Welcome to the second issue of the Volunteering and International Psychiatry Special Interest Group Newsletter

We welcome article submissions. Details for potential authors on page 11. Don’t forget to leave feedback on what you thought of this issue of VIPSIG newsletter at www.surveymonkey.com/s/VIPSIGnewsletterfeedback

In this newsletter, we hear from volunteers working in a range of very different but equally challenging environments. Dr Zinkstok describes the experience of working with the homeless at Christmas (page 5) and we have reports from Malawi (page 2), Zambia (page 14) Somaliland (page 7) and Sierra Leone (page 9). What these reports all describe are the challenges and also the rewards of working without the backup of colleagues, hospital services and unlimited pharmacy. We have our first book review on page 12 in which the psychological and emotional impact of the trans-generational effect of slavery on Caribbean men and women of African origin are discussed.

We hope you enjoy the newsletter!

Dr Susannah Whitwell
Dr Daniel Wolde-Giorgis
Dr Manshant Rani Kaur
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Volunteering and International Psychiatry SIG Newsletter Editorial Team

If you have comments about any of the articles in this issue or would like to get more involved in the SIG VIP please us on susie.whitwell@gmail.com

Next VIPSIG meeting will be held on April 19, 2012 at RCPsych
For more details check the VIPSIG webpage at www.rcpsych.ac.uk
Malawi, in south east Africa, is about the size of Scotland with twice the population (14 million). It is bordered by Tanzania and Zambia to the north and west and by Mozambique to the east and south. The life expectancy is only 41 years and HIV infection is endemic (about 17% of pregnant women are HIV+, United Nations 2007). The average annual income per capita is US$160 with half the population below the poverty line (The World Bank 2008). Despite this, Malawi is rightly regarded as the ‘Warm Heart of Africa’ as the culture stresses community and hospitality.

Malawi has a long association with Scotland that started with Dr David Livingstone in 1859. Livingstone was born in Blantyre, Lanarkshire, after which Malawi’s commercial capital is named. He was sponsored by the London Missionary Society to spread ‘Christianity, Commerce and Civilization’ after which colonial rule was established with the British Nyasaland Protectorate. Shortly after independence in 1964, Ngwazi Dr. Hastings Kamuzu Banda assumed life presidency. Banda also knew Scotland as he had studied medicine at the University of Edinburgh and worked as a GP in Renfrew. Malawi has been a multi-party democracy since 1994.

Psychiatry in Malawi
The prevalence of schizophrenia, bipolar disorder and postnatal depression in Malawi is similar to that in high-income countries (Odejide et al 1989, Stewart 2007) but Malawi has faced a number of difficulties when providing mental health services and education (Kauye 2008).

There are 2 psychiatric hospitals: the government-run Zomba Mental Hospital in the southern region and the NGO-run St John of God Mental Health Service in the north. Mental illness in Malawi used to be managed in Zomba Central Prison until the Zomba Mental Hospital was built in 1953. Zomba Mental Hospital is now staffed by one psychiatrist, 5 clinical officers and about 20 psychiatric nurses. It serves a catchment area of 8 million.

The Scotland Malawi Mental Health Education Project (SMMHEP), supported by grants from the Scottish Government and private donations, has provided educational assistance to the Malawian psychiatric service since 2006. SMMHEP volunteers teach psychiatry to the University of Malawi, College of Medicine,
undergraduates and postgraduate psychiatry trainees. SMMHEP also supported the establishment of a postgraduate training scheme onto which the first trainees were recruited in May 2011. SMMHEP is involved in the training of midwives and the development of the Malawi Mental Health Handbook for use in primary care settings and SMMHEP supported Zomba Mental Hospital in providing a modern ECT service through provision of equipment and training.

During the medical undergraduate teaching blocks, SMMHEP volunteers teach psychiatric theory at the College of Medicine in Blantyre and oversee the concluding examination which was adapted from the University of Edinburgh equivalent. Clinical training is based at Zomba Mental Hospital with visits to the Queen Elizabeth Central Hospital and a primary health clinic in Limbe. Tutorial discussion topics include the role of traditional healers and the effect that culture and tradition can have on the content and interpretation of psychotic symptoms. SMMHEP volunteers assess the undergraduates’ clinical performance directly and via a written long case and oral examination.

Occasionally, the Malawian undergraduates are skeptical of the western understanding of mental illness but the course has been shown to lessen the stigma of mental illness and introduce psychiatry as a viable medical career (Baig et al 2008). In fact, some of the medical students taught by SMMHEP volunteers are now registrars on the MMed Psychiatry degree course at the College of Medicine, Malawi, which was designed in conjunction with SMMHEP.

Of course, the many interesting and arresting contrasts between the Malawian service and our own makes SMMHEP an education for volunteers too: About half the patients with intact reality testing think that witchcraft is responsible for their mental illness. Clinical presentations that are very rare in Britain, like HIV psychosis and cerebral malaria, are common (Beaglehole et al 2008) but deliberate self harm is rare (perhaps because deliberate self harm is not a culturally sanctioned communication of distress in Malawi). A study of patients admitted to Zomba Mental Hospital from the Criminal Justice System found that the majority absconded (Hayward et al 2010) but recent changes introduced by the hospital have reduced this.

**Volunteering**

SMMHEP volunteers need to be consultants, staff grade doctors or higher trainees in any of the psychiatric specialties. Out-of-Programme Training (OOPT) or Out-of-Programme Experience (OOPE) placements and combinations of annual leave, study leave and special interest sessions, have been used to cover the teaching blocks that vary from 2 to 6 weeks. SMMHEP can advise prospective volunteers on how to arrange these training opportunities and gain the necessary approvals before honorary lecturer status at the University of Malawi is awarded. There are also opportunities within the College of Medicine for long term lecturing posts of 1 to 2 years.
Interested psychiatrists should discuss their intention with their colleagues or educational/clinical supervisor before contacting the regional SMMHEP volunteer coordinator and completing a Volunteer Interest Form. The regional SMMHEP volunteer coordinator liaises with the National Volunteer Coordinator to match volunteers with teaching opportunities.

Of course, as well as the chance to contribute and learn with SMMHEP, volunteers can experience something of what else Malawi has to offer: There are safaris to enjoy, massifs to climb (JRR Tolkien is supposed to have written The Hobbit after visiting Mt. Mulanje), tea plantations and lakes to visit (Lake Malawi is the most bio-diverse freshwater lake on earth), and bustling markets to explore.

SMMHEP is an effective and sustainable project that offers volunteers a valuable educational experience. If you would like to volunteer please contact Dr Selena Gleadow Ware, National Volunteer Coordinator (swmhc1@doctors.org.uk) or Dr Robert Stewart, Head of Department of Mental Health, College of Medicine, University of Malawi (robcstewart@mac.com). You can also learn more about SMMHEP at www.smmhep.org.uk.

References

Interested in their work? A film on the work of SMMHEP is available to be watched on the SIG VIP pages of the RCPsych website.
The year 2011 was a wonderful year for me: I moved from Amsterdam to central London to live with my fiancée, I started working as a consultant at the Maudsley Hospital, we got married in October, and went to Sri Lanka for a relaxing honeymoon. I decided that after all this great fortune that had befallen me, it was time to give something back. And as we were planning to stay in London for Christmas, I impulsively signed up as a volunteer for Crisis at Christmas (CC for insiders).

Crisis is a large charity for single homeless people, aiming to end homelessness by offering support, housing, and employment opportunities. Every year during Christmas, Crisis organizes a large event during which shelter, meals, services and activities are provided for homeless people all over London, called Crisis at Christmas.

I initially wanted to sign up as a ‘general service volunteer’, thinking that pouring coffee would be a nice change from my daily responsibilities as a consultant psychiatrist (that in all honesty I found weighing rather heavily on my young-ish shoulders). However it appeared that doctors were very much in demand and I deliberated that I hadn’t done my long training not to use it as much as possible.

An introductory meeting for first-time volunteers was mandatory and on a sunny Saturday morning in November I headed to Spitalfields, where the CC headquarters are located. Queuing for coffee, I met needle workers, podiatrists (lots of them), hairdressers, nurses and doctors, and learned that the most popular service offered by CC, is a haircut. The second thing I learned at this meeting was that at CC, patients were called guests. Most of all, I was massively relieved to learn that we were not supposed to do anything invasive! This included sectioning people… I had been slightly worried about this: how would my professional responsibility for psychotic and vulnerable people relate to the low-key, non-judgmental, welcoming and low-threshold environment that CC tried to provide? But no – suturing and sectioning were both considered ‘invasive medical procedures’ and not part of the package offered by CC. There would be plenty of volunteers available who could escort guests to A&Es to be assessed and treated for more serious conditions.

On Boxing Day, my alarm went off at 6.30am. I had not realized (until Christmas Day) that my shift started at 8am, meaning that I had to leave the house at 7.15am – and this on Boxing Day! There was also the logistics of getting to places with hardly any public transport at this time of day, as it was Boxing Day. I do not own a car and my only transport option was my bicycle. Luckily it wasn’t raining...

We met at the ‘hub’ in Bermondsey and I was allocated to a medical team that was sent to the Addictions Centre. We were transported to the...
centre by minivan, and were driven through a deserted City to the centre. The Addictions Centre provided activities, meals and beds for guests with alcohol or substance dependency. My team members were a nurse, an SpR in Oncology, and a pharmacist. Our inspiring team leader was a decisive and pleasant Dermatologist in running shoes, who swiftly set up the medical rooms and allocated us patients. We saw a variety of medical problems, ranging from a lady who requested a ‘check up’ for high blood pressure and diabetes, a guy who was beaten up the previous day, and who was sent to A&E for an X-ray because we suspected a zygoma fracture. Another man, in his twenties, described textbook symptoms of agoraphobia with panic disorder (unfortunately offering CBT was not part of the CC package). A lady came in to tell her life story. Our pharmacist monitored the drug prescriptions; our formulary included paracetamol, ibuprofen, Vitamine B, Gaviscon and some ‘flu and cold medicines. The atmosphere in the Centre was warm, welcoming and relaxed; it was striking that there were as many volunteers as there were guests.

The second day I was sent to the Hammersmith Day Centre, located in a large college. This time, before coffee, I saw a guest with a fungal toe infection – I immediately pulled a podiatrist into the room who enthusiastically explained to the guest what the problem was and took him for a thorough clean up. My team leader of that day, an energetic young GP dressed in outdoor clothing as if he was walking in the lake district rather than working, asked me to see a gentleman who had requested a ‘medical interview’ without wanting to say his name as this was ‘classified information’. I took the guest with me and listened to his story. It appeared that he had received a diagnosis of a chronic psychotic illness of some sort, and wanted my help to get out of hospital. After a long chat, I finally (rather desperately) recommended him to contact the Patient Advice and Liaison Service (PALS) to see whether they could be of any help to him. He had not heard about PALS before, and left cheerfully, after having jotted down everything I said (and my name). I was slightly worried about burdening a hard-working colleague with PALS involvement and hoped that I had not complicated matters. Overall, both days were pleasantly busy – with ample time to drink numerous instant coffees with fellow volunteers – and not at all stressful.

I spoke to several CC volunteers; all of them said that volunteering for CC made them happy because they could contribute to the Christmas of people who are less fortunate than they are. When I talked to the guests, it occurred to me that most of them had simply had bad luck (sometimes lots of it) and I realized how fragile life is in a big city, especially when you’re foreign and far from family and friends. Without a social network, it’s surprisingly easy to end up homeless, simply by losing your job and relationship. A foreigner in London myself, I can identify with the loneliness and anonymity that is at times part of living in a big city like London. Volunteering for Crisis at Christmas made me feel more connected to the people of London – an experience that is actually very Christmassy.
Health Partnerships in a Post-Conflict Setting

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Health indicators for Somaliland represent some of the worst in the world. Years of conflict and underinvestment has resulted in the destruction of most of Somaliland’s health-care facilities; a chronic shortage of qualified health professionals; poor governance; and inadequate access to resources. The effects are devastating and nowhere is this seen more prominently than in mental health.

Established in 2000, a partnership involving THET, a specialist international development organisation, King’s College Hospital NHS Foundation Trust and Somaliland Partnership (KTSP) has pioneered a responsive, flexible and innovative approach to address the challenges of post-conflict health needs with a focus on strengthening human resources for health.

The initial focus was on training staff to improve standards of care and providing academic support to the medical school curriculum. As the partnership developed, it began to attract attention from other healthcare institutions such as Hargeisa Group Hospital (HGH), the main government run referral hospital and the University of Hargeisa’s medical school. In addition to the two medical schools of Somaliland, this partnership now includes five other medical teaching institutions all striving to increase not only the quantity but the quality of health professionals available in Somaliland. In total, since this partnership began, 70 doctors have completed their medical training in Somaliland.

From the beginning, the work of KTSP has been driven by the needs of partner healthcare institutions in Somaliland. It draws on the knowledge, skills and experience of dedicated health professionals at Kings College Hospital but always ensures that it is the partner institutions in Somaliland who identify areas where a difference can be made – areas such as mental health, an issue which is critically in need of support.

Fig 1: Mental Ward at Hargeisa Group Hospital

Research indicates that one in five families in Somaliland care for someone suffering from mental health problems. There are no psychiatrists in country to address this need. In response to partner requests, THET and Kings have fed into the undergraduate and postgraduate teaching of doctors and nurses to ensure that each graduate is equipped with an understanding of mental health.

VOLUNTEER ACCOUNT

Dr Kamran Ahmed, Darzi Fellow, CNWL NHS Foundation Trust, participated in a teaching trip to
Somaliland through the King’s THET Somaliland Partnership (KTSP) to work on a mental health programme. The purpose of the trip was to teach a course in undergraduate psychiatry to final year medical students at Hargeisa University, as they are no psychiatrists in the country to deliver this part of the curriculum.

Arriving in Somaliland was a real culture shock. The dry and dusty terrain, few roads, half-constructed buildings and shanty towns told the sad story of a post-conflict region. However, Somaliland has been rebuilding its infrastructure since the end of the civil war and is now making fantastic progress in training the next generation of doctors. We stayed at the Edna Adan Maternity Hospital with the rest of the KTSP team, where we had excellent facilities. We spent the first two days preparing our teaching material and meeting various people including the Dean of the University, staff on the mental health ward and the enthusiastic interns who would be assisting us during the teaching.

The teaching course was intensive since we had to cover all of undergraduate psychiatry in less than two weeks, but the students were a joy to teach and made it an enjoyable experience. We used interactive seminars, role plays, group discussions, and navigated issues such as cultural differences in psychiatric presentations, available treatments and language barriers together. We also spent time on the psychiatric ward where the students clerked patients and presented to us. The severe lack of resources made the ward a difficult environment to care for patients, but the dedicated staff made the best of the resources they had. Towards the end of the teaching programme we held examinations, both written and clinical. Considering the intense nature of the teaching programme and that they were being examined in English, the standard was good and most passed.

Before the trip, I had decided to make a documentary on mental health in Somaliland and took a camera with me for this purpose. I used the documentary to examine the problems with resources, the heart-breaking use of chains to restrain aggressive patients and interviewed a faith healer and users of the drug *Khat* as well as staff and patients. I also had the opportunity to get involved in a clinical case; a young girl with a first episode of manic psychosis. Her family had mistaken her symptoms for misbehaviour and starting beating her, she fled to the house of a relative who brought her to the hospital where I assessed her and initiated treated. I later received an email from one of the interns informing me she had improved and asking for further advice.

Aside from the teaching and filming, I managed to enjoy other aspects of Somaliland; dinners at our residence with KTSP colleagues, the odd lunch at a hotel, a fruit cocktail on the roof at night, a trip to the market with the interns. It was a wonderful insight into a culture, which I would not have experienced had I not had this opportunity. Most of all, it was the students, their enthusiasm for learning and the gratitude that they expressed that made the trip feel so worthwhile.
Teaching in Sierra Leone

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Sierra Leone and Britain have a long history of close ties, ever since the capital Freetown was founded in 1792 as a home for black slaves who fought for the British army in the American War of Independence. Its recent history has been marked by the brutal decade-long civil war which began in 1991. Although the post-war period has seen renewed development, Sierra Leone remains in the lowest 10 ranked countries, at 180th, in the UN’s Human Development Index (2011). UNICEF reports a life expectancy of 48 years. The mental health needs of the population are dominated by poverty, substance misuse and post-conflict issues such as post-traumatic stress, family dislocation and social exclusion.

Mental health services in Sierra Leone

The mental health service largely consists of the country’s sole inpatient facility, Sierra Leone Psychiatric Hospital (SLPH); there are minimal community services available. Conditions at the hospital are extremely basic and practices such as the chaining of patients are common. Human resources and expertise are severely limited. In terms of specialist staff, there is one consultant psychiatrist, one junior psychiatrist and two psychiatric nurses in the country working at SLPH. There are limited opportunities for professional development and the service is dependent on the efforts of individuals rather than a system that can provide a mental health workforce in the long-term.

Partnership

The Barnet, Enfield, Haringey Mental Health NHS Trust Sierra Leone Support Project (BEH-MHT) was started in 2005, creating a link between the Trust and the SLPH. The project is led by four senior clinical staff members who are accountable to the Trust board, and is recently funded by the Tropical Health and Education Trust. The aim of the project is to provide tailored training on the management of mental disorders and service development for multidisciplinary staff and students at SLPH. Training is provided through annual visiting delegations in the UK and Freetown.

During the latest delegation in March 2011, the BEH-MHT group spent six weeks visiting Freetown in relays of two or three group members at a time teaching hospital staff and students. The authors of this article spent two weeks delivering the psychiatry module to 61 community health officer (CHOs) students. CHOs study a similar curriculum to that of medicine condensed into three years. They work in rural areas where access to medical facilities is particularly limited, and can prescribe medications and perform minor operations (including caesarean sections).

Challenges

The richness of psychiatry is brought to the fore when mental disorders are studied in a cultural
context. As we were teaching in an unfamiliar country, it was essential to create a teaching environment of mutual learning between student and teachers. There was a logistical challenge in creating this dynamic in a class of 61 students, exacerbated by the lack of electricity in the hospital’s teaching room which precluded the use of electronic teaching materials as we were used to in the UK. Instead, we combined group exercises, role play and lectures in order to promote active participation by all students. This was the students’ first foray into psychiatry, so we started with the basics, working our way through history taking, mental state examination and the major disorders. The fascinating interplay between cultural factors and models of mental illness was keenly brought to light during discussions about different attitudes and approaches to mental disorders and people affected by them. The differences were starkly illustrated by a report from one student that a few weeks prior to our arrival the first ever suicide in Sierra Leone was officially recorded.

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Some of the local beliefs around mental illness described by the students were not entirely unfamiliar, such as possession by the devil for what could be psychosis or epilepsy. It was interesting to see some students striving to reconcile rather than replace those models with Western psychiatric models. All these ingredients made seminars lively affairs with a buzz of activity and debate, along with some occasional bewilderment thrown in during the role playing.

We also met with traditional healers in the community and learned about their approaches to phenomena we would identify with mental illness. It was striking how radically different their concepts and approaches are to Western psychiatry when it comes to interpreting mental illness and treating people afflicted by them. The apparent irreconcilability was all the more profound given the prominent role traditional healers hold in Sierra Leonian society.

In addition to cultural issues, the other key challenge we faced stemmed from the marked resource gap. The medications that CHOs can expect to have at their disposal in their rural communities are limited to chlorpromazine, haloperidol and amitriptyline. Teaching them about unavailable medical and psychological treatments would be futile and counter-productive. Given the country’s only psychiatric hospital is based in the centre of Freetown, the rural-based CHOs necessarily have to deploy pragmatic, community-based strategies to support their patients. Teaching the management of mental illnesses consequently became student-led – they knew what was practical and acceptable in their communities. The focus was on improving people’s functioning, psychoeducation and working closely with patients’ families in their homes. An essential aspect of this approach was addressing some of the misconceptions about mental illnesses which can provide fertile ground for the growth of stigma against people.
and families affected by mental illness – stigma that can be as damaging to the patient as any symptom, in Sierra Leone and the UK alike.

Under these circumstances, the teacher-student dynamic became one of partnership rather than hierarchy. This helped create a teaching experience which was immensely stimulating. One of the most exciting aspects about this project is the chance to build on this experience over the course of future visits and see how our approaches and our own learning evolve.

We would like to thank Dr. Denny Grant, Dr Ros Furlong, Professor David Winter, and Norma Johnston for their contribution to this article. We would also like to thank the lecturers at UCL medical school who donated their materials for this trip.

We welcome contributions to the Volunteering and International psychiatry SIG on topics of interest to our membership including letters. We are particularly interested in articles from medical students and trainees regarding volunteering internationally and within the UK, from charities and NGOs who provide volunteering opportunities and advice to clinicians who want to undertake this kind of work.

Articles should be a maximum of 1000 words excluding any references or appendices; they need to be submitted in MS word format, we encourage the use of photographs and figures submitted as separate .jpg files. Letters should not exceed 200 words. Please include your full name and titles, place of work and email contact details.

Opinions expressed in the Newsletter are those of the authors and not of the College unless otherwise stated. The editors reserve the right to edit contributions.

Articles to be submitted electronically to Susie.whitwell@gmail.com
**Book Review**

**Transcending the Legacies of Slavery**
*A Psychoanalytic View*

**Barbara Fletchman Smith**  
*published in 2011 by Karnac Books Ltd.*

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It is an inspiration and a privilege to review a book that has made a significant impact on me. In this highly accessible book Fletchman Smith explores the persistent and circular nature of the trauma and the intense psychological and emotional impact of the trans-generational effect of slavery on Caribbean men and women of African origin.

The psychoanalytic perspective casts a clear light on a complex and a much neglected area that has contributed to significant mental health problems.

Research has shown that third and fourth generation British people of Caribbean background have a higher incidence of psychotic illness than within other ethnic groups. (King et al 1994)¹. There is also a high incidence of men from this background in prisons and secure units. Harsh treatment the book suggests only serves to contribute to the circular nature of this intense trauma that is carried across generations.

The book initially explores the particular struggle experienced by black men as slavery was intended to wipe out male power and split maternity and paternity from procreation. A very complex dynamic is created by the sexual and physical abuse endured by women at the hands of slave owners in the knowledge that their men could not save them. This created mistrust, contempt and guilt in men that can be observed even today.

There is no blame apportioned in this book towards the perpetrators of the abuse whereas neither is there any collusion with their actions. Clinical examples are given of actual therapy sessions demonstrating how this heritage has caused breakdowns in relationships between both black and mixed race couples and breakdowns in individuals.

There is a suggestion that feelings of intense fear impose difficulties with working through and resolution of the Oedipus complex. As a result the dominant type of Caribbean family in the UK is the single parent family with the mother as the breadwinner. For African men in the Caribbean the disconnection from paternity and parental authority compromises the father’s authority over his family. Furthermore many black British men who are not criminals or ill and who are qualified to work experience on-going problems of underemployment as a result of racial prejudice. This affects their position within society and is accompanied by false notions of white superiority.

We are taken through a journey of domination, cruelty, exploitation, incredible loss, humiliation and profound disconnectedness and we begin to see the distorted relationships between
Europeans and Africans and how these traumas have invaded the mind. The silence that accompanies this legacy covers both conscious and unconscious shame, rage and despair.

The destructiveness of slavery was never a total success as history tells us that the courage of human nature surfaced and triumphed in freedom. It is however still important to remember the cost of this and also the damage that remains.

There is hope as clinical examples are given of resilience and, with the use of psychoanalysis as a tool, the ability to transcend this heritage. Part of the healing comes from the reduction and eventual absence of cruelty in the present time in both the internal and external worlds, the recognition of self-worth and the creation of a nurturing environment. This could well need good psychological work with the individual, the family and communities.

I am reminded of the words of Bob Marley’s song about slavery and freedom Redemption Song. “Emancipate yourselves from mental slavery, none but ourselves can free our minds”.

In my opinion this very well written book makes a very significant contribution with an in depth and non-judgemental understanding of the legacies of slavery which has not been previously addressed within a psychoanalytic frame. The significance of transcendence is captured in the clinical examples and is a gift to African Caribbean people and to our understanding as clinicians.

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Reference:


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Addressing the Shortfall in Mental Health Professionals in Zambia

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Background

The Republic of Zambia, in Southern Africa, has some of the worst health indicators in the world. Life expectancy is estimated at 48 years and the lifetime risk of maternal mortality is 1:38. There is also a high incidence of HIV/AIDS and Malaria which puts significant strain on an already resource poor and fragile health system.
One of the biggest obstacles to improving health and healthcare in Zambia is the acute shortage of trained health workers. There are currently only 0.14 practicing physicians and 2.01 nurses/midwives per 1,000 people in the country. As in many developing countries Zambia has focused on trying to address issues of shortages of health workers by training community and mid-level health workers. While this has been successful at addressing skills shortages at a basic level there is a great need to increase the level of specialist knowledge in Zambia, one such specialty is Psychiatry.

With a total population of 12,935,000 the country has only 2 qualified psychiatrists, a ratio of 1:6,467,500 as opposed to the UK where the ratio is 1:5,555.5 (OECD, 2009). The majority of people living with mental health problems in Zambia are reliant on services provided by mid-level health workers (nurses and clinical officers) with levels of training in mental health appropriate to their grade but much less than that of a medical specialist. People suffering from psychiatric illnesses are institutionalized in poor conditions and once in the system are unlikely to be discharged. Increasing the number of well-trained psychiatrists is imperative to the improved provision of mental health services in Zambia.

Delivering Zambia’s first ever MMed in Psychiatry

Since 2009 the Ministry of Health and the University of Zambia Medical School have been working with THET, a UK-based international development organisation and dedicated volunteers from the UK to design and deliver the countries first ever Mmed (Master of Medicine) in Psychiatry, at the University of Zambia (UNZA). The first intake of MMed Psychiatry students started the course in June 2010. Eighteen months on there are now 4 trainees on the course, split over 2 years, with an additional 2 trainees set to join the first year group in their second year: they have been exempt from the first year.

The primary challenge of delivering the MMed course is that the UNZA Psychiatry Department does not have the capacity to deliver the full MMed curriculum. In response to this THET has set up a programme that sponsors short-term volunteer health professionals from the UK to visit Zambia for periods of two to three weeks to deliver training on specific elements of the new curriculum. This teaching support is integral to the delivery of the MMed course as the short-term volunteers provide the additional teaching capacity not available at UNZA. The UK volunteer health professionals delivering the course bring expert knowledge in sub-specialties and also vast experience that is not available locally.

Specialist skills are not the only thing that the UK volunteers contribute, they also bring different understandings of education and

“It will really boost our MMed students as they will get a chance to come across a wide array of professionals who are experts in different psychiatric sub-specialties”.

Dr Ravi Paul, Head of Psychiatry Department, UNZA
teaching skills as well as research skills. The Department are particularly interested in using the MMed course as an opportunity to develop research and are hoping that short term volunteers will support this positive development.

The MMed programme is currently supported by a team of 16 volunteers from across the UK. For those who have already been to Zambia to deliver training the experience has been equally rewarding and they have described their experiences as ‘empowering’ and ‘liberating’. The volunteers have found the ‘students are very motivated’ and working with them has been a ‘wonderful, highly rewarding experience’.

As the course progresses there are new opportunities for volunteers to deliver training in the following topics, as well as general psychiatry:

- Development; infancy to old age
- Medical sociology
- Social anthropology and cross-cultural psychiatry
- Drug, alcohol use disorders
- Behavioural genetics
- Community psychiatry
- Epidemiology
- Research
- Neuropsychiatry
- Consultation liaison psychiatry

If you are interested in becoming a volunteer with the THET programme, please contact Emily Measures, Zambia Programme Manager, at emily@thet.org

The Tropical Health & Education Trust (THET) is a UK-based international development organisation with over 20 years of experience in strengthening human resources for health in low-income countries through partnerships that harness the expertise and experience of UK health professionals. It is a London-based organisation that also has country offices in Zambia and Somaliland. THET is a UK-registered charity. www.thet.org