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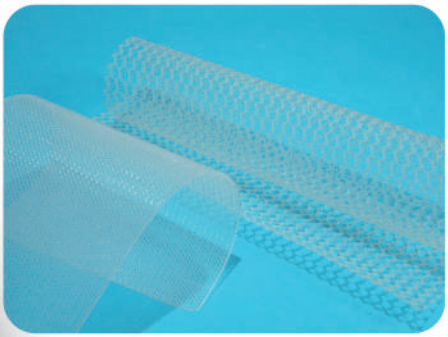

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Sense of Belonging

Social belonging is a psychological necessity and basic human requirement, part of our DNA. As social animals, humans require an emotional connection with others around them. We desire to feel part of a group and to communicate, support and be supported within our communities.

As the world is constantly changing and evolving, external events like climate change, political instability, global pandemic, discrimination, war, are making us feel polarized, less stable, and volatile, causing a sense of frustration, fear, and disruptions. This is leading to individuals finding solace in everyday life. For most of us, this means turning to the work organization to find a sense of meaning and solidarity. However, organizations are going through their own disruptions. Shifts in workforce composition, ways of working, virtual workplace… are leading to changes that leave workers feeling isolated. The pandemic has further, and inevitably, led many to reassess the value and purpose of work in their lives, and employees are increasingly looking to work for personal fulfillment and satisfaction, essential to which is a sense of belonging.

The need to belong is not something that can just be put to the side and ignored; businesses spend a lot of money each year on diversity and inclusion trainings that miss the mark because they neglect our need to feel included. For organizations to build a sense of community and foster collaboration in the workplace, they need to provide employees a non-judgmental space in which to share personal interests, passions, and values. If an employee feels safe opening up in the workplace, they will feel more connected to their work and to the organization.

Without a feeling of belonging, many employees do not feel motivated to work and do not function well within their environment. 40% of people report feeling isolated at work which results in them functioning at a suboptimal level and working below their potential. Exclusion is damaging because it actually hurts, our brain responds to it in a manner parallel to physical pain. And it's a sting we've all experienced at one time or another. To feel left out is a deep human problem, which is why its consequences carry such heft and why its causes are so hard to root out of even the healthiest workplaces. Recent research shows that if workers feel like they belong, companies reap substantial bottom-line benefits: 56% increase in job performance, 50% reduction in turnover risk, 75% decrease in sick days.

A desire to achieve a sense of belonging in the workplace, as part of a team or the overall organization they work for, is today driving career decisions for many. A survey – carried out by Randstad, *workmonitor 2023* - found that a majority of workers (54%) would quit if they didn't sense they belonged at their company. 42% wouldn't take a job if the company's values wouldn't align with their personal ones. 94% of the workforce consider work-life balance important and more than half (61%) wouldn't accept a position that would disrupt this balance. A significant share would quit if they found themselves in a toxic working environment (34%), and an even greater portion (48%) would quit a job if it prevented them from enjoying their life.

These numbers validate the importance of creating a business culture in which employees feel a sense of belonging; recruiting great talent requires more than just competitive pay and benefits. It's clear that talent today want the whole package: secure, flexible, inclusive, and financially stable employment in a place they feel they belong. Although this is not always straightforward, measures have to be taken to make work enjoyable and desirable for your employees.

I believe that if we give people the equitable opportunity to not only be employed, but to have employment with purpose and passion, our society can and will do great things. It's a measurable good for everyone.

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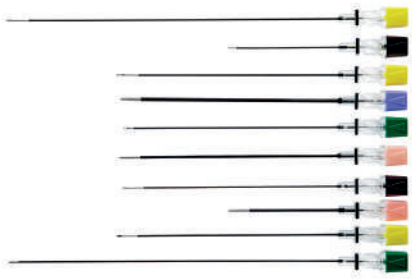

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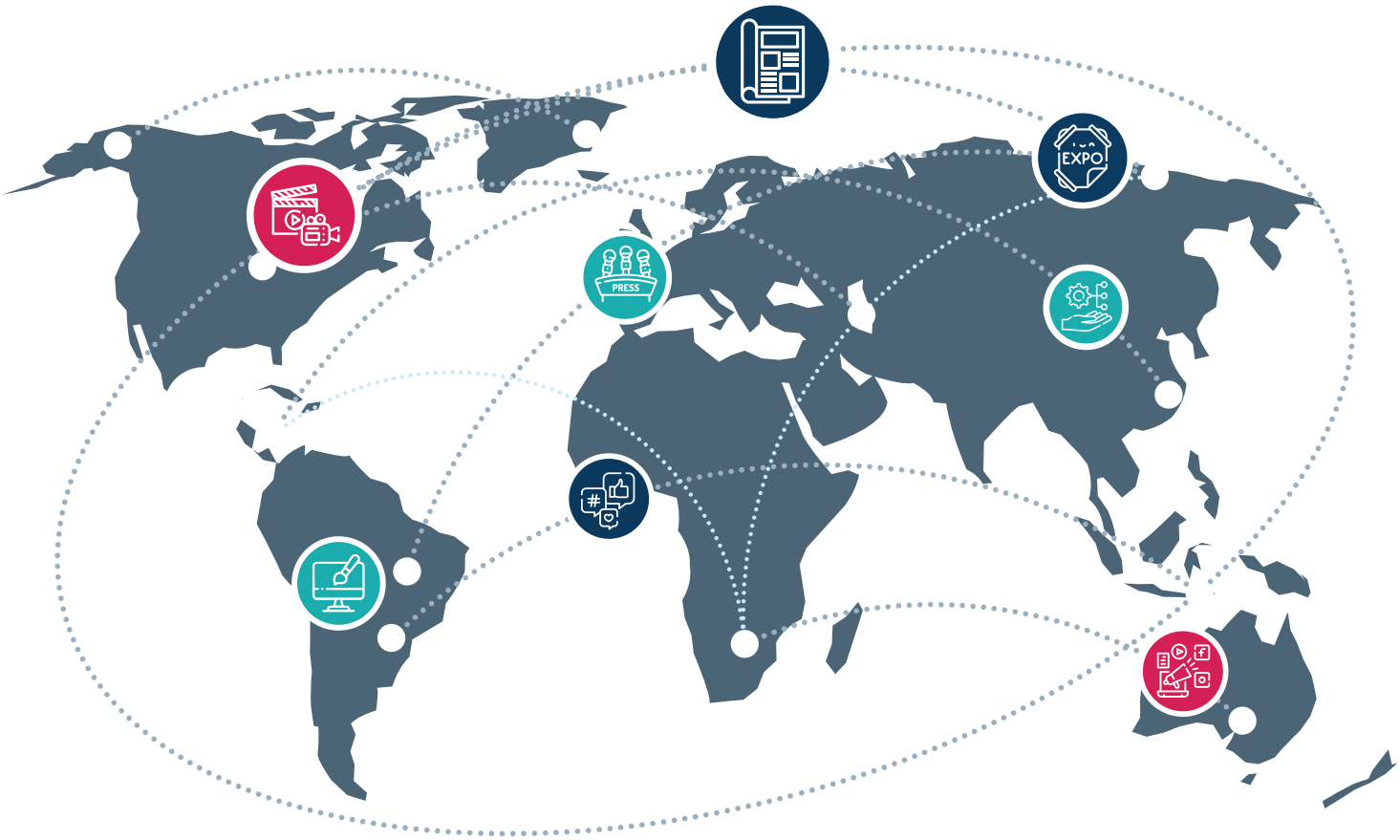

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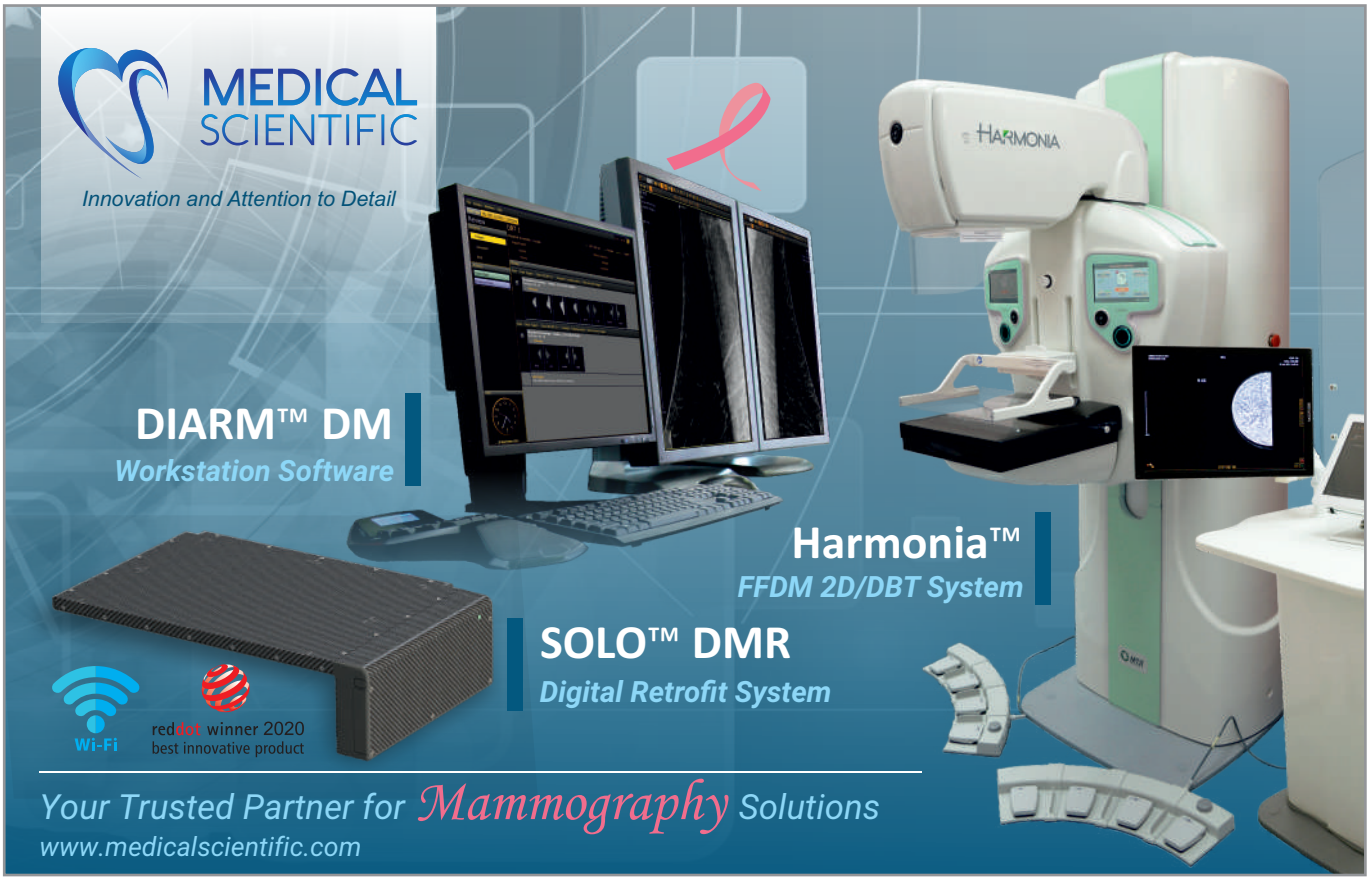

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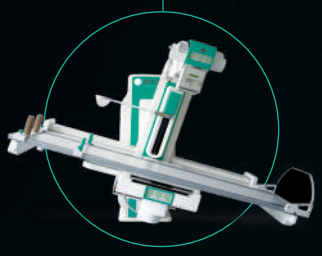

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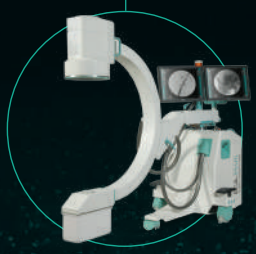

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Advancing Patient Care in Europe: The EURAMED rocc-n-roll project launches a Strategic Research Agenda and Roadmap as a guide for future research in the field of medical applications of ionising radiation and related radiation protection

EUROPEAN SOCIETY OF RADIOLOGY

Vienna, Austria, 31 August 2023
The EURAMED rocc-n-roll project is proud to announce the release of its Strategic Research Agenda (SRA) for medical applications of ionising radiation and related radiation protection, as well as a corresponding roadmap. These documents, which were developed through extensive consultation with stakeholders from the health, radiation protection, and digitisation sectors, including representatives from academia, regulators, industry and patient organisations provide a comprehensive overview of the current state of research in this field and outline a clear path forward for future European research efforts based on identified gaps and research needs. EURAMED rocc-n-roll is a flagship project of pillar 3 of the SAMIRA action plan focusing on facilitating innovation and the technological development of medical ionising radiation applications.
The project ran from September 2020 to August 2023 and brought together a consortium of experts from various disciplines including radiation biology, medical physics and dosimetry, ethics, clinical expertise, regulatory and health policy, AI, and industry experts. EURAMED rocc-n-roll was able to generate an understanding between the representatives from the health sector and from the radiation science sector, fostering cooperation in the field and allowing innovation and groundbreaking achievements in the future.
"We are thrilled to release these documents, which represent the culmination of three years of strong collaboration by our consortium and our stakeholders," said Prof. Christoph Hoeschen from the Otto-von-

Guericke University Magdeburg, the project's scientific coordinator. "We believe that they will serve as an invaluable resource for policymakers, funding bodies, researchers, practitioners, and industry players working in the field of medical imaging and radiation protection to improve patient care on an individual patient basis across Europe."

"As we mark the successful conclusion of the EURAMED rocc-n-roll project," stated the project's clinical coordinator Prof. Guy Frija from the University of Paris, "we take a transformative stride toward optimising the balance between innovation and patient welfare. The EURAMED rocc-n-roll SRA and roadmap underscore our commitment to steering the course of medical progress and effectively harnessing ionising radiation's potential while upholding the highest standards of ethical practice and patient-centred care."

With the release of the SRA and the Roadmap, the EURAMED rocc-n-roll project marks a significant step forward in shaping the future of funding for medical applications of ionising radiation, ensuring that Europe remains at the forefront of cutting-edge healthcare technologies allowing its citizens equitable access to safe, highest-quality personalised care.

For more info visit:
roccnroll.euramed.eu

EURAMED ROCC-N-ROLL

About EURAMED rocc-n-roll

The EURAMED rocc-n-roll project (*EURopeAn MEDical application and Radiation prOteCtion Concept: strategic research agenda aNd ROadmap interLinking to heaLth and digitisation aspects*) was a 3-year initiative aimed at advancing medical applications of ionising radiation while prioritising patient safety and patient-centred care. The project brought together experts and stakeholders from various fields to create a strategic research agenda, roadmap, and interlink document, facilitating collaboration, innovation, and progress in the field of medical imaging and radiation protection. The goal of the project was to identify research and radiation protection needs in the field of medical imaging, and to develop education and training schemes to increase Europe's research capacity in this area.

The EURAMED rocc-n-roll consortium is made up of a multidisciplinary team of 29 partners from leading research institutions in 17 European countries: European Institute for Biomedical Imaging Research (AT), Otto von Guericke Universität Magdeburg (DE), Université de Paris (FR), Panepistimio Kritis (EL), Bundesamt für Strahlenschutz (DE), Ruđer Bošković Institute (HR), The University of Exeter (UK), Studiecentrum voor Kernenergie/Centre d'étude de l'Energie Nucléaire (BE), European Organistation for Nuclear Research (CH), Institut de Radioprotection et de Sûreté Nucléaire (FR), Umea Universitet (SE), Fundacio Privada Institut d'Investigacio Oncologia de Vall-Hebron (ES), Universitätsklinikum Freiburg (DE), Fondazione Toscana Gabriele Monasterio per la Ricerca Medical e di Sanita Pubblica (IT), Ludwig-Maximilians-Universität München (DE), Istituto di Ricovero e Cura a Carattere Scientifico Burlo Garofolo (IT), European Cancer Organisation (BE), Commisariat a l'Energie Atomique et aux Energies Alternatives (FR), Tartu Ulikool (EE), Stichting Het Nederlands Kanker Instituut – Antoni van Leeuwenhoek Ziekenhuis (NL), University College Dublin (IE), Comité Européen de Coordination des Industries Radiologiques Electromedicales et d'Informatique de Santé Aisbl (BE), Nemzeti Népegészségügyi Központ (HU), Instituto Politécnico de Coimbra (PT), European University of Cyprus (CY), Erasmus Universitair Medisch Centrum Rotterdam (NL), European Alliance for Medical Radiation Protection Research (AT), Universiteit Gent (BE), Vrije Universiteit Brussels (BE).

Improving Patient Care through Novel and Optimised Medical Applications of Ionising Radiation – A Strategic Research Agenda:
roccnroll.euramed.eu/scientific-research-agenda

European Research Roadmap or Medical Applications of Ionising Radiation for Better and Individualised Healthcare to Improve Patients' Lives:
roccnroll.euramed.eu/roadmap

EU funding

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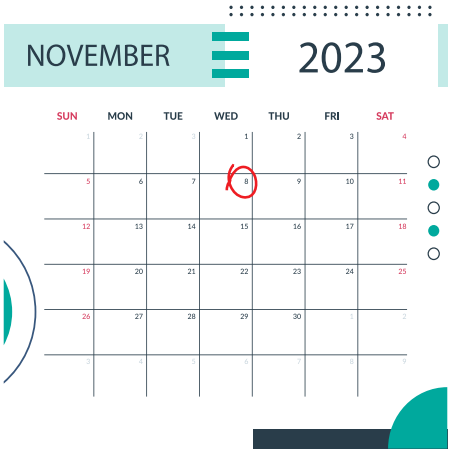
International Day of Radiology
November 8, 2023



The International Day of Radiology is a yearly event celebrated every November 8th, the anniversary of the discovery of x-rays, and promotes radiology's role in healthcare.
The European Society of Radiology (E.S.R.), the Radiological Society of North America, and the American College of Radiology (A.C.R.) jointly launched it in 2012. Nearly 200 national sub-specialty and allied organizations around the world recognize and celebrate the International Day of Radiology. Every year, a theme is chosen that focuses on various radiology specialties. To commemorate this day, we have taken a day in the life of a radiologist, a radiotherapy patient, and a radiographer from the E.S.R. website.
Enjoy the reading!

A DAY IN THE LIFE OF A RADIOLOGIST

Call me Giovanni – A few minutes ago – never mind how long precisely – my alarm clock rang. It is about 6:30am and I have to go to work. I live downtown, not too far from the hospital. I am a radiologist working at the Emergency Department and I have to be there at 8 o'clock to start my morning shift. Today, I will have to take care of all patients sent for a computed tomography (CT) scan, another colleague will deal with plain film x-rays, and we will have to share the workload in ultrasound (US). Emergency radiology is a job I like: you have to deal with acute (suddenly arising) cases, you can, hopefully, provide a great contribution to solving their problems and you feel you are important for these patients. Furthermore, all radiologists in the emergency department have been able to create a good feeling with our colleagues specialising in other areas of medicine. Emergency physicians respect our opinion and rely, maybe too much, on our diagnostic skills. It is stressful (too many patients, always in a hurry), but it is a satisfying profession.

As always, traffic jams are a problem in the morning, but I have been able to arrive on time. There are already four patients on the list today. They arrived at the hospital during the night and were not emergencies, so they were able to wait until my arrival. Taking a look at the request forms, there is a patient with a bad fracture of the knee; the orthopaedic surgeon requests a CT examination to plan his operation. One is an old lady with a very swollen abdomen due to a suspected intestinal obstruction. Another patient has renal colic (abdominal pain originating from the kidneys) and is obese. The last patient is a 17-year-old girl with suspected acute appendicitis; I will first do an ultrasound examination on this patient and then decide whether to proceed with a CT scan or not. There are no neurological cases (patients with a problem relating to the nervous system) for me, since in my hospital neuroradiologists have their own patients; their CT area is just 50 metres from here. Let's start. I call the technician and the nurse and ask them to let the first patient come in. My reading space – the area where I study the images resulting from the examination – is just behind the control room of the CT scanner. I work quite closely together with the technician who operates the equipment and the nurse who takes care of the patient. I know there are different ways of working, but I like this continuous contact with my co-workers: we are a team. I make a quick check of the patient's chart and decide on the scanning technique. Some patients require an injection of a substance called 'contrast medium', which helps to make certain things more clearly visible in the image, but this isn't necessary for my first patient. I will have to prepare some 'nice' 3D images for the orthopaedic surgeon; they say they are quite useful in planning their

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surgical approach. The CT image shows it's a bad fracture. He will have to work hard to put all the fragments back together; good luck to both surgeon and patient! I see they plan to operate on him tomorrow, so I can postpone my report to the end of the day. The second patient is the old lady; she needs a contrast enhanced examination, which means using contrast medium. She's old and may have other medical conditions in addition to the current complaint. an obturator hernia! This is rare, and difficult to diagnose without imaging. No wonder they did not spot it when she came in tonight. I must write down the report immediately and make a phone call to the doctor who referred the patient to me; they have to call surgery and operate on her soon. The hernia is causing dilatation of the loops of the small bowel, but their walls do not show signs of permanent damage. The prognosis does not look bad.

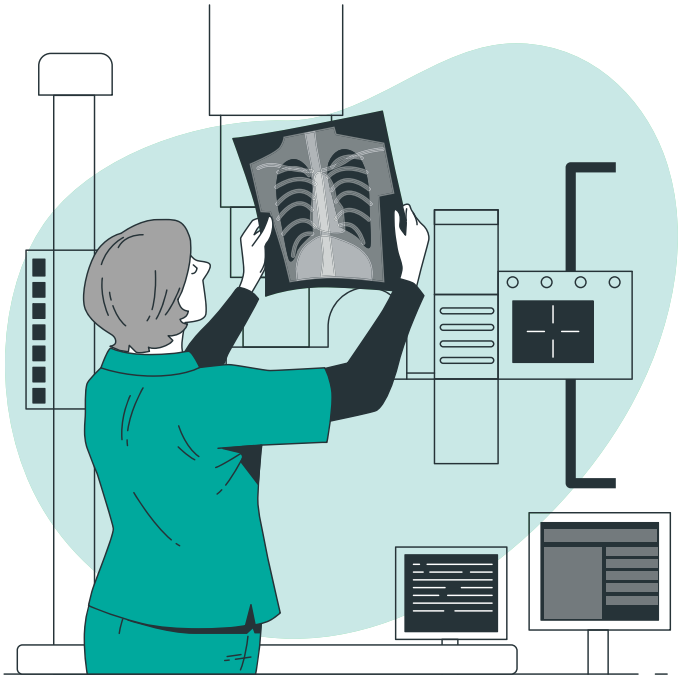
stones pass spontaneously in a couple of days, but patients have pain, and they want to know the reason why. Urologists prefer to decide immediately which cases they have to admit, and which can be sent home. It is always a battle. This was an obese patient, and it would have been difficult to examine him with ultrasound, but I usually prefer to start with an ultrasound study in cases of suspected renal colic. For more than 50% of these patients, we can often work out the problem while avoiding any radiation exposure. A phone call informs me that the girl has arrived in the US examination room. It is time to go. She is already on the examination table: a quick "good-morning",

The function of her kidneys has already been checked with a blood test, and from the chart it looks ok, so I can proceed with the contrast injection; but first I have to talk with her and get her informed consent for the injection. In my country, this is a duty of the radiologist, and we have to keep the signed informed consent form with the patient's charts. I decide on the scanning technique and let her in. The nurse has some problems in finding a suitable vein for the injection, but she is an expert, and she manages. The scan is finished in a few minutes and the images arrive at my workstation. Wow! The cause of the intestinal obstruction is

While I am writing the report, the technician and the nurse have already finished scanning the patient with the kidney-based pain; the technician knows exactly which low-radiation procedure to use in this kind of study, there was no need to tailor the examination for this specific patient. A quick scan has shown a 7mm stone at the middle third of the right ureter, which is the tube that leads out of the kidney to the bladder. Diagnosis done. But I always wonder if all these stone studies are really necessary. Most, if not all these patients, need a 'standard' therapy: analgesics, fluids, and anti-inflammatory drugs. Most

"where does it hurt?", "don't worry, I won't harm you, I will just need to put some gel on your belly", and the examination starts. She is a lean girl, easy to study. The inflamed appendix is easily visible. The report is ready in a few minutes. At this time, two additional patients are waiting outside the examination room, and a phone call invites me to come back to the CT station: two more patients have arrived. The two rooms are next to each other, so I can manage. I ask the nurse to let in one patient who is here for a US examination, and I go to the CT. These are two follow-up examinations from the oncologic clinic (we have to take care of some of their

requests during our daily work). Both patients were already here a few months ago. I remember one of them. The technician knows the examination procedures to be used in these cases; I let him and the nurse work with them and go back to US. The first patient has come due to upper abdominal pain; I see a stone pressing against the neck of the gallbladder but the walls are not thickened and there is no tenderness at the base. And there are no other anomalies within the abdomen. The second patient is more of a concern: he has been admitted early this morning with jaundice. There is a mass at the head of the pancreas and the bile ducts are dilated. This is a serious problem; it looks like a pancreatic tumour. I can see the lesion completely surrounds a major vein; this is bad finding, as the lesion does not seem surgically removable. In the report, however, I suggest a CT exam to provide accurate and complete analysis; it will be probably done in the late morning or this afternoon, before sending the patient from the emergency department to a ward for palliative treatment. In the CT waiting room, two new patients have already arrived from the emergency room. A check of their charts, a chat for their consent to contrast injections ... but, while the first is ready to enter the examination room, there is a phone call informing me that an emergency patient has just arrived. The emergency physician informs us that he will arrive within 15 minutes. If I hurry, there is just enough time to examine one of the waiting patients! As soon as we are finished, the emergency is at our door. The patient is on a stretcher, is receiving breathing assistance, and is covered in life-support devices. We have to examine him from head to toe. He fell from a ladder while at work. A head injury is suspected, plus there are signs of chest and pelvis injuries and an exposed fracture of the right leg. We do the examination. I send the head images to the neuroradiologist and start looking at the body. There are fractures at the shoulder and a few ribs, some bruising to the lung, bad fractures of the pelvic bones, with blood infiltration within the pelvic muscles, and there is fluid in the abdomen. Stop! Don't take him out of the scanner! I need to do another scan. Fluid in a patient with pelvic fractures can be urine from a ruptured urinary bladder. We need a late scan to see if the contrast medium we have injected passes into the peritoneum (which is the lining that covers most of the abdominal organs). In the late images I see the fluid shows the typical signs of urine, which must be from a ruptured bladder. This means the patient has to be assessed by a multidisciplinary team including the urologic surgeon. I need to make a note of this study and keep the images for teaching the trainees. The neuroradiologist says the patient is ok for her: no head or spinal cord injury. He has enough trouble already without neurological ones!



Back to ultrasound: there is a young man with renal colic, and I can see a stone at the junction of the tube leading from the kidney into the bladder. The outlook for this patient is good. There is also a case of a painful lump in the neck that developed during the night: it is a thyroid cyst. The patient can go back to her family doctor; there was no need to come to emergency. It is almost noon. I get a coffee from the automatic machine and go back to CT. Three other patients: an old lady with a suspected blockage in the artery that transports blood to the lungs and a sudden onset of shortness of breath; a patient with an aneurysm of the abdominal aorta who needs to be checked before surgery (it seems they sent him to emergency radiology because they think we have no waiting list!); and a patient with blood in his urine, in whom my colleague has seen a mass in the kidney during a US examination. It is probably a tumour. The patient needs a 'staging' examination, to precisely determine the extent of the mass before surgery. Two more US exams and my morning has gone! Another case of appendicitis; easily visible, no need for CT. The last patient is a young lady with acute and strong pelvic pain: she has a mass on the right side with both solid and liquid components, and a small amount of loose fluid. But her pain is on the left side. Could it be a cyst that has become twisted? Quite often a twisted mass may move from its normal position. I must suggest the diagnosis and talk with the gynaecologist: if it is confirmed at his visit they need to operate on her quickly. It is 2pm. The radiologist on duty this afternoon has arrived. I still have to spend some more time at my workstation; I need to finish and sign all the reports that are still open, make a few phone calls and go to prepare my lesson for the radiology trainees tomorrow; the first in a series on emergency radiology, called Roles and responsibilities of the radiologist in emergency care. There is quite a lot to say.

A DAY IN THE LIFE OF A RADIOTHERAPY PATIENT

Call me Heather – I am in the middle of a six-week stay in London, where I am having fractionated stereotactic radiotherapy for a low grade non-malignant brain tumour. I say 'non-malignant' as I refuse to use the word benign because mine has certainly not been benign in effect. It's cost me a thirty-two-year career in nursing and has left me with a constant sensation of vertigo, fatigue, occasional disorientation, facial pain (as it is compressing one of the facial or 'trigeminal' nerves a bit), and occasional petit mal and absence seizures. My day starts at about 8:30am. I am staying at a friend's apartment in Ladbroke Grove, which is about 40 minutes to an hour away from the Royal Marsden Hospital in Chelsea, where I am having my radiotherapy as an out-patient. I come from Penzance in Cornwall, about 400km away. The hardest part of this is having to live away from my home and my husband for so long. Getting up is not too much of a problem, but with fatigue as one of my symptoms sometimes I really have to drive myself out from under the bed covers. I have managed to set up a daily routine, and, so far, have really enjoyed my time in London and am making the most of it as I do not know how the radiotherapy will affect me over time. Certainly, there will be side effects and there is already a stabbing pain at the top of my head, and the prickling, numbing and sometimes sharp sensation of pain I started to get down the right side of my face, as a symptom of my tumour, has intensified. As a result, I have recently been prescribed a drug specifically for nerve or 'neuralgic' pain.

My brain tumour is called 'Algernon' or Algy for short. I first became aware of him back in 2010, when I collapsed at work, ironically on a medical ward at the local hospital where I worked as a Registered Nurse in the town where I live. I had begun to suffer from dizzy spells for about three weeks beforehand and had not been terribly well over the previous winter. Looking back, I remember the number of times I had falls, usually from tripping over something or just seeming to lose my balance, over the years. There was something else I was occasionally getting which was suddenly feeling faint or if waking up from a doze, the sensation of not being able to move and my blood pressure dropping through my boots. After a consultation with an ear, nose, and throat (ENT) clinic, a problem with my core balance was identified and so I was referred for a CT (Computed Tomography) scan. This was done at the hospital where I was working at the time, and I knew the radiology staff there. The procedure was explained clearly, including any risks, because although different to standard x-rays, it is still a radiological procedure that uses x-rays with computer technology. After explanations, I was assisted on to the scanner table; a cushion was placed under my knees to keep me comfortable as the table moved under the scanner, taking not very long. If I remember correctly, it took about ten minutes, something like that. Afterwards, the staff kindly helped me up on to my feet. The results at the time would be sent to my ENT consultant after review. What the CT picked up was a 'mass' impacting on the right side of the pons, which is part of the brainstem. As a result, I was referred for an urgent MRI (Magnetic

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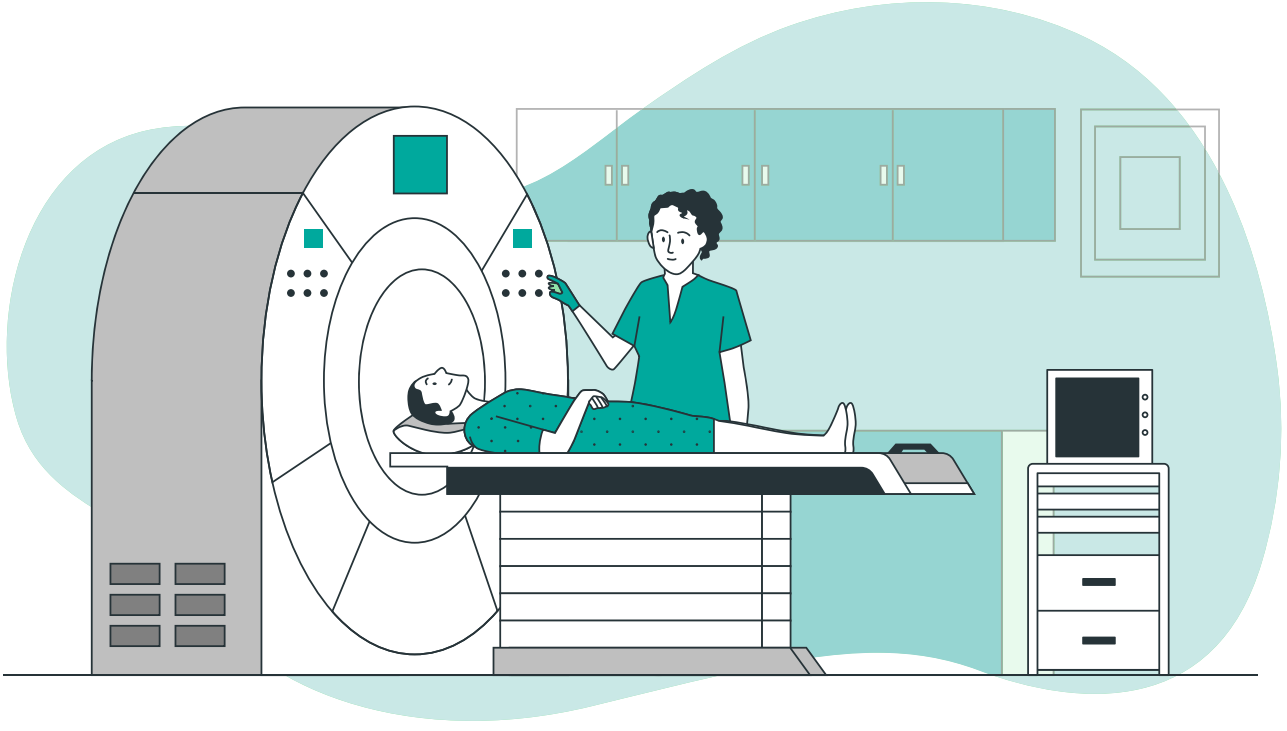

Resonance Imaging) scan at RCH Treliske Hospital in Truro and also for a neurology appointment at Derriford Hospital in Plymouth. The MRI scan experience was different to the CT scan. Beforehand, I was sent information about the appointment and also a request to see my family doctor for a blood test to see if my kidneys were ok, as I will need to be injected with contrast medium, which needs to be excreted. On arriving at the department, I was given a questionnaire to fill out about whether I had had any recent surgery, metal implants and so on, in case there was anything that could be affected by the magnet in the scanner. The scan itself involved being placed in a much narrower and longer 'tube', which I found very claustrophobic. Also, because the scanner at Treliske is second-hand, it is very loud as the magnet spins, well deserving of the name 'Old Clunker'! I was given a set of headphones and a choice of music, or I could bring in my own music, which I did, but not even my loudest heavy rock music could drown out or lessen the intensity of the noise! Also, my head was encased in a frame which for some might add to the discomfort, so it is important to speak to the staff beforehand about any difficulties you may have. There is a microphone inside the machine and the staff can speak to you, and will stop the scan at the slightest hint of trouble. An MRI scan is important as a 3D image can be taken of the tumour, which can provide more detail if needed. I also needed a liquid 'contrast medium' injected into a vein in my arm, which highlights certain areas and the tumour itself. This wasn't always an easy process, as my veins tend to be reluctant to have a cannula pushed into them, and the experience varied over five sessions in three different hospitals. You have a scan first then the contrast is injected halfway through, then the scan repeated. After that, the cannula, which is the tube through which the medium is injected, is removed. From my own nursing experience, it is very important to take your time placing the cannula, by making the patient more comfortable, preferably sitting with their arm resting on a pillow or support. Some hospitals have special chairs for this. In my case, this didn't always happen, and on one occasion the cannulation was very painful. At the Royal Marsden there was more up-to-date equipment and more experience. As their sole specialty is in dealing with cancers, the staff are much more used to damaged or small veins, so cannulation was much more comfortable. The MRI scanner was not quite so claustrophobic and a little quieter, and there was maybe a little more space in the 'tunnel' as well. The scan, which could take anywhere from thirty to forty minutes at Treliske in Truro and Derriford in Plymouth, took not even twenty-five minutes to complete, even with contrast. In all three hospitals, I was treated with courtesy by the radiology staff, there were no problems with answering questions and all tried their very best to make sure I was as comfortable as possible during the procedures.

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Getting back to the diagnosis. Of course, after Algy was found, it became clear that the 'fainting spells' were nothing to do with having blood pressure problems but actually petit mal seizures where the tumour was impacting on the brain's temporal lobe from underneath. The hardest part about receiving my diagnosis wasn't even the fact I have a tumour in my head, but the consequence of the eventual loss of my job, career, and financial independence. Having to go through the rigours of applying for financial support and a pension, as well as everything else, was very frightening, especially while also feeling unwell. Initially, I was placed on 'watch and wait' surveillance for two years to see if Algy would progress. Even when the symptoms became more obvious, I felt there was a reluctance to start treatment due to the potential long-term effects that can result from radiotherapy. Eventually the tumour had become large enough to cause the symptoms to intensify, including neuralgic pain, and the number of seizures – although not as intense, as I had started medication – certainly were becoming more frequent. Cutting a very long story short, I was eventually offered radiotherapy, which I could have had done at Derriford Hospital in Plymouth, but I would have had to wait, due to installation of new equipment. As a result, I was offered a referral to the Royal Marsden in London, and knowing the wonderful reputation they have, jumped at the chance.

So here I find myself now. I am sitting in a small café across from the hospital (Café Roma if anyone is interested) where I have a cup of hot chocolate and one of their wonderful sandwiches. When done, I head over to the hospital and down to the radiotherapy department for my session. The team there are very friendly and reassuring, willing to have a little chat when setting you up for your treatment. Let me explain a little about the treatment I am having. Algy is considered inoperable because of his location, so radio-

therapy has been offered, the intent of which is to prevent the tumour from getting any bigger and hope that also there could be some shrinkage. I had an initial consultation earlier in the year and it was determined that I should have the longer and more traditional radiotherapy treatment, or 'fractionated stereotactic radiotherapy' where a dose of radiation is prescribed, the dose divided and given over a number of sessions. There are various options, and you may have heard the terms 'Gamma Knife', 'radiosurgery', stereotactic etc. These terms refer to the type of machine used, the intensity of radiation delivered and delivery time. In my case, because of where Algy is in relation to some very sensitive areas of the brain, it was decided to deliver the dose of radiation prescribed over thirty sessions, which is not so intense and less likely to have an impact on the areas surrounding the tumour. For this I have had to be fitted with a mask before I started treatment, to keep my head completely still during the session, which is vital since the beams are targeted very precisely at the tumour and it would not do for the target to then suddenly move! This, for me, was the worst part, not because of any pain but because the mask itself can be claustrophobic to wear as it encompasses the whole head. Fitting the mask was very quick and painless. It is made from a plastic-type material which is heated in hot water, applied over the area to be treated – in this case over the front of my head and moulded around my face. A hole was quickly opened for my mouth and nostrils to enable breathing. Clips were then fixed on the edges of the mask as it is clipped on to the table to secure you. I was hoping that the Royal Marsden would allow me to take pictures of the stages of fitting but sadly their policy is not to allow any, so I can only go on other people's accounts of the actual session, as I could not see it! Now I have got used to the routine of going in, lying down, and having the mask clamped to the table, I can feel quite relaxed as there is the option of having music played during the session, as with the MRI scans earlier. The session ends quite quickly, and the mask is then removed, plus I am helped to sit up as I need to regain my balance before getting off the table. After a quick goodbye, I leave the hospital and depending on how I am feeling at the time, might go for a walk and some lunch, or head back to where I am staying if I am feeling very tired, which does happen. In all, my experiences with radiotherapy have not been unpleasant so far, but everyone will have a different experience, depending on the type of radiotherapy offered and where. For me the worst will probably come later as the side effects become more noticeable and to that end, my husband will be joining me in London during the last week of my treatment as I have been warned that the fatigue and the disorientation could intensify for a while. I just hope this works and that Algy will no longer be trying to occupy more skull space in the future.

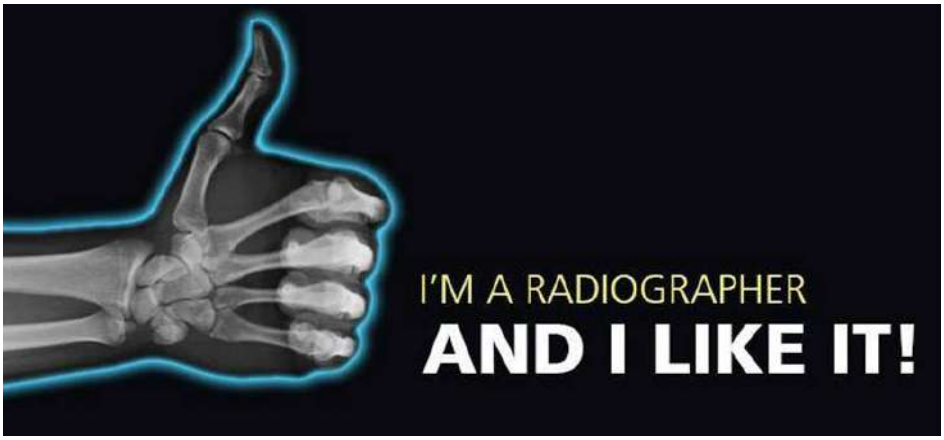
A DAY IN THE LIFE OF A RADIOGRAPHER

Call me Clizia – I am a radiographer working at the radiology department of the county hospital where I live. Today I am doing the morning shift, so I need to be at my department by 7am. My radiographer colleagues and I always start the day with a cup of coffee while we are debriefed by the radiographer who did the night shift. This morning he told us that there were several emergency CT examinations which he had to perform on patients from the accident and emergency (A&E) department. All went well and the patients have gone back to the wards; he has tidied up the CT equipment and refilled all supplies so we can start the morning shift as planned. Today I will be performing general x-rays, however as there are several radiographers on vacation, I will most likely also help out in CT as they have quite a few examinations booked for today. The phone rings and it is from the intensive care unit (ICU). They need an urgent chest x-ray for a patient in a critical situation. I quickly gather up a few x-ray cassettes and take them up with me to the ICU to use with the mobile digital x-ray unit. Arriving at the ICU, I consult with the ICU staff to ask for the x-ray referral and for some information on the patient needing the x-ray. While preparing the mobile x-ray unit for the examination I notice that there is another patient close by who is not mobile enough to be taken away while I perform the x-ray. I place a lead apron on this patient to try to minimise the scattered x-ray radiation that she would be exposed to while I perform the x-ray on the other patient. The ICU nurses help position the x-ray cassette underneath the chest of the patient and do their best to prevent various medical instruments and wires from overlapping the area being examined. After making the chest x-ray, I quickly consult with the ICU physician to confirm whether the x-ray image is suitable for his requirements. Making chest x-rays on patients lying in a bed is not ideal. We need to find ways of maintaining good image quality on patients who are unable to cooperate, cannot hold their breath, or have lots of medical instruments around them and lots of wires or cables across them. I enjoy doing x-rays in the ICU as the staff are very helpful and do their best to help me and my work; I am glad that I can contribute to the care of patients in the ICU.

> Today I will be performing general x-rays, however as there are several radiographers on vacation, I will most likely also help out in CT as they have quite a few examinations booked for today.

Going back to the radiology department, I realise that there are several patients waiting to have x-ray examinations. Reading through the

referrals, I see that one has come for a chest x-ray, another one for an ankle x-ray and another one for an abdomen x-ray. I ask the assistant to check with the patients to prioritise their needs. While she talks with the patients, I double check to make sure that all the referrals are signed by the clinician. I also check to see whether the patient consent forms have been filled out and signed by the patients themselves. I start with the chest x-ray. This time the conditions are ideal. After the patient has taken his shirt off, I position him standing in front of the cassette. This time I use a routine setting on my digital x-ray system. Having a look at the image on my screen, I am pleased to see that it is exactly what is needed. I finalise and save the image through the picture archiving and communication system (PACS). This is a great tool as it allows the referring clinician as well as the reading radiologist to view the x-ray image straight away, in their office or on the ward. I have heard that there are some places where the clinicians get the images sent straight to their smartphones. Wow! This is one of the reasons why I love my profession; the technology supporting radiology is changing dynamically with the latest innovative IT features always being integrated into our systems to improve the quality of patient care we provide. Next, I call in the patient coming for an ankle x-ray. I ask the patient to remove his shoes and to lie down on the x-ray table. I first cover his lap with a lead apron, again to minimise unnecessary radiation dose, and position the cassette. This time I have to make two images from two different angles. This is the routine in the case of an ankle x-ray. After checking the images and disinfecting the table, I call in the other patient who is here for an abdominal x-ray. I quickly ask whether the patient has had anything to eat that morning. Not surprisingly, she says that she had breakfast. I explain to her that I will need to consult with the radiologist to double check whether it is possible to take an x ray now or maybe it would be better if she comes back at a later time with an empty stomach. We wouldn't want her to be x-rayed twice, especially if it is not an urgent case. I quickly



> Looking around the operating room, I noticed that the anaesthesiologist and the nurse are not wearing lead aprons. I provide them with lead aprons and ask all others to leave the room while I make the x-ray.

cross the department to the radiologist who is already making reports based on the previous x-rays I have done. After I explain the situation, he decides to postpone the examination until he has consulted the referring clinician. Even though this is the standard procedure at our department, I am happy to experience once again that the team in the radiology department do their best to prevent people from receiving unnecessary radiation.

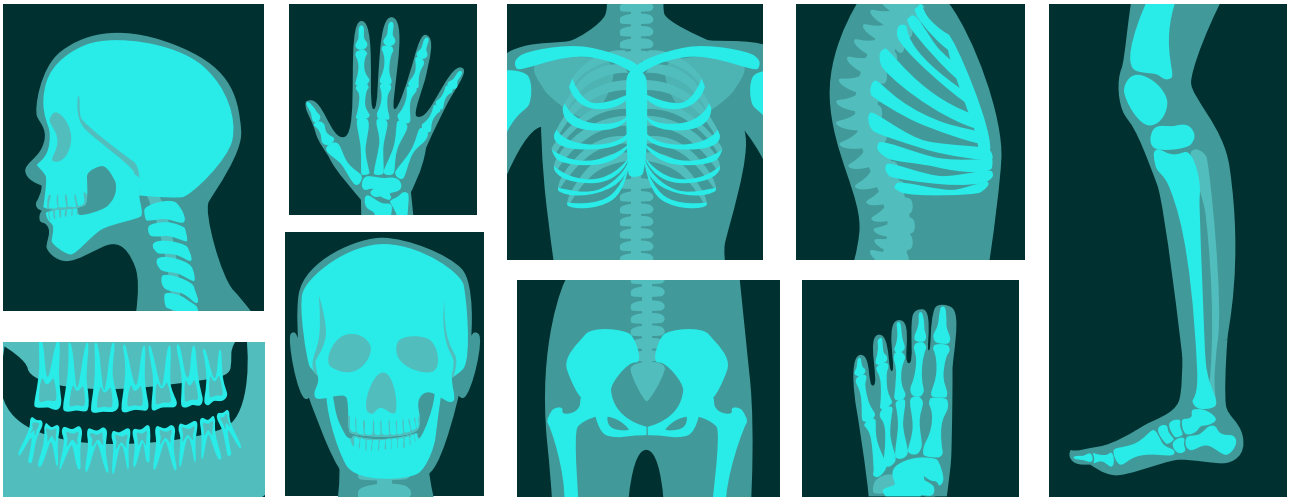
Seeing as there are no more patients waiting for x-rays, I decide to go over to the CT area to see whether I can help them. I get there just in time, as a team from the A&E department, together with the neurosurgeon, rush in with a head trauma patient who needs an urgent CT scan of the head. I quickly ask the assistant to notify the radiologist on duty while I rush in to help. Positioning the patient is not easy because of his accident. This time we need to fasten the patient to the table to prevent further accidents from occurring. The CT scan of the brain is ready by the time the radiologist arrives. It shows a severe epidural haematoma, which is a build-up of blood between the skull and the outer membrane of the brain. We quickly save the images to the PACS system so the neurosurgeon can have easy access to them in the operating theatre. Once again, I am proud that I can work with an excellent team in the radiology department, supported by the latest technology which not only allows for fast and precise imaging of patients, but caters for patient safety at the highest level. Next there is a 10-year-old boy, suffering from acute abdominal pain, who is waiting with his parents. Quite understandably, they are all very worried. The surgeon has asked for an abdominal CT as he suspects appendicitis in the young boy. We decide to consult the radiologist as he might prefer to have a talk with the surgeon and start by doing an ultrasound exam instead of CT, to avoid unnecessary exposure to ionising radiation. Luckily both clinicians decide it is best to start with an ultrasound. I have a word with the parents to calm them down and to say that the radiologist will be there soon to explain why another examination will be performed instead. I phone my colleague at the ultrasound station so she can prepare for this extra examination besides the pre-booked examinations. Then the assistant comes into CT to say that we are needed in the operating theatre where there is a hip operation in progress. I quickly head up to the operating theatre and change my clothes. I see that the assistant has already prepared the mobile C-arm, which is a special C-shaped piece of

equipment that is used to connect the x-ray source and x-ray detector to one another, with the patient in the gap of the 'C'. Looking around the operating room, I noticed that the anaesthesiologist and the nurse are not wearing lead aprons. I provide them with lead aprons and ask all others to leave the room while I make the x-ray. I understand that it could be uncomfortable to wear such heavy aprons, but safety comes first, and I have an obligation to maintain safety for staff and patients. I take some x-ray images for the orthopaedic surgeon so he can confirm that the implanted screw is really in the correct position. After cleaning up and disinfecting the C-arm, I return to the radiology department. The radiologist is just leaving the department for lunch. He tells me that the ultrasound showed no evidence of appendicitis in the 10-year-old boy and thanks me for taking the action of calling him. I am thankful that, in the end, we have avoided exposing the child to unnecessary ionising radiation. Back in the radiology department, I hear that two trauma patients have arrived at the A&E department following a car accident. One has multiple traumatic injuries (known as polytrauma) with several fractures. The nurses are already cleaning the blood from the wound and removing bits of glass that probably came from a broken car window. I go over to the CT area to help the radiographers prepare for the patients. We put on disposable aprons and gloves prior to receiving the patients. We are aware of the hazards associated with blood

> I go over to the CT area to help the radiographers prepare for the patients. We put on disposable aprons and gloves prior to receiving the patients.

contamination and it is our obligation to do all that we can, not only for patient safety, but for our own safety. The first patient brought to CT has breathing difficulties, so an urgent chest CT is requested by the emergency team. The patient is taken to the CT scanner where I see that not only are his sternum and four ribs fractured, but he has a perforated lung. The chest surgeon is called to have a quick look at the images and after consulting with the radiologist, he asks us to help organise the transfer of the patient to the operating theatre. Our assistant is glad to help and offers to help take the patient away. We quickly clean the CT table and get ready for the next patient. Luckily, the next patient has only suffered minor trauma with no apparent fractures. Nonetheless, a CT scan with a low dose of radiation and an injection of contrast medium (a substance which helps to make certain things more clearly visible in the image) is needed to rule out any internal injuries. My colleague goes over the consent form with the patient and discusses safety aspects and potential hazards before asking for the patient's signature. It is always very important to document all aspects of patient care as these may be significant in the future. In the meantime, I prepare the contrast medium injector and after positioning the patient, I connect the injector with the tube placed in the patient's right arm. Everything goes well during the examination. We are glad to see that the patient doesn't have any further injuries. After the patient is taken away, I help clean up the CT area for the afternoon shift. As my morning shift comes to an end, I go off to have a coffee in our lounge with some of the radiographers and radiologists. We talk of how colourful our work is, no matter whether we do routine shifts or weekend shifts, so many incredible things happen, and we are always ready to contribute to patient care by helping other clinicians and staff members at the hospital. We all believe that the radiographers and radiologists make a perfect team here! It is now 2pm; my radiographer colleagues have arrived for the afternoon shift. It has been an intense day, but at the end I feel happy because I have had the opportunity to achieve the best of this profession: to help others in need. I'm proud to be a radiographer!

Articles taken from:
https://www.myesr.org/patients/



Sustainability in Glove Manufacturing

In an age where sustainability has become a global imperative, industries increasingly embrace eco-friendly practices. One such industry where sustainability plays a pivotal role is the manufacturing of personal protective equipment like gloves. Hand protection is indispensable in various sectors, including construction, healthcare, manufacturing, and more. As we delve into this world, it becomes evident that overall sustainability is beneficial for all stakeholders and businesses.

Before we dive into the sustainability aspects of hand protection manufacturing, let's recognize the critical role hand protection plays in ensuring workplace safety. From safeguarding construction workers' hands from heavy machinery to protecting healthcare professionals during medical procedures, hand protection is a linchpin in preventing injuries and accidents.

The Environmental Impact of Traditional Manufacturing

Historically, glove manufacturing was not always aligned with sustainability goals. Conventional manufacturing methods often lead to adverse environmental impacts. Resource-intensive processes, excessive energy consumption, pollution, and waste generation were commonplace in the industry.

Thankfully, the paradigm is slowly shifting. Sustainable alternatives and innovations in materials are now making their way to the forefront. These alternatives include using recycled and responsibly sourced packaging, biodegradable materials, bio-based sources, and the development of eco-friendly production processes such as using thermal energy and biomass.

Ethical sourcing of materials also plays a crucial role in sustainable hand protection manufacturing. Manufacturers contribute to fair labor practices and environmental protection by ensuring that materials are sourced responsibly.

Green Manufacturing

Single-use gloves have become ubiquitous in various industries where hygiene and safety are paramount. While these gloves are critical in preventing the spread of infections and ensuring safety, they also contribute to a significant amount of waste. This waste poses environmental concerns as these gloves are typically made from materials like latex, nitrile, or vinyl, which are not easily biodegradable. The reluctance to adopt more sustainable practices underscores the need for greater industry-wide commitment to eco-conscious innovation.

One company, SW Sustainability Solutions Inc., has been leading the change in product innovation and sustainable practice in the glove industry. Embracing sustainability in a holistic approach, they have transitioned their single-use gloves to become a sustainable solution by reducing waste when disposed of in landfills. Traditional gloves that take a hundred years to biodegrade take only two and a half years to decompose. In their approach to circular economy, an innovation to use bio-based liner for their general-purpose knitted glove was their solution. Use of Forest Stewardship Council-certified materials is imposed on all recycled and responsible sourced packaging materials.

Their comprehensive approach recognizes that environmental responsibility is just one facet of a complex interplay between people, planet, and prosperity. Much importance is given to the effect of their products on the health & safety of their users and the social impact of workers, communities, and factories.

Benefits of Sustainable Hand Protection

Manufacturers adopting sustainable practices report cost-effectiveness in the long run. Sustainable materials and production processes often lead to reduced operational costs.

Additionally, using eco-friendly materials can enhance the quality and performance of hand protection equipment. This results in products that are not only safe but also durable and comfortable for users.

Furthermore, companies prioritizing sustainability tend to gain a competitive edge in the market. As consumers become increasingly aware of environmental issues, they are more likely to choose products from companies that share their values.

Challenges and Obstacles

While the benefits of sustainability in glove manufacturing are compelling, it's essential to acknowledge the challenges and obstacles manufacturer's face during the transition. Initial investment costs for sustainable practices can be higher, and supply chain complexities may arise when sourcing ethical materials.

R&D and innovation typically involve a lengthy development cycle. During this time, a company may not see immediate returns on its investment, which can be a concern, especially for businesses with short-term financial goals. Markets are dynamic, and consumer preferences can change rapidly. An innovative product or solution may not gain traction if it doesn't align with market demands or if competitors launch similar offerings first.

Industry standards and certifications related to sustainable manufacturing can be complex due to frequent changes or development of regulations. Adhering to these standards ensures that products meet quality and safety requirements; compliance can be a challenge.

Businesses that are primarily focused on profits fail to prioritize the interests of other stakeholders. The lack of a firm definition of their corporate sustainability goal results to a lack of accountability and stagnation.

Future Trends and Innovations

The future of sustainable hand protection looks promising, with emerging trends and innovations taking center stage. Glove technologies, enhanced materials, durability, and innovation on performance are just a glimpse of what lies ahead.

Sustainability is no longer a choice but a necessity. Embracing eco-friendly practices yields cost savings, improved product quality, and a competitive edge. As sustainability continues to gain momentum, it is imperative that manufacturers recognize its significance and actively work towards a greener, safer, and more sustainable future. By doing so, they not only protect hands but also the planet.

*Credits to **SW Sustainability Solutions Inc.***
www.swssglobal.com

Market Outlook

Low labor costs

Market and economy constantly growing with lower costs (labor, managers, rents, etc.) to China and other ASEAN countries, with an excellent university tradition.

Manufacture on site to export to Asia and the world

The Philippines offers an advantageous base to operate in East Asia with access to all major markets of the area thanks to a dense network of treaties and free trade agreements signed within the ASEAN framework. Local legislation provides strong tax incentives and other facilities for activities aimed at exporting (by settling in one of the numerous Special Economic Zones scattered throughout the country), to the substitution of imported products (e.g., biofuels instead of oil), or to the introduction of innovative technologies.

Rich in human and natural resources

63% of the Philippine population is aged between 15 and 64, with an estimated literacy rate of 96%. The country is considered among the top 5 in the world by overall level of mineral resources (calculated at 1.4 trillion USD). Second for gold deposits and third for copper, the Philippines has reserves in the subsoil for 152 million barrels of oil and 105 billion cubic meters of natural gas.

The Philippines distinguishes itself from the rest of Asia in language, religion, and mentality

Strongly catholic and deeply linked to the USA, the country is accessible to Western countries thanks to the universal use of English, second official language of the country and taught in all schools.

Strong economic growth and excellent economic indicators

For the next few years, GDP average growth rate is estimated above 6%. To complete the context, a high level of foreign exchange reserves, low inflation (in recent years it has fluctuated between 3 and 5%, despite the rapid economic growth), low level of public debt (little less than 50%), the status of IMF net creditor, and the international recognition of the level of "investment grade" with regard to the credit rating.

The Philippines differs from other Asian countries in the elevated level of consumption, covering 70% of the GDP

Due to the growth of the middle class, formed largely by young people, to a clearly more hedonistic culture than the thrifty one that characterizes many Asian countries, but also to a specific phenomenon: the strong inflows of remittances from abroad (valued at ~ 8% of GDP), sent to families by about 10 million Filipinos who emigrated to the world, which translates into substantial volumes of purchases that are channeled into the shopping centers of the country, among the largest in Asia.

Infrastructures improvement
The government has launched a massive "Build, Build, Build" infrastructural improvement project (roads, ports, airports, etc.). to be implemented through partnership actions between the public and private sectors.

The Philippines will spend about $4.4 billion on digital infrastructure over the next six years
Priority subsectors include cybersecurity, the cloud, and telecommunications.

The Philippines

Fully Immersed in the Asian Boom

READING TIME 7.00 min

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Over the past few decades, the topic of health has become increasingly more important in the Philippines, where the healthcare system continues to grow thanks to the rise in public and private investments, to address the increasing demand for health services.

With around 117 million inhabitants, the Philippines is among the most populous countries in the world and one of the most dynamic economies in the East Asia-Pacific region.
Characterized by a market and an economy fully immersed in the Asian boom, its average annual growth increased to 6.4% between 2010-2019 from an average of 4.5% between 2000-2009. Categorized as a newly industrialized country, it is transitioning from one based on agriculture to one based more on services and manufacturing.
The Philippine economy has also made progress in achieving inclusive growth, highlighted by the decline in poverty rates and the Gini coefficient. Poverty decreased from 23.3% in 2015 to 16.6% in 2018, while the Gini coefficient decreased from 44.9 to 42.7 over the same period. However, the COVID-19 pandemic and the community quarantine measures imposed in the country have had a major impact on economic growth and poverty reduction. Growth contracted significantly in 2020, due to the sharp decline in consumption and investment growth, exacerbated by the slowdown in tourism and remittances.

Nonetheless, the economy has started to recover with a 5.6% year-on-year expansion in 2021, supported by public investment and the recovery of the external context. The economy is expected to rebound further, thanks to domestic recovery, as well as the reopening of the economy. However, the economy faces downside risks stemming from the weakness of the external environment, which is being affected by an expected deceleration of global growth, rising inflation and geopolitical turmoil. The recovery should have a positive impact on further poverty reduction.

The health sector in the Philippines continues to change after a decade of increased public spending on healthcare.
It is characterized by a dual health system composed of a public sector next to a well-developed, and expanding, private sector.
The sprawling country of over 7,600 islands has a very decentralized system of government which is reflected in the governance and structure of the healthcare system.
The Manila Capital Region (MNC) and Luzon are the economic heart of the country and also contain the largest share of both public and private healthcare infrastructure (47% of the population is urban and rising again in the last decade).

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Health services in the public sector are provided by health facilities run by the national and local governments and are largely financed through a tax-based budgeting system. The health system is a complex, multi-layered system in which responsibilities are fragmented, and shared between the central government (the Ministry of Health), and Local Government Units that have full autonomy to organize and finance their 'own' regional systems. **While the private system is composed of**

	2018	2019	2020	2021	2022	2023 est.	2024 est.
GDP (bln € at current prices)	306.4	318.5	323	344.4	341.3	392.4	423.9
GDP growth rate at constant prices (% change)	6.3	6.1	-9.4	5.5	7.6	4.8	6.4
GDP per capita at current prices (US$)	3,188	3,408	3,223	3,454	3,493	3,681	4,013
Unemployment rate (%)	5.3	5.1	10.4	8	5.5	5.7	5.5
Population (million)	108.6	110.4	112.2	113.9	115.6	117.3	119.1
Total export volume (€ billion)	61.4	60.1	58.3	65.4	66.9	73.4	76
Total import Volume (€ billion)	105.6	99.4	85	108.1	123.7	133.9	138.8
Export of goods & services (% of GDP)	30.2	28.4	25.2	25.8	28.2	28.5	28.2
Import of goods & services (% of GDP)	42	40.5	32.9	37.8	44.3	44.6	43.8

Notes: (1) Import volume data 2021, Population 2022 and pro capite GDP 2022 (2) Both Imports and Exports are considered as FOB
Source: Processing by the MAECI Economic Observatory on Economist Intelligence Unit data, taken from InfoMercatiEsteri report, Ita - Italian Trade Agency

> The relative affordability of private healthcare can be seen in the emerging popularity of the Philippines as a medical tourism destination, mostly for low-cost aesthetic and dental procedures.

thousands of for profit and non-profit providers involved in the delivery of various health products and services.

Private health is largely market-oriented, where health services are generally paid for through user fees at the point of service, though the Philippine Health Insurance Corporation (PhilHealth) also purchases services from both the public and private sectors.

The private health sector is regulated by the Government through a system of standards and guidelines implemented through the licensure procedures of the Department of Health (DOH) and the accreditation procedures of PhilHealth. It consists of clinics, infirmaries, laboratories, hospitals, drugstores, pharmaceutical and medical supply companies, health insurance companies, academic and research institutions and informal service providers that include traditional healers (herbolarios) and traditional birth attendants (hilots). **The private sector's collective contribution to health service provision is enormous and their capacity augments the gaps and inadequacies of the public sector.**

While private services are generally considered to be expensive by locals, they are in fact relatively cheap by most international standards. The relative affordability of private healthcare can be seen in the emerging popularity of the Philippines as a medical tourism destination, mostly for low- cost aesthetic and dental procedures. The Philippines ranked 24th out of 46 countries on the 2020 Medical Tourism Index, with competitive medical services prices and English-speaking medical professionals. Private hospitals are consistently upgrading their facilities to be on par with other countries.

The country has implemented several rounds of reform to strengthen its health system: a decentralized health governance in 1991, a social health insurance program– PhilHealth – in 1995 and has actively pursued universal health coverage (UHC) since 2010. In 2019, former President Rodrigo Duterte further signed the Universal Health Care Bill into law, ushering in massive reforms in the health sector.

Among the salient features of the UHC Law is the expansion of population, service, and financial coverage through an array of health system amendments. This is accompanied by a planned paradigm shift to primary care, which is the core and center of all health reforms under the UHC.

As a consequence of its focus on the health sector, and general socioeconomic development, the country has achieved significant improvements in life expectancy and immunization coverage, as well as a twofold reduction in infant and under-5 mortality. This is attributed mainly to improvements in living conditions, better access to health services, and improved management and treatment of infectious diseases, like pneumonia and tuberculosis. Although much has been achieved to date, there are still many concerns that need to be tackled, such as prominent regional and socioeconomic disparities in the availability and accessibility of resources. There is maldistribution of health infrastructure and human resources across and within regions, which are mainly concentrated in Metro Manila and other major cities. While the overall quality of the Philippines' state-subsidized public healthcare is good, healthcare in rural areas is of significantly lower quality than at hospitals in large cities. Public healthcare also faces strain from treating the substantial number of Filipinos who rely on it. There is also a trend of Filipino medical staff migrating to Western countries, which has resulted in understaffing in some hospitals and delays in treatment. The adoption of the Universal Health Care Bill is considered a crucial step to address such inequalities. **The UHC Law aims to cover at least 50% of medical expenses to encourage Filipinos to visit specialty doctors and undergo advanced medical procedures. However, increasing the depth of the coverage will remain an ambitious target for years to come.** Reforms also emphasize strengthening Service Delivery Networks through general practitioners and family physicians and a gatekeeping processes, increasing compliance with clinical practice guidelines and providing health services closer to people through use of mobile clinics, subsidies to patient transport costs and the use of telemedicine.

National Health Insurance Program

The National Health Insurance Program (NHIP) is carried out by PhilHealth, which receives premiums from households, firms, and government.

PhilHealth reimburses healthcare costs at both public and private facilities. However, it matches only part of the total health care costs.

Although central in organized healthcare financing, > 90 percent of Philippines were directly or indirectly covered before 2019, the role of PhilHealth is limited due to the skewed distribution of health facilities, limitations in type of care covered and limited 'depth' of financing services, or the share of the healthcare costs reimbursed.

Health Facility Type	Total Facilities	Government	Private	No License	Licensed
Barangay Health Stations (Village basic, first-hand healthcare facility)	25,617	25,616	1	1,139	39
Birthing Homes	2,965	1,251	1,714	7	2,930
Rural Health Units	2,604	2,604	0	118	199
Hospitals	1,350	463	887	26	1,311
Infirmaries	650	360	290	10	639
City Health Offices	43	43	0	12	3
Other Health & Health related facilities	7,366				

Source: National Health Facility Registry: https://nhfr.doh.gov.ph/Home

In terms of human resources for health, the top four categories of institution-based health workers are nurses (90,308), doctors (40,775), midwives (43,044) and medical technologists (13,413) (2017 figures). The public sector engages a higher proportion of nurses (61%), midwives (91%) and medical technologists (53%). Compensation is considered better in public facilities. **The distribution in terms of place of work of institutional health workers is hospital-centric, thus curative in nature. Only 9% of doctors work outside the hospital in primary care settings.** Average density of doctors is 6 per 10,000 population, much lower than in Thailand and Vietnam or China, but higher than Indonesia. **The Philippines is a well-known supplier of doctors and nurses worldwide, based on qualifications and command of the English language however, health worker's migration deprives the health sector of much needed health workers and doctors who often work abroad.** Despite many different policy efforts to reduce the flow, an average of 13,000 nurses are still migrating every year. Many remain for substantial periods overseas before returning or they try to naturalize (in particular in the USA).

Government health expenditure has increased significantly in nominal terms, but it has been eclipsed by private sector funding sources, which have grown rapidly with the economy. The three major flows of public health financing have overlapping coverage. The Department of Health funds regional and apex hospitals, while local government fund primary and secondary-level care. PhilHealth, the National health insurance, reimburses government as well as private health facilities. It reportedly covers 92% of the population, 40% of which is the poor population and subsidized by the Government for premium payments. Covered services are focused on inpatient care and inadequate outpatient care that only covers the poor members of PhilHealth. Despite efforts to reform the provider payment system to increase financial protection, the share of facilities' bill covered by PhilHealth is on average 30% to 52%. **PhilHealth cannot yet be considered a strategic purchaser of services, mainly because it accounts for a small share of total health expenditure, while out-of-pocket spending continues to be the dominant source of financing for healthcare.** While PhilHealth membership coverage has expanded, its benefit coverage remains mainly for inpatient care, and it provides only limited financial support. Access remains highly inequitable due to the maldistribution of facilities, health staff and specialists.

> Despite efforts to reform the provider payment system to increase financial protection, the share of facilities' bill covered by PhilHealth is on average 30% to 52%.

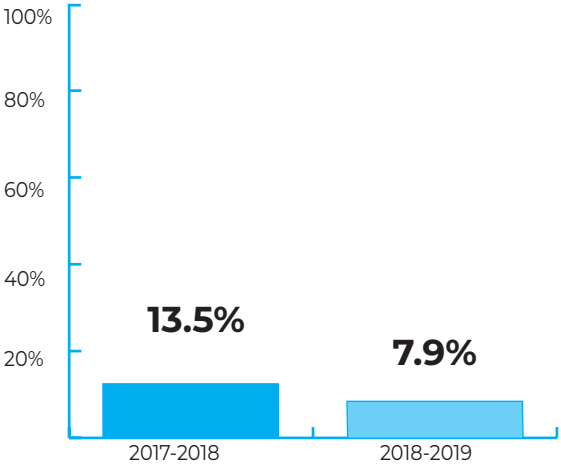
While deployment programs are easing these problems, these strategies result in monitoring and sustainability problems. Patient satisfaction and user experience of health services may show improvements, but balance billing, i.e., service charges set by the hospital, which are not covered by PhilHealth case rate payment, are billed to the patient and outside-hospital purchases continue to impoverish patients.

The limited number of health facilities relative to the growing population, overprovision of physicians, under-provision of care and poor physician adherence to clinical practice guidelines contribute to a low quality of care.

Current Health Expenditure (CHE), 2019	€ 14 billion (10.9% higher compared to 2018)
Total Health Expenditure (THE), 2019	€ 16 billion (up by 7.9% from 2018)
Share of THE to GDP, at current prices	4.6%
Out-of-pocket payments, 2019	47.9% of CHE
Per capita current health expenditure in PPP, int$ (2019)	USD 379

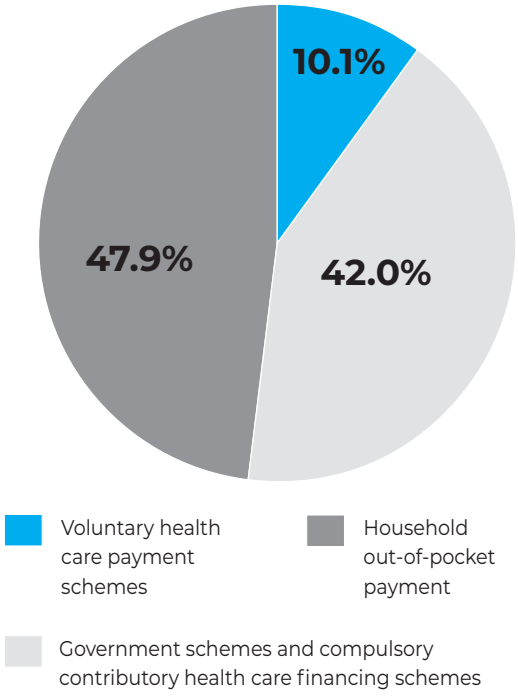
Source: Oral Health Country Profile, WHO / Health Care in The Philippines, Orange Health Consultants, Commissioned by the Netherlands Enterprise Agency, April 2021

Total Health Expenditure Growth Rates (in percent)



Source: Philippine Statistics Authority

Current Health Expenditure by Health Care Financing Scheme: 2019



Source: Philippine Statistics Authority

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Facts and Figures on EU Health Status and Demographic Transition

In the last twenty years, the gradual increase in life expectancy in the EU has been one of the main factors contributing to the ageing of the EU population — alongside relatively low levels of fertility that have persisted for decades. From some years, Europe is going through a period of profound demographic and societal change which will have a lasting impact on the way we live and work together.

Across Europe, over the last 50 years, life expectancy has increased considerably. People live longer and healthier lives. At the same time, there is a continued trend of fewer children being born. Even though Europe has higher rates of immigration than emigration, the gradual decline of the EU's population and labor force is expected to continue. A decreasing and ageing population brings new challenges. **The shrinking working-age population puts pressure on labor markets and welfare states; increases the old-age dependency ratio; and raises the per-capita burden of public debt.** To sustain economic growth, the working age population must increase, labor-force participation rates must go up and/or productivity has to increase through technological advances and/or skills development. **Population ageing also entails the needs to adapt our workplaces, welfare, and public health systems to accommodate the increased demand for accessible and affordable quality health care and long-term care.** Migration can both exacerbate and help address the problem of a shrinking working-age population. Over a more long-term perspective, climate change and environmental degradation may contribute to a reduction in life expectancy and displacements within and across national borders.

The EU's share of the global population has declined considerably and is projected to continue falling in future decades. On 15 November 2022, the world's population reached a projected 8 billion people. **At the same time, according to the latest UN World Population Prospects, the share of the world's population living in the 27 countries that now constitute the EU decreased from 12% in 1960 to 6% today and is expected to fall to below 4% by 2070.** Conversely, there has been a remarkable increase in Africa's share of the world's population, which rose from 9% in 1960 to 17% today and will rise to a projected 38% by 2100. Asia, which had the highest share of the world's population in 1960 and has today more than half of the world's population, is expected to decrease to 45% by 2100. Oceania, North America, Latin America, and the Caribbean do not show major projected changes over time in their shares of the world's population.

Demographic trends do not affect every country and every region in the same way. Although the European population is ageing as a whole, demographic developments are far from uniform, with considerable variations both between and within individual EU Member States. **Population decline has been particularly acute in some Eastern EU Member States, which have experienced high levels of emigration as well as people moving within their home countries from rural regions to predominantly urban areas in search of better opportunities for work and education and training possibilities.** The resulting demographic differences can exacerbate existing economic, social, and territorial inequalities, and provoke political divides.

> Even though Europe has higher rates of immigration than emigration, the gradual decline of the EU's population and labor force is expected to continue.

HEALTHY LIFE YEARS AND LIFE EXPECTANCY AT BIRTH

Whether extra years of life gained through increased longevity are spent in good or bad health is a crucial question. Since life expectancy at birth is not able to fully answer this question, indicators of health expectancies, such as healthy life years (also called disability-free life expectancy) have been developed. These focus on the quality of life spent in a healthy state, rather than the quantity of life, representing an important measure. **In 2021, the number of healthy life years at birth was estimated at 64.2 years for women and 63.1 years for men in the EU, this represented approximately 77.4 % and 81.7 % of the total life expectancy for women and men**. Analyzing the figures, the gender gap

Healthy life years
(2021)

	Healthy life years at birth			Healthy life years at age 65		
	Females	Males	Difference	Females	Males	Difference
EU	64.2	63.1	1.1	9.9	9.5	0.4
Lithuania	59.8	55.4	4.4	6.6	5.2	1.4
Poland	64.6	60.7	3.9	8.9	7.7	1.2
Slovenia	67.3	63.7	3.6	11.4	10.0	1.4
Bulgaria	65.1	61.6	3.5	9.0	7.7	1.3
Latvia	55.4	52.2	3.2	5.0	4.4	0.6
Estonia	58.0	54.9	3.1	7.6	6.2	1.4
Czechia	63.4	60.7	2.7	8.2	7.0	1.2
Cyprus	66.8	64.5	2.3	9.3	9.1	0.2
Hungary	63.5	61.6	1.9	7.8	7.1	0.7
Greece	66.6	64.7	1.9	7.7	7.6	0.1
Germany	66.5	64.7	1.8	11.4	10.2	1.2
Ireland	68.0	66.4	1.6	13.0	12.3	0.7
France	66.9	65.5	1.4	12.6	11.3	1.3
Croatia	59.3	57.9	1.4	5.2	5.1	0.1
Slovakia	57.5	56.2	1.3	5.1	4.8	0.3
Romania	58.2	57.3	0.9	4.0	4.0	0.0
Italy	68.5	67.7	0.8	10.7	10.8	-0.1
Finland	61.7	61.6	0.1	11.4	10.3	1.1
Austria	61.3	61.5	-0.2	9.7	9.3	0.4
Belgium	64.4	64.8	-0.4	11.3	11.0	0.3
Spain	62.6	63.0	-0.4	10.3	10.7	-0.4
Malta	68.5	68.9	-0.4	11.6	12.2	-0.6
Luxembourg	61.6	62.3	-0.7	11.2	10.7	0.5
Sweden	67.9	68.9	-1.0	14.8	14.5	0.3
Netherlands	59.6	61.0	-1.4	9.7	9.2	0.5
Portugal	57.4	59.3	-1.9	7.4	8.4	-1.0
Denmark	54.8	58.2	-3.4	10.2	9.5	0.7
Norway (1)	66.7	70.5	-3.8	14.9	15.5	-0.6
Switzerland	59.3	63.2	-3.9	10.9	11.6	-0.7
Iceland (2)	59.0	65.7	-6.7	11.8	13.2	-1.4

(1) 2020 instead of 2021.
(2) 2018 instead of 2021.
Source: Eurostat (online data code: hlth_hlye)

eurostat

> COVID-19 caused a sudden, temporary decline in life expectancy in the EU, being responsible for 1.2 million additional deaths in 2020-2021.

is considerably smaller in terms of healthy life years than it is for overall life expectancy; men tend to spend a greater proportion of their somewhat shorter lives free from activity limitations.

Life expectancy at birth has risen rapidly during the past century due to a number of factors. These include a reduction in infant mortality, rising living standards, improved lifestyles and better education, as well as advances in healthcare and medicine.

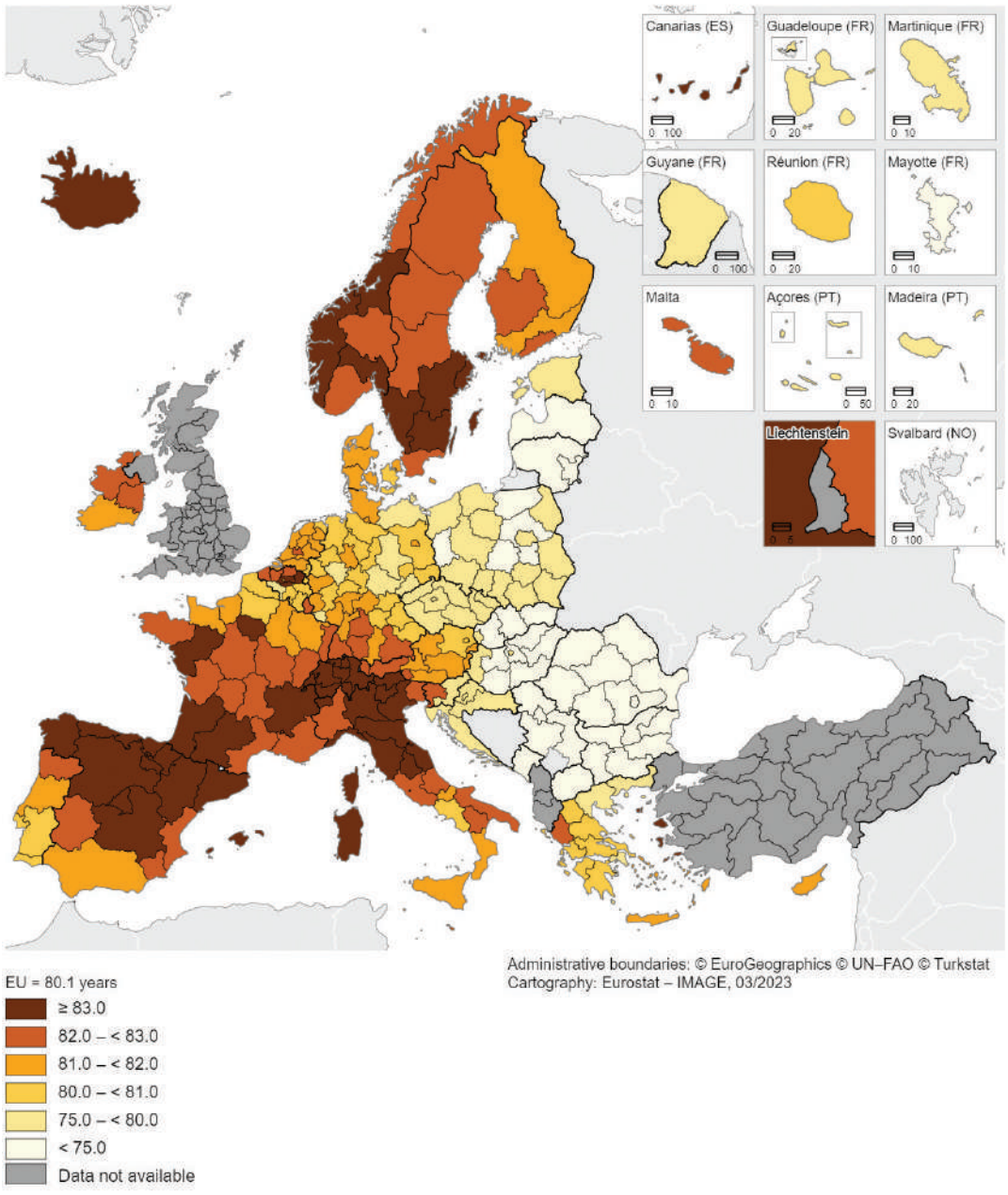
In 2021 life expectancy at birth in the EU was 80.1 years, down from 80.4 in 2020 and 81.3 in 2019. Official statistics reveal that life expectancy has risen, on average, by more than two years per decade since the 1960s. COVID-19 caused a sudden, temporary decline in life expectancy in the EU, being responsible for 1.2 million additional deaths in 2020-2021. Latest data suggest that, in 2020, this indicator declined in 23 of 27 Member States, the exceptions being Denmark, Estonia, Finland and Cyprus. The decline was steeper for men than women. Following the sudden drop during the pandemic, however, the long-term trend of gradual increase in life expectancy has resumed.

- **COVID-19 accounted for 8 % of all deaths of EU inhabitants in 2020.**
- **There were almost 12 % more deaths in the EU in 2020 than the average of the four previous years.**
- **Finland had the lowest standardized death rate from COVID-19 in 2020**

In total, 5.18 million deaths of EU inhabitants were reported in the EU in 2020. Around 85 % of all deaths occurred among people aged 65 years and over. The leading causes of death were diseases of the circulatory system and cancer (malignant neoplasms). The third most frequent cause of death in 2020 was COVID-19, followed by respiratory diseases. COVID-19 and respiratory diseases are age-related, with the vast majority of deaths from these diseases recorded among the elderly.

There has been a general decline in the standardized death rates of the leading causes of death over the years 2011-2020 in the EU: cancer (-10

Life expectancy at birth, 2021
(by NUTS 2 region; in years)

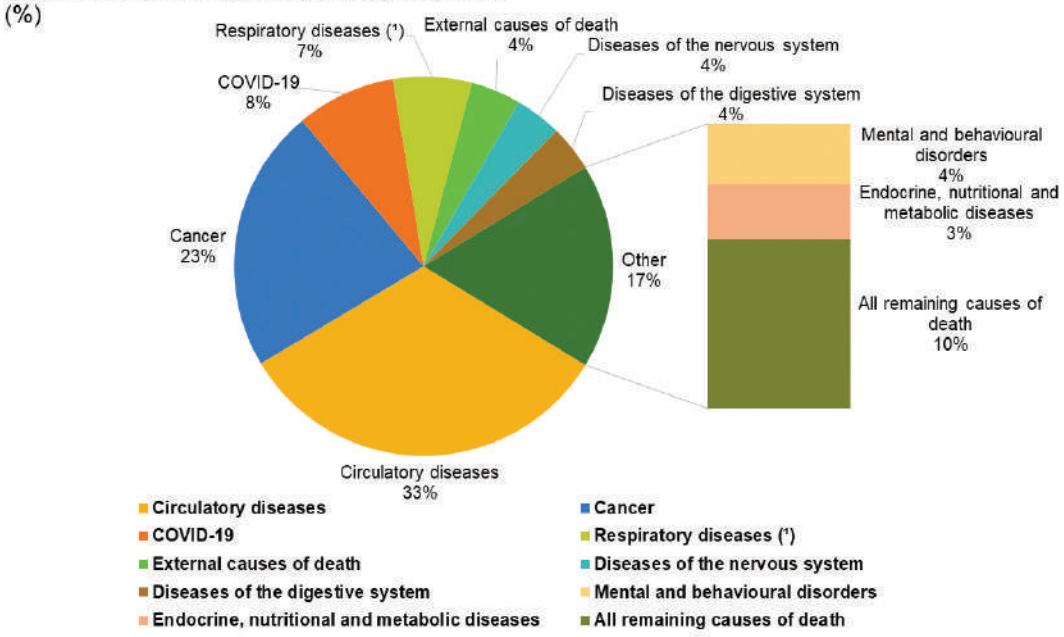


Less than 1 year
Source: Eurostat (dataset code demo_r_mlifexp)

%) and ischaemic heart disease (-22 %). Of the different types of cancer, the death rate of lung cancer decreased by 12 %, and breast cancer and prostate cancer decreased by 7 %. The standardized death rate of transport accidents decreased by 34 % and intentional self-harm by 17 %. The rate of respiratory disease as a cause of death decreased by 6 % and may have been affected by the increase in COVID-19 deaths.

In the long run, the increase in the number of days with unusually high temperatures and heat waves may start to have long-lasting consequences on mortality. Research suggests that around 70,000 deaths could be attributed to the extreme temperatures of the heat waves of July and August 2003, which affected many parts of Europe. Around 3,000 deaths in France were attributed to the heat waves in 2015. In addition to these specific episodes in recent years, analysis of weekly death counts by age across the EU for 2015-2022

Causes of death by frequency, EU, 2020
(%)



Notes:
(1) Respiratory diseases does not include COVID-19
Source: Eurostat (online data code: hlth_cd_aro)

eurostat

Main causes of death by age and sex, EU, 2020
(standardised death rate per 100 000 inhabitants)

	Men		Women	
	Cause of death	Rate for male inhabitants	Cause of death	Rate for female inhabitants
Below 65 years old	Lung cancer(1)	20.59	Breast cancer	12.78
	Accidents	20.22	Lung cancer(1)	10.81
	Heart attack	15.88	COVID-19(2)	6.31
	COVID-19(2)	15.02	Colorectal cancer(3)	5.23
	Chronic liver disease	13.97	Cerebrovascular diseases	5.21
	Intentional self-harm	13.55	Accidents	4.68
Age 65 and above	COVID-19(2)	570.53	Cerebrovascular diseases	319.47
	Cerebrovascular diseases	378.87	COVID-19(2)	311.16
	Lung cancer(1)	288.85	Dementia	168.51
	Heart attack	213.65	Heart attack	110.97
	Chronic lower respiratory diseases	190.29	Breast cancer	108.33
	Prostate cancer	176.97	Chronic lower respiratory diseases	88.97

(1) Malignant neoplasms of the trachea, bronchus and lung
(2) See section 'Classification of the causes of death' for details on how COVID-19 deaths were calculated.
(3) Malignant neoplasms of the colon, rectosigmoid junction, rectum, anus and anal canal
Source: Eurostat (online data code: hlth_cd_asdr2)

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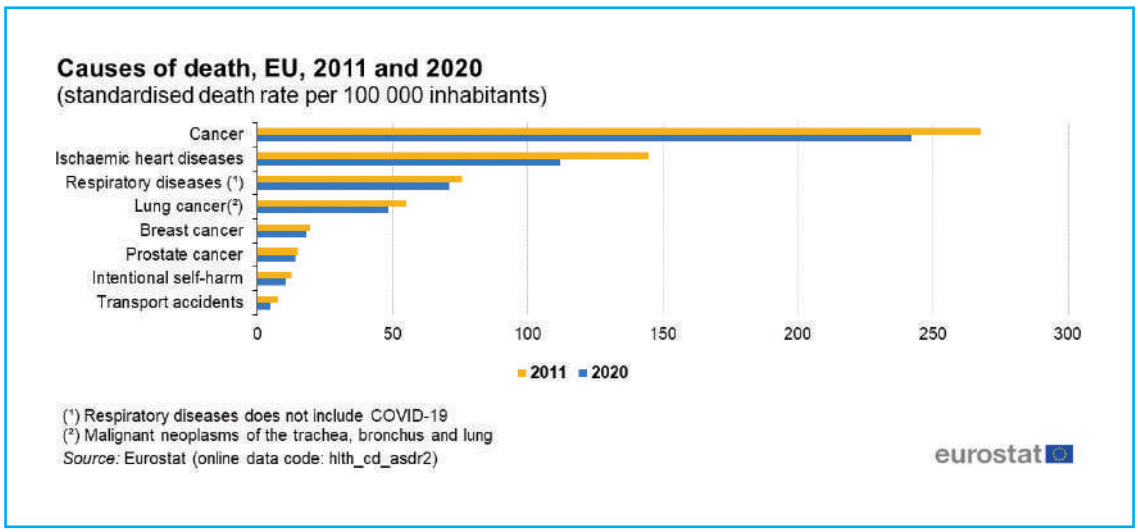
shows that the increases in mortality during summer months since 2018 are starting to become significant. These increases in mortality during summer represent an additional systematic seasonal component of elderly mortality at the same level of significance as the winter peaks associated with influenza.

HEALTH EXPENDITURE

Based on the data shown most EU Member States, all except Greece, recorded an increase in healthcare expenditure within the last years (2012-2020). **Germany had the highest level of current healthcare expenditure among the EU Member States, valued at €432 billion in 2020. France recorded the second highest level (€281 billion), followed by Italy (€160 billion) and Spain (€120 billion).** Current healthcare expenditure in Germany and France was equivalent to 12.8 % and 12.2 %, respectively, of gross domestic product GDP), more than in any other EU Member State. The next highest ra-



tios were in Austria (11.5 %), Sweden (11.4 %), the Netherlands (11.1 %) and Belgium (11.1 %). Spain, Portugal, and Denmark were the only other EU Member States to record double-digit ratios. Note that current healthcare expenditure in Switzerland was equivalent to 11.8 % of GDP and that Norway also had a double-digit ratio (2019 data). By contrast, current healthcare expenditure accounted for less than 7.5 % of GDP in six Member States, with Luxembourg recording the lowest ratio (5.8 %).

Relative to population size and in euro terms, current healthcare expenditure in 2020 was highest among the EU Member States in Luxembourg (€5,875 per inhabitant) and Denmark (€5,642 per inhabitant). It is interesting to note that Luxembourg had the highest ratio per inhabitant despite having the lowest ratio of healthcare expenditure to GDP, reflecting the high level of GDP in Luxembourg. A significant proportion of workers in Luxembourg are cross-border workers and live outside the country. Note that, as non-residents, the expenditure on their healthcare is not included in Luxembourg's health accounts while their economic activity does contribute to Luxembourg's GDP. Following on from Luxembourg and Denmark, ratios over €5,000 per inhabitant were also observed in Ireland, Sweden, Germany, and the Netherlands, while in Austria the ratio was just below this level. In turn, these were followed at some distance by another group – Belgium, France, and Finland – with ratios in the range of €4,138 to 4,380 per inhabitant. There was then a relatively large gap to Italy (€2,686 per inhabitant), Malta (€2,575, 2019 data) and Spain (€2,538). All of the remaining 14 EU Member States recorded average expenditure of €2,110 per inhabitant or less in 2020, with four of these recording an average spend on healthcare below €1,000 per inhabitant. The lowest levels of average expenditure per inhabitant were in Bulgaria (€754) and Romania (€713). As such, the ratio between the highest (Luxembourg) and lowest (Romania) levels of expenditure per inhabitant was 8.2 : 1.

These disparities are less apparent when expenditure is expressed in purchasing power standards (PPS). This measure adjusts for differences in price levels between the EU Member States. Germany (4,831 PPS per inhabitant), the Netherlands (4,302 PPS per inhabitant) and Austria (4,095 PPS per inhabitant) recorded the highest ratios of healthcare expenditure per inhabitant in PPS terms. Croatia (1,448 PPS per inhabitant) and Romania (1,428 PPS per inhabitant) had the lowest ratios. As such, by taking account of price level differences, the ratio between the highest (Germany) and lowest (Romania) levels of healthcare expenditure per inhabitant was considerably narrower than the equivalent ratio in euro terms mentioned above, as it was 3.4 : 1.

> In addition to these specific episodes in recent years, analysis of weekly death counts by age across the EU for 2015–2022 shows that the increases in mortality during summer months since 2018 are starting to become significant.

Sources:
Text and graphics/tables taken from Eurostat Statistics Explained. For a detailed report on "Health in the European Union - Facts and Figures": https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Health_in_the_European_Union_%E2%80%93_facts_and_figures
Furthermore, on 17 January 2023, the European Commission published the Staff Working Document on "The impact of demographic change in a changing environment" which provides further analysis of the demographic consequences of the COVID-19 pandemic. More information of the work of the European Commission 2019-2024 to tackle the impact of demographic change in Europe can be found in the European Commission dedicated pages. For more details: commission.europa.eu/system/files/2023-01/Demography_report_2022_0.pdf

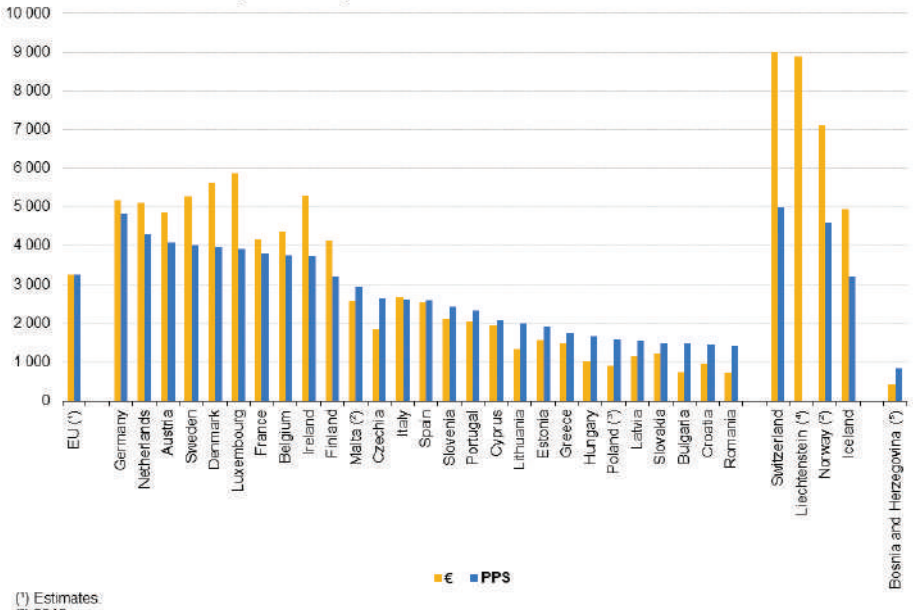
Current healthcare expenditure, 2020

	€ million	€ per inhabitant	PPS per inhabitant	% of GDP
EU (*)	1 462 373	3 269	3 269	10.9
Belgium	50 535	4 380	3 764	11.1
Bulgaria	5 226	754	1 478	8.5
Czechia	19 889	1 859	2 649	9.2
Denmark	32 902	5 642	3 964	10.5
Germany	431 805	5 192	4 831	12.8
Estonia	2 080	1 565	1 900	7.8
Ireland	26 479	5 311	3 740	7.1
Greece	15 720	1 469	1 731	9.5
Spain	120 203	2 538	2 588	10.7
France	281 065	4 160	3 807	12.2
Croatia	3 897	963	1 448	7.8
Italy	159 628	2 686	2 609	9.6
Cyprus	1 750	1 961	2 065	8.1
Latvia	2 194	1 154	1 561	7.5
Lithuania	3 732	1 335	2 006	7.5
Luxembourg	3 704	5 875	3 918	5.8
Hungary	9 965	1 022	1 672	7.3
Malta (*)	1 298	2 575	2 943	9.2
Netherlands	89 098	5 108	4 302	11.1
Austria	43 524	4 881	4 095	11.5
Poland (*)	34 183	902	1 591	6.5
Portugal	21 108	2 050	2 331	10.6
Romania	13 728	713	1 428	5.3
Slovenia	4 435	2 110	2 419	9.5
Slovakia	6 659	1 220	1 480	7.2
Finland	22 880	4 138	3 206	9.6
Sweden	54 687	5 282	4 008	11.4
Iceland	1 811	4 941	3 216	9.6
Liechtenstein	346	8 892	:	6.5
Norway (*)	38 113	7 127	4 588	10.5
Switzerland	77 824	9 009	4 997	11.6
Bosnia and Herzegovina	1 723	:	:	9.8

(*) Estimates.
(*) 2019.
(*) Provisional.
Source: Eurostat (online data code: hlth_sha11_hf)

eurostat

Current healthcare expenditure per inhabitant, 2020



(*) Estimates.
(*) 2019.
(*) Provisional.
(*) Purchasing power standards: not available.
(*) 2018.
Source: Eurostat (online data code: hlth_sha11_hf)

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38th Korea International Medical & Hospital Equipment Show (KIMES 2023)

Remark of KIMES 2023

Proposing a new direction for the medical environment and industry in the New Normal Era under the theme of "Better Life, Better Future"

Exhibits including AI, VR, Medical robots, Smart Healthcare, Big Data, as well as advanced medical devices reflecting the trend of convergence between different industries were put on display. Ever since the spread of COVID-19 in January 2020, this is the first exhibition to be held in the entrire 1st and 3rd floor of COEX, occupying Halls A/B/C/D, as well as the Grand Ballroom, covering a total area of 40,500sqm.

Reflection of Smart healthcare, AI and Robot Rehabilitation technologies

At KIMES 2023 which is the largest exposition of medical devices in Korea, majority of exhibitors joined the show to expand their business. Digital healthcare, AI, Robot technologies being in the limelight these days were one of highlights at the show.

Linked Events for Business Synergy Effect

- Medical Korea 2023 (Global Healthcare & Medical Tourism Conference, Korea Health Industry Development Institute)

Medical Korea 2023 (Global Healthcare & Medical Tourism Conference), held in conjunction with KIMES this year to create a business synergy effect, is an annual international medical conference and exhibition organized by the Korea Health Industry Development Institute that provides a platform for entry to the international medical market, promotion of policies to retain foreign patients, as well as global branding of Korea's medical sector, aimed at the exchange of information in the international medical market and expansion of domestic and foreign networks.

- GMEP 2023 (Global Medical Equipment Plaza, KOTRA)

Following last year, the [Global Medical Equipment Plaza(GMEP 2023)] was held innconjunction with KIMES. As a trademark conference in the biomedical field organized by KOTRA, GMEP organized export consultation conference in order to support the growth of domestic firms in face of the New Normal Era.

- MedicomteK 2023 (Medical Components Technology Korea)

The medical device field has expanded its spectrum beyond medical devices, reaching out to fields including AI, Deep Learning, and Robot Science. MedicomteK 2022, as a medical components and technology exhibition designed to promote the development of advanced medical technology, provided an opportunity to not only exchange the latest information, but also witness the present and future of the components and devices ndustry and gain a competitive edge.

KIMES 2023 Concurrent Events

- KIMES 2023 Conference and Seminar

The COEX Conference Center provides
specialized medical information on a variety of topics via medical technology seminars, hospital opening consulting seminars, startup seminars, digital healthcare seminars, medical policy briefing sessions and licensing related seminars.

- Components and Materials Special Zone

As the technological development of the medical device field has expanded beyond existing medical devices and into the territory of deep learning, and even robot science, we hold MedicomteK 2023 (Medical Components Technology Korea) that reflects the heightened interest in high-end parts and materials (COEX Hall D)

- KIMES Live! - Promotion and Marketing Support for Untact Exhibitors

In the New Normal Era, we operate 'KIMES Live!' in order to support the online marketing of exhibitors in response to the new business environment. We simultaneously run the live broadcast in sync with the offline exhibition, where a professional reporter visits the exhibitors' booths in person and introduces them in both English and Korean in real-time for buyers and clients who are not able to physically attend the exhibition. After the show is over, we produce edited content for each exhibitor and post it on our official YouTube channel for exhibitors to utilize.

Organizers:
Korea E & Ex Inc. / KMDICA / KMDIA

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01/01-31/12/2023

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Italy

Organized by:
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www.smartmedicalfair.com

OCTOBER

31/10-02/11/2023

ARM 2023 8th Annual Radiology Meeting in UAE

Dubai - United Arab Emirates

Organized by:
Index Conferences & Exhibitions
General information:
Siddarth Nanthur (Senior Project Manager)
E-mail: info@radiologyuae.com
Dir: +971 4 520 8867
Mob: +971 50 476 2417

In collaboration with:
Radiology Society of the Emirates (RSE)
Email: info@rse.org.ae
Phone: +971 4 255 6655

Venue: Dubai World Trade Centre - DWTC
Dubai
UAE

www.radiologyuae.com

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NOVEMBER

13-16/11/2023

MEDICA and COMPAMED 2023

Düsseldorf - Germany

Organised by:
Messe Düsseldorf GmbH
Messeplatz
40474 Düsseldorf
Tel: +49 211 4560-01
Fax: +49 211 4560-668
Web: www.messe-duesseldorf.de

Venue: Duesseldorf Trade Fair Centre
Messeplatz
40474 Duesseldorf
Germany

www.medica-tradefair.com

26-30/11/2023

RSNA 2023

Chicago, IL – USA

Annual Meeting: Nov. 26–30, 2023
Technical Exhibits: Nov. 26–29, 2023

Radiological Society of North America (RSNA)
820 Jorie Blvd, Suite 200
Oak Brook, IL 60523-2251 USA
Phone: +1 630 571 2670
Email:customerservice@rsna.org
Website: www.rsna.org

Exhibition services:
exhibits@rsna.org
Phone: +1 630 571 7850

Venue: McCormick Place
Chicago, IL
USA

www.rsna.org/Annual-Meeting

NOVEMBER

30/11-03/12/2023

Healthcare Expo Taiwan 2023

Taipei – Taiwan

Organised by: Institute for Biotechnology
and Medicine Industry & Research
Center for Biotechnology and Medicine Policy

Email: chinhuishen@rbmp.org.tw

Venue: Taipei Nangang Exhibition Center
Taipei
Taiwan

https://expo.taiwan-healthcare.org/en

DECEMBER

12-13/12/2023

Biofit- Hybrid

Marseille - France

Hybrid event:
December 12-13, 2023 in-person
December 15, 2023 online meetings

Organised by: Eurasanté
310 avenue Eugène Avinée, Parc Eurasanté Ouest
Loos - 59120
France
Phone: +33 3 28 55 90 73

Venue: Parc Chanot
114. Rond-Point du Prado
13008 Marseille
France

www.biofit-event.com

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14 Months of Pain Ended

KidsOR surgery for children

More children die every year from surgically treatable conditions than from malaria, HIV and TB combined. KidsOR Operating Room is working hard to change this by installing children's operating rooms and provide specialized training to build local surgical capacity. Brian is a 12-year-old from Lilongwe, Malawi, who went through nearly 2 years of pain that no child should suffer.

Brian was living an ordinary childhood growing up in Malawi. He was in year 5 at school and enjoyed playing football with friends.

It started in November 2021. While in school, Brian began to suffer fever and pain. Symptoms commonly associated with malaria. Concerned, Brian's parents kept him off school and took him to a local clinic. Then another. Then to their nearest hospital. Still, Brian's condition wasn't improving. It was getting worse. Malaria-like symptoms were replaced by a severely swollen and painful stomach.

Doctors at the local hospital were unable to identify the issue. They were given pain management and sent home.

A month later, no improvement. In fact, Brian's stomach was now even more extended. Even more painful. After returning and spending a week at hospital, Brian was admitted to Kamuzu Central Hospital, a facility with a KidsOR Operating Room.

Here, Brian was diagnosed with tuberculosis. For a child in a low- and middle-income country, this has potentially fatal consequences.

But Brian's condition was to worsen still. 3 days into treatment, his abdomen burst. He's too malnourished to undergo surgery so the team are unable to properly treat him.

It's now March. Three months have passed, and Brian has not been able to put on enough wait for the operation he needs. The decision is made that he needs to undergo an exploratory procedure to examine the root of his issues. While essential to treat Brian, at his current weight this procedure is risky. His parents are counselled and agree to the operation. Their alternative, to take Brian home for palliative care, is unthinkable.

The surgery is a success. During the operation, the team identifies and cures a series of perforations in Brian's stomach.

Recovering in isolation because of his TB, Brian's wound collapses. Another surgery is performed. A week later Brian is operated on again, this time to fit a stoma.

Alone in isolation, Brian is trying to recover from a series of operations and multiple surgical wounds. He weights just 15kg - dangerously low for his age.

Thankfully, by April, Brian was on the right track. He was sitting upright and walking. By the end of the month, he'd recovered enough to return home.

He spent the next 11 months regularly returning to Kamuzu Hospital for check-ups and would often amaze the team there with his recovery.

Now, Brian is fully recovered. "It felt like he was near death for two years. We're so grateful to the surgical team," his mother told us. "Brian is delighted to resume school and play football again. We're so happy that our life is back to normal."

About KidsOR

We believe in a world where every child has equal access to safe surgery. Our vision is for a world where every child is treated equally. Our mission is to support local doctors through the provision of training and infrastructure to ensure they can use their incredible talents to care for their nation's children.

Our Africa goal is to radically overhaul surgical infrastructure for children's surgery across Africa by the end of 2030. Since forming Kids Operating Room we have sustained a program of opening world-class, child-friendly operating rooms in low-resource settings at more than one a month. Our plan is to increase this pace of delivery as we further develop our local networks, expand our regional offices and welcome new donors to this life-saving cause.

www.kidsor.org

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