Access to Specialized Surgical Care

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The narrative of surgical disease in Africa is changing. Long neglected from health interventions to reduce the global burden of disease (GBD), it is today acknowledged that about 10-30% of GBD is attributable to surgery (1, 2). Injuries, malignancies, congenital anomalies and pregnancy complications enjoy high mentions as contributors to this burden (1). For DALYs (Disability Adjusted Life Years) lost due to surgical conditions, Africa has the highest rate of 38 per 1000 people (1).

But what exactly is the burden, complications and unmet needs in Africa? What resources are required to improve access to surgical care? Widening the definition of access to include timeliness, surgical capacity, safety and affordability, the lancet commission on Global surgery has estimates that > 95% of populations in Central, East and West Africa do not have access to surgery (3). While several other global players have supported efforts to improve access and safety of surgery in our part of the world, African practitioners need to document and tell the story of surgery in continent more in order to record progress (4, 5).

The Bellagio Essential Surgery Group (BESG) was formed to advocate for increased access and reduce the burden of surgery in Africa (4). The WHO Global initiative for emergency and essential surgical care purposed to reduce health/disability in injury and pregnancy related complications (6). The WHO essential trauma care project set reasonable, affordable minimum standards for care of the injured and defined the human and physical resources required (7).

A number of articles in this issue of the Annals of African surgery are consistent with the spirit in the initiatives above. The Bellagio group recommended (i) strengthening surgical services at district hospitals (i) improving system of delivery of trauma care (iii) expanding and suppling quality of health workers with surgical skills and (iv) building evidence to inform interventions to improve access for surgery. The paper from Tenwek in this issue depicts how a peripheral unit can improve to provide a wide range of surgical services (8) for the community. Availability of staff, basic infrastructure, essential supplies, working conditions and costing dynamics have likely allowed provision of critical care services several kilometers away from Kenya's capital city. It is difficult to imagine that the facility now enjoys the confidence of the surrounding community and a model for other regional hospitals to emulate.

Trauma will account for about 20% of global burden of disease by 2020 (9). The paper by Njihia et al reminds the readers about the sub-optimal status of prehospital trauma care in the region (10). Metrics including mortality rates and lengths of hospital stay are important to trend performance with regards to care at the hospital. The numbers the authors present suggest room for improvement. As they argue, embracing trauma registries and systems, shown to work in advanced economies, will be part of the answer to the prayer in the second recommendation by the Bellagio group (4).

Expanding the supply and quality of health workers with surgical skills has taken many forms in the continent. While training non-physicians and non-surgeon physicians to operate may work, they must be trained and supervised well. Ojuka in this issue argues for reassessment of surgical training with emphasis on the non-technical skills and innovation (11). Whatever shape our efforts to expand the supply of "surgeons" will take, the training curriculum must spell out the learning outcomes and evaluation metrics. While the need for trauma and emergency surgery

is acknowledged, the papers from the Aga Khan hospitals in Nairobi and Mombasa are pitching for elective operations which may demand sophisticated surgical approaches (12, 13). Local training programs should incorporate technological advances including laparoscopy to cater for the growing number of patient who may demand them.

The last tenet by the Bellagio group recommended initiatives to build evidence for interventions in surgical access. This is about information. Good data can be effective tool for informing policy. In line with this, the argument by Ojuka that competencies beyond knowledge and technical skills matter (11), graduating surgeons should be well versed with policy, advocacy and research skills to be able to argue for "surgery" at all levels of decision making in our communities.

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