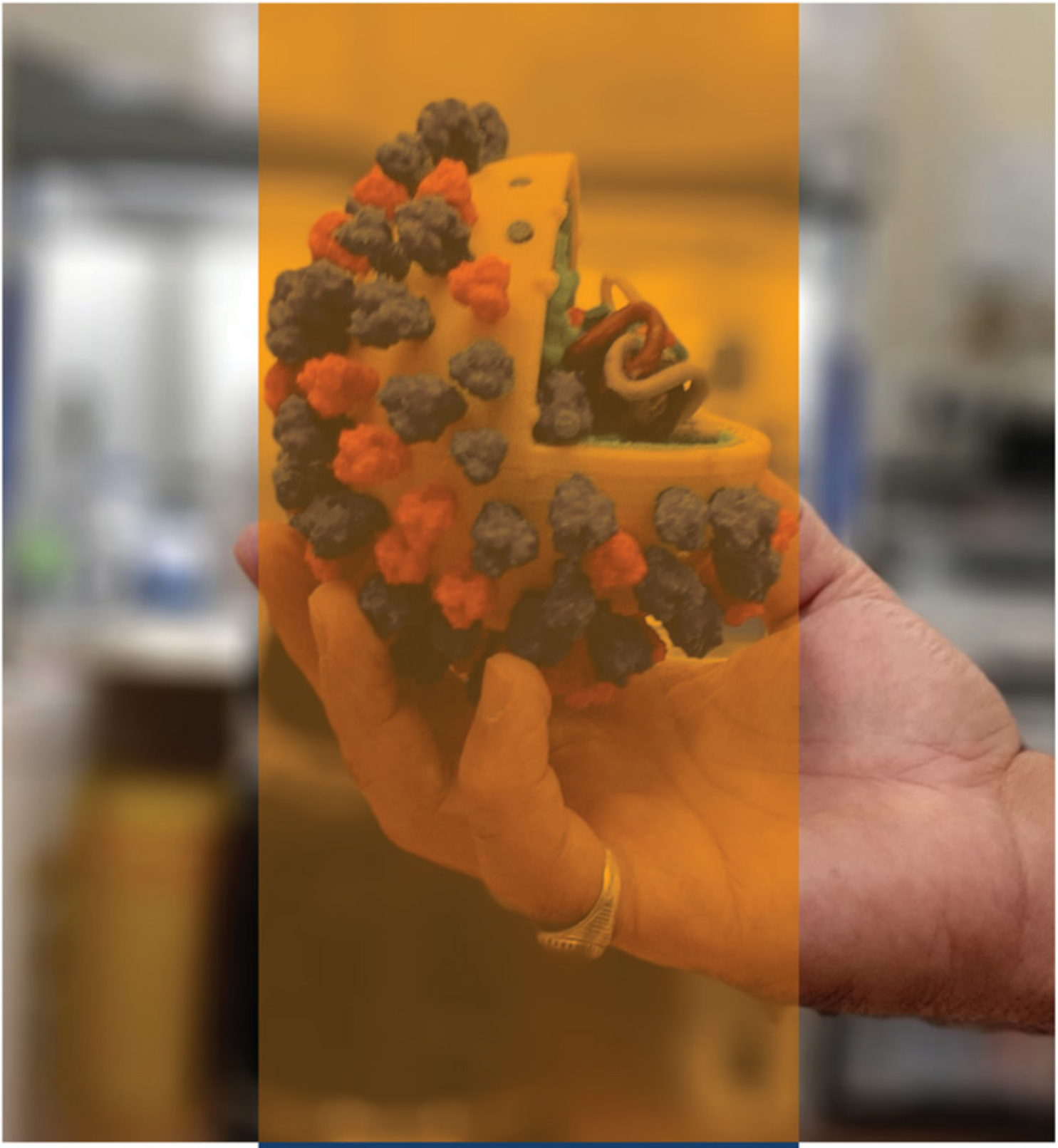

WITS UNIVERSITY

CENTRE FOR SURGICAL HEALTHCARE

SOUTHERN AFRICA DEVELOPMENT COMMUNITY

SURGERY, OBSTETRICS AND ANAESTHESIA TECHNICAL EXPERTS WORKING GROUP ON SURGICAL HEALTHCARE

JULY 2020

SOA-COVID-19 SITUATION AND ACTION REPORT

INTRODUCTION

The Southern Africa Development Community (SADC) Technical Experts Working Group on Surgery, Obstetrics, Anaesthesia was established through two consecutive resolutions of the SADC Senior Official and Health Ministers Conference (i.e. Decisions I, of 2018 in Windhoek, Republic of Namibia and Decision XXI of 2019 in Dar-Es-Salaam in United Republic of Tanzania) to, inter alia, provide policy and strategic advisory initially to the 16 Member States, the SADC Secretariat and other partners and stakeholders such as African Union through the African Centre for Disease Control and the World Health Organisation (WHO) and though a multi-disciplinary, public-private partnership jointly working to accelerate and scale up universal access to timely, safe, affordable, appropriate and quality surgical, obstetrics and anaesthesia healthcare for all the 345 million population of the SADC region. This is aimed at contributing to the bigger goal of revitalisation of Primary Health Care (PHC), Strengthening Health Systems (SHS) and attaining and sustaining Universal Health Coverage (UHC) towards, WHO-3Billion and Sustainable Development Goals (SDG).

The SADC Technical Experts Working Group on Surgery, Obstetrics, Anaesthesia (SADC-TEWG-SOA) is composed of Member State (Ministry of Health) representatives in the form of health service delivery professionals and Focal Point Persons (Health Policy and Managers, Surgery, Obstetrics, Anaesthesia, Theatre Nursing, Emergency/Critical Care and Public Health); representatives of the appropriate health professional associations; academic institutions; as well as other non-state actors. The SADC-TEWG-SOA is actively engaged every week (SADC SOA-Situation Room Conference Calls) and deliberates cost-effectively through global health diplomacy and engages on current SADC SOA priorities, challenges and solutions, leveraging current advances in communications and digital technology, to provide policy and strategy advisory in the form of recommendations channelled through the SADC Secretariat to support acceleration and scaling up of surgical services as its outputs. The work of the SADC-TEWG-SOA is coordinated and advanced through mobilisation and sharing information and resources through the SADC Regional Collaboration Centre on surgical health care- the Wits Centre of Surgical Healthcare (WiCSH), whose motto is “sustainable development through Primary Healthcare & Universal Health Coverage”

METHOD OF WORK: SADC-SOA/COVID19 “SITUATION ROOM” PLATFORM

The SADC-TEWG-SOA on Surgical Healthcare first action was to establish a **SADC SOA-COVID situation room** to review the role of SOA in COVID respiratory infection pandemic prevention and control especially in critical care and sustaining access to essential and emergency SOA service in COVID and non-COVID patients.

Since April 2020, the SADC-TEWG-SOA has been deliberating, through a weekly tele-conference, on the following strategic objectives as part of the country and region-wide COVID19 preparedness and response to minimise COVID specific and overall morbidity and mortality;

1. How Member States working with other stakeholders/partners can **maintain essential and emergency surgical, obstetric and anaesthesia healthcare services (EESOA)** while protecting their limited surgical heath workforce from infection during the COVID19 pandemic.
2. How Member States working with other stakeholders/partners can rapidly map and **expand their anaesthesia and emergency/critical care capacity** as part of their preparedness and response for life support required in the management of severe and critical COVID19 cases.
3. How Member States working with other stakeholders/partners can **leverage emergency investments made into healthcare and lessons learnt** during the COVID19 in expanding access to anaesthesia and critical to advance the sustained access to timely, safe, affordable, appropriate and quality surgical, obstetric and anaesthesia healthcare.

OUTCOME AND FINDINGS

I. The SADC-TEWG-SOA first action was to develop **SADC SOA-COVID policy and strategy paper** to guide the surgical healthcare contribution to the COVID19 pandemic response (see appendix 1).

The goals of the *SOA-COVID19 policy and strategy paper* is to reduce the high morbidity and mortality due to respiratory emergencies associated with severe COVID-19 disease and pneumonia, by rapidly increasing access, equity, and coverage to quality acute and emergency care (A&E) centres, high dependency (HDU) and Intensive care (ICU) beds and facilities with essential and emergency surgical, obstetric and anaesthesia (EESOA) service delivery supported by high level of infection prevention and control (IPC) and personal protection and special motivation of health work force (HWF).

The proposed joint *SOA-COVID19 strategic Interventions* are:

- To establish a **national SOA Situation Room** to complement the national COVID-19 situation room supported by the SOA task force and network of provincial and district EESOA focal points.
- To conduct a national rapid review and establish data base of capacity and required **temporary and long-term expansion all A&E, HDU and ICU facilities** and designate safe and COVID19 infection isolation sections at all levels of the national health service.
- To conduct a national rapid review and establish data base of **ambulances and medicine, PPE commodities supply vehicles** for emergency transfer from home and primary health care units to district hospitals and referral between hospitals
- To define the required national number of **generalist and specialist A&E and Anaesthesia health staff** with adequate PPE required per Emergency Centre, HDU and ICU bed and unit
- To define the required type and number of **national medical and surgical equipment** required per A&E, HDU and ICU bed and unit
- To define the required type and number of national **medical drugs and consumables** required per A&E, HDU and ICU bed and unit
- To provide simple regional **algorithms and wall charts** to guide diagnosis, treatment, rehabilitation and palliative care of severe respiratory distress and for emergency and essential surgery patients
- To advocate and lobby for **continuation of a defined triage of emergency and essential obstetric and surgical services** through and parallel supporting safe SOA structure and systems in line with completion and implementation **of national SOA strategic plans and resource mobilisation**

Most SADC countries are still in the process of developing and putting in place the appropriate COVID19-SOA healthcare policy and response measures.

II. The SADC-TEWG-SOA continued with several interactions and presentations on the **Country SOA-COVID Profile's** obtained through the SADC-SOA-COVID19 Country Situation and Profile Rapid Assessment Tool;

IIa. SOA Health Work force

Most Member States have included part of the surgical health workforce especially Anaesthetist and Emergency Medicine specialists into their national taskforce on COVID19 preparedness and response. This has presented a great opportunity for contributions on critical care and life support for severely ill COVID19 patients to reduce morbidity and mortality. This has highlighted the current low levels of anaesthesia specialist health work force and inadequate HDU and ICU infrastructure to support adequate access to high quality SOA service

delivery. All countries have used this opportunity to secure extra health financing to increase numbers and different types of health staff and also support them with complimentary emergency allowances. **Surgeons and obstetricians need to be included and to be more active in all national COVID19 Task-force platforms to ensure that routine essential and emergency surgery is continued in both COVID infected and non COVID patient in need of surgical care.**

IIb. SOA Essential and Emergency Service Delivery

Most SADC Member States scaled down essential SOA services but maintained emergency surgical healthcare during the initial phase-1 lockdown response to the COVID19 pandemic. All countries continue to face major challenges in sustained supply of Protective Personal Equipment (PPE) and the **training and mentorship of surgeons, obstetricians, and anaesthetist in use of PPE has been inadequate to ensure adequate infection prevention and control (IPC).**

During the lockdown period, it was also noted that surgical volume due to road traffic accident and inter-personal violence and injury reduced dramatically. The access to essential maternal and obstetric services declined due to security roadblocks and limitations in transport. Following the relaxation of the lockdowns and lifting of the ban on the sale of alcohol in some of the SADC countries, a surge in trauma, road accidents and inter-person violence cases presenting to A&E facilities as been observed. This observation needs further scientific research scrutiny and if proven could potentially guide future surgical public health policy to manage the associated role of alcohol in the incidence of injuries as a non-communicable disease (NCDs) epidemic.

IIc. SOA Health Infrastructure

All SADC countries with support of the World Health Organisation (WHO) and partners have conducted rapid reviews of their infectious disease and acute care HDU and ICU health facility capacity and have rapidly moved to expand isolation facilities and open central health facilities to increase COVID19 designated HDU and ICU beds. They have established national guidelines for COVID19 prevention and treatment with follow up training of different categories of health workers in infections prevention and control and use of different types of PPE and early diagnoses and treatments of COVID cases. Innovative approaches have been used such as clinic tents and field hospitals and prefabricated buildings and repurposing existing hospitals and stadiums. All have faced challenges in procuring and supply of equipment and consumables with slow and fragmented supply lines and inflated costs.

Even before COVID19, all countries have been focusing on emergency and lifesaving SOA services due to limitation in functional health infrastructure such as operating theatres, HDU and ICU and general surgical beds with inadequate numbers and motivated surgeons, anaesthetist and obstetrician especially in secondary and primary district hospitals with limited equipment and sustained supplies of surgical consumables. **The cessation of what ongoing limited essential surgery has greatly increased the backlog of long surgery waiting lists.** This additional *COVID19 collateral SOA damage* due to further break down in access to essential surgical services need to be recorded and documented. Increase in COVID19 associated collateral surgical burden and mortality has been summarised in an advocacy editorial for scientific publication and mobilisation of senior health policy makers and managers.

IId. SOA Peri-Operative care

Improving the emergency and peri-operative environment could serve both the COVID19 and the surgical patient needing emergency and essential surgical healthcare. However, **there is need to include more surgical health workforce**

at country level in COVID19 management training with special attention to infection prevention of COVID19 in symptomatic or asymptomatic patients of unknown sero-status with a surgical condition.

III. Best Practice were documented from the SADC country situation and profile presentations from country focal-points and experts for improved capacity to manage both COVID19 and emergency and essential surgery cases were shared (See highlights below)

All countries indicated that they were still in the process of establishing appropriate protocols and guidelines for safe and quality surgical healthcare during the COVID19 pandemic.

IIIa. Oxygen Therapy Surge CapacityZambia developed tools to assess gaps in adequate and sustained oxygen supply for critical care for severe COVID19 respiratory disease and other respiratory infections. This was also followed by the development of an oxygen training program and advocacy strategy to fill gaps and support Oxygen delivery and on-site support for high quality critical care.

IIIb. Enhancing Emergency Surgical Obstetric careA case of a central women and new-born hospital was presented to showcase the increasing of the number of dedicated operating theatres for caesarean sections through private-public partnership and efficient use of this facility through triage and effective operating theatre management to reduce waiting time and maternal and perinatal morbidity and mortality. This model was also used to prepare operating theatre for COVID19 infections requiring surgery.

IIIc. Multidisciplinary SOA-COVID TeamsThe importance of the different health professionals such as surgeons, obstetricians, anaesthetists and theatre nurses working as a cross-cutting service delivery teams with infection control and emergency medical physicians was brought up by all SADC countries in effectively addressing the COVID19 and SOA preparedness and response.

RECOMMENDATIONS

1. Essential and Emergency Surgery, Obstetrics and Anaesthesia should be continued by all public and private hospitals in all SADC countries with designated COVID19 hospital or wards in different health facilities with HDU/ICU and Operating Theatres for all COVID infected patients requiring surgery.
2. All SADC countries to nominate and encourage SOA specialists in public and private healthcare, professional associations and academic institutions to join SADC-SOA network of experts.
3. SADC countries are encouraged to establish a real time hospital data base to track available critical care capacity such as HDU and ICU beds and specialist work force with required essential diagnostics, equipment and drugs and PPE and consumables with ongoing SOA work load and back log.
4. SADC countries are further encouraged to establish an SOA surveillance within their health information system to track COVID19 hospitalisation of moderate and severe and critical cases in isolation, HDU or ICU and number and types of health workers with COVID infection and disease.

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