Report on Palliative Care Works visit

to Addis Ababa, Ethiopia

7th to 18th November 2016

Departure from UK 6th November, arrival in Addis Ababa 7th November.

Departure from Addis 19th November, arrival in UK 19th November.

Location: Addis Ababa

Objectives:

1. To support the integration of palliative care into the health care systems of Ethiopia through training health care providers.
2. To consolidate the relationship between Palliative Care Works (PCW) & Rotary International (RI) and Dr Nicola Ayers, PhD, MSc, BSc (Hons) RN, the Palliative Care Adviser to the Federal Ministry of Health of Ethiopia (FMOH) in developing and delivering a palliative care training and mentorship programme in Ethiopia, 2016-2018.
3. For the PCW/RI team to meet with FMOH Officials to discuss this collaborative project.
4. For the PCW team to deliver a one day refresher course on Palliative Care to previously trained heath care workers.
5. For the PCW/RI team to visit Hospice Ethiopia.
6. To meet the members of the FINOT Rotary Club of Addis; the 'host club'.
7. For the PCW team to deliver a 5 day Palliative Care Toolkit training to 28 Addis based health centre staff.

Visiting Team

From PCW

Mrs Ruth Wooldridge, OBE (Palliative Care Nurse and Palliative Care Mentor) - RW
Dr Gillian Chowns (Social Worker and Palliative Care Mentor)-GC
Dr George Smerdon (Medical Doctor and Palliative Care Mentor)-GS

From Rotary International

Mrs Christine Davies, District Governor Elect, East Midlands, UK -CD

Context and background

Palliative Care Works is a not for profit UK-based consortium of experienced palliative care practitioners, educators and managers. PCW aims to support and develop palliative care services in resource limited settings through training and mentorship, in collaboration with existing initiatives and organisations. PCW uses as its resources the Palliative Care Toolkit (its three authors, one of whom is RW, being PCW Trustees) and its Trainer's Manual (both available on PCW website- www.palliativecareworks.org)

This initiative to work in Ethiopia had arisen as a result of a personal approach made in early 2015 by Christine Davies of the Rotary Club of Market Harborough, UK, to Ruth Wooldridge, a PCW Trustee. CD, as District Governor- elect of the East Midlands Rotary Clubs was looking to raise funds, as part of the charitable aims of her year of office, for a palliative care project in a resource limited region of the developing world, her primary objective being the distribution of the Palliative Care Toolkit and, where possible, supporting a translation into the local language. Contact had already been established with Dr Nicola Ayers of FMOH in Ethiopia but a number of other possibilities were considered by the PCW Board, before confirming its recommendation that this work be taken forward in Ethiopia. PCW is hugely impressed by Dr Ayers' work on palliative care in Ethiopia where she has worked and continues to work tirelessly with the FMOH to promote the service. We were pleased to offer our services of support at this crucially important stage in rolling out further training, in partnership with RI as the donor organisation.

In September 2015, a working group from PCW, the Rotary Club of Market Harborough and Dr Nicola Ayers was set up to take this forward. Over the course of the next 12 months a series of planning meetings both face to face in UK and via emails and Skype culminated in this visit. Key to the sustainability of the programme is not only delivering Toolkit training and its dissemination but also Training of Trainers which would come later in the programme. Ideally, the Toolkit needs to be translated into Amharic for its wider use and it is to be hoped that this can become part of the project.

PCW was aware of the changing political situation in Ethiopia during September and October. When a six month State of Emergency was declared on October 17th the advice from the UK Foreign and Commonwealth Office was not to travel and it looked as if we might have to postpone. However, we were reassured when this advice was soon relaxed, though only as regards travel to Addis, enabling us to go.

Funding by Rotary International

This project was only feasible on the basis of external funding and PCW is extremely grateful to Mrs Christine Davies, who personally approached all the clubs in her District, and also to the members of those Rotary clubs for their generous support for this project. However, the funding of this project has been problematic. Explaining the complex statutory procedures of Rotary International whereby locally raised funds are matched by its Global Fund is beyond the remit of this report; suffice to say it is a formidable administrative exercise. This work programme was budgeted for and planned in the expectation that funds would become available on time but when the time came to book flights and accommodation, etc., despite generous monies being pledged by the East Midlands' Rotary clubs, no funds could be released. After urgent discussion with the PCW Board the trustees very kindly agreed to advance a loan to cover the costs of this first visit and CD was happy to give an undertaking that this would be repaid. Whilst in Addis, CD had the very welcome news that a critically important problem to do with the release of the 'matching' funds had been resolved. However, at the time of writing this report, PCW is still not aware of what monies will be at its disposal to fund the programme. This remains a cause for concern because of the uncertainty it creates around future planning, given that the proposed duration of the programme is through to 2018.

Background to the current Palliative Care situation in Ethiopia.

In 2013, at the African Palliative Care Association's Conference in South Africa, Ethiopian Ministry of Health officials renewed the Government's commitment to integrate palliative care into health systems through the adoption of the Johannesburg statement, entitled, 'Consensus statement for Palliative Care Integration into Health Systems in Africa: Palliative Care for Africa'.
In the forward to the impressive and comprehensive **National Palliative Care Guidelines, Federal Ministry of Health, Ethiopia**, **June 2016,** written by Dr Nicola Ayers, Dr Kebede Worku, MD, MPH, the then State Minister of Health states "Palliative Care is a relatively new concept in Ethiopia. It started with palliative care needs arising from the HIV/AIDS epidemic, now rising cancer rates and people suffering from non-communicable conditions require this specialised care"
He goes on to say," Affordable and effective protocols and palliative care service delivery models exist to relieve pain and other symptoms that can be integrated into the Public Health Care System. The Federal Ministry of Health hereby recognises the pivotal role of palliative care provision towards improving quality of life of people living with life limiting illnesses and it is with these fundamental precepts in mind that these guidelines have been developed. It is with great pleasure that I recommend these guidelines to be a primary document for the scale up of palliative care services in Ethiopia."

In her paper, **'Proposed Palliative Care Training for Health Care Professional in Addis Ababa '** (copies available on request), Dr Ayers describes the Pain Free Hospital Initiative run jointly in Ethiopia with the American Cancer Society whereby doctors, nurses and pharmacists in hospitals in Addis receive teaching and training on pain assessment and control along with the provision of oral morphine. An introduction to palliative care is included in the course. Currently, locally produced oral morphine is available in nine targeted hospitals in Addis but the plan is to scale up the initiative to other hospitals and key cities in the country. National pain Management Guidelines were completed in 2007 and are being incorporated into the palliative care guidelines.

Dr Ayers goes on to state that the situation with regards to implementation is that the main providers of end of life care are hospitals. The only specialised palliative care services currently available are through small NGOs; these rely on fundraising and donors for finance, namely Hospice Ethiopia founded by Sister Tsigerada Yisafowessen and Strong Hearts Ethiopia.

Training is a priority and in March 2016, Dr Ayers, under the auspices of the Medical Services Directorate of the FMOH, delivered a three week palliative care course to 24 health care providers from 4 'hub' hospitals; St Paul's, Yekatit 12, ALERT and Black Lion. This was to be followed by a training of staff from the Health Centres that refer into these hub hospitals thus developing a network of trained palliative care practitioners, who would then act as champions, leading by example with ongoing support from FMOH.

PCW had been asked to assist with and support this, but as funding had not yet been secured, it was not possible to proceed at that time. However, the content of the course had been discussed, based as it was on the Toolkit training model.

THE VISIT
Accommodation

This was at the Desalegn Hotel, Cape Verde St, Bole, Addis Ababa. It worked well for us, coming highly recommended, with comfortable, spacious and quiet rooms. All services functioned reasonably well. The staff were most welcoming and helpful and the food was good. There were difficulties with internet access but local texting and making phone calls was not a problem.
We felt totally safe to walk about the city and were welcomed at all times. We enjoyed several meals in restaurants in the city with good to outstanding food.

Transport

During the first week we used a mixture of local Lada taxis and offers of lifts from our hosts.
In the second week, one of RW's friends in Addis gave us her car and the services of her driver for which we were extremely grateful. Travel by car around Addis is mostly very slow due to heavy congestion so travel times always had to be factored in.

Week 1 Meetings, visits, presentations and getting to know people.

Monday November 7th 2016

After a good overnight flight and easy journey to the Desalegn Hotel, we were able to rest before meeting up with Nicola for a briefing. Nicola was wonderfully welcoming and confirmed the objectives of the programme of our stay. We all felt positive and excited to be in Addis.

Tuesday November 8th

To the Federal Ministry of Health where we met Dr Ayers' assistant Sister Emebet Tarekegn, who is now working exclusively on the palliative care programme. Emebet is passionate about PC and was hugely helpful at all times especially in the second week at the course.

1. Meeting with Dr Desalegn, Head of the Clinical Services Directorate, FMOH. Dr Desalegn has been in post for two months, having previously been in charge of the big hospital in Gondar in the north of the country. He too was most welcoming and we very much appreciated the time he gave us. We had a very interesting discussion as he described some of the challenges faced by the health care system in Ethiopia, especially in relation to life limiting conditions. He outlined the plans to roll out palliative care in Ethiopia, stressing the need for support over training. He paid tribute to Dr Ayers in pushing this work forward and confirmed to us how highly regarded she is. We were left extremely impressed by the work of the Ministry. www.moh.gov.et
2. Meeting with Ms Genet, who gave a most interesting and impressive presentation about the Pain Free Hospital Initiative (PFHI). Her work as the trainer and disseminator of the 'Treat the Pain' programme is funded by the

American Cancer Society and it is clearly having an increasingly significant impact. We were given the 'Treat the Pain' presentation on a memory stick which is also given to all participants in the PFHI (available on request)

To a working lunch to meet Dr Cara Franey and Dr Rachel Nunn, British GPs working in Faculty of Family Medicine at Addis Ababa University. They are working on introducing a palliative care module into the Family Medicine programme which is training doctors to work in Primary Care. Again, this gave us a really helpful insight and we plan to keep in touch with them both.

Afternoon was spent on continued preparations for the one day refresher course.

Wednesday November 9th

In the morning, to Hospice Ethiopia (HE) where we were delighted to meet up with Dr Yoseph Mamo (YM), HO Ephrem Abathun (EA) CEO of HE, and the Nursing and Administrative staff. Dr Mamo is a nationally recognised Consultant Physician working at Jimma University and is also the Non Communicable Diseases (NCD) Adviser to FMOH. See a profile of his work on NCD and a THET project on the eHospice website (www.ehospice.com) He is already well known to RW and has recently visited the UK as a guest of the Mumfords. Yoseph gives his time to support HE and regularly assists with home visits. EA has worked full time at HE for several years, initially as a clinician but now has the onerous task of managing HE. NB Both YM and EA had met with GS in August when GS passed through Addis after the APCA conference in Kampala. That meeting had been most useful giving, in particular, insights into learning styles of the health care workers.

Hospice Ethiopia is based in a suburb of Addis and, as stated before, receives its precarious funding from a number of sources. This Spring, the Norwich diocese of UK is supporting HE with a one-off Lenten Appeal for a new vehicle for the hospice. Jamie and Sue Mumford plan to co-ordinate fund raising through a newly-formed charity, Hospice Ethiopia UK, and will continue to visit HE regularly. More about the wonderful, extraordinary and humbling work done by this outstanding team can be found not only in the recent report by Sue and Jamie Mumford, 31/1/2016-12/2/2016 (available on request) but also on the website of eHospice, www.hospiceethiopia.com as well as several short films about their work on YouTube. These should be viewed.

GC and CD were privileged to accompany HE staff on a home visit to see a patient who has advanced breast cancer, whilst RW and GS went to see another patient suffering with complications arising out of HIV/AIDS. Both patients were very seriously ill and these were follow up visits. They were very moving and it was clear

from seeing the reactions from these patients and their families, how crucially important the treatment and care given to them is. This is exemplary. We are very much aware of how uncertain the future is for the Hospice because of its funding difficulties and although we would have wished to help in a more substantive way, at the present time, this is not a role for PCW. We pay tribute to the dedication of the staff of Hospice Ethiopia.

This visit was followed by a working lunch with YM and EA and some of the Trustees of Hospice Ethiopia, including its founder, Sister Tsigerada Yisfawessen. It was a huge privilege to meet her and hear more about how she came to found HE. Very sadly, Sr Tsigerada has had to retire due to ill health but remains, none the less, a true inspiration and role model. Sr Tsigerada was keen to pay tribute to the tremendous support HE receives from the Mumfords.

We were also very pleased to meet, for the first time, Dr Lue Tekola, PhD., who is chairman of the Board of HE and, also, a member of the FINOT Rotary Club in Addis. He and CD had been in correspondence as part of planning what, apart from funding, Rotary would/could bring to this project. We were enormously impressed by his energy and commitment to HE but, as he spends several months at a time working in the US, it is difficult for him to be the presence he would like to be. None the less, for CD and indeed the PCW team, this was a vitally important personal contact to have been made.

Evening. To a meeting of the FINOT Rotary club of Addis for formal introductions and the establishing of formal links between East Midlands Rotarians from UK and Addis based Ethiopian Rotarians, collaborating on various aspects of this project. Also present was Richard Power an orthopaedic surgeon from Leicester University NHS Trust as well as a Rotarian. He should have been in Gondar where there is an ongoing link but was unable to travel at the time due to the State of Emergency. It was useful to meet him and share experiences.

We were warmly welcomed by the club Chair and CD gave an account of the project and its aspirations. PCW team introduced themselves and invited club members to a morning meeting on the Friday to hear an 'Introduction to Palliative Care' presentation.

Thursday November 10th

To ALERT Hospital to deliver the one day Palliative Care refresher course to members of the previously trained staff from the 4 hubs. In particular, the PCW

team hoped to meet key individuals from the hubs, potential PC champions, who would be the links for the clinical placements of the following week's course as well as potential mentees. NA was not sure how many would turn up due to work commitments, transport problems etc.
After consultation with NA a teaching schedule had been prepared for the day. PCW felt it was important for the participants (doctors, nurses and a pharmacist) to also help set the agenda by bringing topics for discussion including patients' case histories. NA had also been asked to include a revision session on Morphine.
It was unfortunate that the day started over an hour late and the schedule became disrupted as a result of this. In addition to this, participants came and went throughout the day as determined by their work commitments

However, at the outset, we were not clear about their language skills, though we were assured that their English was likely to be adequate to good. In the event, it was the natural shyness and diffidence of the participants that was problematic as well as a mutual difficulty in understanding each other's accents. We had been advised that as the sessions were going to be in English, the participants would feel uncomfortable in the open, plenary type situation so we had planned for small group work.

We showed Mike and Ruth Wooldridge's film 'Front Line Palliative Care-The Kenyan Experience', at the beginning of the day which powerfully set the scene and it was clear that it was going to be a very useful teaching and learning resource. This film can be viewed on YouTube by searching under its title.
The Morphine session went well and provoked a useful discussion. We also revised palliative care assessments and how to treat, and care and prescribe appropriately. New handouts, to supplement the TK on this, were also given out.
In the event the day was especially memorable for the sharing of experiences two doctors had had, caring for patients. These were described very movingly in the final session. One was all the more remarkable as the doctor concerned had been highly sceptical at the start of NA's course but had been totally convinced by the end, even writing a poem about palliative care.
We very much enjoyed making these contacts but felt the day could have been more productive. However, it was a very useful experience which would help us prepare for the 5 day Toolkit course. The venue in the Training Centre at ALERT hospital was pleasant and well equipped and the catering good.

Friday November 11th

We had invited FINOT Rotary club members to Desalegn Hotel where CD, NA and the PCW team jointly delivered a presentation on Palliative Care. Most of our audience had no knowledge of palliative care and again, we included the Frontline Palliative Care film. A very useful discussion followed and the feedback very positive. There followed a working lunch with the Rotarians. RW and GS then met with NA to review and amend the 5 day course whilst GC met with EA, at NA's request, to discuss some of the challenges at HE.

Later, the 3 PCW staff met to further consider the teaching plans for the following week, and then worked individually on their own sessions.

Saturday November 12th

More lesson planning after which we were taken on a sightseeing trip and a visit to a local craft enterprise by a delightful group from the Rotaract (Rotary In Action-RI sponsored groups for 18-30 year olds) associated with FINOT Addis.

Sunday November 13th

Remembrance Sunday and to St Matthew's Church.

Week 2 THE COURSE

Venue. ALERT Hospital Training Centre, Addis Ababa.

The journey from Hotel to ALERT on the first morning took 45 minutes due to very heavy traffic but we had the good fortune to have Siefu as our excellent driver and a very comfortable car, courtesy of RW's friend. Travel times and conditions were similar each day, though on one day we were an hour late due to a road closure. We had experienced, in the previous week, the excellent facilities in the Centre with its extremely helpful staff and good catering, both in the Centre and in the hospital staff canteen. However, the room that we had been allocated, and which would have been a good size, was full of large desks and had two pillars, effectively dividing the room into half. We knew we had to move the desks to create a better interactive atmosphere but were counselled by NA over the effect that this might have on the participants.

TIMETABLE

Monday	Tuesday	Wednesday	Thursday	Friday	
Opening address, pre-test etc. NA	**Recap and reflection GC**	**Recap and Reflection GS**	**Recap and quiz NA**	**Recap and reflection GC**	***15 mins***
Getting to know you, ground rules, expectations etc. GC	**PC assessment to include treat, care and prescribe. Tools GS**	**You can help different symptoms 1 RW**	**Palliative Care Site visits for Clinical Practice**	**Feedback on site visits: key points GS**	**9.15 – 10.30**
What is PC? RW	**You can assess pain, other problems and prescribe. Tools GS**	**You can help different symptoms 2 RW**	**Clinical Practice**	**You can give bereavement support. Including end of life care. RW**	**11 – 12.30**
Lunch	***Lunch***	***Lunch***	***Lunch***	***Lunch***	***12.30-1.30***
You can do PC in your setting – examples GS	**Spiritual Pain/Spirituality GC**	**Psychosocial care – Breaking bad news YM**	**Homework/reading**	**Teams. Training, team building, self-care. GC**	**1.30 - 3.00**
Communication GC	**Morphine, analgesic ladder RW**	**Psychosocial care - Children and families. GC**		**Close, post-test, evaluation. Graduation.**	**3.15 – 4.15**
Round up RW	**Round up GS**	**Round up GC**			**15 mins**

As on previous occasions, we prepared the course, using the Palliative Care Toolkit and its Trainer's Manual - the 5 day course - as the basis for our teaching. It was also in consultation with NA as, for this course, the participants were going to be given not only their own copies of the Toolkit but also the National Palliative Care Guidelines from FMOH as course resources. Having only seen these excellent guidelines when we arrived in Addis, the PCW team and NA wanted to ensure that the two resources correlated so as to avoid confusion. In the event, we used both and gave references from both.

As before, when preparing a course like this, individual PCW team members took responsibility for each module/session, then delegated to other team members individual pieces of work from within that module/session. This is a well tried and successful method. One significant change, though, had been suggested by NA who recommended that the Breaking Bad News session be given in Amharic by Ephrem Abathun from Hospice Ethiopia.

There was, however, an unfortunate misunderstanding whereby the PCW team had been preparing on the basis of four 90 minute sessions each day, with the usual breaks for mid-morning, lunch and mid-afternoon. On arrival, though, we found that we had to cut 15 minutes off the first and 30 minutes off the last sessions of each day due to working times. There was also uncertainty about the clinical placement day so we had plan to allow for it NOT to happen OR for it to be a half or a whole day. NA advised that we should plan for it to be a whole day which meant considerable re writing/editing of the schedules for each of the other four remaining days. We also wanted to modify the course to allow for more time for small group work on the basis of advice and experience from the refresher day. That, and the other uncertainties mentioned above, all added to the challenges of the week ahead.

We had received a list of participants on arrival and we were delighted when they all arrived on time. This full attendance and impressive time keeping continued throughout the course and included observing the ban on mobile phones in the classroom; this was a welcome change as it has never happened before when we have been teaching in Africa!

There were 28 participants in all, Health Officers and Nurses, from 8 of the Health Centres which refer into the 4 hub hospitals. In addition there were two senior

nurses from the Prison Service as well as an observer, another senior nurse, from St Paul's Hospital (one of the hubs).

Working as Nurses and Health Officers, all had received at least three years' university education where much of the teaching is in English but we were uncertain about the participants' verbal skills. It had been useful spending time with the previously trained staff whose English was generally good. However, again, there was some mutual difficulty understanding each other's accents which made initial contact somewhat hesitant. Despite this, they proved to be a delightful and was most rewarding group to work with.

Everyone was delighted that Dr Desalegn had been able to come to open the course and his talk was clearly inspiring. His support and that received from the FMOH for this work is proving invaluable.

CD sat in on the first two days of the course and this and other occasions gave her valuable insights into how PCW goes about its business. These experiences will be extremely useful when feeding back to our Rotary colleagues.

Rather than describe each module we prefer to share some reflections on the week.

Reflections on Addis Ababa teaching week

What went well.

We worked well – and hard - as a team

Moving the desks (!!) and creating, what proved to be, a very effective interactive space.

Role plays were very successful and effective.

Small group work, pairs, threes and sixes worked well. We had been advised that the participants would be shy and diffident to start with and we soon observed this. Curtailing the post presentation 'calling out' in favour of small group work proved very productive.

Games – Margolis wheel/line-up

Writing privately on post-its

The Film –'Front-line Palliative Care –the Kenyan Experience' proved a great resource –we could show the whole film, then use sections throughout the week to stimulate/reinforce learning and create role plays.

Very pleasant training centre setting.

Use of TK –frequent reminders to students to find relevant page etc.

Frequent reference to the National PC Guidelines, cross referencing with TK.

Building the relationship with the participants. We were delighted with how quickly we 'gelled' together as a group. A lovely story from GS to share here. "At coffee on Day 2, one of the participants, a slightly older Health Officer, who had seemed rather aloof, approached Gillian with something along the lines of,' There is a problem with Dr George. He speaks softly and uses long words I don't understand. Also he needs to explain more of the medical terms'. Gillian passed this back to me and I was grateful and touched to have this feedback but also cross with myself. I took note and made, what I hoped, were helpful changes. At the end of the day he came up to me and, with a smile, said, 'Thank you, you were much better'"

Lesson planning and the actual delivery of the course.

Teaching aids (computer presentations, and use of previously prepared flip charts as back up when the electricity went off).

Participants' attendance-full house on time every day!

Time keeping.

What went not so well and/or didn't work

With the clinical placement taking out a whole day, the 5 day course we had planned had effectively to be delivered in 4 days. Too much information to get across, often delivered rather more hurriedly than we would have liked with little time for checking back/revision.

Shortened teaching day - 6 hours of actual teaching time per day, rather than the usual 7.

Language –often comprehension better than actual speaking. Mutual difficulty with understanding each other's accents.

Abstract concepts sometimes seemed difficult for participants to engage with.

We felt that the group was too big at 28 and we found that we needed more space for some of the whole group exercises.

Monday morning –registration, badge writing etc., v time consuming. We also needed to take into consideration participants' English verbal skills when asking them to read out things - difficult if you are self-conscious about these skills.

Plenary work due to participants' diffidence. Yet, this is a necessary part of the course.

Providing only one copy of the case scenario per group – need to do copies for everyone.

Having to rearrange timings at short notice.

The unequal length of sessions was unfortunate and made for a less well balanced day.

Needed to allow time, initially in the first few days, for participants to find their way round the TK.

Forgot to remind group re personal learning points – need to do it at end of every session

The participants did not have a copy of week's programme. Needed a PCW folder with programme, flyers etc., for each participant.

For practical purposes, NA organised the pre and post course confidence ratings exercise, the test and the course evaluations. (PCW staff would normally administer these themselves.) We await the outcome of these and they will be added to the report. These data are essential not only for us and future planning etc., but also for our donors in RI.

Learning the names of the participants and what their roles/jobs are took longer than usual.

Walking wall. The shortened sessions meant that there was often not enough time to enable these to be read properly after the group work; a lost opportunity for discussion both by us and the participants.

Group work tasks were often not clear to the different groups who needed extra clarification.

As is our usual practice,all of these will be taken into consideration when planning our next teaching

Clinical Placement Day

This took place on the Thursday with teams visiting the 4 hub hospitals; Black Lion, Yekatit 12, ALERT and St Paul's. We are very much aware of how time consuming this was for NA to arrange and we are extremely grateful to her for her persistence in obtaining the necessary permissions. NA divided the participants into 4 groups led by NA, GC, RW and GS and each had a link person who had been on NA's previous course. Each of us will describe the experience, which was with variable success for both the participants and the PCW team.

1. **GS Visit to Yekatit 12 with 7 participants.**

Our link person at Yekatit 12 was Dr Emanuel but an Emergency Room Nurse, Tadese had organised the selection of patients and accompanied us to the Female Medical Ward. Tadese is one of NA's previously trained staff and we had met him and been impressed by him on the refresher day. We were made most welcome by the Resident who introduced the patients. It was very gratifying to watch as the participants divided up and started with their palliative care assessments, including pain assessments using Tools 1&2 from the Toolkit. I was extremely impressed with the way that they were with these very sick patients, readily demonstrating sensitivity and compassion and keen to try out their new skills.

The first patient was a 43 year old lady who had been in hospital for 5 weeks. She had been admitted with a chest infection and heart failure but her principal problem now is severe pulmonary fibrosis which has worsened following the infection. She is HIV + on ARVs and on constant oxygen support from a cylinder. Because she cannot afford home oxygen she has to stay in hospital. Her only son, her carer, was sleeping on the floor beside the bed. He has had to give up work to be with his mother in hospital.

The second patient was a 33 year old lady with HIV/AIDS who had been admitted two weeks previously with opportunistic infections following stopping her ARV regime. This lady is very sick and not responding to treatment. As the assessment progressed it became clear that, like the first patient, this lady has additional serious psychosocial problems with very limited family support, is in poverty with no income

and uncertainty about where she might live if she becomes well enough for discharge.

The third patient was a 65 year old lady with severe pulmonary fibrosis and again, like the first patient was on continuous oxygen therapy. She has been in hospital for 14 weeks, but has good family support and could go home if domiciliary oxygen was available.

We then had a long group discussion when my group reflected on the experience. It had clearly been a powerful experience. All seven had found using the Tools helpful, especially drawing up the problem list though opportunities for easing these seemed very limited. It was observed that none of the patients had an understanding of their conditions. The ethical issues raised by the situations these patients found themselves in was touched on but there was a reluctance to delve more deeply and we agreed we would not explore this.

The objective of the day was for the course participants to use the assessment tools and gain some confidence in their effectiveness. The group felt this had been achieved.

However, the participants in my group said that working where they do, they would not be seeing patients with serious life limiting illness, let alone such sick patients.

2.Visit to St Paul's Hospital, Addis, by Gillian Chowns and six participants (health centre staff) on the TK course.

After a courtesy visit to the Medical Director, we went up to the wards where we were met by a staff member who had clearly had training in palliative care. However, he was not the person, Bulcha, who had originally been designated to facilitate the visit, and it became apparent that there had been some miscommunication as to the nature of the exercise. The facilitator took the group to three patients but then proceeded to give a detailed case history at each bedside, thus pre-empting the plan for the students to conduct their own assessments. The group were clearly inhibited and generally passive, asking only a few questions, although by the time they came to the third patient they had gained some confidence and once one student directly engaged with the patient, others followed that lead.

The first patient appeared semi- comatose, and students were initially told that he could not speak. His 12 year old son was standing by the bedside, but neither the facilitator nor the students interacted in any way with him. The second patient, a

former soldier, had been transferred after surgery, with a wound that was failing to heal. He had initially been aggressive and non-compliant, but staff had involved his spiritual leader and there had been a notable transformation: he had previously said that he was ready to die (although he was neither palliative nor terminal) but now he was prepared to return home.

The third patient was a 40 plus woman with CA lung. Her husband, on the staff of St Paul's himself, was aware that her prognosis was poor, but she herself was unaware and her main concern was her elderly mother. One of the students engaged with her almost immediately, which provoked a tearful response, and then other students became involved. However, once again, they completely ignored the relative in the room, a young woman who was sitting on a mat/makeshift bed.

On leaving the wards I asked if we could find somewhere to reflect in private and we adjourned to an empty office, where I highlighted some key issues. In relation to the first patient, the importance of communication, even if he can't speak, through eye contact, touch etc, and, crucially, through communicating with the relative (the 12 year old boy): to the second, the question of spirituality, role of pastors etc.,: to the third, clarifying what is the main concern of the patient, as opposed to what the staff see as the main issue, and the ethical issue of the husband knowing the prognosis, while the patient is in ignorance, and the communication challenge this poses. Additionally, the failure to connect with the relative in the room was disappointing, given that the previous day both Ephrem and I in our respective sessions had highlighted the importance of the family.

3.Visit by Ruth Wooldridge and 7 health centre staff attending the PC course and Sr Emebet Tarekegn, deputy to Dr Nicola Ayers at FMOH to wards at Alert Hospital.

ALERT is a medical facility on the edge of Addis Ababa specializing in Hansen's disease, Leprosy. It was originally the All Africa Leprosy Rehabilitation and Training Centre but the official name is now expanded to include TB, so named All Africa Leprosy, Tuberculosis and Rehabilitation Training Centre.

ALERT's activities focus on its hospital, rehabilitation of leprosy patients, training programs for leprosy personnel from around the world, and leprosy control (administration of the Ethiopian Ministry of Health's regional leprosy control program). There is currently a 240-bed teaching hospital, which includes dermatology, ophthalmology, and surgery departments, also an orthopaedic workshop, and a rehabilitation programme but little cancer.

The deputy director of Alert had been advised of our visit and asked to look out for patients who may require palliative care. We were taken to a ward and left with the staff who showed us the various bays and sick patients some with need for pain relief, others no PC needs, and so we took it up ourselves to organise the visit as best we could.

The team divided up and spent an hour assessing the patients identified which included two with severe drug reactions and skin loss, one female patient with a sarcoma and large wound in her groin and upper thigh area, an male patient with a debilitating skin infection of hands legs and feet for 8 years and investigations had not produced a diagnosis.

Also a 25 year old man suffering from 50% burns after a domestic fire in severe pain when dressings were being changed, and a ten year old boy admitted from a rural area following an RTA. He had one leg amputated and the other leg was pinned but with foot drop and under review from the plastics dept. This child was very distressed and looked depressed too. Not sleeping and pain when dressing were changed or he was moved. He came from a very poor single parent family and his mother was tearful too. At the bedside of both patients we discussed the use of morphine for pain relief especially during change of dressings. The staff had access to oromorph and had just changed from using Ketamine to morphine for the burns case and would get it prescribed for the RTA patient.

We also visited the female AIDS bay with 6 beds all occupied by patients with advanced illness. The patients were unwilling to be interviewed by the students and we respected this.

The students gathered after an hour of doing their assessments, some had worked together and some did assessments alone.

We discussed each case regarding PC needs, pain and pain assessment in total pain, psychosocial, and spiritual needs. It was clear that the students had asked sensitive questions and probed areas that before the course they would not have done. They took social histories and explored emotional and spiritual areas where they felt that had gained confidence during the course.

The last day of the course included an exam which NA administered.

We were delighted to welcome back Dr Deslegn who gave a short address then engaged with the participants in a discussion about the course and the way forward for PC in Ethiopia. This was in Amharic and it was heartening to see how animated several participants became. NA was pleased about how well the participants talked

about the course explaining to us that they were challenging the FMOH to do more to integrate PC into the health care systems. It was clear to us that here we had a meeting of minds between a dedicated policy maker and executive and now, these committed practitioners eager to use new skills.

Certificates were awarded by Dr Desalegn, on behalf of the FMOH, and GS on behalf of PCW. In addition to their certificates, each participant received a rose and 500gms of the finest Ethiopian coffee.

In her closing remarks Dr Nicola urged the participants, “Go and give your family and friends coffee and, as you do, talk to them about palliative care”.

Inevitably the question we as trainers and mentors are left with is how much of what was learned will be taken away and put into practice. We are in the fortunate position of having established a very close personal and professional relationship with Dr Nicola Ayers and through her we hope we can continue to offer support with this translation of theory into the practice of delivering palliative care.

WE WOULD LIKE TO RECORD OUR THANKS TO ALL THE PARTICIPANTS ON THE COURSE, TO DR NICOLA AYERS AND HER TEAM AT THE FMOH FOR ALL THAT THEY DID TO ORGANISE AND FACILITATE THIS COURSE, TO THE FEDERAL MINISTRY OF HEALTH OF ETHIOPIA ITSELF AND TO ROTARY INTERNATIONAL.

NEXT STEPS

For PCW. We await an evaluation of the course.

The PCW team will write a report and present it to the PCW Board for its January meeting.

With the agreement of the PCW Board, the report will also go to Dr Desalegn at the FMOH, Rotary International and the African Palliative Care Association

To share this experience with others involved in supporting palliative care training in Ethiopia.

The PCW team will discuss with NA the possibilities of mentoring key individuals and how that might be done.

It is essential to maintain regular contact with NA, not only to support her in her work but also with a view to planning the next courses, booked for June 5-17th 2017

The role of FINOT Rotary Club in Addis to be developed in collaboration with its UK partners.

And finally, but most importantly, to nourish the friendships made during this visit.

Gillian Chowns

Ruth Wooldridge

George Smerdon

Palliative Care Training Participants from different Health Centres

	Name	Health Centre	Hospital	Phone No
	1. Getachew Adugna **2. Temsgen Shitalem** **3. Bahirnesh Fekadu**	**Selam H/C**	**St Paul**	**0913186616** **0911642256**
	1. Yabessa Mohamed- HO **2. Sr Hane Siyum** **3. Sr Etaferahu Dembel**	**Felegemeles H/C**		
	1. Yabi Amare **2. Abnet Pawlos** 3. **Sr Mekdes Haylu**	**Cotebe H/C**	**Yekatit 12**	**0913000517** **0111260389**
	1. Sr Chaltu Degebassa **2. Sr Mekdes Abebaw** **3. Yeshwatsehay Kassahun**	**Jalmeda H/C**		
	1. Yoliana Tadesse **2. Yohanis Habte** **3. Hadra Behija**	**Teklehaymanot BLH**	BLH	**0911190254** **0911190123**
	1. Nurse Kassay Teklu **2. Sr Sintayehu G/Michael** **3. HO Melese Gebru**	**w-3 BLH**		
	1. Fetle work T/stadik **2. Semret Raya** **3. Shimelis Gebre**	**Alem Bank**	**ALERT**	**0118494504**

	1. Martha Edossa HO 2. Simegn Markos 3. Hawa Hussen	**W-5**		**0911865384**

Hospital	Name of participant answered with telephone	
ALERT	Sr Selamawit	They promised to call all participants
St Paul	Bulcha	
BLH	Sr Helen	
Yekatit	Tadese	