Africa Mercy in Togo

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Introduction

This was the fourth visit of a Mercy Ship to the port city of Lome since 1990. Whether much has improved in the country over the past 20 years is debatable.

In the book 'Blood River' which graphically described journalist Tim Butcher's adventures down the Congo River in an attempt to mimic the 1879 journey of Stanley, he makes the statement "*where logic ends the Congo begins*". This could perhaps be applied to much of Africa but should not prevent one trying to make life better for few whom we come across in that challenging continent.

The '*Africa Mercy*' (fig 1) arrived in Togo in February 2010 just before the Presidential Election which took place relatively peacefully with allegations of ballot rigging not proven.

Fig 1. Africa Mercy docked in Lome

This was my 25th time on a Mercy Ship and 5th on board the *Africa Mercy*. My three-week visit could be divided into three distinct parts:

1) working in the operating rooms
2) visiting land based Mercy Ship projects
3) running an Anaesthesia Conference.

Travels

Our journey to Lome via Paris was uneventful unlike that experienced two weeks later by five of my conference team who went on a 36 hour detour via Casablanca. Our Swiss friend Pierre kindly managed to help us circumvent the normal slow arrival process at the airport by using his special badge. During the drive to the ship he described a visit by a local orthopaedic surgeon who was surprised at the number of club-feet being treated by the Mercy Ships team mainly using the Ponsetti technique. He said that he was not aware that there were so many children with this problem in Togo but, as Pierre commented, his private clinic is too expensive!

At 7am on the first morning I made the mistake of going for a jog with two more acclimatised and fitter crewmembers. 40 minutes later I had to walk back to the ship after being physically drained by the heat and the oppressive air as a result of the Harmattan, a hot choking wind blowing fine particles of dirt from the Sahara.

In the operating rooms (ORs)

Only four of the six were being used because of unacceptable noise from the two harbour generators which along with the four Fricks will all be replaced by four new machines in Durban between August and January thus significantly increasing the operating capacity on board when the ship returns to Freetown in February 2011. All the ORs had recently been equipped with a new Paragon Platinum FC430 anaesthetic machine (fig 2) thanks to the generosity mainly of the good citizens of Denver (USA).


Fig 2. Using new anaesthesia machine

These are more compact than the previous second-hand Draegers and worked well both at low flow and for paediatric use.

The anaesthetic team on board apart from myself and Matt from the UK, consisted of consultants from New Zealand, Canada and Germany plus Clo-Anne, a CRNA from the USA. The latter told me that until recently she had worked six years as a solo anaesthesia provider at an 80 bed hospital in Texas, on-call 24 hours a day – maybe Mr Obama needs to address many issues in USA healthcare provision. Guidelines do differ between countries – Nancy from Canada says that at her hospital the total gas flow is not permitted to go below 3L/min if sevoflurane is being used. I found myself relatively supernumerary which allowed me to spend time preparing for the impending conference and also to visit land based projects.

Two ORs were being used for eye surgery each with two tables (fig 3).

Fig 3. Two eye operations

In OR 3 Dr Gary was operating on cleft lips/palates, cases of noma and large facial tumours sometimes requiring fibreoptic intubation (fig4).

Fig 4. Fibre optic intubation

Fig 5. Bent legs.

The 4th OR was used for paediatric orthopaedic surgery. The anaesthetic technique for the children undergoing mainly lower limb osteotomies for bent legs (fig5) consisted of GA plus a caudal with 1ml/kg of 0.25% bupivacaine and clonidine 2mcg/kg.

Post operative morphine infusions were used with a dose of 1mg/kg in 50 ml saline at 1-2 ml/hr. The surgeons were Dr Frank from the USA and Dr Malcolm (fig 6) whose anaesthetist I had been some 20 years before at Wexham Park Hospital in Slough.

Fig 6. Dr Malcolm operating

Malcolm is a remarkable man who was finally retired from the Health Service because of age but for the past six years has been Medical Director of a Mission Hospital in Lusaka (Zambia). He told me about the challenge of constructing a new facility which was to build the walls higher during the day than could be stolen at night!

Educational Projects

Ophthalmologist Dr Glen Strauss was teaching local eye surgeons his sutureless ECCE technique. He had recently visited the Gaza Strip where he discovered that one side of the Palestinian conflict would pay the anaesthetists on the other side not to work.

Glen was also trying to institute a three months training scheme for members of PAACS (Pan African Association of Christian Surgeons) on board the Ship, equally distributed between general surgery, maxillofacial/plastics and anaesthesia.

My colleague Matt commented that one month's anaesthesia was not long enough for them to realise how dangerous it could be. Glen also asked me to consider what education we could provide for anaesthetists on board. The problem is that with such sophisticated equipment and drugs on the ship compared to local African hospitals all one could do to help would be to give training in airway management and pre and post-operative care.

Local friends

I met student William 15 years ago in a taxi in Lome. I helped him initially to complete a computer course and then set up an internet café, using computers supplied by 'Reusing IT' a charity based in Edinburgh. Two years ago, because of the unpredictable electricity supply, I provided him with finance to install solar panels to make the supply of electricity to his computers more reliable. Initially I had baulked at the cost but changed my mind after our cat was run over and the vets bills were similar to amount which William needed.

Recently I had managed to get 20 more computers delivered,12 of which were flat-screened and would help update his internet café named after my wife and myself (fig 7).

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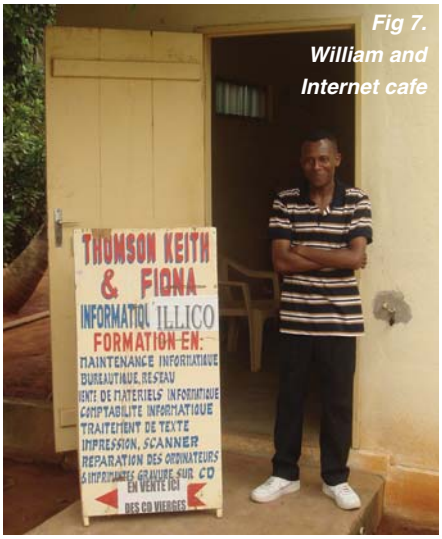

Fig 7. William and Internet cafe

When we visited William's parents' house part of the afternoon turned into an outpatient clinic. A child with a club foot, a young woman with a left quadriceps muscle paralysis (fig 8) (probably as a result of an


Fig 8. Left quadriceps paralysis

intramuscular injection of quinine which is neurotoxic), a child with a hole in the left cheek through which teeth were visible, probably noma (fig 9) and a child with a cleft palate. I did manage to arrange for all to be seen by surgeons on the ship.


Fig 9. Noma

My wife and I went with long-term crewmember Clementine to visit her family house on the outskirts of Lome. There we were privileged to meet her sister, her mother, her daughter and her recently born grand-daughter (fig 10).


Fig 10. Four generations

Visit to land based projects

We accompanied a senior management team, led by Donovan Palmer the new Managing Director (fig 11), on a visit to five shore based sites.

Fig 11. MD of the Africa Mercy

Firstly the Mercy Team House where volunteers who work off ship live then the Hospitality Centre where some patients stay before and after surgery. We also visited the eye screening where patients were being selected for surgery, provision of spectacles or medical treatment with eye drops. At the maxillofacial screening clinic trained nurses were selecting patients to be seen by a surgeon at a later date.

The final stop was at the dental clinic where there was a very comprehensive setup of autoclaves, generators, instruments and a remarkable amount of work being done by a British lady dentist and Dr Dag from Norway (fig 12), who was treating three patients at the same time. A third dentist had returned to the ship because of a needle stick injury, a salutary


Fig 12. Dental extraction

reminder of the risks for medical staff in this part of the World.

The Market

We visited the market with a group of fellow volunteers on two occasions, William and some friends acted as our guides and protectors. I continue to be amazed at what African women carry on their heads (figs 13, 14).


Fig 13 Bag carrier


Fig 14. Chicken hat!

On the first occasion I found some rather unusual British West African half pence coins with the year of birth of both my wife and myself on them. I also bought several metres of dress making cloth for 18yr-old Niki (fig 15) who was born on an island off the coast of Abidjan. I met her in 1991 when she was an abandoned premature baby weighing just over 1kg.

Fig 15. Niki in Canada May 2010

She now lives with her adoptive parents on Vancouver Island. At the end of the first visit we had a drink at a roadside cafe with our team of minders, which now numbered five – the inevitable African wood-carvings seemed to start appearing on our table converting it into a mini market.

The Conference

This took place during our final three days at the main hospital in Lome (CNHU Tokein) and was attended by 99 anaesthesia providers from 23 different hospitals. Our nine strong team including three UK trainees and two French translators all stayed as guests on board the *Africa Mercy*, perhaps some of them might also be tempted to work on board in the future?

We all thought the conference was a success but how one judges whether it might have any long-term beneficial effect on the provision of anaesthesia for the population of Togo I do not know.

I returned home after another very rewarding three weeks in West Africa.

Over the past 19 years it has been a great privilege to have been one of many thousands of volunteers on board the Mercy Ships who have played a small part in helping to make life more bearable for some of the most disadvantaged people in the World.
www.mercyships.org.uk