

Foreign report

Psychiatry in Bangladesh

REZAUL ISLAM, World Health Organisation Fellow in Psychiatry, Overseas Office, Institute of Psychiatry; and ROBERT HOWARD, Lecturer, Section of Old Age Psychiatry, Institute of Psychiatry, London SE5 8AF

The country

Bangladesh has a population of 120 million, most of whom live in the countryside in 64,000 small villages, with the capital Dhaka having a population of just over 6 million. A large majority (85%) of the population are Muslims with small populations of Hindus, Buddhists and Christians. Outside the capital, 99% of the population are engaged in agricultural production but the country is still subject to enormous food deficits and is dependent upon imported food. The literacy rate in the country is 17% and almost every year the country is subject to well-publicised natural calamities; cyclones, typhoons, or major floods. The government system is modelled on the British one, with democratic elections, a President and a Prime Minister. The current government are centrist in their politics.

Psychiatric services in Bangladesh

There is a Ministry of Health and Family Welfare with a cabinet minister responsible for health. In the entire country there are a total of only 30 practising psychiatrists with ten DPMs, six MRCPsychs and one FRCPsych. The total mental health facilities in the country are listed below.

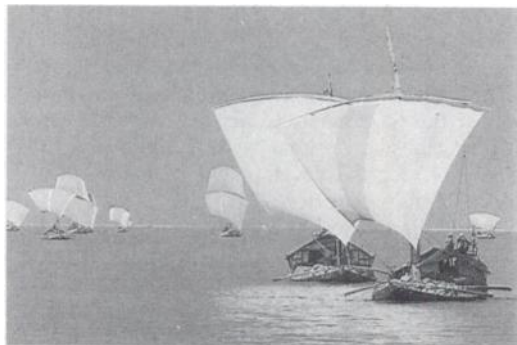
(a) The Mental Health Hospital in Pabna is an asylum-type hospital mostly for chronic patients. Although there are 500 beds, only approximately 50% of these are occupied at any one time.

(b) Nine small psychiatric units within each of the medical college hospitals in the country, each with 30 beds.

(c) The Institute of Postgraduate Medicine and Research in Dhaka has a small psychiatric unit with 30 beds under the supervision of Professor A. A. Munib.



The Institute of Postgraduate Medical Research in Dhaka.



Traditional sailing boats on the Ganges delta.

(d) Two in-patient psychiatric units at military hospitals are available for military personnel with mental illness.

(e) The Institute of Mental Health and Research at Dhaka Medical College has 30 beds under the supervision of the Professor of Psychiatry, Professor Hidayetul Islam. At this centre, research is carried out into the demography of mental illnesses in Bangladesh and the development of community psychiatric services for the country. The Institute is also the national centre for the training of general physicians, paramedical staff, nurses, pharmacists and hospital administrators who wish to become involved in mental health services.

(f) The Institute for Mentally Retarded Children in Dhaka is partly funded by the government and partly run by a charitable organisation. This has both in-patient and out-patient facilities and the majority of patients' families pay for a proportion of treatment.

(g) Four drug addiction centres. Bangladesh is experiencing a dramatic rise in cases of opiate addiction. Heroin from India, Thailand and Burma has traditionally been transmitted through Bangladesh to the United States and Europe. Now that cocaine has become a major drug of abuse in the United States, the market for heroin from the Far East in the States has dried up and supplies are flooding into countries along the export route such as Bangladesh.

The patients

The majority of psychiatric patients consult, or are taken by their families to see, a traditional healer. Generally patients who attend western-style psychiatric clinics are the more chronic ones and have often been seen for several years previously by such traditional healers. There is, however, a tendency for severely manic or agitated schizophrenic patients to turn up in out-patients clinics somewhat earlier.

Mental illness is commonly viewed by village people in Bangladesh to be a supernatural punishment indicative of possession by demons, evil spirits or a jinnee. Traditional treatments often begin with exorcisms and may progress to torture, punishment and the use of traditional herbal or root remedies. Priests and astrologers also offer religious treatments which bear a resemblance to forms of unstructured psychotherapy and seem to be extremely effective in minor neurotic disorders. This may in part be responsible for the extremely low suicide and marriage break-up rates among rural communities in Bangladesh.

Mental illness in Bangladesh

It is extremely difficult to determine prevalence figures for psychiatric disorders in Bangladesh since the majority of patients are contained within their families and will never seek any outside help. Certainly, chronic patients are not seen sleeping rough on the streets as in the west. Sufi shrines in the country appear to attract populations of schizophrenic people who may find some conformity with their beliefs in the philosophy and culture that exists among the staff at the shrines. Certainly the members of the Sufi shrine culture are extremely tolerant of the behaviour and experiences of schizophrenic people in Bangladesh. The patients with schizophrenia who are seen in hospital clinics are very similar to descriptions of patients from the west. There are some differences, however, in that catatonia is common in Bangladesh and schizophrenic delusions more often have a religious or affective content than in the western world. Cases of simple schizophrenia are also not infrequently encountered in Bangladesh. In general, Bangladeshi patients with schizophrenia show a remarkably good response to antipsychotic medication, certainly better than that seen in the west, and schizophrenic deterioration with the development of marked negative symptoms appears to be relatively rare.

Minor depressive disorders are rarely seen by psychiatrists since such conditions are often interpreted in terms of religious experience and are dealt with within the extended family with guidance from priests. More significant depressive illness frequently presents as physical complaints in the GP or general medical clinic. Many of such patients are treated with benzodiazepines. When depression is so severe as to merit referral to a specialist psychiatric unit, treatment is along western lines with tricyclic antidepressants and ECT mostly administered on an out-patient basis. There is no Mental Health Act or its equivalent in Bangladesh, so psychiatrists are totally reliant on the persuasive powers of the family should a patient decide not to accept treatment.

Ongoing developments in psychiatry in Bangladesh

The Institute of Postgraduate Medicine and Research now runs a three-and-a-half years course in psychiatry that parallels the British MRCPsych and confers the title FCPSpsych from the College of Physicians and Surgeons in Dhaka. So far the number of trained fellows is only of the order of two to three per year.

The final MB examination now contains compulsory psychiatry questions. It is hoped that this will encourage medical students to investigate a career in psychiatry and help with the current shortage of

trained staff. A re-orientation course for GPs who wish to specialise in psychiatry is also now available at the Institute of Mental Health and Research.

The country aims to have a trained psychiatrist in each of the 64 districts to act as a referral centre for physicians and primary care workers and to be responsible for the development of mental health services in his own region.

Finally, Bangladesh is investing a great deal of its resources in the recruitment and training of family welfare workers who will operate at the village level and will be involved in the identification and diagnosis of psychiatric cases, their referral to district specialist services and follow-up.

Psychiatric Bulletin (1993), 17, 494–495

The times

Community care: Italy's 'U' turn

HENRY R. ROLLIN, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Give or take a few months, it must be 20 years since I led a College Study Tour Group on a tour of Italy, or, to be more exact, of the area north of Rome, economically privileged and steeped in the academic tradition from the Renaissance onwards.

Each and every city we visited had a magic all of its own – Verona, Padua, Venice, Gorizia, Trieste and Bologna. The hospitality was unforgettable: the official banquets, of which there were several, were occasions for self-indulgence on a Babylonian scale. But study tours, even Italian study tours, are not organised in order to furnish the participants with a Roman holiday. There was work to be done.

We visited a range of psychiatric facilities under the auspices of different university departments. From a clinical standpoint, there was little cause for surprise. Italian schizophrenic patients, or those with learning disability, are indistinguishable from their British counterparts, although it came as a surprise to see them nursed together, not only in the same hospi-

tals, but in the same wards. There were, however, obvious differences in management, particularly marked in the use of physical restraint in patients who, we were told, were a danger to themselves or others.

However, what struck us smartly between the eyes was the dramatically changed concept of mental illness in certain areas of Italy together with the changed role of the psychiatrist himself. It was all too apparent that these changes stemmed from the political thinking of individual psychiatrists, or were a reflection of the political climate of the area concerned. At at least two meetings it was in the context of politics rather than psychiatry that discussion became heated, if not red-hot. At one our host was none other than the late Professor Franco Basaglia, an aristocrat by birth and a Marxist by conviction. He wore an air of superiority tinged with arrogance reflecting both these threads in his make-up. But in spite of, or, indeed, because of these traits, he was at