Mental health and Community Wellness (2015-2016)

"Mental health is everywhere.

Recognized or not, it is there in every person, every community, every country."

--- World Health Report on Mental Health and Development

Introduction

Fundamental to the agenda of sustainable development are people and their rights to economic, socio-cultural and environment stability. One of the fibers that connect these components together is people's right to health.

Indigenous people's right to health is not similar to that of non-indigenous people considering the dynamic interaction of colonisation, relationship to land and geography, history, culture, knowledge systems, language and spirituality in their lives. Along with biological, social, economic and physical determinants of health (genetics, nutrition, location, housing, health care, sanitation, access, income, livelihoods, life style, government systems & policy, literacy, gender, environment of health), special focus needs to be laid on factors that have influenced indigenous health but have not been effectively addressed for wellbeing. To ensure wellbeing, it is imperative to equally prioritize mental health when focusing on people's right to health.

According to WHO, Mental Health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." Wellbeing in indigenous communities is not only about making contributions to the community but also about the balance of physical, mental, spiritual and environmental health.

Indigenous communities have been highly impacted by change right from the time of colonization leading to disempowerment, identity confusion, disintegrating cultural beliefs, social structures and leadership, shift from collectivistic thought to individualistic thought and economic disadvantage which has a negative impact on mental health. They are stuck at crossroads between two ways of life, one their traditional way of life and another of transitioning to mainstreaming constantly causing stress.

At Keystone Foundation, the notion to start with mental health was to understand the mental health of vulnerable communities when they are at crossroads and highly impacted by environment, economic and socio-cultural change. The mental health program views itself as a

continuum from mental ill-health to well-being. The focus for the first year was on severe mental health issues and identifying ways to better mental health outcomes.

When an individual has a mental health issue coupled with the already existing barriers there is a manifold increase in the burden due to poor access to health care facilities, knowledge gap, lack of support from the communities/families for basic needs, complex health seeking behaviours, lack of trust within communities, gender burden, and constant discrimination from hospitals and other health centres that demotivate further health seeking.

Focusing on mental illness has provided an entry point to understand the mental health as a broad entity to move from illness to wellness. Also, as the scope of the programme broadens, to see a positive understanding of identity and culture and culturally determined relationships to land, forests, family, and community as they can be protective factors for resilience. Upholding this can promote social and psychological wellbeing.

Objective

To explore ways of addressing mental health in the indigenious communities, with a focus on the Irulas and the Kurumbas of the region.

Background

The mental health program interventions started with linking individuals with mental illnesses to health care facilities. Later mental health camps were held in the Kotagiri (Aracode and Konavakarai) and Sigur area to address the issue of people with mental illnesses not receiving any mental health care. The camps were held in association with The Banyan initially (2 camps) and later with the District Mental Health Program (DMHP) in the Kotagiri area and ASWINI in the Sigur area. (Detailed Timeline in Annexure I)

Learning

Though the larger objective of the program was about mental health and not just mental illness, identifying individuals with mental health issues was the necessity of the hour and a road to understand the socio-cultural complexities of the scenario and to link them to existing health care systems. A larger program will be built based on the findings from the first year.

1. **Location of delivery of service**

The location and the access to the place of delivery are very important. Clients feel more comfortable if it is in Sholurmattam/ Vazhaithotam. When they had to come for consultation to Kotagiri GH/ASHWINI they consultation rate dropped to 30-40%.

Also in Vazhaithotam, because the camps were in a central locality many people who came with general health complaints were diagnosed with depression/ dysthymia. Extrapolating on that, it is felt that PHC doctors would be the first persons to be able to identify mood and anxiety disorders and need to be trained or re-trained in recognizing symptoms and patterns.

The tele-consultation was quite simple to organise as it meant the clients didn't have to travel a long distance. Rather, they had to all congregate at the Keystone Field station in Vazhaithottam where a Keystone staff would have arranged the tele-consultation. It was a cost and time effective procedure; however, the health team felt that if the doctors at Ashwini are sent a copy of the case history of each client, the consultation would be more fruitful.

2. **Delivery of medication**

This has been a concern from the beginning of the camps. To stock medication and dispensing to the patients is legally not permissible for Keystone Foundation as a non-medical organization.

Though the first two camps took place with Keystone dispensing medication, it was a huge risk for the patients where the doctor in Chennai was adjusting medication dose and dosage based on the reviews of the client that was conveyed to him by telephone. Delivering medication to the clients between camps involved multiple visits to the village which was an extra expense that was not covered by the already existing meagre budget.

3. **Stigma**

Individuals with mental illnesses face stigma due to the lack of understanding of the illness and inability to know how one can help them. They are given shelter and food in the village when there is no family to care for them. However, they will not be looked after by the villagers by helping them seek treatment with a healer or doctor.

People with mental health issues (with family support) are usually taken to the temples and festivals in a belief that it will make them better. They are not excluded from the community activities nor are they included.

When it comes to livelihood options, individuals are not employed in jobs that would require them to interact with other people in a thought that they might get violent or abusive. However, a few clients have been employed or continue to work in estates or for daily wage work like NREGA. Individuals with severe mental disorders are also the only people in our clientele who do not have an employment opportunity, there is no information on the employability of individuals with common mental disorders.

4. Adherence to medication

One big hurdle to symptom management and recovery is long term adherence to medication. Anti-convulsants and psychotropic medication require the patient to be regular for months or years together. Bringing about the level of adherence these medications require is extremely challenging given the general health behaviour, current level of psychoeducation, and community health worker monitoring. Adherence is highly dependent on the caregiver and their involvement with the patient. It has been possible to provide one on one psychoeducation by the health team and community health worker only to the caregivers (community level awareness camps would have been ideal to bring more community engagement and de-stigmatization). This would happen after the camp, during home visits (the availability of the care giver would also affect these sessions).

5. Social support

Women in the Sigur area have frequently voiced how they cannot trust their neighbours because they might become the talk of the village hence do not talk with the other women of the community about their personal life and difficulties

During the baseline health survey, a few conversations were held with young married women in the Aracode area who had moved there from another area. These women conveyed that they feel like they do not belong there due to the lack of mobility or freedom to be themselves, along with the pressure to living up to expectations. This feeling was more common with women who have moved from the Dhimbam and Hasanur areas to Aracode, although this cannot be generalised to the rest of the areas.

Across communities, families do not feel supported by the community or neighbours/villagers. It has been difficult to identify even one house/individual that is ready to voluntarily (without honorarium/remuneration) take responsibility to provide medication or check on patients regularly.

An Irula woman of 35 years (a mother of 3 children), had to be taken to the hospital because she was severely anaemic and had psychotic symptoms. Her husband was abusive and she would run away from home and wander into the forest. When she returned from the hospital there was no support from the family and the neighbours to give her the medication. The health worker had to ask a number of people to give her the medication once a day, they would take it but not give it to her. The villagers would complain to the health worker about her getting violent and sick. There was a relapse after this and she had to start her medication again. The CHW then had to

ask the person incharge of the village Balwadi to give her the medication regularly. This constant support from the Balwadi has helped her get better.

Community unity and support is the crux of the issue for medication adherence. When there are no caregivers coupled with lack of community support, intervening with medication is extremely difficult and dangerous because there is no monitoring.

6. Family support

When it comes to chronic illnesses (debilitating physical conditions like stroke) and especially mental illness the support of the family drastically reduces. Giving the medication regularly over an extended period of time is tiresome, especially when that person is a non-earning member of a family. When the client is not extreme in their behaviour, proactively seeking treatment for them is rare. Even if they have been having active hallucinations, delusions and depressive symptoms (which is distressing for the client), support from the caregiver is minimal.

7. Sex ratio and Gender roles

During the camps, it was noted that in Aracode, a larger number of women than men were affected by psychotic conditions whereas in Sigur, there have been more women reporting for mood disorders as opposed to men who have been identified for psychotic conditions (schizophrenia).Even though these women were not identified by the Nilgiri Seemai Sudhi reporters or community health workers, the gender trend noted in the camps does indicate a need for closer intervention for women at the family and individual level where prognosis is better with social support, counselling and family interventions, as opposed to long term medications where adherence is a big concern.

During the survey, many women reported difficulties of managing home, children and earning. The women are expected to do much more than a man and failure to meet these responsibilities are stigmatised internally and externally. There is not much data available on a man's perspective to their roles and worries because, being a team of women, it was difficult to initiate and sustain conversation with men emphasising on their problems and them sharing.

8. Community cohesion

There have been a lot of reports about the decline of community cohesion. The effect of this on physical health and especially mental health is significant. Right from supporting a person for a doctor visit or taking care of a neighbouring family's child or helping with livestock is no longer a practice. This restricts the caregivers who lose out on other duties making it a 'this or that' choice and eventually the caregivers are forced to choose income-generation work.

In Sigur area, the *oorkatalai* (traditional leadership) or *thalaivar's (*head of the village*)*responsibilities will be evoked for theft, land issues or other problems between families but never has been for a person who is ill with chronic disease, even if it might be life threatening. However, these existing social structures can be considered to effectively deliver healthcare during emergencies.

One of the fallouts of lack of social cohesion is the indifference and lack of initiative to take responsibility for a sick person unless it is a medical emergency. This coupled with the knowledge gap on health has further disempowered them to make decisions about health. This applies as much to the immediate family as it does to the extended family or community.

A common behaviour in the communities that was noticed during interactions was that they would complain about an ill person in the village and how difficult it is for the person to live there and for them to live with the situations that the person creates. When they were asked to provide some support for their medication or for reporting an emergency situation, no one would come forward to take responsibility - a situation that is a good example of a bystander effect.

In Siriyur, a man of 35 years (approximately) had been showing psychotic symptoms where he would wander off into the forest and return after days together, murmuring, had anger outbursts with his mother and uses foul language with her, aggressive behaviour towards the villagers etc. He attended the first camp in Valzhaithotam and the Dr. had put him on anti-psychotics. After the camp, he hardly took his medication because he lacked insight and would wander off into the forest making it impossible for his mother to reach him to give him the medication. He was not willing to come for further camps. When the health team including the community health worker met with the mother, she said that it was impossible to bring him to the camps because she had to be home everyday to feed the cattle and earn a day's wage. The CHW then asked the neighbours if they could look after their cattle for a few hours that the mother could take the client to the camp. They disagreed saying they have their own matters to attend. The neighbours also asked Keystone Foundation to do something for the client as he would have violent outbursts in the village and having him around was a difficulty.

9. Substance use

Predominant in almost all households and, in some with both women and men, alcohol and substance use is one of the most significant burdens on wellbeing faced by the communities. Alcohol coupled with drug use like marijuana starts at a very early age, sometimes as young as 12years, making it a chronic problem to deal with. Boredom, lack of interest in education, lack of a stimulating environment and peer pressure have been major grounds for starting alcohol at a young age.

Apart from that a major share of the households' income (earned by the man especially) is spent in buying alcohol which has an effect on their overall wellbeing such as disharmony and violence at the family and village level.

Home-brewed alcohol is part of indigenous culture and was mostly tied to ceremonies and its use was restricted to adults in the community. The outlawing of home brew and the concurrent easy availability of cheap alcohol in TASMAC (government owned liquor shops) and local shops (without licence) has made the use of alcohol widespread. In the year 2006, there has been instance where the liquor sold in the TASMAC was also adulterated causing death during a festival in Sholur (mostly men).

Most people who go for wage labour get their wages on the weekend, which is when the men (especially) drink with the intent of getting drunk. Some men say that they like drinking every evening because they are physically exhausted after the day's labour and a few drinks mitigate bodyache. Children are increasingly being exposed to alcohol use within the family and the transition age from observer to consumer is decreasing at alarming rate.

Tobacco is consumed by young and older adults alike. Perhaps there isn't any immediate behavioural change like in the case of other substances people don't perceive it as a threat. Thus there is no taboo on chewing tobacco and this is not reprimanded in the community.

During the gender equality meetings held in villages, most women said that it is difficult to be around the men when they are drunk, because they would be aggressive and abusive. When the male head of household is an addict/ problematic drinker, it augments the burden on the woman to be financially more independent and be able to support the family emotionally (in many cases with children).

Even though this concern has been voiced by many women, the already existing social structures like village leaders and *oorkatalai* have failed to address this issue either because the men are indifferent to the *katalai* or that the leadership has not been influential to have an impact. This has also caused the decline of unity in many communities.

A ray of hope in this matter is that, some villages in Sigur and Nilambur take the responsibility to tackle this issue by tying the drunken person to a post for the night and giving him a

punishment in the morning. While this has not reduced the number of people drinking, it has reduced instances of violence and shouting in public.

10. Cultural factors

Traditional knowledge, cultural beliefs and new knowledge from *English marunthu* (Allopathy) form a complex network of health seeking behaviour leaving the communities at cross roads of knowledge systems.

Generally there has been a change in the belief on the effectiveness of traditional medicine and healers. Even though the people say that their belief is declining many patients with mental health issues have sought the help of priests and traditional healers.

In many conversations with elderly women and mothers in the village, they say that, now that their children and grand children are not raised eating millets traditional medicines (*pachamarunthu)* will not be as effective as it was for them and a better way to seek effective treatment is to take them to the doctors for Allopathic medication.

When priests and traditional healers are not able to cure the infirmity, the affected individual has been taken to the allopathic doctors for medication. Sometimes, when the consulting doctor is not aware or skilled enough to detect mental health issues or when there is a referral to a bigger hospital likes the Coimbatore GH, people choose not to go there because it is unknown, and hence intimidating. These pathways continually shift from family to family and across priests, healers and doctors giving no consistency to any treatment and a set pathway. This process also requires us to gather more knowledge from the traditional healers and priests on how they perceive mental illness. The traditional healers that the health team met with did state that mental health issues are not always treatable by priests and healers. They call it a *puthunoi* (new disease) and would ask individuals to visit a doctor. Sometimes they might also refer the individual to another priest or healer.

There are two parallel systems of medicine (modern medicine and traditional healing) and there is not enough information to understand why the patient chooses a particular system or chooses to switch between systems.

Kathu (directly translates to wind but has the connotation of ill wind) and *Seivinai* (black magic) have been two major concerns of communities when it comes to unexplained illness. *Kathu* has been associated with vomiting, body aches, headache, fever and chills. Past conflict with a person/family is tied to *seivinai* that causes behavioural changes that the affected person or the

caregiver cannot explain. For both these issues, people go to the priest who has a system to identify what has affected an individual and gives a remedy accordingly. This though cannot be generalised across all priests, but is a general outline. Concern about *kathu* and *seivinai* was most predominant in the Irulas of the Sigur region. Unexplained deaths in the village, especially of young men and women have been directly associated with *seiviai* , suspecting a relative or a community member who is jealous of a person's progress.

11. Cultural presentation of illnesses

There have been reports of instances of possession attacks being associated with mental illness in the communities. It can be a normal cathartic process to engage with their ancestors/God during a festival or a given instance. When these attacks happen in a situation out of the norm for eg away from a temple then is associated to a mental illness. Management of the occurrence of such attacks is deemed as a necessity of involving visiting a priest. However, people with such notions are also open to trying out allopathic medication. The bases of this decision making process is still unclear.

Almost all the caregivers and clients themselves during conversations usually mention worsening of symptoms during *amavasai* (no moon).

With some patients when they talk about their hallucinations they also mention that they hear their ancestors talking to them or guiding them with right and wrong. From the individuals perspective this seems like a supportive mechanism and not something that always has to be managed. However, they do say that it would be good to get rid of aggressive hallucinations and delusions.

One of the clients who have been having psychotic symptoms like hallucinations and delusions spoke about how he hears his ancestors guiding him. His wife later said that he would always worry that as a family they live away from their parents in a different village and he has always felt that he has not done enough for his ancestors.

With cultural presentation of symptoms there was always a gap in the discussion where caregivers and patients were hesitant to talk about. This is something that the CHWs, when given proper training, can gather more substantial information.

Irulas and Kurumbas

The presentation of symptoms or health seeking behaviours is not very different between the Irulas and Kurumbas. As per the existing clients database, there seem to be more Irulas affected with severe mental illnesses as opposed to Kurumbas.

Aracode: There are 10 existing clients in the Aracode area out of 20 from the first camp. Children with intellectual disabilities are not part of the camps because they need behavioural interventions. There have been many dropouts because they do not have supportive caregivers. The interventions with the CHWs have not been consistent, with the drop out of workers or irregularity in visits. The consulting doctors (Dr. Kishore and Dr.Purnajith) have also re-scheduled the camps several times that people have had to travel back and forth.

Rapport with the beneficiaries and community members is better with villages that are easy to access as opposed to the ones that are remote. However, there are more clients from villages that are well connected by roads, have better facilities from the government and is not necessarily a tribal village but a mix of tribal and non-tribal, Kurumba and Irula .

Konavakkarai: There were 4 patients initially. Now 2 are following up with Dr.ValsaKoshy, the caregiver of the third patient (minor – suffering from epilepsy) is planning to switch to homeopathy. The fourth patient is irregular in taking medication and in follow up. She has a problem with alcohol abuse. The team has not been able to give her the constant attention she requires to stay motivated and on treatment. This is because there is no CHW to service that area.

Irulas of the Sigur region

During several conversations with the Irulas in the Sigur area, they spoke about their wellbeing directly linked to them appeasing their Gods. This binds them to their religion and is also a factor of anxiety when they feel that they have done something wrong that will displease their God. These beliefs seep into their healthcare where they delay emergency consultations with doctors in life threatening situations by going to a priest or a traditional healer. On the other hand working to appease their Gods brings the communities together for a ritual promoting social cohesion and support.

Sigur: In Sigur there are 8 existing clients out of 15 from the initial camp. In this area there have been new clients mostly with severe mental illness. This is because there the team in the area has an active, consistent CHW. Access to the villages is easy and this is also a factor that aids the mobility of the CHW.

12. Precipitating and Associated factors

Looking into the most predominant precipitating factors of mental illness across individuals is the loss of a close relation or single women and men (forced bachelorhood). With almost 8

clients, death of a spouse or a sibling, or separation from their spouse, has been a precipitating factor of their illness. (5 of the clients have schizophrenia and 3 have depression)

One of the most common associated factors is poverty. In some instances poverty might be perceived by an individual or a household. A household might not be under the poverty line, but in a village where the community is shifted to cash based life their income and housing might not match that of the village causing a perception of poverty forcing them to take more jobs or daily wage work. The insecurity of this perception burdens the caregiver to earn more compensating for the one non-earning member of the family.

13. Barriers to care

Distance, lack of awareness about illness, persistence of symptoms, lack of financial resources and lack of social support are the most predominant barriers to care as recorded in the in-take form from the mental health camps with The Banyan.

Some individuals said that the decline of the effectiveness of traditional medicine was one of the reasons why they did not seek treatment with other healers or doctors. Some family members also feel that they had not appeased their Gods and hence had an illness. In this case, they go to a priest and if the individual's condition does not improve they think that it is something they have to live with.

14. Burden

There are multiple burdens to an individual with mental illness and their caregivers. The burden multiplies when the patient is not earning, there are no resources to support their treatment, caregivers have to go for daily wage work, and lack of livelihood options for the individual after he/she recovers; all this added to the community not knowing how to treat them.

When the affected individual is a widow or a person who lacks family support, intervention is difficult making them more vulnerable to relapses and chronic conditions.

15. General health seeking

Other than mental illnesses when people in the communities have chronic illness they do not seek a cure immediately. If they know an antidote for an ailment they try it at home. If it persists they go to the closest help like the NAWA ambulance/a village nurse/PHC doctors. When it

comes to debilitating conditions, not always do they proactively find a remedy but move from quick short attempts with the closest resources available.

16. Nutrition and mental illness

85% of the women who have been diagnosed with schizophrenia and major depressive disorder are malnourished and were given supplementary medication by Dr. Kishore, Dr. Purnajith or the consulting general practioner.

Anaemia is very common with the women. Nine out of fourteen women from Aracode and Sigur area have been given iron supplements.

Having a mental illness directly affects the nutrition because 90% of the clients who have reported with severe and common mental disorders complain about low appetite or having very little food. When the diet of an individual is already influenced by the Public distribution shops (ration shops) to rice being the only grain consumed on a daily basis (unless a family takes the effort to buy other grains or millets) their nutrition is severely compromised. Rice is usually had with *rasam* (a soup made with tomato and tamarind usually) or *sambar* (lentils cooked with vegetables) with very few vegetables for 3 meals. This severely takes a toll on their nutrition leading to anaemia and malnourishment. Three women who were diagnosed with schizophrenia were severely anaemic that they immediately needed blood transfusion.

Future directions:

The most immediate changes that need to be made are:

1) Awareness camps starting with villages where there is less support from the village or where there are more patients in the same locality. Also, through training for CHWs to deliver psychoeducation modules.
2) Alcohol and Substance use
   Problematic drinking and alcohol and substance abuse are major concerns with the communities. There needs to be a focus on this to prevent its effects perforating health and wellbeing. This could be an area of focus through the youth and also including more community level interventions through the women by empowering them to handle situations of conflict due to substance use by creating a safe space.
3) Free medications and medication support
   Delivery of free medications needs to be extended to everyone who has chronic illnesses. In some cases there could also consider paying for part of the medication to ensure that they buy it if they can afford it. This can be done only with individuals who have mild mood disorders. The risk of relapse would significantly increase when done with people who have severe psychotic symptoms.
4) Alternate systems of medication delivery
   The systems in place for delivery of medicines are not effective for extended periods of time. Given that psychotropic medications are long term and require close supervision, it would be highly beneficial to identify systems already in place like a village nurse, volunteers, Balwadi resource people to help keep a check on families and individuals with severe mental health issues
5) Advocacy
   To ensure that the doctor is available and to assure the availability of medication and to access it when required, it is necessary to talk about the work so far and create more awareness even amongst the doctors and staff in the PHCs because that is the first point of contact for many communities unless they make a conscious choice to seek help from another doctor.
6) Culture
   After a year of concentrated efforts into intervention, more efforts into understanding the cultural manifestations of symptoms is required.

These 5 points are important to consider when planning for the next years work but are not limited to them.

Annexure I

Timeline

November 2015

The initial months were about understanding the prevalence of mental health disorders and illnesses in the Irula and Kurumba communities.The health team started with involving the Nilgiri SeemaiSudhi volunteer (NSS) reporters to develop a resource map and a list of patients who have mental health issues in all of Keystone's working areas.

The resource map of the existing health facilities in the Aracode area got us acquainted with Dr.Purnajith the government Psychiatrist and, through him,UdavumKarangal an NGO that works in Coonoor area on mental health. Dr.Purnajith said that hevisits the KotagiriGHoncea week on Thursdays but is rarely available.

Links were established with several organizations like ASHWINI, Naveen hospital, Udavumkarangal, GH, Banyan, and looking to various models of health care delivery to address the treatment needs of people who required immediate care.

A Psychological in-take form was also designed to fit the context. (Annexure 1)

January 7, 2016

The first action for the program started with intervention when a 45 year old woman from Bangalpadigaihad to be immediately taken to the hospital because she was aggressive and suicidal.She was taken to Naveen Hospital in Coimbatore because the doctors there were familiar with Keystone's work and wasready to give us a concession. There she was diagnosed with Acute Confusion Psychosis and wason anti-depressants. When she was in the hospital she was diagnosed with a cyst in her urethra and the consulting Gynaecologist recommended a surgery. The caregiver and the patient immediatly wanted to come back home to see their chidren and so she was discharged with a catheter and further consultations in the GH in Kotagiri. After a week at home she had a Urinary Tract Infection because she had the catheter from Naveen Hospital that would help her urinate. She was taken to the GH in Kotagiri and subsequently referred to the Coimbatore GH. The patient, her husband and her son went along with her to the Coimbatore Medical College Hospital that is attached to the GH.They came away in a day and were unable to express clearly what exactly happened in the hospital. She was home for a week and again she could not urinate and had to be taken to the hospital. She was then taken to ASHWINI. After 12 days there she got better and was sent home. Dr. Shyla from ASHWINI, after consultation, said that urine retention was a side effect for the medication. She was diagnosed with unspecified schizophrenia and was given anti-psychotic medication. Over the past 10 months, she has been

doing better. There was a relapse once when the caregivers did not supervise her medication. She has been getting better. She now works in her farm and her son is supervising her medication.

February 2016

Banyan had visited after Andrew's mailwith advice on Keystone's mental health program. The health team (Sharanya,Selvi and Pavitra)went on a field visit with a team from banyan (Dr Vandhana, Ms Kamala and Dr Kishore) and Prof Andrew, to Baviyur to meet two womenDevi and Lakshmi. During the visit, both of them were diagnosed with schizophrenia and were recommended medications. The health team did not follow those recommendations as it was not a formal consultation and was not provided with prescriptions that could be filled for the client. The team could not follow through as there was no team in place to review the patients later. The Banyan also said that they would conduct a camp for the already identified patients. Aracode and Sigur areas were selected for the two day camps because of accessibility. The camps, which were initially scheduled for March, were eventually conducted in April based on Dr Kishore's schedule.

CAMP 1

The first camp was on the 2nd April (Aracode, Kotagiri) and 3rd April (Sigur).

For the first camp, the Keystone team and the team from Banyan (Dr. Kishore,Nisha and Nabiya) met 5 clients out of 9 from Kotagiriand 12 out of 20 from Aracode. One of the clients in Aracode was diagnosed with schizophrenia and anemia and had to be admitted to hospital in an acute condition because she lacked family support. In Sigur,both the teams met 11 clients out of 16 and four individuals who had general health issues. In all three areas, the clients had diagnoses of schizophrenia, epilepsy, mood disorders and mental retardation.

The next camp was planned in 2 months in June and the medications were handed out accordingly. During that period the health team from Keystone had to call Dr. Kishore on every Thursday and later every Tuesday to give him a report of the clients in the three areas.

Camp 2

The second camp took place on the 6-7of August after 5 months. Between the camps the health team had to give medication from the stock that was already there in Keystone after consulting with Dr Kishore. During this time, the organization had also made the decision to move to other local models of delivery like involving the District Psychiatrist, Dr Purnajith, and ASHWINI because Keystone as a non-medical NGO cannot store or dispense medication.

During this camp there were several dropouts. These were people who either had not improved significantly with the medication (clients with Intellectual disabilities) or did not have caregivers.

During the second camp in Sigur,the volunteers informed us about 2 individuals, one with mood disorder and the other with psychotic symptoms. The team from Keystone and Banyan visited them at their homes and were assessed and prescribed treatment.

Camp 3

The third camp happened in two locations – Sholurmattam and Sigur.

Dr.Purnajith was the consulting doctor for the Sholurmattam camp. The camp was initially slated for a Saturday morning but was postponed to 8.9.2016, a Thursday at 3 pm by Dr Purnajith; as he had another commitment on Saturday. This camp was not a success with only 4 clients in total being attended to. However the history and home visit reviews had helped him to prescribe the medication. Medications were prescribed for two months. One major reason for this was the time of the camp. People were hesitant to attend an evening camp, as they would have to walk back to their village after sundown and this was considered dangerous due to wildlife encounters. The second reason was the clients found a weekday to be inconvenient for them and had preferred the Saturday camp. One positive fallout of this camp was that the PHC doctor and nurses became aware of a mental health intervention in the communities (earlier camps had been held in the community hall in Sholurmattam)

Camp 3 in Sigur happened on the 13th of September 2016. Thangamani, a new health worker,took all the patients to ASHWINI to consult with Dr Sushmitha. Only 4 clients went for the camp because they had to travel early to the hospital. The Dr. looked at the review and prescribed medication for a month. From this camp, it was decided that Keystone will support by paying the cost only for clients who could not afford medications.

Camp 4

This camp happened only in the Sigur area because medication was given only for a month. Dr **Sushmita**of ASHWINI consulted with the 4 clients (out of the 10 being followed) who came to the hospital. Many did not come because they found it difficult to travel by bus, or did not want to spend money for the hospital visit.

The doctor also suggested that having telecampsvia Skype to make it easier for people to access the clinic.

Camp 5

For the Kotagiri camp conducted in the GH, people only from the Aracode area had come. Again only 5 clients had come all of them who had epilepsy and depression. Other clients who had schizophrenia did not come either because it was not conveniently located, or they could not be contacted on the day of the camp.

Sigur-

As the availability of psychiatrist to do a regular review or follow up was becoming more and more difficult especially in the Sigur Area, the health team had consulted Ashwini seeking for advice and the clients were accompanied to Gudalur along with a health worker for consultation with a psychiatrist. However, the number of clients declined as it was difficult totravel and many couldn't afford to lose a day's wage. Also for Keystone, it was difficult to manage the vehicles expenses within the budget. After voicing these concerns to Ashwini, they suggested that tele consultation could be attempted, where the Keystone team would set up a tele-conversation between the clients and the Doctors at Ashwini. The first tele consultation took place on 30.11.2016 in which 6 old clients and 1 new client consulted. With the help of the of the health worker the doctors understood the symptoms and accordingly prescribed the dosages and the medicines. The prescriptions were then scanned and sent across for the Keystone team to print and hand it over to the health workers for buying the medications.

Cost analysis of medical camps and financial burden:

Camps with banyan would approximately cost Rs 20,000 per camp including medicines and transport for clients and accommodation and transport for the Banyan team.

With local resources like the GH and ASHWINI once in two months consultation would cost around Rs 5000 to 6000 including medication (Most medications were available in the GH and ASHWINI had subsidized medications)

Sigur– There wasn't much expense related to the teleconsulting experiment as it was a very cost effective procedure as mentioned above. Instead, the team could spend on providing medication to ensure proper dosages and also to recruit health workers in order to carry forward the agendas of the health team in the communities.