LEADING ARTICLE

Mental health services in South Asia: Past, present and future

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Introduction

South Asia is home to more than a fifth of humanity. Of the 6.8 billion global populations, more than 1.6 billion live in the 8 countries of South Asia. South Asia is the poorest region on the earth after Sub-Saharan Africa. South Asia is also a region of great contrasts. During the past couple of decades, the region has witnessed rapid social and economic change. Mental, neurological and substance use related disorders account for a major share of the burden of diseases in the South Asian countries. This paper describes issues related to mental health in South Asia and traces the historical development of mental health services in the region. The paper also provides an overview of the current situation of mental health services in the region and speculates about what is needed in the future.

South Asia

South Asia includes Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. These countries share several socio cultural, economic and demographic conditions. In recent years, some countries in South Asia have registered very impressive economic growth. However, the world's largest population of poor, hungry and illiterate live here. The World Bank (2010) classifies economies according to their gross national income (GNI) per capita, into low income (US$ 995 or less), middle income (sub divided into lower middle income, US $996 – US$ 3945 and upper middle income, US $3946 – US $12195) and high income (US$ 12196 and above) countries. According to this classification, Afghanistan, Bangladesh and Nepal are low income countries and all the other South Asian countries except Maldives fall under the category of lower middle income group. Maldives which has the smallest population (396,334) amongst all the South Asian countries had a per capita GNI of US$ 3970 in 2009 which made it move up to an upper middle income country. India with a population of 1.198 billion is the second most populous country in the world. Pakistan (180 million) and Bangladesh (162 million) have the sixth and seventh largest population in the world.

Although countries in the South Asian region have very many similarities such as, a British colonial past, an under developed industrial base, agriculture based economies, very low standards of living and similar problems of inadequate resources and capacities, these countries do not constitute a very homogenous group. There is considerable heterogeneity within these countries. There are striking differences between the countries as well as between different regions within the countries. They show widely varying profiles of development. The Gross National Income (GNI) may not always provide a complete picture of a country's overall development. The United Nations Development Programme (UNDP) has developed a composite index called the Human Development Index (HDI) to better capture the complex relationship between a country's income and human progress. HDI which indicates average progress of a country in human development is a measure of three dimensions of human development - namely living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and school enrolment at the primary, secondary and tertiary level) and having a decent standard of living (measured by purchasing power parity, (PPP), income). Since 1990, the UNDP has released the Human Development Report (HDR) annually. The

HDR ranks all the countries in the world according to their HDI. Tables 1 & 2 provides some of the human development indicators and the HDI ranks for the countries of South Asia in 2010. Only Sri Lanka among the South Asian countries has achieved acceptable levels of under 5 mortality rate (per 1000 live births), adult literacy rate and life expectancy at birth.

Table 1 - Human Development Indicators (HDI) in South Asian countries 2010

Country	**Life expectancy at birth** (years)	**Expenditure on health, public** (% of GDP)	**Under 5 mortality** (per 1000 live births)	**Adult literacy rate** (both sexes)	**Human Development Index (HDI) Rank**
Afghanistan	44.6	1.8	257	28	155
Bangladesh	66.9	1.1	54	56.5	129
Bhutan	66.8	3.3	81	52.8	NA
India	64.4	1.1	69	68.3	119
Maldives	72.3	6.4	28	97.3	107
Nepal	67.5	2.0	51	60.3	138
Pakistan	67.2	0.8	89	54.2	125
Sri Lanka	74.4	2.0	15	90.8	91

Table 2 - GDP per capita (2008 PPP – Purchasing Power Parity – US$) in South Asia

Country	**GDP per capita** (2008 PPP – Purchasing Power Parity – US$)
Afghanistan	1419
Bangladesh	1458
Bhutan	5532
India	3354
Maldives	5721
Nepal	1189
Pakistan	2625
Sri Lanka	4995

About 70% of the population in South Asia live in rural areas and continue to depend largely on agriculture. The male population is slightly larger than the female population and majority of the population belong to the younger age groups. The literacy rates of the male population are slightly better than the female population. It is estimated that between 35% and 40% of the population in the region live below the poverty line of less than US$ 1.25 a day. A similar proportion of population do not have access to either safe drinking water or adequate sanitation. South Asia has one of the highest child malnutrition rates in the world.

South Asia is ethnically diverse. Numerous languages and dialects are spoken across the region. India has 22 officially recognized languages. Hinduism, Islam and Buddhism are the major religions in South Asia. India, Pakistan and Bangladesh were under British rule till 1947. Nepal and Bhutan were protectorates of Great Britain.

While most countries in the region currently are parliamentary democracies, Bhutan continues to be a constitutional monarchy. Pakistan is an Islamic republic. The region has witnessed long – running conflict and is considered to be one of the most violent places in the world. While an ethnic conflict of more than 25 years in Sri Lanka ended

recently, Pakistan and Afghanistan continue to be violent places. Equally common are natural and manmade disasters of various types and intensity, affecting large populations in all the countries of the region.

Although the countries in the region had formed the South Asian Association for Regional Cooperation (SAARC) more than 25 years ago, there has not been satisfactory integration between the countries due to a variety of political and socio economic reasons. The integration has been least trade wise; the trade between South Asian states is only 2% of the combined GDP of the states. Along with rapid and impressive growth, income inequalities and health inequalities too are steadily growing in many parts of South Asia. A recent commentary on 'the poor half billion in South Asia' notes that the rapid economic growth has created 'two South Asias' – one dynamic, urbanized and globally integrated, and the other rural, impoverished and lagging (Ghani, 2010).

South Asia today is well known for its large scale poverty, increasing income inequality, frequent natural and manmade disasters, chronic ethnic conflicts; violence and war, gross underdevelopment and uneven development. All these factors are important social determinants of population mental health. Health is comparatively a low priority area for all the countries in the region as evidenced by the low spending on health, usually below 2 per cent of the GDP. Bhutan and Maldives which spent 3.3 and 6.4 per cent of their GDP on health are exceptions.

Mental health services in South Asia: Past

Up until the time of independence of most of the countries in South Asia (in the Indian sub-continent) from British rule in 1947, mental health services in the region were exclusively centered in the large mental hospitals, previously called asylums, located in some of the cities of the region (Madras, Bombay, Calcutta, Poona, Ranchi, Lahore, Colombo etc) – a reflection of the pre-chlorpromazine era asylum based psychiatric services in Britain and other western countries. Even after attaining independence, mental health services continued to be centered in asylums for several more years. In some countries, more asylums were established. Like asylums everywhere else in the world then, these were large, overcrowded, underfunded and poorly staffed. Mental health services were marked by gross neglect due to a variety of reasons which included pervasive stigma, widespread misconceptions, grossly inadequate budgets and acute shortage of trained personnel (Neki, 1973). There were very few trained psychiatrists and other mental health professionals in any of the countries to develop alternate mental health services. Centers or facilities for training in any of the mental health disciplines were also nonexistent. Most of the few psychiatrists who worked in South Asian countries then were trained in Britain.

In 1954, India set up a mental health training institute – the All India Institute of Mental Health, to train psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses, in Bangalore, attached to the state government run mental hospital located in Bangalore. This institute later became the National Institute of Mental Health and Neuro Sciences (NIMHANS) and is today one of the leading and recognized mental health training and research centers in the whole developing world (Isaac, 1996). With the number of trained psychiatrists increasing steadily, particularly in India, more academic departments of psychiatry came up in various places in the country. Over a period of time, post graduate training in psychiatry started elsewhere in the region too.

By the 1960s, small psychiatric units with inpatient facilities were set up in many of the general hospitals (General Hospital Psychiatry Units). Their numbers and acceptance steadily grew (Wig, 1978). However, the total numbers of psychiatric hospital beds available was far below the requirements, in all the countries. All the services were exclusively located in urban areas. Most persons with serious mental disorders were looked after by their families in their homes and communities.

Various traditional, religious and alternate methods of treatment were popular for all forms of mental disorders and were extensively used across the region (Kuruppuarachchi and Rajakaruna, 1999, Kapur, 1975). Ignorance, stigma and

misconceptions about the causation and management of mental disorders were widely prevalent resulting in all forms of violation of human rights of persons with mental disorders. Involuntary admissions and discharges from mental hospitals were regulated by the archaic Indian Lunacy Act 1912.

An enquiry into the conditions in mental hospitals by the National Human Rights Commission of India in 1999 noted that "38 per cent of the hospitals still retain the jail like structure that they had at the time of inception, patients are referred to as inmates and persons in whose care the patients remain through most of the day are referred to as warders". The Commission also noted that "the deficiencies in the areas described so far are enough indicators that the rights of the mentally ill are grossly violated in mental hospitals" (National Human Rights Commission, 1999). In 2001, 28 chained mentally ill persons were burnt to death due to an accidental fire at a religious healing center in Erwadi in Tamil Nadu state of South India (Murthy, 2001). Media exposes and public interest litigations about the poor and scandalous situations in many mental hospitals coupled with assertive action by the courts contributed to initiation of mental hospital reforms in many centers. Legislative action to modernize and replace the old "lunacy" laws too was begun.

Realizing that the then existing mental health services (mental hospitals and psychiatry units in general hospitals) were centralized in urban areas while more than 70% of the needy population lived in rural areas, some centers, notably in India initiated pilot programmes to develop and evaluate extension of mental health services for the rural underprivileged population. These programmes demonstrated that basic mental health care could be provided by health workers and doctors in rural primary health centers, if they were adequately trained, supported and supervised(Indian Council of Medical Research - Department of Science and Technology, 1987, Isaac et al., 1982, Wig et al., 1981). India adopted a "National Mental Health Programme" in 1982, which had integration of mental health into general health services as the primary approach for delivering mental health care throughout the country (Director General of Health Services (DGHS), 1982). The National Mental Health Programme in India was operationalized through a pilot programme covering 2 million population in the district of Bellary in Karnataka State (District Mental Health Programme) (Isaac, 2010). Similarly, in Pakistan a community mental health programme was launched in 1985 and a National Programme of Mental Health was formulated with the aim of integration of mental health services into primary care (Yousaf, 1997).

Mental health continued to occupy a very low priority in terms of allocation of funds, in the background of overall poor funding of around 1% of the GDP for health. The severe shortage of trained mental health professionals was further complicated by constant "brain drain" (Patel, 2003). The treatment gap in the field of mental health continued to remain wide.

Mental health services today

Mental health has come into greater focus in South Asia during the past decade due to a variety of reasons. This began with the publication of the World Bank / World Health Organization / Harvard University report on the Global Burden of Diseases which showed that mental and neurological disorders accounted for about 13% of the global burden of diseases and this was equally true for countries in the developing world (World Bank, 1993). In 2001, the World Health Report published by the World Health Organization focused on mental health (World Health Organization, 2001). Subsequently, a number of influential international reports and recommendations have highlighted the urgent need to strengthen and improve mental health services in developing countries (Hyman et al., 2006, Institute of Medicine, 2001). More recently, the Lancet series on Global Mental Health provided evidence for the huge treatment gap in the field of mental health in developing countries and the Lancet's Call for Action appealed for scaling up services for mental health (Chisholm et al., 2007).

The coverage and effectiveness of public health services including mental health services are grossly suboptimal in all countries in South Asia except perhaps in Sri Lanka. Health systems

are constrained by chronic shortage of motivated and adequately trained staff, low budgets, irregular supply of drugs, and lack of transportation, non-functioning equipment, poor organization and management. Health systems which are consistently inequitable in their distribution often fail to reach disadvantaged sections of the population effectively. Widespread misconceptions about the causation and management of mental disorders and stigma towards mental disorders continue to be rampant in all the countries. Consequently, even when mental health services are provided, their utilization is generally low. The percentage of population on any kind of health insurance is very low. For a large majority of the population, out-of-pocket expenditure is the primary method of payment for general health as well as mental health services. It is known that the proportion of persons with mental disorders who receive services in a country correspond to the country's percentage of GDP (gross domestic product) spent on health care (Wang et al., 2007).

The lack of systematic information about the nature and extent of available resources for mental health care delivery in South Asian countries was filled to some extent by WHO's Mental Health Atlas project (World Health Organization, 2005). Comprehensive country profiles obtained using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) (Saxena et al., 2007a) – a comprehensive assessment tool for mental health systems designed for low and middle income countries consisting of six domains namely policy and legislative framework, mental health services, mental health in primary care, human resources, public information and links with other services and monitoring and research – are now available for Afghanistan, Bhutan, Bangladesh, Maldives and Nepal (World Health Organization, 2007b, World Health Organization, 2007a, World Health Organization, 2006). The International consortium on mental health policy and services (Gulbinat et al., 2004) also developed tools for assessing a country's mental health status (context, needs, demands, programmes, services, care and outcome) and using the tool, generated detailed profiles of Pakistan, India and Nepal (Regmi et al., 2004, Khandelwal et al., 2004, Karim et al., 2004). These profiles confirm that the available mental health resources and services are grossly inadequate in these countries when compared to the enormous needs. The profiles also indicate that countries in the region show wide variations in the availability of different components of mental health services. A recent review of the availability of resources for mental health in developing countries showed that resources were not only very scarce but were inequitably and inefficiently used (Saxena et al., 2007b).

Although well conducted epidemiological surveys of mental disorders are few, the wide prevalence of all forms of mental disorders in most parts of South Asia is well documented by several reports, notably from India, Pakistan and Bangladesh (Math and Srinivasaraju, 2010, Hosain et al., 2007, Gururaj and Isaac, 2004, Mumford et al., 1997). The presence of mental disorders in about 25% of the attendees of primary care settings in developing countries including countries in South Asia is also well established (Ustun and Sartorius, 1995, Harding et al., 1980). Surveys have shown that common mental disorders such as anxiety and depressive disorders present predominantly with various somatic complaints (Husain et al., 2004). A large number of such patients with unexplained bodily complaints undergo unnecessary and often very expensive investigations. Most such patients are prescribed a variety of pills, including psychotropic medications contributing to "medicalization of human distress", as a commentator from Pakistan has observed. The murky relationship that exists between pharmaceutical industry and psychiatrists in developing countries such as Pakistan enhances this process of medicalization of human distress (Khan, 2006). In Bangladesh, a significantly high prevalence of common mental disorders was found in the economically poor, those over 45 years of age and women from large families (Yousaf, 1997). A link between poverty, social disadvantage and deprivation and common mental disorders is found in many developing countries (Patel and Kleinman, 2003).

Suicide and attempted suicide rates have steadily gone up in many countries in the region (Khan and Prince, 2003, Gururaj and Isaac, 2001).

Since suicidal attempt is a punishable criminal offence in countries such as India and Pakistan, a large majority of them remain unreported and reliable figures are unavailable. While Sri Lanka was known as a country with very high suicide rate for many years, some recent reports from India suggest that rural southern India may have one of the highest suicide rates in the world for young females in their teens and twenties (Aaron et al., 2004). Alcohol use is steadily increasing in the region in countries such as India and Sri Lanka and alcohol contributes to a substantial proportion of mortality (Gururaj et al., 2011). Drug addiction has emerged as a problem in Pakistan where heroin is the most popular drug of abuse followed by charas (hashish) (Yousaf, 1997). There are an estimated 3 million drug addicts in Pakistan (Khan, 2006).

Coupled with the severe shortage of trained mental health professionals such as psychiatrists is the poor quality of psychiatric training in medical schools of South Asia. Psychiatry is neither taught adequately nor examined at the medical graduation level except in a few medical schools in the region (Trivedi and Dhyani, 2007). As a result, most primary care doctors and physicians have no skills or interest in diagnosing and managing mental and emotional disorders.

During the past decade, a private sector in mental health care has grown steadily in the metropolitan areas of the region. However, this care is accessible to only a small section of the population who can afford the price which is often out-of-pocket expenditure. Specialized services such as child and adolescent mental health services, addiction services, community based and rehabilitation facilities and specialized counselling services have come up in many centers. Another sector which is increasingly playing a role in certain aspects of mental health care delivery in all the countries of the region is the not-for-profit, civil society organizations – both national and international non-governmental organizations (Thara and Patel, 2010).

In Sri Lanka, although the country trains adequate number of psychiatrists (88 during the period 2002-2009), shortage is caused by migration of many trained psychiatrists to high income countries. To cope with the shortage of psychiatrists, the country started a one year diploma course in 2008 and those who qualified were appointed to work in rural areas. In addition, a three months mental health training programme for medical officers ("medical officer of mental health") facilitated appointment of these trained non-specialist in rural clinics (de Silva and Hanwella, 2010). The training in psychiatry for medical graduates is substantially better in Sri Lankan medical schools and students are examined in psychiatry during the final year of their training.

Future

The urgent need in all the countries of the South Asian region is to quickly enhance the scale and quality of mental health services at all levels. All governments will have to recognize services for mental and neurological disorders as an important priority and sanction adequate funds to develop services. Mechanisms will have to be created at federal, state and district levels to plan, implement and oversee feasible mental health care delivery programmes suitable to the country. Based on past experiences from each country and evidence generated internationally from low and middle income countries, feasible and effective country specific as well as region specific programmes will have to be developed taking into consideration the limited number of trained and motivated human resources available in each country.

From the currently predominant institution (mental hospital) based and centralized care, public mental health services will have to increasingly become community based and integrated with existing system of primary health care. There is need for strengthening primary health care as well as primary care mental health services. The quality and spread of state run primary health services need great improvement. The main goal will be making basic mental health services accessible to all so that the current high levels of treatment gap can be steadily reduced. Capacity building for mental health will have to be undertaken on a war footing. Training positions in psychiatry and allied disciplines will have to be increased. Content, quality and duration of training in mental health in undergraduate medical, nursing

and paramedical education will need to be considerably improved.

The mental health Gap Action Programme (mhGAP) launched recently by the World Health Organization aims at scaling up services for mental, neurological and substance use disorders in low and middle income countries. The mhGAP has developed an intervention guide for mental, neurological and substance use disorders for use in non-specialist settings. The intervention guide presents integrated management of priority conditions using protocols for clinical decision-making. The priority conditions included are: depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, self-harm/suicide and other significant emotional or medically unexplained complaints (World Health Organization, 2010). The guide is developed for use by health-care providers working in non-specialized health-care settings and needs adaptation for each country/region setting. Adaptation, pilot testing and use of this guide in countries of the region holds promise.

There is also need to initiate research in issues relevant to the region such as implementation research, research on service development and evaluation of specific care and intervention strategies. Research capacity has to be enhanced in all the countries and adequate resources will have to be provided for research. Governments will have to pay adequate attention to prioritize and invest in improvement of the various social determinants of mental health.

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