MARIE STOPES INTERNATIONAL

(MSI)

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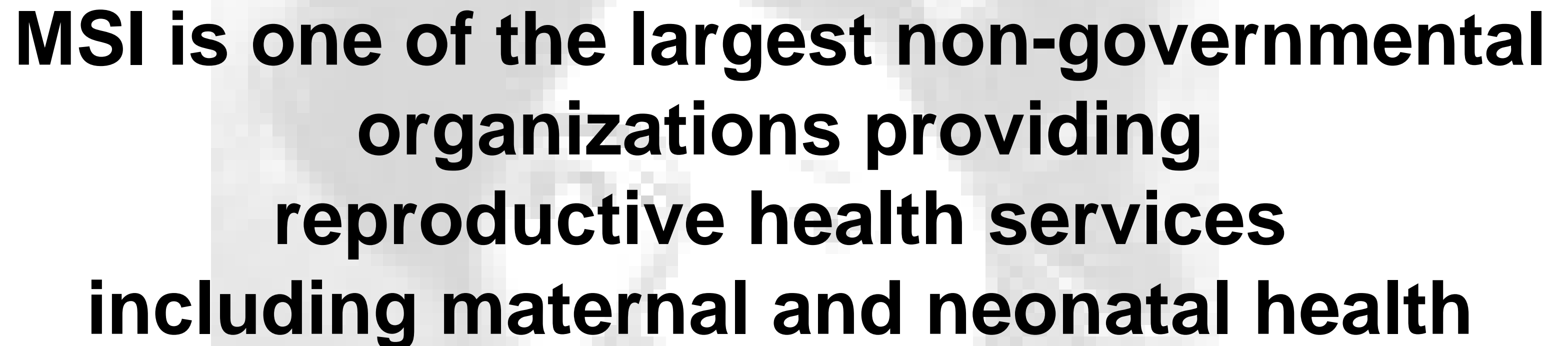
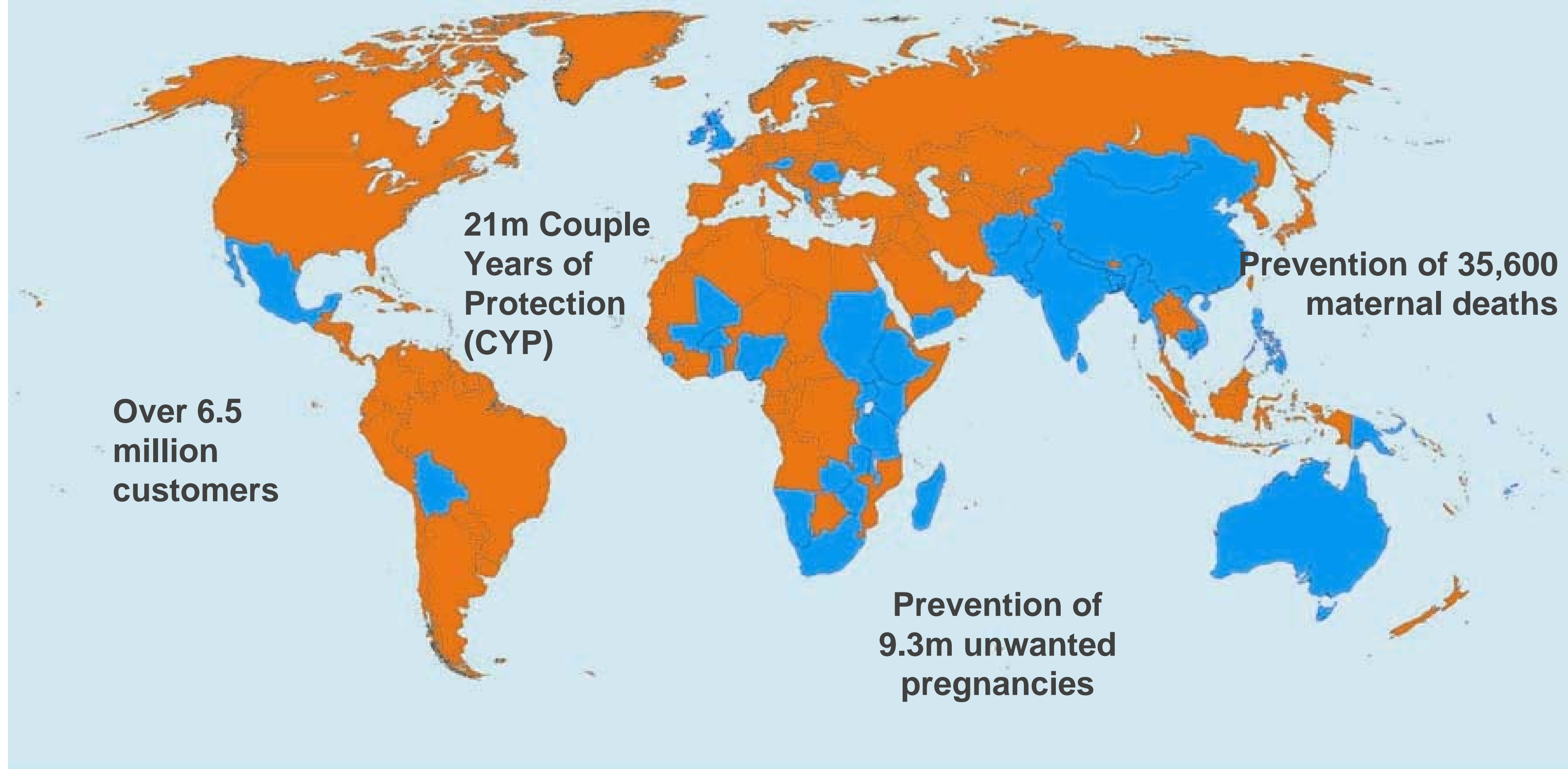


MSI is one of the largest non-governmental organizations providing reproductive health services including maternal and neonatal health

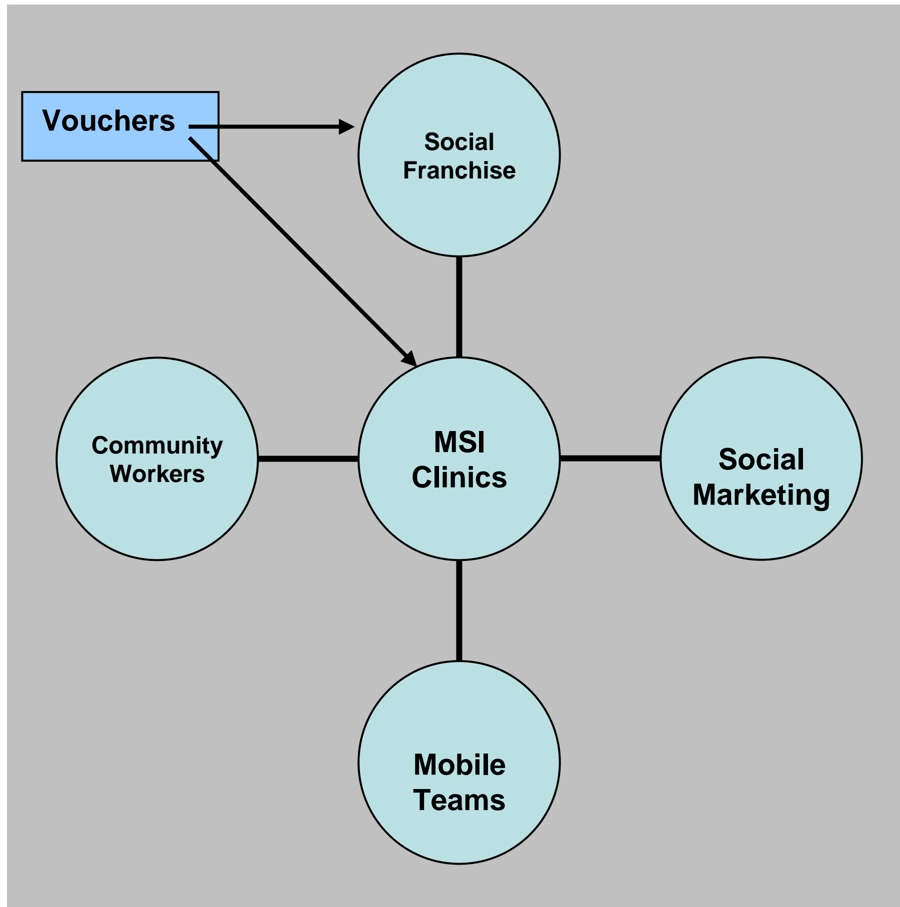
The MSI Mission

Defend the right of couples and individuals to have Children by Choice, Not by Chance

The MSI Global Partnership
Scale and Impact



Integrated Health Services of MSI



Collaboration with Government

Collaboration with other agencies eg. humanitarian

- Family Planning
- Pre and post natal care
- Safe deliveries
- Emergency obstetric care
- Safe abortions (in legal contexts) and post-abortion care
- Sexual and reproductive health
- HIV / AIDS (and other STIs)
- Childhood diseases and immunizations
- Malaria, tuberculosis
- General Health Care

One of the fundamental philosophies of MSI is to support the provision of our services through mid-level providers

What is task sharing?

Moving specific tasks "where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health." (WHO 2008)

Why do we task share?

- Global shortage of more than 4 million health workers

- Healthcare workers are typically concentrated in urban locations

- Skilled healthcare employees move from country to country in search of better career prospects

- Skills vary significantly and may not match health needs

CASE STUDY 1:

Task Sharing to Insert Intrauterine Device (IUD) in Philippines

BACKGROUND

- IUDs consitute only 23% of all contraceptive use worldwide, 25% use in Asia.
- Lack of skilled service providers - doctors and nurses seek more lucrative nursing jobs abroad
- Physicians, nurses and midwives are permitted to insert IUDs as long as they have training in family planning
- There already exists a structure of midwife providers
- Midwife providers are trained by MSI in a one-to-one setting

MOBILE OUTREACH

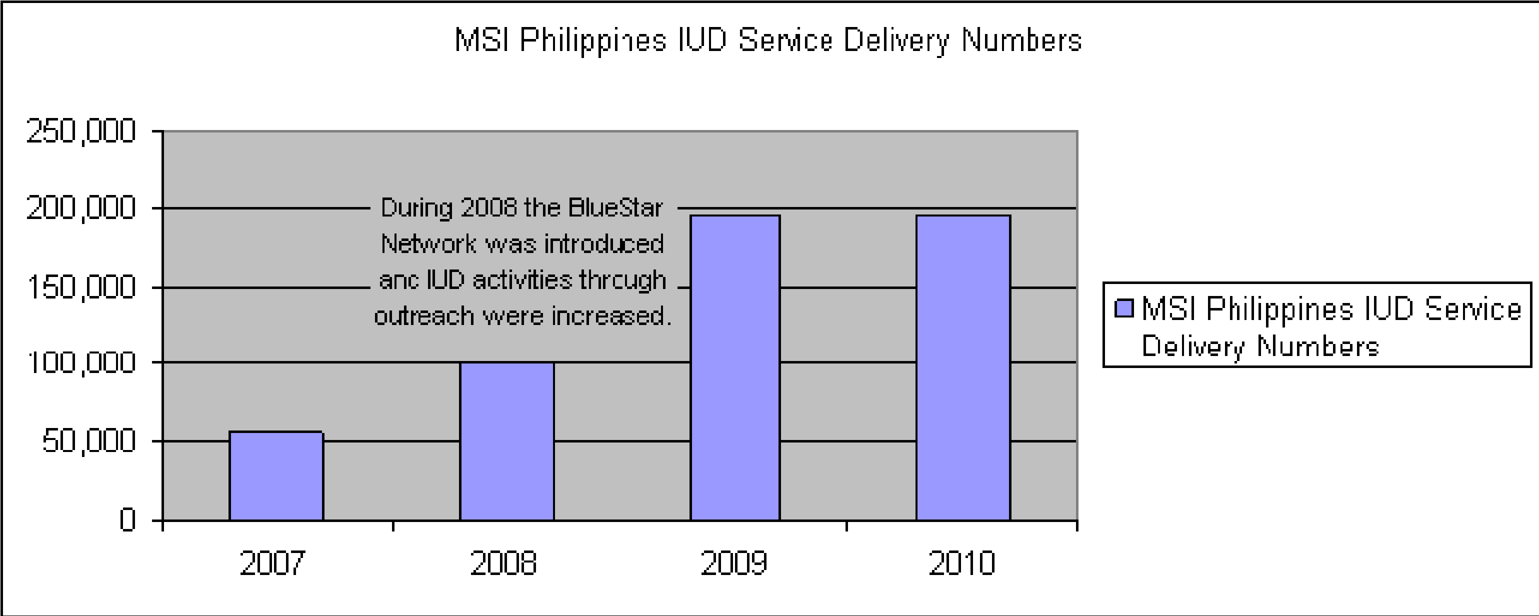
- Philippines is largely rural and travel often requires crossing bodies of water - this means limited access to SRH services for most of the population. MSI's brings SRH services to communities through its mobile outreach teams.

- MSI lobbied with local government units to enable midwives to provide IUDs within non clinical settings such as village council halls, providing that existing infection prevention standards are observed.

BLUE STAR SOCIAL FRANCHISE NETWORK

- Midwives can operate private practices
- MSI enrolled clinics within its Blue Star Social Franchisee network
- BlueStar Pilipinas has added IUD insertions to midwives' services and provides training, and subsidized commodities
- BlueStar Pilipinas is MSI's largest franchise network with 307 midwife providers located in urban, peri-urban, and rural areas.

IMPACT



CASE STUDY 2:

Task Sharing to Deliver Tubal Ligation (TL) in Malawi

- In 2007 MSI provided 477,000 tubal ligations (brand name Marie Stopes Ligation) in 24 countries.

- Sterilization is favored in Latin America where 31% of married women aged 15 to 49 who use contraception, have been sterilized.

- In Sub-Saharan Africa the figure falls to 2% and the majority of women rely upon contraceptive injections or the contraceptive pill.

- This regional disparity is due to the relative ease with which injectable contraceptives and the pill are available in Sub-Saharan Africa compared to sterilization.

BACKGROUND

- A shortage of doctors has restricted the provision of healthcare services, particularly in rural areas
- In the 1970's the Government introduced the Clinical Officer cadre to increase provision of health care
- Clinical Officers train for 4 years
- Malawi government policy allows for clinical officers to perform Tubal Ligation

INTERVENTION

- MSI has developed a simple but effective procedure which can be performed by trained clinical officers
- MSI trains clinical officers to deliver TL in a de-medicalised environment – thus further reducing the burden on pre-existing health care providers
- The MSI training includes two weeks of practical and theoretical lessons, based on the latest clinical standards

IMPACT

- MSI provides 38,000 tubal ligations a year (83% through outreach)
- In 2010 MSI provided 50,000 TLs (37% of the modern contraceptive market)
- A 2009 study looking at delivery of MSI TL through outreach by clinical officers showed only a 3% complication rate
- Task sharing is a viable mechanism to deliver family planning services to women

CASE STUDY 3:

Task Sharing to Deliver Safe Abortions in Nepal

BACKGROUND

- In 2002 it was made legal for trained providers to offer first trimester abortion in Nepal. Government-trained and private sector providers expanded the market for abortion provision meaning greater access to safe abortion.

- Approximately 3/5 abortions in Nepal are unsafe due to a lack of trained service providers as there are very few doctors in the country, and providers are not willing to be located in remote or hard to reach areas.

SURGICAL ABORTION (SA)

- MSI's partner in Nepal - Sunaulo Parivar Nepal (SPN) worked closely with other stakeholders to lobby at district and central government levels, for the para-medicalisation of SA provision in Nepal.

- In 2004 the Government announced that Staff Nurses could perform Comprehensive Abortion Care (CAC), up to 8 weeks and through MVA. To be qualified as a SA service provider they need to have 14 days training on CAC and receive a Government License

- It took the MOH 4 years to develop the policy and bring it into the practice. During these 4 years the MOH trained and supervised senior and experienced nurses at a Government Maternity Hospital who were already providing post abortion care, to perform CAC.

INTERVENTION

- SPN runs a Training Centre, located in Kathmandu, and is certified by the Government to provide training in CAC

- In 2008 the Government provided CAC training to 100 staff nurses and by 2011 the Government had certified 400 Staff Nurses including MSI's.

IMPACT

	2004/2005	2005/ 2006	2006/ 2007
Grand total of registered abortions	11,280	47,451	73,474
SPN safe abortions	3,076	34,518	55,225
SPN contribution	27%	73%	75%

MEDICAL ABORTION (MA)

- MA remains under-used and inaccessible for many women in developing countries because almost all national regulations restrict its prescription and supervision to doctors.
- 2009 - Government of Nepal made MA available in Nepal for pregnancies of less than 9 completed weeks
- 2010 - the Government allowed MA to be provided by Auxiliary Nurse Midwives provided they have completed an 18 month nursing course, 2 months Skilled Birth Attendant (SBA) training from the Government, and MA training from a government certified centre.
- Provision of MA services by nurses is limited to government facilities in which a doctor is present

INTERVENTION

- The SPN Training Centre provides MA training for ANMs provided a) they have 5 years work experience in RH and Family Planning

  b) they have SBA training (2 months) from a government training centre.

- Dr IK Warriner et al conducted a study in April 2011 included in the Lancet Vol. 377, Issue 9772 “Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal”.

- Findings: midlevel providers with previous training in abortion care can, after additional training in MA, independently administer MA safely and effectively in a low-resource setting where pregnancy tests, antibiotics, and ultrasonography are available but rarely used.

LESSONS LEARNED

- Success in task sharing from physicians to midwives is often due to recruitment from rural communities; and female to female interaction.

- Task sharing often means that family planning services are provided at lower costs whilst being more locally-driven and acceptable to rural communities. Local recruitment encourages employment opportunities in rural areas.

- Task sharing has evolved from an emergency approach to a development strategy for professionalizing the workforce and strengthening the health system.

RECOMMENDATIONS

- Ensure

a) Comprehensive and integrated reconfiguration of health teams

b) Enhanced training and supervision infrastructure

c) Medium/ long-term funding

d) Compliance of regulatory bodies

f) Adequate resources

- Tackle divergence between countries regarding what tasks can be performed by whom

- Engage government, donors, UN, NGOs in discussion on task sharing

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