Appendix 1. Housing for homeless women with mental illness

Suhasini (*) remembers the first time she experienced what she calls ‘losing her mind’. It was the end of the Summer in Rajasthan, India. At that time, Suhasini was living with her husband, mother-in-law and children at the officer’s quarters in the air force station. An ‘aandhi’ (that’s Hindi for squally dust storm), was raging over the area. The howling, billowing winds outside mirrored the pain within her, finally unleashed, unable to be borne any more.

For years, her aspirations were systematically crushed by an abusive spouse and mother-in-law. Her desire to educate her daughters was mocked for its perceived insolence. Broken and ill, Suhasini navigated through several hospitals and doctors before finally being abandoned in Chennai. In that city, she came in contact with Transit Care Centre, a multi-disciplinary institutional service run by The Banyan, a not-for-profit based in India. Yet, her recovery at this facility was marked by increasing uncertainty over where she would head next. Unable to trace her family, yet unsure of taking the plunge to live independently in the community due to her age, she often pondered her prospects.

Unlike Suhasini, not much is known of Saroja’s (*) past. The past ten years of her life were spent in the throes of paranoid schizophrenia at the same Transit Care Centre. Persistent efforts by the clinical team to aid her recovery over the past decade concluded in little or no change. Her life was reduced to sitting in a corner of the facility, spitting repetitively, living in fear of bodily contamination, muttering to herself, and being completely disinterested in personal care or social relationships. With no gains in her recovery, and unable to trace her family, the team at The Banyan found itself looking for options to secure her long-term care needs.

Homelessness and mental ill-health combined represent a complex set of issues that require equally complex responses. From our experience of running the Transit facility, we believe that hospital beds serve the need for acute care and can enable recovery, with user-centred ethos and values.
However, different people need different solutions and there’s a wide variety of choices to be made on the road to recovery. A majority of homeless women with mental illness who access The Banyan’s Transit Care Centre eventually make the choice to return to their families or communities of origin, and are facilitated in their efforts to reintegrate. For some, like Suhasini and Saroja, this is not a feasible option. Sometimes, families are resistant to welcoming these women back; at other times, families cannot be traced. Yet another group of women choose not to return to their families. In our twenty years of running the transitory facility for recovery, we found that approximately 10% of women do not exit the facility. This situation is more urgent in other places, such as state mental hospitals, which more often than not serve as the only facilities open to homeless people with mental illness: 38% of people living in these institutions are estimated to stay there for one year or more (Mental Health Atlas 2011, World Health Organization).

With the support of Grand Challenges Canada, The Banyan started to offer shared housing, as a response to the needs of women experiencing long-term care needs. The Banyan was successful in creating independent living arrangements, wherein a group of women share rent and other responsibilities in a home. They extended that same concept to include supportive service elements, such as onsite staff and intensive case management that may be necessary for women like Saroja, with higher clinical needs, or Suhasini, with continued social care needs.

Home Again, a housing intervention with supportive services, is envisioned as a cost-effective and sustainable option for addressing long-term care in mental health. The intervention aims to provide pathways for rehabilitation of people in institutional spaces, improve their quality of life, mental health outcomes and community functioning, while promoting human rights. These homes are spread across rural villages and in urban areas, in the vicinity of The Banyan’s other services. Women live there as part of an affinity group (a formed family). Some of them have their children around, who attend nearby schools and play with other children in the neighbourhood. Recreating a family environment, offering each other support and friendship in solidarity, stability and peer support encourages them to further their pursuits, however big or small. Going to work, talking to neighbours, transacting with local
vendors, decorating their homes, regular visits to places of leisure and worship, learning something new – all these and more fill their lives.

In 2013, Suhasini moved into such a home rented by The Banyan, with a group of four other women, at Perur, a small fishing hamlet, fifty kilometres south of Chennai. She is the anchor in this new home, a leader and a peer facilitator. To supplement her income, she works at the Bistro, a social enterprise run by formerly homeless women with mental illness. Engaged in facilitation of daily living activities, from care of herself and shopping to leisure exploration, Suhasini says that, in the process of enabling other women like her but with higher clinical needs, she has finally found herself.

In a similar vein, about a year later, Saroja moved into her new home with a group of peers and an onsite care coordinator. In a space unconstrained by a schedule, she slowly found the rhythm to engage in daily living activities at her own pace. Over time, the home grew into a shared space of comfort, with responsibilities, choices and interpersonal relationships. By talking with other members of the household and through social visits by case managers and other staff at The Banyan, Saroja slowly regained her ability to bond, connect and form new friendships. The personal approach of the home enabled her to explore and use different rooms of the home, from the kitchen to her own sleeping space, without being confined to one corner. She started to care for this personal space, partaking in daily household chores along with her peers and care coordinator. Today, Saroja is happy to be part of the small nest that they have built with bonds and aspirations. She says, “I have moved into our new home six months back, but I have to say that this place makes me feel more safe and there is a sense of belongingness. I am able to do more regular work than before. This place is less crowded and I like staying here.”

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Appendix 2. Breast Alterations and Women’s Mental Health: A Case for Public funding?

Lakshmi Narasimhan and Vandana Gopikumar

Last month, the state government of Tamil Nadu, India, announced that breast alteration surgery would now be free for women from low income backgrounds through the plastic surgery unit at Stanley hospital, a publicly funded tertiary care centre. The hospital, which had reportedly already been performing free reconstructive surgery for breast cancer survivors, will now extend the service to women "who want to increase or reduce their breast size," although the BBC reports that women seeking augmentation will have to pay some money for implants.

Several countries, foremost among them Brazil, already have a culture of beauty as a right, with people from low socioeconomic backgrounds offered cosmetic procedures for free or at discounted rates. Proponents of the initiative in Tamil Nadu say that cosmetic procedures, including invasive ones, should be accessible to people from diverse socioeconomic backgrounds and that there are psychological benefits as a result of breast alterations. The notion of aesthetic choices being accessible across a broad spectrum of socio-economic realities is at the face of it progressive, and perhaps consistent with the principle of autonomy. As Kathy Davis points out in her book *Reshaping the Female Body*, cosmetic procedures may be empowering for many women who experience oppressive beauty ideals, as it offers them a way to determine how their bodies are perceived.

However, the idea that women’s body image issues and the associated effects on self-esteem can in some way be “fixed” by a cosmetic procedure does not always stand on firm ground. While studies have demonstrated that many women report postoperative satisfaction, the effects of cosmetic surgery on long term psychological outcomes are mixed; with some studies finding a higher than expected rate of suicide among women who underwent breast
augmentation. This association does not, of course, indicate causality—other factors may be at work, including the likelihood that women who undergo breast surgery may have had psychosocial risk factors prior to the procedure. Nevertheless, the current level of evidence suggests that we should be cautious in attributing psychological benefits to cosmetic surgery.

More importantly, the remit of women's mental health goes far beyond body image issues associated with having imperfect breasts. India performs poorly on indices of gender equality, with women facing considerable inequalities in terms of their health, education, and economic rights. Women are disproportionately affected by common mental disorders that are associated with socioeconomic deprivation, gynaecological morbidity, and gender based violence.

Poverty among women in India is often multidimensional: it manifests not only in income, but also in lower educational attainment, poor sanitation, low social rank, and pervasive gender disadvantages. These disadvantages manifest at the policy level with low representation and participation of women across various levels of the government. In Tamil Nadu, one of the few states in India with the reputation of having a better public health system, over half of women continue to have anaemia, over three quarters were not paid in cash for work or did not own their own land/home, and three quarters of women in rural villages had no access to sanitation. Despite making strides in infant and maternal mortality rates in Tamil Nadu, women's health still requires far more substantive investments than the INR 52 800 crores set aside for health at the national level—one of the lowest health spending among low medium income countries.

Our work at The Banyan, a not for profit organisation in Chennai, focuses on supporting homeless women with mental health problems; their stories of descent into homelessness are often characterised by disruptions in dependency relationships against a background of extreme poverty. In such a context, can women from marginalised communities truly make choices to use cosmetic procedures as autonomous subjects for their own desired ends? These seemingly choice based transactions become contentious in an imperfect world where women’s bodies are constantly scrutinised under the
hegemonic male gaze. Prioritising cosmetic surgeries is already debatable given the many critical unmet health needs among women, but especially so when you consider the gender politics of Indian society.

Breast alterations may make many women feel more in tune with the look they want for themselves and by all means the option to make such choices should not remain in the realm of the rich. However, in a society largely shaped by a patriarchal order, where women often lack agency, promoting such an initiative as a means of improving self-esteem may end up perpetuating sexist notions of the ideal female body. With many women in Tamil Nadu facing serious and multifaceted poverty, their psychological needs may be better served by helping them identify and assert their agency and femininity beyond sexist narratives. Then women will truly be able to make choices.

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