



USAID
FROM THE AMERICAN PEOPLE

THE POTENTIAL OF PRIVATE SECTOR MIDWIVES IN REACHING MILLENNIUM DEVELOPMENT GOALS

December 2006

This publication was produced for review by the United States Agency for International Development. It was prepared by Patrice White, CNM, DrPH, and Leah Levin, MPH, for Private Sector Partnerships-One project.



PSP-One

PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

Technical Report No. 6

Technical Report Series: PSP-One Technical Report Series addresses important issues relating to the private sector's role in reproductive health and family planning. Papers in the series may discuss lessons learned and best practices, highlighting PSP-One technical areas.

Recommended Citation: White, Patrice, Leah Levin. December 2006. *The Potential of Private Sector Midwives in Reaching Millennium Development Goals*. Bethesda, MD: Private Sector Partnerships-One project, Abt Associates Inc.

Download: Download copies of PSP-One publications at: www.psp-one.com

Contract/Project No.: GPO-I-00-04-00007-00

Submitted to: Susan Wright, CTO
Bureau of Global Health
Global Health/Population and Reproductive Health/Service Delivery Improvement
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development



Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600 ■
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916
■ www.psp-one.com ■ www.abtassoc.com

In collaboration with:

Banyan Global ■ Data Management Systems ■ Dillon Allman and Partners
Family Health International ■ Forum One Communications
■ IntraHealth International ■ O'Hanlon Consulting ■ Population Services
International ■ Tulane University's School of Public Health and Tropical
Medicine

THE POTENTIAL OF PRIVATE SECTOR MIDWIVES IN REACHING MILLENNIUM DEVELOPMENT GOALS

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

CONTENTS

- Contents..... iii**
- Acronyms..... v**
- Acknowledgments..... vii**
- Executive Summary ix**
- 1. Background..... 1**
 - 1.1 Health Care Crisis and Context..... 1
 - 1.2 Importance of the Private Sector 1
 - 1.3 Evolving Role and Scope of Private Practice Midwives..... 2
 - 1.4 Objective..... 3
- 2. Methodology 5**
- 3. Overview of Country Cases 7**
- 4. Findings 11**
 - 4.1 Colonial Legacy Affects PPMW..... 11
 - 4.2 Motivation to Enter Private Practice..... 13
 - 4.3 Requirements to become a private practitioner..... 14
 - 4.4 Services Private Practice Midwives Offer 16
- 5. Challenges and Opportunities confronting PPMWs.... 17**
 - 5.1 Challenges..... 17
 - 5.1.1 Financial Realities and Sustainability Issues 17
 - 5.1.2 Training for Extended Role (Pre- and In-Service)..... 19
 - 5.1.3 Supervision and Interface with the National Health System 20
 - 5.1.4 Lack of Business Skills..... 21
 - 5.1.5 Professional Jealousies and Competition 21
 - 5.2 Opportunities 22
 - 5.2.1 Professional Associations..... 22
 - 5.2.2 Community Acceptability..... 24
- 6. Conclusions 27**
 - 6.1 Impact of PPMWs on Service Delivery 27
 - 6.2 Factors Associated with Successful PPMWs 27
 - 6.3 Factors Associated with Struggling PPMWs..... 28
- 7. Recommendations—Create an Enabling Environment and Systems to Support Extended Roles as PPMWs 31**

7.1 Support the Ability to Deliver Quality Services.....	31
7.2 Support Financial and business Sustainability	31
7.3 Support Links to the Formal Health Sector	32
Annex A: Key Informants Interviewed.....	35
Annex B: Questionnaire for Field-Based Telephone Interviews	37
Annex C: Questionnaire For Midwifery Leaders	39
Annex D: Questionnaire For Technical Advisors	43
Annex E: Country Interviews.....	45
Annex F: References	47

LIST OF TABLES

3.1. Demographic Overview	8
3.2. Midwifery Overview.....	9
4.4 Expanded Services Provided	16
5.6a Overview of Midwifery Associations	22
5.6b Mission of Midwifery Professional Associations.....	23
5.6c Professional Associations' Current Activities to Support PPMW ..	24

ACRONYMS

ARV	Antiretrovirals
BPS	Badan Pusat Statistik-Statistics Indonesia
DHS	Demographic and Health Survey
DOTS	Directly observed treatment short course
IBI	Ikatan Bidan Indonesia (Indonesian Midwifery Association)
ICM	International Confederation of Midwives
LDC	Less developed countries
MDG	Millennium Development Goals
MVA	Manual vacuum aspiration
MOH	Ministry of Health
PAC	Post-abortion care
PHMH	Private Hospitals and Maternity Homes
PMTCT	Prevention of mother-to-child transmission
PPMW	Private practice midwife
PSP-One	Private Sector Partnerships-One
STI	Sexually transmitted infection
TFR	Total fertility rate
UPMA	Ugandan Private Midwives Association
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization
ZNA	Zambian Nurses Association

ACKNOWLEDGMENTS

This study was conducted with support provided by the United States Agency for International Development under Contract No. GPO-I-00-04-00007-00.

The authors are grateful to Ruth Berg, Barbara O'Hanlon, Nancy Pielemeier, Mary Segall, Jim Shelton, and Mary Ellen Stanton for reviewing this paper and providing excellent comments.

The authors also thank the stakeholders and country informants who, despite grueling schedules, graciously participated in these interviews and shared their experiences and insights: Gloria Abbey, Dora Alice Amoyaw, Deborah Armbruster, Hilda Baca, Annie Clark, Flavia Cruzado, Barbara Kinzie Deller, Milka Dinev, Earnestina Djokotoe, Betty Farrell, Frances Ganges, Deborah Gordis, Anne Hyre, Enrique Lu, Patricia MacDonald, Nur Ainy Madjid, Godfrey Magumba, Mary Lee Mantz, Margaret (Peg) Marshall, Nester Moyo, Asmuyeni Muchtar, Jennifer Munsaka, Goreti Musoke, Genevieve KK Mwale-Musokwa, Mary Namusisi, Theresa Nantale, Pius Okong, Dorcas Phiri, Miriam Solis, Mariama Sumani, Damaryanti Suryaningsih, and Elizabeth Yalan.

EXECUTIVE SUMMARY

Government health sectors in many countries face an uphill battle to reach the Millennium Development Goals (MDGs) set for 2015. In the last six years, Ministries of Health (MOHs) in many less developed countries (LDCs) have been unable to invest sufficiently in their health systems. To achieve the MDGs despite inadequate resources, new approaches for delivering critical clinical services must be considered.

This paper explores the potential for private-sector midwives to provide services beyond their traditional scope of care during pregnancies and births to address shortcomings in LDCs' ability to reach MDGs. This paper examines factors that support or constrain private practice midwives' (PPMWs') ability to offer expanded services in order to inform the policy and donor communities about PPMWs' potential.

Data was collected through literature reviews, stakeholder interviews, and field-based, semi-structured interviews in Ghana, Indonesia, Peru, Uganda, and Zambia.

Ghana, Indonesia, and Uganda were chosen because they are countries where PPMWs provide expanded services. Peru and Zambia were selected as examples where midwives have struggled to develop private practices or they provide expanded services despite issues about midwives' roles and legal sanctions for private practices.

Four major factors influence PPMWs' ability to expand beyond traditional services: the nature of the country's colonial legacy, the PPMW's motivation to enter and expand private practices, the legal and regulatory requirements to enter and expand private practices, and the access to capital and supplies to open and expand private practices. The data also illustrated opportunities and challenges for midwives in or interested in entering private practice. Challenges include insufficient access to capital and financial sustainability, a lack of training in additional services, inadequate supervision by and weak interaction with the national health system, scant business skills, and competition from physicians. Opportunities included the professional association's advocacy potential and the communities' trust of midwifery services.

PPMWs are often the only professional providers in poor and remote areas that offer a range of primary health services. They often are the first contact for health care in settings where the public sector does not provide services. In countries where PPMWs have flourished, they provide a substantial amount of essential clinical services nationally.

Separation of the formal health sector from the private sector can weaken the former's ability to mobilize personnel and resources, measure health statistics, and assess expenditures and manpower needs. In addition, the quality of clinical services in the private sector can suffer without a link to the formal sector and national standards of care. Start-up capital is beyond the reach of many midwives, especially in African countries, and traditional commercial-sector loans are difficult for most midwives to obtain and repay as interest rates are high.

The authors of this paper recommend that donors, governments and implementing agencies:

- further support PPMWs to acquire business, continuing clinical and monitoring and evaluation skills and help them adapt approaches and tools for quality improvement
- further support PPMWs' ability to access financial capital and business-skills training
- explore alternative financing mechanisms, including contracting out, vouchers, and community-based insurance by which PPMWs can sustain their practices while still serving vulnerable populations
- identify and strengthen links between PPMWs and formal governmental and nongovernmental sectors so that the MOH and PPMWs have stronger connections through regulatory agencies, professional associations, and policy support to remove barriers that prevent the success of PPMWs

I. BACKGROUND

This paper was commissioned by the PSP-One project to explore the potential for private-sector midwives to provide services beyond their traditional scope of care during pregnancy and birth. In reality, midwives practicing in many developing countries provide an array of primary health care services, often to underserved vulnerable populations. This paper examines factors that support or constrain private practice midwives' (PPMWs') ability to offer expanded services in order to better inform the policy and donor communities about their potential.

I.1 HEALTH CARE CRISIS AND CONTEXT

Despite concerted work in many countries, each year 6.6 million children die worldwide before their fifth birthday, 4 million newborns die in their first 28 days of life, 3.3 million babies are stillborn, and 529,000 women die as a result of pregnancy (WHO, 2005a). Major infectious diseases, including malaria, tuberculosis, and HIV/AIDS, result in an additional 5 to 6 million deaths annually (CDC 2004, WHO 2005, and WHO 2006b). In addition, many women do not have access to modern contraceptive methods. More than 120 million women say they would prefer to avoid a pregnancy but are not using contraception; this unmet need is occurring while the largest cohort of women ever are entering their reproductive years (Ross and Winfrey 2002).

Government health sectors in many countries face an uphill battle to achieve the Millennium Development Goals (MDGs) set for 2015. Countries with the worst health indicators have been unable to invest sufficiently in their health systems. In the last six years, ministries of health (MOH) in many less developed countries (LDCs) have encountered challenges because of the emigration of health care workers and increasing infectious diseases caused by HIV/AIDS. The burden of these diseases coupled with health-sector reform and decentralization has further decreased the size of the workforce. In many cases, economic downturns, humanitarian crises, and political instability have further stretched national health systems. In addition, health-financing systems in these countries are inefficient and under-funded, referral systems are weak, and transportation and infrastructure from rural to urban settings is frail or nonexistent. The availability of drugs in LDCs is sporadic; even when stock is available it quickly expires. Finally, health information systems in LDCs are often weak. Client records, if they are kept at all, are frequently incomplete, making it hard for governments to assess critical health information and make informed decisions on how best to invest in solutions.

To attain the MDGs and reduce mortality, new approaches to delivering critical clinical services must be considered. This paper explores the potential for the increased use of private-sector midwives.

I.2 IMPORTANCE OF THE PRIVATE SECTOR

In recent decades, development aid for health has focused on strengthening the public health sector, but that sector is incapable of meeting health needs in many countries for the aforementioned reasons. During the last decade, the private sector has become an increasingly important provider of health services in LDCs. In many countries, including those with the highest mortality and morbidity rates, significant portions of the population use the private sector for primary care because the public sector cannot meet needs. According to recent Demographic and Health Surveys and World Bank surveys, in

many countries the private sector delivers 60 to 80 percent of health care services (Jamison, D.T. and Mosley 1991). In Cambodia, among the lowest income quintile, 48 percent of ill respondents chose a private provider (Ha, Berman, and Larsen 2002). In India, private health services accounted for 56.5 percent of health services utilization in the most deprived households (Srinivasan and Mohanty 2002). In Uganda's rural population, the private sector accounted for 44 percent of medical services used (National Bureau of Statistics, 2002). And 60 percent of outpatient contacts in Vietnam occur in the private sector (Ha, Berman, and Larsen 2002).

I.3 EVOLVING ROLE AND SCOPE OF PRIVATE PRACTICE MIDWIVES

Along with the growing importance of the private sector has been the realization that while midwives in that sector deliver a range of services to underserved populations, they could do even more. In the midst of the challenging contexts many countries face, midwives are uniquely positioned to deliver essential primary and reproductive health care. Midwives are often present in the most underserved areas and are able to deliver care in a cost-effective and culturally appropriate manner.

Historically, midwives have entered the profession through two mechanisms— directly after completing the requisite schooling or as an additional course of study after completing general nursing studies. Both of these mechanisms result in professional midwives who meet the International Confederation of Midwives (ICM) definition of a midwife. Traditionally, as their name suggests,¹ midwives have cared for women during pregnancies, attended births, and treated women and infants immediately after deliveries. The focus of their practices was antepartum, intrapartum, and postpartum care.

In the past three decades, however, their scope of work has extended to include a range of family planning services, including counseling and the provision of short- and long-acting contraceptive methods. Since the 1990s, midwives in many LDCs have been trained to provide other reproductive health services, including diagnosis and treatment of sexually transmitted infections (STIs), postabortion care (PAC), voluntary counseling and testing (VCT) for HIV/AIDS, and prevention of mother-to-child transmission (PMTCT) of HIV. In many settings private practice midwives (PPMWs) also provide additional primary care services, including care for children under 5 years old (such as growth monitoring, integrated management of childhood illnesses, and immunizations), management of acute and chronic illnesses (such as diarrhea, malaria, tuberculosis, and HIV/AIDS) and trauma in all age groups. PPMWs in many LDCs are often frontline providers of care that impact MDGs four through six: reduction of the mortality rate of children under 5 years old; reduction of the maternal mortality ratio; and combating HIV/AIDS, malaria, and other diseases.

While data about the percentage of services midwives offer compared to other cadres and information contrasting midwives in private practice with those in the public sector is lacking, in Peru, Indonesia, Ghana, and Uganda about 10 to 30 percent of all midwives practice in the private sector. For the last 50 to 80 years, PPMWs in Ghana and Uganda have provided an array of primary health services to rural and urban populations. Currently 28 percent of Indonesian women obtain family planning services from PPMWs (Badan Pusat Statistik-Statistics Indonesia (BPS) and ORC Macro 2004).

¹ The word midwife comes from Old English “with woman.”

I.4 OBJECTIVE

Because of the growing gap between services the public sector needs to deliver but cannot and the shortage of qualified health professionals in areas most impacted by HIV/AIDS, the Private Sector Partnerships-*One* (PSP-*One*) project commissioned this paper to better understand the role of private-sector midwives, particularly those offering reproductive health, family planning, and primary health services. This paper describes successful cases of midwives in private practice and identifies barriers they have overcome. It presents examples of PPMWs delivering expanded reproductive health and primary health care services to illustrate common barriers or contextual factors that helped them provide these services. The paper concludes with recommendations to strengthen PPMWs' ability to deliver essential reproductive and primary health services.

2. METHODOLOGY

The literature review consisted of searching for combinations of the terms “midwife/midwifery,” “developing country,” and “private sector” combined with individual countries on databases including PubMed, NLM, and Google. Few journal articles were found. The review primarily yielded gray literature, including trip reports, project summaries, project or program reports, and evaluations of projects that focused on work with private-sector midwives. Most projects clustered in the areas of clinical training, business-skills training, loan schemes, professional-association development, and quality assurance through branding and franchising of private-sector providers. When relevant, this literature will be cited. Most of this report’s findings, however, came from the interviews.

Seven stakeholders participated in unstructured face-to-face interviews to help identify countries for case studies and three more participated in telephone interviews (a list of interviewees is in Appendix I). Stakeholders included international midwifery leaders; representatives from the United States Agency for International Development (USAID), ICM, and American College of Nurse Midwives; and midwifery technical advisors who had worked with USAID contracting agencies in developing countries. Informants agreed that Ghana, Indonesia, and Uganda were examples countries where private setcor midwives have been able to provide expanded services. Peru and Zambia were selected as examples of countries where midwives have struggled to develop private practices and provide expanded services, despite long traditions of midwifery in the countries and legal sanctions for private practice. Informants supplied contact information for midwifery leaders or technical advisors who had worked with midwives for subsequent interviews in these five countries.

Once the countries were selected, two interview instruments (Appendices 3 and 4) were developed to guide the semi-structured interviews. Questions focused on the background of the person interviewed (to provide context), the situation in his or her country for private midwifery practice, requirements for establishing a private midwifery practice, the scope of practices and services offered, and practice operations and financial sustainability (to determine contextual factors that foster or hinder the development of private practice midwifery). A consultant midwife conducted 18 telephone interviews in English while a bilingual Abt Associates staff member conducted four additional interviews in Spanish. All interviews occurred in February to April 2006.

3. OVERVIEW OF COUNTRY CASES

Countries were selected that represented different regions of the world, had dissimilar histories of midwifery practice, and had different levels of income. However, in all countries selected, PPMWs are addressing similar health challenges. This section provides an overview of selected socio-demographic and health variables to provide context for findings from the five countries being reviewed. The health indicators selected relate to the scope of services midwives in private practice can and do address in case-study countries.

The countries selected range from Indonesia, the sixth most populous nation in the world, to Zambia, which is 79th in terms of population (CIA 2006). While Peru and Indonesia are middle-income countries, both have significant disparities in income levels and substantial levels of poverty in peri-urban and rural areas. All of the African countries reviewed have considerable portions of their population living in poverty. Approximately a quarter to a third of all women in the African countries have an unmet need for family planning. The total fertility rate (TFR) in these five countries ranges from 2.3 percent in Indonesia to 7.1 in Uganda. While antenatal care coverage is 85 percent or greater in all five countries, only in Peru and Indonesia do trained providers attend the majority of births. Not surprisingly, maternal mortality ratios are high in countries where attendants are untrained or not present. Child mortality rates are above 90/1,000 live births in Ghana, Uganda, and Zambia. Three of the countries in this study have HIV/AIDS prevalence rates greater than 3 percent in their adult population (ages 15 to 49). While only Peru meets current WHO recommendations for health care coverage by physicians, the midwife to population ratio is higher than that of physicians in all of the countries.

TABLE 3.1. DEMOGRAPHIC OVERVIEW²

	Ghana	Indonesia	Peru	Uganda	Zambia
Population (in millions)	22.1 (2005)	222.7 (2005)	27.9 (2005)	28.8 (2005)	11.6 (2005)
Percent of the population living on less than \$1 a day	44.8 (1999)	7.5 (2002)	18.1 (2000)	84.9 (1999)	63.7 (1998)
TFR	4.2 (2004)	2.3 (2004)	2.8 (2004)	7.1 (2004)	5.5 (2004)
Contraceptive prevalence rate	25.5 (2003)	60.3 (2003)	68.9 (2000)	22.8 (2001)	34.2 (2002)
Percent of married woman with unmet need for family planning	34 (2003)	8.6 (2002–03)	10.2 (2000)	34.6 (2000–01)	27.4 (2001–02)
Percent antenatal coverage	90 (2003)	97 (2003)	85 (2000)	92 (2001)	94 (2002)
Percent of births attended by a skilled provider	47 (2003)	66 (2002)	71 (2004)	39 (2001)	43 (2002)
Less than 28 day mortality per 1,000 live births	27 (2000)	18 (2000)	16 (2000)	32 (2000)	40 (2000)
Less than 5 year mortality per 1,000 live births	112 (2004)	38 (2004)	29 (2004)	138 (2004)	182 (2004)
Maternal mortality ratio per 100,000 live births	540 (2000)	230 (2000)	410 (2000)	880 (2000)	750 (2000)
HIV/AIDS adult (15 to 49 year old) prevalence rate	3.1 (2003)	0.1 (2003)	0.5 (2003)	4.1 (2003)	16.5 (2003)
Doctors per 1,000 people	0.2 (2004)	0.1 (2003)	1.2 (1999)	0.1 (2004)	0.1 (2004)
Midwives per 1,000 people	—	0.2 (2003)	—	0.1 (2004)	0.3 (2004)

²All data in the table is from WHO 2006a except information regarding unmet family planning, which is from Measure DHS 2006.

In all countries described in this paper, midwifery educational programs began pre-independence based on the colonial power's unique midwifery model. Midwifery began as a post-nursing qualification in the former British colonies or protectorates (Ghana, Uganda, and Zambia), but direct entry options have been added recently in some countries. In Indonesia and Peru, midwifery began as direct entry, but in Indonesia the midwifery qualification post-nursing now exists. In all of the countries except Zambia in this study, private practice has been an option for midwives for many years. Indeed, in all other countries about 10 to 30 percent of all midwives practice in the private sector.

TABLE 3.2. MIDWIFERY OVERVIEW

	Ghana	Indonesia	Peru	Uganda	Zambia
History of midwifery (Different models are discussed in section 4.1)	Has been a profession since the 1920s (British model)	Has been a profession since about 1912 (Dutch model)	Has been a profession since 1826 (French model)	Has been a profession 1918 (British model)	Has been a profession since 1947 (British model)
History of private practice midwifery	Supported by colonial government in 1927	Legal since profession began	Legal since profession began	Legal since 1948	Legal since 1997
Education required to become a midwife	Nursing plus 18 months midwifery or direct entry	Nursing plus midwifery training or direct entry	Five-year university degree—direct entry	Nursing plus midwifery training or direct entry	Nursing plus 12 months midwifery
Total midwives in country	About 5,000 to 5,500	88,000 to 89,000	21,000	About 5,000	About 9,000
Total PPMWs	About 500	28,000	3,100 to 3,200	About 600	None
PPMWs as a percent of total midwives	About 9 to 10	31 to 32	14 to 15	About 12	NA

4. FINDINGS

4.1 COLONIAL LEGACY AFFECTS PPMW

Historical factors in each country have shaped a unique context for private-sector midwifery. The colonial power that influenced the educational system and the pre- and post-independence political and economic systems that influenced government services (including health) have affected the current context, including supporting or constraining midwives' ability to engage and succeed in private practice.

“The government doesn’t discourage or distress us.”

British colonial powers influenced all of the African countries in this review. Zambia and Uganda were protectorates for 40 and 67 years respectively, while parts of Ghana were an official colony for 82 years (Federal Research, Library of Congress 1992; Federal Research, Library of Congress 1995). In Ghana and Uganda, the colonial administration invested in higher education and professional training schools, and universities were well developed before independence. Midwifery educational programs in all of these countries began before independence and were based on a British model where midwives are viewed as competent professionals capable of independent practice and the preferred attendants for births. Midwives in Ghana and Uganda have a strong and continuing tradition of private practice. Midwives in both countries have been running their own maternity homes for the last 50 to 80 years; currently about 10 percent of midwives in each country are engaged in private-sector practice. In contrast, Zambia had no history of support for private practice during the colonial period and had a socialist government for three decades post-independence, during which time private-sector practice was prohibited. Since legislative restrictions were lifted in 1997, few midwives have been successful in developing private independent practices. Currently there are no PPMWs in Zambia.

We work hand in hand. The Ministry of Health is not against private practice midwives at all. We are all working to decrease maternal and infant mortality and to keep people alive.
Midwife, Uganda

Without PPMWs in rural areas where 70 percent of the population lives, [they] would get no attention. We are where most Ghanaian Health Service people won't go—to the rural, remote, cut-off places.
Midwife, Ghana

In the 1920s, government-service midwives in Ghana were given stipends upon retirement if they returned to their natal villages and opened private maternity homes. In Uganda PPMWs started after World War II. In both Uganda and Ghana, private maternity homes have been, and to some degree still are, viewed as extensions of government services to the community. Neither country has laws to limit the scope of PPMWs. Until recently, Ugandan midwives have had the most liberal regulations regarding private practice of any health profession in the country. Similarly, private-sector midwives in Ghana have a wide scope of practice and repeatedly stated they were not bound by any restrictive legislation.

While Ghanaian midwives are no longer given subsidies to start maternity homes, the government does provide tax exemptions to new private maternity homes to help with start-up costs. Lobbying efforts are underway to ensure that private-sector midwives are reimbursable under the new Ghanaian health insurance scheme.

Especially in the last 20 years the government is more open to working with the private sector. MOH has recognized that PPMW are providing a good service at low cost, and they are not trying to block [the practice of PPMW].
Physician, Uganda

While the Ugandan MOH has never given subsidies to midwives to establish private practices, it has provided free or highly subsidized contraceptive supplies to PPMWs. The Ugandan MOH is trying to identify special services it can subsidize if provided in the private sector, including EPI coverage, vitamin A prophylaxis, VCT, PMTCT, and monitoring antiretrovirals (ARVs).

Midwifery education began in Indonesia in the early 1900s and was founded on a Dutch-based model of direct entry and home-based care. After independence the Indonesian government followed the colonial pattern of low investment in public-sector health care (Federal Research, Library of Congress 1992). Consequently, PPMWs have existed as long as professional midwifery has been in Indonesia. In the 1980s, the government trained and deployed over 50,000 midwives to villages on three-year government contracts with the expectation that after their contracts were over they would remain in the villages and continue in private practice. As a result, the delineation between the public and private sectors in Indonesia is blurred. Midwives often practice in both sectors simultaneously—working in government facilities in the morning and in their birthing houses in the afternoons and evenings. Upon retirement from the government, many midwives devote their time entirely to private practice. Private-sector midwives have been providing family planning services for decades, a service the government trained them to perform (Kenney 1989 and Bour and Bachri 1990). Currently, 28 percent of Indonesian women obtain family planning services from private-sector midwives (BPS and ORC Macro. 2004). In addition, the government subsidizes PPMWs for providing specific services to indigent citizens.

The government doesn't have enough to provide services for everyone in Indonesia, so private practice is viewed positively.
Midwife, Indonesia

Midwifery in Peru is based on the French direct-entry model and has been recognized as an official profession since 1826. Private practice has been legal since the profession began; in fact, a generation ago, many urban women gave birth at home and were attended by private-sector midwives. This situation has changed in recent decades. Now those who can afford to pay for services often seek care from physicians who are considered more skilled and prestigious. In the past, PPMWs were reimbursed for services provided in settings where public services were not available. This policy no longer exists. While no laws or regulations prohibit private practice, no current government programs encourage or support private practice. The current government policy of providing free maternal and child care has, in fact, led to decreased demand for services from private-sector midwives.

They [the MOH] doesn't give a lot of importance to the private sector, which supplements the public sector and many times even replaces it.
Midwife, Peru

4.2 MOTIVATION TO ENTER PRIVATE PRACTICE

Midwives decide to enter private practice for a variety of reasons. Whether driven by economic considerations, lack of jobs or job security in the public sector, personal preference, wanting to live in a certain location, or needing flexible hours so that they can care for family members with HIV/AIDS—their personal situation and the context of the country in which they practice shapes their decision.

In Ghana and Uganda, midwives historically entered private practice after retiring from the mission or public sector. Because of changing social and economic conditions—in part the effects of health reforms with extensive retrenchments in the public sector, increasing financial burdens due to taking in AIDS orphans or losing spouses from AIDS, and deteriorating working conditions in the public sector due to the emigration of health professionals—midwives in both countries are entering private practice at earlier ages. One physician in Uganda stated that private practice in the current economic climate was less of a choice than a default for many single-parent midwives who cannot survive on low government wages, are not absorbed into the government sector after graduation, have been made redundant, or need supplemental income after retirement. While many midwives working in Africa's private sector cannot live off of the revenues of private practice alone, private practice is often seen as their hope for a better life. Some midwives stated they began a private practice so they could live in the region of the country that was their home, in their linguistic or cultural group, amidst their family. Others said that they wanted to live in the same location as their spouse, be independent, serve their communities, and have more opportunities for professional updates.

The nurse midwife is the doctor, the nurse, the counselor, the pastor... [she] is involved in everything in the community. We are nearer to the people than the government or the public-sector health facilities... Because of continuing education activities, we are on our toes. We do whatever for our clients. We save lives.
Midwife, Ghana

Before you venture into private practice, you must love the work. We put in our money, our strength because we love it... In your own small way you want to help these people.
Midwife, Ghana

In Indonesia, the situation is a different because midwives legally can practice in both sectors simultaneously,³ but motivations are similar. Midwives start private practices because they want to work for themselves, because they want to supplement their government salaries, and often because of community demand. In addition, due to recent proliferation in the number of midwifery schools in the country,⁴ there are more midwives graduating than there are jobs in the government sector. Hence, midwives are entering private practice in large numbers shortly after graduation and licensure.

As soon as neighbors know they are a midwife, they ask them for care.
Midwife, Indonesia.

Like their Indonesian colleagues, Peruvian midwives can work in the public and private sectors simultaneously, but most choose the public sector because government-sector employment is perceived as more stable. According to midwifery leaders, most midwifery graduates do not consider becoming a PPMW an option unless they are unable to get a job in the government sector. Recent changes in the

³ In Uganda, regulation does not permit midwives to work in both the public and private sectors, but many do unofficially. Typically Ugandan midwives work in the public sector and then retire for personal reasons and set up their private practice. In Zambia, the regulation allows midwives to work in both the public and private sectors.

⁴The number of midwifery schools in Indonesia has increased from around 60 to over 200 in the last six years.

government sector, including hiring health professionals as contract workers rather than government employees, however, has led to more midwives opening private practices to supplement their incomes.

In countries like Ghana, Uganda, and Indonesia, where midwives attend the majority of births and private practice has existed for generations, some children grow up wanting to be private practice midwives. Apart from motivations to enter private practice, the vast majority in private practice felt they were doing important work. Communities hold PPMWs in high esteem, serving as a continuing motivation to enter and continue in private practice.

4.3 REQUIREMENTS TO BECOME A PRIVATE PRACTITIONER

Most countries have regulations that stipulate requirements a midwife must meet to enter private practice. These prerequisites usually include having a current professional license, a certain amount of clinical experience, certain equipment and supplies, a clinical site that is inspected and approved (along with its contents), and, in some settings, a special license for private practice. In all countries where private practice is common, midwives stated that the steps to engage in private practice were well known. While involving many steps, the legislative requirements and fees are not burdensome for most midwives. The start-up costs for purchasing, renting, and renovating facilities, equipment, and supplies, however, are a major barrier for many midwives who aspire to open their own practices.

Five years of clinical experience in a public or faith-based hospital has been the standard requirement for midwives wishing to open birthing homes in Ghana, Indonesia, and Uganda. In addition to the professional license needed for clinical practice, midwives starting a private practice also must obtain a facility license or permit. Facility requirements vary from country to country, but in all of them the midwife must demonstrate that the facility meets minimum standards that generally focus on having the requisite equipment, furnishings, supplies, and medicine, and meeting requirements for space, ventilation, construction, sanitary waste disposal, and infection prevention. In some places, in addition to the professional and facility license, the midwife must obtain a local trading license and pay local taxes. Facility licenses often are renewed annually and professional licenses every two or three years. In some countries the midwife must have a personal license for private practice in addition to her midwifery license.

Requirements to Open a Private Maternity Home in Ghana

- Be a qualified, registered midwife with a certificate with the Nurses & Midwives Council of Ghana
- Have five years of experience in a government or mission hospital
- Apply to the Private Hospitals and Maternity Homes (PHMH) board
- Apply through the regional public health nurse, who inspects the premises as instructed by the PHMH board
- The Environmental Protection Agency inspects the premises as instructed by the PHMH board
- The PHMH Board issues a facility certificate after it is satisfied with all of the inspection reports
- A retention fee (of an amount the board decides upon) is paid annually and the professional identification number is renewed every three years after the midwife produces a certificate of any workshop attended within the period in which infection prevention is included

While the law has sanctioned private practice midwifery for almost a decade in Zambia, barriers do exist that have prevented a sizable number of midwives from opening maternity homes. According to guidelines written after passage of the 1997 Nurses and Midwives Act, maternity nursing homes must include a minimum of 10 rooms, many more than other countries in this study require (General Nursing

Council of Zambia 2004). Thus, start-up costs are more onerous in Zambia. Midwives who wish to open private practices in Indonesia, Ghana, and Uganda can start with a few rooms and expand their facility slowly, an option Zambian midwives do not have under the current legislation. In addition, the Medical Council of Zambia has taken the position that any facility delivering health care services must have a physician in charge. Again, this requirement creates a significant barrier to opening a private practice given the shortage of physicians in the country.

Start-up costs are difficult to estimate because of the variation in facilities and in the prices of supplies and equipment between rural and urban areas and in different countries. Whether the property is rented, built, or purchased and refurbished also impacts the start-up costs. Nevertheless, respondents in Uganda and Ghana estimated that to start a simple practice in a rural area, they would need between \$165 and \$550 for locally purchased equipment, supplies, and medicines, and locally constructed furniture; midwives in Indonesia estimated that they would need \$3,000 for start-up funding. In Indonesia and Ghana, midwives can buy equipment in installments, so they can gradually accumulate equipment before they begin their private practice. In all settings, respondents agreed that it was expensive to rent premises for the practice. In some settings, landlords required 6 to 12 months' rent paid in advance and increased the rent "if it looked like [they] were busy." Midwives who continued in private practice usually purchased or constructed facilities at some point. The African midwives interviewed all stated that they had started small, often in a rented facility; built their practice over time; and eventually constructed or bought their own building. In Indonesia, midwives often started by using a few rooms in their house and gradually building additional rooms as their practice grew. On both continents, most midwives put all the profits they could afford to back into their practices.

According to numerous African respondents, the finances needed for start-up are beyond the reach of most midwives; to obtain funds they borrow money from family members or friends or secure commercial loans. Commercial loans in many countries, however, are difficult to obtain without collateral in the recipients' name, something many midwives do not have. Historically, the commercial banking sector has not viewed private midwifery practices as businesses and has been reluctant to approve loans for them. In addition, small-business loans, if available, often are geared towards agricultural projects where payback can be accomplished in a short period of time (three years maximum). Private midwifery practices often require more time to become profitable. Respondents reported that commercial interest rates range from 24 to 42 percent. One Ugandan informant reported that some microfinance schemes existed where one could borrow with only 20 to 40 percent of the loan value as collateral. Most respondents stated that problems accessing start-up funds restricted the number of midwives entering private practice. Indonesian midwives, however, have an easier time starting businesses, because their professional organization has a mechanism in place with the Bank of Indonesia that allows them to access credit.⁵

In Peru, start-up costs appear to be less of a barrier than in other settings. Most midwives start their practices in their homes and they can secure loans through the Ministry of Labor, which has a program to help set up private businesses. If midwives cannot afford to open a solo practice, two or three of them pool their resources to rent premises and begin a private practice as a group. The procedure is the same as in other countries.

⁵The PROFIT project began this loan scheme (Djuadi, Escueta, and Chee 1997)

4.4 SERVICES PRIVATE PRACTICE MIDWIVES OFFER

As mentioned previously, in addition to traditional midwifery care of women during pregnancy and birth, PPMWs also are offering a variety of clinical services. For decades, midwives in the most rural parts of Africa have been treating minor trauma and acute illnesses in their maternity homes. Peruvian midwives have been providing contraceptive services since the 1970s. Since in-service trainings in the mid-1980s, private-sector midwives in Africa and Indonesia have been offering a variety of short- and long-acting contraceptive methods (including intrauterine devices and implants). In recent decades, private-sector midwives have been trained to offer a variety of additional services, including diagnosis and treatment of STIs, PAC, immunizations, and integrated management of childhood illnesses. Private-sector midwives are slowly being trained to provide other services, including PMTCT, VCT, ARV provision and monitoring, and directly observed treatment short course (DOTS) in countries heavily affected by HIV/AIDS.

As summarized in Table 4.4, in countries studied for this paper, midwives appear able to offer any services sanctioned within the scope of practice legislation. There seems to be no difference in what midwives in the public sector can offer versus what those in the public sector can provide. Midwives in some countries are prohibited from delivering certain expanded services (for example, manual vacuum aspiration (MVA)), but such restrictions are rare. The most common barrier to delivering expanded services is training and, in the case of some contraceptives, a reliable and affordable supply of commodities. The cost of equipment was mentioned as a barrier only to provision of MVA services.

TABLE 4.4 EXPANDED SERVICES PROVIDED BY PPMWS

	Family planning	Care to children less than 5 years old	Childhood immunizations	VCT	PMTCT	PAC	MVA	STI	Malaria	DOTS	Diarrhea
Ghana	X	X	X	X	X	X	X	X	X	X	X
Peru	X			X		X	X	X			
Uganda	X	X	X	X	X	X	X	X	X		X
Indonesia	X	X	X	VC only		X		X			

5. CHALLENGES AND OPPORTUNITIES CONFRONTING PPMWS

Midwives face many challenges depending on the context of their countries, including the economic situation and public health sector policies. At the same time, by virtue of their location and traditional role, they are positioned to deliver services that address MDGs related to primary health care.

5.1 CHALLENGES

5.1.1 FINANCIAL REALITIES AND SUSTAINABILITY ISSUES

In many cases, private-sector midwives provide services in underserved areas that public-sector services do not cover. They often help clients who cannot pay them. These midwives are the least likely to be able to establish practices that are profitable and many engage in income-generation activities outside the health sector to survive.

Maybe I'll bring you my chicken. Statement of a client who could not afford to pay, as reported by the private midwife who attended her birth.
Uganda

In Ghana and Uganda, despite their history of private practice, community acceptance, and government support for private practices, many PPMWs cannot live off the revenue their practice generates. The reasons for this shortfall vary. Some midwives have little experience managing the financial or business aspects of their practices. In urban areas, PPMWs face competition from other private providers, including increasing numbers of physicians and public health facilities. Some midwives practice in remote rural areas with low population densities and people who are impoverished. Midwives practicing in rural areas said that few people could afford to pay for private-sector care, especially when the government offers subsidized or free care. Sometimes rural women will come to them for antenatal care, but go to public facilities to give birth, which may be free or subsidized, or birth at home with a traditional birth attendant who charges less than professional midwives.

The more rural you go, the harder it is to recoup the start-up investment. The vast majority of PPMWs survive, but they have to supplement their income from the practice with other activities.
Physician, Uganda

If they can't pay you cash, they'll pay you in kind so you can live. We don't charge much [PPMW stated that if their fees were too high, clients would choose to go to a government facility]...If you are from the area, everyone thinks the care should be free [because they are relatives]. Often they don't have funds to pay and pay in kind with yams or fish, like a barter system.
Midwife, Ghana

Some interviewees stated that direct-entry midwives who do not have a nursing background had more difficulty having profitable practices in rural areas. Because of their lack of a nursing background, these midwives could not offer as wide a scope of services (for example, treatment of minor trauma, and pediatric and adult minor illnesses). Others mentioned that many PPMWs in rural areas were getting older and could not provide 24-hour coverage or a full compliment of services; hence their practices were no longer profitable. In Ghana, midwives are aging and unable to offer total coverage or a complete range of services, yet younger ones are not from rural areas and are not attracted to beginning private maternity homes in rural areas that have fewer amenities. Despite these factors, PPMWs often deliver services to women who cannot afford to pay for them.

Usually women pay a deposit before the time of the birth, but sometimes they just arrive pushing. So there's nothing you can do [if they don't pay]... Sometimes [another] husband will pay more than you ask, so it balances out. You do what you can. It's been like that for a long time...but it's getting worse now.
Midwife, Ghana

Sometimes you give services knowing the woman cannot pay... [but] you must act to save the life of that baby or that mother... We [PPMWs] care for them. [This is] unusual compared to the cash-and-carry mentality of the [public] hospital.
Midwife, Ghana

Midwives reported that some services are more profitable than others, although they varied depending on the country and location of the practice within the country. Overall, midwives reporting making money from antenatal care and attending births, but in settings where these services are free in the government sector, midwives could not compete. In urban settings, midwives stated that the provision of certain contraceptive methods was profitable while others were not if they were subsidized or available cheaply in the market.

Women in urban areas can usually afford private midwives, but often women who cannot afford the services come. The midwife will attend their birth, and then they cannot pay... [but] we continue to serve the country.
Midwife, Uganda

In summary, midwives primarily reported the following reasons for why they were unable to make a profit or live only on the revenue generated from their private practices:

I try to live within my means. I do just what I do... [it's] not enough, but I'm surviving.
Midwife, Ghana

- competition from the government sector or private physicians
- free or subsidized services in the government sector
- the catchment area is sparsely populated
- the population in the catchment area cannot afford to pay for services
- contraceptive commodities or antibiotic treatments for STIs are cheap and easily available in the open market

African midwives supplement their income in a variety of creative ways. Those in rural areas are often engaged in raising poultry, farming, goat grazing, soap making, and petty trading. In urban or peri-urban areas, midwives often operate other businesses, including medicine shops, bakeries, market stalls, and beauty salons.

In Indonesia, where the gross national income is two to three times that of the African examples, more people can afford to pay for private-sector care; hence more midwives support themselves solely from the income of their private practice. In addition, most PPMWs live on the more densely populated islands where they can draw from a large enough client base to be profitable. Still, some women cannot afford care from PPMWs. This problem is handled in two ways. First, Ikatan Bidan Indonesia (the Indonesian Midwifery Association) (IBI) has an official policy to encourage all PPMWs to adopt two to three indigent families in their neighborhood and give them free care as a community service. In addition, the government reimburses indigent care for specific services. Each PPMW is linked to a local health center where she submits periodic statistics and details of services provided to clients unable to pay. The local health office then calculates what she is due and pays the PPMW for services rendered to indigent clients.

Since most work from home, when they aren't busy with patients they have freedom to do other things in their down time.
Midwife, Uganda

Peruvian midwives face competition from the government sector, which offers free services, as well as from physicians who also offer private-sector care during pregnancy and birth. As a result, those practicing in urban middle-class areas have developed innovative new services to attract clients, including hydrogymnastics for expectant mothers, parent preparation classes for couples, prenatal massages, and other health promotion activities. They market their services at community events. Most Peruvian PPMWs' income is from the delivery of family planning services and STI diagnosis and treatment. The majority of midwives cannot support themselves off of revenue from their private practice, however, and have other jobs to supplement their income.

I don't believe that a private practice is sufficient to support a midwife. The majority of midwives have other jobs in addition to their private practice, for the state or private [clinics]. The demand for private practice is very variable; there are months when things go well and others when they don't.
Midwife, Peru

5.1.2 TRAINING FOR EXTENDED ROLE (PRE- AND IN-SERVICE)

Midwives must have the knowledge and skills to be effective independent practitioners capable of providing quality clinical services in the public or private sectors. Unfortunately in too many pre-service midwifery programs, neither the content offered nor teaching methods used have resulted in midwives who are prepared for an independent extended role. Educational systems in many countries historically have focused on rote memorization and authoritative teaching methods (Physicians for Human Rights 2004). While some people may argue that this type of educational system can produce midwives able to perform competently in a structured environment with continuous clinical backup, in settings without immediate backup, the need for critical thinking and complex problem-solving skills is more acute. Until recently, the pre-service curricula in many countries where midwives attend the majority of births did not include emergency obstetrical knowledge and skills. Only in selected settings have pre-service curricula prepared midwives for the realities of independent practice and included the needed depth and breadth of knowledge and critical-thinking and problem-solving skills.

Historically, rather than targeting pre-service programs, expanded clinical content and clinical updates have been introduced to midwives primarily through in-service training funded by international donors (Aitken and Kemp 2003, Physicians for Human Rights 2004) and disseminated often through professional associations. As well as being expensive and unsustainable without continued donor funding, PPMWs often must sacrifice income and leave their clients unattended to go to in-service trainings. Many technical advisors interviewed said these problems were major issues. Unfortunately, midwives who are the most rural, who often provide the greatest range of services with the least amount of backup, and

who are most in need of updates, find it the most difficult to travel to sites where these updates are offered.

International agencies that sponsor training can often afford to train a small number of midwives to provide the new and expanded services. Recently in Uganda, 50 midwives were trained to provide PAC services and 12 were trained to provide PMTCT services. With approximately 1,000 midwives practicing in the private sector, this training is an expensive way to disseminate new clinical content. Focusing on in-service training (rather than pre-service education) ensures that every year new graduates of pre-service midwifery programs will enter the workforce without the knowledge and skills to provide new clinical services.

In Peru, this deficiency appears to be less of an issue as all midwives are educated in a five-year university-based degree program that includes most of the knowledge base and skills to prepare midwives for independent practice. Continuing education, however, remains a problem for those practicing in remote rural areas.

5.1.3 SUPERVISION AND INTERFACE WITH THE NATIONAL HEALTH SYSTEM

To be delivered effectively, private health services must fit in to the national health system in order to be monitored and supported. Midwives in private practice often face systemic barriers when delivering clinical services, including a lack of access to supportive supervision and continuing education and prohibitive regulatory and operations constraints. Despite being in private practice, midwives need the government to support the health system by enabling service providers (public and private) to effectively offer quality and necessary services.

Although in Indonesia and Peru midwives can practice simultaneously in the private and public sectors, in other countries doing so is prohibited. Historically Ghanaian and Ugandan midwives practicing in the private sector have been viewed as extending public-sector services, but despite this notion the relationship between private and public sector often has been troubled. One midwife had to move her private practice three times before she found a setting where the authorities did not view her as competing with a local health center. Others stated that while they are welcomed to the community, local health authorities could limit their scope of practice. In one instance, a midwife who had attended government training to be certified to provide immunization services was prohibited from delivering these services in her clinic. In Indonesia, an example of a decentralized health system, the scope of practice for midwives in the private sector varies by location and appears to be determined by local health authorities. Thus, in one part of the country PPMWs are permitted to start intravenous drips and prescribe antibiotics, while in others they are not. In these same countries, midwives reported that in some districts they often were considered part of the district health management team, while in others the district authorities just collected their statistics each month. In all three countries with a strong history of private practice, conditions varied by district and appeared dependent on local conditions and personalities.

In Ghana, where the professional midwifery association has members from both sectors, one of the officers explained that each has a prevailing myth about the other, a myth that appears in most countries. Government-sector midwives believe that private-sector ones wait too late to refer complicated, high-risk obstetrical cases to hospitals; private-sector midwives believe their public-sector colleagues treat women rudely and provide low-quality care. Midwives practicing in the most peripheral underserved sites reported the least amount of barriers from the government sector to offering extended services. In urban areas with more government facilities and more physicians, midwives reported the most barriers in providing expanded services, as they were perceived as competitors.

[Sometimes] the mother can't afford any kind of health care. If I refer her, the woman will cry, she pleads with you to keep her in the maternity home.
Midwife, Ghana

5.1.4 LACK OF BUSINESS SKILLS

One midwifery leader stated that she thought most midwives had “an inappropriate mental set” and viewed themselves as providers of services rather than business managers. While one could argue both are needed, many midwives cited a lack of business acumen as a barrier to establishing as successful private practice. In many countries, the commercial banking sector has not viewed private health providers as appropriate recipients for business loans.

Several donor-funded projects working with PPMWs have included basic business-skills training as part of their focus.⁶ In Uganda, since the end of a donor-funded project that focused on increasing the business knowledge of midwives, the Ugandan Private Midwives Association (UPMA) has encouraged midwives wanting to start private practices to take a business-management course from a private school. UPMA officers reported that midwives who received business training have more profitable practices than those who did not. In Peru, the Colegio de Obstetras (Midwifery College) recently held a course on business and management that was well received by members interested in private practice.

The trained provider, by default in most cases, will be a midwife, not an obstetrician. Specialists, for the most part, rarely attend normal deliveries... They prefer doing caesareans and gynecology. Midwives refer caesarean sections to them and sometimes successful midwives in private practice hire obstetrician/gynecologists to hold [high-risk] clinics at their maternity clinics.
Physician, Indonesia

5.1.5 PROFESSIONAL JEALOUSIES AND COMPETITION

The relationship between midwives and physicians is a complicated one in many countries. While midwives repeatedly have demonstrated their abilities to manage most births, certain obstetrical conditions require the skills of a physician. Midwives must practice with some obstetrical backup—whether they are in the public or private sector—to perform services they cannot (chiefly, caesarean sections). In settings where birth is culturally viewed as a normal event, which does not need to happen in a hospital, midwives are often the preferred attendants. In settings where a biomedical view of birth has been accepted, physicians often are the attendants of choice. The more physicians that are present, the more they may be in competition with midwives. In settings like Indonesia, where there are few physicians and many midwives, midwives are the preferred providers, even among those who pay for

⁶ Summa Foundation supported a microfinance program that provided business-skills training and revolving loans to private sector midwives in Uganda (Agha, Balal, and Ogojo-Okello 2002), and SEATS provided basic business management skills training via UPMA (Mantz 1997)

private-sector care. In the urban areas of many countries, however, as more physicians provide obstetrical services in the private sector, midwives increasingly are seen as competitors. Several informants also mentioned that PPMWs met the most opposition to offering expanded services, like treatment of STIs or well-child care, in urban areas with a high concentration of private-practice physicians.

In Lima, Peru, midwives reported that doctors are emphasized while midwives are viewed as less important. Outside the cities, where there are fewer doctors, however, midwives feel freer to practice. This sentiment was echoed in Africa where midwives in the private sector noted that physicians viewed them as competition in the cities but as valuable in rural areas.

If you can afford private sector care, you'll go to a physician, not a midwife, because they [physicians] are perceived as having more skill, being more prestigious.
 Technical advisor, Peru

5.2 OPPORTUNITIES

5.2.1 PROFESSIONAL ASSOCIATIONS

In all countries, nursing and midwifery regulatory bodies exist either as a section of the government or as parastatal organizations that establish the standards for licensure and registration of professional midwifery according to that country's laws. In addition to bodies that accredit and regulate midwifery, professional associations, which are nongovernmental organizations, represent the interests of midwives. Professional associations vary in their constituencies. In Zambia, the Zambian Nurses Association (ZNA) is the professional association for both nurses and midwives, as 70 percent of nurses in Zambia also are qualified as midwives. In Indonesia, Ghana, and Peru, the professional associations include public- and private-sector midwives. Uganda has a professional association for both nurses and midwives working in the public and private sector (the Uganda National Association for Nurses and Midwives), as well as UPMA, the professional association for private-sector midwives.

TABLE 5.6A OVERVIEW OF MIDWIFERY ASSOCIATIONS

Midwifery professional association	Ghanaian Registered Midwives Association (GRMA)	Ikatan Bidan Indonesia/ Indonesian Midwifery Association (IBI)	Colegio de Obstetras Peru/College of Midwives Peru (COP)	Uganda Private Midwives Association (UPMA)	Zambian Nurses Association (ZNA)
Established	1953	1951	1975	1948	1950
Membership	300 to 500	68,722	21,000	210	4,000
Potential PPMW membership	About 500	28,000	3,100 to 3,200	1000	None
Potential total membership	5,500	88,000 to 89,000	21,000	1,000 (estimated)	13,000
Percent eligible members who are members	5 to 9	77 to 78	100	35	31
Membership sectors and percent each represents	Public (18 percent) and private (82 percent)	Public (57 percent) and private (43 percent)	Public and private (membership mandatory)	Private (100 percent)	Public (vast majority) and private

While their focuses vary by country, all professional midwifery associations are concerned with their members' professional development. Many have received technical assistance in recent decades and, as a result, are better able to manage their internal organizational and business affairs, train their members, and manage donor-funded projects. Most have a significant role in disseminating in-service and continuing education, serve as the official voice for midwifery with their respective governments, and lobby to ensure that private-sector midwives are heard regarding critical issues. Most have decentralized branch structures, the capacity to reach and mobilize members from different regions of the country, and some role in supporting private-sector midwives. Donor efforts, however, largely support these associations. Some collect dues, but these funds are insufficient to sustain the associations' efforts.

TABLE 5.6B MISSION OF MIDWIFERY PROFESSIONAL ASSOCIATIONS

Ghanaian Registered Midwives Association (GRMA)	Ikatan Bidan Indonesia/ Indonesian Midwifery Association (IBI)	Colegio de Obstetras Peru/College of Midwives Peru (COP)	Uganda Private Midwives Association (UPMA)	Zambian Nurses Association (ZNA)
To promote training, development, and entrepreneurship, and serve as an advocate to midwives; to improve the standards of midwifery practice through community participation and promote the provision of equitable high-quality services to women, children, and their families nationwide.	Development of self-reliance, competitiveness, and capacity of IBI. To enhance the professionalism of Indonesian Midwives in order to save lives of mothers and newborns. To ensure professional provision of services provided by Indonesian midwives to the community.	Surveillance and promotion of practice according to standards of ethics and of the skills established in the "professional profile." In addition to serving as a technical-scientific reference in the area of reproductive health, the Colegio promotes integral development of its members whose actions contribute to improving social indicators.	To provide quality, accessible, and affordable reproductive health services including primary health care to the community.	To be a vibrant self-sustaining nongovernmental organization that protects and promotes the interests of nurses and midwives in Zambia. In so doing ZNA will promote the highest level of professionalism and integrity in the delivery of health care services to the community.

TABLE 5.6C PROFESSIONAL ASSOCIATIONS' CURRENT ACTIVITIES TO SUPPORT PPMW

Ghanaian Registered Midwives Association (GRMA)	Ikatan Bidan Indonesia/ Indonesian Midwifery Association (IBI)	Colegio de Obstetras Peru/College of Midwives Peru (COP)	Uganda Private Midwives Association (UPMA)	Zambian Nurses Association (ZNA)
Procures drugs in bulk to sell at discount to members, works with private medical-supply companies to market directly to members and set up payments in installments, distributes donated goods to members, supports continuing-education activities, supervises PPMWs in the association, lobbies at the national level for PPMWs to be reimbursed under national insurance scheme, credit union for loans, provides legal council for members	Operates branding and quality recognition program (Bidan Delima), participates in PROFIT loan scheme, continuing education and training, lobbies at national level	Offers courses on marketing, how to set up a private practice, and how to access credit; program to update provider skills and improve the quality of services	Writes funding proposals for one- to four-week continuing education classes and, if funded, conducts classes so that PPMWs can get continuing education units needed for relicensure; organizes groups of PPMWs to take business-skills training from private commercial colleges	Provides social support and encouragement for those starting private practices

At the same time, most professional associations face major challenges regarding their long-term sustainability. In many LDCs, large numbers of midwives are not members of their professional association. While the organizations have proven successful in working on projects, they often have difficulties adapting to changing circumstances and developing initiatives without donor funding. Most associations have not been able to develop enough income to pay full-time staff without donor support. And without full-time staff, most are dependent on the volunteer services of midwives who can afford to volunteer their time, usually urban retired midwives.

5.2.2 COMMUNITY ACCEPTABILITY

Because midwives often speak the same language and come from the same cultural group as those around them, they usually are accepted in the community without reservation. In urban areas particularly, the private midwives' afternoon and evening hours are convenient for working mothers and the atmosphere is more relaxed than in government facilities. As an Indonesian midwife stated, "Women can chat with the midwife; she's their neighbor." Midwives are generally seen as valuable members of the community, as the following quotes illustrate:

- *PPMWs are respected as the health care providers of the communities. People use them for more than just births.*
Midwife, Indonesia.
- *There is a general perception that private-sector midwives are good. [Clients] get more time [from PPMW]; they are more flexible and negotiate with clients. They sit down with them, discuss, and explain. Midwives in the public sector don't have time [to do this]. Family planning is a service that requires time, to negotiate, counsel, discuss. It needs*

personalization. PPMWs do this better than public-sector midwives. They are doing a good job.

Physician, Uganda

- *Midwives are located in their own communities. They are easy to access; women are comfortable with them. It's sort of like going to your neighbor's [house].*

Physician, Indonesia

- *In rural areas they are very well recognized by the local population.*

Midwife, Peru

6. CONCLUSIONS

6.1 IMPACT OF PPMWS ON SERVICE DELIVERY

PPMWS are often the only professional providers in poor and remote areas that offer a range of primary health services. They often serve as the first contact for health care in settings where the public sector is not offering services to at-risk populations. For example, in addition to providing care during pregnancy and birth in their private maternity homes, for decades Ghanaian midwives have offered vaccination services, treated minor trauma, cared for children less than 5 years old, and treated infectious diseases (including diarrhea, malaria, and tuberculosis) in rural, remote, and impoverished regions.

In countries where private-practice midwifery has flourished, midwives provide a substantial amount of essential clinical services nationwide. Members of GRMA, 82 percent of whom are private providers, attend one-third of all births in Ghana (statistic from interview who was quoting the most recent unpublished DHS data). In Indonesia, private-sector midwives provide 28 percent of all family planning services in the country (BPS and ORC Macro. 2004). In Indonesia, Ghana, and Uganda, if private-sector midwives stopped providing care, the government sector would be unable to meet the demand for these critical health services.

6.2 FACTORS ASSOCIATED WITH SUCCESSFUL PPMWS

This paper presented case examples—where private-practice midwives are delivering reproductive health and primary health care services—to illustrate contextual factors that helped them or barriers that prevented them from delivering these services. Countries that were success stories shared the following factors, which created an enabling environment for establishing private-sector midwifery practices:

- a strong history of midwifery as a respected profession
- clear legislative sanctions for private practice
- a demand for services
- training to enable midwives to provide expanded services (often donor-funded and facilitated through professional associations)
- a history of government support (for example, subsidization of start-up, tax incentives, reimbursement for provision of services to those unable to pay)

This paper also identified factors that constrain private-practice midwifery, even in countries where it has been successful. Unless addressed, these factors could restrict the numbers of midwives who will enter private practice as well as limit those who will be able to continue their established practices. The following paragraphs describe these factors; recommendations to address them are in Section 7.

6.3 FACTORS ASSOCIATED WITH STRUGGLING PPMWS

Countries that were struggling lacked the enabling factors listed above and also shared the following additional hindrances for establishing private-sector midwifery practices:

- weak links to the formal health sector
- lack of financial sustainability and business skills

Weak Links to the Formal Health Sector

The links between private-sector midwives and the formal public health sector are ad hoc and at times tenuous. While many PPMWs serve on national regulatory bodies (for example, nursing and midwifery councils) or on local district health committees, this linkage usually depends on the location and individual rather than anything formal. In a similar way, the professional association is often the de facto voice for private-sector midwifery at an MOH. But this relationship is rarely formalized and, therefore, it too is dependent on the setting, circumstances, and individuals. Separation of private-sector midwives from the formal health sector can weaken private-sector practices by excluding midwives from beneficial public-sector programs, such as access to commodities and equipment, continuing education, supportive supervision, and proper compensation. Separation of the formal health sector from the private one also can weaken the formal health sector's ability to mobilize personnel and resources in times of crisis, measure health statistics, and assess health expenditures and manpower needs. In addition, without a link to the formal sector and national standards of care, the quality of clinical services in the private sector can suffer.

Lack of Financial Sustainability and Lack of Business Skills

While PPMWs provide a substantial number of essential services to high-risk populations, they face many obstacles in starting and financially sustaining their practices. Start-up capital is beyond the reach of many midwives, especially in African countries, and traditional commercial-sector loans are difficult for most midwives to obtain and repay due to high interest rates.

Midwifery informants in all countries reported that clients who were unable to pay for services came to them for care and that they cared for them without compensation. In remote rural areas, the services of the private-sector midwives are often the only option available; in urban areas, private services are perceived as more culturally sensitive, of higher quality, and cheaper than those available in the public sector. As a result of the economic context in which they practice, many private-sector midwives are unable to live on their income from the practice alone and, even with the best business-management skills, they cannot be profitable without subsidization or reimbursement. At the same time, training in basic business skills is critical and needed for private-sector midwives. Those interviewed repeatedly stated that midwives who had business-skills training were usually more successful in establishing profitable practices.

Despite the common fact that all of these private midwives would benefit from formal business-skills training, profitable businesses depend on *paying* customers. To attract enough paying clients, midwives need to be in places where there is a large enough middle class that is not being served by the public sector or by private-practice physicians. Many midwives, however, especially in the African countries included in this paper, continue to serve poorer, at-risk communities where public services are unavailable or seen as poor quality and where there are no physicians. These midwives need to be paid for services they render through alternative financing mechanisms. In Peru, midwives are faced with

competition from private doctors and are not able to attract enough paying clients to sustain a profitable business. Again, through alternative financing mechanisms, these midwives could serve poorer populations that the government cannot cover—but not without proper compensation. Finally, in Indonesia, there is a large enough middle class and the government supports and promotes PPMWs and subsidizes the care they provide to indigent clients. It is no surprise that Indonesian midwives enjoy profitable practices.

7. RECOMMENDATIONS—CREATE AN ENABLING ENVIRONMENT AND SYSTEMS TO SUPPORT EXTENDED ROLES AS PPMWS

7.1 SUPPORT THE ABILITY TO DELIVER QUALITY SERVICES

- Support acquisition of new skills through new models of distance learning so that learning activities are affordable and efficient. Continued donor support is needed for disseminating new clinical skills and content so that PPMWs can deliver new, expanded, and quality clinical services. In-service training is the only viable option to reach practicing midwives, but as discussed earlier, it has many disadvantages for busy midwives or midwives practicing in remote areas. New models for in-service training need to be explored. IBI is using a combination of traditional in-service courses with self-study modules and one-on-one mentoring to disseminate new content and ensure the quality of clinical services. Whatever mechanism is used, there must be the opportunity for the mentored clinical practice of new skills. To ensure the continued diffusion of new clinical knowledge and skills to future PPMWs, mechanisms must be developed to guarantee that the new content is quickly integrated into existing pre-service midwifery educational programs.
- Support adapted approaches and tools for quality improvement that serve as a supplement to a formal supervisory structure in the private sector. Midwives working in private practice are primarily in small facilities that they own, are not part of a supervisory structure, and have limited access to continuing education. It is imperative to adapt the existing approaches and tools the public sector uses for quality improvement (for example, the Yellow Star program, performance improvement reviews, and COPE⁷) for midwives working in the private sector.
- Regulations for ensuring the continued competency and accreditation of private services also should be strengthened; systems by which these regulations are easily implemented should be designed. There is a role for ongoing quality improvement through COPE and the PSP-One quality-improvement tool, but these efforts should be coupled with formal continuing-competency requirements for individual practitioners and formal accreditation for facilities. Recertification and re-licensing of individuals and regular accreditation of services should be assessed in these countries and redesigned if necessary to apply to and support PPMWs.

7.2 SUPPORT FINANCIAL AND BUSINESS SUSTAINABILITY

- Increase access to capital to start and maintain business. Estimates of start-up costs varied widely in countries studied, but whether the amount is hundreds or thousands of dollars, in reality, start-up

⁷ EngenderHealth's Process for Improving Quality Health Services

funds are beyond the reach of many midwives. As a result, many midwives who want to enter private practice do not. Programs like PROFIT and the Summa Foundation have demonstrated in countries like Uganda and Indonesia that revolving loan schemes can assist midwives to start private practices or expand the services they offer (Djuadi, Escueta, and Chee 1997; Agha, Balal, and Ogojo-Okello 2002).

- Provide business-skills training so that new businesses can flourish. Midwives receive little if any business-skills training in their midwifery educational programs. While this training needs to be incorporated into pre-service programs, midwives currently in private practice can benefit from basic business-skills training, including bookkeeping, budgeting, income projections, and profitability calculations. In settings where this content has been disseminated via in-service trainings sponsored by professional associations, midwives are better able to manage the business aspects of their practices (Quimby and Mantz 2000).
- Provide better economic compensation for services delivered through a variety of financial strategies: contracting out, vouchers, and insurance. PPMWs deliver essential services to clients who cannot pay for them. Financing mechanisms should be explored in which the public sector pays for specified services that the poor and other vulnerable groups are obtaining from PPMWs. For example, the government can establish contracts with PPMWs in which they are compensated for providing a pre-determined package of services to a specified population, preferably in areas MOH facilities do not cover. A voucher scheme also can be established in which target populations (usually the poor) receive vouchers they can use to pay for specific services and which the PPMW would then use to be reimbursed by the government. Another option is to include PPMWs in insurance plans, such as social insurance or community-based plans, by certifying them as participating providers of those plans. In this case the insurance scheme would reimburse them for providing specified services to their members.

7.3 SUPPORT LINKS TO THE FORMAL HEALTH SECTOR

- Strengthen the interface between the MOH and PPMWs. Better information and data-collection systems need to be instituted to track the number and quality of services the private sector delivers. Midwifery regulatory agencies (for example, councils) could be the link between the MOH/public sector and the private sector by mandating continuing education for the private sector and systematic quality-assurance mechanisms. In a complementary role, professional associations could be implementing bodies for such mandates. In addition, national standards of practice need to be disseminated and used in the private sector.
- Give professional associations marketable services that can be sold to strengthen their role. While professional associations in all of these countries face the continuing challenges of economic sustainability and reliance on volunteer leadership (unless they are donor funded), the associations have existed for decades, have communication networks, have relationships with the MOH, and historically have been the primary mechanism for dissemination of new clinical content and skills to their members. They have the potential to serve as the liaison body between the government and private sectors. As mentioned previously, professional associations are strategically positioned to ensure that midwives in independent and private practice have access to continuing education, receive assistance in reviewing the quality of the services that they provide using a self-assessment approach, and are linked to the public sector.
- Reduce regulatory and legislative barriers that prevent midwives from entering private practice. The public health sector, through the national government, needs to acknowledge that private-sector

midwives contribute significantly to addressing MDGs and national health goals. National governments need to foster increased political will to reduce barriers to midwives who wish to enter into private practice, to better support their expanded scope of practice, and to provide a better interface for PPMWs with the national health system.

ANNEX A: KEY INFORMANTS INTERVIEWED

Deborah Armbruster, Director of the POPPI Project, POPPI/PATH

Annie Clark, Senior Technical Advisor, Global Outreach Division, ACNM

Barbara Kinzie Deller, Senior Midwifery Advisor, JHPIEGO

Betty Farrell, Medical Associate, Engender Health

Frances Ganges, Independent Midwifery consultant

Deborah Gordis, Director, Global Outreach Division, ACNM

Patricia MacDonald, Senior Technical Advisor, Service Delivery Improvement, USAID

Mary Lee Mantz, Independent Midwifery Consultant

Margaret (Peg) Marshall, Senior Advisor on MCH and ID, LAC Bureau, USAID

Nester Moyo, Program Manager, ICM

ANNEX B: QUESTIONNAIRE FOR FIELD-BASED TELEPHONE INTERVIEWS

I. Introduction

Hello. My name is _____ and I am a _____ working with the Private Sector Partnerships-One project. The PSP-One project is a five-year USAID funded project with the goal to increase private sector participation in the delivery of critical health services, namely family planning, reproductive health, maternal health and HIV/AIDS. Over the last decade, the private sector has increasingly become an important provider of essential and basic health services in the developing world. Midwives⁸ are a significant and growing segment among this group of private providers. Despite their essential role in private sector service delivery, midwives in independent practice often encounter significant barriers to establishing their practice and to providing long acting family planning methods and other reproductive health services.

This interview, which should be no more than one hour in length, will help set the stage for a paper that identifies the necessary policy and environmental conditions for successful independent practice of private sector midwives. Although we are focusing on legal and regulatory barriers, an important set of constraints to successful independent midwifery practice are non-policy or environmental conditions, such as professional jealousies by physicians, or reliance on midwives because of limited number of physicians, or difficulty accessing credit to start up private practices. So, anything you can share about the factors, which enable and constrain the independent practice of private midwives, will be helpful. In our final paper we hope to highlight lessons learned and strategies used to strengthen the private practice of midwives in developing countries.

I understand that all information given may be used in the aforementioned paper, but that my identity will remain confidential unless I give permission to be quoted.

- I agree to being quoted and want to be interviewed
- I disagree to being quoted but want to be interviewed

(verbal consent of interviewee)/date

(signature of interviewer)

⁸For the purposes of this study, a midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery (taken from ICM definition of a midwife).

ANNEX C: QUESTIONNAIRE FOR MIDWIFERY LEADERS

A. Basic Information

Name: _____

Organization/position: _____

Midwifery education: _____

Years experience as a midwife: _____

Years experience in Private Practice Midwifery (PPMW): _____

Contact information: _____

B. Country Background

1. Is private practice midwifery (PPMW) legal in your country?
 - a. If **yes**, since when?
2. Are there specific laws that regulate or promote or limit the scope of PPMW in your country?
 - a. If **yes**, what are they?
 - b. What organization is the regulatory body governing PPMW?
3. What is the attitude of the Ministry of Health towards PPMW? /How does the MOH view PPMW?
4. Is there a professional association of midwives in your country?
 - a. If **yes**, what is its name?
5. Is it composed of public midwives, private midwives or a mix of both?
 - a. If a **mix**, what percent are from each sector (estimate)?
6. Does the professional association in any way provide support for PPMW?
 - a. If **yes**, how does it provide support? /What kind(s) of support does it provide?

C. Setting Up Private Midwifery Practice

1. What motivates midwives in your country to start their own private practice?
2. Describe the typical PPMW in your country (age, experience).
3. What does a typical private practice look like (i.e, is the midwife working solo)? Where is her practice located? Is she part of a network? Does she have physician backup/hospital for referral?
4. Based on your experience or knowledge, is it difficult to set up a private midwifery practice in your country?
 - a. If **yes**, what are the difficulties?
 - b. How are they addressed?
 - c. If **no**, what factors made it easy?
5. How is a PPMW licensed? (Detail process and cost if possible.)
6. Is her facility accredited?
 - a. If **yes**, how? (Detail process and cost if possible.)

D. Practice Operations

1. How much start up funding is needed to open a private practice in your country? or
Is much start up funding needed to open a private practice in your country?
2. Are these funds a problem for most midwives to obtain?
3. If **yes**, how do they obtain them?
4. Does lack of start up funding limit the number of midwives entering PP?
5. Are there other barriers that limit the number of midwives entering private practice?
6. In addition to care during pregnancy and birth, can PPMWs provide other services (FP, STI diagnosis and treatment, EPI, HIV counseling, ARV provision, PAC, etc.)?
 - a. If **yes**, what services are commonly provided by PPMWs in your country?
 - b. If **yes**, how do PPMW acquire the permission, knowledge, skills, equipment, space, etc. to deliver these extended services?
7. Are there laws, regulations or other barriers that limit the types of services that PPMWs can offer?
 - a. If **yes**, what are the barriers and how do the barriers prevent PPMWs from offering extended services?

- b. If **yes**, how are these barriers being addressed?
8. Based on your experience and knowledge, what is the largest challenge for PPMWs in starting up and maintaining a private practice and what can be done to overcome it?

E. Sustainability

1. What services generate the largest income for PPMWs?
2. What services generate the least income for PPMWs?
3. Are there clients who cannot afford the services of PPMWs?
 - a. If **yes**, how is that handled?
 - b. If **yes**, where does the woman get care/services?
4. Are the clinics/practices of most midwives in private practice profitable (i.e., they can recoup operating expenses and live off on income generated from private practice)?
 - a. If **no**, what are their other sources of income?
 - b. If **no**, why can't they live on that alone (loan payment too high, not big enough catchment area, poor catchment area, can't expand services)?

F. Summary Contextual Factors

1. On a scale of 1-5 (with 1=doing very poorly and 5=doing very well), how would you assess the state of PPMWs in your country?
2. What factors in your country explain/contribute to this? (List factors positive and negative.)
3. Which factor is the most important?
 - a. If **negative**, what can/is being done to address this factor?

G. Closing

Thank you for your time and contacts. We would be pleased to share a copy of the report upon its completion. (Get address if person wants a copy.) We are very interested in disseminating this report widely to raise awareness on the major contributions private sector midwives play in increasing access to RH/FP services as well as highlight some of the barriers they confront so we, as a donor community, can begin program activities to help address these barriers.

ANNEX D: QUESTIONNAIRE FOR TECHNICAL ADVISORS

Name: _____

Organization/position: _____

Relevant Project/Country/Dates: _____

Contact information: _____

1. Can you tell me a bit about your project and its purpose, challenges you faced and achievements you accomplished?
2. How is/was midwifery perceived in _____ (name of country)?
3. Is private practice midwifery (PPMW) legal in _____ (name of country)?
 - a. If **yes**, since when?
4. Are there specific laws that regulate or promote or limit the scope of PPMW in the country?
 - a. If **yes**, do you have information on them? Where I can get information about them?
5. Do you know what organization is the regulatory body governing PPMW in _____ (name of country)?
6. How is/was PPMW perceived in _____ (name of country)?
7. How is/was PPMW perceived by the MOH in _____ (name of country)?
8. What kind of services do PPMWs offer in _____ (name of country)? Do you know since when?
9. How are PPMWs prepared/trained/educated to provide these extended services?
10. What is/was the role of the professional association with PPMW?
11. Compared with other professional associations you have worked with or are aware of, how would you assess this association?
12. During the time you worked with (name of project), what contextual factors did you notice which either enabled or served as barriers to private MW practice in _____ (name of country)?
13. List of enabling factors

14. List of barriers and how they were addressed/overcome
15. On a scale of 1 to 5 (with 1=doing very poorly and 5=doing very well), how would you assess the state of PPMW in _____ (name of country)?
16. What factors contribute most to this score?
17. Which factor is the most important?
 - a. If negative, what can be/is being done to address this factor?
18. Are there any documents you know which may contain information relevant to this study?
 - a. If **yes**, where could I obtain copies?

Closing

Thank you for your time and contacts. We would be pleased to share a copy of the report upon its completion. (Get address if person wants a copy.) We are very interested in disseminating this report widely to raise awareness on the major contributions private sector midwives play in increasing access to RH/FP services as well as highlight some of the barriers they confront so we, as a donor community, can begin program activities to help address these barriers.

ANNEX E: COUNTRY INTERVIEWS

Ghana

Gloria Abbey, Private Practice Midwife, Gloria's Maternity Home, Legon, Accra

Dora Alice Amoyaw, Trainer, GRMA

Earnestina Djokotoe, President, GRMA

Mariama Sumani, Chief Nursing Officer, Ghana Health Service

Indonesia

Anne Hyre, Senior Midwifery Advisor, JHPIEGO, Jakarta

Enrique Lu, Senior Reproductive Health Advisor, Family Planning/Reproductive Health Center of Excellence, JHPIEGO, Baltimore

Nur Ainy Madjid, Secretary General, Indonesian Midwives Association (IBI), Jakarta

Asmuyeni Muchtar, Senior Midwifery Advisor, JHPIEGO, Jakarta

Damaryanti Suryaningsih, Program Manager for STARH, JHPIEGO, Jakarta

Peru

Hilda Baca, Dean of Midwifery and Nursing School, Universidad de San Martin de Porres, Lima, President of Asociacion Peruana de Escuelas y Facultades de

Obstetricia

Flavia Cruzado, private practice midwife, Clinica San Miguel, Lima

Milka Dinev, Country Representative, PATHFINDER, Catalyst Project

Miriam Solis, Director Midwifery Licensing (IDREH), Presidenta del Sistema Nacional de Desarrollo Profesional de Obstetricia (SINADEPRO), Colegio de Obstetras de Peru

Elizabeth Yalan, Dean of the Colegio de Obstetras de Lima

Uganda

Godfrey Magumba, JSI Private Sector Specialist, Uganda Program for Human & Holistic Development (UPHOLD)

Goreti Musoke, Former President (1997-2000), UPMA

Mary Namusisi, Branch Coordinator, UPMA

Theresa Nantale, District Liaison Officer, UPMA

Pius Okong, President, OB/GYN Association of Uganda, UPMA board member, Senior Consultant Obstetrician Gynecologist, MOH Uganda, Head of Obstetrics & Gynecology, St. Francis Hospital

Zambia

Jennifer Munsaka, Executive Director, Zambia Nursing Association

Dorcas Phiri, Compliance Manager, General Nursing Council, Zambia

Genevieve KK Mwale-Musokwa, Technical Advisor, Home Based Care RAPIDS Program, Catholic Relief Services

ANNEX F: REFERENCES

- Agha, S., A. Balal, and F. Ogojo-Okello. 2002. The Impact of a Microfinance Program on Client Perceptions of the Quality of Care Provided by Private Sector Midwives in Uganda. Country Research Series, Number 6. Washington, DC: USAID/Commercial Market Strategies.
- Aitken, J.M. and J. Kemp. 2003. HIV/AIDS, Equity and Health Sector Personnel in Southern Africa. Regional Network for Equity in Health in Southern Africa (EQUINET) Discussion Paper, Number 12. Harare, Zimbabwe: EQUINET.
- Badan Pusat Statistik-Statistics Indonesia (BPS) and ORC Macro. 2004. Indonesia Demographic and Health Survey 2002–2003. Calverton, MD: BPS and ORC Macro.
- Bour, J. and N.C. Bachri. 1990. Improving skill and knowledge of midwife practitioners to facilitate better quality services in MCH and family planning by Midwifery Association. In: A midwife's gift: love, skill and knowledge. Proceedings of the International Confederation of Midwives 22nd International Congress, Kobe, Japan.
- Centers for Disease Control and Prevention. "Malaria Facts." Centers for Disease Control and Prevention. www.cdc.gov/malaria/facts.htm (accessed March 29, 2006).
- Central Intelligence Agency. 2006. "The World Factbook." Central Intelligence Agency. www.cia.gov/cia/publications/factbook (accessed May 2, 2006).
- Djuadi, D., D. Escueta, and G. Chee. 1997. Revolving Loan Fund for Midwives, Indonesia. Final Evaluation Report: April 1995–August 1997. Arlington, VA: USAID/Promoting Financial Investments and Transfers to Involve the Commercial Sector in Family Planning (PROFIT).
- Federal Research, Library of Congress. 1992. Uganda: A Country Study. Washington, DC: Federal Research Division, Library of Congress. <http://library.thinkquest.org/C001142/credits.php> (accessed April 25, 2006).
- Federal Research, Library of Congress. 1993. Government support in Indonesia: A Country Study. Washington, DC: Federal Research Division, Library of Congress. Also available at [http://lcweb2.loc.gov/cgi-bin/query/r?frd/cstdy:@field\(DOCID+id0079\)](http://lcweb2.loc.gov/cgi-bin/query/r?frd/cstdy:@field(DOCID+id0079)) (accessed April 26, 2006).
- Federal Research, Library of Congress. 1995. The colonial era: British rule of the Gold Coast in Ghana: A Country Study. Washington, DC: Federal Research Division, Library of Congress. Also available at [http://lcweb2.loc.gov/cgi-bin/query/r?frd/cstdy:@field\(DOCID+gh0017\)](http://lcweb2.loc.gov/cgi-bin/query/r?frd/cstdy:@field(DOCID+gh0017)) (accessed April 25, 2006).
- General Nursing Council of Zambia. 2004. Nursing Home Guidelines.
- Ha N.T., P. Berman, and U. Larsen. 2002. Household utilization and expenditure on private and public health services in Vietnam. *Health Policy & Planning*. March. 17 (1): 61–70.
- Jamison, D.T., and W.H. Mosley. 1991. Disease Control Priorities in Developing Countries: Health Policy Responses to Epidemiological Change. *American Journal of Public Health*. January; 81(1): 15–22.

- Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO). 2005. AIDS Epidemic Update: December 2005. Geneva: UNAIDS. Also available at www.unaids.org/epi/2005/doc/report_pdf.asp/ (accessed March 29, 2006).
- Kenney, G.M. 1989. The Economics of Private Sector Family Planning Service Provision in Indonesia. Washington, DC: Urban Institute.
- Mantz, M.L. 1997. Business Management Skills for Private Midwives: Curriculum and Guide for Trainers. Arlington, VA: John Snow/Family Planning Service Expansion and Technical Support Project (SEATS), 1997.
- Measure DHS. 2006. "Demographic and Health Surveys." Measure DHS, www.measuredhs.com/countries/ (accessed May 25, 2006).
- National Bureau of Statistics. Uganda National Household Survey 1999/2000. National Bureau of Statistics. World Bank Group. 2002.
- Physicians for Human Rights. 2004. An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa. Boston: Physicians for Human Rights.
- Quimby, C.H. and M.L. Mantz. 2000. Expanding Access to Reproductive Health Through Midwives. Arlington, VA: John Snow/Family Planning Service Expansion and Technical Support Project (SEATS).
- Ross, John A., and William L. Winfrey. 2002. Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate. International Family Planning Perspectives, Vol.28.
- Srinivasan, K., and S.K. Mohanty. 2002. Health Care Utilization by Source and Levels of Deprivation in Major States of India: Findings from NFHS-2. Mumbai: International Institute for Population Sciences.
- World Health Organization (WHO). 2005. World Health Report 2005: Make Every Mother and Child Count. Geneva: WHO. Also available at www.who.int/whr/2005/whr2005_en.pdf (accessed March 29, 2006).
- World Health Organization (WHO). 2006a. "Core Health Indicators." WHO, www3.who.int/whosis/core/core_select.cfm (accessed May 25, 2006).
- World Health Organization (WHO). 2006b. "Tuberculosis Factsheet." WHO, www.who.int/mediacentre/factsheets/fs104/en/print.html (accessed March 29, 2006).