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Suggested Learning Objectives:

By the end of the rotation at St. Paul’s Hospital Millennium Medical College, the student should complete the following:

Overall

• Observe the differences in physician training as compared to UMHS and discuss the advantages and disadvantages of the Ethiopian model.
• Attend didactic sessions with residents and medical students.
• Observe the differences in patient care, including inpatient and emergency care services, as compared to UMHS.
• Explore the nature of the physician-patient relationship and compare to that seen at UMHS.
• Observe recent changes in the national Ethiopian health system and their effect on health care and medical training.
• Observe care offered at institutions other than St. Paul’s Hospital with attention to differences based on the type of facility.

Obstetrics

• Observe antenatal care of pregnant women and explore the services and counseling offered.
• Observe the labor and delivery process.
• Observe postnatal care, including maternal education.

Gynecology and Family Planning

• Explore differences in the treatment of sexually transmitted infections compared to UMHS.
• Observe gynecological surgeries for common conditions.
• Observe post-operative care and management.
• Observe outpatient management of common gynecological conditions.
• Explore the current climate regarding contraceptive and abortive services, especially opinions of medical students and residents.
• Observe family planning services currently offered.
Background Information

Obstetric and Gynecologic Care in Ethiopia

Maternal Health and Obstetric Care

With a population of 91 million, Ethiopia is the second most populous country in Africa. The average Ethiopian woman has 5.39 children, and 40% of the population is under 15 years of age. Although the total fertility rate has decreased slightly in recent years, maternal mortality remains high. In 2010, the maternal mortality ratio was 350 per 100,000 live births, and it is estimated that 1 in 67 Ethiopian women will die from complications related to childbirth.

The high maternal mortality ratio is largely due to barriers to obstetric care, with 82% of reproductive aged women residing in rural areas. As a result of such geographic obstacles, only 28% of women receive antenatal care at least once, and 12% of women achieve the recommended four visits. In addition, a mere 6% of births have a skilled attendant present, leading to a range of obstetric complications, including obstetric fistulae, uterine rupture, and maternal death. One retrospective analysis found that 1 in 110 deliveries in Ethiopia resulted in uterine rupture, an astounding number when compared to a rate of 1 in 1,146 deliveries in the United States.

Family Planning and Contraception Use

Despite the growing population and high maternal mortality ratio, there is a scarcity of family planning and contraceptive resources available for Ethiopian women. As of 2008, an estimated 41% of pregnancies in Ethiopia were unintended; only 3% of these pregnancies were due to a failure of contraception. Rather, the vast majority of unintended pregnancies resulted from a lack of access to reliable family planning methods, as only 14% of Ethiopian women use modern methods of contraception. A recent study placed that number closer to 40%, indicating great improvement; however, much unmet need still exists.
In 2005, abortion was legalized in Ethiopia in limited circumstances, including fetal anomalies, cases of rape or incest, or pregnancies that endanger the health of the mother.\textsuperscript{11} Almost 400,000 induced abortions were performed in Ethiopia in 2008, with an annual rate of 23 per 1,000 women aged 15-44. Approximately half of all Ethiopian health facilities perform induced abortions, but second trimester abortions are only available in 9-10\% of facilities.\textsuperscript{9} Although progress has been made, unsafe abortion remains the leading cause of maternal mortality; a 2010 report by IPAS and the Guttmacher Institute estimated 6 out of 10 abortions in Ethiopia are unsafe.\textsuperscript{4} In 2008, approximately 52,600 Ethiopian women sought treatment for complications of an unsafe abortion, and providers estimate that this number represents only 25\% of those requiring such care.\textsuperscript{4,9} The majority of women suffering from complications after obtaining an abortion never receive care in a skilled facility.

**Recent Changes**

Since his appointment as Minister of Health in 2005, Dr. Tedros Ghebreyesus has implemented changes in the delivery of health care with much success. The Ministry of Health in Ethiopia has focused on community-based health care, fostering change from within the rural villages and areas with the greatest need. Nearly 30,000 health extension workers, usually high school educated women with one year of additional training, have been sent to work in rural communities.\textsuperscript{10} These workers provide direct care to women in addition to acting as referral resources. The Ethiopian government is also working to further develop the available health infrastructure, with plans to build 2,500 new health centers.\textsuperscript{12} These facilities will be staffed by an expanding class of physicians. The Ministry of Health and Ministry of Education have recently developed the New Innovation Medical Education Initiative, under which medical schools throughout the country will aim to admit 2,000 students per year.\textsuperscript{4} The expansion of access to primary health care has led to substantial improvement in maternal mortality. Estimated at 850 per 100,000 live births from 1994 to 2000, the maternal mortality ratio has dropped substantially to 350.\textsuperscript{13}

The Ministry of Health continues to seek improvement, with plans underway to develop a Health Transformation Army consisting of a member from each family in rural communities. This vast team will help encourage education about and prevention of disease. The ministry has also created a Balanced Scorecard, a method to allow all ministry workers to measure their performance against the country’s health priorities.\textsuperscript{10} It is hoped that these changes will help promote not only primary care and prevention, but also accountability within the government.
St. Paul’s Hospital Millennium Medical College Overview and History

St. Paul’s Hospital, the second largest public hospital in Ethiopia, is located in Addis Ababa. Built by Emperor Haile Selassie in 1961, it primarily serves those unable to afford care elsewhere, providing services free of charge to 75% of its patients. An estimated 800 clinical and non-clinical staff provide care to approximately 110,000 people each year. St. Paul’s receives referrals from around the country and is under the guidance of the Ethiopian Federal Ministry of Health (FMOH).

In 2007, St. Paul’s added a medical college, St. Paul’s Hospital Millennium Medical College (SPHMMC), with a current enrollment of 275 students. At least 30% of these students are recruited from rural areas of Ethiopia, and at least 30% of students are women. SPHMMC is unique in that its students must take a qualifying exam specific to SPHMMC. They also complete an application that provides information on academic achievements and extra-curricular activities.

In Ethiopia’s medical training system, students enter medical school immediately after high school. During their senior year of high school, students take a national exam, the school leaving exam, and rank their desired specialties, including medicine, teaching, and engineering. Based on their scores, they may be chosen to begin medical school, which is paid for by the government. Ethiopian medical students complete six months to one year of pre-medical classes, two years of pre-clinical classes, and two years of clinical classes. Upon completion of these
requirements, students take a qualifying exam. A pass allows them to begin their intern year, which accounts for their last year of medical school. At this time, they function as a doctor under the supervision of consultants (attending physicians). Interns function similarly to those in the US; however, they are still attached to their medical school and have not applied to a specific residency, rather they rotate in all fields.

After their intern year, if deemed competent by their supervising physicians, Ethiopian medical school graduates complete at least two years of general practice in the community. They act as independent physicians, and their time serves as a form of repayment to the government for their medical education. Following their service, students are eligible to apply for residency programs.

In May 2012, SPHMMC started an OBGYN residency training program.4 There are currently seven residents in their first year of training. They work alongside senior residents from Black Lion Hospital and Addis Ababa Medical University. Residents complete rotations in four areas: Gynecology, Maternity, Labor, and Outpatient, which consists of both scheduled appointments and emergency services. Through collaboration with the University of Michigan, family planning education was integrated into the curriculum at SPHMMC in 2012. The program employs training and didactics to provide midwives, general medical practitioners, and OBGYN residents with the skills and knowledge necessary to provide safe abortion and contraception services.4

First year OBGYN residents at SPHMMC with University of Michigan visiting faculty
Clinical Experience and Curriculum Proposal

Obstetrics Service Overview

Daily Activities
• Morning Report
• Case Presentation
• Rounds
• Floor Management
• Post Graduate Lecture
• Outpatient Department

Conditions Seen
• Normal labor
• Obstructed labor
• Obstetric fistula
• Preeclampsia
• HELLP Syndrome
• Cord prolapse
• Chorioamnionitis
• Chronic hypertension
• Placental abruption
• Placenta previa
• Oligohydramnios
• Postpartum psychosis

Experiences

Morning Report:
Morning report occurs each morning at 8 AM. Interns present all cases admitted to the Obstetrics and Gynecology services over the previous 24 hours. Attending physicians are present, and ask questions regarding treatment and management decisions made by the resident and medical student team. As a visiting medical student, I attended morning report but did not present cases.

Case Presentation:
On Tuesdays and Thursdays, a resident presents a case following morning report. This is similar to Morbidity and Mortality conferences back home, with challenging questions posed by the attending physicians.
One such case was that of a G9P9
woman who was admitted for a Cesarean section. Following an uncomplicated operation, she developed a wound infection on postoperative day 3. Despite antibiotic treatment, she progressed to sepsis and multi organ failure and died on postoperative day 19. In this case, the care and management decisions had been made primarily by the resident team without consulting the attending physician. In the medical training system in Ethiopia, residents are granted much greater autonomy in formulating treatment plans, and they often act without the guidance of their attending physicians. The residents and attendings alike believe this allows trainees to develop their own plan, fostering greater independence. As a visiting medical student, I was often surprised by the apparent lack of supervision. In this case, the attending physician was very displeased that he was not consulted in the management of the patient, especially given the perhaps avoidable outcome.

*Rounds:*

The resident and medical student team rounds from approximately 10 AM to 12 PM each day. There are both postpartum and labor wards, and formal rounds are performed for the postpartum patients. Patients are bedded in wards with 8-10 beds per room. An intern presents the patient and that day’s plan. On Tuesdays and Thursdays, teaching rounds occur during which attending physicians join rounds. Typically, 20-25 people attend these rounds, with a variety of medical students and residents present. Rounds are similar to those back home, with the attending or senior resident asking questions of the intern presenting the patient.

Several notable differences exist between rounds at SPHMMC and those at UMHS. At St. Paul’s, patients seem to be less involved in decisions about their care, and they rarely ask questions during rounds. This is partially due to the language barrier existing between patients and the medical team, as most patients do not speak English. In addition, the nature of ward rounding prevents the patient privacy we often take for granted back home.

*Floor Management:*

Following rounds, the care team implements decisions made during rounds for postpartum patients. Laboring patients are followed by interns, with contraction...
frequency documented by a manual count every 10 minutes. A fetoscope is used to monitor the fetal heartbeat. Vaginal deliveries and cesarean sections are performed by the senior residents without an attending physician present. Forceps and manual breech extractions are much more common in Ethiopia, and these are also completed by residents. While I was on service, a woman presented to the outpatient department in active labor. After a normal vaginal delivery, it was discovered that she was, in fact, pregnant with twins, and the second baby was breech. The senior resident completed a manual breech extraction without complications.

Women with normal vaginal deliveries are monitored for six hours and are then discharged. Cesarean section patients remain inpatient for 48-72 hours if there are no complications. As a visiting medical student, I was invited to assist in both vaginal and cesarean deliveries.

Post Graduate Lecture:
Each Monday at 2 PM, there is a postgraduate lecture led by an attending physician for the first year residents. On the first Monday of the month, this is a journal club. A resident presents a new article, which is then discussed by the faculty and residents present.

Outpatient Department:
The outpatient department encompasses both scheduled and emergency obstetric visits, and it is run entirely by the residents and interns. For scheduled visits, women are given a date and told to come in either the morning or afternoon. Visits are then conducted on a first come, first serve basis. Women also present to the outpatient department in labor, and they are admitted to the floor if there are available beds. Frequently, there is not time or space to allow a floor transfer, and women deliver in the emergency room. The outpatient department is fast-paced and very exciting, and I spent several afternoons a week here. Although patients speak in English, the residents and interns are happy to translate for you. In addition, all notes are handwritten in English, and this is a good way to follow along. As a visiting medical student, I primarily shadowed the residents and interns.
Gynecology Service Overview

Daily Activities
• Morning Report
• Case Presentation
• Rounds
• Floor Management
• Post Graduate Lecture
• Operating Theater
• Outpatient Department

Conditions Seen
• Ovarian Cyst
• Ovarian Cancer
• Ruptured ectopic pregnancy
• Myoma
• Gestational trophoblastic disease
• Cervical cancer

• Missed abortion
• Uterine rupture
• Pelvic inflammatory disease
• Utero-vaginal prolapse
• Cystocele
• Polycystic ovarian syndrome

Experiences:
Morning Report, Case Presentation, Rounds, Floor Management, Post Graduate Lecture:
These activities were conducted in the same manner as those for the Obstetrics service, with morning report, the case presentation, and the post graduate lecture taking place with the Obstetrics team.

Operating Theater:
On Monday and Wednesday mornings, scheduled gynecologic cases take place in the operating theater. Operations are mainly completed by the senior residents. While there, I observed repairs of cystoceles and utero-vaginal prolapse, the removal of a myoma, and endometrial ablation. As a visiting student, I was invited to participate in some of the cases. This was at times difficult as it could be hard to understand instructions because of the residents’ accents.
Cases are conducted much as they are at UMHS, with anesthesia, a scrub nurse, and the surgeon present. Some of the instruments are older, which can make operating frustrating. In addition, power outages are known to occur; however, this did not happen while I was there.

*Outpatient Department:*
The outpatient department is similar to that for obstetrics, and both scheduled and emergency cases are seen. One notable difference is the treatment of sexually transmitted infections. National guidelines in Ethiopia promote a syndromic approach to STI treatment. Given the scarcity of testing options, it is felt that this is the most cost effective and successful way to treat diseases.\(^{15}\) Thus, if a patient presents with a genital ulcer, he or she is treated for all of the possible causes without confirmatory testing (see Figure 1).

*Hamlin Fistula Hospital:*
One afternoon, I toured the Hamlin Fistula Hospital in Addis Ababa. Dr. Lia Tadesse at SPHMMC helped me set this up. Established in 1974 by the Australian physicians Reginald and Catherine Hamlin, the hospital has treated over 30,000 women with obstetric fistulae with a cure rate of approximately 90%. They now treat 2,500 women a year from all over Ethiopia, free of charge. The hospital is committed to treating the whole patient, providing a “haven of healing” with compassionate and holistic care. Many of the women seeking treatment have lived as social outcasts in their communities for years and arrive at the hospital with nothing more than their urine-soaked garments. Often malnourished, they receive nutritional supplements and physical therapy for contractures and nerve damage they may have sustained. They also work on developing sellable skills and attend classes. The mission of the hospital is not only to cure fistulae but also restore some of the lost dignity of these women. Upon completion of their treatment, women receive a new dress to symbolize their fresh start. The only payment expected is a commitment to help spread the message of the treatment available at the hospital.\(^{16}\)
Figure 1. Treatment algorithm for genital ulcers using the syndromic approach.\textsuperscript{15}
Recommended Improvements and Changes

My time in Ethiopia was both challenging and rewarding. To enhance the experience of future visiting UMHS students, I offer the following suggestions:

• As the first UMHS student to work at SPHMMC, there was limited formal curriculum in place. Having a standard schedule would have allowed me more continuity and perhaps given me the chance to develop greater autonomy. Future students would benefit from spending a week in each of the four rotations: Gynecology, Maternity, Labor, and Outpatient. Students should work with one resident for each of these four weeks, initially shadowing him or her. By the end of the week, the student may be able to act as an intern under the guidance of the resident, making independent care and management decisions for patients.
• Future students should present at morning report at least twice during their month long experience while on the Labor or Gynecology service. This would allow the student to be a more active member of the resident and intern team.
• Students should prepare a case presentation or journal club presentation and plan to present at least once at either morning report or the post graduate lecture during their rotation.
• Lastly, students would benefit from traveling with either another student or a visiting resident. Although there are many exciting travel and sightseeing opportunities, it was at times difficult to safely plan weekend trips alone. Completing a rotation in pairs would allow students to more fully take advantage of the many available cultural experiences.
Practical Information

Contact Information:
University of Michigan:
Dr. Senait Fisseha: Chief, Division of Reproductive Endocrinology and Infertility
   Email: sfisseha@umich.edu

Dr. Diana Curran: Assistant Professor of Obstetrics and Gynecology
   Email: dianacur@umich.edu

St. Paul's Hospital:
Dr. Lia Tadesse: Vice Provost for Medical Services, SPHMMC
   Email: liatadesse@yahoo.com
   Phone: 0911 40 53 97 or 0930 014195

Dr. Mesfin Araya: Provost, SPHMMC
   Email: mesfinawt@yahoo.com
   Phone: 0911 408950

Dr. Balkachew: Attending Physician in Obstetrics and Gynecology, SPHMMC
   Phone: 0911 374910

Before you leave:
• Visa/Entry Requirements: I used Perry International (www.perryvisa.com) to obtain a visa before leaving. In total, this cost around $70, and I received my visa in approximately 10 days. You can also purchase a visa at the Addis airport upon arrival for around $20. This is probably the easiest (and cheapest) option, but there is a long line to do so.

• Travel Clinic: Make an appointment well in advance of your departure (at least 6 months). You’ll need to get a variety of vaccinations, including yellow fever, hepatitis A, typhoid, a polio booster, a meningitis booster, a tetanus booster, and the flu shot depending on the season. If you have traveled internationally in the past, you may be able to avoid a couple of these, but make sure to bring your documentation with you. The travel clinic will also give you prescriptions for Cipro and malaria prophylaxis.

• HTH Insurance: OMSE will help you set this up. It’s very cheap ($1.25 a day), and covers most emergencies, including evacuation. I does not cover natural disasters, terrorist attacks, or accidents that occur while under the influence of drugs, alcohol, or on a motorbike.
What to pack:

• Clothing: Dress is more formal in the hospital, although residents occasionally wear jeans. Women wear pants or long skirts, but short-sleeved shirts are acceptable. Everyone wears a white coat in the hospital. Bring thick-soled hospital shoes such as Danskos. Outside the hospital, jeans and T-shirts are the norm. Also be sure to pack some nicer outfits for going out to dinner.

• Documentation: Make copies of your passport and other important documents. I carried a sheet with contact numbers with me. Make sure you have your HTH insurance card and a copy of your yellow fever vaccination card as well. Bring your UM ID card and a name badge holder to wear around the hospital. In addition, make sure you have a copy of the grading sheet for international electives for your attending physician to fill out.

• Medicine: Cipro is a must. Occupational Health at UMHS will supply you with HIV post exposure prophylaxis for free if you make an appointment with them. I also brought various over the counter medicines, including Ibuprofen, Imodium, and Benadryl. Addis Ababa is too elevated for malaria prophylaxis to be necessary, but if you plan on traveling outside of Addis, make sure to bring some. Addis is 7,700 feet above sea level; you may want to consider altitude sickness medication.

• Weather gear: I was there during the fall, and it could get pretty chilly at night. It was the end of the rainy season, but make sure to bring a good rain jacket and umbrella depending on the time of year you are there.

• Medical Gear: I brought 3 pairs of scrubs, gloves, shoe covers, OR caps, eye covers, masks, alcohol wipes, and lots of hand sanitizer. Although scrubs and gloves are available, I was happy to have my own that I could easily find when I wanted them. You'll be given a locker in the OBGYN office, and I kept my supplies there.

• Miscellaneous: It could get loud outside my hotel at night, so I was happy to have ear plugs! I also carried toilet paper or tissues with me wherever I was, as they’re not always in the restrooms. Make sure to bring European outlet converters. I was happy to have several.

Money:

The local currency is the Ethiopian birr. The exchange rate while I was there was approximately 18 birr to one dollar. You can exchange cash at any hotel, and many of the tourist locations will take American money. There are ATMs in most of the nicer hotels, but there is a fee for international withdrawals. In addition, most of the hotels take credit cards. I brought around $500 in cash and kept it in the safe in my room.
Communication:

Most everyone has a cell phone in Addis. I borrowed an international phone from a friend, but phones are very cheap in Addis if you choose to buy one when you are there ($25). My hotel had Internet, and I was happy to have my computer with me. I was able to check my email and video chat with friends and family back home. Video chatting using Gmail is free, and phone calls using Gmail to the United States are only .01/minute. There are Internet cafes available, but they can get expensive.

Housing:

I stayed at Soramba hotel, which was approximately $50 per night. They had great Internet and breakfast every morning. The staff was extremely friendly, and I felt safe staying there. Other options include more upscale hotels such as the Intercontinental, the Radisson, or the Hilton. Because so many University of Michigan faculty and residents are planning on working in Ethiopia in the future, they are hoping to work out a guesthouse option for visitors.

Activities:

There are endless activities and sightseeing opportunities in Addis Ababa and the surrounding area. Some suggestions:

- Mount Entoto: Located just outside the city, this is where former ruler Menelik II built his palace in the late 1800s before founding Addis Ababa. There are several beautiful churches, and local guides will take you on a tour. You can either take a cab or minibus to the top (or walk if you're feeling brave).
• National Museum of Ethiopia: Near Addis Ababa University, this is home to the famous Lucy (or at least a replica of her skeleton). The museum also houses beautiful artwork and many archeological finds.
• Holy Trinity Cathedral: Built to commemorate Ethiopia’s liberation from the Italians, the tombs of Emperor Haile Selassie and his wife are both inside. It is considered the most important place of worship in Ethiopia after the Church of Our Lady Mary of Zion in northern Ethiopia.
• Edna Mall: Located near the airport, it has several movie theaters that show fairly recent Western movies.
• Sheraton Hotel: This is the largest hotel on the continent, and it is definitely worth checking out. You can pay to swim in their pool or just enjoy the lobby for free. They also have several great, albeit pricy, restaurants.
• Shopping: The best places to find beautiful souvenirs are either Selam’s (near Madon Alem Church) or the Post Office Market (off of Churchill). Be ready to barter for the best prices!

Language:

English is used in the hospital for all discussion of patient care. It can be difficult to understand the accents; however, it does become easier with time. Most patients prefer to speak Amharic. An Amharic phrase book is recommended.

Transportation:

There are a variety of transportation options. Mini buses are very cheap ($0.20-0.30). These can be more difficult to navigate depending on where you are going, so be sure to ask someone for assistance the first time. There are also many private cabs, which can cost $3-$7 American dollars. Be prepared to barter, and never get in a cab without asking the price first. I used the same driver most mornings with an agreed upon fare to and from the hospital. Most cab drivers carry cell phones, and you can call them for a ride when you need one.

Before you arrive, contact your hotel (if you’re staying at one), and they will set up a shuttle to take you from the airport.
Food:  
Traditional Ethiopian food is delicious; make sure you take advantage of it while you’re there! Food is inexpensive by American standards. At local Ethiopian restaurants, lunch can cost $2. Injera, a spongy flatbread made from teff, is available at most local meals. It is customary to wash your hands before eating. Injera is then spread out with various meats and stews piled on top, and those present use their hands to pick up injera and other food. There are also numerous Western restaurants in Addis; however, they are more expensive than local food. Try to avoid raw fruits and vegetables and most street food.

Miscellaneous Notes:

• Doctors are addressed by their first names rather than last names. A person’s last name is the same as their father’s name, thus it seems as though you are calling them by their father’s name. This can create confusion, especially for women!
• Other terminology differences: rotations are attachments, attendings are consultants, and call is duty.
• Floors are numbered differently. The first floor is considered floor zero, the second floor is floor one, etc.
• The Ethiopian calendar is seven years behind our calendar. If someone’s last menstrual period was seven years and nine months ago, they are probably ready to deliver!
• Ethiopians also use a different time system, with 6 AM corresponding to 0:00. Most people are familiar with “European time,” but make sure to confirm before you make arrangements.
References: