Emergency and Essential Surgical Care at Primary Healthcare Level in Low and Middle income countries

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Background
Surgery is at the end of the spectrum of the classic curative medical model and has not been yet considered as part of the traditional public health model. Although disease treatable by surgery remains a ranking killer of the world’s poor, major financers of public health have shown that they do not regard surgical disease as a priority even though, for example, more than 500,000 women die each year in childbirth; these deaths are largely attributable to an absence of surgical services and other means of stopping post-partum hemorrhage [1]

Equally unattended, among the very poor, are motor-vehicle and farm accidents, peritonitis, Long-bone fractures, and even blindness [2][3][4]. In some settings, surveys reveal that surgical disease is among the top 15 causes of disability [5]. Up to 15 percent of world’s DALYs (Disability Adjusted Life Years) are from conditions that are very likely to require surgery. [6]. The poorest 35% of world’s population received only 3.5 % of all surgery undertaken. [7]

Introduction
Experts have identified four types of surgically significant interventions with a potential public health dimension: [8]

1) the provision of competent, initial surgical care to injury victims, not only to reduce preventable deaths but also to decrease the number of survivable injuries that result in personal dysfunction and impose a significant burden on families and communities
2) the handling of obstetrical complications (obstructed labour, hemorrhage)
3) the timely and competent surgical management of a variety of abdominal and extra-abdominal emergent and life-threatening conditions
4) the elective care of simple surgical conditions such as hernias, clubfoot, cataract, hydroceles, and otitis media.

This article describes the efforts of the author and other volunteers across the globe for improving emergency and essential surgical care at primary health are level. They believe training in procedural skills (such as emergency medicine, surgery and advanced life support) and ensuring adequately resourced health settings in first care level are vital to have success towards this issue. They are of the opinion that the WHO Program for Emergency and Essential Surgical Care (EEESC) [9] is a way forward to strengthening health systems, achieving universal health coverage, and ensuring the safety and efficacy of clinical procedures in Anesthesia, Surgery, Orthopedics, and Obstetrics.

The WHO Integrated Management for Emergency & Essential Surgical Care (IMEESC) e-learning toolkit [11] has been developed by the Clinical Procedures Unit in collaboration with the GIEESC program. This tool targets policy-makers, managers, and health-care providers (surgeons, anaesthetists, non-specialist doctors, health officers, nurses, and technicians). This tool contains WHO recommendations for minimum standards in emergency, surgery, trauma, obstetrics and anesthesia at first-referral level health-care facilities [13].

How to address this issue?
This issue requires advocacy for task shifting to policy makers. More often peripheral health facilities are equipped with emergency kits for primary (including surgical) care but human resources for health stationed there with an attitudinal frame to refer immediately rather than taking care of emergent requirement. If HRH strategies take care of enhancing competence of workers...
at grassroots to take care of trauma, or conditions requiring surgical attention, it can go a long way in reducing mortality and morbidity.

Objective

The objective of this article is to seek support from all over the world to put this issue on world health assembly’s agenda assuring that essential surgical care is included in National Health Plans around the World. The world health assembly would meet in May, 2014. Dr Emmanuel Makasa (counselor-Health, Permanent Mission to the UN, Republic of Zambia) has already made a statement supporting access to surgical care to treat and to prevent disability at the Executive Board meeting in January 2014.

We have 3 major goals to attain before the World Health Assembly:

Goal 1: Our colleague Dr Neema kaseje (an African pediatric surgeon working in Geneva) has started a campaign to achieve this goal in her own individual status. We have to get as much as possible signatures from all parts of the World. This petition can be accessed at the following link; https://www.change.org/petitions/world-health-assembly-2014-pass-a-resolution-for-access-to-essential-surgical-care-for-all

We have collected signatures from 37 countries of world from all WHO regions.

Goal 2: To engage with the World Health Assembly decision makers.

The main decision makers are:

(1) The World Health Organization (WHO) Executive Board chaired by Prof. Jane Halton (Australia), (2) Health Ministers of the 194 WHO Member States. We will have to access them to express our concern regarding the lack of access to essential surgical care and ask them to support the resolution. The Executive Board sets the agenda for the yearly World Health Assembly. Please visit the link below to know more about WHO EB; http://www.who.int/governance/eb/en/

The Executive Board (EB) is composed of the following member states: Albania, Andorra, Argentina, Australia, Azerbaijan, Belgium, Brazil, Cameroon, Chad, Croatia, Cuba, Democratic People’s Republic of Korea, Egypt, Iran, Japan, Lebanon, Lithuania, Malaysia, Maldives, Mexico, Myanmar, Namibia, Nigeria, Panama, Papua New Guinea, Qatar, Republic of Korea, Saudi Arabia, Senegal, Sierra Leone, South Africa, Suriname, Switzerland and Uzbekistan. Goal 3: Once this issue is on WHA’s agenda, we have to assure the support of at least 135 Member States.

Conclusion

Access to emergency and essential surgical care (EESC) helps save lives and alleviates sufferings of people. The role of surgery as a preventive strategy in public health needs to be stressed and we have to play our role more extensively to make emergency and essential surgical care a public health priority. This article highlights an extremely important problem that people in Pakistan and worldwide face every day. It is unavailability of EESC services at first care level which results not only in worsening of problems but often in avoidable death of victims. Women are affected with devastating consequences: more than 100,000 women die per year from complications of pregnancy, and over 2 million women live with debilitating obstetric fistulas. The irony of this situation is that Ministries of Health and Policy Makers in most of the countries of world have not charted out any Policy for Emergency and Essential Surgical Services at primary level.

The importance of inclusion of Emergency and Essential Surgical services at primary healthcare level has to be realized in all countries of world. EESC should be included in their health policies. There is need for increasing advocacy efforts (individual, civil and professional societies, NGOs, academia) for strengthening EESC in the national health plans. It is of immense importance that care providing physicians at first care level or district level must have right knowledge and skills of emergency and essential surgical care. The WHO’s GIEESC and IMEESC toolkit can help in all relevant activities to address this issue.

Nepal has this model where Family Medicine and Emergency care are combined together and with excellent results. With the belief of wholesome medical care and approach, the department of General Practice and Emergency comprises of both the General OPD services and emergency care services since 2009. [14]

References


Further to our recent feature on RMC Pakistan: RMC ANZ Alumni (RMCAANZ)

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RMC Alumni Pakistan

This is the largest Alumni of Rawalians working throughout Pakistan. Dr Saqib Abbasi is President of this Alumni

RMC ANZ Alumni (RMCAANZ)

The RMC graduates in ANZ region do not have a formal organization as yet, but the process of getting Rawalians together is in progress. They have contributed towards Multi Organ Failure Treatment center at Holy Family Hospital. The following Rawalians from ANZ region attended Islamabad Club Meeting in December, 2013.

Dr Majid Naeem Gondal, Dr Abrar Maqbool Qureshi, Dr Yousuf Haroon Ahmad, Dr Syed Raza Shabbir and Dr Arshad Hussain.

A group photo of Rawalians at Islamabad Club with Principal Professor Omar (6th from left) Dr Saqib Abbasi (5th from left in first row)