



BasicNeeds
BasicRights

Respecting the Rights and Needs of People with Mental Illness

Baseline Study Report

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Executive Summary

Background and Methodology

BasicNeeds (BN) is an international mental health organization, which has developed a community-based approach to mental health called the Mental Health and Development Model (MHDM). BasicNeeds is working in partnership with Nav Bharat Jagruti Kendra (NBJK) to implement the Mental Health and Development Model in India. NBJK is an Indian development organization working in Bihar and Jharkhand. The NBJK mission is to educate, organize and empower the rural poor by promoting development as a liberating force for achieving social justice, economic growth and self-reliance NBJK's local partner organizations support rural people impacted by poverty through vocational training, loan programmes, self help groups and employment placement services.

This joint BasicNeeds-NBJK baseline study conducted a situation analysis on the project areas in Bihar and Jharkhand. The project areas cover 7 districts in Bihar and 8 districts in Jharkhand. The study utilized the following methods for data collection: document review of national and local policies, 4209 individual interviews with people with mental illness in the project areas, key informant interviews with government health professionals, and field observations in the project areas.

The NBJK MHD programme covers a large breadth of area across two states, posing some unique challenges for the project. In terms of socio-economic status, the two states are similar. However, Bihar and Jharkhand are at different phases in the development of mental health services and their governments require different levels of engagement from NBJK. Bihar has not yet begun to introduce DMHP. In Jharkhand, the DMHP reach is limited in Dhumka and Palamau and mental health services are currently not available at the community level.

Thus far, there has been little effort to integrate mental health into primary health care. Doctors and other medical professionals have received little (one-day workshop) or no mental health training. Also, the government DMHP has also not addressed livelihoods or working with families and communities to create a supportive environment for treatment.

The baseline data analysis of incoming participants revealed that users from both states will require strong livelihoods support, since almost half are illiterate and not earning or engaged in any productive work. Those who have been receiving treatment are generally seeking services in Jharkhand from RINPAS or one of the two DMHP districts. Users from Bihar have generally not been able to access mental health services except through private channels and the new Koilwar Hospital.

Strong mental health advocacy efforts are required to turn district and national policies into actions at the community level. Particularly, advocacy efforts are needed to ensure that psychiatric medicines are actually available at all levels within the government health infrastructure as is outlined in the DMHP guidelines.

Key Recommendations

Project Output 1: 7000 people with mental illness will have access to mental health and development services in Bihar and Jharkhand.

Identification of new people with mental illness or epilepsy will be critical as mental health clinics are increasingly offered at the community level. Effectively creating awareness for these clinics will be very

important to ensuring that people with mental illnesses or epilepsy know about and have access to receiving treatment at the clinics.

To address livelihoods issues and create a supportive family and community environment, NBJK's partner NGOs will play an important role in offering comprehensive interventions, through the MHD model, to the treatment people with mental illness and epilepsy receive through mental health clinics. Linking up people with these initiatives and following up on their progress will be a critical area for NBJK to address. NBJK and its partners will need to have an in-depth understanding of the entire model in order to implement it most effectively.

Project Output 2: The capacity of partner organizations will be strengthened to implement the Mental Health and Development Model

NBJK will require strong management and coordination to implement the MHD programme throughout all 25 partner organizations, linking these NGOs to government mental health services. It will be necessary for NBJK to hold frequent trainings to ensure that the programme is implemented consistently across all project areas.

Collective advocacy may be achieved through data and evidence from practice-based studies, such as this baseline study, the DMHP policy study and evaluative studies. Ensuring accurate and timely data collection across partners will also be very important to the project's success.

Project Output 3: The User Movement will be developed and strengthened at the national, state and local levels to carry out advocacy.

Mental health users-led advocacy at the district, state and national levels can be accomplished through effective SHG networks. While NBJK has already fostered the development of community groups with its previous project, it must build upon this community group infrastructure to continue building up an active SHG network, which allows users and carers to advocate for themselves.

Participatory Data Analysis can be an effective research tool for advocacy as it involves users and carers in the process of generating and analyzing information about themselves to find and advocate for solutions to their problems.

NBJK can also take a leadership role in promoting practice-based evaluative mental health research in the project areas. Studying the impact of the MHD programme on users and carers will help BasicNeeds and NBJK to better understand the needs of people with mental illness in the project areas. Publishing such studies will further BasicNeeds and NBJK's reach to national and international levels of advocacy.

Project Output 4: A system for health care delivery involving the District Mental Health Programme will be promoted and advocated.

Effective mental health training for doctors and nurses will be critical to the programme's success. NBJK will need to advocate for fully integrated mental health services through the DMHP. NBJK relationships with the Bihar government will need to be very strong to help facilitate implementing DMHP in this region. NBJK can continue to assist both governments in training medical personnel through workshops and the use of training manuals¹ translated into Hindi.

Awareness-raising will be important in both states, but especially in Bihar where mental health services have been particularly scarce. Consultation meetings held in communities can help the community to

¹ BasicNeeds has developed training manuals for community health workers and is currently developing a training manual for general practitioners.

better understand the needs and treatments available to people with mental illnesses or epilepsy. NBJK will also need to promote awareness of MHD among health professionals within the communities. Additionally, working with traditional and religious healers will help communities to become more aware of people with mental illnesses or epilepsy and assist in identifying people who may benefit from treatment.

Finally, a crucial component will be for NBJK to raise awareness among government officials and other key stakeholders about the need to expand DMHP services. NBJK also has the opportunity to promote DMHP at a national level through connecting with the newly formed Indian Ministry of Health Policy Group. NBJK may seek to consult with the group as they draft a National Mental Health Policy and Plan. User SHG groups may be included as stakeholders to the Policy Group.

Acronyms

DMHP – District Mental Health Programme

LMIC – Low and Middle Income Country

MHD – Mental Health and Development

NMHP – National Mental Health Policy

PHC – Primary Health Care Center

NGO – Non-Governmental Organization

CMH – Community Mental Health

CHC – Community Health Center

BMO – Block Medical Officer

RINPAS – Ranchi Institute of Neuro-psychiatry and Allied Science

RFPTC – Regional Family Planning Training Center

ANM – Auxiliary Nurse Midwife

CIP – Central Institute of Psychiatry

CP – Clinical Psychologist

PSW – Psychiatric Social Worker

NRHM – National Rural Health Mission

SHG – Self Help Group

Table of Contents

ACKNOWLEDGEMENTS	2
EXECUTIVE SUMMARY	3
ACRONYMS	6
INTRODUCTION	9
METHODOLOGY	9
STUDY AIM	9
STUDY OBJECTIVES	10
DATA COLLECTION	10
DATA ANALYSIS	10
STUDY FINDINGS	11
COUNTRY BACKGROUND	11
OBJECTIVE 1: UNDERSTANDING THE MENTAL HEALTH POLICY CONTEXT IN BIHAR AND JHARKHAND	11
MENTAL HEALTH SITUATION IN INDIA	11
GOVERNMENT MENTAL HEALTH INITIATIVES	12
MEDICINES	13
PROGRAMME AREAS AT A GLANCE	14
BIHAR	14
JHARKHAND	14
OBJECTIVE 2: ASSESSING THE CONDITION OF GENERAL HEALTH FACILITIES IN JHARKHAND AND BIHAR	15
JHARKHAND	15
BIHAR	17
OBJECTIVE 3: SITUATION AND NEEDS FOR PEOPLE WITH MENTAL ILLNESS OR EPILEPSY IN THE PROJECT AREAS	18
OBJECTIVE 4: DESCRIPTION OF PARTNER CAPACITIES FOR PROVIDING MENTAL HEALTH SERVICES	19
OBJECTIVE 5: PROVISION OF MENTAL HEALTH SERVICES IN DHUMKA AND PALAMAU DISTRICTS OF JHARKHAND	20
STUDY LIMITATIONS	21
DISCUSSION	21

KEY RECOMMENDATIONS	23
CONCLUSION	24
REFERENCES	25
APPENDICES	26
APPENDIX A: TERMS OF REFERENCE	26
APPENDIX B: BASELINE DATA COLLECTION TEMPLATE	28
APPENDIX C: HEALTH FACILITIES CHECKLIST	31
APPENDIX D: PARTNER CAPACITY ASSESSMENT FOR IMPLEMENTING MHD PROGRAMME	33

Introduction

Nav Bharat Jagruti Kendra (NBJK) is a development organization working in the Indian states of Bihar and Jharkhand. The organization was established in 1976. Their mission is to educate, organize and empower the rural poor by promoting development as a liberating force for achieving social justice, economic growth and self-reliance. NBJK's local partner organizations support rural people impacted by poverty through vocational training, loan programmes, self help groups and employment placement services in 22 districts in Jharkhand and 38 districts in Bihar. (NBJK Annual Report 2008-2009, 2010)

BasicNeeds (BN) is an international mental health organization, which has developed a community-based approach to mental health called the Mental Health and Development Model (MHDM). The model aims to provide a framework for implementing cost-effective community mental health care in low and middle income countries (LMICs) through five separate but interlinked modules: capacity building, community mental health, sustainable livelihoods, research and management and administration. Stressing the link between mental health and development, BasicNeeds (BN) puts these five modules into practice through its work with local partner organizations. BasicNeeds is currently operating in LMIC countries across Asia and Africa (Mental Health and Development: a model in practice, 2008)

In 2002, a pilot community mental health programme was launched in Jharkhand and Bihar under tripartite partnership between BasicNeeds, BasicNeeds India Trust and NBJK. NBJK selected 25 local partners to work in 15 districts. In March 2006, the follow-up programme received support from Big Lottery Fund, United Kingdom for a period of three years. The aim of the project was to develop locally sustainable initiatives for supporting people with mental health problems living in poor communities in the two Indian states of Bihar and Jharkhand. This project was intended to encourage people with mental disorders to participate in the development process in their own communities.

Mental Health and Development in Bihar and Jharkhand

The current project is a partnership between NBJK and BasicNeeds and will focus on supporting the government to actively provide mental health services through the District Mental Health Programme (DMHP). This project builds upon the 2006-2009 project which identified 5860 individuals for receiving mental health treatment (Final Evaluation Report NBJK, 2008). The current project will trace those users from the previous project, as well as identify new users. **By 2014, the project plans to implement mental health services through government health facilities in 7 districts in Jharkhand and 2 districts in Bihar.**

The project will implement the Mental Health and Development Model by increasing access to mental health services in government health facilities through the DMHP. NBJK will train partner organizations to implement the Model in full, including building partner capacity for data collection. Furthermore, users will form self-help groups and user federations to strengthen advocacy efforts.

Methodology

Study Aim

This baseline study conducted a situation analysis on the project areas in Bihar and Jharkhand with a purpose to identify benchmarks for change in implementing the Mental Health and Development Model. (See Appendix A for study terms of reference.)

Study Objectives

- 1) To understand the overall mental health policy context at the national, state and local levels in Bihar and Jharkhand.
- 2) To assess the condition of general health facilities in Bihar and Jharkhand.
- 3) To understand the situation and needs of people with mental illness or epilepsy in the Bihar and Jharkhand project areas.
- 4) To understand the current capacities of partner organizations to implement the Mental Health and Development Model in the project areas.
- 5) To understand how the District Mental Health Programme is working in Dhumkha and Palamau districts of Jharkhand.

These objectives analyze the baseline situation for each project output, informing effective ways for NBJK to implement each project output.

Data Collection

Methods used for data collection include: document review, individual interviews and field observations. A BasicNeeds researcher conducted a document review which included documents related to the mental health policy context of the project areas as well as basic background information on the states of Bihar and Jharkhand.

Quantitative information from newly identified individuals was collected in December 2010. Staff from local partner organizations was trained by NBJK and BasicNeeds to collect baseline data using a template developed by BasicNeeds. This baseline data template was used to track individuals who had participated in the previous NBJK project and are now continuing to participate in the new project. Baseline data from a total of 4209 individuals was collected and entered into an Access database for analysis in this study. (The baseline data collection questionnaire template is found in Appendix B.)

Mr. Manoj Singh, NBJK programme manager, carried out field observations of health facilities in Bihar and Jharkhand based upon a template developed by PPD. The Health Facilities Checklist Template is found in Appendix C.

Data Analysis

Data collected from the document review, individual interviews and field observations was consolidated and analyzed by two BasicNeeds researchers. Qualitative and quantitative data from the document review and field observations was coded against the study objectives and data collection templates. Furthermore, key findings from the District Mental Health Policy Study (conducted simultaneously with the baseline study) were analyzed to understand how DMHP is working in Dhumkha and Palamau Districts of Jharkhand.

Individual quantitative baseline data was cleaned for accuracy by two BasicNeeds researchers and analyzed by a third BasicNeeds researcher using an Excel spreadsheet. The researcher utilized descriptive statistics to analyze the data available.

Study Findings

Country Background

India has a population of approximately 1.2 billion people, making it the world's largest democracy. While Hindi is the national language, each state and union territory has its own official languages and the country recognizes 21 different scheduled languages. The service sector makes up 54% of GDP, the agricultural sector 28% and the industrial sector 28%. Over 70% of India's population resides in rural areas. India recognizes 212 tribal groups, representing 7.5% of the country's population.

While the country's economic growth has accelerated considerably in the last decade, poverty remains a major challenge throughout the country. One third of the world's poor resides in India with almost 38% of the population (about 410 million people) living below the poverty line. Government resources from the recent economic growth have been allocated to several programmes to provide education, basic health care, rural connectivity, health insurance and other services to people living in poverty (World Bank, 2010).

India's National Health Policy offers a universal health care system; however, the government health sector is understaffed and underfinanced. India has only 0.7 hospital beds per 1000 people and 40% of the primary health centers are understaffed.

The Indian community health care delivery system is comprised of a three-tier delivery system: community health centers (CHC) primary health centres (PHC) and sub-centers. Primary or first contact care is provided at the PHC, the secondary care at the CHC and tertiary care is provided at medical colleges and district hospitals. PHC involves curative, preventive and promotive services. CHCs are referral centres for PHCs with an approximate ratio of 1:4. At the state level, the principal secretary is in charge of health issues. At the district level, the civil surgeon is the chief health and medical officer. At the block level, the block medical officer (BMO) heads the health administration (World Health Organization, 2011).

Objective 1: Understanding the Mental Health Policy Context in Bihar and Jharkhand

Mental Health Situation in India

In India, close to 10 million people with severe mental illnesses have inadequate access to mental health treatment. Less than one psychiatrist is available for every 300,000 people. Rural areas of India are estimated to have less than one psychiatrist per 1 million people (World Health Organization, 2011). An analysis of ten studies conducted in various states across India yields the following prevalence rates for all mental disorders per 1000 people) found in Table 1.1 and specific mental disorders in Table 1.2. (Madhav, 2001)

Table 1.1: Prevalence Rates for Mental Illness in India (Per 1000 people)

	Rural	Urban	Combined
Median	64.4	66.4	65.4
Range	18-142	24-207	18-207

Table 1.2: National Prevalence Rates for Specific Mental Illnesses (Per 1000 people)

	Median	Range
Schizophrenia	2.3	1.1-14.2
Affective disorder - depression (psychotic and neurotic)	31.2	0.5-53
Anxiety Neurosis	18.5	11-70
Hysteria	4.1	2.5-17

Nearly 66 people out of 1000 have a mental illness in India. In a country of 1.2 billion, approximately 79 million people are living with mental illness. Affective disorders were found to be the most common, followed by anxiety neurosis.

Government Mental Health Initiatives

To address the mental illness burden the National Mental Health Programme began in 1982 to ensure the availability and accessibility of basic mental health care, particularly for the most vulnerable sections of the population. The NMHP also seeks to promote mental health knowledge in general health care and to facilitate community participation in the development of mental health services. As a revision to the 1858 Lunacy Act, the Mental Health Act followed the NMHP in 1987. The Act provides safeguards against stigmatization and discrimination for people with mental illness. The latest phase in the development of mental health services in India is a community care approach. A model for community-based mental health care at the district level was developed and field-tested in the Bellary district of Karnataka by NIMHANS² between 1986-1995. This model has been adapted into the District Mental Health Programme (DMHP). Recently, the Ministry of Health and Family Welfare has constituted a policy group to frame the first National Mental Health Policy and Plan, as well as restructure the National and District Mental Health Programmes.

The District Mental Health Programme aims to improve mental health care by training government health professionals in diagnosis, treatment and health promotion activities. It also seeks to upgrade government psychiatric wards and hospitals and introduces psychiatry in the medical curriculum. DMHP applies a public health approach to mental health care where people with mental illnesses are encouraged to use district mental health services, beginning with primary health care centers (PHC). Mental health services available at the PHC level should include medical treatment, educational support, counseling services and linkages with non-governmental organizations (NGOs).

The current primary objectives for DMHP are as follows:

- To establish Centres of Excellence in mental health by upgrading and strengthening identified existing mental hospitals to address acute human resource shortages

² NIMHANS is the National Institute for Mental Health and Neuro Sciences located in Bangalore. It is a multidisciplinary institute for patient care and research in the area of mental health and neuroscience.

- To support other training centres (i.e. govt. medical colleges, general hospitals, etc.) to begin or further develop courses in mental health
- To modernize state-run mental hospitals and upgrade psychiatric wings of medical colleges and general hospitals
- To add life skills training, counseling in schools and colleges, workplace stress management and suicide prevention services
- To address the research gap in mental health
- To conduct an intensive media campaign
- To increase the reach of community mental health (CMH) initiatives through NGOs and public-private partnerships
- To improve monitoring at the central, state and district levels

As of May 2011, the DMHP is under implementation in 125 districts throughout the country. Grants have been released for upgrading psychiatric wings of 75 government medical colleges and general hospitals and modernization of 26 mental hospitals (Indicus Analytics, 2008).

Medicines

The following medicines (found in Table 1.3) should be available in every PHC, community health center (CHC) and Taluk hospital,³ according to the NIMHANS Operations Manual for District Mental Health Programme list of psychiatric medicines.

Table 1.3: Psychiatric Medicines That Should Be Available through DMHP

Sl.No	Name of the drugs.	PHC/CHC/Taluk	District
1	Tab. Chlorpromazine 100mgs	Yes	Yes
2	Tab. Risperidone 2mgs	Yes	Yes
3	Inj. Promethazine 50 mgs	Yes	Yes
4	Tab. Imipramine 75 mgs	Yes	Yes
5	Inj. Fluphenazine 25 mgs	Yes	Yes
6	Tab. Trihexyphenidyl 2 mgs	Yes	Yes
7	Tab. Lorazepam 1 mg	Yes	Yes
8	Tab. Phenobarbitone 30 & 60 mgs	Yes	Yes
9	Tab. Dephenylhydantoin 100 mgs	Yes	Yes
10	Tab. Lithium carbonate 300 mgs	No	Yes
11	Tab. Carbamazepine 200 mgs	No	Yes
12	Inj. Haloperidol	No	Yes
13	Cap. Fluoxetine 20 mgs	No	Yes

The above listed psychiatric medicines should be available at the PHC level free of charge, according to the NIMHANS Operations Manual for District Mental Health.

³ PHCs are the first-line units providing primary health care. CHCs are referral hospitals for PHCs with 30-50 beds and some specialist facilities. Taluk hospitals have over 100 beds and provide specialized services.

Programme Areas at a Glance

Bihar

Bihar is a state in Northeastern India with a population of 83 million people, accounting for 8.07% of country's population. Bihar holds the third largest state population in India. The state is broken down into 38 districts. There are 9032 gram panchayats⁴, 7 municipal corporations⁵ and 42 municipalities⁶.

A vast majority (89.5%) of Bihar's population resides in rural areas. Almost 58% are under 25 years of age and over 30% live below the poverty line. Bihar's literacy rate is 47%.

When Jharkhand separated from Bihar in 2000, 70% of Bihar's total production went to Jharkhand. Bihar suffers from slow economic growth, persistent poverty, complex social stratification, poor governance and very poor infrastructure. Bihar's Gross Domestic Product (GDP) is comprised of 42% from the agricultural sector, 48.98% from the service sector and 9.02% from the industrial sector. Comparative figures of major health and demographic indicators are found in Table 1.4 (GherziEastern and Genesis Fintec, 2008).

Table 1.4: Demographic, Socio-economic and Health Profile of Bihar State as Compared to India figures

S. No.	Item	Bihar	India
1	Total population (Census 2001) (in million)	82.9	1028.61
2	Crude Birth Rate (SRS 2008)	28.9	22.8
3	Crude Death Rate (SRS 2008)	7.3	7.4
4	Total Fertility Rate (SRS 2007)	3.9	2.6
5	Infant Mortality Rate (SRS 2008)	56	53
6	Maternal Mortality Ratio (SRS 2004 - 2006)	312	254
7	Sex Ratio (Census 2001)	919	933
8	Population below Poverty line (%)	42.60	26.10
9	Female Literacy Rate (Census 2001) (%)	33.1	53.7

Jharkhand

The state of Jharkhand was carved out of Bihar in 2000. It has a population of 26.94 million people spread across 24 districts. Much of the state is still covered by forest. About 77.8% of the population resides in rural areas with 26.3% belonging to tribal communities. There are over thirty tribes residing in the rural areas of Jharkhand. The literacy rate is also low at 59.6%. The state is known for its vast reservoir of natural resources in terms of forest area as well as minerals. In spite of Jharkhand's wealth of natural resources, it has not been able to utilize them properly. Jarkhand's difficult geographical terrain, poor socioeconomic status and lack of sufficient infrastructure are key reasons for almost 30% of its

⁴ A gram panchayat is a local self-governing body that provides basic infrastructure and services at the village level. Villages of at least 300 people may comprise a gram panchayat. A cluster of villages with populations under 300 people can also constitute a gram panchayat.

⁵ A municipal corporation is a constitutionally provided administrative unit that provides basic infrastructure and services for large urban areas with populations over 20,000 people.

⁶ A municipality is a constitutionally provided administrative unit that provides basic infrastructure and services in cities and towns with populations under 20,000 people.

population living under the poverty line. Intensified militant activities of naxal⁷ groups in recent times has further added to the problems (Bary, 2006).

In certain areas of Jharkhand, poverty and consequent malnutrition have given rise to diseases like tuberculosis, malaria and leprosy, which have become endemic in state. Fluoride in groundwater presents a public health problem. Comparative figures of major health and demographic indicators in Jharkhand are found in Table 1.5 (RHS Bulletin, Ministry of Health and Family Welfare, GOI).

Table 1.5: Jharkhand Demographic, Socio-economic and Health Profile as Compared to India

S. No.	Item	Jharkhand	India
1	Total population (Census 2001) (in million)	26.9	1028.61
2	Crude Birth Rate (SRS 2008)	26.1	22.8
3	Crude Death Rate (SRS 2008)	7.3	7.4
4	Total Fertility Rate (SRS 2007)	3.2	2.6
5	Infant Mortality Rate (SRS 2008)	48	53
6	Maternal Mortality Ratio (SRS 2004 - 2006)	312	254
7	Sex Ratio (Census 2001)	941	933
8	Population below Poverty line (%)	30	26.10
9	Female Literacy Rate (Census 2001) (%)	38.9	53.7

Objective 2: Assessing the Condition of General Health Facilities in Jharkhand and Bihar

Jharkhand

In Jharkhand, there are 3958 sub-centres, 330 PHCs and 194 CHCs⁸. Additionally, Jharkhand has 4 medical colleges and 24 district hospitals. Jharkhand district health infrastructure is provided in Table 2.1. Other health institutions in Jharkhand are found in Table 2.2 (RHS Bulletin, 2010).

Table 2.1: Jharkhand Health Infrastructure

Health Resource	Number
Sub-centre	3958
Primary Health Centre	330
Community Health Centre	194
Multipurpose worker (Female)/ANM ⁹	5011
Health Worker (Male) MPW(M) at Sub Centres	1922
Health Assistant (Female) at PHCs	-
Health Assistant (Male) at PHCs	660
Doctor at PHCs	330

⁷ Naxal refers to militant communist groups operating in parts of India under various organizational envelopes.

⁸ Sub-centres are the peripheral outposts of the Indian healthcare system, providing basic treatment for common illnesses in rural areas.

⁹ Auxiliary Nurse Midwife

Obstetricians & Gynecologists at CHCs	30
Physicians at CHCs	0
Pediatricians at CHCs	0
Total specialists at CHCs	40
Radiographers	0
Pharmacist	348
Laboratory Technicians	381
Nurse/Midwife	429

Table 2.2: Other Health Institutions in Jharkhand

Health Institution	Number
Medical College	3
District Hospitals	24
Ayurvedic ¹⁰ Hospitals	1
Ayurvedic Dispensaries	122
Unani ¹¹ Dispensaries	30
Homeopathic Hospitals	2
Homeopathic Dispensary	54

As shown in Table 2.2, Jharkhand has an expansive network of government health institutions. The two government mental health institutions are Central Institute of Psychiatry (CIP) and Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS). CIP in Ranchi is a central government-run institution, which has a community mental health programme. A team of psychiatrists, clinical psychologists (CPs) and psychiatric social workers (PSWs), led by the consultant/senior resident makes once a month visits to the Tata hospital at West Bokaro and the Bisheshwar Nursing Home in Hazaribagh. General psychiatric cases, including cases referred by the general physicians, are assessed by the team. The team also visits the army hospital at Deepatoli Cantonment in Ranchi every week providing mental health treatment for army personnel, as well as an epilepsy clinic at the Deepsikhka Institute for Child Development and Mental Health, Ranchi. The team also visits the Holy Cross school at Hazaribagh as part of a school mental health programme. In 2007, CIP treated 55, 903 people through its outpatient department (OPD). People receiving in patient care totaled 3047 and 1008 were treated through outreach clinics.

RINPAS at Ranchi is a state government institute of mental health. RINPAS had a total of 51,647 psychiatric patients attending its OPD in the year 2008-9. A total of 1777 cases were admitted and 1605 discharged during the period. In addition to providing clinical services, vocational training is also available for users. Since August 2003, it has opened a total of 4 satellite clinics (i.e. mental health camps) with 28,000 people receiving consultations and free medicines at monthly satellite clinics in 2008-2009. RINPAS is also the nodal agency¹² for DMHP.

¹⁰ Ayurveda is a system of traditional medicine that originated in India

¹¹ Unani is a form of traditional medicine native to South Asia

¹² A nodal agency is the main agency responsible for implementing a programme, in this case the District Mental Health Programme.

Although several public and private health facilities are available in Jharkhand, the existing health infrastructure is lacking due to human resource shortages and inadequate health facilities. A limited number of people with mental illness or epilepsy currently have access to DMHP services as well as CIP and RINPAS. However, there is only one private psychiatrist in Palamu. Both districts have a district hospital. Palamau has 12 PHCs and Dhumka has 8 PHCs. As discussed in section 4, many people face the serious implications of poverty and mental illness together. An interview with a psychiatric social worker from RINPAS revealed that stigma and discrimination attached to mental illness is strong in these communities. Witch craft, religious healing and traditional local healers are commonly used for treatment where medical treatment is not available or popular. Nevertheless, he feels that through the existence of RINPAS and DMHP, there is an emerging understanding among the general populous that medical treatments can effectively treat mental illness (Bhutto Z.A., pers. comm, April 2011). So far, DMHP has been implemented in Dhumka, Palamu and Gumla districts of Jharkhand. At present, it remains as an outreach effort rather than an integrated aspect of public health.

Bihar

Each state has the jurisdiction to decide when and how DMHP will be implemented. In Bihar, the DMHP has not been implemented in any district until now. The following Table 2.3 details the health infrastructure and human resources in Bihar. With 1641 PHCs and 70 CHCs, there are many areas where DMHP may be introduced to the state through mental health training provided to the health professionals listed in Table 3.1 Other health institutions in Bihar are listed in Table 2.4 (RHS Bulletin, 2008).

Table 2.3: Health Infrastructure in Bihar

Health Resource	Number
Sub-centre	8858
Primary Health Centre	1641
Community Health Centre	70
Multipurpose worker (Female)/ANM	9127
Health Worker (Male) MPW(M) at Sub Centres	1074
Health Assistant (Female)/LHV at PHCs	479
Health Assistant (Male) at PHCs	634
Doctor at PHCs	1565
Obstetricians & Gynecologists at CHCs	21
Physicians at CHCs	38
Pediatricians at CHCs	17
Total specialists at CHCs	104
Radiographers	15
Pharmacist	439
Laboratory Technicians	135
Nurse/Midwife	1425

Table 2.4: Other Health Institutions in Bihar

Health Institution	Number
Medical College	8
District Hospitals	25
Referral Hospitals	70
City Family Welfare Centre	12
Rural Dispensaries	366
Ayurvedic Hospitals	11
Ayurvedic Dispensaries	311
Unani Hospitals	4
Unani Dispensaries	144
Homeopathic Hospitals	11
Homeopathic Dispensary	179

The mental health situation is very poor in Bihar. Prior to 2000, people with mental illnesses in all of Bihar could have gone to RINPAS for treatment. After the formation of Jharkhand in 2000, RINPAS became a part of Jharkhand and Bihar lost access to RINPAS. The government of Bihar has formed Bihar State Mental Health and Allied Sciences to provide mental health services at a former TB sanatorium. The Institute is located in the Koilwar, Bhojpur hospital. Formerly a strictly outpatient facility, the institute recently began offering in-patient treatment services. According to Bhutto, about 2000 people with mental illness are treated at the institute each month. Apart from the Koilwar Hospital, none of the district hospitals have a psychiatrist. In fact, there are only 14 public psychiatrists and 25 private psychiatrists in Bihar, whereas the number of public psychiatrists in Jharkhand is estimated to be approximately 35.

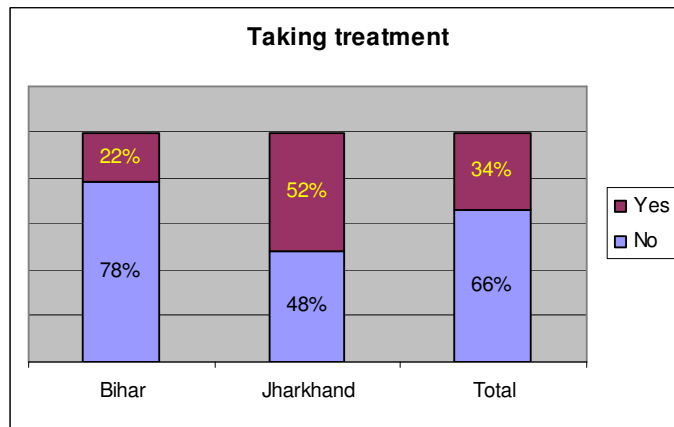
Objective 3: Situation and Needs for People with Mental Illness or Epilepsy in the Project Areas

In December 2010 and January 2011, individual baseline data was collected from 4209 people with mental illnesses and epilepsy identified within the project areas. An analysis of this data reveals some basic demographic trends and cross-cutting issues which may be applicable to people with mental illness or epilepsy in these project areas.

Out of 4209 individuals, 2584 came from Bihar and 1625 came from Jharkhand. Participants tracked from the previous project totaled 3897, while only 312 newly identified people are included in this sample. In total, 2581 are male and 1628 are female. Diagnosis was not given for 84% of people in Jharkhand and 81% in Bihar. This included all of those tracked from the previous project. Of those with diagnoses, the most common were epilepsy (251), depression (128) and schizophrenia (127) for both states.

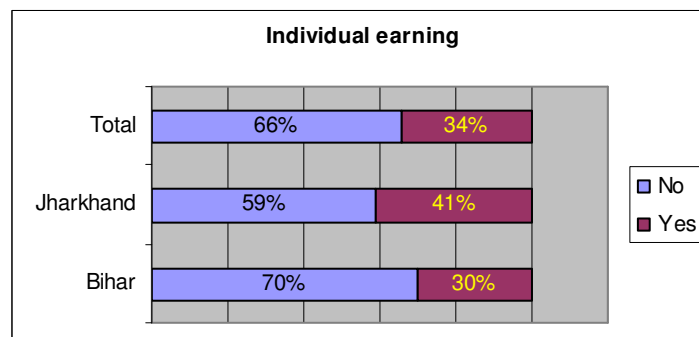
According to Graph 4.5, in Bihar, only 22% of the sample reported receiving treatment. Yet, in Jharkhand, that percentage is more than doubled with 52% reporting that they were currently receiving treatment. In Jharkhand, 38% of those receiving treatment did so through the NBJK camp in the current project, which began in October 2010 and data was collected in December 2010. A total of 33% reported receiving treatment at RINPAS. In Bihar, 28% of those receiving treatment did so through Koilwar hospital and 22% were receiving treatment privately.

Graph 4.1: Number of Participants Currently Receiving Treatment



Notably, 39% of Jharkhand users and 43% of Bihar users were illiterate. Most common occupations included agricultural work, business and domestic work for both states. According to Graph 4.2, 70% of Bihar users and 59% of Jharkhand users were not earning any income. Of those earning income, the majority for both states were earning between Rs. 1001 and Rs. 5000 (22-111 USD) per month. In Bihar, 43% of users were not earning *or* engaged in productive work. In Jharkhand, 40% of users were not earning *or* engaged in productive work.

Graph 4.2: Number of Users Earning Income



Yet, in Jharkhand, 80% of carers were earning income at baseline, while only 68% of carers were earning income in Bihar. Most carers in both states made an income between Rs. 1001 and Rs. 5000 (22-111 USD) per month.

Objective 4: Description of Partner Capacities for Providing Mental Health Services

NBJK was founded in 1976 and has much experience managing projects, working with government, other NGOs and private partners. Its work covers development issues related to mental health issues, such as water, sanitation, general health, livelihood, education, disability, women, children, empowerment, micro-credit and advocacy. Their well-established network is spread across Bihar and Jharkhand.

NBJK has partnerships with 25 organizations for the Mental Health and Development Programme. They have 11 partners in 8 districts of Jharkhand (Dhumska, Hazaribag, Ranchi, Palamu, Saraikela,

Loherdagga, Godda & Koderma districts) and 14 partners in 7 districts of Bihar (Gaya, Muzaffarpur, Nalanda, Patna, Nawada, Bhojpur & Jamui districts). The local partners are working in 15 blocks of Bihar and 12 blocks of Jharkhand. Out of 25 partners, 13 of them are working in the field of health along with mental health. Apart from health, they are working in the one or more areas including: education, livelihood, disability, micro-credit, family counseling, vocational training, horticulture/agriculture programmes, environment, women and children issues, HIV-AIDS, reproductive health, sanitation, and empowering marginalized groups. NBJK promotes the formation of self-help groups for users and carers through its local partners.

BasicNeeds provided a capacity building training session for NBJK before the project began to discuss knowledge of mental health issues among NBJK staff and across partner organizations. NBJK brought a knowledge of mental health and development to this project as it had already partnered with BasicNeeds to implement the Mental Health and Development Model beginning in 2002. The NBJK capacity assessment showed that they have an understanding of mental illness, its causes and treatments available. They also understood how to integrate people with mental illness into existing SHGs and understood its importance for advocacy. They also had an understanding of existing mental health services in Bihar and Jharkhand and the need to adopt a community mental health approach. They displayed confidence in their ability to build the capacities of each partner organization to carry out the Mental Health and Development programme.

While the project may be new, NBJK has managed effective relationships with its partners since 2002. Partnership strengths rely upon a well-established rapport with the community, offering a vast resource base. With these 25 partners, NBJK has been able to create a well-developed presence in the Jharkhand and Bihar in the area of mental health through their work implementing MHD from 2002 to 2008. They've fostered the development of community groups in their project areas. Out of 2637 total members in self-help groups (SHGs) and federations in their project area, 731 are comprised of mental health users and carers. They've also established strong connections with the governments in both states. As NBJK moves into a more instrumental role in the development of DMHP in these areas, these connections and resources they've built up will be very useful to the project and ultimately, DMHP.

Objective 5: Provision of Mental Health Services in Dhumka and Palamau Districts of Jharkhand

Within the NBJK project area, two districts in Jharkhand have already begun implementing DMHP. Dhumka and Palamau districts provide an example of how DMHP is currently working in Jharkhand.

Dhumka has a population of 1,106,000 people and the literacy rate is about 48 %. Dhumka has one sub-division comprised of 10 blocks. The entire district has topography with high ridges and valleys bounded by mountains and rivers. Palamu has a population of 1,533,000 people and the literacy rate is 45.67%. It has three sub-divisions with 12 blocks (Government of Jharkhand, 2011).

The DMHP was initiated in February 2006 in both districts. The nodal agency is the Ranchi Institute of Neuropsychiatry and Allied Sciences (RINPAS). The following DMHP components exist in each district:

The DMHP Team: The RINPAS-based team consists of a psychiatrist, clinical psychologist, psychiatric social worker, staff nurse and a clerk (report keeper).

Outreach Clinics: Mental health services are delivered through monthly outreach clinics where individuals can receive diagnosis, medical treatment and counseling services. The clinics are carried out at district hospitals and users must approach the clinic for treatment. NBJK with two other NGOs support the outreach clinics. An outreach clinic facility has one hospital cot with bedding, one electro convulsive

therapy (ECT) machine and all but four of the recommended psychiatric medicines. Diagnosis and prescription information are maintained in a patient record book.

Training – Supported by RINPAS, the DMHP team provided a one-day training in 2010 to doctors on mental health in both districts. Two one-day trainings on mental health for auxiliary nurse midwives (ANMs) were conducted in 2010 at Dhumka.

Information, Education and Communication (IEC) – Mental health awareness was organized on World Mental Health Day at the District hospital. But its reach is very limited. Under DMHP Dhumka, a sensitization programme was held once at the district local administration meeting. A stall of DMHP was put up in the Health Mela¹³ in both the districts and there was an article on DMHP in a RINPAS publication. In three of the high schools, two hour counseling sessions were held for students.

Both Dhumka and Palamau districts were found to be fairly consistent in the resources they have and services they offer under DMHP. Outreach clinics are only available at district hospitals and there is a shortage of medical staff trained in mental health. Some of the psychiatric medicines listed in Table 3.3 are actually unavailable at the PHC and CHC levels. Medicine shortages make it necessary for some people with mental illness to either go without treatment or buy medicines from a private pharmacy. These gaps are also consistent across the two districts and may be generalized to the remaining districts in Jharkhand.

Study Limitations

This baseline study poses a number of limitations. Because information on people with mental illnesses is scarce in India, our most reliable demographic data comes from our own programme. As programme staff administered the questionnaire to programme participants researcher bias could have played a role in altering the accuracy of the information. However, the data has been reviewed at 3 different levels for accuracy to address this potential bias. Also, because it was not feasible to take an in depth look at all of the districts in the project area. Dhumka and Palamau districts in Jharkhand were highlighted because DMHP has been implemented in these districts. This sample may not be exactly representative of the issues in other districts, but we feel that the findings from this analysis will be applicable to other districts as well because the districts hold several similar elements in resources available.

Discussion

The NBJK MHD programme covers a large breadth of area across two states, posing some unique challenges for the project. A majority of both Bihar and Jharkhand's populations reside in rural areas. In both states, around 30% of the population lives below the poverty line. Bihar's literacy rate is almost half (47%) of the population and Jharkhand's literacy rate is actually more than half (59.6%) of the population. In terms of socio-economic status, the two states are similar. However, Bihar and Jharkhand are at different phases in the development of mental health services and their governments require different levels of engagement from NBJK.

As Bihar has not yet implemented DMHP, NBJK relationships with the Bihar government will need to be very strong to help facilitate implementing DMHP in this region. In both Bihar and Jharkhand,

¹³ Health Mela is a health fair held in India where each health department promotes awareness of their cause through stalls.

implementing and scaling up DMHP will be a pioneering effort, requiring very close, sustainable and effective partnerships between NBJK, the government and local NGOs.

In Jharkhand, the DMHP reach is limited in Dhumka and Palamau with its monthly clinics limited to few places. Mental health services are currently not available at the community level and people with mental illnesses must either travel to the district hospital once a month or go to RINPAS. Access to mental health services has not been achieved for most people.

Thus far, there has been little effort to integrate mental health into primary health care. Doctors and other medical professionals have received little (one-day workshop) or no mental health training. Focused efforts on training medical personnel will be very crucial to the success of providing sustainable mental health services.

The government DMHP has also not addressed livelihoods or working with families and communities to create a supportive environment for treatment. NBJK's partner NGOs with its large breadth of experience in livelihoods and community work will need to be important contributors to working with the government to address these gaps, allowing service access in a community environment at the PHC and community levels.

There is very little information available about the situation of people with mental illness in Bihar and Jharkhand, including prevalence numbers and basic demographic and livelihoods information and also what mental health services people are able to access. The baseline data analysis of incoming participants revealed that users from both states will require strong livelihoods support, since almost half are illiterate and not earning or engaged in any productive work.

Those who have been receiving treatment are generally seeking services in Jharkhand from RINPAS or one of the two DMHP districts. Users from Bihar have generally not been able to access mental health services except through private channels and the new Koilwar Hospital. NBJK will need to be vigilant in working with its partners to identify new people with mental illness or epilepsy, particularly in Jharkhand. The efforts towards generating awareness of mental illness have been limited. Stigma and discrimination pose major barriers to receiving treatment in both Jharkhand and Bihar.

Strong mental health advocacy efforts are required to turn district and national policies into actions at the community level. Particularly, advocacy efforts are needed to ensure that psychiatric medicines are actually available at all levels within the government health infrastructure as is outlined in the DMHP guidelines. These advocacy efforts need to be fostered through the users and carers themselves, facilitated by effective self-help groups working to ensure that people have access to medical care and other required assistance such as livelihoods and loan programmes.

NBJK's partners bring many different areas of expertise to the project. NBJK will need to continually strengthen the capacities of its partners to implement the MHD programme. BasicNeeds needs to support NBJK and its partners to carry out collective evidence-based advocacy. Effective coordination on data collection is a key component to capacity building among partner organizations. Furthermore, building partner capacity to integrate people with mental illness into existing SHG networks and livelihoods activities requires a special understanding of mental illness and unique issues that may arise.

Key Recommendations

The key findings from this study inform effective ways for NBJK to implement each project output.

Project Output 1: 7000 people with mental illness will have access to mental health and development services in Bihar and Jharkhand.

Identification of new people with mental illness or epilepsy will be critical as mental health clinics are increasingly offered at the community level. Effectively creating awareness for these clinics will be very important to ensuring that people with mental illnesses or epilepsy know about and have access to receiving treatment at the clinics.

To address livelihoods issues and create a supportive family and community environment, NBJK's partner NGOs will play an important role in offering comprehensive interventions, through the MHD model, to the treatment people with mental illness and epilepsy receive through mental health clinics. Linking up people with these initiatives and following up on their progress will be a critical area for NBJK to address. NBJK and its partners will need to have an in-depth understanding of the entire model in order to implement it most effectively.

Project Output 2: The capacity of partner organizations will be strengthened to implement the Mental Health and Development Model

NBJK will require strong management and coordination to implement the MHD programme throughout all 25 partner organizations, linking these NGOs to government mental health services. It will be necessary for NBJK to hold frequent trainings to ensure that the programme is implemented consistently across all project areas.

Collective advocacy may be achieved through data and evidence from practice-based studies, such as this baseline study, the DMHP policy study and evaluative studies. Ensuring accurate and timely data collection across partners will also be very important to the project's success.

Project Output 3: The User Movement will be developed and strengthened at the national, state and local levels to carry out advocacy.

Mental health advocacy at the district, state and national levels can be accomplished through effective SHG networks. While NBJK has already fostered the development of community groups with its previous project, it must build upon this community group infrastructure to continue building up an active SHG network, which allows users and carers to advocate for themselves.

Participatory Data Analysis can be an effective research tool for advocacy as it involves users and carers in the process of generating and analyzing information about themselves to find and advocate for solutions to their problems.

NBJK can also take a leadership role in promoting practice-based evaluative mental health research in the project areas. Studying the impact of the MHD programme on users and carers will help BasicNeeds and NBJK to better understand the needs of people with mental illness in the project areas. Publishing such studies will further BasicNeeds and NBJK's reach to national and international levels of advocacy.

Project Output 4: A system for health care delivery involving the District Mental Health Programme will be promoted and advocated.

Effective mental health training for doctors and nurses will be critical to the programme's success. NBJK will need to advocate for fully integrated mental health services through the DMHP. NBJK relationships with the Bihar government will need to be very strong to help facilitate implementing DMHP in this region.

NBJK can continue to assist both governments in training medical personnel through workshops and the use of training manuals¹⁴ translated into Hindi.

Awareness-raising will be important in both states, but especially in Bihar where mental health services have been particularly scarce. Consultation meetings held in communities can help the community to better understand the needs and treatments available to people with mental illnesses or epilepsy. NBJK will also need to promote awareness of MHD among health professionals within the communities. Additionally, working with traditional and religious healers will help communities to become more aware of people with mental illnesses or epilepsy and assist in identifying people who may benefit from treatment.

Finally, a crucial component will be for NBJK to raise awareness among government officials and other key stakeholders about the need to expand DMHP services. NBJK and BasicNeeds also has the opportunity to promote DMHP at a national level through connecting with the newly formed Indian Ministry of Health Policy Group. NBJK may seek to consult with the group as they draft a National Mental Health Policy and Plan. User SHG groups may be included as stakeholders to the Policy Group.

Conclusion

The BasicNeeds-NBJK partnership with its experience in implementing the MHD model will be very valuable to its continued work in the Bihar and Jharkhand states. As NBJK enters a new phase of supporting the introduction of DMHP in some areas and building up its implementation in other areas, its strong partnership capacity building, research and grassroots advocacy work will be as important now as ever. NBJK is well-positioned to use the MHD model to build up the government's infrastructure for delivering mental health services, ensuring that services are sustained far beyond the project timeframe.

¹⁴ BasicNeeds has developed training manuals for community health workers and is currently developing a training manual for general practitioners.

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Appendices

Appendix A: Terms of Reference

NBJK-BasicNeeds Baseline Study

1. **Aim:**

This baseline study will conduct a detailed situation analysis on the project areas in Bihar and Jharkhand with a purpose to identify benchmarks for change in implementing the Mental Health and Development Model.

2. **Study Objectives:**

- (a) To understand the overall mental health policy context at the national, state and local levels in Bihar and Jharkhand
- (b) To understand the situation and needs of people with mental illness or epilepsy in Bihar and Jharkhand project areas
- (c) To understand the current capacities of partner organizations to implement the Mental Health and Development Model in the project areas
- (d) To assess the capacity for self help groups (SHGs) to carry out advocacy
- (e) To assess the condition of general health facilities in two locations in Bihar and two locations in Jharkhand
- (f) To understand how the District Mental Health Programme is working in the Dhumka and Palamau districts of Jharkhand

3. **Methods:**

- (a) Personal Interview
- (b) Focus Group Discussion
- (c) Document Review
- (d) Field Observation

4. **Collection Tools:**

- (a) Health Facilities Template (Appendix A)
- (b) District Mental Health Programme Checklist Template (Appendix B)

5. **Data Source:**

1. Individual Baseline Data of 5000 people with mental illness or epilepsy who have already participated in the MHD model in Bihar and Jharkhand. (objective b)
2. Process Documents of first one or two field consultations held in January (objective b)
3. Documents and reports with NBJK on existing SHGs/other community groups in the NBJK project areas (objective d)
4. Focus group discussions with existing SHG members and other community groups in the NBJK project areas (objective d)
5. Partner capacity report from NBJK team training in Bangalore and partners' training in Ranchi review of any existing documents (i.e. MOUs, partner meeting notes, etc.) (objective c)
6. Observation of health facilities in project areas (objective e)
7. Observation of DMHP in Dhumka and Palamau (objective f)

8. Focus group discussions with staff at the health facilities in project areas in Bihar and Jharkhand (objective e)
9. Review of documents related to existing policy (objective a)
10. Personal interviews with key policy personnel (objective a)

6. Data/Information consolidation and analysis (as required)

1. Review of all data/information gathered against each objective of the baseline report
2. Consolidate quantitative data as required by objective
3. Consolidate and paraphrase qualitative data by objective

7. Report

Draw down on the consolidated/paraphrased data into the report format

*Follow report Outline as given in next page.

Baseline Report Outline

1. Introduction with methodology (of how baseline report was conducted) – (1 -2 pages preferably less than 2 pages)
2. Background Section (1- 1 ¼ pages)
 - Regional Situation:** This section will provide an understanding of the context and norms of the programme areas where our programme participants reside. To include the following sub-subsections:
 - i. **Geography**
 - ii. **Political Situation**
 - iii. **Average Income/Educational levels** (for the general population)
3. Policy Context (2-3 pages)

This section will provide an understanding of mental health policy for Bihar & Jharkhand and, more specifically, the local programme areas. To include the following sub-sections:

 - i. **National Mental Health Policy**
 - ii. **Current Government Initiatives including via health and/or other policies/legislations**
 - iii. **Local-level Government Initiatives for Mental Health**
4. Situation and needs of people with mental illness or epilepsy in Dhumka and Palamau (3-4 pages)
5. Description of partner capacities for providing mental health services (2 pages)
6. Description and Details of existing SHGs/other community groups in the NBJK project areas (2-3 pages)
 - including also potential for integrating people with mental illness or epilepsy
7. Conditions for provision of mental health services in Dhumka and Palamau (3-4 pages)
8. **Recommendations** (1-2 pages)

This section will offer recommendations for programme implementation based upon information consolidated in sections from 2 – 6
9. Conclusion

****** Total Baseline Report – 15 – 18 pages preferably but no more than 20**

Appendix B: Baseline Data Collection Template

1	Individual Code		
2	Name		
3	Sex	Male <input type="checkbox"/>	Female <input type="checkbox"/>
4	Age		
5	Father's/ or mother's/ or Spouse's name	Name	Relationship
6	Address		
7	Village name		
8	District name		
9.1	Is the individual presently taking treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, from where?	
9.2	If no, what are the reasons?	Not identified the problem <input type="checkbox"/> <input type="checkbox"/> Not willing to get treatment Did not know about the treatment places (hospital) <input type="checkbox"/> Treatment places are far way from village <input type="checkbox"/> There was no carer to look after <input type="checkbox"/> Family has no money to access treatment <input type="checkbox"/> Others (mention)	
10.1	Education level (Studied up to)		
10.2	Present education status	Studying <input type="checkbox"/> Vocational Training <input type="checkbox"/> Not applicable <input type="checkbox"/>	
11.1	Is the individual earning?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
11.2	If yes, type of work and amount	Type of work	Average Income per month

	earned per month?			
12.1	IF NOT EARNING , is the individual doing productive work?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> – (if you answered ‘yes’ to 11.1, tick ‘Not applicable’ here. – If you answered ‘no’ for 11.1, tick ‘yes’ or ‘no’ here, as appropriate)		
12.2	If yes (doing productive work)	Household chores <input type="checkbox"/> Vocational training <input type="checkbox"/> Going to school <input type="checkbox"/> Others <input type="checkbox"/> Others (mention)		
12.3	Individual does nothing at present.	Yes <input type="checkbox"/> No <input type="checkbox"/> (Tick ‘yes’ if you answered ‘no’ for BOTH 11.1 and 12.1)		
12.4	Any income earned without having to work?	Disability pension <input type="checkbox"/> Old age pension <input type="checkbox"/> Retirement pension <input type="checkbox"/> Income thorough property <input type="checkbox"/> Others <input type="checkbox"/> mention		
13	Is the individual member of any community Self Help Group?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
14	Any other group membership?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
15.1	Present Carer (If applicable)	Name	Sex	Age Relationship
15.2	Is the Carer earning?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
15.3	If yes, type of work and amount earned per month?	Type of work	Average Income per month	
16	Data collection date	DD <input type="checkbox"/>	MM <input type="checkbox"/>	YYYY <input type="checkbox"/>
17	Data collection location			
18	Data collected by	Name	Position	Signature

Following Data to be taken ONLY from Doctor or psychiatric professional’s notes/sheet.

19	Diagnosis	Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Phobia <input type="checkbox"/> Psychosomatic disorder <input type="checkbox"/> Depression with Psychotic symptoms <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Unspecified Psychosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Suicidal tendencies <input type="checkbox"/> Alcoholism/ Substance abuse <input type="checkbox"/> Other mental disorders <input type="checkbox"/> Mention Diagnosis not known <input type="checkbox"/>		
20	Diagnosed by	Name	Profession	Date of diagnosis DD MM YYYY <input type="text"/> <input type="text"/> <input type="text"/>

Appendix C: Health Facilities Checklist

Name of District	Population
------------------	------------

A. Public (government)	Number	Facilities available
a. Zonal Hospitals		
b. District hospitals		
c. Primary Health Care Centers		
d. Health Posts		
e. Sub Health Posts		
f. Community level		
i. Community Health Volunteers/ TBA		
ii. Outreach clinics		
B. Private		
C. Others		

Checklist for each facility

a. Infrastructure:

	Yes/ no	Comments
Own building		Eg. Room size, number, etc
Toilet		
Water supply		Eg. Drinking, washing,
Electricity		
Furniture		Eg. Tables, beds, chairs, etc
Telephone		
Generator		
Refrigerator		
Laboratory		
Vehicles (other than ambulance)		
Computer		
Blood bank		
Other, specify		

b. Personnel

	Number	Male	Female
Nurse			
Midwife			
TBA			

Female Community Health Volunteer			
Outreach worker			
Medical Assistant			
General Physician			
Surgeon			
Specialist doctor			
Anesthetist			
Pharmacist			
Counselor			
Nutritionist			
Psychologist			
Psychiatrist			
Social worker			
Others, specify.			

c. Services

	Yes/ no	If yes, cost	If no, where referred
Antenatal care			
Delivery			
Family planning			
Counseling			
Surgery			
In-patient care			
Out-patient care			
Pharmacy			
Ambulance			
First aid			
Health camps			
Health awareness programmes			
Home visits			
Diagnosis & referral			
Outreach clinics			
Health insurance			
Training			
Mental Health care			
Other, specify			

d. Medicines available

List.

Appendix D: Partner capacity assessment for Implementing MHD Programme

1. What do you think about people with mental illness?
2. What do you know about mental illness?
3. What do you think about working with people with mental illness? Do you think it is same as your current work or will it be different?
4. What do you think about including people with mental illness into your existing SHGs? How do you think you will do that?
5. What information do you have about mental health related policy in your country?
6. What information do you have about mental health services in your project area?
7. Do you expect any special challenges in implementing the Mental Health and Development programme?