To advance global surgery and anaesthesia, train more advocates

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FRONT-LINE HEALTHCARE PROVIDERS AS ADVOCATES

The COVID-19 pandemic has revealed, perhaps more than ever, the tight interlinkages between health and politics. Policies adopted or neglected by politicians without adequate input from healthcare workers often adversely affect healthcare workers’ ability to care for their patients. While most healthcare and public health practitioners may prefer to remain in their clinics, consulting rooms, laboratories and operating rooms, and not involve themselves in policymaking, the reality is that policy decisions made in their absence directly affect their ability to do the work that they so care about. Therefore, there is a strong case for the need for healthcare providers to be equipped with advocacy tools which will enable them to effectively champion policies that promote their interests and those of their patients.

Advocacy and policy engagement is an opportunity and responsibility that clinicians must not shy away from. Too often healthcare practitioners have the mistaken belief that all that is needed is to generate research outputs, because ‘data speaks for itself’. While appropriate data are usually necessary, they are insufficient by themselves to lead to policy change. Effective advocacy must convert research data into palatable forms that nudge policymakers to implement appropriate actions. In this regard, the global surgery community has a long way to go.

GLOBAL SURGERY ADVOCACY

The global surgery and anaesthesia movement, which aims for equitable access to safe, timely and affordable surgical and anaesthesia care for all, is currently at a crossroads that marks a remarkable momentum generation if seized. Significant progress has been made since The Lancet Commission on Global Surgery. Global surgery research, in particular, has grown substantially and the number of global surgery academic institutions is expanding as well. One of the ways that countries like Nigeria, Ethiopia, Rwanda, Pakistan, Madagascar, Tanzania and Zimbabwe have sought to increase access to surgical and anaesthesia care has been through the development of national surgical, obstetric and anaesthesia plans (NSOAPs). Although NSOAPs are arguably useful strategic policy documents, their impact and outcomes have been disappointingly limited. This is partly because most countries have failed to prioritise and allocate sufficient funding to their implementation. Why is this the case? To answer this question, it is necessary to consider which voices have been missing from the global surgery discourse thus far and where most of this discourse is happening.

Individuals and communities that are closest to a problem are often the most powerful advocates for public policy change. In the case of global surgery, one of these individuals is the front-line surgical or anaesthesia provider who struggles to deliver care to patients in the most challenging circumstances. For example, the front-line surgeon, anaesthetist or nurse at the district hospital understands all too well the realities of conducting an emergency laparotomy using the light from a mobile phone because the operating room lamps are non-functional, or the challenge of providing anaesthesia with limited training, inadequate medicines and oxygen supply shortages. Sometimes they are forced to work with sparse personal protective equipment, unstable electricity and running water. An overwhelming number of studies have evidenced the deficits of surgical systems in many low-income and middle-income
countries (LMICs). In addition, poor remuneration and working in unsafe environments are also challenges that many healthcare workers in LMICs face.

These front-line surgical and anaesthesia providers, who live every day in the reality of resource-constrained health systems, can also be the most powerful change agents because the stakes are so high for them and the patients they treat. They are also the ones to whom politicians are ultimately accountable. Yet it can be argued that their voices have not been adequately elevated locally and globally. This is partly because much of the global surgery discourse seems to occur on platforms and locations that are largely inaccessible to them. Much of the global surgery discourse has been happening in high-income country (HIC)-centric spaces, such as publications in elitist journals and conferences that are primarily in North America and Europe.

GLOBAL SURGERY AS A LOCAL PROBLEM

For sustainable impact, global surgery needs to become a topic of debate and discussion in local media. Television programmes, radio shows, newspapers, social media platforms, community groups and other media should be platforms where consequential local problems of surgical access and quality are discussed and organic solutions advanced. Basically, global surgery will not truly be a ‘global’ problem unless it first becomes a ‘local’ problem.

To advance global surgical and anaesthesia care, providers need to be equipped with the tools needed to make their voices heard by policymakers. They need to understand the language of policymakers and speak it fluently. Advocacy skills such as policy brief writing, storytelling, pitching, opinion writing, media advocacy and community mobilisation need to be taught to trainees and practitioners. These skills will be useful whether they are attempting to negotiate for the amendment of a departmental policy to a hospital administrator or for funding for the implementation of NSOAPs to the minister of finance.

Thus, medical and nursing schools must consider offering elective courses in policy and advocacy so that students can gain the fundamentals of public policy and acquire essential advocacy skills. Embedding such knowledge and skills training into the curriculum will ensure that every physician or nurse graduating has fundamental skills needed to be policy advocates. In many HICs, dual-degree programmes are common. Perhaps offering opportunities to students in LMICs to complete dual degrees in medicine and public policy or communications could be beneficial in giving healthcare practitioners a voice at the table.

THE GLOBAL SURGERY ADVOCACY FELLOWSHIP

In November 2022, inspired by the Aspen Institute’s New Voices Fellowship and a previous editorial in BMJ Global Health, Operation Smile, the University of Global Health Equity and Nkafu Policy Institute launched the Global Surgery Advocacy Fellowship. The fellowship aims to provide surgical and anaesthesia care providers in LMICs with skills to be advocates for surgical care within their communities and globally. The fellowship consists of three components: skills development, mentorship and a capstone advocacy project (with seed funding). Throughout the non-residential fellowship year, fellows develop advocacy skills such as op-ed/opinion writing, public speaking, story-telling, social media advocacy, popular mobilisation and more through a series of in-person and virtual training sessions.

Experienced mentors provide ongoing mentorship to help the fellows define their advocacy goals and design and implement a capstone advocacy project to address a surgical problem in their community.

The five inaugural fellows from Colombia, Madagascar, Rwanda, Ghana and Ethiopia have already begun putting their advocacy skills to work, including urging the Ethiopian government to reconstruct surgical facilities in postconflict Ethiopia, advocating for surgical care for refugee children with cleft conditions in Colombia, supporting respectful maternal care in Rwanda, standardising surgical practices in Madagascar and scaling up laparoscopic surgical training in Ghana. The long-term goal is to train 150 global surgery advocacy fellows based in LMICs over the next decade. However, this will not suffice to meet the need. Other institutions should develop similar programmes and training institutions.
and professional societies need to embed advocacy skills into their curriculums.

COUNTERFACTUALS
One might argue that it is unrealistic to add policy and advocacy skills training to the already packed curriculum of medical students or residents. However, the counterfactuals need to be considered: frustration and burnout. Often when healthcare workers face consistent structural challenges that require policy change/reform, they often do not know how to address those challenges without the right skills. After years of working in dire situations, they become frustrated and burnt out.23,24 The repercussions of this burnout and frustrations can be lower quality care, emigration to HICs for better opportunities, the so-called brain drain problem or perhaps moving out of healthcare practice altogether.25 The frustrations can be compounded when policymakers attempt to enact legislation contrary to the interests of healthcare workers, such as the recent bill introduced in the Nigerian parliament mandating doctors to work in the country for at least 5 years postgraduation before being licensed.26

It is also important to note that policy change is a complex process. Policy changes often necessitate numerous advocacy approaches (top-down and bottom-up/grassroots) at different levels (community, national, regional and international). Nonetheless, the global surgery community has not sufficiently focused on grassroots advocacy and needs to invest more in such advocacy strategies.4

CONCLUSION
If the global surgery and anaesthesia movement is to achieve its goals of ensuring that everyone, particularly vulnerable populations globally, has access to life-saving surgical and anaesthesia care when needed, they must train surgical and anaesthesia providers to be advocates. This means equipping them with the capabilities and confidence that they need to elevate their voices and that of patients to decision-making tables, which are too often driven by politics as opposed to the interest of those who will ultimately be affected by the policies in question. They need to be able to hold policymakers and politicians accountable and demand their rights.

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