Improving Surgical Services in Developing Nations: Getting to Go

Danny O. Jacobs

Published online: 21 August 2010
© Société Internationale de Chirurgie 2010

In 2001, members of the United Nations and many important international health organizations established millennium development goals based on the United Nation's Millennium Declaration, which was signed in 2000. These were goals that were to be achieved by 2015 if the social and economic well-being of the world's poorest countries would be improved (<http://www.un.org/millenniumgoals>). Eight broad and expansive overarching goals were enumerated and these were to: (1) eradicate extreme poverty and hunger; (2) achieve universal primary education; (3) promote gender equality and empower women; (4) reduce child mortality; (5) improve maternal health; (6) combat HIV/AIDS, malaria, and other infectious diseases; (7) ensure environmental sustainability; and (8) develop a global partnership for development. Although the most recent report indicates that some good outcomes have been realized, the overall progress to date has been slow and much work remains to be done. Furthermore, it appears that the gap between desired and accomplished outcomes may be greatest in sub-Saharan Africa where stronger ties and better coordination needs to occur among the various humanitarian, developmental, and economic missions (ref: Overseas Development Institute).

Some key requirements for successful outreach programs were outlined in a consultation that was prepared to help guide President Barack Obama's Global Health Initiative. This document articulated a belief that patient care in developing countries could only be optimally addressed by the effective and efficient development and use of country-led platforms. These were the best methods of improving

health care delivery, and these were the platforms that would appropriately emphasize the delivery of essential health care and public health programs in a sustainable manner. Four components that were believed to be critical for success were identified: (1) do more of what works; (2) build on and expand programs that foster stronger systems and, thereby, yield more sustainable results; (3) innovate; and (4) collaborate for impactful results (http://www.usaid.gov/our_work/global_health/home_publications/docs/ghi_consultation_document.pdf).

A global health committee convened by the U.S. Institute of Medicine in 2008 to investigate the country's commitment to global health problems and to define how the United States might best help address the world's health care problems highlighted similar principles. Five key needs were identified: (1) a scaling up of existing interventions that have already been found to be effective; (2) to generate and share knowledge generated by studying the best health care delivery systems and rigorously evaluated their efficacy; (3) an investment in capacity building; (4) an increase in financial commitments for global health because such is an absolute requirement if poor countries are to meet the health related millennium development goals; and, perhaps most importantly, (5) how to engage in respectful partnerships to ensure that the developing countries retain ownership and accountability for their issues.

It is increasingly apparent that there is a great need for surgical care in many, if not all, developing countries. For example, traumatic injury that might be amenable to surgical intervention accounts for a significant percentage of the loss of useful work capacity as defined by disability adjusted life years (DALY). Here, one "DALY" represents the loss of 1 year of equivalent work that an individual could accomplish at full health. Indeed, it is striking that the United Nation's developmental goals do not more

D. O. Jacobs (✉)
Department of Surgery, Duke University Medical Center,
Durham, NC, USA
e-mail: danny.jacobs@duke.edu

specifically address surgical treatments per se, except for the case of emergency obstetrical care. Other conditions that are amenable to surgical therapy, and that are especially pervasive in sub-Saharan Africa, include malignancies, congenital anomalies, cataracts, and perinatal conditions. Couple these truths with the disparate burden of disease in third-world countries relative to the amount of care that is received, the cost-effective nature of many surgical interventions compared with therapies for other burdensome disease processes, the possibility that building surgical services could only improve delivery systems overall and strengthen primary care, and the realization that surgery is an important health care issue is unambiguous. It is illustrative to note that less than half of all developing countries systems can provide appendectomy, only 32% can repair congenital hernias, and only 44% can perform caesarian sections. Even fewer facilities can provide goggles and gowns to help protect their health care workers from HIV [1].

Many experts and opinion leaders have commented that the goal of developed societies should be to move away from models where individual students or faculty members work in a hospital in a developing country for a short while and then leave—a move away from volunteerism or itinerant services, despite their obvious contributions and importance, to the promotion of sustainable relationships that build capacity and adds services or generates otherwise mutually beneficial activities [2]. Economists at the 2008 Copenhagen Consensus meeting when asked what would be the best ways to advance to welfare of a developing nation if the United States provided additional financial resources listed improving surgical capacity as one of their list of 30 best applications.

Given the well-considered opinions regarding actions that need to be taken, yet the persistent opportunities to minimize or eliminate health care disparities in the

developing world, what should be done and in what order? How can theory best be translated to practice, especially when data indicate that insufficient progress has been made? Such is the topic of the publication by Luboga et al. in this issue of the *World Journal of Surgery* [3]. A multidisciplinary group representing government health care administrators, health care providers, academicians, international health care officials, and other stakeholders recently met in Kampala, Uganda to develop consensus recommendations regarding priority areas in health policy to improve health care in that country. A list of priority items was developed in the areas of human resources, health systems, research, and advocacy. The strength of this approach is its collective engagement of all who could be instrumental in solving a very complicated set of problems and inaugurating what is akin to a “grass-roots” approach to answering a call to action. Many of the broader principles enunciated in the concept documents referenced earlier are translated into specific recommendations that are more applicable to the needs of Ugandans—and, there are no real surprises. Perhaps this is what is needed for advancement and maybe what is learned will inform efforts in other countries.

References

1. Kushner AL, Cherian MN, Noel L et al (2010) Addressing the millennium development goals from a surgical perspective. *Arch Surg* 145(2):154–159
2. The PLOS editors. A crucial role for surgery in reaching the UN millennium development goals. *PLoS Medicine*. Published online 2008 August 26. doi:[10.1371/journal.pmed.0050182](https://doi.org/10.1371/journal.pmed.0050182), PMID: PMC2522259
3. Luboga S, Galukande M, Mabweijano J et al (2010) Key aspects of health policy development to improve surgical services in Uganda. *World J Surg*. doi:[10.1007/s00268-010-0585-2](https://doi.org/10.1007/s00268-010-0585-2)