PROMOTING UROLOGICAL CARE AND EDUCATION WORLDWIDE

Urolink trip to Ethiopia May 2026

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Will and Matt were following up on previous mentored training for our colleagues in Hawassa. Shekhar and Steve were in place to observe phase two of the emergency Bootcamp for BJUI. Sachin was a robotic fellow from Australia, based in Norwich, who wanted to know more about the provision of simulation-based education in an LMIC environment with the intention of setting something similar up in Sri Lanka, his ancestral home. His prime objective was to observe the EUSTs and see whether this form of SBE would be viable under an Australian banner in Sri Lanka. Ravi was a 2024 TUF fellow who, unfortunately hadn't been able to travel previously due to logistic difficulties in visit centres since the award. His intention was to observe PCNL in the raw as well as doing some teaching in a low-resource environment, different to that he'd experienced whilst training, and working, in India.

The team met in Addis Ababa having utilized the well-trodden paths, using Ethiopian Airlines, from Manchester and Heathrow. We were met in Addis Ababa by our colleagues Dr. Ramzi and Dr. Fitsum who took us for breakfast and picked up equipment that would be

useful in the boot camp taking place in Addis later in the week. Large amounts of equipment were brought into Ethiopia for both the PCNL workshop as well as emergency urological simulation training sessions. This included new metal Alken dilators for PCNL access as well as a new lithoclast foot pedal, and probes, which Shekhar had procured from India. Having explanatory documentation from UK donors and our Ethiopian colleagues proved extremely helpful; we were stopped for an inspection of the luggage at customs at every point! All instrumentation was, eventually, allowed through without additional costs being accrued.

Following the transfer from Addis to Hawassa we stayed in the Oasis International Hotel where we met many old friends.

Clinical interactions

After dropping off our bags we headed straight to Hawassa University Comprehensive Specialized Hospital and spent some time looking at the images of nine patients who were prospective candidates for PCNL. It was decided that three patients were not suitable; one did not have sufficient contrast CT images to adequately determine the stone burden or the position of the stone; one had had a ruptured renal pelvis following an obstructing PU J stone in a solitary kidney within the previous few weeks and was still being drained by a PCN and the third had calcification in an atrophic area in the lower pole of the kidney following previous surgery. This was thought to be dystrophic calcification rather than being due to calculus disease; the patient was asymptomatic.

The six cases that appropriate for PCNL are outlined in the table below:

Patient	Gender	Age	Clinical issue	PCNL	Surgeon	Mentor
AZ	M	55	1.2 PUJ and 8mm lower pole calculus RIGHT	12/05	GT	MT
TB	F	18	3 lower polar stones LEFT	12/05	TL	WF
UM	M	50	Bifid pelvis with lower moiety partial staghorn LEFT	12/05	TA	MT
DD	M	45	Obstructing PUJ stone LEFT	13/05	TL	WF
EG	M	30	Multiple stones in lower pole of solitary kidney LEFT	13/05	GT	MT
BT	M	32	2cm + renal pelvic stone RIGHT	13/05		WF

On days two and three the listed patients underwent percutaneous surgery in the new operating theatres at HCUSH. A theatre in the complex was opened specially for the camp; it is not clear when the remaining theatres will be fully commissioned. Patient checks were performed by the extant methodology of two- or three-point photo identification. The C-arm jointly purchased between BJUI and the university was put to good use. In combination with grey scale ultrasound location for renal access the C-arm proved to provide extremely high-quality imaging for track dilatation and stone location.

On the first operative day three cases were undertaken. There was some considerable delay in getting the list started due to 'training' with the C-arm as well as a shortage of oxygen cylinders. The older patients all had their surgery performed under spinal anaesthesia whilst the young girl had a GA. Each case was performed by the local surgeons with mentorship from Will Finch and Matt Trail.

The Alken dilators proved extremely effective. All cases achieved their objective of disobstructing the upper tracts; however, all systems were comparatively complex which meant that there were some residual peripheral calculi at the end of some procedures, inaccessible with the access achieved. In a high-income environment these would require supplementary treatment with either intraoperative antegrade or retrograde flexible instrumentation and laser fragmentation or ESWL at a later date

On the second operative day the list started on time and all cases were performed under spinal. The third case proved difficult as the temperature inside the theatre was almost 30 degrees and this meant the C-arm kept cutting out as the X-ray generator was reaching temperatures of >50 degrees.

By switching the machine off and using a fan it was possible to get the equipment back into service. However, this is a significant logistic issue which needs to be resolved between the C-arm provider and the hospital, who could ensure the theatre is cooled. We had the opportunity of discussing this with the hospital director, who was accompanying us to the airport for the flight to Addis on day 3.

Emergency Urological Simulation Training

The skills lab at HUCSH was visited after the ward round on the Sunday. Everything was found to be extremely well organized by Dr Tilaneh and the education centre staff. Donated trays were set out together with locally sourced instrumentation. The EUST was carried out on the first full day of the trip. The local organizer, Dr. Tilaneh, provided excellent leadership which enabled a seamless course provision. Presentations were provided by local colleagues, and the faculty was composed entirely of general surgical and urological consultants from within the region.

The course was observed and metrics generated regarding the faculty's confidence and their global experience in course provision. 12 delegates attended the course; they were all surgical residents on the HUCSH rotation. Modules one and two were provided synchronously with groups swapping round at lunch time. Course feedback demonstrated excellent knowledge gain, great feedback and increases in faculty confidence.

The Hawassa course demonstrated that sustainable local delivery is achievable through strong leadership, faculty development and institutional commitment.

On the fourth day, we had an evening transfer to Addis and stayed in the Best Western Dynasty in the city centre. That evening we went to ensure that everything was in order at the skills centre at Black Lion Hospital. All seemed in order, but the following morning there were problems with the provision of the animal models, especially kidneys and bulls' penises. In addition, the number of local faculty available to provide the course was lower than anticipated.

A combination of these factors meant that some of the UK group had to get involved in the course to provide some of the lectures and one-to-one tuition for delegates. It also meant that some of the procedures had to be demonstrated by expert faculty rather than being undertaken by the delegates in their entirety.

Twelve residents participated; two thirds were urologists in training the remainder were trainee general surgeons.

While the course itself was successfully delivered and trainees remained highly engaged, the experience underscored the importance of strong local leadership and institutional commitment. The contrast with Hawassa demonstrated that sustainability is not achieved uniformly and requires ongoing investment in faculty development and local ownership.

Despite these challenges, the course maintained high educational standards, and valuable teaching was delivered to participating trainees who rated the experience extremely highly. Importantly, the difficulties encountered provided useful insights that will help guide future programme planning and support.

The cost of provision of the EUST in Hawassa was £240; similar data is still awaited from Addis.

Following previous discussion with BJUI it had been decided to recompense local faculty each with a $50 honorarium as they do not receive study leave and would be losing out on income generation. This was gratefully received, and it remains to be seen whether this inducement may improve faculty participation in the future.

Further scoping visits to St. Paul's and Black Lion Hospitals

Following an initial scoping visit to St, Paul's in November 2024, further arrangements had been made for the whole team to visit the CEO there and at Black Lion Hospital. It was obvious that both centres have the same limitations, and needs.

Both executives outlined their hospital's ambition and their desires to help progress technical development on their sites. There is, however, very significant technical short falls in being able to reach the anticipated levels of activity in both institutions, particularly as far as equipment and radiological support is concerned. Whilst able to carry out trans-urethral surgery and prone PCNL, there is a need at both sites to develop supine renal access as well as complex, and posterior urethral reconstruction. As majority of Ethiopian trainees pass through these two institutions, there is a considerable opportunity for Urolink to develop Addis-wide links encompassing both sites. Although there is a desire to progress more complex surgery it was suggested that it would be reasonable to seek funding for a conjoint approach to mentored training and to commence this to see how things worked out. It would be possible to carry out synchronous workshops across both sites with two different teams to mentor stone and reconstructive packages. We are awaiting confirmation from our local colleagues about how a conjoint training platform could be orchestrated.

Social interactions

After the EUST a dinner was held at the Oasis international which was a great opportunity to mingle with colleagues from Ethiopia as well as representatives of the pharmaceutical industry (Aurobindo Pharma); they may be potential donors to help provide local funding for the course in the future.

On the second night a dinner was very kindly and very generously provided by Dr. Tizazu at his home, which was delightful. We were very well looked after, fed and watered.

After the scoping visits to the CEOs at St. Paul's and Black Lion, we visited Entoto Park on the periphery of Addis, and Sachin visited a variety of museums.

After the Addis EUST we were entertained in the Monarch hotel rooftop.

Unfortunately, there was a fair amount of 'illness' during the trip which interfered with full participation by all members apart from the stalwart Will! No one, however, was excluded from participation in the entirety of the trip.

Conclusions

Supine PCNL is viable and starting to be practiced in Hawassa and is a paradigm for the development of stone services in Addis. It has been shown that with appropriate, sustainable, equipment and support, a viable service can be provided with 3 on-site visits and ongoing remote support from the UK.

EUSTs are deliverable locally, but there may need to be more than just remote support in some sites. In particular there needs to be widespread dissemination of knowledge about an honorarium accompanying the courses to improve faculty compliance, and better organization of the model animal material. It may be that utilization of a technician to help source and prepare the material would be the ideal way forward and prior procurement and storage of frozen material in advance of the course would obviate the problems encountered in Addis.

Finally, we think there is merit in considering a major commitment to Addis Ababa. This will open another Urology training hub for dissemination of training to a larger part of North-East Africa. Financial support for this endeavour needs to be sought, and secured, before a 2–3-year development programme can be structured and started.

A SWOT analysis of the viability of the combined hospitals in Addis as a new link centre will be presented to the next meeting of the Urolink Executive.

Acknowledgements

We would all like to thank our colleagues in Hawassa in Addis for their contribution and continued dedication to development in their centres. We would also like to thank the theatre and post-graduate teaching/Sim Lab staff who helped make the EUSTs such a valuable resource to local trainees. We would also like to thank Urolink and BJUI for their continued financial support to enable the development of supine PCNL in Hawassa and to companies, and individuals who provided equipment that could be used to help render patients stone free. We are also grateful to BJUI for its continued support for this opening round of the second phase of the EUST programme and for Aurobindo for considering continuation of funding to provide this training in the future. Finally, we were very glad of the opportunity to have Sachin with us; he bought into the Urolink mentorship model, and is something he hopes to develop when he is back in Australia later this year.