A WACSy time in the Cote D'Ivoire (28 Feb-7 March 2015)

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Introduction

I was part of a five strong team representing Mercy Ships (**www.mercyships.org**) and ACTs (African Conference Teams) who attended the 55th annual WACS (West African College of Surgeons) meeting. This had previously been held in Nigeria (13 times), Ghana (9), Sierra Leone (5), Senegal (5), Cameroun (4), Togo (4), Benin (3), Cote D'Ivoire (2), Guinea (2) and The Gambia + DRC one each. In 2014 it was in Kumasi (Ghana), this year it was in Abidjan. Next year's meeting will take place in Yaounde, Cameroun from 14-20 February.

The Team (fig 1)

Dr Keith Thomson, *Consultant Anaesthetist (retired)*
Dr Gary Dickinson, *Consultant Anaesthetist, Winchester*
Dr Joe Masters, *ST5 Anaesthetist, London*
Dr Adam Beebeejaun, *CT1 Anaesthetist, Boston (Lincolnshire)*
Mr Stefan Lako, *Mercy Ships IOC, Texas, USA*


Fig 1. My team

Visa

Obtaining this was a challenging business. After paying 58 euros and booking an appointment on the website, I was 5 min into my train journey to London when I was phoned by a lady from the Ivorian embassy to say that the country had won the African Nations cup (9-8 on penalties against Ghana) the evening before and the staff were all taking the day off to celebrate. The ticket office lady at Ascot station very kindly gave me a refund as she thought my excuse was so extraordinary it must be true. I returned the following day with all the required paperwork but forgot the essential yellow fever certificate. This was rectified after a 3 hr round trip. I collected my passport 48hr later. However at Abidjan airport after an uneventful Air France flight, entry formalities were remarkably simple.

The Conference

The venue was the 5 star *Hotel Ivoire* which had the largest outdoor swimming pool (fig 2) I have ever seen.

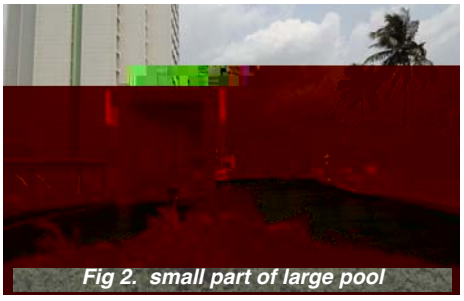
Fig 2. small part of large pool

The chair of the LOC was Prof Alexandre Kokoua.

A team representing Mercy Ships had been invited by the current and 27th President of the executive committee of WACS, Prof Yangni-Angate who had visited the *Africa Mercy* in Pointe Noire, Republic of Congo.

After a challenging registration process we found our way to the WACS anaesthesia section meeting chaired by my old friend Prof Stella Eguma from Nigeria whom I had last met in 2008 in Monrovia at the JFK Hospital. She spent a year there running the anaesthetic service and training anaesthetic nurses.

Various issues were being discussed including low fellowship pass rates, the naming and shaming of those who had not yet paid their annual sub and also those who were not pulling their weight on committees (one person responded that he did not know that he was on that committee!). They also discussed bringing in OSCEs as part of the fellowship exam. I suggested that my colleague Joe might help give advice on the latter as he had recently passed his final FRCA.

Currently the WACS anaesthetic fellowship takes 5 years but they are considering introducing a three year Masters programme. The available one year DA (Diploma in Anaesthetics) is now not proving popular as most want to continue and gain the higher qualification.

That afternoon there was an impressive opening ceremony with about 150+ WACS members attired in red gowns and mortar boards progressing slowly to music into the main conference hall. This was followed by various introductory speakers including the Minister of Health and AIDS (fig 3) and Carlos Pellegrini from the USA, recent past President of the ASA who was given an award (fig 4).

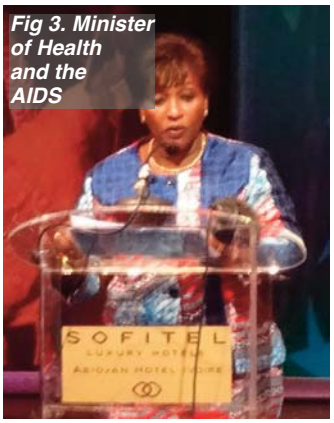

Fig 3. Minister of Health and the AIDS


Fig 4. Carlos receiving award from Prof Yangni-Angate

The majority of the delegates were from Nigeria (population now approaching 200 million) but I met old anaesthetic friends Michael Koroma and Eva Hanciles from Sierra Leone (fig 5) as well as Martin Chobli from Benin and surgeon Lawrence Sherman from Liberia.

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Fig 5. With Eva and Michael from Freetown

The devastating Ebola epidemic in nearby countries did not seem to have prevented doctors from attending. It was good to meet Dr Andy Leather from Kings College London, also involved with the *Lancet Commission* and various interesting surgeons from the USA including Prof Sherry Wren from Stanford and Prof John Tarpley + educationalist wife Margaret from Nashville. (fig 6).

Fig 6. Sherry, team 'Tarpley' and Andy

The food provided was excellent – the buffet lunch, assuming you arrived on time and were at the front of the queue was substantial and the menu at the superb Gala Dinner (fig 7) accompanied by fine French wines was remarkable.

Fig 7. Gala dinner menu

Unfortunately the entertainment consisting of more than an hour of dancing accompanied by loud drumming followed by a shouting stand- up comedian and loud disco type music was not to my taste.

Overall the conferenced organisation left room for minor improvements. Registration queues unless you arrived early were long (ask Gary!). None of our team ever received our name badges – there was a daily bird's nest of badges which never seemed to include ours (fig 8).

Fig 8. Where is my badge?

Finding the appropriate lecture venue also seemed to be a daily problem as the names seemed to change.

The single session dedicated to anaesthesia during the whole week barely lasted two hours. Members of our team had submitted two items for oral and two for poster presentation but these had not been confirmed. On arrival we discovered that only one of the oral presentations had been accepted and that had only been allocated 5-10 min – I needed at least 30min for '*Airway Adventures in Africa*' but managed to show 54 slides in 15 min. Joe (Availability of essential anaesthetic resources in Malawi: a nationwide survey of 26 hospitals) and Adam's (*Preventing post-operative deaths in Sierra Leone: impact of Lifebox and the Safer Surgical Checklist*) posters had been translated as requested into both French and English but had to be presented orally and not displayed (fig 9a, 9b). They both did an excellent job in the circumstances.

Prof Martin Chobli (fig 10) gave a couple of interesting presentations. He has, with backing from the Catholic University of Louvaan in

Fig 9a. Joe presenting

Fig 9b. Adam presenting

Fig 10. With Prof Martin Chobli

Belgium, run an excellent anaesthesia training school over the past 18 years for French speaking African doctors in Cotonou (Benin).

He emphasised that the lack of professional physician anaesthetists is a real problem for health systems in Africa. Most anaesthetics are still provided by para-medical staff. His training school has had 154 candidates from 17 francophone countries, the 'brain drain' has been 17%, dropout rate 3% and mortality/incapacitation 12%.

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The average time taken to complete his course is 5.3 years. He stated that in five West African countries there had been a significant increase in physician anaesthetists over the past 30 years:

1984	
Cote D'Ivoire	**10**
Benin	**3**
Burkina Fasso	**2**
Niger	**1**
Togo	**1**
2014	
Cote D'Ivoire	**118**
Benin	**25**
Burkina Fasso	**23**
Niger	**15**
Togo	**10**

But there are still no physician anaesthetists in the Central African Republic or Guinea Bisseau. To that list I can add Liberia and The Gambia.

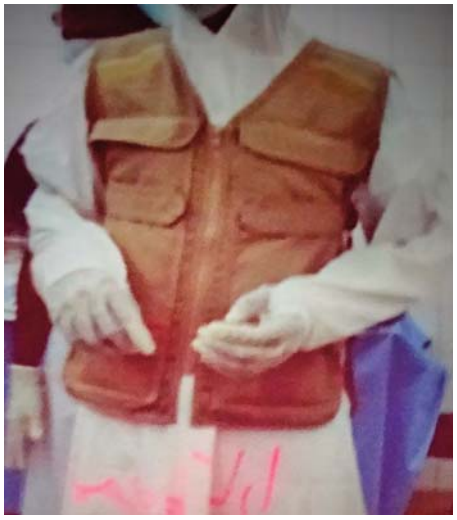
Prof Chobli concluded by stating that co-operation between anaesthetists from the developed world and their colleagues in developing countries can change 'the bad face of the dangerous practice of anaesthesia'. He mentioned particular organisations currently involved in training in Africa which included the French Society of Anaesthesia and Reanimation Program in Africa, Special co-operation with Cardiff University and Mercy Ships.

Prof Sherry Wren from the USA summarised the current situation with Ebola. She was then followed by Freetown surgeon Dr Kamara (fig 11)

Fig 11. Michael Kamara from Freetown

from.01

and Monrovia surgeon Dr Sherman (fig 12) who discussed general surgical issues resulting from the epidemic, like operating in protective suits (fig 13).



Sadly 12 doctors in Sierra Leone and 5 in Liberia have died during the epidemic which included a Ugandan surgeon I met at Redemption Hospital in Monrovia 15 months before.

Local Hospital Visit

Gary and I visited CHU Cocody the main public hospital in Abidjan. I had left my phone in the taxi but Dr Yapi our host just rang the number and the driver returned it – justifying a generous tip!

We were met by three of the department's 14 anaesthetic consultants (there were also 12 trainees, 4 from each of the final three years of a four year training course). Apparently every morning at 7.30 am there is a department meeting for two hours to discuss all the cases from the previous day. A pile of anaesthetic charts, each of which had been meticulously filled in, were on a table.

We were then shown round firstly the 5 bedded ITU and 3 bedded HDU which seemed well equipped and staffed (fig 14) although there was

only one patient (fig 15). Sedation for ventilation was provided with fentanyl and midazolam infusions with additional boluses when necessary. The cost to the patient is at least 50,000 CFA ($100) per day. There were about 6,000 deliveries annually in the Maternity Department with a 33% C-section rate, costing 150,000 CFA ($300) each – the Government are discussing the introduction of free sections. They do on average ten per day, mostly under spinal anaesthesia using 26G pencil point needles and 10mg of Marcain plain. The three maternity theatres were staffed by three anaesthetic nurses, one of whom is always responsible for post-operative ecovery. The senior midwife was willing to let us see their statistics which showed an MMR of almost 1000 (fig 16).

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There was even a 5% epidural rate (cost per procedure 50,000 CFA or about $100). The neonatal unit looked well equipped and staffed (figs 17, 18).

Fig 17. Neonatal unit

Fig 18. Healthy newborn

Anaesthetic drugs readily available included thiopentone, propofol, ketamine, (etomidate in the cardiac dept), vecuronium but no suxamethonium, morphine (provision is free), plain Marcain, ephedrine, atropine, isoflurane, halothane (no sevoflurane), ondansetron was available at $10/ampoule.

We plan to return from 5-12 December 2015 to do a three day anaesthesia conference at the hospital. It was unique to be able to make arrangements face to face (fig 19) in advance.

Fig 19. Local anaesthetists

Bernadette

At 7am on our first morning the bedroom phone rang – it was the hotel reception saying that I had a visitor (fig 20). I had last seen a distraught Bernadette in Cotonou (Benin) in 2009 on board the *Africa Mercy*. She had travelled there from Abidjan with her 18-year-old daughter Ruth Esther whom I had anaesthetised in 1991 for the repair of her bilateral cleft lip (figs 21a, b) on board the *M/V Anastasis*.

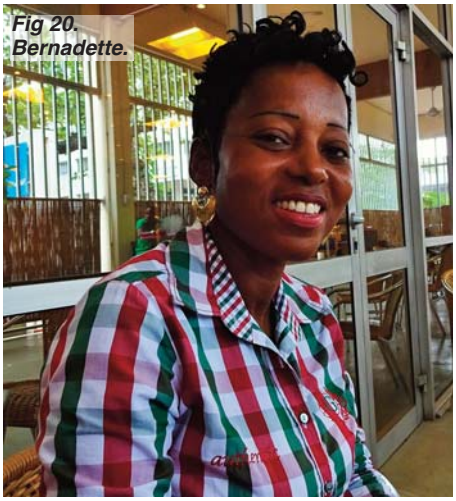

Fig 20. Bernadette.

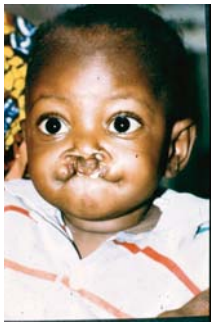

Fig 21a. Ruth Esther pre-op 2001

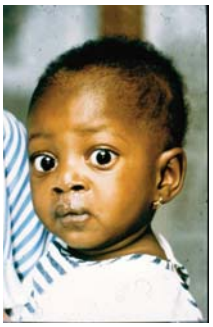

Fig 21b. Ruth Esther post-op 2001

Anaesthesia was complicated by the fact that she had congenital cyanotic heart disease subsequently shown to be a double outlet right ventricle for which some months later she underwent a Blalock Taussig shunt at a hospital in Abidjan. Sadly Ruth Esther collapsed in the market in Cotonou and died (fig 22).

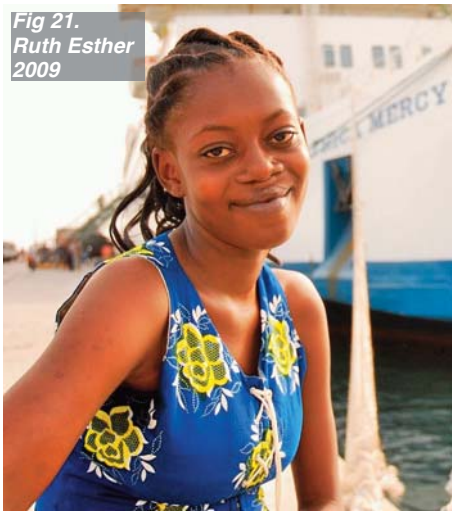

Fig 21. Ruth Esther 2009

As I was still recovering from a late evening arrival and a chest infection I decided to decline Bernadette's offer to visit her church for a three hour service. Later in the day she joined the five of us as our guest (fig 23) at a restaurant where the cost per person was about half her monthly rent.

Fig 23. At lunch with Bernadette

A few days later she invited us all to lunch at her home. She escorted us up the river by water taxi, complete with evangelist (figs 24 a, b, c),

Fig 24a. Queuing for the water taxi

Fig 24b. Floating evangelist

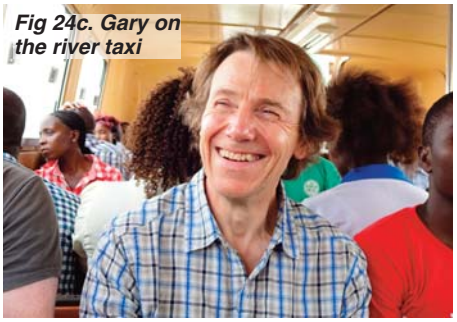

Fig 24c. Gary on the river taxi

then in a blue painted taxi (the colour apparently defined the area of town) to her abode. This was in a relatively poor area but at least the buildings were made of bricks and mortar. Her locked front door (fig 25) led into a single small room with a mat on the floor (her bed), a suitcase (her wardrobe), a box (her dining table) and small stools for us to sit on.

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Fig 25. Entrance to Bernadette's abode

There was no running water or electricity and she cooked on a gas stove. She had prepared a fantastic meal of fish, chicken, rice and foufou mixed with banana (fig 26).

Fig 26. Lunch chez Bernadette

Fig 27. Friendly neighbours

In the communal courtyard there were other friendly ladies (fig 27) plus their children who at the same time seemed both inquisitive and coy (figs 28, 29).

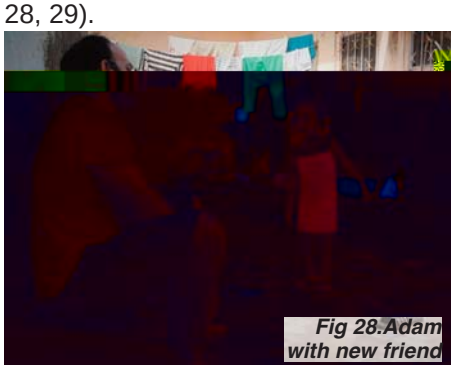

Fig 28.Adam with new friend

Fig 29. Happy kids dancing

We were able to climb up steps onto the roof and view the surrounding scenery (figs 30, 31).

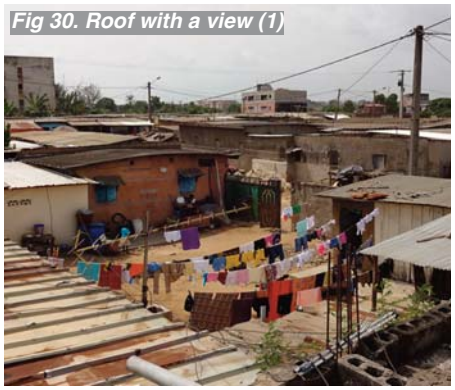

Fig 30. Roof with a view (1)

Fig 31. Roof with a view (2)

It was a privilege for us to have left our 'smart' *Novotel* in the

Fig 32. CBD of Abidjan

Plateau District (fig 32) and to have experienced even though briefly the conditions under which many people in the country have to live. But everyone seemed very friendly and cheerful – as a young woman said to me many years ago in a bar in Verbier (Switzerland) 'People who have no money think it buys you happiness, people who have money know it doesn't.'

Extra curricula activities

We stayed at the *Novotel* in Avenue Charles de Gaulle. It had clean rooms each with a double and a sofa bed which expanded into a single. There was a TV, plenty of hot water, a kettle with coffee/tea and a small fridge (provided on request). The main issue was the daily building works on the floor directly above with unremitting banging and crashing noises from 8am to 6pm. Adam and Joe managed to obtain some recompense which consisted of free breakfasts for the last 3 days, a checkout time at 7pm rather than midday on our day of departure plus two rooms free for 3 days if we returned to the hotel in December. There was also a reasonable sized outdoor swimming pool for the use of guests. The team sampled several restaurants and bars during the week. I remember particularly the street food in Treichville (excellent barbecued capitaine fish + 600ml bottles of beer) (fig 33), a restaurant

Fig 33. Excellent street food

Fig 34. Dining at '21'.

called '*21*' (fig 34) and a reggae club named *Parker Place* (fig 35) which had bible verses in French etched in the roof beams.

Fig 35. Parker Place

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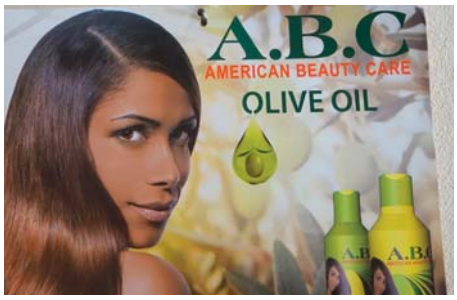
Fig 36. Alternative ABC!



Also a street advert (fig 36) which gives a new meaning to 'ABC'.

In summary

It had been a productive trip for several reasons.

1. A successful networking opportunity
2. Meeting old friends from Sierra Leone, Liberia and Nigeria. Dr Stella Eguma was prepared to discuss the idea of anaesthesia training for English speaking African doctors in Nigeria. At present there is nothing to compare with the excellent training for French speaking doctors provided by Martin Chobli and colleagues in Benin.
3. Setting up future ACTs visits to Cotonou from 26 September-3 October and Abidjan from 5-12 December.
4. Planning to help organise an increased anaesthetic input and also promotion of the Lancet Commission on Global Surgery at the 2016 WACs conference in Yaounde, Cameroon from 14-20 February.

Please view the Lancet Commission video on:
http://www.thelancet.com/cms/attachment/2029397647/2047238420/mmc2.mp4

Lancet Commission on Global Surgery

Dr Andy Leather

Royal Society of Medicine – London 27/04/2015

THE VISION – key points

Universal access to safe and affordable surgery and anaesthesia care when needed.
Improves the health of individuals and positively affects the economic productivity of nations.

Key messages:

1. 5 billion people cannot access safe surgery and anaesthesia care when necessary.
2. 143 million procedures are needed annually at a minimum
   - 90% of population in sub-Saharan Africa don't have access
   - Shortage of staff, space, stuff
   - All facilities should do caesarean section, laparotomy and fixation of open fractures
3. 33 million people annually are pushed into catastrophic expenditure paying for surgical care, heavy reliance on OOP (out of pocket) in many lower and middle income countries.
4. Investing in surgery is affordable, saves lives and promotes economic growth.
5. Surgery is an indivisible, indispensable part of healthcare and is important across the whole life course.

Fig 37. Premature baby Niki on Vert island 1991

Postscript

In 1991 during a visit to the Mercy Ship *Anastasis* in the Port city of Abidjan I rescued a dehydrated premature baby from Vert island (fig 37).

She was subsequently adopted by a Canadian couple who were volunteers on the ship. Fig 38 shows a cheerful Niki, as she is now, living and working in Victoria, BC.

Fig 38. Niki in Canada, 2015