KNOWLEDGE, ATTITUDE AND PRACTICES ABOUT THE MENTAL HEALTH AMONG THE RESIDENTS OF DISTRICT THARPARKAR

SINDH MENTAL HEALTH AUTHORITY

MAP OF DISTRICT THARPARKAR

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ACKNOWLEDGEMENT

On behalf of the Sindh Mental Health Authority, I am pleased to extend my heartfelt gratitude to all the collaborating partners and stakeholders who contributed to the successful completion of the research project on “Mental Health Knowledge, Attitudes, and Practices among the Residents of district Tharparkar.”

This research, conceptualised and led by Dr. Abdul Razzaque Nohri as the principal investigator, was carried out under the esteemed umbrella of the Sindh Mental Health Authority. The collaborative organisations played an instrumental role in the project’s success. Those were namely, the Health Department, Liaquat University of Medical & Health Sciences Jamshoro, Thar Foundation, and the Sir Cowasji Jehangir Institute of Psychiatry & Behavioral Sciences Hyderabad.

I would like to extend special thanks to the 250 Lady Health Workers who were trained in mental health awareness and data collection for this study. Their dedication and efforts were essential in gathering meaningful data from more than 5000 participants and ensuring the smooth execution of the project in the region.

Last but not least, I would like to congratulate the entire research team for their tireless commitment, professionalism, and dedication in carrying out this important study. Their hard work has significantly contributed to the advancement of mental health awareness in Tharparkar and beyond. Thank you.

Senator Dr. Karim Ahmed Khowaja
Chairman,
Sindh Mental Health Authority

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1	**Sindh Mental Health Authority**	Umbrella Institute to conceptualize, manage and integrate the research activities.
2	**Health Department, Government of Sindh**	Tool Development, Data Collection, Analysis, Manuscript Writing and Mental Health Awareness Sessions
3	**Liaquat University of Medical & Health Sciences, Jamshoro**	Technical Inputs and Questionnaire Printing
4	**Sir Cowasji Jehangir Institute of Psychiatry & Behavioral Sciences, Hyderabad**	Mental Health Awareness Sessions
5	**Thar Foundation**	Logistic Support and Management of Sessions in all Talukas

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EXECUTIVE SUMMARY

This study was conducted over three months (September to November 2024) by the Sindh Mental Health Authority (SMHA) in collaboration with several stakeholders, including the Health Department-Government of Sindh, Liaquat University of Medical & Health Sciences, Sir Cowasji Jehangir Institute of Psychiatry & Behavioral Sciences and Thar Foundation. The primary goal of the study was to assess the mental health knowledge, attitudes, and practices of the people in Tharparkar, a region experiencing significant mental health challenges, particularly related to poverty, social issues, and increasing suicide rates. The research was designed as a descriptive cross-sectional study, surveying over 5000 residents across the various Talukas of Tharparkar. A random sampling technique was employed.

The results of the study revealed that 52.55% of respondents had an awareness of mental health issues, but the overall level of knowledge was generally low, with 53% of participants possessing poor knowledge of mental health. Interestingly, while 59.93% believed in medical treatments for mental health conditions, a large portion of the population (35.57%) attributed mental illness to past sins, and 28.32% linked it to supernatural causes. This indicates the persistence of cultural and religious misconceptions surrounding mental health. Regarding the recognition of symptoms, respondents identified a variety of behaviours, with the most common being a mixture of symptoms (31.07%), followed by wandering (13.98%) and aggression (11.99%). However, the perception of recovery was largely pessimistic, with 63.61% of participants doubting the possibility of recovery from mental health conditions, further hindering treatment-seeking behaviours. Barriers to accessing mental health services were primarily financial, with 27.98% of respondents citing financial constraints and issues related to access and transportation. A lack of awareness about available services and the stigma surrounding mental health (both societal and familial) were also significant obstacles. Additionally, many respondents (69.8%) believed that mental illnesses are contagious, highlighting the need for continued education to dispel such misconceptions and reduce stigma. This belief, along with the high levels of fear regarding interactions with mental health patients (88.23%), underscores the importance of fostering a more supportive community environment for those affected by mental health issues.

Overall, the study paints a picture of a community that is still grappling with cultural misconceptions and significant barriers to accessing mental health care. While there is a foundation of awareness and belief in the importance of mental health, much work remains to be done to improve knowledge, reduce stigma, and make mental health services more accessible. The study highlights the need for targeted mental health campaigns, culturally sensitive programs, expanded services, stronger community support, and reduced care barriers to improve mental well-being in Tharparkar.

BACKGROUND

Tharparkar, a district in the southeastern part of Sindh province, Pakistan, is characterized by its arid landscape, cultural diversity, and unique socio-economic challenges. Over the past decade, the region has witnessed a concerning rise in mental health issues, particularly reflected in increasing suicide rates.

Tharparkar spans approximately 22,000 square kilometers and is home to over 1.65 million people. The district's economy is predominantly agrarian, heavily reliant on monsoon rains for agriculture and livestock farming. However, recurrent droughts and limited infrastructure have exacerbated poverty and food insecurity. According to the United Nations Development Programme's multidimensional poverty index, 87% of Tharparkar's residents live below the poverty line. [1]

Tharparkar has emerged as the district with the highest number of reported suicide cases in Sindh province. Between 2016 and 2020, the Sindh Mental Health Authority (SMHA) recorded 767 suicides in the province, with 79 cases reported in Tharparkar. [2, 3]

In 2021, the district witnessed 115 suicides, including 68 women.[4] The trend continued in 2022, with 129 suicides.[5]

A significant proportion of suicide victims in Tharparkar is young individuals. A study titled "Psychological Autopsy of Suicide Cases Registered in District Tharparkar" revealed that over 60% of individuals who committed suicide were teenagers aged between 10 and 20 years.[2, 6]

Additionally, the female-to-male ratio among suicide victims was 4:1, indicating a higher prevalence among women.

Several interrelated factors contribute to the mental health crisis in Tharparkar:

1. Poverty and Economic Hardship: The pervasive poverty in the region leads to financial stress, food insecurity, and limited access to necessities, adversely affecting mental well-being.[1]

2. Domestic Violence and Social Issues: Domestic conflicts, forced marriages, and social discrimination, particularly against marginalized communities, contribute to psychological distress.[7]

3. Lack of Mental Health Services: Tharparkar faces a severe shortage of mental health professionals and facilities. As of 2021, 20 out of 30 districts in Sindh did not have mental health services, highlighting a significant gap in care.[8]

4. Cultural Stigma: Mental health issues are often stigmatized, preventing individuals from seeking help and leading to underreporting of mental health problems.[9]

Despite the challenges, there have been efforts to address mental health issues in Tharparkar:

- Tele-Counselling Services: In 2020, the Sindh Mental Health Authority (SMHA), in collaboration with non-governmental organizations, launched tele-counselling services to curb the rising trend of suicides in the district.[10]

- Engagement of Community Health Workers: In 2021, community health workers, including lady health workers, were engaged by SMHA to connect patients with mental illnesses to psychiatrists, aiming to provide sustained mental health services across Tharparkar's villages.[11]

- Research and Awareness: Studies like the "Psychological Autopsy of Suicide Cases" conducted by SMHA have provided valuable insights into the causes of suicides, emphasizing the need for decriminalizing suicide and introducing preventive legislation.[6]

The mental health crisis in Tharparkar is a multifaceted issue rooted in socio-economic hardships, cultural practices, and systemic gaps in healthcare services. Addressing this crisis requires a holistic approach that includes poverty alleviation, enhancing mental health services, community engagement, and destigmatizing mental health issues. Empowering the community through education, economic opportunities, and accessible healthcare can pave the way for improved mental well-being in Tharparkar.

OBJECTIVES

1. To assess the knowledge, attitude and practices of the residents of Tharparkar about mental health.
2. To identify the barriers to seeking mental health services.

RATIONALE

The study aims to assess the community's knowledge, attitudes, and practices regarding mental health to inform targeted interventions and awareness programs. Understanding these factors is crucial to overcoming stigma and improving access to mental health care in the region.

METHODOLOGY

STUDY SETTING

The study was carried out on the residents of all taluks of district Tharparkar, namely Diplo, Kaloi, Mithi, Chachro, Dahli, Islamkot and Nangarparkar.

STUDY DESIGN

A descriptive cross-sectional study was conducted, to carry out the snapshot of the community and find out the prevalence and factors/barriers.

DURATION OF STUDY

The study was conducted over a period of three months, from September, 2nd 2024 to November, 28th 2024.

SAMPLE SIZE

A sample size of **5000** respondents was proposed to carry out the robust study with minimum possible bias and that can be generalized. With 10% of non-respondents, the final sample size came out to be **5500**. However, after receiving the filled questionnaires, we found that **5378** responses were valid to be incorporated into the study.

SAMPLE TECHNIQUE

Data was collected using a simple random probability sampling technique

TOOL DEVELOPMENT

A pilot study was conducted on a semi-structured questionnaire of 50 respondents and then necessary amendments were made to the questionnaire.

SELECTION CRITERIA

INCLUSION CRITERIA

1. Both adult male and female participants were included in the study.
2. Healthy individuals were part of the study.

EXCLUSION CRITERIA

1. The study did not include Participants from regions other than Tharparkar.

2. Participants who recently migrated/relocated to Tharparkar were not part of study.

3. Mentally ill patients were not part of the study.

4. Participants unwilling to participate were excluded from the study.

DATA COLLECTION METHODS

From September, 2nd 2024 to September, 28th 2024 Mental Health Awareness Sessions were conducted in different Talukas of Tharparkar, under the Umbrella of SMHA and their stakeholder institutions. Data Collection and data entry process took time of 6 Weeks. Data Analysis and Writeup took 2 weeks and Final Manuscript review took 1 week.

Data was collected by around 250 LHWs (Lady Health Workers) of different Talukas of District Tharparkar, which were facilitated through the support of District Health Department. During the Mental Health Awareness Sessions, they were trained in understanding and filling out the research questionnaires. After research orientation, they collected data from their respective field areas/communities. A written consent was obtained from every relevant respondent for participation in the study. LHWs submitted their collected Data to their respective LHS (Lady Health Supervisor) and further, they submitted it to the Principal Investigator.

DATA ANALYSIS

The data was compiled with proper coding in Microsoft Excel and further analysed using the Statistical Package for Social Sciences (SPSS) for Windows, version 29. For categorical variables, frequencies and percentages were calculated. Graphs and pie charts were used for graphical presentations.

ETHICAL CONSIDERATIONS

1. The study was conducted after obtaining approval from the Research Ethics Committee.
2. Consent was obtained from all respondents, and participants were informed about the purpose of data collection and the study.
3. Confidentiality of all records was ensured, maintaining the anonymity of respondents.
4. The research process did not negatively affect the participants. The records were used solely for research purposes.

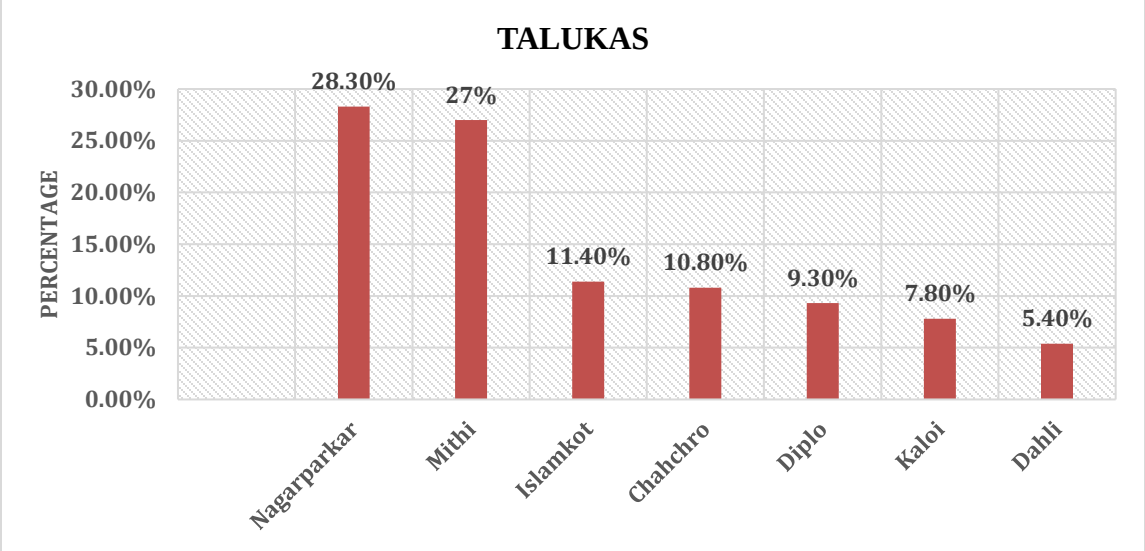
RESULTS AND DISCUSSION

CONSOLIDATED DEMOGRAPHIC VARIABLES

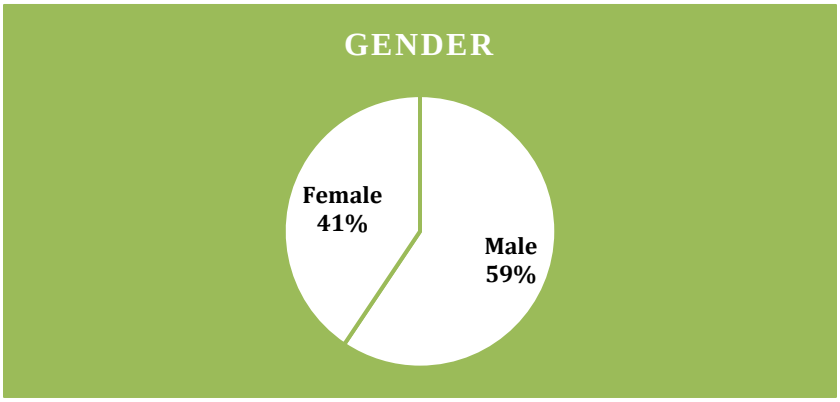
VARIABLE	SUB-VARIABLE	FREQUENCY	PERCENTAGE (%)
Taluka			
	Nangarparkar	1521	28.3
	Mithi	1450	27.0
	Islamkot	611	11.4
	Chahchro	583	10.8
	Diplo	500	9.3
	Kaloi	420	7.8
	Dahli	293	5.4
Gender			
	Male	3194	59.4
	Female	2184	40.6
Education			
	Uneducated	2454	45.6
	Primary	1623	30.2
	Secondary	1029	19.1
	Graduate	272	5.1
Marital Status			
	Married	3889	72.3
	Single	1183	22.0
	Widowed	306	5.7
No of Children			
	Three or More	3315	61.6
	Not Applicable	1183	22.0
	Two or Less	880	16.4
Occupation			
	Unemployed	3011	56.0
	Govt Employee	1369	25.5
	Pvt Employee	655	12.1
	Self Employed	343	6.4
Ethnicity			
	Non Muslim	4061	75.5
	Muslim	1317	24.5
SES			
	Less than 15K	3009	56.0
	More than 45K	1405	26.1
	Between 25K to 45K	550	10.2
	Between 15K to 25K	414	7.7

Age: Almost half (48%) of the participants fall in the age group between 18-38 years, while remaining half (52%) fall in higher age group. Mean age was 35 years, with a mode of 20 years, indicating significant skew towards younger age.

Taluka: The sample was predominantly from Nangarparkar (28.3%) and Mithi (27.0%), providing valuable insights into mental health awareness and attitudes within these major Talukas.



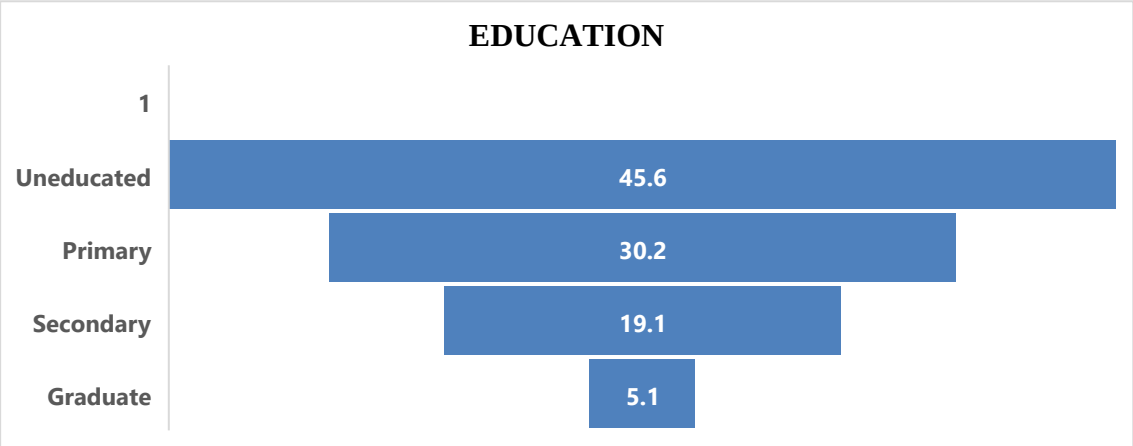
Awareness campaigns and educational outreach could be concentrated in Nangarparkar and Mithi initially, given their higher representation, with subsequent efforts in smaller Talukas. This approach will ensure that key areas in District Tharparkar receive focused mental health education to potentially elevate the entire region's awareness regarding mental health.



Gender: With 59.4% male and 40.6% female respondents, the study reflects a bit gender disparity in participation, which may mirror societal norms or the accessibility of mental health awareness initiatives. To gain a comprehensive understanding of mental health knowledge and attitudes across genders, future studies or interventions should focus on increasing female participation. Gender-specific approaches to mental health awareness could address unique

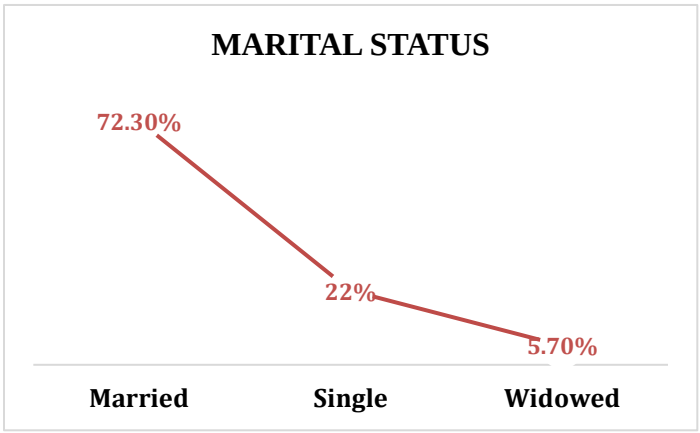
needs and perceptions, as males and females might experience and express mental health issues differently.

Education: A significant portion of respondents were uneducated (45.6%), followed by those with primary education (30.2%). Only 5.1% had a graduate-level education. Educational background significantly impacts mental health knowledge. The high

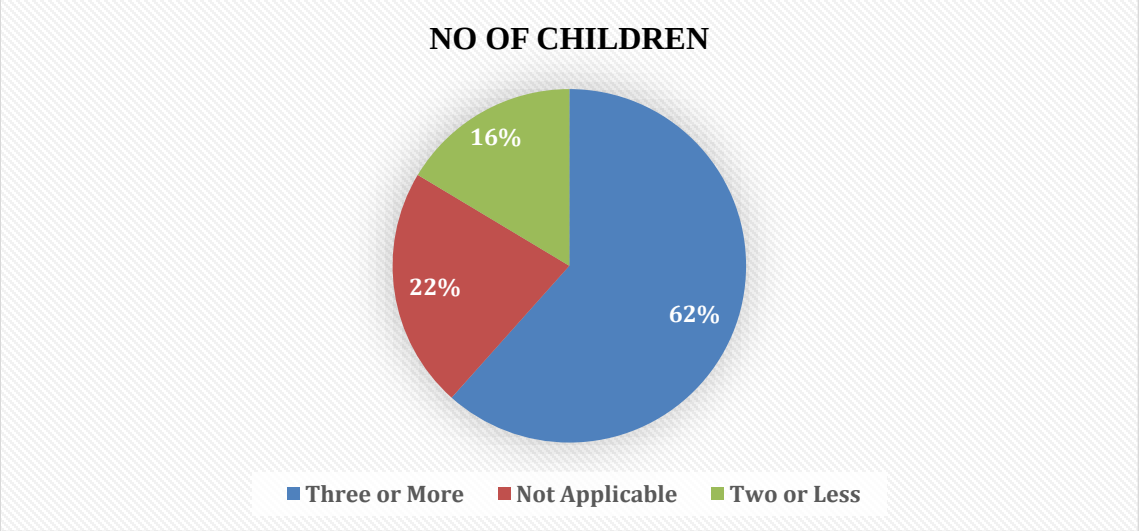


percentage of uneducated respondents suggests that many might lack formal knowledge about mental health. Outreach programs should employ simple language and culturally relevant examples to effectively communicate mental health information, making it accessible for those with lower educational attainment.

Marital Status: Most respondents were married (72.3%), while singles and widowed individuals constituted 22.0% and 5.7%, respectively. Married individuals may have different mental health attitudes due to family responsibilities and support structures. Programs can focus on family-oriented mental health education, helping couples and families to recognize and address mental health issues collectively. For singles and widowed individuals, community-based support could play a crucial role in promoting mental health awareness.

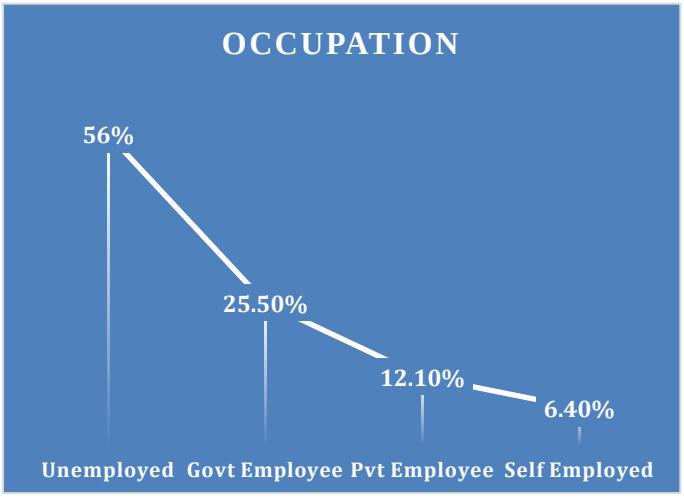


Number of Children: The majority had three or more children (61.6%), with a smaller proportion having two or fewer children (16.4%). Those marked "Not Applicable" (22.0%) likely include individuals without children or those who were single/unmarried.

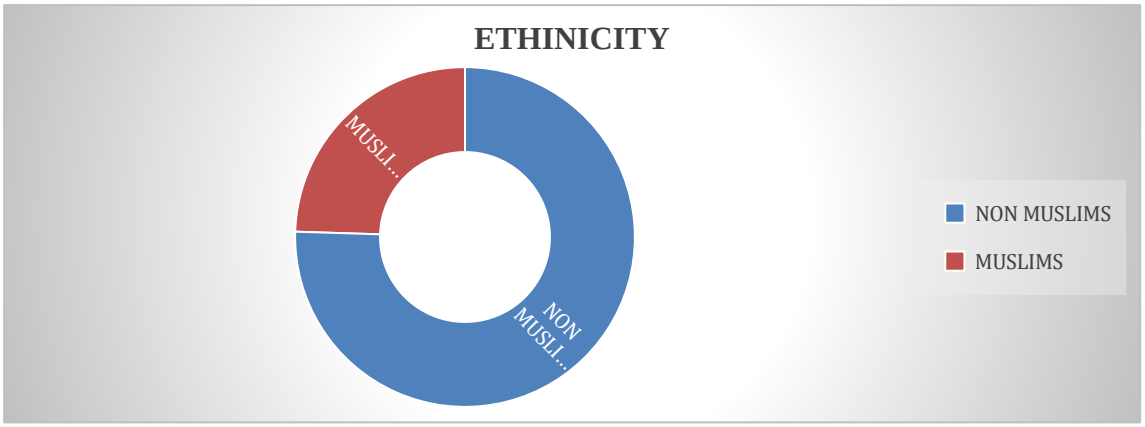


Family size can influence stress levels and, consequently, mental health attitudes. Larger families might face more stressors, making them ideal targets for stress management education and mental health resources. Family-oriented mental health practices could be encouraged to foster an environment that promotes positive mental health attitudes**.**

Occupation: Over half of the respondents were unemployed (56.0%), which could significantly influence mental health attitudes due to financial instability. The remaining participants were distributed among government employees (25.5%), private employees (12.1%), and self-employed individuals (6.4%). Employment status can shape mental health perceptions, especially in regions with high unemployment. Providing mental health awareness to unemployed individuals might focus on managing stress related to financial constraints, while workplace mental health programs could benefit those who are employed.

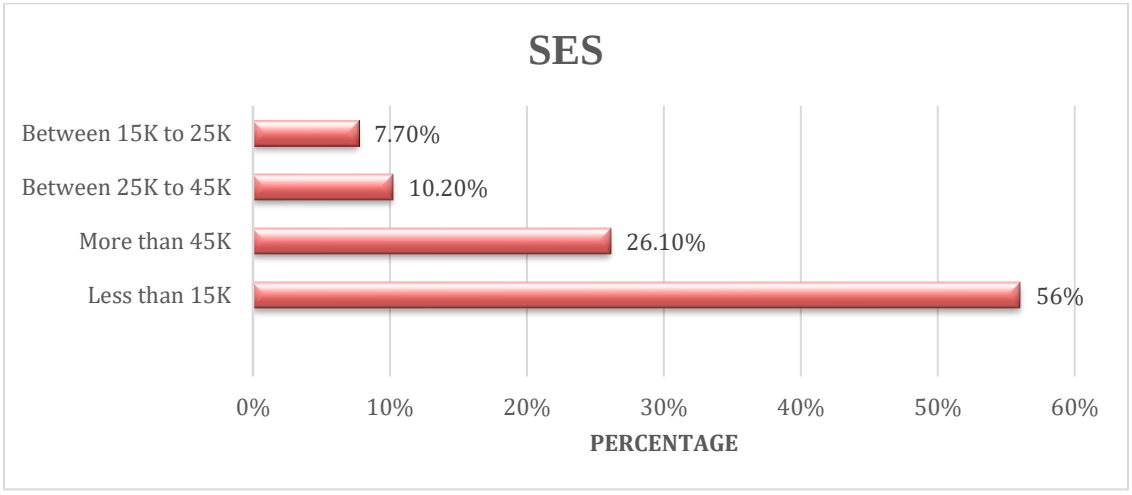


Ethnicity: Non-Muslims form a majority (75.5%) of the sample, while Muslims make up 24.5%. Mental health attitudes can be influenced by cultural and religious beliefs. Non-Muslim communities, being the majority, might have unique perspectives on mental health that differ from those of Muslim communities.



Cultural sensitivity in mental health awareness programs is essential to effectively address beliefs and practices among different groups.

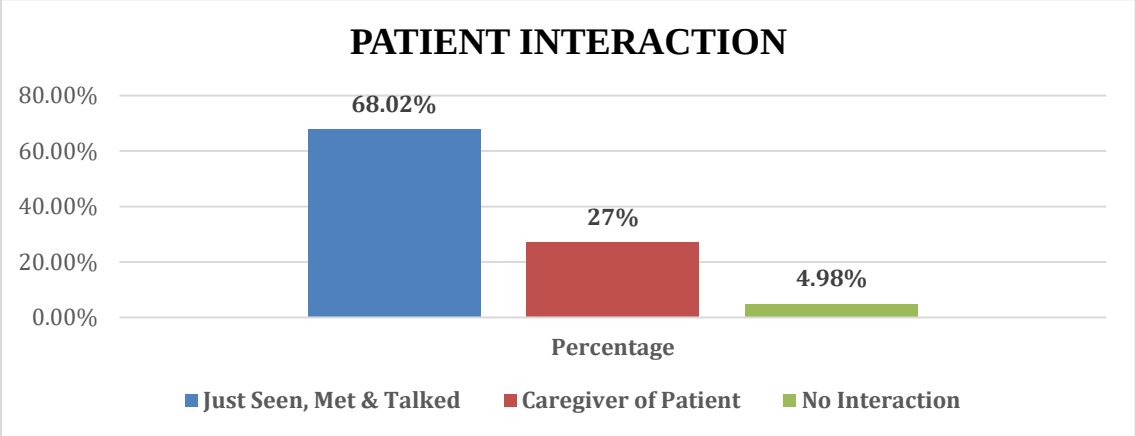
Socioeconomic Status (SES): A significant portion of respondents had an income below 15K (56.0%), suggesting economic hardship. The remainder is spread across higher income brackets, with only 26.1% earning more than 45K. Economic factors heavily impact mental health attitudes, as financial constraints can limit access to mental health resources. Awareness programs should address the mental health challenges related to financial stress and provide accessible resources or information on affordable mental health services, particularly for lower-income groups.



PATIENT INTERACTION

Response	Frequency	Percentage
Just Seen, Met & Talked	3658	68.02
Caregiver of Patient	1452	27.0
No Interaction	268	4.98

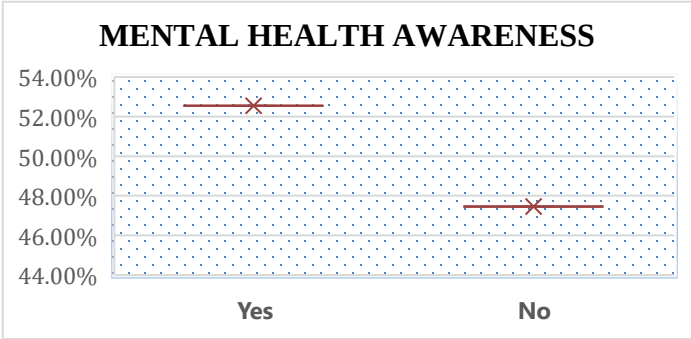
The data reveals that 68.02% of respondents reported limited interaction with mental health



patients, such as merely seeing or talking to them. A smaller proportion (27%) acted as caregivers, while 4.98% reported no interaction. These findings suggest that while many individuals may encounter mental health patients, their involvement remains superficial, indicating a need for deeper community engagement initiatives to foster understanding and empathy.

MENTAL HEALTH AWARENESS

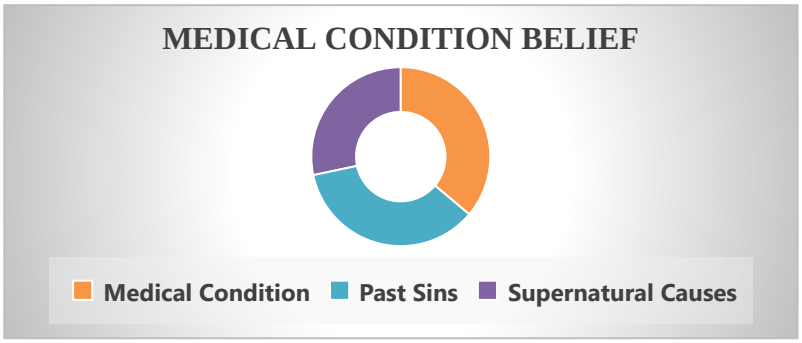
Mental health awareness among the population was almost evenly split, with 52.55% affirming awareness of mental health issues. This modest majority indicates significant progress but also underscores the need for continued awareness campaigns to close the gap and ensure comprehensive understanding across the community.



MEDICAL CONDITION BELIEF

Response	Frequency	Percentage
Medical Condition	1942	36.11
Past Sins	1913	35.57
Supernatural Causes	1523	28.32

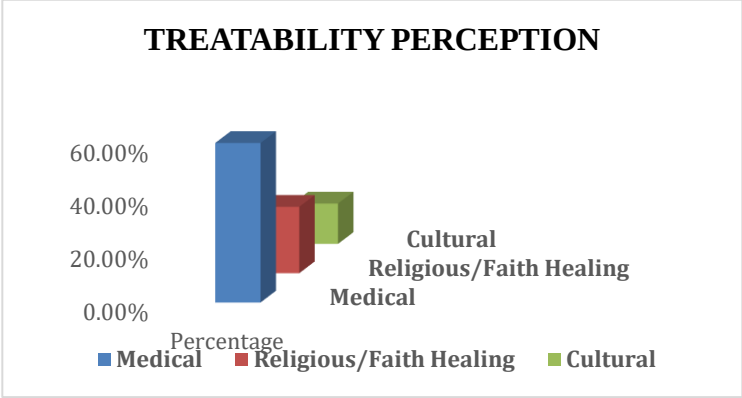
Respondents expressed diverse beliefs regarding the origins of mental illness, with 36.11% attributing it to medical conditions, 35.57% to past sins, and 28.32% to supernatural causes. This highlights the influence of cultural and religious ideologies, suggesting a need for culturally sensitive education programs to challenge misconceptions and encourage evidence-based understanding.



TREATABILITY PERCEPTION

Response	Frequency	Percentage
Medical	3223	59.93
Religious/Faith Healing	1341	24.93
Cultural	814	15.14

The majority (59.93%) of respondents believed in the medical treatability o f mental health conditions, while 24.93% and 15.14% rely on religious faith and cultural approaches, respectively. These findings highlight the importance of integrating medical and cultural frameworks to improve acceptance of professional mental health treatments.



RECOVERY BELIEFS

Response	Frequency	Percentage
No	3421	63.61
Yes	1957	36.39

A pessimistic outlook on recovery prevails, with 63.61% of respondents doubting the possibility of recovery from mental health issues. This perception can discourage help-seeking behaviours, emphasizing the need for campaigns showcasing successful recovery stories to inspire confidence in treatment outcomes.

CONTAGIOUS MISCONCEPTION

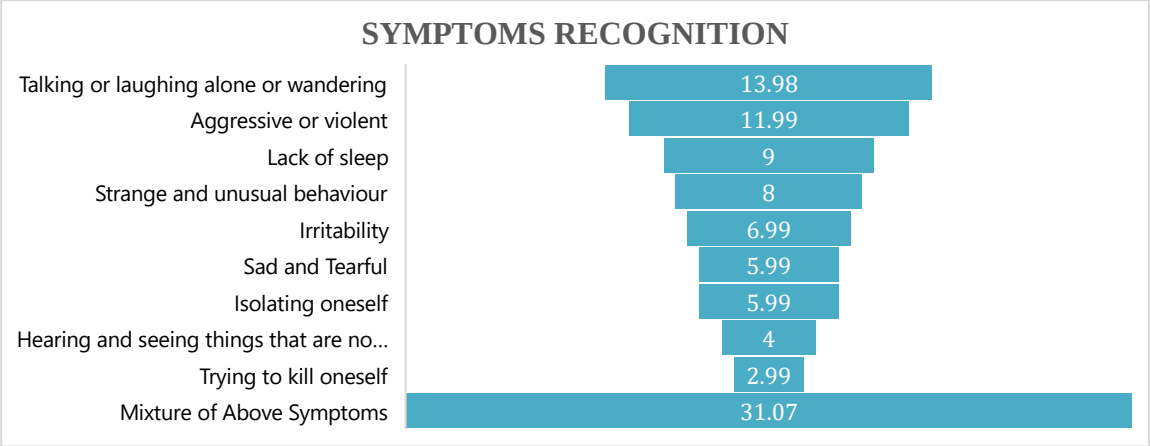
Response	Frequency	Percentage
Yes	3754	69.8
No	1624	30.2

A significant proportion (69.8%) of respondents believed that mental illnesses are contagious. This misconception reinforces stigma and contributes to social isolation for affected individuals. Public education is essential to dispel such myths and promote inclusive behaviours.

SYMPTOMS RECOGNITION

Response	Frequency	Percentage
Talking or laughing alone or wandering	752	13.98
Aggressive or violent	645	11.99
Lack of sleep	484	9.0
Strange and unusual behavior	430	8.0
Irritability	376	6.99
Sad and Tearful	322	5.99
Isolating oneself	322	5.99
Hearing and seeing things that are not there	215	4.0
Trying to kill oneself	161	2.99
Mixture of Above Symptoms	1671	31.07

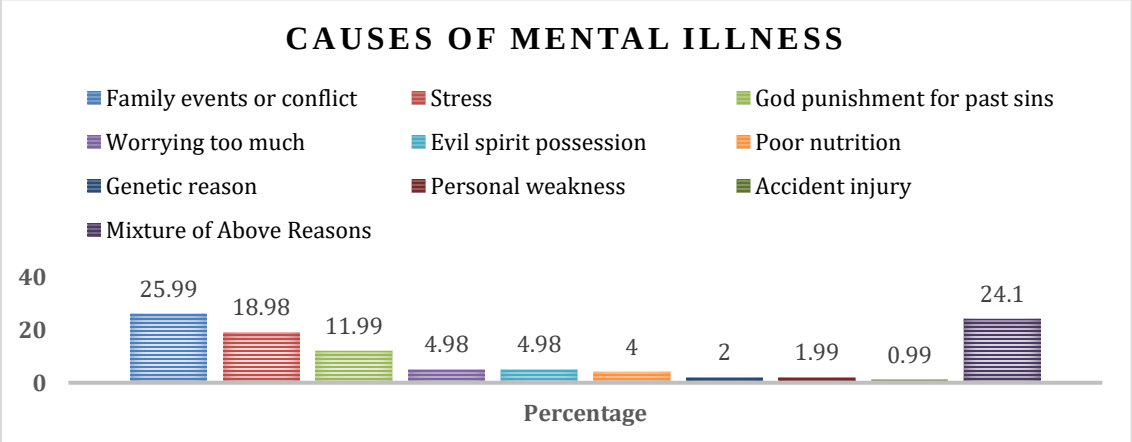
A wide variety of symptoms were recognized by respondents, with "Mixture of Symptoms" (31.07%) being the most common response. Specific symptoms such as wandering (13.98%), aggression (11.99%), and lack of sleep (9.0%) were also noted. These findings suggest a moderate level of symptom awareness but highlight the need for targeted education to improve the accuracy of recognition.



CAUSES OF MENTAL ILLNESS

Response	Frequency	Percentage
Family events or conflict	1398	25.99
Stress	1021	18.98
God punishment for past sins	645	11.99
Worrying too much	268	4.98
Evil spirit possession	268	4.98
Poor nutrition	215	4.0
Genetic reason	107	2
Personal weakness	107	1.99
Accident injury	53	0.99
Mixture of Above Reasons	1296	24.1

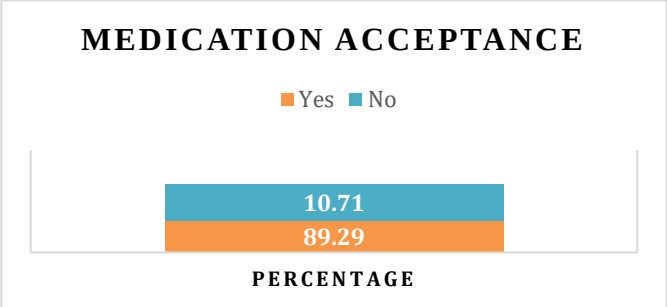
The perceived causes of mental illness include family conflicts (25.99%) and stress (18.98%), alongside misconceptions such as divine punishment and supernatural causes. This highlights the importance of addressing these beliefs while emphasizing scientifically backed causes to improve understanding.



MEDICATION ACCEPTANCE

Response	Frequency	Percentage
Yes	4802	89.29
No	576	10.71

High levels of medication acceptance (89.29%) reflect a positive attitude towards professional treatment. This strong foundation can be leveraged to improve adherence to prescribed treatments and foster trust in medical interventions.



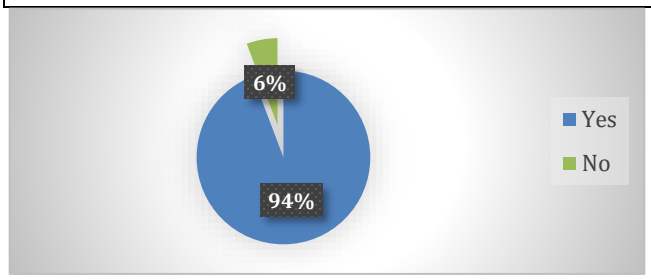
HOME MANAGEMENT

Response	Frequency	Percentage
No	4070	75.68
Yes	1308	24.32

Most respondents (75.68%) thought that mental health issues can not be managed at home, reflecting a lack of family involvement in patient care. Promoting family-based interventions and equipping families with basic caregiving skills could significantly improve patient outcomes.

FAMILY ISSUES AS TRIGGERS FOR MENTAL ISSUES

Response	Frequency	Percentage
Yes	5068	94.24
No	310	5.76



An overwhelming 94.24% of respondents identified family issues as triggers for mental health problems. This finding highlights the critical role of family dynamics in mental health and the need for family-focused intervention programs.

FAMILY STIGMA

Response	Frequency	Percentage
Yes	4389	81.61
No	989	18.39

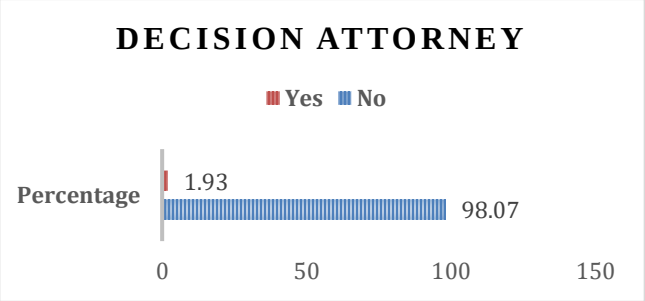
Family stigma (Stigma and shame associated with having a family member diagnosed with a mental illness) remains a significant factor, with 81.61% acknowledging its presence.

This stigma not only affects the patient but also deters families from seeking timely help. Addressing familial stigma through targeted campaigns is essential for holistic mental health support.

DECISION ATTORNEY

Response	Frequency	Percentage
No	5274	98.07
Yes	104	1.93

Nearly all respondents (98.07%) reported no delegation of decision-making authority to psychiatric patients regarding mental health treatments. Promoting shared decision-making practices can empower families and improve patient outcomes by fostering collaboration.



FEAR OF INTERACTION WITH THE PATIENT

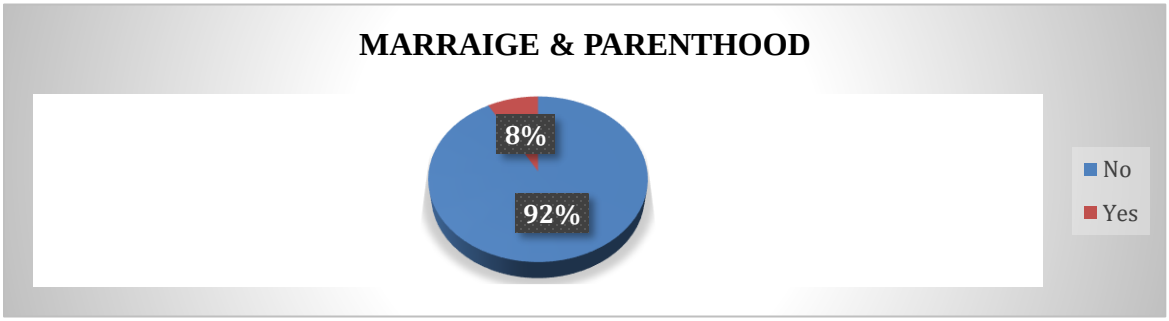
Response	Frequency	Percentage
Yes	4745	88.23
No	633	11.77

Fear of interacting with mental health patients was reported by 88.23% of respondents, reflecting a significant barrier to social acceptance. Normalizing such interactions through public awareness programs can reduce this fear.

MARRIAGE AND PARENTHOOD

Response	Frequency	Percentage
No	4937	91.8
Yes	441	8.2

About 91.8% of respondents believed that mental health issues affect marriage or parenthood, so patients with mental health issues should not marry and be the parent.



SHAME OF HAVING RELATIVE PATIENT

Response	Frequency	Percentage
Yes	3504	65.15
No	1874	34.85

A considerable proportion (65.15%) of respondents reported feeling shame regarding relatives with mental health issues. This familial stigma must be addressed through culturally appropriate education and community dialogue to foster acceptance.

MENTAL HEALTH IS EQUALLY IMP AS PHYSICAL HEALTH

Response	Frequency	Percentage
Yes	5378	100.0

Encouragingly, all respondents (100%) agreed on the equal importance of mental and physical health. This consensus provides a robust foundation for advocating for increased investment in mental health infrastructure and services.

REFERRAL OF PATIENT TO CONSULTANT

Response	Frequency	Percentage
Yes	4517	83.99
No	861	16.01

A positive finding is that 83.99% of respondents support referring patients to professional consultants, indicating trust in professional mental health services. Leveraging this trust can encourage earlier intervention and diagnosis.

ACCOMPANYING PATIENT TOWARDS CONSULTANT

Response	Frequency	Percentage
No	3012	56.01
Yes	2366	43.99

Only 43.99% of respondents accompany patients to consultations, reflecting a lack of practical support. Family involvement in the treatment journey must be prioritized to ensure consistent care and emotional support for patients.

COMMUNITY DEMORALIZE PATIENTS

Response	Frequency	Percentage
Yes	4678	86.98
No	700	13.02

A significant majority (86.98%) perceive that communities demoralize mental health patients, exacerbating stigma and social exclusion. Community-level interventions should aim to foster supportive environments for affected individuals.

FEAR OF CONFIDENTIALITY BREACH

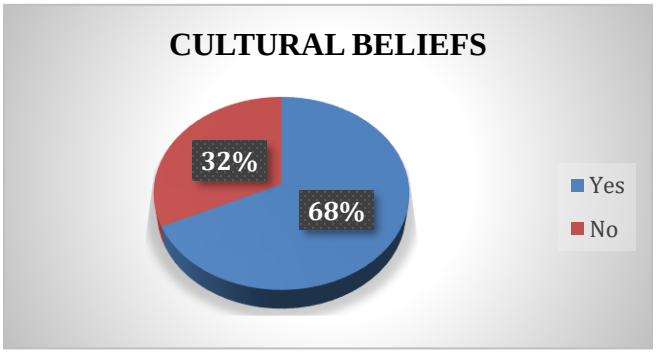
Response	Frequency	Percentage
Yes	4087	75.99
No	1291	24.01

Concerns about confidentiality breaches were reported by 75.99% of respondents, highlighting a critical barrier to help-seeking. Strengthening privacy protocols and assuring patients of confidentiality can build trust in mental health services.

CULTURAL BELIEFS

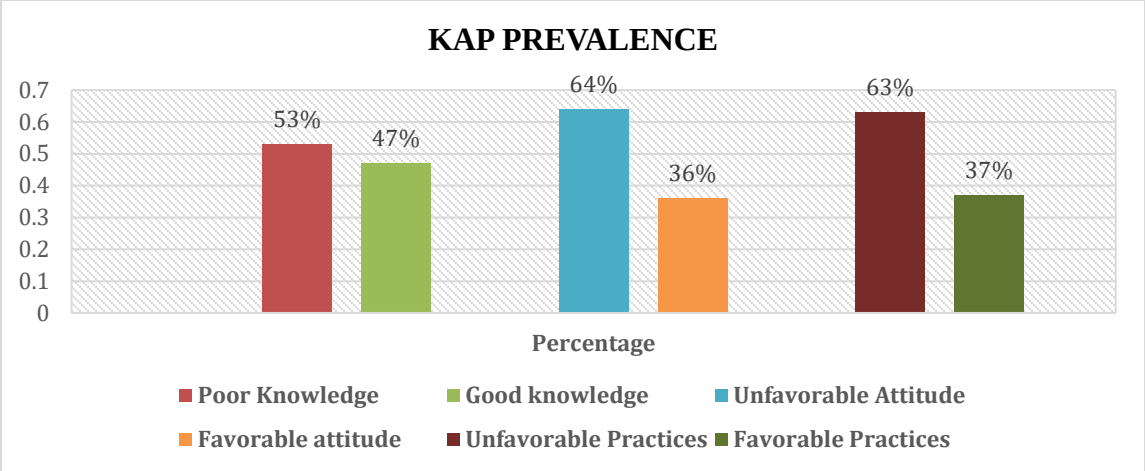
Response	Frequency	Percentage
Yes	3657	68.0
No	1721	32.0

Cultural beliefs influence mental health perceptions for 68% of respondents, emphasizing the importance of culturally sensitive approaches in awareness and treatment programs to ensure community acceptance.



PREVALENCE OF POOR KNOWLEDGE, UNFAVORABLE ATTITUDE AND PRACTICES TOWARDS MENTAL HEALTH

Variable		Percentage
KNOWLEDGE		
	Poor Knowledge	53
	Good knowledge	47
	TOTAL	100
ATTITUDE		
	Unfavorable Attitude	64
	Favorable attitude	36
	TOTAL	100
PRACTICES		
	Unfavorable Practices	63
	Favorable Practices	37
	TOTAL	100



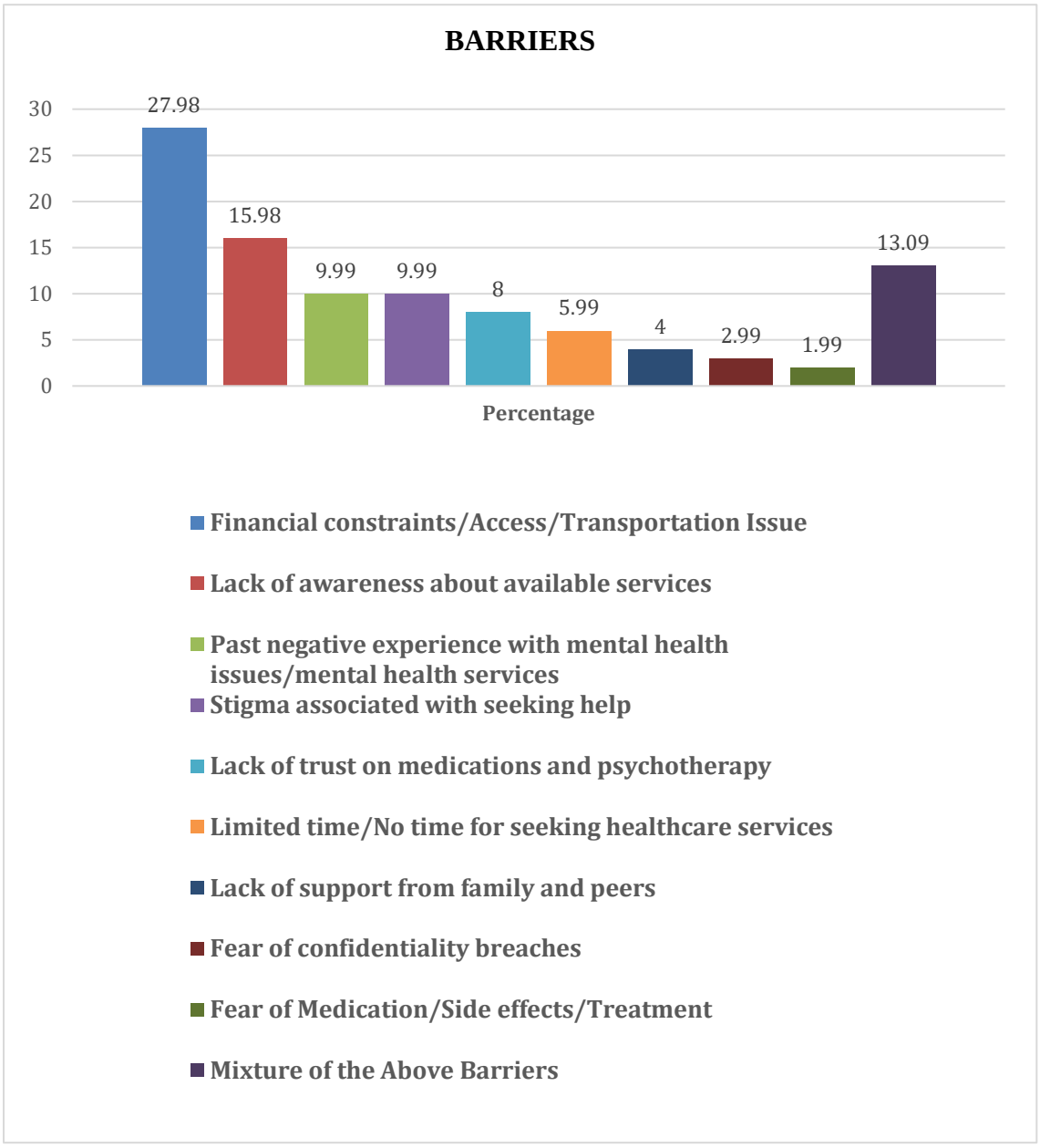
The above chart highlights the prevalence of Knowledge, Attitude, and Practices (KAP) among the population. It shows that 53% have poor knowledge, 64% demonstrate an unfavorable attitude, and 63% exhibit unfavorable practices, whereas 47%, 36%, and 37% show good knowledge, favorable attitude, and favourable practices, respectively. These findings indicate a need for targeted interventions to improve knowledge, foster favorable attitudes, and promote better practices.

BARRIERS TO SEEK MENTAL HEALTH SERVICES

Response	Frequency	Percentage
Financial constraints/Access/Transportation Issue	1505	27.98
Lack of awareness about available services	860	15.98
Past negative experience with mental health issues/mental health services	537	9.99
Stigma associated with seeking help	537	9.99
Lack of trust on medications and psychotherapy	430	8.0
Limited time/No time for seeking healthcare services	322	5.99
Lack of support from family and peers	215	4.0
Fear of confidentiality breaches	161	2.99
Fear of Medication/Side effects/Treatment	107	1.99
Mixture of the Above Barriers	704	13.09

The data regarding barriers to mental health access in District Tharparkar reveals a multifaceted landscape of challenges. Financial constraints, access issues, and transportation difficulties emerge as the most significant obstacles, cited by 27.98% of respondents. This finding underscores the critical need for affordable and geographically accessible mental health services. Lack of awareness about available services, identified by 15.98%, indicates a gap in public knowledge, highlighting the importance of outreach and information dissemination. Negative past experiences with mental health services and stigma associated with seeking help, both at 9.99%, suggest that trust and perceptions of

mental health systems must be rebuilt through community engagement and evidence-based service delivery. Distrust in medications and psychotherapy (8%) and limited time for seeking care (5.99%) reflect systemic and individual-level barriers that hinder timely intervention. The lack of support from family and peers, reported by 4%, adds a social dimension to the barriers, pointing to the need for family-inclusive mental health initiatives. Additionally, fears of confidentiality breaches (2.99%) and side effects of medications (1.99%) further deter individuals from seeking help. A notable 13.09% cited a mixture of these barriers, demonstrating that interventions must be multifaceted, addressing financial, logistical, social, and cultural factors simultaneously to effectively improve mental health access in the region.



RECOMMENDATIONS

1. **Increase Mental Health Awareness and Reduce the Stigma**
   Launch awareness campaigns across media platforms to educate the public and reduce stigma. Create culturally relevant materials to inform communities about mental health signs and treatments.
2. **Strengthen Mental Health Services**
   Expand mental health clinics and mobile units in underserved areas. Train local health workers to identify and refer individuals for proper care, offering tele-counselling for remote residents.
3. **Focus on Youth Mental Health**
   Introduce school-based counselling and mental health programs. Develop peer support networks to help youth manage stress, anxiety, and depression.
4. **Future Research**
   Future research to be done on drug dependence as well as genetic research.
5. **Increase Government and International Support**
   The government to write the World Health Organization (WHO) to establish Suicide Prevention Centre or Mental Illness Prevention Centre.
6. **Telepsychiatry Services**
   Telepsychiatry services should be extended in all THQ Hospitals of the District.
7. **Playgrounds and Indoor Games**
   Green areas and playgrounds for men and dedicated indoor games for women should be established.
8. **Address Socio-Economic Stressors**
   Implement poverty reduction initiatives to improve access to food, water, and housing. Support agricultural projects and disaster relief to reduce the impact of droughts and economic strain.
9. **Combat Domestic Violence and Social Issues**
   Launch programs to prevent domestic violence and support survivors. Strengthen legal protections and ensure better access to social services for vulnerable individuals.
10. **Build Local Capacity**
    Provide mental health training for healthcare providers in rural areas. Engage community leaders and educators to promote mental health awareness and support in local communities.
11. **Promote Community-Based Support Systems**
    Create local mental health support groups to encourage community solidarity. Involve religious and community leaders in spreading awareness and providing support.

12. **Improve Legal and Policy Framework**
    Advocate for the decriminalisation of suicide and introduce preventive measures. Develop a tailored provincial mental health policy addressing Tharparkar's unique needs.
13. **Enhance Collaboration and Partnerships**
    Foster partnerships between the government, NGOs, and international organizations to strengthen mental health services. Encourage multi-sectoral approaches involving health, education, and welfare sectors.
14. **Culturally Sensitive Approaches**
    Integrate indigenous knowledge and cultural practices into mental health care. Train professionals to offer care that respects local values and traditions.

CONCLUSION

This research highlights the significant mental health challenges faced by the residents of Tharparkar, exacerbated by cultural misconceptions, stigma, and limited access to care. Despite some awareness of mental health issues, the study reveals a general lack of knowledge, with many residents attributing mental illness to supernatural causes or past sins. Pessimistic views on recovery and widespread misconceptions, such as the belief that mental illnesses are contagious, further hinder treatment-seeking behaviors. Financial constraints and a lack of awareness about available services remain major barriers to accessing mental health care. The study underscores the urgent need for targeted mental health awareness campaigns, culturally sensitive education, and improved mental health services to reduce stigma, increase knowledge, and ensure better access to care for the people of Tharparkar.

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PICTORIAL GALLERY

RESEARCH-RELATED MEETINGS AND DISCUSSIONS WITH STAKEHOLDERS

MENTAL HEALTH AWARENESS AND RESEARCH ORIENTATION SESSIONS






DIAMOND HOTEL
empowering
women
enhancing
care


DIAMOND HOTEL

KEYNOTE SPEAKERS

WHOM TO CONTACT FOR QUESTIONS OR COMMENTS ABOUT RESEARCH?

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DISCLAIMER

SOCIAL MEDIA EXISTENCE OF SINDH MENTAL HEALTH AUTHORITY

WEBSITE	https://smha.sindh.gov.pk/
FACEBOOK	https://www.facebook.com/smha.gov.9/
YOUTUBE	Sindh Mental Health Authority
X	https://twitter.com/SindhMental
EMAIL ID	info.smha@sindh.gov.pk smha.gov.org@gmail.com
PHONE NO	021-35308771, 72, 73, 74
HELPLINE	021 111 117 642 021 992 157 20 022 111 117 642

ANNEXURE-1 (QUESTIONNAIRE)

تحقيقي سوالنامو

ضلع ٹرپارکر جي رهواسين م ڈهڻي صحت بابت جاڻ، رويو ۽ عملن بابت سوالات

DEMOGRAPHIC VARIABLES

تاريخ: / /2024 **سيريل نمبر:** _____

يونين کائونسل ۽ تعلقو: _____ **:عمر (سال)** _____

:تعليمي پس منظر

a. پرائمري
b. سيڪنڈري
c. گريجوئيٽ
d. پوسٽ گريجوئيٽ
e. غير تعليم يافته

:ازدواجي حالت

a. غير شادي شده
b. شادي شده
c. بيوه
d. طلاق ٿيل

:جيڪڏهن شادي شده ته بارن جو تعداد a. به يا ان کان گهٽ b. ٽي يا وڌيڪ

:پيشو

a. گهربلو عورت
b. حڪومتي ملازم
c. خانگي ملازم
d. خود روزگار
e. بيروزگار

:نسل ۽ ذات

a. ذات ,مسلم _____
b. ذات ,هندو _____
c. ذات ,عيسائي _____
d. ٻيا _____

:سماجي ۽ اقتصادي حيثيت/ماهوار آمدني

a. 15 هزار کان گهٽ
b. 15 هزار کان 25 هزار تائين
c. 25 هزار کان 45 هزار تائين
d. 45 هزار کان وڌيڪ

ذاڻي تجربو

1. **جا توهان کڏهن کنهن ڈهڻي مريض سان ملاقات کئي آهي؟**	a. ها b.نه
2. **جا توهان کڏهن کنهن ڈهڻي مريض سان ڳالهايو آهي؟**	a. ها b.نه
3. **جا توهان کڏهن کنهن ڈهڻي مريض سان کم کيو آهي؟**	a. ها b.نه
4. **جا توهان کنهن ڈهڻي مريض جي سنڀال کنڊڻ آهيو؟**	a. ها b.نه

جاڻ

1. **جا ڈهڻي بيمارين طبي بيمارين جو هڪ قسم آهن؟**	a. ها b.نه
2. **جا ڈهڻي بيمارين وبائي آهن؟**	a. ها b.نه
3. **جا شديد ڈهڻي بيماري وارا ماڻهو مڪمل طور ٺي صحتياب ٿي سگهن ٿا؟**	a. ها b.نه
4. **جا اڪيلائي م جڏن ڈهڻي بيماري جو علاج آهي؟**	a. ها b.نه

5. **ڈهڻي بيماري جون کهڙا علامتون آهن؟**

a. - جڙجڙاين
b. - اڪيلائي م گهاڻ يا ڪڻ
c. - هيڏانهن هوڏانهن گهمڻ
d. - غير معمولي واقعو
e. - عجيب ۽ غير معمولي رويو
f. - زياده گفتگو
g. - غصو يا تشدد
h. - اهڙيون شيون ڏسڻ ۽ ٻڌڻ جيڪي اصل م موجود نه هجن
i. - نند جي کوٽ
j. - خودڪشي جي ڪوشش
k. - ٻاڻ کي الڳ ڪرڻ

6. **جا عمر رسيده ماڻهن م ڈهڻي بيمارين ٻيدا ٿي سگهن ٿيون؟**	a. ها b.نه
7. **جا بارن م ڈهڻي بيمارين ٻيدا ٿي سگهن ٿيون؟**	a. ها b.نه
8. **جا ڈهڻي بيمارين مرد ۽ عورت بنهي م ٻيدا ٿي سگهن ٿيون؟**	a. ها b.نه

9. **جا هيئين مان ڪو ڈهڻي بيماري جو سبب ٿي سگهي ٿو؟**

a. - موروثي/ جينيٽڪ سبب
b. - پريشاني
c. - حادثاتي زخمي
d. - دماغي فنڪشن جي غير معمولي حالت
e. - خانداني واقعا يا تڪرار
f. - شادي م تڪرار
g. - گهٻي ڳٽي
h. - نيرو ٽرانسميٽر جي عدم توازن
i. - ماضي جي گناهن جي سزا
j. - جنات جو ٿڙيري روح جو قبضو
k. - ذاڻي ڪمزوري
l. - خراب غذا
m. - آلوده ماحول

10. **جا پروفيشنل مشورو ڈهڻي بيماري لاءِ اثرائتو علاج ٿي سگهي ٿو؟**	a. ها b.نه
11. **جا ڈهڻي بيماري جو علاج ٿي سگهي ٿو؟**	a. ها b.نه

12. **جيڪڏهن ها، ته کهڙو؟**

a. طبي
b. مڈهبي
c. روايتي

13. **جا دوائون ڈهڻي بيماري لاءِ اثرائتو علاج ٿي سگهن ٿيون؟**	a. ها b.نه
14. **جا ڈهڻي بيماري جو علاج ڈهڻي اسپتال م ٿين ٿيوجي؟**	a. ها b.نه
15. **جا ڈهڻي بيماري ڪي ڪامياب سان گهر م سنڀالي سگهجي ٿو؟**	a. ها b.نه
16. **جا ڈهڻي بيماري جو علاج ايمان جي شفا ڏيندڙن کان ڪرڻ ٿيوجي؟**	a. ها b.نه
17. **جا ڈهڻي بيماري ڪي شادي ڪرائن سان علاج ڪري سگهجي ٿو؟**	a. ها b.نه
18. **جا صحتياب ٿيل ڈهڻي مريض ڪي ڪارآمد طور ٿي ملازمت ڏئي سگهجي ٿي؟**	a. ها b.نه
19. **جا گهٽ معاشي طبقي/غربت سان تعلق رکندڙ ماڻهن م ڈهڻي بيماري جو خطرو وڌي ٿو؟**	a. ها b.نه

رويو

1. چا ڏهڻي بيماري وارن کي فيصلا ڪرن ڪان روڪن گهرجي، جيتوٿيڪ اهي روزاني معاملن سان تعلق رکن؟ a. ها b.نه
2. چا توهان ڏهڻي بيماري واري شخص سان گڏجهان ڪان ڏجندا آهيو؟ a. ها b.نه
3. جيڪڏهن مان ڏهڻي صحت جي بيماري سان متاثر هجان، ته مان ٿو چاهيان ته ماڻهو ان بابت جاڻن. a. ها b.نه
4. چا ماڻهو عام طور تي ڏهڻي بيماري وارن ماڻهن سان همدردي ڪندا آهن؟ a. ها b.نه
5. چا ڏهڻي بيماري وارن کي شادي ڪرن نه گهرجي؟ a. ها b.نه
6. جيڪڏهن شادي شده هجي ته ڏهڻي بيماري وارن کي بارن کان روڪن گهرجي؟ a. ها b.نه
7. جيڪڏهن منهنجي خاندان ۾ ڪنهن کي ڏهڻي بيماري جي سڃاڻپ کڻي وئي آهي ته چا مان شرم محسوس ڪندس؟ a. ها b.نه
8. جيڪڏهن مان پنهنجي خاندان جي ڪنهن فرد يا پاڻ سان ڏهڻي صحت بابت پريشان آهيان، ته چا مان پنهنجي علاڻي جي ڄاڻڻ سان گڏجهائن ۾ آرام محسوس ڪندس؟ a. ها b.نه
9. چا ڏهڻي بيماري جو علاج ٿئو تي سگهي؟ a. ها b.نه
10. چا ڏهڻي بيماري وارن مان اڪثر ماڻهو صحتياب ٿين ٿا؟ a. ها b.نه
11. چا ڏهڻي بيماري جو علاج اسپتال کان ٻاهر تي سگهي ٿو؟ a. ها b.نه
12. چا مان ڏاڻي مسئلن بابت گڏجهائن ۾ آرام محسوس ڪندس؟ a. ها b.نه
13. چا مان سنگين جذباتي مسئلي جي صورت ۾ پيشه ورانه مدد لاءِ وڃندس؟ a. ها b.نه
14. چا مان شرم محسوس ڪندس جيڪڏهن منهنجا دوست جاڻن ته مان هڪ جذباتي مسئلي لاءِ پيشه ورانه مدد حاصل ڪري رهيو آهيان؟ a. ها b.نه
15. چا توهان يقين رکو ٿا ته ڏهڻي صحت جسماني صحت جيتري اهم آهي؟ a. ها b.نه

عمل

1. چا توهان ڪڏهن پنهنجي ڏهڻي صحت لاءِ پيشه ورانه مدد طلب ڪئي آهي؟ a. ها b.نه
2. چا توهان ڪنهن ڏهڻي بيماري وارن کي پيشه ورانه مدد لاءِ صلاح ڏيو ٿا؟ a. ها b.نه
3. چا توهان ڪنهن ڏهڻي بيماري وارن کي ايمان جي شفا حاصل ڪرڻ لاءِ صلاح ڏيو ٿا؟ a. ها b.نه
4. چا توهان کي لڳي ٿو ته توهان جي علاڻي چا ماڻهو ڏهڻي بيمارين کي لعنت سمجهن ٿا ۽ انهن کي لڪائين ٿا؟ a. ها b.نه
5. چا توهان جي ڪميونٽي ڏهڻي بيمارين سان متاثر ماڻهن کي نااميد ۽ حوصلو شڪني ڪري ٿي؟ a. ها b.نه
6. چا توهان ڪنهن ڏهڻي بيماري وارن شخص جي ڳالهه بڌڻ لاءِ تيار آهيو؟ a. ها b.نه
7. چا توهان ڪنهن ڏهڻي بيماري وارن کي مدد حاصل ڪرڻ لاءِ همٿائڻ ۾ مددگار آهيو؟ a. ها b.نه
8. چا توهان ڪنهن ڏهڻي بيماري وارن کي مدد حاصل ڪرڻ لاءِ سائس گڏ وينڊو؟ a. ها b.نه
9. چا توهان ڪڏهن ڏهڻي صحت جي آگاهي واري ورڪشاپ يا ليڪچر ۾ شريڪ ٿيا آهيو؟ a. ها b.نه

رڪاوٽون

توهان جي خيال ۾ ڏهڻي صحت جون خدمتون حاصل ڪرڻ ۾ ڪهڙيون وڌيون رڪاوٽون آهن؟

a. موجود خدمتن بابت آگاهي جي کوٽ -
b. مالي تنگي -
c. مدد ونڊ سان لاڳاپيل بدنامي -
d. رسائي/ٽرانسپورٽ جا مسئلا -
e. ٻولي جون رڪاوٽون -
f. ثقافتي فرق -
g. دوا/سائيڊ ايفيڪٽس/علاج جو ڊپ -
h. دواڻون ۽ نفسياتي علاج تي اعتماد جي کوٽ -
i. خاندان ۽ دوستن کان مدد جي کوٽ -
j. رازداري -
k. ڏهڻي صحت جي مسئلن/ڏهڻي صحت جي خدمتن سان ماڻهن جا منفي تجربا

Name of the Respondent (Optional)	Signature (Thumb impression)
Name of the person taking consent	Signature
Name of the Principal Investigator	Signature

Karoonjhar: Witness to Earth's Ancient History – Estimated at 3.5 Billion Years Old, a Timeless Geological Marvel Studied by Dr. M.H. Panhwar

Jain Temple is around 1000 years old