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Setting the agenda in emergency medicine in the southern African region: Conference assumptions and recommendations, Emergency Medicine Conference 2014: Gaborone, Botswana

Établir le programme d'action en médecine d'urgence dans la région Afrique australe: Hypothèses de la conférence et Recommandations pour la médecine d'urgence 2014, Botswana

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The first international emergency medicine (EM) conference in Botswana was held on 15th and 16th May 2014 at the Gaborone International Convention Centre. The support from key stakeholders positioned the conference, from its conception, to deliver expert guidance on emergency medicine relevance, education and systems implementation. The conference theme was aptly: "Setting the Agenda in Emergency Medicine in the Southern African Region." Over 300 local, regional and international delegates convened to participate in this landmark event. Country representation included Botswana, South Africa, Zambia, Namibia, Zimbabwe, Swaziland, Lesotho, Nigeria and the United States of America. Conference assumptions intersected emergency care, African burden of injury and illness and the role of the state; the public protection ethic of emergency care, and the developmental, economic and health interest in promoting EM. The recommendations addressed emergency care relevance; health systems research as an imperative for emergency systems development in southern Africa; community agency as a requisite for emergency care resilience; emergency care workers as pivotal to the emergency medical system, and support of EM system implementation. The conference recommendations – by way of setting an agenda, augur well for emergency care development and implementation in the southern African region and are likely to prove useful to the southern African countries seeking to address health service quality, EM advocacy support and implementation guidance. Emergency medicine is the only discipline with 'universality' and 'responsivity' at the point of need. This implies the widespread potential for facilitation of access to health care: a public health goal nuanced by the African development agenda.

La première conférence internationale sur la médecine d'urgence (MU) s'est tenue les 15 et 16 mai 2014 à l'International Convention Centre de Gaborone, au Botswana. Le soutien affiché par les principales parties prenantes a permis de positionner la conférence, dès sa conception, sur la délivrance de directives proposées par des experts sur la pertinence de la médecine d'urgence, son enseignement et la mise en œuvre de systèmes s'y rapportant. Le thème de la conférence était, fort à propos, « Établir le programme d'action en médecine d'urgence dans la région Afrique australe ». Plus de 300 délégués, locaux, régionaux et internationaux, se sont réunis pour prendre part à cet événement marquant. Les pays représentés incluaient notamment le Botswana, l'Afrique du Sud, la Zambie, la Namibie, le Zimbabwe, le Swaziland, le Lesotho, le Nigeria et les États-Unis. Les hypothèses de la conférence ont permis de croiser les soins d'urgence, le fardeau des blessures et de la maladie en Afrique et le rôle de l'État avec l'éthique de protection publique des soins d'urgence et l'intérêt développemental, économique et sanitaire associé à la promotion de la MU. Les recommandations portaient sur la pertinence des soins d'urgence ; la recherche sur les systèmes de santé en tant qu'impératif de résilience des soins d'urgence ; les urgentistes comme pivots du système médical d'urgence, et l'appui à la mise en œuvre du système de MU. Les recommandations de la conférence – par la mise en place d'un programme d'action – sont de bon augure pour le développement et la mise en œuvre des soins d'urgence dans la région Afrique australe et sont susceptibles de s'avérer utiles pour les pays d'Afrique australe qui cherchent à palier les problèmes de qualité des services de santé, d'appui au plaidoyer en faveur de la MU et de directives sur sa mise en œuvre. La médecine d'urgence est l'unique discipline associée à une « universalité » et une « réceptivité » au lieu de consommation des soins. Ceci implique un potentiel étendu de facilitation de l'accès aux soins de santé : un objectif de santé publique nuancé par l'agenda de développement africain.

Introduction

The first international emergency medicine (EM) conference in Botswana was held on 15th and 16th May 2014 at the Gaborone International Convention Centre. The conference was organised by Boitekanelo College, a private higher education institution and was co-sponsored by the Republic of Botswana: Ministry of Health, Botswana Education Hub, the Human Resource Development Council (HRDC) and the

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Motor Vehicle Accident (MVA) Fund.[1] The above support from key stakeholders positioned the conference, from its conception, to deliver expert guidance on emergency medicine relevance, education and systems implementation. The conference theme was aptly: setting the agenda in emergency medicine in the southern African region.

Over 300 local, regional and international delegates convened to participate in this landmark event (with little attrition on day two). Country representation included Botswana, South Africa, Zambia, Namibia, Zimbabwe, Swaziland, Lesotho, Nigeria and the United States of America. The conference was officially opened by the Honourable Assistant Minister of Health, Dr. G Somolekae[2] and the keynote address[3] was by Professor S.V. Mahadevan (Director of Stanford University's Emergency Medicine International). Topics presented included a range of emergency medicine (EM) related matters including what the current state of EM was in respective countries, what was needed and possible, resource and other constraints, system and policy imperatives and lessons learnt from EM endeavours in African countries, India, Nepal and the USA.

The conference foundational assumptions and emergent recommendations are presented below (numbered for reference, not hierarchy), in a deliberately streamlined format so as to foreground the conference conceptions.

Conference assumptions

The conference endorsed 11 major assumptions upon which its recommendations were predicated. These assumptions became self-evident from recurring similarity of statements in expert presentations, panel discussions and delegate participation that were not in dispute and did not require multiple levels of abstraction.

Emergency care, African burden of injury and illness and the state

The first assumption is that (1) emergency care needs abound in the southern African region.[4–10] However, the burden of injury in sub-Saharan Africa appears misaligned with global and African funding agendas that have a disproportionate focus on the burden of HIV.[11] The second assumption is that (2) health related emergencies promote and may emanate from vulnerability, inequity and poverty.[12] This socio-economic burden impacts the State's ability to manage pre-existing vulnerabilities and the simultaneous creation of new burdens that undermine hard-earned developmental gains. The following assumption therefore, is that (3) the State (particularly in constitutional democracies) is the principle custodian of a country's health and health care and as such, should create an enabling regulatory environment for EM.[13]

The public protection ethic of emergency care

The above is nuanced by the conference assumption/assertion that (4) a 'poor emergency care response' can render the health system complicit in the vulnerability that a citizenry endures. No doubt then, (5) the demand for emergency care exceeds its supply. In terms of this preceding premise and in the interest of sustainability of solutions, (6) there is an ethical obligation to manage emergencies, scarce EM resources and EM related costs. Given that vulnerability is deeply embedded in southern African communities (and countries) at risk, (7) this presents an opportunity to enhance the value proposition of emergency medicine in the developing world context.[13]

There is a developmental, economic and health interest in promoting EM

Finally, the conference also adopted as its founding assumptions: (8) that everyone has the right to emergency care; and therefore, (9) no patient may be refused emergency care. Linked to the notion of universal access is the assumption (10) that emergency care should be free[3,10,13] at the point of consumption. (11) The conference validated that the southern African region has a developmental, economic and health interest in promoting EM in its countries and in the region. Indeed, the conference presented the opportunity "...to write our own African story."[14]

Conference recommendations[13]

Emergency care relevance is relative to its public health contextualisation in southern Africa

The conference endorsed the notion of (1) emergency care as a right that promotes public safety and crisis intervention. It further endorsed (2) the use of health economic[15] and epidemiological lenses to 'view' emergency medicine (EM) implementation. As such, (3) the conference values the ethical implications of the 'market-failure principle' of emergency medicine as a theoretical tool to avert perversity and undue corporatisation in EM endeavours.[13] In essence, the health value proposition of EM must not be undermined by undue fiscal risk (particularly in neoliberal contexts[12]). (4) In implementing EM, the country specific influences on health needs and the reciprocal value proposition of emergency medical care must be considered.[3,11] Further to the public health contextualisation of EM, (5) the conference elected to professionalise the EM response in the region, with international comparability but with regional relevance, with regard to service delivery, education and research.

Health systems research is imperative for emergency systems development in southern Africa

The conference adopted several research imperatives for health and emergency systems in the southern African context. It adopted (6) the enhancement of evidence-informed guidelines across the spectrum of EM theory, praxis, practice and policy. To avoid therapeutic and economic misconceptions, both (7) health economic[15] and epidemiologic measures of health must determine EM effectiveness. (8) EM design must be sustainable to promote population confidence and public safety. Further to the efficiency argument, (9) micro-economic evaluations at the treatment level are likely to identify cost drivers. (10) The development of an evidence-informed policy landscape for EM is paramount to guide sustainable and ethical implementation, relevant to country need and resource availability. (11) Positive feedback mechanisms after EM evaluations are likely to enhance quality.