

EXAMINING THE ROLE OF PRIVATE MATERNITY SERVICES IN NEPAL, INDIA AND TANZANIA

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Literature Review & Case Study Tool Kit

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ABBREVIATIONS

ACMN	American College of Nurse-Midwives
ANC	Antenatal Care
B/CEOC	Basic/Comprehensive Essential Obstetric Care
CMC	Center for Research in Contraceptive
CS	Caesarean section
DHS	Demographic and Health Survey
EOC	Essential Obstetric Care
FP	Family Planning
IUD	Intra-Uterine Device
JSI	John Snow International
LSS	Life Saving Skills
MCH	Mother and Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MMRD	Maternal Mortality Reduction
MoH	Ministry of Health
MVA	Manual vacuum aspiration
NGOs	Non-governmental Organisations
PFP	Private-for-profit
PNFP	Private-not-for-profit
PSMC	Private Safe Motherhood Care
PSPs	Private sector providers
QOC	Quality of Care
TB	Tuberculosis
TBA	Traditional Birth Attendants
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

1. INTRODUCTION

The maternal and child millennium development goals (MDG) call for a reduction of maternal mortality by three-quarters and child deaths by two-third between 1990 and 2015. It is widely acknowledged that a functioning healthcare system is essential to achieve these aims.

To date, Maternal and Newborn Health (MNH) initiatives have primarily focused on improving skills, resources, and referral systems within public sector services. The private maternity care sector has received little attention. However, in many low income countries, there is reportedly a growth in the non-government provision of maternity and obstetric care, and health sector reform strategies are promoting private and public sector “mixes”. If the ambitious targets set for reduction in maternal and child health are to be reached, the role played by different elements within the private sector, their limitations and their capacity, and their interface with government services in key areas such as skilled attendance and essential obstetric care, all need to be far better understood.

This literature review brings together existing knowledge concerning private (non-government) sector maternity care provision in low-income settings and identifies some key issues for future exploration. It presents a set of tools designed to gather information about private sector provision of maternity care at National or sub-National levels. These tools were simultaneously piloted in three settings, the State of Andhra Pradesh in India, Nepal and Tanzania. Separate reports from each of these pilot studies have been prepared (Ensor & Dey 2003; MacDonagh & Neupane 2003 and Murry & Nyambo 2003). A synthesis report that draws out the key issues arising from this review and across the three settings is also available (MacDonagh, Murray and Ensor 2003).

Section 2 explains the scope of and methods used in the review of the literature. Section 3 provides an introduction to some of the terminology and typologies used in discussion of the “private “ healthcare sector. Section 4 outlines the findings of the literature review on private sector maternity care in developing countries, and Section Five draws out five key areas where further investigation is required. In section 6 examples of existing initiatives in work with private sector providers of maternity care are outlined. Section 7 introduces a “tool kit” designed to assist local study of private sector provision of maternity care, and the annexes contain the pilot-tested tools.

2. MATERIALS AND METHODS

Searches for literature were performed during the second half of 2002 using Ingenta, Medline, Popline, Science Direct, as well as a general web search using the Google search engine. Specific sites were searched including that of World Bank, WHO, Population Council, PHR/Abt Associates, FHI, the Futures Group, and the Demographic and Health Surveys. The review also makes reference to existing related reviews, and to published and unpublished materials serendipitously collected by the authors during the course of this work.

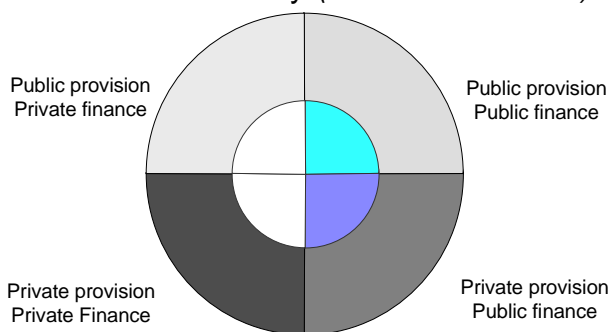
The premise of the Safe Motherhood Initiative is that successful maternal mortality reduction requires intervention of an allopathic nature. We have therefore confined our review to interventions of this type - elements of focused ANC, skilled attendants / attendance at delivery and Basic /Comprehensive Essential Obstetric Care B/CEOC).

3. UNDERSTANDING WHAT IS MEANT BY THE “PRIVATE” SECTOR IN HEALTHCARE

3.1 DEFINING “PRIVATE”

In-depth analyses of health care systems suggest that the boundaries between “public” and “private” sectors are not straightforward. Burchardt et al’s (1999) classification of public and private welfare activity usefully modifies the conventional four-quadrant scheme of the different combinations of financing and provision across the sectors. They add another dimension of the purchasing of services – that of decision-making - which may also be private or public (Fig 1). Even this classification, however, does not fully capture the complex permutations of private beds / wards within public facilities, or care providers who work in dual practice across both sectors (Kean et al 2001).

Fig 1: Classification of public and private healthcare activity (Burchardt et al 1999)



Inner circle – public decision Outer circle – private decision

Where maternity care services are offered within both public and private sectors, women may move in and out of sectors at different stages of their ante/intra/post partum trajectory according to their estimation of the relative costs and benefits at each stage.

3.2 “FORMAL” AND “INFORMAL” SECTORS

Women may also move in and out of the “formal” and “informal” sectors of private care provision. In developing countries, for example, it has been noted that antenatal care coverage tends to exceed delivery care coverage in the formal healthcare system by a considerable margin. In Tanzania, 90% of pregnant women access some antenatal care but only 44% deliver at a health care facility (National Bureau of Statistics 2000). Some women seek delivery care from within the informal sector, most notably with traditional birth attendants (18%). In India the role of both traditional birth attendants (Dais) and unqualified ‘doctors’ is important. A recent study of the latter in two districts of Andhra Pradesh found more than one of these providers for every village. 60% attended deliveries although only 15% have a delivery room (Sharma 2003).

Although the dichotomous terminology of “formal” and informal” sector is often used in the literature, it is not unproblematic either. “Informal sector” care is understood as care provided outside of the jurisdiction of the official health care services and may cover a very wide range of activity and skills, from traditional birth attendants, to the “unorthodox” deliveries that take place in spiritual churches in South-East Nigeria (Etuk et al 1999), to the home deliveries of friends and neighbours conducted by professional nurse-midwives in an informal capacity (Walsh 2001).

3.3 PRIVATE FOR PROFIT AND PRIVATE NOT FOR PROFIT

The terminology private-for-profit (PFP) and private-not-for-profit (PNFP) organisations can be used to distinguish those entrepreneurial concerns for whom profit is the dominant *raison d'être* from those for whom the primary consideration is on delivering a service to the public (Ferrinho et al 2001). However, the few data available usually fail to differentiate between these. PNFP commonly go under the label of NGOs but as Ferrinho et al. points out, the simple classification of NGOs as not-for-profit may sometimes be misleading. In Tanzania, for example, some private clinics paid fees to charitable organisations in order to use their names and obtain favourable tax concessions (Benson 2001). NGO status notwithstanding, they actually functioned as for-profit-organisations.

3.4 DIVERSITY OF THE PRIVATE SECTOR

Private sector provision in many developing countries may encompass hospital level facilities, solo or group practitioners at primary care level, pharmacies, diagnostic facilities, and NGOs including community based organisations that provide some health care within their broader remit (Chakraborty & Harding 2001). Berman et al. 1995 from their analysis of non-governmental health care provision in Zambia distinguish three broad groups of providers on the bases of commercial orientation and ownership: employer-provided services, non-government organisations, and for-profit providers. Within these three groups a larger number of distinct types of providers can be identified. Each of these types varies in their commercial orientation, structure, activity and distribution in different parts of the country. Of these, church missions, for-profit clinics, and TBAs (but, surprisingly, not the flying doctor services) were described as key private providers with potential for a further increased role in the area of maternal and perinatal conditions.

Table 1: Typology of private providers in Zambia (Source: Berman et al 1995 tables 2.5 and 5.5)

Employer-provided	Non-government organisations	For-profit
Mines	Church Missions (moderate current contribution to maternal/perinatal area: 5.4% of deliveries in 1992 & high potential)	Modern formal – private clinics (Low current contribution to maternal / perinatal area & moderate potential)
Other employers	Islamic organisations	– private hospitals
	Zambia Flying Doctor Service	
	Other NGOs – Local NGOs – Foreign NGOs	Pharmaceutical retailers – pharmacies – drug stores – market vendors
		Traditional – herbalists / mang'anga – spiritualists – TBAs (moderate current contribution to maternal /perinatal area: 9.4% of births in 1992 & moderate potential)

3.5 PRIVATE SECTOR PROVIDERS

The term “private sector providers” (PSPs) has also been used more specifically to refer to the individuals rather than the service configurations. For example the definition by Smith et al of “health care providers who work outside the direct control of the state.... PSPs may be formally trained or informally trained; they work on their own or in institutions, and they may

provide health care or other products such as drugs and contraceptive services.” (Smith et al 2001)

The characteristics of these individual private maternity service providers may cover a wide range in terms of legal status, training, facility base, nature and complexity of the service offered, and proportions of time spent in private practice (Smith et al 2001:5). And some parts of private sector provision are likely to be far more visible than others, typically the formally trained and organised (Brugha & Hanson 2000).

4. PRIVATE SECTOR MATERNITY CARE PROVISION IN DEVELOPING COUNTRIES: WHAT IS KNOWN

4.1 COVERAGE OF PRIVATE MATERNITY CARE

For healthcare in general the private sector has an important share of the market. Hanson and Berman estimate, for a sample of 40 developing countries, that an average of 5% of physicians work in the private sector and 28% of health care beds are private beds, 21% private for profit (1998). However, there are wide differences within and between countries and the information remains scanty (Ferrinho et al 2001). Although there are a few country analyses that give some overview of the extent of private health care provision (Berman et al 1995, Centre for Health Policy 1998) these tend to deal with numbers and distribution of private physicians or private beds across all specialities and there is little data available on the maternity sector specifically.

There have been two main approaches used in an attempt to quantify private sector provider involvement in maternity care. The first is a community level survey of users in order to ascertain what proportion of deliveries or of signal functions of antenatal care are attended to in the private sector. Berman and Rose (1996) conducted an analysis of eleven DHS surveys in order to obtain information on the use of private providers in MCH and FP services. Within these five countries they found information on usage of provider patterns for maternal tetanus toxoid vaccination (Bolivia, Guatemala, Botswana, Sudan and Uganda), one - Uganda -reported significant private provision of this service (20% in the 1988/9 DHS).

Four of the eleven DHS surveys contained questions regarding delivery in the public or private sectors. The question only concerned identification of location of delivery (public facility/private facility/home/other), and not whether the care provider attended the birth in a public or private capacity, nor whether the organisations were PFP or PNFP. In three of the four countries with location of delivery data (Bolivia, Indonesia, Morocco, Tunisia) home births accounted for over 50% of the births in the previous 5 years. The estimated proportion of deliveries occurring in private facilities was 10.4%, 11.5%, 4.6% and 4.2% respectively. Berman and Rose (1996) conclude that private providers of one kind or another (ranging from TBAs to nurse-midwives to doctors) would seem to be the dominant source of birth attendance in many developing countries. Intra-regional variations are apparent however. In India the private for-profit sector accounts for around 47% of institutional deliveries (Peters, Yazbeck et al., 2002). Estimates in Andhra Pradesh suggest that more than 41 percent of women deliver in the for-profit sector while a further 22 percent deliver at home usually with the assistance of a 'private' TBA (IIPS/Measure_DHS+, 2000). However, in neighbouring Nepal where the overall institutional delivery rate is very low (9%) only 1% of women deliver in a private for profit facility (Nepal DHS 2002).

The second approach is to ascertain the proportions of practitioners working in each sector. The 1998 technical report to the South Africa Health Review is one of the few to study the private-public sector breakdown by speciality: showing 75% of the 764 anaesthetists and 65% of the 636 obstetrician gynaecologists to be working in private facilities. Overall, 29% of hospital beds were in the private sector (Centre for Health Policy 1998). Most of the more detailed studies concerned with private sector work relates to the activities of medical doctors. Far less is known about other healthcare practitioners (e.g. midwives) in this regard. Even in a country with relatively sophisticated data sources such as South Africa, the number and distribution of nurses working in the private sector is hard to ascertain. The South African Nursing Council does not collect this information and unlike with doctors, there is not a single dominant representative association in a position to collect this data. One Central Statistical Service survey conducted in South Africa in 1990 showed that private sector institutions

overall employed 26.1% of all fulltime nurses, 24.2% of enrolled nurses and 30% of auxiliaries

While there is little documentation available on the social and geographic distribution of private sector providers of maternity care, the impression is one of uneven spread across populations with a high concentration of formal sector private providers in dense urban areas with richer populations. In the Philippines, in the early 1990's, private professional providers assisted 34% of urban deliveries and 7% of rural ones in the early 1990s (Schwartz et al 1993). There is some evidence from Tanzania to suggest that where the private sector has expanded, people living in highly populated areas are given greater choice, that but people living in peripheral areas tend to remain underserved (Benson 2001). However the extent to which this is the case may vary according to type of provider. While specialist obstetricians are almost universally to be found in large urban centres, general doctors who have some obstetric skills might be found in smaller towns, particularly once saturation of the private health market for their skills has been reached in the major centres. Nurse-midwives may be more evenly distributed in smaller communities. Of 134 private midwives taking in part in family planning workshops in Ghana, for example, two-thirds had maternity homes in urban areas and one third in rural areas (McGinn et al 1990). Most had always practised in the same community. Where skilled attendants are unavailable or inaccessible lower level cadres of health care staff as well as TBAs may sometimes be providing some sort of midwifery services.

4.2 PROVIDERS OF PRIVATE SECTOR MATERNITY SERVICES

There is some indication that staffing patterns in private sector maternity facilities may be quite different from the public sector. The private sector tends to be "top heavy" with doctors performing many functions performed by nurses in the public sector. These are partly due to the reimbursement practices in the for-profit private sector, which tend to be reinforced by insurance schemes. Whereas public hospitals allocate attendance of uncomplicated deliveries to midwives, and have obstetricians manage only complicated cases, private obstetricians are required to attend deliveries themselves (Centre for Health Policy 1998). Aljunid and Zwi (1996), in their study in Malaysia found that private clinics were run by older doctors, with more experience but these were supported by less well trained staff than doctors in the public sector. A study of private sector medical care in the Greater Accra region of Ghana found that 86% of the doctors working in private practice (in their survey) were over 45 years old, and suggests that in this setting many specialists enter private practice only after retiring from the public sector (Obuobo et al 1999). However, patterns vary widely and have considerable implication for professional updating in the private sector.

In many setting dual practice is commonplace, where the proportion of public sector providers also work in the private sector. The reasons for dual practice include inadequate income in the public sector; income earning opportunities in the private sector and the regulatory framework (Jan 2003) and may lead to the neglect of public sector commitments (Ferrinho et al 1998). Jan (2003) notes that as the boundaries between public and private practice become blurred there are potential two forms of adverse incentives: to misappropriate public sector resource and to divert patients into private treatment. However, there is no documentation on the specific impact of such working practices on maternity services.

4.3 WHO IS USING PRIVATE MATERNITY CARE AND WHY?

Ferrinho et al (2001) suggests that the reason to seek private care in urban areas is often one of accessibility and convenience. They cite country studies from Malaysia, Mexico and Tanzania that suggest that private services may be used because they are more accessible in terms of the flexibility of their clinic schedules, their operating hours, and their geographical location. PFP and NPF providers tend to have high comparative advantage in terms of their client-friendliness and the more personalised nature of the service.

When Bloom and Standing (2001) reviewed the literature they found no consistent pattern emerging. A number of factors influence choice of provider, including historical patterns of use, convenience, opportunity costs, availability, severity of illness, perceived quality of service, staff attitudes, gender, age and status.

Pritze-Aliassime (2000) suggests that in communities where women prefer to deliver at home, private providers may be able to satisfy an important demand for care provision. Walsh's (2001) study in Northern Nigeria bears this out, suggesting that nurse-midwives are unofficially providing these services within the Moslem community. The extent of such informal service provision in different settings is not well documented and there is little information upon which to estimate its significance, or its future potential.

Some studies have looked at the relationship between socio-economic status and use of private health care providers. Brugha and Pritze-Aliassime report on DHS data, broken down by wealth quintile, from five large low and middle income countries (Brazil, Kenya, India, Egypt, Indonesia). In all countries, coverage of the private sector for delivery care increased across the wealth quintiles with the wealthiest most likely to use private maternity care. Between 10% and 15% of all deliveries took place in a private facility; this ranged from 30% in Kenya to 42% in Egypt in the highest socio-economic category (Brugha and Pritze-Aliassime, 2003). Analysis of the 1996 Tanzania Demographic and Health Survey indicates that 3.3% of respondents used private sector maternity care at that time, with 2.3% of the poorest quintile and 4.7% of the richest quintile having their labour and delivery care from some sort of private formal sector providers. (www.worldbank.org/hnp). Surveys in Andhra Pradesh indicate a steep gradient between use of private for-profit facilities and income with more than 70 percent of the wealthiest third of the population using these facilities for delivery (IIPS/Measure_DHS+, 2000). Yet even among the poorest third more than 13% delivery in a private facility.

5. COSTS AND FINANCING ISSUES

Total costs of accessing care undoubtedly play a role in decision of where or when to access services. User costs can be divided into three components: official service cost, unofficial costs and non-service costs. Public services often have lower official service costs than non-government providers. On the other hand the unofficial costs (under-the-table payments) may be significant. Non-service costs include the cost of transport and time given up to obtain services.

In India several studies have observed willingness to pay relatively large sums for private services even where free point-of-delivery public services exist. In Madras, for example, Muraleedharan (1999) found strong demand for private services in slum areas even though the cost of services was no less than in more affluent suburbs. Generally evidence suggests that women are willing to pay significantly more for private service because of the perception that quality of services is superior to that obtained in public facilities.

There are relatively few studies that consider the comparative costs of public and private maternity services. One study undertaken in Malawi (Levin et al 2000) found that with the exception of the paying ward in the public hospital in Malawi, the costs to clients of using maternity care were higher at the mission facilities than at public facilities, either because of higher user fees or higher transport costs. This difference was particularly large at health centres since fees for service were lower at public health centres. In countries where formal charging arrangements are present public-private official price differential tends to be lower. Some data was also collected on private midwives fees in Uganda and Ghana. Their fees were close to the total unit costs. They were often higher than those fees charged at health centres and more comparable to those at public hospitals (mean \$7.8 and \$8.99 respectively for a vaginal delivery) (Levin, et al. 2000).

A comparison of formal charges does not give the whole picture of costs to the user. Many health facility workers also operate informal user charging to patients using public sector services. A study from Uganda in the mid-1990s found informal charges for maternity services to be high, commonly \$US5 for a normal delivery at a primary level facility and reaching levels as high as \$US200 for cases of obstructed labour at a district hospital, once the range of charges levied by different health workers for different services were included (Ssengooba and McPake 2001). In Bangladesh, one study reported that the hidden costs of 'free' maternity care at government facilities in Dhaka were unaffordable for 51% of users interviewed and, of these, 79% had to borrow from a moneylender to pay these hidden costs (Nahar and Costello 1998). Recent unpublished evidence in Dhaka study found that, when official and unofficial charges are included, that the cost of a delivery in a private medical college was only 13 percent higher than in a public medical college. In addition the private facility scored higher across a range of quality indicators including behaviour of staff, information on contraception, advice on exclusive breastfeeding, cleanliness and quality of food¹.

Other costs are sometimes included in comparisons of costs. These may include transport, costs of time away from work or household duties, including the time of any household member accompanying the woman, and can be vitally important within the context of a fragile household economy.

¹ Conducted by Dr Masuda Mohsena, Gono University, Dhaka in 2001. This was a small (unpublished) study last year of user costs and perceptions of quality amongst 60 patients attending for normal delivery for private and public care.

For a variety of reasons there is relatively little information on the relative cost-effectiveness of the government compared to the non-government sector. Where information is available it is mostly in the form of a unit cost or cost-minimisation analysis. Levin et al's study in Malawi, Ghana and Uganda compared the costs of services in public and private facilities (Levin, et al. 2000). The study found no clear pattern with higher costs in the mission hospital than the public hospital in Uganda, but the reverse in Ghana and Malawi. Estimates in Bangladesh suggest the cost of a private MCH bed-day in a private hospital is around 66 percent higher than a bed day in a public tertiary facility (Begum, Hossain et al. 2001). The cost of an outpatient visit was however lower in the private facility.

A recent systematic review of the costing of maternal health services in low and middle-income countries also provides mixed evidence on relative cost-effectiveness (Borghi 2001). Overall very few studies reported information on the private sector. Costs of normal delivery services in Argentina were generally found to be higher in hospitals compared to private nursing homes - a result probably influenced by the generally higher-level staff providing care in government facilities. In contrast Ghana and Uganda the costs of mission facilities appear to be lower. In general these studies do not adjust for outcome and while the estimates are for a similar intervention (e.g. normal vaginal delivery) the complexity of the case or relative history of the patient is generally not recorded.

It is important to consider the role of incentives in encouraging certain patterns of maternity care. The impact of the method of payment on the provision of services is well established in the broader literature (Ensor and Witter 2000). In general fee for service or fee per patient systems encourage higher levels of activity than either salary or capitation methods. Salary or budget based payments are generally associated with the public sector while fee for service or fee per patient is more commonly associated with private care. In India, for example, one study found that around 70 percent of private providers used fee for service while the remaining 30% based payment on a consolidated case based system (Bhat 1999). The latter is preferred to the extent that it gives patients more certainty over the final cost of services provided.

A key issue is the extent to which the typical private sector provider over- or under-delivers services relative to the needs of patients as a direct result of its private sector (for profit) status. In many countries, for example, there are often few incentives to provide low cost services such as antenatal care. Instead private practitioners can make more money from curative services and prescribing. In India a social marketing NGO Janani has addressed this problem through a contract with accredited private practitioners that pays a commission for referring patients to urban clinics. In return these practitioners must deliver the low cost and less profitable services (Peters, Yazbeck et al. 2002).

Voucher schemes are suggested as one way of giving purchasing power to users to obtain desired types of service and have been used in other areas of reproductive health care with some success (Pearson 2001). A voucher scheme set up for the very poor to finance MCH care in Yunnan Province, China (Kelin, Kaining et al. 2001) in which vouchers can be used to pay for routine ante and postnatal care, hospital delivery, first aid for severe obstetric complications and medical treatment for infants under three months.

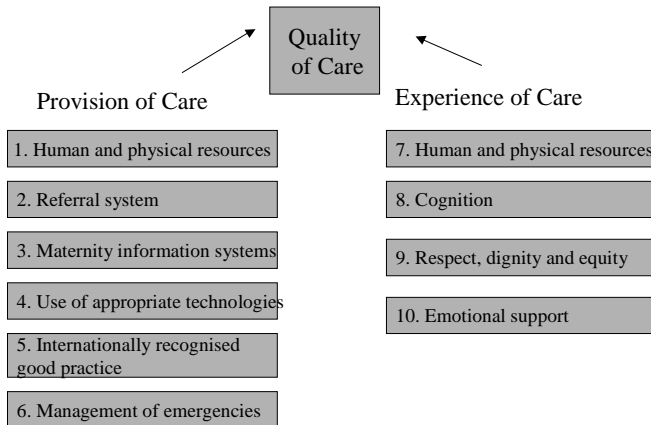
An insurance approach that allows women to select health care facilities is gaining in popularity in some countries. The advantage of the insurance approach is that through specification of entitlements together with careful accreditation of public and private facilities able to offer services financed from insurance, control can be maintained over the type and quality of care and also the referral paths. India has a scheme for civil servants and also a growing number of NGO managed community schemes. Ssengooba and McPake (2001) reported that most of the Ugandan pilot schemes link to NGO hospitals and have included antenatal care and delivery care in the services packages, with delivery services coverage

conditional to a specified minimum of three antenatal care visits made by the mother. However, the cost of treatment for maternal complications such as instrumental delivery and post abortion care were not covered. In one hospital the community insurance scheme introduced coverage for caesarean sections by providing 50% of the hospital costs, but when their report was written there was not enough data to assess impact on access to maternity care (Ssenooba & McPake 2001). Ugandan government policy is to collaborate with non-governmental sectors in the implementation of sectoral programmes, and hospital-based NGOs providing services in under-serviced area have been assisted with grants to make their services available to the poor. However, this financing has yet to be tagged to incentives to improve maternal health services specifically for example fee waivers for expensive EOC procedures such as caesarean section (Ssenooba and McPake 2001).

In other countries there are some examples of public-private partnership projects that have been established that are attempting to introduce demand side community funding to encourage private practitioners in the area. One such project in Bangladesh is attempting to develop a network of private village doctors that are linked to the public facilities and eventually financed through a community pre-payment scheme (PPP website: <http://www.ppp-bangladesh.org/index.htm>).

6. QUALITY OF PRIVATE SECTOR MATERNITY CARE

Fig. 2 Expanded Quality Assessment Framework, Hulton et al.



It is recognised that the expectation of better quality ‘experience of care’ is a key reason in choice of provider (Hulton et al 200). It is probably the case that interpersonal care aspects of QOC in the private sector are superior to the public sector and may be a significant influence upon choice of maternity care provider. PNFP services e.g. mission hospitals have generally had a reputation for competent technical quality also. However, in general knowledge on private sector “provision of care” aspects of QOC is less clear. One study in India found that around 80% of cases of septic abortion had been carried out in unauthorised establishments (Chabra and Nuna, 1993). Although such practice is commonplace there are no standards in place to regulate quality due to the unauthorised nature of the work.

Drug shops are a frequent early point of contact for medical care in Nepal. Kafle et al (1996), using mystery clients, found that such drug retailers (including those who had had training about pharmaceuticals) demonstrated little evidence-based knowledge when asked for advice for anaemia in pregnancy. In addition, knowledge of referral criteria was poor and drug recommendations frequently included vitamins and tonics that were inappropriate for pregnancy-related anaemia. It is likely that self-treatment, using drugs purchased from medicine shops, for pregnancy problems such as anaemia and malaria is common. This may be particularly true for lower income women and it is highly possible that the technical quality of treatment, advice and referral is poor in such settings.

It is increasingly common to see high caesarean section rates² in private sector facilities (Chanrachakul et al Thailand; Matshidze et al South Africa; Mishra and Ramathan India; Murray Chile; Potter Brazil) but with little evidence to suggest that these were conducted as life-saving procedures (Price and Broomberg 1990). Fee-for-service reimbursement of doctors and or time management concerns tend to lead to increased intervention in labour and delivery care, often manifested in higher induction and caesarean section rates (Price & Broomberg 1990, Murray 2000). When obstetric intervention is used for non-medical reasons there is risk of increasing maternal mortality and morbidity due to risks inherent in the procedure. Much of the existing literature comes from middle-income countries, but considerable anecdotal evidence suggest that this pattern is also being repeated in urban

² Footnote re CS Rates (facility)

centres in low income countries, and the issue requires further exploration in such settings. Encouragingly McCord et al found that a network of private clinics linked to a voluntary low cost hospital was providing appropriate and effective emergency obstetric care, including caesarean section, in rural Maharashtra, India (McCord et al 2001).

7. INTERACTION BETWEEN LEVELS OF PROVISION – MATERNITY REFERRAL SYSTEMS

Referral is one of the ten elements in the Hulton et al quality of care framework. Because access to EOC is such a key component of Safe Motherhood strategy, and may require referral into or out of the private sector, it merits particular consideration in understanding the contribution of the private sector maternity care to maternal and newborn wellbeing. In some settings private facilities may possess an important proportion of the EOC facilities. Here the point of enquiry needs to be about their usage and accessibility in emergency situations. Pritze-Aliassime in her 2000 review could find no study that assessed the contribution of the private sector in terms of coverage, distribution and utilization of EOC. One subsequent study from India presents an interesting picture of a network of private clinics with a voluntary hospital in rural Maharashtra apparently succeeding in achieving effective emergency obstetric care at very low per capita cost (McCord et al 2001).

In other settings small-scale private providers may be reliant upon the public sector facilities when obstetric emergencies arise. In Uganda for example, the private sector has tended to avoid investment in costly care options such as emergency surgery (Ssengooba and McPake 2001). However, little has been documented about the referral mechanisms used within the private sector in general. One study that has explored this in the context of private sector medical care as a whole is Obuobi et al (1999)'s case study in Greater Accra, Ghana. Obiobi et al surveyed 100 randomly sampled registered members of the Ghana Society of Medical and Dental Practitioners, the professional organisation for doctors working in private practice in that area. Of the 69% who responded, 61% worked in solo practice and many offered obstetric services as part of their practice. 59% of respondents provided antenatal care, 49% post partum care, and 35% delivery care. The report does not provide details specifically on their obstetric referrals though 55% of respondents said that their clinics formed part of a referral network. They reported they received referrals from other private clinics, from government hospitals, from churches, from pharmacists, from traditional healers and from laboratories. 44% of respondents reported that they referred cases to public hospitals.

The same study carried out a focus group discussion with a group of private midwives who worked in solo practice and operated maternity homes, averaging 12-15 deliveries per month. This group of midwives reported difficulties with MOH public providers who sometimes refused to cooperate with them with referrals. Anecdotal evidence from elsewhere in Ghana suggests that an unwillingness to accept responsibility for private sector problem cases may even distort the official records of maternal deaths in public sector hospitals, and indicates that data collection on private – public sector referral may be far from straightforward³.

³ G. Kumah personal communication reporting findings during maternal mortality verbal autopsy study carried out for MSc dissertation Institute of Child Health (UCL) 2002

8. THE CHANGING REGULATORY/POLICY ENVIRONMENT

In many countries nurse-midwives who provide private childbirth care services to neighbours and friends have not been permitted to set up private practices officially. National level regulatory frameworks often function by limiting competition and providing opportunities to favoured groups – principally this has been to doctors who have often been the sole group with the right to private practice (Bloom & Standing 2001). Regulations in most countries allow dual working for medical practitioners and anecdotal evidence suggests that most obstetrician-gynaecologists have private clients. Although it is accepted that this may interfere with their availability to the public sector, it is also often seen as a necessary mechanism enabling retention of medical staff within the public sector services (Gruen et al 2002).

Where health sector restructuring has been undertaken the picture can be a rapidly evolving one. In Zimbabwe in 1993 for example, only about 3% of health services were provided by the PFP sector. By 1996 about 45% of registered doctors were estimated to be working full time in the private sector, 56% of whom were based in Harare. In this case the growth in the private sector had been aided by the increase in the number of people taking up private health insurance, (Kumaranayake et al 2000). In Tanzania after the prohibition on private medical practice was lifted in 1991, there was a 36-fold increase in the number of PFP dispensaries and a 5-fold increase in the number of for-profit hospitals (Munishi 1997)

Midwife and nurse-midwife activity in the private sector has tended often to have more restrictions placed on it. There have been changes in government policies in a number of African countries (eg Tanzania, Zimbabwe, Uganda, Zambia) during the 1990s that have opened up the possibility of official private practice to midwives. In Indonesia, where great efforts have been made to place “one midwife in every village” , some 56,000 young midwives were placed on 3-year contracts between 1991 and 1997 and then encouraged to go into private practice to support themselves when that contract expired (Geefhuysen 1999).

Some of the “grey” literature on important aspects of the policy and regulatory environment may only be found locally. We found no specific published information from developing countries on quality assurance mechanisms for private sector maternity care, for example, nor on the degree of comprehensiveness of data collection from the private sector for Health Management Information Systems. Yet both of these would be important for the linkage of private sector activity into Ministry of Health policymaking and standard setting.

9. EXISTING INITIATIVES TO WORK WITH PRIVATE SECTOR PROVIDERS OF MATERNITY CARE

There have been a number of pilot initiatives, mainly supported by USAID funding, that attempt to encourage private maternity care provision and to strengthen or extend the skills of private providers. They fall into four main categories:

9.1 SCHEMES TO HELP PROVIDERS SET UP AND RUN PRIVATE PRACTICES

Examples: with USAID assistance between 1995 and 1999, the Indonesia Midwives Association set up a Revolving Fund Loan and Entrepreneurship Training through project PROFIT which focused upon establishing private midwife-provided Family Planning services, covering 1,113 midwives in 5 provinces. Although there was a target of 20% only 5.6% of borrowers were village midwives (www.cmsproject.com). In the Philippines, the USAID-funded TANGO II helps to establish and operationalise midwife-owned Family Midwife Clinics. At the end of 2001 some 190 of these clinics were providing basic MCH services and were supervised by 8 partner NGOs (www.jsitango.com/abouttango2.html). In Cambodia, the USAID-supported RACHA programme piloted a loan scheme for midwives to buy motorcycles (www.engenderhealth.org/otf/midwives.html). MAPS included business management skills and advice on setting up private practices in its work in Zimbabwe and Uganda.

Also in Uganda, the Market Day Midwives project, a joint effort between SOMARC (Social Marketing for Change), and the Uganda Private Midwives Association set up midwives in community markets as a distribution system for family planning, SOMARC provided each midwife with a sales booth, training through SEATS (Service Expansion and Technical Support) and a uniform, and sold the products to midwives at wholesale prices (Futures Group International 1995). Then, in January 2001, the Summa Foundation created a USD175,000 revolving fund to provide micro-credit to private health care providers (Nurses, midwives and doctors) to expand or improve their practices. CMS Uganda (Commercial Market Strategies) provide training in business skills, marketing and credit management alongside this, and have produced a Business Handbook for Private Health Providers. The three-year USAID funded project is expected to provide training and finance to 280 private healthcare providers (www.cmsproject.com/country/africa/uganda.cfm?view=normal). In Kenya the Futures Group Europe also initiated a small network of 38 private sector market-day midwives to provide a range of reproductive health care advice and services. In this case, as well as free contraceptive and vaccine supplies, the MoH supplied the midwives with free bednets and malaria treatment, with the sale of the bednets serving as a revolving fund for the midwives (www.fgeuropoe.com/site/mdmken.asp).

Such projects seem to have potential but are generally small scale and the long-term sustainability once donor project funding has ended is unclear. These types of pilots have tended to focus on the low technology end of activity e.g. ambulatory care and family planning. Little has been focused upon encouraging the development of private facilities providing EOC.

9.2 SUPPORT TO PROFESSIONAL ORGANISATIONS AND NETWORKS

Examples: during the second half of the 1990's the USAID-funded MAPS (Midwifery Association Partnerships for Sustainability) initiative -a special initiative of SEATS II implemented by JSI and ACMN- worked in capacity building of midwifery associations and their members in 7 countries, developing sub-projects in four: Senegal, Uganda, Zambia and Zimbabwe. These increasingly focused on midwives' growing private sector activities. More

recently, CMS has provided technical assistance to the Uganda Private Midwives Association in the areas of marketing, the creation of income generation activities, management guidance and financial oversight for the UPMA clinic in Kampala, and the establishment of a group purchasing plan for FP commodities (www.cmsproject.com/country/africa/uganda.cfm?view=normal).

In 1997, UNICEF facilitated the creation of a Private Midwives Association in Bari Region of Somalia (North East Zone), and signed an agreement for the delivery of immunisation and other MCH services, including the provision of antenatal care through the association (UNICEF Somalia 1997).

9.3 TRAINING INTERVENTIONS TO IMPROVE CLINICAL SKILLS AND TO EXTEND PRACTICE AREAS

Examples: PROFIT (Promoting Financial Investments and Transfer to involve the Commercial Sector in Family Planning) piloted a training programme for private physicians, pharmacists and nurse-midwives in safe and effective use of contraceptives in Zimbabwe and Romania in the mid 1990's (Deloitte & Touche Tohmatsu International 1997). In Ghana there have been several small-scale skills training initiatives with private midwives. At the end of the 1980's USAID funded an initiative by the Ghana Registered Midwives Association, with technical assistance from the American College of Nurse-Midwives, to include FP within the routine services offered by midwives in their private practices. In the later half of the 1990's training in Post-Abortion Care, including the use of manual vacuum aspiration (MVA) was provided to private midwives in Ghana through the Ministry of Health, the Ghana Registered Midwives Association and the USAID-funded PRIME initiative (Billings et al 1999). IPAS has also provided PAC training to private midwives in Kenya in an 18-month training project (www.intrah.org/nairobi/kenyapac.html).

In Cambodia in 1995, RACHA (the Reproductive and Child Health Alliance), working under the auspices of USAID, began providing LSS (Life Saving Skills) training to midwives who work both in government health centres and after hours in private practice domiciliary care (www.engenderhealth.org/otf/midwives.html). In Uganda, Family Care International has worked with the Uganda Private Midwives Association to provide training for its members in provision of "youth friendly" reproductive health services (www.familycareintl.org/work/work_aaugandaw.html).

9.4 SCHEMES TO IMPROVE ACCESS TO PRIVATELY PROVIDED CARE

Examples: pilot schemes in community health financing have been tried in a number of countries. In Uganda, the largest was the Health Financing project supported by DFID. Ssengooba and McPake report that most of the Ugandan schemes link to NGO hospitals and have included antenatal care and delivery care in the services packages, with delivery services coverage being conditional to a specified minimum of three antenatal care visits by the mother. However, the cost of treatment for maternal complications such as instrumental delivery and post abortion care were not covered. In one hospital the community insurance scheme introduced coverage for caesarean section by providing 50% of the hospital costs, but when their report was written there was not enough data to assess impact on access to maternity care (Ssengooba & McPake 2001).

In Uganda, the government policy is to collaborate with non-governmental sectors in the implementation of sectoral programmes, and hospital-base NGOs providing services in under-serviced area have been assisted with grants to make their services available to the poor. However, this financing has yet to be tagged to incentives to improve maternal health services specifically for example fee waivers for expensive EOC such as caesarean section procedures (Ssengooba and McPake 2001).

In Andhra Pradesh where a contracting approach is being used to extend a 'comprehensive basic package' to the poor through both private and public facilities (Nanda, 2001). This will pay an annual capitation fee to accredited public or private facilities to look after the health care needs of people living in (target) poor rural areas. The project will establish a system of accreditation for facilities. Standards must be met and maintained in order to be financed under the scheme.

10. CONCLUSION, SOME KEY ISSUES

Although the literature is sparse it is sufficient to indicate that use of the private sector for various elements of maternity care may be significant and is probably widespread. It will therefore be important for consideration to be given to how existing and potential strengths of the private maternity sector can be engaged with to meet public health priorities and how the limitations or risks inherent in private sector maternity care can be minimised. In order for these questions to be addressed some key areas require greater understanding and analysis than currently exists.

The first is **the social and geographical coverage of private maternity care**. Despite the potential for private midwives to act as skilled attendants, and for private facilities to provide B/CEOC, there is **a lack of evidence about who uses different types of private sector care and the reasons/motivations for this**. There is very little information available on maternity service provision at the less costly end of the market. Anecdotal evidence suggests that the poor may use some aspects of private sector maternity care e.g. medicine shops, low cadre health service personnel working in the private sector informally, solo practitioners, more than others e.g. private hospitals. Their treatment from providers may be also be different due to bias around social status. Greater understanding of the health seeking behaviour and experiences of the poor in relation to private sector maternity care is needed in order to understand not only the overall contribution of private sector maternity care to maternal mortality reduction but also any specific impact on the poorer section of society.

Secondly, **improved understanding of the staffing patterns and working practices** (particularly in terms of which cadres of staff perform particular tasks) in the private maternity sector is required to understand how regulatory and financing mechanisms may impact upon maternity care provision. Such knowledge could also assist in developing rational plans for private provider continuing education.

Thirdly, here are **key concerns around technical aspects of quality of care** and in particular the contribution that the private sector may make toward skilled attendance at delivery, and the capacity of facilities and providers to provide EOC. Parallel to this, the frequently observed tendency for over-medicalisation in private maternity care is of great concern. Much deeper knowledge in local settings is required in order to understand the dynamics behind this and to be able to put in place interventions (e.g. supplier side regulation and/or incentives; community insurance approaches involving accreditation of facilities and control of service quality, and consumer education and protection) that may help to minimise the risk that private sector practice will increase, rather than avert, maternal morbidity and mortality.

Fourthly, although there is widespread understanding that many private providers also have a public sector job, little analysis is available on the **impact of dual practice on the public sector**. Asimwe and colleagues' work on the private sector activities of public sector workers in Uganda alerts us to the general importance of this issue, but it is yet to be fully investigated just how public sector midwives' or obstetricians' behaviour and practice within the public sector are influenced by their private practice role (e.g. times worked, recruitment of private clients for delivery through ANC contact, leakage of supplies/drugs, attrition or retention). Equally it is unclear if skills and capacity building of maternity care providers through public sector programmes impacts on changing practice in the private sector.

Fifthly, there is still **much to be understood about the interlinkages and interface between public and private contributions to maternity care**, and the extent to which in any given context the private sector's principle role is one of *filling gaps*, *occupying niches* or *poaching* (Ferrinho et al. 2001). The interlinkages, particularly those between public and for-

profit sector are rarely planned or formalised. Particularly vital for Safe Motherhood and newborn care is the question of the role of the private sector in provision of, and referral to, EOC facilities. The little evidence available indicates that referral in cases with complications tends to be based on informal arrangements, and is often (but not always) from the private sector to the public sector. Given the critical nature of rapid and appropriate first aid and referral in the event of an obstetric emergency it will be essential to improve understanding of the dynamics of such referral systems, and to give practical consideration to how these can be maximised.

11. ANALYSING PRIVATE SECTOR CONTRIBUTION TO MATERNITY CARE IN A SPECIFIC LOCAL OR NATIONAL SETTING: A CASE STUDY TOOLKIT

Annexes 1 to 3 present a set of tools that have been developed and tested to assist analysis of the private provider contribution to maternity service provision in a particular national or local setting. These tools assist the investigator in providing an structured overview of allopathic private sector provision of maternity care in a given setting, using a mix of secondary and primary data sources.

In advance of a study of this type permission should be sought from the relevant authorities and joint decisions made on the size of the study and focus areas for study (e.g. geographical capital city, rural or urban and subject area e.g. as per the areas outlined in 7.1 below).

11.1 STEP A: LOCAL LITERATURE REVIEW

The first step in this process is to review and collate existing knowledge. Annex 1 presents a framework for reviewing available literature with reference to the key questions identified in the conclusion section of this report. Seven key areas for consideration are provided in column 1 of the framework:

- Area 1: Coverage of private maternity care
- Area 2: Regulatory and policy environment
- Area 3: Private providers
- Area 4: Service Costs (efficiency and cost effectiveness, and costs to user)
- Area 5: Quality of care
- Area 6: Interaction between levels of provision: maternity referral systems

Investigation of these areas will assist in analysing issues raised in the final two areas of the framework:

- Area 7: Impact of private sector provision on public sector resources
- Area 8: Likely impact on health outcomes for mothers and infants at population level

Sub-areas for which data can be collected are given in Column 2. Column 3 gives illustrations of the type of instruments that may be used to gather this data, and Column 4 gives examples of their use.

The second framework presented in Annex 1 assists in analysis of data on utilisation patterns of privately provided 'marker' maternity services, which can be applied within Area 1 (coverage of private maternity care). Data may be found from a range of sources, most commonly in DHS reports for the country.

11.2 STEP B: DATA COLLECTION THROUGH INTERVIEWS, CHECKLISTS AND REGISTER REVIEWS

Annex 2 provides a set of questionnaires for gathering data on the private sector maternity services at a country or local level. Sections of the questionnaire relate to the 'areas' identified in the matrix in Annex 1, though they are presented in a slightly different order to allow a logical flow of questions. Separate questionnaires have been designed for each of the five key informant groups:

- ⇒ Policy makers – MOH, regulatory departments/ministries, regional/state health departments, associations of private providers, professional associations.

- ⇒ Donors/INGOS – engaged in health sector reform and/or working with the private sector.
- ⇒ Managers and/or owners of private maternity services/facilities. Parts of this questionnaire can also be used with the senior managers of public referral level maternity services.
- ⇒ Practitioners of maternity services in the private sector.
- ⇒ Women who have recently (in the last 12 months) had a baby and who are users or non-users of private facilities.

Whilst many policy makers will need to be accessed in the capital city a decision will need to be taken on other geographical areas of focus for the study. This should be done in collaboration with policy makers and/or the studies final audience. Decisions need to be pragmatic, for example in the pilot study in Nepal the relevant department with responsibility for implementation of the National Safe Motherhood Plan set up a steering group to guide the study. This steering group advised that study areas should be outside of the capital city and encompass both hill and terai (flatland) geographical areas. They also advised that given the paucity in knowledge that all subject areas should be investigated. However, in Andhra Pradesh local DFID advisors suggested that carrying out the study in slum areas and a concentration on the regulatory and policy environment would be of most use to fill gaps in knowledge about the PFP sector.

Once the areas of study have been clarified investigators should visit these locations. With the assistance of local people e.g. in the pilot study in Tanzania local Reproductive and Child Health Co-ordinators assisted and in Nepal the local District Health Office staff, the area should be 'mapped' to show where private health facilities/practitioners are located and where the main public sector referral unit for maternity cases is.

From information gained in this mapping exercise a stratified sample of private maternity care facilities should be selected for study. These should represent the range of private facilities that offer maternity (preferably labour and delivery) care. The investigators should then contact these facilities and arrange for interviews with managers/owners and practitioners at them. Sampling of facilities should be purposive in an attempt to source a wide range of experiences and perspectives. The sampling of practitioners will then be largely opportunistic, conduct of interviews with those that are on duty at the time of the visit. Whilst it cannot be ensured that data collected in this way is completely representative, this approach does permit some identification of commonalities and differences across the private sector.

Interviews carried out in this way obtain the interviewee's 'public account' of the situation. This has its obvious limitations in an area in which interviewees might have reason to present a particular image or to not disclose certain facts that might be considered detrimental. However, during the three country pilot studies it was our impression that most interviewees were open and co-operative. They were willing to give their time and talk about what they did and their opinions on key issues. The option of anonymity may have been important in some settings.

Sampling of women who have recently given birth for the users questionnaire can be done in a number of different ways. If private sector usage is high within the community then recruitment of women respondents at local baby immunisation clinics may be possible (provided that immunisation rates are known to be high). If private maternity sector usage is thought to be confined only to certain pockets of the population, then recruitment of respondents via the private facility client group (for example, prior to discharge on the post natal wards) may be more practical. The manner in which results can be interpreted and used will then vary accordingly.

Instructions for use are provided on the front of each questionnaire. The questionnaires are quite long and with the exception of the 'recently delivered women' questionnaire they are not intended to be used in full with every respondent.

The aim of the study is to gather all relevant information, not to test the knowledge of individual respondents. In advance of the interview the interviewer needs to assess which sections are relevant/required and then use these to guide the interview process. This decision should be guided by 1) the gaps in knowledge e.g. if knowledge on the regulatory process is quite complete there is no need to ask about this area, 2) the type of knowledge that the interviewee may have e.g. if your interviewee is an expert on health financing the interview would focus on sections relating to cost and information available on cost/cost-effectiveness rather than on sections relating to clinical quality of care, 3) the time available for the interview i.e. the interviewer will need to prioritise their areas of questions depending on the time available for the interview.

Visits to the public sector hospitals can also provide information for comparison purposes on the standards of care within public services, and information from the registers can give insights on women's movements across private/public sector in the course of their maternity "journey".

Annex 4 provides some information for the interviewers, including checklists to guide them during the study process. During pilot studies these check lists were not produced at facilities or during interviews but were used by interviewers themselves to continually review if all necessary information was being collected and to assess where there were gaps.

11.3 STEP C: ANALYSIS

While some of the instruments in this "toolkit" might serve for adaptation for use in larger and more rigorous research studies, they are primarily designed to enable "rough and dirty" data collection in a short time period. The aim is to draw on individual and collective knowledge in a reasonably methodical way, and through this to identify the key issues for that particular setting. The case study method of multiple owner/practitioner/user interviewees and observational checklist permits crosschecking of accounts, and often captures fuller and more complex pictures of service provision and usage than any single account would have been able to do.

Analysis can be carried out by bringing together the information about each theme from all data sources. Care should be taken to identify and explore exceptions and apparently contradictory findings, as well as to highlight the common features from which tentative generalisations may be drawn. Case studies may be useful for illustration, if they do not compromise participants' anonymity.

12. REFERENCES

- Assimwe D McPOake B Mwesigye F et al The private sector activities of public sector workers in Uganda in S Bennet M McPake A Mills (eds) *Private Health providers in Developing Countries. Serving the Public interest.* 1997 Ch 9 140-157 London & New Jersey Zed Books.
- Aljunid SM, Zwi AB 1996 Differences in public and private health services in a rural district of Malaysia. *Medical Journal of Malaysia* 51(4):426-36.
- Begum, T, Hossain N, Nadiya S. (2001) The supply patterns in the private healthcare sector of Bangladesh, Data International prepared for the World Bank, Dhaka.
- Benson JS 2001 The impact of privatization on access in Tanzania. *Social Science and Medicine* 52:1903-1915.
- Berman P, Nwuke K, Rannan-Eliya R. Mwanza A. 1995 Zambia: Non-Governmental Health Care Provision Data For Decision Making Project Report January 12, 1995 pp1-107.
- Berman P Rose L 1996 The role of private providers in maternal and child health and family planning services in developing countries *Health Policy and Planning* 11(2): 142-155.
- Bhat, R. (1999). "Characteristics of private medical practice in India: a provider perspective." *Health Policy and Planning* 14(1): 26-37.
- Billings DL, Baird TL, Ankrah V et al. (1999) Training Midwives to Improve Post Abortion Care in Ghana: major Findings and Recommendations for an Operations Research Project NC:lpas.
- Bloom G, Standing H. 2001 Pluralism and Marketisation in the Health Sector. Meeting health needs in contexts of social change in low and middle-class countries. IDS Working Paper 136 Brighton: Institute of Development Studies.
- Borghi J 2001 What is the cost of maternal health care and how can it be financed? *Studies in HSO&P* 17:247-296
- Brugha R Hanson K 2000 Presentation at the Commission on Macroeconomics and Health Planning Meeting Working Group 5, 8-9 June 2000, cited in Smith et al 2001
- Brugha, R. Pritze-Aliassime, S (2003) Promoting safe motherhood through the private sector in low and middle-income countries. *Bulletin of the World Health Organisation* 81 (8): 616 – 623.
- Burchardt T, Hills J, Propper C 1999 *Private Welfare and Public Policy* York: Joseph Rowntree Foundation.
- Centre for Health Policy 1998 Technical Report to Chapter 3 of the 1998 South African Health review [available online at www.hst.org.za/sahr/98/private/ accessed 19/7/02]
- Chakraborty S, Harding A. 2003 Conducting a private health sector assessment pp 75-156 in A Harding & AS Preker (eds) *Private Participation in Health Services, The World Bank Washington.*
- Chhabra, R. and S. C. Nuna (1993) Abortion in India: an overview, Population Council
- Chanrachakul B, Herabutya Y, Udomsubpayakul U 2000 Epidemic of cesarean section at the general, private and university hospitals in Thailand. *J Obstet Gynaecol Res* 26(5): 357-61.

- Ensor, T & Dey, R (2003) Private For Profit Maternity Services, Andhra Pradesh Case Study. Options Consultancy Services Ltd, Department of International Development
- Ensor, T. and S. Witter (2000). Provider payment systems. Health economics for developing countries: a practical guide. S. Witter, T. Ensor, M. Jowett and R. Thompson. London, Macmillan.
- Etuk SJ, Itam IH, Asuquo EE. 1999 Role of the spiritual churches in antenatal clinic default in Calabar, Nigeria. *East Afr Med J* Nov;76(11):639-43.
- Ferrinho P, Bugalho AM, Van Lerberghe W. 2001 Is there a case for privatising reproductive health? Patchy evidence and much wishful thinking *Studies in HSP&P* 17:343-370
- Gani A 1997 Improving Quality in Public Sector Hospitals in Indonesia in W Newbrander (ed) *Private Health Sector Growth in Asia Issues and Implications* Wiley: New York pp 197-217
- Geefhuysen CJ 1999 Safe Motherhood in Indonesia: A task for the next century in Berer & Sundari Ravindran (Eds) *Safe Motherhood Initiatives: critical issues* Blackwell science Ltd London 62-72
- Gruen R, Anwar R, Begum T, Killingsworth JR, Normand C. 2002 Dual job holding practitioners in Bangladesh: an exploration *Social Science and Medicine* 54:267-279
- Hanson K. Berman P. 1994 Assessing the Private Sector: using Non-Government Resources to Strengthen Public Health Goals Data for Decision Making Project Harvard School of Public Health / USAID
- Hanson K Berman P 1998 Private health care provision in developing countries: a preliminary analysis of levels and composition *Health Policy and Planning* 13(3):195-211
- Hulton LA, Matthews Z, Stones RW 2000 A framework for the evaluation of quality of care in maternity services. Southampton University.
- Jan, S. *Health Economics and Finance Exchange*, London School of Hygiene and Economics.
- Kafle KK et al 1996 Can licenced drug seller contribute to safe motherhood? A survey of the treatment of pregnancy related anaemia in Nepal. *Social Science and Medicine* 42(11):1577-88.
- Kean J, Light D, Mays N. 2001 *Public-Private Relations in Health Care* London: King's fund
- Kelin, D., Z. Kaining and T. Songuan (2001) A draft report on MCHPAF study in China and quoted in A. Soucat and A. Wagstaff NHP and the poor: an integrated framework for improving the outcomes for the poor, session 8, <http://www.worldbank.org/poverty/strategies/chapters/health/session6.pdf>
- Kumaranayake L, Lake, Mujinja P et al 2000 How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe *Health Policy and Planning* 15(4): 357-367
- Levin A McEuen M Dmytraczenko T, et al 2000 Costs of Maternal Health Care Services in three anglophone African Countries Special Initiatives Report 22 Bethesda Maryland Partnership for Health Reform Project Abt Associates Inc
- Macdonagh, S. Ensor, T & Murray. S (2003) Examining the Role of Private Maternity Services: A Synthesis of Findings from 3 Country Case Studies, Options Consultancy Services, Kings College London and the Department for International Development.

- Macdonagh, S & Neupane, R (2003) Private For Profit Maternity Services, Nepal Case Study. Options Consultancy Services Ltd, Department for International Development.
- Matshidze KP et al 1998 Caesarean section rates in South Africa: evidence for bias among different 'population groups'. *Ethn Health* 3(1-2):71 – 9.
- McCord C Premkumar R Arole S Arole R 2001 Efficient and effective emergency obstetric care in a rural Indian community where most deliveries are at home *International Journal of Gynecology and Obstetrics* 75:297-307
- McGinn T, Aboagye-Owusu, Dugan R, Nudanu M, Lauro D. 1990 Private midwives: a new approach to family planning service delivery in Ghana *Midwifery* 6:117-124
- Mishra US, Ramanathan M 2002 Delivery related complications and determinants of caesarean section rates in India. *Health Policy and Planning* 17(1):90-8.
- Munishi GK. 1997 Private Health Care in Tanzania: Private Health Sector Growth Following Liberalization in Tanzania, *International Health Policy* working paper.
- Muraleedharan, V. R. (1999) Characteristics and structure of the private hospital sector in urban India: a study of Madras city, Indian Institute of Technology, Madras
- Murray, S & Nyambo, M (2003) Private for Profit Maternity Services, Tanzania Case Study. Options Consultancy Services Ltd, Kings College London and the Department for International Development.
- Murray SF 2000 Relation between private health insurance and high rates of caesarean section in Chile: qualitative and quantitative study. *BMJ* 321(7275): 15-01-5.
- Nahar S, Costello A. 1998 The hidden cost of 'free' maternity care in Dhaka, Bangladesh. *Health Policy and Planning* 13(4): 417 – 422
- Nanda, L. (2001) SERP Comprehensive Basic Health Package for the poor, Hyderabad, Society for the Elimination of Rural Poverty
- Obuobo AAD, Pappoe M, Ofosu-Amaah S, Boni DY. 1999 Private Health Care Provision, Greater Accra Region of Ghana. Small applied research & Bethesda, MD: Partnerships for Health Policy Reform Project Associates Inc. {accessed online at: www.phrproject.com on 19/07/02}
- Pearson, M. (2001) Demand side financing for health care, DFID Health Systems Resource Centre, London
- Peters, D. H., A. S. Yazbeck, R. R. Sharma, G. N. V. Ramana, L. H. Pritchett and A. Wagstaff (2002). Better health systems for India's poor: findings, analysis and options. Washington, World Bank.
- Potter JE et al 2001 Unwanted caesarean section rates among public and private patients in Brazil: prospective study. *BMJ* 323(7322):1155-8.
- Pritze-Aliassime S. 2000 Achieving Safe Motherhood Goals through collaboration with the Private Sector: Evidence and Options Unpublished MSc dissertation LSHTM
- Price M, Broomberg J. 1990 The impact of the fee-for-service reimbursement system on the utilisation of health services. A comparison of caesarean section rates in white nulliparous women in the private and public sectors. *South African Medical Journal* 78:136-8
- Schwartz, J. B., J. S. Akin and B. M. Popkin (1993) Economic determinants of demand for modern infant-delivery in low-income countries: the case of the Philippines, *Health economics research in developing countries*, A. Mills and K. Lee, Oxford, New York, Oxford Medical Publications.

Sharma, B. V. (2003) Pilot Inventories Of Unqualified Private Health Care Providers In Two Districts In Andhra Pradesh, Hyderabad, Report submitted to DFID India, British High Commission New Delhi, Department of Anthropology, University of Hyderabad

Smith E, Brugha R, Zwi A. 2001 Working with Private Sector Providers for Better Health Care. An introductory guide Options Constancy / LSHTM London

Ssengooba F McPake B 201 Case example; Financing Maternal Health Services in Uganda (Background document to World Bank Institute's Third Annual Adapting to change Core Course). Available online: wbweb5.worldbank.org/database/reprohealth/06%20Reading%203-Uganda%20case-WBI.pdf accessed 31/07/02

Walsh M. 2001 An exploration of professional midwives' unofficial midwifery activities in Sokoto state, Northern Nigeria. Unpublished MSc Dissertation Institute of Child Health. UCL

ANNEXES

ANNEX 1. TOOL A: FRAMEWORK FOR REVIEWING PRIVATE PROVIDER CONTRIBUTION TO MATERNITY SERVICES

Tool to assess private provider contribution to maternity services			
Key areas for review	Sub-areas for data collection	Type of instruments used	Examples
Area 1: Coverage and patterns of usage of private maternity care	<ul style="list-style-type: none"> – geographical and social distribution of, & access to, private maternity care – key dimensions upon which this pattern varies – reasons for accessing private sector care – specifically, what type of maternity care do poor people access and why 	<p>National/local community-level surveys of maternity care - seeking behaviour & expenditure</p> <p>questionnaires & FGDs in community</p>	<p>Obuobi et al 1999 Ghana *</p> <p>Amooti-Kaguna & Nuwaha 2000 Uganda</p>
Area 2: Regulatory and policy environment	<ul style="list-style-type: none"> – legal and regulatory context & degree of enforcement – accreditation mechanisms, financing mechanisms – linkages into MOH networks – quality assurance mechanisms – data collection feeding into HMIS – key stakeholders views 	<p>Key informant interviews with policy makers, members of professional councils and regulatory boards, consumer groups</p> <p>Newspaper reports of medical malpractice / negligence cases</p> <p>Stakeholder analysis</p> <p>Health management information system data</p>	<p>Patterns of coordination between NGOs and MOHs: Gilson et al 1994</p>

<p>Area 3: Private providers in maternity care system</p>	<ul style="list-style-type: none"> - typology of providers - ways of working within this sector and across sectors - motives of providers, incentives, constraints - trends over time 	<p>National/local community-level surveys</p> <p>Registers of PSPs from professional bodies plus on the ground mapping of providers /facilities</p> <p>provider questionnaire surveys</p> <p>in-depth interviews with providers</p> <p>Newspaper or professional journal reports of changes, incentives etc</p>	<p>National studies: Some DHS info on private and public facilities (but not on providers)</p> <p>Berman & Rose 1994 USAID/Harvard SPH/Abt Associates case studies of private sector in Kenya, Tanzania, Senegal & Zambia (Hursh-César 1994, Berman et al 1995 etc)</p> <p>Initiatives/ JSI national survey of private health facilities in Ecuador South Africa Health Review (Centre for Health Policy 1998)</p> <p>mapping of private providers: Cambodia Urban Health Project</p> <p>Provider questionnaire surveys: Primary Care Interview Template in Harding & Preker 2002 * Obuobi et al 1999 Ghana *</p> <p>Studies of provider motivation: (doctors) -Ferrinho et al 1998 French speaking Africa Gruen et al 2002 Bangladesh</p>
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<p>Area 4: Service Costs Analysis of efficiency and cost effectiveness, and costs to user</p>	<p>Input and price data</p>	<p>Administrative data</p> <p>Facility based costings including time and motion study and recording of goods and services associated with different categories of services</p> <p>Exit interviews to users</p>	<p>Facility based costings of public and NGO maternal health care services: Levin et al 2000, Ghana, Uganda, Malawi</p>
<p>Area 5: Quality of care: Encompassing resources, quality of technical care assessed against technical, professional and ethical norms, and quality of interpersonal care assessed against socially defined norms of acceptability and good practice</p>	<p>Provision of care including:</p> <ol style="list-style-type: none"> 1. Human and Physical Resources 2. Maternity Information System 3. Use of appropriate technologies 4. Internationally recognised good practice 5. Management of emergencies 	<p>Checklist on availability and quality of key inputs such as drugs</p> <p>Assessment of actual staffing against minimum standard and patient workload to assess service readiness/capability to perform</p> <p>Clinical vignettes Observation of consultations / activities – checklists Interview with in-charge/other staff Record reviews</p> <p>Patient registers at facilities Administrative records at higher level & extraction of: Provider outputs / activities: to number of units of services rendered (antenatal visits, deliveries etc)</p>	<p>Equipment and drug checklists: DHS+ SPA facility inventory WHO Safe Motherhood Needs Assessment (1996) AMDD Women’s Right To Life and Health Tools Nepal (2000) NSMP inception phase observation checklists (1997)</p> <p>Clinical vignettes:</p> <p>Observation of care checklists: DHS+ SPA ANC observation* facility inventory: DHS+ SPA *</p> <p>data extraction forms: WHO Safe Motherhood Needs Assessment (1996) partograph reviews for normal delivery, eclampsia, obstructed labour</p>

	<p>Experience of care including:</p> <ol style="list-style-type: none"> 6. Human and Physical resources 7. Cognition 8. Respect, dignity and equity 9. Emotional support 	<p>⇒ Intervention rates e.g. Caesarean section eleration/ episiotomy ⇒ Case Fatality Rates</p> <p>Interviews with clients exit polls community surveys, focus group discussions Newspaper reports</p>	<p>Resources for tracer conditions: Tanzania Reproductive and Child Health Facility Survey – equipment for normal deliveries, vacuum extraction and neonatal resuscitation (National Bureau of Statistics 2000)* Garner et al 1990 study in Papua New Guinea used obstetric tracer conditions of neonatal asphyxia and maternal PPH</p> <p>data extraction forms: WHO Safe Motherhood Needs Assessment (1996)*</p> <p>Beneficiary perceptions: DHS+ SPA ANC Exit interview*</p> <p>data extraction forms for CFRs: UNICEF/WHO/UNFPA 1997</p>
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<p>Area 6: Interaction between levels of provision: maternity referral systems</p>	<p>Mapping of referral networks used by private providers</p> <p>Incentives for and against referral</p> <p>Assessment of health impact of referral decisions/ routes in complicated tracer conditions</p> <p>Cost of referral to user, to referrer and to receiving service</p>	<p>Private provider questionnaires</p> <p>Patient register reviews</p> <p>User surveys</p> <p>Family member interviews in maternal death verbal autopsy</p> <p>Newspaper reports of events/cases</p>	<p>Questions related to referral links of private providers: Obuobi et al 1999 Ghana *</p> <p>Questions on emergency communication and transport for referral, 24 hr and on-call EOC; signs and symptoms indicating need for referral: WHO Safe Motherhood Needs Assessment (1996) District Health Team I facility in-charges & midwife interview tools*</p> <p>Data extraction forms for EOC facility review (UNICEF 1997)</p> <p>Data extraction forms for referral decision-making and outcomes: Lusaka WFSP 2001</p> <p>Questions for verbal autopsy: Mbizvo et al 1994</p>
<p>Area 7: Impact of private sector provision on public sector resources</p>	<p>Staff leakage / retention</p> <p>Drug / equipment leakage</p> <p>Costs of referral between private and public providers</p>	<p>Provider surveys and depth interviews</p> <p>Inventories</p> <p>Facility based costings</p> <p>User interviews</p>	

<p>Area 8: Likely impact on health outcomes for mothers and infants at population level</p>	<p>Proxy indicators for positive impact:</p> <ul style="list-style-type: none"> – Provision of high quality care in “normal” birth to significant population – Provision of accessible EOC facilities – Provision of maternity care services to previously underserved population – Satisfactory resolution in expected proportion of complicated tracer conditions <p>Indicators for negative impact: Significant fresh stillbirth rates Significant nos of APGAR scores <7 at 5 mins Significant rate of post partum sepsis/ other morbidity requiring medical treatment Over-intervention including high c/section rates Non-use or low use of activities of proven usefulness High case fatality rates relative to public hospitals</p>	<p>Facility surveys Observation of clinical care</p> <p>District mapping of services</p> <p>Reviews of patient registers and case notes Review of private sector referrals to district hospital</p> <p>Reviews of patient registers and case notes</p> <p>User survey at baby immunisation clinics</p> <p>Observation of consultations</p> <p>User exit interviews</p>	
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Acknowledgments: this matrix draws upon previous work on health sector assessment techniques by Smith et al (2001), Harding & Preker (2002) and Lindelow & Wagstaff (2001),

* denotes tools are available in the public doma

ANNEX 2: ANALYSIS TOOL FOR ASSESSING PATTERNS OF UTILISATION OF PRIVATE SECTOR MATERNITY CARE (ADAPTED FROM HANSON & BERMAN 1994)

	% Public sector	% private not for profit	% private for profit sector	Issues	Quality/ effectiveness Issues
Family Planing - Pill - Condom - Injectable - IUD - F/sterilisation - M/sterilisation					
Antenatal check ups - TT - Anaemia - Malaria - RTI					
Labour and delivery care - place of delivery - presence of skilled attendant					
Abortion care					
Postnatal care					

ANNEX 4: CHECKLIST FOR INTERVIEWERS

INCREASING UNDERSTANDING OF PRIVATE PROVISION OF MATERNITY SERVICES – A THREE COUNTRY (PILOT) STUDY

CHECKLIST FOR INTERVIEWERS

Data should be gathered for each of the following areas during the study:

1. Coverage and patterns of usage of private maternity care
2. Regulatory and policy environment
3. Private providers in maternity care system
4. Service Costs
5. Service Quality of care
6. Interaction between levels of provision – maternity referral systems
7. Impact of private sector provision on public sector resources

A checklist for each of these areas can be found on the following pages and should be used as follows:

- ⇒ Refer to the checklist regularly during data collection to see if you are managing to get information on each of the areas outlined.
- ⇒ Keep your team members informed if you feel that an area is being missed.
- ⇒ NOTE that this study is not designed to collect in-depth data on quality of care but only to get an overview of what may be happening... you are unlikely therefore to be able to gather data on all the areas outlined. However, data on quality assurance mechanisms should be gathered and where possible.

TOPIC AREA: COVERAGE AND PATTERNS OF USAGE OF PRIVATE MATERNITY CARE

Sub area	Issues to ensure information asked/gathered
Numbers of practitioners and geographical distribution	How many private practitioners/facilities are registered? (by type) How many private practitioners are members of private institution organisations? Where are these practitioners/facilities operating?
Key dimensions upon which this pattern varies	Of these how many are in rural/urban areas or different geographical areas of the country/state?
Reasons for accessing private sector care	Location/proximity Reputation of service and/or poor reputation of public service Status Fee level Type of clinician working in facility Type of procedure (e.g. for abortion) Quality of care (how defined)
What type of maternity care do poor people access and why	Where do poor people seek care? Specifically marginalised groups e.g. adolescents, widows, low-caste/untouchables, HIV infected. Do they use any segment of the private sector – why do they make this choice (see above reasons for accessing private care) Is the private sector accessible to the poor? – if yes, which parts of the private sector are used by the poor? Is there any data available on use of the maternity services, which is poor sensitive?

TOPIC AREA: REGULATORY AND POLICY ENVIRONMENT

Sub area	Issues to ensure information asked/gathered
Legal and Regulatory context	<p>What policy documents exist? What legal documents exist? What policies/laws are in place to protect a client from poor practice? What has the history/evolution of current policy/law been? How is the law/policy implemented? What are the advantages of the current policy/law? What are the disadvantages of the current law/policy? Are any changes/review planned? What changes do respondents think should happen?</p>
Accreditation mechanisms	<p>How are private practitioners accredited as fit to provide care? What has been the history/evolution of this practice? How often is accreditation reviewed and how? In reality does this really happen – what happens? Is a register/s of private practitioners maintained? How does a private practitioner enter on the register? What incentives are there for providers to comply with accreditation and registration regulations? Why might a provider try and avoid these regulations? Are professional organisations encouraged to exist and self-regulate their profession?</p>
Financing mechanisms	<p>In what way does the MOH/Central Government control/set guidance for pricing in the private sector? In what way is pricing guidance monitored? Does pricing guidance ensure access for the poor?</p>
Linkages to MOH networks	<p>Is there a sense that MOH has oversight of the private sector as a part of the health system? (or concentrates only on the public sector?).</p>

TOPIC AREA: PROVIDERS OF PRIVATE MATERNITY CARE

Sub area	Issues to ensure information asked/gathered
Typology of providers	<p>Complete typology matrix for country – = Employer based health care e.g. mines, large factories = NGO run e.g. mission hospitals, refugee camps, NGO outpatient clinics etc – are these all non-profit? = for profit e.g. hospitals, nursing homes, private sections of public facilities, pharmacies, individual practice of public providers, traditional healers</p> <p>Gain an understanding about dual public-private practice for different cadres of staff (medical, nursing, auxiliary, non-clinical)</p>
Ways of working within this sector and across sectors	<p>Type of services available from the various providers</p> <p>Type of service typically not available privately (i.e. covered largely by public sector)</p>
Motives of private providers, incentives, constraints	<p>Motives e.g. financial, professional status, secure income in urban areas, client demand</p> <p>Incentives e.g. tax incentive, ease of balancing this with public sector work</p> <p>Constraints e.g. registration, accreditation mechanisms, competition, time balance with public sector work, tax dis-incentive</p>
Trends over time	<p>In amount or type of service available</p> <p>Why do respondents think these changes have happened: e.g. changes in policy, changes in demand</p>

TOPIC AREA: SERVICE COSTS

Sub area	Issues to ensure information asked/gathered
Input and price data	<p>Are any studies/data on costs available? Are any studies, which compare costs or cost-effectiveness across the public and private sector available? If so get.</p> <p>Is there any guidance from central level on maximum level of prices to clients for services?</p> <p>What do key services cost (normal delivery, planned CS, emergency CS, unit of blood)? How do the costs differ across providers?</p> <p>What does the cost include? e.g. transport, bed cost, drugs, consultant time, nursing/midwifery time/care, food, extras such as anaesthetic</p> <p>What do clients estimate are the total costs of pregnancy/delivery/PNC for a normal or complicated delivery across various providers?</p> <p>How do clients raise the money to pay for this care?</p>

TOPIC AREA: QUALITY OF CARE

Note this study is not assessing QOC in depth.

Sub area	Issues to ensure information asked/gathered
PROVISION OF CARE	
Human and Physical Resources	<p>Human: Is a staff list available – numbers of professional (consultant, medical, nursing, midwifery, physiotherapy) and non-professional (support, cleaner) staff available for the facility?</p> <p>Are recommended staff numbers/type/ratio mentioned in any of the policy documents?</p> <p>Physical: Is there running water available? Is there 24-hour electricity? Is rubbish, particularly sharps well disposed of?</p>
Maternity Information System	<p>What information is gathered on the maternity register? – Take copy of top line is possible.</p> <p>What information are private facilities obliged to provide HMIS? – Are copies of the information available?</p> <p>Do facilities/providers comply by providing information to HMIS?</p> <p>Are any reviews processes e.g. audit, peer review in place?</p>
Use of appropriate technologies (may not be able to assess unless on protocols)	<p>No routine: pubic shaving, enema, IVI, episiotomy, supine position for delivery, manual revision of uterus.</p> <p>Use of vaginal examination in labour kept to minimum.</p> <p>Intramuscular oxytocin not used to speed up labour.</p> <p>IVI oxytocin not used routinely to speed up labour.</p> <p>The use of C/Section is within appropriate limits Effective pain relief used for procedures</p>
Internationally recognised good practice (may not be able to assess this other than from protocols – get copies where possible)	<p>Magnesium sulphate drug of first choice for eclampsia. Women actively considered for a vaginal delivery after one C/S. Prophylactic antibiotics are used routinely for emergency C/S Ventouse is instrument of first choice for an instrumental delivery. Woman allowed social support during labour</p>

	<p>and delivery Woman and fetus's wellbeing assessed regularly during labour Women allowed to adopt position of own choice for labour.</p>
<p>Management of emergencies Unlikely that can do thorough assessment</p>	<p>Qualified staff and emergency drugs/equipment available on a 24-hour basis.</p> <p>Supply of blood rapidly available.</p> <p>Stocks of oxytocics, IVI fluids, magnesium sulphate in place and adequately stored.</p> <p>Partograph used effectively in labour.</p> <p>Capacity to undertake emergency CS 24hrs/day</p>
<p>EXPERIENCE OF CARE – SHOULD GET SOME INFO FROM CLIENT INTERVIEWS</p>	
Human and physical resources	Was the client satisfied that the staff and facility were sufficient to meet her needs?
Cognition	<p>Were procedures and treatments all well explained?</p> <p>Did the client feel like she had sufficient information?</p> <p>Were all clients treated the same in this regard?</p>
Respect, dignity and equity	<p>Did the client feel respected, treated as central to the care?</p> <p>Was her dignity and privacy respected at all times?</p> <p>Did she feel that all clients were being treated equally – do poorer/marginalised clients feel they would be treated the same way as the wealthy?</p>
Emotional support	<p>Were visitors allowed?</p> <p>Was the woman allowed have a companion of her choice in labour?</p> <p>Did she feel emotionally supported?</p> <p>Did relatives feel emotionally supported and informed during traumatic events?</p>
Quality Assurance Mechanisms – should get good overview from questionnaires	<p>What mechanisms exist at national/state and at a facility level to assure quality – e.g. protocols, audit processes, peer review, infection prevention guidelines, records and reviews of intervention rates.</p> <p>How are these processes carried out – any formal routines in place?</p> <p>What incentives are there to providers to use QOC guidelines e.g. disciplinary processes, regular review of practitioner practice, salary increment/ promotion for good practice, client awareness, fear of losing registration.</p> <p>What actually happens if standards are not maintained?</p> <p>Is there any mechanism for consumer</p>

	<p>advocacy to ensure that high standards and appropriate care is available?</p> <p>Are consumers aware of what 'good' care consists of?</p>
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TOPIC AREA: INTERACTION BETWEEN LEVELS OF PROVISION: MATERNITY REFERRAL SYSTEMS

Sub area	Issues to ensure information asked/gathered
Mapping of referral networks used by private providers	<p>Have any exercises to map referral processes been undertaken?</p> <p>Are referral patterns formalised between providers?</p> <p>From information gathered (manager/provider questionnaire) can referral pattern be mapped in study areas?</p>
Incentives for/against referral	<p>What are the incentives/disincentives for providers to refer, particularly in case of an obstetric emergency</p> <p>For:</p> <ul style="list-style-type: none"> Don't want potential death within private practice Culture of good practice Financial incentive to refer from public into private practice <p>Against:</p> <ul style="list-style-type: none"> Don't want to loose fees Lack of prestige/status if can't handle case <p>Who gets paid in the event of a referral – the referring person, the person/facility referred to or both?</p>
Assessment of health impact of referral decisions/routes in complicated tracer conditions	Unlikely that we can assess this during this study
Cost of referral to user, to referrer and to receiving service	Unlikely that we can assess this study

TOPIC AREA: IMPACT OF PRIVATE SECTOR PROVISION ON PUBLIC SECTOR RESOURCES

Sub area	Issues to ensure information asked/gathered
Staff leakage/retention	How does dual practice in public and private sector get balanced? - <ul style="list-style-type: none">- less hours of service in public sector- very long working hours- private practice during public working time/facility- high level of intervention or controldelivery times
Drug/equipment leakage	Any reports from any providers/ manager's etc of public sector drugs and equipment being used for profit in the private sector?

TOPIC AREA: LIKELY IMPACT ON HEALTH OUTCOMES FOR MOTHERS AND INFANTS AT POPULATION LEVEL –

This is unlikely to be covered by the study unless there is national data held separately for public and private units. Find out if such data available.