Assessing mental health needs and assets with a remote community – North India

Kaaren Mathias, Meenal Rawat, Anna Thompson, Rakhal Gaitonde, Sumeet Jain

burans

Emmanuel Hospital Association

mariwala health initiative

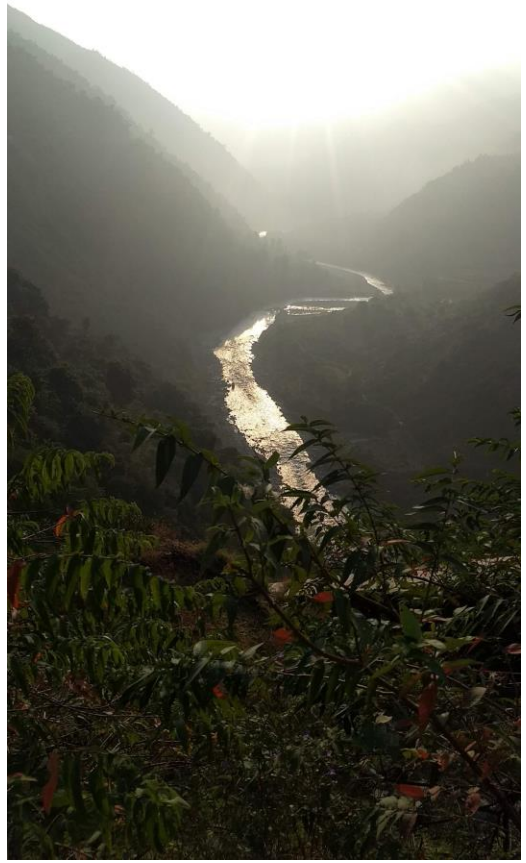
Herbertpur Christian Hospital

Overview

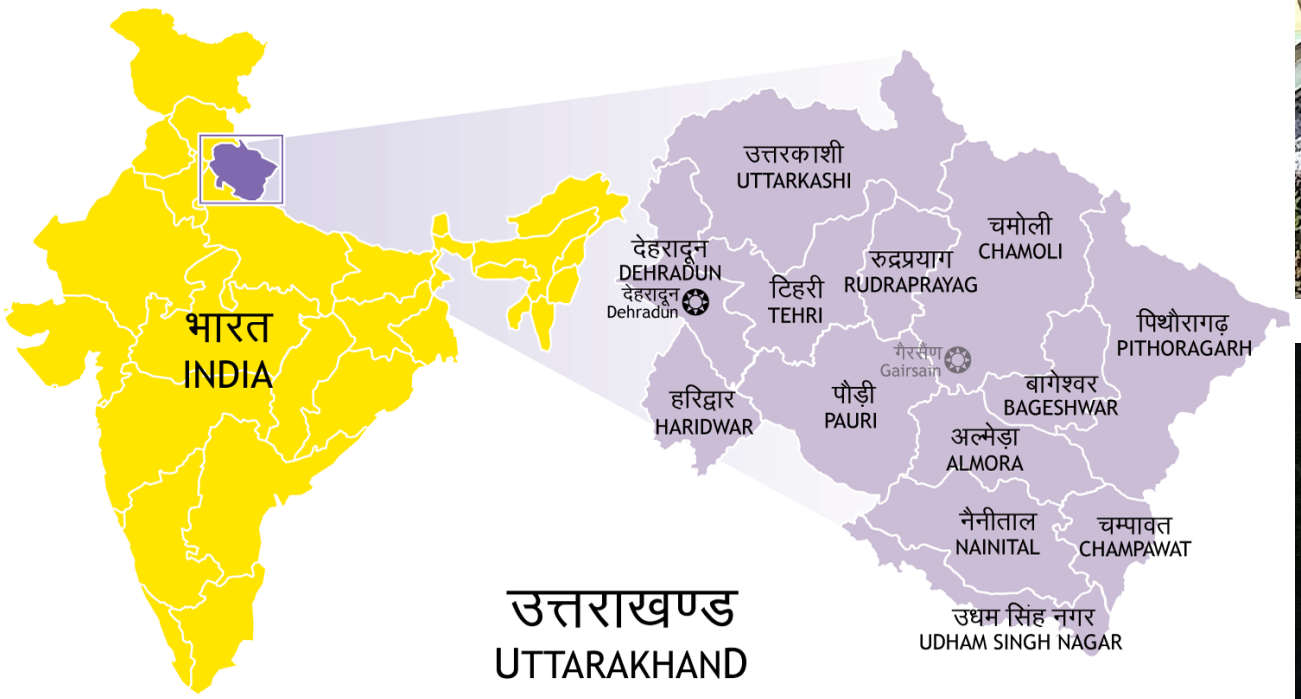
- Background
- Methods
- Results
- Implications and conclusions

Background – Yamuna valley

- Sacred pilgrimage route
- 300,000 residents
- 4 – 10 hours travel - secondary health services
- Government health services – 50% Dr vacancies
- Traditional society – hierarchies prevalent
  - Caste
  - Gender
  - Age
  - Class
  - Education
  - Ability



Where


भारत
INDIA
उत्तरकाशी
UTTARKASHI
देहरादून
DEHRADUN
देहरादून
Dehradun
टिहरी
TEHRI
रुद्रप्रयाग
RUDRAPRAYAG
चमोली
CHAMOLI
गैरसैण
Gairsain
पिथौरागढ़
PITHORAGARH
हरिद्वार
HARIDWAR
पौड़ी
PAURI
बागेश्वर
BAGESHWAR
अल्मेड़ा
ALMORA
नैनीताल
NAINITAL
चम्पावत
CHAMPAWAT
उधम सिंह नगर
UDHAM SINGH NAGAR
उत्तराखण्ड
UTTARAKHAND

Background – mental health in Uttarakhand

- Treatment gap in rural areas 95%
- District – 300,000 – one doctor primary mental health care
- State (10 million) – 8 Government psychiatrist, 15 private psychiatrists
- One residential State mental institute

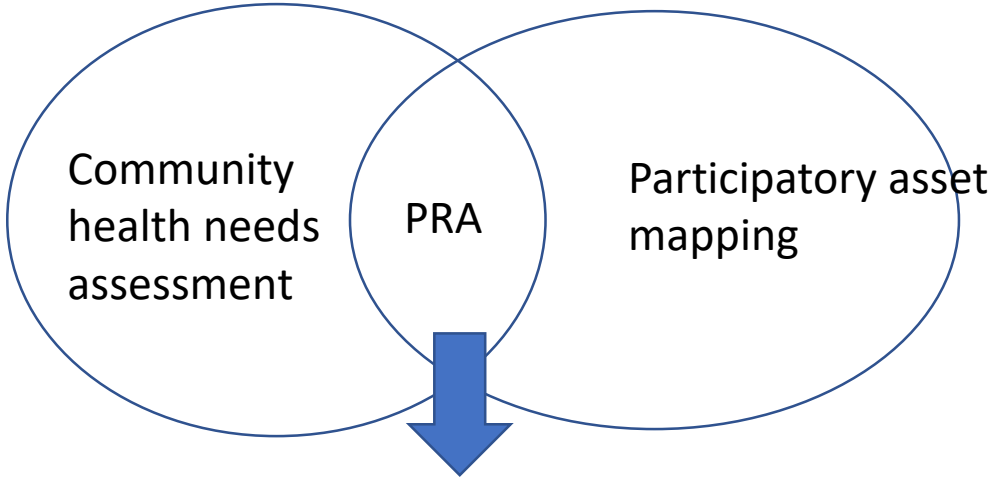
- **Central to care gap is poor system responsiveness to local context**

Background- Burans – partnership initiative
working with communities for mental health

- Started 2014
- Annual budget NZD$150,000
- 35 staff
- New team in Yamuna valley from 2019

Health needs and assets assessment

- Aim: conduct a participatory community assessment to identify assets, needs and priorities for mental health in Uttarkashi, North India



Participatory rural appraisal = community generate and analyse own data

Mathias KR, Mathias JM, Hill PC. An asset-focused health needs assessment in a rural community in north India. Asia Pac J Public Health. 2011;27(2):NP2623-NP34.

Methods – mixed methods

Quantitative

- Survey of existing public and private health service providers

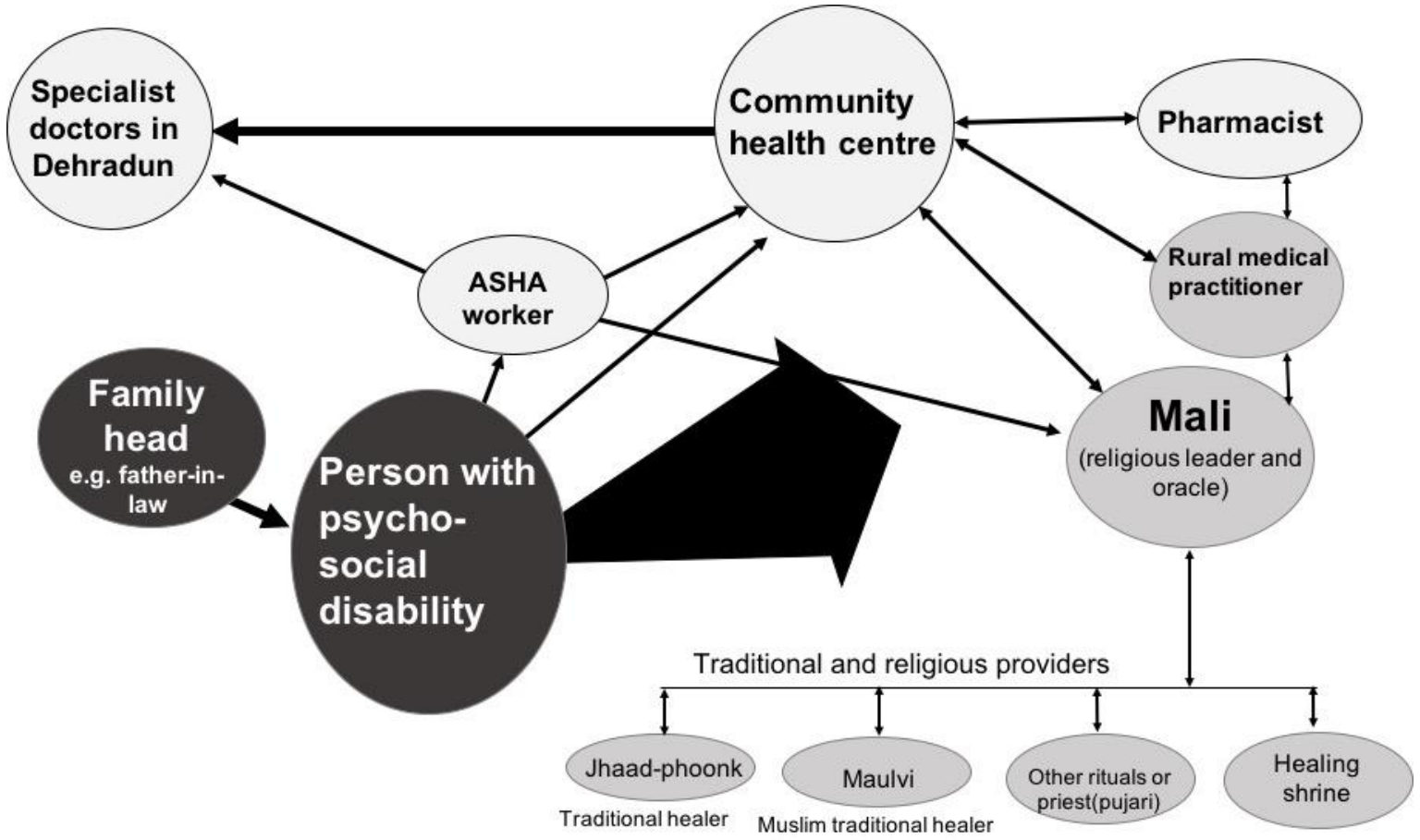
Qualitative

- In-depth interviews with community, people with MH problems, traditional healers, biomedical providers N=28
- Participatory rural appraisal with 10 groups – total people N = 120
- Ethnographic observation
- Thematic analysis of transcripts (753 codes, 93 categories)

Findings

Meta-theme	Needs	Assets
Place	More accessible and coordinated care	Natural resources and beauty provide welcome
People	Social structures that are less hierarchical and excluding	Social support to people with mental health and other problems
	Greater collective action and advocacy	Cultural practices support mental health
Practices	Respect, regulation and quality in services	Pragmatic pluralist practice
		Community and primary health services are operational and accessed

Findings


Specialist doctors in Dehradun
Community health centre
Pharmacist
Rural medical practitioner
ASHA worker
Family head
e.g. father-in-law
Person with psycho-social disability
Mali
(religious leader and oracle)
Traditional and religious providers
Jhaad-phoonk
Traditional healer
Maulvi
Muslim traditional healer
Other rituals or priest(pujari)
Healing shrine

Place – blessed but limited access to care

- **Need - more accessible and coordinated health care**
- “We have to travel six hours just to get an x-ray” **–**

- **Asset – Natural resources, clean air, water, mountains**:
- In cities a poor person has many hardships. Even if you want a glass of water you pay. ( ) Here it is so pure: the water, weather, everything... May whosoever come, they will be served. (F, 40y, IDI, C)

People – tightly knit but hierarchical

- Asset - Strong social support
- “Here people help each other. Like when all the people in a household are sick or have some problem, others take care of their children ( ) or make their haystacks for them.” (M,25y, IDI, C)

- Need – equal participation for women, Dalit, young people
- Woman 1: “So, what makes me angry is, like, I want to go to my mother’s and my husband won’t permit me to go and it feels so unfair”. [ ]
- Woman 2: “What isn’t unfair? The jobs in the house, women do nearly everything. Cooking, cleaning, caring for children, caring for animals, caring for mother and father in law. There are a few changes from when I was a child to be honest, although nowadays some men cook a little.” (F, 25y, PRA, C)

People – limited social accountability

- Actually, the people in that village will not speak out or say anything. They cannot as it is a member of their own village and they know them very well and then there could be problems. But everyone knows who is lazy or active, of course” (Government functionary).

Practices - porous, pluralist and fragmented

- **Asset -Pragmatic pluralism**
- “We cannot do anything without the patient needing to consult the gods [ ]. If we speak against them even fewer people will seek care so we try to acknowledge that Bhagwan (the Lord) is overall but that medicines can also be helpful [ ]. [ ] So, people go back and forth and we just have to work with that” (Government functionary)
- **Asset - The doors are open daily**

- **Need – Increased quality and regulation** – private providers

Practices - fragmented

Need – quality of care

- *Even though we have equipment like XR machines, there is no surgeon. ( ). Actually "aaspital khud bimarhai" (the hospital itself is unwell.*) (IDI, government functionary)

Need – respect

- *"We can't sit when we consult the doctor so while we stand there they just write on the slip that we should go to Doon hospital and send us off."* (M, 50y, FGD, C)

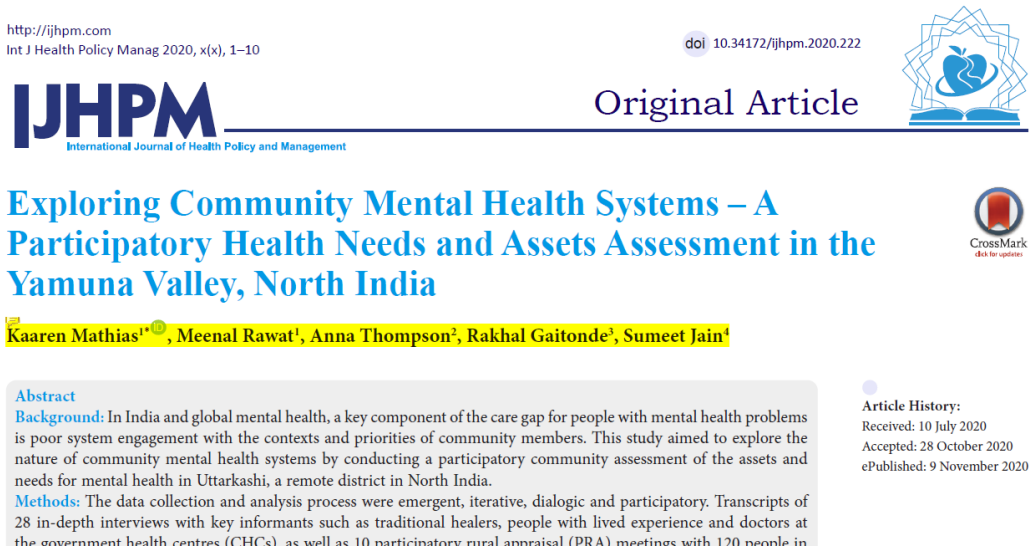
Benefits and challenges participatory methodology

- More relevant questions through the action, reflection cycle
- Shared learning among research participants. Eg CT scanner to ‘knowledge’
- Data collection by community- increased dialogue and validity
- Included voices of those typically excluded (disabled persons organisation, Dalit, women, young people)
- Cohesive communities also meant less willingness for ‘social accountability’

Participatory methods – space for nuance

- Question dominant perspectives (biomedicine/ caste/ ablism) – decolonising?
- Acknowledge local context and resources – no OSFA in health and less ‘force-fit’ of communities to dominant paradigm (Need vs Asset)
- Private care and public-private partnership and vertical programmes compromise universal health and mental health

Implications



http://ijhpm.com
Int J Health Policy Manag 2020, x(x), 1–10

doi 10.34172/ijhpm.2020.222

IJHPM
International Journal of Health Policy and Management

Original Article

Exploring Community Mental Health Systems – A Participatory Health Needs and Assets Assessment in the Yamuna Valley, North India

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Abstract
Background: In India and global mental health, a key component of the care gap for people with mental health problems is poor system engagement with the contexts and priorities of community members. This study aimed to explore the nature of community mental health systems by conducting a participatory community assessment of the assets and needs for mental health in Uttarkashi, a remote district in North India.
Methods: The data collection and analysis process were emergent, iterative, dialogic and participatory. Transcripts of 28 in-depth interviews with key informants such as traditional healers, people with lived experience and doctors at the government health centres (CHCs), as well as 10 participatory rural appraisal (PRA) meetings with 120 people in

Article History:
Received: 10 July 2020
Accepted: 28 October 2020
ePublished: 9 November 2020

- Cultural competency in India's National mental health programme?
- How to use 'both /and' ie. Western biomedical psychiatry and traditional and informal care
- National policy increase focus on social and structural determinants / inequities related to intersectional identities

Questions?

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