Developing Emergency Medical Services in Nigeria

Nicholas Maxwell B.S., NRP

Abstract

Due to the lack of out-of-hospital care that was identified in Calabar, Nigeria, a program was designed in an attempt to train future out-of-hospital care providers. To do this, a scope of practice was created based on the primary emergencies faced in the community that was cognizant of the limited resources available. In efforts to have the program be self-sustaining, future teachers of the program were identified and equipped to lead and measures were taken to publicize the program including televised interviews, skills demonstrations, and meetings with the government and medical school staff. In the end, there were many successes indicating high potential for the future and a couple of lessons were learned that enabled us to do better as we continue.

Introduction

Near Calabar, Nigeria, a city of roughly 500,000 people, the Joseph Ukpo Hospital and Research Institute (JUHRI) is being constructed. My physics professor, the visionary and creator of the hospital, described to me his desire to have mobile clinics based there as well as the absence of any emergency medical services (EMS) in the region. Given my passion for and background in EMS, we agreed I should teach a course in out-of-hospital care there. It would serve as a pilot course for future programs as well as provide unique training for those that would staff the mobile clinics. Through a contact we had at the University of Calabar Teaching Hospital (UCTH), we were able to establish a teaching site and gather resources. However, since there is no EMS there, the program we created was started from square one on a truly blank slate.

Course Development

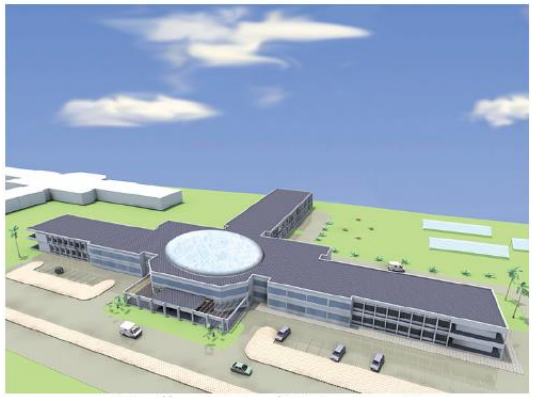
For this program my colleague and I, identified the need for a customized course that was cognizant of the emergencies most frequently faced in the region, the resources available, and the short time frame allotted for the program. After speaking with physicians at UCTH, it was clear that the overwhelming majority of their patients are trauma patients. In response to this, we customized our scope of practice and the associated treatment plans around this while utilizing a minimalist approach in regards to equipment. This includes things like showing how to utilize triangular bandages for tourniquets, splinting, and fashioning backboard straps. As a result, a highly effective yet cost efficient approach to healthcare was created for them.

There was only enough time to hold two seven-day courses to train approximately 40 students. Since the time frame was so accelerated and the course was unique, we created a small textbook and sent it to the students three weeks ahead of time. For each of the three weeks, there were recommended assignments and review questions. This enabled students with minimal or no background in healthcare to familiarize themselves with things like medical terminology and basic anatomy and physiology. This also freed up more in-class time to focus on skills training and scenario practice.

On-Scene Work

The class structure consisted of morning lectures followed by afternoon skills training. Then at the end of the course we had a final exam and two scenarios to test their skills. The goal of this format was to learn, then apply while also maximizing student engagement since the course went all day each day. However, upon arrival, much of the equipment we were promised was not there. We adapted by doing things like cutting our own triangular bandages out of sheets and our splints out of cardboard. In hindsight this was a blessing because we were able to prove our methods are effective and sustainable even with the minimal equipment they had available.

To accomplish our objective of making the program self-sustaining, we constantly kept an eye to the future while we were there. We focused on publicizing the program and finding teachers who would lead future courses and continue the push to create an EMS system. For publicity, a car crash scenario at one of the major intersections in the city was performed in conjunction with the military. Camera crews, government officials, and university representatives were present so they could see what level of care is easily achievable. We were also interviewed on television and met with the Dean of the medical school and Vice Chancellor of the University to tell them about the program. To continue the program two of the top physicians as well as one nurse from the program were selected. We left them all of our teaching materials as well as the EMS textbooks that we had brought from the U.S.



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Successes

1. A physician student has been approved for sponsorship by UCTH to study emergency medicine in the U.S.
2. Another student is attending Creighton University this year to get his B.S. in EMS.
3. The medical school wants to incorporate the program into their curriculum.
4. The State Security Advisor wants us to return to train the military to be the primary EMS provider for the region.

Lessons Learned

1. A prolonged presence in the area is needed.
2. The program should already be self-sustaining prior to handing it over.

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