


2012

Community midwifery services in Kenya: Implementation guidelines

Kenya Ministry of Health

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Ministry of Health

Community Midwifery Services in Kenya

Implementation Guidelines

Second Edition

August 2012



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Foreword

Globally, there has been some modest improvement in reducing maternal and neonatal mortality rates over the last decade as shown by United Nations reports. However, in Kenya, more effort is still needed in order to make any meaningful progress towards the attainment of especially MDG 5 which targets achieving a significant reduction of maternal mortality ratio (MMR) to 147/100,000 live birth by 2015. The Kenya Demographic Health Survey (2008/09) indicates that the maternal mortality ratio in Kenya has remained unacceptably high at 488/100,000 live births. It is worth noting that neonatal mortality rate only reduced marginally from 33 to 31 per 1000 live births between 2003 and 2008/09.

The slow progress in achieving maternal and newborn health (MNH) targets in Kenya has been attributed to limited availability, poor accessibility and low utilization of skilled birth attendance during pregnancy, child birth and postnatal period, low coverage of basic emergency obstetric and newborn care and poor involvement of communities in maternal and newborn care.

The community midwifery model was commissioned by the Minister for Health in 2006 as an attempt to increase access to skilled assistance at birth. The first edition of the community midwifery guidelines were developed in 2007. These guidelines have been revised in order to standardize the implementation of community midwifery services as a strategy for improving skilled attendance in the provision of maternal and newborn health care at the community level. The revised guidelines address key policies that are outlined in the Kenya Health Policy (2012-2030) regarding the provision of essential packages for health in line with the new constitution, Vision 2030 and the Community Health Strategy.

The Kenya Health Policy, which seeks to contribute to the attainment of Vision 2030 aims to provide equitable and affordable health care of the highest affordable standard to all citizens. It emphasizes a shift of focus to preventive and promotive health care. Major strategies include improving access, realizing equity goals and providing quality services as well as strengthening the institutional framework for effective delivery of health services.

The revised guidelines also highlight the role of the community midwife in the provision of continuum of care during normal pregnancy, childbirth, postpartum period, and in counselling for and providing family planning services as well as newborn care and referral. The community midwife's role in linking with community health workers, community health extension workers, local committees, facility staff and county teams is also highlighted.

The revision of the guidelines was a collaborative effort and I wish to acknowledge all individuals and institutions who were involved. In particular, UNFPA is acknowledged for having supported the process of revising and printing of the guidelines.



Dr. S.K. Sharif, MBS; MBChB, M.Med, DLSHTM, MSc.

Director of Public Health and Sanitation
Ministry of Public Health and Sanitation

Acknowledgements

The revision of this guideline was through a consultative process that involved various organizations and individuals who play different roles in reproductive health particularly maternal and newborn health care in Kenya. The revision process took into account existing materials and resources on maternal and newborn health.

In particular, the following institutions and organizations are acknowledged for having taken part at various stages of the development of this revised edition: the Division of Reproductive Health (DRH), Nursing Council of Kenya, Population Council, Department of Nursing, Division of Community Health Services, Jhpiego- APHIAplus zone 1, National Nurses Association of Kenya (Midwifery Chapter), KOGS, University of Nairobi, WHO, UNICEF Kenya and Kenyatta University (OBGYN Dept). We would also like to acknowledge the role of UNFPA for providing technical and financial assistance towards the development of both the community midwifery guidelines and the orientation package. Individuals who participated in the revision of the guidelines and the institutions they represented are listed in Annex 7.

Thank you all for supporting the process of improving maternal and newborn care by increasing access to skilled attendants.



Dr. Bashir Issak
Head, Division of Reproductive Health
Ministry of Public Health and Sanitation

Abbreviations and Acronyms

AMREF	African Medical Research Foundation
ANC	Antenatal Care
CBHC	Community Based Health Care
CBO	Community Based Organization
CDF	Constituency Development Fund
CHAK	Christian Health Association of Kenya
CHEW	Community Health Extension Worker
CHW	Community Health Worker
CM	Community Midwife
CMs	Community Midwives
DHMB	District Health Management Board
DHMT	District Health Management Team
DRH	Division of Reproductive Health
DRHTST	District Reproductive Health Training and Supervision Team
EOC	Essential Obstetric Care
FBO	Faith Based Organisation
HIV	Human Immunodeficiency Virus
KEPH	Kenya Essential Package For Health
KDHS	Kenya Demographic and Health Survey
KOGS	Kenya Obstetric and Gynaecological Society
KEM	Kenya Enrolled Midwife
KECHN	Kenya enrolled Community Health Nurse
KRCHN	Kenya Registered Community Health Nurse
LATF	Local Authority Transfer Fund
MDG	Millennium Development Goal
MNH	Maternal and Newborn Health
MOH	Ministry of Health
NHSSP	National Health Sector Strategic Plan
NNAK	National Nurse Association of Kenya
PMTCT	Prevention of Mother to Child Transmission
PRHTST	Provincial Reproductive Health Training and Supervision and Team
SWAp	Sector Wide Approach
UNFPA	United Nations Population Fund

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1. Introduction

1.1 Background

The maternal mortality ratio in Kenya is unacceptably high. According to the Kenya Demographic Health Survey of 2008/2009 there were 488 maternal deaths per 100,000 live births. Many of these deaths could have been averted if women had timely access to skilled attendance and essential obstetric and neonatal care. Neonatal mortality rate is 31 per 1,000 live births, with majority of the deaths occurring within the first week of life. Infant mortality rate is 52 per 1000 live births. Only 2.6% of infants are exclusively breastfed by 6 months. Less than 5% of pregnant women and under-fives sleep under insecticide treated nets to prevent malaria. Contraceptive prevalence rate is at 46% and 70% of women have unmet need for family planning in the first year postpartum (KDHS 2008/09).

Evidence from a number of studies globally has shown a reduction in maternal and perinatal mortality when women have access to a skilled attendant providing a continuum of care from pregnancy, at birth and during the postnatal period. In Kenya, as in most of sub-Saharan Africa, although the majority (92%) of women attend antenatal clinic at least once during pregnancy, more than half (56%) give birth at home without any skilled assistance, and only 10% of those delivering at home receive any type of postpartum care (KDHS, 2008/2009).

The main focus of strategies to increase skilled attendance in East and Southern Africa has been to provide comprehensive antenatal care, ensure that pregnant women are prepared for the birth and strengthen obstetric care provided within facilities. Although many facilities have improved the quality of care available, many women are still not using the facilities for childbirth and still prefer to deliver in their own homes. This calls for an approach that can address the issue of childbirth at home and a skilled attendant to assist the women. The community midwifery model addresses this gap by ensuring that skilled care is available during pregnancy, labour and child birth and follow-up of both mother and baby postnatally in the community.

The Community Midwifery Model (CMM) uses skilled out of work or retired licensed health care professionals who are resident within a given community and seeks to contribute towards the achievement of Millennium Development Goals (MDGs 4 and 5). The Community Midwifery model also contributes directly to the overall goals of the the National RH Policy of 2007, National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya] and , the Community Health Strategy.

1.2 The Policy Context

Kenya Health Policy (2012-2030)

The community midwifery model is aligned to the Kenya Health Policy (2012 – 2030) which seeks to support the provision of equitable, accessible, affordable and quality health and related services at the highest attainable standards to all Kenyans using the primary health care approach. The health policy objectives are to: eliminate

communicable conditions; halt, and reverse the rising burden of non-communicable conditions; reduce the burden of violence and injuries; provide essential health care; minimize exposure to health risk factors and strengthen collaboration with health related sectors.

Kenya Health Sector Strategic and Investment Plan

The Kenya Health Sector Strategic and investment plan (KHSSP) for the period 2012-2018 provides the overall framework for implementing health sector priorities and high impact interventions. The mission of the strategic plan is to “deliberately build progressive, responsive and sustainable technologically driven evidence-based and client-centred health system for accelerated attainment of the highest standard of health to all Kenyans”. The plan emphasizes the implementation of interventions and prioritization of investments that relate to maternal and newborn health which are considered to be major impact areas for which progress was not attained in the previous National Health Sector Strategic Plan for the period 2008 to 2012.

Kenya’s new constitution, Service Delivery levels and Essential Package for Health

The adoption of a new constitution by Kenya in 2010 introduced a rights based approach in the provision of services and a redefinition of governance levels for all services including those delivered by the health sector. Thus, it is expected that the health policy and its strategies will integrate human rights norms and principles in the design, implementation, monitoring and evaluation of health interventions and programmes. Respect for human dignity, attention to the needs and rights of vulnerable groups, equal access to health care systems are examples of key issues to be observed in designing and implementing health care interventions and in offering health services. Therefore, in accordance with the devolved system of government to be implemented under the new constitution, four levels (or tiers) of care are recommended.

1.3 KEPH Tiers of Care and Service Cohorts

Kenya Essential Package for Health refers to an approach for integrating various programmes into a single package of interventions that seek to improve the health status of the population. KEPH is a life cohort based approach. The Kenya health policy and the KHSSP define the priority services that are necessary to be provided at the following 4 distinct levels/tiers of care:

- **Community level:** The foundation of the service delivery system, with both demand creation and specified supply services that are effectively delivered at the community.
- **Primary care level:** The first physical level of the health system, comprising all dispensaries, health centres & maternity /nursing homes. It is the 1st care level, where most clients’ health needs should be addressed.
- **County level:** The first level hospitals, whose services complement the primary care level to allow for a more comprehensive package of services.
- **National level:** The tertiary level hospitals, whose services are highly specialized.

Specific KEPH cohorts are:

- **Pregnancy and the newborn (up to 28 days)**
- **Childhood (29 days – 59 months)**
- **Children and Youth (5 – 19 years)**
- **Adulthood (20 – 59 years):** The economically productive period of life
- **Elderly (60 years and above)**

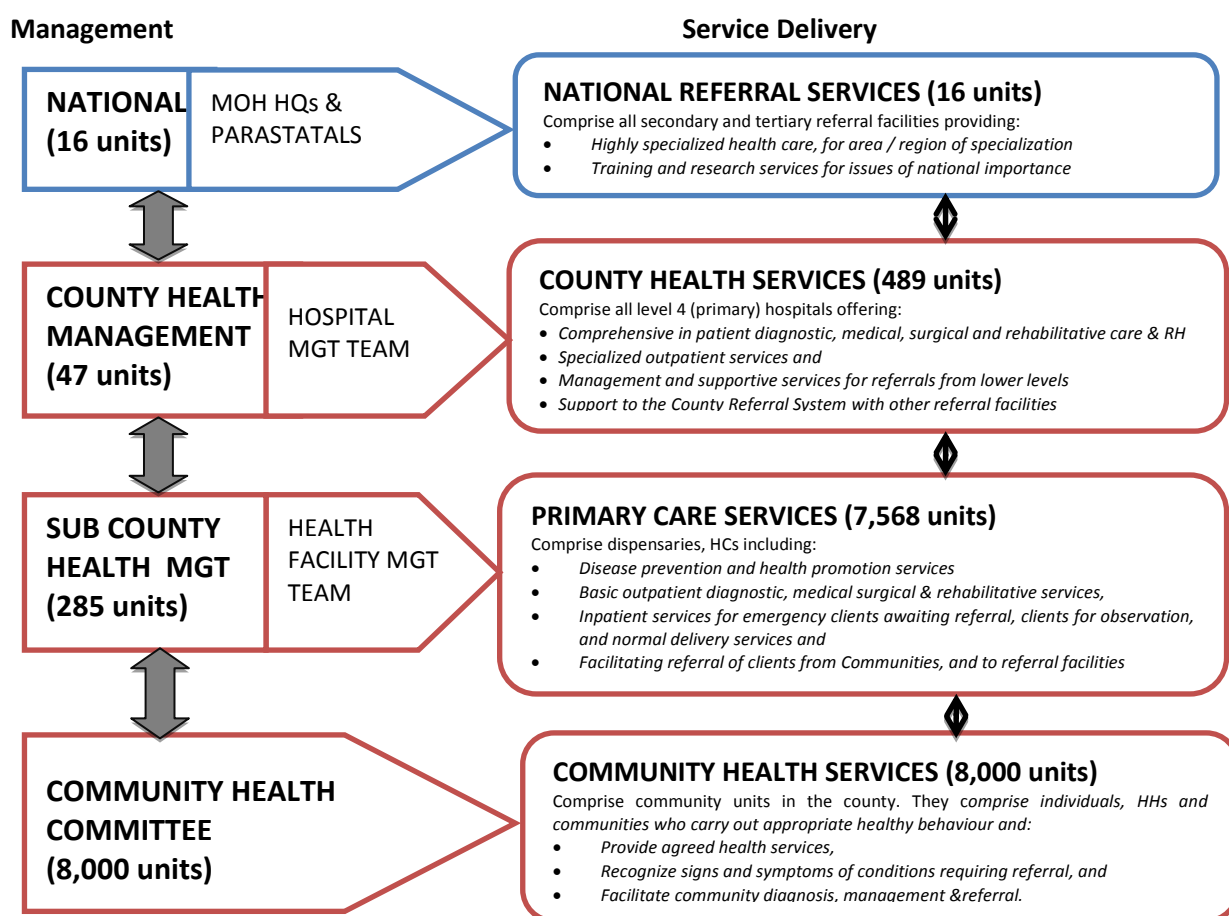
KEPH services offered at community level

The KHSSP (2012-2018) and the 2006 Community Health Strategy outline the services that could be offered at the community level. These include: immunizations, child health, maternal and newborn health, screening for diseases, water and Sanitation, provision of basic curative care, prevention of HIV/STIs, and family planning among others. These services are offered by key providers at the community level; namely Community Health Workers (CHWs), Community Health Extension Workers (CHEWs) and Community Midwives. The range of services includes provision of education and information on preventable and promotive activities & basic curative care interventions.

1.4 Organization of Health Services Delivery

The KHSSP 2012-2018 target for a community unit (CU) is 5,000 persons, giving an overall target of 8,000 CUs. Fig. 1 outlines how health services are organized at all levels.

Figure 1: Organization of health services delivery



Source: KHSSP July 2012 – June 2018 (Draft). Ministry of Medical Services and Ministry of Public Health & Sanitation

1.5 Implementation Experience with the CM Model

In the original community midwifery model, a community midwife was expected to conduct a delivery in a woman's home. However, findings from recent evaluations show that women in labour are increasingly demanding to give birth at the community midwives' homes. Common reasons cited by women include lack of privacy in their own homes, inability to keep away children and inadequate space especially where the family stays in one room. Other reasons cited include long distances, high cost and uncooperative staff in some facilities. On the other hand, community midwives cited insecurity (especially at night), long distances and requests from clients to deliver at the community midwives' homes as reasons that explain the rising number of deliveries that take place in their homes¹.

In addition, findings from a recent study showed that community midwives have now improved clients' access to a comprehensive package of RH/HIV services. These are: ANC, delivery, post-natal care services including long-term family planning methods, HTC among others². The results also showed that although the majority of women in the reproductive age group are interested in receiving services from community midwives, few of them are willing to pay for the full cost of these services. For instance, over 90% of clients were interested in receiving delivery services from community midwives, and yet only 15% of previous clients and 8% of potential clients³ were willing to pay for modest increases in the current prices. Hence the need to address sustainability issues of the community midwifery model.

2. Community Midwifery Model

2.1 Definition

According to a joint statement by WHO, the International Confederation of Midwives (ICM), and the International Federation of Obstetricians and Gynaecologists (FIGO), a 'Skilled Birth Attendant' (SBA) is defined as "an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in identification, management and referral of complications in women and newborns" (WHO, 2004).

Midwifery is a healthcare profession in which providers offer care to childbearing women, labour, childbirth and during the postpartum period. They also care for newborn and assist mothers to breast feed (WHO, 2012). This Community midwifery model recognizes deliveries/births conducted by skilled birth attendants at home.

¹ Strengthening the Delivery of Comprehensive Reproductive Health Services at the Community Level in Kenya: Findings of Formative Study; February 2011. Ministry of Public Health and Sanitation/ USAID

² Willingness to pay for midwifery services: in "Strengthening the Delivery of Comprehensive Reproductive Health Services through the Community Midwifery Model in Kenya" -2012; APHIA II OR Project in Kenya. Population Council and Ministry of Public Health and Sanitation, Nairobi, Kenya.

³ In the study cited, previous clients are those who were assisted by community midwives during their last delivery while potential clients are those who were interested in receiving future assistance from community midwives during child birth.

2.2 Selection Criteria

In selection of potential candidates for community midwifery services, the following prerequisites are essential and should be verified with the relevant professional body⁴:

- A health professional with evidence of one of the following qualifications:
 - Registered Nurse/ Midwife; Enrolled Nurse/ Midwife Registered
 - Clinical Officer
 - Medical officer
- A retired or out of employment health professional with obstetric/midwifery skills.
- Has residency within the community to be served.
- Evidence of retention on a professional register (Nursing Council of Kenya, Kenya Clinical Officers' Council, the Medical Practitioners and Dentist Board)

For example, see criteria for licensing nurses and midwives by the Nursing Council of Kenya in Annex 5.

Additional criteria:

The community midwife will be expected to undertake the following activities:

- Get involved in the running of health related or welfare activities within the community as a sign of the community's trust in them
- Be ready to be supervised and monitored by the District Health Management Training and Supervisory Teams (RH Coordinators)
- Link with the health care system through the nearest health facility for support such as updates, transport, supplies, equipment and their sterilization
- To work closely with the community leaders and community groups to identify the most common health problems and work together for a solution.

2.3 Roles and responsibilities of the community midwife

The roles and responsibilities of the community midwife are divided into three key areas:

- ✓ Providing care to women and their family members
- ✓ Serving as a link between level I and the formal health system
- ✓ Data collection and reporting

⁴ Adapted from WHO /FCH/RHR/03.11 *Working with Individuals , Families and Communities to Improve Maternal and Newborn Health*

a) Care provided to women and their families

Under this component, the roles and responsibilities of the community midwife are divided into two broad areas, namely health promotion activities and service provision in maternal and newborn as well as other reproductive health service areas.

Health Promotion Activities

Roles and responsibilities of a community midwife in health promotion activities include:

- Provision of information and education on preconception care and early initiation of antenatal care to women.
- Provision of information on the importance of when and where to seek health care services during pregnancy, labour and childbirth and the postnatal period for mother and baby
- Provision of information on importance of testing for HIV and referral for HCT and PMTCT
- Educating women and their families on the importance of an individualized birth preparedness and postnatal plan.
- Assisting a woman and her family to prepare a birth, postnatal care plan including postpartum family planning
- Educating women on the identification of danger signs in pregnancy labour, childbirth and postnatal period
- Educating women on how to recognize danger signs in the newborn including sepsis to ensure family seeks early treatment
- Provision of education to clients on how to prepare or plan for emergencies (funds, support, permission, etc)
- Provision of reproductive health knowledge among women and their male partners
- Provision of information on the importance of health timing and spacing of pregnancies
- Provision of information on the importance of breastfeeding.
- Provision of information on the availability of family planning commodities
- Educating women on the importance of completing immunization schedules for infants/children and TT schedule for women.
- Linking with civil society and the provincial administration in advocating for skilled attendance for various maternal and newborn care services.

Service provision in maternal and newborn areas and other RH areas

Roles and responsibilities of a community midwife in service provision in maternal and newborn as well as other reproductive health service areas include:

- Dissemination of key messages to support safe pregnancy and delivery of a healthy newborn and early childhood care
- Monitoring of pregnancy through FANC (including birth planning and emergency preparedness, IPT and ITNs for malaria, PMTCT, tetanus toxoid).

- Following up with the link facility to ensure that antenatal profile is done
- Giving care to women with uncomplicated labour and delivery (Essential Obstetric Care)
- Stabilizing women and/or their newborns who have complications prior to referral. Some of the key drugs to use include oxytocin, antibiotics and MgSO₄ and IV fluids.
- Provision of essential newborn care – warmth, resuscitation, , early initiation of breast feeding, hygiene, etc.
- Provision of targeted postnatal care to women. Specific services to include information on danger signs, early detection and treatment of problems, Vitamin A supplements in accordance with WHO guidelines^{5,6}, care of breasts, advise on caring for the newborn among others.
- Counseling and testing for HIV among the pregnant and postnatal mothers.
- Supporting HIV care including ART adherence, EID, opportunistic infections management and linkages to HIV support centres and local support groups
- Counseling women on exclusive breast feeding and Lactational Amenorrhoea Method (LAM) as well as on broader aspects of nutritional counseling
- Receiving or visiting women in labour and assisting them during childbirth. Working closely with CHEWs and CHWs and recognising the role of each in the provision of various health services at the community level.
- Promoting the principle of task-shifting in service delivery between community midwives and community health workers such that the tasks which the latter group cannot handle are referred to the former. For example, CHWs may distribute and counsel clients on condom use and also advise women on the need for skilled attendance at child-birth while community midwives could insert long acting FP methods and conduct deliveries.
- Counseling women and partners for FP and provision of contraceptives
- Provision of minor curative services as defined in the community health strategy
- Referral of clients who need for example long acting family planning methods such as implant, IUCD to other community midwives with appropriate skills or to facility based skilled providers.
- Referral of clients to health facilities for laboratory tests, immunizations, etc
- Receiving referrals from community health workers for further management.
- Coordination of activities with the health extension workers and community health committees
- Actively participating in maternal and perinatal death surveillance, review and response at the community level by using, for an example the verbal autopsy tool and notification of maternal deaths at the community.

⁵ WHO Guidelines (2011):Vitamin A supplementation for infants and children 6-59 months of age.

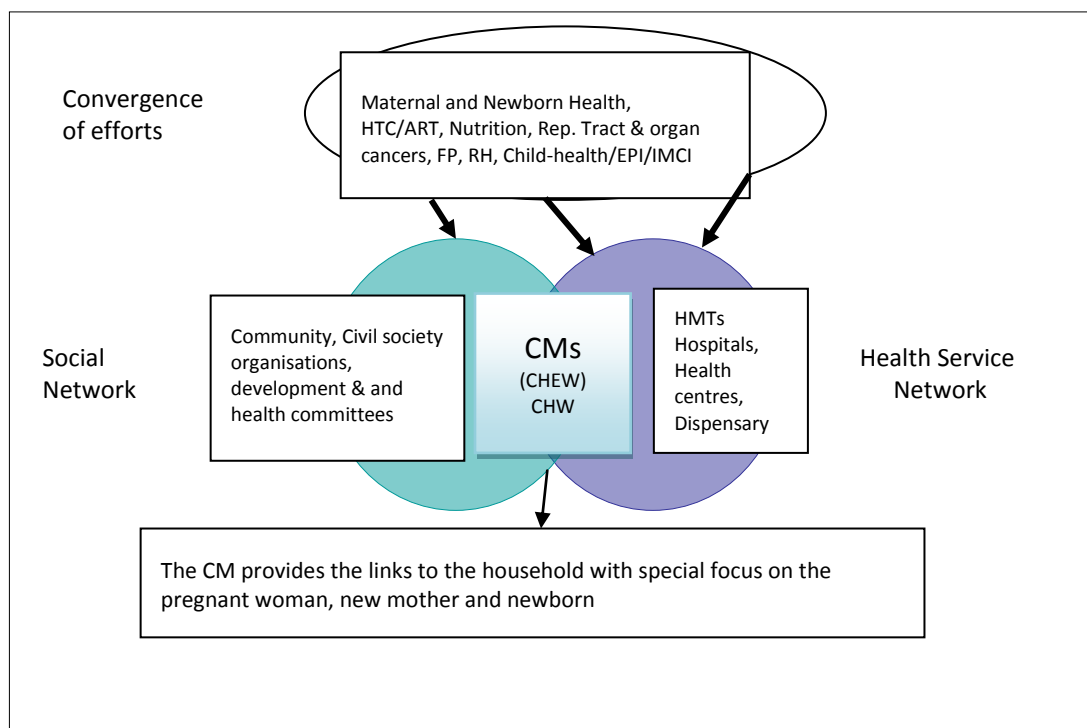
⁶ WHO Guideline: Vitamin A supplementation in postpartum women. World Health Organization, 2011.

b) Linkages and Networks at Level I and with formal health system

The community strategy recommends the delivery of maternal and newborn health interventions at the community level. Working in close collaboration with the Community Health Extension Worker (CHEW) and the CHW, the community midwife is the principal actor in the provision of maternal and newborn health services at the community level.

In order to work effectively and to enable families access these services, the community midwife is required to link with other players at the community level and also to establish regular contacts with various teams as well as the formal health system. As shown in Fig.2, the community midwife plays a central role and can be instrumental in facilitating linkages with other key stakeholders.

Figure 2: linkage between social and health service networks⁷



Linkage between Local health committees and the community midwife

Local health committees usually organize activities that are often intended to make significant contributions to the health status and wellbeing of the target community. By virtue of her/his technical skills in health care provision, the community midwife will be a co-opted member of the local health committee and a key advisor on maternal and newborn health issues. The operations of the community midwife will be governed by the existing policies and structures.

The main role of the local health committees will be resource mobilization (from the local community and from outside sources to support the work of a community midwife

⁷ Adapted from WHO /FCH/RHR/03.11 *Working with Individuals , Families and Communities to Improve Maternal and Newborn Health*

and RH activities in general), educating households on matters pertaining to disease prevention and control and environmental sanitation and hygiene; family planning, environmental conservation, food supply and nutrition.

Other roles include providing leadership support for safe pregnancy and childbirth and facilitating the acquisition of key infrastructure for community health workers and community midwives such as equipment, IEC materials; supplies such as ITNs, condoms, household registers, chalkboards and drugs for the treatment of common conditions. The local community through their health committees will also be responsible for providing security and where possible they will organize or facilitate transport for the community midwife to be able to attend to cases promptly or during referral of emergency cases to health facilities.

Health facility linkage with a community midwife

The health facility in-charges and the facility management teams supported by the DHMTs or by county and sub-county authorities will provide support to the community midwife by:

- Overseeing the performance of the community midwife and other extension workers
- Supplying the community midwife with drugs, equipment and other supplies
- Facilitating referral of clients (or women) with complications or other forms of emergency to static health facilities by availing transport.
- Providing stationery or forms to the community midwife for monthly reports.
- Strengthening infection prevention and control efforts e.g. in the disposal of sharps and sterilization of equipment, etc.
- Organizing for in-service training/Continuing Professional Development, involving the CM in relevant stakeholder meetings, verbal autopsies among other roles.

Community Midwives and Community Health Workers

Community midwives and other CHEWs will provide overall support to community health workers with a view to building their skills and knowledge in the core basic and technical components outlined in their curriculum and training manuals. The components are divided into two; basic modules and technical modules as outlined in the Textbox 1.

Text Box 1: Core components under the partnership between community midwives and other CHEWs with community health workers	
Basic Components or Modules	Technical Components or Modules
<ul style="list-style-type: none">• Community Health, Development and Partnerships• Communications, advocacy, social mobilization and networking• Management and use of community health information• Governance, leadership and management• Basic health promotion and disease prevention• Basic case management and life-saving skills	<ul style="list-style-type: none">• Water sanitation and hygiene• Community nutrition• Integrated community case management• Maternal and Newborn health• Family planning• HIV/AIDS/STIs, TB and malaria and• Non-communicable diseases

Within the maternal and new born health components, the community midwife will equip the CHW with appropriate skills and knowledge to be able to:

- ✓ Advise the woman on preparing the household before delivery (e.g. water, firewood)
- ✓ Advise on items required for the delivery (warm water, clean cloths, pads etc)
- ✓ Assist the woman and her family to identify somebody to assist her after childbirth
- ✓ Advise family to look out for danger signs in mother and baby (especially in the first three days)
- ✓ Advise the mother/family to register the baby's birth with the local administration
- ✓ Advise on taking baby to health facility for immunizations and growth monitoring and women for postnatal care
- ✓ Map where all pregnant and newly delivered women live
- ✓ Encourage the woman's family to provide social support in pregnancy/ postnatal period
- ✓ Report on any deaths of mothers and infants in the community including any stillbirths

Referral system

A referral system is an interlinked network of service providers and facilities that provide a continuum of care for acute and chronic illnesses. A community midwife should be conversant with referral protocols and be able to refer the client using a referral form (see Annex 3) to the most appropriate health facility. In the event of an emergency, the Community Midwife should initiate management, secure transport and alert the receiving facility.

c) Data Collection and Compiling of Reports

A community midwife will be able to:

- Compile data, write and submit reports to the local health management teams and committees promptly.
- Register or advise the woman on where to register the birth
- Notify the civil registration office/health facility of any death in the community
- Share monthly reports with the link health facility using the appropriate register(s) or document(s) from the ministry of health. The report should include; Number of women assisted during childbirth; Number registered for birth certification; Number of Stillbirths (FSB and MSB) and any maternal deaths.
- Document the number of referrals; reasons for referral for both mother and newborn; means of transport used; source of funds for transport; person accompanying patient and the outcome of the referral process (if known).

2.4 Practice Setting

Health facility delivery is still the recommended practice. In the event that this is not possible, a community midwife shall render services in the community where she/he resides. Thus, a community midwife being a skilled provider may conduct normal deliveries at the woman's home or at her/his (i.e. community midwife's) home.

Among other considerations, the decision regarding the place of delivery at the community level has to take into account the provisions in the new constitution especially articles 32, 43, 53-57, 174 and 232 that emphasize freedom of conscience, belief and opinion, respect and dignity; the client's right to services including emergency medical treatment; right of access to quality care; and roles and functions of various government agencies and institutions in the context of a devolved system of governance.

In the course of her/his practice, situations could arise where a community midwife may be required to accompany a client or woman to a health facility. In situations where a community midwife accompanies a woman in labour to a nearby health facility for delivery, such a delivery will be considered as a facility based delivery and will be recorded or notified as such.

A private practitioner may be licensed as a community midwife (see Annex 6) on condition that she/he assists a woman during childbirth at the woman's home or in her/his home. Private practitioners' who may be licensed as a community mid-wife will not be allowed to refer women in labour to their private clinics to avoid conflict of interest and a clash of public health objectives and market or business driven preferences except in emergencies (where such referrals are permissible under article 43 of the new constitution which states that "...a person shall not be denied emergency medical treatment").

2.5 Scope of Practice

The Community midwives scope of practice is preconception care counselling, **normal pregnancy, childbirth, postpartum, new born care and family planning**. Community midwives will practice within the guidelines and protocols developed by regulating bodies. Sometimes a woman's pregnancy moves out of "normal" and her care must be transferred to a specialist. Even in such a case, supportive care from a midwife will still be necessary.

Drugs, equipment and supplies

Community midwives will stock and administer the following drugs: oxytocin, antibiotics, anticonvulsants, analgesics, local anaesthetics, routine haematinics, IPTp in malaria endemic zones, antihelminthics, PMTCT ARV prophylaxis during labour, intravenous fluids as per guidelines, antihelminthics, Tetracycline eye ointment, Vitamin K. They should have sufficient equipment and supplies to be able to perform procedures such as vaginal examinations, deliveries, perineal tear/episiotomy repairs, injections. (Annex 2)

2.6 Training

All midwives at retirement, resignation or departure of formal employment are qualified and experienced. However, it is important to note that the environment they start working in as Community Midwives differs from the formal health facility setting. Therefore, all skilled health providers who are interested in practising as community midwives will undergo orientation training before they are accredited/ allowed to practise in this capacity.

All potential community midwives must complete the following steps:

- Orientation
- Clinical attachment in a busy health facility for skills updates.
- Certification and
- Licensing.

Orientation:

The orientation will focus on the following core skills:

- Maternal and newborn care
- Maternal and perinatal death surveillance and response.
- Recording and reporting data.
- Infection prevention and control
- Family planning
- communication and referral

It is recommended that the community midwives can undertake the following trainings/orientations:

- Entrepreneurship and marketing skills
- Interpersonal and communication skills.

Clinical attachment

The practical attachment should be at a busy health facility where there is a high client load and a range of maternal and newborn health care services provided. The Community Midwife will be provided with a log book to record required procedures which should be carried out under supervision. The content to be covered by community midwives during clinical attachment is outlined in Annex 1.

Certification

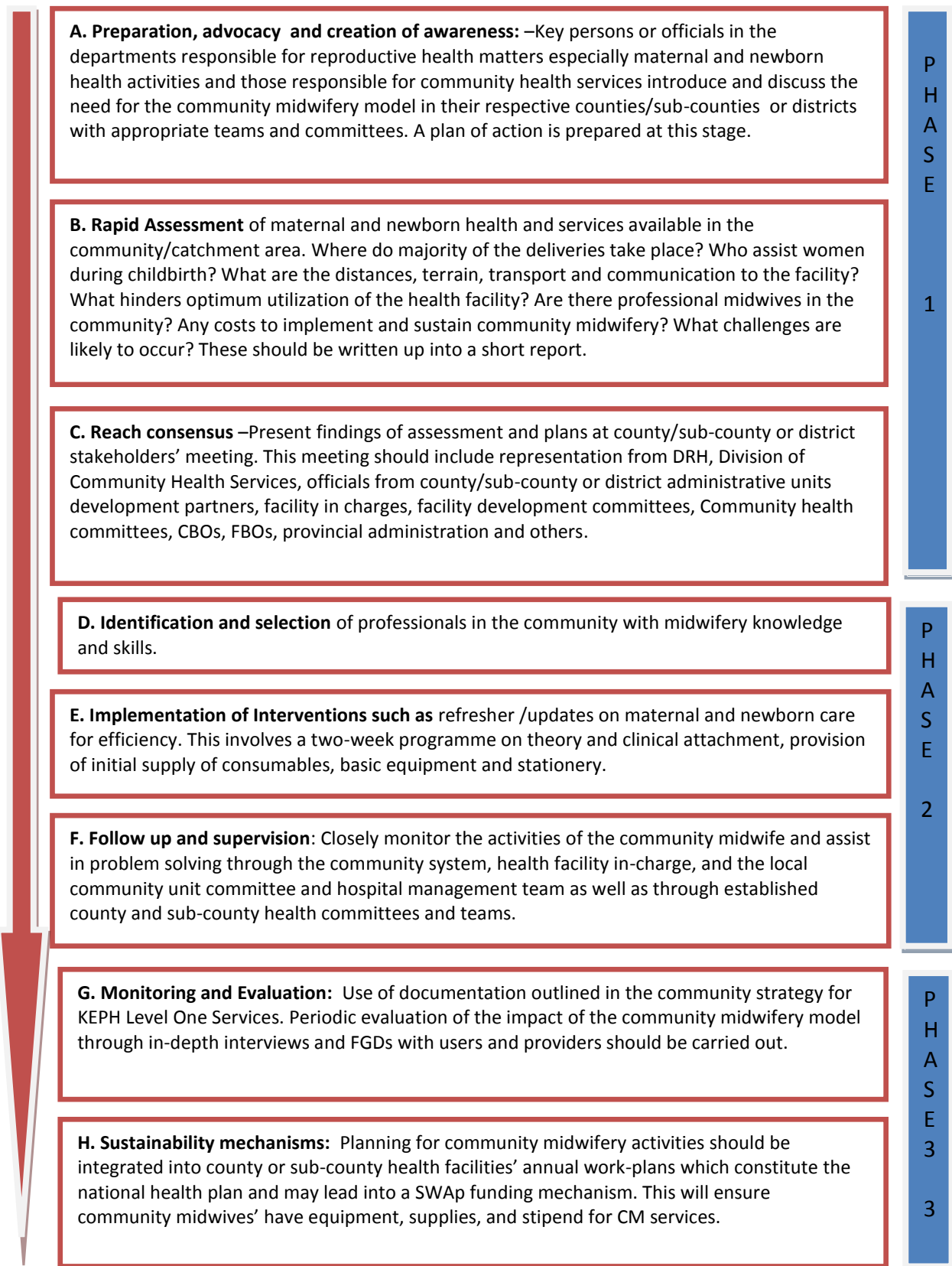
Once the Community Midwife has satisfactorily completed all the procedures outlined in the log book, they will be certified by the Ministry of Health. A regulatory body such as the (Nursing Council of Kenya or its equivalent) will then issue a license to the health provider to practice in the community (see Annex 6 for an example of licensing requirements for community midwives by the NCK). The community midwives will be required to have relevant regular updates and refresher courses in order to meet requirements for retention.

3. Process of Implementing Community Midwifery Services

Following proper steps is key to successful implementation of the community midwifery model. Any county or sub-county entity wishing to start the community midwifery model or programme should be guided by the following steps or process activities: Preparation and awareness creation, rapid assessment, reaching consensus, identification and selection of skilled professionals, implementation and interventions, follow-up and supervision, monitoring and evaluation and building sustainability mechanisms.

These steps are detailed in Figure 3 below. Although the steps are organized chronologically, several actions within each broad step overlap in time and may also be revisited over time.

Figure 3: Implementation Steps for the community midwifery model



4. Institutional Framework and Implementation Mechanism

For successful implementation of the community midwifery model, all levels (national, county, sub-county or district and community) have to play complementary and supportive roles to each other. Good working relationships should be nurtured through all the phases of programme planning and implementation. Key activities that are critical in the implementation are addressed under the respective levels of the health care system.

In accordance with the new constitution and the Kenya Health Policy (2012-2030) four levels are critical in the management and coordination of health services, namely the national level, county level, sub-county or primary care level and the community level. For purposes of simplicity the national or strategic level will deal with policy stewardship. The county level will provide leadership and management functions while the community level will be responsible for the day to day running of the community midwifery activities.

Recognizing that maternal and newborn health is a broad social issue and that a reduction in maternal and newborn morbidity and mortality will only occur when all line ministries and other stakeholders work together towards achieving the MDGs, this chapter is divided into three sections. Each section describes activities at different levels: strategic, operational and tactical.

4.1 Strategic level

Policy and Stewardship

Key activities at national level revolve around policy and stewardship, creating an enabling environment which includes licensing, certification and clear policies on the linkage between the community and the formal health care system. The Ministry of Health (MOH) will provide overall stewardship and linkage to other line ministries. The MOH will ensure that the KHSSP and other relevant policy documents (e.g. the Community Health Strategy and RH policy) are disseminated to counties, sub-counties or districts and within community units.

Specifically the strategic level will:

- Provide leadership, advocacy and coordination of reproductive health activities at all levels and among stakeholders.
- Create procedures and regulations (through professional boards and councils for skilled providers willing to work at the community level) (see NCK criteria in appendix I)
- Disseminate and distribute policy briefs and discussion papers on emerging MNH issues such as the implementation of community midwifery in the region
- Advocate for increased funding for RH including stipends for CM.
- Provide support for implementing and scaling up Community Midwifery through the County Health Management Teams and Regional Training and Supervision teams.
- Mobilise resources including lobbying for increased finances and personnel for community level activities

- Lead/coordinate/ monitor and evaluate Community Midwifery as part of the wider community approach – joint assessment of progress and enhanced learning
- Organise periodic forums for disseminating results and sharing experiences - to enable sustainability as well as mutual accountability
- Develop advocacy materials on CM for distribution at county and sub-county levels
- Lead the development of generic IEC and BCC materials for the community

Thus, the key roles of the strategic level will be: coordination, supervision, monitoring, evaluation training, quality assurance and resource allocation.

As outlined in the previous chapter, the process of implementing the community midwifery model goes through three broad phases, namely phases I, II and III. Sub-section 4.2 (operational level) and 4.3 (tactical level) outline the specific actions or tasks of the main institutions involved in the implementation of the model.

4.2 Operational level

The operational level provides leadership and management in mobilizing resources and the infrastructure and systems to support the introduction and sustainability of the community midwifery model. “The County/ sub county Health Management Team and District Health Management Boards (HMT and HMB) in conjunction with the county/sub county stakeholders forum, provides governance and technical support respectively to all Level One Services that include planning, implementation, monitoring and supervision” (MOH 2006). These institutions through the County/sub county RH Training and Supervision Team⁸ will address the following issues in 3 phases:

Phase 1

- Complete an SMNH assessment to identify gaps and challenges to increasing skilled attendants at birth and the availability of Level One Health Services in the community.
- Identify community strengths and opportunities in the provision of MNH care
- Create awareness among key sectors on the rationale of community midwifery model and their respective roles in reducing the high maternal and perinatal morbidity and mortality
- Create awareness and build consensus on the local situation, strengths, weaknesses and challenges in maternal and newborn services.
- Share international, national and regional information on the current situation on maternal and newborn health care services at stakeholders’ forum
- Reach consensus on the way forward and incorporate into County/sub county health plans – the roles of the various sectors and local government, advocacy and resource mobilisation
- Involve all stakeholders in improving the well being of families: social services, provincial administration, planning, and women organizations, CBOs and FBOs

⁸ Much of the coordination at the operational level is expected to be carried out by the officials in charge of reproductive health and community health services at the county and sub-county levels.

Phase 2

- Facilitate identification and recruitment of Community Midwives
- Identify potential local facilitators to conduct updates and on-job training for CMs
- Facilitate training of trainers for Community Midwives
- Train Community Midwives according to guidelines
- Register all Community Midwives working in the district
- Ensure all Community Midwives have the appropriate licensing documents
- Organizing capacity building and CPD/in-service training
- Identify sources of supplies, equipment and essential drugs
- Provide Community Midwife with necessary equipment
- Ensure re-supply of consumables through facilities and or District stores,
- Support supervision
- Details for communication set up
- Referral mechanisms for emergencies agreed with VHC and HF Management Boards

Phase 3

- Lobby to CDF and other community funds such as LATIF for increased funding
- Coordinate on-going support supervision
- Coordinate monitoring and evaluation implementation of MNH activities
- Compile monitoring data and produce periodic reports
- Facilitate collaboration with stakeholders and secure resources for the program
- Review community level IEC/BCC materials and make recommendations to the strategic level

4.3 Tactical level - Management of Level One Services

This level will work closely with the operational level. The level of support from operational level to the tactical level will entail skills transfer, capacity building, resource deployment, supervision and coordination among other roles. This level will perform the following tasks in three phases:

Phase 1

- Create awareness and build consensus on the local situation, strengths, weaknesses and challenges in maternal and newborn services.
- Share regional and district information on the current situation on maternal and newborn health care services
- Emphasise local status of maternal and newborn indicators and care services.
- Encourage dialogue between community and health service providers
- Strengthen community involvement in decision making
- Establish a link between health sector and community
- Identify cultural beliefs and practices that promote health care seeking behaviour

Phase 2

- Discuss the role of the community in the referral system
- Identify existing innovations that worked in the past (revolving funds/ cost sharing etc)
- Define referral mechanism and provide support to community midwives to:
 - Carry out her/his job at night
 - Deal with complications when they occur
 - Ensure availability of community phone
 - Provide linkage to health facility vehicle (where they exist)
- Link with administration to ensure birth and death registration
- Strengthen linkage between the community and the formal health sector.

Phase 3

- Lobby for CDF for increased funding
- Build a health social fund to meet transport and communication expenses for emergencies
- Monitor community health status and promote early detection of ill-health and timely action
- Set up maternal and perinatal death review/verbal autopsy sub committee

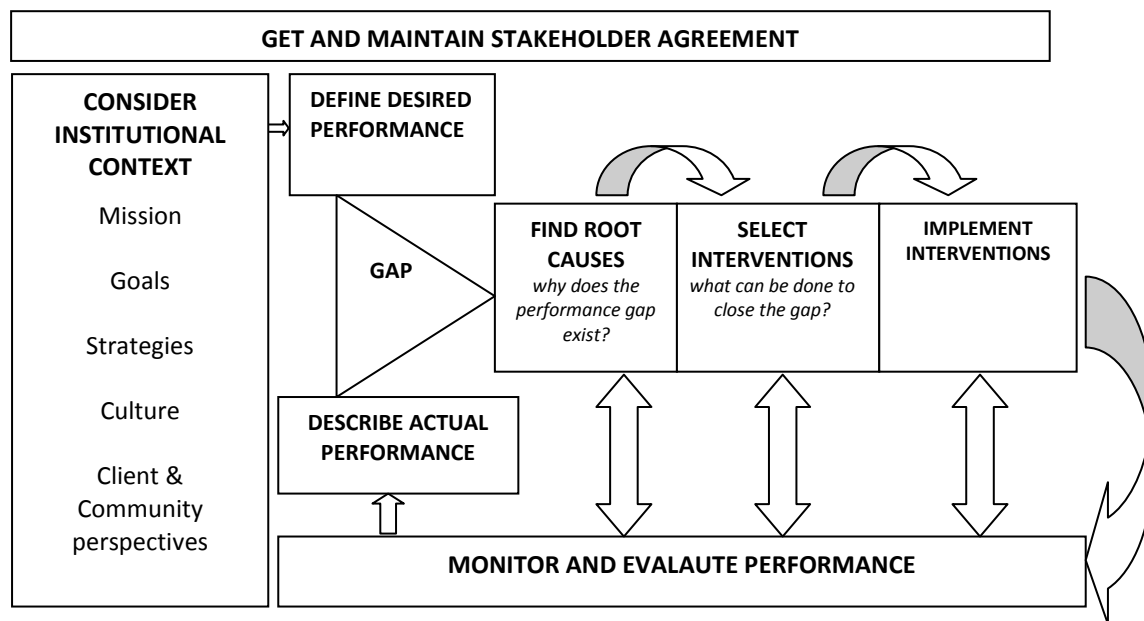
5. Quality Assurance

5.1 Concepts

In the health sector, quality assurance refers to the practice of managing the way services are provided to make sure they are kept at high standard. In the context of this document, the purpose of quality assurance is to assess the performance and quality of community midwifery services. The quality assurance practice described in these guidelines is based on the performance and quality improvement (PQI) framework shown in Fig.4. It was developed by the USAID supported performance improvement consultative group⁹.

⁹ Source: JHPIEGO (2004): Site assessment and strengthening for maternal and newborn health programmes.

Figure 4: The Performance and Quality Improvement Process



Source: JHPIEGO (2004): Site assessment and strengthening for maternal and newborn health programmes.

Quality assurance for CM will take into account the structures, processes and outcomes to improve the performance and quality of RH services in the community.

5.2 Quality Assurance Core Components

Assessment of the quality of community midwifery activities will focus on three components:

- Core services that a community midwife ought to provide
- Supportive services that are critical to the provision of community midwifery model
- Tools for monitoring quality assurance

5.3 Core Services

In accordance with the scope of practice, a CM will provide the following core services: focused antenatal care, labour and delivery, postpartum care, new born care, FP services & referral. Key aspects (of these components) to be assessed for quality of care are outlined in Text Box 2.

Text Box: 2: Quality of care elements for Key MNH components at the Community level

Focused Antenatal Care

Find out if CMs are offering the following services:

- Early initiation of ANC & 4 timely ANC visits
- Individualised Birth Plan & Emerg. Preparedness
- Assessment of danger signs e.g. pallor, oedema
- History taking (including Previous BOH)
- Health messages on FP, BF
- Use of LLINs
- ANC profile- HB, urinalysis, blood group; VDRL
- CT for HIV and follow up care (PMTCT)
- Provision of ARV prophylaxis,
- IPTp provision in malaria endemic areas
- Referral for Tetanus Toxoid
- Iron and folic supplements
- Identification of danger signs and First Aid/referral
- Deworming (esp. hookworm)

Post partum care

Find out if CMs are offering the following services:

- Early initiation of breast-feeding ; EBF
- 1st PN exam for Mother and Baby (24-48hours)
- Counselling on FP method mix
- CT HIV and follow up care
- Initiation of infant on NVP during breast feeding
- Mother counselled to return at six weeks
- Encouraging partner involvement
- Use of national guidelines, SOPs, IEC materials

New Born Care

Find out if CMs offer the following services:

- Hand washing with soap and water by care giver
- Recording of Apgar Score assessment
- Check-up within 24-48 hours after birth
- Care of the normal newborn (e.g. clearing airway)
- New born resuscitation
- Newborn phy. exam including assessing for LBW
- recognition of danger signs
- PMTCT: ensure ARV prophylaxis at birth
- Early initiation & support for EBF/infant feeding
- Community based IMCI
- Growth monitoring
- Referral for immunization
- Hygienic cord care

Labour and Delivery

Find out if CMs are offering the following services:

- Monitoring of labour using partograph
- Clean delivery
- Skilled delivery/care
- Recording duration of labour, delivery time
- Counselling and testing for HIV
- Provision of ARV prophylaxis; follow up care
- Antibiotics for premature rupture of membranes
- Verbal autopsy
- Counselling and referral of clients to facilities for PPIUCD (if requested by client)

Family Planning

Verify the status of the following quality of care indicators

- Equipment and Commodities inventory for FP
- Condition of Room/where FP services are given
- Availability of IEC Materials and activities on FP
- Evidence of supervision in the past one month
- Availability of protocols and guidelines on FP
- Use of information from clients in the past 3 months
- Service Statistics (No. of clients who received FP services from a CM in last 4 completed quarters)

Referral

Assess the CM's referral activities in terms of:

- Use of referral form/notes
- Recording of personal details of clients/patients referred
- Whether accompanied by CM, relative, etc or not
- Whether mode of referral is socially and culturally acceptable
- Accessibility to the majority of people in the community
- Affordability by the majority of people in the community
- Appropriateness to majority of people in the community
- Availability on daily basis
- Whether managed by local health committees
- Availability of revolving fund for emergency transport
- Community involvement in referral
- Linkage with a health facility
- Directory of referral sites/facilities with contact details

Source: 1) Maternal, Newborn Health, Child Survival and Development Retreat (With a focus on high impact interventions): Workshop Report; Nakuru; 15-17 March 2010; Ministry of Public Health and Sanitation.

2) Liambila W., Obare F., Birungi H., Wayua Muia R., Maina J., Maina M., Awuor C., Mohamed I., (2011) Linking HIV – Positive Family Planning Clients to Treatment and Care Services in Kenya; APHIA II OR Project in Kenya/ Population Council: Nairobi, Kenya.

3) WHO (2009): Framework for Developing Model Integrated Community-Level Health, Promotion Interventions in Support of WHO Priority Programmes Regional Office for Africa, Brazzaville.

5.4 Supportive Components

These include:

- Effective leadership
- Availability of equipment, infrastructure and supplies
- Availability and access to policies guidelines, IEC materials e.g. job aids
- Availability of transport, communication facilities
- Effective infection prevention measures
- Evidence of documentation and reporting
- Participation in local maternal and perinatal death review meetings
- Effective health management information system
- Continuing professional development
- Interpersonal communication
- Clients friendly services and feedback
- Mutually supportive linkage with community health workers that promotes task-shifting with a view to freeing a community midwife from activities that could effectively be done by a community health worker as she or he concentrates on performing technical tasks within the community such as providing long acting family planning methods (e.g. implants and IUCD) and deliveries.
- Effective supportive supervision:

Community midwifery model requires monthly supervision primarily by the link facility and quarterly by the county/subcounty or district level health management team. The areas for supervision will include assessing knowledge and skills in the area of practice to be verified or observed such as infection prevention and control. Continuing professional development (CPD) of the CM will also be assessed. Log books will be reviewed to verify CPD progress. CMs require at least 40 hrs of continuing professional development per year.
- Monitoring and evaluation:

The community midwife (CM) will be expected to report on routine service data to the facility in-charge on monthly basis. The CM will use the following tools in compiling the report: Monthly summary reporting forms, patient case notes, referral forms, community verbal autopsy, antenatal register, delivery register, post natal register, community midwifery supervisory book, FP Register and birth and death notification forms. Periodic evaluations of the impact of the model will be done through review of records, in-depth interviews, community surveys and focus group discussions.
- Availability of action plan or programme of work by community midwives

5.5 Tools for monitoring quality assurance

The tool for monitoring quality assurance is found in Annex 5. Some Examples of issues to look at are: Management processes, equipment, supplies, infrastructure, Referral System and RH training/updates in:

- ✓ Life savings skills (EmoNC)
- ✓ Family planning
- ✓ PMTCT
- ✓ Partograph use
- ✓ FANC
- ✓ Post rape trauma counselling

6. Sustainability of Community Midwifery Model

The Ministry of Health's interest in sustaining the community midwifery model is to ensure that current programme activities and the proposed ones together with the benefits they produce are continued long after the initial funding would have stopped especially from development partners. In this section, three important issues are addressed, namely, the critical sustainability factors for the community midwifery model, financing strategies and entrepreneurship.

6.1 Critical Sustainability Factors

Sustainability factors which are critical in ensuring the programme's success are:

(i) Target group knowledge, attitudes and practice

The degree to which the principal target groups are knowledgeable and motivated to utilize community midwifery services and their benefits improves sustainability. Low knowledge, poor motivation and non-use of services are a threat to sustainability.

(ii) Service quality

The degree to which high quality services can continue to be provided in the future is a pointer towards programme sustainability. Low quality or the absence of key services can be a threat, while high quality may increase demand for services and support.

(iii) Management support

Management support for activities such as planning and supervision enhances the chance of sustaining programmes. Weak or missing support services can be a threat to sustainability.

(iv) Organizational capacity

Effective organisation and coordination of the community midwifery model will contribute greatly to the sustainability of programme activities.

(v) Policy makers commitments

High, broad-based commitment by policy makers is conducive to sustainability; low, narrow-based commitment is a threat.

(vi) Retention of community midwives

Attrition or loss of community midwives is a threat to sustainability. Their retention will ensure continuity and stimulate interest in expansion and growth of the programme.

(vii) Adequacy of Revenue

Inadequate income is obviously a threat especially to community midwives who are in private practice. Community midwives should constantly assess revenue trends, threats and opportunities with regard to revenue generation especially with regard to funds meant to support interventions and purchase supplies.

(viii) Programme expenditure

High programme costs are a threat to the sustainability of the community midwifery model. As with revenue, community midwives should monitor expenditure trends and make individual efforts to contain costs and improve efficiency in financial management.

6.2 Community Midwifery Financing

Availability of adequate financial resources is critical to efficient and effective implementation of the community midwifery model. This section identifies and discusses various sources of financial resources that could support the implementation of the community midwifery model.

Government (Treasury Allocations)

The need for the government to finance the community midwifery activities is critical. Services provided by the community midwives have strong components of public goods (such as preventive activities, health education) and some of them have negative externalities (e.g., the infectious nature of HIV/AIDS, STIs, immunizable diseases, etc). Private sector health markets have little incentive in providing public goods, and therefore, government financing is crucial in enhancing the provision of equitable services and in sharing healthcare costs across all populations.

The Government may allocate funds to support the implementation of the community midwifery activities through three potential mechanisms; namely: Health Sector Services Fund (HSSF), Output Based Aid (OBA) and direct budgetary allocations to community units under the primary health care/rural health vote or sub-vote.

Health Sector Services Fund (HSSF)

HSSF is a scheme established by the government to disburse funds directly to rural health facilities to enable them improve services to their local communities. The Fund is operated by the Ministry of Public Health and Sanitation (MoPHS). The scheme was established in December 2007 through a legal notice issued by the Minister for Finance to give local facilities the autonomy to manage their resources and to enable the communities to participate in health care delivery systems. According to the legal notice that established the scheme, the funds will be sourced from the exchequer, from grants or donations, from cost-sharing revenue and from any income generated from the activities of the fund itself.

HSSF provides direct financing to health centres and dispensaries. The fund provides resources for medical supplies, rehabilitation and equipment and is disbursed in four installments per year. Since the HSSF targets to benefit all Kenyan households that seek medical care, local health facility management committees, may decide to use part of the money as an incentive to community midwives for certain outputs or tasks such as deliveries, or for the first post partum check-up visit made within 24-48 hours, etc.

This option could be implemented by enhancing the current disbursement levels by a certain percentage that will be determined on the basis of the number of community midwives available in each county or sub-county/district/community unit.

Output based Aid (OBA)

Community midwifery activities could be linked to pro-poor financing strategies such as the Output based aid or Approach (OBA). The OBA is designed to test the best mechanism of delivering and targeting public subsidies in ways that promote quality care and maximize utilization by the population living in poverty. The OBA concept is based on financing agreed upon outputs with pre-defined quality rather than pre defined inputs by selling vouchers for safe motherhood and neonatal health (SMNH) and Family Planning services at subsidized prices to clients.

In Kenya, the OBA Voucher Scheme provides access to high quality health services to poor people as well and, perhaps more importantly; it gives them the opportunity to choose the health facility – public or private-they wish to go to. The program focuses on subsidizing maternal and newborn care and family planning services to members who purchase vouchers and present them to accredited voucher service providers. The program makes use of a competitive voucher scheme in delivering health services to the target population during pregnancy labor, childbirth and puerperium including family planning and new born care.

Despite the intended benefits of this program, there are still a number of clients who purchase the OBA vouchers but are unable to access the static health facilities due to various factors such long distance and cultural factors. The CMs operate at the community level within the reach of the households. Linking CM to OBA program could address some of these constraints. Since OBA is one of the flagship government programmes for realising vision 2030, it is anticipated that linking the CM to the OBA scheme will address sustainability goals of the community midwifery model.

Direct Budgetary allocation to Community Units

As a strategy to strengthen the effort of the Ministry of health (MOH) to reverse the poor maternal and newborn indicators at the community level, the MOH could allocate more funds to community units. This will support the provision of various basic curative, preventive and promotive activities including giving incentives to community midwives for their labour costs and as a modest compensation for the medical (consumable) supplies they use in addressing various needs of clients.

These funds could either be channelled through the departments that are in-charge of reproductive health services or community health services at the national, county or sub-county levels.

Details on the levels and frequency of disbursement and the nature of activities to be supported could be worked out by the Division of Reproductive Health and the Division of Community Health Services in collaboration with the department of policy and planning and local health management teams and committees.

Private financing for community midwifery services

This could be in the form of personal payments made directly to practising community midwives. User fees fall under this category. Private financing for the community midwifery services is in line with the guiding principles of RH policy, especially regarding the need to build participatory approaches with the local community and foster partnerships in the delivery of RH services.

National Hospital Insurance Fund (NHIF)

This scheme has great potential in attracting additional financial resources to the community level. The anticipated NHIF reforms, including increasing the benefit package to cover out-patient services, has the potential to support community midwifery activities through the link facilities where community midwives are attached.

External Sources (Support from Development Partners)

External funds could support mainly commodities, supplies, training, drugs and technical assistance. External finance may promote allocative efficiency by targeting funds to intended purposes or activities. These resources can also be used in enhancing equity goals and in supporting the establishment of community midwifery activities in underserved areas.

Donations by Foundations and Charities

A deliberate effort to forge partnerships with foundations and charities could be made, with a view to engaging them to fully participate in community midwifery activities.

Leveraging of Local Development Funds

In recent years, local leaders have used the Constituency Development Fund (CDF) and LATF funds to build various infrastructure, including health facilities. With good justification, it is possible to revisit the initial objectives of these funds and redirect the strategies towards supporting high impact interventions.

6.3 Entrepreneurship

To sustain the CMs' services, it has been estimated that the charge for a total package of ANC, childbirth and PNC should be at least \$23 (or about Kshs.2,000) per client. Another solution for improving the sustainability of the community midwifery model is to facilitate clusters of CMs to pool their resources through a 'Merry-Go-Round'. This approach will enable them to buy supplies in bulk or to purchase equipment that can be shared. A Merry-Go-Round is an income-generation and resource-mobilization activity whereby members in a group contribute to a common kitty at specific intervals.

The group contribution is then distributed to members in turns until all members have had a share. In some counties or districts, CM groups have also linked themselves to

local microfinance enterprises (such as the Lugari and Murang'a district midwives) and benefited from the continuous motivation received from the microfinance field offices.

Business skills training

On average, the CMs were charging approximately US\$7 for assisting in childbirth, which was well below the cost of materials used and did not reflect the time spent. Other services such as ANC, PNC and newborn care services were being offered free. Community-wide poverty was cited as the main reason for low or non-payment of fees and failure to pay debts.

As the majority of CMs do not have any business skills, they lack the capacity to view their services as a business opportunity that could be used to sustain their livelihood. There is need to develop a short training module and to conduct business management skills training for the CMs. The training will equip the midwives with knowledge and skills to be able to provide midwifery and other services as a business. The training is expected to:

- a) Equip the trainees with entrepreneurship skills and relevant concepts to manage a successful community midwifery business, including setting realistic prices for the services provided and identifying strategies for getting paid for the services provided;
- b) Sensitize the trainees with (practical) application of the entrepreneurship and relevant skills and strategies to develop or initiate successful business.

A training workbook on business skills for beginners could be adapted for use as a training document in a group training workshop. The workbook has five modules (Text Box 3) and was designed to help trainees review the business ideas, with the aim of equipping them with the relevant business management skills.

Tex Box 3: Training workbook on business skills- Possible Modules for adaptation	
Module	Possible content of the Community Midwifery business skills training
Introduction to entrepreneurship	<ul style="list-style-type: none"> • Personal experience in business • Characteristics of a good and bad entrepreneur • Self assessment as an entrepreneur
Marketing	<ul style="list-style-type: none"> • Knowing your customers • Knowing your competitors • Location of the business
Organization	<ul style="list-style-type: none"> • Cost of business • Control of quality • Control of debtors
Financing	<ul style="list-style-type: none"> • Cost of materials • Projection of income • Keeping a cash record
Planning	<ul style="list-style-type: none"> • Making a business implementation plan

Source: Annie Mwangi and Charlotte Warren 2008 Taking critical services to the home: scaling-up home-based maternal and postnatal Care, including FP, through community midwifery in Kenya. FRONTIERS Final Report; Washington DC.

6.4 Replenishing Supplies

Replenishing consumable supplies such as drugs, pads, dressings, syringes, needles among others remains one of the biggest challenges community midwives face. Often the capacity of community midwives to replenish life-saving drugs such as antibiotics, anticonvulsants, analgesics, routine haematinics, IPTp in malaria endemic zones, and basic equipment such as speculum is limited.

Trained midwives should be provided with a range of essential equipment and supplies by MOH (*see* annex 2 for the list of recommended equipment and supplies). Although development partners may assist in offering the initial set of required start-up medical supplies during the intervention period, subsequently, MOH through county and sub-county /DHMTs and the link health facilities will be responsible for ensuring that these supplies are available and that re-fills are obtainable when needed by the community midwives. In return, the midwives will be required to submit monthly reports on the number of clients reached.

It is recommended that a social franchise model, which involves a network of providers (in this case community midwives) be established for community midwives who operate their own clinics. This arrangement will help to guarantee a steady flow of supplies to community midwives. The arrangement will also help them standardize payments (based on services provided). The other advantages of using a social franchise include quality assurance, rapid scale up of the number of providers (by encouraging others to join), creates a mechanism for supervision, offers cost-effective services (compared to other service delivery options) and promotes equity goals (to serve all population groups emphasizing the poor and those in need).

A social franchise also provides a platform for communicating messages to generate awareness and demand for services offered by the members of the franchise. In addition, a franchise ensures that key commodities and supplies are available all the time and are accessible by those in need.

Annexes

Annex 1: Clinical attachment

In ANC Clinic

- (a) Understand focused antenatal care (diseases prevention and health promotion , IBP)
- (b) Participate in Health talks
- (c) Head to toe examination including palpations to identify the gestation, lie, presentation and position
- (d) Breast examination
- (e) TT immunisation, heamatinics, IPT for malaria ITN
- (f) PMTCT
- (g) Assist 5 women prepare an individualized birth and postnatal plan
- (h) Record all procedures in the appropriate documents (ANC card and registers)

Labour and delivery

- (a) Admit women in labour (history taking)
- (b) Manage labour using a partograph
- (c) PMTCT
- (d) Assist mothers during childbirth (10)
- (e) Active management of third stage of labour (AMTSL)
- (f) Manual removal of retained placenta
- (g) Suturing of any simple tears or episiotomy
- (h) Record all procedures in the appropriate documents (delivery, PNC, ANC card)
- (i) Familiarize with the data collecting tools

Post natal

- a) Carry out complete postnatal check on mother before leaving hospital
- b) Carry out complete postnatal check on the baby before discharge
- c) PMTCT care and follow-up (know where to refer CCC/support groups etc)
- d) Record all procedures on appropriate documents (ANC/PNC card and register)
- e) Postnatal check at 14 days
- f) Postnatal check at 6 weeks
- g) Family planning advice - LAM and transition to other methods
- h) Breastfeeding support
- i) Essential newborn care - specifically in nursery
- j) Health education/counsel the woman eg on danger signs for both mother and newborn
- k) Immunisations /child welfare clinic

Documents

- Monthly summary reporting forms
- Patients case notes
- Referral forms
- Partographs
- Maternity Register
- Post natal register
- Mother Child Health Booklet

Annex 2: Basic requirement of equipment and supplies

The community midwife will have the custody of a minimum of two delivery kits each kit equipped with the following instruments and supplies

Delivery Kit

a) Instruments

- Foeto scope
- Artery forceps (2)
- Cord scissors (1)
- Episiotomies scissors (1)
- Needle holder (1)
- Toothed dissecting forceps
- Small galipot (1)
- Cord ligature (1)
- Large kidney dish (1)
- Mackintosh (1 metre² thick plastic/rubber)
- Suction /mucous extractor (penguin)
- Large metal tray with lid
- Newborn Ambu-bag
- Blood pressure machine
- Stethoscope
- Thermometer
- Mackintosh apron

b) Supplies and drugs

- Gloves
- Syringes (2ml, 5ml and 10ml)
- Needle (21G)
- Lignocaine 1%

- Injection oxytocin (5mg/ml)
- Magnesium sulphate
- Calcium gluconate
- Antibiotics Suture
- Disinfectant (e.g. Hibitane)
- Pads/gauze
- Sodium hypochlorite
- Baby Weighing scale
- Bucket with lid for decontamination

Vaginal examination kit

- 1 kidney dish
- 2 gallipots
- 1 green towel
- 1 speculum
- Sponge holding forceps
- Swabs

Items for mother/family to ensure are in the home before birth:

- Clean cloths for drying baby
- Cloths for wrapping baby
- Nappies
- Pads
- Warm water

Annex 3: Patient referral form

To

Dear Sir/Madam

I am referring:

Age: Para: Last delivery: LMP:

EDD:Gestation: Presented on (date/time)

With a history of:

.....

.....

Last examination (findings)

.....

.....

.....

Treatment given.....

Reason for referral:

.....

.....

.....

Thank you.

Village

Name printed

Signature

Date and time of referral

Tear off here and send back to referring provider with escort or relative

To (midwife)..... Date and time.....

Diagnosis:

Management:

Outcome:

Thank you.

Facility

Name printed Signature

Annex 4: Monthly summary reporting form

Indicate month of data covered in the report.....

CountyDistrict:Division

LocationSub-location-.....Village.....

Facility linked to

Antenatal Services	Number seen	Number referred for service
First ANC visit		
Second visit		
Third Visit		
Fourth Visit		
ANC Profile		
Tetanus Toxoid		
PMTCT (counselled & tested)		
IPT		
Anaemia		
TB Screening		
PET		
Eclampsia		
APH		
Labour and childbirth Complication		
Post Partum Haemorrhage		
Prolonged/ Obstructed labour		
Retained Placenta		
Sepsis/Infection		
Ruptured Uterus		
Malpresentation		
Others Specify		
Total Number of clients		

Assisted childbirth

Mode of delivery	NUMBER			
	LIVE BIRTHS	FSB	MSB	TOTAL
SVD				
BREECH				
Totals				

Postnatal services

Assessments	NUMBER		
	Seen	Referred	TOTAL
Within 24 hrs			
Within 3 days			
Within 7 days			
Within 2 weeks			
Within 4-6 wks			
Other (specify)			
Totals			

Neonatal services:

Assessment	Number		
	Seen	Referred	Total
Babies assessed within 24 hours			
Babies assessed within 3 days			
Babies assessed within 7 days			
Babies assessed within 2 weeks			
Babies assessed within 4 – 6 weeks			
Referred and reasons for referral			
Congenital Abnormalities			
Jaundice			
Infection			
Immunization and growth monitoring			
Problems associated with Asphyxia			
Prematurity			
Low birth wt			
Other			
Totals			

Number of times in contact with the facility linked to.....

Number of community activities attended..... Number of professional updates.....

Midwife's Name.....

Signature.....

Date.....

Annex 5. Quality assurance tool

	Activity	No	Yes	Comment
	CHC and facility Meetings attendance (Evidence minutes)			
	Supportive supervision mechanism in place (<i>Evidence of the supervisor's notes</i>).			
	Verbal autopsy Committee in place and meetings as per guidelines. (<i>Evidence- Minutes, Copies of completed MPDR forms</i>)			
	Evidence of Infection prevention and control measures (eg. Use of decontamination etc)			
	Documentation and reporting of RH Services conducted by CM (<i>records</i>)			
	Utilisation of data generated on RH services for planning and decision making in Community midwifery (<i>records, trends</i>)			
	Appropriate data storage facilities in place (e.g. cabinet, drawer, cupboard etc)			
	Current individual work plan for RH activities			
	Certificate of retention with their respective regulatory bodies.			
	Awareness of Roles and responsibilities			
	Continuing Professional Development (<i>see- booklet- for updates</i>)			
	RH training/updates in the last one year. <ul style="list-style-type: none"> • Life savings skills (EmoNC) • AMSTL • Family planning • PMTCT • Partograph use • Adolescent sexual and reproductive health • FANC- • Post rape trauma counselling • RT/Organs cancer screening & Counselling 			

	Equipment	Available and satisfactory	Available but not satisfactory	Not available	Comment
	General Equipment				
	Weighing scale – Adult and infant				
	Functional Portable light/Torch				
	Digital clinical Thermometer				
	Blood pressure machine				
	Stethoscope				
	Foetal scope				

	Availability of FP				
	Records				
	Registers for ANC, CWC, PNC, FP, Delivery				
	Mother and child health booklets				
	Partographs are accurately and consistently completed				
	Birth/Death Notification forms				
	Monthly reports on RH services well completed				

Maternity unit-(ante-natal, labour wards and post natal)

	Equipment:	Not available	Available & not usable	Available & usable	Comments
	Vaginal Examination Kits – comment on the no.				
	Delivery Kit				
	Resuscitation equipments				
	Bulb syringe for suction				
	Ambu bags(newborn and adult)				

Referral System

Purpose: To evaluate efficient and effective referral of clients occurs and to assess Knowledge and practice among CM on referral process

no.	Details			
	Protocols and guidelines on the referral of clients is in place and known to the staff			
	CM has access to ambulance or a reliable form of transport.			
	The CM accompanies clients during referrals			
	Existence of functional communication system to alert the facility of an imminent referral and the telephone numbers available			
	CM has forms and registers for recording cases for referral			
	Functional feedback mechanism between CM and the referral facility			
	Clients records completed by CM			
	Total			

Comment on strengths, weaknesses and recommendations of the facility in the referral process

Annex 6: Criteria for licensing Community Midwives

Maternal mortality rate is a major public health problem in Kenya. As per the Kenya demographic health survey of 2008/09 there were 488 maternal deaths per 100,000 live births. Many of these deaths could be averted if women had access to skilled attendance and essential obstetric care on time. The proportion of Kenyan women benefiting from institutional care is low partly due to physical and financial issues, while others prefer the convenience and familiarity of community based health providers or relatives to facility based services, hence the need for the Nursing Council to develop a policy document to licence nurses and midwives to offer community midwifery services. This is an effort to compliment government efforts to achieve the 5th millennium development goal.

Criteria for Licensure

1. Must be a Kenyan citizen
2. Must be a registered or enrolled community health nurse or midwife by the Nursing Council of Kenya
3. Must be holding a current practice licence.
4. Must be either, retired, resigned, unemployed or a licensed nurse private practitioner.
5. Must be trained on essential obstetric care and certified by the DHMT.
6. Must present a letter of introduction form the DHMT.
7. Private practitioners may be licensed as community midwives on condition that they deliver the mothers in their homes.
8. Must have had a 6 months experience in a maternity set up post registration/ enrolment.
9. Must have worked for at least 10 years post registration/enrolment.
10. Must submit, together with application and recommendation letter latest curriculum vitae detailing:
 - i. Date of registration/enrolment
 - ii. Registration/enrolment number
 - iii. Continuing education in the last one year.
 - iv. Name and address of last employer. (if any)
 - v. Last date of employment
 - vi. Areas of practice (deployment) since qualification.
 - vii. The applicant should also present:
 - a. Certified copies of registration/license and enrolment certificates
 - b. Copy of ID card
11. Indicate the nearest health facility where he/she can refer his clients to.
12. Appear in person for initial application and renewal of the license at the Council offices.
13. Will pay the prescribed fee for licensure and license will be renewable every three years.
14. Always carry on them the license when performing the community midwifery services.
15. A midwife undertaking community midwifery must not, except in grave emergency, undertake any treatment which is outside his/her normal professional practice.
16. A nurse midwife undertaking community midwifery must refer to the nearest health facility all cases he or she is unable to manage.
17. The midwife must keep custody of all clients' records and submit a copy to the DHMT at the end of every month.
18. If the client dies, the midwife in attendance at the time of death or who was called immediately shall notify the DHMT and police within 48 hours. A midwife undertaking private practice must bear any legal liability relating to his/her practice.
19. A nurse/midwife undertaking community midwifery must observe rules and regulations set from time to time by the Nursing Council of Kenya and the DHMT.

Annex 7: Participants involved in the revision of the CM Guidelines

Number	Name	Institution/Organization
1.	Dr. Issak Bashir	Head DRH/MOH
2.	Dr. Shiphra Kuria	MOH/DRH
3.	Dr. Nakato Jumba	MOH/DRH
4.	Dr. Dan Okoro	UNFPA/DRH
5.	Dr. Nande Putta	UNICEF/DRH
6.	Ruth Muia	MOH/DRH
7.	Judy Maua	MOH/DRH
8.	Alice Mwangangi	MOH/DRH
9.	Jane Koech	MOH/DCHS
10.	Agnes Mutinda	MOH/Dept. of Nursing
11.	Annie Gituto	MOH/DRH
12.	Anne K. Njeru	MOH/DRH
13.	Elizabeth Washika	MOH/DRH
14.	Milcah Akala	Jhpiego-APHIAplus Zone 1
15.	Patience Ziroh	Jhpiego- APHIAplus Kamili
16.	Dr. Marsden Solomon	FHI360
17.	Jones Abisi	FHI360
18.	Wilson Liambila	Population Council
19.	Dr. J. Lavussa	WHO
20.	Clarice Okumu	MOH/DRH
21.	Angela Njiru	MOH/Nairobi –PMO
22.	Lucy Gitonga	MOH/Department of Nursing
23.	Louisa Muteti	Midwifery Chapter
24.	Mary Nyawira Nyamboki	Nursing Council
25.	Catherine Gachanja	MOH/RHC Muranga
26.	Jane Makona	DPHN/RHC- Lugari District
27.	Dr. Stephen Mutiso	Kenyatta University
28.	Margaret Njoro	KMTC

For more information, please contact:

Division of Reproductive Health
Old Mbagathi Way
P. O. Box 43319 - 00100
Nairobi, Kenya
www.drh.go.ke

