WORLD HEALTH ORGANIZATION
Emergency & Essential Surgical Care Programme

Meeting Report

WHO Global Initiative for Emergency and Essential Surgical Care

Eighth Biennial Meeting

06 May 2019

Bangkok, Thailand
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1) Executive summary

The eighth meeting of the Global Initiative for Emergency and Essential Surgical Care (GIEESC) was convened on May 6th in Bangkok, Thailand, in conjunction with the 88th Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS). The meeting was held at the Bangkok Convention Centre at CentralWorld. The purpose of the meeting was to discuss the progress that has been made toward achieving the goals set out in recommendation WHA68.15, focusing on the Western Pacific and Southeast Asia member countries. Speakers from 15 different countries or professional societies highlighted the recent contributions to expanding surgical and anaesthesia care. A panel discussion was held to discuss surgical indicators, data collection efforts, and the successes and failures of carrying out this process.

2) Background

Deficiencies in access to emergency and essential surgical and anaesthetic services result in unacceptably high rates of preventable death and disability from a host of surgical conditions. This is especially true at first referral level (district hospital) facilities in low- and middle-income countries, where there are significant gaps in infrastructure, physical resources and supplies, as well as human resources for health. With the goal of strengthening emergency and essential surgical care (EESC) at the primary referral level, the WHO established the Clinical Procedures Unit (CPU) in 2004, which was charged with “ensuring efficacy, safety and equity in the provision of clinical procedures in surgery, anaesthetics, obstetrics, and orthopaedics, particularly at the district hospital level” and “promoting the appropriate effective and safe use of cell, tissue, and organ transplantation”. The Services Organization and Clinical Interventions Unit (SCI) has since replaced CPU, although programmes and goals of the EESC programme have remained constant.

The WHO Emergency and Essential Surgical Care Programme (EESC) cuts across a wide variety of vertical initiatives that each incorporate components of surgical care. These include maternal, newborn and child health, non-communicable diseases and injuries, male circumcision to prevent HIV transmission, Buruli ulcer, filariasis, and many others. Activities have been focused at the regional and country level, and have encouraged collaboration between WHO, ministries of health, professional societies, academia, and both local and international partners. At the 68th World Health Assembly in May 2015, WHO member states unanimously adopted Resolution WHA68.15: Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage. This commitment was augmented at the 70th World Health Assembly in May 2017, when Decision Point 70(22) was passed, requiring WHO Secretariat to report on progress every two years until 2030. The EESC has been instrumental in the implementation of these commitments. Working with Member States and partner organisations, they have developed tools for monitoring and evaluating surgical care systems as well as providing support and guidance for countries in the development of national surgical obstetric and anaesthesia plans (NSOAPs) that are fully embedded within the National Health Policy, Strategy or Plan.

The WHO GIEESC was inaugurated in December 2005 at WHO headquarters in Geneva to encourage collaboration between a diverse group of individuals, institutions and organizations from various disciplines who are concerned with improving access to safe, timely and quality surgical services, especially at the district level in LMICs. The ultimate goal was to strengthen local and country health care systems by better integrating emergency and essential surgical, obstetric and anaesthesia care into health
3) Objectives

The specific objectives for this eighth WHO GIEESC meeting were:

1. Gather data on progress of implementation of WHA resolution WHA68.15 at the country level, particularly in the Southeast Asia and Western Pacific regions.
2. Clarify roles and timeline of partners in continued progress towards implementation of WHA resolution WHA68.15 and decision WHA70.22.
3. Exchange good practice recommendations for data collection, gap analysis and National Surgical, Obstetric and Anaesthesia Plan development.
4. Foster exchange from experience of capacity building for surgical, obstetric and anaesthesia service delivery.

4) Session I: Opening of Meeting

4A. Dr Walt Johnson, Director, WHO Emergency and Essential Surgery Programme

In his opening address, Dr Walt Johnson recounted the history and tremendous growth in global surgery, anaesthesia, and obstetrics care since his first attendance of a GIEESC meeting in 2011. He reviewed the major paradigm shifts from 2015, including four major events. First, the World Bank’s Disease Control Priorities 3rd Edition (DCP3) was published with the first volume on Essential Surgery. Second, the Lancet Commission on Global Surgery revealed that 5 billion people did not have access to safe, affordable, timely surgical care, and brought recognition to the cost of not investing in surgery. Third, the United Nations (UN) transitioned from the Millennium Development Goals (MDG) to the Sustainable Development Goals (SDG). SDG 3 states to “ensure healthy lives and promote well-being for all ages,” and includes 13 targets, 9 of which require improvement in surgical, anaesthesia and obstetric care. Four major targets that will never be achieved without surgery include the targets regarding reduction in maternal mortality, infant and under-five mortality, premature death from non-communicable diseases (NCDs), and deaths from road accidents. Finally, the World Health Assembly (WHA) passed resolution WHA 68.15 which includes surgery as an essential part of universal health coverage (UHC). A short video in which Dr Tedros Adhanom Ghebreyesus, Director-General of the WHO, expressed support of surgical care was shown.

4B. Somprasong Tongmeesee, Ministry of Public Health Thailand

Dr Somprasong Tongmeesee, President of the Royal College of Surgeons of Thailand, welcomed all attendees to the GIEESC meeting. Showing the map of Thailand, he outlined the 178,000 annual surgical emergency and trauma cases by region. The leading cause of in-hospital death included several acute surgical conditions. Length of stay for acute surgical conditions averaged 10 days in Thailand. Dr Tongmeesee reviewed the distribution and mortality of acute appendicitis, acute cholecystitis, acute cholangitis, pancreatitis, peptic ulcer perforation, acute bowel obstruction, acute limb ischemia, and ruptured abdominal aortic aneurysm. For trauma deaths, traumatic brain injury (TBI) is the leading cause inpatient mortality, followed by abdominal and chest injuries.
4C. Ed Kelley, WHO HQ

Dr Ed Kelley, Director of the Department of Service Delivery and Safety at the WHO, welcomed attendees to the GIEESC conference and reviewed the critical role of the WHO in global surgery. As the specialized technical agency for the UN on health, the WHO hosts offices in 154 countries worldwide, with six regional offices and WHO HQ located in Geneva, and serves as the world’s public health agency. Director-General Dr Tedros Adhanom Ghebreyesus is leading the WHO into a new direction as an implementation agency, which has significant relevance for surgery. Dr Kelley emphasized the importance of international dialogue while pursuing the goal of the 2030 target of UHC due to variability between countries on per capita spending on healthcare. Dr Kelley challenged the misconception of surgery as a luxury and highlighted that surgery is a core part of primary care. Thus, surgical care is critical for primary health care and UHC. The Organization aims to achieve the “triple billion” targets in the next five years: one billion more people benefitting from UHC; one billion more people better protected from health emergencies; and one billion more people enjoying better health and well-being. Dr Kelley advocated for engagement of Ministries of Health and regional offices to push for advancement in surgical, obstetric, and anaesthesia care.

The WHO has had major success in surgery through the Global Patient Safety Initiative, Surgical Safety Checklist, and Infection Prevention and Control with the recently published WHO Global Guidelines for the prevention of Surgical Site Infections. Dr Kelley reviewed this guideline in detail. He emphasized the need for a multidisciplinary team and a multi-modal approach of “build it, teach it, check it, sell it and live it” to move guidelines into practice. Finally, Dr Kelley shared that safe surgical care around the world is a personal challenge, as surgery has directly impacted his family. He advocated for surgeons and member states to work with the WHO to realize the goals of UHC and safe surgical care for all.

4D. John Batten, Royal Australasian College of Surgeons

Dr John Batten, Chair of the RACS Board of Directors and Orthopaedic Surgeon in Tasmania, discussed the role of RACS as a major organization for surgical research and advocate for safe surgery in Asia and the Pacific region. Australia and New Zealand also face unique challenges of caring for rural, indigenous Australian and Maori communities. The Asian and Pacific region is home to 60% of the world’s population and hosts a 1.3 million shortage of healthcare professionals. Southeast Asia has only 1% of the world’s health expenditure but has a relatively higher burden of disease. RACS is committed to leadership and clinical training in Asia and Southeast Asia, supporting 20 global health scholarships annually. The College has maintained long-standing relationships with the pacific islands, including Papua New Guinea (1975) and Fiji (1995). The RACS is committed to helping create a world with access to safe, timely surgical care that is affordable for all. Affordability and health leadership are vital to accomplish the goals outlined in Resolution WHA 68.15.

4E. Rod Mitchell, Australian and New Zealand College of Anaesthetists

Dr Rod Mitchell, President of the Australian and New Zealand College of Anaesthetists, discussed the role of anaesthesiologists in both perioperative and pain management. The College is focused on the Asia-Pacific region but acknowledges the global deficit in surgical and anaesthesia care. Dr Mitchell noted exemplary areas of work, including collegial support networks throughout the Asia-Pacific region; collaborations between professional societies, universities, and governments; Essential Pain Management courses held internationally; and the work of the Lancet Commission and WHA Resolution 68.15. Dr
Mitchell called for increased contribution to foreign aid from Australia and New Zealand, as well as more effective engagement of stakeholder countries in LMICs. He simultaneously highlighted the need to adequately address the inequity and isolation challenges of the indigenous peoples of Australia and New Zealand. Finally, Dr Mitchell advocated for increased efforts by the College and RACS in Africa.

5) Session II: Member State Updates

5A. Nobhojit Roy, Mumbai WHO Collaborating Centre on Surgical Care

Dr Nobhojit Roy, Lancet Commissioner for both Global Surgery and NCD & Injuries, from the Mumbai WHO Collaborating Centre (CC) on Surgical Care, discussed the use of the WHO Situational Analysis Tools (SAT) in district hospitals in Bihar, where there are two surgeons for 500,000 people, as well as their work in assisting the WHO in dissemination of best practices. This has led to the development of a national trauma registry, a program to empower nurses in trauma care, adaptation of Standard Treatment Guidelines to the unique context of India, and enhanced reporting of challenges to access to safe blood transfusions. The WHO CC also provides technical assistance to member states in the field of surgery, including in the field of oncologic care. Finally, Dr Roy reviewed how the WHO CC supports surgical care delivery at the regional and global level through adaptation of SAFE Operating Course to LMIC context and through the support of multiple centres of excellence for surgery throughout India.

5B. Abebe Bekele, University of Global Health Equity, Butaro, Rwanda

Dr Abebe Bekele, Dean of Health Sciences at the University of Global Health Equity (UGHE) in Rwanda, presented its innovative undergraduate medical school curriculum. This sparked from the collaboration between Partners in Health (PIH) and the Rwanda Ministry of Health that began in 2005. PIH and key stakeholders such as the Gates and Cummings Foundations were pivotal in funding the University. UGHE offers a Master of Science in Global Health; Executive Education Certificates in health systems and policy; Centre of One Health for studies of the interplay between human, environmental and animal health; Institute of Global Health and Global Surgery Centre; Educational Development and Quality Centre; and Centre for Gender Studies. Most significantly, UGHE now has an innovative 6.5-year combined MBBS/MGHD degree, which will include vertical and horizontal integration of global health and community-based education. The first class of 30 medical students will begin in July 2019 and graduate in 2025. These students will rotate in district hospitals, aiming to demonstrate that quality training in such environments is possible. Recognizing that the primary care provider performs the majority of emergency procedures, graduating students will be proficient in performing Caesarean sections, exploratory laparotomies, wound care, fracture management, and anaesthesia. Finally, UGHE plans to establish a General Surgery residency program in 2022 using the College of Surgeons of East, Central and Southern Africa (COSECSA) curriculum with a goal to “de-specialize” surgeons to adequately prepare residents for surgical practice in Africa.

5C. Nguyen Thi Bich Uyen, University of Medicine & Pharmacy of Ho Chi Minh City, Viet Nam

Dr Nguyen Thi Bich Uyen addressed the challenges and opportunities in paediatric surgery at her hospital, Nhi Dong 1. Viet Nam has a population of 97 million, ranking as the 15th most populous country in the world and the 8th most populous in Asia. Following economic reforms in 1986, Viet Nam has
transformed into a lower middle-income country. Historically, the three major cultural regions of Viet Nam are the North, South and Central regions. Ho Chi Minh City, also known as Saigon, is the most populated urban area in the South of Viet Nam with 9 million inhabitants. Ho Chi Minh City has three tertiary care children’s hospitals. Nhi Dong 1 was founded in 1958 and still faces issues of understaffing and lack of resources. There are multiple pathways to become a paediatric surgeon, leading to variable quality of training for paediatric surgery in Viet Nam. Dr Nguyen advocated for training of more surgeons in Viet Nam and improvements to the current surgical resident curriculum. She welcomes international collaboration and looks forward to a bright future of continuing improvement for surgical care delivery in Viet Nam.

5D. Alito Soares, Hospital Nacional Guido Valaderes, Dili, Timor-Leste

Dr Alito Soares, a general surgeon, discussed the state of surgical care in Timor-Leste. The country is mostly rural with 1.3 million inhabitants. Up to 50% of the population does not have access to surgery. There remains a high unmet need in surgical volume in Timor-Leste. The surgeon, anaesthetist and obstetrician density is 3.8/100,000. Despite free direct costs for health services at the hospital, indirect financial expenditures such as travel expenses remain high. The post-operative mortality rate is 0.6%, which is improved from 0.8% however still below the goal Lancet indicator. In discussion with audience member, Dr Glenn Guest, impoverishing expenditures may not be accurately captured by the Lancet metrics, as 86% of the population is considered impoverished preoperatively versus 87% postoperatively.

5E. Nissanka Jayawardhana, Sri Lanka

In Sri Lanka, surgical training requires 6 post-graduate years including 2 which are done in a HIC. There are 12 teaching hospitals in Sri Lanka and some private hospitals as well. The MOH has developed a free ambulance system in 2 provinces with plans to expand it to the entire country. Public health is completely free but the rest of care is out of pocket or privately insured. They anticipate increasing costs of healthcare due to an aging population and therefore need to cultivate change in the way patients think about and value the services they get. He also highlighted the need for trauma care, better bed management and increased infrastructure to support surgeons in areas with fewer resources. Possible strategies include working with other leaders in politics, religion etc and using families to help with post-hospital care.

5F. Kashim Shah, Nick Simons Institute, Nepal

Nepal has a population of 28 million. Dr Shah is senior program manager of the Nick Simons Institute (NSI) which was established in 2006 in collaboration with the government to provide care in rural regions. They identify gaps in health services and develop and pilot programs to address them. NSI’s Rural Hospital Support Program covers 50% of hospitals, particularly in areas where doctors don’t want to go. They support human resources, equipment, communication, CME and living support. They are taking a task sharing approach to support to human resources for health. More recently, NSI has added a Hospital Management Strengthening program that identifies gaps and readiness for surgical care. The goal is to increase provision of life-saving surgical care, hospital incomes and patient satisfaction.

NSI has also initiated NSOAP planning through the Ministry of Health Policy (MOHP) and have a hospital strengthening grant. In terms of baseline data, surgical volume is 387/100,000 (with 80 of those being major cases). Rates of surgery are low in the districts and mostly caesarean sections are done. Dr
Shah met last week with the minister of health who is supportive of a national surgical plan but they need lots of support to implement the changes.

5G. Ganbold Lundeg, Mongolia WHO Collaborating Centre on Surgical Care

Mongolia has the lowest population density in the world. They have the first WHO Collaborating Centre on Surgical Care, which has been operational since 2014. They have many partners including the Swiss Surgical Team, the Swanson Family Foundation and University of Utah. Most people live in metropolitan centres and 83.6% have 2-hour access to surgery. SAO density is above 40 but that is counting obstetric providers who do not do surgical procedures. Surgical volume is 6000/100,000 which has steadily increased until 2013 when they switched to ICD-10 and there was a sharp increase since all small procedures were also being recorded. In conjunction, POMR decreased but in general is low in Mongolia because patients prefer to die at home. Caesarean sections in Mongolia are free but the other bellwether procedures carry risk of catastrophic expenditure to 50% of those needing them. Health insurance covers 75% of other procedures at the present.

5H. Jemesa Tudravu, Fiji

RACS has been supporting surgery in Fiji since 1997. By 2002, there was a masters of surgery program as well as urology, paediatric surgery, plastics and neurosurgery. As they develop subspecialties, the vision and support needed is clearer so they can request visiting teams that will meet their needs and can focus more on training local practitioners when they come. Just under half of graduates continue to work in the public sector after they finish their training. In 2015, the curriculum was revised in order to better suit the Pacific Island setting. The only other surgical programs that Fijians can attend are in Timor Leste and Papua New Guinea. Specialists are greatly needed in the community, not just major cities. In Fiji, they are fortunate that the minister of health is a surgeon. Dr. Tudravu says they are planning another meeting of Ministers in August when they will discuss surgical service expansion. Fiji and Tonga are also co-hosting a surgery related side-event at the World Health Assembly this year.

They continue to need visiting teams to teach, mentor and support professional development for local specialists. There is significant loss in migration overseas and to the private sector. There is also need to expand surgical services to include surgical subspecialties, biomedical services, speech therapists etc. They would like to have a WHO collaborating centre and greater access to journals.

5I. Dr Shein Myint, Myanmar

Myanmar has a population of 60 million people of which 70% is rural. The government is committed to improving health care. In April 2016, there was a forum with health officials to try to get Lancet indicator data. SAO density is 1.1 and POMR as reported by 21 hospitals is 0.96% but higher (1.5%) at tertiary centres where the complexity of cases is higher. There are 5 medical universities where students can receive surgical training and they have developed an emergency medicine program. The Myanmar Surgical Society has 200 members of whom 140 are currently working. There have been 26 graduates of the emergency medicine program. In 2015 they signed a capacity building MOU with RACS to adapt RACS skills courses to the Myanmar context. They are also working to develop training and certification for subspecialties such as Paediatric surgery, Cardio-Thoracic, Neurosurgery and Urology.
6) Session III – Data collection and NSOAP Development

6A. Dr Rachel Koch: NSOAP updates and the way forward

National Surgical, Obstetric, and Anaesthesia Plans (NSOAPs) are developed through an 8-step process and cover 6 key domains. As NSOAPs are being written around the world, 3 models have emerged: a centralized model where the federal government leads a national plan (e.g. Zambia, Ethiopia, Tanzania, Rwanda), a decentralized Federal-Provincial model where the federal government casts a vision and engages stakeholders but each province develops its own plan (e.g. Pakistan), and a regional model where a group of countries with similar economics work together to create one plan (e.g. SADC region). NSOAP financing encompasses 3 main pillars which include the right fiscal setting on the part of the government, stakeholder engagement plan and stakeholder analysis. Dr Koch suggested that regionalization may be a useful strategy for the SEARO and WPRO regions going forward. At the Dubai high-level meeting held earlier this year, many from these regions were involved. The PGSSC has several key ways to support countries with technical assistance and networking for NSOAP development and implementation.

6B. Berlin Kafoa, Secretariat of the Pacific Community, Fiji

The Secretariat of the Pacific Community was formed in 1948 as a technical agent to support Pacific Island Nations with societal development such as land resources, statistics and health. They had a meeting of regional directors and ministers to discuss development of NSOAPs and recognize that improved regional collaboration is needed to identify regional approaches that would capitalize on economies of scale. For example, they have identified a need to improve perioperative nursing, worked to implement evidence-based planning and decision making. Importantly, we must collect data to inform policies. Dr Kafoa discussed helping the WHO with data collection and tracking the SAO workforce in the region. Finally, he discussed the need to develop regional guidelines via the Pacific clinical specialty organizations and the Secretariat’s role in partnering with other national and international organizations to accomplish large goals such as NSOAPs.

6C. Panel Discussion: Indicator Collection (Chair, Dr David Watters)

Kee Park, Liz McLeod, Villami Tangi, Berlin Kafoa, Glenn Guest

Dr Watters hosted a productive panel around the theme of partnerships and research collaboration. He began by asking how to sift through the list of many potential partners to find useful ones. Dr Kafoa said that many interest parties come wanting to work in the Pacific region but if they really want to help, they should seek advice from those in the region to avoid duplicating what is already being done.

Secondly, how do we make sure that research partnerships work for both the LMIC partners and the academic institutions that need to produce output? Kee Park shared the PGSSC model but noted that the people involved are not sufficient to accomplish all the technical assistance necessary for NSOAP creation and implementation. Therefore, partnerships are essential. He emphasized that graduated transfer of responsibility with regard to research development is key to ensuring equity with authorship. Dr McLeod added that no one academic institution can do this alone. An audience member asked if it is better for these partnerships to be formal or informal. The panel agreed that drafting an MOU is important and can help program reviewers to see that there are adequate established partnerships to make it worth
supporting. Another audience member pointed out the importance of coordinating between the needs of visiting groups so that the logistics don’t prevent provision of care, while another said that we can evaluate outside partners by whether they come in with ideas that don’t fit the context or wait to speak until they understand the local context better.

The third question to the panel was about collection of post-operative mortality rates (POMR) data. The panellists stated that the rate of death should be normalized to the number of procedures so shouldn’t go up when more procedures are done. POMR represents an important quality indicator – hospitals must be tracking the outcomes of their patients in the hospital or perhaps they shouldn’t be allowed to do surgery, as one audience participant stated. It is also important to risk stratify – elective cases in Australia have a 0.1% mortality but emergency cases are closer to 1%. In LMIC hospitals where this difference is likely already greater, the majority of cases are also done emergently so this will increase POMR.

The fourth question was about how to realistically measure 2-hour access to surgery and whether geospatial mapping is a useful method. There is seasonality to access via roads and rivers. Dr Guest suggested that perhaps having each hospital draw its 2-hour borders could be more reliable but that is not a practical goal. Dr Tangi pointed out that for the Island communities, 2-hour access will never be a realistic measure since many on small islands would have to go to a different island by sea to seek surgical care. Dr McLeod agreed that we should not change the goalpost before we have measured all places against it at least once.

Regarding specialty care, Dr McLeod said that metrics for pediatric care are not yet well defined with regard to a comparable set of bellwether procedures but discussions are underway. Dr Park was then asked if craniotomy for trauma should have been a bellwether procedure. He answered that of the 60 million head injuries per year, most are in developing countries. We could never train enough neurosurgeons to care for them all. Therefore, task sharing is imperative.

Finally, regarding ease of collection of the Lancet indicators, Dr Kafoa mentioned the health Systems Information System which seeks to collect the indicators for the Pacific region. Ministers need to budget for additional SAO providers so that some can spend time doing research and policy work on these issues. Tonga has developed an electronic system to collect POMR data from the pre-existing electronic medical record system.

7) GIEESC—Future Directions

Dr Walt Johnson: Lead, Emergency and Essential Surgical Care Programme, WHO

Since its inception in 2012, GIEESC has seen a rapid growth in membership, from 624 members initially, to 2421 members at present. Dr Johnson explained that there has never been a formal vision and mission statement for the GIEESC, however, one has now been proposed and will be shared with members soon. The GIEESC member listserv is being updated in hopes to continue to be an avenue to share information about the work of the WHO and EESC program in global surgery. All interested parties were encouraged to join by going to the WHO surgery webpage if not already members.
8) Annex

8A. Annex 1: List of participants

**Erick Akwan**
Jayapura, Papua Province
Indonesia

**Sophie Alpen**
Royal Darwin Hospital
Australia

**Tristan Anderson**
QLD Health, Corinda, Queensland
Australia

**Russell Andrews**
Los Gatos, California
United States of America

**Donald Aronggear**
Jayapura, Papua
Indonesia

**Mich Atkinson**
Orthopaedics
Sydney, Australia

**Abebe Bekele**
University of Global Health Equity
Kigali, Rwanda

**Maloni Bulanauca**
Labasa Hospital
Fiji

**Jitoko Cama**
Waikato DHB
Hamilton, New Zealand

**Deb Colville**
Royal Australasian College of Surgeons
Melbourne, Victoria, Australia

**Hamish Ewing**
Fitzroy North, Victoria
Australia

**Malin Fredén Axelsson**
Lund University
Farsta, Sweden

**James Gedy**
Jayapura, Papua
Indonesia

**Marc Gladman**
Adelaide Medical School, University Of
Adelaide
South Australia, Australia

**Michael Griffin**
Royal College Of Surgeons Of Edinburgh
Edinburgh, United Kingdom

**Glenn Guest**
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Waurn Ponds, Victoria, Australia

**Lars Hagander**
Lund University, Lund, Sweden

**Kenneth Harris**
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Ottawa, Canada

**Graham Hextell**
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Australia

**Jess Hill**
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West Footscray, Victoria, Australia
Andrew Hill
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Auckland, New Zealand

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Darwin, Australia

Michael Hollands
RACS
Australia

Prue Ingram
Interplast AU and NZ
Australia

Aishah Ishak
Australia

Aiza Ismail
Australia

Berlin Kafoa
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Chris Kimber
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Clayton, Victoria, Australia

Natalie Kew
General Surgery
Melbourne, Australia

Rachel Koch
General Surgery
Nashville, TN, USA

Hnin Laie Yee Cho
Myanmar

Richard Lander
RACS
Wellington, New Zealand

Philip Le Page
Australia

Jacob Lepard
Neurosurgery
Birmingham, AL, USA

Ida Marie Lim
Philippines

Ganbold Lundeg
Mongolian National University of Medical Sciences
Ulaanbaatar, Mongolia

Yin Myo Lwin
Department of Surgery, University of Medicine (2), Yangon, Bago, Myanmar

James Macneil
Australia

Elizabeth McLeod
RACS
Carlton North, Victoria, Australia

Kenneth Mealy
Royal College of Surgeons in Ireland
Dublin, Ireland

Rodney Mitchell
Australian and New Zealand College of Anaesthetists
Melbourne, Victoria, Australia

Mark Moore
Australian Craniofacial Unit
Adelaide, SA, Australia

Sie Thu Myint
University of Medicine (1), Yangon
Yangon, Myanmar
Mayzin Myo
Yangon, Myanmar

Sonal Nagra
Deakin University
Geelong, Victoria, Australia

Suresh Khanna Natarajan
Singapore

Jade Nunez
University Of Utah Center For Global Surgery
Salt Lake City, Utah, USA

Kee B Park
Neurosurgery
Harvard Medical School
Boston, Massachusetts, USA

Richard Perry
RACS
New Zealand

Aryono Djuned Pusponegoro
South Jakarta, Indonesia

John Quinn
RACS
Brisbane, Queensland, Australia

Tasmea Sefa
Liverpool Hospital
Warriewood, New South Wales, Australia

Mohammed Kashim Shah
Nick Simmons Institute, Nepal

Claire Sharpin
Alfred Health
Melbourne, Victoria, Australia

Haitham Shoman
Harvard Medical School
Boston, Massachusetts, USA

Manuel K. Sibhatu
Jhpiego, Johns Hopkins University
Addis Ababa, Ethiopia

Alito Soares
Hospital Nacional Guido Valadares Dili
East Timor

Christopher Strader
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Villami Tangi
Tonga

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Royal Darwin Hospital
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Neil Wetzig
RACS, Heal Africa Hospital, Democratic Republic of Congo
Brisbane, Queensland, Australia

Rachel Wilkins
Albury Wodonga Health
Australia
Katsuhiko Yanaga
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New Guinea
### Meeting Agenda

**WORLD HEALTH ORGANIZATION**

Emergency & Essential Surgical Care Programme

WHO Global Initiative for Emergency and Essential Surgical Care

Eighth Biennial Meeting

Bangkok, Thailand

06 May 2019

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<td><strong>BREAKFAST &amp; REGISTRATION</strong></td>
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<td><strong>Session 1: Opening Ceremony and Welcomes</strong></td>
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<td>Chair: Dr Walt Johnson</td>
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<td>08h45</td>
<td>Opening of the Meeting and D-G video presentation</td>
<td>Walt Johnson</td>
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<td>09h00</td>
<td>Royal College of Surgeons Thailand</td>
<td>Somprasong Tongmeesee</td>
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<td>09h15</td>
<td>WHO HQ</td>
<td>Ed Kelley</td>
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<td>Royal Australasian College of Surgeons</td>
<td>John Batten</td>
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<td>09h45</td>
<td>Australian and New Zealand College of Anaesthetists</td>
<td>Rod Mitchell</td>
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<td>10h00-10h30</td>
<td><strong>COFFEE BREAK</strong></td>
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<td><strong>Session 2: Regional and Member State Updates</strong></td>
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<td></td>
<td>Chair: Dr Annette Holian</td>
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<td>10h30</td>
<td>WHO India Surgical Collaborating Centre update</td>
<td>Nobhojit Roy</td>
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<td>10h45</td>
<td>Innovative Medical School Education</td>
<td>Abebe Bekele</td>
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<td>Time</td>
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<td>11h00</td>
<td>Viet Nam</td>
<td>Nguyen Thi Bich Uyen, Megan Vu</td>
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<td>11h15</td>
<td>Timor-Leste</td>
<td>Alito Soares</td>
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<td>11h30</td>
<td>Sri Lanka</td>
<td>Nissanka Jayawardhana</td>
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<td>11h45</td>
<td>Nepal</td>
<td>Kashim Shah</td>
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<td>12h00</td>
<td>WHO Mongolia Surgical Collaborating Centre update</td>
<td>Ganbold Lundeg</td>
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<td>12h15</td>
<td>Fiji</td>
<td>Jemesa Tudravu</td>
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<td>12h30</td>
<td>Myanmar</td>
<td>Shein Myint</td>
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<td>12h45-13h30</td>
<td><strong>LUNCH BREAK</strong></td>
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<td><em><em>Session 3: Data Collection and NSOAP</em> Development</em>*</td>
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<td><strong>Chair: Dr Abebe Bekele</strong></td>
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<tr>
<td>13h30</td>
<td>NSOAP* Development</td>
<td>Rachel Koch</td>
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<td>13h45</td>
<td>Secretariat of the Pacific Community</td>
<td>Berlin Kafoa</td>
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<td>14h00</td>
<td>Panel Discussion: Indicator Collection</td>
<td>Kee Park</td>
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<td>Moderator: David Watters</td>
<td>Berlin Kafoa, Liz McLeod, Viliami Tangi, Glenn Guest</td>
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<td><strong>Session 4: GIEESC Business Meeting</strong></td>
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<td><strong>Chairs: Dr Megan Vu and Dr Rachel Koch</strong></td>
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<td>15h15</td>
<td>WHO GIEESC—business and future directions</td>
<td>Walter Johnson</td>
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<tr>
<td>15h30</td>
<td><strong>MEETING ADJOURNED</strong></td>
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*National Surgical, Obstetric and Anaesthesia Plan*
8C. Annex 3: Speakers

Session I

Dr Walter Johnson: Lead, Emergency and Essential Surgical Care Programme, WHO HQ

Dr Somprasong Tongmeesee: Secretary of Surgical and Trauma Care, Ministry of Health, Thailand

Dr Ed Kelley: Director Patient Safety and Service Delivery, WHO HQ

Dr John Batten: President, Royal Australasian College of Surgeons

Dr Rodney Mitchell: President, Australian and New Zealand College of Anaesthetists

Session 2

Dr Nobhojit Roy: WHO India Surgical Collaborating Centre

Dr Abebe Bekele: Dean, University of Global Health Equity, Butaro, Rwanda

Dr Nguyen Thi Bich Uyen: Paediatric Surgeon, Viet Nam

Dr Alito Soares: General Surgeon, Timor Leste

Dr Nissanka Jayawardhana: General Surgeon, Sri Lanka

Dr Kashim Shah: Program Manager, Nick Simons Institute, Nepal

Dr Ganbold Lundeg: WHO Mongolia Surgical Collaborating Centre

Dr Jemesa Tudravu: Fiji

Dr Shein Myint: President, Myanmar Surgical Society

Session 3

Dr Rachel Koch: Research Fellow, Harvard Program in Global Surgery and Social Change

Dr Berlin Kafoa: Secretariat of the Pacific Community

Dr David Watters: Past president of RACS

Dr Kee Park: Harvard Program in Global Surgery and Social Change

Dr Liz McLeod: Paediatric surgeon, Melbourne

Dr Viliami Tangi: Tonga

Dr Glenn Guest, Program Director ATLS Australia