(preferably by direct formal assessment), and that the process of providing supervision be monitored so that inadequate supervision can be identified and corrected.

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Equity and participation in outreach surgical aid: Interplast ANZ

Go to the people,
Live with the people,
Learn from the people,
Plan with the people,
Work with the people,
Start with what they know,
Build on what they have,
Teach by showing,
Learn by doing,
Not a showcase, but a pattern,
Not piecemeal, but integrated,
Not odds and ends, but a system.
Not to conform, but to transform.
Not relief, but release.
Jimmy Yen, 1930[1]

Cleft lip and palate deformities affect approximately 1 in 600 newborn babies worldwide. On the assumption that 15 000 children are born per hour globally, then a child is born with a cleft somewhere in the world every 2.5 min.[2] From birth to maturity, multiple surgical and non-surgical procedures disrupt these children's life.

The incidence of clefts is higher in the developing world and may be even as high as one in three hundred live births. The disability adjusted life-year rate (DALY) is estimated to be similar to that for cataracts, a condition which is often stated to be a priority in least developed countries.[3]

Unrepaired clefts within disadvantaged communities represent a significant burden of disease, as many of these children are not educated, lead reclusive lifestyles, are unable to marry, do not work, and are a burden to their families and communities. Resource-poor settings have insufficient medical and nursing staff to treat these children, and most facilities have a chronic shortage of qualified surgeons that makes the situation even worse. Although there is a huge diversity in treatment protocols in relation to cleft conditions, it is clear that early surgical intervention provides the main stay of treatment.

Although surgery is recognized as an essential component of basic healthcare in the developing world, it has often been viewed as a luxury. This has led to weak healthcare policy that does not reflect the needs of children.[4]

Social factors that effect facial clefts in resource poor settings include:[5]

- poverty;
- lack of transportation;
- a shortage of trained providers for cleft repair;
- limited awareness about repair possibilities;
- poor integration of surgery; and
- marginalization of patients with unrepaired clefts.

It is our experience that cleft lip and palate surgery can be safely performed on well-selected patients in appropriately selected resource-poor settings.

The Laos Cleft Lip and Palate Program is an example of a program that has been run by Interplast Australia and New Zealand (Interplast). And this paper highlights issues of equity, participation and human rights in surgical aid.

Interplast is an accredited non-government organization (NGO) accredited with the Australian Government Agency for International Development and is a member of the Australian Council for International Development.

Interplast's vision is to improve lives through the treatment of disabling conditions that inhibit full engagement in society by providing access to surgical and allied health services, and by supporting and building capacity within local health services to enable them to deliver surgical or other healthcare interventions.

Access to education, professional development, new technologies and mentoring aim to alleviate profession isolation, attract human resources, encourage commitment and cultivate expertise. The Lao Peoples Democratic Republic (Laos) has a commitment to primary healthcare and an improvement of surgical care to patients at all levels and in remote areas.[6] Interplast has been working with the Ministry of Health in Laos since 1996 to improve access to cleft lip and palate patients from disadvantaged communities.

Laos is a land-locked mountainous country bordering China, Burma, Thailand, Cambodia and Vietnam. Its population of 5.9 million people, composed of four different ethno-linguistic groups, is among the poorest in Asia. Healthcare indicators such as an infant mortality rate of 79 deaths per 1000 live births rank it 135th in the United Nations Development Programs human development index.[7]

This program started in 1996 when the then Australian ambassador to Laos (Mr Roland Rich) noted the apparent high prevalence of unrepaired cleft lips and palates within the country. Interplast has since made 12 visits to Laos to assist in the management in these cleft cases. Interplast teams generally consist of two surgeons, two nurses and an anaesthetist. This program has resulted in the establishment of the local Laos cleft lip and palate team from the Mahosot General Hospital (Vientiane) comprising of three surgeons, an anaesthetist and a dedicated operating room nurse. The local team is now capable of providing cleft lip and palate services, outreach programs in the provinces, and the teaching of surgeons in provincial centres.

The objectives of this program have been to:

1. perform reconstructive cleft surgery on indigent children; and
2. to foster long term sustainability of cleft lip and palate surgical services in Lao Peoples Democratic Republic.

And this has been achieved by:

1. building local capacity for the Mahosot surgical team by training the skills essential to provide surgical management of cleft lip and palate in Vientiane and provincal areas;
2. training nurses and anaesthetists to assist with the delivery of surgical services,
3. developing and improving local capacity of provincial surgical, hospital and nursing staff;
4. supporting outreach work to rural areas; and
5. monitoring and measuring outcomes associated with the program.

As the Interplast visits progressed, greater participation by theatre, nursing and medical staff resulted in progressive knowledge and an increase in confidence. By as early as 1998, many cases were being performed by the local team in our absence, and the results were objectively assessed and considered to be of a high standard. Following consultation with the Laos Department of Health, a rural outreach concept was developed. This led to the establishment of the Laos cleft team that was able to travel to provincial centres, improving access to rural areas. In 2001, one of Laos's surgeons repaired 166 cleft lips and palates in four provincial centres and 20 clefts in the capital Vientiane alone. All of these cases were fully documented and reviewed with pre- and post-operative photographs. In collaboration with the Laos Government, development of the outreach service has continued.

The last formal cleft 'service program' of Interplast to Laos was carried out in February 2007. On that program, Interplast confirmed that the Laos surgeons were able to carry out the vast majority of cleft lip and palate surgeries, and the additional expense of an Interplast team appeared to be no longer warranted. Interplast will however continue to support the long-term sustainability of outreach programs.

Discussion

Primary healthcare is a relatively modern approach, and is essential healthcare made universally accessible to individuals and families within communities by means acceptable to them, through their full participation, and at a cost that the community and country can afford.[8] The underpinning principal of primary healthcare is that health is a basic human right.

Surgery is an essential but often forgotten component of the public health system in developing world agendas. The treatment of cleft deformities clearly fall within the mandate of the declaration of Alma Ata,[9] and as such must be included as a primary healthcare priority in planning agendas.

Equity is inexplicably linked to access, both geographically and financially. In spite of this, healthcare has developed into a two-tiered system in much of the developing world, with relatively sophisticated urban hospitals and a system of basic peripheral primary healthcare centres in rural and remote areas. This fails to deliver care for surgical conditions, because the people who need the treatment cannot access or afford it. Our experience is that children born with clefts are much more likely to have timely repair of these conditions if they live in city centres, as opposed to rural villages. This health inequality is not an isolated problem to Laos,[10] and the outreach program aims to alleviate the poor/rich differences seen in this case.

Funding issues are a source of difficulty, and the long-term viability of outreach programs will depend on the availability of sustainable funding. Health facilities in Laos rely on user fees for most of their income. The user pay system limits access to the poorer members in the community, and particularly to surgical procedures. Interplast has funded these out-of-pocket expenses in partnership with other NGOs; however, long-term funding options, which include voluntary cost recovery and local health insurance schemes, are being explored.

Participation of local stakeholders in outreach programs is essential, and we encourage community consultation regarding the operation and management of these services. Careful negotiations and formal memorandums of understanding between donors and governments assist in the long-term viability of surgical aid.

Interplast has avoided a vertical approach to program planning and management. Local resources have been mobilized to identify prevalent cases. Education of primary healthcare workers in local communities will improve the referral system. Local participation improves decision making, and ultimately local surgical trainees will be expected to become leaders and provide health services and training within their country.

There still remains a need for the development of a seamless approach to the management of cleft lips and palates from birth to maturity. Hopefully, this will evolve with time, and we aim to foster the inclusion of all aspects of the healthcare system.

Many barriers affect the success of outreach programs. Financial resources will be the main barrier to a sustainable local cleft outreach service, and the long-term commitment of Interplast and other international NGOs to support the ongoing funding will assist to this end; however, the local team will still require professional development that is in our opinion best delivered in-country by visiting teams.

In conclusion, the Interplast cleft lip and palate program in Laos has been a success since 1996. The training of a local cleft team and commencement of an outreach program has lead to equity and participation via an integrated approached. The ongoing success will depend on the long-term commitment by Interplast and other international NGOs, a stable local counterpart and a teaching/educational culture that supports sustainability and growth.

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