Resource Enhancement of all Stakeholders in Community Mental Health and Development Programme
7th Quarter Review Report (October – December 2009)

Introduction

To review the progress of the last quarter and chalk out plans for the next, a meeting was organized at Bhawanipatna, Kalahandi (project area of partner organization, DAPTA) on 21st and 22nd December 2009. Project staffs of nine partner organizations and Programme Officer, Basic Needs-North India, Coordinator and the Data Manager- Orissa programme were a part of this review.

The first day of meeting focused on review of the activities. Each organization presented both quantitative and qualitative achievements concerning the project activities during the last quarter (October- December) along with the challenges faced. The sharing by a clinically stable Person with Mental Illness and her caretaker was an exclusive experience as it revealed the problems and challenges faced by the caretaker in the process of treatment and recovery. Although it was planned to present the month and week wise advocacy action plan, due to time constraint it was shifted to Day 2.

The second day included preparation and presentation of the action plan for the next quarter and discussion on obtaining information through RTI (Right to Information) Act.

1. Summary:

With the completion of the 7th quarter the project has taken a tangible shape in terms of identification of Persons with Mental Illness (PWMIs). A total number of 1765 PWMIs have been identified with 1082 male and 683 female (please refer to Chart 1 for quarter-wise total identification). The percentage of female identification is 38.69% out of the total identified till date. In this quarter specifically, 329 PWMIs are identified out of which 188 are male (58%) and 141 are female (42%).

Treatment facilities are being provided at all the implemented districts either through government or with support from private practitioners. As a result, out of all identified, 51.61% i.e. 911 persons are availing treatment, in which 626 are male and 346 are female (please refer to Chart 2 for number of PWMIs availing treatment). However, in terms of regularity in treatment (please refer to Chart 3 for number of PWMIs availing treatment at a regular basis) variation can be seen among organizations, which is varying from 0.5% to 47%. 188 persons are stable including 108 male and 80 female out of all under treatment.

The programme is being implemented in 7 districts; however some parts of other 3 districts are also covered as project areas of a partner organization. Total number of 41 blocks, 7 Municipalities and 1 NAC (Notified Area Council) been covered by 1140 villages, 77 urban slums. Under the programme head till date total no. of 56 PWMIs are provided with the livelihood support loan (please refer to Quantitative report). Through efforts of partner organizations 27 PWMIs (13 male and 14 female) and families are benefited through various government livelihood and other schemes. Besides this, 168 persons (103 caregivers and 65PWMIs) are included into Self Help Groups.

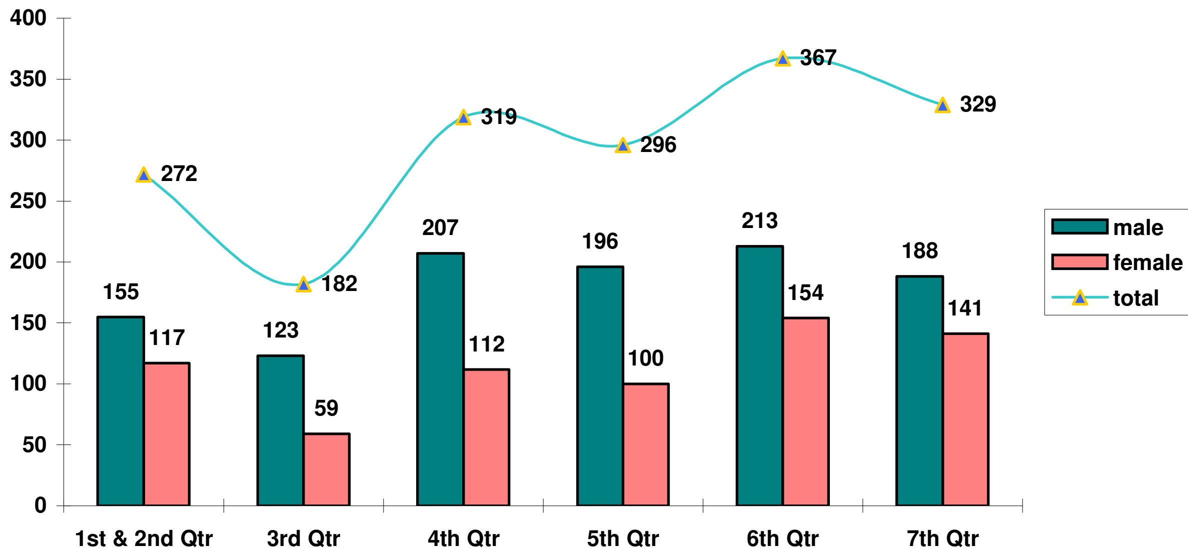
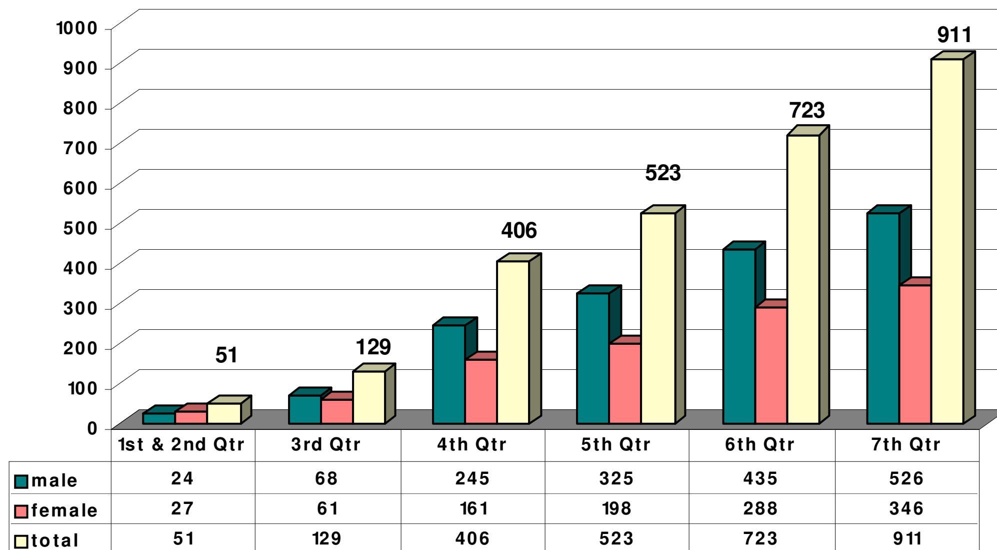


Chart 1: Quarter wise detail of PWMIs identified



	1st & 2nd Qtr	3rd Qtr	4th Qtr	5th Qtr	6th Qtr	7th Qtr
male	24	68	245	325	435	526
female	27	61	161	198	288	346
total	51	129	406	523	723	911

Chart 2: Total no. of PWMIs under treatment

Regularity in treatment

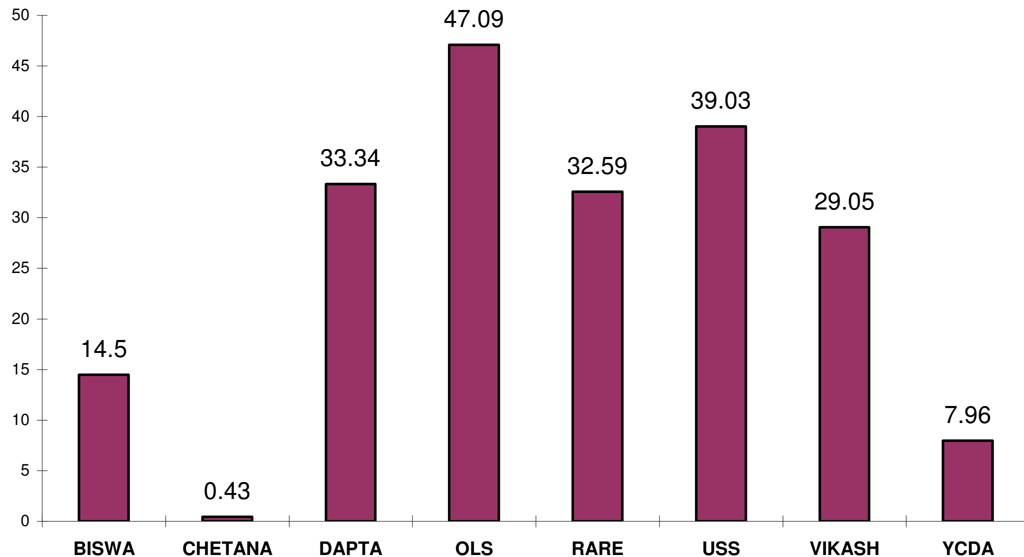


Chart no-3: % of regular under treatment with respect to total identification till November 2009

Partner organizations like OLS, DAPTA and RARE are leading in providing regular treatments (please refer to Chart 3), yet they have not been able to touch the benchmark of 65%. The major causes behind this are lack of family counseling and community sensitization. Organisations like CHETNA and YCDA are falling far behind due to irregular follow up and lack of rapport building with community.

By the end of this quarter almost all the organizations managed to provide treatment services through government and private psychiatrists. Two organizations BISWA and USS are accessing services of government psychiatrists with the availability of medical colleges in their areas and rest of the organizations are still relying on private psychiatrists who are available during camps once in a month.

Out of all the implemented districts four districts are coming under either DMHP or are having Medical College Hospitals. Apart from Cuttack, in no DMHP implemented districts treatment services and allied facilities are available. As the concerned authorities in the DMHP implemented districts are not submitting the UC (Utilization Certificate) regularly, new medicines are not issued by the NMHP. In the meantime it is known that 10 new districts are going to have DMHP implemented in the near future.

2. Background of the Project:

Worldwide it is estimated that one quarter of the population is affected by mental and behavioral disorders at some time during their lives. In most of the communities, PWMIs experience stigma, discrimination, human rights abuse and destitution. Adding to the misery most of the countries are not equipped with infrastructure and manpower to counter the mental health issues. So is India.

Though there are 42 mental hospitals across India, but still many states doesn’t have a single of it. Orissa is one such state. Under resourced manpower, meager funding support, lack of effective policies shows that government is not serious about the issue.

To address these needs BasicNeeds India designed a Community Mental Health and Development model emphasizing issues of access to treatment, inclusion & dignified life, livelihoods, human rights and development. The model is delivered in partnership with community based organizations and nongovernmental organizations. In the whole process, BNI seeks to develop linkages with various governmental and nongovernmental organizations to sustain the changes. This approach is potentially of a lower cost – avoids travel to long distances, time and money of escorts etc.
The objectives of the model are

- To develop strategies to influence mental health policy development and the effective implementation of existing mental health and related legislations, programmes and schemes
- To strengthen communication and resource mobilization strategies
- To enhance access to quality care and improve the quality of life of PWMI and their caretakers

BNI with its partners has collected first hand data for preparation of a baseline document. Some partners have already furnished the data and for some it is under process.

3. Program Findings:

Based on the implementation of the programme after the completion of one year and nine months following have been the findings:

- Regular follow up to individual families has been a major challenge for the partner staff. Operational areas being vast and scattered, it becomes difficult to cover and communicate to all the identified PWMIs at a regular basis.
- Irregularity in treatment hampers the recovery
- Family members are not keen for contributing in treatment process
- Improper intake of medicines due to gap in orientation.
- Female staffs are facing problems in moving to remote places (in western side of the state).
- Substance abuse has been found out to be a major cause leading to mental illness and affecting treatment as well (in eastern side of the state)
- Over dependence on private psychiatrists creating problem in organizing camps at regular basis.
- Internal problem of the organization delimiting the project staffs action.
- Communication gap is prevailing within the project staff and organization heads and vice versa
- Community sensitization is low
- Destitution is always on the rise in holy places like Puri and Konark (project areas of OLS and VIKASH).
- Non-availability of medicines at DMHP implemented hospitals due to government procedure of audit and requisition is delaying the process.
- Acute poverty across the districts restricting families to provide better care to PWMIs.
- PWMIs are unable to avail certificates (Disability Certificate) due to non-availability of psychiatrists in district hospitals. Mental illness as a type of disability is not mentioned in the certification form.
- Even if the number of Women With Mental Illness (WWMI) is substantially high, the identification of them is abysmally low. Due to cultural barriers and negligence towards women identification process is hampered. Women are mostly affected by minor mental disorders, but being confined it becomes difficult to identify.
- The district administration is not paying due attention nor taking any interest in addressing Mental Health issue.

3a. Fulfillment of Objectives

With the completion of one year and nine months a total of 1765 persons have been identified including 1082 male and 683 female. Out of the total identified persons 911 persons are availing treatment, which is 51.61% in which 626 are male and 346 are female. Treatment camps are more or less being regularized at all the partner places by taking help from DMHP and private psychiatrists. Medicines are provided by hospitals at very few places and other requirements are met out under project budgetary provisions. As a result, 188 persons have shown sign of improvement and with doctors advise, some have also stopped medication being stable.

This quarter has significantly contributed to the capacity building of BNI staff, staff of partner organization and community level volunteers. With various training programmes like documentation training, volunteer orientation training the partner staffs are being execute more efficiently. On the other hand, the formation of a pool of community volunteers to support the programme marks the capacity building of the community.

Along with the support for treatment process the livelihood opportunity is being enhanced by the project with interest free revolving loans to PWMIs and families. Till date 56 numbers of families have been supported with this loan, which has helped them to earn their livelihood. Besides, 27 persons are benefiting from rehabilitation schemes under government and non-government institutions as a result of proper linkages.

Advocacy, in this quarter has made a visible progress. Both district and state level advocacy has been initiated. An information seeking behaviour has been developed; partner staffs are using RTI to the full effect to obtain information concerning the treatment facilities for mental illness, certification, sanctioned amount under DMHP and expenditure over the year etc. The implementing partners have shown a sense of dynamism in contacting and mobilizing district authorities, and celebrating the World Mental Health Day in a much more relevant way. This year the celebration included sensitization programme at schools, colleges, community, involving government authorities unlike the celebrations of previous years, which were limited to distribution of tiffin packs and fruits amongst hospital inmates.

3b. Project Design and Implementation:

The project implementation process was designed after rounds of discussion with implementing partners. In those discussions, it was finalized that one field staff would directly implement ground level activities under the programme. He/she will identify people with mental illness, counsel them, motivate to come for treatment and follow up. Besides, he/she would also sensitize community on the issue of mental health. The field staff would report to the coordinator of the organization who would help him further fine-tuning of the project activities. The organization would report to the CMH Coordinator / Data Manager of BNI.

Though the implementation plan is designed after discussion with the partner organizations but the field staff at the same time is given authority to suggest changes in procedure keeping vision of the programme intact.

CMH coordinator and Data manager of BNI are responsible for field support and monitoring of the partners. They will visit to the partners and review their programme at field level as well as suggest ways for betterment of programme.

Programme Officer of BNI is also responsible for supporting the partners through CMH Coordinator and Data Manager as well as reviewing the whole programme at least once in quarter.

3c. Project Outputs and Dissemination:

This quarter has marked a difference in preparation of IEC materials by the partner organizations itself on CMHD project, which gives a holistic view of the project. USS has taken the initiative to commonly develop a poster for all, which can have multi purpose use. It can be used as an awareness material in public places and also for orienting volunteers and community. At the same time leaflets and hand notes are prepared by all the organizations on symptoms of Mental Disorders and misconceptions related to it. Wall paintings have also been made by some organizations.

Partners have played a key role in information dissemination though print and electronic media. Treatment camps and the problems related to mental health are now being covered regularly (on a monthly basis) at RARE, Sonepur through ETV. USS being centrally located at Cuttack is also taking initiative in publishing any information related to Mental Health through its own fortnightly newspaper 'Janamancha' in order to reach out to wider population and also to draw attention of government authorities.

Grass root advocacy has been initiated through formation of caretakers associations, self-help group formation by Persons With Disabilities (PWDs) by few organizations. Groups are oriented on their rights and govt. benefits. As a result, at some places, disability certification has been ensured.

This time quite enthusiastically, the partner staff motivated the reluctant district law unit for celebration of World Mental Health Day at each district and succeeded too.

Networking with Jana Swasthya Abhiyan (JSA)-Orissa was an important step taken in this quarter. JSA with its networking partners has agreed to spread the massage of mental health at district level and with the support of OVHA it will work at state level to bring policy level changes.

This year OVHA, the state advocacy partner has taken initiatives to organize network meeting and sensitization programme for General Practitioners.

3d. Capacity Building:

Capacity building being the corner stone of this project is given adequate emphasis. Under capacity building measures, training programme on documentation was organized. It focused on the importance of documentation as a project module, the training served to all intents and purposes with partner staff learning and reflecting the same in their practice.

Besides this, community and village level meetings are organised at a regular basis with participation of family members, Persons With Mental Illness, PRI members, SHG leaders, ASHA and Anganwadi members etc. with the aim to disseminate information regarding mental illness, reducing social stigma and discrimination with increased Community support in identification, follow up, livelihood support and social acceptance. Field consultation workshops are also initiated at some partners level.

As staff capacity building is concerned a first phase Training Of Trainers (TOT) was organized at Bangalore by CBR forum participated by BNI-Orissa staffs which focused on personal leadership development. The next phase training will cover on Mental Health topics.

4. Project Management Section:

This project emphasizes on a top to down and bottom to top approach. As far as the reporting of the field activity is concerned, it is bottom to top approach. The field coordinators report to the BNI staffs on the activities done and the financial report on monthly basis. Report of other activities in field is shared by the field staffs from time to time. Through BNI staffs a narrative report of the activities and financial report on monthly basis are shared with the PO, North, which is later, intimated to the Programme Director.

As far as the programme monitoring and evaluation is concerned, it is top to bottom approach. The Coordinator and the Data Manager regularly visit and evaluate the activities of the partner organizations on monthly basis. The Programme Officer also ensures the monitoring and evaluation through quarterly visits. Where as the field coordinators monitor the activities of the community volunteers. Sometimes basing on the project needs, the Programme officer visits the partner areas.

The smooth functioning of the project depends on time-to-time consultation of the BNI staffs (CMH Coordinator, Data Manager) with the field coordinators of the partner organizations and vice versa. Besides regular communication between programme officer, CMH coordinator and data manager through internet and phone supplements the process.

Quarterly meeting takes place both at the Head Office (Bangalore) and state office (Orissa) to review the activities of last quarter and plan for next quarter. Besides the review meetings, cluster meetings are also designed where smaller groups of partners could meet and review their programme. These cluster meetings happen once in between two quarterly reviews. The future course of actions is chalked out by the project staff based on the field needs.

As part of this quarterly review two separate action plans were developed by the project staffs. Alongside the regular quarterly plan, a week wise advocacy action plan for the next three months has been developed and shared. Extracts of the planning are:

1. Intensified advocacy at both levels will be made by implementing partners. Regular contact will be made with district administration and the related offices like CDMO, Collector for full-fledged implementation of DMHP, availing medicines and treatment services by contacting the concerned CDMOs.
2. At state level authorities like Director, Health and Nodal Officer, DMHP to be contacted for effective and full fledged implementation of DMHP.
3. Initializing discussion to avail support from DMHP to organize treatment camps at block level.
4. Discussion with CDMO and medical board to avail Psychiatrist for disability certification.
5. Emphasis to benefit from the government and non-government schemes/ facilities through Disability certification (e.g. disability pension, bank loans etc.)
6. All the organizations to ensure sending letter to the Chief Minister through fax on fourth Wednesday of every month mentioning the area specific issues of PWMIs along with their signatures.
7. Parent associations, self help groups formation to start pressure groups at grass root level .
8. Mobilization of fund at block level for PWMIs and for people having other types of disabilities. Besides Sarapanch and BDOs will be contacted to involve PWMIs under various schemes.
9. Proposal to Women and Child Development Department and Social Welfare Department for providing residential home for home less and destitute PWMIs.
10. Media coverage of treatment camps and important activities.
11. Proposal for funding support to different corporate houses, Red Cross, district administration for organizing treatment camps.
12. Taking help of RTI (Right to Information) Act to get information.

13. Contacting District Social Welfare Office (DSWO) to get information on various district level Poverty reduction schemes.
14. Orientation to other Staffs, community level volunteers like Anganwadi Karmis, ASHA workers, Trained Birth Attendants, Health Workers, youth group leaders, PRI members, Self Help Group leaders etc. for creating a strong pool of volunteers for future follow up.
15. Proper planning for regularizing follow up services.
16. Organise Field consultation workshop by parents, PWMIs, Community members and Field staffs.
17. More emphasis on repayment of earlier taken loam under the project head.

5. Impact:

After one year and eight months of the implementation, the project has taken a concrete shape. There have been a lot of challenges faced and gaps that need to be addressed. But indubitably, it has been able to make some impacts like:

- For the first time almost all the organizations celebrated World Mental Health day in an unified and different way. They have been influential in mobilizing Government and celebrating the day with a cause to sensitize public on Mental Health care.
- School and college students were sensitized on the issue through different competitions like essay, debate and painting.
- OLS with its continuous effort has ensured appointment of a Psychiatrist at District Hospital-Puri under DMHP.
- Information sought through RTI have been obtained, project staff have been encouraged and confident.
- Chetana at Bhubaneswar in consultation with Xavier Institute of Management has opened a website where the life histories and case studies of PWMIs will be uploaded.
- Community consultancy has increased in identification. Community, caregivers of PWMIs directly contact the organization staff to give information over phone or in person.
- Steps are being taken by the organizations to train volunteers on Mental Disorders, which at later stage will be beneficial for the project in terms of follow up and for community itself.

6. Overall Assessment:

With the end of seventh quarter, the project has taken definite shape where partners become more independent in conducting programmes like treatment camps, volunteer trainings with partial support from BNI. Now they are able to initiate the process of district advocacy after getting all sort of information from BNI. Though creating sustainable livelihood opportunity and poverty reduction requires more time especially in a state like Orissa but process has already been started by partners. Besides, few partner organizations have come solid and strong after facing the challenges met during project implementation, with newer strategies they have taken up advocacy both at grass root and policy level. Quite encouragingly one partner organization which was lagging behind has shown significant improvement.

However, at the state level advocacy is not very active and situation also continues over the second year of the project. A three-month's deadline was given to the State Level Advocacy Partner to improve on advocacy at state level. In case it fails to execute sincerely some decisive steps will be taken.

7. Recommendation:

Follow up visits: The need of regular follow up visit is strongly felt. Discontinuity and taking wrong dose of medicines has come to notice in most of the partner areas. Proper and individualized planning for regular follow up should be made which will be beneficial for staff to make quality follow up in less time.

Community involvement and sensitization: To regularize the process of treatment community involvement and sensitization is necessary. Besides identification community has a major role to play in supporting, accepting and accessing the recourses available for the benefit of PWMIs and breaking stigma associated with the disease. Along with community, family members, PRA members, SHG members and other stake holders associated should be sensitized through different programmes like meetings, individual home visits through time to time. Different communication channels should be used for different group of population.

Advocacy: Rigorous advocacy should start at both the levels. People centered grass root level advocacy through formation of associations and federations is required where the voice of affected people will be more effective in bringing about change. At the same time State level advocacy is required to bring about policy level changes.

Networking: There is a strong need felt to be united in a single platform to discuss issues of common interest and to take action. For this purpose a district and state level networking is strongly felt which will influence the government to bring policy level changes.

Capacity building: Capacity building of community level volunteers is the immediate need of the project. Providing follow up services through individual home visits is the base of the programme. As the project is growing in terms of increase in numbers of PWMIs and due to scattered geographic regions, it is factually impossible to cover all the identified persons with limited number of project staffs. Strong orientation to community volunteers like ASHA, Anganwadi Karmis, Health Workers, youth group leaders, PRI members Self Help Group leaders, parents support groups should be provided who will make quality follow up.

Documentation: Being the integral part of the project, documentation needs to be given special emphasis. At a period like now, it is of immense importance for usage in advocacy and also for future reference during planning.