ADVENTURES IN MOGADISHU, SOMALIA

Day1, 4th April

In the Beginning of March 2017 I was invited by Physicians Across Continents (PAC) to join a team of Surgeons on a 'risky' journey to save Vesicovaginal fistula (VVF) patients in Mogadishu Somalia.

VVF is a dehumanizing condition that happens to usually young girls delivering children as a result of disproportion between the baby's head and the incompletely developed pelvis leading to often the death of the baby and a hole forming between the girls vagina and urinary bladder leading to continuous leakage of urine. It usually happens in less developed societies with malnutrition, early marriages and unavailability of obstetric services.

Somalia is a war torn and very unstable country with the perfect recipe for endemicity of VVF. Unfortunately VVF surgeons like myself are likely to be reluctant to offer services in this war torn region with weapons everywhere, common terrorist activities and kidnappings.

Well for me, I feel so passionately about this that nothing can prevent me going to save the lives of these unfortunate girls. So when the invitation was tendered I thought to myself…time for an adventure!! And despite advice to the contrary from family and close friends and financial losses both in real time and my absence from work, I made the decision to go.

My trip was fraught with difficulties and my first attempt to travel in March was unsuccessful due to problems with travel documents. Things were eventually sorted and I was set to go by 29th March 2017.

Air journeys in West Africa are grueling due to lack of direct flights. To go to Mogadishu I would have to go to Dakar first then catch a flight either via Kenya or Turkey before getting a connection to Mogadishu. It turned out that the flight via Turkey (Europe) was more convenient and cheaper. The Earliest flight available was for Monday 3rd April and the only flight available for Dakar was on Friday 31st March meaning I had to stay in Dakar for two days doing nothing but just waiting for the flight. I therefore chose to wait until Sunday night to travel by road which would be a 10hr journey rather than 30mins by air. This was to allow me attend a very important meeting on Saturday evening and perform a necessary surgery on Sunday morning.

On Sunday while I was getting ready to go for the dreadful ferry crossing before proceeding to Dakar by road, I was called by a colleague who knew I was travelling to inform me that the hospital he worked for was evacuating a patient by air and proposed that I join that flight as escort for the patient. The flight was to leave in an hour's time. I therefore thankfully joined the flight and instead of arriving on Monday Morning just in time for my flight to Turkey, I was in Dakar just an hour later on Sunday. That was indeed a good start for my journey!

This gave me an opportunity to go to a hotel and rest over night before embarking on an almost 20hr journey to Mogadishu. The first leg of the Journey was from Dakar to Istanbul. This was a direct flight of 8hrs most of which I spent working on a plan to expand my operating theatre. I left Dakar 0750 and arrived Istanbul at around 1800 with the time difference. My next flight was at 0050 (6hrs layoff) and this was to my final destination Mogadishu via Djibouti with a total travel time of 9hrs.

I arrived Mogadishu just after 11am on Tuesday having left Gambia on Sunday afternoon. I was initially worried due to delays in immigration clearance. Anyway, after a long wait it was indicated that I could

go to the counter for clearance. A person came with 60 US Dollars on my behalf (from PAC) and my passport was stamped for entry.


Passengers at the arrival lounge getting immigration clearance

When I came out of the airport there was no one with a placard waiting for me. I panicked but remained calm. Eventually, while trying to buy a sim card to call the office, Abubacarr Sheikh, one of my correspondents during the plans for my visit arrived . He was very nice and welcoming.

In the terminal there were no armed personnel which I think is a good thing for people like me coming in. Outside the airport was different. There were many armed soldiers walking about among the large crowds of people. We soon arrived at the parking lot and an airconditioned and comfortable 4wheel drive Toyota pickup with tinted glasses and two armed soldiers at the back was waiting for us. There were several other vehicles with armed soldiers perched at the back just like ours. We then slowly snaked through check points and barricades until we got out of the airport gates. Chaos reigned and once in a while our soldiers jumped out of the vehicle to negotiate our passage through the thick traffic jams sometimes having to stop other vehicles coming from the opposite direction so that we overtook vehicles in the traffic jam to move forward. The place was swarmed with soldiers all armed to the teeth some with machine guns and bullet rolls wound around their bodies. On the way I called my wife and reassured her that I had arrived safely. I intentionally left out the information about armed soldiers all over the place.


Physicians Across Continents headquarters.

Finally we arrived at the PAC headquarter which also had soldiers guarding it just like a military barrack. Inside I finally met Noora, the secretary who spoke good English and corresponded with me throughout the plans for this journey and my unsuccessful first journey. I also met the director of the office who offered me tea and fresh Mango juice. We exchanged niceties but I did not waste time telling him that I wanted to start immediately. He was surprised indicating that I should probably rest having been on the

journey for over 24hrs. I however declined because I felt very energetic and insisted that I wanted to go to the hospital immediately to start work.



Mogadishu from on top of the Pac Headquarter building

We then drove about 20km through very bad roads. Again, there were soldiers everywhere and evidence of damaged buildings and bullet ridden damaged vehicles. I knew then that this was one journey that would not include site seeing trips. I knew I would be glued to the hospital throughout the trip.

At the hospital, I immediately noticed a lot of women sitting in groups on the ground waiting. These were my patients. They were the reason I left the safety of my home and came on such a risky journey. I was introduced to Dr Muhammed Areed, the resident paediatrician from Egypt; Dr Muezz a general surgeon from Sudan who had just joined the hospital a month ago; Shams the female Somalian junior doctor; and Adel, the scrub nurse from Sudan. We all had lunch together and I was shown my room, which was a very basic room with a small single bed at the corner, a mosquito net over the bed and a fan. This was to be my room for the next one week.


Armed guard at the clinic entrance *My sleeping space for the trip*

As soon as I freshened up and prayed, I went to the clinic. There were more than 60 women waiting patiently. I was told that the women had set up camp in the hospital since the beginning of the program. The surgeons who were before me had done about 27 patients but had to go. There was also going to be a group of surgeons coming on the day I leave. I made a resolve to work long hours and do as many cases as possible before I left. The clinic door was guarded by an armed personnel and I insisted to take

a photo with him to show in my country when I went back quickly adding: 'by the grace of God' in my mind.

Shams speaks both good English and Arabic and is a good interpreter. In any case the information I needed was basic for the quick running of the clinic. I wanted to know the age of the patient, the parity, whether the leak was continuous or stress or urge induced, duration of symptoms and outcome of the delivery (live or stillborn) then I examined the patient. As usual it was sad seeing the girls and as soon as they exposed themselves you see gushing out of urine with excoriation of the vulva skin from the irritation of the urine and the sad and shameful look in their eyes. Although we had to be mechanical so as to see as many as possible we were gentle, reassuring and I used the little time to establish rapport.

After a few hours, having seen 19 patients, Shams and her team of female nurse assistants announced they had to leave and handed over to Nour and Abdoulkadir both junior doctors to continue. The next patient came in and I sensed her discomfort having to expose herself to three men in the office. She is only 20yrs old. After taking the history I gave her the choice to wait until the next day when female nurses would be available for the exams. She went to the door and came back saying she would rather be seen and examined today. I could see that although it was an ordeal for her she was ready to go through it considering that she had been leaking for 2yrs and had a failed repair 6 months ago. She did not want to miss the chance for a quick repair. I examined her and found that her urethra was absent and she was leaking from a gaping hole in the bladder. I felt very sad as I know the only feasible chance of being dry for her would be a diversion. This would involve a three hour surgery and a bag on the abdomen to collect the urine or diversion through the rectum with its many complications. Why should a beautiful young lady at the prime of her life have to go through this ordeal?

After seeing her, I suddenly felt very tired and informed the two male nurses that we should call it a day since the women would be very uncomfortable to be seen by an entirely male team. We then came out and broke the bad news to the disappointed patients who had been waiting for their chance pretty much the whole day. It was already almost 11pm. We however reassured them that we would continue the next day.

I could hardly walk back to the residence. On returning to the residence, I realized that I did not come with soap or a towel having stupidly thought that I would be lodged in a comfortable hotel like when the team was in Gambia. Here, hotels will be very unsafe and I was thankful I was going to stay in the safe hospital environment. I could sacrifice luxury for safety any day!! In addition the my flat mates were very friendly and helpful and we had a nice time knowing each other and chatting after work.

One of the staff members arranged for a new soap bar and I happily jumped under the shower…Well that would have been luxury. Actually I took a scoop of water from a bucket and splashed it onto my tired body repeatedly, scrubbed my body with the soap bar and dried myself with my shirt and wore scrubs as a pajama.

We then had dinner and I went to bed and slept like a log under the net with mosquitoes swarming over it. I felt the satisfaction of seeing them attempting to get a taste of my blood without success.

Day2, 5th April

At 0450 I was woken by a knock on the door from one of the colleagues to get up for group prayers. I woke up feeling well rested, brushed my teeth, performed ablution and joined the prayers. I then went to bed again and woke up at 0630 when I had a shower and wrote on my diary while waiting for 8pm to start the cases.

Alhasan the Sudanese anaesthetist and Aadel the scrub nurse went ahead of me to prepare the theatre and patients. At 8am I was in theatre but for some reason or another I could not start until 9am. Dr Afrah (junior Gynae resident) scrubbed with me.

The theatre is reasonably furnished but light is poor and instruments not adequate. No long scissors, needle holders etc. There is no anaesthesia machine for GA cases as well. There were however good and adequate sutures. Staff is very keen and helpful.

the condition under which I did a bilateral ureteric implant; no anaesthesia machine, no proper theater light. No self retaining retractor, no proper ureteric stents… to name a few. Just a cheerful support staff and basic instruments

I had chosen to do what I thought to be the easy fistulas first. My decision was based on only outpatient digital vaginal examination which can sometimes be inaccurate. Sod's law had it that this one was a wrong assessment as it turned out that even though it was a midvaginal small fistula, it was very lateral in a fat lady with capacious vagina making it difficult to access and retract all rugae for visibility, compounded by the availability of only short scissors and forceps. The girl is a very pleasant 22yr old girl who had her fistula 3yrs previously and had a failed repair in 2015 which should have triggered warning signs to me. Anyway about one and a half hours later I had finished with a very good outcome and a negative dye test. She was given one unit of blood by the anaesthetic staff. Although I did not think she needed it I conceded without argument since I was already having a tough time myself and worried that the staff with whom I was working for the first time might doubt my competency with negative impact on teamwork. Anyway, with a negative dye test, I sensed relief in their tone.

The second case was that of a 21yr old lady who complained of urinary leak continuously despite a previous repair one year ago. Outpatient examination did not seem to show a fistula and she was booked for Examination under anaesthesia. She lost her only baby months ago following prolonged labour and looked quite miserable. On examination under anaesthesia she had demonstrable stress with fibrosed and markedly stenosed bladder. Dye test was negative for VVF. She was reassured and taught pelvic floor exercise and to consider sling surgery on the next visit if she was still leaking. I was

however itching to do some more operating and could not wait for the next one to come in to be able to build confidence with the team

All doubts however were washed away by the time I did the third case which took very little time and with good outcome despite it its complexity. This was the case of a 25yr old girl with a distal fistula and complete disruption of the urethra (circumferential fistula). This type of fistula is among the most complex and difficult to repair. I was however able to do a good mobilization and achieve a water tight anastomosis in less than one hour. She was set to be dry after 18months of being wet all the time and waking up on a wet and smelly bed every morning. She would this next morning wake up in a dry bed. I sometimes wonder the emotions they go through when they wake up, but it must be good. This may make her begin to forget the pain of delivering a stillborn baby 18months ago.

The team approach had begun to solidify I could see from their face that their confidence in me was getting quite high. It was now getting past 'breakfast' time but we decided to do one more case before breaking. I was told from the beginning that there would be only two meals…one around 1pm which they refer to as 'breakfast' and I would probably rename 'brunch', and another around 8pm which is dinner. I did not mind at all because that was probably my eating pattern back home. Anyway although it was past 1pm we decided to go on. The next patient was luckily a typically simple mid vaginal fistula and we would take less than 30mins from beginning to end. This lady only had her fistula for over 1 month. Although we normally wait for 3months for the fistula to mature before tackling it, I was happy to go ahead with this one because the position was very favourable and I could properly mobilise it. She is also lucky that unlike the majority, her baby is alive and well and she experienced this awful disease for only a month! So this is a good story I guess.

She wanted to know if she could breastfeed her baby and I said yes!

Once done we broke for brunch and prayers. I later regretted this because it was difficult getting people together to restart. In fact I had to do the spinal myself for the next patient to let them know that I meant business. My skills in spinal anaesthesia was also invaluable as I had to help the anaesthesia team a couple of times when they found it difficult to have access. The fifth case is one of the possible disasters of Obstetric fistula. This is a very unfortunate 25yr old Para4 whom I saw already with a

colostomy. I am not very clear about the history due to language barrier. However, her problems started 7 months ago when she finally agreed on a Caesarean section after more than 24 hours of labour for her fourth pregnancy even though her previous delivery was by Caesarean section. The baby was still born and she ended up with double incontinence (VVF and Rectovesical fistula- RVF). She had an operation which according to her was aimed at diverting the stool and repairing the fistula. What I found on examination was total mayhem. The urethra was disconnected from the bladder (circumferential fistula) and the urethra had a blind ending proximally. In addition the huge fistula filled the whole vagina from only 1.5cm proximal to the urethral orifice to the cervix. Just distal to the cervix was a huge RVF. I was devastated and spent several minutes trying to decide on the best course of action: Repairing the fistula is a huge undertaking which would need two surgeons; one working from up and the other from below; we would most likely need ureteric stents as the orifices were too close to the edge of the fistula; the likely hood of success would be very minimal; our anaesthesia support is basic.

At the end, it was not difficult deciding only to deal with the RVF although the patient will not have any change as she will still have a colostomy and will still be leaking urine. It was painful when I went to see her post operatively in a drenched bed when she looked at me with her eyes clearly saying…"you've not done anything for me…look at my bed!!!". Believe me, even though I don't speak her language and even though the people translating only speak poor English and I don't understand them half the time, and even though she did not say a word, her message was loud and clear through her eyes. I felt really inadequate standing there trying to explain to her that I had gone one step towards solving her problems while she is still the same!! Then she, indicated by mostly sign language that I should fix a catheter for her like the other girls who were dry and again I disappointed her by saying there was no point. In fact there was nowhere to insert the catheter. One of the most painful moments for me so far. Total devastation. I just explained to her that eventually, the worse scenario would be reversal of the colostomy and urine diversion through an ileal counduit which means she will be able to pass stool normally and have another bag, only this time it would be collecting urine.

It was a relief that the next patient was a straightforward midvaginal fistula although it was large. I wasted no time repairing it and dye test after the surgery showed it was water tight. We would later learn that it was not that straightforward afterall as there was no urine flowing into the bag when we did a post operative round and that her bed was drenched in urine. It was at that time she showed me a CT scan she had done previously showing that both her ureters were disconnected from the bladder. In short, apart from the VVF she also had bilateral ureteric fistulae although I am not sure if it is ureterovaginal or uretero-uterine. This means she needs bilateral ureteric reimplantation which I will do on the next available list on Saturday.

We started our 7th and last patient of the day at 1830pm expecting only a juxtacervical fistula which can be difficult on its own but we somehow hoped it would be easy. Dye test however revealed that apart from the juxtacervical fistula there were two small fistulae next to each other laterally around the right midvaginal area. The girl involved had been leaking for two and a half years and had a failed repair about a year ago. Ok, another 30minutes additional work. So we just accepted fate and cheerfully went on doing our work. We finally finished about 2hrs later, our reward being a watertight repair with no leak despite adequate dye instilled into the bladder to make it leak periurethrally. It was a good day's work after all.

Leaving the scrub nurses to clear the mess we had made during the day, I cajoled the junior doctors to join me on the post op ward round. In addition I was in turn cajoled to review a patient who was done by the previous team four days ago and is leaking profusely.

All my patients were dry apart from the mixed incontinence on whom we only repaired the RVF and surprisingly one of the midvaginal fistulae whose dye test was absolutely water tight and described above. We flushed the catheter and even changed it to another catheter and planned for EUA the next day if still leaking. I also examined the patient referred to me and she was also leaking profusely. Somehow although this seems awful and selfish it lightened my grief because it made me feel I am not the only one who fails with VVF repairs. We then retired at the guest house and I was able to finally have my second meal of the day and take a bath. I was promptly picked up by the two junior doctors to go and see more outpatients who have been waiting all day. We spent another almost two hours seeing patients some of whom needed 3 swab tests and I could hardly carry myself when I went back and just slumped into my bed around midnight. No time or energy for anything much more writing on my diary. That can wait for the next day!!!

Day 3, 6th April

This day started the same way being woken up at 10minutes to 5am for prayers after which I went back to bed with the intention of waking up at 0630 to work on my diary but unfortunately I could not get the will power to leave the comfort of my bed and protection of the mosquito net from the wicked blood sucking vampires. I ignored all the alarms I set and only groaned out of bed at 0745 knowing that all staff will be ready waiting for me by 8am and if I did not make it they may lose their seriousness. All my joints creaked while walking to the bathroom for a splash of water but everything seemed to click back to normal with a drive of energy as the first scoop of cold water hit my body. As usual, my bath was all done in a jiffy and I was in my clothes all wet as I was still expecting my towel, and off to theatre. I passed by the ward for another round and sent a nurse to theatre to ask them to call me as soon as the first patient was anaesthesized.

This morning an additional patient was wet. This was the last patient I had done with the multiple fistulae and who's dye test was also absolutely negative!! What a bad start to the day. I was so confident of my repair that I said straight away that I will have to take her back to theatre as I suspected there must be something amiss. All others were dry so far making 2 out of six repairs wet. One wet due to additional ureterovesical fistula which was not diagnosed and the other to be investigated. Anyway I just informed the staff that we would do an examination under anaesthesia later to determine if our repair had failed.

We were able to start earlier on this day and by 0830 the first patient was ready to go. This is an 18yr old girl who had prolonged labor on her first pregnancy 8months ago and was rewarded with a dead baby and continuous leakage of urine. Examination under anaesthesia revealed a very small capacity vagina with fibrosis and no cervix to be seen…buried somewhere in the fibrous tissues. This was not a very good start to the day. Anyway I was able to mobilise the fistula adequately enough for a repair. I could not see the ureteric orifices and in fact did not waste much time looking for them as there were no ureteric stents or other facilities to adequately deal with them. So although there was a chance I could catch one of them in my stitch I just decided to do the repair and deal with any problems that

arise afterwards. The worse would be obstruction of the ureter in which case I could do a reimplantation for her. Thankfully the repair was watertight and review at the end of the day showed she was dry and urine draining into the bag. She would need Gynae review later to possibly have a vaginoplasty to be able to have meaningful and painless intercourse and possible fertility.

The second patient is a 20 year old who had Caesarean section following obstructed labour 7months previously for her first pregnancy. Again a dead baby was delivered and she was leaking urine. Examination revealed another dreaded circumferential fistula. I began to accept that this was not going to be a great day. An unexpected leak in a seemingly straightforward case, the first case which was rather difficult and now this! Well, at least, the amount of concentration I needed for this case made me quickly forget my other troubles as I immersed myself into the procedure. It took over 90minutes and the reward was a negative dye test and a smile from the patient after I got up from my stool and went to her side.

Our 3rd patient for the day and 10th for the mission was not going to be easy either. Maybe putting the 3 and 10 adds up to 13 (unlucky number) if you believe in such things. Anyway she is over 100kg 32 year old girl who had a fistula 15yrs previously at the age of 17 and has been continuously leaking urine since then. What a wasted and painful life!! She had a failed repair in 2013 and was now coming back for a second chance to regroup her life after a 15yr sentence even more painful than prison. I examined her in lithotomy position and turned to my team to say that even though it will not also be easy from above (open), I thought she would be better served with open approach as her fistula was way up and my instruments not adequate. I however got passionate resistance from both the anaesthetic and scrub nurse team and yielded to their pleas to go ahead vaginally. After finishing the case I promptly promised the scrub nurse that I was going to report him to my wife for spoiling my back as I had to contort my self in all imagineable positions to get access for a reasonable repair. I was however secretly thankful they insisted as one can only imagine how an open procedure would have gone with her size, poor lighting and state of the instruments. Well we again ended up with a watertight repair but will only know the final outcome in the next few days.

Now, there is a verse in the Quran which says that ‘after every difficulty will come ease’ and that was indeed the case here. The next two cases were rectovaginal fistulae and it took me barely 20minutes to repair each of them. The interesting thing is that the sufferers are mother and daughter. The mother is 70yrs old who had been having stool incontinence through her vagina for nearly 40years and never attempted repair. The daughter is 46yrs old and has a similar condition for 20yrs. What a coincidence!! I wondered if they could easily believe that this is natural for every woman who has delivered to leak stools through the vagina. Well I was pleased that it only took about 40minutes of my effort to end 60yrs of combined suffering and shame. With permission, I later took a picture with the husband and father of the patients who was all smiles. It is such a great picture that I cannot resist sharing it here.

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Mother and daughter both just had successful rectovesical fistula repair and their husband and father

It was just around 1730 and we had done all our 5 booked cases. I therefore asked the patient who is leaking following repair from my predecessor to be brought in for examination. The repair was already 4 days previously. Dye gushed out of the vagina once I instilled barely 30mls in the bladder. This was indeed a failed repair and I really could not do anything at this point because the tissues will be rather friable and any attempt to do anything would only cause more harm. I could not however muster the courage to be there when she was told that she will have to wait and be perpetually wet at least 3 months for her next attempt at repair. I delegated the difficult task to, naturally, the most junior doctor.

Then I had to bring in my own 'failed' repair from the other day. She had clear urine draining into the bag but was still drenching with urine. A dye test however revealed that the repair was intact with no leakage after 200mls of dye instilled in the badder and reasonable pressure applied suprapubically. There was non-dye stained urine with what looked like old blood coming through the vagina. This therefore means beyond doubt that apart from her vesicovaginal fistula she has a uretero-uterine or ureterovaginal fistula. I was relieved that in fact my repair had not failed and reassured her that she would be operated and from all intents and purposes will be dry. She is planned for IVU to try to determine which side is affected and ureteric reimplant following that.

Finally we were ready for dinner early. It was only 7pm. I forgot to mention that I did have my brunch as shown below in between cases but refused to allow an official break to avoid delays. I did a quick post op round and was happy that most of the patients were doing well.

Brunch consisting of cloxacillin and metronidazole with tea and pancake!! The drugs metamorphosed to milk and sugar once opened.

I then retired to the residence to freshen up, pray and have the main meal of the day before setting out for more outpatient consultations. I was limited to seeing only 10 patients by my team which worked out very well for me as I really wanted to have an early day. By 10pm we had seen all ten patients and even did a small procedure for one of them. Afrah, whom I have been teaching how to assess VVF patients, and got her to examine before I did, had started to get more accurate diagnoses. I am a passionate teacher and always very keen to teach and learn from those working with me. The procedure we did was for one of the patients who had repair of a perineal tear some months ago and had a perineal band across the anus which I excised under local anaesthesia much to her delight.

I was able to go to bed early and wake up this morning to do the diary.

Day4, 7th April

I woke up fresh and well rested and after having prayed with the group came straight to my room to write this. I am excited and apprehensive about the double ureteric implant booked for today. I had asked the team to get me a self retaining retractor and longer instruments if possible but have no idea if they will be available. In addition I asked the resident general surgeon to assist me during the operation as I will need more hands and he has agreed. There are no ureteric stents so I might have to improvise with feeding tubes. I really hope that it will be good news I report later.

ADVENTURES IN MOGADISHU, SOMALIA

Two female doctors on a wrist fight to determine most fit for assistant position (mainly for retraction) for the reimplant case!!

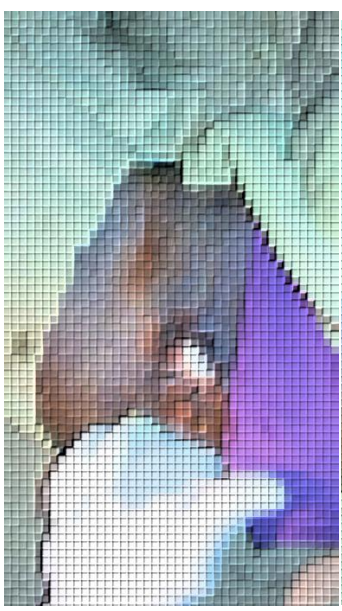
I started with a ward round as usual just after 8 o clock having informed theatre that I am around. None of my team members is around apart from the foreign staff (Adel the scrub nurse and Hasan the anaesthetist). It is a public holiday on Friday and staff is expected to come late. I decided to do the ward round on my own purely through sign language which I must say is as fluent as my Russian; in other words, zero.

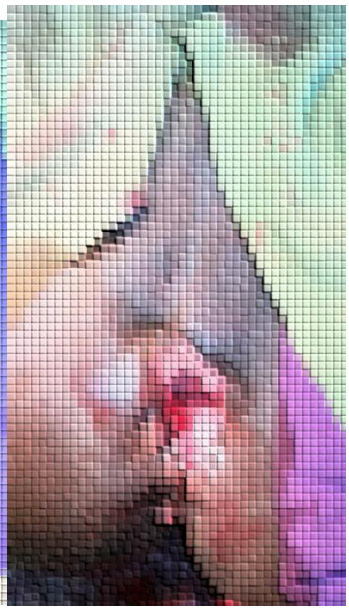
Again, one of my patients of the previous day was leaking. This time I suspect a failure rather than other issues because it was one of the difficult ones described above. I however flushed the catheter and asked her to lie down prone and will review later to consider EUA and revision in case she was leaking.

The rest of the patients were dry drinking and draining, a satisfactory outcome if things remain that way.

I then went to theatre and we decided to start on our own. Even telling the patient to come into theatre was a big task as none of us speaks the local language. Finally we were able to convince the pretty and pleasant girl to come in to the theatre and sit her down on the operating room and poke a needle into her back bone without being able to explain any of that in advance. She was amazingly cooperative though and the skilled anaesthetist was able to get a spinal within a just minutes.

What I saw on examination amazed me. She had a type 3 female genital mutilation with both labia majora and minora completely excised and the clitoris excised as well. In addition it seems the first person who saw her following the RVF thought that by just closing the vagina up the stool leakage would stop!! They also probably just blindly took big bits and sewed them together. The result is the inferior two thirds of the introitus was closed with considerable scarring and the rest of it could barely admit a finger. It was actually easier accessing the otherwise capacious vagina through the anus and the RVF!!! So my first action was to reopen the introitus to have access to the vagina and I then mobilized the fistula with some difficulty due to the extensive fibrosis. But once that was done it was easy to close it up and revert the vagina to normal anatomy. I am sure this would be a relief for both her and husband.





Before demonstrating fistula *Before* *After*

The next patient made me hope that this is going to be the usual pattern with the first couple of cases being horrible and the rest easier. She is a very unfortunate 16yr old girl who developed a fistula 1yr ago following a prolonged labour with delivery of still born. There is evidence of multiple perineal tear with crude repair and thereby the fibrosis and stenosis. I tried to increase the capacity of the vagina by cutting through the stenosis and was able to eventually insert two fingers with tight grip. The urethra had a blind end proximally and the bladder and urethra were plastered to the pubic bone. There was no point trying to repair her. I had to explain that the best option for her would be diversion. I nearly shed tears as I looked at her looking so calm and collected with a hint of smile on the operating table. She is only 16 for God sake. Can you imagine a 16yr old girl having any future sexual life and fertility destroyed with her only option of being dry a urostomy bag attached to her abdomen for the rest of her life. All because of inequalities that exist in this world! My 18yr old daughter finds it difficult dealing with lack of a phone for only 24hours when it is seized as a punishment and would certainly feel the world is over if she does not get the opportunity to go to a particular university in a particular country and do a particular course. And look at this girl now only 16 with no education facing the prospect of life with no sex and probably no viable marriage and no children and having to deal with buying and managing a urine bag attached to an ugly stoma on her abdomen every day of her life which is just beginning. I just can't begin to explain my emotions.

The troubles of this day seem not to be ending as I brought in the leaking patient from yesterday's list in and a dye test quickly revealed a failed repair with dye gushing out. I guess a suture has given up and this could easily be sorted if we go in today. Therefore I have decided to have a second look later to see if things can be remedied. Is this turning out to be a black Friday?

It is now 1321 and I am back from mosque and in theatre waiting. My anaesthetist was the imam (pastor) at the mosque and led the prayers. I guess he is going to take his time and there is nothing one can do about it as he is the boss having led us in prayers. It is like when you are really in a haste to go

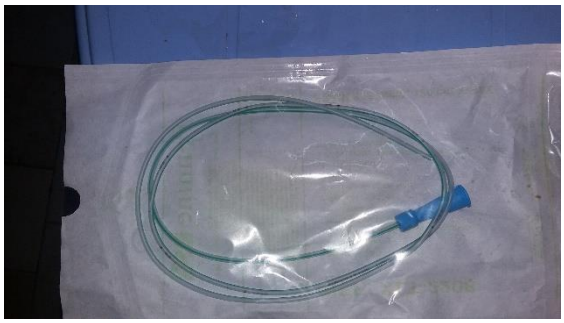
out and your wife is busy doing her makeup which you will not even notice anyway!!! I am sure the men understand what I'm saying.

 *my anaesthetist just before we started the ureteral implant surgery*

Adel is in the theater trying to get instruments ready. Success in this one will drown all the morning disasters but failure will make it a black Friday indeed. I must admit, even though I have done this operation successfully many times and never had a failure, I am nervous with this one as I am working with bare minimum and improvising everything. For now there is no ureteric catheter. The smallest thing I have got is size 10Fr suction tubing which I intend to improvise. Just as I am writing this Dr Afrah comes in with a size 8Fr long NG tube which I can improvise and thing it will work very well indeed! Things are beginning to look up. Now I will go check if we can get the diathermy to work and if it does I will even feel happier.

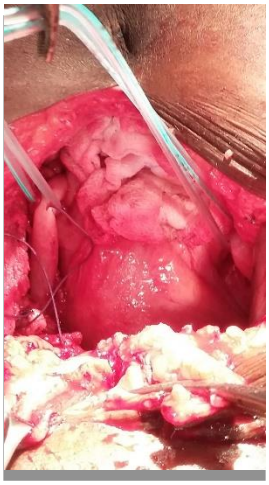
Wow!!! What a nice end of the day! Definitely not a black Friday. Just completed a bilateral ureteric reimplantation for the patient. Blood loss less than 200mls. I had to deal with lots of adhesions but took less than 2 hours!!! The Gynae doctors who did the C/S and subsequent hysterectomy must have tied or transected both ureters. I used two long NG tubes size 8Fr as ureteric catheters and they are almost as good as the real thing. Now I must say I am happy and satisfied. Even if this is the only case I did here, it would have been worth it. This lady has just been given a new lease at life.

Patient about to receive spinal anaesthesia with cloth in her mouth to prevent herself making any noise



NG tube improvised as ureteric catheter

The team around the operating table assisting me; At the top Saleh who did a wonderful spinal that lasted the whole procedure: opposite me as first assistant is Dr Muez, General surgeon, also opposite me is the junior doctor in Hijab, Dr Afrah and next to me is Adel the scrub nurse. The two small spot lights seen are the only lights I used for the whole procedure.



Here the two ureters are already isolated both with improvised slings around them. The bladder is also already bivalved prior to the reimplatation but the reflection from the flash obscures it

After this great success I am now ready to face yesterday's failure. I decide to bring her to theatre and try to look for the source of leakage and hopefully fix it. There is nothing more pleasing than fistula work when it is successful. I am really over the moon at the moment and have the energy to go on for the next 24hrs operating but obviously I have to think about my team and we are breaking after this next patient for the day.

The patient arrive in theater around 6pm and after spinal anaesthesia she was again positioned and I found that she was leaking from an inaccessible corner where the circumferential fistula was repaired. I managed a coupl of stitches which reduced the leak considerably and abandoned ship so as not to cause any harm. I hoped that with good catheter care and drainage she may be dry. Otherwise it has to be looked at again in the future.

Following this attempt we went back to the ward and checked on our ureteric implant who was over the moon. All the other patients were dry except the other ureteric fistula awaiting surgery on Sunday.

Overall we had only one failure so far which I revisited today and hope it would resolve. This is really good outcome especially considering that a good number of them have had previous failed repairs.

I then went back to base for dinner, freshening up and back to the clinic. We saw 10 patients in total after which my team had to go to do a caesarean section for an obstructed labour of over 24hrs duration. I just hope this was not going to be another fistula. The cases we saw included an 18month old with abdominal distention, recurrent constipation and leakage of stool per vagina. Rectal examination was consistent with distal Hirschsprung disease and I advised the mother to dilate the anus daily and see paediatric surgeon if things do not resolve.

Now tired but fulfilled I am in bed to get well deserved rest. It is exactly midnight.

To be continued…

Day4, 8th April 2017

Again, just like clockwork, my colleagues woke me up at 0450 for the group prayers after which I did not waste time going back to bed. Even then I found it difficult to wake up on my first alarm at 0715 and ignored the subsequent ones. I only got off the bed at the nick of time hoping that two minutes would do for taking a bath dressing up and taking the 3minutes walk to the ward, peek at my patients and arrive in theater exactly at 8. Unfortunately, much to my surprise, it did not work out just like that and I was in theater only around 0720.

My patients have all remained dry except the patient I took back to theater last night who is still leaking although less than before. I had to resign to the fact that this would be my first real failure of the trip and who knows others will come. She seems to be taking it very well though and still can afford a smile when she sees me approaching. It was however funny trying to explain to her and all the nurses that she should lie down prone (on her tommy). In fact, to demonstrate, I physically had to lie down prone on the next bed beside another female patient, which they must have found either offensive or hilarious although no one laughed or screamed at me. I could not do it on her bed because it was rather wet.

We booked six cases for today but having discussed with the general surgeon, I transferred the one for colostomy reversal to him so that I could do more fistulae.

The first patient to be done is a 20yr old para two whose last baby survived the prolonged labour that caused her fistula unlike most fistula patients who lose their babies as well. In addition she is lucky in the sense that, if I am right depending on my digital exams in the clinic, it is a midvaginal fistula and will be easy with up to 90% success rate in my hands.

It is now 0916 and we are yet to start. The first patient could not be cannulated because no veins were visible or palpable and everyone tried including myself without being able to get a line. We decided to put her on hold and bring in the next one while she is tried for cannulation in the ward and if it does not succeed, I will do a cut-down.

We decided to do the next patient on the list who has been leaking urine continuously for 2yrs. She is 30yrs and has no child because all her last three pregnancy including the one that caused her fistula

ended up in stillbirth. To my dismay the theatre resources had started getting drained including even heavy equipment!! The theatre bed broke down yesterday and can no longer tilt head down or head up. This means I will find it difficult to position the patient properly for easy repair. In addition, we have started running out of sutures and I have to now start managing with either bigger sutures or bigger needles. This patient was another circumferential fistula!!! Most of my cases have turned out to be complicated! Anyway, one has to move on and this time I had to start using my great gymnastic skills. Since the table cannot be tilted, the surgeon has to tilt or contort himself into strange positions!!

Squatting in front of stool To get better view

One of the uses of a bucket right here

Anyway following 1hr of gymnastics, the difficult circumferential fistula was adequately mobilized and repaired with no leak after instillation of 200mls of methylene blue despite the difficult circumstances. Now it was time to celebrate with brunch.

Brunch, and I ask myself what is this?

Turned out to be just a pancake

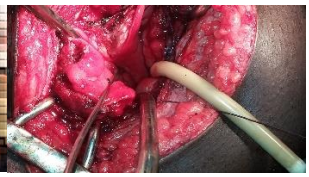
After brunch we took in a 30yr old who complains of continuous leakage of urine not associated with stress or urge for 10months. She is para 4 with all children alive and well and no history of pelvic surgery. Examination under anaesthesia is absolutely normal with normal vulva and perineal skin (no dermatitis associated with urine leak). Dye test both rectally and in the bladder yielded no leak. She was catheterized and given frusemide to see whether she will leak from a ureterovaginal fistula. Review later in the ward revealed she was dry. She probably just has stress incontinence!!

The next patient is a 16yr old para1 with a live baby who came on account of stool incontinence and was found to have an anterior anal sphincter tear and she was successfully repaired in a procedure that took less than 30minutes.

Since they still could not get a line for the first patient, I now advised for the last one to be put in while I try to put in the line myself. There was indeed no visible veins and after several failed attempts for peripheral venous access, I resolved to put a line in the subclavian using an ordinary green (18g) canula instead of a formal central line. It worked but I warned the team about the dangers of doing it this way.

I then went to theatre to find the next patient already anaesthetized an on the table ready for action. This one is a 23yr old girl who had three previous pregnancies the last one being a twin gestation in which she finally delivered one stillbirth and had caesarean for the second twin also stillbirth and ended up with the fistula. The fistula was high up (juxtacervical). We started off trying to tackle it vaginally but I got frunstrated because of the immobility of the operating table and very short instruments like the one shown on the picture. So I converted to open and was able to confidently repair it from above with omentum brought town between the bladder repair and the vagina. It was another triumphant moment despite the difficulties. The spirits were so high after this that the staff started simultaneously singing somali songs which I recorded in video. I personally felt very fulfilled.

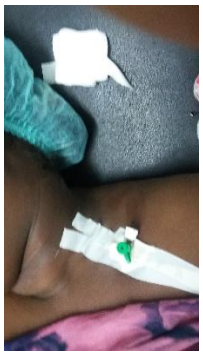
Short instruments



converted to open with good outcome

Now it was turn for our patient who had to wait the whole day because we could not get IV access which is in place now having used my central line insertion technique. I thank God for having learnt so many skills and continue to advise junior colleagues to do so in case they get into situations like the ones I have described above where I had to step up to do somethings not expected from Urologists, to save the situation.

Struggling for a line



subclavian line finally!

Now in theater ready to Tango

This case, at the end, brought us from the peak we had reached previously to the lowest trough. I left the theater after this feeling very down especially that I had developed a wonderful rapport with this young girl who's name Gaalo, is translated as 'love'. She is 20yrs old and had been leaking for 6yrs prior to meeting me. Her first deliver was a caesarean section and thank god she had a live baby for her troubles. Unfortunately during her second delivery she took too long trying to deliver vaginally which

probably was never going to happen due to her height. She still ended up having a caesarean section to deliver a dead baby and ended up with her fistula. My initial assessment was a midvaginal fistula but in theatre we found out it was a nasty circumferential fistula with a short urethra of less than 2cm(one finger breadth). The table again was an issue and now I began to run out of the proper sutures as well. After struggling for more than 2hrs with all sorts of gymnastics to get to the right angles with the short instruments and too small or too large needles, I gave up trying to achieve a watertight anastomosis. I think I was also at this point getting fatigued. I just could not take the fact that this pleasant girl who had patiently endured for six months and also patiently endured several people puncturing her skin to get an IV line, endured the spinal anaesthesia and uncomfortable position on the operating table; the girl who agreed to take a picture with me in theater and smiled for the picture is going to end up wet and may have very little chance of getting completely dry in the future except with a diversion. It was a painful moment. Maybe I should sometimes emotionally distance myself from these patients but I can't help it.


Now as I am writing this, it is a quarter to 8am on my penultimate day with so much to do and now realizing that I cannot do them all. I have to now go take a bath and head off to theater. I hope I get a better day today. I was promised someone will have a look at the operating table to see if there can be improvements and that sutures will be brought in.

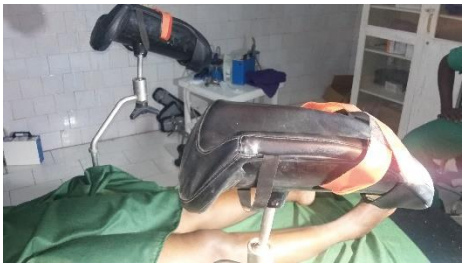
Day5, 9th April 2016

This is the penultimate day and my patients have remained the same. All dry, so far, apart from two. One of the two is, definitely, a failure but I plan to take the other back to theater today if the conditions are better. As I was going to theater all my thoughts were on how to sort out the theatre table problem and if more sutures will be provided. I started regretting not bringing my own special scissors and needle holders.

As soon as I got to theater we decided to change the operating room to the second of the two available because there was a better bed in that one. I guess the staff sensed my silent frustration yesterday and all were over cooperative today. Also just before commencement of the second case, new good sutures were brought in.

Moving theater

Additionally, although I was going to use it only for one night, my room was fitted with an air conditioner!!! No more sweating and twisting and turning at night due to the heat. Furthermore during our search in the theater and vicinity we found an old abandoned table and with it very good stirrups for lithotomy and promptly took them, cleaned them and installed them in the table.



Therefore we have a new theater, new operating table, good sutures and all ready for work!!

The first patient of the day was a 39 year old lady survived 9 vaginal deliveries but on her 10th, 8 months previously, she could not win the battle and ended up having a caesarean section yielding a still born baby and subtotal hysterectomy. She, being a grand multiparous, must have had more of uterine atony than cephalopelvic disproportion. Hers was a juxtacervical fistula giving the suspicion that the fistula could be iatrogenic during the caesarean or hysterectomy. Anyway, the fistula was easily mobilized and water tight repair achieve without difficulty. The new operating table made a big difference!

Following this, came in a very young girl claimed to be 17 but, I could wager that, age testing will prove she is no more than 15! A pretty little girl who should have been in school rather than in our operating theater going through the most horrible experience a woman can go through. She was married 2 yrs previously to a 40yr old man, got pregnant and ended up with horrible perineal tears and some degree of incontinence. One could see the fear and shame in her eyes for something she had no hand in. Luckily for her, there was no fistula and urethral length was good. She may however have some weak anal sphincter due to possibly tear of some of the fibers of her external anal sphincter. I thought it was better just to treat conservatively and only made some releasing stitches on the fibrotic areas causing vaginal stenosis and asked the girls to teach her pelvic floor exercise and see how things go.

Naimo ?17 and me

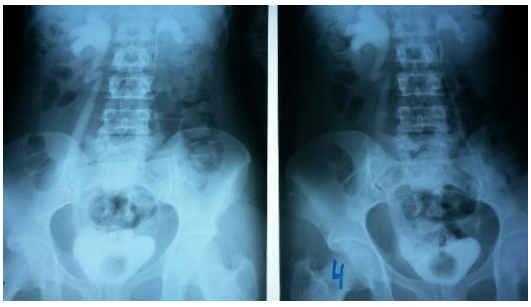
Improvising hat for mask…looks trendy!

Dr Afrah Now Position Patient
And Put Retracting Stitches while I chill

The next patient has had her condition for over 10yrs and endured a previous failed repair. She is 28yrs and currently has no children to show for her troubles in a country where the worth of a woman is measured by the number of children she delivers. She also had a juxtacervical fistula which again was mobilized from the cervix and repaired with little difficulty. The repair was water tight.

We were going very well and although we started around 10am due to the move from one operating room to another, we had already done three cases before our usual brunch. This was obviously all due to the improved condition and I no longer had to struggle to see some nooks and corners. While waiting the IVU for the patient with suspected ureterovaginal fistula came back and everyone looked at me with awe like a magician because I predicted one side would be hydronephrotic and lo and behold here we are with a gross hydronephrosis and hydroureter of the right side with leaking at the end of the right side! So now we know which side to go for when we open up. I promised the young resident surgical consultant an opportunity to be the main surgeon for this one and he was elated.

Brunch with 'fool' (fava beans) and Omelette



IVU of UVF patient with hydronephrosis and leakage on the right

Our 4th patient of the day was a 50yr old lady who suffered for 17yrs with her condition with 2 failed attempted repairs. On exposure, one could easily see evidence of previous repairs with scarring. I was not sure if where the dye is coming is just the end of a tract beginning somewhere else. One can easily

have this in a previous repair where the corners were not well apposed and a tract is formed leaking more medially. I therefore made it a point to raise bigger flaps and mobilise adequately and was able to see three fistulae; two medially which I joined to make one and one on the right lateral aspect. I repaired the fistulae and was able to achieve a negative dye test. This may be her third time lucky. As is documented, the most likely fistula repair to succeed is the first and the more the attempts, the lower the success rates. In this campaign, I have done several second and third time repairs and they are, so far, dry. I will have to document this if they remain so and share my techniques.

The next patient is a 19yr old lady whose problem is 'inability to consummate her marriage for 2 years' because her husband could not 'penetrate' her. She also does not have menstrual cycle. I had requested for an ultrasound scan to confirm presence or absence of uterus but they found it convenient to comment on all other abdominal and pelvic organs but not the genitalia!! Anyway, examination under anaesthesia revealed agenesis of the vagina with no cervix felt. On bimanual examination, a uterus was not ballotable. She has normal female hair distribution and normal breast development. I do not know the epidemiology of vaginal and uterine agenesis but made a mental note to read on it. I advised the girls to counsel her on her condition after insisting on proper ultrasound scan and also suggesting vaginoplasty to be done by the incoming team.

The 6th and final patient of the list, before bringing our 'failure of the previous day', is a challengingly huge circumferential fistula in a 25yr old girl who has only two children out of 3 pregnancies because she lost the last one during a prolonged labour and ended up with this horrible fistula. Because of the size of the fistula one was looking straight into the bladder on retracting the introitus. We could in fact see both ureters clearly and catheterize them. We then mobilized the bladder by blunt and sharp dissection and tubularised the anterior end around the proximal end of the urethra while we closed the inferior aspect with running vicryl 2/0 suture. The outcome was also a watertight anastomosis. I worry about stress incontinence because of the short urethra.

Although the last patient took a lot of time and it was already way past closing time, I insisted on bringing back the patient we could not repair properly the previous day due to the theater condition. I hope your remember her, I even mentioned her name, Gaalo which means 'love'.

I insisted because, I now know that she can have a better chance with the improved theater condition and if we left it for the next team they would not be able to do much because tissues will be too friable to handle and the best would be to leave her for another 3months. The theater staff, as usual, was very understanding and cooperative and brought her in, in no time for a second attempt at repairing her. As usual she was all smiles. I just cannot believe this girl who is taking things so well at the face of so much adversity.

Anyway, her patience and perseverance and our insistence paid off because after the repair a dye test was negative. We achieved this by reopening the whole wound and undoing the previous anastomosis. We then mobilized both ends more, which was possible because of the bed position. Patient positioning is one of the most important aspect for fistula repair and all aspiring fistula surgeons should be taught this. I sincerely hope that the anastomosis holds to justify the over 3hrs work in 2 operations and one third of her total life spent leaking urine continuously. It would be a major thing waking up in a dry bed the next morning for her.

ADVENTURES IN MOGADISHU, SOMALIA

Seven cases for the day left us tired but in high spirits because all went well and are, so far, dry!! Ward round was also pleasant with no unexpected twists. I was looking forward to my last day and to seeing my family soon but I was also already feeling sad having to leave my patients behind and my new colleagues and new friends including the armed guard…for good reasons!

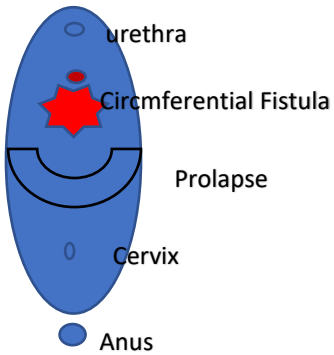
Final Day, 10th April 2017

Since I woke up this morning for the group prayers, I have been on my computer doing several things including; amending a discharge instruction letter I give to all my fistula patients, a hand over note for the next team, and writing on the diary. I intend to go to the ward by 0745 so that 0800 we can have 'knife on skin'. My flight from Mogadishu is tomorrow morning so I will have to go tonight to spend the night there. I have to be out of the village by 5pm because it is unsafe to travel in the dark which is the same reason I could not wait until dawn tomorrow to leave the village.

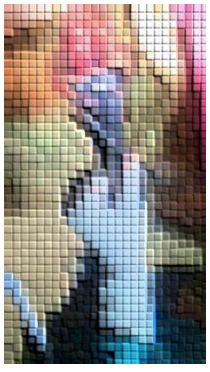
For some obscure reason we again started late today although I was, as planned, in the ward by 0745 doing my rounds and was in theater by 0815. However, on arrival there was no one on sight and they only started trickling in one after the other a little later…African phenomenon I guess! Ward round was very encouraging with all dry except the one already known established failure. It was nice going bed after bed and writing the three Ds (Dry, Drinking and Draining).

The first patient today is another grand multipara (para11) who 'lost the skill' to deliver probably from uterine atony and ended up with a fresh still born and a fistula 6yrs ago. She also had an anterior vaginal prolapse. The fistula turned out to be another circumferential fistula as can be seen on the attached picture. Dissection and mobilization was straightforward, anastomosis was done without difficulty and dye test was negative. However we continued to have instrument attrition with one of our better scissors found broken in the set.

Circumferential fistula



Schematic diagram



Broken scissors in set

We were beginning to realise that we may not be able to do all the booked cases for the day…thanks to the avoidable late start. I was called by headquarters to request me to stay a couple more days because the team that is supposed to take over from me is delayed. Unfortunately, I had to decline because I

had other major commitments back home. It was a pity that there would be a pause to the program much to the anxiety of the awaiting patients.

Anyway, it was time to put the patient with the ureterovaginal fistula in. The findings were, as expected, of right hydronephrosis and a ureterovaginal fistula. This would be the third UVF I have seen that was not iatrogenic during my whole carrier. Actually one was about 12yrs ago in a teenage girl who had never delivered a baby and she did not have any urinary problem at younger age. I suppose I was then working with Mike Bishop (but I am not sure). We never worked out what the cause was. Unfortunately we did not report it.

I supervised Dr Muez to do it and it went on without any hitches except that, at the time of stenting the ureter, we suddenly did not find any of the few NG tubes we had put aside for it and we had to run helter-skelter and finally settle for a size 8Fr suction tube. Although short and could not adapt to the urine bag, it was ok at the end. Dr Muez was very grateful for being given the opportunity to be the main surgeon in this one.

Now we were running very late and I had to chose one of the three remaining cases for the day and it was indeed a tough decision. We settled for what we thought was the most difficult being a juxtacervical fistula. The patient is a 32yr old para 5 who developed her fistula 18months ago and had a failed repair 5 months ago. A new consultant Gynaecologist had heard about our campaign and came to learn from me so she assisted this case. I took it as a teaching case and showed her how to raise the flap and how to dissect the cervix off the bladder safely which is the most critical step. I think she learnt a few things and regretted not coming earlier during the campaign. The repair was water tight and I left the team to clear up while I dashed to change my shoes and go for a final ward round. Getting away from the theater was very emotional and I was really close to tears having to explain to the two outstanding patients that we would not be able to do them and see them burst into tears out of despair. I told them that although delayed, my reliever would be arriving soon. It seems that word had gone round that the success rate so far was very good and they were hoping that I did their case. In any case I have total trust in Dr Salleh, an experienced fistula surgeon whom I worked with in The Gambia. Although delayed he will be coming and I know he they will have the best chance possible in his experienced hands.

I had to do a final check on the in-patients and say bye. This was also a little emotional but lots of smiles and show of love and appreciation in a population that is usually very meager with their emotions. Gaalo showed me a wet spot on her bed but I sincerely hoped it was just secretions or leakage around the catheter since her urethra was so short. We will certainly know in the next few weeks when it is time to remove the catheter. The others were all dry apart from Amina who was declared the only established failure a couple of days ago.

I then wasted no time rushing to the residence to freshen up before going to the city to spend the night so as to make the early morning flight tomorrow. At the residence I had to say goodbye to staff and newly made friends and we took pictures and selfies and I was really treated like a hero and according to one of the local staff, in poor English, ‘a legend’. This was a real complement, assuming he knows the meaning, because although this was my first time here the hospital had gone through several other fistula campaign this being the fifth for PAC.

Gift from Efrah and Team

Selfie By Dr Muhammed, Paediatrician

Efrah trying to hide from Muhammed's snap

At the residence entrance

Male team

With female members too

Front Right to Left: Shiekh Hasan (anaesth), self, Mr Adel (scrub)
Back Right to Left: Diadin (lab), Dr Muez (surgeon), Dr Mohammed (paed)

Once the vehicle set off, I heard Adel on the back seat sobbing profusely. I really felt sad but I am not one of those who shed tears easily. Anyway, when he got his breath back he explained to me that the reason he could not hold back was when he noticed the desperate look of the women watching us leave. The realization that there is no turning back, having been there waiting for so long and having hoped we will sort their problems out and having seen several of their fellow patients go in and knowing they are now dry. According to him, the look in their eyes seem to ask: "How can you people go and leave us here with our problems when you can do something about it?" It is really sad.

Anyway, this is the end of the trip for me. After over 48hrs travel and five days of work, I saw about 50 patients and did about 30 procedures for about 25patients mostly with complicated and previously failed repair with over 90% success rate so far. I am really proud of this achievement and think that the few people whose lives I have touched and those younger colleagues I have inspired was worth the trip.

For the young doctors who worked with me one thing I left with them is the quote that the characteristics of a good surgeon are "heart of a *libaax*, eyes of a *gorgor* and gentle fingers of a *marwaada*". On the last day one of my assistants was following my continuous suturing and just before my suture got entangled around forceps she spotted it preventing it in a difficult moment and the other praised her saying: "*gorgor!"*. The somali words *libaax, gorgor* and *marwaada* stand for lion, eagle and lady respectively. I had given them this quote on my first day and made them teach me the translation. Hearing them use it now meant they at least got something from me!

ADVENTURES IN MOGADISHU, SOMALIA

I really thank PAC for giving me this opportunity to serve humanity and thank my family for the understanding and the sacrifices they have taken to let me come to presumably one of the most dangerous areas on earth. Although the campaign was purely voluntary from my side with no monetary gain, PAC was kind to refund all my travel expenses and hotel accommodation for both the successful and earlier failed trip. PAC had also done all possible to make my stay comfortable with and provide feeding for all staff during the entire campaign. May Allah reward PAC for this great work.

The staff are very dedicated and hard working. I thank Dr Afrah and Dr Shams for being available all the time. Mr Adel for making sure that the available equipment were sterilized in time and managed properly. Mr Alhassan for promptly and safely anaestetising the patients under difficult circumstances. My special thanks also goes to the local staff who worked tirelessly and always with a smile to enable us do such a large volume of work in only 4 and a half working days!

I now have to go back to The Gambia to face other challenges. I have exchanged addresses with the doctors and administration so that I get a full report on all the final outcomes which I may even publish. I will not mind considering to come another time if it does not clash with any other of my many activities.

My second to last patient Hindow has the same name as my mum (Hind). I got someone to tell her just before her operation and she gave me a glowing smile just like my mum's. She has been leaking for over six years now and had a failed repair in the past. I did both a vesico vaginal fistula repair and ureterovaginal fistula repair for her and she is most likely going to be dry now.

I would therefore like to dedicate this trip and all the goods achieved to my dear mother whose aspiration it was for me to become a doctor and encouraged me. Her famous words were: 'doctors are angels' and she has inspired and always encouraged me to become a doctor, to be a kind doctor and to be a caring doctor for no other reason but to serve humanity and God.

My Dear Mum: Hind AbdelAleem Jah

ADVENTURES IN MOGADISHU, SOMALIA

Abubacarr Jah: MBBS, $MRCS_{ENG}$, $FWACS_{UROL}$, FEBU
Consultant Urologic Surgeon
Senior Lecturer at the Medical School of University of The Gambia
Fistula Surgeon