Vuvuzela harms hearing

The 2010 Soccer World Cup spectators will experience the unique sound of the African horn, called the vuvuzela, which is blown by many avid South African soccer supporters. Swanepoel, Hall and Koekemoer investigated the intensity of the sound it produces.[1]

Traditionally made from a kudu horn, the vuvuzela was used to call people together for meetings and could be heard by distant communities summoned to attend. The intensity of the sound caught the attention of the global soccer community during the 2009 Confederation Cup in South Africa. Despite complaints by international commentators, players and audiences, FIFA has approved the vuvuzela as part of the signature South African World Cup.

The authors found that the vuvuzela produced high sound intensities. According to the South African National Standard regulating occupational noise exposure, no one within a 2-metre radius of a vuvuzela, including the person blowing it, should be exposed to it for more than a minute. The cumulative effect of numerous vuvuzelas, typically blown together for the duration of a soccer match, may put spectators at significant risk of noise-induced hearing loss.

Improving rural perinatal outcomes

District rural hospitals in South Africa are under-resourced and have low doctor/population ratios. Benjamin Gaunt[2] provides an encouraging account of how health outcomes can be improved in rural areas. The *SAMJ* receives many submissions of audits of local experiences with general statements of what should be done. This contribution illustrates the kind of paper that we prefer, i.e. an audit followed by intervention and measuring outcomes.

The approach described by Gaunt is simple: focus on areas of most morbidity and mortality, keep excellent records, apply appropriate health management protocols, extend training and audit activities, have regular clinical and education meetings, etc. However, it is clear that the most important factor is the presence of a core of skilled staff with long-term commitment to the hospital (and willingness to be available at all times for emergencies!). This has enabled them to attract enthusiastic community service doctors and overseas doctors on contracts. Gaunt also notes that policy-makers should not underestimate the role of up-to-date equipment in staff morale and the provision of quality care.

At a time when services at public health care facilities are generally deteriorating, such a shining example of what can be done should serve as an encouragement for others to do the same.

Brits Hospital hammers health

The ANC has recently been publicly emphasising that government intends to focus on improving the poor quality of service delivery in the public sector. About time! But Pfaff and Couper provide a case study of how when planning is inadequate things can go badly wrong and have a seriously adverse effect on health care.[3]

The case study is about the apparently simple decision to increase bed capacity at Brits Hospital from 66 to 267 beds. It was decided to demolish the existing hospital and rebuild the new one on the same site. A makeshift temporary hospital was planned, and it was envisaged that clinical services would be moved to primary care clinics. However, the planning process did not adequately examine the consequences of the move, logistic or financial. Among other things, a decline in patient care resulted in doubling of the perinatal mortality rate after the hospital moved.

The authors conclude what should be obvious – that hospital revitalisation requires detailed planning so that services are not disrupted – and provide several such examples from other parts of the world.

FAST scanning improves trauma management

Focussed assessment sonography in trauma (FAST) scanning is well established in major urban hospitals. But specialised services are rarely available in rural facilities. Smith, Postma and Wood assessed the utility of ultrasound for the purposes of FAST scanning in their developing world emergency department.[4] The study was part of a requirement to perform a number of supervised scans before accreditation for FAST.

Their study showed a higher rate of FAST positives (20.8%) compared with other studies (5.2% in the UK). This reflects the severity of injuries in this population in South Africa, and the challenges it represents. In blunt trauma alone, the sensitivity was 81.3% and negative predictive value 91.6%. Sensitivity in penetrating trauma was poor (62.5%). FAST has largely supplanted diagnostic peritoneal lavage for blunt trauma assessment.

On the basis of their encouraging results the authors propose the use of FAST scanning in all peripheral hospitals to assess blunt trauma patients. It can play a valuable role in primary and subsequent assessment of trauma patients, and is cost effective and sustainable. Training programmes and accreditation are required for rural areas in South Africa.

JPvN

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4. Smith ZA, Postma N, Wood D. FAST scanning in the developing world emergency department. *S Afr Med J* 2010; 100: 105-108.