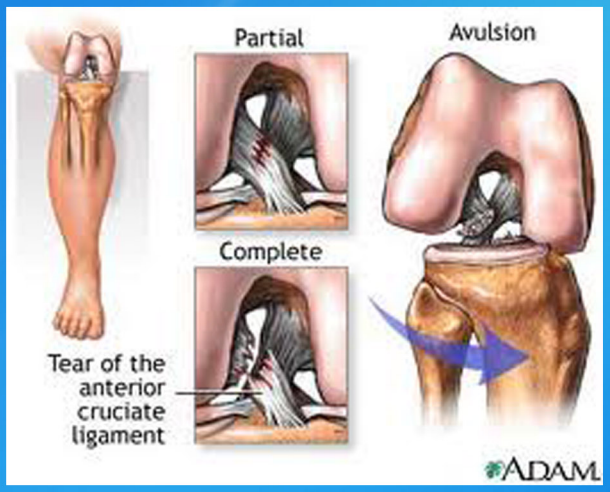
Ethiopian Society of Orthopaedics and Traumatology (ESOT)
Yearbook - II (2011)



ዝግጅት ክፍሉ

አሳታሚ
ኢትዮጵያን ሶሳይቲ አፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ (ኢሶት)

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ቴዎድሮስ አጥላው

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መስፍን ክበበው
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Dear Members, Colleagues and Partners:

I would like to thank you all for electing and giving me the privilege to serve you as a President this time. I am also glad to lead with the other pulsating executive committee members: Drs. Elias, Yiheyis, Fekadu, Tilahun, Zegene and Tadesse. Dr. Samuel and Bereket are in charge of editorial and electronic work.

Despite many challenges, in the last few years the orthopedic train of Ethiopia has been moving fast: Total joint replacement surgeries are started in our country, Arthroscopic surgery for sport injuries is in practice, more residents are applying to orthopedic training institutions, orthopedic implants are in a process of being included on national drug list, and many more. Above all, SIGN remained our main engine and young enthusiastic surgeons are the lead drivers. It changed everything! I have no enough words to thank Dr. Lewis the founder/president, Jeanne the CEO and all the SIGN staff. Thank SIGN now patients who were managed with horrible tractions for 4 months are now walking on the 4th day!

ESOT is closely working with the AMREF, Surgical Society of Ethiopia (SSE) and the FMoH in promoting surgery and makes it accessible to the underserved community. Our members traveled distances and operated on a number of patients organized for surgical camping. We founded NaPAN with other partners that work on prevention and treatment of Podoconiosis affecting our farmers.

This year as we are hosting College Of Surgeon of Eastern Central and Southern Africa (COSECSA) + ECSAOA meetings and ESOT is working hard with SSE to celebrate the COSECSA AGM from Dec 5 to 7, 2012 vibrantly! We expect over 1,000 surgeons from all over the world! I have a great believe that we will make this event unforgettable to all our guests.

Eligible private, NGO or government hospitals who are not yet accredited can use this opportunity to get accredited by COSECSA. I would also like to remind all orthopedic surgeons who are eligible to take orthopedic COSECSA exam to use this opportunity and become member of COSECSA by examination. Please contact ESOT office or SSE secretary.

One of the main pre-COSECSA CMEs this year is the International AO-Operative course for orthopedic surgeons and the AO-ORP course for orthopedic theatre Nurses. ESOT, together with AO-SEC for Africa, has already finalized and prepared the program. Congratulations!

Please mark your calendar (Dec 5 to 7, 2012) to attend and actively participate on the joint SSE and COSECSA AGM. Also follow for developments at www.cosecsa.org

Wish you a healthy prosperous future and stable, anatomic rigid fixation!

Biruk L. Wamisho,
M.D; FCS; Associate
Professor of Orthopedic Surgery.

Ethiopian Society of Orthopaedics and Traumatology (ESOT) Yearbook - I (2010)

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በኢትዮጵያ የአጥንት ህክምና ራሱን ችሎ መሰጠት ከጀመረበት እና ሥልጠናውም በከፍተኛ የትምህርት ተቋማት ዲፓርትመንት ተቋቁሞለት ባለሙያዎችን ማፍራት ከጀመረበት ጊዜ ወዲህ የህክምናው ፍላጎት እና ህክምናው በሚሰጥባቸው የጤና ተቋማት ላይ የሚፈጠረው ጫና ከጊዜ ወደ ጊዜ እየጨመረ ነው:: በአንጻሩ የህክምና አሰጣጡ እና በሙያው የሰለጠኑ ባለሙያዎች ቁጥር ከፍላጎቱ ጋር ያለው ልዩነት እጅግም ሲጠብ አይታይም:: ያም ሆኖ ከቅርብ ጊዜ ወዲህ እየታየ ያለው በህክምና ዘርፉ የሚያሰለጥኑ ተቋማት እና በሙያው መሰልጠን የሚፈልጉ ተማሪዎች ቁጥር እያደገ መምጣት፣ ህክምናውን የሚያግዙ መሳሪያዎች እና ህክምናውን የሚሰጡ የግል ሆስፒታሎች መፈጠር ለአጥንት ህክምና የተሰፋ ጊዜ እየመጣ መሆኑን ያሳያል::

የዚህ መጽሔት ዝግጅት ክፍል አባላት የአጥንት ህክምና በኢትዮጵያ ያለበትን ደረጃ ለማሳየት በሐገሪቱ በአምስት አቅጣጫዎች በሚገኙ ሆስፒታሎች ተዘዋውረን ህክምናው በአጠቃላይ ስላለበት ሁኔታ የሚያስቃኘውን ይህንን ዘገባ አዘጋጅተናል::

አንድ ለሚሊኖች

በመላው ኢትዮጵያ በዘመናዊ ሐኪሞች እና በሕክምናቸው ላይ ህዝቡ ያለው እምነት ዝቅተኛ ስለመሆኑ ብዙ ጥናቶች እና ምልከታዎች ያረጋግጣሉ:: በማናቸውም የህይወት ዘርፎች ህዝቡ የሥልጣኔ ቀደምትነት ቢኖረውም፣ በልማድ እና በባህል ይዞ ያቆያቸውን እምነቶቹን ትቶ ወደ ዘመናዊነትን እንዲመጣ ማድረግ ፈታኝ ሒደት ነው:: በአጥንት ህክምናም የታየው ሁኔታ ከዚህ የተለየ አይደለም:: በአብዛኛው የአገሪቱ ክፍል ህዝቡ የሚያጋጥሙትን የአጥንት እና የመገጣጠሚያ ችግሮች ሐኪም ዘንድ ሔዶ ከመፍታት ይልቅ በወጌሻዎች ታሽቶ እና ባህላዊ መድኃኒቶችን ተጠቅሞ መዳንን ይመርጣል::

“አብዛኛው በሽተኛ ሆስፒታል ይመጣል ማለት አንችልም፣” ይላሉ የድሬዳዋው ድል ጮራ ሆስፒታል የአጥንት ህክምና ክፍል ኃላፊ ዶ/ር ማንያዘዋል ደሴ በድሬዳዋ እና በዙሪያው ህብረተሰቡ ከህክምና መስጫ ተቋማት ይልቅ ለባህላዊ ሐኪሞች ያለውን አመኔታ ሲያስረዱ:: “አብዛኛው በሽተኛ ባህላዊ ሐኪሞች ጋር ተውጦ ይቀራል::” በሽተኞች ወይም አደጋ የደረሰባቸው ሰዎች የሆስፒታልን ደጃፍ የሚረግጡት ችግሮቻቸው ከተባባሱ እና መዳን አስቸጋሪ የሚሆንበት ደረጃ ላይ ከደረሱ በኋላ መሆኑንም ያነጋገርናቸው ሐኪሞች ይናገራሉ::

ያም ሆኖ ግን አሁን በየካባቢው እየተስፋፉ ባሉት የህክምና ተቋማት የሚሰጡት አገልግሎቶች በተለያዩ መንገዶች እየተዋወቁ በመምጣታቸው እና በሌሎችም ምክንያቶች የህክምና ፈላጊው ቁጥር ከጊዜ ወደ ጊዜ እየጨመረ መጥቷል:: ካነጋገርናቸው ባለሙያዎች ለመረዳት እንደቻልነው የአገልግሎቱ ፈላጊዎች ብዛት ከዓመት ዓመት ከፍ እያለ ነው:: የአጥንት ህክምና ከፍሉ አርሲ እና ባሌን ጨምሮ በዙሪያው ለሚኖሩ ወደ 3.5 ሚሊዮን ለሚደርሱ ሰዎች አገልግሎት እንደሚሠጥ የሚነገርለት የአሠላ ሪፈራል ሆስፒታል የአጥንት ህክምና ባለሙያ ዶ/ር ቃኘው ውብሸት በዚህ ሐሳብ ይስማማሉ፤ “ሰዉ ከባህላዊ የወጌሻ ህክምና ወደ ዘመናዊ ህክምና እየመጣ ነው:: ዘመናዊውን ህክምና የሚፈልጉት ተገልጋዮች ቁጥር የጨመረው ለህዝቡ የግንዛቤ ማስጨበጫ ተሠርቶ ሳይሆን በአጥንት ህክምናው በሚታዩ ውጤቶች አማካኝነት ነው::”

በወጌሻ ህክምና የሚፈጠሩት ውስብስብ ችግሮች በታካሚዎች ላይ ከሚያደርሱት ጉዳት እና በዘመናዊ የህክምና መስጫዎቹም ላይ ከሚፈጥሩት ጫና አኳያ የግንዛቤው ማደግ መልካም ሆኖ ሳለ፣ ይህንን ባህላዊ ህክምና ሸሽተው እና ዘመናዊውን ፈውስ ሸተው ወደ ጤና ተቋማት ለሚመጡት ታካሚዎች በሐገሪቱ ያለው የአጥንት ህክምና አገልግሎት ምን ያህል በቂ ዝግጅት አለው ብለን ስንጠይቅ በተለይ ቅኝት ባደረግንባቸው አካባቢዎች የተመለከትነው የአገልግሎቱን የሚያበረታታ ጅምርነት ነው::

“በአገር ደረጃ ያለው የአጥንት ህክምና እድገት እንጭጭ የሚባል ነው:: ህክምናው ገና በመጀመሪያዎቹ ደረጃ ላይ የሚገኝ ከመሆኑም በላይ ጓዳ ውስጥ ያለ ነው:: በአገሪቱ ያሉት የአጥንት ሕክምና ባለሙያዎች በጣም ጥቂት ናቸው:: በአብዛኛው ህዝብ ባህላዊ የወጌሻ ህክምና ላይ ነው ያለው:: ዘመናዊ የአጥንት ህክምና ገና እየታወቀ ያለ ነው:: ከተጀመረበት ጊዜ ይልቅ አሁን አሁን እየታየ ባለው ውጤት የህዝቡም ግንዛቤ እየተለወጠ መጥቷል::” በማለት ለውጡ ግን አዝጋሚ እና አለም ከደረሰበት የህክምናው ደረጃ ጋር ሲነፃፀር በጣም ገና መሆኑን ዶ/ር ቃኘው ይናገራሉ::

በተዘዋወርንባቸው አምስት የሐገሪቱ ክፍሎች ባየናቸው የአጥንት ሕክምና የሚሰጡ ሆስፒታሎች ውስጥ ያገኘናቸው ሐኪሞች በሙሉ በሚሊዮን ለሚቆጠሩ ነዋሪዎች በብቸኝነት አገልግሎት የሚሰጡ የአጥንት ቀዶ ሕክምና ባለሙያዎች ናቸው:: በዚህ ረገድ የደሴ ሪፈራል ሆስፒታልን በምሳሌነት ማየት እንችላለን:: የሆስፒታሉ ተገልጋዮች ከአፋር፣ ከወሎ፣ ከሸዋ ሮቢት እና ከሌሎችም የሰሜን ኢትዮጵያ አካባቢዎች የሚመጡ ሲሆን ሀኪም ቤቱ እስከ 7 ሚሊዮን ለሚደርሱ ሰዎች አገልግሎት የሚሠጥ ሆስፒታል ነው:: ከደሴ ሆስፒታል በተጨማሪ አንድ የግል ሆስፒታል ውስጥ የአጥንት ህክምና መሠጠቱ የሪፈራል ሆስፒታሉን ጫና ይቀንስለት እንጂ፣ ሆስፒታሉ የሚሰጠው አገልግሎት ከህክምና ፈላጊው ጋር አይነፃፀርም:: ይህንን ጫና ከሚያባብሱት ምክንያቶች ዋነኛው ደግሞ ይህንን ሁሉ ህዝብ እንዲያገለግል የተመደበው የአጥንት ሐኪም “አንድ ለእናቱ” መሆኑ ነው:: በሶዶ፣ በድሬዳዋ፣ በአሰላ እና በወሊሶም ያየነው ይሄንኑ ነው፣ አንድ የአጥንት ቀዶ ሐኪም ለሚሊዮኖች::

የባለሙያ እጥረት በመላው ሐገሪቱ የሚታይ ችግር ነው:: በአዲስ አበባ ዩኒቨርስቲ የአጥንት ህክምና የትምህርት ክፍል ተባባሪ ፕሮፌሰር የሆኑት ዶ/ር ተዘራ ጫካ በጽሑፎቻቸው እንዳመለከቱት በተለያዩ የአጥንት ህክምና ንኡሳን ዘርፎች የሰለጠኑ ባለሙያዎች ቁጥር ዝቅተኛነት በአጠቃላይ የህክምና አገልግሎቱ ከሚያጋጥሙት ዋነኛ ችግሮች ቀዳሚው ነው:: በአዲስ አበባ ዩኒቨርስቲ የአጥንት ህክምና የትምህርት ክፍል ከተቋቋመበት ጊዜ አንስቶ እስካለፉት ሁለት ዓመታት ድረስ ለማስተማር የሚቀበላቸው እጩ ሐኪሞች ቁጥር ከሦስት እና ከአራት አይዘሉም ነበር:: በመሆኑም በየዓመቱ ወደ መላው ሐገሪቱ አካባቢዎች በባለሙያነት የሚሰማሩት ተመራቂዎች አንድ ሁለት ቢሆኑ ነው:: ባለፉት 25 ዓመታት ያፈራቸው ባለሙያዎችም 46 ብቻ መሆናቸውን የዶ/ር ተዘራ አንድ ጽሑፍ ይናገራል:: ይሔ ደግሞ ከጊዜ ወደ ጊዜ እያደገ ከመጣው ፍላጎት ጋር ሲነጻጸር እዚህ ግባ የሚባል አይደለም::

ጊዜ የማይሰጡ ችግሮች

ከአዲስ አበባ ውጭ በቃኘናቸው አካባቢዎች አንድ ሆስፒታል፣ ባለው አንድ የአጥንት ቀዶ ህክምና ባለሙያ አማካይነት በነርሶች እና በሌሎች በቀጥታ የአጥንት ህክምና ሥልጠና በሌላቸው ረዳቶች እገዛ በአመት በሺዎች ለሚቆጠሩ ታካሚዎች የህክምና አገልግሎት ይሰጣሉ:: እነዚህ ባለሙያዎች በቀን ከ10 በላይ ቀዶ ህክምናዎችን ይሰራሉ፤ ከእነዚህ ህክምናዎች በአማካይ እስከ ሰላሳ በመቶ የሚሆኑት ከፍተኛ፣ የተቀሩት ደግሞ መካከለኛ ቀዶ ህክምናዎች ናቸው::

ዶ/ር ዱቄን አንደርሰን በሶዶ ክርስቲያን ሆስፒታል ዳይሬክተር እና የአጥንት ህክምና ባለሙያ ናቸው፤ በሆስፒታሉ ብቸኛ የአጥንት ቀዶ ሐኪም መሆናቸው የፈጠረባቸውን ጫና ሲገልፁ፣ “በአንድ ቀን እስከ 13 ቀዶ ህክምናዎችን እናደርጋለን፣ ከእነዚህም መሐል አምስቱ ከፍተኛ ሲሆኑ ሌሎቹ አነስተኛ ቀዶ ህክምናዎች ናቸው፣” ይላሉ:: በሁለት የቀዶ ህክምና መስጫ ጠረጴዛዎች በተመሳሳይ ጊዜ ሁለት ታካሚዎችን የሚያከሙበት ጊዜ መኖሩንም ይናገራሉ:: የድል ጮራው ዶ/ር ማንያዘዋልም አዋዋል ከዚህ አይለይም:: በሳምንት ሃያ እና ሰላሳ ታካሚዎችን በአንድ የአጥንት ህክምና ጤና ረዳት ታግዞ ማከም በእሳቸውም ዘንድ የተለመደ ተግባር ከሆነ ከራርሟል:: እንደ ዶ/ር አንደርሰን ያሉት ጫናው የበረታባቸው ሐኪሞች የተጣለባቸውን የሙያ ኃላፊነት ለመወጣት ሲሉ የሻይም ሆነ የምሳ የእረፍት ሰአቶቻቸውን ሥራቸው ላይ በማሳለፍ በሰው ኃይል እጥረት ምክንያት

ሊፈጠር የሚችለውን የአገልግሎት ክፍተት ለመሙላት ይሞክራሉ።

ሆኖም፣ የሐኪሞቹ እጥረት ሳያንስ በአብዛኞቹ አካባቢዎች የሚገኙት ሆስፒታሎች ህክምናቸውን በበቂ ሁኔታ መስጠት የሚችሉባቸው የህክምና መሳሪያዎች አልተሟሉላቸውም። "ይህ በአገር አቀፍ ደረጃም ያለ እውነታ ነው። የአጥንት ህክምና በኢትዮጵያ ከፍተኛ ፍላጐት አለው። ለዚህ ታላቅ ፍላጐት ተመጣጣኝ አገልግሎት ለመስጠት የሚያስችል የባለሙያም ሆነ የቁሳቁስ አቅርቦት ግን የለም፣" ይላሉ የአሰላው ዶ/ር ቃኘው ውብሸት። "የቦታ ጥበት፣ የቁሣቁስ እንደልብ አለመገኘት እና የባለሙያዎች እጥረት ዋነኛው የአጥንት ህክምና እድገት እንቅፋቶች ናቸው።" የደሴው ዶ/ር ዘላለም ታምሬም ይህንኑ ሐሳብ ያጠናክራሉ፣ በእሳቸው አባባል፣ "የአገልግሎት ፍላጐት መጠን ከሚሰጠው አገልግሎት ጋር ሲነጻጸር ዝቅተኛ ነው። ፍላጐቱ ብዙ ሲሆን በተለይ የባለሙያ እና የቁሳቁስ እጥረት አገልግሎት አሠጣጡን አዳጋች አድርጐታል።"

በሆስፒታሎቹ ያሉት በቂ ያልሆኑ አልጋዎች እያንዳንዳቸው በዓመት ከአቅማቸው በላይ ታካሚዎችን ያስተናግዳሉ። የሌሎች ወሳኝ የህክምና ቁሳቁሶች አቅርቦትም አገልግሎቱን አይመጥንም። ዶ/ር ብርሃኑ አያና፣ በወሊሶ ቅዱስ ሉቃስ ሆስፒታል የአጥንት ህክምና ክፍል ኃላፊም፣ የህክምናው መገልገያ ቁሳቁስ እንደ ልብ አለመገኘቱ ህክምናውን በሐገሪቱ ለማዳረስ እንቅፋት መሆኑን በአፅንዖት ይናገራሉ። ህክምናው በአብዛኛው በአዲስ አበባ ተወስኖ የቆየው ከዚህ የተነሳ መሆኑን ያምናሉ።

የአሰላ ሪፈራል ሆስፒታል ደግሞ እንውሰድ፤ የአጥንት ህክምና ክፍሉ አገልግሎት በሚሰጥባቸው አርሲ እና ባሌን ጨምሮ በዙሪያው ባሉ አካባቢዎች በግልም ሆነ በመንግስት ደረጃ የአጥንት ህክምናን የሚሠጥ ሌላ ህኪም ቤት የለም። በዚህም የተነሳ እራሱን የቻለ ዋርድ ስለሌለው የቀዶ ህክምና ክፍልን ከመሣሠሉ ሌሎች የህክምና ክፍሎች ጋር በሚጋራቸው አልጋዎች ታካሚን መከታተል አዳጋች ነው። የራሱ አልጋ አለመኖሩ ብቻ ሳይሆን ራሱን ችሎ ባለመቆሙ እና ከአገልግሎት ፈላጊው ጋር የተመጣጠነ የመኝታ ክፍል እንዲሁም የተለያዩ ውስብስብ እና ዘመናዊ አገልግሎቶችን ለመስጠት የሚያስችሉ ዘመናዊ መሣሪያዎችን አለማግኘቱ የአጥንት ህክምና አሠጣጡ ላይ የራሱን አሉታዊ ተጽእኖ አሳርፎበታል።

በዚህ ሁሉ ሁኔታ ውስጥ ግን አስቀድሞ እንዳልነው፣ የህክምናው ፍላጎት ከጊዜ ወደ ጊዜ እየጨመረ መጥቷል፤ ስለ አገልግሎቱ መረጃ ከመስማት እና አገልግሎቱም በተለያዩ አካባቢዎች መስፋፋት ከመጀመሩ ባሻገር ፍላጎቱ እንዲጨምር ዋነኛ ምክንያቶች የሆኑት አብዛኞቹ የአጥንት ጤና ችግር መንስዔነት የሚጠቀሱት አደጋዎች ናቸው። በተዘዋወርንባቸው አብዛኞቹ ሆስፒታሎች የሚገኙ የአጥንት ህክምና ክፍሎች በአደጋ ምክንያት በተጎዱ ታካሚዎች አዘውትረው ይጨናነቃሉ። ወደክፍላቸው ከሚቀበሏቸው ታካሚዎች አብዛኞቹ የአደጋ ሰለባዎች ናቸው። ለምሳሌ በድሬዳዋ በየዓመቱ ድል ጮራ ሆስፒታል ከሚቀበላቸው 1008 ገደማ አዳዲስ ታካሚዎች 80 በመቶው በሰው ሠራሽ አደጋ ተጎድተው የሚመጡ ሲሆኑ የተቀሩት ደግሞ ተፈጥሯዊ ችግሮች ያሉባቸው ናቸው።

እነዚህን በመላው ኢትዮጵያ በአጥንት ህክምና ላይ ጫና እየፈጠሩ ያሉ የበሽታ መንስዔዎች ስንመለከት፣ በመኪና እና በሌሎች እንደ ባጃጅ እና ሞተር ሳይክል ባሉ ተሽከርካሪዎች የሚደርሱ አደጋዎችን፣ የመውደቅ አደጋዎች፣ ግጭቶች እና የመሳሰሉትን እናገኛለን። በድል ጮራ ሆስፒታል የአጥንት ህክምና ክፍል ኃላፊው በዶ/ር ማንያዘዋል ትንታኔ መሠረት በአደጋ ምክንያት ወደ ክፍላቸው የሚመጡ ታካሚዎች ችግሮቻቸው ይህንን ይመስላሉ፡-

- የመኪና አደጋ - 45 በመቶ
- የመውደቅ አደጋ - 30 በመቶ
- ማሽን እና ጸብ - ከ15 እስከ 20 በመቶ ይይዛሉ።

በደሴ ሆስፒታል ደግሞ ከትራፊክ አደጋ ቀጥሎ ከፍተኛውን ጉዳት እያደረሰ እና በሆስፒታሉም ላይ ጫና እየፈጠረ የሚገኘው የሰዎች አካላዊ ግጭት እና መጎዳዳት ነው። በወሊሶ በጸብ ተጎድተው ወደ ሆስፒታል የሚመጡት፣ በትራፊክ አደጋ ከሚጎዱት ሁሉ በቁጥር ይበልጣሉ። በድሬዳዋ እና በዙሪያዋ ሰዎች ሲጋጩ እንደ ሜንጫ ባሉ ስለታማ መሣሪያዎች እርስ በርስ ስለሚጎዳዱ በዚህ መልኩ ከፍተኛ ጉዳት የደረሰባቸውን ታካሚዎች ቶሎ ቶሎ ማየት የተለመደ ነው። በአሰላ እና በዙሪያውም ቢሆን በአብዛኛው ለአጥንት ህክምና ፈላጊዎች መብዛት ምክንያት የሚሆኑት በሰዎች የእርስ በርስ ጠብ መንስኤ የሚከሰቱ አደጋዎች ናቸው። ከቅርብ ጊዜ ወዲህ ግን መንገዱ በዘመናዊ መልክ መሠራቱን ተከትሎ በባጃጅ እና በመኪና አደጋዎች ምክንያት ለህክምና የሚመጡት ሰዎች ቁጥር በእጅጉ እየጨመረ መጥቷል።

ከከተሞች መስፋፋት ጋር ተያይዘው የሚመጡ የመንገድ ዝርጋታዎች እና መንገዶቹን ተከትሎ የሚመጣው የትራፊክ እንቅስቃሴ መጨመር ለትራፊክ አደጋው መብዛት፤ የግንባታዎች መስፋፋት እና የደኅንነት ጥንቃቄዎች እኩል አለማደግ ለግንባታ አደጋዎች መብዛት እንዲሁም የእርስ በርስ ግጭቶች ለተጎጂዎች መብዛት ምክንያቶች ተደርገው ሊወሰዱ ይችላሉ። ያም ሆነ ይህ፣ የአጥንት ህክምና በኢትዮጵያ ነገ ዛሬ ሳይባል በባለሙያ እና በቁሳቁስ ተጠናክሮ እንዲስፋፋ የግድ የሚሆንበት ዋነኛ ምክንያት፣ ከላይ የጠቀስናቸው፣ ሆስፒታሎቹ ላይ ጫና የሚፈጥሩ መሠረታዊ

ችግሮች በፍጥነት እየተባባሱ እንጂ እየተሻሻሉ ሲመጡ አለመታየታቸው ነው። ዛሬም ከትናንት በባሰ ሁኔታ በመላ ሐገሪቱ ሰዎች በትራፊክ አደጋ ይጎዳሉ፣ ይሞታሉ፤ ዛሬም በግንባታ እና በማሽን ሥራዎች ላይ ከደህንነት ጥንቃቄዎች መጓደል የተነሳ ከትናንት በባሰ ሁኔታ ሰዎች ለአደጋ ይጋለጣሉ፤ ዛሬም በተለያዩ ምክንያቶች ሰዎች ተጋጭተው እርስበርስ ይጎዳዳሉ።

ሌላው ይህንን ውጥረት የበዛበት የህክምና አገልግሎት የሚፈትነው የተጎጂዎች በወጌሻዎች ከተበለሻሹ በኋላ ወደ ሆስፒታሎቹ መምጣታቸው ነው። በዚህ ከግንዛቤ እጥረት በሚመጣ ችግር ሐኪሞች ይማረራሉ፤ ምክንያቱም አብዛኛውን ጊዜ ከወጌሻ መልስ ወደ ሐኪሞቹ የሚሔዱት ምንም ሳይነካኩ ቢተዉ የሚድኑ ችግሮቻቸው ከተወሳሰቡ እና ተስፋ ከቆረጠባቸው በኋላ ነው። በቀላሉ ይድኑ የነበሩ ችግሮች ተባብሰው ሆስፒታሎች ላይ አላስፈላጊ ጫና ይፈጥራሉ፤ ለዚህም ነው ዶ/ር አንደርሰን የኢትዮጵያ ባህል ተለውጦ ሕዝቡ የአጥንት ቀዶ ሐኪሞችን እንደ ብቸኛ የአጥንት እና የመገጣጠሚያ ችግሮቹ ፈቺ አድርጎ ቢወስዳቸው ታላቅ ስኬት እንደሚሆን የሚናገሩት። የባለሙያ እና የቁሳቁስ እጥረት ባለበት ሁኔታ እንዲህ ያሉ ችግሮቹን የሚያባብሱ ሁኔታዎች መከሰት በእንቅርት ላይ ጆሮ ደግፍ ይሆናል።

ዕድሎች እና ተስፋዎች

"በቁጥርም ሆነ በአስከፊነት እየጨመሩ ካሉት የአደጋ ሰለባዎች እና ሌሎች የአጥንት እና የመገጣጠሚያ ችግሮች አኳያ ሲታይ፣ ሙያውን በመላ ሐገሪቱ የማስፋፋት አስፈላጊነት አያጠራጥርም። በመስኩ ገና በጅምሩ ላይ ያለው የተሻሻሉ የህክምና ዘዴዎችን የመጠቀም ነገር ሊበረታታ ይገባዋል።"

ይህ በተባባሪ ፕሮፌሰር ተዘራ የቀረበ የይሁንታ ሐሳብ ነው። እስካሁን የዘረዘርናቸው የአጥንት እና የመገጣጠሚያ ህክምና ተግዳሮቶች ጠቅላላ የህክምናውን ድባብ የሚያጨልሙ ተደርገው መወሰድ የለባቸውም። ህክምናው እነዚህን በመሳሰሉ ችግሮች የተከበበ ቢሆንም፣ በተለይ በተዘዋወርባቸው ሆስፒታሎች ማየት እንደቻልነው፣ በተጨናነቀ ሁኔታም ውስጥ የሚሰጡት የህክምና አገልግሎቶች በአዝግሞትም ቢሆን ከጊዜ ወደ ጊዜ እየተሻሻሉ መጥተዋል። በየቦታው ያገኘናቸው የጤና ባለሙያዎች ዕውቀታቸውን፣ ጊዜያቸውን፣ ጉልበታቸውን ሳይቆጥቡ፣ ደከመን እንረፍ ሰለቸን እንተፋ ሳይሉ አገልግሎታቸውን እንደሚሰጡ ተረድተናል። ይሄ ቀናነት በኢትዮጵያ በዘርፉ የሚያጋጥሙ ችግሮችን በተሻሻሉ ህክምናዎች ለማቃለል የሚረዳ አንድ ትልቅ ግብአት ነው። በሀገር አቀፍ ደረጃ ሊደረጉ የታሰቡ ማሻሻያዎች ቢኖሩ ይህንን ግብአት በመንደርደሪያነት መጠቀም ይቻላል።

ወደ ገፅ- 10 ዞሯል

“ይህ ዓመት ከፍተኛ ቁጥር ያላቸው ሀኪሞች በአጥንት ህክምና ትምህርት ስፔሻላይዝ ለማድረግ የመጡበት ነው”

ዶ/ር ብሩክ ላምቢሶ የወቅቱ ኢሶት ፕሬዝዳንት ናቸው፡፡ የኢትዮጵያ የሐኪሞች ማሕበር ዋና ጸሐፊ፣ በፌዴራል ጤና ጥበቃ ሚ/ር የህክምና ባለሙያዎች ስነ ምግባር ኮሚቴ ሰብሳቢ፤በአዲስ አበባ ዩኒቨርሲቲ የህክምና ትምህርት ቤት ተባባሪ ፕሮፌሰር፣ በጥቁር አንበሳ ሆስፒታል የአጥንት ህክምና ኮንሰልታንት ስፔሻሊስት፣ የሰርጀካል ሶሳይቲ አፍ ኢትዮጵያ የሥራ አስፈጻሚ አባል ናቸው፡፡ ዶ/ር ብሩክ የኢትዮጵያ የአጥንት ሐኪሞች ማኅበርን (ኢሶት)የሥራ እንቅስቃሴ በተመለከተ ከመጽሔቱ ዝግጅት ክፍል ጋር ቃለመጠይቅ አድርገዋል፡፡

ያለፈው አመራሮች አዲስ ከተቋቋማችሁት ከእናንተ የተሻለ ሥራ ይጠብቁ ነበር፣ እንዴት ናችሁ?

የተሻለ እንደደምንሥራ ቃል ተገባብተናል ምክንያቱም ያው የቀድሞው አመራር ላይም ከፍተኛ ተሳትፎ ነበረን፡፡ ስለሆነም የት የት ጋር መሻሻል እንደሚያስፈል እየተናበብን ስለነበረ የቆየነው እሱን መቀጠል ከባድ ለእኛ አልነበረም፡ ፡ ወዲያው ነበር የተቀጠለው፡፡ ለመጀመሪያ ጊዜ ወጣት የሆኑ ሬዚዳንቶች በአመራር እንዲሳተፉ ስለተደረገ የተሻለ ነገር እደሚጠበቅብን እኛም እንጠብቃለን፡፡ እስካሁንም ጥሩ እየሄድን ነው፡፡

ኢሶት ዓላማ ብሎ የሚሠራባቸው ሦስት ዓላማዎች አሉት ምርምር፣ ስልጠና እና አገልግሎት፤ በዚህ አመራር የኢሶት ቀዳሚ ትኩረት በየትኛው ላይ ነው?

እንግዲህ እነዚህ ሦስቱ ዓላማዎች የኢሶት ብቻ ሳይሆኑ በአጠቃላይ የህክምና ትምህርት ቤት ዓላማዎች ናቸው፡ ፡ እኛ እንደማህበር በጣም የምናተኩረው አገልግሎት ላይ ነው ፡፡ትኩረቱ ይለያያል እንደማህበር የእነዚህ ቅደም ተከተል ሊቀያየር ይችላል፡፡በይበልጥ አገልግሎት ላ ይ እናተኩራለን ምክያቱም እኛ ባለሙያዎች ነን፡፡ ከዚያ በመቀጠል ደግሞ ሌሎቹ ዓላማዎች ይከተላሉ፡፡ ስልጠናን በተመለከተ እውቀት ማስተላለፍ ላይ፣ ከሌላ ሀገራት ጋር ልምድ መለዋዋ ላይ እናተኩራለን፡፡ የምርምር ዓላማችንን ለማሳካት ደግሞ በየጊዜው የሚዘጋጁ ስብሰባዎች ዋና ዓላማ የተገኙ ግኝቶችን ለመለዋወጥ እንዲያመች ነው፤ አንዱ አንዱ ጋር የሰራበትን እና ጥሩ ውጤት ያገኘበትን ለሌሎቹ በዚህ አጋጣሚ እንዲያሰራጭ መድረክ መፍጠር የእኛ ሚና ነው፡፡ ከእነዚህ ሦስቱ በተጨማሪ አራተኛ የጨመርነው በፖሊሲ አቅጣጫዎች እና በመንግስት ትኩረት አቅጣጫዎች ላይ በሰፊው መሳተፍ መጀመራችን ነው፡፡ ከመኪና አደጋ ጋር በተያያዘ ስብራት እና ቁስል ያላቸው ሰዎች በፍጥነት የሚታከሙበትን፣ በመተባበር እየሠራን ነው፡፡ አመራሩና አባላቶቻችንም በተለያዩ ሚዲያዎች ህዝቡን ስለስብራት አደጋ፤ስለ አጥንት ጤናና እንክብካቤ አስተምረዋል፡፡

አሁን በጣም ልንሳተፍባቸው ስለሚገቡ ሁለት ሃሳቦች ከቱሪዝም ሚንስትሩ ጋር ተነጋግረናል፡፡ከፊት በብሔራዊ ደረጃ የምንሳተተፍበት የሩጫ ስፖርት አለ፡፡ ከአትሌቲክስ ፌደሬሽን ጋር መስራት ይቻለል የሚለውን ሃሳብ ስብሰባ ላይ ሰዎች አቅርበው ከተነጋገርን በኋላ ብዙም ሳንሄድ ይቻላል አይቻልም የሚለውን ነገር አይተን ነበር፡፡ በዚህም ጥሩ አቀባበል ነው ያገኘነው፡፡ ስፖረት ሜዲሲን የአጥንት ሕክምና አንድ ንዑስ ሴፔሻሊቲ ነው ፡፡ አደጋ የሚደርስባቸው እግር ጀርባና እጅ የሚጠቁሙ ስፖርተኞች በሙሉ እኛ ጋር ነው የሚመጡት ስለዚህ ይሄ እንግዲህ የማይነካው የስፖርት ዓይነት የለም፡፡ከአትሌቶች፣ ከፌደሬሽኑ ወይም ከተለያዩ ኮሚቴዎች ጋር ይህን ግንኙነት ለመፍጠር እየሰራን ነው፡፡

አዲስ ነገር ነው ማለት ነው?

አዎ! በብሔራዊ ጉዳዮች ላይ መሳተፍ የሚለው አዲስ የጨመርነው ነገር ነው፡፡ ሌላው ደግሞ ትልልቅ ፕሮጀክቶች አሉ እንደ ግድብ፤ቤቶች፤ መንገድ እና የመሳሰሉት ግንባታዎች፤ እንዚህንም በተመለከተ ፖሊሲ አውጭዎችን የማማከር እና አቅጣጫ የማስያዝ ሥራ እየሰራን ነው፡፡ እንዲሁም በተለይ ባለፉት በቅርብ ወራት ሌላ በጣም አነጋጋሪ ጉዳይ ሆኖ የመጣው አዲስ አበባ ሊፈነዱ ስለነበሩ ቦንቦች ተያዙ ተብሎ በሚዲያ የተነገረውን ሁላችንም ሰምተናል፡፡ ያ ቢፈነዳ ኖሮ እኛ ዝግጁዎች ነበርን ወይ? የሚለውን ነገር ስብሰባ ላይ በጥልቀት አይተነዋል፡፡ እንደ አጥንት እና ተያያዥ በሽታዎች ስፔሻሊስት እንደ አደጋ ተቀባዮች ተዘጋጅተን ነበር ወይ? የሚለውን ግምገማ አድርገናል፡፡ የቅድመ ጥንቃቄና ዝግጁነት ምክሮችን ለመንግስታችን አቅርበናል፡፡

የአቅም ጉዳይ ግን ተመልሶ አይመጣም እዚህ ጋር?

ለሚመጣ ነገር ተዘጋጅቶ መጠበቅ ምንም አቅም አይጠይቅም፡፡ መዘጋጀት እና ሊመጣ ነበር ብሎ አለማሰብ ነው እንጂ እንደሚመጣ ብንጠብቅ ይህቺ አገር ከዚህ የሚበልጡ ሰባ ሰማኒያ ሺህ ሰው የተጎዳበት ጦርነቶች አሳልፋለች፡፡ እንደ ኢትዮጵያ በአደጋ የሚደርስ ጉዳትን በመቋቋም ልምድ ያለው የለም፡፡ በደንብ መዘጋጀት ይቻላል፡፡ ሉበዙ አመት የካበተ ልምድ አለን፡፡ ፍንዳታ እና ጥይት ለኢትዮጵያ አዲስ ነገር አይደለም፡፡ ግን ነጥቡ አልተዘጋጀንም ነው፡፡ መሐል መርካቶ ቦንብ ይጠመዳል ብሎ ያሰበ የለም፡፡ ስለዚህ ከዚህ ትልቅ ትምህርት ተወስዶ መንግስትም በዚህ አቅጣጫ ማማከር፣ መነትነት እናም ሁልጊዜም ቢሆን ዝግጁነት መኖር ስላለበት ዝግጅቶቹ እንዲጀመሩ አስፈላጊ እርምጃች ወስደናል፡፡ እንዲሁ ሳይፈነዳ እግዜር ምሮን አመለጥን እንጂ ያ ቢፈነዳ የትኛው ሆስፒታል የት ቦታ ምን እንደሚደረግ ምንም ዝግጁነት አልነበረም፡፡ እዚህ ላይ በጣም መስራት አለብን፡፡ እንዲህ ያለ ነገር ደግሞ አሁን ባለው ዓለም ፋሽን እየሆነ ነው፡ ፡ የኛ ሀገር ደግሞ እያደነች ስለሆነ የሚቀናባትና የሚተናኮላት ከውጭም ከውስጥም መፈጠሩ አይቀርም!

ነገሩ ልክ ነው፤ ግን አሁንም በየዕለቱ እየደረሱ ያሉ አደጋዎች አሉ፡፡ እነሱን ራሱ ተቀብሎ ማስተናገድን በጣም ከባድ የሆነበት ሁኔታ ነው ያለው፤ ይሄንን በራሱ መቻል ከባድ በሆነበት ሁኔታ ተጨማሪ ጫና ለመጠበቅ እና ለማስተናገድ የአባላት ብዛት በመጨመር አልያም ተጨማሪ የሰው ሃይል በሌላ የህክምና ዘርፍ ሰርጅን የሆኑትን በአጥንት ህክምና ለለማሰልጠን አቅድ እንደነበረ አውቃለሁ፡፡ በዚህ ዓመት ይህ አደጋን በቅልጥፍና ለማስተናገድ ዝግጁነት እንደሚያስፈልግ እና ከስተቱ ሊመጣ እንደሚችል ከማወቅ አንዲሁም ጥያቄውን ከማንሳት ባለፈ በተግባር የተሠራ ነገር አለ?

በጣም የተሰራ ነገር አለ፡፡ ለመጀመሪያ ጊዜ በእኛ ሀገር የአጥንት ህክምና ታሪክ ከፍተኛ ቁጥር ያላቸው ተማሪዎች በአጥንት ህክምና ስፔሻላይዝ ለማድረግ የመጡበት ዓመት ይሄ ነው፡፡ ለቃለ መጠይቅ የመጡት 33 ነበሩ ከዚያ መሐል 12ቱን ወስደናል፤ አንደኛ አመታቸውን ሊጨርሱ ነው፡ ፡ ትልቅ ቁጥር ነው፤ ድሮ ለስልጠና 4 እና 3 ሰው ነበር የሚገባው፡፡ በሚቀጥለው ሳምንት ሌላ ከፍተኛ ቁጥር ያለው ተመዝጋቢ ለመግቢያ ፈተና ቀጠሮ ተይዞለታል፡፡ይሄ በጣም ትልቅ ስኬት ነው፡፡ ብዙ ፍላጎት ያላቸው ተማሪዎችም አሉ፡፡ ዲፓርትመንቱም በዚህ ጉዳይ መመስገን እንዳለበት እናምናለን፡፡ በዚህ መልኩ ከቀጠለና አስር እና አስራአምስት እየተባለ ከተሄደ ሌላ ቦታም ስልጠናው ከተሠጠ ጥሩ ነገር ይመጣል፡፡ ብዙ ቦታ ሜዲካል ትምህርት ቤቶች እየተከፈቱ ነው ፡፡ ሰርጀሪ ከተከፈተ በኋላ ነው ብዙ ጊዜ የአጥንት ህክምና የሚጀመረው፡፡ ሰርጀሪ አሁን መቀሌ፣ ሀዋሳ፣ ጅማም ስለተጀመረ የአጥንት ህክምና ትምህርትም ከኋላው መከተሉ አይቀርም፡፡ ጥሩ ጥሩ ጅምሮች ስላሉ የሀኪሞችም ቁጥር ይጨምራል፡፡ የአጠቃላይ ሀኪሞች ቁጥር ከጨመረ በአጥንት ቀዶ ህክምና ስፔሻላይዝ የሚያደርጉ ሀኪሞች ቁጥርም መጨመሩ አይቀርም፡፡ ትልቅ ተስፋ አለኝ፡፡

ስለዚህ ከዚህ በኋላ ለመከፋፈል ይመቻል?

በጣም ይመቻል፡፡ በዚህ በጣም ደስተኞች ነን፡፡ ስናስተምራቸው ሁሉ በጣም ደስ እያለን ነው፡፡ ለአደጋ ጊዜ ዝግጁ መሆን ከተለመደው አገልግሎት መብዛት አለመብዛት ጋር አይያያዝም፡፡ ዝግጁነቱ ያስፈለገው ምንልባት ቢከሰት ከሚል ነው፡፡ በየአምስት ዓመቱ ሊሆን ይችላል በዓመት አንዴ ሊሆን ይችላል አናውቅም፡፡ ግን አንዳንዴ በሞዴል ሁሉ ልምምድ እንዲደርግ ተደርጎ ተዘጋጅቶ መጠበቁ መልካም ነው፡፡ በውጭ ሀገር አደጋ ቢፈጠር እንዴት ከፍተኛ ቁጥር ያለውን ህዝብ እንደሚያስተናግዱ ልምምድ ያደርጋሉ፡

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አገልግሎቱ ቅልጥፍና እንዲኖረው ነው?

አዎ! ማን ምንድነው? የት ጋር ምን አለ? የሚለው ሁሉ ተጣርቶ እና ተደራጅቶ ሂደቱ ተዘጋጅቶ ቁጭ ይላል:: እናም ነገሩ ሲከሰት ያንን ማንቀሳቀስ ብቻ ነው:: ብዙ ጉዳትና የሞት ቁጥር መቀነስ ይቻላል::

ወደ ሌላ ጉዳይ እንግባና ከጤናጥበቃ ጋር ወጪሻዎችን ኢጋሮቻችሁ ለማድረግ ፈንድ ለመጠየቅ ሃሳብ ነበራችሁ ይህ ጉዳይ ቀጥሏል ወይስ ምን ደረሳችኋል?

ወጪሻዎች ማህበር ነበራቸው:: ያ ማህበር ፈራርሷል እና እነሱን በማህበራቸው በኩል የማግኘቱ ነገር አታካች ሆነ:: ስለዚህ አሁን እየተደረገ ያለው ነገር ከተማ ለከተማ አንድ በአንድ እየገኘናቸው ነው:: የተወሰኑት የመደበቅም፣ የመበርገግም አመጡ፣ በጣም ዝነኞች የሆኑ የለመዱ እና ከተማ ውስጥ ለብዙ አመት የሰሩ ካልሆኑ በስተቀር በየሰፈሩ ያሉት አሁን ብዙዎቹ ወደ መተዉ ደርሰዋል: : የጤና ኤክስቴንሽን ሰራተኞች ቤት ለቤት እየሄዱ ነው:: ይህም ትልቅ የፈጠረው ነገር አለ:: ሰዉም እያወቀ ነው :: በእነሱ የተነሳ የሚመጣውም ችግር በጣም እየቀነሰ ነው:: በእያንዳንዱ ገበሬ ቤት አንድ ነርስ ትሄዳለች ይሄ ከዚህ ቀደም የነበረ አልነበረም :: ነርሷ ጤና ጣቢያ እንጂ ወጪሻ ጋር ሂዱ አትልም:: በቃ እስቲ ከተማ ከተማ ትልልቆቹን እንገናኝ እና እናሰልጥን የሚለው ነገር መጣ ከዚህ ቀደም የማህበራቸው ፕሬዝዳንት ተብሎ የመጣው ሰውም እንደፈረሰ እና እንደተበታተኑ ነገረን፤ ስለዚህ ስታራቴጂያችንን መቀየር እንዳለብን አሰብን፤ የሚፈጥሩት ችግር እየቀነሰ ሲሄድ ያው እንዳንዘናጋ ብንፈራም የኋላ አጀንዳ አደረግነው::

በአፍሪካ ካሉ የኢሶት አቻ ማህበራትጋር ያለችሁ ግንኙነት እንዴት ነው?

ጥሩ ነው:: የምስራቅ፣ የደቡብ እና መካከለኛው አፍሪካ ሰርጅኖች ማህበር (ECSAOA) አለ::የ እኔና ዶ/ር ኤፅከ ኢትዮጵያን እንወክላለን::የዚህ አመታዊ ስብሰባ አዘጋጅም ኢትዮጵያ ናት::በአዲሱ የአፍሪካ ህብረት ለማድረግ ዝግጅት ላይ ነን::

ከሌሎች አፍሪካ ሀገሮች ጋር ሲነፃፀር ኢትዮጵያ በምን ደረጃ ላይ ናት?

በጣም ተሰፋ ሰጪ ነው :: ሌሎች የአፍሪካ ሐገሮችን ሁኔታ ሲታይ በጣም ነው የሚያሳዝነው:: እኛ እዚህ ባለው ነገር እንማረራለን:: ማላዊ ብናይ አንድ የሀገሪቱ ዜጋ ሰርጅን ነው ያለው:: ሌሎቹ ከሌላ ሀገራት የመጡ ናቸው:: ሰሜን አፍሪካ ኬኒያ፣ ናይጄሪያ ደቡብ አፍሪካ ከእኛ የተሻሉ ናቸው በተለይ በዕቃ አቅርቦት ይበልጡናል፤ በተረፈ አሁን እዚህ ሐገርም በአሜሪካ የጥራት ደረጃ የሚሰራበት ሁኔታ አለ በተለይ ቦታውን ካወቅሽ አንድ ዕቃ ለእንቺ ብቻ ሆኖ ድጋሚ ሳይጠቀሙ በዓለም አቀፍ ደረጃ ህክምናው ይሠጣል:: በገጠር አካባቢ ያለው ነገር ግን አሁንም ያሳዝነናል ተደራሽ መሆን አለብን በዚህ ላይ እየተሻሻልን እንደምንመጣ ተስፋ አደርጋለሁ:: በየዓመቱ መሻሻል አለብን እየተሻሻልንም ነው: : ግን በአጠቃለይ የሚበልጡንም አሉ ከብዙ ሀገሮችም እንሻላለን:: አምና ያልነበሩ ዘንድሮ የጀመርናቸው ብዙ ነገሮች አሉ :ወደፊትም ዓለም የደረሰበት እንደርሳለን::

አዲሶቹ ተማሪዎች ወደ ውጭ ለመውጣት ፍላጎት አላቸው፤ከውጭ ሀገር ወደ ሀገር ውስጥ የመመለስ ነገርስ እንዴት ነው?

አንደኛ ውጭ ሀገር ኦርቶፔዲክስ መማር ቀላል አይደለም: : የመማር ዕድሉን ለማግኘት በውድድር አንደኛ ወይም ሁለተኛ መውጣት ያስፈልጋል:: ለአንድ ሬዚደንሲ ቦታ እስከ 400 ሰው ይወዳደራል::ሃበሾች በጣት የሚቆጠሩ ናቸው ከአምስት አይበልጡም:: በጣም ብዙ ስለሚከፈላቸው ወደዚህ አይመጡም የእኛን የአምስት ዓመት ደሞዝ በአንድ ሰርጀሪ ያገኙታል:: የተለየ አስተሳሰብ ከሌላቸው በቀር በዘመቻ መልክ ብቅ ብለው ይመለሳሉ እንጂ ወደዚህ ሀገር አይመለሱም::

ተማሪዎች ከዚህ ይሄዳሉ ብላችሁስ አትሰጉም?

አንሰጋም፤ ምክንያቱም ውጪ ሄዶ በኦርቶፔዲክስ ለመቀጠል ከባድ ፈተና አለው:: ወደሌላ ስፔሻሊቲ ለመሄድ ካልፈለጉ ለምሳሌ የውስጥ ደዌ ወይም የህፃናት ሕክምና ከሆነ እንጂ ከምር ኦርቶፔዲክስ ከሆነ የሚፈልጉት የትም አይሄዱም:: ሁለተኛ እዚህ ያለው ነገር በጣም ጥሩ ሆኗል: : ሥራ መስራት ለሚፈልግ ሰው ሥራ አለ:: አልቦሽም ለፍተሽም እየተመሰገንኩ በህዝቤ መሃል ልኑር ከተባለና ወገብን ታስሮ ከተሰራ ይገኛል::የባለቤቱ ጉዳይ ነው:: ድሮ ገንዘብ አይገኝበትም ነበር አሁን ግን ይገኛል:: ድሮ ከዚህ ሆስፒታል በውስጥ ደዌ አስር ሐኪሞች ተልከው አስሩም የጠፉበት አጋጣሚ ነበረ:: ኮንፍራሱ ላይ እንኳ ሳይሄዱ ዲሲ ከኤርፖርት ነው እልም ያሉት:: ድሮ ሴሚናር ሲኖር ይጠፉ ነበር አሁን ግን የሚጠፋ ቢኖርም እንኳን አብዛኛዎቹ ይመለሳሉ::

በአጫጭር ስልጠናዎች የሰራችኋቸው ስራዎችስ ምን ይመስላሉ?

አሁን የሥራነው ፖዶኮንዩሲስ (Podoconiosis) ላይ ነው: : ፖዶኮንዩሲስ የሚባለው ድሮ ዝሆኔ እየተባለ የሚያምታታን ነገር ነው:: ያበጠ እግር ሁሉ ድሮ ዝሆኔ ነበር የሚባለው:: አሁን ግን አዲስ ሳይንስ መጥቷል:: በአብዛኛው እሳተ ጎሞራ የፈነዳበት አካባቢ ላይ የሚከሰት ነው:: እሳተ ጎሞራው የሚሊቃቸው ኪሚካሎች በአካባቢው የሚኖሩ ገበሬዎች ላይ በእግራቸው ውስጥ ገብተው ሊምፋቲክ ሲስተማቸውን እንዲቆጣ ያደርጉታል:: ከዚያም ቫልቩን ይቀዱትና ውሃው እንዲያመልጥ ያደርገዋል ያም ረግቶ እግራቸውን ያሳብጠዋል:: እኛ ይህንን ለመከላከል የሚሠራው ፕሮጀክት ፓርትነር ነን:: በጋራ ናፓን (NaPAN) የሚባል ሀገር አቀፍ ትልቅ ማህበር መስርተናል::ኢሶት የዚህ ማህበር ምክትል ሊቀመንበር ነው::

የፕሮጀክቱ ቀዳሚ አጀንዳ ህክምና ነው ወይስ መከላከል?

መከላከል ነው:: አሜሪካ ያለ ቶም ሹዝ የሚባል የታወቀ ብራንድ አለ:: የጫማ ፋብሪካው ባለቤት መጥተው ነበር:: አንድ ጫማ በተሸጠ ቁጥር ወደ እዚህ ለአንድ ገበሬ አንድ ጫማ መግዣ ይላካል:: ከዚህ ቀደም መኪና አደጋን በተመለከተ ከተማ ላይ ነበር የሠራነው፤ አሁን ደግሞ ገጠር ገበሬዎች ላይ እየሠራን ነው :: በባዶ እግር መሄድን ለማስቀረት እየሠራን ነው::ኢትዮጵያ ውስጥ ወደ አንድ ሚሊዩን የዚህ በሽታ ተጠቂዎች አሉ:: በዓለም ላይ 4 ሚሊዮን ናቸው!

ጫማ በማድረግ ብቻ መከላከል ይቻላል?

ይቻላል በባዶ በእግር ከተሄደ ብቻ ነው በሽታው የሚመጣው::

ባለፈው ዓመት ኢሶት የተሳካለትስ ምንድን ነበር?

እኛ ሐገር ድሮ አንዱ ችግር ኦርቶፒዲክስ በደንብ ከተሠለጠነ በኋላ መስሪያ ዕቃዎቹን አግኝቶ መስራት ነበር:: ዕቃዎቹ እዚህ አይመረቱም የሚያከፋፍል ወኪልም የለም:: የሚያስፈልጉ ዕቃዎች የመድኃኒት ዝርዝሮች ላይም ያልነበሩ ነበሩ:: ወደ ሐገር ውስጥ መግባት የሚችሉት ደግሞ የመድኃኒት ዝርዝሮች ላይ ካሉ ብቻ ነበር:: አሁን ግን ብዙ ገፆች ፅፈን አስረክበናል:: የጥቁር አንበሳ የመድኃኒት ዝርዝር ውስጥም ገብቷል:: በሀገሪቱ የመድሃኒት አቅርቦት ዝርዝር ውስጥም ይካተታል:: መፅሃፉ እየተጠረዘ ነው:: ይህ ለመጀመሪያ ጊዜ የተሳካልን አፈፃፀም/ድል ነው:: ከመንግስትና አምራች አካላት ጋር ወደ ሀገር ውስጥ እንዴት የአጥንት ህክምና መሳሪያዎችና ብረቶች (Implants & Instruments) እንደሚገቡና ብሎም እንደሚመረቱ እየተነጋገርን ነው:: ጥሩ አቅጣጫዎች አስቀምጠናል::ብቻ በአጠቃላይ ጊዜው ጥሩ ነው! ተስፋውና የሚታዩት ውጤቶች ጥሩ ናቸው!

እናመሰግናለን!

አንድ ትልቅ ድጋፍ በማግኘታችን የፀነስነው ራዕይ እ
እንደሚሆን ማረጋገጫ ምልክት ሆነን::

የኢሶት / ESOT / ምስረታ;...

በግንቦት ወር 1995 ዓ.ም ህጋዊ ፍቃድ እንዳገኘን ለማህተም ማስቀረጫ እና ለደረሰኝ ማሳተሚያ የሚሆን ገንዘብ ከአደራጅ ኮሚቴው በመሠብሰብ አሠርተንና እስፓንሰር አፈላልገን ከሳይንስና ቴክኖሎጂና ከጥቂት ድርጅቶች በተገኘው የገንዘብ ድጋፍ የመጀመሪያ የማህበሩን ስብሰባ በሰሜን ሆቴል አደረግን::

በዚህ ወቅት የማህበሩ ስራ አስፈፃሚ ኮሚቴን ማስመረጥ ነበረብንና አስመራጭ ኮሚቴ ተሠይሞ ምርጫ ሲካሄድ የአደራጁ ኮሚቴ አባላት የነበረን ብዙዎቻችን በድጋሚ የሥራ አስፈፃሚ አባላት ሆነን እንድንቀጥል በአባላት ግፊት ተደርጎ ምርጫ ሲካሄድ የማህበሩ የመጀመሪያ ፕሬዚዳንት በመሆን ተመረጥኩ:: ህጋዊ ማህበርን ማንቀሳቀስ ቀላል ጉዳይ ቢመስልም በአባላት የጊዜ እጥረትና የአንዳንድ አባላት በተለያዩ ምክንያት ያለመገኘት አንዳንዳቸንም በሥራ ጫና በትምህርት ከሀገር መውጣት የማህበሩን እንቅስቃሴ ውስን አድርጎብን ነበር:: ሆኖም ግን በነበሩ አባላት ያላሰለሰ ጥረትና በእናት ዲፓርትመንታችን ድጋፍ የመጀመሪያውን አመታዊ ስብሰባ /Annual Conference/ በግዬን ሆቴል ሳባ አዳራሽ የጤ.ጥ.ሚ ተወካይ፣የእህት ማህበራት የአመራር ኮሚቴ አባላት፣ ስፓንሰር ያደረጉን ድርጅቶች፤ የተለያዩ ጥሪ የተደረገላቸው እንግዶች እና አባላት በተገኙበት በደማቅ ሁኔታ አከበርን:: ምንም እንኳን በዚህ የማሟያ ምርጫ ቢደረግም በቀጣዩም ጊዜ ተመሳሳይ ችግሮች በመከሰታቸው የማህበራችን እንቅስቃሴ ቀዝቀዝ ያለበት ወቅት ሆኖ ቀጠለ:: ሆኖም በተገኘው አጋጣሚ ሁሉ በመጠቀም ባሉት የስራ አስፈፃሚ አባላት ጥረት የሁለተኛውን አመታዊ ጉባዔ እና ሳይንሳዊ ኮንፍረንስ በ April 2006 አካሄድን:: እንግዲህ በዚህ ወቅት ነበር የውጭ የስራ እድል በማግኘቴና የአገልግሎት ዘመናችንም እያለቀ ስለነበር በህገ ደንባችን መሠረት የሚረከቡን አባላት እስኪመረጡ ሃላፊነቱን ለዋና ጸሐፊያችን በማስረከብ የወጣሁት::

- የኢሶት ጉዞ በአጭሩ በኔ እይታ እስከ 2006 እ.ኤ.አ ይህን ይመስል ነበር::

በማጠቃለያም:- በዚህ ሁኔታ ተመስርቶ የተጓዘን ማህበር አሁን ያለበት ደረጃ ላይ ደርሶ ማየት የሚሰጠውን እርካታ በቃላት መግለጽ ይከብዳል:: አሁን ላለበት ደረጃ መድረስ የአባላት ከፍተኛ ድጋፍና በየወቅቱ የተመረጡ የሥራ አመራር አባላት ያልተገደበ ጥረት መሆኑን ለመናገር የተለየ ችሎታን አይጠይቅም::

ማህበራችን የተቋቋመበትን አላማ እግቡ ለማድረስ ረጅሙን ጉዞ በትክክለኛው ጎዳና ጀምረናል:: ግቡን እንዲመታ የአባላት የስራ አስፈፃሚ አካላት ጥረት፣ ትግስትና አይበገሬነት :ጥበብን ይጠይቃል:: ለዚህም ወጣት አመራሮች እና አባላት ብቃቶቻቸውን በማሳየታቸው ብሩህ ተስፋን ማብራት ጀምረዋል: : ሁሉም አባላት በተግባር በርቱ ሁሌም ከጐናችሁ ነን ልንላቸውና ልንቆምላቸው ይገባል እላለሁ::

የኢሶት አላማ የሚሳካው በሁሉም አባላት የማይበገር ጥረት ነው እንጂ በአስፈፃሚዎች ጥረት ብቻ ባለመሆኑ በምንችለው ሁሉ በሙሉ ሃይላችን እንተባበር::

ወሩንና ቀኑን በትክክል ለማስታወስ ብቸገርም በ1993 ዓ.ም ለሥራ ጉዳይ ወደ አጥንት ህክምና ትምህርት ክፍል ኃላፊ ዶ/ር ተዘራ ጫካ ቢሮ ጐራ ብዬ ከሥራ በኋላ ስንጨዋወት ስለ አጥንት እስፔሻሊስት ሃኪሞች ማህበር በሃገራችን መቋቋም አስፈላጊነት ስንወያይ፡ በወቅቱ የብዙ ሙያተኞች ፍላጐት መሆኑን በተገኘው ኢጋጣሚም መነሣቱን አውስተን፡ ጉዳዩን ለምን ወደ ተግባር አንተረጉመውም በሚል ተስማማን፡ ፡ ሃሣቡንም በያለንበት በቅርብ ለምናገኛቸው ሙያተኞች እንድናካፍልና ይህም ጉዳይ የሙያተኞች የአብዛኛው ፍላጐት ከሆነ እንድንሰበሰብ ተባብለን ተለያየን፡፡ በወቅቱ የአባላት ቁጥር አንድን ማህበር ለማቋቋም የህግ ወሰን ካለው ቁጥራችን ጥቂት በመሆኑ ሊገታን ይችል ይሆን በሚል ስጋትም ነበረን፡፡ ሆኖም ግን በፍትህ ሚ/ር የማህበራት ምዝገባ ክፍል በሠጠን መረጃ መሠረት አምስት እና ከዚያ በላይ ከሆናችሁ ሌሎች መስፈርቶችን አሟልታችሁ ማቋቀም ትችላላችሁ በመባላችን ሥጋታችን ተወገደ፡፡

ዶ/ር ለገሰ ይግዛው

የኢሶት / ESOT / ምስረታ ትዝታዎች

በሚቀጥለው ጊዜ ስንገናኝ የብዙ አባላትን ድጋፍ በማግኘታችን እንዴት እና የት እንሠብሰብ የሚለውን ጉዳይ አንስተን ስንወያይ ኢ.አ ውስጥ ያሉትን ጠርተን ሃሳቡን እናካፍላቸውና የመሰብሰቢያ ቦq የኢ.አ ሠርጂካል ዲፓርትመንት የመሠብሰቢያ አዳራሽ አስፈቅዳለሁ በማለት ዶ/ር ተዘራ ሃላፊነቱን ወስዶ ቀኑን ወስነን በያለንበት ለአጥንት ስፔሻሊስት ሃኪሞች ስለዚህ ስብሰባ መኖር በተቻለን መጠን በአካልና በስልክ መልክቱን እንድናስተላልፍ ኃሃላፊነቱን ወስደን ተለያየን፡፡

በተባለው ቀንና ቦታ ጥሪው የደረሳቸው አባላት በሙሉ በተገኙበት የጥሪውን አላማ በማስመልከት አጭር ማብራሪያ ከተሠጠ በኋላ ከተሠብሳቢዎች የድጋፍና የማበረቆቻ አስተያየት ተሠጥቶ ጉዳዩ ከግብ ለማድረስ እንዲቻል፤/String Committee / ማቋቀም እንደሚያስፈልግ ታምኖበት አምስት አባላት ተመርጠው፡የሥራ ድርሻ ራሳቸው እዲመዳደቡና የሚከተሉትን ጉዳዬች ማለትም

1. የማህበሩን ስያሜ
2. የማህበሩን ምልክት
3. የማህበሩን ህገ ደንብ

አዘጋጅተው በተወሰነ የጊዜ ገደብ ለአባላት አቅርበው እንዲያፀድቁ ተወሰነ፡፡እንግዲህ በዚህ ጊዜ ነበር የኮሚቴው አባል በመሆን ተመርጨ የሥራ ድልድል ስናደርግ የሠብሣቢነት ሃላፊነት የተሠጠኝ፡፡

የተሠጠንን ሃላፊነት ለመወጣት ቀና ደፋ ማለት የጀመርነው ከዚህ ጊዜ ጀምሮ ነበር፡፡ በመጀመሪያ የመሠብሰቢያ ቦታና ቀን በቋሚነት ለመገናኘት እንድንችል መወሰን ነበረብን፡፡ ከመጀመሪያውም ለብዙዎቻችን ትምህርት ቤታችን የሆነው የአጥንት ቀዶ ህክምና የትምህርት ክፍል ከቢሮ እስከ ቢሮ አገልግሎት ሙሉ ድጋፍ እንደሚያደርግልን በወቅቱ በነበሩት ሃላፊ ሲነገረን ትልቅ የምስራች ነበር፡፡

በዚህ ቢሮ ውስጥ ሁነን ነበር ሥራችን ለመጀመር እቅድ መንደፍ የጀመርነው፡፡ የተሠጠንን ኃሃላፊነቶች ለመወጣት እንቅስቃሴ ቀጠልን፡፡

1. የማህበራችንን ስያሜ በተመለከተ ከአባላት አስተያየት ከሰበሰብናቸው ጥቂቱን ለማስታወስ .... Ethiopian Orthopedic Association (EOA), Ethiopian Society of Orthopedics, (ESO) Ethiopian Society of Orthopedic and traumatology(ESOT)

2. የማህበሩ ህገደንብበተመለከተከምንመሠርተው ማህበር አላማ ጋር እንዲጣጣም ለማድረግ ከፍትህ ሚ/ር በወቅቱ የማህበራት ምዝገባ ጽ/ቤት ሙያተኞችና ከሌሎችም የህግ ሙያተኞች ጋር በመመካከር ከብዙ ጥረትና ውጣ ውረድ በኋላ እንዲዘጋጅ አደረግን፡፡

3. የማህበሩ ምልክት (Logo) ለማዘጋጀትም የአባላት አስተያየትና የሙያተኞች ምክርን ለማግኘት በየፊናችን መንቀሳቀስ ቀጠልን፡፡

አደራጅ ኮሚቴው በተሠጠው የጊዜ ገደብ መሠረት ጥናቱን አጠናቆ ለውሣኔ ለጠቅላላ ጉባዔው በወቅቱ አቀረበ፡፡

1. ህገ ደንቡ ተነቦ አስተያየት ከተሠጠ በኋላ ወደ ፍትህ ሚኒስቴር የማህበራት ምዝገባ ጽ/ቤት ቀርቦ ህጋዊ ፍቃድ እንዲያገኝ ተወሰነ፡፡

2. የማህበሩን ስያሜ በተመለከተ አባላት ሁሉም ላይ እአስተያየት ተሰጥቶ ESOT የማህበራችን መጠሪያ እንዲሆን ሲወሰን የተሠጡት ምክንያቶች፡፡

ሀ. ሥራችን በአብዛኛው ከአደጋ (Trauma) ጋር የተያያዘ ስለሆነ የሙያችን አንዱ ክፍል በመሆኑ 60% ከአደጋ ውስጥ ኦርቶፔዲክስን ስለሚመለከት፡፡

ለ. ያለነው ሞያተኞች ጥቂቶች በመሆናችን የአባላት ቁጥርና የሙያውን አድማስ ለማስፋት (Trauma) መካተት አለበት ተብሎ በብዙሃኑ በመወሰኑ እንዲጸድቅ ሆነ፡፡

3. የማህበሩ ምልክት/ሎጐ/ በተመለከተ ጥቂት ጥቆማዎች ተሠጥቶ ሙያተኛው ምክር

እንዲጠየቅና እንድናሰራ ሥልጣኑን ተሠብሳቢው ሰጥቶን ተበተነ፡፡

አድካሚው ውጣውረድ የበዛበት ምዕራፍ የመጀመሩ ደወል የበሰረው ከዚህ በኋላ ነበር፡፡ አንድን ነገር ከምንም መጀመር በጣም አስቸጋሪ ብቻ ሣይሆን ተስፋንም የሚፈታተን እንደ ነበር በወቅቱ የነበሩት የኮሚቴው አባላት እንደሚስማሙ አምናለሁ፡፡ ህጋዊ ፈቃድ ለማግኘት የገጠመን ውጣ ውረድ ቀላል ባይሆንም የገንዘብ ድጋፍ Sponsor ለማግኘት አዲስ በመሆናችንና ሊደግፉን ለሚፈልጉ ድርጅቶች ህጋዊ ደረሰኝ ባለመኖሩ የገቢ ምንጮችን ማግኘት ሌላ ፈተና ሆነብን፡፡

ከፊቶችን የተደቀኑትን ችግሮች ለመፍታት ሎጎ አሰርቶ ህጋዊ ደረሰኝ ማሣተም የግድ በመሆኑ የአደራጅ ኮሚቴው አባላት ለምልክት /ሎጎ/ ሥራ ሞያተኛ ለማነጋገር ወስነን በያለንበት ለማነጋገር ሙከራዎች አደረግን፡፡ ሆኖም ብዙዎቹ ለስራው የጠየቁን ክፍያ የሚታሰብ አልነበረም፡፡ በዚህ ወቅት ነበር አርቲስት ልዑልሰገድ ረታን ስለጉዳዩ ያማከርነው፡፡ ከፍተኛ ምስጋና ይድረሰውና ሙያዊ ድጋፉን በነፃ እንደሚለግሰን በገባልን ቃል መሠረት የዛሬውን ምልክት /ሎጐ/ ሠርቶ ለማህበራችን አበረከተልን፡፡ ገና በማህበሩ የሊጋ ዘመን ይህን

ወደ ገፅ- 6 ዞሯል

External Fixator አሻሻዩ በዕውቀቱ

በዕውቀቱ ደምሴ

በዕውቀቱ ደምሴ ራሱን የሚመድበው ቀደም ሲል ባለእጅ ተብለው ከሚታወቁት የህብረተሰብ ወገኖች ነው፡፡ ስለትምህርት ሲጠየቅ እስከ አስራሁለተኛ መማሩን ይገልፃል፤ ይሁንና ሱዳን ሐገር በስደተኝነት በኖረበት ጊዜ በጀርመኖች በሚረዳ የሙያ ትምህርትቤት ውስጥ ለአራት አመታት ያህል በኤሌክትሪካል ኢንስትራክተርነት አስተምሯል፡፡ ለማስተማር ብቁ ያደረገውን ቴክኒካል ዕውቀት ያዳበረው በመደበኛ ትምህርት አልነበረም ይልቁንም እሱ የሚያስታውሰው ገና የ12 ዓመት ልጅ እያለ ጀምሮ ቴክኒካል የሆኑ ሥራዎች እና በግሉ ተመራምሮ የሚፈጥራቸው አዳዲስ ነገሮች ይመስጡት ነበር፡፡ በራሱ ፈጠራ በቆዳና ፕላስቲክ ውጤቶች ላይ የደረቅ ህትመት (Embossing) ማተሚያ ማሽን ሰርቷል፡፡ ይህ ሥራውም በተለያየ ቦታ አገልግሎት ላይ ውሏል፡፡ያ የልጅነት ዝንባሌና ከህሎት አድጎ ነው አሁን በዚህ ፅሑፍ የምናነሳው ዋና ጉዳይ External Fixator (EXFIX)ለመስራት እንዲበቃ ያደረገው፡፡ ሆኖም ሀሳቡ አዲስ እና ከራሱ የመጣ አልነበረም፤ ይልቁንም የተሰጡትን ዲዛይኖች ይዞ ሀገር ውስጥ በሚያገኛቸው እቃዎች አስመስሎና አሻሽሎ መስራቱ ነው፡፡

በዕውቀቱ ስለ EXFIX አጀማመሩ ሲናገርም የአጥንት ህክምና ስፔሻሊስቱ ዶ/ር ይሄይስ ፈለቀ ከአየርላንዳዊው ፕሮፌሰር (ዶ/ር) ፊንታን ሻነን ጋር ያስተዋውቀዋል፡፡ ዶ/ር ፊንታንም በመጀመሪያ X- Ray reviewer የተባለ light box እንዲሠራለት ያዘዘዋል፡፡ በዕወቀቱም የታዘዘውን ሠራ፡፡ እንግዲህ ይህ ሥራ ከታየ በኋላ ነው ለተሠበሩ አጥንቶች ጥገና ከፍተኛ እገዛ የሚያደርገውን external fixator መሥራት እንዲሞክር ሃሳብ የቀረበለት፡፡ “ይህንን ውጪ ሀገር ተሰርቶ የመጣውን መሳሪያ እንድሞክር ሦስት ዓይነት ዲዛይኖች ተሰጠኝ፡፡ ዲዛይኖቹን ሀገር ውስጥ በማገኛቸው እቃዎች አስመስዬ ሠርቼ አሳየሁ፡፡ ሥራውን ከተመለከተ በኋላ ይህ ኮፒ ነው ስለዚህ ሀሳቡን ወስደህ በራስህ ፈጠራ ለመሥራት ሞክር አለኝ፡፡ በዚሁ መሠረትም በቀላሉ ሀገር ውስጥ በማገኘው ዕቃ የተለያዩ ዲዛይኖችን ሰርቼ ጊዬን ሆቴል በተካሄደው 4ኛው አገር አቀፍ የማህበሩ ስብሰባ ላይ በዶ/ር ይሄይስ ፈለቀና በዶ/ር ብሩክ ላምቢሶ አማካኝነት ለሙከራ ያህል የተሰበረ እንጨት ላይና የተሰበረ የእንስሳ አጥንት ላይ ተገጥሞ በሞዴልና በፎቶግራፍ ለተሣታፊዎች አቀረብኩ፡፡”

በስብሰባው ላይ ከተሣታፊዎች በመጣው አስተያትና የድጋፍ ማበረታቻ በኋላ ጅምሩን በሰፊው ተግባራዊ ለማድረግ መነሳሳቱን ያስታውሳል፡፡ ከዚህ ስብሰባ በኋላም በዶ/ር ፊንታን 10 EXFIX እንዲሠራ ታዘዘና ሠርቶ አቀረበ፡፡ በድጋሚም በተለየ ዲዛይን ተጨማሪ 10 EXFIX እንዲሠራም ታዘዘ፡፡ ለመጀመሪያ ጊዜ በዕውቀቱ ባሻሻለው EXFIX የተሠራውን ሙከራ ያስታውሰዋል “ በሠራሁት EXFIX ከጉልበቷ በላይ ሁለት እግሮቿ የተሰበሩ ልጅ ላይ በ ዶ/ር ፊንታን አማካኝነት ነበር የተሠራው፡፡ ነገር ግን ማስታወስ የምፈልገው ነገር ወደ ሰውነት ውስጥ የሚገባው ብረት (ፒን) እኔ የሠራሁት ሳይሆን ከውጭ ሃገር የሚመጣ መሆኑን ነው፡፡ ” ይላል በዕወቀቱ፡፡

ከዚህ ጊዜ ጀምሮ የተለያዩ በሽተኞች ላይ እየተሠራበት ይገኛል፡፡ ከእነዚህም መካከል በዕውቀቱ “በዶ/ር ብሩክ ላምቢሶ በተሰራው የአገጭ ስብራት ላይ፣ በዶ/ር ይሔይስ ፈለቀ ደግሞ ከክርኑ በላይ ስብራት የደረሰበት ሰው ላይ የተሠራው ለሙከራ ባሻሻልኩት ቀላል ዲዛይን የተሠራ ነው፡፡” ብሏል፡፡ በዚህም ማሻሻያውን በራሱ ፈጠራ እየተካ መሥራት እንደሚችል በዕውቀቱ በራሱ አምኗል፡ ፡ የሚፈልገው ነገር ከማህበሩና የአጥንት ስፔሻሊስት ሀኪሞች ጋር እስካሁን ያለውን መልካም ግኙኝነት ጠብቆ ሕልሙን ማሳካት ነው፡፡ እሱ እንደሚለው ከመጀመሪያው ጀምሮ መሻሻል የሚገባውን እየጠቆሙት በማሻሻል ላይ ይገኛል፡፡

በእውቀቱ ስለሚሰራቸው EXFIX ጠቀሜታ ሲያብረራ፣ ዋና ጠቀሜታው፡- የተሰበረ አጥንትን በቦታው ተመልሶ እስኪድን ድረስ ከሰውነት የውጨኛ ክፍል አካል በመሆን ይዞ የሚያቆይ መሣሪያ ነው፡፡ በእኛ አገር ውስጥ ስለሚያመጣው ለውጥም ሲናገር “አንድ- አገር ውስጥ መሠራቱ ከዋጋው ርካሽነት አንፃር ጠቀሜታ አለው፡፡ ሁለት- በሃገራችን ውስጥ ከእኔ የተሻሉ ብዙ ባለሙያዎች ስላሉ ከእነርሱ ጋር በመሆን ብንሠራ በአብዛኛው በልመና የምናመጣቸውን መሣሪያዎች እዚሁ በመሥራት ከልመና እንወጣለን፡፡ ” ይላል በዕውቀቱ፡፡

እንደ በዕውቀቱ ሃሳብ EXFIX መሥራት የሚፈልገው ቋሚ የሆነ የሥራ ቦታና የሥራ መሣሪያ አደራጅቶ በአዕምሮ ውስጥ የሚመላለሱትን የ EXFIX ዲዛይኖች ማምረት ነው፡፡ ሃሳቡ በዚህ ብቻም አይገታም ከተለያዩ የህክምና ባለሙያዎች ጋር በመተባበር አጥንት ውስጥ የሚገቡትን ፒን ፕሌቶች መሥራትንም ያልማል፡፡ “ለአዳዲስ ሥራዎች ሙከራ ወጪ ይጠይቃል፡፡ ስለዚህም አንዳንድ የውጭ ሀገር እርዳታ አድራጊዎች ሲመጡ ሥራዎቼ ቢታዩልኝና ትዕዛዞችን ባገኝ፤ የተለያዩ ዲዛይኞችን በብዛት ለመሥራትና ወደ ዋናው ዓለማዬም እንድደርስ ያስችለኛል” ይላል፡፡በዕውቀቱ እስከ አሁን ድረስ ከ50 በላይ EXFIX መሳሪያዎችን አምርቷል፡፡ የማሻሻያ ባለቤትነት መብት ለመጠየቅ በዝግጅት ላይ ነው፡ ፡ ማህበሩም እንደተለመደው ሙያዊ እገዛ እያደረገለት ይገኛል፡፡

በዕውቀቱ በመጨረሻም በጥቁር አንበሣ ስፔሻላይዝድ ሆስፒታል የአጥንት ህክምና ትምህርት ክፍል ባለሙያዎችን በሙሉ “ላደረጉልኝ ቅንነት ያልተለየው እገዛ እዚህ ስላደረሰኝ አመሰግናለሁ፡፡ እንዲሁም በጣም ላመሰግነው የምፈልገው ለመጀመሪያ ጊዜ ለፈጠራ ስራዎች መነሻ የሆነኝን መሳሪያ ኮፒ አድርጌ እንድሰራ የተባበረኝን አቶ ዘላለም ክንዴን ነው!” ብሎ ምስጋናውን አድርሷል፡፡

የህንፃ ግንባታው ዘርፍ የሠራተኞቹን ደህንነት ያስቀድማልን?

አዲስ አበባም ሆነ ወይም ሌሎች የኢትዮጵያ ከተሞች ብቻ ሕንፃ የሚሠራበት አካባቢ ስትደርሱ ቀና በሉና ተመልከቱ:: ምን ታዘባችሁ? አብዛኞቹ ህንፃዎች ለመወጣጫ የሚጠቀሙበት ከእንጨት የሚሠራርብራብን ነው:: ይህ ርብራብ ደግሞ ከረምት ከፀደይ ያለ አስታዋሽ አንዴ ከተሠናዳ በኋላ ሲሰራበት ይከርማል:: እናም አንድ ቀን ይህ ለሆነ ሰው ወድቆ የመሠበር ወይም እስከወዲያኛው የማለፍ ክስተት መነሻ ሊሆን ይችላል::

ከህንፃ ግንባታ ኮንስትራክሽን ዘርፍ ሌሎች ምክያቶችም ቢኖሩም አደጋ ከሚደርስበት ሰበብ ቅድሚያውን የሚይዘው ይኸው የመወጣጫ (scaffolding) አያያዝ ችግር ነው::በዚሁ በመወጣጫ ሰበብ በቅርቡ በባህርዳር ዩኒቨርስቲ 18 ሴቶች ወዲያውኑ የሞቱበት እና ከተወሰኑ ቀናት በኋላ አራቱ የተከተሉበት አደጋ አይረሳም:: 22ቱም ሟቾች ሴቶች ናቸው:: ፲፩ ሰዎች ላይ ከባድ ጉዳት ደርሶባቸዋል:: በወቅቱ መወጣጫው ላይ ወደ ሰማኒያ ሰው ነበር የወጣበት፣ ይህ እንግዲህ በአንዴ ብዙ ቁጥር ያላቸው ሰዎች ያለቁበት አደጋ ስለነበረ ነው አሁንም ድረስ ምሳሌ አድርገን የምናነሳው:: በየዕለቱስ በየቦታውስ ምን ያህል ሰዎች ለአንዴና ለሁልጊዜ አካላቸው ተሰናክሎ ከአልጋ ውለው ይቀራሉ፣ ሥንቶችስ ውድ ህይወታቸውን እንሥራ ኑሮን እናሸንፍ ብለው ጎንበስ ቀና ባሉ፤ ኑሮን መግፊያዬ ባሉት የሥራ ቦታቸው ተደፍተው ይቀራሉ? ለመገመት አስቸጋሪ ነው:: ጥቂት አለመሆናቸውን ግን በአዲስ አበባ ጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል ከሚመጡትም ሆነ በኢትዮጵያ የተለያዩ ክልል ሆስፒታሎች ውስጥ ያሉት የአጥንት ህክምና ዶክተሮች ሰዎች ተጎድተው የሚመጡት ከመኪና አደጋ ቀጥሎ በኮንስትራክሽን (ህንፃ ግንባታ) ምክንያት መሆኑን ሁሉም የሚመሰክሩለት ጉዳይ በመሆኑ ለማወቅ ይቻላል::

የጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል የአጥንት ህክምና ከፍልም ሆነ ሌሎች በተለያዩ ክልሎች ያሉ ሆስፒታሎች በመኪና አደጋ የሚማረሩትን ያህል በኮንስትክሽን ሰበብ የሚከሠቱ አደጋዎችንም ጫና ሳያነሱ አያልፉም:: ዶ/ር ውባለም ዘውዴ ከኢሶት ቁጥር አንድ መፅሔት ጋር ባደረጉት ቃለ ምልልስ "በየጊዜው እየጨመረ የሚመጣው የመኪና፣ የማሽንና ከግንባታ ጋር የተያያዙ አደጋዎች ቁጥር በሆስፒታሉ የድንገተኛ ክፍል የሚፈጥረው ጫና ከፍተኛ ነው" ሲሉ ተናግረዋል:: አደጋውን ባለን አቅም ሙሉ በሙሉ ለማስቀረት በአንድ ጊዜ ባይሆንልን እንኳን በየዘርፉ የሚከሠቱትን አደጋዎች ለመቀነስና ለመከላከል ግን እንችላለን:: በኮንስትራክሽን ዘርፍ ይህንን ፅሑፍ ስናዘጋጅ የተረዳነው ከባድ ነገር ቢኖር የአሠሪም ሆነ የሠራተኛ ግዴታን እና መብትን ጠንቅቆ አለማወቅ ወይም እያወቁም አለመተግበር ነው::

በድፍን ኢትዮጵያ በተለይም በአዲስ አበባ ኮንስትራክሽን (የህንፃ ግንባታ) ከፍተኛ ደረጃ ላይ የደረሰበት ወቅት ላይ ነን:: ህንፃ መገንባቱ፣ በሌላም ዘርፍ ለውጥ እየታየ መምጣቱ በመሠረቱ መልካም ሆኖ እያለ ህንፃዎቹ ሢሠሩ ግን የሥራው ሁኔታ ለሠራተኞች 'የሙያ ደህንነት እና ጤንነት' ቅድሚያ ሰጥቶ የመሥራቱ ነገር ላይ ግን ገና ነን:: የኢሰማኮ ኮንስትራክሽን ፌዴሬሽን ማኅበራት ማደራጃና ማኅበራዊ ጉዳይ መምሪያ ኃላፊ የሆኑት አቶ እታለማሁ አዳሙ ለሠራተኛው ጤንነት እና ደህንነት ቅድሚያ ሰጥተው የሚሠሩ ጥቂት ድርጅቶች እንዳሉ ይናገራሉ፣ እንደ ሞዴልም ሚድሮክ ቴክኖሎጂ ግሩፕን ይጠቅሳሉ፣ " ግን እነዚህ ድርጅቶች በአጠቃላይ ካለው ሁኔታ አንፃር ሲታይ የሌሎቹን አይገልፁትም" ይላሉ::

የሙያ ደህንነት ጤንነትን በተመለከተ በአሠሪና ሠራተኛ ጉዳይ አዋጅ ቁጥር 377/96 አንቀፅ 92 ላይ የአሠሪ ግዴታዎች ንዑስ ርዕስ ሥር የተዘረዘሩ ድንጋጌዎች አሉ: : ይሁንና ድንጋጌው ጥቅል በሆነ መልኩ የሙያ ጤንነት ደህንነት ለሠራተኞች ቅድሚያ መስጠት የመጀመሪያውና አማራጭ የሌለው መሆኑን ይዘረዝራል እንጂ፤ ድንጋጌው

ላይ ይሄ ለፋብሪካ ይሄ ለኮንስትራክሽን ተብሎ ተለይቶ የተቀመጠ ነገር የለም:: አቶ አዳሙ እንደሚናገሩት በኮንስተራክሽን ዘርፍ "አደጋዎች እንዳይደርሱ በኢትዮጵያ ደረጃ ወጥ የሆነ ፖሊሲ የለም፣ የሙያ ጤንነት ደህንነት ፖሊሲ በሀገራችን ገና በፕሮፖዛል ደረጃ ነው ያለው፣ ለሶስተኛ ጊዜ ውይይት ተደርጎበታል:: አሁን የመጨረሻው እየተጠበቀ ነው::በዓለም ደረጃ አሁን ሲታይ በየቀኑ ከ550 ሺህ በላይ አደጋዎች እየደረሱ ነው ያሉት:: በሀገራችን ስለማይሰበሰብም መረጃው የለም፣ መረጃ ስጡ እንኳን ተብሎ አሠሪው ቢጠየቅ ይደብቃል እንጂ አይሰጥም: : አወጣው ማለት ገበናው የወጣ ነው የሚመስለው:: "ይላሉ::

አቶ አዳሙ ለኮስትራክሽን ብቻ ተብሎ ፖሊሲ የመውጣቱን ፋይዳ ሲያስረዱ እንዲህ ይላሉ "ፖሊሲ ከወጣ ለየትኛውም አሠሪ እንደ አንድ መመዘኛ እርካብ ሆኖ አንድ ለውጥ ሊያመጣ ይችላል ብለን እንጠብቃለን፣ አዋጁ የሙያ ጤንነት ደህንነት አንቀፅ 92 ላይ ለእሱ ማስፈፀሚያ መመሪያ ወጥቶለታል ማንም ሰው የሙያ ጤንነት ደህንነት ተከታታይ ኮሚቴ ማቀቋቋም አለበት ተብሎ ወርዷል:: ማን ይተግብረው? አስፈፃሚው አካልም ያንን ያወጣውን መመሪያ የማስፈፀም አቅሙ፣ የሰው ኃይሉና የገንዘብ ኃይሉ ምክያንቶች ሆነውበታል:: ኃላፊነቱን መውሰድ ያለበት ራሱ በኮንስትራክሽን ዘርፍ የተሠማራው ባለሃብቱ ነው፣ አንድ ንብረቱን ይጠብቃል፣ ሁለት የሰው ልጆችን ወድ ህይወት ያድናል:: ለ15 ዓመት አብሮ ሲሰራ የቆየ ሰው እጅ እግሩ ተሰብሮ ጭንቅላቱ ተፈንክቶ ከቤት ዋለ ማለት ሌላ አዲስ ባለሙያ ነው የሚሰለጥነው፣ሃብት እየባከነ ነው፣ ቤተሰብ እየተበተነ ነው፣ ከተጎጂው ጀርባ ስንት ልጆች አሉ?" ይጠይቃሉ አቶ አዳሙ::

እስከዛሬ አካሉ የጎደለውን፣ የተበተነው ቤተሰብ፣ የባከነ ንብረት የቆጠረ የለም ምክንያቱም ይህንን ተከታትሎ የደረሰ ጉዳት ይሄን ያህል ነው ብሎ ሊነገር የሚቻልበት ዘዴ ኢትዮጵያ ውስጥ ገና ተግባር ላይ የዋለ አይደለም:

: አቶ አዳሙ በቅርብ እንደታዘቡት አብዛኛዎቹ አሠሪዎች ከምትገኘዋ ትርፍራፊ ገንዘብ የሚገኘውን ጥቅም ማየት እንጂ ለሠራተኞች ደህንነት ቅድሚያ ሰጥቶ የመስራት ነገር የላቸውም:: ተስፋ የተጣለበት በቅርቡ ተቀርፆ ይጠናቀቃል ተብሎ የሚጠበቀው ፖሊሲ ነው:: "ፖሊሲው ጫፍ እየደረሰ ነው የሠራተኛ እና ማህበራዊ ጉዳይ ኃላፊነቱን ወስዶ ሥራውን እየሠራ ነው:: ግን ዘግይቷል::" ይላሉ አቶ አዳሙ::

አቶ አዳሙ እንደሚናገሩት "በዓለምአቀፍ ደረጃ መወጣጫ እስከ አራተኛ ፎቅ ድረስ በእንጨት መሥራት ይቻላል: : ከአራተኛ ፎቅ በኋላ ግን በምንም ተዓምር በእንጨት መሥራት ክልክል ነው:: በእኛ ሀገር አሁን ያለው ነገር ግን እስከ አስራሁለተኛ ፎቅ ሁሉ ድረስ በእንጨት ይሠራል:: ያ እንጨት ደግሞ አንድ ከረምት ሙሉ ዝናብ እንዲወርድበት ይደረግና በዚያው እንጨት ላይ ሰዎች እንዲወጡ ይደረግና ሰዎች ይወድቃሉ:: አሁን ስለ አጥንት ጉዳት ነው የምናወራው አይደለም? ግን ህይወት ይጠፋል::"

ለኮንስትራክሽን ዘርፍ ተብሎ ለብቻ የተደነገገ ነገር ባይኖርም የአሠሪና ሠራተኛ አዋጁ አንቀፅ 92 የአሠሪው ግዴታዎች ቁጥር 3:- ለሠራተኞች የአደጋ መከላከያ መሣሪያ ልብስና ሌሎች ቁሳቁሶች ያቀርባል፤ ስለአጠቃቀሙም መመሪያ ይሠጣል:: ሲል ይደነግጋል:: በቁጥር 6 ሥርም የሚከተለው ተደንግጓል: - የድርጅቱ የሥራ ቦታና ግቢ በሠራተኞች ደህንነትና ጤንነት ላይ አደጋ የማያስከትል መሆኑን ያረጋግጣል፤ ይላል፣ እዚህ ጋር ግን የአቶ አዳሙ ጥያቄ በድጋሚ ይመጣል- ማን ይተግብረው? ህጉ ያስቀመጠው የአሠሪውን ግዴታዎች ብቻ አይደለም አንቀፅ 93 የሠራተኛ ግዴታዎች ቁጥር 3 ሥር ሠራተኛውም ለገዛ ጤንነቱና ደህንነቱ ኃላፊነት እንዳለበት ሲያስቀምጥ :- አደጋ ሊያደርስ ይችላል ብሎ ለማመን ምክንያት ያለውንና በራሱ ሊያስወግደው ያልቻለውን ማናኛውንም ሁኔታ እንዲሁም በሥራ ሂደት ወይም ከሥራ ጋር ግንኙነት ባለው ሁኔታ በጤንነት ላይ የደረሠን አደጋ ወይም ጉዳት ለአሠሪው ያሳውቃል፤

ህጉ የሚተገብረው ቢኖር ማንም ቢሆን እሠራ ብሎ ጉዳት እንዳይደርስበት፤ ሲሆን ምንም ዓይነት ጉዳት ከመድረሱ በፊት በሚመለከታቸው መስሪያ ቤቶች እንደ ሠራተኛና ማህበራዊ ጉዳይ ሚኒስቴር ባሉ አስፈፃሚ አካላት በተቻለ መጠን የተለያዩ መመሪያዎች ወጥተው ተፋፃሚ እንዲሆኑ ይሞከራል:: ሙከራው ከችግሩ ግዝፈት አንፃር የሚያስመካን አይደለም:: ለዚያም ነው በየዕለቱ አደጋን የምናስተናግደው:: አቶ አዳሙ ሁኔታውን ሲያስረዱ "ከደርስንባቸው ያልደረስንባቸው ይበልጣሉ:: ኮንትራክተሩ ለምሳሌ ለኢንሹራንስ የሚከፍለው አለ፣ ለዚያውም

ሲነቃበት፣አለበለዚያም እንዲሁም ተጠቅልሎ በመኪናም ተወስዶ የሚወደቅባቸውም አጋጣሚዎች አሉ፣ ማህበር በሌለባቸው የኮንስትራክሽን ዘርፎች ሙሉ በሙሉ የምናገረው ነገር፣ወድቆ ምናልባት ሆስፒታል አድርሰውት ሊሆን ይችላል፣ ምናልባት ወይ ሆስፒታሉ ተቸግሯል፣ ብቻ ብዙ ነገር እንሰማለን፡፡ መረጃው እጃችን ላይ ደርሶ የቀረፅነው ነገር ባይኖረንም፤ እንደዚህ ዓይነት ሽሽት የሚደርግበትም ሁኔታ አለ፡፡ የታክሲ ስጠውና ራሱ በታክሲ ይሂድም ይባላል፡፡ የሰዎች ሰብዓዊነት ምን ያህል እንደሆነ ማየት ነው” ይህ እንዳይሆን ፣ በተለይ ከአዲስ አበባ ሠራተኛና ማኅበራዊ ጉዳይ ጋር በመተባበር “እኛ በፌዴሬሽናችን እንደአቅማችን የአስተሳሰብ ለውጥ እንዲመጣ፣ ወደ ሥራው ሲገቡ ቅድሚያ ለጤንነታቸው መጠበቂያ የሚረዱ አልባሳትን ፣ መከላከያዎችን እንዲለብሱ፣ ቢያንስ በዓመት ውስጥ ሁለት ጊዜ ከ80 በላይ ለሚሆኑ ማህበራት መሪዎች ግንዛቤ እንዲያገኙ እናደርጋለን፡፡” ለወደፊቱ የተሻለ ግንዛቤ ያላቸው ሠራተኞች እንዲሁም አሠሪዎች እንዲኖሩ ለማንቃት የጎንደር ዩኒቨርስቲ በዚህ ዙሪያ ላይ የሚሠሩ የሙያ ጤንነት ደህንነት ባለሙያዎችን እያስተማረ መሆኑንም አቶ አዳሙ ይናገራሉ፡፡በኢሰማኮ ኮንስትራክሽን ፌዴሬሽን ሥር 92 ድርጅቶች አሉ፣ የእነዚህን ድርጅቶች አመራሩን ለማብቃት፣ ኢሠማኮ አቅሙ ውስን ነው፣ ስለዚህም ከማቴ እዲቋቋም ያደርጋል፣ የተቋቋሙባቸው ጥቂት ድርጅቶች አሉ፣ጉዳዩን ተከታትለው ደግሞ እየሠሩ ያሉ በጣም ጥቂት ድርጅቶች ደግሞ አሉ፡፡

ተስፋው መልካም ነው ግን በተግባር ለመዋል ጊዜ የሚሠጠው ጉዳይ አይደለም፡፡ በኮንስትራክሽን ዘርፍ ከመወጣጫ አያያዝ ጉድለት ችግር ውጪ ሠራተኞች የሚጎዱበት ብዙ ጉዳዮች አሉ፡፡ እንደምሳሌ የመተላለፊያ፣ የመሠረትና የግድብ ቁፋሮዎች ውስጥ የሚያጋጥም ናዳ፣ከከፍታ ወዳቂ ነገሮች፣ በአግባቡ አገልግሎት ላይ ያልዋሉ ወቅታዊ ጥገናና ምርመራ የማይደረግላቸው የኮንስትራክሽን ማሽነሪዎችና ተሽከርካሪዎች፣ ወ.ዘተ ግን የትኛውም ዓይነት የአደጋ መንስዔ ሊሆን የሚችል ነገር ቅድመ ጥንቃቄ እስከተደረገ ድረስ ሊቀነስ የሚችል እና ሲሳካም ሙሉ በሙሉ ሊቀር የሚችል ነው፡፡ የእንጨት መወጣጫን ከብረት ይልቅ መርጠን የምንጠቀምበት ዋና ምክንያት የአቅም ጉዳይ እንደሆነ ይነሳል፣ ይሁን ከዓመት ዓመት የተበላሸ የሚመስለንን አካባቢ እንኳን ለማደስስ ምን ያዘን የተወሰነ ወጪ ከሰው ልጅ ውድ ሕይወት ሊወዳደር አቅም አለው? ኪሣራ የሚሠላው በገንዘብ ብቻ ከሆነ ውጤቱ አሳሳች ይሆናል፡፡ ሳይት ላይ አንድ ሠራተኛ ወድቆ ሞተ፤ በሚቀጥለው ቀን ሌሎቹ ሠራተኞች እንደከዚህ ቀደሙ የሥራ ብቃታቸው አብሮቸው ይኖራል? የዚህ ኪሳራስ?

ማንም ቢሆን ወደ ስራ የሚሄደው የሚሠራው ሥራ ምንም ይሁን ምንም ኑሮውን ለማሸነፍ ነው፡፡ በመግቢያችን ላይ ያስታወስናቸው የባህርዳር የቀን ሠራተኞችም ወደ ሥራቸው የመጡት ለዚሁ ነው፡፡ ግን አደጋው የደረሰባቸው ዕለት፤ የዕለቱን ተግባራቸውን አጠናቅቀው ወደየቤታቸው ለመሔድ እየወረዱ እንዳለ የእንጨቱ መወጣጫው ተደርምሶ ከ7ኛ ፎቅ ቁልቁል ተምዘገዘጉ፡ : ከሥር ምን ተቀበላቸው? ይህ የዕድል ጉዳይ አይደለም ትክክለኛ አሠራር ሰዎችን የሚያስቀድም ሥርዓት ቢኖር መጨረሻቸው እዚያ ጋ ላይሆን ይችል ነበር፡፡

ልማት መፋጠኑ ደግ ነው ግን የሰው ልጆች ደህንነትስ? ይህን ጉዳይ አስመልክቶ በአዲስ አበባ ሠራተኛና ማኅበራዊ ጉዳይ ሥር በየሩብ ዓመቱ እየታተመች የምትወጣው “አዲስ ምዕራፍ” መፅሔት በቅፅ2 ቁጥር 5 ጥር 2003፣ ከከቡር ዶ/ር ዘሪሁን ከበደ የፌደራል ሠራተኛና ማኅበራዊ ጉዳይ ሚኒስቴር ሚኒስትር ዴኤታ ጋር ቃለምልልስ አድርጋ ነበር፡፡ ሚኒስትር ዴኤታው ስለ ሥራ የሙያ ጤንነት ደህንነት ሲናገሩ የሚከተለውን ብለዋል “በሥራ ቦታ የሙያ ደህንነት ጤንነት ጥበቃ ጉዳይ ከሌሎቹ ቁልፍና ቀዳሚ ተግባራት ባነሰ ደረጃ የሚታይና ሲሞች ብቻ የሚከናወን ተደርጎ መወሰድ የሌለበት የህልውና ጥያቄ ነው፡፡ የሠራተኛው ደህንነትና ጤንነት መጠበቁ ሳይረጋገጥ ስለቁሳዊ ሃብት ወይም ስለምርትና ትርፍ ማሰብ ለዘላቂ ውጤት የሚያበቃ አይሆንም ... በአሠሪና ሠራተኛ ህጋችንም በግልፅ ተደንግጓል፡፡” ጉዳዩ የመንግሥት ወይም የአንድ አስፈፃሚ አካል ወይም ቅሬታ ሠሚ ኮሚቴ ጉዳይ አይደለም፡፡ የሁሉም ነው አሠሪዎችም እዚህ ግባ የማይባልን ጥቅም በማሳደድ ወይም ድፍን ባለ ቸልተኝነት ሥራቸው መከወኑን ብቻ ሳይሆን፤ ህጉ እንደሚጠይቀው የሠራተኞቻቸውን ደህንነትና ጤንነት የማይጎዳ የሥራ አካባቢ የመፍጠር ኃላፊነታቸውን መወጣት ይገባቸዋል፡ : ሠራተኞችም ግዴታቸውን አሟልተው መብታቸውንም አውቀው ራሳቸውን የመጠበቁን ኃለፊነት ለራሳቸው መውሰድ ግድ ይላቸዋል፡፡

የአጥንት ህክምና...

ከዚህ በተጨማሪ በአዲስ አበባ እና በሌሎች ከተሞች በሚገኙ ዩኒቨርሲቲዎች የአጥንት ህክምና ትምህርትን በተለያዩ ደረጃዎች የማስፋፋት እንቅስቃሴዎች በዘርፉ የሚሰጡትን አገልግሎቶች በበቂ ሁኔታ ለማዳረስ ተስፋ የሚሰጡ ሁኔቶች ናቸው፡፡ ዶ/ር ዘላለም እንደሚሉት ህክምናውን በአገር አቀፍ ደረጃ የማሳደጉ ነገር ብዙ ሊሠራበት የሚገባ ነገር ነው፡፡ “ባለሙያዎችን ማፍራት፣ ያሉንንም ባለሙያዎች በተደራጀ እና በአግባቡ መጠቀም ቢቻል እና የእውቀት ደረጃቸው ከፍ ያሉ ባለሙያዎች የልምዳቸውን የሚያጋሩበት ሁኔታ ቢመቻች መልካም ነው፡፡ ትኩረት ሰጥቶ ከተሠራ የአጥንት ህክምና አስደሣች እና ውጤቱም የሚያረካ የህክምና መስክ ነው፡፡” ሥልጠናውን በማስፋፋት ረገድ የህክምና ተቋማቱ በየአካባቢያቸው ካሉ ዩኒቨርሲቲዎች ጋር እየሠሩ መሆናቸው ለነገ የዘርፉ መጠናከር ከሚኖረው አስተዋፅዖ ባሻገር ተማሪዎች በ“ሬዚደንስ” የህክምና አገልግሎታቸውን እንዲያግዟቸውም ያስችላቸዋል፡፡

በአንዳንድ ዩኒቨርሲቲዎች ከታየው ጅምር በተጨማሪ በአዲስ አበባ ዩኒቨርስቲ የአጥንት ህክምና የትምህርት ክፍል የታየው ለውጥ ትልቅ ተስፋ የሚያሰንቅ ነው፡፡ ትምህርት ክፍሉ ባሳለፋቸው ሃያ አምስት ዓመታት የሚያስመረቃቸው በሙያው ስፔሻላይዝ ያደረጉ ተማሪዎች ቁጥር አንዴም ሲወርድ አንዴም ሲወጣ የነበረ ቢሆንም አሁን በሀገሪቱ አሉ ተብለው የሚጠሩትን ሐኪሞች ለማፍራት ተችሏል፡፡ የዚህ ዓመት የተማሪዎች ቁጥር ግን በዚህች ሐገር ታሪክ የተመዘገበ ትልቁ ቁጥር ነው፤ ቀድሞ ሦስትም አራትም ተማሪዎችን ያስመርቅ የነበረው አዲስ አበባ ዩኒቨርስቲ ዘንድሮ 12 ተማሪዎችን ተቀብሎ በዘርፉ ማሠልጠን ጀምሯል፡፡

ሕክምናውን የተሻለ ለማድረግ መንገድ ከሚያመቻቹ ነገሮች አንደኛው ነገር ብለው ሁሉም ያነጋገርናቸው ሐኪሞች የሚስማሙበት በሀገሪቱ ባሉት ባለሙያዎች መካከል የልምድ ልውውጥ መኖሩን እና፣ ሥልጠናዎች እየተበረታቱ እና እየተስፋፉ መምጣታቸውን ነው፡፡ ይሁንና ባለሙያው ብቻውን የቱንም ያህል ሁኔታውን የተሻለ ለማድረግ ቢሞክር የህዝቡ ግንዛቤ እና በፖሊሲ አውጪዎች ዘንድ ለአጥንት ሕክምና የሚሰጠው ትኩረት እስካልተጠናከረ ድረስ ችግሩ ማቆሚያ አይኖረውም፡፡

በመሆኑም ባለሙያዎች በቅንነት ተቀራርበው በመሥራት እና የእውቀት ሽግግርን በማመቻቸት፣ እንዲሁም አዳዲስ ቴክኖሎጂዎችን ለመሞከር ፈቃደኛ በመሆን፤ የሚመለከታቸው መንግሥታዊ አካላትም ተገቢውን ድጋፍ በማድረግ የአጥንት ህክምናን በመላዋ ኢትዮጵያ ማስፋፋት እና ማሻሻል እንደሚችሉ እንተማመናለን፡፡

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NEWS & BRIEFS

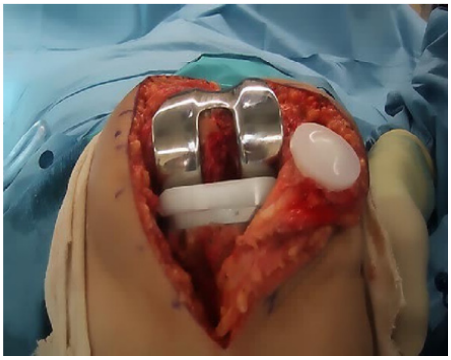
SIGN News, ETHIOPIA:

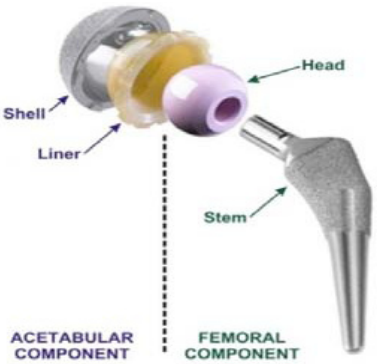
The second SIGN visit to Addis; by Dr. Lewis Zirkel (Founder +President) and Jeanne Dillner (CEO) was one of the main events last year. Operated at BLH, St. Paul and did experimental surgeries on sheep.

Dr Lewis selected four papers from Ethiopia to be presented at SIGN annual conference in the USA-Richland. Drs. Biruk, Anderson, Samuel and Robel successfully made this trip.

Dr. Lewis demonstrating the Sheep Surgery in a VET-OR in Addis. SIGN has 4 lambs for this experiment.

The first Total Joint Replacement campaign at BLH





Dr. Kebret Kebede and Dr. Robin Herlands of NSC (Nevada State Collegem USA) have organized the first Total Joint Replacement Surgical campaign at Black Lion Hospital. The team was composed of 11 other Medical personnel including students. BIOMET donated the instruments and implants. Of about 800 patients listed for the surgery, 15 were operated during the 2 weeks campaign. Dr, Birhane was the first patient to benefit from TOTAL KNEE REPLACEMNT jointly done by Drs Eric, Kebret and Biruk. Members of the society were observing and attending the procedure. Kebret and Herlands were holding several national mass media/press releases.

Per their promise, we expect repeated such visits from NSC and NSF. The society encourages this effort and thousands of disadvantaged patients have to be operated in this country.

Dr. Kebret Kebede

The first Total Joint Replacement campaign at BLH

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Preparation of SPAN of Orthopaedic Surgeon's practice in Ethiopia with Federal MOH and FMHACA.

The Federal Minster of Health approached ESOT to prepare the span of an orthopaedic surgeon's practice. It is also known that the Minstry is on the way to give all accreditation services and rights to the ethiopian Medical Association and its Sister Societies. Based on this two major CMEs were conducted on accreditation and EMA is in the future the main accrediting body of medical doctors.

ESOT delegated Drs Elias and Biruk to prepare the span of practice for Ethiopian Orthopaedic Surgeon and they have submitted the guidelint to MOH/FMHACA. All sub-specialities of Orthopaedics are included.

NEWS & BRIEFS

CME on trauma and Wound care, Wound VAC

This was a very "international" event , first of its kind, jointly organized by ESOT, EMA, SIGN and AAU.

Dr. Lia Tadesse, representing EMA has addressed the CME and officially opened the meeting. All excutives of EMA and EMA office staff were there. Total attendance as reported by EMA was 85.

EMA is thanked for picking orthopaedic topic as CME and this has to continue every year.

We thank Dr. Loch Trimmengham for his kind contributions in buying wound VAC machines from US and from Kim Jinko. Dr. Loch is our regular visitor and mentor. Loch also brought Cynthia, Wound Specialist with him. Stephane from the US, representing Stryker was active in organizing the setup and the 'mess" in the OR. She has tought the theatre Nurses and spent several days to arranging the implants and sets we have in both Orthopaedic ORs at BLH. She is expert in inventory! Dr. Duane Anderson came all the way from Soddo-Ethiopia (about 400Km) and shared his experience on open fractur and wound care. Dr. Mike Laurence from WOC-Uk has made valuable commens at the CME. Orthopaedic Surgeons managed to come from all over the country: Soddo, Mekele, Diredawa, Asela, Wolliso…. Were there. Prof. Yeweynhareg, EMA president was among th main speakers. Resident's (Samuel, Geletaw, Tadesse and Worku) presentations were super! Orthopedic department consultants Nurses were also among the discussants. ESOT thanks the sponsors and all involved!

Agenda of 1st National CME on Open Fracture and Wound Care

ORGANIZED BY EMA, ESOT, AAU & SIGN: NOV. 17,2011

Venue: AAU, Black-lion Hospital, Orthopedics Building; Conference Room 308

Time	Activity	Presenter/Responsible	Remark
	Overall coordenation & Managment	Dr. Biruk	
08:00a.m08:30am	Registration	W/o Yemenashu	
08:30a.m – 8:45 am	Opening/Key-note address	Dr. Lia	EMA/ESOT Executives
8:45am-9:45 am	Open fracture and principles of management	Dr. Loch	Moderators: Dr. Mike & Dr. Woubalem
9:45 a.m-10.30a.m	Proposed protocol for open # care in Ethiopia	Dr. Geletaw/Dr. Worku	
10:30a.m – 11:00 a.m	Tea/Coffee Break		
11:00a.m-11:45a.m	General wound care	Cynthia	Moderators: Dr. Tezera & Dr.Bahiru
11:45am-12:05 p.m	Analgesics in trauma	Dr.Tadesse	Dr. Dereje
12:05p.m-12:30p.m	Diabetic wound care	Prof. Yeweyenhareg F.	Dr. Fekadu T
12:30p.m -2:00 p.m	Lunch Break		
2:00p.m -03:30 p.m	Panel discussion on soft tissue coverage/flaps	UCSF/IGOT Flap course attendees (Biruk, Elias, Dereje, Samuel)	Moderators: Drs. Anderson & Dr. Biruk
	Closing remarks	Dr.Abiy Hiruye	EMA Office
	Group Picture		
03:30p.m-04:00p.m	Tea/Coffee Break		
03:30p.m-04:30 p.m	Demonstration of NPWT machines (VAC) from SIGN & Kim & Tour to future wound care Clinic site in BLH	Dr.Loch & Cynthia	Dr. Yehyis F
04:30 p.m	End of CME	Ato Alehign & Ato Abraham	Group Picture
Notice	NEXT WEEK , There will be several additional sessions for Orthopedic residents and all Orthopedic Nurses		

South African Orthopaedic Association (SAOA) International foot course.

This, first of its kind shall be conducted in Addis Ababa starting from November 30th 2012. Dr. Jim W. Harrison , Chairman of the AO-SEC for Africa region has confirmed the shedule. Please see the shedule attached. Surgeons, Senior residents and Orthopaedic OR Nurses all over from our country shall use this opportunity to get an advanced international training! Registration shall be conducted at ESOT office.

The SAOA foot course shall be conducted in the first week of December 2012. Register at ESOT earlier!

The regular Non operative AO- courses were successfully conducted in Adama and Mekele cities.

NEWS & BRIEFS

Grand Round: Musculoskeletal complications of Diabetes:

This was held at BLH togeather with the department of Internal Medicine, Endocrinlogy unit.

Many attended the grandround. Dr. Loch, Prof. Yeweynhareg, Biruk, Samuel and Tadesse presented. Residnets from Internal Medicine as well.

DVT protocol development:

With the departments of Haematology and Pharmacology, we are developing a national DVT prophylaxis guideline. It is under publication and the unit has started practicing this. Drugs are now avaliable and listed in the Natiopnal Essential drug list book of Ethiopia.

PODOCONIOSIS and the birth of NaPAN:

ESOT is one of the constituent members of NaPAN (National Podoconiosis Action Network). NaPAN is a national consortum aimed to eradicate podo in our life time. Effective April 2012, NAPAN is chaired by IOCC (International Orthodox Christian Charities) and ESOT is a vice Chair.

Rural Orthoapedic surgery outreach campings with AMREF:

Dr. Florence Temu of Tanzaia is the new AMREF country director for Ethiopia.-just arrived.

Deputy country director Dr. Awoke and our usual "Friend" Sr. Abeba togeather with Dr. Biruk have prepared a warm welcome cermony at Dr. Biruk's ofice. Biruk discussed how AMREF works with ESOT in addressing surgial campings in the rural Ethiiopia. Our Society members Especially Drs Fekadu, Yiheyis , Biruk, Selamu and Zegene are heavily involved with AMREF in voluntering for rural surgical campings.

It is important to note that ESOT supports and welcomes AMREF's outreach surgery activities to the Orthopaedic department at BLH in funding Saturday surgeries doe to decrease waiting list and handle open fractures in time. ESOT wants this to expand to other Hospitals as well.

Welcome Dr.Flo! Ready for COSECSA.

Implants to be listed on Essential drug list of ETHIOPIA.

For the first time, in history of our country, Orthopaedic Implants and Instruments are prepared tobe listed in the national Essential drug list book of FMHACA(DACA) March, this year. Pharmaceutical Fund and Supply Agency (PFSA), TASH through its DTC (Drug and Therapeutic Committee) worked with the Orthopaedic department in preparing this basic list. Black lion Hospital preparedd its own comphresnsive drug, supplies, implant and equipment list. Dr.Biruk presented the ortopaedic list prepared at a 2 day conference held in Churchil Hotel. The book is finalized and will be submitted to MOH (FMHACA) for publication-you can referr to the soft copy available!Basic Implants and products from the smallest screw to Joint replacement sets are included to make importing and local manifacturing easy. Drs Elias, Woubalem and Tezera helped in preparing the Orthopaedic implants list.

It is learned that H.E Dr. Tedros Adhanom, MOH; encourages and supports the development of a technology to manifacture basic/common orthopaedic implants in our country and; Ato Yehulu Denekew, main excutive Director of DACA (FMHACA) supports and his office is ready to facilitate import of standard/certified ortopaedic implants to Ethiopia .

This 18 year-old girl is ten days out from a motorcycle crash and is being visited on grand rounds by the residents. She broke both femurs and had both fixed with SIGN nails. She is walking and working on her knee motion and will be discharged soon. Photo: Dr. Neil J. White

A Progressive Partnership - SIGN in Ethiopia

By Amanda

B uried in the Horn of Africa, Ethiopia is a land rich in history and natural beauty but wracked with famine, war, and poverty. Over 90 million reside in the landlocked country and the WHO reports that gross national income per capita is $220 compared to the United States where GNI per capita is $46,040. Like most countries that SIGN works with, Ethiopia faces an epidemic of road traffic accidents. In 2006, over 2,000 people were killed in road traffic accidents and in 2007, almost 25,000 road traffic related injuries were reported, a number that has only continued to rise. Black Lion Hospital, located in Addis Abba, is one of only two university hospitals in Ethiopia and is the largest general public hospital in the city. They have been a SIGN program since 2009 and after garnering a reputation for quality orthopaedic care, have been inundated by a flood of patients. Upon his arrival at Black Lion Dr. Neil J. White wrote in an email to SIGN, "The head of ortho [Dr. Woubalem Zewde] at Black Lion cried when I delivered the implants. She said they had been scrambling for the last month and were on the brink of ordering cheap implants from China." An adequate supply of tools, training, and implants can do much more than just help the patients that receive them. It builds credibility and trust with patients like this young woman pictured above, who will in turn, share their experience with others in the community.

NEWS & BRIEFS

Good Orthopaedics is More Than Implants

By Dr. Lewis Zirkle

Orthopaedic surgeons, like all people, have problems whose solutions are more dramatic than others. The case of Mastwal Hailu, who had a tumor excised and avoided amputation by using allograft bone and SIGN nail, (see sidebar) was a dramatic event for all who participated. Treatment of open fractures where the soft tissues are penetrated leaving exposed bone is not included among these dramatic events. Surgery cannot be scheduled for these patients as they arrive at all hours of the day and night. Some patients arrive shortly after injury and some come days after injury. This delay compromises treatment results. Hospital facilities and personnel must be prepared for all patients.

Treatment of open fractures involves prompt surgery and long hours spent cleaning wounds to decrease infection and provide the optimal environment for healing. If infection cannot be controlled, amputation of the extremity, sepsis and death are distinct possibilities. The treatment is a long process involving multiple debridements (removing dead tissue from the wound). Patients may need flaps which means transposing tissue from one part of the body to another.

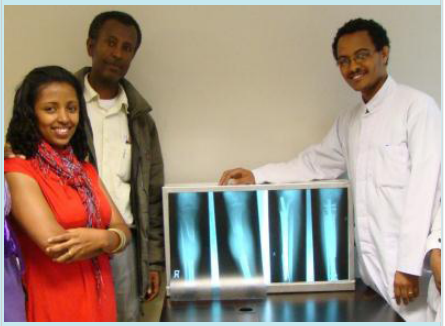
SIGN and SIGN surgeons prepare to treat open fractures by learning how to do flaps, proper debridement and stabilization using implants.

Hospitals must spend precious funds to provide operating room and hospital beds to treat open fractures. If the fractures become infected, hospital beds in isolation is the standard of care.

Treating open fractures is difficult, inconvenient and expensive. Patients with open fractures need advocates to facilitate optimum treatment. Orthopaedic surgeons and hospital administrators must be special people to recognize and provide facilities and take time to treat open fractures. Dr. Woubalem, chief of orthopaedic surgery at Black Lion Hospital in Addis Ababa, Ethiopia, has worked to improve care of open fractures. Her staff and the administrators at Black Lion recognize the need for available operating rooms and personnel that are prepared to treat open fractures on a timely basis.

Dr. Woubalem and the staff's expressions demonstrate their concern for a patient with complications from an open fracture

Institute for Global Orthopaedics & Traumatology (IGOT) San Francisco conducts an annual flap course for SIGN surgeons before the SIGN conference at the San Francisco General Hospital



First Bone Transplant in Ethiopia

At Black Lion Hospital, Jeanne met a remarkable 25 year-old female college student named Mastewal Hailu. She had nearly lost her tibia due to a rare malignant tumor called Adamantinoma. Her father was able to share her moving story about the troubles they initially faced and then of her extraordinary recovery.

When they first learned that her tumor was cancerous, their friends and family raised enough money for them to travel to Norway to receive treatment. They were nearly ready to purchase the airline tickets when they found out that their daughter was not eligible to receive treatment because she was not a Norwegian citizen.

They only became more discouraged when they learned that without treatment the best course of action was to amputate her leg – because leaving the tumor in her body would compromise her life. Her father's eyes filled with tears as he relived the moment when Mastewal refused to have her leg amputated. Their family, friends, and congregation turned to prayer, and asked every medical professional they encountered for alternative methods of treatment.

A year later they met Dr. Biruk from Black Lion Hospital who consulted with Dr. Erik Gocken, an orthopaedic surgeon stationed at CURE international in Addis. They removed the tumor from her tibia along with 15cm of her tibia. Dr. Gocken was able to get Ostetech to donate allograft to replace the bone that was removed and a SIGN nail held the allograft in place while her bone reformed, eventually allowing her to walk again and return to school to finish her degree.

NEWS & BRIEFS

Grappling With Tradition

By Amanda Wang

D espite a low average annual income per capita amid a turbulent history, Ethiopia is slowly picking itself up and beginning to thrive. The government has promoted a growing export industry in flowers and sesame seed production has begun in response to demand from China. However, poverty still blankets the vast majority of the population that resides in the countryside while traditional culture clashes with forays toward modernity.

Black Lion Hospital in Addis Abba is a quintessential example of a SIGN program that has the training necessary for quality care but often lacks the tools and implants to meet the incredible demand pressing down upon them. With the incidence of road traffic accidents rising sharply, the pervasive practice of initially consulting a traditional bonesetter healer, or "Wogesha," as they are called in Ethiopia, only serves to further complicate the cases that orthopaedic surgeons at Black Lion see.

This cycle persists because bonesetters are often the closest means of treatment. By the time something is clearly wrong and patients present themselves at hospitals like Black Lion, it is often too late. However, some intervention methods have been developed. A two-year retrospective survey in southern Ethiopia revealed that one-day instructional courses for traditional healers had the potential to reduce amputations of gangrenous limbs by as much as 50%.[1] Dr. Neil J. White describes below one of the many preventable cases.

"I was asked to see an 8 year old boy today who fell and broke his elbow (type III supracondylar) 10 days ago in Ambo. A town about 125kms to the west of Addis. I hesitate to even tell this story, but I guess one is meant to blog what is on their mind. He was treated by a Wogesha (bonesetter). A tightly wrapped bamboo splint was applied. The bone was not reduced. Now, ten days later, the limb is motionless, pulseless, cold and turning black. I took clinical photos, but I honestly don't have the heart to attach them (or look at them). It really brings me down. Nothing to be done now. We take our own awareness of health and wellness for granted (even those of us that abuse ourselves). We take our access to care and to information for granted… If you think a problem is simple - that is only because you have the knowledge to solve that problem."

Timing is of the utmost importance when it comes to treatment of injuries. Open fractures must be cleansed and debrided within 6-12 hours of injury as Dr. Zirkle describes on page 2. Antibiotics also must be given as soon as possible after injury. Additionally, compartment syndrome often results from fractures treated by bonesetters because the splints are applied so tightly. Compression of an extremity will cause increased pressure in the muscle compartments. This increased pressure will kill the muscles and damage the nerves if not relieved. The little boy that Neil described had unfortunately developed this condition. Neil writes, "The young boy who was treated by Wogesha with the tight bandage for his elbow fracture underwent above the elbow amputation. This is not a good thing anywhere but I do believe it is a worse situation in a developing country."

With your generosity, Black Lion Hospital can increase their capacity to treat more patients. As news of successful outcomes at Black Lion spreads throughout the country, fewer patients will arrive with delayed unions and infections because they trust their care to Black Lion who works in partnership with SIGN.

Graham Forward, MD, working through Australian Doctors for Africa, also recognized the need for operating

rooms to treat open fractures and is providing funds to implement this. Prompt treatment of open fractures will alleviate the crowded emergency rooms where these patients await treatment. Patients will have less disability and complications due to prompt and appropriate treatment.

Neil White, MD, who just finished his trauma fellowship in Edinburgh, Scotland, is spending three months in Africa assisting surgeons who treat these difficult problems. His blog can be read at www.signblog.org.

SIGN provides instruments, implants and other equipment as well as training related to treating open fractures as well as the dramatic surgeries. We salute the leaders mentioned and the hundreds of SIGN surgeons dedicated

to proper treatment of patients globally. This process of treatment of open fractures is repeated in all SIGN programs. We appreciate donor support which facilitates this treatment. Treating open fractures is a global effort with many supporters.

A Moment with a renowned Rotarian

Professor Torsten Jacobsen

Dear Professor Torsten Jacobsen;
On behalf of our Orthopedic Society (ESOT), I thank you for giving us your time to conduct this valuable interview. We all learned a lot from your presentation on Haiti's catastrophe. We know that you are involved in handling mass causalities In Vietnam, Iraq, Haiti and other nations. Every calamity should leave a lesson to the remaining so that awareness and preparedness increase.
In light of this, please kindly reply to the questions outlines below. With our kind permission, we are publishing this on our yearbook and website so that policy makers, consultants, residents and first-time responders could use it.

Tell us about your orthopedic practice in short. We like to read your past practice and experience.

I received my orthopedic training at the University Of California Medical Center in San Francisco. Subsequently served three years with the U.S. Armed Forces overseas. Did an AO/ ASIF fellowship training in Europe. Functioned as clinical professor of Orthopedics in the Netherlands for four years before retuning to the U.S. Functioned as an AO instructor at various universities on the West Coast while also in full time private practice with heavy emphasis on trauma.. Acted as Chief of Orthopedics at one of John Muirs medical facilities East of San Francisco before focusing solely on overseas projects for the past 5 years. My overseas work has also included SIGN projects in South East Asia, Uganda and of course in your country: Addis Ababa, Gondar and Mekele.

With mass causalities/ disasters, man-made and natural, what trends have you observed so far?

Regarding mass casualties/disasters experienced, aside from military conflicts, with out a doubt the recent earthquake in Haiti with an estimated 400,000 deaths and well over 1 million serious injuries and 1 1/2 million homeless was the worse. The trend over the past few years has been more major natural disasters due to climate instability, and growing number of mega cities around the world with concentrations of many millions of people. I believe that, for example, the capital of Brazil is now up to 19 million!

When you were in Haiti to help treat the victims of the shocking earthquake that killed nearly half a million, what have you personally observed? How was the severity? Because sometimes we do not understand numbers, please tell us in comparison to the deaths from atomic bomb dropped over Japan, WW-I or WW-II deaths.

Haiti represented the greatest number of deaths and injuries occurring in one day in recorded history. While the total number of people killed with the two atomic bombs dropped on Japan in WW-II was approximately 250,000, there were very few survivors and thus patients, since those not vaporized by the bombs soon died of irradiation exposure or severe burns. Being greeted on landing in Haiti with a parking lot filled with people with day old multiple severe soft tissue crush injuries and compound, open fractures is almost beyond comprehension. Many required multiple extremity amputations.

Please outline the basic principles you follow in handling mass causalities.

Regarding basic principles of handling mass causalities, the very first principle is preparation,preparation, preparation That means doing drills in advance.!!! In the U.S. each hospital to maintain accreditation must do at least one drill a year with mock patients and coordination with first responders i.e. fire departments, ambulance and police etc.. Communication systems must be tested, since in a real crisis cell phone, telephones and other forms of electronic communication can not be relied upon. Short wave radios may be needed. The military must be integrated, since they often are the only ones with enough emergency equipment.
In addition an initial needs assessment is essential. What are residual resources? What hospitals are functioning? What specialties and supplies are still there? Wounds are usually grossly contaminated and must be left open. Severe crush injuries do not lend themselves to decompression (pressure monitoring devices are very, very helpful esp since patients sometimes can not communicate at all) but require amputation most often. Treatment rendered must often be written directly on the patients dressing, since there are no medical

records initially. Initial surgery may have to be definitive, i.e. not staged procedures. Africa has few earthquake faults, so that crush injuries. Secondary to building collapse might be less.

infected, though in children frequently O.K. due to short term use. Cast treatment is very difficult due to lack of close follow up, contamination etc. What is really helpful is to have wound

What is the importance of centralized logistic command and coordination during such times?

Centralized logistical command and coordination will likely only occur early enough, if there has been previous drills and preparation. The situation in Japan would have been much, much worse, were it not for the fact that the Japanese are the best prepared and were it not for the huge tsunami wave they would have done well. Each hospital or Field unit must have one person who is the General and each surgical area likewise must have one person calling the shots as to what can and can not be done. Likewise someone MUST coordinate the actions of all NGOs etc that show up-some simply to get International attention.

What orthopedic supplies are important to put in the stock for such incidences?

Regarding orthopedic supplies, In Haiti we learned that we did not have enough anesthesia, adequate power, and adequate facilities for sterilization. Complex internal fixation should be avoided-though the cleanest hospitals did well with SIGN nails, whereas just about all external the fixation got

specialists on hand to deal with repeat wound care and thus freeing up the surgeons.

What do you advise our orthopedic /trauma Society and the leaders of the country involved regarding the general preparedness to handle a mass causality that may happen anytime, anywhere to anybody?

The best advice for preparation is preparation. Drills must be done to show all weak spots. Civilian preparedness must be integrated with the military whenever possible. In Haiti we used the military ships, transport, communications etc. The military should not be given the wrong mission, such as focusing on security. In Iraq the single greatest factor in decreasing the death rate to 10% (all previous wars at least 25%) was due to rapidity of medical care. The forward support emergency tents could be set up in 6 min.! The combat support hospitals with 284 beds and 6 O.Rs took only 24-48hrs!

Would you summarize the important lessons we have to lean from Haiti's case?

Lessons from Haiti include: initial needs assessment (as occurred in Chile),need for potable water for population- THE greatest source of panic from thirst and becomes the greatest sources of contamination and disease, functioning emergency communications system,, clearing road debride for transport, tracking patients using military system, leaving wounds open for multiple debridements, not doing faciotomy on massive crush injuries esp. if not fresh, the extreme importance of health care providers helping and supporting each other-this is a 24 hour "war fare scenario" and enough to make grown men cry from fatigue and the overwhelming human suffering.

Having the current world full of terrorism, increased traffic injuries, urbanization, boarder disputes, increased construction concrete, machines and industrialization. Do you think the future is demanding for an orthopedic surgeon?

The greatest single factor in increasing the demands on orthopedic surgeons now and in GTE future is road traffic accidents-THE pandemic around the developing world-costing ten times as much as all the world aid. Only the government can improve this by investing in transportation infra structure, roads rules and regulation-rather than spending enormous resources on warfare. Until they do this the pandemic will only increase forever and cost the country much more not only inhuman suffering but cost.

Anything more you want to say/emphasize?

I would also add that disasters are indiscriminate-they kill the rich as well as the poor and politicians as well as non-politicians. Both man-made and natural disasters suddenly kill anybody, anytime anywhere! So those that think they can escape by dashing off elsewhere for life saving emergency medicine are diluting themselves.

In Haiti those at the top were hit and killed as much as those at the bottom.

This should motivate all leaders to prepare! Prepare! Prepare!

"I am willing to have anybody come here and work with me."

Dr. Duane Anderson
Soddo Christian Hospital

On behalf of ESOT, we thank you for the interview.

Please introduce us yourself, including education- where you got trained, years of service…

I was educated at the University of Minnesota, both my medical school and orthopedic training. I am board certified in orthopedic Surgery in the US and I am also board certified by college of surgeons in the East, Central and South Africa. I have been in practice in United States for about 17 years and then I have been in Ethiopia for 7 years. I hope to finish my orthopedic practice here in Ethiopia. I am very grateful to be able to live in Ethiopia and to help the training of General Surgeons and Orthopedic Surgeons in Ethiopia.

I think it is a tough decision to move and live here in Ethiopia. What made you do so? What challenges have you faced in establishing the hospital?

Well… I believe God, from even before I was finished with high school, wanted me to come to Africa. So I asked my wife, even before I married her - are you willing to live in Africa? That was one of the questions even before we had our first date. We were married two weeks before I started medical school. She has been with me all through my medical training. We had four children during the time that I was in medical school and residency. My oldest son is now 35 and he is going to be an orthopedic surgeon, he is in training in the US. Hopefully may be someday he will be here.

Give us a short introduction of Soddo Christian hospital- initiative, its nature, missions, principles, establishment, – who is the founder? What is your position? Staffing?

This hospital was started by Dr. Kelemu Desta and Dr. Harold Adolph. Dr. Kelemu Desta was behind the establishment and initiative of the hospital. He was a nurse and a dresser during the time that Dr. Harold Adolph was a missionary Surgeon at Ottona(Wolita soddo) Hospital. The Ottona Hospital, that is now a government hospital, was a missionary hospital in the 60's and 70's in my calendar. Then when the 'Derg' came Dr. Adolph left. When Dr. Adolph left, Dr. Kelemu went to medical school and then did General surgery at Black Lion Hospital and Plastic Surgery in Wells. and he came back and worked at Ottona hospital. He called Dr. Adolph and said please come and help me built another missionary hospital. So construction begun in 2001 and the doors of the hospital were opened and the first surgeries were done in February 2005.

I came in September 2005, so we have been doing Orthopedic surgery here in Soddo Christian hospital since that time. We had many other Orthopedic Surgeons come and help me and help train our Surgery program. So we began training General Surgery residents right from the first day. About two years ago we received full accreditation for our training program. I am the hospital director now and the only Orthopedic Surgeon here. We have about 13 physicians, an internist, 5 or 6 general practiners , 6 General surgery residences and 5 expatriate physicians- in this coming we will have 3 more- a pediatrician and emergency room physician and another General surgeon and those will be additional expatriate physician.

What services are you giving, catchment area, training?

This hospital was formed by two surgeons; so up to this date it has been primarily a surgical hospital. Dr. Kelemu and Dr. Adolph began the general surgical training, now we have 7 expatriate physicians who are helping in the training of these residents. Our residents spend 5 years here in Soddo and they spend totally one year in orthopedics. We hope by God's will that we will open additional training in family practice, orthopedics and ophthalmology. We have patients from Walaita, but they come all over Ethiopia.

What are the main orthopedic services offered at your hospital, implants and orthopedic equipments?

We have an orthopedic ward that has 27 beds, usually that is full and we usually have 5 or 10 in our general surgery ward as well, that has been happening for the last few years. So we frequently have 30-40 orthopedics patients in the hospital.

We are trying to take care of all the fractures and disocations that come to us except the spinal fractures. Fractures that need spinal internal fixation, we don't have implants for yet and I really don't have the expertise in that area, but we hope to learn how to do that, we hope to get spine implants, but that it is a very small part of our practice now. We take care of basically all the rest of fractures- foot fractures, ankle, tibia, knee, femurs, hip, pelvis, acetabulum, hand, wrist, forearm, elbow, humerus, scapula fractures. All those fractures presently we have

challenges with your colleagues?

Well, I have informal network of friends in the US and in Ethiopia that I seek advice for serious injuries, so I take photographs of the x-rays and then I send it out and get advice. So I have some friends who are very quick to respond within 8 hours they get me some good advice. Dr. Lewis Zirkle from SIGN has been a very big help to me, Dr. Lundy from Atlanta whose is a traumatologist, Dr. Neil White who has been a visiting surgeon both here at Soddo and at Black Lion is another one who is very quick to respond and get me good advice, Dr. David Solfelt from Minnesota he is also has been here and has been very helpful as well.

the implants to take care of and so we are trying to do as much as we can with the patients that we receive. We also manage neglected dislocations, mainly shoulder and elbow. Right now we have plain x-ray machine, C-arm that works and in the next year we are getting digital x-ray machine, CT-scan and so our services will be improved. We have a functional blood bank and we are requiring all elective surgical patients and all trauma patients to have their families donate blood. That portion of peoples' care is improving and our laboratory is improving as well in terms of the services that we can provide there. We do a limited number of hip and knee replacement. Biomet International is providing the implants for us. We do arthroscopy here including ACL reconstructions, other ligament reconstructions and meniscectomy.

What are the main causes for fracture in the areas your service cover?

Car accidents are the routine cause of people coming here- people that are involved in head on collusions in Bajajs, motorcycles, mini vans and buses; people that are hit by motorcycles and trucks; truck and bus roll overs – all these are the most common cause of the injuries of people that come here.

Please outline the basic principles you follow in handling patients.

We try to treat everyone who comes at the door of the hospital. Many people cannot afford care and so for some patients they get free care. We are private hospital and we do charge patents for the services, we have many orthopedic patients, especially severe trauma and they run out of money and we have benevolent fund that is able to help many pay for their care. We have patients stay up to six months in the hospital. Our laboratory is improving, our x-ray services are improving and we hope to get eventually a full time pathologist and start doing full process of pathology hopefully for the whole Southern nations region.

Do you see complications from Bone setters? Any outreach programs?

I see more than I would like to see! People who have been mismanaged, either by Wegesha or by some other health provider and delay in fracture care and dislocation make the care much more complicated. So it would be very nice to see things change in Ethiopia where people came who had a joint injury or bone injury they would come and see orthopedic surgeon first. We hope to see that culture of Ethiopia change, people only see orthopedic surgeon as the only person orthopedic fracture care that would be very nice accomplishment. We have very limited outreach programs at this point to the hospital primarily because we can't handle the trauma that we see now, it is just too much work now…

How do you share the orthopedic

What do you suggest about knowledge transfer?

I think orthopedics in Ethiopia is progressing very rapidly and I am very happy to see residents from Black Lion having big interest in improving open fracture care, learning how to do hip and knee replacements. It is exciting to be here in Ethiopia at this time. There are many, many changes!

What extent are you working with local surgeons, medical schools, institutions, and professional associations?

I am willing to have anybody come here and work with me. I have had Dr. Kagnew from Asella Hospital, he spent a month with me. I am open for any surgeon that wants to come here and work with me for a week or a month. I give lecture at Assela and Hawassa medical school, I have been at Black Lion participating in conferences there , have been to Ethiopian Surgical Society meeting several times, so those are the three medical schools I have been invited to speak and work at. The trouble with doing a lot of traveling is then you have patents waiting for surgery here in Soddo that makes it difficult.

Do you have any difficulties with governmental agencies in order to facilitate your hospital needs? Any

thing to say regarding what should be done in the future? Customs problems?

We are a private hospital, we pay a fair wedge for our employees and we try to keep the charges as low as possible, so that many people as can afford orthopedics care here at Soddo Christian hospital. So we want to send a message out that we want to be fair by paying our employees fair wedge and we want to be fair to our patients and we don't want to take of advantage of them. Soddo Christian hospital dose provide free care but doesn't provide free care for everyone. Only those run out of money and very poor. We have seen by some government officials as a private hospital, like other private hospitals, but really we are not trying to provide ourselves a profit. I am one of the owners of this hospital but I have only given money to this hospital and I have never received anything for the return. So our goal is not to make money for ourselves it is to provide excellent medical care for those who come to Soddo Christian hospital and our goal really is as a Christian missionary hospital to provide excellent medical services and share the good news that Jesus can forgive the sins of anyone and to encourage people to follow Jesus, those are the three things the hospital is based on. In that sense we are not the usual private hospital.

Every hospital in Ethiopia has customs problems. Black Lion, the premier hospital in Ethiopia, has trouble importing things. The Ethiopian government has to provide for itself and customs is one of the ways they do that. We understand that and we are willing to pay customs but we also ask the government to be looking for other ways to make money because always charging import duty on things is not promoting the general health of the Ethiopian people. But we understand that they have to do it. Every hospital has difficulty. It is huge challenge!

What do you say about efficiency in general and especially in the Operating Room?

I am grateful that the other services at Soddo Christian Hospital are not as busy as orthopedics because many days I have three operating tables to work on (2 tables in the Orthopedic operating room and frequently have one other table as well). We have plenty of operating room staff and anesthesia providers and so the residents and I sometimes will be working on two patents at a time, most commonly though we operate on one person at a time, but the residents and I stop operating at the time that the hardware implant is finished and we allow our nurses to close the fascia and the skin, and the next patient is already prepped and draped and ready for surgery and so we are able to move from one patient to the next. So we have done up to 13 operations in one day, but most commonly we do about 5 major cases and a few minors. I am blessed with God providing us really efficient team - we make rounds from 7 to 9 and we operate from about 9 to 3 or 4 in the afternoon then we see out patients. Until we have seen them all sometimes it takes us till 6 or 7 o'clock at night.

Well to be able to be efficient; you have to have the cooperation of everyone! From the porter that brings the patient from the ward to the sterilizing people, the nurses, the anesthesia people and the cleaners. Unless everyone is working together to be efficient, it will not happen. So everyone has to agree that lunch is not important, it is the patient that is important. My tea is not important; it is getting anther surgery done that day that is important. Service and the patient is number one not me or my comfort or my eating… that is not number one.

People recognize if their family member is waiting for surgery for two weeks- the surgery is more difficult, it is more complicated and so that if everyone works together the work, it is done! But one person can stop that efficiency. If the sterilizer doesn't do his job, the place is shutdown. So change is difficult and change needs to come from the top, but everyone needs to see that the hospital is not for the physicians and nurses, it is for the patients.

Message to orthopedic surgeons handling orthopedic problems all over the country?

I think that we need to work together. The next problem that I think we need to solve is getting implants. I am just talking about simple things like 3.5 cortical screws. We have to work together with DACA to get these things into the country, so that when I run out of 14mm, 3.5 screws and I don't have to wait for a month or two months and I don't have to go to Germany to get them and I can get them from DACA. The plates and screws, rods, hip and knee all these things; that is the thing that we need to work together on it. The medical schools, customs and hospitals need to work together, so that we have a system where we easily have these implants available to us in high quality implants at a reasonable prices. So not only the reach person in Addis Ababa can have his fractures fixed, but that many and I am not say all because I think that is not realistic. We need to make it good orthopedic care available to as many people as we can. As a health care provider, you have to charge more than it costs you to provide that care. Otherwise the system doesn't work or breaks down… so you have to keep your charres as reasonable as possible because you have to charge what it costs you. Most Ethiopian can't go to Thailand, Israel or Germany or South Africa for fracture care or for hip and knee replacement. They can't afford it. So we have to work together to provide as many implants at reasonable price as we can. We need the Ethiopian government help to do that.

Anything more you want to say/ emphasize?

I am just very thankful for partnership with and friendship, which I have in Ethiopian medical community, for the friendship that I have with Black Lion Hospital, Assela Hospital, Hwassa and Soddo University, am so grateful for these partnership.

Orthopedics In Ethiopia- the way forward.

Tezera Chaka, MD, FCS (ECSA)
Associate Prof. of Orthopedic Surgery
School of Medicine
College of Health Sciences
Addis Ababa University

Through a hard time with many ups and downs now we are at a glimpse of hope. In the last 25 years of its existence, the Department has produced 46 Orthopedics Specialists and currently there are 24 residents on training. These graduates are serving in different parts of the country as well as abroad and some are involving in the teaching activity of the profession. During this period the numbers of patients that have been treated are immense. In addition to the huge burden of service activity and teaching a useful and relevant Research activities have been performed and Research papers have been produced.

With the increasing of cases of Trauma Victims (Road Traffic, Construction sites, Industrial, etc…) in number as well as in severity and other orthopedic pathologies, there is no doubt the need for expansion of the profession through out the country. Advanced methods of treatment in the field has to be encouraged which is currently at its infancy and is just beginning.

In the field of orthopedic Surgery there are a number of subspecialty Trainings approved internationally out of which we need to select those are currently appropriate and relevant to the need of the Country. This endeavor again needs the involvement of the International Orthopedics community in terms of human as well as material resources.

What are currently needed Subspecialty Trainings in the field of Orthopedics in Ethiopia? In my opinion the followings have to be considered.

1. Orthopedics Trauma.
2. Pediatrics Orthopedics
3. Hand surgery
4. Arthroscopy and arthroplasty
5. Spine Surgery
6. sports Medicine

The training program can be conducted abroad, in the country and also can be combined. It is my sincere hope that united as usual we can achieve our goal and fulfill our vision in this noble profession – ORTHOPEDC SURGERY.

List of Graduates from Department of Orthopedic Surgery since 1991 G.C

1991 - Dr. Ahmed Taha Makki (Yemani Citizen)
- " Eskinder Afework
- " Lakew W/ Amanual

1993 - Dr. Tawfik Abdulahi
- " Temesgen Fitru
- " Tezera Chaka
- " Worku Mekonnen
- " Wondimu Wolde

1994 - Dr.. Teshome Worku
- " Woubalem Zewdie

1996 - Dr. Legesse Yigzaw
- " Solomon E/ Yonas

1997 - Dr. Dereje Tekalign
- " Mesfin H/ Mariam
- " Tadesse Alemayehu

1998 - Dr. Asfaw Ayele
- " Dagne Feleke

2000 – Dr. Hailu Shewa-amare

200 - Dr. Gizachew Nigussie

2002 - Dr. Birhanu Beyer
- " Wondaferaw Wondimu

2003 - Dr. Biruk Zewdie
- " Genanew Admasu
- " Hailu Legesse

2004 - Dr .Manyazewl Dessie

2005 - Dr. Kinfe Araya
- " Zelalem Tamirat

2006 - Dr. Biruk Lambisso
- " Elias Ahmed
- " Daniel Ayalkibet
- " Kagnew Wubishet

2007 - Dr. Birhanu Ayana
- " Tesfaye Lema

2008 - Dr. Abebaw F/ Sillasie
- " Dereje Negash
- " Fekadu Teshome
- " Fisseha Bekele
- " Yiheyis Feleke

2009 – Dr. Andargachew Workineh
- " Demissie W/ Kidan
- " Mekonnen Wordofa

2010 - Dr. Nigussie Seifu
- " Selamu Dessalegn
- " Solomon Aweke
- " Tilahun Desta

2011 -Dr. Daniel Teferi

Residents on Training
(2012 G.C)

Year IV

1. Dr. Alemayehu Silassie
2. Dr. Bezu Chemeda
3. Dr. Mohammed Adem

Year III

1. Dr. Nesredin Yusuf
2. Dr. Nigussie Hailu
3. Dr. Samuel Hailu
4. Dr. Tadesse Shimelis
5. Dr. Teshome Mosissa
6. Dr. Wondwossen Tekola

Year II

1. Dr. Ebrahim Ahmed
2. Dr. Geletaw Tessema
3. Dr. Tekalign Tsegaye
4. Dr. Sham Abrahim
5. Dr. Worku Belay

Year I

1. Dr. Ephrem G/Hana
2. Dr. Esubalew Abebe
3. Dr. Habtamu Bayissa
4. Dr. Mamo Dikessa
5. Dr. Merawi Getle
6. Dr. Tewodros Daba
7. Dr. Tinsae H/Michael
8. Dr. Yilkal Geremew
9. Dr. Yoseph Zekarias
10. Dr. Zerihun Tamirat

ROTATION FOR ORTHOPEDICS RESIDENCY TRAINING

Rotation through the subspecialties in orthopedics has been the basis for learning Orthopedics worldwide.A resident would typically rotate through subspecialty services during the residency once as a junior resident and again as a senior resident. A competitive residency program would have these subspecialty rotations incorporated in the curriculum:Joint Replacement/ Adult Reconstructive, Foot and Ankle, Orthopedic Oncology, Orthopedic Sports Medicine, Pediatric Orthopedics, Spine, Hand/ Upper Extremity and Orthopedic Trauma Rotation. Besides these a resident would have good exposure in ICU, Vascular surgery, Emergency Medicine, Anesthesia, Musculoskeletal Radiology, Physical Medicine and Rehabilitation, Plastic Surgery and Research.

Many would agree if I dare to say Orthopedics is at its infancy stage in Ethiopia. Thanks to different organizations, including mission hospitals, the scope is widening and we hope to be toddlers sometime soon. It would take a while till we have the subspecialties established, but that does not mean residency trainingshould keep on the stage of infancy.I see many opportunities, both domestic and abroad, for the residency program to improve ahead of subspecialties establishment. The mission hospitals with good Orthopedic service in and outside Addis are underutilized, namely CURE Ethiopia and Soddo Christian Hospital. Residents who have stayed two months in Soddo would confirm this fact. I believe the Mission Hospitals should take the lead and be open to support train orthopedic residents, as that is a good opportunity to improve orthopedics care in the country. I believe that is one of the missions why they are here.

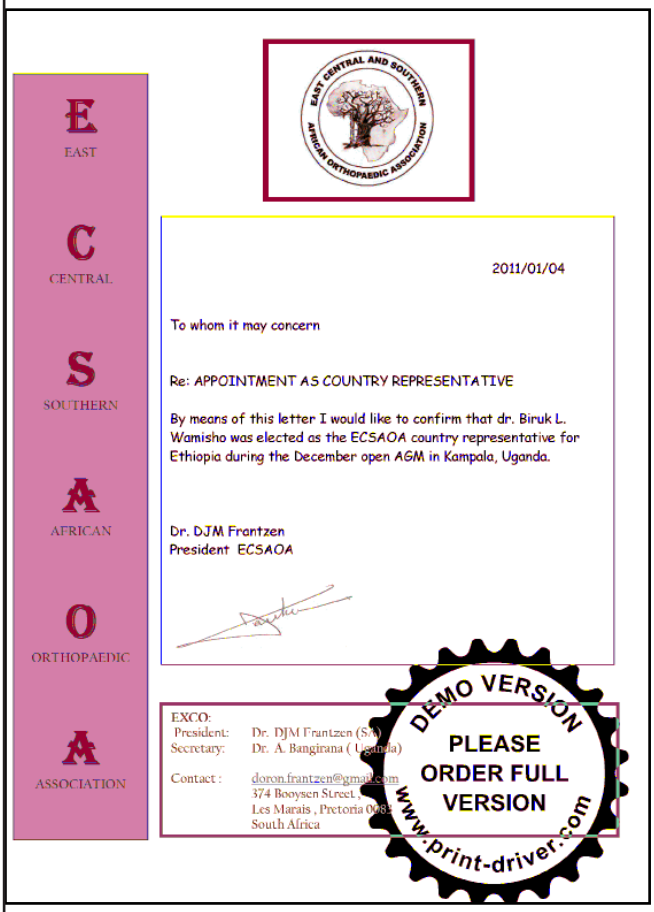
Thanks to Dr. Zirkle and the SIGN family, I had the opportunity to get some exposure how the 'OUTSIDE' world looks like. Three days flap training course is just practical enough to come back and do limb saving flaps back home. The SIGN conference was a good experience; there I have understood that there are people out there who are ready to improve our traininghere and abroad. Thanks to Dr. Trimingham, I attended the 2012 American Academy of Orthopedic Surgeons annual meeting held in San Francisco, CA. That is when I realize how vast Orthopedics is and how powerful the Orthopedic Society could be. I know Dr. Forward through Australian Doctors for Africa is doing a great job to improve Orthopedics care and training in Ethiopia. I also understand that he and his organization would be supportive of abroad rotation.

I appreciate ESOT's work on it and I think it should take the primary responsibility to make sure we, Orthopedics Residents, get the standard training through rotations both in the country and abroad. The way forward to improve quality of orthopedic service in the country is, to graduate orthopedic surgeons who are well trained, competitive and capable of practicing Evidence Based Medicine. Ministry of Health, DACA/FMHACA and stake holders should directly be involved, as orthopedic problems are by far the leading cause of preventable and treatable disabilities that we face in our country! There is a lot to work, change and make a difference in mother land, WE WILL COME BACK AND HELP OUR PATIENTS AFTER GETTING TRAINING ABROAD!

Samuel Hailu, Year III Orthopedic Resident

Email- samiethio@gmail.com

We can continue the discussion on Resident corner of our website: http://www.esot-ethiopianorthopaedics.org



ASSA The Association of Surgeons of South Africa

Dear Colleagues,
Community Surgeon Travel Awards for 2013

The International Relations Committee is pleased to announce two new travel awards for surgeons aged 30-50. These awards, in the amount of $4,000 each, provide international surgeons with the opportunity to attend and participate fully in the educational activities of the annual Clinical Congress. They are proposed to specifically assist surgeons who work in community or regional hospitals or clinics in countries other than the United States and Canada, or who are from struggling academic departments of surgery in low or middle income countries. For the year 2013, preference will be given to candidates from Africa.

A successful applicant will show evidence of commitment to high quality surgery, to surgical teaching, and to improving access to surgical care in his or her community. Each awardee will receive gratis registration to the Annual Clinical Congress and to one available postgraduate course within the Congress. Assistance will be provided to obtain preferential housing in a thrifty hotel in the Clinical Congress city. In 2013, the Clinical Congress takes place in Washington, DC, October 6-10.

Following the Clinical Congress, the awardee will send a brief report of his or her experiences to the International Relations Committee, specifically focusing on the value of the visit to the awardee and the potential beneficial effect to patients in the country of origin.

For the full requirements and the online application form, please see the ACS Scholarship web page,http://www.facs.org/memberservices/research.html. Supporting documents and questions should be directed to:

Administrator
International Liaison Section
American College of Surgeons
633 N. Saint Clair St.
Chicago, IL 60611-3211
USA
kearly@facs.org or 312-202-5021 (facsimile)

Completed applications for the Community Surgeon Travel Awards for the year 2013 and all supporting documents must be received at the office of the International Liaison Section prior to July 1, 2012, in order for an applicant to receive consideration by the selection committee. All applicants will be notified of the selection committee's decision in November 2012.

SANOFI

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Miliard Derbew MD.FRCS.FCS(ECSA) Associate Professor of pediatric Surgery,
Medical Education Partnership Initiative (MEPI)PI School Of Medicine, Addis Ababa University,Ethiopia
President, Surgical Society of Ethiopia

PODOCONIOSIS MAPPING IN ETHIOPIA

By Kebede Deribe , Gail Davey

Podoconiosis (endemic non-filarial elephantiasis) is a non-infectious geochemical disease arising in barefoot subsistence farmers who are in long-term contact with irritant red clay soil of volcanic origins. The disease causes progressive bilateral swelling of the lower legs. Mineral particles absorbed through skin are taken up into macrophages into the lymphatic system and result in an inflammatory process leading to fibrosis and obstruction of the vessels. This leads initially to swelling of the foot and the lower leg, which progresses to elephantiasis: gross lymphoedema with mossy and nodular changes of the skin [1, 2].

Worldwide Distribution

Podoconiosis is found in three continents; namely Africa, Central America and Asia [3, 4]. An estimated 4 million people in highland tropical Africa are affected with podoconiosis. In Africa at least 10 countries with the disease were identified; in Ethiopia, Kenya, Tanzania, Uganda, Rwanda and Sudan; Burundi, Equatorial Guinea, Cameron, islands of Bioko, Sao Tome & Principe and the Cape Verde islands. Historically the disease was prevalent in Northern Africa (Algeria, Tunisia, Morocco and the Canary Islands) and Europe (France, Ireland and Scotland); due to widespread use of shoes the disease is no longer found in these areas [4]. Previous studies documented the association of the disease with irritant red clay soils, which are generated in areas with >1500 masl, >1000 mm annual rainfall and temperature of 20 0C [1]. Across tropical Africa the majority of affected individuals are agrarian, who have long term contact with the red clay soil, due to the nature of their work.

Prevalence

In Ethiopia prevalence estimates from 56 market counts range from 0.42% to 3.73% [5]. More recent studies in Ethiopia estimated prevalence up to 5.46% in Southern Ethiopia [6]. The presence of significant geographical variation of the prevalence of podoconiosis in these countries might suggest the presence of some spatial pattern of distribution.

Potential for Elimination

Podoconiosis is one of the NTDs with the greatest potential for elimination as a public health problem [4]: it is preventable if shoes are consistently worn, and early stages can be successfully treated using a simple lymphoedema regimen [4]. While one million people are estimated to be affected with podoconiosis in Ethiopia [7], and a further 11 million at risk, control efforts are hampered by a lack of information on geographical distribution – aside from recent isolated studies, the only previous mapping of this disease was based on podoconiosis cases from market counts and school inquiries in 1970s [8].

Historical map of podoconiosis in Ethiopia

Historically in Ethiopia, Ooman counted patients in 56 markets in 1969 and estimated prevalence for each location. Based on his work and 105 school enquiries, Price developed a map of podoconiosis in Ethiopia [8]. Although the historical maps informs the overall distribution of the disease there are inherent limitations. First the mapping focused on areas with possible risk, and excluded significant parts of the country without any accessible data [2]. Second the market count is based on counting the number of visible cases of lower leg swelling in the market as the proportion of those attending the markets. Third, the surveys used observation or physical diagnosis, and biomedical techniques to exclude other causes of lymphoedema such as Lymphatic Filariasis were not used. In light of the availability of rapid diagnostic tests for Lymphatic Filariasis, utilization of them will decrease misclassification in areas where these two diseases overlap.

Why we need mapping of podoconiosis

There are proven prevention and treatment approaches for podoconiosis.

Gail Davey

Prevention of podoconiosis can be achieved through preventing contact with red clay soil of volcanic origin. Consistent shoe wearing is thought to prevent podoconiosis [4]. For individuals who have already developed the disease there are effective treatment approaches. To target prevention and treatment, it is important to know the geographical distribution, the population at risk and the projected number of patients. However in practice, targeted treatment and prevention services exist in few parts of Ethiopia, although there are some recent initiatives to expand these services within Ethiopia, and to adapt them for use in other African countries.

The other important justification for mapping podoconiosis is to document the burden of disease in larger geographical areas and advocate for global resource commitment for the control and elimination of the disease. Previous advocacy has been effective: podoconiosis was included in the Ethiopian NTD master plan in 2010, in the WHO's list of Neglected Tropical Diseases in 2011, and an International Podoconiosis Initiative was launched recently [www.podo.org]. Building on these achievements, there is a need for global financial commitment for the control and elimination of the disease. We believe the mapping of podoconiosis will contribute to advocacy and effective control activities. Previous mapping projects have stimulated global

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Date: 28.05.2012

Dear Colleagues in Ethiopia,
Greetings from SHOPOPL.

SHPOPL is first orthopedic manufacturer in India incepted as early as 1960. Today, it is a strong force of professionals committed to the world movement of health care with the aim of producing quality products at affordable price. Today SHPOPL have a strong presence in 26 states within India and about 29 countries globally.

We are ISO:9001 company having all our products CE certified for European community and FDA approved under license in Form-28 from Central Government License Authority in India.

SHPOPL has the largest range of products in Orthopedics. The presence of SHPOPL has been felt in many specialty products in the field of orthopedics. The development and promotion of Ring Fixator System and Rail external fixator devices has given a strong foothold to the company in overseas market. The dedicated spinal system and variety of Intramedullary locking nails has
helped SHPOPL to gain confidence of Orthopedist globally.

The Company has demonstrated strength by developing new products keeping up with international trends from time to time in the field of orthopedic implants and instruments. These developments are achieved by professional attitude supported by sound technical backing. In SHPOPL efforts are always uni-directional that quality is always apex to business. The company has a reliable infrastructure at MIDC, Bhosari, Pune, SHPOPL manufactures all the products in reliable CNC machine set up. The entire product upbringing is done by using latest engineering techniques and with comprehensive usage of SAP system.

As a practice in SHPOPL, Professional team of engineers supports the developments of the new products based on ideas from surgeons with modern tools like 3 D solid modeling and Finite element analysis. The product before release is tested bio-mechanically as per recommended S. H. Pitkar Orthotools Pvt. Ltd. protocols Promotion of products by means of continuous medical Education is a way of life at SHPOPL.

These programmes have been initiated in India by SHPOPL in 1991. Every year about 15 such symposiums are designed and executed for surgeon's trainings on various orthopedic applications. The graded symposiums with application Labs/workshops are designed through international faculties.

SHPOPL has been awarded ISO 9001-2000 quality system from year 2000 and has been certifiedfor ISO-13485 & CE certification in year 2004. SHPOPL was the first Indian manufacturer to comply with application formalities to the newly introduced FDA manufacturing License in 2006. It would be a pleasure for us to interact with you. Looking forward for your Support. Kindly contact us for further details.

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ADVANCES IN JOINT REPLACEMENT SURGERY

(A brief overview)

Joint replacement Surgery ,specially for the hip and knee joints started more than half a century ago but recent advances in the technology has made these operations very successful with long lasting results and this has be achieved because of following developments.

1, Materials & Bearing surfaces

2, Implants for higher range of motion

3, Minimal invasive surgery

4, Computer assisted surgery

5, Difficult reconstruction surgery

MATERIALS & BEARING SURFACES:-

There has been significant improvement in the metals and their manufacturing process and design .With increasing understanding of biomechanics of the hip and the knee joint the designs of modern prosthesis have undergone improvement to last for long duration. The metals used for the prosthesis are usually Titanium or Cobalt-Chromium Alloy, the later being the most popular.

The bearing surfaces (moving surfaces) have improved a lot. The new bearing surfaces are like Ceramic on ceramic(made of either zirconia or alumina) have shown extremely low wear rate resulting in long survivorship of the life of replaced joint .Improvements in the quality of the polyethylene has been remarkable after the production of X-3 highly cross linked polyethylene. Highly cross linked polyethylene is produced by irradiation of the polyethylene with very high doses (8 to 10 mega rads) of radiation .This reduces the free radicals and makes the polyethylene very strong and many times more wear resistant and long lasting as compared to the traditional polyethylene.

IMPLANTS FOR HIGHER RANGE OF MOTION:-

In the hip joint replacement we can now use femoral heads of larger diameters (up to 36mm) that gives more stability and high range of motion which is very important in Asian and African countries because of our life style. This has been possible, as mentioned above, because of the development of ceramic and highly cross linked polyethylene.

In case of knee joint the new development for high range of motion is the advent of high flex knees by making appropriate changes in the design of femoral component and the polyethylene liners that can make people to sit easily on the floor and in cross-legged fashion which again is quite common in our continents.

MINIMAL INVASIVE SURGERY:-

In the hip joint minimal invasive surgery involves two small incisions ,one for implanting the femoral component and the other one for the acetabular component. This technique has attracted lot of orthopaedic surgeons because the soft tissue trauma is less, post-operative rehabilitation is quicker and duration of hospitalization is less which also reduces the cost.

In case of knee replacement, minimally invasive techeque is used for unicondylar knee replacement in selected cases. For a total knee replacement muscle sparing (quadriceps sparing) approaches like mid-vastus and sub-vastus approaches, are considered minimally invasive as compared to the traditional medial para-patellar approach. This also leads to quicker post-operative rehabilitation of the quadriceps muscle.

Many surgeons, however, still prefer traditional approaches because it gives them better access to the joint and reduces the chances of component mal positioning.

COMPUTER ASSISTED SURGERY:-

Hip and knee replacement surgery with the help of computerised navigation has become quite popular over the last decade. This technology needs special training and the equipment is expensive. The advantage of computer navigation is in making the bony cuts precise and more accurate than with the traditional jigs. Computer navigation, therefore, is a useful modern tool specially in difficult cases as with para-articular deformities. It can also be very helpful in minimal invasive surgical approaches where visualization with naked eye is poor. In that situation computer assisted surgery can help in proper positioning of the implants.

DIFFICULT RECONSTRUCTION SURGERY:-

In case of hip and knee replacements where there are big areas of bone deficiency, patients with loss of legaments in the knees, require specialised reconstructive strategies. This has become possible because of the newer customized prostheses specially designed for compensating for big bone defects and in cases of bony tumours. There have been advances in banking the bone and in the development of materials which act as bone substitutes.

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AMREF is an international, non profitable and nongovernmental regional organization with a vision of lasting health change in Africa; communities with the knowledge, skills and means to maintain their good health and break the cycle of poor health and poverty. AMREF focus on long term change as opposed to short term, and emergency solutions.

Currently, AMREF has developed business plan. Within this plan AMREF focuses on transforming communities by improving the health of women and children based on three health systems building blocks namly: - Human Resource for Health, Community systems strengthening and Health Mangement information Systems, with strong focus on evidence based advocacy, operational research and policy change.

AMREF 's Headquarter is in Nairobi, Kenya since it was Founded in 1957. It also has country programmes in Kenya, Ethiopia ,Uganda, Tanzania, South Africa and South Sudan.

AMREF in Ethiopia currently operates in four regions: Afar, Addis Ababa, SNNPR, Oromiya and Cross- regionally. Furthermore, the Programmes focus primarily on women and children Health; Scaling up HIV , TB and Malaria responses, Prevention and control of diseases related to water and sanitation or hygiene(WASH),Increasing access by disadvantaged communities to quality medical, surgical and diagnostic services and Develop a strong research and innovation base to contribute to health improvement in Africa.

Clinical Specialist Outreach Project

This is how the Project Emerged

It was in 1957 that the flying Doctors service was established by three surgeons in Kenya. Since then, the flying Doctors have been involved in many health care projects is an extension of the flying of the doctors service.

Why the need for this project

In Ethiopia, the Clinical Specialist

Outreach project has been Operational since 2006. It has three basic components: Specialist Outreach Service Provision including conducting Surgeries; and Patient consultations for very poor patients who live at great distances from hospitals; Medical equipment installation and Maintenance service and capacity building of the local health personnel within existing government hospitals through on-the-jobs trainings. The programme is in high demand because it meets the great area of the need in health service provision in the country through mobilizing existing health professionals form central and University hospitals.

Services offered:

This project offers the following medical services which were identified during an assessment conducted by the programme:

- General and Special surgery (ORTHOPAEDICS; Urology ,plastic Reconstructive Surgery , Etc)
- Gyn& OBS(e.g.V.V Fistula and uterine prolapse)
- Ophthalmology
- Radiology service
- Internal Medicine and

Endoscopy services

- OR Techniques and Anesthesia
- MedicalInstrumentinstallation & Maintenance
- Infection prevention training
- On jop training for local staffs at government hospitals

The way we do what we do:

The project aims to provide health services and on jobs training in fourteen (14) selected government hospitals throughout the country. This is done by mobilizing volunteer health specialists from the University teaching hospitals within the regional and referral hospitals. The professionals include specialist and sub specialist Doctors, Nurses, Anesthetists, Medical equipment maintenance technicians to date the specialists provide outreach services, and local stuffs using practical sessions and lectures.

Areas of Operation; Axum, Mekele, Hyder, Gondar, Debre tabor, Debremarkos , Adama, Nekemete, Mettu, Shashemene, Arbaminch, Hosanna,Yirgalem and Durame Hospitals

Key Partners; Federal Ministry of Health (FMOH), University Hospitals, targeted Hospitals, Professional societies and Volunteer professionals.

What we achieved;

In five years,AMREF has organized 110 visits mobilizing more than 160 specialist and sub-specialist doctors,30 anesthetists,32 Bio-Medical technologists,18 scrub nurses and conducted 9,450 consultions,3,864 surgeries and various number of un functional medical instruments/ equipments were maintained. Furthermore, 1,600 medical professionals had received training, these include; surgeons, Gynaecologists, Nurses and Anaesthetists.

Leason Learent

There is a huge demand in all Hospitals for the services

Creating access through specialist out-reach services is more cost saving as compared to patient referral

Those who had not accessed these specialist services before can now be served with the project.

We proved that professionals are committed to serve their communities voluntarily.

Effective mobilization of local resources can help to address local problem and challenges.

Major Challenges: Attrition;

☐ There is high turnover of the health professionals at the targeted hospitals

Supplies and Equipment;

☐ There are lack of medical equipments and instruments for different specialty services

PODOCONIOSIS MAPPING...

commitment and resource mobilization for Soil-Transmitted Helminths (STH), schistosomiasis and malaria.

Work on progress

Currently we are preparing to conduct mapping in Ethiopia. Our mapping technique is derived from three practically proven methodologies for lymphatic filariasis, Loa loa and onchocerciasis mapping in Africa [9, 10]. In addition our method uses model-based geostatistics which have been used in mapping malaria, schistosomiasis, and STH. Since podoconiosis has clear topographic and environmental determinants, use of GIS tools will enhance traditional epidemiological and statistical mapping. In the first phase we will develop risk model to exclude areas with no risk. Due to the nature of the previous maps (data were collected from areas with risk for podoconiosis) it was difficult to produce robust risk model using existing data in Ethiopia. Hence data will be collected across the country to represent areas with and without risk of podoconiosis from previous observations. This will enable us to develop a comprehensive map which can be tested in other African countries and subsequently used to exclude areas with no risk of podoconiosis.

Conclusion

In conclusion, an up-to-date and reliable map of podoconiosis is needed to design geographically targeted and cost-effective interventions in Ethiopia and other countries where the disease is prevalent. As the global commitment to eliminate podoconiosis increases understanding the spatial distribution of the disease is very important to produce risk and distribution maps to guide decision making. This mapping project will give rise to a comprehensive district-level map, will identify populations at risk and will quantify the burden of disease in Ethiopia.

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TOP 10 SCARY MEDICAL MALPRACTICES IN THE WORLD. Collections from the Court

http://t3.askmen.com/top_10/entertainment/top-10-scary-medical-malpractice-cases_10.html

Medical malpractice is professional negligence by act or omission by a health care provider in which the treatment provided falls below the accepted standard of practice in the medical community and causes injury or death to the patient, with most cases involving medical error. Standards and regulations for medical malpractice vary by country and jurisdiction within countries.

Medical malpractice can be generally defined as substandard treatment by a physician or other healthcare professional that directly results in physical or economic damages to the patient. "Substandard" care refers to care that violates normal medical practices. Therefore, there are three factors that must be present to prove medical malpractice: liability, damages, and a direct causal link.

To meet the requirement of liability, it must first be proven that a professional relationship existed between the patient and health care provider. This is rarely a problem. Proving substandard care can be difficult, however, depending on the nature of the violation. Inadequate care in and of itself does not amount to malpractice.

Injury, suffering or economic damages must be present and must be a direct result of the negligence. Many facets of medical care, including surgery, have inherent risks even with proper care. Unless negligence can be proven in such a case, a bad outcome alone is not grounds for malpractice.

Medical malpractice can take many forms. Some examples are failure to diagnose a life-threatening disease, errors made in medication, surgical errors, failure to provide proper follow-up care, prenatal or delivery room errors, and miscalculations with anesthesia. According to the Journal of the American Medical Association some 225,000 deaths annually (in the US) are attributed to medical malpractice, making it the third largest cause of death. About 82% of these are due to either adverse reactions that should have been anticipated to medications, or contracting infections while staying at a hospital. About 9% are caused by miscellaneous errors and another 9% by unnecessary surgery or medication errors.

Bringing a medical malpractice suit against a hospital employee can be more complicated than suits brought against private practitioners. Often, select members of a hospital staff are provided by private contractors. In that case the negligent party and the contractor are named in the suit, rather than the hospital itself. Exceptions do exist to this rule, as when a hospital has had prior warning about an employee.

Different from medical malpractice is medical battery, the intentional violation of a patient's rights to direct his or her own care, as in the case of refusing treatment, either by advance decree or through a health-care proxy. No injury or negligence is necessary to find medical battery.

The following is a list of top 10 Scary Medical Malpractices judged at different courts.

1/ Forced Rectal Exam

After suffering an on-the-job head injury, Brian Persaud, a 38-year-old construction worker, was rushed to a nearby hospital in downtown New York City. What followed became the subject of a major malpractice lawsuit. Mr. Persaud contested that, after receiving stitches to his head, doctors forced a rectal exam upon him even though he furiously resisted. The emotionally injured Persaud then sued but eventually lost his case when a jury found that the hospital did nothing wrong: The rectal exam was meant to check for damage to Persaud's spinal cord and was never completed.

2/ The Wrong Egg / Women inseminated!

When young couple Matthew Hayes and Nico Swift checked into an Oregon hospital, they paid thousands in hopes of using Matthew's sperm to artificially inseminate his fiance (at least, that was the plan). In a colossal man-made mix-up, the clinic accidentally used Mr. Hayes' sperm to inseminate the wrong woman! Making matters worse, the unidentified "wrong" woman requested an anonymous donor, and thus, the law prevented Mr. Hayes from even seeing the resulting child. Hayes currently has two lawsuits in

court and is emotionally devastated by the ordeal: "They put my sperm into a stranger's vagina."

3/ Deaf From Diarrhea

Sue Gonzales went to her local Dallas hospital for routine treatment, but left unable to hear a single sound. Gonzales was receiving antibiotic therapy via IV for diarrhea, however, the IV was left in too long, and the antibiotic permanently damaged the nerve cells in her ears. What's worse is that her doctor recognized the IV had been in too long, yet failed to have it removed. Gonzales now cannot perform a task as simple as answering the phone and she can't even sue for her damages: Texas law has made it economically unviable for malpractice lawyers to take on such cases.

4/ Healthy Lung Removal

In the summer of 2005, Laurence Ball of the UK complained of chest pains to his doctor. Ball was referred to NHS Grampian, where he was diagnosed with lung cancer and had his lung removed. Problem was that Ball didn't have cancer, and the removal was an utter mistake. Ball was left a frail man, exhausted after little to no exertion. He received no apology or explanation, and finally took the case to court, but not until recently. Though he hopes to settle matters outside of the courtroom, someone has to pay for this mammoth mistake.

5/ Sleeping Surgeon while Operating!

All patients want competent doctors -- that's why our next story is truly frightening. When Michael Hicks went to Beth Israel Deaconess Medical Center for a second round of liposuction surgery, he was told the procedure would take close to 90 minutes. Instead, the Boston-area native endured a nightmare at the hands of surgeon Dr. Loren Borud. When all was said and done, the procedure took over six hours. Borud was noted as being impaired and falling asleep on the job, yet coworkers did nothing to stop him. Borud has since been fired and is awaiting litigation for malpractice.

6/ Burning Man

Waking up after surgery can be a disorienting experience, but waking form surgery to find that you have suffered serious burns defies description. Such was the case for Robbin Reeves when he underwent liver transplant surgery at Vancouver General Hospital in 2005. Reeves awoke to find a large, bloodied bandage on his shoulder. Apparently, Reeves' heart had stopped during the operation, and in the rush to emergency surgery, disinfectant alcohol on his neck and shoulder caught fire. To further complicate matters, Reeves' liver transplant failed. Though Reeves' malpractice lawsuit is pending, it's hard to think he won't receive some form of compensation.

7/ Botched Birth

The following story is not for the squeamish -- a warning that was delivered to jurors in a trial brought forth by Texas resident Sarah Wallace. In 2003, Wallace was a patient at Mid-Jefferson Hospital. She had gone into early labor, so on-call doctor Donald Long performed an episiotomy (an operation involving a surgical incision through the vagina to assist in childbirth). Unfortunately, Long neglected to check for a rectovaginal fistula, a hole between the anus and vagina. The result: Sarah began passing stool through her vagina. Long is now being sued for neglecting the appropriate standard of care (duh!).

8/ 30-Year-Old Sex Change

Moving from scary to downright haunting comes a peculiar case from Germany. Nearly a half century ago, Christiane Volling was born with indeterminate external genitalia. As a result, she was named Thomas and raised as a boy (a common practice at the time). However, when Christiane was 18, she underwent an appendix operation during which her surgeon discovered an intact set of ovaries -- which he set about removing. After learning she was female some 30 years later, Christiane felt robbed of her womanhood, and German courts settled in her favor: Her surgeon illegally performed an invasive operation without discussing all possible options before proceeding.

9/The Wrong Limb Amputated!

In perhaps the most publicized case of surgical malpractice, a Tampa surgeon mistakenly removed the wrong leg of 52-year-old Willi King during an amputation procedure in 1995. Apparently, a chain of errors led to the mishap, and the surgical team even realized their error halfway into surgery, but by that time it was too late, and the leg had to be removed. King eventually received over $1 million in compensation, and the case prompted a new wave of precautionary measures at University Community Hospital to prevent such ordeals from happening in the future (let's hope).

10/ Vasectomy Gone Wrong

Being a men's website, askmen.com; it's no wonder that the following case made it all the way to No. 1. After his wife became pregnant with a fourth child, Daniel Stalker went for a routine vasectomy. However, during the operation, Mr. Stalker began experiencing intense pain despite having been anesthetized. Stalker's doctor, Dr. Paul Dewart, continued anyway until the operation was abandoned when Stalker keeled over vomiting. One of Stalker's testicles then turned black and doubled in size! Years later, Stalker required his testicles be removed due to searing pain. Fortunately, he successfully sued Dewart for $1.76 million (but is that really justice?).

MALPRACTICE STATISTICS

$4 billion dollars paid by insurers for malpractice in the USA 1999 (When Good Doctors Get Sued, 2001)

- Estimated 25% of practicing physicians sued annually (When Good Doctors Get Sued, 2001)
- Estimated 50-65% physicians sued at least once during their career (When Good Doctors Get Sued, 2001)
- Estimated 10-20% of malpractice claims reach trial phase (When Good Doctors Get Sued, 2001)
- Majority of malpractice cases involve misdiagnoses, diagnostic errors or delayed diagnosis (When Good Doctors Get Sued, 2001)

PODOCONIOSIS: SUMMARY FOR ETHIOPIAN PROFESSIONALS

By Kebede Deribe , Gail Davey

This summary presents information on podoconiosis recently reveiwed in Lymphology, Annals of Tropical Medicine & Parasitology and The Oxford Textbook of Clinical Medicine. It is not as such intended to be read as a new publication but as a practical summary of these reviews.

Prevalence

Podoconiosis prevalence estimates have been made in Ethiopia and, recently, in Cameroon. Early estimations of prevalence using counts of attendees at fifty-six markets ranged from 0.42 to 3.73% (1), and further investigation in Wolaita zone, southern Ethiopia demonstrated prevalence of 5.38% across five markets. In the village of Ocholo, located at 2000m altitude in the mountains west of Lake Abaya, southern Ethiopia, elephantiasis was present in 5.1% of long-term residents (2), while in two resettlement schemes in Ilubabor, western Ethiopia, 9.1% of long-term residents were affected, and 5.2% of people resettled some 7-8 years previously (3). More recent population-based surveys in northwest (4), southern (5) and western Ethiopia (6), and north western Cameroon (7), have documented prevalence of 6%, 5.4%, 2.8% and 8.1%, respectively.

Age, Gender and Occupation

Early reports based on clinic attendees cannot be relied upon to derive an accurate sex ratio. Price found a male: female ratio of 1:1.4 in market studies, which he attributed to greater use of footwear by men (8). Genene Mengistu documented a male: female ratio of 1:4.2 in a survey in Ocholo, but many men of working age were absent from the community at the time (2). By contrast, Kloos noted higher prevalence among men in three of four resettlement communities in Keffa Region (3). In a single village in Pawe, Hailu Birrie found a male: female ratio of 1:1.4 among sufferers (4). The most recent community-based study in Wolaita recorded a gender ratio among podoconiosis sufferers (1:0.98) that was not significantly different from the zonal gender ratio (1:1.02) (5).

All of the major community-based studies have shown onset in the first or second decade and a progressive increase in podoconiosis prevalence up to the sixth decade. Development of podoconiosis is closely associated with living and working barefoot on irritant soils. Farmers are at high risk, but the risk extends to any occupation with prolonged contact with the soil, and the condition has been noted among potters, goldmine workers and weavers who sit at a ground level loom.

Pathology and Pathogenesis

The pathogenesis of podoconiosis is not yet fully elucidated. At present, most evidence suggests an important role for mineral particles on a background of genetic susceptibility, but the possible role of other co-factors (for example chronic infection or micronutrient deficiencies) has not been explored. Colloid-sized particles of elements common in irritant clays (aluminum, silicon, magnesium and iron) have been demonstrated in the lower limb lymph node macrophages of both patients and non-patients living barefoot on the clays (9). Electron microscopy shows local macrophage phagosomes to contain particles of stacked kaolinite ($Al_2Si_2O_5(OH)_4$).

Price describes changes in the dermis, afferent lymphatics and lymph nodes of affected individuals. The primary lymph sacs become dilated and surrounded by lymphocytes, while oedema and disorganized collagen production occurs. This fibrosis affects the afferent lymphatics, narrowing and eventually obliterating their lumen. If fibrosis predominates, both dermis and subdermis become bound to underlying deep fascia by collagen fibres, eventually destroying sweat and sebaceous glands and hair follicles. If oedema predominates, afferent vessel walls become rigid and dilated, provoking valvular dysfunction (10). No animal model has yet been developed for podoconiosis, but experiments have shown that silica suspension injected into rabbit lymphatics can provoke intense macrophage proliferation followed by lymphatic fibrosis and blockage (11). Further histopathology and imaging studies using modern methods will be vitally important to understanding pathogenesis, but are limited by the remote locations of most podoconiosis communities.

Clinical Pathology.

The pathology and natural history are described in a range of articles (12-14). Podoconiosis is characterized by a prodromal phase before elephantiasis sets in. Early symptoms commonly include itching of the skin of the forefoot and a burning sensation in the foot and lower leg. Early changes that may be observed are splaying of the forefoot, plantar oedema with lymph ooze, increased skin markings, hyperkeratosis with the formation of

moss-like papillomata, and 'block' (rigid) toes. The 'mossy' changes predominate in a slipper pattern around the heel and border of the foot, reflecting the distribution of underlying superficial lymphatics.

Later, the swelling may be soft and fluid ('water-bag' type); or hard and fibrotic ('leathery' type), often associated with multiple hard skin nodules (15), or intermediate with both sets of features. Acute episodes (acute adenolymphangitis, ALA) occur on average 5 times per year, and patients become pyrexial with a warm, painful limb, necessitating on average 4.5 days off work each episode (6). These episodes appear to be related to progression to the hard, fibrotic leg.

Genetics.

Among many families, exposure to irritant soil is more or less uniform, yet not all family members will develop podoconiosis during their lifetime. Recent studies in a southern Ethiopian population demonstrate the contribution of both genetic and environmental factors to the pathogenesis of podoconiosis. The estimated heritability was 63%, with sibling recurrence risk estimated as 5.1. The 'best-fitting' genetic model was an autosomal co-dominant major gene with age and footwear as significant covariates (16). A genome-wide association study has shown significant association between podoconiosis and single nucleotide polymorphisms (SNPs) in or near the HLA-DQB1, HLA-DQA1 and HLA-DRB1 genes (17).

Economic Consequences.

A comparative cross-sectional study was performed in 2005 to calculate the economic burden in a zone endemic for podoconiosis. Total productivity loss for a patient amounted to 45% of total working days per year, and in a zone of 1.5 million people, the total overall annual cost of podoconiosis was calculated to exceed US$ 16 million per year (18). Projected to the whole of Ethiopia, the direct and productivity costs would amount to at least US$ 208 million per year.

Social Stigma and Access to Health Care.

Social stigma against people with podoconiosis is rife, patients being excluded from school, denied participation in local meetings, churches and mosques, and barred from marriage with unaffected individuals (19). The belief that there is no effective medical treatment may act as a barrier to accessing health care.

Understanding of and attitudes towards podoconiosis in local communities has been investigated in Ethiopia and Cameroon. In Cameroon, most (77.8%) respondents knew a descriptive local term for the condition, and 81.4% recognized the disease when prompted with a photograph (7). These findings are consistent with those in a community endemic for podoconiosis in southern Ethiopia (20). Almost all (91.6%) adult respondents in this study knew local terms for podoconiosis, and 93.5% recognized the disease when shown a photograph.

Both studies demonstrated stigmatizing attitudes towards disease in endemic communities - in Cameroon only 7.2% thought that healthy community members would consider marrying a person with lymphoedema (7), in Ethiopia 53.9% would not eat with a person with podoconiosis (20). Such attitudes may be linked to relatively low levels of awareness of treatment: only 32% of the Cameroonians interviewed and 41.4% of Ethiopians were aware that treatment was available. More worryingly, more than half of the Ethiopian health professionals interviewed thought podoconiosis was an infectious disease, and all held at least one stigmatizing attitude towards podoconiosis patients (21).

The potential harm that may be done to patients through research that identifies them as having podoconiosis is very real for such a thoroughly stigmatizing disease. Strategies to minimize the consequences of research on podoconiosis stigma have been investigated and may be used by other groups planning research in podoconiosis (22).

Assessment of Disease: Staging System.

Investigators in Ethiopia developed a staging system with the aims of enabling disease burden to be measured and interventions to be assessed (23). Initial attempts to validate the Dreyer system (a seven-step system for staging filarial elephantiasis, indicated that this existing system did not transfer adequately to podoconiosis. A new system was developed through a series of iterative field tests. This system is designed to be used by community workers with little health training, has five stages and is based on the proximal spread of swelling, knobs and bumps. The stage is recorded together with presence or absence of mossy changes (M+ or M) and the greatest below-knee circumference. The repeatability and validity of the staging system were assessed, and showed good inter-observer agreement and repeatability. The staging system has, anecdotally, been adopted with enthusiasm by patients who are grateful for a method by which their treatment efforts can be measured.

Assessment of Disease: Cardiff Dermatology Life Quality Index

The Dermatology Life Quality Index (DLQI) has been translated and used to assess feasibility of use, internal consistency and concurrent validity among podoconiosis patients in southern Ethiopia (24). The DLQI was easy to administer, taking approximately 4 minutes per patient. The overall value of Cronbach's alpha was 0.90, indicating high internal reliability. Concurrent validity was assessed through comparison of patients at first visit to the treatment outreach clinic with those who had been treated for at least three months (median scores 13 and 3, respectively, $p<0.001$). The investigators concluded that the Amharic DLQI was another useful tool in assessing podoconiosis patients at presentation, and in evaluating physical and social interventions.

Differential Diagnosis

The conditions podoconiosis must most often be distinguished from are filarial and leprotic lymphoedema, endemic Kaposi's sarcoma and

chronic recurrent erysipelas. Clinical features of podoconiosis that help distinguish it from filarial elephantiasis include the foot being the site of first symptoms (rather than elsewhere in the leg) and bilateral but asymmetric swelling usually confined to the lower leg (compared to the predominantly unilateral swelling extending above the knee in filariasis). Groin involvement in podoconiosis is extremely rare. A recent study using both midnight thick film examination and BinaxTM antigen cards has confirmed that in a podoconiosis-endemic area, community workers' diagnoses are highly predictive of podoconiosis (25). Podoconiosis may be distinguished from leprosy lymphoedema by the preservation of sensation in the toes and forefoot, the lack of trophic ulcers, thickened nerves or hand involvement.

PREVENTION AND TREATMENT

Primary Prevention

Evidence suggests that primary prevention should consist of avoidance of prolonged contact between the skin and irritant soils. This may be achieved by use of robust footwear or covering of floor surfaces in areas of irritant soil. Several non-government organizations now train treated patients to make low-cost durable leather boots and shoes for their communities in an attempt at primary prevention. In addition, new partnership with TOMS Shoes (a US-based business whose founding principle is to give away a pair of shoes to a child in need for every pair sold) has allowed the distribution of nearly 100,000 pairs of shoes through podoconiosis prevention programs in Ethiopia since 2009. Operational research to measure the effect of this prevention campaign is much needed.

Secondary Prevention

Secondary prevention (prevention of the progression of early symptoms and signs to overt elephantiasis) takes the form of training in foot hygiene (washing daily with soap and water, using antiseptics and ointment), and use of socks and shoes. Compression bandaging is highly effective in reducing the size of the soft type of swelling, but bandages are often difficult for patients to afford. Progression can be completely averted if these measures are strictly adhered to, but compliance must be life-long (26). Relocation from an area of irritant soil (13) or adoption of a non-agricultural occupation are also effective, but may not be feasible for the patient.

Tertiary Prevention

Tertiary prevention (the management of those with advanced elephantiasis) encompasses secondary prevention measures, elevation and compression of the affected leg, and, in selected cases, removal of prominent nodules. For elevation to be successful, at least 18 hours with the legs at or above the level of the heart are needed each day. Previously, Charles' operation (removal of skin, subcutaneous tissue and deep fascia to lay the muscles and tendons bare, followed by grafting of healthy skin), or a variant, was used (12, 15), but long-term results are disappointing. Follow-up of patients suggests that those unable to scrupulously avoid contact with soil experience recurrent swelling which is more painful than the original disease because of scarring. Social rehabilitation is vital, and includes training treated patients in skills that enable them to generate income without contact with irritant soil.

International Health Aspects

Worldwide, very few public or private sector organisations offer treatment to people with podoconiosis. This is the result of a lack of evidence-based treatment options compounded by patchy acknowledgement that the disease even exists. Ethiopia leads the world in terms of podoconiosis interventions: in Wolaita, Gamo Gofa, Dawro, East Wollega, West Wollega, Qellem Wollega, East Gojjam and West Gojjam zones, non-government organizations now offer prevention and treatment on a relatively small scale. A national forum, the National Podoconiosis Action Network (NaPAN) has recently been formed, with the aim of coordinating and enhancing the work of these organizations, and bringing podoconiosis control into mainstream government health policy. In February, 2011, the World Health Organisation included podoconiosis in its list of Neglected Tropical Diseases. Also at the international level, Footwork the International Podoconiosis Initiative (www.podo.org) was launched in March 2012, to advocate for inclusion of podoconiosis into integrated NTD programs globally.

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World Orthopaedic Concern

Newsletter No 119 - May 2012
Distributed from:-
laurence.woc@gmail.com
and through
Websites:- www.worldortho.com
www.wocuk.org
www.worldorthopaedicconcern.org

ETHIOPIA

This Newsletter is circulated through the internet, and through all WOC Regional Secretaries in the hope that they will be able to download and distribute it to those not connected through the "net." It is addressed to all those interested in orthopaedic surgery in Areas of the World with Limited Resources but with maximum need.

Dr Fintan Shannon has just returned from one of his regular six week working visits to the Tikur Ambassa (Black Lion) University Hospital in Addis. These are very much "hands on" teaching and service commitments, enhancing rather than replacing the ordinary schedule of the hospital. He refers to the huge load of daily trauma (167 surgical cases completed) and the now familiar obstruction to the free flow of urgent cases from emergency room to emergency theatre. The Saturday morning operating session, initiated by Shannon and Forward, continues largely at their expense, and although this hugely eases the pressure on the available theatre time, Fintan feels that the trainees need even more supervision and support from the heavily committed senior staff at the BLH, than currently seems possible. He is very conscious of the value of constant guidance, encouragement and correction of error in surgical technique, actually on the operating table.

While he was there his colleagues from Australia (Drs Graham Forward, Michael Wren, and Tim Keenan,) visited to present a two-day workshop on the basic techniques of orthopaedic surgery. The visit was made possible with assistance from the Emirates Airline Foundation, Synthes Australia and the supporters of "Australian Doctors for Africa."(ADfA). Michael Wren was the main convenor of the programme which was divided between lectures on basic orthopaedic surgical principles and a practical workshop using "saw bones," drills, plates and screws and wires. Tim Keenan also took a three day detour to Juba, the capital of South Sudan, to assess the medical and orthopaedic needs in that newest African country. Altogether six very busy days.

Graham Forward writes:-

"Clearly, there remains a need for more operating theatre time (at the Black Lion), and for this, ADfA is committed to construct three new operating theatres in the new Rehabiltation block. A memorandum has been signed between ADfA, the Dean of the University Medical School (Dr Dereje) and the CEO of the Black Lion Hospital (Dr Aster). Agreement has been reached regarding the financial contribution by the Hospital and ADfA, and a commitment was given by the hospital fully to fund the staffing, maintenance and on-going costs once the theatres are opened. The plans were changed in response to the Black Lion request for an extra theatre to deal with contaminated cases. The architect (Mr Getaneh Retta) has been commissioned with a large pro bono contribution towards the design, submission and supervision of the project."

<laurence.woc@gmail.com>

TEN WHO FACTS ABOUT ROAD TRAFFIC SAFETY:

Lili Hailemichael; RN, MPH

1. More than 1.2 million people die in road traffic crashes every year
2. As many as 50 million people are injured or disabled by road traffic crashes every year
3. Half of all crash victims are vulnerable road users such as pedestrians, cyclists, and motorcyclists
4. Road traffic crashes cost countries up to 4% of their Gross National Product
5. Correctly used seat-belts reduce the risk of death in a crash by 61%
6. Mandatory use of child restraints can reduce child deaths by 35%
7. Helmets reduce fatal and serious head injuries by up to 45%
8. Enforcing a drinking and driving law around the world could reduce alcohol-related crashes by 20%
9. For every 1km/h reduction in average speed, there is a 2% reduction in the number of crashes
10. Simple low-cost engineering measures are saving thousands of lives

Tubercular bursitis of the ulnar bursa

(compound palmar ganglion)

Dr. Fekadu Teshome .

Tuberculosis has been a health concern for several thousand years , and millions continue to be afflicted with this disease . It remains a major source of morbidity and mortality world-wide.

Though ubiquitous in distribution , It has firmly entrenched itself with developing nations.

Extra - pulmonary tuberculous involvement of the musculo-skeletal system mercifully is not as common as pulmonary tuberculosis , accounting for only 10% of tuberculosis cases.

The diagnosis of tuberculous synovitis is usually delayed as it mimics many other conditions which can lead to complications. Other swellings of the fingers , hand or wrist that may be difficult to distinguish from the swellings of tuberculous bursae , and occasionally with a secondary pyogenic infection, complicates the tuberculosis as a disease and makes the diagnosis difficult.

Here , we present a 30 year old female patient with a confirmed diagnosis of compound palmar ganglion .

To our knowledge this diagnosis has not been registered from Ethiopia and Africa as well .

Case report

A 30 year old house-wife , mother of three children presented to our clinic in August 2010 complaining Of a swelling on the left distal forearm of 4 years duration. It increased in size gradually and was painful Occasionally.

No one in the family has similar illness.

Denied any history of trauma or chronic medical illness and the system review was non-contributory.

One year prior to her presentation , she visited a nearby health institute where surgical intervention was undertaken and different antibiotics were administered , but all endeavors were to no avail.

Physical examination revealed a longitudinal surgical scar with a spindle-shaped doughy , non-tender

Swelling on the volar aspect of the left wrist medially , bulging above and below the flexor retinaculum

With positive cross fluctuation.

No interference with finger movements.

Provocative tests for impingements were all negative.

With a clinical diagnosis of compound palmar ganglion , decisions for further investigations and excisional biopsy were made.

All the routine laboratory investigations were within normal limits except the ESR to be 56 mm at the end of the first hour.

Roentgenogram of the chest and wrist showed no abnormality.

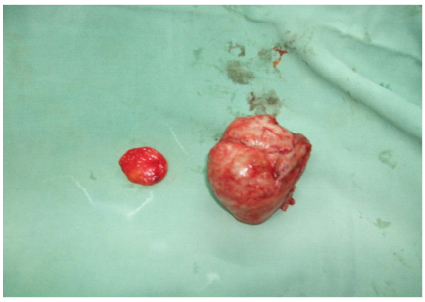
Nerve conduction study of the upper limb was also reported normal.

Serology for HIV was found negative.

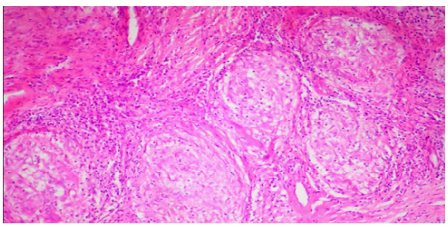
Finally, through a longitudinal incision medial to the Palmaris longus , median nerve being retracted

laterally , the lesion was isolated and subsequent radical en block excision was undertaken without

difficulty . Pressure over the palm expressed one melon-seed body from the wound .



Histopathological examination of the excised tissue with the melon-seed body was reported as synovial and subsynovial tissues showing morphologic features of caseous granulomatous inflammation consistent with toberculous synovitis.



Subsequently having finalized the diagnosis , as chemotherapy is the mainstay of the management , anti-tubercular treatment was initiated promptly according to the current national protocol.

The bugbears of the treatment being its long duration, poor patient compliance, emergence of drug resistance and others , with meticulous follow-up carried out favorable clinical response was obtained.

Discussion

Primary tuberculous synovitis of the palmar synovial bursa is a rare condition.

The mechanism may be direct innoculation from adjacent bone or joint infection or seeding from a tuberculous lesion in the pleuro -pulmonary or genito -urinary system.

The precipitating factors include trauma , old age , low socio-economic status , mal-nutrition , alcoholism , Immuno-suppression and steroid injections.

The onset of the disease is gradual with slow progression leading to well advanced disease before presentation.

Patients usually present wih an insidious , slow growing , sausage-like mass with no or little pain. They

may also present with discharging sinus and carpal-tunnel syndrome. Tendon rupture is a rare presentation but it may occur when treatment is delayed.

There are different histo-pathological forms of tuberculous tenosynovitis as a result of the long duration Of the disease, the resistance of the individual , and the varying virulence of the micro - organism (bacilli) .

If healing by fibrous tissue formation fails to curtail the pathologic process , extensive caseation and granulation occurs. Although the granulomas (caseating or non-caseating) occur in most cases, rare cases might show non-specific inflammation only without granulomas .

" Rice-bodies" or " Melon-seeds" represent fibrinous masses (tubercles) ,which are present in 50%

tuberculous cases.

Laboratory findings are generally negative , except the ESR which is usually increased.

The main problem remains the difficulty in diagnosing the disease because of the non-specific Clinical signs that point to a number of other possibilities.

The most effective treatment involves a combination of medical and surgical therapies.

The tendency for local recurrence in tuberculous synovitis is not absolutely nil, so close follow-up Should be carried out in every case.

Conclussion

Though compound palmar ganglion is a rare event , delaying the diagnosis and even missing is not uncommon due to the slow progression and numerous differential diagnoses which often leads to functional disabilities and other complications.

Early radical excision of the infected tissues coupled with anti-tuberculous multi-drug therapy gives good functional outcomes , prevent complications and recurrence.

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Announcement

The SOUTH AFRICAN ORTHOPAEDIC ASSOCIATION (SAOA) is prepared to deliver instructional course on FOOT problems in the first week of December 2012.

TOPICS INCLUDE:

1. Bunions
2. MP Fusion
3. Bunionette
4. Triple Arthrodesis
5. Ankle Arthrodesis ?
6. Diabetic foot
7. Ankle arthritis treatment options - Chris

8. Trauma
9. Other
- Cavus foot – Adriaan
- Neuroma – Nick
- Sesamoiditis – Willem
- O.D lesions in talus – Chris
-

10. Flat foot
- Adult flatfoot - Nick
- Juvenile flat foot - Ryno
- Arthroereisis - Ryno

11. Tendon problems
(a) Achilles tendonoses - Willem
(b) Peroneal tendon problems
- Chris – Peroneal tendon dislocations
- Chris – Peroneal tendon disorders

12. Club foot – Ryno du Plessis

13. Forefoot
- Assessment of the forefoot before surgery - Chris
- Lesser metatarsal shortening – Chris

14. Paralytic foot
Different tendon transfers – Ryno du Plessis

For early registration, please contact ESOT office.

NECAT

PHARMA —ORTHO:

Published in Science Translational Medicine Rapid Publication on February 16 2012
Sci Transl Med 22 February 2012:
Vol. 4, Issue 122, p. 122ra21
Sci. Transl. Med. DOI: 10.1126/scitranslmed.3003276
Research Article

DRUG DELIVERY

First-in-Human Testing of a Wirelessly Controlled Drug Delivery Microchip

A study from USA. Send correspondences to I: rfarra@mchips.com

The first clinical trial of an implantable microchip-based drug delivery device is discussed. Human parathyroid hormone fragment (1–34) [hPTH(1–34)] was delivered from the device in vivo. hPTH(1–34) is the only approved anabolic osteoporosis treatment, but requires daily injections, making patient compliance an obstacle to effective treatment. Furthermore, a net increase in bone mineral density requires intermittent or pulsatile hPTH(1–34) delivery, a challenge for implantable drug delivery products. The microchip-based devices, containing discrete doses of lyophilized hPTH(1–34), were implanted in eight osteoporotic postmenopausal women for 4 months and wirelessly programmed to release doses from the device once daily for up to 20 days. A computer-based programmer, operating in the Medical Implant Communications Service band, established a bidirectional wireless communication link with the implant to program the dosing schedule and receive implant status confirming proper operation. Each woman subsequently received hPTH(1–34) injections in escalating doses. The pharmacokinetics, safety, tolerability, and bioequivalence of hPTH(1–34) were assessed. Device dosing produced similar pharmacokinetics to multiple injections and had lower coefficients of variation. Bone marker evaluation indicated that daily release from the device increased bone formation. There were no toxic or adverse events due to the device or drug, and patients stated that the implant did not affect quality of life.

Get full text from this site: http://stm.sciencemag.org/content/4/122/122ra21

Some Historical Landmarks in Orthopedic Surgery

(http://en.wikipedia.org/wiki/Orthopedic_surgery)

Nicholas Andry coined the word "orthopaedics" in French as orthopedie, derived from the Greek words orthos ("correct", "straight") and paideion ("child"), when he published Orthopedie (translated as Orthopaedia: or the Art of Correcting and Preventing Deformities in Children) in 1741.

Jean-Andre Venel established the first orthopedic institute in 1780, which was the first hospital dedicated to the treatment of children's skeletal deformities. He is considered by some to be the father of orthopedics or the first true orthopedist in consideration of the establishment of his hospital and for his published methods.

Antonius Mathysen, a Dutch military surgeon, invented the plaster of Paris (pop) cast in 1851. Many developments in orthopedic surgery resulted from experiences during wartime. The use of intramedullary rods to treat fractures of the femur and tibia was pioneered by Gerhard Küntscher of Germany. However, traction was the standard method of treating thigh bone fractures until the late 1970s when the Harborview Medical Center in Seattle group popularized intramedullary fixation without opening up the fracture.

External fixation of fractures was refined by American surgeons during the Vietnam War but a major contribution was made by Gavril Abramovich Ilizarov in the USSR. He was sent, without much orthopedic training, to look after injured Russian soldiers in Siberia in the 1950s. With no equipment he was confronted with crippling conditions of unhealed, infected, and malaligned fractures. With the help of the local bicycle shop he devised ring external fixators tensioned like the spokes of a bicycle. With this equipment he achieved healing, realignment and lengthening to a degree unheard of elsewhere. His Ilizarov apparatus is still used today as one of the distraction osteogenesis methods for limb lengthening.

Ruth Jackson became the first female Board-certified Orthopedic Surgeon in the U.S in 1937. Orthopedics continues to be a male-dominated field. In 2006, only 12.4% of orthopedics residents were women.

David L. MacIntosh pioneered the first successful surgery for the management of the torn anterior cruciate ligament (ACL) of the knee. This common and serious injury in skiers, field athletes, and dancers invariably brought an end to their athletics due to permanent joint instability. Working with injured football players, Dr MacIntosh devised a way to re-route viable ligament from adjacent structures to preserve the strong and complex mechanics of the knee joint and restore stability. The subsequent development of ACL reconstruction surgery has allowed numerous athletes to return to the demands of sports at all levels.

Arthroscopy was pioneered in the early 1950s by Dr. Masaki Watanabe of Japan to perform minimally invasive cartilage surgery and reconstructions of torn ligaments.

The modern total hip replacement was pioneered by Sir John Charnley in England in the 1960s. He found that joint surfaces could be replaced by metal or high density polyethylene implants cemented to the bone with methyl methacrylate bone cement. Since Charnley, there have been continuous improvements in the design and technique of joint replacement (arthroplasty) with many contributors, including W. H. Harris, the son of R. I. Harris, whose team at Harvard pioneered uncemented arthroplasty techniques with the bone bonding directly to the implant.

Job advertisement

Paediatric Orthopaedic Fellowship
Beit CURE International Hospital
Malawi

Supported through generosity of AO Socio Economic Committee

Applications are invited for 6-12 month posts in Paediatric Orthopaedics based at the Beit CURE International Hospital in Blantyre, Malawi (accredited for COSECSA training)

- Applicants should be post Membership of COSECSA
- Engaged in, or having completed a training in orthopaedics and traumatology
- Competitive remuneration package
- Flights to and from Malawi included
- Clinical post with commitment to surgical research and audit
- Offering experience in general paediatric orthopaedics including management of :
  - bone and joint sepsis
  - common congenital deformities
  - burn contractures
  - complex limb reconstruction using circular frames (ilizarov and TSF)
- Further adult experience in hip and knee joint arthroplasty, trauma and arthroscopic surgery.

Further application details from :

Dr John Cashman,

Beit CURE International Hospital

PO Box 31236, Blantyre 3

Or

john.cashman@cureinternational.org

APPLICATION CLOSING DATE: **1st October 2012**

cure Malawi

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National Podoconiosis Action Network /NaPAN
2nd General Assembly, April 07/2012
United Nations Conference Center / UNCC/
Addis Abeba,Ethiopia
TOMS
One for One

Abstract

a pilot study **OF TREATMENT OF** Crush Fracture of the Os Calcis. By a simple mode of eliminating the deforming force by defunctioning the triceps cruri, releasing the T.A. AT ADDIS ABABA UNIVERSITY, IN ETHIOPIAN

Authors:

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Addis Ababa, ETHIOPIA.

Bahiru Bezabeh, Michael laurence

ABSTRACT

Objectives: This is a pilot study with an objective of a simple mode of eliminating the deforming force by defunctioning the triceps cruri, releasing the T.A. and thus to allow a degree of freedom for the bone to resume its anatomical shape without the upward pull of the triceps cruri.l from October 2011 – May 2012. Faculty of Medicine, Black-Lion Hospital (BLH), Addis Ababa University, ETHIOPIA,

Setting: Addis Ababa University, Black-Lion ('Tikur Anbessa') Hospital-BLH, is the country's highest tertiary level referral and teaching Hospital. The 67-bedded orthopedic department, only one in the country, runs under-graduate and post-graduate/ residency programs and receives referred patients from all over the country.

Methods: All the 14 consecutive Crush Fracture of the Os Calcis f patients admitted to the department's wards during the study period were recruited for the study. They are prospectively followed after obtaining their consents. the operation was performed and kept in the hospital for capable of days for checking control x-ray and for other post op complication .all patients are discharged with two crutches and walking as pain tolerated followed every one month in out patient department clinically and radiological evaluated

Hip Replacement at The CURE Hospital:

A Preliminary Review of the First 44 Cases
Eric Gokcen, MD; Biruk Lambisso, MD.
The CURE Hospital
Addis Ababa, Ethiopia

cure INTERNATIONAL

Hip replacement surgery is often cited as one of the most revolutionary advances of all time in orthopaedic surgery. However, in developing countries, the availability of this procedure is typically very limited. We report on the outcomes of our first 44 hip replacements, including total hip replacement and modular hip hemiarthroplasties, and discuss the limitations and viability of hip replacement surgery in Ethiopia.

Abstract

The outcome of pelvic fracture surgery at SCH

Dr. Duane Anderson, Dr. Segni Bekele, Dr. Moges Mulu
Soddo Christian Hospital

A system for assessment of function after major pelvic injuries is proposed. This numeric system of functional assessment is adopted from five years prospective study done in 1989 by Dr. Said Abdul Majeed from Kuwait University on 60 patients.

Five factors were assessed and scored: pain, standing, sitting, sexual intercourse and work performance. The total score then gave a clinical grade as excellent, good, fair or poor. The scoring system allows comparison between early and late results and also between various methods of treatment.

Worldwide there are many reports on treatment of pelvic fracture surgeries, but we have not come across one in our country. The results of most of these studies lack objectivity and often are expressed in vague terms, like returning to work, pain or gait improvement and other symptoms. Studies that use numerical scoring system to assess the outcome of pelvic fracture surgery is more objective and we have adopted a study done by Dr. Abdul Majeed to evaluate pelvic fracture surgeries done on four patients at Soddo Christian hospital.

Operative treatment of displaced serious pelvis fractures is commonly done worldwide. With the development of CT scanners, sophisticated live x-ray machines and the study of pelvic bony anatomic variations, percutaneous procedures of sacral- iliac fracture/dislocations are routinely done in major centers in Europe and the USA. Combination procedures of the anterior pelvis (either open plating or percutaneous external fixation) with a posterior procedure are commonly done for complex instability patterns.

At Soddo Christian Hospital we are seeing more complicated pelvic injuries as the volume of road traffic accidents increase and as referral patterns are established. We have developed an open technique for placement of sacroiliac screws that has proved to be possible. In conjunction with open SI plating and well established open procedures for the anterior pelvis, major instability of the pelvis can be handled without the use of live x-ray. We are presenting our limited experience over the last year with short term results of these procedures

METHOD

Five criteria were chosen for functional assessment after major pelvic fractures: pain, standing, sitting, sexual intercourse and performance at work. Each of these clinical parameters is scored, the total being a maximum of 100 points for patients who were working before the injury and 80 points for those who were not. We have used serial x-rays and videos to collect information from our patients. The limitation of our study is that we have only four patients and they are assessed at various time intervals following the surgery. As this is an ongoing study, we will include more patients in future.

The five sections of the assessment are scored as shown in Table I and discussed below:

Pain: Pain is an important sequel of major pelvic injury, and is given a score of 30 points, allocated according to the six grades listed in Table I.

Standing: Weight-bearing in the erect position is given 36 points, in three main categories (aids, gait and walking ability), each of which has six grades.

Sitting: Sitting is an important function in relation to the pelvis, but less so than gait or walking ability. A total score of 10 points is given in four grades.

Sexual intercourse: For both men and women, four points are allocated for comfort during sexual intercourse. This does not take account of neurological or psychological impotence and is recorded in four grades. If, for any reason, sexual intercourse has not been attempted, a score of four points is given.

Work: Work performance is allocated 20 points in five grades, ranging from no regular work to return to the same job as before injury with no loss of

Abstract

performance. A patient who was not working at the time of his injury is not scored; his overall assessment is then out of 80 points.

Table I. System for function assessment after pelvic fractures

Pain - 30 points	
Intense, continuos at rest	**0-5**
Intense with activity	**10**
Tolerable, but limits activity	**15**
With moderate activity, abolished by rest	**20**
Mild, intermittent, normal activity	**25**
Slight, occasional or no pain	**30**
Work - 20 points	
No regular work	**0-4**
Light work	**8**
Change of job	**12**
Same job, reduced performance	**16**
Same job, same performance	**20**
Sitting – 10 points	
Painful	**0-4**
Painful if prolonged or awkward	**6**
Uncomfortable	**8**
Free	**10**
Sexual intercourse – 4 points	
Painful	**0-1**
Painful if prolonged or awkward	**2**
Uncomfortable	**3**
Free	**4**

Standing – 36 points	
A walking aids (12)	
Bedridden or almost	**0-2**
Wheelchair	**4**
Two crutches	**6**
Two sticks	**8**
One stick	**10**
No sticks	**12**
B Gait unaided (12)	
Cannot walk or almost	**0-2**
Shuffling small steps	**4**
Gross limp	**6**
Slight limp	**10**
Normal	**12**
C Walking distance (12)	
Bedridden or few meter	**0-2**
Very limited time and distance	**4**
Limited with sticks, difficult without	
Prolonged standing possible	**6**
One hour with a stick limited without	**8**
One hour without sticks slight pain or limp	**10**
Normal for age and general condition	**12**

Table II. Clinical grade based on a score out of 100 points for working and 80 points for non-working patients (see text)

Working before injury	Not working before injury	Grade
>85	>70	Excellent
70 to 84	55 to 69	Good
55 to 69	45 to 54	Fair
<55	<45	poor

Abstract

Table III. The outcome following pelvic fracture surgery at Sodo Christian hospital is shown below.

	Name	Age sex	Fracture	Operation type	Duration after operation	Total score	Complication
1.	Dubale	28 / m	Ischial ramus + Left sacral , and SI dislocation	Anterior approach SI screw and and anterior ex-fix	3 1/2 months (14 weeks)	63 %	none
2	Tesfaye Yaya	30/ m	Left SI joint dislocation, symphisis pubic diastases	ORIF with symhysis pubis Plating and SI joint screwing	11 months	91%	Unrecognized extraperitoneal bladder rupture, Infected surgical wound involving the anterior plate and screw, L5 nerve root temporary injury
3	Firehiwot Abebe	39/ f	Right sacro iliac joint dislocation + symphysis pubis diastases + left superior ramus #	ORIF-plating + screw fixation of SIJ	11 months	91 %	none
4	Zerihiu Simon	24/ m	Iliac bone # + left SI Jt dislocation	ORIF – plating -Anterior approach and ex-fixeter anteriorly	18 months	94 %	none

DISCUSSION

We have operatively treated 4 complex pelvic injuries in the last year at Soddo Christian hospital. We have done this with limited complications. The results over the short term are encouraging. We expect that long term results will improve with time in these injuries. In Africa where there is limited access to CT scanners and live x-ray, development of surgical procedures that are straightforward and safe is important in taking care of the critically injured pelvis.

As live x-ray becomes available in Ethiopia we hope to be able to learn how to place SI screws percutaneously, until then we will continue to use open techniques to provide posterior fixation of the SI joint and continue to apply anterior plates where it is applicable.

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Moges Mulu, MD
Segni Bekele, MD
Abebe Chala, PT

Abstract

OUTCOME OF SURGICAL MANAGEMENT OF OPEN TIBIAL FRACTURE IN ADULT PATIENTS AT ADDIS ABABA UNIVERSITY, SCHOOL OF MEDICINE ADDIS ABABA, ETHIOPIA FROM April–March, 2012

Investigator: 1Geletaw Tessema, worku Belay,2Woubalem Zewde, 3Biruk Lambisso, Neil white
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Background

Open Tibial fractures is one of the commonest fractures in adult patient being the most common fracture . In our hospital open Tibial fracture is the commonest cause of hospital admission. Open and closed tibial fracture accounts 16%(1177/7317) in Tikur Anbesa Hospital.

Its management is difficult and complications are common. If it is managed in time with appropriate way its outcome is rewarding and the complications can be minimized significantly.

Objective

The objective of this study is to assess the new management protocol outcome of patients who presenting with open tibial fracture to Tikur Anbessa Specialized Hospital (TASH), Addis Ababa, Ethiopia.

Methodology

Prospective cohort study will be conducted in patients presenting with open tibial fractures to TASH. Petiens will be evaluated and managed by a protocol according to the type of fracture sustained using the available options of management in our setup. The data will be collected based on the prepared and pretested structured questionnaire by the primary investigator. The initial evaluation and outcomes of the different modalities of the management used will be assessed using different statistical methods.

Work plan

The study will be conducted for 1yr period from April, 2012 up to March 2013.

Dissemination of results

Ongoing presentations will be conducted throughout the process of the study. Final write up of the findings will be available and disseminated to the scientific community, patients and the public after March, 2013.

ACL Reconstruction

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Anterior cruciate ligament (ACL) tear can be a career ending injury in professional athletes and lead to significant limitations in activities in non-athletes. Over the past few decades, major advances in ACL reconstruction (ACLR) have allowed many athletes and non-athletes to return to previous levels of activity. The purpose of this talk is to review some of the advances in ACLR, discuss the pros and cons of current techniques including graft selection, review outcomes, and open a discussion of the place of ACLR in Ethiopia.

Abstract

PATTERN OF FRACTURE AT TIKUR ANBESSA UNIVERSITY HOSPITAL:

Prospective study

1. Department of Orthopedics, School of Medicine, Addis Ababa University

2. Department of Surgery, School of Medicine, Addis Ababa University

ABSTRACT

BACKGROUND:Fractures and dislocations are major cause of disability in our set up. This study aims at assessing the patterns observed and highlights the common disabling fractures.

METHOD: Prospective three and half months study of patients who presented with fracture and/or dislocations to emergency room.

RESULT: Total of 588 (5-6patients/day) patients presented with fracture and/or dislocations. Of which 25.2% children and 74.3% adults with the average age being 30yrs (1day-94yrs). The commonest mechanism of injury was fall accident 248(42.2%) followed by road traffic incidents 201 (34.2%) and fight43(7.3%).

Majority of fractures involve long bones.Femur being the commonest in 17.86%(105/588), followed by tibia 93 (15.82%),humerus 84(14.29%) and radioulnar fractures 54(9.18%). Fractures involving the hand were seen in 45(7.65%), ankle 35(5.95%) and foot 30(5.1%). Shoulder was the commonest joint to be dislocated 16(2.72%), followed by hip 5(0.85%), elbow 3(0.51%) and acromioclavicular joint 2(0.04%).

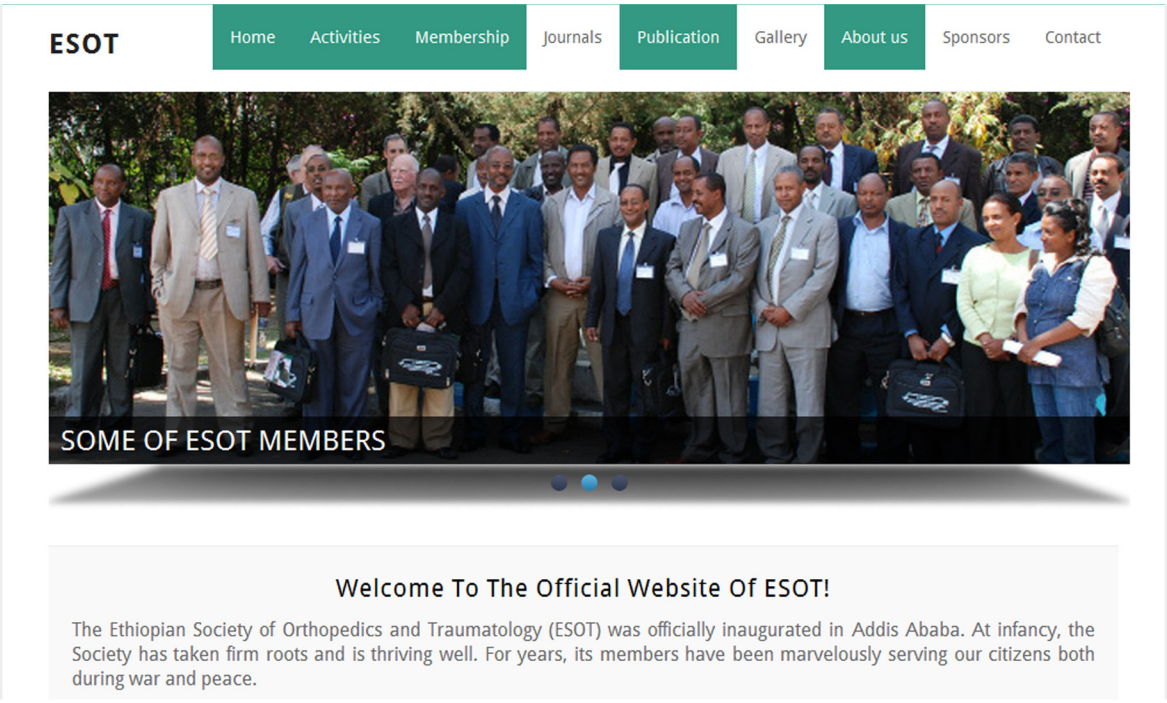
Open fracture was seen in 107(18.2%) patients, while 481(81.8%) were closed. Among all open fractures tibia was the commonest site to be complicated by soft tissue injury. 36/93(38.7%) tibia shaft fractures were open. Among which half were Gustilo grade III (Gustilo IIIA: 12/36 (33.3%), IIIB: 5/36 (13.9%), IIIC: 1/36 (2.7%)). While 10/36(27.7%) were Grade I and 8/36 (22.2%) were Grade II.

CONCLUSION: Fall accidents needsemphasis and we recommend detail studies. Significant number of fractures is open. Hencedue attention should be given to open fractures, especially tibia open fractures as it is the major open fracture observed and the management is always a challenge.

Note

Note


Roche
AVASTIN
bevacizumab
Turn down angiogenesis
Xeloda
capecitabine
PEGASYS
peginterferon alfa-2a (40KD)
MABTHERA
RITUXIMAB
REBUILDING LIVES
MIRCERA
methoxy polyethylene glycol-epoetin beta
Continuous activity. Targeted stability.
Recormon
Epoetin Beta
Energy to make a difference
ACTEMRA
tocilizumab
MABTHERA
RITUXIMAB
B CELL THERAPY. LASTING SUCCESS.
Bonviva
ibandronate
The Effective and Preferred Treatment for Osteoporosis
Herceptin
trastuzumab
Precision • Power • Promise
Rocephin
ceftriaxone
KYTRIL
granisetron HCl
Trusted control and simplicity



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