

# **Developing a Urology Service in Gambia**

## **A most deserving cause – a most frustrating prospect**

I have been afforded great hospitality while visiting the Gambia and there is no doubting the good will; that the local doctors have shown me over the last 2 visits to the Gambia. In spite of all the difficulties which I will outline below I am still convinced that we must make every effort.

Gambian health care is not free but the cost of a consultation plus a prescription, an operation and hospital stay are purely nominal (40p, £1 and £2 respectively would cover a TURP). One can contrast this with the neighbouring Senegal where a TURP would cost about £200. The difference is that no TURP has been performed the Gambia NHS sector for about 2 years whereas it is performed several times a week in Senegal and then this is replicated in many centres.

The main hospital in Gambia is the Edward Francis Small Teaching Hospital. This has an annual budget of around £500,000 which is spent on salaries and maintenance. There is a central pharmacy supply for the whole country (about 1.5 million people) and hospitals request their supply of scalpel blades, gloves, catheters and irrigation fluid (in addition to drugs) from the agency. It is usual to only receive a proportion of the budget and the disposable items applied for.

*There is no mechanism for raising extra funds for the purchase or repair of surgical devices without appealing directly to the Health Minister or the President's wife. Any equipment purchased is not guaranteed to be maintained; it will probably not even be stored properly.*

### **The chain of command**

There are two house offices who are under the control of a Cuban and Syrian local consultant. There are no registrars. The locum consultants are answerable to the Head of Department (HOD) Surgery. The HOD Surgery reports to the Chief Medical Director (CMD) of the hospital who in turns reports to the Minister of Health and from there up to the President. This all seems straightforward but one needs to understand some of the recent history. UP until 2 years ago there was a Gambian CMD of the Hospital but in a move to import some talent into the administration and performance of their NHS the President invited Syrians to Gambia. The Gambian CMD was summarily replaced with a Syrian and at the same time the Minister of Health was removed from administering the Edward Francis Small Hospital and the CMD was answerable only to the Presidential Office. We therefore had a situation where Syrians could leap frog the HOS of Surgery to talk to the CMD and the CMD could leap frog the Minister to talk to the President. Satellite hospitals could function in a more orderly manner because they remained under the control of the Ministry of Health.

## **The first two visits to Banjul**

On our first visit to Banjul and the EFSH we met with the Syrian Consultant the CMD and the HOD of Surgery. We were assured of their full support and we discussed a proposal to supply equipment and training. In return we asked for a person to be nominated who would have the responsibility of maintaining and storing the equipment. We also asked for a prospective future Urology Consultant to be identified so that we could train him or her for his future role.

On second visit was with an accompanying Urology trainee, Dr Alexandra Zachou, and a work experience student, Phoebe Crane. Over the first two days we performed an open prostatectomy and a complex substitution urethroplasty using buccal mucosa. We performed two bilateral orchidectomies for prostate cancer. We would have performed more operations but there were too few beds – emergency admissions filled the beds before we could get our elective cases in. On the third day we managed to find a light source and cable so that we could perform straightforward cystoscopy on a female patient. This only became possible when the Syrian Consultant kindly brought his key to an annexe where the Urolink equipment lay. No other person in the Department held a key to this annexe. To his credit the CMD of the hospital agreed that from that moment on the HOD of Surgery and the Cuban consultant would also have a key. It is apparent that cystoscopies are not performed currently.

## **The Urolink equipment**

The Urolink equipment lay in the Obs and Gynae Theatre cupboard and the Syrian consultant held the key. There was the following equipment there:

- Olympus semi-rigid ureteroscope plus a light cable A2940A
- Olympus OTV-56 camera (part of the Obs and Gynae laparoscopy stack)
- Tristar camera system OTV-56 HIL camera system
- Storz resectoscope 28F 27040//A with thick loop – no telescope and no light lead
- Olympus 27Ch resectoscope sheath with passive mechanism OA2761 no lead and no telescope
- Olympus urethrotome sheath and hand piece
- Olympus LF2 bronchoscope
- Wolf flexible cystoscope 0124 7305006 (still usable but many broken fibres)
- Cystoscopy sheath Olympus A2134
- Cystoscopy sheath plus introduce A2642
- 1 catheter introducer

Therefore one could do a ureteroscopy but not a cystoscopy

The equipment was not only hidden from the rest of the team but it was also not put away in a safe way. There was still the proper container for the Olympus ureteroscope but the ureteroscope itself was lying in a single plastic crate with all the other equipment. It will not last for long if that continues.

## **Main Priorities**

In Urology the most common diseases are prostatic outflow obstruction and urethral stricture disease. There should be a dedicated Urology Theatre in which equipment used only by urologists should be stored. It is not feasible to be sharing a stack with the gynaecologists and to have urology equipment locked in their Theatre. The following is a list that should be submitted to the Minister of Health:

- Endoscopic light source
- Diathermy generator capable of bipolar as well as unipolar resection of the prostate
- Light lead
- Olympus telescope compatible with the existing resectoscope and urethrotome
- Storz telescope for use with the Storz resectoscope
- A bipolar resection system (Storz or Olympus)
- Unipolar and bipolar resection loops, electrical cables x 4, Clutton sounds for dilating the urethra
- Hey Groves sound for urethroplasty and suprapubic catheter insertion
- Prostate biopsy needles
- Ultrasound for examination of kidneys and prostate including transrectal probe for prostate biopsy
- Engraving pen
- Flow rate meter
- 3 litres bags of saline and glycine for the surgery and post operative irrigation
- Post TURP 3 way catheters 22 F as well as a full range of catheters so that TUR catheters are only used when appropriate and cheaper catheters can be used for other times

### **To start immediately**

- That the Urolink equipment in a plastic crate is put into separate boxes and stored on the shelves. There must be a named nurse (and a named biotechnician eventually) who are responsible for the safekeeping of this equipment.
- When new kit arrives that this is marked with a permanent engraving pen and this also is packed in appropriate protective boxes on shelves
- There must be an inventory stating what stock is owned and of any parts of the equipment sent for repair
- When there is equipment available then I will ensure a succession of training visits is started during which we will hope to have Gambian trainees attending so that they can then continue to perform these operations once judged competent.

## **Meeting with the Minister of Health**

We had the honour of meeting with the Minister of State for Health on 24<sup>th</sup> August 2014. He has asked for a list of equipment and has given his word that the equipment will be purchased. The Minister suggested that we should have a Urology Unit at the Serrekunda Hospital because there is more operating space and more beds available. I suggest that basic modifications are made to the theatre so that a central draining the operating theatre can deal with the outflow of the endoscopic procedures by drainage directly into the sewage system where it can be treated safely.

### **Dr Abubacarr Jah**

Dr Jah is the most highly trained urologist in Gambia and he is a Gambian national. He is invaluable to the provision of urology to the Gambia and he must be coaxed back into the NHS urology for a full day of Theatre and a half day of consulting. He will provide the continuity necessary to move Gambian urology on to be among the leaders of West Africa nations in health care provision.

### **Conclusion**

Gambia has the advantage of being small and therefore a single Urology Department could be designed so that Gambian urology not only caught up with its neighbour Senegal, but also surpassed it to become the premier Urology centre in the region.

Graham Watson