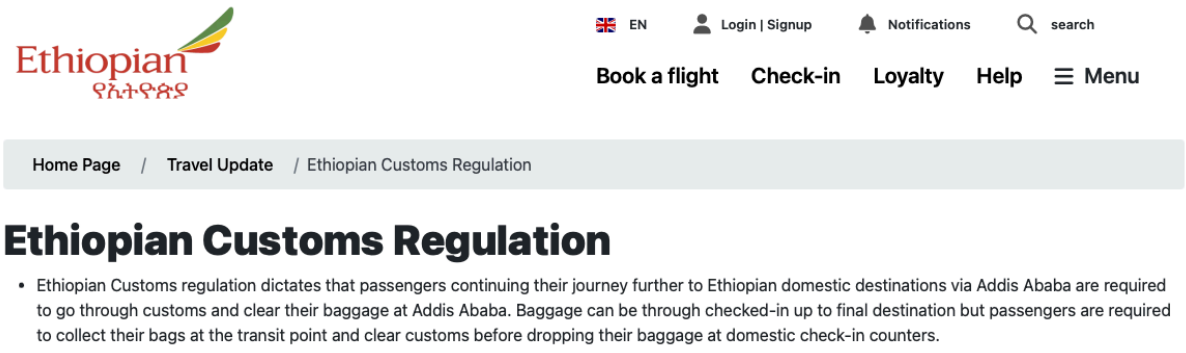
Visit report	
Country visited	**Ethiopia**
Institution or workshop	**Hawassa University Comprehensive Surgical Hospital (HUCSH)**
Dates of visit	**11-15/05/2025**
Team members	**Shekhar Biyani** **Will Finch** **Paul Anderson** **Steve Payne**

Will and Paul travelled to Addis on Ethiopian from Heathrow where they met Steve and Shekhar who travelled there from Manchester via Geneva. All had plenty of luggage and the 2x23Kg allowance is great on the outbound journey if there is plenty of kit to take, but if returning just to Hawassa on the way back it must be remembered that the domestic luggage allowance is only 20Kg! We all picked our luggage off the carousel, despite, it being booked all the way through due to the Ethiopian Customs requirements. There was a 6 hour lay-over between the connecting flight to Hawassa.



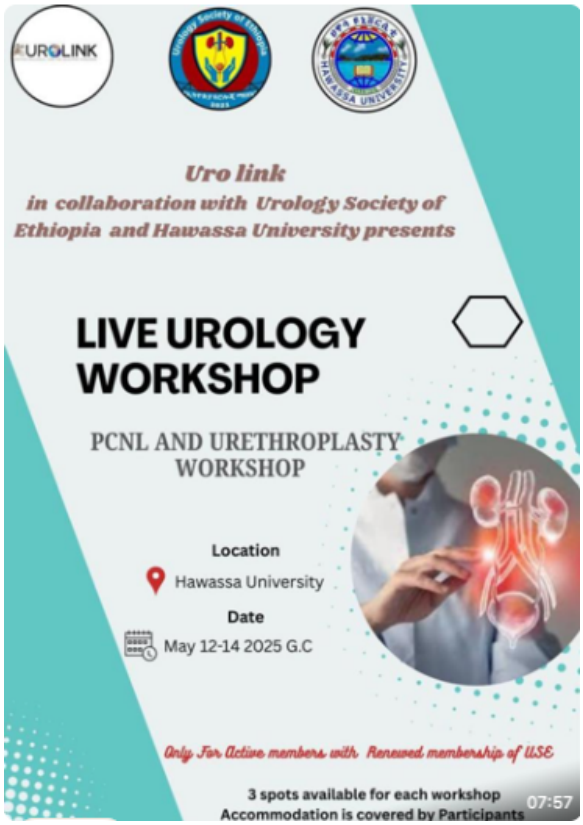
Online visas are easy now, and on this occasion, we used data only eSIMS bought through Airalo for £9.50 for 1Gb for 7 days which is just about enough if used judiciously with locally available WiFi. We were picked up and delivered back to the airport by university transport organized by Tilaneh.

We received a warm welcome at the Oasis International in Hawassa, which was funded by the University. All meals in the hotel were included and there are two ATMs outside the hotel, so there is no absolute necessity to exchange money at Addis before travelling down.

On arrival we arranged to meet up with our hosts, who took us to do a ward round at HUCSH. Despite the difficulties there are in medicine in the country at present (see below), there were a full retinue of residents to present cases. In fact the preparation for, and the

standard of case presentation was excellent with all relevant material (notes, imaging, data, relevant documents) being available.

Patient identifier images of the patient and their information were taken, with the patient's consent, as usual. Seven stone, and eight reconstructive, cases were presented. The stone cases were a mixture of simple, but predominantly challenging, upper tract stones. One 40-year-old male patient with a left-sided renal stone had a low haemoglobin and incipient renal failure, the cause of which wasn't clear. One 40-year-old male patient with a very proximal bulbar stricture, planned for an EPA, was hypertensive. Both cases were postponed from further involvement in the workshop.



The workshop was billed as an educational opportunity for regional urologists (left) but because of the local staffing issues it wasn't, perhaps, as well attended as it could have been. A few did make it through. The teams split into two teams, as they would each be operating in separate theatre locations. Will and Shekhar operated in the orthopaedic theatres where a C arm was available, whilst Paul and Steve were in a separate theatre. The old theatres are still not functional which, it seems in part, is due to the withdrawal of USAID funding. Will decided to use occlusion balloons to stop stone migration and to facilitate dilatation of the collecting system. He felt this was a positive step that would change his practice in an LMIC environment.

Twelve cases were operated on over three days, six in each theatre.

Stone cases

There were some issues with the lithoclast probes available and spares had to be borrowed from the private sector. Shekhar brought a semi-rigid ureteroscope with him as a gift from Luke Gordon, which was gratefully received.

Day	Age	M/F	Issue	Procedure	Operators
Monday	60	M	Previous left open surgery. X2 residual left renal stones.	L interpolar PCNL	SB/TL
	27	F	Previous pyelolithotomy. Right renal stone in infundibular diverticulum.	R calyceal diverticular PCNL	WF/TL
Tuesday	30	M	Previous left nephrectomy for stone. X2 stones in right kidney.	Parallel punctures for calyceal PCNLs	WF/TT
	35	M	NF L kidney. Previous R pyelolithotomy. Multifocal stones on right with large stone burden in the upper ureter.	Ureteroscopy for upper ureteric stones, then PCNL	WF/TT
Wednesday	67	M	2.5cm Right renal pelvic stone	R Infra XII PCNL	GT/SB
	23	M	2.5cm obstructing left renal pelvic stone with 1.5cm stone in inferior pole	L Inferior pole PCNL	GT/SB

Will felt that there was generally good skill acquisition, with no renal pelvic fenestrations during dilatation, and that the rate limiting step in progression was the availability of a C arm. The team are clearly doing PCNL between workshops, but this is logistically difficult.

Most of the patients were discharged home stone free within 48 hours of surgery having Foley nephrostomy tubes removed. The patient with a large stone burden had x2 residual peripheral calyceal stones, will be booked for a second look ureteroscopy in a month and consideration will be given to separate PCNL of the residual stones.

Reconstructive cases

One 52 -year-old man's procedure was cancelled on the Wednesday session as the first case was technically extremely demanding. Several of the cases necessitated antegrade endoscopy to check the anatomy before, or during, the procedure.

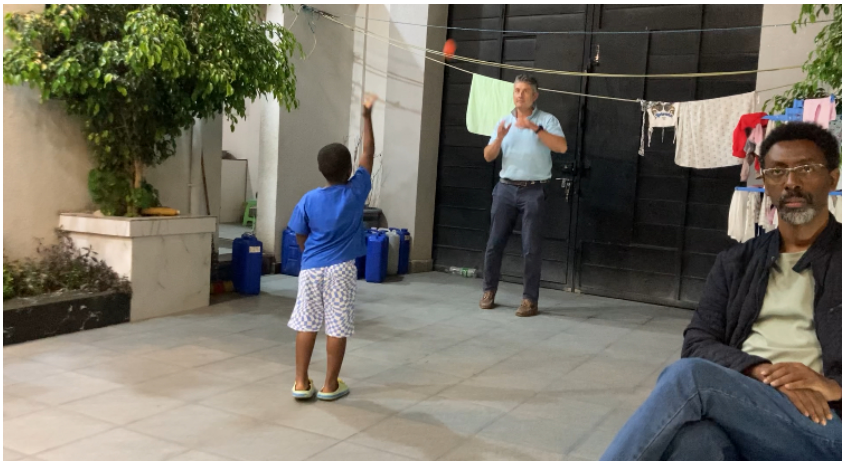
Day	Age	M/F	Issue	Procedure	Operators
Monday	60	M	Mid-bulbar stricture 3cm	Ventral buccal mucosa augmentation	PA/TT
	38	M	PFUD following mining accident	BPA with Stage 2 mobilisation	PA/TT
Tuesday	28	M	PFUD following RTA	BPA with Stage 2 mobilisation	GT/PA
	35	M	PFUD following RTA	BPA with Stage 2 mobilisation	GT/PA
	60	M	Short mid-bulbar stricture	UD	GT
Wednesday	37	M	PFUD following RTA	BPA with Stage 2 mobilisation	PA/TL

Paul felt GT clearly had good skills acquisition and was told that roughly 50% of the urethroplasties he was performing were for PFUD injuries; Paul gave Getch a hand with a private PFUD case the following day. There are still issues with the availability of bipolar diathermy, an essential piece of equipment for diathermy ripping to minimize blood loss during urethral mobilization.

All patients did well post-operatively and will return for further catheter management, determined on an individual basis.

Social interactions

This was a tough few days so there were limited interactions for socializing. Shekhar and Steve both had Hawassa tummy, but a very pleasant evening was spent with Tizazu and his family, who hosted us to a fantastic meal yet again, accompanied by his now famous jugs of gin and tonic!



A shopping trip on the Thursday morning before we set off for Addis was cut even shorter by the inundation of street kids who swamped us in the centre of Hawassa. There is the impression that the community are struggling, and the poor are only getting poorer. This is, perhaps, another manifestation of the issues that there are in Ethiopia at the present time.

The current situation in Ethiopia

During our visit in became obvious that the situation in Ethiopian medicine is quite precarious and this is having a significant impact on healthcare provision, all around the country. There are several factors contributing to these difficulties, but these all boil down to the finance available to run a sustainable healthcare system.

The changes in global aid funding available to central government, from USAID and other NGOs, has had a deleterious effect on health infrastructure. However, it is the resource distribution policy of the Ethiopian administration that has had the greatest impact on the funds available to healthcare in the country. Ethiopia has been fighting several separatist civil wars for the last decade with the focus having shifted from the northern region of Tigray to Asmara on the Sudanese border. Prioritization of military expenditure has produced a significant strain on all civilian services and health provision is one of the casualties in this funding conflict.

There is a significant, and palpable, decrease in commitment to the government health service which has manifested in a few different ways. An inability to obtain regular employment following graduation, a decline in post-graduate training opportunities and decrease in incentives when trained have all promoted a diaspora from the government sector and from the country. New graduates cannot find employment, trainees cannot complete their training, and consultants have been paid their base salary but not supplements for additional activities such as on-call for many months, sometimes a year. In combination with a sizable level of inflation this has meant that the relative value of a government salary will not sustain even a small proportion of the most basic standard of

living. Notwithstanding the suspension of any infrastructural development, or improvement in standards of practice, this has meant significant despondency and disillusionment among the medical workforce at every level.

The reduced central appreciation of the benefits of a healthy population has led to widespread strikes within the healthcare sector with inevitable effects on the accessibility to treatment. This has also accelerated the diaspora with some opportunities in high-income environments, but many are in other LMICs with better economies, being capitalized upon. It is common knowledge that trained urologists in Rwanda will earn at least 10 times more than in Ethiopia and that those who stay in Ethiopia will have to supplement their salaries with income from the private sector, something the government is seeking to restrict by cancelling contracts of employment for doctors making this transition.

In Hawassa there has been no infrastructural investment so there has been no forward momentum in the new theatre complex nor in the acquisition of a C-arm, for urology, so that regular PCNL can take place. The lack of supplemental income has already forced one urologist to leave to work full time privately, so that he can provide for his family during this time of substantial inflation. Previously, even when he was paid his salary, this did not cover the running costs for his car. It is conceivable that the other consultants will follow the same route out of HUCSH notwithstanding their undoubtably dedication to the concept of universal health coverage, and the very considerable effort they have invested in service development at HUCSH over the last 7 years.

It seems unlikely that the government is going to change its stance on healthcare provision in the foreseeable future and we think the best Urolink can do is continue to support the surgeons we have helped mentor in the programme to date. We know that, given the opportunity, these dedicated individuals will provide as accessible a urological service as it can to the widest community based on clinical need.

This was a fantastic trip, which was possible only because of the staff at HUSCH, who came in to work whilst others were on strike, always smiled, were helpful and courteous and good at their jobs. We can’t thank them enough. We’re also grateful for the continuing brilliant support we have received from our colleagues in Hawassa, their committed junior staff and their families, all of whom are clearly going through a tough time now. We look forward to being back with them as soon as we can, and to supporting them virtually in the interim via dedicated Stone and Reconstructive WhatsApp groups.

Acknowledgements

To everyone who donated kit that made the journey so much more viable. Most of this was left behind after we left.

Steve
Will
Paul
Shekhar **May 2025**