IEMSIG

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Editor Chris Curry

Tropical Medicine

Greetings from Liverpool England, the centre of the Tropics. Where the sun does shine. Occasionally.

The first School of Tropical Medicine in the world was established here in 1898/1899, just months before the competition in London. There was a time when there was more human traffic from the Tropics through Liverpool than through any other port in the world. Now they struggle to find patients for us to see. But they do have a good laboratory and can grow lots of the better known parasites. And there are folks here who have been almost everywhere. Collecting specimens. As the British are inclined to do.

Afghanistan

A British doctor and Australian wife have been in Afghanistan for several years. They are looking for a couple of generalists to work in Kabul. It would be paid work with HOPE WorldWide involving primary health care for Afghan and expatriate patients, and training Afghan health professionals. The duration is up to the individual- anywhere from 2 months to 1 year.
Contact Mark Timlin.

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Papua New Guinea

I am now planning rotations through the Senior Lecturer in Emergency Medicine post at the University of Papua New Guinea for 2005. The preferred time frame is a Medical School term which is 9 weeks, however shorter time frames will be considered, especially for first timers.

We have secured a University flat very close to the Medical School and the Port Moresby General Hospital. It has two bedrooms, so Senior Lecturers could accommodate companions, visitors, registrars, medical students etc.
Information on the programme is available in a report in Emergency Medicine Australasia:
"The first year of a formal emergency medicine training programme in Papua New Guinea".
Curry C, Annerud C, Jensen S, Symmons D, Lee M.
Emergency Medicine Australasia 2004; 16, 343-347

Please contact me if you are interested or if you would like more information.
Email: chriscurry1@compuserve.com

Solomon Islands

Kenton Sade is a Solomon Islander who trained in Papua New Guinea. He presented a paper at the ACEM ASM in Sydney in 2002. He wanted to join the PNG emergency medicine programme but has been obliged to return to the Solomon Islands for the time being. He has written a description of his activities, Appendix 1 below.
If you would be interested in visiting an aspirant emergency doctor in the Solomon Islands, please contact Kenton directly. He could use some support.
Email kkhospital@solomon.com.sb

Advanced Paediatric Life Support (APLS) scholarship for the Pacific Region

APLS Australia wishes to support activities which foster and strengthen paediatric emergency community links between Australia, New Zealand, and the countries of the Asia-Pacific region. They have established a scholarship to assist neighbours to participate in an APLS course and to visit an Australian emergency department.
"From 2004 APLS Australia/ New Zealand will offer an outreach scholarship, Paediatric Emergency Development Scholarship (PEDS). Its purpose is to support the development of paediatric emergency systems in countries where these are in their infancy, and where funds for such activities or for overseas education are limited."

See Appendix 2 for details.

Roundabout

Gerard O'Reilly has visited Iran, Kerala (India) and PNG.
David Eddey has done the DTM&H in Liverpool and has put it to use in PNG.
Simon Jensen and David Symmons have been at work in PNG.
Megan Cox has been investigating East Africa.
Varna Amarasinghe is making connections in Sri Lanka.
I am developing a possibility in Indonesia.

If you have news, developments or stories to tell, please let me know.

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Post Script:

"The Developing World".
It is rich countries that are developing. Many poor countries in the so-called 'developing world' are struggling and some are failing to develop.
Consider the following:

- The World Bank says that the average Japanese cow gets $7 per day in subsidies. In Europe the support is $2.20 per day for every cow. Almost half the world's population lives on less than $2 per day.
- The world's richest countries spend 1bn on subsidies every day of the year.
- Least developed countries account for more than 40% of the world's population but less than 3% of world trade.
- Rich countries export goods and services worth approximately $6,000 per person. The equivalent figure for 'developing' countries is $330, and less than $100 for poor countries.
- In 2000, 'developing' countries received $50bn in overseas aid, but lost $65bn because of rich country protection of textiles and agriculture.
- In 2001, Mali received $38m in US aid. It lost $43m in cotton export earnings because of US subsidies.
- When exporting to rich countries, producers in poor countries pay tariffs that are four times as high as those paid by producers in other rich countries.
- Mozambique received $136m in EU aid but lost $106m in sugar export earnings because of EU subsidies.
- A Ghanaian farmer gets 1.2% of the price a British consumer pays for a bar of chocolate. Between 1996 and 2000 Ghana increased cocoa production by almost a third but was paid a third less.
- Every day people in the poorest countries lose out on $1.3bn because of unfair trade rules. This is 14 times what they receive from aid.
- Africa has lost the equivalent of 50% for every dollar received in aid because of the falling prices it gets for its home-produced commodities.
- Increased patent protection for companies in rich countries costs 'developing' countries $40bn each year for medicines, seeds, software and textbooks.
- A good trade agreement at the end of the Doha round of World Trade Organisation talks could add $520bn to global incomes by 2015 and lift 144 million people out of poverty.

Source: The Guardian Weekly. September 24-30, 2004.

Appendix 1/Appendix 2 - below.

Appendix 1

Perspective:

The Status of Emergency Medicine in Makira Ulawa Province, Solomon Islands

Kenton Sade

Introduction

I am a Solomon Islander. I trained in medicine in Papua New Guinea (PNG) and my interest in emergency medicine (EM) was fostered while a medical officer in Lae. Now I am the sole doctor at Kirakira Provincial Hospital in Makira Ulawa Province on San Cristobal Island. This Perspective is a personal view of the status of EM here.

The Solomon Islands (SI) is a nation in the Melanesian archipelago of the western Pacific. It shares ocean borders with PNG in the west and with Vanuatu in the east. It consists of six main islands and many scattered smaller islands and is home to 400,000 people. The most common and cheapest transport is by sea, by outboard motor boat for local travel and by passenger ship for inter-provincial travel. Flying is very expensive and only a few can afford it.

The capital Honiara, on Guadalcanal, was the centre of the recent crippling ethnic unrest. It has the only adequately equipped hospital, the National Referral Hospital (NRH). There are two other places with specialized physicians, Gizo Hospital of Western Province and Kilufi Hospital of Malaita Province, which is currently manned by two doctors. Other provincial hospitals have one or two doctors providing medical services for the whole province. Only Western and Malaita provinces have church-run hospitals operating.

Major emergencies that reach provincial hospitals have previously been airlifted to Honiara NRH. Air transport is very expensive and consumes limited funding to the provinces.

Emergency Medicine in Makira Ulawa Province (MUP), San Cristobal

Knowledge and skills

The nursing staff at the Kirakira provincial hospital have very limited knowledge of the basic principles in recognizing and responding to threats to life. For example, recognition of hypovolaemic shock and how to deal with initial stabilization, and how to respond to acute shortness of breath were lacking and have almost cost several people their lives. Basic resuscitation procedures were also not known and staff seemed to be afraid to perform them. Previous medical officers had made very little progress in ensuring that basic concepts in resuscitation were passed on to the staff who were with the patients around the clock.

There are only two midwives in the whole province and they both work in the hospital. They handle some of the difficult labours and consult the doctor when they can go no further. Vacuum Extraction has assisted very much in some cases.

Pre hospital care is even more rudimentary than in the hospital. Patients often arrive with life hanging by a thread.

Equipment

When I arrived at the hospital at the beginning of 2004, basic resuscitation equipment had gone missing from the stores. Laryngoscopes (handles, blades and batteries) were all over the place. There were no chest tubes, underwater seal bottles or connecting tubes. I had to use a large feeding tube (18 gauge), suction bottle and oxygen tubing to drain a spontaneous pneumothorax that had developed tension (the patient is still alive and well today). There are no endotracheal tubes available.

However, emergency drugs are available - adrenaline, lignocaine, sodium bicarbonate, hydrocortisone and others, - but in very limited quantities. They have helped with some of the situations that I have encountered thus far.

Support Services

Laboratory services offer basic haematology, serology and microscopy. Biochemistry and histology specimens are prepared and sent to Honiara. Basic radiological studies and ultrasonography are available and the one radiographer is very helpful.

Rural Clinics Referrals

Ideally referrals flow from Nurse Aid Post (NAP) to

Rural Health Clinic (RHC) to Area Health Centre (AHC) and so to the Provincial Base Hospital (PBH). However, there are some NAP and RHC that are close to the hospital and send patients directly to the PBH. Some of these cases are not genuine emergencies and are costly to transport.

Genuine serious medical, surgical and obstetrics cases which cannot be handled at the PBH are sent to Honiara. Some are sent on scheduled flights but for some a charter flight is organised. The cost of around SBD $18,000.00 to charter is usually shared between the Provincial Health Services and the NRH.

Recently RAMSI made some mercy flights to medevac some of our very ill surgical patients to NRH. However, this service has ceased now.

The Emergency Scenario in 2004

Having trained in Papua New Guinea, I have been able to provide some definitive surgical and obstetric interventions. I have undertaken three laparotomies for ectopic pregnancies, two appendicectomies and six Caesarian sections (4 emergencies and 2 electives). These operations were undertaken using Ketamine infusions, spinal anaesthetic and local infiltration. In the case of emergency caesarian section, ketamine is delivered by IV bolus after delivery of the baby.

There have been two chest tube insertions done, both for spontaneous pneumothoraces that developed tension.

Since March 2004 there has been only one emergency referral to Honiara. This was a patient with acute bowel obstruction. He had a bowel resection done by the surgeons in NRH for an intussusception of a diverticulum.

In-service

Because the level of knowledge and confidence in the ability to do active resuscitation was very low in the nursing staff, I provided a two day in-service. Subsequently we had quite a number of emergency cases that were handled more appropriately:
A pregnant mother who presented irritable and hypotensive had a haemoglobin of 13gm/l (normal 110-160). She received adequate fluid resuscitation and was cross-matched and transfused with 4 units of fresh whole blood. She was discharged and subsequently readmitted for safe hospital delivery. A man with severe respiratory distress from chronic obstructive airways disease was managed with everything we have at hand: Aminophylline, adrenaline, Ventolin nebulizer. He settled down and has been discharged. At the same time we had to do an emergency Caesarian section using a small generator for lighting and fans. There was a power black out at the time. Baby and mother have since been discharged.
These are some examples of what adequate and appropriate knowledge can do to help those of us in the periphery with limited resources to save lives.

Future Plans

Because of the scarcity of doctors in the provinces, the future planning for emergency services in Makira Ulawa Province will put emphasis on Post Basic Emergency Nursing trained personnel who will be stationed in the Area Health Centres (AHC).

The three AHC are located on the eastern and western ends of San Cristobal Island and one on Ulawa Island. Kirakira Hospital is located in the middle of the northern side of the main island, San Cristobal. Thus the RHC and the NAP within the catchment of the AHC can send emergency or semi-emergency cases to these AHC for assessment and appropriate intervention or for referral to Kirakira Hospital. A Referral Guideline has been established and is currently in use. At Kirakira Hospital the doctor can then decide the next course of action. A doctor with some emergency training can at least undertake some surgical intervention at this level.

We do not have any skilled emergency nurses yet. If we are able to recommend a candidate for training at the University of Papua New Guinea in Acute Care Emergency Nursing in 2005, we should have at least one qualified emergency nurse within our workforce by 2006. By 2008 we could have three, who will be stationed at the AHC around the province.

We have two qualified midwives at the hospital. Others that are currently in training will be posted to the AHC to provide care to mothers in the rural areas.

For doctors, we have only general practitioners with MBBS and experience. If we had specialist doctors then other skilled medical services could be offered. A priority is to provide training for health personnel in dealing with emergency scenarios, so they can recognize signs of severe illness or injury and can intervene before it is too late.

Conclusion

In the Solomon Islands there is some organizational structure in existence to deal with emergencies, although it is ill defined. Currently there is a lack of

skilled personnel to ensure that help is there when it is needed. Support is barely available but those here are making the best out of the very limited resources available. There is a lot of room for improvement.

We might not have the logistic support that others enjoy but we have an idea of what will work for us. You have to come and experience it for yourselves before you can really appreciate what it means to provide health services here in Makira Ulawa Province. Emergency Medicine skills are what we need to have out here, because it is a generalist capability that is most useful for us at the moment.

We manage to save a few lives. We could save more if we had the right tools, and emergency medicine is one of them.

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Appendix 2

APLS Australia
Paediatric Emergency Development Scholarship

Background
From 2004 APLS Australia/ New Zealand will offer an outreach scholarship, Paediatric Emergency Development Scholarship (PEDS). Its purpose is to support the development of paediatric emergency systems in countries where these are in their infancy, and where funds for such activities or for overseas education are limited.

Activities which foster and strengthen paediatric emergency community links between Australia, New Zealand, and the countries of the Asia-Pacific region, are acknowledged as important by APLS Australia.

Principles of the Scholarship:
Applications are made to the APLS PEDS Committee via the National Executive Officer, APLS. The closing date is 1 November of the calendar year prior to the Scholarship year, and applicants will be notified, in writing, of the outcome of the submission within 2 months. Funds will be available from 1 February of the scholarship year.

The PEDS committee will consist of a minimum of four and maximum of five APLS instructors and will including representation from each of the following:
- APLS Board
- Co-opted APLS Course Co-ordinator
- Co-opted APLS Instructors

The functions of the PEDS committee will be to
- disseminate information about the APLS PEDS scholarship,
- review applications,
- select scholarship recipient,
- reply in writing to all applicants,
- co-ordinate scholarship including airfare, accommodation, course placement, and recommended hospital placement, with the support of the course coordinator/s
- recommend and/or support mentors
- review outcomes of scholarships.
- inform the APLS Board about the progress of the above functions.

Membership of the committee will be by appointment by the Board. The Board will consider nominations to the PEDS committee from/of any APLS instructor with an interest in this field. Preference will be given to those with a background in health care for developing regions. Robyn Brady is appointed by the Board as the inaugural chair. Subsequent chairs will be elected, from time to time, by the committee. All APLS Instructors will be notified of the Scholarship and PEDS committee position vacancies by email.

Up to $A 5,000 may be granted each year. These funds would be expected to cover:
- Return economy airfares from home country
-
- Basic accommodation during the course
- Living costs during hospital attachment if applicable (see below)
- Associated costs (health insurance/ visa etc)

The recipient will be provided with a current APLS manual and will attend an APLS Course without charge.

The opportunity to link course attendance to a short term (2 week) hospital attachment in an appropriate discipline is highly desirable and would reinforce the learning experience. This is particularly true when the applicant is from a non-English speaking background, as hospital immersion prior to the course would be expected to greatly enhance the participant's subsequent APLS experience. This may be possible to organise by the PEDS committee through their

links with APLS provider/instructors in the children's hospitals or other appropriate hospitals throughout Australia and New Zealand; and applicants should state whether they would like to avail themselves of this option. Costs of this attachment would have to fall within the total $5,000 cap or be paid for external funding sources. Billeting or hospital accommodation may minimise the cost.

Previous experience has demonstrated that the existence of a mentor is critical to the success of overseas placements. Therefore an established relationship with a local mentor who is an APLS Instructor is a requirement for every scholarship recipient. The mentor will support the recipient on the course and during the hospital placement, and be a first point of contact for issues or problems that may arise. In circumstances where a specialist is seen to be particularly well-placed to influence paediatric emergency management in their home country, the PEDS committee may be able to help establish appropriate potential mentor relationships. Instructors willing to act as potential mentors should make their details available to the PEDS committee.

The PEDS committee reserves the right not to award a scholarship if there is no suitable applicant in a given year. Pro-rata funds may be offered depending on the committee's assessment of individual circumstances/ requirements.

Preference will be given to submissions:

- from the Asia-Pacific region
- from individuals whose core work involves the management of ill or injured children
- from individuals with established and demonstrable links to structures (university, hospital administration, health administration) which could disseminate paediatric emergency training within their community. Awareness of local country infant and child morbidity and mortality, and the pre-hospital and hospital structures available to address these problems, will be important background information. Documentation of institutional support will be required.
- An applicant with a demonstrated plan for incorporating APLS teaching or principles into an established local structure will be given preference over an applicant wishing to attend the course for personal benefit only.
- Basic English proficiency is a requirement. Previous experience has shown that APLS course participation is difficult for individuals with lower than ILS 7 English level. Applicants from non-English speaking backgrounds should attach documentation of English proficiency.
- A letter of support from an established hospital mentor will be required

Applications should be submitted on the official APLS PEDS application form. This is available on the APLS website. When completed fully it will provide all the information necessary to assess the application. Useful additional information, such as references, CVs, publications, and teaching proposals may be included.

Reporting: Recipients of the Paediatric Emergency Development Scholarship are required to submit a written report, within a year of completing the scholarship, to the PEDS committee. A form will be provided to assist in this compilation, which will invite comments on costs, value, and difficulties experienced, as well as outcomes of any proposed local community development project.

Advertising: The PEDS committee will be responsible for disseminating information about the APLS PED scholarship to APLS members and to relevant bodies in countries in the Asia-Pacific region eg university, WHO links. Information about the scholarship should be posted on the APLS website not less than two months prior to the closing date for submissions (ie 1 September).

Special circumstances for 2005 scholarship: in view of the delayed organisation of the website notice, the closing date for submissions for the 2005 scholarship will be 1 December 2004. Notification and monies will still be made available by 1/2/05.