MID-TERM MID-TERM EVALUATION REPORT (MARCH 2015)

Community Mental Health Programme, SHARE PROJECT

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EXECUTIVE SUMMARY

Context and Background

The introduction of India's first ever Mental Health Policy in 2015 indicates the recognition of the issue in the country after years of struggle. With this positive change at the policy level, a need for a multi-sectoral collaboration and an inter disciplinary coordination is therefore the need of the hour.
With rampant malnutrition, diarrhoea and common childhood illnesses, the statistics of Uttar Pradesh only reveals the poor and dismal health scenario of the state. There is little or no data on the Mental Health situation in the state which shows the need for an immediate intervention in the aforesaid issue.
The SHARE Project (Service for Health and Rural Education), an organization in the Seohara block in Bijnor in UP, has been working relentlessly in promoting good health, with a special focus on 'mental health' since 2013-14.
With the goal to '***promote positive mental health and resilience among people in Seohara Block, by building on resources in the communities'***, the following are the objectives of the Community Mental Health Program by SHARE:-

- *Strengthen government primary mental health services of 3 CHC/PHC of Seohara block by end of 3 years.*
- *Empower People Living with Mental Disorders (PLWMDs) and their families with skills and knowledge for mental health,*
- *To increasing mental health (knowledge & skills-emotional resilience program) and resilience among adolescents in colleges/school and community levels.*
- *Strengthen the 50 CBOs of Seohara block to increase skills in mental health literacy, first aid and positive mental health.*
- *To improve the reach, visibility and effectiveness of RNTCP through SHARE Society support in 2 districts- Bijnor & Moradabad.*

The program has been running successfully for around 2 years now and a mid -term evaluation of the same has been conducted to understand the progress and shortcomings in it. The aim is to also provide suitable recommendations for the next phase of the program.

The scope, approach and methodolgy of the evaluation

The mid term evaluation has been conducted by Ms. Gracy Andrew, Ms.Poorvaja Kumar and Dr. Sunita Varghese. The fieldwork included visits to the organisation, the villages where SHARE Project is operating and discussions with stakeholders at community, organisation and Government level. The team visited the field between the 13th to 15th of March 2015 followed by the in-depth assessment of findings documented in the following the evaluation report during the same month. The scope of the study includes the following: -

a. Studying all the components under the Community Mental Health programme of SHARE Project.
b. Review of the functions of the Government Mental Hospital/CMO office and CHC/PHC.
c. Review and assessment of the project progress in relation to the set objectives and the overall goal.
d. Review of the progress made so far in terms of project implementation, and the financial and resource management.

Research methods and steps
a. **Preliminary meeting** b. **Secondary literature review** c. **Primary research** d. **Data review and report writing**
The tools used for the field-study
a. **Brief Interviews** b. **Focus Group Discussions** c. **Case-studies**
List of respondents
1. **People living with mental illness, Seohara** 2. **Caregivers of people living with mental illnesses.** 3. **Community members of Govindpur , Dhindarpur , Shahpur-Roorpur, Budanpur Shyamabaad village,Seohara** 4. **SHG/CBO members at Govindpur, Shyamabaad Shahpur-Roorpur, Budanpur and Dhindarpur village, Seohara** 5. **School teacher, Government Junior school, Seohara** 6. **ASHA and ANMs in Govindpur Shahpur-Roorpur, Budanpur and Dhindarpur village, Seohara** 7. **Anganwadi worker, Shahpur-Roorpur, Budanpur Shyamabad,Dhindarpur village, Seohara** 8. **Program Manager, SHARE Project** 9. **Staff, SHARE Project** 10. **Village Health Guide** 11. **CHC doctor, Seohara** 12. **Youth volunteers, school program on resilience**

The findings and observations

1. **Community and village profile :** The Seohara block of Bijnor district is quite complex and heterogeneous in terms of religious groups and caste distribution. The SHARE project focuses on the underprivileged minority groups belonging to the Muslim community and the schedule castes, who have little or no access to Government facilities. The Muslim communities engage in skilled jobs like handicrafts, tailoring, carpentry or weaving. The Hindus (SC) are mostly landless labourers who work on agricultural farms or rear livestock at home. Many villagers work as construction workers or at the brick kilns as brick moulders. The Muslims usually live in the semi-urban set ups or in the rural areas and the Hindu settlements are spread across the block. Poor levels of literacy, poor infrastructure , lack of access to health facilities and absence of alternative employment are some issues in the community.
2. **SHARE PROJECT: Staff composition**: The SHARE Project team comprises of a Project Manager and a Project Assistant at the higher level of the management. This is followed by community coordinators and volunteers at the field level. The village area is divided equally between the community coordinators. The Project Manager plays a significant role not only as a supervisor but also throughout the implementation process.
3. **Process and strategies of programme implementation**: After a detailed matrix study the organization chose to work on issues of Mental Health. The process followed by the organization is linear and stepwise, starting from awareness building to creating access to treatment. For the mental health programme, the first year was dedicated to staff training, awareness building, identification of persons living with mental disorders and reducing stigma. The strategy that SHARE has adopted is to get the patients and their caregivers from villages to come to Seohara on Friday,

where overnight accommodation is made available and on Saturday morning SHARE staff escorts all patients and their families to the Bareilly hospital. The organisation makes the overnight stay arrangements. The cost of transportation to Bareilly is borne by the patients and their accompanying member, however financial support is provided for those in need. People with mental illness receive free medication from the Govt. mental hospital Bareilly, this is the great help for poor & marginalized communities.

3.a Knowledge and awareness in the community: As per the programme document, the organisation has designed some IEC materials, engaged with stakeholders like ASHAs,CBOs and Anganwadi workers, Rural Health Care Providers (RHCPs) conducted discussions and meetings in the past and also engaged in home visits to make the communities aware of the issue. However gaps have been noticed in the knowledge and awareness within the community and among the stakeholders. There are cases where stigma and discrimination has reduced significantly especially in some cases of epilepsy and depression, but the negative attitude towards the severe mental disorders still exists. IEC materials and wall paintings have been designed and developed but their outreach has been poor. Home visits by SHARE staff and community referral has been most effective in getting people to access the mental health facility in Bareilly.

3.b Identification of persons with mental disorders (PLWMD): One of the primary activities for the organisation is of identifying persons with mental health issues from the community. For this purpose, the community coordinators use a 'quick tool' with preliminary questions that ascertain the illness/disorder. The Project Manager has developed this quick tool after referring to the standardised PHQ, psychiatric books and also after consultation with a few psychiatrists. This early assessment was conducted in 2013-14 in 223 identified 455 persons with common mental and 185 with severe mental disorder. The shortcoming of the current quick assessment tool is the possibility of large number of false positives, resulting in unnecessarily medication.

3.c Creating access to treatment: As per the records, out of the total identified patients of Epilepsy and mental illness, 121 are getting treatment for Epilepsy, 92 people for CMD and 52 people for SMD. The factors that impede the progress of the programme are the time and the cost involved in the process of treatment. The families who depend on daily wages face adverse financial repercussions by foregoing one day of work every 15 days. This leads to low adherence to the treatment.

3.d Strengthening networks and building rapport with the stakeholders : The organisation has effectively partnered with the existing stakeholders like ASHAs, ANMs, Anganwadi, RHCPs and CBOs.

However it was observed that the lack of adequate and continuous training among the aforesaid stakeholders poses to be a challenge. Community dynamics such as caste differences between the ASHAs and the community have also acted as a barrier in the programme.

3.d Training and Capacity building: The programme documents give significant importance to trainings at different levels but the discussions with the ANM, ASHA and CBOs indicate inadequacies in their understanding and knowledge about mental health. The CBOs had some knowledge on mental illness but did not report to have discussed such issues in their regular meetings. At the management and the staff level also, an the urgent need for training and capacity building was observed.

3.e Reporting and quality assurance: The staff of the organisation maintains various registers and forms to record the details of the patients and the activities conducted. Among these are the village wise patient history, the follow up register, the village wise CMD-SMD register, a daily dairy, the Bareilly hospital

register and weekly planning register for arranging transportation. Apart from these, the staff also maintains informal documents of patients and their progress. As per the discussions, the staff activities and registers are only monitored by the Project Assistant.

Keeping in view the findings and observations the following recommendations have been made *:*

1. Amendments and modifications need to be made to the CMD-SMD identification tool . This should be done under technical assistance from experts.
2. A cyclical approach needs to be adopted in programme implementation to maintain the continuity of each process.
3. A need for enhancing and strengthening the 'knowledge and awareness' activities like better coverage of IEC materials, usage of community radio, health camps is highly recommended.
4. The training of stakeholders at all levels (community, management and government) needs to strengthened.
5. The record needs to be maintained electronically and the quality assurance processes needs to be enhanced further by appointing second line management.
6. The organization a needs to monitor quality of training through feedback forms and also assess knowledge of participants after every training.
7. To enhance the access to treatment, the organisation needs to create access of medicines within Bijnor district.
8. Focusing on few mental illnesses that have high prevalence in the community will ensure effective implementation of the programme.
9. Village health camps are also recommended to ensure better coverage.
10. To overlook field level activities, second-line staff must be appointed. This will reduce the burden of the Project Manager , ensuring efficient delivery.
11. The organisation must adopt a participatory approach to ensure 'collective ownership' of the programme by the community. For this programme to be sustainable, the organization has to change its overall strategy and outlook and the entire team would also need be facilitated and trained to change their perspectives.

SECTION 1: CONTEXT AND BACKGROUND

INDIA: An overview of the health

Today, community development enjoys something of a revival worldwide (Craig and Mayo 2002)[1]. 'Health' is one of the most important indicators of community development considering the fact that the poorest of countries have the poorest of health (Campbell and Scott, 2009)[2].

While India today, is the world's third largest economy in terms of its Gross National Income (in PPP terms) and shows great potential for growth, gaps in health outcomes continue to widen (National Health Policy 2015 Draft)[3]. Needless to say that the scenario of illness, premature death and diseases is high in our country, the National Health Policy (2015) also highlights the severe inadequacies of the health systems to deliver at such a massive scale.

In 2014, the Planning Commission had constituted Steering Committees in order to identify and understand problems in the health sector of India[4]. The committee in its report recommended the need for improvement in varied issues from child mortality to malnutrition to other structural recommendations. One such recommendation was the urgent need to prevent and reduce of burden of communicable and non-communicable diseases -including mental illnesses[5].

Recognising the same, in a country where mental illness has been ignored for years in spite of its prevalence (6-7% for common mental disorders and 1-2% for severe mental disorders[6]), a comprehensive mental health policy had been long awaited.

While no significant improvement in the national health scenario was observed even till the turn of the millennium, one ray of hope that India experienced recently was the unveiling of the country's first ever mental health policy.

This policy calls for an increase in funds to provide those with mental illnesses, treatment that is affordable and accessible. Though, the implementation of the same is going to be tough and depends largely on the passage of the mental health bill that is pending in parliament, the policy also calls for a higher number of mental health professionals to be trained, from community-based NGOs/ counselors to specialized psychiatrists. A multi-sectoral collaboration and inter disciplinary coordination is therefore the need of the hour.

HEALTH SCENARIO: UTTAR PRADESH

As per Unicef, Uttar Pradesh, the most populous Indian state, about 380,000 of the children die before the age of five years, falling victim to malnutrition, diarrhoea, and common childhood illnesses. The state has also the largest population of socially excluded communities – scheduled castes, scheduled tribes and other so-called "backward castes" – and several indicators of health, nutrition and education are amongst the worst in India.[7] With such poor health indicators, the health status of people in Uttar Pradesh is amongst the

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[1] Craig, G. (2002). Towards the Measurement of Empowerment: The Evaluation of Community Development, Journal of the Community Development Society, 33.

2 Campbell, C, and Scott, K (2009, submitted for publication) Building transformative social spaces through mediated health communication.

3http://www.thehinducentre.com/multimedia/archive/02263/Draft_National_Hea_2263179a.pdf

[4] Planning Commission has constituted a High Level Expert Group (HLEG) on universal health coverage, seven Working Groups and Two Steering Committees to define the appropriate strategy for the Health sector for the XII Plan.

[5] http://planningcommission.gov.in/sectors/health.php?sectors=hea

[6] Ministry of Health and Family Welfare, Annual Report 2012-13, p. 161

[7] http://unicef.in/StateInfo/Uttar-Pradesh/Introduction

lowest in the country[8]. With little or no data available on the mental health scenario in Uttar Pradesh one can only imagine the adverse state of people living with mental illnesses and their access to treatment.

Going back to the multi sectoral approach in the area of mental health, an immense need for involving the non-governmental organizations is therefore observed in UP. This step should be taken not only to create awareness on the issue but should also advocate for provision of adequate mental health facilities in the state.

Though currently very few institutions are engaging in the area of mental health in the state, SHARE Project is one such organisation in the state of UP that runs its community mental health programme in the villages of Bijnor district.

SHARE PROJECT: AN INTRODUCTION

The SHARE Project (Service for Health and Rural Education), started by Ted Lankester in 1985 began with the concept of '*health for all*'. The project works under the Emmanuel Hospital Association (EHA), and is partially funded by New Zealand Head of Mission Fund and other support from donations. The project first started working in the remote villages of Tehri Garhwal, Uttrakhand by providing primary medical assistance and health education to the needy and suffering people. Owing to the health needs in Bijnor district in Uttar Pradesh, the SHARE Project shifted to Seohara block in Bijnor in the year 2007 where they started a community health and development project (see map to understand areas of operation in Annexure 1) . The shift was made keeping in view the poor health status of Seohara district and the absence of adequate health facilities in the block. Ever since then, the organization has been working relentlessly in the area of health and community development and engaging in activities like formation of CBOs, handpump installation, awareness and treatment on Tuberculosis and reproductive health.

Bijnor has 11 blocks and Seohara is one of them. The SHARE Project is in its 8th year of operation in Seohara, which administratively consists of 71 Gram Sabhas and 10 Nyay Panchayats. The Government Health infrastructure includes a community health centre/primary health centre with a network of 2 additional PHC and 25 ANMs sub centers. The SHARE project covers 68 Gram Panchayats in Seohara and 4 blocks adjacent to it[9]. The villages have been divided into 4 clusters to supervise and monitor the program effectively.

In 2013-14, the SHARE Project ventured into the area of Mental Health by initiating a new Community Mental Health Project. This programme was selected after an in depth needs assessment of the communities. The study revealed the absence of a Mental Health Hospital or a Psychiatrist in Bijnor District, which compelled the Project Manager and his team to take this issue up sincerely .The absence of NGOs in Bijnor working in the area of Mental Health further, reiterated the need for a community mental health programme. The funds from the CBCI card , which supported the TB programme, were utilized for Project Axshya activities in 2013-14.

With the goal to '***promote positive mental health and resilience among people in Seohara Block, by building on resources in the communities'***, the following objectives were set out as a part of the project: -

- *Strengthen government primary mental health services of 3 CHC/PHC of Seohara block by end of 3 years.*

[8] http://nrhm.gov.in/nrhm-in-state/state-wise-information/uttar-pradesh.html#health_profile
[9] The organization covered this through its TB programme.

- *Empower People Living with Mental Disorders (PLWMDs) and their families with skills and knowledge for mental health,*
- *To increasing mental health (knowledge & skills-emotional resilience program) and resilience among adolescents in colleges/school and community levels.*
- *Strengthen the 50 CBOs of Seohara block to increase skills in mental health literacy, first aid and positive mental health.*
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The program has been running successfully for around 2 years now and a mid -term evaluation of the same has been conducted to understand the progress and inadequacies in it. The aim is to also provide suitable recommendations for the next phase of the program.

SECTION 2: THE EVALUATION: SCOPE, APPROACH AND METHODOLOGY

The mid term evaluation has been conducted by Ms. Gracy Andrew, Ms.Poorvaja Kumar and Dr. Sunita Varghese. The fieldwork included visits to the organisation, the villages where SHARE Project is operating and discussions with stakeholders at community, organisation and Government level. The team visited the field between the 13th to 15th of March 2015 followed by the in-depth assessment of findings as well as review of available reports. These have been documented in the following evaluation report during the same month. The scope of the study includes the following: -

e. Studying all the components under the Community Mental Health programme of SHARE Project.
f. Review of the functions of the Government Mental Hospital/CMO office and CHC/PHC.
g. Review and assessment of the project progress in relation to the set objectives and the overall goal.
h. Review of the progress made so far in terms of project implementation, and the financial and resource management.

The mid-term evaluation included building an in-depth understanding of the working and functioning of the SHARE PROJECT in operating the community mental health programme in Seohara. This assessment intends to facilitate the NGO and its staff to re-design and re-plan the approaches and interventions that are aimed at addressing the core issue of mental health in the Seohara community.

Research methods and steps

The study entailed use of both primary and secondary data collection.

a. **Preliminary discussion –** A meeting with the Program Manager was arranged on the 13th of March 2015, to understand the terms of reference and the scope of evaluation. Relevant secondary literature including annual reports, needs assessment reports was collected and a brief discussion on the programme was held.
b. **Secondary literature review-** Review was conducted of all the relevant documents/ reports collected from the organization. The literature review helped in development of the context for the study which enabled designing the study tools.
c. **Primary Research-**The on-site primary data collection was conducted. The primary data collection used qualitative methodology. The team visited six villages in Seohara block, namely Govindpur, Shahpur-Roorpur, Budanpur and Dhindharpur. And brief discussions and focus group discussions were held with Stakeholders at different levels; the providers (SHARE personnel & govt. health personnel) and the beneficiaries (families of people with mental health

problems) as well as other stakeholders who have been the community partners in the program (ASHA's; CBO's) (list given below). The photographs are attached on Annexure 2.

d. **Data analysis and report writing:** The analysis included triangulation of information received from these various sources in order to assess the Community based mental health programme's progress and shortcomings. The tools used for the field-study are:

I. ***Brief Interviews:*** Semi-structured brief interviews were conducted with government officials, PRI members, school teacher, local NGO representatives, and persons/family experiencing mental illness. These discussions focused on understanding of the issue and the NGOs role in the process.
II. ***Focus Group Discussions:*** Small focus group discussions were conducted with community based organisations, youth groups, families of persons with mental illness, persons with mental illness and NGO representatives.
III. ***Case studies:*** Detailed cases were collected from the stakeholders at varied levels.

List of respondents:

- **First level key stakeholders:**

1. People living with mental illness, Seohara
2. Caregivers of people living with mental illnesses.
3. Community members of Govindpur , Dhindarpur ,Shahpur-Roorpur, Budanpur Shyamabaad village,Seohara
4. SHG/CBO members at Govindpur, ShyamabaadShahpur-Roorpur, Budanpurand Dhindarpur village, Seohara

- **Second level key stakeholders:**

1. School teacher, Government Junior school, Seohara
2. ASHA and ANMs in Govindpur Shahpur-Roorpur, Budanpur and Dhindarpur village, Seohara
3. Anganwadi worker, Shahpur-Roorpur, Budanpur Shyamabaad,Dhindarpur village, Seohara
4. Program Manager, SHARE Project
5. Staff, SHARE Project
6. Village Health Guide
7. CHC doctor, Seohara
8. Youth volunteers, school program on resilience

Table 1 Location wise data collection

Data collection location	Brief interviews	FGDs
Govindpur village, Seohara	4 (Patient, PRI member,caregivers)	
Dhindharpur village, Seohara	5 (Patients, caregiver and CBO member)	
Shyamabaad, Seohara	2 (ASHA and Anganwadi)	1 (CBO members)
Shahpur-Roorpur	2 (ASHA and Anganwadi)	1 (CBO members)
Buranpur		1 (Caregiver, patient and CBO member)
SHARE Project office	8 (Patients, caregivers, Program Manager,	3 (Staff, Patients/caregivers and

	ASHA)	Corstone representatives)
Junior School, Seohara	1 (School teacher)	
CHC, Seohara	1 (Doctor)	

Table 2 Data collection tools per respondent

Respondent	FGDs	Brief interviews
Program Manager, SHARE Project		✔
Staff, SHARE Project	✔	
School teacher Government Junior school, Seohara		✔
People living with mental illness	✔	✔
Pradhan, PRI representative		✔
ASHA and ANMs in Shahpur-Roorpur, Budanpur Shyamabaad, Govindpur and Dhindarpur village, Seohara	✔	✔
Anganwadi worker, Shahpur-Roorpur, Budanpur, Shyamabaad ,Dhindarpur village, Seohara	✔	
Village health Guide		✔
CHC doctor, Seohara		✔
People living with mental illness, Seohara	✔	✔
Caregivers of people living with mental illnesses.	✔	✔
Community members of Govindpur and Dhindarpur village, Seohara	✔	
SHG/CBO members at Govindpur and Dhindarpur village, Seohara	✔	✔

Table 3 Total number of FGDs and Interviews conducted

Respondent	No.of Interviews	No. of FGDs
NGO Staff		1
Program Manager, SHARE Project	1	
CBO members	2	2
Patients	7	1
Caregivers	8	1
School teacher	1	
Adolescent girls as motivators (Corstone)		1
CHC doctor	1	
PRI representative	1	
ANM/ASHA/ANGANWADI	2	2
Village Health Guide	1	
TOTAL	**24**	**8**

Limitations of the study

- The evaluation team had time constraints and therefore the field level data collection was restricted to three days. The team therefore could not cover all the

stakeholders. To overcome this problem the NGO arranged for many FGDs and interviews in the SHARE office building itself.

- Due to these time restrictions the team could not collect quantitative data, which would have required a minimum period of one month.
- Many stakeholders were unavailable during the period of the visit. The findings of the study and the analysis are therefore based on the responses of the available respondents and the secondary data presented by the NGO staff.
- The research process hindered the work of the community, as most people worked as agricultural labours who had extreme work pressures to meet the target and earned on piece rate or daily rate basis. This reduced the possibility of maximum interaction. To overcome this limitation the data collection team conducted brief interviews that lasted not more than 20 to 30minutes and FGDs extended up to 30-40 minutes only.

SECTION 3: THE FINDINGS AND OBSERVATIONS

1. COMMUNITY AND VILLAGE PROFILE:

Since it's inception the SHARE Project's primary aim has been to provide health education and medical assistance within a developmental paradigm to underprivileged communities. SHARE began work in Seohara block in Bijnor district in 2007 and since then has been implementing community health programs mainly having focussed on TB and Reproductive and sexual health. Simultaneously they have been facilitating formations of CBO's as a way of empowering the communities to become self-reliant as well as partner with them in their community health program. The program documents show that the current mental health programme has adopted a similar approach in its design and mode of implementation.
The Seohara block of Bijnor district is quite complex and heterogeneous in terms of religious groups and caste distribution. The SHARE project focuses on the underprivileged minority groups belonging to the schedule castes, who have little or no access to Government facilities.
While the Muslim communities mostly engage in skilled jobs like handicrafts, tailoring, carpentry or weaving, the Hindus (SC) are mostly landless labourers who work on agricultural farms or rear livestock at home. A few who have their own land cultivate crops for self –consumption only. Many villagers work as construction workers or at the brick kilns as brick moulders. Seasonal migration for work is also common among these communities. Most people in these communities earn daily wages or are paid on piece rate basis. Though very few reported to have a Ration or BPL card, it was reported that most families fall under the category of 'below poverty line'.
The Muslims usually live in the semi-urban set ups or in the rural areas closer to the town, owing to the nature of work they engage in. The agricultural lands on the other hand are widespread, where rice, wheat and sugarcane is grown, which explains the reason for the Hindu settlements in villages spread across the district.

Poor literacy level was observed during the field visit. Only few adults are educated beyond primary school but most children in the village seem to be attending school. The women in the Hindu families not only worked as agricultural labourers but also performed all the household chores. The women in the Muslim families were usually not employed in any job.
All discussions indicate that options of any alternative livelihood are very low in these communities. NREGA has been highly unsuccessful in providing employment to people. Some villages visited during the field visit had minimum access to water through hand pumps. Health facilities in these villages were remotely located and had very poor infrastructure. The absence of electricity and toilets in all households worsens the conditions for the villagers further. Many families preferred accessing private doctors and schools.

2. SHARE PROJECT: STAFF COMPOSITION:

The SHARE Project team comprises of a Project Manager and a Project assistant at the higher level of management. This is followed by community coordinators and village health guides at the field level. The village area is divided equally between the community coordinators, who are recruited under the EHA policy. The Project Manager also recruits some of the staff internally.

" My name is Maya, I have been working with SHARE Project for many years. I started working in the area of RCH and now promote mental health in the community " – Maya, Village Health Guide Rampur Krishna , KuriBangar

All staff have past experience of working in the health and the education sector and are well versed with the community. Many of them have been working with SHARE for several years and are committed to their work. It was observed that apart from the project assistant there is no other middle level management personnel. The Project Manager plays multiple roles right from working along with the Project Assistant in overseeing the field staff, strategizing and planning for the entire program, assessing progress and staff performance, fund raising, training staff, networking with the government as well as reporting to the funders and EHA.

"There is a lot of work we are doing in TB promotion and treatment, we try and take out time for mental health. I manage and train the staff on these issues and also engage with the other stakeholders"- Mr David Abraham, Project Manager, SHARE Project

3. PROCESS AND STRATEGIES ON PROGRAMME IMPLEMENTATION

After a detailed matrix study[10]the organization chose to work on issues of Mental Health, an area that has come with its own set of challenges. The process followed by the organization is linear and stepwise, starting from awareness building to creating access to treatment. While outcomes that arise from each step inform the next, each step has it's own specific set of objectives and outcomes laid out in the beginning. This pedagogy has been used for TB and other health programs and has been extended to the mental health program too.

For the mental health program the first year was dedicated to staff training, awareness building, identification of persons living with mental disorders and reducing stigma. As per the project manager's report, building awareness and identification brought forth the demand for treatment for services from the community. SHARE began exploring available treatment sources in and around Seohara. While the local primary health centre did not provide services to people with mental disorders the local private psychiatrists proved to be an expensive alternate. The closest available government service was at the mental hospital in Bareilly.

The strategy that SHARE adopted was to get the patients and their caregivers from villages to come to Seohara on Fridays. Overnight accommodation was made available for them on Friday. On Saturday morning SHARE staff escorted all patients and their families to the Bareilly hospital. After consultations at the hospital they all returned back on Saturday evenings, those who had no transport back were housed in Seohara on Saturday night and they went back to their homes on Sunday. The number of patients steadily increased over time according to the project manager. At present patients are taken every 15 days for medications. The organisation makes the overnight stay arrangements. The cost of transportation to Bareilly is borne by the patients and their accompanying member, however financial support is provided for those in need. This process of community mobilisation and taking the patients to the hospital is followed unfailingly by all staff members and this is a major strength of the programme. The cumulative increase in patient intake can be seen in the records (Annexure 4: Figure 13).

The evaluation team through review of documents as well as interviews and discussions with all stakeholders including beneficiaries tried to assess the strengths and barriers of each strategy.

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[10]The matrix rankings of Mental Health problem was conducted in 16 villages through PRA/PLM tool and each issue was ranked as per the score. Unemployment, Depression and Alcoholism got high scores in the ranking given by the community.

3.a Knowledge and awareness in the community: As per the programme document, the organisation has designed some IEC materials, conducted discussions and meetings in the past and also engaged in home visits to make the communities aware of the issue. The reports also indicate the role of CBOs in reducing stigma around mental illnesses and making people aware of the merits of availing medical treatment instead of resorting to seeking treatment from traditional healers.

"Our daughter, Naina is 7 years old, she has been getting epileptic attacks for sometime. Even I used to get these attacks but I went to the shaman and got better. I took her also. But the last time she got a big one! I will go to the doctor this time. I will take both the treatments shaman and medical doctor'- Naina's mother, Dhindharpur village.

During the field visit the team received mixed responses on issues related to mental health/illness. There are cases where stigma and discrimination has reduced significantly especially in some cases of epilepsy and depression, but the negative attitude towards the severe mental disorders like schizophrenia still exists. Even though many cases of severe mental disorders were sent to the hospital for treatment and families have seen change, patients were still referred to as 'pagal' or 'mad' by their families and community. For treatment, while some visit the hospital, some continue to visit 'shamans' and spiritualists. There are many who take both kinds of treatments simultaneously.

Neetu Kumari is a CBO member in Dhindharpur village whose sister-in-law Sudha Devi has been getting epileptic attacks since childhood. While Sudha's parents tried to treat her, none of the treatments worked on her.
After marriage her husband and his family also tried to get her some treatment but could not support her for long due to financial constraints. The treatment from Bareilly was also discontinued because of financial constraints and also due to constraints in traveling. Sudha's husband is disabled and cannot afford to travel that long. No other family member wants to travel with her as she has certain behavioral issues that nobody is able to handle.
Sudha not only has Epilepsy but also has some other mental illness as she maintained no eye contact and remained quiet and straight faced throughout the interview. The family tags her as being 'mad' and aggressive and considers her a burden. The family reports that Sudha refuses to take medicines. None of the members have an understanding of her condition and everyone is unwilling to help her with the treatment.

Responses indicate that home visits have been effective in getting the people to seek medical help, however no other community level mobilisation activity like health campaigns/camps, radio programs have been used for building awareness and knowledge as yet. In terms of awareness programmes in schools and hospitals gaps have been observed in the understanding of the stakeholders about SHARE project and its activities and the issues it deals with.

" I went through depression but I discontinued my medicines after I started going to the Christian congregation. I have been feeling better since then" - Rajbala, ASHA ,Shyamabad

While reports suggest that awareness activities on alcoholism have also been conducted in the community, not many cases/or instances of this kind were observed on the field.

The IEC materials such as the pamphlets developed by the SHARE provide adequate information on all mental health issues. A few wall paintings and banners on mental health at the CHC and in the community is also indicative of the positive efforts made by the organisation in promoting the programme. However the discussions show a gap in the reach of these IEC materials. Many reported to have not received any IEC material and some who received it did not have adequate knowledge about the issue. The reason for this gap could be attributed to the delay in development and distribution of the pamphlets as well as poor literacy levels among the people. In the first phase the SHARE team had community meetings and created awareness about the program though posters, which continue to be displayed on a few walls. The samples of a few IEC materials and wall paintings are attached in Annexure 3.

The awareness activities initiated by the organisation last year have been terminated this year, as the focus is now on creating access to medical facilities. This termination, has however not affected the patient flow in the organisation, as those who have undergone or those who are undergoing the treatment keep referring people to the NGO. Many patients have also contacted the organisation through the contact number provided on the wall paintings.

Omkar Singh, a 35-year-old man is extremely satisfied with the work that SHARE Project is doing in Bijnor. He lives with his family in a village called Bijaynangala and is really proud of his daughters who study in English medium schools. His wife, who has completed B.Ed. works as a teacher in a Government primary school in Noorpur, Bijnor. Today, he only wants to see his wife and daughters prosper. However, such was not the situation a year back when Omkar visited the SHARE Project office.
Omkar, after completing his second year BSc started a licensed pharmacy store from where he earned a decent income. In 2010, Omkar met with a fatal road accident during which he underwent series of operations. After he recovered, he started getting epileptic attacks that kept increasing in frequency. The situation got worse within months and he had to close down his pharmacy shop. The community around recommended him to seek help from the shamans (Bhagat) who performed witchcraft. His wife often went to spiritual healers for help but his health condition remained the same. He got himself treated from several private doctors but there was no improvement in his condition. Such sudden epileptic episodes brought his confidence and morale down. He was in a state of helpless and had lost the will to live and eventually resorted to consuming tobacco in the form of cigarettes or chewing beetle leaf.
It was only last year when one of his uncles from the nearby village referred him to the SHARE Project for treatment. The uncle had seen his own wife get better from mental illness, and spoke highly of the treatment rendered through the organisation. After meeting the SHARE Project staff, Omkar was taken to the Government Hospital in Bareilly where he was put on medicines to control his epileptic attacks.
Omkar has been taking the medicines for a year now and has only had two episodes since then. He is adhering to the treatment and visits the Bareilly hospital to collect the medicine in every 15 days with the SHARE Project staff.
Omkar is very confident today; he has been referring people to the NGO and narrating his success story to the people in the community. Though he currently works as an agricultural labourer but plans on reopening his pharmacy store very soon and continue his business. He only wants the medicines to be made available at Bijnor so that he does not waste so much time travelling.

3.b Identification of persons with mental disorders (PLWMD):

One of the primary activities of the organisation during the initial phase was of identifying persons with mental health issues from the community. For this purpose, the community coordinators use a 'quick tool' with preliminary questions that ascertain the illness/disorder. The Project Manager has developed this quick tool after referring to the standardised PHQ, psychiatric books and also after consultation with a few psychiatrists. Based on the responses to the set of questions, the community coordinator identifies the illness (if any). For instance a set of questions indicating prolonged state of sadness coupled with issues in sleeping patterns is categorised under 'common mental disorders' like depression, on the other hand hallucinations, poor hygiene and delusions would be categorised as schizophrenia which falls under 'severe mental disorders'. The assessment tool has been kept short for the team to be able to cover maximum households.

" We went to several households and filled up these assessment sheets and identified the persons living with mental disorders. These mental disorders were categorised into CMD and SMD"- Handry, Community coordinator, SHARE Project

This early assessment was conducted in 2013-14 in 223 households, where 1500 families were interviewed. As per records maintained by the field staff persons identified with common mental disorder like depression and anxiety has reached a total of 455 and those with severe mental disorder are 185 as on 14th March 2015.Home visits have been made after the identification and the families have been encouraged to seek medical help through the NGO.

The observations show that the present tool used for identification is quick in assessment but has its own loopholes. The persons with mild anxiety or sadness that is situational or social can get easily categorised as 'depression' or 'anxiety-disorder' and put under the category of 'common mental disorders' thus resulting in a large number of false positives who would unnecessarily receive medication.

While treatment is ensured to all the people identified as mentally ill. There are some who have not seen anything change for them after the treatment.
The Pradhan of Govindpur village acts as a role model to the villagers, as he openly talks about mental health and the need to treat mental illnesses. He speaks very highly of the SHARE Project and its contribution to the village.
The Pradhan's wife, who was identified to be suffering from 'anxiety-disorder', by SHARE staff, had been receiving treatment at the Bareilly Mental Health Hospital for six months. The woman was diagnosed with 'anxiety-disorder' as she showed some changes in the behaviour. It was reported that she was irritable and tensed all the time. However, none of her behaviours had any adverse effects on her family members or disrupted any of her daily functions.
The Pradhan's wife has been prescribed with two kinds of anti-anxiety medicines that she recently discontinued because of other physiological issues (some issue in her ear). While she was on high dosage of anti-anxiety pills, she attributes her stress and tension to daily household chores and activities; a case where counseling might have helped more.
Similar is the case of a 70-year-old man, Omprakash, who is on anti-depressants for the past 6 months, prescribed by the Psychiatrist at the Bareilly hospital. However, he has not shown any improvement in his condition so far.
Omprakash lost interest in his job as a teacher during retirement. He has also been very lethargic and the pace at which he functions has reduced considerably. Due to his old age, he has to be accompanied by some one every time he travels to Bareilly for medicines. A few months back, in an attempt to travel alone Omprakash got into the wrong train. Ever since then he has been scared to go alone. Omprakash's son is reported suffering from manic-depressive disorder, which is also a constant worry for him.
The reason that could be attributed to Omprakash's condition could be age related

(common geriatric issues) and/or other social factors that are creating problems for his family. A re-assessment of his condition would be suitable to see if the situation needs clinical attention or social support.

3.c Creating access to treatment in mental illness:

" My son's seizers have reduced considerably, thanks to the support provided by SHARE Project. Now I don't even accompany him to the hospital… he travels on his own"- says Mohammed Ansari, father of Shakeel Ansari

The SHARE Project is a stand-alone NGO which functions in a district which has inadequate health facilities and no mental hospital but the organisation has been working relentlessly in providing medical services to the PLWMD in Seohara, Bijnor.
The community members acknowledge the efforts of the NGO and are appreciative of their initiative.
The area has many cases of Epilepsy (355 total identified) and 121 people suffering from Epilepsy are receiving medicines from the Government Mental Health Hospital, Bareilly[11]. As per the records, out of the total identified patients with mental illness 92 people with CMD and 52 people with SMD are receiving treatment through the SHARE Project. Even though the organisation is ensuring medical support to the patients in Seohara, there are several factors that impede the progress of the programme and leads to low adherence to the treatment by patients.

Desraj, who is also called 'Chotu' at home, is undergoing the treatment for epilepsy in the Government Hospital in Bareilly. He studies in grade 9 in the Government school nearby. His elder brother, Divakar accompanies him to collect the medicine. Chotu lives with his mother and has 4 other siblings but the only earning member in the family is his elder brother.
Chotu's father has been missing since one year. As per Rekha, Chotu's mother, her husband had a paralytic attack last year and had been behaving strangely for months. He hardly spoke to anyone and remained irritable most of the times. "On one morning he went for his usual stroll around the village but never returned," she says. The family and villagers have been looking for her husband and have also informed the Police about it but there has been no progress on this matter.
Rekha and her 5 children live with minimal resources. The elder son is the only earning member working as a labourer, getting paid on daily basis. He gets an income of around INR 1500 to 2000 a month. Every time Divakar accompanies Devraj to the hospital, the family not only losses one day's income but also incurs an expenditure on travel.
Keeping all these factors in mind, Rekha appeals to the organization for bringing the medicines to Bijnor, as it would be very difficult for her family adhere to the treatment for her son in future.
A similar request has been made by Gaurav's mother, Asha Devi who stays in Govindpuri village.
In a family of four, Gaurav is the elder son who showed signs of slow learning and lethargy since childhood. Gaurav has been taking medicines from the Bareilly hospital and is improving noticeably accordingly to his mother. However, Asha Devi doubts that her son would be able to adhere to the treatment.
With five children to take care of and a husband, who is the only earning member, the family faces severe financial issues. The family falls under the BPL category, and has received housing facilities through the Indra Awas scheme. However, the

[11]It is a very alarming figure. There are cases of morbidity also.

monthly household income of the family is only INR 2000 to 2500 that does not meet the basic needs of the family.
To collect the medicines every 15 days, Gaurav is usually accompanied by his brother who is himself physically disabled and finds it very difficult to travel. Sometimes Gaurav is accompannied to the hospital by his father also. However, due the financial and the physical difficulties, adherence to the treatment is highly unlikely in this case.

The hospital being 4 hours away from the Bijnor district by train, the task of staying and travelling to Bareilly is extremely time consuming. The families depend on daily wages for their living and foregoing one day's work has adverse financial repercussions on families with few earning members. Since most patients need assistance during travel, only those who have members accompanying them regularly are able to adhere to the treatment. In some cases patients need more than one person to manage them. A demand for making medications available in Bijnor has been made repeatedly by the community members.

While many patients reported of relief and better health after taking medications provided at the Government Hospital in Bareilly, some have discontinued them mid-way due to side effects. Many were unhappy with the psychiatrists at the Bareilly hospital, who do not spend enough time with the Seohara patients due to high patient load.

"The OPD is always crowded and the doctor does not even have time to see the patient, or talk to them. I wish the services were better"- Relative of Anshal Kumar, a patient of Schizophrenia

3.d Strengthening networks and building rapport with the stakeholders:

The SHARE Project has been working very hard in developing innovative and cost effective strategies in engaging with the communities and implement the programme. As reported in the programme documents, the organisation has effectively partnered with the existing stakeholders. The programme also facilitates CBO formation, and these CBOs have been used for awareness building and identification of persons with mental illness. While eventually the organisation set up a separate cadre for awareness building called 'village health guides', the engagement of ASHA, ANM, Rural Health Care Providers (village doctors) and Anganwadi workers in the programme has helped in reaching out to maximum people. The challenge of no female field staff in the organisation was overcome by engaging with these stakeholders who have well-established rapport with the communities.
However it was observed that the lack of adequate and continuous training among members of the CBO, ANM, ASHA and Angawadi workers poses to be a challenge. In some cases the ASHA or/and Anganwadi worker may be from a higher caste and this acts as a barrier in families from lower castes in getting benefits of the government services.

The lack of trust within the community created various impediments in the formation of the CBOs in Shyamabad. Initially, the villagers did not trust SHARE Project either; they believed them to be companies that were there exploit them. However, with time when the NGO started working with the community on the mental illness issues, the trust was built. An adult with schizophrenia in their community started showing signs of improvement after treatment was provided through SHARE. It was this instance when the CBOs started getting formed.

The CBO called Nayi Disha in Shyamabad encourages savings, with each member depositing INR 100 per month. The same is used for providing loan to people. The CBO was provided information on the mental health issues last year by SHARE Project staff and some members had even referred people to the organisation.

However the members have not played a very proactive role in educating the community on these issues, discussing the same in the meetings, or making home visits for awareness.

Similar to Shyamabad are the CBO groups in Shahpur-Roorpur villages namely Aakash, Saraswati, Bhoomi, and Jeevan. These groups were also formed after a lot of mobilization and are presently participating actively in creating savings and providing loans. They have managed to save up to INR 1,34,000 altogether and their loan has gone up to INR 90,000. The CBOs stated that epileptic attacks; sleep disorders and hallucinations are the symptoms of mental illness. Some have referred people with epilepsy to the Share Project staff.
The CBOs in Shyamabad and Shahpur-Roorpur reveal how the internal dynamics affect the implementation of a programme.
The members of Nayi Disha do not trust their Pradhan with any work. In spite of making repeated efforts, the Pradhan remains oblivious to the village problems. The CBO therefore wishes to restrict itself to activities that promote savings and provide loan.
The issue of trust in CBOs formed in Shahpur-Roorpur is worse. The members detest the Government facilities so much so that they only access private hospitals and schools. They feel that all Government facilities exploit the villagers and provide fake medicines. The caste dynamics also play a huge role in building trust and bridging gaps. The ASHAs in the Shahpur-Roorpur villages belong to the upper caste and the women in the CBOs belong to lower caste, which creates an unsaid social barrier between the two. Poor institutional delivery and absence of mid-day meals for the children of the lower caste are two indicators of this distrustful relationship between the two. The dissemination of information through ASHA to the community is therefore highly unlikely.

Another effective strategy adopted by the Project manager was of introducing the concept of mental health along with the existing TB programme. This has not only aided in disseminating the information effectively but also helped in dealing with the topic cautiously owing to the stigma attached to it.

"I recommend the SHARE Project to make a presentation on the issue of mental health issues and take a session for the ASHAs who come for meetings every Thursday at the CHC"- Doctor Khalid, CHC, Bijnor

As per the reports, the networks strengthened include the ICDS centres, the PHCs and the CHCs. Schools and colleges have also been approached in this process. During the visit, the doctor at CHC in Bijnor gave a positive nod to supporting the programme but the school teacher of Government Junior School in Seohara, did not have much information about the SHARE Project or on the issue of mental illness. The facilitators working with the adolescent girls & boys groups, implementing the Corstone programme on building resilience in schools are aware of mental health issues, however, they have not yet incorporated the same in their programme. Due to time restraints and school exams the evaluation team did not intercat with adolescents who have been part of the resilience program.

" We work in schools and take sessions on resilience, I see a lot of scope in spreading the message about mental health through us in school"- Nisha, school facilitator, Corstone

The organisation has recently started its advocacy efforts and contacted the Chief Medical Officer for making the provision for medicines for Epilepsy available at the PHCs and CHCs in

Bijnor district. This effort was made by mobilizing all the families of PLWMD who signed an appeal making this request. 17 families attended this meeting and this document was presented to the CMO. The meeting ended on a positive note and the team is hopeful.

The mental health program does not have special funds especially for staff salaries. The funds that were received were given specifically for infrastructure, training costs and travel costs. The staff has to take time off from their existing work under the TB programme, as it is target oriented. Taking special interest in Mental Health, the Project Manager is making all efforts to present the organisational and district situation to stakeholders during discussions and meetings (like Unit Management Committee meeting, Governing Body/AGM Meeting etc.) that he attends. In this process many have come forward and extended their support, either financially or otherwise. The Duncan Hospital, Raxual gives Rs 10,000 a month and Dr Pfeifer, a Psychiatrist from Switzerland so far twice supported the organisation financially.

3.e Training and Capacity building:

The programme documents give significant importance to trainings at different levels. The organisation keeps records of how many trainings have been conducted.At field level, the ANM, the village health guide and ASHA worker's training and follow up has been indicted along with the training of CBOs created by the organisation. The training schedule as per the programme document includes exposure visits to medical facilities and group-training programme organised by the SHARE Project.

While the mention of 'training' as an activity in the reports indicates the importance given to this aspect by the organisation, the same outcome was not observed during the field visits. The ANM, ASHA and CBOs with whom the team interacted have very limited knowledge about mental illness. Their role is restricted to identification of the persons living with mental illness and referring them to the SHARE Project staff.
The response of the ANM, ASHA and CBOs showed that no tool is used for the identification of the PLWMD. It is merely based on their basic understanding of mental illness, which is limited to the external appearance and behaviours such as epileptic attacks, poor hygiene, hallucinations and prolonged sense of unhappiness. The CBOs, Angawandi workers and ANMs informed of some discussions on mental illnesses by the SHARE staff during few of their meetings about a year ago.

" We do not know much about mental health as we missed attending the training given by SHARE PROJECT"- Suman Tyagi, ASHA, Shahpur-Roorpur

" When a woman feels sad and tensed post delivery, we tell her we will support her. This is the counselling we do"-ASHA, Shyamabad

While the annual report claims to have identified six patients with Post-natal depression and 116 mothers with mental health issues in 2013-014, Anganwadi and ASHA who concentrate on child and women health exclusively did not indicate having any knowledge on postpartum depression or child related mental illnesses.

The CBOs had some knowledge on mental illness but did not report to have discussed such issues in their regular meetings. However, in spite of the training inadequacies some CBO leaders and ASHAs have played a proactive role in referring people to the SHARE Project staff, making them a very significant resource for the organisation.

At the management and the staff level the urgent need for training and capacity building was observed. The staff is educated and experienced in community mobilisation but none of the staff members have technical degrees or certificates in subjects like psychology or psychiatry,

therefore leaving gaps that need to be filled through training and close supervision by a technical expert.

"We refer the books on mental health if we have any queries"- Kala Abraham, Project Assistant, SHARE Project

The staff indicated of having undergone trainings by experts on mental health, for two to three days in the past. Also the Project Manager along with the staff members holds weekly discussions and meetings to explain and understand mental health issues better. However, the discussion with the SHARE Project staff indicates a lot of gaps in the understanding on the issue of mental illness. For example, while all the staff members are clear with their concepts on 'severe mental disorders', they are unable to distinguish between distress and depression. This might lead to incorrect identification of persons in the category of depression.

3.f Reporting and quality assurance:

The staff of the organisation maintains various registers and forms to record the details of the patients and the activities conducted. Among these are the village wise patient history, the follow up register, the village wise CMD-SMD register, a daily dairy, the Bareilly hospital register and weekly planning register for arranging transportation (samples attached as Annexure 4).Apart from these, the staff also maintains informal documents of patients and their progress. As per the discussions, the staff activities and registers are monitored by the Project Assistant. The data is entered manually and kept in hard copies as none of the staff members are computer literate.

" We make home visits and check the medicines to monitor if the patient is taking the pills regularly. We make a note of the information in our personal sheets for our reference "- Sanjay Singh, Community coordinator, SHARE Project

While all these forms and registers are effective in capturing the information, no formal record has been maintained to capture adherence. Information on patient continuing treatment and follow up is only maintained loosely by the staff. A formal register for this data would be highly essential to study the issues of adherence, which would in turn be useful to evaluate the long-term impact of the programme.

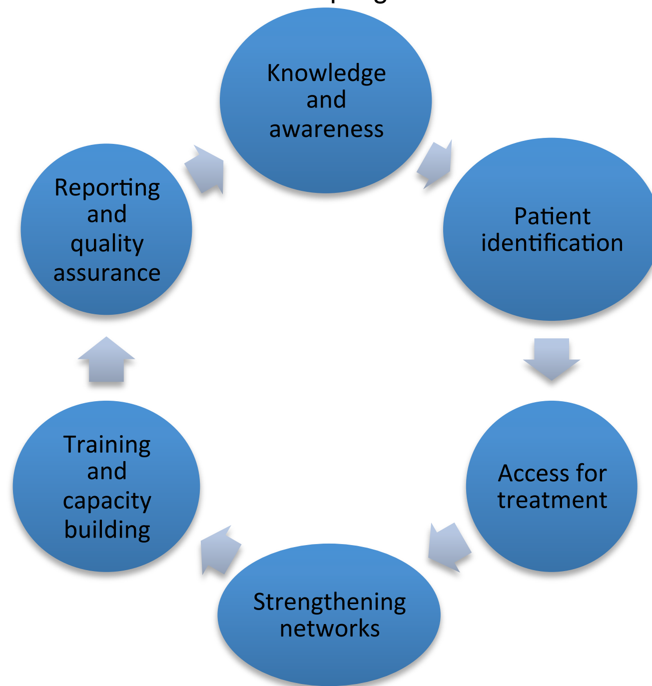
SECTION 4 CONCLUSION AND RECOMMENDATIONS

The SHARE Project is doing a good deal of work considering the fact that it is a stand-alone organisation with minimal external support. While some of its strong points are its dedicated and efficient staff, the innovative and cost efficient strategies and treatment-oriented approach, some areas like identification, awareness building and staff support require further attention. In the next phase of implementation the organisation is recommended to make certain changes in order to progress steadily and also achieve the overall goal of promoting positive mental health in Seohara, Bijnor. The following are the recommendations from the team of evaluators: -

Recommendations for the mental health program:

1. **Identification**
   - There is a need to make amendments and modifications in the tool for identification of the persons with 'common mental health disorders'. For this purpose, a psychiatric doctor may be consulted who would provide her/his technical expertise in designing the tool.
   - The processes and strategies in the programme are more linear in nature that looks at each process independently. A cyclical and more interconnected process would

keep all the processes running simultaneously, establishing better flow from awareness to adherence. The assessment of progress would also be effective.



2. Awareness building and community engagement:

- The knowledge building and awareness activities in the communities need to be resumed. The activities should be more intense and not be restricted to just the information on treatment. They should also focus on stigma, the role of family in the whole process, side effects and adherence. These activities need not be limited to community meetings. The organisation could develop campaigns using radio, theatre, films etc., arrange for talks by doctors and disseminate information through IEC materials.
- The usage of IEC needs to be intensified. The documents developed need to be distributed widely and home visits should be made to explain these materials. More banners, posters and wall paintings should be demonstrated at important spots like grocery stores, markets, train stations etc. A pictorial/visual description of the issue always attracts the eye more than a text-heavy message.
- The organisation needs to strengthen and widen its network by engaging with religious leaders, shamans and other spiritual leaders. A support from these would be very helpful in creating awareness within the community.

3. Training

- There is an immense need for trainings for all stakeholders. While the CBOs, ANMs, ASHA and Anganwadi workers need to be trained on mental health issues (especially on postpartum depression among women and alcoholism) and their role in the programme, the staff on the other hand needs a refresher training on concepts of mental illness and community mobilisation. It would be good for staff to learn to enter the data in the computer, as it will make the record maintenance effective and the data easily computable.
- There is a need to monitor quality of training through feedback forms and also assess knowledge of participants after every training.

4. Documentation and Monitoring progress

- The records and registers should maintain a sequence rather than be independent sources of information. The records should be able to provide all information from

patient history to follow up to adherence. Revised formats of data entry could be worked out.

- Better quality assurance mechanisms need to be adopted, which ensures regular monitoring of activities and records. This maybe done through external agencies on a quarterly basis or through appointment of second line staff appointed specially for this purpose.

5. Providing access to treatment:

- The availability of drugs should be the made as the focus of the advocacy activities of SHARE Project. This would ensure better coverage and adherence.
- The organisation may consider narrowing their area of engagement to Epilepsy and severe mental disorders, as assessment of common mental disorders requires high-level expertise and more sensitive tools.
- The organisation needs to plan for more sustainable options like arrange for 'village camps'. These may be arranged not only for awareness building but also drug distribution. This step would not just be cost-effective but also provide for an opportunity for one on one discussion between the patients and the doctor. This would ensure patient satisfaction and rightful diagnosis.

6. Project management:

- Explore for funding to support the mental health programs, this is the urgent need of the project.
- To overlook field level activities, second-line staff must be appointed. This will reduce the burden of the Project Manager , ensuring efficient delivery.

7. Recommendation for overall organizational strategy:

- From interaction with staff and several stakeholders 'one observation that needs to be considered was on the general strategy being adopted by the organization. At present although the organization is putting a lot of effort to build partnership with the community and mobilize them to partner on various health issues there is a perceived gap. The processes are not participatory enough and the community is not taking ownership for their own health and wellbeing. The community treats the organization as a provider and has very high expectations from it. The organization is struggling to meet these expectations and raise funds thereby continuing in the role that the community has assigned to it. It is time for the community to take ownership and the organization to play a supportive role rather than the role of a central provider moving from one health issue to another. For this the organization has to change its overall strategy and outlook and the entire team would need be facilitated and trained to change their perspectives. However, if this is accomplished, in the long run the organization will grow and the community too will grow and benefit simultaneously.

ANNEXURE 1 : Areas in which SHARE Project operates

ANNEXURE 2 : Photographs of evaluation team with various stakeholders

Figure 1 CBO interaction Shyamabad

Figure 2 Interaction with Dr Khalid in the CHC

Figure 3 Roorpur-Shahpur CBO interaction

Figure 4 Interview with family in Budarpur

ANNEXURE 3 : IEC materials and wall paintings

Figure 5 :Banner on Mental Health Day

Figure 6 Wall painting in the Govt. Hospital, Seohara

Figure 7 Banner on mental health in the SHARE office

Figure 8 Pamphlets on mental illnesses for distribution

ANNEXURE 4 : Records maintained by SHARE Project

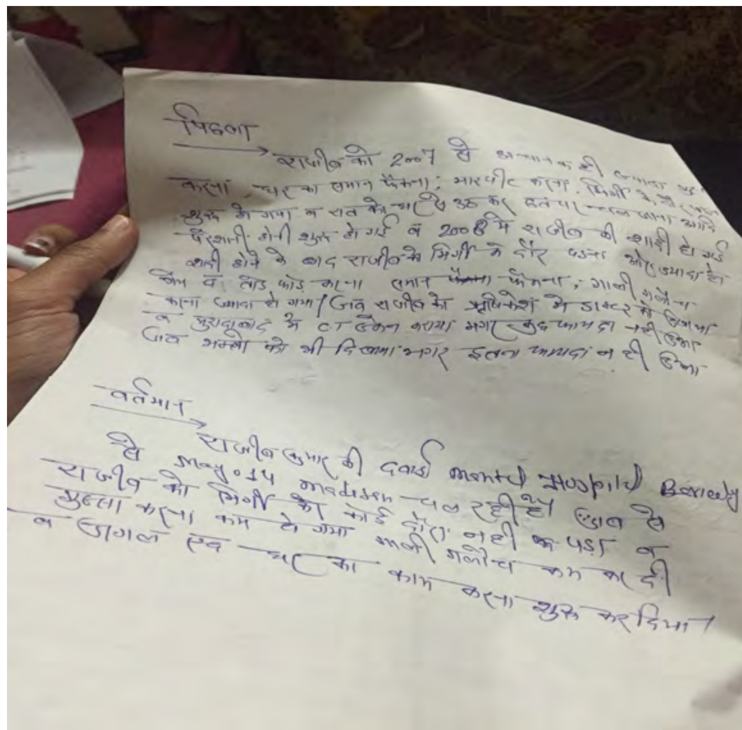


Figure 9 Patient history maintained by village coordinator

Figure 10 Patient register

Figure 11 Patient hospital visit record form

Figure 12 CMD/SMD assessment form

SHARE PROJECT, Dist. BIJNOR, UP										
Community Based Mental Health & Development Programme										
Mental Hospital Bareilly Trips										
Months	**Dates**	**No of Trips**	**New PLWMDs**		**Total (A)**	**Old PLWMDs**		**Total (B)**	**Total A+B**	**Cumulative**
			Male	**Female**		**Male**	**Female**			
Apr-14	05/April/14	1	3	1	4	4	5	9	13	
	12/April/14	2	2	2	4	5	3	8	12	
	19/April/14	3	6	1	7	7	6	13	20	
	26/April/14	4	1	2	3	6	1	7	10	
			12	**6**	**18**	**22**	**15**	**37**	**55**	**55**
May-14	03/May/14	5	4	0	4	11	0	11	15	
	10/May/14	6	4	0	4	6	4	10	14	
	17/May/14	7	5	3	8	14	5	19	27	
	24/May/14	8	4	1	5	8	1	9	14	
	31/May/14	9	14	4	18	5	2	7	25	
			31	**8**	**39**	**44**	**12**	**56**	**95**	**150**
			43	**14**	**57**	**66**	**27**	**93**	**150**	
Jun-14	07/June/14	10	0	3	3	7	1	8	11	
	14/June/14	11	3	1	4	17	6	23	27	
	21/June/14	12	0	0	0	8	4	12	12	
	28/June/14	13	3	3	6	12	1	13	19	
			6	**7**	**13**	**44**	**12**	**56**	**69**	
			49	**21**	**70**	**110**	**39**	**149**	**219**	**219**
Jul-14	05/July/14	14	0	0	0	0	0	0	0	
	10/July/14	15	0	0	0	2	1	3	3	
	12/July/14	16	0	0	0	9	4	13	13	
	16/July/14	17	1	0	1	6	3	9	10	
	19/July/14		0	0	0	0	3	3	3	
	22/July/14	18	0	0	0	2	0	2	2	
	26/June/14	19	2	0	2	15	3	18	20	
			3	**0**	**3**	**34**	**14**	**48**	**51**	**270**
			52	**21**	**73**	**144**	**53**	**197**	**270**	
Aug-	02/August/14	19	1	0	1	5	1	6	7	

14	09/August/14	20	2	0	2	11	1	12	14	
	16/August/14	21	2	0	2	3	3	6	8	
	23/August/14	22	2	2	4	12	4	16	20	
	30/August/14	23	8	1	9	8	1	9	18	
			15	**3**	**18**	**39**	**10**	**49**	**67**	
			67	**24**	**91**	**183**	**63**	**246**	**337**	**337**
Sep-14	07/September/14	24	4	0	4	8	5	13	17	
	13/September/14	25	1	5	6	18	2	20	26	
	20/September/14	26	7	3	10	12	5	17	27	
	27/September/14	27	2	0	2	13	4	17	19	
			14	**8**	**22**	**51**	**16**	**67**	**89**	
			81	**32**	**113**	**234**	**79**	**313**	**426**	**426**
Oct-14	04/October/14	28	1	0	1	10	4	14	15	
	11/October/14	29	0	0	0	8	0	8	8	
	18/October/14	30	6	1	7	9	6	15	22	
	25/October/14	31	0	0	0	9	2	11	11	
			7	**1**	**8**	**36**	**12**	**48**	**56**	**482**
			88	**33**	**121**	**270**	**91**	**361**	**482**	
Nov-14	01/November/14	32	1	1	2	14	3	17	19	
	08/November/14	33	1	1	2	13	1	14	16	
	15/November/14	34	0	2	2	13	3	16	18	
	20/November/14		3	0	3	0	0	0	3	
	22/November/14	35	1	1	2	12	2	14	16	
	29/November/14	36	1	1	2	12	5	17	19	
			7	**6**	**13**	**64**	**14**	**78**	**91**	**573**
			95	**39**	**134**	**334**	**105**	**439**	**573**	
Dec-14	06/December/14	37	2	1	3	11	1	12	15	
	08/December/14	38	1	0	1	0	0	0	1	
	13/December/14	39	**3**	**3**	**6**	**16**	**5**	21	27	

	20/December/14	40	1	0	1	8	3	11	12	
	27/December/14	41	1	1	2	14	4	18	20	
			8	**5**	**13**	**49**	**13**	**62**	**75**	**648**
			103	**44**	**147**	**383**	**118**	**501**	**648**	
Jan-15	03/January/15	42	1	0	1	9	2	11	12	
	10/January/15	43	1	0	1	14	6	20	21	
	17/January/15	44	0	0	0	9	2	11	11	
	24/January/15	45	1	1	2	17	5	22	24	
	31/January/15	46	0	0	0	10	3	13	13	
			3	**1**	**4**	**59**	**18**	**77**	**81**	**729**
			106	**45**	**151**	**442**	**136**	**578**	**729**	
Feb-15	07/February/15	47	0	0	0	13	5	18	18	
	14/February/15	48	1	1	2	9	2	11	13	
	21/February/15	49	0	0	0	15	4	19	19	
	28/February/15	50	3	1	4	9	1	10	14	
			4	**2**	**6**	**46**	**12**	**58**	**64**	**793**
			110	**47**	**157**	**488**	**148**	**636**	**793**	
Mar-15	07/March/15	51	4	0	4	13	3	16	20	
	14/March/15	52	5	0	5	12	4	16	21	
	21/March/15	53	1	1	2	18	2	20	22	
	28/March/15	54	0	2	2	5	5	10	12	
			10	**3**	**13**	**48**	**14**	**62**	**75**	**0**
		Total	**120**	**50**	**170**	**536**	**162**	**698**	**868**	**868**

Figure 13 : Data on patient intake