A Gambian Experience
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Introduction

The main reason for going to Banjul, apart for some winter sun, was to do a three day conference for Gambian anaesthetic nurses. The idea had started a year before when Dr Anuraag had been part of a Mercy Ships surgical team doing cleft lip and palate repair surgery at the Royal Victoria Teaching Hospital (RVTH). She contacted me and I said let's go for it, you organise and I'll help. Between us we gathered a team of 10 anaesthetists, five from Manchester and five from Wessex, consisting of three consultants and seven trainees. The best deal was found to be a Thomas Cook package tour for £600 each to the Laico Atlantic Hotel which was situated beside the beach and just across the road from the RVTH.

The Wessex team (arrived 17th February [fig 1])
Keith Thomson (Consultant, Basingstoke), *Emma Halliwell* (Consultant, Salisbury),
Liz Shewry (SpR 5, Southampton),
Zoe Smith (CT2, Portsmouth),
Claire Khaghani (ST3 Basingstoke – accompanied by husband Jonathan),
Louise Emmett (Midwife, Basingstoke),
Rebecca Thomson (ambulance tech/conference admin),
Duncan Thomson (training for the Marathon des Sables/AV technician).

Fig 1. Wessex anaesthetists + Dr Anuraag

The Manchester team (arrived 18th February [fig 2])
Anuraag Guleria (consultant),
Inese Kutovaja (ST5),
Richard Ramsaran, *Matthew Jackson* and *Lorna Howie* (all ST4),
Jainy Chackorcham (ODP)


Fig 2. Manchester anaesthetists

All the trainees, both from the North West and Wessex, received financial assistance from their Deanery and the conference was also supported by the AAGBI, both financially and by the donation of three anaesthetic text books per delegate.

Day 1 – The Journey

Baggage on the Thomas Cook flight was limited to 20kg in the hold and 5kg of hand baggage but Mercy Ships UK (**www.mercyships.org.uk**) kindly provided a letter which allowed each of us to have a further 10kg of equipment for charitable purposes. At Gatwick the Wessex team discovered they still had more weight than they were technically allowed but innovative means were used to decrease apparent hand baggage for example I put a laptop and an IPAD down the front of my shirt inside my safari jacket and at a final weighing of hand baggage prior to boarding Duncan jumped on the scales thus creating a diversion which allowed a 4kg projector to be slipped on board!

The six hour flight to Banjul was uneventful but it took a further two hours to reach the Laico Atlantic hotel in time for some lounging by the swimming pool, pre-supper drinks and our first experience of the very varied and interesting food at the self-service buffet dinner. I also met with local YWAM (Youth with a Mission) missionaries Sam and Vicky who had kindly helped organise the catering for the conference and came with a packet of dalassies, the local currency, for the team to exchange for pounds.

Day 2 – Anaesthetic staffing/ drugs

The team met Momodou Baro, the senior anaesthesia provider of Gambian origin (fig 3), who had been practising for the past 30 years.


Fig 3. Baro + Cuban anaesthetist

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The only physician anaesthetists in the country were two Cubans and one Indian. The Cubans are there for two years and are paid $250/month by the Gambian government and $300/ month back in Cuba. Their 'normal' salary back home was apparently only $50/month so there was some incentive in going to Africa. The future of Gambian anaesthesia may be in the hands of a young nurse anaesthetist called *Lady* who is now a fourth year medical student. She would like to train as an anaesthetist in the future – but in which country and who will pay?

There were six full time anaesthetic nurses at the RVTH and only four more in the whole country – one at each of the four Government hospitals. There are others who only work part time particularly in private hospitals – most need other jobs to survive. There are 19 trainees currently undergoing a 27 month programme which Baro co-ordinates.

We were taken on a guided tour of the hospital. There was the common African scenario of a limited supply of anaesthetic drugs including no analgesics, few functioning monitors and no staffed post-operative recovery area. Disposable tracheal tubes were used until they fell apart. Caesarean sections were only being done under GA because they had run out of bupivacaine, ephedrine and spinal needles. Their GA technique consisted of thiopentone, suxamethonium, intubation, 0.5% halothane and then, once the baby is delivered, a bolus of syntocinon followed by 50mg ketamine. The annual drug budget for the hospital is about 40 million dalassies, just under £1million, but departments have to compete with each other for their drug requirements.

That afternoon we went to the nearby market accompanied by several local lads known as 'bumsters' whose motto was *it's nice to be nice*! All went well apart from an incident in which Jonathan had a slight contra-temps with an armed guard near the Presidential Palace, no one is quite sure why, other than perhaps he was holding a camera in a large suspicious looking case. It reminded me of the anecdote – 'what do you call an African with an AK 47' – Sir!

Day 3 – church/clinic

Nine of us were transported to the *Gilead Healing and Deliverance Ministries* by Sam and Vicky (fig 4).

Fig 4. In the church

There were 1000 people attending the church service but after about 10 minutes, during which I introduced the team, we were guided to a nearby school to run a free clinic for the poor people of the area (figs 5,6,7).


Fig 5. Matthew in the clinic


Fig 6. Mum and daughter


Fig 7. Checking pills

In nearly three hours we saw well over 100 patients with all sorts of problems, the saddest of which for me was a woman of 60 with a large fungating carcinoma of her right breast with fixed hard axillary nodes. There was nothing I could do other than write a referral letter to an unknown surgeon at the RVTH.
The rest of the team returned to the hotel for an afternoon on the beach but I was invited to lunch by Vicky and Sam, originally from India, who had been missionaries in the Gambia for the past 15 years. After returning to the hotel I had a 10 minute free neck massage, part of the Thomas Cook package, and then dinner with the team at a beach restaurant called *Nefities*.

Day 4 – bird watching

Some of us had breakfast at 04.30am before meeting our local guide for a dawn bird-watching trip in the mangrove swamps. Just after 5 o'clock there was still no sign of him so Louise phoned and was not at all pleased to discover that he was still in bed. He did eventually turn up 30 min later. I think he was probably on what was called locally GMT (**G**ambian **M**aybe **T**ime). We arrived at the boat at 06.30 but then had to wait for another half hour before departure while Thomas Cook clients were bussed from nearby hotels in the area. It was an interesting trip (fig 8). The sunrise at dawn was spectacular (fig 9) but there were very few birds. We probably only saw about a dozen in all in an area that was reputed to be well known for

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Fig 8. Daybreak on the boat

Fig 9. Duncan at sunrise

bird watching. While enjoying a second cooked breakfast we disembarked at a place called *Lamin Lodge* where, standing amongst piles of discarded shells (fig 10) we were given a talk by a local man about the commercial uses of oysters.

Fig 10. Shells

We then drove to *Abuko Nature Park* (fig 11) for a two hour walk before returning to our hotel.

Fig 11. Entrance to nature reserve

We saw some birds there including a swallow-tailed bee eater, a black kite (fig 12) and numerous vultures sitting (fig 13) in a tree above an enclosure where there were several hyenas

Fig 12. Black kite

Fig 13. Vultures

(fig 14). We also fed some monkeys (fig 15).

Fig 14. Hyena

Fig 15. Feeding a monkey

The morning had cost us each about £15 but the 'official' Thomas Cook clients had paid £42 each for exactly the same trip.

Early that evening I went to the house of the missionaries Sam and Vicki to attend a meeting with people involved with various NGOs in the Gambia. I was guided there in a taxi by a man called Bob who, interestingly, had had a cleft lip repaired (fig 16) a year ago by

Fig 16. Bob's well repaired lip

Dr Tony Giles of Mercy Ships and our current team leader Dr Anuraag may well have been his anaesthetist.

Back to the Hotel

Fig 17. Laico Atlantic Hotel

The Laico Atlantic (fig 17) was situated beside a beautiful sandy beach, along which some of us used to go jogging at the cooler times of the day, either at 0730 or just before supper. We were often accompanied by up to six dogs all of whom were friendly – no sign of excessive salivation or craziness. We used to run about 20 min each way along the sand past a dead dolphin which attracted an increasing number of vultures as the week progressed.

Fig 18. Marathon des Sables man

Duncan used this opportunity to train in heat and sand for his attempt at the 150 mile long *Marathon des Sables* in the Sahara in April. He sometimes ran for over two hours during the hottest time of the day wearing an all-in-one white suit and red cap,

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carrying running poles plus up to 12kg of water bottles in specially designed back and front packs (fig 18). This training undoubtedly helped him finish 255 out of 795 finishers in the 2012 MDS, the World's toughest foot race.

Day 5 – Conference Day 1

After registration at which all delegates were given a lanyard, a pouch containing a name badge and a printed programme, there was a welcome ceremony. I gave the first presentation on *Anaesthesia in Africa*, illustrated by some of my experiences over 20 years in West Africa and more recently also in Uganda. Baro then gave an interesting talk about anaesthesia services in the Gambia, followed by a trauma lecture by Liz and a presentation about *drugs in anaesthesia/management of the sick laparotomy patient* by Matt. The last event before lunch was a trauma assessment/resuscitation demo with Jonathan playing the patient and Liz leading the 'admitting' team (fig 19).


Fig 19. Trauma moulage

Zoe was the narrator and projected relevant slides on the wall behind the patient. The whole scenario was extremely effective. The afternoon consisted of four workshops:


Fig 20. BLS workshop


Fig 21. Intubation training

the acutely ill patient for laparotomy, *Basic Life Support* (fig 20), *difficult intubation* (fig 21) and *resuscitation of the obstetric patient.* We then had a prize quiz which consisted of statements projected on a wall. The delegates were made to stand up and when they had read the question they had to shut their eyes and put their hands on their heads (fig 22) if they


Fig 22. Quiz - the answer is 'true'

thought the answer was true and by their sides if they thought the answer was false. The eventual winner was given a cash prize. The quiz has now proved to be a popular event in six different African countries. Before they left each delegate was given a conference T-shirt (fig 23).

Fig 23. T-shirt

Day 6 – Conference Day 2


Fig 24. Listening to a lecture

The morning consisted of four more lectures (fig 24), *Obstetric Physiology*, *Obstetric Emergencies*, *Newborn Life Support* and *Oxygen Therapy*. The afternoon workshops consisted of *Obstetric Team Scenarios* (fig 25), *Obstetric Patient Arrest*,


Fig 25. Obstetric emergency moulage

Newborn life support (fig 26) and


Fig 26. Neonatal life support

Management and Recognition of the critically ill child. During this day the anaesthetic delegates were joined by nine midwives. Louise organised a competition to guess the amount of blood in several different receptacles (fig 27).


Fig 27. Blood competition

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Just before lunch Iranian born obstetrician, Mr Hassan Azadeh, gave a fascinating presentation on FGM (female genital mutilation). Apparently there are 33 countries in the World where this is still practised. He said it is not an Islamic custom and is not mentioned in the Koran. Apparently between 60-86% of women in the Gambia have undergone this barbaric practice which can lead to physical/psychological/social and sexual problems. One of the delegates did say to me 'what on earth does that have to do with anaesthesia?' I agreed but said it was an interesting talk anyway.

Day 7 – Conference Day 3

Morning lectures were on *management*, *recovery issues*, *paediatric anaesthesia*, *WHO check list* and lastly *audit/critical incident reporting*. These were followed by a final competitive quiz and then presentation of prizes for the essay (fig 28) and the blood loss competitions.

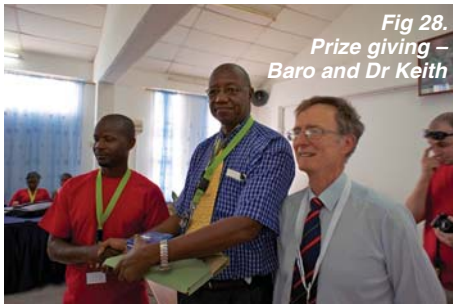

Fig 28.
Prize giving – Baro and Dr Keith

The final event was a brief closing ceremony followed by the presentation to every delegate (fig 29) of an

Fig 29.
With AAGBI donated books

attendance certificates and three text books (Oxford Handbook of Anaesthesia, Anaesthesia in the Developing World and Obstetric Anaesthesia – fig 30) supplied by TALC and funded

Fig 30
3 textbooks and certificate

by the AAGBI. Jonathan showed an excellent five minute video he had compiled.

During the morning I had a meeting with Baro and the hospital CEO Dr Ahmet Secka about the possibility of senior trainee anaesthetists coming to help with training on an on-going rolling basis. My idea is for trainees to spend two months at RVTH, overlapping with their predecessor and successor for one month. Dr Secka thought it was a good idea and would be able to provide free accommodation but he did not have any resources to offer a salary. My hope is that maybe the deanery could help with finance or even perhaps DFID or THET. The best option would be just to allow them to go on their ordinary pay but maybe this idea would be a step too far for the NHS in these financially challenging times!

Day 8 – The Final Day

I went for a final run along the beach with Duncan and Zoe. We passed the dead dolphin for the last time and then back again to the hotel where we enjoyed the usual excellent cooked breakfast, finished packing and then boarded transport, either bus or taxi, back to the Airport for the return flight to Gatwick.

Before leaving the hotel we said good-bye to all our friends from Manchester who were not leaving until the evening of the following day. Also saying a more affectionate 'au revoir' were several young Gambian men who had become friendly with middle-aged English women. These type of ladies are apparently referred to as *Cougars*. Also at the hotel were some rather older men who seemed to be involved with very young looking Gambian women.

Overall it had been an excellent trip. The holiday hotel on the beach seemed to work well and all members of the team were enthusiastic about returning next year to do a follow up conference. For me it was rewarding to see two of my agendas in West Africa being fulfilled namely bringing anaesthetic education and also encouraging the next generation of anaesthetists to become involved with the problems of that continent (fig 31).

Fig 31
The team and delegates

Postscript – comments from a delegate

I want to register my heart-felt gratitude for the useful conference. We've found it very useful & educative. This is the kind of forum that the Gambian anaesthesia fraternity have been yearning for in many years. This is the first of its kind I hope & wish it continues forever and ever.

In Gambian culture, when one has a visitor, one is expected to feed and shelter him and give him small present when he/she is going home. You people came to The Gambia fed us, cloth us and most importantly gave us knowledge. The books we received are serving as good reference materials. Thanks very much indeed.