Bangladesh
WHO Special Initiative for Mental Health
Situational Assessment

I. CONTEXT

The People's Republic of Bangladesh is located in Southern Asia, bordered on the west, north, and east by India, and the southeast by Myanmar. The country is densely populated, with more than 162 million persons occupying an area of 147,570 square miles.[2] The majority of people inhabit deltas of three large rivers that flow to the Bay of Bengal on the southern border. Half of the labor force is employed in the agriculture sector, where rice is the main product. Garment production is the backbone of Bangladesh's industrial sector, accounting for more than 80% of total exports. While temperatures and humidity are consistently high, recent climatic changes have resulted in increased frequency of monsoon rains and cyclones, causing floods that render a growing proportion of the Bangladesh population landless and challenged to cultivate flood-prone land. Approximately 1 million Forcibly Displaced Myanmar Nationals (FDMN), half of whom are children, have fled extreme violence and persecution in Myanmar and occupy settlements in SE Bangladesh.[6]

Bangladesh has been an independent state since 1971. The government of Bangladesh is a parliamentary republic with eight administrative divisions: Barisal, Chittagong, Dhaka, Khulna, Mymensingh, Rajshahi, Rangpur, and Sylhet. Within the divisions are 64 districts and 545 upazilas/thanas (subdistricts). The capital, Dhaka, with a population of over 11 million, is the political, cultural and economic center of Bangladesh.

Bangladesh has a well-structured public health network in the country reaching out to the grass-roots level - Director General of Health Services

Table 1: Demographics

Demographic information	
Population	162,700,000[1]
Under 14 years	30.4%[1]
Over 65 years	4.2%[1]
Rural population	62.6%[1]
Literacy	72.3%[1]
Languages	Bangla[2]
Ethnicities	Bengali (98.5%)[2]
Religions	Muslim (89%), Hindu (10%)[2]
GDP per capita	1,698.3 USD[3]
Electricity	32% of homes[4]
Sanitation	61% of homes[4]
Water	87% of homes[4]
Education	60.3% completed primary school[5]
Health information	
Infant mortality	24 deaths per 1,000 live births
Maternal mortality	182 deaths per 100,000 live births
Life expectancy	72.2 years at birth
Leading causes of death	Heart disease/heart attack (24.6%) Cancer (7.7%)
HIV seroprevalence	0.1%
Antiretroviral treatment coverage	70%
Domestic violence towards women	28.8%
Substance Use	Highest in 15-30yo men; Growing problem in youth
Healthcare Access and Quality Index	47.6

Health care is cited in the Constitution as a basic necessity with the state having responsibility for ensuring that health services are accessible for Bangladesh citizens. The public health system reaches the population by extending government, private, and NGO-sponsored health care providers, hospitals, health centers and clinics through all administrative levels and to unions and wards. The 2018 Health Bulletin reports success in public campaigns to increase family planning awareness, vaccination rates, and sanitation and to decrease maternal and neonatal mortality rates and deaths from communicable diseases. Of the overall annual health budget in Bangladesh, 0.05% is designated for mental health services, of which 60% is dedicated to psychiatric hospitals.[7,8] In 2018 Bangladesh Parliament approved a new Mental Health Act. A new Mental Health Policy, approved by the Ministry of Health in 2019, reflects a shift from a medical to a psychosocial treatment model with emphasis on decentralization and community-based services and support for persons living with mental illness.

An essential pillar of the Bangladesh mental health system is the strong political commitment of the Government of Bangladesh and Ministry of Health & Family Welfare - Director National Institute of Mental Health

II. METHODS

The Rapid Assessment used a modified version of the Programme for Improvement Mental Health Care (PRIME) situational analysis tool[9] to assess the strength of the Bangladesh mental health system. The assessment was carried out from January to March 2020. We expanded the tool to include multi-sector entry points for mental health promotion and services, a focus on vulnerable populations, and stratification of relevant sociodemographic and health indicators across the life-course. The PRIME tool assesses six thematic areas: 1) socioeconomic and health context, 2) mental health policies and plans, 3) mental disorder prevalence and treatment coverage, 4) mental health services, 5) cultural issues and non-health sector/community-based services, and 6) monitoring and evaluation/health information systems. The complete situational analysis tool for Bangladesh is available for review in **Appendix 1.**

Desk Review

The majority of data on socioeconomic status, population health, policies/plans, and the mental health-related readiness of health and other sectors came from secondary sources, including the World Bank, Demographic and Health Surveys, published peer-reviewed and grey literature, the Global Health Observatory, and a detailed review of available mental health policies and plans and other government documentation. We also accessed the National Health Management Information System to assess treatment coverage, staffing complements, and facility numbers. Finally, national-level estimates of the prevalence and rate of priority mental health conditions, stratified across the life course, were derived from the 2017 Global Burden of Disease Study (GBD).[10]

Key Informant Interviews

We used qualitative data to inform our description of the strength of the mental health system. Interviews followed structured guides. Participants were sampled purposively. We aimed to sample at least one participant from each group: people with lived experience, advocates for mental health, clinicians and implementers of mental health programs, and mental health system policymakers. The final sample included five key informants: one innovator and advocate, one person with lived experience and advocate, one advisor to Bangladesh mental health policy/planning initiatives, one health minister, and one director of national mental health organization.

Facility Checklists

We also conduced visits to health facilities to document key indicators related to readiness to provide mental health services. We used an adapted version of the WHO Service Availability and Readiness Assessment (SARA) instrument.[11] Facilities were sampled purposively. We aimed to sample at least one facility from each group: specialist mental hospitals, psychiatric units within general hospitals, and primary care clinics. The final sample included three facilities: one Upazila government-sponsored health center in a rural area, one government-sponsored national referral general hospital in an urban setting with outpatient and inpatient mental health services, one government-sponsored national referral psychiatric hospital with outpatient and inpatient mental health services, National Institute of Mental Health in Dhaka.

Analysis

It was not possible to calculate treatment coverage in Bangladesh for specific mental health conditions, as estimates of numbers of patients treated for specific mental health conditions were not available. However, the nationally representative Bangladesh Mental Health Survey of 2018-2019 estimated that 92.3% of persons with diagnosable mental disorders were not receiving mental health treatment. We used simple, deductive thematic coding to align interview content with the sections of the situational analysis tool, outlined below. We also abstracted and summarized data from each facility checklist.

III. RESULTS

Mental Health Policies and Plans

Political Support

The government of Bangladesh recognizes mental illnesses among the top ten priority health concerns in the country. The Bangladesh Ministry of Health and Family Welfare (MOHFW) sponsored the Bangladesh Mental Health Act to replace the outdated Indian Lunacy Act of 1912. The new legislation describes government-sponsored health care benefits, including mental health care, that are inclusive across population groups and extend throughout the country. The Mental Health Act makes provisions for involuntary admission and treatment. The Mental Health Act was passed by the national Parliament in 2018.

The public spending on mental health is approximately 0.08 USD per capita, representing 0.05% of the total health budget.

Table 2: Components of National Mental Health Policies and Plans

		Policy	Plan
Components	PHC integration	■	■
	Decentralization	■	■
	Hospital integration	■	■
	Maternal	■	■
	Child/adolescent	■	■
	HIV	■	■
	Alcohol/substance use	■	■
	Epilepsy	■	■
	Dementia	■	■
	Promotion/prevention	■	■
	Suicide	■	■
Equity	Gender	■	■
	Age/life course	■	■
	Rural/urban	■	■
	Socio-economic status	■	■
	Vulnerable populations	■	■

■ Included ■ Not included -- Not assessed

Mental Health Policy and Mental Health Plan

A multi-disciplinary Working Group with representatives from government Ministries, mental health professional organizations, and advocacy groups collaborated to draft a National Mental Health Policy, which was approved by the Ministry of Health in 2019 is currently awaiting endorsement by the Cabinet. The Working Group also drafted a National Mental Health Strategic Plan 2020-2030, anticipating implementation over the next decade, through successive 5-year action plans. To date neither the Policy nor the Strategic Plan has been implemented. Adoption of the Strategic Plan within the MOHFW general health
care plan is anticipated in 2020.
Described below are key components incorporated within the Bangladesh
National Mental Health Policy 2019 and National Mental Health Strategic Plan 2020-2030.

Key Components of the Policy and Plan

Primary Health Care Integration

The Policy and Plan call for integration of mental health services across all tiers of the public health care system. Mental health services will be integrated into primary health care through strengthening the existing health care delivery system.

Decentralization

Decentralization will be achieved by extending mental health services to divisions, then districts, and upazilas/thanas in both rural and urban areas.

Equity

Equity and justice are one of the prime values and principles of the policy. Addressed are gender equity, a life course approach, decentralization to both rural and urban areas, and integration of mental health into social and economic development. A section is devoted to describing mental health services for at-risk and vulnerable populations (e.g., refugees, incarcerated persons).

Innovative programming

The mental health plan describes a digital platform for extending the reach of mental health services through e-health. Psychiatrists based at the National Institute of Mental Health supervises and mentors providers at 88 district hospitals via videoconference twice monthly. In addition, providers and field officers are trained using distance-learning modules delivered via tablets on mental health care. NGO's bring potentially scalable models of mental health programming to address effects of traumatic stress within the FDMN population in Cox's Bazar.

The mental health policy documents are being developed to establish a comprehensive, multi-sectorial, integrated and responsive system to ensure universal access to and effective utilization of quality mental health and psychosocial services and information system - Director General of Health Services

Prevalence and Treatment Coverage of Priority Mental Disorders[10,12]

A 2018-2019 door-to-door prevalence survey of a representative sample of Bangladesh citizens found 18.7% of adults and 12.6% of children to meet criteria for a mental disorder.[13] The report estimates that the "treatment gap" for adults with mental disorders nationwide is 92.3%, meaning that an estimated 7.7% receive mental health treatment. Mental health treatment is not systematically documented in the health information system so, other than this overall estimate from the survey, there are no estimates of treatment coverage for persons with specific disorders.

Mental health is a taboo in Bangladeshi society and most people afflicted with such ailments usually do not seek medical help. Perhaps, it is the village shaman who is consulted first when people suspect one is suffering from mental ailments. Due to social stigma, most mental health sufferers never get to meet a specialized doctor. Most qualified mental health specialists are located in cities, and the cost of bringing patients to their attention is prohibitively high - Spokesperson for mental health service user

GBD 2017[10] estimated the prevalence of schizophrenia in Bangladesh to be 0.2%, compared to 0.3% for the South Asia region and 0.3% globally. Bangladesh estimates for epilepsy and bipolar disorder are comparable to regional and global estimates. The estimated prevalence of alcohol (1.5%) and drug use disorders (0.6%) are higher in Bangladesh than regional estimates (1.2% AUD, 0.5% DUD), and are closer than S. Asia to global estimates for AUD (1.5% global, 0.6% regional). In Bangladesh the estimated prevalence of depression (2.8%) is higher than in the overall S. Asia region (2.2%), especially for women (3.6% vs 2.7%). Women in Bangladesh have been shown to have a higher suicide rate than men (8.7 vs 6.8 suicide deaths/100,000 population). Researchers point to the high prevalence of depression and suicidal ideation during pregnancy, malnutrition and illness in children, and domestic violence, low literacy and poor household economy as factors contributing to the high risk of depression among women, particularly in rural areas of Bangladesh. [14–18]

The Bangladesh household mental health survey yielded prevalence estimates in the adult population for schizophrenia and related psychotic disorders of 1.0% and for major depressive disorder of 6.7%, markedly higher than GBD estimates.

GLOBAL MENTAL HEALTH
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World Health Organization

Table 3: Prevalence and Treatment Coverage of Selected Mental Disorders

		Prevalence				Total				Treated
		NMHSB (95% CI)*		GBD (UI)**		NMHSB (95% CI)*		GBD (UI)**		
Schizo-phrenia	Overall	1.0%	(0.7-1.4%)	0.2%	(0.2%-0.3%)	1,627,000	(1,138,900-2,115,100)	380,706	(332,168-439,876)	--
	Female	1.1%	(0.6-1.6%)	0.2%	(0.2%-0.3%)	732,600	(325,200-1,056,900)	174,666	(152,447-202,305)	--
	Male	0.9%	(0.6-1.5%)	0.3%	(0.2%-0.3%)	895,400	(488,400-1,221,000)	206,040	(177,956-237,033)	--
	Young adults (20-29)	--	--	0.3%	(0.2%-0.4%)	--	--	78,174	(58,845-101,063)	--
	Older age (70+)	--	--	0.2%	(0.2%-0.2%)	--	--	11,552	(10,011-13,158)	--
Bipolar Disorder	Overall	0.5%	(0.2-0.8%)	0.6%	(0.5%-0.7%)	650,800	(162,700-976,200)	902,891	(774,185-1,063,666)	--
	Female	0.3%	--	0.6%	(0.5%-0.7%)	246,900	--	463,858	(395,281-551,566)	--
	Male	0.7%	--	0.6%	(0.5%-0.7%)	403,900	--	439,033	(375,204-516,354)	--
	Young adults (20-29)	--	--	0.8%	(0.6%-1.0%)	--	--	216,325	(166,077-274,936)	--
	Older age (70+)	--	--	0.5%	(0.4%-0.6%)	--	--	30,839	(25,651-36,671)	--
MDD	Overall	6.7%	(5.8-7.6%)	2.8%	(2.5%-3.1%)	10,900,900	(9,436,600-10,900,900)	4,294,374	(3,892,354-4,777,117)	--
	Female	7.9%	(6.7-9.2%)	3.6%	(3.3%-4.1%)	5,284,500	(4,227,600-63,414,000)	2,834,601	(2,542,693-3,171,435)	--
	Male	5.4%	(4.3-6.5%)	1.9%	(1.7%-2.1%)	5,698,000	(4,639,800-67,56,200)	1,459,774	(1,320,546-1,624,793)	--
	Young adults (20-29)	--	--	2.8%	(2.2%-3.6%)	--	--	788,949	(606,650-1,011,745)	--
	Older age (70+)	--	--	6.3%	(5.3%-7.4%)	--	--	387,387	(324,707-459,137)	--
Epilepsy	Overall	0.3%	--	0.3%	(0.1%-0.6%)	--	--	505,797	(129,067-896,981)	--
	Female	0.1%	--	0.3%	(0.1%-0.6%)	--	--	249,447	(63,084-442,710)	--
	Male	0.9%	--	0.3%	(0.1%-0.6%)	--	--	256,350	(65,381-455,163)	--
	Young adults (20-29)	--	--	0.3%	(0.1%-0.6%)	--	--	94,728	(24,512-173,383)	--
	Older age (70+)	--	--	0.5%	(0.1%-0.9%)	--	--	30,762	(7,969-56,241)	--
All Substance Use	Overall	0.5%	--	2.0%	(1.8%-2.2%)	325,400	--	3,056,430	(2,712,819-3,432,207)	--
	Female	0.1%	--	1.4%	(1.2%-1.6%)	325,200	--	1,094,569	(959,598-1,231,818)	--
	Male	0.9%	(0.3-1.5%)	2.6%	(2.3%-2.9%)	81,400	--	1,961,861	(1,735,091-2,208,975)	--
	Young adults (20-29)	--	--	3.6%	(2.9%-4.5%)	--	--	1,002,774	(804,607-1,234,742)	--
	Older age (70+)	--	--	2.0%	(1.8%-2.3%)	--	--	2,991,183	(2,647,682-3,364,733)	--
Alcohol abuse	Overall	*0.5%*	--	*1.5%*	*(1.3%-1.7%)*	--	--	*2,280,119*	*(1,962,786-2,624,558)*	--
	Female	*0.1%*	--	*1.0%*	*(0.9%-1.2%)*	--	--	*807,311*	*(686,280-934,614)*	--
	Male	*0.9%*	--	*1.9%*	*(1.7%-2.3%)*	--	--	*1,472,808*	*(1,262,251-1,710,946)*	--
	Young adults (20-29)	--	--	*2.5%*	*(1.9%-3.3%)*	--	--	*700,858*	*(513,801-918,750)*	--
	Older age (70+)	--	--	*0.8%*	*(0.7%-1.1%)*	--	--	*52,478*	*(42,010-66,045)*	--
Drug abuse	Overall	--	--	*0.5%*	*(0.5%-0.6%)*	--	--	*817,538*	*(698,269-961,317)*	--
	Female	--	--	*0.4%*	*(0.3%-0.5%)*	--	--	*297,288*	*(249,833-354,879)*	--
	Male	--	--	*0.7%*	*(0.6%-0.8%)*	--	--	*520,250*	*(441,426-612,665)*	--
	Young adults (20-29)	--	--	*1.1%*	*(0.9%-1.5%)*	--	--	*316,583*	*(245,368-404,147)*	--
	Older age (70+)	--	--	*0.2%*	*(0.2%-0.3%)*	--	--	*13,125*	*(9,956-16,881)*	--
Suicide Deaths	Overall		--	6.0***	(5.0-6.9)	--	--	9,343	(7,882-10,770)	--
	Female		--	6.0***	(4.9-7.3)	--	--	4,778	(3,860-5,806)	--
	Male		--	5.9***	(4.4-7.2)	--	--	4,565	(3,440-5,617)	--
	Young adults (20-29)	--	--	9.7***	(7.4-12,2)	--	--	2,723	(2,087-3,431)	--
	Older age (70+)	--	--	11.2***	(7.8-13.3)	--	--	693	(484-820)	--

*Estimates from National Mental Health Survey of Bangladesh, 2018-2019; **Estimates from GBD 2017; ***Rate of suicide deaths per 100,000 population; UI: Uncertainty interval.

Mental Health Services

Governance

Public mental healthcare in Bangladesh is coordinated by the Directorate General of Health Services, which sits within the Health Services Division of the Ministry of Health and Family Welfare (MoH). Tertiary, specialist services are managed by their respective institutes (e.g., National Institute of Mental Health), while secondary and primary care-level mental health services are managed by Bangladesh's system of district hospitals and Upazila (sub-district) health centers and clinics.

Human Resources

Bangladesh has an estimated 260 psychiatrists, or approximately 0.16 per 100,000 population, as well as 700 nurses who provide mental health specialty care (0.4 per 100,000) and 565 psychologists (0.34 per 100,000). Almost all specialists are concentrated in major urban areas. General nurses trained in mental health are found only at the country's two mental hospitals, while there are no specialized mental health nurses.

Table 2: Human Resources for Mental Health

		#	Rate per 100,000
Generalist	Doctor	20,914	12.9
	Nurse	27,432	16.9
	Pharmacist	*n/s*	*n/s*
Specialist	Neurologist	225	0.1
	Psychiatrist	270	0.16
	Psychologist	565	0.34
	Psychiatric nurse	700	0.4
	MH social worker	3	0

The number of mental health professionals is very low, especially compared to the number of people suffering from mental illness. - Innovator and founder of key advocacy group.

Pre-service mental health training is incorporated into the basic curriculum at the 111 public, private, and military medical colleges for doctors and 208 training colleges for degree and diploma nurses. Medical doctors also receive seven hours of mental health training during the internship period. The new government-approved curriculum for medical students has increased the mental health training to 85 days.

Healthcare Facilities for Mental Health

Bangladesh's largest specialty hospital, the National Institute of Mental Health and Treatment, is located in Dhaka and has 500 beds. The density of psychiatric beds is five times higher in Dhaka than in the rest of the country.[14] A minimal .05% of expenditures from the Ministry of Health and Family Welfare is devoted to mental health, of which an estimated 67% is invested in mental hospitals.[14] A total of 56 public hospitals have psychiatric outpatient facilities.

Table 3: Healthcare Facilities for Mental Health

		Total Facilities	Facilities/ 100,000	Total Beds	Beds/ 100,000
Inpatient	Mental hospital[8]	2	0.001	700	0.3
	General hospital psychiatric unit	56	0.03	504	0.3
	Forensic unit	1	0.0006	16	0.01
	Residential care facility	72	0.04	3645	*2.2*
	Child/adolescent facility	2	0.001	33	0.02
Outpatient	Hospital mental health	69	0.04	*n/a*	*n/a*
	Community-based /non-hospital mental health	*n/s*	*n/s*	*n/a*	*n/a*
	Alcohol/drug/other facility	5	0.003	*n/a*	*n/a*
	Child/adolescent	20	0.01	*n/a*	*n/a*
	Other facilities	*n/s*	*n/s*	*n/a*	*n/a*

Three facilities were visited during the assessment process. These are described below. All noted a lack of qualified staff to provide psychosocial interventions. The general hospital had some essential psychotropic medications but had no injectable antipsychotic medication and inadequate supplies of the other medicines.

Table 4: Facility Checklist Results (n=3)

Description	Psychi.	Psych. Nurses	Psychol.	MH Beds	Psych. Meds	Psych. Interventions
National referral mental hospital with inpatient and outpatient services. Teaching facility. MoHFW. Urban (NIMH).	28	250*	1	200	Comprehensive, available**	PST, BAT, supportive counselling, CBT, IPT, brief alcohol interventions, MET, PP, family support
National referral hospital with inpatient psychiatric ward and Outpatient mental health services. MoHFW. Urban (Pabna Mental Hospital).	4	226	1	500	Partially comprehensive, inadequate supply***	PST, BAT, supportive counselling, CBT, IPT
Referral and teaching hospitals (medical colleges), MoHFW - 36 govt owned: 76 private & military.	45 in govt owned facilities, no data in private	--	--	--	Comprehensive, available	Supportive counseling
Upazilla Health Complex. Outpatient, only. MoHFW. Rural.	0	0	0	0	Limited amounts of amitriptyline, haloperidol, chlorpromazine, phenobarbitone, diazepam	Supportive counseling

*These are not psychiatric nurses, but degree nurses who work in the psychiatric hospital.

**Meets or exceeds criteria defined by World Health Organization Model List of Essential Medicines, 2019

***Does not meet criteria defined by WHO Model List of Essential Medicines, 2019

Abbreviations. MoHFW: Ministry of Health and Family Welfare. NGO: Non-governmental organization. PT: Part-time. BAT: behavioral activation therapy. CBT: cognitive behavioral therapy. PST: problem solving therapy. MET: motivation enhancement therapy. IPT: interpersonal therapy.

Primary Care Integration

Bangladesh was one of the first countries in South Asia to launch mhGAP. As of January 31, 2020, a total of 302 health care providers (166 doctors and 136 non- doctors) working with FDMN in the Cox Bazaar region have received 3-days of training followed by supervision/consultation with trainers who are experienced psychiatrists.[19]

Psychiatric Medications

Stocks of psychotropic medications, including antipsychotics, antidepressants, anxiolytics, mood stabilizers, and antiepileptics are held and dispensed from hospitals, health centres, and health posts. Prescribing of these medications can be carried out by doctors, nurses, medical officers, and community health officers. One Facility Checklist completed in a rural health center reported having only one psychotropic medication (diazepam) in stock.

Psychosocial interventions

There is almost no availability of psychosocial interventions in Bangladesh outside of the national psychiatric hospital and national medical teaching hospital. A total of 17 psychologists in these two settings provide a wide range of psychotherapies, including problem-solving therapy, cognitive-behavioral therapy, behavioral activation, and supportive counseling.

Health Information System

The Ministry of Health and Family Welfare manages the DHIS2-based national health information system. Data are sent by Union level, Upazila level, and District level health workers on digital platform. Cases of mental health and substance abuse disorders and suicide deaths are reported.

Undergraduate and post graduate courses in mental health

The undergraduate medical curriculum (MBBS) does not include an adequate psychiatry learning and assessment system. There is no specific distribution of psychiatry-related marks and questions in the final evaluation for undergraduate medical training. In post graduate courses (FCPS Psychiatry, MD Psychiatry, MD Child & Adolescent Psychiatry and MCPS Psychiatry) around 20 students are enrolled per year, which does not allow to meet the country's need of psychiatrists.

In public university there are masters and MPhil courses in Psychology, Clinical Psychology, Education and Counselling Psychology and also masters courses in Clinical Social Work. Only one institute (BHPI-CRP) offers graduate courses on Occupational therapy and Speech and Language therapy.

Community

Sociocultural Factors

Family networks: The most common family unit in Bangladesh multi-generational and is called the "barhi", composed of parents, their unmarried children, and their adult sons with wives and children.[20]

Extended family networks act as a mechanism for protection as they provide more opportunities for persons with mental health conditions to participate in social activities/gatherings and have a larger network of people to rely on for support when needed. – Mental Health Advisor

Community support: Half-way houses, other supported housing, vocational training and community support activities for persons recovering from mental illnesses have very limited availability.

Stigma: Stigma towards mental illness and mental health treatment is widespread within Bangladesh. Many attribute symptoms to possession by evil spirits. A high proportion of sufferers, particularly those in rural areas, seek help from local traditional and spiritual healers.

There is still significant stigma associated with mental health conditions, so often the family has to hide if they have a loved one who is experiencing mental health issues or has a diagnosis because the cultural impact is such that, people often believe as though it is contagious. It's not just the person with the mental health condition that gets stigmatized but it's the whole family and this makes it even more challenging to reach out for services. -Mental Health Advisor

Innovative programming: Several organizations are providing app-based mental health care in underserved areas. Several mobile platform-based health programs sponsored by donor countries and NGOs have been implemented with pregnant women targeting reduction in maternal and child mortality.[21]

Technology has spread over the country and most people have access to it. Using this widespread information technology, we are now serving people across Bangladesh. Through online content and professional counseling, we are promoting mental health and informing people and encouraging the people suffering to take mental health services - Innovator and founder of key advocacy group.

A pilot psychosocial support program has been implemented in Dhaka and Gazipur districts to provide gender, sexuality, and mental health education to young women from urban slum settlements. Innovations include enlisting "shomaj shongees," or social companions, who are young adult women trained to deliver the educational curriculum, as well as creative arts and opportunities for individual and group counseling in junior secondary schools. Targeted outcomes include reducing school drop-out, early marriage, and pregnancy and promoting help-seeking.[22]

Non-health Sector Activities

Education system: Key informants point to children and adolescents as priority populations for targeting mental health care. To date, the public education system has not addressed the challenges of mental health and substance use problems among children and adolescents. There are no guidance counselors, school psychologists/social workers/nurses trained and deployed within Bangladesh public schools. Neurodevelopmental disorders, but neither mental illness nor substance use topics, are incorporated into national teacher training curriculum. Special education programming for children with serious emotional health problems is not available, and mental health/substance use are not incorporated within life skills curriculum. Schools would be a good platform for educating students, teachers, and parents about youth substance abuse and prevention.

Bangladesh needs to include religious leaders, school teachers, and local government opinion leaders in promotion of mental health and early detection and prompt management. – Director, National Institute of Mental Health

Child development system: Bangladesh has 15 Child Development Centers (CDCs) affiliated with medical college hospitals, staffed by child physician, child psychologist, and development therapist. CDCs conduct comprehensive assessment and intervention for children with autism spectrum disorder and other neurodevelopmental disorders.[7]

Criminal justice system: The criminal justice system offers programming geared towards prevention and treatment of substance abuse. The "war on drugs", launched by the government in 2018, has resulted in deaths and punitive measures taken against users.

Mental health support of FDMN: NGOs and government-based health facilities are actively providing resources, including psychosocial support, to Forcibly Displaced Myanmar Nationals and the local population living in Cox's Bazar. Since 2017 the Bangladesh Ministry of Health and Family Welfare has collaborated with members of the Bangladesh WHO Mission and the National Institute of Mental Health to offer 12 mhGAP trainings for 302 medical and psychosocial support providers working with the FDMN population. Evaluation of the initial 3-day training plus refresher showed trainees to utilize skills acquired to assess and manage mental health problems.[19] WHO organized 10 additional 3-5 day mhGAP trainings through early 2020 to ensure that all health facilities in the camps had at least one mhGAP trained staff.[6] To date, a total of 302 health care professionals working in the Cox's Bazar area have been trained, including 120 government and 182 non-government affiliated personnel.[23]

Advocacy and Awareness-raising

Knowledge of and access to specialty mental health care is challenging due to very low designated government resources, few specialty providers and concentration of resources in large urban centers. A number of advocacy groups, including the Shuchona Foundation, Moner Bondhu, Innovation for Wellbeing, and Walk to Serenity are working to reduce stigma, raise awareness about mental disorders and promote mental health literacy. These organizations disseminate messages via radio, TV, and written and electronic media. The Center for Disability in Development and the Directorate General of Health Services function as coordinating centers, supporting advocacy groups and communities to strengthen their ability to promote understanding and help for their citizens with mental illnesses and other disabilities. To date mental health messages have targeted general and youth populations, religious leaders and journalists. Mental health leaders believe that efforts to fine tune media messages to address relevant problems, such as distressing family relationship patterns, could strengthen impact of educational messages about mental health. For the past three years Bangladesh has celebrated World Mental Health Day.

IV. CONCLUSION

As the Situational Analysis shows, in many ways, Bangladesh is well-situated to implement reforms to better support the mental health needs of its people. Essential ingredients of adopting a modern Mental Health Act, crafting a Mental Health Policy, and proposing a Mental Health Plan have been accomplished through the work of a team of committed professionals who are supported by the Ministry of Health and Family Welfare. Bangladesh has established a public health infrastructure that extends the reach of basic health services throughout the country. The public health system creates a platform for broader dissemination of mental health services. There is also an extensive network of institutions that train medical providers and nurses dispersed throughout the country. The centerpiece of the public mental health system is the National Institute of Mental Health located in Dhaka, which serves as the psychiatric specialty hospital, administrative center, outpatient mental health treatment facility, and research center for mental health in Bangladesh. While most of Bangladesh's 162.7 million citizens are living in rural areas, specialty mental health services are highly concentrated geographically in the capital and a few urban centers. Government funds devoted to mental health and to mental health care beyond hospital beds are minimal. The key challenges that Bangladesh currently faces are how to apply their momentum, expertise, and experience towards taking first steps to develop a broader base of financial and human resources. The goal will be to will make measurable improvements in access to trained care providers and community-based supports for persons living beyond urban centers who are suffering with mental illnesses.

A number of initiatives serve as models for expansion. Bangladesh has achieved a scale up of training general health care providers working in camps with FDMN in how to recognize and treat mental disorders using the WHO mhGAP curriculum. A new government-approved plan will extend psychiatry training of medical students at 111 medical training institutions from seven hours to 85 days. Innovators are experimenting with technology to provide remote mental health treatment and support. Mental health advocacy groups have emerged to work with families and policy makers on behalf of persons with mental illnesses. Media messages are breaking the silence and stigma by educating the public about the importance of promoting mental health and treating mental illness. There is potential to collaborate with the many NGO's who offer programming to specific populations and address specific concerns. Skilled Bangladeshi researchers are conducting surveys, intervention trials and observational studies of mental health conditions within the local population.

Leaders have clearly articulated their priority goal of ensuring there are competent providers who can offer effective mental health treatments to adults and children in rural areas of Bangladesh. That will require strengthening their ability to support and monitor uptake and utilization of skills in general medical care settings, at the subdistrict level. For the WHO Mental Health Initiative, the first question will be to decide what $1,000,000 investment will optimize current assets and provide the best foundation for addressing these priorities.

With the current initiatives and future plans, the mental health and psychosocial services in Bangladesh are expected to gain new momentum - Director General of Health Services

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