IEMSIG

Newsletter of the International Emergency Medicine Specialist Interest Group of ACEM

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In this Edition

Papua New Guinea
PNG is the largest recipient of Australian overseas aid, administered by AusAID. The emergency medicine programme is supported by AusAID and by ACEM. The College has contributed A$25,000 again in 2005 to support the efforts to develop EM training there. This year we have embarked upon the development of a Diploma in Emergency Medicine for health extension officers (HEOs) and nurses at Divine Word University in Madang. Sandra Rennie is the first ACEM advanced trainee to contribute to developments in PNG.

Aceh
Fellows of the College have had substantial input into Aceh in the aftermath of the Boxing Day tsunami and the Easter earthquake. Gerard O'Reilly reports on his contribution with the International Rescue Committee.

Iran
The Alfred Hospital in Melbourne is supporting the training of Iranians in emergency medicine, with the purpose of enhancing the capacity of Iranian physicians to develop the specialty at home. Gerard O'Reilly visited Iran.

The Solomon Islands
The Regional Assistance Mission, Solomon Islands (RAMSI) continues its contribution to redevelopment. Kenton Sade, who has published in Emergency Medicine Australasia, is now director or emergency medicine at the National Referral Hospital in Honiara. Bryan Walpole reports on his visit. (This article has also appeared in Your Direction).

Uganda
Ngaire Caruso, an ACEM advanced trainee, has worked with MSF previously in Asia and now reports from the strife in Northern Uganda. It is an environment requiring an unusual level of dedication and commitment.

Sri Lanka
In the aftermath of the Boxing Day tsunami and the damage done in Galle in particular, there are plans afoot to develop an emergency department and EM training in Galle. Aled Williams visited

India
The EMCON conference in Vellore in October includes several Australian speakers. See the website: www.emcon2005.org

If you have been involved in, or are going to be involved in, or know of someone involved in international emergency medicine, please let me know! My plan for 2005/2006 is to put together three newsletters, as in 2004/2005.
Best wishes,
Chris

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Papua New Guinea

Message to the 4th Emergency Medicine Meeting at the Annual Symposium of the Medical Society of PNG

Chris Curry

This is the 4th Emergency Medicine specialty meeting. The first was conducted in Alotau in 2002. At that time the only PNG doctor pursuing emergency medicine was Yongoe Kambue, then on rotation to Townsville, Queensland.

In 2003 the program for the Master of Medicine, Emergency Medicine was launched. The first doctors on the program included Yongoe Kambue in Lae, Sam Yockopua in Mt Hagen, and Marcella Seve in Port Moresby.

In 2004 new appointments to the program were Nick Dala in Goroka, Moses Lester in Mt Hagen and Alfred Raka in Lae.

This year the Postgraduate Committee of the School of Medicine and Health Sciences accepted Vincent Atua in Madang, Desmond Aisi and Wala Marjen in Port Moresby, Sonny Kibob in Mt Hagen and Julius Plinduo in Rabaul.

So there are now 11 doctors on the Masters of Medicine Emergency Medicine program, supported by 5 hospitals.

The National Department of Health has identified Emergency Medicine as a priority for development. The Plan for development envisages the eventual inclusion of an emergency doctor on the staff at eight additional hospitals, Alotau, Wewak, Vanimo, Daru, Manus, Buka, Kimbe and Kavieng. The School of Medicine and Health Sciences envisages a University role for three emergency doctors in Port Moresby.

The role and scope for graduates of the Master of Medicine Emergency Medicine will be particular to Papua New Guinea. The program will provide PNG with hospital generalists, doctors with the skills to provide primary care for the full spectrum of acute illness and injury. Training includes rotations in surgery, anaesthetics, medicine, paediatrics, obstetrics and gynaecology, so emergency doctors will be uniquely qualified to contribute to hospital services on a wide basis. The program encourages trainees to undertake Diplomas in Anaesthesia, Paediatrics and O&G. These qualifications will expand the roles that emergency doctors can take on. In addition there will be opportunities in hospital management, pre-hospital care, teaching and research.

The development in PNG of a capacity to provide for acute illness and injury requires the development of training for all primary care providers. For much of PNG the first and often sole providers are Health Extension Officers and Nurses.

Billy Selve, Dean of Health Sciences at Divine Word University in Madang, is now working on the development of an emergency medicine syllabus for HEO undergraduate training, and on providing a Diploma in Emergency Medicine as a postgraduate training for HEOs and Nurses. This is a very important initiative that will improve the capacity of primary carers to provide appropriate care to the majority of Papua New Guineans.

There is also a component for emergency nursing included in the Nurses program at the School of Medicine and Health Sciences in Port Moresby.

Emergency doctors from Australia and New Zealand will maintain, and I hope will expand, their contributions to these developments. It is also my hope that emergency nurses will play a role as well. The Australasian College for Emergency Medicine will continue its support.

While expats can assist in some limited areas, the main drive for development needs to be by Papua New Guineans for Papua New Guineans. It is

heartening to see this happening, as senior people in the medical fraternity become involved and as trainees themselves develop through the program. Involvement of national emergency doctors in teaching medical students at UPNG and in teaching the Primary Trauma Care course demonstrates this expanding capacity.

So does this, the 4th Emergency Medicine Meeting at the Annual Symposium. It is being run by nationals for nationals. The Meeting program includes the Keynote topic of snakebite envenomation, a major clinical challenge for PNG that emergency doctors will make an increasing contribution to. Sessions on Research, Education and Clinical Emergency Medicine are provided by national trainees. The Annual General Meeting of the South Pacific Society for Emergency Medicine will provide a forum for discussion of issues impacting on the development of emergency medicine. The presentation of a short course for Primary Trauma Care and Resuscitation is a clear demonstration of the increasing maturity of the PNG emergency medicine community.

A very important purpose in a meeting of this sort is the opportunity for 'networking'. This is the person to person contact, the face to face meetings that can lead to greater understanding, co-operation and collaboration towards a common purpose.

So I wish you well in your two days of collective engagement with emergency medicine, and I wish you well for a constructive and motivating meeting with people of like mind.

A Diploma in Emergency Medicine for Health Extension Officers and Nurses in Papua New Guinea

Chris Curry and Sandra Rennie

The Faculty of Health Sciences at the Divine Word University in Madang, PNG, is developing a Diploma in EM for health extension officers (HEOs) and nurses. Dean Billy Selve expects that the course will be on offer for the 2006 academic year. He is being assisted by Sandra Rennie, an advanced trainee with ACEM from Fremantle Hospital, WA.

Divine Word University was established in 1996 and took over HEO training from the National Department of Health in 2003. Clinical training is mainly at Modilon Hospital, the government funded provincial hospital in Madang.

HEOs and nurses are the backbone for health care provision in most of PNG. They are commonly the sole providers for rural communities, where 80% of the population live. They also play a major role in hospitals, functioning with considerable independence. In Outpatient and Emergency Departments they provide sole care for the majority of attendances.

HEOs and nurses train in three year undergraduate programmes. Until recently the curricula have not included emergency medicine. The Diploma in EM will be offered as postgraduate training to enhance the capacity of primary providers in the delivery of appropriate care for the full spectrum of acute illness and injury in the rural PNG context.

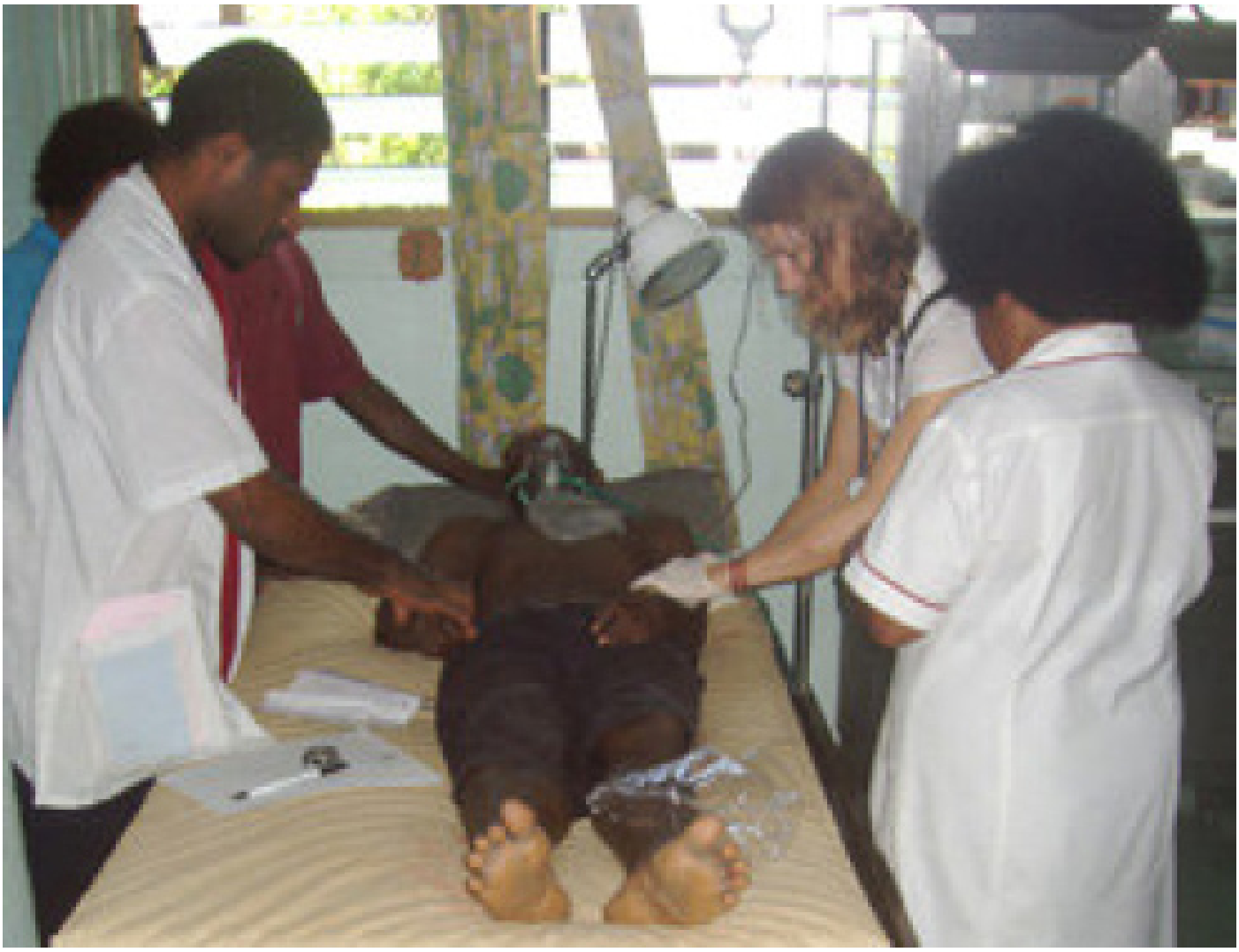
The curriculum will be based upon the 'Standard Treatment Guidelines for HEOs, Nurses and Doctors' that have been produced by the disciplines of medicine, paediatrics and O&G at the School of Medicine and Health Sciences, UPNG. HEOs learn a range of minor surgical skills, which will be enhanced.

The Diploma will address the specific needs of health care workers in Papua New Guinea, who often face issues of extreme isolation and remoteness, together with a high rate of emergency situations accompanying illness, injury, reproduction and childhood. Sources of

injury include motor vehicle crashes, falls from trees, natural disasters (volcanoes, tsunamis), domestic violence and clan violence.

Topics will include personal protection and adequate preparation for emergencies, triage in large scale emergencies and natural disasters, and appropriate evacuation of patients to centres of definitive care. Students will gain confidence in their ability to anticipate, assess and manage emergency situations, improve individual patient outcomes and contribute to community wellbeing.

The Diploma will also need to address the challenges related to limited resources and transportation.



Sandra Rennie assists in the assessment of a critically ill patient with altered level of conciousness in the resuscitation area of the ED at Modilon Hospital, Madang.
(photo C.Curry)

Aceh
Public Health following the Boxing Day Tsunami

Gerard O'Reilly

The international response to the Boxing Day tsunami was unprecedented. Amongst many humanitarian groups was the International Rescue Committee, a large, independent non-government organization which deals with refugee health. Many of the contexts in which IRC would work in are in conflict or post conflict. Aceh, as a huge post-natural disaster relief effort, required an enormous scale-up of human resource needs in a very short period.

Ric Brennan, FACEM, is the dynamic medical director of IRC, based in New York. Aware of his interest in employing Australian Emergency Physicians, and given my previous work in the humanitarian arena, I took the position of Emergency Health Manager in Aceh Utara district, Aceh, on the 2nd of February, 2005. This was a six-week position and matched the Emergency Public Health role I would expect.

After several days assisting in Banda Aceh, I took a helicopter to Lhokseumawe, in Aceh Utara, 300km east of Banda. There were two main refugee camps with more than 8000 refugees. I joined an IRC team of 5, including a Health Coordinator, Nurse, Logistician, and Team Leader. The Ministry of Health was proactive and sensible, and IRC worked comfortably alongside their representative, Dr Hadi.

The major emergency public health roles in this context included epidemiological surveillance, communicable disease control, and emergency health care.

Surveillance involved casting a safety net for the most lethal and likely diseases to spread through the refugee camps if left unidentified and unchecked. Cholera, fortunately, did not rear its ugly head. Measles invariably does. There were several dozen cases of measles in my first three weeks in Aceh Utara. The context of mass population displacement demands early measles immunisation, and we effected a mass campaign.

Malaria, typhoid and dengue fever, shigellosis and meningitis were all present, but fortunately isolated in number. By the end of the first three weeks, IRC had augmented the epidemiologic surveillance in the main refugee areas of Aceh Utara.

Communicable disease control involves many aspects including effective water and sanitation, case identification, and, of course, immunisation. Case identification was the process of following up cases noted in the surveillance reports. Suspected cases of measles, dysentery, malaria and meningitis were tracked through the patient registration and confirmed or not confirmed. If confirmed, treatment and disease control measures were implemented.

Emergency health care is about supporting health care in the emergency phase. This is capacity-building rather than substitution. Elements include training of doctors, nurses, midwives, and community health workers; training of the trainers; supervision; sustainable pharmaceutical support and the refinement of focussed reporting practices.

Finally, it needs to be emphasised that these measures serve as a safety net to further tragedy peculiar to refugee camps. Whilst IRC was assisting with lost livelihoods through the rebuilding of fishing boats, no effort could reverse the enormous loss of life.

I am grateful to Ric Brennan for his enthusiasm and support, and to Chris Curry, for catalysing the integral links that created these opportunities.

Iran
Overseas Trainees in EM: Iran and the Alfred, Melbourne

Gerard O'Reilly

Twelve months ago, the Alfred Emergency and Trauma Centre received a number of applications for international students to undergo Emergency Medicine specialist training in Australia. This was in addition to regular requests to spend periods of weeks or months rotating through the Emergency Department for experience or a small portion of training.

The interest for long-haul Emergency Medicine training was coming from locations with a fledgling exposure to Emergency Medicine as a specialty, but burgeoning national government support for the same. Such countries included Iran, Saudi Arabia and Oman. Scholarships were awarded to candidates, and a bond (e.g. mortgage of the family house) created, to ensure that this investment would be realised through the development of Emergency Medicine locally.

Aware of the length, intensity and demands of the FACEM training program, and the significant investment in Emergency Medicine being made by these governments, I visited Iran in July 2004 to interview several candidates and to meet with the relevant government representatives.

Whilst in Iran I met with senior members of the Ministries of Health and Education. I conducted lengthy interviews with applicants from Iran and Saudi Arabia, and I met with referees whilst visiting the relevant hospitals.

At the Rassoul Akram Hospital in Tehran the senior staff in the Emergency Department had an eclectic background and included a paediatric surgeon, a rheumatologist and an anaesthetist. Six month rotations to emergency rooms in the U.S.A. have been undertaken by senior staff, and the first residents were about to graduate from their three year Emergency residency training program. This was the only hospital with such a training program in Iran.

Whilst in Iran I made a visit to Bam, which seven months previously had been the site of a devastating earthquake that had destroyed the city with its ancient citadel and killed 30,000 people.

In November 2004 and February 2005 the successful applicants from Iran and Saudi Arabia, respectively, arrived with their families in Melbourne to commence their training at the Alfred Hospital. The demands on these people are many. Cultural changes for whole families can be huge, even before the assimilation into the ways of western medicine. Clinical workload and the looming primary examination add to the stressors.

This initiative is not about cheap labour, or increasing our workforce reserves. It is about sharing in the pioneering advances made by countries of varying resources into the field of Emergency Medicine. The college has been very supportive and I am aware that a number of my Emergency Physician colleagues have embarked on similar roads, to the mutual benefit of Emergency Medicine globally.

The Solomon Islands
Sojourn with RAMSI in the Solomons

Bryan Walpole

During May/June 2005 I acted as aero medical retrieval co-ordinator for the Regional Assistance Mission in the Solomon Islands (RAMSI). Honiara, the capital on Guadalcanal, is 3 hours by jet from Brisbane.

Five years ago in June two platoons of the Malaitan Eagle Force (a local militia) staged a coup by taking over Honiara, including the radio station and parliament. They held the Prime Minister at gunpoint then forced his resignation.
From then it was all down hill as Treasury was ransacked, law, public safety and healthcare all deteriorated, and many people left the country for personal security and employment. Eighty five percent of the islanders live in a subsistence economy with taro, coconut and green vegetables from kitchen gardens and with chicken and fish to provide protein, so there was no famine.

Several UN attempts at rapprochement (Honiara Accords, Townsville Agreement) failed as too weak, so finally the Solomons Government invited their Pacific neighbours from 6 countries (as RAMSI is) to send first troops then police to restore law, democracy and financial accountability.

We will be there for some considerable time as the political problems are immense, age old, and deep rooted in pre-colonial tribalism.

The 500 officers and support staff of RAMSI are protected by a medical corps equipped with Australian standard health services. Two GPs, a surgeon, an anaesthetist, a dentist and an emergency physician together with four paramedics, pathology scientist, radiographer (with ultrasound), eight nurses with theatre and ICU skills provide round the clock cover for all contingencies.

The Solomons cover an area of the Pacific the size of Western Australia, with 9 provinces, 200 inhabited islands and 400,000 population. So for transport there is a Superpuma 8 ton jet helicopter on immediate standby, backed up by a BK 117 and a Bell jet ranger. The Puma has such a powerful draft that we cannot land near villages as the blast will destroy the huts. It was a wonderful but noisy retrieval platform with huge doors, internal space, million lumen night sun, speed and comfort.

On station a fully equipped Toyota Troopy intensive care equipped ambulance covers local retrieval. A 10 million dollar portable theatre/ICU/ Recovery ward/ radiology suite from UK together with a stand-alone dental suite, GP clinic and 8-bed ward make for a formidable response unit. By far the most sophisticated outfit in the South Pacific.

The five doctors sleep on station on rotation. The surgeon, physician and EP are on constant call. The EP should be inside the helicopter within 30 minutes of callout or huge financial penalties apply, thus one is confined to town, the hotel pool, or snorkelling with a scout.

Honiara, a ramshackle town of 40,000 or so, has a rustic charm, with potholes to swallow a Mini, occasionally lit streets at night with pitch black Melanesians to find and avoid, and the ubiquitous betel nut sellers representing the local equivalent of welfare recipients everywhere. The world-wide film of E.Coli is spread thick around Honiara, with water and sanitation still not restored post coup.

Health maintenance for the police was onerous. Malaria protection, hydration, clean water, minor infections, skin cleanliness, diving related issues, and all the home type chronic health problems kept the GPs busy. Half the force is scattered to distant islands with HF radio contact, so "'phone medicine" is a needed skill.

Much the most pleasurable part of the work was liaison at National Referral Hospital, where I attended the weekly grand rounds and did two weekly rounds in the ED with director, registrar, intern and nurses. Solomon Islanders study medicine in Fiji (University of the South Pacific) or in PNG. Nurses train locally. All are immensely practical.

There is rudimentary triage, usually 2 or "other". Nurses do much of the history taking, will make common diagnoses and commence treatment, usually IV fluids and antimalarials or antibiotics, with the management confirmed by the single doctor (for 45,000 attendances per year) when time permits.

Malaria is holoendemic, both falciparum and vivax. The former is treated successfully with quinine IV, (I saw a girl with fitting from cerebral malaria become conscious and lucid within 3 hours, and fit for discharge), and the latter with chloroquine. Artemether is used if there has been poor response or if the patient has been referred on from the nurse-run community clinics, where most simple cases are treated. Avoquinone/proguanil and mefloquine are too expensive. Locally trained technicians do Giemsa thick and thin films for diagnosis, and report the percent parasitemia.
Eighty percent of locals are carriers, and eradication is but a dream, with only a rudimentary public health presence. We by contrast took prophylactics, slept with nets and fogged the station twice weekly with permethrin.

Children with febrile bloody diarrhoea are common and it is a high cause of mortality when untreated. Presumably most cases are enterohaemorrhagic E Coli. No cultures are done as they mostly respond rapidly to IV chloramphenicol and are discharged from the ED. Beds in the childrens ward (there are 12) are often accessed after a few days of waiting, so the Obs Ward in ED is overflowing with children. High fever with abdominal pain is presumably typhoid, and also responds to chloramphenicol IV.

A 3 year old girl and her grandmother consumed fresh fish and the grandmother quickly died. The child presented by taxi with a paralytic illness, was ventilated with an adult ventilator without ABG monitoring (the first child ever ventilated there) and also died. No diagnosis made but it may have been tetradotoxin (puffer fish) poisoning.

Major trauma is unusual, with abominable roads, no tall buildings and inter-tribal violence low with RAMSI present.

The ED staff does a wondrous job, with no ICU, CT, endoscopy, angiography or neuro/cardiac/ENT surgery, with one doctor per shift and days of access block. Clinical acumen is king and queen. Listen, ask, look, feel and move, then occasionally X/Ray, gets them by. Rather as the responders to the tsunami reported in the last IEMSIG Newsletter.

However, the ED director Kenton Ratu Sade has a vision and plan for EM in the hospital, the province and the country. So when economic conditions permit, as in Australasia 30 years ago, he is ready to roll out a plan.

I can recommend NRH for an elective student or registrar looking for a challenge and fervently wish College will approve short rotations to such rich posts.

Uganda
Working with MSF in Uganda

Ngaire Caruso

Introduction
I am currently working for Médecins Sans Frontières (MSF, or Doctors without Borders) in Northern Uganda. I'd like to share with you some background information on MSF, the general situation here in Northern Uganda, the work of our project and my own personal experience here.

Médecins Sans Frontières
MSF was founded in 1971 by five French Red Cross doctors. They were frustrated by the silence of the International Committee of the Red Cross (ICRC) on the cruelties they had witnessed during the Biafran Civil War in Nigeria.
The MSF Charter states that MSF offers assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict, without discrimination and irrespective of race, religion, creed or political affiliation. The MSF charter also emphasizes the principles of neutrality, impartiality, medical ethics, respect for human rights, and independence from all political, economic and religious powers.

MSF workers are volunteers who receive a per diem for field expenses and a small stipend. There are two main aspects to the work – provision of medical aid, and witnessing. Witnessing consists of our presence among people in danger, and a duty to report on the situation and fate of these people.

The Uganda project
Since 1986 the Lord's Resistance Army (LRA), led by Joseph Kony, has waged a war in Northern Uganda. The LRA attack Ugandan Government forces and civilians. During the conflict, the LRA have abducted more than 20,000 children, forcing them to be child soldiers and for sexual exploitation. The insecure situation has forced over 1.2million people to move from their villages into Internally Displaced People (IDP) camps.

In northern Lira District it is estimated that up to 80% of the population is currently displaced and living in IDP camps. Living conditions are terrible. The tukuls (huts) are packed tightly together. Access to fields for cultivation (and therefore food production) is largely restricted because of the insecurity. Basic services such as clean water, sanitation and medical services are grossly lacking.

We have a large project here in Lira District and a large team of 13 expatriates. The medical team comprises a team leader (me), 3 doctors, 3 nurses, 1 laboratory technician and1 mental health officer. We also have over 400 national staff. We work in seven sites – 6 IDP camps and a therapeutic feeding centre here in Lira town. Between 20,000 to 40,000 people live in each camp, so in total we serve a population of around 170,000 people. In each of the 6 camps we have a clinic which provides basic health care, and a water and sanitation program.

The camp clinics each see around 600 patients per week. Malaria is overwhelmingly the major cause of morbidity. The other main causes include diarrhoea, respiratory tract infections, wounds and skin infections. At the moment we are not testing for or treating HIV/AIDS, but clinically we suspect the prevalence is quite high. In keeping with the suspected HIV/AIDS prevalence, there is quite a lot of tuberculosis as well.

It is remarkable how many lives can be saved with antimalarial drugs and simple antibiotics – a far cry from the way we practice medicine back home. On the other hand, it is difficult to cope emotionally with the other 5% or so of patients for whom we can do nothing here, but could easily help if we had adequate resources.

As well as basic medical care in the camps we do antenatal care, have a supplementary feeding program for moderately malnourished children and are starting family planning. We also have a mental health programme - counsellors in each camp who conduct individual sessions, group sessions and psychoeducation. We are working in

conjunction with the Ministry of Health to provide immunizations.

The therapeutic feeding centre in Lira town provides feeding and treatment for severely malnourished children. Our occupancy varies from around 150 up to 320 patients. We're also treating malnourished children who have tuberculosis, and are planning to expand our tuberculosis program to treating people of all ages in the camps.

On the water and sanitation side of things, we are building 24 boreholes, protecting 8 springs and digging 4 shallow wells. Access to clean water is a nightmare for the IDPs – earlier this year a survey found they have access to 1.7 litres/person/day. The internationally recognized minimum standard is 15-20 litres/person/day. Following our water and sanitation program, access has increased to 5.6 litres/person/day, but there is obviously still a long way to go. We are also providing tools and equipment for the construction of 2,244 latrines – the international standard is 20 people per latrine. In our camps we found a ratio of around 69 people per latrine.

As I mentioned above, part of our mandate is witnessing and then advocating on behalf of our beneficiaries. For example, a survey by Action Contra La Faim (ACF) found a global malnutrition rate in Apac District which was double the rate here in Lira District. ACF wanted to establish supplementary feeding centres in Apac District. We, MSF, lobbied strongly and successfully for the World Food Programme to supply supplemental feeding centres run by ACF. As part of my job I am constantly lobbying and pushing the Ministry of Health/District Health Services here to improve their level of services to the camps.

My role in Lira

I'm here for seven months as the Medical Team Leader. It is a fairly managerial and administrative role, rather than a clinical role. I coordinate our medical activities and liaise with other actors (the Ministry of Health, ECHO, UNICEF, and other NGOs). Other areas of responsibility include providing medical advice and support to the medical team, epidemiological surveillance, managing the drug orders with the logistician, training of National Staff, National Staff health, and following our referred patients.

It's a big contrast to my previous two missions with MSF where I was very much directly involved in working in clinics, and my vision was fairly restricted to the work in front of me. I miss the clinical aspects of work, however I feel I'm learning a lot in this new role. I am gaining a wider perspective – on our project here, the direction we should be going in, and also about the way the aid industry functions in general.

I can't really describe an average day for me here as it varies a lot. I spend a lot of time in meetings with other actors, working on protocols and strategies, and writing reports (doesn't sound very glamorous does it?). In reality the statistics and reports can get a bit dry, but the rest of the work is interesting and challenging. It's been great to be part of the team implementing new activities, such as starting immunizations and antenatal care, and significantly improving the management of our tuberculosis patients.

In the camps

I really enjoy spending time in the field – meaning in the camps, rather than in Lira town. When you consider the conditions under which these people are living, it is amazing that the camps are not an oppressive depressing place. Walking around the camps you see old men sitting around playing cards, young men playing soccer, women preparing food or carrying water or washing their children (as usual it is the women doing the work). We are met with friendly smiles and greetings, and are followed by a hoard of barefooted dirty laughing children chanting "munu, munu" (white person). Some small babies just howl with fear when they see these strange white people, much to the amusement of everyone else.

Certain incidents bring you back to the harsh reality of their lives. Two women presented to our clinic with multiple scalp lacerations. They were part of a group of seven who had gone to the fields to collect seeds. They were attacked by seven LRA rebels, most of whom are teenagers. The other five people were killed, these two survived by pretending to be dead. Another woman we sent down to Kampala for plastic surgery - the LRA had cut off her lips and her ears.

The young boys aged 11 to 15 have a weekly session with one of our mental health counsellors. These

are children who were abducted by the LRA but have now managed to return to their families. Often they have been forced to kill members of their own family, so face huge difficulties when they return to live with their families. They seem to greatly enjoy the chance to draw pictures on books given by our counsellor – the pictures are full of LRA and UPDF (Ugandan Army) soldiers shooting each other or cutting off limbs. Occasionally there is a soccer player thrown into the mix. They told us of their nightmares, where they find themselves strangling people or cutting off limbs with an axe.

Then there are the people who do not have war injuries but are suffering because of the lack of services here. One 14 year old epileptic girl had a seizure whilst cooking and fell head first into the fire. We are managing her horrific burns in our clinic. Babies die of pneumonia, although I know I am really dreaming when I think of intubating and ventilating them. A young girl who is paralysed presented with horrific pressure sores (her femur was on view). We referred her to the local hospital who did very little. She self discharged but then returned for further care at our urging. The hospital staff refused to readmit her. She died several weeks later. On the other hand it's absolutely wonderful to see the kids in the TFC transform from listless skeletons into chubby energetic kids.

Living in Lira

Living conditions for the expat team here are surprisingly luxurious. In Lira town we all live together in 2 houses, and have quite decent food, electricity (most of the time) and running water, and a volleyball net and badminton net in the back yard. Lira town has a few places to go out for a drink or a bite to eat. I think it's a challenge in any MSF project that you are living and working closely together with the rest of the team, 24/7 – but I feel lucky to have a supportive and very sociable team here.

Living conditions for us when we're in the camps is obviously a lot more basic – we stay in tukuls, with basic food, pit latrines, and the shower is a barrel filled with water. Basic but comfortable, and we have the luxury of the Lira house to return to on the weekend.

Close

My time here has been busy and challenging, filled with many highs and lows. Overall I feel very glad to be part of a project that really is helping a lot of people. If anyone is interested in finding out more about MSF, working for MSF or giving us some money, please have a look at the MSF Australia website:

www.msf.org.au

Sri Lanka
Prospects for EM training in Sri Lanka

Aled Williams

This trip to Sri Lanka started off with one of those long shot coincidences. I was watching the 730 report in January this year. The feature was a round up of some Tsunami stories and I was amazed to hear the story of Sian Hughes, a Melbourne Pediatrician who was in a beach resort in southern Sri Lanka when the tsunami swept through the lobby of her hotel. Luckily she and her family were on the first floor, survived and Sian went on to do a lot of medical work with the survivors in the next few days. Amazing story really and all the more so as Sian and I both went to school in a small west Wales village called Aberaeron.

I got in touch with her and in July we met up in Changi airport on the way back to Sri Lanka. She was involved with a group of Victorian doctors providing aid to the Karapitiya hospital near Galle in southern Sri Lanka, they'd wanted an emergency physician to go along and ...well we Welsh stick together!

The group wanted an EP along as the Victorian Government was in the process of funding a project to build an emergency wing in the hospital and wanted some input on the ground. It was a fascinating experience. The 'outpatients' area is mobbed by about 1000 people a day who presented for treatment. No real triage area, you just took your number and stood in the queue. If you were really sick and somebody noticed it you were ushered through to a tiny 2 bedded emergency area where 2 very junior doctors administered inexpert but enthusiastic resuscitative care. If the area was full that was tough luck.....off to the ward with you and whoever may be there to look after you.

I was amazed though by the enthusiasm of the doctors and nurses to learn and the amount of theoretical knowledge they had. They would be a great team to train up. If you are interested you might get the chance. After speaking to the representatives of the aid division of the Victorian government it is highly likely that they will approach ACEM through the IEMSIG to provide trainers once they have built some infrastructure on the ground.

Watch this space!

India
Emcon 2005, Vellore, India

25 - 28 October 2005

The theme is 'Critical Decisions in Emergency Medicine.'
The venue is the Christian Medical College, Vellore.

The program includes International Faculty from Australia, Pakistan, Singapore, Sri Lanka, Sweden, UK and USA.
The Australian contributors include Frank Daly, Tony Joseph, Anne-Maree Kelly, Sally McCarthy, Lindsay Murray.

www.emcon2005.org

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