The Association of Surgeons of Great Britain & Ireland

Report on the
Introduction to Surgical Skills
Course
at
The College of Medicine & Health Sciences School of Medicine
Hawassa, Ethiopia

28th February - 4th March 2011.

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Surgical Skills Course at The College of Medicine & Health Sciences School of Medicine, Hawassa, Ethiopia

28th February - 4th March 2011

Faculty
Mr Robert Lane – Convenor
Mr Paul Gartell
Mr Yogesh Nathdwarawala
Mr Simon Flemming
Mr Steve Mannion – World Orthopaedic Concern (WOC)

Urolink Team
Mr Shekhar Biyani
Mr Joby Taylor
Mr Jaimin Bhatt
Sister Denies Ellis

Introduction

The Association of Surgeons of Great Britain & Ireland (ASGBI) was invited by Dr. Shemsedin Musefa, Acting Director for Clinical Service and Practical Training at Hawassa University Referral Hospital, at the request of Dr. Aberra Gobeze, Surgeon and External Health Link Co-ordinator, Department of Surgery. The invitation letter was sent in both English and Amharic.

The programme for the Course was essentially the same as last year but with the addition of half a day for urological emergencies. Mr Steve Mannion, Chairman of WOC (UK), would assist in the running of the Orthopaedic and Trauma module. Mr Paul Gartell and Mr Simon Flemming would assist with the General Surgical Module. Mr Shekhar Biyani, Mr Jaimin Bhatt and Mr Joby Taylor would run the urology module. It was planned that the Course would coincide with a visit from the Southern Ethiopia Gwent Health Care Link.
It was again the intention, as last year, that the equipment based at the Black Lion Hospital in Addis Ababa would be available for us to use in Hawassa for the duration of the Course. Dr. Mulat Taye, President of the Surgical Society of Ethiopia (SSE), thought that this should be possible but confirmation was never forthcoming and despite enormous efforts by the Ethicon Rep., Arega Wondimu, we headed south to Hawassa without any equipment. However, we were grateful to Mr Steve Brockie, Ethicon GB Business Director, East and Southern Africa, for supplying a full set of sutures without which the Course could not have been undertaken. Dr Aberra had sent a list of instruments that he had access to in Hawassa and I complimented those with enough to accommodate 20 participants. I also took out a full set of knot tying jigs, skin pads, cork mats, neoprene, plastic buckets etc.

Contact had been made with the visiting Faculty prior to departure and all pre-course proceedings were undertaken in the usual manner. Immunization and insurance advice was given and indemnity forms signed prior to departure.

**Acknowledgements**

I should like to acknowledge Dr. Aberra Gobeze for his tireless efforts with regard to Surgical Training and his assistance and support for this Course, to Ethicon GB and in particular Steve Brockie for his continued support, Mr Biku Ghosh of the Southern Ethiopia Gwent Healthcare Link (SEGHL) for his enthusiasm and assistance and to Doctors Tariku and Eskedar for their help in organising the Course. I acknowledge Miss Bhavnita Borkhatria for her help in booking the flights, general administrative duties and for arranging prompt reimbursement of the expenses, Mrs Jane Gilbert for her excellent secretarial assistance and to all the Visiting Faculty for their unstinting support and hard work during this Course. I should also like to thank Miss Ruth Bird who assisted in the Airways Support and Tracheostomy Module in between working on her audit on post operative pain post Caesarean Section. Finally, I acknowledge the continuing support of the Research Foundation of the Association of Surgeons and the British Journal of Surgery.
Itinerary

Outward Journey

The four members of the ASGBI Faculty (Bob, Paul, Yogesh and Simon) met the other members of the party; Biku Ghosh, Ruth Bird, Shekhar Biyani, Jaimin Bhatt, Joby Taylor and Denies Ellis together with two midwives (one with her daughter) from the SEGHL at Terminal 3 LHR on Friday 25th February at 17:30 hours in preparation for checking in at the Ethiopian Airways desk. The luggage allowance was 46kg each so we did not have to pay for any excess baggage.

The flight itself was moderately full and the food excellent. We landed on time at 07:15. The vast majority of passengers on the flight were in transit to other destinations in Africa and thus the queue for a Visa was very short. All luggage was retrieved. I had to show two of my cases to the customs officials but this was no great problem. We explained our purpose in Ethiopia and showed the relevant Certificates from the RCS (Eng) and the Research Foundation of the ASGBI.

We met Dr. Aberra on the concourse and also Arega Wondimu who was very apologetic that he had not been able to obtain the kit. I attach no blame to him whatsoever. He tried really hard on our behalf.

Three minivans were waiting for us and we set off at 08:30 for the journey south to Hawassa. The traffic was light and we stopped at the Daema Hotel, Mojo, for breakfast. We visited the Haile Resort hotel at the northern end of Lake Hawassa at 15:30 for refreshments. This is a new hotel built by Haile Gebreselassie (record breaking Ethiopian Marathon runner) which opened last August. It looked very modern and we all thought it was worthy of further inspection at a later date. We arrived at the Haroni International Hotel, a few miles down the road in the centre of Hawassa, at 17:00.
Inward Journey

The visiting Faculty together with Ruth Bird departed Hawassa at 11:10 on Saturday 5th March. Joby sat in the front because there was more leg room and he had not been well the day before. The remainder made themselves as comfortable as possible. The journey was fairly uneventful and we again stopped at the Daema Hotel in Mojo for refreshments and arrived at the Black Lion Hospital in Addis Ababa at 17:30. We met Yogesh, Steve, who should have been in Malawi but the plane took off without him, and Mike Laurence who heads the WOC programme at the Black Lion. WOC rents a flat on the first floor of a block of residences which was quite pleasant when one entered through the front door. However, the corridors and stairways were a bit decrepit. We had light refreshments and set off for the Ristorante Castelli where we had a very pleasant Italian meal. We then departed in the mini van for the airport where we said goodbye to our driver and his son and checked in at the Ethiopian Airways desk. The plane took off and landed on time. This was the first occasion that we didn’t have to refuel in Rome which meant that
we had a moderately good nights rest. All luggage arrived at LHR and, after saying our farewells, made our way home.

Typical scenery en route to Hawassa

Summary Itinerary

Outward Journey – Ethiopian Airlines, Flight No. ET701

*Friday 25th February 2011*
Departed LHR Terminal 3 at 20:25
Arrived at Bole Airport, Addis Ababa, the following morning at 07:10

Inward Journey – Ethiopian Airlines, Flight No. ET710

*Sunday 6th March 2011*
Departed Bole Airport, Addis Ababa at 01:45
Arrived LHR the following morning at 07:15
The Haroni Hotel looked just as we had left it last year. I, and for some reason I cannot explain, chose a room on the 4th Floor. I think I thought that it was going to be less noisy, which it was, but didn’t take into account the eight flights of stairs! The rooms were clean but some of the fixtures and fittings were either loose or came off in the hand. Several light bulbs were not working but at least on the 4th floor the shower was functioning. One new feature since last year was the fact that we could watch BBC World News in our rooms which is probably one of the more boring programmes in that it keeps repeating itself every 10 minutes of so!

An hour or so after arriving we met in the bar and thence went along the road to the Pinna Restaurant and had a very pleasant meal after which we retired somewhat exhausted.
One of the mini vans was at our disposal throughout our time in Hawassa. We therefore transported our kit to the Skills Lab at the Hawassa Referral Hospital which is about a 10 – 15 minute drive through the centre of town. The Skills Centre had been partitioned since last year and three sinks had been put in together with two modern lavatories. The partitions were made of glass and the whole area was well lit and well ventilated. We set up in the largest of the rooms available. The tables were of a size that could be shared by two participants. Dr Aberra’s list of instruments was correct and we were able to compliment that with those that I had brought out from the UK. We used new cork mats and the new knot tying jigs.

I did not bring out the large deep removable angled cylinders for tying at depth because of their size and their inappropriateness for basic surgical training. We used the “old” knotting material which is thicker than that supplied with the new jigs.

Each table was laid up accordingly and the remainder of the instruments, sutures etc were set out on side tables for easy access. Each member of the visiting faculty had a complete set of requirements and instructions for running the Course. We were unable to test the AV system because the projector was not available. This was unfortunate and had consequences for the following morning.

We had finished setting up by 12:30 and drove to a small restaurant by the lakeside for a light lunch. That afternoon Paul and I went bird watching along by the Lake which was great fun. The Lake itself is the smallest in the Ethiopian Rift Valley covering an area of around 9,000 ha. It is set in an ancient caldera without any outlets but has an abundance of fish and also some hippos. The bird life surrounding the Lake is magnificent.

That evening we had dinner at the Lewi Piazza Hotel which is a 10 minute walk from the Haroni.
**Introduction to Surgical Skills Course**

**Monday 28\textsuperscript{th} March 2011.**

Our minivan collected us at 08:00 and we arrived at the Skills Centre at 08:15. We had to wait 20 minutes for the projector to arrive. The projector and loud speakers worked well but both Paul and Simon, who are both very computer literate, had difficulty with the DVD. Precisely why, we never discovered but eventually the system behaved itself and we were ready to start the Course at 09:00.

The participants were 19 second year and 9 third year students on the MSc Emergency Surgery Course; the latter having attended the Course last year. They came from Hawassa and the surrounding towns of Hossana and Yirgalem. Unfortunately, they had not received the objectives and therefore these were discussed with them. This is important so that they know precisely what the aim is for this Course and, furthermore, prevents them making impractical suggestions during the evaluation process at the end of the Course.

The knot tying and the suturing exercises went well. The third year students were in attendance to give advice and help to the second year students. They acted a little like a local Faculty but still have some way to go before they can take over that role. The new knot tying jigs were well utilised and the deep removable cylinder for tying at depth was not missed as the intermediate sized cylinder was perfectly adequate. It became apparent that we needed four boxes of black braided Mersilk (3/0) on a curved (3/8 circle) reverse cutting needle (W328H). This despite each box containing 3 dozen such sutures. During the morning between the knot tying and suturing exercise a refreshment break was taken just outside the Skills Lab. As last year the refreshment and meal breaks were on time.
We had just entered Lent so there were two menu’s for lunch; fasting and non fasting. There were plenty of meat and fish dishes, rice, vegetables and ample quantities of injera; a large, sour tasting, pancake shaped substance made from tef, a nutty tasting grain that is unique to Ethiopia.

Paul and Bob assisting in the suturing exercises

The participants were fairly prompt in returning at 14:00 for the start of the anastomosis sessions. By now the computer was behaving itself and the three anastamoses were undertaken without undue problems. We had a moderately large sheep, as last year, but the mesentery was not very extensive and there were not many lymph nodes to dissect out. However, the intestine itself was satisfactory, although in some cases the lumen had to be divided obliquely or a slit made on the anti mesenteric surface (Cheadle’s slit) in order to obtain a satisfactory anastomosis without stenosis.

The day finished with a brief discussion. There were no particular problems with regard to language although this is sometimes difficult to appreciate because some of the participants are not very forthcoming when it comes to asking questions and one wonders whether this may be because they don’t understand enough English and are not confident to contribute in this way. On the whole the third year students were helpful and had a further opportunity to remind themselves of the techniques that they learnt last year.

The Faculty washed the instruments, the cork mats and working surfaces. The instruments were left out to dry in preparation for the next day. The loud
speakers and laptop came back to the Hotel with us. The projector remained in situ as it belonged to the hospital. We returned to the Haroni Hotel and later that evening went to the Hotel Lewi by the Lake for a very pleasant dinner.

*The venue showing excellent lighting, good projection and the glass partition down the right hand side*

*Tuesday 1st March.*

The participants registered and the Course started on time at 08:45. The arterial exercises went well but we had to repeat these sections of the DVD on one or two occasions as is often the case. There were no mosquito forceps available but none the less they understood the technique of using rubber shod forceps. I had foreseen that the sheep arteries would not be of much use and had brought out a set of simulated arteries from “Limbs and Things” and these were satisfactory. Even in the best of circumstances it is difficult to get enough arterial length from the abattoir material unless a pig is used. After the mid morning refreshment break the participants broke up into two groups; one undertaking the tracheostomy exercise led by Paul Gartell and the other the chest drain insertion exercise led by Simon Flemming. After 45
minutes the groups changed over. We used a blown up balloon inside the thorax for demonstration purposes. It was possible to harvest the trachea, heart and lungs from the goat and this made for a good demonstration of a heart-lung preparation.

After lunch the abdominal wall closure exercise was undertaken. Nobody burst a balloon but one collapsed of its own accord! I then gave the WHO lecture on the Surgical Safely Checklist which is part of the Safe Surgery Saves Lives Campaign. This engendered some discussion and useful points were raised.

The day ended again with a brief discussion of the days events.

That evening we went to the Haile Resort Hotel for dinner. This is a first class establishment on a par with any hotel in Europe. The ambience and the food were excellent and not that much more expensive than dinner in town. Steve Mannion arrived that evening from Addis and it was great to see him and catch up with his news.

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**Report on the Orthopaedic Module**

**Yogesh Nathdwarawala**

*Wednesday 2nd March - Thursday 3rd*

**Goal and Participants**
The healthcare provision in Ethiopia is generally poor but provision of orthopaedic and trauma care lacks behind even further. In the part of southern Ethiopia we visited, the surgeons in the hospitals were comfortable performing a number of operations such as laparotomy, Caesarean Section, burr holes etc but there are hardly any orthopaedic operations performed. There are an increasing number of vehicles on the roads and consequently more road traffic accidents. Considering their impact on the young earning
population, training regarding management of trauma would be greatly beneficial to Ethiopia.

Participants on our course were 2nd and 3rd year MSc health officers (non-doctors). It is anticipated that after completing the 3 year MSc course they would fill the vacant posts of Surgeons in various peripheral hospitals. In case they go back to a Health Centre they should be able to deal with some of the common injuries like dislocations and fractures locally instead of referring them to the hospitals miles away. Third year MSc students participated in this course last year. For them the course was a refresher and they acted as the local faculty.

**Trainers**

Mr Steve Mannion, a Consultant Orthopaedic surgeon, and Mr Simon Flemming, a surgical trainee were my co-trainers for the course. Mr Steve Mannion is very passionate about healthcare in Africa and has a wealth of experience in the Region. A very dynamic and dedicated man indeed! I am extremely grateful for the invaluable practical help that Mr Robert Lane, Mr Paul Gartell, Dr Ruth Bird gave me during the course. I am very grateful to Paul for his help in dissecting the goat. I also had an opportunity to discover his and Mr Lane’s skills at making aprons from plastic bags. An example of a true craftsmanship! Mr Lane provided me with the guidelines for the course and I had preliminary discussions regarding the content of the Course with Mr Mannion.

*Yogesh and Steve, together with Simon who is sitting down to the right of the screen, conducting the Orthopaedic Module*
### The Time Table

#### Wednesday 2\textsuperscript{nd} March

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<th>Activity</th>
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| 8.30 to 9.00  | Overview of the day
|               | Principles of fracture management                                         |
| 9.00 to 10.45 | DVD
|               | Open fracture debridement
|               | Tendon repair                                                             |
| 10.45 to 11.00| Coffee                                                                   |
| 11.00 to 12.45| Amputation, Fasciotomy and Compartment syndrome                           |
| 12.45 to 13.45| Lunch                                                                    |
| 13.45 to 15.15| Fracture reduction Below elbow back slab                                  |
| 15.15 to 15.30| Coffee                                                                   |
| 15.30 to 17.00| Lower limb full plaster                                                  |

#### Thursday 3\textsuperscript{rd} March 2011

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<th>Time</th>
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<tr>
<td>8.30 to 9.00</td>
<td>Preview of previous day and overview of the day</td>
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| 9.00 to 10.45 | Group A
|               | Skin and Skeletal traction
|               | Skills:-
|               | skin traction
|               | Dunlop traction
|               | Distal femoral /proximal tibia /calcaneal pins                           |
| 10.45 to 11.00| Coffee                                                                   |
| 11.00 to 12.45| Group B
|               | Skin and skeletal traction                                              |
| 12.45 to 13.45| Lunch                                                                    |
| 13.45 to 15.15| Group B
|               | External fixation and taste of Internal fixation                        |
| 15.15 to 15.30| Coffee                                                                   |
| 15.30 to 17.00| Group A

Group B: Upper Limb Injuries and spinal injuries
Skills:-
Reduction of dislocation - shoulder, elbow, fingers supracondylar fractures, forearm and wrist.
Log roll, Halter traction collar, spinalboard.
**On the day**
The 2 days of the orthopaedic course were quite full as we were trying to cover a large number of topics. However, we were well rewarded with high attendance and enthusiasm of the participants. They stayed during their lunch and coffee breaks and continued practicing and also came quite early. We ensured (and almost insisted) that each of them had tried all of the practical exercises including plastering, skin traction, skeletal traction and external fixation as well as internal fixation. It was quite encouraging to see the two girls breaking their subconscious barriers and getting their hands on the plasters!

The entire course was run as practical sessions with maximum time devoted to the participants doing hands on training.

![Yogesh overseeing skin traction being applied (a) and insertion of a Steinmann Pin (b)](image)

**What went well; what can be improved**
The orthopaedic aspect of the basic Surgical Skills Course covers the debridement and tendon repair. We extended this to include amputation and fasciotomy for the compartment syndrome. However, we need to think long and hard to find suitable animal models for amputation and fasciotomy.
The facilities in the clinical skill labs have improved compared to last year. It is also noteworthy that all the equipment that we left at the last visit was readily available to use this time.

External fixation with plaster has been very popular. One of the participants told me that since learning it on last year’s course he had put 3 of these on open tibial fractures. One patient had to have an amputation but it worked very well in the other 2 patients. A photograph of the external fixator is included in last year’s report.

Dr Abera has been busy with the Urology course. However, Dr Tariku, a General Practitioner in the hospital gave us very good help.

Mr Steve Mannion shared a number of his experiences in dealing with orthopaedic emergencies in Africa. He also shared his special techniques of skin grafting.

**Medical Students**

I taught final year medical students on chronic osteomyelitis. Dr Eskedar helped to co-ordinate this.

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**Report on the Urology Module**

*Shekhar Biyani*

**Friday 4th March 2011**

We drove to the Skills Lab and at 08:15 the MSc students arrived. This is the first time we have done a session on urology emergencies as part of the ASGBI course. We prepared a model to teach suprapubic cystostomy using an obstetric manikin, saline bag, foam and rubber sheets. We had thought about this model a day before and were pleased to see that it worked well. There were 19 health officers who were in their 2nd year (of three) of their MSc
in Emergency Surgery and 8 were in 3rd year. They were divided into 3 groups and rotated after an hour.

Mr Taylor discussed suprapubic cystostomy and all participants performed the procedure on the model.

![](image1.jpg)

**Joby supervising suprapubic cystostomy on an obstetric manikin**

Mr Bhatt took a session on urological emergencies. I discussed urethral catheterisation and delegates were asked to practice male and female catheterisation on manikins. We finished our session at 12:00.

![](image2.jpg)

**Shekhar discussing urethral catheterisation**
Mr Taylor started to feel slightly unwell and returned back to the hotel. Mr Bob Lane, Convener & Programme Director for International Affairs at the ASGBI, arrived at 10:30 to prepare certificates of attendance for participants. After our session he asked them to fill in an evaluation form. I did manage to go through them and it appeared that they all liked the urology session. Mr Lane and Dr Aberra handed over certificates of attendance to all participants.
**Evaluation**

**Second Year Students:**

There were 19 who scored an average of 9.9 out of 10.

They all found the course useful and the following areas were reported as being **most** useful – everything (8), anastomoses (7), all orthopaedics (5), urology (4), knot tying and tendon repair (3 each), skeletal traction, suprapubic catherisation and fracture management (2 each) and suturing (1).

Only one participant mentioned a **least** useful aspect of the Course and that was urethral catheterisation.

Suggestions for improving the Course included adding sections on hernia repair (2), arterial anastomosis (1) and study on live patients (1). Three participants wished the Course to be extended. Other comments mentioned included adding an obstetric and gynaecology aspect (11), a hard copy of the manual (6), training the trainers and emergency surgery (2 each) cholecystectomy (1) and a per diem for Hawassa students. (1). They should have had the manual in hard copy but unfortunately we didn’t send it to Aberra this year.

It would seem that they definitely need a separate obstetric and gynaecology course and it is difficult to assess at the present moment whether enough will be included in the Emergency Surgery Course (in preparation). The alternative would be the Life Saving Skills – Essential Obstetric Care and Newborn Care run by the Royal College of Obstetricians and Gynaecologists but this would need financial sponsorship as Ethiopia is not on DFID’s list for support at the present time. They also need clinical lectures on emergency surgery which probably will be covered by the Emergency Surgery Course. Further consideration might be to ask Andrew Kingsnorth to run a hernia
workshop in Hawassa. There is no reason why they cannot have a Train the Trainers Course.

**Third Year Students:-**

The 9 participants scored an average of 9.33 out of 10.

All thought the course useful bearing in mind that this is the same course that they did last year. The *most* useful elements mentioned were all the Orthopaedics (5), everything (4), bowel anastomoses (2), knot tying, vascular exercise, tendon repair and urological emergencies (1 each).

Only one participant mentioned a *least* useful aspect of the Course and that was urethral catherisation.

Areas for improvement included hernia repair (6), skin grafting (2), head injury, tracheostomy done with the skin intact, live patients and Caesarean section (1 each). Other comments suggested were that the course should be for all MSc students. They were very complimentary with regard to the Faculty. It is interesting that the third year students need training in hernia repair and skin grafting. Again this situation would be suitable for Andrew Kingsnorth and I shall make enquiries as to how feasible this would be.

Overall it is the obstetric and gynaecology aspect and hernia repair which seem the most important areas of need but these are outside the remit of this course.
What went well

- There is no doubt that the MSc students are a bright group; some of whom are fairly experienced with regard to surgical techniques. There seems to be no difference in training them as opposed to qualified doctors. They were enthusiastic and extremely appreciative which does beg the question as to how much hands on training they get on their MSc course.

- Dr. Aberra is to be congratulated for upgrading the Skills Centre to one which is now comparable to most in the UK. There were two new modern toilets, three sets of washing facilities for instruments etc and the large area that we worked in last year has now been divided into
sub sections with glass partitions which are sound proof which means that more than one room can be used at any one time.

➢ The overall lighting and ventilation were good. The projector provided by the hospital worked well. The loud speakers that had been brought from the UK also worked well.

➢ The participants were on the whole punctual which meant that the programme could start on time each day. The refreshment breaks were always on time and were positioned just outside the lab which made it extremely convenient. However, this didn’t stop the participants wandering off afterwards and sometimes one had to wait for them to return from wherever they had gone in order to start the next session. This was especially so after the lunch breaks.

➢ The visiting Faculty spoke clearly and slowly and there were no perceived problems with language. It was an advantage having the third year students present because they undoubtedly helped explain aspects of the exercises to the second year students.

➢ The majority of the second year students were all at the same level of expertise and thus, with a few exceptions, they finished the exercises more or less on time.

➢ We used the simulated vessels for the vascular module and these were a suitable substitute for animal arteries but not quite so realistic. However, they were better than nothing and of uniform diameter. The pig is the only animal with suitable arteries and is also ideal for intestinal anastomoses.

➢ The Course photograph was undertaken and the Course dinner this year was again a success and brought everybody together i.e. the Faculty, the participants and, importantly, the University representatives.
The Orthopaedic Module was again highly successful.

For the first time we ran a Urology Module which included urethral catherisation, suprapubic catherisation and the management of urological emergencies. This aspect covered some of the deficiencies which were reported from last year’s course and was extremely successful.

It was interesting that the participants reported that they had access to Vicryl and Prolene sutures and that probably explains why their techniques are more advanced than in other areas of Africa.

The transport to and from the venue was punctual and the driver extremely helpful.

The camaraderie of the whole visiting team, both Faculty and otherwise, was extremely good and everybody worked very hard to make this course a success.

What could we have done better?

Despite the projector and loud speakers working extremely well the laptop developed several glitches which, even with experienced operatives at the helm, took many minutes to sort out! In future we may well try using a simple DVD player which has been trialled in the UK and found to be very satisfactory. Perhaps not having all the sophisticated applications that laptops have is an advantage.

We ideally need a larger animal. The arteries were virtually unusable and the intestines were only just of a reasonable diameter. The simulated arteries were a satisfactory substitute. There are other animals that we haven’t explored such as pigs, cows etc and it would be worth discussing this with Dr. Aberra.
It was mentioned last year that we should attempt to film the tracheostomy and chest drain insertion exercises and these could be on live human patients and on animal cadaver material. We could also provide data sheets with diagrams etc. We shall look again into this during the coming year.

Although much requested, we are not really in a position to supply a DVD to each member of the Course because of copyright issues at the RCS (Eng).

Despite informing the local Faculty well in advance about the requirements for the Course, many disposable items were not present. Paul had to design gowns out of yellow plastic sheeting and it took an hour and a half for two of us to cut them out. It is the simple relatively cheap items which are so important such as scrubbing brushes to clean the instruments, washing up liquid, soap, towels or cloths of some sort to dry the instruments and clean down the working surfaces, plastic gowns and non sterile gloves. The requirements for the orthopaedic module are extremely important; not only the POP but also stockinette or some substitute.

*Paul and Bob manufacturing plastic gowns.*

*Something to do in retirement!*
There is a temptation to add more and more to the Course but it is also easy to forget that the Course is essentially about basic surgical skills and many of the requests at the end of the Course are really not related to these skills.

Although there were not enough instruments Dr Aberra did let us know well in advance and we were therefore able to bring out additional items to compliment what he had.

We should have insisted that the manual that had been provided last year via pdf should have been available this year for the participants before the course started.

**Items for future Courses**

- 4 boxes of W328 for 20 participants.
- 10 balloons for the chest drain exercise.
- 4/0 Prolene (W8845) or 2/0 Ethilon (W786) and not 2/0 Ethilon on a straight needle (W776) for the tendon repair.
- 20 ml syringes x 10 for debridement exercise.

I do have some concerns for the future as to where Hawassa will get all the requirements for the Course and especially the sutures, without which it could not even begin. It would not be difficult to compliment the instruments because they are reusable. The neoprene could possibly be repaired with superglue and insulation tape. This would mean that each sheet could be used over and over again. Most of the other disposable items can be obtained locally.
Conclusion

This has been, by all accounts, a highly successful basic Skills Course and the first time that we have included Urology. The visiting Faculty worked extremely hard and the venue and the local support were tremendous. In fact this course has been more than the accepted basic skills course for over four and a half days it included far more aspects appropriate to clinical officers who are going to have to work independently in district hospitals/clinics once they have obtained their MSc.

I believe that in the not too distant future this course could be sustainable at least as far as having a local faculty but what is more challenging is access to some of the disposable equipment, especially sutures. Whether Ethicon will be willing to support a second skills lab in Ethiopia (the first being at the Black Lion Hospital in Addis Ababa) remains to be seen. We have met nobody who is so committed to training residents and clinical officers in Hawassa as Dr. Aberra and it would be churlish not to offer further assistance but there will come a time when skills training must be conducted solely by a local faculty. We shall offer Training the Trainer Courses to help towards achieving this goal.

We also have a deep admiration for what Biku Ghosh continues to achieve in this region. It still makes our contribution seem very small.