John Ross's
Ugandan Diary

The experiences of a Canadian Doctor helping to establish post-graduate medical training programmes.

For readers wishing to print this Diary it consists of 176 US Letter Sized pages made up of 168 text pages followed by 8 pages of colour photographs.

©John Ross, St. John's 1994

CONTENTS

Preface and Portrait 3

Eulogy 8

Foreword...10

Map of Uganda 12

Acknowledgements 13

Diary Part 1:. February, 1990 - July 16th 1990 14

Diary Part 2: September 3rd, 1990 - June 1st, 1991 45

Diary Part 3: October 17th, 1991 - July 16th, 1992..................................67

Diary Part 4: August 24th, 1992 - June 23rd, 1993 98

Diary Part 5: August 4th, 1993 - March 16th, 1994 141

Plate 1 –Colour photographs – Tororo hospital views..............................169

Plate 2 – Colour photographs – Residents and surgery at Tororo 170

Plate 3 –Colour photographs - Tororo people 171

Plate 4 –Colour photographs – Local scenes and people 172

Plate 5 –Colour photographs – Kitovu staff, Mulago Hospital and bicycles 173

Plate 6 –Colour photographs – An incomplete Siamese twin, herpes in AIDS ..174

Plate 7 –Colour photographs – Animal scenes 175

Plate 8 –Colour photographs – Spousal care and the tragedy of AIDS 176

John Munro Ross 1928 - 1999

Preface

A brief account of the career of John Munro Ross is of interest as it will give a better understanding of his work during the period covered by the Diary. He was born at Kisumu, in Kenya, in 1928, the son of a Scottish doctor in the Colonial Health Service and an Australian missionary mother. His initial primary education took place at Kenton College in Kenya, and subsequently at Prince of Wales School, in Kenya, and Scotch College in Melbourne, Australia, where he had relatives. He later studied medicine at the University of Aberdeen, graduating in 1953. Initially he considered a career in surgery and his early appointments in the UK were in this field, with a view towards obtaining his surgical Fellowship. This initial career period was interrupted by National Service in the Royal Army Medical Corps where, in view of his knowledge of the language and the

country he expected to be posted to somewhere in Africa - naturally he was posted to Germany! Eventually he did get a little closer to Africa by being transferred to Jordan.

Following this service in the R.A.M.C. he gained further surgical training in the U.K., but decided that perhaps full-time surgery was not really his first choice of a career. Thus in 1957 he came to work in the cottage hospital system in Newfoundland. For the first year this was at Channel Cottage Hospital in Port aux Basques in south-western Newfoundland. It was during his first term of duty there that he met the lady that was the following year to become his wife. In 1957 Doreen Janes, a British trained SRN and midwife, was the Nurse in Charge at Channel Hospital. The following year John was appointed as Senior Medical Officer at Bonne Bay Cottage Hospital and it was during that time that John and Doreen were married. Throughout John's career Doreen has been a very important partner as will be appreciated from the Diary. For a further year (1959 - 1960) John Ross returned to the Channel Hospital. Then in 1960 John was appointed to Placentia Cottage Hospital in the south east of Newfoundland, here he spent a further ten years in the Cottage Hospital system. He still remains in the fond memory of the many patients he cared for and delivered during that time. In those days as well as obstetrics the work in the Cottage Hospitals often included a significant surgical load. During this period he also took time off for a further surgical rotation in St. John's to update both his surgical and medical skills.

Between 1963 and 1965 in addition to his clinical work-load he served as the President of the Newfoundland Chapter of the Canadian College of Family Physicians.

Although he returned for a further year to the Channel Hospital it was no surprise that the new medical school being established at Memorial University in St. John's sought him out and recruited him in 1971 as the first Chairman of the Family Practice unit of the Medical School. He stepped down from this position as Chairman of Family Practice in 1973, handing over an already well organised and enthusiastic department to Dr. Keith Hodgkin. During John Ross's time as Chairman, and subsequently as an active professor in the unit, he continued to help establish a strong program for developing community health services. In 1972 he was awarded the Fellowship in the Canadian College of Family Physicians. Further community involvement included periods when he served as Vice-President of the Planned Parenthood Federation, and President of the Physicians for Social Responsibility.

In 1985 in association with a programme to assist in developing medical services in Uganda being spear-headed by Dr. Donald Hillman, the then Chairman of Paediatrics at Memorial, John visited Uganda and spent three months reviewing the situation. He returned to Uganda in 1989 to devise a training programme for primary physicians in and for that country. This led to the period covered by the Diary (1990 - 1994) when he was actively participating in that programme. Each year John would send back a "floppy" computer disc containing his diary entries for the year. These were then printed and circulated to a dozen or so of his many friends in St. John's.

The possibility of making an account of his experiences during this period available to a wider readership was considered on his return. He had hoped that it would help other physicians, particularly young ones in other parts of the world, to become more aware of the many difficulties they would have to face should they be interested in serving in some way in the Third World. Although it is now some eight or nine years after the period covered in the Diary and changes may well have occurred in Uganda the problems encountered will still be common in many parts of Africa. As will be seen from the Diary not only are the medical conditions they would have to face be very different from those they may have encountered during their training in the Western world but so also would be the political, social and cultural differences they would encounter and have to deal with. The problem of AIDS for example is, growing more serious all the time. In the belief that his, and Doreen's, experiences, recounted here, will be of wider interest, and also be of use to others planning to serve in third-world countries, his Diary entries have been put into this format.

For his many services to the people of Canada John Ross was made an Officer of the Order of Canada in 1994.

After returning from Uganda and retiring from the University, John Ross maintained his interest in clinical work, firstly by spending a year as a locum for various practices in a number of Australian states. More recently he had been active in helping to develop a teaching programme for nurse-practitioners in the Province.

In 1998 when I at last managed to convince him that his memoirs would be of great interest to very many others he agreed that they should be put together in a more standardised format than was on the original "floppies". His original text and style has not been altered significantly and we met regularly while this was being done by me. We had long been good friends and one day he called to see me and told me that he had an inoperable cancer of the large bowel. He had decided, no matter what the course his condition might take that he had no intention of undergoing any surgical procedures to alleviate any complications in the hope of prolonging his demise, he had no illusions about the likely progress of the disease. He planned to stay at home receiving only such medications that would control pain and dehydration. We continued to meet up until a few days before his death on the 2nd of December 1999.

As will be appreciated from various entries in the Diary, John Ross had always been a keen salmon fisherman, as well as a great hiker and incidentally as a poet. A founder member of the East Coast Trail Association in Newfoundland, John had also spent his retirement years helping to blaze new hiking trails around the east coast of the Avalon Peninsula so that others may also enjoy our beautiful scenery. He was loved and respected by numerous friends as well as all his old patients. I find it difficult to describe him, apart from being a great friend I always thought of him as "a doctor's doctor", someone we might all aspire to be.

The reason behind my encouragement to John Ross to prepare his Diary for a wider readership was primarily to recognise at least one part of his life's contribution to humanity and his day to day experiences and thoughts during this particular period. As such, it was not meant to be a detailed study of primary care services in Uganda at that time, though obviously much comment is made on that subject. For a more formal presentation of the training programme that John was involved in the reader is referred to two articles by him which appeared in the Canadian Family Physician, soon after his return to Canada and which were published in the Canadian Family Physician in 1996 (General Practice Training in Uganda Part 1, **42**, 213-216, and Part 2, **42**, 226-228. Reprints of these articles can be found in the pocket inside the end-papers of this printed edition of the Diary.)

At the time of preparing, along side with him, his diary's computer files into a standardised format I was unaware that he had previously made an attempt to collate the text and had prepared a Preface for it. He also seemed to have forgotten this. I did not find this out until after his death. I mention this as, in addition to the introductory material to be found in Part 1 of his Diary presented here, he had included his thoughts on why such a text might be useful. He had also included a brief history of the delivery and development of western medicine in Uganda from the time of arrival of Anglican medical missionaries in 1876 to the development of the most up to date and widely respected Medical School in Makerere University at the time of Independence in 1962 The political and social upheavals in Uganda after Independence, particularly during the dictatorship of Idi Amin, led to serious deterioration of medical services which were only starting to recover at the time of John's involvement with medical training in Uganda.

The support given to help establish improved medical care and training programmes in Uganda by the Canadian International Development Agency (CIDA), which helped finance John Ross's involvement, continues to this day by the involvement of the Family Practice Department of the Medical School of Ottawa University, and CIDA's Child and Maternal Health Care programme. Another Canadian organisation, the Canadian Network for International Surgery, whose offices are in British Columbia, also has programmes in African countries including Uganda. That organisation delivers a short course of surgery to establish essential surgical skills appropriate for primary medical care.

John Ross's opening two paragraphs of the original Preface mentioned above has been inserted below.

> *"The major reasons for sharing this account are twofold:. Firstly to be of service to anyone contemplating a similar project in a developing country, giving some idea of problems which were encountered, the frequent sense of frustration with one's inability to get things done within a reasonable time, the seeming lack of caring by those in authority and the almost daily laceration of one's feelings, caused by the poverty, suffering and cruelty so often witnessed. At times coping with these things became wearing indeed, and required*

continuous patience, with frequent analysis of the real reasons for the problems, and constantly attempting to understand "Why?".

Secondly, for doctors who may think of devoting some time to working in a developing country, and to give them an idea of the incredible range of morbidity and pathology likely to be encountered, particularly in a hospital based general practice. They are likely to have to deal with a lack of facilities and amenities to which they have become accustomed, and have to work with both a lack of materials and drugs which will necessitate innovation and the use of a very low level of technology. I am fairly certain that very many of the same problems will be encountered, in all of sub-Sahara Africa, The experiences encountered will apply to similar situations in many other developing nations.

Also it is to highlight, and give some insight, as to just how incredibly well off we are in the so called "developed countries", and to remind us all that the finer feelings of compassion, justice, honesty and caring are so very much easier for an individual to display in a society where the majority live in security and freedom, and where the simple task of day to day survival for oneself and family is not a major preoccupation. Under today's circumstances, with unrealistic salaries, and collapsing economies, the display of honesty and justice by most people living in the poorest countries of the world does require remarkable and dedicated individuals, and there are some. At tribal village levels their dealings with each other are very personal, and family commitments always honoured above all else. I view our role in any attempt to assist peoples in a developing country, as never trying to judge them, or their actions, by our own standards, but rather attempting to understand the reasons underlying their attitudes and behavior, and demonstrating an ability to work within the limitations encountered, while trying to adapt to the prevailing customs and conditions and making the best use of whatever is available in the way of manpower, equipment, technology and facilities."

For those that did not know him personally I have attached some excerpts from the oration given by another close friend and ex-patient, Dr. John Molgaard, on the occasion of the gathering to celebrate the life of John Munro Ross.

Brian Payton,
Discipline of Surgery,
Memorial University of Newfoundland.

Passages from a eulogy given by John Molgaard December 6th 1999

"John and Doreen Ross asked me to say a few words here on behalf of them and their family. John truly enjoyed the many visits he was able to receive at home during his illness. He, Doreen, and all the family around him, were deeply touched by the extraordinary kindness and support their many friends gave them during that time.

This was also felt in no small way by John's brother Ian and Ian's wife, Shirley, who were here recently from Aberdeen. The family for whom I speak also includes Wendy, Andrew and Joanne, George, Wendy's children Joey and Anne, Doreen's brother and sisters Victor, Anne, and Shirley, and others related and connected to them.

The gratitude of the family is particularly extended to you who are here today to honour John and provide comfort by your presence and participation.

As a friend I can also speak to the family on behalf of all their friends. Elke, my wife, and I have known John for the best part of thirty years. First he was our doctor, and a better doctor we have never had. Then the Rosses became our neighbors, neighbors who became our firm friends. Both families have gone through many stages of life, with both joy and pain along the way, much of it shared with each other.

This is how John and Doreen shared themselves with so many in numerous places, and as we all now share with them, as best we can, the pain and loneliness of parting from John.

As is abundantly evident here, friendship with John and Doreen was a privilege extended widely, for John was a person to whom you could quickly bond. You also quickly knew that Doreen and John were a powerful couple, enjoying, as John said several times in different ways during his last weeks, a full and rewarding relationship which he looked back on with immense gratitude and no regrets. A relationship which reinforced the quiet strength with which he approached death without fear, accepting the inevitable sadly but in peace.

John explicitly did not want this to be a medical obituary but, of course, he was a physician, a role in which he touched so many and contributed so much. He was a healer who touched the mind as well as the body wherever he worked, a thinking human - to steal a phrase Rex Murphy used to describe John.

Key words with which to place John's work geographically include the Middle East, Port aux Basques, Bonne Bay, Placentia, Uganda, Australia, and of course MUN and St. John's. Along the way a professional partnership in rural health care between John, a young Scottish doctor, and Doreen, a young English nurse, became a partnership for life.

In addition to the many he helped into the world and through life, there are younger doctors who are better physicians now for their time with John, and also nurses, nurse

practitioners, and midwives, for whom he was a champion and guide.

It was entirely characteristic of John that he would devote five years at the end of his career to encouraging doctors in Uganda to become more like him. Far from a luxurious safari, this was an offering of himself to the continent of his childhood, a continent enduring political and social turmoil.

His final medical stint in outback Australia was in comparison just an adventure, a busman's holiday, when his friends were relieved to know that he was not dodging bullets, machetes, or AIDS, nor exposed to the lesser hazard of losing his wedding ring in Lake Victoria while swimming with a nun, as happened in Uganda, for John's life was not all work and no play, even in hazardous circumstances.

He enjoyed a quality life wherever he was, within and outside the home, in and with his family and among friends, in pursuits for his own enjoyment and that of the family, in activities shared with and for others. Throughout his last weeks he could look at the superb intricate model he made of HMS Bounty.

His manual skills, which he had used in surgery, were also employed in angling and in accomplished tying of flies. His lifelong passion for the outdoors was latterly devoted to the East Coast Trail, to which he enjoyed taking his children and grandchildren, and anyone else who would share his love for the rugged and beautiful parts of Newfoundland.

If there was any unfinished business for John at the end of his life, it probably was his custodial responsibility for part of the Trail. That is where his ashes will be scattered privately and one place where his spirit will be found, as it will be deeply and firmly in our hearts and memories.

Thank you John."

Dr. John Molgaard,

Foreword

As a background to the geography and the sequence of political events in Uganda since Independence, the following information may be of interest to the reader. The total population of Uganda during the 1990s was in the order of 17,000,000.

The populations given below will serve as a rough guide to some of the places mentioned in the diary. The population of Kampala, like many of the other larger towns is growing so these figures are not that accurate.

Kampala	774,000
Jinja	53,000
Masaka	49,000
Mbale	24,000
Mbarara	23,000
Entebbe	21,000
Moroto	8,000
Tororo	7,000
Siroti	7,000

Many of the places mentioned are only small villages. Although some of these above towns appear to have small populations they serve surrounding regions where the population may be as high as 500,000.

Almost all of the place names mentioned in the Diary have been included in the accompanying map but the following information may also be of help.

Initially there were four teaching hospitals located in Kampala which served the medical programme of Makerere University. Nysambia Hospital is one of these, and is a mission hospital, the other three hospitals were, Rubaga Hospital, Mengo Hospital, and the old Mulago Hospital. The new Mulago Hospital is now a new seven story University teaching hospital built by the British at the time of Independence.

Kitovu Hospital is a mission hospital near Masaka in South Buganda. Manjabi High School is in Tororo. John and Doreen spent most of their time in Uganda at the government hospital in Tororo. The St. Anthony Hospital, a Catholic mission hospital, is also located in Tororo. Kisumu is in Kenya and is the birthplace of John Ross.

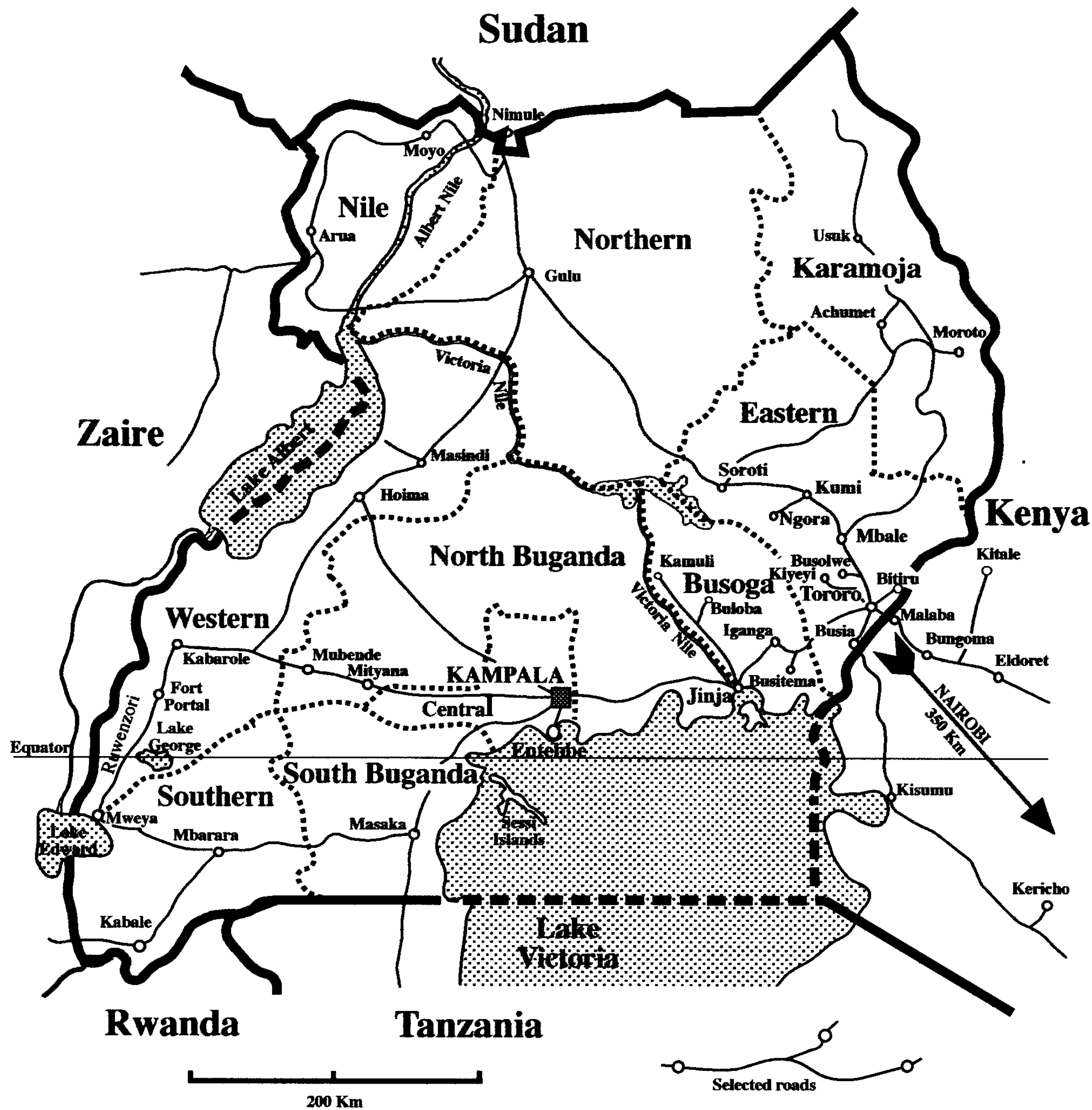
The sequence of political events in Uganda and which are commented on in the Diary are as follows:

1962	Independence.
1962-1971	Prime Minister was Milton Obote.
1971	Military coup by Idi Amin
1978	Idi Amin invades Tanzania.
1979	Tanzania invades Uganda and deposes Idi Amin.

1980	Obote again becomes Prime Minister.
1985	Obote is deposed in July and Okello becomes Prime Minister until January 1986
1986	Yowere Museveni becomes Prime Minister.
1995	New Constitution for Uganda.

B.W.P.

Ugandan Provinces and Neighbouring States



In comparison with many other African states Uganda is a relatively small country. It is bordered on the west by Zaire, now known as the Democratic Republic of Congo, on the north by Sudan and on the east by Kenya. Its southern border is shared by Rwanda and Tanzania though much of the Tanzanian border lies across Lake Victoria.

Ugandan Provinces

For administrative and historical reasons Uganda can be divided into 10 regions; the Southern in the southwest, Western and Nile in the northwest, Northern in the north, Karamoja in the northeast, Eastern in the southeast. Both these eastern regions border on

Kenya. In addition to these there are 4 central regions, each of which borders in part on Lake Victoria. These are Busoga to the west of the Eastern region while to its west lie the three other regions, South Buganda, Central Province and North Buganda. The capital city is Kampala.

Acknowledgments

I would like to thank the previous Dean, Ian Bowmer, and the current Dean, J. Rourke, for their financial assistance towards allowing this material to appear in print. Likewise I appreciate the facilities made available to me by Drs. Maroun and Pollet, chairpersons of the Discipline of Surgery, during time spent setting out the Diary. The support given by the Family Health Discipline is also appreciated. The staff of the Health Sciences Instructional Media Services were a great help in putting me right in the use of Pagemaker, Aldus Freehand and Photoshop, and Terry Upshall kindly showed me how material can be placed on a Website. Although many of the photographs had been gone through with John Ross before his death the final selection did not take place until some time later and I thank Doreen Ross for correcting me in preparing the legends. Finally the people in the Health Sciences Centre's Print Shop who not only prepared the final duplicate copies but also a number of earlier 'editions' that went to interested persons for information and comment, have as usual been willing and helpful.

Part 1

February, 1990 - July 16th, 1990

Pages 14 - 44

PROJECT DIARY.
Commenced February 1990.

The end of the year of 1989 might best be described as the 'end of the beginning' of the project in Uganda, and the first week of February 1990 marked the completion of exactly one year in Uganda. It took every minute of the time from first arrival in February 1989, to the end of December just to get the teaching programme truly started, with the first of the post-graduate students enrolled into the programme.

In 1985, while in Uganda for a very brief period of time working with the programme of primary and preventive Child and Maternal Health Care, administered by Drs. Don and Elizabeth Hillman and going under the acronym of CHAMP, funded by the Canadian International Development Agency (CIDA), discussions took place with the Department of Health and Professor Raphael Owor, who was Dean of Medicine at the time, regarding primary Health Care in the rural areas of Uganda. From these discussions the project was first conceived as a promising method of training primary care doctors for the rural hospitals of Uganda, and also a method of involving the community in the support of their own local hospital with responsibility for the payment for health care services being funded at a local level.

CIDA were sanguine about funding any new programmes in Uganda at the time, because following the downfall of Idi Amin the country had been through a series of military coups. They had had such devastating consequences to the whole economy, that by the end of 1985, and after the coup which displaced Obote as the President, in favour of Mr. Tito Okello, Uganda was in as near a state of complete anarchy as has ever existed. Inflation was rampant, personal security for the average person was almost non existent, random violence and killing was a daily event, with an astonishing number of guns and other weapons in the hands of a disaffected group of erstwhile soldiers and people calling themselves rebels. In 1987, the most recent of the series of coups was headed by Yoweri Museveni, and this time there seems to have come about a certain measure of peace and the promise of security, with an end to the internecine wars, and fighting which had so drained the country. That year I returned to Uganda for a brief period to resume discussions with the Department of Health, and the Medical School at Makerere University, and to carry out a feasibility study in order to see if the programme as it had been conceived was indeed a viable proposition. The situation was reviewed, in the light of the now relative stability of the country, its needs and the available facilities for teaching. At the time the matter of accommodation was also examined, particularly as

the proposal involved setting up a teaching programme in a 'Model Rural Hospital' some distance from Kampala, where it was known that accommodation was a matter of extreme difficulty, even for the Government doctors who had been posted there as District Medical Officers.

This visit resulted in a report which recommended the project be attempted, in spite of the many problems which it so obviously faced, on the grounds that the need was obvious, and the officials in both the Department of Health and Makerere University indicated that they fully supported the concept; furthermore if it was not attempted, the status quo would certainly be assured, and a self-fulfilling prophecy of failure would be the result.

Thus it was that late in 1988, CIDA agreed to funding the programme for a period of five years, and following the necessary preliminary preparations, I arrived in Uganda early in February 1989 to begin working as a faculty member seconded to Makerere from Memorial University for this period of time. It had been agreed, because of previous experience of delays and difficulties in initiating projects in Uganda, that I would come out alone and return home for a brief visit in August, and that Doreen, my wife would wait till then before accompanying me when I returned. This proved one of the wisest decisions taken in the whole project. From the very beginning the programme was fraught with delays and frustrations which would have been magnified if they had affected two people instead of only one. These were not the ordinary kinds of frustration which if shared could be ameliorated, they were frustrations which involved long periods of waiting for various officials both in the government and University in dingy and dirty offices, and, as a result considerable periods of boredom. During these waits one had to learn to adapt to a new and strangely different concept of time, and one had to exercise considerable patience and self control in accommodating to many situations which could often end with frustration, when as so often happened, one felt that one had achieved nothing even after seeing the Minister or Registrar etc.. One had to attempt to understand the reasons for these situations, and then use them as constructively as possible. A true 'Learning Experience', to use the current overworked and jaded educational jargon.

ACCOMMODATION

This seemed to be one of the initial priorities to be tackled, and indeed one full year later it remained as one of the more festering kind of sores of the programme, with the final building still incomplete.

The buildings ordered were three small prefabricated wooden houses, one for the project director, one for the students, and one for the second assistant Canadian teacher. It took over three months to get permission to build the homes, following submission to the various authorities in Tororo, in Mbale, the site of Regional Housing Offices, and in Kampala, where the Central Housing Office is situated. Everyone had to give their opinion and grant their permission before the houses could be built. Next came the survey of the land once the building plans had been approved, and this again proved an

expensive and lengthy process, with visits to Mbale on at least two occasions, and payment for the procedure, for cement, markers, transport of the workers, and their meals and accommodation for a day, in spite of the fact that once they began, the actual work of surveying only took about three hours to complete.

The work of building actually began near the end of May and the promise was that it would be completed within six weeks. This was indeed an empty promise, and though the shell was complete and the roof in place by the beginning of August, when I went home on leave, in order to return with Doreen, none of the internal work had been begun. On returning in mid September it was with horror I discovered that nothing whatever had been done in my absence, and that the building was no further forward. Doreen had deferred her return, in order to celebrate the one hundred and third birthday of Mrs. Lilian Butler, but also because of a severe episode of bradyarrythmia while I was home, had caused her to feel unable to undertake the journey until she had recovered from this episode. However there were guests due, one of my previous Residents Dr. David Beach, and his fiancee Dr. Margaret Tromp, had arranged to visit and work in Tororo for a couple of weeks. It was hoped that the house could be completed by the time they arrived. This however proved once more to be a vain hope. The place was far from complete, and there was still no water or electricity hooked up by the time they had arrived. Therefore arrangements were made to take two weeks off and to visit Mweya National Park, by which time it was hoped that the house would be ready for occupancy. Once more this proved a vain hope, and it was only by dint of becoming very angry that the water and electricity was finally installed, and the house slowly completed while I occupied the place in its incomplete state. Not very comfortable, but it got the work done at last only a couple of weeks before Doreen's arrival in November. The process would have been speeded up each step of the way, and each visit to a municipal or government office, with a little 'lubrication' in the form of money. This was made clear on a number of occasions, however patience and perseverance it seems, will eventually accomplish the things one needs to get done, but it is very hard on the temper and self control. The reason which was always given for refusing to offer any form of bribe, was always that the project had to work with a very limited budget. This has eventually become accepted, and things do not seem to take as long to get done working at the local level now, though one gets clear indication that 'Quid pro Quo' in the form of medical services to be rendered when sought, will facilitate things in the future. It is of interest to note that the local word for a bribe is 'chai', the Swahili word for tea; the origin of this is probably the fact that tea, or extra food was one of the "perks" of a job in the old days.

The building of the students' house was still incomplete by mid February 1990, and therefore an ultimatum was issued that if it was not fully completed by the end of the month, the building of the third house, for the second Canadian doctor, would be cancelled, and alternative plans made for the project. At the time of writing, the end of February is still two weeks away, and the subsequent more regular record of events will chronicle the outcome of this threat.

It is indeed an ill wind that blows nobody any good, and the delays at least forced the trip with David and Margaret to Mweya Lodge. This game park is in the process of

rehabilitation, having been devastated by the marauding military during the wars, and the ivory poachers from Zaire had decimated the elephant population. We were singularly fortunate in seeing a large number of elephant, with their young, the herd is coming back very rapidly now from near extinction. There was one rather exciting incident which happened, when we were watching the herd of elephants with their young, and one matriarch suddenly lifted her trunk and trumpeted a warning that we were too close. Following this event, and just as darkness was falling the rain began, causing the road to become extremely slippery, and we slid gently into the ditch. Putting the car in four wheel drive did not seem to help in any way, by this time the darkness was complete and it was difficult to see. We were becoming covered in mud, and the car was filthy, however it was eventually discovered that someone had changed the freewheeling front axle to a fixed axle, and as a result when four wheel drive was engaged, the front axle did not engage. As soon as this was rectified, getting out of the ditch was easy. The current number of lions in the park is five, and we were fortunate enough to see three of them while on the boat ride. It is indeed an irony to think that this game park together with the others in Uganda, far outshone any of those in Kenya at one time, but the recent lack of personal security, and condition of the roads and accommodation for tourists has so degenerated that only a small handful of visitors is ever present in any of the game parks to-day, and these visitors, if they are not Ugandan citizens, are almost all in the country on work permits, and therefore not strictly speaking tourists in the ordinary sense of the word. At present the game park at Mweya is still well worth seeing, for a wealth of wild life, Uganda cob, hippos, elephants and birds are particularly spectacular.

There is no doubt but that the saga of accommodation is not yet over, the roof still leaks in places, so do the windows, and there will be more to come in the future chronicles of the project. One other item may be worth mentioning in this regard, namely the furnishing of the houses, which was agreed to be the responsibility of the Uganda Government. The under-secretary, one Mr. Abola, was to be the person to arrange this, and as things began to move, there was still no sign of the furniture, so I bought my own. However at this time a singularly attractive Ugandan lady, Rosette, has been put in charge of the furnishing arrangements. She actually came out to Tororo to visit the house and take measurements for curtains etc., so things look like they're happening in that department at least.

Insert written on the 6th June 1990:

This insert is being fitted in at the beginning of June 1990, and is to mention that the problems of accommodation are far from over, even at this late stage. (1) The students' quarters and the house which we occupy are complete except for the persistent leaks in both the roof and the windows, also the walls in certain places, (2) the students' furniture, which is one of the very few material things that the Uganda government is being asked to provide, had still not materialised. What this means is that the last few student rotations this year have been thoroughly messed up, as we were supposed to have one of them out here in February, and one at the beginning of this month, but with nowhere to live, we have had to alter the order in which they go through the various disciplines, and for the last three months of this academic year we will have to have two

of them working here at the one time - perhaps not altogether a bad thing, but it has been a thoroughly frustrating time to say the least.

The last house for the second Canadian doctor is now built, and having the plumbing and electricity dealt with at present. Again it is frustrating though, in that it was supposed to have been completed six months ago! The next occupant, who is one of our Memorial Graduate Residents by the name of Charles Gardiner, is not arriving till November, so I most sincerely hope things should be completed by that time.

TRANSPORT

The saga of purchasing a car is worth a mention. The local prices at the current bank rate of exchange are horrendous, but even when the purchase is with hard currency the prices are inflated considerably. It was difficult to get a permit for tax exemption, even though the vehicle will revert to the Uganda Government at the termination of the project. Once more the delays, and letters required between the Department of Health, and the Department of Finance, then the Inland Revenue created a strain on the temper. Meanwhile the transport I had been using was generously supplied by the Franciscan Sisters at Nsambya. It was a very tired but willing car, with a shattered windscreen, a lot of paint gone, and a temperamental engine, and which I named "Rosinante", while tilting at the various windmills in government departments. Finally permission to purchase without taxation was granted, then came the licencing: this was as farcical as anything else connected with the purchase. At a very considerable price, third party insurance is included, but it took two more weeks waiting for licence plates, as there were none in the country. Uganda it seems, buys its licence plates from Kenya, and because Kenya had not been paid for some time, they stopped delivery of anymore until the account was settled; so I waited. Whilst waiting, inquiry as to collision insurance resulted in the information that the cost was so high that I would have paid for the car again in four years at the rate they charged, mind it is probably a realistic charge if all accident claims were paid out. Finally the car, a four wheel drive Dihatsu 'Rocky' was on the road and paid for in late April, and with a brief christening ceremony was named 'Gandalf'.

So far the vehicle has given Spartan service, and taken me over many miles of rough roads with no problems whatsoever, I dread an accident or other crippling of the vehicle before the end of the project as replacement would be almost impossible.

ACADEME

The actual teaching project itself got off to a very slow start. Academe in Africa is as bad as or worse than it is anywhere else in the world, and protocol must be followed meticulously, even though ordinary communication by means of the telephone, typing, copying of notices or documents etc. is almost non-existent. Meetings are convened somehow, the notification being by messenger as a rule, and even this does not ensure

everyone knows that a meeting has been called, because academic offices are rarely occupied. The Faculty members being engaged in the making of money in their private clinics more often than they teach. Mind the salaries paid by the University are probably in proportion to the very little time academics spend on academic activities! Eventually the scheme for a three-year training post-graduate programme was presented to the Faculty as a whole, and all disciplines who would be involved had been briefed. Most disciplines wanted to have their say, and this delayed things further, until everyone agreed with the curriculum, and the means of evaluation, and was satisfied that the programme was no threat to their particular 'Turf'. It was now getting well on to the time when the first of the students should begin the programme, however it had to go before the Senate for final ratification, and nothing could be done till then. The Senate meets only once every two or three months, to add to the problems. However Raphael Owor, the very able Dean of Medicine, patiently advised that we start things moving, with as little fuss as possible, and have things ready to go immediately the Senate gave their approval. In a moment of folly I went to the President, and suggested that approval was almost certain, therefore we should just go ahead. The reaction was interesting, as I suppose nobody likes to think that they act as a 'rubber stamp' for decisions made at another level, and I was informed in no uncertain terms that approval of the Senate was essential to any decisions made regarding the establishment of new courses. So wait I did, and finally approval was granted, and the first three students enrolled in the programme. There were initially five who received approval to begin, however one student was offered a training programme in 'Medical Statistics' at a university in China, and took the offer. I wonder at times if he was in any way a witness to the violence and repression of the Chinese students. If so, he would have felt right at home after experiencing Ugandan troubles of the past few years, even though it has been only recently that there has been any student unrest to speak of. Medical statistics are a far cry from primary care, and I cannot help but wonder at the commitment to the discipline that he would have brought. It is a fact though, that travel is the aim of most educated Ugandans, a great number of whom try very hard to leave the country to work elsewhere, and seek by any means to leave to go on courses etc., hoping to get work permits while abroad; the 'brain drain' of all races from Uganda, has probably been greater than that from any other African nation. The other student who applied had been posted to a distant hospital near the Sudanese border, and it has proven impossible to reach him, even by mail, and though he has been notified on a number of occasions that he has been accepted into the programme, we have heard nothing of him for the past many months, neither has the government. What provokes considerable anxiety as to his safety, is that there has been fighting in the region, and recently one of the Ugandan hospitals in the area was bombed - perhaps it is not surprising that no mail gets there!

The students eventually began their course on the first of November, one in Tororo, and two in new Mulago Hospital, doing medicine and paediatrics respectively. There is still one minor hitch though, and that is that they are not yet registered as Post-graduate students, because of a typographical error from the Department of Health, which stated that they had been accepted to do the course of M.Med. (Master of Medicine) Private Practice, instead of M.Med Community Practice - the University, sticking blindly in its usual manner to formalities and protocol, refuses to recognize the degree of M.Med.

Private Practice! It is in the process of being sorted out, and will probably be featured again in the ongoing project diary.

The programme has had one or two interesting developments with regard to the people who are involved. First there seemed to be a 'palace revolution' in the university, and Dean Owor, who was one of the initiators of the project was ousted. It seems that the Deanship is voted on at intervals, and that even though he had been the Dean, and had taken the medical school through some of the most difficult years it is possible to imagine, when things eased up he was rejected. Dr. J. W. Mugerwa, who like Prof. Owor is also a Professor of Pathology, is the successor; at present he seems supportive enough, though he is very unsure of himself and a real stickler for red tape. It is not at all certain if this is a delaying or obstructionist kind of tactic or whether it is just a remarkably bureaucratic trait - time alone will tell.

GOVERNMENT INPUT

At the very outset the project required government support, and this seemed to be very genuine, as the need for 'upcountry doctors' in Uganda is very great. Most of the doctors are sent out into the world following an internship, with a two-year commitment to work in a smaller 'upcountry hospital'. It is known that the majority are pretty ill equipped to deal with many of the day to day problems they encounter, and have to learn things the hard way. The initial Minister of Health, Dr. Ruhakana Rugunda was the person in the Government who initially approved the scheme; he was a pupil and a great friend of Dean Owor. Shortly afterwards he was given the portfolio of Minister of Transport, but his successor seemed to approve of things on the advice of the then Director of Medical Services, one Dr. Kyabaggu. The structure of the Department of Health, or indeed any Government Department in Uganda, is interesting. At the most senior level is the 'Permanent Secretary', usually a civil servant of many years experience in a given department, then comes the 'Director', an 'Under Secretary', then 'Assistant Director' etc.. At the outset of the project the Permanent Secretary was a Mr. Ogola, who actually came from the Tororo area. He had previous overseas postings, and was the very supportive of the scheme, coming as he did from Tororo area. Then came a real upheaval because of alleged corruption within various government departments by senior officials, and a number of heads rolled, Mr. Ogola's included. This hiatus left us very worried, however once again the scheme seems to have survived particularly well, and the new appointment is of one Mrs. Freels, a Ugandan lady who was at one time the Ugandan Ambassador to Germany, very able and personable, and who also, with our sustained incredible luck, comes from the Tororo area! So the project remains well and truly afloat and swimming strongly still, with full support from the Government, and declared support, yet to be fully tested or trusted however, from the University. The changes in personnel in both the Government and the University make for considerable anxiety at times, and it seems the characteristic of a Permanent Secretary is not permanence, whatever else. Mrs. Freels, formerly Mrs. Owolo, is currently married to a most interesting German Internist, Dr. Jaques Freels who has been working in the main teaching hospital of the Medical school, New Mulago Hospital, for the past five years or

so. She seems to be one of the very bright spots on the horizon, and my impression is that she has a greater degree of altruism than the average Government official, and seems to be above the usual corruption which prevails at all levels. This is primarily due to the appallingly low salaries which are paid to all the Government employees in Uganda, and their need to make a reasonable living somehow or other.

THE WORK TO BE DONE

The work to be done in just dealing with illness which presents itself on a day to day basis almost precludes a lot of preventive work being done. Of course the most pressing problems as always get the most immediate attention, and most often the most immediate problems turn out to be surgical in nature. As a result there has been a heavy dose of surgery, first in Nsambya Hospital during the first six months period while awaiting the house to be completed, then here in Tororo, once the programme had begun, and finally in Kitovu, the Mission Hospital, where we spent some time, during the Christmas period. At Nsambya, the previous rash of bullet wounds that constituted the bulk of the surgical emergencies requiring attention, has slowed to a mere trickle, in fact I think I only saw one during the whole time I was there. In its place however, there has sprung up a terrible number of serious traffic accidents, very frequently pedestrians struck by passing vehicles. The injuries from these are always severe, and most often they are compound and multiple in nature resulting in a very long hospital stay. On the less traumatic side, the most notable features surgically speaking, are the AIDS-related problems; all kinds of infections from every possible source in the body, I have seen three psoas abscesses in young people, multiple cases of pyomyositis, which involve almost any muscular part of the body you could name. Then there is the ubiquitous pelvic inflammatory disease, which is definitely on the increase, and which is causing all kinds of dilemmas in treating. After trying a number of methods and techniques, the one which works best, I find, is simple putting them on an appropriate antibiotic and then waiting patiently until the temperature settles. Once this happens one can either drain the abscess which invariably results, or else try to deal with it in a more definitive manner, if it seems warranted. The next time that patient comes in, it is probably wise to let nature take its course. People are individuals, and I guess have to be dealt with individually, which is what makes it so very difficult to withhold treatment, even if it is the best course in the long run.

At Kitovu there were a few truly bizarre cases. One man fell off a truck, after trying to hang on to another one which was passing. He was whipped out of his own truck, and went under the wheels of the passing vehicle. On the way though, he totally de-gloved his penis ! This noble organ was left completely without skin, and the scrotum was torn off also. Besides these injuries he had bilateral fractured femurs, in fact he was in a general mess. The scrotum was also found almost hanging by a thread, and the penile skin, which had been avulsed from the glans was with it. It required considerable time and patience to put the whole thing together again. It healed quite well, but I lost touch with the man after I left Kitovu, and do not know how the organ works for other than the passage of urine!

Then there was the lady who was trapped under a car for a long period of time, and came in shocked, and bleeding into the pelvic and gluteal regions. She was quite unable to move her left leg on admission. Exploration of the injury revealed that she had de-gloved most of the skin over the lateral side of the leg, in that the skin and subcutaneous tissue was sheered from the underlying structures, and floating on a bleeding oozing mess of bare muscle. Once one went in to explore the situation it was found that the origin of most of the muscles arising from the pelvic brim were neatly displayed, with the some of them torn from their origin. It was felt necessary to examine the sciatic nerve, which seemed intact, and over the next three months she did in fact pretty fully regain the use of the leg.

Then there was the young man who was carrying a load of firewood on his head, and had slipped and fallen, breaking his neck, at the level C 1-2. He was brought in three days after the injury, completely and utterly quadriplegic, unable to move even his little finger. In spite of the lateness in seeing him, it was thought worth while putting him on traction, but whenever our backs were turned, his father emptied the water bag, and decreased the weight as a result. I understand from the doctor who took over his care that he took three months to die .

Then there was the small boy of 12 who was bitten by a puff adder. His leg swelled up grossly, then it went gangrenous, and finally required amputation.

Then there was also the young girl, who was accused of stealing, and who was tied up with her wrists behind her back, and toes barely touching the ground -I guess it is a form of the Spanish 'Estrapada torture'. She died within an hour of admission, and one can only imagine her agony before that.

All in all Kitovu proved extremely instructive in every way, and will probably be used as a training site for some of our postgraduate students, if they are independent learners. It is the 'gateway' of the AIDS epidemic in Uganda, as it was along the Masaka road that the 'liberating forces' from Tanzania came to oust Idi Amin, and place that arch rogue Milton Obote back into power. Again though, the gunshot wounds have been almost non-existent in Kitovu for the past couple of years now.

March 20th.

From here on entries in the diary will be on a more regular basis while events are fresh in one's mind, in fact this will be the start of the regular diary keeping; it will be interesting to see how consistently I keep up with entries.

We had been into Kampala and stayed at Nsambya with the Franciscan Sisters for a celebration of St. Patrick's Day, which was held in the Sheraton Hotel. At the Sherraton were about 300 Europeans. I never thought there were so many in Uganda, but they have been returning to the country at an ever increasing rate of late, since there has been a

measure of peace and security for the first time in years. It was a pleasant affair, with the usual Irish songs and dancing, and a very reasonable meal. At this function one met everyone one knew once again, the white community being still somewhat close knit in its makeup, and there were, as usual at these functions, very few Ugandans - but I guess St. Patrick doesn't mean that much to the majority of them anyway.

We left Kampala by about 9.30 a.m., and got home just after 1 PM. but on the way a small stone flew up from the wheels of another car and struck the windscreen of the car, knocking out a tiny chip from the glass. This seemed harmless enough on the face of it, however next morning, after a gentle rain through the night, the windscreen was found to be completely shattered, and fell out like large lumps of crystalised sugar. So off I went back to Kampala to get it replaced. On arrival the storekeeper was at a funeral, and no one else had the key, so I had to wait till 4 PM. before the windscreen could be replaced. The storekeeper remarked that he had been to more funerals in the past six months than he'd been to in his whole life before, explaining that they were all either relatives or good friends, and had succumbed to AIDS in one form or another. The windscreen was replaced with hardened glass, a laminated windscreen not being available, so I fear it will almost certainly happen again, the roads being what they are just now- It is the second windscreen to be replaced in the past three months, at 185,000/- a shot. (The current bank rate is 370/- to the U.S. Dollar.)

At this point it would not do to omit mention of one of the most major events of the project to date. We had three-day visit from a Dutch plastic surgery team sponsored by a group known as 'Interplast'. The group were hosted while in Kampala by Rotary International, and the local infant Rotary group here in Tororo helped to host them here.

They are a lively team, Dr. Rein Zeeman is the surgeon, highly skilled and a good and patient teacher. Guys Witte the anaesthetist, is an old Africa hand having practiced for a while in Kitale; he is totally unflappable, constantly cheerful and is completely at home with the E.M.O. machine. Maria Bakker is the theatre nurse, a happy sort of person, competent, efficient and able to improvise and tolerate all sorts of uncertainties. During the three days of their visit we did 13 cases, the majority being severe cleft palates and hare lips. Who says you can't teach an old dog new tricks? This old dog did three or four of the cases of hare lip, almost without help during the last case. There was a magnificent demonstration of what life in Tororo can be like on the last operating day. There was a terrific thunderstorm, and as so often happens, the lights went out, just as one of the kids was taken off the operating table. Then there came a distress call from next door, where one of the other doctors was operating on a ruptured uterus: the lady was only 22 weeks pregnant, by the way, and the foetus was lying free in the peritoneum, he was trying to sew up the uterus in the darkness. What was rather terrifying was that, because the emergency generator could not be induced to work, one of the nurses came in with a hurricane lamp where they were using ether as an anaesthetic. In the end a flashlight was eventually produced, by this time I had taken over the problem, and managed to finish the job just as the lights came back on again. In spite of this happening, we went ahead with the last case of repair of a hare lip. A tribute to Dr. Zeeman as a teacher is that he let me do the case, in spite of the fact that I took much

longer than he would have done to complete it. This is 'taking appropriate risks 'African style!' Their visit to Tororo culminated with a formal kind of dinner and 'disco' dance at the Rock hotel - speeches all round. Like most of us, the Ugandan Rotarians like to hear the sound of their own voices!

To-day the 'case of the day' was something I have never seen before: a primipara who had delivered spontaneously two days before, a child with features of anencephaly, and most of the brain tissue outside the skull thinly covered with the meninges already infected and smelly. We had nothing beyond sympathy to offer the mother in spite of the babe's obvious suffering. A case for active euthanasia if ever there was one.

For the rest, most of the kids with palates and lips which had been repaired last week were discharged home with utterly delighted parents. The children had all been cared for post-operatively in the female ward side rooms, as the sister in charge is the kindest and most reliable of the ward sisters.

The female ward remains a diagnostic challenge, even though all but four of the patients on the medical side have clinical AIDS - we have currently run out of reagents, and therefore cannot perform the HIV testing. It is of interest to note that the patients are offered 'counseling' by a lay group of citizens known as the TASO Group, before they have their testing done, and if they refuse we never know the result. The striving for confidentiality and anonymity in a small community is hindering in large measure our ability to look objectively at the medical aspects of this condition from a therapeutic or diagnostic point of vie, as the majority of the results are not seen by anyone except the medical superintendent, and then with no knowledge of either who the patient is or what were their symptoms and signs. All very difficult, and more than a little confusing and irritating. Then there is the problem of the lab assistants not wanting to do the testing, for obvious reasons, and looking for extra money for doing it. The pandemic rages on in this part of the world at an ever accelerating rate, and if a diagnostic problem presents which one has never seen before, it is AIDS until proven otherwise.

The admin block is to be painted by one Mr. Egnu, and he was supposed to have turned up to-day for a briefing. However, in true Ugandan style has not yet appeared on the horizon. The housing for the students is almost complete, the water having been installed to-day, though no electricity as yet. The firm building these houses (Casements) asked for further payment, their chief cashier having taken off for parts distant with large sums of their money, and left them almost bankrupt! However, until the housing is completely finished, because of the utterly unconscionable delays they have incurred, I have refused them payment till the work is complete.

A long day which culminated in one of the heaviest rains we've had for a very long time. However the garden needed it badly, both mine and that of the gardener, who has a large shamba to grow his foodstuff at the bottom of the compound. The poor old chap whose name is Francis, ate a chicken he owned which became sick, and the next day came down with an acute bout of food poisoning, with bloody stools, a bad stomach pain - the lot in fact.

March 21st.

Today's case was an extensive case of pittyriasis rosea, which I had never seen in a black skin before. It is remarkable how very silvery the scaling is to see, and how very well the condition shows up the outline of the soma distribution on a black skin.

Doreen and I finished unpacking the drugs to-day, very many of the badly outdated ones we had to discard. There exists a law in Uganda, that any shipments of outdated drugs will mean their destruction, but all other drugs, out of date or not, in the same shipment will also be destroyed.

To-morrow will be a heavy day, so far lined up following review in the female ward, are 2 hysterectomies, a possible bowel resection, a repair of a lower lip, and a removal of a huge cystic growth of the abdomen, which I haven't a clue as to its origin or nature. The lass for the lower-lip repair had it bitten off by an irate husband! I know what I'd like to do to such an animal like male.

Mr. Egnu turned up for the briefing regarding the painting job. Because of the dreadful habit of the average Ugandan so far who has been working to a contract which was agreed upon, to abscond with the money and spend it on something else, then come crying for more money, claiming inability to finish the work, because they could not now pay for materials, an agreement has been made with Mr. Egnu that I purchase the materials with him, and pay him the labour costs after the work is complete. This will be future policy from here on with all the contracts put out for the project·

March 22nd.

This has been quite a day! The operating theatre started almost on time, and they got through more work than I have ever seen them manage before. The cases for surgery were all quite fascinating into the bargain.

Case 1. An elderly lady who had what I thought was a carcinoma of colon, which was mobile enough, that I felt it worth removing. Her history was of increasing constipation with bloody diarrhoea for the previous few weeks, and recent considerable loss of weight. On opening the abdomen, there was a smooth mass in the colon which turned out to be an intussusception, the origin of which was a huge malignant polyp above the splenic flexure, which has intussuscepted right down to the sigmoid. It did require a considerable resection of the colon, but she stood the procedure quite well.

Case 2. Next the lip of the lady who had been bitten by her husband, who in his viciousness had bitten off most of her lower lip; this required a large pedicle graft from under the chin to be pulled up and inserted into the defect, a procedure really which went quite well all things considered.

Case 3. A large pedunculated mass of the lower abdomen proved to be an accessory mammary gland! I have a photograph of it before removal.

Case 4. Next there was a very large cyst, arising possibly from the fallopian tube, but invading the whole of the broad ligament. Very difficult to mobilise, and it had to be freed from the pelvic wall, with a nice dissection of the ureter. This is the second one of these I've encountered here. The right fallopian tube was closed, and seemed to be starting the same kind of process. It was opened, freed, and sutured next to the ovary on that side. It will be interesting to see if she does get pregnant after this procedure, incredibly slight though the chances are.

The next two cases were pyomyositis, which are probably AIDS related problems.

Doreen went to Kenya for the day with Joan Linnaker, the Salvation Army officer, who cares for the Lions Salvation Army home for orphan boys. They brought back two wood-burning stoves for the home. It seems to have been an enjoyable trip.

March. **25th** (Sunday.).

2 days ago, Friday, I wanted to get at the rest of the things in the trailer which have been lying in the store for some time now. Doreen and I finished sorting the drugs, but there is a lot of stuff yet to be sorted out and distributed. However, the Thursday list was not completed so we had to press on with a couple of cases in the O.R., one of which proved to be a real problem. What looked like a simple hysterectomy for a fibroid uterus turned out to be an impossibly adherent fibroid of the lower segment, with a hydrosalpynx on the left side, attached to the sigmoid bowel and deeply embedded in the pelvis. The uterus was mobilised, but without blood it was felt that discretion was the better part of valour, and she was closed with removal of the hydrosalpynx only. The rest of this day was spent with a chap from Johns Hopkins University, who is out here doing something to do with diarrhoeal diseases, though he did not manage to make it clear exactly what he wanted from us in Tororo, if anything, or whether he was one of the visitors who seem to come from time to time, sent out by the Department of Health. We had a visit from Dr. Matzemutu, a Japanese Professor of Tropical Medicine, who the Department of Health were trying to induce to become interested in putting up some money for trypanosome research. It seemed like a real snow job they were putting over the poor professor, and I feel that unless the whole of the trypanosome research programme here in the Tororo area is taken over by someone very competent, and who is willing to be on the spot in order to supervise the operation very closely, it will merely continue to be a lab wherein the people who run it do so for their own benefit rather than what it is supposed to be. At one time indeed it was one of the leading research labs anywhere in the world as far as trypanosome research was concerned. Now however, much of the local medical diagnostic work is done there, and the patients are charged for it by the staff. Very little significant work with regard to trypanosome research is done, or can be done by the present Ugandan staff any more .

Saturday morning spent in the garden, planting and getting things ready, after a visit to the hospital where one young lass was suffering from a horrendously painful and swollen leg. I guess it was because she was one of those who could pay little that no one brought her to my attention. She required extensive I & D, and debridement of the necrotic tissue in the anterior compartment of the tibia. An X-Ray shows a large bone abscess and osteomyelitis, almost certainly another case of the Pandemic we have here.

Poor Francis Onyet, the gardener is really sick. I had him down to the hospital yesterday, and all the signs and symptoms point to AIDS as the problem! It is such a pity, as he's such a good worker, and seems to enjoy working here very much. Time will tell, and then we have to decide what to do about it.

Sunday, today, a lovely day spent in the garden, planting all sorts of cuttings and cannas. Then trying to waterproof the windows and the roof. It seems that after the heavy rain the roof is leaking worse than ever - hopefully today's efforts at tarring the places which seem to be leaking will at last cure the problem. The rains have certainly been terribly heavy of late, with thunder and lightning which can be almost constant for an hour or more at a time. Last night we lost the lights quite early on in the evening as a result of the storm, and did not get the power back till late afternoon.

Doreen spent all day in Church to-day, she had to give a sermon, it being Mothering Sunday, on the subject of the place of women in the world to-day. I gather she 'wowed' them- at the second service the sermon took half an hour, as it had to be translated into Luganda!

We face a new week, with a teaching session in Kampala to look forward to, and I have to ask Bernadette Freels, the Permanent Secretary for Health to see about getting furniture for the students' house, or we cannot get Dr. Ndoliire out here yet.

March 26th.

Francis Onyet, the gardener has his pericardiocentesis today, and this produced about 200 ccs of serosanguinous fluid. He is looking very ill now and it seems certain that it is the pandemic from which he suffers. The average Ugandan has to leave home in order to find work, and their marriages are remarkable in that they spend long spells apart. The children are often distributed amongst relatives, who will look after the children while they perhaps attend school in one of the towns. As always the education in the towns is considered superior to that which is available in the villages. Interestingly enough there seems to be an occasional village teacher who is quite outstanding, and this person will often produce a whole lot of kids who are eager to learn and who will strive to get a higher education if it is in any way possible. Professor Owor, and his sibling and friends had such a teacher I believe.

Returning to the plight of Francis, he is a person who has worked most of his life quite hard, and at a variety of jobs. His last one was as an 'askari' - which is a Swahili word for a soldier, but which has come to mean any sort of peace officer or security guard. It is the fact that with almost every job he has had, he has had to be away from his wife and family, and even though he drinks no alcohol whatsoever, he is still subject to the other temptations of the flesh, and in Uganda to-day, this means almost certain AIDS. Thus it comes about, I guess, that he is now suffering with the condition.

One of the local priests, of the Benedictine order who has worked now for the past 11 years in the Tororo area, was recently arrested. He has been accused of possessing firearms. It seems that an automatic weapon was found in his premises, so he spent the next few days in jail. Since that time, he has been allowed free on the recognizances of the cardinal in Kampala, and has returned to work here. It seems that there was some jealousy within the church as far as an appointment to the priesthood was concerned, and the gun was 'planted' on his land somewhere, for the police to find. The upshot of the event so far is that he has to appear in Kampala every month, and has had his passport confiscated. Once things go sour in one of these projects, with the division of loyalties, and with the vendettas that are carried on it is probably wise to cut one's losses and get out of the situation just as soon as possible. However, in this case, there is a commitment of ten years, and a rather forceful personality who would find it very difficult to call it 'quits' and leave his work behind. Like so much in Africa, the success of a scheme so often depends too much on a single individual, and if this linch pin lets go, the whole thing reverts again to the status quo. I think this is how this person feels, and that his understudies are not yet ready to take on the enterprise alone. So he'll probably stay, and it will be interesting to observe the future developments as they unfold.

The past few days there have been shots heard quite frequently in the evenings. One of the episodes was rather serious, when the some of local people caught a soldier who had been stealing. First they buried him alive, then after finding out the names of a few others involved, they beat him to death. There is still this kind of lynch law in operation, and it can be more than a little cruel. When Doreen and I were working in Kitovu, we had a girl admitted, but she died within hours of coming into the hospital. This girl had been caught stealing, and the villagers had tied her up by the wrists, with her arms behind her back, and with feet barely touching the ground - a form of the Spanish Estrapada torture (see page 10).

Into Kampala this week for a teaching session, and stayed with Dr. Jacques Freels, a German doctor seconded to Makerere as a teacher of Internal Medicine. He's been here for five or six years, and in the process of designing and building a house for the Permanent Secretary of Health, Mrs. Owolo, a Ugandan lady who was at one time the Ugandan Ambassador to Germany. The upshot of this collaboration with the building was that they got married! There is no doubt that she is an extremely able and personable lady, and one of the government officials who seems to take the job seriously. The way in to Kampala this time was fraught with anxiety, as there is a gasoline shortage - one of the chronic and recurring events here, when it seems, Uganda does not pay for the storage facilities it uses in Kenya. Kenya then shuts off the tap, and the roar of Uganda traffic

still rapidly, as they have little in the way of reserves. It needed an hours queuing in order to get enough gas to get home again. Now I have an empty tank, with no gas obtainable in the whole of Tororo.

April 3rd.

A rather extraordinary day, in that I was asked to work in St. Anthony's, a Mission hospital which was founded by the European Franciscan sisters, and which has been handed over to be run by the African Franciscan nuns. It was a Dr. Nadjuka who had lined up a list of surgery for the afternoon and who had requested this, she is a nun who is one of the Franciscan Order of Sisters, who qualified in medicine last year. So many of these Sisters are a product of their time in Africa to-day, and I fear that many of them have a rather inflated opinion of their station in this life. Africans accord the religious orders considerable deference, which I suppose leads in turn to a rather arrogant attitude on the part of so many of the religious leaders in any Uganda community. Humility amongst the African priests, clergy or nuns is a very rare commodity indeed. As always there are one or two who are everything one could wish for in a religious person, and they certainly shine out when you meet them.

It is Dr. Nadjuka's first year in practice, and like all the graduates in medicine of Makerere University, she has to do a year in one of the 'upcountry' hospitals. It was convenient that there is a Franciscan convent here in Tororo, so that she can live there, while working in the Government hospital. But like so many of these situations, she was spending more time in the mission hospital than in the Government one, until there was an opportunity to learn something in the Government unit, when it was used to the full! Initially the excuse for non-arrival was that there was no transport to take her to the Government hospital, in spite of the fact one saw the other Nuns out in their cars quite frequently. There has been considerably more rivalry, rather than co-operation, between these two units, and of course it is based primarily on finances. It is ironic that once the Government hospital developed the capacity to do the obstetrics and surgery once again, the doctors who had worked out of St. Anthony's before, now found it was now much more of an economic proposition to work in the Government institution, and so the Mission hospital is going through a period of having great difficulty in attracting medical personnel to work there, and is recruiting volunteers. It is my hope that there will eventually develop a spirit of co-operation between the two units, and that St. Anthony's will look after the Obstetrics and paediatrics, leaving the other hospital to do the Medicine, Surgery and Tuberculosis, with emphasis on the AIDS prevention programme.

Anyway, back to the medical aspects of the day, and the cases Dr. Nadjuka wished me to help with. The first was a solitary sub-serosal fibroid which was attached to the lower segment of the uterus, and which proved the very devil to get a clear picture of the anatomy of the region, so distorted was it. The solitary fibroid weighed 1.5 Kgs, but eventually shelled out quite nicely. The next case was a 40 year old lady with an appendix abscess - a most unusual phenomenon in a Ugandan, who lived on a village diet: they so very rarely ever get appendicitis. The third case was a young girl of 22 who

had surgery for a tubal pregnancy, and ruptured ectopic in 1988 at Nsambya Hospital. She presented with a mass in the lower abdomen and some fluctuation in the old midline scar. An incision let out a welter of pus, and probing revealed a large abdominal swab which had been left inside her. The last case was a man with a dislocated shoulder, which he had put out of joint two days beforehand !

To-day the list was delayed because of rain. When it rains early in the morning, people just do not go to work until it stops, unless they have a car or other means of transportation. However when we finally got started I did the first hare lip to be done here since the plastic surgeons left us; it was a young boy of 10, and hopefully it will be a reasonable result- I did take some photographs beforehand, and hope to get some of the result later on.

April 9th.

Went across the border to Bungoma, in Kenya, to-day. Doreen stocked up with 'goodies' for me, for when she leaves in a few days time. The border is worth a word or two of commentary. There was a time, not very long ago, when the border between most of the East African countries was a mere formality, and there was no need for passports etc. for anyone. Now however, the border resembles many borders in Africa, where they seem to have learned all the tricks that were usual between the Eastern bloc countries and the NATO countries. Total madness, and the similarity between the Berlin wall, and the Kenya/Uganda border is more striking, because whereas in Germany it is a country divided, in Kenya/Uganda it is the same tribe on both sides of the border, with an arbitrary and artificial boundary. On both sides of the current boundary or border, there is all kinds of fuss and form filling to be done. All the Africans have to have a passport, and it is very difficult indeed for them to get one, evidently there is fear that they may defect or something, and go over the border. There was one very sad sight on the Ugandan side of the border as we went over in the morning, namely the presence of a mother and four young children being held in jail. They had almost no possessions whatsoever, and one of the police women had allowed the mother to sit outside the cell with the children. The poor kids were cramped and confined, but so good and making so little fuss, playing in an apathetic kind of manner. They were still there when we returned about six or seven hours later. Why they were being held heaven only knows, they certainly did not look to be of danger to anyone. The whole border issue is a problem, and it typifies the lunacy of borders between these or indeed any countries. Though the authorities on both sides are reasonably polite to most white people, they can be incredibly difficult with their own people, and make life very difficult indeed. On the Kenya side there was a man in the police station undergoing a rather rough kind of personal body search. The passivity of the people under the circumstances is quite incredible, and one wonders how they put up with some of the abuse they get.

April 14th.

Doreen left on the plane to-day. She'll be in England to-morrow, and in St. John's on Easter Monday- I can just imagine the welcome she's going to get. I must say that I am now looking forward to a break myself, as I find my irritability threshold is dropping rapidly, and I find that I am far less patient with the staff in the hospital, when they carry on at the snail's pace that is the norm, and when they can tolerate the level of dirt that is again the norm. A rest will perhaps restore some of the old equanimity that has been a major standby over the past few years, and this last one in particular. The toleration of all the unnecessary delays etc. caused by mindless red tape and what so often seems to be just plain stupidity, as well as the deeply ingrained attitudes towards time and cleanliness in particular, of a people just emerging into the so called civilization of the West, which make getting anything done by someone else a really major exercise in patience and tolerance is wearing thin. Yes, a brief respite will be very welcome.

April 18th.

The past couple of days seem to have seen a resurgence of the shootings. Easter seemed perhaps to have something to do with it, as many folk seem to use it as an excuse for a bit of a celebration which they enhance by imbibing too much alcohol, and the ensuing violence where guns abound leads to certain trouble.

The first patient with a gunshot to come in was admitted from Busia, near the Kenya border, shortly after we had done a resection on a man with the biggest volvulus I have ever seen; he required removal of about 7 feet of gangrenous small bowel. The former man was shot just above the iliac crest, and the exit wound was beside the spine posteriorly, the bullet traversing just to the side of the ureter, and perforating the mesentery of the descending colon - the bowel itself remaining intact - and almost brushing the internal iliac vessels near the aortic bifurcation. A very lucky man indeed!

The next patient shot was from Malaba, and was brought in the next morning in a wheelbarrow! The bullet had grazed his left anterior thigh, passed right through the scrotum, again just missing the femoral artery on the right, and finally ploughed into the head of the femur, shattering it. Right now he's up in traction, but miraculously his urethra is intact, and so far he's not needed surgical exploration.

The third one was a thief who had stolen a motor bike, and was shot while attempting to escape. They obviously aimed to kill by shooting him in the head, but the bullet entered behind his right ear and went right between the masseter and the jaw, and out below the zygoma! He was bleeding profusely on admission, and required the wound to be opened up in order to secure hemostasis, and to-day it is obvious that the facial nerve has been severed by either me or the bullet. This morning he tried to escape, in spite of his injury, and so they now have him handcuffed and chained to the bed. Incidentally, we have two other prisoners in the hospital who are also chained to their beds. I guess that Uganda's problems are far from over as far as gunshot wounds are concerned.

The treatment of prisoners is far from the most humane, and they are mostly living in conditions of filth and squalor which leave much to be desired. Not only that, they are quite uninhibited about the way they transport prisoners. When transferred, they are roped together, and on one occasion I saw a group of about 30 men all tied and bound together with sisal rope, being led along by a huge armed man with a large club, and behind them, a guard with an automatic weapon! When one goes into the police station where they may be holding suspects before transfer to the jail, one sees the police enter with a large pot of steaming unadorned posho, which they put into a tin plate, then the prisoners are herded in and they crouch down on the cement floor, and eat under the vigilant eye of a couple of armed guards. The guards do not hesitate to shoot, and in Entebbe one day I saw a prisoner about to be tried, who made a break for it, and was shot in front of me, just as he reached the other side of the road. A very crude and rough violent kind of justice seems to be the order of the day.

May 6th.

There has been quite a hiatus since the last entry, partly because we were getting things ready for Doreen's departure. She is leaving early, in order to get to the schools before they break up, so that she can bring them up to date with the project in a lively and more personal and realistic manner. Not only that, she can also take the school childrens' letters back, so that at last the schools can begin to correspond with each other, and the whole exercise of the school involvement should become more individual and vivid for each child who participates in this manner.

We had to discharge the man who was shot behind the ear, on the fifth or sixth post-operative day, because his 'friends' came round to the hospital, well-armed, and wanting to finish the job. They were only prevented by the armed askari on duty that night - I guess his days are numbered, because they'll get him in time. They certainly take their revenge killings seriously. It was much the same in 1985, when a number of patients were shot in their beds by members of the army, while recovering from illness or injury. The other day we had a policeman in who shot himself in the foot when he dropped a loaded pistol on the floor! Altogether there have been six separate incidents involving shooting injuries, intentional or accidental.

A couple of interesting problems last week, again surgical in nature. All to often it seems that one is getting trapped into dealing with the most urgent matters, which is always the surgical or obstetric problems, and they leave all too little time for the more important community matters. Anyway, one was a multiple fibroid uterus, where one of the fibroids, about the size of a 30 weeks foetus' head, had prolapsed through the cervix, and was filling the whole vagina. It was a hell of a job to remove it abdominally, but it did come out in one piece. Interestingly enough, when the procedure was almost complete, and the hysterectomy part was done, we had a visit from Dr. Maura Lynch, one of the Sisters from Kitovu, where Doreen and I spent Christmas last year. Maura came in to witness the final stages of the surgery, she being on her way for a little break in Kenya, and was duly impressed at the general state of a government hospital! The Government

hospital in Masaka, near the mission hospital of Kitovu, is a complete shambles. There was one incident when a patient was admitted, and they could not find a doctor, so they got in touch with the senior medical officer, who refused to come, as he was not on call. The patient died that night, and proved to be that same senior medical officer's brother!

The other case was of a typhoid ulcer which had perforated. It is the first one I've seen this time in Uganda, though the last time there was a mini-epidemic in Kampala when I was working in Nsambya Hospital, probably water-borne at that time, because the year before they had the serious outbreak of water-borne cholera.

May 15th.

Doreen's letters are beginning to arrive on a regular basis, that I am missing her may be judged by the fact that I reread the first letter four times the day I got it! Anyway, she's got a busy schedule of catching up, and clearing the decks for schools, Medical Students, and the Residents who will be arriving in September. One certainly does get a bit starved for 'cultural stimulation' when living alone. The culture gap is a bit too wide to be bridged when discussing things with the average person in Uganda, and this is in no way being derogatory of their abilities, it is a matter of the profoundly different cultural programming, and lifelong interests which go to make up the background of each of the races. At work, though on the face of it there should be very little or no difference in the goals or objectives as far as treating or preventing illness is concerned, one is constantly aware of a tremendous difference in priorities, attitudes, and general outlook. There seems to be a fundamental difference in the concepts and perception of exactly what illness is or why it happens, and one is increasingly aware that staff and patients alike want to blame something or someone for illness or injury alike. Examples are numerous, and one finds that someone injured in say a bus accident, will look for the influence, spell, call it what you will, that caused the accident. The driver may have been speeding, but that may not be viewed as the cause, and the patient may seek advice from a local healer as to who put on the 'spell' or evil influence which caused the accident. This attitude is deeply ingrained it seems, and the majority of Ugandans seem to consult the local healer first, and then when this fails they seek help from Western type of medicine. That they consult their local healer is often readily apparent, as the site of the pain or discomfort is readily discerned by the small scarification marks which the healer makes in the course of his treatment. I have witnessed these 'therapeutic marks', and everyone calls them that, on the immediate families of qualified physicians, wives and children, and even on the doctors themselves.

A word or two on the attitude towards dirt is worthwhile. Musseveny, the current President, is said to have remarked that the majority of Ugandans have lived with dirt since they were born, and therefore don't notice it. I guess that, it is true, as is the case with so many people here, when one is born in a village, where almost everyone lives in a mud hut, and where the school is little better, with no running water, and little in the way of obvious toilet facilities. Water itself is almost a way of life, and from their earliest years, the majority of Ugandan children have to take their turn to go and fetch and carry

water, little is then used for the purposes of cleaning, the priorities being cooking and drinking. Dirt and the cleaning of it is non-existent for the majority of people, simply as a result of their poverty, resulting in the kind of upbringing that breeds these attitudes.

When these are the attitudes which prevail amongst those who are responsible for the operating room, the anaesthesia, the nursing and the general level of patient care, the results are incredibly difficult to influence. In any case, to compound all these problems, the recent anarchic state of the country left the majority of hospitals totally without any effective means of carrying out their work; they were looted, and left without electricity or water. Drugs and simple cleaning materials like soap were not supplied, so a devastating kind of inertia set in. The aftermath of this is still very apparent, and as already mentioned, the wages paid by the government are simply not enough to live on. It seems to me that in most things in this life, when the people themselves want to change, then they will, and not before; in fact to try coercion can be totally counter-productive. So when the majority of people involved in the delivery of health care, or those who attempt curative medicine, are educated to seeing dirt, and understanding its implications, then perhaps they will want to change. In the meantime, one can merely point the way, teach and demonstrate as best one can, what cleanliness etc., is all about!

June 3rd.

Again a bit of a hiatus in the diary, owing primarily to having to spend last week in Kampala in order to arrange for the second year teachers to be aware that their students begin the surgical and obstetric rotations in October. I went over all the objectives etc. with the two faculty members involved. For surgery we have Mr. Kahwa, who though he is a neurosurgeon does seem to have an idea as to what it is all about. He will be coming out to Tororo for a couple of days to see the set up, and get a feel for what is needed, and the scope of what needs to be taught in the field of surgery. Charles Matovu is the person who will be responsible for obstetrics and gynaecology, and he also wishes to spend some time out here. Both of them, thank goodness, agree that a limited time only need to be spent in Mulago Hospital, and that the students should be given a good bit of their experience in Rubaga and Nsambya Hospitals. I must say that I did anticipate having to fight for the students' right to be sent to the hospitals where the majority of the surgery and gynae is being done on a regular basis. It will be time enough to use Mulago hospital for post-graduate training when they have a functioning operating room and staff to man it.

A word about Mulago Hospital may not be out of place at this point. It was a gift from the British at the time of independence and was an absolute showpiece. It was the teaching hospital for Makerere University school of medicine, and probably the foremost training hospital in all Africa, with a full complement of students, and their teachers and faculty. There was active research going on into many aspects of medicine in Africa, and the graduates from Makerere school of medicine were accepted all over the world, and were able to get medical jobs with very little difficulty anywhere. Then came Obote, followed by Amin, and standards fell in the most incredible fashion. Somehow or other

the university graduated students annually, though they got less and less teaching as time went on. Finally in 1985-86, things probably bottomed out, and the conditions simply could not get any worse. The hospital was without electricity most of the time, and all the electrical fittings had been looted. There was no water most of the time, and what little there was had to be carried by hand, and this is a seven story building! The sewerage system had completely broken down, and the stench was awful most of the time, particularly in the childrens' wards.

As regards the faculty, their salaries were so completely unrealistic that they had to spend the majority of their time doing clinical work in their offices almost exclusively, in order simply to make a living. Students taught each other, and it was a case of the blind leading the blind most of the time. In short the most astonishing thing is that the medical school even managed to survive at all.

Currently, the hospital is having extensive rehabilitation work carried out, and there are now the basic things like water, sewage, electricity etc. in place once again. The salaries of the faculty and staff are still totally unrealistic however; though recently it is becoming evident that gradually at last there is some teaching by the faculty beginning again. A number of expatriates are now once more assisting in the teaching programmes, and the students are hungry for any teaching they can get from anyone who will spend the time of day with them. It is ironic that of the total health budget of the country, Mulago hospital gets the real lions' share of the government and external aid money. One source quoted Mulago Hospital as getting more than 65% of the total health care budget of Uganda!

Enough of Mulago, like many teaching hospitals it is an impractical hospital for giving care to a reasonably large number of patients, and one cannot help thinking that the developing countries ought to think of the small to medium sized hospitals as their primary training resource, with a level of technology applicable to the both the patient needs and the amount of money available.

Case of the week this time was a prolapsed rectum in a male aged about 35. It was enormous, and he resembled a large male baboon, with the maximum sexual display apparent. It was reduced under general anaesthesia, and a large stitch put in place, because the rectum was so large subsequently that it almost admitted a fist! The whole of this procedure was carried out in St. Anthony's, the local Mission hospital in Tororo, but they were very cross about his behaviour, because he 'ran away' after only two days in hospital and disappeared into the bush from whence he came, without paying his bill, at which the staff were duly indignant. The follow up of this matter will be of great interest, as he will almost certainly require a resection, if a permanent cure is to be aimed at!

June 6th.

Quite the week so far in the clinical sense, with a lot of trauma of the 'beating up' kind. First a child admitted with a large gash in his scalp, which when lifted revealed a

piece of wood sticking out of the skull!. This required removal. At first I tried with local anaesthetic, however, as the child was only six, and shifting the piece of wood proved more than he could tolerate, he was finally given a light general anaesthetic. The piece of wood measured four by one and a half inches, and it was all inside the skull, only the tiniest piece sticking out. It could not be simply pulled out, and required a considerable enlargement of the hole in his skull before it would come out easily - then it bled, and further extension of the opening was required in order to catch the bleeder, and stop it. Next morning the kid was fine, with 'not a feather out of place' it seemed - he's still doing well.

Then there was the man brought in having been beaten by soldiers, with a long linear fracture of his skull, and seemingly no obvious defect. He is in hospital being watched at present. Then to-day another was brought in with a hemiplegia and resulting flaccid paralysis of his right arm and leg. There was no obvious external injury whatsoever, and his family could not afford to get an X-ray taken of the skull - the injury having been done two days previously! The X-Ray technician treats his machine as a pure business venture of which he holds the monopoly, and is quite adamant that he will do no X-Ray without cash on the barrel head. Mind, he has to purchase the X-Ray films out of his own pocket, the government supply only lasting about four or five days of the month. Anyway, after that little aside, which typifies the very mercenary approach to all medical care by health professionals in the government service, on to describe the outcome of the problem of the man with the hemiplegia. His pupils were equal, but because the onset of the paralysis seemed to be slow it was felt that he had a subdural bleed, and that we had better have a look see, X-ray or no X-ray, so the scene was set to do the procedure in the afternoon. However, when we came to examine him again, about four hours after admission, he could move fingers and toes, so the case rests at present, and we are awaiting to see what happens.

Then there were the two thieves who were admitted late one afternoon, and no one was informed of the fact till the next day. One of the nurses told me that she knew they were part of an 'international gang of criminals'! I am not altogether sure that she knows what exactly an international gang of criminals comprises. This pair it seems are notorious locally, and were caught by the police and taken into custody. In the course of the arrest it seems that one of them was shot in the buttocks, and has a huge gash across the gluteus, and the other was struck with a panga above his left knee. They were held in remand for eight days before being brought in for medical care, and as a result their wounds were filthy and septic, having had no care of any kind, nor were they allowed anything to wash with. As a result, they stank to high heaven on admission, and three days later, though the wounds are a lot cleaner, they are still grossly infected. This I am told is 'par for the course' for anyone wounded in the act of stealing, and is 'part of the punishment'. Furthermore, now that they are in hospital, they get very little in the way of compassion from the medical staff, drugs being withheld if they cannot purchase them, and they are not given beds, but sleep on the floor, and generally are made to feel terribly inferior and disliked by everyone. To get the staff to see them as human is very difficult, but I suppose that the average Ugandan has been through so much at the hands of thugs and thieves, who rob with violence mostly, that it is an understandable attitude on their

part. I can see it is going to be an uphill job to get any treatment for this pair over the next few weeks. Not only that, but there is an armed guard outside the ward who tells me that he would not mind one bit if he had to shoot either one of them.

June 15th.

This week has flown past, and the last entry was on the 6th June, but a lot has happened since that time. The kid with the piece of wood in his head went home, none the worse for his experience it seems. The two thieves are still having their wounds 'treated' by the staff, who have had them outside at the time ward rounds are done, so that they are apt to get overlooked. The man with the panga wound of his leg, is going to have a plaster cylinder put on it, to the chagrin of the ward sister, who announced that it would be a good thing if he ended up with a crooked and stiff leg, he would not be able to run away if detected stealing again in the future! This pair get little sympathy from the ward team.

The man with the hemiplegia finally ended up two days later requiring a burr hole in his skull, and we found a very large haematoma, with some active bleeding still apparent from the middle meningeal artery. This was dealt with, and two days later he was walking again, the remarkable powers of recuperation of the average Ugandan are really quite phenomenal, and they literally rise from the dead when severely ill or injured. However, with a mortality rate of more than 25% in the first 5 years of life, it has to be the fit who live to attain adulthood, and the powers of recuperation remain, often in spite of the poor diet, poor water supply, and lack of any of the usual convenience or comforts of adequate clothing and shelter.

The Friday afternoon we did the burr hole, we had two cesarean sections of the more horrendous kind. The first lady had a ruptured uterus, with the tear extending right down into the cervix on the right, and this we had to do without the benefit of blood, but again she survived. Interestingly enough she had four previous pregnancies all delivered at home with no difficulty, but on this occasion she took 'mumbwa', which I am sure I have already mentioned as being one of the herbal medicines prescribed by the traditional healers when labour seems to be prolonged, and the substance is a most powerful oxytocic giving contractions of extreme severity in some women. The second cesarean section was for a 'failure to progress' with the head jammed deep within the pelvis. She had been in labour four days and that afternoon she took a dose of 'mumbwa'. The baby was dead in utero, and by the smell must have been dead for more than 18 hours, and the head had so pressed on the anterior cervix that it was almost gangrenous, and very difficult to sew together, and know where the cervix was and the bladder began. Again she survived thank goodness. However that night one of the other doctors resident in the hospital, was called to see a mother who was in labour because of foetal distress, and so he did a section right away delivering a healthy son. The father in this case is a local school teacher, and is now left without a wife, as she died following the procedure because of an incompatible blood transfusion it was thought. It is of some interest the staff did not inform me of this maternal death, and I heard of it outside the hospital; I am

not certain whether they did not think it was of sufficient interest or importance, also their reaction when I asked about the case was that he will marry again as soon as possible to get someone to look after the child, as it seems that he is not in his own tribal district, and his relatives are at present unable to travel, being in one of the relocation camps that have sprung up beyond Soroti and north of us, where 'rebel' activity has intensified of late.

These relocation camps are an attempt on the part of the government to contain the activities of the rebels, who are marauding and ambushing army units in order to steal the weapons and ammunition from the soldiers. The rebels live by the gun and they feed by robbing the villagers and small land holders, and terrorise them into providing food and shelter when they need it. If the villagers act as informers to the army, other rebels come and seek vengeance, and if they harbour the rebels, the army will abuse them, so they are in a dreadful position, of having little choice of action, and being plundered by both sides. These relocation camps are very little publicised, and I have heard nothing on the radio, nor have I read anything substantial in the papers about them, which is surprising, as the Uganda press is pretty vociferous and not in any way muzzled - in fact they seem to thrive on living dangerously.

We have had the first results of relocation in the hospital recently, in the form of a starving child and his father who 'escaped'. It does seem that the people in the relocation camps are watched pretty closely by the army, and are not allowed to go to their villages to grow or cultivate their land, nor are they allowed to travel elsewhere. They are promised food by the government, who are supposed to bring in their supplies, but again the passage of these supplies is by no means evident. The father and son who were brought in were emaciated, and are the first victims of true starvation that I have seen in Uganda since I came. Kwashiorkor is still seen, but is more in the class of malnutrition rather than starvation; this child had the sunken eyes, scaphoid belly and inertia of simple lack of food. I have a feeling that there will be real trouble brewing in these camps if nothing is done very soon, already relatives of these people who live in this area find that they cannot contact relatives, and it is doing neither Museveni nor his army any good to continue this kind of treatment of such large sections of the population, because one hears the beginnings of rumblings on all sides in this eastern region of the country, i.e.: non-Museveni territory.

Today the surgery was done at St. Anthony's, the mission hospital where Dr. Nadjuka works. The main reason for going there was to try to close a small exomphalos in a baby, and having done this, we were then faced with an elderly man who presented with sigmoid volvulus, which last year someone had resolved surgically, without doing a resection. This is a truly Ugandan phenomena, and I have I hope some photographs of this one. The condition is by no means infrequent, and usually happens in men after ingesting a large quantity of matoke, a variety of banana plantain. Technically the operation is not very difficult, but is quite spectacular and dramatic to witness for the first time. The sigmoid can be up to four feet in length, and of very large diameter, and gets blown up like a motor-car tire. When resected it can weigh up to 10 lbs, and is full of liquid, which is blood stained if there is delay in performing the surgery. One really feels a sense of achievement after resecting one of these sigmoids!! Again, recovery is

surprisingly rapid, as long as they come within the first 24 hours of the volvulus happening, and after that, morbidity rises rapidly with any further delay.

June 18th.

Today Francis the gardener went home to his village, it was rather a sad event, as he has been working here for the past six months, and a couple of months ago he developed the pericarditis which signalled the end of his working life, and in fact it is now in the more terminal stages of AIDS. He had a pericardiocentesis done on three occasions, and each time it returned faster than before, and he also has a large amount of ascites to go with it now, and can hardly walk the length of himself. During the last six weeks, he's been seeing one of the local traditional healers, but for the first time the other day, he has recognised that the end is very much in sight, and that there's very little that traditional or western medicine can do for him now. So we put him on the bus with all his worldly goods tied up in a couple of cardboard boxes, and sent him off to his village just beyond Soroti. He was talking of seeing his mother, not his wife, children, brothers or sisters, just his mother! She has married twice, her first husband, who was killed in the troubles, was Francis' father, but he rarely spoke of him, as I believe he was too young when he died. His step-father also had a number of children, but these step-brothers, once Francis was no longer earning money, did very little for him, and kept clear of him altogether these past few weeks. I have had experience in the past of some of the Ugandan men being very attached to their mother in a rather touching manner.

So Francis has gone out of our lives, but he will certainly be remembered, and a few weeks ago I did write a poem entitled 'Victim' as part of the series of 'Ships That Pass in the Night'. This was largely based on his remarkably phlegmatic acceptance of life's unfairness.

One other odd event, the man who is acting as 'askari', or guard over the building contractor's timber and other material which is littered round the construction site, asked me to circumcise him, with the statement "This is the year for it". He is a member of the Bagisu tribe and in his mid to late 20's I would estimate, and in no need whatsoever of a circumcision on medical grounds. When I pressed him on the matter, he told me that on even years, about the month of August, a band of those males who have been circumcised get together and roam the country looking for their tribal brothers who have not yet been circumcised, and if they find them, they do it forcibly. He describes it: "They hunt in a band and if they get you, and find you have not been circumcised, they just cut you and leave you! They beat you up if you flinch or show pain while they circumcise you". I asked him how many people died, and he said some do, but a lot of the others get badly infected with some pretty drastic results, and I guess this explains some of the rather mutilated looking organs which have been presented for viewing and inspection, with a request to "tidy it up". I thought these were circumcisions done in childhood, and messed up a bit, and it also explains the shyness and reluctance on the part of the owners to actually tell me exactly what happened to them. He has been booked to

have the procedure done in a weeks time, as I am going to Kampala on a teaching session this week.

June 28th.

Again a bit of a hiatus in the write up. Since the last entry I have been into Kampala for a teaching session, and while there I arranged to have Mr. Kahwa come out to visit Tororo for a few days; he is a neurosurgeon, and is the person who has been designated to undertake the supervision of the surgical training block in Kampala. However when the time came for him to arrive, he did not turn up, and it was only yesterday that I was told that the reason was that his wife fell ill, and he had to stay behind. Communication still remains a major obstacle to overcome in Uganda. I had also arranged for a Dr. Matovu to visit us this week, he being the person who will be primarily supervising the students' obstetric experience in Kampala. He arrived in his own car, a rare possession even for a doctor here in Uganda, and stayed at the 'Rock Hotel'. I felt that it was important for these teachers to have some experience of the conditions which prevail in the outlying areas. While in Tororo we got him to do a couple of rather difficult hysterectomies, and on this occasion I took the chance of closely observing and watching the locally trained nurse anaesthetist at work, and was quite pleased as they are doing pretty well on the whole. For the first time in the operating theatre we had the cardiac monitor going for the two operations, and it certainly makes for a greater sense of security in these long cases. Dr. Matovu said that the set-up is equal to Mulago, in fact a whole lot better, as we had a working theatre which could respond easily to emergencies. He mentioned that Dr. Kahwa had tried to phone and let us know he was not coming the week before, but found it impossible to get through to us. As already remarked, communication is impossible unless one actually goes to see about things in person. In fact the trip in to town on this occasion was to choose the new candidates for places in the first year of the training programme this coming October. However the officials from the Department of Health, who feel that they have a big stake in the training programme, were not present. I am not really certain whether they did not know about the meeting, or whether they did not get the notice of it. The upshot was that the meeting was cancelled and will be held to-morrow, which means a whole day wasted from my point of view. It will be interesting to see if the Department of Health officials do indeed turn up, because this time the meeting is scheduled to take place on a Friday, and members of most Government departments are notorious for their absence from their offices all day on Fridays.

The Community Practice Training Programme is the only one of the post-graduate training programmes which is oversubscribed this year, and in fact so far we have eight applicants for five places. On paper the applicants all look good, including one who was trained in the Soviet Union; his University transcript looks good, and he achieved 'excellent' in his evaluation in both Russian language, and Socialist Doctrine. I think he will be one of the most interesting ones to compare with his Makerere trained colleagues if he is selected. We also have the first woman to apply to the programme, for which I am grateful, as I think they will add so much to medical services outside the

larger centres of Uganda, and perhaps balance the more aggressive attitudes of the males. So the final few weeks before I go on leave will be very busy ones, making out timetables and plans for the whole programme for this coming academic year.

The need for clinical training in greater depth and breadth has been so well demonstrated this past year working in Tororo. Nowhere is this more true or obvious than in the discipline of obstetrics. The problems one encounters in obstetrics are more often than not neglect at the very primary level, and when patients are admitted to hospital, they are often in extremis, and need the most urgent and frequently 'heroic' kinds of medical intervention. However, there is an attitude change on the part of many doctors that is also required. It is all too frequent that some doctors will 'bite off a little more than they can chew' at times, or will do things without asking for advice or really taking the trouble to get a good history, as demonstrated by the following cases. One of the doctors who had been graduated at least four years, has performed at least two laparotomies to my knowledge, on women with swellings in the lower abdomen, which at surgery turned out to be nothing more than a normal pregnant uterus. Then there is the matter of leaving swabs behind in the abdominal cavity. There are some circumstances where it is quite understandable that this can happen, such as the times when there is a power failure in the middle of one of the more bloody kinds of procedure. However the three case I have encountered so far have been fairly routine kinds of problems, and the only excuse is that there was no swab count. It is the attention to the basics and the important details which is so lacking in such vital matters as swab counts, sterility in preparing and setting up for operations, care in autoclaving instruments, the failure to supervise the cleaning of the theatre properly, together with a general lack of being able to supervise the staff by those people in charge who should be doing this.

This business of supervision is interesting. On the whole the Ugandan people seem to dislike giving orders to each other, and have difficulty in correcting faults in the performance of the daily duties of any subordinate. As a result there is an almost universal kind of 'sloppiness' which is accepted in the performance of so many tasks, and which seems to be tolerated by the people who are supposed to be in charge; this results in a standard that would be totally unacceptable to the majority of people working in the same situation or position in most Western societies. Whether it is the insecurity of tenure of any position of authority, or whether it is a cultural attitude which makes it difficult for them to give orders to other people, and carry out any kind of truly rigorous supervision, I find it very difficult to tell. Many people in authority may be at times the victims of the whim of those above them, and it seems that they may loose their jobs and be replaced not on grounds of incompetence, dishonesty or for any other reasonable cause, but more likely on tribal or political grounds, a fact which is probably more obviously apparent for people who have political appointments.

July 16th.

Recently, as previously mentioned, I have had a rash of circumcisions to perform on adult males, all at their own request. I could not understand why this should be for

quite a while, until one man explained it. In the custom of the Bagisu tribe force is always implied because if the person does not consent then it is done without his consent, but they have great admiration for the man who does not flinch during the operation. Anyway, I did the operation on quite a few of the people who came to me requesting that it be done on them, but the last one I did, they redid!! It seems that they feel that the victim must suffer, and should not be allowed to go about with trousers on. It is the custom that he wears a loincloth which looks like a skirt, after the event. I asked Dr. Wabomba, who is one of the Bagisu tribe, why they recircumcised this man, and he said "Because not enough skin was removed by you.". He then asked me if I wanted to see one of these done, and at that very moment, there came to the front of the hospital, a whole crowd of people dancing and singing, with one guy whose face was all smeared with white paste like substance. This was the candidate, and the tribe were getting themselves all geared up for the event which was to take place the next day. So I agreed to go with Dr. Wabomba to witness the event; he asked if I would take some pictures of it, so I consented to do this. Well, what a carry on! I'll try to describe it briefly: relatives and friends form quite a crowd, and they go round the town first singing and dancing, and generally working themselves up into a frenzy. They do this with feasting and drinking for a couple of days, then on the day appointed, the time having been settled on beforehand, they finally come to the appointed spot, which has usually been well advertised before the occasion, so that there is always a considerable crowd of onlookers, including women and children, waiting there. When I got there, they ushered me right to the front so that I was standing beside the 'surgeon' who had his knife at the ready. The 'surgeon' by the way is unknown till the actual event, and arrives only minutes before the candidate finally appears. When he arrived, he was still dancing more wildly than any of the others, in a real lather, and still his face decorated with white paste. His trousers had the crotch cut out, so that all he had was on full display, and literally waving in the breeze. He came to a halt in front of the surgeon who then carried out his part of the show with astonishing rapidity - it was done in under 10 seconds! But, and here's the most astonishing thing, they make the circular cut about half way along the shaft of the penis, take all the subcutaneous tissue away, and leave almost no mucous membrane near the glans whatsoever. They then leave it to heal by itself, and I gather it may take well over a month or two in the majority of cases. The occasional person dies of tetanus or some other infection, and sometimes one of them will bleed to death. This chap hardly bled at all, and he did not flicker an eyelid while it was being done; the crowd thought him a great hero. All very barbarous, and a great crowd-pleaser, judging by the number of witnesses, but one feels that it is all rather reminiscent of people watching an execution or some other blood sport. The reason for the custom, I am sure, is a form of menstrual envy. In many primitive societies, they recognise the fact that it is menstruation in women that is the real life force, and I suppose that a little genital bleeding for a month or so by males shows they can do it too. There can be no other rational reason for such a barbarous display. The Bagisu tell the story of one of the Air Uganda pilots, who was well above the average level education, and who did not live in their tribal area, but had a home in Entebbe. It seems that they went in a group to Entebbe, warning the police not to interfere, and forcibly circumcised the poor man one night. The whole event has made a deep impression on me, and if I do any more circumcisions surgically in any of the Bagisu, I will certainly know how much of the prepuce I have to remove to satisfy the

tribal custom next time! However, I fear that if they are circumcised in a proper surgical manner, and sutured, that the tribe will certainly want to remove the sutures if they find out that it has not been done their way.

Back to the project then, after that little diversion. Since the last entry there has been quite a hiatus, but a couple of most encouraging and interesting events have taken place. First there has been the meeting of the Postgraduate Studies Committee, who spent the whole of one day deliberating over the entries to the various postgraduate specialty training programmes. To my astonishment there were no less than 12 applications for the Community Practice Programme; I finally settled for six of them to enter the training programme this year. Not one of the other programmes had anything like their quota of applicants, in fact Internal Medicine had only two. It was a meeting with a fair bit of acrimony between some of the individuals there, and it was most interesting to see the academics in action. Most of them are older, and were trained when things in Uganda were very different, but most display a rigidity that is worrying, in that they are pretending that all is well, and that their programmes are all in order when such is far from the case. The teaching time given by the majority of the Faculty is really totally inadequate, as all the trainees will tell one. Not only that, but they try to teach as though all the facilities that were there at one time are still in place. That is when they do actually teach, they teach with reference to lab tests and investigations that are not obtainable, and recommend treatments that cannot be carried out, with drugs that one cannot get. The Faculty seem to ignore reality in a Grand Manner, and function in the old pompous fashion in which they themselves were brought up. The real tragedy is that the actual time spent in clinical teaching by the Faculty is still an absolute minimum, with the excuse perhaps that what they are paid for teaching is laughable, and after all, they do have to make a living which they do in their private clinics, with no students to witness or be present to benefit from their skills.

All in all this Postgraduate Committee meeting was most instructive, and also highlighted the annoying difficulties in communication which is a constant still in this country. I went in to Kampala on Wednesday to attend the meeting which had been scheduled for that day, notices having been sent out two weeks ahead of time, only to find that the Government representatives were absent, disclaiming all knowledge of the meeting, the only government representative present saying that the others had not been informed. In the end the meeting was rescheduled for Friday, and after I had personally delivered the letters to the various offices of the Government officials in Entebbe, there were sufficient people to make a quorum. Friday was not a popular day, as the week-end for most government officials begins on Friday, and most of them do not get back from their villages until very late on Monday morning !

The other heartening news is that McGill University has sent three of their senior representatives in their International programmes to offer aid to Makerere, with a promise of assistance and CIDA funding. They are proposing links with the Department of Internal Medicine, and Public Health, and have suggested that over the next ten years or so, they send Canadian teachers to work in Makerere in order to strengthen these Departments, and build up a reasonable teaching programme once again. The three individuals concerned were: Dr. Creuss, their Dean of Medicine, Dr. J. Dick MacLean,

the Director of their Centre for Tropical Diseases, and Dr. Yves Bergevan, their International Programmes Director. In just two working days, they had managed to meet with all the important people in both the University and the Government, and get Letters of Intent signed to take back to Canada. This is a real feat of communication and co-ordination by Professor Mugerwa the Dean of Medicine at Makerere. Mind, it needed a lot of communication between McGill and myself in order to get things moving in the first place, as the Dean in Makerere has no phone, no access to Fax, and the mail to the campus is erratic, because though it gets to the University, it does not get distributed to the addressee till the spirit moves one of the runners or people who are responsible for the actual delivery of letters, and mail can still sit undelivered for days on end at times. It will be a tremendous boost, both for Makerere and for our Memorial programme if McGill does indeed do manage to pull this venture off, and get started next year.

Part 2

September 23rd, 1990 - July, 1991

Pages 45 - 66

September 23rd, 1990.

We have been back in Uganda exactly one week now following a few weeks break in both Canada and the U.K., which was very welcome and refreshing, even though it was one of the very few years in which I did not once wet a line in pursuit of the Atlantic salmon, having to be content with a couple of days fishing for trout only. However, this was a balm to the soul, and a few days camping in the woods, with some most excellent catches of trout more than restored one's equanimity, and put the world in proper focus once again. One of the most notable features of the brief visit to Britain was witnessing the exponential increase in the volume of road traffic. The motorways at present are no pleasure, and both the speed of the vehicles and the sheer congestion of the roads which was encountered, made driving a car a distinctly unpleasant experience.

Following the usual tedious flight from Britain, arriving in Nairobi at 5 am in the morning, and not leaving for Entebbe till 2 PM, it was heartening indeed to witness the changes which have taken place in our brief absence from Uganda. There has been a considerable amount of cleaning up of the buildings and surrounds of Kampala, and there has been a lot of new construction starts evident on all sides, even in Tororo.

There has been a very significant development in the currency exchange procedures, it seems that the 'magenda rate' of exchange, which was the previous 'black market' rate of exchange, is now legal! For a couple of years most of the Uganda newspapers regularly published what they called the parallel market exchange rate alongside the official bank rate, in spite of the fact that it was supposed to be highly illegal to use it, and indeed one or two expatriate people were deported when caught using it. It seems that now the government, in an attempt to bring hard currency into the country has allowed the bank rate to float and find its own level, so that even in the banks one can now get a rate of 700/- (Uganda shillings.) to the dollar, even though the official bank rate remains at 500/- to the dollar. It will certainly make life a lot easier if there is only one rate of exchange to worry about in future.

Mwase the gardener did a tremendous job on the grounds round the house in our absence. He has completed the building of a small hut for us to sit in the shade and coolness when the house becomes too hot, which it occasionally does in the mid to late

afternoon, when the sun has been beating down on the roof all morning. Not only that, but he has made a couple of parking places for cars, and has planted around the second house some cannas, and a few of the cuttings which I had taken from various places, and grown in milk cartons till the shoots appeared.

On the negative side of things, there was no work whatsoever done on the houses after I left on vacation, in fact the houses were completely abandoned, as far as the workmen were concerned, the moment I left to go on leave. As before, as soon as my back was turned, and I went on leave, they did nothing whatsoever for the whole of the time I was away, and the workmen gave the usual excuses, of having been given no materials by Casements, the construction firm. Now one week later they seem to be nearing completion, though I fear that it will still be a considerable time before all is done to our complete satisfaction, and the workmen finally disappear from our orbit. It is now over 18 months since they began the work, and the initial assurance given to us was that the homes would take only six to eight weeks each to complete. The other most annoying thing is that the furniture for the students' hostel is still not in place, even though I was assured before I left on leave that the cheque for payment of it had been signed, and that the furniture had all been ordered, and was just awaiting delivery. It is the only tangible contribution to the whole project that has been requested of the Ugandan Government, and even this they seem to have failed to honour. There should have been one of the students out here a couple of weeks before our arrival back in Tororo, however, because there is no accommodation for him, he has gone home to Kisoro on leave, and it is not at all certain when he will reappear again!

The new intake of students seem to be a rather singular lot, and there are one or two quite outstanding ones, I am pleased to say. It is only to be hoped that the delays in the accommodation here do not prove to be too much of a problem in causing delays in their coming to the Community Practice rotation in Tororo. The first of the Memorial students to come here on an elective flew out with Doreen and I, and has completed her first week. She is Elizabeth Mate, in her final year of medicine at M.U.N., a mature and thoughtful person who should prove a very real asset to the programme and let the Makerere students see that there are students in Canada who care enough that they are willing to come out and see what is needed in the developing countries and work there in spite of all the difficulties to be encountered. I only hope that she is not too discouraged by conditions of dirt, the attitudes engendered by striving for simple survival, and the lack of drugs and materials that are still so evident, as soon as one begins to work in the hospital once again. Again the second doctor who was to have joined the programme has backed out for a variety of reasons, one of which is the fear of personal safety in the current setting in Uganda. I feel that this is quite an understandable emotion for a younger doctor just starting out on a medical career, in view of current publicity and our lack of any real hard knowledge on the transmission of AIDS, as well as the rather tenuous political situation which exists in the country as a whole, and the tendency to resort to violence when solving their political problems. On the other hand it is quite extraordinary to experience people saying "Thank you for coming back.", and to Elizabeth, "Welcome, and thank you for coming." One does get the impression that they

genuinely mean it, and that they are truly appreciative of anyone from outside who seems to be willing to help in any way whatsoever.

As far as the work is concerned, the week has been a relatively slow one, whilst one picks up the threads again from where one left off. One of the cases of note was a lass who had been shot at the level of the 12th rib posteriorly a couple of weeks before, and had a discharging faecal fistula, from a presumed perforation of the colon. The strange feature is that there seemed to be little evidence of either liver or kidney damage, in spite of the site of the entry wound, and the presence of the bullet still evident in the abdomen in the region of the splenic flexure of the colon. The pathway of the bullet baffles me, but by the end of the week the discharge from the fistula seems to have lessened greatly, and perhaps there may be no need to interfere after all. Next, Dr.Wabomba, an exceptionally nice and gentle person, asked me to see a lady who had an enormous mass in the lower pelvis. Her history is that she had a rather premature infant which did not live, a few years previously, then a few months ago, she developed a swelling in the lower abdomen which became very painful a few weeks before admission, and she became very ill. She was diagnosed as having bilateral salpingitis, and treated with what antibiotics were available. She improved considerably, became apyrexial, but was still in a lot of pain, so a laparotomy was decided upon. At operation it was found that she had a bicornate uterus, with a dead pregnancy in the left cornu, and a terrible endometritis with copious pus in the right cornu. Both cornu were drained, as it was impossible safely to attempt a hysterectomy owing to the adhesions, and the fact that we had no blood available, and even if we had, I find in myself a great reluctance to use blood here, even if it would ordinarily be considered life saving.

In other ways there seems to have been a continued level of improvement in the general morale of the hospital workers, and in theatre they seem to be more on the ball, and almost on time in getting ready for surgery. Whether this represents a permanent state of affairs, or is purely a temporary business remains to be seen.

A word on the new ambulance! This machine was sent to Tororo by the Department of Health just before I left for home. It is a brand new Peugeot ambulance, presumably donated by the French Government. The previous ambulance was of an almost similar kind, but having been systematically wrecked over a period of about five years, it lies languishing in the hospital garage, looking ten times its real age. Then there was also a Volkswagen Ambulance donated by the German Government four years ago, and that one lasted only three years before it was wrecked, and is currently up on blocks having been completely ruined by lack of maintenance and poor driving, resulting in all kinds of damage. This present new ambulance I have seen on many occasions recently absolutely full of people being driven all about the countryside, and already they have put 7,500 Kms on the machine in six weeks. How long it will last at this rate it will be interesting to see. The capability to wreck automobiles, and almost any kind of machine or mechanical device, is truly an astonishing feature of the average African scene. Maintenance is not a characteristic which is very apparent, and inappropriate aid seems to do nothing to change the attitude that there are plenty more machines or vehicles from where the previous ones came from.

October 10th.

A rather long hiatus, due to considerable pressures on many sides. It seems that some of the new intake of students have not turned up, and I am informed by the others that this is not uncommon, as they will 'hedge their bets', and often apply for more than one position at once. One of the interesting options which one of them seems to have taken is to go to the Italian hospital in the Karamoja area, and even though there is considerable unrest there, the attraction seems to be twofold: (a) They get paid in dollars at the end of their contract - it seems that this holds them to their commitment, and (b) There is the possibility of getting to study abroad at the end of their time in this rather remote, and less than hospitable area of Uganda. It is the aim of so many Uganda doctors to get out of their own country and go abroad, and I suppose that the current conditions of Government service, and even private practice with the tragic lack of real facilities to work properly, is the reason behind this..

The student in question is one Anthony Okoth, who comes from the Tororo area. I knew him as an intern, and he stated that he was interested in joining the programme right from the outset. Last year, when working in the local Mission hospital at St. Anthony's, we had a case of a girl who had an ectopic repaired at Nsambya hospital a year before, and presented with a large abdominal swelling which proved to be a very large abdominal swab which had been left behind at surgery. Radio-opaque markers are not used here, as all the swabs are home-made if large, and if small, they are just rolled up bandage, cut into appropriate lengths for swabs. One has therefore to have eyes in the back of your head literally, as they rarely do a swab count at the end of an operation either, because they never know how many swabs were in the packs originally! Anyway, inquiry at Nsambya Hospital, which is one of the very few hospitals in Uganda where follow-up of a patient by inquiring about the records is possible, indicated that the surgery had been done by Anthony Okoth! Again, even in the best situation here, it is likely that interns will be allowed to operate unsupervised, particularly if the senior doctor on call is Ugandan, and this is in no way unusual in the larger institutions like Mulago. However it is my experience that in the majority of hospitals throughout Uganda, the emergency services at present are almost non-existent at night. While this is perhaps understandable in a place like Tororo, where the security of individuals after dark is a real problem, and no one travels after dark, no matter how ill or badly hurt they may be. In Kampala, the security situation is nothing like as bad, however after 7 PM, one is very unlikely to get medical attention anywhere except at Nsambya or Rubaga hospitals.

One of the other students has who not yet appeared works in the hospital at Soroti, and the times are rather troubled there, as there is a lot of 'rebel' activity in the region, and also many of the Teso tribe, who are the predominant people of the region are in 'camps for their own protection' and this has led to a lot of discontent and disaffection as far as the government is concerned. Mail takes three or four weeks to get

to Soroti, and occasionally just does not get there, and the telephones of course do not work, so we will just have to wait to see if he turns up. It's a shame, as there were two people at that hospital who had expressed a desire to join the teaching programme, and one of them was refused. Finally Dr. Aliita, who was working in Jinja, has not turned up. He was trained in the Soviet Union, and I was looking forward greatly to seeing him in action, and having a chance to assess the training he received while in Russia. On looking over his credentials and curriculum vitae it was interesting to note that he gained a distinction in Russian language, and also on Communist doctrine. Perhaps he will still join, as he was having difficulty getting a reference from a Ugandan doctor as he had practiced here so little.

The state of the programme then, is only three students clearly enrolled at the present time, and one of them is already showing signs of being a problem, with alcoholic tendency already rather apparent, and a rash which worries me greatly.

November 18th.

An even longer gap in the entries to this diary, but there seems to have been so little free time since Elizabeth came, and the fact that she was staying in the house, as the other homes were not completed, has made a big difference, and it seems there was a lot more social interaction with the other expatriates while she was here! Elizabeth left two weeks ago, and now at last it seems we are on our own again, though it was so nice to be able to get a real 'worms eye' view of medicine again, and feel what it was like to be a medical student today. While she was here it was pleasant to be able to discuss the many problems with an objective observer, and Elizabeth fitted in marvelously well, being very sensitive to the many cultural differences, and not being too critical of the performance of the staff at times when criticism in any other setting would have been mandatory. Then there are a number of Makerere students here at present, as the University has been closed all this semester, probably due to the shooting of a couple of students on campus by the police a few months ago.

At long, long last the houses are complete, and we seem to have finally finished with the firm of 'Casements'; it has been a phenomenal struggle to get the last stages of the work done. They kept pressing for payment of 'something on the account', but by this time I realized that once they were paid we would get nothing done in the future, and even then it required a lot of pressure to get them to complete the final stages of building the homes, and they repeatedly wanted to put in the most shoddy material possible. The last run-in was with the plumber who had the final contract with them. He announced that the firm wanted him to stay in Tororo until the work was completed, but that any material he required should be paid for by me, and they would reimburse me at the end of the job. Whether this was true or not I am not sure to this day, even though the directors of the firm, Zahid and Khalid Alam, swore that this was not the case their previous behaviour left me unsure as to who was telling the truth. In the end, there was a row in their office, and we refused to come in to see them any more till the work was done, and following this, within a week they had the places completed. It has been quite a saga all things

considered, and a singularly frustrating experience, like so many other things here.

A couple of weeks before Elizabeth Mate left for Canada we went to Mweya National Park, so that both Doreen and she could see it. The trip was quite eventful, in that just outside Imberara, they were mending the road, and a flying stone smashed the fourth windscreen! Just about three weeks earlier on the way back from Mbale, where they had again been mending the road, we had a flying stone from a passing vehicle smash the third of the windscreens. This required a trip into Kampala to get it fixed. They use the hardened glass in the windscreens here, which shatter into a thousand pieces when even a small stone strikes it. This time though, we could not get a new windscreen in Mberara, but managed to cut a piece of plastic glass to shape, and it fitted in nicely, being completely waterproof. I now polish it with hard Turtle Wax, and every time it rains use the wipers very sparingly, and so far it is working very well, in fact we were struck by a stone that would have smashed another windscreen but the plastic is only slightly scratched. I am in the meantime waiting for the firm to get in a laminated windscreen, which will solve the problem for the rest of the project - hopefully. I have, though, been observing the windscreens of the other cars here, and it seems that one out of every five has a major defect of the windscreen, caused by the flying stones. Driving is certainly not done with a great deal of care, and speeding, even in the most decrepit of cars, is the rule, and most Ugandans drive with their foot right through the floorboard. The life of the average car, should it be a donated vehicle by some AID Agency, is little more than two years, and a friend tells me that a Leyland bus that lasts 12 - 15 years anywhere in the U.K. lasts 5 years at the outside here. I know that the hospital here has two ambulances in the garage, one a Volkswagen donated by the Germans, which lasted three years, before it was wrecked completely, and a Peugeot which lasted even less. All the small regional hospitals each received a new ambulance about four months ago, and already the Tororo one has done 25,000 Kms! It is always on the run, but never to carry patients. It is used as transport and I suspect that the drivers and others are supplementing their incomes by driving people round, just like a taxi service. It is always packed full of people when it is going anywhere, and already the inside looks filthy and ill-used in the extreme.

Mweya was wonderful, and a tremendous experience. The place is coming back to life again, and the elephant herd is large and healthy, with a lot of younger animals in evidence. We were fortunate in seeing about 40 of them come down to the water's edge to drink and we saw a couple of the mothers feeding the young elephants while they were drinking. There are many Uganda cob to be seen, as well as waterbuck, and other game. One fortunate thing was that we saw the Rowenzori range clearly, with the snow-capped peaks one evening, which is a fairly rare event. On the way home we came via Fort Portal, and motored along the foot of the Rowenzori range, a very spectacular drive, but the road from Fort Portal to Mityana is unspeakable. It took the whole day to reach Kampala, with solid driving, rarely going more than 30 Kms/hr for the majority of the way. There is a small game park between Masaka and Mbarara, which is coming back to life wonderfully. This park is full of antelope, and we saw impala, cob, Thompson's gazelles, and even oryx and a couple of kudu. There is a lot of bird life by the shores of a small lake there, with masses of pelicans and other water birds etc.. Altogether the trip

was a very pleasant interlude.

Right now, I am trying to rehabilitate the operating room, as the major project for this year, and I begin to understand clearly how Sisyphus felt. The ubiquitous nature of dirt in Uganda is incredible, but what is totally mystifying is how people trained as nurses or doctors can tolerate wards which are filthy, operating theatres that are obviously filthy, and they never clean anything except at a very superficial level. The E.M.O. anaesthetic machine which was brought over from Canada new, is already scratched and dirty, with all the metal labels coming off, the oxygen reducing valves and gauges are all broken, and they use one that works only off the reducing valve. One cannot see how much oxygen is left therefore. I fixed one of them to be functional out of three which had been broken; two had been broken simply because the screws had been overhauled and the threads torn, the people seem to have a perfect gift for using too much force on things all the time, and when something is broken, it is never mended, but just discarded, without even keeping it handy for spares.

In the wards, the mattresses are sponge-rubber foam, which are supposed to be covered with plastic, but rarely are. They are beyond description as far as dirt is concerned, and are by far one of the most problematic items one has to deal with. They are regularly stolen by the patients if they are looking new, so mostly they are just covered by the patients' sheet or blankets, and any blood or pus which may be present from wounds or dressings etc. simply soaks into the sponge mattress, to infect the next occupant of the bed. Perhaps the worst ward of all is the paediatric ward, where the mattresses are soaked in urine and diarrhoea as well as blood and pus. There are times when I feel that the majority of the hospitals in Africa would benefit from treating patients on the floor, using only their traditional papyrus mats, and have no beds except for people who do have a bed at home, and are therefore used to them. Even in this case, perhaps these people should bring their own mattresses etc. into the hospital on admission and their families be the ones to care for the cleanliness of them. Nursing is 90% done by families in all the Uganda hospitals, and probably in the majority of African hospitals, since they got independence. The teaching of cleanliness is certainly the biggest hurdle to overcome in the active treatment of patients, and probably in the teaching of health care of any kind. On reflection though, the majority of people come from villages and live in small mud huts, with a large number of people sleeping in a very small space. Cooking is in the main done out of doors. In a lot of schools the pupils are taught out of doors. The majority of the smaller school buildings are of elementary construction, with walls made of mud and wattle or other wood, and floors frequently simply beaten earth. Sewerage is non-existent, water usually from a village pump. So it is therefore a real problem to suddenly put people into the position of living in housing which has running water, sewerage etc.. Even the majority of people who inherited the homes vacated by the expatriates when they left, or the Asians when Idi Amin threw them out of the country, and which were handed over to the Ugandans in superb condition at the time of independence, are now all run down, and filled to overflowing with relatives and hangers on. Then the homes have steadily been allowed to fall into disrepair, with absolutely no attempt at maintenance whatsoever, so that to-day these same homes are mostly falling apart. It seems that the second law of thermodynamics applies to Uganda in no uncertain

manner, and if the country is viewed as a closed system, the place certainly tends towards entropy!

The second intake of students remains at three which is rather disappointing. What was so troublesome is the out and out thoughtlessness of those who have denied places to other students who also applied. There are a couple of students who have requested to join the programme late, but the rigidity of the system is unlikely to grant them permission to join at this stage, even though it is little more than a month into the second intake. The system within the academic setting is completely rigid, and allows for no flexibility whatsoever, so we will have to wait till next year and try to devise some method of ensuring that those who apply for places actually mean to join, and are not just hedging their bets, and making sure of a place in some programme. I have heard that the doctor from Soroti was persuaded by the people there to stay on, and given considerable inducement to do so in the form of monetary reward. Perhaps it is better this way, if the community do indeed value his services so highly, and he must therefore be doing a good job.

At long last some of the furniture has arrived for the student hostel in Tororo. There is still quite a lot yet to come, and one will have to try to pressure the Government to provide it. It has been interesting, in that almost certainly the original money voted for the furniture went though 'astray', and into someone's pocket. This furniture is coming from the prisons at Mbale, and is a complete re-order. They say that the first list of furniture which was ordered was lost! They were given three copies of the list.

The cases of note which have been dealt with recently include a new case of leprosy, a disease which I have never actually diagnosed before. There is still a Franciscan mission at Buloba which deals with leprosy, and there is an elderly Polish doctor there who is one of the world experts still practicing, though who will take over when she retires is a real problem, as so very few other people have any real experience with the condition. Whether leprosy will make a resurgence with the current epidemic of AIDS as is the present case with tuberculosis, is an interesting speculation.

The shootings continue!! We have had a rash of robberies involving matatus (taxis), and buses, in which armed robbers hold them up, and steal money or goods. It seems that the people returning from Kenya are particularly vulnerable, as the thieves feel that these vehicles may be carrying goods or money worth stealing. There was a recent case wherein a young man returning to school, was in a bus that had been held up by armed gunmen, and he attempted to flee, so they shot him in the leg. He was admitted to our hospital at about 6 PM. with a fractured femur. He did have a peripheral pulse at the time of admission, but was obviously bleeding badly, and when I saw him I asked that he be put in traction immediately, and monitored for further blood loss, being very reluctant to undertake an amputation in a person so young, with a chance of recovery. Next morning I was horrified to find that he had died, owing to the out and out neglect of the duty doctor, who did not even visit him once, in spite of many requests by the nursing staff. It was one of the few cases where the parents, being people of some consequence locally, kicked up enough fuss that the Department of Health had to take

note, and the duty doctor is currently under threat of suspension. This would not be a bad thing, as this same young doctor subsequently cobbled up a chest wound in a man who had been shot in the chest, and had perforated the lung, without putting in a chest tube etc.. This man died two days later on the operating table, when I returned and attempted to do something about it, and tried to drain the huge haemothrorax, surgical emphysema, and tension pneumothorax which had resulted.

Then there was the man who was smuggling and was shot in No-Man's Land by the Kenya police. This nearly resulted in a border incident, with the Ugandans firing back at the policeman who shot him. Thank goodness some civilians standing round prevented the Ugandan soldiers from shooting back. Anyway, this poor man was shot in the buttock, with the bullet shattering the ischial spine, and impinging on the pubic bone which it also shattered. The base of the bladder was also torn as a result. This particular piece of surgery required reconnection of the urethra to the bladder, and it seems to be holding and draining well three days later.

Then there was the meningo-myelocele, in a two day old infant, brought in from the village. It was a large one, though there was still movement in the child's legs. It has been closed, and so far seems fine 21 days later, with no leakage, or increase in intracranial pressure so far evident. This one Elizabeth helped with, and though there was a small leak a week after the surgery, it sealed itself off it seems. The kid is now doing well. A real tragedy in this case was that the child came from a long way off. Except for the mother the relatives did not stay with her, and so the mother has been alone for most of the time the child has been in hospital. Of course what little money she had, ran out, so that she became hungry, and unable to breast feed the child properly. She is one of the first African women I have ever seen weep quietly with what seemed like pure desperation. A small donation, a matter of 1,000/- (a dollar fifty at the magendo rate.) saw her with food for a couple of days! What an unfair world it is most of the time; particularly for mothers and parents of young children in the developing nations, where life is still cheap, and the seeming callousness of people is probably due to the general uncertainty of survival and the very real uncertainty of survival of any child under the age of five - mortality rate being still in the region of 20%, and climbing with the AIDS epidemic.

There is a Benedictine priest here, known as Father John (Neudiger) who has been working in the Tororo area for a number of years. He has established a number of small industries in his project, such as brick making, carpentry, gardening, farming, and a number of other things like a driving school, a course for mechanics etc.. He has also established a sale for used clothing and other things, as well as a primary care clinic and eye testing clinic which dispenses cheap glasses. In the process of doing all of this he has made a number of enemies it seems, and had a couple of guns planted on his property. The military then moved in and also found an air gun on his property. They then had him arrested, with a resultant court trial etc.. He was acquitted following his trial in Kampala, but almost immediately rearrested and held for trial in Tororo, a lesser court! It is the kind of thing that could only happen here, and now six months later the trial is still going on, having been postponed on a number of occasions, while waiting for expert witnesses

etc.. In the meantime one of the Benedictine brothers, in fact Father John's secretary, was murdered one night by gunmen who carried out this killing for as little as 15,000/- ($20.00 at the magendo rate of exchange.) this being the price of life in Uganda. Then we had a patient brought in by Father John, shot through the arm, with the brachial artery and nerves destroyed; another man in the house had been killed by the gunmen, and on this occasion it was because the man had sold a bull, and had the money in his home, about 50,000/-. He is still in hospital. I attempted to repair the artery, but failed, though there is still a circulation from somewhere, keeping the hand alive, the nerve we will wait and see, in the meantime he has a complete wrist drop.

In 1986 there was a surgeon in Kampala by the name of Wilson Carswell, who had been through the whole of the problem period of Uganda's recent history, with the Amin and two Obote wars, and the Museveni coup, and who was one of the first people to see the writing on the wall as far as the AIDS epidemic in Uganda was concerned. Because he made fairly public his concerns, the same kind of campaign was begun against him as seems to be happening with Father John. Wilson's house servants were brutally murdered, and he was finally declared *persona non grata*, and was ordered out of the country and had to leave Uganda at incredibly short notice in spite of the very considerable period of time he spent here in dedicated service during some of the country's most difficult and dangerous periods - when the vast majority of expatriate peoples had long ago left the place.

At present there is a real problem bringing things into the country, even as free gifts in the form of aid. The North West Rotary International Club of St. John's has generously sent a gift of 10 bicycles free to the staff of Tororo hospital. These bikes have been waiting over a month in Mombasa, awaiting clearance from the Uganda Customs. The Ugandan customs laws now make it seem that the country is determined to shoot itself in the foot, and make it as awkward as possible to import anything. In fact they wanted to charge the British Aid people duty on a whole lot of Land Rover vehicles which were sent as free gifts to the Police, and Water Services! In the same way, they want me to pay duty on the bikes which are a free gift to the medical services, and will eventually be owned by the Uganda Government! I also have a shipment of medical textbooks which are a donation from members of the Faculty of Medicine in Memorial University, and they want me to pay duty on these. I have said that I'll ship them back home sooner than do this, and am having a running battle with the Customs and Excise office. If it was not so sad it would be enormously funny, and make a great plot for a comic opera. The bureaucracy here is something to be experienced before it can be fully appreciated. I made application to be able to take the project car over the border into Kenya from time to time. One needs a letter for this, and the letter is only good for six months at a time. It takes at least three months to get the letter sometimes! On this occasion the application had been in to the department for External Affairs, where a very sour faced, sulky and pregnant secretary is the person one has to deal with. She sent off the application, which took three visits to her office to complete. Each time she will send you off for a photostat of the car licence and other particulars, then she sends one to get photostats of the licence etc. - and so it goes. Eventually the application, with all the necessary forms etc. went to the Department of Finance, though what Finance has to do

with this, I do not know, for a signature of some 'wheel' there. I visited this office on at least three separate occasions over the next month, and on each occasion was told that the letter had not been signed. Eventually last week it was signed, and then when I asked for it was told that it could not be given to me, but had to be given to a particular policeman who works in the Department of External Affairs, and to no one else. So this meant that I had to go from the Dept. of Finance, back to the Dept. of External Affairs, collect the policeman, who solemnly took the letter back to the Dept. of External Affairs, where we both had to mount the stairs, and see the sour faced secretary, and sign for it. The whole exercise has taken six weeks to complete, with four visits to one of the offices, and six visits to the other. One has some hard 'learning experiences' at times, but on this occasion at the last visit to the Finance Office, when they told me about the necessity of getting the policeman to take the letter to the other department, I just could not help burst out laughing, to the huge annoyance of the secretary in the Finance Office, who takes her work and things in general so terribly seriously.

The problem of treating thieves and others who have been caught in the act of stealing, particularly if it is with arms, remains extremely difficult. We have a man in the ward at present, who was beaten up by the villagers nearby. He has been known to have carried out armed robberies, it seems. They certainly beat him up thoroughly, and fractured his left tibia and fibula. As I understand it, a relative brought him to hospital and dumped him on the doorstep so to speak. When I first saw him, he had been in hospital for two days and was lying in bed in the clothes he came in with. He had not been treated by any of the ward staff whatsoever. Urine was dripping through his mattress, and his clothes were soiled with faeces. Someone had put a very thin plaster back slab on the broken leg, which was still angulated and had clotted blood on a large area of the thin plaster. The staff said that he had refused to eat. In actual fact, I don't think that he had either been offered, let alone given, anything to eat since admission, and I am not sure whether he'd been given anything to drink either. There is certainly little sympathy for thieves, as witnessed by a man we saw being taken to the police station for having stolen a bike. He had his hands tied in front of his abdomen, with a stout stick through the elbows behind, and they were lifting him up by the stick and hurrying him along in this manner, while the onlookers threw things at him, or struck him as he was being taken along to the police station - a very uncomfortable form of torture, and something they call 'triangling'. We saw a young girl, who had been tied up like this for a couple of days, while I was working in Kitovu, and she died within an hour of having been admitted.

March 23rd 1991.

This is the longest absence from recording events since I began the diary! The narrative report for CIDA, and the budget took me almost three weeks this time, by which time we were approaching Christmas, and this was accompanied by a real escalation in the violence for a period of time. There was a great number of gunshot injuries to be dealt with. One night, the thieves held up a matatu, and killed the driver and six other people, and it was simply to steal the money for the fares which had been

taken. Then it seems that every year at this time, people who have their own private vehicles and who enter Uganda from the Kenya side through one of the check points, at either Malaba or Busia, can be the victims of armed robberies, as they are often thought to be carrying what are perceived to be valuable goods such as radios, televisions, video-recorders and other things they have purchased while in Kenya. The robberies which take place when the objects stolen are videos etc. are legion. It seems that these are most desirable items, and if the thieves do not want them themselves, they can very easily dispose of these items for money. So between it all there was a lot of extra work at the time. Then the socialising of the Christmas period began, and further delayed my getting down to any serious writing, followed by the response to Christmas mail, and other letters regarding the project. So between one thing and another no diary entries for some time, and what is worse no notes of memorable events, so I'll have to rely on memory to fill in this past couple of months I have missed.

Of interesting cases we have had, the following is a short selection of the problems encountered which stick in the mind. One of the prison guards fell off a tractor, and was admitted in a confused state, rapidly going into coma. He had a rather nasty fracture, and needed a burr hole done. Finding the bleeder was difficult, as it seemed to be nothing but a diffuse steady ooze, but eventually after chiseling away a lot of bone it became obvious where it was coming from, and could at last be brought under some kind of control. He is now a prison warden with a fairly large defect in his head - not a happy state if someone decides to hit him! I hope to bring back a plate with me when I return from vacation this year. We had another couple of excursions into the head, one man being struck with a panga, which did him no good - he came in aphasic and paralysed down his right side, and again bleeding was difficult to stop. He had a lot of brain damage also, but he's talking, though still paralysed, and how on earth they are going manage to care for him in the village beats me.

We continue to encounter at least one ruptured uterus every month, due to mumbwa as a rule. I am trying to get some of this medication to take home for analysis, because it is a most potent oxytocic drug. Obstetrics otherwise continues to cause me acute concern. Our delivery table is filthy with rust, and quite impossible to clean any more, so they have almost given up even trying. Post-partum care by the nursing staff is almost non existent most of the time, and this is true even for those patients who have had caesarean sections. Doreen, who is a lot closer to a number of women who will speak fairly freely and frankly to her about the problems the people encounter having babies in the hospital here, tells me that there is a charge levied by the nurses and others for everything that is done for them during labour. Evidently it is 2,000/- to be paid on admission, then another 2,000/- to be moved into the delivery room, and for each and every service the women get from the nurses there is a payment to be made. As already stated, the Uganda government under the British Protectorate, provided free medical services to everyone, and this policy was continued following independence. However, with the complete collapse of the economy resulting from the misrule of the Obote and Amin governments, there is little if any money in the government coffers, and the staff salaries are totally impossible to live on, drug supplies are sporadic, and in spite of a lot of external aid, totally misused. The drugs appear in the local market within days of

arriving in the hospital, and everyone from the pharmacist to the nurses sell them, not only that, the staff will often charge the patients for their medication, even though it has been supplied free by the government. I strongly suspect that patients are being charged money to be referred to see me, as I am trying to see only those patients with whom the doctors and medical assistants are having real difficulty with, otherwise it would be an impossible free for all, to try and hold a front line clinic all by myself. I would be overloaded constantly, and not only that, it would be rather invidious for the Ugandan doctors on staff. One of the real problems is that no one will be honest enough to say that they are being charged, or they fear that they will get no treatment whatsoever if they complain to anyone in authority. And so the almost universal corruption continues, though for the majority it is in the main due to their low salaries and general struggle for basic survival which drives them to it. However, one finds that as is the case so often even in our society, it is frequently those who are truly very well off, and who are actually often wealthy, who are frequently the most corrupt of all. All this has led me to put forward 'Ross's law' as it relates to the honesty of the Uganda politicians, policemen or government officials. The law states that 'Their honesty is inversely proportional to the length of their belt. '

Makerere University is still closed, and it looks as though the majority of students will miss a whole year of their studies. It is not certain what the real reason behind the closure is, but is would seem highly political in nature. The students have in the past not had to pay for tuition, and have also been supplied with books, stationery and other allowances. So as with everything else, the government has said the students will now have to pay, and there are rumours of their having to pay fairly substantial educational fees as well each semester. The recent protests which resulted in the deaths of two students were due to the fact that they were not going to be given books and stationery. At present every couple of weeks or so, the government gives out a new date for the opening of the University once more, but this has now gone on for a period of about five months. One of the small benefits accruing to this hospital in Tororo is that we have four students working here most of the time now. Three are very good, and one is dreadful beyond description, and a person I would kick out very smartly. He is in his final year, with a negligible knowledge base, and the most cavalier attitudes you could imagine. I have remarked before on the fact that so many of the students, and even a number the doctors, will embark on procedures with the most elementary knowledge of what they are doing, and sometimes without any previous experience. This is alright for cases where there is no alternative, and where they may happen to be the most qualified person to do it at the time, in cases of emergency. However, it is all too often that they will do things of an elective nature, or which could be referred. Again, all too often, it is money that is the driving force behind this kind of behaviour.

Not all is bad however, and there is one really bright spot on the horizon. There is a doctor, Simon Peter Odongo who worked at the Mission Hospital, St. Anthony’s, here a couple of years ago, and who was sponsored by that hospital to do his postgraduate surgery in Kenya. He is a Ugandan who is returning to fulfill his obligation to the sponsors, but seems to be a thoroughly nice chap into the bargain. He is very interested in co-operation between the Mission and the Government hospitals, and a pooling of the

local resources. He is due to return here in August, and I look forward greatly to having someone else to do the heavy stuff, and give me time to get on with the more important matters of trying to get the Tororo Hospital Board set up, and the cost-sharing process begun - more on that later.

One of the other rather remarkable things which happened recently was when the hospital ran out of pentothal, and the thought of going back to the days of inducing anaesthesia for the patients with open ether filled me with horror. Memories of struggles with hefty men in the old cottage hospital days in the outports of Newfoundland, and even on one occasion being struck between the eyes, and sent reeling across the operating room, made me most reluctant to try this kind of exercise with the hefty Ugandans. Not only that, the thought of having to do the anesthetics for all the Cesarean sections was not appealing- no one else on staff here gives spinal anaesthesia, and I am reluctant to train anyone but my own students in the techniques, because of the terrible standards of sterility etc. which are the norm. Anyway, one of the anaesthetic assistants had the brilliant idea to go to the smaller hospital at a place called Busolwe, where very little surgery is done; so off we set on Friday morning, over very rough roads to this hospital only 30 Kms from us, and the existence of which I was totally unaware, and visited this little hospital which is just beautiful. Evidently it was one of the last hospitals built under Idi Amin's regime, and was looted badly in the fighting after his downfall. However it has been partially rehabilitated by AMREF, and has about 70 beds; the reason for building it seems to have been because of a Chinese rice farm development of considerable size situated nearby. When we got there it was about 11 am. and we found that the senior secretary was out, the senior doctor was not available, and they did not know where the other chap was. However, we found the theatre sister, and the nurse in charge. These two were most helpful, and found the store keeper. Then ensued a scenario that was just like the highland of Scotland: the Buswale hospital staff knew we had come specifically for something, and our anaesthetic assistant knew what he wanted, but the preamble before coming to the point was priceless. We heard the history of the two nurses and their family, and the storekeeper's childrens' progress at school was discussed. Finally the big question was asked, “Do you have any thiopentone?", and the response was, "Yes, we might have, but do you have anything in exchange?". There was more discussion, which ended in the Buswale crowd saying we could have 400 vials of the stuff! You see this is not a readily saleable item of pharmacy stock, so they had plenty of it, as it seems that they only do about three operations a month, so they never use their quota. What was also pleasing about the episode was that no money changed hands, and they seemed genuinely pleased to be able to help us. Their only request was for us to make up some I.V. fluids with our machine - they use this for rehydrating some of their AIDS patients. This hospital at Buswale was fairly clean on the whole, and was two stories high, which made it difficult for patients to be fed by their relatives etc.. Not only that, but there were indoor toilets upstairs, but no running water, their electric water pump had broken down, so their toilets upstairs smelled a little worse than ours in Tororo, and Lord knows they can smell bad. One of the features of Ugandans is that they do not like to ‘crap' where anyone else has, and we have great difficulty getting patients to use the toilets, either the flush kind, or the 'bombers'. It was notable that there was a constant stream of people filling their jerry cans from the borehole hand pumps.

May 10th.

Doreen has gone home six weeks ahead of me this time, in order to get the 'Newsletter' to the schools, and attend to a lot of our business at home, which we cannot do from over here. I will be following in mid July, and look forward to the break enormously. My equanimity is somewhat in need of restoration, there are times when the sheer frustration of the place, the lack of drugs, dressings, or other medical equipment which we would consider as being 'essential', is overwhelming. The constant dirt, and battle for cleanliness, the seeming lack of care or compassion for many of the patients who are admitted, by the majority of the trained staff, and this very much includes the doctors, is very wearing and can be so very emotionally draining. That the hospital is getting better, there is no doubt, and that morale generally is improved is also obvious, but there is such a lot to be done, and still so far for them to go, before their standards approach anything like an acceptable level. There are two major problems which stand in the way of any degree of rapid progress in Uganda: (1) The inability of the average person to take individual pride or responsibility for their work or actions generally; it seems that people will neither delegate tasks nor will they give each other orders. There seems to be a universal cultural barrier to either place or accept the blame for things being lost, broken or stolen, and (2) There is a rather singular inability to work together as a team. Cooperation is rare, and there seems to be a general lack of trust in each other. In fact the average person seems very much to prefer working alone and entirely for themselves.

Administration and the bureaucracy is astonishing, and the proliferation of forms to fill in, most of which are immediately lost, and the number of people 'working' for the government is quite astonishing. Let me give a simply classic example: I wished to get some anaesthetic ether, some pentothal and some local anaesthetic from the central stores in Entebbe, this being the source of all government supplies to the hospitals. So I went to ask where it said 'inquiries' how to set about getting the stuff. I was sent to see a man who was sitting reading a newspaper at his desk which was in a large room in which about six women were 'working', two of them were pregnant and one of these was reading her newspaper, and the other just sitting staring into space. Two of the women were sound asleep with their heads resting quite unashamedly on their desks, only one of the others seemed to be working, and she was writing something. I spoke to the man at the desk and gave him my request for the drugs I came for, so he put down his paper, filled in a form which he then gave to one of the women who got up when called, and came over to the desk. She was instructed to take me round to get the drugs, and I must say that without her help the task would have been impossible. Well, we went from desk (a) to the chief pharmacist's office with the form the lass had been given, only to find that the chief pharmacist was out and had not been in that day, it being now 11 am in the morning. We were directed then to a person who had 'signing authority' if the pharmacist was out. She was out too, and had not yet come to work, so we were directed back to desk (a), however at this point in came the lady we

were looking for with the 'signing authority', who proceeded to get behind her desk and assemble pens pencils etc., then put on some lipstick! Following this performance, she signed and stamped the form, and we went back to desk (a). Here the man stamped the form, and gave it to my guide who took it to one of the women who was awake in the room, and she entered it into a ledger she had. We were then to go back to desk (b), the lady with 'signing authority', with the stamped form which had been entered into the ledger. She then proceeded to stamp the form again, sign it, and enter it into a ledger. From here we went to the pharmacist's main store to desk (c), where a man, again reading the day's news, put down his paper, took the form, entered it into a ledger, and then put 'out of stock' for the pentothal and local anaesthetic, on the original form, stamped and signed it again. He now directed us to the 'wet store' to get the ether. We went to the 'wet store' to desk (d), where the form was again entered into a ledger, stamped and given to us to take behind his office where we were to get the ether. Here we came to desk (e) where the form was taken from us and entered into a ledger once again, and given back to us, and we were given the ether - half the quantity we asked for. From here we went back to desk (a) where details were once more entered into a ledger, and I was given a gate pass that indicated I had been given the ether. This whole process took a full hour to complete, and seemed quite the most monumental waste of time, however I guess that it gave a salary of some kind to many people, none of whom was extended by the job they did in any way. It is a waste of very able people to use them in this fashion, and all the forms do not prevent the loss, theft and general disappearance of drugs anyhow. We are still out of pentothal, and local anaesthetic, from government sources, and but for some very innovative scrounging from UNICEF, and some of the other nearby hospitals, we would still be out of these drugs altogether, and therefore unable to perform any surgery. The hospital at Mbale has just accepted the status quo, and made no attempt to obtain these drugs, so we are saddled in Tororo with doing a lot of their surgery. The ability of Ugandans to accept things I guess hinges on the vicissitudes and difficulties they have been through in the past few years. I suppose that one of these days their inertia will wear off?

May 20th.

Makerere continues to be closed, but it seems now that the date of opening will soon be announced for certain. The students will have missed two whole semesters, which in real terms means that they have missed a full academic year. There is some talk of their attempting a 'crash course' of concentrated study, in the hope that they can make up the year. It seems indeed a forlorn hope, and if they do try it this will only serve to further degrade an already abominably low academic standard, in what was once the best university in Africa. The demoralization of the teaching staff at Makerere, with some of the 'purges' of the 'intelligentsia' in the University and elsewhere, has left a skeleton staff many of whom can best be described as academic 'dinosaurs' in the sense that time and tide have passed them by, and but for tenure would normally have had any contract terminated long ago. In medicine, I fear that this is particularly true, and at the top there are very few, if any, innovative or interested teachers left. The older professors of the major disciplines seem to have left off thinking long ago, and seem to live in fear

of the progress of the younger people who are now yapping at their heels. The pass rates in the post-graduate courses are all very low. Medicine for instance, has not passed a single post-graduate candidate for the past five years. It seems that they do not think this reflects on their teaching abilities, but rather reflects a 'tough academic course' with high pass requirements. The students themselves on the whole, are far too placid and compliant, and all of them state that they do not get into any form of controversy with their teachers, as they will be most likely to fail the course as a result! It is one of the tragedies of Uganda that education is becoming increasingly inaccessible to the majority, right from primary school level up to and including university and post-graduate education. The major factor is that schools and universities are now demanding fees for education which used to be 'free'. In the face of the current rather desperate economic situation, the majority of people just cannot afford to pay the school and university fees demanded. The recent Gulf War has had its usual devastating effect on the developing countries, The price of gasoline doubled overnight, and the cost of everything has risen accordingly. Not only that, but the subsequent rise in the value of the U.S. dollar has pushed the magendo rate to 900 Uganda shillings to the dollar, and it is certain to be 1,000/- within a couple of weeks. During the actual war paraffin became almost unobtainable, and there were long queues for it. Paraffin is one of the chief cooking fuels here, but I guess that the need of this fuel for jet aircraft overrode the needs of the people in poorer countries, many of whom use it as a cooking fuel on their little primus stoves. It is one of the real ironies that something as remote to Uganda as the conflict in Iraq should have such an impact on an already strained situation, and this only serves to put education even further beyond the reach of the majority. One of the astonishing features of the Ugandan students is their acceptance of the status quo, in a rather quiet manner. There was one protest, and it was notable that the police were rather quickly sent to the campus, and then there was an incident in which some high strung policemen shot a couple of students and killed them. Even following this incident, the protests were mild, in comparison to those in most other countries and it was this incident which seemed to trigger the closure of the University.

June 1st.

The University has at last opened again, and they are talking of doubling the teaching time, and trying to catch up the year! A truly hopeless waste of time. Museveni has been talking to the students, and he has laid it on the line for them, that nothing is 'free' any more. There will be real fees to be paid, textbooks, paper, pens etc., will all have to be paid for by the students. Accommodation is no longer 'free'. The Tororo Girls School recently had a fund raising effort, and Museveni was out here for this, amid terrific security precautions, such as soldiers everywhere, all armed to the teeth, on the roofs of the buildings, and in the clock tower etc.. It is very true in these countries that 'Uneasy lies the head that wears the crown' is the case. Again though, one realises that Museveni is certainly one of the best of the African leaders. It seems that he has a real grasp of the essentials, and 'tells it like it is'. He seems to have a greater altruism than the majority of African leaders, and seems not to have been out for Number One all the time, He is not showy, and does not seem indecently wealthy as the majority of the

others are. He seems genuinely to be trying to come to grips with the ubiquitous graft and corruption which is so prevalent at all levels. Anyway, he gave a speech which was short and to the point. He pointed out that Tororo Girls School, which was built by the Americans, was a bye product of the ‘cold war days'. The Russians retaliated by building a technical college at Busitema, just about 20 Kms away from Tororo. It seems likely that this sort of competitive situation is quite finished, and they will not be able to play each side against the other any more. Again Museveni pointed out that from here on, the Girls School will have to be a self sustaining entity, with almost nothing in the way of finance from the Government.

One still gets angry with the fact that defence, largely in the form of the army in Uganda, still takes the lion's share of the budget. It is a very large army, with a lot of very idle young men, mostly very poorly educated, and all of whom have guns, and use them far too readily and most inappropriately at times. The budget for education is forever depleting, and is only the fourth largest item of Government spending. After all, any country's wealth lies in its educated people, and nowhere else. So when they are putting less and less emphasis on state funding of education, the whole country will become poorer each decade if this sort of thing continues. An example of the army mentality and behaviour recently gives a vivid picture of the problems. There was a 'security' operation being held in a village nearby here. These security operations are ostensibly looking for weapons, 'rebels' and army deserters etc.. They come into a village in the small hours of the morning, and round up all the males in every hut, and herd them at gunpoint to a place where they are searched, and have to produce their identity cards etc.. They will often be kept for hours in the sun, without food or water etc., while they then conduct a search of the village huts etc.. Anyway on this occasion, the troops in question, were in two separate lots working together, and once they had rounded everyone up, the other lot came and looted the village of anything moveable, and ended up raping a couple of the women they found. Well the local army commander, when he heard of this, got a few of the villagers to identify those of the culprits they could find, and then he ordered a 'field court martial', and proceeded publicly to execute four of his men by firing squad in a field nearby one of the local high schools. Rough and ready justice, but his logic was that if it was left to due process of law, they just might have got away with their crimes.

The Russian technical school mentioned by Museveni in his speech, is at a place called Busitema, and has been in operation for about 20 years now. Like so many other things here, it is suffering from a certain great lack of maintenance, even though the Russian presence is still very much in evidence. I guess that this means the Russians themselves do not place a high priority on it as a showplace any more, and that they just have not got the money to maintain it as they would like to. The Russian teachers live in less than ideal conditions, though they are evidently paid well by their standards, but very poorly by the standards of most of the other expatriate groups working in Uganda. We got to know a couple of families quite well, and had them as guests, as well as visiting them in their homes. One of them, who was once a submariner earlier on in his career, I asked if he'd ever seen Canada, to which he replied "Yes, and I have seen your harbour of St. John's through the periscope." However they seemed to be a very nice

bunch on the whole and all most anxious about what was happening at home, and seemed to have very mixed feelings about Gorbachev.

July.

This will be the last, but very wide ranging, entry until I return to Canada, as things are getting quite hectic, and I have to go in to Kampala to buy some furniture for the second doctor's house, as well as arrange for storage of the container full of equipment, which has arrived in Mombasa, and which I have had to arrange shipment to Tororo via a different firm to that with which I had originally negotiated, as this new firm are the affiliates of the Kenya shippers who have brought it this far. I have such little trust in storage of the container at the hospital, that I have arranged for Father John at the Benedictine monastery to have the shipment unloaded and stored on his premises, and will take the equipment piecemeal to the hospital when I return. A shame, but if I did not do it this way, I would almost certainly loose a whole lot of the items, which would find a ready market locally, if the hospital staff ever got their hands on it before I had been able to see to things.

A very good example of some of the abuse of equipment, is the current use of the ambulance. There are two derelict ambulances in the hospital compound, one is a Volkswagen, donated by the German Government which is now approaching five years old, but has a wrecked engine, and only lasted them three years before it gave out. The other is a Peugeot which was donated by the French, it is now about six years old, but long ago became a wreck. When I arrived, I spent some money on it, with a new battery, a 'ring job' etc., and got it going. It lasted about six months before I discovered that they had sold the new battery, and substituted the old one from the Volkswagen, and they had now seized the engine solid, by running it without oil! Recently they acquired a brand new one, which the Ministry of Health had provided, again a Peugeot, but bought with aid money from the World Bank. This one is still going, after about a year in operation, but in this time it has barely carried more than half a dozen 'live patients', and about 50 dead ones (these are trips for which the relatives pay for transportation to the various villages from which the deceased came). However, it carries the staff, and particularly the relatives and friends of the medical superintendent, here there and everywhere. It also seems to carry people, and be used as an income generating taxi service. I gather this is where they get the money for gas to operate the vehicle. On one recent occasion I discovered that it was full to the brim with firewood, being transported for the chief housing officer (a relative of the medical superintendent) and shortly after that the medical superintendent's home was painted, probably a quid pro quo? In the meantime, the chief nurse in charge of the outpatient department has been waiting to have electricity put into her home for the past six years. She currently cooks indoors with a charcoal stove of the type they call a 'sigeri', a sort of circular tin can perforated to let the air in to the fuel. The sigeris are used for outdoor cooking, being more than a little dangerous if left unattended for any length of time. Anyway, ambulances are rarely used for carrying the sick or ill, and there was a rather amusing incident recently when the machine ran out of gas, and the medical superintendent, the driver, and two

'passengers' were pushing it to the gas station. They asked a couple of the people standing around to help them, but one of them, acting as the spokesman, said "You've never helped us when we needed rides to the hospital when we were ill, so you can push it yourselves!"

When we went to Kisumu, last April I think, and stayed for a couple of days rest and recuperation, I managed to get a new windscreen, laminated this time, and it was only $75. The last one I had put in while in Kampala cost more than $350. It only cost another $20 to have it installed. This was the fifth windscreen I have had put in, as I have already indicated. The last one was perspex, but was so difficult to keep from getting scratched, and required waxing almost daily with 'Turtle Wax' polish, and now I can use the wipers whenever I wish. The only other visit to Kenya this time was a brief sortie to Eldoret, which is the last posting at which the Hillmans were working. We went to visit the place, primarily because Joan Harvey, a nurse who has been a friend since the cottage Hospital days in Bonne Bay, was visiting and wished to go there as their church in New Brunswick is affiliated with the church in Eldoret. Well, off we set, once we had negotiated the Uganda and Kenya border guards, customs officers etc., and into Kenya we drove, only to find that the direct route through Bungoma was closed, and we had to make a detour. The road we took, and which seemed to be the most logical if the signs were to be believed, began to get worse and worse; because of the deteriorating nature of the road. We inquired of at least three people we passed as to whether we were on the right road to Eldoret, and were assured that we were. Almost three hours later, we came to a large bifurcation at a large, paved, good looking crossroad, and asked again. We were directed the way once more, and arrived in Eldoret about three quarters of an hour later. On the road back, it took us half an hour to reach the detour at Bungoma. I guess that the local peoples take us very literally when we ask if this is the road to somewhere, and if it does eventually lead there, they'll agree that this is indeed the way there. I think that they think the Msungus are mad enough to want to take the scenic route, no matter how bad the road is.

A couple of very recent incidents which clearly display the local customs of taking the law into their own hands bear reciting, but at the same time, it should be remembered that our society has done many worse things in the past. At the same stage of social evolution, we could show most peoples of the world a thing or two about cruelty to each other, or whoever was unfortunate to be a victim of our system of 'justice'. Anyway, we had one man admitted with a terribly infected, and almost gangrenous leg, following a gunshot injury five days before which had shattered his femur. He had also had his right ear sliced off. On inquiry, it turned out that he had been shot by the police, and showed evidence of having been beaten up rather badly. I was all for writing to Amnesty International, the human rights commission and anyone else who would listen. However, I found that the hospital staff were most unwilling to feed him, or treat him in any way. Again on asking for the reason for this, I was told that he had tied a father and son together in their hut, and sliced them up with a panga until they had told him where they had hidden their money, some 50,000/- (about $45 U.S.) which he then stole, and set fire to the pair of them in their hut. The villagers caught him, gave him a beating and branded him by cutting off his ear, so that no one would give him

food or shelter afterwards. The police saw him, and when he tried to escape, they shot him, then beat him up to get a confession to the killings. Thank goodness he died shortly after admission, and I did not have to insist on amputating his leg to save his life. Then again we had another assassination in Tororo: it seems that one of the soldiers became jealous of a man who had been paying attention to his girl friend, so he hired a killer to do the job. This man went into the home and shot his victim with little trouble. But the girl friend was foolish enough to say that she had seen him, and knew who he was, so he shot her as well. To my knowledge the police have not yet got him, and I'd love to know what the price of this 'hit job' was, because it was 15,000/- in the case of the attempt on the life of Father John, if I remember correctly (about $12 U.S.).

We have had our first really major community emergency, and the hospital did not come out with shining colours. A truck carrying lime, and many people standing on it, overturned on the Mbale highway, and we had 13 admissions within a few minutes, all of whom were rather badly injured, many with severely crushed limbs. Quite the worst was a young man with his eyes bleached white with the lime dust, and completely blinded. He had a dreadfully crushed right arm and leg, both of which required amputation. Over the next couple of days he died of respiratory failure when it became obvious that he'd inhaled a lot of the dust, and his lungs must have been destroyed in the same way as those gassed with chlorine in the first world war. There were three others that needed amputations over the next couple of hours, as well as all sorts of lacerations and fractures to be dealt with. Next day we had two more amputations to do, as there were four patients admitted from Mbale hospital where they had been taken, and subsequently transferred to us. The excuse for the transfer given was that there was no electricity, however all of these patients were in the same filthy condition they were in when they were taken to Mbale hospital, there had been no attempt whatsoever to do a single thing for them, they were not cleaned, nor were they treated in any way whatsoever, two of them had completely crushed legs or feet, and again required amputation. It is quite amazing how they can sit by and do nothing for very severely injured patients, not even bathing them or cleaning them up. It was one of the most depressing incidents I have so far encountered in the whole project so far.

Another rather depressing incident involved one of my favourite doctors in the hospital. I had returned one evening to pick up some papers from the hospital, and saw the lights on in the operating room. When I investigated, there was the doctor in question operating on a woman with very large fibroids, but these were completely adherent to everything, and he was right out of his depth, and had been about to call me in. The next couple of hours were rather difficult, as it was not an easy task to complete the job. Again it seemed to illustrate their rather cavalier attitude in tackling things which they were not really trained for or able to do well. In this particular incident, they were operating after normal hours on a case which was completely elective, but the wife of one of the most influential citizens of Tororo, and who I am sure was being charged heavily for the service being performed. I have found in the past that some of the elective surgery done after hours is done so that I am not aware that it is being done, and in these instances, the patients are usually those who can pay well. The whole business of payment for the medical services is a very difficult one, because they do have to charge

something, in order to make a bare living, yet there are no guidelines for the patients, and the charges can be arbitrary. In fact there was one doctor working in Jinja, who took down the intravenous infusions, and stopped all drugs postoperatively on a patient who could not pay, and who had been operated on by another surgeon who had not charged for his services!

For the past year or so, I have been talking to many of the local 'traditional healers', with a view to trying to evaluate some of their herbs and medicines, in order to see if it is possible to help them to some form of standardization of the content of the medicines, and discover those that may have some real definite pharmacological actions. The stuff they call 'mumbwa' most certainly does, and is a very powerful oxytocic drug, and I have seen a good many women suffer a ruptured uterus as a result of using the stuff, so I'd very much like to get some specimens of it for analysis. There have been several meetings with this group now, none of which has been very profitable, because they always end up wanting to know how they are going to be paid for coming to the meetings, or else how are they going to be paid for parting with their 'secrets'. They have been egged on by the local District Administrator, who told them that their 'knowledge' is always worth something, and should be paid for. I have asked them if they really want to know what is in their herbs, and if I find out for them, what will they pay me for the knowledge. To which there is always a rather stony silence. There are however, one or two of them who seem genuinely curious as to what is in the plants and herbs they are working with, and with a little patience, perhaps something quite interesting may come of this little exercise. These traditional healers are all terribly suspicious of each other, and will come individually to ask if any of the others have been to see me, and offer to bring herbs etc. if I do not tell the others. They say it would spoil their practices if others got to know their secret remedies! It seems that our profession does not change very much, no matter what stage of evolution they are at.

Finally, the bicycles sent out by Rotary in St. John's have still not arrived; they have been almost a whole year on the way so far, so I have sent off an insurance claim on them at long last. I feel sure that they have been 'liberated' somewhere between Tororo and Mombasa. I shall have to tell the Rotarians this when I get back home.

This time the journey home is truly needed, as I feel a daily shortening of my 'fuse', and have on a number of occasions recently let fly at people, and it is nearly always the wrong persons who get shouted at, as they were the nearest ones to vent one's temper on. Never mind, a few days on a river will cure all that, because as the Assyrians said over 2000 years ago, "The Gods do not subtract from the allotted span of men’s lives, those hours spent in fishing."

Part 3

October 17th, 1991 - July 16th, 1992

Pages 67 - 97

October 17th, 1991.

I have been back in Uganda over six weeks now, and it has been not without excitement or event. It is about the longest delay yet in writing up the diary, but so much seems to have happened, and with the advent of Dr. John Lewis and Noreen, who arrived a week after my own return, to assist in the project, there has been a lot to do, and it has left little in the way of leisure time in the evenings.

So let's start at the beginning. When I arrived back it was the start of a brief dry season, and very hot indeed, with the garden beginning to wilt, and a couple of the cuttings which were put in have succumbed. However as soon as the equinox had passed, within a week we began to have rains again, and for the past two weeks it has rained pretty steadily, and the whole countryside has become green again, and all the vegetation has perked up.

John Lewis and Noreen arrived about a week after I did, and they were in very good form revisiting the Hospital where John had worked, and the house where they had both lived many years ago. It was a really touching time to see them reliving the past briefly, and contemplating the present situation in this poor country. Though the condition of almost everything is improving daily at a fairly obvious rate, so that the place is becoming cleaner and new building activity is greater than it has been for the past 20 years or so. There is still a subsurface tension in Kampala mostly, and to a much lesser extent in the smaller places. John and Noreen were pretty rapidly indoctrinated into some of the more violent aspects of the place. About a week after we arrived and got settled, we had to go from Tororo into Kampala on one of the regular Wednesday teaching days, and on arrival at noon we were driving up to Nsambya Hospital to drop our cases when we saw the bodies of two men who had been shot and left lying in the ditch. There was a large crowd gathered round them, looking on. We later discovered that the men had been shot as thieves, about midnight the evening before. The police had deliberately left the bodies lying where they had fallen, as a display to deter others who might think of following their example. They were not collected to be taken away till about four o'clock in the afternoon!

The next day, we were sitting at supper in Nsambya, when we were informed that an Icelandic man, working for a Danish aid group, had just been shot. He had been walking along the street with his wife, in broad daylight, carrying a small briefcase, when a car stopped beside him, and a man inside tried to take the briefcase. Encountering resistance he shot the poor man in the foot, then, still finding resistance, shot him in the abdomen, a wound from which he subsequently died from haemorrhage. The bullet must have hit the internal iliac vessels, and caused a massive internal haemorrhage. This couple had only been in Uganda about a month and had just completed arrangements for the education of his three children. His poor wife who had been with him, and had witnessed the whole event, was of course grief stricken.

Still in Kampala. The next time we were in for a teaching session, and just a few days before Doreen returned to Uganda, I was returning to Nsambya after a visit to a friend's house at about 10.30 one evening, when I was accosted by a man who was armed with a sub-machine gun, who was pointing it at the car, and beckoning me to stop. As I slowed the car, a couple of his buddies stepped out from the bushes on the passenger side of the car, and tried to open the door which was locked. As the gunman stepped towards the car, and was just in front of my door, I managed to open it with considerable force, and accelerated as hard as I could. I was extremely lucky, in that it took him completely by surprise, and knocked him off his feet. In falling, his feet must have gone under the wheels, as I did feel a very distinct bump as I ran over them. In the mirror I could see the outline of his friends trying to help him, as I sped off as hard as I could. It seems that nobody reported to either Mulago nor Nsambya Hospital with crushed feet the next couple of days, so I wonder how he is getting on. This is the first incident of this kind I have been involved in since being in Uganda, and I hope it is the last, as it is a decidedly unpleasant experience.

Since I went on leave I was told that there had not been a single shooting admitted to the hospital in over six weeks. This is definitely a record, and most people attribute it to the effect of the field court martial held by the local army commander, when four soldiers were publicly shot in the grounds of Manjasi High school for looting a local village when they were carrying out a 'security operation' in the area. These 'Security Operations' are carried out periodically by the military, when they round up all the able bodied males of the area and herd them together in a compound; they are then kept all day while the soldiers screen them and their home for weapons and identification. In this case it seems some of the soldiers went back to the village and looted it, raping some of the women into the bargain; whereupon, the headman of the village complained to the commanding officer of the unit. The C/O then asked the villagers to identify the culprits, which they did, and he had a 'Field Court Martial' held immediately, and sentenced them to be shot. His rationale being that the ordinary courts would take too long, and they might have got off anyway. It certainly seems to have deterred the troops from further outrages, for the present at least. It does seem that the soldiers are responsible for much of the violence in the area. However, recently there was a soldier who had been in custody for being A.W.O.L. and who tried to escape, he was shot. He had the classical injury we see so often these days of an entry wound in the area of the buttocks, and an exit somewhere near the symphysis pubis. This chap was kept in the barracks for five

hours before being transferred to us in the hospital, and again, it seems that he'd received a wound which damaged a major blood vessel, as he was white on admission and died within half an hour of his arrival, blood being unobtainable in time. Again it seems that the delay in transfer was quite deliberate and was being used as an example to others who in the future, might try to escape custody. And so it goes.

There are some quite bizarre happenings these days, which leave one quite mystified as to what is going on. We had a Chinese National admitted to the hospital, quite late one evening. He was severely injured in an automobile accident. It seems that there were two Chinese people with an African woman, and since the event we have heard that there was a soldier also involved. They were driving very late at night from Busia, and as they came towards a police road block in the area, the African lady began to scream and ask for help. The Chinese driver thereupon turned the car round and sped back along the road to Tororo, with the police firing at them. They turned the car over, and in the accident the African lady was killed. The driver sustained severely fractured ribs, with extensive surgical oedema and sundry lacerations - this is the chap who was admitted to our hospital. The other Chinese man disappeared from the scene of the accident, and was not to be found, however, we later learned that a Chinese man had been admitted to Nsambya hospital with injuries that were quite consistent with his having been in the same car. The Chinese said that he had been injured in an accident on the Port Bell Road, but the car was not found and his injuries were certainly consistent with him having been a passenger in the accident. Anyway, our Chinese man was visited the next day by a couple of Chinese doctors from Jinja Hospital, one a young anaesthetist, and the other a 'professor'. I was called to the hospital as this couple had managed to get the injured man into their vehicle, a sort of minibus, and were about to take off to Jinja Hospital with him. It is still difficult to know how they knew he was in our hospital, because we could not get through to anyone on the telephone to let them know he was an in-patient with us. We guess that the injured passenger must have made it to Jinja and informed them there. It was about 6.30 in the evening when they eventually set off for Jinja, but were again stopped at the Busia road block, and ordered back to Tororo. When they arrived back at the hospital the staff tried to persuade them to put the patient back in bed in the ward, but they refused. At this point I was called, and also tried to persuade them that the patient would benefit from being in a proper bed However they were quite adamant in keeping him in their van all night! In the morning they tried to set off for Jinja once again, but were thwarted by the police, who carried out an inspection of the vehicle, and a 'post mortem' on the dead African lady. The post mortem simply consisted of a very brief inspection of the body by one of our doctors. They finally departed for Jinja with a police escort, and subsequently we learned that the Chinese had moved the injured man to Nsambya hospital, and had smuggled him out of that hospital without informing anyone as to where he was being taken. It looks as though they are trying to 'lose' him. What the whole episode was about is still totally mystifying, particularly as the injured Chinese man worked at Kabale, way over in the West of Uganda. It seems that he must have been visiting Kenya and returning through the Busia border town. There are many Chinese in Uganda still, mostly engaged in road building at present, though there are still a few of them who are training Ugandans in the cultivation of rice, which they grow in the many swampy areas round Lake Victoria once the papyrus is

cleared. Uganda is of course an ideal place to grow rice with so much swamp land and good rainfall, combined with a warm climate, so that many of the rice fields can grow at least two crops annually.

November 5th.

The Dutch plastic surgical team have visited Tororo again, and as always have done sterling work for us with a lot of teaching into the bargain. John Lewis and a couple of the new postgrad students got a lot out of their visit. This time I did very little with them, as they are coming back sometime in May probably, and I'll have them all to myself at that time. Dr. Rein Zeeman, the leader of the team, is a superb teacher, and takes his vacations doing this kind of work in developing countries. He has brought two new partners with him, a male operating room technician, and Jan, the anaesthetist, who has had a wealth of experience using our primitive anaesthetic machine. The old EMO machine, was designed in Oxford mainly for troops in wartime. It was designed as a very rugged emergency anaesthetic machine, which can therefore withstand even the African treatment of equipment, and believe me, that is saying something! It is horrendous to use on children, without air or oxygen under some pressure, but Jan uses the bellows on the machine to maintain a steady flow for the kids with hare lips etc., that are being done. It means that most of the time two people are needed to operate the machine.

Cases of Interest:

Since our return there have been a number of the usual interesting problems, and the number of patients with AIDS has continued its steady increase. However before going into the particulars of some cases, a mention should be made of the current dreadful situation with regard to drugs, anaesthetics and other medications. It is now over six months since we got a supply of pentothal, or any other anaesthetic, so we again have had to scrounge for it from other hospitals who are doing less surgery than us - with moderate success. That supply is now run dry and the future would look rather bleak but for the fact that we recently received a shipment of pentothal, donated by the schools in Newfoundland. This will enable us to do at least 300 more major operations, and possibly tide us over till the Ministry of Health get their act together once again. Since I went on vacation there has been another change in the post of Permanent Secretary for Health, the last one having been fired because of the discovery of an illicit association with the proprietor of the garage in Kampala which has the franchise for Peugeot Cars. It seems that a three year supply of Peugeot ambulance spare parts disappeared from the Ministry of Health stores, and the guess is that they were 'flogged' to the owner of the Peugeot dealership.

There has also been a change in the Minister of Health, who, for the first time since the project started, is a doctor, as is also the new Permanent Secretary, who combines the post with that of Director of Medical Services. One would think that this would be a team that would understand the problems of doctors in this country and the difficulties in keeping them in Uganda, however, the complete opposite seems to be the case. This pair have managed to alienate more doctors in a shorter time than anyone

since I began the project. They have begun their reign by moving almost all the doctors in charge of the various hospitals in the most decerebrate manner imaginable, it seems that the moves have simply been moving a doctor from one hospital to the hospital in the next town, and none of the doctors in charge of these hospitals have been given any valid reasons for the move whatsoever, but have simply been 'ordered' to comply with the transfers. The brain drain to the African countries of Ugandan doctors is already acute, and the present Ministry officials seem to be trying to drive people away. The other bizarre action on their part has been to take all the 'seconded doctors' out of the Mission Hospitals. The reason for this action is said to be to relocate these doctors in the 'upcountry' hospitals where they are 'needed'.

It should be pointed out that over 80% of the active treatment and curative medicine is carried out in the Mission hospitals, and that posting functioning doctors from Mission hospitals to the non-functioning government operated hospitals will solve nothing, and only aggravate an already sad situation. It so often seems that the Ugandan Government civil service has an uncanny knack of doing quite the wrong thing, and 'shooting themselves in the foot' so very often.

November 16th.

Again a long hiatus! Work seems to have taken precedence over the writing of late, and having 'help' seems to have had the effect of making things even busier as far as the clinical side of things go. John Lewis has taken the plunge with a vengeance, and has discovered the joys of 'doing things' being busy honing up his surgical skills. In fact hehas managed to undermine a great deal of the 'system' of referrals which was intended to force the Ugandan doctors in the hospital to do their fair share of the work, and has taken referrals from all and sundry, including the medical assistants. I had set up a fairly rigid system of getting the doctors to do referrals, so that they had to see all the patients first before I would see them. However once the system is undermined the doctors take the opportunity to absent themselves in the knowledge that the patients will all be seen by a doctor. In the meantime they go off to their private clinics and see the patients there, giving them opportunity to make more money privately. While one cannot blame them, being as poorly paid as they are, but it leaves the hospital with a bit of a vacuum, as far as their presence is concerned. Not only that, but they are less able to be contacted for emergencies that they should be handling. Worse still, they learn nothing. However after general practice in Canada, the opportunity to be a 'real doctor' once again is too tempting to be passed up I guess! I suppose I should not grumble too much.

We had a rather horrendous case recently. A lass with a fairly extensive carcinoma of cervix presented and refused to go to another hospital more suited to deal with this sort of problem. The reason given was that she could not afford it, so I ended up doing the surgery. The lesion was far more extensive than I had anticipated, and in the process I managed to cut both ureters without realizing it. This meant going back in again, and trying to transplant them, which was achieved by using fairly fine polythene tubing, and threading them into the ureters, which were transplanted into the bladder once

again, and the tubes threaded through the urethra, beside a catheter which was left in situ. It has worked very well so far, and the tubes are due out in a couple of days, so the results will be known in a few days time when the tubes are removed. It is one of the more horrendous kinds of decisions one has to make when one is forced to do surgery which is really beyond the normal scope of the operator, but the buck certainly stops right at one's doorstep, and at times cannot be passed.

AIDS of course takes precedence over everything else at the present, and the variety of presentations is truly amazing. We have had a couple of cases of transverse myelitis of late, and these poor people come in with paralysis of all below the level the lesion. So far none of them has improved, and it seems that they go on to a fairly rapid terminal state after this has happened. Since I came back, at least two of the hospital staff have died of AIDS, the most notable one was our plumber, a particularly nice older man who had kept the whole of the rather creaking plumbing system from completely falling asunder in a most ingenious manner, using the minimum of materials. Once he died, the whole system suffered a rapid collapse, necessitating the spending of a lot of money replacing pipes which had been the originals when the hospital was built. They were utterly furred up - completely stenosed, and it was amazing that any water could get through at all. We had to hire two men who worked for a week, and spent over $1,000 to fix the water supply once again - this has put a real strain on the project budget!

There is another most remarkable thing about the AIDS problem I discovered recently when talking to one of the university contractors. He told me that originally the University undertook the responsibility of providing coffins for any student who died while in the course of studies, and not only that but had agreed to transport the body to the village or home. He now makes at least one coffin every day, with a maximum of seven one day! This in what should be the young and healthiest group of the population. Ninety nine percent of the deaths in the University are due to AIDS. At home the death of a student is one of the most remarkable things in any university, and is usually due to an accident of some kind. The original agreement by the university to provide this kind of service was begun in 'the good old days' when a student death was a rarity, and now of course, the whole matter is going to have to come under review. They cannot possibly afford this strain on their meagre budget for any length of time to come. Some of the student come from long distances, and the cost of transporting them home is considerable.

November 25th.

A few days ago, a young Canadian named Roderick Leighton, arrived in Tororo, the very same day as a letter arrived telling us he was coming! I knew him as an intern in St. John's, and a member of 'Physicians for Social Responsibility' (later to be called IPPNW). A most independent young man, who is currently doing surgical training at the Grenfell Hospital in St. Anthony. I had heard from him about a year ago when he was asking to come, but it seems that he went to Afghanistan instead at that time - during the

time of their warfare with the Russians. He certainly gets around, and I guess is going to continue to work in the third world countries on a more permanent basis, when he feels that he is ready and sufficiently trained or competent to handle the problems one encounters in these places. He has taken the lady with the cut ureters under his special care, and is doing a very good job with her. She is still draining through the ureteric catheters, so I hope all goes well with her.

A further addition to the saga of the disappearing Chinese. It seems that the injured man we had in our hospital, and who eventually landed in Nsambya Hospital, was spirited out of the place, under the noses of the police guard they had, and has simply vanished. I am interested to know how on earth they get him out of the country eventually, if that is what they are going to try to do. Clever people these Chinese!

December 1st.

The lady with the cut ureters has not done well. Once we took out the catheters from the ureters, she developed a pseudo bladder, and began to drain suprapubically. I have managed to persuade the family to take her to Nsambya at last, where Dr. Miriam Duggan will undertake a further repair if possible. Rod Leighton has proved a valuable asset, and is helping the other doctors in the ward tremendously. They do seem to value him as someone of their own generation, and he's working very well with them. He is the kind of chap who is never satisfied until he has tested his powers of endurance to the uttermost. He has more or less insisted on staying at a rather run down place called the Christian Guest House. He runs miles every day, climbs Tororo Rock, some 1,500 ft, every day almost, and at night has climbed up a very high communication tower put up there some time ago with the help of Uganda's one and only military helicopter. This is the same helicopter that was used by Obote when he made his escape from Kampala at the time of the military coup led by Titus Okello in 1985.

December 15th.

Rod Leighton has left for home, he certainly left his mark on the place, as being one of the 'cream of the crop ' of young graduates I have met in a long time. I have had nothing but bitter disappointments with many of the others who have said that they wished to come to work in Uganda, and then let me down at the last moment. The most recent person was an Irish graduate, who had said she wished to work here, and with whom I have been in touch with for over two years now. During which time she was unwavering in her 'desire to work in a developing country'. Then at the last moment, just over three months before she was due to come here, she wrote saying she was not coming! I have nobody else wishing to come during this particular period of time, but John Lewis will probably wish to stay on for a longer period than the original six months agreed on. Rod Leighton, before he left, said that he would look for someone else though, and thinks he knows a couple of people who just might want to come out. Let's hope so. I have already been let down by one of our MUN Family Practice Residents,

who backed out of his commitment with even less notice than the Irish graduate. There is another MUN ex-resident who is wanting to come in September, but I'm not banking on it any more, believe me. In fact I think that I'll do the last year here alone.

December 20th.

The Lewises have left for a vacation in Kenya, intending to go to Mombasa, and visit the game parks etc. on their way home. Meantime with some dread, if last year was any indication, one views the advent of Christmas here with some misgiving. The level of violence usually escalates markedly. Already there has been a rash of highway robberies of the 'matatus' as they come from the border towns of Malaba, and Busia. It seems that at this time of year that they figure that people returning from Kenya have Christmas gifts, and often more money than usual, so the hold-up these mini-bus taxis and rob the occupants. At least nobody has been killed, though one of the drivers had a very lucky escape indeed. A shot was fired by someone on the Kenya side of the border at the Matatu, and the bullet penetrated both the drivers' arms, leaving him with a fractured humerus in one arm, and a flesh wound in the other! Just a split second later, and it would have gone right through his chest killing him outright!

December 27th.

A lovely Christmas. Doreen and I spent the day with the children at the Salvation Army orphanage, run by that indefatigable Scottish Lass, Joan Linnaker. Doreen has taken a very active role in the home, being now chairperson of the Board, and is doing a wonderful job of assisting Joan in some of the more difficult decisions to be made. On Christmas Eve the kids all came to sing carols at the house adjourning the hut for what they call 'sodas' (soft drinks to us.) and cookies. This time, we all went down to the hospital, and they sang carols to the patients there. It was so appreciated by most of them, that it was quite touching. Even in the T.B. ward, where the majority suffer from AIDS, the patients seemed to enjoy the thoughtfulness of the children going to sing to them. The dinner at the Boy's Home was well worthwhile. There is a little chap, the youngest they have had for a long time, called John Mousa, a real character. He has taken to Doreen and Joan in a big way and is getting quite spoiled in the process; he's a real winner, with the most astonishing ability to evoke a happy kind of radiance in all about him. It has been so pleasing to see his personality develop over the past couple of years.

Yesterday was Doreen's day to cook Christmas dinner, and we had Paul and David, a couple of 'Brits' working with the roads and the World Bank respectively. It was a first-class spread with a turkey and all the usual traditional trimmings. The turkey was a gift from the father of a patient who lost his eye when he was kicked during a football game. He now has an artificial eye, a gift from a German eye surgeon who works periodically with an optometrist called Wolfgang Gindorfer. Wolfgang has been in Tororo running an eye clinic for about six years now and is very much part of the local establishment - one of this world's real altruists, and host to a number of other Germans

who seem to pass through the place in a regular stream, and who we meet from time to time. In fact we have another German benefactor to Uganda in the place now, one Helmut Anseld who recently gave us 50 beds which had been discarded from German hospitals and which he collects from home and then distributes to hospitals here. These beds are far better than any of ours, and are so simple to operate that it is a joy - practically no moving parts to be wrecked!

We learned to-day that four people had been stabbed to death at a small border village not far away, in a cattle raid by Kenyans from across the border. How they got the cattle over the border without being seen I can not imagine, there being a fairly rapidly running river at Malaba and Busia. However I guess that there are some places where it can be forded, or at least the cattle driven over. This kind of behaviour is quite usual in Karamoja, where cattle raiding is a form of 'manly sport' to be indulged in by all young men on reaching maturity, but I have not heard of people from Kenya doing it for years - though the rumour is that the raiders were Ugandans based in Kenya. Then again there were two people shot and killed in a gas station at Busia last night, but so far no one has been admitted to the hospital with a gunshot wound this 'Festive Season'.

On Christmas Eve we did have a man from the Office of the Ministry of Internal Affairs admitted with appendicitis, I gather one of the 'higher officials ' of the place, a rather large gentleman and a bit difficult to do, surgically speaking. Appendicitis is rare in Uganda, except those Ugandans who eat Western type food, such as bread etc., instead of the traditional foods of the place. However, they get worse conditions such as sigmoid volvulus from some of their foods. This an astonishing kind of encounter when one sees one's first case because the sigmoid dilates to the size of an inflated car tyre inner tube, and looks not unlike one!

January 2nd, 1992.

On New Year's Eve we had a man admitted with a volvulus of almost the whole of the small bowel, and the majority of it was quite gangrenous. The only solution was resection. Astonishingly he is still alive and has passed flatus and a watery stool. I just do not see how he can possible survive. Then again the maddening thing about this place - I was called to see a man who had a dislocated hip and who had been admitted five days ago. Because he could not pay for an X-ray, and because he did not have money to hand to the orthopaedic assistants, nobody informed me of his presence in the hospital! Anyway, with some difficulty the hip is now back in place, and the X-ray was not needed anyway. The two postgraduate students left today for their next rotation in Kampala. This pair has been the best we have had to date. Dr. Welishe comes from Mbale, not too far away, and is by far the most knowledgeable we have had in the programme to date. I have marked him for one of the future faculty members of the programme once he has graduated. The other chap is Dr. Omodo, who is a major in the Army Medical Corps - a most energetic chap, who does some quite unusual things but seems to be a thinker at least, which is a nice change from the majority. Some of the staff do not like him because of his rather bluff manner, but once you get behind it he seems to be a chap who

does seem to care quite a lot about his patients. This couple of students have been by far the best and most consistent workers of any so far.

This day there was a very stormy interview with the Matron of the hospital, during which time I had occasion to call her “Nothing but an ornament in the place, and not a very pretty one at that.”. The standard of nursing care has become quite abysmal, and patients who have had vesico-vaginal fistulae repaired get minimal attention, so that I have had two of them break down recently. Nurses here do not take daily temperatures, or input-output charting, or indeed any of the most basic functions of nursing that they were ostensibly taught. The cry being "We have no thermometers", or "They got broken." I often feel that they break them so that they do not have to take the temperatures, or else, more likely, they sell the thermometers I have given out to the various private clinics, of which there are so very many. Uganda Law states that doctors have to supervise all the 'private clinics', but there's nobody to enforce this law, and in the Tororo area one clinic is supervised in name by a doctor who has since died of AIDS, another is 'supervised' by a doctor who is currently studying in China, and so it goes! It is interesting that these doctors do get paid by the clinics on a regular monthly basis for the use of their names as being the 'Supervisor'. Our last Medical Superintendent used to go to Iganga to collect his dues on a regular basis as supervisor of a clinic in his name there, and Iganga is about an hour and a half drive from Tororo.

The Lewises got back from their trip to Mombasa and other places today, and seemed to have enjoyed themselves very much.

This was a heavy surgical day, with an amputation of the right arm. A young driver who had rolled his car over with his arm hanging out of the window and got it mangled as a result. Then an albino man who had a huge fungating tumour of his ear, necessitating removal of the whole of the external ear, and the canal. I have tried a very large pedicle flap graft taken from his neck, but it looks infected. I had to go right down to the bone to get all the tumour. Albinos certainly do get cancer of the skin much more easily than most people.

January 6th.

An astonishing thing has happened - the Ministry of Health has provided many of the up-country hospitals with ultrasound machines! They are not the best in the world, but by no means the worst either, and have both sector and linear scans. We got our machine a few days ago, and I got it working to-day for the very first time. The first patient was a lass who saw one of the doctors and he thought she had an intrauterine death, however all was well, and the babe was fine - a nice opening case . These machines are very definitely a 'Third World' tool. One needs no photos or films, and they only require a good and regular power source. Anyone planning to go to a developing country should learn the basics before coming out, as they are a marvelous non invasive investigation tool. In the hands of the person who actually wants the information, the ultrasound can give terrific reassurance.

January 12th.

Doreen and I, egged on by Joan Linnaker, the Salvation Army Major who runs the local boys' orphanage, decided a few days ago to have a very short break in Nairobi, so we set off on the 9th, and are now enjoying a spot of civilization at the Fairview Hotel, a very nice place that I discovered is run by a schoolmate, Charles Slapak, from the dim and far off days in the 'Prince of Wales' School.' His brother who was actually in the same class as myself is now a renal surgeon of some note in the U.K.. We nicknamed him 'Taffy', for some obscure schoolboy reason. We did not get any reduction in the hotel rate though!

On the way to Nairobi, we stopped off at Kisumu to get some Kenya money at a better than average bank rate, from some Asian friends, then went on to Nakuru staying the night at the Kunste Inn, which is run by a German. In Kenya there is a real German presence, particularly in Mombasa. To me it is quite amazing that one can go from Tororo to Nakuru in a day's very leisurely driving, stopping a good time in Kisumu. In my youth, going from Kisumu to Nairobi took a full day's dusty, dirty driving, with many flat tires on the way! One of life's tragedies though is the dearth of wildlife now. In the 30's we saw every imaginable creature on the way, in huge herds. Now nothing to see, and everything all fenced off, so that the animals cannot get about and their migration is completely thwarted, all being herded into the game reserves. This the price of 'progress'.

I met an old friend of my childhood, Rosemary Charles (nee Hodgson.) whose father ran Barclays Bank in Kisumu. She did nursing and then came out to Tanzania to work for many years, meeting her husband there. Her mother, still alive and living with them at the age of 94, is most forgetful, suffering from Altzheimers and cannot hold her attention for any length of time. Very sad indeed - so many of us live too long these days.

In the evening went to see Susan Scarlet, now the Canadian Vice-Consul in Nairobi. She's living in a house rather like Fort Knox for elaborate security arrangements, but it was so nice to see someone we knew from Home.

16th January.

Arrived home again yesterday, and it was good to be back. The trip back from Nairobi was most pleasant. This time we took the high road, via Eldama Ravine and round to Eldoret, which has the most magnificent scenery imaginable. The road from Bungoma to the border at Malaba is now almost complete, so the trip was a very easy one indeed.

At long, long last the bicycles which were a donation from the St. John's West Rotary International Club have arrived! The history of these bikes is stormy. Mrs. Lucy Dobbin, who was a member of this club, raised the money for 10 bicycles to be sent to us

in Tororo for use by the hospital staff. Bikes are still the most useful form of transport here, and the people prize them as we do our cars. Most of the staff cannot afford a bike and have to walk, often miles to work, so I thought it would be a good way to assist the staff. Mr. Owen Redfern contacted his brother in the U.K. who arranged a shipment of 10 Raleigh bikes to be sent. They took six weeks to get to Mombasa, then got stuck there in spite of my repeated effort to get them out, as they were prepaid to the door of the hospital. It seems that the Mombasa shipping firm were at loggerheads with the company who shipped them from Britain, and just held on to them, in the meantime dunning me for demurrage! I discovered subsequently that this firm had held up shipments to many other parts of Kenya and Uganda, including drugs, medical supplies, machinery, and had driven many other companies mad in the process. This state of affairs lasted for over 14 months, but finally, one day, after a friend had visited the Mombasa warehouse, and seen the crates of bikes, and demanded their release, they were sent on to us and arrived in the most appalling condition. When we saw the cases we realized that they had been pretty selectively pilfered, and lost $120 worth of parts, which miraculously we managed to purchase locally and had them assembled in the hospital grounds. The best part was that the chap who assembled them for us only charged $3 per bike! a real bargain, if ever there was one. Now we have a number of staff members with bikes who are so pleased with themselves. Only a pity that we did not have more to give out. So almost a year and a half late the hospital got their bikes - many thanks to Rotary.

January 20th.

Almost had a tragedy today, John L wanted to do a skin graft on a man who had terrible burns of the neck. I had excised the scars some days before, which were now ready for grafting. During the anaesthesia induction he vomited and inhaled. It was touch and go for a while, he became the blackest of black men I've ever seen during the resuscitation process.

I had the whole sewage system overhauled recently. It had become blocked in many places, and the stench was becoming quite overpowering. Needless to say the Uganda Government would do nothing about it. The highlight was when four men stripped off completely and got into the main sewage septic tank, up to their waists in it, and by hand they shoveled all the shit of ages out, mixed with plenty of non-biodegradable plastic! This they shoveled into a huge pit, and covered it all with soil - took them a whole day to do, and all for 10,000 shillings each (about $10 Canadian.) I also bought them plenty of soap, and they seemed happy enough. The terrible things people will do if they are poor enough, but doing things by hand is the only method we have here.

January 26th.

Doreen's birthday, but we celebrated it last night with a Robbie Burn's night. There are few enough of us Scots here, just Joan Linnaker and I, but we had a grand night

of it when some folk from Kampala came to help the festivities with the usual speeches and recitations from 'the Bard', haggis and the works. No piper, but recorded pipe music to bring in the haggis etc. We even got a welcome letter from the Caledonian Society in Kampala, to which I replied with a 'Doric poem', written in the braid Scots.

January 28th.

Case of the year so far was a man from whom I removed a huge cyst on his forehead which had been growing for 13 years! It had displaced his eye downwards, and measured 9" by 6". It proved to be a periosteal cyst that had eroded his skull in the area, right down to the meninges! Quite unbelievable that he should have tolerated it for so long. He now has a large dent over his right eyebrow where it was growing, with his right eye lower than the left. He can see with the right eye in spite of its different level, but is having trouble focusing with both eyes, and I think he'll continue to suppress the right vision until he adapts to it, if ever. Africa continues to astonish completely, and bewilder one with the terrible gross nature of the things that they do not get done, because they cannot afford it. The other astounding thing yesterday was when one of the doctors called me to deliver what he thought were 'locked twins'. This proved to be a siamese twin type baby with two heads! I had to decapitate one of the heads in order to effect the delivery. However the mother was quite all right, and very good indeed about it all.

January 30th.

This continues to be a month of the most extraordinary cases, this time a baby was admitted, two days old, with a huge tumour of some kind growing out of the sacral area. At first I thought it was a meningomyelocoele but on close inspection, it obviously was not that. Next I thought of a teratoma, but it was not like that either. I did not give a lot of hope for the infant, but the mother persuaded me at least to try to remove it, so as the buck stops right here, and she refused to go to Kampala, I began the dissection under local anesthetic. This time it proved to be a pseudo-Siamese twin! I took photos before and after, and the main part of the swelling was a well developed brain, supplied by two large arteries running beside the sacrum, the rest was a rudimentary face, and even more rudimentary limbs. The brain shelled our quite easily, and the baby lost very little blood of its own. Anyway the baby did well with the surgery, and looks as though it will survive.

The next two cases were a lass with what looks for all the world like Paget's disease of the nipple, with a tumour below it, but she's only 18, and I cannot believe it, and have temporarily diagnosed it as a breast abscess with a reaction around the nipple. Then a young boy of 10 came in with a tumour of the breast, very hard and nasty looking. This has been there for a period of six months and is growing. He's for surgery.

February 4th

The young lad with the breast lump looks as though he's got a rhabdomyosarcoma! It was a hard mass in the pectoralis major muscle, so I took off most of the muscle, but the prognosis is terrible - I never ever saw one survive.

Last Friday, a special trip to Kampala, to meet with the various discipline coordinators, who are supposed to be looking after our residents in Mulago. Not one single one turned up, in spite of two weeks notice. Give them more notice then they say they forgot, less and they say it's too little. When it's just right they don't turn up anyway, you can't win! Africa, and the people's disregard for time etc. can drive one completely mad.

February 6th.

Yesterday, there was a meeting with the traditional healers of the area, they want to conduct 'research' on some of their herbs! Their agenda was interesting, they wanted money to collect herbs for photographing, and containers to keep them in (Bottles and jars are at a premium here, and there is a lively market in old bottles that goes on in the local market.). However, I managed to steer them away from this and asked them to bring their criteria for diagnosing AIDS, i.e. what symptoms did they consider were the most important in their diagnosis before they started their herbs? The results of their collective thought should be of great interest, but I think most of them are pretty good at the diagnosis part by now, they've all certainly seen plenty, even though some claim to be able to 'cure' it.

Together with John Lewis I operated on a man with carcinoma of the rectum, doing an abdomino-perineal resection. He took the top, and I took the bottom end, but the Africans in Uganda have such huge sigmoids, that it is easily possible to mobilize it and bring it down to the rectal area, and suture it there. It is much more acceptable to them, than a colostomy, which would make them a social pariah and outcast almost. I had done two before this - alone, working both ends, and both of these cases worked very well indeed, and after a time, the bowel sets its own rhythm, necessitating little more than a sort of diaper to be worn. Diarrhoea is the only trouble, but it is rare in the adults here. Only the kids get it a lot, and they die of it, a sort of 'natural selection' - if you survive your first five years. It takes a lot to kill you if you are a Ugandan!

February 9th.

A big week this, as Professor Mugerwa actually visited Tororo for the first time, and came with his wife, who is quite charming and full of life. He is the Dean of Medicine at Makerere and it is the first time he's actually seen the programme, and what we are trying to achieve. He even came out to Kiyeyi with me to visit the Finnish people who run a Primary Care Health Centre, in fact I think it is the best one in Uganda. He left

us quite impressed, and I think it was the best public relations exercise we've ever had. Doreen of course fed them well, and that put them in a very good frame of mind. She's absolutely terrific at getting an 'instant meal' for the numerous visitors who drop in quite unannounced - everyone from the Sisters, Margie and her lot at Karamoja, to the Nsambya crowd, the British 'Bobbies', Ministry of Health officials etc., etc.. No one can let us know when they are coming, they just arrive, because the telephones never work, and communication is well nigh impossible most of the time.

Then we went to Kamuli with Manfred Stoermer, the German lad who has come to help with the cost sharing we are trying to set up in order to finance the hospital with drugs, dressings etc., and leave it on a footing that it can be self-sustaining when I leave. How Manfred came in the first place is a case of real serendipity. A Dr. Robert Lenius visited me at the hospital about a year ago. He was taking up an appointment in charge of the German Volunteer Agency, D.E.D., here in Uganda, and just dropped in to see the hospital - no particular reason, except that he wanted to compare a government hospital with what he'd been working with in Tanzania. To my astonishment he declared ours was a 'class hospital' compared with those in Tanzania, so what they must be like I cannot imagine. Before leaving he asked if he could help by sending a German volunteer doctor to help us! I replied that if he could get us an economist or someone with third world experience who knew accounting etc. it would help me set up the 'cost sharing' scheme, which is an integral part of this project, I would be more than grateful. He seemed to like the idea of the community paying something towards their medical care, as the governments of Africa, being what they are, just do nothing for the smaller outlying hospitals, and little enough even for their major teaching hospitals. This accounts for the constant shortages, and corruption in the form of under the table payments to the staff, disappearing drugs, money and food etc.. The whole cost sharing scheme seemed to me to be getting more and more difficult to set up, with all the clinical and other administrative work I had to do, and I was getting a little desperate about it. Anyway, Robert promised to get me someone, and this is Manfred Stoermer, a most delightful companion and help, who seems to be able to keep his patience and his cool, with all the delays and frustrations, so I have at least some hope that things will indeed begin to work out.

We went to Kamuli, where Manfred has been looking at the charges for medical services levied at a Mission Hospital that has been handed over entirely to the Ugandans. His conclusion was that they are not very busy there, because the charges are more than the people can afford, so we will have to modify things quite a lot. It seems that the missions are not the best models for us to use as a pattern. While in Kamuli, we met with a number of German volunteers, helping to set up a primary care health unit. They are a delightful group, presently going through all the problems in exactly the same way as I did in the first year of this operation!

February 15th.

My beautiful ultrasound machine was broken by two 'technicians' who came out from the Ministry to give me a voltage regulator for it!!! They managed to pull the cord in some way, so that it broke contact. Another lovely example of 'give us the job and we'll finish the tools'. Anyway, I did manage to fix it, but they're never going near it again, if I can help it. There is a story going the rounds that there was a Ugandan put ashore on a desert island, and asked to look after three cannon balls for the time he was there, when they met him again, they could not see the cannon balls, so they inquired and to their inquiry he said: "Well you see, one of them got lost, one got stolen and the other one got broken". The capacity to break good equipment is quite fantastic. A chap in the agriculture department tells me that the average life of a brand new tractor in Uganda has been estimated at only 1,000 hours!

We have a new medical superintendent in the hospital, one Dr. W***. As I think I have mentioned the government shunted all the doctors in charge of the hospitals down the line towards Kampala, i.e. from Soroti to Mbale, from Mbale to Tororo, from Tororo to Iganga, from Iganga to Jinja etc., in a rather mindless moment, right in the middle of the school term. Each of them is furious with the Ministry of Health, who gave no rational reason for their action, it just seems pure whimsy. Our previous superintendent, though he did have a few faults, such in running a clinic at Iganga, a posho mill here, as well as a couple of private clinics in the town. Most of the doctors really do have to have a side business in order simply to make a reasonable living, but it does detract very much from their effectiveness as medical superintendents and administrators of a hospitals. He did have a lot going for him, being very likable, and interested in the teaching programme, and the cost-sharing exercise. The new chap, W***, talks a good line, but he comes with a rather negative reputation from the doctors at Mbale, so we shall have to wait and see what develops.

February 20th.

At long, long last the University has reactivated the 'Planning Committee', a body which meets to consider new programmes. I have been asking that this teaching programme be formally recognized so that when I have done with it, all the necessary planning for future funding, student intakes, office and secretarial help etc., is in place. The excuse always given was that they had not met, so when I asked the Dean for the names of the chairman or other people involved, so that I could speak to them, I got the reply "I'll send it to you". I now discover that it just fell into dissolution because 'there have been no new programmes since 1982!' They have simply not met since then, and the previous chairman is no longer in Makerere. Anyway, there are a number of new courses and programmes starting up again, so they have reactivated the Committee at long last. I have given them all the requirements, together with a budget, which is very modest, and which they should be able to manage, particularly as they do not have to pay for rooms, furnishings, and there are a lot of secretaries sitting about doing nothing.

Later in the evening Doreen and I visited Dean Shuey, an American, working with AMREF, a body primarily funded by Canada now by the African Medical Research

and Emergency Fund. It was started by a doctor in Kenya who began their Flying Doctor Service, I've forgotten his name, but he's written an excellent book called 'Different Drums', well worth reading. Anyway Dean is based in Kampala, working with the Ministry of Health in Entebbe, and getting very frustrated into the bargain

February 28th.

Dr. O***** our surgical coordinator for our residents in Mulago Hospital came out here as his home is somewhere nearby. He brought his brother in to see me with acute pancreatitis. Dr. O***** has been here to operate, as a 'teaching exercise' on one occasion. A most unprepossessing character, very fat, a Demerol addict, who is quite one of the worst surgeons I've ever seen. It is the one and only time he'll ever be asked to come to Tororo to teach, and I have asked that we be given another person to coordinate the students as they rotate through surgery.

Saw a Catholic priest to-day, a charming Dutchman, who has been here for 35 years, teaching at the Tororo Girls' School. He was very run down and anaemic, though why I have not yet determined, unless it is repeated bouts of malaria, for which he treats himself - as do most people here.

March 5th.

The ultrasound machine continues to astonish and delight me. Saw a hydatidiform mole to-day, and a man with caseating intra-abdominal T.B. glands. The latter condition I had come across for the first time here in Uganda. On that earlier occasion I did not know what I was looking at. He had come in with weight loss and a painful mass in the abdomen, which looked polycystic on the ultrasound; anyway, at laparotomy I found a dense mass of matted glands in the peritoneum, he obviously had AIDS as well. But one does not make the same mistake twice, and the present chap has begun anti-T.B treatment without a laparotomy as a result of having the ultrasound available.

Mr. Esyapet, the senior O.R. technician, came to the door this evening having admitted his wife to the hospital. She was having a miscarriage, and had bled a lot, but the poor chap had wheeled her on his bike (one of the ones given by the Rotary Club!) some seven miles to the hospital. This is not at all unusual here, many of the patients come in on the pillion of a bike, when they cannot walk, pushed by one or two people, often for colossal distances - some ambulance! He was saying how grateful he was to have a bike of his own, poor chap just could not afford to buy one himself.

One of the best signs of Uganda's recovery and peacefulness has been the removal of almost every road block. They are all gone between here and Kampala and Entebbe. These blocks were ostensibly to check on people and their identity to find and stop the 'rebels'. However, they were mostly a form of 'Chai' for the Police and the Army men.

'Chai' is the Swahili word for tea, and with the rather nice sense of humour of the Africans, has come to mean bribes. In fact if anyone did not have proper identity they bribed their way out of the mess with ease, so the removal of road blocks has not been altogether welcomed by the police, but they still get their 'chai' from the overloaded taxis and broken down trucks which should not have been allowed on the roads normally. They have to make a living somehow.

March 11th.

We had a baby admitted to-day with its hand chewed almost completely off by a pig! What a mess, it lost two fingers and the thumb, and I do not know if the other two fingers can be saved. The hydatidiform mole came out quite neatly with a syntocin drip, but we have no methyltrexate, and cannot do a lab follow up on her for HGC, so will just have to wait and see. The baby with the pseudo-Siamese twin went home to-day, with the wound almost completely healed. I do have photos of it, and hope to see it again, but they just disappear into the bush till the next illness forces them back.

Met again with the traditional healers, who came up with some very good lists of diagnostic signs and symptoms of AIDS, as well as some very bizarre ones. However after a while got them to look at the WHO criteria, and report back a consensus amongst them as to what they'll accept, and if they will let us evaluate the patients they diagnose. We have no reagents for doing serology, and I feel that the clinical diagnosis is often too nebulous, unless it can really be confirmed serologically.

A word about the drought: it has not rained except very, very occasionally for over four months, and the place is looking quite parched, and the dust is getting into everything. There has been a warning of famine in many parts of the country, unless we get rain. However we are still well-off in comparison to most of the rest of sub-Sahara Africa, and even Kenya has felt the pinch. There is no milk, and no other dairy produce, sugar, maize and a lot of other staples coming from them, in fact Uganda is now exporting some of these items as a result. Prices are going up every day as a result of shortages of many commodities. Not only that but the recent budget has hiked the price of gasoline quite markedly, and the result can only be worse inflation, as this affects every single thing. Governments, because the gasoline sales are so easy to record, just cannot help taxing this commodity, but they never seem to realize that it affects the price of everything else and just fuels the inflation enormously, devaluing their currency in the process.

March 20th.

Having a week in Kampala with Dr. Prenderville, a paediatrician, also a Franciscan Sister, to learn a bit more about the ultrasound - she's a real expert. So far we have seen a chap with pyloric stenosis, a lass with quadruplets, many fibroids and various pelvic masses. It has certainly taken me a long way ahead with the machine.

Tried again to meet with the clinical coordinators, and again got the same result. They have all been given the objectives, and an outline of the teaching programme but have requested a meeting with all of them present, and which I would like to see happen. However, once again, with prior notice of the meeting not one turned up to it!

A batch of drugs on its way from Entebbe, the Ministry of Health Central Stores, which was a gift from CIDA got hijacked on the way. It was worth some $950,000 but obviously it was an 'inside job' as no one else could have known it was on its way to Kampala for distribution.

March 25th.

We have a new surgeon Dr. Simon Peter Odwong, he came to St. Anthony's Hospital, the local mission hospital. He has been trained in Kenya, and is one of the few Ugandans to come back to fulfill his commitments to the country after training abroad. He seems such a nice chap, and has expressed a great willingness to cooperate with this hospital in the future, but time will tell how far we'll get in this direction. I become a little cynical at this stage of the project, when so many people promise something and then do not deliver the goods.

March 31st.

Received 50 beds from Helmut Anseld, a German who is in Uganda helping provide various hospitals with discarded equipment from Germany. These beds are ideal, easy and simple to operate, easy to clean, and have made the wards look already 100% more presentable. Many of our beds are literally on their last legs, with all the springs broken and in a dreadful state for the most part. The ones I initially brought from Canada are doing yeoman service, primarily in the Maternity and Childrens' wards. Helmut promises another 50 sometime, when he returns from Germany again in a few months time.

Have had about five hare lips to repair recently, but am saving some of the worst ones for the return of Rein Zeeman and his team of plastic surgeons from Holland.

April 7th.

At long last the rains have started thank goodness, and it looks like the long drought for Uganda is over. The place comes to life instantly. I have some sweet corn to plant, given by an American who lost his wife with malaria a year ago in Kampala. The dried-up garden has suddenly become green again, and it looks as though most of the flowers have survived O.K.. Better still it looks like the threat of real food shortages in this area has been averted.

Our resident with AIDS was refused by the doctors in Nsambya to do his rotation through Obs/Gynae. Admittedly he has fairly obvious Karposi, but I do feel he should have been given a chance, because of his courage in carrying on with the programme in spite of repeated bouts of sickness. However, with the Dean's blessing we have between us devised a really significant alternative. He is going to work with the TASO (The Aids Support Organization) from Nsambya hospital, at a project which aims to make AIDS victims self reliant and self supporting. Not only that he's also going to do a research project looking at 'The knowledge attitudes and practices of health professionals towards patients with AIDS.' Something nobody has looked at here. I only hope he can manage it before the disease gets him.

April 14th.

I was astonished when one of the nurses from Tororo Girls School brought in a young patient to me and asked me to see if she was pregnant. I asked what the lass was suffering from, only to be told that she was not complaining of anything. Ultrasound showed she was not pregnant, then the nurse brought in three others with the same request. At this point I asked what was going on, and she said that these girls all had positive pregnancy tests, so I asked why the tests were done, only to be told that it was mandatory that toward the middle of the term all girls had pregnancy tests done, and that it was the school rules. I refused to be any part of this process, and told her to go and find another doctor to examine them, so she demurred, saying I was the only one with an ultrasound machine, and it was easy for me to do it. I fear I told her to go to hell, and do what she'd always done before in these cases, and that I was going to be no part of such an invasion of the personal privacy of the girls. Subsequently I asked around, and was told that it is routine in all the secondary girls schools that they have a mandatory pregnancy test from time to time!

April 19th.

Doreen and I have just come back from a four day visit to Karamoja District. We were invited there by Sister Margie Conroy, originally from Newfoundland, whose uncle was Dr. Jim McGrath, the Minister of Health when I first arrived in Newfoundland. We have come to know her quite well over the past few years, and she's a regular visitor at our home, on the way to and from Karamoja, where she is the School Principal. The drive up to Karamoja was done in company with Margie and her vehicles, for security reasons they rarely ever travel singly, and more than one vehicle is called a convoy, and tends to be less frequently attacked. The country changes markedly after one passes Soroti, and is largely a rather dry arid kind of scrubland, with the usual green trunked, flat-topped thorn trees abundant. In the way of animal life, there is still the odd buck to be seen, but this time on the way we saw a number of the very large and colourful ground hornbills, as well as a huge monitor lizard.

Karamoja is one of the more remote areas of Uganda, inhabited by the Karamajong tribe, a rather warlike group who have many similarities to the Maasai in Kenya, in that they are a pastoral people, whose whole existence hinges on the 'manly sport' of cattle raiding their neighbours and each other. Their order of priorities is : cows, bicycles and women, in that order according to one of the Dutch Sisters working there. The area has been one of unrest for many years, and the constant skirmishes between them and the Ateso people has kept the place in a constant state of turmoil. Currently it is viewed as the least 'secure area' in Uganda, with a strong army presence to try to keep order. They are dealing with a tribe that sees its traditional ways dying out, and is resisting change. Up until quite recently the men were totally naked, and some of the older men still are, but the majority of men now wear a blanket, slung over their shoulders with nothing underneath; the women on the other hand tend to be rather nicely ornamented in their traditional way. The villages are of the classical old African type, and each collection of huts is surrounded by a dense hedge of dried thorn tree branches; the whole village is centred round the cattle compound into which the beasts are driven every evening. One can see that cattle are the very centre of their lives. Getting into the village itself is a real art, as they make the entrances to each family group very low indeed, and one almost has to crawl through it to get in. Their possessions are pitifully few indeed, and mostly things they have made themselves, like cooking pots, baskets and such very simple items of daily use. It is like stepping back in time. It is quite astonishing to find sometimes quite well-educated people, living among their relatives in such a village, who speak good English, and are having quite a hard time of it trying to persuade the others that education has any real benefits. One of the rather nasty things that is happening of late is that when they go on the rampage against their neighbours, they set fire to the thorn trees round the village, and shoot anyone trying to escape from the fire. Rather like the massacre of Glencoe. The problem with access to modern firearms and flashlights is that they can kill many more of their fellows than they used to, and whereas before nocturnal raids were unknown and they all retired at sundown to their villages, they can now occasionally hunt each other at night, and do so. How long this area will take to eventually settle down and leave off their cattle rustling ways is anybody’s guess.

Of the missionaries in this area, there is a group of Italian Sisters and a couple of priests, the Presentation Order to which Margie belongs, but few others. They are all having a hard time proselytizing, Christianity does not have deep roots except in a very few areas here. On Good Friday we visited a hospital run by the Italians about 20 Kms away from Margie's school; the young Italian doctors contract to come out for a three year stint, and to give some idea of the mentality which prevails among the Karamajong men, one of the doctors, who I met first doing an orientation course at Nsambya hospital in Kampala, told me that in spite of being there for three years and doing a lot of good work, any gratitude on the part of the patients is not to be looked for. In fact he says that he does not go outside the hospital compound now, because he knows so many of the people he has treated, that in the event of being held up at gunpoint in the car, a not infrequent event in Karamoja, he would be one of the first to be shot, because he could identify so many people, and be a witness, if any of them were taking part in the hold up!

The hospital in which he works is very well run indeed, but largely in the hands of Italian doctors, though they do have an African surgeon.

Some of the attacks on vehicles and individuals are a little bizarre, for example an African priest on a motorbike was shot, and the word is that he was a 'sacrifice', and his death was ordered by one of the local witch doctors. Then nobody in a white pick-up truck dares to go out at the time we were there, as there is one of the local officials who has become a 'marked man' for some reason, and due to be killed on sight. They have already killed someone, just because he was driving in a similar vehicle. Margie got a new white pick-up recently, and they are busy painting distinctive markings on it.

On the way to the Italian Hospital, on Good Friday, we passed most of the missionary group and their flock, headed by a priest with a garland of thorns round his head and carrying a cross, enacting the crucifixion. They were all proceeding to the one and only hill in the area, some 1500 feet in height, where they conducted the service.

One of the highlights of the stay was a visit to Morotto where we saw the Government hospital there. It makes our place look very good in comparison, their equipment is even more destroyed than ours, if such were possible! Next day we had to go back to Morotto, because there had been 'leaks' in the exam papers for the senior students, and try to get the new papers for the students to sit. The students sit a common exam, set in Kampala, and distributed to all the schools in the country. On this occasion the whole country had to get new exam papers and sit them simultaneously. As if a few days later would have mattered in Karamoja, because there is almost no traffic in or out of the place that is not known: the phones do not work, and mail takes a dog's age to get there. However poor Margie was saddled with the task of getting the new papers from Soroti, so off we went to Morotto to try to get some of the officials, or police to go and get the exam papers, which was really their responsibility in the first place, but with the usual inertia, unless pushed, nobody was willing to take the initiative. When we got there, we found the police vehicles were all out of action, so we contacted the High School Principal, and he lead us a real dance round all the local officials, trying to track down the elusive District Administrator. First we went to his home, where he changed ready for the journey to Soroti. Outside the house was his wife and half a dozen of his kids. She was cooking the mid day meal, all very dirty and unkempt, poor little beggars; one wonders how he's ever going to educate his tribe on his miserable salary. It was by now 2 PM, and off we set again looking for the D.A., who we finally ran to earth in the local army barracks, and who with the very nice army commandant found a roadworthy vehicle. So our friend the headmaster went off to Soroti, with a loan of money to pay his board for the night. At the same time we left Karamoja, he had just returned and the poor kids were about to sit their exam again for the second time. The whole episode would have made a lovely short movie scenario. During the waiting around period we met a couple of Brits working for the World Lutheran Foundation. This couple lived in relative luxury compared to anyone else in Karamoja, being well provided with a lovely house, T.V., video and the 'works'. They fly in and out of the area, no motoring on the awful dusty roads for them, it seems that their head office is very security conscious indeed, and

goes to some lengths to make sure their people are as comfortable as possible in the remote postings to which they go.

On the way back we stopped at a remote isolated mission run by a few of the Franciscan Sisters we knew in Nsambya early on in our stay. Sister Barbara, who had delivered a couple of John Lewis's kids and is now getting well on in years, is running a small midwifery station, and hospital. She has gone right back to her original days in Africa in the 30's, because the hospital is a series of very clean and neat mud huts, well thatched - the delivery room included. She's made her own obstetric beds, just a wooden bed which can be taken apart in halves, and a place for stirrups in the top half, because she uses the vacuum extractor, and conducts most of the local deliveries, having trained a couple of midwives to help her. Again, she is breaking new ground in the old traditional way of the first medical people in Africa, but with the deteriorating conditions and economy, this sort of help is by far the most practical.

April 28th.

A busy week. First, met again with the traditional healers, but as we can get no reagents to carry out HIV testing, the whole exercise looks pointless, though they are most eager, and want to go ahead with some form of research into their herbs on clinical grounds, but there is really no point without being sure what is being treated.

We had a man shot through the leg by the Kenya Police. He was smuggling evidently, and running away from them, but was shot on the Uganda side of the border. The bullet went right through his femur, and perforated the femoral artery into the bargain. The people had applied a tourniquet, had splinted his leg with cassava sticks, and tied them together with banana leaves made into a kind or rope. It was first-class first-aid, given the materials at hand, and the unwillingness of anyone to tear up their clothes. He was pretty far gone when he arrived at the hospital and as always we had no blood to give him. A very rapid amputation was done, but he died in the night, just from blood loss - nothing more. The blood problem gets worse and worse every month, and we get almost none from Kampala, and the local people all fear transfusion because of AIDS, and I do not blame them.

Manfred conducted the most major meeting on the cost sharing business this week, and seems to have some excellent ideas. Presently he is meeting with all the hospital staff in groups, and explaining what we hope is in it for them. The next step when this is complete is to take it to the people outside in the villages, and to their leaders, and gauge their reaction. Most people now realize that they will have to pay for any treatment, as the government just cannot pay up, and even if they could, the money would disappear somewhere. Local control of their money is the only way possible, and even that may be open to the kind of 'siphoning off' into various pockets along the way, unless we can build in some real control mechanism, but I am not too sanguine that we will succeed.

May 8th.

We have had Rein Zeeman and his team here again. They did their stuff in the usual magnificent way, and did 12 cases for us, all complicated, but the worst was a huge haemangioma in a kid of seven, and which took three hours to dissect free, the most remarkable thing was that just before the end of the procedure we had a really good thunderstorm, and as always lost the electric power; It happened just at the very end of the procedure thank goodness, because the chap who looks after our emergency generator was away in his village, and we would have been really stuck. This time the visit was combined with a fund raising effort for Interplast Holland, and they brought a couple of journalists with them to take photos of the work, and some of the previously treated patients. Doreen has done a great job of speech therapy with the three children of a teacher, all of whom had repairs of cleft palates and hare lips. I've never heard of three in the one family before in my life. The journalists all went to the village, and got their fill of good material for the magazine. I'll be interested to learn how much they made on their fund raising trip to Uganda.

It is always a delight to have Rein, his wife, and the team here, they are all such nice people. Rein himself is one of this world's altruists, and takes his holidays to come here and work, altogether he must have done about 60 cases in the past four visits he has made to us in Tororo.

I took Rein and his team to Kampala, and they'll fly home in a few days time. In the meantime, I met Ken Leighton at the airport in Entebbe, and as it was an afternoon arrival, we only got as far as Jinja where we stayed the night before coming on home to Tororo. Doreen had spent the last few days after the Lewises left, cleaning up the other house ready for Ken's arrival, and supplying it with the basics to begin cooking and generally living in it.

The trip home with Ken was fascinating, as we had a great time reminiscing, both being graduates of Aberdeen, both having been in the army in the Middle East, and even having run in the same running team as undergraduates at the university. Life is full of coincidences. Ken comes from a place called the Muir of Ord, only a few miles from where my father was born and lived his youth. So we have a very common background, and much to discuss. He is an anaesthetist, who was head of the University of British Columbia anaesthesia department, and has been all over the place, Sweden, Honduras, Zimbabwe, Australia, Japan etc., so should be pretty readily adaptable to the new surroundings here in Uganda.

May 15th.

This week was a 'teaching week' in Kampala, and Ken had his first experience of the Seminars we conduct every second or third week. One of the students presented a case of a man who was shot through the chest, the bullet tearing the dome of the

diaphragm, so that his stomach rose into his chest cavity. From an initial X-ray, and his symptoms of increasing dyspnoea, he seemed for all the world to be suffering from a tension pneumothorax, but this lad recognized it for what it was, and when the man was getting very short of breath, by the simple expedient of putting down a naso-gastric tube, relieved his symptoms immediately. Dr. Welishe is certainly one of the best students we have, and I give him full marks for this particular diagnosis and appropriate action.

Following the meeting, I was given a letter from the clinical coordinators who had met amongst themselves, in spite of having missed three meetings with me. They presented ridiculous demands of wanting $500 U.S. per term, retroactive to 1990! This, in spite of having been told that CIDA does not pay local salaries, and that Makerere University was responsible for their payment and allowances. As well they wanted to be provided with a car, 'to take them out to the various communities', although not one of them has done a community visit in years, being 'specialists' in the various clinical disciplines and teaching entirely out of Mulago Hospital. There were other equally stupid demands, so they got a stinking letter from me in reply, with a copy to their chiefs, and there the matter rests for the moment, and I'll await with interest the developments. The rationale they set out was that all overseas funded programmes pay well, and I guess they thought there's no harm in trying it on for size. The nature of aid to developing countries is going to have to be revised and looked at very carefully now, particularly as so much of the aid disappears into individual pockets if there is no real control of the money by the donors. Supervision by the donor agencies is an absolute must until the ubiquitous corruption by so many people in places of power is somehow overcome, and even the ordinary working Ugandan people here admit this fact of life, and in the words of one of my residents: "We do not trust each other, specially with money."

May 23rd.

This week's case was of a young man of rather simple mentality, who was tortured by the local soldiery They had put him under a tree and dropped scalding hot fat on him from a jerry-can hung on a branch. He was admitted, and it was a couple of days before I saw him and realized that it was burns he was suffering from; the ward staff simply said that he was 'beaten up' by the soldiers and left it at that, in the meantime doing nothing about it. One of the real problems is our new Medical Superintendent, Dr. W***, who is a total disaster to the place, and has nobody looking after the male surgical ward. This man does one round on the medical side a week, does no on-call duties, and is the worst administrator I've met in Uganda, and that is saying something. Anyway, no one was taking any interest in this kid, who was lying, attended only by his Mother, and in considerable pain without complaining to anybody. The upshot was that I got the police in to investigate the matter, but lord knows what they can do when the army is involved, but they say they'll try to get some disciplinary action taken against the troops concerned. And so it goes..... I guess that Uganda has to go through the same stages as our countries did in the middle ages, before the inherent cruelty in mankind leading to these kind of atrocities is brought to light and people no longer condone such behaviour. One should always bear in mind that our behaviour was in many ways far worse, and our

torturing and mutilations were more sophisticated and beyond anything that the African people do to each other. It is just that we view things from our viewpoint of Human Rights etc. which have taken such a long time to develop.

May 30th.

This week has brought its share of troubles. Dr. O***** our surgical coordinator was at the teaching seminar in Kampala this week, and his behaviour was outrageous, he tried to dominate the whole proceedings, in fact I thought he'd been drinking, and ruined the whole thing for the students who were too polite or frightened to say anything to him. It is a feature of Ugandan students, that they are very passive in the face of stupidity on the part of their faculty, and fear to criticize, as they all tell me that they will be failed if they do not conform to the 'rules', and any criticism of the faculty is simply not tolerated. This expression is so universal that I have no doubt that it is true. At the end of the seminar, I went into O*****'s office in 'Musungu' fashion, after only a brief knock on the door (the Ugandans wait till they are asked to come in.) and to my amazement found him injecting himself with some drug. He is a known demerol addict, but I never thought to catch him in the act. I have since written to the chief of surgery, and asked that we have a new coordinator, when again to my amazement he said "Thank you, we've been trying to prove this for a long time, and get rid of him from the Department of Surgery, and now we can do so!" . I did suggest that he be asked to go on sick leave and at least get some kind of treatment, but I fear that he's certainly going to blame me for his discharge and at times this can lead to problems, as vengeance is very high on their order book, as witness poor Father John Neidiger and his 'frame up' with weapons found in his Monastery, and murder of his secretary some time ago. Ken Leighton was also a bit shattered by this experience at the seminar, but it is the first one at which there has been any real problem.

We have an ex-Memorial graduate, Dr. Monica Griffen visiting Tororo at present. She phoned the other night from Canada, saying she was due in to Entebbe in a few days, giving flight numbers etc.. Mind, she was most exceptionally lucky to get through on the phone from Canada, it is only the third call we have had from overseas in all the time we've been here, as most people give up after many attempts. Monica had written a tentative letter in February, saying she was 'thinking of coming', to which I replied. Then she says she 'faxed me' on two occasions giving her flight numbers etc.. However she was witness to the fact that I got these faxes well after she had arrived. I am constantly amazed at the naiveté of these young folk who expect all the modern communication facilities in a developing country, but omit writing a simple letter, which often only takes two weeks to get here. Then having said they'll come, expect to be met at the airport over 300 Kms away, and also involving an overnight stay in Kampala, and finally complain about it. What Monica hopes to get out of the experience I do not know, and she really has not made it very plain, except that she wants to come and look and see what it would be like to work here, perhaps with a view to coming back. A month or six weeks tells one very little about the place, its workings, or the people, and coming to these places on short term visits is not, I think, a good way to approach making decisions about working here.

While at dinner the other night, there was much shooting going on outside our house. It seems that they we are trying to rob the D.A.'s secretary, who handles a fair bit of money, but his armed guards opened fire at the intruders who shot back in return. Nobody got hurt, and the robbers got away unidentified! We had Ken, Monica and the De's, a very nice Asian couple, in for supper that night. There was considerable concern because of the length of time the shooting went on, and the guests were I know all rather worried.

June 6th.

We are due to have our first lot of students sit their final exams in a very short time now, and I am more than anxious because I have not heard from McGill who are supposed to be sending someone to act as external examiner for us, and incidentally to do an appraisal of the project to date. I have been corresponding with them since January, and for the past few months there has been a dreadful lack of response from their end. One of the residents, Dr. Odu, recently had his son operated on at St. Anthony's Hospital by Dr. Simon Peter, for 'intestinal obstruction'. The boy then developed complications and needed a second operation, for which Ken gave the anaesthetic. I fear that the son suffers from being a doctor's child, and has surgery done to allay doctor's anxiety, in case something has been missed. A little time, and I don't think he would not have needed the initial operation in the first place, because at the second operation, only dilated bowel was seen, with a small perforation of the gut from the first operation. However, he's an otherwise healthy kid, and though he'll have a stormy course, he should survive, but it is an awful worry for him at this stage, with the exam looming over his head.

We had the first hypoglycaemic coma I've seen in Uganda admitted the other day. He was a policeman, whose wife was also in the police, a charming and very intelligent lady, though she did not know how long he'd been in coma. With some difficulty we got some 50% glucose made up, and gave it to him. He became warm, but did not wake up, then in the afternoon, one of the doctors, without consulting anyone gave him 50 units of Insulin! He was brain dead when admitted I guess, but the insulin did not help. Diabetes in Africa is a real problem, as often insulin is not available, and we cannot do blood sugars here, at least we couldn't till Ken brought a glucometer with him. Even urinalysis is difficult, and we have to rely on Benedict's solution still to estimate urine glucose, so all in all it is too often a fatal kind of disease, infrequent as it is - thank goodness.

I have been trying to buy some paint in order to rehabilitate the T.B. ward, but it is proving quite difficult, as none of the paint companies have any undercoat in stock, and those that make their own paint cannot get the ingredients. There is a lot of painting and cleaning up going on in Uganda these days, specially by the Coca-Cola, Pepsi-Cola and cigarette companies, so the price of paint has simply rocketed up as a result.

June 11th.

Still no word from our external examiners, and it looks as though the exam will have to be postponed for the present. I did not expect this kind of trouble from a Canadian source, however, perhaps it is an 'ill wind', because poor Dr. Odu lost his youngest sister when she was bitten by a snake recently, and off he went to the funeral the other day. He certainly has had his fair share of trouble, poor chap.

We saw a fascinating case on the ultrasound the other day. A policewoman from Busia came in, complaining of abdominal pain and swelling. Examination showed what seemed to be a pregnant uterus with an attached very large and tender mobile mass on her left side above the uterus. The ultrasound showed a pregnancy of about 20 weeks, with another extra uterine pregnancy of about the same age, both foetuses were living with good heartbeats visible. I advised surgery to be done the next day, and she said she'd go home and get her things. It is now three days ago, and we have not seen sight nor sign of her. The operating room staff tell me that there are some funny superstitions connected with twin pregnancies, one of which is that it is very bad luck to operate on twins - perhaps the voices of past experience. I do not know what will happen to this lass, because when they disappear, it means that they are seeking their traditional healers cures usually, and it may be weeks if at all before we see her again, and then it may be a real emergency.

Ken has been trying to rehabilitate an old Boyle's machine to give safer anaesthetics, and has almost got it going except for an ether bottle. Well, we spent a whole day looking for one at various hospitals, Mbale, Iganga, Bugiri etc., motoring about 250 Kms seeking one. We finally ran one to earth in Jinja Hospital, on a very old Boyle's machine in far worse condition than ours, and asked if we could have it, as it was no earthly use to them, and their machine had been out of action for years anyway. But the Medical Superintendent was out of the hospital, and as a result they refused us. So in the meantime, when we next go in to Kampala, we are going to try again, and see if we can find the medical superintendent and plead our case. If only they were as scrupulous with money and drugs Uganda would have no problems.

June 18th.

I have had to postpone the exam until August 31st, still not having heard from McGill. In the meantime, we went in to Entebbe recently to introduce Ken to the Permanent Secretary for Health, an enormously fat chap called Dr. M*****. Manfred also came in with us to meet Dr. M***** and discuss the cost-sharing scheme but getting anything out of the Ministry of Health in the way of a decision is like trying to pick up quicksilver with your fingers. However he did say go ahead, but did not give Ministry support in writing or anything like that, and many Ugandans will not do anything without approval in writing, so we plan to forge ahead anyway, and act as though we had approval in writing.

Doreen leaves for home in two days time, and that means a bachelor existence for a while. I will miss her tremendously I know, as she's the complete sheet anchor to existence here.

June 29th.

Last week was an easy week, as the exam had to be canceled, and it left me with a little time to see about a few things in Kampala, in the University and Entebbe at the Ministry of Health. At long last I had managed to set up a meeting with Manfred Sturmer and Dr. M*****, the 77, and we had a more full talk about the cost-sharing project. M***** is a huge, fat and unhealthy individual, who has obviously 'loved the fleshpots', a born politician, who gives away nothing in writing that he can be held accountable for. However, as I mentioned before we did get the promise of Ministry support, as long as they were kept informed and we got the local authorities to be fully part of the scheme, which was the original idea anyway. The result is that we are going to write up a set of minutes of the meeting, and to go ahead full steam. I believe that this is what the Ministry would very much like, as long as we are willing to do the spade work, and harness the local community effort. If it does not work, the Ministry gets no blame, and if it works, then they get the credit. We have nothing to lose in the process, but I would dearly like this particular part of the project to succeed as it is the key to the whole subsequent ability of the country to sustain their Health Care Service, in the face of the Government's obvious current financial inability to do so. Things are falling apart in the whole Health Care sector, with hospitals totally ill-equipped with drugs, dressings etc. of the most elemental kind, and more and more the treatment of illness goes private, at a cost that is not affordable to the majority of the local people. But at least the private doctors do manage to make a reasonably good living out of their private clinics, which are totally uncontrolled in any way whatsoever.

One thing we did get from Dr. M***** was a letter to the crowd in Jinja Hospital, authorizing them to give us the ether bottle from their old Boyle's machine, and I collected it on the way home. . We have taken it back in triumph, still not having met the medical superintendent of that hospital! Jinja Hospital have been ordered by their town council, and the local R.C. 5 to go cost sharing, but they are totally unprepared for it, and are in the greatest difficulties about the whole thing. They are threatening to come out to Tororo and have a look at what we are trying to do, but I do not think it will apply to their situation, as they have just been ordered to get it underway on the first of August, and they do not have time to prepare their patients or the people of the area for the abrupt start of the operation. We at least have set a deadline for January 1993, and just may be able to meet it by then, though there's a lot of preparation to do beforehand..

Today being Monday, I had a very heavy clinic awaiting me when I got to the hospital, but this was curtailed by the fact that the man we had admitted for a sigmoidectomy tomorrow became an emergency over the week end with his third volvulus! He was admitted for a 'bowel prep' prior to the surgery, but to my horror, nobody had done a thing for him, and he was by this time distended, and completely

obstructed, so we went ahead and did the necessary surgery. Ken gave the anaesthetic, and it was the first sigmoid volvulus that he'd ever seen, and like all of us first encountering this most peculiar Ugandan phenomenon was duly astonished at the sight of the sigmoid - the size of a large inner tube of a motor car tyre. At least he had his camera with him, and it is recorded for posterity. However the whole point of the exercise in trying to do the operation in a well prepared manner was completely upset by the laissez faire attitude of the ward staff who did not even seem to know that he was in the hospital, in spite of them having been given his notes with a full explanation of what to do for him prior to admission, and, not only that, the staff had been told to look out for him well beforehand.

There was another interesting problem of a young lass of 16 with a haematocolpos whose parent thought she was pregnant! Again, the ultrasound to the rescue initially, though a simple physical exam was quite sufficient to establish her diagnosis.

July 8th.

Oh boy, what a week, what a week! Dr. M***** sent my last Interim Narrative Report to CIDA to Dr. W***, the Medical Superintendent. It contained some pretty harsh remarks on his behaviour, to which he took complete exception, and was furious about the statement that the hospital "Was like a ship sailing before the wind without a rudder". He then attacked me with all sorts of spurious allegations in front of some of the senior members of the staff. I have rarely seen a man so out of control of his anger or emotions as he was on this occasion, at one point actually breaking down in tears and appealing for sympathy, saying he was at 'the zenith of his career' and I was trying to undermine him. The staff were very good indeed, as the majority kept silent for the most part, except on the occasion when he accused me of 'promoting corruption' by giving the ward staff their monthly cleaning materials, and the operating room staff money for 'lunches' when they worked late hours on a long operating list. Then they accused him of doing all kinds of things, of which I was previously unaware, such as siphoning off money from the gate-men who look after the patients' bicycles etc., to pay for the ambulance which he uses as his private means of transport. Anyway, he came to me afterwards, and promised to do a few ward rounds, and to tidy up his act, if I would write to the Ministry of Health to this effect, to which I did agree.

July 14th.

This is my last day at the hospital before going on leave, and though the atmosphere between Dr. W*** and I was still somewhat tense all last week, I now do not know what is going to happen, as the staff have written a letter to the Ministry of Health, the District Administrator, the R.C. 5, the Police and the patients complaining about Dr. W***, and asking that he be removed. Ken was speaking to the senior anaesthetist about the letter, and he said that the staff want rid of the man, and a replacement for him. It

seems it was initially triggered by his behaviour all along, and they had already planned this action but it was finally precipitated by his scene with the senior staff and myself. A very, very bad way to end this part of the teaching project, and I worry about what will happen in my absence, though Ken seems to be reassured that things will all turn out for the best in the end. I only hope so, but feel a little anxiety about the whole affair, and how it will affect things when I get back.

July 16th.

Last entry: A good meeting with Professor Mugerwa, the Dean of Medicine, who has at last created a Department of Community Practice, and has put in the projections for a five year budget which has been approved by the Planning Committee. So after all this time, things are really moving, and both the University and the Faculty have given their full and final blessing to the teaching programme. Ken Leighton has taken the car back to Tororo, and will meet us when we return on the 24th August, which will only be a week before the actual exam for the final year students will be held. I'll be fascinated to see the actual outcome, and hope most sincerely that the students do manage to measure up, though I have very little doubt, and I am quite proud of the fact that they have come a long, long way from what they were at the outset of their teaching programme, and can now think for themselves in an analytical way.

Part 4

August 24th, 1992 - June 23rd, 1993.

Pages 98 - 140

August 24th, 1992

Return to Uganda, after an exceptionally busy time at home, with only one or two days fishing in all, and a lot of time spent on the project matters, and trying to arrange for an External Examiner to come here. I did manage to speak to Mr Roman Ozga in CIDA, and he has agreed tentatively to come here for a project evaluation in March 1993. In the meantime, I have made arrangements for Dr. Charles Larson from McGill, and who has worked for a number of years in Ethiopia, to come as both the external examiner, and also to do a project assessment. CIDA makes it clear that a 'project assessment' is not a 'project evaluation', though what the difference is I cannot imagine, it must be some bureaucratic jargon which only bureaucrats can understand.

On the way over this time, we spent some time in Thame with George, whom is having a great time it seems. He was lucky in getting employment at the college for the whole of the summer break, and considering the unemployment rate in the U.K. at present he was very lucky indeed. He has certainly come a long way since he began, and some of the creative kind of workmanship he is now managing to do is really very good indeed, not only that, but he seems to enjoy it immensely into the bargain. While in Britain we traveled up northwards, and visited Keith and Ro Hodgkin in Little Ayton, then went to Skipton where we met my brother who came down from Aberdeen to meet us halfway. Then down to the outskirts of London, to meet with one of Doreen's former classmates in nursing. She married an Asian doctor who became an E.N.T. specialist and who is now retired, doing a few odd jobs and locums, even going to do voluntary work in the West Indies, and enjoying life generally. So all in all we slept in a different bed almost every night we were in the UK.

So back in Uganda we were met by Ken Leighton in the project car, a 4-wheel-drive Dihatsu, named 'Gandalf', because of its marvelous capacity to behave itself well and get us where we want to go with a minimum of fuss, no matter how terrible the road. Some roads over here defy description. As the plane got into Entebbe quite early, we went straight on to Tororo, and home. It seems quite a lot happened while we were away: first Mwase, the gardener up and left, very shortly after I had gone on leave. It seems that he decided to set up his own business in a rather sleazy area of the town, making recordings for other people. This he does by 'pirating' tapes and reproducing them at a small fee. It seems that he managed to buy a fairly large tape recorder which

he's put to commercial use by playing music at 'discos'. Though I do admire his enterprise, I fear that he'll have the recorder 'liberated' in fairly short order and be left without anything to make a living with. Many of the folk here seem to have little in the way of foresight and will abandon some degree of security for what they see as an easy way to make a living. With the amount of time he had off each day he only worked from 7 am to 11 am, and from 3 PM to 5 PM, i.e.: the cooler hours of the day. He could easily have done the job of recording in his spare time. Not only that but he had a large area of the garden all to himself in which to grow foodstuff, and from which he managed to sell enough to buy his tape recorder. Ken was rather worried, living on the compound alone, which was rather a mess, without having had any care for a month or so. Not only that, but there had been a number of shootings about the place in our absence, a couple of expatriates having been raided at gunpoint one night and robbed, which only added to Ken's anxieties at being on the compound alone at night. So much so that he stayed at the home of one of our German friends, Wolfgang Gindorfer, who runs an eye clinic, dispensing glasses, doing refractions etc.. As far as work was concerned Ken said that very little had been done in the hospital since we left on leave, and I think he was more than a little bored into the bargain. Ken at least has only been dealing with patients who present primarily as teaching cases, and has a very clear idea that he should not be the person to be doing things which could be done by the Ugandan doctors, or the anaesthetists etc.. That is to say, he has been acting on a consultant basis only. For this I am immensely grateful, as it means that the other doctors have been forced to make some attempt to cover the place and be responsible for seeing that the emergencies do get treated.

August 26th.

No sooner back, than into trouble! Last night someone cut the barbed wire round the compound, and then proceeded to steal the headlights and anything else moveable from the cars, both Ken's and mine! The spares for Ken's are going to be very difficult to get, as it is an unusual model, and about 9 years old, mine will be somewhat easier to replace. We have now made arrangement to park the cars at Wolfgang Gindorfer's place as he has a couple of armed guards on at night and his compound is much more difficult to get into. The police tell me that there is a rash of this kind of thing going on at present. It seems that a gang of thieves comes out from Kampala, going to a different settlement each night, where they strip cars of all accessories before moving on to the next place. The best of it all was that in Tororo - these same thieves stole a lot of spare parts from cars in the police compound where they impound vehicles, or put cars involved in accidents or traffic offenses, until the owners pay up for the accident or offense committed. One finds that eventually the stolen spare parts all turn up in one of the local markets in Kampala, and we are likely to have to go there to 'buy them back'! The worst of it is that they strip or cut the wires out by the roots, which it makes it very difficult to get the circuitry together again so that all the lights, flashers, etc.. work properly. I have been to one of these markets, and I'm sure you could find the parts for any vehicle made in the last 20 years. They call it the 'Showry Yako' market, which literally translated means 'Your fault' or 'Your concern' Market. I guess it's your fault if you don't take care

not to have spare parts stolen. When taking a car into a garage here, one has to stand by and watch the work being done, to be sure that they are not putting old parts in place of your new ones, a very common trick in all garages. On the subject of cars gas prices have been hiked again, and are now running at $1.00 Canadian per litre. I certainly did not bargain for this kind of inflation in my initial budget!

August 27th.

To-day visited Dr. Simon Peter Odwong the medical superintendent and surgeon at St Anthony's hospital. It was quite instructive. Simon Peter, as I think I have mentioned is a surgeon, trained in Kenya, at the Kenyatta Hospital there. He is totally fearless, and will tackle anything. Ken tells me that he was wanting to go ahead with a huge goitre in a 45 year old woman and wanted him to 'stand by' for the anaesthetic, because he felt his 'anaesthetist' might have some trouble intubating. Ken tried to dissuade him, telling him he was tackling something that would have taxed to the utmost the facilities at the best Canadian teaching hospital. Evidently he did not take the advice, because one day Ken was visiting the hospital for something else, when they spotted him and asked him to come to the O.R. quickly as they were having trouble. To his horror Ken found the anaesthetist in great trouble, trying to intubate this lady, who was far 'blacker' that any black person should ever be. He did manage to persuade them to desist, and to my knowledge the lady is still alive, and walking about with her huge goitre still intact. At present we are trying to set up some kind of liaison between the two hospitals, but with this kind of problem, I'm not so sure that it will be altogether fruitful. I saw a patient for him who I had previously operated on a couple of years ago for acute necrotizing pancreatitis, and for whom I did a simple general peritoneal clean up at the time. The patient did manage to survive the surgical assault, and the following a very stormy convalescence. At the time Simon Peter asked me to see him he had what was pretty obviously a pancreatic pseudocyst seen on the ultrasound, and which needed draining. He tried to do a radical removal of the thing in this very fragile elderly man, instead of just doing simple drainage. The patient never got off the table alive. As I say he's pretty fearless! Anyway, on this occasion he had invited the District Administrator to visit the hospital and show it off generally. So we duly went round the place and then found that he'd also set up a reception and speech making affair, at which all and sundry were asked to say something. Simon Peter himself declared intentions of cooperation and general good will between the hospitals. Why it all took place, and what the objective of the exercise was I am still not too sure. The day was rounded off with all the little children from the local Catholic schools, and some of their parents, producing a long concert, interspersed with a few short plays. All this time we, the guests of honour, sat on a raised dais and watched the proceedings. Half way through we were regaled with Coke and Cookies; the audience watched us consume them, while sitting on the ground below and waiting for us to finish eating. All very embarrassing.

September 3rd.

This has been a hectic week. I am now expecting Charles Larson to come here tomorrow, both as the External Examiner, and to do an assessment of the programme to date. We have just administered the first two written papers to the first batch of students in their final exams. Charles Larson will be here for the orals which are to be held over the next couple of days, and then he'll come out to Tororo to see the project at first hand. Thence back to Kampala to see the University and Government officials. Stephen Tuunde, my counterpart is doing his stuff there well, and we have set up both multiple-choice papers, which they are not used to here as well as written essay type exams, to which they are well accustomed. We are conducting the orals in both Nsambya Hospital and Mulago Hospital. At Mulago they have insisted on having one member of faculty present at the orals, from each of the disciplines concerned in the teaching programme, as well as the External Examiner, Dr. Tuunde, and myself. It should be pretty awesome for the poor students taking the exam, to have to face four or five people questioning them about the patients they have worked up.

September 7th.

Charles Larson arrived in good time, and in good form. A long time 'Africa Hand' who is well aware of the problems and difficulties in dealing with both the academics in African universities, and the vagaries of government officials, with whom one has to deal, their dreadful habit of never keeping regular hours, and then appearing at all sorts of odd times for prearranged meetings, or else not turning up at all, generally not seeming to care a damn about anything. So the programme assessment should prove very interesting. The exams are over and the dust is settling. I am pleased to say the students performed well, this in spite of the fact that there were so many examiners for them to contend with in Mulago Hospital. It seems they are used to this kind of tactic by their examiners, and it did not seem to faze them one bit. The written papers were a bit of a mess in the multiple-choice exam but the rest were all O.K. (They have not been used to multiple-choice, though they have had a few from me over the past few years, but they obviously do not like them.) The orals, they did well in, and Charles has just finished reading their dissertations, which on the whole, were quite commendable, specially seeing that they have not done any research ever before, nor had they been taught the methodology of preparing research proposals, and writing them up. One did his thesis on 'False Teeth' and other oral/dental procedures carried out by the traditional healers. The custom of removing 'False Teeth' is a bizarre one, called locally 'Obinye'. The healers dig in the gums of infants at about nine to ten months of age, and allege that they have extracted the false teeth which they claim are a source of diarrhoea and gastro-intestinal upsets. I guess that when the kids come to weaning age, and are not so frequently breast fed, they are then subject to the invasion of pathogens from the filthy water, cows milk, and methods of food preparation prevailing, and so get diarrhoea. This fact is exploited by these healers who do their 'surgery' with dirty instruments; not infrequently the kids get tetanus. They claim to find the false teeth all over the body, and dig them out from everywhere. The other thing that Dr. Odu covered in his thesis was uvulectomy, which is common here, and I have had to do two tracheostomies for kids in acute distress following this procedure. Of note is the fact that one of the local Church of Uganda (

formerly Anglican) bishops I saw as a patient complaining of a sore throat was without a uvula, and I asked him about it, and he described a procedure done when he was 12 years of age. The healers, he said, use a piece of hollow bamboo, and through this they thread a piece of strong sisal, with this instrument they snare the uvula, and thus remove it. The modern and progressive ones now do it with the tube of a ball point pen, through which they thread a wire, and snare the uvula with this. If only they sterilized the instrument it would spare some of the present great dangers attendant on the procedure, but alas, this is not the case. They will do as many as four or five of these procedures a day, without any cleansing between. Altogether the thesis was of great interest to me. The other lad, with the marvelous name of Deusdedit (meaning ‘God given’ I presume) Kaharusa, did a thesis on the ‘Attitudes and Practices of Traditional Birth Attendants’ with some fascinating beliefs and practices emerging. Very like the 'Handy Women' in the outports of Newfoundland, who used to conduct labour and delivery in the outports not so very long ago. Anyway, on the whole both the candidates seemed to have passed their exams pretty well, so I am quite pleased.

September 11th

Charles Larson left for Ethiopia yesterday having completed his assessment of the programme. He is not too optimistic that the programme will be sustainable once I have left Uganda: there are times I am in full agreement with what he says, but in my heart I still like to think that it just may be possible that the teaching programme will continue, and even flourish, after I have left, though my head, like Charles Larson, tells me otherwise. Anyway Charles met with most of the students first, then had a look at the hospital, which he agrees is no worse than many hospitals in Africa, and indeed far better than most of those which are government operated. This is a bit of a digression, but there is no doubt that the mission hospitals are far better than the government operated ones, but the majority of them are still run by expatriates of various religious hues, and depend heavily on external funding from overseas as well as charging fees for their services, which are mostly out of the reach of the average villagers. Those mission hospitals which have been taken over by the African churches and missions are still a good bit ahead of those operated by the Government, as far as general cleanliness, drug supplies etc., but they do not cater to the real needs of the people, and their services are most often quite definitely out of financial reach for the average Ugandan patient. Anyway, back to the Programme Assessment: Charles met with the Dean of Medicine, some of the Faculty, and with Stephen Tuunde, my Ugandan counterpart who will be taking over the whole show once I have left for good and all. He stayed with us a few days in Tororo and Doreen did a wonderful job of giving him a taste of 'Newfoundland Hospitality' while he was with us. I shall now look forward to his report with interest, and see what an objective observer, who knows the problems of dealing with officials in Africa, thinks of the whole thing so far. He did go with me to Entebbe to try to see the Minister of Health and the Permanent Secretary, one Dr. M*****. Needless to say, both of these individuals were out of the country; again, a digression, but they spend more time abroad than they do at home - all at Government expense. I could run the whole of Tororo hospital for a year on what these two spend in going abroad to their various 'conferences' e.g. for the

World Bank, the World Health Organization, various AIDS conferences and other equally non-productive functions each year. As to what they do when they are away, one never gets any information from them, and few if any reports of what they have been up to filter to the average medical person in their employ. In spite of all their visits to donor agencies abroad, the supply of drugs, dressings, AIDS testing kits etc., etc., etc. it never gets any better. In the meantime Dr. M***** in particular, gets fatter and fatter. He is the epitome of Ross's First Law: "The honesty and integrity of Ugandan politicians, public servants, and policemen is inversely proportional to the length of their belts".

September 12th.

Just before Charles Larson left, Roderick Leighton, Ken Leighton's son, a young doctor who had worked with us in Tororo last year while on holiday from doing a surgical Residency at the Grenfell Mission Hospital in St Anthony, decided on paying a surprise visit to his father who is working with us at present. On the way here he suffered a truly dreadful experience on the bus from Nairobi. Rod had been working in Somalia with a kala azar project there, but finding that he was not needed, he then took a post with a project doing medical work in the Turkana region of Kenya, but found that the chap he was to have replaced had decided to stay on. So he decided, seeing that he was in Kenya, to go and climb Mount Kenya, which he did. Rod has been described as a young man who has to use every molecule of ATP (adenosine triphosphate) in his body each day, before he's happy. If there is a mountain he has to climb it, he goes most places by bicycle, if he does not run there, and if not he canoes, kayaks, rafts or moves on the face of the waters by muscle power alone. He is incredibly fit as a result of all this expenditure of energy, but on the way to Tororo, when leaving Nairobi by bus, he was assisted by a helpful and friendly young African lad to get his gear aboard the bus, and get a relatively comfortable seat. Once the bus was underway, he was offered a candy in the form of a wrapped up toffee, which he took and ate. That was the last thing he remembered doing for the next 18 hours. Evidently he was rendered unconscious by whatever was in the toffee, and was found comatose when the bus arrived at Malaba next morning. Thank goodness there were a couple of young New Zealanders on the bus, who got him into the police station at the Malaba border, and who very kindly stayed with him till he regained consciousness, which was not until about four o'clock that afternoon. They came past the house that afternoon, and told Ken what had happened. I was in Kampala with Charles Larson at the time, so Doreen got moving and arranged transport for Ken with some Asian friends living a few doors away. Ken certainly was not in a very fit state to drive after receiving this news of his son. Anyway they got Rod home across the border just as darkness was falling, and he had a raging thirst which was somewhat assuaged with a couple of gallons of water, he then went to bed and rested for the night. He was robbed of his travellers cheques and about $200, together with his passport while he was unconscious on the bus. The police tell us that they sometimes have taken people off the bus, dead, when it arrives at Malaba. Altogether a terrible experience for the young man. I have no idea what the toffee he took was laced with, but am sure that it is a plant alkaloid of some kind, and will try to find out.

September 14th.

Examiners' meeting held to-day was again a lovely example of the Ugandan's adoption of all that is worst in the academic examination process. A whole lot of wrangling about the most petty details, with little or nothing on the overall individual candidate's progressive assessment. Just the final examination results, with a lot of hair splitting as to what a 'Pass Mark' should be, and so many of their candidates seem to fall into the 45- 50% bracket, this in spite of the fact that almost all the exams are of the essay type, where it can be fairly simple to take into account a student's years work, and mark accordingly. Mind, the majority of the students do not see their 'professors' or other teachers for the whole year, and in fact there were two complaints by the students, read out to the Examination Committee stating this very fact! The students say that the examinations marking cannot be fair when the faculty do not even know them. It takes a lot of courage on the part of any student to complain about faculty members here in Uganda because their generally passive attitudes in the face of the awful teaching, and behaviour of the teachers, which they have to endure, is due to the fact that they all say that, if they do complain, they will never pass, and that the Faculty will indeed see to it that they won't. In fact I am told that in the discipline of Internal Medicine, until last year nobody had passed the final examination for the previous eight years. The students say this accounts for the fact that there have been almost no applications to the postgraduate training programme in internal medicine for the past three years. They believe that the faculty do not want any new graduates who might be a threat to their practices or university appointments! It is fairly obvious at these meetings that there is a remarkably superficial view taken of the endeavours by the students, and the meetings are conducted with a lot of the most inappropriate laughter, and snide comments about their students by the majority of faculty members. I find it very hard to take most of the Faculty Meetings, because there always seems to be an 'agenda' that is obvious to the majority of the more established members, and which they will implement in spite of anything rational that may be said by one or two of the more sensible and dedicated people. There are a few of these, and notably most of them are much younger than the 'Old Guard', who very firmly hold on to the reins of power.

There was a marvelous meeting recently when, in the absence of the Dean, Professor Mmiro was the chairman, when they were charged with the responsibility of dividing up 36 millions shillings (about $32,000,) the whole of the teaching budget for the year, between the twelve Departments of the Medical School. Dr. Mmiro, an obstetrician, started the meeting only 15 minutes late, when only five of us were there, and declared a quorum. There are about 25-30 people on the Faculty Board, and meetings always start an hour later than scheduled, with people wandering in up to two hours after the starting time. On this occasion Dr. Mmiro just divided the money up with 2 million shillings for each discipline, dividing the remainder of it amongst the newest Departments, who he said were in greater need, and got us all to agree. The meeting was over in just over half an hour, by which time the Professor of Medicine, Dr. Roy Mugerwa, came in. He is one of the worst offenders as far as being late is concerned, and a singularly contentious individual when he is present at any meeting. He was presented

with a complete fait accompli, and was fit to be tied, declaring that the Department of Medicine was the biggest, and therefore should have had a much larger share etc., etc.. However he was firmly put down, and told that the meeting was over and a consensus had been achieved by the members present. He harbors a grudge against Dr. Mmiro, and makes it obvious each meeting, but I am glad to say, is finding himself rather isolated as a result.

September 17th.

In the seminar this week one of the students produced a most unusual case of chronic cough and chest problems, which was almost certainly aspergillosis. The general run of extraordinary respiratory problems resulting from the AIDS epidemic continues to create dilemmas as to what one should do. Though AIDS is incurable, many of the complications are treatable for limited periods of time, even with the few drugs available to us. However these drugs are either expensive if purchased by the patients and their families, or else in very limited supply. If the patient has to buy the drugs, the family are deprived, often of essential foods or else other necessities, or of the means whereby to send their children to school. As I have mentioned before, school fees are a national preoccupation here in Uganda, and families sacrifice a lot for their children to go to school. However it should be borne in mind that they educate the children, often as a sort of insurance policy for themselves in their later years, because any successful member of a family is expected to look after all other members of a family. For example, the majority of doctors have so many 'hangers on', in the form of relatives, all of whom they are expected to provide for. This is so much the case that they do not ever seem to be able to get their heads above water themselves. Almost every doctor who has been in working in Tororo has had at least a dozen people, all relatives, actually living in his house at any one time, and probably as many others in the villages where they come from, all depending on him. What is extraordinary to me about this set up is that the parasite bunch just sit about and do very little except sleep, eat and be clothed. Anyway, I digress from the main theme, which is the problems with 'treating' AIDS sufferers. It seems to me that more than 85% of the patients presenting with T.B. also have AIDS. I guess that waning immunity against T.B. is one of the first indications that the immune system has become compromised. At first these patients respond quite readily to the anti-T.B. drugs, but they never clear completely it seems, and the thing becomes chronic, and I am certain we are breeding resistent strains, which will probably eventually get back into the uncompromised and immune healthy population and spread T.B. amongst them also. The general population, specially the women and children, are not always too well nourished and able to withstand disease. I often wonder whether to die of AIDS in its earlier stages, with something like pneumonia or other more fulminating infection might not be preferable, rather than go on the very bitter end, which is horrible and with a lot of suffering and deprivation to the family, with probable further spread of the disease. The longer the AIDS patient survives, until physically weakened, it does not seem to change the behaviour of too many people. The disease is still obviously on the increase estimated by the ever increasing number of obviously affected people one sees; so even though we have no means of HIV testing for the past 12 months now, and have to rely on

clinically obvious cases as a means of assessment, there still is pretty clear evidence of a rising incidence, based on the number of clinically apparent cases. Then there is the ever present denial by the Ugandan doctors, and foolish pretence in overlooking obvious or ignoring symptoms and signs, and pretending they are treating something else more treatable. They so frequently send me a patient for diagnosis and investigation, with some spurious diagnosis, who is so obviously suffering from AIDS, that I think they are hoping that I will tell the patient the prognosis, rather than them. I have steadfastly refused to do this, and send the patient back to them with the request that they make up their minds whether or not to tell the patient the truth. As I think I have mentioned, they, the Ugandan doctors, all seem to feel very strongly that the patients should not be told of their condition if they suffer from AIDS, and when speaking to either doctors or medical students, they all tell me that they themselves would rather not know if they had the disease - a curious form of denial to my way of thinking, and I wonder at the very great difference between us in this respect.

After the seminar, we were on the way back to the German Guest House where Ken was staying for the night, after having been out to a Chinese restaurant for a meal, when there was a power cut. Most of Kampala was plunged into blackness, and as a result I managed to walk straight into a manhole, which, like so many in Kampala, had its cover removed at some time, and then disappeared right up to my armpits; I was extremely fortunate not to suffer anything more than a rather severe bruising of my leg, and a wetting from the water flowing through the drain. Dangerous place in the dark!

Tried to send a Fax message home to-day, to warn young John Lewis who is due to come for an elective, not to take any candies or drinks from strangers when he travels from Nairobi to Malaba: to my disgust one cannot send faxes from Uganda to Canada at present, because Uganda has not paid its telephone company dues. Notably the only countries to cut them off entirely have been Canada and Dubai.

September 22nd.

Back again to full clinical work this week. On Monday the first four cases were ultrasound requests for multiple pregnancy. Three cases of twins and one hydramnios were the outcome. Then one chap who came in with extensive Karposi sarcoma, and when I asked him what he thought was the problem, he swore that it was the result of a curse put on him by the local witch doctor. When I asked what I could possibly do about it, he told me that I could lift the curse with more powerful medicine; I found it very hard to convince him that this was not indeed the case, so I fear that my reputation will probably suffer greatly as a result of such an admission, certainly in his village area at least.

On Sunday I was called to the hospital to see a policeman who had been shot in Busitema Forest, about 25 kms away, however, by the time I got there he'd breathed his last. The police had been carrying out an exercise in the forest against smugglers, who smuggle goods across the border from Kenya, evidently quite a lucrative trade, but they

came across a group of army deserters who were well armed, and he was shot through the abdomen, and had to be carried by his mates to the roadway. First they had to flag down a passing car to bring him to hospital at Tororo, then they had to find the doctor on duty who eventually called me, but he had lost too much blood by this time, and was dead when I saw him. This is going to be the latest of our problems, because the Ugandan armed forces are in the process of being reduced quite drastically. As a result the soldiers who came from other parts of Africa, such as Rwanda, Somalia, Kenya etc. know they'll be the first to go, so they are deserting with their weapons, and have taken to living by the gun. It has been a real problem in the past, but was just beginning to die out, as many of those from Obote's army and other 'Rebels' were by this time, running out of ammunition. Now it looks like it will flare up again for a long period of time in the future, so we can stand by for more shootings. It is interesting that the Karamajong tribes, who are fairly well organized, and who have long lived by cattle raiding, and general banditry have taken to ambushing army units. Their prime purpose is to get ammunition and new weapons, there being nothing political in their activities, only organized robbery as a way of life.

September 29th.

Last Friday, I met with a group of insulin dependent diabetics, about 14 of them in all, trying to set up a diabetic association. These people can get no blood sugars done, they cannot even get reagents to test urines for sugar, and they have to pay for insulin and syringes themselves. It is to try and get them to form a body of people who can take some collective action in the area, because most of them are fairly prominent citizens, of the rather more obese variety, though there are two who seem to have type 1 diabetes. I have promised to write a letter to the Ministry of Health, outlining what their problems are and suggesting some appropriate action. It just may be that we could get the supplies of insulin, syringes and test reagents sent to the diabetic association for them to administer themselves, rather than the hospital which continues to be a sink into which drugs are poured, and are drained off to the private market in very short order - insulin and other diabetic requirements into the bargain. There have been some very good articles of late in the B.M.J. by doctors working in Tanzania, actually questioning whether it is worth even treating insulin dependent diabetes in Africa, for the very same reasons that we suffer from here in Uganda. Though in the Cottage Hospitals in the late 50's we were quite successfully treating diabetics on the basis of urinalysis alone, not having the facilities for blood sugars in those days. However, we could always get insulin and test reagents for appropriate urinalysis, which is certainly not the case here in Uganda these days. Anyway, we'll see how the association fares.

Had a heavy day in the operating theatre to-day. First case a child with a large granulating growth of the hymen. She had been raped some months before. Next a vaginal hysterectomy and repair for a very long standing prolapsed uterus. We are getting a lot of these nowadays, as this seems to be one of the very few hospitals doing this. I am using spinal anaesthesia mostly, but one has to hurry to get the procedure done before anaesthesia wears off! Then a man with a huge lipoma of his left side for removal,

and I mean huge, I do have a photograph of it; this was done under local anaesthesia, and I had to use quite a lot of it, but have taken to diluting it to half percent Xylocaine, which is as effective as the 2% solutions which we have, and certainly makes it go much farther. Finally a lady came in with a ruptured spleen which she had sustained following an attack on her person by her husband, who had kicked her in the stomach because she did not have his food prepared on time! The most amusing happening in this instance was that when I requested one of the operating room nurses to get things ready in theatre for the necessary surgery, I told her it was for a ruptured spleen, recounting the fact that the patient's spleen had been ruptured by her husband because his wife had failed to have a meal ready for him on time. The nurse, without batting an eyelid or cracking a smile, asked me "Was it lunch or supper she didn't get ready?" !! The poor patient was rather bloodless before we began, but seems to have done very well in spite of that. The husband refused to donate blood for her of course - I guess he's still angry?

October 13th.

Past couple of weeks have been more quiet than usual, except for the fact that we had a real tragedy at Manjasi High School. It seems that there was a student reprimanded for stealing, and the police handled him a bit roughly, to which the other students took exception. Following this, it appears they were about to begin throwing stones at the police who then opened fire, killing two of the students who were not even participating in the riot, and who had just arrived on the scene. It has left a rather nasty lot of ill-feeling toward the police in the whole community, which we could well do without in these troubled days.

Young John Lewis Junior arrived in good shape on the 1st October for his elective. He'll spend a couple of months here followed by a month at Kitovu hospital, a well-run mission hospital near Masaka - one of the few hospitals left almost completely medically supervised by expatriates, and therefore a much higher standard than any of the government run hospitals. They get their drugs and supplies from overseas, and are one of the very few hospitals able to do HIV testing. I am told they gave over 1,200 blood transfusions to children under five last year, and their criteria for transfusion is a Hbg below 4 Gms! Malaria is still the prime cause of the terrible anaemias we see here, but in our hospital we do not transfuse till the haemoglobin level is below 3 Gms, and find that most of them do fairly well on oral haematinics with chloroquine or other anti- malarial medication. We still have not got any reagents to enable us to test for HIV, neither have any of the other government hospitals, and there seems to be little prospect that we'll be getting any in the foreseeable future; this of course makes any of the statistics published by the Ministry of Health regarding the incidence or prevalence of AIDS completely meaningless.

We had a real problem in theatre the other day when I was operating on a nulliparous lass for a large ovarian cyst, which was easy enough to remove, but she also had multiple small fibroids of the uterus. Knowing the tendency of these to grow rather alarmingly large, I wanted to do a hysterectomy while we were in there. However the

theatre staff all rebelled, and said that the husband had not given his consent for hysterectomy (in actual fact he did not even accompany her when she was admitted to hospital) - even the female theatre staff were adamant that no hysterectomy could be done without the husband's consent!! So she was sewn up again without the procedure, and I am sure that she will have to have the hysterectomy done at a later stage. I had not done an ultrasound on this lady, as she had been referred to me and was supposed to have been fully worked up by one of the other doctors here. The ovarian cyst was large, and very easy to diagnose clinically. However I would have seen the fibroids had I done an ultrasound. My mistake in this instance, and not to be repeated. I should know better by now, but all pelvic surgery to be done will have an ultrasound scan done beforehand in future!

Met with the diabetics again, this time only two showed up. Last meeting I had asked them to draft a letter to the Ministry of Health, saying that they were forming a diabetic association. The idea was that they are all fairly well to do citizens in the area, and I felt that they might have some influence on the Ministry in getting supplies of syringes, needles, testing reagents and insulin, if they all signed the letter. They did not write, and in fact had not met together since I met with them, so we are no further forward. It is still quite surprising to me that people here will not act collectively, and do not seem to realise the power of collective action, but I guess it is a result of the past confusion and the disruptions of their civil wars etc. that has made them quite cynical as to any help to be got from official sources, and they think it is not worth the trouble to try to get anything out of the government. It is, to say the least, quite disheartening trying to get people to act together for their benefit. Even cooperatives in Uganda do not thrive, and many people will tell you quite openly that "We just do not trust each other"! What can one do in the face of this attitude?

October 22nd.

I am writing this entry in Nairobi. I wanted to visit the CIDA headquarters there, as I have only just learned from Charles Larson, when he visited, that there is a Uganda representative based in Nairobi, a delightful person, Nicole Chartrand-Tresh. Nobody in CIDA ever told me of her role or even of her existence, and she visits Uganda quite often, but never came near Tororo, as we are an inter-institutional project, and she deals with smaller projects as a rule, not visiting other projects unless requested. However she does have quite a bit of 'clout' with our Ministry of Health, as she often deals with CIDA drug supplies etc. I only wish I'd known of her existence before this, as she could have put a lot of pressure on the Ministry to act a bit more energetically long before this. Anyway CIDA headquarters in Nairobi is quite something- the security system is intense, one is frisked by a security guard, just like at an airport, before going in to the place. The doors open with plastic cards, and are locked automatically behind one etc. etc. One feels like one is in Fort Knox. Doreen and I met with Susan Scarlett, daughter of Maurice and Shirley Scarlett who were in the Geography Department at M.U.N. Susan is now a member of the Canadian Embassy in Nairobi, and lives in a large house just outside the township. Again security is all too apparent, and makes me appreciate Uganda. For all

our problems here, we do not have this elaborate security system in operation. Security is big business in the whole of Kenya, and I would not like to live in that country any more.

The drive from Tororo to Nairobi was very pleasant, we went via Eldoret and Nakuru. The border crossing took over an hour and a half this time. Again the only animals we saw the whole way were a couple of zebra. As a boy, growing up in Kenya I remembered the whole countryside was alive with game of all descriptions, and the trip when traveling to Nairobi from Kisumu then was like passing through one huge game park the whole way. Because of the massive agricultural development which has taken place in Kenya since that time, all the game has been displaced by farming and fences. It is not the killing of the animals which has caused them to disappear, as much as mankind's need to grow food has left nowhere for the animals to go. They just get driven off, and their grazing vanishes, but I guess it was the same that happened in both Europe and North America, causing the disappearance of the majority of wildlife there as well.

Doreen flew off to Australia to visit her sister Anne today. Anne's husband died last year, and she's trying to decide where to live in the future - whether to stay in Australia, or return to the U.K. where the majority of her relatives live. Australia is such a long way off, and when one's income is reduced after retirement, it is very expensive to visit anywhere else from Australia. Doreen has been looking forward to the trip for a long time now, as she has not seen Anne for quite a few year, and they are quite close. I am motoring back from Nairobi, and am staying at a hotel in Eldoret for the night. Shall be returning to Tororo tomorrow in time for a major meeting with regard to setting up the 'Cost Sharing' scheme in Tororo hospital.

October 24th.

On arrival back in Tororo I learned that Ken Leighton and his son Roderick had returned from a trip they had undertaken to climb Mount Kilamanjaro, the same day we left for Nairobi, and arrived in Tororo only to be greeted by the news that Roderick's girlfriend, a young Canadian doctor who had been working in Addis Ababa with a McGill CIDA project, had died very suddenly and mysteriously in her flat. Poor Roderick was terribly upset, and flew to Addis immediately, then escorted the body back to Canada. Ken is dreadfully upset by this latest disaster to strike his son, and is very understandably, terribly depressed as a result. There is little one can do in the way of helping him come to terms with it all. The most terrible ill-luck seems to have dogged Rod ever since he came back to Africa this time.

October 29th.

Ken Leighton left for home today. I am very genuinely sorry to see him go; we had so very much in common, both being Aberdeen graduates, only a few years apart, with an almost identical experience in the armed forces etc.. It was great to be able to lapse into speaking the broad 'Doric', which nobody else could comprehend. However it

has been a very traumatic time for him all in all, particularly with what his son Roderick went through. There is still no word as to exactly how Rod's girlfriend died, or what was the cause of death. However, I am beginning to think that the candy Roderick ate was laced with scopolamine. There is a plant here which they call the belladonna plant, which grows a huge white flower, the active ingredient of which seems to be scopolamine. I am told that thieves dry the flowers, then pulverize them to a very fine powder, which it is said they blow in through the windows, causing the inhabitants to fall into a deep sleep. I guess that inhaled, it might just work very quickly, and scopolamine is a drug which could be used in small enough quantities to be put into a candy, and prove quite effective.

The major cost-sharing meeting took place on the 23rd of October, and was a most astonishing thing. It took the whole day, with everyone giving speeches, and much hot air was vented on all sides. Everybody it seems wanted to get in their five cents worth. However, we are definitely due to start it on the 15th January - not very far off now. Manfred Stormer has done his homework quite well, and it might just work, given a bit of good will on the part of the medical staff at the hospital. In the evening we were invited to the home of a Mr Paul Etyang - a real political survivor, he was in Idi Amin's government, as ambassador to the U.K., then survived to serve with Obote's crowd, and now is Minister for Trade & Commerce in the Museveni government. He regaled me with a plan he has to start a sort of super clinic and hospital in the Tororo area. It is to be, he said, staffed with doctors hand picked, and well paid, and he wants a team of specialists to come from Kampala and Kenya to work on a visiting consultancy basis. The Hospital he wants to build is to be for the very well off, and well-heeled Ugandans or Asians with money, and anyone else who can pay large fees. He seems to be dead serious about it, but I cannot see it working here in Uganda. Etyang is a man with a considerable fortune I should think, as he has a house in London, in St John's Wood area, as well as three or four large residences here in Uganda! He certainly knows the country and its people, and is unlikely to make a bad investment, but all the same I cannot see a clinic of this kind working in a place like Tororo, when Kampala cannot provide any kind of really good medical services, even with well-to-do doctors there, who are in the game of medicine for the money they can make, and nothing else.

The other day we had a fascinating series of cases for diagnosis with the ultrasound machine - I'm getting addicted to it! There was a lady with a huge endometrial polyp, a case of polycystic kidneys, a pancreatic pseudocyst in a man who'd had acute pancreatitis some time before and a man with pyloric stenosis - all in the one day!

November 10th.

It would seem that the Ugandan Ministry of Health is determined to undermine the whole training project in Tororo. Their latest stupidity is to post the first two graduates to areas as far from Tororo as it is possible to send them. Dr. Odu has been posted to Lira, and Dr. Kaharusa has been posted to Kalengali. Kalengali is a district

which includes a lot of offshore islands, including the Ssesi Islands in Lake Victoria. There's no hospital there, and he will be unable to use his hard acquired clinical skills in that situation. Lira Hospital is some distance away in the north of the country, and one of the least pleasant postings. However both these postings have strong political overtones, with the government ministers responsible for them in fairly high positions in the cabinet - I guess that is the reason. However, I had banked on them as being future Faculty Members in this discipline when Dr. Tuunde takes over. I wrote strongly to Dr. M*****, the D.M.S. threatening to discontinue the whole teaching programme if the postings were not revised.

This week there has been a major seminar on the Kiyeyi project from which the Finnish people are withdrawing to hand it over to the Ugandans after eight years they spent in setting it up. They are not too sanguine as to the eventual outcome of their project either, as already some of the vultures are in the wings, waiting to take over the running, and as they say, some of them are not the most dedicated to the original objectives, and see the programme as a good way to feather their own nests. The appointment of some of the people to key positions has not been from the local people, or others who were in at the start and have worked so well all along, but come from other areas where the Ministry of Health administrators want to appoint their own people. Nepotism, both tribal and family, is rampant. Anyway one person who was at the seminar was Dr. M*****, who has promised to reverse the postings of our first graduates, and send at least one to the Tororo area, and the other to Kiyeyi. This would be ideal if indeed they do it, but I am not too sanguine with all the politics involved.

On the lighter side, a word about the new phenomena of 'Hitch Hikers' in Uganda these days. There are the strangest bunch of young people you ever saw wandering round the country, back packing and hitch-hiking. They stay and eat at some of the sleaziest hotels one could imagine. Obviously all are on the most minimal of budgets, they seem to be universally in need of a bath and a change of clothing, both the males and females of the species. It cannot be a very pleasant experience many of them are undergoing, and one sees them occasionally as patients, usually for rather intractable diarrhoeal conditions or else malaria. They come from the U.K., Australia, a few from the States and Germany, with the very occasional Canadian. A few of them have been robbed while here or in Kenya, and most carry a small handbook, put out in the U.K describing briefly the places to visit, and giving lists and descriptions of the hotels and their prices.

November 19th.

A really hectic week with the Dutch Plastic Surgeons and their team here once again. This time three of them, Rein Zeeman and Mathilde, his wife, and a Dutch student doing his postgraduate residency in plastic surgery, stayed in the other house on the compound, and two of them stayed at the Crystal Hotel - they said it was not too bad at all. With Doreen away, I had to cook for them for the four days they were here, and with the schedule of surgery they put on it was pretty busy. Again though, I have learned a few more clever tricks from Rein Zeeman - he's certainly one of the best surgical teachers I've

ever encountered, being very patient with those who are more fumbling, handless, and less skilled than he is. One of the amusing happenings was that one of my students took Rein into the female ward to see a patient he thought to have a really huge ovarian cyst. Rein agreed and asked me to do the operation and put her on the list for the next day, so that he could get a couple of photos a bit different to the work he usually did when here. Anyway, when I saw her I really did not think that it seemed to be of ovarian origin, so I took her for an ultrasound examination, and to my astonishment saw that she had the most enormous fibroid with a small 20 week pregnancy also in the uterus, quite viable with a good foetal heart beating away. I am not sure exactly what to do about it, as she'll never deliver normally, but I'll ask Dr. Miriam Duggan when I see her in Kampala next visit teaching.

The last day Rein and his team were here, we were all entertained by the local Rotarians, at an outside barbecue. The subsequent speeches were, to say the least of it, lengthy and repetitious, with only one spark of humour, quite unconscious it seems. When the local R.C.4 (equivalent to the Mayor of Tororo) was thanking those who prepared the foods, he spoke about the excellence of the food, which "So distended his stomach that the rats which had recently been troublesome at his home could no longer climb up it." and continued to tell us that he "Was happy that the rats could not climb up and disturb his rest tonight!"- I am still not sure exactly what he was trying to say or what he meant, and whether his meaning was literal or not. Before going to supper, we all climbed up "The Rock", a 1,200 ft huge volcanic plug that dominates the town of Tororo, and Rein challenged the Rotarians to hold their next farewell dinner up at the top of the Rock. The majority of them are very prosperous people in the community, and therefore fairly rotund, not like the average Ugandan, who is in superb physical shape - I really do not think they'll rise to the challenge.

November 29th.

Went to a community called Kapuwai with Tom Barton, the American research expert, who has been helping our students with their research projects, and Stephen Tuunde. Tom wanted us to go to see this community which is of great interest to him, because a rather unique primary health care service was begun by some ex-Makerere students who found that there was no employment for them once they had graduated and who decided, rather than leave their home area, to start a number of local Self-Help organizations in their own community, one of which, was their primary health care project. This was the subject of a meeting to which they had invited us to attend. It was very interesting to see what they had achieved on their own, without any government help or support from outside the community. Tom describes it as the most empowered community in the whole of Uganda. They have also started a communal school, staffed mainly with volunteer teachers, whose only payment is that some of the parents help the teachers farming efforts so that they have time to teach. It is good to see that there is a community with such a really cooperative spirit, because it is extremely rare in Uganda even to see any of the more established cooperatives working, mostly because those in charge have the bad habit of absconding with the funds, and the lack of real trust amongst

folk here is one of the most depressing things. As I have mentioned before, a lot of Ugandans say - "We just do not trust each other!"

In the meantime here in Tororo we have had a great number of meetings about the proposed cost-sharing to begin in January. Things are at last beginning to take shape, and the public's awareness of the fact that they are officially going to have to pay for their health care in future seems to have been well accepted, given the proviso that they do not also have to pay the customary 'under the table payments' to the health workers as before.

Surgery this week included a gastrectomy, the first I have had to do here, for a severe pyloric stenosis; so far he's doing well. But the funny case was a lady who had a carneous mole from a missed abortion at about 20 weeks gestation which had died in utero about six months ago; she was put on the list for an evacuation, with possibility of a hysterotomy. Anyway she turned up having produced the mole spontaneously at home some few days before she was booked for the procedure to be done, and to prove that she had passed it, she brought a photograph of the abortus which had been laid it on a sheet of white paper. Ultrasound confirmed that she had indeed passed it complete!

December 8th.

Since the last entry I have been to Nairobi again to meet Doreen coming back from her visit to Australia to see her sister Anne. Believe me it was good to get her home again all safe and sound, and she does seem to have enjoyed the visit very much indeed, but her remarks were that Australia seems to be full of Asians from the Far East, because of the tremendous influx of Vietnamese, people from the Philippines, Borneo etc. The culture shock of being in Australia, at a time when they were gearing up for the Christmas season was great indeed. The glitter and gloss of our society, the shops and frenetic activity of the people was just a little too much to take after being so long in Uganda.

We interviewed people for the post of finance officer to run and administer the cost-sharing scheme, and decided to employ a Mrs Anyango, certainly a very impressive lady. It is interesting that the majority of Ugandans trust women to handle money much more than they trust men. The reason they give is that women are much more reliable, honest and trustworthy generally, which I do find an interesting statement coming as it does from the chauvinistic males of this country. Mrs Anyango is one of the brightest spots to appear on the horizon of our cost sharing scene. Manfred and I wish to employ a patient advocate, as a sort of ombudsman, who can oversee the scheme on a day to day basis, and let us know if there is any hanky panky, such as under the table charges still being levied. We both have the same person in mind, but the medical superintendent, Dr. W***, is dead set against her. I believe it is because she can be trusted to do her duty, and bring complaints to the management Board, and I feel pretty certain that W*** himself would stoop to charging illicitly if he felt he could get away with it.

An interesting sidelight the other day, when we had a patient who came in, very ill indeed, who declared that she'd been poisoned by a neighbour. It was evidently over a land dispute in the village in which she lived, that had been dragging on for ages, with terrific enmity between the families concerned by this time. The hospital staff tell me that she definitely had been poisoned, and that this was not uncommon over land ownership, and that the other thing they do is to put a bad spell on the neighbour, which they tell me is just as effective as poison when the spell is carried out by a witch doctor. I find the ownership of land an interesting phenomenon which must have only been developed over the past 50-60 years, because before European settlement, there was almost no land cultivation done whatsoever, the majority of peoples were hunters, very mobile, always following the game, and they only gathered local fruits etc. to augment their diet. The only tribes to whom land mattered were the cattle tribes, the Maasai and the Karamajong, and even they never settled in any one spot, grazing were the grass was greenest, and the rains sufficient. Now they have as much bitterness over the land ownership as any of the people in the so-called developed nations.

December 14th.

Gave the two first year students, who have been here for the last three months, their exam today. The Ugandan students have an addiction to exams, they seem to like them, and ask that they be set. Anyway, both Dr. Wanume and Mayombwe seemed to do very well. They are having the kind of exams they have never had before, a few multiple-choice, then patient problem, then they have to outline the problems they have perceived in the running of the hospital, and come up with solutions which they think are appropriate and applicable to the Ugandan scene. Most solutions we would think of, particularly those of an authoritarian kind, such as ordering someone to do something, or to set up rules to abide by, are quite impractical, and the interrelationships between people would not allow it. They just cannot give orders to other people and see that they are indeed carried out, as it seems to go against their whole way of life. Anyway their answers are interesting, and encouraging, in that they are beginning to think, and not just regurgitating facts from books they have read.

We had a couple of young American doctors here, who are seconded from Case Western Reserve University, and doing a stint of teaching in Mulago hospital. One is an obstetrician, who is in the process of setting up a teaching programme for both undergraduate medical students, and midwives. She is having the most monumental problems with 'the establishment'. The other is an internist, who has specialized in ambulatory care internal medicine in the States, and who is trying to establish some form of teaching programme for the postgraduate students at Makerere, and is likewise having her problems. Most of these stem from the Established Order, who do not like newer teaching methods, particularly as they do so very little in the way of teaching themselves, being so immersed in their private practice ventures, by which they make the major part of their living. They therefore feel that all these foreigners are just there to show them up as incompetent teachers! Being seen as a threat, she is getting very little help in her endeavours as a result. Of course the obstetrician, Cheryl Walker was fascinated by our

lady with the huge fibroid, who is lying there incubating her foetus, and she wants to come out to Tororo to witness the delivery. One of the projects being pushed by the Case Western Reserve Nursing Faculty is to establish a degree course leading to a B.Sc. Nursing. This in a country where the major teaching hospital has not even got clinical thermometers, no stethoscopes, and no blood pressure machines, and where the nurses do not chart even the most basic of vital signs, strikes me as the height of nonsense. They declare that unless the standard of nursing can be brought up by degree nurses, it will never happen. I feel it will take more than a few degree-holding nurses to motivate any of the underpaid and ill-equipped nurses in Uganda. I have even given up doing vesico-vaginal fistulas (V.V.Fs.) at this hospital, because of the desperate lack of post-operative care the patients receive from the nursing staff, and it is too difficult to train the families, who do most of the patient care in the hospitals, to look after V.V.Fs.. We did have one very good nurse on the female ward, and the success rate at that time for V.V.Fs. was excellent, but she left to go on some course or other, and the present crowd just have no interest in what they are doing, and post-operative care is abysmal.

December 28th.

Well, Christmas 1992 has come and gone. It was the quietest one we've ever had so far as gunshot wounds go - only one this year. There were nine the first year I was here, seven the next, so the score is going down. Mind, the number of deaths is not, there were four or five people killed in armed robberies, and at the local Shell station the three guards were clubbed to death with tyre levers one night, and the thieves only got away with 300,000 shillings, the equivalent of about $300 Canadian. Life is indeed very cheap. Christmas always brings a rash of hold-ups, specially of people entering Uganda from Kenya, as thieves think that they are bringing back radios, T.V. sets and other 'desirables' at this time. All very sad.

We spent Christmas with the boys in the Salvation Army Orphanage, as usual. Joan Linnaker, that wonderful Scottish lass who has spent most of her working life in Africa, and was in Uganda through most of the troubles, always has a Christmas dinner for the boys, in which Doreen and I have participated and helped at the last couple of years. Roast goats meat, Matoke, and other 'local delights' being the order of the day. The kids love it, and we go through the motions of enjoying the meal though there are dishes I do prefer. But the spirit of the place is just wonderful, and makes up for everything. Then on Christmas Eve, we have started a tradition of going to the hospital for a little carol singing, which the patients do enjoy, and Doreen does her bit Santa Claus, distributing milk, biscuits a little money, and to the very needy, blankets. A very different set of gifts to those that people expect at home.

One of the joys of Christmas here, is that one is not bombarded with the dreadful commercialism that one encounters at home, and I did not once hear Bing Crosby sing that he was 'dreaming of a white Christmas'. I think when I finally leave Uganda, I'll just hibernate for the whole of the Christmas season, and wake up when it is all over.

An amusing Christmas time episode happened when we were given a turkey by a 'grateful patient'. At the right time, I asked Richard our gardener to slaughter it and pluck it for us. However, when he seemed to be a long time at the job, Doreen became very suspicious that he was chopping it up, and asked me to go and check. Sure enough, he'd already chopped it up into three large pieces, and was preparing to do further damage. The Ugandans rarely have ovens or other cooking facilities to speak of, and therefore tend to boil or fry everything, and their methods of preparing poultry and ours differ profoundly, they have to fit everything into the one pot. However, I did finally manage to suture the bird together with surgical silk, and Doreen then managed to stuff it and roast it quite well in the end. All things considered, I thought that it was a very good plastic surgery job, and when it was on the table on Boxing Day, you could hardly see where it had been sewn up! We had the usual crowd in on Boxing day, a bit fewer than in the past, as most of our friends here had taken off to go home for Christmas. However it was an enjoyable day, and certainly the Christmases here seem to have a lot more meaning, and in many ways are so much more enjoyable as a result.

January 5th, 1993.

Another year gone by. I suppose that something has been achieved during 1992, though here in Uganda one always wonders what is going to happen when one leaves, and whether anything will be left behind of any value whatsoever. It would be so nice to think that it has not all been a monumental waste of time and effort; progress toward any goal one sets is always so painfully slow as to be almost imperceptible at times. Expatriates working here invariably have a sense of futility and frustration, alternated with short lived bursts of optimism. One of the long time Catholic Missionaries, a priest, said to me "When people first come out to Africa, they think that the Africans can do nothing wrong, followed by a stage when they feel that the Africans can do nothing right, and the next stage is who cares what the hell the Africans do anyway?". When I asked him what stage he was at, having been here for 45 years, and seen all the changes and turmoil, he answered that he "vacillates all the time between all three stages, and often all three stages in a single day".

We went to visit the Finns at Kiyeyi on New Years Eve, and had a lovely Finnish meal. They offered us a sauna following the meal, but on this occasion I declined. Like all good Finns they built a sauna very shortly after they arrived in the place, and I must say having experienced a sauna in Africa, it has a lot going for it. After the first experience of it, I felt that it was almost the first time I ever felt completely dust-free since coming here. Llena Salin, who is one of the main participants, with her husband who is the overall coordinator, are a delightful couple. They were missionaries in Ethiopia for a number of years before coming to Kiyeyi, where they have been working for the past eight years, setting up their Primary Health Care project there. Llena took a year off to go to the States, in order to do a Ph.D in Health Care Management, she was successful in getting her degree, and has just returned to finally hand over the whole project to the Ugandans within the next three months. Following this 'little exercise' they

are going to Malawi, for another Health Care related project there, again they will be funded by the Mannerheim League of Finland.

Last week I did the very first cholecystectomy I have had to do in Tororo. Cholecystitis is a disease from which Ugandans do not suffer, as the majority have such low fat diets, and almost no female takes the birth control pill. Even the tremendous parity rate of the women does not seem to induce gall bladder trouble, but again, in Kampala where many have adopted Western ways and diets they are beginning to see a few cases now, I know that I had to do a couple when working in Nsambya hospital.

January 20th.

No entry for a while, as the last week was the most terrible and traumatic week since coming to Uganda. We had a very good teaching seminar last Wednesday, and I stayed on the Thursday to visit the Ministry of Health, collect some equipment for the hospital from Entebbe. We left Kampala to come home on the Friday, leaving rather later than usual, as we had to pick up Joan Linnaker and a couple of her orphans who were visiting Kampala that week. A week before I had been having a little trouble with the car, when it overheated badly one day, but then seemed to correct itself; I could not find where the thermostat was located when investigating the problem, thinking that was the most likely cause, but all that week it functioned fine, and we had no trouble going in to Kampala, or Entebbe. However, on the way home we stopped for a drink of soda, and filled up with gas at Jinja, then left for home, a little later than our usual time of travelling, when in front of me was a petrol tanker, towing an empty trailer. When this vehicle was going downhill the trailer was swinging rather wildly, so when it was going up the next hill, and the swaying had stopped I began to overtake it; beside the tanker, walking in the middle of the road was a Ugandan pedestrian. There was a very good footpath beside the road where all the others were walking, and I thought he would naturally move over, but no, in spite of sounding the horn loudly, he took no notice, until it was too late, and even with the screeching of my brakes as I tried to stop, and the horn sounding, he didn't even look over his shoulder, and I fear that I struck him as I swerved behind the tanker trailer. When I got out of the car to see what had happened I found that he was indeed dead. By this time a few people had begun to gather, so I got into the car and went on to Iganga, the next police station to report the incident and get help. It is always wise in Africa to get away from the scene of an accident as quickly as possible and go to the nearest police station, because mob justice reigns in these instances, and there have been many incidents of people being injured by an angry crowd at the scene of an accident. We did stop a short way along the road when we thought there were policemen in uniform, but they turned out to be soldiers, and advised us to go on to the police. When we got there, Doreen and I had to go back to the scene of the accident with the traffic police and they took all the measurements of skid marks etc.. The dead man had by this time been taken to the hospital at Jinja. The police finally let us proceed home to Tororo, with a broken right hand side headlight, they initially wanted to impound the car there and then. By this time it was late, and there was nowhere at all to stay in Iganga, specially with Doreen, Joan and her two boys. We promised not to get any

repairs done, and would bring the car in on Monday for official inspection. So off we set at last, and by this time darkness was falling; we had gone about 80 kms since the accident, and I noticed that the car was definitely overheating, and the water in the radiator was boiling. I let it cool, and put in more water, but it boiled again in no time - by now it was dark, and we decided that getting home was the first priority, and pushed on in spite the overheating vehicle, which was getting more and more sluggish all the time. My greatest worry was getting stuck in Busitema forest, a notorious spot for hold-ups etc. at night. However when we stopped briefly to try to get the engine cooled, and fill with water once again, a very nice couple from Tororo stopped to help, and they drove behind us all the rest of the way home, and by this time we were limping along at about 25 Kms an hour. We got to Joan's compound gate when the car stopped altogether, and refused to budge another inch. However, we all got home safely, but the next day, Saturday, very early I went to the local garage, run by a very nice family called Hussein, and found that indeed the engine was fried, and the cylinder head warped. They had nothing with which to shave the head, and so we went to Mbale with the cylinder head, where they have more facilities. Finally an inspiration - we took the cylinder head to the Russians at Busitema Forest, and they did a very rapid job for us. They have a truly impressive workshop there, with all kinds of heavy equipment, and had the job done for us in about 20 minutes. Back to Tororo, and I was still anxious to find out why the engine had overheated in the first place. Anyway to cut a long story short, we eventually found the thermostat, in quite the oddest place, and almost inaccessible, without taking major parts out! It was indeed the culprit, and had seized solid. I had asked Hussein's to get me some radiator fluid some time ago, when they had to drain the radiator to fix a small leak, but they never got it in, saying that in Africa water was good enough. However, our Tororo water is so full of calcium, and very, very hard as a result, so that was what had eventually seized up the thermostat. By Sunday, the car was ready again, and working well enough to get it back to Iganga, for the police, where Doreen and I spent the whole day, having had to take the car to Jinja to be inspected by the Vehicle Inspector. The police finally gave us our clearance, and we got back home, very late again, and the car is now in the garage again, having the headlight and dent repaired. Meantime, I am using Stephen Tuunde's car which I am looking after while he's in Canada for the training course. Mind, the poor old car has done 120,000 Kms, and this is the very first hint of trouble I have ever had with it, but I wish I could have found the thermostat in the beginning. The thought of the accident is still very fresh in my mind. When we went back to Iganga to see the police, we met the 'brother' of the dead man, who by the way he was not a true brother, but a tribal brother, and probably not a close relative at that, and he wanted us to pay him 500,000/- (about $500 Canadian.) and he said this would close the matter completely. I fear that I told him I would report the matter to the insurance company, and await the outcome of investigation by them. What was even more interesting was that when talking to him a little later on, and I'd asked if his 'brother' was deaf, he said no, but went on to make the statement that "When a man is dying, his thoughts would be very far away, and he would not realise what was happening to him, or what he was doing." I very much wonder, as does Doreen and a friend who was with us during this conversation, if he was a victim of the AIDS pandemic here, because his behaviour on the road that night is otherwise quite unaccountable.

January 26th.

Doreen's birthday, and it was Robbie Burn's birthday yesterday. This year we held the celebrations for the Bard on Saturday, the 23rd, as we had folk come out from Kampala to join us for the event. This time we had a couple of Australian nurses who have come out here to work at St Anthony's Hospital, the mission hospital in Tororo. They have come out through an Australian Roman Catholic Church organization, and are working for very little more than a Ugandan salary. Thank goodness they say they do have some personal savings with which to augment an otherwise completely unrealistic salary, even for Ugandans, all of whom have to have more than one job, or at least a field for growing some food, otherwise they just could not survive. So this year we had English, Australian, American and German people, with myself as the only Scot. Even Joan Linnaker, though she has a broad Scottish accent, and was brought up in Scotland, is really English. Anyway it was a good evening concluding with Scottish dancing, a sport at which I managed to produce complete confusion, dancing being one of the things I not only like least, but do worse than anyone else could possibly manage; anyway, I don't think they'll ask me to do it again, thank goodness. The speeches and toasts were all very reasonable, with the imported Haggis piped in by music recorded by Ken Leighton on the pipes when he was here.

I went with a Mr. Omaswa, a cardiothoracic surgeon from Kampala, to a hospital at a place called Ngora. It is a Mission Hospital, set up many years ago, in fact it was the first mission hospital outside Kampala, having been founded by the Anglican Church. It is still semi-funded by them, but entirely staffed by Ugandans. We took a couple of British surgeons with us, a Mr. John Craven and Mr. John Church, both of whom had worked in Uganda in the 60's and had been Makerere teachers for many years. It seems they have an organization at home willing to sponsor young surgeons from Britain to come and work here for six month, or longer, stints, and are looking at rehabilitating Ngora hospital for this very purpose. It would be ideal from my point of view, as it is not far from Mbale, and would give us another good teaching unit nearby, to which we could send our Residents for some of their surgery rotations. I was quite impressed during my visit to Ngora, as it is better than any of the Catholic mission hospitals staffed by Ugandans I have seen outside Kampala, and is still one of the very few which is functioning quite reasonably as a local small hospital. So we will await developments. Mr. Omaswa, by the way, is an impressive man, a very good surgeon, who has almost nothing to work with at Mulago, the National Teaching Hospital, and what little cardiothoracic work he does, is done at Nsambya Hospital. He has recently been appointed by the government to head up the training programmes for surgery in Uganda, and is very interested in this postgraduate training programme, geared as it is towards the more remote hospitals in the country, and where the need is by far the greatest.

February 3rd.

Last week I attended the graduation ceremony of our first two students. It was much the same as any other graduation ceremony, with all the academics dressed up in fancy dress, and making speeches right and left. Museveni, President of Uganda, is also the Chancellor of the University, and was there with full security etc.. Actually he is such a common sense sort of chap, and seems so down to earth, that what he says is often really worth listening to. Nyereri, the retired President of Tanzania, was also there receiving an honorary degree. Again, he's an African leader for whom I have a lot of time, his ideas were good, but the rather sad outcome of the country he tried to govern in a very humane manner, is the product of the ubiquitous and all pervasive corruption at all levels of their society. Just the same as Kenya and Uganda. It seems a phase all developing countries have to go through, and that even with the best leaders, such as Museveni and Nyereri, it is impossible to contain or control the behaviour of the many opportunists and other corrupt officials who the leaders of a developing country have to rely on. Mind, very many of the politicians in our so called developed countries could show the people here a few pretty clever tricks in the way of corruption which they haven't yet thought of. It is not just the politicians here though, it is almost everybody who has to bend the rules just to survive and make a living, when almost nobody is paid even a half-decent living wage. Imagine, the police here get as little as 10,000/- per month when they start (about $10 Canadian.) so of course they have to take bribes etc. to get by. Anyway, back to the graduation ceremony; I had to wear a suit and tie for the occasion, and with the temperature outside at a cool 32 degrees, I was cooked to a cinder by the time it was all over. That evening I attended a party given by the two graduates, and met all the relatives, and it was well worthwhile, and quite enjoyable. Dr. Bernard Odu has now been posted to the position of District Medical Officer in Tororo, and will possibly become one of the new faculty members of the discipline when Dr. Tuunde returns. At least it is nice to have one of the lads nearby, and a good person with whom I'll be able to work in future.

By the way, our lady with the pregnancy and the huge fibroid is still in the ward, and incubating the baby very well. It will not be too long before we have to think about delivering her. In the meantime, Doreen has agreed to pay her hospital bill out of moneys donated by friends in Canada, so that is a relief, as it is a very long stay indeed, and she comes from so far away, it would be impractical to send her home, and she seems happy enough here anyway.

February 11th.

The cost-sharing has been going for the last few weeks at last, and so far so good, but it is very early days yet, and far too early to make predictions. Manfred Stormer and I put up the "seed money" for drugs, for the first month - after this the hospital pay for all drugs, X-Rays and other materials used. The patients seem quite happy with the scheme so far, and we have a clear list of the charges put up everywhere. We have a Mrs Helen Opio appointed as 'Ombudsman' or person to deal with patients' problems or complaints; she is the nurse in charge of outpatients, and one of the most reliable and hard-working nurses we have in the whole hospital. Dr. W*** the Medical Superintendent, was dead

set against her, as she's about the only person who will stand up against him, and 'tell it like it is', to use the current idiom. It will be at least a couple of months before we see where things are likely to go, or else just drift along.

I attended the first meeting to take place between members of the Ministry of Health, and the University for over eight years! It was precipitated by this training programme, and the need to try to get some sort of planning for the future, as to what kind of doctors they want to train for Uganda. All kind of good suggestions were put forward, and all kind of commitments made, even to holding regular meetings of a similar kind. I am not holding my breath, and not too sanguine as to the real outcomes of the deliberations. I'd love to be wrong, but so much hot air is talked, with so little in the way of action results from the majority of meetings here, that I feel it will be like everything else, and just go by default.

February 16th.

I got cold feet, and decided to do the section on our lady with the fibroids yesterday. She had come to almost 40 weeks as far as one could judge looking at the baby when it was delivered, though the ultrasound said about 38 weeks, by bi-parietal diameter. Anyway, it went remarkably well!! She was delivered of a healthy male infant, almost full term. The fibroid was as huge as anticipated, and took a bit of delivering out of the abdomen, even after extending the incision. In fact it had undergone very considerable red degeneration, and was full of messy fluid, bursting as it was delivered. The subsequent hysterectomy went well, and she lost very little blood, thank goodness we did not have to transfuse her. I have some photos of the event which I hope come out, and do justice to the size etc. of the fibroid. It is an enormous relief to have it all over and behind one, she's been weighing on my mind such a lot these past few days, trying to decide the optimum time to do it etc.

I spoke about this case to Dr. Miriam Duggan, an Irish Franciscan Sister, who originally trained as an obstetrician and gynecologist, but who out of sheer necessity is also a superb general surgeon, and who has been working in Nsambya Hospital for many years, and right throughout the war years and years of turmoil in Uganda. She had seen a couple of very similar cases, one of which must have had an even bigger fibroid than this lady, from her description of it. Dr. Duggan is a person whose memoirs through the most turbulent years in Uganda should be put on record sometime; there were more than one time when she was threatened with a gun, once a soldier brought a wounded officer into the hospital and threatened to shoot her if she did not treat the officer. She rather contemptuously said to him "Guns take lives, they do not save lives, put it away, of course he'll be treated.". Then there were times when marauding soldiers would come in to try to shoot enemy patients convalescing in their beds. When soldiers came in as patients carrying weapons, she took them away and buried them in the hospital grounds. Then in 1985, during the 'Okello coup', she once admitted a policeman as a patient to Nsambya when in doing his duty, and trying to stop a drunken army officer from entering the police barracks he had shot and killed the officer after he had been wounded

himself, having been shot through the chest in the process. After she had done the needful surgery, and left the policeman with a chest tube and an underwater drain in place, he was put to bed. Next morning the brother of the dead officer came to the hospital looking to kill the policeman, at which point Dr. Duggan and her cohorts put him in a very small ambulance, with his chest tube drainage and all, and sent him off to a distant mission hospital- he recovered. The unsung heroics of the Sisters during these times really does deserve to be recorded for posterity.

February 22nd.

There is now an Australian doctor also at St. Anthony's hospital, a young lad named Peter Fletcher. He has just completed his internship, and done a couple of other house jobs. He has come out under the auspices of the same group that has sent the two nurses, and like them, he's working for very little more than a Ugandan salary. The only perks they get are fares paid out, and some food allowances, with an agreement with the diocese to supplement their income slightly. They have come for a two year stint. Hopefully the cooperation between the two hospitals may improve as a result.

We went to Kisumu for the week end, leaving on Friday, primarily to get some ether for the hospital, which is almost unobtainable in Uganda these days, and as a result surgery becomes almost impossible. The absolute inertia of the hospital administration in anticipating their needs is appalling, and they always wait till they run out of things, going from crisis to crisis. This applies to drugs, dressings equipment, and even such things as surgical blades, sutures etc.. When they run out, the patient is expected to pay for the items which are then bought in dribs and drabs locally, all very expensive and stupid.

The visit to Kisumu was refreshing, and it was so nice to get away for the week end. The Kenya roads to Kisumu have been vastly improved since we came, and it is little further than going to Kampala now. The shopping in Kenya is much easier, but there is an uneasy atmosphere about the place that makes one rather thankful to get back home again. It is always rather a nostalgia trip for me to go to Kisumu, where I was born, and which has been completely transformed from the place I remember, being the third largest town in Kenya now. When I left Kisumu, the settled area consisted of no more than 100 houses, and one street of shops. It is now a fairly large town, with a very good shopping area, and most facilities one would find anywhere - all very different from what I remembered. There was always a herd of Impala which used to roam round the lakeshore, and which were a constant plague to my mother when she tried to grow flowers etc. in the garden - they are now contained in a fenced off area, and have to be culled to keep the population within bounds. The hippos which were so numerous have all but gone. There are still a few left, which people come to view every evening when they come close to shore as darkness falls. They have a truly wretched mini-zoo down near the lakeshore, with a couple of leopards, baboons and a few other animals all piteously confined in tiny cages.

March 1st.

Our hospital ambulance was arrested the other day for trying to smuggle flour from Kenya to Uganda. There has been a freeze on hiring new employees for the hospital, however the medical superintendent evidently hired this new driver. He was accompanied by a policeman, and as they approached the road block set up by the Revenue Authority, they put on the blue emergency light, and pretended they were transporting a patient to Kampala (an almost unheard of event as far as this ambulance is concerned) thereby attempting to get through the roadblock. However the Revenue people insisted on looking into the back, upon which the driver took off and has not been seen since. The Medical Superintendent who hired the man, in the meantime, swears he knows nothing about the incident. Anyway, the ambulance is now impounded in Kampala, and they are trying to get it back. I hope it is kept for a long time, as it is nothing but a drain on the resources of the hospital to keep it running, and few patients ever get the chance to use it. It has done a greater mileage than my car, in spite of being a year younger, and I do a lot of long distance driving when going to Kampala for the teaching seminars etc.. It is certainly a 'going concern', and can be seen carrying all kinds of people at all times, going whither I know not.

March 9th.

This week I did surgery for a hare lip on a young Karamajong boy. He was pointed out to me when playing golf by the caddie who usually accompanies me, and who asked if anything could be done. It seems that he's been 'loaned' to a local family by his parents to herd cattle, which he does on the golf course. It is one of the hazards of the game in Tororo, that and the mischievous monkeys who steal the balls if they land too close to them! Anyway, Doreen has accepted the responsibility for paying his fees, courtesy of some people in Port aux Basques who sent money for charitable use. We send them photos of the kids we help, and Doreen writes an account of the money and how it is spent. A small but very worthwhile use of some of the money we have sent to us by people wanting to help in some way. Unlike UNICEF and a few other organizations working here, there are no overheads, and I do think that the best way to spend money in Uganda and other poorer countries is to send directly to someone working in the field. UNICEF workers certainly seem to live very 'high off the hog' from all observations that Doreen and I have made, and very few seem to work far from the Capital or the other major centres, certainly this seems to be the case in Uganda anyway.

The other case worth mentioning is of Karposi sarcoma of the penis. We are seeing a number of these of late, and always it seems to be a rapid growth, and requires amputation of that 'noble organ', which at least limits the spread of the pandemic by that particular male. Once they have got this sort of lesion, their subsequent lifespan is not too long, and surgery is only palliative anyway, but does give some degree of comfort to an otherwise extremely distressing and uncomfortable condition for the patient concerned.

March 23rd.

What a weekend! I have been seeing one of the Franciscan Sisters, Anne Schotelcotte, working at a place called Achumet on the border of Ateso and Karamoja areas. It is very isolated indeed, and a hard mission to be working in at the best of times. I first saw her some months ago with an attack of malaria, from which she recovered. Then I saw her a few weeks ago, when her prime complaints were of occasional rigors, and feeling cold, then arthralgia, extreme tiredness, and general malaise, with nothing very specific on examination, beyond some suprapubic tenderness. There was no malaria at this time, a normal blood smear, but a very obvious high sed rate. I sent her in to Nsambya hospital for a few more definitive diagnostic tests- We were out of X-Ray film at the time! Anyway, the X-Ray there was reported as ? miliary T.B. or Sarcoid. There were some punched-out lesions in the pelvis visible, and she'd developed an area for all the world like erythema nodosum over the elbow. All in all, after talking it over with a Dr. Prenderville, another Franciscan Sister who had done the rest of the investigations, we opted for sarcoid as a working diagnosis, and suggested that she go home to the States (she's an American) or to Ireland for investigations. However she was due to leave anyway to go on vacation by way of Zaire and Holland, and wanted to wait it out, promising in the meantime to rest. Doreen had been alone as I was in Kampala on a teaching session, when on Friday last Anne presented in an almost moribund state, having been complaining mostly of severe headache and vomiting quite badly for a day or so in Achumet. Luckily Dr. Geraldine Prenderville who had seen her in Kampala came out here to visit us in Tororo, accompanying me on the way back from Kampala. On examination this time, she had a low grade temperature, and a slightly stiff neck, but a lumbar puncture did show a few white cells, but we still thought the best diagnosis was sarcoid, but now both insisted, reinforced by Doreen who had been nursing her, that she fly home as soon as possible. She was treated with steroids immediately, and by the next day had responded quite well. Anyway we took her into Kampala today, and she is due to fly out the day after tomorrow, though she does seem a lot better already. It was very difficult to turn the other house into a 'hospital'; it was built for the second Canadian doctor, but is now used as a guest house, and is quite frequently occupied. But that is where Doreen 'admitted her' before we got home on Friday, and did a tremendous nursing job while waiting for us to get back, and for the next couple of days. It was certainly better than admitting her to either of the hospitals in Tororo. Life is certainly never dull in Tororo!!

March 27th.

Our son George is due to arrive in Uganda for a couple of weeks visit tomorrow, so we are in Kampala and go to meet him tomorrow morning. Both Doreen and I are looking forward to the visit tremendously, and I have taken a couple of weeks out to be able to show him some of the countryside. An account will follow I'm sure.

In the meantime, a funny case we had the other day: a child of about five years old was admitted with an extraordinary lesion of the penis. I was convinced that someone had tied a tight string round the organ, as it was grossly swollen, with a livid looking rather blue, black ring round the mid shaft, and a lot of swelling distal to the ring. In fact it looked gangrenous. It obviously required surgery, and a sort of macro circumcision proved to be the best solution. I finally found out what it was that had happened to cause the problem in the first place. Earlier in the diary I am sure I have recorded the circumcision practices of the Gishu people. They have adult circumcision of young males, and a week before there are all sorts of initiation ceremonies, with a grand finale on the day of the circumcision, which is a very public event, and they all march along with drums going and much dancing etc. on the way. If the young man flinches while the deed is being carried out, he's considered less than a man. Most do not bat an eyelid, but they all seem pretty high by the time they get to the spot where it is done, and probably do not feel a lot of pain. It is a wild ceremony to watch. Anyway some children were playing at being Bagishu, when this poor youngster, though not a Bagishu, was the 'victim' and the other kids tried to circumcise him, Bagishu fashion, resulting in the extraordinary lesion we had to deal with!

Another odd case was a child with an imperforate anus, the first one I've seen here in Uganda. Again they could not afford to go to Kampala, so yours truly had to read the books a few days before, and do the necessary surgery, which did seem quite successful, in that the kid survived, and went home passing stool, though there will not be much in the way of sphincter control because as far as I could tell there just wasn't one to be found. I'll be seeing her again in six months to review.

April 2nd.

For the past few days have been visiting the Western part of Uganda with George. It is great to see the country through really fresh eyes, in that George has had no experience of Africa, or any other developing country, before this, and his reactions are general amazement, with difficulty in understanding how the people can manage to live under the circumstances and conditions prevailing. I know that to this day, I find that I still have my feelings lacerated almost every day by the inability to do something about so many of the problems people present with, the children particularly, and the general misery and suffering that so many have to tolerate. The seeming great insensitivity of most Ugandans to many of their own people is due more to their own poverty, their inability to help resulting from this, and the fact that they just have to accept what most of them must feel completely powerless to do anything about.

Anyway, enough of the more sad side of the country. When George arrived, we whisked him off to Kitovu hospital, where Doreen and I spent the first Christmas we were in Uganda, and he had a relatively good sleep, recovering from an overnight flight from Britain. Joan Linnaker accompanied us on the trip, because in spite of the fact that she's spent over 28 years in Uganda, she's never seen the Western part of the country, so it was a good opportunity to take her along to enjoy the trip. Next day we went to

Mweya national Park, where we spent a couple of very pleasant days seeing the wildlife of the place. The Queen Elizabeth National Park (not yet renamed!) at one time had the highest 'biomass' - an odd term they use of animals in the whole of Africa, mind, most of the biomass came from hippos and elephants, which were very plentiful. The hippos still are, and the elephants are coming back again in fairly large numbers. The park is still one well worth seeing from many points of view. The scenery is spectacular, as it looks over the junction between lakes George and Edward, with the Rowenzori mountains in the background. The first day we went on the boat trip, both boats having been completely renovated now. The bird life is fantastic, so also are the hippos and water buffaloes which abound, and which can be approached almost as close as one can touch. Some of the hippos have scars from where the boats have run over them in the water! Next day we went looking primarily for elephant, but it being the wet season, they were very elusive; however there was plenty of other game to be seen. That night, Doreen came to the door of our bedroom quite late and woke George and I up (she and Joan were sharing a room, and George and I another) to tell us that there was a hippo outside the window! We went out to have a look, and there, just beside our veranda, going along like a mowing machine, eating the plants as it went, was a large hippo, close enough to touch. George got a couple of good flashlight photos of it, which I am sure will come out well. We spent the next day still looking for elephant, before going on to Mbarara that afternoon. We were finally rewarded by finding a very tame young elephant in a fishing village, which was obviously adopted by the people there, and quite at home amongst them. The little creature came and even put its trunk into the car window to be fed! We had already had another close encounter with a baboon that climbed onto the bonnet of the car, again looking for tourist food.

A word about the fishing village is in order, as this was once a thriving industry , providing most of the fish for Kampala at one time, with a freezing and processing plant, much like those at home. They even had an airfield from which they then used to fly the fish out. However, like so much else in this country, it is in a state of complete disrepair, and falling apart, most of the roofing having been pillaged to make houses for the nearby villagers.

We went on that night to Mbarara, where we spent the night in the University guest house, which was nice, except for some fleas in the bedding which I encountered, thankfully nobody else seemed to suffer. Then we spent a few hours in a small game park on the way back to Kampala the next day. Again the wet season made the game rather difficult to see, but George had an amusing time when I managed to slide off the road, and get well and truly stuck for a while in a deep ditch. However, after getting messy, and putting the car in four wheel drive we managed to get free eventually, and got back to Kampala where we spent a couple of days 'seeing the sights' of the 'big city'. This consisted of visiting the Kasubi tombs, the seat of the Kabakas of Uganda, visiting the various cathedrals, and also the magnificent Bah'ai Temple which has been recently rehabilitated and renovated throughout. We got home today, and tomorrow I'll have to spend some time at the hospital, as we have a meeting of the Board of management.

April 14th.

The meeting on cost-sharing was rather stormy to say the least. One of the issues brought up by the Medical Superintendent, Dr. W***, was that one of my students did an abortion on a nurse. He states that the doctor perforated the uterus, so that the nurse required a hysterectomy in the end. Abortion is still illegal in Uganda, but it is all rather circumstantial evidence that was put forward, as there was no real enquiry into the event. The nurse herself was not questioned, neither was the doctor, just Dr. W***'s statement, though there is no doubt that the nurse did have a hysterectomy, but it was done four days after the evacuation, the reasons for which were not established. Dr. W*** does rather tend to shoot from the hip, and form conclusions on a minimum of evidence, though if his facts are correct, the student concerned will have to leave the programme. Then there was the case of one of our anaesthetists who has been caught charging patients 'under the table', which has been banned since the cost-sharing scheme began. He has been suspended pending an investigation by the disciplinary committee of the hospital. It will be interesting to see what they do.

Then we went to a small mission at a place called Usuk with George, so that he could see the other Uganda. This mission is in Atesot country, run by some venerable Sisters, again of the Franciscan Order, they are rather ubiquitous here, having been the first to found medical missions under a marvelous nun called Mother Kevin from Ireland; they have left a legacy up and down the country, and went into the hardest and most difficult places to work, in the very early days of British rule. Sister Barbara is a nurse who specialized in midwifery, and has taught countless generations of Ugandan midwives now. Then as a sort of grand finale, off she goes to Usuk, to start up another primary care health centre. Anyway, George did enjoy the trip, because it is so different to the West of the country. Here the countryside is rather arid, and the crops and vegetation rather poor, the people likewise. He saw his first baby delivered while we were touring the health centre, with Sister Barbara officiating very nicely; one's first witnessing of human birth is always a rather awe-inspiring event, and I'm glad he has had the opportunity. The wards at Usuk are mud huts, clean, but nevertheless mud huts. and the patients sleep on papyrus mats which they bring with them. It must have been the way most medical missions began in Uganda. I have seen photos of Mother Kevin's first hospital, and that was a mud and brick building, made almost entirely out of local materials, and from these early beginnings sprang up the Nsambya Hospital of today. In those days the nuns concerned came out committed to stay in Africa the rest of their lives, and wore the most dreadfully hot-looking habits, reaching right down to their ankle. Nsambya is still the most reputable hospital in the whole of Uganda, even though the standards are beginning to slip badly, now that the Sisters presence is fast diminishing, and in a couple of years will be gone altogether. What they will do as far as financing the operation of the hospital when overseas funding dries up will be interesting to contemplate, but I fear it will go the way of most of the other mission hospitals when they become 'Africanised', and will become the most expensive and exclusive form of health care in the country, serving the most wealthy, with standards dropping to the same level as the others. The poorest people, who were those for whom the hospital was built, and who were those for whom the service was originally intended, will be completely left out.

On the way up to Usuk, we saw a truck full of cotton, that did not make a corner just before a bridge, and was upside down in a swamp, with cotton bales everywhere. On the way back, the truck was there still with the all local 'vultures' round it, pillaging anything removable! The tyres were gone, likewise the wheels, and they were working on stripping the engine apart when we saw them. Most of the cotton had disappeared also. Usually when a truck overturns or gets stuck, the owners very quickly hire an armed guard to watch over the remains. In this case the owners must have been some distance away, and not able to take appropriate action in time.

The last Uganda trip we made with George was to a place called Ssipi Falls. It is one of the real local beauty spots, only about 60 kms from Tororo, and situated in Bagisu country. It has a most incredible road leading up to it with tremendous gradients all the way, and very twisty all the way up, and at each corner one turns there is a new and magnificent panorama opens up. The falls itself is a rather beautiful sight, some 120 feet or so, with spray at the bottom wafted this way and that by the winds, and a lovely walk down to the foot of them. No fish in the little river though!

Very briefly we took George across the border into Kenya, again primarily so that he could see the place, and see where his grandfather worked for so many years. We went via the Nandi escarpment route, which is so beautiful, and on to Kericho the first night. Then the next day came down to Kisumu where we spent a day and a half before coming home again. The Nandi escarpment when I last saw it, over 45 years ago now, was a dirt road, with an impossible gradient. I spent my very last holiday at a tea estate at the top of the Nandi Hills, which had been carved out of the hillsides and planted by a couple named Judy and Dick Pearce. In those days there was a wonderful rain forest, with a valley running through that was full of collabus monkeys, and the most wonderful bird life. It is all gone, largely replaced by sugar cane plantations. Interestingly enough, the Pearce's house I stayed in, and which they built themselves, is still there, though the tea estate is so much bigger now, and all the forest is completely gone, and with it, the wild life. When I went with the Pearce's on that particular holiday, it was the rainy season, and the road was very slippery. Dick drove an ancient Chevrolet car, which was having a terrible time getting up the hill, even with chains on the wheels, so Dick turned it round, and drove the car backwards all the way up the hill, the remaining 15 miles or so to their home- I have never seen that done before or since, but he told me that it was the only way to get up the escarpment sometimes.

George is due home in a couple of days; the time seems to have flown by, and I have a teaching session in Kampala the day before he flies, however he does leave at a respectable time, about 11.30 in the morning, by Sabena airlines. Sabena have been one of the very few consistent airlines to fly in and out of Kampala, even during all the troubles. British Airways have now begun flights again, after having stopped them about 8 years ago.

April 23rd.

George left on the 17th, and I was in to a meeting of the Faculty Board at Makerere next day. At this meeting they were again discussing the need for a Bachelor of Nursing Science degree to be started at Makerere Nursing School, under the auspices of Case Western Reserve University in the States, and for which they are looking for the imprimatur of the Medical School. I think I have already commented on it, but of all the mad schemes, I think this is about the maddest in the Uganda medical or health care setting; to think of starting a degree nursing course, when even the National Teaching Hospital nurses do not chart even the most basic of clinical data, and where they will not take a temperature 'because the thermometers are broken' or where there are no blood pressure readings 'because there are no B.P. machines'. Even the pulse rate is not recorded, I guess that's because they cannot count or something, though they never give one a reason when asked why they do not even record that. It looks very much as though they are going to go ahead and start the course!

April 28th.

"Alice in Wonderland" has nothing on Uganda at times! Dr. W***, the Medical Superintendent has now accused one of the anaesthetist of doing an abortion. He was snooping round the hospital fairly late one evening, in itself an unusual happening, as he's never here in the afternoons as a rule, vanishing to his office at about 10.30 am. and staying there the rest of the day. However on this occasion he found a lass waiting outside the operating theatre who had been sent by Dr. Wabomba to have an evacuation, as she'd been bleeding a couple of days, and thought she'd had a miscarriage. However W*** took it into his head that she'd had an abortion, and under duress he took her to his office where he did a vaginal examination, and 'found blood', to quote him. His immediate assumption was that the poor anaesthetist had done an abortion - mind Dr. W*** has his knife into this particular chap, and seems determined to get him fired. He accosted the doctor concerned next day, who listened to the accusation, and got really mad with W***, accusing him of chasing the patient away, and slammed the door. W*** in the meantime has laboriously written out his accusation, and is going to take it to the next Board meeting of the Hospital Management Committee. I spoke to Dr. Wabomba, and his explanation is entirely logical. Not only that, but I have spoken to the nurse who was accused of having an abortion when one of my students was alleged to have perforated the uterus. Again it seems to have been an entirely reasonable action that the student took, in that the nurse had also been bleeding, and passed products of conception. She was fine after the original procedure, till about four days later she complained of pain, and saw the doctor who did a subtotal hysterectomy on her, and found indeed that there was a small perforation of the uterus. I must say that in the circumstances described, I think I would have been a lot more conservative in the management and not done a hysterectomy, however, that is a matter of judgement. The student concerned meantime, had quite legitimately gone to the district to complete his research project, and had not 'run away', as Dr. W*** claimed. The nurse told me she had tried to find the student concerned as she had confidence in him, before she consulted the other doctor who eventually did do the hysterectomy.

W***'s latest action seems almost unbelievable: it concerns Dr. O******, one of the doctors we had posted here recently, and who has indeed been on the mat before the Uganda Medical Council for many actions, including causing a patient's death following an abortion. He is also an out and out alcoholic, which is well known to the Ministry of Health. The operating room staff have complained a number of times about his techniques, many of which they say are highly questionable. On this occasion he was called to do a cesarean section one night, but was found to be more than a little intoxicated. On the third attempt to get him to come, he did indeed arrive at the hospital where he went ahead with the section, and he managed to get the baby out, whereupon, with the woman still anaesthetized on the table, he said he was going outside for air, and just didn't return! The poor anaesthetist then had to try to sew up the uterus and abdomen, a thing he'd never done before - needless to say the poor woman died next day. W***'s response to this was to put him into the children’s ward, and tell him he was not to operate any more! Imagine putting him into the ward with the most defenseless of all patients, and where there is more acute illness than in any other ward, rather than telling him to get out of the place altogether. W*** and I do not see eye to eye, and he's certainly undermined the morale of the hospital more than any other individual in the place. With him in charge, this will never ever be even the most substandard teaching hospital, and I feel terribly sorry for Dr. Tuunde if he is going to have to work with him when I'm gone.

May 4th.

Being my birthday, I spent the evening filling out my old age pension forms! I'll have to apply for same when I get home - ah, time marches on.

Meantime, Mrs Opio's husband has finally died of AIDS. She is the nurse in charge of outpatients, and one of the really bright lights of the place. I fear for her, even though she tells me she's 'had nothing to do with her husband' for the past couple of years 'because of his drinking and behaviour with other women', to quote her. Mr Opio had a vicious Karposi sarcoma of the face and tongue, and went to the local Medical 'Mecca', which is the Italian hospital at Lira, where they do have a still-functioning cancer treatment centre. I am constantly surprised at the attempts of people, even in the face of the most inevitable diagnosis, to spent so much money in cases where there is absolutely no hope of cure, or even of palliation in so many cases. It is the same at home, the search for 'cures' of the incurable, with families willing to go into all kinds of debt as a result, but here in Uganda, with all the poverty, and where debt is such a terrible burden to them, this kind of action seems much worse somehow.

On the lighter side, One of the Sisters from Karamoja was regaling me with the story of Sister Margie Conroy, originally from Newfoundland, but who lived most of her younger years in Montreal (Her mother was Jim McGrath's sister, he was onetime Minister of Health in Newfoundland). Anyway, Margie is now in charge of a mission school in Kangole, far up in the Karamoja area, and it seems that some time ago, the

school had negotiated through all the usual channels, for a piece of land for the girls at the school to grow food on. Well, it seems that some of the local men wanted the land back again, and in fact had got a few of their women to plant some sort of food on it. There being an unwritten rule in Uganda, that you do not plant where others have already done so, and you never steal what someone else has already planted, the girls in the school very carefully planted their seed some distance away. However some of the elders accused the schoolgirls of usurping the land, and they sent their women round to the school to beat up poor Margie - note, the men did not come, but sent the women. There was a commotion at the school gates, and the women were there with sticks and stones ready to do what they'd been sent to do. However one of the younger sisters got the car going, and steamed right through the crowd scattering them as she went to get the District Administrator and the police, who eventually found out what the problem was, and managed to restore things to more or less normal. It seems that the basic accusation was that Margie had allowed the school girls to plant their crop on what they considered to be their land, and they had been told by the local Witch Doctors, that this was the reason that the rains had failed to come, and that unless they sought redress and punished the offender (Sister Margie) the rains would continue to stay away! I am told that the rains came very shortly after this episode, and that tempers have now cooled off somewhat.

May 9th.

Never a dull moment these days. In Canada, it is the start of winter when the kids come in with broken bones and injuries caused by falling on the ice. In Uganda it is the ripening of the mangoes; the kids fall out of mango trees, doing themselves considerable harm at times. On this occasion, I was called to the hospital at about 11.45 pm on Sunday night. At about 4 pm a child belonging to one of the hospital staff members had fallen out of a tree, and had been admitted with an acute abdomen. A blood transfusion was thought to be necessary, so they sent for the lab technician, but he refused to come, saying he was busy in his shop downtown, so they sent the kid to St. Anthony's hospital the mission hospital nearby, where they found that there was no surgeon available - he'd gone to his village. So back the kid came, with a note from the Australian nurse at St. Anthony's saying that some blood could be obtained from them, but that they could do little more. The poor kid was taken back to our hospital, and the doctor just sat and waited, for what I do not know, except that he said he "thought that she was too anaemic to undergo surgery". Eventually they decided to call me to see the kid, and when I went there, the kid had a fairly good blood pressure, though she'd obviously lost a lot of blood, and had fairly obviously ruptured her spleen, judging by the bruising of her abdomen, so I tried to get the theatre ready. There was one very sleepy nurse on duty, and Dr. Wabomba, who'd been dealing with the kid up to this point eventually called the anaesthetist , and we finally managed to get things ready for surgery, by this time it was almost 1 a.m.. The surgery went well, and we gave her some of her own blood which we retrieved from the abdomen, but to crown it all, when we'd finished the sleepy nurse came in with some blood that had evidently already been cross matched by the technician some time before, but he had just had omitted to tell anyone he'd done it! We are a well organized group in this hospital I can tell you!

Last Friday, I was called in to see a child who had been injured in a hand grenade attack on a home. It seems someone had a grudge against the family, and had lobbed a hand grenade into the house where the family had been sleeping. An adult and a baby were killed outright, and this child had a wound in the right side of her chest which was sucking as she breathed, and she'd pretty obviously got a collapsed lung as a result. She's at present in the ward with an underwater drain in situ, but has some shrapnel wounds in her arm and a few other places also. A few weeks ago, a couple of Professors at Makerere were killed in a similar attack on a restaurant where they were eating. It seems that they were not the actual targets, but it was another person eating in the same place who was unhurt in the attack. These indiscriminate grenade attacks are not uncommon these days.

Another rather nasty development is that in Nakasera market, the main market place in Kampala, Msungus (white People) are being jabbed with hypodermic needles. It seems a sort of obscure form of attempted revenge for the AIDS epidemic, which they are trying to blame white people for these days. Whether the needles are from people infected with AIDS or not is not really known, but with the mentality at large, I rather fancy that is the case, and am not going to be found near crowds, or near Nakasera in future.

May 14th.

Doreen left for home a couple of days ago. She goes home earlier to liaise with the school children before the schools break up for the summer. Some schools have been helping by donating money collected to send drugs etc. to the project. We spent the last night she was here at the Lake Victoria Hotel in Entebbe, as there have been a lot of hold ups of cars carrying people to the early morning British Airways flight. One has to be at the airport at about 6.30 am, and on one occasion a group of Germans on their way home for the last time were carrying a whole lot of equipment which was stolen at gunpoint. There have been a couple of other cases, so rather than risk things, we stayed at Entebbe for the night. The flight left on time, and when I got home it was to a very empty and lonely house. I guess I'll survive the last few weeks till I go at the end of June. As we used to say approaching demobilization from the army, "Only 42 days, and an early breakfast left to go."

Our Permanent Secretary for Health, Dr. M*****, who Ken Leighton used to call 'the Gorilla' has been featured in the "Uganda Confidential" recently. This is a paper put out, which is well researched evidently, and which gives details of all sorts of misbehaviour by prominent people, with details of their doings, or rather more of their wrongdoing. It is one of the most uninhibited newspapers I've ever read, not unlike "Private Eye" published in the U.K. M***** is an incredible chap, though a doctor, he's one of the fattest male Ugandans I have ever seen, and on reading the article in the Confidential, he certainly fits in with "Ross's First Law of Uganda", which states that 'the

integrity or honesty of the average politician or policeman in Uganda is inversely proportional to the length of his belt'.

May 20th.

Joan Linnaker and I went to the 'Last Rites' for Mrs Opio's husband last Saturday. There will be a final one to take place a year after his death, when he'll be allowed to be forgotten, and all he possessed finally divided up by mutual agreement amongst the family remaining. The final one is usually rather a festive sort of affair, with the family providing food and drink for those attending. Mrs Opio, since her return from Lira had a bad attack of pleurisy with a basal pneumonia. She attributes it to the vigil where she spent the night sleeping outside, as required by custom, before her husband's burial. I only hope that is indeed the case, because it would be a tragedy for the hospital if anything happened to her, and she becomes another victim of 'the disease'.

The most incredible case this week. an elderly lady of 68, elderly by Ugandan standards that is, presented with a history of very sudden onset of severe pain in the left upper abdomen, three days before admission, with vomiting persistently ever since. When I examined her I found a very hard tender mass in the left upper quadrant of the abdomen, to the left of the rectus muscle, extending rather obliquely down from just under the ribs to just above the pelvis. On palpation there was definite crepitus to be felt, which was felt by myself and the doctor who referred her in. I was sure it was some form of bizarre hernia, and on ultrasound saw what looked like splenic tissue, I made sure that there was no bowel in the mass, and disbelieved that what I saw was the spleen, thinking that it had to be a large piece of omentum I was seeing. It being now just after 5 pm. I decided to leave it for the present, but book her for surgery the next day. Well, next day, the mass was still very tender, but the crepitus had gone now. So at surgery I was horrified to find that indeed it was spleen sticking through the abdominal muscles, and that half of it was rather black and gangrenous. It sort of fell apart as I tried to dissect down to where it had herniated through the abdomen, but began to bleed badly at this point, so very hurriedly, I just cut through the muscles, including the rectus, with a wide subcostal incision (thank goodness that was the way I'd begun to do the dissection.) and did a very rapid splenectomy, hampered a bit by the fact that it was very large, and adherent to the diaphragm. It actually weighed two and a half kilograms- I think I do have photos of it for posterity, that is if the anaesthetist has managed to work the camera right!

May 29th.

I had booked a lady for vaginal hysterectomy and repair last operating day, and she did not turn up. This was the first one of these cases not to come for surgery, but as I left the hospital that day, her husband came up to me and said that they could not raise the money required, and could she be done another day when they had it. The cost-sharing scheme, like all payment for medical services certainly hits the poorest of the

poor hardest of all. I have told them to come, and that somehow we'll find the money - another case for Doreen's charity box.

Medically no day is ever like another. As I was going home for lunch the other day, one of the nurses asked me to see a lady who was bleeding badly, when I asked what kind of bleeding, she said "from her mouth!". This was a lass who had seen one of the traditional healers, and had a uvulectomy done. Dr. Bernard Odu's thesis was on just this topic. He had interviewed many of the Healers who extracted 'False Teeth', and did uvulectomies. They use a piece of hollow bamboo, and through it they thread a piece of string or sisal, with which they snare the uvula, and then pull on it thereby cutting through the uvula. On this occasion the Healer had taken a goodly piece of the soft palate along with it, and it was certainly bleeding. I only have six vials of succinyl choline left, and this was one of the cases for which it was needed. When it is necessary to give muscle relaxants, I give the stuff myself, and do the intubation, because though the anaesthetic assistants are fairly good at intubation, they tend not to see the urgency of it in the presence of a paralysed or bleeding patient, and just take their time. Most of the cases we intubate during surgery are well prepared, and well under with ether beforehand. All was well however, and she's now got a sore throat only. The uvulectomy is done for a persistent cough, though very few of them bleed like this, and I've never before seen one that would not stop, as in the case of this lady who'd been bleeding for about 18 hours before she came in. Often their chronic cough is due to T.B., this being sometimes the very first manifestation of clinically obvious AIDS.

I was stopped by a lady who flagged down the car just outside the magistrates court the other day, and asked if I wished to buy some gold! Evidently there is gold mine exploration going on near Busia, not far from Tororo, and it does seem there is gold in quantities sufficient to open up a commercial mine there. I guess that thieving of the gold has already begun, if one is being accosted to buy the stuff. I'm afraid I didn't even ask the price of it.

June 7th.

Last week I went to see the local prison. I had tried to get there on a number of occasions before this, primarily because in the past we have had some rather serious problems, mostly diarrhoea, with patients who had been admitted to hospital from there. The senior prison officer had promised to take me to see it on a number of occasions, to see what we could do to help out with the sanitation and the clinic they run in the prison etc., but he never seemed to get round to it. However we have recently had a young medical officer, Dr. Obonyo, appointed to the hospital, who is also going to act as part time medical advisor to the prison, and also do some work in their prison clinic. Dr. Obonyo is also actually living in quarters owned by the prison authorities as part of the overall deal he's made with them. It is a prison established by the British, mostly for civil offences, and with a view to some form of real rehabilitation of offenders, in that it is situated in a very large farm complex on which the prisoners work. I have often seen them going to and fro, working at jobs in the Tororo community. Most of them seemed to

be very poorly clad, often riding in an open unsprung metal trailer towed by a tractor; the guards seemed to be very few in number, and rarely armed with guns, unlike the local police, many of whom seem to have automatic weapons of some kind. On court days, one can see the prisoners being walked off to the jail after sentencing, often roped together, with armed guards escorting them.

Anyway the prison itself, compared with so many things in Uganda, is not at all bad, all things considered. The farm area is extensive, and at one time it was wholly self-sufficient, and provided a good deal of food both for the prisoners themselves, and the guards, but also a good deal for sale on the open market. There is minimal security, with little more than a chain link fence, and some barbed wire to prevent escape. The majority of the guards are unarmed, and were helpful. The housing of the prisoners is in large dormitory type buildings, and there is a clinic provided, but with pitifully little in the way of either drugs or equipment. In the past we have had many of the prisoners come in to hospital with AIDS, or AIDS related diseases and the majority of diarrhoeas we treated turned out in the long run to be AIDS related. All in all I was quite pleasantly surprised at the conditions, expecting a lot worse from the state of some of the inmates we have had to deal with. It is not unusual for the prisoners admitted to hospital to be chained to the beds, and to have guards present most of the time of their hospital stay - regulations I guess. However, many prisoners who are admitted do not have anything in the way of personal possessions, even blankets for their beds, and the prison clothing worn has nearly always seen better days, much of it being in rags and tatters. I will expand on some of the much more difficult problems we have encountered in the past, later on.

Recently, at one of the cost-sharing meetings with the Hospital Board of management, I had a real run in with Dr. W***, the Medical Superintendent of the hospital. He had brought up the cases of the student accused of doing an abortion, and the anaesthetist he accused of doing the same thing. I just could not let him get away with what he was presenting as 'facts' to the Board. His investigations had been minimal, all based on either prejudice, or surmise, and on no occasion did he ever interview the people or patients concerned, except the girl he forced to have a vaginal examination done under clear duress. It has resulted in a lot of bad feeling; the majority of Board members who would like to support Ugandan doctors, specially those in charge, and yet they do not wish to alienate me. Dr. W*** himself is furious at being challenged in front of the Board, being completely autocratic in all his dealings with those under him, and rarely listening, and never taking any advice from them, he feels he's in great danger of 'loosing face', which is something more hurtful to his pride than anything that could happen. I'm sure he could see me far enough, and will be delighted when I go on holiday this month!

More medical 'fascinatingomas' (a neologism): I had done a sigmoidectomy on a man for sigmoid volvulus three years ago, and he presented the other day with a grossly distended abdomen, which he said had been increasing in size over the past three months, with gurgling and general discomfort. He'd had reasonably normal bowel movements, he said, and no vomiting, but on examination, his abdomen was indeed most spectacularly distended and tympanitic. I figured that perhaps the anastomosis from the previous

surgery was constricting, giving the picture of a very subacute obstruction, and therefore decided on a laparotomy in order to be sure. Oh, for the possibility of being able to do a reasonable barium enema, or colonoscopy, which would have given the answer right away; mind, a sigmoidoscopy did indicate that there was no stricture of the anastomosis, but I then concluded that perhaps an adhesion higher up was the cause of his distension & other symptoms. At surgery absolutely no obstruction whatsoever could be found, the previous anastomosis was fine, and there was just a most enormously dilated transverse and descending colon, very like the dilated sigmoids one sees in the plantain eaters of Uganda. I postulate that the same mechanism which causes the dilatation of the sigmoid does the same to the rest of the colon, given time, after the sigmoid has been removed. All the articles seem to blame tryptophan from matoke, or other plantain foods such as bananas as being the cause of sigmoid volvulus, and I figure with the sigmoid gone, the next segment of bowel taking over its function undergoes the same changes. There can not be many people who have seen the results of their handiwork three or four years after the event, as most surgeons here tend to have been transiently located in the smaller hospitals, or in the larger teaching or referral hospitals where, though they would tend to have been more permanent, may not have had the chance to see the same patients on their return. Anyway, it is something to think about, and I am going to suggest that one of my better students undertake some research on this after I have left, as I do not have sufficient time here left to do it myself. It is a syndrome I would like to call ‘post sigmoidectomy megacolon’ due to high plantain diet.

Last night I had my very first ever operative death on the table. It was a man who had been admitted to St. Anthony’s hospital, but their surgeon had "gone to the village"- a phrase use here for not being available, sometimes they have gone to the village from whence they came, often staying there for three or four days, without telling anyone they are going. However, he was admitted to our hospital with a diagnosis of a ruptured spleen, subsequently established as having been due to "a row over a woman", when he got beaten up by his rival the evening before admission. Why he waited over 12 hours before coming into hospital I do not know, but delay is often caused by their need to consult the local healers, who give herbs, or do their scarification to remove bad spirits, as the standard forms of treatment; in some cases they will consult the witch doctor in order to find out who is to blame for the illness, accident or injury. This particular man was very powerfully developed and a very strong looking young man, but was deathly pale by African standards. One looks mostly at the mucous membranes, but when they bleed badly, some can look a sort of ashen colour. By the time I had been called they had two units of blood ready and cross-matched, and had already started to give one of them before surgery was begun; his blood pressure was recorded as 60/30. As there was no hope of obtaining more blood, I decided to go ahead, and the surgery itself was pure nightmare. It was a large African spleen, torn completely in half, and adherent to everything, the diaphragm above, the pancreas and much of the omentum, thus proving very difficult to mobilize. When I finally got it free, and could ligate the pedicle, much of the splenic capsule remained adherent to the lateral abdominal wall. When the abdomen was entered, blood gushed out, and I estimate about a litre went on the floor, then from the abdominal cavity we got 2 litres of blood in the suction bottle, but we could not keep it for autotransfusion, as there was no anticoagulant available in the hospital!

There was still a lot of blood in the abdominal cavity as I began closure of the abdomen, but just as I began to do this, I noticed that the anaesthetic assistant was assisting the patient's breathing. I had asked him to stop the anaesthetic just before commencing closure, at which time I had asked him if the patient could not breathe for himself, which he had been doing fairly well up to this point. I was told "the patient was gasping", so asked if he could give me the pulse rate or blood pressure, as I continued closure, there was another doctor watching the procedure, and he tried to hear a heart beat, without success! How long he'd been dead up to this point I do not know. After the surgery, one of my students, Dr. Mutenyo, who was assisting me, asked if he could show the damaged spleen to the relatives. When I asked him why, he said "So that they could see how bad things were, and would not attach any blame for the death." - one way of handling the bad news he had to give them. I still feel terrible about it, but considering the limitations imposed on one when working under present conditions pertaining in all the government operated hospitals, and also the majority of Mission Hospitals without expatriate support, it leaves one with very few choices of action in the long run I fear, and one is always working with a calculated risk factor. On the positive side, the average Ugandan is an extremely hardy individual, and they do make the best surgical patients imaginable from the surgeon's point of view, the majority of them being real true survivors by the time they are adults.

A rather sad case today of an old lady. When I asked her age it was given as sixty, but pretty clearly she was a great deal older, physically if not chronologically. Anyway, she presented with an eroded area on the hard palate which was obviously neoplastic, and quite inoperable as it involved the whole of the hard palate. It is not an uncommon lesion, specially in women, who if they smoke, and many do, tend to smoke with the lighted end of the cigarette in their mouths - I am never sure why they do this, though the local peoples' explanation is that the cigarette lasts longer that way. It is equally strange that I have never seen men smoking cigarettes in this very locally carcinogenic-inducing manner.

June 23rd.

Am in Entebbe, and will be flying to Finland tomorrow to spend a few days with the Salins, the Finnish couple who were working at Kiyeyi about 40 kms from Tororo for the past eight years, where they had set up a Primary Health Care Teaching Unit; they invited me to visit them for a spot of salmon fishing, and to see the country. Having never visited Finland before, and with the real chance of getting a large salmon, I of course jumped at the chance, and here's hoping for a really large fish taking it into its head to commit suicide.

It is something that has happened to me so often, that as I am about to go on leave, or to leave a hospital for any length of time, that there is an emergency to be dealt with just before going away. Well, it happened again the evening before I left Tororo: I had just finished the packing up and sending things from the house to Joan Linnaker's for safe keeping while we are away this time, and had packed my bags all ready to depart

early in the morning, when Dr. Mutenyo called me to say that they had an emergency in the hospital they wanted me to see. This was at about 6 p.m.. I went down to see what the trouble was, and discovered a desperately sick looking man, who had an abdominal wound, only about 5 cms in diameter, with some omentum sticking out of it. He was very febrile and hot, though not sweating, a temperature of 39.5 degrees C, and with a B.P. of 100/46. The history I got was that at about 4 am. in the morning he had been injured when a hand grenade went off in his house, killing his friend, and injuring him. They could not tell me what he was doing with the hand grenade, though someone on staff suggested that he and his late friend were going out on a 'raid' of some kind, and deserved all that they got! It seems that he did not immediately seek medical attention, but stayed at home till fairly late next morning, when they eventually took him to a nearby hospital for treatment, as he was by now complaining of severe abdominal pain, and getting very sick indeed. They kept him in the hospital till about 2 PM. but when they had not been able to locate any of the doctors working there by this time, they brought him by car some 70 kms to us in Tororo. I gather that he arrived about 4 PM. and they called me to come and see him at 6 PM; nothing had been done for him in the interim, other than the doctor on duty seeing him and writing a brief note on his condition, but giving no orders for treatment - he didn't even have an intravenous fluid infusion begun. Well, then the fun began, this time I refused to go ahead until she got some blood, but our lab technician was nowhere to be found. They said they'd send someone to find him, and call me when they were ready with the operating room, and had the blood ready; they assured me that blood was available, as they had gone to Mbale the day before, and had got some blood of most groups, from the blood bank there - a rare happening indeed in our setting. I had also asked that they get a plain abdominal X-ray taken to get some idea as to where the shrapnel was, particularly asking that they be sure to get the X-ray technician to put the marker on the correct side. In the meantime, I went home to await developments, but by 8.30 PM. was getting increasingly anxious, not having heard by this time, so went down to see what the delay was. I had trouble finding the doctor, but when he finally appeared, he said that as they found they did not have the proper blood group he did not know what to do! Anyway I persuaded him to come with me to St Anthony’s' hospital, and see if they had any blood there. On arrival, we found a nurse on duty, and asked if they had any blood, she did not know, but said she'd go and get the lab technician and find out for us. When she got back, she said that the technician would "come when he was ready", it was by this time almost 10 PM. So we waited for about 25 minutes and then went to ask the nurse what the technician was doing, and when might he be 'ready'. She said he wasn't doing anything, but would come when he was 'ready'. It took another 25 minute wait for him to appear, and he eventually got us 2 units of blood of the appropriate blood group. While waiting for the blood, I asked the doctor with me why things took so long, and why in Africa was there never any sense of urgency of in so many urgent situations. He replied: "If you had just produced 2,000 shillings (about $2.00), the technician would have been there for you very quickly". In Uganda, as is the case almost everywhere else, money talks and gets things done quickly, the only difference is that it is so universal, and taken so much for granted in Uganda, and there seems to be so little in the way of compassion for other people's sufferings, unless a relative is involved. Even in the case of a relative, one never knows whether it is a case of caring and compassion for a sick relation, or the deeply instilled sense of duty towards

one's relatives, and what others in the tribe might think in the case of not being seen to fulfill what are considered as proper duties and obligations. Anyway, we finally got underway with the surgery at 11.30 PM, not before finding that the X-ray technician had once again put the marker on the wrong side, but the shrapnel was seen under the liver, the entry wound being on the left side of the abdomen, so I felt that it would have done some damage on the way, and sure enough, it had grazed the spleen and caused a fair bit of bleeding therefrom and obliquely penetrated right through the stomach just above the pylorus, and embedded itself behind. There was an abdominal cavity full of blood and stained gastric contents and fluid, with autodigestion of the small bowel etc.. After suturing the holes and generally tidying things up, he seemed to improve a fair bit, and was fully conscious and looking fairly good in the early morning next day, just before I left, though what the ultimate outcome will be is anyone's guess at the moment, and he's got a long convalescence in front of him. The ultimate irony was that just as I was cleaning the abdomen, and he was undressed on the operating table, I noticed that he had scars from an attack of herpes zoster, which in a man of this age in Uganda meant that he had AIDS! I was in two minds whether to go ahead with the surgery, because if he survives, he's due for an uncomfortable end in the not too distant future anyway. The case illustrates very well the full spectrum of problems to be dealt with in Uganda: the insane violence and deaths of young people from modern weaponry, the frustrations and inertia in the face of urgent situations, the lack of facilities and the utter futility of dealing with the problems presented by the AIDS epidemic.

One final note in a more humorous vein: an item appeared in the paper the other day that the chief of police at a town called Iganga, with a few of his own policemen, had been caught in the act of siphoning gas from one of the tanker transport vehicles, by the Uganda Revenue Authorities. The people in the Ministry of Internal Revenue have recently been given very wide powers of search and arrest, and have as a result, become very active indeed of late. It seems that the place where the policemen were caught is called 'Kuwait' by the locals, because it is such a common practice for them to steal gasoline from tankers which stop there overnight, before proceeding on their way to the storage depots in Kampala next morning. The Ugandans have a lovely sense of humour in the way they name people or places, e.g.: they call the Minister of State, and other wealthy people who own Mercedes cars, the Wabenzie - literally translated it means the people with Mercedes Benz cars. In the old colonial days, they used to call prisons 'Kingi Georgi Hotel', as it was a place where they were guaranteed reasonable meals, accommodation and medical treatment. One of the British policemen who is here on a training scheme with the Uganda Police Force was telling me of a chase by the police in their vehicle in pursuit of some thieves who had stolen quite a lot of money when they ran out of gas, so that the thieves got away in their stolen car as a result - so perhaps they had a real need to steal the gasoline from the tanker for 'official purposes'??

One final note: I have since heard that Sister Ann Schoetecotte was eventually diagnosed as having had miliary T.B. and has made a very good recovery since she went home, thank goodness, though we did look carefully for acid fast bacilli, but saw none when she was here.

Part 5

August 14th, 1993 - March 16th, 1994

Pages 141 - 168

August 14th, 1993.

After a rather hectic vacation, the first 10 days of which I spent in Finland, we arrived back in Uganda on the 9th, only to find, to my utter dismay, that the exams had been arbitrarily put forward a month by the University, and that the first paper was to be sat by our candidates on the 11th August! I am only too grateful that I did have the foresight to set the examination papers before I left, and had asked Dr. Tuunde, on his return from Canada, to select the questions, and add any of his own. Thank goodness I had done all the multiple choice questions, as he's still not used to setting this type of exam, so he had very little to do when they only gave both him and the students 10 days notice of the change in dates, and he rose very well to the occasion in having the exam papers all ready when we got here. However it did mean that we had to stay a couple of days in Kampala to supervise the exams, before getting back to Tororo. The clinical and oral part of the exams are to be held next week, so it will mean coming into Kampala again next week for this, and then the week after to attend the examiners meeting, at which they all sit round and discuss the outcomes of each and every discipline. It is a truly archaic system left over from the time when Makerere was largely run along the lines of the British system of the 1940's, all very ponderous and a rather pointless waste of time, much more time being spent by the Faculty in discussing the demerits, rather than the merits, of the examinees, and laughing at them . I am also deeply thankful that I had arranged for the external examiner to come from Kenya this year, as being much cheaper, and workable in the future. I left all the necessary instructions with Dr. Tuunde who has made all the necessary arrangements, and Dr. Julius Meme, from the Kenyatta Hospital in Nairobi has proved to be flexible enough to be able to accommodate to the new date at very short notice. It was quite a welcome back to find this state of affairs all the same.

A word about the vacation is in order: The Finnish sojourn was terrific, even though I did not get the 30 pound salmon I still dream of, but it is always nice to have something still left to look forward to, and maybe some other time? I was met at Helsinki airport by Kyto and Leena Salin, who had been so very kind to us during their time at Kiyeyi, and with whom we have become fast friends. They took me to their 'country cabin', which is for all the world like any cabin in Newfoundland. The whole country is like Newfoundland, and the northern part is just like Labrador, so I felt very much at home right away, the only real difference is that there was 24 hour daylight all

the time, a most disconcerting sensation to the normal diurnal variation one experiences, as we fished all night, often going to bed at 6 am, and not feeling a bit tired, in fact getting to sleep, even after being awake more than 24 hours seemed very difficult at times. We went first to the Tana River, a huge river between Norway and Finland, where we stayed in a lovely log cabin on the banks of the river, as guests of one of the directors of one of the largest banks in Finland, the Kansella Osaki Pannki, whose logo, aptly enough, was a squirrel. The method of salmon fishing in Finland I found distressingly crude: we got into long river boats, clinker built, with a high prow, and with an outboard motor. We were then taken up the river at high speed, till we got to the spot where they began to fish; this consisted of the 'fisherman' sitting in the stern, and the boatman up front, where he criss-crossed the river with oars, while the rods were set up in the stern, four in all, two with 'wobblers', fishy looking lures, and two with large salmon flies. These we towed back and forth across the river, waiting for the fish to strike, meanwhile it was very cold, in spite of the fact that we were dressed in kind of skidoo suits. The first night we spent doing this nobody even got a rise, and we stopped for a 'mug-up' round a fire at the end of it. While they were boiling a kettle, I took my small 10 foot rod, and set off down stream, fishing from the bank, in the classic style I am far more used to, casting the fly etc., and to my huge delight got into a nice 12 lb fish within 15 minute of setting out. When I was landing it, the boatmen all came down with gaffs and large landing nets to get it ashore, and were rather chagrined when I politely refused to have their help, and landed the fish by plucking it out of the water by the tail when it was played out - a rather nice moment, and one I did manage to repeat each of the subsequent two night we fished! There is nothing better for a fisherman to get a fish when nobody else has caught one, specially fishing somebody else's home territory, very selfish I know, but immensely pleasing. These were the only three fish we took from the Tana river, and Rene said this was more than they usually got! We then went to the River Neider in Norway, where I met a Tuomo Silenius, a manager of the K.O.P. who is even more of an avid salmon fisherman than I am, if such a thing is possible, and someone who knew the river backwards. It was a real pleasure to be with him, and together each of us did manage to get a couple more fish, again I got mine fishing from the bank as before, he got his from the boat. One of the real pleasures is the variety of fish in the rivers, I got many grayling, who seem to think that salmon flies are meant exclusively for them, but they usually do not inhabit the same pool on the river as the salmon, so with a little local knowledge, one can fish for them with lighter tackle. Also there are large brown trout in the river, often in the same lies as the salmon, they grow up to about 8 lbs, and make good fishing. While there, I found that the waters were very high, as they'd had a late spring, and very cold, so the main run of salmon had not yet come in. I would just love to return when the main run of salmon come in, as this is when they get the really big fish, and they do grow up to 45 or 50 lbs, and every year there are quite a few fish of this size taken from the Tana river particularly.

After the fishing we spent a lovely couple of days touring round Lapland, seeing the reindeer - remarkably like our caribou, even to eat they are similar, and the Finns cook the meat just beautifully. Then back to visit Helsinki the last day before flying home.

Once home, I contacted CIDA, but found that there was really no hope of funding for any extension to the project, so had to resign myself to the fact that it will end in January, though I may be able to stay on till March, and wind things up. But there is so much to do, that I feel that it will probably be a rather unsatisfactory kind of ending to the whole show, but there is little I can do to alter the fact. The rest of the time was taken up with sorting out the finances, arranging to get the Old Age Pension- a real landmark! and arranging with the University authorities about pension etc., as I will have to officially retire from Memorial on the 31st August. What the future holds on our return I will face at that time. It was quite a busy time, one way and another, and I only had a few days in Terra Nova National Park with the grandchildren, who have grown to a most remarkable degree since we last saw them, Joey now being taller than Doreen.

We stopped off in Britain for a couple of days to see George, who has a summer job in a small village near Northampton. He is gardener and general factotum to the owner of Weetabix! This chap has a fairly large country estate, with a golf driving range attached, which George has to mow with a full sized tractor. He also owns a private helicopter in which he flies to work most days, and when he cannot do this he drives there in a large Bentley. Both he and his wife pilot the helicopter. George does seem very happy with the state of things, and is enjoying the experience tremendously.

However, now back to Uganda and the Project.

August 19th.

We have just completed the oral and clinical part of the examinations, and I fear only one of the four students has passed this time. They all put on the most dismal performance imaginable, though they all got the diagnoses of almost every patient they saw, I am quite mystified how we as teachers, managed not to observe that their clinical skills, specially the most basic part of clinical examination, was so terribly flawed. They could not even demonstrate many of the most basic of clinical signs, none of them could do a reasonable neurological exam, and generally it was a very depressing couple of days. On the more positive side, all their dissertations were excellent, and prompted Dr. Meme, the External Examiner, to remark that one could hardly believe the dissertations were written by the same doctors we examined! But they were, and I could vouch for that, as I had gone over their work at each and every stage of the writing. Also the theoretical part of the written papers were all reasonably well done. So it remains for three of them to sit supplementary examinations within the next three months.

A word about Dr. Julius Meme is in order. He is quite outstanding in every way. He is a trained paediatrician, who has done a fair bit of postgraduate work at McGill University, particularly in the area of primary health care, and community medicine. A highly intelligent man, and an original thinker, who realizes that high technology Western type medicine is totally unsuited to the African scene. He is currently the medical superintendent of Kenyatta Hospital in Nairobi, and is cutting down on many of

the services he considers just too expensive to be practical; he has already managed to close 200 beds, putting much of the money saved therefrom into out-patient services, or community based health care projects, and research into dealing with the problems found in the urban slum areas of Nairobi. As we were walking from the campus guest house at Makerere where he was staying, we passed through a rather depressing area of tin shacks with human excreta and the mess made by cattle, goats and hens etc., on the way to Mulago hospital where the exams were being held. He remarked to me that how on earth could any country tolerate the squalor and filth of a small settlement like that, with the obvious breeding site of dirt and disease, and yet build a complex like Mulago Hospital right next door to it. As he remarked, the money spent on the hospital, and on treating the patients admitted from just such an area as we had walked through, would be much better employed in the prevention rather than the cure of illness. Africa needs many more doctors with just the same outlook as his. With all his achievement, he is a most humble, thoughtful and kind person, and throughout the whole examination process was teaching as much as he was examining. I only hope that Dr. Tuunde gets him back for next years batch of students, all of whom I do expect to pass with flying colours, as they are the best intake we've ever had, and who I know from experience and observation, are all good clinicians. I only hope that they do get on with their research projects before the end of my time here, as they are all a little behind in this regard, and will be in need of a lot of guidance towards the end, in the writing up of their dissertations.

August 21st.

We got back to Tororo quite late last night, and I was called to the hospital to see my first patient since returning. This was a poor chap who was shot the evening before by robbers who killed his brother, and shot him through the stomach. When I saw him he was terribly febrile, dehydrated, and had a lot of small bowel hanging out from his belly, in the right iliac fossa. Nothing had been done for him since admission a few hours before, and for those who have read the previous diary, one might recollect a similar problem with the chap injured by the hand grenade the evening I left Tororo to go on leave, and who died on the operating table. Well this poor chap was in the same state, and suffered the same fate, dying as we were closing the abdomen after an extensive resection. He had to have about six feet of terminal ileum removed, as he'd got a number of bullet perforations through the small bowel in that area, and a whole lot of faeces in the peritoneum, also there was no way we were able to get sufficient blood for him, so perforce had to go ahead under less than ideal circumstances. I gather that there has been an increase in the number of armed robberies since I left to go on leave, which the folk tell me, is due to the fact that many soldiers are being demobilized, and their very poor prospects for getting any kind of work and the resulting economic conditions on leaving the army, as well as the fact that many have managed to keep their weapons, is making life a life difficult and insecure for people in the areas where these soldiers are returning home.

August 26th.

The Examiners' Meeting was held a couple of days ago, and was as predicted, accompanied by gales of laughter at the discomfiture of many of the candidates, and a recounting of some of their mistakes and shortcomings in the examination process. Thank goodness it is the last of these meetings I shall ever have to attend. Then we had the seminar yesterday, but as yet are not allowed to impart the information as to who passed or failed their exams - this has to await the next Senate meeting, and their formal confirmation of the results!

To-day, there was a Faculty Board Meeting, and at long, long last I have managed to get a date set for all the disciplines who are involved with our teaching to meet with Dr. Tuunde and I in order to iron out what they are expected to do. In the past they have been presented with the objectives we hope them to meet in teaching our candidates while rotating through their discipline, and have even provided a set of assessment forms, with a 'tick off' list of procedures performed, and of achievements of the students while in their teaching programmes. Both Dr. Tuunde and I have set previous dates, on about five different occasions over the past three years, and on each occasion except one, when one of the surgical representatives came, have found ourselves alone, with nobody else turning up to the meeting! This time the notice has gone out through the Dean's Office, and as representatives of all the various disciplines involved were present at the last Faculty Board Meeting, they should all know, and there should be no excuses, but we'll wait and see what happens.

September 1st.

This has been a singularly busy week for Doreen, who has been hostess at a couple of Birthday parties with at least 16 or more guests, mainly for Joan Linnaker, of the Salvation Army Boys orphanage, and we seem to have had an endless stream of visitors to stay with us. On one occasion it was a Dr. Michael Nichols, of the University of Arizona Family Medicine Department. One of the Ugandan Professors, Dr. Anakobongo, a pharmacist, who had just done a refresher course there and had invited Dr. Nichols to come and see if he could assist the Ugandan Primary Health Care situation, by trying to get funding of some kind. Anyway, it was suggested that he come to see what we were trying to do in Tororo, and see if he could fit in or continue to assist this teaching programme once CIDA input ceases. Dr. Nichols was rather non-committal, and I think wisely so, and has gone to consider the matter, though I don't really think much will come of it. He brought his son with him, as well as a Chinese American student, both of whom were very interesting people to talk to, and vaguely thinking of some experience in a developing country.

Then Riita, from Kiyeyi visited, after having had a rather depressing visit to Kiyeyi, where she thinks that things are not going all that well, and the Ugandan new administration is being a little guilty of diverting money from the community project to other uses than intended. She was very depressed, specially at the treatment meted out

to some of the more able and committed staff, who have seen the Finnish project from its inception, and who really want to make a go of it. Poor Doreen had to do a little listening and 'counseling', about the need to be able to stand back, and what one can realistically expect to happen, when the expatriate control passes to other hands. Eventually the Ugandans will have to sort it out themselves, though the process is bound to have its ups and downs. This project is subject to exactly the same problems, but maybe something worthwhile will have been achieved after we've gone, but time alone will tell, and everyone has to have some failures in life. However I do believe that trying is well worth the effort, even if the results do not in the end measure up to one's expectations.

September 5th.

A further few days of various visitors, one of the more amusing ones was a Dr. John Maitland, who was for some years in the 1960s working at a Mission Hospital at Ngora, which is run by the Church of Uganda, previously the Anglican Church. He comes back to Uganda from time to time, and we met him on his last visit to Tororo, which seems to be one of the places on his visiting list; he sends out an itinerary some time beforehand, expecting a welcome by each of the recipients of this missive. Anyway he arrived on the week-end, before he was expected, and had to be put up. It was funny before he left, when he was trying to decide the best form of travel to Nairobi from Tororo, whether to go by train or 'taxi'. His anxiety arose from speaking to the local Bishop, who had expressed some doubt as to the safety of the Kenya Railways of late - there have been a couple of derailments, one caused by an inadvertent flash flood having washed away a bridge overnight, and the train plunging into the river killing quite a few people, the other a minor derailment of very little consequence. However, the 'taxis', though cheaper, are desperately uncomfortable, and the accident rate is indeed rather high. Anyway Dr. Maitland, after much agonizing, which he tends to do before making a decision, finally decided on the train, so off we went to the station at Malaba, on the Kenya side, and lo and behold, there was the engine which was to take them to Nairobi, off the rails, and awaiting a crane to get it back again! I fear at this point I did leave him buying his ticket, with considerable misgiving as to what lay ahead.

September 12th.

Rather an odd week, I spent a whole day disassembling the suction machine which the staff had managed to wreck in my absence. It was seized solid, due to the fact that they had managed to get the safety bottle to overflow into the lubricating oil, and this had corroded the whole machine. It was absolutely filthy, and the oil stank to high heaven with the old messes of blood and pus that had been sucked into it. Luckily enough I did manage to free the works again, and it is in good order once again, though for how long I don't know.

Then we had a visit from Wendy, a lass who is trained as a physiotherapist, and employed by the “Cheshire Homes”, a group working with disabled kids in Britain. Wendy goes round minding everybody's business for them, and who has the most remarkable verbal diarrhoea, hardly pausing for breath when she visits, and giving all sorts of unasked for information about her life and relationships. She means extremely well, and is for ever trying to help someone; carting kids with polio from their villages, and taking them to get 'treatment' where she thinks most suitable, often in Kampala, or miles from their homes. On this occasion she'd been to Kumi Leprosy Hospital, where she discovered a kid with a terrible arm. Evidently the kid had been admitted to Mbale hospital about 35 Kms from us, where she had been a patient for about two months, only to be discharged nearer home to Kumi hospital, which is a leprosy centre. The child who is just over two years of age, had a dreadful messy arm, with the bones all exposed at the elbow joint, and in a terrible state of nutrition at the same time - almost certainly one of the young AIDS victims. The surgeon was away, and the other doctor, an extremely nice Australian, by the name of Nathan Sweck, was down with severe malaria, so Wendy felt the kid had been left without adequate treatment, so she brought it here for me to see. The poor kid has AIDS, the father is dead, and the mother is very sick-looking indeed. The child proved to have a dreadful joint, which had been destroyed by osteomyelitis of the elbow, involving the radius, ulna and humerus, so in the end I had to amputate the arm by the shoulder, mainly to make nursing the child easier and less painful, but I wonder if it will heal - most of the children with AIDS just do not heal after surgery. I only wish Wendy would leave the African doctors to do things, and not interfere so much, as it is making her relationships with them rather painful on the whole.

Then Nathan Sweck had to come here when he found that he was not improving sufficiently quickly after his bout of malaria at Kumi. It seems that he'd been taking paludrine daily, then when he had the symptoms had taken mefloquine, then fansidar, and had begun himself on chloroquine! I must admit that he looked quite dreadful when I first saw him, and still had a few parasites in his blood, so I began him on a full week of quinine, and he now looks much better, thank goodness. He is an Australian whose German ancestors were amongst the very first of the voluntary settlers there, and were pioneers in their wine making industry. Nathan is such a decent chap, most interesting to speak to, currently working in the Leprosy Mission Hospital at Kumi, and hoping to be in Uganda for the next three years. While he was recuperating from the malaria, he stayed with the other three Australians at St. Anthony's hospital, so at least Doreen was spared having the care of another patient on her hands.

Finally, Dr. O****** was found dead in the early hours of the morning yesterday. Previous readers of the last installment of the diary, may remember the chap who was called to do a cesarean section one night, and arrived drunk, but went ahead with the surgery, but abandoned the woman after removing the baby from the uterus, so that she had to be sewn up by the poor anaesthetist, who'd never attempted anything like that before in his life. The woman died later that night. He had an almost similar mishap another night, since when he'd not been allowed into the operating theatre, but was put in charge of the Childrens' Ward, with the most vulnerable of all patients under his care!

Anyway, that was Dr. O******, and he'd evidently been drinking more heavily than usual recently. Nobody seems to know how the death happened, but I often wonder what was driving him to these incredible extremes; he looked to me more and more as though he was another person suffering from AIDS. He'd been losing weight steadily over the past year, which people put down to drinking, however I feel he may just have put an end to it all, by his own hand, as the only way out of the messes he'd got himself into, and I cannot but feel sorry for him, as I do for so many of the Ugandan doctors, who face so very many desperate problems in making a living, quite unimagined by their counterparts in Canada, or anywhere else in the so-called developed world.

A digression from the project itself, but something which does have a direct bearing on life in Uganda, is the "magendo" trade which goes on. I suppose that the literal translation of magendo, is "smuggling". In the majority of developing countries, smuggling is almost a way of life, and the only way to avoid the taxes, and "Chai" levied on everything. Properly the word "Chai" means tea in Swahili, but with the lovely sense of humor Africans have, it has now come to mean bribes; I believe that it was the custom of police or anyone in authority granting favours to people, to ask for something with which to buy extras like tea etc., before granting the favours, or not arresting offenders. So when coming over the border, having bought things in Kenya, the guards or customs officials will ask for a little "chai", before letting people carry their goods over. Recently the government has had a big crack down on tax collection, and hired a group of expatriates to put this into effect. A list of all items and the duties to be imposed has been drawn up, and they have set up road blocks at many points, specially at the border towns, and are stopping all traffic, making people get out, and conducting full-scale searches of vehicles and passengers. The Uganda Revenue Authority people, all armed with guns, and sporting red berets as part of their uniform, have appeared at all major roads leading into and out of Kenya and Tanzania. They have certainly managed to slow down traffic at these points, with long queues of taxis and buses, with their passengers having to get out and be searched they are generally bitterly resented by everyone. Some of the items one can understand, such as motor vehicles, radios, videos and other 'luxury items', on which one has to pay up to 120% duty. However, they are harassing people bringing over bread and flour and such items. In actual fact these items help keep prices charged on Ugandan goods in check. For instance, it is cheaper to buy Kenya sugar than Ugandan sugar, and if it were not for the Kenya product, the Ugandan prices would be even higher. There is a regular game going on now, and the matatu drivers warn other vehicles of the whereabouts of the 'redhats', and the passengers will all disembark before reaching the road block, and hide their purchases in the bushes, getting people to carry them by footpaths well off the main road to meet up again with the passengers some distance after the road block. I gather they have to pay for the goods to be carried in the bush in this way, but it is cheaper than having the stuff confiscated, or else have to pay the chai to the ‘redhats’ I guess it is like smuggling anywhere else in the world, and considered entirely legal, and more or less a kind of sport when it comes to trying to avoid paying customs duty, but I must say that my sympathies are entirely with the people in this little minor war they are waging with authority.

September 19th.

An interesting week, as it was the 'Seminar Week' once more, these being held every two or three weeks, depending on whether there is a meeting in Kampala for me or Dr. Tuunde to attend. We never let it go longer than three weeks between the seminars, they are certainly a very good sort of cement, holding the students together as a discipline, and so far almost none of them has ever missed a seminar. It begins with a sort of social get together, and they have lunch, following which the teaching session begins, the main part of which is discussion of a particular topic, chosen the session before, for one of them to research and discuss before the others. They also have practice with a series of 'multiple choice questions' on a given topic which they mark themselves, so that they can see how they fare without having anyone else know, it is much less threatening this way, and much as I hate M.C.Qs, it does get them used to this type of examination format, which like medical students everywhere, they have to suffer at the end for their final examinations. They also have to present one long and one short case for discussion and comment by all and sundry, so that the whole seminar takes the whole of an afternoon to complete, but as I say, it is something they seem to look forward to, and participate in most enthusiastically.

A real surprise was the long anticipated meeting with the heads of all the major disciplines. It took three Faculty Board meetings, usually a month apart, to get it finally set it up, but at long last it has taken place. The surprise was the amount of declared support for the programme, which at long last seems to be understood, and it seems that there is at last great willingness on the part of the other major disciplines in helping and participating in the training of our post graduate students. To me it is real *deja vu* in that it was almost exactly the same when I started the Family Practice programme at M.U.N.. The initial suspicion amongst the major disciplines, that we were training 'mini-specialists' who would be a threat to the standards they had set for themselves, was obvious, but at long last they saw that the outlying hospitals do need generalists who can handle the majority of problems locally. This is paramount in this country, where, as everywhere else, the majority of specialist are in the urban centres. Here the great difference is that it makes little difference to the major disciplines as far as the referral system goes, because if the patients are not treated locally, then they are not treated at all, because the great majority of patients just cannot afford to travel to the major centres to seek treatment anyway. It was one of the most heartening meetings I have ever attended at Mulago, and caused considerable euphoria, though I have little doubt that much of this will evaporate over the next few months, when it comes to their making real commitments to see that things go well in future - however it is nice to think that some of the seeds are germinating, if only a little, and that the soil for the seeds is not too hostile anymore. All the various heads of departments were given the programme objectives once more, and there is to be a meeting with the government Ministry of Health Officials, to try to get some tangible financial support for the programme, once CIDA pulls out, and that is not far off now. I only wish I was starting the programme now, as it would have had a much better chance of success, now that the country is at last getting its act together, and things are so much easier than when we came.

Interestingly enough, Zimbabwe is starting a similar four year programme, and have asked me for an outline of our programme with all the objectives etc. to be sent to them.

At this week's seminar the final year students had to present an outline of their proposed research projects, some of which are quite interesting, and I hope to get their dissertations sent to me after I have left. Dr. George Welishe is looking into the knowledge, attitudes and training of primary school teachers, with regard to the education of their students in AIDS prevention. Dr. Wanume is looking into the consultation patterns of mothers with sick children, I have asked him particularly not only to look at consultations with people trained in Western medicine, but also to look at the consultations with the traditional healers, 'injectionists' ('injectionists' are an odd bunch of people, usually untrained, who have got hold of syringes and needles, and go about giving injections for various illnesses, often with rather disastrous results, particularly as they do not sterilize things very often, and are responsible for some of the spread of AIDS in the very young). Also he should look at the drug store owners, because they are often the first line of consultation by so many people who cannot afford other forms of treatment, yet may feel the need of drugs with which to treat their childrens' illnesses. The other two students still are trying to decide on their topics, but they'd better hurry now, as time is running out on them, if they are to get the go ahead, and the funding required for their projects.

September 27th.

An incredible week surgically! Monday began with a bang, in that we had a small child of eight admitted with an acute abdomen, examination showed a large mass in the left iliac fossa, and the ultrasound told me that it looked rather like spleen, though much denser than usual. It proved to be a torsion of spleen with an incredible long pedicle, so that it became stuck in the opposite quadrant of the abdomen to that in which that organ usually resides, she had been ill for a couple of days, and with the congestion of the spleen it became adherent to the structures in the left lower abdomen, but the adhesions were quite easy to free, and the operation rather simple, though initially the diagnosis was not. Then we had a chap admitted about two in the afternoon, who had been beaten up. Someone had hit him in the abdomen with a heavy stick or something the evening before. This was done by robbers, but the poor chap could not get transport to hospital till late the next day. His abdomen was a mess, with a huge haematoma of the lower abdomen, and the terminal ileum had been ruptured at the junction with the ileocecal valve, but when cleaning things up I was astonished to find a huge ascaris worm floating free in the peritoneum. Quite miraculously it looks as though he's going to survive the assault!

We had a visit from a couple of nice young lads, who are training to be missionary priests with the Roman Catholic Millhill Fathers. One is Dutch, and one Irish, neither of whom has been in Africa very long. The Irish lad was horrified to see a cyclist lying dead on the road, with branches of trees placed at his head and feet, and a crowd of people standing round staring. When he stopped to ask if he could help he was

told they were waiting for the police to arrive - he'd been knocked down well over an hour before and that nobody could help the chap as they knew he was dead. If one sees branches of trees lying on the roads here, one very quickly learns that this is the sign that an accident has happened. It is quite a useful technique, because it is done quite conscientiously when a car or truck breaks down, the owner gets out and strips branches of trees growing at the side of the road, and places them quite conspicuously for quite a distance in front of and behind the vehicle, there never being any shortage of foliage available to do this with, it is a handy signal. All cars are supposed to carry reflecting triangles, but in fact very few do, and if they put the reflectors out, someone else is most likely to come along and steal them anyway!

Tuesday's list proved to be problematic in that I had booked a case of fibroids as well as a couple of others, but the fibroids proved to be the very worst I have encountered, and took me almost three hours to dissect out and do the hysterectomy. I guess that I needed taking down a peg or two, as I'd come to regard large fibroids as rather routine cases, and size seemed to make little difference in most cases, but these were so multiple and densely adherent to everything, the ureters included that it took ages to get the job done. One of the other cases was of anal condylomata, and I have seen quite a few of these, almost always in men, which makes me pretty sure that homosexuality is more prevalent than usually admitted to in Uganda, in fact they hotly deny its existence, and most try to tell one that it is a "Western aberration" as they express it.

Thursday I had to amputate a man's leg for malignant melanoma of the sole of the foot. This is another surprisingly common condition here, and I cannot tell why it seems to happen on the sole as often as it does, though the probable reason is that so many people do not wear shoes here.

There is an odd thing happening in Uganda at present, which I cannot quite fathom. They are holding 'Politicization Courses', mostly for those in charge of departments; most people call these courses "machaka machaka", and I do not know what it means. They are all seen marching up and down, drilling in military fashion with dummy guns, these drill exercise being mostly conducted by sergeants in the army; but they also have lectures mostly in the afternoons which seem to last for long periods of time. The whole course seems to take a full month of a person's time, and the courses are being conducted all over the country. The common people seem very suspicious about the whole thing, and they are beginning to say that it means that there will probably be no multi-party elections held next year as has been promised.

October 4th.

This week I attended a meeting of surgeons in Mulago, after having been invited. The theme was 'Surgical Training in Uganda', and followed the annual meeting of the Association of Surgeons of East Africa. This is the first time I have attended a meeting held on Makerere campus, and it was in the newly rehabilitated Science and Technology

building, which is really quite impressive. At the meeting I met with Dr. John Church once again, and was made a bit despondent to learn that his proposal to staff Ngora Hospital with younger British surgeons has fallen through, largely because there have been no takers. It seems that the fear of AIDS amongst the surgeons is the major reason for their reluctance, once again this experience of reluctance to do surgery on AIDS patients, by people in the developed countries, has been repeated for me, altogether I find it rather sad.

The poor old car, ever since the accident has been having trouble. Every time the engine temperature goes up there is a fearful clatter of the tappets, and it sounds awful. Not only that, but I found that there was no compression in the No. 1 cylinder recently, and it had burned out. We have tried almost everything so far to no avail, and this has included trying to put schims in the rocker arm mounting to adjust the tappets that way, because they are no longer individually adjusted, but hydraulically operated in unison. That didn't work, then we tried two cylinder head gaskets, and that didn't work, and the mechanic seemed to be baffled as to the cause, telling me that the noise did not really matter, and that it was doing no harm - this in spite of the burned out valve in No.1 cylinder that we had found. Anyway, in the end I borrowed his manual for this particular Toyota type engine, and I think I have found the cause. There are some hydraulically operated springs which close the valves forcibly after each time the rocker arm opens them, and we found a couple of these were very weak indeed, probably having been fried when the engine overheated and seized that terrible night after the accident. These springs were then replaced, they cost $150 altogether, and lo and behold it seems to have affected the cure because so far the noise has gone, and the engine purrs like a kitten once again. I feel really pleased at the 'diagnosis' without the aid of the mechanic, who claims to be duly impressed, even though it was he who carried out the ultimate treatment!

On the medical side, I saw an African nun recently with a pretty clear case of cardiac neurosis, for which I could find no obvious cause when taking her history. This did strike me as exceedingly strange, because one would have thought that in her sheltered environment, such a problem would have been very unlikely. The Sisters here are well-fed and well housed, they are educated at church expense, and would seem to have very little to worry them compared with the lot of the average Ugandan women. However, in discussing the matter with my secretary, I was told that they have all kinds of hidden pressures put on them by their extended families, who still do expect a lot in the way of support once a daughter enters a convent! It seems that many of them, she told me, because it is difficult to get money from the church, can only get this support for their families in the form of money obtained from "men friends"! She claims that in the event of a pregnancy, they get an extended leave to go to the village to have the baby, who is then cared for and becomes 'owned' by a relative. The incredible parasitic nature of the extended family in Uganda is universal. People are expected to pay back the family for their education, and in the case of doctors, I know for a fact that all of them have a horde of relatives living with them, and are expected to provide for them, and provide a good bit for the education of their younger siblings. My secretary herself is expected to provide a good bit towards the education of her two younger sisters, and

says that this is their custom always, and just cannot be shirked by anyone. While it has some advantages, the problem does remain that so very few people can 'get on' and make a go of things for themselves when they are so continuously drained in this manner.

October 10th.

The operating room staff had a fit of real 'efficiency' the other day, and we managed to get through five major cases, including two hysterectomies! One of these ladies was married at the age of 16, and had been unable to have children, so I guess that she must have been suffering from the early stages of the problem at that time, because the other three wives had all had children by the same husband! Of course, she was the general 'dogsbody' in the home, as she was barren, and being 'useless' as a bearer of children, was expected to do all the dirty work. Her fibroids were not huge, but densely adherent to everything, and it was the most difficult hysterectomy encountered to date.

Last night I got a call by phone from the obstetric ward, to say that they had a lady who needed a cesarean section, and would I come? I asked who was the doctor on duty, to be told that they could not find the ambulance driver to pick him up, and that they had not contacted him. In a truly hard-hearted way, I told them to find the driver, and inform the doctor, and I would come and help, only at his request. They phoned back later to say that they still could not find the driver, so I told them to contact the police, and get them to pick up the doctor. I heard no more till next morning, but had a sleepless night worrying, when they told me that they did eventually find the driver, who, though he was drunk when they found him, did go and get the doctor, but the baby was delivered by vacuum extraction- (they do not use forceps at all in Uganda, and perhaps it is a good thing in the long run, as they'd do more harm with forceps without adequate training). I am getting quite adamant that now the only time I will come to the hospital for any emergency is at the request of one of the doctors. When I am gone, which is not too far away now, they will have to take on the burden of responsibility themselves; the doctors in the past have been all too prone to disappear and have not been able to be found when needed. I can now walk past someone truly ill, and asking for help, and tell them to find the doctor on duty, and if he wants me I will come at his request. It is very traumatic to have to do this, and one leaves the patient, with a terrible feeling of guilt, well aware that some of the poorest and most deserving, will possibly go without any treatment. As is all too often the case, unless the patient can afford some form of payment, the doctors will just refuse to treat them.

October 17th.

Dr. Busulwa, a new postgraduate student arrived in Tororo to-day. He is the last of the students I will have to deal with here for his three month rotation through this hospital, which is a measure of how little time I have left, with such a lot to be done, if the programme is to continue after Doreen and I have left for good. CIDA, it seems are

unwilling to grant an extension, and this at such a critical stage, when the new faculty appointments have to be made, and even Dr. Tuunde's appointment not yet ratified by the University. I cannot help but feel that unless there are some faculty members appointed, and in place by the time I depart, that they will drag their heels over this matter for a long time, and I know that Dr. Tuunde will have a truly terrible job, living as he does in Mbale, to get the University to move on the appointments.

We have had to do a couple of amputations recently, one for a rather nasty looking osteosarcoma of the femur. We now face the terrible problem of being unable to get artificial limbs for the amputees. The Italians established a unit able to do this work at Mbale, not far distant, but it was burned down one night about four years ago. The nearest place which makes limbs is now in Kampala, but few of the patients can afford to go there, and they have to pay a considerable amount towards the cost of a limb anyway. However it is astonishing to see how well the majority of patients manage without. Some fashion peg-legs for themselves, and others without a leg still manage to get about with very considerable agility and the aid of a single strong stick.

We had a small boy in the hospital recently with a massive swelling of his right forearm. A biopsy report came back "dense fibrous reaction and portions of a worm.". I summoned enough courage to tackle it, and found that indeed the diagnosis was correct, and that he had most of the brachialis muscle involved in a dense fibrotic stroma, fairly easy to dissect as it turned out, and pathology has confirmed that it was probably due to 'mango fly'. Interestingly enough he'd had it for 18 months before his father brought him to hospital, as it seemed to be relatively painless, and the growth of the tumour had distorted the ulna quite considerably.

Not long ago in the Manchester Guardian Weekly, there appeared the question "Who ever thought of ironing clothes?", with a comment as to how stupid such an occupation seemed. I was delighted to see a reply from someone in Ethiopia pointing out that if clothes were not ironed in his country, then mango flies and other such infestations might result!

October 26th.

We had an old man in hospital with a huge liver. On ultrasound he had the most massive polycystic condition of that organ. The cysts were huge and thin walled, and there are literally hundreds of them, some fairly large. I haven't a clue as to what it is, and am reading up on echinococcosis, though there have never been cases of it elsewhere in his neighbourhood.

Otherwise, a fairly uneventful week or so, with only routine type surgery and paediatric problems, other than the eternal problems of new AIDS patients, and the doctors refusal to diagnose it when it is staring them in the face. This form of medical denial still confounds me, and the doctors' continuous bleat that it would be terrible to give the patient this kind of 'bad news'. But perhaps it is what their culture accepts, and

that continuing to treat even the most hopeless problems, often with expensive drugs which can be difficult to obtain, and very little in the way of palliation, may be viewed as giving some kind of hope to the patient, in spite of the prolongation of suffering entailed. What is to me more of a problem is that even my own postgraduate students, for the most part indulge in this kind of behaviour, with two notable exceptions, Dr. Welishe and Dr. Busulwa, who are willing to discuss the diagnosis with patients , and try to review the problems they are likely to face in the future. They both tell me that the patients seem to appreciate this approach, and that the majority do indeed want realistic information; they admit however, that the patients will often go straight away to the local healer, and seek his opinion as well, and try to find out who is putting a spell on them. So many of the African patients firmly believe that illness, other than malaria which they all seem to accept as an unavoidable fact of life, in the majority of instances is caused by evil spirits, or someone wishing to do them harm. By far the best example of this so far was the man in Kitovu in the first few months I was here. He was carrying a heavy load of wood on his head who slipped in the mud, dislocating his neck in the process; he became almost immediately quadriplegic, but his family took him home to consult the local 'witch doctor' in order to find out who had caused him to fall - they brought him into hospital two days later for treatment. In this case even though he was really beyond any useful treatment, I did put him into skeletal traction, but was somewhat dismayed to find that his father, who was tending him in hospital, kept taking the weights off the traction 'because it was causing him discomfort'. Even people involved in car accidents will often be taken to their village for the 'witch doctor' to find out who wished him evil and caused the accident to happen.

November 2nd.

The old man with the liver cysts 'ran away' from the hospital, as they say here, I guess that in his wisdom he figured that there was very little we could do for him, so just took himself off. It is always difficult to trace the patients who do this, and we've often enough had patients for whom we could do something run away before treatment or surgery can be done. Again it is the same business of going to consult the local healer to see whether they should indeed have the treatment. It tends to make a bit of a problem with operating lists, as the patient will either not come in for treatment, or else just flit during the night before surgery is to be done, if they have been already admitted to the hospital.

The surgery the past couple of operating days has been mainly on women either wanting children or suffering from the effects of having children. We had the first Stein-Leventhal syndrome I have encountered here so far, and hopefully the wedge resection of the ovaries will benefit her. I also did one of the few myomectomies I have done, I only wish I could be around to see if it works. The way fibroids seem to behave here makes me very cautious in doing simple myomectomies, because I feel sure they'll only return, but this lass had four fairly small fibroids to be removed, and she was only 23. The others were V.V.Fs, which I have been encouraged to take up again, as Josephine, my secretary 'Girl Friday', has added to her repertoire looking after the post

operative after care of these unfortunate women, and she's conscientious enough to do it properly; mind, the nurses do not like to have her doing it, as they feel it is a slight on their efforts, which it indeed is intended to be, because they just did not care, and left the poor patients to get on with it, so that it became a waste of time, after-care being the key to any success with this operation. Other problems were sequestrectomies in a couple of kids, one involving almost the whole humerus, and a parotid tumour of a rather odd nature, I think mixed parotid, but will find out in a couple of months, when eventually the pathologists deign to look at the biopsy specimen.

There was a break-in at the Franciscan Convent at Laverna, the other day, when we went in for the seminar last Wednesday. The average age of the sisters in this particular convent must be approaching 75+, and one of them awoke to find, as she said, "Two Black Men, standing over my bed". One of the sisters in an adjoining convent rather dryly remarked "What did she expect but black men in Africa?". Anyway they stole the usual things, including some money, their T.V. radios etc., but one of these elderly nuns who'd had her watch stolen asked the thief "Why do you want to rob an old lady like me? I wont be able to tell the time now." at which one of them ordered that it be given it back to her. They then locked the sisters in their rooms and made their escape, but the one who'd had her watch stolen, eventually managed to climb out of the window, which was quite a feat for someone of her years and build, and call the police.

November 11th.

We had a visit from Don Campbell, a Scot who is in charge of the Bata shoe factory in Kampala, and who is acting on behalf of the Canadian Consulate in Uganda - I guess he got this post because Bata is a good Canadian company, even though he has not a word of French at his command, and speaks with a broad lowland Scottish accent. Don brought Susan Scarlett out to visit us for the week-end - (her father was at M.U.N. in the Geography Department). Susan is now working in the Canadian Consulate in Nairobi, in the Immigration Department, and seems to enjoy herself there. We visited her when in Nairobi a couple of years ago, and found her living on the outskirts of the town, in a house previously occupied by a Canadian couple who were working in the Canadian High Commission, but who were both killed in a car accident on their way back from Nakuru. I gather they had two children with them who survived the crash, and were sent home to relatives afterwards. Anyway, the house is one of those in which Diplomatic personnel are housed at our taxpayers expense, and is secured rather like Fort Knox. The diplomatic people in Nairobi all carry portable radios with them, which they seem to wear rather ostentatiously, they live in these large and well-secured quarters, and all in all seem to have a rather nice kind of existence, certainly when compared with the people working on various projects or other forms of aid to the countries.

We visited the Russians at Busitema while Susan was here, Nicolai, their interpreter came to say farewell, and invited her to come on a visit to view some

gemstones, of which he has some knowledge, and has been collecting during the few years he's been in Africa. It is rather sad to think that they'll all be leaving very soon now, as there has been a Russian teaching presence for the past 20 years or so at Busitema, but with the collapse of their economy, they are withdrawing all their workers, and are now bringing them home to Mother Russia. We always had a good relationship with them, and found them so pleasant and easy to deal with, they used my services for any medical help they needed so I got to know them quite well. The Russians were on even more of a shoestring budget than we are, there being about nine families most of the time. For transportation they depended on a single Volkswagen bus into which they all piled when they were going anywhere, and were always chronically short of gasoline. Lothar Schnell, the German in charge of the road maintenance between Tororo and Jinja used to give them gas for their car, in exchange for some work they often did for him in maintaining his vehicles, as they had a beautifully equipped machine workshop. It was rather ironic to see the cordial relationship we all had with each other while in Uganda, and this even before the end of the so called 'Cold War'. Anyway Susan enjoyed her visit, and learned something about gemstones. I rather regret that I did not accept Nicolai's offer to give me a large bronze bust of Lenin which they were going to leave behind when they left, but I could not see packing it to take home, though I'm sure it will become a collectors item in future. In the meantime, I wonder just how long the Ugandans are going to be able to keep up the teaching programme. I'm certain that they'll have everything, all the tools and machinery etc., all smashed up in pretty short order once they are on their own, and spare parts for these things will be almost unobtainable, being of Russian manufacture.

November 17th.

Met with Prof. Mugerwa, the Dean of Medicine, the other day, and told him that there would definitely be no extension of the funding from CIDA, also that I intended to officially finish working at Tororo by the end of December, so that they had better get on with making arrangements in a hurry for our departure. I hope to get down to do some writing up of the project, and to make a series recommendations for the future after I have left. I fear that I get less and less sanguine about the commitment to the teaching programme, and a lot will depend on Dr. Tuunde and how he manages in future. My greatest fear is that he's not really a heavyweight in the University Hierarchy, and just may get pushed around a bit, specially if like me, he is still based in Mbale, and does not get to attend the various meetings where decisions are made. It has been a perennial problem when one has had to rely on notice of meetings by mail, and the notice does not get to one until the meeting is over! This problem of communication, and the lack of any useful form of telephone contact, has beset the whole project ever since it began. The constant need to go into Kampala whenever it has been necessary to get a decision has been one of the greatest of all the frustrations encountered. Dr. Tuunde and I have recently outlined the future budgetary requirements once the CIDA input is at an end, and have submitted this document to the Ministry of Health and to the university, and obtained statements, albeit verbal only so far, that things will be taken care of in due course. However that remains to be seen, even

though the budget is fairly modest all things considered, and in Canada would be quite laughable; the new budget for the medical school will not be approved until September 1994, so the programme is going to have a lean time of it once I have gone, until it is seen what has actually been committed to the programme, but in the meantime I am going to try to leave Dr. Tuunde with some operating money just before leaving Uganda for good and all.

We learned very recently that the plastic surgery team are once again visiting Uganda, and will be coming to Tororo in the very near future, so have had the news put on the radio etc. and only hope we have time to round up enough patients for them. This will be the last visit while I am here, and am looking forward to seeing Rein Zeeman and his team once again.

Had a truly fascinating problem the other day: a man was admitted on whom I had done a sigmoidectomy for sigmoid volvulus some three years ago. This time he was distended hugely, but had been passing stool, though infrequently, for the past couple of months. There was no acute obstruction, and we got a gale of wind on passing a flatus tube, and a fair result after a few good enemas, and discharged him with instructions to lay off the matoke which are plantains which they eat in large quantities, and it seems are responsible for the megasigmoid which becomes the source of volvulus. He was discharged home, only to return again a month later, and on this occasion with more serious signs of large bowel obstruction. On opening him, it was found that he a had hugely dilated half of the transverse colon and all of the descending colon, which had twisted and caused a volvulus of the splenic flexure area. It was not too difficult to untwist it, and resect a large portion of the colon, anastomosing it to the remnant of the previously anastomosed bowel, which by the way looked quite good still, so he ended up with almost a complete hemicolectomy anastomosed to the rectal colon, and so far is doing very well post operatively. I guess that the process causing the megasigmoid in the first place caused a similar megacolon above, unless they stop eating matoke.

November 24th.

The Dutch plastic surgery team have been and gone, and we had plenty for them to do. It was great to see Rein again, and this time he brought Dr. Guys Witte with the team as the anaesthetist. Guys was with the team on their first visit, and it was good to see him again. This time the team did about 26 cases in the 3 days they were with us, and seemed to enjoy their stay as always. Doreen of course providing the sustenance in her inimitable manner. Three of them stayed as guests in the other house on the compound, but initially we were hard put to it to find suitable accommodation, as the local Rotary club in true Ugandan manner had failed to make any bookings for them, and when it came to it we found that that arch thug, President Daniel Arap Moi of Kenya, was making a state visit to Uganda, and had taken all the accommodation available in Tororo for his retinue of hangers on and security guards! However Lothar Schnell came to the rescue, and put a few of them up in his house until the Moi crowd left. This time the only thing the Rotarians did was to arrange a dinner for the team on

the last night of their stay, with the usual speeches all of considerable length. It rather grieves me to think that the team is very unlikely to visit Tororo again, as I cannot see anyone willing to keep the contact and make arrangements for their stay. I have suggested that they look at the possibility of going to Mbale in future, and perhaps Stephen Tuunde would be willing to host them there, because they are a truly marvelous teaching resource in every way, and are still hoping to make Uganda an annual event in their calendar.

December 3rd.

For some peculiar reason we have had three huge ovarian cysts to deal with in the past couple of weeks. Each one proved to be a cystadenoma of considerable proportions, also a run of adults presenting with undescended testes. It is always surprising to me how things seem to go in runs. Another run has been anal condylomata in men, of considerable proportions which makes me think they may be AIDS related because every infection in those afflicted seems to run riot, as also happens with vaginal condylomata in women. These patients are in need of extensive cauterization, and in the case of the males, it rather makes me suspect that there is a lot more homosexual activity in Uganda than is usually admitted. However one of the real surprises this week was a chap I was called to see, who was involved in a fight after a drinking bout, and who complained of abdominal pain after he had been clobbered with the proverbial blunt instrument in the lower abdomen a couple of days before admission. They had tried to catheterize him, but had got nothing for their pains, then they had aspirated the abdomen and obtained urine. It was pretty obvious that he had a ruptured bladder, confirmed at surgery when a large rent in that organ was cobbled together after evacuating two days of urine from the abdominal cavity. He's doing fine so far, but I guess that he must have been hit when, after a good few drinks of the local beer, he had a very full bladder to make it possible to have such a very large tear in it.

December 10th

One of the Asian members of the Tororo community, a Hindu, has died of AIDS - this is a first amongst the Asian people in Tororo and their community is rather understandably upset. I saw this young man first, with a very nasty attack of herpes zoster involving the whole right arm, this happened very shortly after he'd been married, so I was not greatly surprised when his first born infant died very shortly after birth. His wife has a second child, who is now a couple of weeks old, but looks much better than the first baby when born. The lady members of the golf club are all very worried since his death, Wilson my caddie tells me that evidently before he was married, he was a bit of a rake and womanizer, and he played a lot of golf and other 'sports' of the indoor variety with the lady members I am told, so it seems a possible mini-epidemic of the disease will break out amongst the members of the golf club in the not too distant future.

The golf club itself is well worth a brief mention. It was opened in the very early 50's, having been designed by a Mr. Cameron, who was the District Administrator I am told - trust a good Scot to have founded a golf club. It must have been just beautiful originally, with water piped individually to each green, and the holes lined with jacaranda, flamboyant, and fig trees. The club house itself was a lovely low building which had indoor facilities for badminton, billiards, and the performance of plays and skits, while outside there was a swimming pool and five tennis courts. Since independence it all fell into decay, with the club house windows all broken, the roof leaking, the tennis courts almost unplayable and the swimming pool a green slimy surface, through which even the frogs who live in it can hardly penetrate. This past three years there has been a real effort to rehabilitate it, the club house has a bar which is very well patronized by the members, but many of whom run up large bills which they have little hope of paying off. When the bills are found to be outstanding for six months or more, the committee moves and bans that member till he pays up. I gave them a motor-mower shortly after I came to Tororo, to try and bring the greens back to some semblance of playability, but they had it broken before the first month was out, so went back to the hand mower I had originally given them, and which is a superb advertisement for English "Qualcast" mowers, as it is still working after a couple of years! Lothar Schnell the German, road engineer, has learned to play golf after a fashion, and we go out on Sunday mornings for our 18 holes; Lothar has made himself responsible for maintaining the large mower used on the fairways, and admits that it is almost a full time job, because after every mowing, some part of it needs fixing. I have also played with some of the Ugandan members on occasions, but they are far too competitive for my liking, and always want to play for money. They take their game very seriously, and though they have some rather unique golf styles, they all seem to have a very good ‘eye for the ball', and usually manage to hit it well, taking great pride in the distance they can hit. One of the local hazards that I always find amusing is that the monkeys sometimes come out on the course, and tend to swipe the balls if they come anywhere close by, and it is very amusing to see an irate person chasing a monkey who's made off with the ball.

There was a British expatriate, an accountant working with the World Bank, David Jackson, whose job was looking after the finances of the Agricultural Development Programme in Tororo. Well, he was a very keen golfer, and wished to get the club and the golf course into some semblance of order with real fiscal responsibility, so he became a member of the Committee, and took the post of treasurer. He was horrified when he saw the state of the books and the finances, and set about trying to put things to rights, but I fear that in the process managed to antagonize the majority of members who wanted no Msungus telling them what to do, or how to run their affairs. Though for a very short time he did have the place running very well, with the fuel for the tractor which pulled the mower always paid off after each grass cutting, the bar bills all sorted out, most of the club members dues paid up and it seemed as though things were going to work in future. However there was eventually a rebellion engineered by some of the members who had been kicked out because of non-payment of dues and bar bills, accusing poor Jackson of spoiling the 'Fellowship' of the club, and accusing him of breaking the rules and going contrary to the constitution of the golf club, though quite

how they made this out was really a mystery to most of us, and within a very short time, the club was back to square one, and in debt as usual, but they maintained that the good 'Fellowship' of the club and its members had been preserved - perhaps it had been, in their eyes at least.

Finally, I have a delightful young caddie named Wilson, who is the most scrupulously honest young lad, and who looks after the golf bag as though it was his own. If a ball is lost and has to be abandoned, he will often go back after hours and find it for me - so far I've only lost one ball. Wilson has a real sense of humour, and a realization of what Western medicine can do, often bringing patients with deformities or hare lips for me to see. However he still has a firm belief in the witch doctors' powers, often regaling me with their feats. Recently he told me of an elderly man who was asked to give a younger man a lift on his bicycle. He agreed to do this if the young man was to do the pedalling, and he would sit on the pillion, and off they went. When the came to a small store, the young man asked his pillion passenger to nip into the store to buy him some cigarettes, but then made off with the old gent's bicycle. So a witch doctor was consulted, and a spell duly put on the thief, which was that he would not be able to eat or sleep, because he'd hear the bicycle bell ringing in his stomach! It turned out that the thief did loose weight, and could not sleep, and after a couple of weeks of this consulted the witch doctor, who said he'd lift the spell, but it meant returning the stolen bike, and payment to the witch doctor of two cows. The old man who owned the bicycle was not charged for the service rendered, and the witch doctor has put it about that he'll do the same for anyone else in the area who has had property stolen from them.

On the other hand I am not sure if I documented the fact that Wilson on one occasion consulted a lady healer of some repute when he was suffering from abdominal pain and anorexia himself. He was in the garden telling me of this, saying that the healer had scraped his skin over the liver area, and had "removed a stone", which he showed me. Then rather remarkably at this point in his story, he fainted, falling on the grass. He came to very quickly, but I found that he was quite jaundiced when I examined him, obviously suffering from hepatitis, so had a few weeks off work and bed-rest prescribed. Though I think he still believes that his recovery was entirely due to the 'stone' having been removed, rather than the effects of bed rest etc..

December 22nd.

Well, it is the end of my formally working in Tororo. Christmas is almost here, and yesterday was my last operating day - all very routine cases, three children with hernias, a sequestrectomy, and a couple of cases of chronic salpingitis. However we had a remarkable triad of paediatric cases the past week: a case of Guillan Barre syndrome, following measles it seems, a case of pseudohypertrophic muscular dystrophy, and a case of recurrent parotitis in a child of seven. Dr. Busulwa has certainly had a very good experience in his Tororo rotation, and he is a young doctor who shows the greatest potential of any of the students except for George Welishe. George is that much older, and his experience shows in all he undertakes. If only these two young doctors are given

the chance, and in due course given faculty positions, then I think that the programme might survive with some credibility. Stephen Tuunde is going to push for this, and I only hope that he has better luck than I had with the first two graduates. Dr. Dhikusoka, is only fair, and would not be the best as a post-graduate trainer, but it does look as though he might be posted to Tororo to fill in temporarily, but I hope in no more than a stop-gap capacity. Bernard Odu is now in charge of T.B. and Leprosy in the Kumi area, which is quite a promotion, and he will be very useful in teaching the community practice aspects and problems of these conditions, specially T.B. which is escalating because of the AIDS epidemic, like wildfire, and becoming one of the major public health problems of the future, and I cannot help but think that the Ministry of Health is going to have to consider adding AIDS to the duties of the T.B., Leprosy appointments.

I have just had the car licensed for the coming year, and what a palaver! First I had to get a vehicle inspection done, and this took three trips to Mbale, as the policeman who did the tests was absent so often, but the fee for this test was 1,500 shillings (about $1.50.) and paying this took three trips to the bank and the licensing office before all the receipts were in order, and I could go and get the test. The test itself was a farce, the policeman first of all asked me to put on all the lights and indicators, then he took the car and went tearing out of the compound at an incredible speed, finally standing on the brakes causing the vehicle to skid for about 30 feet, then reversing furiously and standing on the brakes again. He then went off on his own, out of sight for about 15 minutes, and came racing back to stand on the brakes, skidding to a stop once more, following which he declared that it was road worthy and gave me the certificate. A final visit to the licensing office, and they wanted me to take the cheque to the bank and come back in two days once it had gone through the bank, and been cleared, to get the licence. Talk about a labour intensive society.

The next few weeks are going to be spent in writing up the report for the Ministry of Health, the University, and for CIDA. I will also be going to Kampala a bit more often to try to get them moving on faculty appointments and funding for the programme in future. Also, I have promised to work in the hospital at Kitovu, in order to let Sister Maura Lynch go on vacation. The first Christmas we spent in Uganda, we spent at Kitovu, as I thought it would be an almost ideal hospital to send our postgraduates to, indeed I still think so, and have recommended that the surgery and obstetrical rotations might well be done there. Anyway it is a hospital run by a group of nuns known as Medical Missionaries of Mary, Maura is the surgeon there, and has more than enough to do, but the place is so much better run and organized that the government hospitals, and there are lab facilities to do the HIV testing etc..

January 10th, 1994.

Christmas has come and gone, and we spent the day with Joan Linnaker at the Salvation Army Boy's home, as we've done for the past four years now. Doreen had our Christmas Dinner and celebration on Boxing Day, which is a minor tradition in Tororo now, and on this occasion, the turkey which we'd managed to get was put in the oven

whole, and had not been cut into three pieces as it was last year- no reconstructive surgery required.

Then Doreen's sister Anne arrived for a visit on New Year's Eve, so we first took her to Usuk, to visit the Sisters there, and to see a truly African missionary approach to health care in the small unit run be Sister Barbara. Barbara is only about 73, a British trained nurse and midwife, who in her retirement has begun a health care and maternity centre, way out in the bush. She does about five hundred deliveries a year, and treats most of the people for AIDS or other medical conditions which she can manage together with three other nuns working with her. In the process she's training the African midwives as well, but the most intriguing aspect of her work is that she's built a number of well appointed mud huts, which serve as 'wards'. The incredible selfless devotion of these people never fails to make one extremely humble, and to see what is achieved with almost nothing other than locally made buildings etc. is astonishing.

Following the visit to Usuk, we went to the National Park at Mweya, and showed Anne the marvellous wildlife of the area. We were accompanied by a delightful young Irish lad, a friend of Julie who is the Australian nurse at St. Anthony's hospital. This National Park is one of the most beautiful of all in Africa I am sure, with the Rwenzori mountains in the background, and these two lovely lakes, Lake George and Lake Albert in the park itself. Not only that, but they say that there is the greatest 'bio-mass of animal life of all the National Parks at Mweya. However, as there are hundreds of hippos, that does not mean the greatest number of animals! This time we saw an amusing incident, in that a huge solitary female elephant moved away from us, and straddled a huge ant hill, proceeding to move back and forth, scratching her belly - I think it must have been a monstrous itch to have been felt through her skin.

On the way to Mweya, we developed a leaking radiator, the vibration wreaks havoc with the joints where the hoses fit, and with no garage nearby it was a real problem. However, a very good tip: I used crazy glue to put on the leak, and then a thin layer of fine soil, more crazy glue, and more sand, gradually building up a very water resistant seal which held all the way back to Kampala.

Anne left only yesterday, and we are in Kampala at present, and I am trying to arrange for the transport of a container to take some of our furniture and possessions back home once we leave for good. It has been a problem, but they promise to have it sent out for packing in the not too distant future, certainly before we leave to go to Kitovu.

January 20th.

Had an extraordinary thing happen last night: we have been packing things in boxes ready for the container when it comes, and I went over to the other house to put something over there, leaving Doreen sorting some papers in the bedroom of our house. When I got back, I noted that the door of the house was open, and vaguely wondered

why. However later in the evening Doreen asked me what I had done with our small short wave radio, the only electronic luxury we have, and after a short search found it was indeed missing, so someone must have been watching me in the dark, going over to the other house, then nipped in smartly and swiped the radio! Nothing else was stolen, but obviously the thief has an intimate knowledge of our house and habits, and suspicion rests on the gardener at present, though so far he's been so honest and good I just cannot believe it was him. When I went to the police next morning to report it, for what good it will do, I noted a burnt out car at the police station, and asked them what happened. They told me that the driver had hit someone and killed them, after which the angry bystanders beat up the driver, and the car and then set fire to it.

January 26th.

Further robberies: Father van Gessel, a Dutch priest working at Tororo Girls' School was robbed the other night. They had already tried and failed to steal the windshield of his car a few days before. This time they came in the wee small hours of the morning, and ransacked the place while he slept, however he did wake, and they dropped a whole lot of stuff on their way out. Next morning he went to the police they got tracker dogs, which I did not know they had, and found that they were led to one of the 'Askaris', who are the guards. He had a whole lot of the stolen stuff in his possession, and under police questioning, which at times is not any too gentle, they got the names of his two accomplices, one of whom they arrested, but the other managed to escape over the border to Kenya. There has been a real rash of thefts of late, but at least Father van Gessel got most of his stuff back.

Then we had an extraordinary visit from a chap who was passing himself off as a policeman, even flashing an identity card. We had two previous experiences with this chap, the first time he said he was investigating a hit-and-run accident which he said occurred outside Nsambya hospital, and someone had said they saw our car passing that day, so he asked if we'd seen the accident. The next time was just before Christmas when he came with a long story about the Revenue Officers having impounded his mattress which he'd purchased in Kenya, and he needed a loan of 10,000/- ($10.) in order to get it back, promising to pay me back as soon as he got his pay. Doreen was a little mad with me for having given him the money, but his story sounded fairly convincing. This time he presented himself, after we'd received a phone call allegedly from the police station at Mbale saying that one of the drivers from Nsambya hospital had been arrested after an accident in which a child had been injured. The caller went on to state that Sister Miriam Duggan had sent one of the other drivers from Kampala with 500,000/- bail money, and if that was not enough could I pay the rest and give it to the policeman, John Waba, and Dr. Duggan would reimburse me later. It all sounded very fishy indeed. Well, John Waba eventually presented himself, and proved to be the chap we'd had previous dealings with, so we asked him to wait the arrival of the driver with the money from Nsambya. We were told that the bail set had to be paid before the close of the magistrates office at Mbale, but we insisted that he wait the arrival of the money, and if the magistrate's office was closed for the day, then next day would do, though he

said that the magistrate would not be there next day. However, after a bit of a wait, John Waba said he'd go and wait at the local police station, and we could let him know when the money arrived. We saw no more of him, however we learned later that Julie, who'd met him with me at the post office when he first arrived, went to visit a friend out at Butiru, some miles away, and found that this character was out there asking the Dutch priest for money to take a prisoner back to Mbale! Father Hank thereupon got the local police who arrested him, and we've not heard of him since. Needless to say Nsambya had no word of one of their drivers being sent to Mbale, let alone being arrested there. A finale was told us by Father van Gessel, who had a similar experience a year or so ago, when this guy came to him with a story that there had been a hold up in which a couple of African priests had been injured, and their car damaged. This time he was looking for money to get the car towed back to Tororo. When he was refused, he went off to another couple of Dutch Priests, Father Wilm and his brother, and there he was given some money! His stories are really quite remarkable, ingenious and elaborate, he'd do better writing fiction.

February 5th.

I held our last seminar with the postgraduate students the other day, and we all had tea with the Dean. They gave presentations for both Doreen and I, which was quite touching. Doreen got a lovely dress done in local materials, and they gave me a Kansu, a garment worn primarily by elderly men these days! It is rather a sad time in some ways, and I only wish that the teaching project was a little more secure on its foundations, however, given the circumstance prevailing I guess that one could have done very little more. If the project had started two years after it did, more might have been accomplished by the time we left, as things are so much better these days, but anyway it does not do to grieve too much over 'might have beens'.

There was an astonishing story in the local newspaper recently, entitled "Giant Rat". The gist of it was that a couple had a terrible row when a husband thought his wife had stolen some money and some items of a woman's underwear from him, which he'd hidden. In the ensuing fracas, the baby was killed, and the wife went off to the witch doctor to make him impotent. They then preceded to bury the baby, and when digging the grave, they uncovered the money and garments in the hole of a giant rat!! These rats are an edible delicacy - I'm not sure exactly what they are, but they are rare and much prized as a Ugandan gourmet meal. The story ends up with relatives and friends all having very much enjoyed the meal!

The container arrived in due course, and was packed up as well as we could, and is now on its way to Mombasa. While packing, we had a large wooden box with some of my books and electrical equipment, which was quite heavy - the driver pointed to it and remarked to his co-driver 'Sanduke yake' - his coffin!

February 20th.

We have been in Kitovu for a week now, and it has been hectic. They have a super ultrasound machine, a Philips, with print-out and using only paper, and everything included, and it is fabulous to use compared with the one I have at Tororo, with much clearer definition, a real joy to use. The first day we did a major round, getting to know the patients, and the first operating day was very busy, the worst case being a lass who'd had a ruptured uterus after four day in labour, she was grossly infected with a hydrocephalic baby. Next day there was the delivery of twins followed by a Cesarean section in a primipara, then a child with an imperforate anus for which a simple colostomy was done as it seemed a complete atresia of the rectum. Then we had a lady with cerebral malaria, and the rash of herpes, so almost certainly AIDS related, but she was pregnant and at term, and is presently on I.V quinine. On Friday we had 3 sections, one following a symphysiotomy, done by one of the interns (they do a lot of symphysiotomies here in an attempt to avoid sections, and I'm not sure I agree with the procedure at all, even here) she had a stillborn infant in the end. Then the usual hernias, skin grafting etc., and last but not least a poor chap who'd been stabbed on the apex of his lung, and who needed underwater drainage, but nothing more extensive thank goodness.

On Saturday, we went Kampala to say a final farewell to Sister Margie Conroy from Karamoja, who has been such a good friend these past years. She's been posted to Kenya in charge of the Presentation Sisters there. Margie is originally from Newfoundland, but has worked in Kenya and Uganda for a very long time now, and usually in the more remote and less hospitable postings. Her last posting in Karamoja was, I should think, one of the most taxing of all. The unique and rather unpredictable Karamajong tribe, who are resisting to the last the inevitable change in their traditional way of life, and who are going down, fighting to the very end, trying to preserve their 'cattle culture'. These people believe that every cow is theirs by right, and if possession is disputed by some other tribe who may own cattle, they feel perfectly justified in stealing and killing in the process if necessary. As a result, they have always been at war with their neighbours, particularly the Atesot tribe, and carry on their cattle raids to this day; what is so different today is that in the past they only had spears and bows and arrows, and it was a limited number of people they could kill in any cattle raid, but to-day with automatic firearms it is a very different matter indeed. Not only that, but darkness usually curtailed their raiding activities and confined these to the daylight hours, but now they have taken to night raids on their neighbours and set light to the thorn bush fencing round the villages, and as the inhabitants emerge, they are mown down with automatic fire directed along the beams of powerful flashlights. The only hours when they seem less active, are the small hours of the morning, and as a result, when any of the Sisters have to travel to Kampala, they get up at 3 am, and drive in the darkness, usually arriving at our house in time for breakfast. However recently one of the nuns who came from Argentina very recently, was killed on her way to the airport in the early hours of the morning a few days ago, so I guess that no time is a completely safe time to travel. Hold-ups on the Entebbe airport road are becoming all too frequent recently, because they seem to have learned that people leaving the country, even on holiday, seem to have money or other valuables worth stealing.

It now feels very much that we are definitely coming to the end of the five years, and in doing the last two weeks in Kitovu it is certainly ending with a flourish, but I'm glad to leave Uganda knowing that I can still do an honest days work, and take my share of 'on-call', though I must admit that in future I wouldn't like to look forward to having to do it for any great length of time!

February 29th.

Back in Tororo for the very last few days, to pay up all the bills to date, and close the houses, hand the keys and vehicle to Stephen Tuunde. I shall miss the old car no end, it has done faithful service indeed, over the five years it clocked 160,000 Kms on the odometer, and never really let me down once, other than the terrible night of the accident.

The last few days in Kitovu were busy and fascinating as the practice of medicine always is out here. The pregnant lady with cerebral malaria died very shortly after going into spontaneous labour and delivering a live infant, even though she remained deeply unconscious; the relatives took the baby home, but I feel the chances of its survival are negligible. I saw the very first strangulated umbilical hernia I've ever seen on my last operating day. She was huge, just fitting on the operating table, with an irreducible umbilical hernia that was easy enough to put back surgically, though both the anaesthesia induction and the final closure of the wound were mildly problematic. Then we had a lady whose home had been robbed, and who'd been hit in the forearm with a panga, severing all the extensor tendons of her forearm, and fracturing the radius - the repair was a very long procedure, and I left before I could see the end-result, though she could move every finger before leaving the operating room. One of the really sad cases was a child of ten, who'd been in hospital when I first arrived in Kitovu; He had sustained a fracture of the upper end of the humerus after being struck by his teacher. The fracture became infected, and he now has a septic joint and what looks like the beginning of osteomyelitis setting in.

On our return to Tororo we found that our house had been broken into in our absence, and once again the thief entered by taking the burglar bars and window panes out, and ripping the mosquito netting. However Richard the gardener, heard something and saw the thief moving about in the house after he'd broken into the place, and managed to hit him on the head with an iron bar as he emerged to take his loot outside. Richard called the neighbours, missionaries from next door, who nailed up the window for us. The loot which had been piled up ready to be stolen was quite an odd assortment, but we'd pretty well emptied the house and packed most things other than the furniture, even taking the mattresses off the beds, just before we left for Kitovu. He had piled up a case of milk cartons, an unopened box of 'Omo' soap powder, a kettle, an assortment of glasses which we were giving to Wolfgang, the optometrist, a very old pair of my shoes and other odds and ends.

March 16th.

We are due to fly out to-morrow morning, so this is the very last entry. Just before leaving Tororo, we hardly had a single meal at home, what with farewells etc.. The whole crowd of Msungus, managed to have a surprise party for us, that was a true surprise in every way - even Doreen suspected nothing until we were right at the door of Manfred's house where it was being held. We were lured there in the pouring rain by Julie who we were supposed to be taking home to St. Anthony's Hospital, she had asked us to call in at Manfred's where she said she'd left something, and on our arrival, there was the whole crowd there, but it was a lovely party for all that. The hospital staff also gave us an elaborate send off, with the member of parliament for the area, the District Administrator, the District Executive Secretary, and other 'Big-Wheels' in the Tororo area. There was a presentation of gifts - and we are already overloaded with excess baggage!

To-day the Sisters at Nsambya had a special meal for us, and presented us with a huge drum to take home. We are already well overweight with our baggage, and how we are going to handle this huge drum as well, and whether the airlines will allow us to take it remains to be seen.

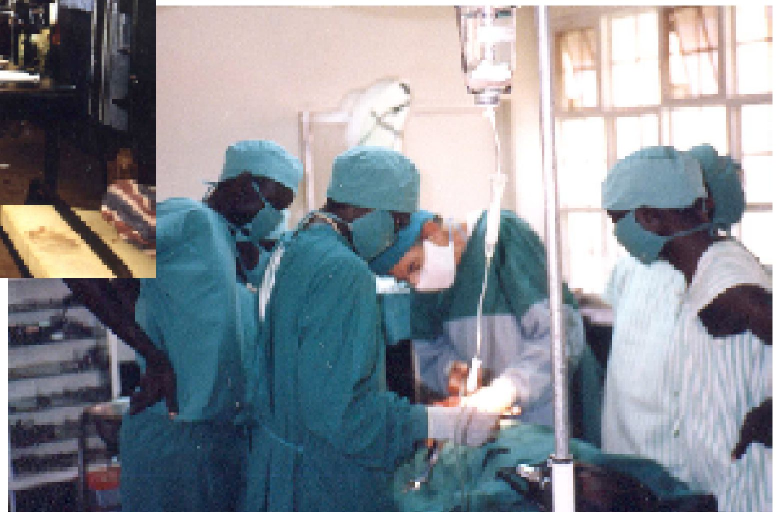
In retrospect one cannot help but wonder what the five years here has achieved- Whether the teaching programme, or the cost-sharing programme will survive in the long run. The five years have been nothing if not a fascinating experience, from which Doreen and I have gained immeasurably, and probably much more than our African students, friends and colleagues. In the last analysis it is the people of Africa who will have to make it on their own, and in their own way, and all we can do is to try to understand the problems they face, and help them, if we can, to make the very most of their limited resources. One thing this experience has taught me, is that one can do a very great deal with the very limited technological facilities available in a developing country. The armamentarium of drugs required is also limited, and the majority of the most useful ones are not very expensive. Without the medical demands of an aging population, or people whose lifestyle predisposes to cardiovascular or other self-inflicted diseases, the level of useful technology required beyond one's own clinical skills is really very limited. Of course, the worst health problems still facing most tropical developing countries, are mostly amenable to improvements in public health, hygiene and basic education. All except AIDS that is, and I see no real way of controlling it until an effective treatment is developed, and even then if it ever is, Africa, or other developing countries will still be the last to benefit.

The Ross residence in the Tororo Hospital compound.

The garden hut, Doreen and ‘Gandalf.’

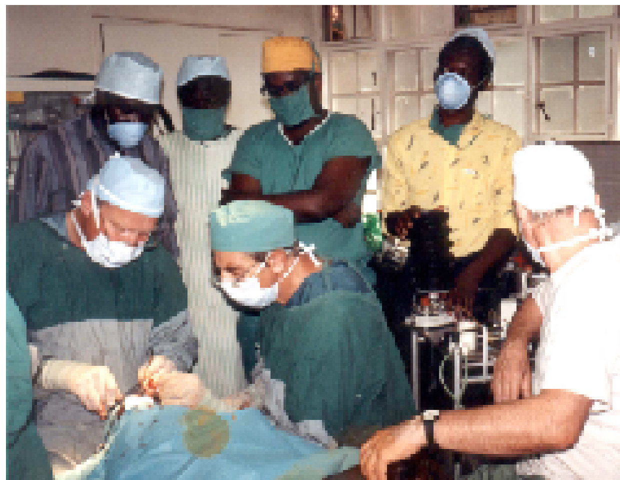
Doreen straddling the Equator at South Buganda.

The Tororo Hospital male ward as it was in 1990.

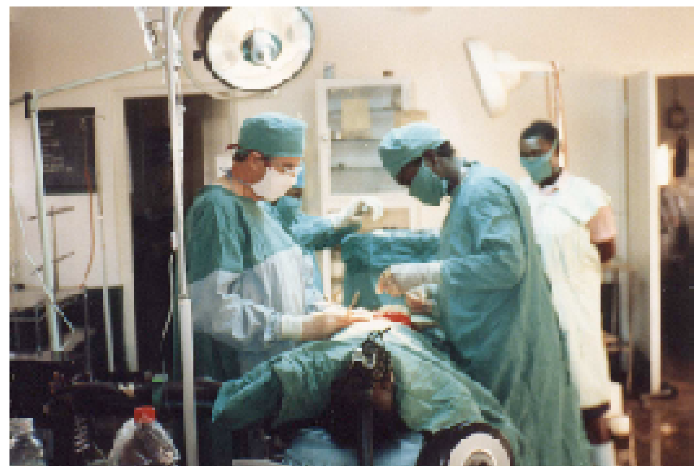


The operating room at Tororo.

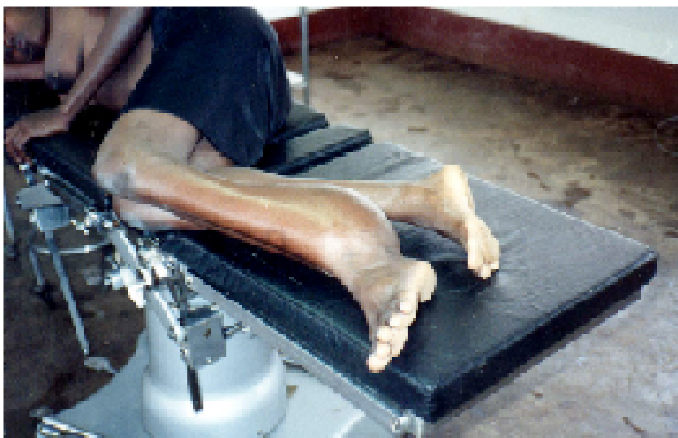
John with residents:
Front: Drs. Dhibusoka, Mary Amongin, Matenyo
Back: Drs. Hdoleerie, Kahaarusa, Odu.



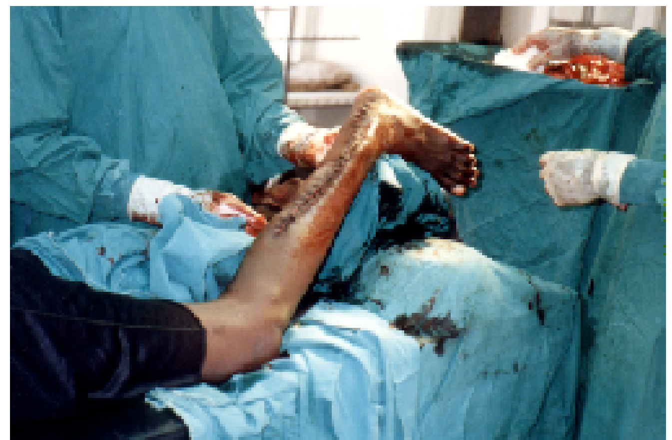
Dutch plastic surgeon Rein Zeeman operates assisted by John and Gys Witte whilst residents watch.



Dr. Odu, a resident. operates while John asssists.



A synovioma of left leg.



Post operative appearence after removal.

Elizabeth Mate, a MUN medical student on an elective joins a group of residents during a teaching break.

Josephine, John's invaluable secretary who also sterilized his instruments.

Dr. Stephen Tuunde.

John's operating room boots outside the OR at Tororo, drying off after being washed.

Wives outside the ward cooking for their relatives.

'Neighbours" coming to collect water from the Ross residence with the 'Tororo Rock' in the background.

Downtown Tororo - the taxi rank.

John meets with relatives of one of the Tororo Hospital staff.

Mozes, with a group of handicapped persons at a residential rehabilitation centre near Kampala

Moses on a borrowed tricycle. Moses had polio as a baby and was found on a gar - bage dump where crows pecking at his skull had made a lar ge indentation.

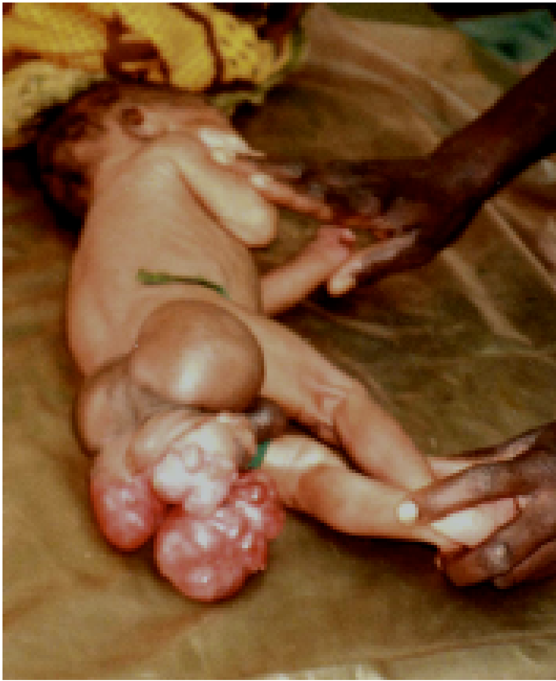
John with the head nurse at the Kitovu Hospital.

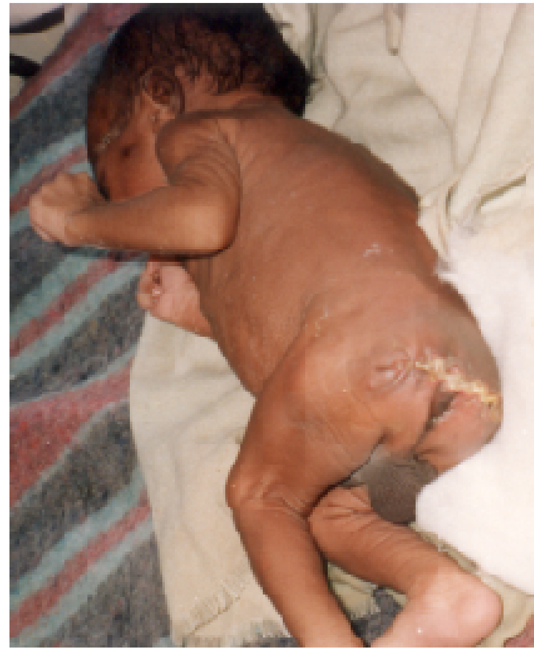
The new Mulago Hospital of Makerere University in downtown Kampala.

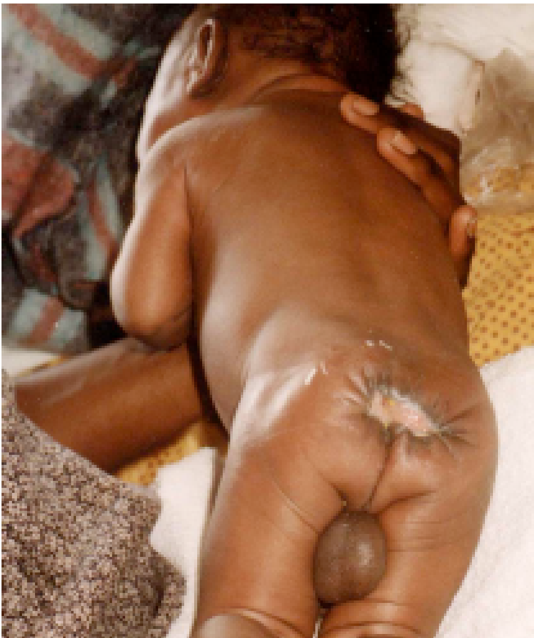
A ward at the Mulago Hospital.

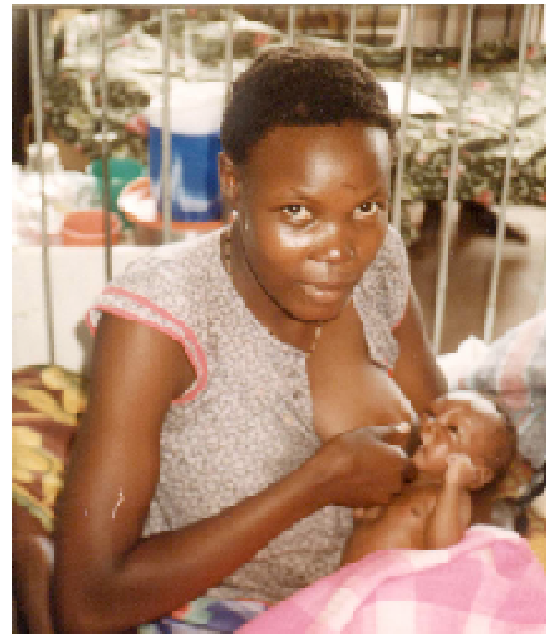
Doreen and the nursing staff at Kitovu Hospital.

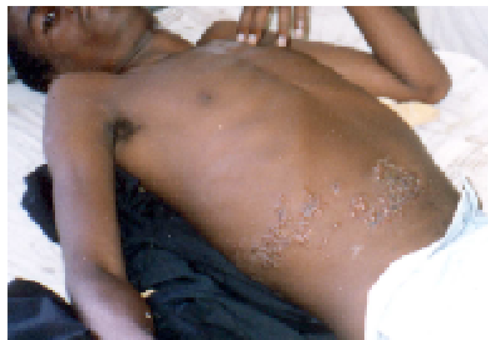
The Rotary bicycles arrive at last!


An incomplete Siamese twin.


1 week postoperative.


2 months postoperative. prior to skin grafting.


Feeding after surgery.


An AIDS patient with herpes zoster.

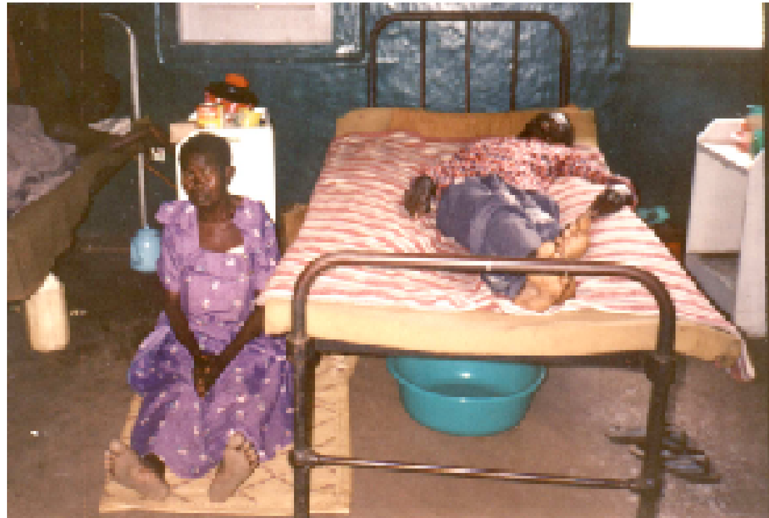
Hippos and water buffaloes.

John finds a dead lizard by the roadside.

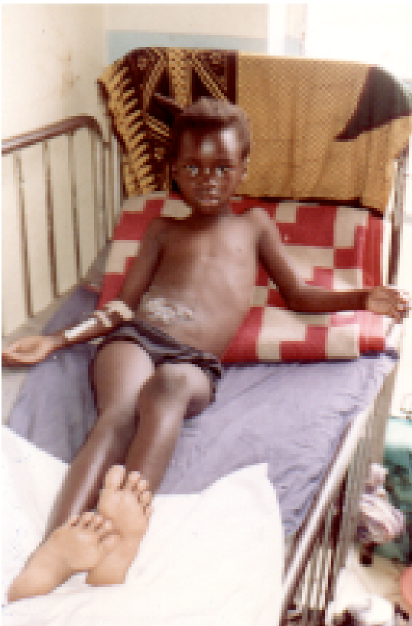
Mother and child? Father and son?.

"There's a hippopotamus at the bottom of my garden."

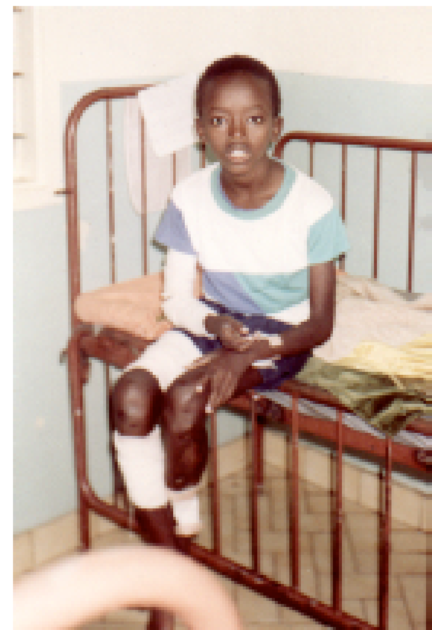
What sort of illustrated African Diary would this be without a picture of elephants?



A wife looking after her husband whilst he is in hospital.



Two young AIDS victims in
Nysambia Hospital
-now dead.



A rainbow over the 'T ororo Rock.'