General

Guideline Title

WHO recommendations on postnatal care of the mother and newborn.

Bibliographic Source(s)

World Health Organization (WHO). WHO recommendations on postnatal care of the mother and newborn. Geneva (Switzerland): World Health Organization (WHO); 2013 Oct. 62 p. [120 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The rating schemes for the quality of the evidence (very low, low, moderate, high) and the strength of the recommendations (weak, strong) are defined at the end of the "Major Recommendations" field.

Provision of Postnatal Care to Mothers and Newborns

Timing of Discharge from the Health Facility

Recommendation 1

After an uncomplicated vaginal birth in a health facility, healthy mothers and newborns should receive care in the facility for at least 24 hours after birth.

— Weak recommendation, based on low quality evidence

Remarks

- Appropriate standard of care for mothers and newborns should be provided in health facilities, as per other existing World Health Organization (WHO) guidelines. For the newborn this includes an immediate assessment at birth, a full clinical examination around one hour after birth and before discharge. See the WHO Web site .
- "Healthy mothers and newborns" are defined in the safe childbirth checklist to be used to assess mothers and newborns at the time of discharge; mother's bleeding should be controlled, mother and baby should not have signs of infection, and baby should be breastfeeding well.

Timing and Number of Postnatal Contacts

Recommendation 2

If birth is in a health facility, mothers 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 all mothers and newborns, on day 3 (48–72 hours) and between days 7–14 after birth, and six weeks after birth.

— Strong recommendation, based on moderate quality evidence for newborn outcomes and low quality evidence for maternal outcomes

Remarks

- Content of postnatal care to be received in first 24 hours, during days 3–14 and six weeks is defined later in these guidelines.
- The location of contact, i.e., home or health facility, is flexible. Postnatal care contacts may be complemented by additional mobile phone-based contacts between the health system and mothers.
- If possible, an extra contact for home births at 24–48 hours is desirable.
- If there are issues or concerns about the mother or baby, additional contacts may be required.

Home Visits in the First Week of Life

Recommendation 3

Home visits in the first week after birth are recommended for care of the mother and newborn.

— Strong recommendation, based on moderate quality evidence for newborn outcomes and low quality evidence for maternal outcomes

Remarks

- Postnatal visits are usually linked with home visits during pregnancy, particularly in high mortality settings.
- Home visits during pregnancy do not replace antenatal care; they promote utilization of it.
- Depending on the existing health system in different settings, these home visits can be made by midwives, other skilled providers or well-trained and supervised community health workers (CHWs).
- Postnatal contacts also occur at clinic visits.

Content of Postnatal Care for the Newborn

Assessment of the Newborn

Recommendation 4

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:

- Stopped feeding well
- History of convulsions
- Fast breathing (breathing rate >60 per minute)
- Severe chest in-drawing
- No spontaneous movement
- Fever (temperature >37.5ºC)
- Low body temperature (temperature <35.5ºC)
- Any jaundice in first 24 hours of life, or yellow palms and soles at any age

The family should be encouraged to seek health care early if they identify any of the above danger signs in-between postnatal care visits.

— Strong recommendation, based on low quality evidence

Exclusive Breastfeeding (EBF)

Recommendation 5

All babies should be exclusively breastfed from birth until 6 months of age. Mothers should be counselled and provided support for EBF at each postnatal contact.

— Strong recommendation, based on moderate quality evidence

Remarks

- This recommendation is applicable in all settings.
- EBF should be promoted during all antenatal and postnatal care contacts.
- Particular support for EBF should be provided when the mother has had a caesarian section or the baby is born preterm.
- The National Guideline Clearinghouse (NGC) summary of the WHO guidelines on optimal feeding of low birth-weight infants in low- and-middle income countries recommends exclusive breast-milk feeding for all preterm and low-birth-weight infants.
- The Guideline Development Group (GDG) reviewed evidence for neonatal outcomes; the six-month duration is based on existing WHO recommendations and an updated Cochrane review.

Cord Care

Recommendation 6

Daily chlorhexidine (7.1% chlorhexidine digluconate aqueous solution or gel, delivering 4% chlorhexidine) application to the umbilical cord stump during the first week of life is recommended for newborns who are born at home in settings with high neonatal mortality (30 or more neonatal deaths per 1000 live births).

Clean, dry cord care is recommended for newborns born in health facilities, and at home in low neonatal mortality settings. Use of chlorhexidine in these situations may be considered only to replace application of a harmful traditional substance, such as cow dung, to the cord stump.

— Strong recommendation, based on low to moderate quality evidence

Other Postnatal Care of the Newborn

Recommendation 7

Bathing should be delayed until after 24 hours of birth. If this is not possible due to cultural reasons, bathing should be delayed for at least six hours.

Appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults and use of hats/caps.

The mother and baby should not be separated and should stay in the same room 24 hours a day.

Communication and play with the newborn should be encouraged.

Immunization should be promoted as per existing WHO guidelines .

Preterm and low-birth-weight babies should be identified immediately after birth and should be provided special care as per existing WHO guidelines.

The above recommendations are based on existing WHO guidelines for which the GDG did not feel the necessity of a new evidence review.

Content of Postnatal Care for the Mother

Assessment of the Mother

Recommendation 8

First 24 hours after birth:

All postpartum women should have regular assessment of vaginal bleeding, uterine contraction, 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 six hours.

Urine void should be documented within six hours.

Beyond 24 hours after birth:

At each subsequent postnatal contact, 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.

Breastfeeding progress should be assessed at each postnatal contact.

At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have, and their usual coping strategies for dealing with day-to-day matters. All women and their families/partners should be encouraged to tell their health care professional about any changes in mood, emotional state or behaviour that are outside of the woman's normal pattern.

At 10–14 days after birth, all women should be asked about resolution of mild, transitory postpartum depression ("maternal blues"). If symptoms have not resolved, the woman's psychological well-being should continue to be assessed for postnatal depression, and if symptoms persist, evaluated.

Women should be observed for any risks, signs and symptoms of domestic abuse. Women should be told who to contact for advice and management.

All women should be asked about resumption of sexual intercourse and possible dyspareunia as part of an assessment of overall well-being two to six weeks after birth.

If there are any issues of concern at any postnatal contact, the woman should be managed and/or referred according to other specific WHO guidelines:

- Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice
- Managing complications in pregnancy and childbirth: a guide for midwives and doctors
- The NGC summary of the WHO recommendations for the prevention and treatment of postpartum haemorrhage
- The NGC summary of the WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia

— GDG consensus, based on existing WHO guidelines

Counselling

Recommendation 9

All women should be given information about the physiological process of recovery after birth, and told that some health problems are common, with advice to report any health concerns to a health care professional, in particular:

- Signs and symptoms of postpartum haemorrhage (PPH): sudden and profuse blood loss or persistent increased blood loss; faintness; dizziness; palpitations/tachycardia
- Signs and symptoms of pre-eclampsia/eclampsia: headaches accompanied by one or more of the symptoms of visual disturbances, nausea, vomiting, epigastric or hypochondrial pain, feeling faint, convulsions (in the first few days after birth)
- Signs and symptoms of infection: fever; shivering; abdominal pain and/or offensive vaginal loss
- Signs and symptoms of thromboembolism: unilateral calf pain; redness or swelling of calves; shortness of breath or chest pain.

Women should be counselled on nutrition.

Women should be counselled on hygiene, especially handwashing.

Women should be counselled on birth spacing and family planning. Contraceptive options should be discussed, and contraceptive methods should be provided if requested.

Women should be counselled on safer sex including use of condoms.

In malaria-endemic areas, mothers and babies should sleep under insecticide-impregnated bed nets.

All women should be encouraged to mobilize as soon as appropriate following the birth. They should be encouraged to take gentle exercise and time to rest during the postnatal period.

— GDG consensus, based on existing WHO guidelines

The above recommendations are based on existing WHO guidelines, for which the GDG did not feel the necessity of new evidence reviews.

Iron and Folic Acid Supplementation

Recommendation 10

Iron and folic acid supplementation should be provided for at least 3 months after delivery.

— GDG consensus, based on existing WHO guidelines

Prophylactic Antibiotics

Recommendation 11

The use of antibiotics among women with a vaginal delivery and a third or fourth degree perineal tear is recommended for prevention of wound complications.

The GDG considers that there is insufficient evidence to recommend the routine use of antibiotics in all low-risk women with a vaginal delivery for prevention of endometritis.

— Strong recommendation based on very low quality evidence

Psychosocial Support

Recommendation 12

Psychosocial support by a trained person is recommended for the prevention of postpartum depression among women at high risk of developing this condition.

— Weak recommendation based on very low quality evidence

The GDG considers that there is insufficient evidence to recommend routine formal debriefing to all women to reduce the occurrence/risk of postpartum depression.

— Weak recommendation based on low quality evidence

The GDG also considers that there is insufficient evidence to recommend the routine distribution of, and discussion about, printed educational material for prevention of postpartum depression.

— Weak recommendation based on very low quality evidence

Health professionals should provide an opportunity for women to discuss their birth experience during their hospital stay.

— GDG consensus based on existing WHO guidelines

A woman who has lost her baby should receive additional supportive care.

— Weak recommendation based on very low quality evidence

Remarks

- For further guidance, see the Mental Health Gap Action Programme (mhGAP) intervention guide for mental, neurological and substance use disorders in non-specialized health settings available at from the WHO Web site.
- Based on the studies supporting this recommendation the GDG considered the following conditions as risk factors for postpartum depression: previous postpartum depression, previous mental illness, vulnerable population, traumatic childbirth, infant born preterm, stillbirth or neonatal death, infant admitted to intensive care and history of being a neglected child.

— GDG consensus, based on existing WHO guidelines

Definitions:

Categories of Evidence

Level of Evidence	Rationale
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the effect.
Low	Further research is very likely to have an important impact on estimate of effect and is likely to change the estimate.
Very Low	Any estimate of effect is very uncertain.

Strength of Recommendations

Strength of Recommendation	Rationale
Strong	The Guideline Development Group (GDG) is confident that the desirable effects of adherence to the recommendation outweigh the undesirable effects. The quality of evidence required to make such a recommendation is at least *moderate*, although the panel may make exceptions.
Weak	The GDG concludes that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, irrespective of the quality of evidence. However, new evidence may result in changing the balance of risk to benefits OR the benefits may not warrant the cost or resource requirements in all settings.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Maternal and neonatal health in the postnatal period

Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Family Practice

Nursing

Obstetrics and Gynecology

Pediatrics

Preventive Medicine

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Other

Physician Assistants

Physicians

Public Health Departments

Social Workers

Guideline Objective(s)

To address timing, number and place of postnatal contacts, and content of postnatal care for all mothers and babies during the six weeks after birth

Target Population

Mothers and newborns in resource-limited settings in low- and middle-income countries

Interventions and Practices Considered

1. Provision of postnatal care to mothers and newborns
    - Timing of discharge from the health facility
    - Timing and number of postnatal contacts
    - Home visits in the first week of life
2. Content of postnatal care for the newborn
    - Assessment of the newborn
    - Exclusive breastfeeding
    - Cord care
    - Other postnatal care of the newborn (e.g., bathing, clothing, communication and play, immunizations)
3. Content of postnatal care for the mother
    - Assessment of the mother
    - Counselling
    - Iron and folic acid supplementation
    - Prophylactic antibiotics
    - Psychosocial support

Major Outcomes Considered

- Maternal morbidity (including haemorrhage, infections, anaemia and depression)
- Neonatal mortality and morbidity
- Growth
- Cognitive development
- Breastfeeding status

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

A literature search of the Cochrane Database and OVID-Medline was conducted in July 2010 to identify high quality, systematic reviews from the previous two years that were relevant to the priority population, intervention, comparison, outcome (PICO) questions. Where data were not available or up-to-date from the two sources, systematic reviews were commissioned to various groups to collate the evidence.

The systematic reviews, meta-analyses and Grading of Recommendations Assessment, Development and Evaluation (GRADE) profiles were done by different expert groups using the methodology recommended by the Guidelines Review Committee (GRC). Where data were lacking, systematic searches were conducted from various electronic sources, including Medline/PubMed, EMBASE, Cochrane Central Register of Controlled Trials (CENTRAL), National Library of Medicine (NLM) Gateway and World Health Organization (WHO) regional databases. Studies from low- and middle-income as well as high- income countries were considered for inclusion in evidence reviews. Efforts were made to identify relevant English as well as non-English language articles.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Categories of Evidence

Level of Evidence	Rationale
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the effect.
Low	Further research is very likely to have an important impact on estimate of effect and is likely to change the estimate.
Very Low	Any estimate of effect is very uncertain.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

A standardized form was used to extract relevant information from studies. Systematically extracted data included: study identifiers, setting, design, participants, sample size, intervention or exposure, control or comparison group, outcome measures and results. Quality characteristics also were recorded for all studies: allocation concealment or risk of selection bias (observational studies); blinding of intervention or observers, or risk of measurement bias; loss to follow-up; and intention-to-treat analysis or adjustment for confounding factors. For each question, data on critical and secondary outcomes were extracted and appraised by evaluating the quality, consistency and external validity of the evidence.

Grading the Quality of Evidence

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach for assessing and grading the quality of evidence was used. Quality was defined as the extent to which one could be confident that an estimate of effect or association was correct. The quality of the set of included studies reporting results for an outcome was graded as high, moderate, low or very low. The implications of these categories are detailed in the "Rating Scheme for the Strength of Evidence" field.

The assessment of quality of a set of studies (the majority of those included) was based on the following criteria:

- *Study design*: randomized controlled trials (RCTs) – individual or cluster RCTs (CRCTs); non-randomized experimental studies; or observational studies.
- *Risk of bias*: risk of selection bias – allocation concealment in RCTs and comparability of groups in observational studies; risk of measurement bias – blinding or objective outcomes; extent of loss to follow-up; appropriateness of analysis – intention-to-treat, adjustment for cluster randomization in CRCTs, adjustment for confounding in observational studies.
- *Consistency*: similarity of results across the set of available studies – direction of effect estimates, most studies showing meaningful benefit or unacceptable harm.
- *Precision*: based on the width of confidence intervals (CIs) of the pooled effects across studies.
- *Directness*: whether the majority of included studies evaluated interventions relevant to the identified questions.

Additional considerations included the magnitude of the effect, presence or absence of a dose-response gradient, and direction of plausible biases. GRADE tables from systematic reviews were cross-checked, and a discussion on benefits and harms, values and preferences of health care providers and policy-makers, and whether costs are qualitatively justifiable compared to the benefits in low- and middle-income countries (LMICs) was drafted. No efforts were made to collate the values and preferences of the persons addressed by the guidelines (i.e., mothers). Data from observational studies were considered to have a risk of bias, thereby resulting in moderate quality evidence, if there was no very serious risk of bias due to methodological issues, imprecision, consistency or directness. Thus, the highest possible quality of evidence when data were from observational studies was "moderate".

Methods Used to Formulate the Recommendations

Expert Consensus (Consensus Development Conference)

Description of Methods Used to Formulate the Recommendations

To initiate the guidelines update process, the World Health Organization (WHO) convened a technical consultation in October 2008. At this consultation, existing WHO and other agency guidelines related to postnatal care were reviewed for best practices and supporting evidence. Areas were identified where guidance was non-existent or conflicting, and these were prioritized for further work. The process of evidence review synthesis and establishment of a Steering Group and Guidelines Development Group (GDG) was taken up during 2011–2. Systematic reviews were commissioned to address the timing and content of postnatal care and contacts for the mother and newborn following normal childbirth. The GDG consultation to formulate recommendations was held in Geneva from 3–5 September 2012.

Recommendations were formulated and drafted in accordance with procedures outlined in the WHO *Handbook for guideline development* (see the "Availability of Companion Documents" field), and guided by the quality of evidence using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology.

Formulation of Recommendations

In drafting the recommendations, the WHO Steering Group used the summaries of evidence for the critical outcomes, quality of evidence, risks and benefits of implementing the recommendations, values and preferences, and costs.

The draft recommendations, evidence summaries, GRADE tables and information on benefits and risks, values and preferences, and costs were presented to the GDG at its meeting held at WHO headquarters in Geneva, Switzerland, in September 2012. The GDG reviewed and discussed this information to finalize the recommendations. Individual members of the GDG filled in a worksheet to comment on the quality of evidence and the strength of each recommendation, before discussing these as a group. Where the GDG determined that there was insufficient evidence, consensus within the group was used as the basis of the recommendation.

The decisions on the final recommendations and their strength were made by consensus or, where necessary, by vote. In deciding on the strength of the recommendations, the GDG was guided by the agreed-upon assessment criteria described in the "Rating Scheme for the Strength of the Recommendations" field.

When the GDG felt that the benefits of a recommendation outweighed the harms in some situations but not in others, the situation to which the recommendation is relevant was explicitly stated.

The recommendations, their level of strength, and remarks were circulated to the GDG for comments before finalization.

When existing WHO guidelines are referenced, they were not updated, and a decision was made whether to use or endorse that guideline. In one case, the GDG did not feel the necessity of new evidence reviews. Existing guidelines approved by the WHO Guidelines Review Committee are so indicated.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

Strength of Recommendation	Rationale
Strong	The Guideline Development Group (GDG) is confident that the desirable effects of adherence to the recommendation outweigh the undesirable effects. The quality of evidence required to make such a recommendation is at least *moderate*, although the panel may make exceptions.
Weak	The GDG concludes that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, irrespective of the quality of evidence. However, new evidence may result in changing the balance of risk to benefits OR the benefits may not warrant the cost or resource requirements in all settings.

Cost Analysis

The costs of implementation were considered for each recommendation (see the original guideline document), but no formal cost analysis was performed.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

A set of peer reviewers identified by the World Health Organization (WHO) Steering Group reviewed the final recommendations and provided their feedback. The Steering Group reviewed the comments and made appropriate modifications – factual errors were corrected and lack of clarity was addressed by improving the language. However, when there was a conflict between the peer review comments and the decisions of the Guideline Development Group (GDG), no changes were made to the guidelines.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Appropriate postnatal care of the mother and newborn will help to reduce maternal and neonatal mortality and morbidity.
- The balance of benefits and harms of implementing each recommendation is considered in the original guideline document.

Potential Harms

- There is very low quality evidence that discharge within 48 hours does not increase the risk of maternal or neonatal readmission. The effect of time of discharge on breastfeeding was less clear. While there was evidence of benefit in terms of reduced risk of mothers stopping breastfeeding at six weeks, there was a suggestion of increased risk of stopping breastfeeding at six months if mothers and newborns were discharged within 48 hours of birth, compared to a later time of discharge.
- The combination of danger signs that should be assessed during postnatal contacts should have a high sensitivity so that it can capture most neonates with severe illness. On the other hand, a high specificity is important to avoid unnecessary referrals causing overloading of the health facilities.
- Use of medications, including antibiotics, by the mother in the postnatal period may carry risks for the baby. There are concerns with inappropriate use of antibiotics in the postnatal period. However, selective use of antibiotics in high-risk conditions for sepsis (e.g., third and fourth degree perineal lacerations) helps to reduce morbidity.
- The balance of benefits and harms of implementing each recommendation is considered in the original guideline document.

Qualifying Statements

Qualifying Statements

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Implementation of the Guideline

Description of Implementation Strategy

The ultimate goal of these guidelines is to improve the quality of postnatal care and health outcomes for mothers and newborns. Therefore the dissemination and implementation of these guidelines are crucial steps that should be undertaken by the international community and local health care services.

Guidelines Dissemination

The recommendations in these guidelines will be disseminated through a broad network of international partners, including World Health Organization (WHO) country and regional offices, ministries of health, WHO collaborating centres, other United Nations agencies and non-governmental organizations. They will also be published on the WHO website. A policy brief will be developed for a wide range of policy-makers, programme managers and clinicians, and then disseminated through WHO country offices.

Guidelines Implementation

The first steps in implementation after the final approval of the guidelines will be to revise all WHO publications that deal with postnatal care. These include the clinical guides for maternal, newborn and child health: *Pregnancy, childbirth, postpartum and newborn care*; *Managing complications of pregnancy and childbirth*; *Managing newborn problems*; *Pocket book on hospital care for children*; and *Safe Childbirth Checklist*. The existing training package, *Essential newborn care course*, will also be updated, as well as the related tool for computer-assisted learning. The recommendations will also be incorporated into community level tools including *Caring for the newborn at home*. In addition, service standards for the immediate care of the newborn, care of the umbilical cord and routine postnatal care for the mother and the neonate will be developed. These tools will be made available as printed materials or in electronic format. They are already used in a majority of target countries.

The successful introduction of evidence-based policies related to postnatal care into national programmes and health care services depends on well-planned and participatory consensus-driven processes of adaptation and implementation. These processes may include the development or revision of existing national guidelines or protocols based on this document.

The recommendations contained in the present guidelines should be adapted into locally-appropriate documents to meet the specific needs of each country and health service. Modifications to the recommendations, where necessary, should be limited to weak recommendations and justifications for any changes made in an explicit and transparent manner.

An enabling environment should be created for the use of these recommendations, including changes in the behaviour of health care practitioners to enable the use of evidence-based practices. Local professional societies may play important roles in this process, and an all-inclusive and participatory process should be encouraged. WHO's Department of Maternal, Newborn, Child and Adolescent Health (MCA) has substantial experience of introduction of WHO guidelines and tools into national programmes.

Monitoring and Evaluating Guidelines Implementation

Monitoring and evaluation will be built into implementation, in order to provide important lessons for uptake and continued implementation. With regard to monitoring and evaluation of their impact on quality of care, priority will be given to the strong recommendations.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

World Health Organization (WHO). WHO recommendations on postnatal care of the mother and newborn. Geneva (Switzerland): World Health Organization (WHO); 2013 Oct. 62 p. [120 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Oct

Guideline Developer(s)

World Health Organization - International Agency

Source(s) of Funding

The United States Agency for International Development provided financial support, without which this work could not have been completed.

Guideline Committee

Guidelines Development Group

Composition of Group That Authored the Guideline

Guidelines Development Group Members: Professor Ebun Adejuyigbe, Obafemi Awolowo University, Department of Paediatrics, Ile Ife, Nigeria; Professor Wally Carlo, Director, Division of Neonatology, Director, Newborn Nurseries, University of Alabama at Birmingham; Dr Guillermo Carroli, Director, Centro Rosarino de Estudios Perinatales, Santa Fe, Argentina; Dr Agustin Conde-Agudelo, Colombia; Ms Sheena Currie, Senior Maternal Health Adviser, MCHIP, Washington DC, USA; Professor Indra Malik Goonewardene, Head, Department of Obstetrics and Gynaecology, University of Ruhuna, Galle, Sri Lanka; Dr Ekawaty Lutfia Haksari, Department of Child Health, Faculty of Medicine, Gadjah Mada University, Sardjito General Hospital, Indonesia; Professor Ruby Jose, Christian Medical College, Tamil Nadu, India; Professor Dame Tina Lavender, University of Manchester, Manchester, United Kingdom; Dr Joy Lawn, Director, Policy and Evidence, Saving Newborn Lives, Save the Children, Cape Town, South Africa; Dr Carolyn Maclennan, Director of Pediatric Training, Royal Darwin Hospital, Darwin, Australia; Professor James Neilson (*Chair of GDG*), NIHR Dean for Faculty Trainees, Professor of Obstetrics & Gynaecology, Department of Women's & Children's Health, University of Liverpool, United Kingdom; Professor Vinod Paul (*Chair of the Newborn Health subgroup of GDG*), Chief, Division of Neonatology, Department of Pediatrics, A.I.I.M.S., Ansari Nagar, New Delhi, India; Dr Heather Scott, Department of Obstetrics & Gynaecology, IWK Health Centre, Halifax, Nova Scotia, Canada; Dr Mandisa Singata, Nurse/Midwife, East London Complex Hospital, East London, South Africa; Dr Anita Zaidi, The Aga Khan University, Karachi, Pakistan; Professor Jun Jim Zhang, Director and Professor Vice Dean, Shanghai Jiao Tong University, Shanghai, China

Financial Disclosures/Conflicts of Interest

All Guideline Development Group (GDG) members completed a World Health Organization (WHO) Declaration of Interests form. Several members of the GDG declared that they had conducted research projects or done systematic reviews in the areas relevant for postnatal care of the mother and newborn. In addition, Wally Carlo declared that he had a patent pending to blend oxygen and air and that he had received travel support from the American Academy of Pediatrics (less than US$ 1000 per year). These largely academic declarations of interests were considered by the WHO Steering Group, who found that they did not pose a major risk of bias in recommendations. None of the above experts were therefore precluded from participation in the GDG meeting to formulate recommendations.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the World Health Organization (WHO) Web site .

Print copies: Available from the WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland; Phone: +41 22 791 3264; Fax: +41 22 791 4857; E-mail: bookorders@who.int.

Availability of Companion Documents

The following are available:

- World Health Organization (WHO). WHO technical consultation on postpartum and postnatal care. Geneva (Switzerland): World Health Organization (WHO); 2010. 65 p. Electronic copies: Available in Portable Document Format (PDF) from the WHO Web site .
- World Health Organization. WHO Handbook for guideline development. Geneva (Switzerland): World Health Organization (WHO); 2012. 63 p. Electronic copies: Available in PDF from the WHO Web site .

Patient Resources

None available

NGC Status

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