THE ASSOCIATION OF PEOPLE WITH DISABILITY (APD)

**Since 1959….**

**1. Project Related**

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| Title of the Project | Rehabilitation of Persons with Mental Illness |
| Location of the Project | Belagavi |
| Project Duration | April 2019 – March 2020 |
| Project Beneficiaries | 600 Persons with Mental Illness |
| Budget Required | INR 2,563,956 |
| Name of the Donor | The Live Love Laugh Foundation |
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| **2. About the Organization**  [The Association of People with Disability (APD)](https://www.youtube.com/watch?v=TIeIxek6qKM), a grass root non-governmental organization which works in the rural communities, has been pioneering the cause of helping Persons with Disability since 1959. Our aim is to empower persons with disability to become active, contributing members of society. At any given time, through its wide-ranging institutional and district development programs, APD reaches out to around 50,000 persons with disability annually. APD as a leader in this sector is focused on building an eco-system by enhancing the capacities of NGO partners, government officials, care-givers and other Stakeholders.  Key Programs:   * Early Intervention and Early Education for 0-6 years of age * Inclusive Education for 6-18 years of age * Vocational Training & Livelihood across Karnataka for 18-35 years of age * Spinal Cord Injury across Karnataka with 3 Centers for Rehabilitation across all ages   Cutting across all programs, Physical & Social Rehabilitation and Policy Advocacy are the key areas of operation. APD follows a Life cycle approach where physical, social, mental, educational and vocational inclusion is addressed. APD as leader in the disability sector is creating a strong eco-system by implementing programs via collaboration with local government systems and institutions linked with five departments.  The Economic and Social Council (ECOSOC), a Body created by United Nations, has granted "Special consultative" status to The Association of People with Disability (APD). APD is one of the six NGOs with Special consultative status in India, which enables APD to actively engage with ECOSOC and United Nations secretariat, program, funds and agencies. | |

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| **3. About the Project** |
| 3. 1. As per the 2011 census, the disabled population of Karnataka is 13.24 lakh, of this, around 6 lakh are living in North Karnataka. The Census provides the demography of disabled population in 8 categories of disability. The visible disabilities have been captured. Due to lack of technical knowledge of the Census enumerators the numbers are under estimated. Few disabilities such as multiple disabilities, mental retardation, cerebral palsy, mental illness are not adequately represented in the census data. Apart from this, each Government line department follows its own parameters for segregating data of PwDs.  Magnitude of Community Mental Health in India:   * Mental health is a growing concern that calls for immense focus from all quarters. It is estimated that 1% of the population, almost 10 million people in the country suffer from some form of mental illness. * State level figures report over 50 Lakh Persons with Mental Illness (PWMIs) and Mental Retardation in Karnataka who are being supported by less than 700 health care professionals, doctors and social workers. * The focus of public health system is still on mortality rather than morbidity and dysfunction which are on the rise in India. * Access to mental health care is another major issue that is compounded by social stigma and lack of awareness. Among economically challenged social groups, both urban and rural, PWMIs are subject to neglect, isolation, abuse and traditional forms of treatment -all of which tend to have a negative impact. |
| **3.2. Project Objectives**   * To identify new PWMI and provide follow up for the existing PWMI to access Psychiatric treatment and continue medication. * To capacitate the primary and secondary stakeholders through mental health training to bring about changes at the district and state level. * To ensure psychological, social and economic independence among PWMI to lead a dignified life. |
| **3.3. Scope of the project**  Based on a preliminary sample survey in 5 taluks of Belagavi District, APD proposes to commence an intensive Community Mental Health Programme that will reach out to 600 persons with mental illness. APD has recognized the urgent need for such a programme based on:   * 2011 Census estimates that there are 1553 PwMI in Belagavi district alone and have been increased over a period of 8 years. * The lack of mental health care in Primary Health Care centers and Taluk Hospitals (psychological services, medical services, counseling etc.) creates a massive obstacle to access to treatment. PWMIs need to travel roughly 50-60 km, sometimes as much as 80 km to reach the District Hospital in Belagavi Town. * Availability and access to free medication is inadequate at the district centers. Intervention with Government health agencies and lobbying for budget allocation is required on a regular basis to ensure that the medication is available and provided when required to PWMIs. * Social barriers that exist due to lack of awareness among the rural communities as well as among various government groups such as ANMs, VRWs, ASHA workers etc. Further the strong belief in traditional healing methods means that PWMIs are not being urged to consult with medical professionals. * There is a need for social integration and economic rehabilitation of PWMIs through development of acceptance and knowledge among communities, training and support for caregivers and creation of sustainable livelihood opportunities for PWMIs once they have stabilized.   **Key Activities & Outcomes:**   |  |  |  |  | | --- | --- | --- | --- | | **Input** | **Output** | **Outcome** | **Impact** | | **Identification and follow up support** | * 600 persons (600 new identification from 5 taluks) with mental illness identified in 5 taluks of Belagavi (Bailhongala, Chikkodi, Gokak & Hukkeri.) | * PWMI access psychiatric treatment and continue medication. | Persons with Mental Illness stabilize; access treatment & medication; get back to their previous jobs/self-employment | | **Access to Mental Health Care** | * PWMIs identified in Belagavi will be directed to the District Hospital and District Disabled Rehabilitation Centre in the town to access treatment. * Organized camps twice a month with support from the government doctors to ensure that PWMIs in this Taluk get requisite care and medication * Follow up and keep records on each case, ensuring that the PWMIs access regular care and receive necessary medication * Organized camps twice a month with support from the government doctors to ensure that PWMIs in this Taluk get requisite care and medication * Provide transportation, facilities to Psychiatrists * Ensure availability and access to medication through intervention with district health officials and financial assistance to extremely poor PWMIs | * 600 PWMIs will be able to access mental health services- psychological care, counselling and medication. * Detailed records of services accessed by the PWMIs will be maintained to ensure that they receive regular treatment. * Financial support will be provided to extremely poor families to pay for medication and transportation to camps. | | **Capacity Building among communities and government agencies.** | * Monthly meetings of carer/parents groups in each Taluk. * Facilitate 3 days Residential camps for federation members * Provide training to VRWs, ASHA workers, Anganwadi teachers, ANMs and health officials at Taluk and PHC levels. * Create social awareness through street plays and exhibitions, wall writing, posters and handbills in the 6 taluks of Davanagere District * PWMIs and carers will be encouraged to form a federation at the Taluk level and given inputs on self-advocacy and leadership to be able to lobby and seek enforcement of their rights | * 4 carers/parents groups will conduct monthly meetings and maintain minutes. * Taluk level Federations for PWMIs and carers will be functional with regular meetings. * Residential camps for about 200 PWMIs and carers will be conducted. * 500 Government workers, ASHA workers, SHG members will be trained. * DPOs and Volunteers will actively participate in CMH program and involve advocacy work. | | **Vocational Rehabilitation:** | * Social integration and rehabilitation involves creating acceptance among family and community groups through regular orientation and counselling * Provide vocational training on appropriate skills for stabilized PWMIs to open up new livelihood opportunities * Facilitate reinstatement of PWMIs where appropriate, into their previous or similar jobs * PWMIs from rural communities will be provided assistance in procuring MNREGA cards that will enable them to seek some employment | * 15 PWMI will receive support to promote vocational activity. * 40 PWMIs will be able to go back to their previous or similar employment. * 15 PWMIs will receive vocational skills training. | | **Collaboration & Partnership with NIMHANS** | * Two psychiatrists visiting once in fortnight and conducting camps to screen, assess and for medical intervention on on-going basis. | * Support will add value to the project and ensure the quality intervention support for persons with mental illness in their vicinity. | |
| **3.5. Monitoring and Evaluation**  APD measures the impact of the program through ‘Outcome Based Plans’. APD’s monitoring and Evaluation (M&E) function periodically reviews the evidence-based outputs and outcomes, identifies gaps in commitments (to Donors/APD Board), and draws up revised plans to improve performance and achieve results.  **Project Governance will be ensured through -**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Sr. No. | Activities | Monitoring Technique | Frequency of monitoring | Responsible staff | | 1 | Review meeting | Reports/Meeting of the team. | Monthly | Program Coordinator | | 2 | Financial review | Review financial utilization | Monthly | Program Coordinator | | 3 | Review | Program Review | Quarterly | Deputy Director/ Coordinator/ M&E Team | | 3 | Reports | Project Status Reports to be submitted to Donor | Quarterly | Coordinator and Donor Relation Support Team. | | 4 | Internal evaluation | Evaluation | Yearly | Deputy Director | | 5 | Trainees Feedback | Questionnaires | Yearly | Coordinator | |

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| **4. Project Budget**   |  |  |  | | --- | --- | --- | | **Belagavi** | | | | **Particular line Expense** | **Details** | **in Rs.** | | **Staff Expenses** |  |  | | Program Coordinator / Clinical Psychologist | 30000 X 12 monthsX1 | 360,000 | | 4 CMHP staff and 1 Advocacy Officer | 20267 PM X 12 months X5 | 1,216,020 | | Staff welfare | 300pmx6 staffx12 months | 21,600 | | Staff Training | 6000X6 staff | 36,000 | | **Subtotal of salaries** |  | **1,633,620** | |  |  |  | | **Programme Expenses** |  |  | | Survey costs | 20000 | 20,000 | | Taluk level Camps at all 5 taluks. | 6000X5 Camps= 30000 | 30,000 | | Medical intervention support |  | 18000 | | Federation Meetings, Capacity building ; Exposure visit to PWMI federations and Livelihood opportunities | Belagavi-1200 X 60 meetings= 72000 ( 5 taluks X 12 meetings =60 ) | 72,000 | | Capacity Building programmes for front line health workers like ASHA, ICDS workers at Belagavi | 500 members X 100 rupees (RP cost, Training Materials & Food) | 50,000 | | Street exhibitions and awareness material | Each exhibition Rs.5000X 5 Exhibitions=25000; and Rs. 35000 for Printing Posters, Books and handbills. | 60,000 | | Residential camps | 5\*25000 | 125,000 | | Professional support cost | 12\*3000 | 36,000 | | Monitoring, Evaluation & Review | 10000\*4 (Review every quarter) | 40,000 | | Staff travel & conveyance to field | 6 staff X 1500p.m. X12 | 108,000 | | **Subtotal of Programme** |  | **559,000** | |  |  |  | | **Program Overhead** |  |  | | Office maintenance cost | 5000X12 months x 1 office | 60,000 | | Postage, Internet and Telephone | 2500x 12 months | 30,000 | | Printing and Stationery | 2000X12 | 24,000 | | **Subtotal of Overheads** |  | **114,000** | |  |  |  | | **Capital Items** |  |  | | Laptop for the Coordinator | 1 Laptop @Rs.35000 | 35,000 | | LCD for project to create awareness & capacity building programme | LCD projector to create awareness & capacity building program | 25,000 | |  |  |  | | **Subtotal of Capital Items** |  | **60,000** | |  |  |  | | **APD organization Cost** |  | **197,336** | |  |  |  | | **Grand Total** |  | **2,563,956** | |

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| **6. Risks and Risk Management**  Risks:   * Change in Government Policies * Involvement of External stakeholders   Risk Management:   * Upgrading the staffs skills * Accessing Government funds for Self-employment |

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| **7. Project sustainability**  APD as a leader in the disability sector has a responsibility of building capacity of smaller NGOs both in terms of knowledge, technical, financial support and other ability to continue the program cost effectively. APD has an advocacy team lead by a Senior Leader who works on the collaborations to ensure a strong eco-system for the continuity of the program in line with the Right to Persons with Disabilities (RPD) Act 2016. We have worked closely with the Government to take forward the Capacity Building program frontline Government workers. The emphasis this year is also on building strong Parent/Caregivers group so that they will take ownership and demand facilities from the Government. |