ESOT'S YEARBOOK
የኢሶተ ዓመታዊ መፅሄት

VOLUME-IV; 2014

ኢትዮጵያን ሶሳይቲ ኦፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ
Ethiopian Society of Orthopedics & Traumatology

Construction and Work Related Injuries.

MIOT International

Kilimanjaro at 65? Why not ?

Only a perfectly matched implant fitted with zero error precision can give you a joint replacement that lasts a lifetime.

After 35 years in this field we've realized that every replacement is a special case. The hip or knee that has deteriorated due to arthritis is different from a joint that's deteriorated due to fracture. We also have to take into account the severity of the disease, the extent to which the bone has been damaged, the angle and wear and tear of the bone - all of which differ from person to person. And that's only half the picture...

No "one size fits all"

We now have to find an implant that suits all these conditions and also one that suits your age and level of activity. Implants come in different sizes and different materials – from chrome cobalt to titanium, from cemented to uncemented. Choosing the right one for you will make a crucial difference to your comfort and mobility. This implant will then have to be accurately fitted to last you a lifetime. Therefore, the two key factors to having a 'Joint for Life' is finding the perfectly matched implant and then, fitting it accurately.

The largest range of implants

At MIOT Hospitals we have understood that to find the perfect match we need access to the widest range of variations in implants. That's why, unlike other centers, we do not tie up with any particular manufacturer, but keep our options open. Without the exactly matched implant you will experience discomfort, a change in gait and increased wear and tear that will ultimately lead to another revision surgery being needed.

MIOT's Joint For Life

Our Joint for Life programme begins with an expert evaluation of the disease and health condition. This is followed by imaging of the knee or hip using state of-the-art equipment. Next, comes selecting the implant.

Walking tall with MIOT

The chosen implant will be fitted by MIOT's expert surgical team in an infection free environment, using minimally invasive techniques that will reduce scarring and pain. MIOT was the first hospital to introduce computer navigation that enables us to fit the implant with zero error. You will be able to walk on the same day after surgery. With physiotherapy you will return to your normal life and enjoy full activity.

You will be walking tall for life!

Only MIOT brings together 35 years of experience - 37,000 hip and knee replacements, largest range of implants, minimally invasive surgery, computer navigation for zero-error, infection-free environment to give you a Joint for Life.

MIOT Joint for Life

Hip and Knee Replacement Surgeries

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Presidential Address

Guest of honor Excellency Ato Mekuria Haile; Minster of Ministry of Urban Development, Housing and Construction (MUDHCo,) FDRE;

Dear member Surgeons, International speakers, Residents, Med Students, Sponsors and Invited guests of ESOT;
I humbly welcome you all to this wonderfully prepared 9th national annual general meeting and scientific conference of the Ethiopian Society of Orthopedics and Traumatology (ESOT). Welcome!

Few months back, on December 17th, we celebrated our 10th year anniversary and the executive and the organizing committee was working hard to prepare this meeting with in the given shot period of time. All is well prepared and I thank my friends.

This year's conference main theme is "Construction and work related injuries in Ethiopia". We will thoroughly and scientifically explore the Ethiopian booming construction sites in relation to accidents.

Last year, we focused on Transport Injuries and it was honor to have the presence of the Minster of Transport, H. E. Ato Workeneh Gebeyehu and the Federal marsh band among us. We also enjoyed the COOL international course just a week back. This year, again we are honored to have the presence of Minster of Construction between us. It is very clear that Building related injuries are one of the main causes of fractures and orthopedic problems in our growing country. I appreciate the ESOT-EC for selecting this topic as a theme of our conference. Researches and surveys done in our country revealed that work related injuries are prevalent; 30-39%!

We are specially favored to have the world renowned senior Neurosurgeon, Dr. Rakesh Ranjan. He will be giving state-of-the-art lecture on evaluation and treatment of orthopedic spine injuries from fall accident. Welcome Sir!
Ethiopia is huge mass of 24 hours construction everywhere: roads, railways, factories, houses, dams, etc. It is high time that we surgeons have to update our skills of treating construction related injuries.

Dear Colleagues, Partners and Guests;

This year's shining event is made possible thanks to our respected main Partners: Ethiopian Airlines; UniHealth, MIOT Hospital and our regular pharmaceutical partners Please join me to humbly thank them for discharging their social responsibilities of sponsoring this wonderful scientific conference and medical exhibition.

Dear members;

This morning, as we already announced during our Anniversary meeting, we shall have an election, audit report and some discussion.

All ESOT members must attend this general assembly meeting after the first tea break. Lunch and special break meal well is prepared and will be served here at ELILLY International five star Hotel. Please socialize. Meet old friends and get new friends. Take time and talk to exhibitors, look into products and markets. ESOT is yours! This is your society and it is our national private time!

Once again, I thank you all for coming and enjoy the conference, enjoy Ethiopia!

With best regards

Biruk L. WAMISHO, M.D, FCS
President, ESOT

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የትራንስፖርት ሚኒስትሩ መልዕክት

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ክቡራትና ክቡራን

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ለበዓሉ ደማቅ አከባበር ጥሪ ተደርጎልኝ በመካከላችሁ በመገኘቴ የተሰማኝን ታላቅ ደስታ እገልፃለሁ፡፡ እንደገና እንኳን ደስ አላችሁ!
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እንደ ትራንስፖርት ሚኒስትርነቴ የሙያ ማህበራችሁ “የአጥንት፤የመገጣጠሚያ፤የጡንቻና ተያያዥ በሽታዎች በኢትዮጵያ በለው የዘርፉ ህክምና ላይ የሚፈጥሩት ጫና” የሚለውን መሪ ቃል አመራራችሁ የዚህ አመት ዋና የመነጋገሪያ አጀንዳ አድርጎ መውሰዱን ሳላደንቅ አላልፍም፡፡ ምክንያቱም ከትራንስፖርቱ ዘርፍ ከፍተኛ ቁጥር ያለው ስብራትና አደጋዎች ወደያንዳንዳችሁ ሆስፒታሎች ይመጣሉ፡፡

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ዋናው ጉዳይ አደጋ እንዳይከሰት መከላከል ቢሆንም ከደረሰ በኃላ ደግሞ ሞትና ቋሚ የአካል ጉዳት እንዳይደርስ በሚደረገው ርብርብ የእናንተ አስተዋፅዎ በከፍተኛ ደረጃ ይጠበቃል፡፡ አደጋ የደረሰበት ሰው ሆስፒታል ደርሶ እንዳይሞት ከፍተኛና የተቀናጀ በትጋት የተሞላ ቀልጣፋ የህክምና አሰጣጥ ይጠበቅባችኃል፡፡

እናንተ የአጥንት ህክምና ስፔሻሊስት ሀኪሞች የሚገጥሟቸውን ውስብስብ ፈተናዎችና አደጋዎች በየዕለቱ በመጋፈጥ የምትሰሩትን ስራ መንግስታችን ይገነዘባል፡፡ የምትሰሩት ስራም የላቀ ነፍስ የማዳን ሥራ መሆኑን እንድትረዱ እያሳሰብኩ የመስሪያ ቤታችን ማንኛውም አስፈላጊ እገዛ እንደማይለያቸሁ አረጋግጣለሁ፡፡
የተጠቀሱትን የአገራችን ችግሮችም በጋራ በማቀድና ሳይንሳዊ በሆነ በጥናትም በተደገፈ መንገድ ቀርፈን ለዜጎች ምቹ የሆኑ መንገዶችና ተሽከርካሪዎች እንደሚኖሩን ተስፋ አደርጋለሁ፡፡

ይህንን ጉባኤ ስኬታማ እንዲሆን በዝግጅቱ የተሳተፉትን ሁሉ እያመሰገንኩ ኮንፈራንሱና አውደ ርዕዩ በይፋ መከፈቱን አበስራለሁ፡፡

አመሰግናለሁ፡፡

ወርቅነህ ገበየሁ
የትራንስፖርት ሚኒስትር ኢትዮጵያ

የኮንስትራክሽን ኢንዱስትሪው

በዶ/ር ይሄይስ ፈለቀ

በአጥንት ህክምና ዘርፍ የሚያጋጥሙ አደጋዎች የተለያዩ ናቸው፡፡ በመንገድ ላይ የሚያጋጥሙ የተሸከርካሪ ግጭትና መገልበጥ ፤ ከተለያዩ ከፍታ ቦታዎች ላይ መውደቅ፤ ድብደባ፤ የጥይትና ፈንጂ አደጋዎች፤ የማሽንና ፣ልዩ ልዩ የግብርና መሳሪያዎች አጠቃቀም ጉድለት እና ሌሎችም ጉዳት አምጪ ነገሮችም ይጠቀሳሉ፡፡

እንደየሀገራትና የእድገት ደረጃ የአደጋዎቹም ዓይነትና መጠን ይለያያል፡፡ሀገራችን አሁን በምትገኝበት የእድገት ደረጃ ከፍተኛውን ቁጥር የሚይዘው የተሸከርካሪ አደጋ ቢሆንም የማሽን፤ የመውደቅና በህንፃ ሥራዎች አካባቢ የሚደርሱ አደጋዎች ቁጥር በየጊዜው እየጨመረ ነው፡፡ በተለይም ትላልቅ ህንፃዎች በሚገነቡበት አካባቢ የሚደርሱ አደጋዎች በህይወትና በአካል ላይ የሚያደርሱት ጉዳት ጨምሯል፡፡

የአደጋው መጠን

“ልማት ከተማ” በተሰኘው የከተማ ልማት ቤቶችና ኮንስትራክሽን ሚኒስቴር መፅሄት ቅፅ1 ቁጥር 4 የካቲት 2006 ዓ.ም እትም ላይ እንደተገለፀው በአለማቀፍ የሰራተኞች ድርጅት (ILO) መረጃ መሰረት በአለማችን በየ6 ደቂቃዎች የኮንስትራክሽን አደጋ ይከሰታል፡፡በሀገራችን በዚህ ዘርፍ ሰፊ ጥናት የሚያስፈልግ ቢሆንም በጥቁር አንበሳ ሆስፒታል የአጥንት ህክምና ክፍል ከመስከረም ወር አስከ ግንቦት ኢ.ግማሽ 2006ዓ.ም ድረስ በድንገተኛ አደጋ ምክንያት ለመታከም ከቀረቡት 1654 ህሙማን መካከል የመኪና አደጋ ትልቁን ቦታ ቢይዝም (501) 30 በመቶ የሚሆኑት በመውደቅ፣ አደጋ እግርና እጆቻቸው ላይ ጉዳት የደረሰባቸው ናቸው፡፡ ከእነዚህ ውስጥ 207 (41%) ህፃናት ሲሆኑ 294 (59%) ዋቂዎች ናቸው፡፡

የህንፃ ግንባታዎች ለመሰራት ከሚታቀዱበት ጊዜ ጀምሮ በግንባታ ሂደት፤ ግንባታዎች ከተጠናቀቁም በኃላ ለአገልግሎት ሲዘጋጁ፤ አደጋ እንዳያደርሱ መደረግ ያለባቸው የጥንቃቄ ስራዎች በተገቢው መልኩ መከናወን ይገባቸዋል፡፡በኮንስትራክሽን ኢንዱስትሪው ዘርፍ የሚደረጉ ጥንቃቄዎች መሻሻል በአጥንት ህክምና እና በሌሎችም ከአደጋ ጋር በተያያዙ የህክምና ዘርፎች አካባቢ የሚኖረውን ጫና ከመቀነሱም በላይ የጉዳቱ መጠን መቀነስ አምራች የሆነውን የህብረተሰብ ክፍል በሀገር እድገት ላይ ከፍተኛ አስተዕዎኦ ለማድረግ ያስችለዋል፡፡

በህፃናት ላይ የሚከሰቱ አደጋዎች አብዛኞቹ በት/ቤት አካባቢ ሲሆን ከህንፃ ደረጃዎችና እንደሸርተቴና ሽክርክሪት መጫወቻዎች ላይ መውደቅና ደረጃቸውን ባልጠበቁ መጫወቻ ሜዳዎች ላይ የሚደርሱ አደጋዎች ይገኙበታል፡፡ በአዋቂዎች ላይ ብዙ አደጋዎች በህንፃ ኮንስትራክሽንቦታዎች ላይ ይከሰታሉ፡፡ ህንፃዎች የሚዋቀሩባቸው መወጣጫ መሰላሎች በተገቢው ቁሳቁስ አለመሰራት ለምሳሌ

-ከእንጨት የተሰሩ መሳሎችን በረጃጅም ህንፃ ግንባታ ስራ ላይ መጠቀም እንዲሁም እንጨቶችን በተደጋጋሚ መገልገል

ለጤና እና ደህንነት ያለው ትኩረት

-ጥራታቸው የቀነሰ የህንፃ ግብአቶችን በመጠቀም የተጀመሩ ግንባታዎች የመፍረስ አደጋ ያስከትላሉ
በግንባታ አካባቢዎች በተገቢው መንገድ ያልተቀመጡ የመገልገያ ቁሳቁሶች በመናድ አደጋ ያደርሳሉ
በግንባታ አካባቢ የሚቆፈሩ ግድጓዶች እንዲሁም ለአዲስ ግንባታ ሲባል የሚፈርሱ የቆዩ ቤቶችና ህንፃዎች ጥንቃቄ ከሌለ በመናድ ብዙ ሰዎች ላይ እስከሞት የሚያደርስ ጉዳት ሲያስከትሉ ይስተዋላል፡፡ ለግንባታ ሥራዎች አጋዥ የሆኑ ማሽኖችም የሚያደርሱት ጉዳት ከፍተኛ ነው፡፡

መደረግ የሚገባቸው ጥንቃቄዎች

በግንባታ ሥራዎች ላይ የተሰማሩ ባለሙያዎች የአደጋ መከላከያ አልባሳት ማለትም ጫማ፣ ቱታና ጭንቅላት ላይ የሚጠለቅ ሄልሜት ያስፈልጋቸዋል፡፡
መርዛማ የሆኑ ግብአቶችም እንደዚሁም በተገቢው መልክ መያዝ ይኖርባቸዋል፡፡
በግንባታ ሥራዎች ላይ የተሰማሩ ባለሙያዎች ግንባታዎች ታቅደው ወደ ሥራ ከመገባታቸው በፊት አስፈላጊው የጥንቃቄ ስልጠና ቢያገኙ አደጋዎች በእጅጉ ይቀንሳሉ፡፡
በግንባታ አካባቢ የደህንነት ማስጠንቀቂያ ፁሁፎች በጉልህና በግልፅ መቀመጥ ሰዎች ላይ ሊከሰት የሚችል ጉዳት ይቀንሳል፡፡
ከላይ ለጠቀስናቸው ችግሮች መፍትሄ የሚሆኑ ብዙ አመላካች አቅጣጫዎች ቢኖሩም ግንባታዎች በህግ የሚመሩ መሆናቸው የሚያጠያይቅ አይሆንም፡፡

የህግ ድንጋጌዎች

የህንፃ ግንባታ ህጎች ከ 4 ሺህ አመት በፊት ጀምሮ እንደነበሩ ታሪክ ያስረዳል፡፡ “ልማተ ኩተማ” መፅሄት በየካቲት ወር 2006 ዓ.ም ህትመ የባቢሎን ንጉስ የነበረው ሃሙራቢ ክክርስቶስ ልደት በፊት በ2 ሺህ ዓመት የህንፃ ሥራ ህግ ደንግጎ እንደነበር ይገልፃል፡፡ በዚህ የሃሙራቢ ህግ መሰረት ለምሳሌ የህንፃ መዋቅር ቢፈርስ ገንቢውን በዓይነት ተጠያቂ ያደርጋል፡፡ በዚህ ምክንያት የህንፃው ባለቤት መዋቅሩ ፈርሶ የሞት አደጋ ቢያጋጥመው ህንፃውን የገነባው ተቋራጭ በሞት ይቀጣ ነበር፡፡
በአሜሪካም በ19ኛው ክ/ዘመን መጀመሪያ የህንፃ ግንባታ በህግ የተመራ ነበር፡፡ የአክሱም ሃውልቶችና የላሊበላ ውቅር አቢያተ ክርስቲያናት እንዲሁም የጎንደር ቤተ መንግስቶች ግንባታ የክትትል ስርዓት ሊኖራቸው እንደሚችል ይገመታል፡፡

በሀገራችን በታህሳስ ወር 2006 ዓ.ም የኢትዮጵያ ኮንስትራክሽን ኢንደስትሪ ፖሊሲ ወጥቷል፡፡ በዚህ ፖሊሲ ውስጥ የተካተተ አንቀጽ 5.9.2. እና 5.9.3 የኮንስትራክሽን ደህንነት ጥበቃን ይመለከታል፡፡
ቀደም ሲል የኢትዮጵያ ህንፃ አዋጅ ቁጥር 624/2001 በህዝብ ተወካዮች ም/ቤት ፀድቆ ሥራ ላይ ውሏል፡፡ ይህ ህግ የከተሞችን ገፅታ በመቀየር ፕላንን ለማስጠበቅ፤ የተገልጋዩን ህብረተሰብ ደህንነትና ምቾት ለመጠበቅ ይረዳል ተብሎ ይታሰባል፡፡የኮንስትራክሽን ስራ በርካታ የሰው ሃይል የሚያሳትፍ የተለያየ እንቅስቃሴዎች የሚከናወኑበት በመሆኑ ጥንቃቄ ካልተወሰደ በስራው ውስጥ የሚሰማሩትንና በአካባቢው የሚንቀሳቀሱ ሰዎች ላይ እንደዚሁም ስራው ተጠናቆ በህንፃው ተገልጋይ የህብረተሰብ ክፍሎች ከፍተኛ ጉዳት ሊያስከትል ይችላል፡ ፡
በሀገራችን በሚካሄዱ ትላልቅ የግንባታ ስራዎች ላይ በዘልማድ ከሚደረጉ ዝግጅቶችና ጥንቃቄዎች በስተቀር ጤንነትንና ደህንነትን ለመጠበቅ የሚደረጉ ጥረቶች እምብዛም አይታዩም፡፡ በዚህም ምክንያት በግንባታዎች አካባቢ ከቀላል የአካል ጉዳት እስከ ሞት የሚያደርሱ አደጋዎች ይከሰታሉ፡፡ የህንፃ አዋጁን ለማስፈፀም በህንፃ ደንብ ቁጥር 243/2003 በኮንስትራክሽን ሥራዎች ወቅት መወሰድ ያለባቸውን ጥንቃቄ አለመውሰድ ከ 3000-5000 ሺህ ብር እንደሚያስቀጣ ያትታል፡፡ በዚሁ ደንብ መሰረት የከተማ ልማት፤ ቤቶችና ኮንስትራክሽን ሚኒስቴር መመሪያ ቁጥር 5/2003ን አውጥቷል፡፡ ይሁን እንጂ በተግባር ሲፈፀም አይታይም፡፡

በተለይም ለሀገር እድገት ከፍተኛ አስተዋፅዎ የሚያደርግ የህብረተሰብ ክፍልን የሚጎዳ ፣ሀገርን ከፍተኛ መዋዕለንዋይ የሚያሳጣ ጉዳይ የሚመለከተን ባለድርሻ አካላት ርብርብ ማድረግ ይጠበቅብናል፡፡

የኢትዮጵያ ኮንስትራክሽን ኢንደስትሪ ልማት ፖሊሲ

(ታህሳስ 2006 ዓ.አ)

5.9.2 የኮንስትራክሽን ሠራተኞችና ሥራ አካባቢ ጤንነትና ደህንነት መጠበቅ

ሀ) ዓላማ

በሃገራችን ኮንስትራክሽን ኢንዱስትሪ የሰራተኛውን ጤንነትና ደህንነት የሚጠብቁ ዘላቂ የኮንስትራክሽን ልምዶች እንዲስፋፉ ለማድረግ ነው፡፡

ለ) ፖሊሲ

1) በኮንስትራክሽን ሥራ አካባቢ በሰዎች ጤናና ደህንነት ላይ አደጋ የማጥሉ የመሳሪያዎች እንቅስቃሴና ሥራ አካባቢ እንዲፈጠር ይደረጋል፡፡

2) በኮንስትራክሽን ኢንዱስትሪው ዲዛይንና ግንባታ ሂደቶች አስገዳጅ የስራ ላይ ደህንነት ማረጋገጫ ስርዓት ይዘረጋል፡፡

3) የኮንስትራክሽን ኢንዱስትሪው የሚሰማራውን የሰው ሃይል መብት፣ ግዴታ እና ጥቅም ለመጠበቅና ለማስጠበቅ የሚያስችል የአሠራር ሥርዓት ይዘረጋል፡፡

4) በኮንስትራክሽን ወቅት የሚለቀቁ መርዛማ ውህዶች (ለምሳሌ ሙቀት፣ ጨረር፣ ድምፅ፣ ተረፈ-ምርት፣ የመሬት መንቀጥቀጥ) ቁጥጥር ይደረጋል፡፡

ሐ) የማስፈፀሚያ ስትራቴጂዎች

1) የሥራ ላይ ጤንነትና ደህንነት ቁጥጥር ሥርዓት አስገዳጅ እንዲሆን የሚያደርግ እና የደህንነት መጠበቂያ አልባሳትንና መሣሪያዎች አቅርቦት እንዲቀላጠፍ የሚያስገድድ የግንባታ አካባቢ ሰራተኞችን ጤንነትና ደህንነት ለማረጋገጥ የሚያስችል የህግ ማዕቀፍ አዘጋጅቶ በመተግበር፤

2) ከሰራተኛና ማህበራዊ ጉዳይ ሚኒስቴር ጋር ተቀናጅቶ በጋራ በመስራት፤

3) በግንባታ ላይ የሚሰማሩ ሰራተኞች የደህንነት መጠበቂያ አልባሳትና መሣሪያዎች አስፈላጊነትን በተመለከተ ግንዛቤ እንዲያገኙ ስልጠና በመስጠት ይሆናል፡፡

3ኛው የትራፊክ ደህንነት ግንዛቤ ማስጨበጫ ሳምንት 2006
3rd Traffic Safety Awareness Week 2014

እንደሚታወቀው የትራፊክ አደጋ በሀገራችን እድገት ላይ አሉታዊ ተፅህኖ በማሳደር በማህበራዊና ኢኮኖሚያዊ ብልፅግና ላይ ዋና እንቅፋት ሆነው ከሚገኙ ችግሮች ተርታ ተመድቧል፡ ፡ ከመንገድ ልማቱ መፋጠንና ከፍተኛ ቁጥር ያለው ተሽከርካሪ ወደ ሀገሪቱ መግባት ጋር ተያይዞ ያለው ከፍተኛ ችግር የመንገድ ደህንነቱ ነው፡፡ በመፅሄታችን ላይ በተደጋጋሚ ሽፋን ከሚሰጥባቸው ጉዳዮ አንዱ የመንገድ ደህንነት አንዱ ሲሆን የዚሁም ዋና ምክንያት በመኪና አደጋ የሚከሰተው የሰው ህይወት መጥፋትና አካል ጉዳት በሀገሪቱ ባለ ሆስፒታሎችና የህክምና ቦታዎች እንደዚሁም ሀኪሞች ላይ ከፍተኛ ተፅህኖ ፈጣሪ መሆኑ ነው፡፡

በዚህ ዓመት ማህበራችን ከተሳተፈባቸው የህብረተሰብ ግንዛቤ ማስጨበጫ መርሃ ግብር አንዱ 3ኛው የትራፊክ ደህንነት ግንዛቤ ማስጨበጫ ሳምንት ላይ “የትራፊክ አደጋ መንስኤዎችና መፍትሄዎቻቸው” በሚል ርዕስ ዙሪያ በተዘጋጀው የግማሽ ቀን ፓናል ውይይት ላይ በዶ/ር ኤፍሬም ገ/ሀና እና አቶ በረከት አለማየሁ መወከሉ ነው፡፡

የትራፊክ ደህንነት ግንዛቤ ማስጨበጫ ሳምንት መርሃ ግብር በ 2004 ዓ.ም አንደኛው ተብሎ የተጀመረ ሲሆን በወቅቱም

‹‹ለህይወት ግብ እንድንበቃ የትራፊክ አደጋ ይብቃ››

በሚል መሪ ቃል የአንድ ሳምንት ግንዛቤ ማስጨበጫ ዓመታዊ የቅስቀሳ ዘመቻ የተከናወነበት ሲሆን የአዲስ አበባ መንገድና ትራንስፖርት፣የአዲስ አበባ ፖሊስ ኮሚሽን፣የአዲስ አበባ መንገዶች ባለስልጣንና የትራንስፖርት ባለስልጣን መስሪያ ቤቶች በጋራ የሚያዘጋጁት ሀገራዊ ዘመቻ ሲሆን ለታሪክ አድሽርታይዚንግ በአስተባባሪነት እየሰራ ይገኛል፡፡

ከ2004 ዓ.ም ጀምሮ እየተካሄደ የሚገኘው ይህው የትራፊክ ደህንነት ግንዛቤ ማስጨበጫ ሳምንት የተሳካ ተግባራት እየተከናወኑበት 3ኛው ላይ የተደረሰ ሲሆን በተለይ በየወቅቱ ከሚሰበሰቡት የህዝብ አስተያየት መረጃዎች ለመገንዘብ በተቻለው መሰረት ተመሳሳይ እና ተከታታይ የሆኑ ግንዛቤ የማስጨበጥ ስራዎች ቢሰሩ የታሰበው መልካም ለውጥ ሊመጣ እንደሚችል

3ኛው የትራፊክ ደህንነት ግንዛቤ ማስጨበጫ ሳምንት 2006

ታምኖበታል። በዚህም መሰረት ቀጣይነት እንዲኖረውና ተጨማሪ ህብረተሰቡን የሚያሳትፉ መርሃ ግብሮች ተነድፈው እንዲተገበሩ የሚያነሳሱ ሆነው ተገኝተዋል።

በዚህ በየዓመቱ ለአንድ ሳምንት በሚካሄደው የግንዛቤ ማስጨበጫ ሳምንት ላይ የተለያዩ ለአሽከርካሪዎችና እግረኞች ግንዛቤ መፍጠሪያ መርሃ ግብሮች እየተነደፉ ሲከናወኑ የቆዩ ሲሆን በተለይ የዝግጅቱ መለያ የሆነውና ግንዛቤ የመፍጠር ሀይሉ ከፍተኛ ነው ተብሎ የተገኘው ከፍተኛ የህይወት ጥፋትና የንብረት ውድመት ያስከተሉና ከጥቅም ውጭ በመሆን በኢንሹራንስ ድርጅቶች ሪከቨሪ ውስጥ የሚገኙ ተሸከርካሪዎችን ለህዝብ እይታ ማቅረብ ይገኝበታል።

በየጊዜው የጥንቃቄ መልህክቶችን የያዙ ቢልቦርዶች፣ ተለጣፊ ፖስተሮች ፣በራሪ ወረቀቶችና የመገናኛ ብዙሃን ማስገንዘቢያዎች በዚሁ የግንዛቤ ማስጨበጫ ሳምንት መርሃ ግብር ላይ የተካተቱ ሲሆን በተለይ ከአንበሳ የከተማ አውቶቢስ ድርጅት ጋር በመተባበር በአውቶቢስ መኪናዎች ላይ ተነባቢ መረጃዎችን መለጠፍና የፎቶግራፍ ኤግዚቪሽን እንዲሁም የፓናል ውይይቶች ዋና ዋና የግንዛቤ ማስጨበጫ ተግባራት የሚባሉት ሲሆኑ በቀጣይ ዓመታትም በሰፊው የሚሰራባቸው ውጤታማ መርሃ ግብሮች ናቸው።

በተጨማሪም በዚህ የግንዛቤ ማስጨበጫ ተግባር ላይ ሚኒስትሮች፣ ከፍተኛ የመንግስት የስራ ሀላፊዎችና ባለድርሻ አካላት ለህብረተሰቡ ምክር አዘል የጥንቃቄ መልህክቶቻቸውን በማስተላለፍና ተሞክሮዎቻቸውን በማጋራት አገራችን ኢትዮጵያ ከትራፊክ አደጋ የጸዳ ቀን እንዲኖራት ያላቸውን ራዕይ የሚያስተላልፉበት “ይብቃ” የተሰኘ ልዩ እትም መጽሄት ማዘጋጀትና ለህብረተሰቡ ማድረስም ይገኝበታል።

3ኛውን የትራፊክ ደህንነት ግንዛቤ ማስጨበጫ ሳምንት በንግግር የከፈቱት የአዲስ አበባ መንገዶች ባለስልጣን ዋና ስራ አስኪያጅ ኢ/ር ፈቃደ ሀይሌ ነበሩ።

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- Saudi Arabia.
- Bahrain.
- United Arab Emirates.
- GCC "Gulf Commercial Council".

የመፅሄታችን እንግዶች (First year female orthopaedic residents)

ዶ/ር አናንያ ካሳሁን የህክምና ትምህርቷን ጎንደር ህክምና ጤና ሳይንስ ኮሌጅ እንደጨረሰች ለአንድ ዓመት እዚያው ጎንደር በቀዶ ጥገና ክፍል ካገለገለች በኃላ ኮሌጁ ለከፍተኛ ትምህርት ወደ ጥቁር አንበሳ ሆስፒታለል ልኳታል::

ዶ/ር ናርዶስ ወርቁ የህክምና ትምህርቷን በአ.አ ዩንቨርስቲ ጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል ተከታትላለች:: ትምህርቷን እንዳጠናቀቀችም ለሁለት አመት በጋምቤላ ሆስፒታል አገልግላለች::

ዶ/ር ማህደር እሸቴ የህክምና ትምህርቷን በአ.አ ዩንቨርስቲ ጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል ከተከታተለች በኃላ ለሁለት ዓመት ያህል በጳውሎስ ሆስፒታል አገልግላለች::

በህክምና ሙያ ውስጥ ምን ዓይነት አገልግሎት እየሰጣችሁ ነው?

የመጀመሪያ ዓመት ተማሪዎች እንደመሆናችን የመጀመሪያዎቹን ሶስት ወራት በትምህርት ውስጥ በማሳለፍ ሴምናርም እያቀረብን ቆይተናል:: ከአራተኛው ወር በኃላ በየሆስፒታሎች ተመድበን የህክምና አገልግሎት እየሰጠንም እየተማርንም እንገኛለን::

የታካሚ አያያዝ መርህ እንዴት ትከተላላችሁ?

በህክምና ሙያሲገባከመጀመሪያው ጀምሮ የምንማራቸው የታካሚ አያያዝ አቀራረቦች አሉ:: ታማሚ በመሆናቸው ብቻ ሳይሆን የሰው ልጆችም ስለሆኑ በሃዘኔታና ርህራሄ፤ ችግራቸውን በመረዳት በህክምና ሙያው ብቻ ሳይሆን በስነ-ልቦናም በማገዝ እናገለግላለን:: ባለን ትንሽ እውቀትም ቢሆን የተቻለንን ለማድረግ እንተጋለን::

አሁን ባላችሁበት የትምህርት ደረጃ ከአጥንት በሽታዎች ጋር የተያያዘ ህክምና ትሰጣላችሁ?

አዎ:: ወደተለያዩ ሆስፒታሎች የምንላከው በአጥንት በሽታዎችና ጉዳት ዙሪያ ህክምና ለመስጠት ነው:: ታካሚዎች ከመርዳት ይልቅ አሁን የበለጠ የትምህርት ጊዜያችን ነው:: ታካሚዎችን እየረዳን እኛም እየተማርን ነው::

በአጥንትና ተያያዥ በሽታዎች ህክምና አሰጣጥ ውስጥ አዳዲስ ቴክኖሎጂ በየጊዜው ይኖራል:: አዳዲስ ቴክኖሎጂ እየተለማመዳችሁ ይሆን?

ለትምህርታችን የኢንፎርሜሽን ቴክኖሎጂ ግብአቶችን እንደ ኒንተርኔት ያሉትን እንጠቀማለን:: በአጥንት ህክምና ዙሪያ ሳይንሄል (SIGN-IM-NAIL)የተባለውን ቴክኖሎጂ የትላልቅ አጥንት ስብራቶችን ለማከም ታላላቆቻቸን በቀዶ ህክምና ውስጥ ሲጠቀሙበት እያየንም እያገዝንም ነው::

አስከአሁን በተገነዘባችሁት መሰረት ዋና ዋና የአጥንትና ተያያዥ በሽታ መነሻ ምክንያቶች ምንድናቸው?

የትራፊክ አደጋ ዋናው ጉዳት አድራሽ ነው:: በዚህ አጭር ጊዜ ቆይታችን የተሸከርካሪ አደጋዎች መንስሄነት ከፍተኛ ሆኖ አግኝተነዋል:: የኮንስትራክሽን ግንባታዎችም፤ በተለይ ከባቡር መስመር ግንባታ ስራዎች ጋር ተያይዞ ከከፍታ ቦታዎች የመውደቅ አደጋዎች እየበዙ ነው:: በጥልና ድብድብ የመሰበር አደጋዎች ይከሰታሉ:: በማሽነሪዎች ምክንያትም ብዙ ሰዎች እየተጊዱ ይመጣሉ: : ከአደጋዎች ውጭ በኢንፌክሽን መከሰት በተለይ በቲቢ ምክንያት የአጥንት በሽታዎች አሉ::

አሁን መሻሻል እያሳየ ያለው የህፃናት አጥንት በሽታዎች ነው:: ከበፊቱ ይልቅ አሁን ማህበረሰቡ ግንዛቤው እየተሻሻለ ስለመጣ፤ የሚሰጠውም የህክምና እርዳታ ለውጥ እንደሚያመጣ እየታመነበት ስለሆነ ብዙ ሰዎች የልጆቻቸውን ችግር ከመደበቅ ይልቅ የሚሻሻልበትን መንገድ ወደ ህክምና እየመጡ መፈለግ እየተመረጠ ነው:: ለምሳሌ ከለብ ፉትን መጥቀስ ይቻላል:: ወላጆች ልጆቻቸውን ይዘው በጊዜ ወደ ህክምና ስለሚመጡ ለልጆች በለጋ እድሜያቸው ህክምና ማድረግ ይቀላል::

በአጥንት ህክምና ትምህርታችሁና የህክምና አገልግሎት ስትሰጡ

በሚቀጥለው ገፅ ይመልከቱ

የቀጠለ

የገጠማችሁ ዋና ዋና ችግሮች?

ለህክምና የመገልገያ እቃዎች በበቂ አለመኖር ትልቅ ችግር ነው፡፡ ብዛት ያለን ተማሪዎች ከመሆናችን አንፃር የተመጣጠነ የቀዶ ህክምና ክፍል የለም፡፡ የጥቁር አንበሳ አጥንት ህክምና ትምህርት ክፍል ከሌላው ወቅት ከፍ ያለ የተማሪዎች ቅበላ ስላደረገ የቀዶ ህክምና ክፍል በበቂ አለመኖር በልምድ ማዳበር ላይ ተፅህኖ ያመጣል፡፡ እየተገነባ ያለው አዲሱ ክፍል ወደ ስራ ሲገባ ይህ ችግር የሚቃለል ይመስለናል፡፡

በአጥንት ህክምና መስጠት ዘርፍ የሴቶች ቁጥር እጅግ አናሳ ነው፡፡ ይህ ለምን ይመስላችኃል?

ከበፊት ጊዜ ጀምሮ የሚታሰበው ኦርቶፔዲክስ የወንዶች ስራ ተደርጎ ይወሰዳል፡ ፡ ከቴክኒካዊ እውቀት ይልቅ ጥንካሬ ነው ተግባር ላይ የሚውለው ተብሎ፤ የህክምናው አብዛኛው ክንዋኔ የሚያታግል ነው የሚል ግንዛቤ ስለነበረ ነው፡፡ ተማሪዎች ሆነን የምንሰማቸው እንዚህን መሰል ወሬዎች ስለነበሩ ለሴቶች ምርጫ ብዙም የቀረበ መስክ አልነበረም፡፡ በጥቅሉ አሁን ግን የማህበረሰቡም አስተሳሰብ እየተቀየረ ነው፡፡ እንደ ኦርቶፔዲክስ የመሳሰሉ አይነኬ የወንዶች ብቻ ተብለው የታሰቡ መስኮችን ስንቀላቀል ብዙ ሰዎች ገፋፍተውናል፤ አግዘውናል፡፡ ሴቶች ስለሆናችሁ ምን ይሁን ታዲያ? ጉብታችሁ ሞክሩት ብለውናል፡፡ በሙያው ከትግል ይልቅ ቴክኒክ የሚያስፈልግ መሆኑን ግን መረዳት ችለናል፡፡

በፊት ተማሪዎች ሆነን የቀዶ ህክምናውን ለማየት የነበረን እድል የተወሰነ ነበር፡ ፡ አሁን ግን ቅርበታችን የቴክኖሎጂው አቅርቦትም እየሰፋ እንደሆነ እያየን ግንዛቤያችንንም እየተቀየረ ነው፡፡ ኦርቶፔዲክስ የሚሰራበትን ቦታ ስታይ በስማ በለው ከነበረው መረጃ ይልቅ ምን እየተከናወነ እንደሆነ በትክክል ትረዳለህ፡፡
ቴክኒካሊት ከሆነ እኛመም እንደ ወንድሞቻችን በሙያው ለማገልገል የሚከለክለን የለም፡፡ እንዲያውም እኛ ሴቶች በስነልቦና የተሻለ እንክብካቤ የመስጠት ዝንባሌ አለን፡፡ ሆኖም ግን አካላዊ ጥንካሬ መጠየቁ አይቀርምና አንዳንዶቻችን ጂም ተመዝግበን ስፖርት እየሰራን ነው፡፡ በመንግስ የተጀመረውን አቅም ግንባታዘዴ በአካል ግንባታም እየተጠቀምንበት ነው፡፡
የሀገራችን እድገት ሁኔታ እንጂ የኦርቶፔዲክስ ቴብል ለትራክሽን የተዘጋጀ ከሆነ አያታግልም፡፡ ለኦርቶፔዲክስ ተብለው የሚዘጋጁ ቴብሎች ቢኖሩ ታካሚውን በተገቢው አቀማመጥ ቦታ በማሲያዝ ህክምና መስጠት ይቻላል፡፡ በሌላው ዓለም የኦርቶፔዲክስ ቅደም ተከተሎች እየቀለሉ ነው፡፡

ስለዚህ የኦርቶፔዲክስ ትምህረት መስኩን ወዳችሁታል ልበል?

በጣም ወደነው እየተማርን ነው! (ሶስቱም በሳቅና በፈገግታ)

ከሲኒየር የህክምና ባለሙያዎች ጋር ያላችሁ ግንኙነት ምን ያህል ነው?

አስተማሪዎችም ሆኑ ሲኒየር ተማሪዎች በጣም አጋዦቻችን ናቸው፡ ያበረታቱናል፡ ፡ የምንጠይቃቸውን ለማሳወቅና ለማስተማር ከፍተኛ ፍላጎት አላቸው፡ ፡ ሁልግዜም ከጎናችን ናቸው፡፡ በዲፓርትመንቱ የሲኒየር ጁኒየር ግንኙነቱ በወንድማማችና ህትማማችነት ላይ የተመሰረተ ስለሆነ በመከባበርና መተጋገዝ ላይ የተመሰረተ ነው፡፡

ማህበራዊ ተሳትፏችሁ ምን ይመስላል?

ጥሩ ነው፡፡ ሃኪም ስትሆን ካለብህ ሃላፊነትና የስራ ጫና የተነሳ ማህበራዊ ተሳትፎ ይቀንሳል፡፡ ብዙ ሰዎች ያለብንን የስራ ጫና ስለሚገነዘቡ ማህበራዊ ተሳትፋችንን ላላ ያለ መሆኑ የታወቀ ነው፡፡ ቤተሰብ ማህበራዊ ተሳትፎውን እንድናጠናክር ቢፈልጉም ከኢኮኖሚው አንፃርም የግል ስራዎች ስለምንሰራ ብዙውን ጊዜ በስራ ስለምንጠመድ ይህን ይገነዘባሉ፡፡ ማህበረሰቡም በስራ ጉዳይ ያለውን ጫና ይረዳል፡፡ በስራ ላይ 36 ሰዓት ያህል የመገኘት ግዴታ ሊኖርብን የሚችል ሲሆን ብዙ ጊዜ ወደ ቤታችን ደክሞን እንሄዳለን፡፡

የህክምና ሙያ አሁንም በማህበረሰቡ ዘንድ እንደተከበረ ያለነውን ?

የሙያ ስነምግባርን ሁሉም ሀኪም ስለተባለ ብቻ የሚጠበቀው ነው ባይባልም በሀገራችን የህክምናና ተያያዥ ጉዳዮች ክስ ደረጃ ዝቅተኛ ነው፡፡ ሰው ከሰው እንደሚለያይ ሁሉ ሀኪም ፡፡ አንዳንድ ሰው በጥንቃቄን ጉዳዮች ሊከሰስ ይፈልጋል፡፡የሚሰራበትን ተቋም ጥያቄ ውስጥ እንዲገባ ያደርጋል፡፡ ይህ ሁኔታ እንደኛ ላሉ አዳዲስ ባለሙያዎች ፈታኝ መሆኑ አይቀርም፡፡ ግንዛቤ መፍጠር ብዙ ጊዜ የሚፈልግ ስራ ነው፡፡ ሙያዊ ስነምግባርን ተከትሎ መሄድ ግን የተማርንበት ግዴታ ነው፡፡

ህክምና ምን አይነት ሙያ ነው?

የሙያ ትልቅና ትንሽ ባይኖርም የህክምና ምያ ግን ከሌሎች ስራዎች በጣም የተለየ ነው፡፡ ህክምና የሰው ልጅ ህይወት ግድ የሚባልበት ትልቅ ቦታ ነው፡፡ የእኛ ሙያ ሁልጊዜ ከሰው ጋር የሚያገናኝ ፤ህይወታቸው በእጃችን ላይ ስለሆነ ከፍተኛ ጥንቃቄና ማስተዋል የሚያስፈልግ የተከበረ የሙያ መስክ ነው፡፡ አንዳንድ ጊዜ በቁሳቁስ አቅርቦት እጥረት መነሻነት የሰው ህይወት ሲያልፍ የሚታይበት አሳዛኝ መስክ ስለሆነ ስኬቱንም ችግሩንም የምትጋራበት ነው፡፡ የስነልቦና ሽክምም አለበትና አንዳንዴ ልባችን ተሰብሮ ወደቤታችን እንሄዳለን፡፡ ታካሚዎች ድነው ስናይ ደስታውና እርካታው ወደር የለውም፡፡

አሁን የአንደኛ ዓመታችሁን የቲዎሪ ትምህርት ጨርሳችሁ ፈተና ልትፈተኑ ነው፡፡ ደግሞም በቅርቡ ከአውስትራሊያ (ADFA) የአጥንት ህክምና ሀኪሞች ጋር በመተባበር ሰፊ ወርክሾፕ (እጃችሁን ለማፍታታት እና ለመለማመድ) በሞዴል አጥንቶች ላይ በተግባር ስትማሩ ነበር፡፡ አስኪ ስለዚህ ስልጠና ንገሩኝ?

ስልጠናው በጣም አስፈላጊና በየዓመቱ በናፍቆት የሚጠበቅ ነው፡፡ ወደ እውነተኛው የሰው አካል ኦፐራሲዎን ማድረግ ሳንገባ በፊት በሞዴል አጥንቶችና Simulators surgical skill ማዳበራችን ወሳኝ ነው፡፡በኃላ የምንሰራባቸውን እውነተኛ የኦፐራሲኦን እቃዎችን እየተጠቀምን መማራችን ወደፊት ኦፐራሲኦን ክፍል ውስጥ ግር እንዳይለን የሚረዳን ሲሆን ከባባድ ኦፐራሲዎኖችን አስተማሪዎቻችን በሚያሳዩን ጊዜ በፍጥነት ለመማር ያግዘናል፡፡ ADFAን በተለይም Dr. Grahamን እና ቡድናቸውን በጣም እናመሰግናለን፡፡ አዲሱን ዘመናዊ የኦፐራሲዎን ክፍሎችን የሰሩልን እነሱ ናቸው፡፡ በጣም እናመሰግናለን፡ ፡ በዚህ ዓመት ማለቂያ ተመርቆ ስራ ይጀምራል ስላሉን በናፍቆትና በዝግጅት እየጠበቅን ነው፡፡

የወደፊት እቅዳችሁን ምን ይመስላል?

ዶ/ር ናርዶስ - እንደ እግዚያብሄር ፈቃድ የጀመርኩትን ትምህርት ጨርሼ፤ ትዳር ይዤ፤ ልጆች ወልጄ ከቻልኩም በኦርቶፔዲክስ ሰብ-ስፔሻሊስት ተምሬ ህዝብ ለማገልገል ነው፡፡

ዶ/ር አናንያ የተጀመረው ትምህርት ሲያልቅ በሙያዊ ህይወቴ ጀይንት ሪፐሌስመንት ሰብ-ስፔሻላይዝ አድርጌ መቀጠል እፈልጋለሁ፡፡ በሰብ-ስፔሻሊቲ የመጀመሪያው ሴት መሆን እፈልጋለሁ፡፡ ቤተዶብ መመስረቴም የማይቀር ነው፡፡

ዶ/ር ማህደር አዳዲስ ነገሮች ይመጣሉ ብየ ተስፋ አደርጋለሁ፡፡ ወደፊት የኦርቶፔዲክስ ህክምና ዘርፉን ሌሎች ሴቶችም ይቀላቀላሉ ብዮ እጠብቃለሁ፡ ፡ ቴክኖሎጂውም ይሻሻላል፡፡ በጉልበት መታገሉም ይቀንሳል፡፡ የመማር ማስተማሩም ሂደት የሚቀል ይመስለኛል፡፡ ወደፊት አሪፍ ሀኪሞች ይወጣናል፡፡

LEARN SAYING "THANK YOU", practice ACKNOWLEDGING!

By ESOT Executive Members

Orthopedics is an art and science: it involves lots of hands-on and doings. In this room there are surgeons from all levels: med students, residents, juniors, seniors, same levels and even impending surgeons and residents. Let me start by asking a question: how many of us practice saying thank you? Or are we always critic and picky! Check yourselves.

More often than not, people don't—or won't—acknowledge you for your contributions and accomplishments. This may seem a little strange since almost all of us harbor hopes for such recognition—one reason, perhaps, that the expression "fishing for compliments" is so well-known. But though it might seem intuitive that people would be more than willing to give what they'd greatly appreciate getting themselves, this typically isn't the case.

Assuming that you're like the majority of us, wishing (maybe even yearning) to be explicitly recognized for what you do relates to the fact that validation from others just feels good. Reaching all the way back to childhood and your need for your parents' reassurance and approval, being acknowledged by others helps you feel more accepted and secure. And consequently, more comfortable inside yourself. More important still, such recognition assists you in perceiving yourself as desirable, valuable, and esteemable. In a word, special.

In one way or another, virtually everybody dreams of standing out, being admired, acclaimed—even, well, applauded. To be viewed, and to view ourselves, as merely "average" or "adequate" really doesn't do very much for us—or rather, our ego. And this may be all the more so because we live in a meritorious, American-Idol-type society that refuses to celebrate or lavish praise on individuals unless they're judged exceptional. This circumstance explains why we may experience a certain envy when we hear drums banging for someone else. Secretly, we long to hear a drum roll beating for us.

Granted, there may be an element inherent in our nature—grandiosity, no doubt—that makes us wish to be thought highly of. For when complimented, we're likely to grow internally. Approbation from others whose authority we respect serves to verify our sense of inner worth. And such external approval is especially important for those still plagued by self-doubt. Unfortunately, master manipulators can take advantage of this almost universal susceptibility to compliments by guilefully employing them to seduce us into emptying out our wallets. As long as we're tricked into trusting their ingratiating kudos, we're liable to be taken in by them. For to feel favorably recognized wonderfully addresses one of our heart's (okay, ego's) deepest desires.

But, and probably much more often than not, the recognition that we hope for simply isn't going to happen. So when someone fails to acknowledge you when you think what you've done deserves acknowledgment, it's wise not to take this to heart. For various reasons, it's crucial that when you've executed something well, demonstrated skill or talent, behaved generously or selflessly, you learn how to congratulate yourself. That way you can avoid the let-down, the frustration, discouragement, or disgruntlement—and maybe even the anger and indignation—that otherwise will likely accompany your disappointment. Think of it. It always makes sense not to have to depend on others' reactions in order to regard yourself positively. Ideally, your goal should be to feel unconditionally good about who you are independent of any external "favorability meter"—and also free of whether you're presently embarked on some course of self-improvement.

What I'd like to suggest here is that by better grasping the underlying causes of why so many people might resist offering you the acknowledgment you wish for, their denial should be a lot easier to take. So consider the descriptions below that explain why many people (including—just possibly—yourself?!) can be so stingy with compliments. These are some reasons why some people, whatever best you do, do not acknowledge or say thank you at all!

•If they were "recognition-deprived" in growing up (by parents far more likely to criticize than to commend them), praising another might feel uneasy or unsettling (and for reasons that, consciously, they can only dimly perceive). Bestowing on someone else the acknowledgment they never received themselves might open the lid on long-suppressed psychic pain, making them experience afresh never-healed emotional wounds. In short, if you are raised by a family that never says thank you, you will do the same thing! Esp. a boss who never or rarely thanks, suffers and confuses his staff!

•If they're competitive—because they need constantly to prove themselves—then explicitly paying tribute to another's achievements might make them feel as though they're admitting inferiority, ineptitude, or defeat—a confession of failure their fragile ego might lack the strength to tolerate. Even beyond that, some individuals can only feel good about themselves by putting others down, in which case the only compliments they're capable of are backhanded ones.

•If they think that another's accomplishments and contributions (particularly their children's) are no more than what ought to be expected from them, they may not regard such acts as even worthy of acknowledgment.

•If they believe (or had drilled into them by praise-withholding parents) that lauding another for their achievements might go to the recipient's head—that is, lead them to become conceited, cocky, or egotistical—then they may intentionally withhold recognition (and regardless of how much the situation might warrant it).

See next Page

•If they're in denial about their own unmet need for acknowledgment, it might not even occur to them that positively recognizing another—and for that person's efforts, as well as accomplishments—might be in order. For example, commending a friend, when appropriate, is a responsibility (in fact, almost a "requirement") in a close relationship; yet they're unable to do so.

•If they have a strong sense of entitlement (because, say, their parents actually prompted them to believe the privileges they received were actually "rights"), then whatever recognition they receive from others will be expected, or taken for granted. And so any sense of obligation to respond in kind won't be part of their (narcissistic) behavioral repertoire. They actually won't even consider expressing appreciation, thanks, or gratitude when someone acts generously or kindly toward them.

•All of which is to say that you're not being acknowledged likely says much more about the other person than it does about you—or your worthiness. So in such situations you'll be far better off once you learn to be content simply through becoming more adept at self-acknowledgment.

•Cultural barriers? I am not sure about this, but this may also be a factor not to say thank you.

The Power of a Simple "Thank You"

Positive psychology tells us we have it within our own power to "self generate positivity whenever we choose." That's right. We really can choose our attitude, which affects not just us, but those around us as well.
It's as easy as saying "thank you." It's as simple as saying to a peer, colleague or subordinate, "I notice you and your work. I appreciate what you do. Your efforts are valuable to me, to the team, to the company if we are to succeed."

LEARN SAYING "THANK YOU"

What's the impact of actually extending and expressing gratitude? Studies published in the Journal of Personality and Social Psychology and discussed on PsyBlog tell us:
"Studies have suggested that being grateful can improve well-being, physical health, can strengthen social relationships, produce positive emotional states and help us cope with stressful times in our lives.
"But we also say thank you because we want the other person to know we value what they've done for us and, maybe, encourage them to help us again in the future. …
"Those who were thanked were more willing to provide further assistance. Indeed the effect of 'thank you' was quite substantial: while only 32% of participants receiving the neutral email helped with the second letter, when Eric expressed his gratitude, this went up to 66%."
If you would just tell me "thanks" for what I did, I'll happily do it again. It's that simple. But too many leaders and managers still refuse to do so in the workplace, citing: "But it's their job to do it. They get paid for it. That's thanks enough."
So please learn to acknowledge people for every good they do. Learn saying thank you! According to positive psychologists, saying 'thank you' is no longer just good manners; it is also beneficial to the self.

For more readings please refer: THANK YOU!

1.http://www.spring.org.uk/2010/10/why-thank-you-is-more-than-just-good-manners.php
2.http://www.compensationcafe.com/2010/10/the-value-of-thank-you-proven-scientifically.html
3.http://www.psychologytoday.com/blog/evolution-the-self/201301/why-people-dont-acknowledge-you

THANK YOU!

News and Briefs

Ethiopian is visioning for the next 20 years of Health Sector Development as middle income country

http://www.moh.gov.et

A three day conference of the public wing in the health sector has been held from May 8 to 10, 2014 at the United Nations conference Center (UNCC).

Guest of Honor to the conference H.E Prime Minister Hailemariam Desalegn has indicated that it's his government strong belief that professionals associations can contribute a lot on the nation's journey to renaissance.

H.E Prime Minister Hailemariam Desalegn

Minister of Health, H.E Dr. Keseteberhane Admasu has also address the conference. In his speech he has indicated that professional associations in the health sector have to play key role in resolving the challenges encountering in the provision quality health service.

At the first date of the conference, Dr. keseteberhan has presented a paper focusing on the past 20 years progress of the Ethiopian health sector. Following his presentation discussion has been held on the issues pertinent to the paper. Ethiopian Health Sector 20 year vision-Consultation Workshop opened today here in Addis Ababa at Hilton Hotel.

As Dr. Kesetebrhan Admasu Minister of health of Ethiopia in his opening speech said that, the health sector development program has brought tremendous change in healthy life of the community at all levels of the country, he highlighted the health extension program as a factor for the achieved results in health.He also mentioned that the country achieving remarkable results with government transformation plan which include health sector development program and which also visioning the country to reach to middle income country after some 10 years, as he stated the target will be achievable.

He said that the visioning document preparation will help to redesign equitable health service to fulfill the needs of middle income country public, as Dr. Kesete there will be different approach in health service quality in the visioning of the next 20 years. With this idea the visioning document preparation was started two years ago by establishing health visioning committee.

In the afternoon of the opening day, representatives of four associations –namely Ethiopian Medical Association (EMA), Ethiopian Public health Association (EPHA), Ethiopian Nurses Association (ENA) and Ethiopian Pharmacy Association (EPA) have forwarded questions and suggestions to His Excellency the Prime Minister. Addressing to the issues raised by the representatives of the associations, Ato Hailemariam discussed in detail what the government's stand is on health sector development and professionals' expectations.

The conference, on its second day, has continued in group discussions. Hot and interesting discussions have been observed in all six groups.

A panel discussion was the main event of the third day of the conference. Six panelists, from different associations, have presented their papers. One of the very important panel discussion topic was "Medical Ethics" and a three years proceedings and decisions of 60 Medical Ethics quarries , investigations and decisions made was presented by Dr. Biruk Lambisso, Chair of the Medical Ethics and Malpractice Council at the Federal level. This was a hot topic of discussion. Discussions were held, among panelists and participants, on the suggestions and matters raised by the panelists.

Before its conclusion, the conference has managed to produce a communiqué of six points.

ESOT was represented by Drs. Yiheyis, Zegene, Tesfaye, Kagnew and

News and Briefs

Review of the Ethiopian Health Professionals Council Professional Ethics Proceedings of the past three years

Jan 2011- Dec 2013

1.Dr. Biruk L. WAMISHO 2. Ato Mesafint Abeje & 3. Prof. Yeweynhareg Feleke

It is known that the Ethiopian health professional council (EHPC) is established by law endorsed by the council of ministers Regulation No.76/2002. Since then this council receives, investigate s and forwards decisions on health professional ethics and malpractice issues. In a fair and balanced way, the council evaluates practice of health personnel, a health institution or a client/patient. In the last three years (Jan 2011- Dec 2013), applications were filed on 55 health professionals. The complaints were received directly from the patients/relatives (19, (34.5%)), the police (14), A.A Health Bureau (11), MOH (6) and others (4). Two health professionals sued other health professionals.

Of the 55 health professionals on whom malpractice applications are filed, 43 were specialist doctors of which 22 (51.2%) were gynecologists. 9 were general surgeons and 5 were orthopedic surgeons. GPs accounted 4, nurses 4, and even there was a resident. Three of the professionals were not Ethiopians. Only on two cases more than one professional were accused. Six of the applications had additional administrative issues. Most of the events happened in hospitals (37), clinics (14). 27 of the applications were from patients treated at private institutions and 26 were from government institutions and two are from non- government centers. During investigations, problems were encountered in 10 cases; in six of which the original documents were taken by other entities than the police, the court or other legal office.

Most subjective complaints and explanations were not objectively documented. On average the investigation has taken a little over six months (6.5 months); fastest decision being made in less than a month (5) and longer ones took more than a year (6).
The council asked and received additional opinions from responsible professional societies in 17 cases. University departments were consulted in three cases and senior professors commented on three other cases where there are contradicting opinions between the council and professional societies.
Considering the final decisions of the council; there were no malpractices or any bridge of medical ethics in 30 (54.5%), 13 (23.6%) professionals were purely found to have either malpractice or professional insufficiency. Three institutions were closed, 6 licenses were perma

nently revoked of which three are not Ethiopians (Canadian, Russian, Cuban). Seven personnel served different degrees of measures. Six Gynecologists of the 22 complaints were proved to have some form of ethical bridge or insufficiency. Re-applications needing the explanation on the council's decision were made in 5 cases.
Eight cases are under final review. Only this week, four new complaints are filed. The council can't pass its decision on 3 cases due to inaccessible patient documents.

Conclusions: Health Professional Ethics is gaining huge attention; Surgical disciplines hosted most of the complaints. Clear communication between surgeon and patient; completed documentation of sequence of treatment events avoids unnecessary confrontations. OBGY is a single specialty where most complaints are filed and needs further detailed discussion with all stake-holders.

1.Chairman, Ethiopian Health Professionals Council
2.Director, Health Institutions and Professionals Registration and Licensing Directorate, FMHACA
3.President, EMA

GOOD JOB!

ESOT appreciates and thanks Dr. Reuben G. Gobezie from Cleveland Shoulder and BEZA International for funding a rural medical mission which was held between April 6-11, 2014 in SURMA-one of very remote villages of Ethiopia

Together with the specialists' team, Dr. Reuben has treated 883 patients.

Almost all of the medical problems encountered were preventable. PODOCNIOSIS, TRACOMA, TRAUMA, PARASITES and traditional harmful practices are leading health problems needing urgent priority and intervention. Other Participating specialists were Dr. Yemisirach Hailu and Dr. Yishak. Dr. Biuk L. Wamisho has planned, organized and lead the team through Biruk's Consult.

Dr. Reuben

News and Briefs

Inter-Society Cooperation

In 2013 our ESOT executive committee member and Secretary Dr. Yiheyis Feleke participated on behalf the society on preparation of the first edition of "Emergency Triage Assessment and Treatment Plus Ethiopia" (ETAT+ Ethiopia).

This is the first in its kind in Ethiopia, a training manual and treatment guideline which is adopted from WHO generic ETAT. The first round training of the manual for pediatricians and other medical staff working in pediatrics from all over Ethiopia started from March 24-29, 2014. Dr Yiheyis participated on this six day training as facilitator and trainer

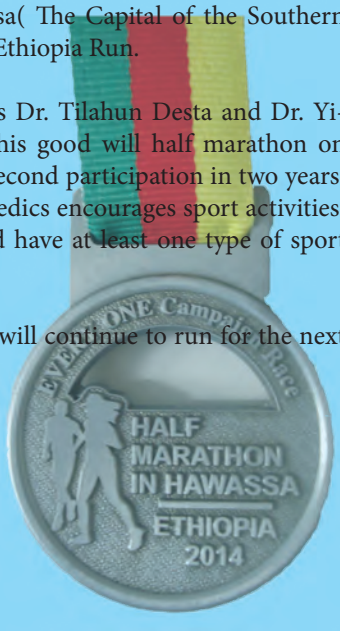
AMREF Campaign

AMREF
Better Health for Africa

As in previous years ESOT members continue to participate in the campaigns of AMREF on this year edition two of our ESOT members, Dr. Bezu Chemeda and Dr. Yiheyis Feleke voluntarily participated for the campaign at Mekelle hospital from March 17-21, 2014.They performed different types of orthopedic surgery. Bezu also is scheduled to go for ESOT+ AMREF rural surgical campaign to be held in Yergalem.

ESOT's participation in the voluntary campaign will continue in the future. We thank AMREF for helping needy patients particularly in the rural Ethiopia. ESOT keeps on collaborating with AMREF.

ESOT and Marathon Running



Saving the lives of newborn babies this was the aim of the 21km half marathon race in Hawassa(The Capital of the Southern Ethiopia) ,organized by Great Ethiopia Run.

Our ESOT executive members Dr. Tilahun Desta and Dr. Yiheyis Feleke participated in this good will half marathon on May 11, 2014. This was their second participation in two years. Dr. Thilahun said that Orthopedics encourages sport activities; every Ethiopian citizen should have at least one type of sport activity.

He also added, God's will, he will continue to run for the next 25 years.

News and Briefs

Ethiopian Medical Association's 50th AGM

The Ethiopian Medical Association, EMA has held its 50th AGM on Feb 27-28/2014 at Hilton International Hotel, in the presence of the Federal Minster of Health Dr. keseteberhan Admasu. For the first time, the President of World Medical Association, Dr. Margret has been in attendance. Overall attendance was great and ESOT was well participating in all activities. Best medical students and physicians were awarded at a special ceremony.

News and Briefs

HAVE YOU HEARED THAT WE ARE GOING TO LIVE LONGER and BETTER?

The Editorial team

We heard the following astonishing news few days back, May 22, 2014 (BERNAMA-NNN- ERTA) -- Ethiopia's average life expectancy has improved significantly and achieved the second biggest (following Liberia) gain in average life span, says the World Health Organization (WHO).

According to WHO's report on the state of health around the world for 2014, Ethiopia recorded a rise in average life span from a low of 45 years in 1990 to 64 years in 2012.

Recently, the United Nations has singled out Ethiopia as a leading performer in meeting the MDG on reducing child mortality rates. Ethiopia has also substantially reduced HIV and malaria prevalence. The report says all these improvements have contributed to the rise in average life expectancy in the country.

Ethiopia has been at the forefront of significant health improvement over the past decade, making it one of the few low-income countries on track to meet the Millennium Development Goals (MDG) in health.

The 67th session of the World Health Assembly which opened on Monday (May 19, 2014) in Geneva is expected to adopt new global measures to consolidate the successes achieved so far and tackle emerging health problems.

GENEVA, Switzerland (AFP) — Life expectancy in the world's poorest countries has risen by an average of nine years over the past two decades, thanks to major improvements in infant health, the United Nations said yesterday.

In its annual statistics, the UN's World Health Organization (WHO) said that six of the countries had even managed to raise life expectancy to over 10 years between 1990 and 2012.
The top achiever was Liberia, where average life span increased by a full 20 years, from 42 to 62.

Next in line were Ethiopia (from 45 to 64 years!), Maldives (58 to 77), Cambodia (54 to 72), East Timor (50 to 66) and Rwanda (48 to 65).

"An important reason why global life expectancy has improved so much is that fewer children are dying before their fifth birthday," WHO Chief Margaret Chan said in a statement.
Globally, average life expectancy rose by six years during the same period.

Based on global averages, a girl who was born in 2012 can expect to live to around 73 years, and a boy to the age of 68, the WHO said.

"But there is still a major rich-poor divide: people in high-income countries continue to have a much better chance of living longer than people in low-income countries," Chan said.
A boy born in 2012 in a high-income country can expect to live to the age of around 76 -- 16 years longer than a boy born in a low-income country.
For girls, the difference is even wider, with those in high-income countries likely to live to the age of 82 and those in poor nations to 63.
Female life expectancy in all the top 10 countries of the globe is 84 years or more, the WHO said.
Women in Japan enjoy the world's best life expectancy, at 87 years, followed by Spain, Switzerland and Singapore on 85.1 years each.

Life expectancy among men, meanwhile, is 80 years or more in nine countries, with the longest in Iceland (80.2), Switzerland (80.7) and Australia (80.5).

"In high-income countries, much of the gain in life expectancy is due to success in tackling non-communicable diseases," said Ties Boerma, head of the WHO statistics division.
"Fewer men and women are dying before they get to their 60th birthday from heart disease and stroke. Richer countries have become better at monitoring and managing high blood pressure for example," he added.

Declining tobacco use is also a key factor in helping people live longer in several countries, the WHO said.
At the other end of the scale, life expectancy for both men and women is still less than 55 in nine sub-Saharan African countries: Angola, Central African Republic, Chad, Democratic Republic of Congo, Ivory Coast, Lesotho, Mozambique, Nigeria and Sierra Leone.

Please Read more from the following links:

1.http://www.jamaicaobserver.com/news/Life-expectancy-improves-in-world-s-poorest-countries_16671094
2.http://www.bernama.com.my/bernama/v7/wn/newsworld.php?id=1040327

Ethiopia has been at the forefront of significant health improvement over the past decade.

News and Briefs

Happy 5th Anniversary to CURE Hospital!

By Julie Lortz; invited guest

ESOT gratefully recognizes and congratulates the work of CURE in Ethiopia. On May 22, 2014, CURE celebrated it's 5th anniversary of service in our country. With a goal of serving disabled children, CURE has performed over 6000 surgeries free of charge. CURE offers surgery at the highest standard of excellence in a compassionate and joyful atmosphere. The service provided by CURE corrects the disability of children, offering them the chance to attend school and lead a normal, productive and happy life.

CURE performs over 1000 surgeries every year! With a waiting list of over 1000 patients, Executive Director, Adey Abate, discussed plans to expand capacity, offering over 2000 life transforming surgeries every year! Not only is CURE changing the lives of Ethiopia's children, but the staff is passionate about training the future generation of healthcare professionals. CURE is in the final stages of opening a full-fledged Orthopaedic specialty/residency program. Currently, residents from Addis Ababa University, Orthopaedic department, regularly perform surgery at CURE hospital.

The 5th anniversary celebration was attended by First Lady, Mrs. Roman Tesfaye, who offered her appreciation to the organization for the work and contribution of CURE's staff and surgeons. ESOT executive members were present in support of the hospital's work. Three powerpoint presentations were given by Dr. Mary, Dr. Mesfin, and Dr. Tim. The ceremony also included testimonies of those who have received care at CURE hospital. We sincerely thank CURE for their indispensable contribution to Ethiopia's children and the orthopaedic community. We are hopeful that the next 5 years will surpass the first!!

Congratulations!

ESOT's 2013/1014 activities in Pictures

Photo Gallery

Thnaks Dr. Tilahun for the Band!

Special Award

ESOT 2014 Service Awardee

ESOT 2014 Service Awardee

ESOT 2014 Resident Awardee

ESOT 2014 Resident Awardee

AMREF Awardee

ESOT Executives

Enjoy your magazine

AMREF Awardee

AMREF Awardee

AMREF Awardee

Photo Gallery

Photo Gallery

Teaching Med. students

Media is important!

"Fikir eske Mekabir" an Amharic equivalent for "Love until the grave"

By Dr. Nardos worku, Orthopaedic Resident

This story will bring you memories of Shakespeare's Romeo and Juliet.
Our Romeo is Dinka and our Juliet is Sifan. Dinka and Sifan were involved in a terrible traffic accident. They each sustained similar fractures to the femur bone. Unlike the old story of Romeo and Juliet, their story did not end tragically; rather it has a happy ending.

Many thanks to the Orthopedic Surgical team at Black-Lion Hospital and the kind donations of best fracture fixation implants by SIGN, their femurs are well fixed and they started walking in four days after major surgery! Group-II specializing residents, supervised by Dr. Biruk and Dr. Yiheyis, performed the surgeries. Great moments! Let me share you this astonishing story from the beginning….

Once upon a time, 7 years ago, far away in Ambo, true love begins. One day, Sifan walked into her friend's house. This is where she first met Dinka, a grade 12 student. Dinka instantly laid eyes on beautiful Sifan. Some would say it was love at first sight. After this introduction, they spent more and more time together. They became close friends and eventually became high school sweethearts. Love blossomed!

Classes ended for the year. It was summer, and the two were inseparable. Their love continued to grow. Even during some difficult times, their love remained strong.

The next year, Dinka joined Diredawa University to study Accounting. When distance separated them, they kept in touch over the phone. Dinka graduated in 2002. At that time, Sifan was a 2nd year Literature student. Dinka knew in his heart that he wanted to marry her. One day, when he came for a visit, he surprised her - he got down on his knees and proposed. They were engaged! The couple could not have been happier, but they waited to announce the engagement to their friends and family.

After 2 years, Sifan graduated. Dinka, showed up at her graduation ceremony with red flowers in hand. With a proud smile on his face, he gave her a huge hug.
Last year, the lovely couple moved to Addis. Dinka began a job at Rift Valley College and Sifan worked as an assistant at a private company. Life in Addis was different, and sometimes hard, but the couple was happy because they were together. Their dreams were coming true. They were in love and they enjoyed life together!

One night earlier this year, as they discussed their future, they decided to announce the engagement to their families. The Easter holiday was approaching and the visit home would be the perfect time to share the happy news.

As planned, they started their trip to Ambo (125k.ms west of the Capital) on the Wednesday before Easter. At 7pm in the evening they climbed into the "Dolfin" minibus-fastest king of the night!. The driver was a little sleepy and he was driving quite fast. Two hours after beginning their journey home, the minibus collided with a "FSR" truck. It was a tragic accident. There were more than 20 passengers on the minibus. Four people died instantly, including the driver's assistant.

Those who survived the car crash were immediately taken to Ambo Hospital where they received emergency treatment. Sifan and Dinka were later referred to Addis Ababa and they reached Black Lion Hospital in the morning. After spending one day in the Emergency department, they were admitted to the orthopedic ward. Both were injured and got closed femoral shaft fractures - Sifan on the right leg and Dinka on the left, at the same level. The accident was scary and they were in pain, but they were grateful to survive the crash and still be alive.
During their hospital stay, they were in different wards, separated by one floor.

See FIKIR ,pg. 37

The Impact of Mobile Phone Use on Driving and Traffic Accidents

The mobile phone and car fiercely compete for our attention. In today's world of busy driving, the number one cause of car accidents is distracted driving. Research demonstrates that using a cell phone while driving quadruples the risk of a car accident requiring hospital attendance.1 More than 25% of all car crashes in the U.S. are associated with talking or texting while driving.2 The World Health Organization (WHO) reports traffic accidents as the leading cause of death among young people (age 15-29) worldwide.3 Traffic accidents account for 1.4 million deaths each year. An additional 20-50 million people suffer non-fatal injuries, many of which result in a disability. Compelling evidence exists demanding drivers abstain from phone use while driving.

Certainly you have been witness to traffic accidents. "At least one person dies out of [every] five car accidents occurring in this country," said Bamlaku Alemayehu, inspector of Ethiopia's National Road Safety Coordination Office.4 The Ethiopian National Road Safety Coordination Office reports a road crash fatality rate of 114 deaths per 10 000 vehicles per year but the real figure may be higher due to underreporting.5 Ethiopia is losing over 400 million birr yearly as a result of road accidents.6 Thousands of injuries each year are attributed to traffic accidents. Many of these injuries and deaths can be prevented.

Driving is an active process that necessitates a large portion of one's attention. It requires multiple brain functions, including visual, manual and cognitive activity. Engaging in phone use causes a person to divert brain function needed for driving. Research indicates that when a person uses the phone they fail to process a portion of their external surroundings.7 This may cause up to 50 percent of the driving environment to be excluded. In effect, distracted drivers do not adequately process environmental cues, external surroundings, potential hazards and other drivers. This leaves them lacking the capacity to respond appropriately to avoid dangerous and life-threatening situations.

Texting is perhaps the most risky activity for a driver. Some sources report that texting while driving increases the likelihood of traffic accidents 23 times.8 Texting requires a person to look down for an average of 5 seconds.9 During those 5 sec, a car moving 72 kmh travels 100 meters. Other distracted drivers, pedestrians, and additional hazards likely fill this distance. Not only do your eyes look away from the road during this time, but one or both hands come off the wheel. Similarly, dialing a number requires eyes to come off the road and increases the risk of accident.

Additional alarming research compares driving while using a cell phone to driving while intoxicated.

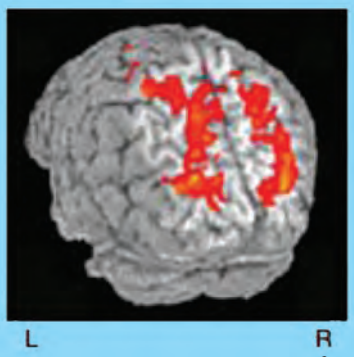
Julie Lortz visits Ethiopia from the United States. She recently finished her second year of medical school in South Carolina. She is enjoying the people and country of Ethiopia while learning about Orthopedic Surgery. She hopes to return many times in the future and continue to work with the medical community here.

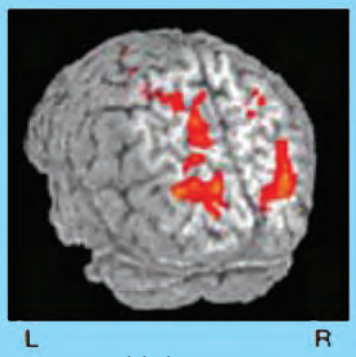
Additional alarming research compares driving while using a cell phone to driving while intoxicated. It is well known that drunk driving significantly impacts information processing, decision making and reaction time. Have you ever considered that talking to your friend on the phone while driving or reading a text may be equivalent to driving after drinking? One study showed that drivers using cell phones record a slower reaction time than drivers impaired by alcohol at a .08 blood alcohol level.10 Disturbing reports state that texting while driving is 6x more dangerous than driving while intoxicated.8

Some may argue that it is possible to engage in conversation while driving. Perhaps this reasoning accounts for many countries permitting the use of hands-free devices. This may seem reasonable, yet research still suggests that hands-free cell phone conversations result in increased accidents. Engaging in conversation and driving are two activities that demand our cognitive attention. Our brains do not adequately support multiple attention demanding tasks. Thus, each task is performed at a less than optimal level when we attempt to multitask. This results in missed information. For example a driver engaged in phone conversation will not see a car turning, a stop signal or a pedestrian. Furthermore, constantly switching our attention between driving and conversation yields slower reaction times.2 Even fraction of a second delays can be dangerous when driving or braking.

See next Page

Driving alone





Driving with sentence listening

Figure 1. fMRI images parietal lobe.
Sourece: Carnegie Melon University

A study by Carnegie Melon University used functional magnetic resonance imaging (fMRI) to record the impact of auditory language comprehension on drivers' brain activity. The participants drove on a simulator and listened to spoken sentences they were asked to judge as true or false.11

The images reveal that listening to sentences on cell phones decreased parietal lobe activity by 37 percent. Conversation takes cognitive activity away from driving activities performed by the parietal lobes, such as spatial processing. The same study similarly found decreased activity in the occipital lobes when drivers listen to sentences. These drivers drifted out of lanes and hit guardrails more often. Further, the researchers concluded the results may underestimate the distractive impact of cell phone conversation, since participants were only asked to listen and answer true or false.2

In both cases, the decrease in brain activity occurred without the added distraction of holding a cell phone or looking down. The study shows that driving ability deteriorates with listening comprehension alone, providing a counter argument to the idea that hands free devices do not carry a risk of accidents.

Countless lives have been lost and injuries suffered due to cell phone use while behind the wheel. Please choose to be a safe driver and avoid using your cell phone while driving. This will make roads safer and reduce traffic accidents. This is one of the most important things you can do to save lives today.

1 McEvoy, S. P., Stevenson, M. R. (2005). Role of mobile phones in motor vehicle crashes resulting in hospital attendance: a case-crossover study. British Medical Journal: 331:428.
2 National Safety Council (2010). Understanding the distracted brain: why driving while using hands-free cell phones is risky behavior. distracteddriving.nsc.org.
3 World Health Organization (2013). Road Traffic Injuries. Fact sheet No358.
4 http://www.irinnews.org/report/94165/ethiopia-government-moves-to-address-road-accident-toll
5 World Health Organization (2009). Global status report on road safety: time for action.
6 Tewolde Mekonnen (2007). Empirical Analysis on traffic accidents involving human injuries. Addis Ababa University.
7 Strayer, D. L., Drews, F. A., & Johnston, W. A. (2003). Cell phone induced failures of visual attention during simulated driving. Journal of Experimental Psychology: Applied, 9(1), 23-32.
8 U.S. National Highway Traffic Safety Administration
9 National Highway Traffic Safety Administration. Blueprint for Ending Distracted Driving. Washington, DC: U.S. Department of Transportation. National Highway Traffic Safety Administration, 2012. DOT HS 811 629 ??
10 Strayer, D. L., Drews, F. A., & Crouch, D. J. (2006). A comparison of the cell phone driver and the drunk driver. Human Factors, 48 (2), 381-391.
11 Just, M. A., Keller, T. A., & Cynkar, J. A. (2008). A decrease in brain activation associated with driving when listening to someone speak. Brain Research, 1205, 70-80.

Speech by Workneh Gebeyehu
Minister,Ministry of Transport Ethiopia

On ESOT's Aluminum Anniversary and 8th Annual General Meeting

Dear ORTHOPAEDIC Surgeons, International speakers, Residents and Medical Exhibitors;

CONGRADULATIONS on your Aluminum Anniversary and 8th annual national conference!
It gives me a great pleasure and honor to be amongst your celebration. Congratulations again!!
Ethiopia, economically booming nation and one of the fastest growing Economy, need all its fellow Citizens to be in a state of good health and full participation in the development. It is clearly known to the world that Ethiopia is investing substantially to develop the nation's infrastructure. Transport and energy are particular priorities. Our country is spending $US 1.3 billion, 10% of its GDP, annually on infrastructural development. This is recorded as the highest in Africa!

When you walk on the streets of Addis Ababa and regions in Ethiopia, it feels like the city is one big building site. It is the time for our renascence and the awakening of a sleeping giant!

Our government appreciates the priceless service offered by you the Orthopaedic Surgeons both during war and peace. Orthopaedics is the corner stone of healthcare. At this time of booming construction, increased transport related injuries, terrorism, natural disasters, industrial and machine injuries; our country needs your service more than anytime.
The country expects National preparedness from your society and such Scientific conference, which brings together all of you from all over the country is a means to share experiences, network each other and better know other companies and manufacturers. I also understand that there are senior international speakers invited to share their experience from abroad.

As a Minister of Transport, I appreciate your society to choose "The Burden of Orthopedic Problems in Ethiopia" this year as a main agenda of the conference. I can clearly understand that Transport injuries contribute the major share of accidents, fractures and Muskulo-skeletal disabilities. Today, according to an official data from our government, in Addis Ababa only, on average one person dies every day and Seven Ethiopians die every day nationally due to transport accidents! Around ten thousand Ethiopians sustain transport injuries annually. Our death rate from car accidents is 74 per ten thousand registered cars; developed nations have less than 10. In our Growth and Transformation Plan (GTP) we are working hard to bring this number to below 30 deaths. These are all very high numbers compared to developed countries. Let's work together scientifically.

The government of Ethiopia clearly understands how every of these complex injuries challenge each of you every day. Please know that you are doing a Nobel job in saving many lives and please let me express that my office is committed and is ready to work with you in tackling this numbers. Let us work together!

Thanking all who worked hard for the realization of this wonderful event, I hereby declare that the conference is officially opened! I wish you a wonderful scientific conference and medical exhibition.

Thank you!

Workneh Gebeyehu

Minister, Ministry Transport
Ethiopia

The firsts of Menelik-II (1844-1913)

Complied by Julie and Lili

What are the roots of our marvelous history? When did the telephone and the automobile become central to society? In relation to the fractures orthopedic surgeons receive from traffic accidents, we think the histories of these two machines are of orthopedic interest! Let's share with you what we have gathered as 'firsts' of the Emperor.

We look back to the reign of King Menelik- II for many additions to our modern society.

Menelik-II maintains a proud position in the history of Ethiopia. He led the country with dignity and compassion, while introducing many 'firsts' to this nation.

We thank Menelik- II for the first railway (1894), the first postal system (1894), the first modern bank of Abyssinia (1906), the first electricity, the first plumbing, the first cabinet of Ministers, and of course, the first telephone (1890) and automobile (1907). Lastly, we thank Menelik- II for founding the city of Addis Ababa.

Thus, the telephone and the automobile debuted within two decades of each other.

In 1890, the first telephone arrived from Italy. King Menelik- II made the first telephone call to the British Queen Victoria. He explained that she must tell the white people to leave and stop infringing on the Ethiopian land. If she does not act, his people will destroy the Italians.

In 1907, the first motor car arrived in Ethiopia, traveling by sea for 27 days and overland Bede Bentley drove the vehicle, spending 10 days tracking the course to Addis, as there were no paved roads at the time.

We see the telephone made the first appearance in Ethiopia. It beat the automobile in history. Today it is possibly beating the automobile again as it increases the risk for traffic accidents, causing injuries, draining resources and incurring cost.

If you would like to hear the voice of Menelik - II during the first telephone conversation to Queen Victoria in England, log on at http://youtu.be/Ahlp9EDBiTM

In 1876, Alexander Graham Bell was awarded the first US-patent for the telephone he invented.
Mobile phones were Introduced to Ethiopia in 1999.

Traditional/Cultural Practices leading to orthopedic injuries

Dr. Biruh Wubishet

Although motor vehicle accidents cause the majority of traumatic injuries, traditional/cultural practices also result in morbidities and mortalities of variable degrees. We also see many injuries caused by instruments traditionally used for manual work in different communities.

As you might remember the 1994 genocide in Rwanda killed an estimated 500,000–1,000,000 Rwandans constituting as much as 20% of the country's total population and 70% of the Tutsi population. The assassinations were predominantly executed by machetes, as bullets were expensive.

In countries where bullfighting is a tradition, musculoskeletal and other life threatening injuries are common. According to one retrospective study, 9% of bull fighters required emergency assistance, and trauma to upper and lower extremities was most common (66%). Major vascular injuries occurred in 5 % of the cases.

Both professionally and culturally different martial arts are practiced in many countries. Research published in 2005 in the British Journal of Sports Medicine showed a threefold increased risk of multiple injuries in taekwondo over karate.

Ethiopia's scenario

Like other countries, traditional/cultural practices that lead to orthopedic injuries exist in Ethiopia. Below is a discussion of several examples.

1.Injuries at traditional Ceremonies

In many rural areas of Ethiopia it is common practice to fire a gun during wedding ceremonies, and occasionally at the funerals. These practices are not legal and the persons firing the gun are often not experts at handling the weapon. Accidental life and limb threatening injuries at these events add more sorrow to the mourners at the funeral and negates the happiness of the wedding ceremonies.

Recently, in Dera Wereda, Fiche zone, three close relatives were injured after a gun accidentally fired during ceremonial wedding firing festivities. A single bullet passed through the knee of a 36 year old man and then traveled through the thighs of two other children.

The first patient sustained tibial plateau fracture, distal femur fracture and partial injury to popliteal vessels. The second patient in the path of the bullet suffered from left femur fracture, extensive soft tissue injury and complete transaction of the sciatic nerve. After serial debridement and external fixation, the sciatic nerve was repaired. The third patient received only soft tissue injury and after minor debridement she was sent home with oral antibiotics. This is just one of the numerous cases encountered in our clinical practice.

2.Stick Fight Injuries

A number of patients present to our emergency department after stick fight injuries. Most often they are hit over their head or forearm. Usually this is due to casual dispute. But in the Southern region of Ethiopia Bench zone the Surma people of Nilo-Saharan decent traditionally engage in stick fighting ceremonies. This celebration is believed to bring prestige to the men and is especially important when seeking a bride. This traditional fight is known as Donga. The fact that nearly all fighters sustaining injuries are fit, young and productive makes the damage particularly devastating to the community. Additionally, proper initial and definitive trauma care is rarely accessible in this geographic location.

See next page...

Traditional/Cultural Practices ...

3.Machete injuries (Gejera and Mencha injuries)

Injuries from machete can be severely detrimental, causing fatal injury or nonfatal trauma with long term morbidity. The injuries caused by machetes are more often a result of assault than accident. These injuries are almost always compound; extensive soft tissue injury with some degree of damage to neurovascular structures.

Wound infection is a universal complication, particularly when the patient presents late. The management and rehabilitation of these patients requires extensive time and demands a large amount of the families' often scarce resources, in addition to national resources.

These injuries are common in the eastern parts of Ethiopia by Mencha and in the southwest regions of Ethiopia by the so called Gejera.

4.Horseback riding injuries

Horses, among other equines, have played a prominent role in the history and culture of Ethiopia. Horseback riding is an ancient and traditional activity typically practiced in the highland parts of the country. One of these is "Gugs." "Gugs" is a mock cavalry combat played partially for simple pleasure and partially as training for actual warfare, at least in the past. Western type show jumping competitions and polo matches are also currently practiced at Jan Meda, Addis Ababa.

Horseback riding injuries often occur to the upper limb as riders attempt to break a fall. These injuries include sprains, strains, fractures and dislocations involving the wrist, elbow and shoulder. Ankle sprains and fractures can also occur. The most serious injuries can damage the spine and head.

5.Self inflicted injuries following anger

(Technically speaking such injury is not traditional/ cultural)
During development, some toddlers and older children tend to show a behavior of emotional outbreak known as temper tantrum. This behavior normally resolves as the child matures.

Dr. Biruh Wubishet

Nevertheless, anger issues that mirror a temper tantrum persist in some adults, particularly when intoxicated. At Black Lion Hospital, during the month of April alone, we saw four adults who, in anger, attempted to break into/out of their home by punching through a glass door. The result was severe neurovascular damage with tendon and other soft tissue injuries. Two of them were managed in our hospital while the other two, due to their complex/ severe injuries, required referral to hand and plastic surgeons following stabilization.

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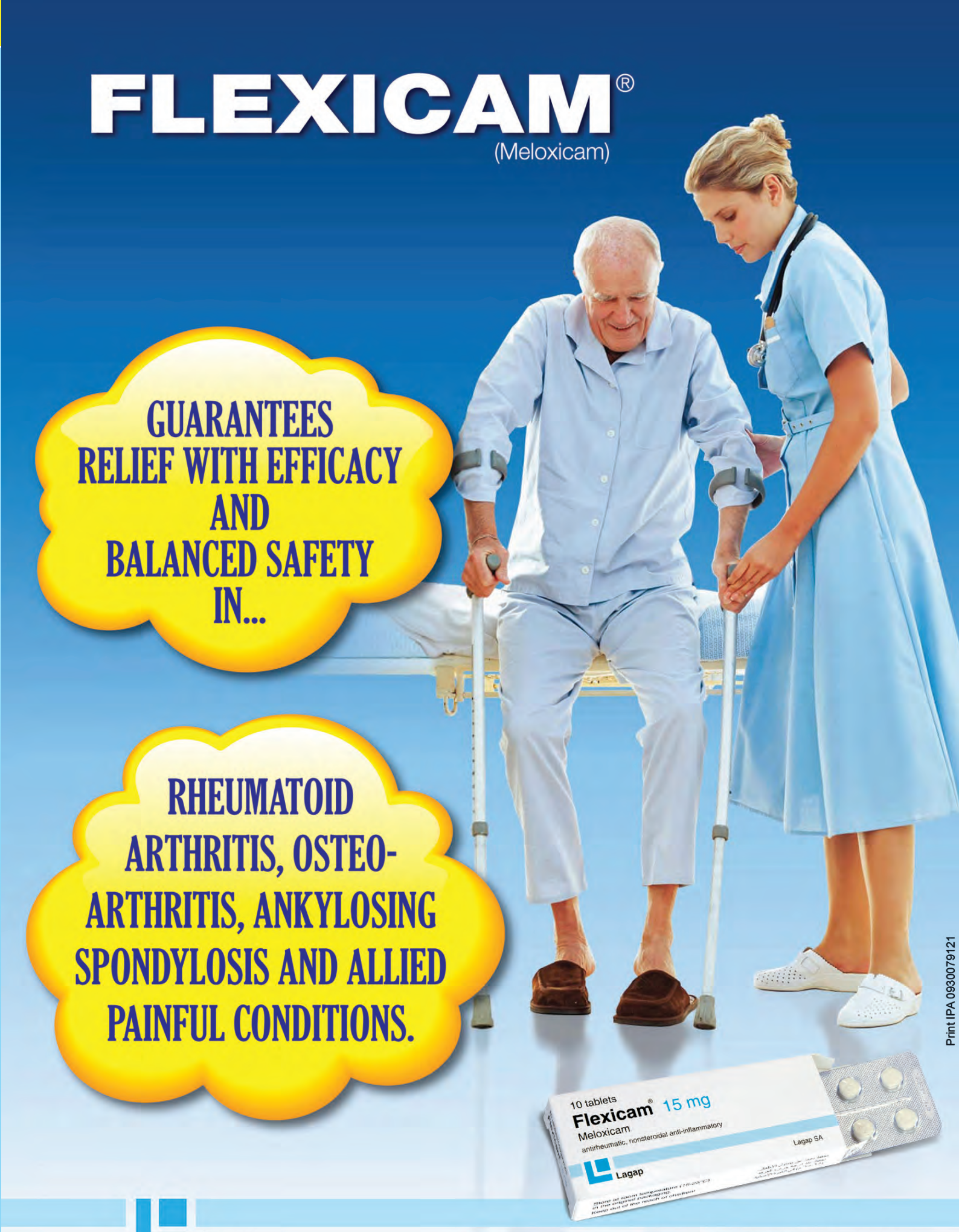

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Residents Corner

COOL spine course in KENYA

COSECSA OXFORDorthopaedic link (COOL) arranged a short advanced orthopaedic spine course exclusively in Kenya , Kijabe with the aim of increasing the understanding of the concepts of treatment and management of spine conditions requiring surgery. The course was held between 22& 25 of April in Kenya, Kijabe AIC-CURE international children's Hospital which is 75 km away from the capital, Nairobi.

Participants were postgraduate senior surgical trainee with a career interest in orthopaedics from COSECSA region and 33 patcipants attended the course among which six delegates were from Ethiopia represented by Dr. Nesredin E, Dr. Geletaw T, Dr. Worku B, Dr.Ephrem G, Dr. Mamo D,. Dr. Getnet A. All travel and Accommodation expenses of the course was covered by COOL project .

The course was well organized regarding the teaching methods and materials . We have found it to be fruitful in providing overview of spine conditions requiring surgery specially outlining management of the common conditions. It was well supported with practical demonstrations and the oversea delegates of the course were expertees with ample working experience and knowledge on the topics.

The course was a good opportunity for international links and a platform to develop a consensus among the participant residents concerning spine orthpaedics. . For different reasons spine practice has been separated from the department of orthopaedics for the past years and the practice has been handled by Neurosugeons exclusively despite it is a common territory. It was a perfect us opportunity to observe how common conditions are managed in setups similar to us.

It is our strong believe at least Basic spine orthopaedics practice could be started soon in our department jointly with the neurosurgery Unit so as to wonder the marvelous scope of orthopaedics in the country.

At last we would like to extend our thanks to the department for allowing interested residents to participate in such kind of courses and this trend should continue for making up the defect in the practice.

ARE SURGEONS REALLY MORE STRESSED?

By Meheret Haile

Surgeons can be required to work at odd hours, and many operations take hours to complete. Operating calls for extreme precision and attention to detail, and can require quick decision making with life or death consequences. In addition, rising malpractice insurance costs are a major cause of stress for many surgeons.

The available evidence suggests that those surgeons most dedicated to their profession and their patients may very well be most susceptible to burnout. Silence on career distress, as a strategy, simply does not work among professionals whose careers, well-being, and level of patient care may be in jeopardy. Additional research in these areas is needed to elucidate evidence-based interventions to address physician distress at both the individual and organizational level to benefit the individual surgeon and the patients under their care.

Surgeons must also be able to recognize how and when their personal distress affects the quality of care they provide (both in the delivery of care and in the emotional support of patients and their families). There is no single formula for achieving a satisfying career in surgery. All surgeons deal with stressful times in their personal and professional life and must cultivate habits of personal renewal, emotional self-awareness, connection with colleagues, adequate support systems, and the ability to find meaning in work to combat these challenges.

Surgeons need to set an example of good health to their patients and future generations of surgeons. To provide the best care for our patients, we need to be alert, interested in our work, and ready to provide for our patient's needs. Maintaining these values and healthy habits is the work of a lifetime.

Surveying 200 different professions based on their potential to strain employees' nerves, the report reveals some surprising trends among the most stressful jobs. Jobs Rated report (http://www.careercast.com/content/10-most-stressful-jobs-2010-3)

Surgeon is labeled as the most stressed professional following Firefighters and senior CEO's. Pilots and policemen are less stressed than a surgeon.

MY ADVICE TO SURGEONS:

I have been closely working with one of the very busy surgeons and I observed that they need some advice/reminder. To deal with the repeated stress of the surgeon life, effective coping strategies must be employed. It is necessary to adopt stress management strategies early, as the life of a medical student or resident is also one of stress and exhaustion. Suggestions to maintain surgeon well-being follow. Look for ways to introduce these techniques into your life.

Take time for yourself

This is critical to your well-being. Maybe you like to play a sport, enjoy the cinema, relax with a massage, or read a favorite book. Whatever it may be, it is essential to set aside time for activities that take care of you. Most likely, this time will not be available naturally, so you must schedule it in your week and ensure that meetings or work do not invade this time. Operating at full capacity requires that one knows how to rest well.

Time with family and friends

Your family and friends know you best. They are a source of strength, encouragement, love and laughter. Be vigilant in maintaining these relationships. Family must come first. Spend quality time with your children. Have date nights with your significant other. Plan family activities or even a vacation throughout the year. Make time for those most important to you and have fun with the people around you!

Exercise

Extensive research proves the benefit of exercise on stress relief. Exercise releases endorphins to improve mood. Maintaining appropriate nutrition and physical fitness will encourage emotional and mental health.

Spiritual health – Prayer and meditation

Many studies reveal the efficacy of prayer and meditation on overall health. Prayer and meditation invites one to be still, be quiet and release the stress or trouble of life. Spirituality connects us to the people in our community. Authentic belief in God arms us with hope, faith, love and forgiveness. Studies show that those who participate in prayer record lower levels of stress hormones. Those who express hope live longer and have fewer illnesses.

Those who actively forgive reduce anger and resentment, and researchers suggest this reduces stress hormone levels. 1 Regardless of the research, you must find your personal connection with God. It only takes a few minutes to close your eyes, be quiet and find peace. Likely this will decrease your stress and benefit your overall health.

Set boundaries

As a physician, need continually surrounds us. People constantly want our opinion and services. Likewise, it is important to participate in medical societies, conferences, research, community

See ARE SURGEONS,pg.33

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SCOPE OF PRACTICE OF THE ORTHOPEDIC & TRAUMA SURGEON IN ETHIOPIA,

March 2014.

1.Category : Medicine

2.Professional in the category: Orthopedic &Trauma Surgeon

3.Definition:

Orthopedic & Trauma Surgeon is a general medical practitioner who has successfully completed the prescribed course in Orthopedic and musculoskeletal traumatology specialty studies from a recognized training institution and has been licensed by the regulatory authority to practice as an Orthopedic &Trauma Surgeon.

4.To do lists:

In addition to the tasks of the general medical practitioner, the orthopedic & trauma surgeon:

- Undertakes complete history, physical examination, investigation & diagnostic procedures in the area of orthopedic and trauma surgery;
- Prescribes preoperative and postoperative medications;
- Prescribes orthosis and prosthesis;
- Administers intra-arthicular injections;
- Applies splints, tractions, casts;
- Replaces a diseased joint with prosthetic devices;
- Performs amputations or disarticulations;
- Performs skin grafts and flaps;
- Performs Arthroscopic examination and treatment of joint diseases;
- Performs closed and open reduction of all musculoskeletal dislocations;
- Performs closed and open reduction and internal fixation of all musculoskeletal fractures;
- Treats torn ligaments, sprains, and strains;
- Treats tendon and nerve injuries, pulled muscles, and bursitis;
- Treats low back pain, kyphosis , scoliosis, spondylolithesis, and spondylitis;
- Treats metabolic bone diseases;
- Treats degenerative, inflammatory and other joint and spine problems;
- Treats all sorts of musculoskeletal infections;
- Treats bone and extremity soft tissue tumors and related conditions;
- Treats all congenital as well as developmental abnormalities and deformities like knock knees, bow legs, bunions and ham mer toes;
- Participates in the rehabilitation of patients in collaboration with physiotherapist and orthotics and prosthetics professionals
- Conducts research in the area of orthopedics and traumatology;
- Educates and train students, residents and other health care professionals in orthopedics and traumatology.

5.Practice Limitation/Restriction:

Orthopedic & Trauma Surgeon is NOT Authorized to Perform:

- Any activity outside her/his scope of practice and outside of the practice stream in which she/he is registered (Orthopedic &Trauma Surgeon);
- Any clinical activity (procedures or service) that requires specific professional competence or additional education (Sub-specialty), training and experience to be performed safely.

6.Reserved Title : Medical doctor, Orthopedic &Trauma Surgeon

ARE SURGEONS REALLY ...?

service, educational events, etc. With never-ending need for our service and involvement, it is necessary that we establish firm boundaries. Knowing how and when to say no, is possible when we identify our priorities and values. While a measure of flexibility is also needed, this must be balanced with the reality that saying yes to one thing results in a no to many other things. For this reason, we must stay aware of where we are saying yes and where we are saying no, and ensure that our answers align with our priorities and values, rather than pressure, need or demand.

Avoid cynicism

Cynicism infects many hospitals and physicians. This attitude may be particularly tempting for a physician, and the environment of other medical professions may encourage this outlook. Cynicism aids in dealing with stress and it rarely improves the situation. Choose to be a leader as a physician and adopt a healthy attitude and outlook.

Instead choose thanksgiving

When anger and frustration come easily or when you resent the demands and pressures on your time and energy, try taking a step back. Remember why you choose this profession and begin with thanksgiving. A thankful attitude can change any situation. Likely, you came to this profession for the opportunity to help people and become an agent of healing. Try to be thankful for the opportunity of being in this position. Without belittling the challenges you face, remember the great privilege of this profession. You worked hard to be here. Be thankful for the life that you get to live. Be thankful you get to do this over the many other jobs available.

Look for a mentor

Look for someone who deals with stress well, and ask them to help you navigate the challenge, stress and demands of being a physician. Find support in your colleagues. Be courageous in asking for help when you need it and most importantly, honestly share how you are with those around you.

Integrating the health of all areas of your life will provide significant benefit. We must maintain health in our mind, body, spirit and emotion.

Learn to recognize early signs of stress. Treating stress when it starts will decrease the risk of burnout, which will prevent impaired performance, medical errors, and health problems.2 Find strategies that work well for your unique situation.

1 https://umm.edu/health/medical/altmed/treatment/spirituality
2 http://www.womensurgeons.org/aws_library/surgeonburnout.pdf

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Need for upgrading knowledge diversity

Dr. Demissie

I got the noble Opportunity of joining Indraprastha Apollo Hospital (India) Orthopedic department for period of 6 weeks, Suffice to mention; I had the explicit privilege to witness the surmountable advancement of orthopedic practice to date. Such remarkable progress ought is be cross-pollinated in our setting in order to escalate the standard and quality of Orthopedic service in our Ethiopia.

During my stay in Apollo, I Attended Several Joint replacement Surgeries (especially knee and Hip joints) arthroscopy and others.

These procedures require high caliber proficiency and the state of the art orthopedic instruments and appliances indeed; the outcome is explicably gratifying both for the patient and the surgeon too.
Hereby mention has to be made that post operative physiotherapy is an imperative prerequisite without which the outcome would be dismal.

Taking into account the increasing incidence of joint problems in our country coupled with the economic growth of the nation, now is the right time to strive for acquisition of the technological skill and hence rendering hi-tech service to the people in need.

In this regard our society shall seek for ways to upgrade and diversify the knowledge and capability of its members. Establishing a sustainable link with overseas advanced orthopedic centers is a plausible mechanism worth considering.

The AAU orthopedic department and ESOT shall take the leading role in promulgating the effort and disseminating the knowledge and practice to fellow Orthopedic surgeons across the country, besides the curriculum shall incorporate short and long term attachments with advanced centers so that the trainee will have ample exposure.

Announcement

Dear colleagues,

I have been emailed by the COSECSA Oxford Orthopaedic Link (COOL) team regarding an upcoming hip and knee arthroplasty course. It had been planned to be in Nairobi at the J&J surgical skills centre, but due to current security concerns they are considering relocating. They have emailed us to see whether we would be happy to host it in Addis. The dates are 14-17th July inclusive.

We could potentially do the morning at Cure Hospital and the afternoons at the Black Lion, much like the upcoming paeds ortho course. There would ideally be a cadaveric component. There would be 6 international faculty.

Would you be interested? We could negotiate that they would give some places to local delegates.

With best wishes,
Rick

Medical students page

Intern Betty after Sweden

In our previous edition, we received many positive comments from our readers of Intern Martha's astonishing story. We are encouraged by to hear this.
This year, we have got to interview one of our best Medical Students-now an Intern.
Her name is Dr. Betelehem Yishak Worku. She is a daughter of Dr. Yishak, who is a vibrant and talented Biochemistry instructor in Addis Ababa University (AAU); and Her Excellency Sinknesh Ejigu Woldemariam, former Minister of Mines, Ethiopia and currently full-flagged Ambassador of Ethiopia in Brazil.
Betty has amazing gifts. She is quiet disciplined, interactive, sociable and cheerful. She is an example of hope of the nation. To all who know her and thought her, she is exemplary hard working med student.
We thank Betty for sharing her story; by sparing sometime from her week-off: Enjoy reading!

Dr. Betelehem Yishak

Tell us how you were brought up?

I was born here in Addis Ababa in a family of four. I have an older brother, who is an Engineer-Nati. My dad was a lecturer in Biochemistry at AAU and my mom was Geo-chemist who worked at Ministry of Mines and Energy for many years. We lived in a very nice location and close neighbourhood with warm Ethiopian affection and care.
I joined elementary school at Nativity Girls School then high school at Lideta Catholic Cathedral. Both schools are in the same compound being run under the Ethiopian Catholic Church which made the places a good place for discipline and learning. After finishing that I then joined AAU-Medical Faculty in the year 2008.

How did you choose to study human Medicine? Who/ What influenced you?

When I look back at it I now feel my joining Medicine was inevitable. I remember since our school was near to Black Lion Hospital, I used to come directly to my dad's office everyday as a little kid, the physiology lab cycle and the anatomy dissection room manikins were play grounds for me and my brother. I felt like I can do anything although everyone said it was hard. I also wanted to make my father proud.

How was your internship stay in Sweden?

It was very encouraging, educational, fun and sometimes emotionally challenging to see the gap. We had three months of stay two of which was in Gynaecology and one month in Cardiology. I can't tell you everything but I would like to take you through my experience shortly. The day we arrived it was snowing; I remember being exited to see snow for the first time but, that feeling didn't last long when I started feeling terribly cold. We were then taken to our student housing, I was fascinated by the smooth public transportation and the living arrangement was nice. Then latter we went to the university for an Introductory Program. Karolinska Institute's exchange program receives close to 380 international students in different fields of healthcare, so on that day we had to meet lot of new faces. The OBGYN attachment was at a hospital called SOS. The main difference I appreciated other than the hospital being obviously big, well equipped and having lots of seniors was the pain management. The shock came when I attached to cardiology at Karolinska Hospital as the difference was more than I can comprehend. The emergency care especially, care on the scene was amazing. While we were in the CCU (Coronary Care Unit) we had ECG from the ambulance even before we saw the patient and we were able to decide the management before the patient came. They had advanced care like heart transplant and LVAD (Left Ventricular Assist Device), Which I haven't learnt or even heard about while I was in Ethiopia. Those made me feel sad when I compared it to here. Truthfully although the internship there is more encouraging where as the internship here is harder and more exhausting; I think we have more hands on training here and we are also more significant to the patients here. As a country we have a lot to improve and I hope I will be part of that change.

Did you incline towards a specific speciality?

No it is hard to decide now. I am just half way doing my internship. Let me explore all departments, I think I have time to decide.

Not even a little bit attraction?

I think I am a little bit inclined towards Surgery. What Speciality of Surgery? I am not yet sure.I like hands-on and enjoy art as well. So ..... we will see. Give me time.
What have you felt when your father and brother re-

See NEXT PAGE...

ceived the gold medal and EMA's award on your behalf?

I was surprising as I was not sure about my results when I went to Sweden, but I was ecstatic when I heard the great news. I was happy to make my parents proud and it was nice to see the pictures they sent me.

This year EMA awarded best scorers of 8 medical universities. You are one of them from AAU. Three of the eight awardees were female students. What do you feel?

That make me feel proud to be a lady and optimistic about the future of Ethiopian females.

What message would you pass on to encourage all female students perusing higher education?

I encourage them to work harder, to believe in themselves that they can achieve a herculean task if they believe in themselves. The whole point is to get focused and work hard and practically show that it is possible. I am lucky to get influenced into a medical field by my Dad, but equally, regarding how to become a strong and influential woman, I got lots of lessons from my Mom.

http://www.ethiopianwomenunleashed.org/profile_detail.php?PId=103

Name	Sex	CGPA	University
Bethelhem Yishak Worku	Female	3.79	Addis Ababa University; School of Medicine
Semir Sultan Ahmed	Male	3.79	Addis Ababa University; School of Medicine
Dr.Alemayehu Getnet Worku	Male	3.64	Hawassa University; College of Medicine and Health Science
Intern Fuad Mohammed Hassen	Male	3.52	Mekelle University; College of Health Science
Mahlet Alemayehu Sirage	Female	3.53	Hayat Medical College
Dr. Birhanu Abdissa	Male	3.77	Jimma University; Medical Faculty
Hailemariam Alemu Astatk	Male	3.65	Gondar University; College of Medicine and Health science
Dr. Ahmed Mohammed Hussien	Male	3.48	Haromaya School of Medicine
Hana Abebe G/Silasie	Female	3.96	St.Paul Hospital; Millennium Medical College

List of Top Scoring Students from Eight Medical Universities in Ethiopia, awarded at EMA 50th AGM

BASIC CONSTRUCTION SAFETY PERSONAL EQUIPMENT

Hard hats, Safety helmets and steel-toe boots are perhaps the most common personal protective equipment worn by construction workers around the world. A risk assessment may deem that other protective equipment is appropriate, such as gloves, goggles, Ear plugs or high-visibility clothing. Others (E.g Electricity protection) may be added depending on the type of work.

The height limit where fall protection is required is not defined. It used to be 2 meters in the previous issue of Work at Height Regulations. It is any height that may result in injury from a fall. Protection is also required when the employee is at risk to falling onto dangerous equipment.
Fall protection can be provided by guardrail systems, safety net systems, personal fall arrest systems, positioning device systems, and warning line systems.
All employees should be trained to understand the proper way to use these systems and to identify hazards. The employee or employer will be responsible for providing fall protection systems and to ensure the use of these systems.
Employees on construction sites also need to be aware of dangers on the ground. The hazards of cables running across roadways were often seen, until cable ramp equipment was invented to protect hoses and other equipment which had to be laid out.

Often pedestrians are forgotten and got injured at work sites. Physically separate the site from pedestrians and provide adequate detour clearly labeled.
Ensure good traffic crosslink and avoid long jams at dangerous construction sites. Check that all traffic controlling devices work. Complete first aid equipment, ambulance and firefighter's telephone numbers have to be available.

Please refer to an exhaustive checklist at the following websites for more info:

https://www.google.com.et/search?q=construction+safety+equipment+list&oq=construction+safety+equipment+list&aqs=chrome..69i57j0.9760j0j8&sourceid=chrome&es_sm=93&ie=UTF-8)
http://www.deldot.gov/information/business/drc/misc_files/atssa_ped_checklist_considerations.pdf

"Fikir eske Mekabir" ...*Continued from page 21*

They spent days apart, but Sifan said she felt as though Dinka was sitting at her side the entire time. After several days, they went to surgery on the same day. Successful placement of the SIGN nail repaired the fractured bones.

I asked Dinka and Sifan for words to describe each other. With tears in her eyes, Sifan shared, "He is calm, understanding and loving. I can't help but smile when I'm around him." Dinka said, "Love is the glue that kept us together through many hard times over the last 7 years. Simply put, she is as important to me as the air that I breathe."

Clearly their love is strong. I was touched by their story as I witnessed true love at its best. I believe their unconditional and undying love has kept them going and will keep them together for many years to come. Orthopedic residents at Black-Lion Hospital were their messangers; taking back and forth in the orthopedic building. Our Romeo and Juliet are healing well and will live happily ever after.

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Our Guest Speaker

Dr.Rakesh Ranjan
Consultant, Neurosurgeon

Education:

Medical School Armed Forces Medical College, India 1993-1998

Rotating Internship Safdarjung Hospital, New Delhi, India 1998-1999

Residency MS (General Surgery) Post Graduate Institute of Medical Education & Research Chandigarh, India 2000- 2002

Superspeciality MCh (Neurosurgery) Post Graduate Institute of Medical Education &Research,Chandigarh, India 2003- 2006

Certificate(Research Methodology & Biostatistics)Post Graduate Institute of Medical Education & Research,Chandigarh, India 2002

Diplomate National Board, Neurosurgery (DNB), INDIA 2007

Visiting Neurosurgeon Department of Neurosurgery, University of California (UCSF),SanFrancisco, USA 2009

Past appointments:

SpecialistDepartment of Neurosurgery(academic) St. Stephen's Hospital,NewDelhi, India 2007-2008

Junior Consultant Max Superspeciality Hospital, NewDelhi, India (2006-2007)

Department of Neurosciences 2006-2007

Senior Medical Officer (Trauma & Emergency) Post Graduate Institute of Medical Education & Research, Chandigarh, Indiaan 2003-June 2002

Junior Resident (pediatric cardiology) All India Institute of Medical Sciences,New Delhi Jan 2000

Papers Published:

1.Ranjan R, Handa A, Choudhary A, Kumar S. Acanthamoeba infection in an interhemispheric ependymal cyst: a case report. Surgical Neurology 2009Aug;72(2):185-9.

2. Ranjan R, Tiwari R, Kumar S. Cervical intradural extramedullary ependymal cyst associated with congenital dermal sinus: a case report. Childs nervous system 2009 Sept;25(9):1121-4..

3. Kumar S, Pandey P, Abbey P, Ranjan R : Intraoperative contralateral extradural hematoma developing during evacuation of a traumatic contusion . The Internet Journal of Neurosurgery. 2009 Volume 5 Number 2.

Manuscripts In Preparation:

1. Ranjan R, Mukherjee KK, Verma N, Khosla VK. Cisternal urokinase irrigation for prevention of cerebral vasospasm after aneurysmal subarachnoid haemorrhage – is it safe?

2. Ranjan R, Gupta SK, Khosla VK, Pathak A. Neuroenteric cysts – a clinical spectrum of 11 patients in Indian population.

3. Ranjan R, Ranjan S, Mishra S. Aspergillus vertebral osteomyelitis in immunocompeten person: a case report and review of literature.

4. Ranjan R, Sethuraman SV. Intraparenchymal supratentorial clear cell meningioma in a child : a case report and review of literature.

5. Ranjan R. Sethuraman SV. Pseudotumor of the cervicodorsal spine: a case report and review of the literature.

Contributions in: CRASH trail conducted by Medical Research Council, UK published in:

CRASH trail collaborators. Effect of intravenous corticosteroids on death within 14 days in 10008 adults with clinically significant head injury (MRC CRASH trail): randomised placebo controlled trail. Lancet 2004; 364:1321-8.

CRASH trail collaborators. Final results of MRC CRASH, a randomised placebo-controlled trial of intravenous corticosteroid

See NEXT PAGE...

Our Guest Speaker

in adults with head injury-outcomes at 6 months. Lancet 2005; 365:1957-1959.

Oral Presentations / Abstracts:

Neurological society of India - Annual Conference Outcome of aggressive therapy in patients with severe head injury with Glasgow coma score 3 at presentation 2009
Congress of Neurological Surgeons- Annual Conference, NewOrleans Vertex extradural hematoma- clinical series of five patients. 2009
Neurological society of India - Annual Conference Vertex extradural hematoma: clinical series of three patients 2008
International Spine and Spinal Injuries Conference Ossification of ligamentum flavum in dorsal spine. 2006
Neurological society of India - Annual Conference Organization of integrated intraoperative high field MRI- technical considerations. 2006

Honors/ Grants Received:

Travel Award- Annual conference of Congress of Neurological Surgeons, NewOrleans, USA. 2009
Travel award – International spine and spinal injuries conference – NewDelhi, India. 2004
Funding for Thesis and research project - Indian Council of Medical Research, NewDelhi, India. 2001-2002
Certificate of merit for standing 3rd in AIDS Quiz - Ministry of Information & Broadcasting , India 1997
Certificate of Merit for standing first in college in Pharmacology - Armed Forces Medical College, Pune, India 1996

Awards & Contributions:

Served as editor of College magazine, Armed Forces Medical College.India 1996-1997
Awarded certificate of merit for essay competition- India medical Association. India 1997
Awarded in science Quiz Competition- Department of Biotechnology, Indian institute of Technology, New Delhi, India 1992
Awarded 2nd prize in Population Quiz competition, East Zone, India- National Council of Education, Research & Technology, India 1989
Awarded certificate of merit and prize in essay competition- Ministry of Environment, India 1988

Professional Memberships:

Neurological Society of India	Life member	2003-
Congress of Neurological Surgeons	International Active member	2009-

Licensure / Certification:

Medical Council of India	License	1999-
Delhi Medical Council, India	License	2006-
Maharastra Medical Council, India.	License	2009-

Recent Workshops participated:

1. Endoscopic skull base neurosurgery 2010, Bombay Hospital, Course Directors: Amin Kassam, Ricardo Ramina, Pablo Capabianca.
2. Venticular system neurosurgery, congress of neurological surgeons annual conference, New Orleans, 2009.

Occupational Medicine & Health Affairs

Adane et al., Occup Med Health Aff 2013, 1:5
http://dx.doi.org/10.4172/2329-6879.1000125

Research Article Open Access

Occupational Injuries Among Building Construction Workers in Gondar City, Ethiopia

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Abstract

Introduction: Construction industry has been identified as one of the most hazardous industries both in industrialized and industrializing countries. Work-related injuries in construction sector present a major public health problem resulting in serious social and economic consequences that could be prevented if appropriate measures are taken.

Method: Institution-based cross-sectional study was conducted from May 1 – 20, 2009 at six licensed construction sites in Gondar city. A total of 401 building construction workers were included in the study by using simple random sampling technique. Data were collected through interviews using structured and pre-tested questionnaire and the collected data were entered and analyzed using Statistical Package for the Social Sciences (SPSS) version 13.0.

Results: The prevalence rate of work-related injuries in the preceding one year was 38.7%. Of the total injuries, more than half (68.39%) were reported by males while the rest reported by females workers. The leading causes of injuries were fall from ground level (21.3%) followed by overexertion during lifting (20.6%), and fall from elevation (16.1%). Old age, being male, job dissatisfaction, lack of vocational training and working overtime were found to elevate the odds of having occupational injuries among construction workers.

Conclusion: The study revealed that occupational injuries were common among building construction workers. Therefore, counter measures such as creating awareness of risk factors, avoiding overtime work, providing training and personal protective devices could be effective to decrease prevalence of occupational injuries.

Impact on industry: The research will be helpful to know the extent of problem and to suggest some interventions.

Keywords: Building construction workers; Occupational injuries; Fall from ground level; Personal protective devices; Ethiopia

Introduction

Construction work involves a serious of occupational risks, such as work at heights (use of scaffolding, gangways and ladders), excavation work (use of explosives, earth moving machines), lifting of materials (use of cranes, hoists), and so on, which are specific to the sector. Thus, construction is often classified as a high-risk industry as it has historically been plagued with much higher and unacceptable injury rates compared to other industries [1,2]. Accidents at construction sites are identified as a major public health problem throughout the world [3]. Even though the number of fatal occupational accidents in the construction industry all over the world is difficult to quantify as information on this issue is not available for most countries, it would be reasonable to estimate that at least 55,000 fatalities occur at construction sites around the world every year. This means globally one fatal accident occur in this sector approximately every ten minutes [1]. According to reports published by the Construction Industry Institute, injuries and fatalities occur in the construction industry at a rate more than 50% higher than all other industries. Each work day, three or four construction workers die from injuries on the job in the U.S. at a rate of 18.6 per 100000 full-time workers, totaling more than 900 deaths per year [3]. The estimated direct and indirect costs of fatal and nonfatal construction injuries totaled about $13 billion annually in this world. The medical expenses of nonfatal injuries alone cost more than $1.36 billion per year [4].

Developing countries like Ethiopia are striving hard to improve their basic amenities by building schools, hospitals, housing complexes, shops, offices, highways, power plants, industries, bridges and other infrastructures. However, all these construction activities are carried out by unskilled labor forces at cheap rate. Occupational injuries and accidents among these workers are high due to illiteracy, poverty, lack of health and safety training and information on health hazards and risks at the work place. Such workers are known to face rapidly changing workplaces, a high degree of competition and bouts of unemployment [5,6]. Hence, in developing countries the occupational health and safety hazards faced by construction workers are greater than those in industrial countries. The impact is also 10 to 20 times higher in these counties, where the greatest concentration of the world's workforce is located [7,8]. However, even though work-related injuries present a major public health problem resulting in serious social and economic consequences, it can be prevented if appropriate measures are taken [9]. In Ethiopia, little work has been done on occupational health and safety aspects of building construction workers and as per literature review there is lack of data about prevalence and determinant factors of occupational injuries among these workers. Therefore, the present study attempted to contribute in determining magnitude and factors

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related to work related injuries among building construction workers in Gondar city, Ethiopia.

Methods

Study design

Institutional-based cross-sectional study was conducted from May 1-20, 2009 at six licensed construction sites existing in Gondar city.

Sample size determination and sampling technique

The required sample size was determined by using single population proportion formula. For the calculation, 95% confidence level, 5% marginal error and 50% injury prevalence (because there was no previous study) were assumed. Based upon the job description, the study populations were stratified in to seven different strata i.e. daily laborer, plasterer, carpenter, mason, welder /electrician, painter, and driver/operator. The number of samples from each stratum was determined by using proportional allocation formula. Finally, simple random sampling technique was employed to select 403 sample sizes from the strata

Data collection procedure

Structured and pretested questionnaire, consisting of both closed and open-ended questions was utilized to collect the data (Annex-1). Five final year Occupational Health and Safety students and two Occupational Health and Safety professionals were recruited to work as data collectors and supervisors, respectively. The data were collected by interviewing building construction workers using the Amharic version of the questionnaire. The questionnaire was prepared in English and translated to Amharic (native language) and then back to English by different independent language experts to verify the consistency and content of translation. Detailed information about the socio-demographic, behavioral and work environment characteristics, awareness and practice towards occupational health among construction workers and episodes of injuries in the preceding one year were collected.

Data quality assurance

The quality of data was ensured through training of data collectors and supervisors, checking the completeness, accuracy, and uniformity of the collected data at each day of data collection.

Data analysis

The data were entered, cleaned and analyzed using SPSS software version 13.0. Descriptive statistics like frequency distribution mean and percentage calculation was made for most of the variables. Bivariate and multivariate logistic regression analyses were performed to identify factors affecting prevalence of occupational injuries. Finally, the results were presented with adjusted odds ratio (AOR) and 95% confidence interval (CI).

Ethical clearance

Ethical clearance was obtained from the Institutional Review Committee of School of Public Health, College of Medicine and Health Sciences, University of Gondar. Permission was also obtained from the local administrative bodies and concerned construction companies. Verbal consent was also obtained from every study subject after clearly half of the injuries (68.39%) were reported by males and the rest by the female workers. Among the injured workers, 61.3% faced injury once whereas, 38.7% of them experienced more than once. The leading causes of injuries were fall on ground level (21.3%) followed by overexertion during lifting (20.6%), fall from elevation (16.1%), being struck by falling object (14.8%), cut by sharp objects (11%) and others (16.1%) like electrocution, vehicle accident, building collapse, machine accident etc. Regarding post injury measures, 52.3% workers got treatment from nearby health institution, 23.2% tried self medication with locally available materials, 10.3% got first explaining the purpose of study. Confidentiality of the data was strictly maintained throughout the study period.

Results

From the total of 403 selected building construction workers, 401 participated in the study. This forms a response rate of 99.5%. Male study participants accounted to 61.6% of all study participants. The age of the respondents' range from 14–57 years with a mean (± standard deviation) age of 25.3 ± 8.4 years. Majority (75.3%) of the workers were in the age group of 14–29 years followed by 30-44 (19.7%) and 45-57 years (5%), respectively. Table 1 summarizes the socio demographic characteristics of the study participants.

Out of the total 401 study subjects, 38.7% had experienced work-related injuries at least once in the previous one year recall period; of which more than aid at the site, 7.1% got treatment from traditional healers and the rest 7.1% did not take any measure due to less injury extent. Self medication by workers may be at site or at their respective homes which mostly include bandaging the injured body part with piece of cloth, softening the injured body parts with butter and pouring the stressed muscles with cold or hot water.

Characteristic		Frequency	Percent
Sex	Male	247	61.6
	Female	154	38.4
Age	14-29	302	75.3
	30-44	79	19.7
	45+	20	5.0
Marital status	Single	204	50.9
	Married	161	40.1
	Widowed	28	7.0
	Divorced	8	2.0
Religion	Orthodox	341	85.0
	Muslim	36	9.0
	Others	24	6.0
Educational level	Cannot read and write	69	17.2
	Read and write only	24	6.0
	Elementary	120	29.9
	Secondary & above	188	46.9
Occupation	Daily laborer	230	57.3
	Plasterer	64	16.0
	Carpenter	40	10.0
	Mason	32	8.0
	Welder/electrician	13	3.2
	Painter	12	3.0
	Driver/operator	10	2.5
Service year	<1	234	58.4
	1-5	130	32.4
	Above 5	37	9.2
Monthly salary in Birr	200-600	288	71.8
	>600	113	28.2

Others: protestant and catholic

Table 1: Socio-Demographic Characteristics of building construction workers in Gondar city, Gondar, 2009.

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Concerning the day of injury, 23.2% of the workers injured on Wednesday followed by Monday (15%) although many workers (40%) did not remember the exact day of injury (Figure 1). More than half (53.1%) of the workers did not hear (had no awareness) about the existence of occupational health hazards. Beside this, majority of the workers (90%) did not have periodical health check up and none of the study participant was found to use personal protective equipment (PPE) at all during work (Table 2). Majority of the workers (87.5%) did not take vocational training for the activities they perform and none of the workers attended any kind of occupational health and safety training. About 72% of the workers reported that they did not have any kind of health services in their company. Even those who reported availability of health services, 92.8% of them reported only first aid services whereas, the rest 3.6% each reported preventive and 3.6% treatment services.

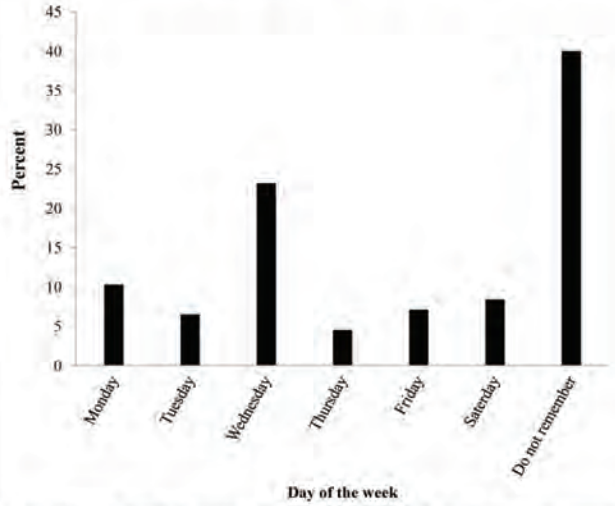

Figure 1: Bar graph showing day of the week when injury occurred among building construction workers in Gondar city, Gondar, 2009.

Characteristic		Frequency	Percent
Ever heard occupational health hazards	Yes	213	46.9
	No	188	53.1
Have periodic health check up	Yes	40	10
	No	361	90
Reason for not using PPE	No provision of PPE	388	96.8
	Not comfortable	6	1.5
	Other	7	1.7

PPE: personal protective equipment; Others: using PPE has no value, decrease work performance

Table 2: Building construction workers awareness and practice towards occupational health in Gondar city, Gondar, 2009.

The result of multivariate logistic regression analysis showed that the prevalence of occupational injury among building construction workers was significantly associated with age, sex, job satisfaction, lack of vocational training, and total work hours/day. Workers above ≥ 45 years in age were 3.16 times more likely to be injured than workers found in the age group between 14–29 [AOR: 3.16, 95% CI: (1.03, 9.64)] however, no statistically significant association was found between workers in the age range of 14-29 and 30-44 years [AOR: 1.47, 95% CI: (0.82, 2.63)]. Similarly, occupational injuries were significantly associated with workers gender i.e. males were 2.01 times [AOR: 2.01, 95% CI: (1.20, 3.37)] more likely to experience injury than females. Likewise, job satisfaction showed statistically significant association with occupational injury; construction workers who reported current job satisfaction were 45% less likely to face injury compared to their counter parts [AOR: 0.55, 95% CI: (0.34, 0.90)]. Also, workers who did not undergo vocational training were 2.37 times more likely to have injury than those who underwent vocational training [AOR: 2.37, 95% CI: (1.08, 5.22)]. In addition, working > 8 hours/day raised the odds of occupational injury by 14.06 folds compared to those who worked for 8 hours/day [AOR: 14.06, 95% CI: (5.67, 34.86)] (Table 3).

Discussion

The study results revealed that out of total participants 38.7% of the workers experienced occupational injuries at least once in the previous one year recall period. This finding was markedly higher than that of the study done in India, where the prevalence rate of injury was 22.92%.

Variables		Injury		Crude OR (95%CI)	Adjusted OR (95% CI)	p-value
		Yes	No			
Age	14-29	105	197	1.00		
	30-44	36	43	1.57 (0.95,2.60)	1.47 (0.82, 2.63)	
	45+	14	6	4.38 (1.63,11.73)*	3.16 (1.03, 9.64)*	.044
Sex	Male	106	141	1.61(1.06, 2.46)*	2.01 (1.20, 3.37)*	.008
	Female	49	105	1.00		
Work hours per day	> 8 hours	47	6	18.12 (7.51,43.73)*	14.06 (5.67, 34.86)*	.000
	< 8 hours	6	4	3.47 (0.96,12.56)	3.30 (0.88, 12.35)	
Satisfied with current job	8 hours	102	236	1.00		
	No	86	88	1.00		
	Yes	69	158	0.45(0.3,0.67)	0.55(0.34, 0.90)*	.018
Underwent vocational training	No	144	207	2.47 (1.22,5.0)*	2.37 (1.08, 5.22)*	.032
	Yes	11	39	1.00		
Smoking	No	130	225	1.00		
	Yes	25	21	2.06 (1.11,3.83)*	0.97 (0.44, 2.46)	

*-significant at p-value <0.05

Table 3: Multivariate logistic regression analysis for potential factors associated with injury among building construction workers in Gondar city, Gondar, 2009.

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[10]. This discrepancy in the prevalence of work-related injuries may be linked to the difference between the two countries in level of development, status of workforce, strengths of occupational health and safety services and diversity and complexity of work tasks, and environments. The other reason might be connected to the difference in the method of data collection.

The three leading cause of injuries were fall from ground level (21.3%) followed by overexertion during lifting and carrying (20.6%), and fall from height (16.1%). The fall injuries together constitute about 37.4 % among the total injuries. Tripping over debris, difficult work terrain (e.g., rocky, muddy, uneven), slope of the lot, lack of backfill around the foundation, and difficult access and/or egress from the building were the main reasons contributing to fall from same level [11]. The finding of the present study was relatively consistent with that of report from Egypt [12], where fall cases represent a significant portion of occupational injuries among construction workers. It was also, similar with other studies conducted in USA [13,14]. In line with the study done in USA [14], comparatively more workers (23.2%) were injured on Wednesday. Most of the workers (53.1%) had no awareness about the presence of occupational health hazards associated with their work and they totally denied access to any of occupational health and safety trainings. In most developing countries construction skills are still mainly acquired through an informal apprenticeship system. In Egypt 85% of craftsmen are trained through traditional apprenticeships [15], and a similar situation prevails in Brazil, India, Kenya and Mexico. Even though vocational training schools do exist in most countries, many workers and contractors see formal training as an unnecessary expense rather than an investment [16]. PPEs are designed to protect against health hazards and accidents. Hard hats, safety glasses, safety boots, masks, and aprons are designed to prevent or reduce the severity of injury during an accident. The construction regulation broadly requires that such protective clothing, equipment, or devices be worn "as are necessary to protect the worker against the hazards to which the worker may be exposed" [17]. However, in this study, none of the worker was found to use PPE during work. This could be due to the fact that lack of provision of PPEs from the employer and some of the workers didn't know the importance of different PPEs in prevention and control of exposure to different occupational hazards and injuries in construction site. This study investigated greater chance of occupational injuries in male workers than females [AOR: 2.01, 95% CI: (1.20, 3.37)]. This difference in chance of getting occupational injury between the sexes of workers might be connected with several factors which can increase the risk of injury such as the difference in task (commonly males do harder tasks); work environment, work organization and so on. Construction workers aged ≥ 45 years were 3.16 times more likely to be injured compared to workers in 14–29 years age range [AOR: 3.16, 95% CI: (1.03, 9.64)]. This might be due to the fact that reduced physical capabilities like strength, balance, and processing speed further increase the risk of injury with older age [18]. In contrary, the risk of work-related injury decreased with job satisfaction (AOR=0.55 95% CI 0.34, 0.90). An increasing number of studies have considered job satisfaction as pervasive and influential factor in the occurrence of work-related injuries in the work environment [19]. This could be linked to fact that when the workers do not satisfied with their job, they could not experience meaningfulness, greater responsibility, and better use of their knowledge and skills in their job and such situation leads to decreased safety in their work and increased occupational injuries. Essentially, when job satisfaction is increased, on- task activities are enhanced, leading to greater attention to safety motivation, knowledge, and compliance [20]. Thus, increasing employee job satisfaction could be as important as eliminating physical hazards in the workplace [21]. Consistent with the national databases report from Germany [22], working > 8 hours/day raised the odds of occupational injury by 14.06 folds compared to those who work 8 hours/day [AOR: 14.06, 95% CI: (5.67, 34.86)]. The reason could be explained by the fact that fatigue associated with long hours of work that may increases the likelihood of work related injuries, and that exceptionally long hours may also result in injuries associated with breaching physical endurance limits [23]. Also, workers who did not undergo vocational training on their current work were 2.37 times more likely to have injury than those workers who underwent vocational training [AOR: 2.37, 95% CI: (1.08, 5.22)]. This finding indicates the importance of provision of training in prevention and control of occupational hazards and accidents.

Conclusion

The study depicted that occupational injuries were common among building construction workers in the study area; the prevalence of the injuries were associated with preventable and modifiable factors such as lack of PPE, working overtime, lack of vocational training and workers dissatisfaction with their job. Furthermore, most of the building construction workers in this study were unaware about the presence of occupational health hazards associated with their work and they denied access to personal protective equipments and health and safety trainings. Therefore, counter measures such providing health and safety training and personal protective devices, creating awareness of risk factors, avoiding overtime work and provision of other occupational health and safety services may decrease injuries among building construction workers.

Authors' Contribution

Mesafint Molla: Initiated the research, wrote the research proposal, conducted the research, did data entry and analysis and wrote the manuscript.

Kassahun Alemu: Involved in the write up of the proposal, conducted the research, did data analysis and wrote the manuscript.

Getahun Kebede: Involved in the write up of the proposal, conducted the research, did data analysis and wrote the manuscript.

Hardeep Rai Sharma: Involved in the write up of the proposal, conducted the research, did data analysis, and wrote the manuscript

Walelegn Worku: Involved in the write up of the proposal, conducted the research, did data analysis, and wrote the manuscript.

All authors read and approved the final manuscript.

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Case Report

ANIMAL BITE INJURIES

(CROCODILE AND SNAKE BITE INJURIES) AND MYCETOMA(MADURA)
Djibouti 2014

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Orthopaedic Surgeon HGP(Djibouti)

INTRODUCTION

ANIMAL BITE INJURIES

Background – Since animal bite is not reported, never registered, so the exact incidence is unknown.

In USA let alone the world is difficult in 2012 there were approximately 70 million pet dog and 74 million pet cat in US. Recent report estimates 4.5 million dog bites per year and in2008 this results in 316,000emergency department visits.

Some of the animal bites occurs in different region of the world are different –

Dog/Cat bites
Alligators/ Crocodile
Horses/Donkeys bites
Monitor/Lizards bite
Lion/Tiger bites
Sharks/Swans / Snake bites
Ferrets/Sheep's bites
Jasmaman/Birds bites
Rats/Hamsters /Camels bites etc.

In our hospital patients bitten by different animals were seeking medical help in Orthopedic department are as follows-
Some cases were bitten by _ Crocodiles, snake,camels,and lions and were treated according to the degree of injury.

CROCODILE BITE INJURIES
AT RIVER AWASH In Ethiopia

Crocodile (Alligators) - It is a reptile, live mostly under water. At lake, sea, river, water pools. Crocodile has big teeth and strong jaw that can leads to crush injury, partial or total amputation ofextremity; in addition to the above its teeth can harbor a flourishing resistant bacterial flora.

The bacteria's cultured from crocodile bitewounds includes-
- Aeromonashydrophilia
-Burkholderiapseudomolli
-Clostridium species
-Enterococcus species
-Proteus species
-Pseudomonas aeruginosa
- Fungi species -Cladosporium species

CASE 1
A 7 years old female patient who was presented to our hospital after she was bitten by crocodile to her Lt. upper extremity(arm) at Awash River in Ethiopia. Relatives used herbal medicine and brought her to our hospital after 10days.
On physical examination , she is sick looking with low grade fever otherwise B/P is 95/60mmhg.

HEENT – pink conjunctiva non icteric sclera . The pertinent finding is on Lt. upper arm – there is a crush injury with massive infected degloved wound , broken and exposed humerus bone, no distal arterial pulsation. Motor and sensory at the distal are absent.

Culture was done from the wound site it was found mixed flora of – proteus species and pseudomonas aeruginosa.
Treatment -- After complete preparation of the patient with necessary blood analysis, and covered with antibiotic for microorganism cultured from the wound, Above elbow Amputation was done. Frequent wound care was done, and the patient was discharged with advice to her family, the need to take care of while crossing or wash aside of the river and also to come to hospital immediacy for medical help rather than taking time on herbal medicine.

A 7 years old female child bitten at her Lt. upper Extremity(arm) by crocodile at Awash River.

The Crocodile injury was crushed – she ends in above Elbow Amputation.

See NEXT PAGE...

CASE -2
An 8 years old female patient who presented with injury to her Rt. Side of forearm after she was bitten by crocodile at Awash river 12 days prior to presentation to our hospital.

On Physical Examination , she is sick looking , otherwise her vital sign was stable, the pertinent finding is on Rt. Forearm , it was splinted with bamboo wood, after the splint is removed there was deep wound 4 cm x 3 cm size infected no tissue loss, distal neuro vascular condition was intact.

Some investigation was done- complete blood analysis, x-ray of forearm shows distal Radio- Ulna was broken.
Treatment- IV- antibiotics weregiven, subsequent wound-care, and the fracture was reduced and POP (Plaster) was applied with window for wound care.
After clinical improvement the patient was discharged with further follow up for the fracture,

An 8 years old female child was bitten on her Rt. forearm by Crocodile and got open distal Radio- Ulna fracture.

Reduction and POP (Plaster) was applied for Radio-Ulna fracture with window for wound care.

SNAKE BITE
Snake bite injuries are also common; some cases are presented to our hospital with bitten to lower and upper extremities. It ends with necrotizing tissue .Some ends in limb lost.

Treatment of Snake Bite
Immediate antevenoum prophylaxis is very important.
Antevenoum(antiofivium serum)- 1ampule is diluted in water for injection, then the dilution will be immersed in 5% of 500ml destrose in saline and infuse it IV within 2-3 hours.

Before antevenoum – give
. Anthisthamine(polaramine)
. Hydrocortisone 100mg x 4/day
. Analgesics eg. Perfolgan
-Antibiotics – Penicillin G. possible other broad spectrumantibiotics too. Wound debridement.
-Cheek for coagulation, by analysis of TP, PTT, can be transfused serum or blood as necessary.

CASE
A 4years old female patient, who was bitten by snake on herRt. upper arm at rural area, and the relatives of the child used herbal medicine and at the same time used tourniquet. The patient was brought to our hospital 2 weeks after she lost her Rt. upper arm.

On Physical Examination - she was sick looking, had low grade fever,non-ictericsclera, B/P 90/55mmHg. The pertinent finding is on Rt. Upper arm – it was already amputated, the stump was infected with necrotic tissue visible.

Treatment – the patient was resuscitated with IV fluids and started intravenous broad spectrum antibiotics, ceftriaxone, gentamycin and flagyl.

After the patient was investigated with complete blood analyses corrective amputation was done, and subsequently wound care. After the wound healed she was discharged with advice to her relatives about the danger of snake bite and poison, and the patient should come to health service immediately rather than applying herbal medicine, and
necessaryto wash with tape water with soap rather than applying tourniquet.


A 4 years old female child bitten at her elbow –forearm by snake at rural area.

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TREATMENT OF MYCETOMA (MADURA)

In Djibouti

MYCETOMA(FUNGAL INFECTION)

Mycetoma- is a chronic subcutaneous infection caused by actinomycete or fungi. The infection results in a granulematous inflammatory response in the deep dermis and subcutaneous tissue, which can extend to the underlying bone.
Mycetoma is characterized by the formation of grains containing aggregate of causative organisms that may be discharged onto the skinsurface through multiple sinuses.

Mycetoma was first described in the mid 1800s and initially named Madura foot , after the region of Madura in India , where the disease is first identified.
The causative microorganism is microaerophilicactinomycetes is termed actinomycetoma and myecetoma caused by true fungi is called eumycetoma. More than 20 species of fungi and bacteria can cause mycetoma.

The causative organism enters to the body through sites of local trauma .Aneutrophilicresponsinitialy occurs, which may be followed by granoulomatousreaction, Spread occurs through skin, fascial plans and can involve the bone.

Epidemiology- mycetoma is rare in USA .Some cases are due to increasing international travel. Mycetoma is endemic in Africa… From Sudan and Somalia through Mauritania and Senegal.Other endemic countries - Mcluch, Mexico and India. It can also found in native area of central and south America, and the middle or far east between latitudes 15degree southand 30 degree north.Mycetoma occurs most often in farmers, shepherds Bedouins, nomads and people living in rural areas. Having frequent exposures to penetrating wounds by thorns or splinters is at high risk.

Mycetoma has no racial predilection, male to femal involvement is—M . F --- 183.81 . Most common age prevalence is age between 20 – 50 years.

Mobidity|Mortality

Mycetoma causes disfigurement, but rarely fatal in the absence of skull involvement. Thelesions are painless and slowly progressive, however, secondary bacterial infection or bone expansion may cause pain, In advanced cases deformities or ankylosis and their corresponding disabilities can appear.

CASE PRESENTATION

Introduction

At Hospital General Peltier atOrthopaedic Department within two and half years duration 21 patients with Mycetoma are seen at consultation .

The Mycetomaare localized at different sites in the body. 19-aremycetoma(foot Madura) , 1- hand Madura, and ,1 – case is mycetoma(Madura) of back. All are males between age25 – 46 . From the above mentioned cases 13 patients were treated. The rest patients were not returned after first visit.

Cases

I .FOOT MADURA - 19 Cases

History of progressive swelling on dorsal aspect of the foot(usually unilateral) through years.Characterized by painless subcutaneous nodule, then the skin ruptured and sinus tract formation. In some cases patient complaining of pain.

On Physical Examination – Depend on duration of the illness the size of swelling and the nodule in different patient are not the same. The appearance of grains varies from purple to black. In some cases patients came with superlative –pusy discharge.

Diagnosis

-History
-Physical Examination
-Laboratory – identifying the causative microorganism with hematosylin- eosin stain from biopsy taken.
-Radiology – to visualized wether the bone is involved.

In all cases the bone is involved- multiple lytic lesions or cavities with cortical thinning or periostal proliferation, disuse osteoporosis.

Treatment

Since the patient appear to our hospital very late , when the swelling, illness attains its pick level, where conservative treatment had no result, on other thing the debulking procedure with consecutivereconstruction will not end to its aim of treatment, because the life style of the patient was not able to follow the sequential procedure.

Our option of treatment was Surgical with Amputation proximal to the Madura. With prophylactic antibiotics to minimize surgical wound infection.
No complication after surgery, patient were discharged with health education and rehabilitation, and the use of prostheses.

2. HAND MADURA

Hand Madura – is a fungal infection the same as foot Madura , it is very rare case, seen only one case. The treatment of choice was surgical ,that was below elbow amputation done.

Rt. Hand Madura
(For 42years old male patient)

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3. MYCETOMA(MADURA) ON BACK

Madura on back is very rare case, registered in our Hospital only one case. And the patient is preparing for Surgical Treatment excision and on further skin graft.

Reference-
-Hospital General Peltier
- Medical literatures
-Campbell Orthopaedics
-Internet
-Harrison Medicine

A CASE REPORT ON CONGENITAL PSEU-DOARTHROSIS OF CLAVICLE

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A 6 year old girl presented to CURE Hospital with a mass on the right side of her neck since birth that increased size gradually . No history of trauma recalled by family , no discharges , no other medical illnesses . The mass was painless up until 1 month prior to her presentation when it became painful when touched . No other major complaints .

Physical exam revealed a mildly tender lump on right mid-clavicular shaft that was mobile . No other gross musculo-skeletal abnormalities detected . X-ray of the right clavicle revealed pseudoarthrosis at mid-shaft . The child was operated on done being open reduction and internal fixation of right clavicle accompanied by iliac crest bone graft . Two months post-operation the girl had no lump , no pain , no restriction of right shoulder motion , and x-ray showed right clavicle had good healing progress .

Case Report

Ipsilateral Combination Monteggia and Galeazzi Injuries in an Adult Patient

Ephrem G, Addisu

Abstract
Monteggia fractures represent approximately 1 to 2 percent of forearm fractures,whereas Galeazzi fractures represent 3 to 6 percent. The combination of theseinjuries in the same extremity is an exceedingly rare occurrence. We report acase of ipsilateral combination Monteggia and Galeazzi fractures in an adul tpatient.

Introduction

The Galeazzi injury involving fracture of the distal one third of the radialshaft with a distal radioulnarjoint (DRUJ) subluxation or dislocation has been labeledas a fracture of necessity mandating operative treatment (2-4). Anatomicreduction and rigid internal fixation of the radius with or without stabilizationof the DRUJ is the accepted standard of treatment (3,5,7,8).The Monteggia fracture is classically described as a fracture of the proximal one third of ulna with an associated anterior dislocation of the radial head(1,2,4,7,8). The Monteggia lesion, described by Bado (1), has furtherbroadened the original description of the injury to include any fracture of theulna with an associated disruption of the radiohumeral articulation (2). Thestandard treatment is anatomic reduction and rigid fixation of the ulna withanatomic reduction of the radial head (2,7,8).Monteggia lesions and Galeazzi fractures represent 1 to 2 percent and 3 to 6 percent of forearm fractures, respectively (2,4). Ipsilateral combinationof these injuries is an exceedingly rare occurrence. This case report represents ipsilateral combined Galeazzi and Monteggia fractures in an adult patient.

case Report

A 28-year old cement mixer machine operator was brought to our emergency OPD after 15 hours of sustaining a machine injury . He was operating on the machine and accidentally his Right hand was trapped and spinned by the mixer.He bleed moderately from the site at the scene and was referred to our hospital quickly. On admission the patient was alert, oriented and hemodynamically stable. He was not moving his affected hand except flickering movement of his fingers. He was complaining of severe pain and had agonizing pain on passive stretching. Radiographic examination shows anterior elbow dislocation associated with ipsilateral combined Galeazzi and

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Monteggia fractures and clinically though it was an open facture had signs of compartment syndrome.

He was taken to operating room on emergency hours and thorough irrigation, debridement and standard forearm fasciotomy done with modified extension of the open wound and closed reduction of both the elbow and DRUJ attempted though it is so unstable so immobilized with POP splint and admitted to ward. The following days he was taken to OR again and ORIF done with eight hole DCP plate for the radius and rush pin for the ulna. Open reduction of the elbow and radial head was possible but it was unstable so ligamentous reconstruction was attempted and elbow splinted in most stable position but subsequently control x-ray shows subluxed radial head a[illegible]

Figs 1-5…demonstrating elbow dislocation, ipsilateral Monteggia and Gallezzi fracture dislocation and post operative reduction of the fractures, radial head & DRUJ

DISCUSSION

Ipsilateral combination Monteggia and Galeazzi injuries are an exceedingly rareoccurrence. Several cases in the literature have been previously reported.Shonnard and Decoster (11) reported a case of combined Monteggia and Galeazziinjuries in an eight-year-old boy. This patient was treated with closedreduction and casting with favorable results. Rappold (6) described a patientwith combination Monteggia and Galeazzi injuries treated with open reduction andinternal fixation of the radius and ulna. After reduction and fixation of thefractures, the radial head and distal radioulnar joint reduced and remainedstable. Ring et al. (10), in a series of Monteggia fractures, described apatient in whom a Monteggia fracture was combined with a Galeazzi fracture, butdetails were not addressed.Galeazzi fractures have been described as a fracture of necessity mandatingoperative treatment (3,4,5,8,12).

The fracture ends are not controllable withclosed treatment because of the deforming forces of the brachioradialis,pronator quadratus, and thumb extensors (3-5).Hughston (3) described the actions of these deforming forces. The hand acts as avolar deforming force on the distal fragment. The brachioradialis shortens thedistal fragment on the ulna, and the pronator quadratus also pulls the distalfragment volar and proximal to the ulna. In addition, the thumb extensors cancontribute to further shortening of the radial side of the wrist. Galeazzifractures involve much more than an isolated fracture of the radial shaft.Anatomic restoration of length and alignment to the radius is essential in themanagement of these injuries (3-5,7). Reduction and stability of the DRUJ are then assessed with forearm rotation. If the reduction isstable, the forearm is immobilized in supination for four to six weeks (8,12).If the reduction is thought to be inadequate, stabilization of the DRUJ is necessary.

This can usually be performed with Kirschner wirefixation or open reduction and internal fixation of an ulnar styloid fragment ifit exists. An irreducible DRUJ may have soft-tissueinterposition, most commonly the extensor carpi ulnaris (4,8). Monteggia fractures are those injuries with a fracture of the ulna and anassociated dislocation of the radial head. Monteggia lesions, however, have amuch broader definition and involve any fracture of the ulna with an associatedradial head dislocation (1). The other injury that deserves mention is the transolecranonfracture dislocation of the elbow.This injury, recently described by Ring et al. (9), involves a complexdisruption of the ulnohumeral articulation with the proximal radioulnar jointremaining intact. After further review of this patient's injury radiographs, itwas apparent that the ulnohumeral articulation was intact but the proximalradioulnar joint was disrupted.

The classification system most commonly used forMonteggia injuries is that of Bado (1) and is based on the direction of theradial head dislocation and the apex of the ulna fracture. Monteggia fractures,in the adult, require operative treatment to anatomically reduce the ulna andrestore its length (2,4,8,10). This allows reduction of the radial head andrestoration of the

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radiocapitellar relationship.

Occasionally, open reduction ofthe radial head is necessary because of soft-tissue interposition impedingreduction.The mechanism of injury for a Galeazzi injury is usually the result of a fall onan outstretched hand combined with extreme pronation of the forearm (4,5,8). Itis thought that forced rotation is the primary cause of a Monteggia lesion. Asone falls on an outstretched upper extremity, the forearm is in pronation. Before impact with the ground, a rotational force is transmitted by externalrotation of the arm on the hand. The amount of rotation exceeds the normalamount of radioulnar pronation and results in a fracture to the proximal ulna.This case represents an exceedingly rare occurrence. The patient was noted tohave sustained ipsilateral combination Monteggia and Galeazzi fractures.Anatomic reduction and rigid internal fixation were attempted for bothfractures to enable restoration of radiocapitellar and DRUJrelationships. Post op the patient still has only flickering movements of fingers and sensation is also intact.we report this case while the patient is in the ward on his rehabilitatin.

Conclusion

Eventhough it is a rare entity, there is a possibility of ipsilateral combination of Monteggia and Galeazzi fracture dislocation- and we think that it may be the first of its kind to be reported from our hospital .

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GENERATING A COMPUTER

friendly and the whole process of rating until print-out will be demonstrated.

Results:

The four main causes of Permanent Musculoskeletal disability observed in Civilians remained to be road traffic injuries, Machine injuries, construction related injuries and falls. “error-practice” both in a form of under and over-rating of percentages was observed. Compressive, easy to use, reproducible software is generated. The software is quite interactive and one has only to click and browse through the menus.

The program was tested practically and welcomed by insurance companies, lawyers and doctors rating disability. It has saved the time and burden on the doctors involved in disability rating. The usability of the completed systems, Esp. Muskuloskeletal system were tested and proven to be very effective, reproducible, transparent, consistent, objective and comprehensive, besides time saving. It also has its own separate database. The software is easily updatable and its patent/copy right is in process. Federal Ministry of Health and other major stake holders are involved at all levels of the progress and are expectantly waiting for the launching of the software.

Conclusion:

Rating disability using a simple computer program will save time, will avoid inconsistency and subjective judgments. It creates transparency and protects both patient and doctors from under or over rating. It benefits insuring companies, lawyers and anybody involved in disability rating. It avoids overrating, underrating or possible emerge of corruption.

The way forward is to develop a National Ethiopian standard of disability rating system across the country.

GENERATING A COMPUTER SOFTWARE FOR PERMANENT DISABILITY/IMPAIRMENT RATING.

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Background:

The burden of orthopedic physical permanent disability is very colossal. But at times rating disability using percentage numbers is difficult, laborious and very subjective. This is a three-phased study aimed at assessing the trends in disability, generating a- user-friendly and compressive computer software that assists in evaluating and rating permanent physical disability and finally evaluating the usability of the software programmed. Besides saving time, the software will also create a transparent and uniform system of rating disabilities for insurance claims, fitness assessments, medico legal requests and compensation purposes.

Settings:

Addis Ababa University, Medical Faculty and Technology Faculty & Dr. Biruk's Consult

Methods:

After observing the last two decade's physical disability trends and difficulties in impairment rating in the orthopedic department of the University, a team of the researchers were organized. The team has attended and completed computer programming classes in the university and was certified. This makes easy communication among the researchers. IRB approval for the whole phases of the project is obtained. An extensive disability rating manuals from American Medical Association (Guides), British Disability Guidelines, Canadian, Indian and other four rating formats were analyzed. An Ethiopian original book on Orthopedic Physical Disability and its rating is written by the PI and it is also used as a reference to develop his rating software. All local formats and schemes available were also included.

The whole body was divided into different systems, musculoskeletal being the largest. Each system is then further subdivided into segments like: hand, wrist, forearm, arm… and every loss like amputation, nerve injury, stiffness, contracture…. was rated and programmed. All the body parts and disabilities were included. The software calculates and provides the print-out version of whole person disability figure and the organ specific disability rate. It also adds multiple disabilities in a special way. The program can be easily installed into computers. The software, which is user-

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Federal marsh band gracing ESOT's AluminiumAnniversary at Hilton


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