

The Lancet Commission on Global Surgery

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Working Group Feedback

Workforce and Education

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Members

Working Group Lead

- Emmanuel Ameh

Facilitator

- Caris Grimes

Commissioners

- Lars Hagander
- Emmanuel Ameh
- Eunice Derivois
- Nyengo Mkandawire
- Caris Grimes
- Nivaldo Alonso

Members:

- Robert Taylor
- James Cusack
- Peter Fagenholz
- Haile Debas

- Keith martin
- David Mooney
- Josh Bleicher
- Rochelle Dicker
- Kristin Hatcher
- Jennifer Kreshak
- Craig McClain
- Hakon Bolkan
- Wendy Williams
- Tom Sato
- Meena Cherian
- Bob Lane
- Laura Luque

Research Assistants

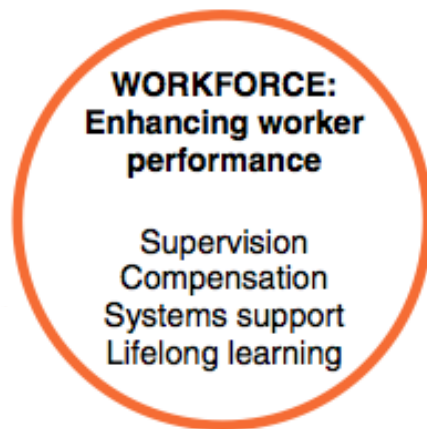
- Jacky Fils
- Jordan Pyda
- Johanna Riesel
- John Scott

Defining the Surgical Workforce

- “All people engaged in actions whose primary intent is to enhance health” (**WHO**)
- Providing Surgical care is providing a surgical **TEAM**
 - Surgical/Anesthetic providers, perioperative care providers, nurses, biomedical engineers, managers, equipment managers, radiologists
- **Prior Work**
 - World Health Report 2006: Working Together for Health
 - Lancet Commission on Health Professionals for a New Century
 - Handbook on Monitoring and Evaluation of Human Resources for Health (WHO, 2009)
 - Working Lifespan Framework

Handbook on Monitoring and Evaluation of Human Resources for Health (WHO, 2009)

Working Lifespan Framework



Entry into the Surgical Workforce

- **Key Issues**

- Planning a system that accommodates new trainees
- Surgical “team” requires a variety of providers & skills
- Re-training the trainees; Teaching the teacher
- HIC-LMIC relationship

- **Outputs**

- **Table** of different training models for mid-level providers
- **Case studies:** 1. Rwanda HRH 2. E-learning



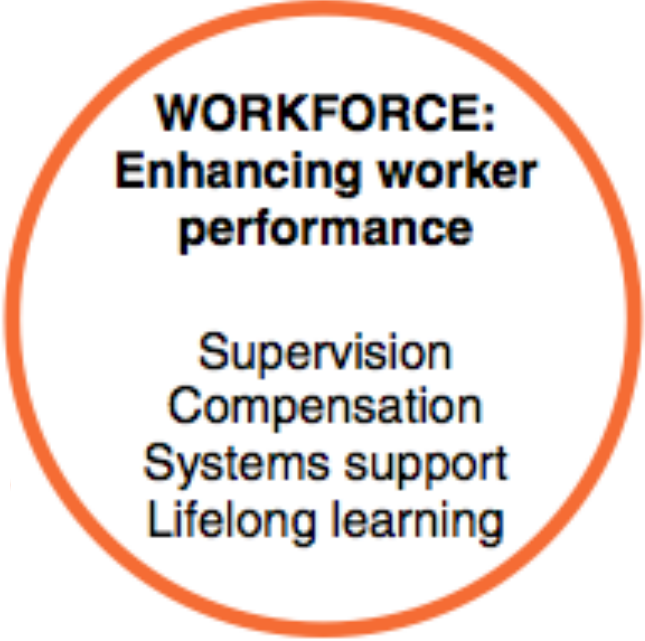
Performance of the Surgical Workforce

- **Key Issues**

- Ensuring Quality
- Scope of Practice
 - Task Sharing
- Accreditation/Monitoring
- Professional Development for all providers

- **Outputs**

- **Research:** 1. Proportion of operations performed by non-MD surgical/anesthesia providers 2. Maps of surgical/anesthetic providers/country and #procedures performed/country
- **Case Study:** Task Sharing in East Africa (Malawi/Moz/Tanzania)



WORKFORCE:
Enhancing worker
performance

Supervision
Compensation
Systems support
Lifelong learning

WORKFORCE PERFORMANCE

Availability
Competence
Responsiveness
Productivity

Exit from the Surgical Workforce

- **Key Issues**

- Migration
 - Rural to Urban
 - LMIC to HIC
 - Public to Private, NGO
- Incentives
- International Policy

- **Outputs**

- **Research:** Surgical migration to HICs
- **Figure:** % Population that is rural vs. % Surgical Workforce that is rural
- **Case Study:** University of West Indies



Possible Metrics

- Presence/absence of Morbidity and Mortality Conferences / Quality Improvement Efforts
- Peri-operative mortality ratio (POMR)
- MOTS 2.0 (minimal operating theater standards INCLUDES surgical team)
- % population w/1 hour access to hospital with MOTS(WHO Survey)
- Surgical/Anesthetic Provider density.
- ?Can we show that Building Surgical Capacity improves health outcomes of entire health system?

Challenges and Recommendations

- **Challenges**

- Attracting and retaining surgical workforce
- Identifying/Accounting for surgical care providers not formally trained in surgery/OBGYN/anesthesia (task-sharers)
- Ensuring quality and monitoring
- Lack of Data

- **Recommendations**

- Encourage government to prioritization of surgery
- Enable HIC institutions to support training, education and partnership with LMIC institutions
- Develop of guidelines/recommendations re: task sharing
- Develop guidelines around monitoring and evaluation of the workforce system