



**Islamic Republic of Afghanistan**

**Ministry of Public Health**

**Reproductive Health Directorate**

**Safe motherhood Initiative**

**Guidance Note  
For  
Scaling Up Coverage of Maternal and Newborn Care Intervention  
At  
The Community Level**

*December 2008*

## **Acknowledgement**

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## Table of Contents

<b>Topic</b>	<b>page</b>
Acknowledgement .....	2
1 Situation Analysis .....	6
2 Purpose of this guidance note .....	7
3 Intended users of the guidance note .....	7
4 Summary of effective interventions for saving newborn lives .....	7
5 Rationale for community and household focus: considerations for selecting interventions for the community MNH package.....	8
6 Objectives of Community MNH.....	9
7 Overview of Intervention Package and Delivery Approach .....	9
8 Standards for implementation .....	10
9 Monitoring, Evaluation and Coordination .....	10
10 Proposed community based newborn care interventions and delivery approach .	11
11 Maternal and Newborn Health Care interventions existing resources.....	14
12 Annexes.....	16
12.1 Annex-1, Sample monitoring and evaluation plan format .....	16
12.2 Annex-2: Continuum of care flowchart: Maternal-Newborn Health.....	18
12.3 Annex-3 Roles and responsibilities for community maternal-newborn care....	19

## Acronyms

ANC	Antenatal care (usually facility-based)
BASICS	Basic Support for Institutionalizing Child Survival
CHS	Community health supervisor
CHW	Community health worker
C-IMNCI	Community-IMNCI (community-based interventions to complement facility services)
CMW	Community midwife
Community MNH	Community-based maternal-newborn health
Etc...	
FHAG	Family Health Action Group
IMCI	Integrated management of childhood illnesses (facility-based)
IMNCI	Integrated management of newborn and child illnesses (facility-based; an updated version of IMCI)
MoPH	Afghanistan Ministry of Public Health
SCF	Save the Children (USA)
UNICEF	United Nations Children's Fund
WHO	World Health Organization



## 1 Situation Analysis

The estimated U5MR is 257 per 1000 live births (LB) and IMR is 165 per 1000 live births (SOWC 2008). However, national estimate differ substantially and show 25.7% decline in child mortality since 2000 (AHS, 2006<sup>1</sup> and corroborating UNICEF & Central Statistics Office (CSO), Government of Afghanistan's (GoA) Best Estimates<sup>2</sup>)

Neonatal mortality rates (NMR) have not been estimated through population based survey. The Lancet Newborn series attributed 24 per cent of under-five mortality to newborn deaths and estimated NMR of 60/1000 LB (Lawn, J.E. et al, 2005)<sup>3</sup>. This NMR and the U5MR 191/1000 LB estimated by the 2004 AHS 2006 would increase the proportion of newborn deaths to 31 per cent, a pointer to the fact that with reducing U5MR, the proportion of under-five deaths contributed by neonatal causes is expected to rise.

The 2003 Reproductive Age Mortality Study (RAMOS) estimated Maternal Mortality Ratio (MMR) of 1600/100,000 LB and a life-time risk of maternal death of 1 in 8 (Bartlett et al 2005). This means, 17,000 Afghan women die of pregnancy-related complications every year<sup>4</sup>. The revised UN estimate for 2005 which adjusts for underestimation, gives a much higher MMR of 1800/100,000 live birth

Less than 15% deliveries take place at a health facility, and only 19% of all deliveries are assisted by a skilled birth attendant (SBA)<sup>5</sup>. There are discrepancies in access to SBA and these are geographic discrepancy with 52% in Kabul and less than 2% in Nuristan; economic discrepancy with 48% of women belonging to more wealthy families having SBA against only 19% of women in general, and by accessibility to health services with 39% women living within 2 hours distance of a facility having SBA against 9% women living more than 2 hours away from a health facility.

There is inadequate focus/effort to mobilize communities and families for **birth preparedness** and complication readiness and to turn the present Maternal and Newborn Care Policy and strategy to more specific practical, actionable steps. The National Reproductive Health Strategy projects only 50% coverage by SBA by 2016. Currently MoPH HMIS reports only 41% of BPHS and EPHS facilities as having the recommended number of trained Community Midwives (CMW). In addition, there is no clear plan to deliver Basic Essential Newborn Care in the facilities that do not presently have skilled birth attendants. Over 80% of mothers and newborns are at homes and their needs are not adequately addressed because there is no clear action plan to reach out basic newborn survival interventions at community and household level.

The Community Health Workers (CHW) training<sup>6</sup> have newborn care but there is little data on the actual practices of the CHWs. As yet, there are no large-scale newborn

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<sup>1</sup> Afghanistan Health Survey (AHS) 2006. Johns Hopkins Bloomberg School of Public Health and Indian Institute of Health Management Research

<sup>2</sup> UNICEF & Central Statistics Office. 2006. "Best Estimates of social indicators for children in Afghanistan 1990-2005. pp. 44-46.

<sup>3</sup> Lawn, J.E., et al. 2005. "4 million neonatal deaths: When? Where? Why?" *Lancet*: 365. pp. 891-900.

<sup>4</sup> This figure varies in different documents from 17,000 – 20,000. For the purpose of this paper, the 17,000 figure is used consistently as it is the figure used in the MoPH National Reproductive Health Strategy document.

<sup>5</sup> AHS 2006

<sup>6</sup> Islamic Republic of Afghanistan, Ministry of Public Health, Community Health Worker Training Manual

community interventions and consequently, there is little awareness about appropriate newborn care in communities and households.

## **2 Purpose of this guidance note**

This note intends to 1) provide a framework to support consistent and coordinated implementation of initiatives to improve maternal and newborn care practices at household and community level; 2) guide actors working at community level to initiate and scale-up coverage of community based newborn care interventions; and 3) provide opportunity for generating further evidence for strengthening of newborn care in Afghanistan at both facility and community level in a coherent manner.

## **3 Intended users of the guidance note**

The intended users of this note are the providers of Basic Package of Health Services; partners interested to support community based newborn care interventions and other actors working at community level to improve maternal and newborn care practices. The document will also serve as basis for cooperation/collaboration among partners to support scaling up of community based newborn care.

## **4 Summary of effective interventions for saving newborn lives**

Family-oriented and community –oriented support self care, including the adoption of improved care practices and appropriate care seeking for illness. With the widespread barriers to care seeking for newborn illness, an important aspect of family –community care is community mobilization and the empowerment of individuals and communities to demand quality services that respond to their needs, these following services can be provided by various workers, and should be tailored to the community’s social and cultural environment. Essential community newborn care intervention as follow:

### **4.1 preconceptions**

- Adequate Care of the female child including nutrition, education and health care
- Immunization, including tetanus toxic.
- Folic acid supplementation

### **4.2. Antenatal interventions**

- Tetanus toxoid immunization
- Counseling on nutrition, birth preparedness and breastfeeding
- Iron, iodine and folate supplementation
- Identification of major risk of obstructed labour
- Prevention and Treatment of malaria\*
- Voluntary counseling and testing for HIV\*

### **4.3 Interventions during labour, delivery and first 1-2 hours of life**

- Clean and safe delivery
- Temperature maintenance
- Immediate and exclusive breastfeeding
- Cord and eye care
- Emergency obstetric care for complications\*
- Antibiotics for premature rupture of membranes\*

- Assess the baby breathing, color and neonatal resuscitation\*
- Management of newborn complications\*
- Prevention of mother-to-child transmission of HIV\*

#### **4.4 Newborn care interventions from 1-2 hours after delivery to 4 weeks**

- Exclusive breastfeeding
- Temperature maintenance
- Cord care and hygiene
- Promote skin to skin contact
- Recognition of danger signs and prompt care-seeking
- Counseling on birth spacing
- Special care for the small baby\*
- Prevention of mother-to-child transmission of HIV\*
- Management of complications, serious infections, severe jaundice and very low-birth-weight babies\*
- Follow up of newborns in need of special care

**Note:**

*All interventions should be available for all pregnant women and newborns except those marked\**

*\* Need to be provided only for illness or complications.*

## **5 Rationale for community and household focus: considerations for selecting interventions for the community MNH package**

In the current context of Afghanistan, over 80% deliveries take place at homes and are not attended by skilled attendants. Considering the shortage, difficulty of recruitment, training and deployment of midwives, the situation is not likely to change quickly enough to address newborn care needs and have impact on MDG target of reducing child mortality contributed by newborn deaths.

In the Lancet newborn survival series, Darmstadt et al<sup>7</sup> conclude that over 50% reductions in neonatal mortality can be achieved through an integrated, high coverage programme of universal outreach and family-community care. Another article in the same series (Knippenberg et al, 2005) concludes that outreach and family-community activities adapted to the local context might be the most feasible option in very low-resource settings and bring early success in saving neonatal lives<sup>8</sup>. Thus, community-based newborn care focus is supported by evidence as well as local feasibility.

In this scenario, programming to reduce newborn mortality in Afghanistan should focus on community and household care. The focus should be on easy to deliver interventions that can be provided at household level by appropriately trained and empowered volunteers or support groups and at community level through outreach programs. The interventions should be packaged within the continuum of care framework to ensure that feasible interventions are delivered during pregnancy, delivery and post-partum period and extended to under-five care where feasible.

<sup>7</sup> Darmstadt et al, 2005, Neonatal Survival 2, Evidence-based, cost-effective interventions: how many newborn babies can we save?, Lancet 2005.

<sup>8</sup> Knippenberg et al, 2005, Neonatal Survival 3: Systematic scaling up of neonatal care in countries, Lancet 200

## **6 Objectives of Community MNH**

The strategic objectives of the Afghanistan community MNH initiative are:

1. To achieve a sustainable increase in the adoption of safe pregnancy, delivery, and postpartum care practices and reduce existing harmful practices.
2. To achieve a sustainable increase in the adoption of healthy newborn care practices and to reduce existing harmful practices.
3. To strengthen the quality and coverage of the continuum of maternal- newborn health services from the community up to the district level.

The specific objectives are:

- a. To increase the proportion of women accessing ANC and clean, skilled delivery
- b. To prevent and manage newborn infections
- c. To prevent and manage hypothermia
- d. To take special care of low birth weight babies
- e. To manage post-delivery asphyxia
- f. To increase early, exclusive breastfeeding
- g. To develop an effective system for referral of sick newborns and pregnant, intra-partum, and postpartum women with danger signs.

## **7 Overview of Intervention Package and Delivery Approach**

A package of relevant and feasible interventions that can be delivered and scaled up in current context of Afghanistan and an implementation approach is proposed in table-1 below. The package is not preventing agencies or institution to introduce additional elements but it needs prior agreement of MoPH.

The primary delivery modality is the community health worker. At this time, there are approximately more than 20000 trained community health workers in Afghanistan, who already provide basic community-based child survival interventions. Slight revision of the national community health worker terms of reference and training standards will enable community health workers to deliver many of the signal functions related to maternal and newborn health.

Community members, such as Family Health action Group (FHAG), may provide additional support, particularly in the areas of behaviour change and case finding. This guidance note will not advocate for a single community mobilization model, understanding that each province or district may require different methods, but rather provide generic guidance on community support required for effective delivery of the MNH care and topics for behaviour change communications.

Finally, it is essential that the community MNH care be closely aligned with facility services to ensure that patients referred for serious conditions access consistent medical

treatment. Furthermore, lessons from other countries suggest that close collaboration between health centre professionals and community health workers can increase the latter group's credibility and thereby improve their effectiveness.

## **8 Standards for implementation**

While each implementing partner is encouraged to adapt the guidelines contained in this document to suit local contexts and resources, the following implementation standards apply and should help guide MoPH-partner coordination:

- a. Community based Maternal and Newborn Care Practices will be gradually expanded to cover all districts in the country. The scale-up plan will be identified after consultation with the technical working group, the MoPH, and BPHS partners.
- b. All implementing partners will use approved training materials, job aids, forms, and formats.
- c. All implementing partners will follow the approved M&E plan.
- d. Joint analysis of data using the current HMIS tool, including interpretation and modification of program will be done on a trimesterly basis.
- e. Implementing partners will receive support from the MoPH and technical working group to follow any modifications made to this guidance note.
- f. The entire district must be covered during the implementation, with special attention to hard-to-reach and vulnerable populations.
- g. Health workers and volunteers will be given initial training and refresher trainings for Community Based Maternal and Newborn Health Care implementation.
- h. Routine technical support visits will be provided from the central and provincial levels to the districts.
- i. Skills of health workers and volunteers will be assessed through monitoring visits and upgraded as per the need.

## **9 Monitoring, Evaluation and Coordination**

Outcome, outputs, processes and inputs will be monitored using a set of pre-defined indicators and compared with baseline established (Please see annex-1). The indicators listed in table-2 could be used as a model for monitoring and evaluation plan. Most data will be collected through existing contacts of service providers FHAG with the beneficiary population including CHWs or other community level actors house visits. Data will be analysed and utilized for future planning at the district and provincial level. The data flow to the national level will be through Provincial HMIS Officer.

The activities will be closely coordinated by the implementing body through a coherent mechanism at the district and provincial level. The RH Officer and Child Health responsible will be the key individuals to coordinate the activities and provide technical guidance on timely manner to the implementing body. If more than one implementing body is there in the province, a coordination mechanism to be laid to exchange experiences and strengthen the support to the MNH activities at the community level.

## 10 Proposed community based newborn care interventions and delivery approach

	Interventions	Delivery approach
Household level	<p>Preconception</p> <ul style="list-style-type: none"> <li>• Adequate Care of the female child including nutrition, education and health care</li> <li>• Immunization, including tetanus toxic.</li> <li>• Folic acid supplementation</li> </ul> <p>Antenatal:</p> <ul style="list-style-type: none"> <li>• Listing/mapping of all pregnancies</li> <li>• Birth planning/preparedness</li> <li>• Awareness of pregnancy related danger signs and appropriate care seeking</li> <li>• Recognition of threatened abortions and it's referral</li> <li>• Promotion delivery by SBA</li> <li>• Health education on safe pregnancy and regarding unsafe abortion</li> <li>• Iron folate/micronutrients supplementation</li> <li>• Preparing for breast-feeding</li> <li>• Referral for TT immunization</li> <li>• Promotion of use of LL-ITN in malaria endemic area and distribution of LL-ITN where feasible</li> <li>• Intermittent presumptive treatment of malaria in malaria endemic area (if not done at household level)</li> <li>• Nutrition counselling</li> <li>• Referral for four ANC visits</li> </ul> <p>Delivery:</p> <ul style="list-style-type: none"> <li>• Clean home delivery kits (if women choose to deliver at home)</li> <li>• Ensure adequate hydration and nutrition for mother during labor.</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate and secure support of community shura to establish <b>Family Health Action Group (FHAG)</b> and task them to support mothers to access basic maternal and newborn care in each village.</li> <li>• Establish and train <b>Family Health Action Group (FHAG)</b> comprising of village women introduced by the village shura and meeting pre-defined criteria, in each intervention village. Where CHWs exist, the female CHW should lead the FHAG. <i>(The FHAG should be enabled to do simple participatory assessment, analysis and action planning for designing community approaches to improve family and community behaviour and care seeking to addressing maternal and newborn health problem and to provide simple messages and basic care at household level).</i> This can happen under close supervision by a Community Health Supervisor (CHS), implementing agency or district authorities where present. While where CHWs are not existed attempt to be made to establish the standard community network or at least FHAG to deliver the services. Linkage of the activities with the Nutrition Promoters (Community Nutrition Volunteers) is needed where the GMP activities are going on.</li> <li>• Try to establish the community network where CHWs are not existed or deliver services through establishment of FHAG.</li> <li>• For defined behaviours and messages to be promoted, provide pictorial charts/counselling cards one for each aspect of care the group is expected to provide, including messages to women and family.</li> <li>• Provide supplies of vitamin A, iron folate, anti-malarials.</li> <li>• Provide clean home delivery kits/promote social marketing of clean home delivery kits</li> <li>• A member of the FHAG ensures that the CHW visits the</li> </ul>

	<ul style="list-style-type: none"> <li>• Consider antiseptic for the cord such as chlorhexidine –could be in the delivery kit</li> <li>• Danger-signs awareness, screening and referral</li> </ul> <p>Post-delivery and newborn care</p> <ul style="list-style-type: none"> <li>• Touching or blowing if the child is not breathing.</li> <li>• Thermal protection of newborn-immediate wiping and wrapping of baby, delaying bathing ( at least 6 hrs, preferable 24 hrs.)</li> <li>• cord care</li> <li>• Immediate breast-feeding and exclusive breast-feeding</li> <li>• Eye care</li> <li>• Vitamin A supplement to mother</li> <li>• Identification of danger-signs in newborn and mother and appropriate care seeking.</li> <li>• Continue Iron folate/micronutrients supplementation</li> <li>• Weigh the baby</li> <li>• Skin-to-skin care/Kangaroo –mother-care (KMC) for pre-term babies and small babies (low birth weight)</li> <li>• Referral for PNC in outreach or health facility</li> <li>• Birth spacing advice and services</li> </ul>	<p>women in her neighbourhood, at home, twice during pregnancy, one in second trimesters and once close to delivery to deliver antenatal interventions as per recommended schedule.</p> <ul style="list-style-type: none"> <li>• A member of the FHAG ensures that CHW conducts visits to the women and the newborn in her neighbourhood, at home during delivery or on the day of birth or 2<sup>nd</sup> day, 3<sup>rd</sup> day, 5<sup>th</sup> day and one visit in week 4 of delivery and additional two visits for pre-term/low birth weight babies. During these visits, the CHW provides post delivery and newborn care and screen and refer the women and newborn if necessary.</li> <li>• Where female CHW are not there or do not conduct home visits, the FHAG member closest to the house of the women visit the women and newborn and provide basic information and services feasible to be provided by them.</li> <li>• CHW, CHS or health worker of the health facility/health post nearby or CBHC trainers/supervisors meet FHAG monthly and supervise, monitor, facilitate the work of the</li> <li>• Take necessary actions to improve the skills of the CHWs, member of FHAG and CHSs. Provide training on birth planning and preparation and assessing safe delivery for CHWs.</li> <li>• Adopt current recoding and reporting documents and train concern staff on use of them.</li> <li>• Compile existing good practices/community based maternal and newborn care materials to make comprehensive community based newborn care training package and support materials covering all aspect of care/interventions.</li> </ul>
Community outreach level	<p>Preconception</p> <ul style="list-style-type: none"> <li>• Adequate Care of the female child including nutrition, education and health care</li> <li>• Immunization, including tetanus toxic.</li> <li>• Folic acid supplementation</li> </ul> <p>Antenatal: Four ANC contacts close to the community doing the following:</p> <ul style="list-style-type: none"> <li>• Listing of all pregnancies and newborn in the</li> </ul>	<ul style="list-style-type: none"> <li>• BPHS providers responsible for a district map of the all villages and list target population and prepare district micro-plan for outreaches</li> <li>• Integrated out-reach service guideline with well define MNCH component to be provided for field staff.</li> <li>• Pre-scheduled outreaches planned with community representatives at least four times a year.</li> <li>• A health worker, preferably a female goes close to the village</li> </ul>

	<p>outreach area</p> <ul style="list-style-type: none"> <li>• Awareness of pregnancy related danger signs and appropriate care seeking</li> <li>• Health education on safe pregnancy and regarding unsafe abortion</li> <li>• Maternal Tetanus Toxoid immunization</li> <li>• Counselling on nutrition, birth preparedness and breastfeeding</li> <li>• Prepare for delivery in a facility or by a SBA</li> <li>• Iron, iodine and folate supplementation (if not done at household).</li> <li>• Evaluation of the pregnant women. Identification of major risk of obstructed labour/other danger signs and referral</li> <li>• Recognition of threatened abortions and referral.</li> <li>• Intermittent presumptive treatment of malaria in malaria endemic area (if not done at household level)</li> <li>• Treatment of STIs and referral for Voluntary counselling and testing for HIV where necessary/feasible</li> </ul> <p>Post-delivery and newborn care</p> <ul style="list-style-type: none"> <li>• Evaluate the mother and baby</li> <li>• Danger-signs awareness, screening, treatment of infection with at least first dose of antibiotics where required and referral</li> <li>• Promote exclusive breast-feeding</li> <li>• Vitamin A supplement to mother (if not given at household level)</li> <li>• Continue Iron folate/micronutrients supplementation (if not given at household level)</li> <li>• Skin-to-skin care/Kangaroo –mother-care (KMC) for pre-term babies and small babies (low birth weight)</li> </ul>	<p>or to the village where the women live on the pre-scheduled date and delivers the interventions.</p> <ul style="list-style-type: none"> <li>• Health worker with supervisory responsibility visits the community periodically to supervise/monitor and facilitate the work of the outreach worker</li> </ul>
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	<ul style="list-style-type: none"> <li>• Birth spacing advice and services</li> </ul>	
Linkage of the interventions with facilities providing BPHS	Emergency obstetric care and newborn care at BPHS facilities	<ul style="list-style-type: none"> <li>• Explore BPHS supported referral services or alternate free referral services.</li> <li>• Where BPHS supported referral is not available support: <ul style="list-style-type: none"> <li>○ FHAG establishes a revolving fund for facilitating referral of women, newborn and children with complications.</li> <li>○ FHAG establishes a standby arrangement/agreement with a local owner of appropriate transport facility to make it available at a short notice.</li> <li>○ FHAG assists women and newborn with complications to go to the health facility using the operated referral support.</li> </ul> </li> </ul>
Planning and coordination approach	<ul style="list-style-type: none"> <li>• Planning of outreaches must be done with community elders</li> <li>• Planning of services to be given at household level must be decided by the FHAG</li> <li>• Seed money for referral funds could be secured through interested partners</li> <li>• The interventions at community and household level should be convergence points of all partners in newborn health. The convergence should ensure continuum of care and avoid duplication.</li> <li>• Monitoring and evaluation should look at process, outputs and outcomes and use indicators listed in annex</li> <li>• Quarterly district and half-yearly provincial level meeting of BPHS providers, CBHC focal points, CHS and other relevant actors</li> </ul>	

## 11 Maternal and Newborn Health Care interventions existing resources

MNH signal function	Delivery modality	Existing resources
<b>Preconception</b>		
Adequate Care of the female child including nutrition, education and health care	CHW, FHAG	C-IMNCI
Immunization, including tetanus toxic.	Vaccinator, CHW (screening & referral)	CHW curriculum, C-IMNCI, EPI Policy
Folic acid supplementation	CHW	
<b>Antenatal care</b>		
Promotion of facility-based ANC visits	CHW, FHAG	C-IMNCI
Tetanus immunization	Vaccinator, CHW (screening & referral)	CHW curriculum, C-IMNCI, EPI Policy
Counselling on nutrition (including iodized salt), rest, and birth planning/ skilled delivery	CHW and community groups	Public nutrition policy, IYCF policy strategy, CHW curriculum, C-IMNCI
Counselling and preparing mothers for early and exclusive breastfeeding	CHW and Community groups	
Iron folate supplementation	CHW /ANC facilities	Usually delivered through ANC but could possibly be delivered by CHWs

Identification of danger signs and referral	CHW and community groups/ANC facilities	C-IMNCI
<b>Intra-partum care</b>		
Promotion of clean delivery and Provision of clean mini delivery kits	Health Posts/CHW or community groups	Revised BPHS
Support birth attendant in clean delivery, dry and stimulate baby, delayed bathing, immediate breastfeeding	CHW/ community groups	C-IMNCI
Identification of danger signs and referral	CHW community groups	C-IMNCI
Emergency transportation	Community groups	Ambulance programs, various community-based pilot programs
Weigh baby (to be introduced gradually) and assess for low birth weight, refer VLBW	CHW	C-IMNCI
Promote early initiation of breastfeeding	CHW community groups	C-IMCI
<b>Postpartum care</b>		
Home visit within 24 hours of delivery, then on days 3, 7, and (for LBW) 14	CHW	C-IMNCI
Clean cord care	CHW, community groups	C-IMNCI
Support early and exclusive breastfeeding	CHW, community groups, breastfeeding counsellors	C-IMNCI but a bit weak, breastfeeding training manual
Support thermal care and special care of the low birth weight baby (skin-to-skin)	CHW	C-IMNCI
Assess baby for danger signs (skin infections, fast breathing, inability to breastfeed, high or low temperature, severe jaundice); treat moderate infections	CHW	C-IMNCI
Assess mother for danger signs and refer	CHW and community groups	
Counselling on birth spacing and nutrition of mother and baby	Community groups	
Promotion of postnatal care and vaccination	CHW	C-IMNCI

# 12 Annexes

## 12.1 Annex-1

### Sample Monitoring and Evaluation Framework

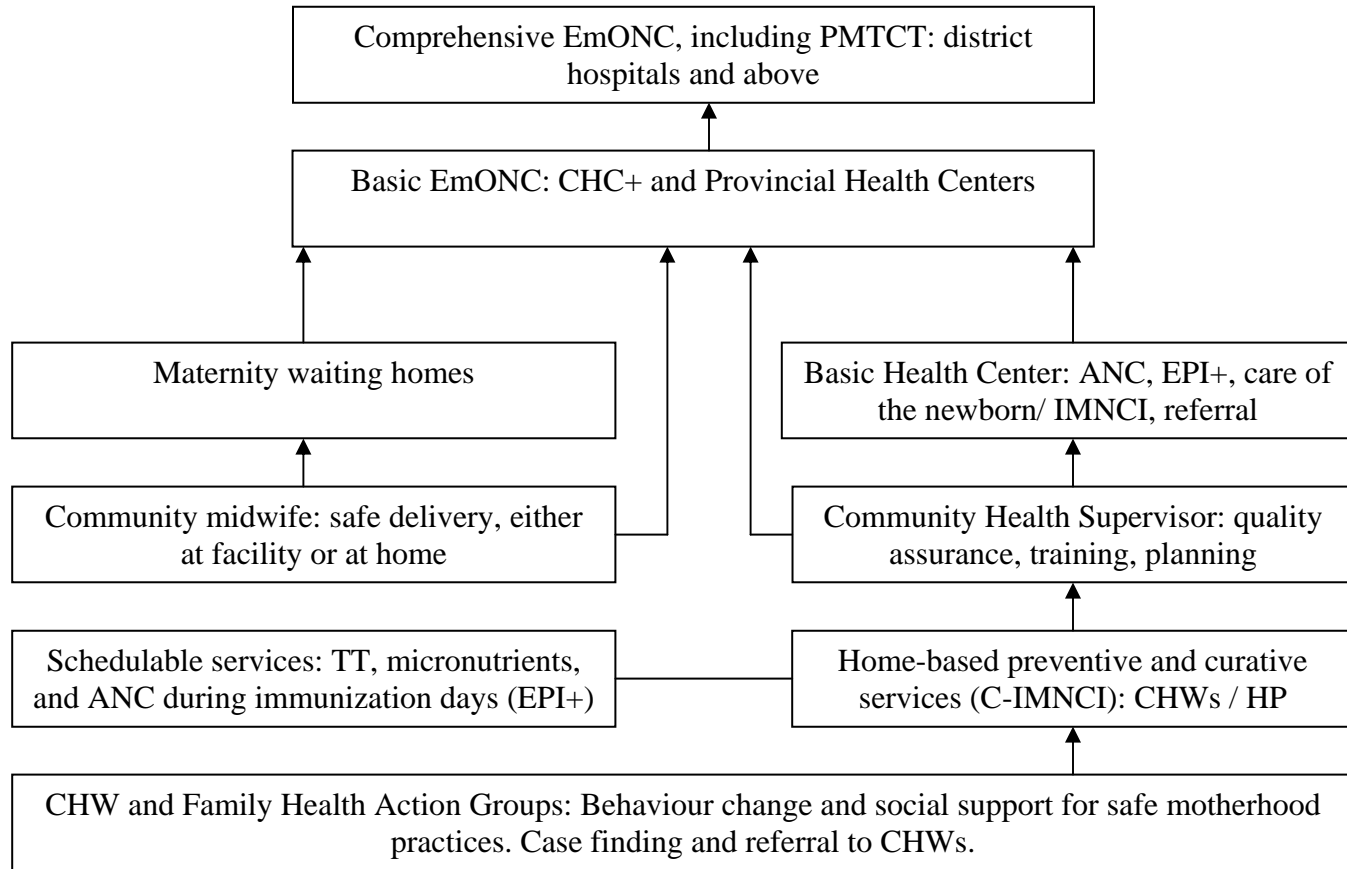
#### Component/ Intervention:

			<b>What is Measured</b>	<b>Levels of measurement</b> Facility / Provincial / National	<b>Periodicity</b> Monthly / Quarterly / Annual / other	<b>Available Data sources</b>
Process evaluation	Monitoring	<b>Inputs</b>	Funding, personnel, equipment, supplies, infrastructure			HMIS, HRD, NHSPA
		<b>Process</b>	% of HP established the FHAG			HMIS
			% of newborn who were weighed on the day of birth.			HMIS
	<b>Service outputs</b>	% of pregnant women visited at least 1 time by CHW during A/N period. % of women visited at least 3 times by CHW during P/N period. % of target villages that had at least 4 maternal and newborn care outreaches in a year. % of mothers who have complication referred by the CHW/FHAG to the nearest health facility. % of newborns who have complication referred by the CHW/FHAG to the nearest health facility.			HHS Outreach/IMCHN HMIS HMIS	
Evaluation	Monitoring outcomes	<b>Utilization outputs</b>				HMIS, NHSPA
		<b>Initial</b>	% of mothers who know at least 2 maternal danger signs. % of mothers who know at least 2 newborn danger signs.			Household surveys
		<b>Intermediate</b>	% of pregnant women who delivered by skilled birth attendant. % of newborn who were breast feed within an hour after birth. % of children age 0-6 months who were exclusively breastfed			Household Surveys

% of newborns who were not bathed before 24 hours of birth.  
% of babies who have birth weight less than 2500 grams.  
% of pregnant women who have done birth

			planning in term of (transportation , blood donor ,skilled birth attendance and money)			
	Impact assessment	<b>Long-term</b>	Maternal mortality ratio Early neonatal mortality rate.	national	Every 3 to 4 years	Mortality,(MICS, DHS, Census, Special Studies)

**12.2 Annex-2: Continuum of care flowchart: Maternal-Newborn Health**



## **12.3 Annex-3 Roles and responsibilities for community maternal-newborn care**

### **1. Family Health Action Group (FHAG)**

FHAG members will be responsible for the following activities:

- Implement healthy practices in their own homes and then demonstrate them to the women of her neighborhood group of households.
- Talk with her neighbors and promote other healthy practices.
- Promote appropriate use of curative and preventive care from the CHW and the health facility.
- Inform CHW about pregnancies, births and sick women and children who need care.
- Encourage families to follow the CHW's recommendation for referral when necessary.
- Provide wider contact with the men of the community to encourage their participation in health improvement activities.

### **2. Community Health Workers**

- a. Identify and map pregnant women, women for PNC and newborns every quarter.
- b. Make home visits to counsel women/mothers (4 antenatal visits and 3 postnatal visits), covering signal functions and education.
- c. Arrange with midwives how to provide PNC services to those mothers and newborns who cannot attend clinics within postnatal period.
- d. Maintain data in the given registers/note books and keep them in a safe place
- e. Participate in monthly meetings at health centres/with supervisors:
  - i. Hand over to, review and discuss with supervisor (CHS, CMW) data
  - ii. Receive technical updates and supportive supervision from the supervisors
  - iii. Discuss/plan activities for the next month
- f. Participate in community mobilization activities as time permits

### **3. Community Health Supervisor**

- a. Aggregate lists/maps of pregnant women from all CHWs
- b. Review and discuss data with CHWs
- c. Provide technical updates and supportive supervision to CHWs
- d. Provide support for advocacy meetings with FHAG
- e. Review lists/maps and plan with C-Midwife for:
  - a. Planning of out reach ANC and PNC
  - b. Planning of outreach birth preparedness activities
  - c. Map calendar of expected births
  - d. Compare facility's delivery activities with calendar of expected births
  - e. Technical updates

### **4. Community Midwife (Check with ToR)**

- a. Review lists/maps and plan for:

- i. Planning of and participation in out reach ANC and PNC
- ii. Planning of outreach birth preparedness activities
- iii. Map calendar of expected births
- iv. Compare facility's delivery activities with calendar of expected births
- v. Technical updates
- b. Address ANC/Birth preparedness/PNC in monthly/quarterly sessions for CHWS
- c. Assist referred deliveries
- d.** Assist referred problems, refer onwards when necessary
- e. Conduction of preliminary basic verbal autopsy whenever receives information on maternal death.