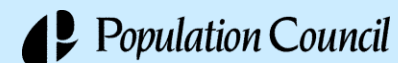


Taking Critical Services to the Home: Lessons Learnt from a Community Midwifery Pilot Project in Kenya

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Addressing poor access to critical services: the CM model

Community midwifery aims to:

- Address the work force gap and build on resources available in the community;
- Increase access to, and demand for, skilled attendants during pregnancy, childbirth and the postpartum period and for FP;
- Operationalize the *National Community Strategy* to utilize human resources outside of the public health sector

Who is a community midwife?

- ✓ A certified health professional with midwifery and FP knowledge and skills (nurse midwife, doctor or clinical officer)
- ✓ A health professional with obstetric skills and a permanent resident within the community
- ✓ A graduate not yet absorbed into the public service, a private practitioner, or a retired professional

Methodology

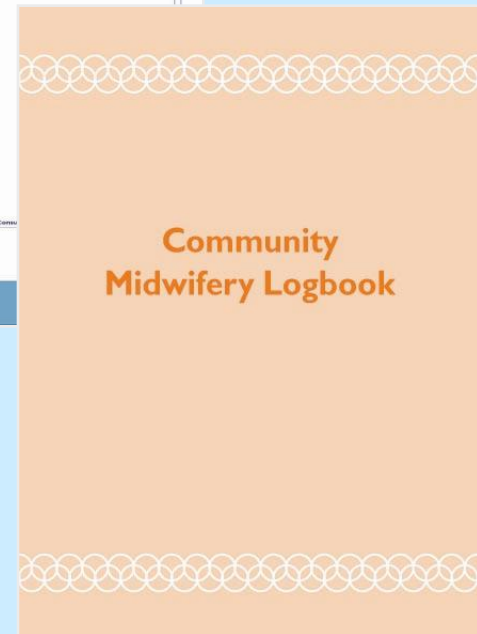
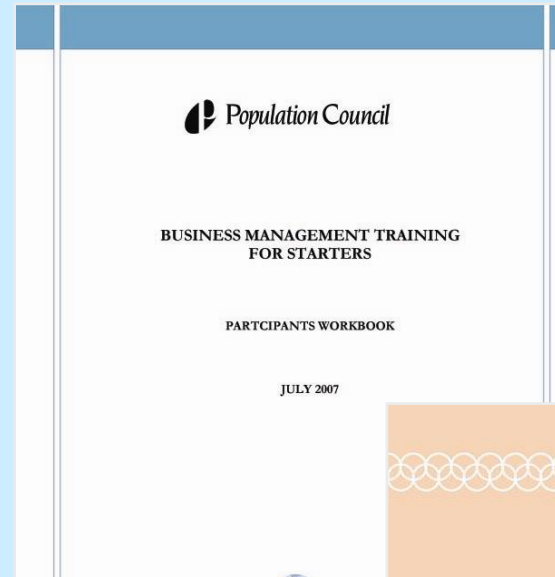
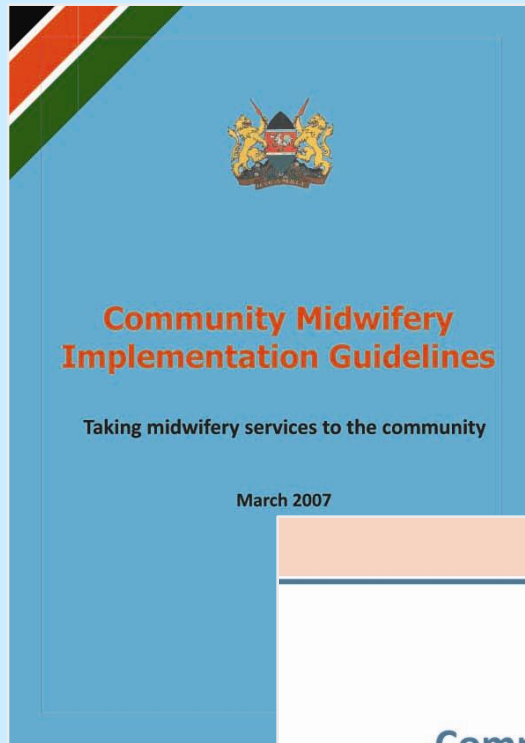
Document the sustainability of a community based midwifery model that had been successfully introduced

Fifty-four retired midwives (out of 100 trained) were monitored for 12 months in four districts

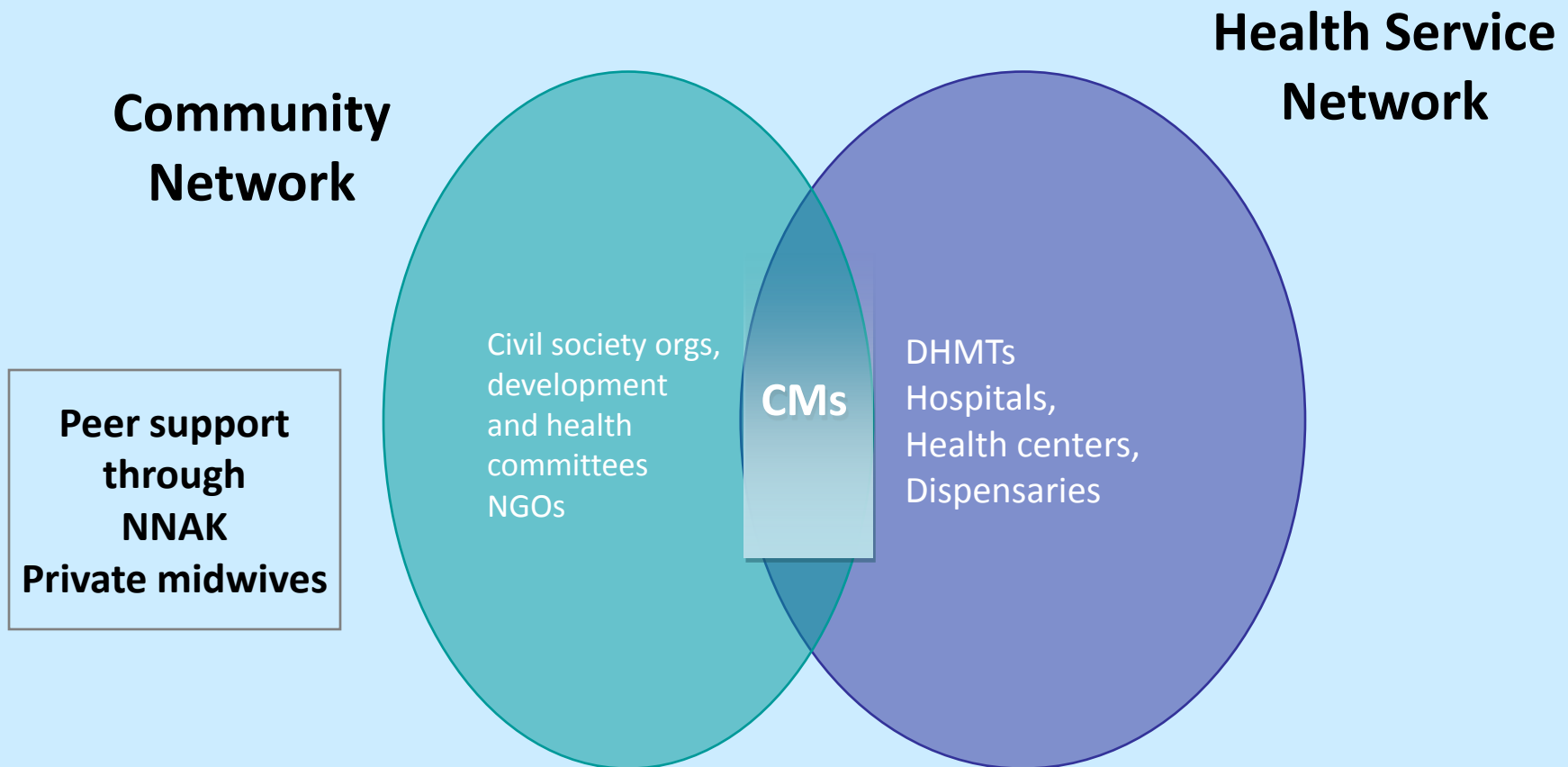
What are the basic CM competencies?

- Care during pregnancy, labour/childbirth and postpartum, including essential newborn care
- Management of obstetric complications and early referral
- Counseling on family planning during pregnancy and the postpartum period
- Knowledge and skills to provide injectables, pills, condoms

Training materials developed with MOH, Kenya



How is the Community Midwife linked to the health care system?



What are the benefits of these linkages?

- The MOH – through the DHMT – provides the CM with:
 - ✓ Equipment and supplies
 - ✓ Contraceptive technology updates and policy guidelines
 - ✓ Commodities (pills, injectables, condoms, gloves)
 - ✓ Reporting forms for community activities
 - ✓ Transport during obstetric emergencies
- The CM provides monthly data reports to the nearest MOH facility
- The CM is the ‘RH expert’ on community health committees

Key findings: Mt. Elgon in 2007

CMs can increase skilled attendance

- Delivering services
- Popularizing facility use

- 9,340 live births
- 13 facilities; 17 CMs
- 10.4% attended deliveries (3.7% in 2003)
- 8.0% facility; 2.4% CM

Can the CM model be scaled up?

- Huge demand for CMs
- CM services recognized and respected by both MOH and community

Challenges:

- Ability to pay; poorest may not have access
 - Can a subsidized voucher system work?
- Can/should communities more actively support CMs?
- Can the MOH contract out these services using public funds?
- Can the MOH sustain this public-private partnership?
- Lack of business skills – training model tested

Potential to provide additional RH services needs testing

- Providing IUD / implants?
- Couple HIV testing?
- PMTCT services?
- ART provision and compliance monitoring?
- TB screening among pregnant women?
- Management of sick newborn?

Acknowledgements

- Nursing Council Kenya
- MOH: Division of RH and Division of Nursing
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- Community Midwives
- Clients