

Multi-skilling for Anaesthesia and Emergency Obstetric Care in South Asia

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PRESENTATION OUTLINE

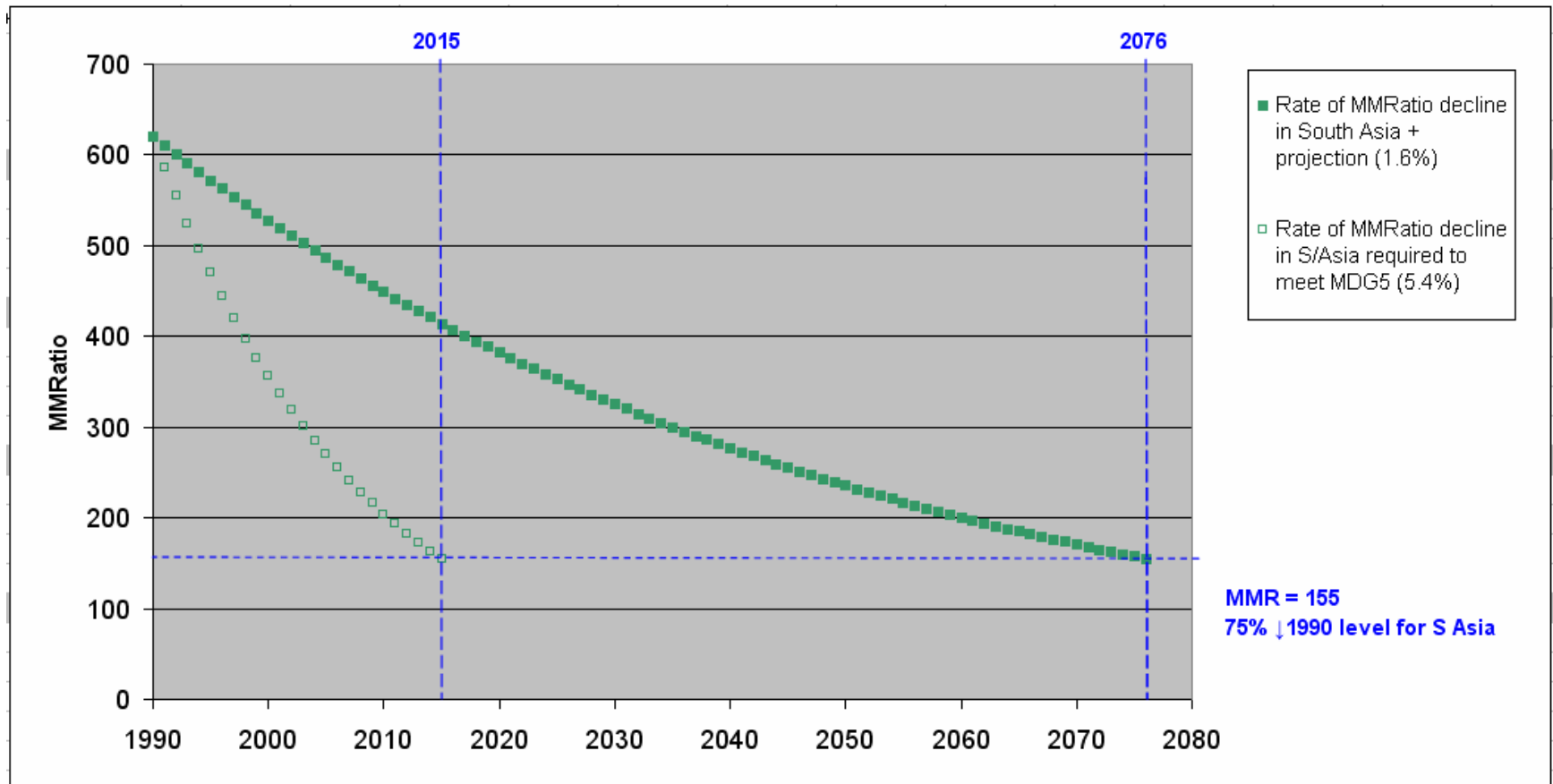
- **MMR in South Asia**
- **Coverage of EmOC and utilization (CS as proxy)**
- **HR crisis in S Asia**
- **Crisis of anaesthesia**
- **HR/ Training strategies for providing anaesthesia services in rural areas**
- **Snippets from the countries- view points especially of the professional societies of anaesthesia**
- **The way forward**

Maternal deaths in South Asia

Country	Population (millions)	MMR/ 100,000 LB (2005)	No. of maternal deaths
Afghanistan	26.0	1800	26000
Bangladesh	155.9	570	21000
Bhutan	0.6	440	280
India	1151	450	117,000
Nepal	27.6	830	6500
Pakistan	160.9	320	15000
Sri Lanka	19.2	58	190
South Asia	1541.2	500	185982

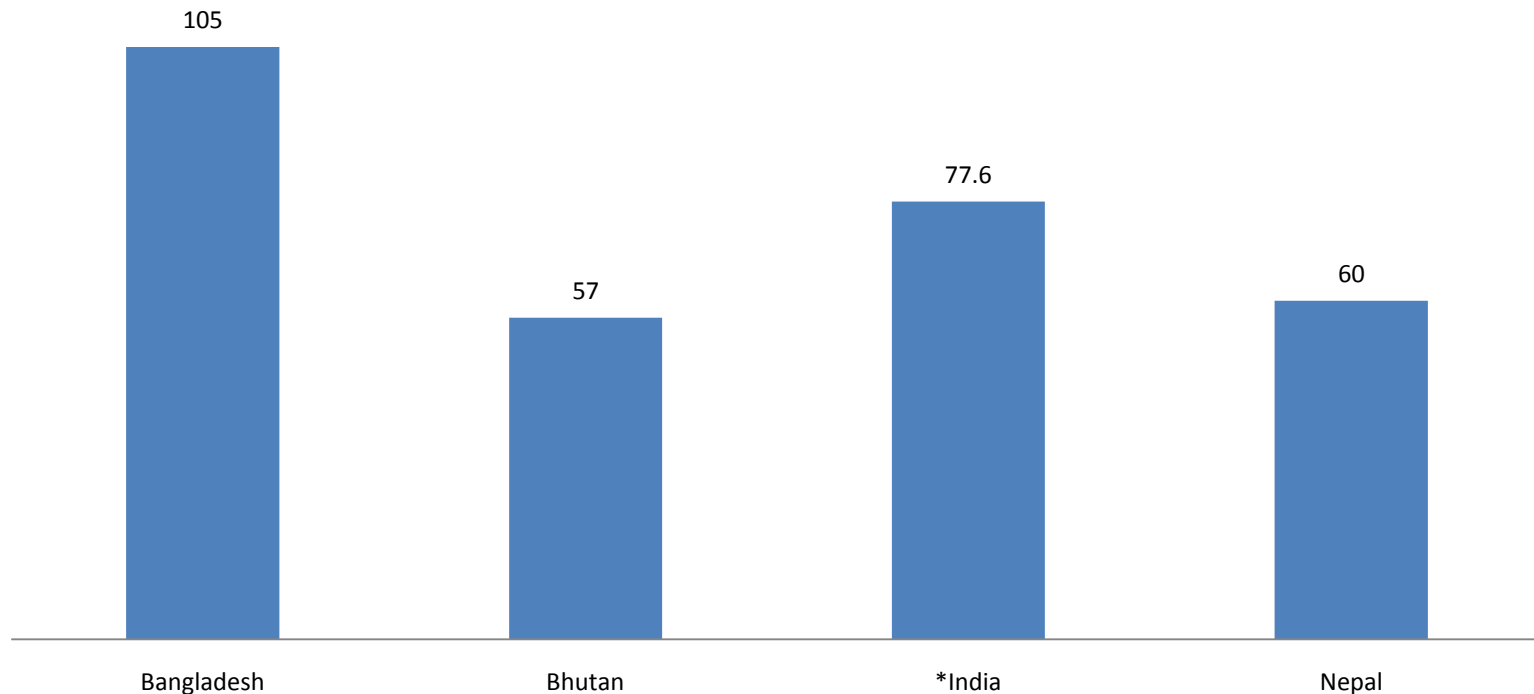
Source-UN Estimates for Maternal Mortality, 2005

Target and actual rates of decline in maternal mortality, South Asia



Coverage of Emergency Obstetric and Newborn Care in South Asia

■ % availability of CEmOC facilities against required



Source: AMDD reports,
*Govt of India-JRM reports

Delivery by Caesarean Section (DHS)

Country	Delivery by CS (%)	Wealth quintiles	
		Lowest	Highest
Bangladesh	8.9	1.8	29.5
India	8.5	1.8	26.6
Nepal	2.7	0.5	11.9
Pakistan	7.3	1.8	20.1

Source-DHS Survey

Human resources in South Asia

(Doctors, Nurses, Midwives)

Required density of HR- 2.28/1,000 population

Country	Total SBA density/ 1000 population	Caesarean Section Rates
Afghanistan	0.41	-
Bangladesh	0.58	8.9
Bhutan	0.27	-
India	1.87	8.5
Nepal	0.67	2.7
Pakistan	1.2	7.3

Source-World Health Report, 2006

Situation Analysis – Availability of Anaesthesiologists Multi-skilling / Task Shifting

Afghanistan

Bangladesh

Bhutan

India

Nepal

Pakistan

AFGHANISTAN

Population (millions)	26
No. of CEmOC required	54
No. of anaesthesiologists	7
Task shifting to nurses	
12 months training nurses	192
High retention	

Source-UN Conference on HRs for EmOC , June 2008



BANGLADESH



Population (millions)	156
No. of CEmOC required	286
No. of anaesthesiologists	700
Multi-skilling of MBBS Dr.	260
4,6, 12 months training	
Retention	60%
*Over all retention Anaesthesia & EmOC trained doctors	65%

*Source-UN Conference on HRs for EmOC,
June 2008*

** **GHWA, WHO*

BHUTAN

Population (millions)	0.6
No. of CEmOC required	14
No. of anaesthesiologists	8
Nurse trained	21
Training for 12 months	
100 % retention	

*Source-UN Conference on HRs for EmOC,
June 2008*



NEPAL

Population (millions)	27
No. of CEmOC required	60
No. of anaesthetists	140
Task shifting to nurses	69

6 months training nurses & NPC

Retention rates

*Study of all trainees- 80% in rural areas,
70% in government service.

**Tropical Doctor 2008*

*Source-UN Conference on HRs for
EmOC ,June 2008*



Nepal-Task shifting for scaling up CEmOC :

Dr BD Jha, Dr M Zimmerman

Anaesthesia by non-doctor: Policies that prevent nurses from giving anaesthesia cost more lives than they save

-American Association of Nurse Anaesthetists

A no. of different workers are involved in multi-skilling and task shifting in Nepal to provide CEmONC in a district hospital :

- **MD GP- Multi-competent specialist General Practitioner who provides CEmOC, anaesthesia, child care, medicine and surgical services for the district hospital**
- **Anaesthetic assistant- trained nurse/ paramedic, who provides anaesthesia under supervision of MD GP**
- **Skilled birth attendant- nurses who are trained to provide BEmOC and provide MRP, MVA, vacuum delivery**
- **Biomedical equipment technician- Peon level staff are trained for 3 months to provide basic repair and maintenance of hospital equipment (task shifting from engineers)**

PAKISTAN



If she can do a pudendal, why can't she do a regional block?

Population (millions)	161
No. of CEmOC required	330
No. of anaesthetists	1674
Task shifting to nurses	
6 months training	
No data on numbers trained or retention	

Pakistan- Situation analysis

Prof S Tipu Sultan, Dr Akhtar Aziz Khan

- 1674 specialist anaesthesiologists in Pakistan (DA, MCPS, FCPS)
- Annual production -46-60 annually
- Majority of postgraduates leave the country
- It will take about 220 years to be self sufficient in terms of anaesthesiologists, at the present rate of production and loss

Pakistan- Strategies for addressing lack of specialist anaesthetists

- **2002- In South Asia, a competency based training curriculum for Anaesthesia (AMDD/JHPIEGO) for nurses, midwives, OT technicians**
- **Duration of training- 6 months**
- **Adopted but did not go to scale:**
 - **Lack of political will**
 - **Lack of clear understanding of the problem by policy makers and professionals**
 - **Mal-distribution of HRs**
 - **Lack of suitable health workers**
 - **Lack of training sites**
 - **LACK OF FUNDS**

INDIA

	India	Coverage of Joint Review Mission 2009
Population (in millions)	1151	999
No. of CEmOC facilities required	2000	1800
No. of anaesthesiologists (at district and sub-district levels)	NA	1392
No. of doctors multi-skilled in anaesthesia		657

18 weeks training

No data on retention



India- National Rural Health Mission (2005-12)

- Architectural correction of the health system to deliver equitable affordable quality health services
- Increased public sector spending on health from 0.9% of GDP to 2-3%
- Recognition of the central role of HRs and massive increase in recruitment of all cadres of staff
- Multi-skilling :
A process by which health providers are trained and certified for a given skill set, normally associated with more specialized service providers, so as to provide an increased range of services

India-Addressing the crisis of HRs for Anaesthesia

- 2002- Multi-skills training for anaesthesia commenced, now in 25 of 35 states.
- 2004- Programme was evaluated ,reporting increase in utilization, if an enabling environment is provided
- However it is not clear how many such LSAS trainees are providing anaesthesia services
- More studies and a review of options for ensuring equitable access to anaesthetic services:
 - Continue LSAS training of MBBS doctors
 - Increase production of specialist anaesthesiologist (10-20 CS/ month/ facility).
 - Train Family Physicians (Masters in Integrated Family Medicine and Surgery) including anaesthesia , for sub-district CEmOC facilities
 - Consider the globally accepted option of training nurses/ NPCs to provide anaesthesia

Situation Analysis – Availability of Anaesthesiologists

Multi-skilling / Task Shifting

Afghanistan

Task shifting to nurses
High retention



Bangladesh

Multi-skilling of MBBS Dr.
60% retention



Bhutan

Task shifting to nurses
100% retention



India

Multi-skilling of MBBS Dr.
No data on retention



Nepal

Task shifting to nurses
Good retention



Pakistan

Task shifting to nurses
No data on retention



Multi-skilling/Task shifting in South Asia- the way forward, Cont.

- **Countries in S Asia need to develop informed policies for evidence based action on multiskilling/ on task shifting.**
- **Although there is more resistance from professional societies , the notion of skills transfer to other less specialized cadres is gaining acceptance**
- **A comprehensive approach to HRM and task shifting/ multiskilling :**
 - **Live data base of skilled HRs**
 - **Licensing by a competent body and registration to perform anaesthesia services, including prescription of anesthesia drugs**
 - **Supportive managerial arrangements-Quality competency based training, adequate equipment and supplies**
 - **Improving service conditions -Legal protection, career structure**
 - **Support from specialist anaesthetists**
 - **Developing institutional support mechanisms**

Professional Societies in South Asia-the way forward

OBSERVATIONS

- **Some professional organizations in S Asia have made significant advances in taking on public health challenges and developing innovative solutions, others have not developed this capacity and are insufficiently engaged.**
- **Governments and international partners are willing to support professional associations, but are concerned about their commitment to a public health goal, often related to weak internal governance & management**

Professional Societies in South Asia, the way forward, Cont.

RECOMMENDATIONS

- **Dialogue with societies of anaesthesia is essential to enable them to change their views towards task shifting and take on support to public health programmes**
- **Better documentation and assessment , quality control of ongoing programmes in task shifting**
- **Although several S Asian countries have developed experience in task shifting/ multiskilling, and Africa has successfully addressed the crisis of anaesthesia, lessons are not systematically shared. Regional and global platforms need to be developed**

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Thank You !