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## REFERRING SUPERVISOR VISIT TO RED CROSS CHILDREN'S HOSPITAL, SCAH, UCT. FEBRUARY 2012

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### VISITING TEAM

- Dr Neil Kennedy (HOD paediatrics and post-graduate studies, Blantyre, Malawi)
- Dr Damte Shimelis (HOD paediatrics Black Lion Hospital, University of Addis Ababa, Ethiopia)
- Dr Muluwork Tefera (Head of Paediatric Emergency, Black Lion Hospital, University of Addis Ababa, Ethiopia)
- Dr Somwe Wa Somwe (Head of Paediatrics, Lusaka, Zambia)
- Dr Sarah Kiguli (Head of Paediatrics, University of Makerere, Kampala, Uganda)
- Dr Michael Ikeogu (Consultant Paediatrician, Mpilo Central Hospital, Bulawayo, Zimbabwe)
- Dr Bashir Admani (Nephrologist, University of Nairobi / Aga Khan University, Nairobi, Kenya – representative for the Kenyan Paediatric Association)

**Site visit activities** – during the attachment dedicated time was set aside for the referring supervisors to undertake the following:-

- a. Meet with the trainees and the local supervisors
- b. Meetings were arranged to facilitate the referring supervisors specific areas of interest
- c. The referring supervisors presented their regions health and training needs and from this identified how the APFP could be of benefit to their service capacity
- d. The referring supervisors participated in a workshop at which the challenges of the APFP were addressed and how best to accommodate the many challenges to gain the optimal outcomes.
- e. The referring supervisors attended the Paediatric Refresher Course which further enabled them to meet with many of the local trainers involved in the programme.

### **Specific Referring Supervisor activities**

Dr Neil Kennedy has a special interest in cardiology and was invited to be part of a symposium held prior to the Refresher Course. He had also expressed an interest in building his neonatal service. He met with Dr Natasha Rhoda to discuss her experience both as consultant at GSH but also her trainer experience for the APFP. In particular she has supported a trainee who is currently working as neonatal consultant at the Kenyatta National Hospital in Nairobi. Both expressed that this was a fruitful meeting and they have a number of plans to build on the service in Blantyre which will benefit from Natasha's support, and in the future, site visits.

Dr Damte Shimelis and Dr Admani have special interests in Paediatric nephrology. They both attended a separate Nephrology symposium also prior to the Refresher Course. Dr Shimelis attended dedicated nephrology clinics at Red Cross Children's Hospital with Dr Priya Gajjar and Dr Pete Nourse (consultants in the service)

Dr Muluwork Tefera spent a morning with Dr Heliose Buys in the Emergency Department at Red Cross Children's Hospital. They were able to compare triage systems and protocols as well as to discuss training needs.

## Specific feedback on the APFP program.

Associate Prof Jo Wilmshurst summarised the history of the APFP, the inclusion and exclusion criteria, the current number of trainees in training or who have completed. The concept of continuing support with site visits and ways to improve on and to expand the program was also addressed. Also the issue of how outcomes could be measured. Associate Professor Minette Coetzee summarised the nursing program.

The presentations delivered by each of the referring supervisors is available on the APFP webpage.

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### Kenya (Dr Bashir Admani)

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To date the APFP has been part of the training of 13 specialists in the fields of nephrology, neurology, neonatology, gastroenteritis, pulmonology and critical care in Kenya. At the current the country can train doctors in general paediatrics but not sub-specialities. Based on the disease spectrum in the country, to improve infant mortality and to achieve millennium development goals Kenya would benefit most from additional specialists in **neonatology, pulmonology and infectious diseases**. Major challenges to the presence of specialists in the country are that >90% are based in Nairobi – this **balance** must be corrected as the trainees return. Other areas identified as in need of promotion included **paediatric radiology, developmental neurology, haematology and genetics**. Future ways to promote the program should be via collaboration in the training of **specialist nurses**. Also supporting **refresher courses** for the returning trainees to participate in, with their local supervisors - this to an extent is already in place with regular visits from the local supervisors who have been part of the annual Kenya Paediatric Association meetings.

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### Ethiopia (MuluworkTefera and DamteShimelis)

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Dr Shimelis summarised his country's health statistics and highlighted the major health challenges – focusing on the need to promote the IMCI teaching and usage, targeting effective nutritional objectives and addressing improved management of the major infections HIV and Malaria. Dr Tefera followed on with a report which noted the changes of health care discrepancies between the rural and the urban districts. To this end the country is promoting the role of Health Extension Workers (HEWs). These trainees gain a certificate to accredit them. This is already established within Ethiopia and at a primary health care level could be a viable concept for other parts of Africa. Ethiopia

has the capacity to train in general paediatrics. The University of Addis Ababa is exploring the optimal way to promote key sub-specialities. They will provide their **own accreditation**. Currently there is collaboration to decide areas of training need and **possible modules** which could be provided by the APFP. As such the prolonged training periods may not be needed for this centre just targeted areas of training need. In a separate meeting Prof Wilmshurst talked with Prof Tefera and the following specific training targets were identified 1. **Emergency medicine**: Need attachments to the Emergency department and the paediatric intensive care unit (PICU) as **specific modules** of 3-6 months each. The specifics would need to be arranged the supervisors for these areas. Emergency medicine at Red Cross is already in the process of training of a doctor from Kenya for 1 year and a template of training has been created, ideally this will lead to a **diploma** so there is a measurable outcome.

2. **Pulmonology**: The service needs a technologist but before this happens there needs to be at least one specialist trained in pulmonology. The trained doctor should then build his or her team, identifying a technologist for training. This would avoid the technologist having to function with no support. This team approach will promote the insight needed to lobby for equipment and facility needs.

3. **Cardiology:** 2 cardiologists are needed. Defining the required outcomes for these trainees are essential i.e. the level of skill they must acquire. Doctors referred from this centre (the Black Lion Hospital) will be equipped for clinical skills and such are likely to require training in ECHOCardiography and potential interventions. There is limited training space at Red Cross as the training requires careful supervision and a high trainer to trainee ratio. The team at Red Cross Children's Hospital / Tygerberg Children's Hospital are investigating developing up a Diploma in cardiology. 4. **Nephrology:** This area has adequate expertise at this time. 5. **Infectious diseases:** The University of Addis Ababa has a curriculum under development in this speciality – it follows the template of 1 year based with the adult specialists and the second year dedicated to paediatrics. This is accredited by the University of Addis Ababa, so if Red Cross Children's Hospital can support with this – then the University of Addis Ababa can provide the outcome. These trainees could come to Red Cross for 1 year for specified training. The exact format would need to be carefully worked out with the HOD, there is space available at this time in the program for this subspeciality. 6. **Gastroenterology, nutrition and hepatology:** This training follows the same template as for neurology and ID (1 year adult speciality and 1 year paediatric speciality). The Red Cross gastroenterology department provided training for many trainees for 1 year periods, so they have great experience in completing good skills exposure in this time allocation. They currently have a number of trainees already committed to their posts and clarifying when they have space available will be important. 7. **Neurology:** Support can be offered for specific modules as requested here.

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### Zambia (Somwe Wa Somwe)

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Challenges in Zambia obstructing the millennium goals targets are human resources, the burden of HIV, malaria, poor infrastructure, out dated, and lack of, medical equipment, and access to health care. Various strategic systems are in place – namely the Zambian Health Worker Retention system (to encourage rural staff to remain), expanding the rural posting to 3 years, maintaining SADC codes of practice, improving the student scholarship program, extending the retirement age (from 55 to 65), introducing new professionals (nurse practitioners, community health care workers) and increasing training through taking advantage of public – private partnerships. The University of Zambia in Lusaka has the capacity to train in general paediatrics. This capacity has been recently challenged as the ratio of paediatric academic staff has changed with currently 5 filled posts for the 28 available posts. Somwe commented, and the group supported him, that there is a significant “brain drain” of experienced staff to International Research projects (located in Zambia, Uganda, Malawi, Kenya etc) e.g. UNICEF, USAID. Requests to the APFP would be **to continue to assist with sub-speciality training**, to enable **exit exams** as part of the program, to assist the University **setting up its own sub-speciality units** and to maintain the established links between Lusaka and Cape Town.

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### Uganda (Sarah Kiguli)

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Priority health needs were maternal and child health, infectious diseases (malaria, HIV, tuberculosis), non-communicable diseases (cancer, sickle cell disease, cardiac, diabetes, hypertension, trauma etc), environmental health and nutritional disorders. To address these issues, the health expenditure should be increased, inadequate human resources improved, the inadequate infrastructure targeted, also the inequities in distribution, the inadequate system of primary care, poverty and the disease burden. Training requirements and expectations for the APFP – to date 6 fellows have been part of the program in haematology / oncology, infectious diseases, pulmonology and allergy, cardiology, paediatric surgery and emergency nursing. For each of these, and further training areas, there must be **more than one specialist** to enable training programs to be developed at home i.e. **to create a team of leaders**. The completion with **qualifications** is important as part of this. With this in mind the APFP should consider targeted capacity building in priority areas. Promoting a fellowship for **nursing**. Consolidating supervision, flexibility of shorter rotations for some faculties, and promoting research collaborations. It is important to train nurses that would work with the specialists to improve service in the different areas of speciality. Dr Kiguli also discussed the importance of nurturing the trainees in general paediatrics from early in their course and gently **encouraging their areas of interest** – otherwise they all seemed to want to do cardiology and neonatology!

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**Zimbabwe (Michael Ikeogu)**

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Of the three consultants based in his unit – they have worked there for 30, 28 and 8 years. As a result in the near future this department, which is already under resourced for paediatrics, will be at serious risk of being left with only one paediatrician. Due to the restricted human resources these paediatricians must undertake complex and risky procedures as there is no other support in place (e.g. liver biopsy). Michael identified a great need to promote and build the number of **general paediatric trainees**. Currently there is limited training evident from the capital and it is not filtering to centres such as his own. He also raised the need for more **publications from the African continent** addressing African needs – without this it is difficult to motivate for the health needs of a country. He also highlighted that in the current setting in Zimbabwe **paediatricians must be highly skilled, have wide range of skills and be willing to fight for child health advocacy issues**.

The following is a list of procedures which general paediatricians carry out:

1. Percutaneous Lung Puncture for bacterial Pneumonia
2. Percutaneous Trucut Lung Biopsy
3. Pleural Empysema Lavage
4. Non-bronchoscopic bronchoalveolar lavage
5. Echocardiography
6. Percutaneous Liver Biopsy
7. Percutaneous Renal Biopsy
8. Percutaneous Lymph Node Biopsy
9. Bone Marrow Aspiration
10. Automatic ventilation
11. Peritoneal dialysis

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**Malawi (Neil Kennedy)**

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Neil illustrated eloquently that in Malawi they are on track for the millennium goal 4 (under 5 mortality) but not for the MDG 5 for maternal mortality / deaths per 1000 live births. This related to the challenges faced by poor infrastructures. Despite effective training at the primary health care level the lack of basic equipment meant that it is not possible deliver effective health care. The “brain drain” has had major impact on the service in Malawi. By 2005 of the 12 specialists who were sent to the United Kingdom to train in paediatrics, only 2 had returned. The department in Blantyre undertook a proactive approach, they have established their own MMED general paediatrics

training program. Two years are spent in Malawi and currently the other 2 years are completed in

South Africa. Six doctors have graduated and of these 5 are now practicing back in Malawi. A further 8 are in training, and will be ready for the final completion of their training in the next 1-3 years. Financial support for this program has been erratic with limited support from the Ministry of Health. Through the APFP the 2 trained general paediatricians are now based in Blantyre and Lilongwe – both are major centres. A further trainee currently completing at Red Cross Children's Hospital will return to one of the resource limited centres. The number of paediatricians is now becoming established and will allow extended training to occur within Malawi, eventually trainees will only come to RSA for selected modules of skills development. The group are now exploring the health needs for sub-specialities and have identified neonatology, as well as oncology as needy areas.

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#### **Points which arose from the discussions.**

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1. **Training flexibility:** The approach to training in Ethiopia is a great example of how the APFP must be flexible. The University is already at the stage of establishing its own curriculum and accreditation system. In this case the role for the APFP would be to support with focused modules of skills training. Ideally this could equate into diplomas being awarded through UCT, and accreditation for the trainees on their return to Ethiopia. Once there is a critical mass of trained specialists it will be possible for the referring centre to take over the training - there would be a transition which the APFP should remain supportive of. This could include the continuum of selected module attachments e.g. for Neurology training this may be dedicated EEG training, for general paediatrics there is a need for short exposure to sub-specialities for the trainee to rotate through. For other centres the complete 2 year training period with UCT accreditation remains important at this stage.
2. **Strategic planning:** All the supervisors had good insight into the health needs of their regions. For some targeting the national issues was not possible as they were not in a position to go beyond their regional needs at this time (e.g. Zimbabwe). However the targeted training in specific health areas was agreed to be a main requirement. These goals will change with time. For example Malawi has focused on building their general paediatrics capacity – based on their policy since 2005, they are now at the stage where substantial proportions of the training can occur within Malawi. The team are assessing the optimal sub-specialities to promote, based on their burden of disease. The centre in Zimbabwe appears to be in a similar position faced by Malawi in 2005 – with imminent threat to service delivery based on the loss of general paediatric support. Uganda and Kenya are building a critical mass of trainees in sub-specialities and should be able to start their own training programs soon – they can select special modules for the APFP to support. Zambia should be in the same position as Uganda and Kenya but their marked attrition in their paediatric department in Lusaka (the main centre) means that they need to build up this critical mass first. Ethiopia illustrated an advanced insight into planning optimal training outcome goals for the sub-specialities.
3. **Funding:** This is always an issue. The support for the training is based at completing the post-graduate training. As such there is no salary, just limited living costs, and the University training fees are covered by the APFP. The local centres agreed that they would make sure the trainees are fully aware of this. They will try to provide additional financial support to the trainee as part of dual commitment.
4. **Communication:** Selection of the best candidate is based on the recommendation from the referring centre. Letters confirming financial disclosure, that the referring supervisor supports the applicant and that a government post is available for the trainee to return to. The trainee and the referring supervisor should have been in regular contact with the local supervisor to ensure there is complete transparency as to the activities of the training period and that all parties are in agreement. Each sub-speciality has been supplying curriculums which should have been read and discussed before arrival. These are on the web-page. Once the trainee arrives under the APFP, it is important that they remain in regular communication with their home supervisor. Three monthly reviews are completed - in future these will be sent to the home supervisor as well. The relationship between the trainee and their referring supervisor must be maintained with regular updates. If there are training issues this is another mechanism to try and pre-empt

problems before they become irrevocable. Further it will permit the referring supervisor to look into preparation for the trainees needs on their return.

5. **Teams and equipment:** A trained specialist cannot operate without a critical mass and a working team. This means it is important to identify how many specialists are needed for the burden of disease they treat - this will require **epidemiological research**. Further specialist services require teams - nurses, technologists, allied specialists (therapists, surgeons etc). These must be identified and worked towards to avoid a specialist returning to an isolated unsupported post which inevitably results in the risk of the "brain drain" i.e. emigration! Similarly for equipment.
6. **Collaboration:** Even following the trainees return, local supervisors from the APFP must remain in contact with the trainee. Site visits are encouraged. These can be focused for specific sub-specialities or part of more national programs such as the annual Kenyan Paediatric Association. **Research collaboration** should continue once the trainee returns and should evolve.

Jo Wilmshurst

Chair APFP

08/03/2012