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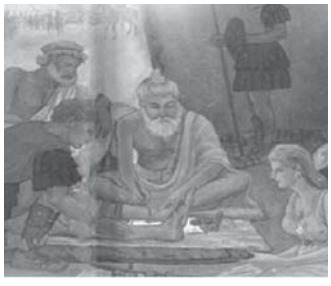

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President's pen

Dear Friends,

By electing me to the high office of the president of our Association, you have bestowed on me a great honour. I am barely fit for it albeit I will do my best to live up to the expectations of our members.

A decade back when we started this organization, it was with a certain concept. Today it has changed. This period of twelve years has been a great period of learning for most of us. It has made me cognizant of the needs and aspirations of the surgeons practicing in rural and semi urban areas and also in periurban slums.

It has also given me a glimpse into the needs and aspirations of impoverished populations not only through my personal practice at the Rural Medicare Society's hospital, but also through holding conferences in small towns and in villages.

Today in our world, 5 out of the 6 billion people have no access to modern, basic surgical care. In India four hundred million out of a total one billion people suffer the same fate. I have seen how the "rural surgeon" desperately tries to reach out to this category of people. How they innovate appropriate procedures. How they suffer from strictures of unethical legislations and I have seen how the impoverished people love them, respect them, and bless them for whatever they receive.

Perhaps it is now time for us to look back, learn from our past experience, and move ahead with double vigour. "Man does not live by bread alone" said Jesus Christ to Satan. Having practiced this in real life, it is time for the rural surgeon to propagate the same philosophy to their urban counterparts, the younger generation of doctors, the corporate hospital wallahs and the western healthcare industry. It is time for us to show our strength of mind and spirit to rise ourselves to higher human values and through our propagation, carry the rest of them with us.

How do we do this? A million dollar question….

We have formed the organization, stabilized this newsletter, waded through the CRS course of IGNOU, established the International Federation of Rural Surgery, and now helping the National Board to start the course of DNB in rural surgery. All these happened in the first twelve years. In the next twelve years, let us pledge to be able to train and initiate a large number of young doctors to start small rural hospitals in the countryside, strengthen the work of existing rural hospitals and standardize rural surgical practice across the country. While 70% of our population is in villages, 80% of hospital beds in the country are in large cities. Our aspiration should be to reverse the scene. Small "Rural Hospitals" providing "essential surgical care" sustainable by the local communities and run by dedicated and innovative doctors is the only way to achieve "health for all" across the developing world.

Our newsletter should come up to the level of a journal of rural surgery. If lack of infrastructure facilities does not allow the rural surgeon access to writing in the Vancouver style, we could ignore this norm but we should not be discouraged from writing and reporting our experiences.

This is the only way to network with our counterparts across the world and learn from each other for the benefit of humanity at large. The rural surgeon looks for useful innovations and not for a "pat on the back" by the western world scientists.

…….All this in the next decade……dear friend, there is no time to stop working, there is no time to rest. Let **WORK** in this direction intoxicate us. Let us serve humanity with our skills without asking for rewards. Let us serve God through serving man and accept this opportunity as our reward.

In the last governing council meeting it came to light that with diminishing interests on fixed deposits, and with our promise not to depend on support of the drug industry for our activities, enormous financial difficulties are round the corner. We have to save to subsidize our conference expenses and to meet the increasing demands of printing costs for the news letter. We therefore decided to resort to sponsorship for meeting the news letter expenses. (We now print a thousand copies to meet the needs of our international commitments and our sister organization the ASRI). We have good friend across the world and in our country as well. I am sure their help will keep our activities alive and also act as stimulus in furthering our work.

May he bless us all.

Dr. J. K. Banerjee
President, ARSI

Congratulations!

Rural Medicare Society Award (2005)
For
The best paper published in "Rural Surgery" Bulletin

Following articles published in "Rural Surgery' in the year 2005 have been adjudged jointly as the best papers for "Rural Medicare Society Award" by
Prof. V.K.Mehta (Vice president and past Editor of "Rural Surgery").

Skin stretching for closure of simple Heel Ulcers in Leprosy affected feet
Dr. Govind Narain Malaviya, Vol 1 No 4, October 2005

Tuberculosis of Uterine Cervix - A case report
Dr. S.K.Baasu, Vol.13 No1, January 2005

While I humbly thank everybody for their appreciation towards my work, being the host for this award, I wish to confer the award to Dr. Govind Narain Malviya only. - ***Dr. S.K. Baasu***

This award will be presented to Dr. Malviya at the ASRICON'06 conference at Mehsana.

New Clinical establishment Acts and Present Status of Rural Hospitals in India

Dr. R. R. Tongaonkar

Many Metropolis cities did have Nursing home Acts like Bombay Nursing home Act 1954 under which the hospitals situated in that area had to be registered. There was no need for the small rural hospitals to get themselves registered, but recently many States are planning to enact new clinical Establishment Acts. Maharashtra and Karnataka has published draft rules but the final act has not been enacted. But in west Bengal this Act has been already implemented. The requirements of this Act are such that it becomes almost impossible for many rural Surgeons to continue running the hospital. Dr. Sitanath De from Jhargram, one of our senior rural surgeons and past president of Association of Rural Surgeons of India, had to close down his nursing home which he was successfully running for over 30 years.

Let us see some of the rules led down under this Act.

1. The premises should be separated from any residential quarters of persons not concerned with The Establishment.
2. The word "Hospital" can only be used for having not less than 25 beds and 24 hours services.
3. The establishment must have Bio-medical waste disposal licence.
4. Operation theatre Complex and indoor area must have space as specified.
5. Operation theatre must be equipped with proper equipments, shadow less lamp, anaesthetic apparatus, oxygen cylinder, diathermy etc.
6. Sufficient number of WCs & bathrooms should be provided as specified in the act.
7. Adequate and wholesome diet must be provided to the patients.
8. No person shall be allowed to sleep on the floor where the patients are accommodated.
9. Rooms for Resident Medical Officer and nurses must be provided.
10. For clinical Laboratories and x-ray units there are specific conditions and requirements.
11. The establishment should not under take test for HIV without a voluntary Testing Counselling centre.
12. It must register under Municipal/ Panchayat authorities
13. The labour room must have obstetric tables, shadow less lamp, and suction apparatus.
14. All the emergency patients must be attended primarily without considering the financial capabilities
15. Monthly report must be submitted to District Health Authorities.

Minimum Requirements

1. RMO --One for 20 patients
2. Registered Nurses 1 for 5 patients
3. General duty attendants 1 for 5 patients
4. Sweepers (24 hours) 1 for 8 patients
5. WCs -
   a. males- 1 per 8 beds
   b. Females- 1 per 6 beds
6. Floor space/bed in ward 65 sq. Feet
7. Cabin (toilet attached) for old establishment 114 Sq. ft. and for new 151 sq. ft.
8. Minimum distances between 2 beds- 6 ft.
9. Minimum areas for OT - 200 Sq. ft.
10. Area for other facilities in OT- 100 sq. ft.

To Study the existing conditions of the Rural Hospitals in our country we sent a questionnaire to surgeons across the country. 86 doctors replied but two of

them were not having indoor hospital beds. Therefore they were deleted from the study.

Amongst the 84 doctors, majority were surgeons but there were few gynaecologist and few orthopaedic surgeons. The study included surgeons from Kullu-Manali in north to Sivakasi in south. Following are the salient points and observations of the study. Similar study can be under taken from small hospitals in big cities like Mumbai, Pune, Delhi, Kolkata or Chennai or even in district places and probably their findings will also be the same.

Out of 84 medical establishments studied 30 were having less than 10 beds, 37 were having beds between 11 & 25 and rest 17 had more than 25. Thus majority i.e. 67 can be called as small hospitals.

Bed Strength (Survey findings)

Bed strength	No.
Below 10	30
11-25	37
26-50	08
50-100	05
Above 100	04
Total	**84**

As per the Act, there should be one registered or qualified nurse for 5 beds.

More than 60% of hospitals did not have qualified nurses.

One thing was noted that many hospitals from South India like State of Tamilnadu had qualified nurses as compared to Central and Northern India.

In absence of qualified nurses more than 60% of rural hospitals will have to be closed.

Nurses Strength (Survey findings)
(Requirement: 1 registered/qualified nurses per 5 beds)

Hospital bed strength	Nurses	
	Adequate	Inadequate
Below 25	24(28.5%)	43 (71.5%)
26-50	02	07
51-100	03	01
Above 100	04	00
Total	**33**	**51 (84)**

Many rural hospitals provide other facilities like X-rays, laboratories, ECG, ultra-sonography and endoscopies etc. Each of these need qualified personnel and registrations under different Acts.

To have an X-ray facility in the hospital one must fulfil the clauses laid down in the safety manual prepared by Atomic Energy regulation board (AERB) under which it is mandatory:

A) To get registered with AERB
B) To wear radiation monitoring badges for each personnel.
C) Wall thickness on which the primary beam falls should be of 35 cm thick brick. Other walls should be at least 23 cm. thick.
D) Room size should be18 sq.meter.
E) An x-ray unit should have personnel with postgraduate degree/ diploma in radiology and a technologist with experience of 1 years' training course.

Out of 47 who have x-ray units only 11 have registered under this Act and out of this 9 were bigger hospitals having bed strength more than 70 and run by either Govt. Agencies or trusts or Societies.

In every rural or small hospital some of the requirements may be fulfilled but to get a radiologist with post graduate degree or diploma is an impossible task. That means all

the x-ray Units in smaller towns will have to be closed and for any X-ray the patient has to travel to the district place where qualified radiologists are available.

Same is true for having our own Laboratory.

In the requirement for supervisory Personnel it is written that a Small laboratory may be manned by a DCP or DTM&H or an M.B.B.S with at least 5 years experience in Laboratory medicine.

Out of 48 hospitals that had a laboratory only 16 had the necessary qualified personnel and again they were the bigger hospitals.

That means if the Act is implemented 32 small laboratories will have to be closed.

A similar Act was coming in Maharashtra few years back. It was Maharashtra clinical laboratory Act under which qualifications like M.D. pathology or at least diploma in that subject was needed to run a Laboratory. It meant that in our district if a patient, residing at a remote place like Dhadgaon or Molagi, wanted to get his or her Hb or even urine sugar tested, he/she needed to travel a distance of around 150 km to go to our district place Dhule to get access to a qualified pathologist. Fortunately it never came in existence.

As regards technical personnel, the minimum qualification needed, is DMLT. At least now these are available even in small towns.

One more condition in the Act is "No clinical establishment should under take test for HIV without a voluntary Testing Counselling centre." This is also absurd. AIDS is spreading like wild fire even in small villages and it becomes necessary to do HIV testing to diagnose whether a particular patient is suffering from HIV or not, and also to prevent inadvertent spread of HIV infection through contamination of instruments and equipment. It is not possible for every rural and small hospital to set up a Voluntary testing counselling centre for HIV.

Many rural surgeons have Ultra Sonography Machine and it has to be registered under PNDT Act. In this respect even small hospitals appear to obey the Law. Out of 42 set up who reported having a USG machine, 38 had registered under the Act.

Regarding the requirement of space for operation theatre complex and indoor area, there appears no problem in rural areas. 77 Out of 84 (over 90 %) hospitals reported having adequate space.

Adequate space for Operation Theatre Complex (Survey findings)

- Adequate space 77 (92%)
- Inadequate space 7 (8%)

Same is true for the operation theatre equipment.

Out of 84 respondents, 60 (72%) have hydraulic operation table, 68. (81%) have shadow less lamps and everybody (100%) has suction machine. 82% have generator back up. 70% think that Air conditioner is not a luxury but a necessity.

Regarding anaesthesia equipment - 80 % hospitals have Boyle's apparatus. Most of them have Ambou bag, Laryngoscopes and Endo tracheal tubes. 62% have Pulse Oxymeters.

Thus, as regards space and equipment, most of the rural hospitals can follow the rules and fulfil the criteria.

One more requirement for a rural hospital is to register under Biomedical Waste Disposal Act. Even though 72 % destroy needles and Syringes and around 50% segregate waste, hardly 40 % have so far registered under the said Act.

Other facilities provided by the respondents (Survey findings)

- X-ray 47 (56%)
- Laboratory 48 (57%)
- ECG 44 (52%)
- Ultrasound 42 (50%)
- Laparoscopy 27
- Upper G.I. Endoscopy 22
- Urologic Endoscopy 17
- Other Endoscopy 04

Every body should try to obey this Law. But in Maharashtra if the recent move to ban the plastic bags becomes a law then we doctors will be in soup. As per the waste disposal Act we have to collect the waste in differently coded plastic bags. Then from where are we going to get the plastic bags?

Few more things need consideration.

One of the requirements is to provide adequate and whole some food to the patients. This is not possible for small hospitals as they do not have any pantry or canteen. More over, especially in rural areas, the food habits of patients vary considerably and it will not be possible to cook different types of foods for different patients.

Similarly the condition, that no person should be allowed to sleep on the floor where the patients are accommodated, is also not tenable.

In rural areas whenever the patients are admitted, they are being accompanied by their relatives who perform some amount of nursing job. A patient in labour is usually accompanied by her mother to look after the new born child. Space constraints in a smaller set up makes it difficult to make alternate arrangements for these accompanying people.

In conclusion even though we need laws to make the clinical establishment better and to follow the standard guide lines, there has to be consideration regarding geographical areas whether the hospital is situated in urban area or in a rural area and also whether it is a big corporate hospital or a small nursing home even in a city like Mumbai. It is absolutely necessary for the rural surgeons to fight the unjust laws or asks the Government to modify them. This is what we did in village blood transfusion services and compelled the govt to modify the law and come out with blood storage centre. Still better is to represent ourselves when the law is being formed and direct the legislator what should be the norms for different categories of the hospitals.

What Mr. Souresh Bhattacharya, a noted journalist from Delhi had written regarding blood transfusion rules in his article published in March 25, 1999 issue of Indian Express is also true even for the Clinical establishment Act. He has written, "It makes no sense to insist that Dr. Tongaonkar's Hospital in Dondaicha village in Maharashtra to be governed by the same blood transfusion rules as are applicable to Medinova Hyderabad or Apollo Delhi".

Lastly one has to look at this Act in different perspective as told by the immediate past president of our Association Dr R D Prabhu in his presidential address.

According to him by this Act

A) The Govt. Will gradually withdraw from its health Care responsibility.
B) Health care will be more and more privately managed.
C) Insurance companies and health Care industries will be major players.

This is very clear from the statement made be Shri Javed Chowdhury, Union Health secretary in 2000 "Union Govt. is clear in its mind that expansion of private health care through the insurance system be accompanied by a strict scientific determination of standards and enforcement of the standards:"

To implement this new foreign concept of health Care, State governments will have to borrow money from World Bank. The Karnataka Govt. has already decided to borrow about 750 Crores of rupees for it.

Once in its grip, World Bank behaves like shrewd moneylenders and dictates its terms. Africa and notably Uganda has been ruined because of such policies.

We in India may lose more than our gains, if there are any, by implementing such policies and Acts. This will increase the health cost tremendously without making any significant difference in quality. Therefore, such Acts should be opposed. We are giving quality services at very low cost in rural areas with the help of unqualified nurses and paramedics trained by us.

Unless the Act is modified to suit the small rural and tribal hospitals or these are excluded from these Acts, these yeomen services will have to be stopped.

This is a point to ponder.

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Abstract

Bed Rest May Not Be Helpful for Threatened Miscarriage

(From Medscape)

April 5, 2006 - An opinion piece in the March 24 issue of The New York Times highlights a controversial issue in obstetrics: the value of bed rest for threatened miscarriage. Although this intervention is widely prescribed, evidence of its efficacy is limited or absent, and some experts suggest that there may be deleterious effects.

There is no evidence that bed rest is beneficial for preserving the pregnancy in cases of threatened miscarriage. Part of the problem in determining the value, if any, of bed rest in this situation is the difficulty in carrying out well-designed, methodologically sound research.

Bed rest for threatened miscarriage has been used empirically in the past, when a 'detachment' of the fetus was held responsible for miscarriage or threatened miscarriage. This approach is currently criticized as our insight into the pathophysiology of miscarriage has improved, and it has become clear that there is lack of evidence to support the [efficacy] of bed rest in this condition.

In many cases of threatened miscarriage the causes are nonreversible, for example, those due to chromosomal abnormality, and bed rest would not be expected to have any effect.

Antepartum bed rest treatment is based on 2 assumptions: that bed rest treatment is (1) effective and (2) safe - i.e., has no major adverse effects. There is no evidence for the first assumption, and there is increasing research to support that bed rest has major adverse effects for the mother and possibly for the fetus/infant.

Two small randomized controlled trials (RCTs) from the early 1990s showed overall lack of effect. In one of these studies, 61 women with viable pregnancies and vaginal bleeding at less than 8 gestational weeks were randomized to receive injections of human chorionic gonadotropin, injections of placebo, or bed rest. Abortion rates were 30%, 48%, and 75%, respectively (Int J Fertil Menopausal Stud 1993; 38:160-165).

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Total Cystourethrectomy in a Rural Hospital

Dr. Philip Alexander

Key words: Periurethral carcinoma, total Cystourethrectomy, ureteroneosigmoidostomy

Introduction:

Total Cystourethrectomy and ureteric re-implantation is a major procedure in any institution. We present one case operated in our rural hospital. We present this case to highlight some of the problems doctors and patients face in rural hospitals and the need to re examine referral patterns in a rural setting in India.

Case report:

A 58 year old lady presented to our hospital in August last year with a Periurethral growth and urinary retention. She underwent a local excision biopsy which was reported as Periurethral squamous cell carcinoma. She was referred to a teaching institution in a major city. She returned to us six months later with a recurrent mass and the report of being given a date for surgery after eight months. She underwent bowel preparation and a total Cystourethrectomy and ureterosigmoidostomy in our institution under spinal anesthesia and then short general anesthesia. A groin node was also excised. She chose the ureterosigmoidostomy over a continent or orthotopic neobladder. She stood the surgery well and is now symptom free and without detectable disease after three months. She has also chosen not to undergo a groin and pelvic dissection. She is on regular follow up. The specimen showed clear tumour margins.

Discussion:

Major oncologic and reconstructive surgery is seldom undertaken in the rural hospital. We present one case which had returned from the tertiary institution with nothing constructive done for her which we decided to operate in our hospital. Her tumour stage was T3 N1 M0. She has done well postoperatively. Major surgery can be undertaken safely and in the best interest of the patient who has either no access to specialized care or has returned without constructive benefit from the tertiary care institution.

Review of treatment modalities has shown surgery to be the gold standard for this rare tumour. Radiation did not prove to be of advantage in decreasing the mortality or morbidity[1,2]. Chemo radiation also has not shown extraordinary benefit[3,4]. Surgery has remained the gold standard, with the best rates for control, particularly in early stage and grade of tumours[5,6]. Radical urethrectomy and cystectomy remains the best advocated modality of treatment, with or without hysterectomy, depending on the stage of treatment.

Our patient chose to have an ureterosigmoidostomy when offered the option between a continent or intubatable neobladder. She has not had any postoperative complication so far, at four month follow up. In this age of continent reservoirs, orthotopic bladders and urinary conduits, the ureterosigmoidostomy remains a viable option especially for developing countries, where resources are limited, and the acceptability of a stoma not universal.[7,8]

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RCT data from Cochrane reviews have rated Antepartum bed rest to prevent threatened miscarriage as a "form of care unlikely to be beneficial." (Cochrane database, 2004).

A retrospective study of 226 women showed that 16% of 146 women prescribed bed rest for threatened abortion eventually miscarried compared with 20% of women not prescribed bed rest (P = .41; Minerva Ginecol. 2001;53:337-340).

Abstinence from an active environment for a few days may make some patients feel safer, and therefore psychologically better. However immobilization would not help even in this setting, as it would only make the patients feel ill and probably responsible for the [potentially adverse] outcome.

Apart from the lack of evidence supporting the efficacy of ante partum bed rest for threatened abortion, there are potentially adverse effects to consider. Muscle atrophy and cardiovascular deconditioning are well documented effects of bed rest in men and nonpregnant women. Ante partum symptoms may include musculoskeletal and cardiovascular deconditioning, sleep disturbances, and other changes in circadian rhythms. Additional problems may include insufficient weight gain and low birth weights.

In Dr. Maloni's longitudinal study of 106 postpartum women who had a singleton high-risk pregnancy and were treated with antepartum bed rest, duration of maternal bed rest was significantly correlated with the number of symptoms at postpartum weeks 1, 2, 4, 5, and 6.(J Obstet Gynecol Neonatal Nurs. 2005;34[2]:163-171). At 6 weeks, at least 40% of women continued to report fatigue, mood changes, tenseness, difficulty concentrating, back muscle soreness, dry skin, and headache.

Though there are no reported adverse effects for bed rest in [threatened abortion]," and direct evidence regarding adverse effects of bed rest in threatened miscarriage is "quite limited, experts agree that pregnancy is associated with a hypercoagulable state. Immobilization, especially strict and/or prolonged, can predispose to thromboembolic events.

This common obstetric practice should be discontinued until RCT evidence is produced to support that bed rest treatment improves fetal and maternal outcome," Dr. Maloni concluded.

(This is an Abstract of the review made by Gary D. Vogin, MD)

Caesarean Section under local anaesthesia

Dr. Savithri Daithota*

Abstract: *There are areas in India where qualified anaesthetists are not available in the hospitals. The surgeons in such situations resort to local anaesthesia to save lives and to give relief to the patients. The experience of the author of using local anaesthesia for caesarean section for about eighteen years has been presented in this paper. Over 1000 ladies have been operated upon under local anaesthesia (but records of only 646 could be traced). Local anaesthesia for caesarean section was found to be effective and safe. There were no deaths or complications attributable to anaesthesia.*

Introduction:

Udupi is a busy coastal taluka head quarters town, well known also for its mythological connection with Lord Krishna, and now a district headquarters town of Karnataka. This town is only 4 kilometres from the medical college and postgraduate centre of Manipal. Government General Hospital in Udupi is the referral hospital for a vast area of South Kanara District; and yet, there was no anaesthetist in this hospital. The Government Maternity and Children's Hospital was a section of this hospital. A Civil Surgeon was in charge of both these hospitals. I was the first Gynaecologist to be posted to this hospital in 1977. Until I came to this hospital, the Civil Surgeon was performing emergency Caesarean sections (c-section) under local anaesthesia. I liked the idea very much. For, during my training I had seen a lady with placenta praevia, who needed immediate surgery; died because the anaesthetist refused to anaesthetise her. Local anaesthesia might have saved her. I did not want this ever to happen again in any hospital where I work.

The day after my reporting to duty, there was a lady in whom I was happy to diagnose cephalo-pelvic-disproportion (CPD). I reported it to the Civil Surgeon. In stead of performing the surgery himself he graciously ordered "you do it, I will assist you." He was used to classical type of c-section but I was trained for lower segment c-section (LSCS). Besides, I was aware of the disadvantages of the 'classical section'. He showed me his technique of giving local anaesthesia and I finished the LSCS without any difficulty. He assisted for one more c-section, then supervised two more and then left me free to work alone but making him available in the area. I worked with assistance of some colleague but mostly alone for the next 18 years as an in charge of the Obs & Gynae patients. I had also performed a few ovarian cystectomies and hysterotomies along with sterilisation under local anaesthesia.

One Staff nurse to assist, one Auxiliary Nurse Midwife (ANM) to look after the head end of the patient and to take care of the new-born baby after delivery and one O.T attendant constituted my team. Sometimes a colleague would assist me and only in the last 4-5 years of my tenure a paediatrician took over the new-born care, which was a great relief for me.

Material:

Though the number of operations exceeded 1000, records could be traced for 646 cases only. 99% of them were full term and in labour. Elective sections were performed at about 38-40 weeks. Patients were from different social strata and with different parity, majority being primi Para. There were also grand multigravidae as many as 14 in number. Repeat c-sections, up to a third time were also performed in this manner; there was one lady who had her fourth c-section under local anaesthesia.

Age groups:	up to 20 years.....	32 (3.6%)
	21- 25 years	303 (47.6%)
	26- 30 years	218 (34.28%)
	31- 35 years	72 (11.3%)
	36 and above	21 (3.3%)
	Repeat C-section	136

Indications (as per the available records):

C.P.D. - 276
Placenta praevia -40
Delayed second stage -32
B.O.H.- 28
Breech presentation- 20
Pregnancy Induced Hypertension. -18
Transverse lie-13
Post maturity- 10
Threatened Uterine Rupture- 7
Locked twins- 4
Hydrocephalus- 3
Monsters - 2
Cervical Uterine dystocia, etc. - 47
Foetal Distress -42
Persistent occipito posterior -28
A.P.Haemorrhage- 21
Elderly primigravida- 15
Precious baby - 11
obstructed labour- 9
Hand prolapse- 8
Cord prolapse - 5
Abnormal Uterus- 4
Oblique lie - 3

Methodology:

Patient was prepared like for any other surgery.

Pre-anaesthetic medication:

1. Diazepam 10 mg. or Largactil 50 mg. and one ampoule of Atropine sulphate were given I.M. 20-30 minutes prior to surgery. We found Largactil was more useful if Fortwin was to be used later in place of Pethidine.

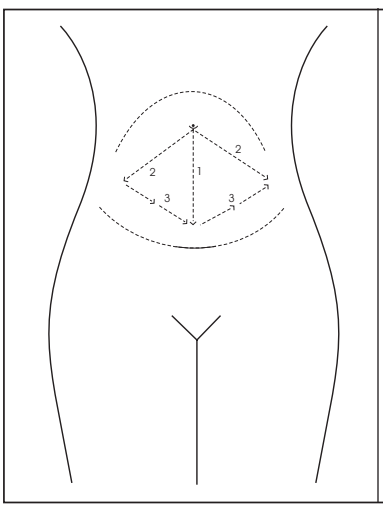
2. I.V.line was started with 5% dextrose solution.

After the patient was on the operation table, the operation area was prepared and painted as usual and the sterile drapes were placed.

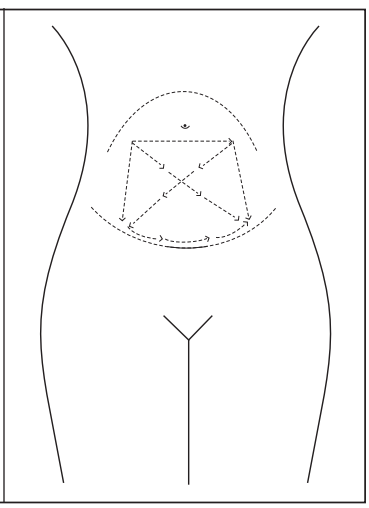
Local anaesthesia:
Anaesthetic: Xylocaine 1% (without adrenaline) was used.

Needle: Spinal anaesthesia needle No. 22 or 23 gauges.

Permissible volume of Xylocaine is believed to be 120 ml of 1% solution but I could work with only 80-90 ml. initially and later needed only 40 ml. If the patient was restless despite of this anaesthesia, I talked to the patient assuringly (vocal anaesthesia) and calmed her down or diverted her attention.



(Figure 1)


(Figure 2)

Technique: (Figure 1)

1. I gave the first Xylocaine injection, subcutaneously, just below the umbilicus and then pushed the needle subcutaneously downwards towards the symphisis pubis; Xylocaine was infiltrated as the needle was being withdrawn.
2. With the same needle in place or with a different point of entry near the umbilicus, subcutaneous infiltration was done on either side of lower abdomen up to the lowermost point of right and left iliac fosse.
3. Any parts of area of surgery not properly anaesthetised were individually infiltrated with further volumes of Xylocaine. Even, transverse infiltration may be needed in the lower abdomen.

Though this is my technique of 'triangular area infiltration', there are people who infiltrate in to a 'rectangular area', by infiltrating along the four borders of the rectangle and then along the hypotenuses. (Figure 2)

The important thing is to cover the whole of lower abdomen and deep up to the posterior sheath of the Rectus muscle. I have not noticed any additional benefit by spraying the Xylocaine in to the peritoneal cavity after opening the abdomen.

After waiting for 5 minutes for the anaesthetic to act, surgery was started. I always used midline vertical or Para median, lower abdominal incisions as was the teaching during my training. However, when 2-3 patients specially requested for transverse incisions, I had used them also. After the baby's head was delivered from the uterus, Pethidine 75-100 mg was injected I.V. slowly. Fortwin may also be used in place of Pethidine. Then the remaining steps of the surgery were completed. Pitocin, Syntocinon or Methergin were used timely like in any delivery case.

In two patients I had used Ketamine 100 mg. I.V. in the presence of a physician.

Most of the cases were performed as lower segment c-section but in few cases classical incision had to be made.

Difficulties:

During all the 18 years of my professional tenure in Udupi, I had been able to deliver the head of the baby without any assistance like giving abdominal pressure or a push through vagina. On a few occasions I had to resort to extension of the uterine incision to inverted 'T' shape. Closing of the abdomen was often difficult, as the abdominal musculature was not relaxed. Similarly, release of adhesions when found, haemostasis at a lower level and closing the peritoneum were difficult at times. But at no time during these 18 years did I call for or search an anaesthetist for these difficulties. In such situations I used an ampoule of Diazepam I.V, and generous 'vocal' anaesthesia.

Once while performing c-section on a restless alcoholic primigravida, there was sudden power failure. Lower segment could not be reached and a classical section had to be performed. The patient recovered well and subsequently had two more vaginal births, not without giving me many anxious moments though. When she finally came for tubal ligation, I was very satisfied to feel the strong and healthy classical section scar in the upper segment.

Another interesting experience was with a second gravida, who came at the middle of night as a case of full term pregnancy in labour with hand prolapse of the foetus for long hours. Surprisingly, foetal heart sound was still present. Usual local anaesthesia and surgery was performed, but the baby could not be delivered through lower segment incision. Even the civil surgeon who was called for assistance, failed in his

attempts. As a last resort the incision was converted in to inverted 'T' and the baby came out and to our relief cried immediately.

Post operatively; we administered only Penicillin injections in 99% of our patients as that was the only drug available to us.

Complications:

No major complications were encountered. One lady had burst abdomen; the general surgeon repaired it and she went home safely. Infection rate was very low.

There was no death attributable to the anaesthesia. There were two deaths in the period of 18 years; one due to massive pulmonary embolism and the cause of the other could not be ascertained.

Conclusion:

In a situation where qualified anaesthetist is not available, caesarean section delivery with local anaesthesia is a safe procedure. Experience with the technique makes the surgeon confident to operate upon more comfortably. It is certainly a viable, cost effective alternative to save many precious lives.

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Readers may recollect that a similar paper on caesarean section under local anaesthesia was published in July 2004 issue, based on the data available from Kerala state which has otherwise made commendable progress in health sector. This time, the data is from adjoining Karnataka state. There is no doubt that due to lack of qualified Anaesthesist, access to emergency obstetric care (EmOC) is badly restricted and the pregnant women in many of our rural and semi urban areas fail to receive life saving critical care.

*While data from both the articles suggest that caesarean section (CS) under local anaesthesia (CSLA) is not only safe but also well accepted by the women where emergency CS is needed, no attempt has been made to up grade or popularise the method even in resource poor setting. CSLA is a recommended procedure by WHO. Therefore in order to provide comprehensive EmOC, more initiative is needed to train and improve the skill of doctors for CSLA- a viable, cost effective, easy to learn procedure that can save many lives. - **Editor***

IFRS Section

The travails of rural surgery in Nigeria And The Triumph of pragmatism

Oluyombo A Awojobi

(This article is an abstract of 3rd Surgery Guest Lecture, delivered by Dr.Oluyombo A Awojobi at Department of Surgery, Obafemi Awolowo College of Health Sciences and Olabisi Onabanjo University Teaching Hospital Sagamu, Ogun State, Nigeria.

All over the world the quintessence of a rural surgeon's traits that set him apart are--commitment, concern for fellow beings, spirit, leadership, motivation, innovation, and imagination. He always stands for his conviction in the espousal of a cause. In the process of pursuing his values of life, he moves on to the society to rebuild and relocate their beings and this change, that he brings, marks the mile stone of his journey through life.

Dr. Awojobi's article mirrored this truth poignantly. Essentially a humanist, Dr. Awojobi's achievement has once again proved the power of conviction and strength of people's movement.

The initial parts of this passage that expressed the author's gratitude and his tribute to various luminaries have been omitted due to space constraints. - Editor)

The travails of rural surgery in Nigeria can be traced in almost all phases of a rural surgeon's professional life.

Whether it is the initial training period for a surgeon or the actual process of his appointment or even the administrative milieu in which he has to work - there are many such stumbling blocks in the journey of a rural surgeon.

Lack of proper infrastructure at the hospitals, the peculiar dilemmas a rural surgeon has to confront 24X7, shortage of financial resources & compromised quality of social life in a rural setting - these are just some of the travails that make pursuit of rural surgery seem like an arduous task.

However, in these travails reside the inherent pragmatic solutions as the adage '*necessity is the mother of invention*' comes into play all the way.

The travails of training the rural surgeons

In the seventies, when I started training at the Ibadan Medical School, my tutors, while teaching every clinical subject from diagnosis to treatment always said: 'In answering clinical questions, you must imagine you are in a rural area like Igboora or Eruwa, where most of the patients live. You then build it up to the teaching hospital level.' At that time, it made some sense in most clinical disciplines except surgery, as there was no example to go by in Ibarapa district where we spent 10 weeks of rural posting.

Although I set out to train as a general surgeon, I started training at the University College Hospital (UCH), Ibadan with a five-month rotation in the cardiothoracic surgical unit, CTSU. Those were memorable days culminating in open-heart surgery, which was fast becoming a commonplace routine then. In this unit I was taught the art and science of documentation, which is the heart and soul of research.

During surgical residency at the UCH, the resident was posted to the District Hospital, Eruwa for one month to provide surgical service to the best of his ability. I was there in April 1980. Although it was unsupervised,

there was discipline in the medical field in Nigeria of those days and the surgical registrar knew his limitations and would not engage in private practice. The system was working fairly well and the experience was worth it. It was to be the second time the would-be rural surgeon would live and learn in Eruwa.

In preparing fully for a rural practice, I ensured that I get rotated through all the surgical units, plus three months of posting in pathology (the first resident to do so) and to utilise my terminal leave in anaesthesia dept. without pay.

Another gruelling task during residency was the dissertation required for the final examinations of the fellowship of the National Postgraduate Medical College of Nigeria. It was and still is the Achilles heel of many residents at the final stage. The late Professor Emeritus T F Solanke had advised me, within one week of starting the residency in 1977, to start preparing the dissertation required five years later. A year thereafter, Professor O Ajayi was very instrumental in getting a viable project started and successfully completed twelve months ahead of schedule. The research findings were accepted for publication in the prestigious American journal, *Diseases of Colon and Rectum*, five months before my first attempt at the final examinations.

Although, the residency training should normally last five years, I spent six years for the residency as I did not avail myself of the optional opportunity of travelling abroad for one year. For this I was failed twice in 1982 in the final examinations to become a rural surgeon.

The mental agony associated with such experience was one of the hidden travails of rural surgery in Nigeria. I had realised that one year abroad at that stage could be disorientating and counterproductive to solving the medical problems in Nigeria. We should remember that open-heart surgery was a common operation at Ibadan and Enugu during that period and there was no need to travel abroad for training in most of the surgical disciplines.

The total effect was that I went back to UCH after National Youth Service to learn to climb a hill (that is general surgery) but ended up with training to conquer the mountain (that is cardiothoracic surgery).

In all, the decision to have my undergraduate and postgraduate training completely in Nigeria was deliberate. It was based on the implicit confidence that all my teachers at Ibadan were world-renowned and could train their kind solely in Nigeria.

Another source of inspiration was the 'Red Devil', the battle tank of the Biafrans that was deployed in battle from Aba, where it was made, until it got stuck at Ore during the civil war, 1967 - 1970. I had inspected the disabled Land Rover turned battle tank at Ore and concluded that Nigerians could solve all their problems with little or no external help.

The third inspiration was that I have always looked forward to a day like this when everything I am to talk about is home grown in Ibadan and Ibarapa district with no foreign influence whatsoever.

Although I had several opportunities to travel abroad for undergraduate and postgraduate training, I journeyed out of Nigeria for the first time in 1995. That was 20 years after becoming a medical officer and 12 years of being a rural surgeon.

The travails of appointing the rural surgeon

Even by 1983 my hardships were not over yet. I wanted to work in this state because of its geographical size and being sandwiched between the two tertiary centres in Lagos and Ibadan. I made nine trips to Abeokuta in

search of a job as a Consultant Surgeon to no avail and for no obvious reasons as there were only three surgeons in the state at that time. I even travelled on Sundays to see the late Ogboye of Egbaland, Chief M O Kuti, who was the Chairman, Ogun State Health Management Board.

However, when my time was running out in UCH, I literally 'ran' back to Oyo State Health Management Board wanting to be posted to the General Hospital, Iwo that I had surveyed cursorily. I remember telling Dr M A Aboderin, the late Director of Medical Services in Oyo State in 1983, that going to Eruwa was like going back home when he suggested my posting to the newly completed Comprehensive Hospital, Ejigbo or the District Hospital Eruwa. He had told me a young surgeon, just graduating from the UK, had been posted to Iwo. This is why I feel I am second time lucky in Ogun State on this auspicious occasion. Once again, I thank them very much for this opportunity.

The last words from Dr Aboderin to me before I set off to Eruwa were: *'we will make your stay in Eruwa comfortable*'. But, in the three years I worked at the District Hospital, Eruwa, all that government did was to pay my salary and allowance. I did not receive any material whatsoever after the stock I met was exhausted.

This initial experience in the public service was serious enough to deter the would-be rural surgeon. I could have returned to the UCH where my teachers would gladly have accepted me. But, the driving force was the "will" to serve the rural populace and give back to them what I had received while being trained from 1970 to 1983.

The administrative travails of the rural surgeon in the public service

Effective medical care cannot be delivered in the milieu of the general orders that operate in the public service. When I arrived at Eruwa in August 1983, the free health service of the outgoing civilian administration was almost at the tail end. Some surgical materials and drugs were available but soon got exhausted by the time the military staged a coup in December.

In April 1984, the military introduced fees into the health sector without providing the drugs and other consumables. The hospital had not only become '*mere consulting clinic*' but the health providers were to become supervisors of sufferings and deaths if they operated by the general orders.

The pragmatic solution was to initiate revolving funds for drugs, surgical materials and x-ray films from monies contributed by members of the community in Eruwa and the prescribed fees collected from the patients but managed by us. Our armour of scrupulous accountability against government sanction was such that my reply to a query from the administrators in Ibadan elicited no reaction for two and a half years.

In the meantime, comprehensive surgical service was brought to the doorsteps of Ibarapa populace. It culminated in the building of a ward with twelve beds within six months, November 1985 to May 1986, from funds raised with our endeavours and donations in cash and kind from the community. A building that would have cost N150 000.00 was constructed by direct labour with N15 000.00.

Government officials did not like this independence of action. So, a letter asking me to stop and confirm in writing that I had stopped, triggered my resignation in September 1986 like an artist that I am, bowing out when the ovation was loudest. Actually, the title of my resignation letter was '*… when the ovation is loudest.*' At the end of my tenure of service, the government auditor came to verify the accounts of the hospital. This exercise eventually led to the State Merit Award for rural medical practice in 1988.

Eruwa community rose in unison and came to my support, not in confronting the ruling elite, but in providing accommodation for our private practice, Awojobi Clinic Eruwa, with the mission statement: *'a private hospital in the public service'*. Our landlords, Chief M O Oladele, Prince A Adelakun, Mr J O Oladele and Papa J O Obisesan, did not charge any rent for the first three months and thereafter accepted from us the rent paid by the former tenants. Papa Obisesan loaned me N5 000.00 without interest or collateral to set up the practice.

Our permanent site, which was built between April 1988 and August 1990, occupies 10 hectares of land, which has been given to us **absolutely** free of charge. In fact, we do not sell land in Eruwa. By this action, the people of Eruwa had provided a pragmatic solution to one of the travails of rural surgery in Nigeria. Our people say: *'ti ona kan koba ti, ona kan kiisi', 'when a door closes another one opens'*. Apologies to my elders, again. In further appreciation of what they own, I was offered the chieftaincy title of Baasegun of Eruwa in 2000. The *iwuye* ceremony is still in gestation!!

(To be continued in the next issue)

Useful information

Dr. Pascience Kibatala is working hard to organize the 2nd International Conference of Rural Surgery in 2007 at Ifakara, Tanzania, under the aegis of IFRS. Dr. Kibatala has widely circulated the survey forms to surgeons, working in rural areas of his country to know more about the challenges they meet in their practice so that those can be evaluated if not sorted out in IFRS forum. Interested surgeons may contact Dr. Kibatala in the following address:

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Laparoscopy in Perforated Appendicitis: Technique, Advantages and Dangers

Egglseder Thomas, Schiedeck Thomas and Weimann Dirk

Background:

Laparoscopy has become a standard procedure in suspected appendicitis. As Laparoscopic Appendicectomy (LA) has proved successful in phlegmonous appendicitis, many surgeons are still reserved against treating perforated appendices by minimal invasive surgery. Numerous studies, both retrospective and prospective randomized, have displayed the usefulness of LA in perforated appendicitis to date. We show the standard procedure of LA and special operative strategy in gangrenous/ perforated appendicitis as it is applied in our hospital very successfully for more than 20 years.

Keywords:

Appendicitis/complications/diagnosis/surgery; Laparoscopy/adverse effects/methods; Treatment Outcome

Abstract:

Standard laparoscopic approach is a three port arrangement, camera port through the umbilicus and two instrument ports into the hypogastrium. The patient is placed in Trendelenburg's position, with a tilt to the left. After inspection of the whole abdominal cavity including mesentery and Douglas' space the appendix has to be separated very gently, all pus has to be sucked out. For dissection of mesentery containing the appendicular artery, we apply bipolar coagulation exclusively. The use of a stapling device is most safe to take off the appendix.

The specimen is removed through the trocar or by an endobag to avoid any contact with the wound surface. Absolutely essential is irrigation of the whole abdominal cavity and systematic drainage.

Conclusion:

Laparoscopy provides an appropriate and safe procedure for all stages of appendicitis and can be performed in most cases of perforated appendicitis. By following the mentioned operation steps, the benefits of LA are less rate of wound infection, less pain, faster recovery and earlier return to work.

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Book Review
Making of a Rural Surgeon

By Dr. Ravindranath R. Tongaonkar

Reviewer- Dr. Rekha Agarwala

Making of a Rural Surgeon: An Autobiography by Dr.Ravindranath R. Tongaonkar is an engrossing reading. From the beginning of the self-narrated journey through various landmarks, till the closing, I found, his achievements and so many "firsts" akin to the pioneering spirit and zeal of the early settlers. As a non-medical management qualified professional, I have had several years of social scientists' working experience. Evaluation and planning of large scale social impact with medical interventions included programs in several countries like South East Asia, India and South America for agencies such as UNESCO,WHO; as Consultants to the National Institute for Mental Health, Bethesda MD, USA and as a researcher in PIPP (physician instruction preparation project), a project of several Midwestern Universities consortium, I found the reading of the present book most exhilarating which left a lingering sense of de ja vu. More specifically, his open minded approach to Holistic medicine and considering the practice of medicine as a calling and that too in a rural setting - urban slums , is most heartening ;fulfilling the gap that had long been existed, felt and somewhat bridged but the incidences are few and far between, still to this day. The present volume will be most rewarding for younger and somewhat set in practice personnel, as he presents an alternative role model or rather a more challenging place based work model which is both rewarding as well as personally providing opportunity to do where their skills and training is most needed; perhaps get recognition faster than being a cog in the medical machinery of large urban hospitals or private practice which is materially more profitable. The central guiding theme of the author in his words, "Jack of all but master of surgery" is meaningful at each step, as he kept learning throughout his 40 odd years of rural practice; whenever he needed further skills, he sought them out and learned them and insisted his colleagues to do the same. It was the need of his times and the early stages of the movement. His breadth of learning ranged from medical techniques to technical advanced methods to ethical-legal implications and facing the consequent problems, is impressive and also lets a reader be aware the extent to which one has to be goal oriented and determined and one track minded. The deep rooted pedagogy but very matter of fact and down to earth reveals his austere but vivid; focused yet eclectic; medical but wider societal scope amply. At times I felt I am looking at a still picture, then to a wider lenses expose and then it became a moving picture with hands on -on going documentary of the unfolding medical events. The approach if that of a generalist; doing ,demonstrating , taking copious notes of learning and observations and teaching by actual performance of each medical activity, shows less reliance on book-theory alone . It also meant evolving and improvising methods and techniques as per situation, demands and available resources available. He is a good student as he learnt all he lacked -needed for his mission and made others to follow his method. He did the hard way, but pioneers or the path finders always have done it in a most round about way. Straight lines had not been their fate! The autobiography is a very close to his heart narration of trials and tribulations to begin a movement in an otherwise elitist medical professional specialty and bringing the newly carved special focus of the otherwise

similar practices, techniques for the benefit of less privileged, poorer strata of society and geographical divide. He details the improvisations, use of indigenous technologies, hands-on trials and errors learning, leading to situational solutions to medical, social and other types of emergencies. All this can be very important for younger doctors and social workers. Essentially, all this can boost confidence, morale and the spirit that 'it can be done' with perseverance, people focus than place bias, and professional skills and approach; he is very convincing and pleads his case with a great sense of self-made case study. However, the book reflects some very fundamental prejudices regarding self professed-vehemence -anti GOD-anti-spirituality - against idol worshipping close-mindedness and rigidity. After reading most of the book, the end came as a rude surprise because of such strong-anti spiritual views, in the light of his self proclaimed devotion to Swami Vivekananda on several issues. He quotes Swamiji on one hand to back his point of view and on the other hand he emphatically denies the existence of God and HIS temple worshipping. Yet he seeks answers to problems of the body-mind in VIPASHANA and other schools of beliefs and practice throughout the length and the breadth of India. In denying GOD, is he not accepting HIS existence? Can anything be discarded if its existence is not even acknowledged? These are some of the major dilemmas the good doctor leaves for the reader. His detailed references to Blind Faith Eradication Society and his own position as its official etc., makes me sense a great conflict between the doctor who started out with can do spirit to a dilettante, fighting for causes has perhaps over stepped little too wide. In all honesty despite he being a regular student of Srimad Bhagvad Gita since young age, his streak of GOD denial is more reactionary than his profoundly held belief structure which made him what he became. I found the book most interesting both for the medical related contents and issues raised, personality of the writer as a path finder and what is required in the make up of a true believer and most of all giving the RURAL SURGERY its due place and respect in the medical field. To conclude, I wonder our hero Arjun and teacher Lord Krishna on the battlefield of Kurukshetra have anything to do with our day-to-day situations and how we manage in the mirage of conflicts and come out successful… is it free-will or destiny?

Dr. Rekha Agarwala is PhD from Michigan University and was an ex-teacher of health Management. She may be contacted through Email drragarwala@rediffmail.com

Members are requested to send articles, short papers, case reports etc. for publication in "Rural Surgery" bulletin. The manuscript may be sent to Dr. S.K. Baasu, Hony. Editor, Rural Surgery, Rural Medicare Centre, PO Box10830, Vill. Saidulajaib, Mehrauli, New Delhi-110030. It may also be E-mailed at skbaasu2004@yahoo.co.in The adjudged best paper, published in the bulletin for the year 2006, will receive Rural Medicare Society Award, a cash award of Rs. 3000/- (Rupees three thousand only)

An Appeal

The quarterly bulletin of ARSI, now called "Rural Surgery", made a small start by the far sightedness of Dr. J.K.Banerjee, the first editor who donated Rs.10, 000 in the very first year of its publication. The bulletin that made such a humble beginning has improved in quality and in terms of contents and printing by the incessant efforts of the next editor Prof. V.K.Mehta and now Dr. S.K.Baasu. Now it is a fine journal that ARSI is proud of. It is sent to all the members of ARSI free and is sent to overseas members too, courtesy German Society for Tropical Surgery (DTC). To convey our philosophy to more number of rural surgeons in India, this year we are sending the copies to the members of ASRI the section of ASI also (ASRI has however, promised to bear the postal expense of every issue). The bulletin Rural Surgery is a beautiful, preserveable and tangible service of ARSI to its members.

The cost of publication and postage used to be less than Rs. 10,000 each year in the beginning. But over the years, both have gone up steeply. ARSI has created a Bulletin fund to generate interest income, but that is not bringing in enough. Even after increasing the budgetary allowance to Rs.60, 000 per year, the editor is unable to meet the expenses. He cannot increase the number of pages either, though he gets many papers and write-ups from the members. We have decided to start a section devoted to the International Federation of Rural Surgery, and this too will need some more pages. All this will necessarily need more funds. Unfortunately, ARSI finds it difficult to increase the allowance any further, since a) the interest rates have fallen steeply, and b) we do not entertain any advertisements from health care industries.

So the Governing Council has decided to appeal to you, the members of ARSI or to any sympathiser of rural surgery to support our Rural Surgery bulletin generously. You may kindly donate any amount. Names of those who donate more than Rs. 500 will be published in the issues. If any one donates Rs 15, 000/-..... or more, he/she will be considered as the sponsor of that issue.

So, please donate generously.

R. D. Prabhu
(Immediate past president)

Cheque/ bank draft to be made in the name of:
"Association of Rural Surgeons of India" payable at honorary secretary's address:
Sushruta Hospital, Khetia Road, Shahada-425409, Maharashtra

DR. ANTIA - FINSETH INNOVATION AWARD (2006)

Association of Rural Surgeons of India offers Antia-Finseth Innovation Award of Rs.10, 000/- for any innovation that is useful for rural health care. Innovation may be equipment, procedure or even a concept.

Innovator may be medical, Para-medical or non-medical person. Apply with details about the innovation, not to exceed two full-scape pages and with pictures if necessary. For more information contact:

Dr. B. D. Patel
Hony. Secretary, ARSI
Sushruta Hospital,
Shahada-425409, Maharashtra

Dr. K. C. Sharma
Chairman, Award Committee
1, Trikuta Marg,
Udhampur-182101

Terms and conditions

1) Selection of the candidate for the award will be made from the written report only. But the committee may decide, if necessary, whether the final selection will be from the report alone or after the candidate presents the innovation during the annual conference of ARSI.

2) The candidate has to personally present the innovation at the Annual conference.

Last date of submission of application for the award is 10th July, 2006

RNI No. DELENG/ 2005 / 16240

ASRICON 2006

Organized jointly
By
Association of Surgeons of Rural India (section of ASI)
(9th Midterm conference)
&
Association of Rural Surgeons of India (ARSI)
(14th National Conference)
In Association with
North Gujarat Surgeons Association

Venue:
Shanku's Water Park
Ahmedabad-Mehsana Highway,
Mehsana - Gujarat

Date:
25, 26, 27th August, 2006

Conference Correspondence:
Dr. Amir V Momin MS FICS
Sonam Hospital and Urology Center,
Doctor house, (near Bus stand),
Sidhpur-384 151, Dist: Patan (North Gujarat)

Second International conference of Rural Surgery
To be held
In
IFAKARA, TANZANIA
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