National Department of Health

Framework for Accelerating Community-based Maternal, Neonatal, Child and Women's Health and Nutrition Interventions

Clusters: **Maternal, Child & Women's Health**
HIV&AIDS and STI
Health Promotion
District Health Systems
Human Resources

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARV	Antiretroviral
BCC	Behaviour change communication
CBO	Community-based organization
CHWs	Community health workers
C-IMCI	Community Integrated Management of Childhood Illness
DBS	Dried blood spot
DHS	Demographic health survey
DOH	Department of health
EBF	Exclusive breast feeding
ECD	Early childhood development
EmONC	Emergency obstetrics and neonatal care
EPWP	Extended public work's programme
EPI	Expanded Programme on Immunization
FP	Family planning
HIV	Human immunodeficiency virus
IYCF	Infant and young child feeding
IEC	Information/education/communication
MDGs	Millennium developmental goals
MNCWH&N	Maternal newborn child and women's health and nutrition
NCCEMD	National committee on confidential enquiries into maternal deaths
NGO	Non-governmental organization
IMCI	Integrated Management of Childhood Illness
KAP	Knowledge, attitude and practice
ORS	Oral rehydration salts
PCR	Polymerase chain reaction
PHC	Primary health care
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
TT	Tetanus toxoid
SADHS	South African demographic health survey
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Over the past decade, South Africa has introduced several high impact health and nutrition interventions in an effort to extend and improve the health and nutrition status of mothers and children. Nevertheless, nearly 9 children still die every hour from causes that could be prevented and/or treated with simple and cost-effective MCH interventions. That translates to almost 75,000 each year. 22,000 of these are newborn infants who die within their first month of life. In addition, 1,700 women die each year from complications of pregnancy and childbirth that likewise could be prevented and managed.

There is convincing evidence that many of the health and nutrition needs of women and children in high-burden countries could be met by community health workers (CHW) with minimal additional training. The World Health Organization has promoted wider use of CHWs to provide selected maternal and child health (MCH) interventions and to promote key family care practices. Technical advances have allowed a wider range of community based approaches to the delivery of proven cost effective maternal, neonatal and child health and nutritional interventions.

The community maternal, neonatal, child and women's health and nutrition (MNCWH&N) framework builds on the existing community Integrated Management of Childhood Illness (C-IMCI) to maximise service coverage, and quality as well as the overall impacts through six main service delivery modes that include regular home visits, establishment of community-based support groups, joint outreach preventive and curative services by professional nurses and CHWs, twice-yearly child health days and monthly visits to ECD centres; all of them supported by an effective community mobilisation strategy.

The delivery of community MNCWH&N interventions will be anchored into the existing community health workers programme in the Department of Health (DOH) to ensure Government ownership and long term sustainability. The capacity of CHWs will be strengthened through training, peer learning, supportive supervision and mentoring as well as the provision of CHW kits and job aids. The role of CHWs will include, but not limited to, community mobilisation, health promotion, nutrition counselling and support including infant and young child feeding (IYCF), and administration of less complex interventions such as vitamin A supplementation and de-worming.

These cadres will be hired and managed through non governmental organisations (NGOs), but the Government will provide technical and financial support at all levels. The national level will be responsible for setting up norms and standards through policy and guideline development and resource allocations. The provincial level will be responsible for implementation oversight, monitoring and resource allocation. The district will be responsible for capacity development, planning, coordination, implementation and on-site support and monitoring.

Regular support and supervision will be provided by the NGO nurse supervisors in collaboration with the primary health care (PHC) facilitators based at the hospitals and community health centres. Both the NGO nurse supervisor and the PHC facilitators should become members of the clinic committees for better coordination of facility and community-based activities.

The achievement of better health and nutrition outcomes for women and children through the community MNCWH&N programme will be monitored at each level of the organizational structure through core indicators that have been identified for progress tracking. Monthly and quarterly progress review meetings will be held by the clinic committees and the district health teams respectively to monitor progress against set targets and enable timely corrective actions.

With significant proportions of maternal and child deaths occurring at home, the community MNCWH&N programme here outlined is expected to help fill the gaps in coverage of proven high impact interventions and thus contribute to lowering maternal and child mortality rates towards the millennium development goals.

1. INTRODUCTION

1.1. BACKGROUND

Since the advent of democracy in 1994, South Africa has made progress to improve access of mothers, children and women to health care and nutrition services particularly for the poor and those in the rural areas. This was made possible by successful introduction and implementation of primary health care (PHC) policies including the revitalisation and building of PHC facilities and introduction of the free health care policy for mothers and children less than six years. As a result of these efforts, the utilisation of PHC facilities has increased to over 100 million visits annually. The ratio of visits of children below five to PHC facilities increased to an average of 4.1 times a year.

Despite these achievements, reducing under-five mortality has remained a major challenge. The 2003 South African demographic and health survey (SADHS, 2003) showed a slight reduction in under five mortality from 60 per 1000 live births in 1990 to 58 per 1000 live births in 2003. The 1998 South African Demographic and Health Survey (SADHS 1998) reported a maternal mortality ratio (MMR) of 150 per 100,000 live births. In 2004, the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) calculated MMR of 147 per 100,000 live births. South Africa needs to decrease under- five mortality rates to less than 20 per 1000 live births and MMR to 38 per 100,000 live births by 2015 in order to meet the MDG target.

The socioeconomic determinants of health such as poverty, illiteracy and gender inequities have contributed to significant disparities in the child and maternal health outcomes; for example, under-five mortality is consistently higher in the non-urban than urban areas, irrespective of the population group. Infant and under five mortality rates for Africans are more than two-fold than that of coloured infants and four-fold than that of white infants. Similarly, under-five mortality rates have been found to be twice as high among mothers of grade 1-5 education level, compared to those of grade 12 and above. Higher maternal and child mortality rates have been recorded in the Eastern Cape, Free State and Northern Cape provinces in which unemployment and low household income are prevalent (SADHS 2003).

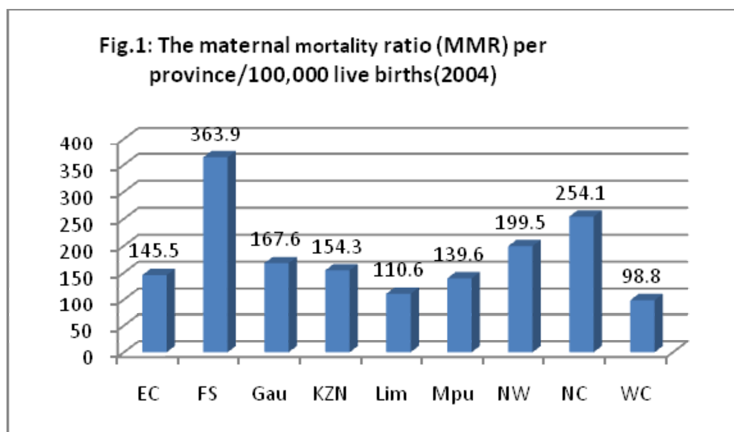
In addition, despite the steady progress in poverty reduction since 1994, 68% (12.3 million) of children in South Africa still live below the poverty data line and therefore do not have access to basic needs (Child Gauge 2007/2008). Poor access to existing health services and inadequate knowledge on how to prevent illness and care for the sick children at community and household levels are factors contributing to high deaths of mothers and children in South Africa

1.2. MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION STATUS IN SOUTH AFRICA

South Africa has one of the highest coverage of maternal and child health services in Africa. Despite that, maternal mortality has remained around 140-150/100,000 live births) over the last 15 years. The main causes of deaths include non pregnancy related

diseases (39%), hypertension (19%) and obstetric haemorrhage (13%). Data from the Saving Mothers Report, 2004 in Fig.1 below show that higher maternal mortality ratios were observed in the Free State (FS), Northern Cape (NC) and North West (NW) consecutively, compared to the remaining provinces. This could be attributable to poor access of women to the available health care by the disadvantaged population.

In addition, one third of pregnant women book for their first antenatal care (ANC) visit after the fifth month of gestation, thus delaying the identification and management of diseases contributing to high maternal morbidity rates such as hypertension and HIV. Maternal nutrition is a challenge in some provinces such as Kwazulu Natal where recent national food consumption survey found that 60% of women in the province had vitamin A deficiency.



Source: Saving mothers report, 2004

In children, the South African burden of disease review of 2005 indicated that the main causes of death were neonatal diseases, diarrhoea, pneumonia and malnutrition in the context of a high HIV prevalence. Among neonatal causes, low birth weight, asphyxia and infections are responsible for more than 80% of neonatal deaths.

Furthermore, malnutrition which is a result of both poverty and disease remains a major challenge for many children in South Africa. 60% of children who die are malnourished and 50% have clinical evidence of AIDS (Saving Children Report 2005). The 2005 food consumption survey showed that 18% of children were stunted, 9.3% were underweight and 4.5% were wasted with children below 4 years and those in rural settings being more affected than others. The study also found iron deficiency rate of 19.7% among children 5-71 months, zinc deficiency rate of 45.3% among children 1-7 years and vitamin A deficiency of 63.6% among children 1-9 years. Community-based delivery of zinc and vitamin A coupled with the fortification of staple foods with micronutrients are two interventions that can help correct these deficiencies.

1.3. Evidence on effective Maternal, Newborn and Child Health and Nutrition Interventions

In South Africa, it is estimated that 75,000 children under five years die every year because of preventable and/or treatable causes. 22,000 of these children die during the

first month of life.[1] Solutions exist and programmes to deliver these solutions have been successfully implemented in different parts of the world. Globally, it is estimated that two of these interventions, that is, oral rehydration therapy and breastfeeding could each prevent over 10% of deaths.[2] These are interventions which could be delivered at community and household level as they do not require sophisticated health systems.

The benefits of exclusive breastfeeding have been widely established for decades and include reduction in childhood morbidity and mortality and enhanced cognitive development. Other interventions that could each prevent at least 5% of child deaths include improvement of complementary feeding, antibiotics for neonatal sepsis, antibiotics for pneumonia, and preventive zinc supplementation. The overall effect of applying multiple interventions does exceed the effect of the sum of individual intervention presented.

In South Africa, more than 40,000 child deaths could be prevented if these proven high impact interventions reached every South African family. Maternal health interventions provide significant benefits in respect of survival for both mothers and children. Children whose mothers die have been suggested to be at three to ten times greater risk of death than those with living parents.[3]

Many proven single maternal health interventions are available to reduce the risk of maternal morbidity and mortality from pregnancy, through delivery and postpartum These include iron and folic acid supplementation, de-worming treatment (Mebendazole), management of hypertension, early recognition and management of maternal danger signs during pregnancy (e.g. premature rupture of membranes) and during labour (e.g. detection of foetal complications) and emergency obstetric care.

These effective single interventions are available for prevention and/or treatment of maternal complications. However, evidence shows that better maternal outcomes are achieved when these interventions are provided in a package during pregnancy through delivery and post-partum.[4] Although most of these interventions are delivered at health facility level by skilled health professionals, the community health workers (CHWs) have played an important role in educating women and assisting them on birth preparedness.

CHWs have shown to be instrumental in mobilising communities to support women to book early in pregnancy in order to allow for timely detection and management of complications. The World Health Organization (WHO) recommends that pregnant women

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[1] Every death counts; 2008
[2] Lancet 2003
[3] Lawn JE, Cousens S, Bhutta ZA, et al. Why are 4 million newborn babies dying each year? *Lancet* 2004; **364:** 399–401.
[4] Maternal survival series, Lancet,2006

in developing countries should seek ANC within the first 16 weeks of pregnancy.[5] In developed countries, ANC is recommended within the first 12 weeks of pregnancy.[6]

1.4. Coverage of Maternal, Newborn and Child Health and Nutrition interventions in South Africa

The coverage of most facility-based high impact maternal and child health interventions is high: 92% of pregnant women attend antenatal care at least once and 73% attend four times, 68% of pregnant women are tested for HIV during pregnancy, 91% of mothers received medical care by a skilled attendant at delivery[7], 97% and 83% of infants are immunised against DPT3 and Measles respectively.[8] However, inadequate quality of maternal and child health care has been documented through the saving mothers, saving babies and saving children reports and only 52% of children are fully immunized.[3]

The challenge has remained with interventions requiring community engagement and family and community behavioural change such as infant feeding practices including vitamin A supplementation, care seeking behaviours and improved household care practices: Only 1.3% of infants are exclusively breastfed at 4-5 months, 39% of children 6-59 receive vitamin A supplementation, 34% of children with cough and fast breathing are not taken to a health provider, 67% of women do not know about oral rehydration packet for treatment of diarrhoea, 30% of children with diarrhoea do not receive oral rehydration therapy. [3]

1.5. Global practices and lessons learnt

Community Health Workers (CHWs) play a crucial role in the support and delivery of health and nutrition services in sub-Saharan Africa. They have shown to be critical in addressing the human resource crisis affecting the health sector in the developing world. In countries such as Gambia, Tanzania, Zambia, Madagascar and Ghana, the use of CHWs has proven to be not only cost-effective, but also to enhance the performance of community health programmes. Different models have been used including part-time unpaid volunteers in Kenya, Lesotho and Uganda, part-time paid workers in Kenya, South Africa and Uganda and full time paid workers in Kenya and Uganda.[9]

With training and supportive supervision, CHWs have been able to deliver a package of less complex maternal and child health and nutrition interventions such as vitamin A

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[5] Villar J et Al WHO antenatal care randomised trial for the evaluation of a new model of routine antenatal care.[comment][erratum appears in Lancet 2001 Nov 3;358(9292):1556]. *Lancet* 2001, 357:1551-1564.
[6] Mortimer GRMDIRMMDJGHBA: Caring for our future: a report by the expert panel on the content of prenatal care. *Obstet Gynecol* 1991, 77: 782:.
[7] South Africa Demographic and Health Survey 2003
[8] WHO/UNICEF Review of National Immunization Coverage 1980-2007
[9] Experiences with community-based worker systems in Kenya, Lesotho, South Africa and Uganda. http://www.kyanya-aicdd.org Accessed 12-9-2008

supplementation, antibiotics for community-based management of pneumonia, ORT for management of diarrhoea, de-worming and insecticide treated bed nets.

Despite very weak health systems and documented acute shortages of human resources in Malawi, Mozambique, Madagascar, Ethiopia and Eritrea, these countries have reduced child mortality by 30-40% between 1990 and 2006. Most of this progress could be attributed to effective community-based delivery of health and nutrition interventions through CHW programmes, home visits, child health days and community mobilisation. These activities form the backbone of community health programmes in many countries.

2. Government Policies and Initiatives

With the advent of the first democratic Government in 1994, South Africa adopted the PHC policy to ensure equitable, accessible and affordable health care for all, especially for the majority of populations who were marginalised during the apartheid era. The focus was laid on preventive and promotive services at the centre of which was the provision of Maternal and Child Health services (MCH). This policy was followed by the Free Health Care policy for pregnant women and children below the age of six to eliminate the economic barriers which prevented many from accessing basic services.

In 2004, the Government of South Africa introduced the national community health workers policy within the PHC system in an effort to ensure decentralised delivery of health and nutrition services including targeting those women and children. The community health programme promotes health promotion, community and home based care and community and civil society engagement and participation. It recommends the following:

- A minimum stipend of R1000 a month for CHW and that they will not be government employee and but will be employed through civil society.
- A Government/NGO partnership model whereby the Government provides grants to NGOs, which employ the CHWs. This might vary according to local conditions.
- Where volunteers are employed, there should not be more than a few hours a week without remuneration.
- *C*ommunity participation in the selection and recruitment of CHWs
- A clinic committee or a community health committee should be established to provide a governance mechanism

In 2004, the Government of South Africa also established the Accelerated and Shared Growth Initiative of South Africa (ASGI-SA) as a poverty reduction strategy aimed at addressing the socioeconomic determinants and the root causes of poverty. Another iniative, the Expanded Public Work's programs (EPWP), was established in 2004 under the Department of Public Works with the aim of providing job opportunities for the neediest while fostering community development by communities themselves.

Together, these programmes employ CHWs and provide stipends to improve household income. Many of these CHWs have been used to support community health programmes, including HIV and AIDS related.

3. GUIDING PRINCIPLES

The following guiding principles are intended to guide the delivery of community health and nutrition interventions to ensure that all those in need are reached regardless of race, gender, age, residence and spiritual orientation:

a. **Equity:** Special attention will be given to meeting the needs of marginalized and vulnerable groups, including the poor, rural populations (including the farms), children and adolescent girls. Policies, programmes and budgets will be designed and reviewed to address inequities at various levels.
b. **Integration:** MNCWH&N interventions will preferably be delivered as packages to maximise their reach, taking advantage of existing programmes and services to deliver more life saving interventions to mothers, women and children,
c. **Care continuum**: Systems will be established to ensure that mothers and their children are provided with all the services they need and regularly followed up within the life cycle continuum, from pregnancy through delivery and early childhood. Services will be delivered through the health system continuum, linking the various levels of care: home, community and health facilities.
d. **Community leadership:** Communities are central to the successful delivery of MNCWH&N services. Community leaders and members will be involved, informed and empowered to own and drive the delivery of community MNCWH&N interventions towards the goal of health for all by 2015.
e. **Family responsibility**: Better health for women and children requires that families take personal responsibility to improve and share health knowledge and to adopt health and nutrition behaviours that will enhance the key family care practices and health seeking behaviours.
f. **Effective partnerships:** Achieving a better health for all is the responsibility of Government, civil society, the private sector and communities themselves. All stakeholders will work together to combine their strengthen through better coordination, pulling resources together and joint monitoring to achieve the highest levels of coverage and quality of community MNCWH&N services.

4. GOALS AND OBJECTIVES

4.1. GOAL:

To improve the health and nutrition status of mothers, newborns, children and women through community based interventions in the 9 provinces with a specific focus in the 18 priority districts

4.2. OUTCOME OBJECTIVES

1. To reduce maternal mortality: Overall mortality by 25% and community based mortality by 50% by 2013

2. To reduce neonatal mortality: Overall mortality by 20% and community based mortality by 50% by 2013
3. To reduce under five mortality: Overall mortality by 30% and community based mortality by 50% by 2013
4. To reduce proportion of under-five children who are underweight from 9.3% to 4.5% by 2013.

4.3. Output objectives

Mothers

1. To increase the proportion of pregnant women who register for antenatal care (ANC) during the first 16 weeks of pregnancy from 32% to 60% by 2013
2. To increase proportion of pregnant women who attended ANC at least four times from 73% to 90% by 2013

Newborns

1. To increase proportion of newborns visited by community health workers within three days of birth from the baseline to 90% by 2013
2. To increase proportion of newborns who are breastfed within an hour of birth from 61% to 90% by 2013

Children

1. Increase exclusive breast feeding rates at 6 months from 1.3% to 40% by 2013
2. Increase vitamin A coverage for children 6 to 59 months from 39% to 90% by 2013
3. To increase the proportion of fully immunized children aged 12 to 23 months from 52% to 80% by 2013
4. To increase the proportion of children 0 to 59 months with diarrhoea receiving ORT at home from 63% to 90% by 2013
5. To increase the proportion of children 0 to 59 months with suspected pneumonia who were taken to health care provider from 64% to 90% by 2013
6. To increase proportion of children 12 to 59 months who receive de-worming in the last 6 months from baseline data to 90% by 2013

Women

1 To increase contraceptive prevalence rate from 65% to 75% by 2013

2 To increase the proportion of women above 30 years referred for cervical cancer screening from 40% to 60% by 2013

5. Strategies

The achievement of the goal of health for all particularly for mothers, women and children will depend on the ability of the Government and its stakeholders to reach the most affected and most in need who are the poor in rural and informal settlements.

Nothing less than universal access will be needed to achieve the desired impacts through the following strategies:

1.1. Advocacy: The leadership, commitment and active engagement of political leaders and key stakeholders are essential for successful implementation of community MNCWH&N interventions. Continued advocacy will be used at all levels to ensure that there are leaders championing MNCW&N and to mobilize resources and develop supportive policies for wide scale implementation.

1.2. Building capacity for effective programme implementation: The quality of services depends on the knowledge, skills, competencies and motivation of service providers. Appropriate training programmes will be developed to equip community health workers and communities to participate more effectively in C-MNCWH&N programmes.

1.3. **Social mobilisation:** The full participation of communities in the transformation of their own health and nutritional status and particularly in the delivery of MNCWH&N interventions will be at the centre of all these efforts. Community leaders and social partners will be mobilised and their capacity developed to work together with all stakeholders in raising awareness and creating demand for services.

1.4. **Programme communication:** The change of health and nutrition behaviours at household and community levels towards better family health and nutrition care practices and timely care seeking is the ultimate goal of community MNCWH&N interventions. Different communication strategies including inter-personal communication involving community leaders and community members will be used to inform and motivate key target groups and bring about desired changes in knowledge, attitudes, and behaviours.

1.5. **Linkages between health facilities and communities:** The strategy seeks to bridge the gap between health workers and communities by linking community health workers with health facilities and forming clinic committees to improve information exchange, referral linkages, coordination between facility and community-based services and promote community involvement in the making of decisions regarding service delivery matters.

1.6. **Improving community-based information collection and utilisation:** Community based information related to the programme implementation will be collected by community health workers regularly and reported to the local clinic for analysis and reviewed by the clinic committee to guide services delivery at each level.

6. Community Maternal, Newborn, Child and Women's Health and Nutrition Framework

The community MNCWH&N framework incorporates a comprehensive community-based approach to the delivery of proven cost effective maternal, neonatal and child health and nutrition interventions. It builds on the existing community Integrated Management of Common Childhood Illness (C-IMCI) to maximise service coverage and quality as well as the overall impacts.

At the heart of this approach is the promotion of care for mothers and children within a life cycle approach from pregnancy through delivery and early childhood and within a health system continuum from health facilities to communities and households. The community MNCWH&N framework include the following six key service delivery modes:

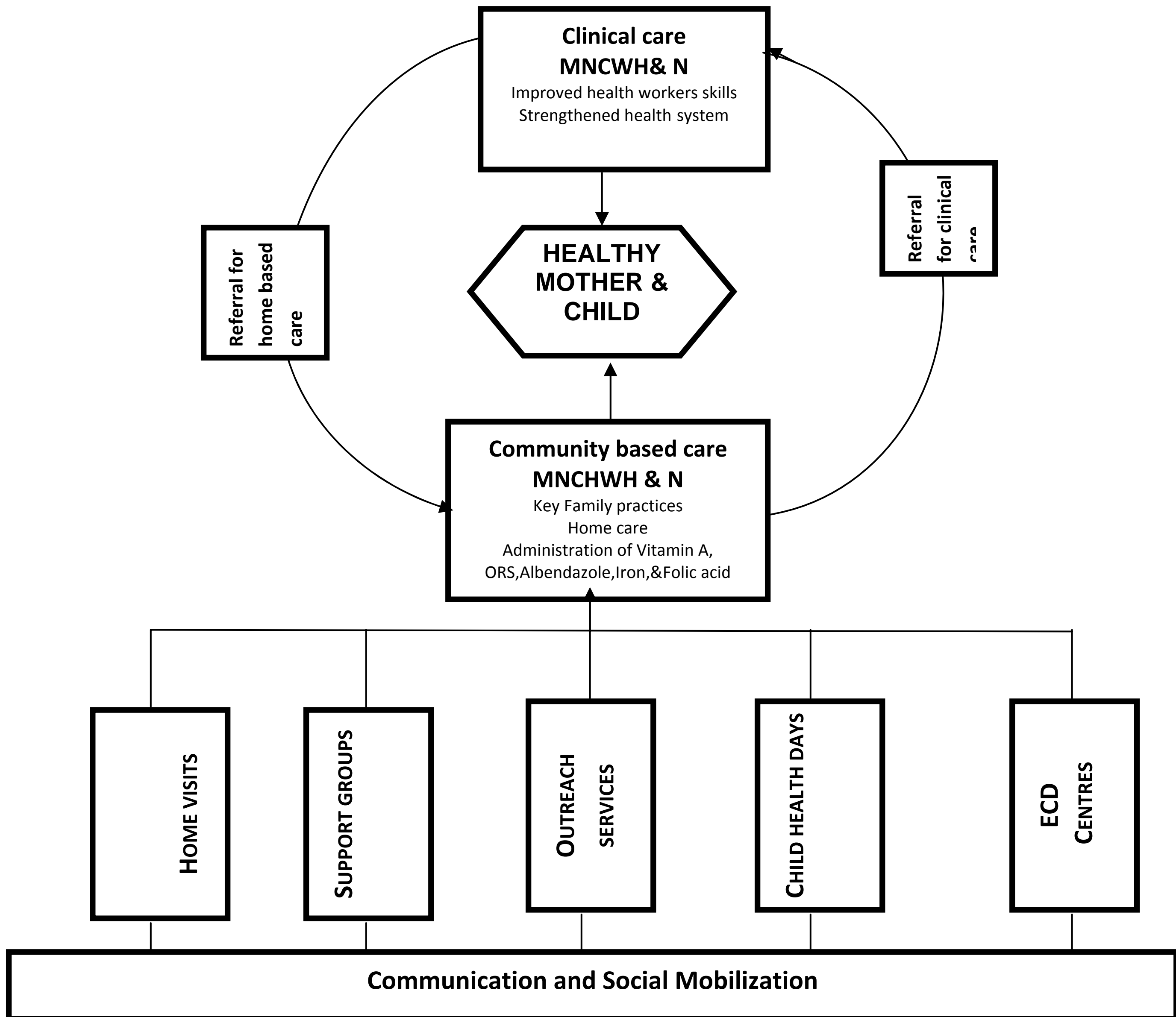
- **Home visits**: Through skilled and motivated community health workers, serving well defined catchment's areas and technically supported from the clinics, households will be regularly visited at least once monthly for health promotion, education on the key family practices, follow up care and administration of low cost high impact health and nutrition interventions such as vitamin A, de-worming and oral rehydration therapy. This will include home visits for the neonates on days 2, 7 and 14.
- **Support groups**: In all their areas of their work, community health workers will develop and animate support groups for mothers to provide them with a platform for peer learning as well as experience and information sharing on issues such as infant and young child feeding, community-based management of childhood illnesses, PMTCT and Reproductive Health.
- **Outreach preventive and curative services**: With the support of district management teams, clinic staff and community health workers will jointly organise regular monthly outreach visits to the most disadvantaged settings in terms of distance, location and infrastructure to provide a wide range of schedulable preventive services (EPI, DBS PCR testing, PMTCT, iron and folate, vitamin A, de-worming and IYCF counselling and support) in addition to curative services. The role of CHWs will include among others mobilising community leaders and members to support and attend these services, health promotion and administration of vitamin A capsules and de-worming tablets.
- **Child health days**: In order to reach those children often missed through both clinical services and outreach visits, special health days will be held at least twice a year in the communities to provide integrated child health and nutrition services including but not limited to, road to health cards, immunisation, vitamin A, de-worming and growth monitoring.
- **The early child development (ECD) centres**: With the acceleration of the roll out of ECD services, ECD centres have become an important entry points for the delivery of health and nutrition services. Every ECD facilitator will be trained on child health and nutrition, parents of children attending ECD centres will be empowered on the key family practices and community health workers will visit

ECD centres at least once monthly to provide basic health and nutrition screening and services

- **Communication and social mobilisation** will underpin these five key delivery modes to ensure that communities are informed and engaged and fully participate in service promotion, demand creation as well as in service delivery. Different strategies will be used to ensure that community leaders and community members have the right knowledge and fully participate in community MNCWH&N activities.

The achievement of better health and nutrition outcomes for women and children through the community MNCWH&N programme will also require that it is supported by strong health systems that allow **referrals of sick children** to the higher levels of the system to be managed by skilled health providers and back to the communities for continuation of care. Systems and mechanisms such as clinic committees, referral forms, joint monitoring meetings will be established to ensure that services are provided within a continuum of care from communities and health facilities and vice versa. Clinic staff will also play an important to provide technical support, supervision and mentoring to boost the skills and motivation of community health workers.

Fig.2: Community Maternal Newborn Child Health & Nutrition services delivery Framework



7. PACKAGE OF SERVICES

The delivery of community MNCWH&N interventions will be improved through integrated approaches that maximize the opportunity that exist to delivery as many life saving interventions as possible. Applying a life cycle approach, service providers at points of contact will be empowered to identify packages appropriate for pregnancy, delivery, postnatal and infancy and childhood as summarised in table 1 below. These will include health promotion for awareness and behaviour change, administration of preventive

interventions, management of childhood illnesses and identification and referral of the sick child.

Table 1: Package of essential C-MNCHW interventions for and Nutrition and their delivery levels

Delivery mode	Pregnancy	Post natal	Infancy/childhood
Home Visits by CHW	• IEC on ANC, PMTCT, ,IYCF, FP, Newborn care, Maternal Nutrition • Birth preparedness	• Counselling on IYCF/EBF, FP and maternal nutrition • 3 Post natal visits for Neonatal Care at days 2, 7, 14 • 6 weeks follow up on PCR and Cotrimoxazole prophylaxis	• Promote Key family practices • Counselling on IYCF/EBF, FP and maternal nutrition • Follow up on services: EPI, PCR, Cotrimoxazole, vitamin A, de-worming • Identification of severe illness and referral for care • ORT for diarrhoea
Outreach Visits through mobile clinics	• IEC on ANC, PMTCT, ,IYCF, FP, Newborn care, Maternal Nutrition • Birth preparedness	• Counselling on IYCF/EBF, FP and maternal nutrition • Post natal care for mothers and babies • 6 weeks follow up on DBS PCR testing and Cotrimoxazole prophylaxis	• Growth monitoring and Counselling on IYCF/EBF • Immunization • Management of sick child • Provision of vitamin A, immunisations and de-worming
Child Health Days		• IEC and Counselling on IYCF/EBF, FP and maternal nutrition	• IEC and Counselling on IYCF/EBF, FP and maternal nutrition • Provision of vitamin A, immunisations and de-worming • Growth monitoring
Mothers Support Groups	• IEC and experience sharing on ANC, IYCF, FP, PMTCT, Newborn care, Maternal Nutrition and birth preparedness		• IEC, Counselling and experience sharing on IYCF/EBF, FP, PMTCT and maternal nutrition
ECD centres			• Growth monitoring • Management of sick child • Provision of vitamin A, immunisations and de-worming

8. Community Maternal, Neonatal, Child and Women's Health and Nutrition Systems

With the exception of outreach services from mobile clinics by trained health professionals, the bulk of community MNCH and Nutrition services will be carried out primarily by trained CHWs. These cadres will be hired by NGOs with technical and financial support from Government at different levels of the system. The national level will be responsible for setting norms and standards through policy and guideline development and resource allocations. The provincial level will be responsible for

implementation oversight, monitoring and resource allocation. The district will be responsible for capacity development, planning and on-site support and monitoring.

8.1. COMMUNITY HEALTH WORKER PROGRAM

The delivery of community MNCWH&N interventions will be anchored into the existing CHW programme in the Department of Health to ensure Government ownership and long term sustainability. The capacity of CHWs will be strengthened for the delivery of a comprehensive package of health and nutrition interventions which include MNCWH&N interventions, TB, HIV and others. This will be achieved through training, peer learning, supportive supervision and mentoring as well as the provision of CHW kits and job aids.

Job description: The role of CHWs will include, but not limited to, community mobilisation, health promotion, nutrition counselling and support including IYCF, and administration of less complex interventions such as vitamin A supplementation and de-worming. CHWs will submit monthly activity reports to the primary clinics in the catchment's areas where they operate. These reports will be discussed during the clinic committee meetings (See annex 2).

Supervision: Regular support and supervision will be provided by the NGO nurse supervisors; PHC facilitators based at the hospitals and community health centres and experienced CHWs with proven supervisory skills who should also become members of the clinic committees.

8.2. RECRUITMENT AND SELECTION OF CHW

The recruitment of CHWs shall be the responsibility of local NGOs with full community participation in the selection and recruitment process. CHWs should preferably be members of the same communities they serve and they should understand both the culture and the language. Preference should be given to those who have completed at least grade 7 and are able to read and write. Consideration could be given to others who are less educated, but clearly demonstrate their ability to understand, clearly communicate and provide community MNCWH&N interventions.

8.3. REMUNERATION OF CHWS

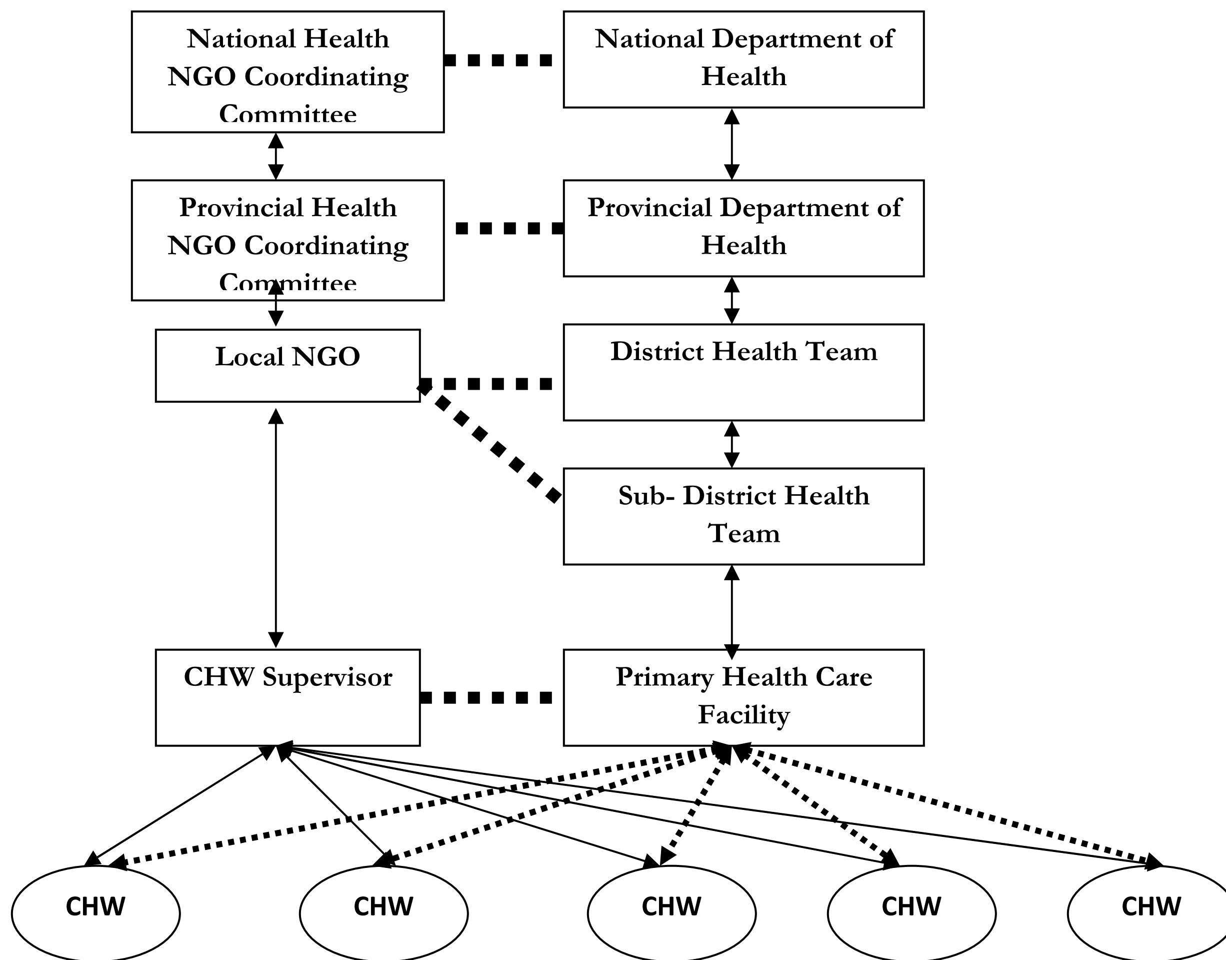
In line with the Government policy on basic salary, CHWs should be remunerated and given a stipend of no less than R1 200 per month to enable them to carry out their work effectively. They should be recognized as community MNCWH&N service providers and be supported and respected in their work by national and local health care providers. One CHW will be responsible for 100 households and one NGO nurse supervisor will be in charge of 10 CHWs.

8.4. MODUS OPERANDI

The management of CHWs will be the responsibility of local NGOs, working hand-in-hand with Government to ensure that training and service delivery standards are adhered

to. Every 10 CHWs will be supervised by a health coordinator who is a qualified professional nurse. The health coordinator will be a member of the clinic health committee and will be tasked with the responsibility to report to the committee on the activities of CHWs.

Fig 3: DOH-NGO Coordination and Reporting Mechanisms



At national and provincial levels, national and NGO coordinating committees will be the umbrella bodies that will work with the Department of Health on the coordination and monitoring of the community MNCWH&N activities.

8.5. TRAINING OF CHWS

The local NGO will be responsible to train, provide technical support and supervise CHWs on regular basis. However, the Department of Health will develop norms and standards, including the community MNCWH&N guidelines, community health worker policy, training manuals and community C-MNCWH booklet for CHWs.

8.6. EQUIPMENT AND TOOLS

The following basic equipment, supplies and job aids will be provided to all CHWs involved in the delivery of community MNCWH&N interventions to facilitate their work:

- *CHW kit:* Every CHW will receive a kit comprising of the following supplies ORS sachets, disposable delivery kits, latex, gloves, contraceptive pills, Iron-folic acid tablets, Mebendazole, vitamin A capsules, Mid Upper Arm Circumstance (MUAC) tapes, thermometer, saltor weighing scale, health promotion checklists, CHW reporting forms, CHW monitoring registers, counselling cards and registration books.
- *Comprehensive community MNCWH booklets:* Each CHW will receive a booklet which summarises basic information about community MNCWH to guide them in their day to day work
- *CHW MNCWH flipcharts:* Each CHW will receive flipcharts to serve as a step by step guide and checklist to be used during health promotion and counselling sessions
- *Household MNCH posters:* Each family will be given a poster with a schedule of essential MNCH&N interventions to foster joint monitoring and joint accountability by CHWs and families
- *CHW Monitoring Registers:* Each CHW will keep a register with up to date demographic and health information of mothers, children and women in the catchment area. This will include services received, services due and dates of appointment to facilitate follow up.
- *CHW Reporting Forms:* Basic community-based information will be collected on a monitoring form to be submitted every month to the clinic for capturing into the national district health information system. This data will be reviewed during monthly clinic committee meetings and feedback will be provided to guide the work of CHWs.

9. TEN IMPORTANT DISTRICT LEVEL IMPLEMENTATION STEPS

- Establish district management and coordination structures
- Identify district community MNCWH&N focal point
- Identify key stakeholders and building partnerships
- Community mobilisation to secure community buy-in, engagement and participation
- Undertake community assessments to review service provision of MNCWH & Nutrition at community level, using the bottom –up approach based on community assessment analysis and action (Triple A) and identify gaps in service provision and availability of CHWs and essential drugs and supplies
- Define the role of CHWs in the provision of MNCWH& nutrition services and establish referral systems
- Develop district comprehensive community MNCWH& Nutrition operational plans with full community participation

- Develop the district MNCWH& N communication strategy
- Implement and monitor district operational plans
- Document and disseminate good practices

10. Community MNCWH&N Monitoring and Evaluation Framework

Key Community Maternal newborn child health and nutrition indicators

I. **National level**

- Maternal mortality ratio
- Neonatal mortality rate
- Under five morality rate

II. **Community level - by Community Health workers/ monthly**

Impacts:

- % of mothers dying at home
- % of newborns dying at home
- % of children under-five years dying at home
- % of children age of under five years who are under weight

Outcomes:

- % of pregnant women who attend ANC
- % of pregnant women who attend ANC at least four times
- % of HIV positive pregnant mothers receiving ARVs for PMTCT
- % of delivery by skilled attendant
- % of newborn who are breastfed within an hour of birth
- % of newborn who receives at least three postnatal home visits
- % of HIV exposed infants given Cotrimoxazole
- Exclusive Breast Feeding rate at 6 months
- % of children with diarrhoea given ORS
- % of children 0 to 59 months with suspected pneumonia taken to health care provider for skilled care
- % of children fully immunised at 12 to 24 months
- % of children 12 to 59 months who receive de-worming in the last 6 months
- Vitamin A supplementation coverage among children 12-59 months
- Contraceptive Prevalence rate
- % of women above 30 years screened for cervical cancer

11. Conclusion

The C-MNCWH and Nutrition is guided by the principle that if the causes of mothers and children are addressed at community level, significant reductions of such deaths could be made, enabling South Africa to get back on track towards achieving the MDGs.

Empowerment of women and improving their socio-economic conditions will go a long way to reduce their vulnerability and that of their children to disease and death. This is the commitment of the Government of South Africa and of its people to better the lives of the most vulnerable in our society.

The basic health needs of women, mothers and children health can only be met if services are accessible, equitable, and affordable and of good quality. The community MNCWH&N programme is an important component of the health system aimed at bringing services to the people in their own environment. Communities will be central to the successful delivery of MNCWH&N services and all efforts should be made to ensure that households and the community at large are informed and empowered to own and drive the delivery of community MNCWH&N interventions towards the goal of health for all by 2015.

Annex 1: JOB DESCRIPTION OF COMMUNITY HEALTH WORKER

Upon successful completion of training on community based maternal, neonatal, child and women's health and nutrition, community health workers (CHW) will execute the following:

I. Undertake regular home visits:

1. *During pregnancy*:
    a. Identify pregnant women by visiting every house in the catchment's area at least once every month, register in the CHW monitoring register and refer them to the nearest community health clinic for antenatal care within 16 weeks of gestation
    b. Using IEC flipcharts and counselling cards, provide health education on the importance of antenatal care and early booking, birth preparedness, danger signs in pregnancy, HIV testing and management during pregnancy and maternal and infant nutrition
    c. At the 7th month pregnancy, complete birth plan (review danger signs in pregnancy and delivery), including encouraging women living far away, where referral in case of emergency difficult, to stay with relatives/friends closer to health facility

2. *During the postnatal period*: Conduct at least 3 postnatal home visits for maternal and newborn baby care on days 2, 7 and 14 regardless of place of delivery. If high risk, 2 additional visits in the third and fourth week of birth. During each visit:

    NEWBORN CARE:
    a. Temperature management of newborn: assist mother in re-warming if necessary
    b. Observe breast feeding and assist for immediate and exclusive breastfeeding. For HIV positive mothers provide infant feeding counselling and support to exclusively feed their infants with the chosen feeding option
    c. Observe cord care and eye care
    d. Count newborn respirations
    e. Screen for danger signs. If present, refer immediately to the health facility if the following are present: Asphyxia, low birth weight (<2000gm), hypothermia, breastfeeding problems and neonatal sepsis
    f. Refer for early vaccination
    g. Assist family with birth registration
    h. Encourage parents and family to talk, sing and play with the newborn
    i. On day 42, encourage clinic visits for immunisation. For infants with HIV infected mothers, refer for Cotrimoxazole prophylaxis and Dried Blood Spot PCR HIV testing

CARE OF THE LOW BIRTH WEIGHT BABY >2000 GM

a. Encourage and teach mothers to ensure warmth –Kangaroo Mother Care
b. Encourage and teach mothers to practice and ensure extra hygiene
c. Observe feeding and assist with breast milk expression or feeding with cup
d. Review danger signs with mother and family members
e. Check for danger signs (hypothermia, breastfeeding problems and neonatal sepsis) and if present, refer immediately to health facility

MATERNAL CARE:

a. Enquire about amount of bleeding
b. Check temperature
c. Ask about breast problems and assist if needed
d. Discuss nutrition
e. Review maternal postpartum danger signs
f. If any danger signs present, refer to the health facility immediately
g. Discuss birth spacing and refer to the health facility
h. Encourage HIV positive mothers to go for ARV and Cotrimoxazole preventive treatments

3. *<u>During infancy and early childhood</u>*: Conduct at least one home visit to each household. During each visit:
    a. Educate the mother/care givers on the key household practices, focusing on the most appropriate for the local community and for the household on the day of the visit
    b. Counsel the mother/care givers on infant and young child feeding practices
    c. Educate the mother/care givers on water, sanitation and hygiene
    d. Educate the mother/care givers on the management of common childhood illnesses at home and ensure they know the danger signs and when to seek care outside the home
    e. Check for diarrhoea, fever and pneumonia and refer to the health facility when necessary
    f. Conduct health screening and check for danger signs (convulsion, lethargic or unconsciousness, inability to drink or breastfeed , vomits everything)
    g. Check for immunization and refer if it is not updated
    h. Check for vitamin A supplementation status and administer if not up to date
    i. Check for de-worming for a child 12 to 59 months and give Mebendazole if not given within 6 months
    j. Check for feeding practices according to the age of the child (exclusive breastfeeding, replacement feeding, complementary feeding with continued feeding
    k. Check nutritional status using MUAC tape and growth chart and refer when necessary

II. Establish community-based support groups

1. Organize group health education talks for pregnant women on prevention of mother-to-child transmission (PMTCT), danger signs, early care seeking and essential newborn care
2. Form mothers support groups to discuss and share experiences on PMTCT, infant and young child feeding and management of childhood illnesses
3. Form other support groups as necessary e.g. Mothers of HIV infected children, TB patients etc…
4. Establish linkages with local CBOs, NGO and FBOs

III. Conduct community mobilization

1. For community leaders and the community at large to increase their engagement and participation in activities related to maternal, neonatal, child and women' s health and nutrition

IV. Organize Maternal and child health days

1. Organize maternal and child health days at least twice a year in collaboration with the local clinic and the district health team to deliver low cost but high impact health and nutrition interventions such as immunisations (catch up), vitamin A, de-worming and IYCF counselling and support

V. Visit ECD centre

1. Undertake regular visits to ECD centres at least once a month for the following:
    a. Assess health of pre-school children and refer when necessary
    b. Check nutritional status using MUAC tape and growth chart and refer when necessary
    c. Check for immunization and refer if it is not updated
    d. Check for vitamin A supplementation status and administer if not up to date
    e. Check for de-worming and give Mebendazole if not given within 6 months
2. Health education of ECD facilitators on water, sanitation and hygiene

VI. Assist health care providers during mobile clinic visits

1. Raise awareness about the mobile clinic schedule and the importance of the services provided and mobilise communities to fully participate.
2. Help bring in communities during mobile clinic visits, particularly women and children who are not up to date, to receive the preventive services they need
3. Help health care providers with the provision of basic services such as weighing, recording, vitamin A supplementation and de-worming among others.

VII. **Collect and submit health information**

1. Collect information on all activities undertaken and maintain the CHW Monitoring Registers

2. Fill in the CHW monthly reporting form and submit complete and accurate report to the area supervisor on the 1st week of the month for the preceding month
3. The area supervisor will compile all CHW reports and submit them to the clinic for capturing in the District Health Information System (DHIS).

Annex 2: COMMUNITY BASED MNCWH&N MONTHLY REPORTING FORM

PHC Facility_____________ **Area**___________ **Month**_________ Reporting ________________

NO.	INDICATOR	DENOMINATOR		NUMERATOR	
1	Maternal deaths at home	Total number of live births in catchment's area		Number of mothers died at home while pregnant or within 42 days of termination of pregnancy	
2	Neonatal deaths at home	Total number of neonates aged 0-28 days in catchment's area		Number of neonates aged 0-28 days died at home	
3	Maternal deaths in the health institution	Total number of live births in catchment's area		Number of mothers died in the health institution while pregnant or within 42 days of termination of pregnancy	
4	Neonatal death in the health institution	Total neonates aged 0-28 days in catchment's area		Number of neonates aged 0-28 days died in the health institution	
5	Child deaths at home	Total number of children 1-59 months		Number of children 1-59 months died at home	
6	Child deaths in the health institution	Total number of children 1-59 months		Number of institutional deaths of children 1-59 months	
7	Under weight prevalence	Total children 0-59 mo in catchment's area		Number of children aged 0-59 months who are under weight	
8	Antenatal care at least one visit	Total pregnant women visited in catchment's area		Number of pregnant women attended ANC at least once during the current pregnancy	
9	ANC early booking coverage	Total pregnant women visited in catchment's area		Number of pregnant women who attended ANC in the first 16 weeks of pregnancy	
10	Antenatal care four visits	Total number of pregnant women in catchment's area		Number of pregnant women who attended ANC at least four times for the current pregnancy	
11	Prevention of mother to child transmission of HIV programme uptake	Total Pregnant women in catchment's area		Number of pregnant women who receive PMTCT counselling and test for HIV	
12	HIV positive pregnant women receiving ARV for PMTCT	Total HIV positive pregnant women giving birth in the preceding month		Number of HIV positive pregnant women given ART prophylaxis in the preceding month	
13	Skilled attendant at delivery	Total delivery attended by skilled health care provider in catchment's area		Number of delivery attended by skilled health care provider	
14	Home delivery	Total mothers who delivered during the month in catchment's area		Number of mothers who delivered at home	
15	Early initiation of breast feeding	Total women with a live birth in catchment's area		Number of mothers who put the newborn to the breast within one hour	

16	Post natal care for newborns	Total newborns in catchment's area		Number of newborn who received post natal visit within two days of birth	
17	HIV exposed infants receiving ARV for PMTCT	Total HIV exposed children		Number of HIV exposed receiving ARV for PMTCT	
18	DBS PCR Testing	Total HIV exposed children		Number of HIV exposed tested for HIV using PCR at 6 weeks EPI visit	
19	Co-trimoxazole prophylaxis	Total HIV exposed children		Number of HIV exposed children who received co-trimoxazole prophylaxis	
20	Exclusive breast-feeding (< 6 months)	Total infants 0-5 months in catchment's area		Number o infants aged 0-5 months who are exclusively breastfed	
21	Exclusive formula fed (< 6 months)	Total infants 0-5 months in catchment's area		Number o infants aged 0-5 months who are exclusively formula fed	
22	Breast-feeding plus complementary food (6-9 months)	Total infants aged 6-9 months in catchment's area		Number of infants aged 6-9 nths who are breastfed and receive nplementary food	
23	Vitamin A supplementation coverage	Total children 12-59 months in catchment's area		Number of children aged 12-59 months receive at least two doses of vitamin A supplement in the last 12 months prior to the current visit	
24	Immunization coverage	Total children 12-23 months in catchment's area		Number of children aged 12-23 months who are fully immunized against Measles-DPT3-Polio3-Hib	
				Number of children aged 12-23 months who are immunized against pneumococcal and rotavirus vaccines	
25	Oral dehydration and continued feeding for diarrhoea	Total children 0-59 months in catchment's area with diarrhoea in the last 2 weeks prior to home visit		Number of children aged 0-59 months with diarrhoea in the 2 weeks prior the visit receiving ORS and recommended continued feeding	
26	Care seeking for pneumonia	Total children 0-59 months in catchment's area with suspected pneumonia in 2 weeks prior to the home visit		Number of children 0-59 months with suspected pneumonia in the last 2 weeks prior to the home visit who were taken to an appropriate health care provider	
27	De-worming	Total children aged 12-59 months in catchment's area		Number of children aged 12-59 months who received Mebendazole in the last 6 months	
28	Birth registration	Total children aged 0-59 months in catchment's area		Number of children aged 0-59 months whose birth was registered	
29	Contraceptive prevalence	Total women currently married or in union aged 15-49 years in catchment's area		Number of women currently married or in union aged 15-49 years that are using contraceptive method	
30	Cervical cancer screening	Total women aged above 30 years in catchment's area		Number of women aged above 30 years referred for cervical cancer screening	

ANNEX 3: COMMUNITY MATERNAL NEWBORN CHILD AND WOMEN MORTALITY AUDIT FORM

Health facility: ___________________Area _____________House no ____Month:________

____

1. Name :___________________
2. Date of birth__________ Date of death___________ Age: Yrs ____Mo___ Days___
3. Sex: a. Male b. Female
4. Place of death: a. Home b. Health institution
5. Was referred to health facility for the most recent illness: a. Yes b. No
6. HIV status: a. Positive b. Negative c. Unknown

MOTHERS

7. She died during: a. Pregnancy b. Delivery c. Postpartum
8. Cause of death: a. Bleeding b. Hypertension c. HIV/AIDS d. Infection e. Prolonged labour f. other

NEWBORNS

9. Cause of death: a. Stillbirth b. Asphyxia c. Infection d. Low birth weight e. Other

CHILDREN

10. Cause of death: a. Diarrhoea b. Pneumonia c. HIV/AIDS d. Malnutrition e. Other

WOMEN

11. Cause of death: a. Cardio-vascular b. Tuberculosis c. HIV/AIDS c. Cancer e. Injuries f. Other

ANNEX 3: COMMUNITY BASED MNCWH&N MONITORING AND EVALUATION INDICATORS

NO.	INDICATOR	INDICATOR DEFINITION	NUMERATOR	DENOMINATOR	SOURCES	FREQUENCY	RESPONSIBILITY
Nutrition							
1	Under weight prevalence	Percentage of children aged 0-59 months who are under weight	Number of children aged 0-59 months who are under weight	Total children 0-59 mo in catchment's area	CBI	Monthly	CHW
2	Exclusive breast-feeding (< 6 months)	Percentage of infants aged 0-5 months who are exclusively breastfed	Number o infants aged 0-5 months who are exclusively breastfed	Total infants 0-5 months in catchment's area	CBI[i]	Monthly	CHW[ii]
3	Breast-feeding plus complementary food (6-9 months)	Percentage of infants aged 6-9 months who are breastfed and receive complementary food	Number of infants aged 6-9 months who breastfed and receive complementary d	Total infants aged 6-9 months in catchment's area	CBI	Monthly	CHW
4	Vitamin A supplementation coverage	Percentage of children aged 6-59 months who received at least one dose of vitamin A supplement in the last 6 months	Number of children aged 6-59 months receive at least one dose of vitamin A supplement in the last 6 months prior to the current visit	Total children 6-59 months in catchment's area	CBI	Monthly	CHW
Child Health							
5	Child deaths at home	Percentage of children 1- 59 months died at home	Number of children 1-59 months died at home	Total number of children 1-59 months	CBI	Monthly	CHW
6	Child deaths in the health institution	Percentage of institutional deaths of children 1-59 months	Number of institutional deaths of children 1-59 months	Total number of children 1-59 months	CBI	Monthly	CHW
7	Full immunization coverage	Percentage of children aged 12-23 months who are fully immunized against vaccine preventable diseases	Number of children aged 12-23 months who are fully immunized against vaccine preventable diseases	Total children 12-23 months in catchment's area	CBI	Monthly	CHW
8	Oral dehydration and continued feeding for diarrhoea	Percentage of children aged 0-59 months with diarrhoea receiving oral rehydration and continued feeding	Number of children aged 0-59 months with diarrhoea in the 2 weeks prior the visit receiving ORS and recommended continued feeding	Total children 0-59 months in catchment's area with diarrhoea in the last 2 weeks prior to home visit	CBI	Monthly	CHW
9	Care seeking for pneumonia	Percentage of children aged 0-59 months with suspected pneumonia taken to appropriate health care provider	Number of children 0-59 months with suspected pneumonia in the last 2 weeks prior to the home visit who were taken to an appropriate health care provider	Total children 0-59 months in catchment's area with suspected pneumonia in 2 weeks prior to the home visit	CBI	Monthly	CHW
10	Care seeking behaviour	Percentage of caretaker who knows at	Number of care takers who knows at	Total number of care	CBI	Mont	CHW

		least two signs for seeking care immediately	least two signs for seeking care immediately	caretakers visited in catchment's area		hly	
11	De-worming	Percentage of children aged 12 -59 months who received Mebendazole in the last 6 months	Number of children aged 12-59 months who received Mebendazole in the last 6 months	Total children aged 24-59 months in catchment's area	CBI	Mont hly	CHW
12	Prevention of mother to child transmission of HIV programme uptake	Percentage of pregnant women counselled for PMTCT and tested for HIV	Number of pregnant women who receive PMTCT counselling and test for HIV	Total Pregnant women in catchment's area	CBI	Mont hly	CHW
13	HIV positive pregnant women receiving ARV for PMTCT	Percentage of all HIV positive pregnant women who received a complete course of ART prophylaxis	Number of HIV positive pregnant women given ART prophylaxis in the preceding month	Total HIV positive pregnant women giving birth in the preceding month	CBI	Mont hly	CHW
14	Co-trimoxazole prophylaxis	Percentage of HIV exposed children who received co-trimoxazole prophylaxis	Number of HIV infected children who received co-trimoxazole prophylaxis	Total HIV exposed children	CBI	Mont hly	CHW
Maternal and Newborn Health							
15	Maternal deaths at home	Percentage of mothers died at home while pregnant or within 42 days of termination of pregnancy	Number of mothers died at home while pregnant or within 42 days of termination of pregnancy	Total number of live births in catchment's area	CBI	Mont hly	CHW
16	Neonatal deaths at home	Percentage of neonates aged 0-28 days died at home	Number of neonates aged 0-28 days died at home	Total number of neonates aged 0-28 days in catchment's area	CBI	Mont hly	CHW
17	Maternal deaths in the health institution	Percentage of mothers died in the health institution while pregnant or within 42 days of termination of pregnancy	Number of mothers died in the health institution while pregnant or within 42 days of termination of pregnancy	Total number of live births in catchment's area	CBI	Mont hly	CHW
18	Neonatal death in the health institution	Percentage of neonates aged 0-28 days died in the health institution	Number of neonates aged 0-28 days died in the health institution	Total neonates aged 0-28 days in catchment's area	CBI	Mont hly	CHW
19	Contraceptive prevalence	Percentage of women currently married or in union aged 15-49 years that are using contraceptive methods	Number of women currently married or in union aged 15-49 years that are using contraceptive method	Total women currently married or in union aged 15-49 years in catchment's area	CBI	Mont hly	CHW
20	Cervical cancer screening	Percentage of women aged above 30 years referred for cervical cancer screening	Number of women aged above 30 years referred for cervical cancer screening	Total women aged above 30 years in catchment's area	CBI	Mont hly	CHW
21	Antenatal care at least one visit	Percent of pregnant women attended ANC at least once during the current pregnancy	Number of pregnant women attended ANC at least once during the current pregnancy	Total pregnant women visited in catchment's area	CBI	Mont hly	CHW

22	ANC early booking coverage	Percent of pregnant women attended ANC in the first 16 weeks of pregnancy	Number of pregnant women who attended ANC in the first 16 weeks of pregnancy	Total pregnant women visited in catchment's area	CBI	Mont hly	CHW
23	Antenatal care four visits	Percent of pregnant women who attended ANC at least four times for current pregnancy	Number of pregnant women who attended ANC at least four times for the current pregnancy	Total number of pregnant women in catchment's area	CBI	Mont hly	CHW
24	Skilled attendant at delivery	Percentage of delivery attended by skilled health care provider	Number of delivery attended by skilled health care provider	Total delivery attended by skilled health care provider in catchment's area	CBI	Mont hly	CHW
25	Early initiation of breast feeding	Percentage of newborn put to the breast within one hour of birth	Number of mothers who put the newborn to the breast within one hour	Total women with a live birth in catchment's area	CBI	Mont hly	CHW
26	Post natal care for mothers	Percentage of mothers who received postnatal care visit within two days of childbirth	Number of mothers who received postnatal visit within two days of child birth	Total mothers with a live birth in catchment's area	CBI	Mont hly	CHW
27	Post natal care for newborns	Percentage of newborn who received a postnatal visit within two days birth	Number of newborn who received post natal visit within two days of birth	Total newborns in catchment's area	CBI	Mont hly	CHW
28	Home delivery	Percentage of mothers who delivered at home	Number of mothers who delivered at home	Total mothers who delivered during the month in catchment's area	CBI	Mont hly	CHW
29	Birth registration	Percentage of children aged 0-59 months whose birth was registered	Number of children aged 0-59 months whose birth was registered	Total children aged 0-59 months in catchment's area	CBI	Mont hly	CHW

[i] CBI –Community based information
[ii] CHW –Community health workers