Field Visit to a Community-Based Rehabilitation Programme for People with Psychosocial Disabilities in Akwa Ibom, Nigeria

An Internal Report for CBM International

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December 2018

Figure 1. Members of the Community Mental Health Programme team after an outreach

Executive Summary:
A field visit to St. Joseph's Rehabilitation Centre in Akwa Ibom was conducted in 2018 for a case study on the integration of mental health into community-based rehabilitation (CBR) programmes in low- and middle-income countries. The Community Mental Health Programme continues to provide community-based services to populations in extremely vulnerable situations who are otherwise unlikely to access effective, affordable mental health care in Akwa Ibom. However, the broader CBR Programme in which it was embedded is now largely defunct after CBM funding was withdrawn in the 2010s without an adequate exit strategy in place. Not only has this reduced the scope of the Community Mental Health Programme to largely biomedical services, it also puts the programme, its clients, and CBM's 15-year investment in disability inclusion in Akwa Ibom at risk. This report outlines the threats to the Community Mental Health Programme specifically and highlights opportunities to address them.

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X. About this Report

This report was prepared for the project **"Integration of mental health in community-based inclusive development: Current approaches and recommendations for future practice**", carried out by London School of Hygiene and Tropical Medicine (LSHTM) with funding from CBM International.

The aim of this project is to provide more tailored recommendations for the integration of mental health into community-based inclusive development in low- and middle-income countries (LMICs), based on "real-world" practice. Two key objectives are:

- To develop detailed case studies of community-based rehabilitation (CBR) programmes taking diverse approaches to mental health integration in LMICs.
- To distil from these case studies key learning about the integration of mental health into community-based inclusive development in LMICs.

This report represents one of the key deliverables of the project: documentation of the field visit conducted to a CBR programme in Nigeria in 2018. Information contained in this report will be incorporated into a three-country (Bangladesh, Bolivia, Nigeria) case study of CBR programmes to be submitted as a research article for publication in a peer-reviewed journal as a further deliverable. Hence, this report should be considered under embargo until the case study is published.

This report may be circulated internally within the offices of CBM International, London School of Hygiene and Tropical Medicine, and St. Joseph's Rehabilitation Centre. Any requests for further dissemination should be directed to the lead author for approval (grace.ryan@lshtm.ac.uk).

I. Methods

This report presents findings of a field visit to St. Joseph's Rehabilitation Centre in Ukana Iba, located in Nigeria's Akwa Ibom State, which took place 11-21 June 2018. During the field visit, the author interviewed the Administrator of the Centre, its Community Psychiatric Nurse, the four volunteers currently supporting the community mental health programme, and twelve beneficiaries, including five service users, six carers, and one user-carer. [Table 1]. Interviews were audio-recorded for further reference. Informal conversations with two of the four sisters managing the Centre were also informative but were not audio-recorded.

Table 1. Interviews by participant type

Participant Type	Male	Female
Centre Staff	**1**	**1**
Volunteers	**3**	**1**
Service Users	**2**	**3**
Epilepsy	1	1
Psychosis	1	2
Carers	**3**	**2**
User-Carers	**1**	**1**
Epilepsy	0	1
Psychosis	1	0
Total Interviews	**10**	**8**

Clinic observations were carried out at the Centre and three outreach clinics: Asaba, Ika and Odorikot. The author also received a tour of the Centre and attended stakeholder meetings with the Parish Priest in Asaba and two psychiatrists from public hospitals in Akwa Ibom. Photographs were taken to document different aspects of the programme's functioning; however, efforts were made

to avoid photographing faces of clients, in order to protect anonymity. Where faces were photographed, subjects were asked to complete a consent form.

The author also reviewed documentation provided by CBM (a 2015 evaluation of 10 CBR projects supported by CBM and three reports of previous visits to the Centre by CBM staff), the Rehabilitation Centre (two sets of handover notes and the 2016 and 2017 Rehabilitation Centre annual reports), and the community mental health programme (quarterly, biannual and annual statistics from 2013 through 2017).

A. Strengths and Limitations

The field visit was conducted by the author, an external researcher with experience conducting case studies of community mental health programmes in Nigeria. A systematic approach was used to document the programme, following the Case Study Methodology to Monitor and Evaluate Community Mental Health Programmes in Low- and Middle-Income Countries developed by the Case Studies Project, a collaboration between CBM and the London School of Hygiene and Tropical Medicine. The Case Study Methodology has previously been used for the evaluation of community-based mental health programmes in LMICs, including in Nigeria (Cohen 2011, 2012).

Unfortunately, self-help group meetings, home visits and vocational training sessions are increasingly rare at the programme in question. Further, transport was not available to observe announcements made in churches; thus, it was not possible to observe these activities, which have historically been important parts of the CBR programme operated by St. Joseph's. Additionally, the direct supervisor of the Community Mental Health Programme was on leave at the time of the field visit and unavailable for interview.

Since this programme was established, there has been significant turnover in the leadership of the CBM Nigeria Country Office as well as the Rehabilitation Centre and the Community Mental Health Programme, specifically. As a result, the institutional memory upon which to draw for the purposes of this case study was also somewhat limited.

Additionally, as CBM is no longer requiring regular reports from the programme, most statistics are not up to date. It was also discovered during the field visit that CBM's format for reporting aggregated statistics on service utilisation produced unreliable data, failing to accurately distinguish between numbers of individual clients and numbers of contacts with clients. A more rigorous evaluation would have entered all data from the programme's daily registries in order to produce a thorough analysis; due to time and resource constraints, only two years of data are analysed, and only from the Centre clinic at Ukana Iba (not outreaches) [Table 5].

B. Ethics

Although formal ethical review by an accredited institutional review board is not always necessary for the conduct of a case study, this field visit involved interviews with service users and carers, and therefore could be construed as human subjects research with a vulnerable population. Ethical approvals were therefore secured from the London School of Hygiene and Tropical Medicine (UK) and the Akwa Ibom State Ministry of Health (Nigeria).

II. Findings

A. History of the Programme

The Community Mental Health Programme is operated out of St. Joseph's Rehabilitation Centre, originally as part of a broader CBR Programme that is now largely defunct. The history of the Centre, CBR Programme and Community Mental Health Programme is described further below and in the timeline provided [Table 2].

1. St. Joseph's Rehabilitation Centre

St. Joseph's Rehabilitation Centre is sited on a property in Ukana Iba belonging to the Catholic Diocese of Ikot Ikpene in Akwa Ibom State, located in Nigeria's oil-rich Delta Region. A rehabilitation centre was initially established here by the first Anglophone African Cardinal of the Catholic Church, with support from the local parish priest, in the wake of the Biafran War. Initially the focus was on providing care for those wounded—particularly amputees— but eventually the Centre started welcoming clients with other physical disabilities. Construction was funded by Swiss Caritas and completed in 1978, the same year that the Medical Missionaries of Mary assumed responsibility for the management of the Centre. At the time, it mainly functioned as a vocational training centre with a physiotherapy unit attached. It became St. Joseph's Rehabilitation Centre after the Daughters of Charity of St. Vincent de Paul in Nigeria started the Ukana Iba Community of St. Joseph's in 1982. It continues to be run by four sisters of the Daughters of Charity.

The first sister in charge was a teacher by training, not a healthcare professional. This was evident in the Centre's focus on special education and skills acquisition. It ran a school as well as vocational training in carpentry, shoe-making, welding and secretarial skills. This work was supported by VSO Netherlands, who provided instructors, though the Centre was responsible for covering their room and board. In 1996 CBM began funding this work as part of the CBR programme, which then had its own office on-site.

The focus on special education and skills acquisition began to gravitate toward orthopaedics after the sister in charge handed over responsibilities to another who was a physiotherapist by training. The Centre added wards, an operating theatre, x-ray department, physiotherapy department, and manufacture of wheelchairs and orthopaedic aids. The Centre then expanded to include general health care and services for HIV and tuberculosis. It established its own laboratory services, ultrasonography and pharmacy. Mobile teams of orthopaedic surgeons (originally from Mkar in Benue State, then from Abuja) began visiting to carry out operations. By 2016, the Centre was designated a full-fledged hospital by the state's medical services.

Figure 2. Entrance to St. Joseph's Rehabilitation Centre

An assortment of different partnerships and funding sources underpin the various facilities and services available. For example, in 2009 Partner for Development sponsored the HIV screening and prevention programme. The same year, the

Centre was selected as a TB Control Centre by Akwa Ibom State Government, which also paid for renovation of the Centre's physical structures. However, CBM was the main funder of the CBR programme for over 15 years until funds were withdrawn, at which point many of the on-site services and facilities targeting people with disabilities—such as the carpentry workshop [Figure 4]—also began to decline.

As with many other states in the Niger Delta region, Akwa Ibom experiences high levels of violent crime. Consequently, the resources available at the Centre have left it vulnerable to theft. The Centre closed temporarily in 2002 following a period of criminal activity in which the perpetrators were suspected to be internal. Most of the staff were removed from their positions and programming halted until 2003.

2. CBR Programme

Building on the services already available at the Centre, CBR was initiated in 1996 with support from Paul Creswell of the disability and development organisation CBM, formerly the Christian Blind Mission. Starting in 1994, CBM had begun funding ten church-based CBR projects spread across eight of Nigeria's 36 states, including two in Akwa Ibom: St. Joseph's Rehabilitation Centre and St. Louise's School, which targets children with disabilities. Initially, two field workers were trained for the CBR programme at St. Joseph's. The following year, additional CBR volunteers were trained. CBM donated nine motorcycles in 2000 to help facilitate fieldwork in the community.

According to a previous evaluation of CBM's support for CBR in Nigeria (Cornielje et al. 2015), programmes like St. Joseph's performed well throughout the late 1990s and 2000s, but began to encounter financial hardships in the 2010s:

> "Programs seem to flourish until 2011 often supported with substantial funding from CBM (and other donors) but also being and becoming increasingly dependent on CBM. The years following 2011 were marked by new policies, reduced funding (e.g. AusAid funds) and a lack of communication between the Country Office and the partner organisations including dwindling support, supervision and capacity building and finally the departure of the CBR coordinator (Mr Tsengu)." (pp.2)

However, a 2010 report from a CBM field visit suggests the programme was already under-resourced and that cut-backs had begun before 2011 (Ita, 2010):

> "There was a palpable low moral [*sic*] among the fieldworkers and volunteers due to poor monthly allowances. The CPN… is threatening to withdraw his support if the recent cut on his monthly allowance is not reversed." (pp.3)

CBM withdrew funding for field workers in 2013, expecting they would either continue to operate on a volunteer basis or that local communities—particularly local parish priests—would continue to support them. Unfortunately, this support did not materialize. Although some volunteers remained, without money for communications or transport, their activities were sharply curtailed.

3. Community Mental Health Programme

A nurse trained in psychiatry was seconded to St. Joseph's Rehabilitation Centre in 2001 and was one of few staff asked to return after the Centre's temporary closure in 2002. Upon the reopening of the Centre in 2003, the Community Mental Health Programme was established as a service embedded within the broader CBR programme. Additional training on community mental health was provided by CBM, and the same CBR field workers and volunteers involved in community outreach for physical disabilities took on responsibilities for psychosocial disabilities.

Perhaps because it grew out of a programme focused on disability, the focus was largely on clients with epilepsy and severely disabling mental health conditions, such as psychotic disorders. Eventually the community psychiatric nurse (CPN) was also trained in the World Health Organisation's mental health Gap Action Programme (mhGAP) interventions for priority mental, neurological and substance use disorders, broadening the scope of mental health conditions treated; however, clients with epilepsy remain in the majority [Table 5].

The Community Mental Health Programme was hard-hit by the withdrawal of CBM funding in 2013, but the CPN and four volunteers continue to provide regular on-site and outreach clinics with support from the sisters who run St. Joseph's, recognizing that a lapse in services would leave many clients in Akwa Ibom unable to access mental health care.

Table 2. Abridged History of St. Joseph's Rehabilitation Centre

Timeline	
1960	• Biafran War ends
1972	• Swiss Caritas agrees to fund rehabilitation Centre
1976	• Construction of Centre begins
1978	• Centre construction complete • Congregation of Medical Missionaries of Mary assume responsibility
1980	• Daughters of Charity of St. Vincent de Paul assume responsibility
1982	• Daughters of Charity of St. Vincent de Paul in Nigeria start the Ukana Iba Community of St. Joseph's
1996	• CBR project funded by CBM • Two field workers trained
1997	• CBR volunteers recruited
2000	• CBM donates motorcycles to support community outreach
2002	• Centre closed due to criminal activity
2003	• Centre reopened • Community mental health programme initiated
2005	• Vehicle donated by CBM to support community outreach
2006	• Grant for economic integration
2011	• Paul Caswell leaves CBM
2012	• More motorcycles donated by CBM
2013	• Withdrawal of subsidy and field workers • Basic computer training commenced
2016	• Centre registered as hospital by state medical services

B. Description of the Programme

1. Conceptual Framework

Although the Community Mental Health Programme was originally embedded within a broader CBR programme, the latter is now largely defunct. Consequently, the Community Mental Health Programme operates more as a mental health clinic with community outreach, rather than as a CBR programme for people with psychosocial disabilities. Table 3 outlines the key elements of the World Health Organisation's CBR Matrix and uses a red/yellow/green system to characterize the support currently available:

- **Red** indicates that support has never been available
- **Yellow** indicates support that was previously available but is no longer or is extremely limited in scope or supply

- **Green** indicates support that is currently available

Table 3. Alignment of Services with CBR Matrix

Health	
Promotion and Prevention	• Occasional community mental health talks on a volunteer basis, but mostly to raise awareness of services
Medical care	• On-site and community mental health clinics • On-site hospital for physical health care
Rehabilitation	• Mostly advice on rehabilitation provided to users and carers during consultations with CPN • Very occasional home visits by CPN and/or volunteers
Assistive devices	• Available for clients with physical disabilities
Education	
Early childhood	• None
Primary	• Some scholarships available to disability-inclusive primary school, though typically for students with physical disabilities
Secondary and higher	• Some scholarships available to disability-inclusive secondary school, though typically for students with physical disabilities
Non-formal	• Centre offers some courses (e.g. computer skills), though typically for students with physical disabilities
Lifelong learning	• None other than "non-formal" education and "skills-development"
Livelihood	
Skills development	• On-site Vocational Training Centre offers welding, carpentry and shoe-making, though activities are limited due to resource limitations
Self-employment	• Some efforts to sell products from Vocational Training Centre, though challenging market context
Financial services	• None
Social protection	• None
Social	
Personal assistance	• None
Relationships, marriage and family	• None other than basic counselling and psychoeducation by CPN during consultations
Culture and arts	• None
Recreation, leisure and sports	• None
Justice	• None
Empowerment	
Advocacy and communication	• None
Community mobilisation	• None
Political participation	• None
Self-help groups	• Two self-help groups for people with psychosocial disabilities, now largely defunct, as income-generating activities were unsuccessful
Disabled people's organizations	• One was established, but largely for physical disabilities

2. Promotion and Prevention

Volunteers speak in churches, schools and other community fora to raise awareness of the availability of services, but it is unclear to what extent they also raise awareness of mental health more generally. A 2010 CBM report observes this was a shortcoming even before funds were withdrawn:

> "Awareness on mental health issues is still lacking among the rural population even more so among the uneducated members of the community. One cannot be certain to what extent the fieldworkers and volunteers had focused on this aspect of the programme. In principle, the awareness-raising activities of the fieldworkers and volunteers are usually scheduled to hold monthly; however, it has been confirmed that these activities are not usually implemented as scheduled." (Ita 2010, pp.3).

In interviews, clients confirmed that most outreaches do start with a health talk by the CPN or a volunteer, but this was not observed during the field visit, and the topics of the health talks do not appear to be pre-determined by any broader prevention or promotion strategy.

3. Mental Health Care

The Community Mental Health Programme offers biomedical treatment as per the mhGAP guidelines. The CPN also offers psychoeducation and basic counselling to service users and carers, with a focus on problem-solving; however, there is no manualised psychotherapy provided. These services are provided either at the on-site clinic at Ukana Iba, or at community outreach clinics across the state. In past, home visits were available for clients in extreme need—either by the CPN or a field worker—however, these have also waned as a result of resource limitations.

Monthly outreach is available in 11 communities spread across eight local government areas [Table 4]. Eight of these communities hold outreach in churches, two in a village hall or civic centre, and in one case, the veranda of a volunteer's private residence is used, for lack of an appropriate alternative. This is on a busy road and doesn't offer much privacy.

Figure 3. Outreach on the veranda of a volunteer's home

The Rehabilitation Centre serves the local population of Ukana Iba, as well as those who cannot or do not want to attend outreach. While there used to be field workers in every community covered by the Community Mental Health Programme, most stopped working after CBM withdrew funds for this purpose. Some continued as volunteers, but there has been attrition in recent years among the volunteers due to changes in their personal circumstances.

Complex cases are referred to tertiary services for treatment, although in practice, few choose to act upon the referral, primarily due to the high cost of healthcare and transport. Accessibility of services is also hampered by poor roads, security issues and inclement weather, particularly when travelling by motorcycle. Consequently, the CPN is often required to manage acute and complex cases, with minimal supervision from a psychiatrist employed by CBM, who visits the programme on an irregular basis.

Table 4. Distribution of Mental Health Services and Volunteer Staff

LGA	Community	Meeting place	Volunteers
Esien Udim	Okon	Village hall	1
	Odoro Ikot	Church	1
	Ukana Iba	Centre	-
Etim Ekpo	Ikot Ebo	Church	-
Ikot Ekpene	Ifuho	Church	-
Obot Akara	Nto Edino	Church	-
	Nto Esu	Church	-
Orukanam	Asakpa	Church	1
	Inen	Church	-
Ukanafun	Ikotakbankuk	Civic Centre	-
Ika	Urua Inyang	Volunteer's Residence	1
Ibiono	Use Abat	Church	-

4. Livelihoods and Self-Help Groups

The CBR programme received a 50,000 naira grant for economic integration in 2006, but a 2010 CBM report confirms this was "still under developed [*sic*]" several years later:

> "Only one client was reported to have benefited from the integration loan. Nevertheless, this client did not use the money properly. Consequently, he is unable to pay back the loan. This is said to be one of the reasons why the Centre is not very keen on supporting the integration programme." (Ita 2010, pp. 3)

Two years later, a revolving loan scheme was portrayed as a desirable addition to motivate newly formed self-help groups:

> "Self help [*sic*] groups have been formed in two locations served by the project—Asakpa and Abiakpo. They have populations of 18 and 14 respectively. They meet regularly and have elected officials to run the affairs of the group. The Psychiatric [*sic*] nurse is soliciting for funds for the establishment of loan scheme [*sic*] to help keep the groups together." (Nwefoh 2012, pp. 2)

However, at the time of the 2018 field visit covered in this report, only one self-help group was semi-active. The group had invested in a cooperative-style party rental business, but the tent and chairs they purchased could not accommodate large gatherings, and also suffered from wear and tear. As a result, it was no longer financially viable.

As the CPN predicted, self-help group members lose interest in meeting unless there is an economic benefit to participation. During interviews, clients who had been a part of self-help groups said they stopped meeting because they couldn't pay dues or because income-generating activities that they used to do as a group had stopped.

5. Additional Psychosocial Support and Rehabilitation

Although there is no formal support for community or family reintegration of people with psychosocial disabilities, the CPN actively encourages family members to be accepting of the service user and ensure that to whatever extent possible, he or she is included in day-to-day activities, such as household chores and community events. Users are also encouraged to stay active, contribute to the household and pursue life goals such as work, education and marriage.

A child who is out of school may be provided a letter along with educational material for his or her teachers, reinforcing that the condition is not contagious, that it is being controlled with medication, and that the student should be allowed to participate on an equal basis with others. School fees for children with disabilities living in extreme poverty are also available for those up to age 25 via the Lilian Fund, though few recipients have psychosocial disabilities.

With CBM funding, the Centre was able to cover materials as well as food and board for people with disabilities to undertake vocational training. Today, all that really remains of the skills acquisition component is welding, although one client with epilepsy is being trained in shoe-making. The carpentry workshop has fallen into a state of disrepair and is no longer used. When functioning properly, on-site welding, carpentry and shoe-making workshops allow the Centre to provide low-cost assistive devices to clients with physical disabilities. Attempts to sell products beyond the Centre have not been successful, perhaps due to the high level of competition in the saturated local market.

Figure 4. Carpentry workshop in state of disrepair

C. Programme Resources

1. Human

The Community Mental Health Programme is mainly run by a CPN who was initially seconded to the programme by the State Ministry of Health and additionally received an allowance from CBM. However, after reaching retirement age, he was no longer eligible for his government salary, and his allowance must now be covered by the Centre. He is supported by four volunteers, one of whom serves as an assistant and attends all outreaches. He is also paid a small allowance by the Centre. The other volunteers are unpaid, and their activities are generally restricted to their own communities. One of the sisters in charge of the Centre supervises the Community Mental Health Programme.

2. Transportation

A Toyota Hilux donated by CBM more than a decade ago remains the main mode of transportation for outreach. When the CBR Programme was operating, field workers were given motorcycles, which were considered the property of the Centre, but field workers were expected to pay for their fuel and maintenance. At least one of the current volunteers who was formerly a field worker can no longer use her motorcycle, as it has fallen into disrepair and she cannot afford to fix it.

Transport is also an issue for clients. One client described travelling for nearly two hours by bicycle to attend outreach—a prohibitively long journey in the rainy season. Others must pay out of pocket for transport, adding to the cost of accessing treatment.

Figure 5. Ageing vehicle used for outreach

3. Funding

Unfortunately, the resources available at the Centre belie its often precarious financial situation. Much of the Centre's funding is either time-limited and project-based or provided as one-off or in-

kind donations— for example, donations of vehicles, generators and buildings which must then be powered, maintained and secured, without sufficient income to cover overheads.

In past, the Centre received support from the former State Governor. He paid for renovations of the hall, physiotherapy unit and outpatients' block, and donated an additional one million naira. The new State Governor has not continued this support. The Universal Basic Education Commission has also provided occasional grants with government funding. However, the Centre's biggest source of income has historically been from development organisations like CBM, Partner for Development, and the Liliane Foundation, most of which appear to have reduced their support in recent years.

The Centre's general health services are starting to charge clients in order to generate more revenue, even though some treatments such as anti-retroviral therapy are still free of charge. For example, it charges for appointment cards, consultations, sale of medications, x-rays, laboratory tests, physiotherapy and assistive devices. An orthopaedic surgeon based at a teaching hospital in Abuja also visits the Centre periodically to perform surgeries, splitting the surgery fee and profit on medications with the Centre. The Centre also occasionally receives local cash donations.

These are creative solutions, but the Centre has not been able to avoid passing some of the financial burden onto clients of the Community Mental Health Programme. A small mark-up on the medications dispensed by the CPN helps to subsidize the programme, and the Centre does its best to cover the rest from other sources of income.

The programme's main costs are for medication, fuel for the outreach vehicle, the driver's salary, a small stipend for the CPN, a small allowance for the volunteer who assists him, client folders and other consumables such as pens and paper.

4. Medications

Medications are purchased on the open market from a trusted supplier with whom the CPN has a long-standing relationship. The consistent good quality is recognised by clients, who often prefer to fill their prescriptions through the programme as opposed to other hospitals or pharmacies. It was intended that a Drug Rotating Fund could sustainably supply medications at low cost to clients; however, the market cost of some drugs has risen sharply in recent months, and some of this cost has necessarily been shifted to clients. Clients now pay approximately 3,000 Naira (£8.23 USD) for one month's supply of medication. Most clients described this as a hardship in interviews. At least two explained that their families now had to choose between buying medications for the client or for another close family member, such as a brother or mother.

D. Information System

1. Data Collection

The CPN maintains a patient file for each client, issued at first visit. The patient file covers the following domains:

- Age
- Gender
- Marital Status
- Occupation
- Diagnostic Category (though this does not cover all mhGAP priority disorders)

It also has space for notes on clinical and functional status, other physical health problems, treatment and referral.

A structured form is not used at follow-up visits, but the CPN will typically note the date and any important changes to clinical or functional status, prescribed treatment and referral instructions.

The CPN also maintains a paper-based annual register which is capable of tracking individual clients' contact with services on a yearly basis. This also records the clients' age, sex and diagnosis, for easy reference.

2. Data Processing and Reporting

All data processing is done by hand by the CPN, using paper forms. The data is then typed into CBM's reporting form by the Centre's secretary. In past, these reports were sent electronically to the CBM Nigeria Country Office every six-months.

It was discovered during the field visit that the Community Mental Health Programme is using flawed tools originally designed by CBM for reporting. These tools fail to accurately distinguish between individual clients and contacts with clients. The process of aggregating the data across multiple months also leads to duplications. These are issues common to the monitoring and evaluation of programmes serving people with chronic conditions, but were not taken into account by CBM, despite several queries raised by the CPN. Recognising this issue, other CBM-supported mental health programmes in Benue, Calabar and Cross-River State have already converted to using the new MIND ME (Mental health Information aND Monitoring and Evaluation) system developed as part of the CBM-London School of Hygiene and Tropical Medicine Case Studies Project. However, as the transition to MIND ME occurred after CBM had already withdrawn funding from St. Joseph's, the Community Mental Health Programme appears to have been left behind.

E. Service Utilisation Data

Due to the limitations of the information system, it is not yet possible to report accurate data on service utilisation of the Community Mental Health Programme. However, in order to aid in understanding the general patterns of service use during the field visit, the author entered and analysed the annual registers for Ukana Iba for the years 2016 and 2017, respectively [Table 5].

Client demographics may be substantially different among those attending services at the Centre in Ukana Iba, in comparison to those attending outreach. However, it does appear from this data that the majority of clients have either epilepsy (40.31-40.38%) or psychosis (9.18-10.33%). This is consistent with observations of outreach and with findings from other CBM-supported mental health programmes in Nigeria.

Table 5. Service utilisation data for Ukana Iba, 2016-2017

	2016					2017				
	Epilepsy	**Psychosis**	**Depression**	**Substances**	**Subtotal**	**Epilepsy**	**Psychosis**	**Depression**	**Substances**	**Subtotal**
	n (%)	n (%)	n (%)	n (%)	**n (%)**	n (%)	n (%)	n (%)	n (%)	**n (%)**
Males	**79 (40.31)**	**18 (09.18)**	**0 (00.00)**	**1 (00.51)**	**97 (49.74)**	**86 (40.38)**	**22 (10.33)**	**1 (00.47)**	**0 (0.00)**	**109 (51.17)**
Children	**29**	**0**	**0**	**0**	**29**	**28**	**2**	**0**	**0**	**30**
0-5	3	0	0	0	3	1	0	0	0	1
6-12	16	0	0	0	16	13	0	0	0	13
13-17	10	0	0	0	10	14	2	0	0	16
Adults	**46**	**17**	**0**	**1**	**64**	**57**	**20**	**1**	**0**	**78**
18-25	14	6	0	0	20	23	4	0	0	27
26-35	23	8	0	1	32	18	11	1	0	30
36-50	6	3	0	0	9	10	3	0	0	13
51+	3	0	0	0	3	6	2	0	0	8
Unknown	**4**	**1**	**0**	**0**	**5**	**1**	**0**	**0**	**0**	**1**
Females	**56 (28.57)**	**29 (14.80)**	**13 (06.63)**	**0 (00.00)**	**98 (50.26)**	**57 (26.76)**	**38 (17.84)**	**9 (04.23)**	**0 (0.00)**	**104 (48.83)**
Children	**17**	**1**	**0**	**0**	**18**	**12**	**3**	**1**	**0**	**16**
0-5	5	0	0	0	5	3	0	0	0	3
6-12	3	0	0	0	3	0	0	0	0	0
13-17	9	1	0	0	10	9	3	1	0	13
Adults	**38**	**28**	**13**	**0**	**79**	**45**	**35**	**8**	**0**	**88**
18-25	17	7	3	0	27	19	8	2	0	29
26-35	13	12	5	0	30	18	13	3	0	34
36-50	5	4	3	0	12	7	9	2	0	18
51+	3	5	2	0	10	1	5	1	0	7
Unknown	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**
Subtotal	**135 (68.88)**	**47 (23.98)**	**13 (06.63)**	**1 (00.51)**	**196 (100)**	**143 (67.14)**	**60 (28.17)**	**10 (04.69)**	**0 (0.00)**	**213 (100)**

III. SWOT Analysis

A. Strengths

The Community Mental Health Programme serves populations in extremely vulnerable situations who are otherwise unlikely to access effective, affordable mental health care in Akwa Ibom. During interviews, many clients reported seeking treatment initially from traditional or spiritual healers or private pharmacists and seeing no change in their symptoms until they came to the CPN. A psychiatrist visiting from the Akwa Ibom State University Teaching Hospital noted that despite the rising cost of medication, the services the CPN provides remain much more affordable than facility-based care and allow clients to remain in their communities instead of being institutionalised.

The quality of the services provided by the CPN is also exemplary, particularly given the strongly hierarchical culture of medicine in Nigeria. The CPN easily spends an hour or more with new clients, and around twenty minutes with returning clients. During the field visit, he was observed consoling distressed clients and their families, advising them on how to take their medications and handle side effects, and repeatedly advocating for clients to be included in family and community activities and to pursue life goals. These are best practices applied by an experienced hand which are sometimes difficult to come by in overstretched, under-resourced services.

The resilience of the CPN and the remaining volunteers is also impressive. Despite substantial cut-backs to what were already modest benefits, they continue to work, sometimes into their 70s, often while maintaining side-businesses to sustain themselves. This demonstrates real dedication to their cause, which could be leveraged to help inspire and motivate a new generation of providers to eventually take up their mantle.

B. Weaknesses

Despite the Community Mental Health Programme's many strengths, it is disappointing to see that it does not have the resources necessary to live up to its potential. What is being provided cannot accurately be described as CBR for people with psychosocial disabilities, as most of the non-biomedical services that were once available are no longer functioning adequately. In particular, it is disappointing that self-help groups have not been more successful, as these have proven crucial for economic empowerment and advocacy in other West African contexts, and may have an added therapeutic benefit. As described in a 2015 evaluation of CBM Nigeria's CBR projects:

> "While CBM (International) preaches CBR as an approach towards inclusion of people with disabilities, we question whether this is practiced in Nigeria… CBR should have a clear focus on raising awareness in the community, on changing attitudes, and working alongside local structures and with local resources and working towards participation, equal opportunities and inclusion of people with disabilities. The majority of the CBR programs in Nigeria do not reflect this. Although such programs do make an impact on the lives of people with disability they often do not target sufficiently inclusion of people with disabilities in the community." (Cornielje et al. 2015, p. 22).

Although the CPN and each of his volunteers already has well over a decade of experience, it is also worth noting that CBM has not lived up to its responsibility to provide regular, in-depth clinical supervision. Particularly given the low rate of successful referral to tertiary facilities, it is important that community mental health providers can consult highly trained specialists to better manage complex cases. More regular and responsive supervision might also have resolved issues with the CBM reporting tools earlier.

Previous reports have also judged the Centre's efforts at stakeholder engagement to be insufficient to ensure sustainability and scale-up. However, even CBM-supported mental health programmes operated at a large scale through public-private partnerships with government and other key partners have struggled to achieve sustainability. The case of the State Governor who formerly offered support—primarily because he lived in close proximity to the Centre—and was then removed from government is illustrative of some of the realities of stakeholder engagement in a challenging political context.

C. Opportunities

The Centre still has the basic infrastructure and expertise in place to reignite its CBR programme and strengthen its Community Mental Health Programme even over a relatively short time-span. Its highly experienced CPN and volunteers are well-placed to train, supervise and mentor new mental health workers to take over some of their more taxing responsibilities and eventually take ownership of the programme. This would be a good candidate for inclusion in CBM's new Community Mental Health Initiative and could further benefit from the expertise specific to self-help groups and livelihoods that the BasicNeeds merger brings. However, CBM and partners must act quickly to avoid missing this window of opportunity.

With more robust research, monitoring and evaluation and communications, CBM could also market its efforts to move St. Joseph's toward sustainability and scale-up as a demonstration project from which funders' other investments in mental health and/or disability can benefit. This sort of creative reframing might entice funders who are otherwise wary of further investment in what can be seen as a sector reliant on "hand-outs" rather than "hand-ups".

D. Threats

This is a difficult time for St. Joseph's Rehabilitation Centre, and the Community Mental Health Programme faces many threats—chief among them are overall sustainability, which is also linked to attrition and mobility, described further below.

1. Sustainability

As it is currently operating, this programme is not sustainable. Services are provided by a single CPN who has already exceeded the age of retirement and is supported by a handful of volunteers who no longer have the resources available to cover their transport and communications, much less their time. As such, it is operating largely on goodwill, in hopes that funding will resume in near future. Meanwhile, any further attrition will severely disrupt services, as new staff cannot be recruited without additional incentives. Even when the programme was receiving CBM funding, benefits were not always competitive enough to retain staff. This is a perilous position for a 15+ year programme relied upon by hundreds of people in vulnerable situations.

Although it is understandable CBM wishes to see evidence of ownership by government and the church—particularly financial ownership— it has not yet put in place a responsible exit strategy to help the programme achieve sustainability. Indeed, overreliance on government financing is a significant threat to sustainability in an environment of political instability, where elections can result in the departure of important champions, changes in budgets and priorities, and emergence of new ethnic and secular interests that may erode government buy-in. Even if commitments are made, lack of accountability is a systemic issue affecting all levels of government in Nigeria. Further, strict hierarchies and bureaucratic processes may strip power from local governments responsible for community-based health and social welfare.

A strong public-private partnership could leverage existing resources in the public sector—such as staff and infrastructure—while also improving donor confidence and accountability crucial to fundraising. Corporate social responsibility, for example, might be a viable avenue to diversify funding, given the programme's location in the oil-rich Delta region. Private philanthropy and other fundraising could also target wealthy individuals from the region, in Nigeria and abroad. In this case, the programme's affiliation with the Catholic Church could provide valuable access to a global network of charitably-minded individuals and organisations.

Investing strategically in viable income-generating activities would be prudent, both in terms of helping beneficiaries to establish sustainable livelihoods, but also in terms of subsidising the activities of livelihoods programmes and self-help groups. It is notable that the only vocational training that has survived is that for which there is a ready demand from the orthopaedic unit. A market analysis is needed to identify other local demands which could be met through a viable social enterprise.

2. Attrition

Mental health services are essentially dependent on a CPN and four volunteers. Both the CPN and two of the volunteers are in their 70s, and none is under the age of 40. The CPN has already tried to retire once before, but upon realising that there was no one available to replace him, agreed to continue. No new volunteers or providers are being trained.

Without adequate compensation, the risk of attrition is especially high. While all the volunteers and the CPN expressed a strong commitment to continuing their work, personal circumstances can easily change. One volunteer, for example, was absent for three months after a family issue forced her from her home.

Figure 6. Community Mental Health Programme volunteer

3. Mobility

Some volunteers' motorcycles have fallen into disrepair, limiting their ability to conduct awareness-raising activities, facilitate self-help groups and visit clients at home. The expectation that volunteers will fuel and maintain their motorcycles cannot be met while they are not receiving allowances.

The vehicle donated for community outreach is over ten years old and used several times per week to travel across often poorly maintained or unpaved roads [Figure 5]. If it breaks down and there are no resources available to repair or replace it, the outreach function of the community mental health may not be able to continue. In addition, banditry can make some roads unsafe to travel.

IV. Conclusion

A 2015 evaluation of CBM Nigeria's CBR projects emphasised that CBR should operate "as a spider in the web". This is an apt metaphor for a "web" of interconnected services that "catches" a person living with disability; the spider is alerted to movement anywhere in the web and takes action (Cornielje et al. 2015). However, CBM appears to have forgotten the significant effort and resources that a spider must expend to continuously repair and strengthen its web. Otherwise, the web inevitably breaks, people fall through the gaps, and eventually, it disappears completely.

Ensuring sustainability means considering the interdependencies in this web, identifying points of vulnerability, and equipping the project to first reinforce them, then repair damage as necessary. CBM must put in place a responsible, phased exit-strategy that empowers projects working in extremely challenging operating environments to continue to maintain—and even improve—their services in the future. Perhaps counterintuitively, weaning projects off CBM funding in the long-term requires additional investments in the short- to medium- term, for example in networking and advocacy, communications for fundraising, and capital for viable income-generating activities.

If no action is taken, community mental health may continue to be offered at reduced capacity for as long as the CPN and his volunteers are willing and able, but the "web" CBM helped to create will continue to break down. Even the mobile dispensary function of the programme may not remain mobile if attrition among volunteers continues, or if vehicles fall into disrepair. Either way, prices of essential medications may continue to rise to cover overheads and higher market costs, even as vocational training, self-help groups and other opportunities for livelihoods support to help clients pay for their medications fall by the wayside. This is not sustainable and puts not only clients at risk, but also CBM's 15+ year investment in integrating mental health into CBR in Akwa Ibom.

Figure 7. CPN distributes medication from his desk at Ukana Iba

V. References

Cohen, A., Eaton, J., Radtke, B., De Menil, V., Chatterjee, S., De Silva, M. & Patel, V. (2012) Case Study Methodology to Monitor and Evaluate Community Mental Health Programmes in Low-Income Countries. CBM International and London School of Hygiene and Tropical Medicine.

Cohen, A., Eaton, J., Radtke, B., George, C., Manuel, B. V., De Silva, M. & Patel, V. (2011) Three models of community mental health services In low-income countries. *International Journal of Mental Health Systems,* 5**,** 3-3.

Cornielje, H., Cornielja, M., Ayuba, S., Ayuba, M., Ibrahim, A., Uyah, A. (2015) Evaluation of 10 CBR Programmes Supported by CBM in Nigeria: Final Report, October 8-23. CBM International and Enablement Netherlands.

Ita, A. (2010) ARO-W Project Visit Report, 15 March. CBM International.

Nwefoh, E. (2012) ARO-W Project Visit Report, 31 January-1 February. CBM International.