

Brief Report:

Teaching Child Psychiatry in Ethiopia: Challenges and Rewards

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Abstract

Introduction: Ethiopia is a country of 81 million people, half of whom are children. The prevalence of psychiatric disorders in children ranges from 3.5-23.2%. However, there are very limited mental health resources in the country, including few psychiatrists. Thus the training of more psychiatrists, including providing them with expertise in child psychiatry, is an imperative. **Method:** The article briefly reviews the development of the Toronto Addis Ababa Psychiatry Project (TAAPP), a collaborative program between the University of Toronto and Addis Ababa University designed to help train psychiatry residents in Ethiopia. The article then focuses on the author's experiences on one recent trip to Ethiopia to provide some of this training. **Results:** Formal teaching sessions as well as clinical supervision were provided to the Ethiopian residents. Content had to be adapted to be relevant to the Ethiopian context, but teaching approaches did not have to be modified significantly. The Ethiopian residents were very enthusiastic learners and made quick changes to their practices based on the teaching. **Conclusion:** Collaborative programs such as TAAPP may be important mechanisms to improve the training of psychiatrists internationally, especially when there are limited local educational resources.

Key words: child psychiatry, medical education, Ethiopia

Résumé

Introduction: L'Éthiopie est un pays de 81 millions d'habitants, dont la moitié a moins de 18 ans. La prévalence des troubles psychiatriques chez les enfants va de 3,5 à 23,2 %. Les ressources en santé mentale sont cependant très limitées et les psychiatres, peu nombreux. C'est pourquoi il est impératif de former des psychiatres et de les exposer à la pédopsychiatrie. **Méthodologie:** Cet article donne une brève description du *Toronto Addis Ababa Psychiatry Project (TAAPP)*, programme de collaboration entre l'*University of Toronto* et l'université d'Addis-Abeba qui est destiné à former des résidents en psychiatrie en Éthiopie. L'auteur fait part de ses expériences lors d'un récent voyage effectué dans le cadre de cette formation. **Résultats:** Les résidents éthiopiens ont suivi la formation théorique et le stage clinique supervisé. Bien que le contenu de la formation ait dû être adapté au contexte éthiopien, il n'a pas été nécessaire de réviser significativement les méthodes d'enseignement. Très motivés, les résidents éthiopiens ont rapidement modifié leur pratique après cette formation. **Conclusion:** Les programmes de formation comme le *TAAPP* jouent un rôle important dans la formation des psychiatres au niveau international, notamment dans les pays qui manquent de personnel enseignant.

Mots clés: pédopsychiatrie, formation médicale, internat et résidence, échange international, Éthiopie

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Introduction

Located in the horn of Africa, Ethiopia is a country of 81 million people, with a median age of just 18 years (World Health Organization [WHO], 2008). Over the past few decades its people have had to struggle with recurrent droughts and famine, and the country has seen border wars and intermittent domestic violence on its path from a feudal system to an elected government. Ethiopia is also one of the world's poorest countries. The gross national income per capita is just 1190 international \$ and 23% of the population earn less than 1 international \$ per day (WHO, 2008).

Children in Ethiopia are particularly affected by these difficult conditions, with 12.3% dying by age five, the vast majority due to infectious diseases (WHO, 2008). Children are also at significant risk for mental health

problems. Epidemiological studies have found prevalence rates for psychiatric disorders in children ranging from 3.5%-23.2% (Ashenafi et al., 2001; Tadesse et al., 1999; Mulatu, 1995). However, there are many obstacles to these children accessing psychiatric care.

Most Ethiopians believe that the manifestations of psychiatric disorders are due to spiritual causes and thus first seek out traditional healers for emotional and behavioural problems (Alem et al., 1999; Alem, 2001). These practitioners use a variety of methods including herbal remedies, holy water, exorcisms and other rituals. Only when such methods fail might a family seek modern psychiatric treatment for their child, often months to years after the onset of difficulties. Behaviour problems in children are also commonly addressed through physical punishment (Alem, 2001) and thus

may never come to clinical attention.

Additionally, even for those who seek out modern psychiatric treatment, resources are very limited. As of 2007, there were 33 psychiatrists in the country, the majority of whom were practicing in the capital Addis Ababa (Desta, 2008; C. Pain, personal communication, July 17, 2008). Psychiatric nurses stationed at regional and district hospitals provide the majority of the mental health care outside of the capital region (Alem, 2001). A children's hospital is soon due to open in Addis Ababa, which will include a 20-bed inpatient unit and an outpatient service. By the time this hospital opens, there will be three child psychiatrists practicing in Ethiopia (Y. Baheretibeb, personal communication, July 9, 2008).

Psychiatric Training in Ethiopia

With such a small number of psychiatrists in Ethiopia, training more psychiatrists and providing them with expertise in child psychiatry is clearly an imperative. Psychiatry was introduced to the medical school curriculum in Ethiopia in the late 1960s (Giel, 1999). However, the first psychiatry residency program was only recently established in 2003, in Addis Ababa. To help provide a significant portion of the formal curriculum and teaching in this residency, the Toronto Addis Ababa Psychiatry Project (TAAPP) was created through the collaboration of the Departments of Psychiatry at the University of Toronto and Addis Ababa University (TAAPP, 2008).

TAAPP assembles teams of two staff psychiatrists and one psychiatry resident, who travel to Addis Ababa to provide one month of teaching and clinical supervision for the Ethiopian psychiatry residents. During the first three years of the program, there were three trips made per year. Each trip has focused on teaching specific topics and areas as determined by the Ethiopian curriculum, e.g., child psychiatry, mood disorders, psychotic disorders, psychotherapy. In 2006, the first seven Ethiopian residents graduated, with several joining the faculty of the Department of Psychiatry at Addis Ababa University. Subsequently, the frequency of TAAPP trips was reduced to twice per year, with the objective of enabling the new graduates to take on more of the teaching and educational leadership roles

in the residency program (TAAPP, 2008). A one-year fellowship program was also started in Toronto for Ethiopian junior faculty.

In 2007 Dr. Clare Pain, TAAPP's director, contacted me and asked me to join one of these trips planned for early 2008. The remainder of this article focuses on my experience in Ethiopia and my reflections on the challenges and the rewards of teaching child psychiatry in a context far removed from typical Canadian practice.

Preparing to Go

The rest of the teaching team was quickly assembled and included two other psychiatrists and a PGY-4 psychiatry resident at the University of Toronto. The first task was to plan and prepare the curriculum for the formal teaching portion of the trip. The formal teaching portion comprised two journal club sessions per week, two seminars per week, and one three-hour workshop that focused on developing clinical skills. The focus of the curriculum was to be child psychiatry, although there was room to incorporate other topics as we and the Ethiopian faculty deemed appropriate.

Several challenges presented themselves in selecting the content of the formal curriculum. Firstly, we had to think carefully about which topics to cover. Certain diagnoses that are significant in the Canadian context appear to be of lower prevalence in Ethiopia. For example, ADHD was found to have a prevalence of 1.5% in one Ethiopian study (Ashenafi et al., 2001), whereas the prevalence has been estimated as 6.7-7.8% in the United States (AACAP, 2007). A second challenge was, for a given topic, to cover treatment methods relevant for a psychiatrist practicing in Ethiopia. What might be standard practice in Canada might not be feasible or culturally acceptable in Ethiopia.

Dr. Pain and the Ethiopian faculty provided specific guidance around these challenges. We were informed that only 14 psychiatric medications were available, with none more recent than fluoxetine. Stimulants were not available at all. We also learned that while there are social workers and psychologists working in various settings (including schools) throughout the country, none have had substantial training in therapeutic interventions with children

(Desta, 2008; Alem, 2001). Given these resource limitations, we had to significantly modify what we taught about treatment approaches. We were also guided by the existing literature on psychiatry in Ethiopia, much of which was authored by the Ethiopian faculty.

A major challenge was to decide on teaching methods. While using interactive teaching methods can be more effective than didactic methods (O'Brien et al., 2001; Steinert & Snell, 1999), how acceptable would such teaching methods be with Ethiopian residents? The experience of Dr. Pain, the Ethiopian faculty, and previous University of Toronto faculty had been that interactive teaching methods had become progressively more successful, but we were still somewhat uncertain to what extent we could apply such teaching methods. Based on the advice of previous University of Toronto faculty and residents, we decided to be prepared to change our planned presentations once we were in Ethiopia and had a chance to see how the residents responded to our initial teaching approaches.

The Formal Teaching Experience

Upon arrival, we quickly realised how wise the advice had been regarding being flexible about our curriculum. Initial feedback from the Ethiopian faculty and residents resulted in substantial changes to the content of the workshops, with some topics eliminated and others added in. For example, because many of the residents were only in their first few months of training, we placed more emphasis on assessment approaches, case formulations, and case write-ups. As we began to see cases with the residents and get a better sense of the mental health system in general, we were able to further adapt our presentations to include more references to the Ethiopian context.

Engaging the residents in interactive teaching methods was initially somewhat slow going. Asking the group a question generally resulted in a long period of silence and it was hard to tell if this was due to shyness, dissatisfaction, or cultural norms for interactions between teachers and students. We sought feedback from the residents about using interactive teaching methods and they all indicated that they valued them – “Silence means ‘yes’,” one reassured us. However, it appeared that we

had to establish more of a relationship with the residents before they began to participate more readily. The residents soon took part in role plays, co-led presentations in increasingly interactive styles, and demonstrated a sense of humour that transcended our divergent backgrounds. (We subsequently learned that the primary teaching method in Ethiopian schools and universities is didactic and that the Department of Psychiatry at Addis Ababa University is an exception in using interactive teaching methods.)

In the end, the few recurring challenges in the formal teaching sessions were generally minor. Acutely psychotic patients intermittently burst into the classroom, somewhat agitated and incoherent. However, they were so respectful of authority that a few firm but friendly words, a handshake, and a gesture towards the door was all that was necessary to escort them back to the hospital grounds. Also, during our seminars the church next door to the hospital was broadcasting prayers and sermons out of speakers at high volume to the point where we often had to speak very loudly or time our talk during brief windows of silence. Fortunately the residents were so enthusiastic about learning that they seemed entirely unfazed by these inconveniences.

The Clinical Supervision Experience

The remainder of the time was spent with the residents in their clinics and on the wards supervising their clinical work. This could take the form of directly observing their assessment interviews with patients and families or in reviewing cases in a rounds format. While some of this time was spent specifically seeing children and families, we also supervised their work with adult patients. We therefore drew upon our more general psychiatric knowledge and experience as we supervised cases of chronic psychosis, acute mania, and other presentations more typical of adult psychiatry.

Although we worried that cultural differences might make it difficult to provide accurate and relevant supervision for cases, we were surprised at how few differences and barriers we experienced. We usually had to rely on intermittent translation to hear the details of the interviews. However, many patients were so symptomatic (due to the length of their

untreated illness) that their phenomenology was obvious without much need for translation. For example, catatonia was a common presentation for people with mood disorders.

The residents asked relevant questions and frequently sought feedback. However, the clinical setting and schedule was not always ideal for detailed supervision. Residents were often expected to see a large volume of patients within a given time frame and the supervision process significantly slowed them down. We regularly asked the residents how to best balance their need for supervision with their need to finish a clinic on time.

At the end of each day, we completed written formative evaluations for each resident we supervised. We strove to reinforce specific strengths of their work as well as provide suggestions about what to do differently. We were constantly impressed by how quickly our feedback was incorporated into the residents' work. Within a day or two of specific feedback, we saw residents change their interviewing techniques, diagnostic approaches, and management strategies. We also provided feedback about the residents' case write-ups and formulation skills resulting in remarkable improvements in these skills within the few short weeks of our stay.

We were pleasantly surprised to see how effective some treatments could be with patients, even with a limited set of medications and even more limited follow-up resources. We met patients and families who were very appreciative of the care they had received. These experiences gave us a sense of satisfaction about the work we were doing.

Conclusions

At the end of our month, we were sorry to leave. We had developed very positive relationships with the residents and very much wished to continue to assist in their training. The fact that the Ethiopian residents were such eager learners and quick studies was highly reinforcing and made us even more motivated to provide the highest quality of teaching possible.

Although the first assumption might be that a child psychiatrist in Canada has little to offer psychiatry residents in Ethiopia, this experience suggests that teaching can cross borders, languages, and cultures surprisingly well.

Collaborative programs such as TAAPP may be important mechanisms to improve the training of psychiatrists internationally, especially when there are limited local educational resources. Collaborations and joint programs between medical schools in different countries are increasing, but many of these involve transplanting an existing curriculum from one university to another (Harden, 2006). TAAPP instead strives to develop a program that is specific to the educational needs of its local context, providing an innovative example for future collaborative educational programs.

Acknowledgements/Conflict of Interest

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