

Appendix 3. Case studies description

Burkina Faso 1

The first case study in Burkina Faso focuses on a rural health facility serving a catchment population of 11,011. The health facility has been around since the 50s and is widely accepted by the local community, thus women generally attend the health facility for maternal and child care. Women usually come by foot, bike or when available by motorcycle. However, due to its remote location, women might not attend the health facility during rainy season as some of the roads become inaccessible.

The health facility is split in two parts: the dispensary (for out-patients) and the maternity located in different buildings. The dispensary and the maternity rely on separate managerial and financing arrangements. The health facility has also a pharmacy located in a third building where patients can buy the prescribed drugs and commodities (such as gloves, syringe, etc.). The health facility lacks some basic resources such as sterilisation equipment.

The health facility is manned by 3 health facility workers (HFWs) that received general training and do not have a maternal and child health profile. Since the health facility is open every day at all hours, the staff is always on call. If one is absent, s/he is not replaced. Due to the lack of staff and the busy workload, some women attending the health facility are asked by the HFWs to help out with the clinics (taking baby measurements, moving boxes, distribution of food supplements, etc.)

The health facility is particularly busy in the morning and has around 30-40 deliveries per month. The health facility provides certain services only on certain days and women can expect long queues (due to the lack of HFWs and numerous registers to be filled out by HFWs during clinics and consultations). For example, Mondays are devoted to consultations for healthy babies (0 to 11 months), Tuesdays and Friday to antenatal care, Wednesdays to consultations for malnourished children and Thursdays to child immunisations (under 1 year old).

During the MOMI training, HFWs from different facilities debated on how to integrate the PPC visit schedule with the infant vaccinations' schedule; which was perceived to be a difficult task. In Burkina Faso 1, there was no change in the health facility structure to accommodate MOMI interventions and the services for infants were not integrated to PPC consultations. According to the HFWs, the only change was that PPC consultations were now available at any time of the day or week.

The MOMI training was well received and HFWs felt more confident as a result to recognise postpartum danger signs and deal with postpartum complications. PPC was neglected before the MOMI intervention with HFWs not telling mothers to come back to the facility for PPC. As explained by the HFWs, with the MOMI community health workers (CHWs) bringing more women at the health facility for PPC and the pay-for-performance pilot rewarding financially the facility for providing PPC, there was more enthusiasm from them to deliver PPC. Furthermore, during the MOMI training, HFWs from different facilities agreed that the best option to insure women did come back for the first PPC visit would be to keep the baby's health booklet at the health facility and only give it back to the mother after the first PPC visit. This would insure women come back since they need the booklet to register the birth of their child. Therefore, Burkina Faso 1 kept the booklets until the mother came back for the first PPC visit.

In the community, each locality designated one female CHW that received MOMI training and conducted home visits and community events. CHWs came to the health facility every month to hand in their reports. All CHWs interviewed commented that the pictorial guide was a good tool to facilitate their activities with mothers. However, at first CHWs had to negotiate access for home visits via the husbands who were unhappy about the CHWs' home visits. But as the CHWs were from the same community they were still allowed to conduct the visit. Some husbands even joined in the conversation. Once the community understood the importance of PPC and the CHWs' work, access did not need to be negotiated.

CHWs in Burkina Faso 1 believed that MOMI brought up changes as women did not know before CHWs' sensitisation that they had to go back to the facility for PPC and assumed that any necessary care was provided during delivery. Furthermore, CHWs were confident that women understood the importance of PPC as many came directly to their CHW to remind her of their upcoming check-up and asked for a referral ticket to take to the facility. Sometimes it was even the husband who reminded the mother about the PPC visit.

Burkina Faso 2

The second case study in Burkina Faso focuses on a rural health facility serving a catchment population of 10,175. Access for women is particularly difficult during rainy season, even for those living close to the health facility, as they need to cross several water streams. Some cannot come at all to the health facility during rainy season for this reason.

The health facility is organised in the same way than Burkina Faso 1 with a dispensary, a maternity and a pharmacy, relying on separate managerial and financing arrangements. The health facility lacks basic resources such as neonatal resuscitation equipment and generally relies on donated equipment.

The health facility is manned by 3 HFWs. One of the nurse is often absent aggravating the lack of staff and the long waiting times for women attending the health facility. Sometimes, CHWs dropping by the health facility are asked to stay and help the HFWs with clinics. There are occasions where all HFWs are away with no one to man the health facility, expecting women thus have to go to Kaya hospital for delivery.

The health facility is particularly busy in the morning and has around 20-30 deliveries per month. Like Burkina Faso 1, the health facility provides certain services only on certain days and women can expect long queues (due to the amount of paperwork and lack of staff). If there are many patients or not enough HFWs, women who came in the morning might have to wait until the end of the day to receive care. Here, HFWs tried to integrate services by making PPC visits coincide with the date for infant vaccination when possible, even if the pay-for-performance system did not take it into account. Like Burkina Faso 1, the HFWs in this facility kept the infant's health booklet so the women had to come back to the first postpartum visit. This, according to the HFWs, also helped them track women who were not coming for PPC as HFWs were able to ask the relevant CHW to get in touch with them.

In the community, most localities designated one female CHW who received MOMI training and conducted home visits and community events. CHWs described that they used the pictorial guide during home visits and community events, which triggered women (and their husbands) to ask questions. They also described the same difficulties than Burkina Faso 1 in gaining access with husbands during home visits at first. Then, women and head of families understood the importance of their message and CHWs did not require permission any longer. In some households, the whole family would come look at the images and listen to the explanations. CHWs pointed out the fact that MOMI involved the village chiefs at first facilitating and legitimising their work.

Women and CHWs interviewed explained that change occurred: in the health facility as women were now followed after birth as well and were attended to if they had complications after delivery; and in the community who understood the importance of PPC. CHWs explained their number of referrals decreased because women went directly to the facility for PPC without waiting for the CHW's visit to remind them. According to them, as long as the next wave of HFWs at the facility provide PPC follow-ups, the women will keep going for PPC appointments without being followed by the CHW.

Burkina Faso 3

The third case study in Burkina Faso focuses on an urban health facility serving a catchment population of 17,093. Access for the local community is not an issue like in Burkina Faso 1 and 2.

Although bigger, the health facility is organised in the same manner than Burkina Faso 1 and 2 and lacks sterilisation equipment. The health facility is manned by 20 HFWs for the dispensary and the maternity, including nurses and midwives. HFWs working in the maternity are assigned certain activities for the week that rotate every week. HFWs at the maternity have at least four registers to fill out when conducting these activities.

The health facility can get quite busy and has around 60-80 deliveries per month. Services are offered every day (Monday-Friday). Burkina Faso 3 integrated the healthy infant consults with vaccinations at the dispensary, during which they triaged the mothers and referred them to the maternity if they did not receive their PPC consultation. However, during the period of observations, women who were referred to the maternity were followed by the researchers and none did the consultation. When asked why, those women explained they did not have enough money with them to pay for the gloves and speculum required for the PPC consultation. This, alongside the long wait, were also mentioned as a barrier to the PPC consult for women interviewed.

HFWs at Burkina Faso 3 gave a lot of importance to filling out the PPC registers properly in order to receive the incentives from the pay-for-performance pilot and thus tried to get the mothers to come back between day 6 and 8 (while MOMI advised between day 6 and 10). HFWs commented that they see much more women at the first PPC consultation since the MOMI community intervention started, leading to an improved indicator appreciated at the national level. Additionally, the arrival of two new HFWs from another MOMI facility during the implementation period boosted the delivery of PPC at Burkina Faso 3.

In the community, each locality designated one female CHW who received MOMI training and conducted home visits and community events. The relationship between the CHWs and the HFWs was good and open. CHWs sent in their reports and HFWs gave recommendations to improve their work.

CHWs in Burkina Faso 3 described a similar protocol for home visits than in previous cases and commented on the pictorial guide being a good tool to start conversations with the women and their husbands. One CHW explained that her work was well accepted by the families and in case of complications, had no issues alerting the husband to take their spouse to the facility. However, CHWs had more difficulties getting women to attend the second PPC visit (around day 42). Indeed, women who attended the first visit and were told they were fine did not see the relevance of going back for the second visit. All CHWs interviewed stated that women would keep on attending the facility for PPC, as long as HFWs were to provide the services.

Burkina Faso 4

The last case study in Burkina Faso focuses on an urban health facility located in the same urban centre as Burkina Faso 3 and serving a catchment population of 16,114. The health facility, organised in the same manner as Burkina Faso 3, has 9 HFWs working in the dispensary and 8 HFWs working in the maternity. The health facility is not as busy as Burkina Faso 3, with 30-40 deliveries per month. The staff is focused on their tasks and interactions with women are limited.

HFWs in Burkina Faso 4 explained that maternal and infant services were integrated and women were referred from the dispensary to the maternity if they had missed or were due for PPC. The observations at this facility did not support the assertions of the HFWs.

HFWs observed more women attending the facility for PPC on one hand because of the community intervention and another hand because HFWs keep the infants' health booklet until women come back for the first PPC visit. HFWs got motivated by the increase in attendance and worked harder to provide PPC in order to improve their PPC indicators.

In the community, most localities designated one female CHW who has received MOMI training and conducted home visits and community events. CHWs commented that the MOMI uniform and pictorial guide were important tools at first to involve women and to get legitimacy. They were confident that women would keep going to the facility for PPC as women have been going for PPC on their own for a while without being prompted by the CHW.

Kenya 1

The first case study in Kenya focuses on a rural health facility serving a very large catchment area of 24,821 across a wide geographic spread. Attending the health facility for women not living near the facility is therefore a time consuming, costly and, for some, a difficult process.

The health facility consists of an outpatient department, a maternity ward, a laboratory and a pharmacy. All maternal and child services are provided by the same staff at the maternity, therefore mothers and their children only have to queue in one place where they can receive all maternal and child health services. The health facility has material resources available to deliver care, including an ambulance.

The health facility is manned by 9 HFWs and 4 CHWs that are employed to provide admin support and assistance with service delivery. Although this facility has enough staff, the shift allocations are not optimal as there is not enough staff during peak times. The health facility has around 40 to 60 deliveries per month. PPC in Kenya 1 focused on the provision of immediate PPC after delivery (or within 72 hours for home births) and provision of postpartum family planning when mothers came for the baby immunisation. This was confirmed by interviews with postpartum women.

50 CHWs, who are elected by their community, are attached to this health facility. In May 2015, only 22 CHWs submitted their monthly report to the health facility. Active CHWs explained that their main responsibility was to make sure that women who delivered at home would go to the facility as soon as possible for a postpartum check-up. Regarding the community dialogues, CHWs took advantage of other outreach activities rather than conducting them as an individual event.

Kenya 2

The second case study in Kenya focuses on a rural health facility serving a catchment population of 7,538. The health facility is closed on evenings and weekends, meaning women have to go to Kwale hospital if they deliver out-of-hours.

The health facility consists of an outpatient department, a maternity ward and a pharmacy. As in Kenya 1, all maternal and child services are provided at the maternity. The health facility has adequate resources to complete daily tasks but does not own an ambulance.

All staff at the facility are female with 3 HFWs and 3 CHWs that are employed to provide admin support. Given the small size of the health facility and the limited opening hours, the facility has few deliveries (5 to 15 per month) as many women prefer to attend Kwale hospital or give birth at home. However, HFWs interviewed have noticed since the beginning of MOMI more women who delivered at home coming to the health facility shortly after birth for immediate PPC. This was facilitated by the introduction from the government of free maternity services around the beginning of MOMI implementation. Yet infant health remained the focus of HFWs and mothers. Counselling on postpartum family planning was only provided during antenatal and vaccination visits.

50 CHWs, who are elected by their community, are attached to this health facility. In June 2015, only 25 CHWs submitted their monthly report to the health facility. The CHWs interviewed found that the MOMI pictorial guide helped trigger discussion during the community dialogue with women. One CHW further explained that they now stress the importance of the postpartum follow-up during their home visits with women responding positively to their message.

Kenya 3

The third case study in Kenya focuses on an urban health facility serving a catchment population of 16,274. The health facility, open 24 hours all week, is accessible to the community because it is located near a major road.

This health facility is organised in a similar way to Kenya 1 and 2 but has more consultation rooms and more resources with their own ambulance, electricity and plumbing.

The facility is busy with around 40 to 60 deliveries per month but this training facility is not understaffed as it is manned by 12 staff and trainees (final year medical students) and 2 CHWs. With trainees and well-organised shift allocations, the staff are not overworked but only 4 HFWs are working in the maternity. HFWs commented that due to the presence of trainees, they had to make sure that their knowledge and skills (including PPC) were always on point. Whilst immediate PPC was standard practice, routine PPC focused only on exclusive breastfeeding counselling, postpartum family planning and infant's immunisation with no physical examination of the mother or baby. Partly due to the renewed focus on the postpartum period by the MOMI project, the HFWs providing maternal and child services instituted a schedule of HIV testing and counselling for all postpartum women at week 1 and month 6 postpartum. HFWs further commented on the change in women's behaviour towards postpartum family planning with more women accepting a family planning method at the week 6 visit. However, this increase in postpartum family planning could not be confirmed by the quantitative data as the numbers fluctuate throughout the implementation period with no clear link to the MOMI intervention timeline of activities.

100 CHWs, who are elected by their community, are attached to this health facility. In August 2015, only 60 CHWs submitted their monthly report to the health facility. CHWs interviewed commented on the MOMI pictorial guide being helpful during community dialogue for women – and men in some events – to have a picture to associate with their own experiences in their village. During home visits, their focus remained on receiving immediate PPC after delivery, breastfeeding and infant's immunisation schedule.

Kenya 4

The fourth case study in Kenya focuses on a rural health facility serving a catchment population of 13,066. The facility is very accessible because it is located next to the main road with access to public transportation. The health facility is closed on evenings and weekends, and women have to find an alternative when they deliver out-of-hours.

The health facility consists of an outpatient department, a maternity ward and a pharmacy. As in Kenya 1, all maternal and child services are provided at the maternity. The health facility has electricity but no plumbing and can have access to Kenya 1's ambulance.

The health facility is manned by 5 HFWs and 4 CHWs, yet due to absences, the maternity is often only attended by one HFW causing long queues for mothers. Additionally, the HFW who was often left alone did not feel confident handling postpartum complications alone and therefore referred all postpartum complications to the next level facility. Similarly to Kenya 2, the facility has few deliveries (5 to 15 per month) as many women prefer to deliver somewhere else due to lack of staff and limited opening hours. Therefore, little PPC was provided at Kenya 4 as most women in this catchment area preferred to deliver elsewhere and would only come back later in the postpartum period for their baby's vaccinations. Two of the women interviewed explained that they came to Kenya 4 two days after delivering and only their infant received care. Additionally, it was observed that during infant's vaccination, postpartum family planning was only offered to women who requested it.

50 CHWs, who are elected by their community, are attached to this health facility. In July 2015, only 20 CHWs submitted their monthly report to the health facility. CHWs interviewed did not use the pictorial guide for community dialogues and admitted they did not talk about PPC. Observations of a community dialogue during the evaluation period further showed that the discussion was not conducted as a participatory process. Women interviewed were not visited by CHWs and received all their health information from Kenya 4.

Malawi 1

The first case study in Malawi focuses on an urban health facility serving a catchment population of 58,061 and referrals from peripheral facilities are sent to Malawi 1. The facility is next to a major road and easily accessible.

The health facility is bigger than the other Malawi case study facilities with a maternity ward, a postnatal ward and an outpatient maternal and child health department. Both the maternity and postnatal wards provide maternal and child care including deliveries and management of postpartum complications while the outpatient department offers antenatal care, family planning, immunisations, HIV care and management of simple postpartum complications. In Malawi 1, only the first infant vaccination was integrated with PPC whereby the HFWs from the outpatient department came to the postnatal ward to provide the vaccination.

The maternity ward sometimes lacks important equipment and need to borrow it from another ward. Although the facility has the highest number of HFWs in the district (28), it is affected by staff shortage due to the high catchment population it serves and the large number of health services it offers. Additionally, out of the 5 HFWs interviewed only 1 received the MOMI training with other HFWs thinking that the project had already phased out. Although the maternal and child health outpatient department is usually manned by 4 HFWs, frequent staff absences lead to one or two HFWs being responsible to attend large groups of women visiting the facility (sometimes more than a 100 women). This was despite the fact the management team allocated more nurses and clinicians to the postnatal ward to accommodate the MOMI interventions.

The maternity's workload is very large with an average of 300 deliveries per month. No immediate PPC or monitoring was provided during the first 24 hours after birth unless complications occurred with the mother or the baby. Before being discharged, women received group counselling on possible postpartum danger signs, hygiene, umbilical cord care, exclusive breastfeeding, postpartum family planning at week 6. Women interviewed who came back for their routine PPC check-ups did not receive any PPC.

28 CHWs are attached to this health facility and conduct activities in the community. However, the MOMI community intervention was only implemented in one traditional authority. Consequently, according to one CHW, the MOMI messages on PPC are not known in the rest of the community. About half of the women who attended PPC check-ups during the observation period were visited at home by a MOMI CHW.

Malawi 2

The second case study in Malawi focuses on a peri-urban health facility serving a catchment population of 48,895 over a wide geographical area. Some women for example have to walk over 20 kilometres each way to get to the health facility.

The health facility has a maternity and an outpatient department located in two separate buildings and lacks basic equipment. The health facility has 7 HFWs, a large workload in the mornings (over 100 women) and has between 100 and 150 deliveries per month. However, staff absences

cause hours of queues for women attending the health facility and can lead to some women delivering at the health facility unattended since the maternity is sometimes manned by only 1 HFW.

In Malawi 2, all MCH services were offered daily to accommodate MOMI interventions but it was observed that HFWs did not refer women to the appropriate services even when those services were offered next door. Provision of immediate PPC was observed – although women interviewed did not receive any PPC after delivery. Before discharge from the postnatal ward, women received group counselling on postpartum family planning, hygiene, umbilical cord care, immunisation and growth monitoring schedules for the baby and were reminded of the first week postpartum check-up. HIV-positive mothers received additional counselling in private. Routine PPC was observed but was only provided after all other services (antenatal care, family planning and deliveries) meaning women had to wait for several hours for routine PPC. Thus, from the interviews and observations, it seemed that most women only came back at the 6th week PPC check-up for the baby's immunisation. For the HFWs interviewed the only change at the facility that occurred as a result of the MOMI interventions was that women were now counselled on PPC before being discharged.

18 CHWs are attached to this health facility and conduct activities in the community. However, the CHWs interviewed explained that the MOMI training was never delivered and as a result their knowledge and activities on PPC were dependent of other projects.

Malawi 3

The third case study in Malawi focuses on a rural health facility serving a catchment population of 14,669. The health facility does not have electricity and lacks material resources such as an ambulance and sterilisation equipment.

The health facility is much smaller than Malawi 1 and 2 and with 2 nurses, 1 community midwife assistant and 1 medical assistant. Although HFWs received training from MOMI on PPC guidelines, one admitted that guidelines were not followed due to lack of human resources and time constraints. However, counselling was provided to women before discharge from the postnatal ward on umbilical cord care, hygiene, exclusive breastfeeding and women were reminded of the first week postpartum check-up. Routine PPC consisted only on checking the baby's umbilicus and asking the mother if she had any problems. Women who were told about and referred for PPC through the MOMI community intervention were therefore very disappointed with the experienced service.

Malawi 3 did not integrate services and only provided services on specific days. For example, Mondays and Fridays are devoted to consultations for malnourished children, Tuesdays and Wednesdays to antenatal care and Thursdays to family planning and clinics for children under 5.

11 CHWs are attached to this facility who work in the community and assist with the clinics for children under 5. CHWs interviewed explained that they received only half of the MOMI trainings to set up and conduct community groups and as a result community activities came to a stop.

Malawi 4

The fourth case study in Malawi focuses on a rural health facility serving a catchment population of 15,280 over a little geographic area. Unlike the previous three cases, which are owned by the government and provide free services, this facility is owned by a faith-based entity and the services are not free. However, to make essential services accessible, all the maternal (up to 6 weeks postpartum) and child health services are paid by the government through the district health office by means of a special service-level agreement. Therefore women tended to attend the facility until the week 6 postpartum check-up. This facility has electricity and a water system as well as its own ambulance and driver. This facility also has material resources for maternal and child care that are not available in other facilities, including the district hospital.

The health facility, with about 100 deliveries a month, has a nurse, a medical assistant, 4 attendants supporting the HIV clinic and one pharmacist. The health facility is small and all services are provided in the same room on specific days (except for the maternity): outpatients and HIV clinics on Mondays, outpatients and antenatal care on Tuesdays, family planning and clinic for children under 5 on Wednesdays, antenatal care on Thursdays and family planning on Fridays. Postpartum family planning in Malawi 4 was integrated with postnatal check-ups and with the under 5 children clinics. Before discharge from the postnatal ward, women were counselled on the umbilicus care, hygiene, family planning, exclusive breastfeeding and were encouraged to come back after a week for PPC for mother and infant. During the 2-week observation period, routine PPC – although not always provided to all postpartum women – was provided more thoroughly than in the other Malawi cases.

11 CHWs are attached to this health facility to conduct activities in the community. However, none of the women interviewed have a CHW working in their village. CHWs interviewed complained of the lack of MOMI supervision and support.

Mozambique 1

The first case study in Mozambique focuses on a rural health facility serving a catchment population of 21,452. The health facility is difficult to access and little means of transportation is available for the local population.

The health facility, open for consultations from 7.30 until 15.30 during the week and is opened 24h for emergencies. The facility is made of six rooms for deliveries, vaccinations, outpatients and the pharmacy. Basic resources are available to undertake those activities. Integration of services took the form of the ‘one-stop shop’ where women received maternal and infant services in the same room (except for family planning). The health facility is manned by 2 HFWs – with no specific training in maternal and child health and with no training for intrauterine device insertion – and a pharmacy technician. The maternity sees around 40 to 80 deliveries per month.

HFWs explained that the PPC checklists facilitated the diagnosis of postpartum complications. Observations indicated however that immediate and routine PPC for mother and infant was not consistent. For example, HFWs were more likely to provide routine PPC to women who gave birth at the facility than those who delivered at home. Additionally, three infants suffered from complications that called for referral to the next level facility during the period of observation. However, only one was referred and the other two died. HFWs in Mozambique 1 did not provide long-lasting family planning methods and only let the women know what was available – pill, condoms and injections – without counselling.

CHWs are often seen around the health facility accompanying women and delivering reports despite the long distances. It was observed that CHWs in Mozambique 1 acted as advocates for the women they accompanied when the women were not receiving PPC. CHWs interviewed believed that the women they visited now understood the importance of PPC and most of them attend the PPC consultations. However, those who experienced poor service from the HFWs will not come back.

Mozambique 2

The second case study in Mozambique focuses on a rural health facility serving a catchment population of 22,310. The closest village to the health facility is 15 kilometres away while the furthest is 130 kilometres away. The health facility is particularly difficult to access as it is isolated from the communities it serves and located on top of a mountain. The facility lacks basic resources and the closest ambulance is 139 kilometres away.

The health facility is organised in the same way as Mozambique 1. All maternal and child health services are provided in the same room. The health facility is manned by 6 HFWs and attends

around 40 to 80 deliveries per month. But due to frequent staff absences some women have to deliver at the health facility unattended or with the help of traditional birth attendants rather than HFWs.

When all HFWs were present at the facility, PPC checklists were completed as routine – although physical examination of the mothers was infrequent – in Mozambique 2 for both postpartum women and babies up to 1 year old. These checklists were filled by the maternal and child health nurse as well as the vaccination technician. The technician did not receive MOMI training but was trained to use the checklist by the nurse. All services were provided in the same room except for vaccinations and family planning. In cases of serious postpartum complications on the other hand, it was observed that the staff was inactive.

The health facility works with 8 CHWs covering the whole catchment population, making the work of CHWs particularly difficult. CHWs interviewed mentioned that they felt more prepared with their checklists to conduct home visits but wanted more frequent supervision visits to discuss their progress and challenges encountered.

Mozambique 3

The third case study in Mozambique focuses on a rural health facility serving a catchment population of 36,039. Access is easier than Mozambique 1 and 2 but some communities are isolated and for those communities, public transportation to the health facility is time consuming and costly.

This health facility has more material and human resources than the other facilities and referrals from peripheral facilities are sent here. The facility is also busier than the others with 100 to 150 deliveries per month. The facility is manned by 44 HFWs, 10 of whom provide maternal and child health services. In Mozambique 3, maternal and child services were never integrated.

Due to the facility being a referral facility, there was more pressure on reporting from the provincial level. But pressure was on measuring and reporting indicators of antenatal care, delivery, family planning, HIV program, vaccination, malaria and nutrition. Hence PPC was not seen as a priority by the HFWs. No checklists for postpartum women were used by the HFWs during the period of observations. Additionally, no routine PPC was provided during the time of observation.

CHWs interviewed were actively referring women to Mozambique 3 for postpartum complications and routine PPC. But unlike Mozambique 1 and 2, CHWs were not seen accompanying women to the facility during the period of observations. Their checklists were found to be a useful tool to communicate the importance of PPC to women during home visits as they contained illustrations of danger signs.

Mozambique 4

The fourth case study in Mozambique focuses on a rural health facility serving a catchment population of 6,007. Given the health facility is located near the main road, communities living near the road (including those from the neighbouring district) have easier access.

The health facility has electricity and is organised in the same way as Mozambique 1 and 2. This facility has 8 HFWs but is quieter than the three others with around 40 deliveries or less per month. Mornings are also quieter for maternal and child health consultations.

Services for mothers and infants were not integrated in Mozambique 4. Checklists were used by the different departments but were not always filled in or used adequately. However, PPC was not seen as a priority due to the high incidence of malaria and HIV in this catchment area. Postpartum women were served last and little information was given by HFWs regarding postpartum follow-ups.