

## **The Role of Traditional Health Practitioners and Community Health Workers in Providing Mental Healthcare Services in Tribal and Rural Areas of Gujarat**

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Traditional Health Practitioners (THPs) hold an exalted place among the tribal populations across the country, including the tribal areas of South Gujarat. Tribal communities depend heavily on the THPs for their day-to-day health and other needs. This also includes mental health problems.

BAIF had some previous experience of working with THPs in South Gujarat before the MHSP Pilot. It was felt that with the MHSP Project, the reach could be widened, the THPs' practices documented, their training arranged, and ultimately integrated into BAIF's development programmes in the area.

The main objectives of the Pilot were to explore the effectiveness of the THPs in tribal areas of South Gujarat in addressing mental health issues, and to mainstream them through training and by forging linkages with the existing healthcare services.

The emphasis initially was on rapport building. This meant paying visits to the THPs in their homes, temples, or fields. This was easier said than done, as many a time the THPs would be unavailable, even after prior intimation. The task was made more difficult with the heavy rains making visits to THPs highly difficult. In addition, since most THPs also practice agriculture, they were busy with work in their fields, thus nullifying many a visit.

Despite the obstacles, steady contact was made with the THPs, and documentation completed. A working classification system was devised to differentiate between the various THPs. 100 THPs have been documented.

Maximum numbers of THPs documented in the Pilot practiced more of magico-religious therapies rather than herbal ones. A majority of them belonged to the age groups between 41 and 60 years, were men, were illiterate, and had an experience of more than 20 years.

Most operated from their home, and generally had a temple in their homes or at least a corner housing idols and photo frames of various Gods. Many of them practiced on particular day(s) of a week. Many were supported in their profession by someone in the family.

A good number of THPs saw on an average more than 100 patients in a month. A great majority of the THPs professed some sort of specialisation, almost a fourth of who claimed they could cure mental illnesses. Some of the THPs offered residential care to the patients. Most patients paid upto Rs. 50 for their treatment.

The commonest diagnostic method employed was taking a fistful of rice grains into a plate and looking into the grains. Magico-religious therapy was an important aspect of treatment. A substantial number of THPs practiced a combination of herbal medicines and magico-religious therapy.

The subsequent part was to train the THPs in a variety of subjects as part of the mainstreaming process. Accordingly, four training programmes were planned and conducted for the THPs at BAIF's Training Centres. The training topics included Record keeping, Referral skills, Biodiversity register, Yoga and Naturopathy and Mental illnesses.

Use was also made of IEC material prepared as part of the Pilot in the training.

Linkages have been established with the Civil Hospitals in Surat and Navsari to refer the patients identified by the THPs for proper treatment.

In Gujarat, the current Project would be integrated into BAIF's ongoing tribal development Projects. The experiences would also be put to good use in other areas, especially in the tribal areas of Maharashtra, where several tribal development Projects are operational.

The Pilot has demonstrated that there is a need to be inclusive while working with THPs. The THPs have generally shown willingness to join the mainstream. There is a need for the Government, policy makers and researchers to recognise the role of the THPs in providing healthcare, including mental health services in the tribal areas. An atmosphere of understanding, trust and respect for their profession has to be developed at all levels. Their problems deserve lending an ear, and their need for recognition, respect and reward should be met.

It is important to continue researching the knowledge, attitude and practices of the THPs, with respect to mental health, as well evaluate their systems for therapeutic significance, cost-effectiveness, and socio-cultural importance.

The trainings have helped develop a framework for training the THPs. This would include contact programmes including classroom lectures, exposure visits, group exercises, as well as activities to be done at home.

THPs could act as a link between the local population and health workers. A troika of Community Health Worker (CHW), Dai, and THP could work in synergy for better healthcare in the tribal villages. A convergence of various sectors and departments is recommended to achieve cohesion and maximise the gains.

BAIF Development Research Foundation (BAIF), Pune had been implementing development and health Projects in the tribal areas of Surat and Bharuch districts. The programmes have facilitated the development of People's Organisations (POs), especially women's Self Help Groups (SHGs), which were being empowered to manage the community development programmes.

There was an established cadre of Community Health Workers (CHWs) trained in providing primary medical care, and basic preventive and promotive care. Linkages had been established with the Government and private health sector.

It was felt that mental illnesses in these communities could be addressed by implementing a Pilot through these CHWs and the various POs, and forging linkages with various Government as well as non-Government agencies.

The main objectives of the Pilot were to train and empower the CHWs to address mental health problems in rural areas, create awareness among the community on MH issues, establish linkages for referral, and ensure follow up and continuing care of the cases.

The initial emphasis was on orienting the staff and CHWs in MH issues, and train them especially in problems more relevant to the local conditions. This was achieved through linkages with the Department of Psychiatry, Government Medical College, Surat.

Subsequently, efforts were made to document the mental morbidity in the areas, viz. SMDs, CMDs, as well as epilepsy, as well as assess people's perceptions about mental illnesses. This was easier said than done, considering MH was a new topic, and the level of the CHWs. The task was made more difficult with the heavy rains and the agriculture season.

It has been observed that MH problems are as prevalent in these tribal communities as in other rural or even urban areas. The elderly, women, and the less educated seem to be more at risk.

The FGDs carried out with different groups too were revealing. People's perception about mental disorders initially was generally restricted to SMDs and epilepsy. Their ideas about causation were vague, and their treatment-seeking behaviour improper.

It is important to continue researching the various MH issues in these areas, including participatory research, and the interplay of various socio-economic and cultural factors.

With the help of the linkages with the GMC, Surat, and a visiting Psychiatrist in Bharuch, camps were held in the Project villages. This enabled patients to come forward and be diagnosed. They were taken to Surat or Bharuch for treatment. Some patients attended the OPD on their own. The CHWs followed up the patients during their periodic home visits, and during meetings.

Considerable efforts were taken to discuss and spread awareness on MH issues especially using the platform of the different POs. Innovative IEC strategies were tried out with increasingly positive results. The camps served as media for dissemination. A Village Health Resource Centre has been established in one of the Project villages, which has been entrusted to the local PO.

Patients and carers have responded to IEC efforts as well as the services. However, they need continuing motivation and support. This can be done by the CHWs as well as the different POs. Further decentralisation of services at the CHC and PHC level would improve treatment compliance.

Problems do persist. As mentioned, most people had wrong notions about the nature of mental illnesses, their causes, and treatment. Generally, patients were taken to Traditional Health Practitioners (THPs) or some centre of faith healing. Consequently, many identified and as yet unidentified cases have not availed treatment, for various reasons like ignorance, non-belief, apathy, long distance for

treatment, lack of carers, etc. Bringing them into the treatment loop remains a tough task ahead.

Although the Pilot has succeeded in putting a considerable number of patients on treatment, their follow up for continuing treatment remains a challenge. In order to make MH care more accessible, further decentralisation at the level of CHCs (and PHCs) has been attempted as a follow up activity.

The CHWs have proven to be an important resource who can be effectively utilised in the effort to provide mental healthcare to the tribal communities. They can serve as the link between several stakeholders, viz. the patients, caregivers, Psychiatrists, PHCs, People's Organisations, etc. In return, their works needs due recognition, respect and reward.

Consequently, their training too has to be structured accordingly. In the current Pilot, the process had to be initiated ab initio, as there was no pre-existing training material at the CHW level. Consequently, CMDs could not be discussed in detail, nor could related topics like counselling.

A modular training schedule is the need of the hour, with the initial emphasis on orienting them towards MH as a unique topic within overall health, followed by discussions on type of mental illnesses, with a distinct emphasis on SMDs. The need is to orient the CHWs towards the patients, and the referral system. Considering the level of the CHWs, periodic training inputs, with ample practical exposure is necessary.

Considering the fact that THPs constitute a significant form of healthcare providers for the tribal people, their involvement and integration into the MH activities is the need of the hour. Therefore, simultaneous efforts for identification of such THPs in the community, and their training, needs to be in-built in the programme.

In fact, a useful model of healthcare workers could be developed for providing healthcare services to the tribal community. This could be in the form of a troika of workers, viz. the CHW, the Birth Attendant (Dai), and the THP working in synergy. The CHW could take the lead in preventive and promotive services, provide primary treatment, and arrange for referrals.

Equally important is the training of the staff members who would work in the Project. They need orientation training on MH issues. They should be given adequate exposure to the work of other agencies, as well as topics like counselling and rehabilitation, something that was not possible in the Pilot. Subsequent refresher trainings too would be essential.

The Pilot has demonstrated that effective linkages can be formed with Government institutions as well as private providers. However, these linkages need to be as close to the community as possible. In the initial stages, the CHCs can be involved in the process. They could at the least function as "drug depots", administered by trained Medical Officers.

The POs have played a useful role in IEC, holding camps, and motivating and supporting patients and caregivers. They should be involved in all stages of the Pilot, starting from research, problem identification, planning of activities, implementation, and evaluation. Evolving mechanisms for their empowerment is essential.

In Gujarat, the current Project would be integrated into BAIF's ongoing tribal development Projects. The experiences would also be put to good use in other areas, especially in areas of Maharashtra, where several development Projects are operational.

It is felt that the efforts of NGOs in providing community MH care need to be strengthened. MH activities can be integrated into the overall health activities with positive outcomes. Ways and means to augment the capacities of NGOs for the purpose need to be evolved within the overall MH scenario, and particularly in organising community MH services. A convergence of various stakeholders from the Government, private and the NGO sectors to take forward the mental healthcare issues is suggested.