IFMSA Policy Proposal
Universal Access to Safe Surgery & Anesthesia

Proposed by SfGH U.K and IFMSA- Honduras
Presented to the 69th IFMSA General Assembly August Meeting 2020

SfGH U.K

Name of National Member Organization 1

Sign and stamp of President of National Member Organization 1

IFMSA- Honduras

Name of National Member Organization 2

Sign and stamp of President of National Member Organization 2

Policy Commission
- Wezi Ngwira (wngwira99@gmail.com) & Nelson Evaborhene (evaborhene@gmail.com) SfGH U.K
- Kiomi Perdomo IFMSA-Honduras – chomiperdomo@gmail.com
- Omnia Elomrani LPH – lph@ifmsa.org
Policy Statement

Introduction:

It is inevitable how access to safe surgery and anaesthesia remains a major challenge globally. Traumatic events that require surgery are constantly rising; physical injuries, cancer, and complications of chronic diseases. Unsafe surgical procedures cause substantial impacts on mortality rates and post-surgical complications which puts global healthcare systems at increased risk. Yet, half of the damage caused by unsafe surgeries is preventable. 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. That is why surgical and anaesthetic care are an essential component of health services and a chief pillar in attainment of Universal Health Coverage.

IFMSA position:

The IFMSA affirms the significance of the advocacy to bring safe and equitable access to surgical and anaesthetic care and the need to increase the focus on surgery and anaesthesia as a global health priority. IFMSA recognizes that in order to improve safe access to surgery and anaesthesia governments must procure coverage in surgery and anaesthesia healthcare personnel, and ensure supply of surgical and anesthesia resources. IFMSA also affirms that surgical and anaesthetic skills should be guaranteed and improved especially in low-resource settings through training endorsed by international surgical standards. Lastly, IFMSA acknowledges the crucial role that medical students worldwide have in the molding of current and future policies to achieve universal access to safe, affordable, surgical and anaesthesia care when needed.

Call to Action:

IFMSA calls for Governments to:
- Develop and ensure the implementation of evidence-based policies and guidelines to standardize the safety and quality measures of surgical and anesthesia procedures at all levels;
- Integrate access to safe surgery and anaesthesia as a key pillar in universal healthcare coverage and equity;
- Ensure competent training and education of healthcare professionals, including but not limited to surgical and anesthetist staff, as to cope the demand of the surgical disease burden;
- Invest in safe and effective equipment that meets local needs and train technical staff to maintain and upkeep the equipment to ensure provision of adequate surgical services;
- Improve transport links between distant/rural communities and district hospitals that offer surgical treatment.

IFMSA calls for: The World Health Organization (WHO) to:
- Work with countries and multidisciplinary partners to raise awareness and mobilize political commitment to implement patient safety initiatives such as the Safe Surgery Saves Lives Programme.
- Monitor global progress and impact in achieving access to safe surgery and anaesthesia for all in line with the 2015 World Health Assembly Resolution.
- Develop a platform for global stakeholders to collaborate and share best practices and standards for surgical and anaesthesia care;
- Strengthen education and training programmes to improve surgical and anaesthetic services.

Healthcare Facilities, Hospitals and Medical Schools to:
• Abide by international safety measures for surgical procedures, including but not limited to WHO Surgical Safety Checklist and safety parameters for anesthesia;
• Condemn all practices and protocols that threaten the integrity of human life during unsafe surgical procedures;
• Provide continuous, equitable and open medical training to residents, medical students, surgeons, anesthetists, and other essential staff;
• Guarantee the generational replacement of technicians, nurses, surgeons, and anesthetists to prevent staff shortages in hospitals where there are a limited number of surgeons and anesthesiologists;
• Work collectively with healthcare professionals and specialists in reaching neglected places with equitable healthcare services and condemn the lack of surgery and anaesthesiology personnel;
• Integrate surgical and anaesthesia guidelines in the curricula of health students, residents and continued professional education for surgery specialists;
• Ensure updated, inclusive, feedback and evidence-based medical training according to the health needs of the community where they are established.

National Member Organizations (NMOs) and Health Students to:
• Condemn all practices and protocols that threaten the integrity of human life during unsafe surgical procedures through national campaigns, activities and projects;
• Advocate for more equitable access to surgical and anaesthesia care in their countries, and to organize events promoting this issue and its integration in universal healthcare;
• Collaborate with multidisciplinary partners and organizations that promote global surgery or global health at their institutions;
• Advocate for the integration of global surgery in the curricula and throughout undergraduate and postgraduate training.
Position Paper

Background information:

Equitable access to safe surgery and anaesthesia is a critical component of strengthening health systems especially in low and middle-income countries (LMICs), and should be prioritized in global development goals. Availability of basic surgical care services would prevent 77.2 million disability adjusted life years lost (DALYS) annually. As many LMIC transit from communicable to noncommunicable diseases such as cancer, cardiovascular diseases and injuries, the need for equitable access to urgent surgical is expected to increase substantially. This is because a study has found that the burden of disease in countries in east and central has shifted to non-communicable diseases providing the NGOs the chance to focus their efforts in equitable access to surgery (25).

Access to safe surgery and anaesthesia remains a major challenge globally, affecting an estimated 50% of the global population. A significant proportion of this burden resides in lower- and middle-income countries (LMIC) (5), where the percentage of people who do not have access to surgical treatment can be as high as 95% (1). A survey conducted by The World Federation of Societies of Anaesthesiologists between 2015 and 2016 revealed that, out of 153 countries, 70 have less than 5 anaesthesiologists per 100,000 inhabitants. Once again, numbers were higher in LMIC countries such as sub-saharan Africa and southeast Asia. In order to meet the suggested minimum requirement of 5 specialists per 100,000 inhabitants (the number being only an estimate due to the difficulty in determining the optimum number required) for all countries, an additional number of 136,000 anaesthesiologists is needed (1). It is estimated that a 10 unit increase in the number of surgical staff; including anaesthetists, would result in a decrease of maternal deaths by over 10% (24). Some of the major barriers between this minimum requirement include: delay in presentation to hospitals, critical shortage or, in some cases, inequitable distribution of trained healthcare professionals, limited access to analgesia and sedatives, lack of appropriate surgical and anesthetic technologies (3).

In order to reduce death and disability from untreated surgical conditions, timely, safe, affordable and equitable to access is critical. An additional 143 million surgical procedures are needed in LMIC. However, only 6% of 313 million surgical procedures occur in underserved populations. Despite affecting more than half of the global population and with existing huge disparities within and between countries, these growing unmet surgical needs are still largely neglected in global health discourse. As it is often misconceived that surgical interventions are not cost-effective. However, this has been proven to be untrue as economic cost benefit analysis revealed it is in the same range as prevention of malaria prevention and routine vaccination (13).

Discussion:

Definition of Global Surgery:

To address the cross-cutting interface between surgery, anaesthesia and global health, a recent term was adopted to ensure the provision of equitable surgical care of quality across all health systems worldwide. Global surgery is an uprising, multidisciplinary field established to encompass advocacy, education, research and interprofessional collaboration between surgeons, anaesthetists, nurses and other healthcare providers to identify barriers and improve access and optimization of surgical care (30) Finally, the Lancet Commission on Global Surgery shaped a powerful vision for surgical and anaesthesia care to be universally accessible, safe and affordable. (31)
Access to Surgical and Anaesthetic Care:

**Barriers to Access**

In spite of how the role of surgery has imminently increased in the global health agenda, barriers such as accessibility, availability, affordability and acceptability of surgical care has led to significant disparities between high-income and LMICs impeding the progress in this global health concern.

Barriers to realize universal and safe access to surgical and anaesthetic care have been divided according to patient, physician, institution and structural factors. Physician-related barriers are led by the shortage in the health workforce and lack of sufficiently-experienced professionals, while patient-related barriers comprise health literacy that impact adherence of the patient to treatment and financial obstacles. Economic factors are also linked to institution-related barriers through the lack of investment in appropriate infrastructure to perform surgeries safely, essential equipment and consumables.

Additional barriers that hinder access to surgical care also include communication and language barriers with the patient and patient’s family despite how qualified a healthcare professional can be. The inadequacy seen in referral systems with limited capacity to conduct effective patient transfer and continuity of care presents another barrier to quality of care. Finally, the lack of certain surgical procedures in healthcare facilities leads to turning away patients and leaving them untreated (32).

**Cost-effectiveness of Interventions**

It has been suggested that 11% of the global burden of disease is surgically treatable, chiefly injuries and malignancies. When such conditions are left untreated, this leads to a consequential social and economic toll on both individuals and society as a whole. As a result, interventions to improve surgical care, especially in LMICs, can be cost-effective. A study suggested that the cost per surgical DALY gained at a district hospital is between US$ 19–102, similar to the cost-effectiveness of antiretroviral therapy for HIV infection in sub-Saharan Africa estimated at US$350-1494. Thus, it is imminent to invest in the infrastructure of healthcare facilities, training of healthcare professionals and governance at all levels, generating substantial long-term benefits as seen in the case of DALYs gained (32).

Moreover, one of the key issues that makes access to surgical care difficult is a shortage of trained surgical staff. Some countries such as Malawi and Mozambique have managed this shortage by training medical officers or non-physician healthcare professionals to carry out specific surgical procedures (11). This would not only greatly benefit patients in terms of health as they would now have access to surgical care from a professional, it would also benefit their local communities and the economy due to reduced disease burden which reduces time out of employment due to illness which would ultimately aid economic growth (10). This is because roughly 15 essential surgical conditions that have pre-existing treatments could account for up to 80% of the surgical needs that commonly occur in rural or resource low settings (9) and these conditions can be managed by medical officers provided they receive focused surgical training for these specific procedures. One way this could be capitalised on is through the development of programmes similar to an apprenticeship on a much wider scale that would allow surgeons who are either working short term in rural communities or long term in larger hospitals in more populated areas to train medical officers using a set curriculum to teach them how to surgically manage hernias, hydroceles, goiters etc (2).

However, increased access to surgical care must be accompanied by increased access to anaesthesia. A pilot study found that there is a significant lack of both physician and non-physician anaesthesia providers with the ratios being between 0.1 to 1.4 per 100,000 people (14).

**Surgical Care in Sustainable Development:**
According to the World Bank President, Dr Jim Yong Kim, “surgery is an indivisible, indispensable part of health care” and “can help millions of people lead healthier, more productive lives” (19). While some progress has been made to advance global surgery, there is still more to be accomplished. Some of the goals outlined in the Global Surgery 2030: Report Overview are to call for “global health and development organisations to include indicators of surgical care within existing health goals and monitoring systems, international partners to support local leaders in their efforts to provide equitable surgical care and governments in LMICs to strengthen surgical services and the national health systems that provide them” (29). Progress has been seen and can be built upon. This is particularly seen in The Royal College of Surgeons Ireland (RCSI) and its collaboration with the College of Surgeons of East, Central and Southern Africa (COSECSA) to not only provide training to surgical trainees but to also provide teaching to existing surgical professionals as to teach future trainees as well. Carrying out these schemes on a much wider scale will provide change that meets the needs of trainees and trainers in LMICs. This, along with other changes, would help meet some of the goals mentioned in the report, in addition to reducing premature deaths, stimulating economic productivity, capacity and freedom leading to long-term development goals.

Universal Access to Surgery and Anesthesia:

In order to achieve equity in global health and sustainable development goals, universal access to safe, affordable surgery and anaesthesia is vital. It would prevent over 100,000 maternal deaths due to caesarean sections and consequently reduce neonatal mortality by 30-70%. (22). It is also essential with the rise in noncommunicable disease burden in LMIC as it would be critical in managing complications and subsequently prolonging life. This is important to consider as currently, over 950 million women do not have access to emergency obstetrics care when pregnant. (2). This poses a major setback in reducing maternal mortality. In addition, in Uganda, timely access to essential surgical services for breast cancer is challenging as over 77% of women present late with stage iv disease compared to 11% in the United State (3) further increasing disability and deaths.

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 (16). 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 (18). 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.

Global Surgery as a Growing Field:

Student interest and involvement in this issue has also been growing, starting with initiatives such as Global Surgery Day (16) and continuing with the establishment of both national and international Global Surgery student societies (18) such as the Global Surgery Students Alliance and IniciSioN (International Student Surgical Network). The British Foundation for International Reconstructive Surgery and Training has written an article to help guide students who want to get involved in global surgery at both the undergraduate level such as medical electives, research projects and conferences to give them the opportunity to network with professionals in the field (26).

However, a survey aimed at medical students in the United states showed that while students had an increasing interest in global surgery, almost 80% mentioned that issues related to global surgery are not addressed or they are only briefly mentioned in their curriculum. Additionally, approximately 50% of students were unaware that their university offered opportunities (courses or conferences) related to global surgery (27). Currently the most common way students and trainees are exposed to global surgery is through electives which have been integrated into the curriculum in many medical schools in the United Kingdom and Europe and global surgery is briefly mentioned in some medical schools.
However, making these opportunities and teaching a standard part of the curriculum not only benefits the countries most impacted but also helps develop more well-rounded medical professionals who have a better understanding of the subject. A report published in the Journal of Surgical Education found that students who went on electives improved their clinical skills, gained a better appreciation for the human side of medicine and also learned to manage patients using limited resources (28). This highlights the need for medical schools and healthcare facilities to be more involved in educating students and trainees about global surgery, providing information on how they can pursue a career in the field and encouraging them to go on electives and attend conferences related to global surgery.

In conclusion, integration of surgery and anaesthesia into the global health framework would strengthen the existing health system and provide leverage for the improvement of other services as well. In the words of Jim Kim, “it is an indivisible, indispensable part of health care” (23) Hence, It should be prioritised and act upon with absolute urgency.

References:


Bylaws Paragraphs concerning Policy

Bylaw Paragraph 17.2 Definitions
a. Policy statement: Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement includes neither background information, discussion related to the policy, a bibliography and nor 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 Liaison Officer. 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 proposer.
   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.

d. Policy Reviewing Committee: A policy reviewing committee is composed of Vice-President for External Affairs, with 3 representatives of the NMOs. A Policy Reviewing Committee shall submit a report to the Executive Board and the National Member Organizations according to Annex 1. A report shall include the review of all submitted policies and reasons behind the final recommendation.

Bylaw Paragraphs 17.3 -17.7 Adoption of policies
• A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer in accordance with Annex 1. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.
• 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. A corrected version of this document may be submitted according to paragraph 9.5. Correction may not be used to add members to the policy commission.
• Policy statements and position papers must be presented to NMOs during the first working day of the IFMSA General Assembly.
• A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary by two NMOs from different regions or an IFMSA Official, the IFMSA Team of Officials or the IFMSA Executive Board. Adoption requires ⅔ majority.
• Amendments may be sent to the proposer in accordance with Annex 1. Amendments made during a General Assemblies or after the deadline stipulated in Annex 1, shall be submitted to the Chair at the latest 23:59 observed in the timezone of the relevant General Assembly on the day before the scheduled start of the session in which the policy will be voted on. These amendments require ⅔ majority to pass.