An End-Line Evaluation Report of

Rehabilitation and Reintegration Support for Abandoned Women with Mental Health and Psychosocial Issues Project

Report Submitted to

KOSHISH, National Mental Health Self-Help Organization

Lalitpur, Nepal

Submitted by

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Finally, the evaluation team is solely responsible for the contents of this report, including any inconsistencies.

The Evaluation Team

The Evaluator

Mr. Sandesh Dhakal, a psychology lecturer and Ph.D. candidate at Tribhuvan University, has considerable experience in teaching, training, project design, implementation, monitoring, and evaluation, as well as overseeing graduate students' thesis and coursework projects. Mr. Dhakal has also provided mental health-related project development, implementation, and evaluation consulting services to GOs/NGOs/INGOs. Mr. Dhakal has a long list of publications in national and international journals, mostly in the fields of mental health and psychology. Mr. Dhakal is now working on a number of cross-cultural mental health research projects.

The Outreach Worker

Ms. Bhagawati Bastakoti is an outreach worker/social worker at KOSHISH. With experience working as a social worker at KOSHISH, Ms. Bastakoti is mainly responsible for the rescue, reintegration, follow-up of the reintegrated beneficiaries, and coordination with government bodies and communities.

A member of the Self-Help Group (SHG)

Ms. Sabita Basnet is a person with lived experience of mental health problems. An active member of one of the SHG initiated by KOSHISH, Ms. Basnet is involved in activities of the SHG.

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List of Acronyms

CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
EAT	Empowerment Assessment Tool
HIMS	Health Information Management System
KII	Key Informant Interview
MoU	Memorandum of Understanding
MHPSD	Mental Health and Psychosocial Disability
MHPSS	Mental Health and Psychosocial Service
MHPSI	Mental Health and Psychosocial Issues
MoWCSC	Ministry of Women, Children, and Senior Citizens
M&E	Monitoring and Evaluation
OECD	Organization for Economic Co-operation and Development
SDG	Sustainable Development Goals
SHG	Self Help Group
ToR	Terms of Reference
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UHC	Universal Health Coverage
UNCAT	United Nations Convention against Torture

Executive Summary

The project "Rehabilitation and Reintegration Support for Abandoned Women with Mental Health and Psychosocial Issues" was implemented by KOSHISH with the overall objective of "Universal health coverage for people living with mental health conditions and psychosocial disability is ensured through accessible community- based holistic rehabilitation services in Nepal". The project had three aspects: development and management of the transit home for the rehabilitation of vulnerable women, sensitization and strengthening of government and communities on mental health issues, and acceptance of transit home as a rehabilitation model by stakeholders working in the field of mental health and psychosocial well-being of women with MHPSI.

Between May 12 and June 10 of 2022, an independent expert hired by KOSHISH assessed the project. The evaluation's goal was to gather, analyze, and provide evidence-based information using a primarily qualitative approach, which was supplemented by quantitative data, in order to determine the extent of convergence between planned targets and actual achievements and to synthesize lessons that can help improve the selection, design, and implementation of future activities. Relevance, coherence, effectiveness, efficiency, impact, and sustainability were the six primary criteria used to evaluate the project. The following are some of the report's major findings:

Relevance of the project: Concerning the relevance to the needs and priorities of the beneficiaries, interviews with the beneficiaries, their family members, and stakeholders indicated that holistic community-based rehabilitation and reintegration of vulnerable women were very relevant, especially for marginalized and economically disadvantaged women. The project is found relevant contextually and in relation to existing policy environment. In addition, the

methodology used in the project is highly relevant and suitable for the realization of the envisioned changes.

Effectiveness of the project: Some of the log-frame indicators exceeded the target, while a few were underachieved. The underachievement of some key indicators, as well as the lack of data on the achievements of some indicators, is partly explained by the fact that the project aspires to achieve those goals and collect the achievement data by the end of the project. Beneficiaries and stakeholders reported that the project was effective in the bringing about attitudinal change in public about mental health issues. The program provided service to more women than targeted and was able to educate family members and community people, although the latter was under-achieving. Strong links with the government in-line agencies and local government bodies are the project's major strengths.

Coherence: Assessment of internal coherence showed that the project was in line with the relevant international norms and standards to which KOSHISH adheres. Furthermore, it was consistent with the previous projects undertaken by KOSHISH, particularly “Mainstreaming Mental Health and Psychosocial Disability” project. Co-ordination of KOSHISH throughout the project life with government line agencies and other actors working on the same field indicate that external coherence of the project was also considerably high and notable.

Efficiency of the Project: The project was run with a minimum administrative and management cost. The project with regard to human resource management, it was found that project staffs were competent and dedicated and that an effective and systematized management structure was maintained, with clear role boundaries and effective communication practiced at each level. KOSHISH was able to sustain itself with a small team and a low budget primarily due to solid ties with local government bodies and the community. The internal monitoring system

for information flow and keeping records at the local and central levels was found to be good. For monitoring and evaluation, Honorable Minister and representative of Ministry of Women, Children, and Senior Citizens, Secretary of Ministry for Commerce, and Chairperson of Women and Social Affairs visited transit home of KOSHISH in 2020. In addition, annual financial audits were also performed to meet government requirements.

Impact: The project has been successful in terms of sensitization and awareness and changing attitudes. Both the output and outcome level achievements have been consequential in making the project impactful. The key impact level indicator established by the project was universal health coverage for people with mental health conditions and psychosocial disabilities. One major component of universal health coverage, i.e. financial protection (which measures the extent to which the population is protected from the financial hardship of accessing needed health care), should be given due consideration, and coordination with local government bodies and the healthcare sector would be beneficial.

Sustainability of the project: The ability of the project to achieve a conducive environment for the long-term achievability of the endeavors leading to the reinforcement of the capacity of the vulnerable women, partnership with relevant organizations and government bodies for advocacy, recognition of the project as highly essential, relevant and replicable by the government, befitting nature of the project to the local needs and issues, and community-to-community reproducibility of the project have rendered the project sustainable. Furthermore, the high degree of ownership of the intervention by the beneficiaries and their families indicated in the interviews attests to the sustainability of the project. However, the relapse and high risk of relapse for some of the beneficiaries reflect the need for more focus on educating beneficiaries

and their family members to recognize the early symptoms of relapse. Also, a system of symptom monitoring and a crisis plan would help to ascertain the sustainability of the project.

Section One: Introduction and background

1.1 Background

The basic purpose of this end-line project evaluation is to assess the accomplishments, strengths and weaknesses of the project entitled "Rehabilitation and Reintegration Support for Abandoned Women with Mental Health and Psychosocial Issues", launched by KOSHISH Nepal, concerning its overall impact and upliftment of lives. Moreover, the crucial factors that have proved critical in facilitating or impeding change are scrutinized to draw lessons for future programming. The project employed multilayered rehabilitation services with the comprehensive goal of incorporating all elements of rescue, rehabilitation, reintegration, advocacy, livelihood and income generation of abandoned women with mental health and Psychosocial Issues, largely by developing and managing a model transit home. In general, the project sought to help vulnerable women achieve maximum functionality in all areas of life. This report will assess the extent to which the anticipated changes have been brought, gauged against the pre-determined objectives and outcomes.

1.2 Project Description

The project was implemented from 2020 to 2022 with the consideration of three aspects together within the framework of the triad: i) replicable model of transit home for the vulnerable women, ii) enhancement of their quality of life, and iii) accomplishment of advocacy and awareness programs at different levels of communities and political units. The twin-track approach employed by KOSHISH through the simultaneous implementation of advocacy and awareness programmes and delivery of services has been consequential in ensuring holistic, community-based rehabilitation and reintegration services and sensitizing the relevant stakeholders on the mental health and psychosocial issues of the women.

According to Human Rights Watch (2020), the evidence of shackling (chaining or locking in confined spaces) people with real or perceived psychological disabilities is mounting, particularly about the unique risks and abuse faced by women primarily due to the multiple and intersecting forms of discriminations based on factors such as age, marital status, ethnicity, etc. The situation of vulnerable women is markedly deplorable in the case of low-income countries such as Nepal, where the stigmatization of mental health-related issues has permeated communities.

1.3 About KOSHISH

KOSHISH- registered in Kathmandu in 2008- is a non-profit, non-governmental self-help organization that works on a broad spectrum of mental health issues in Nepal. It works by employing a twin-track approach to implement awareness programs and advocacy campaigns in addition to service delivery. KOSHISH aspires to develop a replicable model of recovery-oriented, person-centered mental health services that includes mental health and psychosocial support (MHPSS) within and beyond the health system (e.g., social protection, employment, etc.). In addition, it actively works towards reducing and removing obstacles that prevent people with mental disabilities from inclusion and participation on par with others. The organization seeks to promote total compliance with the guidelines and principles set forth by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

1.4 Objectives and Scope of the evaluation

1.4.1 Overall objective (long-term impact):

The project's goal is “to develop and manage a model transit care services for women who have been locked up, chained, or abandoned due to mental health and psychosocial issues in collaboration of government of Nepal”

The project's primary objective is "Universal health coverage for people living with mental health conditions and psychosocial disability is ensured through accessible holistic rehabilitation services in the community in Nepal.'

Table 1: Project outcome and Outputs

Project Outcome and Outputs:
Outcome 1: Recovery and reintegration of previously locked, chained and abandoned women and girls with mental health and psychosocial issues.
Output 1.1: Women who were previously locked, chained, and abandoned were rescued and received specialized MHPSS services through model transit care services
Output 1.2: Women who received specialized MHPSS services in model transit care reintegrated in family and community
Outcome 2: Sensitized, reinforced and supportive Governments and communities on issues of mental health and psychosocial well-being and rights of persons with MHPSI
Output 2.1: Local government representatives and staff oriented
Output 2.2: Family members and community people oriented to mental health and psychosocial well-being and issues
Output 2.3: Lobby and advocacy with federal, provincial and local governments to mainstream mental health and psychosocial support
Outcome 3: Transit Home care accepted as a rehabilitation model by stakeholders working in the field of mental health and psychosocial well-being of women with MHPSI
Output 3.1: Annual project sharing workshops organized with government and other line agencies
Output 3.2: M&E visits of the project by government line agencies
Output 3.3: Funding opportunity available for rehabilitation and reintegration support for the beneficiaries identified and documented

Scope of the evaluation: The scope of the evaluation considers the disparities between the project's targeted goals and accomplishments and assess project progress based on the project log frame specific timeline, funds spent, reach to target groups, advocacy, and sensitization of the

local government, organizational set-up, policy, and institutional context. The entire 28-month period should be considered in the evaluation of the project.

Section Two: Methodology

2.1 Study Area

The evaluation of the project was conducted based on the information collected from the selected nine districts of Province 1, Madesh Province, and Bagmati Province.

2.2 Study Design

A cross-sectional study design with a qualitative approach to data collection was adopted for the evaluation study. The study was designed following the ToR to evaluate the project's output and results framework under the specific project objectives. It was designed to collect information on the performance of the project's planned outputs and results to meet the project objectives. Secondary data were project proposals, progress reports, and other relevant records and reports acquired from KOSHISH. Primary data was collected through the interviews with beneficiaries and relevant stakeholders during the field visit.

2.3 Study Population

Beneficiaries to participate in the interview were selected for interviews according to the quota sampling method. The quota was determined based on province, marital status, source of referral (community-based organization or family), the severity of the problem at the recovery time of intake, the status (good, mild, moderate and partially recovered) the time of reintegration and types of disorder (mood disorders or psychosis). Stakeholders include family members and neighbors of beneficiaries and representatives of local governments.

2.4 Data collection method and data analysis

After meeting with the KOSHISH team, the assessor developed a preliminary understanding of the project and the overall mandate for the evaluation. Primary data were collected from field visits through interviews with beneficiaries and relevant stakeholders.

Secondary data was garnered through the project proposal, progress reports, and other relevant records and reports.

Table 2: Data Collection Methods and Participant Distribution

S.N	Method	Respondent	No.
1	KII	Beneficiaries who have been reintegrated into the family, community, or institutions.	14
2	KII	Family members, close relatives, or care takers of the beneficiary	14
3	KII	Local Government's representatives, social workers, or organization heads	3
4	Documents Review	Project documents include project proposal, budget, logical framework, annual reports, national policies, and guidelines.	Variable

2.4.1 Data Collection Tools

Interview guidelines were developed for conducting interviews with beneficiaries and key informants. The interviews were recorded with the permission of the interviewee. The audio recordings of the interviews were transcribed and prepared for analysis.

2.4.2 Data Analysis

The qualitative data analysis method was employed to assess the congruence between the achievement of the project and the pre-determined targets. Its overall success was evaluated based on six criteria: relevance, coherence, effectiveness, impact, and sustainability.

2.5 Ethical Consideration

Before beginning the interview and discussions, each beneficiary gave verbal or written informed consent. Before the interview, the evaluator informed all participants about the study's

goal, their voluntary involvement, and their ability to withdraw or terminate the interview or conversation at any moment or refuse to answer any question. Throughout the evaluation procedure, anonymity and standard research ethics were rigorously upheld. Consent was also obtained from the guardians/family members of the beneficiaries.

2.6 Constraints / Limitations

Data for the study were collected primarily based on face-to-face interviews with the beneficiaries, their relatives and other stakeholders, which may have limited the possibility to collect information from multiple sources using multiple mediums. Beneficiaries were selected based on quota sampling, a nonprobability sampling technique, which may have limited the chances of participation. Additionally, a local level election was held during the evaluation which led to the unavailability of the local level representatives (owing to replacement by new representatives) who coordinated with KOSHISH during the project. Another limitation of the study is that some of the project log frame indicators were vaguely defined and did not lend themselves to quantifiability, which objective evaluation of the project effectiveness. Furthermore, some of the data related to outcome-level and output-level indicators were not ready at the time of the evaluation because they would only be determined at the end of the project.

2.7 Organization of the Report

The report is organized into four sections. **Section one** delineates the background of the evaluation, project description, some information about KOSHISH, objectives, and scope of the evaluation. **Section two** lays out the methodology, which includes study area, study design, study population, data collection methods, data collection tools, and data analysis method. Additionally, ethical considerations and limitations/constraints of the study are incorporated into

this section. Key evaluation findings are presented in the **section three**. It includes the six major criteria of evaluation namely relevancy, coherence, effectiveness, efficiency, impact and sustainability of the project. In addition, this section comprises an analysis of the level of empowerment provided by the project. Section four provides a conclusion and offers recommendations and way forward. Finally, **the annex section** includes the interview guideline, sampling plan, descriptive results, Terms of Reference, relevant interview transcripts, Admission Guidelines and Rescue and Reintegration Protocol of the project.

Section Three: Key Findings

This section includes the key evaluation findings based on the OECD criteria: relevance, coherence, effectiveness, impact, and sustainability. The findings are based on the integration of the data acquired through field visits and desk reviews of the project documents.

A total of 16 beneficiaries were interviewed; they represented different mental health and demographic backgrounds, various types and levels of mental health problems, and different levels of recovery at the time of reintegration. The number of beneficiaries interviewed was determined on data saturation. Among them, 14 were interviewed by the evaluator based on the interview guidelines. Fourteen beneficiaries and one caretaker/family member of each beneficiary were interviewed, with the exception of two cases wherein only a beneficiary and only a family member were interviewed. Two beneficiaries did not want to talk about their past problems and two did not like the evaluation team meeting their relatives and talking about their problems.

The evaluation team included three members: the evaluator, an outreach worker who worked closely with beneficiaries and was also involved in the treatment process, rehabilitation, and regular follow-up, and a member of a self-help group who had lived experience with mental health problems. The outreach worker and the SHG member talked to the family and neighbors about the beneficiary's current status. Each team member used a rating scale independently to rate the beneficiary's current status, available family support, risk of relapse etc. (Annex 9). An average rating was calculated for each criterion for each beneficiary based on a discussion among the evaluation team before meeting the next beneficiary. Regarding their geographical location, 9 were from Bagmati Province, 3 from Madesh Province and 2 from Province 1. The district-wise frequency of the beneficiaries is appended in Annex 8.

3.1 Relevance of the Project

The project's relevance is assessed based on how the project objectives and design respond to beneficiaries, global, country, and partner/institution needs, policies, and priorities.

The project is deemed highly relevant for the vulnerable women, as vulnerable women were in dire need of the intervention initiated by this project. There is a shortage of interventions tailored to the needs of the abandoned or shackled women with mental health problems in Nepal, so the holistic community-based rehabilitation and reintegration of the vulnerable women were very pertinent, especially to the marginalized and economically disadvantaged women. The methodology used and the strategies set in the project were highly applicable to meet its objectives. The objectives are still very relevant despite the changes in circumstances since its inception. The evaluator was aware of significant gaps in understanding effective strategies to address the mental, physical, social, and livelihood problems of the abandoned and shackled women with mental health and psychosocial issues at the local and national policy level. Through the implementation of the project, KOSHISH has not only addressed these existing gaps and the ensuing problems but has also become a forbearer in helping to shape how interventions can be designed and implemented to maximize relevance to the vulnerable women.

The discussion with the beneficiaries suggests that the crucial value added by the project was its ability to improve the quality of life of the beneficiaries and their awareness of the importance of seeking psychological and medical help when necessary.

One of the beneficiaries said:

"If not for KOSHISH, I would have been in a very dark condition. I used to be unaware of where I was and what was happening around me. Still, now I can do household chores, attend social functions like marriages and pujas, and speak to others unhesitatingly. I voted for the local-level election and felt that my voice was heard and that I was treated with dignity. If I meet anybody with mental health problems, I will tell them to take medicine regularly and encourage them to contact organizations like KOSHISH"

(Beneficiary B)

In addition to highlighting the value of community-based psychological services for vulnerable women, KOSHISH has provided stakeholders and family members with the capacity to understand mental health services as a fundamental right of all. The project has actively sensitized and reinforced them, thus endowing them with the implementation of competence to monitor the mental health services at different levels, and demand accountability from duty bearers.

Regarding the relevance of the methodology used, it was found that the twin-track approach to service delivery and advocacy and lobby activities were highly relevant. To bring significant attitudinal and structural changes in mental health outcomes and improve policy, legislation and service development, the advocacy approach is highly effective.

3.1.1 Relevance to country policy

KOSHISH sought to enrich the lives of vulnerable women and ensure universal health coverage for people with mental health conditions and psychosocial disabilities through accessible community-based specialized rehabilitation services in Nepal. This is expressively aligned with five policies in the area of mental health devised in National Mental Health Policy-2073 to ensure easy availability and accessibility of basic quality mental health services for all

citizens: prepare necessary human resources to deliver mental health and psychosocial service, protect the fundamental human rights of people with psychosocial disability and mental health problems, enhance public awareness to promote mental health and combat stigma resulting from mental health problems, and promote and manage health information system and research. By providing a replicable model of home transit for vulnerable women, the project has successfully contributed to their reintegration and rehabilitation, as specified in the Rights of Persons with Disability Act (2017) and The Public Health Service Act, 2075. In addition, the project is in line with the Disability Management (Prevention, Treatment, and Rehabilitation) Policy, Strategy, and Ten-Year Action Plan (2016-26)[1.]

3.2 Coherence

The extent to which other interventions (particularly policies) support or undermine the intervention and vice versa. The internal and external coherence of the project was assessed.

3.2.1 Internal coherence

The synergies and interlinkages between the project intervention and other interventions carried out by KOSHISH and the consistency of the intervention with the relevant international norms and standards to which KOSHISH adheres were analyzed. The project is well-aligned with the overall vision, mission and goal of KOSHISH regarding the service rendered by the organization in the mental health and psychosocial well-being field. Since 2011 KOSHISH has been managing transit home, which included a wide spectrum of services, including psychosocial

[1] Leprosy Control Division(2018). *Disability Management (Prevention, Treatment, and Rehabilitation) Policy, Strategy, and Ten-Year Action Plan (2016-26).* http://www.edcd.gov.np/resources/download/policy-strategy-and-10-years-action-plan-on-disability-management

counselling, psychiatric support, medication, proper nutrition, involvement in therapeutic and skill development activities, nursing and caring support in a healing environment. This project is highly congruent with the previous projects implemented by KOSHISH and particularly complements the Mainstreaming Mental Health and Psychosocial disability project undertaken by KOSHISH.

Concerning its consistency with relevant international norms and standards, the project is in line with the guiding principles of UNCRPD. It considers liberal and relational perspectives on autonomy, as highlighted in UNCRPD[2]. Furthermore, by encompassing the rescue, rehabilitation, and reintegration components and seeking to instantiate optimal participation of vulnerable women, the project has rendered coherence with the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and the Convention against Torture and other Cruel, Inhuman, or Degrading Treatment (UNCAT)[3]. In addition, the project has shown its commitment to meeting the SDGs of No Poverty; Good Health and Well-Being; Decent Work and Economic Growth and Reduced Inequalities. However, the economic growth aspect of the SDG is less heeded; To reduce the material hardships and improve economic stability, the project should work towards linking beneficiaries to livelihood programs before or immediately after reintegration into communities.

[2] United Nation Organization(2008). *Convention on the Rights of Persons with Disabilities.* https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

[3] Office of the United Nations High Commissioner for Human Rights(1984). *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment.* https://www.ohchr.org/sites/default/files/cat.pdf

The mother of a beneficiary opined: *“She [daughter] has completed her B.N and thinks that she would get much better if she got a job. She gives exams for jobs, works hard for them but to no avail. She is frustrated all the time. "* (Mother of Beneficiary E).

Similarly, one beneficiary said: *"There is always the problem of money now, how to pay for children's school fees, how to raise them. We can't fulfill their desires; my husband can't get jobs...due to unending financial problems, sometimes I think life is not worth living." (Beneficiary C)*

3.2.2 External Coherence

The evaluator discerned the external coherence of the project by considering its alignment with the projects carried out by other actors in the field of psychosocial disability and coordination with government representatives and other organizations. The project has been working in close coordination and partnership with relevant government bodies at the local and national levels. KOSHISH has a Memorandum of Understanding (MoU) with three government line agencies, that is, the Social Development Ministry, the Metropolitan City, and Ministry of Women, Children and Senior Citizens (MoWCSC) to provide rehabilitation services to women with MHPSI and have allocated budget to provide service and support through the KOSHISH transit home of KOSHISH.

3.3 Effectiveness

The effectiveness of the project is evaluated by gauging achievements against the planned target. The factors that helped or hindered the achievement of objectives; effectiveness of psychoeducation and sensitization programs in raising awareness among family members, community people and local-level authorities; strengths and weaknesses of the approaches

adopted to implement the project; and the effectiveness of coordination, collaboration and participation of local government in project implementation are highlighted in this section.

Table 3: Project Goal, Outcome and Output level targets vs achievements

Project Goal: To develop and manage a model transit care services for women who are locked up, chained, or abandoned due to mental health and psychosocial issues in collaboration with the Government of Nepal				
Project Goal Indicators	Indicators	Target	Achievement (By the time of the evaluation)	Data Source
1.1	% of previously locked, chained and abandoned women who improved quality of Life and psychosocial well-being after the project intervention	80%	75%	LFA
1.2	The cost of rehabilitation of the transit care beneficiaries reduced	Per person rehabilitation cost reduced by 30%	Reduced by 12% in 2020 and Reduced by 20% in 2021	Financial records
1.3	A model for the mental health transit care service is documented	3	2	Clinical Protocol and Service Operating guidelines (Annex8)
Outcome 1: Recovery and reintegration of previously locked, chained and abandoned women and girls with mental health and psychosocial issues				
Outcome Level Results	Indicators	Target	Achievement	Data Source

1.1	% of previously locked, chained and abandoned women who received service from transit home and experienced recovery after the project intervention in project period	80%	75%	LFA
Output Level Results	Indicators	Target	Achievement	Data Source
1.1.1	Number of women who were previously locked, chained and abandoned rescued and received specialized MHPSS services in the project.	150	117	Progress Reports 2020/2021
1.2.1	Number of women reintegrated in family and community after specialized MHPSS services in Transit Home	150	98	Progress reports 2020/2021
Outcome 2: Sensitized, reinforced and supportive Governments and communities on issues of mental health and psychosocial well-being and rights of persons with MHPSI				
Outcome Level Results	Indicators	Target	Achievement	Data Source

2.1	Number of municipalities which initiated MHPSS program post project intervention	0		It will be measured at the end of 2022
2.2	% of the beneficiaries who say that their family environment is supportive	70%		Testimonies of beneficiaries at the time of intake, during first sixth month of the project and at the end of the project which is in 2022.
2.3	% of the beneficiaries who say they are able to lead dignified life.	70%		Testimonies of beneficiaries at the time of intake, during first sixth month of the project and at the end of the project which is in 2022.
Output Level Results	Indicators	Target	Achievements	Data Source
2.1.1	Number of elected local government representatives and staffs oriented on government laws and policies on MHPSD and UNCRPD	150	30	Progress Reports 2020/2021
2.2.1	Number of family members and community people oriented to mental health and psychosocial well-being and issues	2250	749	Progress Reports 2020/2021
2.3.1	Number of lobby and advocacy meetings	72	20	Progress Reports 2020/2021
Outcome 3: Transit Home care accepted as a rehabilitation model by stakeholders working in the field of mental health and psychosocial well-being of women with MHPSI				

Outcome Level Result	Indicator	Target	Achievement	Data Source
3.1	Number of government line agencies with which KOSHISH has a Memorandum of Understanding (MoU) to provide rehabilitation services of women with MHPSI	5	**3**	Progress Reports
3.2	Number of commitments from government line agencies for replicating similar practices	1		It is in progress. One of the government line agencies is in coordination with KOSHISH for adapting similar practice.
3.3	The records of the beneficiaries of the project updated in the Health Information Management System (HIMS) of the government	100%	**100%**	Recorded copy of the records shared with HIMS.
3.4	Budget allocated by government to provide rehabilitation support through the Transit Home	5	**3**	Progress Reports 2020/2021
3.5	Number of government line agencies which recognized the transit home care as a model for rehabilitation of women with mental health condition and psychosocial issues	70% of identified line agencies	Developed questionnaire to assess elements of model transit home	Progress Reports 2020/2021

Output Level Results	Indicators	Target	Achievements	Data Source
3.1.1	Number of projects sharing workshops organized	3	**0**	Due to the COVID-19 pandemic, the activity couldn't be conducted in 2020 and 2021
3.1.2	Number of M&E visits from government line agencies	12	**6**	Progress Report
3.1.3	Number of funding opportunities identified for rehabilitation and reintegration support for the beneficiaries	5	**5**	Progress Reports 2020/2021

3.3.1 Project Goal Achievements:

Overall, the project has succeeded greatly; some of the indicators exceeded the target, while few were under-achieved. Against the goal of reducing the cost of transit home by 10 % in 2020, the project was able to cut the cost by 12% and in 2021 project was able to reduce the cost by 20%. Concerning the model transit home documentation, significant progress has been made in developing the protocols and guidelines that include admission guidelines, risk assessment guidelines, abscondment guidelines, rescue and reintegration guidelines, suicide risk assessment protocols, and violence and aggression guidelines. Close examination of the preceding documents reveals the need for coordination with diverse sectors and partners to instantiate the transit home into a model transit home, and detailed delineation of the guidelines provides a strong basis for community-to-community reproducibility of the transit home.

3.3.2 Outcome Level Achievements

Due to the ambiguity and lack of quantifiability of some of the indicators, it was relatively difficult to assess their achievements

Outcome 1: To ascertain whether the beneficiaries witnessed recovery after the project intervention, improvements in their daily living skills were assessed using WHO Disability Assessment Checklist, which showed that 75% of women experienced recovery against the target of 80%; although the indicator was underachieved by a small margin, the functional improvement in daily life skills was considerable. **Outcome 2**: The number of municipalities that initiated MHPSS program post-project intervention will be determined at the end of the project. The project has been particularly successful in sensitizing family members of the beneficiaries, as evidenced by the high proportion of beneficiaries who say their family is supportive. Furthermore, 63% of women said that their family was supportive, and the same proportion reported that they are able to lead a dignified life, both of which are marked improvements over the baseline although the results did not achieve its target set at 70%.

Outcome 3: Regarding the recognition of transit home as a model for rehabilitating women with mental health and psychosocial issues, the project successfully agreed with three government line agencies to get budget allocation for rehabilitation through transit home. The project is in progress to coordinate with government line agencies for replicating similar practices. So far, the project has identified one government line agencies who have committed to adapt similar practices. Regarding the records of the project beneficiaries updated in the Health Information Management System (HIMS) of the government, the project has achieved its target by 100%. The project has prepared the questionnaire to assess the key elements of the model transit home to provide to the government line agencies, but it will be finalized at the end of the project. Although the recognition of transit home as a model for rehabilitation and reintegration

of women is not rendered by the government, the positive responses (e.g., Signing MoU, allocation of budget, coordination with a government agency for replication of the model) show that the transit home will be recognized as a replicable model by government agencies in all likelihood.

Field Visit Results: Of the 16 beneficiaries interviewed, 11 were in remission, 1 had recovered, and 3 were in the recovery phase. Only 1 had relapsed. Regarding family support, more than half of the 16 respondents considered the level of their family support low (7) or medium (2), while only 4 and 3 considered it high and good, respectively. Among the beneficiaries interviewed, according to the nonclinical assessment more than half (9) were psychotics, while 4 had depression and the remaining three had other mental health problems. The risk of relapse was high in 6 beneficiaries, medium in 4, and low in 6.

3.3.2 Output Level Achievements

The number of vulnerable women who received specialized MHPSS services in the project fell short of the target by 32, and the number of reintegrated women is 98 against the target of 150. This suboptimal result can be explained by the fact that the project will be in action for the next six months, at which point these targets may be accomplished. Fewer local representatives were sensitized than targeted, less than one-third of the targeted family members and community people were oriented, and less than one-third of the targeted lobby and advocacy meetings were conducted. This underachievement could be attributed to the effects of the COVID-19 pandemic and the lockdown during the project implementation, which also affected the number of M&E visits from government-line agencies to the transit home. There were 3 M&E visits from government-line agencies in 2020 while the yearly target was 4, and the overall

target was 12 for three-year period. The project identified 3 funding opportunities to support rehabilitation and reintegration of beneficiaries against the target of 5.

***Outcome-Level Descriptive Results*:** An analysis of the data available from the project record was performed. The beneficiaries' stay at the Transit home ranged from 1-365 days, with a mean stay of 84 days. The beneficiaries' ages ranged from 15- 71 years, with a mean age of 36. A significant proportion of the beneficiaries were referred by their family (45%), KOSHISH itself (31%) and Community Based Organizations (15%). Almost three-quarters of them (70%) were reintegrated into their families, while a minority were reintegrated into CBOs. (Around 40% of them were afflicted by schizophrenia, followed by Psychosis NOS (20%). The remaining 17 disorders accounted for the remaining 40%. Regarding their current status, 40% have recovered substantially, 5% have mild recovery, and about 22% recovered moderately.

Regarding the improvement in scores of WHO-DAS sub-scales, Cognition, mobility, self-care, getting along, life activities and participation all showed significant improvement over time. As reported in the progress report, most of the beneficiaries' (55%) mental health condition is improving, while 2% of the beneficiaries required re-admission due to irregularity in their medication and lack of family support. KOSHISH has the arrangement of receiving the ones that require residential psychosocial support, and the outreach team will stay in contact with the family members. In terms of medication intake, 96 recipients take their medications regularly. It was shown that 64% of beneficiaries take their medicine independently, 30% of beneficiaries require assistance or reminders from family members to take their prescription, and 4% of beneficiaries receive medication support from the organization's employees. 2% of the beneficiaries discontinued taking the medication.

3.3.3 Project Strength

The strengths of the project were identified in terms of its achievements at different levels and the adoption of the approaches that facilitated its implementation based on information collected from various sources. The project garnered attention from relevant government line agencies and other stakeholders, such as a wide range of community people, family members, media, police, etc., which led to a coordinated effort to strengthen the rights and well-being of women with mental health problems and psychosocial well-being. Furthermore, by adopting a "twin-track" approach of simultaneously working on rendering psychological and overall service to the vulnerable women and conducting advocacy and lobbying for mainstreaming and scaling up mental health interventions and raising awareness and capacity building. The project can be rated successful in contributing to the current local and national requirements for mental health issues. At the local and project implementation levels, partnerships worked quite effectively. The project built strong links with municipal authorities, increasing the chances of internalizing policy and sustainability. A more targeted approach through the communication of current results and achievements should be employed to retain and enrich the support of local and national government authorities.

3.3.4 Themes Generated from Interview Transcripts

The following themes were generated from the analysis of the interview transcripts:

- **Need for livelihood programs**: A significant proportion of the interviewed beneficiaries stated that they were in a dire financial situation. They were guilted for their inability to provide for their children. In some cases, economic problems were involved in their

suicidal ideation. Some qualified women were also unable to get jobs and were frustrated; they expected the organization to link them with employment opportunities.

- **Disdain from family and community people**: The stigma related to mental health problems is declining but still very substantial and potent, as evidenced by derogatory terms such as “pagalni”, and “baulai"” by the neighbors and community people. Some beneficiaries felt that their children did not want to meet or maintain any associations with them due to their MHPSSI.
- **Satisfaction with their stay in Transit home and desire for a longer stay**: Although few of the beneficiaries felt the need to visit the Transit home again, some of the beneficiaries and their family members felt that staying longer would be more promising for their treatment and mental well-being.
- **Feeling of helplessness in the caretakers**: In the case of the caretakers of a few beneficiaries, the level of frustration and sense of helplessness was markedly notable. Some of them felt that their sacrifices did not amount to anything and were guilt-ridden due to their inability to help the vulnerable member of the family despite trying their best.
- **The mischaracterization of the people with MHPSI’s unwillingness to work as “laziness”**: Some of the family members repeatedly used the word ‘lazy’ while referring to the day-to-day activities of the beneficiaries. The major reason behind the lack of understanding is that mental health problems can manifest through psychological symptoms such as anhedonia and psychomotor retardation.

3.4 Efficiency of the project

Efficiency was assessed on the extent to which results have been delivered with the least expensive resources possible and the efficiency of the project management delivery and monitoring system.

3.4.1 Utilization of the resource (plan and expenditure of budget)

The table depicts the year-wise budget allocation and expenditure trend. The budget was underspent in the year 2020 by 2% against the allocated budget, while in 2021, it was overspent by 2%. The total budget for the first two years was 21,356,244.00, out of which the total expenditure incurred was 21,382,099.00, hence the efficiency of the project was found very good analyzing the budget expenditure for 2020 and 2021, which was at almost 100%. The project has been implemented smoothly and efficiently so far by adhering to the basic principles of financial management and by maintaining financial accountability through the adaptation of a systematic financial management system. However, the overall efficiency of the project depends on the utilization of resources in 2022, since 44% of the allocated budget is to be spent in 2022.

Table 4.: Budget efficiency analysis (plan vs expenditure)

Year	Annual Budget	Expenditure (NPR)			% Expenditure	Remarks
		Program Expenditure	Admin Cost	Total Expenditure		
2020	8,538,873.00	6,673,581.00	1,663,319.00	8,336,900.00	98%	
2021	12,817,371.00	11,333,519.00	1,711,680.00	13,045,199.00	102%	Interest income and exchange gain were utilized

2022	16,600,146.00					Running year (2022)
TOTAL	**37,956,390.00**	**18,007,100.00**	**3,374,999.00**	**21,382,099.00**	**56%**	

Source: KOSHISH finance department

Table 5 presents the allocated and actual program cost (program cost+ program staff salary) and admin/management cost. A total of 81% of the budget was allocated for program costs while the allocation for administration and management costs accounted for 19% of the total budget.

Table 5: Budget efficiency analysis (Program vs admin/management)

SN	Items	Year 1	Year 2	Year 3	Total Amount	Total (%)
1	Program Cost (program + program staff salary)					
1.1	Allocated	6,855,938.00	11,083,755.00	12,929,367.00	30,869,060.00	81%
1.2	Actual	6,673,581.00	11,333,519.00		18,007,100.00	47% (Year 1and 2)
2	Admin/Management cost (including admin staff)				-	
2.1	Allocated	1,682,935.00	1,733,616.00	3,670,779.00	7,087,330.00	
2.2	Actual	1,663,319.00	1,711,680.00		3,374,999.00	9% (Year 1 and 2)
TOTAL Allocated		**8,538,873.00**	**12,817,371.00**	**16,600,146.00**	**37,956,390.00**	
TOTAL Actual		**8,336,900.00**	**13,045,199.00**	**----------**	**21,382,099.00**	

Source: KOSHISH finance department

3.4.2 Human Resources and Management

The pre-existing full-time staff, who were working at the transit home, worked for the project on a cost-sharing basis. The team was deemed to be highly competent and worked hard to achieve

the project goals. It was discovered that an effective and systematized management structure existed at the district and national levels, with clear role boundaries and effective communication maintained at each level. KOSHISH was able to sustain itself with a small team and a low budget primarily due to solid ties with local government bodies and the community. This has allowed KOSHISH to achieve broad reach and substantive impact with minimum resources.

3.4.3 Monitoring and evaluation

As the baseline for some of the indicators was not available, monitoring and evaluation was relatively challenging. The internal monitoring system for information flow and keeping records at the local and central levels was found to be good. For monitoring and evaluation, Honorable Minister and representative of Ministry of Women, Children, and Senior Citizens, Secretary of Ministry for Commerce, and Chairperson of Women and Social Affairs visited transit home of KOSHISH in 2020 and representative from National Women Commission and Department of Children visited in 2021. In addition, annual financial audits were also performed to meet government requirements. However, over the project's life cycle, the social audit – a useful instrument for assessing service performance and incorporating a wide variety of stakeholders, including beneficiaries – would have added strengths to the project.

3.5 Impact

The impact was assessed with the criteria to determine to what extent the project output and outcomes were achieved and contributed to the completion of the project’s purpose. In addition to the changes in the lives of the targeted beneficiaries, the assessment sought to determine the extent to which the project affected policy change and changed the attitude and behavior of community members and key stakeholders toward people with psychosocial impairments. The overarching objective was achieved to some extent, but beneficiaries should be

linked to economic activities to ensure universal health coverage through holistic rehabilitation services. The significant impact is the increased awareness of mental health issues in communities and relevant government bodies. One of the local representatives highlighted that this program had become an impetus for future awareness programs.

> *"What this project has done is commendable. But more counseling sessions are needed for the family members to make them aware of their role in the patient's well-being and recovery... A three- or four-day course should be designed to teach parents about mental health issues. We are very positive about coordinating with KOSHISH and anyone who can help us realize this goal."* (KII, Local Representative)

The impact of the project on the women with oppressed intersectional identities and financially disadvantaged women was acknowledged by stakeholders. One official from National Women Commission opined, “For the women who are poor and discriminated and marginalized, what this project has achieved is highly commendable. If we all can coordinate and make medicine free and readily available to the beneficiaries, which is achieved to some extent now, it would be even more impactful.”

By influencing policy planning, promoting the rights of people with mental health problems, and enhancing their advocacy capacity, the project has a positive impact on building confidence and reducing the stigma related to mental health issues. Concerning the impact level indicator "Universal Health Coverage(UHC) for people living with mental health conditions and psychosocial disability is ensured through accessible, holistic rehabilitation services in the community in Nepal", one key component of UHC namely, financial protection (which measures the extent to which the population is protected from the financial hardship of accessing needed

health care) should be given more consideration by strengthening collaboration with government bodies and relevant authorities.

3.6 Sustainability

Sustainability is the likely ability of an intervention to continue delivering benefits for an extended period after a project's completion. The sustainability of a project depends on several factors. One of the most significant factors is the degree of ownership. Throughout the project's implementation, a high level of local ownership has been identified, given, among other aspects, that the project was based on the high-need issue of abandoned and shackled women with mental health problems and psychosocial problems. However, in-depth interviews with beneficiaries and their families revealed that many women have relapsed. The caretaker of one of the beneficiaries said:

> *"Sometimes she cries, almost always spends time alone and ruminates, and she does not open up much with us. She seems happy when she gets to talk to her children, but getting them to talk to her is difficult. We want her to be more active; she cannot do simple tasks like wrapping quilts. She does not take medicine; if she suspects that her medicine is given by mixing them in food, she revolts."* (Caretaker of Beneficiary D)

Furthermore, an official from National Women Commission indicated the project's long-term significance, stating, “Local representatives of many local bodies have called me to inquire about such organizations working in the mental disability field, and I have suggested they contact KOSHISH. These services are needed in the long run in our country. Although some organizations are working by helping abandoned people with basic needs, they don’t have the expertise and resources like that of KOSHISH. I hope KOSHISH will continue its service.” (Stakeholder, National Women Commission)

Educating families regarding relapse prevention, early detection and management of symptoms seem essential for the sustainability of the project's achievements.

The project has attempted to create an enabling environment for the long-term feasibility of project interventions to enhance the capacity of vulnerable women. Still, as highlighted above, the project has only partially achieved sustainability with regard to the ability of the beneficiaries to lead a dignified, resourceful, and higher quality of life after intervention from the project is stopped. KOSHISH has developed a committed and close-knit partnership with government bodies, other relevant organizations, and local bodies which is directly pertinent to the project's sustainability. However, more efforts should be expended on the capacity of the target groups so that the feeling of ownership of the intervention is enriched to a greater degree.

3.7 Empowerment

Simply put, empowerment is the process of gaining power over decisions and resources. It underscores people's ability to expand their ability to make strategic life choices previously denied to them. The questions related to the degree to which there is change in output, outcome, and impact level; the level of empowerment achieved at an individual, societal, or structural level and the difference in empowerment level in about six thematic areas are answered through the integrated analysis of information acquired from the project reports with the perspectives and experiences offered by interview participants by employing the Digni's Empowerment Assessment Tool (EAT). The detailed criteria for Level 1 to Level 5 are as follows:

LEVEL 1 (Output):

Resources: have increased, been provided by the project to individuals and/or community and/or other target groups

Agency: No demonstration of target groups has changed their behavior or using resources to act.

Achievement/Results: There are no documented changes in the target groups situation.

LEVEL 2 (Output):

Resources: have increased by project to individuals and/or community, some local resource mobilization.

Agency: Target groups say that they have gained “power within, " increased their self-esteem, and/or changed perspectives. Still little change in behavior and signs of the agency.

Achievement / results: There are few documented changes in the target groups’ situation.

LEVEL 3 (Outcome):

Resources: have increased by the project to individuals and/or community and/or other target groups. There may be some local contribution of resources to the project.

Agency: Target groups show that they have gained not only individual power, but also some collective agency, the “power with”. There are some documented actions.

Achievement/Results: There are documented changes in the situation of target groups.

LEVEL 4 (Outcome):

Resources: have increased, been provided by the project to individuals and/or community, and/or local resources are contributed.

Agency: Target groups show that they have gained both individual power and collective agency, the “power to” act. There is documented community/target group action.

Achievement / results: There are documented changes in the situation for direct and immediate indirect target groups. There are indications of results at “structural level” for instance

stakeholders such as local government and/or others power elites are providing some resources or changed their behavior/practice to some degree.

LEVEL 5 (Impact):

Resources: have increased, been provided by project, and/or local resources are contributed and/or provided by stakeholders.

Agency: Target groups show that they have gained collective agency, the “power to” act, and some “power over”. There is documented community/target group action.

Achievement/Results: There are substantial documented changes that most often go beyond improving the situation for the direct target groups. Changes are often perceived to be sustainable and the results are often at a "structural level". There might be multiplication effects and adoption of the project methodology by others. Examples may be change in norms and harmful traditions, policies and laws; Stakeholders such as local government and/or others power elites are providing increased resources or changed their behavior and institutional practice.

Table 6: Digni Empowerment Assessment Table

DEGREE AND LEVEL OF EMPOWERMENT						
Theme/Domain	**Output**		**Outcome**		**Impact**	**Comment**
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
Strengthening Civil Society			**X**			Although there is a low degree of organization in the target groups, extensive sensitization programmes have led local communities to identify the problems; local government bodies and other relevant stakeholders found making a collaborative effort to solve the problem. Interviews have revealed that right-holders had become more aware and are likely to hold duty-

						bearers accountable. There are minimal documented changes at the structural level, as some government agencies have allocated budget for providing service through the home transit system.
Health				**X**		The target beneficiaries can access adequate health facilities such as drugs and psychotherapeutic services. With the help of disability card, the beneficiaries can get medicines for free but some of the beneficiaries complained about having to buy expensive medicines from pharmacy. The target beneficiaries have some knowledge about conditions that affect their health, but had difficulty in translating that knowledge into their capacity to influence conditions about their health and well-being. Some of the target beneficiaries and family speak against the stigmatizing attitude of people towards mental health problems.
Gender Equality				**X**		All the beneficiaries of the project were women. Involvement of women in the training and other activities conducted by the project is substantial.
Overall project assessment				**X**		

In addition to the three domains elucidated in the matrix, two significant themes of empowerment namely Awareness and Sensitization and Peaceful Co-existence were also assessed in order to ascertain the level of changes rendered by the program at individual, community and structural level, particularly pertaining to the changes in public attitude towards mentally ill people and their co-existence with other community people.

Awareness and Sensitization: As raising awareness and sensitizing family members, community people and relevant stakeholders was one of the outcome level goals of the program, significant progress has been made in this regard. Most of the beneficiaries felt that they were living life of dignity after rehabilitation, without loss of their social value and status attributable to their mental health issues. Local representatives were highly sensitized, leading some of them to conceptualize awareness and counseling programs for family members and immediate relatives of the beneficiary. In the interviews, a lack of concern or negative attitude toward beneficiaries by their family members was reported, but most of the beneficiaries felt that their family supported them

Peaceful Coexistence: Some of the target beneficiaries experienced psychological abuse at the hands of family members. Due to MHPSI in parents, children are forced to undertake a life of low economic standard and their safety and well-being are compromised. Interviews revealed that there were some changes in behaviors and signs of agency, felt a heightened sense of individual power as well as collective agency.

Section Four: Conclusions

The project was suitable for addressing the rescue and rehabilitation issue of the vulnerable women who have been abandoned, chained, or locked. The project had successfully

coordinated with government bodies and other relevant stakeholders, and the project was found to be highly relevant to the needs of beneficiaries and the pertinent national policies. Although some of the indicators were underachieved, the project successfully implemented the targeted action as delineated in the proposal. The results and achievements have been consequential in achieving the overarching objective of ensuring universal health coverage for vulnerable women through accessible, holistic and accessible rehabilitation services of the community in Nepal to a large extent. Overall, despite its limitations and problems, the project has been successful; and future directions should consider reinforcing the positive aspects demonstrated by this project, building on the initial benefits. Given the project's positive results, continuation would be highly recommended to attempt to replicate and upscale the activities already undertaken and move beyond them. The project was successful at managing symptoms and has improved the overall wellbeing of the beneficiaries at the institutional level, but the long-term effectiveness of the achievements seems questionable. Field study and consultation with family members and caretakers revealed that most of the beneficiaries are at risk of relapse, and many of the family members want to send the beneficiary back to the transit home; in extreme cases, family members are not willing to accept them into the family.

Section Five: Recommendations and Way forward

On the basis of the findings rendered by desk review and interviews with beneficiaries and stakeholders, following recommendations are made by the evaluator:

- Effective means of preventing relapse by addressing the biopsychosocial aspects of the beneficiary seem essential.

- Proper education about early symptoms of relapse to the beneficiaries, their family members and community people and systems of symptom monitoring and crisis plans need to be implemented.
- The problems associated with a livelihood must be integrated into the rehabilitation process so that beneficiaries can start doing something meaningful that keeps them engaged and also helps them become independent.
- Family members are to be involved in the overall process, from rescue to reintegration; they are to be educated, sensitized, and made responsible for their family members' health and wellbeing.
- It would be more beneficial if intervention and rehabilitation strategies were tailored to the individual beneficiaries' needs so that effective rehabilitation and relapse prevention can be ensured.
- Except for M&E visits, the concerned government line- agencies' involvement in the overall activities of the project seemed minimal. Strong lobbying for including a provision of "model transit care service" for rehabilitation and reintegration support for abandoned women with mental health and psychosocial issues at the national, federal, and local levels is recommended.
- Coordination and partnership with relevant government bodies are recommended while developing projects, such as the Ministry of Women, Children & Social Welfare, the National Women Commission, and other relevant government bodies. Such partnership would help develop a sense of ownership and an increased sense of responsibility regarding the issues of abandoned women with MHPSI.

- Since strong links with local authorities increase the chances of internalizing policy and sustainability, their support needs to be built through a more targeted approach, primarily through disseminating current achievements.
- Despite sensitization activities, community mental health knowledge gaps and services were noticeably high. Future projects need to employ media and other relevant dissemination tools to sensitize people on mental health issues at grassroots levels.
- To reduce the likelihood and severity of relapse, family members and community members should be educated to recognize early Symptom of relapse; symptoms monitoring and a crisis plan should be arranged at the outset.
- During the design of such projects, the concerned body should pay more attention to the likely livelihood problems and vulnerabilities that beneficiaries may face after reintegration into the family and community. Interviews with beneficiaries and family members indicated that financial difficulties in beneficiaries' lives are almost ubiquitous, which may be implicated in their relapse.

Annexes

Annex 1 Interview Guideline

सेवाग्राही/परिवारका सदश्य/छिमेकी संग अन्तर्वार्ताका लागि प्रश्नावली

- अहिले कस्तो छ ?
- पहिले कस्तो थियो ?
- औषधि सेवन गरीरहनु भएको छ कि छैन ?
- नियमित follow-up ?
- दिन कसरी बिताउनु हुन्छ ?
- के-के कठीनाइहरु छन्
- यो परियोजनाको क्रियाकलापहरु तपाइको/तपाइको आफन्त/ छिमेकी को लागि कत्तिको प्रभावकरी भयो ?
- तपाईलाई राम्रो लागेका कुराहरु
- तपाईलाई नपुगेको जस्तो लागेका कुराहरु
- के गर्न पाएको भए अझै राम्रो हुने थियो
- जीविकोपार्जनका लागि सहयोग (Livelihood Support) को आवश्यकता
- तपाइँ आफुलाई अब आफ्नो भविश्य कस्तो होला जस्तो लाग्छ ?
- दैनिक जीवन चलाउन कत्तिको सहज भएको छ ?
- पारिवारिक/सामुदायीक क्रियाकलापहरुमा कत्तिको सहभागी हुनुहुन्छ ?
- घरपरिवार/छरछिमेकी/समुदाय/स्थानीय सरकार बाट कत्तिको सहयोग पाउनु भएको छ ?
- दैनिक जीवनमा गर्नुपर्ने कामहरु गर्न सक्नु हुन्छ ?
- समाजमा हुने गतिविधिहरुमा भाग लिनु हुन्छ ?
- आफूलाइ जस्तै समस्या परेको अरुलाई भेट्नु भयो भने के गर्नु हुन्छ ?
- अब कोशिशको सहयोग छुट्यो भने के होला ?
- तपाईका हक अधिकारका बारेमा जानकारी छ ?
- आफ्नो हक र अधिकारका लागि आफै पहल गर्न सक्नु हुन्छ ?
- समाजले/परिवारले तपाईलाई हेर्ने दृष्टिकोणमा (कोशिशमा जानु अघि/कोशिशबाट फर्के पछि) कुनै परिवर्तन आएको छ ?
- यदि कोशिशको सम्पर्कमा नआउनु भएको भए के हुन्थ्यो होला ?
    - अन्तमा अरु केही भन्न चाहनुहुन्छ?

Annex 2 Sampling Plan

S.N.		Age	District	Code	Adress	Married	Unmarrie	Separated	CBO	GO	Family	KOSHISH	Family2	Organizat	Schizophr	Psychosis	Other Psy	Schizoaffe	Depressiv	BPAD	Mood Dis	Other	Mild	Moderate	Severe	Good	Moderate	Mild4	Minimal	GovYes/N	Days	Relapse y	Readmiss
1		45	Udayapur		Triyaga-9	1				1	1		1		1										1	1				1	125	1	0
2		25	Sarlahi		Nawalpur	1					1		1							1					1		1			1	50	0	0
3		28	Udayapur		Triyaga -08		1		1		1		1			1									1	1				0	34	0	0
4		53	Makawanpur		Bhimphadi-07	1						1	1			1									1	1				0	61	0	0
5		54	Makawanpur		Bhimphadi-02		1					1	1			1								1			1				92	0	0
6		35	Sarlahi		Lalbandi-02	1					1			1		1								1			1			1	47	0	0
7		35	Makawanpur		Bhimphadi -07		1				1	1	1					1							1		1			0	75	0	0
8		29	Udayapur		Triyaga -04			1			1		1		1										1	1			1	104	0	0
9		50	Bara		Simara-02				1					1	1									1		1			0	63	1	1
10		30	Makawanpur		Bhimphadi-05		1					1	1			1								1		1				0	61	0	
11		34	Makawanpur		Bhimphadi-01		1					1	1		1										1					0	82		
12		21	Makawanpur		Bhimphadi-03		1					1	1	1			1							1			1			0	82	0	0
13		38	Udayapur		Triyaga -04		1		1				1			1									1		1			0	15	0	0
14		28	Sihdhuli		Dudhauli-03	1				1			1		1										1	1				0	104		
15		48	Sindhupalchowk		Sangachowkgadi	1					1		1							1			1				1			0	9	1	1
16		25	Kavrepalanchok		Bhulmu-8	1					1		1							1				1		1				1	54	1	0
17		19	Sindhupalchowk	Benificiary-B	Helambhu-05		1				1										1			1			1			0	84	1	1
18		36	Kavrepalanchok	Benificiary-G	Panuti-03			1				1	1								1				1		1			0	19	0	0
19		26	Dolaka	Benificiary-C	Bhimeshor -02	1					1		1			1								1		1				1	21		
20		35	Kathmandu		Manamalju		1				1		1		1										1	1				0	89	1	1
21		38	Kavrepalanchok		Panauti-11							1	1					1							1		1			0	78	0	0
22		35	Bhaktapur		Bhaktapur -09		1					1	1		1										1		1			0	90	0	0
23		46	Bhaktapur	Benificiary-H	Suryabinayak -04	1						1	1		1										1		1			1	54	0	0
24		40	Lalitpur		Godawari-10	1						1	1					1							1		1				7	0	0
25		25	Bhaktapur		Bhaktapur -09		1					1	1		1										1	1			0	90	0	0
26		39	Kavre	Benificiary-E	Panauti-06		1					1					1								1			1			14	0	0
27		17	Lalitpur		Godawari-05							1			1								1			1					73	0	0
28		46	Sindhupalchock		Lisanku -07	1					1		1				1							1		1				0	50	1	1
29		16	Lalitpur		Godawari-05		1				1		1				1								1		1			0	31	0	0
30		49	Dolaka	Benificiary-D	Bhimeshor -02	1						1		1			1								1		1			1	79	1	1
31		36	Lalitpur						1					1							1			1		1				1	31	0	0
32		36	Kavre	Benificiary-F	Panauti						1		1							1					1	1				1	30	0	0
33		60	Lalitpur		Lalitpur -14		1				1				1										1	1				0	41	1	1
34		20	Sindhupalchock	Beneficiary-A	Helambhu-05		1				1									1					1	1					61		
35		45	Tanahun		Bhanu-11		1					1	1			1								1			1			1	58	0	0
36		25	Rolpa		Tribani-1		1		1				1		1									1		1	1			1	87	0	0
37		15	Tanahun		Bandipur -03		1				1		1					1							1	1				1	21	0	
38		35	Lamjung		Basishar-02	1						1									1			1			1			1	60	0	0
39		45	Lamjung		Marsyandi-04			1				1	1					1							1			1		1	118	0	0
40		40	Rolpa		Runtigadi-09	1					1		1			1									1	1				0	166	0	0
41		21	Rukum		sanobheri-01		1				1		1		1									1	1					0	95	0	0
42		15	lamjung		Besishar 11		1					1	1				1							1			1			0	13	0	0
43		30	Lamjung		Besishar-06			1				1	1											1			1			1	32	0	0
44		58	Dhading		Nilkantha-07	1					1		1			1								1			1				38	0	0
45		60	Tanahun		Bhanu-10	1						1			1										1								
46		23	Kaski		Pokhara -16	1					1		1			1									1		1			1	66	0	0
						17	20	4	5	2	21	21	35	5	15	10	6	5	0	5	4	0	2	17	28	25	17	2	0	17		9	7

Annex-3 Descriptive Results based on Record of the Project

Age

Descriptive Statistics

	Valid	Missing	Mean	Std. Deviation	Range	Minimum	Maximum
Age	118	0	35.737	11.805	56.000	15.000	71.000

Frequencies for Age

Age	Frequency	Percent	Valid Percent	Cumulative Percent
15	4	3.390	3.390	3.390
16	2	1.695	1.695	5.085
17	2	1.695	1.695	6.780
19	3	2.542	2.542	9.322
20	1	0.847	0.847	10.169
21	3	2.542	2.542	12.712
22	1	0.847	0.847	13.559
23	1	0.847	0.847	14.407
24	1	0.847	0.847	15.254
25	5	4.237	4.237	19.492
26	4	3.390	3.390	22.881
27	2	1.695	1.695	24.576
28	5	4.237	4.237	28.814
29	3	2.542	2.542	31.356
30	6	5.085	5.085	36.441
31	2	1.695	1.695	38.136
32	2	1.695	1.695	39.831
33	1	0.847	0.847	40.678
34	4	3.390	3.390	44.068
35	9	7.627	7.627	51.695
36	7	5.932	5.932	57.627
37	3	2.542	2.542	60.169
38	3	2.542	2.542	62.712
39	2	1.695	1.695	64.407
40	10	8.475	8.475	72.881

Frequencies for Age

Age	Frequency	Percent	Valid Percent	Cumulative Percent
42	3	2.542	2.542	75.424
43	1	0.847	0.847	76.271
45	5	4.237	4.237	80.508
46	2	1.695	1.695	82.203
48	2	1.695	1.695	83.898
49	1	0.847	0.847	84.746
50	5	4.237	4.237	88.983
51	2	1.695	1.695	90.678
53	1	0.847	0.847	91.525
54	3	2.542	2.542	94.068
55	1	0.847	0.847	94.915
58	1	0.847	0.847	95.763
59	1	0.847	0.847	96.610
60	2	1.695	1.695	98.305
66	1	0.847	0.847	99.153
71	1	0.847	0.847	100.000
Missing	0	0.000		
Total	118	100.000		

Frequencies for Marital Status

MaritalStatus	Frequency	Percent	Valid Percent	Cumulative Percent
Divorced	2	1.695	1.724	1.724
Married	50	42.373	43.103	44.828
Separated	21	17.797	18.103	62.931
Unknown	2	1.695	1.724	64.655
Unmarried	37	31.356	31.897	96.552
Widow	4	3.390	3.448	100.000
Missing	2	1.695		
Total	118	100.000		

Frequencies for Rescued district

Rescued district	Frequency	Percent	Valid Percent	Cumulative Percent
Baglung	1	0.847	0.847	0.847
Bara	1	0.847	0.847	1.695
Bhaktapur	7	5.932	5.932	7.627
Chitwan	5	4.237	4.237	11.864

Frequencies for Rescued district

Rescued district	Frequency	Percent	Valid Percent	Cumulative Percent
Dhading	3	2.542	2.542	14.407
Dhanusa	1	0.847	0.847	15.254
Dolakha	3	2.542	2.542	17.797
Eastern Rukum	1	0.847	0.847	18.644
Gorkha	1	0.847	0.847	19.492
Ilam	1	0.847	0.847	20.339
Jhapa	2	1.695	1.695	22.034
Kaski	3	2.542	2.542	24.576
Kathmandu	10	8.475	8.475	33.051
Kavrepalanchok	6	5.085	5.085	38.136
Lalitpur	8	6.780	6.780	44.915
Lamjung	4	3.390	3.390	48.305
Makwanpur	8	6.780	6.780	55.085
Morang	1	0.847	0.847	55.932
Myagdi	1	0.847	0.847	56.780
Nawalpur	1	0.847	0.847	57.627
Nuwakot	1	0.847	0.847	58.475
Okhaldhunga	2	1.695	1.695	60.169
Palpa	1	0.847	0.847	61.017
Panchthar	1	0.847	0.847	61.864
Parbat	1	0.847	0.847	62.712
Pyuthan	1	0.847	0.847	63.559
Ramechhap	5	4.237	4.237	67.797
Rolpa	2	1.695	1.695	69.492
Saptari	1	0.847	0.847	70.339
Sarlahi	5	4.237	4.237	74.576
Sindhuli	3	2.542	2.542	77.119
Sindhupalchok	6	5.085	5.085	82.203
Sunsari	2	1.695	1.695	83.898
Tanahun	6	5.085	5.085	88.983
Udayapur	13	11.017	11.017	100.000
Missing	0	0.000		
Total	118	100.000		

Rescued Place

Frequencies for Rescued Place

RescuedPlace	Frequency	Percent	Valid Percent	Cumulative Percent
Banau-06	1	0.847	0.885	0.885
Bandipur -05	1	0.847	0.885	1.770
Bandipur-03	1	0.847	0.885	2.655
Barabishe -08	1	0.847	0.885	3.540
Basishar-02	1	0.847	0.885	4.425
Basishar-11	1	0.847	0.885	5.310
Bayas	1	0.847	0.885	6.195
Beni-11	1	0.847	0.885	7.080
Beshishahar-06	1	0.847	0.885	7.965
Bhaktapur-09	2	1.695	1.770	9.735
Bhanu-10	1	0.847	0.885	10.619
Bharatpur-07	1	0.847	0.885	11.504
Bhimad 05	1	0.847	0.885	12.389
Bhimeshor -02	1	0.847	0.885	13.274
Bhimeshor-02	1	0.847	0.885	14.159
Bhimphadi-01	1	0.847	0.885	15.044
Bhimphadi-03	2	1.695	1.770	16.814
Bhimphadi-04	1	0.847	0.885	17.699
Bhimphadi-07	2	1.695	1.770	19.469
Bhumlu -08	1	0.847	0.885	20.354
Chandragiri Municipality	1	0.847	0.885	21.239
Dhorpatan- 6	1	0.847	0.885	22.124
Dudhauli -03	1	0.847	0.885	23.009
Dudhauli -06	1	0.847	0.885	23.894
Dudhauli -10	1	0.847	0.885	24.779
Duwakot	1	0.847	0.885	25.664
Fagunanda-04	1	0.847	0.885	26.549
Fidim-11	1	0.847	0.885	27.434
Gadi-02	1	0.847	0.885	28.319
Gaurinagar	1	0.847	0.885	29.204
Godaita -08	1	0.847	0.885	30.088
Godawari-05	2	1.695	1.770	31.858
Godawari-10	1	0.847	0.885	32.743
Helambhu-05	1	0.847	0.885	33.628
Helambu-05	1	0.847	0.885	34.513
Home	1	0.847	0.885	35.398

Frequencies for Rescued Place

RescuedPlace	Frequency	Percent	Valid Percent	Cumulative Percent
Imadol	2	1.695	1.770	37.168
Jaluke -03	1	0.847	0.885	38.053
Jambwa	1	0.847	0.885	38.938
Jorpati	1	0.847	0.885	39.823
Jutpani-2 (Padmabhumesori Oldage Home)	1	0.847	0.885	40.708
Kalanki-14	1	0.847	0.885	41.593
Kanchanpur Safe house	1	0.847	0.885	42.478
Katahari-04	1	0.847	0.885	43.363
Katahari-12	1	0.847	0.885	44.248
Katari-03	1	0.847	0.885	45.133
Katari-07	1	0.847	0.885	46.018
Katari-13	1	0.847	0.885	46.903
Lalbandi-02	3	2.542	2.655	49.558
Lalitpur-14,	1	0.847	0.885	50.442
Madhyabindu -07	1	0.847	0.885	51.327
Madi-05	1	0.847	0.885	52.212
Magdhe -06	1	0.847	0.885	53.097
Maiti nepal	1	0.847	0.885	53.982
Manamaiju	2	1.695	1.770	55.752
Manthali -01	1	0.847	0.885	56.637
Manthali -04	1	0.847	0.885	57.522
Manthali-1 (Mahila sachetana Manch)	1	0.847	0.885	58.407
Marsyangdi -04	1	0.847	0.885	59.292
Melung-01	1	0.847	0.885	60.177
Nakhkhu	1	0.847	0.885	61.062
Nilkhantha ,07	1	0.847	0.885	61.947
Pachkhal-06	1	0.847	0.885	62.832
Paluntar -07	1	0.847	0.885	63.717
Panauti-03	1	0.847	0.885	64.602
Panauti-11	1	0.847	0.885	65.487
Panchakanya-05	1	0.847	0.885	66.372
Pepsicola, Kadhaghari	1	0.847	0.885	67.257
Pokhara -16	1	0.847	0.885	68.142
Ranipauwa-09	1	0.847	0.885	69.027

Frequencies for Rescued Place

RescuedPlace	Frequency	Percent	Valid Percent	Cumulative Percent
Rapti -02	1	0.847	0.885	69.912
Ratnanagar -03	1	0.847	0.885	70.796
Runtigadi-09	1	0.847	0.885	71.681
Sabaila -01	1	0.847	0.885	72.566
Sagachockgadi-12	1	0.847	0.885	73.451
Sanichare-10	1	0.847	0.885	74.336
Sanovari-01	1	0.847	0.885	75.221
Sathi Organization	1	0.847	0.885	76.106
Shivasatasi-05	1	0.847	0.885	76.991
Siddicharan-2	1	0.847	0.885	77.876
Sidhicharan -05	1	0.847	0.885	78.761
Simara -12	1	0.847	0.885	79.646
Street	1	0.847	0.885	80.531
Sunapati-02	1	0.847	0.885	81.416
Suryabinayak -05	1	0.847	0.885	82.301
Suryabinayak -08	1	0.847	0.885	83.186
Suryabinayak-04	1	0.847	0.885	84.071
Tansen	1	0.847	0.885	84.956
Thaha -02	1	0.847	0.885	85.841
Tirbani -01	1	0.847	0.885	86.726
Tokha -04	1	0.847	0.885	87.611
Triyuga -04	1	0.847	0.885	88.496
Triyuga -06	1	0.847	0.885	89.381
Triyuga -08	1	0.847	0.885	90.265
Triyuga-04	1	0.847	0.885	91.150
Triyuga-09	1	0.847	0.885	92.035
Triyuga-10	1	0.847	0.885	92.920
Triyuga-9	2	1.695	1.770	94.690
bhimphadi-02	1	0.847	0.885	95.575
koteshor 32	1	0.847	0.885	96.460
lisankhu-07	1	0.847	0.885	97.345
panauti-06	1	0.847	0.885	98.230
surendranagar ,05	1	0.847	0.885	99.115
umakunda-02	1	0.847	0.885	100.000
Missing	5	4.237		
Total	118	100.000		

Province

Frequencies for Province

Province	Frequency	Percent	Valid Percent	Cumulative Percent
Bagmati Province	65	55.085	55.085	55.085
Gandaki Province	18	15.254	15.254	70.339
Province 1	22	18.644	18.644	88.983
Province 2	8	6.780	6.780	95.763
Province 5	5	4.237	4.237	100.000
Missing	0	0.000		
Total	118	100.000		

Days

Descriptive Statistics

	Valid	Missing	Mean	Std. Deviation	Range	Minimum	Maximum
Days	84	34	78.048	63.286	356.000	1.000	357.000

Frequency Tables

Frequencies for Days

Days	Frequency	Percent	Valid Percent	Cumulative Percent
1	1	0.847	1.190	1.190
5	1	0.847	1.190	2.381
9	1	0.847	1.190	3.571
11	1	0.847	1.190	4.762
12	1	0.847	1.190	5.952
14	1	0.847	1.190	7.143
15	1	0.847	1.190	8.333
16	1	0.847	1.190	9.524
19	2	1.695	2.381	11.905
21	1	0.847	1.190	13.095
23	2	1.695	2.381	15.476
24	1	0.847	1.190	16.667

Frequencies for Days

Days	Frequency	Percent	Valid Percent	Cumulative Percent
27	1	0.847	1.190	17.857
28	1	0.847	1.190	19.048
29	1	0.847	1.190	20.238
30	1	0.847	1.190	21.429
31	1	0.847	1.190	22.619
32	2	1.695	2.381	25.000
34	3	2.542	3.571	28.571
36	1	0.847	1.190	29.762
38	1	0.847	1.190	30.952
45	1	0.847	1.190	32.143
46	1	0.847	1.190	33.333
47	1	0.847	1.190	34.524
50	3	2.542	3.571	38.095
53	1	0.847	1.190	39.286
54	1	0.847	1.190	40.476
57	1	0.847	1.190	41.667
58	3	2.542	3.571	45.238
59	1	0.847	1.190	46.429
60	1	0.847	1.190	47.619
61	2	1.695	2.381	50.000
62	1	0.847	1.190	51.190
63	1	0.847	1.190	52.381
64	1	0.847	1.190	53.571
65	1	0.847	1.190	54.762
68	1	0.847	1.190	55.952
71	1	0.847	1.190	57.143
73	1	0.847	1.190	58.333
76	1	0.847	1.190	59.524
78	1	0.847	1.190	60.714
79	1	0.847	1.190	61.905
84	2	1.695	2.381	64.286
86	1	0.847	1.190	65.476
87	1	0.847	1.190	66.667
90	2	1.695	2.381	69.048
92	1	0.847	1.190	70.238
95	1	0.847	1.190	71.429
101	2	1.695	2.381	73.810
102	1	0.847	1.190	75.000
103	1	0.847	1.190	76.190

Frequencies for Days

Days	Frequency	Percent	Valid Percent	Cumulative Percent
105	1	0.847	1.190	77.381
106	1	0.847	1.190	78.571
112	1	0.847	1.190	79.762
113	1	0.847	1.190	80.952
114	2	1.695	2.381	83.333
116	1	0.847	1.190	84.524
118	1	0.847	1.190	85.714
122	1	0.847	1.190	86.905
125	1	0.847	1.190	88.095
141	1	0.847	1.190	89.286
151	1	0.847	1.190	90.476
166	1	0.847	1.190	91.667
194	1	0.847	1.190	92.857
201	1	0.847	1.190	94.048
205	1	0.847	1.190	95.238
208	2	1.695	2.381	97.619
302	1	0.847	1.190	98.810
357	1	0.847	1.190	100.000
Missing	34	28.814		
Total	118	100.000		

Referred By

Frequencies for Referred by

Referred by	Frequency	Percent	Valid Percent	Cumulative Percent
CBO	18	15.254	15.254	15.254
Family	54	45.763	45.763	61.017
GO	6	5.085	5.085	66.102
Go	3	2.542	2.542	68.644
KOSHISH	37	31.356	31.356	100.000
Missing	0	0.000		
Total	118	100.000		

Reintegrated To

Frequencies for Reintegratedto

Reintegratedto	Frequency	Percent	Valid Percent	Cumulative Percent
CBO	10	8.475	10.638	10.638
Family	83	70.339	88.298	98.936
organization	1	0.847	1.064	100.000
Missing	24	20.339		
Total	118	100.000		

Diagnosis at Intake

Frequencies for Diagnosis

Diagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
ADS	1	0.847	0.847	0.847
ATPD	1	0.847	0.847	1.695
BPAD	6	5.085	5.085	6.780
Dementia	2	1.695	1.695	8.475
Depression with dissociative disorder	2	1.695	1.695	10.169
Depressive disorder	2	1.695	1.695	11.864
Intellectual Disability	6	5.085	5.085	16.949
Mood Disorder	9	7.627	7.627	24.576
Non-Affective Psychosis	2	1.695	1.695	26.271
OCD	2	1.695	1.695	27.966
Organic personality change with cognitive impairment	1	0.847	0.847	28.814
Personality Disorder	1	0.847	0.847	29.661
Psychosis	1	0.847	0.847	30.508
Psychosis NOS	23	19.492	19.492	50.000
Schizoaffective Disorder	6	5.085	5.085	55.085
Schizophrenia	47	39.831	39.831	94.915
Seizure Disorder	2	1.695	1.695	96.610
Under Observation	3	2.542	2.542	99.153

Frequencies for Diagnosis

Diagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
Post encephalitic sequaelae	1	0.847	0.847	100.000
Missing	0	0.000		
Total	118	100.000		

Status of Diagnosis at the time of Intake

Frequencies for Statusofdiagnosis

Statusofdiagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
Mild	12	10.169	13.043	13.043
Moderate	36	30.508	39.130	52.174
Severe	44	37.288	47.826	100.000
Missing	26	22.034		
Total	118	100.000		

Current Status

Frequencies for Status

Status	Frequency	Percent	Valid Percent	Cumulative Percent
Good Recovery	47	39.831	55.294	55.294
Mild Recovery	6	5.085	7.059	62.353
Moderate Recovery	27	22.881	31.765	94.118
Minimal Recovery	5	4.237	5.882	100.000
Missing	33	27.966		
Total	118	100.000		

Exposure to GBV

Descriptive Statistics

	GBV
Valid	65

Descriptive Statistics

	GBV
Missing	53

Note. Not all values are available for *Nominal Text* variables

Frequency Tables

Frequencies for GBV

GBV	Frequency	Percent	Valid Percent	Cumulative Percent
No	26	22.034	40.000	40.000
Yes	39	33.051	60.000	100.000
Missing	53	44.915		
Total	118	100.000		

Annex- 4 ToR

1. **Evaluation Summary**

Program/Project, Project Number	Rehabilitation and Reintegration Support for Abandoned Women with Mental Health and Psychosocial Issues Project
Partner Organisations	HimalPartner and KOSHISH, National Mental Health Self-Help Organization
Project start and end dates, Phase of project	2020-2022 Final Evaluation
Evaluation Purpose	To assess achievements/outcome of the project and provide guidance for further project development and a follow-up project to start over in 2023
Evaluation Type (e.g. mid-term, end of phase)	Final Evaluation
Commissioning organisation/contact person	Sangam Khatri Program Officer sangam@KOSHISHnepal.org Contact no.: +977-9801856683 KOSHISH
Evaluation Team members (if known)	External Consultant with support and facilitation of project staff
Primary Methodology	• Planning workshops • Desk Review • Questionnaire development • Key Informant Interviews

	• Focus group discussion with beneficiaries and stakeholders
Proposed Evaluation Start and End Dates	10 May – 10 June 2022
Anticipated Evaluation Report Release Date	10 June 2022
Recipient of Final Evaluation Report	Social Welfare Council, KOSHISH and HimalPartner

1. **Introduction**

1.1 **About KOSHISH**

KOSHISH is a national, non-governmental, non-profit, self-help organization which works in mental health issue in Nepal. The organization started to work informally in the mental health sector from 2004. It was formally registered in the year 2008 in Kathmandu District Administrative Office (registration number 086/065) with the approval of the Nepal Social Welfare Council (registration number 25676).

KOSHISH takes a twin track approach, carrying out advocacy and awareness programs as well as service delivery simultaneously. These programs take a public-private partnership approach to mental health services and advocacy for mental health prevention, promotion and protection.

KOSHISH has been providing emergency short-term residential psychosocial support for abandoned women with mental health problems which aim to rescue, provide specialized care/ psychosocial support, and finally facilitate reintegration in their family and community.

1.2 **About Project**

The project aimed to develop and manage a model transit home for the women in collaboration with the Government of Nepal. The project was implemented in coordination of

Government Line agencies of Health and Women. They were the essential part of project monitoring and steering team. The project was holistic as it has all the components of rescue, rehabilitation, reintegration, advocacy and livelihood and income generation. The project has three aspects:

First, by the end of the project, we purposed a replicable model of Transit Home with evidence of success which can be taken as a base for similar initiatives in future. For facilitating replication, KOSHISH focused on lobby, networking and regularly update to government and likeminded organizations on the progress. KOSHISH identified referral mechanism which can support and replicate practices of the transit home. For increasing involvement of government in the project, KOSHISH involved government line agencies in monitoring and evaluation from the beginning of the project. KOSHISH documented the project progress and achievement regularly for generating evidences for the advocacy and lobby. Annually sharing workshop has also been conducted to share the finding and effectiveness of the project.

Second was to improve the quality of life for 150 vulnerable women and the lives of their families through increased access to specialized quality mental health and psychosocial support (MHPSS) services in the project. This component of the project also provided necessary evidences for the efficiency and effectiveness of the project.

Third, to carry out lobby, advocacy and awareness programs for improving mental health inclusive frameworks, programs and practices and community based livelihood initiatives at the different level. This was done through the social mobilization component which was facilitated by Outreach worker in the project. This was primarily focus on those municipalities from where either the women are rescued or reintegrated. This component also included exposure of relevant stakeholder to the activities and practices of transit home. It aimed at influencing stakeholders for replicating model transit home in other areas and services. Along with the advocacy at local level, KOSHISH regularly advocated for budget allocation with provincial and federal government for community based rehabilitation services for the beneficiaries through advocacy programs. In this period, KOSHISH strongly work toward developing Public Private Partnership (PPP) with the government for rehabilitation of the beneficiaries. The project conducted lobby (seek to influence) with government and other stakeholders for budget, program and policies for rehabilitation of the beneficiaries based on evidence generated by the project and previous project In past, the transit home of KOSHISH was very effective in the rehabilitation and reintegration of vulnerable women. This project provided a new low-cost model of transit home by proper documentation and evidence development. It continued best practices of existing Transit Home, emphasizing evaluation report of the existing Transit Home and incorporating new initiatives in the field.

Overall, the project worked toward improvement of socio-economic status, security, and self-advocacy efforts of women with and at risk of mental health and psychosocial issues in Nepal. KOSHISH planned to influence women's wellbeing through advocacy at a local level to encourage reformation and implementation of programs, policies, and practices that are inclusive of MHPSD. The project also spread awareness and sensitized community stakeholders on mental health and psychosocial wellbeing and issues.

1.3 **Overall objective (long-term impact):**

Universal health coverage for people living with mental health conditions and psychosocial disability is ensured through accessible community based holistic rehabilitation services in Nepal

1.4 **Project geographical coverage:**

The project focuses on providing service to the abandoned and marginalized women with mental health and psychosocial issues from different parts of Nepal. Thus, the project targets to reach the vulnerable group from all over the country.

1.5 **Project Outcome and Outputs:**

Outcome 1: To develop and manage a model transit care services for women who are locked up, chained, or abandoned due to mental health and psychosocial issues in collaboration of Government of Nepal

Output 1.1: Women who were previously locked, chained and abandoned rescued and received specialized MHPSS services through model transit care services

Output 1.2: Women who received specialized MHPSS services in model transit care reintegrated in family and community

Outcome 2: Sensitized, reinforced and supportive Governments and communities on issues of mental health and psychosocial wellbeing and rights of persons with MHPSI

Output 2.1: Local government representatives and staff oriented

Output 2.2: Family members and community people oriented on mental health and psychosocial wellbeing and issues

Output 2.3: Lobby and advocacy with federal, provincial and local government for mainstreaming mental health and psychosocial support

Outcome 3: Transit Home care accepted as model for rehabilitation by stakeholders working in the field of mental health and psychosocial wellbeing of women with MHPSI

Output 3.1: Annual project sharing workshops organized with government and other line agencies

Output 3.2: M&E visits of the project by government line agencies

Output 3.3: Funding opportunity available for rehabilitation and reintegration support for the beneficiaries identified and documented

2. Evaluation Objective, Scope, and Intended use

2.1 Scope of the Evaluation

The scope of this evaluation is to assess the project progress made according to the project log frame, specific timeline, funds spent, reach to target groups, advocacy and sensitization with local government, policy and plan of local government inclusion with mental health, organizational set-up, policy, and institutional context. This is also expected to get to know discrepancies between the planned and actual implementation of the development intervention, learning and best practices, and challenges in meeting the indicators and results.

The evaluation will cover the entire 28 months period from the beginning of the project until now. All project implementation areas as described above.

2.2 Specific Objectives

The specific objectives of the final evaluation are:

- To assess how the activities undertaken by the project have led to achievements of its results and objectives;
- To assess project accomplishments and aspect of effectiveness and efficiency in delivering the desired results;
- To assess if the project was relevant to the needs of the beneficiaries;
- To identify key lesson learned of the project;
- To assess the impact of the project in the community as well as in institutional level and sustainability features of the project;
- To generate recommendations to KOSHISH and donor/partners for further support in establishing sustainable mental health and psychosocial care support in Nepal

2.3 Target audience and intended use

The main target audiences are women experiencing mental health and psychosocial issues, families, caregivers/families and their communities and local government, and service providers, as well as KOSHISH and HimalPartner learning from the process.

The findings of the evaluation will guide local government to mainstream, practice person-centered and rights-based approach on mental health service delivery and inclusion of person mental health and psychosocial issues.

The evaluation consultant will prepare selected key recommendations for the project implementing agencies and key stakeholders. The consultant will share his/her key findings, recommendations, and learning to all project audiences through a debriefing workshop. Accessibility and necessary reasonable accommodation should be highly considered throughout the process.

The findings, recommendations, and learning will further be assessed by KOSHISH, and KOSHISH will provide its management response and incorporate recommendations while implementing the project in the remaining 6 months with required adjustment and modification in the plan.

3. **Purpose for the evaluation:**
    - Conduct end-term evaluation of the project and write an evaluation report including information from field visits in Bagmati Province and Gandaki Province and participation in programs.
    - Evaluate fulfillment of the project's purpose, assess KOSHISH's success in delivering outputs and outcomes and the approaches used, highlight lessons and use evidence to make recommendations to improve KOSHISH's work in the future and possible way forward.
    - Make an analysis of public resources used on mental health during the project period.

    The evaluation should consider:

I. **Relevance**
    - What was the relevance of the projects approach and activities in view of the envisioned change?
    - In what way do you see the project benefits the community?
    - Did the project approach and activities suit the priorities and needs of the target groups?
    - Were the inputs and strategies identified, and were they realistic, appropriate and adequate to achieve the results?
    - Are the project strategies and interventions relevant to KOSHISH strategy, policy, and values?

II. **Effectiveness**
    - To what extent has the results been achieved, in relation to the project results framework?

- What factors were crucial for the achievement or failure to achieve the project objectives thus far?
- How effective have the psycho-education and sensitization programs been in raising awareness among family members, community people, and local level authorities?
- What are the strengths and weaknesses of the approaches adopted to implement the project? How might the project's approaches have been improved?
- What are the effectiveness of coordination, collaboration, and engagement of local government in project implementation?

III. **Efficiency**

- Have the funds been utilized in the best possible and efficient way to achieve results?
- Has the project made best use of the resources?

IV. **Sustainability**

- How realistic are the sustainable targets of the project at the local level complying with the available resources and policies?
- To which extent are the changes brought by the project likely to be sustained beyond 2022?
- Which partnerships have been created (both at federal, provincial and local levels) and how are the newly created relationships between the various actors and their respective roles likely to be sustained beyond the project?

V. **Impact**

- To what extent have project outputs and outcomes been achieved and how has it contributed to the fulfillment of the project purpose?
- Have there been any unplanned consequences of the project, whether positive or negative?
- To what extent have the positive unplanned consequences shaped the program/implementation?

VI. **Empowerment**

The assessment of degree of empowerment achievement should be based on Digni's Empowerment Assessment Tool (EAT).

- To what degree is there change in empowerment- at output, outcome or impact level?
- At what level is the empowerment taking place- individual, community or society?
- Are there differences in empowerment with regard to "themes/areas of work" in the project?

4. **Methodology**

The methodology is expected to be participatory. Participatory tools may include:

- **Review of documentation:** Project documents, project progress reports, publications and success stories, HimalPartner and Digni strategy, Norad requirements, Digni's Empowerment Assessment Tool, etc.
- An **initial meeting** with KOSHISH to finalize the methodology for field work and data collection, as well as finalizing work plan and itinerary and to clarify roles and expectations.
- An **extensive field visit** in the locality of the beneficiaries to find out the changes achieved because of the project.
- **Meetings & discussions** with KOSHISH board, members and staff of project districts, Ministry of Women, Children and Senior Citizen, National Women Commission, Lalitpur Metropolitan Municipality-Health Section, etc.
- **Interview with beneficiary:** have interaction with beneficiaries and their family and relatives to assess the effect of service in their life**.**
- **Key Informant Interview (KII) and Focus Group Discussion (FGD)**: with the representatives of local governments i.e. municipalities and wards other agencies with whom project worked in coordination
- A **de-briefing** meeting with KOSHISH team.
- A draft report will be submitted and after incorporating feedback from KOSHISH and HimalPartner develop a **final report**.

Whenever necessary, KOSHISH and the project team will coordinate for local communication to facilitate the evaluation process. The consultant will provide the finalized methodology through an inception report before evaluating within one week of the agreement. The evaluator will collect quantitative and qualitative data and information through primary and secondary stakeholders.

5. Evaluation team and management responsibilities

5.1 Evaluation team

The evaluation process will be led by the external consultant and be supported by KOSHISH for local communication and coordination. The Project Coordinator of KOSHISH will facilitate the overall evaluation process.

The evaluator should form an inclusive team, which includes minimum one representative from project staff (outreach worker) related to transit home and one person with

psychosocial disability who have become self-advocate for the cause – KOSHISH will support to identify such persons.

The representative from HimalPartner might be part of the team as per the situation.

A. **Consultant's Profile: Experience and Qualifications**

- Proven experience in evaluation of non-governmental health and community development integrated programs of at least 3 years
- Familiarity with quantitative and qualitative research/evaluation methods
- Sound knowledge and understanding of service provision to persons with mental health and psychosocial disabilities, national standards, health sector policies, and systems.
- Sound knowledge on mental health, Sustainable Development Goals (SDG), UNCRPD, disability rights & inclusion, and local development process.
- The consultant must possess a Master's degree in social sciences, public health from a recognized university and has experience in evaluating health and disability rights and inclusion-focused programs.
- Good understanding of organizational development and systems strengthening
- Proven experience in analyzing evaluation findings and concisely presenting them in a written report (English) and a short presentation to all audiences.
- Excellent spoken and written English and Nepali language.
- Experience as a team leader for similar evaluation teams.
- Communications, coordination, and others professionals skills for the evaluation procedure.

Consultant/ consultancy should be registered in VAT, latest renewal and Tax clearance certificate legal document should submit in the process.

B. **Safeguarding Policy**: As a condition of entering into a consultancy agreement, the evaluators must sign KOSHISH's Safeguarding Policy and abide by the terms and conditions thereof.

6. **Management of the Evaluation and Logistics**

Detail specific **responsibilities of the consultant** regarding logistics:

Roles and Responsibilities of the Consultant

- Work with KOSHISH & HimalPartner to develop an appropriate evaluation design and data collection tools based on indicators as described in the project proposal including performance monitoring and evaluation framework.

- Review key program documents shall include but are not limited to the background project document, annual work plans, progress reports, and other documents related to the Project.
- Conduct data analysis as appropriate and generate a draft evaluation report detailing evaluation methodology, process, key achievements, challenges, lessons learned/suggestions for the program.
- Review the draft report to include feedback from KOSHISH and HimalPartner to provide the final copy of the Report.
- Should conduct extensive field visit, reach the beneficiaries, and related areas as far as possible based on the representative sample from the cluster based on the evaluation objectives.

HimalPartner has responsibility to: *Provide technical support throughout the End-term Evaluation process especially developing the ToR, feedback for the evaluation methodology, questionnaires and ensure the inclusion and quality of the evaluation process and provide feedback to finalize the report.*

Project Partner has responsibility for:

- Coordination with HimalPartner to organize a meeting schedule for the evaluation team.
- Identifying "neutral" and accessible locations for interviews/ meetings to take place (where people will feel free to speak as openly as possible) in case of face-to-face evaluating process and provide other support in case of virtual support like provide number, etc.
- Organizing interviews with beneficiaries according to the evaluator's requests/methodology.
- Arrange logistic and local level coordination for the consultant during the evaluation period.
- The arrangement, confirming community level SHGs to whom to conduct FGDs, confirming key local government stakeholders, individuals for the KII, ensure local level field staff.
- Ensure reasonable accommodation and accessibility throughout the evaluation process.
- Adapting safety and precautions measures against COVID-19 during the communication, coordination, and consultation and FGD, KII, and another visit for the evaluation team and the stakeholders/beneficiaries' safety.

7. **Expected Results from the consultant**

The evaluator will provide the end-term evaluation report consisting of the following contents:

- Inception report including a detailed schedule, responsibilities during the evaluation process, detailed methodology, and assessment tools.
- A briefing workshop with agreed stakeholders at the end of the assessment phase to present initial results.
- Draft evaluation report for input, discussion, and revision
- The final report should be 20 – 30 pages, excluding annexes, and should be written in English. It should contain an executive summary of a maximum 2 pages. The report should follow the following format:
  - Title page
  - Short description of evaluators
  - Acronym list
  - Executive Summary
  - Introduction/ context
  - Objectives
  - Methods
  - Constraints / Limitations
  - Findings
  - Conclusions
  - Recommendations and Way forward
  - Annexes
- A visual of the main findings and recommendations that can be easily understood by all members of the project and communities. Considerations for accessibility and easy language for inclusion.
- Appendices (as required i.e. Case stories, TOR, work schedule, list of respondents, background documentation including meeting records, surveys, and other documents) that add to understanding to the evaluation process and results.

8. **Timeline**

The evaluation will take place from May 10 –June 10, 2022. The actual duration work for this assignment will be 30 working days [for a consultant] with the following provisional schedule.

The final reports and all deliverables must be completed by of June 10, 2022.

SN	Particular	No Days required	Remarks
1.	Documentation review and consultation meeting with KOSHISH	2	
2.	Field visit	10	
3.	Information compilation and processing	3	
4.	Report writing, and first draft sharing	7	
5.	Feedback from KOSHISH	5	
6.	Consolidation of feedbacks from KOSHISH and final report submission	3	Dissemination program will be organized in Kathmandu with participation of key stakeholders of the project

8. **Outcomes of this Assignment**

This work will not just document the final evaluation of Rehabilitation and Reintegration Support for Abandoned Women with Mental Health and Psychosocial Issues Project run by KOSHISH since 2020 through 2022, simultaneously this will analyse the project effect at broader spectrum and link it in the following areas as well;

- Assessing KOSHISH initiatives and their contribution toward the broader health and mental health context of Nepal.
- Review the coordinative efforts of KOSHISH with local government, other health stakeholders and the government of Nepal.
- Stakeholders' analysis and view the sustainability of the work.
- Assess the quality/standard of KOSHISH service in terms of
    - Nepal's context
    - Legal compliances
    - Patient confidentiality
    - Clinical qualifications of staff

- Relative quality of clinical services
- Relative quality of residential services
- Assessing quality of follow-up and linkage services

- Recommendation will cover but not limited to the following areas;
  - Specific recommendations on clinical and psychosocial practice in the Nepal context
  - Recommendations for improving local context
  - Recommendations for connecting/coordinating with Local, Provincial, and Federal government and others in the sector

9. **Additional Documentation**

The evaluators will receive the following background material:

1. Project description, log frame and cost plan
2. Annual Narrative report
3. Semi-annual project progress report
4. Financial report and Audit Report
5. Case stories from the field
6. CRPD principles
7. Project related disaggregated data
8. Organizational policies-safeguarding policy and all other relevant documents.
9. Other publications related to the project (IEC, hoarding board, radio episodes, and books if applicable.
10. Disability Right Act, 2017
11. Any other relevant documents applicable

10. **Selection procedure of the consultant:**

Resource persons will be called from resource pool of KOSHISH considering goodwill and expertise. A team will be formed to assess the strength and qualification of resource person based on qualification and financial accessibility. The team will have the final decision to select the resource person. The selection process will consist of 3 member of committee comprising of Program Director, Program Officer, and Finance Officer.

11. **Costs and payments**

The cost of consultant will include the entire consultant charge including Fee, airfares, food and accommodation, local transport.

Consultant cost will be paid as per the organizational policy under the available budget for the purpose.

Annex 5 Relevant Interview Transcripts

"If not for KOSHISH, I would have been in a very dark condition. I used to be unaware of where I was and what was happening around me. Still, now I can do household chores, attend social functions like marriages and pujas, and speak to others unhesitatingly. I voted for the local-level election and felt that my voice was heard and that I was treated with dignity. If I meet anybody with mental health problems, I will tell them to take medicine regularly and encourage them to contact organizations like KOSHISH" (Beneficiary B, Sindhupalchowk)

"She[daughter] has completed her B.N and thinks that she would get much better if she gets a job. She gives exams for jobs, works hard for them but to no avail. She is frustrated all the time. " (Mother of Beneficiary E, Kavre)

"There is always the problem of money now, how to pay for children's school fees, how to raise them.We can"t fulfill their desires, my husband can't get jobs...due to unending financial problems, sometimes I think life is not living worth living." (Beneficiary C, Dolakha)

" I have been hospitalized 3 times after KOSHISH. I kept having persistent headache from 4 days and became unconcious. I am helped by maternal side and family side but as I started to feel unsupported by them, I started to have suicidal thoughts. Not interested in public events. Even to pay for my hospital expenses, We asked money from others." (Beneficiary C, Dolakha)

"What this project has done is commendable. But more counseling sessions are needed for the family members to make them aware of their role in the patient's well-being and recovery... A three- or four-day course should be designed to impart parents' knowledge about mental health issues. We are very positive about coordinating with KOSHISH, psychology

students from Tribhuvan University and anyone who can help us realize this goal." (KII, Local Representative, Dolakha)

"Sometimes she cries, almost always spends time alone and ruminates, and she does not open up much with us. She seems happy when she talks to her children, but it is difficult to get them to talk to her. We want her to be more active, she cannot do simple tasks like wrapping quilts. She does not take medicine, if she suspects that her medicine is given by mixing them in food, she revolts." (Caretaker of Beneficiary D, Dolakha)

"All she does is laugh, wander in the village; she has a sense of entitlement, so she does not do any kinds of work in home also. She never stops asking for money. So much money is spent on her treatment. Almost 1 lakh was spent in her treatment, we took her to traditional healers and hospital before taking her to KOSHISH, but to no avail. Even now, she is not fine. I would not say she is totally "mental", she talks fine and is clever but the problem persists."(KII, Beneficiary A's relative, Sindhupalchock)

"She was in road before, abandoned by her family. She does not take medicines, have not consulted doctor. She says that If the problem arises again, she will start taking again. Her Children don't come to visit her, she becomes happy when her children contact. When she is not with others, she says she starts to ruminate."(KII, Beneficiary D- Caretaker, Dolakha)

"She is very fine after returning from KOSHISH. I help her with money to buy medicines and care take care of her. We try not to give any stress to her, that is our duty. We must try to understand her situation. We need to be compassionate towards the vulnerable people instead of treating them inhumanely. I am very angry with the way society treats them. It is a shame."(KII, Beneficiary 00,…....)

"I have always been involved in the household chores, however troublesome the situation may be. Now, I have no fear of returning to the previous condition, but I know I must not stop medication. I don't spend time in thinking about this and that, and I don't burden my mind with unnecessary thoughts, so I don't have any problems nowadays. KOSHISH helped me get back my life."(Beneficiary G, Kavrepalanchok*)*

"People should also be made aware that mental health problems can be treated like physical health problems if early intervention is provided. It is not possible to bring positive changes in people's behaviours towards mentally ill people by enforcing laws, people must realize it deeply in order to bring changes in their attitudes and behaviours to realize the changes we have envisioned." (KII, Local representative, ….....)

Annex 6 Guidelines and Protocols developed so far

KOSHISH

National Mental Health Self-help Organization

Lalitpur

Admission Guidelines

Admission to KOSHISH safe house may be needed to treat a person with mental health conditions who requires care in a 24 hours supervised facility. The severity of health problems for admission to KOSHISH safe house are based upon the signs and symptoms exhibited by the person , their functional impairments , and the level of risk involved that are of such severity that the treatment in their family or community setting would be unsafe or ineffective. Admission to KOSHISH may provide the opportunity for the treatment at a safe and secure environment where direct observation, regular monitoring and continuous therapeutic support are provided.

Criteria for Admission:

A. Diagnosis:

The beneficiary must be suffering from a mental health problems.

B. Severity of Health problems (signs, symptoms, functional impairments and risk potential):

At least one of the following manifestations is present:

1. Severe Psychiatric Signs and Symptoms
    - Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living so the person cannot function at a lower level of care.
    - Disorientation, seriously impaired reality testing, defective judgment, impulse control problems severe enough to endanger the welfare of the person and/or others
    - A severe, life-threatening psychiatric syndrome or unusually complex psychiatric condition exists that has failed, or is deemed unlikely to respond to less intensive levels of care, and has resulted in substantial current dysfunction.
2. Disruptions of Self-Care and Independent Functioning
    - The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essential activities of daily living due to psychiatric disorder.
    - There is evidence of grave impairment in interpersonal functioning and/or extreme deterioration in the person's ability to meet current educational/ occupational role performance expectations.
3. Harm to Self

- Suicide: Attempt or ideation is considered serious by the intentionality, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, and psychological symptoms), history of prior attempts, and/or existence of a workable plan.
- Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.

4. Harm to Others
    - Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.
    - There is expressed intention to harm others and a plan and/or means to carry it out and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).
    - There has been significant destructive behavior toward property that endangers others.

C. Drug/Medication Complications The person has experienced severe side effects from using therapeutic psychotropic medications.
    - The person has a known history of a psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the adjustment or re-initiation of medications following discontinued use that requires close and continuous observation and monitoring, and this cannot be accomplished at a family or community settings due to the beneficiary's condition or to the nature of the procedures involved.

Criteria for Continued Stay:

Severity of mental health conditions criteria for continued stay will be decided if the beneficiary needs prolong stay at the safe home due to different reasons as follow:

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
    - the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or
    - the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or
    - that reintegration into the community have resulted in, or would result in exacerbation of the psychiatric health problems to the degree that would necessitate continued stay at the safe house, or
    - a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting of the safe house, documented in daily progress notes by a trained nurses in addition to the consultation of consultant psychiatrist.

Exclusion criteria for admission:

KOSHISH's safe house is a specialized care home for the people living with mental health conditions whose management at the community or family is challenging and may need continued care under supervision. However, KOSHISH's safe house has its own limitations and has some exclusion to admission criteria owing to the fact that the management of these conditions may need special care at different centre directed towards such conditions.

Some criteria of exclusion for admission are:

- The beneficiary is under 16 needing specialized child psychiatric treatment and child psychologist care
- The beneficiary has significant active or invasive medical treatment needs
- The beneficiary's primary diagnosis (or diagnoses) is/are: substance abuse, substance dependence, dementia, intellectual disability, autism
- The beneficiary has active alcohol and/or drug dependency
- The beneficiary has highly contagious disease such as active pulmonary tuberculosis, Hepatitis B
- The beneficiary with complicated and chronic physical health problems.

Types of admission at KOSHISH:

- **Voluntary admissions:**

The beneficiaries who are in need of psychiatric treatment willingly agrees to be admitted at KOSHISH. However, this unfortunately, may not always be possible and the beneficiary in dire need of psychiatric treatment may refuse to be treated or is unable to make a decision regarding his/ her treatment. In that case other types of admission may be considered.

Other types of admission
other types of admission at KOSHISH may be:

- **Involuntary admission:**

When the beneficiaries with mental health conditions are incapable of making informed decisions due to his/ her mental health status and refuses health intervention, involuntary admission may be done. They are either brought in by their family, community members and/or through the referrals of local government representative.

Admission Procedure:

Admission procedure begins once the beneficiary is received at the KOSHISH safe house either through rescue process or family or community referral.

- The nurse on duty will be responsible for the admission and the process to follow after admissions.
- All beneficiaries will be admitted according to the admission criteria.
- All admission must be informed to the consultant psychiatrist and the head offices within the first 24 hours of receive.
- Ensure all the necessary papers are filled and are signed by the relatives/ family members/government representative/community representative and the admitting nurse.
- Physical assessment and mental health assessment are to be carried out during the admission provided the patient is cooperative. If the co-operation is challenging due to mental health status and safety is the main concern it can be carried out at the earliest convenience after the beneficiary is stabilized and cooperative.
- Medication card (Cardex) to be filled by the doctor after consultation following admission.
- High risk beneficiaries (suicidal , forensic/criminal history, violence/aggression, absconding, psychotic) needs risk assessment at the time of admission
- All the staffs of the KOSHISH safe house to be made aware of the beneficiary if any risk is identified for needed vigilance and care.
- Brief summary of the beneficiary's history including psychiatry and medical history is to be obtained at the time of admission.
- Orientation to the newly admitted beneficiary regarding the safe house and activities that are carried out at safe house to be provided depending upon the beneficiary's mental status.
- Beneficiary's belongings and valuable belongings are handed over to the relative/ family members/ community representative or kept safely at the safe house . The admitting staff needs at least a witness from staff team members to check and document their belongings safely.
- Beneficiary at the time of admission needs to be thoroughly checked /searched by at least two members of the staffs in presence of their family/community members/community representative, if possible depending upon their mental state.
- Baseline vital signs and weight to be taken within 24 hours of admission depending upon their mental state.
- Admission report including brief mental state examination report to be completed within first 24 hours of admission.
- Inform head office accordingly.

KOSHISH

National Mental Health Self Help Organization

Lalitpur

Rescue and Reintegration Protocol

1. ***Rescue Protocol***

The safe house of KOSHISH plays a central role in overall treatment process of a beneficiary. Rescue is considered when a team of expertise from KOSHISH receives the beneficiaries with mental health conditions who are subjected to human right violations at their own community/family deprived of basic needs, care and treatment. These beneficiaries include those who are chained, tied up, locked up, caged or neglected to care at their own community. Admission to the safe house following rescue provides safe therapeutic environment under direct observation and care that aids in recovery of the beneficiary. Rescue, therefore, is a crucial part where a beneficiary is assessed and brought in to the safe house of KOSHISH for the treatment. Rescue is carried out by the team of experts available.

Rescue Team:

At least 1 certified medical team member (Nurse/ H.A.) and social worker and/or other team member as per availability

Rescue process:

Before Rescue:

- Assessment :
  - To be done prior to rescue by the relevant team member (nurses, community outreach social worker). Community Referral form which is used as a guideline highlighting the need for specialized care at the safe house along with the relevant history) to be forwarded to the line manager beforehand for rescue planning. Referral form, preferably, to be completed by the health care team to get detailed information regarding the beneficiary to be rescued.
  - Necessary paper works with family and/or community members or local government representative to be followed by the community outreach social worker.
  - Before or during the rescue process, the community outreach social workers should liaise with local government representative and inform local human right defenders, municipality, ward representative , police (as per need) about the rescue of the beneficiary and seek for possible cooperation/collaboration through the official letter

- Specify if any physical health problems including physical disabilities is present and/or if special care is required for the beneficiary during or after rescue including dietary modifications, functional limitations to determine its management at the safe house of KOSHISH.
- Once assessment is obtained, the medical team member will have to consult the consultant psychiatrist prior to rescue for the possible management during the rescue.
- Medical team member along with the pharmacist will check, count and record the number of medicines taken with the first aid box and the same to follow after rescue process is completed. In case if the pharmacist is not available it needs to be double checked with the other health team member.
- Community outreach social worker to plan the rescue process in co-ordination with available health team member and local referral source including reservations needed for vehicles or living arrangement.
- The medical team member has to carry their valid license during the time of rescue.
- During this COVID-19 pandemic, in order to minimize risk of transmission, PCR test of each beneficiary is mandatory before their intake in transit home.

During the rescue process:

- The medical team member will be responsible for the medication administration (if required under the consultation of consultant psychiatrist) and the management of any emergency during the process of rescue when needed.
- The history of drug sensitivity should be obtained before the administration of any medicine (If there is any known sensitivity then the use of medicine of same class should be avoided and the consultant psychiatrist must be notified)
- On spot brief field assessment needs to be carried out before any action is taken and document and report as per need.
- Consult with the consultant psychiatrist to update about the assessment and discuss regarding the management if medication need is seen.
- Medicine can be administered only after the consultation of consultant psychiatrist. Oral medications are preferred to injection medicines which can only be used as a last resort after a proper assessment is done. All the medicines administered should be recorded and reported including special events if any occurred. Medical team member will be responsible for the safe disposal of injection when used.
- The medical team member will be responsible for assessment regarding impending potential medical emergencies and its timely management.
- The rescue team needs to explain and obtain consent from the client, community, family or bystanders about the actions that will be carried out especially in terms of medications and possible complications.
- During the transportation, safety of beneficiary will be ensured by the rescue team and their basic needs such as food, toilet needs need to be assured.

- Safety must be ensured if a beneficiary tied up to metal chains needs to be freed by cutting those metallic chains. Take help of local people if such intervention is needed. Similarly, note for injury due to metallic chains or any other means by which they are tied up.

After Rescue:

- The rescue team will have to notify at the safe house about the rescue process highlighting special events if occurred so that necessary arrangement can be made prior to admission.
- Once the beneficiary is admitted to the safe house, all the documentations need to be properly completed, recorded and reported. Rescue report will be completed by the rescue health team member. Admission process to follow as per the admission guideline.
- The on duty medical staff will inform and notify the consultant psychiatrist about the rescue and necessary management to be done after the admission.
- The rescue team will also provide necessary documentation including official letters to the head office and a copy of it to the safe house.
- Settlement post rescue will be done by the responsible team member at the head office.
- Action plan for proper nursing care will be planned based upon the assessment and need of the beneficiary in co-ordination with the nursing manager and team.
- Notify and inform line manager as per need.

2. ***Reintegration Protocol***

Reintegration planning should begin at the time of rescue or admission into the safe house of KOSHISH. The benefits of conducting reintegration planning for the beneficiaries with mental health conditions are to link them to appropriate next step resources based on their needs; to minimize likelihood that client will "relapse" or have to return to care post successful completion of treatment; and to prevent vulnerable clients from becoming homeless and/or criminalized; and to assist clients with re-entry to community.

The reintegration planning for beneficiary is a structured process for ensuring safe and successful transition of persons with mental health conditions treated at KOSHISH to their respective family and community. In fact, reintegration is a very crucial step following the recovery of the beneficiary. It aims to help beneficiaries discharged from the safe house in safe reintegration at their family and community. Health team members, Community outreach social workers along with the responsible community members and/or associated NGOs, representatives of ward offices or municipality plan there integration with the beneficiary and their family/community. During the reintegration, it should be ensured that the reintegration planned is collaborative, person-centered and suitably-paced, so the beneficiary does not feel their reintegration is sudden or premature.

Reintegration procedure:

- **Maintaining links with the community :** Work with the beneficiary throughout their stay to help them:
    - Identify their links outside the transit home.
    - Restart activities of daily living as soon as possible with assistance where needed
- **Helping the beneficiary prepare for reintegration:** Reintegration planning must be informed and individualized for each beneficiary. Before reintegration, series of individualized psycho education sessions depending upon their readiness for people with psychotic health problemses to promote learning and awareness is advisable to be done by the psychosocial counselor. Psycho education sessions should be started while the beneficiary is under treatment at the KOSHISH's safe house. Psycho-education should cover the symptoms and their causes, coping strategies, risk factors and relapse prevention strategies and medication management.
    - Before the reintegration, the accommodation arrangements and medications support arrangement must be ensured to determine if they are available for long term. The responsible focal person or organization should work in co-ordination with the community outreach worker and arrangement of reintegration should be discussed before rescue. During reintegration, group psycho education support planning for care givers can be done to support and sensitize the community on the treatment service that KOSHISH provides and on the mental health condition for which the beneficiary is going to be treated at KOSHISH. This should include information on the specific condition of the person they care for. Abandoned individuals with mental health problems are at risk of being abandoned again by the community so planning for safe reintegration must be started before discharge.
    - A personal care plan along with support arrangements written in simple language can be provided in collaboration with the person being discharged. A personal care plan including possible relapse signs, recovery goals, social networks and details of medication and who to contact and where to contact during crisis can be beneficial to the beneficiaries ready to reintegrate. Information related to physical health needs, treatment and support plan can also be included in the personal care plan. A thorough assessment of the person's personal, social safety and practical needs need to be assessed and the assessment should include risk of suicide as well.
    - Discuss follow-up support with the person before reintegration and let them know about the aims of follow up and how often it would be done. At discharge, the consultant psychiatrist should be informed and a discharge summary should be drafted. Medicine arrangement and proper direction for medication intake must be discussed. The nurse should collaborate with the pharmacist to provide information on medications and their complication and direction individually to the beneficiaries.

- **Reintegration planning with the family/community :**

- Identify a support person (family member/community member/organization representative) who will provide assistance to the beneficiaries following their reintegration.
- Information to share with the patient and caregiver prior to discharge should include, but need not be limited to:
  - KOSHISH safe house's criteria and reasons for initiating reintegration.
  - The beneficiary's diagnosis, treatment recommendations, and safety issues.
  - Risk factors for suicide and what steps to take if danger exists and creating a plan to monitor and support the patient.
  - The patient's prescribed medications including dosage, explanation of side effects, and process for obtaining refills, as applicable.
  - Available community resources including case manager, field officers, support groups, and others if applicable.
  - The circumstances under which the beneficiary or carer should seek immediate medical attention.
- Conduct a risk assessment of the beneficiary's risk of suicide. Review :
  - Assessment and beneficiary's history when needed
  - Discuss safety plan and crisis support if needed with the beneficiary and the caregiver.
- Conduct a need assessment to understand the long-term needs of the patient. The assessment should include questions regarding the beneficiary's s income, housing situation, medicine arrangement and other support available for the beneficiary. At minimum, the assessment should help the provider determine: The patient's capacity for self-care, including but not limited to:
  - The risk that the patient may engage in self-harm as identified in the risk assessment.
  - The patient's support network in place at the location of anticipated discharge.
  - Patient resources and ability to access prescribed medications or travel to follow-up appointments.
  - The patient's need for community-based services.
- Coordinate the beneficiary's care and transition to outpatient treatment. The post-discharge treatment plan should be discussed with the beneficiary and caregiver and provide an explanation of:
  - The next level of care, how it differs from safe house of KOSHISH, and what the beneficiary should expect from outpatient treatment.
  - Contact information for the outpatient care including address and phone number of the site/provider.
- Schedule a follow-up appointment after reintegration.
  - If a follow-up appointment cannot be scheduled within a month or as directed by the consultant psychiatrist, document the applicable barriers in the patient's medical record.

- As necessary, provide instructions to the beneficiary or their family members /community members or caregivers of other organizations during their reintegration. Instructions should address how to provide assistance to the patient and may include securing and administering medications, safety plans, name and location of follow-up appointment and community resources, or any other anticipated assistance relating to the patient's condition.
- Notify the family or community members in advance of beneficiary's reintegration after the planning is made so that the necessary arrangement can be done.
- Plan with line manager and inform head office about the reintegration and medicine support if it's to be done from KOSHISH.
- Plan psycho-education as needed at the family/community depending upon the need.
- Planning for disability card and citizenship card attainment (if the beneficiary doesn't have the citizenship card) can be done if required.

Reintegration procedure:

- Once the beneficiary is planned for reintegration, a designated key worker, preferably community outreach social worker is responsible for coordinating the implementation of the reintegration plan. In doing this, the key worker must work in collaboration with the health team members and the caregiver/family members/community members/organization representatives.
- Psychosocial counseling should be initiated at the earliest when the beneficiary can attend the sessions and ensure termination prior to reintegration.
- Arrangement of medicines for long term support must be ensured prior to discharge in co-ordination with the local community members and family members or who is responsible for arrangement.
- Program focal person must be notified regarding the reintegration to plan if needed.
- Arrangement of reintegration, transportation is done by the responsible key workers.
- After discharge letter is obtained the beneficiary can be discharged at the presence of the family members or any other authorized personnel (in case of any organization is involved)
- A photograph at the time of discharge must be taken for record.
- The nurses should record and report the discharge process along with the discharge nursing note.

In case of any confusion, you can contact:

Sangita Laudari (House-incharge/Psychologist): +977-9801856773

Sangam Khatri (Program Officer): +977- 9801856683

Annex 7 Rating scale

S.N.	Name of the Beneficiary	District	Visit date	Beneficiary	Key Informant	Current Status	Level of Recovery	Family	Impression	Risk of Relapse
1	Example Sharma	Jogbani	6/6/2022	1(means yes, interviewed)	0 (no, not interviewed)	Remission (absence of symptoms but may relapse anytime)	Good	High	Psychosis	Minimal

Annex 8 Descriptive Results of the interviewed beneficiaries

Frequencies for Current Status of the beneficiaries

Current Status	Frequency	Percent	Valid Percent	Cumulative Percent
Recovered	1	6.250	6.250	6.250
Recovering	3	18.750	18.750	25.000
Relapsed	1	6.250	6.250	31.250
Remission	11	68.750	68.750	100.000
Missing	0	0.000		
Total	16	100.000		

Frequencies for Family Support

Family	Frequency	Percent	Valid Percent	Cumulative Percent
Good	3	18.750	18.750	18.750
High	4	25.000	25.000	43.750
Low	7	43.750	43.750	87.500
Medium	2	12.500	12.500	100.000
Missing	0	0.000		
Total	16	100.000		

Frequencies for Impression

Impression	Frequency	Percent	Valid Percent	Cumulative Percent
ConductDisorder	1	6.250	6.250	6.250
Depression	4	25.00	25.000	31.250
OCD	1	6.250	6.250	37.500
Personality Disorder	1	6.250	6.250	43.750
Psychosis	9	56.25	56.250	100.000

Missing	0	0.000
Total	16	100.0

Frequencies for Risk of Relapse

Risk of Relapse	Frequency	Percent	Valid Percent	Cumulative Percent
High	6	37.50	37.500	37.500
Low	6	37.50	37.500	75.000
medium	4	25.00	25.000	100.000
Missing	0	0.000		
Total	16	100.0		

Descriptive Statistics Province wise distribution of beneficiaries

	Province 1	Madhesh	Bagmati	Gandaki	Lumbini
Number	2	3	11	0	0

Frequencies for District

District	Frequency	Percent	Valid Percent	Cumulative Percent
Bara	1	6.250	6.250	6.250
Bhaktapur	1	6.250	6.250	12.500
Dolaka	2	12.50	12.500	25.000
Kavre	3	18.75	18.750	43.750
Makawanpur	2	12.50	12.500	56.250
Sarlahi	2	12.50	12.500	68.750
Sihdhuli	1	6.250	6.250	75.000
Udayapur	2	12.50	12.500	87.500
Sindhupalchok	2	12.50	12.500	100.000
Missing	0	0.000		
Total	16	100.0		