The worldwide burden of surgically treatable disease is rapidly growing. Each year, more than 230 million surgeries are performed worldwide, more than double the number of childbirths. Surgical complications are estimated to result in one million patient deaths, and another 7 million disabilities yearly. More than half of these complications are thought to be preventable by following established safety practices.

Sadly, many of the complications occurring in developing countries result from surgery care following road trauma to young adults who are the primary family wage earners. Deaths associated with anesthesia have been reported to be as high as 1/150 in some sub-Saharan countries in Africa, 50% of which were obstetrical patients, compared to 1/200,000 in the industrialized countries. The lives of many are potentially affected by each lost life or disability of family care-takers.

In May 2002, the World Health Organization (WHO) decided to address the issue of patient safety. Two years later, the WHO World Alliance for Patient Safety was established to focus on this growing public health issue. Their first challenge addressed “Clean Care in Health Systems,” which covered basics such as hand washing and infection control in clinics and hospitals. The initial effort had 7 government sponsorships. Today, thanks to their campaign, 80% of the world’s governments have pledged their commitment and have incorporated campaigns into their health care systems.

The World Alliance second global patient challenge is “Safe Surgery Saves Lives”. In January, 2008, some 120 health professionals (representing all those on a surgical team – surgeons, anesthesiologists, nurses, clinical engineers, etc, as well as associations addressing patient safety) met in Geneva to review the initial draft of a tool designed to improve the safety of surgical care. The tool is designed to be used in operating rooms worldwide and its systematic use has the potential to drastically decrease the incidence of complications.

What is this miraculous tool? A simple, one-page checklist which calls for three specific times (prior to induction of anesthesia, prior to skin incision, and prior to the patient’s departure from the operating theatre) when the team can identify the patient,
I read an interesting article in the January/February issue of Health Affairs called “Happiness and Health: Lessons-And Questions-For Public Policy”. Imagine my surprise to learn that there are “happiness economists” who have researched the link between health and happiness. According to this article, there is a “substantial body of evidence that health is a consistent determinant of self-reported happiness – one that transcends national boundaries, belief systems, and the highly subjective nature of happiness.”

That there is a link between health and happiness, of course, is not a surprise at all. Being healthy, for many of us, is something we take for granted until that day when something happens. It is when you are sick that suddenly you realize how important your health is and how much you would give to “feel good” again.

For millions of people around the world today, however, good health is not a given and access to health care when you need it is a remote possibility. There are many reasons behind the failure of health care delivery systems – lack of resources (human and financial), outdated infrastructure and poor planning, overwhelming burden of disease, etc – the list goes on. HVO’s portfolio of programs addresses one of the critical underlying issues – the need for training and education. HVO volunteers, more than 425 people annually, routinely get onto airplanes and fly enormous distances with one thought in mind – share what you know and learn something in the process.

In April, as part of HVO’s observance of World Health Day, we announced the recipients of the 2008 Golden Apple Award. Established in 2006, this award is meant to recognize those volunteers who have made extraordinary educational contributions to HVO programs. This year there were nine recipients honored…and what a remarkable group of people they are! When reading the nomination forms, I was struck by the fact that all were cited for their enthusiasm for teaching, their caring demeanor, and their remarkable stamina. For more information on this year’s honorees, visit the HVO web site at https://www.hvousa.org/vrcfm.

I hope you will enjoy this issue of the Volunteer Connection. For those of you who have not yet made the plunge, I hope that the volunteer quotes on pages eight and nine will inspire you to call and learn more about opportunities that await you. You can volunteer at one of our sites, make a financial contribution in support of our programs, get your friends involved, etc. There are lots of ways to participate!

Nancy A. Kelly, MHS
Executive Director
Please Note: New programs are added regularly and volunteer assignments are made on a rolling basis. For the most up-to-date information on volunteer sites and scheduling, contact the HVO Program Department: programs@hvousa.org or 202-296-0928. Visit the web site www.hvousa.org.

### Program Sites

**Anesthesia**
- Eritrea.............................2 - 8 weeks
- India ................................2 - 4 weeks
- Peru..................................1 - 4 weeks
- South Africa ................2 week minimum
- Tanzania...........................3 - 4 weeks
- Vietnam ............................2 week minimum

**Burn Management**
- India ................................2 - 4 weeks
- Malawi ................................2 weeks
- Zambia ...............................2 - 3 weeks

**Dentistry**
- Cambodia ............................2 weeks
- China ................................2 weeks
- Laos..................................1 - 2 weeks
- Nicaragua ..........................1 week
- St. Lucia ............................2 - 4 weeks
- Tanzania ............................2 weeks
- Vietnam .............................1 - 2 weeks

**Dermatology**
- Costa Rica ..........................1 - 2 weeks
- Palau ..................................2 weeks
- Peru..................................1 - 4 weeks
- St. Lucia ............................2 - 4 weeks
- Uganda ............................ 3 - 4 weeks

**Hand Surgery**
- Honduras ............................1 week
- Peru..................................1 - 2 weeks

**Hand Surgery/Hand Therapy**
- Nicaragua ..........................1 week

**Hematology**
- Cambodia ............................2 - 4 weeks
- Uganda ............................. 2 - 4 weeks

**Internal Medicine**
- Cambodia ............................2 - 4 weeks
- India ................................2 - 4 weeks
- Peru..................................2 - 4 weeks
- Uganda ............................. 1 month

**Nurse Anesthesia**
- Cambodia ............................2 - 8 weeks
- Eritrea .............................2 week minimum

**Nursing Education**
- Cambodia ............................1 - 2 weeks
- India .................................2 week minimum
- Tanzania ............................3 - 4 weeks
- Vietnam .............................3 - 4 weeks
- Uganda .............................3 - 4 weeks

**Oral and Maxillofacial Surgery**
- Cambodia ............................2 weeks
- India ................................1 - 2 weeks
- Peru..................................1 - 2 weeks
- Samoa .................................2 - 4 weeks
- Vietnam .............................2 - 4 weeks

**Orthopaedics**
- Bhutan ...............................1 month
- Cambodia ............................2 - 4 weeks
- Cameroon ............................1 month
- China ................................2 - 4 weeks
- Ethiopia .............................3 weeks
- Malawi ...............................1 month
- Moldova .............................2 weeks
- Nicaragua ............................2 weeks
- Peru..................................2 week minimum
- St. Lucia .............................2 - 4 weeks
- South Africa .........................1 month
- Uganda ..............................1 month

**Pediatrics**
- Cambodia ............................1 month
- Malawi ...............................1 month
- St. Lucia ............................2 - 4 weeks
- Uganda ..............................1 month

**Physical Therapy**
- Bhutan ...............................4 months
- India ................................3 weeks
- Nicaragua ............................1 - 2 weeks
- Peru..................................2 - 4 weeks
- St. Lucia .............................2 - 4 weeks
- Suriname ............................2 - 4 weeks
- Tanzania ............................2 weeks - 3 months
- Vietnam .............................2 - 4 weeks

**Wound Management**
- Cambodia ............................1 - 2 weeks
- India ................................1 - 2 weeks
- Peru..................................1 - 2 weeks
**Anthony Rankin Elected AAOS President**

The American Academy of Orthopaedic Surgeons (AAOS) has just named Dr. E Anthony (Tony) Rankin as their new president. He is the first African-American to serve as president. Dr. Rankin became a member of AAOS in 1975 and has held a number of leadership positions in the AAOS over the years. Dr. Rankin became a member of Orthopaedics Overseas (OO) in 1982, prior to OO’s affiliation as the founding division of Health Volunteers Overseas in 1986. He served as a volunteer in Ethiopia in 1985 and in Malawi in 1995. He also served as a member of the OO Board.

In addition to his new responsibilities with AAOS, Dr. Rankin is the chief of orthopaedic service at Providence Hospital, clinical professor of orthopaedic surgery at Howard University College of Medicine, and clinical associate professor at Georgetown University School of Medicine. Dr. Rankin is the recipient of numerous awards and honors. He is a five-time recipient of a Certificate of Commendation from the government of the District of Columbia, and for ten consecutive years he has been recognized by the Georgetown University/Providence Hospital with their Teaching Excellence Award. He has also been awarded the Teaching Excellence Award from Howard University and has been a seven-time recipient of the AMA’s Physician’s Recognition Award. Dr. Rankin served as a major in the medical corps in Vietnam and is a decorated member of the U.S. Army. He is a recipient of both the Bronze Star Award and the Army Commendation Medal.

**And the winner of the Humanitarian Award is....**

Dr. Kaye Wilkins, an HVO member and volunteer, was the recipient of the ninth annual Humanitarian Award presented by the American Academy of Orthopaedic Surgeons at their annual meeting held in March. The award honors the renowned pediatric orthopaedic surgeon for his commitment to teaching people around the globe to become more self-sufficient. His commitment has included training US students to provide vaccinations in Central and South America, providing continuing education in pediatric orthopaedics to physicians in Iraq, and establishing a project to provide free orthopaedic and rehabilitation assistance to special needs children in Mexico.

For the past 13 years, Dr. Wilkins has been involved in bringing continuing education in pediatric orthopaedics to the Haitian orthopaedic community. Between 2002 and 2005, Dr Wilkins undertook 6 trips to Haiti under the auspices of HVO. He has been instrumental in establishing the Haiti Clubfoot Project in conjunction with the Pediatric Orthopaedic Society of North America. Dr. Wilkins volunteered in Vietnam in 1995 and 1996. He currently sits on the OO Board of Directors.

Dr. Wilkins was also recently the winner of the American Airlines “American Way” Road Warrior Contest. For his winning submission on what it takes to be a road warrior, he received 1 million miles and 2 million hotel points. He promptly donated the entire prize to the Pediatric Orthopaedic Society of North America, so that physicians from developing countries can be flown to the US for training seminars.

*Photo courtesy of American Airlines American Way Magazine.*
Decline in Global AIDS Deaths

For the first time since the AIDS pandemic was identified a quarter-century ago, “we are seeing a decline in global AIDS deaths,” reports Dr. Kevin De Cock, director of AIDS at the World Health Organization (WHO). Revised figures released by WHO and the Joint UN Programme on HIV/AIDS (UNAIDS) also show that new infections from HIV have begun to fall as well.

Citing more accurate data-collection methods, the AIDS Epidemic Update 2007, estimates that there are about 33.2 million people worldwide living with HIV, compared with the figure of 39.5 million released the year before. The change in the number of people living with HIV was not an actual decline, but a statistical revision of estimates after detailed national surveys in about 30 countries demonstrated that earlier totals were too high.

In adjusting their overall estimates retroactively, the two UN institutions revealed some positive trends over time. First, new infections with HIV were likely to have peaked in the late 1990s, when more than 3 million people became newly infected annually. The revised estimates indicate that this total has actually been declining since then, to some 2.5 million newly infected in 2007. Second, the number of annual deaths from AIDS has also started to fall, from a high point of around 2.4 million in 2005 to about 2.1 million in 2007.

‘Real Nightmares’ in Africa

Neither the shift in the disease’s overall trend nor the revision in the estimates has changed one glaring fact: sub-Saharan Africa remains the epicenter of the global malady. Of all those living with HIV, 68 per cent of the world’s total are in sub-Saharan Africa. The region accounts for the same percentage of people newly infected with the virus, as well as 76 per cent of those who die of AIDS annually.

“AIDS continues to be the single largest cause of mortality in sub-Saharan Africa,” says the report. In contrast to other world regions, women and children are far more vulnerable to the disease in sub-Saharan Africa. Of those Africans living with HIV, 61 per cent are women, while 90 per cent of all HIV-positive children in the world are in sub-Saharan Africa.

Statistical Refinements

In the case of HIV/AIDS, earlier estimates were based mainly on information collected on young women visiting the public health clinics. Those results were then extrapolated to the rest of the population to come up with estimated national infection rates. But over time experts realized that data from urban clinics were skewed: they gave too much statistical weight to sex workers, drug users and people with multiple partners, relative to other sectors of the population.

According to UNAIDS, analyses of national survey results in India in July reduced estimates of the number of people living with HIV in that country by more than half, from 5.7 million people to 2.5 million, a revision that accounted for half of the decline in the global estimate.

No Time for Complacency

Whether the numbers are going up or down, there should be no complacency. The Update reports that prevalence rates are rising again in Uganda, which was once hailed for its success in bringing down HIV rates.

Current international spending, at around $10 billion annually, continues to fall short of actual needs. UNAIDS and WHO are planning to issue a report in 2008 on financing the global campaign against AIDS. It is possible, says Dr. Paul De Lay, a UNAIDS Director, that projected treatment costs will be around 5 per cent less in 2010 than previously estimated. But that total will be around $38 billion – far higher than current AIDS financing.

“We have to recognize the very long-term nature of the HIV pandemic,” says Dr. De Cock. “We’re facing decades of this problem.” Of those currently infected, “some of them require treatment now, and all of them will in time. The qualitative implications have changed very little.”

(Excerpted from Ernest Harsch’s article in the January 2008 issue of “United Nations Africa Renewal”.)
**New WHO Initiative for Patient Safety** continued from page 1

review the procedure to be conducted, check that all necessary equipment is available and in working order, discuss possible adverse conditions, prepare for possible blood loss, etc.

Dr. Lena Dohlman, chair of HVO’s Anesthesiology Division, attended the conference and was convinced that the “Safe Surgery Saves Lives” program is an important step in setting standards for surgical care throughout the world. The checklist is a work in progress that is designed with the understanding that it can be modified to address needs in different settings. By establishing these standards, WHO may encourage government health ministries to advocate for improved equipment, training and safe practices in health care facilities.

WHO plans to launch their official campaign from Washington, DC this June. HVO intends to provide its endorsement. HVO members can play a significant role, both in the US and abroad, by discussing and incorporating the goals of the campaign: (1) raise awareness that improvement in surgical safety is essential to public health, (2) back the concept of a WHO safe surgery checklist as a tool for teams everywhere to better ensure that patients receive the correct operation at the correct site with safe anesthesia, known infection-prevention measures, and effective teamwork for safe care, and (3) support the establishment of “surgical vital statistics” asking countries to track surgical volume and in-hospital surgical death rates.

Safe surgery can have a dramatic impact on patient outcomes and it can all start with something as basic as a checklist. For more information, check the WHO website at: www.who.int/patientsafety/challenge/safe.surgery

**Further Information**

- World Health Organization  [www.who.int/patientsafety/challenge/safe.surgery](http://www.who.int/patientsafety/challenge/safe.surgery)
- The chair of the Safe Surgery Saves Lives initiative is Dr. Atul Gawande, a general and endocrine surgeon, an Assistant Professor at Harvard’s School of Public Health and of surgery at Harvard Medical School. His article, *The Checklist* appeared in the December 10, 2007 issue of “The New Yorker” and can be accessed at: [http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande](http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande)

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**2008 HVO Photography Contest**

HVO is now accepting entries for its second photo contest. All HVO volunteers, their friends and family who have been to any HVO site in the last 22 years are eligible to participate. Photos, taken while on an HVO assignment, can be submitted for any of the five themes: humor, children, nature, volunteers in action, and local scenes.

To learn more about this year’s photography contest, including submission guidelines and to submit an entry form, please visit the HVO website ([www.hvousa.org](http://www.hvousa.org)). Please note this year we are only accepting on-line, digital submissions. The deadline for submissions is June 30, 2008.

Pictured left: 2007 Winner, Best in Show - Fluffy Infiltrates.
**The HVO KnowNET Continues to Expand**

HVO's *KnowNET* (short for “Knowledge Network”) continues to roll out. This web-based platform serves as a forum for the exchange of ideas, information, and knowledge. Open to all HVO members and to our colleagues at more than 70 training sites around the world, the *KnowNET* will facilitate communication between and among volunteers, program directors, staff and the sites.

There is a wealth of material available about the programs on this site. Every program has a folder which typically has the following — the program description, background materials such as information on obtaining visas, previous volunteers’ hints and suggestions (where the best restaurants are, for example); volunteer lectures, copies of the curriculum in use, trip reports from previous volunteers, etc. There are also links to a variety of resources, including articles of interest, in addition to other organizations such as the World Health Organization.

There is a section for announcements about upcoming events or needs at sites, as well as the potential for discussions on topics of interest to the community. Eventually we will have listserv capabilities as well.

Active pages at present include:

- Anesthesia
- Burn management, dermatology, and wound care
- Internal medicine, pediatrics and hematology
- Orthopaedics and hand surgery
- Physical therapy and rehabilitation

Plans for this year include developing pages for oral health and nursing education. If you are a member of HVO, you may sign up for access to one or all of the pages. For information on setting up your login and password, call the office at 202-296-0928 or e-mail info@hvousa.org.

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**Navigation Hints for the KnowNET**

**+ Sign**

A “plus” sign next to a folder means that there are additional folders inside. Click on the + to open the folder.

**Search Feature**

Located at the top right of the page. This allows you to search for all items related to a particular word. For example, you could search for all items related to:

- a clinical topic such as “tumors”
- a person such as “Kelly”
- a country such as “Bhutan”

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*Are you missing the HVO Net Connection?* We need your e-mail address to send you our secure, monthly newsletter on-line. Contact the HVO office at info@hvousa.org to add your e-mail address to our subscriber list or sign up through the HVO web site www.hvousa.org.
Reflections from the Field

Ted Sussman, MD ~ Internal Medicine - Cambodia

Spending time in Cambodia has been an incredibly rewarding experience for my wife and me. Working at SHCH has been a professionally fascinating and amazing experience that would be difficult to duplicate in this country. We have met wonderful people whom we now consider family. Personally it has allowed my wife and me a glimpse of the world that we would never normally have the chance to see from the vantage point of our own lives here in the U.S. I will continue to strongly recommend this program and hospital to all who are interested in volunteering in the future.

Jennifer Hayes, MD, SEA-HVO Fellow ~ Anesthesia - Tanzania

Occasionally the power or electricity went off or water was unavailable during morning report such that there were no cases that day, so instead I prepared a lecture to give earlier in the day than the usual 3pm. I also met students in the PACU to answer questions and go over brief teaching points. Toward the end of my stay, I participated in rounds in the ICU on a few days after morning report, as well as internal medicine rounds in the general wards in order to gain understanding of the general patient population and common local diseases. This was extremely beneficial in terms of “getting the big picture” of healthcare in this region and I highly recommend it. The “pre-call” students also participated in ICU rounds after morning report, so they frequently asked questions there as well as received mini teaching sessions from Dr. Koebler.

Robert Nassau, MD ~ Pediatrics - Cambodia

I think AHC continues to benefit from generalists and specialists. Each year there are new Khmer doctors at AHC, often working in OPD with little supervision. Generalists are well suited to help supervise the OPD physicians. Dr. Heng is now Chief of the OPD. This has led to continuity of senior staff in OPD. Volunteers who have experience working with students and residents in an outpatient setting can be good mentors for him and help him further define his role. Specialists are always helpful in OPD and Dr. Heng and Mr. Vibol can make sure that the appropriate patients are called in to see the specialists. One generalist in OPD at a time is probably ideal, but some time overlap of volunteers would lead to continuity of teaching methods.

Patricia Grover, RN, CCRC ~ Nursing Education - Uganda

We spent time on 4 pediatric wards teaching 2-4 classes per day and Wednesdays we participated in diabetes clinic. Our goal was to teach the etiology of diabetes, survival skills, management and DKA to anyone who would listen to us, mainly the nurses and residents. I found the response and interest from the nurses and residents to be sincere and enthusiastic. We were fortunate to be working with Dr. Buwule and her two diabetes designated nurses, Florence Ayoo and Florence Alupo. I found both very eager to learn everything they could about diabetes. We worked together to set up a clinic shadow file system using new flow sheets for each diabetic patient seen in diabetes clinic and left enough supplies for a total of 72 charts. Meter training and the distribution of home meter supplies to families was one of my goals. After training the two new diabetes nurses on the meter, they were able to teach six families of young diabetic patients how to use the home blood glucose meter. Free supplies were given to these patients much to their surprise and gratitude.

Ann Gerhardt, MD ~ Internal Medicine – Peru

I found the doctors to be very intelligent, diligent, and caring about their patients. It was a joy to work with them. They expected and wanted an advanced level of information. Everyone with whom I worked was helpful and respectful, and I hope that I exhibited those qualities also...I presented information about metabolic syndrome, nutrition support, diabetes, and transplant medicine in my formal talks, including cutting-edge topics and late-breaking results. The doctors recognize that they lag in knowledge about these topics and
expressed great interest. On the other hand, they would not have appreciated simplistic, basic information… At both hospitals the patient presentations and patient-related questions increased as the week passed. I suspect this is because it took the doctors some time to figure out what my expertise might be and how they could best use me. Also, it is only natural that it would take some time for the doctors to decide if I were worth their time. I’m glad that it appears that they grew to believe that I was.

_Jeana Wilcox, PhD, RN, CNS ~ Nursing Education - Cambodia_

At times I had to change an example for cultural reasons. For example, I was speaking about anxiety disorders, discussing simple phobias, and gave the example of a fear of spiders. The room erupted into laughter. I asked why and was told they are not afraid of spiders because they eat them… time for a new example… Cambodians are afraid of snakes.

_Michelle Fraser, BScPT ~ Physical Therapy - Nicaragua_

Monday’s session consisted of an introduction to clinical reasoning. The theory was taken from a clinical reasoning form originally developed at the University of Australia which was adapted by the University of Toronto and is now being used to teach physiotherapy students there.

Principles from this session were brought forth into the subsequent learning sessions. These principles were applied to the cervical spine, shoulder, elbow, thoracic spine, lumbar spine, hip, knee and heel. The general idea was to develop a hypothesis of possible clinical syndromes based on the subjective findings, then proving or disproving the hypothesis using objective testing. Treatment options for each clinical syndrome were presented with a holistic approach (example: when treating heel pain, the lumbar spine and any other area of the lower quadrant may need attention). Treatment was heavily based on home exercise programs. Due to time constraints, I did not have time to translate the handouts that I usually give to my patients. Therefore, the participants needed to write out the exercise instructions, which has its advantages and disadvantages. In the future, I will have the handouts ready to share with the participants.

The students were extremely enthusiastic about the whole process. The participation level was high, during both the lecture and lab portions of the sessions. My impression was that the students enjoyed and appreciated the opportunity to learn. I was glad to see many familiar faces from last year’s learning sessions.

_Suggestions:
As mentioned earlier, what I would have done differently is as follows:
- more clear and detailed communication with my teaching assistant, Kay, in order to prepare her for the experience. Keep in mind that email can play tricks: the message sent and the interpretation of the message is not always the same!
- when teaching exercises, provide handouts to free up time to practice the exercises
- allow ample time for lab sessions; this is an art – how to allow enough, but not too much time._

_John C. Weaver, Jr., MD ~ Internal Medicine – Cambodia_

I was most favorably impressed with the clinical knowledge, ability, and judgment of the medical staff at Sihanouk Hospital. They have an outstanding chief in Dr. Kruy Lim. Dr. Lim possesses a remarkable breadth and depth of medical knowledge. In particular, I thought the physicians there showed excellent practical judgment adapted to an environment with less medical resources than what American visitors like me were accustomed to. We saw a very large number of very sick patients in the E.R. and the staff had to be selective as the hospital has only an 11 bed medical ward, and no formal intensive care unit. I must acknowledge I was often stumped, and saw a number of patients for whom we could narrow down a differential diagnosis to 3 or 4 entities, and go no further. I think the staff did a very good job of treating these patients for the worst or most likely diseases they may have had in a setting with limited diagnostic capabilities.
Peace Corps Seeks Health Care and Public Health Professionals

As part of its on-going effort to bring more skilled and knowledgeable Volunteers to the field, the Peace Corps is reaching out to Health Care and Public Health professionals who are interested in new and challenging opportunities or considering alternatives to traditional retirement. Currently, there is a high demand for trained health educators, care givers, and dedicated persons to serve in Central and South America, Africa, Eastern Europe, and Asia.

Peace Corps Volunteers work on projects that provide maternal and child health services, nutrition and hygiene messages, support at community clinics, and education about prevention of infections, vaccines, and HIV/AIDS education and awareness. In helping communities take more responsibility for their own healthcare, Volunteers work to ensure the sustainability of their projects. The most competitive candidates apply to join the Peace Corps with a degree in health education, nutrition, nursing, dietetics, or another health-related discipline.

To learn more about Health Care and Public Health Volunteer opportunities with the Peace Corps, call 1.800.424.8580 or visit: www.peacecorps.gov/index.cfm?shell=learn.whatvol.health&cid=prhlth

A planned gift ensures that HVO will be able to continue to make important educational strides in the improvement of health care in developing countries.

When you write or review your will, please consider leaving HVO a charitable bequest as an investment in HVO’s future. You may bequeath a specific amount of money or a percentage of your estate. Another relatively simple option is to designate HVO as the beneficiary of a life insurance policy or the assets of a retirement plan.

If you are interested in creating a charitable bequest in your will or in discussing some other charitable aspect of your estate planning, please contact Nancy Kelly at giving@hvousa.org. If you have already made a charitable bequest, please let us know! We will honor all requests to remain anonymous.
The nurse anesthetists at Angkor Hospital for Children (AHC), a teaching hospital in Siem Reap, Cambodia first contacted HVO about volunteer support in September of 2003. Since that time a variety of CRNAs have worked with the 3 nurse anesthetists at AHC teaching them about pediatric airway management, anesthetic gases, fluid replacement, respiratory physiology, regional anesthesia, and many other topics. This teaching brought the practice of the nurse anesthetists to a higher level in a department that sees 7 to 15 cases per day. The next step for the nurse anesthesia staff was to become a resource for other nurse anesthetists and nurse anesthesia students in Cambodia.

Although the nurse anesthetists at AHC, Mr. Chenda, Mr. Bunrum, and Mr. Sakoun, have become very proficient at delivering high quality anesthetics, they were new to teaching. Volunteers with expertise in teaching were assigned to AHC in 2005 to work with the nurse anesthetists on improving their clinical teaching and lecture skills. This included lectures on precepting, teaching methods, evaluation, and presentation development. This preparation has helped move the nurse anesthesia department toward becoming a resource for nurse anesthesia students and nurse anesthetists at other hospitals in Cambodia.

Preparation for teaching by the nurse anesthetists at AHC has not only included lectures on teaching but has also included practicing clinical teaching with students from the US. Two nurse anesthesia students from the University of Pittsburgh, Sarah Johnson SRNA and Bryan Read SRNA, were selected to travel to Siem Reap for a 2 week clinical rotation taught by the nurse anesthetists at AHC. This clinical rotation would be considered the final rotation for these students in their Nurse Anesthesia Program at the University of Pittsburgh School of Nursing. The students were accompanied by the author.

During the 2 weeks that the students were at AHC they participated in a variety of activities with the nurse anesthetists. Students made pre- and postoperative rounds, provided anesthesia care in the operating theatre, provided sedation in the medical procedure room and participated in round table discussions during lunch. Students also conducted projects on infection control and made a home care visit. The nurse anesthetists at AHC worked on providing feedback to the students and writing evaluations. The nurse anesthetists attended sessions provided by Rick Henker and Suzanne Brown (HVO’s Program Director and a recipient of the HVO Golden Apple Award in 2007) to reinforce teaching principles. They also received feedback about their teaching.

Preparation for this clinical rotation included a variety of activities by those involved. The nurse anesthetists at AHC worked on the schedule for the students and developed a teaching plan that included discussion of topics such as Cambodian culture, and pediatric airway management. Suzanne Brown has developed the overall program at the Cambodia nurse anesthesia sites. Michelle Dea with HVO kept in touch with all parties involved to provide logistical support for the trip. The nurse anesthesia students, Sarah Johnson and Bryan Read, brushed up on their pediatric skills by providing anesthesia at Children’s Hospital of Pittsburgh prior to the trip and they also completed assigned readings about Cambodian culture. Richard Henker attained approvals from the University of Pittsburgh with the support of Jan Dorman and Kim Mowrey from the School of Nursing at the University of Pittsburgh.

(Editor’s note: Feedback from the staff at Angkor Hospital for Children, the CRNAs, and the volunteers has been extremely positive about this cross-cultural educational experience. The program will continue for the next few years, which will aid the Cambodian nurse anesthetists in developing their teaching skills).
Special Thanks

DONORS & IN-KIND DONORS

…to the following individuals and companies who have so generously donated teaching materials, equipment, supplies, and other support:

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University of Minnesota

…to the following donors for their generous financial support:

Juanita Accardo, PT
Susan Adler, MD
Brian Allender, DMD
Peter Amadio
Anchorage Fracture & Orthopaedic Clinic
Gary Anderson, MD
Henry & Gay Anderson
Jeffrey Anglen, MD
George Armstrong, MD
Will Aughenbaugh, MD
Raffi Avedian, MD
Richard Baker, MD
Samuel Baker, MD
Kenneth Baldwin, MD
Marshall Balk, MD
Ursula Banzha
Channing Barnett, MD
Ted Barr
Kevin Barry, MD, MBA
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Eric Bartel, MD
Gerard Bashein, MD, PhD
J. Robert & Leslie Beatty
David Beebe, MD
Eugenio Beltran, DMD, MPH, DrPH, MS
James Bennett, MD
Molly Benson
Pamela Benson
Linda Berlin, DrPH, RNC
Annechien Beumer, MD
Terrell Blodgett
Joseph Bocklage, MD
Vince Bogan, CRNA, MS
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