Dr. Darshan Trivedi at GEP

Boston meeting, AID

Annual Report 2017

REDEFINING APPROACH TO MENTAL HEALTH CARE .....

Trust For Reaching The Unreached

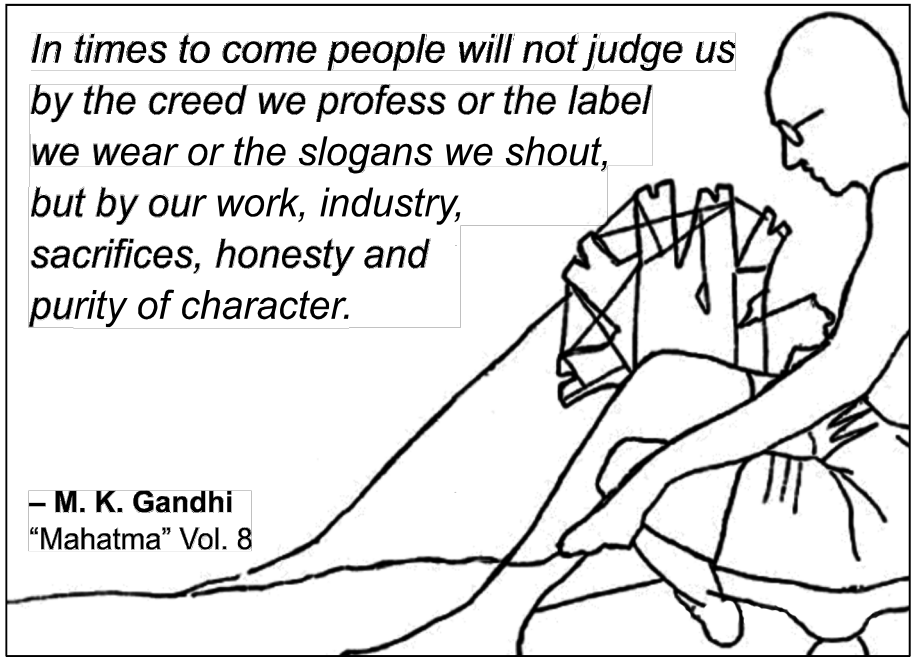
લોકસ્વાસ્થ્ય મંડળ

41, Vishwas Colony, Alkapuri,
Vadodara - 390007

Tel No. 91 265 2338117
Email : truvadodara@gmail.com
Website : www.truguj.org

Annual Report 2017

Redefining Approach to Mental Health Care .....



Courtesy : Mumbai Sarvodaya Mandal.

Trust For Reaching The Unreached

લોકસ્વાસ્થ્ય મંડળ

41, Vishwas Colony, Alkapuri,
Vadodara - 390007

Tel No. 91 265 2338117
Email : truvadodara@gmail.com
Website : www.truguj.org

CONTENTS

Foreword – Crisis in Health Sector

We feel very happy to write the foreword for the 30th year of TRU's existence. A lot has gone by and a lot is still to happen. When we started we used to feel that the health sector is passing through a crisis. Even today we feel that the crisis is on. But surely the nature of crisis has changed a lot though underlying fact remains the same that poor and remote population keeps suffering from all sorts of discrimination.

At that time effort was to strengthen public primary health care by strong administrative and political will. Still most of the efforts were concentrated around immunisation, family planning, treatment of communicable diseases and supplementary nutrition programs. There was a limited success over years due to lack of enough infrastructures and lack of motivated staff. Even the number of medical doctors was inadequate which today is fulfilled in Gujarat by appointment of Ayush doctors. Availability of medicines is also improved over a period of time. The National Rural Health Mission (NRHM) mainly focussed on the above aspects only over years. There has been improvement in building of the primary health centres. Basic facilities have seemingly improved. ASHA and ANM helpers were added to the human resource at the grassroots.

Still the poor eventually are left to go to private sector in nearby towns and cities. Access to services is as difficult as it used to be in past. This is seen in terms of out of pocket expenses the common man incurs in order to maintain health of his/her family.

All govt budgets over a period of time have decreased or kept the status quo about health care provisions and are not able to change the spending pattern despite of the so called success of the NRHM. Even there is a fall in budget in immunisation, communicable disease treatment and prevention program, maternal and child care etc. The 2018-19 Budget has reduced the investment into primary healthcare by approx 25 – 30% in different programmes.

Both in rural and urban areas there is a shift towards increased use of hospital care in private sector. Poor investments in the public health sector as well as expansion of health insurance schemes, including government-financed health insurance for the poor directs most patients to private hospitals. The health seeking behaviour of the general population is also changing due to these mega trends. People tend to go to specialist care for most of their needs i.e. use of secondary care in private sector has increased. Use of investigations and expensive medicines is also aspired

and admired by the general population. There is less and less emphasis on using the primary physician. More people prefer going to the higher level of consultation mostly in private sector.

The major change we see is that the govt primary health infrastructure has grown but overall quality of care is not up to the mark. So people's attention is towards more glossy and more impressive care in secondary private set ups. This results into increased out of pocket expenses. The new medical technologies and diagnostics have resulted into health services to become less affordable for the poorer quintiles.

Medical Insurance schemes have become fashion of the day. Universal Health Coverage is being discussed but not put into practice. So called biggest Health scheme in the recent national budget (Feb 18) also aims to enrich the private sector. Govt exchequer makes the people in general to pay for the health of poor by increasing the tax table. But this money as it is planned will go to the private medical sector or to the private insurance companies. It remains only a point of conjecture and discussion that the money that is used in paying for the medical insurance for the people if used in strengthening the district hospitals will have more permanent benefit for the population in general. Why our govt shuns away from giving amicable better health services through public sector is a big question mark. Primary health care is also still inadequate as it used to be in past.

For most health activists like us it is important that the health status improves with ultimate effect on reducing inequality among the people. The male - female discrimination, the rich - poor divide, the urban - poor gaps, etc are a point of worry. Comprehensive health care as it was propagated way back in eighties is still to be achieved.

International evidence shows that enhancement of primary health care (PHC) services for disadvantaged populations are essential to reducing health and health care inequities. However, little is known about how to enhance equity at the organizational level within the PHC sector.

Eighty two percent of the wealth generated last year 2016 went to the richest one percent of the global population, while the 3.7 billion people who make up the poorest half of the world saw no increase in their wealth, according to a new Oxfam report released recently. The report was launched at the World Economic Forum in Davos, Switzerland. Thus the processes which enhance inequities are sharper at this time point. Groups like us are not able to affect the mega market forces. Hence the satisfaction for us is to establish the processes for positive health outcomes and achieve

better understanding among the people about how to take care of themselves and use opportunities in the micro environment.

We have managed most activities so far with the same perspective. Learning from the talisman given by Gandhiji we have always weighed our efforts to understand how the end person will benefit from our action. We have sincerely put in practice what would be best for the poor and left out people. Our journey from community health to women's organisation to girls' education and to community mental health signifies our understanding. We have tried to find the gaps in services, created models for ideal services and helped people in the process. After so many years we are happy to say that thousands of patients individually and similar numbers of mothers and children have benefitted from our services. Basics of community health as propagated by us were adapted by a number of voluntary organisations who have in turn helped so many with multiplier effect.

We have created a model for ideal support system for girls in order to promote higher education, encouraged hundreds of girls to accomplish high school graduation and achieve higher goals in their lives. Thus on one hand we have worked towards decreasing death and prevented illnesses and prevented many serious complications of diseases. On the other hand we have worked towards better prospective and upscaling of goals of life for women and families in the community.

Lately by helping the mentally ill persons we have created a model for community mental health programmes in our state and the country. Our model actually proves how in low resource situation we can help by providing most important services in this unexplored area of working for poor people.

We hope for better future for our people and the youth especially the girls. At the end of these three decades of work we feel we are not discouraged and depressed but we feel good about positive outcomes of our work and feel equally enthusiastic and encouraged about our approach.

Having received help from many unexpected corners both financially and by moral support we have survived and we will continue so for some more years to come. We are not sure if we will be around physically to write the fourth decade ending year report or not. But we are sure our efforts will continue under the banner of this organisation by the cadre of workers and friends. We are grateful for the support and thank all those who contributed to us and to growth of TRU.

Nimitta Bhatt & Dr. Ashwin Patel

Annual Report 2017

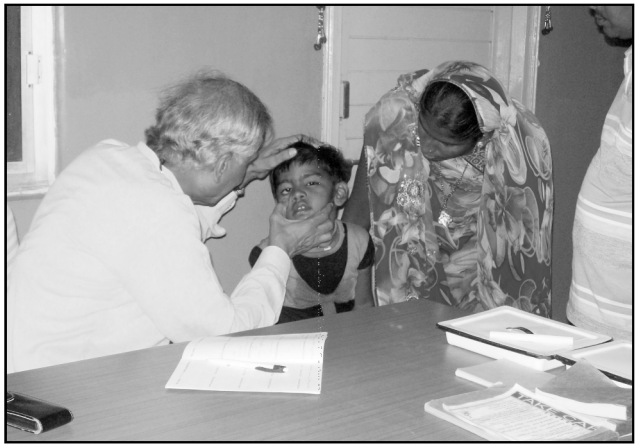
Introduction :

We started way back in seventies with a view to reduce burden of morbidity and hence improve quality of life for disadvantaged people of the remote rural communities. Great deal of efforts and time has gone by and we have been able to help many poor, emarginated people in difficult terrain and unreached areas.

Some of our well-wishers and friends have told us number of times that in every Annual Report, we should give some description of our past involvement in public activities. Following is a brief description in response to their suggestion.

Beginning with our core members working for people in various parts of the state and country we have made enthusiastic contribution to health movement in the state and also by participation at national level. Our only resource in the beginning was knowledge and enthusiasm to do something by choosing a different path from the mainstream. To look at some important contributions please see the following:

We were part of the socio-political movement led by Jay Prakash Narayan. Dr.Ashvin had responsibility to organise health programs in Arunachal Pradesh during 1972 to 1975 as part of the National Integration Program of Akhil Bhartiya Shanti Sena. Peaceful activities against political emergency, Nav-Nirman anti-corruption movement and participation in Gandhian study centres were part of our early involvements (1975 - 76).



Thereafter we spent considerable time consistently (1975 to 1998) in networking for health and in pioneering / establishing and spread of community health approach at national and state level through Medico Friend Circle and Voluntary Health Association. First community health project in Gujarat was started by us in 1977 in rural-tribal area of Bharuch district on health and women's development project as part of Prayas and ARCH. Through Gujarat Voluntary Health Association (1977 - 1998), we worked towards Training of Community Health trainers for a large number of NGOs, pioneered Community Health Movement in Gujarat, Rational Drug Therapy and related advocacy activities in NGO sector, worked towards changing focus of target oriented Family Planning activities / program of the state and central govt, reached concepts in Women's rights movement to enable grassroots activities for last woman in remote communities for basic human rights of the women, etc etc.

Dr. Ashvin Patel also established another Trust called Low Cost Standard Therapeutics with other three friends to ensure good quality generic essential medicines at low/reasonable price to the people through NGO initiative. We have then spear-headed educational activities for correct use of medicines among medical and paramedical groups and also among the end consumers i.e. the people; including co-editing and establishing a magazine called “Aapnu Swasthya” as part of the effort to empower and update people for medical knowledge about their illnesses.

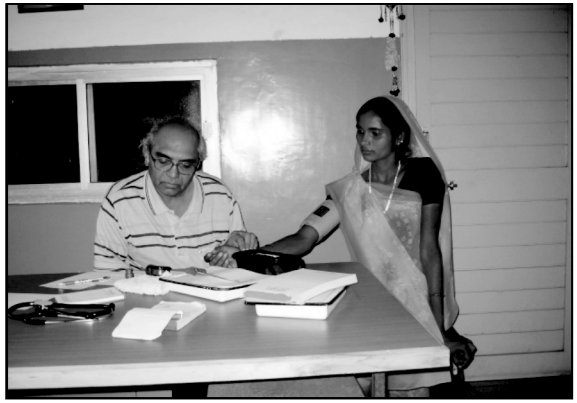
We also established another Trust called Society for Rational Therapy along with many other friends including their monthly bulletin viz Bulletin of SRT which aimed at continuing education of the medical doctors and others about correct / rational therapy for various illnesses.

GVHA Annual Convention - Training of NGOs in NCDs

Trust for Reaching the Unreached (TRU) 1987 onwards :

Community Health activities for various unreached people in PanchMahals district were established by founding the present trust. We have worked with several groups of people and community with a basic understanding that true empowerment of the community takes place when right kind of processes are set up to enable correct decision making in matters of health. Since beginning we would work with specific group of villages for a period of 6 to 10 years, evaluate the results and then switch over to a new area. This included 40 villages around Shivrajpur area, 60 villages in remote Pavi-Jetpur taluka and 15 villages around Bakrol area of Ghoghamba Taluka. Women's self-help groups and promotion of girls' education program, improving level of formal education of the children in primary and now in secondary and higher schools are organised.

As part of this community services we also had established secondary health care services by inviting various consultants to our Shivrajpur centre. At various time-points we provided gynecologist's services for many years. Ophthalmologist, General Surgeon, Ear-Nose-Throat Specialist, etc not only visited our centre by camp approach, but they conducted surgeries for patients referred free of cost / at very nominal rate in Vadodara. Services of a Dental Surgeon have been a regular feature even today because it is still a primary health care issue. Over a period of time people's mobility and access to nearby secondary referral units in Halol, Godhra, Bodeli and Vadodara increased due to advent of more means of transportation and better road infrastructure. We no longer hold camps for the medical needs which may require specialist attention. We started referring individual patients to these services from our clinics.



Dr. Chauhan worked as a Gynecologist for many years.

TRU worked for victims of Kutch Earthquake affected areas of Rapar and Bhachau Taluka in 2001 - 2006, Rehabilitation of victims of Riot affected areas of Sabarkantha 2002 - 2004, Participated and led many national and international advocacy programs and conferences for basic human rights of the people and specifically of the women at large.

Community Mental Health initiative was started since 2004 - 05 aiming at community based rehabilitation (CBR) of the patients. It includes identification, treatment and Community Based Rehabilitation (CBR) of patients as well as specific Mental Health Awareness programs in the area. We started this work in Shivrajpur area of Halol taluka and now we have extended to cover all villages of Halol, Jambughoda, Ghoghamba and Kalol Talukas.

Treatment of mental illness has so far been hospital oriented only. Patients with severe mental disorders are generally outcast from social milieu and happen to permanently remain in hospital wards only. Thus they increase load of work in hospital care. It is advisable that the patients are treated within the community and get rehabilitated within families. The hospitals are to be reserved for tertiary care. More than anything the challenge in Mental Health Program is to increase access to medical services and enable the community to take care of the patients by overcoming stigma. We have strived hard through various activities to affect people's minds on this.

Having lived through so many programs and activities we feel extremely happy that the society has helped us and the core of the TRU activities have continued without a break physically or by way of lack of funds. TRU also has travelled a long distance of time.

Well-wishers and donors are the backbone of TRU.

GENERAL HEALTH CARE

As it has followed from the past so many years' history, we have continued our presence in the area through our general health dispensaries in four centres. We find that most of the knowledge imparted by our community health network in particular field area is retained by the people. We have witnessed the change in knowledge, attitude and practice of the health behaviour of the community. We also find that our dispensaries are still the primary referral point for medical difficulties of the people. Despite of the fact that there are some secondary medical facilities in the Halol and Bodeli town, people keep visiting our dispensary to understand their illnesses and find a proper way out for overcoming the illness. Following is the synopsis of patients received at our various centres in the area.

Synopsis of patients treated at TRU centers :

OPD Center Name	New Patients		Old Patients		Total Patients		Grand Total
	Female	Male	Female	Male	Female	Male	
Shivrajpur	865	903	1392	1505	2257	2408	4665
Talavdi	124	146	0197	0236	0321	0382	703
Waghbod	261	231	0389	0362	0650	0593	1243
Bakrol	262	244	0434	0571	0696	0815	1511
Total	**1512**	**1524**	**2412**	**2674**	**3924**	**4198**	**8122**
Dental Patients at Shivrajpur	34	54	26	51	60	105	165
Dental Patients at Vadodara	224	215	146	110	370	325	695
Total Patients	**1770**	**1793**	**2584**	**2835**	**4354**	**4628**	**8982**

As of now we are at a crucial place in the network of medical services of the area. TRU clinic has better-qualified doctors in comparison to those in a radius of 20 kms from Shivrajpur. We still find that people depend upon the advice given by our senior physician for many illnesses. It is people centric place where people get proper guidance about most common to severe diseases. More important is the explanation about what is happening to the patient's body. Simple diseases like diarrhoea or complex diseases like cancer are explained in detail to the patient and relatives. How the disease

would progress and what are the treatment options available is also explained. Places where the patient would get rational and low cost treatment are also suggested. Often the patients do not have adequate money for carrying out expensive investigations suggested by the other doctors in nearby towns and cities. At such time the patients are advised about most crucial investigations and proper treatment. All these things are quite appreciated by people.

Break up of illness among new patients:

Disease Category	Female	Male	Total
Gastro-intestinal	9%	14.5%	11.5%
Respiratory	18%	23.5%	20.5%
Urinary Tract	0.7%	0.4%	0.6%
Skin	18.7%	20.6%	20%
Gynec	14%	--	7.6%
Aches and Pains	17.8%	22.3%	20%
Nutritional Deficiency	14.5%	4.9%	10%
Chronic Conditions	7.5%	13.8%	10%

We even get patients from long distances like Chhotaudepur, Kavant, Bodeli, Godhra, Sankheda, Savli, Vaghodia, etc. Some patients who may have a treatment option in cities like Ahmedabad and Vadodara also come to our clinic just to understand the body and disease processes.

CHV Training in the Bakrol Community Health Project (1998 - 2006)

MENTAL HEALTH CARE

Our intervention for helpless patients suffering from mental illnesses is now more than 13 years old. After the initial efforts in integrating Mental Health into Community Health program of TRU and also similar effort through training of GOG health cadres of three blocks under the District Mental Health Program we realised that people's suffering is very severe. TRU can work by integrating mental health components into general health care activities in our own work areas. But we cannot wait till the govt takes it up as part of their general healthcare activity in a serious manner so as to reach out help to the poor and remotely based patients. So when govt officials motivated us to take up a program through them, we decided to prepare TRU cadre to take care of the MH issues in the area. Govt gave us a letter saying that ASHA and other govt staff at periphery can be part of this TRU's MH program, but did not encourage their cadres to work for MH activities. As such we had to strike a balance by having village level Link Workers and Guides to carry out all activities. Naturally the ASHAs, AWW, MPWs, ANMs, MOs, etc though sensitized and trained for MH activities do not help this program. Thus TRU manages this program lone-handily having approx. 25 part-time workers to carry out all activities related to this Community Mental Health Program in four blocks of rural-tribal district of Panchmahals.

Below is the population covered by this program.

Name of Taluka	No. Of Villages	Population coverage
Halol	142	237959
Jambughoda	055	042476
Ghoghamba	095	218467
Kalol	076	216371
Total	368	715273

This program aims at achieving Community Based Rehabilitation of the Mentally Ill patients. Thus all activities beginning from identification of patients, bringing them into fold of medical treatment, providing free of cost treatment, retaining the patients till they regain the mental soundness and integrating back into their social and productive roles in the community are carried through our village based cadre of workers. A psychiatrist and a clinical psychologist help them by providing / prescribing medical treatment

to the patients. We have travelled a long distance in this project since 2004-05. Our approach to the problem has also evolved over a period of time. Our awareness programs started in 2004-05 were targeted to elevate the general awareness among the masses we served. While what we do today is to identify the problem cases and carry out targeted awareness and stigma reduction activity. Below is the synopsis of this change:

Activities in 2004-05	Activities in 2014-17
Approach through Community Health Workers during Maternal Child Health program in our Community Health Project area.	Approach through govt health workers and through village based cadres specially trained for Mental Health care and support counseling activities
Research and studies to know the effects of mental illness upon a patient & factors affecting mental health.	House to house identification of patients at village level and bring them into treatment fold of TRU
Pamphlet distribution about Mental health services through Haat (local Bazar), Mela, Exhibition and Padyatra in and around the area under focus.	Extensive pamphlet distribution and display of posters, focus group meetings etc for MH Awareness among general community in proj. Area
Faith Healers' meeting and awareness/ sensitization about MH needs of the community	Activities to spread information about MI and increase people's access to medical services for MI through community leaders
Generally informing the family about the services available and directions on how to reach services	Activities to reduce stigma among the care-givers & support counseling to cope with illness in family
Sensitization of the govt health cadre at village level as a one-time activity	Sensitization, regular follow up and contact with the govt health cadre at village level consistently
Work in centres of TRU	Work in Referral hospitals at taluka level
Work with adolescents mainly for adolescent issues related to MH	Hig-school going adolescents are sensitized about MH needs of the community and how they can help

We are amazed to see what conditions the poor patients live in when they suffer from mental illness. The suffering is endless and the societal factors are gruelling for the patients. The rural tribal community generally does not report any mental problem unless it is paralysing their routine life. The triple burden in the family of a person with severe mental disease is enormous and devastating in many ways.

Ramshankar is a farmer having a half acre land received as ancestral property among three brothers. He makes his living partly by tilling the land growing Maize and Tuver. His mother is old and father died long ago. His two brothers have migrated to the city area in search of livelihood in construction work. Ramshankar's son is a school dropout, now working in a factory as casual contract labourer and living near the factory area with friends in similar work. The son generally is not seen visiting the village or is not found helping the father in any way.

Thus Ramshankar is all on his own taking care of his wife, one daughter and his mother. Daughter's marriage is decided to take place in the next year. Now Ramshankar does not have funds to get through the event and so he is worried. He asked for help from his brothers and the son without any success. He is too worried because he also has to repay the loan from a local money lender.

He had no other option but to lease his farm and somehow manage the event. The brothers came to know that he has planned to lease/mortgage the land, came fighting with him and called bad words and also scolded the mother for it. Ramshankar was listening and became quiet for long time. Daughter's marriage is still way off and the father slipped into depression.

Months went by but he did not come out of his illness. He even stopped looking after his farm as well as himself. No grains, no work, no opportunity, the daughter would go for casual labour in the village to get some money for the daily living. She also needed to look after the father for his daily chores such as bathing and feeding etc. Many a times he would be violent and had to be tied to the tree nearby with help of neighbours.

Most relatives also took side of the other brothers saying he should not have worked towards mortgaging the ancestral land and that he should have taken loan from others in the village, etc. No sympathy for the situation and no active help also. He is all by himself suffering from illness and the family of three slipping into the trap of poverty..The mother care-giver is pretty old and weak to look after the middle aged son. The daughter bears the burden of life of the family by being a casual labourer only bread earner, a care-giver for her father and struggling to find solution for the problem.

Hopeless as she is, she tries most traditional methods to save the father through black magic at the advice of the villagers. These methods proved to be useless. The TRU's mental health services are in place in the area but many villagers keep talking against the medical solution to the problem. She is not too well equipped to take a decision with confidence.

TRU Link Worker came to know about her problem during one of his village visits. He visited her house, met the mother who hardly was able to talk or believe what was said due to faith in black magic. The girl has gone out to work when the TRU MH Worker visits the house. As the worker persistently kept telling the mother about importance of medical assistance, she once mentioned it to the daughter.

The girl saw some hope and thought of trying this option also. She managed to meet the worker by visiting the MH Clinic as was mentioned in the leaflet TRU worker had left with her mother. She came to know that she could keep up all other forms of treatment (mainly faith healing practices) while the patient would be on medical treatment.

She decided to bring the father to MH Clinics. He was prescribed medicines and certain other counselling points were provided to the care giver. Ramshankar started getting medicines as well as ongoing counselling at the clinics. He showed significant improvements within 3 months of taking medicines. His symptoms almost disappeared and his lost confidence started coming back. Soon he thought he is alright and so left the medical treatment under one or other pretext despite of a lot of explanation by the MH worker as well as the psychiatrist. Once again after sometime he started showing symptoms, the illness reverted. The TRU link worker again worked with his daughter and managed to restart his treatment after a blank spell of 6 months.

We are left asking oneself about

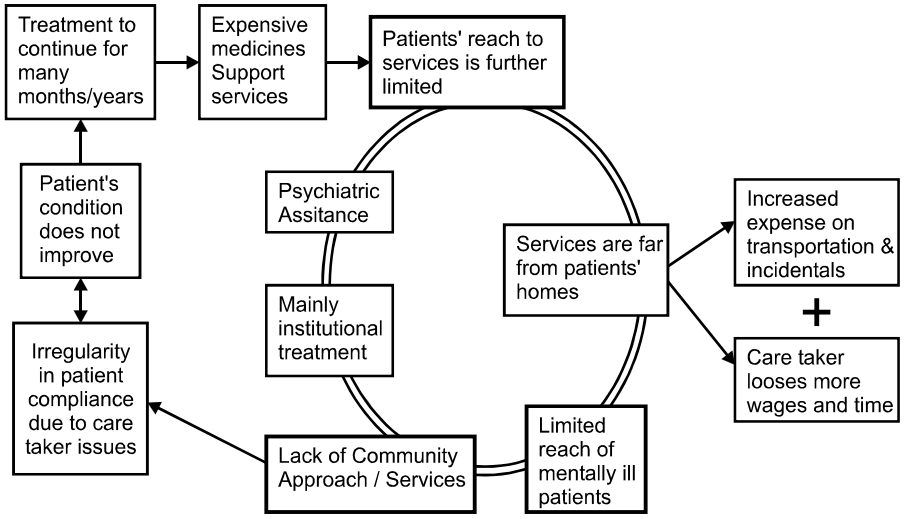
a. ***Who is responsible for Ramshankar's illness ?***
b. ***Why the family does not access modern medical care ?***
c. ***Why relatives not support Ramshankar's daughter ?***
d. ***Why do the patient and his relatives stop medical assistance before the treatment would reach a logical conclusion ?***

We have no standard solution or answer to most questions because the answers are different from situation to situation, from patient to patient and from community to community. But to generalise we can say that the hopeless socio-economic conditions usually are the triggering point for starting the illness. Thereafter delay in getting proper treatment is responsible for continued or worsening situation which gets complicated due to faith in traditional healing methods and poverty.

Further the people's lack of readiness to accept modern healing methods also plays a large role. Good amount of awareness generation through various public programs is done by TRU. But unlike the general health issues, the number of MI patients is low. So cluster effect for awareness generation resulting into changed practice also takes a longer time.

Thus though TRU takes care of hundreds of patients from all over the talukas, at micro level there may be only 3 - 5 patients in one village. So size of the problem is beyond appreciation and notice of the general masses. TRU is motivated to look into this issue because the morbidity and socio-economic impact of this illness is bigger compared to same by any other disease.

Web of issues that needs to be broken in order to increase Patients' access to mental health care



The Psychiatric OPD

In the following table, Project area denotes the respective taluka patients and outside project area means patients coming from outside the respective taluka. Jambughoda is a small taluka having 4 times less population than the other three blocks. So naturally patients are less compared to those in the other OPDs. But it is significant to note that the Jambughoda OPD receives more patients from outside the taluka. We receive patients from Bodeli, Pavi Jetpur and Sankheda, which are part of Chhota Udepur district.

Synopsis of patients helped by our MH Clinics: (2017)

OPD Center Name	New Patients		Patients Revisits		Total		Grand Total	Average Patients
	Female	Male	Female	Male	Female	Male		Per Clinic
Shivrajpur Project area	42	45	693	1074	735	1119	1854	
Shivrajpur Outside Project area	06	10	26	73	32	83	115	
Halol Project area	43	48	796	1011	839	1059	1898	
Halol Outside Project area	21	36	189	169	210	205	415	
HalolTaluka total patients	**112**	**139**	**1704**	**2327**	**1816**	**2466**	**4282**	**89.2**
Jambughoda Project area	14	25	324	356	338	381	719	
Jambughoda Outside Project area	17	38	417	503	434	541	975	
Jambughoda total Patients	**31**	**63**	**741**	**859**	**772**	**922**	**1694**	**70.6**
Ghoghamba Project area	91	107	867	1179	958	1286	2244	
Ghoghamba Outside Proj. area	51	54	343	271	394	325	719	
Ghoghamba total patients	**142**	**161**	**1210**	**1450**	**1352**	**1611**	**2963**	**123.5**
In the project area - All centres	**190**	**225**	**2680**	**3620**	**2870**	**3845**	**6715**	
Outside proj. area All centres	**95**	**138**	**975**	**1016**	**1070**	**1154**	**2224**	
Total All centres	**285**	**363**	**3655**	**4636**	**3940**	**4999**	**8939**	
All centers, All patients	**648**		**8291**		**8939**			**93.1**

OPD Center Name	New Patients		Patients Revisits		Total		Grand Total	Average Patients
	Female	Male	Female	Male	Female	Male		Per Clinic
Kalol OPD Patients	44	66	82	155	126	221	347	14.45
	110		237		347			

The Kalol taluka work is relatively new and so there are a number of problems like frequent changes among staff, the internet based approach adopted for more than a year did not work properly, the govt collaboration regarding medicines also did not work out so good, etc. Of course for now since Nov 17 we have a psychiatrist working regularly for the Mental Health OPD at Kalol. We found that the Halol taluka patients have reduced in this year. This is because of intensive efforts for last 8 years, most of the eligible patients have come under our loop. We have now only newer episodes of patients being identified and coming as new patients in OPDs. In all TRU conducted 120 clinics in the project area in the year 2017. Ours is a fortnightly Psychiatric clinic on alternate Sundays every month.

The table implies that the average patient attendance of MI patients per clinic is 93 for all four centres except Kalol clinic. This is higher than the previous year's average (84.1). The Kalol OPD is a fairly new OPD and is not quite well supported by experienced staff all over the taluka. The average presence at the Kalol OPD works out to only 14.5 patients per clinic. We hope to catch up in the year 2018. Among all centres Ghoghamba poses special attention because the need of this total tribal taluka is great as seen by number of patients attending the clinics (Average of 123.5 patients per clinic).

Further break up of patients attending all clinics of TRU according to severity of diseases they suffer from implies that we have 60% of patients suffering from major severe diseases such as those listed below. As compared to that we have 40% patients who suffer from the common mental disorders.

Disease wise percentage break-up of patients (project area), 2017:

Severe Mental Disorders	Halol	Shivrajpur	Jambughoda	Ghoghamba
Schizophrenia	25 %	22 %	25 %	26 %
Psychosis	19 %	26 %	31 %	45 %
Depression	41 %	44 %	31 %	24 %
Bipolar Mood Disorder	15 %	6 %	13 %	05 %
Mania	--	2 %	--	--
Total SMD patients	100%	100%	100%	100%

Through our field based activities we have tried to rehabilitate these patients into their communities. This is called Community Based Rehabilitation (CBR). It involves working with families in how to help the patient to resume all activities he/she was doing before falling ill. This is based on the basic criteria set by IDEA scale. It has four prongs. They are: Cognitive ability, socialisation ability, extent of productive activities and ability to perform daily routine activities. Every patient on medical treatment loop is evaluated by field workers every month and then every three months the information about patient's progress towards rehabilitation is reported based on the above criteria. Whether the patient continues medicines or not as also the problems and side effects encountered, etc is reported.

Community Based Rehabilitation (CBR)

CBR is carried out for all patients suffering from Severe mental disorders. We calculated CBR for patients who registered in our OPDs during 2014 upto June 2017. It is expected that the patient should have taken medicines for at least 6 months and should have undergone the counselling sessions by our psychologist and the field workers as and when organised.

Following data gives extent of Community Based Rehabilitation (CBR) achieved for Severe Mental Disorder (SMD) patients from January 14 up to June 2017. Total SMD during this period were 1108. Out of them 103 either died or out-migrated from the area. Thus we had 1015 patients for whom all efforts were made by our field teams and the psychiatrist to achieve CBR. As we see in the following table we could achieve 78.7% rehabilitation among SMDs during this period.

CBR Achieved	Total
Total SMD Patients Jan 14 to Jun 17	1108
Not Reachable (migration, death)	0103
Workload for CBR during said project period	1015
CBR achieved and maintained as of Dec 17 for SMD patients (upto June 17) - Project Area	0799 (78.7%)
CBR not achieved	216 (21.3%)

On an average we consider that the patient who attends the clinics and field support for 4 – 6 months can achieve CBR, though he/she needs to continue treatment for maintenance of the biological / mental condition.

Many patients stop medicines once they feel little better or if they have overcome and improved upon the symptoms which burden the family too greatly. The patients who do not take medicines are not forgotten by TRU net. All of them continue to be in loop and their families are helped by counselling efforts of our field workers. Major emphasis is to put the patient back to his routine activities along with medicine intake. Family members are trained for making the patient carry out his/her daily chores in a stepwise manner. This is called training for Activities of Daily Living (ADL). Our ADL intervention includes not only self-care (bathing, cleaning, eating, tidy look, etc) activities for the patient but also includes steps required to put the person back to his/her socio – productive role into the family.

Identification of new patients

There are many patients who reach by self-referral to the Psychiatric clinic. During regular visits to the villages by the field staff, they are able to identify many patients who have not reached the MH clinics. These new identifications by the field staff may be the ones already reluctant or pessimistic of disease process or are not able to accept it as an illness which the doctors can treat. Once identified, the patient remains in our loop for ever, Efforts to pursue the family to access medical care or by support counselling go on. The family is to be supported by to family members.

The data for the last three years is analysed for better understanding of the processes at grassroots. Patients identified in 2014, 2015 and 2016 calendar years are expected to reach the Psych clinics. We have evaluated the lists at the end of Dec 17. We found the following reasons for not reaching to the OPDs.

Patients identified during calendar years 2014-16 by field visits:		724 patients
1.	Patients who reached the OPDs till end of 2017:	338 (46.7%)
2.	Not reached OPDs because symptoms are under control:	61 (8.4%)
3.	Treatment from other medical sources:	54 (7.5%)
	Total of patients who are under care by TRU staff	**453 (62.6%)**
4.	Out migration from field or Death:	39 (5.4%)
5.	Does not want to take medicine/treatment by choice	27 (3.7 %)
6.	No family members to take care of the patient	14 (1.9 %)
7.	Family members' total negligence for the patient	34 (4.7 %)
8.	Staunch believers in faith healing	48 (6.6%)
9.	Other reasons / no reason found for no treatment	80 (11 %)
Those who could not reach any Psychiatric/ medical care		**242 (33%)**
10.	Patients discovered in last quarter of 2017	29 (04 %)

We can infer from above points no 1 to 3 that 453 (62.6%) patients are either better due to disease process and field support counselling or due to taking medicines either from TRU clinics or from other sources. We believe that after many years of efforts in MH awareness and stigma reduction activities a lot of people have changed their belief structure and have reached the OPDs by self referral.

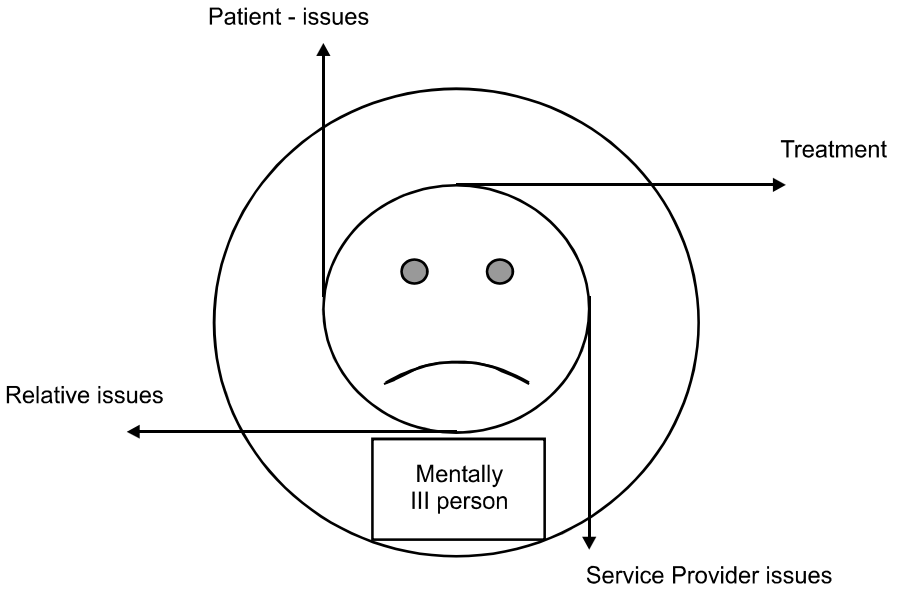
We can also infer from above that 203 (28%) patients somehow could not be brought under treatment either because of lack of social support reasons or because their faith in traditional healing / not convinced about modern medicine for this particular category of illness. The stigma is also there. The last category of patients who are recently found says that TRU's efforts to bring these 29 patients under treatment are still on and they will be soon under the fold of treatment.

The above data is only for those identified newly in the field before reaching any treatment help. Before we started our intensive mental health services negligible percentage of patients used to seek medical care (less than 5%). Due to availability of medical mental health care in vicinity and mental health awareness program for last many years we are happy that the 63% of newly identified are covered under medical care, though TRU OPDs receive many more patients by self-referral.

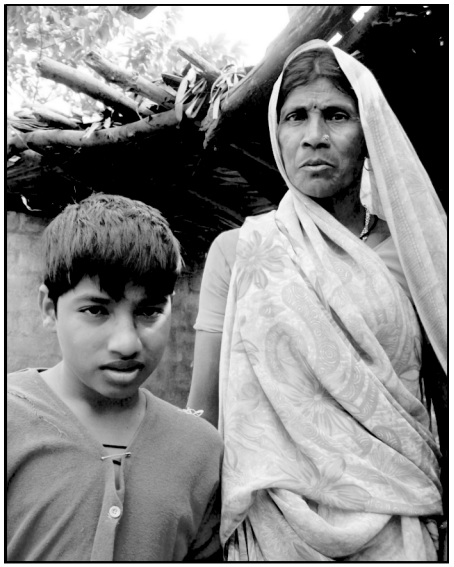
Project area:	New Patients in 2014 = 616,	New Patients in 2015 = 659
	New Patients in 2016 = 759	Total new patients (14 – 16) = 2034

Factors leading to continued mental illness

Patients suffer because there is a great amount of social stigma resulting in social and physical negligence. It is complicated because of lack of knowledge about the disease condition. Typically community mainly thinks that the condition of the patient is not because of any treatable biological condition but it is happening because of previous sins or any black magic prevalent in the area. Thus the project faces direct confrontation with the belief system and taboos for medical treatment. Additionally the patient is a burden in the family. Due to his/her illness there is not only loss of wages of the patient himself/herself, but also that of the care-taker. As the patient's modified behaviour results into damage to social and economic milieu of the family, they lose reputation and face discrimination. In the community where all members of the family have to work for livelihood, this is a great loss. Thus the patient is blamed and faces negligence within the family.



Patient remains without treatment
if these issues are not
taken care of in time
and in right manner



Awareness programme for MH work

So unlike other health awareness issues this program requires special attention. To change people's belief system and demonstrate usefulness of medical approach for achievement of better quality of life for the patient and his/her family we have specially designed our awareness programs. Information dissemination to various groups in the community is required. Second, provision of regular and affordable medical (psychiatric) care to the people to create examples of successfully treated mentally ill persons in every village is helping a lot for facilitating patient to patient communication.

Over a period of time our MH Awareness program has changed its emphasis. Instead of focussing mainly on large and amorphous groups like people coming to haat (tribal bajar) or rally through the area we are now mainly addressing the organised groups like adolescents in schools, gram panchayats, village leaders, care givers as a group, etc. In previous approach there used to be a floating population passing through a particular place. They may be from long distances also. In the new approach we have well-identified groups which can be followed up for KAP (Knowledge, Attitude and Practice). The initial approach helped us to reach out information to many. But the recent approach helps us to identify people who can be evaluated for change.

Care - givers meeting at Shivrajpur

A simple tool depicting certain symptom complex is developed. Through home to home education program every house is visited by village based workers at least once in a year to impart general knowledge about mental illnesses and exercise the symptom check list to identify new patients of MI. We try to influence the community by approaching the Panchayat leaders, Govt health cadres at grassroots, Faliya leaders and care givers of successfully treated patients. We meet the high-school going adolescent groups to influence their social thinking and appeal to their sense of responsibilities towards MI patients in their vicinity.

Awareness programmes for mental health are carried out in High-schools of the area and also among all Panchayat bodies. Most govt health functionaries at village upto PHC level are also part of the awareness lessons. Wide variety of materials is distributed among the community members for helping them reach the medical services as early as possible. The leaflets contain exact information about where and when the psychiatric clinic will be held and also the phone number of the concerned field worker is printed on it. The time to reach health services after onset of disease is slowly decreasing. It was generally more than 2 – 8 years in the beginning of our work. Now a days it is ranging from 7 days to one year. Following is the synopsis of MH Awareness programmes conducted by TRU in the yester year.

Awareness Program at Ghoghamba

Sensitisation of Panchayat leaders

We have started this since 2014. During this project cycle for MH work we have covered all Panchayat bodies of the area. 76 Panchayat bodies of Halol taluka, 20 Panchayats of Ghoghamba taluka and 8 Panchayats of Jambughoda taluka have been covered. Approximately we could meet 2000 important persons of the area. This big effort has resulted into increase in number of patients and stability of patients in treatment. The Panchayat leaders were also surprised to know that there are many patients in their area who need such a treatment. Secondly when they were sensitized about symptom complex of mental illness they could refer some patients to the Psychiatric OPDs. We could also get some help from them regarding defaulting patients - rather the caregivers could be motivated through the leaders to reach the patient to psychiatric OPD. We also appealed that the wondering MI patients need to be reached to their homes and relatives should be convinced to come for treatment. The undue harassment of the patients could also be curtailed to a large extent by their help.

No of Panchayat bodies met with yearwise breakup		Panchayat members attending	Village leaders	Govt. Health functionaries	Total Participants
Year	Nos.				
2014-15	33	229	194	23	0446
2015-16	48	335	202	49	0586
2017-18	79	582	458	104	1144
	160	1146	854	176	2176

Panchayat meeting at Baska village, Halol taluka

High School students' sensitization for MH

In the year 2017 we covered 46 high schools in the Halol and Ghoghamba taluka. Over 3000 students in the age group 15 – 18 were sensitised for the mental health needs of the people. The students gave a post-test after the initial sensitization process and the best students in each school received certificate and prize. There was also an Inter-schools program at Shivrajpur center that was attended by more than 300 students and 50 teachers. There were competitions in slogan making, poster making and MH quiz. The students and teachers participated enthusiastically and best performances were awarded prizes.

Marks out of total 50 Post test for MHA	<20 marks	21-30 marks	31-40 marks	41-50 marks	Total Students
Result (17 - 18)	443	1505	1133	55	3136
Percentage result, 17 - 18	14.25%	48%	36%	1.75%	100%
Percentage result, 16 - 17	10.8%	51.2%	35.6%	2.38%	(100%)

Sensitization of Govt health cadre

We sensitize all health workers at village level through formal and informal interactions to explain the basics of Mental illnesses, how to deal with the MI patients, where the proper care is available, how the patient can be brought to the clinic and the approach for betterment of these patients. They are also paid an incentive for bringing patient to the OPDs. All of them have been elaborately explained about the socio-political and economic dimension of the illness. We try also to motivate the Angan Wadi worker, the ASHA worker, the Multi-Purpose health worker to identify such patients and bring them to the Psychiatric OPDs.

Awareness programme for AWW and other Govt. Health Workers

GIRLS' EDUCATION PROGRAM

This program is very much at our hearts and we feel very good that we are able to help many girls to achieve school graduation which they would have been deprived of if they were left on their own to attend schools. Thus we become instrument to open up the wider horizons for these first generation females to go out to complete school graduation.

New Admissions in June 17 (academic year 17 – 18):

Standard	From AKSK	Outside AKSK	Total
9	--	54	54
10	36	1	37
11	17	--	17
12	12	--	12
	65	54	120

Abhinav Kanya Shikshan Karyakram (AKSK) : 2005 to 2017

Year	Std 5	Std 6	Std 7	Std 8	Std 9	Std 10	Std 11	Std 12	Total
2005-06	01	05	00	03	02	00	00	00	11
2006-07	01	00	05	08	03	02	06	00	25
2007-08	STOPPED		02	38	12	04	07	05	68
2008-09			01	21	34	12	03	06	76
2009-10			STOPPED	36	23	33	11	05	108
2010-11				23	34	25	24	11	117
2011-12				23	36	30	12	24	125
2012-13*				00	43	33	15	15	106
2013-14**				00	31	36	15	15	97
2014-15					49	25	24	14	112
2015-16					30	38	18	21	107
2016-17					38	31	12	18	99
2017-18					55	36	17	12	120

* Std 8 is made part of primary sections of all schools in Gujarat

** More local admissions into the school - govt rule affects numbers at GEP

All the above figures show strength in GEP at the end of the year, i.e. December every year. Generally we have more girls at start of the year. Approx 5-10% of them drop out during the course of the year for social reasons.

Results of the April 2016 Annual exams :

Below is perrformance ranks of our girls in respective classes in the KVS High School.

Stan-dard	Rank in Class	Name	Marks obtained	Perce-ntage	Belongs to
9A	First	Nayak Renuka Arvindbhai	470 out of 600	78.3	AKSK
	Second	Rathva Kailas Viththal	458 out of 600	76.3	AKSK
	Third	Thakor Manisha Vijaysinh	455 out of 600	75.8	AKSK
9B	First	Baria Arti Prabhatbhai	500 out of 600	83.3	Not AKSK
	Second	Rathva Rinku Ramlabhai	472 out of 600	78.7	AKSK
	Third	Rathva Sapna Natubhai	469 out of 600	78.2	AKSK
9C	First	Baria Ansuya Anopbhai	475 out of 600	67.9	AKSK
	Second	Baria Sharmishtha Dinesh	456 out of 600	65.1	AKSK
	Third	Rathva Manisha Narvat	429 out of 600	61.3	AKSK
9D	First	Jadav Harendra Bhimsinh	426 out of 600	71.0	Not AKSK
	Second	Rathva Niru Naginbhai	423 out of 600	70.5	AKSK
	Third	Tadvi Urvashi Ishvarbhai	420 out of 600	70.0	AKSK
10	First	Rathva Niru Viththalbhai	409 out of 600	68.2	AKSK
		Rathva Aasha Nareshbhai	409 out of 600	68.2	AKSK
	Second	Rathva Kalpana Ganpat	399 out of 600	66.5	AKSK
	Third	Rathva Rita Varsanbhai	394 out of 600	65.7	AKSK
11	First	RathvaJyotsnaChandu	606 out of 900	67.3	AKSK
	Second	RathvaKokilaJania	590 out of 900	65.6	AKSK
	Third	RathvaKajal Dinesh	565 out of 900	62.8	AKSK
12	First	Baria Lakshmi Kanubhai	567 out of 700	81.0	Not AKSK
	Second	Baria Urvashi	548 out of 700	78.3	Not AKSK
	Third	Rathva Nuri Shankar	534 out of 700	76.3	AKSK

It is interesting to know that the girls in our program have excelled in their respective classes in KVS High School. Following Result (School classes 1st to 3rd highest) is noteworthy.

Comparison of the Board exams of rest of the school students and results for Abhinav Kanya Shikshan Karyakram (AKSK) helps us to see that how girls can perform better if they are given a good chance to focus on study.

School result April 2016 Board exams:

Std 12th 83.3%, AKSK = 100%

Std 10th 57.2%, AKSK = 96.3%

%age Result, Academic year 16 - 17	Std 9	Std 10	Std 11	Std 12	Total
Less than 40%	00	00	00	00	00
41 – 50%	05	12	01	02	20 (21.7%)
51 – 60%	19	09	05	04	37 (40.2%)
61 – 70%	11	06	06	06	29 (31.5%)
71 – 80%	00	00	00	06	06 (6.5%)
More than 80%	00	00	00	00	00
	25	27	12	18	92 (99.9%)
Details Not available	13	09	00	00	All passed

AKSK result = All (100%) passed except one girl, who failed in one subject - 10th Std

At the start of the second semester we are left with 110 girls at the end of the academic year in our residential program. Some girls dropped out for their own reasons. Till the end of December 17 the school schedules are running well. The new girls have made friends with the older girls in the program. There are three teachers to take care of the supplementary teaching of school curriculum. The teacher for science maths and English is the most difficult mobilisation. We have been able to get one person MSc B.Ed for teaching Science and Maths. But there is no one to teach English.

In the month of February 17 the girls visited the Sun Temple of Modhera and Mira Datar, a Dargah that stands where hindu and muslims both go for getting rid of their issues. Persons mentally unwell also visit this place. So GOG has started a clinic near this Dargah with the cooperation of Dargah management to provide medical treatment to these patients. So it was interesting for us to show how well the religious rituals and modern medicines integrated to give relief to the patients. All our mental health project workers also visited this place along with the girls. All processes were understood well

by the group. There were some issues like tyre punctures on the way and the excursion had to be limited to the above two places only.

After graduation in GEP

Hopes of Tomorrow

Many of them continue their college education or vocational excellence. Many become professionals such as village tailors, shop keepers, Anganwadi Workers, ASHA workers, Mid-day meal Coordinators, foresters, Nurses, school teachers, Talati, etc etc. Most important is that their stay and study makes them eligible for many more options than their friends in villages. We found that out of those who graduate from GEP in Higher Secondary Board - i.e. Std. 12 at least 50% keep working outside their immediate homes. This way they are able to help economic upgradation of the family.

What after 12th std in GEP: We were generally interested in knowing how our girls perform after accomplishing 12th std graduation from GEP. We found that at least 50% work outside their homes also

	Total Girls	B.A.& Beyond	Oth Study	AWW	ASHA	Comp Work	Forest Guard	Tailor ing	Peon	Traffic police	Pvt Job	Nurs ing	At Home
07-08	06				02		01						03
08-09	06		00	01	01						1 KG Teach.		03
09-10	05	02	00	01									02
10-11	10					01					01		09
11-12	19	01			01			06			03		08
12-13	14							02	01	01	03	00	08
13-14	13							02			02	01	08
14-15	14	03						01				00	10
15-16	21	09	03					00				04	05
16-17	18	07	02					02				01	06
Total	126	22	05	02	04	01	01	13	01	01	08	06	62
%Age		17.5%	4%	1.6%	3.2%	0.8%	0.8%	10.4%	0.8%	0.8%	7.9%	4.8%	49%

ABHINAV BAL SHIKSHAN KENDRA (ABSK)

This is a new program at Shivrajpur premises. It has roots in the Manas Day Care Centre we used to run at Halol. The previous year ended after Mid April. The centre at Halol closed on 23rd April and reopened on 5th June 2017. As informed before we closed the Halol centre and shifted it to our Shivrajpur premises.

We have at present a mixed group of normal pre-school children and the Mentally Challenged children of the same/similar mental age. It has been fun for the children and good amount of learning takes place in this mixed group. We have 7 MR children and 25 normal children all having mental age between 3 5 years. i.e. Physical age of normal children is 3-5 years (pre-school age). The physical age of MR children is obviously higher while their mental development is like a 3 year old normal child.

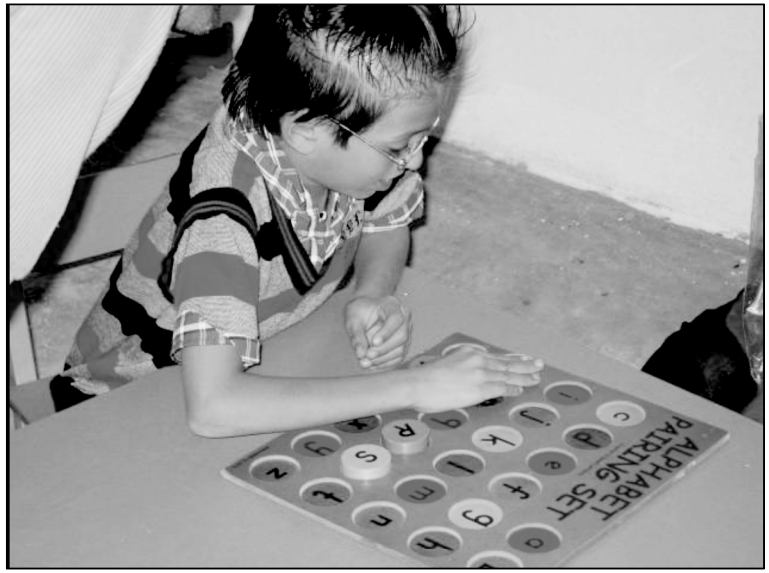
We have two teachers for normal Balvadi children, one part time special education teacher and one helper who work as staff for this program. All of them have been trained for Montessory pre-primary education short course as part of govt training of teachers.

When we restarted in Shivrajpur we worked upon our observation that it is theoretically apt to bring up the MR children with normal children of same age. Usually children in schools are having same physical age. When the MR children attend school with normal children of similar physical age, we see that they are neglected or labelled badly. Thus learning does not take place but they start developing some kind of a complex.

We believe that the children having similar mental age can better play with each other and some amount of learning both social and cognitive can take place faster. The MR would feel at par with these smaller children and the normal smaller children learn about the challenge and get an exposure to the development challenge of these mentally retarded children in the formative years of their life.

As we started with the above approach, we have observed all the children closely. We are happy that the objective of helping the MR children with basic life-skills is easier to achieve in such a group. Even MR children have started learning routine mannerism of daily life, e.g. saying “Namaste” with folded hands, welcome when someone is coming, saying and waving “Avjo” while departing, food-spilling while eating has stopped, drinking water without getting wet, started speaking in sentences, pronunciations have improved, scribbling on paper, copying alphabets, and numbers, conceptualizing of numbers has started (1 3), knowledge of animals, birds, vehicles, mixing and playing in a group, etc etc. For us this is great because we found it extremely hard and had limited success to teach the above skills even after two years in Manas at Halol.

Having been encouraged at this short experience, we see a substance in our approach and would keep experimenting on the same lines in future also.



ABHINAV SHIKSHAN SANKUL

This year we have accomplished the extension of the buildings in Shivrajpur premises. The Education Complex is built separately. We hope to add a mini theatre and an indoor sports complex for the girls. We shall be able to screen educational films obtained from Child Film Society and Bollywood. Games like table tennis can be played in the hall specially created for the same. If we get a proper coach, we shall be able to develop many games over a period of time.

As part of comprehensive education for the children of this area, we have also started a Balvadi called Abhinav Bal Kendra. The play-ground for small children is also made part of the Educational complex.

Students of TISS

Five Post graduate students of Tata Institute of Social Sciences, Mumbai visited us for one month as part of their field internship. They were second year students of M.S.W. course with mental health as a special emphasis.They joined our field workers for various activities and learnt about the grassroots factors affecting mental health of the people. TRU purposefully assigned them to study failures and fallouts from medical and support treatment net of TRU. This was with a view that they could learn from the process in a better way. They also helped in our school health program where school students participated in competitions of four kinds such as drawing, slogan making and quiz about subjects of MH Awareness.

CONNECTING WITH FRIENDS AND WELL WISHERS

As TRU has diverse programs and more and more people are finding it an interesting intervention to study, we get many visitors to the organisation. They include donors, friends, well-wishers, other NGOs, students and other individuals. Family members consistently visit us and take interest in all the happenings and help in many ways to the TRU team. They also help mobilising donations and also help us to keep up the enthusiasm. The friends like Dr.Malti Patel, Mr Nandkumar, Dr H.M.Patel, Shri Jagdish Patel, Harikrishnabhai, Dr.KaushikRathod, Dr.NayanSwadia, Dr SiddharthBartake, Dr PritiBartake, Dr.Rajul Desai, Dr, ArunPhatak, Dr VidyaPhatak, are some of our distinguished well-wishers who took out time to visit Shivrajpur for witnessing our activities. Ms Gita Shah, Shri Mukesh Shah, Shri Jayendra Bhatt, Nayana Bhatt, Shri Mukesh Banker, also came to Shivrajpur and gave us a sense of belongingness in the process. Most of the distinguished doctors and friends visited us along with their spouses. This was very encouraging for all of us. This year most of our urban staff along with their spouses and children also made a visit to Shivrajpur and felt connected. Similarly some of our rural staff and their spouses also met the later with warmth and feeling of oneness.

Nimitta and Ashvin visited USA to meet some of our donors and friends. The main purpose was to be at a family wedding. In the process they met friends from AID with a specific agenda to get acquainted with the volunteers and build a bond of friendship. They also met Hesperian Foundation core group to talk about women's health issues especially in the context of community mental health program of TRU. Some Indian professionals working in Google held a meeting with them to understand the basic processes in community development and what way can they contribute to grassroots development processes in villages. There was also a talk delivered at MIT (Massachussets Institute of Technology) by them about development processes in general and specifically how does TRU deal with the Community based Mental health activities. All of these talks were very interesting and mutually enabled learning.

DIAGNOSTIC CENTRES

The diagnostic centres for urban poor are stable and running at their pace. We are happy that we are able to help many patients through this service. The pathological laboratory, the X-Ray deptt and the Ultrasonography services help the poor and needy with a good amount of precision for quality output. Following is the synopsis of this data:

Name of Center	X-Ray	Sonography	Echo Cardiogram	Laboratory	Total Patients
Alkapuri	2398	2654	–	5605	10657
Dandia Bazar	5354	1082	184	3071	09711
Total	7752	3736	184	5605	20368

The laboratory at Dandia Bazar centre is now run under the banner of Ansuya M. Chhatrapati Charitable Trust, which is also a sister trust. The management is done by TRU.

Number of patients attended RNK in last 18 years:

Year	X-Ray		Laboratory		Sonography		Echo-cardiogram	Total Patients
	Alka-puri	Dandia Bazar	Alka-puri	Dandia Bazar	Alka-puri	Dandia Bazar	Dandia Bazar	
1999-2003	16198	Not started	13402	Not started	3296	Not started	Not started	32896
2004-2008	17215	11445 wef '07	22172	Not started	3563	1094	320	55791
2009-2013	10066	33141	19866	3957 (started in 2011)	8400	7127	1055	83612
2014	2497	5375	4162	1992	2527	1712	?????	18265
2015	2233	5301	4573	2598	2678	1600	206	19189
2016	2264	5375	6497	3260	2758	1177	166	21497
Total all years	**50473**	**60637**	**70672**	**11807**	**23222**	**12710**	**1747**	**232997**

"Achieving planetary health will require a
renaissance in how we define our place in the world
A new narrative will reject the one streaming into our homes
– that happiness comes from relentlessly acquiring more things –
and embrace what we know:
that what truly makes us happy is time spent
with those we love, connection to place and community
feeling connected to something greater than ourselves,
taking care of each other.

The Lancet - Vol. 390, No. 10114, Article on Planetary Health,
By Dr. Samuel Myers, Harvard School of Public Health

Financials in TRU

TRUST FOR REACHING THE UNREACHED

BALANCE SHEET AS AT 31-03-2017

Funds and Liabilities	Rs.	Property and Assets	Rs.
Trust Funds or Corpus	86,38,793	Immovable Properties	2,04,05,322
Other Earmarked Funds	2,84,75,408	Furnitures & Fixtures	84,38,905
Liabilities	15,16,588	Advances	
Income & Expenditure A/c.	1,75,54,629	To Employees & others	45,400
		To TDS Receivable (2011-12 to 2016-17)	12,06,805
		To Grant Receivable	7,60,000
		To Interest Receivable	10,172
		Cash and Bank Balances (including FD with Bank)	2,53,18,814
	5,61,85,418		**5,61,85,418**

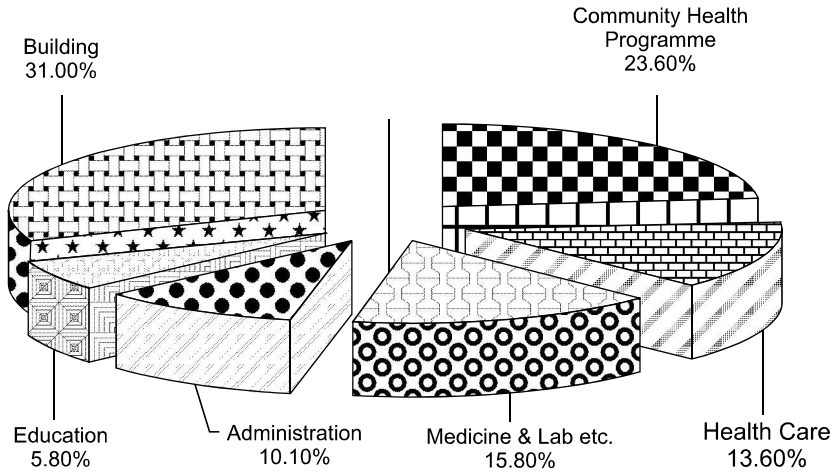
INCOME & EXPENDITURE A/C.
FOR THE YEAR ENDED ON 31-03-2017

Expenditure	Rs.	Income	Rs.
To Expenditure in respect of properties	5,92,794	By Interest on Fixed Deposits	20,70,854
To Establishment Expenses	1,27,261	By Donation Domestic	76,17,724
To Fees & Statutory	3,38,073	International	16,13,511
To Loss on removal of assets	1,47,825	By Transfer from Reserve	55,908
To Depreciation	3,53,142		
To Expenditure on object of the Trust (FCRA)	22,28,808		
To Expenditure on object of the Trust	82,77,670		
To Surplus carried over to B/S	(7,07,575)		
Total Rs.	**1,13,57,997**	**Total Rs.**	**1,13,57,997**

FOR K. K. PARIKH & CO.
CHARTERED ACCOUNTANTS
Vadodara :

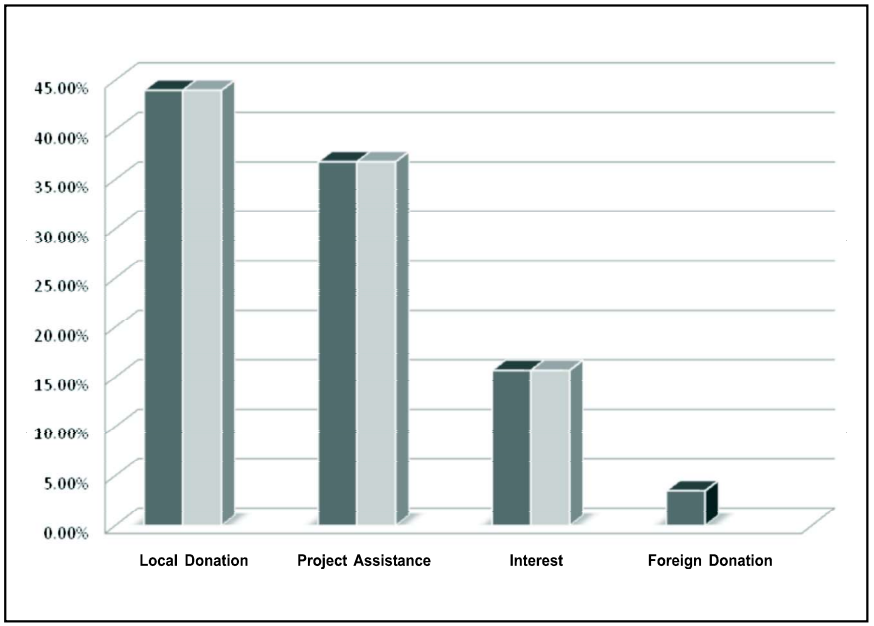
TRUSTEES
Trust for Reaching The Unreached
Vadodara :

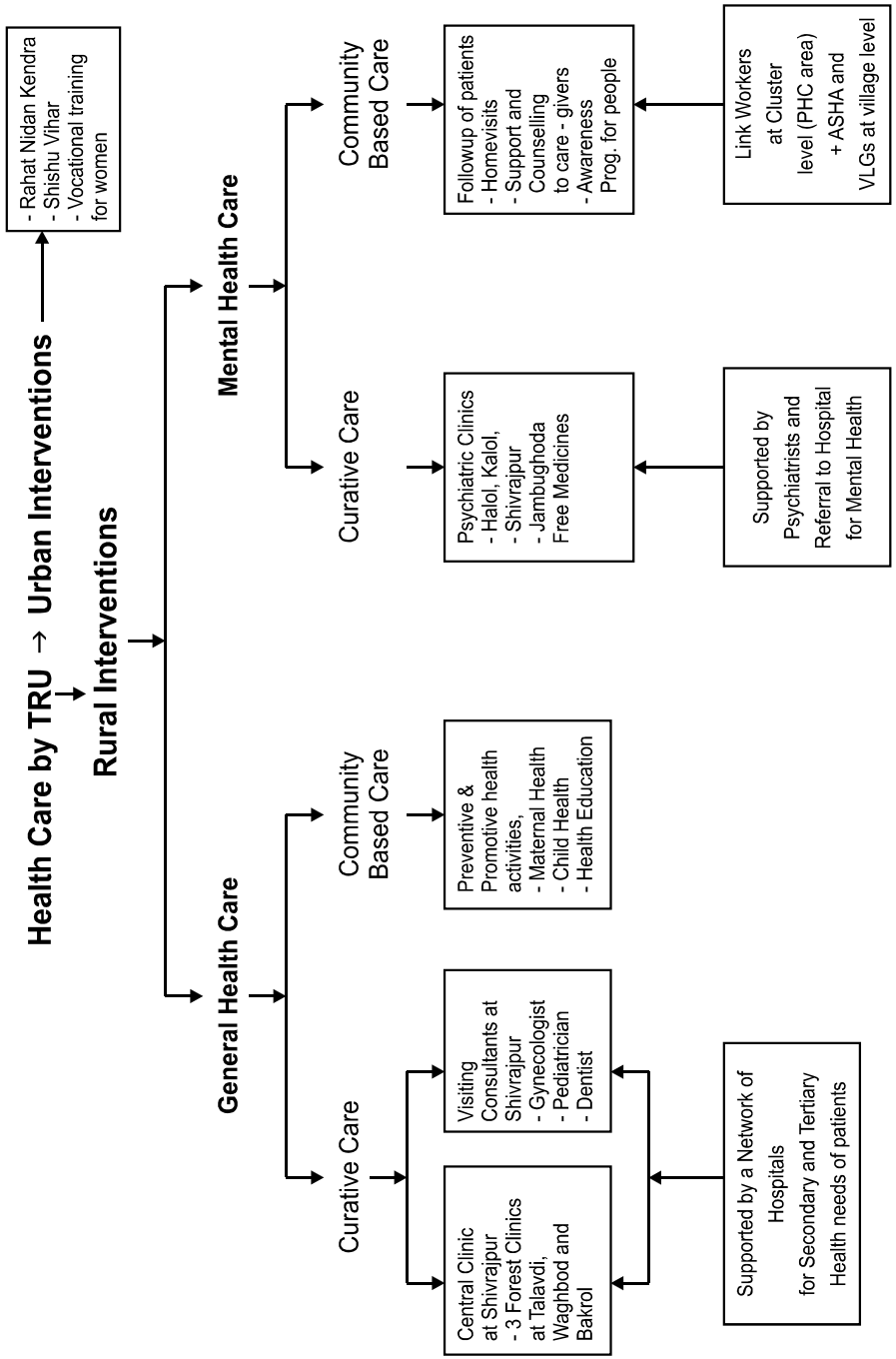
Expenditure Pattern in TRU, F.Y. 2016-17



Total Expenditure = Rs. 1,62,26,861

Income in TRU, F.Y. 2016-17





We are thankful

Our donors for the year 2017-18
(Received between April 17 - March 18)

Sr. No.	NAME	AMOUNT (Rs.)
1	Shri Smitaben M Patel	51000
2	Madgavkar Trust, Mumbai	30000
3	K. D. Parikh & L. N. Parikh Foundation, Hyderabad	21000
4	Dr. Bipin Desai, Surat	10000
5	Rex Resins, Vadodara	10000
6	Shri Ismailbhai Gandhi, Vadodara	5000
7	Shri Rajendra Thakar, Vadodara	5000
8	Shri Mukesh M Shah, Ahmedabad	5000
9	Dr. Sagun V Desai, Vadodara	5000
10	Dr. Pinal Gandhi, Vadodara	4000
11	Shri Madhuben Manilal Shah & Shri Manilal D Shah	3500
12	Bhaichand M Mehta Charitable Trust, Mumbai	7000
13	Harsukh B Mehta Charitable Trust, Mumbai	7000
14	Dr. J D Lakhani, Vadodara	3000
15	Shri Amitendu Gupta, Vadodara	4500
16	Shri Shilpa M Shah, Vadodara	1500
1	Association For India's Development,USA	1136432
2	Shri Nandkumar B Patel, USA	25000
3	Ronak Charity Trust, Vadodara	21000
4	Shri Sharmistha Nalinkumar Patel, USA	10000
5	Human Enrichment By Love & Peace I, USA	4661840
1.1	Shri Mahendra C Patel & Malti M Patel,USA	3215361
1.2	Cheques realised in F.Y. 2017-18	
1.2.1	Shri I I Patel, USA	318222
1.2.2	Shri Mahendra & Chhaya Patel, USA	63644
1.2.3	Shri Kirit Desai & Dr. Panna Desai, USA	63644
1.2.4	Shri Himat Tank & Sharda Tank, USA	31822
1.2.5	Shri Kokila, Vinu & Jignesh Charitable Giving Fund, USA	31822
1.2.6	Shri Jashvantilal Shaku Patel, USA	31822
1.2.7	Shri K C & Divya Patel, USA	15911
1.2.8	Shri Arun Vasudev Parikh, USA	6364
1.2.9	Shri Vasuben Patel, USA	3182
1.3	Cheques received in F.Y. 2017-18 but not realised before 31/03/2018	
1.3.1	Shri I I Patel,USA	323725
1.3.2	Shri Mahendra C & Chhaya Patel, USA	97117
1.3.3	Shri Vatsal J & Kavita Bhatt, USA	64745
1.3.4	Shri Kirit C & Panna Desai, USA	64745
1.3.5	Shri Himat & Sharda Tank, USA	32373
1.3.6	Shri Vinu & Kokila Shah, USA	32373
1.3.7	Shri Katherine E Mahar, USA	32372
1.3.8	Shri Mrudula N Patel, USA	9776
1.4	Individual Donors, USA	222820

Preparing Poster for Health Education Exhibition

Link Workers of Halol CMHP

A Volunteer - Ante natal check up at Shivrajpur

An AID Volunteer teaching paper-folding exercise to Girls of GEP

Dr. Phatak at well wishers' meet

Dr. Siddharth Trustee, AMCC at Get-together

Visit to Forest Nov. 17