

Postnatal care

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Every year in Africa, at least 125,000 women and 870,000 newborns die in the first week after birth, yet this is when coverage and programmes are at their lowest along the continuum of care. The first day is the time of highest risk for both mother and baby. The fact that 18 million women in Africa currently do not give birth in a health facility poses challenges for planning and implementing postnatal care (PNC) for women and their newborns. Regardless of place of birth, mothers and newborns spend most of the postnatal period (the first six weeks after birth) at home.

Postnatal care (PNC) programmes are among the weakest of all reproductive and child health programmes in the region. How can we increase the coverage of integrated maternal and newborn care in the postnatal period? What does PNC include, when and where can it be provided, and by whom? How can we operationalise, improve, and sustain linkages between homes and hospitals? How can PNC be integrated with existing strategies and programmes, especially childbirth care, Integrated Management of Childhood Illness (IMCI), nutrition promotion, prevention of mother-to-child transmission of HIV and immunisation?



Problem

The postnatal period – defined here as the first six weeks after birth – is critical to the health and survival of a mother and her newborn. The most vulnerable time for both is during the hours and days after birth. Lack of care in this time period may result in death or disability as well as missed opportunities to promote healthy behaviours, affecting women, newborns, and children:

Effects on women: Half of all postnatal maternal deaths occur during the first week after the baby is born, and the majority of these occur during the first 24 hours after childbirth.¹ The leading cause of maternal mortality in Africa – accounting for 34 percent of deaths – is haemorrhage, the majority of which occurs postnatally. Sepsis and infection claim another 10 percent of maternal deaths, virtually all during the postnatal period.² HIV-positive mothers are at greater risk of postnatal maternal death than HIV-negative women.³ Access to family planning in the early postnatal period is also important, and lack of effective PNC contributes to frequent, poorly spaced pregnancies (Section III chapter 1). This is a stressful time for new mothers, so emotional and psychosocial support should be available to reduce the risk of depression.

Effects on newborns: Sub-Saharan Africa has the highest rates of neonatal mortality in the world and has shown the slowest progress in reducing newborn deaths, especially deaths in the first week of life. Each year, at least 1.16 million African babies die in the first 28 days of life – and 850,000 of these babies do not live past the week they are born.⁴ Asphyxia claims many babies during the first day, and the majority of deaths due to preterm birth occur during the first week. Thirty-eight percent of babies in sub-Saharan Africa die of infections, mainly after the first week of life.⁵ The majority of these deaths are low birthweight (LBW) babies, many of whom are preterm. In addition, long term disability and poor development often originate from childbirth and the early postnatal period.

Effects on children: At least one in four child deaths occur during the first month of life. These deaths often take place before child health services begin to provide care, usually at six weeks for the first immunisation visit. Low coverage of care in the postnatal period negatively influences other maternal, newborn, and child health (MNCH) programmes along the continuum of care. For example, the lack of support for healthy home behaviours, such as breastfeeding, can have ongoing effects for the child in terms of undernutrition. (Section III chapter 6). Additionally, newborns and mothers are frequently lost to follow up during the postnatal period for prevention of mother-to-child transmission (PMTCT) of HIV.⁶ (Section III chapter 7).

The period following birth in Africa is often marked by cultural practices. Understanding these beliefs and practices is an important part of ensuring effective and timely care. Many communities throughout Africa observe practices that keep mothers and babies indoors for the first month after birth – a period of seclusion. Families are wary about visitors coming in close contact with newborns.^{7,8} If mothers or babies become ill during the period of seclusion, seeking formal health care is often delayed. Yet, sick babies often die within a few hours and delays can be fatal. Delays also affect maternal outcomes. Three crucial delays are outlined in the previous chapter on childbirth care – delay in recognition of complications, delay in reaching appropriate care, and delay in receiving appropriate care.

When a baby dies, the women – not the men – of the family perform the burial. It is often taboo to moan and cry during the burial of a newborn or for relatives and friends to inquire about newborn deaths. In some

countries, it is said that if a newborn baby dies, ‘the baby has gone back and the baby has not been born yet.’

Some cultural practices hinder the health and survival of the newborn, and young first-time mothers are often most likely to follow these practices. Giving newborns cold baths, discarding colostrum, and providing food other than breastmilk soon after birth can be harmful. Applying butter, ash, or other substances such as cow dung to the umbilical stump increase the risks of infection.

This chapter will outline the package for PNC and describe the current coverage and trends for PNC in Africa. Then we will explore opportunities to strengthen PNC at the health facility, through outreach, and in the community, and suggest practical actions that will help address key challenges relating to providing quality care to mothers and babies during the critical postnatal period.

Package

It has been estimated that if routine PNC and curative care in the postnatal period reached 90 percent of babies and their mothers, 10 to 27 percent of newborn deaths could be averted. In other words, high PNC coverage could save up to 310,000 newborn lives a year in Africa.⁹ (See data notes on page 226 for more information on this

analysis) The impact on maternal survival and well being would also be significant.

There is now more consensus on the content of PNC (what),^{10,11} but questions remain about the best timing (when) and place (where) for postnatal visits, and who can deliver this package. Box III.4.1 outlines the current consensus regarding the *what, when, where, and who* of routine PNC.

BOX III.4.1 Routine postnatal care (PNC): What, when, where, and who?

WHAT is routine PNC?

Preventive care practices and routine assessments to identify and manage or refer complications for both mother and baby including:

Essential routine PNC for all mothers

- Assess and check for bleeding, check temperature
- Support breastfeeding, checking the breasts to prevent mastitis
- Manage anaemia, promote nutrition and insecticide treated bednets, give vitamin A supplementation
- Complete tetanus toxoid immunisation, if required
- Provide counselling and a range of options for family planning
- Refer for complications such as bleeding, infections, or postnatal depression
- Counsel on danger signs and home care

Essential routine PNC for all newborns

- Assess for danger signs, measure and record weight, and check temperature and feeding
- Support optimal feeding practices, particularly exclusive breastfeeding
- Promote hygiene and good skin, eye, and cord care
 - If prophylactic eye care is local policy and has not been given, it is still effective until 12 hours after birth
 - Promote clean, dry cord care
 - Identify superficial skin infections, such as pus draining from umbilicus, redness extending from umbilicus to skin, more than 10 skin pustules, and swelling, redness, and hardness of skin, and treat or refer if the baby also has danger signs
- Ensure warmth by delaying the baby's first bath to after the first 24 hours, practising skin-to-skin care, and putting a hat on the baby
- Encourage and facilitate birth registration
- Refer for routine immunisations
- Counsel on danger signs and home care

Extra care for low birthweight (LBW) or small babies and other vulnerable babies, such as those born to HIV- infected mothers (two or three extra visits)

The majority of newborn deaths occur in LBW babies, many of whom are preterm. Intensive care is not needed to save the majority of these babies. Around one third could be saved with simple care,⁹ including:

- Identify the small baby
- Assess for danger signs and manage or refer as appropriate
- Provide extra support for breastfeeding, including expressing milk and cup feeding, if needed
- Pay extra attention to warmth promotion, such as skin-to-skin care or Kangaroo Mother Care
- Ensure early identification and rapid referral of babies who are unable to breastfeed or accept expressed breastmilk
- Provide extra care for babies whose mothers are HIV-positive, particularly for feeding support (Section III chapter 7).

WHAT is routine PNC? (continued)

Early identification and referral/management of emergencies for mother and baby

Appropriate detection, management, or referrals are necessary to save mothers and babies in the event of life-threatening complications

Danger signs for the mother

- Excessive bleeding
- Foul smelling vaginal discharge
- Fever with or without chills
- Severe abdominal pain
- Excessive tiredness or breathlessness
- Swollen hands, face and legs with severe headaches or blurred vision
- Painful, engorged breasts or sore, cracked, bleeding nipples

Danger signs for the baby

- Convulsions
- Movement only when stimulated or no movement, even when stimulated
- Not feeding well
- Fast breathing (more than 60 breaths per minute), grunting or severe chest in-drawing
- Fever (above 38°C)
- Low body temperature (below 35.5°C),
- Very small baby (less than 1500 grams or born more than two months early)
- Bleeding

WHEN and how many postnatal visits should occur?

The optimum number and timing of PNC visits, especially in limited resource settings, is a subject of debate. Although no large-scale systematic reviews have been carried out to determine this protocol, three or four postnatal visits have been suggested. Early visits are crucial because the majority of maternal and newborn deaths occur in the first week, especially on the first day, and this period is also the key time to promote healthy behaviours. Each country should make decisions based on the local context and existing care provisions, including who can deliver the PNC package and where it can be delivered. The following are offered as a guide:

- *First contact:*
 - If the mother is in a facility, she and her baby should be assessed within one hour of birth and again before discharge
 - Encouraging women to stay for 24 hours, especially after a complicated birth, should be considered
 - If birth occurs at home, the first visit should target the crucial first 24 hours after birth
- *Follow up contacts* are recommended at least at 2-3 days, 6-7 days, and at 6 weeks
- *Extra contacts* for babies needing extra care (LBW or those whose mothers have HIV) should have two or three visits in addition to the routine visits

WHERE should PNC be provided and WHO can provide it?

There are a number of possible strategies for delivery of PNC and many of the routine tasks can be delegated, although supervision and linkages are crucial:

- *At a facility:* This is more likely if the mother gives birth in the health facility, but even then women and babies do not necessarily receive an effective PNC contact before discharge from the health facility, and even if mothers initially come to facilities for birth, they may not return in the first few days after discharge from a facility
- *Through outreach services:* A skilled provider can visit the home to offer PNC to the mother and baby
- *Home visits from a community health worker (CHW):* Where health systems are not as strong and human resources are limited, certain tasks can be delegated to CHW, linking to health facilities for referral as required
- *Combination of care in the facility and at home:* PNC may be provided in the health facility following childbirth, at the home during the first crucial two to three days, with subsequent visits to the facility after six to seven days and six weeks, when the mother is better able to leave her home

Sources: Adapted from references^{1,4,12}

Note: This information is not intended to be a detailed clinical guide.

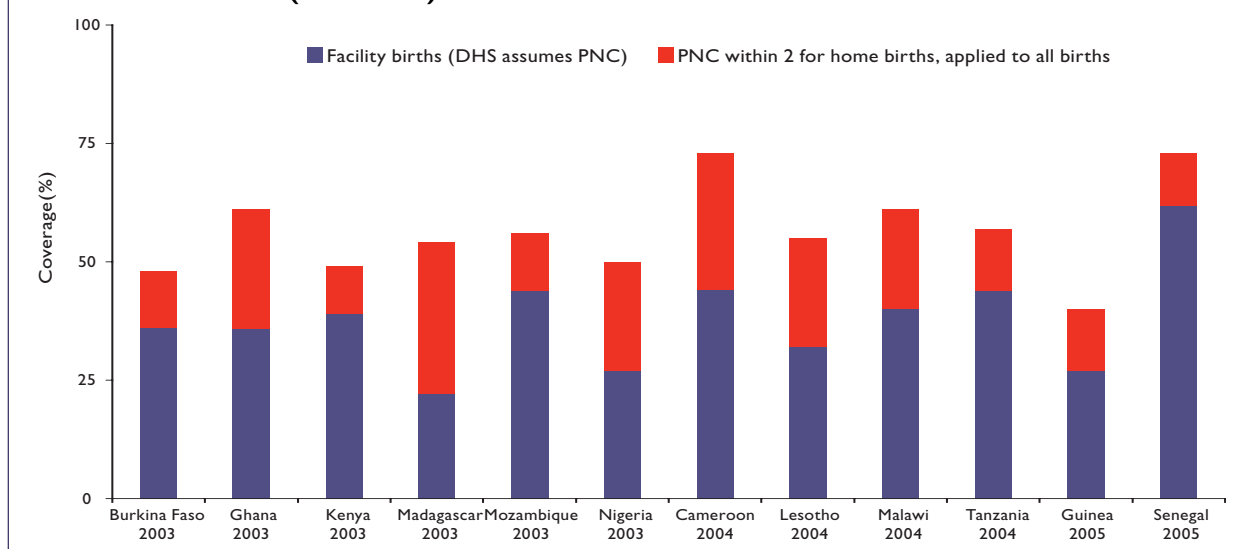
Current coverage and trends

The postnatal period is a neglected period. Despite the fact that the majority of maternal and newborn deaths occur within the first week of the postnatal period,¹ health care providers across sub-Saharan Africa continue to advise mothers to come back to the facility for a first check-up only after six weeks. This is a visit for survivors.

The void of comparable, relevant data for programmes reveals the lack of systematic implementation of this package. There are no consistently measured indicators of effectiveness of national PNC programmes.⁸ The definitions for monitoring PNC are sometimes problematic, including the assumption used in some surveys that all women who have facility births automatically receive PNC. Based on an analysis of 23 Demographic and Health Surveys (DHS), two thirds of women in sub-Saharan Africa give birth at home, and only 13 percent of these women receive a postnatal visit within two days of birth.

According to DHS data in Ethiopia, 90 percent of mothers did not receive any PNC within the first six weeks. Of the few who did have a PNC contact, more than half gave birth in a health facility, where crowds and the practice of early discharge often hinder mothers from receiving proper PNC. In Eritrea, 92 percent of women giving birth at home received no PNC within the first six weeks. Similarly, 85 percent of women giving birth at home in Mali and 70 percent of women giving birth at home in Rwanda received no PNC at all, according to the most recent DHS country data. Aside from measuring the number of births that take place at home, the PNC indicator in DHS gives no information on the content or quality of the visit. This is in contrast to the more comprehensive information provided by questions on antenatal care (ANC), where women are asked if they received a variety of interventions, such as tetanus toxoid injections and blood pressure measurements.

FIGURE III.4.1. Postnatal care within two days of birth in facilities (assuming all facility births receive postnatal care) or at home, according to Demographic and Health Survey (DHS) data in 12 countries (2003-2005)



Source: DHS data for surveys from 2003-2005. DHS assumes that all facility births receive PNC. See data notes on page 226 for more information on this indicator.

A lack of PNC affects the coverage of several essential interventions. Although healthy home behaviours such as breastfeeding are well described, only 30 percent of babies in sub-Saharan Africa are exclusively breastfed. Many newborns are also found to be too cold after birth, even in tropical countries,¹³ and skin-to-skin care after childbirth is not widely practiced.

Family planning is an important missed opportunity in the postnatal period. Focus group discussions in Kenya revealed that virtually all women thought that family planning information could be given during postnatal visits or before a woman leaves the hospital after childbirth.^{14;15} The lactational amenorrhoea method should be the first method of choice for early family



planning among mothers with new babies, also considering condoms to provide dual protection against HIV/AIDS as well as pregnancy.¹⁶ Family planning technologies for the early postnatal period, such as insertion of an intrauterine contraceptive device within the first 48 hours after childbirth, should be considered.¹⁷

Opportunities to strengthen PNC

Across Africa, policy and programmatic opportunities exist to strengthen PNC, given widespread recent recognition that this is a key gap in the continuum of care. PNC contact maintains continuity of care between maternal and child health services, supporting healthy behaviours that should have been introduced during ANC visits and continued during labour and childbirth. In addition, PNC contact is crucial to ensure a seamless continuum of care from home to hospital. Improvement of PNC depends on the capacity and accessibility of local

health systems, the level of decentralised decision making, and common cultural practices, particularly cultural practices regarding seclusion that may reduce care seeking.

Even with agreement on the main content of a global package for PNC, the *who*, *where*, and *how* should be adapted to the relevant health and social context. Approaches for scaling up PNC include different possibilities for women giving birth in a health facility and women giving birth at home. Given that over half of women and their newborns remain at home during and immediately after birth, integrating care for both mother and newborn outside the formal health system is crucial.

Four possible approaches to provide PNC are listed in Table III.4.1, based on the place of birth and the place(s) and providers for PNC. The expected acceptability and challenges of these possible approaches for the mother and the provider and the health system are also detailed.

TABLE III.4.1 Postnatal Care (PNC) strategies: feasibility and challenges to implementation

	Possible strategies	Mother-friendly	Provider-friendly	Challenges for implementation
1	Mother and baby go to facility for PNC	●	●●●	Requires mother to come to the facility within a very short time following birth. More likely following a facility birth.
2	Skilled provider visits the home to provide PNC for mother and baby	●●●	●	Conditional on sufficient human resources, which is challenging and may not be highest priority for skilled attendants in settings where skilled attendance at birth is still low. May be possible where rural health facilities are quiet during afternoons.
3	Community Health Worker (CHW) visits home to see mother and baby	●●●	●	Requires training for CHW and management, supervision, and logistic support.
4	Combination: Facility birth and first PNC visit in the facility, then home visit within two to three days, with subsequent PNC visits at the facility	●●	●●	Requires team approach with facility and CHW, sufficient human resources, good management and supervision, good referral systems, and an efficient information and tracking system so that mother and baby are not lost to follow up.

Key: ●Low ●●Moderate ●●●High

Source: PNC working group composed of chapter authors and editors.

With a supportive policy environment, these strategies can be implemented and integrated within the continuum of care, linking with other services at the facility, home, and community levels. Serious consideration should be given before commitment is made to an approach that would necessitate the scaling up of a new cadre of worker.

1. PNC at the facility level

The most common model used for PNC in Africa is to

ask the mother who has given birth in a facility to return to the facility for PNC.⁷ In sub-Saharan Africa, a high proportion of women attend at least one ANC visit, when providers can counsel pregnant women in their last trimester on the importance of having a skilled attendant at birth and an early check-up for mother and baby. Evidence suggests that women are more likely to have a skilled attendant at childbirth if they receive good ANC, and if they have a skilled attendant at birth, they are more likely to return for PNC.^{18;19}

Women who give birth in a health facility could ideally be encouraged to stay for at least 24 hours before discharge. This allows the health facility staff to observe the mother and the newborn to ascertain whether the preferred feeding option is established and to make sure any maternal or neonatal complications are detected and managed. If specific risk factors are identified in the baby, the mother and baby should be kept another two days to enable feeding, warmth, and care for complications, and the mother of a LBW baby can be taught Kangaroo Mother Care (KMC). Before discharge, mothers should be advised to bring their newborns back if they notice any danger signs. They should be given a specific date to return for PNC, which will increase the likelihood of them attending with their newborns.²⁰ In many settings, however, even if the woman has a facility birth, she will not return for care in the first two days after birth, when the risk of dying is highest for herself and her baby. Where feasible, timely home visits should be arranged and scheduled, or a combination approach can be considered as discussed in the fourth strategy below.

2. PNC as outreach: Home visits by a skilled attendant

Postnatal follow up of new mothers and their newborns can also be provided through outreach visits by a skilled attendant. The attendant can examine both mother and baby, provide essential maternal and newborn care, and identify complications, which can either be managed on the spot or referred appropriately. Successful outreach visits for PNC have already occurred in limited resource settings. In Madagascar, 15 percent of women receive a postnatal visit by a health professional in their own homes. In one pilot study in rural Kenya, retired midwives facilitate childbirth at home and visit the mother and baby two or three times in the first week.⁸ A study in Zambia showed that midwives who educated mothers in their homes on newborn health enabled them to identify danger signs and take action more frequently, resulting in a reduction in the prevalence of health problems in newborns.²¹ In general, however, there are not enough midwives to provide care during childbirth in much of Africa, and adding two or three home visits may be expensive and challenging with current human resource limitations. Additional time and expense for travel to undertake home visits must also be considered. Childbirth care does require a skilled attendant and may be the priority for the midwife's time.

3. PNC at the family and community level

Since the postnatal period is often characterised by seclusion for the mother and baby, community health worker (CHW) visits to the home offer an opportunity to reach the woman and baby with care and build specific health messages into this culturally sensitive time.^{22,23} Certain tasks in routine PNC could be delegated to a less skilled cadre, where feasible and appropriate (Box III.4.2). In countries where CHW programmes are being scaled up nationally, adding home PNC for mother and baby to

the CHW remit and training would have a high impact at relatively low cost. Health facilities serving certain geographic areas can strengthen linkages between formal health workers and community health extension workers, CHW, and other cadres, such as traditional birth attendants, to improve both the knowledge base and care for the mother and baby pair immediately after birth. CHW who are tasked with providing PNC should be connected to the health facility through supervision and a functional referral system. If a CHW visits a mother and newborn and finds a complication, she should refer the patient and accompany her to the health centre, if possible. Experience of home-based PNC is available from several studies and pilots in Asia.^{24,25} Currently there is less experience in Africa, although a number of studies are in process to test adapted approaches for home-based care, linking to the health system.

BOX III.4.2 Is there a role for community health workers (CHW) in postnatal care?

According to a number of recent reviews, with proper training and support, CHW can:

- Increase healthy behaviours for the baby such as exclusive breastfeeding, ensuring warmth (for example, delayed bathing and skin-to-skin care), and hygienic practices
- Provide extra care for the low birthweight (LBW) baby
- Reduce newborn deaths through early identification and case management of pneumonia where referral is not possible²⁶
- Provide information and services for the mother especially for birth spacing and family planning, giving vitamin A to mothers
- Identify danger signs for both mothers and newborns and support referral for management of maternal and newborn complications
- Promote the use of other services such as birth registration and vaccination

Source: Adapted from references ²⁵⁻²⁹

4. PNC through linking facility care with outreach and community care

Instead of a facility-only strategy or a community-only strategy, it may be possible to develop a linked approach, with a skills mix in the team. This is particularly true in countries or settings where access to primary level facilities is good and referral links between primary level and referral level are functional. For example, the woman may give birth in the facility, go home, have a CHW or extension CHW visit her at home on the second day, and then return to the facility after one week and six weeks. A referral slip can be designed to facilitate these linkages. Where maternity waiting homes are available, the new mothers and their infants could perhaps stay for three days to ensure all is well before travelling the long distances home. Referral links, however, continue to remain the weakest point in many maternal and newborn health care programmes.³⁰ One programme that trained CHW to give key messages was successful in improving healthy home behaviours and increasing postnatal attendance among village women of childbearing age in a remote area of Uganda.³¹

Targeting specific groups for additional PNC

Whether births occur at facility or at home, health workers should be able to identify specific risk factors in women and in newborns (LBW, preterm birth, feeding problems, illness and history of prolonged and difficult labour, mother with HIV) and follow up. Extra care is specifically needed for LBW babies and preterm babies. Where the birth is in a facility and specific risk factors are identified, the mother and baby can be kept in the facility longer to enable extra support for feeding, warmth, and care for complications. If appropriate, the mother can be taught KMC. If the birth is at home and a CHW or extension worker is being used for routine PNC visits, extra visits should be considered for LBW babies and others requiring special care, such as babies of HIV-infected women. For PMTCT programmes, the postnatal period provides opportunities for increased support, particularly for alternate feeding choices.³² Integration of PMTCT with MNCH programmes would strengthen the linkages in this crucial handover period to enhance the continuum of care

Challenges

There is a major gap in the continuum of care due to low coverage of PNC. There is limited available research to identify the optimum timing and delivery approaches, and in any case, these may be situation-specific. The challenges may be considered in terms of demand and supply of services.

Increasing demand for postnatal care

There are many delays in seeking care, especially during pregnancy, childbirth, and the postnatal period (Section III chapter 3). Delays in seeking care in the postnatal period often occur because of the restrictions that keep

mothers and babies at home. Another important obstacle is lack of information. Women may not seek care because they do not recognise complications or know the service is available to them.⁷ If care does exist, they may not perceive any benefits in attending, even though they would welcome information on caring for their new baby, breastfeeding, and family planning, either before becoming pregnant or during pregnancy.³³ Women perceive childbirth as a major event but may view the postnatal period with less concern.

Community involvement is crucial for shortening delays in seeking care after birth because family members can significantly influence behaviours. In many areas where husbands work away from home, women may wait for the 'decision maker' to return to give permission and pay for visiting a facility. Additionally, many societies in sub-Saharan Africa acknowledge that grandmothers play an influential role in supporting the young women (their daughters and daughters-in-law) in their community during pregnancy, childbirth, and throughout the care of the newborn (Box III.4.3). Sometimes harmful practices are endorsed by grandmothers, but given the wide-ranging role they play, their influences, and their intrinsic commitment to promoting the wellbeing of women and children, they should be viewed as key actors in the provision of PNC. The influence of other community gatekeepers such as local leaders, traditional birth attendants, CHW, and support groups and their potential for channelling information and swaying behaviour offer both opportunities and challenges.

Improving the supply of PNC

Many countries have some sort of postnatal policy (even if it only exists as a six week check-up), but generally at the national level, there is a lack of guidelines, standards, protocols, and most importantly, human resources for the management of the mother and baby in the early postnatal period.³⁴ Moreover, there is often insufficient coordination between the different health providers, weak links between programmes, and inappropriate use of information. In many countries, unless she decides to seek family planning, a woman may never receive a check-up until she becomes pregnant again. The majority of countries do not have a postnatal register, so even if a nurse has a check-up with new mothers, she cannot record her efforts. To deal with this problem, the Ministry of Health in Kenya has recently designed and instigated a register for three targeted postnatal visits: one visit within 48 hours, the next within one to two weeks, and the third visit at around six weeks.

The quality of care around the time of childbirth will influence newborn care during the postnatal period. Where skilled care is lacking, there are very few providers trained in essential newborn care or care of the sick newborn and very few courses for nurses and midwives to extend their skills.³⁴ Where skilled care is available, providers are often too busy to think about giving information about the importance of having a postnatal

check-up for new mothers and their babies.³⁵ The immediate postnatal period is often a time of uncertainty for programme planners, who question whether PNC is the responsibility of those looking after the mother through a safe motherhood programme or those caring for the newborn through a child survival programme. There is rarely a systematic handover between those who care for the mother and those who care for the baby and child; thus, a disconnect occurs in the continuum of care.

Limited health management capacity as well as referral and communication failures have also been identified at various service levels.³⁶ One study from Tanzania suggests that midwives need more support to provide PNC. Factors that may affect health workers in providing PNC include the gap between classroom theory and practice, political awareness, and involvement in policy making. In addition, lack of confidence in management and referral of women with complications and limitations in dealing with job stress were also highlighted.³⁵

Innovative solutions exist in other regions where PNC packages have been adapted, and Africa should build on these experiences. One project in Nepal aimed to improve the mother and newborn's access to basic, acceptable PNC through a network of CHW delivering home-based care. The results showed that it is feasible for trained volunteers to provide effective home-based PNC of reasonable quality and coverage. The project has also shown high rates of identifying health problems and referring both mothers and newborns, although these results should be interpreted with caution given the low sample size of mothers and newborns with health problems.³⁷

Practical steps

There are a number of practical steps that can be taken by governments and partners in order to scale up PNC services. These include developing an evidence based PNC package, building and reinforcing links between the community and health facility, and improving available information to guide programmatic decision making.

1. Develop an evidence based PNC package

Standardise timing and frequency of care. The timing, frequency, and exact content of PNC visits require further testing and harmonisation. Many countries in Africa have adopted or partially adopted the World Health Organization (WHO) 1998 model of care, which suggests postnatal visits within six hours after birth, three to six days, six weeks and six months (6-6-6-6).¹⁰ However, the most important time period for PNC is the critical first 24 hours, when most maternal and newborn deaths occur (Box III.4.1). If possible, the next contact should be on the second or third day of life, and, if resources permit, a third visit during the first week should be included. The routine visit during the sixth week is important for the baby's immunisation and the mother's family planning counselling. Countries may require

BOX III.4.3 Wisdom from grandmothers on newborn care

In Mali, one programme engaged grandmothers to educate communities about making simple changes to protect the health of mothers and babies. Grandmothers discussed better nutrition, preventing and treating infections, keeping newborns warm and dry, and early breastfeeding. As a result, there were fewer newborn deaths and a decrease in harmful practices such as high workload for pregnant women, bathing within six hours after birth, application of cocoa butter on the baby's umbilical cord, and giving coffee to newborns. Husbands were more willing to pay for medical services and nutrition supplementation during pregnancy and even accompanied their wives to health services for consultation.

One mother's thoughts: "the shame wall between mother-in-law and daughter-in-law falls gradually; money is given by the husband because permission was given by his father, who was influenced by his wife."

Source: Adapted from reference³⁸

support to adapt their PNC package based on existing policy, including who can deliver PNC and where it can be delivered.

Establish leadership at various levels to review, adapt, integrate, and implement a PNC package. Based on individual country situations, high level government officials, donors, and other advocates can collaborate to champion PNC for the mother and newborn. It is important for Ministries of Health to coordinate, integrate, and strengthen the PNC component within existing programmes such as IMCI, child survival, safe motherhood initiatives, emergency obstetric care, and early childhood development.





The leadership team should assess the pre-service and in-service training curricula for all cadres of health providers so that essential PNC is included.²¹ Furthermore, they should adapt, disseminate, institutionalise, and implement evidence based PNC policies.³⁹ Guidelines, training materials, job aids, and postnatal registers for both mother and newborn are available but are not yet combined to make an integrated package for systematic implementation within the region. Where focused ANC has been successfully introduced, coverage can extend smoothly along the continuum of care to deliver a targeted PNC package. Key messages for PNC can also be developed to match other MNCH messages. After implementation, Ministries of Health and stakeholders should plan to review programmatic operations, such as supplies and logistics issues, as well as lessons learned.

2. Integrate programmes: Build and reinforce linkages between community and facility

Connect MNCH services at every service delivery level. PNC requires coordinated care for both mother and baby wherever services are offered (at the health facility, community, and home) and referral linkages to both maternal and child health services. In many instances, the same health worker is providing care for the mother and baby, yet protocols and standards for combining maternal and newborn care have yet to reach peripheral health facilities, or a child health worker is assessing a newborn but has not been trained to do so. It is therefore imperative to bring national level guidelines to those who deliver services – the health workers.

Empower family and community members. Use birth planning programmes and PNC to inform mothers, family, and community members on good maternal and newborn care practices at home. Simple communication and counselling materials can guide families from cultural practices to evidence based essential newborn care, including timely recognition and referral of maternal and newborn danger signs. When suggesting a change in behaviour, it is important to negotiate this change and ensure that community gatekeepers are included in the process.

Provide for supervision, management, and accountability. For various community-based programmes, supervision and quality assurance are the weakest links and failing points. Programme managers as well as outreach and health extension workers should be supported in routine supervision of CHW and volunteers. Performance-based remuneration of CHW should be considered in order to keep CHW motivated and hold them accountable for delivery of services.

Consider the use of maternity waiting homes.

Maternity waiting homes linked to health facilities with emergency obstetric care services may help reduce deaths for mothers and babies, especially for those who live far from the facility and who have known risk factors, such as a previous neonatal death. The new mother and baby can stay in these maternity homes for three or four days to make sure they are healthy before going home.

Bridge the gap between PNC and family planning.

Family planning programmes should increase outreach and bring community-based workers to coordinate efforts with health providers at facilities (and vice versa). Programmes must recognise and respond to the cultural and physical immobility of the mother in the postnatal period as well as the receptivity of mothers and their husbands, grandmothers and other influential family members to advise and support. Counselling strategies should be redirected to include all aspects of newborn care⁴⁰ (Section III chapter 1).

Establish and nurture key partnerships. Use creative ways to recognise and support new and existing partnerships between government, donors, non-governmental organisations, women's groups, traditional health practitioners, and local faith-based organisations. Consider:

- Recruiting the support and cooperation of religious figures, who are often prominent figures in community health
- Recognising the influence of traditional birth attendants and other community health promoters and providers and inviting them to join the 'community health team' to educate parents and grandparents on positive practices
- Expanding formative research on knowledge, attitudes, and behaviours, and negotiating change for practices that are harmful while encouraging those that are helpful

3. Improve available information to guide programmatic decision making

Strengthen monitoring of PNC. Data on PNC coverage are lacking. Standardised monitoring indicators must be developed to promote PNC as an important MNCH programme and to evaluate cross-country comparisons.⁴¹ Routine health management information systems should also include PNC indicators (Box III.4.4). For example,

future DHS and Multiple Indicator Cluster Surveys (MICS) should ask women who have recently given birth about the quality and use of PNC they received, including when, where, and with whom. Compound indicators for essential newborn care are under discussion, such as the percentage of newborns dried after birth, breastfed within one hour, and kept close to the skin of the mother or caregiver.

Conduct relevant operations research. Many questions remain about the *who, where, and how* of providing PNC, particularly for poor and underserved populations, and how to provide PNC in varying settings whilst linking to the health system. Most of the studies so far have been in Asia and there is a dearth of information for PNC programming in Africa. Some of these research gaps include:

- Who can provide care in various settings? How do programmes locate pregnant women and new mothers who do not access antenatal and/or childbirth care? Who can do what for the mother and baby?
- Where is care best provided? Where do women and families want to receive PNC – at home or in the facility? Can services be provided in facilities and homes and linked? How can referral systems be strengthened?
- How frequently should services be delivered for routine PNC and for extra care for small babies? How can PNC services be better integrated with PMTCT and other programmes?
- What is the impact and cost of varying models of PNC delivery?

Conclusion

Many African women and their newborns do not have access to health care during the early postnatal period, putting them at an increased risk of illness and death. Each year, 310,000 fewer newborns would die in Africa and many maternal lives would be saved if the coverage of PNC reached 90 percent of women and babies.⁹ Yet PNC programmes are among the weakest of all reproductive and child health programmes in the region. Advancing PNC policy and programmes is crucial, as is implementing and testing the feasibility, sustainability and cost effectiveness of what we do know. There is an incredible opportunity to adapt PNC to varying settings to reach women and their newborns, especially for the 18 million African women who give birth at home.

BOX III.4.4 Key indicators for postnatal care (PNC)

- Mother/newborn receiving PNC within three days* and subsequent visits
- Place where care is provided and type of care provider
- Timely initiation of breastfeeding within one hour after birth*
- Sick newborns taken for treatment
- Health facilities where skilled or trained health care providers are competent in essential newborn care and management of maternal and newborn complications
- Case fatality rate of newborn complications (by cause if possible)

*Newborn and child indicators in Countdown to 2015 child survival indicator list.⁴² See Section IV for complete list.



Priority actions for strengthening postnatal care

Develop and implement an evidence based PNC package

- Attain global agreement on timing, frequency, and content of care
- Establish or revitalise a national working group to develop and operationalise a national PNC package, for example, one that is linked to the national Road Map
 - Adapt programmatic protocols and key messages for use in PNC
 - Train/retrain health workers
 - Address supply and logistics issues

Strengthen the programme

- Bridge key gaps in implementation at the family/community, outreach and facility level between family planning, ANC, childbirth, and PNC

Improve the information available to guide programmatic decision making

- Improve and standardise monitoring indicators for PNC
- Conduct relevant operations research

