NGO Corner

A Formative Scoping of Mental Health Situation in Rural Satara, Maharashtra

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Suresh, a young boy from a remote village of Mahabaleshwar block, like his friends from his village, went to work in Mumbai. However, he could not cope up with the pace of the city, witnessed the suicide of his cousin brother and resigned from his job. He started having panic attacks. His father brought him back and sought advice of the primary health centre (PHC) doctor. Additionally, the family prayed to various deities. Suresh is now seeking professional help for his mental health. Every month, they travel 100 km to meet the private psychiatrist at Satara. They spend 4-5 hours to meet the doctor who spares 10 minutes for them. The father keeps all his emotions to himself. The family has never discussed about Suresh with anyone due to fear of discrimination and its effect on the marriage prospects of Suresh and his younger brother. Presently Suresh is feeling better. He enjoys his job as a data entry operator in the PHC. which is close to his house. His family is hopeful about his recovery.

Varsha, a separated young woman lives with her parents and two brothers. The family has a hand-to-mouth existence. Her husband is mentally ill, lives in Pune with his parents. Varsha was fed up with his illness, and physical abuse of her and their small son (who is now 6-year-old) and left his house about two years ago. Her husband has been taken to several faith healers and hospitals however he does not take his medicines. Varsha has no hopes about his recovery. She wants to live only for her son. She is doing a tailoring and beautician course to start a small business in their village, a small remote place in Maan block. She is unsure of continued family support and community help, hence does not talk about her situation with anyone.

[Names mentioned above have been changed to maintain the confidentiality]

These and other lived experiences of persons with mental health problems and their families from rural Satara reflect upon…

Mental health literacy, availability, accessibility, and affordability of mental health services in rural areas, skills of health professionals, importance of dialogue within and outside of family, resilience of family, family and community support, mental wellbeing of families, financial constraints and stigma

What Was the Formative Scoping About and Why Was It Conducted?

It is known that mental health problems affect a significant portion (14.3%) of Indian population [1]. Furthermore nearly 83% persons requiring mental health services do not receive those and this gap is even more in rural areas [2]. As a prerequisite to designing intervention research, the Foundation for Medical Research (FMR), a non-government research organization recognized by the Government of India, conducted a detailed scoping to understand the current situation related to mental health in Satara with support from the district health officials during December 2023-May 2024 (6 months). Satara is one of the first districts of Maharashtra to initiate the District Mental Health Programme (DMHP) about a decade ago.

The formative scoping was conducted in two rural blocks- Maan and Mahabaleshwar. These blocks are suggested for scoping by the district health officials on account of being vulnerable due to extreme weather, livelihood challenges, and high scarcity of primary mental health services. Specific objectives of this scoping were to-

- Map existing mental health services
- Understand care-seeking pathways
- Assess current mental health literacy, skills, perspectives, and needs related to mental healthcare
- Identify opportunities and potential of key stakeholders for future intervention

How Was the Scoping Conducted?

The scoping involved informal consultations (n=31) (one-to-one/ group interactions) and interactive workshops (n=3) including participatory activities; with- a) Mental health and non-mental health professionals (N-MHPs)- district and periphery public health facilities; public and private sector and b) Community stakeholders including representatives from community-based organizations (CBOs), teachers, priests, and godmen

What Were the Findings?

About the Area

Maan and Mahabaleshwar blocks of Satara district are different from each other in terms of terrain and climate. Maan block is a plain land with drought prone area under a 'rain shadow'. Most of the people are engaged in rainfed agriculture and grow Jawar, sugarcane, and pulses as main crops. Those with access to varied irrigation facilities, do vegetable and fruit farming viz., guava and pomegranate. Cattle, poultry, and sheep farming are the secondary sources of income. This block with 104 villages and one town; is a home for approximately 2.25 lakh population with 94% Hindu; and Maratha being the dominant caste. Scheduled caste population is 12.6% and scheduled tribe population 0.3% [3].

In contrast Mahabaleshwar block is characterized by its hilly terrain, heavy rainfall, and isolated villages, making connectivity, and commuting challenging, especially during monsoon. It is a hill station and a famous tourist place in Maharashtra. The main economic activities are agriculture and tourism (hotels and home stays). Rice and strawberries are the primary crops. The block has 111 villages and two towns covering seventy-two thousand population. Sixty-one percent of the population are Hindus followed by Muslims (35%) and others (4%). Among Hindus, Marathas are the dominant community followed by scheduled castes (9.62%) and scheduled tribes (2.75%) [4].

Limited livelihood options in these two blocks give rise to social issues such as out migration of young population, addictions, and marriage related problems for young boys as well as villages with increasing elderly population.

The socio-cultural fabric of both the communities is woven by the societal norms such as marriage within relations, belief in faith healers for seeking care, spiritual and devotional practices and patriarchy.

Mental Health Problems in the Area

Currently 370 plus patients (covering both the blocks) are under treatment for mental health problems under the DMHP. Alcohol addiction, depression and schizophrenia are reported as the problems highest in number. The stakeholders reported of depression, stress, addictions, anxiety, obsessive compulsive disorder, psychosis, suicides, insomnia, mood disorders, and disorientation as the common mental health problems.

The reasons for mental health burden include relationship failures, poor communication, mobile addiction (post-COVID among children), impact of social media creating unrealistic expectations, a disconnect between 'real' and 'reel' life, intergenerational conflicts, and financial stress. Issues such as exam phobia, marital maladjustments, mood swings, lack of authority among women, impulsive behaviour, and extreme guilt further contribute to mental health problems. Stakeholders stated that some mental health problems get unnoticed and undiagnosed e.g. post-partum depression (PPD).

"*We do not see much of PPD; it may happen because of some family related tensions... maybe it is unnoticed.*"- *(Private gynaecologist Maan & medical doctor working with a CBO)*

Tobacco and alcohol addictions are prevalent but not considered as a mental health problem. Care-seeking for de-addiction from formal or informal sector is time consuming and costs intensive without effective results and requires sustained family support which is lacking for many.

Suicide is a significant concern, particularly among the young population with reported reasons being breakup in relationship, lack of parental attention, mobile and social media addiction, and absence of

dialogue with family members. Methods of suicide typically include hanging, burning, and poisoning. Currently, there are no strategies for suicide prevention and no data is available about help sought for attempts of suicides or self-harm, if any.
The uncertainty of climatic conditions has emerged as an indirect cause of stress and tension regarding the farm produce and financial output. Youth migration for seeking city-based jobs has resulted in mental health problems due to familial and social disconnects, also resulting in prolonged loneliness amongst the elderly.
Poor mental health literacy results in poor identification and acceptance of mental health problem by the person, family or society and subsequently delays seeking care/ support with underlying fear of social discrimination due to mental health problems.

Formal Mental Health Services
Mental health services are available only at the Civil Hospital Satara through the DMHP with overcrowded psychiatric out-patient departments (1300-1500 patients per month) and an overburdened team in managing clinical and administrative tasks. The Programme faces challenges in terms of skilled human resource, prescription medicine availability and required outreach.

"We currently have 3-4 medicines each in the category of antidepressant and antipsychotic medicines. There is a shortage of 1-2 antiepileptic medicines. The availability of these medicines is variable"- (DMHP Staff)

Availability of space and time for provision of counselling and/or psychosocial support to the patient and families is difficult. Long distances especially from Maan (~80 kms) and Mahabaleshwar (~100 kms) blocks, infrequent transport availability and remoteness due to hilly terrain further affect access to the Civil Hospital. Mental health services including prescription medications have huge gaps at peripheral level highlighting the need for building capacities of the N-MHPs and generating mitigation strategies for regular supply of prescription medications. The N-MHPs including medical officers (MOs), community health officers (CHOs), nurses from PHC and Non-Communicable Diseases (NCD) counsellors are often the first point of contact for formal help seeking but they need more skills and competency to handle the mental health related problems.

"I need training to counsel alcohol addicts for sleeplessness; and cancer patients about their mental health."- (NCD counsellor)

The DMHP involves private psychiatrists in conducting mental health training programmes for peripheral health providers. These are in the form of structured lectures using PowerPoint presentations and can be further improved in terms of frequency and pedagogy.
The DMHP at times organizes mental health screening camps in peripheral areas with support from private psychiatrists however these are implemented as a one-time activity with less support of prescription medications and follow-ups.
Availability of private mental health services is minimal and concentrated in urban areas of selected central blocks of Satara, Miraj or Pune. There are no community-based organizations focusing on mental health in these two blocks. Approaching formal mental healthcare (public/private) is generally characterized with discomfort, fear, inhibition, non-acceptance and embarrassment of consulting a psychiatrist due to stigma.

Informal Care for Mental Health
Approaching informal care providers- godmen, temple priest, faith healer or astrologer is a common practice for seeking any support, advice or care as an alternative or complementary to formal mental health care seeking. The reasons for informal care-seeking include- lack of (mental health) literacy, poor acceptance of medical explanation of disease/ illness, inaccessible and unaffordable formal mental health services, peer/ other community members' advice/ influence, word of mouth, popularity of the provider, family pressure and previous positive experience-self and others.
Community perceptions about causes of mental health problems include black magic or sorcery, possession syndrome, bad karma or previous mistakes. Though families at times mention about wasting time and resources it is the "faith" and "feel good" factor that impact informal against formal care seeking.

Cultural And Societal Practices
There are cultural and societal practices which potentially influence mental wellbeing. Every village organises folk-based and religious programmes (*Bhajan-Kirtan*) during annual fair, festivals such as Diwali, Ganapati, Holi etc. for a period of three, five or seven consecutive days which are mainly attended by the middle-aged and elderly persons. There are other spiritual platforms such as road travel to pilgrimages by large groups (*Waari*) which provide opportunity for villagers to be connected and engaged. It helps in

strengthening unity and '*we feeling*' among them. There are several temples that are integral to the community's spiritual life. Some villages have village level committees and small area specific committees which work as traditional grievance redressal mechanism. To the extent possible, there is an attempt to address any dispute in the village, within the family or between the neighbours over the issues such as land, money by these local redressal committees. Every village in Mahabaleshwar has a deity with a particular day of the week devoted to it. On that day, all villagers gather in the village deity temple irrespective of their work schedule, worship, and discuss community related issues. Such spiritual and devotional practices can be an entry point to implement mental health and wellbeing activities at community level.
Moreover, there are few well-known CBOs working in these blocks with the focus on women empowerment, livelihood or holistic development of villages. These CBOs have expressed interest to work in the space of community mental health leveraging their existing social capital.

Recommendations
This formative scoping highlights that Satara, despite being one of the first districts in Maharashtra to start the mental health programme in the public sector, faces challenges with skilled human resources and availability of prescription medications. Primary mental health services in the rural areas have huge gaps. The scarce mental health services in the private sector are unaffordable and/or inaccessible. Thus, it confirms the need for a comprehensive and collaborative mental health effort to promote mental health literacies of the community, and the development of mental health services The following recommendations illustrate how we can build and implement such care-

- Create advocacy channels for ensuring uninterrupted supply of prescription medications at district and peripheral levels and build capacities of health providers and pharmacists.
- Build mental health care capacities of non-mental health professionals through stepped-care and task-sharing approach, expert guidance and mentoring- cadre specific training for diagnosis, management, care and support.
- Utilize the community potential through developing a cadre of lay counsellors to navigate mental healthcare and support families- CBO members, ASHAs, family care providers as lay/ peer counsellors.
- Improve mental health literacies of families and community stakeholders through co-creation of culturally relevant strategies as suggested by the community e.g. creating spaces around big trees for community dialogues, arranging de-stress sessions at stress-intense workplace for men (detox before leaving for home), community radio run by local CBO, folk-based art, community posters, working with schools- teachers and students.

REFERENCES

1. Sagar R. The burden of mental disorders across the states of India: the Global Burden of Disease Study 1990–2017. Lancet Psychiatry 2020;7(2):148.
2. Patil SKG, Gowda MR, Bijjal S, et al. Trained Professional and Service Opportunity Gap in India in the Field of Mental Health: The Enigma. Ind J Priv Psychiatry 2022;16(1):48–49.
3. Man Taluka Population Satara, Maharashtra, List of Villages & Towns in Man Taluka [Internet]. Censusindia2011.com. [cited 2024 Dec 6]. Available from: https://www.censusindia2011.com/maharashtra/satara/man-population.html
4. Mahabaleshwar Municipal Council City Population Census 2011-2024 | Maharashtra [Internet]. [cited 2024 Dec 6]. Available from: https://www.census2011.co.in/data/town/802863-mahabaleshwar-maharashtra.html

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Acknowledgements:

1. **Provision of inputs for the scoping:** Brian Brown (Professor, Health communication, De Montfort University, Leicester, United Kingdom), Amanda Wilson (Lecturer, Psychology, De Montfort University, Leicester, United Kingdom), and Deepika Saini (Research Assistant, De Montfort University, Leicester, United Kingdom)
2. **Funding support:** Mr Nadir Godrej, Chairman & Managing Director, Godrej Industries Ltd, India
3. **Contribution for field work:** Ms Sandhya Bhosale and Mr Mahesh Madane

4. **Support and co-ordination of field work:** District Health Office and District Mental Health Programme, Civil Hospital, Satara
5. **Facilitation of field work:** MannDeshi Foundation, Maan, Satara; BelAir Hospital, Panchgani, Satara and Grampari, Panchgani, Satara
6. **Administrative and logistic support for implementation and dissemination:** Foundation for Medical Research, India and Foundation for Research in Community Health, India
7. **All the stakeholders:** sharing their experiences and providing pointers for future intervention.

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