ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH

International Child Health Group

A Career in International Child Health

Newsletter Date : November 2006

Volume 2, Issue 3

Inside this issue:

FROM THE EDITOR

We plan to publish the newsletter 3 times a year

Editorial deadlines are

1st February 2007

1st July 2007

1st November 2007

Please send letters and articles for inclusion to

sheilareilly@doctors.org.uk

We're on the Web :

www.ichg.org.uk

I'm on a flight to New York to attend a special session on reaching MDG 4 hosted by the Government of Norway and UNICEF and I'm thinking back to the flight almost 26 years ago when I set off as a Registrar in paediatrics to a 2 year assignment with OXFAM in newly independent Zimbabwe…

The call was for doctors to rehabilitate their rural health service following Independence from Britain a few months earlier. Two years seemed a long time back in the days of no mobile phones or internet; in fact, in the mission station where I was stationed there was neither phone nor mains electricity - only a generator for evening reading up to 9pm and for emergencies!

So was the 4 years since I had graduated enough to prepare me for what lay ahead? Barely. In my 6 months O&G SHO post I had certainly delivered enough babies but I'd only assisted at caesarean sections and done vacuum extractions under supervision. I had a better grip of paediatrics, however, having completed my SHO rotation (including neonates) and 9 months as a registrar. Even so, our Oxfam coordinator (David Sanders - now Professor of Public Health, University of Western Cape, South Africa) made sure we were better prepared for the rural areas by organising a one month attachment at Harare Hospital. Thus, in November 1980, I went to Matibi Mission (a small 90 bedded mission hospital) in the heart of Mwenezi district with key clinical skills.

I was less prepared for the Public Health Duties, however, such as the placement of a new clinic (in tandem with the District planning officer) or advising the newly established District Council on health priorities - prevention or cure?! - and caring for a ward of malnourished children, many of whom had concurrent TB and other infections.

Six-weekly get-togethers of Oxfam doctors who were invariably placed in remote districts enabled us to share clinical problems, teaching ideas and a much-welcome beer or two. I set up weekly teaching sessions for the small nursing staff, and conducted supervision and teaching at the various clinical and rural hospitals of the district. In retrospect, although it was a fantastic experience and giving and learning was mutual, I do think it is better to join as an experienced professional than to have to learn alone. Indeed, I would certainly recommend at least 2 years of SHO posts before venturing to 'help' others: the need is for experience, not just education.

Fast-forward 3 years and I move to the Provincial Medical Office where I joined a very experienced provincial Medical Officer (who unfortunately promptly retired leaving me acting for 6 months). I decided that I needed to get some training in Public Health and went to the London School of Hygiene and Tropical Medicine to do an MSc in Community Medicine.

These days one has more of a choice but the key questions to consider are:

* do you want the qualification to be equally useful in the UK (if so, do the UK MSc with MFPHM)

* are you more interested in Public Health or Epidemiology or Clinical research? This will certainly inspire your choice of courses (as will your budget or sponsorship).

Whatever your aims, a time for reflection, further education and consideration of the future is very useful.

Consolidate or diversify? It is always difficult to decide whether to continue in the same place or move to a new environment. It was not difficult for me to decide to go back to Zimbabwe (my now husband had returned a year earlier), however I did have a unique opportunity to work for the Ministry of Health responsible for Maternal and Child Health at Provincial level then as deputy director at National level. The 6 years in

these two positions gave me a full understanding of the complexities of delivering Maternal and Child Health Services. I am not sure how easy it is to replicate these experiences, combining supervision of clinical paediatrics and teaching in the district (as I did as a provincial Medical Officer) or the public health at national level with university paediaitrics (as I did when at HQ). Whether obtained through the university, government or NGO, these are certainly the experiences we look for when recruiting.

"So how can I get to join WHO?" There are different ways of entering WHO, either as a junior Associate Professional Officer (APO), or as a fully qualified and experienced professional. The APO posts are usually government sponsored and traditionally UK has few of these posts to offer, the Netherlands, Italy, Germany and the Nordic countries also offer opportunities. As an experienced professional you must expect to already have both your paediatric and public health qualifications. For me, it was a combination of luck and good timing. I was initially recruited into WHO by the Zimbabwe country office during the drought emergency of 1992/93, following which I was recruited for the inter-country office covering southern Africa, initially combating the cholera and dysentery epidemics (1993-1996) and subsequently introducing Integrated Management of Childhood Illness (IMCI) into countries of southern Africa (1997-2000). I was appointed Regional Advisor for IMCI in October 2000 and Director of the department of Child and Adolescent Health and Development in headquarters, Geneva in September 2004.

The WHO Regional office in Africa is bilingual - English and French. Portuguese is spoken by 5 countries and so it is an obvious advantage to speak this as well. For the Americas Region which covers the countries of central and South America, Spanish is a must with Portuguese being an advantage. For the other regional South East Asia, Western Pacific, European and Eastern Mediterranean the official working language is English, but knowledge of one more local languages is certainly an advantage, be it Russian, Arabic or Hindi. Entering medical school today there is less emphasis on having all science 'A' levels, and keeping up one language as an option is thus beneficial to an international career. I only took up French again after schooldays when I was appointed regional advisor - so had a steep learning curve and wished I had paid more attention in school! An elective period in a developing country is a good start, both to see if this is the type of career you would be interested in as well as to gain experience in living and working in a developing country.

On reflection as I was sitting on the airplane to Zimbabwe 26 years ago, did I plan out a career in international child health - no - would I have done anything different? probably not.

Elizabeth Mason

Director, Department of Child and Adolescent Health and Development, WHO Geneva

Paediatric Antiretroviral Therapy in Sub-Saharan Africa in 2006

In July 2006 I visited the paediatric antiretroviral therapy (ART) clinic in Lesotho. This tiny country has a population of only 2.3 million but the HIV prevalence is 29%. There are 320,000 people including 22,000 children infected with HIV (1). The paediatric ART clinic, at Queen Elizabeth II Hospital is in Maseru, the capital, and was opened one year ago with funding from the Clinton Foundation. Children are reviewed four mornings each week. There are 130 children on ART and 270 under regular follow up, but not yet on therapy. Doses are calculated using weight based dosing charts commonly used in resource constrained settings (for these charts see http://www.mtctplus.org/). Children on medication are reviewed three monthly for routine bloods and CD4 count; viral loads are unavailable.

Challenges include developing paediatric expertise within the healthcare system. While the clinic has huge experience in terms of numbers of children on ART, they lack longitudinal experience in terms of having children on therapy over a number of years. Other challenges include the procurement and supply chain of paediatric formulations and the concern over sustainability of funding for paediatric medication. The lack of viral loads makes monitoring and the detection of regime failure difficult while not having proviral DNA, which is required to make the diagnosis of HIV in babies who still have maternal antibodies, adds to the challenge of managing babies. One of the most typical scenarios is treating TB and HIV concurrently, as the drugs used for the former alters the pharmacokinetics of the latter. Another problem is that the first line regime in many countries includes Neviripine which is used in MTCT (Maternal to child transmission) programmes and this can lead to resistance and regime failure in the child. Many children present late; one afternoon we reviewed two children with heart failure secondary to respiratory problems, who subsequently died.

Support from the UK and US

The UK umbrella organisation for professionals who care for HIV infected children is the Children's HIV association or CHIVA (http://www.bhiva.org/chiva/). They have been providing training and support for colleagues in KZN in South Africa for the roll out of ART in children.

The Baylor International Paediatric Aids Initiative (http://bayloraids.org/) has opened seven centres of clinical excellence in Africa, including Lesotho. The other centres are in Burkina Faso, Uganda, Tanzania, Malawi, Botswana, and Swaziland. The centre in Lesotho provides outpatient care for 40 children each day. One of the problems encountered by the Baylor centre is the inpatient facilities are not onsite and are not as well resourced as the outpatient facilities.

How many children in Africa are on ART

UNAIDS estimated that at the end of 2005 there were 800,000 adults and children in Sub Saharan Africa (SSA) on ART. This represents less than 10% of those who need to be on treatment in most SSA countries. MTCT of HIV is very poor in most countries, with less than 5% of pregnant women having access to these services (2), resulting in a high number of vertical transmissions. Infants and young children therefore carry the burden of HIV-related morbidity and mortality. Over 50% of HIV infected children currently die before their 2nd birthday.(2) The number of children <15 living with HIV in SSA is of the order of 2,000,000 (3). The number of these on ART is difficult to estimate. One example is Uganda; the number of children aged 0-14 years living with HIV in Uganda is 84,000 (1) with only 6000 children of these on ART (personnel communication) by mid 2006, or 7.5%. In Lesotho from the above numbers, well under 10% are on ART. The vast majority of infected children in Africa have no access to support or treatment.

Since I last worked in Africa, for Child Advocacy International, http://www.childadvocacyinternational.co.uk, in 2001 with HIV infected children (4), there is a notable difference. Children who once would have died due to HIV infection are now living healthy lives. With the roll out of MTCT and treatment of paediatric HIV hopefully fewer children will need ART and it will be available for all of those who do need it. On the other hand, it must be remembered that deaths due to HIV in children less than five years in SSA represents on average 6% (UNIADS) of total deaths while other common conditions including neonatal causes of death and pneumonia and diarrhoea complicated by malnutrition continue to b the major causes of mortality.

Online resources for paediatric HIV in resource limited settings.

- *Baylor provides excellent training, which is available on their online curriculum (http://bayloraids.org/curriculum/).*
- *The excellent WHO handbook is available online - hospital care for children - Guidelines for the management of common illnesses with limited resources has a chapter on the management of HIV http://www.who.int/child-adolescent-health/publications/CHILD_HEALTH/PB.htm.*
- *The WHO 2006 updated HIV guidelines are available at http://www.who.int/hiv/mediacentre/fs_2006guidelines_paediatric/en/index.html*
- *UNICEF/WHO Technical consultation on paediatric ARV formulations – slide presentations are available http://www.who.int/3by5/paediatric/en/index.html*
- *Treating HIV in paediatrics from AIDSMAP http://www.aidsmap.com/*
- *Columbia University Mailman School of Public Health http://www.mtctplus.org/ for the paediatric dosing chart for use in resource limited setting see http://www.mtctplus.org/intranet/pdf/Pediatric_Dosing_Guide_English.pdf*
- *The Handbook on Paediatric AIDS in Africa By the African Network for the Care of Children Affected by AIDS (ANECCA) http://www.fhi.org/en/HIVAIDS/pub/guide/mans1.htm*

References

(1) UNICEF. Monitoring and statistics. http://57 69 14 59/statistics/index_24183 html 2006 [cited 6 A.D. Jan 6];

(2) ANECCA. Overview of ANECCA. ANECCA African network for the care of children affected by HIV/AIDS 2006 [cited 2006 Oct 9];Available from: URL: http://www.anecca.org/

(3) Neff Walker U. UNICEF/WHO Technical Consultation on Paediatric ARV Formulations;- Predicting the need for ARVs: Global estimates of burden of disease. 2004.

(4) O'Hare B A M, Venables J, Nalubeg JF, Nakakeeto M, Kibirige M, Southall D P. Home-based care for orphans infected with HIV/AIDS in Uganda. Aids Care 2005;17(4):443-50. Full text at http://www.caiuk.org/publications/home-basedcare_uganda.pdf

Bernadette O'Hare
Consultant Paediatrician Cardiff

Child Advocacy International (CAI) in Cameroon

Cameroon is a country with all the problems associated with Sub Saharan Africa – underdeveloped systems of care, inadequate infrastructure and poor resources. Over half its (growing) population of around 16million is aged less than 20, infant and child mortality is high, and life expectancy is 46 years. How can a small charity like CAI make any difference in the face of these depressing facts?

CAI is running several projects in the Provincial Government hospital in Bamenda, the main town in the NW province of Cameroon. This is a general hospital, with medical, surgical, maternity, gynae and paediatric wards. Staffing levels of both nurses and doctors are poor. Nursing is not well paid or prestigious, and it is hard to attract and retain staff and to maintain morale. Doctors do not want to stay in this part of the country, but wish to work in the south of Cameroon, where the bigger cities offer more in terms of training opportunities, private practice and even an escape route to practice medicine in the West.

Cameroon is in the 'Burkitt's Belt' in Africa, and in 2002, children with Burkitt's lymphoma started to be treated at the hospital in Bamenda. Dr Peter McCormick used a simple chemotherapy regime (the Malawi protocol) designed for African children with Burkitt's. Peter recruited two nurses to work for CAI, one as the Burkitt's lymphoma nurse, and one as a local project manager, and supervised them himself as CAI doctor. Children were successfully treated with this regime, and although Peter has moved on, CAI continues to finance this chemotherapy and supportive care, treating around 15 new patients/year. Since 2004, there has been a locally trained paediatrician working at the hospital (the only children's specialist in the NW province), and she helps with this work. Professor Hesseling, from the University of Stellenbosch, has given help and advice. The cure rate is now over 60%, but could be improved further. We would like to provide ultrasound more easily at the hospital, and also to recruit another nurse to help to look after these children.

Work is ongoing to try to improve standards of care in the neonatal nursery. Peter McCormick established a breast milk bank, which, against all odds, continues to function well. Mothers who bring their babies to the immunisation clinic are encouraged to donate a few mls of breast milk, and are rewarded for this with a cake and palm wine. Aliquots of the donated samples are cultured, and those that are sterile are pasteurised and frozen for use in the nursery later.

The nursery is overcrowded, with Inadequate hand washing facilities, and high mortality rates to which infection contributes. Earlier this year the concept of hand washing with a 'home made' alcohol/glycerine solution was introduced with success, and this has now been extended to the children's ward. A CAI fundraiser has raised enough money to extend the nursery, with the aim of providing some accommodation for mothers, and other improvements such as glass for the windows, and electric plugs for all the rooms.

In Cameroon, as in other African countries, HIV/AIDS is responsible for much ill health and suffering. There is a National program for antenatal testing and counselling, with uptake by over 90% pregnant mothers. Infants of HIV +ve mothers represent an unmanageable workload for the one paediatrician in the province. This year CAI has employed 2 new nurses to help her with identification and follow up of these babies.

Each of these projects contributes in a small way to improvements in healthcare locally, and CAI's work is appreciated in the hospital. The concern is that projects depend on a few able and hard working individuals. Our challenge is to improve standards of nursing and medical care for children generally, perhaps through educational initiatives, and to make sure that our work is sustainable financially, so that we can develop further.

Alison Earley