Inteleos

The Competency Dividend

How Access to Validated Clinical Proficiency Improves Health Outcomes and Economic Agency for Women

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Executive Summary

Closing the women's health gap could add $1 trillion annually to the global economy by 2040. Every dollar invested returns three.[1] Decades of data show that investment in women works. If the ethical imperative to invest in the health of half the world's population is insufficient, the economic case should settle the matter.

The clinicians closest to women patients globally are midwives, nurses, and community health workers. They are overwhelmingly female and provide most maternal and reproductive care across every region this paper examines. With supportive policy and access to education, training, and certification in additional clinical skills, these clinicians could deliver better outcomes for the women they serve while improving their own financial standing, professional mobility, and economic independence. One example: in Indonesia, 220,000 midwives have earned the trust of the women they serve but lack legal authority to perform the basic obstetric ultrasound that would save lives.[2] The more female clinicians are upskilled with validated clinical proficiency, the more they earn, the more employable they become, the more entrepreneurial they can be. That translates directly to government revenue, improved employment numbers, and stronger local economies. On the patient side, better care at the point of care means healthier women, healthier families, and cost savings from complications prevented rather than emergencies managed.[3] The clinical case and the economic case are the same argument.

Equipping these cadres with validated competency in diagnostic skills like point-of-care ultrasound (POCUS) does two things at once: it puts accurate triage and identification capability where women actually receive care, and it gives the clinicians who deliver that care a credential that changes their professional standing, their earning power, and their mobility.

POCUS is affordable, portable, and versatile, capable of identifying ectopic pregnancy, placenta previa, fetal malpresentation, and other conditions that, undetected, kill women.[4] Unlike conventional ultrasound, it does not require expensive equipment or physician-level operators. Critically, POCUS is a triage tool that works in both directions: it can identify a woman who needs hospital care immediately, and it can confirm that a woman is progressing normally — saving her an expensive and unnecessary referral. When a midwife or nurse holds validated competency in this skill, she carries accurate identification and triage capability into settings that

have never had it. She becomes the person who ensures that every woman receives the right pathway of care, quickly. Physicians receive better-prepared referrals. Health systems reduce unnecessary costs. The clinical value and the professional value are inseparable: the same skill that improves a patient's outcome elevates a clinician's standing.

Validated proficiency takes several forms, from certification programs that assess clinical skill against an independent standard to credentialing systems, structured certificate programs, and continuing education that maintains proficiency over time. What these share is third-party, independent validation. The certifying body is not the employer, the training institution, or the government that sets workforce policy. It is an independent authority whose only interest is whether the clinician can do the work. That independence is what makes the credential trustworthy across borders, across institutions, and across the professional hierarchies that have historically determined who gets to practice what.

This paper examines three regions where the convergence of women's health needs and women's economic agency creates opportunity, but each requires a different pathway to these outcomes. In East and Southern Africa, where maternal mortality remains among the highest in the world and health systems cannot meet demand, the pathway runs through entrepreneurship. Nurse-owned and nurse-operated franchise clinics, like the Unjani Clinic network in South Africa, demonstrate that women clinicians with verified competency can build sustainable businesses that extend care into communities the formal system does not reach.[5] In the United Arab Emirates, the pathway is government-led: Emiratization policy, a dedicated national women's health framework, and academic pipeline investment are deliberately building a homegrown female sonography workforce to serve a population where gender-concordant care is a clinical and cultural priority.[6] Here, certification is already required in imaging professions, but women are still severely underrepresented. In Indonesia and the Philippines, the pathway runs through the public sector: over 220,000 midwives in Indonesia and thousands of barangay-level health workers in the Philippines already hold the trust of the women they serve but lack the verified competency and regulatory authority to perform the obstetric scanning that would save lives. Three systems, three pathways, one principle: when women clinicians are trained and given an opportunity to validate proficiency while being enabled by policy, both health outcomes and economic agency can improve.

This is not a theoretical framework. In Kenya, the work is already underway; from summit to national guidelines to certified clinicians scanning in the field. Inteleos is the trusted, independent validator of proficiency at the center of this pipeline. We operate lean, local, and on the ground — listening before building, observing, and partnering within the cultural and regional systems that sustainable impact requires. Proficiency to local quality standards earns trust from clinicians, communities, and governments alike. This paper provides the framework across three distinct health system architectures, grounded in evidence from the regions themselves. The question is no longer whether investing in women clinicians improves outcomes for women patients, as decades of data have settled that. The question is how we can build on known data to improve outcomes for women, their families, communities, and regions.

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The Economics of Verified Competency

Across global health systems, scope-of-practice restrictions concentrate diagnostic authority and the compensation that follows in physician-centered and male-dominated cadres. Inteleos and Maitri Capital research identifies credentialing as a direct mechanism for breaking this pattern: when women clinicians gain verified competency in higher-value clinical skills, they become harder to exclude from the roles and the pay those skills command.[7]

The returns compound beyond the individual clinician. Women reinvest up to 90 percent of their earnings in their families and communities, compared to 30 to 40 percent among men.[8] When that earning power comes from a clinical skill that also saves lives, every woman scanned earlier and every complication caught before it becomes an emergency represents both a health outcome and an economic one. At the system level, maternal and neonatal mortality in low- and middle-income countries represented a combined welfare loss of $462 billion in 2019, nearly 6 percent of those regions' GDP.[9] Verified competency is what converts training expenditure into functioning capacity. Without it, investment in education and equipment produces clinicians that the system cannot fully trust and from which patients cannot fully benefit.

Three Systems, Three Pathways

If validated proficiency for women clinicians improves both health outcomes and economic agency, the next question is how that plays out in practice. The answer depends on context. Health systems differ in their resources, their regulatory structures, their cultural expectations, and the political conditions that determine what is possible. A model that works in one setting will not transplant directly into another.

This paper examines three regions where the case for women clinicians with verified competency in obstetric POCUS is urgent, the conditions for progress are present, and the pathways differ fundamentally. In Kenya, the challenge is distributional: trained clinicians concentrated in cities while rural (and some urban) communities go without diagnostic capacity. The pathway runs through stakeholder consensus, national policy reform, and certification infrastructure built from the ground up. In the United Arab Emirates, the challenge is structural: a healthcare workforce composed almost entirely of expatriate professionals, with technical imaging and specialist roles historically dominated by men, in a society where gender-concordant care is both a cultural expectation and a clinical priority. The pathway runs through government investment, Emiratization policy, and deliberate workforce pipeline development. In Indonesia and the Philippines, the challenge is one of formalization: massive, already-female, already-trusted community health workforces that lack the verified credentials and, in some cases, the legal authority to perform the diagnostic work they are capable of. The pathway runs through credentialing, regulatory reform, and the digital infrastructure that makes clinical credentials portable across borders.

Three systems, three pathways, one principle: when women clinicians are equipped with verified competency and supported by enabling policy, health outcomes for women improve and economic agency for clinicians follows.

Kenya: From Policy to Practice

Kenya does not have a simple shortage of health workers. It has a system that produces unemployment and unmet need at the same time. The country doubled its health workforce over the past decade to nearly 190,000 active professionals across thirteen major occupations, yet in 2021 an estimated 14 percent of skilled health workers were unemployed, even as counties like Turkana, Wajir, Garissa, and Mandera operated at staffing levels so low they could not deliver the country's own Essential Package for Health.[10] Nairobi holds 8 percent of Kenya's population and 32 percent of its doctors.[11] The problem is not supply but access and distribution.

Obstetric ultrasound makes this barrier concrete. The WHO recommends every pregnant woman receive at least one ultrasound before 24 weeks,[12] but in Kenya fewer than one in five health facilities have obstetric ultrasound available.[13] In rural western Kenya, fewer than one in five pregnant women received any ultrasound during pregnancy, and women with complications were no more likely to receive one than women without.[14] Ten of Kenya's 47 counties account for 90 percent of the country's maternal deaths, and these are overwhelmingly the counties where scanning access does not exist.[15]

In Murang'a County, the only level 5 referral hospital serves over one million people. When an Inteleos team member visited, the line to access care was out the door. Clinicians had never seen a point-of-care ultrasound device — our staff member had to pull up images online to explain what one looked like. This is not a remote dispensary but the county's highest-level referral facility, the place to which every lower-level clinic sends its most complicated cases. If clinicians here have never encountered the tool that could help them efficiently triage obstetric emergencies, the gap runs far deeper than most policymakers realize.[16]

Until recently, only radiographers and sonographers held the authority to perform ultrasound in Kenya, and these cadres are concentrated in urban facilities, many without steady employment. The midwives and nurses who staff rural clinics and provide most maternal care had no pathway to scanning authority, regardless of need. Decades of pilot projects had demonstrated that midwives and nurses could be trained to perform obstetric POCUS safely and effectively.[17] What was missing was a national standard — a unified framework that would move task-sharing from individual projects to system-wide policy.

In 2022, Inteleos set out to strengthen the maternal health infrastructure by bringing stakeholders together in the same room. At the first Maternal Health Summit in Nairobi, co-hosted with the Kenya Healthcare Federation, the full spectrum of the health system was represented: the Ministry of Health, the Nursing Council, radiologists, the OB/GYN society, radiographers, universities, device manufacturers, and financiers. Before the summit convened, Inteleos held a separate listening session with radiologists, hearing their concerns and ensuring a model that

could strengthen referral pipelines to specialists rather than replace them. At the end of Day One, each attendee was asked directly whether scope of practice should expand to include POCUS for midwives and clinical officers, and the consensus was unanimous.[18]

Two years of sustained policy work followed, and in 2024 Kenya's Ministry of Health launched the National Obstetrics Point-of-Care Ultrasound Guidelines, formally authorizing task-sharing of obstetric ultrasound to nurses, midwives, and other reproductive health professionals. That same year, Inteleos hosted the O-POCUS Certification Summit alongside USAID and the American National Standards Institute to operationalize the new policy, bringing the Nursing Council, radiologists, universities, the Kenyan Presidential Unit, the International Finance Corps (IFC), and device manufacturers to the table. In 2025, Inteleos certification launched via the POCUS Certification Academy, and clinicians are now certified and scanning.

That is a three-year arc from convening to national policy to implementation: a systems change, built by bringing existing professional interests to the table rather than overriding them.

What this can look like in practice is already visible elsewhere in the region. In South Africa, the Unjani Clinics network has built over 130 nurse-owned and nurse-operated primary care clinics across the country, all owned by women professional nurses who serve as both clinicians and entrepreneurs in the communities where they practice. The model is a social franchise: nurses receive training, business support, and a pathway to full ownership, while patients in underserved communities gain access to quality care they would not otherwise have. Inteleos serves as the certifier for basic obstetric POCUS within the Unjani network, ensuring that the nurses who own and operate these clinics hold verified competency in the diagnostic skill that matters most for the women they serve. It is a working example of the principle this paper argues: verified competency simultaneously improves clinical care and creates economic agency for the women delivering it.

The policy achievement in Kenya is just the start. After the guideline launch, national implementation remains: training and mentorship at scale, ultrasound equipment in the facilities that lack it, accessible financing, supporting infrastructure, and ongoing quality assurance. What stands between guidelines and impact is investment in training, equipment, supervision, and scaling the certification systems that ensure every clinician scanning a pregnant woman has the validated proficiency to do so. Through the Inteleos Africa office, we continue to develop the pieces to the above ecosystem to expand coverage and sustainable business models.

AI and the Competency Question

AI-powered ultrasound is no longer a future prospect. Devices now on the market can assist with image acquisition, flag potential findings, and guide less experienced users through a scan. Some are designed so that a community health worker can sweep a probe and transmit the images to a physician for remote reading. For health systems struggling to extend diagnostic capacity, this looks like it might bypass the training challenge altogether.

It does not. A device that requires a physician to read the results does not solve the problem of not having enough clinicians to go around; it moves the bottleneck from the point of care to the point of interpretation. And AI changes what a clinician needs to be competent in without eliminating the need for competency. A midwife in a rural clinic must still decide when to scan, what the findings mean for this patient and this pregnancy, whether to refer or reassure, and how to communicate with the woman and her family. If she does not understand what she is looking at when the AI is uncertain or wrong, she cannot course-correct.

This is not an argument against AI in POCUS. To be clear, these tools are already bridging access gaps that would otherwise go unaddressed. But they make the case for verified clinician competency stronger, not weaker. As AI takes on more of the technical acquisition, the clinician's role shifts toward interpretation, judgment, and decision-making. Proficiency still needs to sit with the clinician at the bedside, because that is where the patient is and where the decisions are made.

The United Arab Emirates: Building the Workforce From Within

The UAE's population of roughly 11.4 million is approximately 88 percent foreign national, and its healthcare workforce mirrors that ratio, with about 85 percent expatriate practitioners and only 15 percent Emirati.[19] For decades, technical imaging and specialist roles have been filled predominantly by imported male professionals, creating a dual problem: women patients face a persistent mismatch between who delivers their care and what their culture and clinical needs require, while Emirati women have been underrepresented in a growing professional sector where their presence is most needed. In a society where gender-concordant care is both a cultural expectation and a clinical priority, this is simultaneously a health access failure and a lost economic opportunity.

The government has responded with two complementary policy frameworks that address both dimensions. Emiratization, first introduced in the 1990s and significantly strengthened through the NAFIS program in 2022, mandates annual increases in national workforce participation across public and private sectors, including healthcare. The Abu Dhabi Department of Health provides sector-specific guidance for integrating Emirati nationals into clinical and allied health roles, placing particular emphasis on women entering positions previously dominated by expatriates.[20] The National Policy for the Promotion of Women's Health, launched in 2024, goes further, committing explicitly to enhancing professional staff and institutional capabilities for women's health, promoting maternal and reproductive care, and ensuring universal access to quality care for women at every life stage. Notably, it calls for women's active involvement in shaping health policies, leading innovations, and advocating for solutions that address their specific needs. The policy does not treat women's health as a subcategory of the health system but as a national priority requiring its own infrastructure, its own workforce, and its own standards.[21]

Gender-concordant care is not a preference to be accommodated when staffing allows but a design requirement that shapes how the workforce is built. The pathway runs through government investment and academic pipeline development rather than through the task-sharing models emerging in East Africa, but the underlying principle is identical: when women clinicians are equipped with verified competency and supported by enabling policy, health outcomes for women improve and economic agency for clinicians follows.

Indonesia and the Philippines: Where Trust Meets Opportunity

Maternal mortality in both countries remains stubbornly high. Indonesia's rate of 177 per 100,000 live births is the third highest in Southeast Asia.[22] In the Philippines, an estimated six to seven women die every day from pregnancy-related complications.[23] The leading causes in both countries — hemorrhage, obstructed labor, placental complications, fetal malpresentation — are detectable by ultrasound, but the midwives closest to these women lack verified competency in diagnostic imaging and, in Indonesia's case, lack the legal authority to perform it at all.

Indonesia's Bidan di Desa program, launched in 1989, placed trained female midwives in villages across the archipelago to reduce maternal mortality by making a trusted female practitioner available at the community level. The program now encompasses more than 220,000 bidan operating across hospitals, community health centers, and village birth facilities. Research confirms that midwives are the primary providers of maternal care across all demographic groups, with younger women showing significantly higher engagement with bidan than with any other provider. The trust is structurally produced: a female practitioner, deployed into the community she serves, who speaks the language, understands the cultural context, and is not a male stranger examining a woman's body.

In the Philippines, the barangay health system deploys registered midwives and community health workers across more than 42,000 village-level units as the first line of maternal care.[24] The majority of antenatal POCUS at rural health centers is already performed by midwives and nurses rather than physicians. Pilot programs have demonstrated that midwives can perform obstetric POCUS effectively and confirm that ultrasound utilization rises when patients believe the health worker performing the scan is competent.[25] But no national regulatory framework yet authorizes midwives to scan as part of their standard scope of practice. What exists is clinical capability without credentialing infrastructure: midwives who can do the work, patients who trust them to do it, and a regulatory environment that has not yet caught up to either.

The Indonesian government recognizes the gap. In 2021, the Ministry of Health mandated that antenatal care include at least six visits, two of which must involve ultrasound examination. In January 2024, President Joko Widodo visited a community health center in Central Java and declared that every puskesmas in the country should have pregnancy ultrasound equipment, with data linked to a national monitoring system in Jakarta. The government's SEHAT program, a $350 million collaboration with the Asian Development Bank, is now standardizing medical

equipment across all 10,000 community health centers, including ultrasound devices. The commitment is real, the money is flowing, and the equipment is arriving.

But the regulatory framework has not caught up. Indonesian law still reserves ultrasound operation exclusively for certified physicians and radiologists. While physicians staff a majority of puskesmas, midwives provide the bulk of antenatal care in villages and peripheral puskesmas, especially where doctors are absent or rotating. However, midwives currently have no legal authority to turn on the devices being installed in their facilities. A 2025 legal analysis in *Research Horizon* documented the result: midwives routinely perform basic scans out of necessity in areas without doctors, operating in a legal grey area that exposes them to professional sanctions, civil liability, or criminal charges regardless of patient outcome. The study concluded that the prohibition is unsustainable and called for urgent regulatory reform to grant certified midwives limited, clearly defined authority for obstetric point-of-care ultrasound.[26]

This is the gap that validated proficiency, like certification, is built to close. A government investing hundreds of millions of dollars in ultrasound equipment for community health centers needs a credentialing framework that authorizes and validates the clinicians who will use it. Otherwise, the equipment sits next to the clinician who cannot legally operate it.

The gap is not just clinical. Both countries have long-established policies of training health workers for international placement. The Philippines has exported nurses for decades, with remittances comprising roughly 9 percent of GDP.[27] Yet a midwife trained and trusted in her Indonesian village, or a nurse with years of experience in the Philippine barangay system, faces significant barriers when her qualifications need to be verified across different standards and regulatory bodies. A credential that is not portable loses its value at every border.

This is where digital credential infrastructure changes the equation. Verified clinical credentials linked to interoperable digital wallets allow a clinician's competency to travel with her, recognized wherever she practices. Inteleos is working to ensure its certifications operate within this emerging ecosystem, designed for interoperability with existing digital wallet networks and aligned with the standards that make credentials portable rather than siloed.

Across the three regions this paper examines, the pattern is consistent. In Kenya, standardized and verified proficiency breaks a policy deadlock and puts diagnostic capability at the point of care, while encouraging entrepreneurial frameworks. In the UAE, an ecosystem of education, training, and certification could close a national workforce gap that importing talent alone cannot solve. In Indonesia and the Philippines, standards and validation of proficiency could formalize the trust that millions of women already place in the clinicians closest to them. The clinical case and the economic case remain, as they have been throughout, the same case. Verified competency improves outcomes for women patients. It also transforms the professional standing, the earning power, and the mobility of the women who deliver their care.

The Way Forward

When women clinicians hold verified competency in diagnostic skills like point-of-care ultrasound, health outcomes for women patients improve and the clinicians themselves gain professional standing, earning power, and mobility. These are not parallel benefits but the same process, because the clinical value of the skill and the economic value of the credential are inseparable.

What differs is the pathway. In Kenya, Inteleos helped build stakeholder consensus, contributed to national policy development, and launched certification that has put validated clinicians in the field. In the UAE, government policy is deliberately constructing the female clinical workforce the population requires. In Indonesia and the Philippines, the workforce already exists and what remains is the credentialing and regulatory architecture to formalize what millions of women already trust. Each pathway is shaped by its context, and each confirms the same principle.

Inteleos has spent decades as the global standard for clinical ultrasound certification. The work described in this paper represents the next chapter: extending that standard into the health systems where it is most needed and where its impact on both patient outcomes and clinician livelihoods is greatest. We do this on the ground, in partnership with governments, regulatory bodies, professional societies, and the clinicians themselves, working together towards sustainably improved outcomes.

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Note: Some claims in this paper reflect Inteleos institutional knowledge and firsthand organizational experience, including summit convening, certification development, stakeholder relationships, and the Murang'a County visit. These are sourced from Inteleos internal records and do not have external published citations.

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