Co-Creating a Psychiatric Resident Program with Ethiopians, for Ethiopians, in Ethiopia: The Toronto Addis Ababa Psychiatry Project (TAAPP)

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Background: *Globalization in medical education often means a "brain drain" of desperately needed health professionals from low- to high-income countries. Despite the best intentions, partnerships that simply transport students to Western medical schools for training have shockingly low return rates. Ethiopia, for example, has sent hundreds of physicians abroad for specialty training over the past 30 years, the vast majority of whom have not returned. This represents a highly problematic net transfer of financial and human resources from the Ethiopian people to Western countries that have failed to develop their own adequate health human resource plans.*

Methods: *With this background in mind, in 2003 Addis Ababa University invited the University of Toronto to collaborate on the first Ethiopian psychiatric residency program to be run entirely in Ethiopia. Called the Toronto Addis Ababa Psychiatry Project (TAAPP), it was established on the principle of supplementing the ability of the small Addis Ababa University Department of Psychiatry to teach, provide clinical supervision, and to help develop educational capacity. Over the last 6 years the model has involved a large number of University of Toronto faculty and residents who have spent blocks of 1 month each in Addis Ababa.*

Results: *This article describes the first three phases of TAAPP (I) Development of a model residency program; (II) Enhancing clinical, educational and leadership capacity; and (III) Sustainability, faculty development, and continuing education. Between 2003 and 2009, the number of psychiatrists in Ethiopia increased from 11 to 34; the Addis Ababa University Department of Psychiatry faculty increased members from three to nine. There are new departments of psychiatry established in four other university hospitals in Ethiopia outside the capital city. Mental health services are now being integrated within the national system of primary care.*

Conclusion: *An important issue that underscores such a partnership is the risk of simply exporting Western, America-centric psychiatric training versus creating culturally appropriate models of education.*

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The Ethiopian Context

Located in the Horn of Africa, Ethiopia is about twice the size of France and one of the most populous countries in Africa, with over 82 million people who speak 80 different languages, 200 dialects, and belong to many different ethnic groups. Unique among African countries, the Ethiopian monarchy maintained its independence from colonial rule for thousands of year and was occupied only briefly by Italy during the Second World War. Though it has sustained difficult periods of political unrest, war, famine, and drought over the past 40 years, a formal constitution was adopted in 1994 and multiparty elections were held in 1995. Today, almost half of the population is under 15, 80% of its people live in rural areas, and the average life expectancy is 55. More than half of the pop-

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ulation lives below the absolute poverty line and up until a recent government initiative, illiteracy affected more than one-quarter of the population (1, 2). However, Ethiopia is developing rapidly, and no area is of more importance than its health human resources.

In terms of mental health care, for many years a single mental hospital, converted from a general hospital built by the Italians during the 1940s and staffed by expatriate psychiatrists from Eastern Europe, provided the only mental health services in the country. However, an Addis Ababa University Department of Psychiatry was created in 1973, and a small, dedicated group of Ethiopians who returned from psychiatry training abroad gradually began to develop mental health services and education. Medical student teaching began in the 1970s, and a psychiatric nursing program began in 1987 (2). Psychiatric residency training remained a problem because the only available approach was to send medical graduates abroad. In 2003 there were 11 practicing psychiatrists to serve Ethiopia's over 70 million people; nine in public institutions and two in independent practice (2). While a national "Nazareth Conference" had formally recognized the necessity for Ethiopian-trained psychiatrists as early as 1993, developing and sustaining a residency program was difficult in a department of psychiatry with only three faculty members. After 2000, however, a political commitment from the government to expand postgraduate programs allowed the creation of the first Addis Ababa Psychiatry Residency Program and the admission of seven residents in January 2003. The leaders of the first psychiatric residency in Ethiopia knew that in order to sustain the residency program, international partnerships were essential.

The Problem of International Partnerships and the "Brain Drain"

Unfortunately, international partnerships in medical education often lead to a "brain drain" of desperately needed health professionals from low-income to high-income countries (3). Despite the best intentions, partnerships that simply transport students to Western medical schools for residency or fellowship training have shockingly low return rates and often fail to develop culturally appropriate curricula that are relevant to the needs of the trainees' home country (4). Ethiopia, for example, started registering its health professionals by category in 1987. Between 1987 and 2006, of the 4,394 Ethiopian doctors (3,476 general doctors and 918 specialists) registered, 73.2% had left public hospitals to work for nongovernmental organizations or to emigrate to overseas. Whereas in 1965 the doctor-to-population ratio in Ethiopia was 1:85,000, in 2006 it was 1:118,000, a 74.1% deficit according to WHO's minimum doctor-to-population ratio (5). This represents a highly problematic net transfer of financial and human resources from the Ethiopian people to Western countries that, in large part, have failed to develop their own adequate health human resource plans. Thus, a partnership that would support the training and retention of psychiatrists in Ethiopia would require a model based on psychiatry education led by Ethiopians, for Ethiopians, and in Ethiopia.

Meanwhile, at the University of Toronto, a new strategic plan had been created in the Department of Psychiatry in 2002. Based on a university-wide call by the university President Birgeneau to emphasize "outreach," the plan aimed to develop a limited number of international partnerships, based on best practices, and for the purpose of learning more about engaging appropriately in international program development. When Addis Ababa University, represented by one of the authors (AA), contacted the University of Toronto through another (CP), the needs and interests of the two institutions aligned in a synergistic way (6).

In this article, we describe the educational collaboration between the Departments of Psychiatry in Addis Ababa and Toronto (the Toronto Addis Ababa Psychiatry Project—TAAPP) as it has passed through three phases: (I) Development of a model program; (II) Enhancing clinical, educational, and leadership capacity; and (III) Sustainability, faculty development, and continuing education. In the discussion, we reflect on what we have learned collectively and some of the challenges we face in sustaining what has become a very fruitful partnership.

TAAPP Phase I: Development of a Model Educational Program

TAAPP was created to meet the educational needs of the new 3-year Ethiopian psychiatry training program that was launched at Addis Ababa University in 2003. A small fact-finding committee from the University of Toronto attended the program's inauguration in Addis Ababa in January 2003, and explored a possible partnership. Even during this first visit, the members of the University of Toronto delegation (Vice Chairs of Education, Research and Programs, a resident, and the project lead) were invited to deliver lectures to the new residents. Based on a very positive visit, a letter of agreement was signed between the two departments of psychiatry in the summer of 2003, committing the University of Toronto to provide

teams of three (two faculty members and one resident) who would visit for 1-month blocks, three times a year. Phase I would last for 3 years. The first educational visit took place in November 2003. During Phase I, TAAPP was charged with helping to develop and teach the psychiatric residents in Addis Ababa in modules of contextually relevant seminar and clinical material. The TAAPP syllabus was guided by a curriculum originally developed for the program by the Ethiopian faculty, and was modified regularly as the program evolved.

From November 2003 until March 2007, TAAPP recruited and assembled 11 teaching teams. Each Toronto team visited Addis Ababa for a 1-month period; there were approximately three trips per year. The first class of residents—six men and one woman—graduated from the program in the autumn of 2006. A very moving ceremony held in August 2007 recognized the first cohort of psychiatrists ever trained entirely in Ethiopia. By recruiting from the new graduate cohort, the Addis Ababa University Department of Psychiatry was able to double its faculty compliment to six psychiatrists, including a new member of faculty who returned from South Africa having completed his training at the University of Cape Town.

TAAPP Phase II: Enhancing Clinical, Educational, and Leadership Capacity

At the end of the first 3 years, both departments of psychiatry agreed TAAPP was sufficiently successful to warrant expanding its original mission into a second phase.

TAAPP Phase II would last for an additional 3 years, and would have two goals. First, the University of Toronto faculty would continue to supplement and support the Ethiopian residency training during 1-month trips, but with slightly reduced frequency of visits so that the Ethiopian faculty members could take on primary responsibility for curriculum delivery. As a further step to strengthen the partnership, two of the senior members of the department (AA, MA) obtained cross appointments in the University of Toronto Department of Psychiatry.

An important lesson learned during the first years was the necessity of clinical supervision. Initially we underestimated the importance of direct clinical supervision, the skill of biopsychosocial history taking, and the ability to formulate the relationship between the circumstances and experiences in a patient's life to his or her presenting symptoms. Undertaking in-depth biopsychosocial assessment is a challenge for the Ethiopian residents for several reasons. In Ethiopia, patients making the journey to St. Paul's General Hospital Addis Ababa, where outpatient psychiatric service is given, often attend only once, and expect from the doctor an authoritative and clear explanation of the cause and cure of their mental health problem. Similarly, at the Amanuel Hospital (the psychiatric hospital) the emergency room is so busy that residents' interviews are necessarily brief. These system pressures meant that TAAPP's first cohort of residents tended to focus on rapid DSM axis I diagnoses and treatment with medications. Further, the absence of psychosocial infrastructure in the coutry means there are few options for psychosocial treatment, so obtaining a detailed psychosocial history seemed less relevant to the residents. Finally, it became apparent to the University of Toronto faculty that in Ethiopian culture many of the personal questions involved in obtaining a psychosocial history are experienced as intrusive, making history taking uncomfortable for both parties. The role of the University of Toronto faculty in this tendency to over prioritize axis I disorders to the detriment of the social determinants of health was associated with their own unfamiliarity with Ethiopian culture and relevant nuances. Further discussion of this is addressed later in the article.

Recognizing these issues, in TAAPP's second year the decision was made to limit didactic and seminar teaching to two afternoons per week to allow adoption of a third afternoon entirely dedicated to the development and practice of clinical skills, including comprehensive psychosocial history taking, history-taking with children, the assessment of addictions and extrapyramidal symptoms, and other relevant skills. The remaining time in the week was reserved for direct clinical supervision. University of Toronto faculty now sit with individual residents in their clinics, wards, and the emergency room to provide more tailored help with integrating knowledge and skills with clinical work, and to encourage residents to gain a deeper understanding of their patients' life circumstances related to their mental health problems. The language difference between University of Toronto faculty and patients was seldom found to be a problem, as residents quickly and quietly translated relevant information to the University of Toronto clinical supervisors.

We also found it helpful to attend to the format of the final examination. As Epstein (7) has noted, evaluation powerfully drives learning. For example, students study more thoughtfully in anticipation of certain evaluation formats (8), and changes in exam format can helpfully shift learners toward clinical, rather than solely theoretical, issues (9). Thus we debated what form the final clinical

examination should take. Together, the Toronto and Addis faculty members agreed to use a long-case (50-minute) observed interview, after which the residents would summarize findings, consider differential and preferred diagnoses, and provide a comprehensive formulation and management plan. The skill of the short, focused interview, and diagnosis and treatment planning that is so valuable for day-to-day work in Ethiopia would be given emphasis during daily clinical teaching and assessment. The Ethiopian faculty and residents contributed to the development of an Ethiopian guide to clinical history taking, an examination scoring system and a system of "mock orals" to maximize the ability of residents to practice and receive feedback. In order to further respond to the need for a formative evaluation tool, the University of Toronto faculty helped to modify and implement a "Formative Evaluation Data for Residents (FEDR)" tool developed at the University of Western Ontario. (The Formative Evaluation Data for Residents [FEDR] form was used with permission of Dr. David Haslam, Director, Residency Training Program, Department of Psychiatry, The University of Western Ontario.)

By the summer of 2008, two more cohorts of graduates had successfully completed the program, bringing the number of Ethiopian psychiatrists to 34. During this phase, there was also a significant impact on the country's health system. With a growing cadre of trained psychiatrists, new clinical units were opened in general hospitals in Addis Ababa: Zewditu Hospital and Yekatit 12 Hospital. Services were also improved at St. Paul's Hospital and at Amanuel Hospital, and departments of psychiatry were established in four university hospitals outside Addis Ababa in Harar, Jimma, Nazareth, and Makele, each run by a TAAPP graduate. During this phase an additional partnership was made with the Institute of Psychiatry in London, and together in 2008 the three partners obtained grant funding for Phase III of the project, the first formal funding for a project that has been entirely sustained on the goodwill of the partners and very modest financial contributions from both departments, from individual faculty, members, and from the occasional anonymous donor.

TAAPP Phase III: Sustainability, Faculty Development, and Continuing Education

As TAAPP enters PHASE III, attention must now turn from program development to sustainability. There are several aspects to consider: recruitment, curriculum stabilization planning and renewal, faculty development, continuing medical education, and health services capacity.

Recruitment

The sustainability of any psychiatric residency program depends on its ability to attract appropriate medical students and general practitioners who want to become psychiatrists. Five of the first seven residents accepted into the Addis Ababa program were general practitioners already working with psychiatric patients in Amanuel Hospital. Their motivation was to qualify formally in psychiatry, the area of medicine in which they had already found their calling. While the enormous need for mental health professionals might lead to the recruitment of anyone funded to become a psychiatrist, Ethiopian faculty are acutely aware that the selection of suitable psychiatrists-to-be is of more importance than simply qualifying a large quantity of psychiatrists. High standards of care, ethics, and a broad understanding of health care needs and practice are essential to promote a long-term, stable system of mental health care. It is clear that Ethiopians want dedicated, capable psychiatrists, rather than a quick expansion without adequate monitoring of standards. On the other hand there is a significant stigma associated with working in psychiatry in Ethiopia, and psychiatrists have more difficulty supplementing their income (a necessity for all doctors) in private clinics; psychiatric patients pay less for consultation and treatment than patients consulting physicians in other fields. Both factors work against recruiting psychiatric residents. Improving and refining the recruitment process for psychiatrists is now essential. To this end, TAAPP Phase III will focus on ways to attract the best and brightest to psychiatry, including an increased focus on the undergraduate psychiatric curriculum.

Curriculum Planning and Renewal

In terms of the residency program itself, a curriculum evaluation and renewal conference was held in Addis Ababa in March 2009. In attendance were two TAAPP Toronto faculty members, two Institute of Psychiatry faculty members, and a large group of Ethiopian faculty members including the department chair, director of residency education, director of undergraduate education, and the chief resident—all but two were graduates of the TAAPP program. Outcomes of the meeting included a renewed "resident profile" of competencies expected of graduates (see Appendix 1). This document will be used to continue to standardize the curriculum, to orient new residents, and to facilitate the creation of new tools for resident assessment and curriculum evaluation. Based on a modification of the CanMEDS framework created by the Royal College of Physicians and Surgeons of Canada

(10,11), the "EthioMEDS" framework consists of five core roles (Clinical Expert, Leader, Educator, Scholar, and Advocate), which take the curriculum in an important direction that will align with WHO's suggestion that psychiatrists in developing countries

> have to play multiple roles . . . as clinicians and mental health experts within multidisciplinary teams, teachers imparting knowledge and skills to students and other staff, researchers to increase the repertoire of knowledge on mental health, public health specialists in developing the infrastructure for mental health services, and advocates to increase awareness and needs around mental health issues (12).

While there is much work to be done to validate and refine the EthioMEDS framework, its evolution, and codification is a first for Ethiopia and is likely to influence the development of similar competency-based frameworks in other Ethiopian specialty training programs. With curriculum development ongoing and a strong Ethiopian faculty in place, we are optimistic about the sustainability of the

APPENDIX 1. Graduate Profile March 2009

Clinical Expert

Knowledge:

- Applies knowledge of basic science to clinical psychiatry and evidence-based practice
- Describes the major categories and classification (including DSM IV, ICD-10) of mental disorders
- Able to describe the presentation of common mental health problems and disorders across the age spectrum
- Able to describe the various explanatory models and traditions of healing within the diverse cultural groups of Ethiopia
- Able to describe the main principles and indications for various modalities of psychological therapies and behavioral interventions
- Able to describe a range of community-based resources and social sources for people with mental health problems
- Able to describe the various principles and frameworks related to the rights and responsibilities of patients with mental illness
- Able to outline the conditions under which it is legitimate to detain patients in a hospital and treat them against their wishes in Ethiopia

Skill:

- Conducts a diagnostic interview including history taking and mental status
- Conducts a physical examination and neurological examination
- Collects and integrates additional sources of information
- Synthesizes all sources of information to reach a differential diagnosis
- Formulates a patient's symptoms to his/her past experiences, personality, and social and cultural context
- Conducts an assessment of risk of harm to self and others
- Can administer ECT
- Adapts the clinical assessment and formulation to various settings including acute, medical, and community contexts
- Devises an appropriate management plan, including the multiple roles required by the psychiatrist, across the lifespan of the patient, incorporating bio-psycho-social-cultural elements
- Initiates, monitors, and discontinues psychopharmacologies using evidence-based practices
- Recommends, conducts, and/or refers patients for appropriate psychological therapy and interventions

Attitudes:

- Demonstrates a warm, empathic, and respectful approach to patients and families
- Gives time; uses active listening to integrate the patient's and family's perspective in the delivery of care
- Fosters good working relationships with all health care colleagues and other individuals involved in the delivery of care
- Demonstrates self reflection on own practice
- Demonstrates an enduring commitment to maximize the function and wellbeing of the patient

Leader

- Demonstrates the ability to lead and manage a clinical team effectively
- Manages finite resources effectively and wisely
- Contributes to the planning and organization of health policy and service delivery
- Models the highest quality of ethical and professional behavior consistent with the obligations of a physician

Educator

- Can describe and identify the central issues relevant to teaching methodology
- Teaches and imparts knowledge and skills (psychoeducation) to patients and their families
- Contributes to teaching and assessment of other residents' medical students and other health professional staff

Scholar

- Develops, implements, and monitors a personal continuing education strategy
- Critically appraises sources of medical information
- Contributes to the development of new knowledge and better practice through research, evaluation, or quality assurance projects

Advocate

- Advocates for the inclusion, funding, and resources of mental health issues at all level of health service and medical education
- Uses education and media to raise awareness of and destigmatize mental illness
- Advocates and intervenes with the patient to counter barriers and discrimination

educational program. Most encouragingly, the TAAPP program has become the model for the development of a much broader partnership between University of Toronto and Addis Ababa University. Using the TAAPP program as a model, 14 additional university departments, including medical (surgery, internal medicine, pediatrics, etc.), health professional (nursing, pharmacy, etc.), and non-health professional (engineering, library science, etc.) have launched similar collaborative programs to create, strengthen or extend education into subspecialty programming. A strong and enduring multidepartment partnership between the two institutions is the goal of this new Toronto Addis Ababa Academic Collaboration (TAAAC; http://www.taaac.com/).

Faculty Development

There have been two recent developments in Ethiopia which prioritize the need for an expanded focus on education in general, medical education and psychiatric education. First, there has been a rapid expansion in both medical school enrollment and in the number of medical schools (from three to six). The number of universities is planned to further increase to 21 in the next few years. Second, in 2008 the Ethiopia Ministry of Health determined that psychiatry services should be integrated into the general health system of the country. These two important milestones require a massive educational initiative to equip faculty in the existing universities to develop educational services in the new universities and to enable the psychiatry faculty at Addis Ababa University specifically, to provide leadership so that every health care worker in the country will have relevant training in mental health and illness. To this end, the Addis Ababa University's Dean of Medicine, Dr. Milliard Derbew, is creating an office of medical education with a mandate to provide courses in teaching methods. Consistent with this initiative, and under the auspices of TAAAC, University of Toronto professor Helen Batty is leading a series of 1-week medical education certificate workshops for faculty members in Ethiopia. Built into these trainings is the handover to the Ethiopian faculty for their ongoing administration at Addis Ababa University.

The second priority for both TAAPP and TAAAC is to focus the 1-month University of Toronto teaching trips on providing co-teaching with the Ethiopian faculty and assisting them with the theory and practice of evidence based educational models. An additional, and as yet unexplored, avenue for both TAAPP and TAAAC is to involve community-based psychiatrists and other nonfaculty graduates of TAAPP, and in the future TAAAC, who are not formally appointed to Addis Ababa University, to assist in the clinical supervision of residents.

Continuing Medical Education

New psychiatrists returning to their sponsoring agencies and hospitals are gratefully absorbed like drops of water into the earth before the rains. They are so quickly consumed with work and local commitments that there is an emerging need to actively engage new psychiatrists in ongoing professional development activities. In Phase III, a continuing medical education (CME) component will be developed in the department of psychiatry as a hub of involvement for graduated residents and qualified psychiatrists alike helping them to maintain and broaden their skills and knowledge. Psychiatric CME in Ethiopia is an entirely new venture, and planning for CME workshops may have several beneficial spin-offs, such as attracting psychiatrists from other English-speaking African countries. Addis Ababa could become a center of educational excellence for psychiatrists in Africa. If CME events were to be held in the first new satellite Departments of Psychiatry in Harar, Jimma, Makele, and Nazareth, they would provide further engagement of new graduates located in these decentralized departments, promoting the importance of mental health to their medical colleagues there and offsetting the stigma of mental health outside the capital.

Health Services Capacity

Clinical sustainability has a number of important dimensions. When Amanuel Hospital changed from an "asylum" into a psychiatric hospital in 1995, two of us (AA, MA) worked to discharge patients whose average length of stay was as long as 30 years, to introduce a system of patient admission and discharge, patient charts, and to negotiate for medication to be reliably supplied to the hospital. As the residency program got underway, increasing numbers of severely ill psychiatric patients were thus stabilized, and attempts were made to discharge them back to their communities (13). But with no adequate follow-up in the community these patients required outpatient services staffed by the residents at Amanuel. By 2007 there were so many patients requiring outpatient visits that the residency program was under threat. The residents' learning in clinics was compromised by the needs of relatively stable patients to receive follow-up. The new CEO of Amanuel Hospital, Dr. Keseta Brahan, successfully ad-

dressed this problem by initiating the first stage of psychiatric community services. He requested that 55 local Health Centres see stable discharged psychiatric patients. He delegated a small team of one psychiatrist and several psychiatric nurses to visit and assist these clinics as needed.

In rural Ethiopia, follow-up is significantly limited. For some years there have been 50 psychiatric clinics in the countryside that are staffed by psychiatric nurses who graduated from a 1-year diploma training in psychiatric nursing at Amanuel hospital. However, the relative isolation of these clinics has made medication supplies unreliable and staff morale an issue.

With the recent development of four new satellite departments of psychiatry, attached to universities with medical schools in cities across the country, and the integration of mental health services into the broader primary health care delivery system, regional psychiatric services and follow-up care becomes a real possibility. Although access to medications and personnel for follow-up remains highly constrained at present, many of the health changes in Ethiopia are likely to address these problems. For instance, there is now a Masters for Health Officers in Mental Health and Illness starting in Jimma, Nursing Bachelor of Science programs proliferate, and health care workers at each of the four tiers of the Ethiopian health system are required to be competent to recognize and treat patients suffering from basic psychiatric problems. This essential education is taking place at Amanuel Hospital. Although the continued development of psychiatrists, psychiatric nurses, health officers, clinics, and treatment facilities is important, a long-term solution necessitates a greater push toward community care, and the development of integrated multidiscipline services, which include local traditional healers. These are the challenges ahead for Phase III of TAAPP, a phase that will require increasingly partnership across medical specialty, public health, and allied health professions.

Discussion

As TAAPP moves forward, there are many achievements to celebrate. The partners remember, however, that one of the primary goals was to learn about the establishment of an effective and ethical engagement between a North American and an African University. To this end, we have tried not to lose sight of the need to reflect critically and analyze the project with the rigor we hold dear in universities. In developing such a partnership, uppermost in the minds of these involved has always been the risk of introducing an imbalance of power that could lead to an overemphasis on Western, Anglo-Saxon, or America-centric knowledge and practices that might have questionable relevance for Ethiopia, an issue poignantly raised by Battiste in her book chapter entitled "You cannot be the global doctor if you are the colonial disease" (14). In psychiatry specifically, Belkin and Fricchione (15) have described the concept of bidirectional internationalism as the repositioning of Western countries as partners, rather than solely as experts. They criticize Westerners' tendency to assume that the nosology of disease is universal, and the tendency to overemphasize psychiatric treatment based on neurophysiological paradigms without testing and adapting them through self-reflection in response to cultural diversity and international experience.

Certainly, for the University of Toronto-based faculty members, the experience of teaching in Addis Ababa has drawn attention to cultural biases inherent in basic assumptions underlying North American psychiatric training models that were previously invisible to them. For instance, in Addis Ababa, the first social indication of schizophrenia is the patient's refusal to wear clothes, whereas in the West it is often the patient's complaint of the onset of abnormal perceptions such as delusions or hallucinations. This simple example calls into question one of the fundamental pillars of all psychiatry education programs—the diagnostic taxonomy. Initially, the Addis Ababa University psychiatric residency training director requested that University of Toronto faculty teach Ethiopian residents "what you teach Toronto residents," suggesting the Ethiopian faculty members and residents would act as a corrective to any cultural mismatches, and that the Ethiopian faculty would ensure the alignment between the curriculum and the needs of the Ethiopian patient population, culture and environment. Indeed, the first invited lecture by a member of the University of Toronto faculty was "Classification of Psychiatric Disorders." The tacit question embedded in that lecture was not only "Is it preferable to use the DSM or the ICD system" but also "what are the helpful and adverse effects *of any* classification system, and how did DSM/ICD become dominant?"

Looking in the other direction, it appears that by providing University of Toronto faculty and residents' educational immersion experiences in Ethiopia, TAAPP is challenging, in a very modest way, the relative cultural isolation of North American models of psychiatry. One concrete result has been that in 2006 the University of

Toronto expanded its own cultural psychiatry core curriculum from 6 to 18 hours focusing on issue of cultural competence and *trans*-cultural issues. Recognizing that Ethiopia has many different ethnic groups with over 200 dialects and languages (16), and that Canada is increasingly multicultural with 52% of Torontonians born outside of Canada and speaking over 72 different languages (17), there are mutual lessons learned that will equip residents from both contexts with the skills to work with cultures other than their own.

In retrospect, focusing on similarities in the two countries and skirting obvious differences in culture and resource was useful to get the project underway. Nevertheless, as anthropologist Janelle Taylor warns, medical education tends to function as a "culture of no culture" (18) that renders culture an exotic characteristic that belongs to people other than the doctor. The fact that there are cultures of medicine and medical education can be overlooked. Thus it took some time for the TAAPP program to clearly see the risks inherent in uncritically "exporting" large parts of the University of Toronto curriculum.

One of the first distressing and visible signs, as described above, was that teachers and examiners noted that the Ethiopian residents were focusing too much on specific DSM-IV axis I disorders to the exclusion of recognizing and incorporating the social determinants of mental health issues and disorders. A second was an absence of understanding or engagement with the specific phenomenology and explanatory models used by the patients. These problems, as we have seen, can be partly attributed to system pressures, examination models, and simply expediency. On the other hand, Ethiopian residents were reading primarily Western psychiatry texts, peer-reviewed articles and Internet-resources in which descriptions of the sociocultural and psychological aspects of patient cases are often truncated or too culturally distant to appear as relevant or as useful as biological explanations of illness. Missing are references to Ethiopian models of illness, cultural knowledge about wellbeing and healing, and information about traditional methods of treatment, which remain the first recourse for the vast majority of Ethiopians. To address this gap, the most recent iterations of the curriculum have begun to include topics on mental health issues seen through a cultural lens and taught by Ethiopian faculty members, several of whom have distinguished careers in research and publication concerning mental health and illness in Ethiopia. Much more remains to be done in this area, and we foresee the eventual development of academic research, publication, and creation of texts that can complement, or in some cases, counterbalance and even challenge the dominant Western and America-centric sources of information.

Conclusion

The development and initiation of the psychiatric residency training in Ethiopia exemplifies the ability of the small faculty in the Ethiopian Department of Psychiatry to, in the words of one of our University of Toronto colleagues "think big, start small, and act now" (Mark Sandford, personal communication, May 2007). For the University of Toronto faculty, working to co-develop a residency program in Ethiopia was captured by the words of an Addis Ababa University colleague, translated from the Amharic "slowly slowly the egg develops legs and walks away!" Addis Ababa University started with only three psychiatry faculty members, and in the first two phases of TAAPP has increased the number of psychiatrists from 11 to 34. These numbers alone, however, do not convey the extent of development of health human resources, health care services, and educational programs that have occurred as a result.

The University of Toronto Department of Psychiatry, on the other hand, has learned that there is a great deal it can contribute, but also that it can learn. Toronto-based faculty members continue to be inspired and energized by the Ethiopian faculty's determination, their body of scholarly research, and their comfort and experience in working with overseas teaching faculty (19). The TAAPP model of outreach education seems to have applicability and utility for a broader engagement by the University of Toronto with Addis Ababa University residency and PhD programming as well. Both TAAPP partners have forged a strong collaboration despite limited information to help guide the partnership and the constraints on face-to-face planning across a huge geographic expanse. We attribute the success we have enjoyed to a shared passion for psychiatric education and a mutual interest in understanding and helping those who suffer from mental health problems. Nevertheless, TAAPP requires our willingness to discover the ever finer-grained needs and constraints of our partnership, and sufficient flexibility to modify continually our involvement in the educational process. Inevitably, any new relationship involves a degree of risk and excitement. Our shared relationship has empowered creativity and innovation on both sides of the world and we hope that in sharing our experience we might in some small way engage others

in the pursuit of building capacity to care for patients and families struggling with the burden of mental health problems around the world.

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