



Opportunities and Barriers to Mental Health Services for Youth by Government, NGOs and the Private Sector in Bangladesh



Final Report of the Study on

Opportunities and Barriers to Mental Health Services for Youth by Government, NGOs and Private Sector in Bangladesh

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List of Abbreviations and Acronyms

ADHD	–	Attention-Deficit and Hyperactivity Disorder
AIMS	–	Assessment Instrument for Mental Health Systems
BDT	–	Bangladesh Taka
BSMMU	–	Bangabandhu Sheikh Mujib Medical University
CBT	–	Cognitive-Behavioral Therapy
CDC	–	Child Development Center
DBT	–	Dialectical Behavior Therapy
DC	-	District Commissioner
FGD	–	Focus Group Discussion
GoB	–	Government of Bangladesh
HRQoL	-	Health-Related Quality of Life
IQ	–	Intelligence Quotient
KII	–	Key Informant Interview
MDD	–	Major Depressive Disorder
NGO	–	Non-Governmental Organization
NIMH	–	National Institute of Mental Health
OCC	–	One Stop Crisis Center
OCD	–	Obsessive Compulsive Disorder
OOP	–	Out-Of-Pocket Expenditure
OT	–	Occupational Therapy
PD	–	Personality Disorder
PTSD	–	Post-Traumatic Stress Disorder
SDG	–	Sustainable Development Goals
TRIN	–	Telepsychiatry Research Network and Innovation
UNICEF	–	United Nations International Children's Emergency Fund
UTSA	–	Unite Theatre for Social Action
WHO	–	World Health Organization
WVB	–	World Vision Bangladesh
YPSA	–	Young Power in Social Action

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Preface

Mental health and wellbeing has been one of the most neglected areas of contemporary health care service structure in Bangladesh. While the situation has been extremely critical due to the long impact of Covid - 19, no significant efforts are seen neither by the government nor the nongovernment agencies. This research is one of the very few initiatives that tries to understand the situation in one hand and identify ways to address the issues on the other during the pandemic. In particular, this study focuses on understanding the condition of mental health services available for the youth and adolescents in four major districts Dhaka, Chattogram, Barishal and Dinajpur in Bangladesh. And the project is meant to describe about the availability of necessary mental health services and the barriers to access those services.

With the support from World Vision Bangladesh, for conducting the study, the Dhaka University research team has visited three major districts Dhaka, Chattogram and Barisal but unfortunately due to Covid-19 pandemic couldn't attend the Dinajpur field in-person. However, we employed a trained team from Dinajapur to conduct some of the interviews and with the help of the World Vision colleagues, especially from Dinajpur data collection was properly managed. Working under in the time of pandemic is a completely a different experience which we came across in course of this study. We highly value this learning opportunity.

This Project Report puts light on the youth and adolescents in Bangladesh are facing numbers of mental health challenges including education related stress, school related anxiety, sleeping disorder. Our Research reports some barriers for the youth and adolescents to access the mental health services and marked the rural-urban divide in terms of service availability, price and quality.

We believe that this study will help the practitioners to identify their areas of intervention o which they could build an effective mechanism of mental health care service provision that is accessible to youth and adolescents especially the poor and marginalized sections of the society.

Executive Summary

1. Mental health is in the spotlight more than ever. Covid-19 pandemic is currently going slowly down all over the world. However, a silent mental health pandemic is in full force. The youth has enjoyed relatively lower risks of health outcomes of Covid-19, but the mental health pandemic is targeting the younger age group across the globe; so does in Bangladesh. This research reports the condition of mental health services available for the youth and adolescents in four major districts in Bangladesh. It examines availability of necessary mental health services. It identifies the barriers to access to services. It presents what could be done for improving the access to services for the youth and adolescents.

2. The study is aimed at identifying barriers and opportunities to access mental health service systems in the Covid-19 affected new-normal context in Bangladesh.

3. This research is explorative and inductive in nature. It is pragmatic in approach and design. This study is done during the time of pandemic. It is built on four components – desk review, qualitative data, service providers mapping and policy analysis. There were 150 male and female participants from Dhaka, Chattogram, Barishal and Dinajpur who attended in FGDs and 31 key stakeholders were interviewed as part of the data collections process.

4. Having reviewed the existing literature – data, documents and research papers- including important policies and strategies enacted and/or adopted by Bangladesh government, it is clear that the pandemic Covid-19 has made a huge additional pressure on the existing inadequate mental health services in Bangladesh. Children, adolescents and the youth are suffering the most. In a context like Bangladesh while the entire health care system has been stretched to its maximum in dealing with the pandemic and post-pandemic health challenges, it is not possible for the Government of Bangladesh to address all the mental health issues. Clearly, there are service gaps. In order to effectively address this gap, especially from the perspective of the youth and adolescents, a more comprehensive service structure participated by all government, nongovernment and private sectors is required. In meeting the requirement, comprehensive research needs to be carried out in the first place to build understanding of the real situation on ground with evidence.

5. It is seen that during the pandemic the youth and adolescents in Bangladesh are facing numbers of mental health challenges including education related stress, school related anxiety, income-loss related anxiety, sleeping disorder, domestic violence, verbal abuse, impulse control and conduct disorder, depression, fear of job loss, anxiety of economic hardship, fear of sexual abuse, mood swings etc. However, these challenges are not clinically diagnosed rather identified through analyzing symptoms the research participants mentioned in the interview and FGDs.

6. For seeking support, most of the youth do not take any action. In most cases they try to ignore the issues. For them, parents, friends are not found to be confidence worthy. They feel comfortable on online and tele-help line services. In fact, at the grassroots, overall, service availability is extremely poor.

7. The barriers of accessing mental health care across regions vary, not widely though. Three types of barriers were identified – cultural barriers, economic barriers and institutional barriers for all four study locations. In brief, the *Demand* side of the barriers include, Lack of awareness among the youth and adolescents about the mental health symptoms and its impact on their cognition, behavior and

bio-physical health; Lack of information about the available services; Lack of information about the health professionals/service providers; Lack of awareness among parents about the significance of mental health issues; Social stigmatization (*loke pagol bolbe*); Superstitions - disgrace for family; Misconception about the cost and process of the treatment; Poverty; Busy in managing subsistence; Workload of childrearing, household chore, huge workload for women, especially married women; Fear of husband and in-laws. On the other hand the *Supply* side of the barriers include: Only few service outlets are available at the district level, and most of them are interested in drug addiction cases; Psychiatry departments of medical colleges are not fully equipped, under resourced; No service information is available at the community level through any media: for example billboard, poster or leaflets; Doctors' directories are not easy to find; Psychosocial counsellors are hardly available; High cost of treatment/counselling [travel, medicine, doctor and lengthy treatment]; Poor follow up mechanism by the service providers; Nongovernment organizations have a very limited target group; most of them have no dedicated services; Lack of trained manpower in providing initial services to the people in need; No primary screening mechanism is available at the community level; Poor implementation of Mental Health Policy; Government shows no or less priority in addressing mental health issues and Inadequate budget allocation by the government

8. There have 203 service provider organization and individuals have been mapped with their detail service-related information. It is seen that Dhaka has the highest 72% of the service providers and Dinajpur has the lowest, only 3%. Among the service providers private entities are the maximum in number, 64% of the total providers while NGO consist of 19% and Government agencies are 17%.

9. There are variations in terms of price of the services. Service charge for private providers are way higher than government and NGO services.

10. There are rural-urban divide in terms of service availability, price and quality. With this background the following recommendations are proposed:

National Level Recommendations

National level measures are required to address systemic and policy barriers. In identifying opportunities, we have drawn on the opinions, perspectives and experiences of the research participants.

Preventive Measures

(a) **Initiate Campaign for Reformulating and Updating National Mental Health Policy 2006 and National Mental Health Strategy and Action Plan**

The Government of Bangladesh has enacted National Mental Health Act 2018 which is considered to be a positive step. However, the Act is mainly for regulating some specific activities and ensuring rights of the mental health service clients. But a policy is broader than the Act. Policy provides overarching guidelines for whole range of actors and stakeholders in a society. The existing national mental health policy was formulated in 2006 (WHO-AIMS Report, 2006). There was another updated draft tabled in 2019 but it hasn't been adopted until now. A multidisciplinary working group also drafted a National Mental Health Strategic Plan 2020-2030. But neither of them has been formally adopted and put in implementation. In between, Covid pandemic has added a new dimension to the existing scenario. Thus, at this stage it is important to revisit earlier policy proposals in light of the new reality and advocacy campaign could be launched for the new policy adoption.

(b) Build a broad-based National CSO-professional Alliance for Mental Health

There are several professional associations related with the access to mental health services for example Bangladesh Psychological Association, Bangladesh Association of Psychiatrists etc. at the same time there are civil society led network of service providers such as Bangladesh Association for Child and Adolescent Mental Health. These two types hardly talk to each other. Academics and experts opined that an initiative could be taken immediately to develop a national level broad-based CSO-professional alliance for mental health in Bangladesh.

(c) Launch Campaign for Increased Budget Allocation in Mental Health Services

It has been identified and analyzed by WHO, national level thinktanks and researchers that national budget allocation for mental health affairs is only less than 0.5% of health care expenditures by the government. Which means, the amount is extremely negligible. And it is hard to expect any major change or improvement to take place with this meagre financial resource. Therefore, there is a need for advocacy for increasing national budget allocation for mental health. It requires regular analysis of budget allocation and expenditure and based on which the advocacy plan could be developed.

(d) Engage Media and other Social Forces for Creating Mass Awareness about Mental Health in the Society

It is well established that peoples access to and preference for mental health services is heavily influenced by existing social stigma attached to it. Changing social stigma and taboo is not simple and easy. It requires long-term interventions with whole-society approach. Media probably has one of the most powerful roles to play. Bangladesh has witnessed the power of media while countering social problems like sanitation, dowry, child marriage etc. We have seen in recent years that with successful media campaign awareness about autism has increased. We therefore propose to engage media and other social forces to create mass awareness on issues of mental health. Social media has been extraordinarily influential in shaping peoples' perception and behavior. Thus, the role of social media should be taken into consideration too. It is not only media, but other forces like Scouts, Girls Guide, Theatre Federation, Music Associations etc. should also be engaged with careful initiative in awareness campaign.

(e) Build Partnership and Collaboration with Academic Institutions

Mental health is an extremely sensitive and complex in nature, thus requires regular research and knowledge upgradation. Fact is gap in mental health research in Bangladeshi is vivid. In order to fill the gap a good number of studies are required to be conducted on different aspects. However, it is not easy for a civil society organization or government to do it alone. Rather, it requires multistakeholder engagement. Especially, the NGOs and civil society organizations can build long-term collaboration and partnership with academic and research organizations which could be mutually beneficial for both parties. This partnership can generate necessary knowledge products which could be easily transformed into some kind of *policy brief* and *contents* for further extended advocacy work.

(f) Form a National Forum on Mental Health

Current context of mental health in Bangladesh is quite complex which hence asks for multidimensional but coherent actions from different stakeholders. These actions, however, shouldn't be scattered and thus, a national coordination platform, for example a forum, is a must. This forum must include all types of mental health professionals e.g., psychologists, mental health activists, NGO leaders who are working with mental health issues in Bangladesh, academics, researchers, journalists, lawyers, psychiatrists, and owners of different private clinics and hospitals operating across the country. Their involvement and dialogue will create greater sensitization in the society in one hand, and on the other hand they could figure out many solutions of many practical problems they face in delivering mental health services. This forum, like other forums for example, Global Social Forum, can convene an annual event in Bangladesh.

(g) Strengthen Movement for Appointing Psychosocial Counselors in Every School in Bangladesh

Few years back, the GoB took an initiative to appoint psychologists in educational institutions which later was not being implemented. One of the major reasons is the lack of adequate number of psychologists. Needless to say, appointing this many psychologists within a short period of time seems impossible. With that considered, educational institutions can't be compromised in this regard either. At this juncture, NGOs can help in a very different manner. Instead of appointing this many psychologists, they with the help of experts, can train required number of school/college teachers. Those trained teachers will then continue sessions in a periodic manner to take care of the mental health of their students. In addition, including mental health issues in parents meeting is also pivotal. However, NGOs require extensive programmatic and policy support from the government (central and local) since they lack accessibility and to some extent availability of resources required. In doing so, assurance of honorarium for the trained teachers also need to be taken care. Again, NGOs can arrange training sessions as mentioned above but ensuring regular honorariums for all those trained individuals would be extremely challenging for the NGOs. Thus, government must come forward to ensure the benefits for the trained teachers.

Curative Measures

(a) Develop scientific standardized diagnostic tools

Diagnosis is one of the most important and crucial factors in mental health treatment. It is thus, a must-do is to develop a standardized diagnostic tool for treating the patients. Academics of Clinical Psychology department argued that, this task should be performed centrally with the help of various mental health professionals including but not limited to psychiatrists, clinical psychologists and researchers. This tool will accelerate the pace and efficacy of treatment and indeed, potential to remove extra burden from the psychiatrists about providing other psycho-social treatment to the patients.

(b) Undertake policy advocacy campaign for increasing professional competency and ensuring proper treatment

To ensure proper diagnosis, treatment and care, enhancement of professional competency, and training are must in Bangladesh. However, Psychiatry is not well-preferred among medical graduates

in Bangladesh. Our key Informants informed that, best medical students either choose internal medicine or surgery related specialization, and their decision is driven by a cost-benefit analysis. Moreover, to a very larger extent, family members are not ready to accept the fact that their successors will be a psychiatrist. One of our KII respondents who is a prominent psychiatrist in Bangladesh stated that,

“In Bangladesh, Psychiatry is a less-preferred subject to study. As such, a lot of rooms are left unexplored, and it reduces the efficacy of treatment. Also, the funding for research, treatment and other relevant services required here is very poor. Psychiatrists face institutional deprivation whereas the condition of psychologists are even worse. Without a coordination effort, improvement of mental health condition in Bangladesh I don’t think possible in near future.”

These places requires both policy- and program- centric interventions. Psychiatry must be made a compulsory subject in MBBS curriculum and scope for post-graduation in psychiatry should be increased so that people get the opportunity for taking higher training. Regarding Psychology, the curriculum must be updated periodically so that the students remain competent and resourceful. NGOs or civil society organization can mobilize social forces to undertake such policy campaign to bring these changes.

(c) Develop more Professionals

Though both psychiatrists and psychologists are less in Bangladesh, crisis of psychologists are much prevailing. At the very onset, a very few students are there who are willing to study psychology on their own, stated by an Associate Professor of Psychology, University of Chattogram. Psychology as a subject is found among the bottom of the priority pyramid among the students. Moreover, those who have interest genuinely, can’t go for this due to peer and family pressure. One of the major driving factors are the poor job opportunity for the psychologists. Another obstacle is the curriculum. The curriculum must be updated so that students prioritize this subject. To produce more professionals, national level patronage, coordination and effort is pivotal. If the issue of curriculum and job opportunity are checked, the condition will definitely improve in this regard.

(d) Approve of different models of treatment

In Bangladesh, medical model of mental health treatment is extremely dominant since its inception, whereas efficacy of psychological and social model for treatment of mental health issues are proven already in many countries of the world. The successful model for effective mental health promoting and mental illness treating programme is bio-psycho-social model in any good mental health programme. Despite dilemma for practicing, this medical model is highly prevalent for few obvious reasons. To erode this crisis a central coordination effort is needed. Beyond medical model, expanding psychological model, and establishing social model in the mental health policy and practice will help in many ways, creating job opportunities for psychologists and social workers as valuable and efficient contributor as distinct kind of mental health professional, ensuring proper and efficient treatment for the mental patients. As such from the policy level, multiple models of treatment need to be recognized, approved, and must be made mandatory in any mental health treatment service facility. So far, Bangladesh has tradition of producing Psychiatrists and Clinical Psychologists, but not any place to produce Psychiatric Social Worker. Only exception is the provision of producing Masters level Clinical Social Worker at Dhaka University, only from an evening course, which admits graduates from any background, including dentistry. Bangladesh, thus needs to produce professionally qualified general social workers, as well as psychiatric social workers, to reduce the

mental health service gap, in the current incomplete system. The social work departments of all public universities must update and upgrade their syllabus and their supervised internship programme, to ensure quality production of general and psychiatric social workers, who will be professionally qualified to provide appropriate social support to the mentally disturbed and distressed individuals, family and community, to restore their mental balance.

Community Level Recommendations

There are some initiatives which could be undertaken at the community level directly addressing the clients. Some of them are proposed in the following.

Preventive Measures

a) Develop motivation and awareness programs at the community

The persistence of cultural barriers in terms of mental health service taking from practitioners are heavy. One of the major tasks in this regard is to break the concurrent social stigma and no single actor or strategy can help achieving this. This requires a whole-society approach and strategies. Community leaders, NGO leaders and youth leaders we talked with believe that Government must play coordinating role among multiple stakeholders where NGOs may act as the implementing partner. They may run school and college-based campaigns separately for providing training to the teachers. Besides, involving the local religious leaders, and local print and electronic media is instrumental to increase awareness among people at the grassroots level.

b) Adopt community-based approach and strategies for service providers

Our interviewed experts and NGO managers believe that service providers should adopt a context-specific strategy for any given locality instead of following ‘one size fits all’ method. Mental health issues are diverse and different segments of the society do have different types of problems. As such, service providers must have prior knowledge about the region they are operating in. In addition, building rapport with the community is very important since people are not always ready and comfortable to share their mental condition with others. As such, a community-based strategy will help more to provide efficient service of mental health problems.

c) Engage political leaders, community resource persons, and resources

At the grassroots level of Bangladesh, political leaders, religious leaders, and teachers possess a great hold over the mass people. As such, NGO and community leaders believe that involving them in the process of mental health crisis management will bring fruitful outcome. It will also help the service providers to implement community-based strategies for providing services.

d) Develop paraprofessional personnel with an inclusive team in each operational unit

Usually, we consider only psychiatrists and psychologists as mental health service providers, but it is not limited to these two only. For providing proper mental health service in any locality, a team including (a) psychotherapists, (b) counselors, (c) clinical social worker, (d) psychiatric nurse, and (e) occupational therapist is essential apart from psychiatrist and clinical psychologists. In some places, multiple psychologists and counselors are required with different types of expertise e.g., drug addiction, children, adolescent, relationship etc. However, these professionals are rare in number. Many mental health practitioners across the country strongly argued that it is high time to develop

paraprofessional with short term training who can serve at the primary service outlets at the community level.

e) Develop a cadre of mental health volunteers with proper training on Mental Health First Aid at the community level.

The GoB has long standing commitment to develop mental health volunteers at the community level. Community and youth leaders prescribed that mental health volunteers would be given training on Mental Health First Aid pack. Regarding this, our panel of academicians argued that CSO/NGOs can take similar initiative to supplement or reactivate the existing government initiative. The same training curriculum could be offered by NGOs under the supervision of a mental health technical team to develop their own cadre of community mental health volunteers.

Curative Measures

(a) Develop primary screening and assistance facility at the grassroots

It is clearly found that at the grassroot level of Bangladesh, availability of services is extremely poor, almost nonexistent. Contemporary practitioners prefer practicing in Dhaka or in a large city like Chattagram, to a very small extent, in other divisional and district cities. Even in some divisional cities like Barisal and Dinajpur, availability of services is alarming. Civil society members, academicians, and local citizens themselves also have stated that, with collaboration of government, NGOs and private agencies, dedicated mental health service facility must be developed at the town level, at least at the District Hospitals.

(b) Initiate interventions to reduce maltreatment

All the resource persons we talked with said that one of the major hindrances of our mental health service delivery is the dominance of malpractitioners. It is high time to prevent the malpractices of some so called “Baidya,” “Hujur,” “Purohit” and likewise practitioners. They capitalize the emotions of mass people on religious issues and provide services. A grassroot campaign could be initiated through existing programmes like Girls Club or Community Based Organizations which are already in place.

Apart from this, our panelists suggest disciplinary action against these mal-practicing individuals (e.g., non-trained practitioners) and organizations (e.g., so-called rehabilitation centers). These organizations have capitalized peoples’ limitation of knowledge and vulnerability. Hence, the rehabilitation centers must be brought under a monitoring protocol having a specific guideline of service delivery. In addition, service takers must have an opportunity to inform the respective authority directly by any means (e.g., hotline number, email, letter etc.).

(c) Make services affordable for All

Community members we talked with, academicians and managers of different hospitals said that one of the major interventions in this regard will be lowering the cost since almost all the respondents have reported about the higher out-of-pocket expenditure (OOP). Government can play the biggest role in this regard. Though through KIIs, it has been found that telemedicine service has been functional since the outbreak by National Institute of Mental Health for free of cost, people are

unaware of this. If along with services, information dissemination can be done simultaneously, such initiatives will give higher rate of return.

Secondly, government can incentivize the private hospitals for lowering the cost of mental health by announcing a tax rebate on the earning of mental health service delivery. If it includes the special children too, people will be beneficial greatly.

Thirdly, NGOs can run campaigns of mental health treatment both in medical and psychological/social model in areas where the service delivery lacks affordability or accessibility or both. This will help the marginal and low-income citizens availing the services.

(d) Building online platform/ helpline

Despite the fact that the Covid- 19 pandemic has created enormous pressure in all terms for people of all walks of society in Bangladesh and elsewhere. However, especially in Bangladesh there has been a positive impact that is people has now been familiar with online-based transactions and exchange. During the current pandemic e-commerce and e-services have been burgeoning like anything. We think this is an opportunity to establish more online-based/ Tele-help line services for mental health care. There we found at least six successful initiatives which are already doing great services in Bangladesh. However, this kind of initiatives could be established more. Especially, an NGO could run such services for poor and vulnerable group of populations through a toll-free number. Director of NIMH, former Director of Pabna Mental Hospital, Executive Director of TRIN and Lead Psychiatrist of Life Spring believe that tele-medicine in this context is a major breakthrough for us and it needs further acceleration.

1. INTRODUCTION

Mental health is in the spotlight more than ever. Covid-19 pandemic is currently going slowly down all over the world. However, a silent mental health pandemic is in full force. The youth has enjoyed relatively lower risks of health outcomes of Covid-19, but the mental health pandemic is targeting the younger age group across the globe. So does in Bangladesh. This research reports the condition of mental health services available for the youth and adolescents in four major districts in Bangladesh. It examines availability of necessary mental health services. It identifies the barriers to access to services. It presents what could be done for improving the access to services for the youth and adolescents.

This research is explorative and inductive in nature. It is pragmatic in approach and design. This study is done during the time of pandemic. It is built on four components – desk review, qualitative data, service providers mapping and policy analysis. The report concludes with a set of recommendations to design future programming for the people in need.

This report is structured in broad six sections. The First section introduces background, objectives and methodology of the study. The Second section presents the desk review of contemporary research and policy documents. The Third section presents findings of the qualitative research in detailed. This section identifies the major barriers of accessing mental health services. The Fourth section details out findings of the Service Providers Mapping. And the Fifth section has discussed the opportunities and presented a set of recommendations that can be undertaken. And section Six is to conclude the entire work. Bibliography, and Annexes are added at the end of the report.

1.1. Background

Bangladesh, like other countries across the world, is facing an unprecedented challenge brought about by the Covid-19 pandemic. This coronavirus pandemic has hit the Bangladesh society and economy hard, across all walks of life. The pandemic has brought many challenges to people's lives, including their exposure to Covid-19, lockdowns, self-isolation or quarantine, suspension of educational activities, job losses and so on. A WHO study shows that before COVID-19, roughly 1 in 5 adolescents worldwide was already living with mental health conditions and suicide was the third leading cause of death for teens between the ages of 15 and 19 (WHO, 2018). COVID-19 has only compounded the problem. It's not hard to understand why. Millions of young people can't access school. Jobs are hard to come by, and financial security is harder still. Social and community bonds are wildly disrupted. Alcohol and drug use are up, along with anxiety and depression. Young women in particular bear a disproportionate share of the pandemic's social and economic consequences. Girls and women are taking on a majority of unpaid care work. Domestic violence, child marriages and unwanted pregnancies are all expected to rise. And in what has been called a shadow pandemic, gender-based violence has skyrocketed. Six months of lockdown measures are thought to have led to an additional 31 million cases of violence against girls and women. Bangladesh is no exception to this grim scenario across the globe.

In Bangladesh, mental health has historically been given little importance, more so for children and youth due to the demographic group generally being less vocal about their concerns. Furthermore,

the Bangladeshi society often casts aside concerns about adolescents' mental health and well-being. According to the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) report, from 2007 mental health expenditures from government health departments are very insignificant and are less than 0.5 per cent of the healthcare outlay which got reduced to 0.05% in 2020 (WHO, 2020; Alim, 2020). Unfortunately, children and youth's mental health issues arising from Covid-19's onset have, regrettably, not received the attention they deserve, in Bangladesh. During this challenging time the need for improved mental health and psychosocial support has been higher than ever.

According to the National Mental Health Survey in Bangladesh from 2018-19, around 17 percent of Bangladeshi adults are undergoing mental health problems like depression, anxiety, stress and obsessive-compulsive disorders. Of them, over 92 percent did not seek mental health services due to stigma, negative perceptions, inadequate knowledge of available mental health services, misconceptions about treatment and treatment cost. Although there is limited population-based data on what percentage of Bangladeshi people are suffering from mental health problems due to the Covid-19 crisis, a review of extant studies of Covid-19 has found high rates of psychological distress among Bangladeshi individuals, ranging from 58 percent to 86 percent. This indicates that the pandemic has taken a serious toll on existing mental health problems in Bangladeshi individuals. The the mental health fallouts of Covid-19 have been even worse for some groups like women, children, adolescent boys and girls, youths, older people, healthcare workers, individuals with compromised immune systems. This may act as a barrier to achieving the Sustainable Development Goals (SDGs), especially Goal 3 of reducing by one-third the premature mortality from non-communicable diseases through prevention and treatment and promoting mental health and well-being.

On this backdrop, World Vision Bangladesh has commissioned this research project to identify the barriers and opportunities for the vulnerable youth to access mental health services in both urban and rural context from all potential service providers including government, nongovernment and private sectors.

1.2. Objectives of the Study

The study is aimed at identifying barriers and opportunities to access mental health service systems in the Covid-19 affected new-normal context in Bangladesh. Thus, the research study is planned to pursue the following specific objectives:

- (i) To identify available/existing services provided by the government, NGO and private sectors organizations;
- (ii) To identify key barriers and opportunities to access to mental health services for youth by the government, NGOs and private sectors;
- (iii) To determine the policy and institutional capacity gaps which act as a barrier to access the mental health services for the youth;
- (iv) To explore the role of stakeholders in bridging the gap

1.3. Methodology

This study is drawn on an explorative research design, which means the research mainly explores the current status of the mental health care service in Bangladesh, especially in the selected study districts i.e., Dhaka, Chattogram, Barishal and Dinajpur. Also, the study identifies the barriers and opportunities for the youth to access mental health services based on the information collected from both sources: service providers and clients. The study includes a desk review to identify the policy gaps and find potential roles for the stakeholders in improving the mental health service for the youth in Bangladesh. By design the study draws on qualitative approach, thus appropriate methods were applied to collect necessary qualitative data. The methodology has been finalized in collaboration with the WVB team.

The data collection methods consist of several components including Desk Review, Key Informants Interview (KII), Focus Group Discussion (FGD) and a Service Provider Mapping protocol. For KII a set of stakeholder specific interview checklist was developed and tested prior to the fieldwork. Similarly, for FGDs a guideline was drafted. A brief checklist was developed to collect information about the service provider agency and individuals.

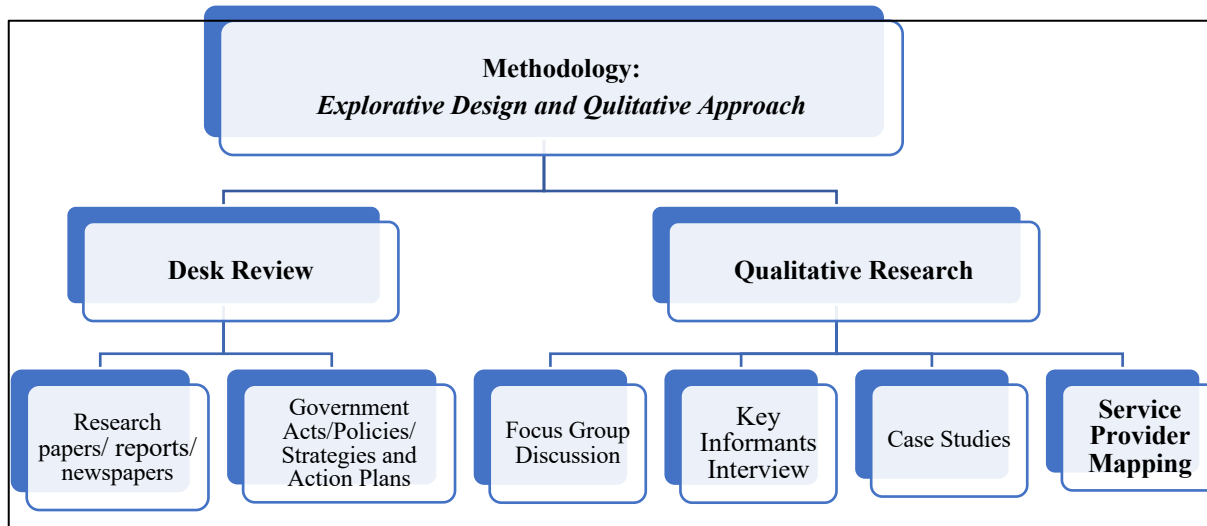
1.3.1. DESK REVIEW

In order to understand the overall situation of the impact of Covid-19 on the youth and adolescents in Bangladesh and across the globe, prevalence of the mental health issues among the youth and overall performance of the existing health care service system in Bangladesh a robust document review was carried out. Review includes WHO reports, Mental Health Surveys, research papers and newspapers clippings published on relevant issues during the pandemic. One of the other main purposes of the Desk Review is to identify the policy gaps in relation to mental health services. This policy analysis includes Bangladesh Mental Health Act 2018, National Mental Health Policy 2006, National Health Policy 2011, Non-communicable Disease Action Plan and Strategy, National Strategy for Adolescents Health 2017 – 2030 and relevant other policy documents.

1.3.2. QUALITATIVE RESEARCH

This is the instrumental phase of this research, especially for collecting primary data. This phase includes tasks to be performed in the field sites in collaboration with World Vision Bangladesh team. For collecting data, a set of interviews was conducted with key service providers, youths, parents, youth leaders and other relevant actors. The research team also carried out FGDs with relevant male, female groups representing both urban and rural background from among the youth and parents. And the service providers mapping was done with a brief checklist.

Four main methods were employed for qualitative data collection, described as follows:



Focus Group Discussion (FGDs)

FGD is to collect qualitative data from the relevant stakeholders, especially the youth and adolescents both male and female groups. Altogether, 15 FGDs were conducted in four study locations with youth and adolescents of both urban and rural background.

In all four study districts 150 participants joined in the FGDs. FGDs were conducted separate for male and females. It is seen that, 54% of the FGD participants were female while 46% were male.

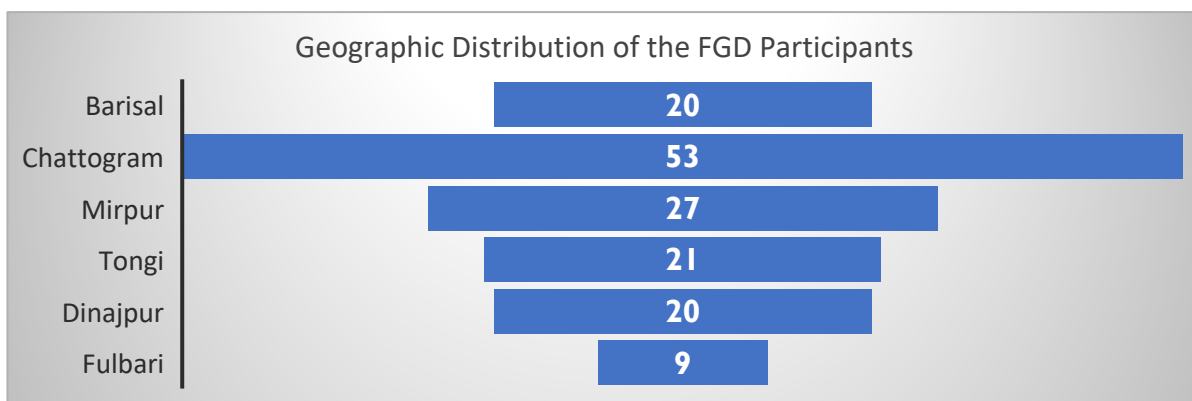


Figure 1: Distribution of FGD Participants across Study Areas

FGD participants were chosen among the age group between 15 to 30. However, there were variations within this age category as well. Analysis of the FGD participants data presents that, majority, 55%, of the participants in FGD represents the age group between 20-24 years where age the youngest group, between age 15 to 19 years, has the lowest participation. The participants of age between 20 and 30 years, consist of 28% of the total participants (Figure 2).

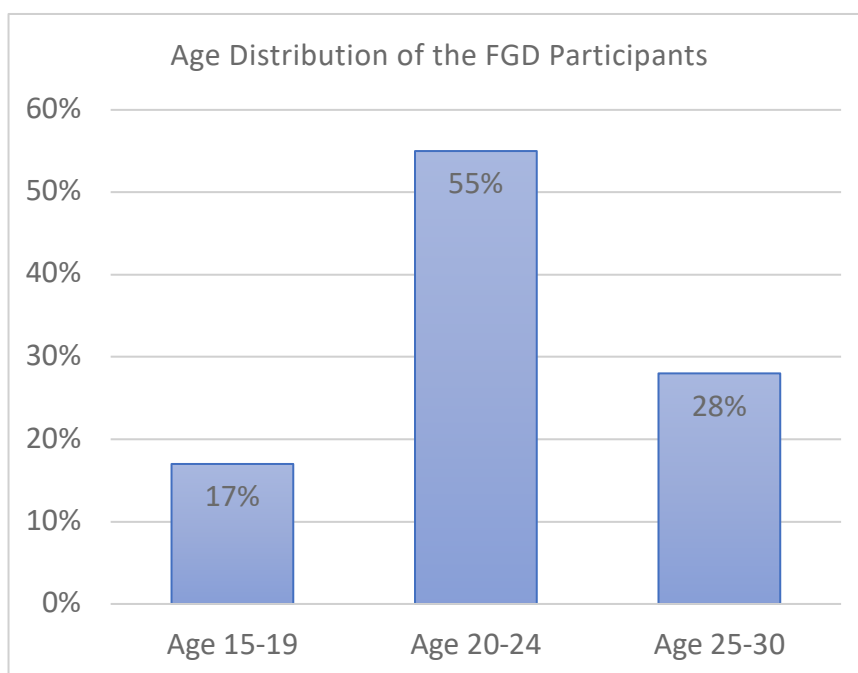


FIGURE 2: AGE DISTRIBUTION OF FGD PARTICIPANTS

Figure 3 shows that among the participants, 54% were female and 46% were male.

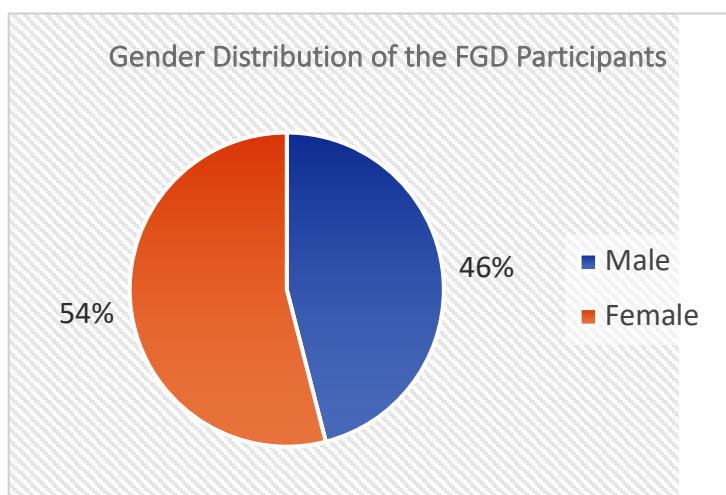


FIGURE 3: GENDER DISTRIBUTION OF FGD PARTICIPANTS

For FGDs specific guidelines was developed after finalization of the list of groups in collaboration with the WVB team. For all FGDs, standard methodological and ethical protocols were properly followed.

Key Informants Interview (KIIs)

In order to gather deeper insights, series of Key Informants Interviews were conducted with a host of stakeholders of various categories. The detail list of Key Informants is given in the *Annex*.

31 KIIs with relevant stakeholders including managers of service providing agencies – both government and nongovernment, government mental health regulators. The categories of KIIs are as follows:

The consultant conducted all together

Government Regulators

1. Director, Non-communicable Disease; DGHS;
2. Director, Directorate of Youth Development
3. Director, One-Stop-Crisis, Department of Social Services

Mental Health Service Provider and Research Institutes

1. Director, National Mental Health Institute
2. Chairman, Department of Clinical Psychology, Dhaka University
3. Director, Nasrullah Psychosocial Counselling Center
4. Chairman, Department of Psychiatry, BSMMU

Non-government Organization

1. Mental Health, Institute of Education and Development, BRAC
2. Mental Health and Psychosocial Support, Save the Children Dhaka
3. Mental Health and Psychosocial Support, Plan Bangladesh
4. Bangladesh Women's Health coalition

Private Sector Service Providers

1. Chief Executive, CREA
2. Managing Director, Psychological Health and Wellness Clinic
3. Executive Director, Monobikash Psychotherapy and Counseling Centre

At the City level (AP Level):

Chattogram

1. WVB AP Manager/Mental Health-Psychosocial support Lead
2. One-Stop-Crisis Center Manager, Chattogram
3. Executive Director, YPSA
4. Professor, Department of Psychology, Chittagong University
5. A parent – having child with mental health issue
6. A psychosocial counselling provider

Barishal

1. WVB AP Manager/Mental Health-Psychosocial support Lead
2. One-Stop-Crisis Center Manager, Barishal
3. Dr. Manisha
4. A parent – having child with mental health issue
5. A youth organization leader (female)

Dinajpur

1. WVB AP Manager/Mental Health-Psychosocial support Lead
2. One-Stop-Crisis Center Manager, Dinajpur
3. Shishu Bikash Kendra, Dinajpur Medical College Hospital
4. A parent – having child with mental health issue
5. A psychosocial counselling provider

The consultant developed stakeholder specific KII guidelines for the interviewees. The exact number and locations of the KIIs were determined in discussion with the World Vision team.

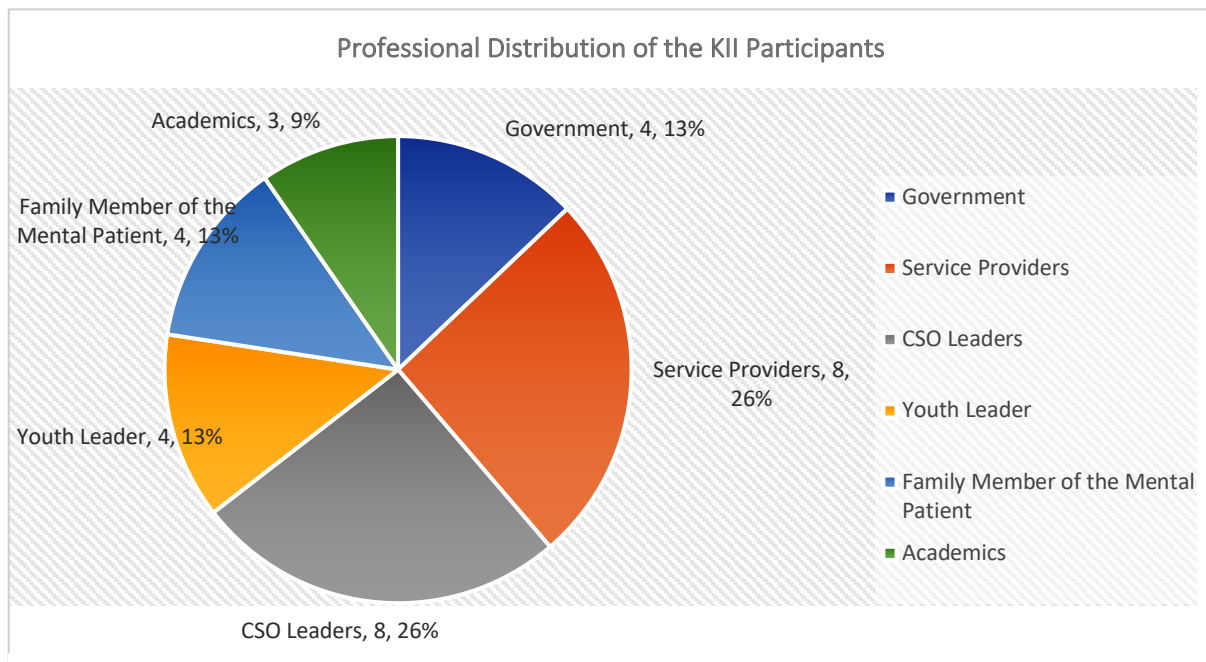


FIGURE 4: DISTRIBUTION OF KII RESPONDENTS

Figure 4 presents that, according to the profile analysis of the KII respondents, NGO/CSO leaders were 26% , while service providers were 26%, government managers and regulators were 13%, academics 9%, 13% were family members or person with mental health issues and 13% were youth leaders.

In addition, there were 4 case studies were also carried out with in-depth interview.

Case Study

For building deeper understanding about the barriers to access to mental health services among the youths 4 case studies among the service clients/potential clients were conducted. For case studies long and open interview-conversation was run with the individual respondents.

TABLE 1: SLECTION OF CASE STUDIES

District	AP	Types of cases	Criteria for case selection
Dhaka	Mirpur	A youth who recovered from mental/Psychological health challenges	1. Age between 15 - 30 2. Had Covid experience 3. Had mental health issues at post-covid phase 4. Male or female
Dinajpur	Dinajpur	A youth who recovered from Covid	1. Age between 15 – 30 3. Had/hadn't mental health issues at post-covid phase 4. Female
Barishal	Barishal	A youth from lower income category had recovered from Covid	1. Age between 15 – 30 3. Had/hadn't mental health issues at post-covid phase 4. Male/Female
Chattogram	Chattogram	A youth leader who had mobilized supports for the community during the covid	1. Age between 15 – 30 2. Had/hadn't mental health issues at post-covid phase 3. Male/Female

1.3.3. SERVICE PROVIDERS MAPPING

This particular tool was administered to map the existing mental health service provisions for the youth in the selected study districts. This is actually an institutional mapping under which with an *institutional checklist* we explored (a) which kind of institutional services are available, (b) what is the disease pattern in the areas, (c) what are the demographic features of the service clients, (d) what is the capacity of the providers (e.g. outpatient service, inpatient services, psychiatry and

psychosocial service provisions, number of trained health professionals), (e) what are the prices of services, (f) what are the main barriers to access the services available and (g) what is require to meet the client's demand.

The service providers mapping will cover all types of available institutional service providers – government, non-government and private sector providers.

Finally, **triangulation** will be done with the information collected from desk reviews and primary data collected from fieldwork.

1.3.4. ETHICAL CONSIDERATION

The consultant was fully aware of ethical issues related with health research in general and especially mental health research. We showed full commitment to comply with the WVB Child Protection Security and Behavioral policy protocol and SWORN statement. In our research parental and child informed consent was taken before engaging any children to any activities. Informed consent means that people have explicitly agreed to participate in the process after being informed in ways that they can understand about all relevant issues clearly.

During data collection, the qualitative research team explained the objective of the research and purpose of the Interviews/KII/ FGD consultations at the beginning. The respondents were informed that their identity would be anonymous in the report and the information will be used only for research/evaluation purposes. It was clearly described that they have no financial benefit for providing information, their participation will be voluntary and that they will not be penalized in any way if they choose not to participate. Before starting the collection of data, their consent was ensured.

1.3.5. SPECIAL MEASURES FOR COVID-19

The study was in the time of pandemic. However, all measures were taken to protect the research team members and research partners form potential Covid 19 infection.

- The entire team was provided Covid-19 health safety training to ensure the health safety of the both the team members and the respondents. They were provided with sanitization materials and PPE.
- For several cases online platforms were used.
- The FGDs were carried out by the Principal Investigator and team members with the help of local partners and team members
- Many of the KIIs were conducted using video conferencing tools if possible; like Zoom
- The field plan had changed several times in order to adjust with sudden lockdown and movement restrictions.

2. Review of Contemporary Research and Policies on Covid-19 and Mental Health Services in Bangladesh

Mental health is crucial to the overall well-being of individuals, communities, and societies because mental, physical and social functioning are interdependent (Devin and Farbod, 2016). Mental Health has now become a public health policy concerns for almost all countries around the world due to the extreme prevalence of SARS-COV-2 (Chevance et al., 2020; Szcześniak et al., 2021).

The Covid- 19 is a global pandemic which has imposed threats on both physical and mental health since its outbreak. The pandemic disrupted life events, affected mental health, jobs, the economy and education, predictions of a worsening situation, and uncertainty of the health care system capacities were significantly associated with poor mental health outcomes. However, countries (like Bangladesh) with a poorly structured health sector and a high population density are struggling to cope the challenges. High population density, poor personal hygiene practices, and poor economic conditions make the majority of the Bangladeshi population particularly vulnerable to this virus. Evidences suggests a nation suffers a wide range of mental health issues related to anxiety, fear, isolation, depression, panic, emotional outburst and sleep disturbances during Covid-19 pandemic. Research demonstrates how a physical loss comes in the form of emotional 'loss,' which creates a knock-on effect, such as diminishing self-worth and motivation. This could be one of the reasons as to why residents in Bangladesh had significantly lower mental well-being scores relative to those for other countries. The psychological impairments are significant to the diagnosed cases, suspected cases, quarantine cases, health workers and their families and relatives. Fear of becoming sick, the isolation of lockdown, the financial necessity to work, and the inability to avoid venturing out in public for essential items such as food may increase psychiatric problems within the general population.

2.1. Covid-19 and Mental Wellness

Covid-19 is an extremely unpredictable and challenging circumstance. In March 2020, the WHO announced that Covid-19 had reached pandemic status, had put the earth in a state of maximum alert, and had grown to dimensions that cannot yet be measured today (WHO, 2020). Many whose well-being is damaged would have their physical, psychological and mental well-being undermined as well as social and economic life (Esterwood and Saeed, 2020). The multifaceted experience of Covid-19 pandemic contributes to unforeseen and multifactorial effects on the mental wellbeing of individuals, especially the marginalized individuals such as children, adolescents and youth.

Though youths are having lower health risks of the virus, yet it can be damaging and dangerous to the mental health of teenagers and youth. Children and adolescents may be highly affected by economic circumstances that result from the pandemic because they are less-informed, have not matured enough and possess unseasoned ability to conceive and comprehend the short and long-term consequences of this outbreak (Spinelli et al., 2020; Crescentini et al., 2020).

Considering the multifaceted impacts of the pandemic in the following section we will try to portray the overall. Condition – both global and national, barriers to access necessary mental services and some opportunities that have already been explored in some places across the globe.

2.2. Sketching the Context

A recent study of Chen et al. (2020) has evaluated 1036 quarantined children and adolescents in China, age range from 6 up to 15 years, of which 112, 196, and 68 presented depression, anxiety, and both, respectively. Another study demonstrated a high prevalence of psychological distress in quarantined children and adolescents due to the Covid-19 pandemic in India. These individuals have experienced helplessness (66.11%), worry (68.59%) and fear (61.98%), compared to non-quarantined children (Saurabh and Ranjan, 2020). Moreover, it was also reported in China that children and adolescents aged 3–18 years presented symptoms of inattention, clinging, worry and irritability during this pandemic (Jiao et al., 2020).

A more extensive study, done by Zhou et al. (2020) illustrated that the prevalence of mild-to-severe depressive and anxiety symptoms in Chinese adolescents during COVID-19 outbreak was 43.7% and 37.4% respectively. The prevalence of adolescents with both depressive and anxiety symptoms was 31.3%. That study additionally unveiled that adolescents living in cities were less depressed (37.7%) or less likely to have depressive or anxiety symptoms (37.7% vs 47.5% and 32.5% vs 40.4%) than the counterparts.

In line, rapid assessment was conducted by UNICEF (2020) which amplified the voices of 8,444 adolescents and young people between the ages of 13 and 29 in nine countries and territories in the Caribbean region. That assessment aimed unmasking the significant impact of Covid-19 crisis on the mental health of adolescents and young people in that region. Among the participants, 27% reported feeling anxiety and 15% depression; for 30%, the main reason influencing their current emotions is the economic situation (Ibid). In addition, their perception of the future has also been negatively affected, particularly in the case of young women who have and are facing particular difficulties. 43% of the women feel pessimistic about the future compared to 31% of the male participants. It is such a situation that generates deep concern and is a call to national health authorities is that 73% have felt the need to ask for help concerning their physical and mental well-being. Despite this, 40% did not ask for help (Ibid). Other regions of the world, as several studies shows, has also faced almost similar outcomes in this regard. For example, developed nations like Germany is also within the devastating radii of covid-19 outbreak.

A nationwide survey (n = 1556) in Germany showed that two-thirds of the children and adolescents reported being highly burdened by the Covid-19 pandemic. They experienced significantly lower HRQoL¹ (40.2% vs. 15.3%), more mental health problems (17.8% vs. 9.9%) and higher anxiety levels (24.1% vs. 14.9%) than before the pandemic. Children with low socioeconomic status,

¹ HRQoL = Health-related quality of life

migration background and limited living space were affected significantly more (Ravens-Sieberer et al., 2021).

2.3. The Impact

A crisis can cause a lot of stress. Adversity is a well-established risk factor for short-term and long-term mental health issues. Research on previous epidemics has demonstrated the negative effect of infectious disease outbreaks on people's mental health (United Nations, 2020).

Changes in daily routine, caused by the infection prevention measurements implemented, particularly harm children and adolescents (Wang et al., 2020), and this could, in turn, become a critical public health problem in the future. There are not only short-term and long-term stressors but also individual psychological responses to various pressure. Opening the cities led to thousands of new cases, which also provokes loud expectations and frustration in many inexperienced youths. (Ibid).

People's feeling of anxiety is, of course, understandable considering the effect of the pandemic on people's lives. During Covid-19 critical incident, people are afraid of illness, dying, and the loss of family members (United Nations, 2020). A large number of people have been victims of adverse conditions and often have undergone stay-at-home orders enforced in strict ways. Domestic violence and harassment have affected women and children the most. Other major causes of stress include unrealistic fear of the AIDs virus and lack of knowledge about prevention. Visual representations of severely ill people and dead bodies are highly distressing and can also disturb us psychologically (Ibid). People who are not able to say goodbye to dying loved ones and are not able to hold a funeral for them will experience severe distress. Definitely, higher rates of depression and anxiety occur in many countries.

A research from Amhara Regional State in Ethiopia found that 33% of the people in that state had symptoms associated with major depressive disorder (Ibid). In order to cope with stressors, people can choose to use substances such as alcohol or drugs or to engage in potentially addictive behaviors such as gaming. Statistics from Canada reveal that 20 percent of the population aged 15-49 currently consumes alcohol during the pandemic (Ibid). The mental health issues need to be fully addressed. During the economic downturn of 2008, “deaths of despair” increased among working-age Americans (Ibid). The percentage of suicide and substance-use induced mortality accounted for most of these deaths, which were attributed to loss of optimism because of the lack of job opportunities and the rise of income inequality. Due to rising economic burden of Covid-19, it can cause mental problems to some individuals, families and even for the societies as a whole.

The impact of Covid-19 on the brain is of a great concern. Neurological symptoms were observed in people who had Covid-19. There may be a negative effect on brain development of young children and teenagers as a result of the pandemic. (Ibid). The impact of this long-lasting social isolation on children and adolescents is still not properly addressed. Moreover, we draw attention not only to the multifaceted and heterogeneous feature of this pandemic which adds new issues and challenges to the population, but also to the fact that this Covid-19 outbreak may heighten pre-existing difficulties and problems in people lives, reaching the broad spectrum of the biopsychosocial framework. Herein, we brought elements for a more comprehensive discussion

around the neurobiology changes triggered by the stress caused by the different facets of Covid-19 outbreak (Fig. 5).

COVID-19 PANDEMIC IMPACTS ON CHILDREN AND ADOLESCENTS

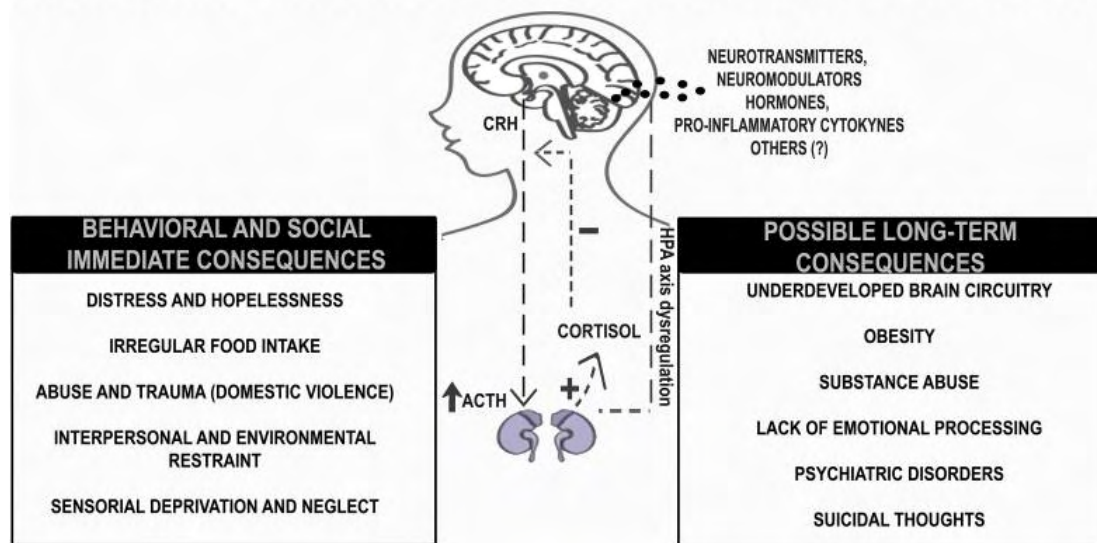


FIGURE 5: HEALTH IMPACT OF COVID ON CHILDREN AND ADOLESCENTS

We shed light on the effects of stress on the HPA axis and the possibility of triggering psychiatric disorders such as anxiety and depression, for example. We discussed neuroinflammation, diets, brain plasticity, social behavior and public health and support making an alert to a long-term public health issue and the need for prolonged governmental support (de Figueiredo et al., 2021).

2.4. Covid-19 and Mental Health Services

Until the outbreak, many societies worldwide did not have access to quality, accessible mental health services. Though Covid-19 virus has receded, we have now further limited access to resources. Key factors that impact programs in mental health facilities are the infection of staff and the risk of infection for patients, and the need for access to open spaces and personal meeting spaces. (United Nations, 2020; de Figueiredo et al., 2021).

There has been significant variation in mental health treatment around the world. The fear of face-to-face mental health service refusal by older people has reduced the demand significantly (Ibid). Many health programs have had to reorganize their services, particularly those concerned with mental health care (Ibid). There has been a lot of emphasis on self-help and mental health resources in interactive platforms and parenting programs (including the use of more basic technologies such as the telephone and SMS). Mental health treatments are relatively less common for people who are illiterate, disabled, and older but they do require effort and time and cost little money. There are other significant methods of family and community support (Ibid). Mental wellbeing and psychological support services received at the community levels are also affected. For instance, groups, associations and community-based initiatives (which bring people together) have been unable to hold meetings (e.g., senior citizens clubs, youth groups, sports clubs, organizations for people with lived experience and their families, mutual-help groups for alcohol and drug dependence, cultural programmes) for many months (Ibid).

Many types of organizations providing protective and psychological services to helpless groups may only provide marginal help to meet current needs. School-based mental health programs have been seriously disrupted and some of them are no longer able to offer effective treatment (Ibid). The billions of children around the world who are already out of school and no longer had access to basic facilities were much more vulnerable to these additional stresses. It is important to sustain and develop mental health services and programmes in order to meet current and potential mental health needs and help avoid an increase in mental illness. The response to the pandemic of mental illness is an opportunity to increase the efficiency and efficacy of different types of therapeutic treatments (Ibid). Some examples of mental health and psychosocial support during the pandemic include:

- In Lebanon, the Ministry of Public Health has launched an action plan comprehensively addressing mental health aspects of Covid-19.
- Teams from Egypt, Kenya, Nepal, Malaysia and New Zealand, among others, have reported creating increased capacity of emergency telephone lines for mental health to reach people in need. This includes reports of services that have helped usher in innovations that are designed to continue post-pandemic.
- In the Bahamas, recently devastated by Hurricane Dorian, the Government, UN agencies and non-governmental organizations are coming together to respond to the mental health and psychosocial consequences of the Covid-19 pandemic.
- A mental health non-governmental organization in Pakistan had to close vocational training centres for economic empowerment, but people with mental health conditions who had been attending the training centres started sewing cloth face-masks for health responders to support their communities.
- In Nigeria, the Nigerian Association of Psychiatrists, the Association of Psychiatric nurses, clinical health workers as well as major mental health NGO's came together to form the Covid19 Partners in Mental Health. They work with both government and civil society to offer training on mental health, teletherapy and research.

2.6. Mental Health Services in Bangladesh: Overall Situation

In Bangladesh, mental health has historically been given little importance, more so for children and youth due to the demographic group generally being less vocal about their concerns. Furthermore, the Bangladeshi society often casts aside concerns about adolescents' mental health and well-being. According to the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) report, from 2007 mental health expenditures from government health departments are very insignificant and are less than 0.5 per cent of the healthcare outlay. Unfortunately, children and youth's mental health issues arising from Covid-19's onset have, regrettably, not received the attention they deserve, in Bangladesh. During this challenging time the need for improved mental health and psychosocial support has been higher than ever.

According to the National Mental Health Survey in Bangladesh from 2018-19, around 17 percent of Bangladeshi adults are undergoing mental health problems like depression, anxiety, stress and obsessive-compulsive disorders. Of them, over 92 percent did not seek mental health services due to stigma, negative perceptions, inadequate knowledge of available mental health services,

misconceptions about treatment and treatment cost. Although there is limited population-based data on what percentage of Bangladeshi people are suffering from mental health problems due to the Covid-19 crisis, a review of extant studies of Covid-19 has found high rates of psychological distress among Bangladeshi individuals, ranging from 58 percent to 86 percent. This indicates that the pandemic has taken a serious toll on existing mental health problems in Bangladeshi individuals. The mental health fallouts of Covid-19 have been even worse for some groups like women, children, adolescent boys and girls, youths, older people, healthcare workers, individuals with compromised immune systems. This may act as a barrier to achieving the Sustainable Development Goals (SDGs), especially Goal 3 of reducing by one-third the premature mortality from non-communicable diseases through prevention and treatment and promoting mental health and well-being.

While the Covid-19 has created a severe impact on the mental health of youths, mental health services in Bangladesh, especially for the youths and adolescents are very scarce. In fact, there is no specific mental health authority in the country and mental health services are not organized in terms of catchment/service areas. According to WHO report, there are 50 outpatient mental health facilities available in the country, of which 4% are for children and adolescents only. These facilities treat about 26 users per 100,000 general population. Of all users treated in mental health outpatient facilities, 44% are female and 7% are children or adolescents. Considering this Covid-affected new-normal situation access to mental health services particularly became challenging for the vulnerable adolescent and youth (14-24 years).

2.7. Impacts of Covid-19 on Mental Health of the youth in Bangladesh

Recent publications suggest mental health during the Covid-19 pandemic is associated with gender, socioeconomic status, occupation, having Covid-19-like symptoms, perceptions of Covid-19 impacts, interpersonal conflicts, social media use, and social support (Mowbray 2020; Wang et al. 2020a). Older adults and individuals with low incomes are at increased risk for poor mental health (Holmes et al. 2020).

Primarily due to the viral outbreak, the mortality rate, essential restriction of mobility, insecurity about future, media reports, social media and connectivity creates a social panic. Also increasing number of the attack on medical staffs are creating a sense of “collective hysteria” and spreads fear even in the days of locked down exploding the expected fate of mortality.

Secondarily, in a locked down situation, the general people staying in a monotonous, unusual and anxious state at home experiencing helpless blaming others to be responsible and slowly progressing to the mental breakdown. The confirmed or isolated cases are prone to have a traumatic experience of fearing to die. The people staying in quarantine can feel bored, alone, anger, depressed, sleeping disturbance and panic that may lead to self-harm, emotional outburst and substance abuse.

Also, psychological issues may be profound in the close friend, family and relatives of the suspected or confirmed cases. Lastly, there is a profound impact on economy due to locked down situations in the markets, offices and business organizations, restriction of movement and the obligations to stay at home. Majority of the Bangladeshi population is depending on a regular income and they are uncertain about when they can return to work, these are making a confounding

impact on their mental health. One of the most profound impacts of quarantine has been the loss of income endured by many families. The findings of some studies revealed that adolescent people in Bangladesh developed suicidal tendency during the Covid-19 pandemic. Another study in Bangladesh found that being female, being divorced, and having no child were emerged as independent predictors for suicidality (Mamun et al., 2020).

Directives of lockdown increase domestic violence against women, with social services focused on mitigating risks limited in their capacity to conduct much-needed outreach during quarantine. Surprisingly, respondents with a graduate level of education experienced high levels of stress more so than those with undergraduate or higher secondary educations. The prevalence of mental health conditions in the adult population was lower (6.5% –31.0%) in pre-Covid-19 Bangladesh, which suggests that the pandemic may be responsible for increases in impaired mental health. Thus pandemic strongly impact mental health outcomes such as anxiety symptoms, depressive symptoms, and acute or long-term post-traumatic stress disorders.

2.8. The Service Providers (GO, NGO and Private Sector) Available for the Youth

Mental health service is a formal activity of health ministry. There is a coordinating body (National Institute of Mental Health, Dhaka) to oversee public education and awareness campaigns on mental health and mental disorders. Ministry of Health & Family Welfare, NGOs, professional associations, private trusts and foundations and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: general population, children, adolescents, women and trauma survivors.

Mental health care providers interact with primary care staffs during their training on mental health, out-reach programme, awareness meeting with public, field survey and such other related activities. Initiatives have been taken to maintain continuous communication with four model upazillas (sub districts) around capital city to develop community mental health services.

A mental health policy and plan has been approved by government in 2006. A draft of the Mental Health Act has been passed in 2018. The mental health information system is yet to start functioning formally, but its importance is intensely felt for development of evidence-based psychiatry in the country. Providing mental health services through trained primary health care physicians and health workers using existing government health network that is extended up to grass root level is the ongoing program of the government. Also, there are some mental health services provided by the government and non-government and private sector service providers available for the youth and other citizens in Bangladesh-

- Mental Health Outpatient Facilities
- Community Based Psychiatric Inpatient Unit
- Counseling and Guidance
- Community Based Psychosocial Service Outlets/Networks
- Correctional and Rehabilitation Centers
- Public Education and Awareness Youth Clubs
- Life Skills Training

- Helpline Services

The spectrum of community mental health facilities is increasing but the existing service is quite inadequate. The inpatient service is inadequate in comparison to outpatient care though the outpatient care is also insufficient. There is one 500 bedded mental hospital in the country (WHO-AIMS Report, 2007), where most of the patients remain admitted for long time leading to service provision for small number of people with bigger investment.

The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.49. The breakdown according to profession is as follows: 0.072857143 psychiatrist, 0.182142857 other medical doctors (not specialized in psychiatry), 0.196428571 nurses, 0.007142857 psychologists, 0.002142857 social workers, 0.002142857 occupational therapists, 0.028571429 other health or mental health workers (WHO-AIMS Report, 2007).

Fifty-four percent of psychiatrists work for both government and private sectors and 46% work for only private sectors. Regarding the workplace, 31 psychiatrists work in outpatient facilities, 56 in community-based psychiatric inpatient units and 4 in mental hospital. The density of psychiatrists and nurses in or around the largest city is 5 times greater than the density in the entire country (WHO-AIMS REPORT, 2007). The amount of money spent for mental health services by the government health department in 2005 was Taka 10, 62, 54,224.00 which was less than 0.5% of health care expenditures by the government.

Of all the expenditures spent on mental health, 67% are devoted to mental hospital. According to National Mental Health Survey in 2003-2005 about 16.05% of the adult population in the country are suffering from mental disorders. A small portion of patients are reporting to government facilities and they receive some psychotropic medicines from the facilities (WHO-AIMS Report, 2007). The government health department receives data from the lone mental hospital, 45% community based psychiatric inpatient units and 28% mental health outpatient facilities but the information is insufficient. Only a small percentage of all health publications in the country are on mental health.

There are 50 outpatient mental health facilities and no facility provides follow-up care in the community. Mental health services are accessible to all people of the country irrespective of social class, religion, language and ethnicity. Special efforts are needed to make it more accessible to poor, tribal minority and the vulnerable. Less than 0.5% of government health budget is spent for mental health and about 67% of that is spent for mental hospital serving a small number of long stay patients.

Training on mental health for primary health care physicians and primary care health workers are ongoing government programmes for more than two decades but the number of trained staff is still less than required number. Essential psychotropic medicines are satisfactorily available in Mental Hospital and the National Institute of Mental Health, but not widely available in general hospital psychiatry units.

There are about 10 NGOs in the country involved in individual assistance activities in mental health. There are no legislative and financial provisions to protect and provide support for mental health service users in respect of employment and protection of rights.

2.9. Mental Health Policies, Acts and Strategies in Bangladesh

Mental health is one of the most neglected issues in a developing country like Bangladesh, where people hardly consider mental health amongst general health issues. Premonitions like mental illness are nothing but a curse from God is still prevalent in Bangladesh society. According to the National Mental Health Survey of 2019, the prevalence of mental health disorders is 16.8% of adults and 13.6% of children in Bangladesh. Among them, 92.3% of adults and 94.5% of children do not get effective treatment for their mental disorder. This deprivation of proper treatment is, if not entirely, at least to a larger extent responsible for about 10,000 suicides annually (Afsana Ferdous Mimi, 2020).

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Bangladesh. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Bangladesh to develop information based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Bangladesh's mental health policy, strategy and plan was approved in 2006 as a part of policy, strategy and action plan for surveillance and prevention of Non-Communicable Diseases (NCD) and community-based activities in mental health is the main approach of the policy. A list of essential medicines is present in the country including antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs.

Bangladesh passed Manoshik Shashtho Ain, 2018 ("The Mental Health Act 2018") has been passed replacing the 106 years old controversial Lunacy Act, 1912. The new law has brought some positive hopes, including involuntary admission, establishing Mental Health Review and Monitoring Committees, disciplinary punishments and property rights of victims, especially the law's reference to 'rights of patient' is more appreciating. But yet the new law completely fails to ensure proper mental health care due to some major flaws. It aims at taking necessary steps for overall welfare of the mental patients around the country, protecting their rights to property, ensuring caring services and rehabilitation. Section 23 of the Act imposes strict punishments for medical practitioner, imprisonment for 3 years or fine up to TK 5 lakh or both, for purposefully issuing false certificates of mental health and for carelessness or mismanagement during the treatment of patients. In Bangladesh, there are only 0.49 psychiatrists for per 1, 00,000 population. This small workforce has to provide a formal diagnosis and subsequent care in all cases of mental illness. It is required to expand quality mental health facilities and develop adequate specialized hospital for mental treatment. It is an urgent need to include mental health into primary and tertiary healthcare and appoint adequate psychiatrists in every district.

2.10. Main Barriers to Access to Mental Health Services in Bangladesh

Progress is being made in overcoming the weakness of mental health service system but it should be accelerated keeping pace with the need of the time. Absence of separate mental health wing in the health ministry, inadequate awareness among people of relevant sectors, unsatisfactory co-

ordination system, limitation of manpower, logistic and financial support are among the prime barriers to progress. The problems of underreporting and under-diagnosis of mental disorders are major challenges for the future of psychiatric epidemiology. There are no mechanisms for supervision and protection of human rights of mental patients in the country. No mental disorder is covered in social insurance schemes. No human rights review body exists in the country to inspect mental health facilities. There is no specific mental health authority in the country. Even the mental health service for prisoners is insufficient. Also the challenges to access to mental health services in Bangladesh:

- Lack of Awareness
- Social Stigma and Superstition
- Limited Coverage of Mental HealthCare
- Lack of Adolescent Mental Health Hospital
- Problematic Parenting
- Domestic Violence
- Sexual Abuse
- Lack of Specialized Adolescent Mental Health Care
- Mental Health Policy

There is challenge estimating the extent of crisis in general population because the Patient-psychiatrist ration is too high and it's been nearly impossible to determine the present mental health need for the health workers also. The factors facilitating progress in mental health sector are emergence of new leadership, increasing attention by relevant sectors including WHO, increasing number of qualified and trained multi-disciplinary mental health manpower and recent development of policy and plan on mental health.

2.11. Gaps in Mental/Psychological Service Delivery in Bangladesh

A grave shortcoming of the new Act is, it doesn't speak about the heavy economic burden of effective mental healthcare. Also, there is immense gap between the existing Mental Health Act 2018 and the real mental health scenario in Bangladesh. There is no specific mental health authority in the country.

Studies report insufficient strategy has been made to concentrate on the mental health issues for the elder persons, they are a large group separated from the family even at their own home.

It is worth noting that currently there is no strategic guideline in Bangladesh's health system for the improvement of mental health practices of adults as a whole. Therefore, it is hoped that the results obtained can showcase the dire need to improve health facilities, especially during the lockdown period. Future studies should evaluate the associated factors explaining a higher prevalence of poor mental health among adults in Bangladesh.

2.12. Opportunities for Improvement of Mental Health Services

Effective Implementation of The Mental Health Act, 2018 needs to be supported by a strong and inclusive mental health policy, which will make up for the flaws and loopholes of the Mental Health Act, and thereby will strengthen the whole legal regime on mental health. The policy should provide for the following matters:

First, the Government needs to strengthen the existing mental healthcare system and build a strong workforce of mental health care professionals. Specialized hospitals for mental treatment should be established with sufficient psychiatrists and clinical psychologists in every district immediately. Such hospitals must have adequate medical facilities, psychological tools and human resources.

Second, mental health helplines should to be established from where people can easily get emergency mental health assistance and primary information on available mental health services.

Third, Special education service needs to be provided for mentally ill people. This way we can remove the existing discrimination against them. Moreover, Bangladesh needs to employ a series of measures concentrating on mental health care during the preparedness, outbreak and post-outbreak period of COVID 19 as fear and panic occur due to limited knowledge or poor adaptability and coping or inadequate healthcare policy on these issues:

- Formulation of Adolescent Mental Health Policy
- Establishment of Adolescent Mental Health Hospital and Planning
- Care and support
- Comprehensive Program Development
- Education and Awareness
- Increasing Budget and Capacity of the Mental Health Sector
- Enabling Evidence-based Advocacy and Research

Numerous studies suggested in favor of online response, training, support and counseling on mental health for health care professionals themselves, public service holders, youth, adults and person with disabilities, prisoners and elderly populations. Zhang and colleagues recommended as a part of preparedness, building a community team, assistant team, rescue team and specialist team on mental health aiming to provide social support, online service, psychotherapeutic interventions and monitoring and training of the subordinates subsequently. The team will work on online support to the mass people, create a positive family support matrix for those who are not infected. Besides, healthy nutrition, access to support, limited browsing to social media, news, avoid unnecessary thinking and regular physical exercise needs to emphasize boosting mental health. Liu and colleagues recommend progressive muscle relaxation exercise might help the persons with exposure to battle anxiety, stress and better sleep quality even can apply to healthy people with fear and stressed to the pandemic.

From various results, it is also evident that Bangladeshi women need to have healthy strategies solely implemented towards them, along with psychosocial support. These programs will not only positively impact the target group but will also have spillover benefits for their families.

In order to strengthen the Mental Health System community based mental health facilities needs to be strengthened through broadening the existing training of primary health care physicians and primary health workers. Strengthening of existing outpatient and inpatient psychiatric facilities in the general hospitals and creation of such facilities in private medical college hospitals and big general hospitals existing at the divisional and greater district level may be considered important steps for development of community mental health services. Initiatives for development of qualified and trained manpower are also urgently needed. Awareness and promotional campaign on mental health involving relevant sectors are also needed.

2.13. Conclusion

Having reviewed the existing literature – data, documents and research papers- including important policies and strategies enacted and/or adopted by Bangladesh government, it is clear that the pandemic Covid-19 has made a huge additional pressure on the existing inadequate mental health services in Bangladesh. Children, adolescents and the youth are suffering the most. In a context like Bangladesh while the entire health care system has been stretched to its maximum in dealing with the pandemic and post-pandemic health challenges, it is not possible for the Government of Bangladesh to address all the mental issues. Clearly, there are service gaps. In order to effectively address this gap, especially from the perspective of the youth and adolescents, a more comprehensive service structure participated by all government, nongovernment and private sectors is required. In meeting the requirement, comprehensive research needs to be carried out in the first place to build understanding of the real situation ground with evidence.

3. Key Findings of Qualitative Research

3.1. Common Mental Health Issues for the Youth

In Bangladesh, mental health has historically been given little importance, more so for children and youth due to the demographic group generally being less vocal about their concerns.

National Mental Health Survey in Bangladesh, 2018-19, reports around 17 percent of Bangladeshi adults are undergoing mental health problems like depression, anxiety, stress and obsessive-compulsive disorders. Of them, over 92 percent did not seek mental health services due to stigma, negative perceptions, inadequate knowledge of available mental health services, misconceptions about treatment and treatment cost. Although there is limited population-based data on what percentage of Bangladeshi people are suffering from mental health problems due to the Covid-19 crisis, a review of extant studies of Covid-19 has found high rates of psychological distress among Bangladeshi individuals, ranging from 58 percent to 86 percent.

In our research we tried to understand the pattern of common mental health issues the youth and adolescents are facing in Bangladesh. We have to acknowledge the fact that it is very difficult to unveil peoples’ psychological universe. However, with long term interactions we were largely able to get their responses.

TABLE 2: COMMON MENTAL HEALTH ISSUES FACED BY THE YOUTH

<ul style="list-style-type: none"> ▪ Sleep disorder ▪ Anxiety about the school, final exam, admission ▪ Stress about online class and exam ▪ Fear of illness ▪ Fear of dying of parents and family members ▪ Lack of concentration to study ▪ Fear of early/forced marriage ▪ Social media addiction ▪ Anxiety ▪ Verbal abuse 	<ul style="list-style-type: none"> ▪ Domestic violence ▪ Depression/Depressive disorder ▪ Disruptive, Impulse control and conduct disorder ▪ Uncertainty about the future ▪ Fear and uncertainty about the joblessness and unemployment ▪ Fear about job loss of the parents ▪ Economic stress ▪ Fear of sexual abuse ▪ Mood Swings
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Analysis of the FGD, interview and case study data show that the youth amidst pandemic they are facing numbers of issues. Table 2 clearly demonstrates that they have reported host of symptoms which could be associated with several mental health disorders. Sleep disorder was found very common even among young and adolescents. Monirul (alias), is only 19, who just had started his 1st year of university education right before the pandemic break out, said that “these days I don’t feel like to go sleeping. I keep doing things, mostly unnecessary things. But I don’t get fell asleep the way I used to be in the pre-covid days”.

Fear and anxiety have been found another very common concerns. Young students are anxious about their academic career, nobody knows when the school will reopen in Bangladesh. There is clear roadmap before the millions of students. And they are now really anxious about their future. They see no certainty of completion of their education, they don't know when they can enter into the job market, what kind of jobs will be available for them. We find grave uncertainty and anxiety among the youth. Table 2 also shows that they reported depressive disorder, mood swings, fear of forced marriage, fear of dying etc. No significant differences were found in terms of the problems they faced across geographical locations. No such difference is reported between urban and rural youth as well. One important thing is found that everyone shows concern about the economic stress they and their parents are facing during the one and a half year because of the shutdown of economic activities. A significant number of participants reported that their parents lost job, closed businesses and are now struggling to manage day-to-day expenses in their family. Many of the youth lost their employment too.

The consultant tried to know about the prevailing mental health problems among the youths in Bangladesh. While addressing this issue, Director of National Institute of Mental Health brought the class-driven variability of problems. For him, depending upon the socio-economic class- type, prevalence, and magnitude varies greatly. Founding directors of two leading private sector service providers in Bangladesh, Life Spring, and Telepsychiatry Research Network and Innovation (TRIN) agree with such statement of Director NIMH but stated that despite the fact he (director) uttered, there are some prevailing problems with higher severity and magnitude among youths (both male and female) in contemporary Bangladesh.

For both of them, 13 to 20 years old children face personality disorder (PD) mostly. Among different types of PD, borderline PD and narcissistic PD are most prominent in this country currently. Regardless the age group variation, in general, youths of Bangladesh face mostly but not limited to (a) anxiety disorder, (b) clinical depression, (c) obsessive compulsive disorder (OCD), and (d) drug addiction.

Other than these mentioned, (a) post-traumatic stress disorder (PTSD), (b) grief reaction due to loss of life and wealth, (c) trauma, (d) acute stress disorder, (e) schizophrenia, (f) mania, and (g) behavioral problem induced by neurological disorder (e.g., autism) are prominent. Among the adults, (a) dementia, (b) different cognitive disorders, and (c) online and offline sexual violence are prevalent mostly.

Now, when the consultant wanted to know the prevalence of mental health issues of the youths amid covid-19, online education and unlimited vacation of educational institutions were being identified by several practitioners and professionals. For them, these two has caused (a) major depressive disorder (MDD) mostly among the youths (both male and female) which was not much prevalent among the youths prior to covid-19 context. Followed by, (b) anxiety disorder, (c) stress disorder, (d) grief reaction, (e) behavioral addiction, (f) drug addiction, (g) bipolar disorder, (h) sleep disorder, and (i) mania are mostly seen. Among these, grief reaction, behavioral addiction, stress disorder, anxiety, and depression has been increased in an alarming rate due to covid-19 outbreak in Bangladesh.

3.2. Support Seeking Behavior among the Youth

The FGD and interview participants were asked of what do they do if he/she feels mentally challenged or uncomfortable or abnormal. In most cases, they replied that they do not take any action. However, further investigation explores several responses as shown in the following Table 3:

TABLE 3: SUPPORT SEEKING BEHAVIOR AMONG THE PARTICIPANTS

<u>Male</u>	<u>Female</u>
<ul style="list-style-type: none"> • DO NOTHING • “I cannot share my problems with my parents, they will not understand what I am talking about” • “It’s no good to share with friends, they will laugh at me” • “I don’t know anyone can help me” • “I thought it’s not that serious thing” • “I talked to one of my friends over phone, he doesn’t live here” • “I checked in the internet” • “I don’t know whom to go for suggestions” • “My parent took me to a doctor” • “We cannot afford to go to a counsellor” 	<ul style="list-style-type: none"> • DO NOTHING • “I told to my elder sister” • “It’s normal, everyone goes through same at some point of their life” • “I pray to Allah” • “I started reading Quran and praying more for peace in my mind” • “I only shared with my mother, she was worried” • “I don’t know if there is anyone who can help me with suggestions” • “I know Medical College Hospital has some mental doctor, but I cannot go there, I don’t know how expensive they are”

Table 3 depicts a grim picture. It clearly indicates that there is lack of awareness among the youth about mental health problems. Firstly, they cannot recognize if he/she is having any mental health problem. Secondly, they have very little idea of how damaging the problem could be in terms of potential long-term behavioral, cognitive or psychological disorders. And most importantly, they also don’t know what they should do to address the problem. In this case, friends, parents were not found trustworthy or helpful to share. Due to persistent social stigma attached with mental health issues the participants remained silent or ignore their challenges. There is a difference between the way male and female participants react to their challenges. We investigated further to understand what are the main barriers for the youth to access mental health services.

3.3. Major Barriers to Access Mental Health Services for the Youth

In order to understand and identify the barriers we primarily categorized the responses in three groups: *Cultural Barriers*, *Economic Barriers* and *Institutional Barriers*. At the same time barriers are discussed in association with specific study areas to see if there are any regional or geographic variations.

3.3.1. THE BARRIERS IN CHATTOGRAM CITY

Chattogram, the commercial capital of Bangladesh, is one of the most pious and traditional lands. People residing in this land are commonly known as wealthy and pious, but poverty is not negligible either. Hence, the persistence of cultural, economic, and institutional barriers in terms of mental health service utilization pattern is utterly diverse. Needless to say, it was further intensified amid the concurrent pandemic.

Unlimited shutdown of educational institutions, and unprecedented economic pressure are the major sources of mental agony among the people of this region. These people, yet, not ready to consider such mental agony, stress and anxiety as mental problem and considers religious practice, smoking, roaming around as coping mechanism. This problem is, however, not a subject to any particular income group. The researchers have found out multidimensional problems in the mental health context evident in Chattogram. The following sections critically discuss the three sets of barriers to access mental health services in Chattagram.

3.3.1.1. CULTURAL BARRIERS IN CHATTOGRAM

It has been found that most of the time, people suppress their mental pain inside due to societal stigma. It is driven by, perhaps, due to the judgmental nature of people. Hence, they are afraid of sharing their feelings to neighboring people and family members. As such, most often, they go to their friends and, indeed, this often led to negative coping mechanism like alcohol consumption, drug addiction, and at the very least, smoking. The consultant found a good number of youths afraid of sharing their mental agony to their parents since it is potential to put their family members under stress. Most of the male and female respondents considers praying or proper religious practice is the best way out. Very few of them, who are aware of these problems, still can't go to the practitioners out of peer pressure.

Reason behind is the persistent social stigma. In most of the cases, neighboring people judge and try to take advantage of their dire situation. When they observe someone visits a place signboard titled 'mental health center', considers them as lunatic and often make fun of it. If a teenager or any youth is mentally ill, his or her family may not emphasize it. They do not take it seriously at all. People are still not aware of mental health properly; some even do not know what it is. This stigma and lack of care from the family always demotivates the sufferers to share their mental problems. They do not have a friendly environment and understanding surroundings.

This problem is found so severe in Chattogram that one NGO leader who works with this mentioned a case of his friend who has been left untreated for years. Instead, he was being married to someone because his family considered marriage as the solution. They belong to higher middle-class family

and are sufficiently influential both socially and politically. Moreover, that family is considerably educated enough. Despite, they were intentionally reluctant towards this problem just because it will “harm their social status.” This depicts the severity of the social stigma in this big city. The biggest challenge here is the ignorance regarding the issue.

Another major problem is the awareness. People, especially those who live hand to mouth, considers mental health issues not a problem and hereby treatment for this is a luxury. Unless and until one doesn't behave abnormally or not a drug addict, the respondents don't consider anyone having mental issues. Hence, only institution they know is rehab center. Counseling, psychotherapy, psychiatry, psychology type of things is widely unknown to them.

Besides, the ongoing pandemic has hugely affected the youth as they cannot attend school and meet friends and cannot engage in co-curricular activities. Also, now that they are confined at home 24/7 and dependent on the internet and online studies. They are suffering from social isolation, increased stress, and anxiety, and of course, virtual learning fatigue. Consequently, the youths are indulging in harmful internet addiction, which increases their mental illness.

Another thing has been spotted that mostly the poverty-stricken people of Chattagram are willing to take help from local religious practitioners commonly known as "*Ojha*," '*Kobiraj*,' '*Hujur*' for cure. They used to provide *tabiz*, *pani pora*, *tel pora* to cure mental illness. Though this is cheap in most of the time, sometimes it is found heavily costly (up to 50000 BDT). The percentage of cure through this is equivocal and no respondent could provide any evidence-based example regarding this. Despite, people possess blind trust on them. Similarly, even to keep young individuals away from drugs, weed, and other harmful addictions, parents take the help of Huzur's instead of professionals.

Another issue was found regarding special children. When children are being observed performing irrational behaviors, their parents and relatives try out performing cultural treatments (infamous spiritual practices and superstitious treatment mainly) in every way possible. It could be *Huzur*, *Kobiraj*, and even the Hindu Purohits – varies upon the suggestion of the neighbors. Sometimes, a very few instances however, parents' complaint about cost of the psychiatrists. Even some parents feel ashamed of revealing their autistic child to the world.

3.3.1.2. ECONOMIC BARRIERS IN CHATTAGRAM

During the lockdown phase, the respondents had gone through the dreadful financial crisis, lack of food supplies, a few garment workers said they lost their jobs, and were very frustrated seeing their kids always being engaged with mobile phone games and away from work and studies. Besides, the students had struggled to focus on their studies because of unstable family conditions; some of them could not participate in online classes without a stable internet connection or a device or enough money to afford it. These circumstances have created a vast digital divide among the students, and for that, they suffered from frustration and mental pressure. Since many of the garment workers received half Eid bonus from the owners and faced cut off from their poor salary, which only rubbed salt in the wound, as the price of daily necessities went up, but income went very down for these laborers. All in all, they all had to endure the curse of poverty and low income.

When the researchers tried to inform the respondents about the "Mental Health Department" existing in the Chattogram Medical Hospital, they stated that, they are not aware of it. A very few respondents however stated that they visited the medical college and faced harassment by the hospital service providers. Some hospital employees (not doctor and nurse) acted as middleman and demanded commission from the general people for free services. Because of this sort of harassment, they preferred not going to the hospital and if there is any severe case, they opt for private clinics.

While visiting private clinics, there are another sort of problems they face. One of the major problems are the costs. Apart from the visits, private clinics costs too much regarding the pathological tests. It also demotivates people from visiting doctors for mental health circumstances. Once if they even visit, they can't afford the follow-up periodically. This once again adds another reason not to utilize the services of mental health.

3.3.1.3. INSTITUTIONAL BARRIERS IN CHATTAGRAM

Researchers found very less mental health service providers in Chattogram. One of the major service providers are the medical college. The environment of medical college is so crowded and the doctors remain so exhausted that people barely remain comfortable to share their heartfelt griefs. Different practitioners and NGO workers have complained about the unsupportive environment.

Another problem is the psychiatrist-psychologist dilemma. In Chattogram specifically, this dilemma is clearly visible, reported by many NGO leaders. They said that the psychiatrists, even if they do not have proper training, intend to provide psychological support, whereas it is supposed to be assigned to suitable psychologists. There are no psychologists appointed in the medical college for general people, OCC (One Stop Crisis Center) is an exception, however.

In addition, the government is reluctant to fill up the vacant posts of occupational therapists and psychologists, many of them reported. Nowadays, few psychologists started practicing in the city which is still very less compared to the need.

Another problem found here is the excessive practice of medical model of mental health treatment. Indeed, medical model is necessary but indeed, insufficient. There are lots of issues which asks for psychological intervention and since its absent, people approach to the psychiatrists. Due to the dilemma mentioned above, the psychiatrist hardly refers patients to the psychologists, complained by different non-medical mental health professional. On the other hand, the doctors complained about the absence of proper evidence-based psychology support center, and this makes them helpless in this regard. Amid this vicious cycle of service delivery, the mass people remain demotivated and suffers greatly.

When the pandemic hit hard, mental health condition deteriorated greatly across the globe, despite, the service delivery in Chattagram hardly improved. The schoolteachers, religious practitioners, and other social figures could help people dealing this crisis but they themselves remain unaware of it. NGOs which aimed working in this sector, were not given with proper support, claimed by many local NGO leaders.

One case the consultant found when a covid-19 affected young adult boy visited doctor and expressed about his mental distress, was scolded by the doctor. The doctor brutally misbehaved with the patient since he was very busy due to excess load of patients. It made that boy much upset, and it took longer time than usual to get rid of this sadness. This indicates two important things, (a) severity of lack of adequate amount of healthcare professionals, and (b) necessity of mental health professionals with a proper doctor-patient ratio.

When talking to the medical college authority, it was found that lack of material and human resource is very prominent. Properly trained nurses and other support mechanism for mental health service delivery is grossly absent which left them out in a very helpless condition. In one stop crisis center, while talking to the assigned psychologist and the manager, it was found that shortage of psychologists persists since long. Moreover, due to lack of bed, with physical treatment the patients are asked to leave since the load of patients are much higher than the capacity. As such, different victims who require long term psycho-social treatment remain deprived. They are however asked to visit OCC for further mental support, but the rate of return is very negligible.

Another issue found prominent in Chattogram is numerous numbers of rehab centers. Most of these possess no trained and certifies mental health professionals. Hence, the service they provide is questioned and the consultant found one respondent whose neighbor visited a rehab center in Kazirdia for three different times and stayed there for more than 4 weeks period each. Despite, no improvement was there and lastly his family approached to a “*Baidda*” who took 50,000 BDT for his early recovery. When this failed also, they then visited Chattagram Medical College and now the patient is performing well. Such cases are not unknown to the authority still visible action is yet to be taken.

3.3.2. THE BARRIERS IN BARISHAL DISTRICT

The researchers discovered a plethora of issues in the mental health setting prevalent in Barishal. Consider the following: severity, lack of knowledge, social stigma, accessibility, religious blindness, blind faith in religious practitioners, and lastly - affordability. The following sections examine closely three distinct categories of impediments to mental health care access in Bangladesh.

3.3.2.1. CULTURAL BARRIERS IN BARISHAL

Our study shows that unawareness is the primary problem among the participants in Barishal. For them, forcing to perform something against his/her will is one of the major causes of mental pressure. Apart from those, economic distress, peer pressure, unhealthy and distorted relationship, conjugal issues are other major causal factors in this regard. There is no wrong having a distorted mental condition, but problem arises when improperly intervened. People are not conscious about mental health. One of the participants said,

“We do not go to doctors. We never felt its necessity.”

Due to the judgmental nature of people, people in this region tend to suppress their mental agony. Sharing problems, they believe, exposes one's weakness. Respondents uttered,

“One of the reasons of not taking mental health support from doctors are thinking about what others will say. People laugh when they hear that someone is going to a doctor for mental illness.”

They are even afraid to share with their families or teachers. They think what others may say. Some of the young boys and girls uttered,

“Sometimes, we share our problems with our parents, but they don’t give any importance to it. Parents do not encourage their children.”

Mentally ill people are mocked, jeopardizing their social status regardless of class. As a result, people may struggle to obtain a good job, a nice spouse, and become socially isolated. In this way, boys often turn to drugs to cope with their issues. Girls' scene is quite different. Despite their inability to openly discuss with their parents, the girls have less freedom to communicate with their peers. Their coping method is to cry alone. However, our respondents claimed they rarely received effective guidance and only occasionally shared their concerns with family members. They were mostly, if not all, misunderstood. The absence of family support and social stigmas prevent sufferers from seeking help for their mental health issues, leading to suicide attempt.

The study in rural Barishal demonstrates that most of the respondents belong to low-income group and have limited access to mental health information. Although teenagers are more familiar with these notions than their elders, guardians are unwilling to recognize that they can also learn from their children. Moreover, when it comes to mental health, this new phenomenon often ends up beating the child. Thus, this area has the best lack of awareness. They are stigmatized, indifferent, and disrespectful of mental health issues.

Additionally, they also assume that psychological therapies are so expensive that those who believe turn to local "Ojha," 'Kobiraj,' 'Hujur' for tabiz, pani pora, tel pora to cure mental illness. Many continue to place their unquestioning trust in those religious practitioners. Likewise, parents seek the assistance of Hujur to keep their children away from drugs, smoking, and other hazardous habits. The respondents believe that they should see a mental health professional if someone becomes crazy; however, this is not essential.

3.3.2.2. ECONOMIC BARRIERS IN BARISHAL

The respondents have endured the awful economic disaster during the lockdown phase. As a result, many parents are opposed to educating their children. As Well, many parents are having a higher number of children, and primarily people here are farmers. As a result, they want their sons to join agriculture and their daughters to marry early. As the males are unable to work and their child desires something they cannot afford, the parents are put under mental stress. One of the FGD participants said,

“People here are poor. They don’t even fetch doctors for physical illness very often, let alone mental illness. The treatment is so expensive.”

Most people encountered financial difficulties, and they were depressed for a variety of causes. Homemakers were depressed as they considered alternative sources of income. Most importantly, everyone was fearful of covid-19. Nobody was permitted to leave the house. They were going

through a financial crisis and were also mentally broken. Those suffering from other conditions could not see a doctor due to lack of doctors, transportation concerns, and budgetary constraints.

It was observed that when the locals' children showed mental illness symptoms and did irrational behaviors, their parents tried to take them to a doctor, but they were not capable enough to afford it. Moreover, as most of them belong to impoverished families, they could not afford all the costs of their medical treatments, such as first visit tests and follow-up expenses.

3.3.2.3 INSTITUTIONAL BARRIERS IN BARISHAL

According to our findings, during the lockdown phase the government had offered relief goods in the rural Barishal, but they were not dispersed effectively. At the time, no NGO intervened to distribute relief products or services. So, they had food shortages and service issues.

Additionally, it was difficult to access healthcare facilities for the local people. It is primarily due to the lack of coordination and the hospital's distance that they suffered the most. Mental pressure was extremely high among them owing to Covid-19 and lockdown. Since the locals are impoverished, they rarely seek medical attention for physical ailments, let alone mental illnesses.

Moreover, there is a dearth of awareness regarding mental health. The shortage of service centers and inaccessibility contribute to the apathy toward mental health services. Due to the rural nature of this area, there is a few approved or professional individual available to give mental health treatments. Even the public do not prioritize this issue. No one is around to encourage locals to seek mental health care. One of the participants said,

“People have not given importance to mental health. Besides, there is no service center nearby. This mental problem will be mitigated with time automatically.”

3.3.3. THE BARRIERS IN DHAKA CITY

The collected data evidently establishes that the Covid-19 pandemic has enormously increased the mental illness and drug abuse in the area of Dhaka. The victims of this impacts are mostly teenagers and adults. Most of the informants identifies shutting down of educational institutions as the reason behind it. As schools, colleges and universities have been closed due to lockdown policy, teenagers and adults have a lot of free times which they have to spend being locked inside the house. As a result, their normal flow of life has been hampered and they now have to spend day after day doing nothing significant in their daily life. This is leading them towards various kinds of mental ailment. A number of informants have also stated that amid this sudden inactiveness and boredom of daily life, youth are getting attracted to drugs out of curiosity and in order to do something stimulating their inactive day to day life. Therefore, the number of drug addicts is alarmingly increasing in this locality. The lockdown policy is also creating impact on the families altogether which later lead onto individual impacts. Amid this lockdown, parents have been remaining in home more than they usually do. A large portion of them have lost jobs or faced cutoffs in salary putting the family into financial crisis. Parents are, for obvious reasons, getting into frustrations. They often impose their rage into their children. For this, children are not feeling safe at home, and they do not have any escape as well. In between all of these, they are being traumatized. Due to being trapped inside home, they cannot reach for help rather have to suffer silently.

As the issues regarding mental well-being and drug addiction is tremendously increasing, it is obvious that the need for help regarding these issues will be in demand. But the study found out that no cases were found where anyone is getting professional help to address mental health issues. In fact, barely any informant even uttered about professional help in curing mental ailments. Through the study, the authors found out a range of factors that are creating barrier in the way of treating mental health as seriously as it requires to be. Knowledge gap, Lack of awareness, social stigma, lack of adequate service, affordability and accessibility of service etc. are some of the main contributors in this regard. For the sake of discussion, the authors have divided the problems into three domains- cultural, institutional and economic. The problems identified in Dhaka are briefly described in this part of the paper.

3.3.3.1. CULTURAL BARRIERS IN DHAKA

From the FGDs and KIIs, it is seen that people in this area to some extent know about mental health. For example- they are familiar with anxiety, frustration, depression, stress and so on. However, the level of seriousness about mental health is far away from being adequate. People are not as concerned about mental illness curing as they are about physical illness. Moreover, mental health issues are still stigmatized and often overlooked. Those who suffer from mental illness barely speak about it and even if they do, they are not listened with significance. There are two reasons behind it. Firstly, families do not feel the necessity to prioritize mental illness over other crises they go through (e.g., physical illness). They think that they are bestowed with more troublesome crises which need to be addressed first.

Secondly, it is considered something to be ashamed of to address mental illness of a person in a family. It is commonly seen that those who are diagnosed with clinical mental illness are teased and bullied by the people in the society, especially in case of young adults in schools. Besides, having mental problem is seen as a barrier of good reputation and parents get worried for their children's future for example- they might not get a good job or be married in a well-reputed family. Thus, people suffering from mental crises do not get any concern from their nearer and dearer ones and eventually they themselves stop caring about it leaving it to be worsen.

However, beside this portion of population who do not acknowledge the significance of mental illness, there is another section of population who do acknowledge that the need for professional assistance. It is observed from the collected data that there are some families where parents get concerned when they observe noticeable change in the behavioral pattern of their children and feel the need to seek help about it. Very unfortunately, whom they seek help from are not attributed to have the ability to treat mental illness. Most popular trend among parents in Dhaka is to go to the teachers of their children to have a guidance. But the teachers are not trained on these issues or do not have knowledge about it in most cases. Another common practice is to seek help from religious sources in the nearabout, mostly "Imam" or "Hujur" from a local mosque or madrasah. They provide with "Tabij" and "Panipora" to the sufferer in order to get rid of mental illness. Instead of seeking clinical help, these are the practices in trend among the population of Dhaka. Surprisingly, rehabilitation centers and experts in mental health are not rare in this area; rather there are a number of rehabilitation center and profound psychologist as well as psychiatrist in practice in Dhaka. People do not have recourse to them because most families cannot afford these services and many of those who can, do not have adequate knowledge about these services. Most of them are wrongly

informed that rehab centers and medical professionals are only for treating drug addiction. Therefore, the unconventional entities like schoolteachers and religious leaders become the only hope of people in this regard.

3.3.3.2. ECONOMIC BARRIERS IN DHAKA

As mentioned before, collected data indicates that mental well-being is not given as much importance as physical well-being among the population of the studied area. Beside cultural barriers, some economic factors also play a significant regard in this matter. The available services in the context of mental well-being are very expensive. The fees of psychiatrists, counsellors, psychologists and rehab programs are mostly beyond the reach of poor and lower middle-class residents of Dhaka.

Four-months long rehab costs lakhs which most families cannot afford. Besides, the drugs used in the medical practice in regard to cure mental illness are rarely produced by local pharmaceuticals; instead, they need to be imported with high cost which also goes beyond the affordability of the major portion of population. For all these reasons, seeking help from appropriate entities becomes beyond impossible for most families which is the most significant economic barrier in practice in Dhaka. However, beside expensive service from private stakeholders, there are cheaper service from public stakeholders also in this perspective. But people are not aware of those services. Therefore, services provided by the public sectors in mental health are barely being utilized or contributing to mental well-being of the population.

3.3.3.3. INSTITUTIONAL BARRIERS IN DHAKA

Institutional shortcomings are very acute in the context of mental health in Dhaka. If we start from the service-providers, the number of psychologists, psychiatrists and counsellors are not adequate in number. Besides, the quality is not satisfactory. Only six universities in Bangladesh offer graduation in Psychology. Those who do, recruit the students with comparatively lower grade in admission process in the department of Psychology. Of them who achieve good results in their undergraduate first degree in psychology, only few meritorious and highly motivated graduates in psychology does pursue post-graduate professional curriculum with internship training in professional psychology with Masters and MPhil degree programme. Moreover, parents do not allow their children to go for a degree in psychology. There are several reasons behind this. First, as the least graded students get a chance into this department, parents feel ashamed of their children having a degree in this subject. Secondly, the cultural practice in here do not let people have a positive insight about mental illness. As a result, students of this subject are often looked down upon in the society. Thirdly, due to people's lack of awareness about mental well-being, building a career as psychologist, psychiatrist, therapist or counsellor is very challenging in this country. For all these reasons, Bangladesh is facing severe inadequacy of mental health professionals.

The scenario of public hospitals for the treatment of mental illness is piteous. In most public hospitals, there the overall environment is not welcoming, it is difficult to find any help desk to find where to go. They are mostly chaotic, noisy and mismanaged. The patients, in many cases, are treated harshly. For example- they are chained, locked, beaten and lead a miserable life while they are under treatment. As e result, despite being cheaper, the service provided by private sectors are not being able to provide a valuable contribution in mental well-being.

Private stakeholders can, however, provide better services than public ones. Especially the organizations in Dhaka, adopt scientific approach to address, diagnose and cure mental problems. They use improved drugs, experts and residents for the patients. The problem still remains with the cost. All these better facilities come in exchange of huge amount of money which is blocking the poor as well as middle-class families to resort to the private service providers. Instead, they have to rely on the public services with very poor quality of service.

3.3.4. THE BARRIERS IN DINAJPUR DISTRICT

The collected data reveals that the problems regarding mental health problem in Dinajpur is dreadfully acute. Especially during this covid-19 pandemic, the situation has gotten into its worst possible status. Worst of all, the people in this area are not even aware of the fact that mental health situation in their area is severely deteriorating.

The most commonly spoken issue in both FGDs and KIIs is the problems raised by financial crisis and shutdown of educational institution. Due to the lockdown policy of the government, many parents have become unemployed or faced a decrease in salary. It is leading them towards frustration which they often rage onto their children. A number of informants has mentioned it as domestic violence against children. In the rural area, financial crises have more intense impact on mental health. The loan interests imposed on poor households by the NGOs are putting them in a difficult position. Due to obstacles in transportations, a significant number of day laborers are out of employment currently. They are not being able to repay their loans and the NGOs are barely giving any flexibility in this case. Being helpless, an alarming number of them are choosing the escape of suicide. In case of youth, closing of educational institutions is causing imbalanced daily life for them which is creating a significant impact on their mental health. They are getting away from conventional pastimes like reading books, spending time with friends, playing outside etc. and instead they are relying onto television, internet and video games for entertainment. These sources of recreations often lead to loneliness, insomnia and even drug or internet addiction (such as Facebook addiction).

3.3.4.1 CULTURAL BARRIERS IN DINAJPUR

The data suggests that majority of the population in this area do not have the bare minimum knowledge about mental health. They are not even familiar with the most common mental illness like- frustration, depression and so on. Parents cannot identify as well as do not care to observe if their children are suffering from any mental ailment. It has been mentioned in the FGDs that if there is a child going through severe mental illness, they go unnoticed by the parents. And if they luckily get noticed, the first thing that is attempted to know is if there is any physical illness. If not, they ignore it and treat the problem like regular sadness while the child might be in serious need of clinical help.

Sometimes when the mental ailment gets into severity due to lack of treatment, to normalize their behavior, help is sought from local religious practitioners. They provide “tabij”, “panipora” to remove unusual “spiritual influence” from the sufferer. It is seen in this locality that the process of these rituals often gets into the forms of physical abuse which adds more layers to the persons mental trauma. Another trend among the youth is to talk about their mental condition with friends

and teachers. But reaching these entities is being impossible during this pandemic. As a result, they have no choice except to endure their sufferings alone.

3.3.4.2. ECONOMIC BARRIER IN DINAJPUR

A significant number of people in this target area live in extreme poverty. They barely have enough to meet the basic needs and live sound. Especially in the rural area, as mentioned before, most people are not employed adequately. The NGOs help them with easy loans in order to make them solvent but at times, these loans become a burden to them. In such circumstance, getting concerned about mental health is nothing but lavishness. Even if they have concern, they cannot afford professional help for obvious reasons.

3.3.4.3. INSTITUTIONAL BARRIERS IN DINAJPUR

The institutional shortcomings regarding mental health in this region is immensely alarming. There is no service available in Dinajpur, especially in the rural area to address mental well-being of the people. There is no well-established mental hospital or clinic, no qualified psychiatrist, psychologist, psychotherapist, or counsellors other than the Dinajpur Medical College. No intervention is visible from neither public stakeholders nor the private ones. Such absenteeism of professional service is one of the most significant reason that the people in this locality is not familiar with the idea that mental health is to be treated with professional help.

Some of the KIIs from NGO workers have mentioned the existing problem regarding mental health. But the authors could not find any NGO that includes addressing this issue in any of their programs or projects. Some of the programs are invested to bring out the youth from the newly created crises but they are barely focused on their mental condition. Besides, the service-givers are not given any training on curing mental health. In fact, in Dinajpur, these services are so rare that most people do not have any idea about the cost of services.

3.3.5. SUMMARY OF THE MAJOR BARRIERS

To summarize this section, the barriers could be categorized in two blocks: *Demand Side barriers and Supply Side Barriers*. The Demand side barriers refer to those connected with the clients, individuals, families and societies where they live in. On the other hand, the Supply Side barriers refer to those which are associated with service providers, policy makers or regulators.

Demand side barriers include:

- Lack of awareness among the youth and adolescents about the mental health symptoms and its impact on their cognition, behavior and physical health;
- Lack of information about the available services
- Lack of information about the health professionals/service providers
- Lack of awareness among parents about the significance of mental health issues;
- Social stigmatization (*loke pagol bolbe*)
- Superstitions - disgrace for family
- Misconception about the cost and process of the treatment

- Poverty; Busy in managing subsistence
- Workload of childrearing, household chore, no time for women, especially married women
- Fear of husband and in-laws

Demand side is heavily influenced by economic condition, education and existence of social stigma and taboo. On the other hand, the Supply side include:

- Only few service outlets are available at the district level, and most of them are interested in drug addiction cases
- Psychiatry departments of medical colleges are not fully equipped, under resourced
- No service information is available at the community level through any media: for example billboard, poster or leaflets
- Doctors' directories are not easy to find
- Psychosocial counsellors are hardly available
- High cost of treatment/counselling [travel, medicine, doctor and lengthy treatment]
- Poor follow up mechanism by the service providers
- Nongovernment organizations have a very limited target group; most of them have no dedicated services
- Lack of trained manpower in providing initial services to the people in need
- No primary screening mechanism is available at the community level
- Poor implementation of Mental Health Policy.
- Government shows no or less priority in addressing mental health issues
- Government services are dominated by medical graduates who hardly gives adequate attention to mental health issues
- Psychosocial counsellors, clinical psychologists are being ignored by the government policy makers
- Inadequate budget allocation by the government

4. Service Providers Mapping: Key Findings

As a part of this study, we conducted a service providers' mapping exercise. With a predesigned *institutional checklist* we conducted in-person, website search and telephone interview with available service providers in four study areas. However, we find that the task is rather complicated. Complicated it because mental health is a vast and complicated subject that requires a variety of care and treatment. Thus, mental health professionals come in a variety of forms, including psychiatrists and psychologists. Their role changes according upon the kind and severity of the individual's ailment. The following section outlines the roles and services of various mental health specialists. Therefore, before, we present findings from the mapping exercise we thought a brief orientation about various categories of mental health professionals would be helpful to understand the analysis follows.

Psychiatrist

Psychiatrists are medical professionals who have completed additional training (in most of the cases advanced post graduate degree) in psychiatry. Psychiatrists give a variety of treatment options, including pharmaceutical prescription and psychotherapy. Psychiatrists can also provide primary medical treatment. Numerous patients who suffer from mental health difficulties also have physical health problems, which psychiatrists may assist with. They will, however, often refer patients to other specialists and doctors for primary care. Psychiatrists treat a wide variety of mental health problems, including anxiety, phobias, personality disorders, various stress disorders, obsessive-compulsive disorder (OCD), depression, and bipolar disorder.

They often tailor therapies on an individual basis. When necessary, they may prescribe psychotherapy to help persons with bipolar disorder manage their depression symptoms. They frequently require patients to be sent to psychologists or other mental health practitioners for the patient's benefit. Apart from this broad profession, some psychiatrists opt to specialize in subfields such as adolescent or forensic psychiatry. They are capable of working in a variety of settings, including private practices and hospitals.

Psychologist

Psychologists are trained to assess mental health difficulties and to provide psychotherapy and psychodiagnosis. Due to the fact that they are not medical professionals, they are unable to prescribe drugs for treatment. Psychologists often hold a doctoral degree in clinical psychology and are experts in the study of the mind and human behavior. They, like other medical professionals, must get a license to practice. Psychology is divided into numerous subfields, such as child and adolescent psychology and addiction psychology. Clinical psychologists receive additional training in diagnosing and treating mental health disorders without the use of medicines. Psychologists can provide psychotherapy to anyone experiencing mental health problems, utilizing cognitive-behavioral therapy (CBT) and dialectical behavior therapy as appropriate methods (DBT). However, certain situations may necessitate medication from a psychiatrist or family physician. Bipolar disorder and schizophrenia, for example, are difficult to manage just by psychotherapy.

Counselor

Psychotherapists and counselors are terms that some people use interchangeably. While both experts are capable of providing talking therapy without the use of medicines, they are distinct. Counselors are master's-level clinicians who offer advice and support to those experiencing specific difficulties. Certain counselors focus only on the treatment of mental disorders. Other counselors, such as marriage or addiction counselors, may handle concerns relating to mental health.

Clinical Social Worker

Individuals' rights and well-being are protected by social workers. Their roles vary according to the context. While some social workers focus only on mental health support, others provide broader case management services. They are capable of assessing an individual's mental health and use therapeutic procedures to enhance emotional wellness. They typically work with individuals who have a range of complex requirements. For instance, a social worker may work at a psychiatric institution, providing psychotherapy and assisting patients with reintegration into the community upon discharge. Social work is a vast discipline that can assist individuals with mental health difficulties in a variety of ways. For instance, certain social professionals focus only on domestic abuse. They may collaborate with other mental health specialists in order to provide assistance.

Psychiatric Nurse, or Mental Health Nurse Practitioner

Unlike the traditional nurses, psychiatric nurses can provide an assessment, diagnosis, and therapy for various mental health conditions, depending upon their level of training and certification.

Psychotherapist

The term 'psychotherapist' is a protected term that refers to anyone who provides psychotherapy. It is an umbrella phrase that refers to all cognitive behavioral therapies as well as the numerous treatment approaches and procedures. A psychiatrist or psychologist, for example, may get training to provide psychotherapy. Psychotherapy comes in a variety of forms; for example, some individuals choose to specialize in psychoanalysis, which focuses on the unconscious motivations of behavior.

Occupational Therapist

Occupational therapy (OT) is a health profession that utilizes ordinary activities, or occupations, to treat physical, mental, developmental, and emotional conditions that impair a patient's ability to do daily tasks. As such, an occupational therapist is a health care professional who employs therapeutic strategies to help patients improve, recover, or maintain their capacity to do daily activities. Occupational therapy is distinguished from other healthcare professions such as physical therapy or nursing by its emphasis on the total patient rather than on a specific injury, illness, or handicap. For instance, following surgery, a nurse may assist a patient with pain management, dressing changes, and post-operative care. On the other hand, an occupational therapist will analyze the

patient's vital activities and teach them how to regain their independence following surgery, allowing them to continue the responsibilities that define who they are.²

4.1. Availability of Mental Health Services in Dhaka

Mental health services in the capital city are much more available than any other districts of Bangladesh. Dhaka possesses more than 80% of total mental health professionals operating currently in this country. Both length and breadth of services are much broad here. Along with government service providers, a good number of NGOs and private practitioners are available here. The price range differs greatly among practitioner to practitioner mainly depending upon their expertise, experience and qualification.

There are as many as 29 government mental health service providers in Dhaka city which includes different universities as well along with the government hospitals. Maximum universities run their mental health service exclusively for their students and employees. They mostly provide personal counselling, couple counselling and career counselling. These services are available for 5 days in a week (working days and hours) and free of cost in most of the cases. Exception is found in Dhaka University's 03 mental health service providing centers. All these three provide services for any citizen of the country and it costs from 200 to 1200 BDT for per session counselling. They provide counselling for individuals, family, couple and groups and the price varies depending upon the services required. Apart from such counselling services, these centers perform IQ test, professional aptitude test, and neuropsychological assessment as well. Government hospitals on the other hand provides almost same services for only 10 taka per session. Two of the prominent medical colleges of Dhaka city, Sir Salimullah Medical College and Hospital, and Shaheed Suhrawardy Medical College and Hospital possesses 'Child Development Center,' which is rare to find in government service providers.

More inclusive services in this regard are given by National Institute of Mental Health (NIMH) and Bangabandhu Sheikh Mujib Medical University (BSMMU). BSMMU possess (a) suicide prevention clinic, (b) OCD clinic, (c) ADHD clinic, (d) relaxation clinic, (e) parenting clinic, (f) child clinic, (g) psychiatric sex clinic, (h) de-addiction clinic, (i) social ability training, (j) IQ test, and (k) dialectical behavior therapy.

On the contrary, NIMH has (a) pain clinic, (b) sex clinic, (c) neurotic group therapy, (d) child guidance clinic, (e) autism clinic, (f) psycho education group therapy, (g) geriatric clinic, (h) addiction clinic, (i) parenting group therapy, (j) OCD clinic, and (k) trauma counselling service. Both the institutes provide services under these clinics once in a week basis; NIMH operates from 8.30 am to 02 pm but BSMMU operates under each clinic for 2 hours only – generally from 11 am to 01 pm.

² <https://www.regiscollege.edu/blog/occupational-therapy/what-does-occupational-therapist-do-roles-and-responsibilities>

Exclusively for children, Dhaka Shishu Hospital has ‘Child Development Centre (CDC)’ where apart from individual, couple and family counselling, multiple types of assessments are being done. Each type of counselling requires 300 BDT per session and for assessments- 200 BDT per session.

Apart from these government service providers, there are no less than 76 private practitioners in this field including different hospitals and clinics. All the private doctors provide medical based psychiatric treatment whereas most of the clinics possesses psychological service protocol along with psychiatry. Almost all of them requires prior appointment to avail services. They generally operate from morning to night and 7 days in a week. In general, the clinics provide individual, group, couple, and family counselling where per session cost varies between 800 BDT to 2000 BDT. Each session typically continues for 1 hour. These clinics, unlike the government service providers, offers a more widen sets of services on a regular basis which includes (a) psychiatric services, (b) counselling, (c) psychotherapy, (d) drug counselling, (e) child development program, (f) adolescent counselling, (g) parenting, (h) relationship counselling, (i) online counselling, (j) online training, (k) epilepsy clinic, (l) multiple disability clinic, (m) developmental therapy, (n) therapeutic intervention for autism, and (o) different types of psychological assessments. Some of these services requires up to 5000 BDT per session or per unit (as served).

NGOs in Dhaka city mainly offers four types of services i.e., (a) schools for special child, (b) counselling, (c) child development centers, and (d) legal support for victims. Counselling service from NGOs are comparatively less costly and easier to avail than the private clinics. Some NGOs, however, charges up to 1200 BDT per session. Spot registration and legal support are the convenient factors which are missing in most of the private clinics and to some extent, public hospitals. Thye in general operates like the government hospitals- 5 days in a week from 9 am to 5 pm.

4.1.1. ESTIMATED COST OF MENATL HEALTH CARE SERVICES

TABLE 4: ESTIMATED COST OF SERVICES IN DHAKA

Service Provider	Service Provided	Estimated Cost Per Session (5 sessions)	Estimated Travel Cost (5 sessions)	Estimated Medicine Cost (6 weeks)	Estimated Total Cost
Government	Individual Counselling	10	200	0	1050
NGO	Individual Counselling	800	200	500	5500
Private	Individual Counselling	1500	200	500	9000

Since there are available mental health service providers in Dhaka, people requiring the service need not to travel much. As the cost of price greatly varies from service to service, clinic to clinic, and doctor to doctor, it is indeed a tough job to presume cost incur for any service enjoyed. However, if it is assumed that one individual requires individual counselling once in a week basis for 5 sessions, and s/he is willing to avail this from any private service providers in Dhaka, the cost incurs is as follows. It is to be noted that the price per session considered here is the lowest available

in the market and it may increase depending upon place and provider. There are experts in Dhaka who costs 5000 BDT per session counselling as well. In some other clinics, 2000 to 3000 BDT per session price is also found here.

4.2. Availability of Services in Chattagram

Other than the capital city, Chattagram is the biggest city in this country. Despite, availability of mental health services is much less compared to other healthcare facilities. Sole government mental health service provider here is the Chittagong Medical College Hospital's department of psychiatry and once stop crisis center. Hence, private clinics and NGOs play the major role in this regard.

Indeed, the availability of services both in amount and magnitude are much less in Chattagram compared to Dhaka. Especially private clinics providing inclusive evidence-based psycho-social support is very less. Majority amount of psychological support comes from private clinics and NGOs.

Practicing psychiatrists in Chattagram usually charge for 1000 BDT for per visit/session against their psychiatric services. Most of them provide medicine-based treatment for mental health problems. When needed, they opt for counselling and psychotherapy as well. It is true that psychotherapy and counselling are designated task of psychologists and psychotherapists but one of the prominent psychiatrists of Bangladesh in his KII told us that

“There is very less amount of evidence-based mental health clinic in Chattagram for which, we are afraid of referring patients there. They often perform mal-treatment. As such, we, the psychiatrists, are bound to provide psychotherapy and counselling.”

However, Serenity, is one of the inclusive mental health clinics in Chattagram established in 2018, possesses 06 clinical psychologists and 01 in study leave. They offer various services of individual psychotherapy, psychometric assessment, psycho-education, group counseling, marital counseling and family therapy and so on. Serenity also conducts workshop and training related to mental health issues and awareness building programs to take preventive measures and some community care like educational institution-based program. On an average, they ask for 1000 BDT for per individual counselling sessions comprising 50 minutes. Having said that, price for other services increases depending upon experts and type and the price is not less than 1000 BDT in any case.

They are situated in Probartok of Chattagram City. Indeed, it is a very large city, and one may find travelling difficult. Hence, Serenity does provide 'Home Visit.' Serenity provides services against any kind of mental health problem including but not limited to stress, depression, anxiety, OCD, trauma, social anxiety, adjustment problem, panic, and psycho-sexual problem going to the home of the patients.

Another institution 'Life Coach' has been operating in Chattagram since November 2019. They mainly provide offline service only in Chattagram yet, online service for all. Having a dynamic team comprising 04 experts, they organize workshops both physically and virtually to literate people about mental health care and how they should respond and overcome mental health-related issues. Besides, they provide (a) psychiatric counseling & consultation, (b) counselling, (c) psychotherapy, (d) stress management services, (e) e-counseling and. (f) 24/7 phone support to the

patients. They don't have any home visit facility like Serenity but what they have is the free 'Live Chat' for all. Since November 2020 they are maintaining this free 24/7 Mental Health Helpline 'Live Chat' program where anyone can reach out to the specialists.

Next milestone **Life Coach** brought for Chattagram is MoU signing with Ark- Addiction Rehabilitation Center. According to them, this is first time in Chattagram a drug support and treatment center are working with a mental health company for supporting their patient. Their typical session (counselling, psychotherapy or any other) continues for 60 minutes and the price floor is 1000 BDT per session. Depending upon the service, time required and expert, the price slightly (up to 500 BDT) increases some time.

About the private hospitals, there are handful in Chattagram where almost all of them provide medical-based psychiatric treatment to the patients, as mentioned above. In these clinics, average cost per visit is 1000 BDT though in some cases, it is reduced up to 700 BDT. On the contrary, NGOs like Young Power in Social Action (YPSA), Unite Theatre for Social Action (UTSA), and Caritas provides psycho-social counselling. YPSA and Caritas provides free service to people 6 days in a week from 8.30 am to 5 pm.

4.2. ESTIMATED COST OF MENTAL HEALTH CARE IN CHATTAGRAM

Due to lack of availability of mental health service providers in Chattagram, people who need the service need to travel mostly to Dhaka. Before establishment of Serenity and Life Coach, people took psychological support either from psychiatrists or needed to move Dhaka, stated one of the founding members of Serenity. She also pointed that the cost of price varies from service to service. Hence, it is indeed a tough job to presume cost incur for any service enjoyed. However, if it is assumed that one individual requires individual counselling once in a week basis for 5 sessions, the cost incurs is as follows. It is to be noted that the price per session considered here is the lowest available in the market and it may increase depending upon place and provider. Unlike Dhaka, the variation is not much in Chattagram and to some extent, it slightly increases up to 1500 BDT, reported by administrative officers of different private clinics. Some psychiatrists, however, asks for 700 to 800 BDT for per visit as well here.

TABLE 5: COST ESTIMATION FOR INDIVIDUAL COUNSELLING IN CHATTAGRAM

Service Provider	Service Required	Estimated Cost Per Session (5 sessions)	Estimated Travel Cost (5 sessions)	Estimated Medicine Cost (6 weeks)	Estimated Total Cost
Government	Individual Counselling	10	200	0	1050
NGO	Individual Counselling	Free	200	500	1500
Private	Individual Counselling	1000	200	500	6500

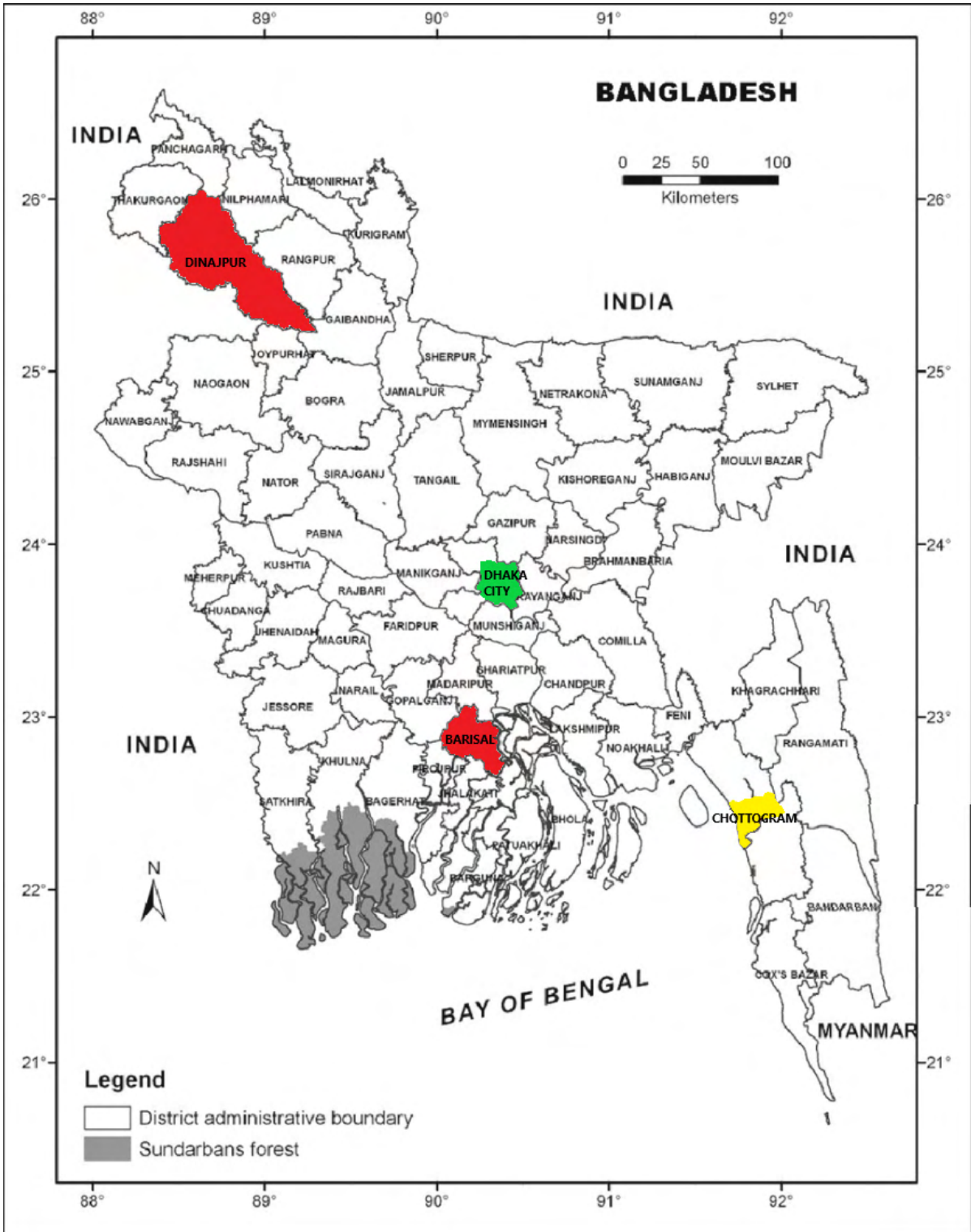


FIGURE 6: OVERALL. SERVICE AVAILABILITY MAP

Figure 6 shows the overall status of mental health care service availability on selected four study locations. On the map, red means low availability, yellow means moderate availability and green color refers high availability. Of course, this low-moderate-high measurement doesn't reflect absolute status, rather it is a comparative scenario drawing on our service providers mapping exercise.

4.3. Availability of Services in Barisal

Barisal is one of those eight administrative divisions of Bangladesh which is located in the south-central part of the country. It has an area of 13,644.85 sq km (5,268.31 sq mi), and a population of 8,325,666 at the 2011 Census. Being one of the largest divisions, Barisal has been developed in many spheres over the years specially in terms of communication, education and digitization. Apart from these, overall health sector has also been expanded at a faster pace across the time. Amid the heavy crowd of developmental aspects, mental health probably got no chance to show its importance and the result is obvious. As per the data of Local Police of Barisal, in the year 2018, 89 people performed suicide which has further been accelerated in the following year. Within first 09 months of 2019, 110 people suicided in Barisal. When police department wanted to know the reason, forensic department performed postmortem and declared that more than 50% of them were mentally ill and rests were suffering from mental breakdown or depression. Amid those 199 suicide cases, only Barisal district faced 129, almost 65% of total suicide cases in those 21 months. Another alarming factor is, out of 199, 121 were females aged between 15 and 35 years. This context explains the dreadful condition of mental health in Barisal.

Up to October 2019, there was only 01 psychiatrist in whole Barisal division.³ Hence, attendants of the mental health patients remain paranoid and anxious. To date, not much satisfactory change is seen.

Availability of services in Barisal is terribly poor. In terms of private service providers, there are only 04 psychiatrists in Barisal practicing in multiple diagnostic centers and clinics like Popular diagnostics, Medinova, and Lab Aid. Among the 04, only 02 are appointed in Barisal and rests belong to NIMH, Dhaka. One of them practice only on Friday and another on Thursday and Friday for not more than 03 hours in each day. Two of them costs 800 BDT per visit and rests 1000 BDT per visit. All 04 provides psychiatric treatment and no psychological and psychosocial services.

Apart from these 04, there are 05 different mental health service providers operating in Barisal among which four deal with drug addiction and rehabilitation and drug counselling only. One of these five only provides psychotherapy and tele-counselling (on request).

In terms of government service providers, there is only the Sher-e-Bangla Medical College Hospital which provides service 5 days in a week from 08 am to 02 pm. For OPD patients, a 10-taka ticket is needed and for admission, it costs 15 BDT. It also has child development center which is exclusively designed for the children. There is an ‘One Stop Crisis Center (OCC)’ designed for

3

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abused women and children. This center provides a wide range of services to the service takers including legal aid, and psychosocial counseling. The cost of OCC is also very negligible.

There is only one NGO provides mental health services in Barisal, known as Prio CREA. Though they mainly operate with drug addiction problem, but they have tele-psychiatry service where one of the mostly known psychiatrists of Bangladesh Prof. Dr. Mohammad Ahsanul Habib provides service at the cost of 600 BDT only. They had in-house psychiatric service as well prior to covid-19 outbreak but now it is temporarily suspended. Apart from these, they offered psychological and psycho-social counselling service system as well with the one and only psychologist of Barisal, Mr. Saidul Islam. After his transfer, this service has been stopped and the manager of CREA, Barisal stated,

“We were the sole provider of counselling and psycho-therapy service in Barisal. There was only one psychologist and with his transfer, Barisal possess no clinical psychologist currently.”

4.3.1. ESTIMATED COST OF MENTAL HEALTH CARE SERVICES IN BARISHAL

Compared to Chattogram and Dhaka, availability of services in Barisal is very negligible. Mostly psychiatry services are available there and currently, no counselling services are available. Along with these, drug addiction clinics are also very available here. The costs of tele-psychiatry are 600 BDT per session and for face-to-face service, it varies from 800 to 1000 BDT per patient per session. Considering one patient requires to visit 5 times to a psychiatrist for proper cure, an estimation list is given below. For the private practitioners, the lowest floor has been considered and it is to be noted that the ceiling so far is 1000 BDT.

TABLE 6: ESTIMATED COST OF INDIVIDUAL SERVICES IN BARISHAL

Service Provider	Service Required	Estimated Cost Per Session (5 sessions)	Estimated Travel Cost (5 sessions)	Estimated Medicine Cost (6 weeks)	Estimated Total Cost
Government	Psychiatric service	10	150	0	800
NGO	Psychiatric service (Online)	600	150	500	4250
Private	Psychiatric service	800	150	500	5250

4.4. Availability of Service in Dinajpur

Despite being a divisional city, Dinajpur is no exception than Barisal. People here also deprived in terms of mental health services. One of our respondents said,

“We hardly get any expert in this locality. We need to go far for avail the services. The number of patients in the private chambers are huge. This discourages us to go to psychiatrists.”

People of this region hardly gets the scope of rendering proper mental health service. There are no psychologists found in this region which adds another dimension in the list of sufferings.

Available services are very poor in Dinajpur. There is no psychologist works in Dinajpur who can provide psychological and psycho-social counselling and therapy. As a result, psychiatrists are doing all these services to the patients. Otherwise, patient has to travel to other districts for availing this service.

From the government side, sole service provider here is M. Abdur Rahim Medical College Hospital, Dinajpur. People can avail psychiatric and psychological support every day from this hospital during the working hour. The outdoor ticket costs only 10-taka and indoor admission fees is 15-taka. All required medicines are free.

There are few private service providers available in Dinajpur. There are two sub-categories in this field, one is the psychiatrists and other is the rehabilitation clinics. There are 03 psychiatrists do general practice in Dinajpur. One of them works only twice a week and the rests operates for 06 and 07 days respectively. Their charge for per session ranges between 500 BDT to 1000 BDT.

The rehabilitation clinics usually offers drug addiction treatment and drug counselling. They comparatively charge a higher amount yet, much less than other districts studied in this research. They usually charge 10000 BDT per month for a drug addict patient. Sometimes this includes the medicines and counselling, but exceptions are found as well. One NGO also provides similar type of rehabilitation program, but they have a package of 90 days. They charge 30,000 BDT for 90 days and its fully residential. Apart from these, no other services are available in Dinajpur in this regard.

TABLE 7: ESTIMATED COST OF INDIVIDUAL COUNSELLING IN DINAJPUR

Service Provider	Service Provided	Estimated Cost Per Session (5 sessions)	Estimated Travel Cost (5 sessions)	Estimated Medicine Cost (6 weeks)	Estimated Total Cost
Government	Psychiatric service	10	200	0	1050
NGO	Psychiatric service	Nil	Nil	Nil	Nil
Private	Psychiatric service	500	200	500	4000

4.4.1. ESTIMATED COST OF MENTAL HEALTH CARE SERVICES IN DINAJPUR

Compared to Barisal, Chattagram and Dhaka, availability of services in Dinajpur is even worse. Mostly psychiatry and rehabilitation services are available there. The costs of face-to-face service varies from 500 to 1000 BDT per patient per session. Considering one patient requires to visit 5 times to a psychiatrist for proper cure, an estimation list is given below. For the private practitioners, the lowest floor has been considered and it is to be noted that the ceiling so far is 500 BDT.

4.5. Cost of Services across Study Locations

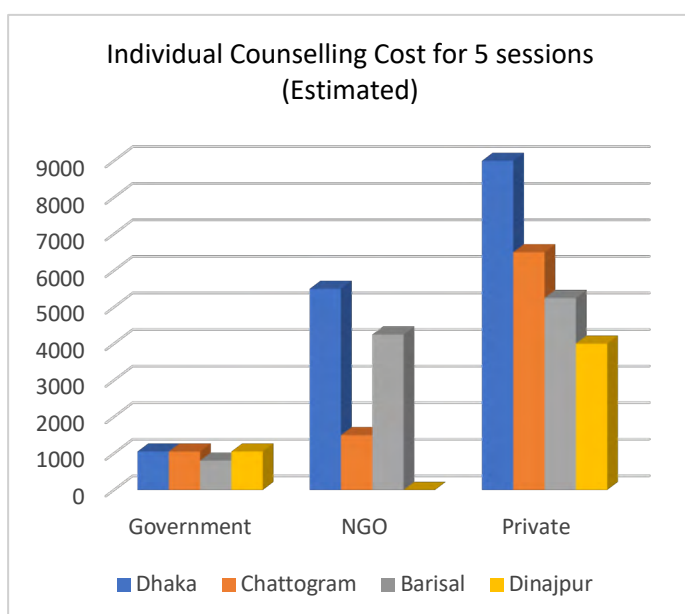


FIGURE 7: COMPARISON OF COST ACROSS DISTRICTS

Analysis of the database brings our attention to the cost variation associated with mental health services across region and providers. Figure 7 highlights that with reference to private health care services there are high variations across districts. For example, a unit of 5-session unit of counselling services costs, on an average, nine thousand taka in Dhaka which is even more than double of what one requires for the same services in Dinajpur. Even, services that are being provided by not-for-profit organizations – NGOs – also do vary across districts. Not surprising that there is almost no variation in cost

of cares provided by the government entities across districts.

Again, if we look at the data on pricing, we would see that there is a huge difference between government and private sector providers. In Dhaka the cost of private services is almost 9 times higher of government services, which six times in Chattagram, five times in Barishal and four times in Dinajpur. Figure 8 shows the cost variations across types of providers.

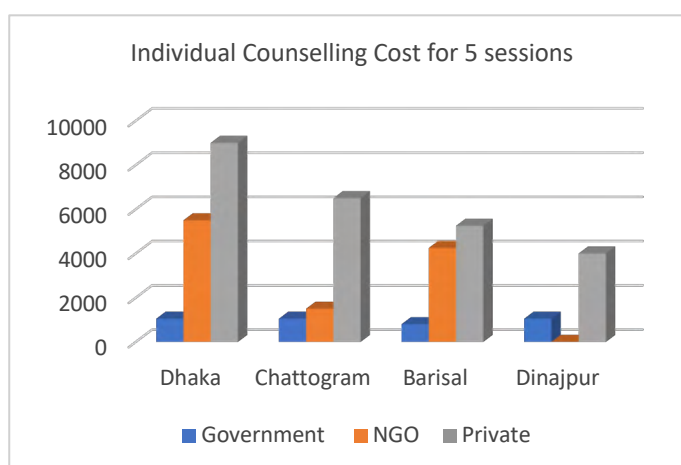


FIGURE 8: COST COMPARISON ACROSS PROVIDER

4.6. Overall Type, Nature and Pattern of Service Providers

Rural-Urban Divide:

In this study, as an outcome of the service providers mapping exercise, a database of 203 organization and individual service providers has been developed. Analysis of the database shows that Dhaka city has the highest numbers of service providers which is a little more than 72%.

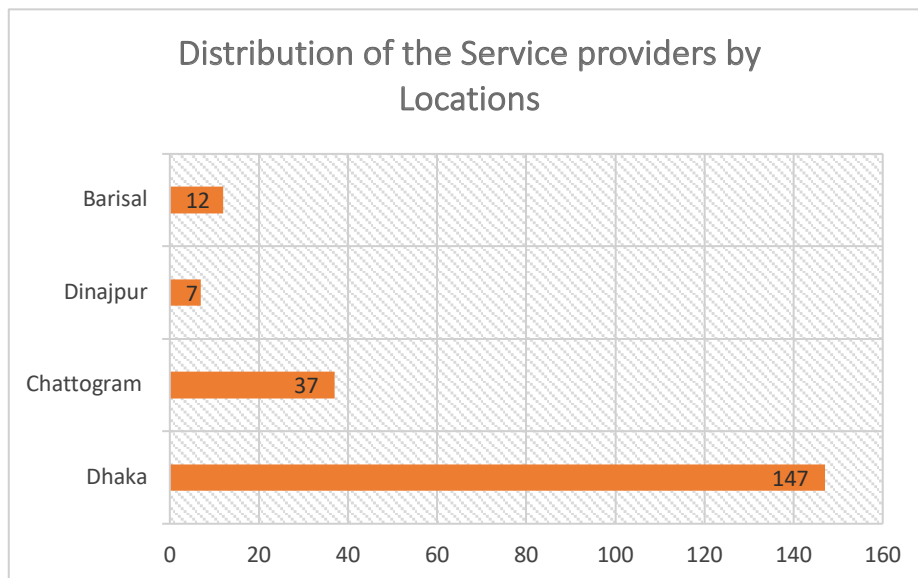


FIGURE 9: DISTRIBUTION OF SERVICE PROVIDERS BY LOCATION

On the other hand, Dinajpur has got the lowest, only 3%. Barishal and Chattogram have 7% and 18% of service providers respectively. The data clearly indicates a significant rural-urban divide in terms of mental health service availability. Two rural settings Dinajpur and Barishal combinedly have got only 9% of the total which is more than ten times lower than that of Dhaka and Chattogram. Figure 9 presents that in Dhaka there have 147 service providers recorded whereas in Dinajpur this number is only 7. In Chattogram there we found 37 service providers and in Barishal 12.

Private Sector is the main Provider:

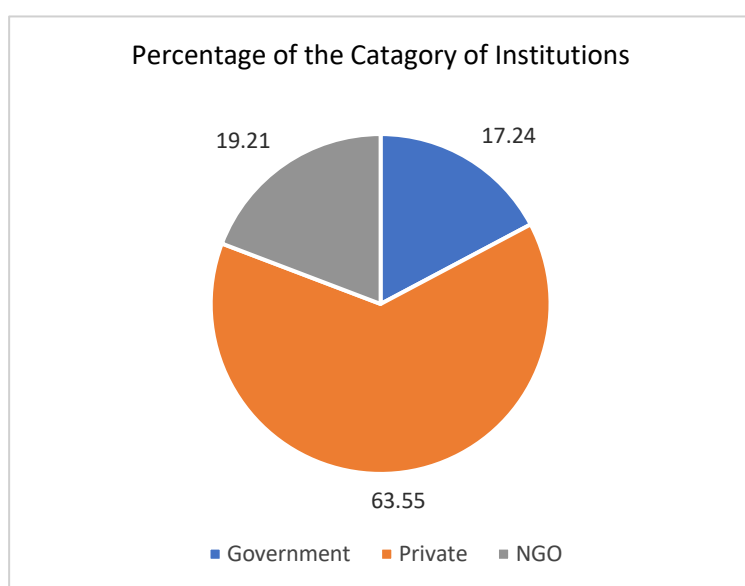


FIGURE 10: DISTRIBUTION OF SERVICE PROVIDERS BY TYPE

The mental health service providers database also shows that among three types of service providers – Government, NGO and Private Sector – private (for profit) entities have been the main service provider. The private sector providers constitute 64% of the total providers listed. Figure 10 shows that the government providers make up only 17% of the providers whereas NGO providers make only 19% of the total providers. This data also highlights the fact that mental health service is highly dependent on the market providers which

also means that the out-of-pocket expenditure likely to be much higher in rendering mental health services in Bangladesh.

High dominance of private sector in the mental health care market suggests that the poor client likely to be excluded due to high out-of-pocket expenditure related with high price of the services.

Dominance of Psychiatrist:

Analysis of the service providers database has underscored another fact that the landscape of mental health care services in Bangladesh is overwhelmingly dominated by psychiatrists. As we mentioned at the very beginning that there are various categories of service providers, for example psychologists, psychotherapists, occupational therapists, counsellor and so on.

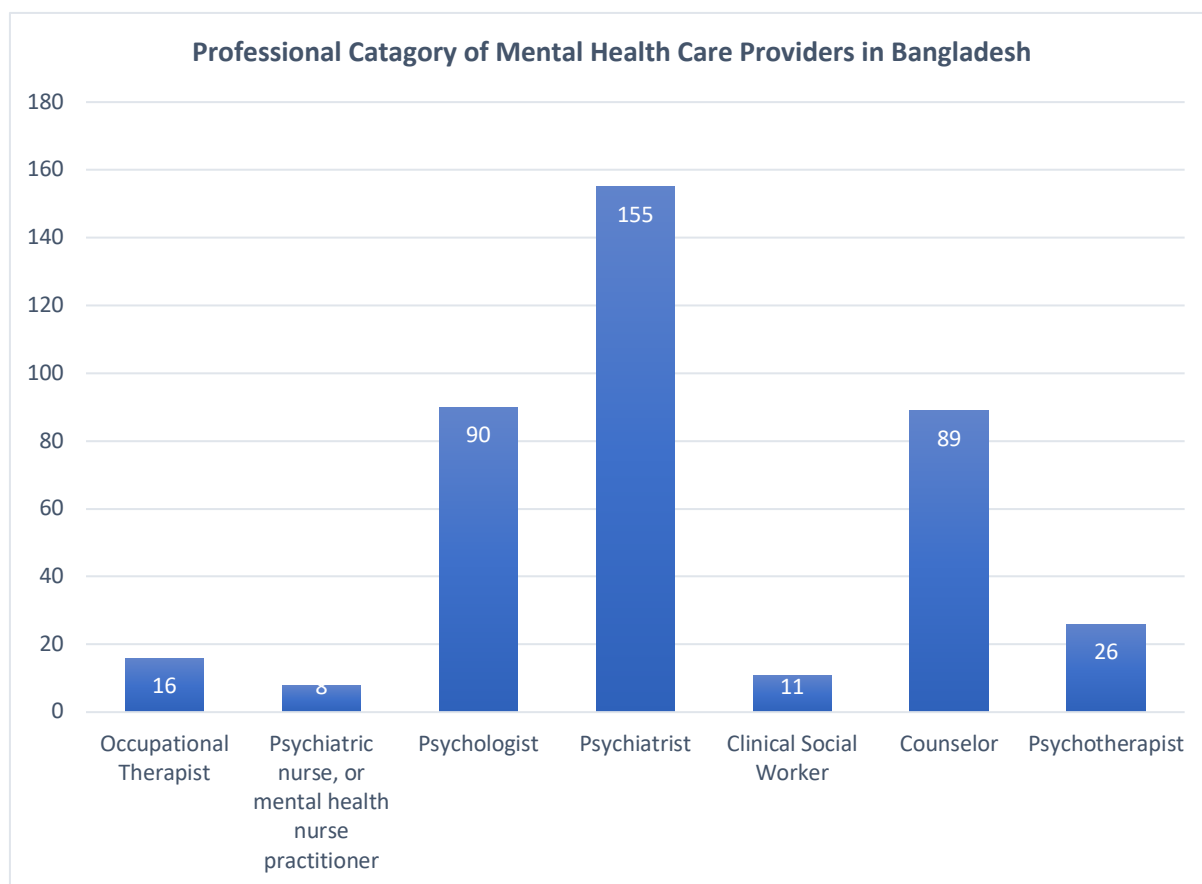


FIGURE 12: CATEGORIES OF SERVICE PROVIDERS

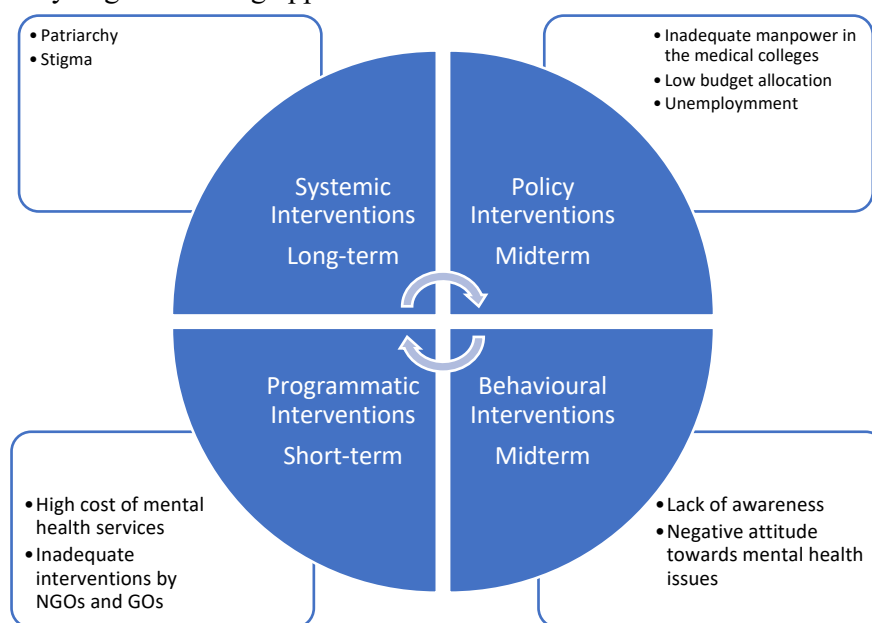
Figure 12 shows among the service providers, Psychiatrists are the largest group of professionals whereas Psychiatric nurses are the smallest category of professionals. Data also shows that psychologists and counselors have also relatively greater presence in the service providers market in Bangladesh. Indeed, we have to keep in mind the overall number of the mental care providers in Bangladesh is extremely inadequate. According to the estimate provided by WHO, it is seen that the total number of human resources working in mental health facilities or private practice per 100,000 population is 0.49. The breakdown according to profession is as follows: 0.072857143 psychiatrist, 0.182142857 other medical doctors (not specialized in psychiatry), 0.196428571 nurses, 0.007142857 psychologists, 0.002142857 social workers,

0.002142857 occupational therapists, 0.028571429 other health or mental health workers (WHO-AIMS Report, 2007).

5. Opportunities for Enhancing Access to Services: Recommendations

Challenges and opportunities are closely associated. In fact, opportunities are to be primarily found from the roots of the barriers. In the Section 3 barriers are analyzed at length. Nevertheless, a closer look at the identified barriers from both – demand and supply sides suggest that barriers are rooted in different domains of social structure with varied degree of strength and implications. We also keep in mind that there is a political economy of a particular type of constellation of actors around a particular type of service regime. Therefore, we need to examine the root of a particular barrier before we find opportunities for removing it.

The closer examination of the list of barriers leads us to put them in four categories as far as their roots are concerned: systemic barriers, policy barriers, behavioral behaviors and programmatic barriers. Having assessed these four categories of barriers the Figure 12 shows the framework of analyzing and finding opportunities to overcome them. It shows that there are some barriers, which



are systemic and not easy to fix. It requires long term interventions, for example, patriarchy or stigma. On the other hand, there are some issues which usually are resulted from policy deficit. For example, inadequate manpower in the public hospitals, which could be addressed with a policy change. Similarly, there are barriers which are associated with

FIGURE 13: FRAMEWORK OF FRAMING AND DESIGNING INTERVENTIONS

behavior of individuals and there are some barriers which could be addressed rather easily with some modifications at the programmatic level.

Considering this framework, we have identified the opportunities for further enhancement of access to mental health services with special reference to the younger population of Bangladesh. Opportunities are identified, framed and presented in the form recommendations in the following passages.

These recommendations are categorized in two broad categories: national and community level measures which are further clustered in two measures for access to curative services and measures

for access to preventive services. These recommendations or areas opportunities are presented in the following.

5.1. National Level

National level measures are required to address systemic and policy barriers. In identifying opportunities, we have drawn on the opinions, perspectives and experiences of the research participants.

5.1. 1. PREVENTIVE MEASURES

(a) Initiate Campaign for Reformulating and Updating National Mental Health Policy 2006 and National Mental Health Strategy and Action Plan

The Government of Bangladesh has enacted National Mental Health Act 2018 which is considered to be a positive step. However, the Act is mainly for regulating some specific activities and ensuring rights of the mental health service clients. But a policy is broader than the Act. Policy provides overarching guidelines for whole range of actors and stakeholders in a society. The existing national mental health policy was formulated in 2006 (WHO-AIMS Report, 2006). There was another updated draft tabled in 2019 but it hasn't been adopted until now. A multidisciplinary working group also drafted a National Mental Health Strategic Plan 2020-2030. But neither of them has been formally adopted and put in implementation. In between, Covid pandemic has added a new dimension to the existing scenario. Thus, at this stage it is important to revisit earlier policy proposals in light of the new reality and advocacy campaign could be launched for the new policy adoption.

(b) Build a broad-based National CSO-professional Alliance for Mental Health

There are several professional associations related with the access to mental health services for example Bangladesh Psychological Association, Bangladesh Association of Psychiatrists etc. at the same time there are civil society led network of service providers such as Bangladesh Association for Child and Adolescent Mental Health. These two types hardly talk to each other. Academics and experts opined that an initiative could be taken immediately to develop a national level broad-based CSO-professional alliance for mental health in Bangladesh.

(c) Launch Campaign for Increased Budget Allocation in Mental Health Services

It has been identified and analyzed by WHO, national level thinktanks and researchers that national budget allocation for mental health affairs is only less than 0.5% of health care expenditures by the government. Which means, the amount is extremely negligible. And it is hard to expect any major change or improvement to take place with this meagre financial resource. Therefore, there is a need for advocacy for increasing national budget allocation for mental health. It requires regular analysis of budget allocation and expenditure and based on which the advocacy plan could be developed.

(d) Engaging Media and other Social Forces for Creating Mass Awareness about Mental Health in the Society

It is well established that peoples access to and preference for mental health services is heavily influenced by existing social stigma attached to it. Changing social stigma and taboo is not simple and easy. It requires long-term interventions with whole-society approach. Media probably has one of the most powerful roles to play. Bangladesh has witnessed the power of media while countering social problems like sanitation, dowry, child marriage etc. We have seen in recent years that with successful media campaign awareness about autism has increased. We, along with different professionals e.g., former Director of Pabna Mental Hospital, Occupational Therapist of NITOR, experts from Life Spring, Monobikash, Serenity and TRIN therefore propose to engage media and other social forces in the society to create mass awareness on issues of mental health. Social media has been extraordinarily influential in shaping peoples' perception and behavior. Thus, the role of social media should be taken into consideration too. It is not only media, but other forces like Scouts, Girls Guide, Theatre Federation, Music Associations etc. should also be engaged with careful initiative in awareness campaign.

(e) Build Partnership and Collaboration with Academic Institutions

Mental health is an extremely sensitive and complex in nature, thus requires regular research and knowledge upgradation. Fact is gap in mental health research in Bangladeshi is vivid. In order to fill the gap a good number of studies are required on different aspects. However, it is not easy for a civil society organization or government to do it alone. Rather, it requires multistakeholder engagement. Especially, the NGOs and civil society organizations can build long-term collaboration and partnership with academic and research organizations which could be mutually beneficial for both parties. This partnership, Dr Tanjir Rashid, Executive Director of TRIN and Dr Sayedul Ashraf, Lead Psychiatrists of Life Spring believes that, can generate necessary knowledge products which could be easily transformed into some kind of *policy brief* and *contents* for further extended advocacy work.

(f) Form a National Forum on Mental Health

Current context of mental health in Bangladesh is quite complex which hence asks for multidimensional but coherent actions from different stakeholders. These actions, for different NGO leaders of MAA, UTSA, YPSA, BRAC and CREA, shouldn't be scattered. We along with them thus proposing for establishing a national coordination platform, for example a forum, a must indeed. This forum must include all types of mental health professionals e.g., psychologists, mental health activists, NGO leaders who are working with mental health of Bangladesh, academics, and researchers, journalists, lawyers, psychiatrists, and owners of different private clinics operating across the country. Their involvement and dialogue will create greater sensitization in the society in one hand, and on the other hand they could figure out many solutions of many practical problems they face in delivering mental health services. This forum, like other forums for example, Global Social Forum, can convene an annual event in Bangladesh.

(g) Strengthen Movement for Appointing Psychosocial Counselors in Every School in Bangladesh

Few years back, the GoB took an initiative to appoint psychologists in educational institutions which later was not being implemented. One of the major reasons is the lack of adequate number of psychologists. Needless to say, appointing this many psychologists within a short period of time seems impossible. Having said that, educational institutions can't be compromised in this regard either. At this juncture, NGOs can help in a very different manner. Mental health experts from NIMH, Serenity, Monobikash, TRIN and Life Spring said that, instead of appointing this many psychologists, they with the help of experts, can train required number of school/college teachers. Those trained teachers will then continue sessions in a periodic manner to take care of the mental health of their students. In addition, including mental health issues in parents meeting is also pivotal. However, NGOs requires extensive support and policy reformation from the government (central and local) since they lack accessibility and to some extent availability of resources required. In doing so, ensuring an honorarium for the trained teachers also need to be taken care. Again, NGOs can arrange the training sessions as mentioned above but, NGO leaders argued for ensuring regular honorariums for all those trained individuals would be extremely challenging for the NGOs. Thus, they ask the government to come forward to ensure the benefits for the trained teachers.

5.1.2. CURATIVE MEASURES

(a) Develop scientific standardized diagnostic tools

Diagnosis is one of the most important and crucial factors in mental health treatment. It is thus, a must do to develop a diagnostic tool for treating the patients. This task should be performed centrally with the help of various mental health professionals including but not limited to psychiatrists, clinical psychologists and researchers. This tool will accelerate the pace and efficacy of treatment and indeed, potential to remove extra burden from the psychiatrists about providing other psycho-social treatment to the patients.

(b) Undertake Policy Advocacy Campaign for increasing professional competency and ensuring proper treatment

To ensure proper diagnosis, treatment and care, enhancement of professional competency, and training are must in Bangladesh. However, Psychiatry is not well-preferred among medical graduates in Bangladesh. Our key Informants informed that, best medical students either choose internal medicine or surgery related specialization, and their decision is driven by a cost-benefit analysis. Moreover, to a very larger extent, family members are not ready to accept the fact that their successors will be a psychiatrist. One of our KII respondents who is a prominent psychiatrist in Bangladesh stated that

“In Bangladesh, psychiatry belongs to one of those less desired subjects. As such, a lot of rooms are left unexplored, and it reduces the efficacy of treatment. As a whole, mental health condition of people become curtailed. Also, the funding for research, treatment and other relevant services required here is very poor. Psychiatrists face institutional deprivation and condition of psychologists are worse. Without a coordination effort, improvement of mental health condition in Bangladesh I don't think possible in near future.”

These places requires both policy- and program- centric interventions. Psychiatry must be made a compulsory subject in MBBS curriculum and scope for post-graduation in psychiatry should be increased so that people get the opportunity of involvement here. Regarding Psychology, the curriculum must be updated periodically so that the students remain competent and resourceful. An NGO or civil society organization can mobilize social forces to undertake such policy campaign to bring these changes.

(c) Develop more Professionals

Though both psychiatrists and psychologists are less in Bangladesh, crisis of psychologists are much prevailing. In the first place a very few students are there who are willing to study psychology on their own, stated by an Associate Professor of Psychology, University of Chattogram. Psychology as a subject is found among the bottom of the priority pyramid among the students. Moreover, those who have interest genuinely, can't go for this due to peer and family pressure. One of the major driving factors are the poor job opportunity for the psychologists. Another obstacle is the curriculum. The curriculum must be updated so that students prioritize this subject. To produce more professionals, national level patronage, coordination and effort is pivotal. If the issue of curriculum and job opportunity are checked, the condition will definitely improve in this regard.

(d) Approve different models of treatment

In Bangladesh, medical model of mental health treatment is extremely dominant since its inception, whereas efficacy of psychological and social model for treatment of mental health issues are proven already in many countries of the world. The successful model for effective mental health promoting and mental illness treating programme is bio-psycho-social model in any good mental health programme. Despite dilemma for practicing, this medical model is highly prevalent for few obvious reasons. To erode this crisis a central coordination effort is needed. Beyond medical model, expanding psychological model, and establishing social model in the mental health policy and practice will help in many ways, creating job opportunities for psychologists and social workers as valuable and efficient contributor as distinct kind of mental health professional, ensuring proper and efficient treatment for the mental patients. As such from the policy level, multiple models of treatment need to be recognized, approved, and must be made mandatory in any mental health treatment service facility. So far, Bangladesh has tradition of producing Psychiatrists and Clinical Psychologists, but not any place to produce Psychiatric Social Worker. Only exception is the provision of producing Masters level Clinical Social Worker at Dhaka University, only from an evening course, which admits graduates from any background, including dentistry. Bangladesh, thus needs to produce professionally qualified general social workers, as well as psychiatric social workers, to reduce the mental health service gap, in the current incomplete system. The social work departments of all public universities must update and upgrade their syllabus and their supervised internship programme, to ensure quality production of general and psychiatric social workers, who will be professionally qualified to provide appropriate social support to the mentally disturbed and distressed individuals, family and community, to restore their mental balance.

5.2. Community Level

There are some initiatives which could be undertaken at the community level directly addressing the clients. Some of them are proposed in the following.

5.2.1. PREVENTIVE MEASURES

a) Develop motivation and awareness programs at the community

Mental health researchers, practitioners and NGO leaders whom we interviewed believe that the persistence of cultural barriers in terms of mental health service taking from practitioners are heavy. One of the major tasks in this regard is to break the concurrent social stigma and no single actor or strategy can help achieving this. This requires more program-centric strategies. Different community leaders from our investigating areas said that Government must play the role to coordinate among multiple stakeholders where NGOs may act as the primary stakeholders. They may run school and college-based campaigns separately for training the teachers. Besides, involving the local religious leaders, and local print and electronic media is potential to increase awareness among people in the grassroots level.

b) Adopt community-based approach and strategies for service providers

Our interviewed academicians believe that service providers should adopt a contextual strategy for any given locality instead of following ‘one size fits all’ method. Mental health issues are versatile and different societies of Bangladesh has different types of problems. As such, service providers must have a prior knowledge about the region they are operating. In addition, building rapport with the service takers is very important since people are not always ready and comfortable to share their mental condition with others. As such, a community-based strategy will help more to provide efficient service of mental health problems.

c) Engage political leaders, community resource persons, and resources

Community leaders we interviewed stated that, at the grassroots level of Bangladesh, political leaders, religious leaders, and teachers possess a great hold over the mass people. As such, involving them in the process of mental health crisis management will bring fruitful outcome. It will also help the service providers to build rapport and to implement community-based strategies for providing services.

d) Develop paraprofessional personnel followed by an inclusive team in each operational unit

Usually, we consider only psychiatrists and psychologists as mental health service providers, but it is not limited to these two only. For providing proper mental health service in any locality, a team including (a) psychotherapists, (b) counselors, (c) clinical social worker, (d) psychiatric nurse, and (e) occupational therapist are a must apart from psychiatrist and clinical psychologists. In some places, multiple psychologists and counselors are required with different types of expertise e.g., drug addiction, children, adolescent, relationship etc. However, these professionals are rare in number. With this backdrop, all of our interviewed participant ranging from government officials

to private practitioners to NGO leaders prescribed that, it is high time to develop paraprofessional with short term training who can serve at the primary service outlets at the community level.

e) Develop a cadre of mental health volunteers with proper training on Mental Health First Aid at the community level.

The GoB has long standing commitment to develop mental health volunteers at the community level. The volunteers would be given training on Mental Health First Aid pack. Thus, CSO/NGOs can take similar initiative to supplement or reactivate the existing government initiative. The same training curriculum could be offered by NGOs as well to develop their own cadre of community mental health volunteers.

5.2.2 CURATIVE MEASURES

(a) Develop primary screening and assistance facility at the grassroots

It is clearly found that at the grassroot level of Bangladesh, availability of services is extremely poor, almost nonexistent. Contemporary practitioners prefer practicing in Dhaka or in large city like Chattagram, to a very small extent, in other divisional and district cities. Even in some divisional cities like Barisal and Dinajpur, availability of services is alarming. Civil Society personnel of those regions strongly asked for collaboration of government, NGOs and private agencies to develop mental health service facility at the town level, at least at the District Hospitals.

(b) Initiate interventions to reduce maltreatment

All the interviewed academicians and professionals very strongly stated that, one of the major hindrances of our mental health service delivery is the dominance of malpractitioners. It is high time to prevent the malpractices of some so called “Baidya,” “Hujur,” “Purohit” and likewise practitioners. They capitalize the emotions of mass people on religious issues and provide services. To curb such practices, our resource persons prescribed for a grassroot campaign could be initiated through existing programmes like Girls Club or Community Based Organization which are already in place.

Apart from this, our panel also suggested for disciplinary action against these mal-practicing individuals (e.g., religious practitioners) and organizations (e.g., so called rehabilitation centers) are also suggested. These organizations have capitalized peoples’ limitation of knowledge and vulnerability. Hence, the rehabilitation centers must be brought under a monitoring protocol having a specific guideline of service delivery. In addition, service takers must have an opportunity to inform the respective authority directly by any means (e.g., hotline number, email, letter etc.).

(c) Making services affordable for All

Practicing government professionals, academicians, NGO leaders and managers of different hospitals whom we interviewed believe that one of the major interventions in this regard will be lowering the cost since almost all the respondents have reported about the higher out-of-pocket expenditure (OOP). For them, Government can play the biggest role in this regard. Though through KIIs, it has been found that telemedicine service has been functional since the outbreak by National Institute of Mental Health for free of cost, people are unaware of this. If along with services,

information dissemination can be done simultaneously, such initiatives will give higher rate of return.

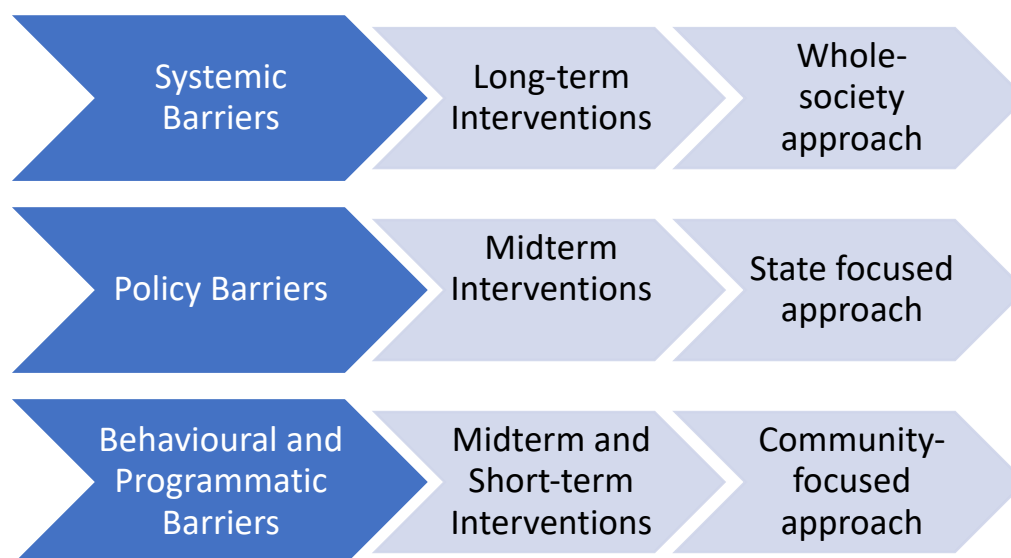
Secondly, government can incentivize the private hospitals for lowering the cost of mental health by announcing a tax rebate on the earning of mental health service delivery. If it includes the special children too, people will be beneficial greatly.

Thirdly, NGOs can run campaigns of mental health treatment both in medical and social model in areas where the service delivery lacks affordability or accessibility or both. This will help the poor people availing the service.

(d) Build Online Platform/ Helpline

Despite the fact that the Covid- 19 pandemic has created enormous pressure in all terms for people of all walks of society in Bangladesh and elsewhere. However, especially in Bangladesh there has been a positive impact that is people has now been familiar with online-based transactions and exchange. During the current pandemic e-commerce and e-services has been burgeoning like anything. We think this is an opportunity to establish more online-based/ Tele-help line services for mental health services. There we found at least six successful initiatives which are already doing great job in Bangladesh. However, this kind of initiatives could be established more. Especially, an NGO could run such services for poor and vulnerable group of populations through a toll-free number. Director of NIMH, Executive Director of TRIN and Lead Psychiatrist of Life Spring believes that tele-service for mental health will be a breakthrough to deal with this crisis.

6. Conclusion



This research has explored that there are systemic, policy, behavioral and programmatic barriers in accessing mental health services which have cultural, economic and institutional dimensions. However, in order to transform the barriers into opportunity a multi-layered multi-stakeholder approach is required. As it presented in the above figure that for addressing systemic barriers one needs to design long-term interventions engaging all potential stakeholders in all phases of the program. It requires to adopt a *whole-society approach*. Similarly, for overcoming the policy level barriers the first thing is that political commitment has to be ensured. Therefore, continuous engagement with policy makers including political parties, Member of Parliament and senior government official is required. These barriers could be approached with Midterm⁴ (3-5 years) interventions and it need to put the government at the center with a *state focused approach*. However, For the behavioral and programmatic barriers smart interventions need to be figured out. Hence, a *community-focused approach* can help for producing expected results.

We have to keep in mind that, in order to achieve the main purpose of the SDGs - leaving no one behind – cannot be achieved if we do not take millions of people who are in dire needs of mental health services across Bangladesh. Since the youth are the future, putting them in risks of lifelong impairment wouldn't help the country achieving any kind of development goal let alone SDGs. Therefore, further research and innovative programs have to be carried out by all stakeholders in collaboration and complementarity.

⁴ *Long-term* refers 6- 10 years of period; *Midterm* refers 3-5 years of period and *Short-term* refers 1- 3 years of period

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ANNEX 1: DATA COLLECTION CHECKLISTS AND GUIDELINES

FGD Guidelines

Target Participants: Youth male and female age between 15 – 30.

Rules: (i) There will be 8 – 10 participants in each FGD session. (ii) At the very beginning demographic information e.g. age, gender, marital status, education, occupation and address will be recorded on a attendance sheet. (iii) The session will be moderated by a trained moderator. (iv) FGDs will be run following all ethical protocol. (v) A session will last for 60 – 90 mints.

Key Issues to be discussed/asked

After brief introduction about the participants and having the purpose of the research explained to them, the main discussion topics will be introduced sequentially. However, relevant follow up discussion and question may continue to be raised outside this FGD issues/questions.

Covid and Impact of Covid

- Tell us about your experience about the covid in your neighborhood
- How had your community responded to lockdown and other government orders about Covid?
- Was there any community support mechanism established for example medical support, testing support, food or anything being provided by voluntary initiative)
- Please tell us what was the most challenging part about Covid in your experience
- What did you do when you found someone identified as Covid positive?
- As a young, please tell us what was the most challenging when you have your schools, sports, clubs closed and movements restricted?
- In your opinion tell us about the most difficult things for the youth of your age to cope with this pandemic
- What you or your friends used to do when you see things are not going right around you (it could be about your education, employment, family, community, government) during the last few months

Mental and Psychological Wellness

- Please tell us your regular involvement with your family members, what do you do for your family, how much time you spend with your family,
- How much comfortable do you feel about having an open discussion with your family members?
- Could you please share what do you mean by mental or psychological wellness?
- How would make difference between physical health and mental health?
- Would you please share if you or any of your friends has gone through any kind of mental/psychological challenges?
- Have you or any of your friends has felt depressed/frustrated/anxiety due to family, social, financial, professional or any other reason in recent months?

- What difficulties have you experienced about your recent mental stress?
- Do you know anyone taking any substance or any other forms of drugs in your friend circle?
- What do you think about the main causes of drug addiction among the youth in your locality these days?

Access to Mental Health Services

- Have you shared your frustrations with family, friends or loved ones? How did they respond?
- What types of help have you got from your surroundings regarding your mental stress?
- Have you/ heard of any of your friends tried to do something extreme resulting from your mental condition? If yes, then why have you/they tried that?
- Have you taken any psychological support from professionals e.g. psychiatrist, psychologist or counsellor etc.?
 - If no, then why haven't you contacted any professional?
 - If yes, then what problems have you faced to get support from the psychologist/ psychiatrist?
- What type of support do you expect from the professionals?
- Have you ever been to a health facility for rendering any services for your/ your friend/family members?
- Please tell us about your experience – how was doctor, how was the facility, medication, behavior, everything you can remember about the health facility and professional
- In your opinion, what could be the main reasons for which one doesn't go to a mental health service provider (for example psychosocial counsellor or psychiatrist)
- In your opinion what are the major barriers for which you/your friend will not go to government hospitals/doctors for services to address mental illness like depression, anxiety or any disorders you feel?
- Do you have any private service provider in your locality/town? Do you know any of them? Have you/your friend has ever gone to any of the private service providers? Why? Why not? Please tell us your experience
- Do you have any NGO/Volunteer organizations who does mental health services in your locality/town? Have you ever interacted with them? Why? Why not? Please tell us your experience
- Do you have any idea of how much it may cost to take mental health services from government/private professionals?
- Please tell us your own ideas of why youths are not as much interested in taking psychological counseling as compared to other clinical support?

What Could be done

- What steps do you think can be done to make people aware of mental health?
- How can be the government mental health service system improved?
- What is your expectation from the private sector in this regard?

- What types of role NGOs could play to improve youths' mental/ psychological health in current situation in your community?
- What is expectation from the education institutions?
- What could be role of social clubs/organizations for the youth in your locality
- Would you like to share any of other ideas that you feel relevant to this discussion, please go ahead.

Thank you very much for your time and cooperation.

The session will be closed with high appreciation and acknowledgement of the participants.

Key Informants Interview Checklist for the Government Regulators

Key Issues to be discussed/asked

After brief introduction and having the purpose of the research explained to the key informants, he/she will be asked the following questions:

Organization

- Please tell us about your role of your organization in mental health services
- What are the key services you do provide, who are the main target population
- What kind of facilities you have in your organization, (beds, IPD, OPD, counselling, drugs, etc)
- How had your organization responded to Covid?
- Has your organization delivered any covid response packages? What exactly did you do? What services you gave, to whom?
- Did you have any services, especially for the youth? What is that?
- On your observation, could you please tell us what are the key challenges our youths are facing, especially during this Covid period?
- Has your organization had any programs addressing youth, adolescents? What are those?

Mental Illness: Prevalence, Causes and Pattern

- What kind of training you received on mental health services?
- With your experience, please tell us the common pattern of mental/psychological illness in among the adolescents and youth in your town/locality?
- In your opinion, what is the prevalence of mental/psychological illness in your working area?
- What is the most common mental illness in this area?
- What is the prevalence of substance use or any other forms of drug addiction in your Working area?
- What do you think about the main causes of drug addiction among the youth in your locality these days?

- With your experience, could you please tell what the youths do when they face any mental/psychological illness?
- In your opinion, what are the main causes of mental illness among the youths and adolescents in these days

Mental Health Services: Access and Policies

- With your observation, what do youths do when they gone through mental stress?
- What types mental health support services are available in Bangladesh from the GoB?
- Please give us an assessment of the Mental Health Act 2018
- What is your opinion about the Mental Health Policy of Bangladesh
- In your opinion, what could be the main reasons for which one doesn't go to a mental health service provider (for example psychosocial counsellor or psychiatrist)?
- In your opinion what are the major barriers for which a youth will not go to government hospitals/doctors for services to address mental illness like depression, anxiety or any disorders you feel?
- In your opinion what are the major barriers for which a youth will not go to private hospitals/doctors for services to address mental illness like depression, anxiety or any disorders you feel?
- In your opinion, what is the main challenges for the government in implementing Mental Health Act 2018 in Bangladesh

What Could be done

- What steps do you think can be done to make people aware of mental health?
- How can be the government mental health service system improved?
- What is your expectation from the private sector in this regard?
- What types of role NGOs could play to improve youths' mental/ psychological health in current situation in your community?
- What is expectation from the education institutions?
- What could be role of social clubs/organizations for the youth in your locality
- In your opinion, what could be the role of media in this regard?
- Would you like to share any of other ideas that you feel relevant to this discussion, please go ahead.

Thank you very much for your time and cooperation.

The session will be closed with high appreciation and acknowledgement of the participants.

Key Informants Interview Checklist for the NGO Managers

Key Issues to be discussed/asked

After brief introduction and having the purpose of the research explained to the key informants, he/she will be asked the following questions:

Covid and Impact of Covid

- Please tell us about your experience about the covid in your working area
- How had your organization responded to lockdown and other government orders about Covid?
- Have you delivered any covid response packages in your working area? What exactly did you do? What services you gave, to whom?
- As a professional, please tell us what was the most challenging part in covid operation?
- Did you have any services, especially for the youth? What is that?
- On your observation, could you please tell us what are the key challenges our youths are facing, especially during this Covid period?
- Has your organization had any programs addressing youth, adolescents? What are those?
- Do you have any mental/psychological health services for any group of beneficiaries, especially adolescents and/or youth?

Mental and Psychological Wellness

- Could you please share what do you mean by mental or psychological wellness?
- Have you ever any training or orientation on mental health/psychosocial counselling?
- In your opinion, what is the prevalence mental/psychological illness in your working area?
- In your own experience, what are the common mental illness/psychological issues you see among the youth and adolescents in your working area?
- What is the prevalence of substance use or any other forms of drug addiction in your Working area?
- What do you think about the main causes of drug addiction among the youth in your locality these days?

Access to Mental Health Services

- With your observation, what do youths do when they gone through mental stress?
- Do you know if there is a system of psychological support from professionals e.g. psychiatrist, psychologist or counsellor etc.?
- What types mental health support services are available in the area?
- Have you ever been to a health facility for rendering any services for you/ your friend/family members?

- Please tell us about your experience – how was doctor, how was the facility, medication, behavior, everything you can remember about the health facility and professional
- In your opinion, what could be the main reasons for which one doesn't go to a mental health service provider (for example psychosocial counsellor or psychiatrist)
- In your opinion what are the major barriers for which a youth will not go to government hospitals/doctors for services to address mental illness like depression, anxiety or any disorders you feel?
- Do you have any idea of how much it may cost to take mental health services from government/private professionals?
- Please tell us your own ideas of why youths are not as much interested in taking psychological counseling as compared to other clinical support?
- With your experience and observation, please tell us what are the main barriers for the youths and adolescents for not seeking mental health services? Please be specific as possible

What Could be done

- What steps do you think can be done to make people aware of mental health?
- How can be the government mental health service system improved?
- What is your expectation from the private sector in this regard?
- What types of role NGOs could play to improve youths' mental/ psychological health in current situation in your community?
- What is expectation from the education institutions?
- What could be role of social clubs/organizations for the youth in your locality
- Would you like to share any of other ideas that you feel relevant to this discussion, please go ahead.

Thank you very much for your time and cooperation.

The session will be closed with high appreciation and acknowledgement of the participants.

ANNEX 2: LIST FGD PARTICIPANTS

OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH			
Field Location: Barishal Date: 28-03-2021		Male FGD Participants List	
Serial No.	Name	Age	Sex
1	Ariful Islam	19	Male
2	Imrul Kayes	18	Male
3	Abir Howlader Shanto	22	Male
4	Md.Somir	27	Male
5	Md.Mainul Islam	22	Male
6	Md.Tajul Islam	22	Male
7	Md.Shakil Mridha	46	Male
8	Badshah	24	Male
9	Jalal Rahman	42	Male
10	Md.Al-Amin Munshi	29	Male
11	Md.Amir Ali	57	Male
12	Md.Salek Gazi	30	Male
13	Badol Molla	28	Male
14	Md.Selim	40	Male
15	Joni Baroi	28	Male

OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH			
Field Location: Wazirpur, Barishal Date: 29-03-2021		Female FGD Participants List	
Serial No.	Name	Age	Sex
1	Riyanti Mollik	15	Female
2	Priyanka Saha	20	Female
3	Dipa Ray	19	Female
4	Ripa Gain	23	Female
5	Sushmita Saha	16	Female
6	Bithi Rani Halder	21	Female
7	Mitu Halder	28	Female
8	Lipi Mollik	28	Female
9	Konika Modhu	20	Female
10	Chandona Halder	28	Female

**OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH
BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH**

Field Location: Chattogram Date: 30-03-2021		CBO Leaders FGD Participants List	
Serial No.	Name	Age	Sex
1	Sanjida Akhtar	15	Female
2	Rabeya Begum	29	Female
3	Nipa Singho	29	Female
4	Sumaiya	15	Female
5	Taslina	16	Female
6	Reshmi	15	Female
7	Nadiya Akhtar	16	Female
8	Ritu Akhtar	15	Female
9	Nadia Sultana	16	Female
10	Sonia Akhtar	15	Female
11	Hasina	30	Female
12	Zaheda Akhtar	16	Female

OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH			
Field Location: Chattogram Date: 30-03-2021		Female FGD Participants List	
Serial No.	Name	Age	Sex
1	Sanjida	15	Female
2	Rabeya	29	Female
3	Nipa Singho	29	Female
4	Sumaiya	15	Female
5	Taslina	16	Female
6	Reshmi	16	Female
7	Nadiya Akhta	16	Female
8	Farjana Akhtar	16	Female

**OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH
BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH**

Field Location: Chattogram Date: 30-03-2021		Male FGD Participants List	
Serial No.	Name	Age	Sex
1	Md.Shohagh	30	Male
2	Md.Reaz	29	Male
3	Md.Polash	29	Male
4	Siam Mahmud	16	Male
5	Sagor Das	20	Male
6	Md.Masum	24	Male
7	Md.Tuhin Mondol	26	Male
8	Md. Jihad Khan	19	Male
9	Md. Shahidul Islam	26	Male
10	Redwan	18	Male
11	Md.Manik	18	Male
12	Md.Sumon	23	Male
13	Jeetu Barua	23	Male

**OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH
BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH**

Field Location: Mirpur ,Dhaka Date: 14-06-2021		Female FGD Participants List	
Serial No.	Name	Age	Sex
1	Maya	24	Female
2	Mahmuda	19	Female
3	Moni	22	Female
4	Sumaiya	20	Female
5	Rani	36	Female
6	Akhlima	50	Female
7	Sathi	29	Female
8	Lota	27	Female
9	Rani Asraf	24	Female
10	Naznin Fatema	28	Female

**OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH
BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH**

Field Location: Mirpur, Dhaka Date: 14-06-2021		Male FGD Participants List	
Serial No.	Name	Age	Sex
1	Md.Mezba	18	Male
2	Md.Shofiq	24	Male
3	Md. Malik Molla	30	Male
4	Md. Mortuza	30	Male
5	Abdul Muktadir	22	Male
6	Md.Sohel	40	Male
7	Md.Anik Khan	21	Male
8	Opu	17	Male
9	Md.Inan	18	Male
10	Md.Reaz	19	Male

**OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH
BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH**

Field Location: Tongi ,Dhaka Date: 19-06-2021		Female FGD Participants List	
Serial No.	Name	Age	Sex
1	Rajia Sultana	25	Female
2	Tamanna Akhtar	19	Female
3	Shahinoor Akhtar	19	Female
4	Sharmin Akhtar	19	Female
5	Nasrin Akhtar	20	Female
6	Yeasmin Akhtar	20	Female
7	Rotna Akhtar	19	Female
8	Salma Akhtar	20	Female
9	Dolon	19	Female
10	Nisha	24	Female

**OPPORTUNITIES AND BARRIERS TO MENTAL HEALTH SERVICES FOR YOUTH
BY GOVERNMENT, NGOS AND PRIVATE SECTOR IN BANGLADESH**

Field Location: Tongi ,Dhaka Date: 19-06-2021		Male FGD Participants List	
Serial No.	Name	Age	Sex
1	Abdur Rahim	17	Male
2	Md.Forhad	16	Male
3	Md. Monir Hossain	22	Male
4	Kayes Bin Sakib	22	Male
5	Robiul Islam Mihir	20	Male
6	Abdullah Al Mamun	20	Male
7	Ripon Islam	19	Male
8	Shohan Molla	20	Male
9	Tanveer	16	Male
10	Mahmudur Rahman	17	Male
11	Sakib	16	Male

ANNEX 3: LIST OF KEY INFORMANTS INTERVIEWED

Barishal

1. *Moni* , Homemaker
2. *Parinita Majumder* ,Parent –having child with mental health issue
3. *Dr. Manisha Chakraborty* ,Doctor & Socialist Party of Bangladesh activist
4. *Liza Sarker* ,Youth who survived Covid-19
5. *Sathi Halder* , *Rina Roy* ,NGO Worker
6. *Md. Zahid Hossain*, Officer (Center-In-Charge), Program Team, CREA Barishal.
7. *Md. Mosharrof Hossain*, Branch Manager, Popular Diagnostic Center, Barishal.

Dhaka

1. *Prof. Dr. M M A Salahuddin Kauser Biplob*, MBBS, MD (Psychiatry), Editor, Moner Khabor
2. *Professor Dr. Md. Ahsanul Habib*, MBBS, FCPS (Psychiatry), Fellow WHO (India), Former Director, Pabna Mental Hospital, Bangladesh.
3. *Imrul Kayes*, Co-founder, MINDO Health.
4. *Sathi Akhtar* ,Youth leader
5. *Dr. Tanjir Rashid Soron*, MBBS, MD (Psychiatry), Founder and Managing Director, Telepsychiatry Research and Innovation Network Ltd (TRIN).
6. *Dr. Sayedul Ashraf*, MBBS, MD (Psychiatry), Managing Director and Lead Psychiatrist, Life Spring Ltd.
7. *Prof Dr. Bidhan Ranjan Roy Podder*, MBBS, DPM, Director, NIM

Chattagram

1. *Md. Arifur Rahman* ,Chief Executive of YPSA
2. *Mr. Bhaskar Bhattacharjee* ,Team Leader of YPSA-HLP initiative
3. *Dr. Syeda Marufa Nigar*, Coordinator, One Stop Crisis Center, Chattagram Medical College and Hospital
4. *Mahjareen Binta Gaffar* ,Clinical Psychologist, One Stop Crisis Center, Chattagram Medical College and Hospital
5. *Mostafa Kamal Jatra* , Executive Director at Unite Theatre for Social Action (UTSA)
6. *Sharif Chouhan* ,General Secretary, Workers Party, Chittagong
7. *Mohammed Afzal Hossain* ,Associate Professor of Psychology, University of Chittagong
8. Youth Leader, Chittagong

9. *Robert Kamol Sarker*, Area Program Manager, Chittagong Urban, World Vision Bangladesh.
10. *Shahrina Ferdous*, Consultant Psychologist & Managing partner, Serenity- a Psychosocial Support center. Former Psychologist: Green University of Bangladesh, Asian University for Women
11. *Md. Ahadul Islam*, Office Executive, Life Coach Bangladesh.
12. *Jahan Ara Begum*, General Secretary, Alliance of Arbun DPO's in Chittagong (AUDC)

Dinajpur

1. *Arabinda Sylvester Gomes*, World Vision Bangladesh-AP Manager
2. *Sabiha Binte Anwar*, One Stop Crisis Center
3. Parent –having child with mental health issue

Fulbari

1. *Lavly Begum*, Head-mistress in Ruddrani Uttarpara primary school
2. *Swapan Singh*, World Vision Bangladesh-AP Manager
3. *Ms. Shahida Akter*, World Vision Bangladesh -Community Facilitator
4. *S K Mohammad Ali*, Headmaster, Sujapur Model School

ANNEX 4: DATABASE OF SERVICE PROVIDING ENTITIES
