



AN INTRODUCTORY GUIDE TO

Human Rights in Global Surgery

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Human Rights in Global Surgery – the concepts

Human-rights based approach to Global Surgery

All humans are born free and equal, and have the same human rights. These rights are described in the **Universal Declaration of Human Rights**, and further elaborated upon in a number of human rights treaties¹, including the 12th article of the **International Covenant on Economic, Social and Cultural Rights**, which are also legally binding for countries that ratify them. One of the universal and fundamental rights is the right to the highest attainable standard of health, in which surgical care is an integral component². Every state in the world has ratified at least one international human rights treaty that recognises the right to health³. Furthermore, domestic constitutions play an important role in the right to health, which is recognised in at least 115 national constitutions⁴.

In order for the right to health to be realised, services, goods and facilities must be “**AAAQ**”:

- **Available**, meaning that they have to exist in a sufficient quantity within the state;
- **Accessible**, such as physically reachable, financially affordable, understandable and based on non-discrimination;
- **Acceptable**, with a gender-sensitive and culturally appropriate approach and respecting medical ethics,
- Of good **Quality**, both in terms of equipment and resources as well as education for health personnel.

¹ Amongst others: The International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (e) (iv); The International Covenant on Economic, Social and Cultural Rights: art. 12; The Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (f), 12 and 14 (2) (b); The Convention on the Rights of the Child: art. 24; The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (e) and 45 (c); The Convention on the Rights of Persons with Disabilities: art. 25.

² <https://www.hhrjournal.org/2013/08/essential-surgery-integral-to-the-right-to-health/>

³ http://www.who.int/hhr/activities/Right_to_Health_factsheet31.pdf

⁴ http://www.who.int/hhr/activities/Right_to_Health_factsheet31.pdf



Governments are responsible to **respect, protect** and **fulfil** human rights⁵, and thus human rights may be a foundation upon which policies, priorities and interventions are shaped. However, if the principles and standards are not taken into consideration through the programming process, interventions implemented albeit with good intentions might not have the sustainable and impactful outcomes desired. The WHO states that the human rights approach “aims to support better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices (de jure and de facto) and unjust power relations which are often at the heart of development problems”⁶.

The rights based approach is characterised by a number of elements and factors, distinguishing it from other approaches such as the charity based or needs based approach⁷. The rights based approach focuses on the outcome, such as achieving equal access to healthcare, but at the same time, the process of how to reach this is equally important. A rights based approach...

- Should have a **participatory process**. Not only should people be consulted about their needs in decisions that affect them, they should receive relevant and understandable information, and have the opportunity to organise themselves, in order to promote local ownership.
- Sees **rights holders** and **duty bearers**, recognising the inalienable rights of every person, and the responsibility of duty bearers to fulfill these. Thus, interventions should aim to develop the capacity of duty bearers, and empower right holders. The provision of relevant services is an obligation of the duty bearers, and not an act of altruism.
- Should be based on **equity and non-discrimination**, in both policy and practice. One such example might be through gender mainstreaming. The interventions should also be sensitive to the vulnerability of specific groups, such as children, women, persons with disabilities, ethnic, religious or linguistic minorities, displaced persons, etcetera.
- Addresses the **root causes** of injustices and problems, and attempts to target them on a **system and policy level**

⁵ <https://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx>

⁶ http://www.who.int/hhr/news/hrba_to_health2.pdf

⁷ <https://www.waterlex.org/waterlex-toolkit/what-is-a-human-rights-based-approach-and-how-is-it-different-from-other-development-practices/>

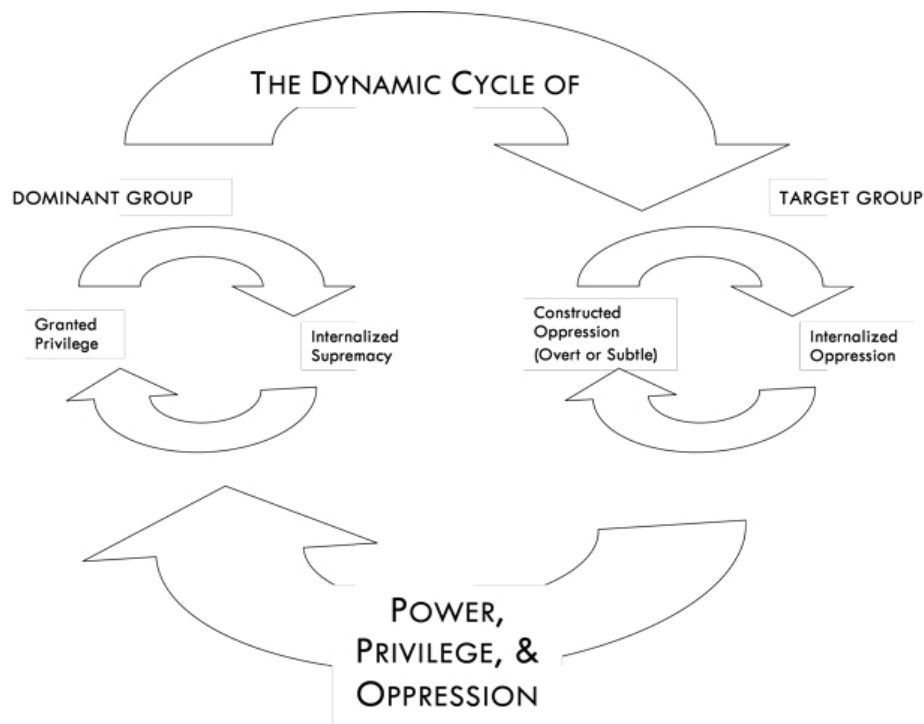


- Has a **holistic view**, where not only the core problem, such as lack of access to healthcare, is address, but also other influencing factors such as social determinants of health is taken into consideration, recognising that health is interlinked with other human rights.
- Works according to the principle of **accountability**, taking responsibility for the consequences of any intervention, research or action. Not only the direct impact on the individual is taking into consideration, but also effects on the society. An organisation should be able to represent and answer to the people that they seek to assist.

Keeping in mind the role that global surgery plays in the efforts of realising the human right of reaching the highest attainable standard of health for everyone, global surgery should be a priority from a human rights perspective. The human rights based approach is a conceptual framework useful to avoid the perpetuation current inequalities or creation of harm for vulnerable populations, and to ensure that human rights are respected and protected throughout the process.

Power and privilege

Understanding the basic concepts related to discrimination of certain societal groups (norms, privilege, oppression, intersectionality, alliance, etc.) is essential for society to build a safer and inclusive space for everyone, including access to safe surgery. This understanding helps to encourage a holistic needs assessment when promoting Global Surgery. For these reasons it is a priority to educate healthcare providers and communities in having an intersectional perspective around the involvement of power, privilege and oppression issues in the imbalance amongst different minorities or communities regarding access to safe surgery worldwide.



Source: <https://www.autostraddle.com/rebel-girls-mapping-power-privilege-and-oppression-254794/>

- **Norm:** Norms are a fundamental concept in the social sciences. They are most commonly defined as rules or expectations that are socially enforced. Norms may be prescriptive (encouraging positive behavior; for example, “be honest”) or proscriptive (discouraging negative behavior; for example, “do not cheat”). The term is also sometimes used to refer to patterns of behavior and internalized values. - *Oxford bibliographies*
- **Privilege:** a special right, advantage, or immunity granted or available only to a particular person or group. - *Oxford dictionary*
- **Rights:** Rights are legal, social, or ethical principles of freedom or entitlement; that is, rights are the fundamental normative rules about what is allowed of people or owed to people, according to some legal system, social convention, or ethical theory - *Stanford encyclopedia of philosophy*



- **Oppression:** a situation in which people are governed in an unfair and cruel way and prevented from having opportunities and freedom - *Cambridge dictionary*
- **Intersectionality** is a concept often used in critical theories to describe the ways in which oppressive institutions (racism, sexism, homophobia, transphobia, ableism, xenophobia, classism, etc.) are interconnected and cannot be examined separately from one another. The concept first came from legal scholar Kimberlé Crenshaw in 1989 and is largely used in critical theories, when discussing systematic oppression. - *Feminist Wiki*
- **Alliance:** An ally is a member of the “majority” group who works to end oppression in [their] personal life through support of and as an advocate for the oppressed population. - *Intro to Power, Privilege, Oppression, and Allyship from NASCO*
- **Stereotype:** a set idea that people have about what someone, a particular community, or something is like, especially an idea that is wrong - *Cambridge dictionary*
- **Discrimination:** treating a person or particular group of people differently, especially in a worse way from the way in which you treat other people, because of their skin colour, sex, sexuality, etc - *Cambridge dictionary*
 - Types of discrimination: ^{8,9}
 - Interpersonal (Eg: A shopkeeper saying that persons of a certain nationality or background are not welcome into their shop)
 - Institutional (Eg: Police officers engaging in ethnic profiling or acting with ethnic bias)
 - Structural (Eg: Racism, sexism – the discrimination exists in all layers of society, both interpersonal and institutional, and occur

⁸ <http://www.g21.com.au/sites/default/files/dmdocuments/DISCRIMINATION.pdf>

⁹ <http://www.pinkfamilies.com/types-of-discrimination-do-you-know-the-difference/>



not only once or twice but consistently through time and space)

- Indirect (Eg: Obligatory uniforms with short)
- Internalised (Eg: Ethnic minority despising their own appearance)

Ethics in Global Surgery

Although it may be a word we use everyday, it can be hard to exactly define what constitutes 'ethics'. One simple definition is that ethics are a system of moral principles that define what is good for individuals and society¹⁰. Different branches of ethical thought focus on different things. In medicine, and in global surgery, the cornerstones of ethics are autonomy, beneficence, non-maleficence, and justice, as well as confidentiality:

- **Autonomy** is the right of a competent patient to make decisions about their own medical care
- **Beneficence** is the duty of the doctor to act in the patient's best interests
- **Non-maleficence** is the corresponding duty to do no harm
- **Confidentiality** corresponds to the safeguarding of the information shared privately in the doctor-patient relationship, unless consent is given by the patient to disclose the information.
- **Justice** in medicine is primarily seen as revolving around the fair and equitable distribution of healthcare resources.

As global surgery is an emerging field, we see this time as an exciting opportunity to position ethical thinking at the forefront of this movement. Surgery in low-resource settings can often be challenging, and in many humanitarian situations in the past decades it is common for doctors, particularly those from high income countries (HICs), to see 'any care' as better than 'no care'.

¹⁰ http://www.bbc.co.uk/ethics/introduction/intro_1.shtml



However at InciSioN, we know that this not necessarily the case, and that rigorous application of these principles in any global surgery project is necessary to ensure that the care given to patients is ethical, and safe no matter who is being treated or where they are.

Autonomy

Two major issues arise when considering the autonomy of patients in a global surgery context.

Firstly, true autonomy requires patients to have effective access to a range of options (for example, the option to have one kind of surgery or another, a medical treatment, or to have no treatment at all). Unfortunately, due to the inequitable distribution of medical expertise and resources, surgical patients in low-resource settings often have limited or no autonomy simply because their options are limited by factors external to their control, whether it be through lack of equipment, lack of staff with relevant training in the specialty, or lack of a safe location to conduct surgery. When provided appropriately, global surgery programs extend these options and (in theory at least) enhance a patient's ability to express their autonomy. However, it is important to recognise that global surgery programs can only recognise and enhance patient autonomy if the surgical care that is provided is of an adequate standard. Poor quality surgical care reduces patient autonomy both in the immediate term, by misleading the patient as to what their options may be, as well as in the long-term, by potentially causing them long-term health issues following improper surgery.

The second key issue that arises when considering patient autonomy in global surgery revolves around consent. Many global surgery projects are based on the idea of medical and health staff, typically from HICs, travelling to LMICs for a limited period of time to provide surgical care that is otherwise not available to the local population. This means that the doctors providing care may not be fluent, or even able to converse at a basic level, with patients. There may also be differing cultural expectations about the nature of the health issues, as well as the surgery and its likely outcomes¹¹. Both of these issues can fundamentally impact the doctor's ability to communicate effectively with the patient, which means that as

¹¹ <http://www.mc.vanderbilt.edu/documents/1anesthesiology/files/Ethics%20in%20Global%20Surgery.pdf>, p1577-9



a result the patient's ability to give valid consent - a fundamental aspect of patient autonomy
- may be reduced, as they cannot be considered fully 'informed' about all the relevant issues.

Beneficence

- "Any care" is NOT necessarily better than "no care"
- Surgical care for necessary procedures (eg Bellwether etc) is an efficient and effective use of resources when done appropriately and safely
- Eg beneficence towards patient themselves (curing their surgical problem) and beneficence towards their community/social system (not wasting their resources and allowing patients to recover from their disease/health issue more rapidly and return to contributing to society where possible)

Non-maleficence

- Outcomes in LMICs should be equivalent to HICs
- Overseas/international surgeons (most commonly from HICs) should not perform procedures that they are not fully experienced in on vulnerable patients in LMICs: "something is not always better than nothing"
- Avoiding eg voluntourism and poor surgery done by surgeons from HICs including lack of follow up - this needs to take into account the fact that HIC surgeons may not be familiar with the best way to treat advanced surgical pathologies that do not occur in their home countries (example of complex obstetric vesico-vaginal fistulae management in LMICs which rarely occur in HICs) ¹¹
- Data on outcomes should also be equivalent to HICs - instead of relying on the "body count mentality" (Dupuis)¹¹
- Ensuring provision of culturally appropriate healthcare BUT managing tensions between what may be cultural practices and what volunteer providers may perceive as unethical (eg FGM/some traditional healing practices)¹¹

Confidentiality

- Ensuring that the patient is respected regarding information provided BUT being ordered by the court to hand over the documents about the patient.



- Acknowledging that the patient's behaviour is a threat to themselves and everyone around the patient OVER losing the patient's trust in the doctor-patient relationship.

Justice

- UHC in surgery is a utilitarian approach to justice: greatest good for the greatest number of people
- Human rights approach: recognition that all human lives have equal value and that provision of surgical care should therefore be equal
- Recognition that lack of resources/experienced personnel is an injustice as well as catastrophic effect of OPPs in many cases
- Triage and prioritization of patients

Recommendations for groups engaging in global surgery to ensure they are engaging in ethical practices:

- Prepare:
 - Know the skills and experience level of your surgeons
 - Know the resources that will be available
 - Be clear about what you can and can't provide to the patient population
 - Clarify expectations around consent
 - Organise high levels interpreter availability in pre-operative assessments
 - Clarify what the outcome measures will be: how will you know if your project has been successful? Immediate term/medium/long-term?

Other Resources:

<http://bioethics.wfu.edu/wp-content/uploads/2015/09/Topic-6-Global-Surgery-and-Global-Health-Metrics.pdf>

Wall AE (2012) Ethics for international medicine: a practical guide for aid workers in developing countries. University Press of New England, Hanover
<https://collections.dartmouth.edu/published-derivatives/wall-ethics-2012/pdf/wall-ethics-2012.pdf>



Focus areas of Human Rights in Global Surgery

A. Ensuring access to safe surgery to all - vulnerable populations

LGBTQIA+ community

The LGBTQIA+ community has faced discrimination in accessing healthcare services primarily based on their sexual orientation. For a long time, access to healthcare for the LGBTQIA+ community has been difficult due to the stigma they face. Historically, this happened because any deviation from heterosexuality was seen as a disease, or even a crime in some societies. The high incidence of HIV/AIDS cases in the LGBTQIA+ community did not help to deconstruct the sexual orientation stigma. Only recently, have we seen widespread advances regarding treatment of LGBTQIA+ community, with the recognition of their rights (even though there is still a long way to go). There is a need for increased competency in healthcare relating to the LGBTQIA+ community as well as an increased awareness amongst training physicians.^{12,13}

Some proposed policies of action to Member States in the United Nations Development Program (2013), as well as “WPATH Standards of Care”¹⁴ give more information on how to best treat Transsexual, Transgender, and Gender Nonconforming People:

“Health workers around the world - even those working in areas with limited resources and training opportunities - can apply many of the basic principles underlying Standards Of Care. These principles include: **(a)** respecting persons with gender variability (differences in gender identity or expression should not be pathologized); **(b)** providing care (or referral to a specialist) that affirms the gender identity of the person using the service, and reduces their discomfort of gender dysphoria, when present; **(c)** to acquire knowledge about the health needs of transgender people and with gender variability, including the benefits and risks of treatment options for gender dysphoria; **(d)** combine the treatment approach with the specific needs of the service users, especially their objectives for the expression of gender and the need to

¹² Jann JT, Edmiston EK, Ehrenfeld JM. Important Considerations for Addressing LGBT Health Care Competency. *American Journal of Public Health*. 2015;105(11):e8. doi:10.2105/AJPH.2015.302864.

¹³ Cannon SM, Shukla V, Vanderbilt AA. Addressing the healthcare needs of older Lesbian, Gay, Bisexual, and Transgender patients in medical school curricula: a call to action. *Medical Education Online*. 2017;22(1):1320933. doi:10.1080/10872981.2017.1320933.

¹⁴ World Professional Association for Transgender Health. <https://www.wpath.org/publications/soc>



alleviate gender dysphoria; **e)** facilitate access to appropriate services; **f)** require the informed consent of the users of the service before providing treatment; **g)** provide continuity of service; **h)** be prepared to support and defend the users of the service within their families and communities (schools, workplaces and other environments). "

Trans people and Depathologization

The trans identity is not something intrinsically of the medical sphere, being a set of characteristics of an individual. However, there was a need for the medical community to assign a denomination to Trans persons. Some trans and non-binary people have gender dysphoria, a condition (not a disease, disorder or anomalous situation) that refers to the discomfort or uneasiness caused by the gap between a person's gender identity and the gender assigned to them (and the associated gender role and / or primary and secondary sexual characteristics) and which, because of this condition, is often associated with high levels of suicidal ideation and the presence of depressive and anxious psychopathology. ¹⁴

Trans and non-binary persons who desire so should have free, ethical and quality access to interdisciplinary therapies or treatments in order to minimize their discomfort, in accordance with the international good practice directives of various associations created by and for persons trans, such as the World Professional Association for Transgender Health (WPATH). Health professionals whose job it is to provide these services must have adequate, up-to-date and certified training in order to provide for the well-being of the binary or non-binary persons involved, who should be involved in their own treatment (as also referred to in the letter of rights and patient duties) in order to communicate and self-determine their unique needs free from pathologization and discrimination.

According to the United Nations Development Program 2013, "Skills in work with transgender people include being sensitive to the needs of those who do not have a 'typically' male or female body or those whose identity documents do not conform with their gender identity or gender identity. "

According to the Yogyakarta Principles, "The self-defined gender identity of each person is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom." According to them, "States must ensure that all persons are informed and empowered to make their own decisions regarding their care, respecting the basis of genuine informed consent, free of discrimination based on sexual orientation and / or gender identity.



Refugees and undocumented persons

Refugees and undocumented persons have long been discriminated against, even though every single person has the right to health as a human right.

Refugees face mainly issues regarding out-of-pocket costs for essential health services, making cost a major factor in care-seeking decisions and locations. Health financing policies need to account for the refugee status and their access to the health system. Focus on availability and quality of essential services is needed to protect both refugee and host populations¹⁵.

On the other hand, undocumented persons are less likely to be placed into rehabilitation following their hospitalization after being provided trauma care, which leads to worse outcomes¹⁶. Moreover, one in five undocumented recipients who reached 21 years of age submitted to kidney transplantation during childhood had lost their graft, mainly because they were unable to pay for immunosuppressive medications due to the limited state-funded insurance¹⁷.

Access to safe surgery for Women

Throughout the world, women globally face significant barriers in accessing appropriate surgical care.

Maternal care

This access is limited especially in terms of maternal health, particularly the provision of fistula care for both obstetric and traumatic fistulae. Obstetric fistula is an abnormal opening between a woman's genital tract and her urinary tract or rectum. The development of obstetric fistula is directly linked to one of the major causes of maternal mortality: obstructed labour. Particularly, obstetric fistula affects over 2 million women¹⁸ in Africa and Asia. This condition is preventable and treatable (90-95% of fistulae can be closed surgically), however

¹⁵ Tappis, H., Lyles, E., Burton, A. et al. Matern Child Health J (2017) 21: 1798. <https://doi.org/10.1007/s10995-017-2315-y>

¹⁶ Wyrick JM, Kalosza BA, Coritsidis GN. Trauma care in a multiethnic population: effects of being undocumented. J Surg Res. 2017 Jun 15;214:145-153. doi: 10.1016/j.jss.2017.02.006.

¹⁷ McEnhill ME, Brennan JL, Winnicki E et al. Effect of Immigration Status on Outcomes in Pediatric Kidney Transplant Recipients. Am J Transplant. 2016 Jun;16(6):1827-33. doi: 10.1111/ajt.13683.

¹⁸ WHO 10 facts about obstetric fistula. http://www.who.int/features/factfiles/obstetric_fistula/en/



lack of access to safe surgery increases the number of affected women by 50 000 to 100 000 worldwide per year.

Another example of lack of appropriate surgical treatment and obstetric violence is the high rates of cesarean section. The recommendation from the international community and the WHO¹⁹ regarding cesarean procedures is to have an idea rate of 10- 15%, as it is conceived as merely a complementary procedure to complicated births through vaginal delivery. However, Obstetric violence is a Human Rights violation, as WHO ²⁰ expresses in its statement “The prevention and elimination of disrespect and abuse during facility-based childbirth” declaring that “Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination”.

For aforementioned reasons, it is key to support humanise birth and empower women during pregnancy. Humanized birth is putting the woman giving birth in the center taking into account cultural, social and ethnicity aspects, thus it is not limited to technical skills and the birth.

Child marriage

Another fact that leads to obstetric violence and high risk pregnancy is child marriage. Apart from the abuse of power, Human Rights violation and systemic violence a child marriage means, maternal mortality is 28 percent higher among females 15 to 19 than 20 to 24 ²¹. Furthermore, early pregnancy among girls often leads to medical complications, such as obstetric fistula and hemorrhaging.

Access to safe abortion

The World Health Organization (WHO) defines unsafe abortion as a “procedure for terminating an unintended pregnancy carried out by either persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both” ²².

¹⁹ WHO Statement on Caesarean Section Rates. World Health Organization; 2015 [cited 6 September 2018]. Available from: http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1

²⁰ World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth, 2014. Available at: http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=

²¹ World Health Organization (WHO), 2008, Adolescent Pregnancy Blanc, A., Winfrey, W., & Ross, J., 2013, New Findings for Maternal Mortality Age Patterns: Aggregated Results for 38 Countries

²² World Health Organisation. 2012. Safe Abortion: technical and policy guidance for health systems. 2nd ed. www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/



According to this organization: “Over the past two decades, the health evidence, technologies and human rights rationale for providing safe, comprehensive abortion care have evolved greatly. Despite these advances, an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47 000 women and disabilities for an additional 5 million women. Almost every one of these deaths and disabilities could have been prevented through sexuality education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion. In nearly all developed countries, safe abortions are legally available upon request or under broad social and economic grounds, and services are generally easily accessible and available. In countries where induced abortion is legally highly restricted and/or unavailable, safe abortion has frequently become the privilege of the rich, while poor women have little choice but to resort to unsafe providers, causing deaths and morbidities that become the social and financial responsibility of the public health system. “

Access to safe abortion is also a priority according to the Agenda for Sustainable Development for 2030: “Target 3.1: Reduce the global maternal mortality ratio to less than 70 per 100,000 births (unsafe abortion is a leading cause of maternal death worldwide).” ²³

For the aforementioned reasons, as global surgery advocates we need to ensure access to safe abortion is a priority in the Global Health and Global Surgery agenda.

FGM

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, UNICEF, UNFPA, 1997). The WHO/UNICEF/UNFPA Joint Statement classified female genital mutilation into four types: ²⁴

- Type I or clitoridectomy: partial or total removal of the clitoris and/or the prepuce.
- Type II or excision: partial or total removal of the clitoris plus the labia minora, with or without excision of the labia majora.
- Type III or infibulation: narrowing of the vaginal opening through the creation of a covering seal by cutting and appositioning the labia minora and/or labia majora,

²³ United Nations. 2015. Transforming our world: the 2030 Agenda for Sustainable Development. <https://sustainabledevelopment.un.org/post2015/transformingourworld>

²⁴ http://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf;jsessionid=F8C2D1A6B918F0F5ED56B300CDD40298?sequence=1



sometimes through stitching, with or without excision of the clitoris. Reinfibulation is also included under this definition.

- Type IV or unclassified: includes all other harmful procedures done to the female genitalia for non-medical purposes. Some examples are: cauterizing, piercing, scraping, pricking or incising.

According to data collected by UNICEF, at least 200 million girls and women have undergone Female Genital Mutilation mainly, but not only, in 30 countries of the African, the Asia-Pacific and the Eastern Mediterranean Region.²⁵ FGM is traditionally performed by elderly people from the community. However, in recent years there has been a medicalisation of this practice, which unfortunately legitimates this practice.

In multiple international conventions and conferences, such as the United Nations Convention on the Rights of the Child and the Fourth World Conference on Women, every form of FGM is recognised as a violation of the human rights of girls, women and children. As Global Surgery advocates it is essential to fight against the medicalisation of this practice to avoid legitimisation, as well as to familiarise ourselves with the *WHO guidelines on the management of health complications from female genital mutilation*, released in 2016.²⁶

Access to safe surgery for children

An estimated one-third of the global burden of disease are related to surgery, and accessibility to surgery is limited in Sub-saharan countries. The most affected are children, who constitute 50% of Africa's population. Sub-Saharan Africa has the highest under-five mortality rates in the world.²⁷ The estimated burden in children <15 years was 115.3 million to 131.8 million and had similar spatial distribution to the all-age pattern, which reflects 87.5% of the total burden.²⁸

²⁵ Female Genital Mutilation/Cutting: A Global Concern. UNICEF. 2016. Available at: https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

²⁶ <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/>

²⁷ Peer S, Vial I, Numanoglu A, Fagan JJ. What is the availability of services for paediatric ENT surgery and paediatric surgery in Africa? *Eur Ann Otorhinolaryngol Head Neck Dis*. 2018 Aug 21. pii: S1879-7296(18)30105-4.

²⁸ Juran S, Broer PN, Klug SJ et al. Geospatial mapping of access to timely essential surgery in sub-Saharan Africa. *BMJ Glob Health*. 2018 Aug 16;3(4):e000875



Recent health policy efforts have sought to promote universal health coverage (UHC) as a means of providing affordable access to health services to populations. However, insurance schemes are heterogeneous, and most schemes have been proven to be ineffective.²⁹ Another challenge might be having permanent surgical workforce for these procedures. One way might entail providing surgical training and capacitate locals, thus increasing the health workforce.

People with Disabilities

People with disabilities have faced constraints accessing healthcare services, and are often discriminated against due to their condition. A study conducted in England showed that adults with physical disability experience difficulties in physically accessing the primary care buildings. Healthcare needs are not met due to difficulty getting to the physician's premises. Increasing age further worsens these problems³⁰. Access to surgery for blind people was also affected by the lack of community-based support, which could be a facilitating factor to overcome the barriers to eye surgery³¹.

Older People

Adults aged sixty-five and over account for a large fraction of all surgeries performed in the developed regions each year. Many surgeries which were previously contraindicated in old age are now being considered due to the increasing life expectancy. Other operative risk factors such as the presence or absence of chronic diseases are in the future supplanting age as an explanation for the high operative mortality rates seen among older patients. Perceptions regarding this age barrier will shift in the coming years³².

²⁹ El-Sayed AM, Vail D, Kruk ME Ineffective insurance in lower and middle income countries is an obstacle to universal health coverage. *J Glob Health*. 2018 Dec;8(2):020402.

³⁰ Popplewell NTA, Rechel BPD, Abel GA. How do adults with physical disability experience primary care? A nationwide cross-sectional survey of access among patients in England. *BMJ Open*. 2014;4(8):e004714. doi:10.1136/bmjopen-2013-004714.

³¹ Amritanand A, Jasper S, Paul P, Kuriakose T. Facilitating factors in overcoming barriers to cataract surgical services among the bilaterally cataract blind in Southern India: A cross-sectional study. *Indian Journal of Ophthalmology*. 2018;66(7):963-968. doi:10.4103/ijo.IJO_216_18.

³² Neuman MD, Bosk CL. The redefinition of aging in American surgery. *Milbank Q*. 2013 Jun;91(2):288-315. doi: 10.1111/milq.12014.



B. Surgery in Primary Healthcare and Rural Health

2 billion people have no access to emergency or surgical care. EESC (Emergency & Essential Surgical Care WHO)³³ has long been recognised as an integral part of Primary Health Care (PHC), providing technical support to countries in scaling up frontline health providers in life-saving and disability-preventive surgical care which requires no expensive technology or sophisticated facilities.

Health in rural areas, how health practitioners there work and the nature of practice, is immensely different from the urban counterpart of a country.³⁴ These differences are due to geography, demography, rural culture, rural morbidity, rural mortality patterns, resource limitations, and workforce shortages.

Primary healthcare has long been recognized as a critical factor in improving rural healthcare and thus serves as a great area to incorporate much needed surgical services to rural populations. Surgical care is needed, just as primary health care is needed at all stages of life, from birth, through the reproductive years, and to the grave.³⁵

The necessity for surgical services is increasingly evident in rural areas, with one of the most needed surgical specialties being obstetrics.³⁶ A study has found that there is economical benefit in including and providing essential surgical skills, such as obstetric services, in PHC.³⁷ InciSioN developed a Policy Document about [surgery in Rural Health and PHC](#).

³³ WHO - Disasters and emergencies Brief flyer - http://www.who.int/surgery/publications/Flyer2009_4page.pdf

³⁴ Scheil-Adlung X. Inequity in Health Protection: Rural/Urban Divide. Social Protection, ILO 2014. Available at: <http://www.social-protection.org/gimi/gess/ShowTheme.action?lang=EN&id=4066>. Accessed on June 1st, 2018

³⁵ Watters DA. Making the case for global surgery. The Lancet Volume 386, No. 10000, p1232, 26 September 2015. [https://doi.org/10.1016/S0140-6736\(15\)00269-X](https://doi.org/10.1016/S0140-6736(15)00269-X)

³⁶ Hung P, Kozhimannil K, Henning-Smith C et al. Closure of Hospital Obstetric Services Disproportionately Affects Less-Populated Rural Counties. Policy Brief April 2017. University of Minnesota Rural Health Research Center. Available at: http://rhrc.umn.edu/wp-content/files_mf/1491501904UMRHRCOBclosuresPolicyBrief.pdf, accessed on June 22nd, 2018.

³⁷ Avery Jr DM, Hooper DE, McDonald Jr JT et al. The Economic Impact of Rural Family Physicians Practicing Obstetrics. J Am Board Fam Med. September-October 2014 vol. 27no. 5 602-610



C. Human Resources

Five billion people do not currently have access to safe, timely and affordable surgical care and anaesthesia worldwide. In low- and middle-income countries (LMIC), 9 out of 10 people cannot access even the most basic surgical services.³⁸

One of the solutions towards ensuring human rights in global surgery is by bridging the human resources gap so as to achieve universal access to safe, timely and affordable surgery. This can be done through:

1. *Task shifting & Task sharing:*

Task shifting is the process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. Task sharing is the involvement of non-specialists (non-physician clinicians or non-specialist physicians) in performing tasks originally reserved for surgeons and anaesthesiologists.

While both are highly relied upon in LMICs and supported by International Organizations³⁹ such as Médecins Sans Frontières, the International Committee of the Red Cross (ICRC) among others, there is some data that highlights the lack of sustainability and the increased unknown risk of patient morbidity and mortality if this is heavily relied on.

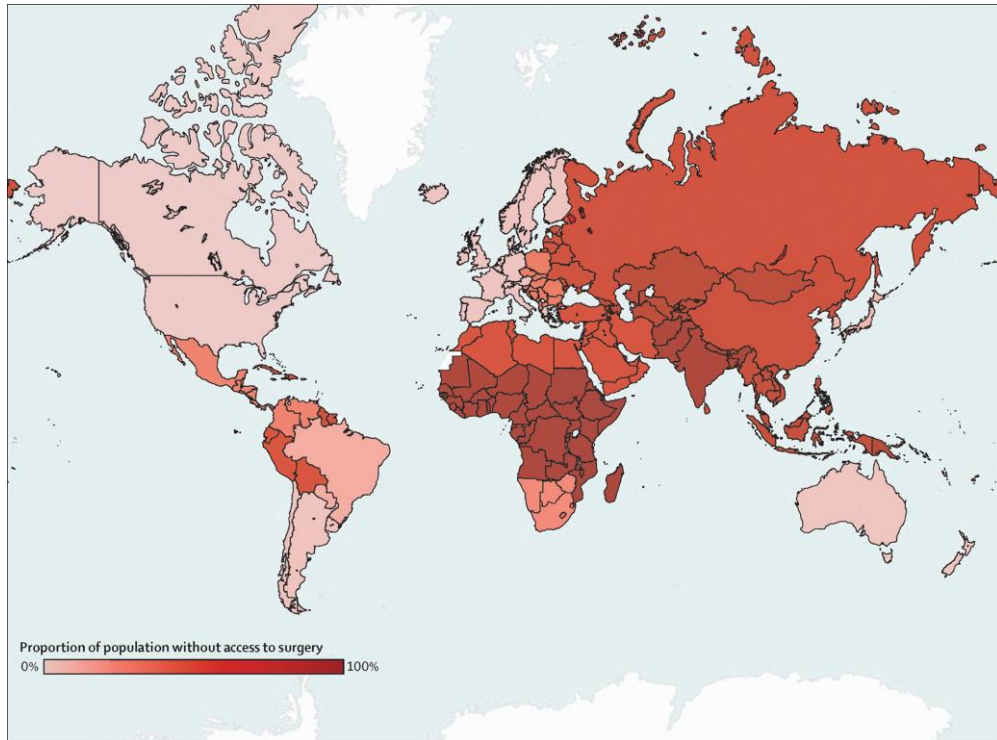
2. *Patient-doctor ratio:*

Despite harbouring a third of the world's population, Africa and Southeast Asia are home to only 12% of the global surgical specialists (surgeons, anaesthesiologists, and obstetricians). Furthermore, the surgical specialist density in these countries stands at only 0.7 per 100 000 yet a minimum density of 20 per 100 000 is considered necessary to tackle the burden of surgical disease.⁴⁰

³⁸ Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. Crossref DOI link: [https://doi.org/10.1016/S0140-6736\(15\)60160-X](https://doi.org/10.1016/S0140-6736(15)60160-X)

³⁹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2677109/>

⁴⁰ Holmer H, Shrimmer MG, Riesel JN, Meara JG, Hagander L. Towards closing the gap of the global surgeon, anaesthesiologist, and obstetrician workforce: thresholds and projections towards 2030.



Of point to note, based on UN World Population Prospects to 2030, it is estimated that an additional 2.28 million specialist surgical, anaesthetic, and obstetric providers are needed worldwide to reach a maximum density of 40 per 100 000 by 2030, even without accounting for migration. To meet this target, the present global surgical workforce would need to double, at a minimum, in just 15 years. ⁴¹

3. Access to safe surgery:

Surgical and anaesthesia care are fundamental for health-care delivery for any country at any level of development. ⁴² Broad scale-up of quality surgical services will prevent deaths, limit disability, palliate suffering, promote economic growth, and help achieve maximum gains in health, welfare, and development for all. ⁴¹

⁴¹ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)60160-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60160-X/fulltext)

⁴² WHA68.15. Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage, 2015. http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_R15-en.pdf?ua=1



Of an estimated 312.9 million surgical procedures undertaken worldwide in 2012, only 6.3% were done in countries comprising the poorest 37.3% of the world's population.⁴³

	Population size of region (millions)	Estimated total need of region		Estimated unmet need* of region	
		Surgical cases (millions)	Cases per 100 000 population	Surgical cases	Cases per 100 000 population
Andean Latin America	53	2.0	3773	0	0
Australasia	26	1.2	4669	0	0
Caribbean	44	2.2	5080	131 050	301
Central Asia	80	3.5	4339	910 432	1136
Central Europe	119	6.6	5515	678 358	570
Central Latin America	231	7.8	3384	0	0
Central sub-Saharan Africa	97	6.0	6255	4 192 980	4343
East Asia	1398	57.8	4136	27 956 507	2000
Eastern Europe	207	10.3	4967	0	0
Eastern sub-Saharan Africa	356	21.9	6145	17 555 748	4935
High-income Asia Pacific	178	9.4	5291	0	0
High-income North America	340	15.8	4647	0	0
North Africa and Middle East	446	19.8	4456	2 115 011	474
Oceania	10	0.4	4501	55 196	555
South Asia	1613	72.9	4520	57 791 550	3582
Southeast Asia	610	25.8	4225	12 480 939	2045
Southern Latin America	60	3.0	4906	0	0
Southern sub-Saharan Africa	70	3.6	5093	291 000	413
Tropical Latin America	202	7.2	3581	0	0
Western Europe	416	22.3	5366	0	0
Western sub-Saharan Africa	336	21.8	6495	18 909 507	5625
Global total	6893	321.3	..	143 068 278	..

Table: Estimated minimum total need and unmet need for surgery by Global Burden of Disease epidemiological region (Data are from Rose and colleagues based on calculations provided by Weiser and colleagues and Hider and colleagues.

⁴³ [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(15\)60806-6.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)60806-6.pdf)



4. Attack to healthcare workers in conflict areas

Health in conflict areas can lead to the following effects⁴⁴:

- a) Destruction of hospital resources and property
- b) Obstruction of access to health care, medicine, and essential supplies
- c) Attacks on healthcare workers at the facility level and/or whilst on transit to offer health services
- d) Military obstruction either during war and/ or when attempting to create peace e.g. taking over of health services

This in the long run leads to loss or lack of access to health facilities, flight of health workers to more stable countries as well as affected individuals being deprived of health care and hence an increased mortality or morbidity risk.

D. Procurements and Material Resources

Initially the problem of global inequality in surgical care was addressed by providing money and resources or sending out surgical missions to address the shortage on a short-term basis.

⁴⁵

However, the Lancet Commission on Global Surgery made clear that a long-term approach with changes at the highest level is necessary, with multidisciplinary work and education being examples of sustainable actions. Nonetheless, financial and material resources are still a necessity in places with scarce access to surgery.

Medical facilities

Medical facilities are often not enough or not used to their full potential. Some examples can be found that can improve the usage of medical facilities for surgical care, especially in rural areas:

⁴⁴ <https://www.safeguardinghealth.org/sites/shcc/files/SHCC2016final.pdf>

⁴⁵ Ng-Kamstra JS, Greenberg SLM, Abdullah F, et al. Global Surgery 2030: a roadmap for high income country actors. *BMJ Global Health*. 2016;1(1):e000011. doi:10.1136/bmjgh-2015-000011.



- A decentralised, integrated care model was created to provide longitudinal care for patients with advanced rheumatic heart disease at district hospitals in rural Rwanda before and after heart surgery, which showed good outcomes.⁴⁶
- A cash program in India, which aims at increasing the number of institutionalised births, has showed a great benefit of this program, reflecting the need to focus on increasing the level of emergency obstetric care functionality in public obstetric care facilities located in rural areas, which will allow more optimal utilisation of facilities for childbirth under the program thereby leading to better outcomes for mothers.⁴⁷
- Rural health facilities in Bangladesh can be utilised for surgical procedures, where they were able to perform surgery in more than 400 children, mainly inguinal hernia repairs, being a good way to provide curative care to the grass-roots population.⁴⁸ The challenge might be having permanent surgical workforce for these procedures.

From these examples, the conclusion taken is that there is a need to improve rural healthcare facilities to provide integrated surgical, anaesthesia and obstetric care.

Material resources

There is lack of material resources in rural areas. Despite not being the main priority when talking about health in rural areas, as they are consumable resources⁴⁹, which expire and can be lost, they are needed for a great number of procedures.

Local markets successfully produce most consumables and unskilled labour. However, in many cases, as in Cambodia, there is a gap between resource allocation and need, which should be addressed through clear policies to prioritize remote areas and to allocate resources based on needs.⁵⁰ Government intervention is needed to ensure that quality and

⁴⁶ Rusingiza EK, El-Khatib Z, Hedt-Gauthier B, et al Outcomes for patients with rheumatic heart disease after cardiac surgery followed at rural district hospitals in Rwanda Heart Published Online First: 20 April 2018. doi: 10.1136/heartjnl-2017-312644

⁴⁷ Sabde Y, Chaturvedi S, Randive B, et al. Bypassing health facilities for childbirth in the context of the JSY cash transfer program to promote institutional birth: A cross-sectional study from Madhya Pradesh, India. Puebla I, ed. PLoS ONE. 2018;13(1):e0189364. doi:10.1371/journal.pone.0189364

⁴⁸ Banu, T., Chowdhury, T.K., Kabir, M. et al. World J Surg (2013) 37: 730.

⁴⁹ World Health Organisation. World Health Report 2000. Chapter 4: What resources are needed? Available at: http://www.who.int/whr/2000/en/whr00_ch4_en.pdf, accessed on July 2nd, 2018.

⁵⁰ Nakahara S, Saint S, Sann S et al. Evaluation of trauma care resources in health centers and referral hospitals in Cambodia. World J Surg. 2009 Apr;33(4):874-85. doi: 10.1007/s00268-008-9900-6



safety standards are met, that reliable information is available about the products, and that a fair competitive environment exists.⁴⁹

Manufactured pharmaceuticals and specialized medical equipment also face barriers, which are overarching in healthcare, such as patenting and licensing requirements, manufacturing standards, large initial investment costs, expensive research, and long development periods. Manufacturers of these inputs hold considerable market power, manipulating prices and demand. Strong policy measures are needed to tackle these issues, to grant access to safe medication for surgery and anaesthetic care.⁴⁹

E. Multidisciplinary work

Tackling Power and oppression within healthcare providers^{51,52}

All healthcare professionals are indispensable and valuable in providing safe and quality surgical care across the globe. As future surgeons, anaesthesiologists and obstetricians, we believe in teamwork and interdisciplinarity as pillars to building global surgery. Nurses, health technicians, social workers and other health workers play a major role in providing the best attainable surgical care. The concepts of task sharing and task shifting are familiar to us and happens among the multidisciplinary team that works in the OR. Moreover, no procedures are carried out if we do not have one another.

However, sometimes doctors abuse the power and set themselves in a higher place, influencing and ordering other healthcare professionals around (as nurses and assistant physicians), not taking into account their opinions, or even disregarding them in many clinical contexts. This can be due to several reasons: as noted before, it can be a case of power and oppression; discrimination as racism or even sexism, among others. Collaboration in healthcare is important and focus on patient is the key.

It is imperative to work together and actively collaborate with these healthcare professionals to develop joint statements and to collaborate on campaigns, capacity building, and community intervention activities.

⁵¹ <https://onlinelibrary.wiley.com/doi/full/10.1111/j.0141-9889.2004.00409.x>

⁵² <https://pdfs.semanticscholar.org/6c54/ff0288541c71fbce2bfb925cfaa0015bdd14.pdf>



F. Gender equity and global surgery

Female Surgeons

Women have been involved in surgery throughout history. However, despite the fact that there are now as many female medical students compared to male students in universities, men still significantly outnumber women in a number of procedural specialties, most notably surgery. There are many factors that can influence women's choice of surgical career, which pose as challenges and discrimination that women can face as surgeons. Moreover, we do not see many women in leadership position in the Surgery field. There is a strong argument for substantive policy change at the individual, organisational, and governmental level to reduce gendered discrimination and gendered stereotypes in surgery.

Organisations as Association of Women Surgeons, Women in Global Health, IFMSA⁵³ and InciSioN work towards equity in Global Surgery. InciSioN has published an article entitled "[Women in Surgery: challenges and opportunities](#)".⁵⁴

G. Ethical placements abroad - Voluntourism in surgery

Every year, an increasing number of medical students travel to LMIC on surgical placements abroad. International experiences help understand other health systems, learn new skills, make long lasting friendships, enhance cultural sensitivity and enrichen the CV.⁵⁵ However, it may not be clear if it really helps⁵⁶ or even harms⁵⁷ local communities in LMIC. Maybe it merely gives students the satisfaction of "doing some good", as many of these students may lack the necessary skills to learn and contribute most effectively.

⁵³ Thompson K, Pericas C. Throwback: Power and Privilege within the Medical Profession. WGH, IFMSA, 2017. <https://ifmsa.org/2017/11/24/throwback-power-privilege-within-medical-profession/>

⁵⁴ de Costa J, Chen-Xu J, Bentounsi Z, Vervoort D. **Women in surgery: challenges and opportunities**. IJS Global Health: July 2018 - Volume 1 - Issue 1 - p e02 doi: 10.1097/GH9.0000000000000002

⁵⁵ <https://academic.oup.com/milmed/article/182/5-6/1566/4158931>

⁵⁶ <https://blogs.scientificamerican.com/observations/the-trouble-with-medical-voluntourism/>

⁵⁷ Bauer I. More harm than good? The questionable ethics of medical volunteering and international student placements. *Tropical Diseases, Travel Medicine and Vaccines*. 2017;3:5. doi:10.1186/s40794-017-0048-y.



Any volunteer participating in a surgical placement abroad has the responsibility of respecting the patients dignity. Dilemma around pre-medical “voluntourism” ⁵⁸ is not about avoiding engaging with health disparities abroad, but rather that it is necessary to actively question how healthcare-related volunteering abroad is carried out. A pre-med student who may not be allowed to do certain procedures in their high income country to protect patient’s safety may have the opportunity to practice those skills with poor supervision in a low resource setting.⁵⁸ Furthermore, as an example, taking photographs ⁵⁹ of patients is an striking act that unfortunately happens often. These should not be done by medical students in their placements as it legitimates harmful stereotypes and violates the patient's rights.

Ethical considerations around the principle “do no harm” ⁶⁰ and the “white saviour complex” ⁶¹ may be done before making the choice of going to a LMIC as a premed student on an individual basis. Streamlined pre-departure training should be provided. ⁶² On a global scale, we urgently need a well researched and evidenced based framework that defines the limits of voluntourism and sets basic requirements for surgical and medical placements in LMIC.

⁵⁸ Wallace LJ. Does Pre-Medical ‘Voluntourism’ Improve the Health of Communities Abroad?. *Journal of Global Health Perspectives*. 2012 Aug 1 [last modified: 2012 Aug 1]. Edition 1.

⁵⁹ <https://www.radiaid.com/>

⁶⁰ Bauer I. More harm than good? The questionable ethics of medical volunteering and international student placements. *Tropical Diseases, Travel Medicine and Vaccines*. 2017;3:5. doi:10.1186/s40794-017-0048-y.

⁶¹ Cole, Teju (2016). "The White Savior Industrial Complex". *Known and Strange Things: Essays*. Random House. pp. 340–349

⁶² Hamadani F, Sacirgic L, McCarthy A. Ethics in Global Health: The Need for Evidence-Based Curricula. *McGill Journal of Medicine : MJM*. 2009;12(2):120.



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