Rural Psychiatry in Developing Countries

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During the last two decades several initiatives have been taken to improve psychiatric services in low-income rural areas in developing countries. They have included the formulation of national mental health programs and establishment of pilot programs for integration of mental health care with primary health care in India, Iran, and other countries in Asia, Africa, and South America. The psychiatrist has multiple roles to play in meeting the many challenges of providing mental health care in rural areas in developing countries. (*Psychiatric Services* 49:967–969, 1998)

Rural psychiatry in the developing countries of Asia, Africa, and South America presents both challenges and opportunities. Challenges in providing mental health care are presented by the limited institutional infrastructure, the lack of trained mental health professionals, and the difficulties in communication between urban centers and remote areas. Opportunities include the availability of community support for patients and for mental health services, increased cohesion in patients' families, and simple ways of life that more easily accommodate patients' rehabilitation and community reintegration. Community tolerance of patients is high. Increased opportunities for prevention of mental disorders and promotion of mental health exist in many developing countries, where traditional life styles often emphasize the importance of social supports in crisis (1).

This paper reviews recent developments in mental health care for low-income rural communities in developing countries, discusses experience with rural psychiatry in India and Iran and its implications for planning mental health care, and suggests some roles for the psychiatrist in this work.

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Approaches to mental health care

Work on establishing mental health care programs in developing countries began relatively recently. The recommendations of the expert consultation committee of the World Health Organization (WHO), published in 1975, provided the major impetus for organization of mental health services in these countries (2). The committee's report emphasized the need for the establishment of national mental health programs and national priorities for use of mental health care resources, the involvement of all health care personnel in providing mental health care, appropriate training for health care personnel, systematic research, and legislative support.

A striking aspect of mental health care in developing countries is the choice of community mental health care as the primary approach for the rural population. Almost all developing countries have a limited number of institutional facilities for care of mentally ill patients and very few mental health professionals.

During the past two decades, after

publication of the recommendations of the WHO expert committee and dissemination of the results of a WHO study of strategies for expanding mental health care (3), several initiatives have been taken at the national, regional, and local levels in developing countries. These initiatives have included the formulation of national mental health programs and establishment of pilot programs for integration of mental health care with primary health care in India, China, Uganda, Tanzania, Nigeria, Colombia, Sri Lanka, and the developing countries of Southeast Asia (4,5).

Mental health care is receiving increased attention in developing countries at a time when a wide range of treatments for acute and chronic mental disorders is available (6). Availability of these treatments enables the use of a variety of levels of care for mentally ill patients with different needs (5) and makes it feasible to consider issues of quality assurance for treatment approaches that go beyond institutionalization.

India

The community mental health movement in India began about two decades ago. Because more than 70 percent of the 960 million people in India live in rural areas, India has developed primarily rural mental health services (7). Two projects that have influenced the development of India's mental health services are the Raipur Rani Project and the Bellary District Project.

The Raipur Rani Project was part of the WHO collaborative study on strategies for extending mental health care (3,7). Seven countries—Brazil, Colombia, Egypt, India, the Philippines, Senegal, and Sudan—were involved in the seven-year study, from 1975 to 1981. Raipur Rani, an agricultural zone of Haryana state in northern India, was the Indian project area. The project focus was evaluation of the integration of mental health care with general health services. The study area had a population of 60,000 and was served by four doctors and more than a dozen paraprofessionals. Systematic efforts were made to collect baseline data, select disorders that would have priority for intervention, develop and implement programs to meet specific needs, and evaluate the impact.

After a one-year intervention period, nearly 4,000 persons had started receiving essential mental health care through existing health facilities. Interviews with clinic patients showed changes in attitudes toward early recognition of mental disorders, treatability of mental disorders, reintegration of recovered patients, and acceptance of a primary health care team. The scope of the project was limited, and systematic data about key issues were not collected. For example, the project did not address the number of persons with mental health problems who were identified by health personnel, the adequacy of care, the level of care provided, and the overall impact of the care on patients and families. However, the results of the initial effort supported the possibility of providing basic mental health care through general health services.

Rural populations in developing countries generally show greater community acceptance of mentally ill persons, lack large numbers of institutionalized patients, and include cohesive families in which mentally ill family members can receive extensive support.

The Bellary District Project, in Karnataka, South India, involved a unit of the health care infrastructure known as a district, which serves 2 million people (4). The district project included decentralized training of primary health care personnel, provision of mental health care in all health facilities, involvement of all categories of health and welfare personnel, provision of essential psychotropic drugs, a simple record-keeping system, and a mechanism for monitoring the work of primary health care personnel in the provision of mental health care. The results showed that it is possible to provide basic mental health care as part of primary health care services. The results were especially noteworthy because the direct involvement of mental health professionals in planning and providing care was limited.

The results of the experiments in integrating mental health care with general health care were used in formulating the national mental health program for India (8). This program has stimulated initiatives for mental health care among professionals, nongovernmental organizations, and citizens using a variety community-oriented care programs.

Iran

Less than 15 years ago, mental health care in the Islamic Republic of Iran was based totally on institutional care and use of trained professionals. Most of the services were in cities. In 1985 a national mental health program was formulated. The program emphasized universal coverage of services and integration of mental health care with primary health care, especially for the rural population. This approach was part of a major reorganization of primary health care that included village-level initiatives carried out by village health workers.

The mental health initiative included mental health training for all health care personnel, development of a district-level mental health support system, establishment of a yearly mental health week, involvement of

professionals and medical schools, and strong political will. As a result, nearly 25 percent of rural Iran now has access to essential mental health care, an achievement of great significance for all developing countries (Mohit A, personal communication, 1996).

Other developing countries

Several other developing countries in Asia, Africa, and South America have been experimenting with integration of mental health care and primary care (4,5). In Colombia, ancillary nurses have provided care for persons with nonpsychotic conditions. In Tanzania, a national program using the integrated approach has been established. In recent years, pilot integrated programs have been started in Bangladesh, Egypt, Nepal, Pakistan, and Indonesia involving population groups of 30,000 to 417,000.

The initial reports from these countries suggest that the approach is effective in reaching the sections of population that are not served by institutional facilities. The countries that have instituted such changes vary in the type of personnel who are involved in mental health care, the degree of responsibility given to health care workers for prescribing psychotropic drugs, and the mechanisms of support and supervision by professionals (4,5).

Implications for planning mental health care

The experiences of developing countries in implementing mental health care in rural areas suggest the broad scope of the effort needed to organize basic services. Populations in rural areas generally show greater community acceptance of mentally ill persons, lack large numbers of institutionalized patients, and include cohesive families in which mentally ill family members can receive extensive support. In planning mental health care, these advantages must be weighed against the limitations created by the small number of mental health professionals, the developing state of primary health care and welfare services, the low priority for mental health in general health services, funding limitations, and lack of public pressure groups.

Mental health programs in developing countries should be implemented in ways that strengthen the positive aspects of rural life. For example, the rural family often provides a major portion of the care for mentally ill patients. However, the family has been seen as a substitute for professional care and not as an essential component of mental health care. Efforts have not been made to understand the needs of families, to provide them with support and skills training, to help organize family groups, and to help families in networking. To prevent families from discarding their ill relatives, these needs must be addressed in a planned manner.

Similarly, the limitations of trained mental health professionals in developing countries must be addressed by enhancing personnel development. There is also a need for creating databases to organize information to aid policy development. Organizing consumer pressure groups is another aspect of a mental health care program that should also receive attention.

Against this background of needs and possibilities in rural mental health care, the psychiatrist has several roles. They include delivering services, training personnel, leading the mental health team, strengthening families, promoting mental health, and preventing mental disorders. Other roles include research, dissemination of information, influencing key leaders, and encouraging policy change.

Conclusions

There are no universal models for mental health care. Even in countries with well-developed mental health programs, a wide variety of problems exist. Sartorius (9) has pointed out that the development of mental health care will continue to be affected by national, regional, and local factors. These factors will influence decisions about which conditions are considered mental disorders, what constitutes a mental health issue, where mentally ill persons will be cared for, who will care for them, and what amount of resources will be made available for these activities. It is fortunate that the needs of mentally ill persons in rural areas are receiving special attention from national and international agencies. Such attention can provide opportunities for new programs and new initiatives (10). ♦

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