Uganda Pediatric Surgery Camp 2013
Dear Colleagues:

The 2013 Pediatric Surgery Camp in Uganda represented the first interdisciplinary collaboration which included both Pediatric Surgery and Pediatric Urology. The Pediatric Surgery Camp was extremely successful with 101 children receiving surgery at Mulago Teaching Hospital in Kampala, Uganda.

We worked closely with our surgical colleagues Dr. Doreen Birabwa-Male, Dr. John Sekabira, Dr. Phyllis Kisa, Dr. Rosemary Nassanga to deliver the care of children. I would like especially thank Sister Agnes Navvuga who is the Senior Sister in the Main Operating Room. Sister Agnes has welcomed us each and every time we come to the Mulago OR, and she works extremely hard to make sure the surgical team is organized and has everything it needs to care for the patients and families. Webale nyo, Agnes Mukwano!

Our time in Uganda also included a site visit to Soroti Regional Referral Hospital. Cheryl Baldwin and I went and visited with Dr. Sister Mary Margaret Ajiko and Dr. Emmanuel Paul Battibwe. The purpose of our visit was to organize the newly established, “Soroti Children’s Project” which now sends four medical students for a service-learning project each summer. We also made preliminary plans for a Pediatric Surgery Camp in March, 2014 to be held in Soroti.

I would like to take this special opportunity to warmly thank our local Canadian colleagues who worked collaboratively with our Ugandan health care team counterparts: Dr. Geoffrey Blair, Dr. Eleanor Reimer, Ms. Cheryl Baldwin, Ms. Kat Lidstone, Ms. Jennifer Dunlop, Dr. Heng Gan, Mrs. Catherine Blair, Dr. Jennifer Stanger, Dr. Sean McLean, Dr. Gareth Eeson, Dr. Marty Koyle, Dr. Niki Kinaroglu, and Dr. Guy Hudson.

Our work at Pediatric Surgery Camp would not be possible without the kind and generous support of our donors and granting agencies. A very special thanks to:

- Mrs. Helen Prowse
- Mrs. Betty McGill
- Mrs. Stella Perdios
- Ms. Marie Rogers
- Mr. Ron Rogers
- The Canadian Association of Pediatric Surgeons
- The UBC Branch for International Surgery
- The BC Children’s Hospital Medical Staff Association
- BC Children’s Hospital Foundation Children’s Circle of Care Program
- Health Partners International of Canada
- Kimberly-Clark Health Care
- The Canadian Association of Pediatric Surgeons

In closing, my most favorite part of the Pediatric Surgery Camp was when Catherine Blair and I would visit the children’s surgical and urology wards at the end of the surgical day. We blew bubbles, gave stickers and visited all the children and their mothers on the unit. We would intentionally stand in the wind of the open window so that our bubbles would blow down the ward. In return, the children greeted us with big smiles, danced, and truly jumped for joy on arrival on the unit. As we would leave, we would say to the families, “Tuka Bulungi” which means, “Safe Travels” in Lugandan.

Yours sincerely,

Damian J. Duffy
Project Coordinator
Uganda Pediatric Surgery Camp
I first made contact with my Ugandan surgical colleagues in 2002. At that time Dr Doreen Birabwa-Male was the only fully trained pediatric surgeon in that country. She and I and others in her Surgical Department spoke then of how it would be a very good thing if somehow a stronger linkage between our UBC pediatric surgeons and the Surgical Department at Mulago Hospital/ Makerere University could grow. Both Canada and Uganda have approximate populations of 35 million, however, unlike Canada where we have a ‘greying’ population, half of Ugandans are less than 16 years of age. Like all nations, its future lies with its youth. To contribute to the health of Uganda’s young as we care for our own is a worthwhile goal. Initially the early partnership consisted of various meetings and visits to each of our countries, including one special visit in 2004 where contingents from our respective Faculties of Medicine met ‘half-way’ in London, England and we forged a Memorandum of Understanding between our University of British Columbia and Makerere University with the hopes of fostering a continuing learning and knowledge-sharing partnership.

It was during a visit to Uganda in 2007 when Dr Doreen suggested that we form a small team to help with a Pediatric Hernia Camp in 2008. She told me and my wife, Catherine, of how she had recently held such ‘hernia camp’ and it had helped many children who otherwise may not have had easy access to straightforward hernia surgery. Childhood hernia is a common condition in both our countries and gets treated within a few weeks or at most a few months of diagnosis in Canada. It can cause chronic pain and may strangulate the bowel if left untreated. Our country has now approximately 60 pediatric surgeons and 16 pediatric health centres wherein those surgeons operate. Access to pediatric surgeons is far easier here than in Uganda where, in 2007 Dr Doreen was the only pediatric surgeon. The prospect of helping in this manner was intriguing. How could we refuse? It seemed like this was something concrete that we could do together to cement the Uganda/Canada pediatric surgical partnership. So the very next year with a nimble team of eight BC Children’s Hospital faculty, staff and residents which included nursing, anesthesia, child-life and pediatric surgical personnel, we participated in our first surgical camp at Mulago Hospital alongside our Ugandan friends. 450 children had their hernias fixed in the short week we spent there. We were keen to come back in 2010.

Logistics and fundraising prevented a 2010 camp, but in 2011 we returned again at Dr Doreen’s invitation. This time it was a hernia camp with a few added ‘pluses’. In addition to repairing hernias during that camp we also operated on many children with more serious conditions; tumours, congenital conditions of the bowel and such like. We spent a week operating at Mulago Hospital but we also spent an extra week holding a similar pediatric surgical camp in the west of Uganda, in the community of Ishaka. Importantly, during this 2011 camp there was more of an educational
component, taking one additional UBC surgical resident with us and having three Ugandan surgical residents and four of their anesthesia residents attached to both the Kampala/Mulago and Ishaka camps. Two European medical students also grafted themselves to the full camp team and proved to be invaluable help. In Ishaka especially there were literally scores of medical students who had good learning experiences in the short week we spent there. In fact, 3 of the Ishaka medical students with whom I am still in touch with made the decision during that camp to pursue surgery as a career. Certainly the 2011 Pediatric Surgical Camp proved to be a rich knowledge-sharing experience.

In 2011, by sheer coincidence, when we arrived at Mulago to begin our camp, there was a team of urologists there for that week, two of whom were pediatric urologists. This proved to be providential as we were faced that week with a series of children with complex congenital problems that required the expertise of both pediatric surgeons and pediatric urologists. It was fate, and we unanimously agreed that our next camp should include pediatric urologists. Drs Hudson and Koyle who were the two pediatric urology specialists there in 2011 enthusiastically agreed that they would be our teammates in the 2013 Pediatric Surgical Camp as well.

So as plans and fundraising for a 2013 Pediatric Surgical Camp got underway, I reflected on the evolution of this unique partnership. Clearly the linkage that had started in 2002 was getting stronger. Evidently, together with our Ugandan colleagues, we had helped some children in these ‘camps’. However, I think most importantly the knowledge-sharing aspect of the linkage was becoming appropriately more prominent and evident and we all agreed that this deserved the emphasis for 2013 and beyond.

The Mulago/Makerere University Department of Surgery has recently recognized the need for more Pediatric Surgeons to serve the needs of their country’s children. Happily since 2007, Dr John Sekabira has been trained and now Dr John, with Dr Doreen, manifests a doubling of the number of country’s pediatric surgeons to two. There is a long way to go, and the dream is to have 10 pediatric surgeons in Uganda within 10 years. The College of Surgeons in East, Central and Southern Africa (COSECSA) has just established a recognized format for pediatric surgical training for East Africa wherein residents must have, after they have completed their General Surgery training, a year of training in Pediatric Surgery either in Ethiopia, Kenya or Uganda (as of December 2013), plus an additional year of Pediatric Surgical training ‘abroad’- and this certainly could be at a Canadian Pediatric Surgical training centre.

So with the evolution of our Pediatric Surgical Camps in mind, we travelled once again to Kampala. There was, I grant you, a certain amount of trepidation, as there had been before the previous camps. What will we be facing this time? Hernias or ‘horrendomas’? Will there be the gratifying mutual partnering as the Ugandans and Canadians mix? Will the educational component be as satisfying, and will it be mutually beneficial, as I believe it was especially in 2011?

The plan this time was to spend the full two weeks entirely at Mulago Hospital. In the months leading up to our departure we had corresponded about the need and wish for some formal educational lecture sessions that would complement the work we would be doing in the operating theatres. It became evident to us that this time much of the scheduling work for our two weeks there was being done by Dr Phyllis Kisa, a young, recently graduated Ugandan General Surgeon who this year works on the Mulago pediatric surgery service aided by a grant from Global Partners in Anesthesia and
Surgery (GPAS). I had heard that her sincere ambition was to become a Pediatric Surgeon. I was certainly looking forward to meeting Dr Phyllis and another recent graduate of General Surgery training who had been recommended to me, Dr Nasser Kakembo.

Two weeks at Mulago! We were sent a list of the proposed patients who we would be hopefully operating upon with our Ugandan compatriots. There were approximately 50 pediatric general surgery cases and 50 pediatric urology cases—all complex, nothing ‘simple’. Many needed the services of both specialties, and all needed expert pediatric anesthesia, pediatric peri-operative nursing and that special care that children need that tougher adults can forego.

We knew that not every child on these lists could be operated upon during the camp and that was regrettable. In fact, we wondered just how many of these children we would get to; our time and our energy was, after all, not limitless and many of these operations would take many hours. We had also committed ourselves to engage in the daily formal educational activities during this camp that in previous camps had not been a factor. Our UBC residents were going to try to initiate a study on pediatric surgery manpower, and surveys were to be done which would take them away from clinical care (which proved impossible to fit in because we were so clinically busy). In addition, for this camp we agreed, where possible, to participate in the surgical care of any emergency patients, and those patients would, we knew, sometimes take the scheduling, resource and personnel priorities. I shall admit that I found it tough to fly into Uganda this time feeling already discouraged in the belief that barely a fraction of the children on the lists would have their turn in an operating theatre, and that our efforts at educating each other would fail in the face of so many children needing surgery!

Dr Phyllis scheduled two kidney tumour cases as warm-up operations! They went very well. We were rolling, and with the willingness of the Ugandan operating theatre staff we operated late into the evening…

It was day after day after tiring but satisfying day of lots of kids with many different surgical ailments. All of the surgery had its challenges. Some children had been last operated upon in infancy and were now showing up in their teenage years for their final surgical correction. It certainly was different doing operations on these older children. In some ways it was easier because their anatomy was ‘bigger’ but the strangeness of doing what is a baby operation in our country was a challenge.

In my view one of biggest challenges came in the form of a 10-day baby girl who had a very serious condition called esophageal atresia and tracheo-esophageal fistula. In Uganda, the British ways still persist and the esophagus is “oesophagus” and this condition that we would refer to as ‘TEF’, we adapted and referred to the condition as TOF. The baby was dreadfully ill and the ethical challenges, quite aside from the technical challenges of surgically correcting this baby so that she could swallow and breath properly were immense. Almost all children with TOF in Uganda die because whereas in Canada TEF babies arrive for care on the first day of life, they most often arrive late, like this baby; sick, weak, malnourished and with pneumonia—hardly able to withstand the rigours of a big operation that is necessary to repair the condition. The baby would need to be ventilated post-operatively. She wouldn’t be able to breathe on her own. Whereas we have banks of ventilators for babies such as this here, the only ventilator we could use post-operatively for this baby was the OR anesthetic machine. If we tied that machine up—potentially for
days - while the baby recovered, it meant that many of the children we planning to operate on would go without surgery. But if we didn’t operate on the TOF baby she would definitely die. At the time it seemed like a question, but a two-minute meeting amongst us made the answer obvious. We had to correct this baby’s TOF, the alternative of just letting her die was not acceptable.

Dr Phyllis was the surgeon, and Jenn Stanger, our Pediatric Surgical Fellow and I were her ‘teaching assistants’. The anatomy, although diseased, was textbook in its pattern, and Dr Phyllis did a fine job putting this baby’s oesophagus and trachea in order. We wheeled the baby and the OR machine up to the Mulago Hospital ICU and knowing this baby desperately needed nourishment we had sewn in a tube through her repaired oesophagus, something I had never done. The little one fought hard and breathed on her own the very next day. We were able to relocate the machine back to the OR to use on more children.

This little TOF baby went on to recover and survive and go home, eating and breathing normally. She was for me the symbol of triumph of this camp. She got better through our partnership, our caring and our ingenuity. Dr Phyllis now knows how to repair this condition. We now know how a simple post-operative ventilator - a piece of equipment we take for granted here - could help future TOF babies in Uganda. I have started to discuss the problems of TOF repair in resource-poor countries with my international colleagues so we can have the collective intelligence of many other surgeons and anesthetists brought to bear on this issue so that it isn’t just the children fortunate enough to be born in countries like Canada who can survive this condition. The ethical dilemma around this one little baby continues to challenge us.

As we left Uganda and our Ugandan friends and the little children we tried to help, we simply felt good. Our Ugandan colleagues had all worked very hard to set up the camp. Together, with them, we had served 117 children over the two weeks - all with complex pediatric surgical and urological conditions, and each with their own challenging pediatric anesthesia, nursing and social challenges. Educational rounds were held almost everyday. We laughed a lot, shared stories, shared meals with each other and there were many, many of those special warm Ugandan handshakes with our Ugandan mukwano mukwano (friends) that always brought a smile to my face. Our plan for this camp was simply based on three pillars - service to the children, knowledge-sharing and expanding the collegiality between Canada and Uganda. We strengthened each pillar - foundation for the future.
This was my 3rd trip to Mulago Hospital in Kampala. Prior to our earlier visits, there were many unknowns leading to a certain level of anxiety. This time we knew the types of cases we would be doing, what supplies we needed to bring and who we would be working with. We even had a list of teaching seminars chosen by the Ugandan team.

My most memorable case – A 1 week old baby presented to us having been born with an opening between her esophagus and trachea and a blind end esophagus. In medical terms – a tracheoesophageal fistula and esophageal atresia. This meant certain death unless we attempted a repair. The challenge was 2 fold, the surgery is complicated and the babies need help with their breathing for a time after surgery. There are no ventilators that are suitable for babies at Mulago. The surgery went well but the baby clearly needed ventilation support for a time after. The suggestion was made to use the anesthesia machine from the OR. That seemed unrealistic at the time but was the baby’s only hope. The transfer and setup went extremely well and the baby survived! There were many other hurdles but she scaled them all and did very well.

Collaboration with our Ugandan colleagues is the primary reason for these trips. Although all the children benefit from our care, we can only do so much in 2 weeks. In spite of the very long 14 hour days, there were many we could not help. The teaching and learning that occurred will benefit many more children in the future. I have seen the anesthesia residency program grow from 6 to 23 doctors which will have a direct impact on the quality and safety of anesthesia care. It is great to see anesthesiologists now on staff who we worked with as residents during the last trip.

We received a significant amount of anesthesia supplies from our donors. These directly benefited the children as many simple drugs are available only intermittently. Also, we were given pediatric sized equipment that is very difficult to resource in Uganda. The medical team was extremely appreciative of everything we brought.

Every time I return from one of these trips, I am overwhelmed with the abundance we have here in Canada. I feel privileged to be able to share some of these resources with the Ugandan children alongside the medical team at Mulago Hospital. I am also looking forward to expanding our partnerships in the future.
It was my privilege to participate in my third Pediatric Surgical Camp in Uganda this year. Each camp has been unique and each camp has allowed me the opportunity to challenge myself and to develop my role as a Family Support/Child Life worker. As in previous trips, my main focus was in receiving the children in the pre-operative area as they arrived from the ward. Additional responsibilities and initiatives included monitoring the patients’ hydration, input on operative slate and postponement updates and ward visits. Through the generous donation of crayons I was able to keep most of the children, their parents and even some staff calm doing “shading”, the Ugandan equivalent of colouring. The pre-op area was brightly decorated with their pictures. Donated bubbles and stickers, as well as books and small wind-up toys provided extra distraction from hunger and long waits. This year “Bubble and Sticker” rounds were initiated on the wards so that all paediatric inpatients were able to enjoy some fun.

I have many memories of the patients who passed through my care. Each child has touched me in some manner. I enjoyed hours of cuddling with unhappy infants who seemed to calm when walked about. I was pleased to be able to share books and word puzzles with older children. I especially enjoyed being serenaded by a lovely 7-year-old boy who performed a spontaneous song about how great it was to play with the volunteers.

I am thankful for the opportunity to participate yet again in this Surgical Camp, to build on relationships with staff from previous visits and to contribute to the comfort and well being of Ugandan children.
My second trip to Uganda this past March was much different from my first. Having been before, I was better prepared for the complexity of disease we would face, the equipment limitations of the hospital, and the long working hours that would ensue. I was also eagerly anticipating the teaching and learning opportunities that I knew would arise and the amazing sense of teamwork and fellowship that develops on a mission of this kind.

Our team worked hard before we left reaching out to many of the companies that we work with through the hospital to obtain donations, in order to keep the costs of our missions as low as possible. The response was tremendous. The generosity of these companies was amazing and contributed greatly to our trip. We were able to obtain the supplies necessary to perform the procedures, to teach our Ugandan colleagues the same procedures, and leave them with supplies for the future.

The complexity and volume of these cases and the patients we encountered unfortunately limited the amount of nursing staff that I came in contact with and therefore limited my time and ability to teach. I of course took advantage of every moment that I could! One of the greatest successes and what I will take away with me following this trip is the gratitude I have for the incredible team of nurses and doctors that I worked with. They exemplified grace under pressure. It takes incredible skill, knowledge, and flexibility to work on incredible complex patients in limited conditions, with unfamiliar instruments, doing complex surgery, anesthesia, or recovering these patients and still use every available moment to teach.

Our amazing teachers drew groups of eager learners. One particular case had our room filled to the brim. We were removing a very large tumour from a very small baby. It was one of those cases that I will always remember. It was a very pervasive tumour, but our team of Canadians and Ugandans persevered for several hours and the surgery was a success. It was an amazing experience to have been a part of.

On returning to Canada, I am again filled with gratitude because I get to live and work here, in an amazing teaching and learning environment with everything I could possibly need just a few steps away. I am also filled with admiration for my Ugandan colleagues who do so much with so little.

Whenever we return from Uganda, I am always inundated with questions about the trip. I talk about how complex the cases can be, the fourteen-hour days, the worry over supplies and whether or not we will have enough, and the sheer numbers of patients that we work with. There are always a few skeptics who comment on the amount of work that it seem to take, and they usually ask if I plan to go back. My answer was and is always a resounding yes!
In March of this year I had the opportunity to travel to Mulago Hospital in Kampala, Uganda as the pediatric surgery fellow in the third surgical camp UBC has supported in Uganda. On my second day at Mulago I had the privilege of meeting a wonderful young man. My involvement in this patient’s care highlights the importance, success and far reaching implications of the surgical camps.

This patient is a 16 year old male who was born with Hirschprung’s disease, a congenital disorder of the rectum that results in severe constipation, recurrent infections and often death if left unmanaged. When he was an infant a surgeon in Uganda recognized the diagnosis of Hirschprung’s disease and created a colostomy. However this young man and his family were lost to follow up and never realized that his colostomy could be reversed and his disease treated. He had recently been admitted to hospital with malaria (a blessing in disguise) and when his medical history was reviewed this patient was subsequently referred to Mulago for assessment at our camp. He was a very quiet boy, withdrawn, only answering questions with nods of his head. At the age of 16 he had only recently begun attending school and was socially isolated because of his stoma. Yet it was clear that he took pride in himself having made the effort to dress up for our clinic visit (it was only later that I discovered that he and his mother had been waiting around the hospital for greater than a week in hopes of being treated in our camp). Stoma care in most of the developing world is limited to simple cloth coverings of the stoma, while this does prevent soiling of the clothes, it does not contain the odor and requires frequent changing. It was clear in my mind and heart that we had to make him a priority of this camp.

As a surgical team we made plans to perform his surgery on the fifth day of our camp. Arranging the operation required strong advocacy and leadership from the surgical team, as we anticipated that it would be a long operation and meant that we would perform fewer surgeries on that day an ethical decision that we discussed as a team and made together knowing the impact it would have for this young man and his family. Myself, Dr. Blair and the Ugandan Pediatric Surgery Fellow performed the case. Given the frequency of Hirschprung’s disease in Uganda we felt it was imperative that the local surgery fellows have this operative experience. The Uganda fellow and myself started the surgery at noon, our first job being to close the stoma by entering into the abdominal cavity. The big challenge for all of us was that the patient was almost a grown man and the final reconstruction had to be done through the rectum, with the patient positioned on their stomach. Typically this is performed in children under the age of one, who are relatively easy to turn over and position, but all of the members of our team pulled together to help and by 7pm that night we had successfully completed the operation.
This young man had an uncomplicated post operative recovery and on our final day at Mulago hospital we were rewarded with the first smile any of us had seen on his face. The Ugandan surgery fellow has been seeing him in follow up and tells me that he is continuing to recover well, is back in school and is developing into a happier, more interactive teen.

This patient is an example of how many people where impacted by the camp. For the local Ugandan trainees it provided an opportunity to learn novel management strategies for clinical problems, it provided valuable operative experience for their fellow and provided a model of collaborative operative management (as all members of the team were essential to the successful operation). For me personally this patient will stick with me for the entirety of my career. Interacting with him and other children and parents of children with stomas has highlighted for me the need for improvements in surgical care, post operative care and follow up for patients with stomas in Uganda and the developing world. I am currently working on a research project to describe and quantify the social impact of stomas on children in Uganda. And hope that this can develop into a long term sustainable program for stoma care and education. From a professional development point of view leading this patient’s care allowed me to experience personal growth as a technical surgeon, but more importantly as a health advocate, collaborator, resource manager and medical expert. Most importantly I think that our presence in Uganda has had a profound effect on this special patient and his family.
In March of 2013 I had the great privilege of travelling to Kampala, Uganda with a team of Canadian surgeons, anesthesiologists, nurses and support staff to participate in the Pediatric Surgery Camp. Through the generous support of our donors and a collaboration between BC Children’s Hospital and Makerere University we were able to provide surgical care to hundreds of children and families in need. As a surgical resident, I was involved in the assessment and treatment of a wide variety of surgically treatable conditions with the support and supervision of our Canadian and Ugandan collaborators. The surgeries that we provided ranged from simple repairs of groin hernias to complex treatment of congenital malformations of the gastrointestinal tract. The ailments that we spent our time treating included simple conditions such as abdominal wall hernias as well as complex congenital malformations of the intestinal tract. Although many of these conditions are easily treatable, they become chronically disabling due to the lack of access and availability of surgical care in Uganda. Through the organized efforts of our team and the generous support of our donors we were able to provide first class surgical treatments for hundreds of children that would have otherwise not be available to them. Perhaps the greatest and most durable contribution of the project was the development of international collaboration, education and research. This partnership serves as the foundation to make sustainable improvements to the delivery of surgical care to the children of Uganda.

My responsibilities as a surgical resident included assessing patients for surgery, assisting with surgery in the operating room, caring for the patients on the surgical ward. The number of children and families that we cared for are too innumerable to recount but a number of children stood out as inspiring examples of what our team was able to provide during our trip. One morning during rounds we came across a 10 year old girl who had been admitted to the ward the previous night. Her father had travelled for several days from a remote rural community to seek medical attention. When she arrived at the hospital she was found to be near death. She was admitted to the ward where her parents were left to care for her and was essentially left to die, unable to afford antibiotics or surgery. We were guided to her bedside the following morning by one of the Ugandan interns that was concerned for her well-being. When I examined her she was hot to the touch from her high fever and her body was lifeless. Her lips were cracked and she lay motionless with her sunken eyes wide open. She didn’t respond to my lame attempts to communicate in Lugandan but cringed with pain when I examined her rigid and distended abdomen. We organized the team and brought her quickly to the operating room where she was started on antibiotics and put to sleep by our anesthesiologists. Once she was asleep we carefully opened her abdomen to find the source of her illness. She was suffering from typhoid fever, a common illness in this area which had led to a perforation of her intestine which had been leaking inside her. We cleaned out the infection and repaired her intestine and sent her to the intensive care unit to recover. She eventually progressed to the surgical ward where she slowly regained her strength and nutrition on the surgical ward until she was strong enough to go home with her family.
Later during our stay, we found out from our Ugandan colleagues that a young mother had brought her 7 day old newborn into the hospital that was unable to feed. It had been discovered that she had a congenital abnormality known as esophageal atresia where a child is born with a blind ending esophagus that doesn’t connect to the stomach, a universally fatal condition without surgery. Our team carefully assessed the child and prepared her for surgery the following day. The baby was barely a week old and weighed only a few kilograms. No ventilators for a child that size were available in the hospital but through the resourcefulness of our anesthesiologist a solution was devised to get her through a successful surgery and post-operative recovery. Her surgery was performed by our Ugandan colleague Dr. Phyllis Kisa and our Canadian team member Dr. Geoffrey Blair in a truly collaborative effort. During the surgery the team was able to repair the newborn’s esophagus to allow her to feed. The newborn was cared for by our team after surgery and within a few days she was able to have her first meal of her mother’s breast milk.

Many of the children that we cared for during our stay suffered from a condition known as anorectal malformations. This congenital malformation occurs when children are born without a normal connection between their rectum and anus. In Uganda, many children die of this condition and those that survive suffer from incontinence and severe stigmatization. As a result of this, most of these children and unable to attend school, gain employment or find partners to marry. With the help of our surgical team we were able to correct these malformations for dozens of Ugandan children who will no longer suffer from chronic disability and lifelong stigmatization.

These examples represent a small sample of the hundreds of children who were cared for during the Pediatric Surgical Camp. The opportunity to care for these children and their families has been amongst the most rewarding experience of my life. The lives of these children have been altered forever and to experience the gratitude and pride has motivated me to continue to be involved in international health initiative in my future career. With the overwhelming success of our most recent camp we look onward to continue our collaboration with our Ugandan colleagues and further develop opportunities to provide essential surgical care to for children without access to such services. The ongoing support from our donors is vital to the success of these and future endeavours.
The pediatric surgery camp that took place in March 2013 was a memorable experience for many reasons. It was a massive undertaking for the organizers, both Canadian and Ugandan, and would not have happened without the years of support from many generous donors. Not only did we help over 100 children by performing life-changing surgery, but we also had the great opportunity to exchange ideas with the Ugandan surgical and anesthesia teams. As an anesthesia resident on my first overseas clinical expedition, I certainly gained a lot of valuable clinical experience, and I know my Ugandan counterparts did as well.

Surgery and anesthesia are definitely very different in Uganda. In Vancouver, we benefit from the availability of many sophisticated monitors, equipment and medications, which are in short supply in Kampala. Our anesthesia team was truly impressed by the Ugandan’s ingenuity when it comes to keeping patients safe and comfortable through the peri-operative period. We were able to share ideas about intra-operative decision making as well as post-operative pain management for our pediatric patients, and I learned a great deal from the Ugandan anesthesiologists.

Likewise, it was clear that the group of anesthesia residents and anesthesiologists benefited from our collaboration. Many of the residents I worked with had limited exposure to certain monitors and medications that were donated to our project. These anesthesia trainees were thrilled to finally apply their textbook knowledge on these anesthesia provisions in the operating room. On several occasions the trainees would stay late to work with us into the night as they realized how rare this opportunity was. We could see their skills evolve over the two weeks we were at Mulago as they became more comfortable with the techniques we were teaching them. It was fantastic to be able to leave a large supply of these sought after medications and equipment with them when we left, and know they would be used efficiently and effectively for the patients of Mulago Hospital.

In addition we conducted several lectures for the surgical and anesthesia trainees that covered topics such as post-operative fluid and pain management, in addition to several topics in pediatric surgery. These lectures took place every morning to a room of about 60-70 staff and trainees, and they certainly sparked a lot of vibrant discussion. These lectures also lead to information resource sharing between us residents (powerpoint lectures, review articles and textbooks), which they were also very enthusiastic about.

I am very grateful for having the opportunity to take part in this amazing experience and I want to thank all of the donors for their contributions to the Ugandan Pediatric Surgery Camp. Without the equipment and supplies that were provided we would not have been able to treat so many children and contribute to the development of surgical and anesthesia training at Mulago Hospital.

Sincerely,
Sean McLean
UBC Anesthesia Resident (R4)
This type of trip can't happen without support through donations of equipment and supplies. Two stories that come to mind involving the use of specific donated materials follows:

A small baby only a few weeks old had undergone a complex surgical procedure to bypass blocked biliary ducts. On bringing him into the Recovery Room from the OR it was necessary to support his breathing for about 10 minutes until he was able to take over fully on his own. A manual resuscitation bag was the method used to assist him in his breathing. We had received donated both manual resuscitation bags and masks to us. After a stay in Recovery Room of about 2 hours this baby, now breathing well on his own, was transferred to the surgical ward and his mother.

The experience of providing safe perioperative care in an unfamiliar environment often involves being creative. Exam gloves were generously donated to us. These gloves assist us by protecting us from infections/contamination and also protect our patients from us. It might seem a stretch to imagine that keeping patients warm can be a challenge in a country on the equator. There were times though that we used exam gloves filled with warm water as "hot water bottles" to keep our patients warm both in the Operating Room and in the Recovery Room. We used materials donated to us in manners common in Canada but in some unique ways also.
I had the opportunity to participate in the 2013 Pediatric Surgery Camp in Kampala, Uganda. This was my second trip to Kampala. I have worked in a few different countries now and the one common theme that I have noticed is that children are all the same no matter where they live. They all love to play and enjoy things like bubbles, stickers and colouring. And just like Canadian parents, Ugandan parents want to be involved in their child’s entire hospital care.

We started our camp this year with some more complex general surgery cases. One of the first patients I looked after was a school aged boy who had a large kidney tumor surgically removed. He was very thin and frail as he was receiving chemotherapy. He was having quite a lot of post operative pain and despite being a complete stranger and the limitations of language; he was comforted just by wanting someone to hold his hand. I saw him a few days later and he was smiling and happy to be making a good recovery. My hope is that if I am given the opportunity to return again to Uganda that I will see parents allowed to stay with their children in their immediate post-operative period. This way it will be the mothers and fathers that are holding their child’s hand. This practice would help in establishing and sustaining true family centered care.

One change that I had noticed from my previous visit was the increase in the nursing staffing levels in the post-anesthetic care unit. This was a positive change in providing safe care to the children immediately after surgery. Every patient that was transferred to this unit was an opportunity for teaching, right from admission to direct care and to hand over to the ward. It was exciting to see how the nursing were interested in our admission assessments and our communication to the anesthesiologist and surgeons if we had any medical concerns. This open dialogue with the surgical team is very important in safe care for the children and I am sure that it is something that will now continue on since we have left.

Our trip would not be possible without the on-going support of the professionals who provided medical supplies and equipment. Often, the local staff is short of specific sized of pediatric medical supplies, if it were not for the generous donations inappropriate sized supplies would be used. Their on-going support both financially and with medical supply donations is critical to the success we have seen.

I have always returned back to Canada with a sense of how lucky we are to be in such a resource rich country in the medical field. I try to evaluate how we have become dependent on this without really assessing the need for all that we use. I am always surprised when major surgery can be done with only a few basic instruments but yet we in Canada we seem to require significantly more. Why is that?