COUNTRY PROFILE

Mental health of indigenous people: is Bangladesh paying enough attention?

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Indigenous people face numerous challenges to their mental health across the world. We consider the situation in Bangladesh, where those living in the remote hill tracts areas of Eastern Bangladesh experience widespread difficulties. Few seek attention for their problems from professional services, in part because of stigma or a lack of awareness that help could be made available, but also because in these remote areas few resources are available. We make recommendations to improve this situation, which could be implemented with the assistance of primary healthcare services and traditional healers.

For many years, the rights and needs of the more than 370 million indigenous people around the world for mental health services has been of little international concern,[1] although the subject has gained more recognition recently.[2] Research efforts to study their mental health problems have been limited compared with the body of equivalent research into the lives of non-indigenous people.[3]

Indigenous people and mental health: a global view

Evidence suggests that indigenous people are at increased risk of developing mental health conditions compared with the majority population of their host country, irrespective of age, gender and socioeconomic status.[4] They are at a relatively high risk of suicide, including collective suicide, substance use disorders, family violence and emotional distress.[5] Aboriginal communities have higher rates of depression among both males and females compared with their non-indigenous counterparts.[2,6] Mood-related problems, anxiety and other forms of mental disorder are more prevalent among indigenous people in both rural and urban situations.[7] Indigenous children experience a greater risk of developing depressive symptoms after experiencing adversity, trauma and discrimination, factors that lead to enhanced sensitivity to stressors in later life.[6] Both youth and adults often become abusers of illicit and prescription drugs, influences associated with suicidal thoughts and suicide attempts.[6] Evidence indicates that indigenous people have a shorter life expectancy than non-indigenous people.[8] Despite these alarming markers of relatively poor mental health, access to healthcare facilities, especially mental healthcare, is often severely limited, in whichever country they live.[9] Numerous factors contribute to the growing prevalence of mental health problems among indigenous people, including relative and absolute poverty, unemployment, housing, food insecurity, social exclusion and systematic discrimination.[6] Furthermore, sociocultural changes, environmental threats and exploitation of natural resources have had an additional negative impact on their everyday lives.[5]

Mental health problems in Bangladesh

Recent research has revealed that approximately 17% of adults and 14% of children in Bangladesh are experiencing poor mental health.[10,11] Despite the widespread nature of these problems, most adults (approximately 92%) who are affected have not sought medical attention. The corresponding figure is even greater for children (only 5% receive help). The latest prevalence figures were published in 2019 and reveal an increase in prevalence over the findings of a similar study conducted in 2005.[11] The reasons those affected have not consulted a professional include widespread stigma around the subject of mental disorder, the lack of awareness of potential treatments and restricted access to mental healthcare in many parts of the country. The recent prevalence study, conducted by the National Institute of Mental Health in Dhaka, did not provide any data pertaining to ethnicity-specific mental health, nor did it mention the mental health status of indigenous people in general.

At present, 270 psychiatrists work in Bangladesh, which amounts to a total of just 0.073 psychiatrists per 100 000 population.[10] By contrast, the number of psychiatrists working in most member countries of the Organisation for Economic Co-operation and Development (OECD) is between 10 and 20 per 100 000 population. Bangladesh has about 500 clinical psychologists.[12] The distribution of mental health professionals between urban and rural areas is grossly disproportionate. The capital city, Dhaka, has the highest proportion of professionals (e.g. psychiatrists and psychiatric nurses), five times greater than the rest of the country.[11] Just 0.44% of the total healthcare budget is allocated to mental health and there is no provision of social insurance to cover expenses for mental healthcare.[10] Out-patient facilities, community-based psychiatric in-patient units and community residential facilities are based in principal cities. There is very limited access to mental healthcare for indigenous communities, especially people living in the Chittagong Hill Tracts (CHT) region. This region, which borders both India and Myanmar in the south-east of the

country, has a population of about 1.5 million people. The CHT occupies about 10% of the land area of Bangladesh, and one-third of the population is of indigenous origin and differs from the Bengali majority in terms of language, culture, physical appearance, religion, dress and farming methods.

The government of Bangladesh has recently produced a Mental Health Strategic Plan. The core values and principles in the strategic plan are guided by the National Mental Health Policy 2021 (currently pending final approval), the Mental Health Act 2018 and several global plans and charters, including the World Health Organization (WHO) Comprehensive Mental Health Action Plan 2013–2020, UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, and the Convention on the Rights of Persons with Disabilities, which have been ratified by the government.[12] There is a plan to integrate mental healthcare at the primary level (subdistricts) across the country in line with WHO sustainable development goals (SDGs). To address the unique mental health experiences of indigenous people, we believe that separate provisions should be integrated into the delivery of systems as well as into policies.

Indigenous people and mental health: Bangladesh perspective

There are 49 different indigenous communities in Bangladesh, and they live in both plain and hill tract areas. Although there are some indigenous communities in the northern part of the country, most live in the CHT. History recounts that those living in the CHT have gone through many adverse experiences, dating back to the 16th century. They have experienced prolonged periods of colonisation, segregation, assimilation, epidemics, relocation and displacement.[5] Compared with the Bengali population elsewhere, they are at relatively high risk of mental disorders such as anxiety and depression, which have become even more acute during the COVID-19 pandemic.[13,14] Members of two of the largest indigenous communities in this region (the Chakma and the Marma) were the subject of a mental health survey during the pandemic. This survey found they had a substantially higher prevalence of depression, anxiety and stress compared with some non-indigenous groups (e.g. university students).[14] These findings suggest that mental health problems are a major issue among indigenous people and warrant mental health action, but to date their plight has gathered little attention nationally. For the most part, they do not have access to mental healthcare. Because the region is located so close to India and Myanmar, it is one of the most heavily militarised regions of the world. Troubled by both 'insurgency' and 'counter-insurgency',[13] these tensions could be contributing to a sense of disaffection that is associated with a variety of mental health problems.

Access to general healthcare is also disproportionately distributed in the CHT regions. Some indigenous groups (e.g. the Chakma) have been more successful in getting access to resources than others (e.g. the Marma).[13] The Chakma people are the largest indigenous population in Bangladesh and they have a relatively higher literacy rate and greater access to healthcare than other indigenous communities.[13] A contemporary study reported that Chakma villages had better treatment facilities and more healthcare providers (MBBS doctors and paraprofessionals) than other ethnic groups.[13] About 73% of Chakma villages have static healthcare facilities within 5 km, compared with 63% for Marma people. The equivalent figure is 23% for the smaller minorities of Mru and Tripura people.[15] Among those living in the CHT, access to better facilities is associated with more health-seeking behaviours.[13] Access to care, geographical location (especially proximity to the divisional cities), and higher literacy rates may be the governing factors for such differences between indigenous communities. Different indigenous communities have unique health needs (irrespective of their geographical location) and they also have diverse priorities that can influence their treatment-seeking behaviour.[16] Many resort to both allopathic and traditional healers, and use homeopathic medicines for treatment, including home-made remedies.[15] However, the enthusiasm for such modalities of treatment varies between ethnic groups: for instance, the desire to consult paraprofessionals and qualified allopaths is more prevalent among Chakma people than other ethnic groups. Seeking treatment from traditional healers and resorting to home remedies is more common among Mru people than other ethnic groups. It is imperative to take local customs and values into account prior to the formulation and implementation of mental health policies and intervention strategies.

Recommendations to improve the mental health status of indigenous people

We recommend a set of actions to address the mental health problems of indigenous peoples, with an emphasis on people who live in the CHT. Community-based activities that promote the values of indigenous cultures should be incorporated into the planning of any intervention strategies. Local resistance to adhering to mainstream cultural values, as well as perceived discrimination, do affect their mental health.[17] Evidence suggests that access to primary healthcare, including mental health resources, could be facilitated by a healthcare system that is owned and managed by indigenous staff who speak the local language.[18] We recommend involving indigenous people in the delivery of their primary healthcare system, and training representatives of the community to provide primary mental healthcare. They could arrange referrals to specialised facilities when appropriate. Because geographical location can be a barrier

when accessing mental healthcare, especially in remote hilly areas, a helpline run by indigenous staff with the appropriate training could be useful. Mental health literacy could be increased by widespread education, to improve community awareness. Involving local government representatives and leaders of respective communities would also help in this regard. Finally, traditional healers have substantial influence among the indigenous population.[16] Therefore, we advise that traditional healers' understanding of mental health is improved with training. We encourage the government to ensure that there is a sufficient budget allocated to this region, to address the mental health needs of its population.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

Md.O.F. was responsible for the inception of the study, reviewed the literature and drafted the paper. M.T.H. reviewed the literature and reviewed the paper. Both authors reviewed and finalised the paper.

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Declaration of interest

None.

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