	2 (2nd & 3rd trimester)		3 (1st, 2nd & 3rd trimester)
Postnatal visits	Day 1, 3, 7, 29	Day 1, 2-3, 4-7		Day 1 (home births), 3, 8

[1]Catchment area population size varies in Nepal depending on terrain; 400 population is based on Terai region such as Bardiya.
[2]HSAs in Malawi also received 6 days additional training in community mobilization as part of the maternal and newborn package.

Findings

Contact with CHWs

The percentage of mothers and newborns that received a home visit varied across countries, and was lower in Malawi compared to Bangladesh and Nepal (see Figure 1). In all countries, the number that received pregnancy home visits was higher than postnatal home visits. If a postnatal visit was received, it was usually within 3 days after birth.



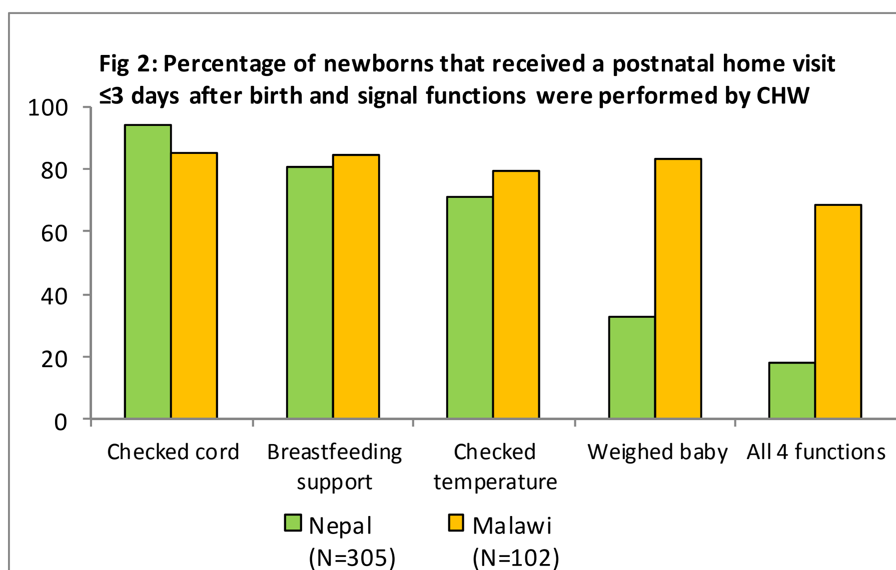
Mothers and newborns were more likely to have received an early postnatal home visit if the mother had received a home visit during pregnancy, the mother reported someone had notified the CHW of the birth, or the birth occurred outside a health facility. Even though non-facility births were more likely to have received a postnatal home visit, they were overall less likely to have received any postnatal care contact (including both facility and home contacts).

What was done by CHWs

Nearly all newborns that received an early postnatal home visit in Nepal and Malawi had at least one key function done by the community worker (see Figure 2 - data not available from Bangladesh). Weighing the baby was low in Nepal; however, FCHVs were only instructed to weigh babies not previously weighed at facility.

Newborn care practices

Selected evidence-based newborn care practices – immediate breastfeeding, delayed bathing, and dry cord care - improved over time in all three countries with a few exceptions (immediate breastfeeding in Bangladesh, dry cord care in Malawi). Similar trends were seen in comparison areas, so changes cannot be attributed to community-based programs alone, though increases were often greater in intervention areas. Mothers that received home visits from CHWs during pregnancy were more likely to have used the key practices. However, the difference was only statistically significant if the mother received 3+ home visits during pregnancy.



Lessons

- **Consider what community platforms can handle:** A low percentage of women and newborns received home visits in Malawi, a country where many tasks have been shifted to HSAs, both at community and facility level. In addition, many HSAs do not reside in the communities they serve, which likely contributes to low numbers of home visits. Even in Nepal where the community platform uses local women, catchment areas are small, and incentives were provided, many newborns were not reached during the early postnatal period. The strategy of visiting mothers and newborn 3+ times during the first week after birth was based on closely monitored community studies . There are challenges to scaling up for any community platform.

- **Health systems are dynamic:** In many countries, rates of facility births are rapidly rising. There is a need to ensure newborns receive quality postnatal care at facilities and to evaluate where care should be provided after birth, within the continuum of care from facility to home. Community platforms can also change — in implementation areas supported by SNL in Bangladesh, 3 types of existing community-based cadres were trained to conduct home visits for mothers and newborns. The program supporting the community nutrition promoter has since ended, so the cadre is no longer available for training in maternal and newborn care. The number of mothers/babies visited will likely vary as the program scales up, depending on the cadres trained in different areas. There is need to continually monitor and evaluate strategies for reaching mothers and newborns as well as the feasibility and need for providing home visits to every mother and newborn.

- **When a postnatal home visit is done, CHWs are performing key tasks.** Information on what is done during postnatal contacts is often unavailable, but the data presented here indicate that community workers are carrying out the tasks they were trained to do. However, there is need to monitor the quality of care that CHWs are providing and whether newborns experiencing danger signs and are at risk for illness and death are accessing the care needed to save their lives.

- **Home visits during pregnancy are an opportunity to counsel on newborn care practices.** Reaching a large proportion of women during pregnancy is possible and easier to achieve than through early postnatal visits. However, it may be difficult to achieve 3+ visits during pregnancy. In addition, social norms and other family members can have a strong influence on behaviors, so programs should not focus solely on counseling mothers. Other means of reaching families include counseling during antenatal care, media messaging, community mobilization, and mothers groups and can all be options for encouraging newborn care practices. How these other methods could be used in conjunction with home visits and the relative impact of each method need to be better understood.

- **Programs need to include strategies to connect families and community health workers.** CHWs can only visit mothers and newborns if they know when visits are required. Programs need methods to help CHWs promptly identify pregnant women in their catchment areas. Programs should also incorporate birth notification strategies including the possible use of mobile phones; raising awareness of the importance of birth notification and postnatal home visits among families, CHWs, and health facility staff; and regular planning and close coordination between CHWs and supervisors at facilities. These strategies could also be used to identify and target newborns at greatest risk, which is likely to be particularly important in settings where there are persistent challenges to reaching every mother and newborn at home.

Photo: Monika Gutestam/Save the Children

A Female Community Health Volunteer in Nepal refers a mother to seek care for her newborn, who has signs of a cord infection.

Acknowledgements

Save the Children's Saving Newborn Lives program is supported by the Bill and Melinda Gates Foundation. Program implementation, management, and data collection was conducted by Save the Children staff in Bangladesh, Nepal, and Malawi; the Ministry of Health and Social Welfare and BRAC in Bangladesh; the Ministry of Health and UNICEF in Malawi; and the Ministry of Health and Community-based Neonatal Care Package (CBNCP) partners in Nepal.

References

1. WHO, UNICEF (2009) WHO-UNICEF Joint Statement on home visits for the newborn child: a strategy to improve survival. Geneva: World Health Organization, USAID and Save the Children.
2. Gogia S, Sachdev HS Home visits by community health workers to prevent neonatal deaths in developing countries: a systematic review. Bull World Health Organ 88: 658-666B.
3. Bang AT, Bang RA, Baitule SB, Reddy MH, Deshmukh MD (1999) Effect of home-based neonatal care and management of sepsis on neonatal mortality: field trial in rural India. Lancet 354: 1955-1961.
4. Baqui AH, El-Arifeen S, Darmstadt GL, Ahmed S, Williams EK, et al. (2008) Effect of community-based newborn-care intervention package implemented through two service-delivery strategies in Sylhet district, Bangladesh: a cluster-randomised controlled trial. Lancet 371: 1936-1944.
5. Kumar V, Mohanty S, Kumar A, Misra RP, Santosham M, et al. (2008) Effect of community-based behaviour change management on neonatal mortality in Shivgarh, Uttar Pradesh, India: a cluster-randomised controlled trial. Lancet 372: 1151-1162.
6. Bhutta ZA, Soofi S, Cousens S, Mohammad S, Memon ZA, et al. (2011) Improvement of perinatal and newborn care in rural Pakistan through community-based strategies: a cluster-randomised effectiveness trial. Lancet 377: 403-412.
7. Requejo J, Victora CG, Bryce J, Barros A, Berman P, et al. (2012) Countdown to 2015 - the 2012 Report: Building a Future for Women and Children. Washington, D.C.: World Health Organization and UNICEF 2012. 228 p.Executive Summary of the Lancet Neonatal Survival Series, The Lancet, 2005

Save the Children