INTERPLAST HOLLAND
surgical camp
Zanzibar, Tanzania

2 Februari – 14 Februari 2026

Team members:

Jurjen Oosterhuis	anaesthetist
Maura Neervoort	anaesthetic nurse
Jolanda Eskes	operating theatre nurse
Elmarie van der Merwe	paediatric urologist (Birmingham)
Ed Hartman	plastic surgeon
Tallechien Tempelman	plastic surgeon (teamleader, report)

Kivunge Hospital

Introduction

This surgical camp started differently from previous years. In 2025 the planned surgical camp did not take place. Mnazi Mmoja Hospital was – and still is – undergoing major renovations, and the temporary alternative setting presented significant challenges for safe surgical and peri-operative care. In consultation with our local colleagues, it was decided not to proceed at that time.

In 2026 we were able to resume collaboration. As Mnazi Mmoja remains under renovation, this surgical camp took place at Kivunge Hospital. We knew beforehand that this would likely mean fewer patients and more logistical unpredictability. Interplast Holland has been coming to Zanzibar since 2009, and over the years Mnazi Mmoja had become a familiar environment, with known colleagues and established routines. Working at a different location inevitably meant starting again in some respects. We were curious to see how this new setting would work in practice.

Unfortunately, Liam was unable to join the surgical camp shortly before departure. We were grateful that Elmarie was willing to step in and travel to Zanzibar at such short notice. She remained with the team for the first week and a half of the surgical camp and made a significant contribution to the paediatric urology programme.

Arrival at Kivunge Hospital, welcoming the team at the start of the surgical camp

Liam, a valued member of the team, who was unable to join

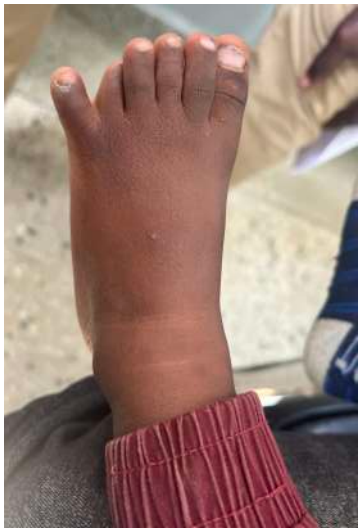
Screening and Indication

Screening and Indication

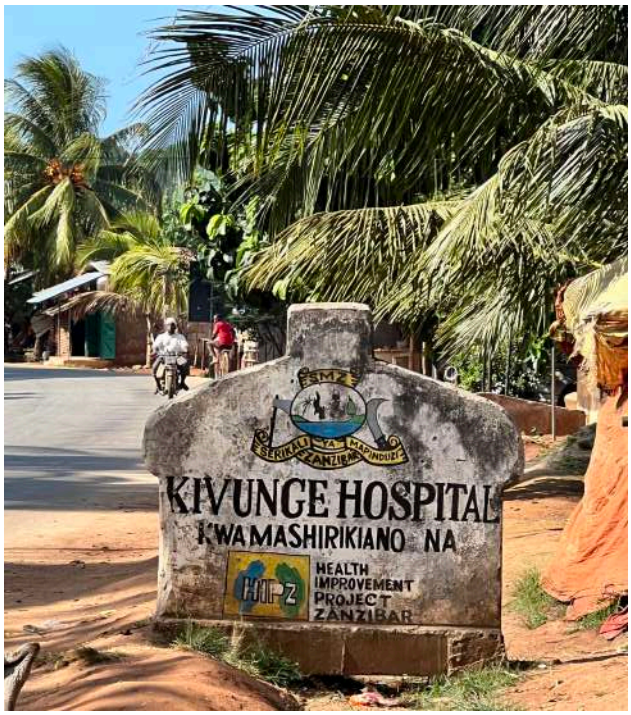
Screening sessions ran smoothly and were well organised together with our local colleagues. Patients were first assessed by Dr Rukia, after which indications were discussed jointly. It was reassuring to see that her initial assessments frequently aligned with our own clinical judgement.

Several patients were not accepted for surgery after careful consideration, emphasising that appropriate indication is as important as operative technique. The discussions allowed space to weigh expected functional benefit against the complexity of procedures in the local context.

Additional patients continued to present in the days following the formal screening sessions and were assessed in the same manner.



The Setting – Kivunge Hospital



Kivunge Hospital includes both newer and older sections, and in several respects appeared more recently developed than what we were used to at Mnazi Mmoja. One of the operating theatres we were allowed to use was clearly modern and well maintained. However, as Interplast customarily works with two operating tables in parallel, and only one of the newer theatres was available, we chose to work in a larger theatre space that allowed this setup. This did mean working in a theatre that was older and showed more signs of wear, similar to what we had previously experienced at Mnazi Mmoja.

Parts of the infrastructure showed signs of intensive use. Instrument sterilisation and packaging required close attention. Occasionally, sterile sets arrived with tears in the wrapping, damp paper, or an instrument protruding through the packaging. Surgical gowns and drapes still carried visible stains from previous use. At the same time, footwear regulations were taken very seriously, which created an interesting contrast. Despite these observations, postoperative infections remained strikingly rare, as we have also experienced in previous surgical camps.

Scrub facilities in the theatre complex, with intermittent water supply

Power cuts were frequent. More than once, the electricity failed precisely at the moment we attempted to review an X-ray, leading to the running joke that perhaps the computer itself was responsible. Fortunately, two independent operating lamps with built-in batteries proved extremely useful. Unlike earlier years, when we occasionally had to use mobile phone torches to illuminate the field, this was no longer necessary and procedures could continue uninterrupted.

On the first operative day we discovered that the bipolar diathermy unit was not functioning. As we were accustomed to working with two units when running parallel tables, this initially limited our programme. A functioning unit was arranged the following day.

One day stood out for an entirely different reason: the operating theatre was unexpectedly visited by a considerable number of flies. The theatre doors did not close tightly and contained visible gaps, which made keeping insects out difficult. The flies were not only attracted to the operating field but occasionally chose a less sterile target — landing on the surgeon's ear and causing momentary distraction. Fortunately, Maura already possessed well-developed fly-catching skills and quietly took care of the situation whenever needed. It became an unusual but very practical addition to her anaesthetic responsibilities.

Two operating tables running simultaneously in the same operating theatre

Team and Local Collaboration

Our team consisted of Jurjen Oosterhuis (anaesthetist), Maura Neervoort (anaesthetic nurse), Jolanda Eskes (operating theatre nurse), Elmarie van der Merwe (paediatric urologist), Ed Harman (plastic surgeon), and myself (plastic surgeon).

Locally, we worked primarily with Dr Rukia, dr Elisabeth and dr Kalkidan.

Rukia and Elisabeth, both currently undertaking further training in plastic surgery in Dar es Salaam

Kalkidan, our colleague from Ethiopia, involved throughout the mission and in ongoing postoperative follow-up.

As in previous years, collaboration with Rukia formed an important foundation for the surgical camp. Screening sessions were well organised and indications were discussed jointly. Several patients were not accepted for surgery after careful consideration, underlining that appropriate indication is as important as operative technique.

Operating was frequently done together, with local colleagues taking the lead where possible. Discussions during procedures — particularly in hand surgery — allowed for exchange of anatomical and technical considerations. For most procedures, it was evident that both knowledge and surgical skill are well established. In more specialised hand surgical cases, there remains room for further development, and these moments provided opportunity for targeted teaching.

Kalkidan continues to play an important role in postoperative care. Now, weeks after the surgical camp, regular contact is still ongoing regarding individual cases, occasionally leading to adjustments in previously agreed treatment plans. This continued communication makes follow-up a shared responsibility rather than a

closed chapter after departure, and reflects a collaborative and constructive working relationship.

Over the years we have come to know our colleagues not only in the operating theatre but also outside the hospital. During our stay we were kindly invited to dinner at Rukia's home, where she lives with her mother, as we were last year — a warm gesture of hospitality. They had clearly put great effort into preparing a delicious meal, which we greatly appreciated.

Collaboration and Knowledge Exchange

Kalkidan performing surgery, assisted by Elmarie

Teaching hand anatomy with local colleagues

Patient Numbers and Case Mix

This year 81 patients were screened in total.

Plastic Surgery

41 patients were screened; 21 were treated. The majority concerned post-burn contractures, followed by congenital conditions and post-traumatic cases.

Complications were limited to one axillary wound dehiscence and one moist wound after syndactyly release.

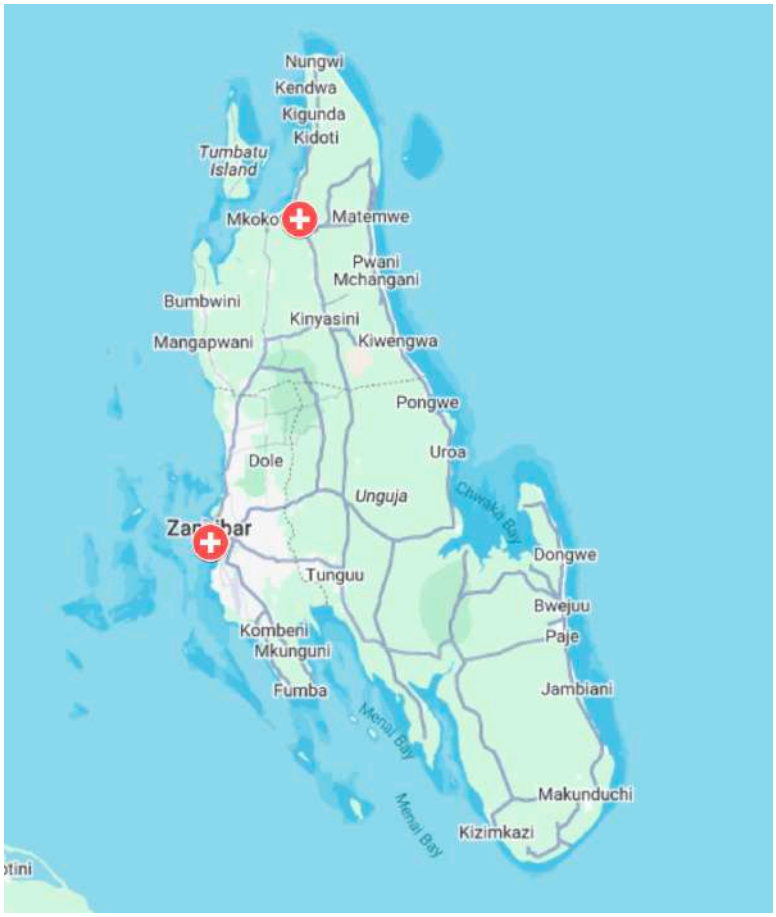
In one case of polydactyly correction, the intra-operative anatomy required modification of the initial surgical plan. In the absence of intra-operative imaging, the resection was more extensive than originally anticipated. The postoperative course was uncomplicated, and early follow-up showed satisfactory function.

Paediatric Urology

40 patients were screened; 27 underwent surgery. Indications included hypospadias (12), urethral fistula repair (9), urethral dilatation (4), labial adhesions (1) and one testicular mass. One patient was cancelled due to illness. Complications consisted mainly of early catheter dislodgement and one possible fistula.

Postoperative recovery in the corridor, where one recovery bed was shared when needed

Compared to some previous surgical camps, the number of patients were lower. This was partly related to the location of Kivunge Hospital in the northern part of the island. For many patients and families, travel from other regions of Zanzibar is too time-consuming, expensive and logistically challenging. In addition, communication about our arrival did not reach the island in the same structured way as in earlier years, when announcements were distributed via radio and local networks.



Clinical Highlight – Upper Limb Compartment Syndrome

One case deserves special mention. A nine-year-old boy presented with a severely swollen arm, oedema and bullae. The initial history was inconsistent; burns were mentioned, then trauma. On reassessment, and after removal of a tight circular dressing, the picture did not fit a burn injury.

Examination revealed sensory loss in the fingers and tense compartments. Doppler confirmed arterial flow. X-ray showed a comminuted olecranon fracture.

Given the clinical findings, extensive fasciotomies of the entire upper arm, forearm and hand compartments were performed. Intra-operatively the muscles appeared pale but viable and bulged after release, consistent with compartment pressure.

Postoperatively, muscle colour improved. Sensation returned to the fingertips and early thumb movement was observed.

We have encountered similar cases in previous surgical camps, often presenting much later as established Volkmann-type contractures, frequently associated with tight non-elastic bandaging or casting after trauma. In this case, earlier intervention may have prevented progression to permanent contracture.

Above: initial presentation prior to intervention

Right: Postoperative ward management with limb elevation and close monitoring

Over several years, we have observed that complications related to tight circumferential bandaging occur more frequently on the island than would be expected for what is generally considered a relatively uncommon condition. Histories sometimes suggest that initial treatment took place outside formal medical facilities, where rigid or non-elastic bandaging techniques may be applied. While the exact circumstances are not always fully clear, the recurring nature of these cases indicates that preventable post-traumatic contractures remain an important local challenge.

Each child receives a small toy after surgery, kindly collected throughout the year by Jolanda's mother

Education and Long-Term Impact

An encouraging moment during the surgical camp was the visit of Dr Juma, who previously received a scholarship through Interplast. He operated together with Rukia, who is currently supported in further plastic surgery training by Interplast. Seeing two locally trained surgeons working side by side illustrated the longer-term effect of sustained educational investment.

This surgical camp, perhaps more than previous ones, showed that high surgical numbers are not the only measure of impact. A slightly less pressured schedule allowed more time for explanation, joint decision-making and shared operating. When local colleagues perform procedures themselves, the effect extends far beyond the two weeks of a visiting team. Skills acquired and refined during such surgical camps enable continued treatment of many more patients throughout the year.

At the same time, it remains clear that for most procedures, knowledge and surgical ability are present. The main limitations are often practical: availability of appropriate instruments and suitable suture materials. Particularly in more delicate procedures, access to finer sutures would significantly improve operative precision and outcomes.

Leadership and Feedback

At the end of the surgical camp, a meeting was organised by Dr Justus, bringing together not only the clinical staff but also theatre nurses, runners, sterilisation staff and other supporting personnel. He openly addressed some of the organisational challenges encountered during the surgical camp and invited constructive feedback from everybody.

This open and structured dialogue was much appreciated. Rather than avoiding practical difficulties, there was a genuine willingness to listen and to reflect on what could be improved in the future. Such openness forms an important foundation for sustainable collaboration.

During this discussion it became clear that the smooth running of the programme depends heavily on the dedication of the extended theatre team. Their contribution is substantial, often involving long working days and additional responsibilities during a visiting surgical camp. For future surgical camps, attention to logistical support for this group — including reliable provision of meals, drinking water and appropriate recognition of their additional workload — would contribute significantly to continued high-quality collaboration.

Final Reflections

This surgical camp differed in volume and tempo compared to some earlier years. The slightly reduced number of cases created space for more detailed discussion, joint operating and reflection during the working days.

Perhaps the most meaningful difference, however, was the opportunity to work more closely alongside our local colleagues. Rather than focusing primarily on case numbers, this year emphasised shared responsibility and continuity of care. When local surgeons gain further experience and confidence, the impact extends well beyond the limited timeframe of a visiting team.

Sustainable collaboration is not measured solely by what is done during two weeks, but by what continues afterwards — in follow-up, in independent procedures and in ongoing professional contact throughout the year.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