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— Chapter 1 —

RE-ORIENTING THE MIDWIFERY PROFESSION IN KENYA

Amos Getanda

Introduction

The term 'reorient' means to orient after disorientation. Orientation is determining one's position in relation to another. Reorientation requires changing of course or alignment. In order to reorient, there is need to know where you are and where you ought to be. What better way to reorient midwifery in Kenya other than according to international standards?

This chapter depicts how the midwifery profession in Kenya may have suffered decades of disorientation. One would agree with me after a clear debate revolving around the sibling relationship that midwifery has with other health professions, important of nomenclature, the percieved point of disorientation, pearls of widom from Ghana, prossessional growth and requirements for professional growth in Midwifery, midwifery legislation in African countries and current and anticipated developments in midwifery.

A Compromised Sibling Relationship

'Whenever and wherever people coexist they are likely to exert some influence over each other.' These are the very first words Rosemary Mander and Lindsay Reid used when introducing their first chapter-Midwifery Power in their book, *Failure to progress: the contraction of the midwifery profession (Mander & Fleming, 2002).* These authors analyzed the state of midwifery in the United Kingdom (UK) at the dawn of the 21st century.

What other ensample would the introduction into the 'touchy' issue of 'Midwifery in Kenya' without seeming 'divisive'.

The historical phenomenon of midwifery's powerful link with Nursing (and also medicine) is a source of 'professional compromise' (Mander and Fleming, 2002). Simply stated, midwifery is so closely related with nursing so much that midwifery is often overshadowed. This has led to the woes that the midwifery profession has, resulting to lack of growth and development- a failure to progress, a failure to thrive.

Let us be clear here, the professional relationship between nursing, medicine and midwifery is a 'sibling relationship' (Hughes 1995 cited in Mander & Purdue, 2002). In this relationship, midwifery is the looser because the balance of inputs (investment) is oft not in midwifery's favor. I like their choice of word- 'Both our sibling professions…' (refering to nursing and medicine) may have contributed to much to the woes of midwifery regionally and locally- lack of professional autonomy, the midwife's adherence to the medical model and continued medicalisation of childbirth among others. Drawing from this analogy, medicine, nursing and midwifery professions are sister professions. This excerpt from World Health Organisation is categorical and should settle the debate once and for all:

> *'Nursing and midwifery share a number of characteristics and issues that enhance their potential contributions within the health system, although, they are distinct professions with overlapping but complementary roles and scopes of practice. To contribute effectively to quality health outcomes, each profession should have established standards and appropriate regulations to support high-quality evidence-based practice.' (Nursing and Midwifery Services Strategic Directions 2011-2015: pg 5)*

Hence, in Kenya, professionally speaking, midwifery is not a daughter of nursing but a sister- may be a younger sister because of the 'failure to

thrive'. This emphasis is necessary because, historically, Kenya has trained midwives after a nursing training which has made many think that midwifery is a specialty (daughter) of nursing.

In order to be gender sensitive, a Jacob and Esau analogy could also suffice. The Biblical account has it that Jacob and Essau, though being brothers, were not the best of friends. At birth, Esau- the first twin was born looking very distinct. Then came Jacob, who took hold of the Esau heel (Genesis25:26) for reasons undisclosed. Later, the latter is taking away the formers' inheritance. Save all the moral lessons from the story, what is evident is midwifery can be regarded as the first twin (Esau), whose heel and latter inheritance (professional autonomy) would be held by his younger twin- Jacob (Nursing). This may not be the most appropriate analogy but it serves just for illustration.

The Nomenclature

The more important questions that require debate are for example: Is a Community Health Nurse a Midwife? Is an Obstetric Nurse a Midwife. Is a traditional birth attendant a midwife? Better still, cant' we call a community health nurse a nurse-midwife? The answers might allude to the need for midwives. And what is so special about the title 'midwife'?

In pursuit of the answer to such question, let us first allow one Michel Odent- a world renowned Obstetrician, to be our agent *provocateur* too. In his most recent book-*Do we need midwives?,* he avers that the world needs midwives now more than ever. Odent foresees that without midwives, mothers are no longer going to give birth naturally. Hence, the need for midwives is about professional autonomy and preservation of midwifery philosophy. Simply put, the 'midwifery profession' is about values that seek to promote, protect and support natural childbirth. It is more than just a name, even when the name is important.

Reflecting on one encounter, during a breakout session of the 6th Biennial African Midwives Research Network (AMRN) conference in Nairobi in

2007, a senior global UNFPA official, while engaging a local team in an intellectual intercourse on midwifery in Kenya, made it vivid that a name is vital in any profession. She said:

> *if you don't value them, you can't name them; if you can't name then, you can't count them; If you can't count them, you can't invest in them.'*

In other words, male or female, midwives ought to be called, legislated and regulated, employed and deployed with respect to their name- 'midwife'. But then we have an inherent confusion of nomenclature with us. A study in Western Kenya portrays this confusion from the clients perspectives: 'Women in the area refer to the *'mkunga'* (Kiswahili word for midwife)' who serves them in their villages; the traditional midwives call themselves *'mkunga'* and the health professionals in the institutions refer to themselves as *'daktari'* (doctor) or *'muuguzi'* (nurse), but not midwife(*mkunga*). The popular use and title midwife, in this area of Kenya, refers only to the traditional midwife or TBA (Mulimbalimba-Masururu & Dietsch, 2011:324). In other words, our clients only see us as either *'daktari'* or nurse and have reserved the title 'midwife' for the TBAs. So, the person attending to a mother during birth is more often than not referred to as a 'nurse.' The name 'midwife' has been 'swallowed' by the 'other sibling.' Kenyans would therefore hardly tell the difference.

But then, how do we see ourselves? Are we midwives, nurse-midwives or nurses with some midwifery skills? With your answer, if you went to any other country to practice, will you be regarded so? Who have we been training in the name of midwife? These also are concerns that the Kenyan government, the regulator, and training institutions need to ponder about, long after programs have been operational to train 'midwives.'

A Jack of all Trades

Evidently, Kenya resorted to training all-round nurses, presumably, as captured in the history, '…who would work effectively as midwives, bedside nurses and within the community'(Nolte & Kanyotto, 2010; pg1047).

Maybe this figure of speech informed this policy direction- 'a jack of all trades master of none is oftentimes better than master of one'.

Even the designers of the KRCHN program thought that it would have taken 2 years each for every contribution to this 'hybrid nurse'- a total of six years. However, this program was compressed to 3 and 1/2 years. This program would latter provide the blueprint for the Bachelors of Science in Nursing programs that runs in Kenya.

With such a process of compressing a program, compromise is inevitable. After many years of operationof the compressed program, the losers should be discerned. This is a very important question to ask. Though obvious that midwifery has lost, anecdotal information has it that even Nursing would be losing. One senior health official once lamented that 'we no longer have bedside nurses… we have nurses who want to be nurses, managers, midwives... at the same time'. In this case, Kenya Registered Nursing graduates would be given preference for bedside nursing while Kenya Registered Midwifery graduates would exhibit more confidence and competence in midwifery. Therefore, as much as they are also important, community health nurses are truly 'a Jack of all trades but a master of none'.

Pearls of Wisdom from the Ghanaian Experience

In her speech during the launch of Midwives Association of Kenya, Dr Jemima Antwi shared lessons from her home country Ghana, who also were in the same professional trajectory in nursing and midwifery like Kenya. She said, '…My country Ghana was one whichadopted the multi-skilled comprehensive nurse-midwife. This meant that such a trained person could work as a nurse, midwife or a public health nurse at any point in time and be posted to serve as and when required. This alsomeant that nurses and midwives were unable to focus and develop their skills in a particular area in order to build careers in any of these areas. Furthermore, it was challenging to identify cohorts of professionals you could refer to us mentors and preceptors of the professions as skills built over time were lost due to frequent postings to different wards and sites (and changeovers).'

Then she presents the change of trajectory- 'With the advent of the MDGs … focusing on promoting maternal health and reducing newborn death, the role of the midwife became critical and countries began to reflect on the statistics and who they could really call midwives'. And '...though many (in Ghana)had been trained as midwives, very few were truly engaged in midwifery.…- and over 50% were due to retire in 5years. This realization led to a policy change…' Then she presents deliberate measures at policy change that Ghana had to take to revitalize midwifery:

1. Re-introduction of direct entry midwifery training at the diploma level
2. Establishment of Bachelors program in midwifery for direct entry and upgrading.
3. Providing additional education in midwifery for Community health nurses trained at certificate level to enable them practice as midwives. As a result, Ghana graduates about 1000 midwives annually to provide services.
4. Provide direct lines of career pathways have been drawn to get nurses and midwives to develop independently.
5. The Government passed an Act creating positions of specialist in nursing and midwifery on the universal salary structure to recognize the training.

She avers that several other African countries have also in the bid to address theMDGs and the new sustainable development goals (SDGs) have introduced or re-structured their midwifery training to make it directly accessible and also at a higher level. Countries such as Ethiopia, Malawi, South Sudan, Zambia, Uganda, and Liberia have stories to tell on what they have done to improve midwifery and midwives. Today, though these countries cannot say outright that they achieved the set goals for the MDGs, they indeed made significant strides {Denis-Antwi, 2016}. Kenya can also leverage of Ghanaian experience to improve midwives and midwifery.

Professional Growth

It has been a long and hectic process to have nurses and midwives being trained at degree level, even much longer to have masters training locally. Currently, we even have universities offering PhD programs. Kenya has been embedded in this growth so much so that we have even forgotten the important definitions in our professions. Problem, we have only been growing basing on the blueprint of the 'quick-fix' program and not on the 'original paradigm'. It would therefore be necessary to restore the original paradigms of these important sibling professions- nursing and midwifery.

Currently, programs for training midwifery are almost inexistent. The Mater Misericordiae and Kenya Medical Training College stopped its diploma program in midwifery in 2005 and 2006 respectively. Pumwani has also recently resumed training in Nursing and Midwifery. Some private facilities like Aga Khan University also started diploma and degree programs in midwifery.

There is an obvious role of policy in this precarious predicament of midwifery. Evidently, though not the only country in Africa on this trajectory, Kenya lacks clear policy directions at entrenching Midwifery.

Requirements for Professional Growth of Midwifery

The overshadowing of midwifery by the nursing and other sibling professions is an important factor. But the blame rests first on the midwives. The woes are blamed on 'midwife's inactivity in the face of erosion...' (Mander & Purdue, 2002). Growth then requires a crop of midwives who are professionally grounded in their numbers, to employ their professional roles (clinician, change agent, educator, leader, and researcher) to advance midwifery in their countries.

Midwives have to resume control over their profession through appropriate education, legislation, resumption of woman centered midwife-led models of care. Midwives have to radically return their orientation and practice (after having lost focus) through training, leadership and evidence based practice (Mander & Purdue, 2002).

Midwifery Legislation in Africa

Outside Africa, like New Zealand for example, Midwifery legislation is so robust that there even exists a separate Midwifery Council. It would therefore be safer to compare ourselves with fellow African countries.

While analyzing the State of the World's Midwifery (SoWMy) Report of 2014, Kenya is among 19 African countries that lack legislation recognizing midwifery as an autonomous profession. However, this in effect makes us fall in the same league with South Sudan and Somalia, the only countries in Eastern Africa without such legislation.

The table below shows the countries with and without such legislation:

Table. 1.1: Countries with and without midwifery legislation

	Countries With Midwifery Legislation	Countries Without Midwifery Legislation
1.	Benin	Angola
2.	Botswana	Burundi
3.	Bukina Faso	Cameroon
4.	Central African Republic	Chad
5.	Congo	Democratic Rep. of Congo
6.	Cote d'Ivoire	Djibouti
7.	Egypt	Eritrea
8.	Gambia	Ethiopia
9.	G hana	Gabon
10.	Guinea	Guinea Bissau
11.	Lesotho	Kenya
12.	Liberia	Mozambique
13.	Madagascar	Niger
14.	Malawi	Nigeria
15.	Mali	Somalia
16.	Mauritania	South Africa
17.	Morocco	South Sudan
18	Rwanda	Swaziland
19.	Sudan	Togo
20.	Tanzania	
21.	Uganda	
22	Zambia	
23.	Zimbabwe	

Being the only 'big brother' in East Africa without such legislation, effort of regional integration especially in Midwifery will have foreseeable challenges.

However, substantial strides are being made in the entrenchment of Midwifery in Kenya.

Current and the Anticipated Developments in Midwifery in Kenya

An association bringing together midwives has been formed. Midwives Association of Kenya (MAK) was registered by the Registrar of Societies in July 2016 and officially launched by the Cabinet Secretary for Ministry of Health on 11th August 2016 during its inaugural scientific conference in Eldoret. MAK has set out with its three-prong mission: advocate for midwifery as an autonomous profession; strengthen the midwifery profession; and promote midwifery as the standard of care for every childbearing woman. This mission is into translated to various strategic objectives and activities in her ambitious 2017-2021 strategic plan that was launched in April, 2017. Formation of the MAK is perceived as an important step in growth of midwifery in Kenya.

With such an awakening, it is anticipated that current policy, legislation and regulation, education and practice implements will be revisited to appropriately entrench midwifery. Eventually, there are possibilities of changes in midwifery education programs to embrace the ICM standards and introduce direct entry courses. Enactment or review of legislation and policy to entrench midwifery as envisage. Such would include a scheme of service for midwives and a act of parliament that regulates midwifery.

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