World Health Organization

human reproduction programme hrp
research for impact
UNDP · UNFPA · UNICEF · WHO · WORLD BANK

WHO recommendations on maternal and newborn care for a positive postnatal experience

Executive summary

Introduction

The postnatal period, defined here as the period beginning immediately after the birth of the baby and extending up to six weeks (42 days), is a critical time for women, newborns, partners, parents, caregivers and families. Yet, during this period, the burden of maternal and neonatal mortality and morbidity remains unacceptably high, and opportunities to increase maternal well-being and to support nurturing newborn care have not been fully utilized. Postnatal care services are a fundamental component of the continuum of maternal, newborn and child care, and key to achieving the Sustainable Development Goals (SDGs) on reproductive, maternal and child health, including targets to reduce maternal mortality rates and end preventable deaths of newborns.

In line with the SDGs and the Global Strategy for Women's, Children's and Adolescents' Health, and in accordance with a human rights-based approach, postnatal care efforts must expand beyond coverage and survival alone to include quality of care. This guideline aims to improve the quality of essential, routine postnatal care for women and newborns with the ultimate goal of improving maternal and newborn health and well-being. It recognizes a "positive postnatal experience" as a significant end point for all women giving birth and their newborns, laying the platform for improved short- and long-term health and well-being. A positive postnatal experience is defined as one in which women, newborns, partners, parents, caregivers and families receive information, reassurance and support in a consistent manner from motivated health workers; where a resourced and flexible health system recognizes the needs of women and babies, and respects their cultural context.

This is a consolidated guideline of new and existing recommendations on routine postnatal care for women and newborns receiving facility- or community-based postnatal care in any resource setting. It provides a comprehensive set of recommendations for care during the postnatal period, focusing on the essential package that all women and newborns should receive, with due attention to quality of care; that is, the provision and experience of care. This guideline updates and expands upon the 2014 *WHO recommendations on postnatal care of the mother and newborn*, and complements existing WHO guidelines on the management of postnatal complications.

Target audience

The recommendations in this guideline are intended to inform the development of relevant national and subnational health policies, clinical protocols and programmatic guides. Therefore, the target audience includes national and subnational public health policy-makers, implementers and managers of maternal, newborn and child health programmes, health facility managers, health workers (including midwives, auxiliary nurse-midwives, nurses,

obstetricians, paediatricians, neonatologists, general medical practitioners and community health workers), nongovernmental organizations, professional societies involved in the planning and management of maternal, newborn and child health services, academic staff involved in training health workers, and women's and parents' groups.

The terms woman, mother, partner, parents and caregivers have been used throughout this guideline. These terms have been defined in an attempt to promote inclusivity of all individuals who have given birth, and in recognition of the diverse roles of all individuals involved in providing care and support during the postnatal period.

Guideline development methods

The guideline was developed using standard operating procedures in accordance with the process described in the *WHO handbook for guideline development*. Briefly, these procedures include: (i) identification of priority questions and outcomes; (ii) evidence retrieval and synthesis; (iii) assessment of the evidence; (iv) formulation of recommendations; and (v) planning for implementation, dissemination, impact evaluation and updating of the guideline. The quality of the scientific evidence underpinning the recommendations was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) and Confidence in the Evidence from Reviews of Qualitative research (CERQual) approaches for quantitative and qualitative evidence, respectively. Findings from individual cost-effectiveness studies were assessed using the Consensus Health Economic Criteria (CHEC) checklist. The DECIDE framework (Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence), an evidence-to-decision tool, was used to guide the compilation of evidence, judgements on the different criteria, and the formulation of recommendations by the Guideline Development Group (GDG), including: the effects of an intervention on maternal, newborn and health systems outcomes, and considerations around values of women, parents and health workers; resources; equity; acceptability; and the feasibility of the interventions. The GDG is an international group of experts assembled for the purpose of developing this guideline – at nine virtual GDG meetings held between September 2020 and June 2021. In addition, existing recommendations from current Guideline Review Committee-approved WHO guidelines that were relevant to postnatal care were identified and integrated into this guideline for the purpose of providing a comprehensive document for end-users.

Recommendations

The GDG meetings led to 63 recommendations to improve provision, utilization and experience of postnatal care: 31 are newly developed GDG recommendations and 32 are recommendations integrated from existing WHO guidelines. Recommendations are grouped according to maternal care, newborn care, and health systems and health promotion interventions. Interventions were classified as recommended, not recommended, or recommended under certain conditions based on the GDG's judgements according to the DECIDE criteria, which informed the direction and category of the recommendation. Where the GDG recommended or did not recommend an intervention, the resulting recommendation is relevant to all women in the postpartum period and newborns, unless otherwise indicated in the recommendation. Where the GDG recommended an intervention only in specific contexts, it judged the evidence to be applicable only to these situations, settings or populations. For all recommendations, the GDG provided remarks, including additional contextual information relating to context-specific recommendations, where needed. Users of the guideline should refer to these remarks, which are presented along with the evidence summaries in the full version of the guideline.

Implementation

These recommendations need to be delivered within an appropriate model of postnatal care, and adapted to the needs of different countries, local contexts, and individual women, newborns, parents, caregivers and families. The GDG proposed implementation considerations for each of the new and/or updated recommendations, and overall considerations for the adoption, adaptation and implementation of the set of recommendations to ensure respectful, individualized, person-centred care at every contact, in accordance with a human rights-based approach.

The WHO postnatal care model places the woman–newborn dyad at the centre of care (Fig. 1). The foundation of this postnatal care model is a minimum of four postnatal care contacts. In particular, the GDG considered the first two weeks after birth to be a key time to promote health, identify health problems, and support the transition to well-women and well-infant care. This current guideline confirms the importance

of postnatal care during the first 24 hours after birth, regardless of the place of birth. More specifically, it recommends a minimum 24-hour stay after birth in the health facility, with continuous care and monitoring during that stay. Expanded criteria before discharge have been identified to assess and manage potential problems and to prepare for the transition to the home. At least three additional postnatal care contacts occur during the first six weeks after birth. This includes the provision of effective clinical practices, relevant and timely information, and psychosocial and emotional support, provided by kind, competent and motivated health workers who are working within a well-functioning health system. An effective referral system, including communication between facility- and community-based care providers, and between health and transport workers in case of complications, are also essential components of this postnatal care model.

Monitoring and evaluation

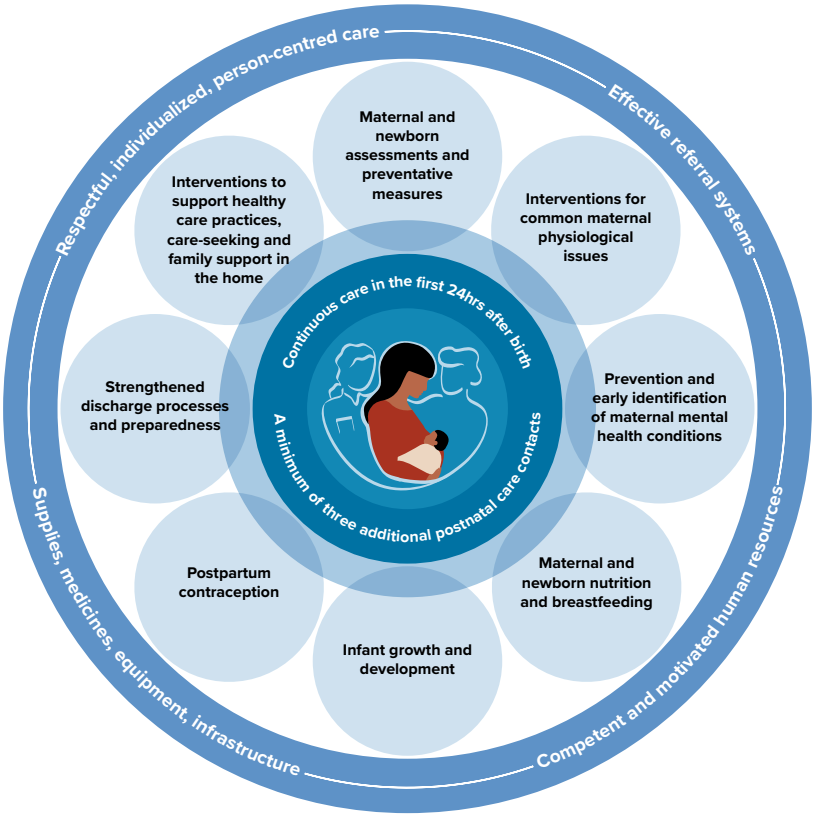
The implementation and impact of these recommendations will be monitored at the health service, sub-national and national levels, based on clearly defined criteria and indicators that are associated with locally agreed targets. The GDG suggests the following indicators to be considered, which have been adapted from current global recommended indicators.[1]

- Length of stay in health facilities after childbirth
- Early routine postnatal care for women (within two days)
- Early routine postnatal care for newborns (within two days)
- Hepatitis B birth dose vaccination

Updating of the recommendations

In accordance with the procedures for updating WHO guidelines, a systematic and continuous process of identifying and bridging evidence gaps following guideline dissemination will be employed. If new evidence that could potentially impact the current evidence base for any of the recommendations is identified, the recommendation will be updated. WHO welcomes suggestions regarding additional questions for inclusion in future updates of the guideline.

Figure 1. Schematic representation of the WHO postnatal care model



1 WHO maternal, newborn, child and adolescent health and ageing data portal: www.who.int/data/maternal-newborn-child-adolescent-ageing/maternal-and-newborn-data/maternal-and-newborn---coverage.

Summary list of recommendations on maternal and newborn care for a positive postnatal experience

Care category	Recommendation	Category of recommendation
A. MATERNAL CARE		
Maternal assessment		
Physiological assessment of the woman[2]	**1.** All postpartum women should have regular assessment of vaginal bleeding, uterine tonus, fundal height, temperature and heart rate (pulse) routinely during the first 24 hours, starting from the first hour after birth. Blood pressure should be measured shortly after birth. If normal, the second blood pressure measurement should be taken within 6 hours. Urine void should be documented within 6 hours. At each subsequent postnatal contact beyond 24 hours after birth, enquiries should continue to be made about general well-being and assessments made regarding the following: micturition and urinary incontinence, bowel function, healing of any perineal wound, headache, fatigue, back pain, perineal pain and perineal hygiene, breast pain and uterine tenderness and lochia.	Recommended
HIV catch-up testing[3]	**2a.** In high HIV burden settings,[a] catch-up postpartum HIV testing is needed for women of HIV-negative or unknown status who missed early antenatal contact testing or retesting in late pregnancy at a third trimester visit.	Context-specific recommendation
	2b. In low HIV burden settings,[b] catch-up postpartum HIV testing can be considered for women of HIV-negative or unknown status who missed early antenatal contact testing or retesting in late pregnancy at a third trimester visit as part of the effort to eliminate mother-to-child transmission of HIV. Countries could consider this only for women who are in serodiscordant relationships, where the partner is not virally suppressed on ART, or who had other known ongoing HIV risks in late pregnancy at a third trimester visit.	Context-specific recommendation
Screening for tuberculosis disease[4]	**3a.** Systematic screening for tuberculosis (TB) disease may be conducted among the general population, including of women in the postpartum period, in areas with an estimated TB disease prevalence of 0.5% or higher.	Context-specific recommendation
	3b. In settings where the TB disease prevalence in the general population is 100/100 000 population or higher, systematic screening for TB disease may be conducted among women in the postpartum period.	Context-specific recommendation
	3c. Household contacts and other close contacts of individuals with TB disease, including women in the postpartum period and newborns, should be systematically screened for TB disease.	Recommended
Interventions for common physiological signs and symptoms		
Local cooling for perineal pain relief	**4.** Local cooling, such as with ice packs or cold pads, can be offered to women in the immediate postpartum period for the relief of acute pain from perineal trauma sustained during childbirth, based on a woman's preferences and available options.	Recommended
Oral analgesia for perineal pain relief	**5.** Oral paracetamol is recommended as first-line choice when oral analgesia is required for the relief of postpartum perineal pain.	Recommended

a High-prevalence settings are defined in the 2015 WHO publication *Consolidated guidelines on HIV testing services* as settings with greater than 5% HIV prevalence in the population being tested.

b Low-prevalence settings are settings with less than 5% HIV prevalence in the population being tested.

2 Adapted and integrated from the 2014 *WHO recommendations on postnatal care of the mother and newborn.*

3 Adapted and integrated from the 2019 *WHO Consolidated guidelines on HIV testing services.*

4 Adapted and integrated from the 2021 *WHO consolidated guidelines on tuberculosis. Module 2: screening – systematic screening for tuberculosis disease.*

Care category	Recommendation	Category of recommendation
Pharmacological relief of pain due to uterine cramping/ involution	**6.** Oral non-steroidal anti-inflammatory drugs (NSAIDs) can be used when analgesia is required for the relief of postpartum pain due to uterine cramping after childbirth, based on a woman's preferences, the clinician's experience with analgesics and availability.	Recommended
Postnatal pelvic floor muscle training for pelvic floor strengthening	**7.** For postpartum women, starting routine pelvic floor muscle training (PFMT) after childbirth for the prevention of postpartum urinary and faecal incontinence is not recommended.	Not recommended
Non-pharmacological interventions to treat postpartum breast engorgement	**8.** For treatment of breast engorgement in the postpartum period, women should be counselled and supported to practice responsive breastfeeding, good positioning and attachment of the baby to the breast, expression of breastmilk, and the use of warm or cold compresses, based on a woman's preferences.	Recommended
Pharmacological interventions to treat postpartum breast engorgement	**9.** The use of pharmacological interventions such as subcutaneous oxytocin and proteolytic enzyme therapy for the treatment of breast engorgement in the postpartum period is not recommended.	Not recommended
Preventive measures		
Non-pharmacological interventions to prevent postpartum mastitis	**10.** For the prevention of mastitis in the postpartum period, women should be counselled and supported to practice responsive breastfeeding, good positioning and attachment of the baby to the breast, hand expression of breastmilk, and the use of warm or cold compresses, based on a woman's preferences.	Recommended
Pharmacological interventions to prevent postpartum mastitis	**11.** Routine oral or topical antibiotic prophylaxis for the prevention of mastitis in the postpartum period is not recommended.	Not recommended
Prevention of postpartum constipation	**12.** Dietary advice and information on factors associated with constipation should be offered to women for the prevention of postpartum constipation.	Recommended
	13. Routine use of laxatives for the prevention of postpartum constipation is not recommended.	Not recommended
Prevention of maternal peripartum infection after uncomplicated vaginal birth[5]	**14.** Routine antibiotic prophylaxis for women with uncomplicated vaginal birth is not recommended.	Not recommended
Preventive anthelminthic treatment[6]	**15.** Preventive chemotherapy (deworming), using annual or biannual[c] single-dose albendazole (400 mg) or mebendazole (500 mg), is recommended as a public health intervention for all non-pregnant adolescent girls and women of reproductive age, including postpartum and/or lactating women, living in areas where the baseline prevalence of any soil-transmitted helminth infection is 20% or more among adolescent girls and women of reproductive age, in order to reduce the worm burden of soil-transmitted helminths.	Context-specific recommendation

c Biannual administration is recommended where the baseline prevalence exceeds 50%.

5 Integrated from the 2015 *WHO recommendations for prevention and treatment of maternal peripartum infections*.
6 Adapted and integrated from the 2017 WHO guideline *Preventive chemotherapy to control soil-transmitted helminth infections in at-risk population groups*.

Care category	Recommendation	Category of recommendation
Preventive schistosomiasis treatment[7]	**16a.** In endemic communities with *Schistosoma* spp. prevalence of 10% or higher, WHO recommends annual preventive chemotherapy with praziquantel in a single dose for ≥ 75% up to 100% of pregnant women after the first trimester, and non-pregnant adolescent girls and women of reproductive age, including postpartum and/or lactating women, to control schistosomiasis morbidity and move towards eliminating the disease as a public health problem.	Context-specific recommendation
	16b. In endemic communities with *Schistosoma* spp. prevalence of less than 10%, WHO suggests one of two approaches based on the programmes' objectives and resources: (i) where there has been a programme of regular preventive chemotherapy, continuing preventive chemotherapy at the same or a reduced frequency towards interruption of transmission; and (ii) where there has not been a programme of regular preventive chemotherapy, a clinical approach of test-and-treat, instead of preventive chemotherapy targeting a population.	Context-specific recommendation
Oral pre-exposure prophylaxis for HIV prevention[8]	**17.** Oral pre-exposure prophylaxis (PrEP) containing tenofovir disoproxil fumarate (TDF) should be started or continued as an additional prevention choice for postpartum and/or lactating women at substantial risk[d] of HIV infection as part of combination HIV prevention approaches.	Context-specific recommendation
Mental health interventions		
Screening for postpartum depression and anxiety	**18.** Screening for postpartum depression and anxiety using a validated instrument is recommended and should be accompanied by diagnostic and management services for women who screen positive.	Recommended
Prevention of postpartum depression and anxiety	**19.** Psychosocial and/or psychological interventions during the antenatal and postnatal period are recommended to prevent postpartum depression and anxiety.	Recommended
Nutritional interventions and physical activity		
Postpartum oral iron and folate supplementation[9]	**20.** Oral iron supplementation, either alone or in combination with folic acid supplementation, may be provided to postpartum women for 6–12 weeks following childbirth for reducing the risk of anaemia in settings where gestational anaemia is of public health concern.[e]	Context-specific recommendation
Postpartum vitamin A supplementation[10]	**21.** Vitamin A supplementation in postpartum women for the prevention of maternal and infant morbidity and mortality is not recommended.	Not recommended
Physical activity and sedentary behaviour[11]	**22.** All postpartum women without contraindication should: • undertake regular physical activity throughout the postpartum period; • do at least 150 minutes of physical activity throughout the week for substantial health benefits; and • incorporate a variety of physical and muscle-strengthening activities; adding gentle stretching may also be beneficial.	Recommended
	23. Postpartum women should limit the amount of time spent being sedentary. Replacing sedentary time with physical activity of any intensity (including light intensity) provides health benefits.	Recommended

d Substantial risk is provisionally defined as HIV incidence greater than 3 per 100 person-years in the absence of PrEP.
e WHO considers a 20% or higher population prevalence of gestational anaemia to be a moderate public health problem.

7 Adapted and integrated from the 2022 *WHO guideline on control and elimination of human schistosomiasis*.
8 Adapted and integrated from the 2016 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach – Second edition*.
9 Integrated from the 2016 WHO publication *Iron supplementation in postpartum women*.
10 Integrated from the 2011 WHO publication *Vitamin A supplementation in postpartum women*.
11 Adapted and integrated from the 2020 *WHO guidelines on physical activity and sedentary behaviour*.

Care category	Recommendation	Category of recommendation
Contraception		
Postpartum contraception[12]	**24.** Provision of comprehensive contraceptive information and services during postnatal care is recommended.	Recommended
B. NEWBORN CARE		
Newborn assessment		
Assessment of the newborn for danger signs[13]	**25.** The following signs should be assessed during each postnatal care contact, and the newborn should be referred for further evaluation if any of the signs is present: not feeding well; history of convulsions; fast breathing (breathing rate > 60 per minute); severe chest in-drawing; no spontaneous movement; fever (temperature > 37.5 °C); low body temperature (temperature < 35.5 °C); any jaundice in first 24 hours after birth, or yellow palms and soles at any age. The parents and family should be encouraged to seek health care early if they identify any of the above danger signs between postnatal care visits.	Recommended
Universal screening for abnormalities of the eye	**26.** Universal newborn screening for abnormalities of the eye is recommended and should be accompanied by diagnostic and management services for children identified with an abnormality.	Recommended
Universal screening for hearing impairment	**27.** Universal newborn hearing screening (UNHS) with otoacoustic emissions (OAE) or automated auditory brainstem response (AABR) is recommended for early identification of permanent bilateral hearing loss (PBHL). UNHS should be accompanied by diagnostic and management services for children identified with hearing loss.	Recommended
Universal screening for neonatal hyperbilirubinaemia	**28.** Universal screening for neonatal hyperbilirubinaemia by transcutaneous bilirubinometer (TcB) is recommended at health facility discharge.	Recommended
	29. There is insufficient evidence to recommend for or against universal screening by total serum bilirubin (TSB) at health facility discharge.	No recommendation issued
Preventive measures		
Timing of first bath to prevent hypothermia and its sequelae	**30.** The first bath of a term, healthy newborn should be delayed for at least 24 hours after birth.	Recommended
Use of emollients for the prevention of skin conditions	**31.** Routine application of topical emollients in term, healthy newborns for the prevention of skin conditions is not recommended.	Not recommended
Application of chlorhexidine to the umbilical cord stump for the prevention of neonatal infection	**32a.** Clean, dry umbilical cord care is recommended.	Recommended
	32b. Daily application of 4% chlorhexidine (7.1% chlorhexidine digluconate aqueous solution or gel, delivering 4% chlorhexidine) to the umbilical cord stump in the first week after birth is recommended only in settings where harmful traditional substances (e.g. animal dung) are commonly used on the umbilical cord.	Context-specific recommendation
Sleeping position for the prevention of sudden infant death syndrome	**33.** Putting the baby to sleep in the supine position during the first year is recommended to prevent sudden infant death syndrome (SIDS) and sudden unexpected death in infancy (SUDI).	Recommended

12 Adapted and integrated from the *2013 WHO document* Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations.

13 Adapted and integrated from the 2014 *WHO recommendations on postnatal care of the mother and newborn.*

Care category	Recommendation	Category of recommendation
Immunization for the prevention of infections[14]	**34.** Newborn immunization should be promoted as per the latest existing WHO recommendations for routine immunization.	Recommended
Nutrition interventions		
Neonatal vitamin A supplementation	**35a.** Routine neonatal vitamin A supplementation is not recommended to reduce neonatal and infant mortality.	Not recommended
	35b. In settings with recent (within the last five years) and reliable data that indicate a high infant mortality rate (greater than 50 per 1000 live births)[f] and a high prevalence of maternal vitamin A deficiency (≥ 10% of pregnant women with serum retinol concentrations < 0.70 µmol/L), providing newborns with a single oral dose of 50 000 IU of vitamin A within the first three days after birth may be considered to reduce infant mortality.	Context-specific recommendation
Vitamin D supplementation for breastfed, term infants	**36.** Vitamin D supplementation in breastfed, term infants is recommended for improving infant health outcomes only in the context of rigorous research.	Context-specific recommendation
Infant growth and development		
Whole-body massage	**37.** Gentle whole-body massage may be considered for term, healthy newborns for its possible benefits to growth and development.	Recommended
Early childhood development[15]	**38.** All infants and children should receive responsive care between 0 and 3 years of age; parents and other caregivers should be supported to provide responsive care.	Recommended
	39. All infants and children should have early learning activities with their parents and other caregivers between 0 and 3 years of age; parents and other caregivers should be supported to engage in early learning with their infants and children.	Recommended
	40. Support for responsive care and early learning should be included as part of interventions for optimal nutrition of newborns, infants and young children.	Recommended
	41. Psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services.	Recommended
Breastfeeding		
Exclusive breastfeeding[16]	**42.** All babies should be exclusively breastfed from birth until 6 months of age. Mothers should be counselled and provided with support for exclusive breastfeeding at each postnatal contact.	Recommended
Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services[17]	**43a.** Facilities providing maternity and newborn services should have a clearly written breastfeeding policy that is routinely communicated to staff and parents.	Recommended
	43b. Health-facility staff who provide infant feeding services, including breastfeeding support, should have sufficient knowledge, competence and skills to support women to breastfeed.	Recommended

f The proposed infant mortality rate of greater than 50 per 1000 live births was calculated based on several assumptions: 50% of the total infant mortality rate are neonatal deaths; 50% of neonatal mortality occurs within the first day after birth; the post-neonatal mortality rate up to 6 months of age makes up two thirds of the total infant mortality rate, and the mortality rate between 6 and 12 months of age makes up the remaining one third; the rate of 30 deaths per 1000 used in the studies accounts for deaths between enrolment in the study up to 6 months of age; and dosing/enrolment almost always occurred within the first 24 hours after birth.

14 Adapted and integrated from the 2013 *WHO recommendations on postnatal care of the mother and newborn*.
15 Adapted and/or integrated from the 2020 *Improving early childhood development: WHO guideline*.
16 Integrated from the 2014 *WHO recommendations on postnatal care of the mother and newborn*.
17 Integrated from the 2017 WHO guideline *Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services*.

Care category	Recommendation	Category of recommendation
C. HEALTH SYSTEMS AND HEALTH PROMOTION INTERVENTIONS		
Schedules for postnatal care contacts	**44.** A minimum of four postnatal care contacts is recommended. If birth is in a health facility, healthy women and newborns should receive postnatal care in the facility for at least 24 hours after birth. If birth is at home, the first postnatal contact should be as early as possible within 24 hours of birth. At least three additional postnatal contacts are recommended for healthy women and newborns, between 48 and 72 hours, between 7 and 14 days, and during week six after birth.	Recommended
Length of stay in health facilities after birth	**45.** Care for healthy women and newborns in the health facility is recommended for at least 24 hours after vaginal birth.	Recommended
Criteria to be assessed prior to discharge from the health facility after birth	**46.** Prior to discharging women and newborns after birth from the health facility to the home, health workers should assess the following criteria to improve maternal and newborn outcomes: • the woman's and baby's physical well-being and the woman's emotional well-being; • the skills and confidence of the woman to care for herself and the skills and confidence of the parents and caregivers to care for the newborn; and • the home environment and other factors that may influence the ability to provide care for the woman and the newborn in the home, and care-seeking behaviour.	Recommended
Approaches to strengthen preparation for discharge from the health facility to home after birth	**47.** Information provision, educational interventions and counselling are recommended to prepare women, parents and caregivers for discharge from the health facility after birth to improve maternal and newborn health outcomes, and to facilitate the transition to the home. Educational materials, such as written/digital education booklets, pictorials for semi-literate populations and job aids should be available.	Recommended
Home visits for postnatal care contacts	**48.** Home visits during the first week after birth by skilled health personnel or a trained community health worker are recommended for the postnatal care of healthy women and newborns. Where home visits are not feasible or not preferred, outpatient postnatal care contacts are recommended.	Recommended
Midwifery continuity of care[18]	**49.** Midwife-led continuity-of-care (MLCC) models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for women in settings with well-functioning midwifery programmes.	Context-specific recommendation
Task sharing components of postnatal care delivery[19]	**50a.** Task sharing the promotion of health-related behaviours for maternal and newborn health[g] to a broad range of cadres, including lay health workers, auxiliary nurses, nurses, midwives and doctors, is recommended.	Recommended
	50b. Task sharing the provision of recommended postpartum contraception methods[h] to a broad range of cadres, including auxiliary nurses, nurses, midwives and doctors, is recommended.	Recommended

g Including promotion of the following: postnatal care, family planning (distribution of condoms [male and female] and other barrier methods, initiation and distribution of combined oral contraceptives, progestin-only oral contraceptives and emergency contraception, and information and general instructions on the Standard Days Method, TwoDay Method® and the lactational amenorrhoea method), postpartum HIV catch-up testing and retesting, sleeping under insecticide-treated nets, nutritional advice, nutritional supplements, basic newborn care, exclusive breastfeeding and immunization according to national guidelines.

h Including: initiate and maintain injectable contraceptives using a standard syringe with needle for intramuscular or subcutaneous injection, insertion of intrauterine device (IUDs), insertion of contraceptive implants.

18 Integrated from the 2016 *WHO recommendations on antenatal care for a positive pregnancy experience.*

19 Adapted and integrated from the 2012 WHO publication *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*.

Care category	Recommendation	Category of recommendation
Recruitment and retention of staff in rural and remote areas[20]	**51.** Policy-makers should consider a bundle of interventions covering education, regulation, incentives and personal and professional support to improve health workforce development, attraction, recruitment and retention in rural and remote areas.	Recommended
Involvement of men in postnatal care and maternal and newborn health[21]	**52.** Interventions to promote the involvement of men during pregnancy, childbirth and after birth are recommended to facilitate and support improved self-care of women, home care practices for women and newborns, and use of skilled care for women and newborns during pregnancy, childbirth and the postnatal period, and to increase the timely use of facility care for obstetric and newborn complications. These interventions are recommended, provided they are implemented in a way that respects, promotes and facilitates women's choices and their autonomy in decision-making, and that supports women in taking care of themselves and their newborns.	Recommended with targeted monitoring and evaluation
Home-based records[22]	**53.** The use of home-based records, as a complement to facility-based records, is recommended for the care of pregnant and postpartum women, newborns and children, to improve care-seeking behaviour, men's involvement and support in the household, maternal and child home care practices, infant and child feeding, and communication between health workers and women, parents and caregivers.	Recommended
Digital targeted client communication[23]	**54.** WHO recommends digital targeted client communication for behaviour change regarding sexual, reproductive, maternal, newborn and child health, under the condition that concerns about sensitive content and data privacy are adequately addressed.	Context-specific recommendation
Digital birth notifications[24]	**55.** WHO recommends the use of digital birth notifications under these conditions: • in settings where the notifications provide individual-level data to the health system and/or a civil registration and vital statistics (CRVS) system; • the health system and/or CRVS system has the capacity to respond to the notifications.	Context-specific recommendation

20 Adapted and integrated from the updated 2021 *WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas.*
21 Retained (following review of new evidence) from the 2015 *WHO recommendations on health promotion interventions for maternal and newborn health.*
22 Adapted and integrated from the 2018 *WHO recommendations on home-based records for maternal, newborn and child health.*
23 Integrated from the 2019 *WHO guideline: recommendations on digital interventions for health system strengthening.*
24 Integrated from the 2019 *WHO guideline: recommendations on digital interventions for health system strengthening.*

World Health Organization

human reproduction programme hrp
research for impact
UNDP · UNFPA · UNICEF · WHO · WORLD BANK

WHO recommendations on maternal and newborn care for a positive postnatal experience: executive summary

ISBN 978-92-4-004407-4 (electronic version)
ISBN 978-92-4-004408-1 (print version)

For more information, please contact:

World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland

Department of Sexual and Reproductive Health and Research
Email: srhmph@who.int
Website: www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)

Department of Maternal, Newborn, Child and Adolescent Health and Ageing
Email: mncah@who.int
Website: www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/

Department of Mental Health and Substance Use
Email: mhgap-info@who.int
Website: www.who.int/teams/mental-health-and-substance-use

Department of Nutrition and Food Safety
Email: nutrition@who.int
Website: www.who.int/teams/nutrition-and-food-safety/overview

9789240044074