Lecture notes on behavioural sciences and psychiatry for medical students in east and central Africa

The teaching of psychiatry is fast taking root in East and Central Africa (Malawi, Zambia, Zimbabwe, Tanzania, Uganda, Kenya and Ethiopia). Between these countries we have an annual intake of about 600 into the first year. The foundation that we give to these students in behaviour sciences and psychiatry will be influential in their decisions to make psychiatry a career as clinicians, academicians/researchers etc. Above all it will make them very effective as general practitioners in situations where a psychiatrist is unlikely to be available into the foreseeable future.

For the last two years I have been carrying out an audit in the teaching of psychiatry in east and central Africa, and also other countries for purposes of comparison, which has confirmed the above observations.

It seems necessary to me that we in this region should harmonize and complement our teaching of behavioural sciences and psychiatry to medical students in our region. I propose that each medical school adheres to its curriculum, but all medical schools should share the strengths in the different curriculums. These curriculums are usually developed to reflect the total context (needs, social-economic, cultural and anthropological) in which they are taught. Therefore the curriculums should be our reference points.

One of the ways of doing this is to come up with Lecture Notes (not textbooks) that take care of and maximize on all our collective strengths and improve all our collective weakness'.

I do appreciate that there are many textbooks of psychiatry on the world market, and many of them are as good as anyone can wish. However, they are often not in the format of lecture notes, and do not take into account the total variety of situations from country to country and region to region. These books may be more useful for post-graduate students, or reference books for undergraduates.

I propose we proceed as follows:

1. Each country to have a coordinator for this project who will scrutinize the behavioural sciences and psychiatry curriculum for all the medical schools in their country and come up with titles for various lectures. These could easily be lifted from the lecture schedules already in operation.

2. Each country to identify the person best suited or better still who has been giving those lectures and presumably already has lecture notes for those lectures. We want to involve as many people as possible if not all the people who have been and are giving lectures in all the departments of psychiatry.

3. The above information will be relayed to me. On receiving those details I will link up lecturers from every department of psychiatry with those from other departments in other medical schools interested in the same topics. Those with the same interest will then work together to perfect the lecture notes so that they would be easily acceptable across the region. Each group will decide on the order of authorship of those notes for particular lecture topics.

4. The compiled notes will be forwarded to a publisher. The University of Nairobi press will publish this as part of academic support, but we are open to other possibilities or suggestions on the best way to publish the notes.

5. Administrative issues:
   - The Country coordinator will also do the following:
     - Obtain copies of the curriculums for their countries, retain a copy and forward on to me
     - Ensure all the lecture topics for their country cover the curriculum
     - Coordinate the activities for their country and ensure deadlines are met.
   - Cross-country co-ordination: The Africa Mental Health Foundation will support the exercise by providing a desk for this activity and a secretariat.
   - All correspondences must be by e-mail.

6. From this experience we can invite others regions to join us in future, improve future editions of the lecturer notes etc.

7. Editorship –At this point there is no designated editor or editors. The decision on this will be made collectively either by consensus or simple majority vote by all the contributors as we go along unless there are other suggestions at this point. All what I am doing is to get the process started and going.

8. It is useful to request an independent person to provide guidance on this exercise. I would suggest Professor Rachel Jenkins, Director, WHO Collaboration Centre at the Institute of Psychiatry, University of London. She has demonstrated very keen interest in mental health in developing countries. She is very well known to most if not all of us.

9. If this idea is suitable with you let me know. I have the following tentative timetable, which can be modified by your suggestions but shall we at least keep the June deadline for a start!

   (i) June - Write to key people in each country to find out suitability of the exercise and who in turn will identify coordinators for their countries and then forward the details and their contacts and e-mails.
Duration of hospitalization in an acute psychiatric unit

Making more efficient use of existing funding and cutting the cost of in-patient care in South Africa has stimulated a lot of debate about the factors influencing the length of hospitalisation. Studies have indicated that whilst a long hospital stay (>7 days) does not decrease subsequent hospitalisation, improve social adjustment or diminish psychopathology, short stay (<7 days) after the initial evaluation is cited as one of the reasons for failure of community care and the emergence of "revolving door" and "new long stay" patients. Diagnosis alone is not an accurate predictor of length of stay but may have predictive ability when combined with other data. When depression, anxiety, and organicity are measured by psychological tests they correlated significantly with longer hospital stay.

A study at the Helen Joseph Hospital (a general hospital in Gauteng, South Africa) found that patients with a short stay included a group of young males, who were abusing substances, had a previous admission to a psychiatric hospital and co-morbid psychological disorder. Van der Merwe et al also identified a similar group of short stay admissions to a psychiatric hospital in Western Cape, South Africa. The objective of this study was to analyse admissions at Johannesburg Hospital (a tertiary academic hospital in Gauteng, South Africa) with the intention of ascertaining factors associated with the length of stay.

Method
The study included all consecutive admissions, 18 years and older, to Johannesburg Hospital during the 4 month period – August to November 2003. All subjects gave verbal informed consent to participate in the study, which was approved by the Committee for Research On Human Subjects, University of Witwatersrand. The study was in the form of a questionnaire, which was completed by the doctor in charge at the time of discharge from the ward. Patients were diagnosed with psychiatric disorders according to the criteria for DSM-IV. Discharge within seven days of admission was considered as short stay.

Results
A total of 114 patients were discharged from the unit during the study period. Patients in the short stay group had the following characteristics: 61% had a previous hospital admission as compared to only 44% of patients for whom it was their first admission (p<0.05); 60% of patients were abusing drugs fell as compared to 40% who were not (p<0.05) (Fig 1). There was a correlation (although weak) with current diagnosis and duration of stay: the absence of co-morbid medical illness was associated with a shorter duration of stay. Patients who are employed had a shorter duration of stay than those that are unemployed; however there is a large difference in

Figure 1: Characteristics of the short stay patient group.