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**Education for improving human resources in mental health - An Ethiopian example**

T. Markos, Jimma/ Ethiopia

The huge treatment gap as a result of increasing burden of mental health problems without concomitant improvement in mental health services has been highlighted by the WHO’s health report 2001. Lack of trained mental health professionals has been found to be the most important limiting factor in developing mental health services in developing countries, Ethiopia is not an exception. After a psychiatry residency program started at Addis Ababa University in 2003, the number of practicing psychiatrists in the country had increased from 12 to a total of 34 in 2007. Nonetheless, most psychiatrists remained in the capital city whereas 85% of Ethiopia’s population lives in the countryside. In the context of limited number of applicant doctors to pursue psychiatry and the lack of adequate number of psychiatrists at Jimma University, we review the milestones of establishing a graduate training program for non-physicians and its implications. We will also review the challenges and opportunities the program faced with particular emphasis on the role of north-south cooperation which resulted in a successful response to the scarce mental health professionals.

**The Master of Science in Clinical and Community Mental Health in Jimma, Ethiopia – The German perspective**

Norbert Müller, Elif Weidinger, Andrea Jobst, Markos Tesfaye, Matthias Siebeck, Sandra Dehning, Munich and Jimma/ Ethiopia

Since 2010, the Global Mental Health working group has been supporting a psychiatric educational program in Ethiopia in order to improve psychiatric treatment and care. In cooperation with the Jimma University health officers are educated in a 2 years master teaching program to mental health officers. The mental health officers will help to provide psychiatric diagnostic, treatment and care ideally spread all over Ethiopia including rural regions. On the other hand, the health officers will be able to overtake and continue the education at the master program of mental health. The first five master students graduated 2012, further 20 students actually path through this program. Until 2013, this educational program will be committed totally to the medical faculty of the Jimma University.. Further support from the Ludwig-Maximilians-University, however, will be provided by annual summer schools which will deepen psychiatric skills and knowledge; furthermore problem- and patient-oriented exchange will take place. Further projects of the working group Global Mental Health at the Centre of International Health (CIH) include cooperative research projects and the implementation of a rehabilitation farm for psychiatric patients.
Dementia - Perspectives from Developing Countries (India)
M. Varghese, Bangalore/India

With demographic changes around the world, developing countries like India, China, and Latin America would have the largest elderly population in the world. As a result the number of persons with dementia the world over would increase in the next 10-20 years. As per the Dementia India Report 2010, it was estimated that there were 3.7 million persons with dementia in India in 2010 and that this number would double in the next 20 years. India would overtake most other countries in number of persons with dementia by 2020. The societal costs in 2010 was estimated as US$ 3.42 billion and set to triple in the next 20 years. The main carers are family members and they need support and training to deal with this problem due to sparse public health services.

Despite the large numbers, the prevalence of dementia in most of the developing world is less than the developed world prevalence of 8-12% over 65 years. In India the dementia prevalence rates for elders over the age of 65 years is about 3%. The reasons for the low prevalence have been postulated. The lack of culture and education fare instruments to evaluate cognition and the shorter survival may be reasons for the underestimation. Also cognitive decline is seen as a normal part of ageing and the deterioration in executive functions needed in diagnostic criteria like the DSM IV is not evident in the developing world. Some of these problems have been addressed by studies carried out in developing countries by the 10/66 Dementia Research Group in the last 10 years.

The process of implementing child psychiatry in Jimma, Ethiopia.
R. Frank, Munich

Priorities of the Jimma University – Ludwig Maximilians University Link for Medical Education (JU-LMU Link) are curriculum development for postgraduate education, postgraduate training and academic staff training. The presentation shows how this applies to child psychiatry.

Curriculum development for postgraduate education
The building block child psychiatry is to develop resources to handle mental health problems in children. Curriculum development relies on the two topics covered in the section mental health in children within the WHO mhGAP intervention guide: developmental delay and behavioural problems. This guide gives comprehensive information on what to do. Teaching has to bring in how to do – that means to focus on training skills.

The structure of the workshop of two weeks was tested and adapted in 2010 and 2012. Teaching material is now available on site. These are lecture, short presentations given by students relying to the WHO guide and videos from patients for case based learning.

Postgraduate training
Postgraduate training relies on clinical experience of patients at childhood age seen mainly in the outpatient department, on knowledge and skills acquired during the two week workshop and one month training in the clinic for child psychiatry in Addis Ababa. To handle child patients some easily available material is necessary such as paper and pencil, colours, building blocks or puzzles. The purpose is to get in contact by means of playing, to offer an occupation and to get an idea in which way children are able to use the material. This enables the examiner to get a rough estimate of developmental status and of abilities and to develop an intervention plan.
For most problems encountered in children local resources are needed – family, school, community. In 2012 due to an increase in manpower within the psychiatric clinic visits to a school and to the children’s rehabilitation project could be organised. The main difference to be taught is between teaching and advocacy. Advocacy is effective only when the target audience is asked to do something. Mobilizing people means asking them to become part of the solution.

**Academic staff training**

To initiate transition from external expertise to local expertise staff training and supervision will now be the main focus. Psychosocial interventions such as occupational activities have been demonstrated. These are crucial in treating children but also apply to adult patients. Staff has to be involved on several levels to develop own skills and expertise. One graduate of the first batch of “master in science in mental health” program took responsibility to deal with child patients. Staff training can be done on site, by doing research on clinical questions, by exchange of experiences with colleagues within Ethiopia and by distant supervision.

**Conclusion**

The process of transition has started. Child psychiatry is still in its infancy and needs time to develop. Follow up is necessary to monitor the growth of capacities in child psychiatry within the department and for the masters going back to their region of origin to practice in a primary hospital.

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**Trauma in Street Children in Jimma, Ethiopia**

S. Dehning, A. Jobst, Munich

Street children experience disproportionately high rates of trauma and posttraumatic stress disorder (PTSD).

This study examined traumatic events and symptoms of PTSD among homeless youth in Jimma, Ethiopia. Street children (N = 89), mean age 13.7, were recruited from an organization providing services to homeless youth (Facilitators for Change).

Results indicate that 84% of respondents had experienced a traumatic event and 32% met criteria for PTSD.

Implications for culture-sensitive screening and intervening with traumatized homeless youth across service settings are discussed.

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**Allowances : incentive or hindrance?**

Dr. Georg Rieder, MPH - kinder unserer welt e.V.

Participants of training workshops, of field research and of development projects expect, NGO / donor agencies offer per diem allowances for attendance or cooperation. The basic question is, if allowances should be paid in development work, specifically in volunteer based community projects.
Advantages of Per Diem Allowances: Basically they should cover work related expenses only. Beyond that, they encourage training, increase staff motivation, offer an additional source of income, and they cover opportunity costs of volunteers.

Disadvantages of Per Diems: They might create conflict among staff / community volunteers; work plans might be based on per diem maximization; they are costly for donor agencies, and they foster manipulation of work practices; finally people expect payment for every activity.

Training allowances may have a specifically negative impact: They are paid as compensation for time spent in a training workshop or seminar, which transforms “capacity building” into “income generation”. Donor agencies on the other hand, offer those allowances in order to increase the number of participants as higher numbers are considered as greater impact of a workshop.

Shall allowances be paid to volunteers in Community Based Projects? Apart from humanitarian or religious values, community concern or social recognition, career-related motives are one of the strongest motives for volunteering, and people would not continue volunteering for the long term without payment.

Donors as well as volunteers have to ask themselves whose agenda they are serving: If it is the agenda of a NGO or an institution, then people are justified in asking for payment. If it is a project that communities are implementing themselves, they should participate without payment, as the results of projects, trainings, or research should be remuneration enough?

**Literature sources & Further Reading**


Considering local human resources -mental health in the developing as well as so called developed world.
P. Kaiser, Schwäbisch Gmünd

Mental Health Services should be community based, and, wherever possible, focus on early intervention at the primary and later at the secondary and tertiary levels of prevention. Prevention and treatment too do need specialists, trained in diagnostic and therapeutic skills. In developing countries, brain-drain (internal as well as the migration to other countries) poses a difficult to counteract problem. One possibility - promoted by the WHO - may be the „task shifting“: The delegation of responsibilities of physicians to medical assistants with a minor medical education (physician assistants, community health workers etc.) is a common response to the shortage of medical professionals, especially in rural and poor urban areas. The hardship to implement and promote mental health services is illustrated using the example of Burma. A discussion will be initiated, whether the answer to the shortage of psychiatrists in developed countries (such as Germany) may be „task shifting“too.

Psycho social impact of globalization on Employees in India
T. Chacko, Bangalore/India

The Indian economy began its journey towards Globalization in the early 1990s under the then Finance Minister (the current Prime Minister) Mr. Manmohan Singh. Since then India has come a long way in opening up its markets to private and foreign participation through a whole host of structural reforms. While globalization has resulted in providing new employment opportunities it has also brought changes in the working environment and the way work is carried out. In order to be able to cope with competition the Indian employee today has to cope with sharper learning curves, changed ways of working and increased pressure for higher productivity, quality of work and shorter deadlines.

These changes create new opportunities and challenges for employees which have both positive and negative effects on their psycho social well being. This presentation will focus on the impact of globalization at a social, cultural and psychological level on Indian employees from a few sectors like the manufacturing, Banking, IT and BPO.
Psychotherapy in the developing world –
What can be done and who should do what?
K. Hoffmann, Reichenau

Psychotherapy or what is called psychotherapy in the Western world is a powerful and effective help for many people worldwide: For about one fifth to one fourth of all therapy consultations, it is the appropriate answer. It should, therefore, be implemented in a primary care approach and become open for dialogue with traditional and faith healing groups and systems. Psychoanalysis, mainly group analysis, can be well adapted to specific economic and cultural settings and taught to nurses and general practitioners. The same applies to behavioural techniques, especially in trauma therapy. Experienced psychotherapists have important tasks in supervising primary health care workers and local networks including traditional and faith healers, priests, and local officials.

Precisely in the age of globalization, developments in the sciences of psychiatry and psychotherapy in Europe and the USA have interactions with developments in other parts of the world. At the first Karl Wilmanns Memorial Lecture on 11 October 2001 at the Reichenau Psychiatry Center, Norman Sartorius, director for many years of the Division of Mental Health in the World Health Organization and president of the World Psychiatric Association, spoke on the subject “The future of psychiatry—are the needs too large?” Worldwide it is essential today that individuals assume more responsibility for their own health. “On the side of society, it’s a matter of capacity to work and of coping with life; on the individual side it’s about quality of life and avoidance of pain. … The difference between poor and rich countries, between developing and industrialized countries is larger today than it was 30 years ago.” Sartorius pointed out already at that time that of the ten major causes of disabling diseases, five came from the area of psychiatry. The use of alternative health care facilities is more important than ever; in this connection Sartorius pointed out that in France, for every visit to a physician, 1.2 practitioners of alternative therapies are consulted. In India the proportion is 1 to 2. “It is important to reduce the stigma of psychiatric illnesses, to strengthen tolerance toward persons who are different, and to promote the attitude that health is not a commercial ware and that psychiatry consists not only of knowledge and skills but also reaches into spiritual dimensions”

Is Forensic Psychiatry important in developing countries?
H. Steinböck, Munich

After a short definition of forensic psychiatry, history and social function of forensic psychiatry in highly industrialized countries are explained, using mental health act and the measures of improvement and security as two examples of forensic psychiatry in civil and in penal law respectively. Then we try to apply these experiences to the situation of low income countries like Ethiopia with special regard to the process of modernization and the needs of anomic conditions.

A country without psychiatrists – Somaliland
W. Krahl, Munich

The government of Somaliland regards itself as the successor state to the British Somaliland protectorate which united with the Trust Territory of Somalia (the former Italian Somaliland) on July 1, 1960 to form the Somali Republic. Somaliland is a Sunni Muslim society that is
based on clans. There is a large nomadic population and high numbers of internally displaced people, many of them traumatized. Somaliland declared independence from Somalia in 1991. However, it is not yet internationally recognized. It has an estimated population of about 3.5 million inhabitants.

Somaliland has only two public inpatient psychiatric units, a ward in the Hargeisa Group Hospital and the Berbera Mental Hospital. Since there are no psychiatrists in Somaliland, the psychiatric patients are treated by nurses and general practitioners. The conditions in the psychiatric ward of Hargeisa Group where formerly described as poor but improved over the last years. Most of the psychotropic drugs listed in the Essential List of Drugs WHO are available in the hospital.

To improve psychiatric services in Somaliland, the Dean of the medical faculty, University Hargeisa, Dr. Derie had requested a workshop on "Basic Mental Health". The workshop was financed locally and supported by i.nez and CIH-LMU. Most of the participants of the workshop had many years of clinical experience and were eager to contribute actively in the workshop. The Dean of the medical faculty was consistently present and got himself actively involved. At the end of the three days workshop the participants (doctors, nurses and social workers) were asked to make suggestions on: "How to improve mental health services in Somaliland". The results included everything that is important in a low-income country to deliver good psychiatric services. At the end of the workshop the organizers came to the conclusion that they made one mistake – instead of calling the workshop "Basic Mental Health" they should have called it "Advanced Mental Health".