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International Federation of
Medical Students' Associations

IFMSA Policy Proposal Access to safe surgery and anesthesia for all

Proposed by the Team of Officials

Presented to the IFMSA General Assembly March Meeting 2017 in Budva, Montenegro

Policy Commission

- **NMO Representative 1 – Zineb Bentounsi IFMSA-Morocco (zbent258@gmail.com)**
- **NMO Representative 2 – Iain Doig Medsin-UK iain.doig@icloud.com**
- **Team of Officials Representative Skander Essafi Iph@ifmsa.org**

Policy Statement

Introduction

The International Federation of Medical Students Associations (IFMSA) affirms that equitable access to safe surgery and anesthesia has long been a neglected component of Global Health. Surgical operations have been shown to be cost-effective, while failure to treat confers a substantial social and economic toll on those suffering and society at large. For these reasons, access to safe, quality and affordable surgical and anesthetic care should become a priority within Global Health.

IFMSA Position

The IFMSA endorses:

- The World Health Assembly (WHA) 68 Resolution, Strengthening emergency and essential surgical care and anesthesia as a component of universal health coverage.

Affirms that:

1. Equitable access to safe surgery and anesthesia should be given a stronger focus in Global Health.
2. Coverage in surgery and anesthesia healthcare personnel and services should be ensured worldwide.
3. Surgery and anesthesia skills should be promoted in low-resource settings.

Calls for:

1. Its National Member Organizations to advocate for a more equitable access to surgical and anesthesia care in their countries, and to organize events promoting this issue.
2. Governments:



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- a. Human Resources: to recruit enough competent surgical and anesthetist staff to meet the population's needs and offer them fair working conditions.
- b. Access and equipment: to provide safe and effective equipment that meets local needs and to train technical staff to maintain the equipment in order to assure adequate surgical services.

Medical Schools to offer and promote enough training opportunities in order to meet local needs for surgeons and anesthetists.

The World Health Organization to further develop action plans on global surgery and anesthesia and monitor global progress in achieving access to safe surgery and anesthesia for all, following the 2015 WHA Resolution.

Position Paper

Background

Despite the estimation that 30% of the global burden of disease can be treated with surgery, at least 5 billion people worldwide lack access to surgical care with the worst access in low- and middle-income countries (LMICs) (1-2). Mortality and morbidity from common conditions requiring surgery have grown in the world's poorest regions, both in absolute terms and relative to other health gains. At the same time, development of safe, essential, life-saving surgical and anesthesia care in LMICs has stagnated or regressed (1).

Surgical care has previously been largely neglected in Global Health discourse. This is mostly due to the misconception that surgery is too expensive and is seen as a luxury. It has now been shown that surgical care is a highly cost-effective intervention, in the same range as vaccinations, malaria prevention and treatment (3). Anesthesia has also been overlooked within Global Health, despite the requirement for anesthesia in nearly all surgical procedures. This has led to an inadequate supply or maintenance of anesthetic drugs and equipment, few trained anesthetists and limited access to analgesia in LMICs (1).

Despite the increasing disparities between surgical and anesthetic care both between and within countries, such as increased costs and a lack of investment in LMICs (1), access to safe surgery and anesthesia has not been included in the Sustainable Development Goals (SDGs) and subsequently may not be prioritised in Global Health. Although interest in sustainably providing equitable access to safe surgery and anesthesia is growing rapidly, and is increasingly recognized as a critical part of strengthening health systems, it remains overlooked.

Discussion

The SDG 3, focusing on health and well-being, does not include access to safe surgery and anesthesia care among its targets (4). However, some of its targets cannot be achieved without surgery, such as Caesarean sections which can be essential for reducing maternal and neonatal deaths (targets 3.1 and 3.2) and access to trauma surgery which reduces deaths from road traffic accidents (target 3.6). In 2015, the World Health Organization has

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adopted a resolution (resolution 68.15) that recognizes the need for strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage, and urges member states to take action towards this goal (5).

In recent years, interest for surgery has grown both among academics and non governmental organizations (NGOs) (6). Some universities have included Global Surgery in their Global health curricula or as a research field. Moreover many NGOs have been working to improve access to surgical care in LMICs. However their interventions are mainly short-term based: for instance organizing surgical trips or donating anesthesia machines. Such interventions are needed currently but in the future, LMICs will surely need to develop their own sustainable solutions to rectify lack of surgical care by training more surgical staff and increasing investment in surgery. Thus, external aid from NGOs should focus on improving infrastructure in LMICs to give them the capacity to develop their own solutions.

Moreover, the provision of safe surgical services requires access to appropriate anesthetic care. Despite this need, anesthesia has continued to remain a low priority in Global Health, mainly due to the misconception that it is too technologically advanced. This has led to severe consequences, with the avoidable mortality rate attributable to lack of anaesthesia as high as 1:504 in Malawi and 1:1923 in Zambia compared to 0.55 per 100,000 in the United States (7). To improve this situation there must be a focus on developing infrastructure, providing appropriate anesthetic training and improving access to analgesic medication.

As anesthesia is primarily technology-based, it depends upon appropriate infrastructural capacity. In a survey of health care centres in East Africa, it was shown that uninterrupted electricity was available in 59% of facilities surveyed and uninterrupted oxygen via cylinder or concentrator was available in 45.2% of facilities surveyed, whilst 35% reported no access to oxygen (8). If a supply of electricity and oxygen cannot be relied upon, it poses a great risk to patients and can adversely affect outcomes. Improving infrastructural capacity would not only aid in the improvement of surgical and anesthetic care, but in all aspects of patient care.

Another issue facing the provision of anesthetic services is the lack of trained physician anesthetists, with most LMICs having a ratio of less than 1 physician or nonphysician anesthesia provider per 100,000 population (7). In some cases, hospitals had no access to a physician anesthetist (9). To address these issues, there is, again, a need for global acknowledgement of the necessity and importance of anesthesia services.

A lack of analgesia in surgery and anaesthesia is a global issue, with 83% of the world's population living in countries with low to non-existent access to analgesics (5). This is chiefly due to the difficulties LMICs face in accessing controlled medications, such as opioids, due to international narcotics regulations. These regulatory requirements often present challenging hurdles that LMICs find particularly difficult to overcome, and in many cases scheduled medications are simply banned (10). Freedom from unnecessary pain is considered a human right, however the prevalence of untreated pain is so high it could be considered to be a global epidemic. (10) Moving forward, there must be a greater appreciation of the effect and complications of untreated pain. Moreover, a holistic approach to improving access to analgesia must be developed.

Student interest and involvement in this issue has also been growing, starting with initiatives such as Global Surgery Day (11) and continuing with the establishment of both national and international Global Surgery student societies (12). In conclusion, Global Surgery and

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Anesthesia is an evolving field, one that is highly relevant and important for the IFMSA to acknowledge. The IFMSA should call upon current medical students across the globe, as the public health leaders and clinical practitioners of the future, to become the next generation of global health surgeons.

References

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10. King N, Fraser V. Untreated Pain, Narcotics Regulation, and Global Health Ideologies. *PLOS Medicine*. 2013; 10: e1001411
11. IFMSA. (2015) Global Surgery Day [Online], Available: <http://ifmsa.org/2015/05/24/ifmsa-global-surgery-day/>
12. IFMSA. (2014) Global Surgery Toolkit [Online], Available: <https://drive.google.com/file/d/0B0VB46upm43Bd0tBM2JoWHBZdkU/view?usp=sharing>

Draft Policy Proposals have to be sent to all National Member Organizations (nmos@ifmsa.org) by the proposer to request for feedback by **January 10 2017 23.59 GMT**. Policy Proposals to be discuss at 66th March Meeting General Assembly 2017 have to be sent to gs@ifmsa.org by **February 1, 2017 @ 23.59 GMT** (please put the code [POLICY] in the beginning of the subject of your email).

Bylaws Paragraphs concerning Policy



15.2 Definitions

- a. **Policy Statement:** Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement does not include background information, discussion related to the policy, a bibliography and neither does it quote facts and figures developed by outside sources. The maximum length of a policy statement is 2 pages, including introduction, IFMSA position and call to action.
- b. **Position Paper:** A detailed document supporting the related policy statement that contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper must cite outside sources and include a bibliography.
- c. **Policy commission:** A policy commission is composed of three people, with 2 representatives of the NMOs and one representative of the Team of Officials. The proposer of the draft is part of the policy commission and is responsible of appointing its members. The tasks of the policy commission are the following:
 - i. They are responsible of the quality of the policy document with the approval of the proposal.
 - ii. Ensuring the content is based on global evidence.
 - iii. Collecting and incorporating NMO feedback after the call for input.
 - iv. Coordinating the discussion during the General Assembly.

Adoption of policies

15.3. A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer and in accordance with paragraph 9.4. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.

15.4. The final policy statement and position paper are to be sent in accordance with paragraph 9.4, using the template provided in the call for proposals. The proposal must be co-submitted by two NMOs from different regions or the Team of Officials.

15.5. Policy statements and position papers must be resented to NMOs during the first working day of the IFMSA General Assembly.

15.6. A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary and submitted by two NMOs from different regions. Adoption requires $\frac{2}{3}$ majority.

15.7. Amendments may be sent to the proposer and in accordance with paragraph 9.4. Amendments made during a General Assemblies or after the deadline in accordance with paragraph 9.4, will be voted upon during the relevant plenary and require $\frac{2}{3}$ majority.