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Uchunguzi (Journal Watch/*Montre de Journal*)

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Uchunguzi means investigation in Swahili and provides a summary of some of the most recent international literature as presented in other leading journals, but with an emphasis on what is relevant to our continent.

Title 1: Saving lives on African roads over the next 10 years

Content: The World Health Organization (WHO) released the Global Status Report on Road Safety 2013. The report presents 2010 data for 182 participating countries and provides a baseline for monitoring the Decade of Action for Road Safety (2011–2020) declared by the United Nations General Assembly in 2010. Forty-four of the 46 countries that make up the WHO African Region participated in the survey. Data show that, despite Africa being the least motorized of the world's 6 regions (it only has 2% of the world's registered vehicles), the risk of dying as a result of a road traffic collision is highest in the African Region with 24.1/100,000 population (the global rate is 18/100,000). Nigeria and South Africa have the highest road traffic death rates (33.7 and 31.9/100,000, respectively) and, together with the Democratic Republic of Congo, Ethiopia, Kenya, Tanzania and Uganda, account for 64% of all road traffic deaths in the region. Despite the high accident rates, most countries in the region suffer limited capacity with regard to managing road traffic crash survivors. One in three countries has no national emergency access telephone number and five countries have no ambulance services at all. In 23 countries with an ambulance service, experts estimate that less than 10% of seriously injured patients benefit from ambulance evacuation. While just over 50% of countries have emergency medicine training programs for doctors, only one-third have formal postgraduate training for nurses. Clearly, Africa has a long way to go if the goals of the Decade of Action as well as those set by the African Union to reduce deaths by 50% by 2020 are to be attained. In order to make substantial gains, the focus in Africa over this decade should include, above other measures, improving the post-crash response for all persons who survive a road traffic crash from the pre-hospital phase through to rehabilitation and reintegration back into society.

Reference: Global Status Report on Road Safety 2013: Supporting a Decade of Action. WHO 2013; <http://who.int/violence_injury_prevention/road_safety_status/2013> [accessed 2 August 2013]

Title 2: Nursing violence in the EC

Content: Workplace violence is regarded as being a complex, dangerous and global occupational burden, especially for the nursing profession. The levels of workplace violence in nursing remain unacceptably high, even with the current trend of under-reporting and in spite of the mounting evidence pointing to the adverse effects on the caregivers, care receivers and the health institution. A qualitative, exploratory study was done in the Emergency Center (EC) of a large academic hospital in the Western Cape province of South Africa. From the study, EC nurses experienced physical threats, verbal abuse and psychological and imminent violence on a regular basis.

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They tended to 'normalize' abusive patient behavior because of the perception that workplace abuse 'comes with the territory', which resulted in under-reporting. However, perpetrators received compromised care by being avoided, ignored or given only minimal nursing care. Coping mechanisms ranged from using colleagues as sounding boards, helping out with duties, taking a smoke break and using friends and family to get it 'off their chest'. The tolerance of non-physical violence and the absence of policies to deal with the violence, contribute to under-reporting. The findings of this study provide a better understanding of how ED nurses interpret and manage workplace violence.

Reference: Nurses' experiences and understanding of workplace violence in a trauma and emergency department in South Africa. Health SA Gesondheid 2013. Available from: < http://dx.doi. org/10.4102/hsag.v18i1.663 > [accessed 2 August 2013].

Title 3: How to set up EM in LMICs: a how to guide

Content: Academic departments of emergency medicine (EM) are becoming increasingly involved in assisting with the development of long-term emergency medicine training programs in low and middle-income countries (LMICs). The argument in favor of EM training in LMICs has been well articulated. Indeed, half of the top 10 causes of death and half of the top 10 causes of disability-adjusted life years lost in these countries are diseases for which there is evidence for saving lives with early and appropriate intervention. Furthermore, where there is limited access to primary care, chronic diseases are often poorly controlled and tend to present emergently in a decompensated state. In this paper, the authors share their experiences working with local partners to implement an emergency medicine residency training program in Guyana. While the establishment of an EM training program in a LMIC country requires a unique approach each time, there are some lessons learnt that may be generally instructive. Successful program initiation was due in large part to the pre-existing interest of several local partners and followed by long-term involvement within the country. As a newer specialty without significant local expertise, resident educational needs mandated a locally present full time EM trained physician to serve as the program director. Both external and internal funding were required to achieve this goal. Local educational efforts were best supplemented by robust distance learning.

Reference: Emergency Medicine in Guyana: Lessons Learned from Developing the Country's First Degree-Conferring Residency Program. West J Emerg Med 2013. Available from: < http://escholarship.org/uc/item/7hr5n2dj > [accessed 2 August 2013].

Title 4: Trauma registry development in LMICs

Content: Ninety per cent of trauma- and injury-related deaths and disabilities occur in low-and middle-income countries (LMICs). A significant number of these deaths can be averted through improvement in trauma care in these countries. However, because information on injuries and trauma from LMICs is most often based on routine health surveys, surveillance reports, police data and hospital-based case series, information about the process and quality of trauma care or clinical outcomes is lacking. Limited useful information on trauma care in LMICs underscores the importance of trauma registries (TRs) in these settings. Trauma registries are databases used to monitor and enhance the quality of trauma care and public health programs related to injury prevention and research. This case study looks at the development and pilot implementation of ''Karachi Trauma Registry'' (KITR), using existing medical records at a tertiary-care hospital in Karachi, Pakistan. It describes the three main steps for trauma registry implementation in a developing country; the process of development of the registry; affordability of its development and implementation and the challenges of the implementation of the software. Similar to other settings, four critical success factors for the implementation of a trauma registry were identified; good patient records, patient identification and documentation of all relevant information; training of personnel and availability of technical support to the staff; sustainable funding, which is by far the most common reason for the lack of a long-term implementation plan for a registry and finally, one of the most important factors which alone can impact these barriers, is institutional buy-in from senior hospital management.

Reference: Development and pilot implementation of a locally developed Trauma Registry: lessons learnt in a low-income country. BMC Emerg Med 2013;13:4. doi: 10.1186/1471-227X-13-4.

Title 5: 1 in 5 adverse events: is pre-hospital RSI safe?

Content: A Cochrane review in 2009 reported that evidence supporting prehospital emergency intubation was lacking, but this did not equate to a lack of benefit and prehospital rapid sequence intubation (RSI) remained controversial. Africa faces unique challenges due to prolonged prehospital times and limited access to physicians. In this retrospective observational study of paramedic RSI performed by a national ambulance service in South Africa, the adverse event (AE) rate was reported at 22%. Some of the complications included: hemodynamic instability (11.6%), tension pneumothorax (3.5%), difficult intubation (2.3%), low ETCO2 (2.3%), high ETCO2 (1.2%), and bronchospasm (1.2%). Four of these patients were hypotensive (4.7%) and two hypoxic (2.3%) at handover to hospital or helicopter staff. Female gender (odds ratio 18.3 (3.46–99.38); $p = 0.001$) and helicopter transport (odds ratio 7.24 (1.44–36.32); $p = 0.016$) remained independently associated with AEs. The 1 in 5 AE rate highlights safety concerns. The importance of a robust clinical governance program to identify problems, refine practice and improve the quality of care is underscored.

Reference: Paramedic Rapid Sequence Intubation (RSI) in a South African Emergency Medical Service (EMS) is effective, but is it safe? Scand J Trauma Resusc Emerg Med 2013;21(Suppl. 1):S29.

Title 6: A systematic review of EM in LMICs

Content: Emergency centers in many resource limited settings are not staffed with specialists with specific training in the discipline, but rather with rotating off-service staff physicians or with residents and interns. Further increasing the burden on

weak emergency medicine (EM) services in these health-care settings is the frequent lack of access to primary care, leading many patients to seek delayed treatment, often in an acute or critical state. As a result, resource-limited settings experience a significant mismatch of needs and services: high rates of critically ill patients and constrained or underdeveloped EM systems. The need for EM services in such settings is clear, yet to date efforts toward establishing EM in resource limited settings have been slow. In this study, the authors conducted a systematic review of the published literature on emergency medicine training programs in resource-limited health-care settings. They focused on the unique challenges facing resource constrained settings in developing EM as compared to high-income countries. Common among the majority of the new programs was the adaptation of components of well-established EM program curricula, principally those of high income countries and Anglo-American EM systems, to ensure training is matched with local needs, priorities and resources. Most of the reported programs also developed international partnerships, with or without exchanges between participating programs. Despite the paucity of currently published data on the development of EM residency training programs in these settings, this review demonstrates the need for encouraging further information exchange to aid in such efforts, and the authors make specific recommendations to help guide future authors on reporting on such efforts.

Reference: A review of published literature on emergency medicine training programs in low- and middle-income countries. Int J Emerg Med 2013;6(1):26. doi: 10.1186/1865-1380-6-26.