Congo Diary: 11-18 May 2013

Dr Keith D Thomson, MB BS, DRCOG, FRCA

Consultant Anaesthetist
Hampshire Hospitals NHS Foundation Trust

African Conference Team (ACTs) - (fig 1)
Dr Keith Thomson, Consultant Anaesthetist, Basingstoke
Dr Wynne Davies, Consultant Anaesthetist, UCH London
Dr Gary Dickinson, Consultant Anaesthetist, Winchester
Dr Philippe Mavoungou, Consultant Anaesthetist, Nantes, France
Dr Willy-Serge Mfam, Consultant Anaesthetist, Orléans, France
Dr Liz Shewry, Post CCT trauma fellow, Southampton
Dr Zoe Smith, ST3 Anaesthetist, Southampton
Dr Alistair Proud, ST3 Anaesthetist, Portsmouth
Dr Judith Highgate, ST3 Anaesthetist, Canterbury
Dr Maria Saito Benz, ST3 Paediatrician Southampton
Ms Louise Emmett, Senior Midwife, Chertsey
Ms Hatty Ivey, Midwife, St Thomas's London
Mrs Mireille Benge (Mimi), translator and Zumba instructor
Ms Beatrice Ivey, translator


Fig 1. The team

Introduction

Congo (Brazzaville) is a former French colony with a population of about 3.5M. It should not be confused with it's much larger and more chaotic neighbour the DRC (Democratic Republic of Congo), the former Belgian colony.

The reason for organising the anaesthesia and midwifery conferences was to gain some insight into the provision of medical care in the country prior to the arrival of the *Africa Mercy* in the Atlantic port of Pointe Noire. The Mercy Ship, equipped with 5 operating theatres, 80 ward beds and a volunteer crew of 450, is scheduled to arrive on the 9th of August and stay for ten months. (www.mercyships.org)

Setting up the visit had its challenges: 10 days before our arrival neither visas nor accommodation were finalised. However, as Congolese born Dr Philippe (fig 2.) kept telling me *don't worry Keith, everything in Africa is arranged at the last minute*. That indeed proved to be the case. Visas were organised by the Mercy Ships advance team and rooms were booked for us at the Hotel du Boulevard by Dr Peggy Mwandza, chair of the local organising committee.

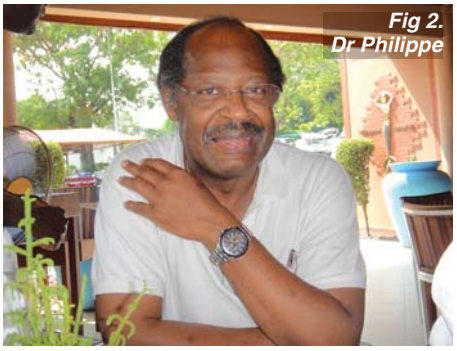
Fig 2. Dr Philippe

Interestingly, in this part of Africa hotels do not provide twin bedded rooms only doubles for the use of either one or two people. The bed and breakfast rate at the hotel was 80 euros/room/night, but on arrival at the airport we were informed that the Ministry of Health had generously covered the costs.

Day 1 – Arrival (11th May)

Twelve of us left on an early morning flight from London Heathrow to Paris where we were joined by our French based colleagues Dr Philippe and Dr Willy-Serge. We arrived at Maya Maya Airport in Brazzaville on schedule but then had to wait for about two hours after collecting our luggage while our free visas were being sorted out by a charming man referred to as 'The Colonel' and Marina whose role was to liaise with the Government on behalf of Mercy Ships. We then boarded a coach kindly provided by the MOH for the week which took us to our hotel where we enjoyed a very welcome Ngok beer (fig 3), the local brew, which came in 650ml bottles.


Fig 3. Cheers!

In my room I turned on the taps in the basin to wash my hands and immediately got wet feet but there was a drainage hole in the floor! But, as they say, *TIA (This is Africa)*. However the shower worked, the bed was comfortable with clean sheets and there was an electrical power socket from which I was able to charge up my laptop, mobile phone and kettle, although I always used a surge protector in case of power cuts.

Day 2

After the first of several 6.30am runs with Dr Zoe and Dr Gary followed by an exercise session lead by Mimi (fig 4), we joined the more sane members of the team for breakfast (fig 5) after which we went on a guided tour of Brazzaville lead by Dr Philippe.

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Fig 4. Early morning joggers


Fig 5. Breakfast at the Boulevard

We initially stopped at the large memorial to Pierre Brazza (fig 6) who had founded the city in the late 1880s.


Fig 6. Pierre Brazza Memorial

From the bank of the Congo River we viewed Kinshasa the capital of the DRC (Democratic Republic of Congo) on the opposite bank (fig 7).

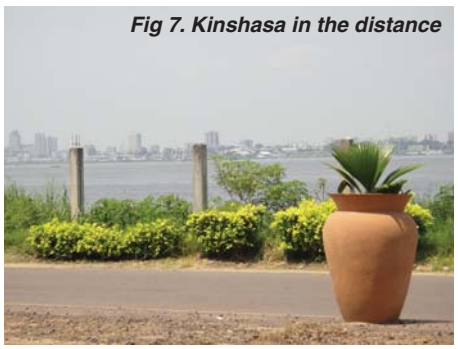
Fig 7. Kinshasa in the distance

Mimi's father was born in Brazzaville and her mother in Kinshasa; they had emigrated to Canada before she was born (fig 8).


Fig 8. Mimi, whose parents were Congolese

This was her first visit to the Congo. We watched some children happily swimming through one of the rapids using big plastic water bottles as flotation devices (fig 9)

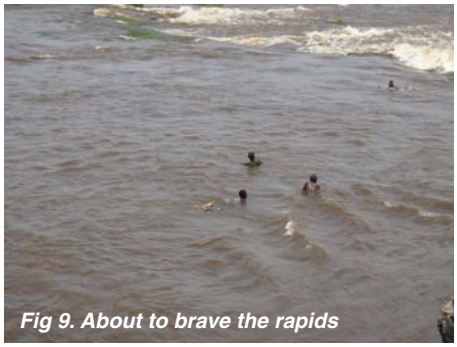
Fig 9. About to brave the rapids

We then enjoyed an excellent lunch at the Mami Wata (mermaid) restaurant (fig 10).

Fig 10. Mami Wata restaurant

Later that afternoon Dr Peggy took Mimi and me to a Pentecostal Church. The journey involved driving up a steep muddy hill in the coach to join a congregation of about 1,000 people. As a visitor and the only white person, I was asked to say a few words. I informed the congregation about the date of arrival of the *Africa Mercy* in Pointe Noire and about types of operations which would be performed free of charge on board over the next 10 months. I apologised (jokingly) that the ship could not come up river to Brazzaville as there were a few waterfalls en route.

But I informed them that a screening would also be held in Brazzaville in November. We left the service after an hour because we had been seated near one of the main speakers and the music was painfully loud.

Day 3

We started by visiting the impressive conference centre (Prefecture) (fig 11) to assess the available facilities in advance.


Fig 11. Conference centre (prefecture)

Once we had found 'the man with the key' we gained access to both the main auditorium and the rooms allocated for workshops. The colour of the screen (sort of brownish) we thought was not ideal but it turned out better than expected thanks to Dr Wynne and his expertise with projection equipment. The promised local technician did not seem to be available. We were then driven to the main teaching hospital, CHU Brazzaville, where we saw the new operating theatres after dressing up in gowns (fig 12), post-operative


Fig 12. In theatre garb


Fig 13. ITU bed

recovery area, and intensive care unit with state of the art equipment which had all been installed in the previous six months (fig 13). Unfortunately the ICU seemed to lack any drugs required to provide a reasonable service. Staff told is they were unable to ventilate a patient as the relatives had to pay for the sedative drugs – most could not afford them. The ITU had at least five syringe pumps beside each bed but we didn't see a single syringe in any of them. The situation reminded me of the anecdote about being given a Rolls Royce but no petrol to run it. We visited the labour ward where staff claimed to have 15 to 20 deliveries per day. There was no analgesia available during labour but the majority of caesarean sections were performed under spinal anaesthesia using 2ml plain bupivacaine plus 25mcg fentanyl. There was minimal post-op analgesia except tramadol or paracetamol, when available. It was good to see our conference advertised near the hospital entrance (fig 14).

Fig 14. Advertising banner

We then visited the Makelekele hospital which had definitely not been recently renovated (fig 15)

Fig 15. Makelekele hospital.

although it did advertise treatment for a wide range of conditions (fig 16). There was a discarded anaesthetic machine outside theatre (fig 17) and we saw a woman in the antenatal area having an eclamptic fit.

Day 4 – Conference Day 1

The organisers were expecting about 180 delegates but said that

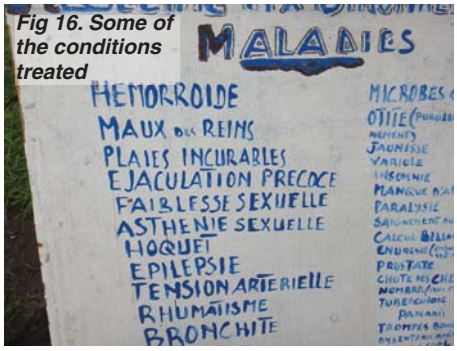

Fig 16. Some of the conditions treated


Fig 17. Discarded anaesthetic machine

over 300 had registered on the first day. There were about 25 midwives, over 150 anaesthesia providers and various other medical practitioners including obstetricians, surgeons and medical students. The initial talk about maternal mortality worldwide was given by Professor Iloti. His excellent presentation included a very interesting fact that the MMR (Maternal Mortality Rate) in the Congo had fallen from over 700 to 400 during the past 4 years due to the introduction of free caesarean sections. Doctor Peggy gave a presentation about the situation with anaesthesia in the Congo. She gave an impassioned request in front of television cameras for more supplies to back up the recent building programme at CHU Brazzaville (fig 18).


Fig 18. Dr Peggy presenting

After an excellent lunch at a local restaurant for the faculty and all delegates financed by the MOH we had the opening ceremony (a few hours late) presided over by a representative from the Ministry of Health. After this, a PPH moulage starring Dr Alistair as the patient caused some hilarity (fig 19).


Fig 19. PPH moulage

The workshops went well but a decision was made to move faculty members between rooms rather than the delegates.

A portable HP printer I had brought allowed me to run off 50 copies of the *Lifebox* needs assessment form which Sarah Kessler emailed us from the London office. While I was doing this, back at the hotel I missed a near riot which occurred when team members handed out t-shirts (figs 20, 21) to delegates as they left the main auditorium at the end of the day.

Fig 20. T-shirt for midwives

Fig 21. T-shirt for anaesthesia providers

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Interestingly our team was blamed for the disturbance by not distributing the t-shirts to the delegates while they were still seated. That evening Dr Philippe took us all out to a local club for cocktails (fig 22) and a

Fig 22. Liz, Lou and Jude share a well earned cocktail

dance (fig 23).

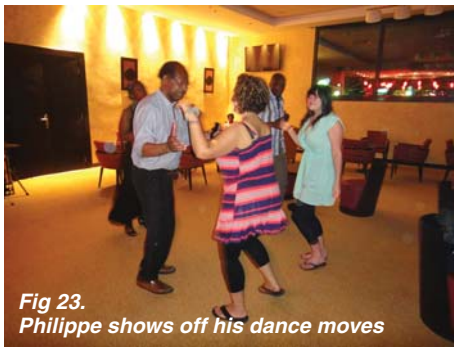

Fig 23. Philippe shows off his dance moves

May 15th – Conference Day 2

I gave a talk on post-operative recovery care which, from my experience in Africa, is either absent or poor, patients often going straight from theatre to the ward without anyone looking after them in that critical period from the end of surgery to when they are awake, pain free and physiologically stable.

Fig 24. Post-operative recovery area

I showed a picture of the brand new post-operative recovery ward at CHU (fig 24) which much to my surprise resulted in general laughter from the audience. I also gave a presentation on 'Airway Adventures in Africa' talking about some of the large tumour cases I have been involved with over the past 20 years on board the Mercy Ships in West Africa. En route to lunch I saw a man in the front of a minivan taxi with a huge ameloblastoma on the right side of his jaw. I hope he hears about the arrival of the *Africa Mercy*.

That afternoon I met Dr Philippe's sister, a senior midwife and also Dr Yanik Makambila a medical anaesthetist who both work in Pointe Noire where the Africa Mercy will be docked from August 9th. I hope to meet them when I visit that city briefly in August for a Mercy Ships International Board Meeting. Our team ran various airway skill stations including the use of the

Fig 25. Gary demonstrates the I-gel

I-gel (fig 25), *Airtraq* (fig 26) and the

Fig 26. The Airtraq

McGrath video laryngoscope (fig 27) which proved to be a very useful because others were able to watch

Fig 27. intubation with a videolaryngoscope

on the screen the efforts of the person who was trying to intubate the dummy, either directly or using a bougie. I was surprised when one man picked up a bougie and said 'what on earth is this, I've never seen one', and another lady inserted a bougie correctly but then tried to intubate the dummy with the tube upside down, only realising what she was doing when the connector impinged on the front teeth. Dr Alistair also demonstrated the technique of cricothyroidotomy (fig 28).

Fig 28. Cricothryotomy with Alistair

In another room Dr Maria taught neonatal resuscitation (fig 29).

Fig 29. Maria demonstrating resuscitation

I visited the room where 25 midwives were being instructed by Louise and Hatty with Beatrice translating (fig 30).

Fig 30. Midwifery conference

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Fig 31. Dancing in labour!

For my benefit they all did some fun dance moves (fig 31) they had been taught by Louise to mimic movements to teach women in labour. Apparently a local obstetrician had told Louise that breech delivery by midwives was illegal in Congo and she should not teach this technique.

That evening we dined once more at the excellent Mami Wata Restaurant and were joined by Tracy and Andrea of the Mercy Ship advance team. Apparently just over one year ago there were three major incidents in the country. First of all a huge explosion in a munitions factory situated in a crowded suburb of Brazzaville which killed about 300 people and injured at least 2000 more. This was followed by both the crash of a cargo plane in a populated area, and then a train crash near Pointe Noire. The Mercy Ships team have been asked to reserve places on the operating schedule for victims of these tragedies suffering from burns contractures. Tracey told me an amusing anecdote that word had gone out that Mercy Ships were going to do breast augmentation surgery – obviously someone had typed 'plastic surgery' into Google!

May 16th – Conference Day 3

This involved various topics – see programme under CONGO on the website **www.africansmiles.co.uk**, including *Lifebox* training. We were given an interesting presentation on a new 'wonder drug' for post-operative pain – the use of an infusion of IV lignocaine. The local anaesthetist mentioned 20 cases he had done over 3 years for major abdominal surgery and claimed it was very effective although he didn't actually compare it against any other technique.

After another excellent buffet lunch proceeded by some impromptu

Fig 32. Pre-lunch exercise

dancing (fig 32) to the entertainment of a band providing background music at the restaurant we returned on foot avoiding the drainage ditches (fig 33) to the conference centre

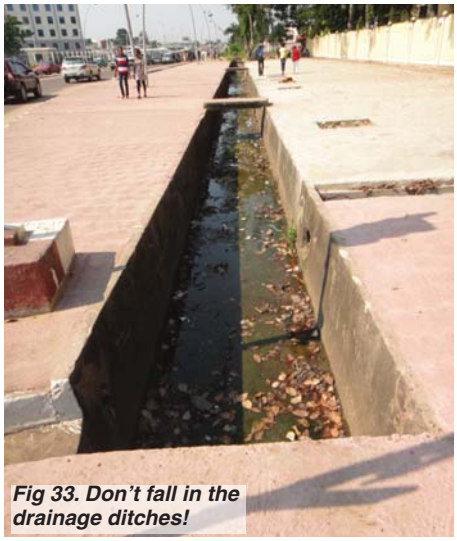

Fig 33. Don't fall in the drainage ditches!

(fig 34), for the final afternoon session.

Fig 34. Main lecture room

At the closing ceremony a few words were said by Dr Philippe, followed by myself. I thanked our hosts for organising the conference and looking after us so well. I particularly mentioned Dr Peggy who was chair of the organising committee and presented her with one of three *Lifeboxes* generously donated by a team member. I emphasized the importance of the WHO checklist and also the use of a *Lifebox* on every anaesthetised patient and suggested that, although there were still over 70,000 operating rooms in the world which apparently do not have a pulse oximeter, I would like the contribution to that figure by the end of 2014 from the Congo to be zero. The Director General of the Ministry of Health then spoke and he suggested, in front of the TV cameras, that the MOH would fund *Lifeboxes* for every operating room in the Congo if training could be provided. This was reported in the newspapers and on the Internet but was edited out of a television programme.

That evening the whole team were invited to a very enjoyable dinner at the home of Dr Peggy's parents. The excellent meal included barbecued piglet from her father's farm and fish from the Congo River, washed down with various liquid options which included whisky, sauternes and a selection of other wines.

Day 7

The team gathered at 8am in the hotel foyer in anticipation of a trip to see some gorillas. Unfortunately this did not happen as we did not have the appropriate permits and not enough time to obtain them, so we went to a holiday resort an hour out of town where we had an excellent swim in the pool. The only problem there was they then tried to charge us 10,000 of the local currency each (about £13) in retrospect for the pleasure of having had a swim (fig 35).

Fig 35. An expensive swim

There was nowhere this figure was advertised around the pool and they had not told us in advance that this was the case. With the help of Dr Willy-Serge a half price deal was arranged. We then drove to an out-door restaurant situated beside a tributary of the Congo River, where we had lunch, which apparently had been very generously paid for by the President.

This included barbecued fish and crocodile. We then went on an interesting boat trip down the river, in two large piroques lashed together (securely?) (figs 36, 37) – we were not

Fig 36. Golden girl Zoe awaiting the river cruise

Fig 37. Pirogues in tandem

sure the boatmen had actually done this before but we eventually arrived at our destination, the main Congo River (fig 38), turned round and motored

Fig 38. Congo river fishermen

back upstream to our departure point, arriving just as the sun began to set. That evening our charming French colleague Dr Willy- Serge, (fig 39)

Fig 39. Dr Willy-Serge

who was born in Russia, trained in Belgium and whose parents were from Cameroon, flew back to Paris to attend a family wedding. He had done an excellent job as a presenter, workshop organiser and translator.

The final day

Some of the team went straight to the swimming pool at the Olympic Hotel, this included Zoe and Judith who were given a morning of viva practice for their impending final FRCA exams by Wynne and Gary (they both subsequently passed at the first attempt), while others visited a local art gallery and craft market (I bought a model wooden vehicle based on the story of *Tintin in the Congo*!),and then joined the others at the hotel for lunch.

Airport check-in that evening was no problem. The 'Colonel' was there to help us again. We also met and were able to thank the advisor to the President on healthcare issues, who had sanctioned payment for the team's accommodation at the Hotel du Boulevard.

In Conclusion

It had been a great week with a fantastic, committed team – what an experience for Zoe, Judith, Maria and Alistair, the four trainees. Thanks also to our translators Mimi and Beatrice with backup from Philippe and Willy- Serge. Hopefully we may be able to send another team out in the next few months to do *Lifebox* training to follow up the pledge of the Director General of the Ministry of Health that they would supply *Lifeboxes* to every operating theatre in the Country. I have asked Dr Peggy to find out how many anaesthetists there are in the Congo as, in my opinion, each one should have their own personal *Lifebox*.

We are also starting to plan an Anaesthetic Conference in Pointe Noire during the last week of March 2014 and also a Midwifery Conference in May 2014. Having the *Africa Mercy* available to provide secure accommodation for the team will make things much easier, particularly if Keith Brinkman, a Mercy Ships long term crew member and Programme Director, is again able to organise similar excellent assistance to that which he provided my team in Guinea (Conakry March 2013), Togo (Lome May 2012) and Sierra Leone (Freetown 2011).

A trainee perspective by *Dr Zoe Smith* (ST3 Southampton)

As a trainee with a particular interest and involvement in developing world anaesthesia initiatives, I am often asked to justify what can be gained from a training/career/CV point of view from gallivanting around Africa teaching anaesthesia. Whilst the primary aim of such projects is always to benefit local healthcare providers, I have become increasingly aware of the benefits of such experiences to my own personal development.

Prior to departure, there is considerable planning for a conference in a country like the French speaking Congo. This included liaising with local anaesthetists to finalise a programme, planning lectures and workshops, obtaining funding, and borrowing equipment for teaching purposes. This particularly tests time management and organisational skills, especially when it must be alongside normal rotas (and exam revision).

Once on the ground, preparation and good teamwork was key to the success of this conference. It was essential to quickly integrate the faculty, which consisted of a mixture of old hands and new faces, into a close-knit team with a common goal. Days were long and hot with "African time" often not allowing things to be done most efficiently and translation adding a extra dimension. It was essential to gain an understanding of the local health system, facilities and problems prior to commencing the conference so that needs could be appropriately addressed and teaching styles adjusted to suit the facilities and attendees' expectations.

An array of skills and attributes desirable in a good anaesthetist were tested and developed by taking part in this conference. These included good communication, multidisciplinary teamwork, commitment, flexibility, dependability, management and organisational skills. The ability to adapt quickly to teaching in a country very culturally different to our own was essential. I returned home with a clear sense of achievement, a renewed appreciation of the NHS and our own training system, moderately improved French and a sun tan. All in all, a fantastic use of study leave.