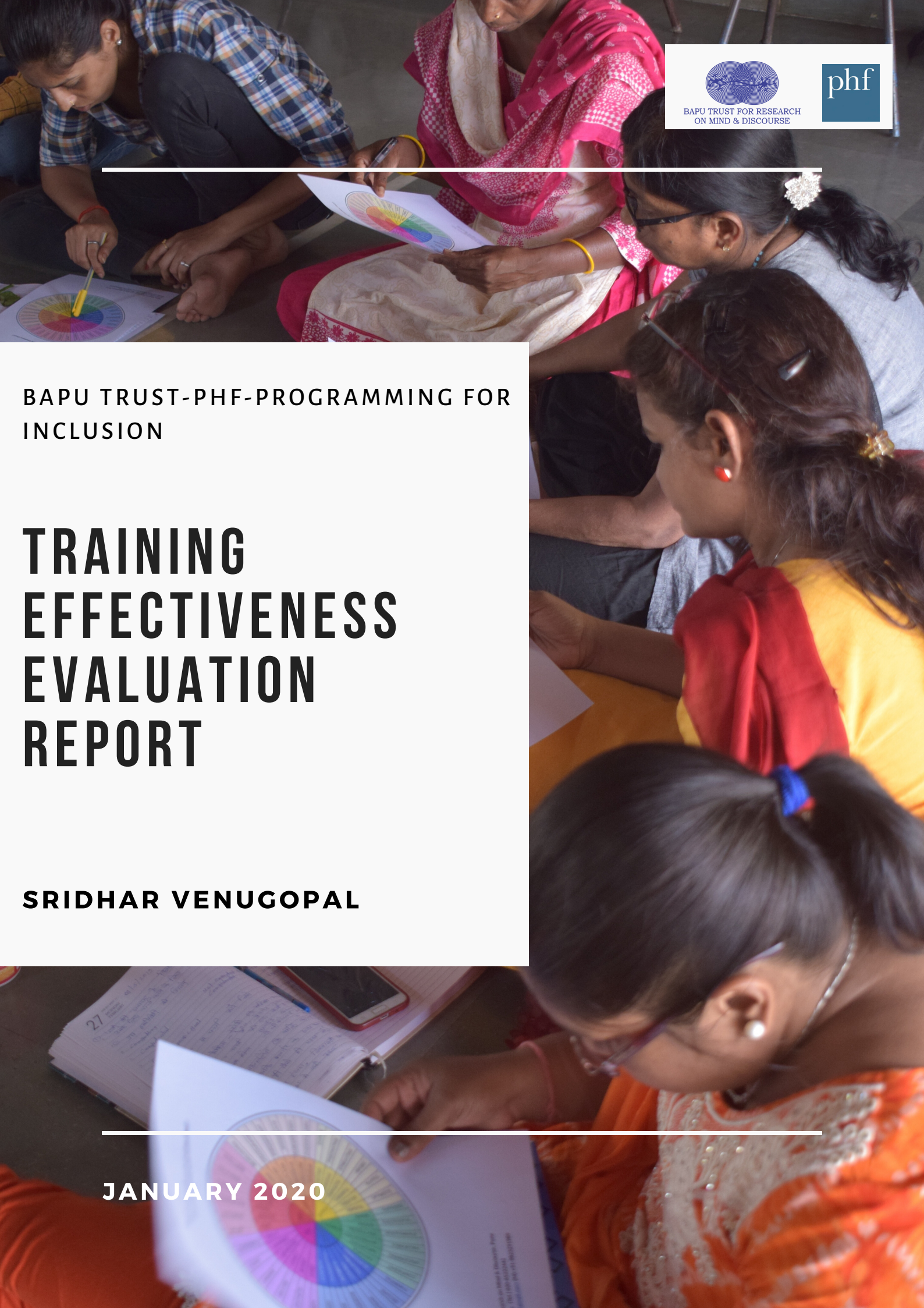

BAPU TRUST FOR RESEARCH ON MIND & DISCOURSE

phf

BAPU TRUST-PHF-PROGRAMMING FOR INCLUSION

TRAINING EFFECTIVENESS EVALUATION REPORT

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Disclaimer: This evaluation was done by an external evaluation team for the Paul Hamlyn Foundation, UK. The views expressed are those of the evaluation team, and not of the Bapu Trust.

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Abbreviations

Art. : Article
BT : Bapu Trust
FB : Feedback
GASVS : Gramin Adiwasi Samaj Vikas Sansthan
HR : Human Resources
IPCHS : Integrated People-Centered Health Services
M&E : Monitoring and Evaluation
MH : Mental Health
MIS : Management Information System
Obj. : Objective
OD : Organizational Development
OM : Organizational Maturity
PHF : Paul Hamlyn Foundation
PN : Partnering
PPSD : Persons with psychosocial disabilities
REM : Rapid Evaluation Method
TEA : Training Effectiveness Assessment
TPM : Training Process Maturity
UNCRPD : United Nations Convention on the Rights for Persons with Disabilities
WHO : World Health Organization

Acknowledgments

I would like to acknowledge and thank Paul Hamlyn Foundation (PHF) for lending their generous support to this project, Dr. Bhargavi Davar of Bapu Trust for envisioning this concept and ensuring it happens. A big thank you to all the staff and team at Bapu Trust for making my arrangements for travel and stay smooth and hassle free and for making material/s available for this evaluation. Thank you to the partner organizations, Samaan Society, GASVS and BKG Agricon for coordinating my travel within their areas and for making themselves available for the study. A sincere thanks to all the participants of the study who gave me their time, shared their experiences and for being a part of this study in all their sincerity.

The human family is complete when everyone is included.

- *Anonymous*

Inclusion works to the advantage of everyone. We all have things to learn and we all have something to teach.

- *Helen Henderson*

Executive Summary

Bapu Trust, Pune [BT] initiated a program for partnering with organizations in the development sector in order to build the capacity for community mental health and inclusion of persons with psychosocial disability [PPSD], in 2 states of India viz Madhya Pradesh and Chhattisgarh. The program was implemented with funding from the Paul Hamlyn Foundation [PHF], India during the period January 2018 to October 2019.

The program included:

1. Building key partnerships.
2. Developing training program.
3. Facilitating program implementation.
4. Knowledge captures and learning cycles.

In November 2019, it was decided by BT to carry out a project evaluation of this initiative, the scope of which included the training effectiveness, the supervision support, MIS and other related services provided by BT to the three partners. The partners in this program were Samaan Society, Indore ; GASVS, Saunsar and Chhindwara (Madhya Pradesh) and BKG Agricon, Raipur (Chhattisgarh).

Sridhar Venugopal, Management Consultant, Bangalore was charged with the responsibility of carrying out a Rapid Evaluation Assessment based on his response to the invitation for proposal from BT. The consultant carried out rapid evaluation assessment in two visits to the two states viz. Madhya Pradesh and Chhattisgarh and a visit to BT, Pune. The visit to the partner locations and BT, Pune happened during the period 21 November, 2019 and 07 December, 2019. Preliminary findings were presented in a meeting of the partners, the Country Director and Regional Manager of PHF and the representatives of the three partner organizations besides BT, Pune.

The consultant developed a model for Training Effectiveness Assessment consisting of four phases viz. *Knowing, Experiencing, Changing* and *Sustaining*. In consultation with BT, Pune

it was decided that the program involved not just Training Programs, but transfer of Seher - Urban Comprehensive Mental health and Inclusion services, to the partner organizations for implementation in the geographies of their operations. This necessitated adaptation of two other evaluation frameworks for Organizational Capability - Maturity of BT and the Partnering Effectiveness. Personal and telephonic interviews and Focus Group Discussions with various internal stakeholders of both BT and partner organizations were the methods by which primary data on the program were generated. The qualitative data that emerged out of the self report during 17 interviews and focus group discussions were coded using Atlas Ti software and analysed to assess the training effectiveness, organizational capability and partnering effectiveness. A few secondary data [documents shared by BT] were also referred to.

The highlights of the findings of the assessment were that the training program consisting of two modules, were assessed as excellent or best in class, that the participants as also the senior management of the partner organizations experienced. The supervision support and the guidance provided for institutionalization of MIS were also acknowledged to be of a good quality.

Broad basing the assessment to include Organizational capability and Partnering Effectiveness in so far as this program goes, led the consultant to adapt the Capability Maturity Model and the 4-Phase Partnering journey. Evidence for maturity of organizational processes essential for transfer of the model, as also partnering process were evaluated based on interviews with the senior management of both BT and the three partner organizations. Further, views of middle managers were also solicited on the same. Data from these interviews and also the assessment by the Consultant based on primary and secondary data base, besides documentary evidence provided, led to the following conclusion:

1. Organizational Capability Maturity for the Organizational Processes of BT were assessed at Initial Level, which is the first and default level of the five levels. The Training Process Capability of BT as an organization were assessed at Managed Level, which is the second level of the Capability Maturity Model.
2. Partnering Effectiveness has been assessed to have reached closer to Scoping and Building milestone. The next milestone is Managing and Maintaining for which a few aspects were evidenced during assessment.

Based on the findings and insights shared by the interviewees and groups, as also the expertise and experience of the Consultant both as part of organizations, as well as trained assessor in the above areas of the program, recommendations are made for long-term, medium-term and short / near-term initiatives. If one were to summarize the recommendations it would be that the next wave of training programs should start with a Competency-based Training Need Identification of persons with psychosocial disabilities, specifically in the context of Inclusion. Inclusion of persons with psychosocial disabilities should be classified based on various contexts, including that of the culture and social systems prevailed in the geographies served by partner organizations and their developmental approach. In addition, intensive supervision support during the early phases of implementation as well as institution of a robust information system for both BT and an extranet to cover partner organization activities in so far as services to persons with psychosocial disabilities. A few red-flags are also raised for consideration of BT and the partner organizations.

Overall, the approach taken by BT, the program design and implementation, as also the values in practice as evidenced and experienced by partner staff and management leads the consultant to conclude that the second wave of training programs as also further modules of the first wave should be initiated with additional partners at the earliest with the above recommendations being considered. A 5 to 7 years' perspective and multiple horizons of strategic planning including development of a shared vision between BT and its partners and reflections on values in practice is essential before further steps of the program are initiated.

Background:

The Consulting Assignment:

Paul Hamlyn Foundation (PHF) funded project on "Programming for inclusion of Persons with Psychosocial Disability [PPSD]" was initiated by Bapu Trust, Pune, India, as a two year program. The program involved a detailed project to identify partners, establish partnerships, train partner staff and supervise / handhold the partners in implementing strategies for the inclusion of Persons with Psychosocial Disability [PPSD]. The three partner organizations operated in the two states of Madhya Pradesh and Chhattisgarh. As a part of this initiative, five partners were initially contracted and their staff trained of which three continued with the partnership in view of their long term commitment to adapt / adopt BT's model of services for inclusion of persons with psychosocial disabilities. It was decided by Bapu Trust that Rapid Evaluation of Training Effectiveness of two training programs conducted is essential before any further steps are initiated on the above project.

Management Consultant and author of this report, V. Sridhar, Bangalore was hired by Bapu Trust to carry out a Rapid Evaluation Assessment of the effectiveness of the training programs conducted as a part of the Project on inclusion of persons with psychosocial disabilities through partnerships in Madhya Pradesh and Chhattisgarh states of India. This report presents the findings of the Training Effectiveness Assessment [TEA].

Inclusion of persons with psychosocial disabilities:

The World Health Organisation (WHO) defines social exclusion as: "*the dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels.*"

Social inclusion is usually defined in relation to the right to full participation in society espoused, through the United Nations Convention on the Rights for Persons with Disabilities (UNCRPD). That is, social inclusion involves feeling accepted, having individual and

collective agency to determine participation, and the removal of structural and attitudinal barriers to participation.

The CRPD shifts the paradigm from a medical model, focused on segregation, institutionalization, and parallel-tracking difference, to a social or human rights model, focused on inclusion, social adaptation, social accessibility, and individual autonomy. It correspondingly guarantees the rights of Person with Psychosocial Disabilities [PPSD] to live in the community with rights equal as others (not in jails or institutions) (Art. 19, CRPD), to access health services in the community on an equal basis with others (with mental health services mainstreamed in the general care system and within development, not in segregated silos) (art. 25, CRPD), and to the exercise of legal capacity (not to have one's decision-making capacities arbitrarily stripped through guardianship laws, imprisonment, or other common discriminatory practices) (art. 12, CRPD).

Methodology:

Rapid Evaluation Method:

Rapid appraisal is a quick and low-cost means of gathering information and often uses a combination of qualitative and quantitative research methods. Some of the ways of conducting rapid appraisal are key-informant or stakeholder interviews, focus group discussions, community group interviews, direct observation and mini-surveys. While research or evaluation done within this framework may not always reach the standards of scientific rigour, if done well, rapid appraisal can be an adequate means of collecting data to help make policies and plans more effective.

The rapid evaluation method (REM) was developed in the late 1980s by WHO in order to assess the performance and quality of healthcare services, identify operational problems, and assist in taking managerial action.

REM aims at bringing prompt and relevant information to planners and decision-makers who need it for a specific purpose. In the present instance, REM was the methodology to be adopted for assessing the effectiveness of the training programs conducted by Bapu Trust primarily for its partners.

Rapid assessment has several characteristics, such as emphasizing the use of field observation in acquiring information from different levels of service delivery, interviewing individuals (limited by scope to internal stakeholders of both Bapu Trust and its partners), ensuring participation of professionals in multidisciplinary teams (one fellow professional was interviewed), using flexible methods for the identification and solution of problems, and providing the results to decision-makers in a timely fashion. Assessment is usually problem-oriented, using interviews with key informants, group interviews, community meetings, and analysis of routine administrative and survey data; it provides findings that can be useful for mid-course adjustments of projects. The rapid evaluation method adopted for this assignment, applies the techniques of rapid assessment of the outcomes of the training program at the level of the participants, besides the middle and senior levels of management of both Bapu Trust and its partners.

The methodology used for finalizing a framework for training effectiveness evaluation was a participative and iterative process. It involved the following steps:

1. Propose tentative framework.
2. Validate framework.
3. Develop framework.
4. Implement.
5. Review and reflection.

The validation of the framework was carried out after the first phase of travel for the assignment - the framework was field tested and then validated in discussion with the sponsor's senior management personnel. Limited review and reflection was shared with the sponsors in the dissemination of the preliminary findings presentation. Further reflections could be initiated after this final report is accepted.

The methodological tools deployed in the assignment were:

1. Rapid Evaluation Method.
2. Personal qualitative interview.
3. Telephonic interview.
4. Self-report.

5. Secondary data- on a limited basis.

The main role assumed by the external consultant in this assignment is to develop and share appropriate methodology, formats and analytical techniques in complementing the work done by the Bapu Trust itself; and make recommendations by bringing the managerial expertise to bear on the assignment.

Characteristics of Rapid Evaluation Methodology Adopted:

* REM was planned and executed with the active participation of sponsors, funding agency [limited to interaction during presentation of preliminary report], partner staff at all levels, staff trainers and supervisors, and the field staff themselves.
* Information produced by REM examines the effectiveness of the training programs on the basis of self-reporting by those interviewed and by the subjective views of the managers of the trainees and the management representative of the respective organizations.
* The results of the REM are very rapidly available to the decision-makers - within days or weeks after the end of the REM study of partners in Madhya Pradesh and Chhattisgarh and Bapu Trust staff and management at Pune. Thus, a Preliminary Report on Training Effectiveness Assessment was presented by the consultant at a meeting of which the participants included the Country Manager of PHF, Regional Manager of PHF, Heads or Management Representatives of 3 partner organizations, Head of Bapu Trust and the Consultant.
* The REM exercise is tailored for and necessarily followed by recommendations for managerial decisions and actions ranging from improvements in training and supervision to building capability in Bapu Trust as also to serve as input for it's plans for sharing the model of service to persons with psychosocial disabilties in the community across the chosen States of India viz. Madhya Pradesh and Chattisgarh.

Possible objectives of the assignment:

Objectives of the project partnered between PHF and Bapu Trust, with 3 new additions during the planning phase were:

- Partnership building for Inclusion through consultative processes.

- Identifying 2 partners in each state to be enablers of inclusion by implementing community inclusion programs (Main objective).
- Partnership building with the government (very limited objective).
- Intensive trainings (Modules I and II) on Inclusion and establishing pilots.
- Research, M&E of implementation.

The Training Effectiveness Assessment is required to focus on the above objectives of which direct field study of community inclusion programs, partnership building with government and Research, M&E of implementation were excluded.

Though the objectives of the TEA were not specified, the above objectives were evolved during the course of the assessment and shared with the client:

➢ To find out if the desired expectations (goals) of the program are met.

➢ To manage the training function more professionally.

➢ To justify and perhaps increase the budget for the program.

➢ To revise and redefine the further course of action.

The following objective was added by the Consultant as a potential objective, after the Phase I travel to Madhya Pradesh and based on discussions at Pune with Bapu Trust Management and Staff as a part of the evaluation:

➢ To identify and reduce constraints that inhibits transfer of Bapu Trust Model to Partners.

Scope of the assignment:

The following are the scope of the consulting assignment on TEA, as specified as a part of the contracting process between Bapu Trust and the Consultant:

- Quality of training.
- Effectiveness of training and supervision in implementation by partner.
- Basic data from programs, effective data gathering and monitoring systems established by

partner.

- Whether MIS system is being followed.
- Mobilisation of staff and resources for project implementation.
- Field visits, exchanges with some people who have benefited from the works.
- Exchanges on the usefulness of the project from stakeholders in the community.
- Money planning for the project.

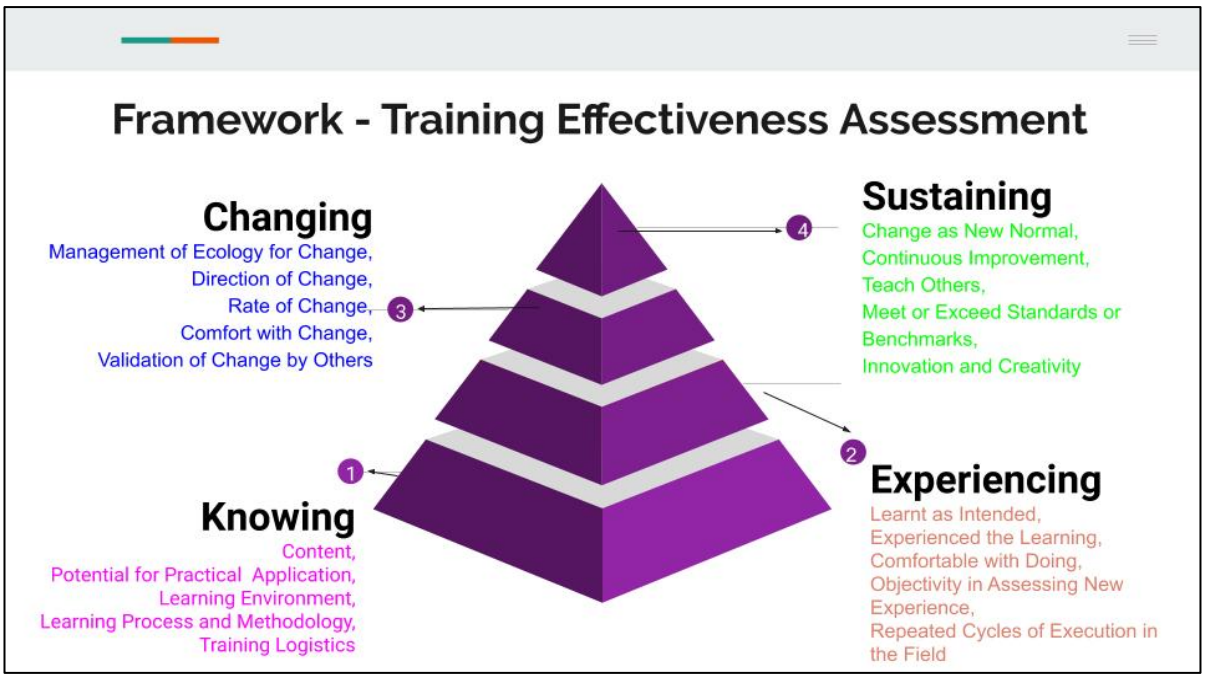
The scope with respect to "field visits, exchanges with some people who have benefited from the works" was advised to be dropped in view of the tight timelines and the method being rapid evaluation assessment. Further, transferring learning from training program to the field in psycho-social services is usually a long drawn process and six months is often inadequate to accurately judge the field level impact attributable directly and exclusively to the training programs. Resource requirements for such an assessment is usually very high, irrespective of the size of the training program budget and is often not justifiable, even in for profit organizations.

Framework:

The following three frameworks were created / adapted even as the assignment progressed in order to assess specific aspects of Training Effectiveness Assessment, Organizational Capability Assessment, and Partnering Effectiveness Assessment. Though only Training Effectiveness Assessment was the core focus of the assignment, considering the positive impact of the training on partner organisations and the potential for continued engagement over a longer period of time in supporting them to take the Bapu Trust's model of services to enable inclusion of persons with psychosocial disabilities to their respective communities it was decided by the consultant to additionally assess the organizational capability [of Bapu Trust mainly] and Partnering Effectiveness [of Bapu Trust's role in partnering mainly].

Training Effectiveness Assessment

Figure 1 : Framework - Training Effectiveness Assessment (TEA)



Organizational Capability Maturing Assessment:

Figure 2: Framework- Capability Maturity Assessment

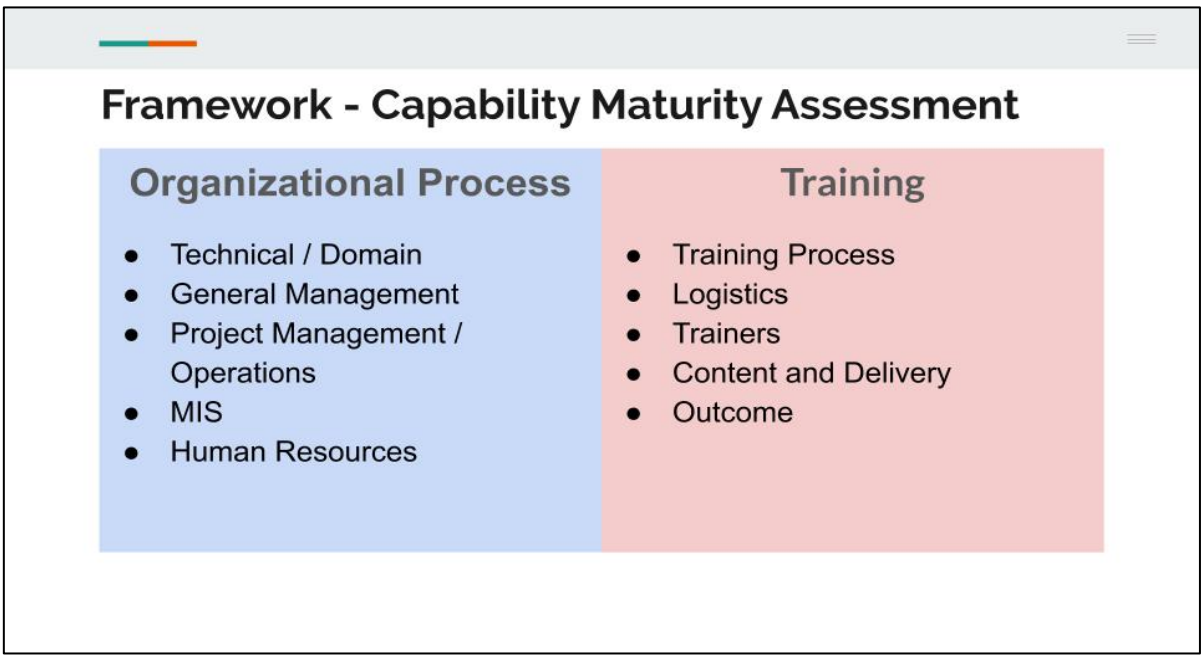
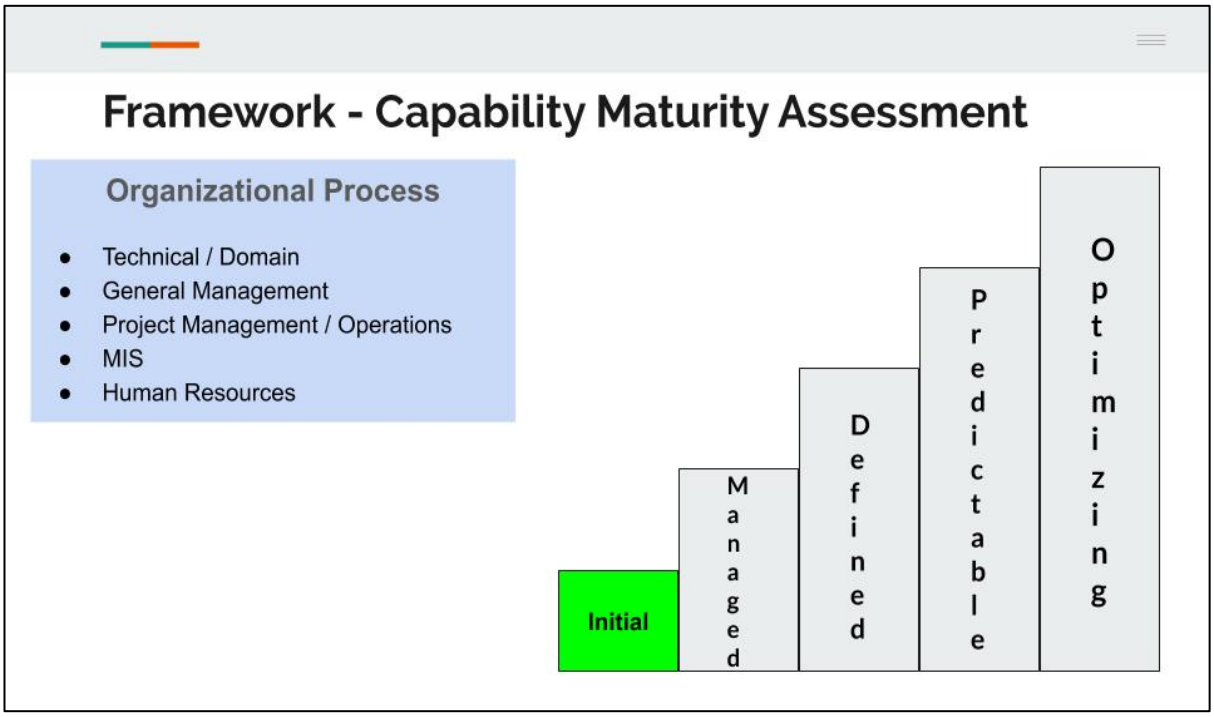
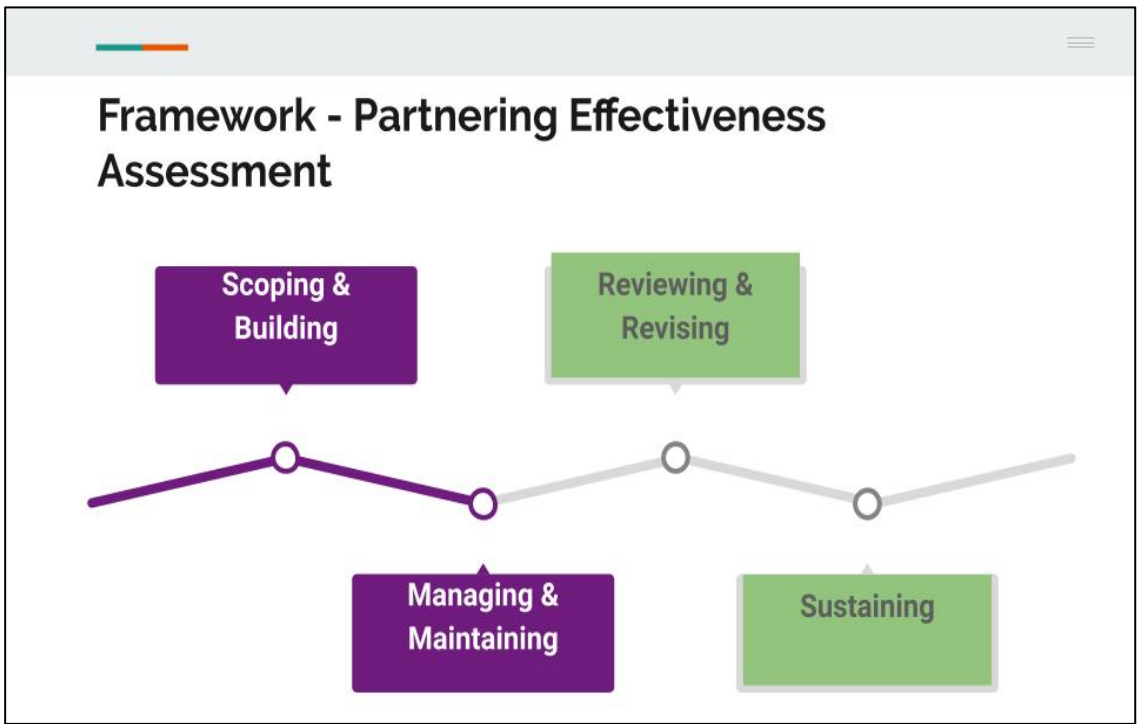


Figure 3: Framework- Capability Maturity Assessment



Partnering Effectiveness Assessment:

Figure 4: Framework- Partnering Effectiveness Assessment



The above frameworks were chosen based on the expertise and training in the first two assessment frameworks of the consultant.

Though the above models look hierarchical and sequential, the processes of training effectiveness, organizational capability maturity and partnering is never a linear one. Individuals and organizations tend to iterate, go back and forth and exhibit characteristics of all phases even if they achieve the highest levels of the models in the majority of the activities concerned.

Staff interviews:

Staff interviews provided an opportunity to obtain information from participants of the training programs, their managers and management of the organizations about their attitudes, issues pertaining to management and supervision, education and training effectiveness, as well as to identify perceived problems and list suggestions for improvements.

Accordingly specific protocols were prepared for interviews, though the interview had a fair tinge of informality and responding to emerging issues rather than straight jacket fit of the above frameworks.

Staff Focus Group Discussions:

These are in-depth discussions among a small group of individuals chosen from a specific target group. A trained facilitator stimulates discussion on the basis of a prepared but flexible outline. The purpose of the discussion is to provide in-depth information not readily available from short structured interviews. Focus group discussions are especially useful for eliciting information on feelings, attitudes and behaviour, or information about sensitive issues which cannot easily be obtained in a household interview. They are often used to provide information about community perceptions on issues related to health problems, health care, and service performance and acceptability.

As a part of the assignment, focus group discussions were held with trainers, supervisors, middle managers, and trained field staff and untrained field staff in a partner organization.

The following guided the consultant while conducting the staff interviews:

- Assessment of the nature of training effectiveness could only be subjective. Objective aspects of training effectiveness such as for example the impact of training on business / service results usually quantified in dollar / currency terms is possible only with a lot of investment and that too in the context of frequent and extensive / repetitive training programs.
- A Positive - Developmental - Quality Model oriented assessment is essential.
- Limited to Self-Reporting by Internal Stakeholders because of the scope of the assignment.
- Relying on Bapu Trust [BT] and Partners for Domain Expertise.
- 6 Months is too short for assessing some aspects of the training effectiveness process.
- What appears linear in the frameworks is not!

Sampling:

REM is carried out usually within a geographical area encompassing both rural and urban conditions. Since REM is designed to meet the needs of different programme managers in a variety of settings, the details of sample design varies from study to study. The minimum sample size is usually determined by the level of precision needed for decisions that would improve health care. In the present assignment viz TEA, the entire population of participants,

their managers in their respective organizations and at least one management representative of Bapu Trust and it's partner organizations was taken as the sample size.

For focus group discussions, issue - role-holders was the criteria and focus group discussion were held. Again, it covered entire population. Where members could not be present in the group, opportunity of the personal interview was taken up to elicit the perspective of the person concerned on the issues from their role perspective.

Findings:

The process followed for primary data collection in the assignment is as follows:

1. The interviews were audio recorded, with the prior recorded approval of the interviewee/s.
2. Appropriate interview protocols to cover the objectives of the assignment were developed and used dynamically based on the response of the interviewee. With one interviewee, written response was solicited since interviewee couldn't devote enough time. In a few instances, management members of the organization were interviewed together, though it was not a focus group discussion. Interview protocol developed was used as a guideline rather than as a systematic and compulsory survey question. Occasionally, additional measures were adopted to solicit non "socially acceptable response". For example, interviewees who claimed that training was perfect, were asked to rate the training on a rating scale and were asked to justify the max rating. Further, when data that was not in line with their socially acceptable response came up, their attention was focused on the same to help them make statements that reflected their objective response.
3. Focus Group Discussion was used only in respect of special cases, e.g. Trainees who went to supervise, Middle Managers, Untrained Field Workers using the Model transferred through the training for field level interventions, etc.
4. Notes were taken simultaneously with the audio recording. Notes were not verbatim of all what the interviewee said. However, the words captured were those of the interviewees' responses.
5. Language was flexible between English and Hindi. Translation was done by the author.

Analysis:

Out of the 14 transcription files, 10 were coded 100% using Atlas Ti software. The codes, and code groups were as follows:

Table 1 : Codes and code groups

Code	Code Groups
Better, Ideal or Different	Appreciative Inquiry
Dream	Appreciative Inquiry
Hi Point	Appreciative Inquiry
Life Giving Force	Appreciative Inquiry
Valuing	Appreciative Inquiry
FB - Beneficiary	Assignment Obj - Others
FB - Community	Assignment Obj - Others
Financial Planning	Assignment Obj - Others
MIS	Assignment Obj - Others
Mobilization of Staff & Resources	Assignment Obj - Others
Monitoring by Partner	Assignment Obj - Others
Supervision	Assignment Obj - Others
Inclusion	Inclusion of persons with psychosocial disabilities
Insights - Strategic	Insights
Insights - Tactical	Insights
Insights - Transactional	Insights
OM - Defined	Organizational Capability Maturity
OM - Initial	Organizational Capability Maturity
OM - Managed	Organizational Capability Maturity

OM - Optimizing	Organizational Capability Maturity
OM - Predictable	Organizational Capability Maturity
Miscellaneous	Others
Red Flag	Others
PN - Managing & Maintaining	Partnering
PN - Reviewing & Revising	Partnering
PN - Scoping & Building	Partnering
PN - Sustaining	Partnering
TPM - Delivery	Training Capability
TPM - Logistics	Training Capability
TPM - Outcome	Training Capability
TPM - Trainers	Training Capability
TPM - Training Process	Training Capability
Changing	Training Effectiveness
Experiencing	Training Effectiveness
Knowing	Training Effectiveness
Sustaining	Training Effectiveness

Statements were sometimes coded with multiple codes. Occasionally, multiple statements were coded together with one code as one Quotation.

The analysis and inferences is subject to the additional caveats below:

1. All the primary data collected were not coded or considered for analysis. Only 10 out of 14 files of transcribed data were coded. 3 audio files haven't been transcribed. Of this, one was a follow-up call. The second was with a senior management member of a partner organization and the third was with a field staff who played the role of trainer.

Since there are other interviewees of similar profiles, the analysis and inference qualities may not be adversely impacted.

2. Coding was limited to the various broad phases or stages in the 3 framework models, the objectives of the assignment, etc. Though the three models talk about multiple factors that contribute to the determination / assessment at various phases or stages, extensive coding at factor level was not done, since it is both time consuming and will impact budgetary assumptions adversely. The justification for this is that the assignment is a rapid evaluation assessment and not a comprehensive assessment.
3. Only the author coded the data. Being a Rapid Evaluation and considering confidentiality related clauses, multi raters were not used. The interviewees were assured full confidentiality and that their identity will be protected by the verbatim, voices, etc. not being shared with anyone else.
4. Codes were developed on a ***priori*** basis. The alternative of ***posteriori*** or more popularly known as grounded theory was not used. However, while coding the 10 documents, any significant data that could not be fitted into any of the 35 codes developed were considered for new codes. Accordingly, Red Flag was added as a code under the Code Group Others to help highlight serious issues which doesn't fall in the codes developed a priori.
5. Inferences and interpretations were based on the linkages inherent in the data, as also by using expert judgment by the author.
6. Recommendations, by and large, are data-based. Occasionally, lack of data is the basis for making certain recommendations.

Summary of number of quotations [may contain multiple statements or even multiple codes] as per code groups:

Table 2 : Summary of number of quotations

Appreciative Inquiry	128
Assignment Obj - Others	120
Inclusion of persons with psychosocial disabilities	37
Insights	34
Organizational Capability Maturity	25

Others	28
Partnering	28
Training Capability	108
Training Effectiveness	104
Grand Total	**612**

Training Effectiveness:

Training effectiveness, as understood and responded by lay participants without much exposure to processes related to training and learning, feedback has been very positive. It is unfortunate that topic-wise, end of training or end of day feedback on training / learning by participants has not been formally solicited. Further, positive inquiry into the effectiveness of the training programs could also colour the response.

In spite of that, it has been observed that there have been progressively fewer responses on the training effectiveness phases, as follows:

Total Sample Quotations: 612
Training Effectiveness Code Group: 104
Knowing: 28
Experiencing: 23
Changing: 15
Sustaining: 0

Rest 38 are multiple codes of which training effectiveness is a part.

One of the reasons for nil response at the Sustaining Phase of training effectiveness could be that it is a bit too early - 6 months only. In effecting changes and sustaining them in so far as mental health related habits are concerned, it is difficult to break age-old habits and form new ones.

Training Process Capability Maturity of BT as an Organization:

As could be understood from the frameworks, Training Process Capability of BT of an organization is different from Training Effectiveness of the two modules of training programs.

Organizational Training Process Capability - Feedback [does not include co-occurrence codes]:

Delivery	-	16
Trainer	-	11
Outcomes	-	36
Process	-	14
Logistics	-	4

The quotations classified as above are more indicative of the transactional and individual capacities and not that of the organization.

Evidence of management practices and control being put in place and repeatability of the processes related to training have been found from senior management's responses, as also confirmed by external stakeholders and secondary data. However, person dependence on some modules and some processes, lack of access to training content after the program, which indicates lack of documentation and or multi-media sources [under design and expected soon], lack of planning for implementation of what has been learnt in the field [documented performance management process with measurement and analysis], etc. indicates that the maturity level of organizational capacity of Training Processes varies between Initial and Managed.

To a certain extent, organizational maturity on training process will also depend on the overall organizational maturity. Overall maturity of the organizational processes is at best at Initial level. In the core technical / domain of focus of the organization viz. Mental Health Services in the *basti* community in Pune, the maturity level could be higher at Managed to Defined levels perhaps [formal assessment is not part of the scope of this assignment]. Many aspects of requirements of the Defined Level of Organizational Maturity including Documented Practices, Training in Processes, Measurement and Analysis, Common Professional Culture besides competency based practices of human resource management may not be met by BT.

This was discussed, though not in depth, during the course of interactions as also shared during the presentation of preliminary report.

Partnering:

Partnering is a journey of a longer duration. It has hardly been a year of partnering of which intense engagement has happened only over the last six months in so far as field level impact are concerned. The partnering pathway has four stages or milestones viz. Sourcing and Building, Managing and Maintaining, Reviewing and Revising and Sustaining.

Based on feedback from the various interviews, partnering has not even reached the Sourcing and Building milestone, though not very far from it. Lack of an agreed plan of action for even a year is what needs to be done to successfully reach the milestone.

Two partner organizations dropping out after training, lack of breakthrough in partnering with governments - central and local, clarity on mutual commitments, etc. are challenges in partnering.

Partnering to transfer knowledge, guide and support, providing training and supervisory support, and setting up connected systems like MIS, etc. have been positively acknowledged by partner staff.

Partnering requires attention from senior management of both BT and partner organizations to successfully carry the BT model of MH services in the field.

It appears that partner organizations are convinced about the MH Initiative in their organization. They have reported that it is giving a holistic picture of the needs of the community they are servicing, it is synergistic with their own core focus / domain and above all they cannot continue to ignore this need of the community if they are to sustain their core services.

The following are the findings regarding the other objectives of this assessment:

Supervision:

After training quality and effectiveness, supervision support rendered by BT Staff deployed at various stages has been appreciated and well received by partner field staff. If anything, they expect more support, since probably capability within the system [i.e. Middle Managers of the partner organizations] are also not adequate to guide them.

Supervisory support has been provided through personal visit by couple of staff visiting partner locations or through telephone. Demand for more personal visits for supervision has been expressed, since telephonic support has its own strengths and inadequacies. Founders and Senior Management of partner organizations are well aware and seem to be clear on not wanting to develop a relationship of dependence on BT. However, given that for all three partner organizations the model of service and the domain of Mental Health Services [non-medicine based] is new expectation is that such supervisory and hand holding support is required for at least 2 years intensely and the relationship of BT as a mentor to their organization would continue long term, when the relationship could transform appropriately.

Feedback on supervision has been very positive and is seen as value adding, clarifying doubts, sharing expert knowledge, practical demonstration of services, and has uniformly made a very positive impact on all staff irrespective of partner organization, location or level of staff in partner organization or level of staff from BT who visited for supervision. Visits by members has strengthened the personal rapport and bonding, building further from the training. The secondary impact of supervision is on streamlining of MIS, clarifying data, filling up of forms, etc.

On occasions, short capsules of informal learning sessions seem to have happened based on the demands and needs that arose during the supervision visit or field visit.

The culture of supervision has also been singled out for appreciation - values in practice. For example, rapport building with clients, ease with which impromptu awareness sessions were done in informal spaces, letting field staff of partner organizations make mistakes and subsequently helping them to reflect and correct the same, etc.

Mobilization of Staff & Resources by Partner Organization:

This is a critical area, which is likely to impact the sustenance and the quality of services offered by the partner organizations. Lack of prior planning, mobilization of resources, especially financial, availability of good quality human resources, and even ability to tap locally available resources is an area of concern. Though it is natural to have a relationship of dependence on BT on the Model of Service, being proprietary and developed to near perfection over two decades, mobilization of staff and resources have not been systematically planned. Nor is there any evidence that this issue has been discussed, agreed upon and a plan executed.

In some instances, staff are part time or volunteers. Untrained staff are deployed after quick informal training or learning sessions. In one instance of a partner organization, implementation of field level service commenced after a few months, by which time the trained staff almost forgot many aspects of service.

Instance of staff finding their compensation to be inadequate have been shared with the author. Middle Managers in the partner organizations haven't gone through both the modules and in some cases either of the modules. Consequently they seem to depend on their generalized approach to guide the staff rather than with full awareness and knowledge.

MIS:

Evidence of senior management of partner organizations having the ability to collect, analyze and report appropriate data has been demonstrated, including during the meeting at Pune when PHF executives were present. Further, the partner organizations have their own monitoring and control processes and mechanisms, including in some instances weekly meetings with founder / senior management.

However, lack of an automated centralized information system, lack of understanding of what is expected from field personnel while filling up the forms, sharing of information through WhatsApp or telegram, etc. indicates scope for systematically approaching to formulate a decision support system. Data collected is sent across, but no analyzed inferences are shared back often. Resource availability and capability are issues that need to be addressed.

6 months is a reasonably long time to replicate information system infrastructure to whatever level of automation.

Monitoring by Partner Organization:

Since all three partner organizations are well established in their respective domains of development, or agri-preunership or livelihood, disability services, etc. they have their own processes for monitoring and controlling the activities of the staff. Based on response to specific questions in the interview, it has been shared that field staff are monitored both remotely and by personal visits. Daily and weekly reviews are done. In some instance, field staff have reported they mutually supervise and monitor each other, which they have found to be very valuable.

Financial Planning:

This has been done in an ad hoc manner and mutual expectations have not been set or if set not adhered to. There is an expectation from partner organizations that financial support or support for planning for finance is essential and they look up to BT for the same. One senior manager in a partner organization has indicated that not financing the MH initiative on a project basis - i.e. just like any other typical development project, has helped their organization to avoid too rigid monitoring, experiment with developing their own ways of approaching the MH services provisioning in the field, etc. Long term viability of the MH services provisioning by the existing partner organizations will depend on their ability to get financial support from funding agencies for their program.

Feedback from Beneficiary and Community:

Positive feedback from beneficiaries and community has been shared by field staff especially. Most are motivated by the positive response of persons with psychosocial disabilities and in some instances even persons with psychosocial disabilities needing high need for support. Though occasional comments from male members and some members of the community has been positive, when the beneficiary is able to make small noticeable changes, the community seems to be open to services being rendered. In almost all locations, referral by those who attend awareness meetings, poster sessions, neighbours, key personnel in the community, and others have been reported. Most beneficiaries seem to be open to being serviced, once the initial rapport building related challenges and mutual trust building happens. Some family members have had to be worked upon to create awareness and to overcome suspicion and stigma. Some

community members tend to make negative comments even after a few months of continuous services. for which the training has not fully prepared the field staff.

Analysis of the relevant encoded qualitative data from interview supports the continuation of the preliminary assessment as final. The same is mentioned below:

Training Effectiveness Assessment:

Figure 5 : Training Effectiveness Assessment

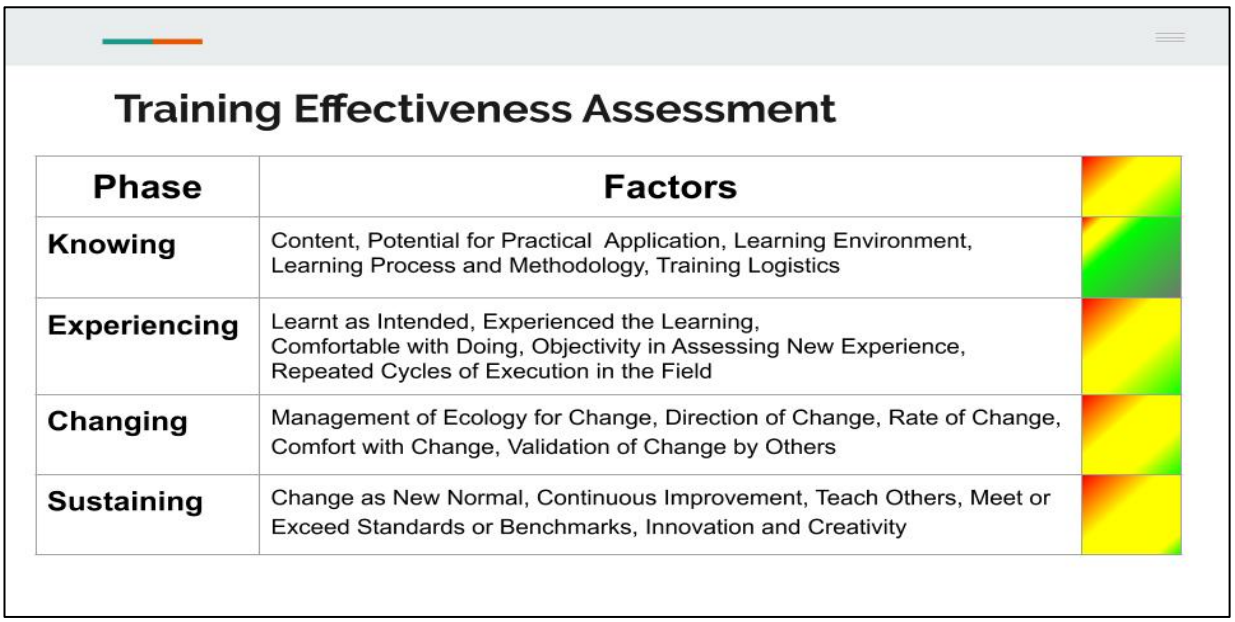
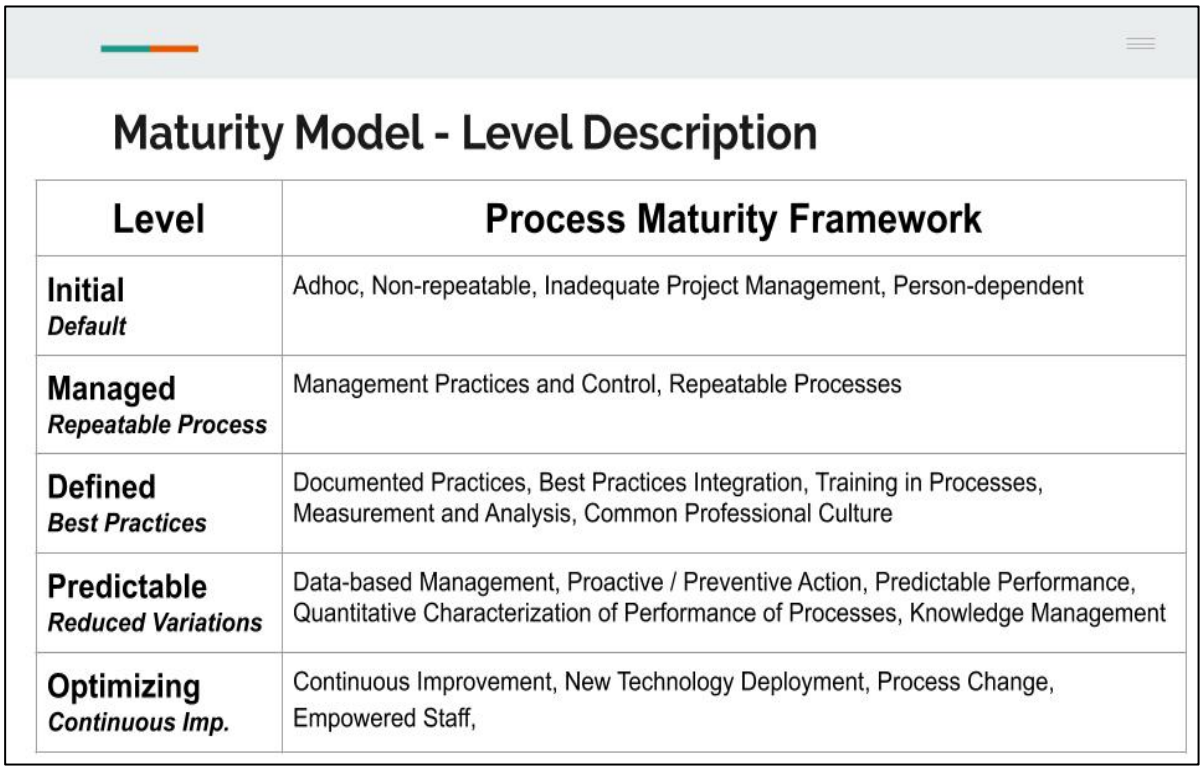


Figure 6 : Maturity Model- Level Description



Maturity Model - Level Description

Level	Process Maturity Framework
Initial *Default*	Adhoc, Non-repeatable, Inadequate Project Management, Person-dependent
Managed *Repeatable Process*	Management Practices and Control, Repeatable Processes
Defined *Best Practices*	Documented Practices, Best Practices Integration, Training in Processes, Measurement and Analysis, Common Professional Culture
Predictable *Reduced Variations*	Data-based Management, Proactive / Preventive Action, Predictable Performance, Quantitative Characterization of Performance of Processes, Knowledge Management
Optimizing *Continuous Imp.*	Continuous Improvement, New Technology Deployment, Process Change, Empowered Staff,

Figure 7 : Framework - Capability Maturity Assessment

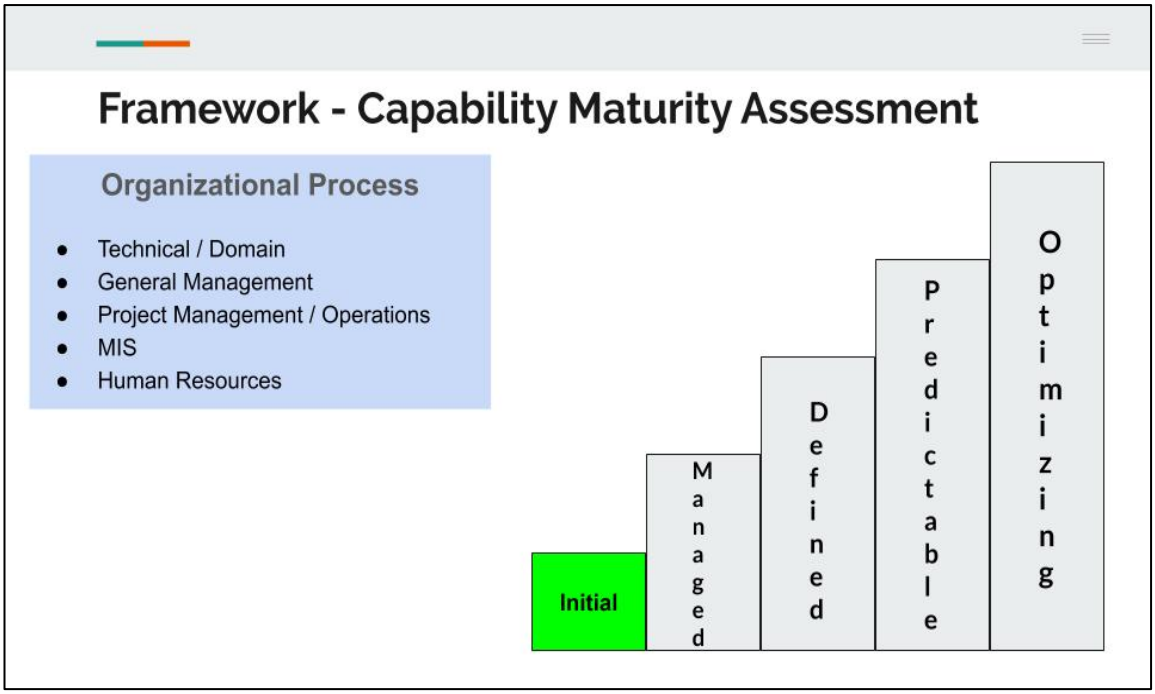


Figure 8 : Framework - Capability Maturity Assessment

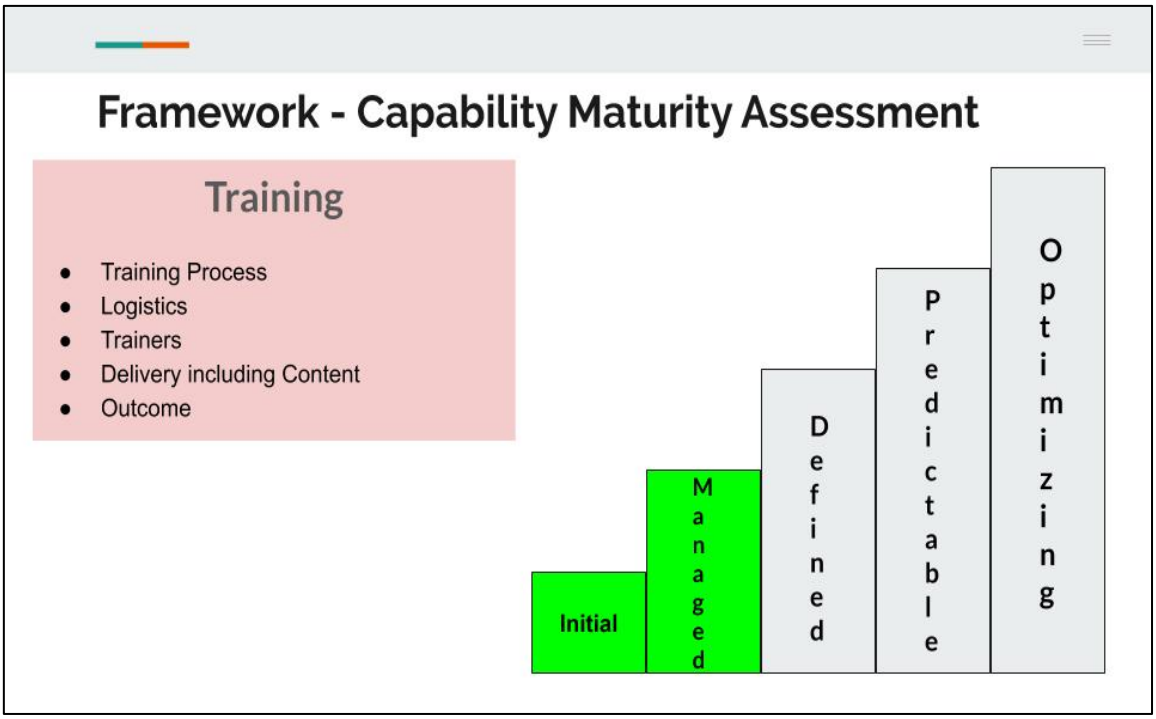
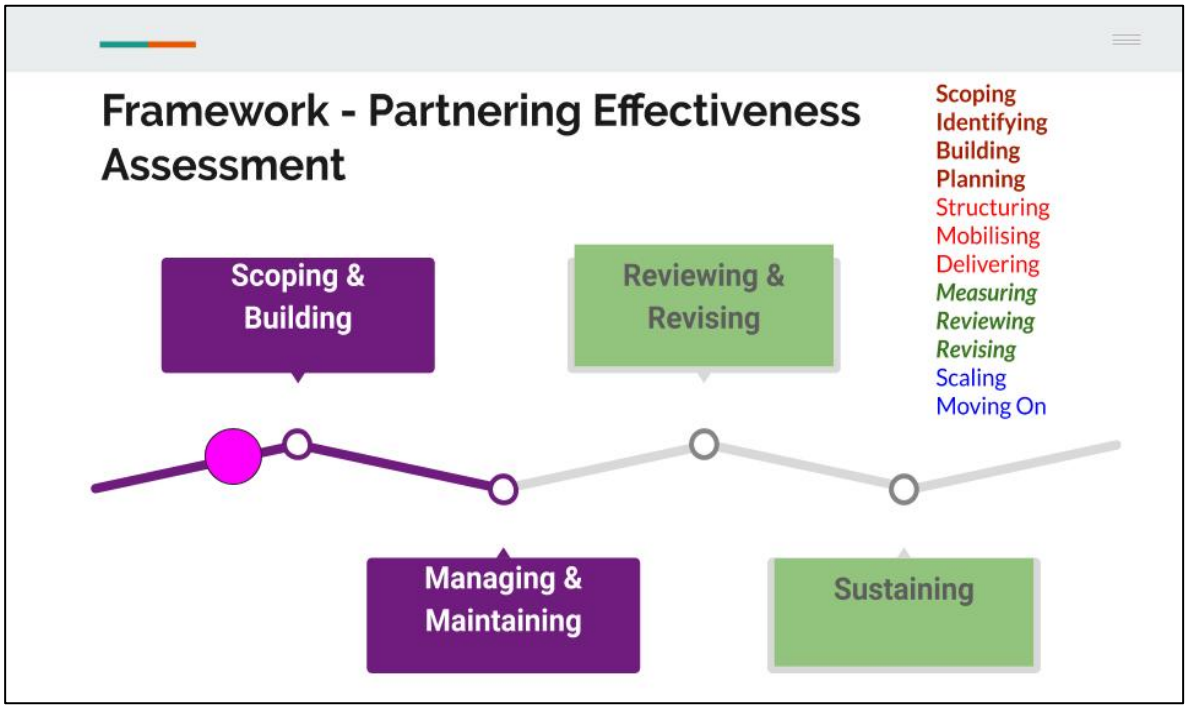


Figure 9 : Framework - Partnering Effectiveness Assessment



Discussion:

Stigma is a key determinant of social exclusion. Stigma is a social and subjective process involving problems of knowledge, prejudicial attitudes, and discriminatory behaviour. Across countries, stigmatising beliefs often cast people with mental illness as dangerous, unpredictable and unintelligent; beliefs which are enacted through discriminatory and exclusionary behaviours. Globally, many people with mental illness are excluded from employment (economic exclusion), denied legal rights to vote, marry or own land (political exclusion), and ostracized (sociocultural exclusion).

Any services that attempts to address the issue of inclusion of persons with psychosocial disabilities, need to be clear about what is meant by inclusion, what inclusion means to the community, and what are the enablers of inclusion. It is not adequate if inclusion is approached at community or even family level. Ultimately, inclusion will be determined by the competencies that are essential in the persons with psychosocial disabilities concerned and creation of appropriate opportunities for increasing levels of inclusion till the person gets fully integrated and included like any other person without any disability.

Training based transfer of models of service to enable inclusion need to start with defining, classifying and characterising various parameters for inclusion. Competencies essential for each type of inclusion requires focus from the service provider besides the family, the neighbourhood and the community concerned, if inclusion has to be achieved to the fullest potential.

Prior work and published literature indicates the following:

Four main barrier themes were: symptoms of mental disorders interfering with social inclusion, unhelpful family attitudes and behaviour, unhelpful community attitudes and behaviours and lack of access to quality mental health services.

Three prominent enablers were: family support and understanding, access to quality mental health services and supportive community attitudes and behaviours.

Five key domains of people-centred health care in the WHO IPCHS are:

1. Empowerment,
2. Participation,
3. Health service model,
4. Intersectoral collaboration and
5. Enabling environment.

The principles and philosophy that guide the advocacy / activism or service typically are as follows: [These however, are not the principles and philosophy that guides BT, Pune]:

- Persons with psychosocial disabilities advocate for their rights and entitlements as equal and full participants in the disability movement.
- Persons with psychosocial disabilities participate in their own development and the development of communities in which they live.
- Persons with psychosocial disabilities are listened to and are able to consent to or refuse treatment in circumstances that are not life-threatening.
- Persons with psychosocial disabilities have access to appropriate community-based treatment and support.
- Families of persons with psychosocial disabilities are provided with the support.
- Persons with psychosocial disabilities and their families are able to earn their livelihoods.
- Community health workers include mental health issues as an integral aspect of their work.
- Persons with psychosocial disabilities are able to access health care and educational services within and outside of the community.
- Persons with psychosocial disabilities participate in the social, cultural and religious life of their communities as they choose.
- Persons with psychosocial disabilities fulfil their roles as community members, family members, parents and citizens.

Inclusion requires skill sets for all stakeholders, including, importantly service providers, family members, community members, and people working in different sectors. As mentioned earlier, inclusion also requires building appropriate and customized competencies in persons

with psychosocial disabilities in line with their choice of inclusion and with the opportunities for inclusion that they or others are able to create.

The above factors were considered while forming subjective views on the training effectiveness assessment.

The assignment started off as a Training Effectiveness Assessment, turned into a Model of Service Transfer along with explicit and tacit knowledge being transferred to partner organizations. After participation in the two decades related celebration and dissemination event of Bapu Trust on 13 and 14, December 2019, it is realized that what is probably being attempted by BT is to transfer the legacy of not only the founders but also of Bapu across the next generation of staff at BT and to the larger community served by newly acquired partner organizations. It involves the transfer of the values and the philosophy, beliefs and culture, etc. This requires deeper contemplation and considered efforts. And each of these three aspects viz. Training, Model of Service or Legacy are mutually influencing.

Discussion on this assignment will be incomplete unless the limitations of the Training Effectiveness Assessment are discussed and acknowledged. Here are some of the significant and known limitations

Limitations of TEA:

The following limitations are acknowledged by both the sponsor and the consultant / author in view of the nature of the assignment being rapid evaluation with limited time and budget:

1. Comprehensive coverage of all Stakeholders: Stakeholder groups across multiple locations are usually interviewed in assignments of this nature: (1) people with mental illness and their families; (2) mental health and social service providers; (3) government decision makers; (4) civil society members; and (5) other community members. However, in the current assignment the scope limited the coverage of stakeholders to internal stakeholders viz. Staff and Management Representatives of the organizations. All parties to the assignment agree that this coverage is adequate to achieve the objectives of the TEA itself as a Rapid Evaluation Assessment.

2. Time and budgetary constraints are also acknowledged. Though compromise is not made on the quality of assessment, it can't be the same as a detailed assessment with a longer timeline and bigger budget. Limitation imposed by this is overcome by discussing the approach, the frameworks and the iterative coverage of various role-holders. On a limited basis one external stakeholder was also interviewed.
3. Self-reporting and secondary data from reports has been the basis of data aggregation in order to do the assessment.
4. Positive - Developmental - Quality Model Bias has been acknowledged by the author going by his background and training / whatever expertise he has. Design of protocols, approach to assessment, etc. prize a qualitative and subjective approach in a transparent and responsible manner rather than quantified, number driven determination on rating scales.
5. Six months is too short a time after the training [second module] for more deeper outcomes of the training to manifest. Therefore, the assessment of especially training effectiveness should be seen from that perspective.
6. This being the first attempt of transfer of model of service, BT cannot be expected to suddenly acquire organizational maturity beyond what it already has.
7. Partnering as a process is time consuming and is expected to be a longer journey. It is too soon to expect rapid or any higher progress. However, expectations of a formal and considered approach to partnering has not been compromised while assessing.

Recommendations:

About Inclusion of Persons with psychosocial disabilities:

1. Classification of Inclusion of persons with psychosocial disabilities needs to be documented and communicated as a part of the training, if not already done.
2. Any training program starts with training need identification. In the present instance, it is recommended that [even now it is not too late], formal and professional competency management system tailored for various types of inclusion of persons with psychosocial disabilities is documented and suitable training provided to all concerned.
3. This generic competency management system should be tailored to individual persons with psychosocial disabilities based on their choice of inclusion and their own proficiency in the various competencies. The intervention to enable inclusion of such persons should be supported by appropriate developmental and learning strategies and

activities to which they must be able to commit and work towards with the support of not only the field staff concerned but all stakeholders around - much like any other person in the community would take the support of others around.

4. Strategies for inclusion of persons with psychosocial disabilities should also consider context, the capabilities and the compatibility / synergy of the current core focus area with the MH services initiative. Ultimately, Health and Happiness of all members of the communities served by the partner should be the focus of their organization, with inclusion of persons with psychosocial disabilities being a sub-set of such a focus much like their current development focus such as livelihood, women's empowerment or resource for disability rehabilitation.
5. Visioning for Partnering is critical for successful transfer of the model of mental health service that BT wants to replicate with or without adaptation by partner organizations in other geographies. A shared vision enables deeper mutual partnering commitments
6. OD and Capability building strategies need to be evolved to support the shared vision.
7. Development of leadership and managerial capabilities, adapting appropriate management practices and essential skill building support needs to be planned for staff of partner organizations to sustain the initiative.
8. Strategies to Quicken, Scale up and Sustain change both within BT and its partner organizations is essential.
9. BT could strengthen its management muscle, plan succession for key roles including that of the founder, build professional capability in its middle and senior managers, and a career path for its staff with the proposed strategy of transferring it's model of service to partner organizations.
10. Long term commitment of funding and mobilization of varying professional resources required for a high quality transfer of its model in varying contexts is recommended. 5 to 7 year horizon for planning, preferably for various scenarios or horizons is essential.

Needless to add, the next wave of training, refreshers, further modules should be planned with learning from the current cycle appropriately incorporated. Besides the above, the following recommendations made in the preliminary report of findings is retained below. Some aspects may overlap or complement the above recommendations.

Strategic:

- BT to make Training as a Core Strategy of sharing its Model, if appropriate.
- BT to explore Partnering as a Strategic Initiative - Existing & New.
- Build a robust Information System Infrastructure including Extranet.
- Build Organizational Capability, especially in HR, MIS and Competency-based Practices.
- Research-based Approach to BT Model Transfer.

Tactical:

- Dedicate a resource for supervision and handholding.
- Deploy a resource for a month with each partner to ramp-up capacity.
- Roll out Further Essential Modules, including Refresher Training and Plan Second Wave of Training.
- Adopt Action Learning by all Field Staff.
- Document and share relevant multi-media resources in Hindi.
- Offer self-level work and counselling to all Staff.

Transactional:

- Make a Plan.
- Senior Management of BT to Visit Partners.
- Coach Middle Managers in Partner Organizations for Strengthening their Internal Systems.
- Strengthen MIS to provide Decision Support.
- Orchestrate a deeper engagement of all Program Staff through all- hands telephonic call periodically - Take WhatsApp based engagement to next level.

Red Flags:

1. The module on rights of persons with psychosocial disabilities could be or, in some cases, is being interpreted as advocating an activist role. Whereas advocacy of the rights of persons with psychosocial disabilities is essential to imbibe by field staff of partner organizations, the organization itself or its context might not support its readiness to become an activist organization. Staff should exercise appropriate caution and judgement. The ability and the rapport of BT with government agencies, including

the judicial system, police, power structures in the community, family's status in the community, etc. has been developed over 20 years and is based on certain philosophical commitments shaped over a period of time. Partner organizations should be advised to make considered decisions and establish appropriate protocols of intervention in such eventualities demanding activist role.

2. Members of partner organizations might have varying levels of mental health and might have suffered traumatic losses. In the field of psychology, professional supervision enables member concerned to ensure that their personal psychological processes do not interfere with their service and they do not end up introjecting from their client or client context to the detriment of their own mental health. Further processes of projection and transference are important and common phenomenon to be understood. In this context, typically training provides space and time for participants to do "self-level process work" and receive empathy / coaching or counselling support. Though the model adapted by BT does not require professionally qualified personnel to render services, certain base minimum professional education may be essential to be integrated in the training. Since the scope of this assignment does not include review of the contents of the training program, this red flag may be ignored if already it is taken care of in the training content.

Some verbatim quotations in this context are provided below:

Table 3 : Verbatim quotations

I cried.
3 members of a family were having MH problem, details moved me.
Kadam and Smile Organizations dropped out.
Activism vs non-Activism
X's daughter is suffering from MH and Y's son is suffering from MH. My relative committed suicide.
6 high risk clients were identified to work with.
Especially men were not getting involved, they get drunk and argue with us. Such people stopped coming, conversion allegations were being made.
First time survey, when BT Staff came with me I learnt that I should not ask directly when others are present, some things to be asked only when client is alone.

Support counselling - role play through stories moved many participants to cry
More open with BT supervisors than my manager. Some hesitation with gents.
MH doesn't require professional qualification. We work with people with whom we can make a difference
People were feeling overwhelmed in the first two days. End of the day feedback indicated it.
Pre and post-test was not done.
Even those who haven't gone through training have learnt effectively from us.

Conclusion:

If one were to summarize the findings of this assignment, it is that training effectiveness has been the best one could expect in this field in this part of the world. However, as a transfer of model of service to partner organizations and potentially replication of such transfers to other partner organizations in other geographies and countries, a different perspective to assessment is taken, which if taken in the right spirit could help BT to scale up to internationally acclaimed provider of not only mental health services to disadvantaged communities but also an internationally recognized gold standard in transfer of a model of service across cultures, geographies and other differences.

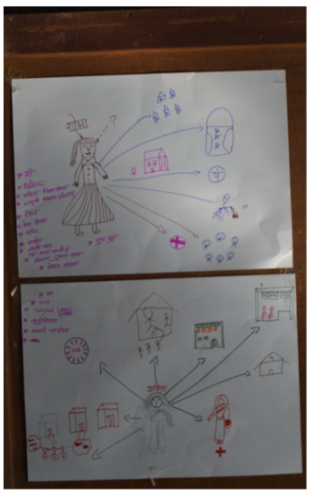
Though short, it has been a journey of learning and intense engagement for the author. The potential for extending the much needed services to persons with psychosocial disabilities, their family and the community both as an adaptive and preventive strategy is immense in many parts of the world, and more so in India itself. It is both a valuable and noble contribution.

The expertise built by BT over its two decades of existence is immense. This report should be seen in the context of assessment of the training effectiveness. It is not a reflection on BT as an organization, which is way beyond this assessment.

Photo gallery

Group games

Role plays



Drawings to elicit discussions

Art based therapies

Self care activities

Art based therapies - Dance

Training I group

Training II group

Appendices

Annexure - 1

What aspect of the training could be different, better or ideal? Sample Responses:

Simulation and role play is different from real life situations in the community.
Rights of persons with psychosocial disabilities to be trained even more, knowledge to be improved, in teaching family care the rights to be made known of well
Culture, nature, etc were good and quite useful. More activities frequently. Listening more than hour is difficult. Every hour some activity.
Have multiple topics in a session. Not one topic for longer duration.
Training should be participative and discussions and interactions to increase. Then our thinking will change. Scope for improvement exists a bit.
More practical application oriented is essential
More days for the training, time to process the information that challenges the belief systems,
How to take it to the field, hand holding for implementation, etc could have been part of training design,
Second module was better than the first module.
Identifying, educating or awareness. Entire flow has not been done.
Rural background understanding.
Planning
Training close by to the field
Training for 10 days and a lot of things get covered. Keep modules small - 1 day or half a day modules with video, documentation is essential.
Activities were urban focussed; we need to customize some of the activities.
How to work together, how to identify from corner meeting or get information, etc.
Hindi was a bit of a challenge, initially I was finding it difficult to understand,

Their method cannot be grasped in one training.
Timing should be reviewed, capacity of participants to take the training during the time available should be reviewed, participants diversity, lot of debates, etc
Time to process information should have been provided.
Management aspect HR / OD input to be provided in refresher at least
Periodically review like Chinese whispers

Bapu Trust for Research on Mind & Discourse, Pune, developed a training program with the aim of promoting an enabling environment and build capacities within developmental sector for community mental health and inclusion of persons with psychosocial disabilities. The trainings were conducted with organizations in two states of India: Chhattisgarh and Madhya Pradesh and this program was supported by Paul Hamlyn Foundation, UK. An evaluation study was then conducted by Mr. Sridhar Venugopal, an external evaluator, to assess the training effectiveness of this program. The current report discusses in detail the various modalities used for the assessment, models developed for this purpose and the findings thus obtained.

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