even intercultural competence, and yet can be acquired by critical incident analysis and using role-play. Teachers are, however, required to be fully sensitive themselves to the personal issues such training may evoke, otherwise prejudice and cultural insensitivity can be increased.

The World Federation for Mental Health in 2007 highlighted cultural psychiatry for World Mental Health Day, and the expressed wish of service users that their beliefs, illness assumptions, rituals and family networks are considered and understood. In order for it to succeed, the *Lancet* movement must likewise consider these cultural issues and the roots of culture in language and religion. The need to scale up child development programmes illustrates well the breadth of this general scaling-up agenda. The early years of life are the cradle of cultural acquisition in low- as well as high-income countries, and are adversely affected by poverty and untreated mental disorder. What happens to the foetus and to pre-school infants is of the utmost importance to the child's ability to become a good citizen. It is politically incorrect, therefore, to omit the newborn from maternal child health (MCH) services – MNCH is indeed a more useful acronym (World Health Organization, 2005).

Religious beliefs (including secular humanism), as well as language and dialect, also express the cultural values of societies. Any 'religiosity gap' or 'language gap' between patient and professional is therefore a disadvantage.

These cultural and training issues need to be carefully considered by any movement that sets out to change the world in which we live. But political correctness is not always an asset.

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THEMATIC PAPERS – INTRODUCTION

Mental health services in sub-Saharan Africa

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Within the continent of Africa, mental health services are relatively undeveloped. In the sub-Saharan countries of Malawi, Kenya and Nigeria, similar problems are faced by dedicated psychiatrists who are struggling to create and sustain an educational, management and political structure for psychiatry.

Malawi exemplifies some of the most pressing issues. As Dr Kauye recounts, this is a country with an excessively low gross domestic product (GDP) per capita, even by African standards. Moreover, the overly centralised administrative structure for medical services militates against the provision of adequate community care. There are very few trained psychiatrists, and in most out-patient and in-patient settings nurses take on major responsibilities for the everyday care of patients. However, the shortage of nursing staff means that many psychiatric nurses end up doing general nursing duties. A further issue, pertinent to the need to retain appropriately trained staff, concerns medical staff who are so poorly paid that retention of their services is often linked to private sponsorship. This provides a temporary supplement to their meagre salaries. The supply chain for medication is especially vulnerable to disruption, and procurement at a national level is less secure than it should be, especially for psychiatric treatments. Ways of tackling this continuing concern are discussed by Dr Kauye.

Kenya and Nigeria are wealthier countries than Malawi, but they experience similar problems. Professor Ndetei describes how difficult it has been to retain psychiatrists in Kenya over the past decade, despite the country having made a tremendous effort to train them. Unfortunately, they migrate in ever greater numbers. As in Malawi, trained psychiatric nurses are often redeployed in order to provide general nursing duties, and at a community level there are few appropriately trained staff to deliver services to individuals with mental health disorders. We have discussed in previous issues the potential benefits of using native healers to supplement conventional psychiatric services; this is an issue discussed by Professor Ndetei with approval. As in Malawi, a lack of epidemiological research has meant that relatively little is known about the nature and scale of disorders at the level of community mental health, and there is an associated danger that research expertise is unduly centralised and remote.

Finally, Dr Olugbile and colleagues discuss the issue of mental health education in Nigeria. They provide a relatively structured account of the current state of knowledge about mental health issues in two surveys, the first concerning primary healthcare workers and the second specifically targeted at general practitioners. The authors discuss, first, a survey they conducted with a national sample of primary healthcare centres. Remarkably, none of the centres surveyed had any psychotropic drugs available in their pharmacies, nor were there any medically trained practitioners working in them. The survey was therefore focused mainly upon nurses

and community health workers (without specific psychiatric training). In all categories, knowledge about mental health problems was regarded as poor. It is perhaps more surprising that similar results were obtained in a further survey of general practitioners (the vast majority of whom were seeing psychiatric patients).

Taken together, this set of papers emphasises the remarkable work being done by psychiatrists in some of the poorest countries in the world to provide better care for psychiatric patients, and stresses how important it is that they are supported in their endeavours by links with centres of excellence in the UK and elsewhere.

Management of mental health services in Malawi*

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Malawi is a country in sub-Saharan Africa bordering Mozambique, Tanzania and Zambia. It has an area of approximately 118000 km^2 and is divided into northern, central and southern regions. It has an estimated population of 13 million, 47% of whom are under 15 years of age and just 5% over 60 years. Its economy is largely based on agriculture, with tobacco being the main export. The projected growth in gross domestic product (GDP) for 2007 was 8.8%; GDP per capita was $284 per annum.

The health system in Malawi is centrally controlled by the Ministry of Health. There are subsidiary zonal offices, which offer technical support to district health offices; the latter oversee the running of health services in all 28 districts. All but four of the 28 districts have their own district hospital. Within each district there are health centres, mainly manned by paramedics and nursing staff. These serve as referral centres for the health posts, which are manned by health surveillance assistants (HSAs). Most districts have at least one medical doctor, who usually performs administrative duties as a district health officer. There is a central hospital in each of the three regions; these act as tertiary units for the district hospitals in their regions. The directors of these central hospitals report directly to the Ministry of Health.

Mental health services in Malawi date from 1910. They were initially managed by the prison services, but in 1951 responsibility was transferred to the Ministry of Health. In 1953, a national psychiatric hospital was created in the southern region, in Zomba. It has about 333 beds and admits between 1500 and 2000 patients per year. Additional in-patient psychiatric facilities (run mainly by psychiatric nurses) are provided by the central hospital in the central region. In the northern region a missionary psychiatric unit is run by the Hospitaller Order of St John of God, which provides both community and in-patient services. (See Kauye & Mafuta, 2006, for further details.)

Malawi, like most countries in this part of Africa, faces a number of problems in relation to the provision of mental health services, including inadequate staffing levels, an over-centralisation of services and inconsistent drug supply. Over the years, it has looked at various ways of addressing these problems, which are reviewed here.

The human resource problem

Staffing problems have long affected all levels of service provision. At the Ministry of Health headquarters there is no national mental health coordinator to oversee activities; rather, Zomba Mental Hospital is currently coordinating mental health activities nationally. This has been successful to a certain extent, in that supervision of district mental health activities, revision of the Mental Health Act and preparation of an 'essential drug' policy for psychiatry have all been achieved. Nevertheless, a national coordinator at Ministry level is desirable.

Overall, there is a major shortage of clinicians with psychiatry as a specialty. District mental health services are mainly run by psychiatric nurses. Malawi has a general shortage of nursing staff, and although we have been training psychiatric nurses for a number of years, they end up doing general nursing duties and minimal mental healthcare. One way we are approaching this problem is by introducing a degree programme in mental health and clinical psychiatry for clinical officers with a diploma in clinical medicine. We hope clinical officers will be motivated to enrol as graduate students by the possibility of promotion on successful completion of the course. We are hoping that these graduates will mainly work in the districts and be at the forefront of promoting mental health, especially at community level.

The government of Malawi has been supplementing the salaries of health workers to a certain extent, in order to reduce their migration to developed countries. An improvement in the conditions of service of general health workers would influence mental health services both directly and indirectly. Having adequate numbers of nurses in the districts will mean that psychiatric nurses can be released to do more mental health activities. Sustaining the programme

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