Dear Colleagues

When I was confirmed as incoming IFSC president at the AGM in January 2022 I promised to write to all IFSC member organisations in order to lay out my vision for the IFSC and discuss ways we plan to get there. It took much longer than expected to get to this letter out for two simple reasons: transition of office took longer than I had anticipated and I wanted to show some value in IFSC membership before writing to everyone.

May I firstly thank everyone who took the time to attend the IFSC AGM for 2021, held over two meetings in November and January for technical reasons. Thank you to everyone who attended, shared ideas, took part in discussions and especially for the support in taking some new ideas forward. A special word of thanks to Bob Lane for his unwavering support in handing over his role and for supporting a change of direction in IFSC’s programme of work. A special thank you also to the new executive board (EB) and other office bearers for making things happen, with a special mention for Jane Gilbert, our executive assistant (EA), who has continued to run the office with precision while split between Bob and my demands.

This letter will further address:

1. New goals for IFSC.
2. Current IFSC structure.
3. 2022 Programme of work.
4. Next steps.
5. How member organisations can contribute.

New president’s goals for IFSC

At AGM I set three principal goals for my presidency:

1. To make IFSC more open and democratic.
2. For IFSC to play its role in decolonising global surgery education, training and research.
3. For IFSC to contribute to protecting planetary health.
This meant:

1. To establish a structure of governance that is robust irrespective of who is president, including a review of our constitution, membership rules and voting processes. One aim is to make IFSC more accessible for smaller surgical societies and training bodies in especially LMICs. The reason for this is that many surgeons worldwide are not trained through traditional colleges of surgery. My hope is to use IFSC’s special status at both the UN and WHO to improve surgeons’ access to these organisations.

2. I specifically said that the time of designing training courses in rich countries for poor countries is over. This was previously a large part of what IFSC delivered but we are working with LMIC colleagues to find ways that we can use teaching expertise from all our members to support learning programmes designed in LMIC units. IFSC strongly supports enabling young surgeons in settings with limited resources to develop their own research ideas into viable projects, therefore our research methodology courses (RMCs) for trainees in COSECSA and CANECSA.

3. Climate change disproportionately affects populations in LMICs. As we drive towards the goal of wider provision of emergency and essential surgical care in especially district hospitals we should consider the environmental costs. It means that we need input from planetary health experts who understand surgery.

Changes to IFSC structure

The newly elected EB were:

- President: Fanus Dreyer
- Immediate Past President: Bob Lane
- Secretary-General: Emmanuel Makasa
- Treasurer: Paul Gartell
- Chair, Education and Research Committee (ERC): Kathryn Chu

Other office bearers:

- EA: Jane Gilbert
- Interim permanent representative to the WHO: Fanus Dreyer
- Permanent representative to the UN: Kee Park

At AGM I raised the matter of expanding input to EB meetings and decision making, potentially through a president’s advisory group. We envisage that the constitutional changes that we will propose at the next AGM will include a statutory council, with members elected through due process by member organisations. For the transition period it is my wish to continue to informally consult widely with surgeons in predominantly LMICs who share our vision for
IFSC’s new programme of work. With their permission these colleagues will be named on the IFSC website as a list of informal advisors to the president.

**Achieved so far in 2022**

2. January-May: Attended series of WHO meetings for civil society on WHO’s plans for health emergencies, as well as pre-WHA meetings for NSAs (managed to get IFSC one of 5 places as a constituency statement co-ordinator on agenda item 16.2 Better preparation for and response to health emergencies).
3. Wrote to all “surgical” NSAs for support to deliver a strong constituency statement on the value of surgical and anaesthesia care in health emergencies planning. Received very positive responses.
4. Attended WHA 75:
   a. IFSC received 4 passes for attendance in person. These were allocated to colleagues already travelling on their own account: IFSC president, Salome Maswime, Kee Park, Walt Johnson.
   b. Delivered constituency statement on 16.2, representing IFCS, ICS, WFNS, WFSA, SICOT, WSO. Also had strong support informally from ACS and the surgical office of MSF.
   c. Supported 3 other constituency statements as co-signatory:
      i. WFNS
      ii. World Health Professions Alliance (2 statements)
   d. Attended 3 side events:
      i. GSF on financing GS
      ii. WFNS/G4 on folate fortification
      iii. G4 Launch of Suva guidelines for safer surgery.
   e. Had numerous very valuable 1:1 discussions with e.g. Teri Reynolds, Ruben Ayala, Walt Johnson, Salome Maswime, Ray Price, Kee Park, Geoff Ibbotson.
5. Agreement for IFSC and GSF to work closely together on GS projects. Agreed in principle to sign a Memorandum of Understanding (MOU) with GSF.
6. Agreement to support UNITAR, RCSI in development and launch of new UN online learning hub for GS. IFSC will depend largely on fellows and members of affiliated surgical colleges and societies to help make this a success (detailed letter to follow in 1-2 months).
7. Suggested an international forum for surgical and anaesthesia organisations who work in Global Surgery, including NSAs that represent surgical or anaesthesia interests (e.g. WFSA, WFNS, ICS), GS organisations (e.g. GSF, ASAP, G4, SADC TEWG on NSOAPs) and schools/institutes (e.g. RCSI IGS in UCT, Stellenbosch, UGHE Rwanda), members of IFSC (Surgical Colleges, Societies), even MOH with strong surgical interests (e.g. Fiji, Malaysia). The plan is to meet 2-3 times per year through video link and share ideas, to know what we all are trying to achieve in GS, how we can support each other depending on individual strengths and weaknesses etc. The aim is to put surgery and anaesthesia in a stronger position in GH, especially after it has moved backwards again due to the pandemic. Strong support from members
of GSF, WFNS, ICS, G4 and individuals with whom discussed. (Letter of invitation to follow soon).

**Next Steps**

1. To continue individual points in our programme of work as set out above.
2. The IFSC is asking all affiliated members to please join us in this change of direction in our contribution to advancing surgical care in especially LMICs. We think this is a challenging time for global surgery but challenges bring new opportunities and we hope we have shown our commitment to these through the above mentioned programme of work.
3. It means that we need to ask all members to contribute financially to IFSC’s administration. To enable this the EB have decided on a new fee structure:
   a. International Colleges or Associations of Surgery: US$200.00 p.a. (50% discount for organisations based in low- and lower-middle income countries according to the World Bank Atlas method).
   b. National surgical societies or other smaller organisations: US$120.00 p.a. (50% discount for organisations based in low- and lower-middle income countries according to the World Bank Atlas method).
   c. These membership fees are per calendar year.
4. Membership fees should be sufficient to cover IFSC’s annual office expenses but not for extra costs. As we have more EB members based in the Global South it becomes important for our EB members to be present at special events at the institutions where IFSC has unique representation such as the UNGA and WHA, and at e.g. ACS, WACS and COSECSA conferences. IFSC has also been asked for financial support for GS meetings in LMICs and to enable women candidates in COSECSA get to their fellowship exams. The IFSC will need donor funding to support such expenses and we will therefore embark on a rational programme for donor support.
5. IFSC has contributed to the Egyptian Society of Surgeon’s conferences over several years through attendance by the president and provision of key speakers. We will continue to approach individuals to contribute through video talks.
6. IFSC intends to deliver a side event at the UNGA, with other GS partners. Kee Park is organising this. We have acquired funding pledges to enable our SG to attend.
7. The president plans to attend the ACS conference in October as there is a forum to speak about IFSC’s programme of work, and the COSECSA conference in December.
8. The AGM will be planned for the Thursday of the COSECSA conference.
9. Before the AGM we plan to circulate some very important documents:
   a. A revised constitution, including changes to the legal structure of IFSC. We intend all governance structures and processes to be transparent and accountable to members.
   b. Proposals on membership categories, voting processes at AGM and other meetings, terms of reference for the ERC, terms of office for the president and all other office bearers, reintroduction of an IFSC council and election processes.
   c. Financial report, potential revision of membership fee structure.
   d. When IFSC was launched, half of members were traditional surgical colleges and half were associations of surgeons. The number of surgical societies who commit to surgical training and who wish to be
IFSC members have grown significantly. We therefore should consider a slight name change to the International Federation of Surgical Colleges and Societies (IFSCS). This will have to be discussed and approved both by the EB and then we will ask IFSC member organisations for their feedback.

We trust that all IFSC’s member organisations will embrace our changes in direction and our new endeavours to keep IFSC a relevant organisation in the drive towards accessible, safe and affordable global surgical care, especially in low income communities. We will appreciate your continued professional, academic, financial and moral support.

Yours sincerely

J.S. (Fanus) Dreyer
**Abbreviations:**

ACS: American College of Surgeons  
AGM: Annual General Meeting  
CANECSA: College of Anaesthetists of East, Central and Southern Africa  
COSECSA: College of Surgeons of East, Central and Southern Africa  
EA: Executive Assistant  
EB: Executive Board  
G4: Global Alliance for Surgery, Obstetrics, Trauma and Anaesthesia Care (G4 Alliance)  
GH: Global Health  
GS: Global Surgery  
GSF: Global Surgery Foundation  
HIC: High income countries  
ICS: International College of Surgery  
IFSC: International Federation of Surgical Colleges  
LMICs: Low and middle income countries  
MOH: Minister/Ministries of Health  
MSF: Doctors Without Borders  
NSAs: Non-state actors (civil society representatives) at the WHO  
NSOAPs: National Surgery, Obstetric, Anaesthesia Plans  
RCSI IGS: Royal College of Surgeons of Ireland Institute of Global Surgery  
SADC: Southern Africa Development Community  
SICOT: International Society of Orthopaedic Surgery and Traumatology  
TEWG: Technical Experts Working Group  
UCT: University of Cape Town  
UGHE: University of Global Health Equity Rwanda  
UHC: Universal Health Care  
UNGA: United Nations General Assembly  
UNITAR: United Nations Institute for Training and Research  
WACS: West African College of Surgeons  
WFNS: World Federation of Neurosurgical Societies  
WFSA: World Federation of Societies for Anaesthesiology  
WHA75: World Health Assembly no 75 (May 2022)  
WHO: World Health Organisation  
WSO: World Stroke Organization