

**Lessons Learned From SEATS' MAPS Initiative**

# Expanding Access to Reproductive Health Through Midwives

Family Planning Service Expansion  
and Technical Support

By Charlotte Houde Quimby, RNP/CMW  
and Mary Lee Mantz, RNP/CMW

January 2000



The goal of the Family Planning Service Expansion and Technical Support (SEATS) Project is to expand access to and use of high-quality, sustainable family planning and reproductive health services.

John Snow, Inc. (JSI), an international public health management consulting firm, heads a group of organizations implementing the SEATS Project. These include the American College of Nurse-Midwives (ACNM), AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), World Education, and partner organizations in each country where SEATS is active.

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# Dedication

The Midwifery Association Partnerships for Sustainability (MAPS) Special Initiative is dedicated to the late Bonnie Pederson, who, in addition to her many accomplishments, was also and always a midwife. Bonnie believed that midwives could *make a difference* in improving the lives of women and children throughout the world, and she dedicated her life and her career to assisting midwives to fulfill their potential as family planning/reproductive health service providers. She provided guidance in the initial development of MAPS and enthusiastic support during the project's implementation.

Bonnie is an inspiration to all midwives everywhere. We think she would be proud of the accomplishments of MAPS.





# Acknowledgements

The Midwifery Association Partnerships for Sustainability (MAPS) Initiative is about midwives, their professional associations, and their tireless efforts to improve reproductive health care for families throughout Africa and the world. The success of the MAPS Initiative is mainly a result of the dedication of these men and women. In particular, the authors would like to thank the following professional organizations and leaders:

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We also would like to acknowledge the strong backing of the USAID missions in Uganda, Zambia, and Zimbabwe.

# List of Acronyms

ACNM	The American College of Nurse-Midwives
AIDS	Acquired immune deficiency syndrome
ANSFS	Association Nationale des Sage-Femmes Sénégalaises (Association of Senegalese Midwives)
CE	Continuing education
CMA	Cambodian Midwives Association
CMS	Commercial Market Strategies Project
CQI	Continuous quality improvement
CYP	Couple-years of protection
DISH	Delivery of Improved Services for Health
ECSACON	East, Central, and Southern African College of Nursing
FP	Family planning
HIV	Human immunodeficiency virus
HPC	Health Professions Council
ICM	International Confederation of Midwives
ICO	Independent Clinics Organization
IEC	Information, education, and communication
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method
LSS	Life-saving skills
MAPS	Midwifery Association Partnerships for Sustainability
MIS	Management information systems
MOH	Ministry of Health
NAMAS	National Medical Aid Societies
NGO	Nongovernmental organization
PMW	Private midwife
PROFIT	Promoting Financial Investments and Transfers Project

PSI	Population Services International
PSMAS	Public Service Medical Aid Society
PVO	Private voluntary organization
RHC	Reproductive health care
SDP	Service delivery point
SEATS	Family Planning Service Expansion and Technical Support
SOMARC	Social Marketing for Change Project
STI	Sexually transmitted infection
TA	Technical assistance
TAMA	Tanzanian Midwives Association
TFR	Total fertility rate
TOT	Training of trainers
UNFPA	United Nations Population Fund
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development
WHO	World Health Organization
YFS	Youth-friendly services
YFT	Youth-friendly training
ZAPSO	Zimbabwe AIDS Prevention and Support Organization
ZINA	Zimbabwe Nurses Association
ZMG	Zimbabwe Midwives Group
ZNA	Zambia Nurses Association
ZNFPC	Zimbabwe National Family Planning Council

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# *Executive Summary*

Population growth is one of the world's most pressing concerns. In the next 25 years, the world's population is projected to increase to nearly eight billion people. The most growth is expected to occur in Africa, Asia, and Latin America—regions with the least resources. If these predictions are accurate, the majority of the people in the world will be affected by reductions in quality of life, in life expectancy, and in environmental and economic stability.

While no simple solution to the global population crisis is likely to be found, associated problems can be successfully addressed. One key problem is lack of access to contraceptives and high-quality reproductive health care services. Providing this access could prevent some of the millions of unwanted pregnancies that occur each year and save the lives of millions of mothers and children. High-quality reproductive health programs are needed that are sustainable, appropriate to local cultures, and sensitive to client needs.

One program that seeks to increase access to family planning (FP) and reproductive health care (RHC) is the Midwifery Association Partnerships for Sustainability (MAPS). MAPS is a Special Initiative of the Family Planning Service Expansion and Technical Support Project (SEATS II)—funded by the United States Agency for International Development (USAID) and implemented by John Snow, Inc. (JSI) in collaboration with its partners. SEATS' partner, the American College of Nurse-Midwives (ACNM), implements MAPS.

The MAPS Initiative promotes the development of midwives as a way to address unmet needs for FP/RHC. MAPS works with midwives in the private and public sectors, through their professional associations. This focus on associations helps to strengthen and maintain high standards and expand services. Activities that support the development of private midwife practices ensure access to high-quality services for clients. MAPS uses a variety of activities—such as training, advocacy, and policy changes—to ensure that midwives can reach their full potential as a community-based resource.

MAPS began its efforts in 1995. Since then, the program has created and implemented projects in four countries in Africa—Senegal, Uganda, Zambia, and Zimbabwe—and assisted midwifery associations in Cambodia, Eritrea, and Tanzania. MAPS has increased access to FP and RHC services by:

- ✦ Providing services in communities where public-sector services are limited or unavailable (e.g., rural areas).
- ✦ Integrating family planning into existing reproductive health care services.
- ✦ Reducing practice barriers.
- ✦ Providing health care alternatives for clients.

MAPS strategies include:

- ✦ Capacity building of associations.
- ✦ Capacity building of members.
- ✦ Creation of more enabling practice environments.
- ✦ Promotion of quality and sustainability.
- ✦ Creation of model clinics.
- ✦ Development of policy initiatives.

These strategies were implemented differently in each country where MAPS worked. Each subproject had a somewhat different focus depending on the situation. MAPS offered flexibility and a wide range of family planning and reproductive health training and association development capabilities to fit specific country needs—a customized approach that proved highly successful.

Sustainability is also a major goal of MAPS. Building the sustainability of an association means building the capacity for self-governance, management, training, advocacy, diversification of funding sources, strategic planning, and marketing. It addresses reducing barriers that prevent private midwives (PMWs) from offering a full range of services, including family planning. To support sustainability of individual midwives, MAPS focuses on improving quality of care, strengthening the marketing capability of PMWs, increasing access to family planning care, and introducing user fees. The project facilitated outreach activities by the PMWs to make communities more aware of their services. In reaching beyond their clinics to the communities they served, midwives learned a great deal about community needs, perceptions of care, and barriers to access.

The MAPS Initiative includes a strong training program to expand midwives' knowledge, skills, and attitudes. Training covered areas such as mobilizing communities, managing a business, keeping records of service statistics, and monitoring quality of care. During the MAPS end-of-project evaluations, midwives reported that these activities contributed greatly to their professional growth.

Despite the short-term nature of most of the subprojects, MAPS accomplished many objectives. The initiative strengthened the capacity of associations and the skills of midwives; it helped position private-practice midwives as change agents; and it helped midwives increase client access to and use of effective contraception.

During the course of the project, MAPS learned many valuable lessons, including:

1. The power of quality can never be underestimated.
2. Flexibility and perseverance are needed to operate within the constraints of a situation or country.
3. Every new situation should be treated as a teaching and learning opportunity, with mid-course adjustments made, and midwives consulted for creative problem solving.
4. Barriers to private practice severely limit the potential contribution of midwives to reducing the unmet need for RHC services.
5. RHC service delivery points are incomplete without minor curative services and immunization capability.
6. In unity, there is strength.
7. The human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) has permanently changed the service delivery environment.
8. Basic business management skills and community mobilization skills are critical to the viability of private midwives.
9. Monitoring and long-term supervision of midwives on a sustained basis is difficult.
10. Learning how to monitor quality takes time.
11. Private midwives serve existing needs and reduce the public-sector burden.
12. Private practice expands service.

The MAPS experience illustrates that, with adequate support, midwives can successfully expand access to reproductive health care. They can reach underserved populations and provide high-quality, integrated reproductive health services, including family planning.

In future efforts, MAPS will concentrate on consolidating its achievements while continuing to build on its strengths. Two special areas that would benefit from continued focus are: 1) strengthening community mobilization and links with nongovernmental organizations (NGOs) and 2) empowering midwives by removing barriers to practice. These activities will continue to expand the role of midwives as a valuable community resource.

# Introduction

The world's population is expected to increase to nearly eight billion people within the next 25 years (U.S. Bureau of the Census 1999). Ninety-five percent of this growth will occur in the developing regions of Africa, Asia, and Latin America—the world's economically poorest regions with the fewest resources for providing health care, housing, sanitation, education, and employment. The burdens of such population demographics have profound and far-reaching consequences on the quality of life, life expectancy, environmental needs, and economic stability of the majority of the world's people:



*Midwives are a key part of solving the crisis of unmet need in family planning and reproductive health care.*

- ✦ In 1998, more than seven million infants throughout the world died before their first birthday. More than 11 million children died before celebrating their fifth birthday. Less than one percent of these deaths occur in the more developed countries. Factors found to be most closely associated with childhood mortality are short intervals between births and minimal maternal education (U.S. Bureau of the Census 1999).
- ✦ Maternal mortality is a major health problem, particularly in less-developed countries. A woman in sub-Saharan Africa has a lifetime chance of 1 in 48 of dying in childbirth compared to a 1 in 1,800 chance in developed countries. The fact that the great majority of maternal deaths are preventable adds to the magnitude of this tragedy (Marshall and Buffington 1998).

## Around the world:

- ✦ 300 million couples use unsatisfactory or unreliable contraceptive methods.
- ✦ 30 million unintended pregnancies occur each year in women using contraception.
- ✦ At least 150 million couples do not have access to family planning.

*U.S. Bureau of the Census, 1999*

Family planning (FP) and reproductive health care (RHC) are key to solving this global pressing need. FP saves women's and children's lives and is a central component of quality RHC services. The single most important determinant of future fertility is the extent to which couples have **access to** and **use** contraception to control the number and spacing of their children.

The need for quality FP services remains unmet. The reasons for this deficiency are many and varied. They include technology issues, barriers to access or to service delivery, and poor quality of services. Social issues—such as the role of women in society, attitudes towards birth control and sex, and national health priorities—also contribute significantly.

The HIV/AIDS pandemic further affects the reproductive health of women and men. HIV and other sexually transmitted infections (STIs) have an enormous negative impact on those they affect, typically when they are at their peak reproductive age.

No single approach can address these problems. Rather, a variety of responses are required that are sustainable, adaptable to the local culture, and sensitive to the complexity of client needs. Models of care are needed that provide high-quality services while addressing client needs for safe sex and for contraception. Also necessary are programs that serve a wide spectrum of population groups, including the underserved.

## **The SEATS II Project**

The Family Planning Service Expansion and Technical Support Project (SEATS II) is one of the efforts addressing the problems identified above. SEATS is funded by the United States Agency for International Development (USAID) and implemented by John Snow, Inc. (JSI) in collaboration with its U.S. and in-country partners. The mission of SEATS is to work with its partners and local organizations to promote the development and expansion of high-quality, client-centered, sustainable family planning and reproductive health services in developing countries and to enhance access to these services.

SEATS works with communities where there is an expressed need and is committed to building the capacity of these communities' members to sustain a better future. By offering innovative approaches and new perspectives, SEATS increases the efficiency, effectiveness, and quality of programs and helps reach groups of people who would otherwise remain underserved. Quality of care is recognized as having a positive effect on FP acceptance and use.

SEATS is linked to USAID’s Strategic Objective # 1: *Increased use by women and men of voluntary practices that contribute to reduced fertility.* An estimated 56 percent of the decline in fertility in the developing world can be attributed to FP programs. Such programs increase contraceptive use, promote breastfeeding, reduce reliance on abortion, help prevent sexually transmitted infections (STIs), and contribute to lower desired family size (USAID 1999).

## SEATS Special Initiatives

The SEATS project developed five Special Initiatives to meet the challenge of reaching underserved populations:

- ✦ The nongovernmental organization (NGO)/private voluntary organization (PVO) Integration Initiative
- ✦ The Urban Initiative
- ✦ The Youth Initiative
- ✦ The Women’s Literacy Initiative
- ✦ Midwifery Association Partnerships for Sustainability (MAPS)

## The MAPS Initiative

MAPS contributes to the goal of increasing **access** to FP/RHC by promoting the development of a particularly underutilized resource—midwives. This Special Initiative is implemented by SEATS’ partner, the American College of Nurse-Midwives (ACNM).

A professional organization for over 40 years, ACNM has extensive experience working with midwives worldwide. Its expertise includes strengthening midwifery associations, developing standards for midwifery education and service delivery, enhancing national and international networks, and advocating for reproductive health and family planning.

Since 1995, MAPS has developed and implemented subprojects in four countries in the Africa Region: Senegal, Uganda, Zambia, and Zimbabwe. (See MAPS Country Project Summaries, Appendix 1.) Also, MAPS has worked with midwifery associations in Cambodia, Eritrea, and Tanzania—supporting their initiatives, involving them in regional activities, and providing limited technical assistance (TA) at their request. MAPS experienced a tremendous growth in the interest in and demand for TA with private-practice midwives. This demand came from midwives themselves due to their increased desire to be in independent practice and from local USAID missions and Ministries of Health due to the growing need for greater privatization of health services.

Full access to, and use of, RHC services provide women with a key to their future, empowering them to develop into fully productive citizens, contributing to their nation socially, culturally, and economically.

One hundred percent of clients surveyed would recommend their Uganda Private Midwives Association (UPMA) clinic to other clients. Ninety percent of midwives felt that cooperating with the community and showing kindness were more satisfying and productive than worrying about their income.

UPMA Endline Evaluation

The time is right for MAPS. The economic burden of government-sponsored health care and the diversion of government funds to meet the burgeoning demands created by the AIDS crisis expand opportunities for private midwives. The increasing demand for high-quality RHC and the growing privatization of health services (compounded by the often low job satisfaction of service providers in the public health sector) support the development of private midwife practices. Also, cultural and legal changes are making it easier for women to own property and pursue independent financial opportunities. At the same time that opportunities for private midwives are growing, Ministries of Health are instituting health reforms and redirecting policy focus to decentralizing and improving quality of services. Since the majority of FP/RHC services are provided by public midwives in Africa, MAPS and the professional associations are well-positioned to offer such services as continuing education and assistance to regulatory bodies in developing and monitoring standards.

### MAPS as a Gender Initiative

It is significant to the work of MAPS that the vast majority of midwives are women (for example, 95.5 percent in Zimbabwe). Women in developing countries have lacked access to professional education, to quality health care, to income-generating opportunities, and to advocacy and political power. As a group, midwives have long been an underserved population. Many midwives wishing to open their own clinics have been denied access to start-up capital since they do not own property to use as collateral. Also, most microfinance programs that do serve women do not extend the level of credit needed with realistic terms of repayment.

Strengthening midwifery associations allows midwives to practice more independently. Strengthening MAPS-supported activities includes providing continuing education (CE) in business skills as well as FP/RHC and advocating with regulatory agencies on behalf of midwives. A byproduct of stronger associations is that individual midwives gain courage and strength by working together in groups toward a common cause.

Women increasingly seek out women providers for their most intimate health needs. MAPS significantly increases the number of women providing high-quality FP/RHC services in service delivery points (SDPs) that are accessible to the clients.

## Publication Overview

This paper reviews MAPS' approach with associations and their member midwives; discusses the rationale, process, and results of MAPS strategies; presents lessons learned; and explores the future of MAPS. For illustration, the MAPS project in Zimbabwe is highlighted. Case studies and examples from other MAPS projects are also used to illustrate particular segments. More complete descriptions of MAPS activities in each country can be found in Appendix 1, MAPS Country Project Summaries.



*MAPS as a gender initiative: 95.5 percent of midwives in Zimbabwe are women.*



# MAPS Approach

SEATS' and ACNM's experience has shown that when properly trained and supported, midwives are dynamic forces for increasing access to high-quality, sustainable services. MAPS works with midwives in the private and public sectors through their professional associations. Private-sector midwives are nationally certified midwives who have met the requirements of local authorities and the national regulatory body to own and operate independent clinics for profit. Most private midwives offer integrated FP/RHC and minor curative services.

Midwives are a key part of solving the crisis of unmet need in FP/RHC. This is true because:

- ✦ Midwives are comparatively well-educated and have chosen to work in women's reproductive health.
- ✦ Midwives are already in place—living and working in urban and rural areas and reaching clients often not served by public-sector programs and facilities.
- ✦ Because there are many more midwives per capita than physicians, midwives are more readily available to women in urban and rural areas.
- ✦ Midwives are trusted in their communities, often elected as community leaders.
- ✦ By training and inclination, midwives regard reproductive health as an integrated whole, viewing women's health needs across the life cycle.
- ✦ Private midwives offer affordable services and decrease the demand on the public sector.

MAPS provides a unique opportunity to build the institutional capacity of local midwifery associations. This focus on associations strengthens the technical and policy support needed to maintain high standards of quality and promote service expansion. Through training programs, advocacy, policy formulation, and other innovative activities, such as the use of a continuous quality improvement (CQI) approach to develop "best practices" clinics, MAPS helps to ensure that this community-based resource achieves its full potential.

## MAPS Increases Access by:

- ✦ Increasing the number of private midwifery practices.
- ✦ Identifying and supporting aspiring private practitioners.
- ✦ Reaching out to underserved populations (e.g., men, youth, miners, and farmers).
- ✦ Expanding the FP method mix.
- ✦ Improving referral systems.

MAPS is about partnerships—in linking professional associations and their member midwives through regional activities such as workshops and study tours; in encouraging participation in international conferences and technical assistance (TA) by midwives from other associations and countries; and in developing communication vehicles, such as newsletters and journals, that keep midwives connected to each other.

### Three Levels of Association Development

The MAPS Initiative works primarily through midwifery associations to support expanded, quality service delivery. MAPS supports these associations as they become stronger and more capable of meeting the needs of the people in their country. Association development activities are implemented at three levels, as shown below.

#### Midwifery Association Partnerships for Sustainability

The MAPS Initiative works primarily through midwifery associations to support service delivery. Although there are many ways to access private-sector midwives, on option—Association Development—is detailed below. The MAPS Initiative also encourages other innovations to meet specific country needs, including franchising or working through informal networks of midwives.

	Association Development	Family Planning/Reproductive Health		
<b>LEVEL 1</b>	<ul style="list-style-type: none"> <li>➤ Needs Assessment &amp; Strategic Planning</li> <li>➤ Leadership Development</li> <li>➤ Training of Trainers</li> <li>➤ Procurement &amp; Logistics</li> <li>➤ Monitoring, Supervision, Evaluation</li> <li>➤ Liaison with National MCH/FP Programs</li> </ul>	<ul style="list-style-type: none"> <li>➤ FP, MCH, Women's Health, STDs/HIV Overview</li> <li>➤ Counseling &amp; Client Information</li> <li>➤ Service Provision Training for:               <ul style="list-style-type: none"> <li>• Lactational Amenorrhea Method (LAM)</li> <li>• Barrier Methods</li> <li>• Oral Contraceptives</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>➤ Traditional Practices &amp; Beliefs</li> <li>➤ Infection Prevention &amp; Control</li> <li>➤ Referral for Hormonal &amp; Long-term Methods, STDs/HIV Services &amp; Pregnancy Care</li> <li>➤ Recordkeeping</li> </ul>	
<b>LEVEL 2</b>	<ul style="list-style-type: none"> <li>➤ Program Planning &amp; Implementation</li> <li>➤ Budgeting &amp; Audit Preparation</li> <li>➤ Recordkeeping &amp; MIS</li> <li>➤ Training of Trainers</li> <li>➤ Establishing Referral Networks</li> <li>➤ Membership-targeted Programs               <ul style="list-style-type: none"> <li>• Business Skills</li> <li>• Community Mobilization</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>➤ Service Provision Training for:               <ul style="list-style-type: none"> <li>• Injectables</li> <li>• Natural Family Planning (NFP)</li> </ul> </li> <li>➤ Counseling</li> <li>➤ Referrals</li> <li>➤ Recordkeeping</li> </ul>	<ul style="list-style-type: none"> <li>➤ Prevention &amp; Management</li> <li>➤ Counseling</li> <li>➤ Referrals</li> <li>➤ Recordkeeping</li> </ul>	<ul style="list-style-type: none"> <li>➤ Normal Antepartum</li> <li>➤ Intrapartum, Postpartum               <ul style="list-style-type: none"> <li>• Life-saving Skills</li> <li>• Partographs</li> <li>• Newborn Assessment</li> <li>• Breastfeeding</li> </ul> </li> <li>➤ Counseling</li> <li>➤ Referrals</li> <li>➤ Recordkeeping</li> </ul>
<b>LEVEL 3</b>	<ul style="list-style-type: none"> <li>➤ Proposal Development</li> <li>➤ Marketing &amp; Fundraising</li> <li>➤ Computer Skills for MIS</li> <li>➤ Training of Trainers</li> <li>➤ Advocacy within International Networks</li> <li>➤ Liaison with National MCH/FP Programs</li> <li>➤ VCS Program Design</li> </ul>	<ul style="list-style-type: none"> <li>➤ Service Provision Training for:               <ul style="list-style-type: none"> <li>• IUDs</li> <li>• NORPLANT®</li> </ul> </li> <li>➤ Counseling</li> <li>➤ Referrals</li> <li>➤ Recordkeeping</li> </ul>		<ul style="list-style-type: none"> <li>➤ Service Provision Training for:               <ul style="list-style-type: none"> <li>• Life-saving Skills (Emergency Obstetrics)</li> </ul> </li> <li>➤ Counseling</li> <li>➤ Referrals</li> <li>➤ Recordkeeping</li> </ul>

## Zimbabwe: An Illustrative Example

MAPS' approach to expanding access to FP/RHC services by strengthening the role of midwives is implemented in different ways in each country where the project operates, based on the unique situation and conditions there. This strategic approach can perhaps best be illustrated by describing how the initiative works in a particular country. The MAPS subproject in Zimbabwe serves as a comprehensive example of MAPS' activities and accomplishments. This section provides the framework for the Zimbabwe subproject; subsequent sections provide more details about MAPS' implementation in that country.

### Background

The primary provider of family planning services in Zimbabwe, as in most of sub-Saharan Africa, is the government. The Zimbabwe National Family Planning Council (ZNFPC), a parastatal under the Ministry of Health (MOH), provides approximately 85 percent of the available family planning training and services in Zimbabwe. The private sector provides only a small portion of these services [12 percent according to a 1996 study by the Promoting Financial Investments and Transfers Project (PROFIT)].

Faced with a burgeoning demand on public-sector facilities, a growing financial burden on the government, inadequate numbers of service providers, a prevalence of short-term family planning methods, and a growing HIV/AIDS epidemic; Zimbabwe sought new approaches to RHC delivery. One logical approach was to explore ways to expand the potential of the private sector. This approach was consistent with the population strategies of the government of Zimbabwe, ZNFPC, the USAID Mission, SEATS, and PROFIT.

In 1996, just before the MAPS project began, very few nurses and midwives were in private practice in Zimbabwe, but interest was growing. The PROFIT project (at the time the coordinating agency for all activities being funded by USAID in the private sector in Zimbabwe) conducted a study in January 1996 of the private sector's contribution to FP services in Zimbabwe. The results of the study documented that private midwives were an untapped resource for delivering FP/RHC services and that developing this group as a resource should be explored. At the time, PROFIT could find only six practicing private-sector midwives. This study also documented the perceived constraints and barriers to practice.

Lack of business training had proven costly to several of the private midwives before MAPS. In one situation, a midwife, thinking to spare herself costly mistakes, hired an accountant to work with her. Within six months, this accountant owned her clinic and wanted her as his employee.

*“Greater and more effective provision of services by the private sector is critical at this juncture. The private sector itself is well organized and has articulated an interest in increased involvement. However... policy reform, the removal of medically unjustified restrictions on the role of nurses...is a prerequisite to greater participation.”*

*USAID Results Framework*

*“At first, I had been practicing in a ‘hiding’ manner. MAPS brought me out of isolation.... I’m able to work wholeheartedly in an environment that is very conducive. I also now have skills to impart better FP information to clients.”*

*Zimbabwean midwife*

Private, independent nursing practice is a relatively new option for nurses and midwives in Zimbabwe. At the outset of the MAPS Initiative, many practicing midwives were virtually invisible, reluctant to come forward, fearing retaliation or reprisal from regulatory bodies.

While these agencies did not explicitly prohibit midwifery practices, they also did not openly permit them. Many regulations were ambiguous at best, leaving the midwives with a sense of risk and insecurity. Initially, the midwives were reluctant to disclose financial data and were not keeping service statistics or credible business records.

### Linkages to PROFIT, SEATS, and USAID Strategies

The main objective of the USAID/Zimbabwe three-year strategy for 1996–1999 was to reduce fertility and increase the use of HIV/AIDS preventive measures (USAID Results Framework, Strategic Objective #3).

At the start of the MAPS/PROFIT collaboration, three areas of opportunity were apparent: standardizing procedures for establishing private practices, informing national and municipal authorities of these procedures, and developing lending mechanisms to provide start-up capital for new practices. Activities were targeted to achieve the following results:

- ✦ Improved quality of family planning services.
- ✦ Adequate supply and proper management of contraceptive logistics (including the introduction of a social marketing program).
- ✦ Improved policies for reproductive health.
- ✦ Expanded behavior change communication interventions in HIV/AIDS/STIs to specifically address women and young adults.
- ✦ Expanded number of service providers in urban and rural areas, using the MAPS Special Initiative capability.

Despite the many impediments they encountered, some nurses and midwives had pioneered into the private sector and developed private practices and collegial relationships with doctors and pharmacists. Initially, little information was available about who these professionals were, where they were practicing, what services they provided, and how they managed to resolve the inherent difficulties of private practice. The MAPS’ subproject in Zimbabwe explored opportunities for working with active and retired nurses and midwives in the private sector.

## MAPS Special Study: The Role of Nurses and Midwives in the Zimbabwe Private Sector

Over a four-month period in 1996, MAPS designed and implemented an exploratory study that focused on nurses and midwives who were practicing privately in Zimbabwe (Special Study Report, *The Role of Nurses and Midwives, Zimbabwe Private Sector* 1996). The purpose of the study was to learn more about the roles of these practitioners, the services they provided, and the factors that facilitated and/or constrained their ability to practice effectively. By review of the Registry of Private Midwives and by word of mouth, 22 practicing and 30 aspiring private midwives were identified.

In addition, data were collected from 61 clients who sought services from private nurses and midwives, from selected professional associations and organizations that might influence this type of practice, and from nurses and midwives who were aspiring to enter private practice.

The results of the study, and the recommendations generated from the results, served as a basis for developing the MAPS Zimbabwe sub-project and provided guidance to stakeholders for planning interventions creating a more favorable climate for private practice (see Special Study Recommendations, Appendix 2).

Barriers to practice, sometimes subtle, often overt, handicap the work of PMWs. Among the barriers in Zimbabwe were professional attitudes that affected the governance of private midwifery practices. For example, regulations permitted the dispensing of contraceptives by community health workers, but prohibited the dispensing (and even the purchasing) of such commodities by licensed private midwives.

The Special Study also identified restrictive legislation on medication prescription—including medications clients could buy over the counter. This restriction created a double standard, since these drugs are ordered and given by nurses in the public sector and in most rural health centers. Health workers and community-based distributors are also permitted to dispense these drugs—under supervision of nurses.

Midwives view private practice as a way of being able to provide higher-quality services, which includes having more time to meet client needs and offering more personalized care.

Clients seek the services of nurses and midwives because the care is felt to be convenient, personalized, and friendly.

*MAPS Special Study*

### Barriers to Practice Identified by the Special Study

Nurses and midwives feel that being able to provide immunizations and simple medications to their clients is an important service, one that they were responsible for providing when working in the public sector, yet once in private practice, they are denied the right to provide.

*MAPS Special Study*

## The Project Begins

MAPS developed a partnership with the Zimbabwe Nurses Association (ZINA) to implement activities for its members in Zimbabwe. This subproject ran from January 1997 to July 1999. Its first major activity was aimed at helping midwives overcome their sense of fear and isolation. A three-day dissemination workshop was held in June 1997 to present the results of the Special Study. PMWs as well as representatives of health and social agencies were invited to attend.

### Immediate Results of 1997 Workshop to Disseminate Special Study Findings

- ✦ ICO grew from three to 50 members.
- ✦ All 50 midwives attending the workshop were provided with training in social marketing and supplies of oral contraceptives and the female sheath.
- ✦ ZINA increased its membership significantly, including new members and many past members who had defaulted.
- ✦ The Public Service Medical Aid Society (PSMAS) agreed to issue billing numbers to PMWs, allowing them to bill directly for their services.
- ✦ PMWs became identified as a provider group clearly seeking to be within the regulatory framework.
- ✦ The Minister of Gender Issues became the patron of the midwives.

The workshop provided midwives with an opportunity to meet and interact with each other. They also had a chance to interact with agencies, groups, and individuals perceived to be obstructive—such as the Drug Control Council, the MOH, Medicaid Societies, pharmacists, and physicians. Representatives from each of these groups presented the roles and regulations of their agency relative to PMWs, and midwives explained their work and how it was affected by existing regulations. These dialogues had a major impact on changing attitudes and demonstrated the PMWs' desire to be within the regulatory framework.

The Independent Clinics Organization (ICO)—a special-interest organization that had recently been formed under the umbrella of ZINA to provide a forum for the special needs of PMWs—participated in the conference and became the focus of the MAPS/ZINA project.

As a follow-up to the workshop, monthly ICO education sessions, coordinated in conjunction with Population Services International (PSI), were offered to new members to provide information on oral contraceptives, the female sheath, male condoms, and social marketing.

# MAPS Strategies

To help programs meet their goals of enhancing the role of private- and public-sector midwives, the MAPS Initiative first identifies existing midwifery or nursing associations with which to work, conducting an assessment of their critical needs. MAPS then works with the association to design and implement a subproject to address these needs. Next, MAPS hires a subproject coordinator who works at the association to implement and administer the project.

While MAPS offers a flexible approach when working with these associations, it consistently applies five strategies to the specific needs of midwives and midwifery associations in each country:

1. Capacity building of associations.
2. Capacity building of members.
3. Creation of a more enabling practice environment.
4. Integration of quality and sustainability.
5. Policy initiatives.

## I. Capacity Building of Associations

Improving the capacity of midwifery associations strengthens the ability of individual midwives to provide high-quality services to their clients. Associations often need support in self-governance, management, training, advocacy, diversification of funding sources, strategic planning, and marketing. After assessing an organization's current capability and identifying areas of weakness or strength, MAPS assists the organization in the following areas:

- ✦ Member surveys and computerized membership databases.
- ✦ Member services, including such activities as producing newsletters and coordinating regional workshops.
- ✦ Strategic planning.
- ✦ Development of sustainability and business plans.
- ✦ Management training and development and strengthening of Board of Directors.
- ✦ Management information systems (MIS) and computerization of financial management system.

- ✦ Information, education, and communication (IEC) and marketing training capability.
- ✦ Policy reform.
- ✦ Creation of a more enabling environment for expanded practice roles.
- ✦ Coalition building.

Member services is a key part of association capacity building. MAPS works with association leaders to emphasize the importance of meeting member needs and then to develop tools such as member surveys and databases as a first step in identifying and meeting these needs. These tools help associations ensure that their programs remain relevant to their members and enable them to draw on the strengths of each individual. MAPS works with midwifery associations to foster a sharing of information and experiences; to provide continuing education, seminars, and technical updates; and to develop training capability within the associations.

Coalition building is another important aspect of MAPS' work with associations, as described in the Case Study on the next page. MAPS encourages partnerships—linking professional associations with each other, with existing resources, and with key stakeholders. As a result of this initiative, midwifery associations have begun to communicate with each other through publications such as newsletters and journals, and more recently, e-mail. Links have also been developed between associations and local, national, and international resources as well as with stakeholders such as clients, community leaders, and Ministries of Health and Gender.

“South-to-south” collaboration has been a major networking effort for the midwifery associations participating in MAPS. This strategy involves making use of skills and resources from other developing countries instead of relying on TA from the north. An example of this networking is the business management and community mobilization training carried out for midwives in Zimbabwe by the trainers from Uganda. Through networking, midwives reach across backyards, townships, and country borders and join with other midwives in their effort to expand quality reproductive health care for women. Also, this approach extends MAPS' impact beyond its subprojects. For example, the president of ZNA shared the skills she learned from SEATS/MAPS with the midwifery/nursing association in Tanzania. The ZNA president shared new knowledge and skills in how to 1) develop and expand association membership services, 2) ensure program sustainability, 3) develop a strategic plan, and 4) improve quality.

The Uganda study tour was the biggest south-to-south undertaking. Details of the tour were published in the June 1999 *Partnership in Population and Development South-to-South Newsletter* (see Appendix 5).

### **CASE STUDY: Coalition Building Through a Study Tour**

In October 1998, MAPS facilitated a study tour in Uganda for 24 PMWs from Senegal, Uganda, and Zimbabwe. The objectives of the study tour were to:



- ✦ Enhance the exchange of ideas and experiences through facilitating group discussions and providing on-site observations of clinical practice.
- ✦ Improve the quality of and access to FP/RHC services by sharing lessons learned.
- ✦ Develop a collaborative relationship for ongoing networking among the three associations.

#### ***The tour included:***

- ✦ A visit to the Uganda Private Midwives Association (UPMA) headquarters and the association's new model clinic site in Kampala.
- ✦ A workshop to discuss private-practice issues.
- ✦ Three days of living and working together at the UPMA midwives' clinics and homes, with ten ZINA midwives and two Senegalese midwives paired with twelve UPMA midwives.
- ✦ A presentation of individual quality workplans the final day of the tour.

Based on what she learned, each midwife identified quality improvement action plans to be implemented at her clinic. Some of the actions identified were to:

- ✦ Increase capital in the clinic to “uplift the standard.”
- ✦ Start a library where nurses can have access to current nursing and medical information.
- ✦ Improve the referral system by following clients and encouraging client feedback.
- ✦ Spend some nights at the clinic to properly monitor staff and provide closer supervision.
- ✦ Construct simple incinerators.
- ✦ Provide suggestion boxes to allow clients to freely voice problems they face, or offer suggestions or compliments to the staff.
- ✦ Provide all RHC services including FP and immunization under one roof.

#### *Results of Study Tour Action Plans*

A six-month follow-up of 22 of the 24 midwives (due to communication difficulties and distance, the Senegalese midwives could not be reached) revealed the following:

- ✦ Ninety-one percent of the study tour midwives had implemented more than half of their intended quality actions.
- ✦ Some actions, though not complete, were in process. Delays were experienced in obtaining permits for such services as immunizations and in addressing such costs as expanding services to include maternity care.

While the tour achieved many goals, its greatest success was in coalition building. Through the study tour, associations from three different countries learned *about* each other, learned *from* each other, and created connections they used to continue strengthening their own work and each other’s. This neighbor-to-neighbor form of collaboration is more likely to survive beyond the life of SEATS than collaboration with a U.S.-based agency, providing a sustainable mechanism for continued improvements and networking.

(See Uganda Study Tour Action Plan, Appendix 3, for more information.)

## II. Capacity Building of Members

Since an association is only as strong as its combined members, MAPS also focuses on improving the capacity of individual midwives.

Training is a central part of this strategy. PMWs need new skills to become successful providers and entrepreneurs. MAPS' training focuses not only on FP/RHC skills, but also on areas such as quality improvement, staff management, profit and loss, competitive marketing, and leveraging.

The table included in this section lists the workshops conducted through MAPS and the number of midwives trained in each. In addition to these workshops, several local and regional workshops were held to disseminate current updates on FP/RHC service provision and on the sustainability of PMW practice. Thirty-four representative midwives from MAPS Project countries attended the international MAPS Dissemination Workshop in Zimbabwe in June 1999.

MAPS also goes beyond training to help position midwives as agents of change—in midwifery training institutions, in regulatory bodies, in such organizations as the East, Central, and Southern African College of Nursing (ECSACON) and the International Confederation of Midwives (ICM), and in the donor community.

### Business Management and Community Mobilization

To assist midwives who own and operate small RHC clinics in learning basic concepts and skills for managing their businesses, MAPS prepared and field-tested *Business Management Skills for Private Midwives Curriculum* (MAPS 1997) and the companion *Community Mobilization for Private Midwives Curriculum* (MAPS 1997).

The business management curriculum (21 hours of instruction) aims to increase the sustainability of private-sector service delivery points and emphasizes the correlation between continuing education, improvements in the quality and scope of RHC services, and business viability.

Midwives learn to manage the resources of their SDPs more effectively and efficiently by:

#### New Tools for New Roles

- ✦ Business Management Skills for Private Midwives Curriculum
- ✦ Community Mobilization for Private Midwives Curriculum
- ✦ Handbook for Aspiring Midwives
- ✦ Standards for Private-Practice Midwifery
- ✦ Family Planning Referral Guidelines
- ✦ Computerized Membership Database

*“When I am involved in my community, I am much more successful.”*

ZINA/ICO member

In Uganda, midwives took different approaches to creating demand for their services. One regularly visits the marketplace in her community, and a second goes to the bus terminals with information about healthful behaviors and services. Within six months of Ugandan midwives carrying out their community mobilization plans, 170 SDPs served by 145 midwives reported a 10–20 percent increase in FP clients per month.

- ✦ Promoting their services and increasing the number of clients who seek their services.
- ✦ Keeping relevant business records and using the records to manage, evaluate, and improve their business.
- ✦ Accessing credit, evaluating the cost and benefits of extending credit, and managing credit effectively.
- ✦ Planning for their SDP using business records and knowledge about the clients/community served.

The community mobilization curriculum (14 hours of instruction) provides basic concepts and skills PMWs need to interact with their communities. The curriculum stresses that, to be effective providers of health services, midwives must be actively involved in the community. Midwives learn to:

- ✦ Become more familiar with community needs and resources.
- ✦ Develop, implement, and evaluate action plans for problem solving.
- ✦ Create awareness of midwifery services in the community.
- ✦ Collect and use data.
- ✦ Develop and/or use IEC materials.
- ✦ Develop a referral system for working with other service providers.

The use of competitive marketing principles, financial records, and business and community action plans represented challenging and exciting new ways of examining their situations, and—as described in the evaluation section of this paper—many fledgling entrepreneurs blossomed from this strategy.

## Handbook for Aspiring Private Midwives

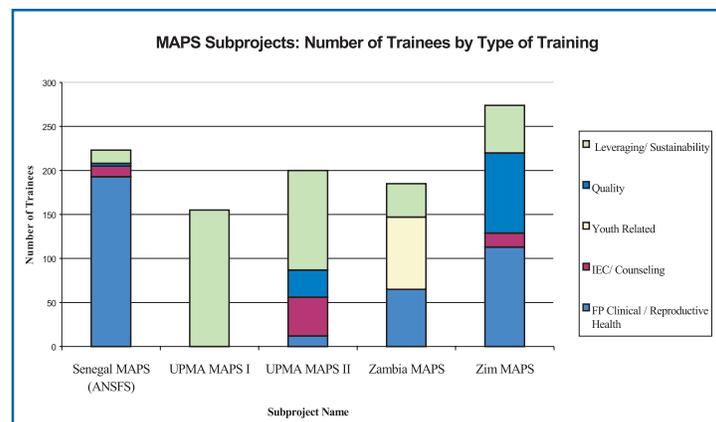
In Zimbabwe, many midwives expressed a growing desire to open private practices and looked to ICO for advice and assistance. ICO leaders, with MAPS TA, subsequently developed a *Handbook for Aspiring Private Midwives*. The book covers topics essential to running a private practice and includes a summary of relevant regulations.

In addition to being offered to aspiring private midwives, the handbook was delivered to major stakeholders in an effort to keep communication flowing and to increase ZINA's visibility. MAPS produced the first 200 copies, and ZINA will update and reproduce the handbook as needed.

## Family Planning Training

The 1994 International Conference on Population and Development in Cairo reinforced women’s needs for high-quality, integrated RHC. This is a concept midwives have long understood. Priority areas for MAPS RHC training include competency-based FP skills development, STI/HIV counseling, community mobilization, CQI, and business management skills.

In Uganda, MAPS training, conducted in collaboration with the Delivery of Improved Services for Health (DISH) project, is comprised of a six-week comprehensive RHC training for private midwives. The training proved to be a major resource for the midwives—increasing awareness of, access to, and use of their FP/RHC services. In Senegal, the Association Nationale des Sage-Femmes Sénégalaises (ANSFS) training focused primarily on the lactational amenorrhea method (LAM). In Zambia, midwives were trained in youth-friendly services (YFS).



In addition to the training shown in the figure, MAPS helped the midwives connect with training opportunities supported by other assistance organizations. For example, PSI sponsored family planning training for ZINA midwives in 1999; over 40 midwives received this training during the year. Also, in Uganda, MAPS made vital links between UPMA midwives and two important groups, the Social Marketing for Change (SOMARC) Project and DISH. Over 300 Ugandan midwives were trained in the social marketing of family planning commodities by SOMARC. Also, through the DISH Project connec-



*Priority areas for MAPS training include competency-based FP skills development, CQI, community mobilization and business management.*

<b>MAPS Training</b>				
<b>Topic</b>	<b>Number of Midwives Trained</b>			
	<b>ZINA</b>	<b>UPMA</b>	<b>ZNA*</b>	<b>ANSFS</b>
Four-Week Basic FP	68	137		
Training of Trainers (TOT)-FP/RHC or YFS		4	27	
FP/STI Counseling	45			
CQI	91			3
CQI ans Sustainability		32		
CQI Monitoring and Evaluation	2	1	1	
Business Management and Community Mobilization	38	234		8
TOT–Business Management and Community Mobilization		7		
Strategic Planning/Business Management			38	
Social Marketing	66	Approx 300		
Strategies for Sustainable Development	2	2	2	2
Leveraging	16	4	4	
LAM Training				193
TOT–LAM				8
Management Supervision (SEATS I)		35		
Youth-Friendly Services			581	
TOT–Youth-Friendly Services			2	
Financial Management		7		
Bookeeping and Accounting		5		
Computer Training		15		
*Zambia Nurses Association				

## CASE STUDY: Serving Youth in Zambia



Three SEATS Special Initiatives—Urban, Youth, and MAPS—were integrated in the Zambia subproject. Implemented by the Zambia Nurses Association (ZNA) and the Lusaka District Health Management Team, MAPS/ZNA targeted nurses and midwives in the public and private sectors. The goal of the subproject was to “strengthen the capacity of ZNA in order to ensure the provision of quality sustainable FP/RHC services to youth.” This was a somewhat different focus than other MAPS projects. The objectives of this subproject were to:

- ✦ Increase youth knowledge of reproductive health and sexuality.
- ✦ Train staff in youth-friendly approaches with quality care.
- ✦ Create a supportive environment and increase youth utilization of available RHC services in the seven SEATS-supported clinics of Lusaka.
- ✦ Promote nurse/midwives’ involvement in STI/HIV prevention for youth at the community level.
- ✦ Provide regional workshops for nurse/midwifery association leadership focusing on the potential role for private nurse-midwife service providers in Zambia.

To effectively reach midwives in Zambia, MAPS/ZNA conducted a TOT on youth-friendly services for 47 participants, representing 27 of ZNA’s 42 branches. These individuals then facilitated YFS update sessions throughout the country, ultimately reaching 501 nurses and midwives.

A final evaluation of the MAPS/ZNA project was conducted in the spring of 1999. Results showed a change in the midwives’ attitude toward caring for youth and providing FP/RHC services to this population (see sidebar). Other indicators of provider improvement include:

- ✦ Increased knowledge and skills of midwives (70 percent knowledge retention; 20 of the 27 respondents scored 100 percent).
- ✦ 11 of 14 stations sampled developed YFS sections.
- ✦ The method mix increased from three options to seven.
- ✦ Midwives took an active interest in participating in their communities, responding to invitations from groups—such as high schools, parents’ groups, and civic groups—to provide information on the RHC needs of youth.

*“I have learned to treat youth as individuals.”*

*“Previously, I felt it was not right to provide FP/RH services to youth, but now I feel this should have been introduced earlier.”*

*“I used to be surprised when youth came for FP, but now I understand and they are most welcome.”*

*“Youth have now noticed that they are welcome in our clinic.”*

tion, 37 midwives received training during MAPS I, and 51 more during MAPS II.

### III. Creation of a More Enabling Environment

MAPS' efforts to create more enabling practice environments for PMWs have centered on reducing the barriers that keep midwives

Service providers in Zimbabwe who offer curative care are required to obtain a National Medical Aid Societies (NAMAS) billing number. This tariff number enables the purchase of drugs and medical supplies and the billing of Medical Aid Societies. However, billing numbers have not been provided to midwives.

Without this number, midwives must bill Medical Aid through their covering physician, which means they are paid four to six months after they send the bill. This creates a difficult cash flow problem for private midwives. Consequently, nearly half of the practitioners must find other means of work in addition to maintaining their private practice.

This situation also has emotional costs. Several midwives described feeling “humiliated” by having to constantly ask for their money or “defeated” that they are paid so much less for their services than are doctors.

Barriers and Constraints to Private Practice in Zimbabwe	
Barriers	Actions Taken
Need for accurate information about private practice rules/regulations.	<ul style="list-style-type: none"> <li>• Workshop held to promote dialogue between PMWs and other stakeholders.</li> <li>• Guidelines developed for PMW practice.</li> <li>• Current regulations pertaining to PMW practice summarized and disseminated.</li> <li>• MAPS and ICO office established at ZINA headquarters.</li> <li>• Legal counsel engaged by ICO to represent members.</li> </ul>
Sense of isolation.	<ul style="list-style-type: none"> <li>• Information about the newly formed ICO provided to members.</li> <li>• ICO strengthened to address needs of members.</li> <li>• Membership database developed to increase communication between association and members.</li> <li>• Regional and international activities carried out to promote networking and communication between associations.</li> </ul>
Limited continuing education opportunities.	<ul style="list-style-type: none"> <li>• FP training provided to bring PMWs to national standards: 85 percent met national standards in 1999 compared to 10 percent in 1996. Training provided in business management, community mobilization, social marketing strategies, and CQI.</li> <li>• Clinical updates (on topics such as dual protection) provided at ICO meetings.</li> </ul>
Reimbursement for services.	<ul style="list-style-type: none"> <li>• Billing number obtained from Public Service Medical Aid Society (PSMAS).</li> <li>• ICO advocating for improved tariffs and NAMAS recognition.</li> </ul>
Procurement, prescription and supply of family planning commodities.	<ul style="list-style-type: none"> <li>• Link with PSI, which provided female sheaths.</li> <li>• ZINA links with PSI to become a subdistributor for socially marketed commodities.</li> <li>• ProFam, a campaign to promote quality private-sector services, developed logo and posters advertising FP services provided by midwives.</li> </ul>
Need for recognition of the role of private midwives in helping to meet health care needs.	<ul style="list-style-type: none"> <li>• Advocacy for change in restrictive regulations.</li> <li>• Representation at meetings for FP/RHC.</li> <li>• Links developed with policy makers, educators, and community leaders.</li> </ul>

In its subprojects, MAPS made intense, coordinated efforts to address these barriers (see box on previous page, “Barriers and Constraints to Private Practice in Zimbabwe”). By facilitating dialogues between midwives and regulatory agencies, advocating for policy changes, developing position papers, and creating links with other organizations, MAPS was successful in laying the groundwork for ongoing efforts to reduce, and ultimately eliminate, these barriers.

#### IV. Integration of Quality and Sustainability

MAPS’ efforts to improve quality and enhance sustainability center on the needs of the client. By providing services that meet client expectations and that are perceived to be of value, the quality of the service and the likelihood of its continuation greatly improve.

##### Quality

Midwives are motivated to enter private practice primarily by their desire to provide quality services to their clients. They also believe that quality care is the best way to compete with other, similar service delivery points.

To ensure quality, MAPS uses continuous quality improvement, or CQI, strategies. CQI is a quality improvement methodology that empowers organizations to undertake quality improvement on their own. It relies on those who work in an organization and are most familiar with its strengths and weaknesses to identify quality problems and develop and implement solutions. CQI takes into account that many organizational problems result from inadequate systems and processes rather than from individuals. The methodology enables staff at all levels to work as a team to analyze the systems and processes in which they work and use the information to design and implement activities for improving services.

The MAPS approach to CQI is built on the Bruce/Jain Framework for Quality of Care in Family Planning Programs (Bruce 1990). It is data-driven, involves the community, is client-oriented, and focuses on “best practices”; the CQI team works together to improve the processes by which they provide integrated reproductive health. A best practice is a documented approach or technique that contributes to the highest standard of FP/RHC service delivery. Best practices are validated by research and, when used consistently, result in sustained positive outcomes or improved performance.

*“Being known and respected for providing quality care is the best part of being in private practice.”*

*ZINA/ICO member*

*Of the 79 clients surveyed, 75 cited quality of the services as the reason they returned to a particular clinic.*

*Uganda Evaluation*

When asked how the quality of the services offered to clients improved as a result of the CQI training, the midwives were quick to identify the results. “After quality training,” explained one midwife, “I learned how to identify problems and solve them. Quality is not a static thing: we must keep trying to improve.”

Tools that support the CQI process include:

- ✦ Client surveys
- ✦ Suggestion boxes
- ✦ Decision-making matrix
- ✦ Cause and effect diagrams
- ✦ Tally sheets
- ✦ Time and flow studies
- ✦ Service statistics
- ✦ Use of charts to graphically view data
- ✦ Use of FP/RHC indicators

Each MAPS subproject developed a quality action plan that included a problem statement, objectives and major activities, type of data collection used, indicators (sentinel or “key”), baseline levels, and achievements. The table on the next page “Quality Objectives and Achievements”, provides a sample of the positive change shown in all key indicators for the subprojects.

### Examples of the CQI Methodology in Action

Problem-solving techniques enabled the Houghton Park Private Clinic in Harare, Zimbabwe, to address a situation that followed a rise in the cost of oral contraceptives. The midwives noted a decline in FP clients four months after beginning to keep statistics, from May to July of 1998. They also received six letters in the suggestion box with complaints about the rise in cost of their oral contraceptive pill. The quality team designed a questionnaire; 50 questionnaires were handed out to clients attending the clinic, and 150 were distributed to community residents. Of these 150 questionnaires, 110 were returned.

In the questionnaire, clients stated that they preferred to buy from the public sector, where pills ranged between \$5.00 and \$10.00 per packet. Although they were happy with the services they received at the clinic, clients were choosing to save money. The midwives then wrote a letter (see box). The strategy worked. Statistics for August to December 1998 reveal a return to previous FP client levels.

#### Examples of Problems Solved With a Suggestion Box

- ✦ “Clients worried that the doctor had been working with ill clients, then coming to the clinic. **Solution:** I made him wear a new overcoat with my clinic’s name on it.”
- ✦ “Our receptionist was turning people away before 7 p.m. **Solution:** I talked to her and convinced her to keep accepting clients.”
- ✦ “ZNFFPC changed the cost for oral contraceptives from \$5 per pack to \$15; clients wanted to know why. **Solution:** Wrote a pamphlet explaining the cost change.”

ICO Member

### Quality Action Plans and Results

	Objective	Achievements
Z N A	To increase awareness among 100 ZNA members of the RHC needs of youth and knowledge about the provision of youth-friendly RHC services.	74.1 percent of 25 midwives tested named five traits of youth-friendly services compared to the baseline of 14.8 percent of 19 midwives tested. ( <i>Evaluating the impact of ZNA/MAPS interventions on reproductive health services to the youth: Youth-Friendly Services.</i> )
	To enhance ZNA's role in promoting youth-friendly services by nurse-midwives through at least two national activities.	Since the midwives had yet to develop action plans with youth activities, the baseline was zero. SEATS/ZNA conducted a follow-up of 14 facilities using observations, informal interviews, and review of action plans and found 11 of the 14 facilities (79 percent) visited had operationalized some part of their action plans. ( <i>Evaluating the impact of ZNA/MAPS interventions on reproductive health services to the youth: Youth-Friendly Services.</i> )
Z I N A	To enhance the referral capability at 25 private midwifery SDPs in order to provide a full range of FP services.	16.7 percent scored "excellent" or "very good" on baseline assessment of referral practices.* Two months later, 93.3 percent scored "excellent" or "very good" on the same endline assessment after development of and orientation to referral guidelines.
	To improve the provision of and access to direct FP services in at least 25 private midwifery SDPs.	<ul style="list-style-type: none"> <li>• 100 percent of PMWs treated clients with respect.</li> <li>• 97 percent provided adequate privacy.</li> <li>• 89 percent gave correct information on how to use method.</li> <li>• 97 percent of clients had correct knowledge of how to use their method.</li> <li>• 94 percent of clients reported they felt comfortable asking question remained (MAQ study).</li> </ul>
U P M A	To enhance UPMA's role in ensuring that all private midwives meet quality practice standards.	<ul style="list-style-type: none"> <li>• Standards for private midwives developed.</li> <li>• 44 percent of midwives fully met at least three of six new standards assessed; 93 percent received a passing score on at least three of the new standards.</li> </ul> <p>(Data from visits to midwives, various methodologies)</p>
	To increase by 50 the number of new SDPs opened or soon to be opened by private midwives.	SEATS assisted, in some way, 77 midwives who were aspiring to private practice. Major forms of assistance: provided CE (primarily business management and FP/RHC), provided assistance in obtaining equipment at affordable cost, provided support/monitoring site visits, and assisted with loans. A total of 73 midwives either opened a private practice (N=48) or were preparing to open a practice in the near future (N=25). MAPS succeeded in increasing the number of midwives in private practice by 9.5 percent.

\* Referral assessment included referral to known SDP; use of standardized referral letter; follow-up with client; separate referral record kept and noted in client record; reason for referral recorded; and contact information available to all referring staff.

The Queen of Peace Clinic in Harare, Zimbabwe, noted a different quality problem: clients complained of long waiting periods. In an effort to address this concern, the CQI team asked the staff to move clients through exams more quickly. Unfortunately, this approach left the clients feeling “rushed.” The CQI team then elected to improve the quality of the waiting time by adding a VCR and television to the waiting room and showing health videos. As a result, 95 percent of the clients responded with positive comments about the changes and the realization that their complaints had been taken seriously.

## Model Clinics

In Zimbabwe, MAPS developed model clinics to promote quality service delivery. These clinics served as practicum sites for aspiring private midwives and models for currently practicing PMWs. Model clinics had the added benefit of providing *transparency*; they let other service providers see what midwives do in order to diffuse some of the professional jealousy.

Initially, the strategy called for developing two model clinics over a two-year period. However, when project staff—armed with criteria for selecting a model clinic—visited potential clinics, they found six sites that met the criteria (see Criteria for Selection of Model Clinics, Appendix 4). A decision was made to select all six private practice sites and to create a Model Clinics Consortium to manage the TA needs of the six sites.

The leaders of these six clinics gained much by collaborating with MAPS and each other. They attained new positions of activity, advocacy, and visibility. The experience of working in a group (the consortium) toward a common goal empowered the midwives and renewed their commitment and strength. They dared to try new activities. They pooled their knowledge and experience during monthly meetings. They became role models for other PMWs and aspiring private midwives. As a result of MAPS, 18 model clinic sites are now operating in strategic areas throughout Zimbabwe.

## **CASE STUDY:** **Developing a Model Clinic in Uganda**

A UPMA-owned clinic evolved in response to two problems: the association had insufficient operating funds and it needed to decrease its dependency on donors. UPMA decided to build a *nursing home* that would offer a variety of medical services in addition to maternity services. In Uganda, a nursing home is a facility that provides a variety of inpatient and outpatient services. As part of the feasibility study, UPMA considered the following:

- ✦ A catchment area with good marketability of services.
- ✦ Distance from competitors offering similar services.
- ✦ Accessibility to public transport.
- ✦ Number of women of reproductive age.
- ✦ Expenditures on health services in the catchment area.

With TA from MAPS, DISH, and USAID/Uganda, UPMA identified a site and developed financial projections for two years. The projections assumed a two to five percent net growth rate, fees for services based on fees in similar facilities, and recurring costs. During the design phase, UPMA leaders involved the community and local council leaders, making them aware of the services to be offered and eliciting their input.

UPMA expects the clinic to serve as an example of private-sector midwives providing FP/RHC services. The clinic will also be a CE training site for private- and public-sector midwives. In addition, it will provide visibility and transparency for regulatory bodies, health care agencies, and other professional groups.

Since opening, the clinic has had a patient load ranging from a high of 299 the first month to a low of 157 during one month. The average number of clients per month has been about 200. The reasons for visits range from maternity care to general curative treatments for illnesses such as malaria. Clients also come for family planning.

UPMA received funding through a local currency fund jointly administered by USAID and the Uganda Ministry of Finance and Economic Planning. “The Family Nursing Home,” purchased with this grant, opened June 30, 1999 (see Appendix 5) with integrated RHC services. Full-scope midwifery, minor curative services, and inpatient services are being provided, with plans to add minor surgery (including surgical contraception), exercise instruction, and, eventually, major surgery (e.g., caesarian sections). Technical assistance, in the form of developing and implementing the clinic’s marketing strategies, is being provided by the Commercial Market Strategies Project (CMS).

## Sustainability

MAPS' integrated approach to quality and sustainability combines a process of continuous quality improvement and enhancement of sustainability based on:

- ✦ Team-based problem solving.
- ✦ Involvement of clients, community members, and midwives.
- ✦ Use of data in a cycle of planning, implementation, evaluation, and feedback.

The SEATS definition of sustainability, which MAPS uses also, is the capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to underserved populations while decreasing dependence on external aid.

Two types of sustainability are germane to continued success of the MAPS subprojects: 1) the sustainability of the associations and 2) the individual long-term success of each provider.

### Association Sustainability

The work of MAPS in strengthening the infrastructure of an association, its bylaws, services, and expanded membership is enormously labor-intensive and requires leadership of a very high caliber. The success of MAPS is due in large part to the intensity and rigor of the technical assistance provided to associations as well as to the dedicated, charismatic, and competent leadership of the project's associations—ANSFS, UPMA, ZINA, and ZNA. While not using a prescribed approach, each subproject has included basic steps, most often in the same sequence. MAPS developed this methodology to provide and sustain the skills required to strengthen associations, efforts that had the potential for benefiting over 9,000 midwives in the countries where MAPS is involved. These components require intensive support during the first few years to ensure the infrastructure can absorb and effectively use TA. But once the knowledge and skills have been transferred and a critical mass has been established, the energy of the whole is far greater than its individual parts. The support includes:

- ✦ Training
  - Competency-based FP/RHC updates for the association members
  - Financial management
  - Proposal preparation
  - Computer training
  - Resource mobilization
- ✦ Development of association-owned model clinics
- ✦ Membership drives
- ✦ Development of local, regional, and international linkages to diversify the power base
- ✦ Needs assessments
- ✦ Leveraging
- ✦ Strategic planning

Strategic planning is the process of examining the organization's current financial and organizational health to better envision the future and develop the procedures and operations needed to achieve stated goals. Developing a strategic plan is an ideal format for TA in training managers. To make effective decisions, many factors must be weighed in the organization's environmental analysis, including:

- ✦ Cultural factors
- ✦ Economic factors
- ✦ Status of current RHC services
- ✦ Demand for services
- ✦ Demographics
- ✦ Access factors (infrastructure, policy and legislation, political support)
- ✦ Funding and donors
- ✦ The organization's staffing structure, governance, organizational policies and procedures, and current programming

Several factors are potential barriers to association sustainability:

- ✦ Volunteers do most of the associations' work; associations do not have a large number of staff.
- ✦ Political and government changes affect the context of their work.
- ✦ Members have limited resources for supporting the associations.
- ✦ Adequately training midwives in management skills requires a high level of effort.

MAPS reviews the associations with a careful eye for existing and potential issues likely to affect the performance of the organization. Strategic objectives are then developed along several continuums: growth, productivity, cost recovery, and/or efficiency.

In Zambia, the primary strategy used to accomplish ZNA's sustainability goals was building its institutional capacity in management, finance, and leadership. To strengthen ZNA's financial viability, its staff was trained in accounting. The association branches conducted "Community Health Checks," which added to community awareness and fundraising. Furthermore, because ZNA expanded the services it offered its membership, it could increase membership fees by almost 100 percent and collect on arrears.

ZNA also received a donation of funds from the Norwegian Nurses Association that enabled it to complete the purchase of an office building. This is an example of yet another component of sustainability that SEATS promotes: leveraging. Leveraging represents the association's ability to use its assets—including skills, expertise, and funds—to mobilize and diversify its resources. Leveraging can be accomplished through loans, contracts with other agencies, grants, appropriate use of volunteers, individual donations, in-kind service, or endowments. Sources for leveraged funds may be as broad as multinational or government organizations, or as narrowly defined as individuals or nongovernmental organizations (NGOs). ZINA and UPMA focus on diversifying their funding base and therefore reducing their dependency on donor funding. With financial assistance from USAID, UPMA operates an association-owned clinic and sells commodities to its members. Both activities serve as vehicles for income generation. UPMA has also used

### **Couple-Years of Protection (CYP) and New Acceptors**

ZINA/ICO's FP/MIS system allowed the association to track CYP services provided by ICO members. Figures show the total generated in ten quarters for ICO was 19,973—almost twice the original expectation of 10,000. The total number of new acceptors was 52,121. The model clinics contributed 22,916 new acceptors and 7,737 CYP to this total.

its newly acquired proposal-writing skills to leverage funds from groups other than USAID. Since 1998, UPMA has been awarded funds totaling more than \$232,000 for eight separate projects from groups such as the World Health Organization (WHO), United Nations Population Fund (UNFPA), Family Care International, CMS, and the Ministry of Health/World Bank.

### **CASE STUDY: MAPS/ICO Sustainability Plan**

To achieve its sustainability goals, ICO developed four focus areas:

- ✦ Continued improvement of the private practice environment.
- ✦ Improvement of ICO management systems.
- ✦ Expansion of ICO membership and services (see ICO Sustainability Action Plan, Appendix 6).
- ✦ Enhancement of revenue base.

ICO membership has grown from six midwives in 1996 to 186 midwives. Members currently manage 136 SDPs in all 10 provinces of Zimbabwe. They conduct monthly meetings, attended by an average of 35-40 members, that feature CE presentations on such topics as clinical issues, managerial issues, and professional advocacy. MAPS provided direct support through equipment and/or training for 109 midwives, representing 85 SDPs.

ICO sustainability is enhanced by participation in activities that affect the health care delivery system in Zimbabwe.

An executive officer of ICO and the MAPS/ZINA project coordinator have been named to the Director of Pharmacy Services Task Force. This group is focusing on issues of quality services and procurement.

With TA from MAPS, ICO prepared a proposal, *Zimbabwe Sustainability for Reproductive Health Care*, to develop an ICO-managed model clinic. The clinic would generate income while serving as a center of clinical excellence, providing high-quality FP/RHC services and clinical training for PMWs in FP/RHC.

## Member Sustainability

*“I most enjoy the continuity with my clients. I can care for them for many years, over the course of a few pregnancies and in between. I can also care for their children and families.”*

UPMA Midwife

MAPS promotes sustainability of individual midwives by improving quality of care, strengthening PMWs’ marketing capabilities, increasing access to FP care, and introducing user fees. The project facilitated outreach activities by the PMWs to make communities more aware of their services. Midwives reached beyond their clinics to the communities they served, and in so doing, learned a great deal about community needs, perceptions of care, and barriers to access. In the MAPS’ evaluations, midwives cited the growth they experienced and satisfaction they received through these outreach activities.

Also, helping midwives sustain their private practice includes teaching them how to run a successful business. Midwives need to have skills in filling out financial forms and keeping track of records and other important documents. In training, they learn the importance not only of keeping business records, but also of using these records to manage, evaluate, and improve their business.

To handle basic accounting and develop budgets for action plans, midwives need to understand financial management principles. Yet they had a difficult time learning to plan and budget effectively. They needed, and received, more practice sessions, supervisory visits, and follow-up reviews than anticipated. The time, support, and monitoring invested to support these new skills paid off. MAPS has been successful in assisting PMWs to:

- ✦ Access credit.
- ✦ Evaluate the cost-benefits of extending credit and managing credit effectively.
- ✦ Use business records and knowledge about the clients and community they serve to develop plans for their SDP.
- ✦ Evaluate appropriate user fees and cost recovery.

Ensuring sustainability is a difficult process. Similar to associations, individuals were also faced with challenges as they strove to make the changes that would lead to their sustainability.

- ✦ Access to start-up capital.
- ✦ Access to affordable equipment and commodities.
- ✦ Formal and informal restrictions to procurement of certain commodities such as intrauterine devices and Norplant® implants.

Follow-up to the business management training showed that 92 percent of the 145 midwives trained were keeping some financial records and service data.

- ✦ Regulatory restrictions pertaining to dispensing curative drugs and services.
- ✦ Sufficient client volume.
- ✦ Reimbursement for services.

Because of these constraints and others like them, the ZINA project focused on reducing barriers to FP practice faced by nurses and midwives in Zimbabwe. These barriers were particularly challenging in Zimbabwe, since the nurses and midwives there are relatively new as private practitioners.

To promote sustainability, midwives learned a new way to improve their services—involving clients and the broader communities. They learned to work with community leaders, seek the involvement and support of families, and ask clients what they liked and did not like about their care. This new way of working required a paradigm shift, one that prompted midwives to seek new heights of personal courage and new depths of support from each other.

Competitive marketing principles, financial records, and business and community action plans were challenging and exciting new ways for midwives to examine their situations. Many fledgling entrepreneurs blossomed using these strategies. Several PMWs have found their practices growing to the point that they have needed to open new SDPs and hire other midwives and nurses.

These changes have also brought some negative repercussions. In Zimbabwe, one landlord significantly increased rent for a practice when he realized the midwives were becoming more and more successful. Undaunted, the midwives conducted market research to find a new location for their practice, and they continue to thrive at their new site.



*MAPS promotes sustainability of individual midwives by improving quality of care, strengthening marketing capabilities and increasing access to family planning services.*

One clinic in Zimbabwe meets the needs of its clients for exercise, relaxation, and child care at the same facility where they receive quality health care. The midwife built a day care center and fitness area. She provides a qualified day care teacher and a trainer for regularly scheduled exercise classes. Men are beginning to use the facility as often as women do. To support working women who need to return to work after exercise, she opened a salon—with shower facilities and hair stylists.

In another PMW clinic, the midwife made her own beautiful bedding, creating quiet and restful client rooms to facilitate recovery. She also grows the vegetables for the clients' meals—assuring fresh, tasty, and healthful food.



*In spite of their need to earn an adequate income, midwives are particularly sensitive to the plight of disadvantaged groups.*

In spite of their need to earn an adequate income, midwives are particularly sensitive to the plight of disadvantaged groups. Most expressed a willingness to provide pro bono services to their clients when necessary. This is, however, an area of concern for the viability of their business.

One midwife from the Model Clinic Consortium in Zimbabwe serves a client base that includes many mine workers. She devotes two days per month to their needs—traveling to the mine to provide condoms, treat STIs, and answer questions. The midwife’s goal is to approach the management of the mine with an *action plan for quality care*, in the hopes of negotiating a contract to provide a broader range of services to the miners and their families and to be reimbursed for the commodities. Another model clinic midwife has a *mobile clinic*. She takes it to community farms in the rural area of Zimbabwe she serves.

## V. Policy Initiatives

Standards define competency and are written broadly enough to apply to all practice settings. In contrast, guidelines, which define the process of client care and its management, focus on client outcomes and are based on scientific evidence, requiring frequent review and updating.

MAPS developed standards for private midwifery services in Uganda. These will serve as a model for other countries. An assessment is currently being conducted in Uganda to determine the percentage of sampled midwives who meet the standards. The results of this assessment will guide future efforts.

*“The miners are starved for health information, but they must ‘foot it’ to any site for care...so I get to the hole before they go down...and talk to them about condoms, family planning, and STIs.”*

*ICO member*

## Family Planning Referral Guidelines

One of the key activities undertaken by MAPS/ICO was developing referral guidelines for family planning clients. These guidelines were important because PMWs found acquiring FP commodities increasingly difficult and were restricted from inserting intrauterine devices and Norplant® implants. Also, more clients were requesting voluntary sterilization, which PMWs cannot perform. Midwives often needed to refer clients seeking contraceptive services to appropriate SDPs. ICO addressed this need by developing, testing and introducing a standardized, efficient mechanism for client referrals.

## Position Paper: Private Midwife Practice in Zimbabwe

In response to the frustration of being relatively invisible to Zimbabwe's national regulatory agencies and decision-making bodies, the model clinic midwives developed a position paper on the status of private midwife practice in that country. They wrote the paper with assistance from MAPS and the Director of Nursing Science at the University of Zimbabwe.

The report is a situation analysis of the current status of private practice in Zimbabwe, with suggestions for improvements to promote the maximum contribution to women's health from private-sector nurses and midwives. The Permanent Secretary for Health, who has approved the paper's distribution to support grant applications and funding requests to outside sources, is very pleased with this document and its articulation of the issues and barriers facing private-practice midwives. The paper has become the centerpiece for continuing discussions with regulatory agencies, insurance groups, and other stakeholders.

### Developing Standards for Private Practice

Standards are authoritative statements by which the... profession describes the responsibilities for which its practitioners are accountable. These standards reflect the values and priorities of the profession and provide direction for practice and framework for the evaluation of practice. Standards define the profession's accountability to the public and the client outcomes for which the provider is responsible.

Taylor 1995



# Lessons Learned

Despite the short-term nature of most of the subprojects, MAPS has been highly successful in strengthening the capacity of associations and the skills of midwives. Further, MAPS has been instrumental in positioning midwifery associations and private-practice midwives as significant change agents capable of delivering high-quality reproductive health services.

During the course of the project, MAPS learned many valuable lessons. The points below are meant to be illustrative rather than definitive.

## 1. **The power of quality should never be underestimated.**

A review of the subprojects' evaluation data reveals that **quality counts**. Clients are willing to pay for quality services; and satisfied clients return and tell others about the care they receive.

Midwives understand that the quality of care provided to women, youth, men, and families is important not only to the clients, but to the midwives themselves. Providing quality care gives them a sense of pride in their work; it also ensures greater financial success. For many midwives, earning a living wage and being able to pay their children's school fees were significant accomplishments.

Private midwives are highly motivated to deliver quality services because their reputation in the community and their livelihood are at stake.

## Lessons Learned

1. The power of quality should never be underestimated.
2. Flexibility and perseverance are needed to operate within the constraints of a situation or country.
3. Every new situation should be treated as a teaching and learning opportunity, with mid-course adjustments made and midwives consulted for creative problem solving.
4. Barriers to private practice severely limit the potential contribution of midwives to reducing the unmet need for RHC services.
5. RHC services and SDPs that include FP/STI/HIV are incomplete without minor curative services and immunization capability.
6. In unity, there is strength.
7. HIV/AIDS has permanently changed the service delivery environment.
8. Basic business management skills and community mobilization skills are critical to the viability of private midwives.
9. Monitoring and long-term supervision of midwives on a sustained basis is difficult.
10. Learning how to monitor quality takes time.
11. Private midwives serve existing needs.
12. Private practice expands service.

**2. Flexibility and perseverance are needed to operate within the constraints of a situation or country.**

Flexibility and perseverance are mandates for MAPS project development. This initiative experienced circumstances that at first seemed discouraging, but later became manageable.

Several MAPS subprojects were plagued with difficulties during implementation. For example, in Senegal, several key staff resigned at a crucial time in the project and in Zimbabwe, the cost of oral contraceptives increased threefold. Project staff in each site had to deal with macro-level challenges such as civil unrest, budgets eroded by unanticipated devaluation of local currencies, adjustments required to support health-sector reforms, persistent problems with communications and overland travel, and the devastating toll of AIDS.

Tenacity, understanding, and support helped project staff achieve results that at first seemed impossible. It is a testimony to the quality of this TA that, despite numerous challenges, **each MAPS subproject not only met, but exceeded, its objectives.**

**3. Every new situation should be treated as a teaching and learning opportunity, with mid-course adjustments made and midwives consulted for creative problem solving.**

Each subproject had a somewhat different focus, and each association was at a different level of development. MAPS offered a wide range of TA to fit specific needs. Because the TA was highly specialized, and much of the training was offered in areas unfamiliar to the midwives, careful coordination was needed. It was also important to ensure an adequate length of time for each training (e.g., more time was needed to transfer business and accounting skills than anticipated) and to select consultants with appropriate expertise and language facility.

**4. Barriers to private practice severely limit the potential contribution of midwives to reduce unmet need for RHC services.**

MAPS worked diligently to reduce official barriers to PMW practice. Advocacy became the critical skill for ensuring success. Continued work to overcome barriers—particularly those that prevent midwives from easily obtaining commodities and dispensing contraceptives, immunizations, and simple medications in their SDPs—is key to continued sustainability.

Unofficial barriers, such as fear of competition from other health care groups, are much more difficult to address. Still, they must be overcome if midwives are to contribute effectively.

**5. RHC services and SDPs that include FP/STI/HIV are incomplete without minor curative services and immunization capability.**

To serve their clients adequately, midwives need to provide minor curative services, immunizations, and comprehensive maternity care. Without such capacity, PMWs lose opportunities to promote health and risk losing clients to systems that provide these services. Many of the midwives' SDPs are also maternity care centers, and many midwives expressed an interest in CE that addressed maternal health issues. Collaboration with DISH in Uganda, and work with the SEATS/MotherCare project in Eritrea and with the SEATS program in Cambodia, provided opportunities for life-saving skills (LSS) training in those countries. Midwifery associations in other project areas could benefit from similar training in safe motherhood skills. Perhaps UPMA's model clinic could provide for such training as an income-generating, south-to-south activity.

**6. In unity, there is strength.**

As a result of the MAPS Initiative, midwives in the project countries are collectively stronger. They have a new way to learn from, and support, each other. They can now view problems as issues that need to be resolved, rather than insurmountable barriers to their personal success.

By strengthening PMWs' capacity to provide services and to operate a sustainable practice and by organizing their collective efforts, MAPS has helped to empower midwives to constructively advocate for policy issues. Where they once hid from regulatory agencies, they now serve on policy-making committees. Training midwives in these skills requires intensive support, but once a critical mass is established, the energy of the whole is far greater than its parts. For example, the fact that the number of private practice midwives in Zimbabwe grew from six to over 200 (more than 85 percent of whom are ICO members) empowers ICO to move forward with much greater visibility and effectiveness.

**7. HIV/AIDS has permanently changed the service delivery environment.**

The reality of HIV/AIDS affects midwifery practices as it does all health and social systems. Midwives, their SDPs, and midwifery associations must know how to counsel clients affected by HIV/AIDS and, equally important, they must know how to protect clients and themselves from cross-infection. They must also learn how to deal with colleagues and staff who become infected. The Model Clinics Consortium struggled with this issue as one that affected quality of care *and* access. Clients quickly became frightened of staff members who appeared ill or thin and began to stay away from the clinic or refused treatment from particular staff members. Future MAPS initiatives will need to deal more extensively with this complex crisis.

**8. Basic business management skills and community mobilization skills are critical to the viability of private midwives.**

Even the most skilled service providers will have difficulty succeeding in private practice without basic skills in business management and community mobilization. Yet almost without exception, private midwives lacked this training before MAPS arrived.

MAPS found that the most difficult concept for midwives was budgeting. Planning and managing finances with an eye to the future is especially challenging when life circumstances have promoted a *day-to-day* existence and when cultural practices have prohibited women from handling money and property of their own. Effective budgeting requires a change in thinking—a change that must happen gradually. MAPS can better support this change in the future by strengthening the curriculum and offering more on-the-job follow-up and assisted supervision.

**9. Monitoring and long-term supervision of midwives on a sustained basis is difficult.**

Midwives are located in urban and rural communities and often in underserved areas. Although one of the qualities that makes them a valuable RHC resource, it also complicates supervision. Professional associations, MOHs, and regulatory bodies generally have limited resources for this activity. Creative approaches to effective supervision must be developed (e.g., peer review or supervisory training of key personnel within the facilities or within a limited geographic area).

UPMA has developed a system of regional representatives who were trained to provide *on-the-job* support, collect service data, supply commodities, and provide a communication link among the association headquarters, member midwives, and the district offices of the MOH. MAPS is continuing to work with UPMA on mechanisms to sustain these activities.

**10. Learning how to monitor quality takes time.**

Process indicators are easy and familiar ways to monitor projects; output and impact indicators are much more difficult—not only for those who design projects, but also for partners who implement them. When projects run for only two years, assessing their impact is especially difficult. Assisting project staff in effectively monitoring the quality of their program is highly resource intensive. Therefore, more resources need to be built into project designs and budgets from the start.

**11. Private midwives serve existing needs and reduce the public-sector burden.**

Private midwives provide affordable, quality alternatives to care for clients who live in underserved areas or who cannot access a private doctor but can afford to pay a reasonable fee for services. The services they provide relieve some of the burden on public-sector facilities and services.

**12. Private practice expands service.**

Private practice offers options to midwives who are leaving public service and who otherwise would be lost to the national health care delivery system. It is a way to keep valuable, experienced service providers within the health field.



# The Future of MAPS

Midwives have tremendous potential for reaching underserved populations and for providing integrated reproductive health services either onsite or by efficient referral. Midwives are trusted members of urban and rural communities, they understand the needs of women, and—with training and support from their associations—they are able to provide a broad range of services. Since private midwives are often the primary providers of family health services, they have the potential to meet people’s needs for reproductive health care throughout their lives.

The future of the MAPS Initiative lies in consolidating what has been accomplished, while continuing to build and expand on the project’s strengths and achievements. Here are some of the main points to be considered:

## 1. Maintain current strengths.

MAPS has successfully developed a capacity to respond with flexibility to midwifery associations’ needs along a developmental continuum. This approach takes into account each association’s management capabilities and capacity to meet member needs. The MAPS emphasis on quality and sustainability increases client access, as well as client and provider satisfaction.

## 2. Maintain features of current program.

Continuing education for acquiring new skills in FP/RHC service delivery, community outreach, and quality of care will be needed until such skills are completely integrated into pre-service training. Interventions to promote sustainability are particularly important at the level of the association as well as of the individual midwife. Training in business skills must be central to any strategy.

To ensure high standards of quality, continued emphasis must be placed on model clinic development and CQI process implementation. The Model Clinic Consortium should be replicated either by mentoring of association members by Consortium midwives or through model clinic development at association branches.



*Since private midwives are often the primary providers of family health services, they have the potential to meet people’s needs for reproductive health care throughout their lives.*

## Suggestions for the Future

1. Maintain current strengths.
2. Maintain features of current program.
3. Extend capacity building to strengthen community mobilization and NGO linkages.
4. Empower midwives by removing barriers to practice.

**3. Extend capacity building to strengthen community mobilization and NGO linkages.**

The MAPS focus on building institutional capacity of local midwifery associations guaranteed the sustained technical and policy support needed for maintaining high standards of quality and promoting service expansion. This emphasis on institutional capacity should continue as a central component, and the focus should be expanded to move beyond current boundaries.

Currently, providers do not have the funds or the expertise to market prepayment plans or to develop the financial systems required to manage such a plan. However, the future of PMWs' sustainability may well depend on MAPS TA in this direction. Most clients who seek private practitioners are covered by medical aid. As reimbursements for services become more equitable for PMWs in the future, the financial viability and sustainability of their FP/RHC services will increase. Finding financial institutions willing to work on this component will be key.

The community mobilization curriculum, while continuing to provide the same core competency in working with the community, needs to be expanded to include optional modules that would enable midwives to access certain key community populations, such as youth, working women, men, and women-at-risk.

Linkages and expanded partnerships between midwives and communities need to include more networking with the public sector, further development of cross-training with other projects or NGOs [e.g., the LSS training with DISH in Uganda and the Zimbabwe AIDS Prevention and Support Organization (ZAPSO) in Zimbabwe], and an increase in social marketing/market interventions. Partnerships between associations and practicing and aspiring private midwives could be used to promote mutual goals while limiting the *isolation* of success and facilitating expansion as interest in private practice grows.

More emphasis is needed on regional and international linkages and activities such as study tours, workshops, association-to-association technical assistance, and collaborative regional research.

#### **4. Empower midwives by removing barriers to practice.**

Empowering women as providers and recipients of quality FP/RHC creates autonomy and trust. As midwives develop the capability to earn an adequate income that meets personal and family needs, their autonomy provides a role model for clients, especially adolescents. Working with their communities to improve health care and quality of services, midwives become empowered to address such issues as female education, maternal mortality, dual protection, postabortion care and abortion prevention, and prevention of domestic violence.

In 1999, the government of Zimbabwe named a midwife, the owner of the Queen of Peace Clinic, as Business Woman of the Year. This is just one example that indicates barriers are falling. MAPS is proud of her accomplishment and proud of the role it played in increasing the visibility and success of all the midwives involved in the project activities.

Cultivating sustainability in professional associations is a developmental process and requires intense and varied technical assistance. In the lifetime of an organization, it could be said that MAPS is entering its adolescence. The next phases of TA, then, will require different core objectives than the early phases, yet they will be equally important. The south-to-south collaborative work that began with ZINA and UPMA as well as their model clinics is moving the two associations toward autonomy and interdependence as health professional organizations. Association members have gained many leadership skills and are mastering the networking skills needed for continued strength. Ideally, the next phase could include an articulation of the dynamics of the process and progress to date, including the variations between associations and their relationships to regulatory agencies.



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# Appendix 1

## MAPS Country Project Summaries

### SENEGAL

Senegal is a Francophone Muslim country with a high fertility rate (5.7 children per woman of reproductive age) and high maternal and child mortality rates (510 mothers die per 100,000 live births, and 139 per 1,000 children die before their fifth birthday).

The MAPS subproject in Senegal was implemented by of L'Association Nationale des Sage-Femmes Sénégalaises (ANSFS). This national association for midwives was founded in 1964, and approximately 90 percent (545) of all midwives in Senegal are members. However, when MAPS came to Senegal, only 150 of the members were active (i.e., they paid their dues on time and attended meetings regularly). ANSFS did not have administrative space or office equipment; data on members were organized in handwritten files.

Also at this time, there was no formal management of training programs for clinicians at the national or regional level, resulting in a wide variation of practice standards, which were often poor. Clinical updates and continuing education were not consistently available for Senegalese midwives nor were they a requirement for practice.

The purpose of the MAPS/ANSFS subproject was to improve FP/RHC service provision by midwives and to strengthen ANSFS' administrative and training capability. The MAPS/ANSFS collaboration targeted 13 SDPs. Vital to the growth of the association was the development of ANSFS administrative and training capability. Specific objectives included:

#### 1. Strengthen ANSFS institutional administrative capabilities:

- ✦ Develop and implement a strategic plan and membership support activities.
- ✦ Develop an income-generation plan.
- ✦ Develop, implement, and analyze a member survey.
- ✦ Develop an MIS system, starting with computerization of member data.
- ✦ Orient ANSFS leaders to business management.

**Dates:** November 1997–  
January 1999 (Activities  
ended in September  
1998)

**Cost:** \$56,400 (excluding  
technical assistance costs)

#### Major Components:

- ✦ Strengthen the administrative capacity of the Association Nationale des Sage-Femmes Sénégalaises (ANSFS).
- ✦ Improve the training capacity of ANSFS in reproductive health service delivery.

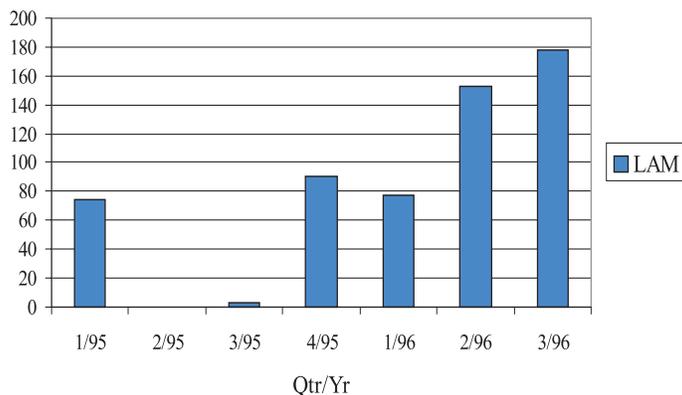
#### Key Populations:

- ✦ 13 service delivery points in Dakar and Thies.
- ✦ 230 midwives.

## Highlights

- ✦ LAM TOT, LAM training (193 midwives/nurses), and follow-up.
- ✦ Significant increase in LAM acceptors, from 361 in the fourth quarter of 1997 to 710 in the third quarter of 1998.
- ✦ Computerization of membership data.
- ✦ Participation of 90 percent of members in survey.
- ✦ Business management training for eight ANSFS leaders.
- ✦ Development and implementation of ANSFS strategic plan.
- ✦ Participation in regional quality workshop.
- ✦ 14 SDPs improved.
- ✦ Developed trainer expertise through training of trainers (TOT).
- ✦ Trained eight midwives in lactational amenorrhea (LAM) and breastfeeding updates.
- ✦ Sponsored ANSFS leaders to attend a quality of care workshop.
- ✦ Developed a training database.

## ANSFS CYP



- ✦ Sponsor at least two ANSFS leaders to attend a sustainability workshop.

## 2. Increase ANSFS members' training capability and provision of RHC services.

LAM training was included based on the results of the needs assessment. Eighty percent of the midwives in the two project regions identified LAM instruction as a training need. In addition, breastfeeding practices in Senegal were not considered optimal, and the National Family Planning Program had launched a major strategy to promote breastfeeding. MAPS/ANSFS planned to train 89 midwives in LAM, but the project succeeded in training 193 midwives and maternal child health workers.

Since it will be some time before ANSFS can operate without some level of donor funding, MAPS provided a workshop in proposal writing and assistance in writing a simple proposal. MAPS also assisted ANSFS in developing a sustainability plan.

Three main factors were responsible for the achievements in this subproject:

- ✦ The commitment of a core group of ANSFS members.
- ✦ The expertise of the MAPS consultant (problems were encountered in placing a long-term consultant in this project; however, the short-term consultant's significant expertise in project management and her multilingual capacity enabled her to effectively assist with project activities).
- ✦ SEATS' commitment to the development of ANSFS.

## Constraints of the MAPS/Senegal Project

The project in Senegal faced several challenges:

- ✦ Unexpected resignation of the MAPS local consultant due to unforeseen family relocation.
- ✦ Lack of a project coordinator/consultant for over six months.
- ✦ Significant language barrier (since this was the only MAPS project in a Francophone country, there were several disadvantages: missed regional opportunities for networking; limited written materials in French; communication with MAPS technical assistance providers, Africa Regional Office, and JSI/Washington was difficult).
- ✦ Early termination (the project ended four months early) due to revisions in the USAID/Senegal strategy.
- ✦ A shift in priorities by ANSFS, which affected the association's ability to complete the program's objectives.

## UGANDA

Uganda has made major inroads in decreasing its total fertility rate—currently at 6.9. The unmet need for contraception is estimated to be 29 percent. STIs are prevalent in Uganda, accounting for 20 percent of all outpatient visits. Life expectancy may be the lowest in the world, 37 years of age, due primarily to the AIDS epidemic. It is estimated that 1,900,000 Ugandans (out of a total population of 20,000,000) are infected with HIV. As a result of many years of political instability from civil war (1966–1987), many midwives are also in need of FP/RHC skills updating.

Private midwives (PMWs) have a long history in Uganda; they have been providing preventive and curative services as well as antenatal, delivery, and postnatal services for more than 50 years. Private midwives have the potential for significantly expanding the efforts of the government of Uganda to provide accessible, quality RHC services nationwide. Although the private sector in Uganda is critical to meeting

**Dates:** April 1998–December 1999

**Cost:** \$342,191 (excluding technical assistance costs)

### Major Components:

- ✦ Strengthen the Uganda Private Midwives Associations (UPMAs) ability to assist midwives in establishing, operating, and sustaining private practices.
- ✦ Establish UPMA as a center of excellence for in-service training of midwifery and reproductive, maternal, and infant health services.
- ✦ Enhance UPMAs financial self-sufficiency and management capacity.
- ✦ Develop linkages between UPMA and other midwifery associations.
- ✦ Develop a model clinic and training site.

### Key Population:

- ✦ 800 private midwives of Uganda (approximately 500 are members of UPMA). This subproject was designed to support the USAID bilateral program, Delivery of Improved Services for Health (DISH).

the growing demand for RHC needs, the number of private facilities and practitioners is limited. At present, PMWs are the only private health practitioners that are operating in rural and urban communities nationwide—making them a significant health care resource.

Midwives retiring from public service as well as new midwifery graduates are increasingly interested in entering private practice. Most of these women need to work to support large families or to supplement an inadequate pension. Many women have become sole supporters of extended family members who are victims of AIDS.

Started by 12 midwives in 1948, UPMA is a registered nongovernmental organization (NGO) in Uganda and a member of the International Confederation of Midwives (ICM). Membership is open to all trained, self-employed midwives who have at least five years experience. UPMA plays a key role in promoting the professional development and socioeconomic welfare of its members through training and access to credit. UPMA is the potential link for accessing, monitoring, and assisting PMWs, as well as expanding the number of practitioners providing high-quality RHC.

### SEATS/UPMA Collaboration

SEATS, through ACNM, has been providing technical assistance to UPMA since 1991 through the following projects:

- ✦ SEATS I
- ✦ SEATS II/MAPS I
- ✦ SEATS II/MAPS II

The objectives of the effort have been to:

- ✦ Increase by 10 percent the number of midwives in private practice through enabling the UPMA to assist midwives in establishing, operating, and sustaining private practices.
- ✦ Establish UPMA's capability and role in setting, implementing, and monitoring standards for obtaining permits to open private practices and for ongoing certification to ensure the provision of quality services by PMWs.
- ✦ Establish UPMA as a center of excellence for in-service training of midwifery and reproductive, maternal, and infant health services.

#### Highlights

- ✦ Over 160 SDPs improved.
- ✦ Increased access to FP services.

- ✦ Significantly enhance the financial self-sufficiency of UPMA by increasing active membership; acquiring and successfully operating a private UPMA clinic and training site; and acquiring an endowment from USAID/Uganda.
- ✦ Improve UPMA's management capacity, including its capability to monitor and control costs and to efficiently and effectively manage an endowment income.
- ✦ Develop linkages between UPMA and other midwifery associations—through the MAPS Africa Regional activities and the ACNM—to gain exposure to innovative approaches for improving quality and sustaining services and to market UPMA's resources to regional associations and PMWs.

As a result of this assistance, UPMA has made significant progress in strengthening its organizational capacity and its efforts to meet the needs of PMWs.

### SEATS I (1991–1994)

During the first SEATS/UPMA collaboration, emphasis was placed on training and equipping 137 midwives in FP, with nearly 300 midwives receiving training in social marketing of contraceptives by SOMARC. In addition, 60 midwives received basic training in business management. Thirty-five regional representatives received training in management supervision, including the development of skills and facility checklists. Efforts were also directed at providing office space, furnishings, and equipment with the intent of assisting UPMA in capacity building. A Board of Directors for UPMA was established, and job descriptions were developed.

### SEATS II/MAPS I (1995–1997)

The overall goal of this phase of technical assistance was to continue to strengthen UPMA's capability, with a focus on sustainability. The process included developing training capability and addressing member issues that emerged from the needs assessment. Two curricula—on

#### Highlights of SEATS II/MAPS

- ✦ Training of 145 members and seven trainers in business management and community mobilization.
- ✦ Formation or improvement of 172 SDPs.
- ✦ Increase in number of clients served (10–20 percent monthly increase at trained midwives' SDPs).
- ✦ Development and piloting of business management and community mobilization curricula.
- ✦ Follow-up supervisory visits for 143 UPMA members.
- ✦ PMWs linked with DISH training—37 PMWs received RHC training from DISH.\*
- ✦ Provision of CQI training and initiation of quality teams in selected sites.
- ✦ Development of Board of Directors.
- ✦ Leadership training for UPMA managers.

\* DISH offers a six-week comprehensive RHC training program to clinicians.

business management and community mobilization—were developed and pilot-tested. A TOT was held for seven trainers, and additional training was provided to 145 UPMA members.

In 1996, UPMA built a small office building through donations from its members and a grant from the Banker Williams Foundation. UPMA headquarters was established as a subdistributor for socially marketed FP commodities (oral contraceptives, condoms, and Depo-Provera), which is a source of income for the association and ensures supply for the members. UPMA also obtains free family planning commodities from the MOH and distributes them to its members.

## SEATS II/MAPS II (1998–99)

The goal of the most recent MAPS/UPMA project was to expand and sustain UPMA’s role in increasing access to high-quality FP/RHC services provided by private-sector midwives in Uganda (see chart of activities). An ACNM advisor was seconded to Uganda to help with the process of locating, purchasing, and renovating a building to be used as a model clinic and training site. This 24-hour clinic, owned and managed by UPMA, opened in mid-1999. It offers full-scope reproductive health services as well as curative and general inpatient and outpatient services.

UPMA is a well-established and mature association. Therefore, the technical assistance was geared to moving the organization toward sustainability as well as national and international visibility. During MAPS II, UPMA built a new clinic training center and renovated headquarters, developed and implemented a financial system, increased its training capability, and trained over 150 midwives. In addition, UPMA has been very instrumental in strengthening the networking among key midwifery associations in Africa.

### SEATS II/MAPS II Activities

#### Sustainability

- ✦ Ensured financial management system.
- ✦ Ensured leveraging of activities.
- ✦ Developed and implemented sustainability plan.
- ✦ Developed and opened model clinic.

#### Capacity Building

- ✦ Put in place and computerized financial and management systems.
- ✦ Held TOT.
- ✦ Computerized member database.

#### Collaboration

- ✦ Hosted study tour for midwives from Senegal and Zimbabwe.
- ✦ Trainers shared expertise with the Zimbabwe Nurses Association (ZINA).
- ✦ Hosted study tour with midwives from Zambia.

#### Quality

- ✦ Provided CQI training.
- ✦ Ensured quality teams are functioning.
- ✦ Developed certification standards.

#### Access

- ✦ Realized increase in members providing quality FP.
- ✦ More than 50 aspiring private midwives assisted in opening SDPs.

#### Training

- ✦ Expanded business management skill training to some branches.
- ✦ Linked private midwives to DISH training.
- ✦ Developed training center and RHC modules for continuing education.

UPMA hosted the ICM Symposium in 1995 and collaborates on a regular basis with ACNM, the Family Planning Association of Uganda, MOH, the World Health Organization, the Cambodian Midwives Association, and others.

## Leveraging

UPMA leaders and members share a tremendous spirit and sense of commitment. The association has demonstrated a strength and tenacity to persevere and to hold its members together under the most difficult of conditions. At the same time, the long-term sustainability of the association is dependent on its ability to develop a stronger financial base. It has been almost completely reliant on donor assistance, supplemented by membership fees. Becoming more self-sufficient enables the organization to continue developing and maintaining programs and activities that ensure quality FP/RHC services and makes them more attractive for assistance such as endowments and long-term financing or loans.

UPMA has been successful in expanding its base of support. United Nations Population Fund (UNFPA) has approved funding (over \$100,000) for a two-year UPMA project to train midwives in life-saving skills and has completed a UPMA project (\$60,000) to train midwives in LSS. CMS is also supporting two ongoing UPMA activities: 1) developing and implementing marketing strategies for the UPMA clinic for \$20,000 and 2) funding the Executive Director of UPMA for \$24,000. A smaller project (about \$14,000), funded by Family Care International, will support sensitization and training of UPMA midwives in adolescent health care services. In addition, proposals have been submitted to WHO and the International Planned Parenthood Federation for projects focusing on Safe Motherhood activities. WHO (\$1,631) and the Ministry of Health/World Bank (\$3,308) have completed activities with UPMA focusing on IEC campaigns and training midwives in STI management and counseling, respectively.

## Highlights of SEATS II/MAPS II

- ✦ Uganda Study Tour (detailed in body of paper) conducted.
- ✦ Model clinic developed and opened.
- ✦ A total of 83 aspiring private midwives were identified. Of the 79 who were followed up with, 77 had received some sort of assistance, 48 had opened a practice and 25 were close to opening a practice by early 2000. SEATS provided them with business management/community mobilization training and delivery kits.
- ✦ Four trainers trained in DISH RHC services, and 51 midwives received RHC training.
- ✦ Training in business management and community mobilization provided by UPMA trainers to 38 midwives in Zimbabwe.
- ✦ CQI training provided and quality teams initiated in selected sites.
- ✦ Standards developed.
- ✦ CE training center developed.
- ✦ Four FP/RHC CE modules developed.
- ✦ UPMA funding base diversified by expanding the number of donors and increasing income-generating activities.
- ✦ Membership database computerized.
- ✦ Computerized financial management developed that allowed UPMA to receive direct funding from SEATS.
- ✦ UPMA membership increased by 14 percent.

## UPMA's Future

The future is very promising for UPMA. Plans include exploring ways to increase access to capital for opening and expanding private clinics; expanding and marketing training capability; franchising the model clinic; improving the availability of affordable equipment and supplies to members; and, by diversifying funding sources, decreasing donor dependence. These are ambitious objectives, but UPMA has demonstrated its determination and capability to succeed.

## ZAMBIA

The devastating impact of the AIDS epidemic and high rates of unsafe abortion among young women were among the reasons the City Council of Lusaka decided to take action. In 1996, it developed an action plan to provide improved reproductive health information and services to youth in all its health facilities. The MAPS subproject in Zambia followed this lead in its focus on youth. The Zambia subproject represented the integration of three SEATS Special Initiatives: Urban, Youth, and MAPS. Implemented by Zambia Nurses Association (ZNA) and the Lusaka District Health Management Team, this subproject targeted nurses and midwives in the public and private sectors, in part by building the capacity of the ZNA.

ZNA draws its members from government, private, mission, mines, and defense force health services. Its mission is to promote and protect the interest of nurses and midwives, advocating the highest levels of professionalism and integrity in the delivery of health care services to the community. Assisted originally by the Norwegian Nurses Association, and with Norwegian funding, an office was purchased and equipped.

The goal of MAPS/ZNA collaboration was to “strengthen the capacity of ZNA in order to ensure the provision of quality sustainable FP/RHC services to youth.” This represented a somewhat different focus than other MAPS subprojects. The objectives of this subproject were to:

**Dates:** October 1997–April 1999

**Cost:** \$112,590 (excluding technical assistance costs)

### Major Components:

- ✦ Strengthen and coordinate pre-service and in-service training through ZNA.
- ✦ Train 35 midwives at Lusaka municipal clinics in youth-friendly services.
- ✦ Link ZNA with nurse/midwifery associations in the region.
- ✦ Strengthen the capacity of ZNA.

### Improve quality service provision by midwives through:

- ✦ Competency-based training (including TOT).
- ✦ Follow-up and monitoring.
- ✦ Continuing education through the professional association.
- ✦ Increased access to services.
- ✦ Integration of services.

### Key Population:

- ✦ Youth of Zambia

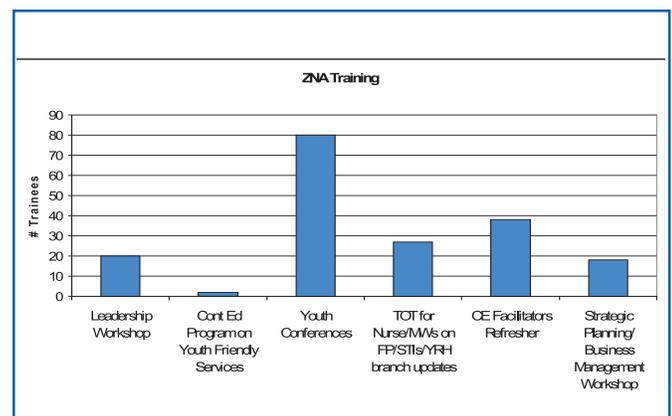
1. Increase youth knowledge of reproductive health and sexuality.
2. Train staff in youth-friendly approaches to quality care.
3. Promote nurses' and midwives' involvement in STI/HIV prevention for youth at the community level.
4. Provide regional workshops for association leadership focusing on the potential role of private nurse-midwife service providers in Zambia.

Through MAPS, three continuing education programs on youth-friendly integrated RHC were provided to ZNA members. MAPS also adapted the national reproductive health curriculum to include youth-friendly approaches. A TOT workshop for facilitators was conducted for ZNA members (more than half of ZNA branches were represented at the workshop) to sensitize health providers, not only to elements of quality services for youth and specific counseling interventions, but also to society's behavior and attitudes toward youth seeking RHC.

A needs assessment (N=172) identified that over 90 percent of the membership required continuing education and wanted a newsletter. Another frequently mentioned need was for access to new information. The MAPS continuing education program included development of training modules, identification of nurses and midwives who could provide update sessions, and competency-based training of nurse-midwives representing 21 of 42 active branches nationwide. The topics covered in the continuing education training included counseling interventions for youth, characteristics of youth-friendly services, contraceptive methods including emergency contraception, STI/HIV/AIDS and other reproductive health issues of significant interest to youth, and facilitation skills. By June 1999, 11 of 14 member SDPs that were followed up with site visits reported youth-friendly actions such as establishing a youth corner within their clinics to make the services more appealing. Youth reported using the youth-friendly clinics for a variety of RHC concerns.

## Highlights

- ✦ Capacity building and strengthening of the association.
- ✦ Computerization of member database.
- ✦ Development of training modules in youth-friendly services.
- ✦ Updates on the topic of FP/RHC for youth (reaching more than 500 nurse-midwives) provided by ZNA facilitators.
- ✦ Training in leveraging of funds and proposal writing.
- ✦ Revival of the association's newsletter.
- ✦ Participation in regional quality workshop.
- ✦ Study tours to Zimbabwe and Uganda.
- ✦ Participation in regional workshop on private practice for nurse midwives and regional dissemination conference.



ZNA's future objectives include continuing with its membership drive; becoming a union for nurses; writing a strategic plan; developing a proposal for developing an association-owned clinic to market to donors; and becoming a strong, self-sustaining professional body by the year 2004.

## Youth-friendly Services

Characteristics of youth-friendly services as implemented in Zambia included:

### Youth Served

- ✦ At one model clinic, the number of young people coming for FP and antenatal care increased approximately 300 percent between 1996 and 1999.
- ✦ 929 new contraceptive users were reported from two clinics.

- ✦ Provide youth with reproductive health education and counseling.
- ✦ Offer appropriate contraceptives to youth.
- ✦ Provide education on STI and HIV prevention.
- ✦ Provide education and services related to safe motherhood.
- ✦ Offer postabortion care and counseling.

In March 1999, association members in four locations in Zambia met with youth leaders and peer educators. These meetings were held to give participants a chance to exchange views and encourage the nurses and midwives to offer youth-friendly information and services at their SDPs. Society's behavior and attitudes toward youth seeking RHC were reviewed and discussed.

## Constraints in Zambia

The duration of the MAPS project in Zambia was short. Current MOH reforms have placed a ban on new training, yet all the current facilities require continuing support. To continue the programs, facilitators will need to network with NGOs such as CARE International and others that provide youth services. ZNA will have to maintain its support in order to address implementation needs. It will need to:

- ✦ Increase its membership.
- ✦ Improve revenue collection measures.
- ✦ Maintain regular communication and updates on activities of the association.
- ✦ Provide up-to-date reference material for facilitators.
- ✦ Ensure that health providers assigned to the youth-friendly services are adequately trained.

- ✦ Ensure consistent support from clinic managers for youth-friendly services.
- ✦ Improve the commitment of ZNA members.
- ✦ Confront apathy and heavy workloads that prevent youth-friendly services from being fully implemented.

## ZIMBABWE

In 1988, the total fertility rate in Zimbabwe was 5.5 births per woman, but declined to 4.2 in 1994. By 1994, about 42 percent of Zimbabwean women of reproductive age were using some form of modern contraception. This contraceptive prevalence rate is now estimated at 60 percent (ZNFPC 1999) and is one of the highest in the sub-Saharan region. Despite this improvement, 15 percent of married women have an unmet need for family planning, and this percentage is almost double in rural areas and for the illiterate and semi-literate. Approximately 12 percent of family planning services are provided through the private sector, which includes private nurse/midwives, pharmacists, physicians, and industries (PROFIT 1996). HIV/AIDS has reached crisis proportions in Zimbabwe. With an estimated 25 percent of the population infected, Zimbabwe is the second most AIDS-affected country in the world. This crisis has strained national health resources, making the need to expand the private sector role in FP/RHC even more urgent.

In 1996, two studies were conducted in Zimbabwe. The Promoting Financial Investments and Transfers Project (PROFIT) studied the private sector's contribution to FP services in Zimbabwe (and found that private midwives were a significantly underutilized resource). In addition, MAPS studied private-practice nurses and midwives to learn more about their roles, the services they provided, and the factors that facilitated and/or constrained their ability to practice effectively. The outcomes of these studies led to the development of a two-year MAPS subproject in Zimbabwe.

**Dates:** January 1997-July 1999

**Cost:** \$149,060 (excluding technical assistance costs)

**Major Components:**

- ✦ Strengthen the FP/RHC service provision capability and sustainability of private nurse and midwife practitioners by creating a more enabling environment for their practice.
- ✦ Increase the number of private nurse/midwife practitioners providing FP/STI services.
- ✦ Improve the quality of FP/STI services rendered by private nurses and midwives.

**Key Population:**

- ✦ Men and women of reproductive age residing primarily in Harare or Bulawayo (women of reproductive age number 407,326 in Harare and 173,840 in Bulawayo).

## Highlights

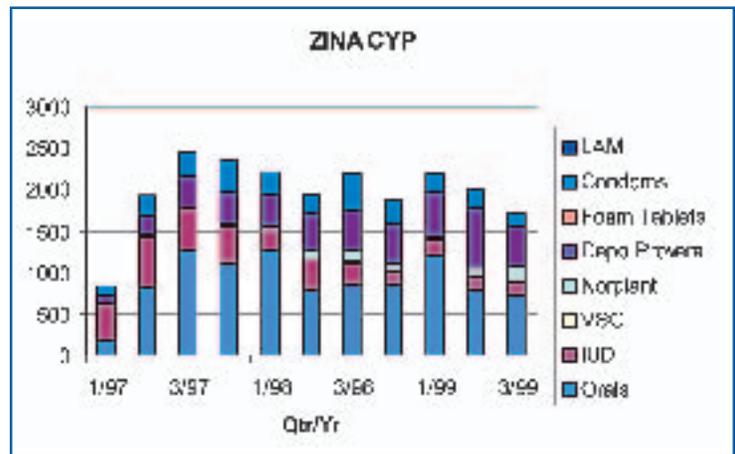
MAPS/ZINA planned to assist 50 midwives. However, the project actually accomplished the following:

- ✦ 109 midwives received assistance through training and/or other support.
- ✦ 54 aspiring midwives opened their practice sites during the project.
- ✦ 41 new aspiring midwives are set to open practices.
- ✦ 27 additional midwives have taken beginning steps to open a service delivery point.
- ✦ The number of private midwives grew from 6 in January 1996 to over 200 practicing midwives by July 1999.
- ✦ ICO grew from 6 members in March 1996 to 186 in April 1999.
- ✦ In September 1996, the 22 midwives identified were working in the two largest cities, Bulawayo and Harare; by 1999, 85 percent of the 200 private midwives served by ZINA/MAPS worked in rural, high-density areas in all ten of Zimbabwe's provinces.
- ✦ 38 midwives received training in business management and community mobilization.
- ✦ The Handbook for Aspiring Private Midwives was produced and distributed.
- ✦ The Model Clinics Consortium was created to provide intense TA in the CQI process and application for improving the clinics' services and management.
- ✦ A position paper on the current status of nurses and midwives in private practice in Zimbabwe was produced.
- ✦ Members of ICO now serve on policy-making committees.
- ✦ The member database was computerized.
- ✦ 85 percent of private midwives now meet national FP standards compared to 10 percent in 1996.

MAPS partners in Zimbabwe were the Zimbabwe Nurses Association (ZINA) and the Independent Clinics Organization (ICO). ICO is a special-interest organization that had recently been created under the umbrella of ZINA to provide a forum for the special needs of PMWs.

The overall goal of the MAPS project in Zimbabwe was to improve access to quality FP/RHC services in Zimbabwe by expanding the role and number of midwife practitioners in the private sector. The objectives were to:

- ✦ Strengthen the FP/RHC service provision capability and sustainability of private midwife practitioners by creating a more enabling environment for their practice.
- ✦ Increase the number of private midwife practitioners providing FP/STI services.
- ✦ Improve the quality of FP/STI services rendered by PMWs.



Based on the results of the needs assessments, MAPS elected to provide:

- ✦ Training in family planning, community mobilization, and business management.
- ✦ Assistance in selecting model clinics.
- ✦ Assistance in developing the corps of aspiring private midwives.

In 1996, aspiring private midwives were found to have the following characteristics as identified in the Special Study. They:

- ✦ Are members of ZINA, but not the Zimbabwe Midwives Group (ZMG) or ICO.
- ✦ Have 10–14 years of experience in the public sector.
- ✦ Are between the ages of 30 and 49.
- ✦ Received basic FP training before 1992.
- ✦ Have had no business management training.
- ✦ Were motivated to open their own clinics by the challenge, the opportunity for independence and financial gain, and frustration with their current employment.

Although the ZINA midwives faced many constraints, the service statistics reported remained fairly steady after a dramatic increase at the beginning of the project—despite policy barriers such as the prohibition to dispense commodities (see figure above).

In addition to its focus on quality reproductive health care for clients within a community setting, ICO regularly provides continuing education updates for its members to ensure updated clinical skills. Priority areas for continuing education (as identified by ICO members) included competency-based FP skills development, STI/HIV counseling, community mobilization, CQI, and business management skills.

A major activity for ZINA was developing a database of midwives and their training needs. PROFIT and SEATS collaborated to provide funding for training, purchase of equipment, and development of a model clinic. Population Services International (PSI) and the Zimbabwe National Family Planning Council (ZNFPC) funded four-week training courses covering basic FP/STI for PMWs who had not had such training and one-week refresher courses for PMWs who had received the basic program.

### Assistance to Other Midwifery Associations

Several midwifery associations that had learned of the MAPS Initiative requested technical assistance. While MAPS was unable to respond to each request, staff assisted whenever possible. Below are some examples of the type of assistance provided.

## CAMBODIA

Cambodia suffered two decades of war, which devastated the national infrastructure and the national health system—especially for maternal and child health care. The hazards of motherhood in Cambodia were described as “disastrous” by several international NGOs. Through USAID/Cambodia’s Reproductive and Child Health Alliance Program, jointly implemented by SEATS, AVSC International, and the BASICS Project, SEATS supported the National Maternal-Child Health Center of the MOH to conduct a situation analysis on safe motherhood in 1997. The analysis was designed to identify significant needs, resources, and gaps in addressing unmet needs related to safe motherhood. Based on the results, the National Safe Motherhood Policy, Strategies, and Five-Year Plan of Action were developed, also with SEATS’ assistance.

Major needs identified in the safe motherhood situation analysis included:

- ✦ Protocols outlining clinical management of common obstetrical and neonatal conditions.
- ✦ Training for midwives in life-saving skills.

Although midwives are usually a woman's first contact with the health care system in Cambodia, most midwives lacked the skills needed to provide high-quality RHC. In June 1998, SEATS provided a consultant to assist in planning and developing a strategy for providing life-saving skills training in Pursat Province.

The Cambodian Midwives Association (CMA) was organized in 1993 with support from Save the Children Fund (United Kingdom) and CARE International. In 1994, it was officially accredited as a professional organization in Cambodia and received funds from USAID. Most of CMA's 2,200 members are government employees, although some are from the private sector or work with NGOs. CMA has 19 branch offices and owns a private clinic. The goal of CMA is to strengthen its members' capacity, knowledge, and skills and improve the morale of midwives to decrease the country's maternal mortality ratio and provide RHC services to Cambodian women. CMA activities are primarily geared to safe motherhood initiatives and include breastfeeding assistance, birth spacing, and "baby-friendly" activities.

CMA is eager to participate in MAPS project activities, and communication with CMA has been geared to building an effective working relationship with the association and providing opportunities for CMA members to network with midwives in other MAPS project areas. SEATS Project funds were used to send members of CMA to the June 1999 MAPS Dissemination Conference and Regional Workshop held in Harare.

## ERITREA

The Government of Eritrea has placed a major priority on improving primary health care services by increasing access to, demand for, and availability and quality of integrated health services. SEATS, as a key partner in the USAID/MOH bilateral Eritrean Health and Population Project, is supporting FP/RHC activities in three early intervention zones, covering 60 percent of the population.

Eritrea's integrated approach called for a comprehensive review of the RHC challenges facing Eritrean women. The total fertility rate in Eritrea is 6.1 and the maternal mortality ratio, at 998/100,000 live births, is one of the highest in Africa. Fifty percent of women receive no antenatal care during pregnancy and 82 percent of births take place in the home. Female genital cutting is nearly universal in Eritrea (95 percent), and a high number of women report problems or medical complications with the procedure (Demographic and Health Survey 1995).

SEATS, through its partner ACNM, supported CQI training and midwife training in life-saving skills through collaboration with the MotherCare Project. MAPS provided technical assistance to Eritrean midwives in a variety of settings. Its activities in Eritrea were geared toward:

- ✦ Facilitating networking between nursing/midwifery associations.
- ✦ Linking public-sector midwives and their communities.
- ✦ Assisting midwives in improving the quality of care.
- ✦ Assisting midwives in resolving concerns with the Eritrean national nurses association.
- ✦ Reducing provider risk from HIV/AIDS.

Three Eritrean midwives participated in a MAPS eight-day Study Tour to Zimbabwe in 1997 to attend the African Midwives Research Conference. The tour provided the midwives with an opportunity to share experiences and mutual problems with midwives from other African nations. Study tour activities included visits to a midwifery training school, a tertiary referral hospital, and public-sector FP clinics.

After the study tour, the Eritrean midwives developed a six-month action plan, which they successfully implemented. The plan included the following activities:

- ✦ Share knowledge and experiences gained from the study tour with the Director General of Health Services, leaders of the Nurses Association of Eritrea, and the director and staff of the hospital on the study tour.
- ✦ Introduce FP counseling to the maternity ward.
- ✦ Introduce FP services to the postabortion and delivery clients.
- ✦ Maintain records of FP services provided.

MAPS' efforts were circumscribed due to two issues—a border dispute with Ethiopia during the MAPS timeline, and the acquisition of Eritrea's nascent midwifery association by the nurses' association. However, MAPS was able to support the introduction of a referral system for FP clients and organize the study tour. Also, its regional technical advisor provided technical assistance to the Eritrea SEATS Project and the Government of Eritrea in conducting an LSS needs assessment. As a result, SEATS could provide LSS training for 57 midwives, LSS TOT, CQI training, and provision of equipment for SDPs.

## TANZANIA

The Tanzania Midwives Association (TAMA) was established in 1992 by a group of midwives registered with the Nurses and Midwives Council. TAMA started out with 100 midwives and has grown in less than seven years to 1,100 active members. This growth is a testimony to midwives' desire to improve their professional knowledge and skills—while strengthening their capacity as a group to provide services to members. TAMA has been working with CARE to promote private practice for midwives in Tanzania, and TAMA members visited Uganda to learn how to develop private midwifery practices.

At TAMA's request, MAPS staff visited Tanzania several times to work on developing a project, and funded several TAMA members' participation in the MAPS Dissemination Conference and Regional Workshop held in Harare June 1999. CARE was actively involved with TAMA at the time and willing to collaborate with MAPS. Although USAID expressed a desire to assist, the Mission was unable to secure field support money for the project. However, MAPS advocated for, and the Mission provided, direct funding to support business management training for TAMA.

# Appendix 2

## Special Study Recommendations

Recommendation	Suggested Implementer(s)
Identify specific laws and policies for nurse/midwives in private practice in Zimbabwe.	Department of Nursing of the Ministry of Health (MOH), Zimbabwe Nurses Association (ZINA)
Complete functions, standards, and qualifications for practice. Conduct pre-service and in-service education based on functions, standards, and qualifications.	ZINA
Develop regulations based on standards of Health Professions Council.	MOH, University of Zimbabwe's Departments of Nursing Science and Medicine, ZINA, Zimbabwe National Family Planning Council (ZNFPC) Health Professions Council
Develop supervisory team.	ZINA
Negotiate for increased fees for private FP services.	PROFIT, ZINA, ZNFPC
Explore credit and savings program for members.	SEATS, ZINA
Develop MIS capability for service data.	Independent Clinics Organization (ICO), ZINA, Zimbabwe Midwives Group (ZMG)
Promote awareness of ZMG and ICO.	ICO, ZINA, ZMG
Develop roster of potential covering doctors and guide for coverage rates.	College of Primary Health Care (PHC), Physicians, Gynecological Association, PROFIT, ZINA, Zimbabwe Medical Association (ZIMA)
Implement group purchasing for equipment, educational materials, supplies, and commodities.	ZINA
Explore possibility of a loan fund for start-up or expansion of private practices.	SEATS, PROFIT, ZINA
Conduct workshops to provide current information about private practice and opportunities for mutual problem solving.	ICO, SEATS, ZINA, ZMG
Develop guidelines for aspiring practitioners.	SEATS, ZINA
Provide training for FP/STI/HIV to selected practitioners.	City Health-Harare/Bulawayo, MOH, SEATS, ZNFPC
Explore feasibility of distance learning program for FP/STI/HIV training.	PROFIT, SEATS, ZNFPC
Network internationally with nurse/midwife associations who are addressing private practitioner issues.	SEATS, ZINA, WHO
Provide business management skills training.	SEATS
Continue collaborative meetings to share information, support, etc.	ICO, ZMG
Increase access and distribution of IEC materials and updated professional literature.	SEATS, ZINA

# Appendix 3

## Uganda Study Tour Action Plan

Each midwife who participated in the study tour to Uganda developed a quality improvement action plan to be implemented at her clinic. This is an example of an action plan.

Needed Action	Steps	Results
Increased access to care to respond to a decrease in clients due to limited hours.	Extend evening hours, providing services up to 8 p.m., six days per week.	Reduced waiting time. Earlier referral to hospital. Number of clients increased by 10 percent per month. Increase in number of clients verbally reporting satisfaction with hours. Increase in number of referrals by satisfied clients.
Expansion of facility to improve privacy and provide day care for working mothers in community.	Opened a fixed account to increase income. Installed a ceiling. Added doors to most rooms.	Improved visual and audio privacy for all clients. Plan for expanding facility. Budget for expansion of facility.

*UPMA Midwives Study Tour*

# Appendix 4

## Criteria for Selection of Model Clinics

1. Inspected and approved by the Health Professions Council (HPC), according to Statute Instrument 132 (1995), and possesses a current certificate of registration with the HPC as a nurse/midwife.
2. Owned and managed by a nurse/midwife who is currently registered with the HPC, has been approved for private practice by the HPC and the local authorities, and is a member in good standing with the Zimbabwe Nurses Association (ZINA) or agrees to join/renew membership within three months.
3. The nurse/midwife owner works in the clinic full time (preferably as a practitioner, as well as an administrator). The nurse/midwife has been in private practice for at least six months.
4. The owner is willing and interested in having her facility become a model clinic (“Best Practices”) site. The practice has an established relationship with a covering physician for emergencies, referrals, and consultation.
5. Provides family planning (FP) and sexually transmitted infections (STI) services or plans to integrate FP/STI services into care being currently provided.
6. The clinic’s geographical location makes it a logical point for a model facility, strategically located and with relatively easy access.
7. Peers recognize the clinic as a “model clinic” in that it has good facilities, strives to offer quality services, and appears successful (based upon the growing number of clients).
8. The nurse/midwife is willing to participate in FP/STI and business management skills training, as deemed appropriate according to training needs criteria, to upgrade knowledge and skills.
9. The nurse/midwife is willing to participate in the dissemination workshop(s) to share and clarify information related to private practice in Zimbabwe.

## Appendix 5

### UGANDA:

## Sharing Experiences in Private Practice Midwifery

The Midwifery Association Partnership for Sustainability (MAPS) is an initiative funded by USAID and organized by the second phase of the Service Expansion and Technical Support (SEATS II) Program. MAPS was established to promote the role of midwifery in reproductive health services. It recently sponsored a working study tour in Uganda that provided midwives from Senegal and Zimbabwe a unique opportunity to meet with their Ugandan colleagues. The aim of the tour was to enable private practice midwives in the three countries to exchange ideas, share experiences and to continue to develop on-going South to South partnerships.

This MAPS activity paired twelve host midwives from the Uganda Private Midwives Association (UPMA) with ten from the Independent Clinics Organization (ICO) of the Zimbabwe Nurse Association (ZINA) and two from the *Association Nationale des Sages Femmes de Senegal* (ANSFS). In the first workshop, a presentation by each association was made, describing the history of both the organization and midwifery in their countries, as well as the accomplishments each achieved under the MAPS sub-projects. ICO, a special interest group under the umbrella organization of ZINA, is almost two years old and has grown rapidly to play a significant role in advocating private midwifery in Zimbabwe. Its participation in the workshop allowed it to gain from the experiences of the older UPMA, who was celebrating its 50<sup>th</sup> anniversary, and ANSFS. The remainder of the



*Ugandan and Zimbabwean private midwives talk with two Ugandan mothers about their babies.*

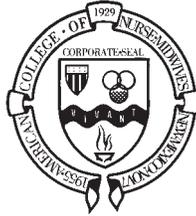
workshop addressed priority issues such as the payment of services and the lack of accessible capital. The workshop closed with a video presentation produced by ICO about private practice midwifery in Zimbabwe, after which participants from Senegal and Zimbabwe joined their Ugandan counterparts for three days in their clinics. The pairs worked side by side, sharing common problems and learning from each other's strengths and experiences.

On the final day of the study tour, the group reconvened to share its experiences and strategize on ways to continue to network and attract aspiring midwives. Participants briefed the group on their clinical experiences and each midwife identified three actions she had learned during the tour which she planned to implement at her home clinic. Participants, for instance, planned to conduct follow-up home visits to clients, give community talks on FP/STIs/HIV, provide quality care during "off hours" and carry out other initiatives upon returning to their home countries. □

# Appendix 6

## ICO Sustainability Action Plan

Objectives	Activities	Elements
Enhance revenue base	<ul style="list-style-type: none"> <li>• Develop proposal to seek funding for own clinic ✓</li> <li>• Develop proposal to leverage donor funds ✓</li> <li>• Participate in SEATS leveraging workshop ✓</li> <li>• Identify funding opportunities ✓</li> <li>• Encourage members to pay dues, recruit new members, and revive inactive members ✓</li> <li>• Review and revise annual fee structure</li> <li>• Submit proposal to donors ✓</li> </ul>	<ul style="list-style-type: none"> <li>• Income generation</li> <li>• Leveraging</li> <li>• Capacity building</li> </ul>
Enhance/improve private practice environment	<ul style="list-style-type: none"> <li>• Develop and submit ICO position paper to MOH</li> <li>• Develop pharmaceutical in-service course</li> <li>• Develop strategies for closer link between public and private sector</li> <li>• Improve transparency of PMW to regulatory bodies and community by having model clinics</li> <li>• Seek opportunities to dialogue with policy-making groups</li> <li>• Link with University of Zimbabwe graduate school of Social Work to be a field placement site for a student</li> </ul>	
Improve ICO management system capability	<ul style="list-style-type: none"> <li>• Computerize membership database ✓</li> <li>• Enhance financial management capability ✓</li> <li>• Subcontract a bookkeeper to develop system ✓</li> <li>• Upgrade financial system to include ICO clinic accounts</li> <li>• Develop strategic and business plan for ICO ✓</li> </ul>	
Expand ICO membership services	<ul style="list-style-type: none"> <li>• Develop strategies for improving communication among ICO members</li> <li>• Develop training capability within ICO for business skills and community mobilization</li> <li>• Offer pharmaceutical IEC</li> <li>• Make ICO clinic available as training site</li> <li>• Offer FP/RHC/HIV management updates at monthly meetings ✓</li> <li>• Seek funding for continued FP/HIV training for ICO ✓</li> <li>• Seek access to FP commodities and RH drugs ✓</li> </ul>	
Increase ICO capacity in assisting members to improve quality and access of health services	<ul style="list-style-type: none"> <li>• Develop private practice standards</li> <li>• Develop training capability within ICO for business skills and community mobilization</li> <li>• Offer pharmaceutical IEC</li> <li>• Make ICO clinic available as training site</li> <li>• Offer FP/RHC/HIV management updates at monthly meetings ✓</li> <li>• Seek funding for continued FP/HIV training for ICO ✓</li> <li>• Seek access to FP commodities and RH drugs ✓</li> </ul>	<ul style="list-style-type: none"> <li>• Commodity procurement</li> <li>• Training</li> <li>• Quality improvement</li> </ul>



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