Cotonou Conference

25-26th, 28th November 2009

Dr K D Thomson
MB BS, DRCOG, FRCA
Consultant
Obstetric Anaesthetist
Basingstoke and North Hampshire Hospitals Foundation Trust

Introduction

It was a new challenge for me to take a group of UK based anaesthetists (including 3 trainees) to a French speaking West African country. The three day anaesthetic conference was attended by more than 200 anaesthesia providers, both doctors (about 50) and nurses (150+). Three of my team had never been to Africa before but the others had all worked on a Mercy Ship in the past. In fact Paul had recently finished a six month OOPE (Out Of Programme Experience) on board [1].

The team (fig 1) consisted of:
Dr Keith Thomson
Consultant, Basingstoke
Dr Andrew Wade
Consultant, Basingstoke
Dr Alex Bojarska
Consultant, Manchester
Dr Anuraag Guleria
Consultant locum, Cardiff
Dr Paul Theron
SpR, London
Dr Emma Taylor, SpR, Basingstoke
Dr Stuart Cleland, CT2, Basingstoke
Ms Stephanie Bazin, Translator, computer engineer, from Canada
Ms Carole Le Vagueresse, Translator, anaesthetic nurse, living in Cotonou

Fig 1. The Team

Planning

This began nine months before when I was working on board the *Africa Mercy* and met Prof. Martin Chobli who runs the only school for medically trained anaesthetists in French West Africa. Currently there are 40 students from eight different francophone countries. The course lasts four years, one of which is spent in either France or Belgium. The training for nurse anaesthetists lasts three years, all in Benin.

Prof. Chobli organised the conference venue at the Ecole de Pharmacie, faculté des sciences de la santé, the catering and the advertising. I organised the faculty, conference T-shirts (www.genesis-uk.com), lanyards, name badges and attendance certificates. We kept in regular contact by email and phone to plan the programme [2]. The consultants were to give three presentations each and the trainees two. Each presentation was scheduled to last 40 min including translation. Most of the summaries were translated into French in advance by Stephanie.

Sponsorship

We wish to thank the AAGBI for help towards airfares, the Noseworthy Trust (St Thomas's Hospital anaesthetic department) for supporting Paul, Mercy Ships (www.mercyships.org.uk) for providing accommodation on board the *Africa Mercy* (fig 2),

Fig 2. The Africa Mercy

a Land Rover + driver for our exclusive use for the week and resuscitation mannequins. Also the Shalimar Trust for funding lunch, T-shirts and lanyards with pouches for name badges.

Translation

Special thanks must go to our amazing French translators Stephanie and Carole ably assisted where necessary by locals Vladimir, Christian and Jijoho.

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Pre/post-Conference

Before the conference began some of our group visited the well equipped HOMEL Maternity (fig 3) and Paediatric Hospital.

Fig 3. Caesarean at HOMEL

The following day all the team were shown round the main teaching hospital, CNHU by Dr Aristide Tallon, an anaesthetist from Benin who works in Paris. In the Emergency department there were several patients who had been injured in a vehicle accident (fig 4).

Fig 4. Emergency Dept at CNHU

They seemed to have been triaged effectively. There was a new theatre and a well equipped recovery ward which didn't seem to be in use yet. There was also a marked lack of activity in the main hospital theatre block, the post-operative recovery ward was empty when we visited at 3.30pm. The modern looking ITU had several patients in it, but the only parameter being monitored seemed to be body temperature.

The three of us who travelled on the 23rd flew to Paris on the final day of Heathrow Terminal two (fig 5).

Fig 5.

The five members of the team who arrived earlier went on an interesting boat trip to visit the stilt village of Ganvie (fig 6).

Fig 6. Stilt village at Ganvie

On the last day most members of the team were taken by Jean, our driver for the week, to a beautiful restaurant/bar/water sports complex called 'Babs Dock' which was situated on an island in the middle of a mangrove swamp. En route their vehicle was stopped by police who, having asked to see Jean's documents, demanded payment for their return! Keith and Paul accompanied Derek and his wife to Mass at the catholic cathedral where there was some beautiful choral singing. Derek from Canada had been working on board the Africa Mercy for five weeks as an anaesthetist and his wife as the ward physician. Croissants and coffee at the *Gerbe d'Or* restaurant was a fitting end to the morning.

Conference

Day 1

Over 200 delegates registered. Each was given a yellow T-shirt and a pre-printed name badge in a plastic folder attached to a lanyard.

Fig 7. Lecture theatre

The lecture theatre (fig 7) was air conditioned, had nearly 200 individual seats and effective *Powerpoint* projection. On the first day six lectures of up to 40 minutes were given before lunch which started at 2.30pm, an hour behind schedule. The delegates were provided with lunch boxes in the lecture theatre

Fig 8. Lunch

but the faculty were taken to a local restaurant (fig 8) returning to the conference centre at 4pm.

Afternoon workshops

The participants were divided into two groups, one in the main lecture theatre discussing 'Prime' issues and clinical cases and the other group doing 'hands on' resuscitation and airway management in two different rooms.

Fig 9. Small group discussion

Alex and I divided our delegates into smaller groups (fig 9) and gave them Prime questions to discuss (www.prime-international.org.uk). The first was '*If a good friend or relative was having an operation what characteristics would you like the anaesthetist to have*'? The second was '*Discuss the qualities of a good professional*.' Each group elected a spokesperson to present their conclusions. The groups then discussed two case histories based on essays submitted at a conference in Sierra Leone six months before [3]. The first case history (translated into French) was about loss of consciousness and hypotension after spinal anaesthesia. Interestingly most wanted to immediately intubate the patient and give adrenaline whereas in the actual history the anaesthetist initially performed mask ventilation, gave ephedrine, atropine and more fluids after which the patient regained consciousness and the operation proceeded.

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The second case was a story of the death of a young woman in Sierra Leone suffering from obstructed breech presentation complicated by ante-partum haemorrhage, at a hospital where there was no blood available, no laboratory investigations, and no anaesthetic machine. The only ambulance had broken down. It described a resource limited maternity nightmare which several delegates acknowledged was the situation in certain other parts of Benin. One doctor recounted how a woman with labour complications died as she was being transported on a zemidjan (motor-cycle taxi) between a regional hospital and a more specialised referral centre.

The practical workshops were organised by the other members of the team assisted by Dr Derek.

Fig 10. Using a Bougie

There were two airway management (fig 10) and two resuscitation stations – neonatal (fig 11) and the assessment/management of the ill patient (fig 12) including instruction in the use of AED and manual defibrillators.

The delegates showed a wide range of ability in performing airway management and basic life support. At the end of Day 1 Paul decided that on Day 2 he would omit training in how to perform a cricothyroidotomy

Fig 11. Neonatal resus training

Fig 12. Teaching the ABC

as delegates seemed much more interested in that rather than essential basic airway skills.

Day 2

This followed a similar format to Day 1 with six presentations including one by a local orthopaedic surgeon on the *management of trauma in developing countries*. When questioned on why helmet wearing was not compulsory for those on motorbikes (fig 13) he replied that the Government had suggested this,

Fig 13. No helmets!

but some women's groups plus their hairdressers had managed to veto the idea by saying that they would not vote for the Government in forthcoming elections if wearing helmets became law. Anuraag spoke on paediatric anaesthesia (fig 14)

Fig 14. Anuraag with translator Stephanie

and Alex (fig 15) gave three

Fig 15. Alex making a point

presentations including *Ketamine, old dog – new tricks*. This generated particular interest when she mentioned its possible use for labour analgesia either orally or intramuscularly (0.5mg/kg).

At midday the Minister of Health, Prof. Issifou Takpara, arrived to officially open the Conference. While sitting beside him at the front table I dropped my pen on the floor, he and I both bent down to pick it up and then to my acute embarrassment we bashed heads on the way up! During his speech he said that for the past seven months caesarean sections and treatment of postpartum haemorrhage had been funded by the government in an effort to decrease the maternal mortality. He also said he wanted anaesthetists to design an anaesthetic pack specifically for caesarean sections. Professor Chobli and I also made brief speeches. I took the opportunity to stress that the anaesthetists in Benin needed to be provided with

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more money and resources to do their challenging job. Laughter ensued after my remark that '*the main role of the anaesthetist was to protect the patient from the surgeon!*' During the ensuing coffee break, the Minister, an obstetrician, was persuaded to demonstrate his resuscitation skills on one of our mannequins in the presence of the local press (fig 16).


Fig 16 .
The minister and the dummy

Day 3

Because of the Muslim festival of Eid, the team had the day off and visited the former slave port of Ouidah, an hour's drive from Cotonou. En route we were usually surrounded by numerous motor bikes, the main mode of local transport. We even glimpsed on one a goat (fig 17) being carried on the handlebars and on another

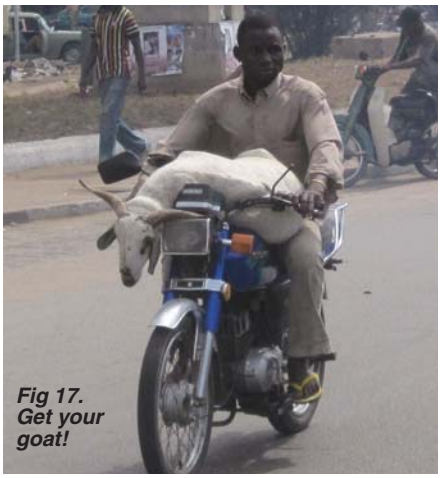
Fig 17.
Get your goat!

a large roll of matting behind the driver (fig 18).


Fig 18.
Bike transport!

The Portuguese slave fort at Ouidah was built in 1721. Our tour guide told many fascinating but morbidly graphic stories which were translated into English by Stephanie. Slaves were often imprisoned in the Fort for several weeks awaiting the next ship to transport them in inhumane cramped conditions across the Atlantic to an unknown fate. They were left deliberately out in the sun, wind and rain with little food or water so that only the strongest survived. The bodies of those who died were thrown to the crocodiles and caymans inhabiting the moat which in those days surrounded the Fort. Some slaves would even cram soil in their mouth in an attempt to suffocate to death. Others would drown after deliberately jumping off the small boat taking them out to the slave ship anchored off shore. They would also drag under the water several others who were manacled to them.

Stephanie remembers one room in the Fort was dedicated to former Kings who had to have a minimum of 41 wives and would instantly decapitate any dissenters to their absolute rule! In another room there were appliqué tapestries on the walls each representing a different bizarre superstition such as the 'cursing broom' which throws small-pox at you which can only be reversed if you have an 'antidote broom' in the house. Voodoo is an official religion in Benin and exists alongside Animism, Christianity and Islam.


Fig 19.
Gate of No Return
at Ouidah

After the Fort we visited the *Gate of No Return* (fig 19) on the beach and also the beautiful *Millennium*


Fig 20.
Millennium
monument

Monument (fig 20) with the shape of the country carved out of a concrete monolith in front of which stood a Cross.

After an enjoyable lunch and a beer at a beach hotel, the *Casa del Papa*, followed by a paddle in the sea (fig 21) we set off on the bumpy but


Fig 21.
Testing
the water

scenic coastal route back to Cotonou, passing the memorial on the airport perimeter fence to lives lost five years ago when a plane had crashed soon after takeoff.

Day 4

This started with such a good presentation by Dr Thomas Locossou on the maternity statics at HOMEL Hospital that I wondered whether he could be invited to give a presentation at a future OAA meeting. He discussed the reasons for 70 maternal deaths a year out of only 5000 deliveries. This was followed by Prof. Montravers from Paris talking about the provision of anaesthetic services in France. Andy, myself and Anu discussed our own particular anaesthetic sub-specialities in the UK and finally Professor Chobli talked about the distribution of anaesthetic personnel and resources in various West African countries (4).

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After another prolonged lunch the final two lectures were followed by a quiz consisting of 20 questions in French projected one by one in *Powerpoint*. If one thought the answer was true one stood up, if false then you sat down. The first two questions eliminated half the audience of about 150, but unfortunately after all 20 questions there were still about 15 people left so we gave them all a prize but the quiz proved to be popular and there was much laughter and hilarity. We then distributed memory sticks containing all the presentations to a representative of each hospital group (about 15) present at the conference. CDs of the presentation as well as photos of individual delegates had been on sale throughout the day. A near riot engulfed Stuart when I asked him to hand out the remainder of our 'give away' goods!

That evening Professor Chobli very kindly invited the whole team back to his house for supper. His wife had prepared an excellent buffet of local fish with beans, fried plantains, rice and couscous. This was followed by fresh pineapple and pawpaw. There was an impressive supply of scotch whisky and wine. We finished an enjoyable evening by toasting each other from a magnum of excellent French Champagne after the Professor had given us all green polo shirts and myself a cap with the words *Big Chief Anaesthetist* (fig22). It was definitely an evening

Fig 22. My friend Martin

to remember. Luckily Paul had organised with the Ghurkha security guards on the Ship that we were likely to return after the 10 o'clock curfew!

In Summary

The conference was a success. All members of the team not only gave excellent presentations but also organised the workshops with great enthusiasm. The disadvantage of having more than 200 delegates was that it was difficult to establish a rapport with individuals but I do remember one trainee anaesthetist from Congo Brazzaville had an interesting photo of his hero Fidel Castro (fig 23) as the screensaver on his laptop!

Fig 23. My hero Fidel

A local anaesthetist commented that such a meeting would have had many fewer participants a few years ago as they would have to be paid to attend but now the delegates paid a small attendance fee and were so enthusiastic that the conference had continued until after 6.30pm every day.

How one measures whether we had any effect on anaesthesia provision in Benin is difficult to quantify but part of the purpose of the conference was to bring together anaesthesia providers from all over the country to meet each other and discuss the common issues that they all face like difficult surgeons, poor pay and lack of disposable resources, drugs and equipment.

References – The following can be seen on the author's website **www.africansmiles.co.uk** under BENIN.

1. Africa Mercy OOPE : January-July 2009
2. The conference programme
3. The two case histories from Sierra Leone
4. Lokossou T, Chobli M *et al.* Anesthesia in French-speaking Sub-Saharan Africa: an overview. *Acta Anaesth. Belg.* 2007; **58**:197-209.