

MINUTES

BOTSWANA MEETING

Tuesday, 24 November 2009

Cape Town International Convention Centre

1. ATTENDANCE LIST

See attached.

2. GENERAL OVERVIEW

Dr Kestler discussed the private hospital developments and the need to start a residency program from January 2011. There is a lot of nongovernmental organisation and private sector interest and development but these are not really joined up in a cohesive way. All sites are actively recruiting, the number one priority is to have more feet on the ground and the number two priority is to make better use of the existing resources.

Dr Corder gave some details on the hospital and private side Bokomoso. They are using the train a trainers system where overseas experts train locals. One of the key features is to try and recruit expats back into the country.

The university of Botswana timeline needs to have a postgraduate programme in place by January 2011 and this training will occur at Princess Marina state hospital. There are a lot of process improvement steps currently going on. In 2012 or 2013 there will be a new teaching hospital opening.

Questions from the floor were directed at the panel. Discussion point included that the university will train medical students, nurses (as currently being trained) and allied health professions. There is no EMS training or system of note. All EMS services are in the private sector. The health professions board recognises EMS but is not in the pay system for government therefore it's going to be some time before a government system can be established.

Medical student training began in August 2009. There will be Medicine and Paeds postgraduate programmes next year: Emergency Medicine and Family Medicine in January 2011; Surgery and Obstetrics possibly and the end of 2011.

The aim is to recruit 60 doctors back into Botswana each year. Most hospitals are run by general Medical Officers.

LW will provide **AK** with the IFEM curriculum for medical students.

The vision for Emergency Care in Botswana relates to the training projection. The population is under two million and in Gaborone two hundred thousand. The ED sees 30 000 to 40 000 patients a year. Lower level hospitals see around 15 000 patients per year. Smaller places run on generalists. The aim is to have Gaborone and Francistown with 24 hour Emergency physician coverage eventually.

Co-ordination of effective outreach is the key. Resuscitation training is critical and a Resus council / CEM(South Africa) are key in this.

Rene Grobler pointed out that some postgraduate nurse training has occurred and this needs continue. The Emergency Nursing association drives this process and it is likely that Rene could get further funding for this. **LW** to pick up with **RG** to discuss how ENSSA could help with this.

The South African Triage Scale is being modified. There is a proposal to rename it the Southern African Triage Scale which would give Southern African countries more freedom to modify it. This will be discussed at the EMSSA exco.

It was noted that this was a tremendous opportunity to start with no system and then end up with a fully developed system. Therefore we should be using every chance to write up what we are doing so that other countries can learn from it. There is no point repeatedly re-inventing the wheels. To drive this data collection would need start now. **AK** and **BC** are looking into this aspect.

A lot of the resources required are already available somewhere in the international community. This is not only academic and research resources but also developmental. The big question that needs answering is, what is the appropriate vehicle to drive co-ordination and implementation of all these resources not only in Botswana but through-out developing African Countries in general.

UB has a fund for five specialist salaries. There is no other public sector funding at the moment. The MBA fund pays for road accident victims at care and they are willing partners for the trauma working group around injury prevention and so on. This may be a source of potential funding.

The College of Emergency Medicine offered to run a DIPPEC examination in Gabarone if there was enough interest there.

Ultrasound training can be done collaboratively with outreach from Cape Town.

3. PLAN

The plan going forward was agreed on as follow:

- a) To link into the newly formed African Federation of Emergency Medicine as the engine for support and co-ordination resources.
- b) To develop a formal list of emergency care needs using the existing 30 part data collection tool (**TM** to supply).
- c) To develop a list of international emergency medicine resources that currently exist for these needs.
- d) To develop possible partners
- e) To develop a list of possible funding
- f) To develop a final plan based on this

4. FINAL

This meeting was very well attended and shows how much interest there is in support in the local area.

All were thanked for attending and LW will develop a distribution list and hope to generate ongoing interest and involvement.