

ENHANCING EDUCATION AND PRACTICE

## Teaching Psychiatry in Poor Countries: Priorities and Needs. A Description of How Mental Health is Taught to Medical Students in Malawi, Central Africa

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**ABSTRACT** **Context:** *In developing countries poor standards of clinical service may be an obstacle to medical education. The paper outlines the inadequate mental health service in Malawi, Central Africa, which as well as failing patients obstructs the training of health workers.*

**Aims and objectives:** *A new mental health curriculum at Malawi's medical school is described. The notion of psychiatry as a medical speciality is abandoned and the focus moved to psychological and psychiatric factors as they present in general clinical settings and primary care. Students are encouraged to consider how they may address mental health issues through the many and varied roles which doctors in resource poor countries must fulfil (administrator, trainer, primary health care doctor, hospital physician).*

**Relevance:** *This training strategy accords with a shift of attention among health service planners world-wide from specialist services towards primary care, and may generalize to other settings in which specialist clinical services are poorly developed.*

**KEYWORDS** *Psychiatry, teaching, developing world, Africa, Malawi, primary care.*

### Introduction

Despite evidence of the socio-economic burden of mental illness in all societies (World Bank, 1993), psychiatric services and training programmes are often considered a luxury beyond the means and needs of the poorest countries (Yousaf, 1997). Problems arise when training programmes precede the development of adequate clinical services where trainees can get experience: attempts to fill this gap by importing Western curricula are quite inappropriate

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(Metcalf, 1996). This paper describes an approach to teaching psychiatry which has been implemented at the College of Medicine in Malawi, Central Africa. The author worked in Malawi as psychiatrist with a medical mission organisation and as part time lecturer at the College of Medicine. Prior to his arrival there was no psychiatrist in the country. This vacuum presented an opportunity at the medical school to frame mental health teaching within community health and de-emphasise psychiatry as a medical speciality.

## **Malawi – The Socio-Economic Context**

Malawi is a land-locked state whose population exploded over recent decades, though with AIDS is now falling. Ninety per cent of the 12 million or so live in rural areas and are principally occupied in subsistence farming. It has remained among the handful of poorest nations on earth, and this is reflected in social and health indices such as infant mortality, life expectancy and adult female literacy. Fifty per cent of the population are under 16 years old. Like its neighbours Malawi has tragically high rates of HIV infection (Taha *et al.*, 1998) and the small urban educated class on whom the fragile economy depends is most heavily afflicted. Infrastructure is poor: the few tarmac roads are badly maintained, and post and telephone networks are slow and unreliable. Malawi lacks mineral wealth, and successive price reductions in the global market for its main export, tobacco, have brought mounting debt and currency collapse. Public services depend upon international aid, and an ever greater burden of essential service provision falls to non-governmental organizations (NGOs) like mission schools and hospitals.

## **Health Services**

The Malawian health service aims to meet the needs of the population through a network of central hospitals (staffed by doctors and providing tertiary services like surgery), district hospitals (usually with a single doctor supervising medical assistants and nurses), and a scattering of maternity units and health posts. The reality is that for much of the widely dispersed rural population the nearest health facility may be several days walk away, and lack or cost of transport usually excludes treatment in hospital. In accordance with World Health Organization recommendations (WHO, 1978) Malawi has supported a devolved health service prioritising primary health care (PHC) and illness prevention at village level, but in reality the state PHC system is patchy and inadequate. Some areas benefit from PHC networks and hospitals run by mission organizations.

Turning to mental health, in north Malawi a medical missionary order runs a new psychiatric service providing a high standard of care to the surrounding population. In the government health system elsewhere, mental health care is assigned to specialist enrolled nurses, who aim to run psychiatric and epilepsy clinics, visit peripheral health centres, and manage a few inpatients. Disturbed patients are taken to the national central mental hospital. In a few districts the service works well, but elsewhere the efforts of the nurses are frustrated by their lack of supervision, unpredictable supplies of essential medicines, and by their redeployment away from mental health work to acute medical wards. The 400 bed central mental hospital at Zomba is staffed by a few psychiatric and enrolled nurses who supervise student nurses and orderlies. The last government psychiatrist left in 1992. In contrast to general hospitals in the region, at the mental hospital there is no tradition of guardians residing to feed and care for their sick relatives. Indeed families may never visit; many are from the opposite end of the country. Clinical assessments are poorly done, often by untrained staff without collateral information, diagnoses may be omitted or wrong, patients are over medicated, bored, rapidly institutionalized, and there is little planning towards discharge and follow-up.

As elsewhere in sub-Saharan Africa traditional healers are consulted widely, especially for mental problems or disturbed behaviour. But most traditional treatments are abandoned within weeks if ineffective, and patients suffering severe chronic mental illness with disturbed behaviour will eventually be brought to the state psychiatric service for treatment, or else be left with no treatment at all. It can be seen then, that outside the small area served by an NGO programme, mental health care for those with major mental illness in Malawi is inadequate.

### **Health Worker Training in Malawi**

In Malawi, nurse and medical assistant training attends little to mental health issues. Some years ago a handful of nurses received specialist psychiatric training in neighbouring Zambia or South Africa, but few of these continue in this field. The specialist enrolled nurses who provide most psychiatric care receive a one year training at the central mental hospital. On return to their home districts many are deployed elsewhere in the hospital. Of the 150 nurses so trained, only 50 continue to work in mental health. So there is precious little mental health expertise at work in Malawi.

Turning to doctors, the first graduated from the College of Medicine, Malawi's only medical school, in 1992. Twenty are trained annually. The few Malawian doctors trained before then studied elsewhere in Africa or in the developed world, where many have remained. Psychiatry is taught as a block in the 4th year. Prior to the author's arrival it was taught by first world psychiatrists flown in for a few weeks. Mental health issues are rarely addressed

elsewhere in training. Clinical teaching in psychiatry takes place at the central mental hospital and in out-patient clinics. This is far from ideal: students' clinical experience is diminished by the poor quality of psychiatric practice, and their enthusiasm for the subject evaporates. Though well used to shoe string services and shortages of the very basics, they are shocked by what they see there.

## **Changing the Mental Health Curriculum at Medical School**

The College medical training emphasises public health, illness prevention and PHC. Soon after the author's arrival the primary health care department proposed a new psychiatry curriculum that shared this emphasis. Rather than portraying it as a clinical specialty in its own right the course would embed mental health within primary health and general medical settings. A tutor would coordinate the course and lead much of the teaching. A curriculum was drafted comprising classroom time, clinic attendance, sessions with various community agencies, and one week clinical placement at the central mental hospital. The course first run in 1997 over 3 weeks, with the author as tutor, increasing to 4 weeks the following year. The course was continued thereafter by primary health care department staff, joined later by a lecturer in mental health, and now the author has left Malawi and has no ongoing role.

Over the first week or so of the course most time is spent in the classroom. Core knowledge is covered in lecture–discussions lead by the tutor. In clinics and mental hospital the tutor co-opts psychiatric nurses to join in clinical teaching, which compliments and extends clinical skills already learnt, encouraging students to see mental health as a component of general health rather than a distinct function with its own disorders, requiring specialist treatments and services.

More specifically, the curriculum has been designed to enable Malawi's future doctors to address mental health issues in four different roles they will fill after qualification: as district health officers with responsibilities for service planning; as competent 'all rounders' able to manage common psychiatric presentations; as hospital physicians managing mixed mental and physical conditions; and as primary care doctors running busy general out patient clinics. These four will be considered in turn.

## **The District Health Officer Role**

After 18 months internship at central hospitals, Malawian doctors are allocated posts as district health officers. DHOs provide clinical leadership, administer district-wide services, allocate resources, and direct manpower. They are ideally placed to promote mental health care and protect sufficient

time and resources to enable the psychiatric trained enrolled nurses to operate the district's mental health service. In our course this service manager's role is addressed by:

- Teaching session presenting economic evidence to justify expenditure on basic mental health care for even the poorest nation; in short, that mental illness is common, burdensome in human and economic terms, and that cheap and proven interventions are available (Blue & Harpham, 1994; Desjarlais *et al.* 1995).
- Limiting coverage of psychopharmacology to the few basic drugs which are cheap, have long shelf lives, and are available.
- Framing mental health within the community medicine teaching programme. Mental health care is presented as integral to PHC, and community nurses and other PHC staff need training and support in this area. Our curriculum has fallen short in this respect but we hope that part of future students' clinical experience of psychiatry may take place in community settings, for instance within the village-based teaching settings already developed by the medical school.
- Sessions in community settings—school, police station, social welfare department, centre for learning disabled—introducing students to the potential for (mental) health education to community groups. We tried a range of agencies and formats for these sessions, some working better than others. For example, a headmaster delivered a long diatribe on the evils of cannabis, less enlightening than policemen sharing their concerns about how to manage the disturbed people they were expected to lock up.

## **The Generalist Role**

Doctors working in poor or isolated regions require a broad range of expertise. They must know enough psychiatry to treat common mental illnesses at district level, supervise psychiatric enrolled nurses, and teach the basics to health staff working in remote settings. To emphasise these basic knowledge requirements we pared down psychiatry to a few diagnostic groups—schizophrenia, affective psychoses, anxiety and depression, substance misuse, delirium and dementia, learning disability, and psychological disorders of children—a simpler system than that suggested in the core undergraduate curriculum devised by the World Psychiatric Association (Walton & Gelder, 1999). A problem-based approach encourages students to contextualize these disorders and their management within familiar Malawian settings, consider aetiological factors important in their society, and compare such factors with local cultural explanations for abnormal behaviour such as bewitchment and spirit possession. The author brought to these sessions conundrums from his own experience of practising psychiatry in rural Malawi, and perhaps learnt as much as his students.

## **The Hospital Physician Role**

The course attends at some length to disorders requiring both psychiatric and medical management: delirium, dementia, and dissociative disorders. With high rates of chronic debilitating medical conditions delirium is common, and as elsewhere is poorly managed, patients dying of acute treatable illnesses. When confronted with disturbed behaviour well learnt clinical responses may be replaced by evasive action; physical assessment and investigations are missed, treatment neglected, and patients may be deeply sedated without diagnosis. The new curriculum aims to reduce such preventable disasters by highlighting the importance of physical assessment, and by learning the safe management of acutely disturbed behaviour. Students share stories of clinical errors in managing delirium, and their vital future role as educators of less well trained colleagues is stressed.

During the psychiatry course, students and tutor offer a liaison psychiatry service to the general hospital, encouraging referrals from wards and discussing their management. Patients with dementia are seen, and the group discuss the practical difficulties of establishing whether cognitive decline has occurred in an illiterate elderly villager brought to town for the first time in her life, who would anyway be reticent to respond to a respected figure such as a doctor. The students arrive at appropriate questions to detect sensitively cognitive impairment in such a person (knowledge of extended family members, church songs, farming and cooking practices), and they consider who might best ask these questions when doctor–patient communication is obscured by etiquette (perhaps a ward orderly or family member).

Hysterical conversion and dissociation states are common in Malawi, and patients with neurological symptoms are admitted to medical wards. They may be correctly diagnosed but are unlikely to receive help in addressing why they developed psychogenic symptoms and what they might do to prevent recurrence. In the psychiatry course at the College of Medicine, hysterical processes are given prominence over neurotic syndromes rare in sub-Saharan Africa, such as phobic and obsessional states. Students are encouraged to broaden their history taking to include psychosocial enquiry and informants. Nurses or lay figures may offer counselling or family meetings, address particular problems facing the patient, and students discuss what form such interventions might take.

## **The Primary Care Physician Role**

Lastly, researchers have repeatedly found high rates of somatization in sub-Saharan Africa (Patel, 1998). As elsewhere, health workers in Malawi fail to recognize it, or fail to offer explanation or relevant treatment. The concept of somatization is covered at length during the psychiatry course at the College of

Medicine. Clinical examples and their realistic management in busy clinics is discussed. For instance, enquiring into interpersonal matters may be a more fruitful use of time than another cardiovascular examination in a frequently attending young adult complaining of palpitations. The students discuss how pressures of the clock and patient expectations push health workers towards inappropriate prescribing—in Malawi usually aspirin and antimalarials. Role playing clinical encounters brings into the classroom these pressures and the awkwardness of resisting them. Medical students are encouraged to see that helpful interventions really do lie within their resources—brief counselling by the local psychiatric nurse, involvement of family or community members, or just offering the patient an explanation for his symptoms which includes psychological and social dimensions.

To consolidate this theme, included in the psychiatry course is a group research exercise that explores in general clinic attendees the frequency of the common mental symptoms that underlie somatization. The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), a self-reporting questionnaire developed for this purpose in the UK, is taken as a template from which the entire student group derives an in-house research instrument. Students translate questions and possible responses into chiChewa (the most widely used of Malawi's many languages), persuade non-medical friends to do so too, and these translations are then translated back into English. Discrepancies in the pooled versions fuel a debate on the pitfalls of trans-cultural research and lead some to question the validity of exporting a Western research instrument to settings very different to that in which it was developed. In this way the students confront for themselves the important universalist vs. culture-specific discourse of cross-cultural psychiatry (Littlewood, 1990). Such a critical approach to research is especially important to doctors practising in a country where nearly all of the 'evidence' is imported. The chiChewa version of HADS is administered by the students to the many hundred general clinic attendees in a single morning as they wait to be seen. Their finding that one-third report many neurotic symptoms is in line with many studies conducted in primary health care settings elsewhere (WHO, 1990). Finally, students present their findings to senior colleagues at the medical school academic meeting, thereby educating their educators.

## **Conclusion**

Malawi's mental health care system is under-resourced and patients receive inadequate care. For trainee health workers too the service is inadequate, depriving them of opportunities to observe and participate in effective mental health care. The paper describes efforts at Malawi's College of Medicine to surmount this obstacle and deliver relevant mental health training effectively. A curriculum has been developed which locates mental health care within PHC

and general hospital settings. Medical students gain the necessary skills and knowledge to practice effectively. They also consider the evidence-based rationale for attending to the psychiatric needs of patients and populations, and are encouraged to take up the role of mental health trainer and advocate to fellow health workers and to the communities they serve. The principles underpinning this curriculum are of relevance to medical educators elsewhere who face the challenge of training students in settings without adequate clinical services.

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