Continuous International Grants Programme
End of Grant Report

Section A – Contacting you and your organisation

A1: Organisation name	BasicNeeds India
A2: URN	IG/1/010173547
A3: Project Name	**"Sustaining a community based approach to mental health and development with or without government support in Bihar and Jharkhand"**
A4: Project Year	February 2006 – January 2009

A5: This report relates to the time period:

From Month/year	February 2006	**to Month/year**	January 2009

A6 Changes to main contact details

If there have been any changes to the details of the main contact for this grant since we were last in touch, please tell us about them here.

Name
Address
Postcode
Phone number Day: Fax number:
Evening: Email address:

Best time to contact

Do you have any specific communication needs?

B1 Your target groups

B1a. In your application form (B3) you stated the types of beneficiaries your project will help. How many people in each of these beneficiary groups has your project helped?

Beneficiaries	Male	Female	Total
People with mental illness living in rural communities of 9 districts in Jharkhand and 7 in Bihar having no access to treatment and other facilities as at the end of year 1	2626	1751	4377
No. of people with mental illness added during the year 2	562	421	983
No. of people with mental illness added during the year 3	408	341	749
Total	**3596**	**2513**	**6109**
People living with common mental disorders and neurological disorders who got better and required no further treatment as at the end of year 1	1185	743	1928
People living with common mental disorders and neurological disorders who got better and required no further treatment in year 2	96	64	160
Total	**1281**	**807**	**2088**
No. of people actively participating in the programme	**2315 (3596 – 1281)**	**1706 (2513 – 807)**	**4021 (6109 – 2088)**

B1b. How did you gather the information to give us these numbers?

The information gathered over the last 3 years through 12 quarterly review meetings and reports, database and quarterly reports from Nav Bharat Jagriti Kendra (NBJK). The field staff collected information from the home visits; same is documented in their diaries/registers and later update all those into individual files of PWMIs. Every quarter the field staff submits a quantitative report to NBJK. The coordinator consolidates from all 25 partners; same will be submitted to BasicNeeds India (BNI). Two types of reports are generated by NBJK, quantitative and a narrative report. The partners maintain a computerized database containing socio-demographic details, medical history, and personal history; same gets updated once in a quarter. BNI in-turn reviews the programme and produces a quarterly report based on the main outcome and cross-cutting outcome.

B1c. If you did not reach the numbers of beneficiaries you intended during the life of the grant, please explain the reasons why.

The programme reached more number of beneficiaries than expected

B1d. If your beneficiary groups have changed in any way please state what the change has been and explain what has led to the change.

There was no change in the group of beneficiaries

B1e. Are there any other people who have benefited from the project? Tell us who these are and how many.

Besides PWMIs, the programme has benefited 30,545 family members and whole community in 34 blocks of 15 districts

B2 The difference your help is making

Based on the information you provided in the outcomes tracking form, tell us about the progress you have made towards project outcomes **over the life of the grant**.

(If you require another copy of your outcomes tracking form, contact your Grants Officer before completing this monitoring report)

Outcome 1:

*Progress towards outcome **over the life of the grant**:*

1. *Tell us about your progress based on the indicators of achievement of project outcome detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*

In the whole programme period 3342 people with mental illness (1998 male and 1344 female) have joined to take the total to 6109 (3596 male and 2513 female) as identified. Among these 6109 people identified, 2088 (1281 male and 807 female) people have reached their pre morbid level of functioning and not requiring any support for medicines but being regularly follow up for other needs. They are part of socio-economic activities.

A total of 5776 (3397 male and 2379 female) people among all identified have accessed treatment at least once in the whole programme period and 3685 (2155 male and 1530 female) people among all identified i.e. 60.32%, were under treatment till end of the programme.

Among all identified, 4142 people (2454 male and 1688 female) i.e. 71.71% of all who accessed treatment, have been stabilised and free from symptoms: 3 months without symptoms; improved self care, personal hygiene and participation in daily activities; voluntarily taking medication and understanding of the illness; regaining judgement and understanding of their life in a balanced way.

2. *Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these:*

    1. **Identifying women mentally illness:** Invariably all partners felt that identifying women with mental illness was a major problem for them as in a conservative community like rural India women are kept inside home. Also family members as well as the women herself don't give importance to any illness. And also family members fear that their daughter or sister could not marry if she was identified as mentally ill. Even in these circumstances, men from those families (families with girls with mental illness) could not get brides. Besides the social issue, partners also felt that as mostly field staff were men, it was difficult for them to identify women with mental illness. Though the partners focussed on minor mental illness in order to find more women with mental illness, but community usually don't accept minor mental illness as an illness. So, finding minor mental illness as well as women with mental illness was a difficulty for partners. So to counter such problem partner raised female volunteers and trained them, sensitised SHG members, took help of stabilised women with mental illness to identify more women. As soon as the camps

started to happen in local vicinity, more people got self identified and the number of women mentally ill also increased. As an effect mostly the partners register reduction of gap between men and women and at some places that has equated also.

2. **PWMIs don't want to take medicine for longer time and drops out:** As nature of the illness, medicine is to be taken for longer time and that every PWMI is told from the beginning. But contrastingly most PWMIs want to dropout within six months of treatment as their symptoms drastically gets reduced. Field staffs face maximum trouble in counselling stabilised PWMI and their carers to continue until Psychiatrists stops medicine. One of the major reasons of dropout is poverty and male members need to go back to their livelihood as soon as they get stabilised and female members need to take are of their family and house hold chores. Once PWMI gets stabilised people used to neglect intake of medicine and also their carers don't keep it in mind. So the partners kept of counselling the families, put pressure through community meetings, etc. Also partners put restriction of distributing revolving loans to PWMIs, making longer treatment a criterion. In community meetings, partners used to invite PWMIs who have relapsed and stabilised both. Using stable patients for counselling other PWMIs was a good idea that gave better results. Now there is decrease in drop out rate as compared to earlier.

3. **Covering a larger geographical area without proper communication facility:** While identifying PWMIs field staff initially covered longer geographical areas and as those people got stabilised with regular medication people from farther places also started coming in. With more and more PWMIs getting self identified, the field staff were needed to cover more areas. Under the programme there were no provision of motor bikes for mobility and field staff took too much pain in meeting and following up those PWMIs as they were dependant on cycles. Also at some regions the geographical structure was so tough that field staffs were required to walk 20 – 25 kilo-meters per day to visit the PWMIs. As the number of PWMIs grew, it became impossible for the field staff to meet each of them at least once in a month. So to find an alternative and keeping quality of the programme intact, they identified volunteers in almost each village. With the help of those volunteers they followed up all PWMIs. Among these volunteers there were stable PWMIs, SHG leaders, youths and some sensitive people.

4. **Involving PWMIs in livelihood with limited resources:** As more and more PWMIs started to get stable with regular treatment, addressing their poverty was biggest challenge for the partner organisations. Most of the PWMIs wanted financial support for starting a business and invest into the existing business. Under the programme, there was scope of revolving loan but the amount was not sufficient according to demand. So, the loan to PWMIs depended on repayment of earlier loans. This typical bottleneck condition delayed in bringing more PWMIs into sustainable livelihood. To counter it, partners tried to access govt schemes and funds but their process was too tedious and lengthy. The PWMI along with the field staff need to meet the block officers several times to get their application passed. Though somehow all partners were successful in accessing the newly introduced Employment guarantee Scheme, but the number of beneficiaries is few. All the effort done in the programme period has resulted in some success.

5. **Families of PWMIs used to consult faith healers first:** The stigma attached to mental illness in community was so strong that families and caregivers of PWMIs used to consult faith healers and black magicians until they get to penury. The families of PWMIs as well as the community believed that mental illness is not an

illness and such behaviour is due to negative effect of supernatural powers. Initially it was very difficult for the partners to break that belief and bring them to modern treatment procedures. Caregivers bring to the modern treatment process only when they completely broke and illness gets serious. Taking the hyper / acute person with mental illness was very difficult task for the field staff also. To take such persons to the camp, staff & family members have always faced problems. With regular meetings the field staff counselled community and care givers that faith healers can not treat such illness and psychiatrist's help is required. Initially the field staff allowed PWMIs to go to faith healers along with to psychiatrist. Slowly the care givers saw development in condition with medicines from Psychiatrist and they stopped going to faith healers. Now even in few instances, faith healers have referred some PWMIs to go to Psychiatrists.

6. **Sometimes medicine was not properly managed by the families making it overdose or lowerdose:** As the whole programme is based on participatory approach, caregivers of the PWMI were always made responsible for monitoring intake of medicines. While the medicines are given to them, each was marked particularly as frequency of intake but in some cases caregivers fail to understand/ remember the dosage of medicines and either feed more medicines at a time or forget to. As the field staff visits once or twice in a month, he/she could only know it late. Even in few instances the care giver did not monitor medicines and the PWMI himself swallows all medicines at a time causing serious problems. Though the field staff mentions on each packet of medicine clearly about the dosage but there has some instances of mis-feed. So, to reduce occurrence of such instances, the field staff with the help of volunteer monitored medicine intake daily and in some case an innovative technique was used. The field staff used to put colours on the medicine packet resembling with morning hour (saffron), noon (white) and night (black) so that care giver can easily understand.

7. **Government system is not sensitised to include PWMI into development and poverty alleviation schemes:** Several times the partners have met government officials, and tried to sensitise them about including PWMIs in all development programmes as under law. Though they agree to the severity of the situation but couldn't do much for the defunct system. There have been few examples when government departments and officials have come forward to help PWMIs and their families, but majority of them are still neglected. With repeated efforts now few PWMIs have been benefiting from Employment Guarantee Scheme, Housing Scheme for Poor (Indira Awas), Below Poverty Line Card, etc.

8. **PWMI needed to travel 70/80 kms for accessing treatment:** As there was limited / no government infrastructure available, PWMIs needed to travel longer distance to access treatment. Travelling to such a long distance has always been time consuming, expensive affair and as well as risky. And as the treatment is for long term, caregivers find it real difficult to afford. With regular advocacy, now there have been outreach camps, DMHPs functioning in Jharkhand, which is supporting more than 2000 PWMIs every month. Government of Jharkhand is also supplying drugs free of cost. In Bihar also, government has established a mental hospital but it is yet to function properly and for all PWMIs belong to rest part of the state, are dependent on private psychiatrists. Of course NBJK has managed to arrange private psychiatrists at nearer places so that PWMIs need not travel longer distance. But still there are few partners who are covering around 50 KMs for treatment.

9. **Some carers did not care about the PWMI (they even desert) and behave very rudely to field staff:** As a result of occurrence of mental illness many people were

separated from their families like women were deserted and sent back to their parents and many men were kept untreated as their siblings don't want to share any parental property with him. In that situation field staffs found it really hard to convenience those families to bring the PWMI into treatment process. Each of those care givers behaved rudely, sometimes did not allow field staff to come in and abused orally also. But the staff continued to counsel them and took help of the neighbours also. Sometimes the field staff had to threaten the caregivers that they will be jailed if they continue to behave like this with PWMI. It took time but with all that pressure those caregivers bowed down and came for treatment. Now many women with mental illness after stabilising have returned to their in laws and staying healthy.

10. **Poverty:** Poverty among the families of PWMIs was so acute that they even can't bear the treatment expenses. Most of the time in the beginning, organisation was burdened with treatment expenses including travel. But when the PWMIs recover, their families became enthusiastic and also financially better as the PWMI could earn, then the organisation need not bear those expenses. This poverty was a major block in continuity of the treatment. The field staff supported the PWMI in earning some with or without financial support. Also with the cheaper treatment process the family members were relieved and could concentrate on their livelihood to earn better.

11. **Maintaining database was difficult for most partners didn't have computers:** As the number of PWMIs grew faster, it became difficult for the organisations keep all records at finger tip and also there was problem of consolidation at NBJK level. So to ease the situation, computer software was developed to store all types of data regarding each individual PWMI. But there were two major road blocks as most of the organisations didn't have computers with them and not all field staff was computer literate. So those organisations that had computer set their computer operators were trained several times along with the field staff. But as the other organisations were dependent on private Data Entry Operators, those operators were also trained several times. But the private operators were sometime arrogant and the dependent organisations suffered. But it was a blessing in disguise for those partner organisations as their field staff took it very seriously and leant how to use the database software. The software was too easy to work on and now almost all field staff was comfortable with it and can use it.

12. **PWMIs needed to be visited several times in a month:** As per the need, each PWMI should be followed up by field staff at least once in a month but as the number grew stupendously, it became difficult for most of the staff. Many more PWMIs came self identified and were scattered geographically, making almost impossible for staff to follow up thoroughly. And in rainy seasons, it became more difficult. This difficulty forced the organisation to follow a new strategy of involving volunteers in the follow up process. The volunteers included young men and women, from all background and income group, were trained properly before giving assignments of follow up.

13. **Psychiatrists were not available at block or district headquarter hospital:** Government has not appointed psychiatrists at block or district level hospitals so whenever a PWMI went to hospital he/she would either be turned back for there was no facility or treated wrong by other doctors as physical illness. Unavailability of infrastructure and manpower needed for psychiatric services at block/ district level forced families of PWMIs to go to farther places and that too to private psychiatrists, making the treatment procedure too costly. As a result of this less no of people accessed services and rest stick to faith healers. And also who accessed

psychiatric services, they could not continue for its high cost. At the same time government doesn't spend a little amount on creating awareness on mental illness as done on other health issues. In such circumstances, community started believing that mental illness is untreatable and permanent illness. Under this programme the partners along with PWMIs and carers have formed an alliance to pressurise government and has resulted in implementation of DMHPs, State health departments inviting NGO partners to join hands in implementing programmes and the community is aware about illness.

14. **Staff turnover rate and trainings not manageable at that time:** Staff turnover in partner organisation have resulted in slowing down of the programme. The time, money and training invested on a staff were high and as soon as he/she leaves the organisation, all that effort goes waste. And not always such training could be arranged for the new staff which ultimately slows down the programme. Though the organisations still continue to fight this issue but now the organisations giving training to more than one person who can be used as backup when in need.

Has this outcome brought about the changes to peoples' lives you expected by the end of the project? (*Where 3 = fully;* ***2=mostly****; 1=partly; 0=not at all)*

0	1	✓ **2**	3

Justification for your rating:

1. **Social inclusion of PWMIs, engagement in livelihood, regain and enhancement in social acceptance by the PWMIs with getting stabilised:** A total of 1226 people (773 men and 453 women) have been supported with financial support to start their business. These 1226 people have been earning in a range of Rs.1200 to Rs.7000 per month from livelihood options such as, animal husbandry, agriculture, petty shop owning, etc. More than 60% of all identified, 3685 people (2155 male and 1530 female) have been regularly accessing treatment and stable. PWMIs are getting involved in mainstream and well accepted as normal human being. A total of 117 girls have got married after getting stabilised and 497 women, once deserted, have been reunited into their in laws family. All members of community have been supporting PWMIs in getting rehabilitated and fight against violation of right. Now the family members and community behaves normally with PWMIs, which is making them stable faster. Out of 6109 people identified, 3184 (1782 males and 1402 females) are people suffering with common mental disorders, 2232 (1397 males and 835 females) suffer severe mental disorders, and 693 people suffer with epilepsy (417 males and 276 females). At the end of three years men and women with mental illness has been identified and accessing treatment in a ratio of 58:42

2. **Involvement of PWMIs in livelihood activities, salaried jobs, businesses and many others:** A total of 1226 people (773 men and 453 women) are earning with financial support for their business whereas 3129 people (1492 men and 1637 women) are engaged in productive work. Also at the same time 187 people (155 men and 32 women) have been either back to their salaried job or taken a new. Many people have migrated to other areas for their livelihood with continuation of medication also. A recent research on "economic impact of the programme" has revealed that there has been significant development in the economic condition of the family of PWMIs. 342 people with mental illness (125 male and 217 female) and 700 care givers (432 male and 268 female) have been included into 479 SHGs.

3. **PWMIs age being invited into social functions, called by name rather than**

“mad”, getting benefit of govt schemes: A total of 117 girls have got married after getting stabilised and 497 women, once deserted, have been reunited into their in laws family. Community is standing along with PWMIs for protection of their rights and formed a larger network in the name of Manshik Rog Shangharsh Samiti. A total 1174 people (623 men and 552 women) have got job cards under NREGS – National Rural Employment Guarantee Scheme, 143 people (33 men and 110 women) have got housing under Indira Awas and 868 people (512 men and 356 women) have received BPL Cards.

4. **Carers are now relieved:** 4946 carers (Around 81%) have expressed relief that the member of their family who was once mentally unstable are stable now and involved in any productive work or income generation activity. Now, average work days missed due to illness – reduced from 21.6 to 4.5, number of primary carers missing work days – reduced from 33% to 6.5%, average work days missed / month for care (primary) – reduced from 20 to 0.27, average annual family income – slight increase from Rs 13,418 to Rs 14,687, number of families selling assets for treatment – reduced from 30% to 1.5%, change seen in type of work with an increased number of people being able to engage in skilled labour (business, tailor, mason etc.) earlier mostly agriculture, average hours for care giving per week – reduced from 11.1 to 7.8

5. **Community is much aware on this issue through meetings, street plays, etc and supporting the PWMIs in rehabilitating:** A total of 347 street plays have been conducted in the community to sensitise. Besides this there has been 2070 community meetings, 138 community trainings, wall writings, distribution of posters and pamphlets, etc to sensitise community. As a result of it now there is self identification and PWMIs after stabilisation are behaving as volunteers also inviting many other people to become volunteers.

6. **Organisation’s value has gone up:** The organisation’s value has also gone up with this work in last years. Now the community remembers the organisation as their saviour and used to refer PWMIs to the organisation. Many of the beneficiaries treat the field staff as God and some as Doctor with golden hand. And now everybody believes and follows whatever the organisation says. In fact families who were once rude are now very polite and supportive.

7. **Now community believes that mental illness is treatable and gives respect:** With starting up of camps within the locality and reachable distance and more and more people getting stabilised, community knows that the illness is treatable but the medicine runs for little long. And also community understands that anybody can become mentally ill if he/she is not positively living his/her life. Also the outreach / rural camps have developed an attitude towards regular treatment. The families now know that not only medicines but also good behaviour towards PWMI helps in getting stabilised faster.

8. **Now field staff doesn’t need to travel a lot to find PWMIs, they came referred:** Now field staffs are not required to identify PWMIs as they comes referred. Each stabilising PWMI now bringing more PWMIs to the organisation for help. To meet with the challenges of follow up of high number of PWMIs, community has joined hands with organisation as volunteer. These volunteers now follow up the PWMI in their locality and later forwarding details to the organisation.

9. **Government has accepted community mental health is a needed for development:** State government of Jharkhand has become very active implementing DMHPs in 7 more districts and have invited NGOs from those districts to support them. The state government has also directed Central Institute of Psychiatry (CIP) to

design a short term course for on psychiatry for its general practitioners so that equipped manpower will be available at each block. As infrastructures are coming up, outreach camps by mental hospitals also continue. In Bihar, the state government has ordered its health department to appoint necessary manpower at its only mental hospital to run OPD, manage hospitalisation of PWMIs, issue disability certificates and run outreach camps. Now all these facilities can be accessed free by any person upon presenting BPL card.

Outcome 2: ***if applicable*** (insert outcome wording here)
Progress towards outcome ***over the life of the grant****:* 1. *Tell us about your progress based on the indicators of achievement of project outcome detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*
2. Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these:

Has this outcome brought about the changes to peoples' lives you expected by the end of the project? (*where 3 = fully; 2=mostly; 1=partly; 0=not at all)*

0	1	2	3

Justification for your rating:

Outcome 3: ***if applicable*** (insert outcome wording here)
Progress towards outcome ***over the life of the grant****:* 1. *Tell us about your progress based on the indicators of achievement of project outcome detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*
2. Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these:

Has this outcome brought about the changes to peoples' lives you expected by the end of the project? (*where 3 = fully; 2=mostly; 1=partly; 0=not at all)*

0	1	2	3

Justification for your rating:

Outcome 4: ***if applicable*** (insert outcome wording here)
Progress towards outcome ***over the life of the grant****:* 1. *Tell us about your progress based on the indicators of achievement of project outcome detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*
2. Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these:

Has this benefit/outcome brought about the changes to people's lives you expected by the end of the project? (*where 3 = fully; 2=mostly; 1=partly; 0=not at all)*

0	1	2	3

Justification for your rating:

B2b Have there been any unexpected positive or negative outcomes? Please describe them below.

Positive Outcomes

1. While following up the increased number of PWMIs, organisations faced real problems and searched for some alternatives. To meet the need, all partners wanted more staff but there was no money to support it. In some community meetings with PWMIs and care givers, when this topic was discussed in community meetings, some stable PWMIs offered voluntary support. These stable PWMIs proved to be ambassadors of the programme and helped in following up PWMIs and identifying new also. NBJK admits that in the beginning they were struggling with increased no of PWMIs and worried about their following up but with the idea of volunteer now they can easily follow up more PWMIs. And at that time nobody expected that once acute ill, the PWMIs will become active volunteers to support the programme.

2. When after repeated liasoning with government did not become fruitful, the partners thought of using Right to Information Act 2005. While asking for information from government, each partner organisations sent letters on behalf of 10 PWMIs. At the time of applying none of the PWMI ever thought that Govt of India would answer their questions. So upon getting answers in writing, they were so enthusiastic that they thought of forming an advocacy group and meet the government officials. Soon PWMIs and their caregivers unite to form a group at block, district and state level. The group is named *Manashik Rog Sangharsh Samiti* and any advocacy initiative taken is now under their name.

3. The partner organisation at Ranchi, Jharkhand, has given loans to PWMIs in revolving manner. But at the time when the field staff under community mental health programme approached their office head, he could not attract any interest and many staff of the organisation thought it's not a good idea to give loans to PWMIs. Even some of the co-staff made funny comments on this type of loans. But with all that suspiciousness in mind and heart, the office head approves loan and the field staff distributed it. Surprising all, the repayment of that loan was so good that the office head has decided to start full-fledged micro credit programme with PWMIs' SHGs. The repayment rate on loans to PWMIs is the best within the organisation and now this is treated as a success story and example to motivate other SHGs of so called normal people.

4. At Gaya, Bihar, one of the programme partners has been trying for quite a long to convince the Psychiatrists in Magadh Medical College Hospital, Gaya to hold outreach camps in rural areas. With repeated presentation she became successful in bringing the psychiatrists from that college to the community where the organisation is working and to the monthly camp (being conducted with a private psychiatrist). The team of Psychiatrist were so impressed by the community mental

health programme being implemented there that they invited Secretary of the organisation to give lecture to medical students on community mental health. The Director of Magadh Medical College also confirmed that not only students will be present in the lecture but also the teaching faculty. The Medical College Hospital is planning to start outreach camps in rural areas every month.

5. At Loherdaga, the District Collector was met and demanded inclusion of PWMIs in development programmes in a meeting. The DC was briefed about the programme and achievements by the organisation and was impressed and promised to help as per her capacity. But after listening to the difficulties PWMIs suffering in accessing treatment, the DC was quick to offer a free-pass facility to them through the organisation. Though she expressed her inability to release an order like this in writing but issued an oral order to the district administration. Based on that order, the PWMI who is regular in treatment at RINPAS and one carer would be allowed to travel free of cost upon showing the registration slip of RINPAS. Now based on that order, each PWMI, who is coming to RINPAS for treatment, travels free.

6. Again at Loherdaga, staff and office bearer from the organisation Loherdaga Gram Swarajya Samiti was meeting Civil Surgeon on reproductive health related issue. Using that opportunity, the Secretary of the organisation expressed concern about PWMIs and how they couldn't access treatment due to poverty and demanded intervention from him. The Civil Surgeon summoned all his colleagues and discussed vividly how to set up a DMHP at the district head quarter. And at the same time, the CS said that as it may take little time to establish such facility but by that time all PWMIs can get financial support for accessing treatment from him under Sahiya Programme. Under Sahiya Programme, each village is provided with one Sahiya (barefoot female health worker), who was ordered to give Rs.500 per PWMI per annum so that PWMIs can bear treatment expenses. Now all 87 PWMIs who are accessing treatment are provided with that monetary support.

7. 2 PWMIs, Anita Devi and Beti Hansda were seriously ill and started coming for treatment almost two years ago. With regular treatment both of them recovered well and got their symptoms reduced. While the organisation, DEEP, counselled them to get involved in any income generation activity, they primarily denied and expressed eagerness to continue with household work. But with repeated counselling both of them agreed to enrol into SHGs. Now under the same SHG, they have received loans of Rs.2.30 Lakhs to start their business. Now they are using this money for rearing cows and selling milk.

8. Rina Kumari of Gangta village, Dumka was seriously ill and was locked inside house for a long. She had developed her illness in twenties as her parents could not get her married off. During her illness she was kept inside a room and given food and water there. But the organisation, DEEP, intervened and brought her to the treatment process. With regular treatment, she recovered well and later she even got a job of Nurse in Dumka district hospital. Interestingly as soon as she got the job, lots of marriage proposals came in and she finally got married in September 2008.

9. In Hasanpura village of Fulwari Sharif block of Patna district, lived a lady named Chandrabati Devi and was identified while survey of PWMIs was going on. Her neighbours were sure that she would die soon because of her acute physical and mental illness. She was in terrifying situation and even could not attend call of nature by herself. She was completely bed ridden. Even though the field worker did not expect any miracle but managed to counsel her family and brought her to the camp for treatment. With all that fear in heart, her treatment continued and within

just 7 months she recovered well and became symptom free. With that treatment she was better than her pre-illness period. While during illness her in laws dumped her thinking she would not survive, they took her back after she stabilised.

10. Usha Kumari from Koderma was just another woman with mental illness in serious condition. She was locked inside a room by her family, digging it all around and without clothes at the time of identification. The field staff was courageous to go near and counsel her and then managed to bring to camp. From the date of identification she has been regular in coming for treatment and her whole family was regularly counselled about hygiene, intake of medicine, etc. At that time the organisation never knew that after stabilising she would one day become anganwadi sevika and demand for mental hospitals, drugs and psychiatrists standing in front of Health Minister of Jharkhand. Now she is a volunteer and identified five more PWMIs. She even once attended a meeting with DC, CS and other district authorities narrating her story to appeal ambulance with fuel from them, which would be used by the organisation to carry PWMIs to camps. The district administration was so impressed by her that the organisation was sanctioned an ambulance with fuel for the purpose.

11. In the month of January 2009, when NBJK with all Bihar state partners met State Health Secretary and Director of Koilwar Mental Hospital in a meeting to demand implementation of district mental health programme in Bihar, they did not discard the proposal but they offer something unexpected. The Health Secretary of Bihar offered to hold camps in any place in Nalanda district (this district is Chief Minister's constituency). In the same meeting, Director of Koilwar Mental Hospital invited PWMIs to come of a certain date to the hospital where the team there would release disability certificate to the eligible. NBJK is in discussion with them to finalise the offer.

12. NBJK and its Jharkhand partners have been regularly demanding implementation of DMHP in at least 4 district headquarters for quite a long time. But recently the state health ministry and RINPAS have developed a proposal to setup DMHPs at 7 districts and was already presented to Govt of India. For those seven districts, RINPAS has asked NBJK to refer some NGOs those who will partner with them. With the help of NGOs, these DMHPs will function now.

Negative Outcomes

1. Dighi Devi of Jiddu village, Ranchi has been suffering with mental illness since long but with regular treatment she had become stable. The field staff was confident that soon she can stop taking medicines and psychiatrist had also same view. But one day there was fight within her family and it was so fierce that there was exchange of stones and sticks. Under that circumstance somebody hit Dighi Devi on back of her head and she became unconscious for some time. She regained consciousness in hospital and started behaving abnormally. Soon she was taken to the mental hospital where the psychiatrist said that she had relapsed and became mentally ill again.

2. Nagiya Kumari of Kumbharia village, Loherdaga was married off to a person despite her illness. At the time of marriage her illness was not prominent so situation was normal for a year and half. But as her illness started showing colours, her marital relationship started taking a dip. Frequent fights started between her and in-laws. By that time her treatment was also not continuing and situation became worse by the day. It became so difficult for her that one day she jumped into a well and died.

3. Anita Sathpathy of Gamharia block, Jharkhand got married to a boy of Rairangpur, Orissa in April 2006. At the time of marriage she was taking medicines for mental illness and stable. Her father did not inform the family of her in – laws about the medication and get her married off. Life for her was fine for almost a year and half. But six months ago her in laws suspected some problems in her and enquired about her history. Knowing a little, they came to her parental village where they came to know about her illness. So they deserted her and came to the organisation, Lokhit Sansthan, to see her records. Though the organisation tried to counsel them that she is stable now but their decision was unchangeable and they went back. As soon as they went back, they filed a case against her and her parents for cheating.

4. Ganesh Singh of Amarpani village, Jarmundi block, was chained at the time of identification. When the field staff found him, he was in complete messy condition and could not talk also. But the organisation managed to unchain him and feed medicines after consulting the psychiatrist. With regular medication he slowly became stable. But one day he borrowed a cycle from his neighbour and went somewhere. It's been 3 months and he hasn't returned to his house and nobody has been able to find him also. An FIR has been lodged by his parents but even police couldn't find him.

5. Meena Devi of Ambadumbria, Dumka, got married to Virendra Jha of Deoghar district on 28th March 2006. But on the day of her marriage she behaved abnormally and her in laws left their house saying she has became mad. But by that time their marriage was over and despite several attempts by her father when she was not accepted by her in-laws, she stayed with her parents and under treatment. With almost two years of medication she is symptoms free and quite stable. Her parents then consulted with the organisation and thought of sending her to in-laws house. Then organisation suggested the parents to go to her in laws first and discuss the matter. But recently when Meena with her parents went to in – laws village, her husband got this news from somewhere and stopped them outside village then threatened to kill if they tried to enter. Frightened by this threat Meena's father did not ever try again.

6. Enthusiastically, Lok Chetna Vikash Kendra, Nawada printed pamphlets on signs and symptoms of mental illness in 10000 numbers and distributed at the nearest bus depot. From the same depot bus travels to many near by and far areas. While these pamphlets got distributed and reached far areas, people from those districts came approaching the organisation for treatment. It was quite encouraging initially but the problem was of follow up. Due to distance the field staff found difficulties in following up and many patients faced problems. Slowly many PWMIs dropped out and the organisation suffered a set back.

7. Pratima Devi of Beria village, Palamu, was suffering with mental illness when deserted by her in laws. She came back to her parents place and stayed there. One day she was identified by the organisation as person with mental illness and brought for treatment. Her treatment continued for almost one and half years and she became stable. When she became stable, her parents thought of sending her back to in – laws and called them. But her husband was getting ready for second marriage and so denied to take Pratima back. The organisation, Partima's parents, community members united and resisted this move of her husband and forced to accept her. Under community pressure Pratima's in – laws accepted her and took back to their village. But sadly, they killed Pratima only 20 days after. The organisation soon lodged an FIR and her I laws are behind bars now.

B3 – Cross cutting outcomes / approaches to work

Based on the information submitted in the outcomes tracking form, tell us about the progress you have made towards each of the cross cutting outcomes over the life of the grant.

B3a **Gender and diversity: Reduced inequalities affecting the most disadvantaged women and men, girls and boys in their access to resources, participation in decision-making processes and exercising of rights.**

Progress towards cross cutting outcome ***over the life of the grant****:*

1. *Tell us about your progress towards this cross cutting outcome, based on the milestones/supporting outcomes and their indicators of achievement detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*

    1. Staff of the organisations were imparted training on gender once and they hold community meetings, street plays, published posters and pamphlets & distributed, wrote wall writings, formed and sensitised SHGs on gender issue including mental heath and emphasising on involvement of women in development process. Organisations identified volunteers of whom necessarily 50% are women and with the help of volunteers community was given training on gender and development and importance given to positive mental health of women in the family.

    2. At the end of three years, the men women ratio in identification stands at 58:42 which has slightly bettered from 60:40. In treatment, the men women ratio is also at ratio 58:42. A study was designed to understand gender issue in the project area by selecting 1 block each in Bihar and Jharkhand as sample. To undertake field investigation 11 field investigators from the same blocks were selected and thoroughly oriented. The field investigators interviewed 220 head of the family of PWMI and conducted 22 focused group discussions, where 267 people (117 men and 150 women) have participated. The information analysis is over and final report is being generated.

    3. In the areas where outreach camps are going on, men women accessing treatment in a ratio of 53:47 where as in other places where PWMIs need to travel more distance for treatment, this ratio is 63:37

    4. Exclusively 1879 SHG meeting have been organisation by the organisation where women member were sensitised and then taken hep for identifying PWMIs and following up.

2. *Tell us about any additional activities not detailed in your outcome tracking form which have enabled you to progress towards this cross cutting outcome (include quantitative and qualitative indicators and ensure that these are split by gender).*

    1. Three women with mental illness have been elected as Sarpanchs (village levels) in Bihar.
    2. 133 SHGs formed in Saraikela district of Jharkhand and out of it 60 are now linked with bank where they used to meet every month and invites more women to become member
    3. Re integrating married PWMIs into their in-laws house and sensitising them to continue with medicines
    4. Utilised occasions like weekly markets, community religious gatherings where women's participation is more, to spread the awareness on mental illness
    5. Under another programme, there was an activity such as orienting school children,

used that opportunity to create awareness

6. Linked with other groups of other organisations to spread the information, trained other network partners (NGOs) and took their help in identifying PWMIs

3. *Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these.*

   1. Carers initially didn't disclose the fact that there is a person with mental illness in their family.
   2. Community was too stigmatised, people did not believe field staff at beginning that mental illness is curable and they continue to consult faith healers
   3. Male members of the community used to protest much when women wanted to come out for any reason and organisation needed to pay for treatment of women with mental illness because their family members were not supporting it
   4. Though mental illness was considered a cause to break marital relationship but women suffered more as women with mental illness were either not able to get married or deserted after marriage. Also at the same time if a women is married to a mentally ill person, she is not allowed to leave her.
   5. Training women on any issue was much time consuming and topic of mimic for men
   6. Male field staff expressed difficulties in identifying women with mental illness as families don't allow men from outside to talk to women
   7. Initially making a team of artistes for street play was quite difficult and while conducting street plays, arranging people was a difficult. Even sometimes people used to take it lightly and laugh at the team. There are few instances when an artiste of street play group faced accident while trying to make it lively performance
   8. Geographical issues and movement of extremist groups threaten any movement in interior areas

4. *Tell us about the impact that work undertaken under this cross cutting outcome has had on the achievement of project outcomes.*

   1) More number of women identified and with treatment got stabilised, women's participation increased in community meetings, they started coming out of house,
   2) Family gets relief, organisation's acceptance in the community increased, practice with black magicians reduced
   3) Over all ratio of men women has reduced from 70:30 to 58:42 and at some places to 52:48
   4) 159 women volunteers has been raised and trained on the issues of mental health
   5) Participation of women has increased in livelihood related activities

B3b **Participation: Increased participation of the most disadvantaged people in all aspects of development projects to ensure that benefits are long term and shared fairly**

*Progress towards cross cutting outcome **over the life of the grant**:*

1. *Tell us about your progress towards this cross cutting outcome, based on the milestones/supporting outcomes and their indicators of achievement detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*

   1. A total 1174 people (623 men and 552 women) have got job cards under NREGS – National Rural Employment Guarantee Scheme, 143 people (33 men and 110 women) have got housing under Indira Awas and 868 people (512 men and 356 women) have received BPL Cards, taking total number of beneficiaries of government schemes to 2185.

2. 1263 women and men with mental illness, caregivers and community members participated in the 88 consultations during the year. Mentally ill men and women participate actively in consultations and express their needs which help to design the interventions based on their expressed needs. All the consultations are documented in local language.
3. 342 people with mental illness (125 male and 217 female) and 700 care givers (432 male and 268 female) have been included into 479 SHGs.
4. Self help groups are trained in mental health issues and how mental illness is treatable and the fact that stabilised mentally ill people can return to work or earn an income.
5. Self help groups now include people who are recovering from mental illness.
6. Members of self help groups have joined micro credit schemes thereby enhancing the family income.
7. Recovered mentally ill people are assisting with the identification of others who are in the early stages of suffering mental illness.
8. While discussing their issues, some self help group members voluntarily identify and discuss their mental health problems
9. SHG members becomes supporters in advocating for the entitlements of PWMI
10. Total 35,811 people including mentally ill, have participated in 2070 community meetings
11. A total of 84 PWMIs have received vocational trainings
12. PWMIs, care givers, community members have come together and formed a group at block, district and district level for advocacy and protection of rights. The group is named as Manashik Rog Sangharsh Samiti.

2. *Tell us about any additional activities not detailed in your outcome tracking form which have enabled you to progress towards this cross cutting outcome (include quantitative and qualitative indicators and ensure that these are split by gender).*

1. Two rural enterprises have been setup with and for stabilised PWMIs. The enterprises which manufacture leaf plates and chalks have given employment to 12 PWMIs where they are earning a modest income of Rs.1200 – Rs.1700 per month. Though currently the marketing of products till now managed by the organisations but now PWMIs are gaining confidence and planning to take care of it.
2. During rallies and public gatherings, PWMIs and their carers participated and shared their experiences to demand better mental health facilities from state government for other PWMIs.

3. *Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these.*

1. PWMIs and their families were hesitant to come out first but later they took part in development
2. Managing PWMIs and dividing responsibilities among them sometimes proved fatal and loss of money
3. While accessing any govt facilities field staff of the organisation used to run around govt departments

4. *Tell us about the impact that work undertaken under this cross cutting outcome has had on the achievement of project outcomes.*

1. People considering mental illness is treatable
2. PWMI can take part in any activity, earn money, is eligible for social acceptance
3. PWMI need to be given equal opportunity

4. Now from the rural enterprise PWMIs have been showing interest to market the product
5. PWMIs could stand in front of govt officers / ministers/ officials to demand mental health facility at remote areas

B3c **Capacity building: Improved capacity of partner organisations, local communities and other stakeholders to tackle the causes of poverty effectively, efficiently and in sustainable way**

*Progress towards cross cutting outcome **over the life of the grant**:*

1. *Tell us about your progress towards this cross cutting outcome, based on the milestones/supporting outcomes and their indicators of achievement detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*

    1. In the programme period, 25 field staff were given training for 14 days on community mental health, 3 days on documentation, 3 days on gender, 2 days on livelihood and 10 days on economic assessment. Besides these trainings all these 25 staff received training on computer database software for 1 day. With the trainings, field staff learnt about recognising symptoms of illness and its types, severe mental disorders, common mental disorders, counselling skills, government schemes for development, legal rights of mentally ill, community awareness skills, human rights issues, role of volunteer in community, wall writing, follow up and file updating, documenting skills, database handling, handling gender issues and assessment of economic change.
    2. All 316 volunteers including 159 women were given by the organisations on mental health and development issues and they are supporting field staff/mental health coordinator in extending home based support for people with mental illnesses. These 316 trained volunteers have been working in their own communities, visiting affected people and their families and implementing individual plans. Most of the male volunteers ate stabilised PWMIs. Also these volunteers were given training on street play.
    3. 12 quarterly reviews held and during the quarterly reviews, each partner's needs as well as the common needs are assessed by reviewing their performance. Plans are developed and agreed for the next quarter. Data base has been gathered at the end of the year.
    4. 138 community trainings has happened during the programme period where more than 2000 people have been trained on types of mental illness, counselling skills, etc.
    5. A total of 84 PWMIs have received vocational trainings on trades like tailoring, candle, incense stick, pickle, leaf plate making, basket weaving, cycle repairing and poultry farming
    6. 1226 people (773 men and 453 women) were supported with loans from the mental health programme and organisation's other programme to strat / strengthens business. They are now involved in livestock development, agriculture, and daily labour, shop owning, etc and getting a monthly income in the range of Rs.1200 to Rs.7000.
    7. In 4 districts, Loherdaga, Garhwa, Dumka, Saraikela of Jharkhand SHGs have been united to form a federation. The SHGs have PWMIs as members along with other women. The SHGs formed in villages form clusters first then elect leaders from the clusters to form a federation. These federations behave as pressure group after being trained on several development issues including mental health. Federations regularly hold meetings among themselves and gather to demand rights at district and block level. Now all PWMIs have united to form state level advocacy group

names *Manashik Rog Sangharsh Samiti.*
8. Partner organisation were trained on using RTI Act 2005 for retrieving information from governemtn departments who in tern trained PWMIs and their association

2. *Tell us about any additional activities not detailed in your outcome tracking form which have enabled you to progress towards this cross cutting outcome (include quantitative and qualitative indicators and ensure that these are split by gender).*

1. 347 street theatres were performed during the programme for creating awareness in the community.
2. More than 46,000 Pamphlets and posters were developed and printed in Hindi and distributed to people in all the project areas of 25 partners. Also 3 manuals and 2 calendars were printed and distributed by NBJK
3. A documentary film on "Best Field Practices" was shot and now used for training other NGOs
4. 342 people with mental illness (125 male and 217 female) and 700 care givers (432 male and 268 female) have been included into 479 SHGs and given training on SHG management
5. Several trainings given to government officers, doctors, nurses, teachers, block development officers, ANMs, ICDS staff, ward members, RMPs, school children to sensitise them on community mental health and involving PWMIs in developmental schemes.
6. 17 stabilised people were provided with support to commence organic farming and eight of them have now started their own plots.

3. *Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these.*

1. While arranging community trainings, bring community people for longer time such as 2 – 3 days was difficult as they were occupied with their livelihood. Sometimes these trainings were divided to some 2/3 weekends.
2. In a situation where officers from different govt departments were invited to be present at one time, organisations found it difficult.

4. *Tell us about the impact that work undertaken under this cross cutting outcome has had on the achievement of project outcomes.*

1. Community is sensitised towards need of PWMIs
2. PWMIs are now part of livelihood programmes, getting job cards under NREGS and socially accepted
3. *Manashik Rog Sangharsh Samiti* formed at village, block, district and stat level
4. PWMIs getting some benefits from govt schemes such as Indira Awas, disability certificate, etc
5. Under RTI PWMIs accessed information from govt departments
6. Govt inviting NGO partners for discussion on implementation of DMHP / NMHP
7. More PWMIs are being referred by stabilised PWMIs
8. PWMIs used RTI Act 2005 to get information regarding their rights and entitlements from Ministry of Social Justice and Empowerment and Planning Commission

B3d **Alliances, collaboration and networking: Developed alliances, collaboration and networks at all levels, both in the UK and overseas, to bring about sustainable development initiatives for the most disadvantaged people**

Progress towards cross cutting outcome ***over the life of the grant****:*

1. *Tell us about your progress towards this cross cutting outcome, based on the milestones/supporting outcomes and their indicators of achievement detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*

    1. 342 people with mental illness (125 male and 217 female) and 700 care givers (432 male and 268 female) have been included into 479 SHGs
    2. 14 organizations in Bihar and 11 organizations in Jharkhand continue to work as a team in the area of Community Mental Health and Development.
    3. All PWMIs along with carers, volunteers and community members have united and formed *Manashik Rog Sangharsh Samiti* at village, block, district and state level. This group now undertakes advocacy activities for the protection of rights of PWMIs.
    4. The staff of the partner organizations are continuously capacitated building their skills in mental health, gender, documentation, development and livelihoods. They have been empowered with information to lobby the district authorities to sensitize them about the need for services and to promote an alliance of PWMI and their supporters to advocate and access their entitlements from the government.
    5. Bihar partners have formed an alliance to influence state government in opening up of Koilwar Mental Hospital with OPD and hospitalisation facilities along with availability of drugs and psychiatrist. Also the alliance has been pressurizing government to implement DMHPs.
    6. Rallies have been conducted in state capitals with participation from PWMIs, carers where they spoke to the health minister and demanded availability of facilities at district level at least. The gathering of PWMIs and carers enabled the media to gain an understanding of the situation; they in turn are now putting pressure on the government. Their voices are being recorded as life stories which will are being used for sensitizing community as well as government.

2. *Tell us about any additional activities not detailed in your outcome tracking form which have enabled you to progress towards this cross cutting outcome (include quantitative and qualitative indicators and ensure that these are split by gender).*

    1. 59 NGOs outside the network of 25 have been trained and sensitised on the issue of mental health. These NGOs are now voluntarily supporting the network.

3. *Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these.*

    1. Initially networking with other NGOs faced some difficulties as there was no funding support
    2. Meeting with government officials was too much time consuming and frustrating as they keep on elongating the process
    3. Initially the care givers of PWMIs were hesitant to demand rights and be part of a larger network

4. *Tell us about the impact that work undertaken under this cross cutting outcome has had on the achievement of project outcomes.*

    1. Director of Koilwar Mental Hospital has agreed to hold one outreach camp every month in the beginning and issuing disability certificates to PWMIs.
    2. Formation of *Manashik Rog Sangharsh Samiti* at block, district and state level
    3. SHGs have been networking and the leaders moved to Disabled People's Organization's office in Ranchi to demand job cards and BPL listing for the PWMIs

4. In Jharkhand 4 district level federations of self help groups of people with mental illness and their carers have been formed at Loherdaga, Garhwa, Dumka, Saraikela, districts These local alliances are formed to support and/or lobby for sustainable community mental health services , stabilised mentally ill people are actively involved in the alliance. In Bihar the Joint Action Network continues its efforts and has brought the issue of mental health in the state assembly of Bihar.
5. 59 NGOs outside the network of 25 have been trained and sensitised on the issue of mental health. These NGOs are now voluntarily supporting the network

B3e **Influencing opinion: Improved responsiveness of decision and policy makers to the needs of disadvantaged people**

Progress towards cross cutting outcome ***over the life of the grant****:*

1. *Tell us about your progress towards this cross cutting outcome, based on the milestones/supporting outcomes and their indicators of achievement detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*

    1. World mental health day was celebrated by all the partners that was used an opportunity to influence Block and district level officers from different departments. Besides these rallies, public gatherings and street theatres were also held. On World Mental Health day a rally was organised at Patna capital city by Bihar partners and PWMIs along with their carers presented a memorandum to the Minister of Health.
    2. Partners have been successful in sensitising Block Development Officer, Police Officers, Civil Surgeons and medical officers, Assistant Chief Medical Officer, Jailer, Deputy Inspector General (Police), Bank Manager, Zilla Parishad Member, Advocates, Block Medical Officer, Press Reporters, Postman, Grocery store owners, Assistant District Programme Officer (Education), Block Agriculture Officer, Member of Legislative Council, Member of Legislative Assembly, on different occasions through workshops at different places.
    3. Partner organisations oriented 1879 SHGs on mental health problems.
    4. 316 volunteers trained on community mental health
    5. Director and Medical Superintendent of RINPAS was met and sensitised on need of setting up DMHPs in remote districts first so that PWMIs from need not take pain of travelling to Ranchi also consultation fee waiver for PWMIs belonging to below poverty line
    6. Health Ministers of Bihar and Jharkhand were met and demanded installation on DMHPs on urgent basis
    7. Director of Koilwar Mental Hospital was also met and demanded outreach camps

2. *Tell us about any additional activities not detailed in your outcome tracking form which have enabled you to progress towards this cross cutting outcome (include quantitative and qualitative indicators and ensure that these are split by gender).*

    1. A rally and protest was organized in Badh Sub division, Patna with 40 PWMI and their carers to persuade the local government to include mentally ill people in National Rural Employment Guarantee scheme (NREGS) and to issue job cards. This resulted in 40 stabilised PWMI being issued with job cards. Another similar rally in Islampur block, Bihar resulted in 30 PWMIs being issued job cards. The job card ensures at least 100 days employment in a year.
    2. On World Disability Day, a workshop was arranged which was attended by District Programme Officer, Block Medical Officer and community members including PWMIs. The issues raised to Indira Awas ranged from PWMI included in NREGS,

disability certificate to pensions being awarded to PWMI. The rally also raised the issue of children of PWMI and their inclusion under the Education Guarantee Scheme. At least one child of a PWMI should be receiving schooling and inclusion into BPL list.

3. Bihar state partners met the Health Minister of Bihar to represent their views about the mental health situation in the State and demand the need for proper facilities and functioning of the Mental hospital and provision of medicines. They also demanded to make necessary arrangements for initiating mental health services and district mental health programme in the state. A memorandum regarding this was also submitted to the Chief Minister of Bihar.
4. Bihar state partners also met the leader of opposition of State Assembly, Bihar and demanded to raise issues during the assembly session. Same was raised, the state government as assured to develop mental health plan for the state.

3. Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these

1. Meeting with government officers, ministers was too problematic as they don't prefer to meet
2. Taking a larger number of PWMI and carers to meet the officials was expensive affair and tedious

4. Tell us about the impact that work undertaken under this cross cutting outcome has had on the achievement of project outcomes.

1. RINPAS has passed an directive to public that any person coming for treatment would get it absolutely free on production of Below Poverty Line card
2. Now Koilwar Mental Hospital's OPD is fully functional and drugs as well as psychiatrists are available
3. In Jharkhand 2 DMHPs are functional and RINPAS has presented aproposal to Government of India to install 7 more DMHPs
4. Koilwar Mental Hospital is ready to start outreach camp in Nalanda district of Bihar and issuing disability certificate to PWMIs
5. Government of Jharkhand has asked Central Institute of Psychiatry to design a six month course for its general practitioners (MBBS doctors) on psychiatry so that they can serve PWMIs at block/ district level

B3f **Other: Provision of services/facilities etc (if applicable)**

*Progress towards cross cutting outcome **over the life of the grant**:*

1. *Tell us about your progress towards this cross cutting outcome, based on the milestones/supporting outcomes and their indicators of achievement detailed in your outcome tracking form (include quantitative and qualitative indicators and ensure that these are split by gender).*
2. *Tell us about any additional activities not detailed in your outcome tracking form which have enabled you to progress towards this cross cutting outcome (include quantitative and qualitative indicators and ensure that these are split by gender).*
3. *Outline any difficulties you may have encountered including factors in the external environment, and how you responded to these.*
4. *Tell us about the impact that work undertaken under this cross cutting outcome has had on the achievement of project outcomes.*

B4 Further information

Use this space to give us any further information about your project that you think will help us to understand what you have achieved. You may wish to include case studies or stories of significant changes to the lives of women and men, girls and boys benefiting from the project.

B5 Project partners and staff

B5a Have there been any changes to your project partner(s) over the past year?

Yes	✓		No	

If yes, you will need to contact your grants officer.

B5b: Please tell us about any changes to **key** staff this year such as the project manager and the impact this may have had on the achievement of project outcomes.

In the past three years, nine field staffs from eight organisations left the job and also the project coordinator of NBJK. Though the assistant project coordinator was immediately promoted to the post of coordinator but the change some impact in management of the programme.

B6 Sustainability

In the application form (Question B11) we asked you about what would happen when our grant ended. Tell us what you have done this year in terms of each of the areas listed below to ensure that changes in lives of beneficiaries will continue in the longer term?

Building management and skill in:

(i.) Government agencies: Both the state governments' health departments have been met many times and sensitised over the issue by the alliance of NGOs along with group of PWMIs. This has resulted in opening up of Koilwar Menatal Hospital and its fully functional OPD, 2 DMHPs in Jharkhand, CIP designing syllabus for short term course of general practitioners. Besides setting up of services by the government, 2185 people have been benefited by government schemes as 1174 people (623 men and 552 women) have got job cards under NREGS – National Rural Employment Guarantee Scheme, 143 people (33 men and 110 women) have got housing under Indira Awas and 868 people (512 men and 356 women) have received BPL Cards.

(ii.) Partner Organisations and NGOs: The partner organizations in both the states have formed two alliances to take up advocacy at state level as well as district level. Documentary films, posters, pamphlets, calendars, manuals, were developed for and by partners and used to build capacity. Partners are well equipped with knowledge on community mental health, gender and livelihood. Their documentation skill has significantly improved as they are capable to handle computerised database and keep records in hard copy. All reviews and evaluations have been a good opportunity for them to learn from peers and implement the best practices at their places and share their own experiences

(iii.) Beneficiaries (women, men, girls and boys) and community groups:

People with mental illness, their carers, volunteers and community members have united to form a group named *Manashik Rog Sangharsh Samiti* at village, block, district and state level. This group is doing advocacy for protection of rights of PWMIs and installation of necessary infrastructure at all level. This group has proved to be very powerful and now enthusiastic to use RTI Act 2005. This group is continuing with its effort

Transfer of responsibility:

(i.) Government agencies: Now government of Bihar has opened up its only mental hospital at Koilwar after long battle of attitude. This mental hospital is now equipped with psychiatrists and a Director. The hospital offers OPD services every day except Sundays and holidays along with medicines. The hospital has also proposed to conduct an outreach camp every month and issuing disability certificate. Government of Jharkhand has been continuing with installation of DMHP, as now 2 of them are fully functional and serving, 7 more in pipeline. The proposal to set these 7 DMHPs has already been submitted to Government of India. Government of Jharkhand has also ordered CIP (Central Institute of Psychiatry) to design a short term (6 months) course for MBBS doctors, which is ready.

(ii.) Partner Organisations and NGOs: As partners were made ready to the end of funding, they were capacitated to build new networks and raise funds if necessary. Some of partners have also succeeded in it and will continue. NBJK as larger NGOs has been trying to raise some necessary funds to continue this programme. They have been very efficient to even keeping their coordinators ready to continue with all advocacy work

(iii.) Beneficiaries (women, men, girls and boys) and community groups: Now *Manashik Rog Sangharsh Samiti* is in place and so as volunteers. The community has pledged to support the PWMI and fight for their rights.

Post Project financing:

(i.) *Government agencies:*

(ii.) Partner Organisations and NGOs: NBJK has been linked with many funding agencies for extending this programme for a year or two as some other partners have been successful in attracting funds from other sources.

(iii.) *Beneficiaries (women, men, girls and boys) and community groups:*

Section D Learning and Development

D1 Please show us whether the factors below influenced the success of your project. Tick one box on each line depending on how these factors have impacted on your project over the life of the grant:

Factors affecting success	Strong +ve influence	+ve influence	- ve influence	Strong -ve influence	Not an influence	Brief Justification
Quality of Situation analysis/baseline	✓					Developing a baseline gave a clear picture of the situation which helped in prioritising, strategising and meeting the need
Experience and Skill of UK and partners	✓					Timely review and evaluation of UK team, continuous communication in between BNI, BNUK and partners have helped in strengthening the programme
Management and Leadership	✓					Effective management in handling a larger network has boosted the programme
Partnership	✓					Potential NGOs as partners have motivated the programme continuously and created a positively challenging environment
Communications	✓					
Finance and resources	✓					The programme had enough funding for programme and administration which has helped in implementation
Gender issues	✓					The high gender disparity spread in community was a challenge and catalyst to counter the situation, which helped in achieving programme outcomes
Beneficiary participation	✓					Participation from PWMIs and their caregivers has given

						strength to the programme activities and advocacy. Formation of groups by PWMIs and carers and their role in advocacy has been significant. Also beneficiaries' involvement in the programme under livelihood, as volunteer has been quite phenomenal.
Capacity of key stakeholders	✓					
Other groups working in the same geographic or sectoral area		✓				Networking with other NGOS outside the partners has supported in finding new PWMIs and bringing them in medication process.
Collaborative work with others	✓					Alliance building within the group of partners, group of PWMIs, government departments has supported the programme in achieving its targets
Awareness raising work	✓					Raising awareness of community, PWMIs, carers, volunteers and most importantly government has supported the programme
External factors Eg political, environmental or economic			✓			Sludgy Government departments, political disturbances and red tapism has always slowed down the pace of programme
Other factors (please state)						

D2 Taking into account the factors you have rated in question D1 above or any other factors, what lessons have you learnt that can be used in future or shared with others?

First, Advocacy with government doesn't mean that it should be always in confrontation mode but sometimes it can be done by making them part of the process. Second, there is no alternative to "unity and empowering voice of the beneficiaries". Their empowerment only will change the system.

D3 Are there any approaches to work that you have used or come across in the course of delivering this project that you consider innovative? If yes, please tell us about them

Giving opportunity to PWMIs to take responsibility though it was not quite supported by the community in the beginning

D4 Please tell us how you will make this learning and innovative approaches available to others – please provide details of, for example, with whom, where, in what format?

The learning and innovative approached will be made public and sharing will be on demand

D5 Have any NGOs or Government agencies shown any interest in replicating all, or some of the project activities?

Several NGOs are interested in taking up of such programmes in fact the community now want to follow the programme through the network of PWMIs and their carer. Government has asked for NGOs to partner with them in implementation of DMHP in 7 district of Jharkhand.