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www.aagbi.org/international/international-relations-committee/world-anaesthesia-society
World Anaesthesia Society Travel Grant

The World Anaesthesia Society is offering a grant of up to £1000 for trainee anaesthetists wishing to work or teach in a developing country.

Application and award of these grants will be through the travel grant system run by the International Relations Committee of the AAGBI with two grants awarded each year.

Further information and application forms available at www.aagbi.org
Welcome to another edition of World Anaesthesia News. This issue, we are excited to launch a closer collaboration with the World Federation of Societies of Anaesthesiologists (WFSA). The WFSA seeks to unite anaesthetists to improve patient care and ensure universal access to safe anaesthesia. It is involved in educational projects, research and advocacy to achieve this. We feature an article by Julian Gore-Booth, the Chief Executive Officer of WFSA, to serve as a reminder of (or an introduction to) the breadth of their work, and we hope to bring you regular updates in the future.

The World Anaesthesia Society co-hosted a well-attended lunchtime seminar at the AAGBI Annual Congress in Harrogate in September. This featured Eoin Harty speaking on the achievements and challenges of working in KwaZulu-Natal, and a talk by Iain Wilson on the Lancet Commission on Global Surgery, which will report during 2015. These are exciting times for global anaesthesia as the Commission is a fantastic opportunity to highlight inequities in access to safe anaesthesia and surgery, and to put these inequities on the political and developmental agenda. We are delighted that Iain, one of the Commissioners, has provided a summary of the aims of the project for this issue. We also have an article on the development of the UK Global Anaesthesia Collaborative, the result of much hard work by Ollie Ross, Liz Shewry and colleagues.

As usual we have several articles illustrating the range of projects and activities one can get involved in. These include a report from Polly Marshall-Brown, a recipient of a World Anaesthesia Society Travel Grant. If you’re planning a project overseas, don’t forget to apply for a Travel Grant!

We are very pleased to have also received some case reports. One describes the management of a challenging case in Tanzania. The other describes the author’s own experience of tropical illness, and reminds us of the importance of taking care of our own health.

As always, this is your Society and we would love to hear from you in the form of letters, articles, case reports etc. Please do get in touch with us at worldanaesthesianews@gmail.com. We hope you enjoy reading this edition.

Sarah O’Neill and Gordon Yuill
Editors
There’s a lot going on at your World Federation. Most important for the anaesthetist with a global perspective is the ongoing shift to a more strategic Programme Approach with Education & Training, Safety & Quality, Innovation & Research and, finally, Advocacy, providing a framework for all that WFSA does.

The continuing education of anaesthesiologists remains very much the focus for WFSA’s efforts, and we have a worldwide network of members and volunteers that help us respond to this challenge. Special mention must be made of Dr Wayne Morris (Chair of our Education Committee – whose profile appears in this edition) and Dr Isabeau Walker (Chair of our Publications Committee and well known to members of the AAGBI) for their untiring efforts in supporting our work. This is evidenced across our programmes and by the fact that not only are we publishing a 29th Update in Anaesthesia (kudos to Dr Bruce McCormick and his team), but also have available more than 300 Anaesthesia Tutorials of the Week on the WFSA site at www.wfsahq.org.

The value of these hundreds of educational articles and tutorials is being recognised with improved search facilities on the website (for example allowing archives to be searched by keyword and category) as well as by online sign up and mailing systems that ensures that our readers are informed as soon as new publications become available. We are also developing a more obvious “Resource” Section.

Fellowship Training Programmes
WFSA currently offer 41 fellowships annually across 13 countries: India, Malaysia, Singapore, Thailand, Egypt, Ghana, Israel, Kenya, South Africa, Argentina, Brazil, Chile, Colombia

Fellowships currently cover General Anaesthesia, ICU, Paediatrics, Regional, Acute and Chronic pain, Cardiac and Obstetrics.

WFSA Update
Julian Gore-Booth

Chief Executive Officer
WFSA

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on the site that points the way, not only to WFSA publications, but also to open source materials from other publishers that we think might be useful to you. We hope that this will move us further along in our ambition for the WFSA site to become a “one stop shop” for anaesthesiologists everywhere, especially those who seek further learning or teaching within the specialty.

Change can also be measured by the increasing number of fellowships now on offer each year, with over 40 being available through the WFSA at the last count. These fellowships are offered in a range of specialist areas within anaesthesia and offer young anaesthesiologists from low and middle income countries extraordinary opportunities to improve their knowledge and skills in a cost effective and impactful manner. They make fantastic use of the WFSA global network and you can find out more about them at [http://www.wfsahq.org/our-work/education-training](http://www.wfsahq.org/our-work/education-training)

Worthy of celebration is the fact that we have now awarded over 100 WFSA-Baxter scholarships. Since 2008 these scholarships have allowed young doctors, who would otherwise not be able to attend, the opportunity to present posters and take part in World and Regional Congresses of Anaesthesiologists. The scholars themselves attest to the value of these awards with 94% identifying positive impact for patients and 98% saying they would encourage their colleagues to apply. This is remarkable and I can add from my own experience of meeting scholars that these awards bring very real value to the outstanding individuals that are selected.

The WFSA is also very proud of the ongoing “Manpower Survey” which is being led by Dr Peter Kemphorthe (New Zealand). This aims to map the availability of anaesthesia provision and education around the world and will ultimately provide a global gap analysis and plan of action for the WFSA. This is a sizeable piece of work and we hope to have collected meaningful data and provided analysis during 2015. If this could be repeated every 4 years it would become a significant measure of progress ... so the ambition is clear! More immediately available is the book “Occupational Wellbeing in Anaesthesiologists” which can be downloaded for free from the website by visiting [http://www.wfsahq.org/our-work/safety-quality](http://www.wfsahq.org/our-work/safety-quality). On the same webpage you can find the International Standards for a Safe Practice of Anaesthesia, and the checklist that goes with the Standards as well as some very useful guidelines for tendering for Anaesthesia machines – especially relevant for those working in environments that do not have access to reliable supplies of oxygen and / or electricity. We also feature Lifebox, the UK based charity of which WFSA is a founder and ongoing supporter. Many of you are already involved with Lifebox in support of their mission to make surgery safer.

Other things to look out for include the launch of our Innovation Awards with a focus on initiatives that demonstrate or strengthen the role of anaesthesia in improving surgical patient outcomes. These awards will be made at the World Congress of Anaesthesiologists in Hong Kong 2016, which we hope many of you will attend, and details about criteria and how to apply can be found here [http://www.wfsahq.org/our-work/innovation-research](http://www.wfsahq.org/our-work/innovation-research). We are also very proud and excited about a new partnership with the

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**Dr. Zin Ohmmar Kyaw (Myanmar) in training at the Bangkok Anesthesia Regional Training Center (sponsored through WFSA by the Finnish Society of Anaesthesiologists)**
International Anesthesia Research Society (IARS) which foresees the establishment of a Global Health Section in the highly respected journal “Anesthesia and Analgesia” (A&A). This affiliation between WFSA and the IARS aims to focus the attention of the best minds in anaesthesia on advancing the healthcare of patients worldwide, and particularly in resource poor environments.

Finally, we are keen to emphasise an area of our work that is both a challenge and a major opportunity for anaesthesiology around the globe. In 2015 the World Health Assembly will vote on a resolution entitled, “Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage”. In his letter to all WFSA member societies WFSA President, Dr David Wilkinson wrote, “If approved, the resolution would change the situation of our profession, and of surgical patients (and those who need surgery) around the world for the better. It is likely that it would also significantly influence the amount of resource made available for anaesthesia, shifting national and donor budgets towards the 11%+ of the global burden of disease that could be addressed by surgery.... With the poorest 30% of our world accessing just 3% of the surgery, and with mortality rates from surgical intervention 1,000 times higher in some parts of the world than in others, it is my sincere hope that we are all bound together behind this resolution.”

This challenge, together with that of drafting Sustainable Development Goals (to replace the Millennium Development Goals or MDGs) that do more to recognise the impact of surgery and anaesthesia on global health, merits the attention of all of us http://www.wfsahq.org/our-work/advocacy

The WFSA Secretariat is your Secretariat. Please feel free to get in touch with Richard Lynas (Programmes Manager programmes@wfsahq.org), Nichola Page (Administrative Officer admin@wfsahq.org) or myself, if you have any questions or if volunteering for the WFSA might be for you. We count on the support of volunteers, many of whom already come from the AAGBI, and you can register with us online at http://www.wfsahq.org/get-involved/volunteer
The Lancet Commission on Global Surgery and Anaesthesia

Dr Iain Wilson, Consultant Anaesthetist and Commissioner, Exeter, UK

In the United Kingdom today, access to skilled surgical and anaesthetic care is considered as a basic component of a highly functional healthcare system. UK anaesthetists deliver much of this care directly, equipped with a modern range of drugs and equipment and funded by a range of payment systems. Safety is recognised as a key concern for patients, and the UK’s National Health Service is improving all the time in the variety of surgical procedures available and in its ability to get patients safely through them.

However, in low and middle income countries (LMIC) an estimated two billion people worldwide are without adequate access to surgical consultation, investigation or treatment. The reasons are often obvious – low numbers of trained surgeons and anaesthetists for the population, chronic under-resourcing of healthcare, lack of basic drugs and equipment and inadequate healthcare facilities. Affordability is a major issue for patients, with many being without insurance or free national healthcare systems.

Although the challenge of healthcare delivery in LMIC has been recognised for many years, the specific issues regarding the provision of surgery and anaesthesia have rarely received the recognition they deserve at the local hospital, healthcare planning, political or international level. It is recognised that many of the common diseases (HIV, pneumonia, malaria etc) that are considered major killers in LMIC have received huge publicity and funding, resulting in major improvements in care. Other diseases such as injury, cancer and congenital conditions are now recognised as causing substantial numbers of deaths and morbidity and are major concerns. Surgery and anaesthesia are key components in treatment, yet despite this, apart from Caesarean section, surgery is rarely promoted even at WHO level. This is a major catastrophe for patients, resulting in many unnecessary deaths and much suffering. Much of the surgery required is basic, inexpensive and extraordinarily effective in transforming lives – cataract, hernia, club feet, cleft palate and fracture care, for example.

Many surgeons and anaesthetists have published academic articles describing the deficiencies in care, so the issues are known, but there has never been an international united, high-profile campaign to portray the issues involved to Ministries of Health, governments, major foundations, healthcare planners and training institutions.

The internationally renowned medical journal The Lancet has run a series of Commissions on issues such as the Health Effects of Climate Change, the Future of Medical Education, Antibiotic Resistance and others. Commissions are essentially peer reviewed 25,000 word reviews of a major healthcare topic, which describe the underlying issues and make practical recommendations to healthcare planners to resolve them.

The opportunity of a Commission allows a global consultation with experts from all backgrounds to contribute, producing a unique collaboration with an overall message. This Commission will be followed by global advocacy to encourage investment in the ideas described and an improvement in affordable access to surgical care.

The Commission on Global Surgery was formally launched by Dr Jim Yong Kim, President of the World Bank, on 17–18 January 2014 at the Harvard School of Public Health, Boston, USA. Over 90 contributors sat together to discuss the issues from a variety of perspectives including workforce, training, measurement and finance (www.gscommission.com). At the same time, the Lancet published the first comment on the work inviting contributions from anyone and everyone with a view.

This is perhaps the first time that global surgery and anaesthesia will have the support of a major international journal to help us make our case – we hope the commission will be published in April in the Lancet.

As the Commissioners state: ‘Surgery and anaesthesia are integral, indivisible components of any properly functioning health system. Our vision is that all people should have access to safe, high quality, affordable surgical and anaesthesia care: universal surgical care with financial protection.’

References
Large numbers of UK anaesthetists are currently working on many different collaborative anaesthetic projects in the developing world. These projects often have the same broad aims of improving safe anaesthetic delivery by using educational resources and programmes. As this work continues to grow it makes not only sense but also it seems vital to increase our collaboration between projects. We became concerned that a lack of information existed to alert fellow anaesthetists to these ongoing projects. We set out to develop a way that knowledge could be shared between projects as well as sharing experience (Box 1).

**Project Aims: (Box 1)**

- Optimise project co-ordination locally with overseas partners and within the UK
- Provide mentoring expertise and resources for all to share
- Provide a contact point for future partners
- Continue the ‘professionalisation’ of the UK overseas anaesthesia links

After an initial survey sent from ourselves at University Hospital Southampton in 2012 to try to establish the amount of current collaborative work, we realized that for this project to really succeed we would have to think big. A partnership was developed between ourselves, the Association of Anaesthetists of Great Britain and Ireland (AAGBI), and the Tropical Health and Education Trust (THET), and the project has since grown dramatically in size.

With the AAGBI & THET during the last 2 years, we have set out and achieved our aim of producing a comprehensive ‘map’ of UK and overseas linked anaesthetic projects, and with that a pool of experts and a virtual library of online educational resources.

We therefore decided to focus our work on the following outcomes:

**Project outputs:**

- Comprehensive survey and ‘map’ of current UK overseas/developing world anaesthetic projects
- An on-line library of educational resources
- Good Practice Guidelines
- Building towards a national group providing advice to such projects
- Develop a new network for future collaboration

**Figure 1**

**The UK Global Anaesthesia Collaboration:**

The creation of a comprehensive map and online resource library

Dr Liz Shewry and Dr Ollie Ross
Together with a working group from the AAGBI International Relations Group and THET, a comprehensive survey tool (figure 1) was created. Emails inviting participation were sent to all AAGBI members, AAGBI linkmen and known anaesthesia links on the THET database plus from other personal sources. The survey was administered by Enventure on behalf of the AAGBI and THET.

We included the following survey questions:

- Information regarding the respondent profile
- Details of each individual project
- Details of local anaesthetic services and individuals involved
- Collaborations with UK groups e.g. AAGBI / DFID
- Collaborations with others specialities e.g. Obstetrics, Paediatrics
- Resources used by projects e.g. Lifebox, lectures
- Project tools e.g. planning tools, theory of change

Funding and leave for UK individuals volunteering

The ‘Survey of Global Anaesthesia Collaboration’ closed in November 2013, and a database created. Two hundred and ten projects were described in the survey, mostly Anglophone & Commonwealth countries (figure 2).

The MAP

Since the closure of the survey the emphasis has been to get the information mapped, to allow the collaborative process to begin. After a lot of discussion regarding various websites capable of hosting the map, the decision was made to go with Google maps. This a free site but surprisingly versatile, support is also provided for charities such as the AAGBI. Fantastic IT support from the AAGBI (Andrew Mortimore) has lead to the development of the map. The map will be hosted via the AAGBI site but open access is available to all.

http://www.aagbi.org/international/thet

Each project has a ‘pin’ on the map based at the site of the collaborative project (figure 3). The following information on each project is available by clicking on the ‘pin’- (figure 4)

Program name/type/organisation:
Overseas Program director/contact person:
UK contact details: UK Lead: UK Contact: email address:
Key Collaborations: Overseas: UK:
Specialities:
Project aim/purpose:
Project outputs:

Resources available to share – Y/N: Yes
The map can also be ‘reversed’ so that one can look for a contact with their local area of hospital (figure 5). The Respondent’s hospital, name, project details and resources can be accessed via this route (figure 6). This allows those starting out to know who to contact within their region. New projects to be added or changes to details can be submitted via the online form.

Finally a virtual online resource library has been created. This will allow the user to judge which resources may be of assistance and contact the individual themselves. Links to common anaesthetic global medicine resources such as Lifebox and Primary Trauma Course (PTC) will be available via the resource library.

The online collaborative map is open access and fully supported by AAGBI, THET, Royal College of Anaesthetists, and World Anaesthesia Society. We believe this map will help those all ready involved in overseas work as well as those interested in getting involved. We are grateful to all participants and we hope all future projects continue to be added to the database. Collaboration with

Figure 2

Figure 3
other specialities (e.g. Royal College of Surgeons) and other countries (World Federation of Society of Anaesthesiologists) is in the pipeline. A formal report of the survey with recommendations will follow in the winter, which will also lead on to a Good Practice Guide.
I would like to take this opportunity to say a big thank you to the World Anaesthesia Society (WAS) for the funding that I received towards my 11-month Out of Programme Career Break (OOPC) volunteering at Queen Elizabeth Central Hospital, Malawi. The experience has been hugely rewarding and would not have been possible without their generosity.

**Introduction**

Malawi is a landlocked country in Southern Africa. It has a population of around 16 million people with its economy heavily based in agriculture. Its Gross National Income per capita was estimated at $383 in 2012, which places it amongst the 10 poorest counties in the world. Correspondingly, the expenditure on health is low ($83 per person per year) and there is estimated to be only 0.02 physicians per 1,000 population compared with 2.77 in the UK.

**QECH Anaesthetics**

Queen Elizabeth Central Hospital (QECH) is a large government-run hospital in Blantyre and is a tertiary referral centre for all of Southern Malawi with approximately 1000 beds. There are eight theatres in the hospital covering general surgery, orthopaedics, ENT, paediatric surgery, plastics, ophthalmology, and obstetrics and gynaecology. Obstetrics is particularly busy with approximately 12,000 deliveries per year. As well as providing a service for the busy theatre department there is an
Intensive Care Unit (ICU) that can provide level 3 care for four beds (though dialysis is unavailable).

The anaesthetic department is made up of five anaesthetic consultants, two registrars and 12 Anaesthetic Clinical Officers (ACOs). ACOs usually come from a health care background and undergo two years of training in anaesthesia before commencing work. Also within the department are six ACOs that have just enrolled in a BSc Anaesthesia (a further two year course) at the College of Medicine.

**My experience at QECH**

I joined the department in August 2013 taking time out of my training program in the West Midlands between CT1 and CT2 and was immediately made to feel very welcome. As a junior anaesthetist my main role was to work closely with the ACOs in theatre helping to decrease the burden of staff shortages, to improve my knowledge and clinical skills, and also to share my experience and knowledge with my colleagues.

Initially it took a bit of time to get used to the differences between working in the UK and Malawi and there were several challenges to overcome. Firstly the equipment that we used: each theatre had a different anaesthetic machine to get used to, and there was no piped oxygen supply, only cylinders or concentrators. We had limited monitoring with pulse oximetry, heart rate, blood pressure and ECG, and only one theatre had CO₂ monitoring. I had to get used to using different drugs to those I was familiar with and the supply was often unreliable. Available drugs were halothane, ketamine, thiopentone, vecuronium, suxamethonium, pethidine, atropine and adrenaline. We also had heavy bupivacaine and tetracaine for spinal anaesthetics. Due to shortages we reused a lot of the equipment such as endotracheal tubes, face masks, guedel airways and suction catheters so at the end of the session they would be soaked in chlorine, rinsed and left to dry for the following day.

Another difficulty that I faced was the number of very sick patients that we took to theatre. Patients would often present very late to hospital with advanced tumours or severe septic shock. Due to the lack of resources that were available sometimes there was very little that we could do to help the patient. I found this a particularly difficult aspect of the work. Finally the language barrier also created some difficulties because although all my colleagues worked in English, a lot of our patients were unable to speak English and I had to find someone to translate for me.

I soon got used to the differences in the working environment and I feel that it helped me to be much more organized and prepared in my approach to each case. I had to make sure that any equipment or drugs that might be needed during a case were at hand and drawn.
up as there are no anaesthetic assistants to help you out. I also learnt to use my clinical skills much more in theatre rather than relying on machines to monitor the patient. During my time in Malawi I feel that I have learnt a huge amount. I have been involved in a wide variety of cases including many paediatric and obstetric anaesthetics which I would not otherwise have had the exposure to at my level of training. The learning curve has been very steep but I feel that my clinical skills have benefitted hugely, particularly in respect to paediatric anaesthesia with 125 cases in under 5 year olds. The surgery that takes place is very varied and interesting and I have been involved in several fibreoptic intubations, seen a pneumonectomy, and dealt with a case of suspected malignant hyperthermia. As my experience increased I was involved in the clinical teaching of the trainee ACOs. These are students from a health care background on an 18-month course to become an ACO. During my list I would be paired up with a trainee. I really enjoyed these one-on-one teaching sessions and it was very rewarding to see the progress that they made.

Aside from clinical work, I have been involved in a study looking at the knowledge of sepsis of clinical officers and final year medical students. This is important information as these are front line staff in the Emergency Department and in the district hospitals who will be the first people to diagnose and treat sick, septic patients. Data has been collected over several years via a questionnaire based on the Surviving Sepsis Campaign guidelines. The results suggest that knowledge is lacking particularly in the treatment of sepsis and we plan to restructure the teaching to focus more on this point.

I have also had the opportunity to be involved in the teaching of the 4th year medical students at the Malawi College of Medicine during their anaesthetic and critical care teaching block. This involved small group teaching on anaesthetic equipment and airway skills, along with moulage stations running through different emergency scenarios with the students. At the end of the two week block there was a written exam paper and a practical assessment for which I was one of the examiners. Overall the students did well with only 2% failing and having to retake the exam.

During my time at QECH I have been incredibly impressed and humbled by the hard work and dedication of the anaesthetic staff. Despite the lack of resources and poor staffing issues they do a really great job. I learnt so much during my time there. It was an invaluable experience and I also enjoyed the opportunity to share my skills and knowledge with the department.

Out of hospital experience and practicalities

Outside of work I had plenty of time to explore the country and found Malawi a very pleasant county to spend time in. Malawians were warm and welcoming and willing to offer help if needed (usually because we were lost or had another flat tyre). I was struck by how beautiful the country was and in particular by how the geography changes over relatively short distances. Tea estates, 3000m mountains and nature reserves by the Shire River are all within two hours drive of Blantyre. The footpaths and tracks between villages provide an abundance of excellent mountain biking terrain. There are a good number of mountain bike enthusiasts in Blantyre with group rides being organized most weekends. I took part in the Luwawa International Mountain Biking marathon race, a 50km course through woodland and tracks.

Weekends away to Mulanje were a common occurrence. I was an active member of the Malawi Mountain Club and I finished off the year by taking part in the Porters race, a 25km circuit up and down the Mulanje plateau with some 5,000ft of ascent and descent. In retrospect this was a very enjoyable experience.

Life in Malawi is not always easy. Aside from the usual difficulties of immigration and car problems, I broke a bone in my elbow and a bone in my foot within 8 weeks of each other. Fortunately I was lucky as my partner is an orthopaedic surgeon so I received excellent care! In many respects the challenge of overcoming these little difficulties all added to my experience in Malawi.

Conclusions

I have had an amazing year working in Malawi and have benefitted hugely from both the life experience of living in Malawi and the clinical experience of working in the hospital. The skill set I have developed over the year will be hugely useful on my return to the UK, and will stand me in good stead for future work abroad. This experience would not have been possible without the generous support of the WAS, for which I am very grateful.
I first became interested in developing world medicine after spending my elective working in hospitals in Samoa in the south Pacific. However, like many other trainees, I was offered a run-through anaesthetic rotation (in south Wales) and joined the conveyor belt that is training in the NHS. During my ST3 year I worked in the Royal Gwent Hospital in Newport and became familiar with the work that the charity ‘Mothers of Africa’ does in sub-Saharan Africa. As an ST3 I wasn’t able to volunteer with them as it was felt I was not experienced enough in anaesthetics (in retrospect I now fully appreciate this decision). However on rotating back through the Royal Gwent as an ST7 I again expressed an interest. The opportunity arose and I was offered a place on the November 2012 trip to Phebe Hospital in Bong County, Liberia.

Liberia is a country in West Africa that endured 13 years of civil war from 1986-2003. The country’s economy, infrastructure and in particular its healthcare system was left decimated as a result. Liberia has a population of almost 4.2 million yet there are no medically qualified anaesthetists within the country - anaesthesia being solely provided by nurse anaesthetists who spend only two years in training. Life expectancy in Liberia is 59 years, they have a maternal mortality rate of 770 per 100,000
and an infant mortality rate of 58 per 1000 live births (4.2 per 1000 in the UK). It is currently one of the poorest healthcare systems in the world.

‘Mothers of Africa’ is a medical education charity whose aim is to train and educate healthcare workers to care for women during pregnancy and childbirth. It was founded in 2004 by a group of anaesthetists from South Wales and has since delivered educational programmes in Liberia, Zambia, Benin, Togo and Ethiopia. As a result anaesthetists from across South Wales have been able to impart their vast collective knowledge, skills and experience in order to support the training and professional development of healthcare workers in poorly resourced settings. The key principles in any programme delivered by the charity are sustainability and empowerment, so that services and healthcare provision can continue into the future lead by local in-country champions.

I thoroughly enjoyed my eight days teaching within Liberia’s challenging environment - I was hooked! On my return I immediately approached the charity’s lead for Liberia, Dr Tei Sheraton (a consultant anaesthetist at the Royal Gwent Hospital), and expressed how keen I was to return. Three months later I was back on a British Airways flight to Liberia, this time for 15 days. I enjoyed the second trip even more than the first - not least because it was very rewarding to return and see knowledge and skills that I’d taught on the first trip being used in everyday practice.

On my return from the second trip I was faced with deciding what to do next in terms of career progression. My CCT was fast approaching and therefore I could either start applying for consultant jobs or think about doing something different. I chose the latter option, mainly because I was aware that my training had been swift and, coupled with the reduction in working hours as a result of the European Working Time Directive, I felt extra clinical and non-clinical experience before consultant jobs would serve me well in my progression from senior trainee to consultant anaesthetist. At that time my current trust (Aneurin Bevan University Health Board - ABUHB) were thinking about developing some post-CCT fellowship posts that would commence the following August. ABUHB have longstanding health links with developing nations and as a University Health Board are keen to promote their employees participation in such links. I therefore floated the idea that one of the fellowships could be linked to international health. Luckily for me this idea went down well, the funding was approved and a ‘Post-CCT fellowship in International Health and Developing World Anaesthesia’ was created. I applied, was successful, and started the job in August 2013.

Now to work out a job plan! I would be working at the Royal Gwent in Newport but would be able to use SPA sessions (2 per week), professional leave (a total of 10 days is supported by the trust for voluntary work in Liberia) and study leave to develop my interest in international health further. In addition the anaesthetic department leads were keen to support my other anaesthetic clinical interests, and so I have been able to do my own vascular surgery list and I am regularly given slots acting as ‘consultant cover’ on labour ward. As this job was created with an element of service provision I was initially providing out of hours cover by working on the senior registrar tier of the on-call rota. However six months into the post the opportunity arose for me to act-up onto the consultant rota which I was keen to do. In addition my pay increased significantly, I had a good
study leave budget and an office! At the time of writing I have been in post for a total of nine months, and it has been a thoroughly worthwhile experience - both professionally and personally. From an international health point of view I have been able to contribute to and deliver many projects, both by making international visits (I have undertaken 2 further trips to Liberia and one to Zambia since starting the post, and have visits to both of these countries planned for this summer) and by using my SPA time to co-ordinate and work on the projects from the UK. Some examples of projects I have been involved with include:

- Undertaking a needs assessment for a critical care facility in Chongwe Hospital, Zambia - funded by Wales for Africa Health Links
- Teaching on an International Health module for intercalating medical students at Cardiff University
- Collecting longterm feedback on ‘short courses’ and educational materials that have been delivered in Liberia
- Teaching on the AAGBI’s SAFE Obstetric Anaesthesia course
- Teaching on two BASIC DHS courses (developed by the Chinese University of Hong Kong)
- Course directing the second of these
- Contributing to the development of course material for BASIC DHS
- Being team leader for the most recent Liberia trip
- Helping to set up and use for the first time medical equipment donated to Phebe and Chongwe hospital by MOA and other organisations (Lifebox, Diamedica and the Peppercoast foundation). In October 2013 this included a new Glostavent and baby-CPAP machine which was immediately put to good use - particularly rewarding to see.
- Helping to develop and write a curriculum for nurse anaesthesia students in Liberia’s only school of anaesthesia
- Collecting longterm follow-up on the use of Lifebox pulse oximeters in Liberia
- Presenting some of the charity’s activities in Liberia at the AAGBI Annual Congress in Dublin last year and at the Junior Anaesthetists of Wales conference 2013
- Organising fundraising activities

As a result my CV has been boosted with publications and poster presentations at national and international conferences. In general the post has enabled me to understand the difficulties of delivering effective teaching and healthcare in the developing world - especially the importance of prioritising strategies and choosing those that are most cost effective. I have learnt the importance of good communication skills and of organisation, patience and perseverance. I now appreciate the importance of good partnerships and sharing of knowledge and experiences - there is little point in re-inventing the wheel. Both the professional and personal benefits of clinicians working in healthcare partnerships are well known3,4, and I have experienced many of these myself. As a clinician I have been able to gain knowledge and skills, and now have experience in clinical situations that I would never encounter in the UK. My management, leadership and problem solving/improvisation skills have all improved as has my resourcefulness (I can now make a Bakri balloon substitute out of a foley catheter and a condom!) On a personal level I am more confident, self-assured, decisive and indeed more motivated.

To summarise I couldn’t recommend this fellowship highly enough. I have thoroughly enjoyed my time working as a post-CCT fellow and been able to make the most out of a great opportunity, which will hopefully stand me in good stead when applying for consultant posts.

This post-CCT fellowship will be re-advertised yearly. Should you wish to find out anymore about the job then you can contact either myself (cerysrichards@doctors.org.uk) or Dr Tei Sheraton (tei.Sheraton@wales.nhs.uk)

References
1 http://www.who.int/countryfoc us/cooperation_strategy/ ccsbrief_lbr_en.pdf
2 http://medicine.cardiff.ac.uk/ mothers-africa/3.
3 The framework for NHS involvement in international development. Department of Health. July 2010
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To be added to the mailing list for early notice of course dates please email events@ndcn.ox.ac.uk.

Further information: www.nda.ox.ac.uk
www.oxfordanaesthesia.org.uk
Introduction
This was my third time working for MSF and I was feeling fairly relaxed and looking forward to the challenge ahead as I boarded the airplane to Jordan. Had I known then just how hard the next three months would be, I might have thought twice boarding the plane. I would learn how inexperienced at managing teams I was, see and treat patients with war injuries far more serious than I had ever previously encountered and discover what it feels like to reach one’s limits in terms of stress and fatigue.

This was all part of my ‘out of programme training’ (OOPT) period, approved by the Royal College of Anaesthetists and remotely supervised by my college tutor back in Bristol. As part of the OOPT approval process, a common question was, ‘what is the educational value in working for MSF?’. I hope this short article, in outlining my experiences and the challenges I faced, will answer that question.

The Ramtha MSF Mission
The mission I was heading for was based in a government hospital in the small Jordanian border town of Ramtha. Just a kilometre from the southern Syrian border, Ramtha hospital had recently been struggling to cope with the influx of war-wounded Syrians. Fleeing across the border, they came to seek urgent medical treatment for their war injuries, away from the relentless shelling back home. Following a lot of tough groundwork by the logistical team, the Ramtha mission had only just started receiving patients when I arrived, and as such many of the challenges for the team here involved having to rapidly evolve
the service to meet what turned out to be an unexpectedly high workload. Within Ramtha hospital itself MSF had refurbished two disused operating theatres ready to receive trauma patients and fitted out some disused buildings to provide the follow-up ward care and physiotherapy required. As is usual in all MSF projects a cohort of local Jordanian nurses, ward doctors, pharmacists, anaesthetists and surgeons had also all been hired to work in the project.

The project was set up to treat war wounded Syrians, and what might be called their ‘patient pathway’ in the UK is worth mentioning. As previously mentioned, when someone sustained a serious injury in southern Syria they would often try to cross the border into Jordan to seek medical treatment. Of course many did not make it to the border but those that did were then assessed by a Jordanian army medic and, if their injuries deemed serious, transported by the Jordanian army to Ramtha hospital where we would take over their care. The result of this system was that virtually all the patients we received had severe or immediately life threatening injuries and we often received three or four such patients at once. A difficult situation even in the best of hospitals.

A normal day’s (or night’s) operating then might consist of applying external fixators to fractured long bones, major emergency vascular repairs, laparotomies for abdominal shrapnel injuries, emergency amputations and also many secondary wound debridements. (One of the mainstays of war surgery is repeated debridements over many days for soft tissue injuries to try to prevent the almost inevitable secondary infection that occurs in all untreated war wounds). Our facilities at Ramtha hospital were fantastic by the standards that MSF is used to elsewhere in the world. For example, we had access to a blood bank, basic lab tests, X-ray and even a CT scanner. Nonetheless, treating the numbers of patients we did with the severity of injuries they had was still an enormous challenge for the whole team.

Challenges in Ramtha
Logistical & Technical challenges

In Jordan MSF was limited to using only drugs and equipment that are permitted for import to public hospitals by the Jordanian ministry of health. One specific example of how this affected our practice was the fact that we had no suxamethonium or rocuronium, despite having perfect refrigeration facilities and the drugs being widely available in the region. The obvious problem here is how to perform a rapid sequence induction given that most of our patients are un-starved, shocked, trauma patients who have been given morphine. We adapted to use what we had which was atracurium and we used what is sometimes described as the timing method. A supra-normal dose (up to 1mg/kg) of atracurium is given upfront and, at the onset of ptosis or if the patient complains of any difficulty taking a deep breath, an induction dose of thiopentone is given. Using this method we achieved clinically similar intubating times to suxamethonium and had no reported cases of awareness.

Patient Challenges

Severely shocked multi-trauma patients always present a challenge especially without all the drugs and equipment with which you are familiar. A particular problem was keeping patients warm without fluid warmers or forced air warmers. Our solution was to fill urine collection bags with tap water, put them in a bowl of hot water from a kettle and then place these makeshift hot water bottles (carefully wrapped in pillow cases) in axillae, groin and neck areas. Although not ideal from a patient safety point of view we frequently managed to maintain quite reasonable body temperatures for our patients.
It quickly became apparent that for the patients that made it across the border and to the operating theatre, reperfusion syndrome was one of the greatest challenges they faced. Quite a number of patients arrived with shrapnel injuries to the major vessels in the groin and had had lifesaving tourniquets applied for many hours prior to arriving in Ramtha. Once their lower limbs were reperfused they became severely unstable. A problem from my point of view was that with no access to blood gases we were ‘flying blind’ somewhat at this stage. Use of calcium boluses and bicarbonate infusions along with use of ephedrine and dopamine (via a 16g cannula in the internal jugular vein) was certainly life saving in a number of patients.

Post-operatively the war wounded patients provided challenges as well, not least from a pain point of view. Many patients had upper and lower limb amputations and went on to develop debilitating chronic neuropathic pain. The addition, halfway through my time there, of gabapentin to our drug formulary made a big difference to some patients.

Managerial Challenges
As the only expat anaesthetist I was in charge of a small team of three local physician anaesthetists as well as being line manger for the anaesthetic nurses, recovery nurses and ITU nurses. Although I had support from my line manager, the process of effectively running the anaesthetic service within the project, and all that entails, rather than just being concerned with my own performance was new to me and an extremely valuable experience. If we ran out of a certain drug or piece of equipment, or if someone didn’t turn up to work this was my problem to deal with! I left with a fuller appreciation of the responsibilities of a consultant.

Cultural Challenges
The many nuances of different cultural norms and practices take years to fully appreciate but the most obviously challenging one from my point of view was the cultural difference towards withdrawal of treatment in patients with no hope of survival. The concept is much less widely accepted in Jordan than it is in the UK. When resources are very limited - we only had one staffed ITU bed - and they are being used by someone who, from a European cultural viewpoint, no longer has any need for them, this can be a very difficult situation to resolve with the patient’s family.

Personal Challenges
As alluded to in the introduction, exhaustion (both physical and mental) was a real issue for the team in Jordan. We worked long hours, were on call for days in a row and witnessed some very troubling injuries, especially those inflicted on children. All of this takes its toll and after six weeks, one night in theatre I was forced to evaluate my ability to carry on working. I was trying to calculate the dose of fentanyl for a child undergoing emergency surgery and found I couldn’t do it. I got my calculator out - I kept putting the numbers in wrong, I still couldn’t do it. I reasoned that if I was so tired that I couldn’t do the most basic of calculations, then I was not safe to anaesthetise patients, no matter how sick they were. I took two days off and returned fresh but worried about how I had got into that state. From then on I was much more careful about managing my workload.

Conclusion
My time in Jordan was an incredible learning experience, very tough at times but ultimately extremely rewarding. To work as a small part of a team committed to MSF’s aims of saving lives and restoring dignity is a huge privilege and I will definitely be back for more.
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African Tick Bite Fever - Important Lessons in Volunteering Overseas

Dr Cerys Richards

Royal Gwent Hospital
Newport

In March 2013 I travelled to Liberia, West Africa for fifteen days volunteering for the charity Mothers of Africa (MOA). My time was spent teaching nurse anaesthesia students and helping to deliver the AAGBI’s SAFE obstetric anaesthesia course to nurse anaesthetists from throughout the country. During the trip our team stayed in bungalows on the compound of Phebe Hospital in rural Bong County whilst delivering the teaching, and in a modest hotel in Monrovia (the capital) at the beginning and end of the trip.

I returned home fit and well on a Sunday evening. The following Tuesday night I went to bed as usual but was woken in the night with an intense burning pain on my right wrist. When I switched on the light I discovered what I now know to be a target lesion on my right wrist (picture 1). In my sleepiness I put it down to a burn (I had gone to bed with a hot water bottle as it was cold!), put a cold flannel on it, took some pain killers and went back to sleep. The next morning the lesion was still there - no bigger no smaller. I continued to take analgesics and by the Friday it had started to shrink (picture 2) which reassured me.

However over the weekend its appearance changed. Firstly it blistered, then it developed a central necrotic area and slowly began to expand. I sought the advice of an infectious diseases consultant at my hospital the following Monday (six days after presentation) who wasn’t entirely sure what the lesion represented. Cutaneous Anthrax, Lyme Disease and African Tick Bite Fever were three of the suggested causes. I also saw a dermatologist who thought it may be a spider bite.

By the following Tuesday its appearance was far more worrying (pictures 3&4) and I was starting to feel unwell in myself with a low grade temperature on two occasions, nausea and lethargy. My hand was now extremely painful, hot and swollen and its movement restricted. I started antibiotics that night (clarithromycin - as I have an allergy to penicillins) and took the next few days off work. Unfortunately things didn’t improve (picture 5) and I was no closer to a diagnosis. By the Thursday more complex screening tests were sent off for analysis and that night I started taking doxycycline. The following day my case history and relevant photos were referred to a...
West African specialist at Liverpool School of Tropical Medicine.

Thirty-six hours after I commenced doxycycline my wrist was improving, as was I. By the Tuesday (14 days after the lesion appeared) I could return to work as the sore had very quickly subsided and my wrist function had improved. A month later I received the results of my blood tests with positive antibody titres that confirmed African Tick Bite Fever. My wrist has healed well however I do still have a scar (picture 6). I have since made three trips with MOA to sub-Saharan Africa and they have passed uneventfully.

Despite having travelled extensively in Africa, Asia, Australia and Polynesia this is the first time I have become unwell as a result of travelling (excluding the odd upset stomach which goes with the territory!). I have always ensured I have had every vaccine needed for the area I am traveling to (err on the side of caution if advice is ambivalent) and have taken the correct anti-malarials religiously when required. I wear long sleeve clothes and trousers in the evenings and routinely spray myself with Deet, spray insecticide in any indoor areas and sleep under a good quality mosquito net. I always ensure I am fit and well when I leave the UK for rural poorly resourced areas, and travel with an ‘emergency medication’ pack which includes antibiotics and fluids.

I remain very grateful that my signs and symptoms appeared after my return to the UK. I believe it would have been a much scarier scenario had I been isolated in rural Africa. However if that had occurred in country I am reassured by the fact that the charity I was volunteering with (MOA) have excellent medical insurance in place for their volunteers that would have allowed me swift access to the best medical care available in the area, or repatriation if needed. When volunteering I also know that quality and reliable help and advice from the charity’s leads (Dr Tei Sheraton for Liberia and Prof Judith Hall for Zambia) is only a phone call away. They both have a great deal of experience in volunteering abroad plus have excellent contacts in each country who, together with themselves, would all work tirelessly to ensure my safety and well being.

I was also extremely grateful for the help and support I received from my local consultant colleagues and the specialist in Liverpool in managing this condition. As medics we always have the benefits of ‘phoning a friend’ and being quickly referred. As a result of my experience and the appreciation I have for the excellent care I received I am hoping to set up a local network of specialists who, linked to the occupational health department, will help ‘fast-track’ NHS volunteers in our Health Board returning from abroad who become ill. I believe we owe this to staff who dedicate their time and money into helping those less fortunate than ourselves.

To summarise, my advice to anyone volunteering abroad is to ensure you have all the necessary vaccinations and take appropriate anti-malarials when traveling, in addition to taking other precautions to avoid insect bites. Only travel when you are fit and well, take an ‘emergency medication’ pack with you and always ensure that you have the best healthcare insurance available (to include repatriation). Put simply do not cut corners or take unnecessary risks. Most importantly take contact numbers with you (electronically and in written format) for those who can provide assistance both in the countries you are traveling to and in the UK, and never be afraid to phone a friend!
Case Report: Severe acquired Stenosis of Oral Orifice - Noma or Cancrum oris acquired after measles infection

Dr Bruno Turchetta

Introduction
Presentation of a child with severe nutritional deprivation due to inability to feed because of severe adhesions of the lips and the angle of the mouth which were progressive, resulting in a tiny oral orifice.

History of presenting complaint
A female child aged 1 year and weighing 7 kg was brought by her mother to the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) Disability Hospital in Dar Es Salaam.

Body weight at birth was 3 kg.
Prescribed diet by the paediatrician was a minimum of a daily supply of 1750 ml milk in divided doses.

There was an increasing difficulty in feeding the child both by the mother and hospital staff.

On Examination
On gross appearance, although the child was small for years, she did not appear to have any other major problem. Examination of the mouth however showed severe adhesions of her lips at both outer angles, leaving a tiny orifice which measured only 2.5 cm.

Body temperature: 36°C
Heart: normal findings, HR 130/min, no arrhythmia, blood pressure normal.
Limbs: NAD.
Abdomen: nothing abnormal detected (NAD).

Investigations:
Hb. 9.2 (slight anaemia)
WBC 9.9 x 10
RBC 3.68
Leuc 6.2 x 10
HT 27.4
Gran 2.8 x 10
Lymph 63 %

Management Issues
It was suggested to feed the child via a nasogastric tube, but there was difficulty regarding positioning and the mother did not agree to this method. Therefore a long-term solution had to be planned between anaesthetist and surgeon. Before the surgical procedure (commissuroplasty) could be contemplated, anaesthesia became a major issue to take into account.

Anaesthetic Problems
Intubation while the child was awake using a Glide Scope was not possible as the orifice was too narrow and no facilities were available for this at CCBRT.

Blind tracheal intubation via the nostril was considered as a second option, but this was rejected because of the risk of trauma and possibly creating a false passage.

Following a departmental conference, it was decided to undertake tracheotomy from which the anaesthetic could be administered.

Attempting to open the narrow orifice was excluded as this could develop bleeding or stimulate secretions, which may lead to acute and severe laryngeal spasm. To clear the airway in that circumstance would not be possible and could result in a high risk of suffocation, immediately followed by a serious drop of O₂ saturation. This could result in possible cardiac arrest.

Because of required paediatric cover the tracheotomy was undertaken at Muhimbili National Hospital where an ENT facility is available.

The child was prepared for surgery on the next ENT list. Preoperative fasting for four hours was ordered. Inhalational induction with halothane and oxygen was used through a face mask. A peripheral vein was cannulated and a pillow was positioned under the shoulder of the baby to expose the neck for tracheotomy.

Atropine 0.1mg iv and fentanyl 10 micrograms iv were given. Inhalational anaesthesia was maintained with halothane 1.5%, and an oxygen and air 50% mixture for spontaneous breathing.

Neck incision was performed, and bleeding carefully controlled by cautery. Secretions were aspirated using the suction machine. The trachea was exposed and a size 3.5 tracheostomy tube was inserted and secured round the neck.

The child recovered consciousness without any complication.

After a few days the child returned to CCBRT for the planned surgery of the mouth.

Because the condition of the child had deteriorated further, it was decided to accelerate the surgery of the mouth.

The child had a size 3.5 tracheostomy tube in place and we thought as a precaution we should have a spare one in case of any problem with the tube.

A replacement size 3.5 tube could not be located so we decided to have a size 3 armoured cuffed tube as a stand by along with the sterile instruments, forceps, Kelly and Klemmer, to be ready to change it in case any difficulty occurred e.g. obstruction of the tube, rupture of the cuff or occlusion of the tracheostomy.

Anaesthetic Procedure for the mouth surgery:
Inhalational anaesthesia of halothane/oxygen mixture was administered through the tracheostomy tube whilst spontaneous breathing. A peripheral vein was cannulated dextrose/saline 5% infusion 100ml, atropine 0.1mg, and fentanyl 10 micrograms were given iv.

Spontaneous breathing was maintained with halothane 1.5 % concentration + oxygen/air mixture.

The Drager Fabius machine was used for spontaneous ventilation.

ECG, oxygen saturation, CO₂ level and NIBP were monitored throughout the surgery.

Post Operative Findings
At the end of surgery the secretions were carefully aspirated. The bleeding was minimal since diathermy cauterization was used.

The chest was clear and the child was able to swallow liquids normally because jaw mobility was.
complete and the opening of the mouth wide.
Analgesia was administered.

**Outcome:**
Since the surgical outcome was successful and the anaesthetic was completed without any complication the child could be discharged on the third post-operative day.

The child will return to Muhimbili Hospital for reversal of the tracheostomy.

This case demonstrates the challenge that was posed when a routine anaesthetic approach could not be followed. Also, as there were no ENT facilities available at CCBRT, how team work with Muhimbili enabled this child to be offered definitive treatment for a serious problem that would have hindered her growth and development.

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Dr Wayne Morriss has been Chair of the WFSA Education Committee since the World Congress of Anaesthesiologists in Buenos Aires in 2012. The Education Committee is very active, with members from Russia, Serbia, Tunisia, Kenya, Malaysia, Philippines, New Zealand, Venezuela, Brazil, United States and Canada.

Trained in New Zealand and Australia, Wayne is currently a consultant anaesthetist in Christchurch, New Zealand — this is the job that pays the bills! He considers himself to be a general anaesthetist with an interest in neurosurgical anaesthesia, obstetric anaesthesia, trauma and education.

Wayne’s path to the Education Committee began when he and his family moved to Fiji in 2000. He took up a position as a Senior Lecturer in Anaesthesia and Physiology at the Fiji School of Medicine and taught undergraduate and postgraduate students from all over the Pacific region. His time in Fiji was important for learning about education and working in a low- or middle-income country. Soon after he and his family arrived, there was an armed overthrow of the democratically elected government, leading to months of political instability and frequent violent incidents, including a military mutiny in November 2000. The medical school and hospital were, at times, put under extreme pressure because of increased patient numbers and fewer staff.

Wayne and his family returned to New Zealand in 2002, but he remained actively involved with...
clinical and educational activities in the Pacific region. He was an instructor and regional coordinator for the Primary Trauma Care (PTC) course, a regular external examiner for the University of Papua New Guinea, and a member of surgical teams providing ENT operations in different Pacific countries. In 2008, he became member of the WFSA Education Committee at the WCA in Cape Town, South Africa.

In 2010, Wayne and Dr Roger Goucke, a pain physician from Perth, Western Australia, wrote a short course called Essential Pain Management (EPM). EPM is a highly interactive one-day workshop, which teaches health workers to use RAT (Recognize, Assess, Treat) to manage patients in pain. The EPM programme includes a short instructor workshop, so that teaching of the course can be rapidly handed over to local instructors. EPM has been taught in over 30 countries since its pilot in 2010. More information is available at www.essentialpainmanagement.org.

As Wayne says, “life has not been dull” since taking on the Chair position of the Education Committee. The committee is responsible for fellowship programmes all around the globe, including programmes in Kenya, Israel, Ghana, India, Thailand, Malaysia, Brazil, Colombia, Chile and Argentina. Most of these programmes provide training in subspecialty areas of practice so that fellows can return to their home countries as teachers and leaders. As an example, the Bangkok Anaesthetic Regional Training Centre (BARTC) has been training anaesthesiologists from other parts of Asia for almost 20 years. During this time, the programme has trained 68 anaesthesiologists and all but two are working in their home countries. The Education Committee also helps with the rollout of short courses such as EPM and the Safer Anaesthesia From Education (SAFE) workshops in Obstetric Anaesthesia and Paediatric Anaesthesia, as well as general anaesthesia training programmes such the Palestine Anaesthesia Teaching Mission (PATM). The committee is also responsible for the WFSA Baxter Scholarship programme, which provides funding for young anaesthesiologists who wish to attend important regional meetings.

Wayne acknowledges that there are many challenges but also many rewards to being part of the WFSA and the Education Committee. Setting up a fellowship can be very hard work, made more difficult by communication difficulties and geographical distance. “It’s easy to forget the difficult environments that many of our colleagues are having to work in. Education is often given a low priority when resources are stretched and clinical need is very high. The paradox is that these places are often the ones that most need good educational programmes and the development of skilled and knowledgeable anaesthesia providers.”

The Paediatric Anaesthetic Fellowship (PAF) in Nairobi, Kenya is a recent success story. It is a collaborative effort between the WFSA, Kenyan anaesthesiologists and the University of Nairobi, with help from the Association of Paediatric Anaesthetists of Great Britain and Ireland, and the Society for Pediatric Anesthesia (USA). The programme offers 12-month fellowships and is aimed at anaesthesiologists living in East and Central Africa. The PAF started in 2013 and a second group of three fellows has just started training. Wayne believes that the programme has the potential to dramatically improve access to and safety of paediatric anaesthesia in the region. Another major benefit is strengthening of the host institution and faculty. “The programme head, Dr Mark Gacii, is doing a great job at developing the PAF and encouraging local staff to participate.”

The PAF illustrates many of the key values of the WFSA’s educational activities – appropriate training, collaboration and teamwork. As educator, clinician and leader, Dr Wayne Morriss demonstrates these values on a daily basis and brings an energy and dedication to the WFSA’s mission that is second to none. We are extremely fortunate to have him with us.

For more information about the WFSA’s education programme please visit http://www.wfsahq.org/our-work/education-training
Useful Information

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Anaesthesia for Developing countries - 5 day course Kampala Uganda (annually)
Contact: Dr Hilary Edgcombe, Nuffield Dept of Anaesthesia, John Radcliffe Hospital
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Developing World Anaesthesia
1 day course in Bristol 30th April 2012
Contact: DWAsouthwest@gmail.com

Organisations

The International Relations Committee (IRC) of the Association of Anaesthetists of Great Britian and Ireland (AAGBI)
The IRC has a major role in co-ordinating and facilitating overseas anaesthetic training programmes, visiting lecturerships for refresher courses and distribution of limited supplies of textbooks and equipment to developing countries. It administers the Overseas Anaesthesia Fund to facilitate donations to assist in this type of work. It runs the Ugandan Anaesthetic fellowship programme and is involved in the global oximetry project, which has informed Lifebox.
www.aagbi.org

World Federation of Societies of Anaesthesiologists (WFSA)
The World Federation of Societies of Anaesthesiologists (WFSA) is a unique organization in that it is a society of societies. By virtue of membership in a national society, an anesthesiologist is automatically a member of WFSA. The objectives of the WFSA are to make available the highest standards of anesthesia, pain treatment, trauma management and resuscitation to all peoples of the world.
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Primary Trauma Care Foundation
An organisation training doctors and nurses in the management of severely injured patients in the district hospital.
Box 880
Oxford OX1 9PG
United Kingdom
www.primarytraumacare.org

PTC Chairman:
Charles Clayton
ceo@primarytraumacare.org

PTC Administrator:
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Douleurs san Frontieres (DSF)
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www.goingoverseasnetwork.org

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Tel: (+44) 020 7404 6600
E-mail: office-ldn@london.msf.org
www.msf.org.uk

Mercy Flyers
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www.mercyflyers.org

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www.vso.org.uk

Mercy Ships
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www.mercyships.org.uk

Mothers of Africa
Mothers for Africa is a medical educational charity that trains medical staff in Sub-Sahara Africa to care for mothers during pregnancy and childbirth.
www.mothersofafrica.org

THET (Tropical health and Education Trust)
THET is committed to improving health services in developing countries through building long-term capacity.
www.thet.org

HINARI
The HINARI Programme, set up by WHO together with major publishers, enables developing countries to gain access to one of the world’s largest collections of biomedical and health literature.
More than 7,500 information resources are now available to health institutions in 105 countries
www.who.int/hinari

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# World Anaesthesia Society Application Form

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Please return this form to:
Rola Alkurai
Honorary Secretary
World Anaesthesia
21 Portland Place
London
W1B 1PY
UK