JOURNAL of ESOT

ETHIOPIAN SOCIETY OF ORTHOPAEDICS AND TRAUMATOLOGY

Annual 2010

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ኢትዮጵያን ሶሳይቲ አፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ

ዓመታዊ 2002 ዓ/ም

የትራፊክ አደጋ፤ የሁላችንም ራስ ምታት

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ORTHOPAEDICS TRAINING IN ETHIOPIA

Referrals of Ethiopian Orthoaedic Patients for Treatment Abroad.

News & Briefs: Orthoaedic Landmarks in 2010

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ኢትዮጵያን ሶሳይቲ ኦፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ (ኢሶት)

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Editorial

At its 6th year very young age, ESOT has committed itself to start a simple publication and expand it gradually. Who knows one day this initiative may give birth to a reputable orthopedic journal?

We, the editorial team have decided to focus on the proceedings of last year's conference and milestone orthopedic activities that happened in 2010. If I call 2010 as been a breakthrough year, you will agree with me in many ways!

You will be reading all of them, but trust me SIGN is our main agenda!

As we are anticipating celebrating the 25th birth day/independence day of the orthopedic department of Addis Ababa University- the only training department in a country of 80 million; it is a timely issue to establish a forum of exchange of views and ideas from all stake holders. This will help to look both backwards and forwards from the current orthopedic position. We hope this small 'book' will do that. I kindly ask all ESOT members, our partners and friends of orthopedics to contribute to this bilingual magazine. We are pleased to present this first edition on ESOT activities to our colleagues and look forward to the discussions, directions and actions it will inspire. The next edition will come in time.

Our government is polishing Ethiopia's History into a good image globally and in light of this, it is our responsibility to polish the orthopedic aspect. Many outstanding achievements are underscored by the health sector (http://www.moh.gov.et/). It is the time that we all collaborate locally, regionally and internationally! Hard work is not enough; we have to work VERY hard! This is an era of networking and collaboration. "Together we stand; divided we fall". "By uniting we stand; by dividing we fall" said George Washington, at the start of the Constitution.

As this is our first work, we welcome any suggestion, especially critics.

Finally, I would like to thank the editorial team and the Oak-tree Communications for working hard in the preparation and publication of this wonderful collection. I thank all interviewees for taking time and our orthopedic department office for letting us use the facility. I extend my special thanks to Jeanne Dillner, SIGN-CEO for helping a lot in this edition.

Enjoy reading and I wish you a most fruitful year,

GOD bless ETHIOPIA.

Biruk L. WAMISHO, M.D, FCS

Editor-in –chief

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በአዲስ አበባ ዩኒቨርስቲ ሜዲካል ፋክልቲ የአጥንት ቀዶ ህክምና ስፔሻላይዜሽን ፕሮግራም 1980 ዓ.ም ተጀመረ። ከዚህ ጊዜ ጀምሮም በተመራቂዎች አማካኝነት በሀገራችን የአጥንት ህክምናን የተሻለ እንዲሆን ከፍተኛ ጥረት ተደርጓል።

በተጨማሪም ከውጭ ሀገር ሰልጥነው የመጡ ኢትዮጵያውያን ባለሙያዎች የበኩላቸውን አስተዋፅኦ ሲያደርጉ ቆይተዋል። እስከ 1995 ዓ.ም ድረስ ባለሙያዎቹ የኢትዮጵያ ቀዶ ህክምና ማህበርና የኢትዮጵያ የህክምና ማህበር አባል በመሆን ሲያገለግሉ ኖረዋል። ከ1995 ዓ.ም ጀምሮ ኢትዮጵያን ሶሳይቲ ኦፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ (ESOT) በሚል የራሳቸውን ህጋዊ ማህበር አቋቁመው እየተንቀሳቀሱ ይገኛሉ። እስከ አሁንም ሀገር ውስጥ እንዲሁም በርካታ በውጭ ሀገር ተምረው የተመረቁ አስፔሻሊስቶችም የማህበራችን አባላት ናቸው።

ማህበሩ በአባላቱ መካከል የሃሳብ፣ የእውቀትና የልምድ ልውውጥ እንዲኖር መድረክ በመክፈት መሰረታዊ የአጥንት ህክምና አገልግሎትንና የአባላትን ሙያዊ ብቃት በማሳደግ፤ ሳይንሳዊ ፅሁፎችን ፤በማዘጋጀት ለህብረተሰቡ የሚሰጠውን የአጥንት ቀዶ ህክምና አገልግሎት ጥራት በመቆጣጠር፤ በሙያው ላይ የምርምር ስራዎችን በማበረታታትና ማቀላጠፍ ላይ እየሰራ ነው። ከዚህም በተጨማሪ መመሪያዎችን በማቀድና በማስፈፀም በሀገራችንና በውጭ ሀገራት ካሉ ማህበራት ጋር ሙያዊ ግንኙነትና ትብብር በማድረግ ከፍተኛ ሥራ እየሰራ ይገኛል።

በተለያዩ ጊዜያት ማህበሩ ብዙ ውጣ ውረዶችን ያሳለፈ ሲሆን አሁን ላለበት ደረጃ እንዲደርስ መስራች የነበሩት የማህበሩ ሥራ አስፈፃሚ ኮሚቴ አባላት ያደረጉት አስተዋፅዎ ከፍተኛ ነበር።ማህበሩ ሠፊ እቅዶችና ራዕይ ያለው ሲሆን መላው አባላቱና ከሙያው ጋር ግንኙነት ያላቸውን በሙሉ በማሳተፍ ህብረተሰቡን ለማገልገል ከምንግዜውም ይበልጥ ዝግጁ ነው።

በዚህም መሰረት በአባላቱ፤በአጋዥ ባለሙያዎችና ደጋፊዎች እንዲሁም በህብረተሰቡ መካከል የምርምር፤ ዓሳብ፤ እውቀትና ልምድ መካፈያ እንዲሆን በማለም ይህ ዓመታዊ መፅሄት የ2002 ዓ.ም የማህበሩን ክንውኖችና አንገብጋቢ ጉዳዮችን የሸፈነ ሆኖ ለመታተም በቅቷል። በዚህ መፅሄት ዝግጅት ወቅት ጊዜያችሁን፤ እውቀታችሁንና ገንዘባችሁን ላበረከታችሁ ሁሉ ማህበራችን ከፍ ያለ ምስጋና ያቀርባል።

“እንደማህበሩ ልጅነት ከሆነ ብዙ ስራ እየሰራን ነው ያለነው::”

ዶ/ር ባህሩ በዛብህ የአጥንት ህክምና ስፔሻሊስት ናቸው:: በጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል ዋና ዳይሬክተር ሲሆኑ የኢትዮጵያን ሶሳይቲ ኦፍ ኦርቶፔዲክስ ኤንድ ትራውማሎጂ ማህበር (ESOT)የወቅቱ ፕሬዚዳንትም ናቸው::

ትውልዳቸው በቀድሞው ከፋ ክፍለ ሀገር ጅማ አውራጃ አዲያካካ በተባለ ቦታ ነው:: ስለአስተዳደጋቸው ሲያወሩ “በድሮ ጊዜ” ተብሎ እንደሚጀመር ተረት ይጥማል:: የመማር እድል ያገኙት በአካባቢያቸው ትልቅ ተሰሚነት በነበራቸው ባላባት ምክንያት ነው:: ባላባቱ የአንድ መቶ ሃያ አምስት ልጆች አባት የነበሩና ልጆቻቸውንም ማስተማር የሚፈልጉ ሰው ስለነበሩ በአካባቢያቸው ትምህርት ቤት እንዲከፈት ምክንያት ሆኑ::

ይህም ለእነ ዶ/ር ባህሩ እና ለሌሎች ዕድለኛ የገበሬ ልጆችም የትምህርት ብርሃን አበራላቸው::

በዚህ መልኩ በዕድለኝነት የተጀመረው ትምህርት በዶ/ር ባህሩ ጥንካሬና በወቅቱም በትምህርታቸው ጥሩ ለነበሩ ተማሪዎች ጊዜው ባመቻቸው ሌላ ዕድል በ1971 ዓ.ም ለከፍተኛ ትምህርት ወደ ሶሻሊስት ኩባ ሄዱ:: በጠቅላላ ህክምና የመጀመሪያ ዲግሪያቸውን እንዲሁም በአጥንት ህክምና እዛው ኩባ ስፔሻላይዝ ካደረጉ በኋላ በ1982 ዓ.ም ወዳገራቸው በመመለስ በተለያዩ ክልሎች፣ በጥቁር አንበሳ እና በጦር ኃይሎች ሆስፒታሎች በሙያቸው ሲያገለግሉ ቆይተዋል::

ከዚያም እ.ኤ.አ በ 2000 ዓ.ም ከሀገር በመውጣት ለሦስት ዓመታት ያህል በሴራሊዮን፣ ቀጥሎም በሩዋንዳና በአፍጋኒስታንም ሰርተዋል::

ዶ/ር ባህሩ በዛብህ ባለትዳርና የሦስት ልጆች አባትም ናቸው:: ከሆስፒታሉ ዋና ዳይሬክተርነት በተጨማሪ በአሁኑ ወቅት የኢሶት (ESOT) ፕሬዝደንት ናቸው:: ስለማህበሩ አጠቃላይ እንቅስቃሴ፣ ዓላማና ተያያዥ ጉዳዮችን በተመለከተ በረከት አለማየሁና መዓዛ ግርማ ከእርሳቸው ጋር አጭር ቆይታ አድርገዋል::

<u>ስለ ኢሶት አመሰራረት ቢገልፁልን?</u>

ማኅበሩ መቼ እንደተመሰረተ ከመናገራችን በፊት፣ ዘመናዊ የአጥንት ህክምና መቼና እንዴት እንደተጀመረ በውል ባይታወቅም ከዓመታት በፊት የተለያዩ ባለሙያዎች በተለያዩ ሆስፒታሎች ይሰሩ እንደነበር አንዳንድ መረጃዎች ይገልፃሉ::

ይሁንና የማህበሩ መመስረት ህጋዊ የሆነው እ.ኤ.አ ግንቦት 1 ቀን 2005 ዓ.ም ነው:: አሁን ስድስት አመት ሆኖታል:: ማህበሩ እንዲመሠረት ዋና እና ትልቁ ሁኔታን የፈጠረው በአዲስ አበባ ዩኒቨርስቲ ሜዲካል ፋከልቲ ውስጥ የአጥንት ቀዶ ህክምና ትምህርት ቤት መከፈቱ ነው:: ሜዲካል ፋከልቲው ምንም እንኳን በዚህ የህክምና ዘርፍ ብዛት ያለው ሙያተኛ በተወሰነ ጊዜ ለማፍራት ባይችልም፤ በሀገሪቱ ባሉ ሙያተኞች አማካኝነት የዚህ ማህበር ምስረታ እውን ሆኗል::

<u>ኢሶት ሲመሠረት ምን ምን ዓላማዎችን ይዞ ነበር?</u>

የእኛ ሶሳይቲ ዓላማዎች በሦስት ነገሮች ላይ የተመሰረተ ነው:: አንደኛ የሀገራችን ህዝቦች የሚያገኙት ህክምና በተሻለና ሳይንሳዊ በሆነ መንገድ እንዲያገኙ ማድረግ የመጀመሪያው ሲሆን፤ ሁለተኛው ከዚህ ሙያ ጋር በሀገራችን ካሉ ችግሮች አንፃር የዚህ ማህበር አባላት በምርምር ዙሪያ ለሀገርም ይሁን ለአለም ጠቀሜታ ያላቸውን ጥናቶች የሚያበረክቱበትን ሁኔታ ማመቻቸት ነው:: ሶሥተኛው ማስተማር ነው::

በዚህ የማስተማር ዕቅድ ላይ የራሱ የሆነ የአጭር፤ የመካከለኛና የረዥም ጊዜ ሂደቶች አሉ:: ረዥሙ ግብ ብቁ ባለሙያዎችን ማፍራት ሲሆን ረዥም ጊዜ የሚወስድ ነው:: የመካከለኛው ደረጃ ግብ ደግሞ ይህን ሙያ ሊያግዙ የሚችሉ የመካከለኛ ባለሙያዎችን አቅም እያዳበሩ ትላልቅ ባለሙያዎችን እንዲደግፉ ማድረግ ነው:: በአጭር ጊዜ ደግሞ አሁን እያደረግን እንዳለነው በዚህ ስራ ላይ በዚህ መንገድ ሊሳተፉ የሚችሉ፤ በሌላ ሙያ የሠለጠኑ ባለሙያዎችን ድጋፍ እንዲሰጡ አጫጭር ስልጠናዎችን መስጠት ነው፤ ማስተማር ነው:: ለምሳሌ የጠቅላላ ቀዶ ህክምና ሀኪሞች፤ ነርሶች፤ የጤና መኮንኖች እንዲሁም ወጌሻዎችን ያካትታል::

ስለዚህ እነዚህ በዚህ ፓኬጅ ውስጥ ነው ያሉት:: እነዚህ ባለሙያዎች በየትም የህክምና ቦታ በሽተኞች በሚመጡ ጊዜ የመጀመሪያ ደረጃ ህክምና ሊሰጡ ይችላሉ:: በእነዚህ ሦስቱ ላይ ነው እየሰራን ያለነው:: ከዚህ ባሻገር የማህበሩን ህልውና መጠበቅ ነው:: እነዚህን ስራዎች የምንሰራው ባለሙያው በሀገሪቱ ባለው የጤና ችግር ላይ የራሱን ተሳትፎ አድርጎ ይህን ችግር በተሻለ መልክ የሚፈታበትን መንገድ በየጊዜው ማመቻቸት እንዲችል ነው::

እንዲሁም ከሌሎች ማህበረሠቦችና ድርጅቶች እንዲሁም ከፖሊሶች ጋር በተለይ አሁን በመኪና አደጋ ዙሪያ ከፍተኛ ስራ እየሰራን ነው :: በመኪና አደጋ ሀገራችን ከአፍሪካ አንደኛ ነች መሰለኝ! በዚህ የመኪና አደጋ ላይ ሦስት የህክምና ሂደቶች ላይ ሰዎችን ለማሰልጠን መስራት አለብን::

በተለይ በሶስቱ የአደጋው ሂደት ሰንሰለቶች ላይ:- እነሱም አደጋው በደረሰበት ቦታ ላይ፣ ህክምና ቦታ ከተደረሰ በኋላ እና ከህክም ቤት ህክምና ጨርሰው ሲወጡ ተመልሰው ራሳቸውን የሚችሉበትን የማገገሚያ ሁኔታ ለማመቻቸት ባለሙያዎችን በማስተማር እየተሳተፍን ነው::

<u>የኢሶት ፕሬዚዳንት እንዲሁም የሆስፒታሉ ዳይሬክተርም ሆነው እያገለገሉ ነው:: ይህንን ኃላፊነት እንዴት ነው የሚያቻችሉት?</u>

የስራው ጫና እየጨመረ ቢመጣም አሁን ባለሁበት የሙያ ማህበሩ ፕሬዚዳንት ሆኜ ሦስተኛ ዓመት ሆኖኛል:: አሁን እኛ ጊዜያችንን ስለጨረስን በሙያው ውስጥ ላሉ ወጣቶችና ጊዜ ላላቸው ሙያተኞች ለመስጠት እየተዘጋጀን ነው:: አሁን ያለው ሁኔታ ከባድ እንደሆነ ይገባኛል:: ያለብኝን ኃላፊነት ለመወጣት የሚገባውን ሁሉ እያደረኩ ነው:: ስለዚህም እኛ ኃላፊነቱን ብንሰጥም ያው አብረን በማህበራችን ያቀድናቸው ተግባራት እስኪፈጸሙ ድረስ አብረን እንሰራለን:: በሌሎች ማህበራዊ ጉዳዮችም አብረን እየተሳተፍን ነው:: ይህንንም የምናደርገው የግድ መደረግ ስላለበት ነው:: በሀገር አቀፍ ደረጃ አንድ የአረጋዊያን ደጋፊ ድርጅት አለ:: እሱንም በፕሬዚደንትነት እየመራሁ ነው:: ህጋዊ እውቅና ተሰጥቶት እየተንቀሳቀሰ ነው:: ዓላማው የኢትዮጵያ አረጋዊያን እድሜያቸው አረጋዊ ደረጃ ሲደርስ እንዴት እንደሚኖሩ ማሰብ ስለሌባቸው ጠቃሚም ተጠቃሚም የሚሆኑበትን ስራ እየሰራን ነው:: ያለው ሁኔታ በጣም አመቺ ባይሆንም ያሰብነው የሚሳካ ከሆነ ብዙ ነገሮችን እናደርጋለን:: በዚህም ጥረታችንን እንቀጥላለን::

<u>የኢሶት አባላት ብዛት ስንት ነው?</u>

ከ40 በላይ እንሆናለን:: ሀገር ውስጥ የተማሩት ከውጭም የሚመጡት፤ ተምረውም ሲጨርሱ አባል ይሆናሉ ብለን እንጠብቃለን:: በተለይም አሁን አሁን ሙያው የሚሰጠውን እርካታ በማየት ብዙ ተማሪዎች ወደ አጥንት ህክምና ትምህርት እየገቡ ናቸው:: አንዱም ይህ ማህበር እየሰራው ያለው ትልቅ ስራ የሙያውን ጥልቀቱን፣ ስፋቱን፣ ውበቱንና ምን ዓይነት ሙያ እንደሆነም ማስገንዘብ እና ለራሳቸውም ለሀገራቸውም እንደሚጠቅም በተለያዩ ቦታዎች በመሄድ ማስረዳት ስለሆነ ለከፍተኛ ትምህርት እያመለከቱ እየተማሩ ይገኛሉ:: ቁጥራቸውም ከምንገምተው በላይ እየጨመረ ነው

ያለው፡፡ የአጥንት ህክምናው ክፍል የአስተማሪዎች ቁጥር እንዲጨምር ጥያቄ አቅርበን ጥያቄው ተቀባይነት አግኝቶ ተጨማሪ የሚያስተምሩ ባለሙያዎች እየተቀጠሩ ነው፡፡ ይህም የማህበራችን ከፍተኛ ጥረት እንዳለበት ነው የሚያሳየው፡፡

ለማህበራችሁ እንቅፋት ሆኖብናል እና ተሳካልን የምትሉት ስራ?

እንግዲህ ከቁጥራችን፣ በሀገራቱም ካለው ሁኔታና የገንዘብ ችግር ጉዳይ እንዳለ ሆኖ እንደማህበሩ ልጅነት ከሆነ ብዙ ስራ እየሰራን ነው ያለነው፡፡

ማህበሩ የጤና ተቋማት ደረጃ ሲወጣ በዚህ ሙያ ላይ ምን ምን መኖር እንዳለበት ስላስገነዘበ በዛ ላይ በሀገሪቱ የጤና ፖሊሲ ውስጥ የሀገሪቱ የጤና ችግሮችን የራሱ አድርጎ ከጤና ጥበቃ ሚኒስቴር፤ ከክልሎች ጋርም እንዲሁም በጤና ዙሪያ ከሚሰሩ ድርጅቶች ጋር አብሮ እየሰራ ነው፡፡ ይህ እንግዲህ ስኬታችን ነው፡፡ ከሁለትና ከሦስት ዓመት ወዲህ በብዙ እየተቀየረ ነው ያለው፡፡

ዋናው ቁም ነገርም የሚቀጥሉት አመራሮች የተሻለ ስራ እንደሚሰሩ በማመን ሁሉም አባላት የማህበሩን ህልውና በመጠበቅ ለመስራት መበርታታችን ነው፡፡

በማህበራችሁ አለማቀፍና አገርአቀፍ ግንኙነታችሁ እንዴት ነው?

አለማቀፍ ግንኙነታችን ጥሩ ነው፡፡

ይህም የእኛ ማህበር ላለፉት ብዙ አመታት በሌሎች የአፍሪካ ሀገራት የነበሩ የትምህርት ሁኔታዎች እዚህም ሀገር እንዲመጡ አድርገናል፡፡ ኤ.ኦ ፋውንዴሽን (AO Foundation) የተባለ በአጥንት ህክምና ላይ በጎ አድራጎት የሚሰራ ዓለማቀፍ ድርጅት ፈንድ አድርጎን እ.ኤ.አ በ2010 ጊዮን ሆቴል የመጀመሪያውን ስልጠና ስብራትን እንዴት ማከም እንደሚቻል ወደ 40 ለሚጠጉ የቀዶ ህክምና ሀኪሞች፤ ነርሶችና የጤና ረዳት ባለሙያዎች ስልጠና ለመስጠት ተችሏል፡፡ በዚህ በያዝነው የፈረንጆች ዓመትም ወደ ሀዋሳ ተጉዘን ለሁለተኛ ጊዜ የሦስት ቀናት ስልጠና በክልሉ ላሉ ባለሙያዎች እንሰጣለን፡፡

በወገኖዎች ስልጠና ዙሪያም ትኩረት እየተሠጠው ነው፡፤ እንዴት ጥሩ አድርገው መስራት እንዳለባቸው ማስተማር የእኛም ትኩረት ነው፡፡ በቀርከሃና በአቡጅዲ እንዴት ስብራትን እና በተለመደው መንገድ ብቻ ሳይሆን በተሻለ መልክ ማከም እንዲችሉ ለማድረግ ለጤና ጥበቃ ሚኒስቴርም የፕሮጀክት ፕሮፖዛል አቅርበናል፡፡ ፈንድም ይሰጡናል ብለን እየጠበቅን ነው፡፡ ገንዘቡ ከተሰጠን በሀገር አቀፍ ደረጃ ብዙ ቦታዎች እየሄድን ልናሰለጥንና የእኛ ኢጋሮች ልናደርጋቸው አቅደናል፡፡

ሌላው በ2012 ዓ.ም ትልቅ ሊባል የሚችል የቀዶ ህክምና ስልጠና እዚህ እንሰጣለን ብለው ቃል ገብተዋል፡፡

እዚህ ላይ የእኛ ባለሙያዎች በሙሉ ተሳታፊዎች ናቸው፡፡

በሌላ ሀገራት የሚሰሩ የወቅቱ ቴክኖሎጂዎችን በሞዴልነት አምጥተው ለእኛ ባለሙያዎች እንዴት እንደሚሰራባቸው ያሳያሉ፡፡ እነዚህን እየተነጋገርን ነው ያለው፡፡ በቂ ዝግጅት ማድረግም ጀምረናል፡፡

ሌላው የእኛ ማህበር በምስራቅ፤ ደቡባዊና መካከለኛው አፍሪካ በአጥንት ህክምና ዙሪያ ከሚሰራ ማህበር ውስጥ አባል የሚሆንበትን ሁኔታ እያመቻቸን ነው፡፡ ተቀባይነትም አግኝቷል፡፡ ኬኒያ ሄደናል፡፡ ኡጋንዳ ሁለት ጊዜ ለማስተማር ሄደናል፡፡

እኛም ከኬኒያ፣ ከኡጋንዳ እና ከኔዘርላንድ ባለሙያዎችን ጋብዘን አምጥተንም ነበር፡፡ ድንበር ተሻግረን በአብሮነት እየሰራን ነው፡፡ ከሌሎችም አቻ የሙያ ማህበራት ጋር ለመስራትም በራችን ክፍት ነው፡፡ ብዙ እቅድ ነው ያለን፡፡

ሀገርም ውስጥ ካሉ ማህበራት ጋር በተለይ ከኢትዮጵያ ሀኪሞች ማህበር ጋር እየሰራን ነው፡፡ በፊት በተራ አባልነት ነበር ተሳትፏችን፤ አሁን ግን ማህበራችን የኢሀማ አባል ሆኖ ከተጠሪነት ይልቅ አሁን በቀጥታ አብሮ እየሰራ ነው፡፡ ከዚህ በፊት ይህ አልነበረም፤ ትልቅ ለውጥ ነው፡፡

ከጤና ጥበቃ ሚኒስቴርም ጋር ተመሣሣይ ስራ እየሰራን ነው ያለነው፡፡ ሚኒስቴር መሥሪያ ቤቱ ከዚህ በፊት ማህበሩን አያውቀውም ነበር፡፡ አሁን ግን እውቅና ከመስጠትም ባለፈ ፈንድ ያደርገናል፡፡ ሌሎችም ስራዎች በጋራ ለመሥራት እያሰብን ነው፡፡ በባህላዊ ህክምናዎች ዙሪያ የምንሰራው ስራም አለ፡፡ ግንኙነቱ ጥሩ ነው፡፡

ህብረተሰባችን የተሻለ ህክምና እንዲያገኝ አገልግሎቱም የተሻለ እንዲሆን ግንኙነቱ ጥሩ ነው፡፡

የአጥንት ህክምና ቴክኖሎጂ በሀገራችን እንዲሁም በዓለም ዙሪያ ምን ደረጃ ላይ ይገኛል?

የአጥንት ህክምና እንደሌሎች ሙያዎች ሁሉ በሌሎች ሀገራት ከፍተኛ እድገት እያሳየ ነው፡፡ እኛ ሀገር ግን አዝጋሚ ነው፡፡ ገንዘብ ያስፈልጋል፡፡ ገንዘቡ ሙያውን ለማሳደግ ብቻ ሳይሆን የተጠቃሚ የመከፈል አቅምም ማደግ አለበት፡፡ አገልግሎቱ ውድ ነው፤ እንደሌሎች አገልግሎቶች አይደለም፡፡ ውድ የሆኑ መሳሪያዎች ስለሚጠቀም እነዚህን ቴክኖሎጂዎች ለማስመጣት አቅማችን አይፈቅድም፡፡

በህክምናው ትምህርት ቤት እንኳን ሙያተኞቻችንን ስናስተምር በሀገራችንና በዚህ ድህነታችን እንዴት አድርገን ማከም እንችላለን ብለን እያሰብን ነው የምናስተምራቸው ::

ያለ ቀዶ ህክምና እንዴት አድርገን ማከም እንዳለብን ነው እያስተማርን ያለነው፡፡ ምክንያቱም ከዚህ ተነስተው ሌላ አካባቢ ሲሄዱ በቂ መሳሪያዎችን ስለማያገኙ በአካባቢው ባለው ነገር እንዴት መስራት እንደሚችሉ በርትተን እያስተማርን ነው፡፡

የኢኮኖሚያችን ማደግ የማህበረሰባችንን የመከፈል አቅም ያሳድጋል፡፡ ለጤና የሚሰጠው እንክብካቤም ይጨምራል፤ አሁን ያሉን ባለሙያዎች በብዛት ጠቅላላ የአጥንት ህክምና ባለሙያዎች ናቸው፡፡ እነዚህ ደግሞ ከተወሰነ ጊዜ በኋላ የ ምንፈልጋቸው ነገሮች በሚመቻቹ ጊዜ በአንድ የአጥንት ክፍል ላይ ብቻ ለምሳሌ የዳሌ አጥንት፤ የጀርባ አጥንት የጉልበት አጥንት ላይ ስፔሻላይዝድ ያደርጋሉ፡፡ ወይም በእነዚህ ላይ ብቻ ይማራሉ፡፡ ይሄንን እያለምን ነው፡፡ እነዚህን ብቻ ሰልጥነው የሚሰሩበት ሁኔታ ይመቻቻል፡፡ ይሄ ደግሞ አገልግሎቱን የበለጠ የተሻለና ጥራት ያለው እንዲሆን ያደርገዋል በዚህ መልክ ነው እይታችን! አሁን ግን ባለንበት ሁኔታ እንዲህ ማድረግ አይቻልም፡፡ሆኖም ግን ቢዘገይም አንዳንድ ቴክኖሎጂዎች ይመጣሉ፡፡ እነሱም በበቂ ሁኔታ አይገኙም፡፡ ሂደት ነው እንግዲህ፤ ጊዜ ነው የሚወስነው፡፡

የሳይን ኔል (SIGN nail) ቴክኖሎጂን እንዴት እየተጠቀማችሁበት ነው?

ይሄ ቴክኖሎጂ ጊዜ ያመጣው ሆኖ እኛም የምናገኘው በእርዳታ ነው፡፡

ቀጣይነት የለውም እንዴ?

አይታወቅም፡፡ አንሰጥም ካሉ ሊቆም ይችላል፡፡ ይህ ቴክኖሎጂ በተለይ ለሦስተኛው ዓለም ሁሉ በነፃ እየታደለ ስለሆነ ነው ህክምናውን እየሰጠንበት ያለነው፡፡ ጥቂት ባለሙያዎች ሠልጥነው እየተሰራበት ነው፡፡ ይሄም ግን ለአደጉ ሀገራት ሳይሆን በማደግ ላይ ባሉ ሀገራት የሚሠጥ ቴክኖሎጂ ነው፡፡

በፊት ከነበረን ግን የተሻለ ነው፡፡ የሚልከውም ክፍል ድህ ሀገራት ሌላ ቴክኖሎጂ ስለሌላቸው ብሎ የሚልከው ነው፡፡ እርዳታው ቢቋረጥ ምን ተክተን እንዴት እንደምንሰራ ከዚሁ ማሰብ አለብን፡፡ ምክንያቱም ከተጀመረ መቋረጥ ወይም መቆም የለበትም፡፡ ሌላ አማራጭ ማሰብ አለብን፡፡ እርዳታውን ብቻ እየተቀበልን እስኪቋረጥ መጠበቅ የለብንም፡፡ የሚተካውን እያሰብን ነው፤ በሰለጠነው አለም ለህክምና የሚጠቀሙባቸው ብረቶች በጣም ውድ ናቸው፡፡ ሰዎች ሰውነት ውስጥ የሚገቡ ብረቶች ስለሆኑ ውድ ማዕድናትን ይጠቀማሉ፡፡ ለዚህም ጥሩ ነገር በአዲሱ የጤና ፖሊሲ መሰረት በጤና ተቋማት ውስጥ የግል ህክምናዎች መጀመር አለባቸው ተብሎ በአዋጅ ስለተደነገገ ምናልባት እርዳታው ቢቋረጥ መክፈል የሚችሉ ሰዎች ሲገለገሉ እርዳታው የሚተካበት ሁኔታ ይኖራል ብለን እናስባለን፡፡ ሙከራዎችም አሉ ለማለት ነው፡፡

በሌላው ዓለም ከስድስት ከሰባትወር በኋላ ቴክኖሎጂው ይቀያየራል፤ አዳዲስ ነገር ይጠቀማሉ፡፡ ይህም ውድ ያደርጋቸዋል፡፡ የእኛም ሙያተኞች በአቅማችን እነዚህን ችግሮች እንዴት በአካባቢያችን ባሉ ቁሶች ተጠቅመው ሙያውን ማዳበርና እንዴት ችግሮችን መፍታት እንዳለባቸው እንዲያስቡም ነው ይህ ማህበር የሚሰራው፡፡ በመሆኑም ሀገር ውስጥ ካለ አንድ የቴክኖሎጂ ባለሙያ ጋር በመተባበር ኤክስተርናል ፊክሴተር (external fixator) የተባለ ለአጥንት ህክምና በጣም ኢጋዥ መሳሪያ በአነስተኛ ዋጋና በቅርብ በሚገኝ ቁሳቁስ ስለተሰራ አሁን መሳሪያዎችን በመሞከር ሂደት ላይ ነን አንዱ ከፍተኛ ጅምርም ይህ ነው፡፡ ባለሙያው የእኛን ችግር እኛው እንዴት መፍታት እንችላለን ብሎ ሌት ተቀን እንዲያስብ ነው የምንፈልገው፡፡

ሁሉም የሚያስብ ከሆነ ችግሩ ይፈታል ብለን እንገምታለን፡፡ በትብብር መስራት እንዳለብን አባላቶቻችን እንዲገነዘቡ በግሌ እፈልጋለሁ፡፡ አዲሱ መመሪያ ለታካሚውም ለባለሙያውም ብሩህ ተስፋ ያለው ነው፡፡ ሁላችንም በጋራ እንድንሰራ ያደርጋል፡፡

እናመሰግናለን!

የትራፊክ አደጋ፤ የሁላችንም ራስ ምታት

በመዓዛ ግርማ

ሄለን ግርማይ(ለታሪኩ ሲባል ስሟ ተቀይሯል) የ26 ዓመት ዕድሜ ያላት የአዲስ አበባ ነዋሪ ናት፡፡ ከባለቤቷ ጋር ሆስፒታል ቆይታ በታከሲ ወደቤታቸው እየተመለሱ ከሳምንታት በኋላ ስለምትወልደው ልጃቸው በደስታ ያወራሉ፡፡ በልጃቸው ስም ጉዳይ ክርክር ገጥመዋል፡፡

“ለልጄማ አሪፍ የመጽሐፍ ቅዱስ ስም ነው የማወጣለት፣” ትላለች ሔለን፡፡

“ከሀገራችን ስም ሳይጠፋ!” እየሳቀ ይመልሳል ባሏ፡፡

“ምን ደህና ስም አለ?”

ከፊታቸው የተቀመጠችው ሴት “አረ ሾፌር ተረጋጋ፤ እንዴ ሰው እኮ ነው የጫንከው” ብላ ሾፌሩ ላይ ጮኸችበት፡፡

የሔለን ባል የቀልድ ፈገግ ብሎ፣ “እንዲያውም ለምን ‘ሾፌሩ’ አንለውም?”

“ሂድዛ! ልጄ መቀለጃህ መሰለህ!”

ከባድ የግጭት ድምፅ ሚኒባሱን አናወጠው፡፡ ሚኒባሱ በጩኸት ተደበላለቀ፡፡ ለማሰብ በሚከብድ ፍጥነት በሔለን አቅጣጫ የሚነባሱ አካል ተጨመታትሮ በደም ተጨመላለቀ፡፡ ከዚያ ወዲህ የሆነውን ማን ያስታውሳል፡፡ የሔለን ባለቤት እንደሆነ ገና በአፍላ ዕድሜው በመኪና አደጋ ሚስቱን እና በጉጉት ይጠብቀው የነበረውን ልጁን በአንድ ቅጽበት ተነጥቋል፡፡

ወጥቶ መግባት ብርቅ የሚሆንበት ጊዜ ላይ የደረስን ይመስላል፡፡ በየማለዳው በየሬዲዮዋችን የምንሰማው የትራፊክ አደጋ መርዶ የምንረግጠው አስፓልት፣ የምንነዳው ተሽከርካሪ፣ የተሳፈርንበት የሕዝብ መጓጓዣ ካሁን አሁን ለአደጋ የሚያጋልጠን እስኪመስለን ድረስ እየሰጋን እንድንኖር የሚያደርግ ነው፡፡ ስጋታችን ደግሞ ሀቅ አለው፡፡ የምንኖረው የትራፊክ አደጋ ከዋነኛ የጤና ችግሮች እና ገዳይ ችግሮች አንዱ በሆነባት አገር ውስጥ ነው፡፡ የትራፊክ አደጋ ከነናችን የቤተሰባችንን አባላት፣ ዘመዶቻችንን፣ ወዳጆቻችንን፣ ወገኖቻችንን እንደ ዋዛ ነጥቆናል፤ ወይ አካል ጉዳተኛ አድርጎ አስቀርቶብናል፡፡

ከአዲስ አበባ ነዋሪ ውስጥ ዘጠና በመቶው እግረኛ ነው፡፡ በመኪና አደጋ ተጎጂነት ቅድሚያውን የሚይዘውም እግረኛው ነው፡፡ ይህንን ጽሑፍ ልፅፍ ሳስብ እንኳን በቅርብ የማውቃቸውና በመኪና አደጋ ውድ ሕይወታቸውን ያጡ ስንቶች ትዝ አሉኝ፡፡

እነዚህ ሰዎች እንኖራለን ብለው ስንቱን ወጥነው ነበር፡፡ እንጂ እንደወጡ መቅረት በሃሳባቸው አልነበረም፡፡ ለመቼም የማይረሳኝና ባሰብኳት ቁጥር እንደአዲስ የምታሳዝነኝ አንዲት ሴት አለች፡፡ ይህቺ ሴት ዕድሜዋን ያጋመሰችው፣ ልጆቿን ያስተማረችውና ጎጆዋን ያቆመችው በጉልት ንግድ ነው፡፡ አንድ ቀን እንደተለመደው የገበያ ውሎዋን ውላ ሲመሻሽ ወደ ቤቷ ለመሄድ ጎደለ ሞላ ስትል ያልጠበቀችው ክፉ ዕድል ገጠማት፡፡ እንዳሰበችው ሰዓቷ ደርሶ ወደ ቤቷ ከማቅናቷ በፊት ምንም እንኳን እሷ ከተለመደው ቦታዋ ባትንቀሳቀስም፤ ያለቦታው የመጣው የአይሱዙ መኪና የዛን ዕለት ማታ ከቤቷ፤ በነጋታው ደግሞ ስትሰራበት ከኖረችበት ቦታ ለአንዴና ለሁልጊዜ አስቀራት፡፡ ይህ እኔ በቅርብ አውቃት የነበረች አንዲት ሴት ላይ ተከስቶ የነበረው አደጋ የተፈፀመው ከዓመታት በፊት ነው፡፡ ሆኖም መልኩን ሳይለውጥ ቁጥሩን ግን ከአንድ ወደ ሃያስምንት አሳድጎ በተጨማሪም ከባድና ቀላል የአካል ጉዳተኞችንም ጨምሮ በአዲስ አበባ ኮልፌ ላይ ተደገመ፡፡ ተጎጂዎቹ ለፍቶ አዳሪዎች፤ ቤተሰብ አስተዳዳሪዎች የነበሩ ሰራተኛ ሰዎች ናቸው፡፡

ዶ/ር ባህሩ በዛብህ ስለዚህ ማናችንም የማይደርስብን ሩቅ ያለ ነገር ስለሚመስለን፤ ነገር ግን በጣም ቅርባችን ስለሆነው ጉዳይ ስንነጋገር የመኪና አደጋ በተለይ እንደኛ ባሉ ታዳጊ ሀገሮች ጉዳት የሚያደርሰው በእንቅስቃሴ ውስጥ ባሉ ሰዎች ላይ ነው አሉን፡፡ “ይህም እኛ ማለት ነን፡፡ ተንቀሳቃሹ ሰው ደግሞ ኑሮን ለማሸነፍ ጠዋት ወጥቶ ማታ የሚገባው ከፍል ነው፡፡ ህፃናትና ሽማግሌዎች ቤት ሊቀመጡ ይችሉ ይሆናል ፤ ሆኖም የእነሱን ፍላጎት ለማሟላትና የኢኮኖሚውን ችግር ለመፍታት ወዲያ ወዲህ የሚሮጠው አብዛኛው ሰው ላይ ነው ጉዳቱ የሚደርሰው፡፡ በሀገራችን ሁኔታ እነዚህ ላይ ጉዳት ሲደርስ ከተጠቂዎቹ ጀርባ ቁጥሩ ይሄ ነው የማይባል ሰው አብሮ ይኖራል፡፡ እነዚያ ሰዎች ደግሞ በእነዚህ በሚንቀሳቀሱ ሰዎች ላይ ጥገኛ ሆነው ያሉ ናቸው፡፡ በዚህም ኢኮኖሚውን የሚያንቀሳቅሱት ሰዎች አደጋ ውስጥ ሲወድቁ በእነርሱ የሚተዳደሩት ሁሉ ከፍተኛ ችግር ውስጥ ይገባሉ፡፡”እንግዲህ ይህም ነው ጉዳቱን እጥፍ ድርብ የሚያደርገው፤ በቀጥታም ይሁን በተዘዋዋሪ ጉዳቱ የማይደርሰው አይኖርም፡፡

በዓለም ዓቀፍ ደረጃ የትራፊክ አደጋ ከአስር ዋነኛ የጤና ችግሮች አንዱ ቢሆንም በተለይ በማደግ ላይ ባሉ ሀገራት ችግሩ እጅግ በጣም የከፋ እንደሆነ የተለያዩ ጥናቶች ያመለክታሉ፡፡ ሀገራችን ኢትዮጵያም በአደጋው የሚደርሰው ጉዳት እጅግ አስከፊ ከሆነባቸው የዓለም ጥቂት ሀገራት አንዷ ናት፡፡ ምንም እንኳን ባደጉት ሀገራት አደጋው በአብዛኛው የሚደርሰው በግል መኪኖች ላይ ሆኖ፣ ዋነኛ ተጎጂዎቹም አሽከርካሪዎቹ ቢሆኑም፣ በሀገራችን የሚታየው ግን የተገላቢጦሽ ነው፡፡ ቀዳሚ የችግሩ ሰለባዎች እግረኞችና የህዝብ ማመላለሻ አውቶሞቢል ተጠቃሚዎች ናቸው፡፡ በዩኤስ አሜሪካና በኢትዮጵያ ያለውን የአደጋ ቁጥር እንደምሳሌ ብናይ በአሜሪካ ከተጎጂዎቹ 60 በመቶ የሚሆኑት አሽከርካሪዎች ሲሆኑ፣ በኢትዮጵያ ግን የአሽከርካሪዎቹ ቁጥር ከጠቅላላው የትራፊክ አደጋ ተጎጂዎች አምስት በመቶ

ብቻ ነው።።

ቀዳሚ የችግሩ ሰለባዎች እግረኞች የሆኑበት ዋነኞቹ ምክንያቶች የአሽከርካሪዎች ለእግረኛ ቅድሚያ አለመስጠት፣ በፍጥነት ማሽከርከር፣ የእግረኛውና የአሽከርካሪው ብዛት ከመንገዶች አቅም ጋር አለመመጣጠን ናቸው።። በእርግጥ አሁን መንገዶች በስፋትና በጥራት እየተሰሩ ቢሆንም ነባር መንገዶች ሆነው ከፍተኛውን የትራፊክ ፍሰት የሚያተናግዱ መንገዶች አሁንም አሉ።። ለአደጋው መብዛት የመንገዶቹ መጥበብ አንድ ምክንያት ሆኖ እያለ አንዳንድ ቦታዎች ላይ ደግሞ እሱም ቢሆን በህገወጥ ንግድ መያዙ እና መጨናነቁ የበለጠ ያከፋዋል።።

ሳጅን አሰፋ መዝገቡ

የአዲስ አበባ ትራፊክ ጽ/ቤት የሕዝብ ግንኙነት ኃላፊ ሳጅን አሰፋ መዝገቡ በከተማዋ አስከፊ የትራፊክ አደጋ ተደጋግሞ በሚደርስባቸው ቦታዎች ማንፀሪያነት የአደጋ መንስዔዎችን ሲያብራሩ “አስከፊ የሞት እና የመቁሰል አደጋ የሚደርስባቸው የከተማችን አካባቢዎች የትራፊክ ፍሰቱ በሚጨምርባቸው እንደ አቃቂ ቃሊቲና ኮልፌ ቀራንዮ ከፍለከተማ ያሉት ቦታዎች ናቸው።። በዓመት ውስጥም ከደረሱ አደጋዎች በርካታ የሞት አደጋ የደረሰውም በእነዚህ ከፍለከተማዎች ነው፣” በማለት ይጀምራሉ።። ሳጅን አሰፋ በአቃቂ ቃሊቲ አደጋው ለምን የከፋ እንደሆነ ሲናገሩ ከሚዘረዝሯቸው ምክንያቶች አንዱና ዋነኛው በአካባቢው መንገዱ ለእግረኞች እንዲመች ሆኖ የተሰራ አለመሆኑና ከፍተኛ የእግረኞችም የትራፊክ መጨናነቅም ያለበት ቦታ መሆኑ ነው።።

“መንገዱ ለእግረኞች እንዲመች ተደርጎ የተሠራ መንገድ አይደለም።። (የእግረኛ መንገድ የለውም) በዚያ ላይ በአንድ አቅጣጫ ሁለት ተሽከርካሪዎች ይጠቀሙበታል።። በእንዲህ ያለ መንገድ የእግረኞች በተሽከርካሪ መንገድ ላይ መጓዝ የተለመደ ነው።። በዚህም ምክንያት አደጋ በተደጋጋሚ ይደርሳል።። ” ከመንገዱ መጥበብና ለእግረኞች አለመመቸት ጋር ለአደጋው መንስዔ የሚሆኑትን ነገሮች ሲጠቅሱም “አቃቂ ብዙ ተሸከርካሪዎች ከተለያዩ ክልሎች የሚገቡበት፣ በእንቅልፍ ማጣት የተዳከሙ፣ ጫት እየቃሙ የሚያሽከረክሩ፣ ሲጠጡ ያደሩ፣ በሌላ በኩል ደግሞ ከፈታቸው ረዥም መንገድ ስለሚጠብቃቸው ከከተማ ለመውጣትም የሚቸኩሉ አሽከርካሪዎች ስላሉ በዚህ ምክንያት ፍጥነት ስለሚኖር በርካታ አደጋ ይከሰታል።። ለእግረኛ ቅድሚያ አለመስጠት ግን ከሁሉም የአደጋ መንስዔዎች ቀዳሚውን ሥፍራ ይይዛል።።”

ሳጅን አሰፋ በተቻለ መጠን አደጋውን ለመቀነስ እየተሞከረ ቢሆንም የመከላከሉ ስራ ብቻ በራሱ በቂ አለመሆኑና ቋሚ የሆነ መፍትሄ የሚሻ ጉዳይ መሆኑንም ይናገራሉ።። ለዚህም ነው የአቃቂ ቃሊቲ መንገድን የተሻለ አድርጎ ለመስራት በመንግሥትም ዕቅድ የተያዘው።። ከአዲስ አበባ ትራፊክ ጽሕፈት ቤት ባገኘነው አሃዛዊ መረጃ መሰረት በመከላከል ስራው በቂም ባይሆን በየዓመቱ የአደጋው መጠን እየቀነሰ ነው።። “መንገዶችን አሻሽሎ ከመስራት እቅድ በተጨማሪ የትራፊክ ፍሰቱ ከፍተኛ በሆነባቸው አካባቢዎች በአራት ኪሎና በጊዮርጊስ የእግረኛ መሻገሪያ ድልድዮች (over pass) ተሰርተዋል።።” ይህ ዓይነቱ መፍትሄ በትንሹም ቢሆን የአደጋውን መጠን ይቀንሰዋል።።

የእግረኛና የመኪና ተብሎ የተከለለው መንገድ ባለበትም ቢሆን ከአደጋ ለመዳን አልተቻለም።። ለዚህ አደጋ ዋና ምክንያት የሚሆነው የግንዛቤ ማነስ እና ድልድይ ላይ ለመውጣት ትዕግስት በማጣት በገዛ ህይወት ላይ የመፍረድ ነገር ነው።። ይህ ሁኔታ ጎልቶ የሚታየው በአደጋ መድረስ ሁለተኛ በሆነው ኮልፌ ቀራንዮ ከፍለ ከተማ በዊንጌት፣ ጦር ሃይሎች እና አየር ጤና አካባቢዎች ነው።። “የእግረኛ መንገድ ተጠቃሚዎች ቀለበቱን እየዘለሉ መሀል ይገባሉ፣ አሽከርካሪዎች ደግሞ ቀለበት መንገዱ ተመቸኝ ብለው በፍጥነት ያሽከረክራሉ።። አንዳንዱ መንገድ ቁልቁለታማ ስለሆነ ሁኔታውን የበለጠ አስቸጋሪ ያደርገዋል” ይላሉ ሳጅን አሰፋ ምን ማድረግ ይቻላል? ዓይነት ጥያቄ ፊታቸው ላይ እየተነበበ።።

በነገራችን ላይ ይህ ቀለበት መንገዱን እየዘለሉ መኪና መንገድ ውስጥ የመግባት ነገር በዕድሜ በፆታ ልዩነት ያለው ነገር አይደለም።። ልጆች፣ ወጣት ሴቶች፣ ወጣት ወንዶች፣ አሮጊቶች እና ሽማግሌዎች ሳይቀሩ እየተንገዳገዱ እየተደጋገፉ ቀለበት መንገድ ሲያቋርጡ ማየት በአዲስ አበባ ብዙም የሚያስደንቅ ትዕይንት አይደለም።። እንደ አደጋው አስከፊነት እና አደጋ ከደረሰ በኋላ እንዳለው ውስብስብ ችግር ግን ይህ እንኳን ሊፈፀም ቀርቶ በአማራጭነት ሊታሰብ የተገባ አልነበረም።። ግን እየሆነ ነው።።

ቀለበት መንገድ ውስጥ እየዘለሉ የሚገቡ ሰዎችን ምክንያታቸው ምን እንደሆነ ለማወቅ የተወሰኑትን ጠይቀን ነበር ፤ የሁሉም መልስ ግን ተመሳሳይ ነበር።። ሁሉም የሚፈልጉት በእግር የሚሄዱትን መንገድ መቀነስ ነው።። ትንሽ በእግር ሔዶ በህይወት (ከእነሙሉ አካል) ከመቆየት እና በስንፍና እና በትዕግስት ማጣት ውድ ህይወትን የአደጋ ስጋት ውስጥ ከመከተት የትኛው ይመረጣል? ምንም እንኳን ለአደጋ መንስኤ የሚሆኑት ምክንያቶች የትየለሌ ቢሆኑም እግረኞች ከፊት እንደመሰለፋችን በእያንዳንዳችን የግንዛቤ ዕጥረትና በቸኮላችን የሚከሰተውን አደጋ ለመቀነስ እስከመጨረሻው መጣር አለብን።።

በሳጅን አሰፋ መረጃ መሰረት በተለይ በአዲስ አበባ የመኪና አደጋ መንስኤዎች ቅደም ተከተል እንደሚከተለው ነው።።

1ኛ. የአሽከርካሪ ስህተት

2ኛ. የእግረኞች የመንገድ አጠቃቀም

3ኛ. የቴክኒክ ብልሽት

4.ኛ የመንገድ ችግር (ለእግረኞች የተመቻቸቸ መንገድ እጥረት)

በሶስተኝነት ደረጃ የተቀመጠው የቴክኒክ ብልሽት ችግር አስተዋጽኦው አነስተኛ ቢሆንም፣ በዚህ ምክንያት የሚያጋጥመው አደጋ ግን በቀላሉ የሚታይ አይደለም።። “የቴክኒክ ምርመራ በዓመት አንድ ጊዜ ይደረጋል።። ተሽከርካሪው በትክክል ተመርምሯል አልተመረመረም ማንም አያረጋግጥም።። መኪናው ይሂድ ሊብሬው ማንም አያረጋግጥም ።። አልፎ አልፎ በተለያዩ ቦታዎች ላይ ድንገተኛ ምርመራ ይደረጋል ካልተሟላ እንዲሟላ ይደረጋል።። የት እንደተመረመረም ይጣራል ።። ከዚያ ባለፈ ግልፅ ጉዳት ያለው ተሽከርካሪ የነዳ ያስቀጣል የሚል ህግ ስላለ ትራፊኮች እሱን ይቆጣጠራሉ።።”

በየዓመቱ የህዝብና የተሽከርካሪዎች ብዛት በፍጥነት ይጨምራል።። ይህም አደጋውን ከሚያባብሰው ምክንያቶች ውስጥ አንኳቢው ጉዳይ ነው።።

ይሁንና አደጋውን ለመቀነስ መፍትሄ ሊሆኑ የሚችሉ ጉዳዮችን በተመለከተ እና አደጋ ከደረሰም በኋላ ተጎጂዎች ስርዓት ያለው ዕርዳታ ሊያገኙበት የሚችሉበት ሲስተምን በተመለከተ የተሰራው ስራ ግን እጅግ በጣም አነስተኛ ነው።።

አደጋ ከደረሰ በኋላ ያለው አሰቃቂ ምስል

አደጋ የታቀደ ነገር ስላልሆነ ተጎጂዎቹ የተዘጋጁ ሰዎች አይደሉም፤ ሁሉም ወደየጉዳያቸው የሚጣደፉ አልፎ ሂያጆች ናቸው።።

የተጎዱት ሰዎች አደጋ ከደረሰባቸው ሰዓት ጀምሮ የሚያስፈልጋቸውን ደረጃውን የጠበቀ ዘመናዊ ህክምና፤ እንዲሁም ማገገሚያ ካገኙ ተመልሰው

ይድናሉ ወይም ጉዳታቸው እንዳይባባስ ለማድረግ ይቀላል፡፡ የዕርዳታው አሰጣጥ ሶስት ደረጃዎችን ማካተት አለበት፡፡ እነዚህም በአደጋው ቦታ(ቅድመ ሆስፒታል ህክምና)፣ ሆስፒታል ከደረሱ በኋላ እና ከሆስፒታል ከወጡ በኋላ የሚደረጉ ዕርዳታዎች ናቸው፡፡

ነገር ግን ከፍተኛው ስህተት የሚጀምረው ገና አደጋው ከደረሰበት ቦታ ጀምሮ ነው፡፡ ምክንያቱም ቅድመ ህክምና የመጀመሪያ ዕርዳታን በተመለከተ አገልግሎቱ በጣም ውስን በመሆኑ አለ ለማለት የሚያስደፍር አይደለም ፡፡ የመጀመሪያ ዕርዳታን በተመለከተ ያለው ነገር የባሰበት ጉዳይ ቢሆንም ቀጥለው ባሉት ሁለቱ ደረጃዎችም ቢሆን የአገልግሎቱ ውስንነት እንዳለ ነው፡፡ ሳጅን ስለመጀመሪያ ዕርዳታ ሲናገር እንዲህ ይላል፡፡ “ የአምቡላንስ አገልግሎት ኋላ ቀር የሆንንበት ትልቁ ነገር ነው፡፡ አሁን እያደረግን ያለነው የማጓጓዝ አገልግሎት መስጠት እንጂ የሰውየውን ደም እያቆምን አክሲጅን እየሰጠን ይዞ መሄድ የለም፡፡ አምቡላንሱ የሚነሳው ከአንድ ቦታ አደጋው የሚደርሰው አቃቂ ቃሊቲ፡፡ ዕድል ገጥሟቸው ሆስፒታል የደረሱ ሰዎች ራሱ ካርድ አውጡ ወረፋ ጠብቁ ሲባሉ ምንም ዓይነት ህክምና ሳይደረግላቸው ህይወታቸው የሚያልፍበት አጋጣሚ አለ፡፡ አልጋ ስለሌለ ወደ ቤት ሄደው በዚያው የሚሞቱ ሰዎችም አሉ፡፡”

የአምቡላንስ አገልግሎት ገና የገፋንበት ጉዳይ ስላልሆነ አደጋ እንደደረሰ በፍጥነት አምቡላንስ የማግኘቱ ነገር የሚታሰብ አይደለም፡፡ “ብዙ ጊዜ በዚያው አደጋውን ባደረሰው ወይም በቅርብ በተገኘ መኪና ነው ተጎጂዎቹ ወደ ሆስፒታል እንዲሄዱ የሚደረገው፡፡

ምንም አማራጭ የለም፡፡” ይህ የባለሙያን እርዳታ የሚጠይቀው ቅድመ ሆስፒታል አገልግሎት ብርቅ ስለሆነ መትረፍ የሚችሉ ስንት ሰዎች እንደዋዛ እንደወጡ ቀርተዋል፡፡

የማደንዘዣ ህክምና ባለሙያው አንስቴዚስት ክብረት አበበ ጠብታ አምቡላንስ የተባለ የግል የአምቡላንስ አገልግሎት ሰጪ ድርጅት መስራችና ባለቤት ነው፡፡ በጥቁር አንበሳ ሆስፒታል በኦፕራሲዮን ክፍል ውስጥ ለ17 ዓመታት ሰርቷል፡፡

በጥቁር አንበሳ በቆየባቸው ዓመታት እንዳስተዋለው አደጋ የደረሰባቸው ቦታዎች ላይ ለተጎጂዎቹ ተገቢ እርዳታ ባለመስጠቱ ተጎጂዎቹ ሆስፒታል ከደረሱም በኋላ የሚሰራውን ስራ የተወሳሰበ እንዲሆን ከማድረጉም በላይ ለሂወት መጥፋትም ምክንያት ነው፡፡ ክብረት እንደሚለው እነዚያን ሁሉ ዓመታት በሆስፒታሉ ኦፕራሲዮን ክፍል ውስጥ ሲያሳልፍ የአንድን ተጎጂ የማገገም እድሉን የተሻለ ለማድረግ የሚቻለው አደጋው ቦታ ላይ በሚደረገው ጥንቃቄ እንደሆነ ተገንዝቧል፡፡

የጠብታ አምቡላንስ አገልግሎትን ሀ ብሎ ሲጀምር ነገሮች የተቃኑ ወይም ተስፋ የሚጣልባቸው አልነበሩም፡፡ ችግሩ እንደ ውቂያኖስ ጥልቅና ሰፊ ነበር፡፡ እሱ እንደሚለው “የሁልጊዜ ጥያቄዬ እኔ ምን ማድረግ እችላለሁ ነበር፡፡ እንደግለሰብ ብዙ ነገሮችን መለወጥ ላይቻል ይችላል፡፡ የእኔ ድርሻ ጠብታን መፍጠር ነው፡፡” ጠብታ አምቡላንስ የቅድመ ሆስፒታል አገልግሎት መስጠት ከጀመረ ሁለት ዓመት ያህል ሆኖታል፡፡ ከችግሩ ስፋት እና ከጠብታ አቅም ውስንነት የተነሳ፣ አስተዋጽኦውም አነስተኛ ነው፡፡ ነገር ግን ጠብታ የአምቡላንስ አገልግሎት በመስጠት ብቻ ሳይገደብ በመላው ሀገሪቱ እየተዘዋረ ለትራፊኮች ስለመጀመሪያ እርዳታ አሰጣጥ ስልጠና በመስጠት በአነሳስ ወቅት መደረግ ስላለባቸው ጥንቃቄዎች ያስተምራል፡፡

ጠብታ አምቡላንሶች ምንም እንኳን ነገሮች አልጋ በአልጋ ባይሆኑላቸውም፤ አገልግሎቱን አቅም እንደፈቀደ ለማዳረስም የተዘረጋ ምንም ዓይነት ዘዴ ባይኖርም፤ ስራውም ከተፈፀመ በኋላ የአገልግሎት ክፍያቸውን ለማግኘት ውጣ ውረዱ ከባድ ቢሆንም፤ “ከትራፊክ አደጋ በኋላ ተጎጂዎችን አፋፍሶ ማንሳት ይቅር” የሚል መፈክራቸውን አንግበው በኢትዮጵያ የተለያዩ ክልሎች እየዞሩ ማስተማራቸውን ቀጥለውበታል፡፡

አንስቴዚስት ክብረት አበበ

ጠብታዎች አፋፍሶ መቅረት ይቅር የሚሉት ድንገት በሚፈጠርብን የአዛኝነት ስሜት ከጥቅሙ ይልቅ ጉዳቱ የሚያመዝን ስህተት ስለምንፈፅም ነው፡፡ እንረዳዋለን ያልነውን ሰው በእርግጥ እረድተነዋል ወይ የሚለውን የሚወስንልን ሳይንሱ ነው እንጂ ያለኝ ቅንነት አይደለም፡፡ ክብረት ስለጉዳዩ ሲያብራራ እንዲህ ይላል “ሰዎችን የመርዳት ስነልቡና ጥሩ ነው፤ ነገር ግን ዕውቀት መታከል አለበት፡፡ ቀላል የሆኑ ነገሮችን ሰዎችን በማስተማር የድንገተኛ አደጋ ምስሉን መቀየር ይቻላል፡፡ ይህን ስንሰራ ሌሎች ሰዎችና መንግስትም ሲተባበረን ደግሞ የበለጠ ይቀላል፡፡ የእኛ ስራ የማይታይ ነው እንዲታይ ለማድረግ መስራት የግድ ነው፡፡”

የአምቡላንስ አገልግሎት ሰጪዎች አደጋ የደረሰበት ቦታ ላይ ሲደርሱ የሚያሳስባቸው ጉዳይ ተጎጂው በህይወት አለ የለም የሚለው ጥያቄ ነው፡፡ ሆኖም ጠብታዎች ከዚህ ያለፉም ጉዳዮች ያሳስቧቸዋል፡፡ “የትኛው ሆስፒታል ነው የሚቀበለን? እዛስ ስንሄድ ምን አለ? ለመተንፈስ የሚያስችል ማሽን አለ? ይህ ሁሉ ሲስተም ባልተዘረጋበት በጨለማ ውስጥ ነው የምንሰራው፡፡”

በእኛ ሀገር ሰዎች እየደሙ ካርድ ለማውጣት የሚታገሉበት ሁኔታ በየዕለቱ በሆስፒታሎቻችን ውስጥ የተለመደ ክስተት ነው፡፡ በሌላው አለም እንዲህ ዓይነት ነገር የለም ህይወትን ማዳን እንጂ ስምና ካርድ አያስፈልግም፡፡ ከአኒስቴሲስት ክብረት እንዳገኘነው መረጃ መንግስት 800 አንቡላንስ ሊያስመጣ ነው ፡፡ ክብረትም የፌደራል መንግስቱ የቴክኒክ ግሩፑ አባል ሆኗል፡፡ ይህ ለውጥ ከብዙ መታገል በኋላ የመጣ ነው፡፡ ክብረት ስለዚህ መልካም ዜና ሲናገር “አንድ ግለሰብ ብቻ ይዞት የሚሆን አይደለም ማሳየትና አብሮ መስራት ግን ይቻላል፡፡ እኔ በዚህ ጉዳይ ላይ ተስፋ አድራጊ ነኝ፡፡”

ጠብታዎች ሶስት አምቡላንስ ነበራቸው ሆኖም ሶስቱም አምቡላንሶች ተጋጭተዋል፡፡ አንዱ ከጥቅም ውጪ ሲሆን ሰውም ተጎድቷል፡፡ የአደጋውን ልክ እንግዲህ በዚህ መገመት ነው፡፡ ችግሩ የቱን ያህልም የከበደ ቢሆንም እነ ክብረት ማንሳት ሳይነስ ነው ማለታቸውንና በአነሳስ ወቅት የሚፈጠረውን ውስብስብ ችግር ለመቀነስም መታገላቸውን ቀጥለዋል፡፡

“አንድ ሊትር የደማና ሶስት ሊትር የደማ ሰው የማገገም ዕድሉ አንድ አይደለም፡፡ ስለዚህ ከደረስን ጀምሮ አንድ ደም ጠብ እንዳትል ማድረግ አለብን፡፡ የመኪና አደጋን በተመለከተ ከባድ ስራ ይጠብቀናል፡፡

እስካሁንም ብዙ ሂወትን የማዳን አስደሳች ታሪኮች አሉን፡፡” ይላል ክብረት ከበዙ ተስፋ ጋር፡፡

አደጋ የደረሰባቸው ሰዎች በሆስፒታል

ዶ/ር አክሊሉ አዛዥ በጥቁር አንበሳ የህክምና ፋክልቲ የድንገተኛ ክፍል ኃላፊ እና በፋክሊቲው ሜዲካል ስኩል የቅድመ ምረቃ ፕሮግራም ተባባሪ ዲን ናቸው የድንገተኛ ክፍሉ ኃላፊ ሆነው እንደመስራታቸው

ወደ ገፅ 11 ዞሯል

ኢሶት እንደ ድልድይ

ወጌሻ Vs ዘመናዊ የአጥንት ህክምና

በመዓዛ ግርማ

ደረጀ ዮሀንስ ይባላል(ለዚህ ጽሑፍ ሲባል ስሙ ተቀይሯል)።

የስምንት ዓመት ልጅና የሦስተኛ ክፍል ተማሪ ነው። እንደሌላው ቀን ሁሉ ከጓደኞቹ ጋር እየተሯሯጠ ሲጫወት ወደቀና እጁ ተጎዳ። ቤተሰቦቹ በመጀመሪያ የመጣላቸው ሃሳብ ደረጀን በሰፈራቸው አለ ወደተባለው ወጌሻ መውሰድ ነበር።ወጌሻው እጁ እንደተሰበረ ነግሯቸው እጁን በቀርከሃ ደግፎ ግጥም እና ጥብቅ አድርጎ አሰረው።

ደረጀ ሲወድቅ ከተሰማው ህመም ይልቅ ሲታሰር የተሰማው ስለባሰበት አምርሮ ቢያለቅስም፣ ልቅሶው ሰሚ አላገኘም። ወደመጀመሪያዎቹ ቀናት አካባቢ እየባሰበት እንደሆነ ቢናገርም፣ ቤተሰቦቹ "እየዳነልህ ስለሆነ ነው የሚያምህ" በሚል ችላ አሉት። ውሎ ሲያድር ህመሙ በድንዛዜ ተተካ። ይሄኔ በቃ ሻረለት ተባለና ተፈታለት። የደረጀ እጅ ግን ጠብቆ በመታሰሩና የደም ዝውውሩ በመቋረጡ ሰበብ ጠቁሮ እና በስብሶ ቀረ።

የደረጀ ቤተሰቦች ዘግይተዋል። ልክ እንዳብዛኛው ኢትዮጵያዊ፣ ዘመናዊ ህክምና የታወሳቸው ነገሮች ከተበለሻሹ በኋላ ነው። የልጃቸው እጅ ከሞተ በኋላ ወደ ጥቁር አንበሳ መጡ። በጥቁር አንበሳ የአጥንት ስፔሻሊስት የሆኑት ዶክተር ብሩክ ላምቢሶ ሁኔታውን እንዲህ ነው የሚያስታውሱት "እጁ ተበላሽቶ ስለነበር የመጣው መቆረጥ ነበረበት፤ ተቆረጠ። አጥብቆ በማሰር ብቻ ብዙ እጆችና እግሮች ተቆርጠዋል። ጉዳቱ ምን እንደነበር በኤክስ ሬይ ስናየው ምንም ዓይነት ስብራት አልነበረውም።

የደረጀ ጉዳት ዝም ተብሎ ቢተው እንኳን በራሱ ጊዜ መዳን የሚችል ነበር። የዛን ዕለት በጣም ነበር ያዘንኩት፤ ምግብ እንኳን ለመብላት አልቻልኩም ነበር። አፍሪካ ውስጥ የስምንት ዓመት ልጅ እጁ ተቆርጦ ያውም ቀኝ እጁ ተቆርጦ ምን ሊሆን እንደሚችል ማሰብ ነው። ድንጋጤው፣ ቆራጣ እየተባሉ ማደጉ የሚያመጣው ከፍተኛ የስነ-ልቡና ቀውስ በጣም ከባድ ነው። የዛን ዕለት በተመሳሳይ ሰበብ የአንዱ ህፃን እጅ የማይታጠፍ የማይዘረጋ ጥቅም የሌለው ሆኖ ሲቀር፣ የሌላው ህፃንም ዕጣ እንደደረጀ መቆረጥ ሆኖ ነበር ::"

በአንድ ቀን የሦስት ህፃናት እጆች በወጌሾች ስህተት ከጥቅም ውጪ ሆኑ። ይሄ የጥቁር አንበሳ ሆስፒታል የአንድ ቀን ገጠመኝ ነው። በወጌሻ ሰበብ በየቤቱ ተበለሻሽተው የሚቀሩትን ወገኖች መገመት ከባድ አይሆንም። እንዲህም ሆኖ ግን ብዙዎች ለስብራቱም፣ ለውልቃቱም ወደ ዘመናዊ ሐኪም በመሄድ ፋንታ ወጌሾችን ሲመርጡ ይስተዋላሉ።

ታዲያ ሰዎች ለምን ወደ ወጌሻ መሄድን ይመርጣሉ?

በ2006 ዓ.ም. (እኤአ) የተሠራ አንድ ጥናት በኢትዮጵያ ሰማኒያ በመቶ የሚሆነው ሕዝብ በዋነኛ የህክምና አማራጭነት የሚጠቀመው ባህላዊ ህክምናን እንደሆነ አመልክቷል። በጅማ ዩኒቨርሲቲ በተሠራው በዚሁ ጥናት መሠረት በተለይ በገጠር የሚኖረው እና ከሀገሪቱ የሕዝብ ቁጥር አብዛኛውን የሚይዘው ሕዝብ ከቀላል እስከ አስከፊ የጤና ችግሮች ሲያጋጥመው ወደ ዘመናዊ የህክምና መስጫ ተቋማት ከመሄድ ይልቅ ወጌሻዎችን፣ ደብተራዎችን፣ ጸበልን፣ ቃልቻዎችን፣ እንዲሁም የቤት ውስጥ ባህላዊ መድኃኒቶችን መጠቀምን ይመርጣል። እንግዲህ በዋና ዋና የኢትዮጵያ ከተሞች ሳይቀር ሰዎች የአካልም ሆነ የአዕምሮ ጤና ችግሮች ሲያጋጥሟቸው በእነዚህ ባህላዊ እና ልማዳዊ ህክምናዎች መጠቀምን የሚመርጡባቸው የተለያዩ ምክንያቶች ቢኖሯቸውም፣ እኛ ግን በወጌሾች ዙሪያ ተወስነን ጥቂቶቹን እናቅርብ።

የመጀመሪያ ምክንያት ተደርጎ በበርካታ የባህላዊ ህክምና (traditional/folk medicine) ጥናቶች ውስጥ የሚጠቀሰው የዘመናዊ ህክምና አዲስ/ እንግዳ ተደርጎ መታየት እና ሰዎች ከማያውቁት ዘመናዊ ህክምና ይልቅ የለመዱትን፣ ከማኅበረሰባቸው ጋር የረጅም ዘመን ቁርኝት ያለውን ወጌሻ መምረጣቸው ነው። "ከማያውቁት መልአክ የሚያውቁት ሰይጣን ይሻላል" የሚለው አባባል በሁሉም ኢትዮጵያዊያን ዘንድ የሚሠራ ይመስላል። ወጌሻዎች እንደ ሁሉም የባህል ህክምና ሰጪዎች በተለይ በገጠራማ አካባቢዎች በህብረተሰቡ ውስጥ ከህክምናነታቸው ባሻገር የሚሰጣቸውም ሚና ከፍ ያለ ነው። የተጣላን አስታራቂዎች፣ የጎሰም ይሁን የቤተሰብ ግጭት አብራጆች፣ ችግር ሲፈጠር ምክር ሰጪዎች በአጠቃላይም የሀገር ሽማግሌዎች ሆነው የሚገኙበት አጋጣሚ ስለሚበዛ እምነት ይጣልባቸዋል። ለዚህም ነው አንድ ሰው ዘመናዊው የአጥንት ህክምና ምንም ያህል ጠቃሚ እንደሆነ ቢያውቅም፣ የአጥንት ችግር ሲገጥመው ግን እናት አባቱን፣ አያት ቅድማያቱን ሲያድንም ሲያበላሽም ወደኖረው የወጌሻ ህክምና የመሄድ ስነልቡናዊ ግፊቱ የሚያይለው።

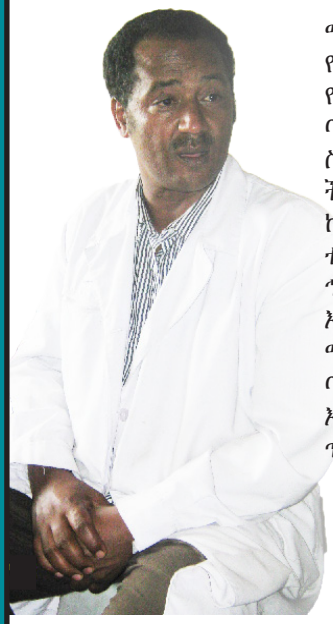
ሁለተኛው ምክንያት ወጌሻነት እንደ አብዛኛው ባህላዊ ህክምና ከእምነት ጋር መተሳሰሩ ነው። በተለያዩ ወገኖች ዘንድ የወጌሻነት ጥበብ ከአምላክ የተሰጠ ተደርጎ ሲታመን ይታያል። ስለዚህ ወጌሻን መጠራጠር ጥበቡን የሰጠውን አምላክ እንደመጠራጠር ሊታይ ይችላል።

ወጌሾች ከዘመናዊ የአጥንት ህኪሞች ይልቅ ቢያንስ በየቀበሌው እንደ ልብ ሊገኙ መቻላቸው ለተመራጭነታቸው እንደ አንድ ምክንያት ሊወሰድ ይችላል። ምንም እንኳን በሀገሪቱ የአጥንት ህክምና የሚሰጥባቸው የህክምና ተቋማት ከቅርብ ጊዜ ወዲህ የባለሙያዎቻቸውን ቁጥር እየጨመሩ

ቢመጡና የተሻለ አቅም ለመፍጠር በከፍተኛ ጥረትም ላይ ቢሆኑም፤ በጎብረተሰቡ ዘንድ ባላቸው ዕውቅናም ሆነ በቁጥራቸው ከወጌሻዎቹ ጋር ሲነፃፀሩ እጅግ በጣም አነስተኛ ናቸው።

ወጌሻው ምን ይላል?

የኢትዮጵያ የአጥንት ሀኪሞች ማኅበር የሆነው ኢሶት የወጌሾቹን ተፈላጊነት እና ተቀባይነት መብዛት የሚመለከተው በአወንታዊ ጎኑ ነው ::



ወጌሻ አበራ ጂማ

ምንም እንኳን በወጌሾቹ እውቀት ማነስ እና በጥንቃቄ ጉድለታቸው የተነሳ እያስከተሉ ያሉት ጉዳት የከፋ ቢሆንም፣ “ያገሩን ሰርዶ ባገሩ በሬ” ነውና፣ ኢሶት በወጌሾች ስህተት የሚመጡትን አስከፊ ችግሮች ቢያንስ መቀነስ የሚቻለው ከእነርሱ ጋር ተቀራርቦ እና በዚህ ተቀባይነታቸው ተጠቅሞ ወደ ጎብረተሰቡ መድረስ ሲቻል እንደሆነ ያምናል። በመሆኑም ማኅበሩ ከእነዚህ የልምድ ባለሙያዎች ጋር ተቀራርቦ እየተማማሩ ለመሥራት የበኩሉን ጥረት ማድረግ ጀምሯል።

ወጌሻነት ዓይነቱ ብዙ ነው። ወጌሾች በአብዛኛው ከአጥንት ውልቃትና ስብራት ጋር በተያያዘ በሚሠጡት የማሸት እና ስብራትን የመጠገን አገልግሎት ይታወቃሉ።

ሆኖም ወጌሻነት ብዙ ዓይነት ባህላዊ ህክምናን ጠቅልሎ የሚይዝ ነገር ነው። አንዳንዶቹ ከማሸት ባለፈ ከሚቀባባ እስከሚጠጣ መድኃኒት ቀምሞ መስጠትን የሚጨምር ህክምና ይሰጣሉ።

ይሄንን ጽሑፍ በምናዘጋጅበት ጊዜ የወጌሻ አበራ ጂማን ህክምና መስጫ ጎብኝተን ነበር። ህክምና መስጫው የተደራጀው አንድ ክሊኒክ በሚደራጅበት ደረጃ ነው። ንፁህነቱን ጠብቆ ለመቆየት ነጭ ቀለም ተቀብቷል። በሞያቸው ነርስ የሆኑ የወጌሻ አበራ ረዳቶች ታካሚዎቹ እንደአመጣጣቸው ቅደም ተከተል እንዲስተናገዱ ለእያንዳንዳቸው ቁጥር በመስጠት ስርዓት ባለው ሁኔታ ስራውን ያስኬዳሉ። ቤቱ መጠነኛ ስፋት ያለው ሆኖ የምርመራ ክፍሉም ለታካሚ የሚመች አልጋ ያለው በወጉ ጓንት አድርገውና በንጽህና ህክምና የሚሰጥበት ክፍል ነው። በእንግዳ ክፍሉ ወደ አስራአምስት የሚጠጉ ታካሚዎች ነበሩ። አብዛኞቹ ተመላላሽ ታካሚዎች ናቸው። ከመሀላቸው ህፃናት፣ ወጣቶች እንዲሁም በዕድሜ የገፉ ሰዎች ነበሩባቸው። ከነገር ሁሉ የደነቀን ግን አንዳንዶቹ ሰዎች የኤክስሬይ ውጤታቸውን በእጃቸው ይዘው ማየታችን ነበር።

ወጌሻ አበራ ነጭ ጋውን ለብሷል :: ታካሚዎቹ በእንግዳው ክፍል ውስጥ በወረፋ ደረሰኝ አልደረሰኝ እየተቁነጠነጡ እንዳለ ነው በመሐል ያነጋገርነው።

እንደ አብዛኞቹ ወጌሾች ሁሉ እሱም ዕውቀቱን የተማረው ከአባቱ ነው። እንዴት እንደጀመረ እያስታወሰ እንዲህ አለን “ገና የመጀመሪያ ደረጃ ተማሪ ሆኜ ነው አባቴን በማየት እና በማገዝ ሥራውን የጀመርኩት። ሁለተኛ ደረጃ ስደርስ ከፍተኛ ፍላጎት ስለነበረኝ ሙሉ በሙሉ ገባሁበት።”

ወጌሻ አበራን ስለወጌሻነት እና ሲሰራ ስለኖረው ስህተት እና አሁንም ስለሚሰራው ስህተት ጠየቅነው። ለስሙ ተብሎ ብቻ ሳይሆን ከተሰራ ሥራው በትክክል መሠራት እንዳለበት እንደሚያምን ነገረን። ከፍተኛ ችግር እየፈጠረ ነው ብሎ የሚያስበውም ለወጌሻነት ምንም ዓይነት መለኪያ አለመኖሩ ነው። “ወጌሻ ሲባል በጅምላ መውቀስ ሳይሆን መለኪያ ተሰርቶ ማነው ጥሩ? እንዴት ነው የሚሠራው? ብሎ ጠይቆ አሻሽሎ የሚሠራበት ነገር እንዲኖር ተባብሮ መሥራት ያስፈልጋል።” ይላል። በግል ልምዱ ህክምናውን በተቻለ መጠን የተሻለ ለማድረግ ብሎ በመጀመሪያ ጉዳቱ በእሱ አቅም ለመሠራት የሚችል መሆኑና አለመሆኑን ለመለየት እንዲሁም ስብራትም ከሆነ እንዴት እንደተሰበረ ውልቃትም ከሆነ ደግሞ ወዴት እንደወለቀ ለማወቅ ኤክስሬይ ያዛል። ይሄ የጉዳቱን ዓይነትና መጠን ለማወቅ ቀላልና በልምድ በዓይን እያዩ ወይም በእጅ እየዳሰሱ ከመገመት የተሻለ ዘዴ ነው። የችግሩ መታወቅ ህክምናው በሚሰጥበት ጊዜ የህመምተኛውን ስቃይ ለመቀነስ እንዲሁም ሙሉ በሙሉ በራስ በመተማመን ለመስራት ጠቃሚ ነው።

“ለሦስት ጊዜ ያህል የኤክስሬይ ውጤት እንዲያመጡ አደርጋለሁ። በመጀመሪያ ተጎድተው እንደመጡ፣ ሁለተኛ ህክምናው እንዴት እየሄደ እንደሆነ ለማወቅና በመጨረሻ ህክምናው ሲጠናቀቅ ሙሉ በሙሉ ድነው እንደሆነ ለማረጋገጥ። ማወቁ ለታካሚዎቹም ቢሆን የተሻለ ነው።”

ወጌሻነት መስፈርት ኖሮት አሁን ‘ለወጌሻነት ብቁ ነህ/ሽ’ ተብሎ ዕውቅና የሚሰጥበት ሞያ አይደለም። በአጋጣሚና ከወጌሻ ቤተሰብ በመወለድ ከትውልድ ወደ ትውልድ ሲተላለፍ የኖረ ዕውቀት ነው። ለቁጥጥር የሚያመች ምንም ዓይነት የተዘረጋ ዘዴም የለም። ተቋቋሞ የነበረው የወጌሻዎች ማህበርም በተለያዩ ችግሮች ስለፈረሰ አሁን እንደአዲስ ተደራጅቶ ለመቋቋም እየተሞከረ እንደሆነ ነው ወጌሻ አበራ የሚናገሩት። በዚህም ምክንያት ሃይ ባይም ስለሌለ እንደየወጌሻው ልምድና ኃላፊነት የመሰማት ነገርም የሚሰራውም ስህተት ልዩ ልዩ ነው። አንዳንድ ጊዜ በእነሱ አቅም ጨርሶ የማይሞከረውን ቀላል ነው ብለው ሲሞክሩ የሁልጊዜ ጉዳት በሰው ላይ እንዲደርስ ሰበብ ይሆናሉ። እንደ ደረጀ ያለምንም ህክምና ቢተው እንኳን በራሱ ጊዜ የሚድነውን ጉዳት ሳይቀር በእነሱ ግድየለሽነት ገና ከጠዋቱ አካሉ ጎድሎ እንዲኖር ምክንያት ይሆናሉ።

ወጌሻ አበራ ጂማ ባህላዊውን የወጌሻ ህክምና በዘመናዊ የህክምና ዘዴዎች መደገፍ እንደሚያስፈልግ ይናገራሉ። በህክምና መስጫ ቦታው ያየነውም ይህንኑ አፍ አውጥቶ የሚናገር ሁኔታ ነው።

“ወጌሻነትን ከዘመናዊው ህክምና ጋር ማስታረቅ ይበጀናል”

ወጌሻነት ሞያ ሆኖ በስፋት እየተገለገልንበት ያለነው ባላደጉ ሃገራት የምንገኝ ደሃ ሕዝቦች ነን። ባደጉት ሃገራት ወጌሻነት ታሪክ ሆኗል። እርግጥ ወጌሻነት ጥቁር ታሪካቸው ነው ማለት አይደለም። ዘመናዊው ህክምና ይህንኑ ጥበብ ተመርኩዞ በጣም ስለተራቀቀና

ለሕዝቡም በሙሉ ስፋትና ጥራት ለመድረስ ስለቻለ የወገሻዎች ሚና ከጊዜ ጋር ያበቃለት ጉዳይ ሆኗል፡፡
ወደ እኛ ስንመለስ ግን በጣም ገና ነው፡፡ አሁንም ቢሆን የአጥንት ስፔሻሊስት ዶክተሮቻችን ቁጥር በጣም አነስተኛ ነው፡፡ እንዲሁም ከበድ ያለ ጉዳት በገጠመ ጊዜ ከድፍን ሀገሪቱ ሁሉና በከተማው ውስጥም ቀላልም ሆነ ከባባድ አደጋዎች ሲያጋጥሙ ሁሉም የሚመጣው ጥቁር አንበሳ ወዳለው ብቸኛ ዲፓርትመንት ነው፡፡ እንግዲህ እዚህ ጭንቅንቅ ላይ ነው በወገሾች ስህተት በሚፈጠር ጉዳት ምክንያት የታካሚው ብዛት አቅምን የሚፈታተን ጫና የሚፈጥረው፡፡
ዕድገቱ ጊዜውን ጠብቆ እስከሚመጣና ዘመናዊው ህክምና በስፋትና በጥራት መዳረስ እስከሚችል የወገሾች ጥቅም አሌ የሚባል አይደለም፡፡ ለዚህም ነው ኢሶት ተቀራርቦ መሥራቱ ያለውን ፋይዳ ተረድቶ ለወገሻዎች ሥልጠና ለመስጠት የጀመረው እና ገናም በስፋት ሊቀጥልበት የሚሻው፡፡ የአጥንት ህክምና ስፔሻሊስቱ ዶክተር ብሩክ ላምቢሶ ይህን የኢሶትን ፍላጎት እና ጥረት ሲያስረዳ “እንግዲህ እዚህ ሀገር ሁሌም የሚቀድመው ወቀሳ ነው፡፡ ነገር ግን እኛ እሱን ወደ ጎን ትተን ሥራውን መሥራት አለብን፡፡

በተደጋጋሚ የሚያጋጥሙ የወገሻ ስህተቶች

ህክምናውን በንፅህና ባለመስጠት ምክንያት ተሃዋሲያን ወደ አካል ውስጥ እንዲገቡና ህይወትን እስከማጥፋት ጠንቅ የሚሆኑበት እድል እንዲኖር ማድረግ

መገጣጠሚያን ለሥራ ምቹ ባልሆነ መንገድ በማሠር በቶሎ ህክምና ካልተደረገ በቀር ስለሚደርቅከአገልግሎትውጪ(የማይታጠፍ የማይዘረጋ) እንዲሆን ማድረግ፡፡

ከመጠን በላይ አጥብቆ በማሰር የደም ዝውውር እንዲቋረጥ ምክንያት ስለሚሆን ለብዙ እጆችና እግሮች መቆረጥ ሰበብ መሆን፡፡

በኃይል (በከፍተኛ ጉልበት) በመጠቀም ህሙማኑ ላይ ተጨማሪ ስቃይ ማብዛት፡፡

ከአቅማቸው በላይ የሆነ ጉዳትንም በድፍረት በመሥራት ታማሚውን ለከፋ ጉዳት ማጋለጥ

ኃላፊነትም ስለሚሰማን ከወገሻዎች ጋር ለመሥራት እየተንቀሳቀስን ነው” ይላል፡፡ ዶክተር ብሩክ ልክ ከልምድ አዋላጆች ጋር እንደተሰራውና የብዙዎችን ሕይወት ማትረፍ እንደተቻለው ሁሉ ከወገሻዎች ጋር በመስራትም ከብዙ ጥፋት መዳን እንደሚቻል ያምናል፡፡ “ነጂ ባህልን እንደምንከላከል ሁሉ፤ ፊስቱላን እንደምንዋጋው ሁሉ ይሄም ጉዳይ መላ መባል አለበት፡፡ ተለምዷዊው እና ዘመናዊው ህክምና የሚያቀራርብ ድልድይ ተበጅቶላቸው መታረቅ አለባቸው” ይላል፡፡
በዘህ ሂደት የመጀመሪያው ሥራ ወገሾቹን ስህተቶችን እንዴት መቀነስ እንደሚችሉ የማንቃት ሥራ ነው፡፡
በዚህ ረገድ በደቡብ ክልል የተሞከረው ሥልጠና ያስገኘው አበረታች ውጤት በምሳሌነት ሊጠቀስ ይችላል፡፡ በአንድ ጥናት መሠረት ለወገሻዎቹ የአንድ እና የሁለት ቀን ሥልጠና ከተሰጠ በኋላ ለጥናቱ በተመረጠው ቦታ በወገሾች ስህተት ያጋጥም ከነበረው የጋንግሪን ችግር በ68 በመቶ ቀንሶ ታይቷል፡፡ የማንቃቱ ሥራ ወገሻዎች ላይ ብቻ የሚሰራ ነገር አይደለም፡፡ ሕብረተሰቡ ለወገሻዎች ያለውን አመለካከት ማስተካከል ሁሉ ሌላ ራሱን የቻለ ፈተና ነው፡፡ ይህንን የአመለካከት ጉዳይ በተመለከተ የዶክተር ብሩክን የቅርብ ጊዜ አጋጣሚ እናስታውስ “የትም ይሁን የትም ጋንግሪን ከሆነ አይመለስም፡፡
የሰውን ሕይወት ለማትረፍ የተበላሸውን የአካል ክፍል እንዲወገድ ሲደረግ ውጪ የሚወራው ሌላ ነው፡፡
በእርግጥ ይሄ ከአለማወቅ የሚመጣ ነገር ነው፡፡
በቅርቡ አንድ በወገሻ ምክንያት እግሩ የተበላሸ ሰው መጣ፡፡ የሞተውን አካል ከጤነኛው ማስወገድ ያስፈልጋል፡፡ ‘ይቆረጥ’ ማለት በጣም ከባድ ነው በተለይ ለሕፃናትና ለወጣቶች ሆኖም ሂወት አደጋ ላይ ሲወድቅ ሌላ አማራጭ የለም፡፡ ‘ይቆረጥ’ አልኩት፡፡ ‘ወገሻው ይቆርጡሃል ሲለኝ እኔ መምጣቴ’ ብሎኝ እንደ ጠላት ቆጥሮኝ ሄደ፡፡ የዚህ ሰው መጨረሻ ያው ሞት ነው፡፡ ” ጥቁር አንበሳ ቆራጭ፣ ወጌሾቹ ግን ለማዳን የሚታገሉ ተብለው ይታሰባሉ፡፡
እውነቱ ግን ሌላ ነው፡፡ በታማሚዎቹ መዘግየትና በወገሻዎቹ ሥህተት ምክንያት ከጥቅም ውጪ የሆነ አካል ይዘው እየመጡ ሕይወታቸውን ለማትረፍ የሚደረገው የመጨረሻ አማራጭ ሌላ ስም ያሰጣል፡፡
ይቆረጥ ሲባሉ አሻፈረኝ ብለው ከሚሄዱትም ሰዎች በተቃራኒ ያሉትንም ሰዎች ቢሆን ማሳመን ከባድ ነው፡፡
ሰው ሠራሽ አካል የተገጠመላቸውን ሰዎች እንዲያዩ በማድረግ በብዙ መከራ የሚስማሙ መሆኑን ዶክተር ብሩክ ይናገራል፡፡

ያለስቃይና በሰላማዊ ሁኔታ መታከም

በወገሻዎች ህክምና የዕድሜ ልዩነት እና የጉዳት መጠን ያንን ያህል የታሰበባቸው ጉዳዮች አይደሉም፡፡ በተለይ ህፃናት (ከአራስ ቤት ጀምሮ ያሉትን ያጠቃልላል) ስቃያቸውን ተናግረው ለማስረዳትም ስለማይችሉ ጉዳታቸው የከፋ የሚሆንበት አጋጣሚ ብዙ ነው፡፡
ወገሻ አበራ ስለራሳቸው ልምድ ሲያወሩ ችግሩ ከታወቀ በአንድ ህመምተኛ ላይ የሚጠፋው ጊዜ አንድ ደቂቃ እንኳን እንደማይሞላ ይናገራሉ፡፡ ይሁንና አብዛኞቹ ወገሾች በማሸት የሚያጠፉትት ጊዜ ረዘም ያለ እንደሆነ ይታወቃል፡፡ ዶክተር ብሩክ በወገሾች ስለሚያባብሱት ስቃይ ሲያብራራ “አንዳንዱ ጉዳት ከውጪ ሲታይ ምንም ላይመስል ይችላል ከውስጥ ግን የተገመጠ ቁስል እንዳለ ዓይነት ነው፡፡ ያንን ማሸት እንግዲህ እንዴት ያለ ጉዳት እና ስቃይ ሊያስከትል እንደሚችል መገመት ነው፡፡ ተሰብሮ ተነቃነቀ ማለት ህመሙ ያሳብዳል፡፡ አንዳንዶቹን ሾክ ውስጥ እስኪገቡ ድረስ ነው የሚያሳብዳቸው፡፡”
ወገሻዎች ማደንዘዣ ለመጠቀም ዕውቀትም ብቃትም የላቸውም፡፡ ምንም እንኳን ዘመናዊውን ህክምና በስፋት ለማዳረስ የአቅም ጉዳይ ዋና ዕንቅፋት ቢሆንም ዘመናዊው አማራጭ ሰዎች ያለስቃይና በሰላም የሚታከሙበት መንገድ ነው፡፡ የጥቁር አንበሳ ሆስፒታል ሜዲካል ዳይሬክተር የሆኑት ዶክተር ባህሩ በዛብህ በቡኩላቸው “በ21ኛው ክፍለ ዘመን የሰው ልጅ ሳያመውና ሰላማዊ በሆነ መንገድ መታከም አለበት፡፡ ሲሰቃዩ የሚሞቱ ወይም አእምሯቸው የሚነካ ሰዎች ይኖራሉ፡፡ ” ይላሉ፡፡ በመሆኑም ወገሻዎች ያለልክ ማሸትና አጥብቆ ማሰርን በመተው ብቻ እንኳን ብዙ ስቃይ ሊቀንሱ እንደሚችሉ ነው የሚታመነው፡፡

መልስ የሚሻ ጥሪ

የኢሶት አባላት ባለፈው ዓመት ተደርጎ በነበረው ዓመታዊ ስብሰባቸው ላይ መሪ አጀንዳቸው ሆኖ የነበረው ከወገሻዎች ጋር አብሮ መስራት ስለሚቻልበት ሁኔታ መወያየት ነበር፡፡ ያሰቡትን ያህልም ባይሆን በተወሰነ ደረጃ ተሳክቶላቸዋል፡፡ ከስብሰባው በኋላም በደቡብ ኢትዮጵያ ለሚገኙ ወገሻዎች ለስድስት ወራት ያህል መሰረታዊ ሥልጠና ለመስጠት ችለዋል፡፡ በወደፊት ዕቅዳቸውም አዲስ አበባን ጨምሮ በድፍን ሀገሪቱ ከወገሻዎች ጋር ተቀራርቦ የመስራት ዓላማ ይዘዋል፡፡
በዘመናዊውም ሆነ በባህላዊው(ተለምዷዊው) የአጥንት ህክምና የሁለቱም ጎራ አብይ ዓላማ የተጎዱ ሰዎችን መርዳትና ወደ ጤንነት መመለስ ነው፡፡ ስለሆነም የአብረን እንስራ ጥሪው ሁለቱም ወገኖች ለቆሙለት ዋና ዓላማ ዕውን መሆን የሚያግዘው ነገር ብዙ በመሆኑ ቀናነቱን ከወገሻዎቹ እንደማያጡት እርግጠኞች ናቸው፡፡ ወጌሾቹም በበኩላቸው ሳይንሱ እጅግ ውስብስበና ህክምናውም እየተራቀቀ መሆኑን ስለሚያውቁ ባላቸው ዕውቀት ላይ ለመጨመር እንደሚፈልጉ ይህን ጽሑፍ ስናዘጋጅ ያነጋገርናቸውና እንዲሁም የኢሶት አባላት እስካሁን በሞከሩት ነገር አረጋግጠውልናል፡፡ ዶክተር ብሩክ ‘ይህቺን ነገር እንኳን አንተ ብታያት ይሻላል’ የሚል መልዕክት አስይዘው በሽተኞችን የሚልኩ አንዳንድ ጥሩ ወጌሾች ሁሉ እንደገጠሙት ይናገራል፡፡ ይሄም አብሮ ለመስራትና አቅምን የማወቅንም ነገር የሚያሳይ በጎ ምልክት ነው፡፡
በየሰፈሩ ቢያንስ ቢያንስ አንድ አንድ ወገሻ አለ ተብሎ እንደመገመቱ ስራው ብዙ ልፋትና ትዕግስትን የሚጠይቅ ነው፡፡ ይህንን በማሰብ ግን የኢሶት አባላት መዳከምን አይመርጡም፡፡ ማንኛውንም የተጨበጠ ውጤት ለማምጣት ስራው መጀመር እንዳለበት ስለሚያውቁ የሚደነቅባቸውም ቢበዛ፣እንዴት ብላችሁ ብላችሁ ከወገሻዎች ጋር ስብሰባ ትቀመጣላችሁ ቢባሉም ያሰቡትን ለመፈፀም በአጭር ታጥቀዋል፡፡ ደግሞም በአንድ ዕለት በወገሾች ስህተት ሶስት ህፃናት ለዕድሜ ልክ ጉዳት የሚጋለጡበትን ሁኔታ መለወጥ መቻልም ትልቅ ቁምነገር ነው፡፡ እንደ ደረጀ ያለው ተሯሩጦ ያልጠገበ ህፃን በዕውቀት ማነስ ሰበብ ያልተሰበረ እጁ ተሰብሯል ተብሎ፤ እንዲሁ ቢተው የሚድንለትን ቀኝ እጁን እንደዋዛ ተቆርጦ ሲወድቅ እየታየ እንዴት ዝም ለማለት ይቻላል?
ያልተነገሩ ብዙ ስህተቶችና ታሪኮች አሉን፡፡ ሆኖም አሁን ለምን ስህተት ተፈጠረ በማለትና በመወቃቀስ የሚባክን ጊዜ የለም፡፡ አሁን እንዴት ስህተት እንደሚፈጠር እንዲታወቅና ያንንም ለማሻሻል ሁሉም እንደሞያው እንዲተጋበት የተገባ ጊዜ ነው፡፡

ቅዳሜን በበጎ ፈቃድ ህክምና

መስፍን ከበበው

በጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል ከፍተኛ የአጥንት ቀዶ ህክምና የሚያስፈልጋቸው ታካሚዎች መቀበያ ከረዥም ወረፋ ፀድቶ አያውቅም፡፡ የታካሚውን ቁጥር ከመጨመር የማያቆመው በየጊዜው በየቀኑ የሚደርሰው የአደጋ ብዛትና ጥቁር አንበሳ ሊያስተናግደው የሚችለው የታካሚ ቁጥር የሚደራረስ አለመሆኑ ነው፡፡ በመደበኛው የሆስፒታሉ የህክምና ጊዜያት ለመጣው ታካሚ ሁሉ አገልግሎቱን ማዳረስ ከአጥንት ህክምና ዲፓርትመንቱ አቅም በላይ ነው፡፡ የዲፓርትመንቱ ሐኪሞች ግን በየቀኑ የሚያዩት የታካሚው ስቃይ እንዲሁም በቀጠሮ መራዘም ምክንያት ሊደርሱ የሚችሉ እስከ ሞት የሚደርሱ ችግሮች ለአእምሯቸው እረፍት አልሰጥ አሏቸው፡፡ ይሄ የህሊና ጥያቄ በሐኪሞቹ እና በአጋሮቻቸው ዘንድ በወለደው ቅን ሐሳብ ምክንያት ሐኪሞቹ የእረፍት ቀናቸውን ለወገናቸው ሰውተው በየሳምንቱ ቅዳሜ፣ አልፎ አልፎም እሁድ በተለያዩ አደጋዎች ምክንያት ከፍተኛ ጉዳት ለደረሰባቸው ታካሚዎች የአጥንት ቀዶ ህክምና አገልግሎት በነፃ መሰጠት ተጀመረ፡፡ ይህ አገልግሎት የሚሰጠው በአጥንት ቀዶ ህክምና ባለሙያዎቹ ሙሉ ፈቃደኝነት ሲሆን፣ በሰንበት ገበተው ለሚሰጡት አገልግሎት የሚያገኙት ክፍያ ቢኖር ታካሚዎቻቸውን በመታደጋቸው የሚሰማቸው እርካታ ብቻ ነው፡፡

የቅዳሜው የበጎፈቃድ ህክምና አገልግሎት የተጀመረው የዛሬ ሁለት ዓመት ነበር፡፡ ለመጀመሩ ምክንያት የነበረው በወቅቱና ከዚያም ወዲህ በከፍተኛ ሁኔታ እየጨመረ የመጣው የድንገተኛ አደጋ ብዛት በጥቁር አንበሳ ሆስፒታል የድንገተኛ ክፍል የፈጠረው ጫና ነበር፡፡ ይህ የቅዳሜ በጎ ፈቃድ አገልግሎት በተጀመረበት ወቅት ወደ ህኪም ቤቱ የሚመጣው የአደጋ ሰለባ ቁጥር በመብዛቱ ቀድሞ የመጣው ታካሚ አገልግሎት ሳያገኝ ሌላ ታካሚ እየመጣ ሁኔታውን መቆጣጠር የበለጠ አስቸጋሪ ሆኖ ነበር ፡፡ በመሆኑም ታካሚዎቹ ወደ ሌላ ሆስፒታል ከመላክም ሆነ በጊዜ አገልግሎት ሳያገኙ እንዳይቀሩ ሲባል የዕለተ ቅዳሜው የበጎ ፈቃድ አገልግሎት ተጀመረ፡፡

በጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል በአጥንት ቀዶ ህክምና ክፍል ህኪሞች የሚሰጠውን የቅዳሜ የበጎ ፈቃድ አገልግሎት የሚያስተባብሩት ዶ/ር ውባለም ዘውዴ ናቸው፡፡ ዶ/ር ውባለም በህክምና የመጀመሪያ ዲግሪያቸውን ከኩባ ካገኙ በኋላ፣ የአጥንት ቀዶ ህክምና ትምህርት ደግሞ እዚሁ አዲስ አበባ ዩኒቨርስቲ ተምረዋል፡፡ በአዲስ አበባ ዩኒቨርስቲ ሜዲካል ፋክልቲ የአጥንት ቀዶ ህክምና ትምህርት ክፍል ሊቀመንበር፤ እንዲሁም እስከአሁን ባለን መረጃ መሰረት በኢትዮጵያ ብቸኛዋ ሴት የአጥንት ቀዶ ህክምና ባለሙያም ናቸው፡፡

ዶ/ር ውባለም ዘውዴ

ዶ/ር ውባለም እንደነገሩን፣ የበሽተኞን ጤንነት በመመለስ የሚገኘውን ደስታ የሚጋሩ ብዙዎች ስለነበሩና እዚያው በጥቁር አንበሳ የህክምና ፋክልቲ የአጥንት ህክምና ክፍል ተማሪዎች የሙያ ክህሎታቸውን የበለጠ ለማሻሻል ካላቸው ፍላጎትና እንዲሁም የአጥንት ህክምና መምህራኑም ተከታይ ተማሪዎቻቸውን ለማስተማር፤ በአጠቃላይም የአደጋ ሰለባዎችንም ለመርዳት በነበራቸው ፍላጎት የቅዳሜውን የበጎፈቃደኝነት የህክምና መርሃ ግብር መጀመር ብዙም ከባድ አልነበረም፡፡ ጥቁር አንበሳ ሆስፒታል ከ40 አመታት በፊት የተገነባና ለ80 ሚሊዮን ህዝብ ብቸኛ የአጥንት ቀዶ ህክምና አገልግሎት የሚሰጥ ሆስፒታል ነው፡፡ “በየጊዜው እየጨመረ የሚመጣው የመኪና፣ የማሽንና ከግንባታ ጋር የተያያዙ አደጋዎች ቁጥር በሆስፒታሉ የድንገተኛ ክፍል በሚፈጥረው ጫና ምክንያት የሚታየውን የታካሚዎች ሰቆቃ ልብ ያሉ የውጭ ሀገር ሰዎች ነበሩ፡፡ በተለይ አየርላንዳዊው ዶ/ር ፊንታን ሻነን ዋነኛው ነበር፡፡ የበጎፈቃድ የአጥንት ቀዶ ህክምናውን ለመጀመር የሚያስፈልገንን ስንጠይቀው ተገቢውን የመነሻ ድጋፍ አድርጎልን በዚህ መልኩ ተጀመረ” በማለት ዶ/ር ውባለም የቅዳሜውን አገልግሎት አጀማመር ያብራራሉ፡፡

የዚህን የቅዳሜ የበጎፈቃድ አገልግሎት መጀመር የግድ ያደረገው ዋነኛ ምክንት ወደ ድንገተኛ ክፍል ከተለያዩ ክልሎች ከሚመጡት የአደጋ ሰለባዎች ውስጥ 80 በመቶ ያህሉ ቀዶ ህክምና የሚሹ መሆናቸው ነበር፤ ለእነዚህ ታካሚዎች የማደንዘዣ አገልግሎት ለሚሰጡት ፤ ቁስሎቻቸውን በማጠብ የቅዳሜ እንዲሁም አልጋ የማስያዙን ሥራ ለሚያከናውኑት ባለሙያዎች የታካሚዎቹ ቁጥር በመብዛቱ በመደበኛው ጊዜ አገልግሎት ለመስጠት ከአቅም በላይ መሆኑ ነበር፡፡ በዚህ የህክምና አገልግሎት ላይ ሶስት የአጥንት ቀዶ ህክምና ባለሙያዎች ፣ ከስድስት እስከ ስምንት የሚሆኑ የትምህርት ክፍሉ ተማሪዎች፣ አምስት የሚደርሱ የጤና ረዳቶች፣ ሶስት የማደንዘዣ ህክምና ባለሙያዎች ፤ ሶስት የንፅህና ባለሙያዎችና የልብስ ንፅህና የሚሰጡና የቀዶ ህክምና መገልገያ መሳሪያዎችን ከበሽታ አምጪ ተሃዋሲያን ነፃ የሚያደርጉ ደጋፊ ባለሙያዎች ተሣታፊ ናቸው፡፡ ለደጋፊ ባለሙያዎቹ የተወሰነ ክፍያ የሚከፈል ሲሆን ዋናዎቹ የህክምና ባለሙያዎችና የትምህርት ክፍሉ ተማሪዎች በነፃ ይሠራሉ፡፡ ለእነዚህና ለተለያዩ ግብዓቶች የሚሆኑ ወጪዎችን በመጀመሪያ አካባቢ የህክምና መርሀ ግብሩ እንዲጀመር ካደረጉት የውጭ ሀገር ዜጎች፤ በኋላ ላይ ደግሞ ከጤና ጥበቃ ሚኒስቴር፣ ከሳይን ኔይል፣ ከአውስትራሊያን ዶክተርስ ፎር አፍሪካ እና ከወርልድ አርቶፔዲክስ ሴንተር ድጋፎችን ያገኙ ነበር፡፡

ምንም እንኳን ከአጀማመሩ ጋር የሚጠቀሱት የባህር ማዶ ሰዎች ቢሆኑም ይህን የቅዳሜ በጎ ፈቃድ ሥራ በዋናነኝነት ሙያቸውን ተጠቅመው ሰውን አክሞ ለማዳን የገቡትን ሙያዊ ቃል ጠብቀው ለራሳቸው ሀሴትን፣ ለህሊናቸው ዕረፍትን፣ ለወገናቸው ግልጋሎትን፣ ለተተኪ ወጣት የህክምና ባለሙያዎች አርያነትን እየሰጡ የሚገኙት ይህችው ሀገር ያፈራቻቸው ከድህው ወገን የተገኙ አንጋፋና ወጣት የአጥንት ህክምና ሙያ ባለቤቶች ናቸው።

ዶ/ር ውባለም እንደገለፁልን፣ ባለፉት ሁለት ዓመታት በአንድ ቅዳሜ በአማካኝ ከአስር እስከ አስራአምስት ለሚደርሱ ታካሚዎች የአጥንት ቀዶ ህክምና አገልግሎት ሰጥተዋል። በዚህም በሁለት ዓመት ውስጥ የአደጋ ሰለባ የሆኑ ግለሰቦች እግሮች ከመቆረጥ ይልቅ በአጭር ጊዜ ተጠግነው ደግመው እንዲራመዱ፣ የደቀቁ እጆች ታክመው በድጋሚ ቆርሰው እንዲበሉ ማድረግ እና ሰዎቹንም ከቤተሰብና ከሀገር ጥገኝነት ለማዳን ተችሏል።

በእነዚህ ሁለት ዓመታት ውስጥ የህክምና ባለሙያዎቹ የቅዳሜ አገልግሎት ደመወዝ የነበረው ታካሚዎች በአጭር ጊዜ ድነው ተማሪው ወደ ትምህርት ገበታው ሠራተኛው ወደስራው ሲመለስ ማየት፤ እንዲሁም በድንገተኛ ክፍል ያለው ሰቆቃ ቀንሶና ሰኞ ጠዋት በሚደረገው የታካሚዎች ጉብኝት ወቅት ስቃያቸው ቀንሶ ጤንነታቸው የተመለሰ ታካሚዎችን መመልከት ነበር።

ይህ አስደሳችና ለህብረተሰቡ ያለው ጠቀሜታ ዋጋ የማይተመንለት አገልግሎት በአሁኑ ሰዓት ያለበትን ሁኔታ በተመለከተ ዶ/ር ውባለምን ሲናገሩ "በአሁን ሰዓት የቅዳሜው የበጎ አድራጎት የአጥንት ቀዶ ህክምና አገልግሎት ቆሟል" አሉን ልብን በሚነካ ውስጣዊ ሀዘን። ላለፉት ሁለት ወራት አግልግሎቱ ቆሟል። ለብዙ ጊዜያት ለታካሚዎች የሚሠጠው ግልጋሎት ላይ በማተኮራቸው ምክንያት የገንዘብ እጥረት ስለገጠማቸው እና የደጋፊ ሙያተኞችን ክፍያ እና የተለያዩ ወጪዎቻቸውን መሸፈን ስለተሳናቸው አገልግሎቱ ሊቋረጥ ችሏል።

ስለ የበጎ ፈቃደኝነት አገልግሎቱ በኢትዮጵያ ቴሌቭዥን ፕሮግራም እንዲሰራለት በማድረግ ግንዛቤ በመፍጠር የተለያዩ የገንዘብ ድጋፎችን ለማግኘት ተሞክሮ ነበር። ነገር ግን ተገቢውን ድጋፍ ለማግኘት አልተቻለም። "በተለይ አግባብ ያላቸው የመንግስት አካላት ይህንን አይነት ሥራ እየሰሩ ናቸውና "ምን እንርዳቸው?" "ለምንስ ተቋረጠ ?" ብለው ይመጣሉ ብዬ ነበር። ነገር ግን ማንም የመጣ የለም" ይላሉ ዶ/ር ውባለም በሀዘኔታ ተሞልተው።

አገልግሎቱ በመቋረጡ ከ50-70 የሚሆኑ የአደጋ ሰለባዎች አፋጣኝ የአጥንት ቀዶ ህክምና ይሻሉ።

እጃቸው ወይም እግራቸው ባለመሥራቱ መራመድና መንቀሳቀስ የሚያዳግታቸው ሊሆኑ ይችላሉ። በተገቢው ሰዓት በአግባቡ መታከማቸው ሊኖሩ የሚችሉትን አስቸጋሪ ሁኔታዎችንና ለማከም የሚፈጀውንም ጊዜ ይቀንሰዋል። ታካሚውንም በአጭር ጊዜ ወደ ምርታማነት መመለስ ያስችላል። ሆኖም በተገቢው ሰዓት ቁስሉ ተጠርጎ እና ታጥቦ ምርመራ ተደርጎለት አስፈላጊው የቀዶ ህክምና ካልተደረገለት በቀላሉ መዳን ይችል የነበረው ቁስል ውስብስብነቱ ጨምሮ እና በታካሚዎችም ላይ የሚያደርሰው ጉዳት ከፍቶ ጊዜን የሚፈጅ መሆኑ አይቀርም። ይህ በራሱ ታካሚውን ፍፁም ጥገኛ በማድረግ ለተለያዩ የስነልቦና ችግሮች ይዳርገዋል። ሌላው የከፋ የሚሆነው ተገቢው ህክምና በዘገየ መጠን ቁስሉ ሽታ አምጥቶ እስከመመረዝ በመድረስ ታካሚውን ለዕድሜ ልክ አካል ጉዳተኝነት ከዚያም ሲያልፍ ህይወቱን እንኳ ለማዳን እስከማይቻልበት ድረስ ለአደጋ ማጋለጡ ነው።

መንግስት ልማትን እያበረታታና አደጋን የመቀነስ ከፍተኛ ሥራ እየሰራ እንደሆነ እየገለፀ ስለምን ይህን በጎ እንቅስቃሴ ትኩረት ነፈገው? ከአደጋው መብዛት አኳያ ሲታይ በመደበኛው የሥራ ጊዜ በቂ የህክምና ሽፋንን ማዳረስ በእጅጉ አስቸጋሪ እንደሆነ እሙን ነው። በዚህም የአጥንት ቀዶ ህክምና ባለሙያዎች የዕረፍት ጊዜያቸውን ወይም በግላቸው በተለያዩ የህክምና ተቋማት በመስራት ተጨማሪ ገቢ የሚያገኙበትን ጊዜያቸውን በመሰዋት የመኪናና የተለያዩ አደጋዎች ሰለባ የሆኑ ህመምተኞችን ለመታደግ በሙሉ ተነሳሽነት ለማገልገል ሲፈልጉ ተገቢውን ድጋፍ መነፈጋቸው በእጅጉ ስሜትን ይጎዳል።

"ይሄ ጊዜ በህክምና በትምህርት ክፍሉ የሚገኙ መምህራንና ባለሙያዎች በጣም የተከፉበትና በድንገተኛ ክፍል ያለውም ሰቆቃ እየከፋ የመጣበት ሰዓት ነው። ዋነኛው ችግር የገንዘብና በቂ የቀዶ ህክምና ጊዜ ማጣት ነው" ይላሉ ዶ/ር ውባለም።

እነዚህ ሀኪሞች ካለባቸው ከባድ የሥራ ጫና አንፃር ተዘዋውረው የተለያዩ ድጋፎችን ከተለያዩ ባለሀብቶች ለማፈላለግና ጉዳዩን አስረድቶ ለማሳመን በቂ ጊዜ እንደሌላቸው ግልፅ ነው። እንደ ዶ/ር ውባለም ገለፃ ሁለት ሚሊዮን ብር የተገመተና ችግሮችን ሁሉ ግማሽ በግማሽ መቀነስ የሚያስችል የቀዶ ህክምና ክፍል ለማደራጀት የገንዘብ ድጋፍ ብቻ ይጠበቃል። ከዚህም በተጨማሪም የመክፈል አቅም ያላቸውን በማስከፈልና የህኪሞቹን ገቢ በመቀነስ አቅም ለሌላቸው ድጋፍን ለመስጠትም ታቅዷል።

የቅዳሜው የበጎ ፈቃድ አገልግሎት ብዙ ታካሚዎች በአጭር ጊዜ ታክመው እንዲድኑ ያስቻለና ባለሙያዎችም የሙያ ሀላፊነታቸውን ይወጡ ዘንድ ሁኔታዎችን ያመቻቸ መልካም የበጎ ፈቃደኝነት ሥራ ነበር። አሁን ግን አገልግሎቱ በመቋረጡ የታካሚዎችም ቁጥርም እንደቀድሞው እየበዛና ሰቀቀኑም በዚያው ልክ እየጨመረ ነው።

ወ/ሮ የኔነሽ መርጋ ለጫጉላ ሽርሽር ባህርዳር ሄደው ሳለ ድንገተኛ የጉልበት መሰበር አደጋ ደርሶባቸው በነፃ የበጎ ፈቃዱ አገልግሎት ተጠቃሚ ከሆኑ ተገልጋዮች አንዷ ናቸው።

የትራፊክ አደጋ፤ . . .

ከገፅ 5 የዞረ

በየቀኑ የሚፈፀመውን ነገር ያውቁታል፡፡ እሳቸው እንደሚሉትም የመኪና አደጋ የሚደርስባቸው ሰዎች በአብዛኛው ጥቁር አንበሳ ድንገተኛ ክፍል ነው የሚገቡት፡፡ “ በተለያዩ ጊዜ የአደጋ ስለባዎችን አሃዝ በምናይበት ጊዜ ከአጠቃላዩ ግማሹ አደጋ በተለይ ከመኪና አደጋ ጋር የተያያዘ ነው፡፡ በቀን ውስጥ ከ75-100 ታካሚዎች በድንገተኛ ክፍሉ ይስተናገዳሉ፡፡ ከዚህ ውስጥ ከ15-20 የሚደርሱት የመኪና አደጋ ተጎጂዎች ናቸው ፡፡ ይህ ማለት ከጠቅላላው የድንገተኛ ክፍል ታካሚ 20 በመቶው የትራፊክ አደጋ ሰለባዎች ናቸው ማለት ነው፡፡ በቁጥር ሲታይ ሆስፒታሉ ላይ የሚፈጥረው ጫና ከፍተኛ ነው፡፡ ከአደጋው በተጨማሪ አደጋው የደረሰባቸው ሰዎች በስሜት ነው የሚመጡት፤ ደረት ላይ በደረሰ አደጋ ታፍነው የሚመጡ አሉ፣ ከፍተኛ ጉዳት የደረሰባቸው አሉ፣ ስለዚህ ብዙ ባለሙያ እዚህ ላይ ይረባረባል፡፡ አንዳንድ ጊዜ የደም ዕጥረት ሁሉ ያጋጥማል፡፡”

የትራፊክ አደጋ ከድንገተኛ ክፍሉ ባሻገር ከፍተኛ ጫና የሚያሳድረው በሆስፒታሉ የአጥንት ህክምና ክፍል ነው፡፡ የአጥንት ህክምና አገልግሎት ፍሊጋ ወደ ጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል ከሚመጡት ታካሚዎች አብዛኞቹ በመኪና ግጭት፣ በመኪና መገልበጥ... አደጋ የተጎዱ ናቸው፡፡ ከትራፊክ አደጋ የተነሳ የአጥንት ህክምና ክፍሉ የደረሰበትን ከአቅም በላይ የሆነ የሥራ ጫና ዶ/ር ባህሩ ሲያስረዱ እንዲህ ይላሉ፡- “ይህ የመኪና አደጋ ችግር አንደኛ በሀገራችን የዚህ የህመምተኞች ቅብብል ሂደት በሀገር አቀፍ ደረጃ ስራ ላይ ስላልዋለ ይህ ሆስፒታል ደግሞ በራሱ ካለው ታሪካዊ እውቅና ከሌሎች ሆስፒታሎች የመጀመሪያውና ከፍተኛ የሆኑ ከህሎት ያላቸው ባለሙያዎች እንዲሁም አዳዲስ ህክምናዎች የሚሰጡበት ቦታ ስለሆነ ቀላል ችግሮች ቢሆኑም እንኳን እንዲሁም በሌሎች የጤና ተቋማት ህክምና ሊሰጥበት የሚያስችል ቢሆንም ብዙው ህመምተኛ ሊታከም ወደዚህ ነው የሚመጣው፡፡ ይህ ደግሞ ያለው የስራ ሁኔታ ላይ ጫና እያደረገ ነው፡፡ ያንን ደግሞ እኛ ልንከላከለው አንችልም፡፡ ይህ በሀገር አቀፍ ደረጃ የጤና ደረጃዎች ምደባ በሚደረግበት ጊዜ ሆስፒታሉ በትክክል እዚህ መታከም የሚገባቸውን በሽተኞች ያገኛል፡፡ ይህም ሆስፒታሉ የሚሰጠውን የጤና ህግጋት መፈጸምና እንዲሁም ጊዜያችንን ለሌሎች ስራዎች ስለምናውል የተሻለ ስራ ይሰራል ማለት ነው፡፡”

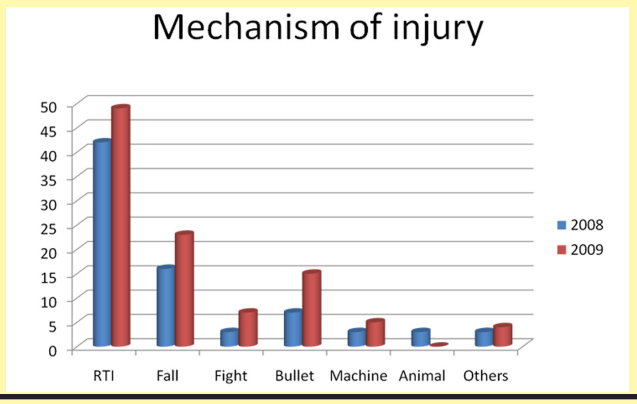
የትራፊክ አደጋ ተጎጂዎች የመጀመሪያ ደረጃ ህክምና ቢሰጣቸው፣ ጉዳታቸው ከሚያስከትልባቸው አስከፊ ችግር ወይም ሞት ለመትረፍ የተሻለ ዕድል ከማግኘታቸውም በላይ በሆስፒታሎች ላይ የሚያሳድሩትም ጫና በመጠኑም ቢሆን ይቀንሳል፡፡ ዶ/ር አክሊሉም በዚህ ይስማማሉ፡፡ “ይህ ዓይነቱ አገልግሎት ሊከሰት የሚችለውን የሞት አደጋ እንኳን ሊቀንስ እንደሚችል የተረጋገጠ ነው፡፡ ስለዚህ ከጠቢታ አምቡላንስም ጋር ሆነ ከሌሎች ማህበራትም ጋር እኛም አንዱ አካል ሆነን እየተሳተፍንና የሚገባውን እገዛም እያደረግን ነው፡፡”

የትራፊክ አደጋ አንዳንዴ የትራንስፖርት ሚኒስቴር ወይም የመንገዶች ባለሥልጣን ጉዳይ ብቻ ተደርጎ ይታሰባል፤ አንዳንዴ ደግሞ የትራፊክ ፖሊሶች እና የመሥሪያ ቤታቸው ጉዳይ ይመስለናል፤ ጉዳዩ ግን ምንም እንኳን የተወሰኑ አካላት ላይ ጫናው የበረታ ቢሆንም እያንዳንዳችንን ይመለከታል፡፡ አደጋውን የመከላከሉም ሆነ አደጋው ከደረሰ በኋላ ውጤቱን የመቀነስ ጥረት የሁላችንንም ትብብር ይጠይቃል፡፡ በዚህ ረገድ ኢሶት “ምንም እንኳን የመኪና አደጋን ሙሉ ለሙሉ ለማጥፋት ባንችልም ባደጉት ሀገራት ተሞክሮ ለመቀነስ እንደሚቻል በዓለም ደረጃ ስለተረጋገጠ፤ እኛም ከልባችን ከጣርንና ከታገልን ቢያንስ መቀነስ እንችላለን” የሚል ራእይ ይዞ ጉዳዩ ከሚመለከታቸው የተለያዩ ወገኖች ጋር በጋራ በመሥራት ላይ ነው፡፡ ኢሶት የትራፊክ አደጋን መከላከል የእነ እገሌ ተብሎ የሚተው ሳይሆን የእያንዳንዳችንን ቤት ሳያንኳኳ የሚገባ የሁላችንም ጉዳይ ነውና ተረባርበን እንቀንሰው ሲል ጥሪውን ያቀርባል፡፡

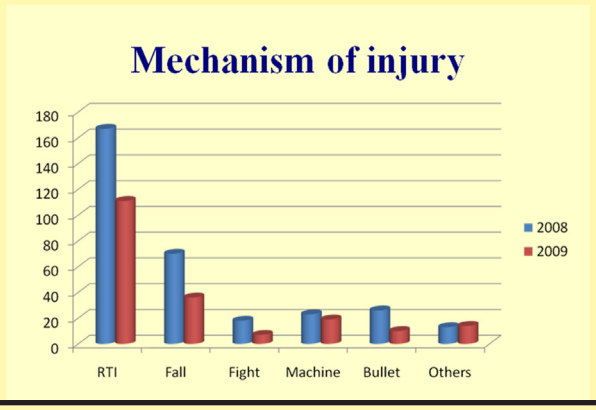
በ2008 እና በ2009 እ.ኤ.አ በጥቁር አንበሳ የድንገተኛ አደጋ ኢጋጥሚቸው ከመጡ በሽተኞች መካከል ቀላል ጉዳት የደረሰባቸው ወዲያውኑ የህክምና አገልግሎት አግኝተው ወደ ቤታቸው በመሄድ የተመላላሽ አገልግሎት ያገኛሉ፡፡ይህ በእንዲህ እንዳለ ከባድ የአካል ጉዳት ያጋጠማቸው በሽተኞች ግን ሆስፒታሉ ባሉት ጥቂት የመኝታ አገልግሎት እና የቀዶ ጥገና ክፍል የነበረውን ጫና ይበልጥ ከባድ አድርጎታል፡፡ ከሆስፒታሉ የመቀበል አቅም በላይ ሲሆኑ ግን ወደ ሌላ ቦታ በሪፈራል መልክ ለመላክ እንገደዳለን፡፡ነገር ግን እነዚህ የተላኩት በቂ የህክምና አገልግሎት የሚያገኙበት ቦታ የለም፡፡ ከሚተኙት እና አልጋ በማጣት ሪፈር ከሚባሉት መካከል ብዙዎቹ የመኪና አደጋ የደረሰባቸው ናቸው፡፡ይህም በሆስፒታሉና በህብረተሰቡ ላይ ያለውን ጫና ያንላዋል፡፡ ከላይ የተጠቀሰውን በንፅፅር ላመሳየት ከታች ያለውን አሃዝ እና ግራፍ ማነፃፀር ይቻላል፡፡

ከዶ/ር ይሄይስ ፈለቀ

	አድሚሽን	የመኪና አደጋ	በመቶኛ
2008	82	42	51.2%
2009	103	49	47.6%



	ሪፈራል	የመኪና አደጋ	በመቶኛ
2008	317	167	53%
2009	197	111	55.9%



ESOT Annual General Meeting 2010

Pictures

Pictures

1st AO course 2010

SIGN Trainning 2010

NEWS and BRIEFS:

By D.r Biruk L. WAMISHO

This column will brief the readers with major/landmark orthopedic events happened in the year 2010.

(herafter, all ESOT members, partners, international staff and colleagues are kindly asked to contribute to this column)

SIGN training given at BLH

Dr. Yiheyis Feleke, ESOT member, has conducted the training at BLH. The training was given for three days- one day theoretical teaching with demonstration and two days on surgery live patients. 20 orthopedic surgeons from all over the country, including two American Surgeons from private Hospitals have received the complete training and got certified by ESOT.

The combination of theoretical lecture, demonstration and practical sessions has made an easy understanding. Dr. Yiheyis said, participation of the trainees was superb and such trainings should continue

The first AO Non-Operative course:

The first AO non-operative fracture treatment course was the other pre-ESOT AGM/conference workshop. 40 general surgeons from all Ethiopia and year-I orthopedic residents from AAU have received the three days training package, in February 2010. The training was conducted at Ghion Hotel auditorium, here in the Capital-Addis Ababa. The event was organized by ESOT and the chairman said such workshops will be conducted every year.

(for details please refer the website below)

http://www.aotrauma.org/eventdetails.aspx?id=391&from=PG_COURSEDIRECTORY

Dr. Lewis G. Zirkle and Jeanne's October-visit to BLH:

At the end of 2010, in December, astonishing visit happened at BLH! Dr. Lew, SIGN's founder and president and Jeanne, SIGN CEO have left their foot prints at Black-Lion Hospital forever!

ESOT members have actively learned "original" surgical skills from Dr. Lewis Zirkle himself.

Jeanne has been encouraging the staff and was advising on leadership skills. They both promised to come and visit BLH next year as well. They are welcome time and again!

THE FIRST ETHIOPIAN SIGN CONFERENCE:

The first ever Ethiopian SIGN conference was conducted during Lew-Jeanne's visit. Research articles related to SIGN were presented and Dr. Lewis has chaired and also presented his articles and lectures on SIGN technique. We all remember that, a year back, in September 2009, Dr. John Tanksley brought the first BLH SIGN set and thought the staff and residents on the technique. The BLH program is one of the best as Dr. Zirkle & Jeanne pointed out. Similar conferences will be held every year and this will network all SIGN surgeons in the country. Dr. Lew said "the SIGN train at BLH has gone far with just one year!" He also appreciated that follow-up reports well uploaded to the database by Dr. Woubalem. Dr. Anderson, founder of Soddo Christian Hospital, 500 K.Ms South of Addis, commented that such local networking should be strengthened. The Orthopedic department at AAU is affiliating the Soddo, Korean and CURE Hospitals to rotate residents. Dr. Biruk reported that it was not an easy task to organize such a conference and present papers at this short time, but thanks to all the staff and residents, we did it! We will also improve.

NEWS and BRIEFS:

The first SHC in ETHIOPIA!

The newly developed surgical system SHC (SIGN Hip Construct) is kindly donated by SIGN. Dr. Lewis and Jeanne have brought the complete equipment during their first visit.

Now in Ethiopia, SHC is done only at Black-Lion Hospital. Five patients were operated during the presence of Dr. Lew. Adult patients with fractures around the hip are now surgically fixed with this implant and results are excellent! Jeanne has trained and assigned Biruk to upload the SHC cases done onto the SIGN database. Finally, after seeing the SHC surgeries performed, Dr. Zirkle commented that the staff at BLH is well skilled in doing SHC and the SIGN train is hurried!

New residents enrolled

In the 24 years history of the department of Orthopaedics in Addis Ababa University, this year the highest number of residents are enrolled for the 4-year specialty training. Nine competent, young and enthusiastic general practitioners were recruited after entrance exams and interviews. We expect similar numbers in the coming years

ESOT has nominated its member:

This year, ESOT has elected and assigned Dr. Biruk L. WAMISHO to join the Editorial board of the EAST AFRICAN ORTHOPAEDIC JOURNAL which is published by the KOA (Kenyan Orthopedic Association).

Biruk is working with the Kenyan colleagues in preparing the journal.

TWO ESOT members have been at SIGN conference in the USA:

Drs. Biruk and Dereje, from department of Orthopaedics, have made it to the US! Dr. Dereje has received the 2010 SIGN scholarship given to the BLH SIGN program and attended the flap course at University of California, San Francisco and SIGN conference at Richland.

Biruk has presented a paper at the SIGN 2010 conference. Biruk said, the flap course at UCSF was marvelous and informed that next year they are planning to start research courses. It makes you understand all types of SIGN technique if you discuss with the Engineers and tour in the factory to see every step of manufacturing (From the long stain less steel rods up to nails in the bags ready for shipping after quality testing.) Every bend and hole has a reason! Orthopaedics demands sound engineering knowledge: both practically and theoretically. We personally met lots of people and made extensive networking that benefits our Hospital and country. Many promised to visit us. The speakers are prominent authors of popular orthopedic books. The club-foot course was conducted by Dr. Pirani himself. The new SHC system, Fin nails and PEDI nails were well demonstrated. The SIGN staff has amazing harmony. They are exemplary hard workers and humble-he added. We learned what harmony means & its effects. “United we stand, divided we fall!”

SIGN’s growth depends on finding programs which are filled with excellent teachers who can ignite a passion for orthopae-dics in their students. We met such teachers and students while visiting Black Lion Hospital in Ethiopia and Kijabe Hospital in Kenya.

Without access to appropriate equipment, practicing ortho-paedic surgery in a busy trauma hospital is like trying to mass pro-duce clothing without a sewing machine. The factory is hard pressed to find enough employees who will agree to hand stitch the clothing when they know the factory next door has modern sewing machines which produce clothing faster and with more consistent quality. Likewise, with inadequate tools to perform surgery, residen-cy programs in developing countries cannot attract the quantity nor the quality of young medical students needed to build the orthopae-dic capability required to treat the growing number of road traffic injuries that occur each day. These young men and women need to be in a program that will give them the opportunity to gain the knowledge and develop the skills required to treat their patients with good results. Successful leaders in the orthopaedic departments of these hospitals persistently seek creative ways to gain access to the equipment, operating rooms and teaching opportunities desired by the best residents.

(L-R: Resident Dr. Hailu, Dr. Biruk, Bethelehem, Dr. Zirkle) Patients like Bethelehem and residents like Samuel Hailu learn from enthusiastic teachers such as Dr. Biruk and Dr. Zirkle.

NEWS and BRIEFS:

We thank SIGN for letting us publish the following three articles from their Newsletter December 2010

The Impact of Decisions

Jeanne Dillner

SIGN patient Betheleham lay in a body cast after a badly fractured hip. Dr. Zirkle & SIGN surgeons were able to evaluate her and give her the SIGN hip construct so she could walk again.

Patients are at the mercy of the medical system in developing countries. During our October visit to Ethiopia, we met Bethelehem, pictured below, 3 months after her accident. She had fallen three stories, where she lay frightened and in pain for 6 hours before she was found. Her family put her in the back of a taxi to transport her to the nearest hospital. The first hospital took an X-ray which revealed a hip fracture and placed a cast on her leg that ended at the level of the fracture. This cast only increased her pain. Her family then took her to a private hospital which had the implants to stabilize her hip. Unfortunately, she could not afford the surgery so the doctors applied a body cast and sent her home. Her fracture did not heal. Normally a cheery person, her face tightened with emotion as she described to me her fear when she thought of living in pain and disability for the rest of her life. She told me that she came to the Black Lion Hospital because she had heard of the excellent care and as a government hospital, the treatment would be affordable. SIGN surgeon, Dr. Woubalem, recognized the severity of the problem and presented her case at the SIGN clinic. Our prayer for these surgeries is that we do not ask that they be easy, but that they just be possible. One of our missions during this visit was to train the surgeons to use the new SIGN Hip Construct device. The timing of our visit was critical to Bethelehem. One day after the SIGN Hip surgery performed by Drs. Biruk and Zirkle, she is recovering with her mother beside her. The pain is replaced with her sensation of a stable hip and femur and the hope of a brighter future.

Discussions we have during all of our site visits illustrate that surgeons are inquisitive, enjoy in-depth research and revel when in the company of others who are as passion-ate as they about building and sharing their knowledge. The best teachers are open-minded, persistent, global thinkers, communicate often and well, and enjoy collaborating with others - no matter their age or experience. This was evident in the operating room as well as the discussions about patients during the outpatient clinics.

Bethelehem relaxing with her mother after surgery.

Private wing initiative at BLH:

As a means of alleviating the huge waiting list of patients for surgery and also staff retention incentive, the government of Ethiopia has started initiating establishment of private wing practice in its hospitals. ESOT members appreciate this and will be working hard for effective accomplishment of this declaration. This is one of the ways our government has designed to retain surgeons in this country.

H.E. Dr. Tedros Adhanom Gebreyesus, Health Minster of Ethiopia had an extensive interview with an English local newsletter and for a more comprehensive story readers can visit the website below :

http://www.capitalethiopia.com/index.php?option=com_content&view=article&id=2084:public-hospitals-am-state-pm-private-&catid=12:local-news&Itemid=4

NEWS and BRIEFS:

Black Lion Hospital - Addis Ababa, Ethiopia

SIGN CEO Jeanne Dillner (L) with SIGN surgeons Dr. Woubalem (C) and Dr. Biruk (R).

Until 18 months ago, the orthopaedic department of Black Lion Hospital was known for its low morale and poor infection control. For several years the surgeons had requested that a SIGN program be started at their hospital. Due to these negative reports, their requests were turned down. When Dr. Zewde Woubalem be-came chair of the department, she started to write more pointedly about the need for a SIGN pro-gram. She mentioned the numbers of patients they were receiving, the discouragement of their residents at the few options they could offer their patients, and the extremely crowded wards which contributed to the high infection rate. Each email she sent told a story about the improvements they were making in the hospital. The speed at which the changes were taking place revealed the caliber of leadership that was in place. In fact, Black Lion is the first East African hospital to obtain IRB accreditation. Her stories made it clear that we should give the surgeons at Black Lion the chance to prove themselves.

With more than 200 hospitals using SIGN, Dr. Zirkle and I now reserve our travel time for disaster relief or to visit the sites that qualify to participate in pilot studies of new instruments and implants such as the SIGN Hip Construct and Pediatric nail. Thanks to Dr. Woubalem's leadership, Black Lion became one of the best programs in reporting and has the highest follow-up percentages. Dr. L.W. Biruk, who is a fine surgeon and teacher, learned the SIGN technique well and has passed on his enthusiasm and that training to the residents. Their cases reflect excellent surgical skills. For these reasons we decided to start a pilot pro-gram for the SIGN Hip Construct at their hospital.

Our first day at Black Lion was af-firming and humbling. Dr. Woubalem, Dr. Biruk and the other professors passionately described their discouragement prior to be-coming a SIGN program and contrasted that with the positive impact that SIGN has had on their teaching program and patients.

Dr. Biruk told us about the vast numbers of injuries caused by the increase in motorbikes and the poorly trained taxi and bus drivers. Dr. Woubalem spoke of the breadwinners who had lain in traction for months unable to return to work to fend for their families. Their colleagues told us that the residents used to dread going to the emergency room because they knew they had little to offer the patients but traction. Without the implants and instruments needed to fix these fractures, they could not offer their residents complete training and their patients suffered.

T he significance of our decision to start a program at Black Lion was enlightening and humbling. We chose to entrust them with a starter kit based on the sincerity and persistence of Dr. Woubalem's emails. Our decision to trust these surgeons impacted the morale of the leadership which spread to the residency program and has benefited hundreds of patients and their families.

The Black Lion Hospital is the only official residency program in Ethiopia. Each resident is sponsored by a hospital located in a rural part of Ethiopia. They are obligated to serve at the sponsoring hospital for two years before taking a post at a larger government or a private hospital. Drs. Woubalem and Biruk have developed a culture of open exchange of ideas which encourages and develops the residents' thirst for knowledge. This daily exchange not only develops their medical knowledge and skills, but it also develops a habit of collaboration which they can continue via phone or email while in the rural location and for the remainder of their careers.

A s a result of our decision, the orthopaedic leadership is energized. Dr. Woubalem has turned her persuasive energy towards obtaining a dedicated orthopaedic operating suite. Dr. Biruk, who enjoys re-search and surgery, is engaging the residents in several interesting studies.

First year residents show off their skills during a SIGN surgery.

Decision Making in Developing Countries

Lewis G. Zirkle, MD
President & Founder SIGN
[This article is stimulated by my contemplations about how to be an effective teacher.]

SIGN is an educational organization that manufactures and donates the orthopaedic instruments and implants to implement the education received. Patient results depend on the problem solving ability of the surgeon as well as the quality of our instruments and implants. We must therefore evaluate the process of information ex-change between surgeons. Evaluation of surgical results is done on a daily basis by reviewing reports including x-rays on the SIGN surgical database. This evaluation is objective. Evaluating the quality of education and how decisions are made is more subjective I had a chance recently to observe and participate in developing the problem-solving abilities of myself as well as the resident orthopaedic surgeons in Ethiopia and Kenya.

The enthusiasm of residents discussing orthopaedic subjects and anticipated patient results was contagious. Each SIGN program has a different process for determining the patient care for each patient. Every program has developed its own conventional wisdom. Examples include use of external fixation versus intramedullary nail for stabilization of open fractures, treatment of infection and timing of weight bearing after surgery. O rthopaedics is a specialty with many alternative methods of treatment plans to guide a fresh fracture to a healed fracture. These choices account for the plethora of orthopaedic devices available in United States to treat different types of fractures. The SIGN system uses the principles we all must follow but the system is used without C-arm or cosistent electrical supply. It has now be-come the conventional treatment in many developing countries. There is a danger that we could become complacent.

Simultaneous femur operations performed in Kijabe Hospital

Pre-operative x-ray. Post-operative x-ray.

complacency is quickly shattered by discussions with residents in training who ask very probing questions. Complacency must also be avoided in our interaction with surgeons in training. After discussions with these residents in Ethiopia and Kenya I realized that the process of decision-making was more important than the actual decisions made in a teaching program. There is an inadequate supply of orthopaedic surgeons in Africa so these young surgeons will rapidly become the leaders of orthopaedics in Africa. They are already developing methods of expressing their views. The importance of studying the process of problem-solving was reinforced by reading how President Kennedy made a poor decision regarding the Bay of Pigs invasion of Cuba. Fortunately he had the insight to examine the reasons for this decision. He consulted former President Eisenhower who informed Kennedy that he should examine the process of how the decision was made rather than the decision itself. Kennedy's decision-making process proved successful shortly after in the Cuban missile crisis. I remembered this as the residents, staff and I learned together in conferences and in surgery. A big factor in conferences is how the older surgeons respect young orthopaedic surgeons. Who makes the decisions? In many programs the pre-op decisions are dictated by the chief who may not be the most capable person. In Ethiopia and Kenya the young surgeon's opinion was valued. The leaders had enough confidence to listen and seriously consider the young surgeon's ideas. I watched the interaction between the residents and the teaching staff. The issues were discussed on a cognitive rather than an emotional basis. I could see the combination and sometimes conflict resulting from using examples from the orthopaedic literature combined with intuition of personal experience. We cited other disciplines such as engineering, chemistry and biology, which are all involved with fracture healing. I n developing countries the surgeons must rely on creativity to achieve equivalent

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Websites:- www.worldortho.com;
www.wocuk.org;
www.worldorthopaedicconcern.org

VISIT TO ETHIOPIA AND SOMALILAND. Australian Doctors for Africa (Adfa)

March 2010

The pattern of work at the Black Lion Hospital commenced with the daily 8.00am trauma meeting, and then involved us in the subsequent fracture clinics, referral clinics, talipes clinic, theatre operating sessions and teaching sessions with the residents… Dr Fintan Shannon was visiting at the same time and we were careful to coordinate our involvement with him. The teamwork amongst the consultants at the Orthopedic Department at the Black Lion Hospital remains at a high standard, thanks to the leadership of Dr Woubelam. It is perhaps understandable that she has to take the opportunity to work on committees and other pressing administration business when visitors are present to shoulder some of the clinical load.

There are eight new first year residents who have joined the orthopaedic programme and the quality of these residents is the best for some long time. In particular there are four who represent outstanding potential; and the others are sound. This represents a wonderful opportunity to train young orthopaedic surgeons over the next four years.

The small theatre adjacent to the emergency department is planned to be handed over to the orthopaedic department, with anaesthetic cover for debridement under anaesthesia, simple manipulations and reduction of dislocations.

The next large project is to convert the available space in the new rehabilitation block to three orthopaedic theatres. This represents a significant capital expenditure but will give the orthopaedic department control of clean/sterile theatres with adequate operating time. For the interim the Saturday operating sessions are going well with the generous support of the orthopaedic consultants and residents.

The next visit of Australian Doctors for Africa has been scheduled for 26th August 2010 which will be led by Dr Tony Jeffries. He will take Dr Tim Fletcher, orthopaedic registrar as well as Paul Maloney, orthopaedic technician and Victoria Gibson with another experienced theatre nurse. The main effort here will be to work on upper limb surgery and also progress the knowledge of sterile technique in theatre by the nurses, residents and consultants.

Dr. Fintan Shannon visited the Black Lion Hospital Ii Addis Ababa, for six weeks through March and April 2010. He reports on the highstandard of work, but also lists the impediment felt in the operating facilities, having to deal with the enormous workload. While he was there, some 300 surgical procedures were carried out; none of them trivial! Fintan himself operated on 30 cases comprising DDH, CTEV, septic arthritis and assorted contractures from delayed fractures and dislocations. Emergency admissions averaged 7 per night. Many normally requiring admission had to be sent home with traction splints for surgery later. This shortage of bed space has a significant effect on the definition of an “Emergency”. Rarely is it possible to admit cases of malignant tumour, infected fracture or congenital deformity. An average of 5 patients were “held” in the back section of the Emergency Dept, waiting for a bed. The new Rehabilitation Dept. is not yet in operation, still awaiting commission.

Fintan reports significant improvement in the “productivity” of the operating theatres, with the provision of battery-operated drills, an Image intensifier, the equipment for “SIGN” Intramedullary Nailing, and the BLH external fixateur, (a local design.)

In the analysis of his six week stay, Dr Fintan makes the following recommendations: The trauma load demands an operative session each day, in order to cope with the “emergencies”. This is emphasized by the fact that the trainees need help, supervision and direction in their surgery, if they are to learn from their experience. Furthermore, Dr. Fintan suggests that the morning surgery sessions should start at 8.30 am. And he wished that the physiotherapy and orthotic services could be integrated with the orthopaedic work, and that the orthopaedic teams be reorganised into four or more separate units. Fintan feels that the wealth of clinical work at the Black Lion, has the potential to produce the greatest training service.

Fintan Shannon [ftshannon@googlemail.com]

Dr. Eric Gokcen

CURE Hospital - Ethiopia

Question- Tell us your orthopedic experience including where got trained and years of service?

Dr. Eric -Received M.D. degree at The Jefferson Medical College of Thomas Jefferson University in Philadephia, Pennyslvania in 1988.

Orthopaedic training at the University of Maryland in Baltimore, Maryland, completed in 1994.

Became board certified by the American Board of Orthopaedic Surgeons in 1996, and have maintained my US medical license and board status. Private practice in the Philadelphia area until 2006. Joined the CURE Hospital in Kenya in 2006, then moved to the CURE Ethiopia Hospital in 2008 prior to its opening, assuming the position of Medical Director and Chief of Orthopaedic Surgery.

Question -Why did you inclined to orthopedics?

Dr.Eric- I always enjoyed fixing things with my hands, so naturally decided upon surgery while in medical school. I gravitated to orthopaedics because I enjoyed being able to care for people of all ages, and, most of the surgeries are to restore or improve function. So most patients are very happy with their results, and that makes for very gratifying surgery.

Question- It is a tough decision to move to Ethiopia and work here permanently. What made you & your family decide so?

Dr. Eric- I had done many short term medical mission trips in the past to many different places, but after I heard of CURE International and their focus on orthopaedics for disabled children, I was interested in that type of work. I did two short term trips to Kenya, and then moved there for a two year commitment. After being there for one year, I told my wife that "this is what I was made to do." At that time, the CURE Ethiopia hospital was being built, and CURE asked me to consider moving there. As you can see, I accepted.

Question- You are the first orthopedic surgeon at CURE Ethiopia. You are also a founding Medial director. What challenges have you faced in establishing the Hospital and running it? When did it start fully operating?

Dr. Eric-Our first surgery was in January 2009. Having come from the US where everything you need is available has made being here more challenging. Our goal is to provide first world orthopaedic care, and that includes modern, up-to-date equipment and supplies, yet importing them can be challenging. In addition, our staff need to be trained in first world care. Fortunately, we have had many different premier instructors provide excellent training for our staff.

Question -Even though it is a very broad question, tell us about CURE? Its nature, principles, missions… How is CURE-Ethiopia established?

Dr.Eric-CURE International is a non-profit NGO based in the US, founded by a pediatric orthopaedic surgeon after he saw the desperate need for surgical care for disabled children in the developing world. CURE's mission is to provide first world orthopaedic care for the disabled children of the developing world, and to actively train medical professionals in orthopaedics. Currently, CURE has opened 10 hospitals in the past 15 years, with Ethiopia being the 9th.

Question- What are the main Orthopedic services offered at your Hospital?

Dr. Eric-Our focus is providing charity surgical care for disabled children, including clubfoot surgery, limb realignment, spinal surgery, and other deformities. We also have a limited private, elective practice, offering sports medicine/ arthroscopic surgery, joint replacement surgery, fracture care, spine surgery, hand surgery, and foot and ankle surgery. The private practice is fee for service, with all of the proceeds used to support and fund the children's charity care.

Question -Your department is known for its high tech TOTAL JOINT REPLACEMENT SURGERY, which joints do you replace? What implant system do you use? Are the costs affordable? Which patients pay and which do not pay?

Dr. Eric- We are currently providing hip and shoulder replacement surgery, using implants manufactured in the US. The hip implants are manufactured by Stryker, and the shoulder implants by Richards. We are currently in discussions to begin obtaining knee replacement implants and hope to begin total knee replacement soon. Our costs are generally less expensive than comparable surgeries done in Thailand and India, yet are done by myself and utilize US implants. All adult surgeries are fee for service, and the children's surgeries are typically charity.

Question- From your database & experience, what are the common causes of arthritis in Ethiopia? How do you compare it with the US?

Dr.Eric- Most of the arthritis I have seen in Ethiopia is post-traumatic, usually because of inappropriately treated acute trauma. In the US, since most of the arthritis is typical idiopathic osteoarthritis.

Question- We hear you do many interventional arthroscopies. Tell us about your scope and the procedures you perform. What are the common diagnoses & surgeries performed?

Dr.Eric- We have state of the art arthroscopy equipment utilizing Olympus and Arthrex equipment from the US. It's actually nicer than the equipment I was using while in private practice in the US. Most of the surgeries have been on the knee for ACL tears and meniscal tears, including ACL reconstruction and partial meniscectomy, but I've also done shoulder arthroscopy and we're equipped to do ankle arthroscopy.

Question- How are you working and integrating with the local surgeons, medical schools, institutions, and professional as-

sociations (regional and international as well)?

Dr.Eric-We are currently accredited by COSECSA as a one year elective, fellow level orthopaedic residency training facility, and have our first resident who began in January. As a member of ESOT and the EMA, I have discussions with orthopaedic surgeons from various facilities around Ethiopia to see how we can collaborate to improve exchange of ideals and ongoing teaching for orthopaedic surgeons in Ethiopia. In addition, I am working on inviting orthopaedic surgeons to come from the US and abroad to come and not only do surgery, but do teaching and lecturing.

Question- What are your main challenges to run the Hospital? What assistance do you need from our government?

Dr.Eric-We would appreciate any help from the government in streamlining the importation of supplies and equipment.

Question- What are your future short and long term plans?

Dr. Eric- Only God knows what to expect in the future, but my personal plans are to stay in Ethiopia long-term, to expand our care to the disabled children from all over Ethiopia, to help improve the orthopaedic standard of care in Ethiopia, and to actively train orthopaedic residents to that standard.

Question- Tell us about knowledge transfer to the local Surgeons:

Dr. Eric-We share in harmony with the Surgeons in Ethiopia. During the first year we were organizing Our Hospital as a first world care center. This is very important and it took a while. Now we have time to do more teaching.

Now we are fully operational for the last two years. We have affiliation with AAU, department of Orthopaedics to rotate residents from Black-Lion. They will get opportunity to see and assist surgeries here. Currently we have one resident. I also know that same rotation for Black-lion residents is arranged with Korean and Soddo Hospitals. I am also planning to

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Decision Making...*Lewis G. Zirkle, MD*

results for patients in the United States. Surgeons in developing countries are not limited by lack of equipment such as C-arms in the operating room. An example occurred in Kijabe, Kenya involving a 37-year-old lady that we helped unload from the car that had taken her to the hospital. She was one of 9 people in a mini bus that had run off the road and tumbled down a cliff killing 4 people. She did not complain of pain as we lifted her from the car to the gurney. She had bilateral fractured femurs. Later in the week we operated on these femurs simultaneously. On one side a closed reduction of the distal femur fracture was done with-out C-arm. For the other side a very minimal incision was made to guide the reamers and the nail into the proximal fragment. This technique was not described in the SIGN technique manual. The surgeons were not limited by past experience or conventional wisdom.

Another example of their skill involved a missionary who had a large infected bone defect in her femur after being shot with an AK-47. The bone defect was being replaced with bone by a bone transport system which was equivalent to bone transport systems in United States. Donated Orthofix systems which had been given to attendees of the SIGN conference were used. I was very impressed with the result.

This two-week period of orthopaedic immersion with many surgeons seeking knowledge to improve the orthopaedic care of their patients was exhilarating. They stimulated me to think about the decision making process. In United States we talk about using evidence-based medicine and use meta-analysis studies to make decisions. This makes the decision-making process passive because it is being done by some-one else who summarized in the literature. Is this otimal? This is but one of the methods orthopaedic surgeons can use to develop treatment plans. The evaluation of our decision-making process should be a lifetime goal. We can learn much by ob-serving outstanding residents learn problem solving in orthopaedics.

The difference between an expert and a creator in orthopaedics is cogent to this discussion. The expert knows the facts and can implement these facts in surgery as well as other treatments of the patient. The creator knows as much as the expert but lives in constant discontent with the status quo.

I introduced our new hip fixation device enthusiastically 18 months ago in Kenya and was surprised when the chief of orthopaedics at Kijabe told me that he was skeptical when he first heard about this new concept during our previous trip to Kenya. I was delighted because he was honest and open to new ideas. We discussed this in our conference. After using the SIGN SHC to stabilize hip fractures, he became advocate for its use and wants to do studies comparing the different treatments of hip fractures with SIGN SHC because they have access to a C-arm.

I n the operating room the decision-making process must be different from discussions during a conference. Decisions in a conference can be made in a lei-surely fashion as in playing golf but decisions in surgery must be made quickly as in playing soccer. There must be a definite hierarchy and a chief surgeon who will make the decisions.

Many factors play a role in the decisions a surgeon must make quickly. Intuition must be balanced by analysis. Analogy plays a role as we all remember past experience and past surgery. We must recognize patterns as well as what is different about the present surgery. What worked in the past?. Is this personal or vicarious analogy? Remember that fracture healing is a complex process with many variables. Case methods and the literature provide us with vicarious experience in different situations. Decision making is not linear. We must sort out conflicting signals and understand the connections and act promptly. This is true in product development and other aspects of our lives.

"SIGN IS DRAMATIC!" Dr. Fintan Shannon

Dr. Fintan, An Irish Bone surgeon, *is one of our best regular visitors. He is liked and rememberd by every staff here. I am sure you'll enjoy our interview with him. Even patients from rural set ups have identified him well. You know how much money he spends to support them in investigations including CTs, transportation and feeding and clothing…."*

Question -When did you first come to Ethiopia?

I first came to Ethiopia in 2003 G.C. Thereafter, I am coming every year for a 6 weeks and staying in the Orthopedic Hostel in the Hospital compound enjoying every orthopedic activity in the department.

Question- what made you decide to regularly visit BLH?

I am so impressed the first time I came. The work load and the hardship here make you decide to help. The staff, patients and staff are well receptive. The culture here attracts me. Everybody is smiling and thankful.

Question -How do you compare the orthopedic problem here and in your home country?

Patients come here late-E.g with advanced tumors and non-unions. In Ireland, patients come with minimal symptoms very early. Most need no surgery-like simple back pain.

Question- How do you see the facility, number of orthopedic surgeons (40) in the Ethiopia and the single training department for 80 million?

We are 5million!-a size of your capital Addis. There are 60 orthopedic surgeons. But we have huge private practice and best equipments. We make huge money to our Hospitals but since the government gets back big tax, it is easy for us to ask for best equipment. Our Hospitals 'handle us well' because we make money for them. And we handle our Hospitals well because they provide us! I see this is coming to Ethiopian situation.

Question- How are our residents?

I am really astonished by the intelligent trainees here. I am always impressed every morning. They need a lot of supervision during surgeries. This is happening here now because the staff number is increasing. I am very passionate. I can say they are capable. The staff is dedicated in training them.

Question- How do you share the orthopedic challenges we face? What shall we do?

It is impossible to handle all orthopedic problems you alone! BLH service has to expand regionally. This needs huge funding. Ortho graduate surgeons have to go to the regions. We have to invest a lot on orthopedic equipment. Research has to be conducted locally to focus on local problems.

Question- How do you see the customs clearance here? How should our country get prepared for any massive orthopedic service?

I will appeal to the Ministry to support developing orthopedic services. Economic cost of trauma presenting late and disability is more. Good care creates rapid patient turn over and produces functional productive citizens. There should always be good preparedness!

Question- what made you start and take initiative to fund the Saturday?

It is now 2 years.I think it came from you-the staff here. At weekends we all feel sad to see patients at corridors due to lack of beds for admission. The Saturday free major surgery helped the poor a lot!

Question -Tell us about the locally manufacture ex-fix here in Addis.

Yiheyis, Dereje and Bewketu were working with me on this. This obviously saves a lot of cost! We are working on improving its quality than importing. Ex-fix is basic equipment. We may also produce plates, screws and pins in Addis.

Question- How do you see SIGN? Comment

"Dramatic" is the word that I use! Few day Hospital stay to stabilize a fracture and back to function/work. More patients operated and high bed turn-over. I am gradually getting used to it. Dr. Biruk and others are using it well. It brought a dramatic change and I am sure it will do further! There is continuous implant supply and extensive expatriate networking.

Question- Anything more?

I am very glad to be accepted here at age past 65! I thank Dr. Woubalem for accepting me at the department. This is part of the fulfillment of my life to come here and help in any way I can.

Question- Dr. Yiheyis how do you comment Dr. Fintan's visit?

Yiheyis: I know him since my residency. He is always liked by everybody from juniors to seniors. He is always on call and hands-on. His contributions are very great. Added to these are the funding of Saturday project and the ex-fix manufacturing. His funds made us pay for our Nurses and supporting staff. Off course the consultants operated for free on Saturdays for 2 years!

Thank You!

Dr. John Tanksley brought the first SIGN set for BLH program in September 2009. Handed it over to the department and did the first few surgeries. He thought the technique to the consultants at BLH and all the residents. He is also our regular visitor who comes every year and operates. John has constructive comments and encourages the progress of ESOT. On behalf of our nation and patients, we thank him.

ORTHOPAEDICS TRAINING IN ETHIOPIA

Tezera Chaka M.D, FCS (ECSA)
Associate Prof. Of Orthopedic Surgery
Addis Ababa University
School of Medicine
Dept. of Orthopedic Surgery

Orthopaedics in Ethiopia developed from the earlier General Surgery and was been considered as a unit in it. At some point an attempt has been made to establish a Department of Orthopedics with a specialist-teaching program by the late Prof. B.O. Barry at the then Princess Tsehay Memorial Hospital. Almost all orthopedic surgeons practicing in the country were expatriates mostly from the then socialist countries such as Cuba, Russia, etc. An Ethiopian Orthopedic surgeon was working in one of the Police Hospital at Asmara.

Teaching in orthopedics in the under-graduate program of the then Gondar College of Medical Sciences in Gondar was given equal emphasis to that of surgery and the consultants from the former German Democratic Republic (GDR) were also rendering service in the Hospital of the College.

1985 -1987

Starting 1985 Volunteer Visiting Orthopedic Surgeons from Orthopedic Overseas (OO) branch of Health Volunteer Overseas (HVO) USA started to visit the Addis Ababa Faculty of Medicine, Department of Surgery for a short period mainly for 3 – 4 weeks to teach Orthopedics and Trauma Surgery to the General Surgeons, Surgical Residents, Interns, Medical students and other staffs.

During these periods a study conducted revealed an urgent need for Orthopedic Surgeons in the country and a suggestion was made to begin a residency program in the field of Orthopedic Surgery in the Medical Faculty of Addis Ababa. It can be recalled that this was the time where there was huge burden of acute as well as chronic musculo- skeletal war related sequel in addition to the prevailing Orthopedic & Trauma Conditions. A curriculum drafting was made with help of volunteers from the UK and USA, which has some similarity with that of the Bangladeshi Program. After approval by the University Senate Residency Training program in Orthopedic Surgery began.

1987 - 1991

In September 1987 G.C with the Funding of the British Overseas Development Agency (ODA) a separate Orthopedics Department was established and the first four Ethiopian Doctors started the four years residency training based on the admission criteria of the Faculty. The academic staffs were a professor from UK, a Scottish Honorary associate Professor who was a hand- Surgeon in ALERT Hospital, an Indian orthopedic Surgeon with a Rank of Assistant Professor and rotating Volunteers from OO-USA.

The stated aims of the Department

1. Teaching of orthopedic Residents, General Surgical Residents and under graduate medical students.
   (All General Surgical Residents will do a rotation of 6 months -1 month in the 1st year, 2 months in the 2nd year and 3 month in the 3rd year of their 4 yrs of training- in the Department of orthopedic surgery, while under graduate medical students do a rotation of 2 weeks in their 1st clinical year and 1 week in the 2nd clinical year at the time of their surgical attachments.)
2. Research in the field of Orthopedic Surgery
3. Provision of a specialized high quality orthopedic care and Trauma Services and also play a leading role in the dissemination of orthopedic and trauma service to the country at large

On the following years because of unforeseen circumstances only few residents were accepted and out of the 1st four intakes only two successfully completed their training and graduated.

The training program was plagued with different problems such as huge number of patients especially Trauma, lack of resources, shortage of staffs, lack of support etc.

At the end of the 1st 4-year the ODA fund ceased and the Department was left with only one expatriate staff.

1992-2001

Donation was obtained for 2 years from USAID and also from the

2nd batch of graduates the Faculty employed two as an academic staff. The first curriculum was reviewed and the training was continued with only very few residents but the orthopedics in patient beds were raised from 48 to 67. After cessation of USAID fund the Department was left with the two inexperienced local staffs. After some negotiation volunteers from World Orthopedics Concern (WOC) and OO started to support in the training process. Additional to the challenges and problems stated above there was a plan to halt the training programs in some Departments of the faculty including in Orthopedics and to amalgamate the Department to Department of Surgery as a unit which was opposed by both Departments. According to the initial plan, by the end of 2000 the Department should have produced about 50 graduates, but the number of graduates were 18 out of which five left the country and two went to private practice.

At this period both the Department and the training program were at the verge of collapse and even some believed it was going to be closed. Thanks to the unreserved support of dedicated volunteers from WOC and OO, it has survived these hardest times.

2001 - To Date

With the government initiative the Addis Ababa University has launched Post-graduate expansion program in all its Faculties, Schools and Departments.

In the Manpower plan of the Ministry of health, Orthopedic Surgeon was included at the level of referral Hospitals. The Department was assigned to train about 60 orthopedic surgeons with in 5 years. Even though it was a very ambitious plan but has created a good opportunity and was a step forward for the revival of the Department.

. The Department formulated 5 years strategic plan.

. The curriculum was revised for the 3rd time

. One Cuban Professor of Orthopedic Surgery was employed on contractual basis for 2 yrs. Due to the low salary scale those staffs recruited from India and most from Ethiopia declined. `

With the construction of the National Rehabilitation Center and incorporation of the Orthopedic Department into it has created a better working environment especially of the outpatient Services. The help of volunteers from the Australian Doctors for Africa (ADFA) has also enhanced the activity of the Department.

Recently the introduction of SIGN system in the treatment of fractures has greatly revolutionized the management of long bone and hip fractures and has very much improved bed turn over by reducing the bed occupancy in the Department.

From its establishment up to date the Department's material resources (books, Journals, implants etc…) are obtained from donations.

Until the end of 2010 the Department has produced 45 Orthopedic Specialists who are working abroad and in Ethiopia in Teaching, Government, Armed Force, Police, as well as Private Hospitals.

Current status and the way forward

- The need and Demand of the specialty is greatly appreciated all over the country.
- The number of applicants to the training program is increasing.
- The type and number of procedures performed are rising
- The training sites are being expanded from the main teaching center, Tikur Anbessa Specialized Hosptal to incude St. Paul's Hospital, St Luke's Hospital(Wolliso), Wolayita Sodo Christian Hospital, Myung Sung Christian Medical Center (Addis Ababa) and Cure Hospital (Addis Ababa) to expose the trainees to varieties of cases and procedures.
- There is still severe shortage of man power at all level, especially academic staffs and there is urgent need to train the trainers in the different sub-specialty of orthopedics.
- Very limited orthopedic beds and those available beds are occupied by the increasing number of trauma victims from Road Traffic, construction site, industrial etc… injuries which makes it difficult to train in cold orthopedics.
- Very limited operative time despite huge number of emergency as well as elective cases. Currently establishment of orthopedics Operation Room in the NRC by modifying existing rooms is in progress.
- Lack of fixed Budget for Orthopaedics materials and instruments.
- Limited or lack of up to date investigative and therapeutic procedures.

The viability and sustainability of Orthopedics Training and Services is getting momentum. The Department of Orthopedics Surgery at the School of Medicine and the Ethiopian Society of Orthopedics and Traumatology are working in unison to strengthen the Profession and discharge their shared duties and responsibilities and serve their citizens with the available resources. The injection of resources in form of human and material should came from the government as well as from well established institutions inside and out side of the country.

Referrals of Ethiopian Orthopedic Patients for Treatment Abroad.

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Background:

Referral for treatment abroad has both advantages and disadvantages that need careful balancing at an individual and at a national level. Advances in medical tourism have made referrals easier and currently patient flow is in both directions between developing and developed countries. Training & equipping local surgeons to perform advanced procedures would stop "unnecessary" referrals from developing countries-there by also saving the hard currency which is already compromised. In fact, such a set up in a developing country could be able to receive patients from abroad and generate a foreign currency.

Setting: Addis Ababa University, Faculty of medicine, department of Orthopedics.

Methods: We reviewed the copies of all orthopedic referral papers from the country's largest tertiary/ teaching Hospital in the whole year 2008.

Results: Only from our department, a total of 115 orthopedic patients were referred for treatment abroad. Most patients were young males from Addis Ababa-the capital. The commonest single diagnosis was osteoarthritis, followed by ACL tear. The top three procedures for which the patients were referred are total hip replacement, ACL reconstruction and total knee replacement. Inter-consultant variation in number of referrals offered was observed. There was no seasonal difference. Over the last five years, we observed an alarmingly increasing trend in the number of abroad referrals.

Conclusion: Total joint replacement and Arthroscopy surgeries are the main reasons to seek for treatment abroad. Sharp and steady increase in number of referrals abroad is observed in the last five years. Different ways to operate these patients inside Ethiopia should be sought.

INTRODUCTION

Abroad referrals for surgical treatment have been exercised since long time and currently the practicality is much easier due to advances in medical tourism. The flow of patients is mainly from developing to developed countries but these days the reverse is also happening-many patients from Europe/US are getting operated in Asia or Africa. There are also referrals between developed countries and between developing countries. (1) Referral for treatment abroad has both advantages and disadvantages that need careful balancing at an individual and at a national level. The thought of having an operation and recovering in a nice country where the weather is warm and the surroundings are relaxing can be a very nice image but there may be a few reasons why having surgery overseas may prove to be a disadvantage. The following could be some of the disadvantages of abroad referrals (2):

Very high surgical costs (usually for surgeries done in developed countries)
Worries about the standards of surgical practice,
Fewer visitors around the patient,
Language barrier,
Travel issues,
What if something goes wrong?

Going abroad for treatment is a very attractive option for some patients while for others the disadvantages far out-weigh the benefits. There are a number of reasons why it may actually be beneficial to seek treatment overseas. Included are:

Lower surgical costs (for operations done in developing countries)
Short or no waiting lists,
Combining surgery with holidays and tourism,
Discreet cosmetic surgery (Some patients show-up after all ups & downs of Cosmo surgery are gone unseen by friends).

For Africans, abroad treatment is costly, for example a single total hip joint replacement in the US may cost over 50,000 USA without including transport, escort, agent issues and accommodation expenses.(3). The idea of this article is not to totally abandon abroad referrals but to stop 'unnecessary' and avoidable referrals.

METHODS

For an insight into the referral pattern of Ethiopian orthopedic patients who are sent abroad by the Federal Ministry of Health for surgery, we reviewed the copies of orthopedic referral papers from the country's largest tertiary/ teaching Hospital in the year 2008.

The abroad referral process in Addis Ababa University, orthopedic department:

Once recommended by the treating orthopedic surgeon, a committee reviews the patient who has requested or is recommended traveling abroad for surgery. The responsible surgeon prepares the details (History, Findings, Investigations, and recommended surgery) on the referral paper. Then, the abroad referral paper will be signed and issued by the abroad-board, which is comprised of three orthopedic surgeons, the orthopedic department head, the Hospital medical director and Ministry of health. The committee may deny the request. Copies are available at each office and with the patient. Escorts accompany each patient, the paper does not specifically mention to which country the patient is referred, patient can go anywhere he prefers to. The paper expires in six months and needs renewal. Before foreign currency exchanges are made, the ministry of health approves the decision of the orthopedic department abroad committee and our Hospital's medical director. Once the referral is given the patient can apply for a foreign currency exchange at the National Bank of Ethiopia.

RESULTS

In the last five years we observed a linearly increasing trend in number of orthopedic patients referred for treatments abroad (Figure 1). Just in a one-year period, 2008, 115 orthopedic patients were granted referral. The orthopedic department has referred the highest number of patients from the faculty with all clinical specialties. Males were 78 (68%) and females accounted for 37 (32%). Most of the patients referred were young adults (Table 2). Two third of the patients were from the capital-Addis Ababa, others from the regions around (Figure 3). The highest number of patients referred by a single consultant was 54 (About half of all the referrals) and there is also a consultant who proposed no any referral abroad at all (Figure 2). The commonest single diagnosis was osteoarthritis, followed by ACL tear. The top three procedures for which the patients were referred are total hip replacement, ACL reconstruction and total knee replacement. The distribution of the diagnoses and procedures is shown on Tables 1 and 3 respectively. We did not observe seasonal variation in the number of referrals across the year.

DISCUSSION

The thought of having an operation and recovering in a nice country where the weather is warm and the surroundings are relaxing can be a very nice image but there may be a few reasons why having surgery overseas may prove to be a disadvantage. The following

during abroad referrals (2):

Worries about the standards of surgical practice

The standards of care in developed hospitals are high and the staff are fully trained in all areas of their specialty and expected to work to the same high standards, following policies and acceptable procedures. Most or all practices are evidence-based, meaning they have been proven to be best practice. Even though it may not always be true, usually the practice in developed countries is better. Many patients from developed countries who are considering overseas treatment worry that the standard of care in other (developing) countries may not be so high. In actual fact, most of the overseas doctors who offer their services to patients from the developed world have worked within those countries at some time or were trained there. It is however, definitely worth looking at the rates of infection in any of the hospitals where the treatment may be offered and to also try and find out the history of the surgeon who will be looking after.

Number of visitors around:

When you have your operation in your own country, whether it is in a private hospital or a government hospital, you will be able to receive visitors everyday until you are discharged. When patients go abroad however, it is true that unless they taking other family members of friends (escorts) with, they are unlikely to receive visitors, aside from the healthcare professionals looking after them. If patients are expecting to stay couple of days, they feel quiet lonely and this may be a challenging moment. For Africans, where extended family visits are experienced, this may have a deleterious psychological effect on the lonely patient.

Language barrier

Staff in hospitals overseas may not speak the same language to the patient are not obliged to learn so the patient might find a few problems with language barriers among the staff. In general however, the surgeon is highly likely to speak good international language and the hospitals often try their hardest to arrange same-language speaking staff when they are expecting overseas patients. If patient does not express his feelings, this could be a distressful event.

Travel issues

Referred patients may feel nervous about the prospects of having travel problems when you are going abroad for treatment. Flight delays, lost luggage and cancellations can all still occur even when they have or are about to pay a lot of money for an operation. Thanks to medical tourism, some agencies from abroad countries have opened their offices everywhere in the world to facilitate patient transport from and back to home (4,5). The authors know that there are few such agencies in Addis (from Bangkok, India, Germany, Saudi….) but these days movement in itself may be a risk!

What if something goes wrong?

small degree of risk including the anesthesia, bleeding, infection….. Anything unexpected may happen. The bad effects and implications of these, while in a foreign land may be additive. Going abroad for treatment is a very attractive option for some patients while for others the disadvantages far out-weigh the benefits. Going abroad for an operation or treatment is not something that appeals to everyone but there are a number of reasons why it may actually be beneficial to seek treatment overseas.

Treatment costs

The cost of the treatment or surgery may well be expensive or cheaper depending on where the patient is and where is planned to go. This is the main reason to fly from developed to developing countries. Some patients from developed countries operated in developing countries claim to save over 80%! But most surgeries done in developed countries are by far very expensive for cost-sensitive patients from Africa. Many patients who wish to pay for their surgery privately are shocked to discover that costs in the UK/US are usually an awful lot higher than in other countries-Even costs in Asia are unbearable for many patients from Africa where some complicated surgery may be done for free or at a very very low cost. Cost may not be a problem for patients coming from developed countries, but is a serious limitation to those from developing nations. Currently, a single total hip replacement (THR) costs 40-60 thousands of USD (Over half million Ethiopian Birr) in the USA,(3). Recently an Indian referral agency based in Addis advertised on a local newspaper (published last month) the comparative costs of main orthopedic procedures done abroad and officially recruits patients to send to India for Surgery. More convincingly for E.g. is the fact that to pay for the services of the top surgeons in the UK you will usually have to pay more especially if you are needing specialized treatment whereas those who are looking into having their procedure performed abroad can expect to pay less for the services of a top surgeon in that particular country.

Surgical waiting lists

The length in waiting times is one of the main reasons why patients may opt for surgery overseas. Although the government and the hospitals are trying hard to cut down waiting times the chances are that patients will still have to wait some time for operation unless it is an emergency. In some parts of Europe the NHS are looking into and have implemented some instances where patients are advised that having treatment overseas will reduce their waiting time and may try and help with funding referrals abroad! These patients are referred to other countries and will shortly undergo the same intended surgery at a lesser cost, but immediately. Waiting times in private practice are very short.

Combining surgery with holidays

For many people the thought of combining appealing. Getting away from all the normal stresses of everyday life and recovering in a warm climate amongst peaceful surroundings is enough to tempt them overseas. If you are having a fairly minor procedure there are a wider variety of options available as many packages now include activities such as safaris and adventure breaks so people can often combine their treatment with a holiday of a lifetime.

The aim of this article is to show the pros and cons of referrals for orthopedic surgery abroad from different angles discussed. By far, for Ethiopians it is advantageous to get operated in their home country once the expertise is available and the country should work in building the capacity of super-specialized surgeons to handle these procedures at home. One way to achieve this goal may be to train committed and loyal surgeons to sub-specialize abroad, share experience with invited expatriates and conduct series of CME& CPD. What is spent to train one super specialist is by far very less as compared to what he saves for the country. The other way is to invite experienced surgeons from abroad (preferably from similar nations) to give hands-on short trainings to the staff here, For example a good lesson can be taken from Kenya where in one Hospital one THR is done per day at a cost of 2-4 thousand USD by renowned surgeons who once used to practice in developed countries (6). The Kenyans are enjoying THR at a very low costs thanks to the commitment of their University Hospitals to adopt the South African System where patients buy the prosthesis from the company they like and officially registered in the Kenyatta National Hospital. The company puts its instruments (lends to) at the Operating room in the Hospital where the surgeon uses. Ethiopia, a home for 75 million, has less than half number of Orthopedic Surgeons than Kenya and is known to have multitude of orthopedic problems to deal with, hence ESOT has to work hard in looking a system to scale-up the quality of practice and address nation's orthopedic issues nationally. We should share experience locally, regionally and internationally. This may not give a complete answer as rightly said by Prof. J.A.O Mulimba, "Kenyan's 'African's' love treatment abroad" for no reason!(6) However, it definitely reduces unnecessary and costly referrals abroad. The other issue to think is Orthopedic surgeons in our country should think of upgrading their skills and always alertly look for further training opportunities to fulfill the surgical demands from their patients. If one does something special, the combination under good professional associations can bring marvelous change! This could even be pronounced more if sister professional associations work together for E.g. in forms of Surgical campaigns. In Kuwait, after the Iraqi invasion, cardiac surgery (pediatrics

→

and adults) represented 50% of the cases sent abroad for treatment. (6,7)This figure has been reduced tremendously in recent years as two pediatric surgeons were requested to visit Kuwait more than six times a year and a senior adult cardiac surgeon from USA started to work in the Chest Hospital. This has helped them to avoid unnecessary & expensive chest evaluation and referrals (8,9).
Once the local expertise is established in different procedures, it could also be turned into hard currency generating activity by receiving patients from abroad; besides it spares the scarce hard currency the nation has.

CONCLUSIONS & RECOMMENDATIONS

In order to reduce the number of patients' unnecessary referrals abroad and spare the needed financial resources, we suggest the following recommendations to our country:

1. Train committed and loyal young surgeons to sub and super-specialize in selected fields that resulted in large number of unnecessary referrals from the country.
2. Recruit experts and experienced expatriates in the specialized fields to establish the services and to train the young generation. Continue to invite experts in different fields to regularly visit the department to see patients, perform operations and train local staff. Provide these experts with good remuneration. The department and the faculty should identify gaps and prioritize the needs.
3. Send reports, X-rays and investigation results to specialized centers for expert opinion before sending the patient so that the highest center makes sure that the patient will benefit from a specific investigation or intervention that cannot be performed locally. Telemedicine in our Hospital helps a lot. This could be worked out through an official agreement with various specialized centers. Currently, when asked to review a difficult case, most overseas centers request that the patient be sent to them and then their reply is quite often negative.
4. Increase the number of local qualified consultants in each hospital and encourage sub specialization among them. There is no substitute for local experts. Contact between the government and private hospitals should be improved so that a sub-specialized expert in one hospital may manage cases that cannot be managed at another hospital. For example, a case of neuroblastoma was sent abroad by one hospital, while three similar cases were treated in another hospital in Kuwait. (10) This particular patient stayed abroad for seven months costing the Ministry a lot of money. What is done where and by who should be known across the nation! Here comes the help from the media.
5. Redirect the hard currency that had been specified for treatment abroad to:
a. The purchase of new equipment and the upgrading of current equipment to perform sophisticated surgeries that necessitated abroad referrals.
b. Recruit and accommodate a high standard surgical staff (Surgeons, and Nurses) to give short-term trainings at homeland.
c. Facilitate and encourage the local young staff to actively look for scholarships. Arrange more posts for the overseas training of junior local staff

ACKNOWLEDGMENTS:

We thank our Federal Ministry of Health, Medical director and orthopedic department offices to let us review the patient referral files.

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TABLES AND FIGURES:

TABLE-1. Distribution of orthopedic procedures to be performed on Ethiopian Patients referred overseas in 2008 from Addis Ababa University, Medical faculty, Orthopedic department.

Procedure	No
Total hip replacement	41
ACL reconstruction	18
Total knee replacement	15
Spine surgery	9
Anomaly reconstructions	6
ORIFs	6
Prostheses fitting	5
Hand surgery	4
Tumor surgey	4
Post polio deformity	2
Nail removal	1
Others	4
Total	**115**

Table-2. Age distribution of Ethiopian patients referred abroad in 2008 for possible orthopedic

Age (Yrs.)	No
0-15	13
16-30	59
31-45	31
45+	12
Total	115

Table-3. Diagnoses of Ethiopian patients referred abroad in 2008 for possible orthopedic surgical treatment.

Daignoses	Frequency
Osteoartritis	55
ACL tear	19
Scoliosis	8
Limb loss	5
Bone tumors	5
Congenital malformations	7
Others	16
Total	**115**

Figure 1. Linearly increasing trends in number of orthopedic abroad referrals in the last five years from Addis Ababa University, Black-Lion Hospital.

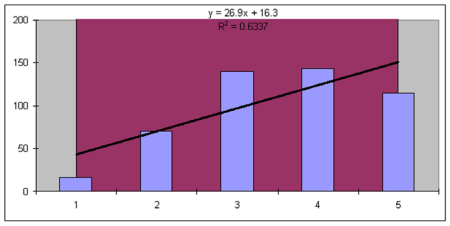


Figure-2. Proportion of patients referred abroad by different Orthopedic consultants at Black-Lion Hospital in 2008.

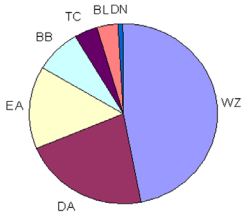
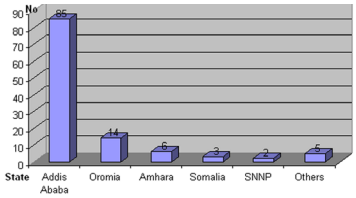


Figure-3. Number of orthopedic patients referred abroad from different Ethiopian regional states in 2008.



Dr. Daniel Admassi, MD

Osteosarcoma of Medical Cunieform

Osteosarcoma is most common primary bone malignancy of childhood and adolescent that is not related to marrow cells. Osteosarcoma usually occurs at the end of long bones commonly around the knee joint. Osteosarcoma of small bones of the foot is very rare. Here I tried to present osteosarcoma of the medial cuneiform bone of the foot in 21 years old male patient.

Introduction

A review of literature reveals sarcomatous lesion were demonstrated in the femur and humerii of Egyptian mummies as far back ancient Egypt(1). Primary bone tumors are rare and account only for 0.2% of human tumors(2). Osteosarcoma os the foot is rare and only a few well documented cases have been reported. The reported incidence of pedal osteosarcoma varies between 0.2-2% of all osteosarcoma and this rarity may lead to delay or misdiagnosis. (3). Osteosarcoma is the second most common malignant primary skeletal tumor, second only to multiple myeloma (4-11). Osteosarcoma usually occurs in the distal end proximal humerus and Osteosarcoma is rarely involving the small bones of the hands and feet(4-9). This report shows an Osteosarcoma which occur in the small bone of the foot (medial cuneiform bone), which gives metastasis to the site of amputation and calcified metastasis to lungs. Up to my knowledge and literature review, there is no reported case of Osteosarcoma that occurs in the small bone of the foot (medial cuneiform bone) in Ethiopia and Africa.

CASE REPORT

A 21 years old male patient farmer by profession came to our patient department of Tikur Anbessa Teaching Hospital, in 2001 GC with pain and swelling of the left foot of the left foot of seven months duration. The pain is usually increased from time to time. Physical examination reveled none tender hard shiny swelling on the medial aspect of the left foot and there was no discharge. All laboratory tests were normal except for an increased WBC count and elevated alkaline phosphates. X-ray of the left foot was taken, that shoed sclerotic bone invading and eroding the adjacent bones and some degree of expansion (Fig 1). The chest x-ray taken at the time of first presentation was normal.

The differential diagnoses that were given at that time were chronic pyogenic osteomylites to rule out malignant bone tumor likely osteosarcoma. The patient as well as x-ray of the foot was presented to joint radiology and orthopedic session After discussion, the joint session decided to take open biopsy that reveled an osteosarcoma. Beloe Knee amputation was made and the patient discharged. After eight months of the operation the patient came to the same hospital for the second time due to pain and swelling at the site of amputation, cough and chest pain. The physical examination at that time showed swelling at the area of the stump. The x-ray of the left knee joint area at the site of swelling showed new bone formation (Fig2). The second chest x-ray was taken at this time that showed multiple calcified metastases in both lung fields (Fig 3).

DISSCUSION

Osteosarcoma is one of the few primary malignant bone tumors that occur in childhood and adolescent. Osteosarcomas usually occur in the physical end of long bones especially around the knee joint(4-8. The distal end of femur by far the most common site(4). Involvement of the small bones of the hands and the feet is rare(4-7). Peter et al reviewed 52 cases Osteosarcoma of the foot between 1941-1996 (for 55 years) and found 28 cases of calcaneal, 6 cases of talus and one case each of cuboid and medial cuneiform bone(3. It has been suggested that major histocompatibility complex linked genes may determine susceptibility to Osteosarcoma(13). Other epidemiological mentioned to be linked are mechanical trauma, ionization radiation and chronic osteomylites(13-16). For a long time, Osteosarcoma has been as-

sociated with low social-economic stratum (17).

Typically conventional radiographs will show an eccentric area of peremeative, bone destruction in metadiaphysis adjacent to knee joint, associated with cortical erosion and soft tissue mass. The soft tissue mass may contain calcification (5). Computerized Tomography (CT), Magnetic Resonant Imaging (MRI) and Scintigraphy have also important role in the diagnosis and staging of the tumor(6).

A slight male preponderance exists, the peak incidence occurring between 10 and 25 years of age. The tumor is uncommon under 10 years and rare under five. Many of the tumors that occur in older age group are usually to a pre-existing disorder of bones, such as paget's diseases (4-6). Metastatic spread occurs by haematogenous route so that search for pulmonary metastasis should be put in mind. In later stages, metastasis develop in bones, and population surveys suggested that these deposits are themselves metastatic from pulmonary lesions (5,6)

The calcified mass around the site of amputation in this patient was likely from lung metastasis that by itself showed calcified metastasis in both lungs. The lungs is the commonest area of metastasis that usually manifested by pnemothorax. Presentence of small calcified granules that is seen in our patient is not common manifestation (6). The only primary tumors which give calcified/ ossified lung metastasis are osteosarcoma, chondrosarcoma, mucinous adenocacinoma of the colon or breast and papillary carcinoma of the ovary (18).

Osteosarcoma in small bones of the hand and foot is rare. Ostrowski et al did a study 240 bone lesion of the hands and feet bones and found benign tumor and lesions comprised 203 cases. The largest single category of neoplasms were enchondromas (29 cases) and chondrosarcoma (15 cases) and no osteosarcoma was found (10).

Lesion of the bones of the hands and feet may be biopsied or treated at hospital level without large orthopedic services. It is important for radiologist and other treating physician to be aware that such rare tumor can present in this rare site and may cause delay in the diagnosis and management of the patients. In addition to that interdepartmental session should be encouraged specially for the benefit of the patients.

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Dr. Eric Gokcen...

start "City grand round" in Addis.

I think you well know that Dr. Biruk regularly operates here on private patients and some charity patients. CURE uses high-tech implants directly imported from the USA. We do very advanced surgeries like joint replacements, ACL reconstruction, Spine surgeries, complex fractures and others. He also has a private clinic par time. He has been with us since the start (from the inception, through organization and until now) of adult private service. He is a "friend" of CURE.

Question- Any plans to Expand CURE?

Dr. Eric-We have plant to locally expand. We have big space of land the government of Ethiopia gave us, we have plans to expand the services already operational and start other new services. We hope it will be a training center to many. We have also regional outreach sites. We have 29 Clubfoot clinics nationally. Dr. Woubalem is the national director of the CURE Clubfoot Clinics.

Question- Anything more to say?

Dr.Eric-Ethiopia has many needs in the provision of excellent orthopaedic care to its citizens. But with the efforts of the ESOT membership, and appropriate support from the government and international organizations, I see a bright future for all

The Private Orthopaedic and Trauma Service Centre.

By Worku Mekonnen Bogale,
Orthopaedic Surgeon.

Yordanos Hospital

There are many difficulties in delivering trauma and orthopaedic care in this country. Patient care is hampered by shortage of equipment and funds. Normally 40% of the surgery cases are orthopaedic and trauma. This number is greatly increased by catastrophes and war conflicts. Diagnoses vary from bone tumors to osteomyelitis, including TB; from congenital deformities to post-traumatic disabilities. Fractures are of every description imaginable with open draining wounds, malunions, nonunions, etc. The cases are truly challenging and the caseload is unending. The tremendous number of cripples from all causes of bone disease and trauma are overwhelming. This adds a great burden on the economy of the country when often simple orthopaedic correction could make these patients into earning members of the society.

The goal of Yordanos hospital is therefore to augment the existing health service in order to achieve a positive change in the overall health status in general and to create a strong and well organized specialized orthopaedic, trauma and emergency services in particular, which could cover not only the country of Ethiopia, but also the whole region of East Africa.

Yordanos Hospital

The first 9 years were spent rendering general orthopaedic and trauma services in the Yordanos Higher clinic.

Starting the clinic was tough because of:

i. Limited resources:
- Finance
- Equipments, instruments, implants
- Facilities
- Professionals

ii. Lack of experience

iii. One specialist covering 24 hours a day, seven days a week, all year round

Managing the clinic was a real life experience with many challenges. Examples of these challenges include:
- OPD work was too much for one specialist. (> 60 Pts/d
- Up to 10 beds (in containers, totally uncomfortable for patients
- Mostly closed manipulations, tractions. There were no surgical facilities
- Minor surgeries were also done, but again with difficulties of anaesthesia, etc

Yordanos Hospital

The next step was to build Yordanos Hospital with improved facilities and the possibility to care for a larger number of patients.

Many different consultants and contacts helped in the growth and development of our orthopaedic service:
- Dr. Ralph Wolf
- Prof.G Walker
- Prof. J. Hauert and Clinic Dr. Guth of Hamburg,
- Dr. Elias Ahmed
- Prof Wolter of Hamburg Emergency Hospital
- Dr. Paul Baxt
- Apollo Hospital, Ahmedabad, India

Future Plans

1. Short Term
   - Involve Experienced orthopedic surgeons (Two foreign orthopedic surgeons already employed)
   - Improvise diagnostic facilities (installation of MRI and CT scan)
   - Starting of TKR
   - Installation of clean air conditioning in OT

2. Long Term
   - Organizing emergency Services
   - Site Expansion
   - Opening of Prosthetic Workshop.
   - Expansion of Wards
- Opening of Nursing homes.

Abstracts

Abstracts

PATTERN OF COMMON KNEE PROBLEMS AND ITS MANAGEMENT IN ADDIS ABABA, ETHIOPIA

Elias Ahmed, MD.
FCS- ECSA, SICOT
Diploma(Ortho).

Background:
knee problems are one of the common complaints in orthopedic visit.
Objective: identify common knee problems and its management.
Methods: prospective study of all patients with knee problems who presented to four hospitals during the year 2009 and who were diagnosed treated and had follow up.
Results: A total of 271 knees in 180 patients, predominantly female with a M:F ration of 1;2 mean age of 48 years. Majority leads sedentary life. All patient presents with pain followed by unable to squat 94% and swelling 67%. One thirds of the patients were over weight mainly female. The commonest findings were limitation of knee movement and crepitation.
Leading problem was primary osteoarthritis 62% followed by secondary osteoarthritis 17% (mainly due to Rheumatoid arthritis and varus deformity of the knee) and meniscus injury 11%. Intra-articular injection of Triamcinolon improves the function of 199 knees for a mean of 5 months and Hyaluronic acids improve the function of 60 knees for an average of 8 months. Thirty one arthroscopic procedure and five open surgeries were done which improves the function. Majority is not compliant for exercise and knee support.
Conclusion: over weight, sedentary life, knee deformity and uncontrolled RA causes majority of this knee problems.
Lists of recommendations are forwarded.

AGE DETERMINATION AT "TIKUR ANBESSA" HOSPITAL.

Samuel H, Robel F, Biruk L,W, Yohannis H, Daniel A
AAU, School of Medicine. Correspondences to lbiruklw@yahoo.com

Background:
Age determinations are based upon a preponderance of available evidence, as judged by a reasonable person. In Ethiopia, school certificates, birth certificates by religious institutions and municipalities are ones used for providing age. Hence, child offenders, criminals and raped ones undergo medical examination needed to ascertain their actual age. The objective of this study is to investigate the profile of clients at TikurAnbessa Specialized Hospital age determination board, composed of an internist, a radiologist and an orthopedic surgeon and the process of age determination.
Patient and Methods:
This is 2 and half years data collected retrospectively beginning from January 2008 upto June 2010 among 976 consecutive cases who presented to Tikur Anbessa Hospital, Addis Ababa University, AddisAbaba for age determination. 74 patients were excluded from the analysis for the fact that they did not know or mention their age.
Results:
Of the total of 976 cases for whom age determination was assessed at black lion hospital, 661(67.7%) were males and 315(32.3%) were females. Their stated age ranges from 5 to 45 years with the median age being 15years (332 cases(34%)) and the mean being 14.97years. 864(88.5%) of the cases were in the age group 12-19years. 74(7.6%) of them did not know or mention their age. 838(85.9%) of the clients were from Addis Ababa. 225(23%) of clients had 3 or more years difference between the stated and radiologic age. 205(21%) of them had stated age less than 3years from the board age. 946(96.9%) of the clients had same age determined by the radiologist and the final board age. The most common reason for age determination was crime 681(69.8%).22.4%(149/634) of the crime cases had stated ageless than 3years from the board age.
Conclusion:
Determination of age of criminals remains a crucial step in implementing the criminal law of any country. Despite the limited resources available in our country, combined radiologic, endocrinologic and orthopedic evaluation still remains the corner stone means for determination of the criminal age. Radiological age is the corner stone for determining age with 96.9% agreement with the board age. Though wide range of ages are involved in the crime, the age group that needs due attention is in the age group 12-19years. Most of the clients tend to lower their stated age. Due attention should be given to determine their actual age.

IMAPCTS OF FREE & VOLUNTARY MAJOR ORTHOPEDIC SURGERIES ON SATURDAYS AT BLACK-LION HOSPITAL,

1Woubalem Zewde, 1 Biruk L. Wamisho.
1 Assistant Professors at Addis Ababa University, College of Health Sciences.

Corresponding to: Dr. Woubalem Zewde, Head of Orthopedic department, AAU,
E-mail: woubalemz@gmail.com

Background: Efficiency of a Hospital's surgical service can be evaluated by its bed turn-over and number of patients on the waiting list. Centers operating on 24 hours, 7 days a week basis have no problems of a long waiting list. This need lots of resources, finance and dedication and is difficult to realize in many Hospitals in developing countries. The number of patients on waiting list for major orthopedic surgery at Black-Lion Hospital is too long. Besides, Specialty training centers will have greater chances of exposing their residents to a balanced case-mix if they have higher number of operating hours. This has alarmed the department which is the only of its kind serving a country of about 80 million inhabitants, to start additional operating day.

Settings: Addis Ababa University, College of Health Sciences, Orthopedic department.

Methods: After observing the long waiting list of orthopedic patients for major surgery, free and volunteer based Saturday surgery was launched a year back. Five volunteer consultants in the orthopedic department were involved and operated freely. Nurses, Anesthetists and other supporting staff were paid. Residents as well, attend and perform some surgeries for free. Regular donors were Dr. Fintan Shannon and Dr. Graham forward. Financial issues and documentations were controlled by the department head. Every week, planned and actually performed procedures were fed into the data base prospectively. The register has columns for age, sex, and type of procedure. Cancelled cases were identified with the reason.

Results:

In the past one year, March 14, 2009-March 13, 2010, a total of 275 major orthopedic surgeries were performed on Saturdays. Males were 189 (69%) and 86 (31%) were females. Age average was 32 years. The distribution of types of major surgeries done is shown. About 40 (14.5%) major planned procedures were cancelled, but it is not significant. Bed turn-over has increased. Referrals to other hospitals have decreased and emergency intake has increased. In one year period about 60,000 birr is spent as an incentive. Statistically significant increasing trends in both number and complexity of surgeries performed is observed (R-squared value= 0.67).

Conclusion:
Addition of operating time, with slightly motivated staff and committed consultants, will decrease waiting list significantly. It also increases bed turn-over, emergency intake and decreases referrals to other institutions due to lack of bed. We recommend that this initiative should propagate across our country and handled by MOH to be sustainable.

EXCISION OF SPINAL TUMOR IN A PATIENT WITH EXTENSIVE MULTIPLE NEUROFIBROMATOSIS

Neyango C MKANDAWIRE1, Biruk L. WAMISHO2.
1= Professor of Orthopaedic Surgery, Spine unit, MALAWI. 2= AAU, School of Medicine.
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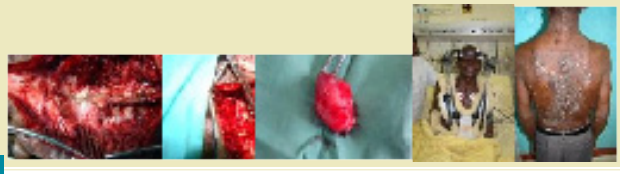
Neurofibromatosis (NF) is a multisystem genetic disorder that commonly is associated with cutaneous, neurologic, and orthopedic manifestations. It is a disorder of the neuroectodermal system that results in benign hamartomatous tumors of any organ or system. (Most notably the skin, the eyes, and the nervous system) that increase in number and size throughout life. These tumors are of tissues derived from neural crest, particularly sensory nerves, Schwann cells, and melanocytes. Two types exist and diagnosis is by criteria set by the National Institute of Health (NIH) Consensus Development Conference on Neurofibromatosis in 1987. NF type 1 (NF1) is differentiated from central NF or NF type 2 in which patients demonstrate a relative paucity of cutaneous findings but have a high incidence of meningiomas and acoustic neuromas (which are frequently bilateral). NF1 has a better prognosis with a lower incidence of CNS tumors than NF2.

An estimated 0.05% of the population worldwide is affected by neurofibromatosis-1. Prevalence is estimated to be about 1 in 3000. Patients with neurofibromatosis-2 have few dermatological findings, but they have a high incidence of meningiomas and acoustic neuromas. Visual loss secondary to optic nerve glioma is the most important ophthalmologic manifestation of neurofibromatosis-1.
In neurofibromatosis type 1 (NF1) spinal tumours cause neurological symptoms in about 2 % of patients.
In this case report we describe in detail, the clinical profile and the spinal surgery we performed in a 48 years old Malawian patient who presented with progressive quadriparesis in the face of extensive cutaneous multiple neurofibromatosis (Over a 1000 lesions!).
Photographic surgical procedure will be explained stepwise.



Drs. Yiheyis Feleke, Dr.Fintan and Bewketu Demisse

Development of low-cost local external fixator

Introduction

External fixator is a method of immobilization that uses Percutaneus pins placed inside the fractured bone and linked with connectors. (bars and connecting devices)

The concept of external fixator started from mid 19th century on the works of Malgaigne. Since then many other external fixator systems introduced and become the standard method for treating open fractures and deformities.

The three major groups are linear, circular and hybrid types.

Basic parts –pins or wires (Schanz screws, Steinmain pins, Kirschner wires)

Elements- clamps ,Aluminium

Connecting rods (stainless steel or carbon fiber rods)

We choose external fixators by their weight, ease of application, rigidity of fixator, fracture characteristics, personal preference/experience,

Biomechanical properties (bending and compression tests)

Abstract-

Sharing ideas of locally developing low cost external fixators for open fractures of limbs.

-Demonstrate the possibilities of developing orthopedics implants and instruments locally

Design- a prospective study

Setting- Addis Ababa University, local workshop

Methods- manufacturing components of external fixator with materials available ,pins& Schanz screws, which are introduced into the limb we used are standard imported

- Application of external fixator on wooden materials and animal bones-(killed)

- Application of external fixator on real patients with open fractures of the limb.

Results- trials are done on 10 patients in various age groups and fractures. Which are results in good bone healing. The fixators are as good as imported ones with some problems which need improvements. Specification and defining biomechanical characteristics and patent rights are on process.

ADAMANTINOMA OF TIBIA IN ETHIOPIA

Samuel Hailu1, Eric Gokcen2, Biruk Lambisso1, JakobSchenider1, Daniel Admassie1, Jemal Hussein3
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2.The CURE Hospital, Addis Ababa, Ethiopia
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ABSTRACT

Adamantinoma of long bones is an extremely rare tumor with no report, to authors' knowledge from neither Ethiopia nor Africa. We are reporting a 25 year old female college student with 1 and ½ years history of right mid leg pain and swelling with radiologically and histologically proven adamantinoma of right tibia. At CURE Hospital, she had undergone complete excision of the tumor with histologically documented clean margins. The limb was salvaged by reconstructing with a fresh frozen tibial allograft obtained from the US and an interlocking intra-medullary nail (SIGN nail).

Such insertion & incorporation of huge allograft using SIGN nail and saving a limb is the first surgery in Ethiopia. Details of the surgical steps will be exposed using Videos and photographs.Follow up serial MRIs, bone scan and x-rays will also be shown. The gradual incorporation of the allograft at different months during follow-up will be elucidated. Finally, clinical presentation, diagnostic work-up, challenges and pitfalls, treatment options, learning curve and the natural course of this extremely rare tumor will be thoroughly described.

CONCLUSION: At times, limb salvage surgery and technology should be offered to selected patients with a chosen type of bone tumor.

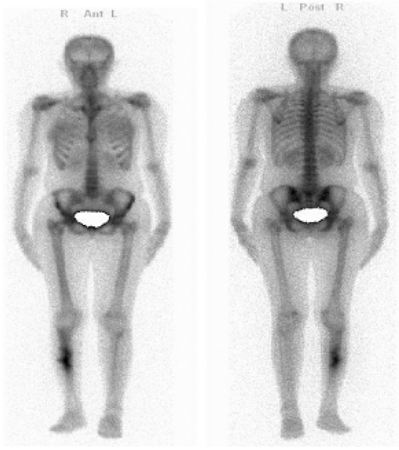

Figure : Whole body Technetium bone scan(done at BLH) showing increased tracer uptake of right tibia at anterior and posterior view

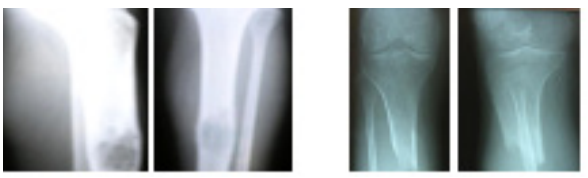

Figure : Plain radiography of right tibia taken 5 months apart

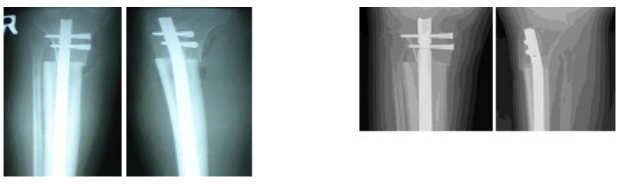

Figure : Right tibia contraolx-rays, immediate, 2months after

Abstracts

TRANSFUSION "TURN-OVER"/PRACTICE AT BLACK LION HOSPITAL

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1 Assistant Professors at Addis Ababa University, College of Health Sciences.

Corresponding to: Dr. Bahiru Bezabih, Addis Ababa, ETHIOPIA.
E-Mail: bongamera@yahoo.com

Background:

As the entire practice of medicine has evolved in the past few decades, so have transfusion practices. Two decades ago, a hematocrit between 0.20 and 0.25 was considered an urgent indication for transfusion, but at the turn of this century, maintaining a hematocrit at this level is considered to be "best-practice medicine". Nearly two thirds of patients admitted to an ICU have hemoglobin levels of 10 g/dl or lower. Although intraoperative blood loss and gastro intestinal hemorrhage contribute to these statistics and are a frequent reason for administering transfusions, only 40% of transfusions administered were because of acute blood loss.

Knowledge of which department uses more transfusion need a frequent audit so that the Hospital can be ready for the requests.

Transfusion services in developing countries are relatively underdeveloped and at times the doctor suffers from lack of blood due to less number of volunteers to donate blood.

Settings:

Addis Ababa University, College of Health Sciences, "Tikur Anbessa" referral teaching Hospital.

Methods:

Prospectively, for a year period (September 2008-September 2009), service and requests at the blood bank in the Hospital were followed. Numbers of units requested and actually taken by each department in the faculty were documented. Other variables were also audited using the data base format prepared.

Results:

Of all the requests made to its unit, the transfusion services unit in 'Tikur Anbessa" Hospital has issued to the patients a total of 3, 732 units of blood in the past Ethiopian year. Slightly higher than half of the patients were females (1997, 53.5%). Blood group "O" was the commonest group (1463, 39.3%) followed by "A" (33.5%), and "B" (22.8%). Group "AB" was the rarest, (165, and 4.4%)

Major source of blood is from the patients donated (3201, 85.8%). Only 531 (14.2%) of the requesting patients have not donated blood.

Of the issued blood from the unit, only 2349 (63%) was transfused to the patients and the remaining 37% was not used. The balance between donated but not used and freely given units at Black-Lion hospital is positive, 25%).

The surgical and orthopedic departments are the two main departments that have used blood for transfusion, 664 (17.7) and 655 (17.5%) respectively. OBGY was the third, 593 (15.9%). Medical and pediatric departments, each were issued 14.1% of the total units. Radiotherapy department has recently started transfusing (224)

The total number of units expired, transfusion reactions reported … are also audited.

CONCLUSIONS:

Knowledge of blood consumptions for transfusion in each department helps to plan a procedure or a treatment.

Transfusion audits help Hospitals to enforce and encourage blood donations.

Abstracts

GENERATING A COMPUTER SOFTWARE FOR PERMANENT DISABILITY/IMPAIRMENT RATING

1 Biruk L. Wamisho, 1Teshome Shibre, 2Israel G.silassie, Dagim Melkae, 1 Yemisirach Tesfahunegn 2.

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E-Mail: lbiruklw@yahoo.com

BACKGROUND: The burden of physical & Mental 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.

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 were certified. This makes easy communication among the researchers. An extensive disability rating manuals from American Medical Association (Guides), British Disability Guidelines, Canadian, Indian and other four rating formats were analyzed. 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-friendly and the whole process of rating until print-out will be demonstrated.

RESULTS:
The three main causes of Permanent Musculoskeletal disability observed in Civilians remained to be road traffic injuries, Machine injuries and falls. Malpractice both in a form of under and over-rating of percentages was observed. Compressive, easy to use, reproducible software is generated. Psychosocial aspect of disability was found ignored. 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, Muskuloskeletal and Mental impairment were tested and proven to be very effective, reproducible, transparent, consistent, objective and comprehensive, besides time saving. This I still being done in the respective departments. The software is easily updatable and its patent/copy right is in process.

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.

Abstracts

MAJOR LIMB AMPUTATIONS AT BLACK-LION HOSPITAL, 5 year trends (2004-2009).

Bahiru Bezabih, Biruk Lambisso and Yiheyis Feleke
Group-I Orthopedic Consultants at BLH

Amputation is defined as the surgical, traumatic, congenital, or spontaneous removal of a limb or projecting body part enclosed by skin. In the last five years (2005-2009); 291 amputations were done at BLH.

Young adults; aged 16-30 were highly affected by traumatic amputations (58/291) followed by old elderly past 60 due to vascular reasons. Kids suffered most from thigh splints by traditional bone setters; "Wogeshas". Pictures of the last 12 children suffered amputation, some without fracture are demonstrated. Overall; total number of victims of traditional bone setters outnumbered the cases of traumatic amputation (52Vs 42). This is an alarm.

The commonest level was Above Knee (140/291) followed by Below Knee (78/291). Diabetes, Bone setters, Tumors and Trauma are the leading causes respectively. There were 31 upper limb amputations where below elbow (12/31) amputation was commonest.

Over all, the right side dominated (155/291). Males accounted for most (204/291) of the cases.

We conclude that most of our major amputations were preventable.

We recommend that preventive measures like: training bone setters "wogeshas", good diabetic care and road traffic safety would decrease the number of major limb loss.

Fig 1: Comparison of All major Orthopedic Operations and Amputations

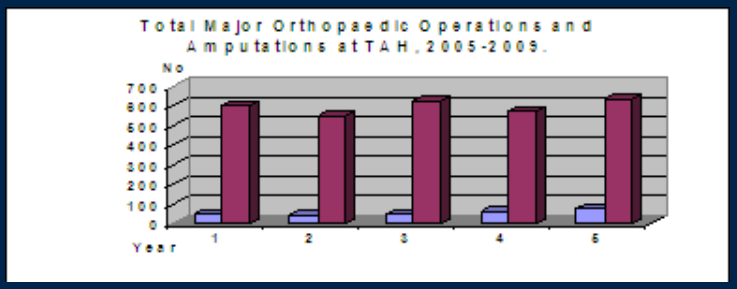


Fig-2: Leading causes of Amputation in the last five years at Addis Ababa University, BLH.

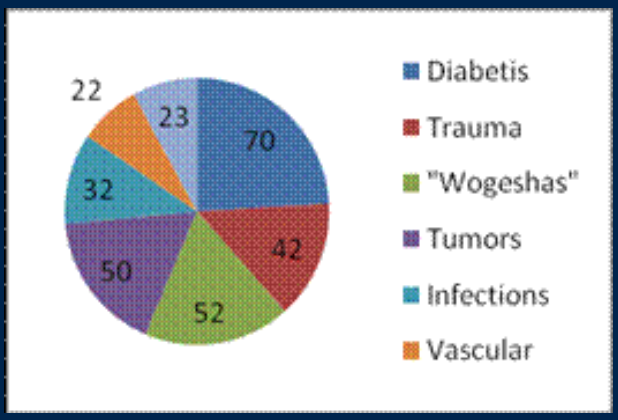
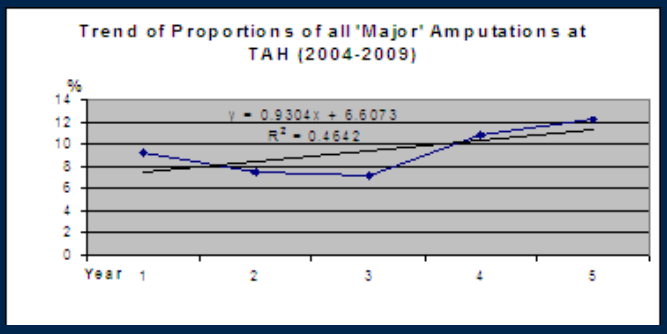


Fig-3: Expected trends of major amputations at BLH. Will we be amputating more?



THE FIRST SHOULDER REPLACEMENT SURGERY IN ETHIOPIA

Eric Gokcen1 & Biruk L. WAMISHO2
1= CURE international hospital, ETHIOPIA
2= Addis Ababa University, School of Medicine, Orthopaedic department, Correspondences to lbiruklw@yahoo.com

Joint replacement is an orthopedic success! To date, hips, knees, being the common ones, almost every extremity joint are replaceable. Shoulder and ankle joints are less commonly replaced.
The first recorded attempt of shoulder joint replacement occurred in 1892 in a patient suffering from severe arthritis. Modern shoulder replacement surgery started in the United States in the 1950s. It was used as a treatment for severe shoulder fractures and arthritic conditions.

In 2002, 400,000 knees, 343,000 hips and 23,100 shoulders were replaced in the United States alone. By the year 2030, it is estimated that the number of knee replacements will increase from 450,400 to 3.48 million. Between the years 2000-2003, 92% of cases of osteoarthritis were treated with total knee replacements. Also by the year 2030, it is estimated that the number of hip replacements will increase from 208,600 to 572,100. In England and Wales there are approximately 160,000 total hip and knee replacement procedures performed each year. Approximately the same numbers of hip and knee joints are replaced. Ankle replacement is a much less common procedure, but the practice is growing rapidly. Hip and knee replacements are carried out in around 400 hospitals. The situation Africa, particularly in the East is quite different.

According to Data monitor, the U.S. and Europe are the two largest markets for hip and knee implants, with a 50 percent and 30 percent share respectively. In the U.S. alone, more than 700,000 primary total hip and knee replacements are performed each year, according to the American Academy of Orthopaedic Surgeons (AAOS). In 2008, the US hip and knee replacement market was valued at $6.7 billion and is forecast to grow by 11.9% over the next seven years to reach $14.8 billion. The market is expected to be driven through 2008–2015 by; increasing incidence of osteoarthritis, aging demographics, trend towards early surgical intervention in younger patients, emergence of new procedures such as joint resurfacing, and greater penetration of existing technologies. This transaction is augmented by Medical tourism.

Africa's situation:
South Africa, Egypt, Ghana, Nigeria, Kenya …. , are capitals where adult reconstruction is well practiced.

JOINT REPLACEMENT IN ETHIOPIA:
Centers are appearing recently. We do hip, knee and shoulder replacements at CURE Hospital.
We describe in detail, shoulder hemiarthroplasty we performed on a Nurse with severe proximal humeral fracture. Indication, contraindications, approach and implant used and follow up results will be discussed. We think this is the first shoulder joint replacement in Ethiopia.

Abstracts

INCIDENCE AND CAUSES OF ADULT ORTHOPAEDIC MORTALITY AT BLACK- LION HOSPITAL :15 YEARS TRENDS

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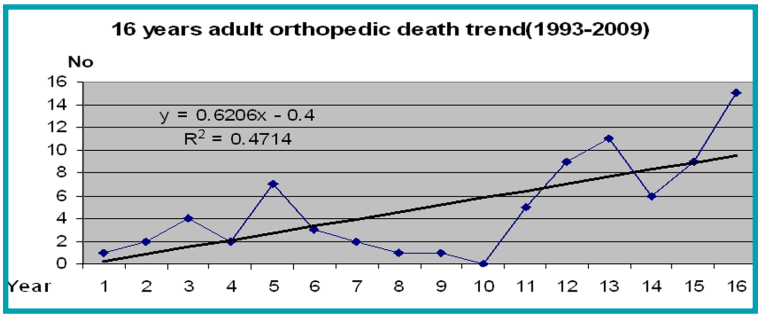
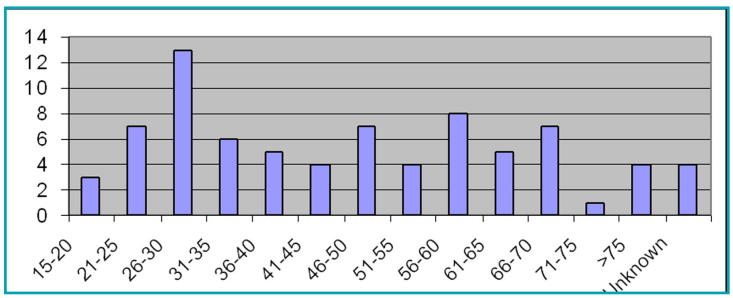
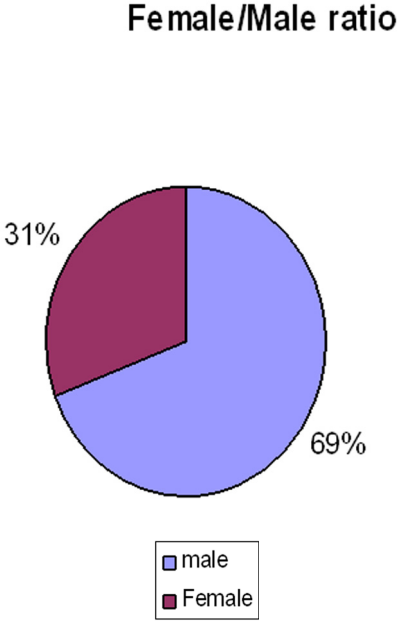
Department of Orthopedics, Addis Ababa, Ethiopia

Background:
Mortality is one of the surgical and medical complications that could be taken as an index of quality of patient care. There have been various studies looking at causes of mortality within the specialty of orthopedics/trauma and in the orthopedic specialty as a whole. It helps to evaluate the standards of critical patient care, referral system, resource management and the health system as a whole. Knowing the trends and patterns of orthopedic mortality enables the care provider to plan on supplies, equipment, expertise and management of such patients. The purpose of this study, therefore, was to analyze the incidence, causes and differences in mortality of adults from admissions in the orthopedic department of a university teaching hospital.
Setting: Addis Ababa University, faculty of medicine, the adult wards of department of Orthopedics.
METHODS: Between January 1994 and March 2009, there were a total of 78 in-patient adult orthopedic/ trauma deaths with a mean age of 46.2 years. Pediatric deaths and OPD deaths were excluded from the study. There were 2,411 acute orthopedic trauma outpatients seen by the department in 2008 and there were 404 admissions in the same period, 2008. The total number of major operations performed in 2008 was 571. The demographic variables, primary diagnosis, presumed cause of death and other all possible patient details were collected from the hospital records and death certificates. The data were computerized and analyzed using SPSS statistical package.
RESULTS: there were a total of 78 (24,30.8% females) adult orthopedic/deaths in the past 15 years. The mean age was 46.2 years (Range 15-89 years). The most common cause of injury was road traffic injury (RTI). The most common primary diagnosis on admission was Poly-trauma with pelvic fracture followed by poly-trauma with femur fracture. The most commonly encountered co-morbidity was diabetes mellitus. Only nine patients have got admitted to and died in ICU.
The mean number of days between the initial admission and death was (range 1 day-5 months). 30 (38.5%) patients were operated and the rest (48, 61.5%)were on conservative treatment. In the death certificate, the most common primary cause of death recorded was sepsis with multi-organ failure followed by fat embolism. Most of the patients with fat embolism were youngsters with long bone fractures. In most of the cases, post-mortum examination was recommended but we could not retrieve any feedback attached on certificate.
CONCLUSIONS: in adult orthopedic and trauma patients the most common cause of death appears to be sepsis with multiple system organ failure followed by fat embolism. High dependency care might have saved the lives of some septic or embolic patients demanding ICU care.







TREATMENT OF FEMUR SHAFT FRACTURES USING PERKINS' TRACTION AT ADDIS ABABA UNIVERSITY, AN ETHIOPIAN EXPERIENCE.

Bahiru Bezabeh, Biruk L. Wamisho.

Objectives: This is a prospective study with an objective to evaluate the outcomes of Perkins' technique in the treatment of adult femur shaft fractures from October 2007 – May 2009. Faculty of Medicine, Black-Lion Hospital (BLH), Addis Ababa University, ETHIOPIA, The study also aims at looking into the spectrum of femur shaft fractures referred to BLH.

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

Methods: All the 68 consecutive femur shaft fracture adult patients admitted to the department's wards during the study period were recruited for the study. They are prospectively followed after obtaining their consents. Standard Perkins' system of traction was applied and the orthopedic team composed of Consultants, Residents, Physiotherapists and Nurses using a Perkins' format/protocol prepared by the researchers followed patients. A physiotherapist attended each patient individually and as a group with similar patients. Knee and quadriceps exercise was done four times a day and recorded. Variables like patient's demography, cause of the fracture, characteristics of fracture, duration of traction, thigh circumference, knee range of motion, limb length, pin tract condition, complications and were included in the format chart. These were recorded every week, fed into computer. Final outcomes at the end of traction were documented and analyzed. Traction is removed when there is clinical and radiological evidence of fracture union. Physiotherapists give gait training and serial check X-rays were taken at outpatient fracture clinics.

Results: From the total of 68 consecutive patients admitted with femur shaft fractures and followed, 60 (88.2%) were males and only 8 (11.8%) were females making the fracture over 8 times frequent in the male sex. About half of the patients lied in the age range 18-28 years. Road traffic accident was cause of fracture in nearly half (49.2%) patients. The right side was more commonly fractured (40, 58.8%) than the left (28, 41.2%). Two third of the fractures (44, 64.7%) were closed. There was one bilateral fracture encountered. Half of the fractures (34, 50%) occurred in the proximal third of the femur. Transverse fracture was the commonest pattern (29, 42.6%), followed by comminuted pattern (18, 26.5%). Only three segmental fractures were admitted. Mean Hospital stay was 45 days and in the majority (33, 48.5%), duration of traction was between 30- 40 days and only eight patients were on traction for more than two months. Shortly at the end of traction; circumference of thigh was reduced only in 8 (11.8%) patients, knee range of motion was more than 90 degrees in 7 (10.3%) patients. At a mean follow-up of 8 months (range 4-20 months), only one patient ended up with non-union and there was also only one mal-union. Shortening of over 2 cm was noted in 11(16.2%) patients. Over-all pin tract infection rate was 11.8 %, 8 patients only.

Conclusion: Outcomes of conservative treatment of femur shaft fracture using Perkins' method are safe, easy, effective and very encouraging in a developing set-up like ours. There is an excellent Practice of Perkins' traction at Black Lion Hospital, Addis Ababa.

Keywords: Perkins' traction, Femur fracture, Conservative treatment, Quadriceps exercise.

The CURE Hospital

Adult
Pediatric
Joint Replacement
Arthroscopy
Spine

The primary mission of the CURE Hospital is to treat children with disabilities. As a service to the community and to help underwrite ongoing charity work, CURE is offering non-emergent Private Practice Services. The services include adult and pediatric orthopaedic surgery, joint replacement using US manufactured implants, arthroscopic surgery using state of the art equipment, subacute fracture care, and spinal surgery with an operating microscope. Our facility also provides first rate inpatient hospital rooms, along with on-site pharmacy, laboratory, and x-ray services.

Our Director of Orthopaedic Surgery, Eric Gokcen, MD, is US-trained and had been in practice in the US for over a decade prior to moving to Ethiopia over 2 years ago. He is board certified in the US by the American Board of Orthopaedic Surgeons and maintains Medical Licensure in the US as well as Ethiopia.

To schedule an appointment, or for further information about our private practice, please contact us at the CURE hospital.

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