Indian Journal of Psychiatry, 1999, 41 (1), 37-41

MENTAL HEALTH CARE : PERCEPTIONS AND EXPECTATIONS OF RURAL POPULATION IN UTTAR PRADESH- A BRIEF REPORT

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ABSTRACT

National mental health programme envisaged integration of mental health care services into primary health care facilities. A house-to-house survey in 9 villages of a block situated near Lucknow city was conducted. A large number of villagers were aware of mental symptoms and indicated drugs as first choice of treatment. However, the majority preferred Government Hospitals and Private Doctors over Mental Hospitals and psychiatrists respectively. There was trend for utilization of available medical facilities but the community was largely unsatisfied with the available treatment facilities for mentally sick. The community suggests alternatives for the delivery of mental health care services based on their expectations. The results have been discussed vis-a-vis existing mental health care services.

Key Words : Expectations, mental health care, perceptions, rural population

India has been progressively developing basic health services infrastructure since independence. In the seventies a number of epidemiological surveys were carried out in this country to assess the morbidity due to mental disorders (Dubey, 1970; Sethi et al., 1972; Verghese et al., 1973; Kapur, 1973; Nandi et al., 1975). The findings of these studies have clearly established that prevalence and distribution of various forms of mental disorders are as much as in western countries. To meet these mental health care service requirements in 1982 a programme for India popularly known as National Mental Health Programme (NMHP) was planned with objectives to "decentralise" and "de-professionalise" mental health services. The programme commenced with much expectations, remarkable interdisciplinary cooperation, enthusiasm and inputs. However, soon when the output was assessed, it became clear that its success is far from the expectations. It seems that the requirements and expectations of the community about mental health care services were hardly studied and incorporated when NMPH was formulated. As a result, the National Mental Health Programme could not deliver those benefits which community expected and eventually met a disappointing fate. In view of this the present study was planned with objectives to study perceptions of the rural community about mental illnesses and available mental health care services and their expectations with regard to mental health care services.

MATERIAL AND METHOD

The study was carried out in the geodemographic universe covered by Mohanlalgaj Primary Health Centre (PHC) which is situated 22 km away from K.G.s Medical College and only 4 km from Sanjay Gandhi Post Graduate

Institute of Medical Sciences. The PHC is part of a reserve parliamentary constituency. Mohanlalganj Block has a total area of 35,460 hectares, and has 97 villages and 62 gram-sabhas. Out of the 97 villages randomly selected 9 villages with total population of approximately 18 thousands were chosen for the study. In the targeted villages,house to house survey was carried out and the head of the family and his/ her spouse were interviewed. In case of non-availability of the spouse (either deceased, or absent for other reasons), the senior most adult of the same sex was interviewed. A semi-structured proforma was administered. The villages were categorised into advantaged if they had mostly brick houses; a primary health centre, post office and primary school within a radius of two kilometres; electric supply and metalled road connections. The villages not having these facilities were categorised as disadvantaged. Both advantaged and disadvantaged villages, however, had similar schooling facilities. The generated data was computer analysed using percentage and X^2 test of significance as and where applicable.

RESULTS

A total of 2442 subjects were included in the study. Of these 278 subjects were excluded as they were not aware of mental symptoms and thus 2164 subjects were finally studied.

Table 1 depicts awareness about mental symptoms. Only a very small number in both the groups were not aware of the mental symptoms. The majority was aware : 89.91% and 78.70% in the advantaged and disadvantaged groups respectively. The difference in awareness of mental symptoms between advantaged and disadvantaged villages was statistically significant ($p < 0.001$). Similarly, a large part of the sample, in both types of villages was aware that the drug is the treatment for mentally sick followed by 12.94% who believed that faith healing is the treatment. More subjects from advantaged village favoured drugs as compared to disadvantaged and the difference was statisti-

TABLE 1
COMMUNITY AWARENESS OF MENTAL SYMPTOMS & TRETMENT OF MENTAL ILLNESSES

	Advantaged village (N=1868)		Disadvantagec village (N=296)	
	N	%	N	%
Awareness of mental symptoms				
Aware and seen the patients	1862	89.91	292	78.70
Aware but not seen the patients	6	0.29	4	1.08
Unaware	203	9.80	75	20.22
	$X^2 = 39.22$, d.f.=2, $p<0.001$			
Awareness of treatment of mental symptoms				
Drug	1640	87.79	227	76.69
Faith healing	226	12.09	68	22.98
Does not know	2	0.11	1	0.34
	$X^2 = 25.93$, d.f.=1, $p<0.001$			

TABLE 2
COMMUNITY'S PERCEPTION ABOUT EFFECTIVENESS OF AVAILABLE FACILITIES

Percieved effectiveness	Advantaged village (N=1868)		Disadvantaged village (N=296)	
	N	%	N	%
Totally effective	332	17.77	57	19.25
Mostly effective	724	38.75	134	45.27
Partially effective	327	17.51	74	25.00
Not benificial	84	4.50	14	4.73
Problem aggravated	2	0.11	0	0.00
Other problems added	2	0.11	1	0.34
Does not know	397	21.25	16	5.41

$X^2 = 45.74$, d.f.=5, $p<0.001$

TABLE 3
COMMUNITY EXPECTATION OF LOCATION OF TREATMENT FACILITY

Location of treatment facilities	Advantaged village (N=1868)		Disadvantaged village (N=296)	
	N	%	N	%
At PHC/sub centre	656	35.12	84	28.38
Mental hospital	54	2.89	7	2.36
In the village	1049	56.16	176	60.14
Medicine with health visitors	60	3.21	13	4.05
Others	20	1.07	7	2.36
Does not know	29	1.55	9	2.70

$X^2 = 11.84$, d.f.=5, $p<0.05$

cally significant. However, the sample, while accepting drugs as the mainstay of treatment, was not equally well informed about the appropriate place for receiving such treatment. This is well demonstrated as only a quarter of the total sample accepted a mental hospital as the appropriate place for treatment for such malady; this aspect was marginally less in disadvantaged villagers(24.32%). The priority was given to Government hospitals by about half the sample (52.59%). In a similar fashion, the sample preferred private doctors (5.64%) over Psychiatrists (2.40%), and a still larger majority gave precedence to faith healers (13.59%). The disadvantaged villages showed a higher percentage in this trend of preferring private doctors (6.42%) over psychiatrists (1.69%) than the advantaged villagers (5.51% and 2.52% respectively). Again a statistically significant difference existed in regard to this aspect of awareness as well as between the two types of villages.

39.65% subjects perceived that the available treatment facilities are mostly effective, while 17.98% perceived it as totally effective and 18.5% as partially effective (Table 2). The data on the community utilization of the available treatment facilities presents a dismal picture with only slightly more than half of the sample utilizing these facilities; the disadvantaged villagers (76.35%) utilized more than the advantaged villagers (58.89%), and a substantial proportion, especially of the later group being unaware of it.

The sample to a large extent (80.08%) was dissatisfied with the available services. The disadvantaged villagers to a significantly greater exteni ($p<0.01$) were dissatisfied than their advantaged counterparts. The data on community expectation of the role of psychiatrist showed some difference between the two groups, albeit it did not attain statistically significant level. The majority in both the groups, preferred a clinic based management (managing the patient in a clinic located in the centre of few adjoining villages), and only less than 5% endorsed a home visit. The majority of the subjects (95.29%) viewed that psychiatrist should see all the patients at one place (a centre place in adjoining villages : clinic based management). Nearly equal was the proportion in advantaged and disadvantaged villages. Of the total subjects 56.7% expected the location of treatment in the villages, while about one third

TABLE 4
TYPE OF VILLAGES AND COMMUNITY EXPECTATION ABOUT COST OF TREATMENT

Sl. No.	Expectation	Advantaged village (N=1868)		Disadvantaged village (N=296)	
		N	%	N	%
1.	Paid consultation free medicine	167	8.94	44	14.86
2.	Free consultation medicines paid for	279	14.94	31	10.47
3.	Free consultation & medicines	1409	75.43	219	73.99
4.	Others	11	0.59	1	0.34
5.	Does not know	2	0.11	1	0.34

*.Sl. No. 4 and 5 pooled together for statistical purposes.
$X^2 = 13.20$, d.f.=3, $p<0.01$

interviewee (34.2%) suggested the location of treatment of PHC/sub centre (Table 3). The expectations of the community about cost of the treatment is displayed in table 4. Majority of the community expected free consultation and medicines, more so by advantaged villagers.

DISCUSSION

This study was carried out in a rural geodemographic area covered by Primary Health Centre, Mohanlalganj. This area forms part of a reserve parliamentary constituency mostly inhabited by schedule caste and other backward caste Hindus.

The respondents were almost equally distributed sex-wise, were mostly married and Hindus. More than half were from average socioeconomic status : a higher percentage of above average economic status dwelled in advantaged villages. In regard to sociodemographic variables the area was similar to any other North Indian village having primarily agrigarian economy. The outstanding feature of the area relates to nearly similar kind of socioeconomics status of the inhabitants even after five decades of independence. More than 60% of the population was illiterate, approximately 35% just literate (primary education) and only about 5% had higher literacy above high school. However, even with this illiteracy level, majority of this population was aware of mental symptoms and had seen the patients and believed drugs to be the primary treatment. The results thus indicate very high awareness about mental illness and their treatment contrary to the belief that there is lack of awareness in the community about these issues. The community was also aware of various places of treatment and about its possible efficacy. Majority of the subjects utilized available treatment facilities indicating that rural community does have a positive health seeking behaviour. The community was found to be generally dissatisfied with the treatment facilities available for mentally sick, the reason being, perhaps, non availability of services in or near to the community. There does exists folk treatment and faith healers but only few believe in that. The majority of the community expects clinic based management by psychiatrists at the village level itself and suggest alternatives for providing consultation and medication. The study provides answer to following questions.

1. Is there low community awareness about mental illness and modalities of treatments ?

2. Is community satisfied with the available treatment facilities ?

3. Are decentralization and deprofessionalization of mental health care services solutions to our mental health service requirements ?

4. What community expects as mental health care delivery package ?

There is no dearth of awareness in community about mental symptoms/illnesses and treatment for mentally sick, and the myth that the community is not aware of these does not hold true. On the other hand, the community is found to be dissatisfied with the available treatment for mentally sick : an issue which needs in-depth exploration as to why the community is having such a negative perception ? One may assume that this is because non-availability of treatment facilities close to community, long distance to reach available services, cost of treatment, fear of going to unknown places etc. In such a situation will the strategies of decentralization and deprofessionalization as envisaged in NMHP will succeed in providing adequate and effective mental health care services to the vast rural community. The concepts of decentralization and deprofessionalization ensures on job training to medical and paramedical staff attached to PHCs to prepare them to cater to basic mental health care needs of the community. However, the success of this programme is dependent upon government's sincere involvements, financial inputs, incentives to the health workers, community's participation, positive attitude etc. There is hardly any effort in NMHP to offer solutions to these crucial issues.

Viewed in terms of expectations of the rural community as found in this study, the NMHP is unlikely to solve the problem as the community expects free treatment at their doorsteps. This strongly suggests need for an alternative model of the mental health care for the rural community, at least in the state of Uttar Pradesh. The issue, therefore, needs to be explored further.

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