3rd ANNUAL SCIENTIFIC CONFERENCE

THEME
MANAGEMENT OF ACUTE TRAUMA IN THE RURAL SETTING:
THE ROLE OF THE RURAL SURGICAL PRACTITIONER

VENUE
TBT HOSPITAL,
GBOKO, BENUE STATE

17th - 20th NOVEMBER 2010

The Production of this Programme Booklet was sponsored by
Drs F F Adams-Momoh, O A Windapo and ARSPON, Imo State Branch
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Day 1  Wednesday 17th November
❖ Arrival
❖ Cocktail at the President’s residence at 7 pm.
❖ Meeting of the Governing Council at 8.30pm

Day 2  Thursday 18th November
❖ Registration,
❖ Opening Ceremony by Benue State Commissioner for Health

Guest Lecture:
MANAGEMENT OF ACUTE TRAUMA IN THE RURAL SETTING: THE ROLE OF THE RURAL SURGICAL PRACTITIONER

Chairman:

Guest Lecturer:  Dr Idoko Oche
Chief Consultant Orthopaedic and Trauma Surgeon
Federal Medical Centre, Makurdi, Benue State

Symposium:
MANAGEMENT OF ACUTE TRAUMA IN THE RURAL SETTING: THE ROLE OF THE RURAL SURGICAL PRACTITIONER

Chairman:

The menace of okada riders in Shomolu, Lagos
Dr Bayo Windapo
Medical Director, Adesola Clinic, Bariga, Lagos.

Causes of trauma as seen in a rural district of South Eastern Nigeria
Dr James Ibeto Umunna
Chief Consultant Rural Surgeon,
Jasman Hospital Ltd. Udo-Ezin inhibite, Mbaise

Pattern and outcome of road traffic injuries in a suburban community in South Western Nigeria.
Drs O O Abodunde#, O A Awojobi*
and B G K Ajayi**
# NYSC doctor, General Hospital,
Eruwa, Oyo State
*Consultant Rural Surgeon,
Awojobi Clinic Eruwa, Eruwa, Oyo State
**Consultant Ophthalmologist,
Ojulowo Eye Hospital, Ibadan, Oyo State

Road construction and maintenance for employment generation - the need for retolling and concession of Nigerian roads.
Dr Tunji Adenuga
Medical Director, Layo Model Hospital, Ikire
President, Omega Foundation Rural Development Organisation Ikire, Osun State.

Cultural night - The Princess Hotel, Gboko

Day 3  Friday 19th November
Panel discussion
Medico-legal Implications of Management of Acute Trauma in the Rural areas.

Free Papers
Surgical practice in an urban slum setting of Oyo - challenges and innovations in Momoh Memorial Hospital, Oyo
Drs F F Adams Momoh#, S A Adelere*, Ajibola Ogulade* and Popoola Tomori**.
#Medical Director, "Medical Officers, Momoh Memorial Hospital, Oyo, Oyo State.

Dr G O Salaudeen
Medical Director, Bissalam Hospital Egbe, Ikotun Egbe, Lagos State.

❖ Lunch,
❖ ANNUAL GENERAL MEETING

Day 4  Saturday 20th November
Departure

CONFERENCE ORGANIZING COMMITTEE
Chairman:
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Herbalists and other traditional medical practitioners can be divided into two groups. Those based in the cities widely advertise themselves and their practices in the press. They like to use long, jaw-breaking medical terms to impress their clients and claim knowledge of the medical sciences. They seem to specialise in diseases that cause human distress, not easily solved by scientific medicine, like cancer, AIDS, infertility, impotence and jaundice—a symptom they often mistake for disease. Their pronouncements on these topics tend to give the impression that they are either being dishonest or they are bent on making money out of human distress. They attempt to potentiate their concoctions by surreptitiously adding such drugs as antibiotics and analgesics.

The village-based traditional medical practitioner, however tends to make more modest claims which may only be distorted by the lack of grounding in the basic medical sciences, but generation of cash does not seem to be the main aim for most. However, as in most analyses of human behaviour, well-defined boundaries do not exist. Some nurses and other ex-hospital workers including non-clinical staff are now going into the business of “traditional doctors,” both in the towns and rural areas, further obscuring the difference between the two groups of “traditional health practitioners.”

It is not possible for doctors working in Nigeria to fail to experience the influence of traditional doctors or healers, most of it negative, in that it is their failures that find their way into our health institutions. No doubt, our failures also find their way into their clinics, so whatever we feel about them is likely to be mutual. This is one of the problems that militate against attempts to integrate traditional medicine into orthodox medical services, and there has been very little cooperation or coordination between the two groups of health workers.

The other factor is the human mind. There are purely psychosomatic diseases, meaning that the mind, for one reason or the other, produces physical, observable and measurable symptoms on the body. Perfect examples are the glove and stocking anaesthesia, caused by hysterical states. Others more complex can also be made to resolve by psychiatric means. Even in organic diseases, the feeling of amelioration can be brought about by psychological means. There is no doubt that traditional medical practitioners’ reputations are built on successes on the outskirts of psychiatry. You can, either through his confidence in you, or through placebos, easily relieve men of sexual impotence or dyspeptic complaints by removing the anxiety state causing the symptoms. The juju man can trick him back to health by mysterious “extraction of harmful objects or charms buried in his body by evil forces of his enemies.” We should also remember that, even in organic disease, the body is capable of healing itself and often does so. All we do is to improve the environment for it to happen and avoid undue interference with the natural healing processes. As it does for us, it also does for the traditional healers. It is the only medicine wild animals depend upon.

You cannot however, trick a badly inflamed appendix from bursting if it has gone beyond the stage of spontaneous resolution. Immobilise the fragments of a fracture properly and the bone
will heal perfectly provided your technique is not sufficiently faulty to cause gangrene or malunion. Lives are wasted in obstetrics by failure to detect problems before and particularly during parturition. No amount of ritual or prayer will stop the awful consequences of uncontrolled post partum haemorrhage.

In scientific or orthodox medicine, the prosperity of a practice is supposed to be driven by the satisfaction of patients and the reputation the doctor acquires. This is the main purpose for banning self advertisement. Generally, advertisement does not necessarily select the best product but the better marketing strategy. The tragedy is that the people who are trained to practice safely are the ones legally banned from advertising their services. The mediocre are therefore having a field day.

In this scenario, how do members of ARSPON interact with traditional medical practitioners in their environments? If relationship were cordial, there would be much to recommend in cooperation, where we teach them to avoid harmful practices like cutting off people’s uvula and recognition of signs of malignancy for early referral. Training of Traditional Birth Attendants is a good example, but midwives generally oppose the idea on grounds that it diverts attention from improving the conditions of practice in their profession. If traditional "fracture doctors" were trained, their results would be improved. Many patients would be saved amputation, deformity, or even septicaemia and death. We would then refer psychosomatic conditions to them—very time-consuming disorders - to treat, and we are always short of time!

If primary health care as recommended by WHO and provided for in our National Health Policy were implemented, the Community Health Officers and their staff would provide excellent services in rural areas. The better and honest traditional practitioners would naturally become part of modern PHC. However, this is not happening.

Management of trauma in rural practice (and for us, this includes “urban slums”) poses numerous problems. Action has to be quick and accurate if we are to minimise death, permanent disability and unduly prolonged morbidity. Members of ARSPON and traditional practitioners are either in cooperation or in competition, perhaps both. We hope to learn what our role is, or should be, in this environment.

MORE PICTURES FROM UDO – AT HRH EZE’s PALACE
GUEST LECTURE

MANAGEMENT OF ACUTE TRAUMA IN THE RURAL SETTING: THE ROLE OF THE RURAL SURGICAL PRACTITIONER

by

Dr Idoko Oche
MB, BS (Ib), FMCS (Ortho), FICS
Chief Consultant Orthopaedic and Trauma Surgeon
Federal Medical Centre, Makurdi, Benue State

INTRODUCTION

All over the world, injuries arising from road traffic accidents, occupational and Industrial hazards, warfare and community clashes, man-made disasters like collapsed buildings claim a heavy toll in terms of morbidity and mortality on human lives. Injury is the leading cause of death and disability in the first four decades of life, even in societies where HIV/AIDS is prevalent.

In the USA, annual estimates run into:

- 50 million Injuries
- 115,000 deaths
- 13 billion dollars

In the UK, annual figures are:

- 60,000 Hospital admissions
- 18000 deaths
- 2.2 billion pound sterling

We do not have statistics for Nigeria.

A significant proportion of morbidity and mortality can be avoided by the improvement of first aid measures. The organization of personnel training and provision of facilities for trauma care deserves priority in the primary health care system in our country.

EMERGENCY RESUSCITATION

It is important that first aid be administered by trained personnel. Knowledge should be disseminated throughout the population especially among hospital workers. The essential principle in handling trauma victims is to protect the patient from further injury. The principle of emergency resuscitation is the same irrespective of the trauma. The rural practitioner must act fast, yet methodically.

A = AIRWAY
The airway must be checked and cleared of secretions, food debris and other foreign objects. The unconscious patient may need an endotracheal tube to ensure adequate respiratory exchange. This is safe for 48 - 72 hours.

If the patient requires further respiratory support, a tracheostomy tube will be required.

B = BREATHING
For the patient who is breathing spontaneously, well and fine. If there is inadequate respiratory effort the surgical practitioner must take over the breathing. AMBU bag with face mask is particularly useful in a rural setting.

C = CIRCULATION
The resuscitation involves maintaining the circulation. An intravenous line with a wide bore cannula is essential. External bleeding should be controlled by pressure bandage and elevation. Tourniquet must be used with caution. It could be forgotten with disastrous consequences.

Other resuscitative measures include:
1. **Urethral catheter** to monitor hourly urine output. Adequate circulation equates to adequate hourly urine output. 1ml per kg in children, ½ ml per kg in adults.

2. **Analgesics** – The surgical practitioner must take care with the use of opiates. The non-steroidal anti-inflammatory drugs are very useful in this respect.

3. **Tetanus Immunization**: this is important for all patients with open wounds. Tetanus toxoid is given stat, then at 6 weeks, 6 months.

4. **Baseline Investigations** include – full blood count, retroviral studies, Blood group and urine sugar.

5. **Monitoring** – This remains essentially clinical in the rural setting. The vital signs and hourly urine output are of significance.

Most trauma patients present with polytrauma. In general, priority of care is determined by the rapidity with which injuries affect cardio-respiratory function. Head and Chest injuries will take precedence over abdominal and orthopaedic trauma.

**REGIONAL SURVEY**

**Head Injury**

This is reputed to be the commonest cause of death in polytrauma patients. Most head injuries are blunt or closed injuries. The presence or absence of skull fracture is not a reliable guide to the severity of head injury. The diagnosis of fracture of base of skull is presumed if there is CSF leakage through the nose or ear.

The most challenging task of a rural surgical practitioner is to be able to make a diagnosis of intracranial haematoma. Headache, drowsiness, restlessness, deteriorating level of consciousness, rising blood pressure, slowing pulse and respiratory rates with papillary dilatation and contralateral long tract signs are suggestive of the diagnosis. The patient requires very close monitoring of the level of consciousness using the Glasgow Coma Scale.

**Glasgow Coma Scale**

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Spontaneous</th>
<th>-</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To Speech</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>To Pain</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nil</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Response</td>
<td>Alert</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Confused</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Inappropriate Words</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Incomprehensible Words</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nil</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Motor Response</td>
<td>Obey Command</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Localizes Pain</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Flexion to Pain</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Abdominal Flexion to Pain</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Extension to Pain</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nil</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>3 – 15</td>
</tr>
</tbody>
</table>

The surgical practitioner in the rural setting must be prepared to do exploratory burr hole which is both diagnostic and therapeutic. The minimum number of burr holes is two (2); with a maximum of six (6). The result could be very rewarding as the level of consciousness could improve dramatically.

**Chest Injury**

About 25% of deaths following road traffic accidents is due to chest trauma. Injury to the chest may produce derangement in respiratory movement resulting in pulmonary hypoventilation, inadequate oxygenation and respiratory acidosis. There may be shock or cardiac dysfunction. The sole aim of treatment is to restore these derangements in cardio-respiratory function to normal as rapidly as possible.

A detailed examination of the patient with particular attention to dyspnoea, tachypnoea, cyanosis, chest compression, tenderness, tracheal shift, chest expansion, percussion note and breath sound is done. A chest
radiograph is obtained as soon as possible. Attention is paid to mediastinal shift, rib fractures, pneumothorax and haemothorax. A blunt costophrenic angle may suggest up to 500mls of blood in the pleural cavity. The surgical practitioner in the rural setting must urgently do a thoracostomy, under-water seal drainage through the 8th intercostal space along mid-axillary line. A modified chest tube bottle can easily be constructed.

**Abdominal Injury**

Abdominal injury is an important cause of morbidity and mortality in trauma patients. The greater per centanges of these patients have blunt abdominal injury. Penetrating wounds are common with the proliferation of small arms in our community. The diagnosis of a penetrating abdominal injury presents no problem. The frequency of organ damage in blunt abdominal injury varies from locality to locality. In one series, the spleen is the most frequently damaged followed by the liver, intestine and kidneys.

The diagnosis of visceral damage in blunt abdominal injury is made difficult in patients with head injury or alcoholic intoxication. The rural surgical practitioner must maintain a high index of suspicion. Clinical signs of abdominal guarding, rigidity and rebound tenderness are useful. A rising pulse rate with a falling blood pressure in spite of resuscitation measures is significant. Abdominal paracentesis is of diagnostic accuracy in 85% of cases. Diagnostic peritoneal lavage is an improvement over abdominal tap.

**Positive peritoneal lavage**

- Frank blood on aspiration
- Presence of bile
- Red blood cells-10⁵ /ml
- White blood cells- 500/ml
- Bacteria
- Amylase

Abdominal ultrasound is becoming very popular in solving the diagnostic riddle. The surgical practitioner in the rural setting must be ready to do exploratory laparotomy. In the words of a wise surgeon, ‘It is better to look and see than to wait and see’

**Genito-urinary Tract Injury**

The injury to the genito-urinary tract is heralded by abdominal pain, distension and haematuria. The presence of blood at the tip of the penis with a suprapubic mass which may be tender is significant. A rectal examination may indicate an upward displacement of the prostate. This will point to a ruptured urethra. A plain radiograph of the pelvis may reveal fracture of the pubic bone (Butterfly Fracture). The role of the surgical practitioner in the rural area is to perform a suprapubic Cystostomy (Urinary Diversion).

**Musculoskeletal Injuries**

Musculoskeletal injuries are the least in terms of immediate threat to the life of the patient. Their management is however important in the reduction of morbidity in the trauma patient. The patient may present with either a fracture or a dislocation or both.

The clinical sign of these injuries include pain, swelling, deformity and inability to use the limb. It is mandatory to have a good plain radiograph of the bone including the two joints at each end of the long bone. The minimum number of views must be two (anterior-posterior and lateral views).

The principles of treatment of fracture include reduction and immobilization. This can be achieved by the closed method and splintage done using plaster of Paris (POP). The surgical practitioner in the rural setting can easily manage simple fractures in the above manner. Dislocations are even more urgent. It is important to reduce dislocations within 24 hours to prevent irreversible chondrolysis with subsequent long term osteoarthritis. The surgical practitioner in the rural setting can reduce most dislocations and immobilize with POP.

In recent times, orthopaedic surgeons practicing in the rural setting have taken high-tech methods of managing fractures to these areas. These include open reduction and internal fixation in the management of compound fractures.
CHALLENGES

The rural surgical practitioner is faced with enormous challenges practicing in the rural setting where about 70-80% of the population resides.

(a) Road and Transportation: We are too familiar with our rural roads. The popular mode of transportation (Okada), may even cause more accidents to the trauma patient (the Second Accident) while being conveyed to the hospital. Government must make deliberate effort to develop the rural areas. This can be enforced through supervision of the third tier of government.

(b) Infrastructure and Staffing: The rural setting is faced with poor infrastructure – theatre space, instruments, anaesthetic machines, poor diagnostic laboratory back up, poor blood bank services. Trained personnel are lacking eg. anaesthetic doctors. Added to these are the problems of water and light. Government can assist voluntary and private health institutions by providing bore holes, generators and post staffs to some of these institutions in order to assist manage the ever increasing number of trauma patients.

(c) Finance: The patient who needs the greatest care may not have the resources. Public spirited individuals, churches and voluntary organizations should be encouraged to come to the aid of the trauma victim and be the Good Samaritan. The rural surgical practitioner is only but the keeper of the inn.

(d) Fear: The rural surgical practitioner must conquer fear. The fear to attempt modification, the fear of criticism by colleagues and fear of failure. There is need for continuous education and reeducation, continuous training and retraining. This will help to build the much needed confidence in the rural surgical practitioner to attend to trauma patients quickly and efficiently.

CONCLUSION

The greater majority of trauma patients are in the rural areas. Our infrastructures are, however, in dire need of diagnostic and therapeutic facilities. The rural surgical practitioner must brace up to the enormous challenges of managing acute trauma in this setting. Continuous training and retraining will build the much needed confidence to attend to these patients. This will go a long way in reducing mortality and morbidity in the trauma patient.

TO THE COMMISSIONER OF HEALTH FOR HIS SUPPORT TO ARSPON
SYMPOSIUM

Management of acute trauma in the rural setting:
The role of the rural surgical practitioner

Chairman:

THE MENACE OF ‘OKADA’ RIDERS IN SHOMOLU, LAGOS

by

Dr Bayo Windapo, FAGP

INTRODUCTION

Commercial motorbikes, popularly known as ‘Okada’, have come to stay not only as a major means of transportation in Lagos in particular and the nation in general, it is also a source of income for the operators ranging from riff-raffs to university graduates and investors.

A convenient cheap and fast means of transport especially with the traffic congestion of Lagos has, however, been bastardized and become the most dangerous means of transportation for various reasons.

1) The operators are usually reckless and overspeed in most cases.
2) They overtake anyhow, anywhere and usually from the wrong side of the road.
3) They stop and turn indiscriminately on the road not minding the traffic coming behind - as if they are the only ones on the road.
4) The bikes are in most cases overloaded either with passengers or even with goods.
5) The riders are mostly illiterates who are not licensed, know next to nothing about traffic rules and safety regulations and don’t even care for their own lives and those of the passengers they are carrying.
6) Most of them operate under the influence of drugs and alcohol.

It is not uncommon to find underage operators.

THE MENACE

The recklessness of the operators in conjunction with the recklessness of other road users, pedestrians inclusive, more especially ‘danfo’ and ‘molue’ bus drivers, has resulted in untold road traffic accidents occurring on an hourly basis.

In our hospital, there is no week that we do not record 2 or 3 cases. In most cases involving a ‘danfo’ driver who sees okada operators as rivals. Hit-and-run cases either of okada knocking a little child down or another bigger vehicle knocking okada off the road are common.

Our data (Table 1) which covered 2007 to date show the number of cases and the injuries recorded as the major ones per case. For instance, a case with fracture could have abrasions as well but the abrasion would not be recorded as another case. It is interesting to note that most of the fractures and lacerations occurred on the left lower limbs.

It is also worthy of note that all road safety campaign efforts and legislation regarding use of helmets have not yielded desired results as shown by the number of head injuries recorded before and after 2008 when the campaign started in full. Ditto for number of cases.

Our referrals were mainly to National Orthopeadic Hospital, Igbobi, Lagos and were due mainly to the uncooperative attitude of the patients.
On the whole, "okada" cases constituted about 80% of all our trauma cases and are a major demand on our surgical facility.

**TABLE 1**

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
</tr>
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<tbody>
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<td>21</td>
<td>26</td>
<td>30</td>
<td>95</td>
</tr>
<tr>
<td>Laceration (heel)</td>
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<td>5</td>
<td>6</td>
<td>3</td>
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<tr>
<td>Others</td>
<td>8</td>
<td>12</td>
<td>10</td>
<td>7</td>
<td>37</td>
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<tr>
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<td>4</td>
<td>7</td>
<td>6</td>
<td>20</td>
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<tr>
<td>Burns</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Severe</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>- Minor</td>
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<td>15</td>
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<td>8</td>
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<td>Referrals</td>
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<td>3</td>
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<td><strong>TOTAL</strong></td>
<td>44</td>
<td>48</td>
<td>58</td>
<td>54</td>
<td>204</td>
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</table>

**CONCLUSION**

"Okada" riding remains a major means of transport and source of livelihood in Shomolu, Lagos with attendant risks of injuries and mortality from frivolous accidents. More effort should be geared toward curbing this preventable menace.
CAUSES OF TRAUMA AS SEEN IN A RURAL DISTRICT OF SOUTH EASTERN NIGERIA

by

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INTRODUCTION
The causes of trauma in our area of practice, which is in the South East of Nigeria, differs essentially from what is seen in the cities and the developed world. The factors involved are summarized here below:

- The Habitat
- Occupational Hazards
- Domestic Events
- Road Traffic Accidents
- Miscellaneous Events

THE HABITAT
- Mud walls and thatched roofs
- Harmattan fires
- Fierce winds
- Falling trees

Most villages in South Eastern Nigeria are removed from the hustle and bustle of the fast environment of the city. This peculiarity opens them up to special types of trauma as most are tucked away in forest clearings with no access roads and only a few are traversed over short distances by highways. Nowadays, modern buildings with solid block walls have sprung up, but there are some places where the traditional mud walls and thatched roofs are still the habitation of people. These latter often fall down during heavy rains and fierce winds with resultant injury to the inhabitants. Interspersed among trees, they are sometimes knocked down by falling tree branches, or even whole trees, as happens with the oil palm tree. Injuries inflicted include bruises, contusions, fractures, head injuries, spinal injuries and even instant death.

During the dry season and the harmattan, such thatched houses are frequently engulfed in fire and the inhabitants may suffer varying degrees of burns.

OCCUPATIONAL HAZARDS
- Farming activities
- Matchet cuts
- Fall from trees
- Sharp wood and thorn injuries
- Animal bites----snakes, scorpions, wild animals
- Hunting

Agriculture is the main occupation in this area for the rural people and it carries with it peculiar hazards. Accidental open injuries with matchets, hoes, axes, shovels and diggers are common and they are of varying degrees of severity, including amputation of fingers or toes, tendon injuries and severed blood vessels. Also, thorns and sharp stumps of cut small plants do cause piercing injuries with retention of pieces of wood in the
tissues. In the past, such injuries were veritable portals for entry of Clostridium tetani with resultant high mortality from tetanus.

Farming activities involve much movements in the bush and expose the farmer to bites from insects, snakes, scorpions and even bigger wild animals. A common cause of trauma in this rural area is fall from palm trees. Palm trees are very important economic trees in this area both for the wine and the oil. Sometimes, they get very tall and men still climb them. Sometimes, the rope bunch which is used for climbing snaps and the climber falls. The resulting injuries are often very serious, including, among others, spinal injury, head injury, ruptured viscus, haemopricardium, haemothorax, fractured ribs. Death is a frequent outcome.

Hunting
Hunting is an occupation of the rural dweller. Hunters operate in groups, individuals positioning themselves to encircle an area where the game is suspected to be. Not infrequently, one so positioned is mistaken for the game and shot at by a member of the group. Various degrees of injury including death have been recorded.

DOMESTIC EVENTS

- Domestic violence
- Hot water accidents
- Kerosine explosions
- Scalds while cooking
- Sexual accidents and rape

Perhaps the most common domestic trauma is caused by domestic violence involving husband and wife. Injuries include a black eye, bruises and loss of tooth. Husbands have been known to drench their wives with hot water or even acid, with resulting burns of various degrees. A husband has been known to shoot his daughter to death with gunshot aimed at his wife. Wives have been known to violently dislocate their husband’s penis by pulling on it. Sometimes the conflict is between two co-wives who inflict bites on each other to the extent of biting off the lips.

Children are often victims of hot water burns, with injuries of mainly first and second degree. Other injuries in the home include scalds while cooking, severe burns from kerosene explosion while refilling burning stoves or hurricane lamps. Electric shock or burns from faulty electrical equipment or careless handling cause severe injuries and death.

Injuries from rape are not commonly reported but they do occur. The woman living with a man, who is rushed to the hospital at the dead of night with severe lower abdominal pains and sudden onset of heavy bleeding, if she is not pregnant, has almost certainly had a tear in a vaginal fornix as a result of forceful sexual intercourse and this must be looked for.

MISCELLANEOUS EVENTS

- Armed robbery
- Land disputes
- Road traffic accidents
- Inter-communal conflicts
- Acoustic trauma
- Psychological trauma

The upsurge of armed robbery has brought with it many cases of severe trauma from gunshot wounds as dane guns and high velocity guns are used in the villages. Axes, matchets, iron rods, daggers, bare hands and feet are used to inflict sharp and blunt wounds on victims.
Road traffic accidents from high speed vehicles are uncommon in these villages as vehicular traffic is low. More common are motor cycle and bicycle accidents occurring at low speed. The resulting injuries are often not severe but may be bad enough to require specialist attention.

Land disputes are common and often involve fights with cutlasses. This is most common during the planting season. Uncontrolled noise from churches and itinerant preachers can cause acoustic trauma while violence of any type inflicts psychological trauma.

**ROLE OF THE SURGICAL PRACTITIONER IN TRAUMA MANAGEMENT IN THE RURAL AREA**

- Education
- Immunisation against tetanus
- Proper patient evaluation and possible treatment
- Early referral as necessary

While many of the injuries seen in rural practice, especially in remote areas, may not appear severe, one must not lose sight of the fact that the full manifestations of injury may not be obvious immediately. This is particularly true of blunt injuries to the chest and abdomen where severe and life threatening injuries may exist: haemothorax, haemoperitoneum, haemopericardium and also femoral fractures. There is need for repeated assessment and the earliest opportunity must be taken to refer patients to the nearest centre where better care may be available.

There are measures within the reach of the rural practitioner and these areas must be addressed with dispatch. These include care of wounds, splinting or fixation of fractures, blood transfusion when indicated, education and advice to patients and their relatives particularly in their common preference for traditional treatment of fractures even when they are complicated.

**CONCLUSION**

The slow life of the rural areas, particularly those situated far from urban cities is associated with infrequent high risk trauma presentations. But there are cases which are peculiar to these areas and which demand familiar acquaintance to be properly handled. This knowledge is important for the practitioner to decide where his limits and when to seek collaboration with colleagues elsewhere.

**AT JASMAN HOSPITAL LTD, UDO-E\INIHITTE, MBAISE, IMO STATE**
PATTERN AND OUTCOME OF ROAD TRAFFIC INJURIES IN A SUBURBAN COMMUNITY IN SOUTHWESTERN NIGERIA.

by

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INTRODUCTION

Trauma, commonly resulting from Road Traffic Crashes, RTC, is known to be a leading cause of preventable mortality and debility globally. Because trauma related deaths and disability primarily affect those in their prime working years, the resultant loss of economic potential to the nation can be considerable.

Notably, these RTC’s indicate a deficiency in the application of safety measures and ignorance of information pertaining to road traffic behaviour. Road traffic crashes have been referred to as a hidden disease of epidemic proportion, a problem that kills on the average 3,242 persons daily worldwide and leave many more disabled. While road crashes have been steadily falling in high-income countries, they continue to rise in low and middle-income countries. This problem deserves an attention commensurate with its incidence with ninety per cent of these fatalities occurring in low and middle-income countries. All these necessitate the need to study and understand the peculiarities and problems of road traffic crashes in our environment so as to recognize liable risks and propose necessary areas of interventions.

This study provides a detailed description of the pattern and outcomes of road traffic injuries as seen at Awojobi Clinic Eruwa, a secondary level health facility, serving a population well over 100,000 in Eruwa, the most populated of seven sub-urban communities which make the Ibarapa district of Oyo State, Nigeria.

METHODS AND MATERIALS

Records were recruited from Awojobi Clinic Eruwa (ACE) from 1994 - 2004. This period was chosen to include 5 years before and 5 years after the return to democratic dispensation. The advent to civil rule heralded and increase in the purchasing power of the people who often opted for personal means of transportation.

Measured variables were age, sex, occupation, type/mechanism of RTC and outcome of RTC. RTC’s were classified based on a pattern involving a primary element and a corresponding secondary element for each singular crash (e.g. Motorcycle-Truck collision or Pedestrian-Motorcar collision). Each victim’s mode of participation in a crash was indicated as his/her situation before the crash. Where possible, the secondary element (person or vehicle) was also recorded. The geographical location of the RTC site and its time of occurrence were recorded in a bid to determine a sociographical trend as described by Odelowo.

Injuries sustained were described on the basis of anatomical location and conventional typing using common terms. An attempt to assess the variety, magnitude and severity of injury was made using the Injury Severity Score (ISS) by Baker et al while applying the trauma chart described by Greenspan et al which combines the Abbreviated Injury Scale (AIS) and ISS. Victims with serious multiple injuries were identified with injuries corresponding to AIS of 3 (serious injury) in at least 2 regions. The surgical treatment of sustained injuries was recorded and outcome was in terms of procedure(s) required, temporal or permanent disability and mortality.

All observations were statistically analyzed (exclusion criteria) using simple ratios, per centages and chart presentation for comparison.
RESULTS

A total of 2714 trauma-related cases were recorded during the ten-year period of which 950 (35%) were RTC’s involving 1027 patients. Table 1 shows the age and sex distribution of these victims. There were 668 male (65%) and 359 female (35%) patients, giving an overall male to female ratio of 1.9:1. This ratio was most striking in the 20-29 year and 40 – 49 age groups (2.8:1 and 2:1 respectively).

The occupations of RTC victims were generally reflective of the sub-urban society and Table 2 shows the occupational distribution. The occupation of one patient (0.4%) was not specified and the rest were children under 12 years. Farmers constituted the largest occupational group (19%) while students, traders and craftsmen were equally well represented. Peculiarly 85% of traders were female while 88% of craftsmen were male. Drivers and motorcyclists were all males. Other victims were 6 religious workers, 5 professionals and one legislator.

Time and site of RTC

Most patients presented within hours of the accident. However, 27 patients involved in different crashes presented more than 24hrs after RTC and 6 patients had unspecified time of arrival. Table 2 shows the period of presentation at ACE. Table 3 shows the location of RTC and Table 4 shows the time of presentation in the hospital.

Mode of participation and mechanism of injury

9.5% of all RTC victims had unspecified primary mode of participation (indicating the situation of victim before collision) as represented in Figure 5.

Injuries sustained and outcomes

The profile of injuries sustained is summarized in Table 6. The most common injuries were to the limbs, (with or without fractures). Our study did not recognize a number of patients with uncomplicated or minor injuries not requiring acute surgical care. Limb injuries were preponderantly to the lower limbs. Facial and scalp injuries were collectively less associated with fractures as only 20% of these had associated fractures (basal or vault skull fractures and mandibular fractures).

All fractures were consistently diagnosed radiologically. This study recognised 180 victims (17.5%) with serious multiple injuries corresponding to AIS of 3 (serious injury) in at least 2 regions. This might be an indication of the magnitude and severity of injuries documented by this study. Peculiar instances worth mentioning include individual victims with open depressed skull fracture, compound skull fracture with cerebral herniation, ruptured spleen from blunt trauma and 2 cases of hemopneumothorax that survived after appropriate treatment.

Patients’ outcome corresponds with their antecedent pattern of injury. Over 55% of patients were treated with immediate wound toilet and suturing of various lacerations while an additional 3% required delayed wound closure. Forty four patients (4.4%) sought discharge against medical advice (DAMA), all of them haven sustained limb fractures. They went to the traditional bone setters in the villages. 13% of victims required reduction of dislocation or fractures with immobilization using mostly POP or skeletal traction (2.4%). A significant minority (<2% each) required dental wiring for moderately serious maxillofacial fracture, open reduction and internal fixation (ORIF) for limb fracture, exploratory laparotomy and closed thoracostomy tube drainage. A total of 23 mortalities were recorded (2.2% mortality rate) mostly from head injuries.

DISCUSSION

The profile of trauma witnessed in the sub-urban setting differs from what obtains in urban communities. Only 35% of all trauma cases seen within a 10-year period were RTC. Records indicate that domestic accidents and occupational trauma (including unintentional fire arm injury among hunters) are of significance in Eruwa. Solagberu et al reported 62% RTC incidents in trauma patients, while Odelowo recorded RTC in 74.2% of overall trauma in urban tertiary health centre studies.

The typical Eruwa RTC victim is a farmer aged between 20-29 years on a motorcycle. Students also constituted a significant proportion of RTC patients. This can be explained by suburban community lifestyle in the presence of an off-campus tertiary institution, the Eruwa campus of the The Polytechnic, Ibadan, which necessitates frequent shuttling of students from their residential locations. The motorcycle is obviously the most available...
means of transportation in many suburban Nigerian communities and presently has become popular even in urban cities.  

Our finding on time and site of collision are corroborated by Adeloye and Odeku who indicated highest presentation in the hospital between 12noon and 6p.m (50%) followed by attendance between 6a.m and 12noon. Odelowo demonstrated that more collisions (37.2%) occurred within the town. However, night traffic appears less in the suburban society as reflected by the contrast with a similar study, 31% versus 7.5%. It is important to state here that high traffic census did not necessarily imply high RTC rate, and therefore advocate that more attempts should be made in recognising subtle socio-geographical factors implicated in Nigerian RTC.

Adequate enlightenment is paramount despite illiteracy to overcome the prevalent ignorance of road traffic rules and regulations. Strict and consistent use of helmet and seat-belts, enforcement of traffic laws including speed limits, erection of traffic calming facilities, prosecution with stringent penalties for drunk driving with or without instance of collision and frequent purposeful vehicle inspection/road worthiness campaigns are affordable life-saving measures which have been employed in other countries as antidote to the woes of increased motorisation associated with wealth creation and industrialization. Better lighting of roads, (especially intra-city routes) to increase visibility will also secondarily serve to prove that RTC are easily preventable in the first instance.

Pedestrian collisions has been a subject of much attention with an incidence of 19.4% of all RTC victims compared with 27.5%, 19.1% and 15.9% as recorded in some Nigerian tertiary center studies. However in developed countries, it is less than 6.2% and this can be explained by obvious demarcation between vehicular traffic and pedestrian lanes, right of way granted by pedestrian traffic lights and zebra crossings. Lane et al also demonstrated that pedestrian collision in developed countries mostly occurred along travel lanes without pedestrian provision or at intersections frequently involving inattentive pedestrians and turning vehicles.

Particular interest is placed on the age of pedestrian victims as being in the extremes. 33% of pedestrian RTC in our study were ≤12 years, Odelowo recorded 50.9% of pedestrian victims <17 years. Also 23.8% of pedestrian victims were aged ≥60 years. This fraction of “elderly pedestrians” is notably overrepresented in morbidity and mortality. This age group being responsible for up to 50% of pedestrian mortality as compared to 10% of pedestrian victims aged ≥65 years contributing 37% of pedestrian mortality in a developed country.

Studies reviewed were unanimous in the magnitude of pedestrian mortalities relative to their incidence with a notable 50% and 68% of injured pedestrians dying during initial resuscitative efforts. Our pedestrian group mortality 31% is high compared to similar urban tertiary center studies, 16.5% and 22%. Similarly, the nature of injuries sustained in pedestrian was of a higher magnitude than that of the overall study, viz head injury-21.5%, limb injuries- 78%, scalp and facial laceration 40% of pedestrians. We observed that 46% of victims with serious multiple injuries were pedestrians. Also we observed a consistent decrease in incidence of serious head injury and corresponding increase in serious extremity injury with advancing age as corroborated by Lane et al.

Nigerian studies reviewed agree that the motorcycle is still the commonest secondary element of pedestrian RTC. Our study recorded the motorcycle as secondary element in 38% of pedestrian as compared with 21.3% and 36.8% respectively. Lane et al highlighted that pedestrian tend to overestimate their actual visibility. Observations that elderly pedestrian are more sluggish and likely to have antecedent visual, auditory or locomotor impairment and children being frequently involved while crossing intratown roads or walking to and from school explains our ≤ 12 years and ≥ 60 years “dependent” age group.

Our study sheds light on the magnitude of motorcycle traffic collisions and injuries. Noted as the second commonest participant in RTC, we recognize the motorcycle occupant (either the cyclist or passenger) as the most common victim in suburban road trauma. Others have noted a varying incidence 9.4%-35% based on diverse inclusion criteria but we have separated pedestrians from our motorcycle trauma observations. The age distribution and profile of injuries sustained by motorcycle victims is much similar to the overall study pattern. Most victims were between 20-29 years old and common injuries were limb injuries, facial and scalp lacerations and head injury.

We recorded motorcycle ocular injuries, which formed the majority of 12 ocular injuries seen in the study. Indeed, our visiting consultant ophthalmologist was confronted with a subtle prevalent disease and suggested a review of the records.
Motorcycle victims constituted 26% of mortalities in our study as compared to 0.7% of RTC mortality recorded by Odelowo with 10.3% incidence in an urban tertiary centre study. Only one of the six such mortalities occurred outside the active age group, the pattern of injuries resulting in mortality also suggests that they were salvageable if passengers and riders of motorcycles consistently wear protective helmet and eye screens.

The pattern of injury sustained in sub-urban RTC appears to vary from those observed in urban RTC. Although limb, head, scalp and facial injuries were common, thorax and abdominal visceral injuries were much less in occurrence. We recorded four abdominal and two chest visceral injuries. In the serious multiple injury group, limb injury (mostly lower limb fractures were combined with injury to the head viz skull of maxillofacial fracture with or without head injury. Other studies indicate occurrence of head and neck injury in combination with pelvic and chest injury. In a direct comparison between rural developing world and urban level I trauma, Mock et al noted a predominance of limb and skin injury in rural developing world as against thorax, abdominal and head injury predominance in urban level I trauma centres. Notably serious multiple injuries comprised of pedestrian RTC (50%). This pattern implies that high speed is not of significance in the morbidity and mortality of non-urban RTC.

Recently extensive public health measures are justifiably being launched at primary care level against polio, malaria, HIV/AIDS and tuberculosis, however relatively little has been done in relation to the rising trend of Road Traffic injuries in rural and sub-urban(non-urban) communities. An adequate understanding of the timing, location and predisposition of these non-urban road traffic injuries is fundamental towards determining avenues where inexpensive interventions can be executed. Thus, the rigor of arranging efficient pre-hospital emergency care, overcoming hospital logistic constraints, ignorance of basic life support processes and the multiplier effect of poverty can be simplified using a thorough situation analysis. Most Nigerian sub-urban and rural communities exist in a shortage of competent medical doctors to consistently and responsibly administer round-the-clock health service. Therefore, non-physician medical professionals, like nurses, have appropriately developed to fulfill this essential role. These non-physician practitioners are frequently the ones to treat patients and institutions like ACE are uncommon in the average non-urban community.

Our study reveals that a significant proportion of victims with common injuries were attended to by a non medical staff with primary trauma survey and initiation of appropriate resuscitation within thirty (30) minutes of arrival at ACE. These qualified nurses have developed competence through monitored training and they readily serve as “physician assistants”. Mock et al in comparing developed and developing world trauma outcomes acknowledged that village health workers and rural clinic nurses offer some form of prehospital care. RTC victims’ care before hospital arrival can be improved by increasing the number and distribution of non-physician health care providers and likewise increasing their training in initial triage and immediate post injury treatment of trauma patients.

Our predominance of limb, scalp and facial laceration without abdominal and thoracic injuries also implies the need to place premium on basic surgical skills (suturing and knot tying), basic life support and trauma management principles in the training of rural health workers and all medical professionals. Pre-hospital care can be improved by either increasing the rapidity of transport or by increasing personnel's capabilities for treatment before hospital arrival or both. Cales and Trunkey in reviewing trauma care system development, noted that effective treatment requires an organized approach from injury through discharge. Where an organised approach obtains, the outcome is better and studies have consistently shown a high proportion of unacceptable care and outcome in the absence of an organized approach.

Solagberu et al in a pioneering effort on preventable trauma deaths in an urban tertiary centre, categorised these factors as prehospital care, inter and intra hospital logistics, poor funding and public health ignorance. The first and last categories have initially been discussed leaving factors of inter intra hospital logistics which are less obtainable in monitored smaller units devoid of much bureaucracy and protocol. Secondary level health institutions should be reinforced to act as pivots for primary emergency care of trauma victims in their proximity.

Adenyemi-Doro in his review of trends in trauma care highlighted eight criteria required for a regional trauma care system while acknowledging that many of the structures required to develop such systems are already in place. Mock et al argued that facilities and interventions are needed to improve survival of patients. They also noted that procurement of such facilities in a developing country did not achieve survival equal to that in the United States in the absence of more advanced and expensive supportive care. A comprehensive regional trauma care system will be cost intensive and may prove as abortive as the NHIS which has been in pipeline for close to a decade. We therefore advocate a categorized trauma care system in non-urban region that will not
necessarily be capital intensive. Centres are required to individually set and maintain good standards for
treatment and reporting of trauma cases, whereas a central authority will ensure a minimum capability.

Cales and Trunkey\textsuperscript{13} also noted that rural fatalities resulted from less severe injuries and occurred sooner after
injury than urban deaths. Timely intervention is called for in rural RTC with technical knowhow and skilled
resuscitation to avoid the most frequent errors of hypovolaemia and offer of life-saving surgical interventions in
the immediate post injury period.

CONCLUSION
This study has the limitations of a retrospective study, but it is presented, nevertheless, to serve as an indication
of Nigerian sub-urban road traffic crashes. It recognizes socio-demographic factors, outlines the pattern of
injuries and outcomes with resultant sequelae as contrasted with observation of other relevant studies.

The prescribed interventions, which will be affordable in poor economies, will be an antidote to combat the
imminent upsurge of road traffic injuries resulting from rapid urbanization and motorization.

\begin{table}[h]
\centering
\caption{ROAD TRAFFIC CRASHES IN ERUWA: AGE/SEX DISTRIBUTION}
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\multirow{2}{*}{AGE (years)} & \multicolumn{2}{c|}{MALE} & \multicolumn{2}{c|}{FEMALE} & \hline
10 & 20 & 38 & 17 & 33 & 108 \hline
10–19 & 32 & 42 & 14 & 26 & 114 \hline
20–29 & 70 & 188 & 35 & 56 & 349 \hline
30–39 & 43 & 91 & 16 & 53 & 203 \hline
40–49 & 23 & 46 & 5 & 30 & 104 \hline
50–59 & 7 & 30 & 10 & 27 & 74 \hline
60 & 9 & 29 & 12 & 25 & 75 \hline
\hline
\textbf{TOTAL} & \textbf{204} & \textbf{464} & \textbf{109} & \textbf{250} & \textbf{1027} \hline
\end{tabular}
\end{table}

\begin{table}[h]
\centering
\caption{ROAD TRAFFIC CRASHES IN ERUWA: OCCUPATION OF PATIENTS}
\begin{tabular}{|l|c|c|c|c|}
\hline
\textbf{OCCUPATION} & \multicolumn{2}{c|}{1994–99} & \multicolumn{2}{c|}{1999–2004} & \hline
 & \textbf{TOTAL} & \textbf{PER CENT} & \textbf{TOTAL} & \textbf{PER CENT} & \hline
Students & 65 & 69 & 134 & 16.5 \hline
Traders & 60 & 116 & 176 & 16.5 \hline
Farmers & 44 & 159 & 203 & 19.9 \hline
Craftsmen & 30 & 33 & 63 & 6.2 \hline
Drivers & 38 & 66 & 104 & 10.2 \hline
Civil servants & 20 & 35 & 55 & 5.5 \hline
Motorcyclists & 42 & 120 & 162 & 15.9 \hline
Children & 60 & 70 & 130 & 12.8 \hline
\hline
\textbf{TOTAL} & \textbf{359} & \textbf{668} & \textbf{1027} & \textbf{100} \hline
\end{tabular}
\end{table}

\begin{table}[h]
\centering
\caption{ROAD TRAFFIC CRASHES IN ERUWA: LOCATION OF CRASHES}
\begin{tabular}{|l|c|}
\hline
\textbf{LOCATION} & \textbf{PER CENT} & \hline
Eruwa township & 196 & 20.6 \hline
Eruwa – Ibadan & 145 & 15.3 \hline
Eruwa – Abeokuta & 141 & 14.8 \hline
Eruwa – Lanlate & 124 & 13.1 \hline
Farm roads & 95 & 10.0 \hline
Unspecified & 249 & 26.2 \hline
\hline
\textbf{TOTAL} & \textbf{950} & \textbf{100.0} \hline
\end{tabular}
\end{table}
TABLE 4
ROAD TRAFFIC CRASHES IN ERUWA: TIME OF PRESENTATION

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>NUMBER</th>
<th>PER CENT</th>
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<tbody>
<tr>
<td>6am – 12noon</td>
<td>257</td>
<td>27.1</td>
</tr>
<tr>
<td>12noon -6pm</td>
<td>475</td>
<td>50.0</td>
</tr>
<tr>
<td>6pm – 10pm</td>
<td>114</td>
<td>12.0</td>
</tr>
<tr>
<td>10pm – 6am</td>
<td>71</td>
<td>7.5</td>
</tr>
<tr>
<td>over 24 hours</td>
<td>27</td>
<td>2.8</td>
</tr>
<tr>
<td>unspecified</td>
<td>6</td>
<td>0.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>950</td>
<td>100.0</td>
</tr>
</tbody>
</table>

TABLE 5
ROAD TRAFFIC CRASHES IN ERUWA: MODE OF PARTICIPATION

<table>
<thead>
<tr>
<th></th>
<th>1994 – 99</th>
<th>1999 – 2004</th>
<th>TOTAL</th>
<th>PER CENT</th>
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</thead>
<tbody>
<tr>
<td>Motor car</td>
<td>97</td>
<td>160</td>
<td>257</td>
<td>27.1</td>
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<tr>
<td>Motorcycle</td>
<td>87</td>
<td>221</td>
<td>308</td>
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<tr>
<td>Pedestrian</td>
<td>48</td>
<td>138</td>
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<td>19.5</td>
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<td>Bus</td>
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<td>63</td>
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<td>9.8</td>
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<td>Truck</td>
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<td>51</td>
<td>69</td>
<td>7.3</td>
</tr>
<tr>
<td>Bicycle</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>0.2</td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
<td>25</td>
<td>35</td>
<td>3.7</td>
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<tr>
<td>TOTAL</td>
<td>292</td>
<td>658</td>
<td>950</td>
<td>100.0</td>
</tr>
</tbody>
</table>

TABLE 6
ROAD TRAFFIC CRASHES IN ERUWA: PATTERN OF INJURY

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scalp/facial lacerations</td>
<td>92</td>
<td>238</td>
<td>330</td>
</tr>
<tr>
<td>Fracture lower limbs</td>
<td>18</td>
<td>134</td>
<td>152</td>
</tr>
<tr>
<td>Head injury</td>
<td>23</td>
<td>118</td>
<td>141</td>
</tr>
<tr>
<td>Multiple fractures</td>
<td>9</td>
<td>122</td>
<td>131</td>
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<tr>
<td>Lacerations/bruises limbs</td>
<td>77</td>
<td>10</td>
<td>87</td>
</tr>
<tr>
<td>Fracture upper limbs</td>
<td>22</td>
<td>60</td>
<td>82</td>
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<tr>
<td>Dislocations</td>
<td>5</td>
<td>36</td>
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<tr>
<td>Pelvic fracture</td>
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<td>12</td>
<td>15</td>
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<td>Chest trauma</td>
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<td>6</td>
<td>13</td>
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<td>Intra-abdominal injury</td>
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<tr>
<td>Spinal injury</td>
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<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Scald</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>260</td>
<td>746</td>
<td>1006</td>
</tr>
</tbody>
</table>

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ROAD CONSTRUCTION AND MAINTENANCE FOR EMPLOYMENT GENERATION-
THE NEED FOR RETOLLING AND CONCESSION OF NIGERIAN ROADS.

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INTRODUCTION
If there is anything that kills faster than HIV/AIDS, malaria, typhoid fever or cholera in Nigeria, it is Road Traffic Accident (RTA). In more than 80% of cases, road traffic accidents are due to the deplorable conditions of Nigerian roads. At best, Nigerian roads are described as death traps, of which the very busy Lagos – Ibadan expressway takes the lead. It has maimed many egg heads of the country and sent many Nigerian geniuses, women and children of glory to early grave.

The Federal Road Maintenance Agency (FERMA) obviously has gone into coma, their little palliative reconstruction is rather infinitesimal to make any meaningful impact.

The total collapse of the rail system and the untapped water transportation system has made the roads to be under too much stress courtesy of the articulated vehicles (trailers) that abound in thousands with their heavy loads that cause major fractures of even newly constructed roads aside poor workmanship on the part of the construction firms who had been forced to do a shoddy job having paid a very reasonable sum of the contract fee as kick – backs to those awarding the contracts.

The greatest enemy of Nigeria, corruption, has ruined the quality of most Nigerian roads. For this reason, you cannot compare the quality of most of the newly constructed roads with those constructed in the early days of our colonial masters and during the era of the premiership of the late sage Chief Obafemi Awolowo, the due process department notwithstanding.

As Nigeria clocks 50 years of her independence yet still battling with myriads of problems including the ubiquitous youth unemployment crisis, it behoves on all patriotic elements to proffer and demonstrate pragmatic solutions to the problems of the country. It is on this note that OFRUDO (an NGO with strong tilt for rural development and
urban decongestion) is prescribing that the government of the day headed by Dr Goodluck Jonathan should explore the limitless possibilities that abound in road construction, maintenance and retolling for:

(i) Employment generation  
(ii) Reduction in morbidity and mortality resulting from road traffic accidents.

Toll gates were introduced on many major Nigeria roads some years back but were scrapped during the era of president Obasanjo for so many hidden and open reasons, one of which is corruption on the part of contractors handling the toll fee in connivance with some government officials since the government was not benefiting much from the huge amount realised. The advantages of tolling were ignored due to the activities of these unpatriotic, selfish money mongers. There is need for reappraising and redesigning the situation.

As long as Nigerian roads are firmly under the control of FERMA, Nigeria will never experience good road network till the kingdom come and RTA will continue to decimate the Nigerian population. FERMA in the newly prescribed arrangement should only be a supervising, monitoring and evaluation agency on road construction, rehabilitation and maintenance.

Nigerian roads can generate more than 20 million employment positions directly and indirectly for Nigerian unemployed graduates.

THE SCENARIO

Other available transport options should be explored like the rail system and water transportation. This will save us from the menace of articulated vehicles otherwise called trailers. The author first wrote on the above modality in 2004 when I lost a new tyre of my vehicle as my driver fell into a big pothole along Lagos-Ibadan expressway around 6pm and the extra tyre that would have saved us the stress had leaked unknowingly in the boot. The rest of the story is better imagined among the armed robbers parading the expressway.

When on 3rd May 2010, we had a repeat episode along the very narrow multiple potholed Akure-Ilesa road with my vehicle somersaulting five times before landing inside a 12 feet deep ditch, I felt compelled to write on the subject again believing God will raise for us goal getters like Governor Babatunde Fashola of Lagos State in many of our states and even at the center who will approach our numerous social problems with serious commitment and determination to effect a change. I was extra lucky, the three occupants in the vehicle with my wife and driver as the other two came out unhurt when we unstrapped our seat belts and meandered our way out in the badly mangled space bus. It was a miracle of the year for us.

A young 41-year old business executive was not that lucky in his better fortified jeep two days earlier as he died on the spot with his driver in the same narrow pot-holed segment of the road. Who says Nigeria cannot become a sought out nation after all, though presently at 50 years we can code us with the Yoruba proverb (adagba ma ni kan agba) meaning that ‘our achievement does not tally with our chronological age’.

METHODOLOGY

(i) All major busy Nigerian roads should be tolled at 50 km interval from the north, south, west and to the east.
(ii) Each 50km stretch should be given to an indigenous contractor for maintenance and rehabilitation.
(iii) The contractor should be given the road maintenance contract on annual basis. In order words, the contract could be revoked if the contractor fails to perform to specification.
(iv) The contractor should collect the toll fee and use the proceeds to maintain the road including vegetation control of the island of dual carriage ways and both sides of the road for single lane roads.
(v) Each contractor should pay VAT or tax to the government from the proceeds collected.
(vi) At every toll point, there should be a police station, road safety office and a mobile court to try all traffic offenders in a jiffy.
(vii) Each toll point should have both public and private health institutions to offer emergency care to prospective accident victims. There should be emergency ambulance coverage for surveillance of every
50km stretch
(viii) Each contractor can be sued by the road users for accidents resulting from negligence in road maintenance on the part of the contractor
(ix) The contractor has the right to drag a vehicle that is not road worthy to the existing mobile court at every toll point, ditto overloaded vehicles including articulated lorries that damage the road easily. For this reason each tolling point should have a weighing lane for objective assessment
(x) The contractor should be given the latitude to employ private security agents in his own stretch of the road to complement the police and road safety officials
(xi) The contractor is expected to install a computerised radar system to track vehicles when need be and there should be networking among different contactors to ensure road sanity.
(xii) After sometime, each contractor is expected to provide a solar powered road light in his own domain.
(xiii) All new road network constructions can be undertaken by the big foreign construction companies or capable indigenous contractors on BOT(Build Operate and Transfer) basis with FERMA serving as a monitoring agent.

OUTCOME
A toll gate at every 50km point in all our major federal cum state roads will have the following advantages
(I) It is a good urban decongestion and rural development strategy because every toll point invariably becomes the nucleus of a new town. Nigerians will fan out with this arrangement. Over congested cities like Ibadan, Lagos, Kaduna, PortHarcourt etc will have breathing space.
(II) The above arrangement will generate employment for so many youths in the construction industry and so many auxiliary employments on self – employment basis.
(III) The polytechnic, technical schools will be forced to admit more students and release such to the construction field.
(IV) Many rickety vehicles will vanish from our roads.
(V) The crime rate will reduce substantially because the roads are now habited and cleared of hide outs
(VI) The rail system and water transportation will be given consideration as alternatives since many articulated vehicles owners who run afoul of the law on road transportation of their goods will prefer that than paying incessant fines on their guilty vehicles.
(VII) Accident rate will reduce substantially and there will be prompt help for the victims when it occurs. Abandoning broken-down vehicles in the middle of the road will now become a thing of the past since the concessionaire contractor would have pulled such off the road to avoid litigation .
(VIII) The state and local governments can now concentrate on intra township roads which can now be handled by direct labour. With this arrangement, the cost of maintaining our vehicles will reduce and the money accruable from this can be invested in other sectors of the economy

QUESTION
Will this not impoverish the overstressed Nigerians the more? I doubt much, because this arrangement will reduce the cost of maintaining our vehicles. It will be safer to spend N500 as toll fee to and fro in a trip from Lagos to Ibadan on a smooth and safe road than spending thousands of naira maintaining a road-induced damaged vehicle.

CONCLUSION
America was built by Americans, Britain by the Britons and even the 42 year old South Korea by their nationals, only truly patriotic Nigerians can build a new and better Nigeria and the time to start is now. Happy birthday Nigeria and happy birthday Nigerians.

A TOOL OF THE TRADITIONAL BONE SETTER
SURGICAL PRACTICE IN AN URBAN SLUM SETTING OF OYO
- Challenges and Innovations in Momoh Memorial Hospital, Oyo

by
Dr. F.F. Adams Momoh, Dr. S.A. Adelere, Dr. Ajibola Ogunlade, Dr. Popoola Tomori

INTRODUCTION
Oyo town is an ancient town located 50 km northwards from Ibadan. The inhabitants are predominantly Yoruba and since it is not too far from the border with the republic of Benin, there are also pockets of Togolese and those from the republic of Benin whose main occupation is farming. There are also rising number of Igbo traders. It has the benevolence of Federal Institutions namely FCE (Special) Federal College of Education (Special), Federal School of Surveying, Federal Government Girls College. It also has two Universities namely Ajayi Crowther University recently established and also Emmanuel Alayande University of Education. About 80% of the population are indigenes and they are predominantly peasant farmers and petty traders which put them at a low setting if grouped in the economic social strata. Their access to health care service many times is when they might have tried the local means and traditional methods. Accessing the health care facility becomes an inevitable option when their first line of approach fails to yield the desired result.

This write up is a retrospective review of surgical procedures carried out from October 2007 to September 2010 and which include
1. Appendicectomy
2. Herniorrhaphy
3. Exploratory Laparatomy and Small bowel repair from strangulation and perforations.
4. Excision of lumps – Lipoma, Breast lumps
5. Supra Pubic Cystostomy
6. Caesarian Section
7. Salpingectomy for Ectopic gestation
8. Bilateral Tubal Ligation
9. Myomectomy
10. Ovarian Cystectomy
11. Total abdominal Hysterectomy

It was observed that since October 2007, more medical officers were employed by the hospital management and this further increased the quality of service. Improvement was observed in the area of waiting time before the patient is attended to and ability to carry out surgery irrespective of the time of the day as at least 2 medical doctors are resident in the premises of the hospital and hence adequate night coverage was guaranteed.

The table below illustrates the pattern of the surgeries, total patient seen at the outpatient monthly
- Total number of surgeries per month
- Total number of deliveries per month
- Total number of obstetric and abdominal ultrasound scans per month – retrospectively for 36 months

**CHALLENGES**

1. Patients often present late after receiving treatment in some health facilities that are not supervised by medical doctors.
2. Many patients don’t give the exact picture for us to know the actual history and duration.
3. Parity is often seen as a taboo that you don’t count the number of children as in ABC – since they believe it is God’s gift except when properly counseled on the need for accurate declaration of parity.
4. Getting donors for blood transfusion is also an area that we keep working hard to see how they will work fast at ensuring good donors for blood transfusion or purchase as the case may be.

**ADAPTATIONS THAT BROUGHT ABOUT A WIN-WIN SITUATION**

1. Prompt and adequate attention once diagnosis is made.
2. The zero deposit policy had to be put in place to ensure that lack of immediate fund for surgery will not turn out to negatively influence the outcome of the result knowing fully well that delaying certain procedures can be very dangerous
3. Ensuring that indigent patients are only allowed to pay whatever little amount they can afford as this serves as humanitarian gesture to them.
4. Ensuring that our laboratory staff receives some monthly packages apart from their salaries to put them at alert for working at odd hours when called upon to do so and allowing them to attend workshops in tertiary institutions.

**IMPROVISATIONS FOR THE RURAL SURGICAL PRACTICE**

1. An improvised surgical theatre table which uses the hydraulic jack of a car to adjust the height of the table. Courtesy – Dr. Yombo Awojobi’s Project. It has been successfully used for all forms of gynaecological, obstetric and general surgery procedures.
2. Foley’s Catheter and N/G tubes are being used as surgical drains after making adequate fenestrations on the sides of the tube to allow easy passage of fluid.
3. Gallows-Splints are being constructed by our local carpenters and good results are usually on the increase.

**DISCUSSION**

Surgical practice in the rural settings requires basic surgical skills and provided the doctor knows his limitations, the lives of the patients having such basic surgical conditions would definitely be salvaged. Encouragement and capacity building on a regular basis are what it takes to keep a practice meeting the needs of the day.

It will be observed that more than 70% of our surgeries include C/S, Appendicectomy, Laparatomy for intestinal obstruction, typhoid pertarartion, ruptured etopic gestation and perforated uterus from septic abortions and a few of hemia surgeries.

It will be observed that the number of deliveries on a monthly basis does not reflect on the number of
### Table I
VITAL STATISTICS AT MOMOH MEMORIAL HOSPITAL, OYO 2007 - 2010

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**KEY:**
- **T/S** = TOTAL SURGERIES
- **TPS** = TOTAL PATIENTS SEEN
- **T/U/S** = TOTAL ULTRASOUND STUDIES
- **T/DEL** = TOTAL DELIVERIES
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<td><strong>Aug</strong></td>
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<td><strong>Sept</strong></td>
<td>36</td>
<td>11</td>
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<td>3</td>
<td>17</td>
<td>5</td>
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**Others:**
1. Myomectomy
2. Hydrocelectomy
3. Suprapubic Cystostomy
4. Bilateral tubal ligation
5. Excision of lumps
Caesarian Section cases carried out as most of the patients operated upon were referred from maternity homes, primary health centres and mission homes and traditional birth attendants outfits in Oyo. The ultrasound table is to show us that accessibility to ultrasonography can be very encouraging if the cost per scan is within the reach of an average rural dweller as a lot of our diagnosis is often further confirmed after thorough scanning. The scanning centre is not located in the hospital premises hence it is fully accessed by other health facilities.

The total number of patients attended to by the accounts department monthly was used as a guide to know the work load on the medical officers consulting at the out patients as it had no direct relationships with the number of surgeries, per month as many of the surgeries too were patients directly or indirectly referred from health facilities where such procedures could not be carried out. Table II explains the breakdown of the various types of surgeries.

REFERENCES
1. Evan Alufohai: Coping with rural surgery
2. James Umunna: Surgeon in the bush

PRIMARY CARE SURGERY IN IKOTUN/EGBE: OUR EXPERIENCE 1991-2009

by
Dr G O SALAUDEEN
MB, BS, MBA, FAGP, DMAS
Medical Director, Bissalam Hospital
Egbe, Ikotun Egbe

INTRODUCTION
Ikotun-Egbe-Idimu is basically Awori land in Alimosho LGA the largest in Lagos state, a rural suburb with a sprawling population of about 2.5 million people. It is characterized as usual with poor social facilities. No good roads, no portable water, with epileptic power supply. There are refuse dumps, here and there. And infact it is on record that this area prides itself has the dumping ground for all the refuse brought from all the other parts of Lagos especially to fill up many excavated laterite areas. No doubt it is the most backward part of Lagos state which became densely populated after the displacement of people from Maroko, Oko-baba in Ebutemetta and other part of Lagos Island to give way to the over Head bridges and Flyovers, including multinational and other corporate buildings in those colonized areas by the upper class in the late 1980 and early 1990.

This area geographically covers from Badagry expressway at iyana iba/ LASU at southern axis to Akesan/Igando/Egan to Ayobo/Itele at the western part sharing border with Otta in ogun state up to Agege Expressway Abule Egba/Oke Odo/Ipaja/Ayobo and finally to Ikotun/Egbe/ Ejigbo up to Isolo at the eastern end. Ironically this is the largest catchments area for politicians’ during election as the highest votes has always come from the area. Hitherto, the Awori people were farmers with large expanse of arable lands, But which has given way to modern buildings.

MY ARRIVAL AT IKOTUN/EGBE IN NOVEMBER 1990
I came into this suburb of Lagos in November 1990 to establish my private clinic – Bissalam clinical and maternity. I had left the Muslim Hospital Shaki 1989 to join Orthopaedic Hospital Igbobi as a Supernumerary post graduate candidate in Orthopaedic Surgery. I need to stabilized in Lagos with good accommodation as Igbobi
has no accommodation for me, hence my incursion into private practice. Work started fully in January 1991, and because of my background in GP posting at the Joint Hospital Uburu and three years as the Medical Director of Muslim hospital Shaki I was able to manage the barage of emergencies and Essential or primary Surgeries at the new Hospital at Ikotun-Egbe. The nearest hospital was Isolo General hospital and people would not readily accept referral to bigger centres for fear of exorbitant charges and the beaureucrasy in General Hospitals. Surgery was heavy, especially with Herniorrhaphy and Caesarian sections for prolong and difficult labours.

At Ikotun-Egbe then, there were a few other surgical hands like my good friends Dr Lanre Shoyinka, Dr Olu Ogunmoede, Dr Mrs. Oluwagbemi and Dr Akinsanya to mention a few early settlers in this area. We related and collaborated very well together for the better management of our patient. We attracted some Laboratory Scientist to this area, most especially for the haematologies and blood transfusion supply for emergency surgery. Many primary care Surgeries were carried out here in Ikotun Egbe between 1991 to 2009 of this period of studies.

**CHALLENGES TO PRIMARY SURGICAL PRACTITIONER**

1. **Anaesthetic Agents**
   As it has been said many times the advent and use of Ketamine –a dissociative anaesthesia with other sedatives and Analgesia has enhanced the practice of surgery in rural and Urban Suburb to a very large extent. This in effect has reduced the referral to bigger centres and has saved many deaths in transit. Nevertheless as the community became more and more enlightened we started attracting mobile anaesthetist to assist in major abdominal cases, because there was limit to what we could with only Ketamine.

2. **Quackery/ Commercial Herb- Doctors**
   Ikotun/ Egbe/Idimu and Suburb is a land of many quacks. It is said that an average man in Lagos is a doctor and want to treat the other fellows either to take a fee or to receive thanks. People were in the habit of first reporting to the quacks before reporting to the hospital. This has caused unnecessary delay and occasionally are fatal especially in prolonged labours.

3. **Religion Overzealousness:**
   This is a land of many faiths, churches, and mosques. The common saying of “I reject operation”, “over my dead body”, “we don’t do it in our family”, are common place. And a Surgeon has to waste time for relations who are enlightened to be sent for or wait for pastor or Imams to pray before you are allowed to move the patient to the theatre. A particular church whose pastor is very famous here forbade followers from taking their complaints to the hospital or for pregnant women and infertile ladies from taking ultrasound scan.

4. **Poverty:-**
   Majority are of low and middle social economic class and incidentally the 80% of the population that are sick, in the 80/20. It is always difficult to charge commensurable bills after incurring costs in taking care of patients before or after surgical operations. This in variably has increased the debt burden of the hospital.

5. **Dubiousness in the City Suburb/ Lack of land for Expansion**
   In the real rural setting where the Traditional African Culture is still intact. Our people are still very appreciative of their doctors, and reward them handsomely with land donations. But in the city suburb where a piece of land may be sold to three or four bidders, a struggling practitioner may lose out many times to land speculators/dubious landlord. He is duped and harassed, and may not have money to prosecute a land dispute case. In the city suburb land is hot cake and sold exorbitantly. Hence he has very little space to spread or developed unlike his rural counter part.

6. **Lack of Availability for Long-Term Bank Loan or Government Support**
   It is believed that any loan to a hospital is a sinking- fund. The general belief is that doctors are bad managers of funds, and have low ability for payback. Unless the practitioner has a good patient flow especially if the bills are moderate, he might not be able to break-even. Only few banks do give long-term loans to hospitals or doctors. So development and business growth becomes very difficult for hospital owners in the Urban Suburb.

30
<table>
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<tr>
<th>OPERATION</th>
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<tr>
<td>Caesarean Section</td>
<td>306</td>
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<td>Herniorrhaphy</td>
<td>148</td>
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<tr>
<td>Appendicetomy</td>
<td>144</td>
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<tr>
<td>Myomectomy</td>
<td>100</td>
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<tr>
<td>Hysterectomy (Vaginal/Abdominal)</td>
<td>83</td>
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<tr>
<td>Lump Excision</td>
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<tr>
<td>Breast Lump Excision</td>
<td>65</td>
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<tr>
<td>Ruptured Ectopic Pregnant</td>
<td>45</td>
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<tr>
<td>Trauma/Orthopaedic Cases</td>
<td>40</td>
</tr>
<tr>
<td>Cystostomy</td>
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<tr>
<td>Hydrocelectomy</td>
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<td>Herniotomy</td>
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<tr>
<td>Burns &amp; Grafting</td>
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<td>Gun Shot Injury</td>
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<td>Prostatectomy</td>
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<td>Amputations</td>
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<td>Ovarian Cystectomy</td>
<td>7</td>
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<tr>
<td>Mastectomy</td>
<td>7</td>
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<tr>
<td>Circlage for Incompetent Cervix</td>
<td>6</td>
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<tr>
<td>Thyroidectomy</td>
<td>6</td>
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<tr>
<td>Orchiplopxy</td>
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<tr>
<td>Intestinal Obstruction/Resection</td>
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<tr>
<td>Haemorrhoidectomy</td>
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<tr>
<td>Repair of Cleft Lip</td>
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<tr>
<td>Fistulectomy</td>
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<td>Permanent Coloostomy</td>
<td>3</td>
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<tr>
<td>Splenectomy</td>
<td>2</td>
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<tr>
<td>Repair of Perforated Gastric Ulcer</td>
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**CONCLUSION**
It is very important to state here that the three tiers of Government should be very ready to assist the Surgical Practitioners who are ready to work in the Rural areas and Urban Suburb to reduce the challenges this class of medical practitioners are facing while trying to help to reduce mortality and mobility. The Government as we know cannot do it all.
ARSPON and the Test of Time

My dear Colleagues,

On this New Year’s Eve, I want to reach out to every member and friend of ARSPON and hope that you are having a whale of a time during this festive season. The culture that brought us the habit of indulging ourselves during this time of the year also bequeathed to us the making of New Year Resolutions aimed at conducting our lives better than we did in the previous year. ARSPON should not ignore this, in the proper spirit of progress. We should particularly resolve to better achieve our raison d’être.

You, the pioneers started this Association to primarily give to our rural brethren what the Nigerian Nation has failed to fully provide: first-class surgical services. We must not falter. The birth of ARSPON for me was a mighty boost of morale, an encouragement to promote what I had poorly attempted to do all my life. Lack of working materials, failure of essential basic infrastructure often compromised what I could do. Introduction of user fees was another barrier erected against my beloved rural dwellers. The opportunity to once again promote their interest in the evening of my life was simply marvellous.

I was particularly pleased to see the birth of a service organisation in an environment consumed by the desire to ‘make money’ without conscience or morals, the acquisition and parading of titles and the celebration of mediocrity. It said to me, “Nigerians are not all like that! We are going to give service!” It saved me from condemning all Nigerians—it would include me because I can never escape from being one! It added to the few factors that have helped me retain my sanity and pride in being Nigerian despite the overwhelming repulsive happenings in and about Nigeria that I see and experience every day. I recognise Yombo who set off the chain reaction that is warming up to become a great organisation can stand the test of time. ARSPON has however stumbled in 2009. We included the taking of examinations and issue of certificates in our draft constitution as an incentive to encourage younger members to have personal targets to aim for, and to have proof of the skills and knowledge they acquire. This was never meant to assume an importance over and above service to the poor or become our raison d’être. I have been pained to hear that some people joined ARSPON because of postgraduate certification, because it was the only attraction it had over and above other Association in medicine; that if there was not going to be any certification, they would depart and form another organisation that would pursue that target! I was rather sad to hear that.

The Postgraduate Colleges run excellent programmes for Fellowships and diplomas. If Associations were allowed to do the same, we might easily apply the Nigerian Factor to render all these programmes useless. I realised this only when the Corporate Affairs Commission disallowed our proposal, thereby reminding me of what happened when I was Chairman of the West African Health Community, the forerunner of the West African Health Organisation. The Associations of Nurses, Pharmacists, Laboratory Scientists, and even NASU might start their own Fellowships and go through the political route and deploy the power of industrial strikes to ensure that they were given equal status with those of other medical associations like the ARSPON, the NMA, General Practitioners; etc. I bet new ones would arise just for the purpose of issuing Fellowships, and the unions would turn them into documents for promotions and status symbols, and ARSPON would have been a major initiator of this race.

We should never give the impression that we are seeking to access to the Postgraduate Fellowship hall through the window because we find it impossible to overcome the academic lock on the front door. ARSPON that starts with a huge number who are there purely because of certificates, in my personal opinion, would be a false start and would not be worth belonging to. It is better to start with only a handful members devoted to skills, innovation to overcome our deficiencies and service to the underprivileged, and to grow slowly if that is what it takes to ensure quality, for quantity without quantity is not worth having. Our certificates should not be a poor shadow of any other existing one. Our members who badly need Fellowships or Diplomas should boldly go in for them; I know each one of us is capable of successfully doing so.

Let ARSPON first make an impact on excellent service to the underprivileged of our society. Let us first become famous for adopting innovations that make us independent of public power and water supply, overcome the lack of imported and expensive materials. Our password should be skills, innovation and service to the poor. When people love and respect us, any certificate associated with us would become highly valued.

I am encouraging the ARSPON Committee on Training to work out a system of training that would not take away for long periods our members from their institutions. I have narrated the method the British Department for International Development (DFID) designed in Benue State; its adaptation should be considered along with any other methods. We can dialogue with the Postgraduate Colleges to institute a recognition that confirms skills, innovation, industry and service to the poor.

Wishing you a happy and powerful New Year!

Shima K Gyoh
President ARSPON
Consent for Operation (CFO)

When a surgeon operates on a patient, on whose request is the operation being done? The logical answer is on the patient's. Who is the main beneficiary of the procedure? If the operation fee were the surgeon's main interest, one could mistake him for the main beneficiary, and he might indeed be expected to request for the consent of his patients, but this is not so. The real beneficiary of the operation is the patient. Therefore, of the two, it is the surgeon who should consent to do the operation on request of the patient. But see who sings the consent form!

The Hunterian oration published in the March edition of the Annals of the Royal College of Surgeons of England1 has prompted debate on the well-established “Consent for operation (CFO)” which we extract from patients before we operate on them. The main purpose is to ensure that a patient knows the advantages and the risks of the operation and avoid post-operative regrets. The legal and ethical requirement provide that the consent should be “informed,” meaning that the knowledge about the procedure, its advantages and risks have been somehow “transferred” to the patient. In practical terms it is nearly impossible to satisfy these criteria in non-medical patients. Most patients who sign the consent forms know very little beyond the belief that the procedure would relieve them of the symptoms that took them to the doctor in the first place. CFO is criticised as being a singular event and not a gradual process of interaction; that in law it is not robust evidence of valid consent, and it is too paternalistic for modern medical ethical standards.

In most medical areas in Nigeria, the ritual of signing the CFO is more or less regarded as a shield against subsequent litigation. If a patient comes to the theatre, and the form is not signed, nobody would dare point a finger at the Consultant Surgeon; it is usually the ward sister or the junior doctor that gets it. It is not rare for the form to be signed in the anaesthetic room even for routine, non-emergency cases.

Some consent forms deliberately strip patients of all rights concerning the operation, claiming that the patient understands that no specific doctor has been assigned to do the operation, it would be done by any doctor in the hospital. It also gives the doctor the right to unilaterally determine the extent of the operation on an ad hoc basis without specific forewarning to the patient. These are very unethical if not unlawful provisions for which no excuse is good enough. Good surgeons are never too busy to personally empower their patients make informed choices by adequate discussion of the issues involved. Since the Consultant Surgeon is legally responsible for all operations done on his patients, including those he permitted his lieutenants to do, the patient deserves a more reassuring statement on who is going to operate. This applies to all operating doctors in autonomous practices, whether they are designated as Consultants or not. Every patient has the right to know who is going to conduct his or her operation, and that person has the ethical duty to personally discuss with the patient all the issues involved. The freedom to determine the scope of the operation should not be open ended; there should be no surprises for the patient when he wakes up, as his approval should have been obtained for each and every procedure. Better discourse between patient and doctor usually occurs in cosmetic surgery, where failure to do so is more tragic and upsetting, but litigation is also more likely.

Request for Treatment (RFT)

Kayvan Shkrollahi, in his Hunterian Oration had this to say on this matter:

“Furthermore, it is illogical on a fundamental level as doctors are seeking consent in a relationship where they are not the main benefactors. Re-organising this relationship in a manner whereby patients requested treatment, rather than consenting to it, provides the opportunity to alter the passive nature of the patient in the doctor-patient relationship, lessen the potential for paternalism, and put patients more “in the driving seat” upholding their autonomy. It also affords patients greater responsibility with regard to their own treatment, and facilitates better communications.”

The more ethical procedure is that the surgeon should not only explain the peri-operative pros and cons to the patient, but should also have ready-printed information on the more difficult subjects (colostomy/ileostomy, tubal ligation, vasectomy, oopherectomy, etc) which the patient can take home and study, discuss with relatives or look up on the internet. S/he should also take home a form titled “Request for Treatment (RFT).” This form must not just have lines on which patients and their witnesses are required to sign. Provision should be made for the patient to write, in her own hand, what she understands about the advantages and risks of the procedure.

The Hunterian lecturer lists the advantages of the RFT as follows:

a) An encompassing mechanism that facilitates, promotes and establishes patient-centred care.

b) A general approach to—and replacement for—consent, focussing on a mutual process of interaction and doctor-patient communication.
c) A method of documenting consent that is more robust than traditional consent, and forms the basis of new in-patient system.

d) A method to ensure high quality information provision to patients

e) A mechanism to involve patients more in their own health care decisions

f) A “soft” method of assessing capacity (to understand the issues at stake)

g) A method of consent for children (parent consent).

h) A potential method of assessment and documentation of Gillick competence for those under 16 years of age

i) A method of protecting doctors and patients against negligent consenting practice

Will the conservative medical world change? Factors involved suggest that a change to RFT is inevitable because CFO forms are not robust legal documents. They fail to pick up patients lacking in capacity to understand the crucial issues involved. By putting the patient in a permissive, passive role, the forms adopt a paternalistic approach which is discouraged by best practice ethics. Research has shown that a large number of patients who sign the traditional consent, even when properly conducted, do not understand the issues. Moreover, the article rightly says, “Listing a large number of risks to patients immediately before an operation is inhumane, counterproductive, stressful and is rarely well-informed.” Very few people will disagree with this. The advantages of RFT are so enormous that, once a few centres begin to adopt them, professional disciplinary councils will look upon the traditional CFO approach as inappropriate and inadequate. In the alternative, CFO might undergo so much revolutionary changes that it would practically encompass the principles enunciated in this wonderful Hunterian Oration.

Not all patients would have the capacity or even the will to participate in the RFT procedure. Although illiterate patients could thumbprint their RFT prepared by a trusted relative or friend, many others might not want to bother, especially in the Nigerian environment where opportunities to have your operation do not come easy; and when they arrive, you might not want to dilly-dally with it! It is likely that the practice of CFO and RFT may coexist, depending on the choice or suitability of patients. It would need careful handling to avoid violating the principle of equity.

Shima K Gyoh

Reference:

1. **AGENDA**
   - Reading of the minutes of the last annual general meeting
   - Matters arising from the minutes
   - Report on the Indian trip
   - Venue of the next Annual Scientific Conference
   - Venue of the joint IFRS/ARSPON Conference in 2011
   - Membership drive
   - Financial Reports
   - Any other matters

2. The minutes of the last annual general meeting had been printed and circulated in the programme booklet of ARSPON 2009. As there was no amendment to be made, Dr Bayo Windapo moved for the adoption of the minutes and was seconded by Dr A O B Adenuga. The minutes were unanimously adopted.

3. Matters arising from the minutes:
   a. The certificate of registration of ARSPON with the Corporate Affairs Commission, CAC, of Nigeria was presented by the National Secretary to the President who read out the details on the certificate before it was passed round to all members in attendance.
      Consequent on the inability of ARSPON to organize training with certification as stated in the conditions for registration with CAC, the subject was extensively discussed and a committee was set up to pursue the feasibility of the objective in collaboration with other bodies empowered to certify.

   **Committee on Training**
   **Membership:**
   Dr J I Umunna (Chairman), Drs A C Sagua, A O B Adenuga, G O Salaudeen, F F Adams-Momoh, J N Afuka, T Z Tule, Prof E Alufohai and Dr O A Awojobi (Secretary)

   **Terms of reference:**
   To determine
   - the aims and objectives of the training
   - what type of certification to be awarded in respect of the training and its relationship to the fellowship in surgery.
   - the personnel and the category of personnel to conduct and supervise the training
   - the proportion of academic and practical components of the training
   - the duration of the training
   - the cadre of eligible candidates for the training

   The committee shall submit its final report within six months of inauguration.

   b. The secretary informed the house of the details of the Association's bank accounts with Skye Bank, PLC Eruwa and the Intercontinental Bank, Eruwa. Thereafter, he handed over the two cheque books, the statement of account and the tellers of payment into Skye Bank to the National Treasurer, Dr Adenuga.

4. Report on the Indian trip was presented by the National Secretary:
   - A 50 member contingent of ARSPON comprising 42 doctors and 8 spouses and children led by Prof O O Ajayi, CON attended the joint IFRS/ARSI conference between 4th – 10th November 2009 at the village of Pipalia, Rajasthan, India.
   - Drs Umunna and Awojobi presented papers at the conference.
   - Prof Ajayi, Dr Umunna and Dr Awojobi were co-chairmen at three scientific sessions.
   - ARSPON was admitted into the International Federation of Rural Surgeons, IFRS and Dr Awojobi was elected Secretary while Prof Ajayi and Dr Umunna were elected Directors of IFRS.
   - Nigeria won the bid to host the 4th congress of IFRS in 2011.
   - Dr Awojobi was installed a Fellow of the Association of Rural Surgeons of India, FARSI.
Linkages were established with members of ARSI and our tour guide, Mr Singh for opportunities of training for Nigerian doctors in India.

5. By a spontaneous acclamation from the floor, the venue of the next AGM meeting was fixed for Gboko in recognition of the leadership role of our President, Prof Gyoh.

6. Also by a spontaneous acclamation from the floor, the venue of the joint IFRS/ARSPON meeting in 2011 was fixed for Awojobi Clinic Eruwa in appreciation of the efforts of the National Secretary. Members of ARSPON in the South West zone will constitute the Local Organizing Committee.

7. Members were implored to go on a membership drive especially to the northern states. The National Secretary wondered why members from the South-South zone who attended the conference last year have not responded to all the email correspondences since the last meeting and have not attended the ongoing conference.

8. Financial Reports.
   - The financial standing of the Association as contained in the programme booklet of ARSPON 2009 was presented to the house by the National Treasurer.
   - The Local Organizing Committee could not present a financial report to the house during the meeting.
   - In order to reduce the cost of hosting the annual conference, the National Secretary suggested we should have some general guide lines and the surplus conference bags could be used next year by pasting sticker plastics to reflect next year’s conference.

9. Any other matters.
   - It was decided that a certificate of membership be issued to all members of the Association who could display such certificates in their practices. The quality of the certificate of participation at ARSPON 2009 was considered excellent and therefore adopted, with modifications, as the certificate of membership.
   - Dr Aderinlewo moved an emotional vote of thanks to the LOC on behalf of the whole house.
   - Dr P Ojinkeya moved for the adjournment of the meeting and was seconded by Dr D Akukwu.
   - The meeting adjourned at 5.15pm.

Prof S K Gyoh
President

Dr Oluyombo A Awojobi
Secretary

Report On The Second Annual Conference Of
The Association Of Rural Surgical Practitioners Of Nigeria,
That Took Place At Jasman Hospital Ltd, Udo-Ezinihitte, Mbaise, Imo State
From 25th To 28th November, 2009.

by

Dr Oluyombo A Awojobi
National Secretary

Wednesday 25th November 2009.

The Local Organizing Committee, LOC, headed by Dr J I Umunna had arranged a radio programme as part of the publicity drive for the Association and the conference. At 1.10 pm, there was a one-hour live programme on Radio Nigeria, Heartland FM 100.5. Owerri at which Drs J I Umunna and O A Awojobi were guests. The moderator was Mr Emma Okere. Initial reactions from the audience were positive.
Prof S K Gyoh, the President, arrived the conference centre and with Dr Awojobi (who had arrived on Tuesday 24th) were guests of Dr and Mrs Umunna at Udo-Ezihinitte. Drs A O B Adenuga, O A Aderinlewo and F F Adams-Momoh arrived Owerri and were received by members of the LOC.

**Thursday 26th November 2009.**

Due to logistical problems viz: delegates were accommodated at Owerri - an hour’s drive to Udo Ezihinitte on bad roads, the day started at 11.00am with a prayer followed by the scientific programme.

In attendance were 33 members, the guest lecturer, Prof B Jiburum, the chairman of the guest lecture, Prof. T C Okeahialam and the chairman of the symposium Dr Amanze Ibekwe

The President of ARSPON, Prof Gyoh delivered his presidential address titled, “LATE LIGHT REVEALS WHAT SPACE IS MADE OF” reflecting the giant strides made by ARSPON within two years of foundation. As was done with the first annual conference, the address had been printed in the programme booklet circulated during registration earlier in the day.

The next event was the Guest Lecture delivered by Prof B C Jiburum, a Professor of Surgery and Provost, College of Medicine and Health Sciences, Imo State University, Owerri. The title of his lecture was EXCELLENCE IN RURAL SURGICAL PRACTICE. The occasion was chaired by Prof. T C Okeahialam, OFR, a renowned paediatrician, who gave an inspiring speech about the early missionary Nigerian surgeons and physicians like Sir Samuel Manuwa, Sir Francis Akanu Ibiam and Dr Michael Okpara. After the guest lecture, all the delegates, the guest lecturer and the chairmen of the guest lecture and symposium moved to the palace of HRH Eze Dr Matthew Chukwuemeka Ukeje, Udo Abia IV of Udo Autonomous Community for a grand and very traditional reception reserved for very important dignitaries.

At the palace, the high esteem at which Dr and Mrs Umunna were held by their community was demonstrated lavishly. The community had earlier displayed a big banner at the entrance to the conference venue congratulating them on the epoch-making occasion.

Soon after the civil war, 1967 – 70, Dr Umunna had established the Jasman Hospital Ltd. in his home village in 1977. His experiences have been documented in the authoritative book, SURGEON IN THE BUSH.

The State Commissioner for Health, Dr Vin Udokwu, joined the team at the palace and together we returned to Jasman Hospital, the conference centre, for him to formally declare the conference open. The Association expressed our gratitude to the Commissioner for the material and logistical support he gave the LOC. Thereafter, the scientific session continued with the symposium: THE PLACE OF RURAL SURGERY IN THE OVERALL HEALTH CARE DELIVERY SYSTEM IN NIGERIA

The speakers at the symposium, chaired by Dr Amanze Ibekwe, included Drs Umunna, C I C Ogbuokiri, C M I Anyaeze and I I Anyadiegwu.

The session continued with the papers by Drs Adams-Momoh and Adenuga which were scheduled for the following day.

Lively and incisive discussions followed the guest lecture, the symposium and the paper presentations.

All the delegates returned to Owerri for a sumptuous cocktail/dinner at the NMA Secretariat.

**Friday 27th November 2009.**

Operative sessions were held in the morning using the two tables in the operating room. Due to a break down in the function of the autoclave in the hospital, it was not possible to demonstrate the Linchenstein mesh inguinal herniorrhaphy using the Indian mosquito net. However, Dr Awojobi was able to simulate the repair using surgical gauze before proceeding to complete the repair employing the Pearson’s method that reinforces the posterior wall repair with the external oblique aponeurosis thereby making the spermatic cord subcutaneous. Drs Umunna and Mejeha were the other surgeons.
Dr Awojobi gave two 20 m² Indian mosquito nets to Dr Umunna from the gift of Dr R Tongaonkar to Operation Hernia. Dr Umunna attended the first mission of Operation Hernia that took place at Awojobi Clinic Eruwa in June 2009.

After lunch, the Annual General Meeting was held. In the evening, the closing ceremony took place at the NMA Secretariat in Owerri. And so ended a successful second annual conference of the ASSOCIATION OF RURAL SURGICAL PRACTITIONERS OF NIGERIA.

POST CONFERENCE REPORT FROM THE SECRETARIAT


1. The meeting started at 7.50pm with a prayer said by Dr A O B Adenuga.


3. In his introductory remarks, the President, Prof S K Gyoh, felt he was presiding over a troubled house because there was an attempt by some members to make the second annual conference at Owerri unsuccessful by organizing a mass boycott. However that did not happen but he had called this meeting so that members of the Governing Council could review the whole situation dispassionately and solve the problems once and for all. He likened the Udo conference to dressing a boil that was ready to discharge and we should actually incise and drain the abscess now.

Also, during and after the Indian trip, some members had spoken and written emails as if they were speaking for the Association. In future, members should seek and obtain the mandate of the Association before speaking on behalf of the Association.

4. Agenda
   - Malaise in the Association.
     a. The personal conflict between Drs A C Sagua (Vice-President) and O A Awojobi (National Secretary).
     b. The issue of training and certification in rural (primary care) surgery
     c. Operation Hernia at St Vincent’s Hospital, Aliade
   - Geopolitical representation/Membership drive
   - Annual conference in 2010.
   - Report on 2nd Annual Conference at Udo/Indian Conference.
   - Next meeting of Governing Council.
   - Any other business

5. Malaise in the Association
   a. and b.

   Most members felt the conflict between Drs Sagua and Awojobi was tearing the Association apart and wished that the matter be resolved amicably.

Dr Awojobi presented his case like he did during the meeting with Prof O O Ajayi (see Appendix 1).

Dr Sagua did the same but this time adding the following:
   - Although the document containing the purported counter allegations against him was not signed by Dr G Amao, he had written an eleven-page rebuttal and deposited same on 30th July 2009 with Dr
A A Adenipekun, the Chairman, Medical Advisory Committee, CMAC, of the University College Hospital, Ibadan his employers. But, there was no reply yet. Dr Sagua said he was not expecting any reply as the CMAC had sent a texted message at the height of the crisis that he was not going to take any further action on the issue no matter what anybody else said or did. He read some portions of the letter which stated clearly that he did not collect any monies on behalf of Dr Awojobi nor passed such to him. He would not give a copy to Dr Awojobi as he had done with previous documents.

- He accused Dr Awojobi of not supporting the certificate in rural surgery programme of the Association despite his stature in Nigerian surgical practice and connections with very senior colleagues like Profs A Adeloye and O O Ajayi.

- Dr Awojobi stood condemned for his negative utterances in India and his email reactions to those of Dr Adenuga about the aspiration of members for the Indian CRS.

- He offered to resign from the Association if it would allow its growth.

In response, Dr Awojobi remarked that he nominated Dr Sagua in absentia as a member of the Committee on Training and Certification, CTC, at the Udo conference and he was in a better position to actualize the CRS programme being the first Fellow by examinations of the West African College of Surgeons, WACS.

Dr Awojobi passed a photocopy of the certificate of registration of ARSPON (Appendix 1) to Dr Atsen who read out the conditions under which the certificate could be withdrawn:

**CONDITIONS AND DIRECTIONS.**

*This certificate is liable to cancellation should the objects or the rules of the body be changed without the previous consent in writing of the Registrar General or should be body at any time permit or condone any diverge from or breach of such objects and rules.*

*Note: This certificate does not bestow upon the Organization the right to establish any institution, engage in any business and the like without permission from the appropriate authority.*

In this respect, the Association was not permitted to initiate any training and certification on its own. It could only influence appropriate bodies like WACS, National Postgraduate Medical College of Nigeria and the National Open University of Nigeria to initiate such programmes.

Dr Awojobi further enumerated the steps he had taken in support of the CRS programme:

- He gave the Indian CRS course booklets to Dr A O B Adenuga who in turn passed them to Dr Tayo Apampa for conversion to digital compact discs which had been done.

- Soon after the Udo conference, he requested from Dr B G K Ajayi, consultant ophthalmologist, the course content for the Diploma in Ophthalmology run by the Faculty in the WACS. He immediately sent an email to the Faculty Secretary copying me. Later in the day I forwarded the mail to all members of the committee on training set up at the last conference and the President.

- Dr Adenuga sent an sms to Dr Awojobi after his meeting with Prof Ajayi and this prompted Dr Awojobi to send the MSc (Surgery) programme of the Department of Surgery, College of Medicine, University of Ibadan to all members of the committee on training set up at the last conference and the President.

- All these were in keeping with his philosophy of training at home for the benefit of the patients, trainers and trainees.

At this stage, Dr Adenuga informed the house that following his enquiry at the Department of Surgery, College of Medicine, University of Ibadan, the programme had not taken off.
Dr Tule (National Public Relations Officer) read out the email contribution of Dr J N Afuka which he sent to Dr Adenuga copying Dr Awojobi who in turn had forwarded the letter to members of the CTC (of which Dr Tule was one) a few days before this emergency meeting:

----- Forwarded Message ----
From: jerome afuka <ndjafuka@yahoo.com>
To: A Adenuga <ofrudo200@yahoo.com>
Cc: ndjafuka@yahoo.com; olayombo2@yahoo.co.uk
Sent: Thu, December 17, 2009 9:03:31 AM
Subject: ARSPON THE WAY FORWARD

My dear Tunji, (Dr Adenuga)

I have been giving a thought to this issue of certification in ARSPON especially as I have been reading the messages from Dr. Awojobi on masters degrees in surgery and that of Ophthalmology. I am wondering if we have not gotten the whole thing wrong. I really do not think that is what many of us have in mind when we talk of certification. To begin with, many of us are no longer young to embark on any extensive academic pursuit if that is really necessary. All we are saying is that we have all sacrificed the better part of our lives in rural practice and have made our marks and want this to be recognized. Not just for our sake but for the future of the profession and continuity of the practice as an incentive to our younger colleagues into rural practice.

Nobody is going to teach me on many of the procedures that I have successfully done many times over. In addition we want to acquire more skills to be adopted into our rural set ups respectively. The bottle necks that have bedeviled the growth of our profession so long which is not the same or not as rampant as we saw in India, that we want to be rolled away and of course not over night but in a gradual process. So any arrangement that would jettison our experience in rural practice or that would jeopardize our present practice will not augur well for us.

The way forward is that ARSPON needs to grow and acquire national reputation and acceptance and continue to expose its members to the outside world which will greatly improve our practices and in the same vein draw government's attention to the infrastructural needs of the rural practitioners were possible.

Thanks,
Dr Afuka J. N.

The President made the following remarks:

- It was wrong of the CMAC to have accepted an unsigned letter and technically, Dr Sagua was right to have kept quiet but it could be misconstrued as acceptance of guilt. Although, the President shared the passion and reaction of Dr Awojobi to the matter, it must be realized that different people would react differently to a given situation as long as the law had not been breached.
- The situation had not got to the stage of Dr Sagua resigning and with him opening up his mind ‘the incision and drainage of the abscess’ had started.
- Contrary to Dr Sagua’s view about the antagonistic stance of Dr Awojobi to the CRS programme, Dr Awojobi had done a lot as enumerated by him.
- No member of ARSPON was against training and certification but we differed on the modality and the role of the Association.
- He implored members of the committee on training and certification to produce a blueprint that would depart from the conventional and be peculiar to our Association. And so, would attract the attention and assistance of bodies that were charged with the duty.

Dr Awojobi reassured the house that the gap between him and Dr Sagua had shortened as a result of the meeting and, given time, some cordiality would return to their relationship.

The President described this restoration as the case of two people attempting to fold a very long apparel which halved each time they met and moved away from the midpoint until it became a small pack.

The summary of views and decisions on training and certification included:
- Nobody is against training and certification.
- Most members want a training that would not take them from their practice.
• ARSPON should seek affiliation with other bodies for recognition of this training.
• Committee on training and certification to report quickly.

c. Operation Hernia at St Vincent’s Hospital, Aliade

The other complaint that contributed to the malaise in the Association was expressed by Drs. Tule and Yandev. Dr. Tule accused Dr. Awojobi of taking away Operation Hernia from Gboko to unwilling Aliade. He was the one who invited Prof Andrew Kingsnorth to set up Operation Hernia in Gboko. Prof Kingsnorth had promised that he would create the centre no matter how deficient the Gboko premises were, pointing out that in Ghana, they did not even have a proper place to store their luggage when they arrived. The two doctors emphasised that instead of arguing the case for Gboko, Dr. Awojobi took Kingsnorth to Aliade, an unwilling centre that was being coerced to accept Operation Hernia. He felt Dr Awojobi was responsible for the change of mind of Prof Kingsnorth.

Dr. Awojobi said the decision to set up Operation Hernia in Aliade was entirely that of Prof Kingsnorth. He took Prof Kingsnorth to Aliade because that was where he served as a National Youth Service Corps doctor in 1976-77.

Dr Awojobi asked if Dr Tule had expressed his views and feelings to either Prof Kingsnorth or Dr Awojobi. Dr Tule replied that during a long telephone conversation with Prof Kingsnorth about the forthcoming Aliade mission, the line was cut off as soon as he initiated his views about the breach of promise. Subsequent dials to reconnect were not picked up by Prof Kingsnorth.

Dr Awojobi remarked that due to the over one generation-long military rule in Nigeria, most Nigerians were not in the habit of open discourse of issues and he would always express his opinions as politely and forcefully as possible to anybody as long as it would not provoke his (Awojobi’s) death!

He encouraged the Gboko doctors to attend the first session at Aliade in February 2010 and remind Prof Kingsnorth about his promise to Gboko if indeed he gave the assurance being reported at the meeting, since a centre at Aliade did not necessarily exclude another one at Gboko.

6. Geopolitical representation/Membership drive.
   Dr G O Salaudeen was quite passionate about the need for ARSPON to spread to other geopolitical zones of the country in readiness for the International Federation of Rural Surgery conference in 2011. He was of the opinion that once the personal conflict between Drs Sagua and Awojobi was resolved, the enthusiasm of members would reawaken and membership drive would improve.

   Dr Yandev, the National Deputy Secretary, informed the house that the Benue State chapter incurred a lot of expenses in carrying out the free surgical service conducted in June 2009 and would not be able to host the annual conference in 2010.

   Dr Awojobi replied that this would not be in consonance with the spirit by which the choice was made at the second annual conference. He reminded the house that the first conference was organized by Dr Adenuga and Dr Miss O Aderinlewo supported by other members in the Southwest zone. And so, with prudence it would be possible to hold the conference at the TBT Hospital, Gboko. The whole house agreed to this proposal.

   The National Secretary presented the report on the second annual conference which contained a report on the Indian trip. See Appendix 2.

   The next meeting of the Governing Council was fixed for 19th June 2010 at the same venue.
10. Any other business

Composition of Governing Council
Dr Sagua suggested that principal officers of the state branches should be members of the Governing Council. The house felt that this should be tabled as a constitutional amendment at appropriate venue and time.

11. Adjournment
Dr Adenuga moved for the adjournment of meeting and was seconded by Dr Salaudeen. The meeting ended at 2.30am on Sunday 20th December 2009.

MINUTES OF THE MEETING OF THE ARSPON COMMITTEE ON TRAINING HELD AT ADESO CLINIC, BARIGA ON SUNDAY 14TH February 2010.

1. The meeting started at 12, 30 pm with an opening prayer said by Dr G O Salaudeen.

2. ATTENDANCE: Drs J I Umunna (Chairman), G O Salaudeen, F F Adams-Momoh, J N Afuka, and O A Awojobi (Secretary). Others: Dr A O Windapo (host) and Dr K O C Awofeso.

   Absent with apologies: Drs A C Sagua, A O B Adenuga, T Z Tule and Prof E Alufohai.

3. AGENDA: 1. MSc (Primary Care Surgery) proposal to the National Open University of Nigeria, NOUN.
   2. Diploma (Rural Surgery) proposal to the West African College of Surgeons, WACS.

4. The Chairman, expatiating on his opening remarks (Appendix 1), stressed that the MSc (Primary Care Surgery) is an academic degree while the Diploma (Rural Surgery) is a professional certificate. He asked if the diploma would not be more relevant to the needs of members of ARSPON. After some discussions, it was resolved that ARSPON should pursue both forms of training highlighting that the MSc programme could be a stepping stone to a PhD which is being demanded of surgeons teaching in the various Colleges of Medicine in Nigeria.

   Dr Awojobi informed the meeting that he has put in an application to enroll for a PhD at NOUN. The subject of the thesis would be: INFRASTRUCTURE IN RURAL HEALTH CARE IN NIGERIA. He was awaiting the response from NOUN.

5. The relevant portions of the minutes of the last annual general meeting at Udo relating to the work of the Committee were read out by the Secretary:

   “Consequent on the inability of ARSPON to organize training with certification as stated in the conditions for registration with CAC, the subject was extensively discussed and a committee was set up to pursue the feasibility of the objective in collaboration with other bodies empowered to certify.

   Committee on Training.

   Membership:
   Dr J I Umunna (Chairman), Drs A C Sagua, A O B Adenuga, G O Salaudeen, F F Adams-Momoh, J N Afuka, T Z Tule, Prof E Alufohai and Dr O A Awojobi (Secretary)

   Terms of reference:
   To determine
   • the aims and objectives of the training.
what type of certification to be awarded in respect of the training and its relationship to the fellowship in surgery.
- the personnel and the category of personnel to conduct and supervise the training
- the proportion of academic and practical components of the training
- the duration of the training
- the cadre of eligible candidates for the training

The committee shall submit its final report within six months of inauguration.”

6. **MSc (Primary Care Surgery)**
   The proposal had previously been circulated widely to all members (Appendix 2). The modification to the document was that the rural surgical training could be split into three rotations of one month each for members who have established practices.

7. **Diploma (Rural Surgery)**
   The Chairman, who attended the recent 50th conference of the WACS in Calabar, briefed the committee of his efforts to get the Faculty of Surgery of WACS to institute the training for Diploma (Rural Surgery). The Secretary also read out the text message from Prof O O Ajayi, a past president of WACS: “Saw paper by Akute & Awojobi (Appendix 3). Case has been repeatedly made. What is now required is a DRAFT CURRICULUM for the consideration of Faculties of Surgery.”

   The Secretary was mandated to draft a curriculum for the Diploma (Rural Surgery), (Appendix 4) and send it to all members of ARSPON for their input. There and then, Dr Adams-Momoh read out his proposal (Appendix 5).

8. We all expressed our gratitude to Dr Windapo for hosting the meeting and the generous hospitality of his staff to us.

9. The meeting adjourned at 2.15pm to allow Drs Umunna and Afuka have enough time to book their flights back to Owerri.

**APPENDIX 1**

Dear colleagues,
May I welcome you to this gathering.
To come here on a Sunday from different parts of the country underlines the importance you attach to this meeting. At the conclusion of deliberations at the 2009 annual conference of ARSPON held at Jasman Hospital Ltd. Udo, we were appointed to deliberate on the question of training and certification for ARSPON members and produce a document to be presented to the whole HOUSE within six months. During this period, some members have painstakingly made consultations and these have resulted in the production of a document for an MSc programme in Rural or Primary Surgery targeted at the National Open University of Nigeria. This is but one facet of the fact findings that have been done, and we are here today to consider all these avenues and compile a report to the House that sent us on this errand for consideration and final decision.

If I understand correctly, the desire of our members is for recognition in the field of surgery which we have been practicing in the rural areas and urban slums, and to do this with a certificate. This is understandable and I add, I am sure you will agree, that this certificate must be a professionally recognizable and acceptable one, that has a name in the field of surgery and one that we can be proud of. Therefore, we have to do a thorough job and produce a document that leads to the desired goal and for which all will be happy.

I therefore, enjoin you to put forth your ideas, respecting other people’s own.
Thank you.
Dr J I Umunna.
INTRODUCTION

“The persistence of Nigeria’s problems is not caused by lack of the knowledge of their solutions. It is often due to the dissociation of theory from practice. This is the case in health.

“The National Health Policy was launched in 1988. It adopted sound internationally accepted principles and adapted them to solve the health sector problems of Nigeria. It was acclaimed by the world as a good blueprint for delivery of first class health care in a developing nation, and requests for copies came from the four corners of the world. Attempts to implement it were seriously made in the first four years during the leadership of the late Olikoye Ransome-Kuti, the then Minister of Health. But, by the time he left office, it had not yet properly taken root. Despite the Primary Health Care Development Agency which he later returned to head, the Federal Executive Council had lost the missionary zeal he had earlier injected into its implementation, and his further efforts, he confided in me, met with several frustrations.

“Nigeria’s health status is deplorable. The revised health policy document admits that preventable diseases account for 70 per cent of Nigeria’s disease burden and that poverty is a major cause of these problems. It admits that our maternal mortality of 1 per cent is ‘one of the highest in the world,’ that some of our health indicators, such as the under-5 and adult mortality rates are higher than the average for sub-Saharan Africa.”

At the millennium conference in New York in 2000, realizing that HEALTH FOR ALL BY 2000 was a failure, 191 UN member nations introduced the MILLENNIUM DEVELOPMENT GOALS by 2015.

However, halfway in the race in October 2008, WHO celebrated 30 years of Alma-Ata Declaration on Primary Health Care and issued the World Health Report 2008. The report noted that inequalities in health outcomes and access to care are much greater today than they were in 1978.

It then called for a return to primary health care, arguing that its values, principles and approaches were more relevant now than ever before.

These values, principles and approaches were made explicit in the WHO’s Alma-Ata Declaration of 1978 with the goal of ‘Health for All by 2000’.

“Primary health care is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

- addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.
- includes appropriate treatment of common diseases and injuries; (Primary Care Surgery) and provision of essential drugs.
- should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.
- relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed.”

These objectives are exemplified in this case scenario:
A pregnant woman attends antenatal clinic regularly and gets all the necessary promotive and preventive care until she is due for delivery. But suddenly at term, she starts bleeding. She is rushed in the village ambulance to the nearest general/district hospital where the resident physician performs a Caesarean section to deliver a live healthy baby(ies) and a surviving mother.

JUSTIFICATION

Surgical diseases such as inguinal hernia and obstetric/gynecological emergencies are being neglected in the developing world. In West Africa, many cases go untreated for several years representing failures in access, lack of health care workers and availability of resources.

Africa’s healthcare workforce is continuing to be depleted as a result of emigration to developed countries and health systems are becoming increasingly unable to deliver surgical interventions. Compounding the situation, the various institutions for training surgeons are facing difficulties due to deteriorating infrastructure and diminishing access to surgical care through prohibitive user fees which have altered their bed occupancy and changed the frequency ratio of diseases for the balanced experience of surgical trainees.

Several teaching hospitals in the West African sub region have resorted to the concept of ‘from the body to the bench’ in teaching basic surgical skills. During one of such workshops in Enugu, many of the trainees indicated that the addition of other procedures such as skin grafting, nerve repair, suprapubic cystostomy, cardiopulmonary resuscitation, basic intubation techniques, minimal access surgery, endoscopy, herniorrhaphy, appendicectomy, venous cut down, ear nose and throat and maxillofacial procedures would enrich the programme. It was a common view that the programme should be made mandatory for all new surgical residents especially within the first three months of their training and that it should be organized more frequently with follow-up courses.

This situation represents inappropriate utilization of available human, material and institutional resources in the face of a high demand for surgical services.

It is in the light of these that the Association of Rural Surgical Practitioners of Nigeria, ARSPON, is proposing to the National Open University of Nigeria, NOUN, the establishment of the MSc (Primary Care Surgery) programme that will train the cadre of medical practitioners equipped to work in the rural areas and urban slums of Nigeria.

OBJECTIVES

This training programme is designed to produce:

- highly qualified graduates with sound basic and applied surgical principles
- surgical personnel who have a profound understanding of the scientific basis of surgical principles to ensure meaningful and purposeful application of such in the rural areas and urban slums of Nigeria.
- surgical personnel who are capable of initiating researches that will effectively link the primary and secondary levels with the tertiary level of the health care pyramid.
- surgical personnel who are able to engage in teaching, collaborative studies and provide excellent services to surgical units in teaching and specialist hospitals as well as international health organizations.

REGULATIONS

(a) Admission Requirements

Only M.B.B.S. degree graduates of Nigerian universities or other universities approved by the Senate of NOUN are eligible for admission into the Master of Science degree programme.

(b) Registration

To be determined by NOUN.

(c) Duration and mode of study

The duration of the programme shall normally be three semesters for a full-time course and five semesters for a part-time course. The details are to be decided by NOUN.
(d) Courses
A course unit represents a period of fifteen (15) hour lecture/tutorials/seminars or 45 hours of clinical sessions/practical experience per semester. Further details to be worked out in conjunction with NOUN. The compulsory, required, and elective courses are as described below.

(e) Requirements for award of Master of Science degree in Primary Care Surgery
To qualify for the award of Master of Science degree in Surgery, the candidate will be required to pass all compulsory courses and obtain a minimum grade of 30% in the required courses. The candidate shall be examined in all the courses for which he is registered at the end of the semester in which the courses are completed. Students are expected to submit a report on their research project.

Examination results in each course shall be recorded as percentage marks and be interpreted as follows:

<table>
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<tr>
<th>Percentage Range</th>
<th>Grade</th>
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<tr>
<td>0 - 39</td>
<td>Fail (Fail)</td>
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<tr>
<td>40 - 49</td>
<td>Pass (Pass)</td>
</tr>
<tr>
<td>50 - 59</td>
<td>Good (Good)</td>
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<tr>
<td>60 - 69</td>
<td>Very Good</td>
</tr>
<tr>
<td>70 - 100</td>
<td>Excellent</td>
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A student who fails in any compulsory course (including the project) shall be required to re-register for the course or project and be re-examined at the appropriate time.

(f) Course venue
As decided by ARSPON in conjunction with NOUN.

(g) Surgery in rural area
This will take place in accredited hospitals located in rural areas and urban slums.

(h) Staff Availability
Lecturers will be drawn mainly from Consultant Surgeons and Consultant Family Physicians who are practising at the primary and secondary levels and those retired consultants who had supported and are still supporting Primary Care Surgical Practice.

The list will include:

1. Prof S K Gyoh, General Surgeon, College of Health Sciences, Benue State University, Makurdi.
2. Prof A Adeloye, Neurosurgeon, Retired, Ibadan, Oyo State.
3. Prof O O Ajayi, General Surgeon, Retired, Ibadan, Oyo State.
4. Prof E A Alufohai, General Surgeon, College of Medicine, Ambrose Alli University, Ekpoma, Edo State.
5. Dr J I Umunna, General Surgeon, Jasman Hospital, Udo Ezinhihitte, Mbaize, Imo State.
6. Dr A C Sagua, General Surgeon, General Hospital, Igboora, Oyo State.
7. Dr I I Anyadiegwu, General Surgeon, Anyad Hospital Eziaha Isiaha Mbano, Imo State.
8. Dr M O Adenuga, General Surgeon, Mataden Hospital, Ibadan, Oyo State.
9. Dr T Ogunseye, Consultant Family Physician, Shekinah Medical Centre, Oyo, Oyo State.
10. Dr A O Okedare, Consultant Family Physician, Catholic Hospital. Oluworo, Ibadan, Oyo State.
11. Dr B G K Ajayi, Consultant Ophthalmologist, Eleta Eye Institute, Ibadan, Oyo State.
13. Dr A Marinho, Consultant Obstetrician and Gynecologist, St Gregory’s Specialist Clinic, Ibadan, Oyo State. For training in ultrasonography.
14. Dr O Obembe, Consultant Obstetrician and Gynecologist, Christus Specialists Hospital, Ibadan, Oyo State. For training in ultrasonography.
15. Dr O A Awojobi, General Surgeon, Awojobi Clinic Eruwa, Eruwa, Oyo State.
CURRICULUM FOR MASTER OF SCIENCE DEGREE IN PRIMARY CARE SURGERY

LIST OF COURSES:

A. Human anatomy
B. Fluid and Electrolyte dynamics
C. Wounds and wound healing.
D. Surgical pathology
E. Development and maintenance of infrastructure and equipment for rural surgical practice.
F. Human genetics, molecular/cellular biology
G. Trauma as a disease and critical care
H. Advanced epidemiology
I. Seminars
J. Biostatistics
K. Research project
L. Health policy, planning and management.
M. Research methodology
N. Surgery in the rural area.
O. Surgical endoscopy
P. Imaging science in surgery
Q. History of surgery and ethical basis of surgical practice

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<tr>
<th>COURSE TITLE</th>
<th>TITLE AND SHORT DESCRIPTION OF COURSE</th>
<th>LECTURE HOURS</th>
<th>PRACTICAL/CLINICAL</th>
<th>UNITS</th>
<th>REMARKS</th>
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<td>infrastructure and equipment for rural surgical practice.</td>
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<td>Energy supply: Building construction</td>
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<td>(concrete mixer, interlocking blocks).</td>
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<td>Natural lighting. Cross ventilation.</td>
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<td>AC supply. DC supply. Solar power.</td>
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<td>Biogas. Charcoal, wood and maize cob</td>
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<td>Deep wells. Earthen dams and ponds.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Channelization of streams.</td>
<td></td>
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</tr>
</tbody>
</table>
### Sewage disposal
Ventilation improved pit latrine. Use of waste water from the bathrooms for sewage disposal.

### Hospital equipment
- Operating table
- Hospital beds and cots
- Water distiller
- Haematocrit centrifuge
- Pedal suction pump
- Histopathology equipment
- Autoclaves
- Washing machine
- Atraumatic sutures
- Alternative dressings (gamgee)

<table>
<thead>
<tr>
<th>Course Code</th>
<th>Course Title</th>
<th>Credit Hours</th>
<th>Type</th>
</tr>
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<tbody>
<tr>
<td>F</td>
<td>Human Genetics, Molecular/Cellular Biology</td>
<td>30</td>
<td>Elective</td>
</tr>
<tr>
<td>G</td>
<td>Trauma as a disease and critical care</td>
<td>15 45</td>
<td>Compulsory</td>
</tr>
<tr>
<td></td>
<td>This course centers on the poly traumatized patient. All systems will be discussed. Management of the critically injured.</td>
<td></td>
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<tr>
<td>H</td>
<td>Advanced epidemiology</td>
<td>30</td>
<td>Elective</td>
</tr>
<tr>
<td></td>
<td>The ecological approach to health and disease. Epidemiological studies, disease screening. Health Policy and administration and international health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Seminars</td>
<td>30</td>
<td>Compulsory</td>
</tr>
<tr>
<td></td>
<td>Literature reviews and presentations on various topics in surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Biostatistics</td>
<td>30</td>
<td>Compulsory</td>
</tr>
<tr>
<td>K</td>
<td>Research Project</td>
<td>6</td>
<td>Compulsory</td>
</tr>
<tr>
<td></td>
<td>Clinically based investigation done independently. Oral examination will be based on this research.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Health Policy, Planning and Management</td>
<td>2</td>
<td>Required</td>
</tr>
<tr>
<td>M</td>
<td>Research Methodology</td>
<td>90</td>
<td>Compulsory</td>
</tr>
<tr>
<td>N</td>
<td>Surgery in the Rural Area</td>
<td>One semester 10</td>
<td>Compulsory</td>
</tr>
</tbody>
</table>
The holistic management of surgical patients in the rural area.

<table>
<thead>
<tr>
<th>O</th>
<th>Surgical Endoscopy</th>
<th>15</th>
<th>45</th>
<th>2</th>
<th>Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental and endoscopic surgery including principles of optics in relation to surgical endoscopy and basic principles of laser technology. Computer aided diagnosis in Surgery.</td>
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</table>

<table>
<thead>
<tr>
<th>P</th>
<th>Imaging Science in Surgery</th>
<th>15</th>
<th>45</th>
<th>2</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic radiology, principles of ultrasonography, CT scanning and MRI. Basic and applied radiation oncology.</td>
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</table>

<table>
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<tr>
<th>Q</th>
<th>History of Surgery and Ethical Basis of Surgical Practice</th>
<th>15</th>
<th>45</th>
<th>2</th>
<th>Compulsory</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Compulsory Units: 41
Required Units: 4
Elective Units: 6
Total number of Units: 51

ACKNOWLEDGEMENT
ARSPON acknowledges, with thanks, that this proposal has been adapted largely from the MSc (Surgery) programme of the Department of Surgery, College of Medicine, University of Ibadan, Ibadan.

REFERENCES
APPENDIX 3
SURGICAL TRAINING IN THE WEST AFRICAN SUBREGION – A REAPPRAISAL
by
O O Akute, FRCS(Glas), FWACS
Department of Surgery, University College Hospital, Ibadan, Nigeria. email: papakute@yahoo.co.uk
and
Oluyombo A Awojobi FMCS(Nig), FARSI
Awojobi Clinic Eruwa, Eruwa, Nigeria. email: oluyombo2@yahoo.co.uk

INTRODUCTION

The current population of West Africa is estimated to be 300 million (2009) and the English-speaking group will easily form two-thirds of this if Nigeria alone is estimated at 148 million (2006) 1.

Surgical diseases such as inguinal hernia and obstetric/gynecological emergencies are being neglected in the developing world. In West Africa, many cases go untreated for several years representing failures in access, lack of health care workers and availability of resources.

Africa’s healthcare workforce is continuing to be depleted as a result of emigration to developed countries and health systems are becoming increasingly unable to deliver surgical interventions 2,3. Compounding the situation, the various institutions for training surgeons affiliated to the West African College of Surgeons, WACS, and the National Postgraduate Medical College of Nigeria, NPMCN, are facing difficulties due to deteriorating infrastructure and diminishing access to surgical care through prohibitive user fees which have altered their bed occupancy and changed the frequency ratio of diseases for the balanced experience of surgical trainees. 4,5

Several teaching hospitals in the West African sub region have resorted to the concept of ‘from the body to the bench’ in teaching basic surgical skills. 6,7 During one of such workshops in Enugu, many of the trainees indicated that the addition of other procedures such as skin grafting, nerve repair, suprapubic cystostomy, cardiopulmonary resuscitation, basic intubation techniques, minimal access surgery, endoscopy, herniorrhaphy, appendicectomy, venous cut down, ear nose and throat and maxillofacial procedures would enrich the programme. It was a common view that the programme should be made mandatory for all new surgical residents especially within the first three months of their training and that it should be organized more frequently with follow-up courses. 8

The current pass rate at the exit examination (Part II) of General Surgery is about 2-3 per sitting, thus averaging less than 10 per year for the two sittings in the year. One does not need to be a patriot to see that this figure is unacceptable for a population of about 200 million people, and the Colleges can and must do something about this. For the purist and idealist who may argue for standard, the question is ‘standard for whom?’.

While we are at this, it is pertinent to note how the Western world we hold up as our standard evolved to their present level, keeping in mind the need to serve their people.

The four Fellowship Colleges in Britain have different exit qualifications for their various specialties and sub-specialties at the initial stages. While it was full Fellowship for General Surgeons, it was Diplomas for Ophthalmology, ENT, Anaesthesia and Radiology. These Diploma holders were adjudged good enough for Consultant status. In some disciplines Orthopaedic and Cardiothoracic Surgery, for example, there were no examinations. Experience was what was required then, but things have changed. Most, if not all, specialties now require full Fellowship, and General Surgery, always not to be outdone, has re-structured the qualification ladder.

The training in Germany is even different. Emphasis was on practical skill acquisition.

In America, there were Board-eligible and Board-certified Surgeons. The first generation of Fellows from Britain thought less of our colleagues from America but here again, things have changed.

Back at home in WACS, there are Diplomas in Ophthalmology, ENT and Anaesthesia. Why not in Surgery to fill the yawning gap? Our usually sedate governments are beginning to get worried about mass failure in at the
ordinary level examinations and heaping virtually all the blames on the teachers. It is surely a question of time before their search light is beamed at us. Before that time, we should begin to put our house in order.

This situation represents inappropriate utilization of available human, material and institutional resources in the face of a high demand for surgical services and it, therefore, calls for a reappraisal.

**REFORM OF STRUCTURE OF TRAINING**

**Training hospitals**

In structure, there are three recognized basic types of surgical residency programmes:

1. The Independent: in which all training is accomplished in one hospital
2. The affiliated: with complemented training in two or more hospitals, last year being spent in the parent hospital and
3. The Integrated: with the parent hospital closely relating with one or more other hospitals.

Although Prof Odeku⁹ (one of the founding fathers of postgraduate surgical training in Nigeria) identified the third option as the ideal, the situation in Nigeria at the onset made the first type the most practicable. It is this structure that has produced the many capable surgeons that have branched out to man the several medical schools and the many private and public specialist hospitals in our nation.

Three decades on, the third option is viable in Nigeria today. Recent reviews of rural surgical practices that have been in existence for over twenty years in Nigeria have shown that close to ninety per cent of surgical patients could be taken care of by a general surgeon working in a secondary level institution, using appropriate and scientifically sound technology and assisted by few nurses, several auxiliary nurses and paramedical professionals¹⁰-¹⁸ (Table I). There are several of such hospitals in Nigeria today,¹⁰,¹₂,¹⁷,¹⁸ which was not the case two decades ago. It is, therefore, possible to identify and accredit such hospitals for rotations in the training of general surgeons as it is done with family physicians. This rotation will enable the trainees acquire hands-on experience quickly.

**Content, duration and certification of training**

Presently, a candidate, after passing the Primary examinations, which may take 2 - 4 years to achieve, enters the programme and moves on to Part I and finally Part II. This usually takes a minimum of 5 – 6 years. If the candidate fails Part I after 4 years in the programme, he is kicked out empty-handed by the training institution. He/she is, of course, allowed theoretically to keep coming for the examination but with the law of diminishing returns dimming his/her chances.

A Diploma in Surgery is recommended for the clinically capable residents who kept on failing the Part I. A structured programme with an exit examination can also be fashioned to accommodate more candidates who do not want more than this. As shown in Table I – “The Eruwa Experience”, this cadre of surgeons will take care of 80% of surgical maladies that afflict our people and if caesarean section is added to this, the figure climbs up to a dizzying 87%! The scheme should be flexible so that those who have the aptitude can move up the ladder. The candidates who kept on failing Part II can be made “eligible” Fellows and this should guarantee them another step in the surgical ladder. The surgical ladder for our sub-region for the moment may look like this:

![Surgical Ladder Diagram](Diagram.png)
Once our society is more sophisticated and most of the needs of our people have been met and there are enough qualified personnel, the post of Diplomas and Eligible Fellows can be scrapped by stopping further recruitment into their fold.

What are the challenges ahead? Some in the profession fear that these cadres of surgical personnel may go beyond their limits. This phenomenon is not peculiar to our environment. Each society writes its rules and enforces it. Besides, the larger society will not remain dormant. It will equally get more sophisticated. And at the end of the day, it will discipline its own if the body set up to do so, fails.

The advantages of this set up to our people far outweigh the fears. Right now, there is no rule preventing an MB:BS holder from doing a total gastrectomy. Our duty is to make them more safe and the College can and must do so.

CONCLUSION

The surgical training programme in West Africa must be relevant, flexible, and adaptable to reflect our needs at all the three tiers of the health care system and we cannot lose touch with new developments and technologies that can be used to manage the changing patterns of disease or the emergence of a new pandemic of diseases common in industrialized countries. The ability to make virtue out of necessity is the greatest and immediate challenge of all.4

REFERENCES


TABLE 1

<table>
<thead>
<tr>
<th>SURGICAL OPERATIONS IN ERUWA 1983 – 2003. (Awojobi1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>External hernia repair</td>
</tr>
<tr>
<td>Excision of lumps</td>
</tr>
<tr>
<td>Hydrocelectomy</td>
</tr>
<tr>
<td>Laparotomy</td>
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<tr>
<td>Caeasaric section</td>
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<tr>
<td>Prostatectomy</td>
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<tr>
<td>Thyroidectomy</td>
</tr>
<tr>
<td>Sequestrectomy</td>
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<tr>
<td>Vagotomy and drainage</td>
</tr>
<tr>
<td>Orchidopexy</td>
</tr>
<tr>
<td>Chest tube insertion</td>
</tr>
<tr>
<td>Major open fracture</td>
</tr>
<tr>
<td>Vaginal hysterectomy</td>
</tr>
<tr>
<td>Splenectomy</td>
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<tr>
<td>Vesico vaginal fistula repair</td>
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<tr>
<td>Nephrectomy</td>
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<tr>
<td>Others</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>
Appendix 4

DIPLOMA (RURAL SURGERY)

A proposal submitted to
the West African College of Surgeons
by
the Association of Rural Surgical Practitioners of Nigeria.
19th February 2010

INTRODUCTION

“The persistence of Nigeria’s problems is not caused by lack of the knowledge of their solutions. It is often due to the dissociation of theory from practice. This is the case in health.”

Africa’s healthcare workforce is continuing to be depleted as a result of emigration to developed countries and health systems are becoming increasingly unable to deliver surgical interventions. Compounding the situation, the various institutions for training surgeons are facing difficulties due to deteriorating infrastructure and diminishing access to surgical care through prohibitive user fees which have altered their bed occupancy and changed the frequency ratio of diseases for the balanced experience of surgical trainees.

Several teaching hospitals in the West African sub region have resorted to the concept of ‘from the body to the bench’ in teaching basic surgical skills. During one of such workshops in Enugu, many of the trainees indicated that the addition of other procedures such as skin grafting, nerve repair, suprapubic cystostomy, cardiopulmonary resuscitation, basic intubation techniques, minimal access surgery, endoscopy, herniorrhaphy, appendicectomy, venous cut down, ear nose and throat and maxillofacial procedures would enrich the programme. It was a common view that the programme should be made mandatory for all new surgical residents especially within the first three months of their training and that it should be organized more frequently with follow-up courses.

This situation represents inappropriate utilization of available human, material and institutional resources in the face of a high demand for surgical services. The case for training the cadre of surgical practitioners that will effectively deal with surgical problems at the primary and secondary levels has been repeatedly made. What is now required is a draft curriculum for the consideration of the Faculties of Surgery of the Colleges.

It is in the light of these that the Association of Rural Surgical Practitioners of Nigeria, ARSPON, is proposing to the West African College of Surgeons, WACS, the introduction of the Diploma in Rural Surgery programme that will train the cadre of medical practitioners equipped to work in the rural areas and urban slums of West Africa.

DURATION

18 months.

ADMISSION REQUIREMENTS

MB, BS. degree graduates who have completed the National Youth Service Corps programme.

DRAFT CURRICULUM

Block 1 rotation. Morbid Anatomy – three months.
Block 2 rotation. Anaesthesia – three months.
Block 3 rotation. Orthopaedics and traumatology – three months.
Block 4 rotation. Clinical surgery – nine months.
The rotations need not follow this sequence for logistical reasons.
INSTITUTIONS FOR TRAINING.

Blocks 1 to 3 will be conducted in accredited teaching hospitals.

Block 4 will be conducted in accredited hospitals located in rural and urban slums of the region.

The criteria for accrediting hospitals located in rural and urban slums will be determined by WACS in conjunction with ARSPON.

POST DIPLOMA TRAINING.

A successful candidate of the diploma course could proceed with the fellowship programme if he passed the primary examinations and be eligible to write the Part I examinations after six months of general surgery and three months of specialty posting.

REFERENCES

10. Ajayi O O  Personal communication. 2010.

APPENDIX 5

Proposal for a Postgraduate Training Programme for members of ARSPON.

Category

1. Those with fellowships from the National Postgraduate Medical College of Nigeria and other recognized postgraduate colleges.
2. Those with 'standard practices' and with not less than 15 years in private practice. What are yardsticks of our own standard practice?
3. Those with less than 15 years in private practice but already have full time medical officers on ground for adequate coverage in the event that they are not on ground.
4. Those that are still running a one-man practice irrespective of the number of years in practice.
5. Those that are still in the public service and also have their private clinics.

Sustainability

1. Re-evaluation committee.
2. Monitoring committee.
3. Presentation of evidence-based reports at least once in 3 years as an update measure.
4. One mini-scientific regional conference apart from the annual national conference.
5. Ensuring that the Association hammers on our worthwhile goals to ensure growth and relevance to the rural population.

Dr F F Adams-Momoh.

1. The meeting started at 11.20am with a prayer said by Dr A O B Adenuga.

   
in Attendance: Dr G O Salaudeen and Dr F F Adams-Momoh.
   
Apologies: Dr Femi Fatokun and Dr T Z Tule.

3. In his introductory remarks, the Vice-President, Dr A C Sagua, presiding over the meeting, insisted he would conduct the meeting according to the dictates of the constitution. So, he used his prerogative to co-opt Drs Salaudeen and Adams-Momoh into the meeting. When asked by the national secretary, Dr Awojobi, which section of the constitution empowered him to do that, the chairman cited Article 14.5 - National Secretary:

   The National Secretary shall be the Chief Executive of the Association He shall have the following duties and responsibilities.
   
i. To have custody of properties – movable and immovable, documents, etc., and to be responsible for their safety
   ii. To summon the meetings of the National Conference and the Governing Council in consultation with the President and record the proceedings of same;
   iii. To make correspondence on behalf of the Association;
   iv. To incur legitimate incidental expenses with the imprest amount to be fixed by the Governing Council from time to time.
   v. To inform all members of the decision of the Governing Council within 6 weeks of the Meeting.
   vi. To do such other work pertaining to the affairs of the Association.
   He shall be in constant touch with the President and act according to his advice and instructions.
   vii. The outgoing National Secretary shall hand over to the incoming within seven days.

stressing ‘He shall be in constant touch with the President and act according to his advice and instructions.’

The secretary was not satisfied with the grounds on which the chairman based his decision stating that unlike the military, he was not bound to ‘obey first and then complain’ about unlawful advice and instructions. At this point, Dr Salaudeen felt he was not wanted at the meeting and walked out. As a result, the secretary withdrew his objection and Dr Salaudeen was prevailed upon by the secretary and others to return to the meeting.

4. Agenda
   - Reading of the minutes of the last meeting of the Governing Council.
   - Adoption of minutes
   - Matters arising from the minutes
   - Next meeting of Governing Council.
   - Any other business
      - Amendment of constitution
      - Theme of ARSPON/IFRS Conference 2011.
      - IFRS website
5. **Reading of the minutes of the last meeting of the Governing Council.**
The minutes of the last meeting was read by the National Secretary.

6. **Adoption of minutes**
Although the chairman raised the objection that Drs G O Salaudeen, R Oriloye and A N Ikparen who were not members of the Governing Council should have come under the category of *In attendance*, the secretary insisted the minutes as read by him were the true report of the proceedings and that the President who presided at the meeting did not make a distinction between members and nonmembers of the Council.

The minutes were adopted by a motion from Dr Yandev seconded by Dr Saliu.

7. **Matters arising from the minutes**

   a. **Malaise in the Association**
   There was a lot of discussion on the personal relationship between Drs Sagua and Awojobi especially in view of the recent email exchanges between them preceding the meeting.

   The two friends reassured the meeting normalization was going apace in spite of recent emails although it might appear slow. Dr Awojobi even prostrated to Dr Sagua when the latter expressed his feeling of being insulted by the former who was several months younger.

7.2 **Training and Certification**
Dr Awojobi as Secretary to the Committee on Training and Certification, CTC, briefed the meeting as follows:

‘A meeting of CTC that took place at Adesola Clinic, Bariga, Lagos on 14th February 2010 hosted by Dr A O Windapo and chaired by Dr J I Umunna considered and adopted the MSc (Primary Care Surgery) document to be sent as a proposal to the National Open University of Nigeria, NOUN, after ratification by the general body of ARSPON.

‘The secretary was mandated to present this document to the President with a request to him for an instruction to the secretary to call an emergency general meeting or the use of an alternative method (email) for ratification.

‘Upon receipt of a texted message from Prof O O Ajayi, former President of the West African College of Surgeons, WACS, requesting a curriculum for a Diploma in Rural Surgery, DRS, to be sent to WACS, the committee mandated the secretary to develop a curriculum for consideration by the committee.

‘After several email exchanges, the president insisted ratification of the MSc document would be considered at the next general meeting in November and not earlier.

‘However, due to the eagerness of NOUN to have the document quickly, Drs Awojobi, Salaudeen, Afuka, Adams-Momoh, Windapo and Awofeso, exercising their fundamental rights, sent the document to the Registrar, NOUN through Dr Salaudeen on 17th March 2010 on the letter head of Awojobi Clinic Eruwa.

‘Dr Umunna, chairman of the CTC, resigned his chairmanship to protest the action of the group led by Dr Awojobi.
'A curriculum for DRS has been developed by the secretary and circulated to members of CTC and ARSPON.'

After a long debate it was agreed that
- The Council should appeal to Dr Umunna to withdraw his resignation.
- We should appeal to the President to allow ratification by members of ARSPON using emails so that the document could be represented to NOUN by ARSPON.
- Dr Salaudeen informed the meeting that a Diploma in Family Medicine has been established at LUTH under the leadership of Dr Olayinka Ayankogbe whose telephone number Dr Salaudeen would furnish the secretary.

7.3 Operation Hernia at St Vincent’s Hospital, Aliade
7.3.1 The secretary briefed the meeting on this subject thus:
‘The first mission to St Vincent’s Hospital, Aliade took place from 2010. Dr Tule was present at the reception organized for Prof Andrew Kingston and his team.
‘Some weeks after the event, Prof Kingsnorth agreed to set up an Operation Hernia, OH, outlet at the purpose-built hospital under construction by Dr Tule in his home village.’

Dr Yandev expressed surprise at the last submission wondering why Gboko has been left out and the issue has become a personal arrangement between Drs Tule and Awojobi on one hand and Prof Kingsnorth on the other. He also wondered why Dr Tule, who had planned to travel with him to the meeting, declined to do so at the last minute.

The secretary, as the Coordinator for OH missions in Nigeria, explained that OH collaborates with individual institutions in Nigeria. Prof Kingsnorth would conduct a site inspection visit to assess the feasibility of the institution to host OH missions. He would be present during the first mission after which he needed not be there with subsequent teams.

Dr Yandev expressed disappointment at the turn of events and promised to iron out the matter with Dr Tule on return to Gboko.

7.3.2 Dr Afuka, on behalf of the South East group expressed the desire for OH to extend her activities to Imo State and for them, it is a group presentation. The secretary promised to acquaint Prof Kingsnorth of this request.

7.4 Geopolitical representation/Membership drive.
This was another issue that was debated strongly. The consensus was that until training and certification programmes suitable for both members and young colleagues were established it might be difficult to increase the geopolitical spread of ARSPON.

The secretary informed the meeting that he had applied for the Fellowship of WACS by election to enable him pursue the adoption of DRS by WACS. The starting of a Diploma in Family Medicine at LUTH was a good development in this regard.

7.5 Annual conference in 2010.
The chairman quoted the constitution which implied that the annual conference should take place in September. After some discussions, it was decided that with the approval of the President and using the email, we should amend the constitution to make a November conference legal.

The chairman stressed the importance of the next annual conference during which elections into national offices would take place and amendments to the constitution would be effected. He requested the National Treasurer, Dr Adenuga, to compile the list of members who have discharged their financial obligations. The secretary promised to send the list of members to Dr Adenuga (Appendix 1) and also informed the meeting he would not seek elective office at the next conference so as to give the non-specialist members an opportunity to hold a national office.

The secretary informed Dr Yandev that 51 conference bags, the leftover from the Udo meeting, were kept with Dr Ella at Aliade from whom he could collect them for use at the next conference.
7.6 Report on 2nd Annual Conference at Udo/Indian Conference.

7.6.1 The chairman, who was not at the Udo conference, was not happy with the ways the choices of the venues for the next annual conference and the ARSPON/IFRS conference were made and the way the decisions were documented by the secretary. He was of the opinion that the choices of venues should have been contested for.

Dr Salaudeen, who moved the motions for the venues and was unanimously supported by the whole house, told the meeting how the decisions were reached. And, in any case the hosts did not object to their choices.

The meeting resolved that this was the time to start preparing for the international conference to be held at Eruwa in 2011 with the south west zone constituting the local organizing committee.

7.6.2 The secretary was mandated to work on the modification of the Certificate of Participation used at Udo for the Association’s Certificate of Membership.

7.7 Next meeting of Governing Council.

The next meeting of the Governing Council was fixed for the day preceding the commencement of the next conference.

8 Any other business.

8.1 Amendment of the constitution.

As a result of the constitutional issues raised at the meeting and that proposed by the secretary on the power of the President as the only authority to call for a meeting of the association, it was decided that the constitution will be amended prior to the elections to the offices due at the next conference.

8.2 Theme of ARSPON/IFRS Conference 2011.

The secretary informed the meeting that some months ago when the President of IFRS, Dr Pascience Kibatala of Tanzania enquired if the theme for the joint ARSPON/IFRS Conference 2011 has been decided, he surveyed the opinion of members using sms messages. There were various suggestions that included training for rural surgery. (Appendix 2) He was of the opinion that training for rural surgery was the main issue for ARSPON and should be adopted as the theme for the joint conference in 2011. This was agreed by the house.

8.3 IFRS website

The secretary informed the meeting that in 2007 when he attended the second conference of the IFRS in Ifakara, Tanzania he was mandated to setup a website for IFRS and this was to be sponsored by the German society for Tropical Surgery, a constituent of IFRS. This task was reaffirmed at the third conference in India in 2009. In February 2010 the secretary, after due consultation with relevant members of IFRS Executive and Prof Andrew Kingsnorth who operates the OH website by himself, got his nephew, Mr Segun Lawal, an expert in this field to create a website for IFRS at a cost of N125 000.00 per annum. However, in an email from the secretary to the President and members of ARSPON suggesting that half of the bill be footed by ARSPON and the other half by IFRS, the reaction was negative without anybody suggesting a counter proposal. So, once again, the secretary paid Mr Lawal the sum of N125 000.00 and the demo website is in operation: www.ifrs-rural.com

8.4 Settling of debt incurred from the first conference.

The chairman raised the issue of paying the debt owed individuals by the Association. It was decided that only the general body could authorize the payment of such debts at the annual conference.

8.5 Reports from the state/zonal chapters

The chairman was happy to know that Dr Adenuga is continuing with his monthly surgical skill acquisition programme at his hospital and implored colleagues in Gboko and Lagos to reanimate the surgical outreaches they initiated last year stressing he and the secretary are available to lend a hand again. The secretary observed that what would be more sustaining would be for our colleagues to make their high quality services more affordable to the patients in their localities.

Composition of Governing Council
9 Adjournment
Dr Anyadiegwu moved for the adjournment of the meeting and was seconded by Dr Saliu. Dr Salaudeen said the closing prayer. The meeting ended at 5.15pm.

Dr A C Sagua
Vice-President

Dr Oluyombo A Awojobi
National Secretary

APPENDIX 1

MEMBERSHIP LIST OF ARSPON ACCORDING TO ATTENDANCES AT MEETINGS AND THE TRAVEL TO INDIA.

THE INAUGURAL MEETING OF THE NIGERIAN ASSOCIATION OF RURAL SURGICAL PRACTITIONERS THAT TOOK PLACE AT THE RESIDENCE OF PROFESSOR S K GYOH IN GBOKO, BENGUE STATE, NIGERIA ON SATURDAY 12TH JANUARY 2008.

Attendance: i. Prof S K Gyohii. Dr E R Saliu iii. Dr A O B Adenuga iv. Dr M H Adabanija v. Dr A C Sagua vi. Dr F N Atsen vii. Dr O J Fatokun viii. Dr Tule Terver Zua ix. Dr Dzer Hembe x. Dr O Awojobi xi. Dr A Idoga xii. Dr Pevkyaa Yandev xiii. Dr Ikparen A xiv. Dr Yaji Samuel xvi. Dr M H Adabanija xv. Dr O J Fatokun Apologies: i. Dr A O Windapo, ii. Dr J K Ladipo iii. Prof E A Alufohai, v. Dr R O Tijani


Attendance: i. Prof S K Gyoh ii. Dr E R Saliu iii. Dr A O B Adenuga iv. Dr A O Windapo, v. Dr A C Sagua vi. Dr F N Atsen vii. Dr T Mustapha viii. Dr Dzer Hembe ix. Dr Fassil Gebreegziabher (Tanzania) x. Dr J I Umunna, xi. Dr J O Adetokunbo, xii. Dr Pevkyaa Yandev xiii. Dr Tunde Campbell, iv. Dr Yaji Samuel xv. Dr Adetokunbo xvi. Dr A O Awojobi xvii. Dr M Adetokunbo, xviii. Dr S O Ogunsina, xx. Dr E N Karibi, xxii. Dr E D Robinson, xxiii. Dr S Kilete, xxiv. Dr J I Umunna, xxv. Dr J C Ihedioha, xxvi. Dr M H Adabanija

Absent with apologies: i. Dr Tule Terver Zua, ii. Dr Ikparen A, iii. Dr M H Adabanija iv. Prof E A Alufohai, v. Dr R O Tijani

THE SECOND ANNUAL GENERAL MEETING OF THE ASSOCIATION OF RURAL SURGICAL PRACTITIONERS OF NIGERIA THAT TOOK PLACE AT JASMAN HOSPITAL LTD, UDODU-EZINIHITTE, MBAISE, IMO STATE ON FRIDAY 27TH NOVEMBER 2009.

Attendance: i. Prof S K Gyoh ii. Dr B E Mejeha iii. Dr A O B Adenuga iv. Dr A O Windapo, v. Dr C C Ogbuokiri vi. Dr J A Okoronkwo vii. Dr G U Nwabueze viii. Dr J C Jedidiah x. Dr P U Ojinkeya x. Dr J I Umunna, xi. Dr N F Ezemajii. Dr P Akotaebe xii. Dr J N Afuka xiv. Dr B O Chukwuka xv. Dr C M Anyaee xvi. Dr A T Ajasine xvi. Dr O A Awojobi xviii. Dr C O Umunna xix. Dr D L A Akuku xx. Dr I I Anyadiegwu xxi. Dr O Madu xii. Dr P N I wunze xii. Dr F Obiyo xxv. Dr I A Aderinlewo. xxvi. Dr (Prince) E Onyiro xxvi. Dr F Akakwam xxvii. Dr C O Ibeduigba xxix. Dr G O Salaudeen xxx Dr J O Ukawuba xxxi Dr H C Anyanwu xxxii Dr F Adams-Momoh

Apologies: i. Prof E A Alufohai (attended the scientific session on Thursday 26th November 2009), ii. Dr Tule Terver Zua iii. Dr A C Sagua
EMERGENCY MEETING OF THE GOVERNING COUNCIL OF THE ASSOCIATION OF RURAL SURGICAL PRACTITIONERS OF NIGERIA HELD IN THE HOME OF PROF S K GYOH, THE PRESIDENT, IN GBOKO, BENUE STATE.
ON SATURDAY 19th DECEMBER 2009.
Attendance: i. Prof S K Gyoh, ii. Dr A C Sagua, iii. Dr T Z Tule, iv. Dr G O Salaudeen, v. Dr R Oriloye, vi. Dr E R Saliu, vii. Dr A O B Adenuga, viii. Dr F Atsen, ix. Dr P Yandev, x. Dr A N Ikparen and xi. Dr O A Awojobi.

MEETING OF THE ARSPON COMMITTEE ON TRAINING AND CERTIFICATION HELD AT ADESOLA CLINIC, BARIGA ON SUNDAY 14th February 2010.
Attendance: Drs J I Umunna (Chairman), G O Salaudeen, F F Adams-Momoh, J N Afuka, and O A Awojobi (Secretary).
Others: Dr A O Windapo (host) and Dr K O C Awofeso.
Apologies: Drs A C Sagua, A O B Adenuga, vii. Dr P Yandev, viii. Dr F Atsen, ix. Dr A O B Adenuga, x. Dr F F Adams-Momoh, and xi. Dr A N Ikparen.

In Attendance: Dr G O Salaudeen and Dr F F Adams-Momoh.
Apologies: Dr Femi Fatokun and Dr T Z Tule.

ATTENDED JOINT IFRS/ARSI CONFERENCE HELD AT PIPALIA, RAJASTHAN, INDIA. NOVEMBER 2009.

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<tr>
<th>1. Dr OGIDIAGBA E</th>
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<th>3. Dr MUSTAPHA T A O</th>
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<td>33. Dr ORILOYE R S</td>
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<td>37. Dr AKINYEMI E</td>
<td>38. Dr SAMUEL O</td>
<td>39. Dr ADAMS-MOMOH F F</td>
<td>40. Dr ADABANIJA M H</td>
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<td>41. Prof AJAYI O O</td>
<td>42. Dr AWOJOBI O A</td>
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A TWO-YEAR ACCOUNT OF LAGOS STATE BRANCH OF ARSPON

Ikotun NMA county forum and the birth of ARSPON Lagos State

A strong member of the Ikotun NMA county forum, who went to Eruwa for surgical posting, Dr. L.A Durojaye was the link. He brought the programme booklet of the first scientific conference of ARSPON at Ikire which had just taken place in 22nd November 2008 to our end of the year family party in December 2008. We went through the booklet and discovered that the constitution of the ARSPON met the aspirations and objectives of the Ikotun NMA forum, hence we quickly resolved to subscribe to ARSPON. This immediately took me on a journey to DR AOB Adenuga of Layo Model Hospital, Ikire and DR Yombo Awojobi of Eruwa. Through DR Awojobi the executive of Ikotun County forum got the blessings of Prof. Shima Gyoh the president of ARSPON to establish the Lagos State branch.

After the initial contacts, and preliminary meetings which we held, the Lagos State branch was finally inaugurated at Ikotun NMA by the vice president Dr A.C Sagua and the National Secretary Dr Yombo Awojobi on the 4th of July 2009 under the full glare of the community, the press, the CDA leaders and representatives of Obas of this area. This event was adequately reported by a popular daily News paper who rightly called us “father Christmas Surgeon”, as free surgical operation were carried out shortly after the official Inauguration at Bissalam Hospital Egbe.
The free surgery was a great success as no death was recorded out of all the 22 cases that were taken. Since the launching and the surgical workshop, the Lagos state branch of ARSPON has moved from strength to strength. Our branch was fully represented at the International Conference of IFRS in state of Rajasthan, India in November 2009.

The surgical workshop has become an annual event of ARSPON in Lagos state. The workshop took place this year at Maciland Hospital Ijegun which is another suburb of Lagos under Ikorodu. It was another resounding success in high level of organizational sense and leadership display. Again, about 31 different surgical cases were operated without any loss of life.

I am using this opportunity to thank our president Prof. Shima Gyoh who gave his blessings to the formation of this branch, our chief Trainer the Indefatigable Dr Charles. A. Sagua, our committed National Secretary and other members of the National Executive council, who are also worthy of mentioning.

The Impact of the Objectives of ARSPON on the Surgical Skill and Interpersonal Relatives of Members

1. Following the unprecedented Surgical Hand-on training at Bissalam Hospital in July 2009, ARSPON became the centre point of discussion among members and other associations. Private practitioners bought the ideal of primary care or Rural Surgery as an opportunity to develop themselves even while still running their hospitals. Hence there was resultant increase in membership.

2. As the chairman of this branch I noticed that members now become closer together more than ever before and could come together to discuss about their patients and plan Surgery jointly or bring senior colleagues. And the cost of Surgery has been brought so much down to help the poor masses.

3. The other dimension is that members now attend social outings together as a matter of social responsibility. Members attend landmark birth-days, House warming, funerals of aged parents, marriages, ceremony of our sons and daughters at least to unwind out of their tight schedules.

4. The love, understanding and friendliness among our members knows no bound now as members could easily go into one and anothers clinic to pay visit or even cover in cases of unavoidable journeys on absence from ones clinic. Thanks to ARSPON.
5. The International Conference at Pipalia, Rajasthan State of India has brought our members into contact with friends from other states and even overseas. Lasting friendship has been established through that journey. This has rightly positioned our members for the hosting of IFRS Conference of 2011.

CONCLUSION
It is pertinent to mention that what informed my decision to influence the Ikotun NMA Country forum to embrace ARSPON was that whatever has brought eminent professors and high achievers like Prof. Shima Gyoh, Prof. O.O. Ajayi, Prof. Adelola Adeloye, Dr Yombo Anjohi, Prof. Ewan Alufahai, Dr James Ummuna and Dr Charles Agbamu Suga together to form this association – ARSPON could only bring something good and bright for our people in particular and this country in general. Hence one was ready to align and work this with these great compatriots.

Long live Nigeria Long live ARSPON.

DR G.O SALAUDEEN
Chairman ARSPON
Lagos state

ARSPON DUES---Lagos State Chapter

--- On Mon, 4/10/10, Rasheed Oriloye <unita_hospital@yahoo.com> wrote:

From: Rasheed Oriloye <unita_hospital@yahoo.com>
Subject: ARSPON DUES---Lagos State Chapter
To: oluyombo2@yahoo.co.uk
Cc: "WINDAPO" <bayowindapo@yahoo.co.uk>, "G Salaudeen" <salaudeengo@yahoo.com>, "DUROJAYE" <durojayelasisi@yahoo.com>, "Dr Awojobi" <oluyombo2@yahoo.co.uk>, "AKINSANYA" <primexhospital@yahoo.com>, "ABAYOMI" <abayomi_waheed@yahoo.com>
Date: Monday, 4 October, 2010, 17:07

Dear Sir,
Below are the names of ARSPON members from Lagos who had paid their membership annual dues of =N=15,000.00 for this year.
1. DR WINDAPO P. O.
2. DR AKINYEMI
3. DR AKOTAIBE P.
4. DR ORILOYE R. S.
5. DR OESH E. J.
6. DR OGUNMODEDE O. G.
7. DR OSISAMI G. B.
8. DR AKINSANYA A. O.
9. DR ABAYOMI W.
10. DR AKINKUNMI
11. DR DUROJAYE L. A.
12. DR (MRS) DUROJAYE O. F.
A cheque of =N=180,000.00 (One hundred & eighty thousand Naira only), has been paid to arspon acct NO 1921770004935. of SKYEBANK ERUWA.
Thank you
Dr Oriloye R. S
Treasurer, Arspion, Lagos State Chapter.
Re: ARSPON DUES---Lagos State Chapter

Tuesday, 5 October, 2010 3:17

From:
This sender is DomainKeys verified
"Gani Salaudeen" <salaudeengo@yahoo.com>
View contact details

To:
"Dr Awojobi Oluyombo" <oluyombo2@yahoo.co.uk>, "Shima Gyoh" <shimagyoh@ymail.com>
Cc:
"A C Sagua" <saguaqbang@yahoo.com>, "Ri Suliu" <arisetmedicalnigltd@yahoo.com>, "James Umunna" <james_umunna@yahoo.co.uk>, "Dr Prince" <emmaonyero@yahoo.com>, "Dr Afuka N J" <ndjafuka@yahoo.com>, jajiyemisi@yahoo.com, "Dr FF Adams-M" <dradamsmomoh@yahoo.com>, "Dr Fatokun" <fatokun@yahoo.com>, "Akinyemi ES" <gestateclinic@yahoo.com>, "G Salaudeen" <salaudeengo@yahoo.com>, "Wole Kukoyi Dr" <wole99k@yahoo.com>, kocawofeso@yahoo.com, "Lanre" <lanreshoyinka@yahoo.com>, "Durojaye Lasisi" <durojayelasisi@yahoo.com>, "Prof Ewan Alufoahi" <ewanprof@yahoo.com>, "Ogidiagba Efe" <efelogiso@yahoo.com>, "Bayo Windapo" <bayowindapo@yahoo.co.uk>, "T TULE" <drtule@yahoo.com>, "Adenuga Tunji" <ofrudo2005@yahoo.com>, "Dr Tayo Apampa" <tayoatkh@yahoo.com>, unita_hospital@yahoo.com, uchendualaeufula@yahoo.com, "Oseh" <dr.osehjovy@yahoo.com>, "Paul" <pakotibe@yahoo.com>, "Akinsanya" <primexhospital@yahoo.com>, "Prof Adeloye A A" <aadeloye@yahoo.com>, "bissalam hospital" <bissalamhospital@yahoo.com>, "''YANDEV P'" <tbthosp@yahoo.com>... more

Dear sir,

I write to quickly correct and put the record straight concerning the payment we in Lagos state has just made and which was wrongly classified as Annual dues for the current year. This payment should be for, according to ARSPON constitution, Article 8, subsection 1 and 2, under subscriptions 

(a) Admission fee........N5000=.
(b) Annual dues ........N10000=
Total per member.......N15000=

Sir, the money should have been paid last year immediately after our State Chapter inauguration on Sat. 4th July 2009, but for the simple fact that I started mobilizing members again collecting money for visa and tickets to the International Conference in India, November 2009, of which Lagos State members were fully represented despite the fact that we were still new in the Association. As the chairman of the Chapter, I explained the financial predicament to the National Secretary then of which he warned that members should pay up as soon as possible.

It was pure discretion that me and my executive members used at collecting these fees together with our Annual Surgical-Training Workshop fees, of which this years is the second edition. Sir, on behalf of the Lagos State Chapter, I Dr G O Salaudeen the Chairman here by solicit or apply for a waiver for the year 2009, which was the year of membership drive in Lagos State. If my plea is accepted, I would expect our admission forms and Constitution which I expect by now should be in booklet form and not at the back of our annual conference brochure should be sent to us. In the same manner the Gboko Conference fee and other contributions will be remitted as soon as our members recoup. I plead with Tulle and Yandev for extension......sir

This is an Election year, so we promise tha all our members must surely be in good financial standing. Thanks

Dr G O Salaudeen, Chairman ARSPON Lagos State.
## ARSPON IMO STATE BRANCH

### REGISTRATION AND 2009 ANNUAL DUES

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<th>NAMES</th>
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The above is our nominal list for 2009 and we are 23 in number. The national registration of =N=5,000.00 is returned for each of the names except for that of Dr. J. I. Umunna who had already registered. Also the annual dues for six members is included making a total of =N=170,000.00 accompanying the list.

Thanks.
Dr. Afuka J. N.
(State Secretary)
### ARSPON SOUTH EAST ZONE

#### NATIONAL DUES 2010/3RD NATIONAL CONFERENCE LEVY

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**Note:** These amounts have been paid respectively into ARSPON national A/C at Inter-continental Bank and Tule’s A/C with UBA Bank. Also, the South East Zone made a collective donation to the conference booklet production of forty thousand naira which has been paid into Dr. Oluyobo’s A/C with Inter-continental Bank.
INTRODUCTION


This was the outcome of the WONCA conference that took place on the Greek island of Crete which I attended in 2009. I was a keynote speaker on the subject ‘Appropriate technologies for improved rural health care delivery in Nigeria – The Ibarapa experience.’ and also took part in a workshop that examined the issue of “Recruitment and retention of health workers in remote and rural areas – innovative approaches and global recommendations”. (Awojobi O A Recruitment and retention of health workers in remote and rural areas – the Nigerian perspective. Rural Surgery 2009; 5 (4) : 37 -38.) WHO officials were in attendance at the conference.

Coming on the heels of this interview was the invitation from WHO to participate in the First Global Forum on Medical Devices scheduled for Bangkok, the capital of the royal kingdom of Thailand from 9 – 11 September 2010. I am a rural surgeon by training but fabricating and inventing machines and medical devices are my hobby.

This invitation was facilitated by Dr Pascience Kibatala, a Tanzanian general surgeon and adviser to WHO.

KNOWING DR KIBATALA

I met Dr Kibatala for the first time in August 2006 at the conference of the Association of Rural Surgeons of India, ARSI, that took place in Mehsana, India. I was in India looking after a friend and colleague who had renal transplant at Apollo Hospital in neighbouring Ahmedabad. We are overseas members of ARSI and shared the same hotel room during the conference.

Dr Kibatala is a foundation member of the International Federation of Rural Surgery, IFRS, and was privileged to host its second conference in 2007 at his base, St Francis Designated Hospital, Ifakara, Tanzania. My wife, Atinuke and I in company of two other Nigerian doctors, J K Ladipo and R O Tijani attended the Ifakara conference relating with Pascience for the second time. During the conference, Dr Kibatala was elected the Vice-President (President -designate) of IFRS.

In November 2009, the Association of Rural Surgical Practitioners of Nigeria, ARSPON, of which I am the national secretary and a foundation member, attended the third conference of IFRS in Pipalia Kalan, Rajasthan, India. During the conference, ARSPON was admitted into IFRS, Pascience was installed the president and I was elected the secretary of IFRS. We were both honoured with the fellowship of ARSI in recognition of our ‘significant contributions and dedication to the advancement of rural surgery’. That was the third encounter with Pascience.

At the forum in Bangkok, I gave him a complimentary copy of the third edition of Davey’s Companion to Surgery in Africa. He was grateful and exclaimed that the second edition of the book was his ‘bible’ during his surgical training. I am the third editor of this edition with my teachers Professors A Adeloye and O O Adekunle. I am also privileged to be the publisher of the book.

THE INVITATION

Upon receipt of the invitation to the Bangkok meeting, I forwarded it to my teachers and colleagues for their information. This action generated a lively debate involving my Indian friends, Drs J K Banerjee, R D Prabhu, R Tongaonkar, Nigerian colleagues, Prof S K Gyoh, president of ARSPON, Dr G O Salaudeen and Dr Kibatala who would also be a participant at a plenary session of the forum and speaking on the Medical devices needs of the developing countries. I was billed to speak at a parallel session and present a poster on Appropriate and innovative medical devices – local solutions.
The main issues in the debate were the misgivings expressed by the Indians on the past roles of WHO in the health care delivery systems of the third world and the perceived poor performance of the host countries in implementing WHO guidelines without the consideration of local factors. They were not optimistic the outcome would be different. However, Pascience and I were strongly supported to attend and present the true picture and the pragmatic solutions to the health problems of the third world as they related to medical devices. Dr Tongaornkar provided me with the details of the affordable Indian mesh used in the Lichtenstein tension-free repair of inguinal hernia—a common surgical problem in developing countries. We have been using this mesh routinely in Eruwa—courtesy of Dr Tongaornkar.

Initially, I was billed to speak at a parallel session. But, a few days to the conference I was rescheduled into a plenary session in addition to the poster presentation. I seized this opportunity to speak on Making the pyramid work—the need for local solutions. Appendix 2

THE TRAVEL
Having obtained the clearance of the National Drug Law Enforcement Agency, NDLEA, of Nigeria—a requirement demanded only of Nigerians, I travelled twice to Abuja, the capital city of my country and with the additional help of the office of the WHO representative in Nigeria, I got my travel visa from the royal Thai embassy.

I set out from Lagos on Tuesday 7th September 2010 on Ethiopian Airlines arriving Bangkok the following day after a stopover in Addis Ababa. The conference took place at Plaza Athenee where I was lodged.

THE CONFERENCE.
At the conference, I met another Nigerian surgeon Dr Khalid Lawal, the Director of Clinical Services and Research at Ahmadu Bello University Teaching Hospital, Zaria, Nigeria. He was sponsored by the teaching hospital and listed as an expert in the programme booklet. Because of the low surgical turnover at the teaching hospital due to several known factors, he offers his services free of charge at the neighbouring Hajiya Gambo Sawaba General Hospital, Kafar Gayan, Zaria.

I briefed him about ARSPON and invited him to our next conference taking place in Gboko, Benue State in November. I also informed him that the next conference of IFRS will take place in Eruwa in November 2011. I wish to seize this opportunity to invite all of you to this conference and see all the technological innovations and medical devices I have talked about.

During the proceedings of the first day, WHO presented the report of the baseline study on medical devices in member states. Despite repeated requests, no data from Nigeria were available. Most African countries completed the questionnaire.

The summary of experiences with medical devices in the developing world has been

- medical devices imported into developing countries have been very expensive,
- 10 to 30 per cent of medical devices (purchased or donated) are barely functioning,
- not enough skilled manpower to use and maintain the medical devices and
- most are not appropriate for the settings they are deployed.

I presented my paper on the second day starting off with the profound statement of a former Director-General of WHO, Dr Halfdan Mahler at the 39th World Health Assembly held in Geneva in May 1986, that

“the main problem (in health) is not the lack of appropriate technology; it is the lack of appropriate application of that technology”.

I elaborated on how we have adopted appropriate technology to the solution of the many problems we have faced in delivering health care in rural Eruwa for the past 27 years. I appealed to WHO to help influence government at all levels in Nigeria adopt this sustainable health care delivery system in these words:

‘But, to have any significant impact on health care at the grassroots and nationally, governments at all levels should be encouraged to show the political will in adopting these time-tested local solutions on a massive scale.’

At subsequent interactions with delegates, I was congratulated on my presentation and was asked why it had been difficult to replicate our system in the public sector. I attributed this situation to the ‘Nigerian factor’ which was understood by most participants.
During the poster presentation sessions, I distributed the flyer of Bells University of Technology, Ota, Nigeria which is the first university to offer an undergraduate program in Biomedical Engineering in Nigeria. Appendix 3

As an associate senior lecturer in the department, I served the second purpose of representing the university at the forum. In this respect, I explored linkages with relevant institutions in India and the forum, in general, provided a lot of resource materials for undergraduate training in Biomedical Engineering and Health Technology.

One of the participants, Anna Young of Massachusetts Institute of Technology, USA sent me the following text message on the conference networking device called SPOTME:

‘Dr Awojobi, Thank you for the inspiring presentation this morning! Your clinic in Nigeria is a fantastic example of local innovation. I hope to learn from you at this conference. Best wishes. Anna Young.’

During a detailed discussion with Anna later, I learnt from her of a Tanzanian who had developed wind mills to generate electricity. This, naturally, was of interest to me because if I could get them installed in Eruwa and using the inverter produced by my son Oluyombo, we could reduce our reliance on fossil-fuel-powered generators by 80 per cent. I will pursue that link vigorously and hopefully add it to our system.

RETURN JOURNEY
I set out on the return journey on Sunday 12th September at 00.35hrs local time arriving Eruwa at 16.00hrs local time via the same route.

ACKNOWLEDGEMENT
I sincerely thank the WHO for this rare opportunity to know more about health technology and present, on a global stage, my modest efforts at offering sustainable and comprehensive primary health care in rural Ibarapa district of Nigeria.

My gratitude goes to Dr Kibatala, Dr A B Adeoye of Bells University of Technology, members of staff, office of the WHO representative in Nigeria, Mr A Ajani of UNDP, Nigeria, Mr Segun Adebayo, Prince Abimbola Makanjuola, Pastor Mathew Ola (my guarantors for the NDLEA clearance) for their roles in making my journey possible.

I thank Prof Gyoh, Dr Salaudeen and my Indian colleagues for their input to my presentations and my wife, Atinuke, Messrs A Oyesomi and Kareem for holding the fort in the clinic while I was away.

Oluyombo A Awojobi
14th September 2010

MAKING THE PYRAMID WORK
– THE NEED FOR LOCAL SOLUTIONS
by
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At the 39th World Health Assembly held in Geneva in May 1986, Dr Halfdan Mahler, the Director-General of the World Health Organization, WHO, asserted that “the main problem (in health) is not the lack of appropriate technology; it is the lack of appropriate application of that technology”.

At the millennium conference in New York in 2000, realizing that HEALTH FOR ALL BY 2000 was a partial success, 191 UN member nations introduced the MILLENIUM DEVELOPMENT GOALS to be attained by 2015. However, halfway in the race, WHO celebrated 30 years of Alma-Ata Declaration on Primary Health Care and issued the World Health Report 2008. The report noted that inequalities in health outcomes and access to care are much greater today than they were in 1978.

It then called for a return to primary health care, arguing that its values, principles and approaches were more relevant now than ever before.
In rural Nigeria, there is severe shortage of electricity from the national grid and portable water from the municipal water supply coupled with a low level of technological development and relative poverty of the populace. There is an ongoing low grade cholera outbreak in my country.

The main problems at the primary and secondary levels of the pyramidal structure of health care could be found in the infrastructure (water and electricity supply) and the inappropriate medical devices installed in the health institutions.

It is not uncommon to find broken down operating tables with sophisticated mechanisms, the haematocrit centrifuge and suction pumps that rely on an erratic power supply to function and the scarcity of intravenous fluids which could otherwise be produced in-hospital if appropriate distiller and adequate water supply were available.

However, over the years, efforts have been made by individuals to solve these problems using appropriate technology and local artisans. But, to have any significant impact on health care at the grassroots and nationally, governments at all levels should be encouraged to show the political will in adopting these time-tested local solutions on a massive scale.

For example, hospital buildings have been constructed to harvest rain water and allow performance of surgery in the day time without recourse to artificial lighting. At night, an operating lamp contrived from an aluminium bowl and energy-saving bulbs is used. The automobile panel beater’s oxygen kit with a humidifier has found its use in resuscitating babies at birth and in the operating room.

The concept of convectional ventilation and the interlocking cement blocks have been introduced in building construction to reduce the effects of global warming and the cost of construction respectively. Seasonal streams have been dammed to increase water supply from deep wells dug nearby. These dams are seeded with fish to control mosquito breeding.

The haematocrit centrifuge has been fashioned from the rear wheel of the bicycle. The disc revolves at 5400 rpm (equivalent to a force of 3360g) enough to pack the red cells in five minutes.

The operating table was made of 90% wood and 10% metal, covered with formica to improve its aesthetics and allow washing down. It costs less than 10% of the imported brand made of cast iron. It is sturdy, has the basic tilts required by the surgeon namely: elevation and depression using the jack of the motorcar, Trendelenburg tilts, neck flexion and extension and the lithotomy break.

The distiller has been fabricated using copper tubing and produces 10 litres of water for use in making normal saline, 25% dextrose and acid-citrate-dextrose solution for blood transfusion. The dry maize cobs have become a source of fuel for autoclaving and distilling water.

The affordable Indian mesh has established itself in inguinal hernia repair, a common operation in the developing world.

A major problem in health care delivery in rural areas is transportation. Poor and expensive transportation system deters the patients from seeking medical help in time. We have contrived a tricycle from the conventional motorcycle and adapted it for a village ambulance.

Recently, the inverter came into use. With a homemade Inverter, it is now possible to guarantee a continuous supply of electricity.

The pedal suction pump is fabricated from plumbing pipe, a piece of leather and a reversed bicycle valve. Atraumatic sutures are made from the nylon fishing line and hypodermic needle.

We have split the reusable cannula along its whole length so that it could be used to insert the common Foley catheter in suprapubic cystostomy.

The ultimate goals will be the availability of affordable health care (especially essential surgical service) at the doorstep, job satisfaction for all cadres of health care givers and a reversal of rural-urban drift with the concomitant enhancement of food security.

In the spirit of President Barak Obama’s ‘YES WE CAN’, I thank you all for your kind attention.
REFERENCES


MORE NEWS FROM THE SECRETARIAT

DAVEY’S COMPANION TO SURGERY IN AFRICA
The third edition of this famous book edited by Profs A Adeloye, O O Adekunle and Dr O A Awojobi and published by Acecool Medical Publishers, the publishing arm of Awojobi Clinic Eruwa was launched in April 2010 at the University College Hospital, Ibadan. The event was well attended and turned out to be a reunion of the old and new members of staff of the College of Medicine, Ibadan. The President of ARSPON, Prof S K Gyoh, was the co-reviewer of the book with The President of the West African College of Surgeon, Prof O Mbonu.

OPERATION HERNIA AND ARSPON, IMO STATE BRANCH
Following a request from the Imo State branch of ARSPON to OPERATION HERNIA, OH and a site inspection conducted by Dr O A Awojobi, Coordinator of OH in Nigeria, Prof Andrew Kingsnorth, Director of OH will be leading a team of UK surgeons to the General Hospital, Abor Mbase in March 2011.

WORLD HEALTH ORGANIZATION and DR O A AWOJOBI
Dr O A Awojobi attended the First Global Forum on Medical Devices that took place in Bangkok, Thailand in September 2010 at the invitation of The World Health Organization, WHO. He is returning to Bangkok in January 2011 to attend the WHO’s Second Global Forum on Human Resources for Health and share his experiences of 27 years practicing in Eruwa.
BIRTH DAY CELEBRATION
On 22nd September 2010, Dr A O B Adenuga celebrated his 50th birthday. He planned to mark the event by offering his surgical services *ex gratia* to 50 patients, but ended the exercise on 1st October operating on 71 patients. We wish him many more years of dedicated service to the rural dwellers of Ikire and environs. ARSPON!! ACZION!!!

OBITUARY
We announce with deep regret the transition of the wife of Dr E O Oseh, an active member of ARSPON, Lagos State branch whose event took place in October 2010. We pray that the Almighty God will grant Dr Oseh the fortitude to bear the irreparable loss. May her soul rest in peace, Amen.