ANNEXES : Progress Report (resolution WHA 68.15)

A. Regional Reports
B. Global Surgery Declaration

A. REGIONAL REPORTS

AFRICAN REGION

ZAMBIA

- As one of the key countries to move forward WHA Resolution 68.15, Zambia has continued to be a leader in including surgery as part of universal health coverage. Through multiple committee meetings as well as writing workshops, the Zambian Ministry of Health has drafted a National Surgical, Obstetric, and Anaesthesia Care Plan (NSOASP). The NSOASP has also been costed. This plan is due to be signed in January 2017, such that it can be integrated into Zambia’s National Health Strategic Plan of 2017-2021.

ETHIOPIA

- The Ministry of Health has developed a National Surgical Plan, along with a implementation strategy with specific targets and indicators relating to surgical care

MADAGASCAR

- Surgical indicators were collected from each district hospital in the country.
- The Malagasy Ministry of Health is planning to partner with Jhipeigo and the Harvard Program in Global Surgery to move forward with a National Surgical Care Plan

TANZANIA

- Initial meetings have been held with the goal of developing a surgical care plan for the country

REGION OF THE AMERICAS

BRAZIL

- A retrospective analysis of the six World Development Indicators, specifically surgical indicators, for Brazil was undertaken. It highlights significant disparities in surgical capacity between the 27 states across all indicators. The results have been discussed with Ministry of Health.
- A meeting was arranged on December 7th bringing together surgeons, anesthesiologists and policy makers from nine Latin American countries to discuss challenges and commit to progress in Global Surgery across Latin America. The group will reconvene in November 2017 to analyse progress.
- In the state of Amazonas, a systematic assessment of surgical capacity is being undertaken, comparing officially reported versus on-the-ground assessments of surgical capacity to determine the reliability of government data when undertaking surgical planning. A multi-centre project is underway analysing barriers to cleft care across Brazil.

ECUADOR

- CINTERANDES, a non-profit Foundation in Ecuador has been providing affordable surgical and anaesthesia care to remote and underserved populations for 23 years by means of a Mobile Surgical Unit and dedicated volunteers. This mobile surgical unit has been utilized to complement governmental health care delivery, and has been deployed to provide aid in disaster situations as well. Currently, research on cost effectiveness and
community impact are underway to determine if this system of mobile healthcare delivery is replicable in other countries.

NICARAGUA
• The Nicaragua Ministry of Health, Operation Smile, and WHO EESC are together collaborating on several initiatives associated with resolution WHA 68.15, including:
  • An 18-month pilot project to advance timely access to and impact of rural emergency and essential surgical care, based at two first-level referral hospitals.
  • Developing a replication framework to identify the key inputs and drivers to efficiently and cost-effectively scale up accessible, outcome-optimized surgical care across referral hospitals of multiple levels throughout Nicaragua and internationally. This will facilitate formalization of a national surgical strategic plan.
  • Strengthening health workforce for surgery, by jointly providing resuscitation training (basic and advanced life support) to all 900 peri-operative Ministry of Health personnel (nurses, technicians, and doctors) throughout Nicaragua. Currently, more than 55% of training is complete.

PERU
• Surgical institutions in Peru and other Latin American countries are developing stronger collaborations with international counterparts such as the case of the Society of General Surgeons of Peru (SCGP), the Latin American Federation of Surgery (FELAC), the American College of Surgeons (ACS), SAGES, SSAT, AAS and IFSO which will help propagate new developments in surgery globally. Such collaborations help strengthen emergency and essential surgical care.
• The non-profit organization Socios en Salud (SES), the Program in Global Surgery and Social Change (PGSSC) from Harvard Medical School and Brigham and Women’s Hospital (BWH) are currently developing clinical and research efforts in the field of surgical care for MDR-tuberculosis patients. Peru is among the top 30 countries worldwide with high burden of drug resistant-TB and in Latin America it is the country with the highest number of MDR-TB cases. This collaboration aims to strengthen Peru’s health system and decrease the burden of disease and disability caused by tuberculosis.

SOUTHEAST ASIA REGION
INDIA
• In India, efforts on implementing the WHA resolution have been organized by strong local leadership from the Association of Rural Surgeons of India (ARSI).
• In Fall 2015, ASRI collaborated with the Lancet Commission on Global Surgery (LCoGS) to hold a meeting discussing priority action items for surgical systems improvement in India. From this event, the Karad consensus statement was developed, focusing on issues of blood deficits, workforce challenges, and infrastructure needs and innovation.
• In March 2016, the WHO EESC, the LCoGS, and ARSI led the Global Surgery India Surgical Forum. This meeting brought together clinicians, industry leaders, government representatives, academics, and civil society members from India and across the world.
• Multiple efforts are currently moving these commitments forward. Several research and implementation projects related to blood availability and surgical safety are currently ongoing. Furthermore, a WHO collaborative centre has been developed to focus on providing surgery in low-resource settings.
WESTERN PACIFIC REGION

MONGOLIA

- Data is being collected and analysed in Mongolia through the WHO Collaborative Centre on Surgical Care, curricula are being developed for surgical and anaesthetic workforce enhancement and country-wide basic surgical education is being conducted.

NAURU, TUVALU, COOK ISLANDS, MICRONESIA, TONGA, KRIBATI, SAMOA, VANATU, SOLOMON ISLANDS, FIJI, TIMOR LESTE, PAPUA NEW GUINEA, NEW ZEALAND, AUSTRALIA, MYANMAR

- Surgeons and Anaesthetists in the Asia-Pacific region are strongly supportive of the WHA 68/15 Resolution
- The support has largely come from Professional Colleges led by the Royal Australasian College of Surgeons (RACS – representing surgeons in both Australia and New Zealand) who have advocated to their Governments, and RACS’ Pacific Island and East Asian Partners.
- Following the passing of WHA 68/15, which Australia supported and co-sponsored, the Royal Australasian College of Surgeons promoted the need to respond and provided the administrative infrastructure for the Bangkok Declaration (August to November 2015).
- In October 2015, the RACS organised its triennial international symposium around responding to the WHA 68/15 resolution and the recommendations of the Lancet Commission. This was attended by Pacific Island and ASEAN surgical college representatives and anaesthetists from our region (The Pacific, PNG, Timor Leste, ASEAN countries).
- It was agreed to collect the metrics for the region using whatever databases or methods were appropriate in each country and to report them at the RACS Annual Scientific Congress in May 2016. A collaborative working group was developed with representatives from each of the participating countries (15).
- All Pacific Island nations within the Pacific Islands Surgical Association have reported their data on the first four indicators. To date Myanmar and Malaysia have reported results for the 4 indicators from the ASEAN region and Cambodia has held a National Surgical Forum with WHO EESC, and is in the process of collecting and reporting their metrics. Myanmar has also held a National Surgical Forum in April.
- 15 countries provided reports on the first four Lancet Commission Global Surgery Indicators. Australia and New Zealand achieved the target for all four indicators. Five of 14 countries (36%) reached the LCoGS target of 2 hour Bellwether access for 80% of the population, whilst the others ranged from 20% (PNG and Solomon Islands) to over 65% (Myanmar and Fiji). Five of 14 (36%) countries reached the target 5,000 surgical procedures per 100,000 population, but seven perform less than 1600. For surgical, anaesthesia obstetric (SAO) workforce, only four countries have at least 20 per 100,000 population, whilst eight ranged from 0.9 (Timor Leste) – 8.2 (Kiribati). All countries were able to report their perioperative mortality rate (0.11 - 0.96%).
- The regional Pacific Islands Surgical Association (PISA) in Samoa (September 2016) gathered representatives from across the Pacific and presentations were made on the Lancet surgical metrics and an agreement to progress national surgical planning with the individual governments and their ministries of health. The PISA President is Lord Villiami Tangi, former deputy prime minister of Tonga and a surgeon (formerly of WHO).
- The two financial risk protection indicators have values for most countries in our region modelled and included in the World Bank development indicators for health (see Table 2). We are currently doing independent studies in a number of countries to verify these (as agreed at PISA 2016).
The 2015 Bangkok Global Surgery Declaration: A Call to the Global Health Community to promote Implementation of the World Health Assembly Resolution for Surgery and Anaesthesia Care

1) We recognize that up to 5 billion people - 70% of the world population - can't access safe emergency and essential surgical care and anaesthesia when they need it, and that access can be greatly improved by efforts to improve service capacity, safety, timeliness and affordability.

2) We recognize that surgical and anaesthesia care play a role in the treatment of conditions responsible for a third global mortality and disability; that surgical and anaesthesia care are cross-cutting services required for effective treatment of some patients in all Global Burden of Disease categories, with at least 25% of all hospital admissions requiring a surgical procedure.

3) We recognize that at present, more deaths and disability occur due to conditions requiring surgical and anaesthesia care than from HIV, tuberculosis, and malaria combined, and much can be learned from the important efforts and significant successes of disease-specific programs.

4) We understand that universal access to safe, affordable and timely surgical and anaesthesia care is an indivisible and indispensable part of any health system, and should be regarded as an intrinsic element of the right to medical care as prescribed in Article 25 of The Universal Declaration of Human Rights and included early in the expansion pathway to Universal Health Care.

5) We recognize that out of pocket expenses related to surgical and anaesthesia care cause many people to become impoverished, and that financial risk protection is an important consideration for surgical care and anaesthesia in many countries.

6) We affirm that surgical and anaesthesia care are cost-effective when compared with many other established common public health interventions.

7) We acknowledge that the associated costs of scaling up surgical and anaesthesia care between now and 2030 to ensure the world’s population access to safe, affordable surgical and anaesthesia care when needed are estimated at US$350 billion.

8) We also acknowledge that such an investment in scaling up surgical and anaesthesia care is a mere fraction of the projected US$12.3 trillion loss of global GDP (2% of GDP for LMICs) if such scale up is not achieved; equating to a significant return on this investment.

9) We emphasize the importance of identifying key health indicators and setting targets in demonstrating progress. We support adoption of the following indicators (advocated in the Lancet Commission on Global Surgery) and recommend their inclusion among the World Bank’s World Development Indicators.

i. 9.1) Capability and Timeliness: Proportion of a population that can access a facility within 2 hours capable of performing the three Bellwether procedures indicative of the ability to provide emergency and essential surgical and anaesthesia care: Caesarean Section, Emergency Laparotomy and appropriate management of a long bone open fracture.

ii. 9.2) Workforce: The number of trained surgery, anaesthesia and obstetric providers per 100,000 population; with an aim of achieving a target of 20 trained surgery, anaesthesia, and obstetric providers per 100,000 population by 2030.

iii. 9.3) Capacity: The number of procedures per 100,000 population conducted in an operating room under the care of a trained anaesthetist able to monitor oxygen saturation through pulse oximetry; with a goal of 5000 procedures per 100,000 by 2030.

iv. 9.4) Safety: The unadjusted perioperative mortality rate (POMR) among patients undergoing a procedure in an operating theatre for each country as a whole. This metric will apprise the number of deaths before discharge from hospital or within 30 days (whichever is sooner) related to surgical and anaesthesia care. (Individual
hospitals and services should undertake efforts to risk-adjust POMR for age, urgency, ASA class and procedure complexity prior to comparing results.)

v. 9.5) Affordability: The proportion of households protected against impoverishing and catastrophic expenditure from direct out of pocket payments for surgical and anaesthesia care.

10) We endorse the implementation of minimum standards for safe surgical and anaesthesia care including: trained surgical and anaesthesia providers; functional infrastructure, equipment, and supplies necessary to perform safe general anaesthesia, loco-regional anaesthesia, laparotomy, caesarean delivery, and open fracture fixation; functional equipment for materials decontamination and sterilization; access to a safe and adequate blood supply; access to essential antibiotics, pain medicines and anaesthetics; postoperative nursing care which includes a record of appropriate physiological observations; 24-hour surgical coverage with the ability to review and respond to a deteriorating patient; preoperative risk assessment and operation planning for elective surgery; and adapted quality improvement processes including audit and reporting of perioperative mortality rates.

Our Commitment

We will work to ensure that the public, policymakers, governments and funders are aware of the gross disparities in access to safe, affordable surgical and anaesthesia care globally and the correlations to poorer outcomes.

We will collaborate with professional, government and non-government organisations and alliances to promote the messages contained within this declaration, and seek to develop and/or promote evidence-based solutions to address identified needs and disparities.

When requested and appropriate, we will undertake support of MOHs in accurate collection and reporting of required and/or relevant data on surgical and anaesthesia care, as well as serving as a resource, when requested, on efforts to implement surgical planning in National Health Plans; the development of standards and guidelines; implementing and/or improving appropriate infrastructure; training, equipping and empowering the necessary workforce; and creation of reporting frameworks to provide monitoring and oversight.

We will promote transparent reporting of financial allocations and costs for surgery and anaesthesia care at the national and international levels.

We will support activities that promote global collaboration among all countries and regions to work towards implementation solutions for ensuring “universal access to safe, affordable surgical and anaesthesia care when needed;” that strengthen health systems through improving and integrating surgical and anaesthesia care; that enhance surgical capacity through education, training, and ensuring appropriate infrastructure; that promote quality through the setting of standards, guidelines and reporting frameworks to provide monitoring and oversight; and that promote sustainability through empowerment of the surgical and anaesthesia workforce and related industries.

There are 65 signatories to the Declaration including nearly all the ASEAN Colleges of Surgeons, Anaesthesia Professional Groups and the Pacific Islands Surgical Association.