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RESEARCH PAPER

Evaluation of undergraduate psychiatry teaching in Malawi

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In Malawi, mental health services account for only 2% of the health budget; there are just 4.5 full-time psychiatrists and 433 psychiatric beds. The Scotland Malawi Mental Health Education Project (SMMHEP) aims to provide sustainable support for psychiatric training for healthcare professionals and has increased the number of psychiatrists in the country. There has been a recent change in the educational programme in order to maximise clinical exposure and experience, particularly with the care of in-patients. The new programme has had a positive effect on students' attitudes towards psychiatry and their consideration of psychiatry as a career. This paper supports the ongoing work SMMHEP does in developing psychiatric services through education.

Malawi is a low-income country in sub-Saharan Africa. Life expectancy is 54 years and the literacy rate is 75.5% for men and 48.7% for women.

Malawi has an estimated population of 15.91 million and an area of approximately 118 000 km^2. It is split into 28 health districts, most of which have a district hospital. The Malawi College of Medicine in Blantyre opened in 1991 and is the only medical school. The country has one government psychiatrist, two psychiatrists employed by the College of Medicine, one psychiatrist from the American Peace Corps and one psychiatrist employed part time by the Scotland Malawi Mental Health Education Project (SMMHEP). The national psychiatric hospital, with 333 beds, is located in the former colonial administrative capital city, Zomba. Two 50-bed units are staffed by nurses and clinical officers, giving a total of 433 psychiatric beds for the country (Kauye, 2008). Two per cent of the country's health budget is spent on mental health (World Health Organization, 2005).

The neuropsychiatric burden for Malawi is 2497.43 disability-adjusted life years (DALYs) per 100 000 and the suicide rate is 7.03 per 100 000, compared with medians for all countries of 2964 DALYs and 6.55 suicides per 100 000 (Jacob *et al*, 2007). The 2002 international 'burden of disease' data from the World Health Organization suggested that unipolar depression is the fourth leading cause of disability in Malawi, following HIV/AIDS, cataracts and malaria (Bowie, 2006).

A recurrent suggestion to address such treatment gaps and lack of psychiatric training is that the UK could provide visiting psychiatrists to support educational programmes in other countries (Hanlon *et al*, 2006; Kulhara & Avasthi, 2007; Mullick, 2007).

The aim of SMMHEP is to provide sustainable support for psychiatric training at the Malawi

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College of Medicine. The College has an annual intake of 60–70 students per year and provides a 5-year programme in which students do a clinical attachment to psychiatry in the fourth year. Historically the whole fourth-year cohort would do their 7-week psychiatry block at once, which proved problematic. In 2009 the curriculum was reviewed and it was decided to divide the students into groups of around 20 for their clinical rotations, so that more effective teaching could be provided. However, the new curriculum presented challenges for SMMHEP in sourcing UK volunteers to provide the teaching throughout the year rather than once only.

Prior to the initiation of SMMHEP (over a decade ago) Malawi had one psychiatrist, despite having a similar burden of mental health to all other countries. Being mindful of cultural issues and sustainability, SMMHEP endeavours to develop psychiatric services through education. The long-term aim is to train psychiatrists within Malawi such that the country can become self-sufficient in terms of psychiatric education.

Previous research has shown positive outcomes, with local medical students achieving results in undergraduate psychiatry examinations comparable to those of Edinburgh students (Baig *et al*, 2008). However, experts have highlighted that mental health education programmes in low-income countries are often too heavily based on theory, without enough practical elements (particularly in the community) (Saraceno *et al*, 2007). SMMHEP has now developed the undergraduate mental health block to maximise the use of clinical attachments in the mental hospital and clinics.

This paper reports how a revised psychiatric teaching programme has been delivered for Malawian medical students, and assesses its impact on students' learning and their attitudes towards psychiatry.

Method

A new undergraduate education programme maximises clinical opportunities and competency achievement. The older programme had separated lectures and case-based learning tutorials from clinic experience. The clinical attachment was mostly at the Blantyre out-patient clinic, with some day trips to Zomba Mental Hospital (which entailed up to 2 hours of driving each way). It was felt that introducing a residential attachment might help to reduce the stigma of visiting a mental hospital, and might encourage the students to be more positive about their engagement with the hospital, rather than seeing it as something to be feared.

There is now a 2-week residential placement in Zomba Mental Hospital, which allows students to undertake a role in the multidisciplinary clinical team: assessing new admissions, reviewing patients' progress and attending ward rounds. They are supported through clinical supervision with SMMHEP volunteers and case-based learning tutorials, which are integrated into the clinical attachments. These are designed to allow the students to research problems associated with a case and discuss their findings.

The students also have 2 weeks of out-patient clinical experience, which includes trips to community clinics and general hospital liaison referrals.

Finally, an applied mental health education workshop has been introduced. Malawians commonly attribute mental illness to illicit drug use, alcohol and spirit possession (Crabb *et al*, 2012). This workshop is designed by the students and is delivered at a local school. The aim is to raise awareness, dispel cultural beliefs and reduce the stigma of mental illness in the community.

Lectures and a rigorous assessment process (involving submitting long case reports and examinations) continue to be used.

Questionnaires with Likert scales were disseminated at the end of the attachment to evaluate the programme. These asked the students to appraise each of the above teaching components. They also gave an opportunity for the repeating students to compare the new course to the old. One part was designed to assess students' attitudes to psychiatry (stigma and career considerations) before and after the block.

Results

Questionnaires were given to all 22 of the medical students and all returned them (100% response rate). Seven students were repeating the block and were able to make direct comparisons between the old and new course.

All aspects of the new course were valuable to the students, with the new Zomba Mental Hospital residency being the most highly valued. The out-patient clinic attachment, lectures and case-based discussion tutorials were also judged to be of particular value to their learning.

The seven students repeating the year were all in agreement that the new programme was an improvement, with the residential attachment contributing to more effective learning.

Prior to undertaking the psychiatry block, only two students had considered pursuing psychiatry as a career and 15 had ruled it out. Following their clinical exposure, none had definitely excluded the option and 11 were interested in pursuing it as a career.

Nineteen students felt that the block had a positive impact on their attitudes to psychiatry, and all students reported that they had been equipped with transferable skills that they could utilise in other specialties.

All additional comments provided in the questionnaires were positive:

- 'We were able to admit patients and see their progress on a daily basis.'
- 'I now understand what psychiatry is about and how diverse it is. It does not only deal with aggressive people!'
- 'I am now able to look at people with mental illness as patients.'

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Discussion

Mental health service provision in Malawi is critically low, with 4.5 full-time psychiatrists in the country and 2.5 psychiatric nurses per 100 000 people (compared with 11 psychiatrists and 104 nurses per 100 000 people in the UK) (Jacob *et al*, 2007). SMMHEP aims to address the treatment gap through education of students, staff and schools, and has helped produce three new Malawian psychiatry trainees.

Delivery of the new educational course was a positive experience for the volunteers but did present some challenges. Resources, such as textbooks, were limited and there were frequent power cuts. Practical difficulties during the Zomba residential attachment included the student accommodation, which lacked mosquito nets and cooking facilities.

Although this evaluation is of a relatively small number of students, there was a 100% return rate of questionnaires, showing that the new undergraduate programme, which includes a residential psychiatric hospital attachment, is a valuable and effective way for students to gain knowledge and skills. It also has a direct effect on reducing stigma and improving attitudes to psychiatric illness and psychiatry as a potential career path. The results of this survey appear positive and similar studies in Malawi support the finding that education improves attitudes to psychiatry (Beaglehole *et al*, 2008).

However, the reality is that although medical students would consider pursuing psychiatry, this interest is not translated into actual careers. In fact, only five graduates have chosen this path since the College first opened and postgraduate training continues to struggle to recruit people to specialise in psychiatry. It is therefore clear that ongoing work, development and support are required from SMMHEP and the College of Medicine to engage and encourage students to work in psychiatry in the future.

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RESEARCH PAPER

Hospital doctors' management of psychological problems at a Nigerian tertiary health institution

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A questionnaire was sent to all consenting doctors at the University of Ilorin Teaching Hospital, Nigeria. It asked about their management of psychological problems in their clinical practice. Over 90% would welcome more time to talk to patients and agreed that psychological and social factors should be routinely assessed and recorded for patients. Most respondents would refer patients with depression or disturbed behaviours. 'Ineffective treatment' and 'dislike of psychiatric referral' were not the main reasons for non-referral. A majority of the doctors had initiated treatment for anxiety and insomnia but not for alcohol withdrawal, psychosis, acute confusional state or depression. Doctors' awareness of 'the impact of psychological factors on the course of physical illness' was high. To sustain this high level of awareness and encourage referral, in-house psychoeducational training of hospital doctors should be intensified. In addition, an increased doctor/patient ratio, public education to reduce stigma and a well developed liaison psychiatric service are imperative.

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