GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

NATIONAL MENTAL HEALTH STRATEGIC PLAN

2020-2030

CONTENTS

CONTENTS

ABBREVIATIONS AND ACRONYMS

4Ws	Who is Where, When, doing What
a2i	Access to Information (programme)
BACAMH	Bangladesh Association for Child and Adolescent Mental Health
BAP	Bangladesh Association of Psychiatrists
BBS	Bangladesh Bureau of Statistics
BCPS	Bangladesh Clinical Psychology Society
BDHS	Bangladesh Demographic and Health Survey
BECPS	Bangladesh Education and Counselling Psychology Society
BIRDEM	Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders
BMDC	Bangladesh Medical and Dental Council
BPA	Bangladesh Pediatric Association
BRAC	Bangladesh Rural Advancement Committee
BSMMU	Bangabandhu Sheikh Mujib Medical University
CBHC	Community Based Health Care
CHCP	Community Health Care Provider
CHW	Community Health Worker
CPMMH	Crisis Preparedness and Management for Mental Health
CRP	Centre for the Rehabilitation of the Paralysed
CRVS	Civil Registration & Vital Statistics
CTC	Central Drug Addiction Treatment Centre
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHIS2	District Health Information System version 2
DNC	Department of Narcotics Control
DPA	Direct Project Aid
DPM	Deputy Programme Manager
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
DSW	Department of Social Welfare
DU	University of Dhaka
ECD	Early Childhood Development
ESP	Essential Service Package
EU	European Union
FDMNs	Forcibly Displaced Myanmar Nationals
FGD	Focus Group Discussions
GoB	Government of Bangladesh
HNPSIP	Health, Nutrition and Population Strategic Investment Plan
HPNSP	Health, Population and Nutrition Sector Programme
HSM	Hospital Services Management
ICD-10	International Classification of Diseases, Tenth Revision
IOM	International Organization of Migration
KPI	Key Performance Indicator
mhGAP	WHO Mental Health Gap Action Programme
mhGAP IG V2	Intervention Guide - Version 2.0
MHPSS	Mental Health and Psychosocial Support
MHRMC	Mental Health Review and Monitoring Committee

ABBREVIATIONS AND ACRONYMS

MHV	Multipurpose Health Volunteer
MICS	Multiple Indicator Cluster Survey
MIS	management information systems
MoDMR	Ministry of Disaster Management and Relief
MoE	Ministry of Education
MoF	Ministry of Finance
MoHA	Ministry of Home Affairs
MoHFW	Ministry of Health and Family Welfare
MoI	Ministry of Information
MoLGRDC	Ministry of Local Government, Rural Development and Co-operatives
MoP	Ministry of Planning
MoPA	Ministry of Public Administration
MoPME	Ministry of Primary and Mass Education
MoSW	Ministry of Social Welfare
MoWCA	Ministry of Women and Child Affairs
MoYS	Ministry of Youth and Sports
NCDC	Non Communicable Diseases Control
NCD	Non Communicable Diseases
NDD	Neurodevelopmental Disorder
NGO	Nongovernmental Organization
NIMH	National Institute of Mental Health and Hospital
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NMHSP	National Mental Health Strategic Plan
NMMHCC	National Multisectoral Mental Health Coordination Committee
NMNCC	National Multisectoral Noncommunicable Disease (control) Coordination Committee
NSPNDD	National Strategic Plan for NDDs
NTCC	National Trauma Counselling Centre
OCC	One Stop Crisis Centre
RPA	Reimbursable Project Aid
RTCC	Regional Trauma Counselling Centre
SACMO	Sub Assistant Community Medical Officer
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behaviour Change Communication
SBK	Shishu Bikash Kendro
SDGs	Sustainable Development Goals
SEAR	WHO South-East Asia Region
SEARO	WHO Regional Office for South-East Asia
SOPs	Standard Operating Procedures
SUD	Substance Use Disorder
Tk	Bangladeshi Taka
ToR	Terms of Reference
UHC	Upazila Health Complex
UHFWC	Union Health and Family Welfare Centre
UNICEF	United Nations Children's Fund
WHO	World Health Organization

PREFACE

Mental and social well-being are rarely, if ever, used for measuring a country's success. Although a few countries are assessed for success through their Happiness Index, it is not considered a viable tool. More countries have begun to realize that despite all the progress human race has made towards increasing comforts in daily living through technology and infrastructure and better opportunities for improving livelihood, happiness and peace have been harder to achieve, whether it be for individuals or for countries. This awareness of the failure of humans to achieve the one thing they desire – happiness – has in many ways led to greater focus in the areas of mental health and psychosocial well-being, especially with regard to health systems. This has been possible only because of the inadequate and ineffective support for mental health conditions that has had an immense economic impact.

Bangladesh, which is at the verge of entering middle-income status, has realized that to grow economically it would also have to grow socially. Despite many resource constraints, issues of psychosocial well-being, disability, concerns of minority groups and other vulnerable populations, is at the forefront of Bangladesh's economic agenda. Unfortunately, less than 1% of the annual health budget is allocated for mental health, and medical training institutions allocate less than 5% of the curriculum on teaching health professionals about mental health and well-being. Therefore, developing a comprehensive mental health plan for Bangladesh, although a daunting task, is the only way forward. Despite every effort to ensure that the mental health plan is as broad and comprehensive as it needs to be, this situation analysis and strategic plan document is only a first major step towards ensuring well-being and resiliency for all Bangalees. This document should be used as a guidebook to ensure that mental and physical health are given equal importance in an economically and socially empowered country.

This National Mental Health Strategic Plan document has been developed at the request of the Ministry of Health and Family Welfare's Department of Non-Communicable Diseases. This document has been prepared with funding from the Department for International Development, and technical support from the World Health Organization's Regional Office for South-East Asia and the Shuchona Foundation. Many governmental and nongovernmental institutions and experts have been instrumental in preparing it.

SECTION 1

Key concepts of mental health

Introduction

Mental health is an integral part of health and well-being as per the World Health Organization's (WHO's) definition of health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Determinants of mental health and mental health conditions include not only individual attributes, such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors, such as national policies, social protection, living standards, working conditions and community social support. Exposure to adversity at a young age is an established preventable risk factor for mental health conditions. These factors need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a "whole-of-government, whole-of-society" approach.

Mental and substance use disorders, suicides and neurological disorders (such as dementia) affect more than a billion people annually, accounting for an estimated third of the global burden of disability and 14% of global deaths (1,2). There has been increasing global recognition of the importance of mental health and the significant global burden of mental health conditions in both developing and developed countries. More than 80% of people experiencing mental health conditions, including individuals experiencing neurological and substance use disorders do not get quality, affordable mental health care.

According to the WHO, approximately 450 million people worldwide are affected by mental and neurological conditions. Mental health conditions account for 13% of the global burden of disease and is expected to increase to nearly 15% by 2030. Depression alone is likely to be the highest contributor to the global burden of disease by 2030, which currently affects 400 million persons and is the single largest contributor to years lived with disability, globally. Mental disorders are associated with high levels of mortality, such as through suicide or due to comorbid medical conditions; people with mental disorders accounted for about 13 million excess deaths in 2010. There are strong associations between mental disorders and other global health priorities, such as between maternal depression and childhood undernutrition and cognitive development (3).

Mental health conditions are associated with more than 90% of the one million suicides that occur annually around the world. Suicide mortality is high (close to 800 000 deaths per year), and disproportionately affects young people and elderly women in low- and middle-income countries. People with mental health conditions have a heightened risk of suffering from physical illnesses (such as acquired immunodeficiency syndrome, tuberculosis, noncommunicable diseases (NCDs)), causing early mortality of 10–20 years. Mental health conditions account for one in five years lived with disability globally, leading to more than US$ 1 trillion per year in economic losses. Effective treatments are available for a wide range of mental health conditions but a treatment gap of more than 75% exists in many low-income countries.

People living with mental health conditions are also more likely to develop physical health problems, less likely to receive quality health care and less likely to adhere to treatment, resulting in poorer physical health outcomes,

including premature mortality. Low- and middle-income countries have a higher burden of mental disorders than economically developed countries (4). Mental disorders have serious negative effects on survival, and when chronic diseases are present as comorbid conditions, serious mental disorders may reduce life expectancy by about 20 years (5).

Global and regional mental health landscape

The global burden of disease attributable to mental disorders has risen in all countries due to major demographic, environmental and sociopolitical transitions. Human rights violations and abuses persist in many countries, with large numbers of people locked away in mental institutions or prisons, or living on the streets, often without legal protection (6). The quality of mental health services is often inadequate and is found to be far worse than the quality of physical health services. The collective failure to respond to this global health crisis results in a significant loss of human capabilities and avoidable suffering.

The Sixty-fifth World Health Assembly held in 2013 approved and adopted the resolution on the global burden of mental health conditions and acknowledged the need for a comprehensive, coordinated response from health and social sectors at the community level. A comprehensive mental health action plan 2013–2020 was adopted in the Sixty-sixth World Health Assembly. Improving mental health, well-being and mental health services is an integral part of achieving the Sustainable Development Goals (SDGs), particularly:

- SDG 3, Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. (Suicide mortality rate is the chosen indicator to monitor progress towards this target.); and

- SDG 3, Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Furthermore, improving mental health by ensuring inclusion of persons with mental health conditions in society and protecting the human rights of those with mental health conditions will enable social and economic development as reflected in several other SDGs, including SDG 8 and SDG 10 and their respective targets.

The WHO Regional Office for South-East Asia (SEARO) envisions to support member countries in South-East Asia in reducing the burden associated with mental and neurological disorders, including substance abuse and harm from alcohol, through the promotion of mental health services and delivery of appropriate care at all levels of society. This will include collection of information on determinants of mental health within populations for appropriate planning and effective interventions. Among the South-East Asia Region (SEAR) member countries, mental health programmes have generally concentrated on hospital-based psychiatry. However, there is increasing awareness in these countries of the need to shift the emphasis to community-based mental health programmes. SEAR is developing strategies for community-based programmes based on the five 'A's: Availability, Acceptability, Accessibility, Affordable medications and Assessment.

Factors associated with mental health

This section highlights key factors across the lifespan associated with mental health that either cause them or aggravate a pre-existing condition or an overlooked area that ultimately leads to disorders associated with lower psychosocial well-being.

Mental health and noncommunicable diseases

There is consistent evidence worldwide of the link between mental health and physical health, and that they coexist because many of the risk factors of poor physical health also are risk factors for poor mental health (7). In addition, childhood malnutrition is a significant risk factor for later onset of NCDs (such as diabetes and heart disease), and is also associated with poor living practices, lower immune systems and onset of mental health conditions in adulthood. It is well known that, depression and anxiety are associated with increased risk of cardiovascular diseases, such as strokes and myocardial infarctions, as well as poor outcomes of cardiovascular illness (8). More research is required on how individuals deal with the heightened stress caused by a change in lifestyle, treatment costs, and other factors, following a diagnosis of diabetes, cancer or even heart disease, and how this may lead to depression and anxiety disorder later. Studies have shown that depression can actually increase the risk for Type II diabetes (9). The prevalence of diabetes among people with schizophrenia has consistently been found to be significantly higher than the general population (~15% vs 2–3%) (10).

Mental health and poverty

Research has consistently shown a strong association between social disadvantage and poor mental health. Poverty, childhood adversity and violence are key risk factors for the onset and persistence of mental disorders, which in turn are associated with loss of income due to poor educational attainment and reduced employment opportunities and productivity (11). In Bangladesh, 24.3% of the population lives below the national poverty line (12). Rural poverty is more severe than poverty seen in urban areas when measured across a range of indicators. Poverty and unemployment directly increase the risk of stress reactions and mental disorders, such as depression and anxiety. They also lead to malnutrition, increased risk of untreated diseases, increased exposure to toxic chemicals and poor health-seeking behaviours. Poverty can lead to other psychosocial difficulties resulting in increased exposure to conflict in the home and violence in the community, heightened insecurity, lower stability, substance abuse and exposure to risk-taking behaviours at an earlier age. While poverty in and of itself does not cause mental health issues and in fact can enable greater resiliency and drive in individuals, the associated issues from lack of adequate nutrition, education, parental supervision and health care as a result of living in poverty, are important factors that may contribute to poorer mental well-being.

Mental health and nutrition

Acute and chronic malnutrition can lead to significant lifelong psychosocial disabilities by inhibiting physical and cognitive development, particularly during infancy, childhood and adolescence. As per the 2014 Bangladesh Demographic and Health Survey (BDHS) 36% children were stunted, 14% were wasted and 25-30% were born with low birth-weight (13). A child can also be affected by malnutrition during gestation. Alarmingly 33% of all children under the age of five years were underweight. As per 2014 BDHS, 50% of Bangladeshi women are anaemic during pregnancy (13). This can result in congenital abnormalities and low birth-weight, which can subsequently lead to problems with

cognitive and intellectual development. Parents/caregivers who are malnourished face their own poor physical and mental health problems which can impose challenges in providing enough psychosocial stimulation for their child with regard to healthy cognitive, emotional and social development (14).

Mental health due to violence, trauma and displacement

The Constitution of Bangladesh recognizes equal rights for women and men in the public sphere, and there is a reasonably strong legal and policy framework guaranteeing women's rights. The National Women's Development Policy 2011 and its National Action Plan provide a base for government action to promote gender equality, and the 7th Five-year plan integrates gender equality issues across a number of sectors with some new sectoral policies addressing gender issues effectively. Currently, gender responsive budgeting is institutionalized across 43 ministries. Bangladesh is internationally recognized for good progress on a number of gender indicators including gender parity in primary and secondary education, and reduction in maternal mortality by 66% over the past few decades. The Global Gender Gap Report 2017 published by the World Economic Forum, ranked Bangladesh as the highest in the Gender Gap Index in south Asia – from 72nd position in 2016 to 47th in 2017 – among 144 countries in the world. This was partly due to the enactment of a number of stringent laws to protect women from violence, such as Prevention of Repression on Women and Children Act 2002, Acid Crime Control Act 2002, Dowry Prohibition Act 1980.

Despite this progress, violence against women and children remains a significant problem in Bangladesh. Violence affects children, adolescents and adults alike with girls and women disproportionately experiencing violence from persons known to them or strangers or the community (15). Women who have been victims of physical and/or sexual violence are at a significantly greater risk of disability and suicidal ideation and are likely to have clinical depression. Childhood experiences of abuse can significantly increase their risk of depression, suicidal thoughts and substance use problems.

Mental health due to humanitarian crisis and displacement

The sudden influx of approximately 1.1 million of Forcibly Displaced Myanmar Nationals (FDMNs) has triggered an urgent need for mental health support and services for the FDMNs and host communities. These FDMNs lost their family members and relatives, lost their homes and belongings, and were exposed to violence, torture, abuse, rape and injuries. Many show significant signs of developing lifelong mental health conditions. This is compounded by daily stressors associated with reliance on humanitarian assistance for food, continued instability of their situation, and the inability to make any concrete plans for their future. There is a need to increase availability and access to specialized mental health services in certain parts of Bangladesh, as well as capacity of the health care workforce to manage common mental disorders in primary health care settings across the country.

Mental health and gender

The prevalence of mental, neurological and substance use disorders varies between the two genders with common mental disorders (such as depression and anxiety) being more often diagnosed among females. Schizophrenia and substance use disorders, particularly alcohol use problems, are more common among men. Globally, depressive disorders account for close to 42% of disability from neuropsychiatric disorders among women compared to 29.3% among men. The first national survey on mental health conducted between 2003 and 2005 documented that 16.1% of the Bangladeshi adult population had mental disorders with the prevalence being higher among women than men (19% vs 12.9%). Pressures associated with the multiple roles and responsibilities of women within families and in the

community, and the high prevalence of negative experiences (such as domestic violence and sexual abuse) also increases risk factors for poor mental health outcomes among women. Furthermore, common perinatal mental disorders affect 15.6% of women during pregnancy and 19.8% women during the postpartum period in low- and middle-income countries (16). This results in adverse consequences for the infant's physical health (such as greater risk for low birth-weight infants, poor early mother–infant relationship and poor psychological development of children) (17).

Perinatal mental health: Perinatal depression is an episode of depression that occurs during pregnancy and/or within the first 12 months after delivery. Perinatal depression impacts both the mother and the infant, as it may be experienced by both of them. Women who are depressed are less likely to care for their own needs (18), more likely to have poor nutrition due to lack of appetite, and be at increased risk of intrauterine growth retardation, perinatal pre-eclampsia and premature delivery. Depression also increases the risk for suicide among young women due to abuse and stress caused likely by events such as unwanted pregnancy (19).

Postpartum mental health: Postpartum depression is a common, heterogeneous and largely undetected public health problem in Bangladesh (20). Screening for depressive symptoms in the last trimester of pregnancy or 6–8 months postpartum ought to be integrated into maternal and child health programmes. Interventions to reduce depressive symptoms during postpartum need to target women who: are poor, have experienced violence during pregnancy, have anxiety symptoms during pregnancy, and had previous history of depressive symptoms.

Gender differences also exist in patterns of help-seeking for mental health problems. Women are more likely to seek help from and disclose mental health problems to their primary health care physician. In general, however, most women and men experiencing emotional distress and/or psychological disorders are neither identified nor treated by their doctors. A particularly vulnerable and understudied group is the "lesbian, gay, bisexual, transgender and queer" group. Although Bangladesh recognizes a third gender, little has been done to study their psychological and social well-being within the larger community.

Mental health in childhood and adolescence

In Bangladesh, children and adolescents (below 19 years of age) and young adults (below the age of 25 years) constitute 43.6% and ~52.2% of the population, respectively (21). Most of the major mental disorders have their onset during childhood, adolescence and young adulthood making them essential target groups for the promotion of psychosocial well-being and mental health prevention programmes (22). Children and adolescents are at risk of developmental delays as well as neuropsychiatric disorders such as epilepsy, learning difficulties, behavioural disorders and emotional disorders. Young adults are also vulnerable and have the greatest need for services for psychosis, eating disorders, disorders of childbirth, drug abuse and personality disorders (23). These disorders are more likely to be complicated by aggression and violence in late adolescence and among young men.

Of the Bangladeshi children and adolescents (age 7–17 years), 13.6% are mentally ill; which is 5% lower than the prevalence reported (18.4%) through a community-based study in 2009 (12). The 2019 mental health survey reported that the occurrence of mental illness is more among boys (13.8%) than girls (12.1%); and slightly higher among urban children and adolescents (13.2%) compared to their rural counterparts (12.7%).

Globally, mental health problems affect 10–20% of children and adolescents worldwide and account for a significant portion of the global burden of disease (24). Suicide occurs at any age and was found to be the second leading cause

of death globally among the 15–29 year old age group in 2015 (13). Suicide rates have also increased in this age group in recent years, particularly among young men (13). In Bangladesh, among students 13-17 years of age, 7% of boys and 6% of girls reported thinking about or attempting suicide (13).

Mental health and disability

The global prevalence of disability is estimated to be 15% of the population (25). However, the Bangladesh Census 2011 data showed a 1.41% (101 585 persons with disability) overall disability prevalence in Bangladesh, which is 7.6% points lower than the Household Income and Expenditure Survey 2010 estimate of 9.01% overall disability prevalence (26). Census 2011 reported six types of disabilities: vision disability, hearing difficulty, physical disability, remembering and concentrating difficulty, self-care difficulty and speech disability.

People with disabilities are more likely to experience barriers to accessing health care, including mental health care, which can contribute to poorer health outcomes, including mental health for people with disabilities compared to people without disabilities. In fact, people with disabilities are known to be at greater risk of experiencing socioeconomic exclusion and poverty, and more likely to experience violence and abuse than people without disabilities.

In particular, children with a disability are three to four times more likely to experience violence, while children with psychosocial or intellectual impairments are more likely to experience violence, including sexual violence than children with other types of impairments or children without disability (27).

Mental health and substance abuse

A 2018 survey in Bangladesh reported the prevalence of substance use to be 3.3%, 1.5% and 0.2% among those 18 years and above, 12–17 years, and 7–11 years, respectively. Prevalence of substance use was 4.8% among males and 0.6% among females. Most frequently used substances included cannabis (42.70%), followed by alcohol (27.5%), amphetamine (yaba) (15.20%), opioid (5.3%) and sleeping pill (3.4%).

Results of a qualitative research showed risk factors for substance use to be curiosity, bad company, easy availability of substances, lack of supervision of guardians and maladaptive parenting. Prevalence of mental disorders was found to be 13.7% among the 18 years and above population and 17.3% in populations below 18 years of age.

Substance abuse is a major public health problem in Bangladesh. The Government of Bangladesh (GoB) is firmly determined to counter all kinds of drug abuse and has implemented a zero-tolerance policy against drug offences. To fulfill this objective, the GoB has adopted three strategies – supply reduction, demand reduction and harm reduction – prescribed and guided by the International Narcotics Control Board and United Nations Office on Drug and Crime.

To modernize the Narcotics Control Act 1990, a new Narcotics Control Act 2018 was formulated and enacted by the GoB which includes provision for the treatment and rehabilitation of people with drug dependency. The GoB provides treatment services to substance users through the Central Drug Addiction Treatment Centre (CTC) located in Dhaka, and three regional treatment centres in Chattogram, Rajshahi and Khulna. The GoB also plans to establish six treatment and rehabilitation centres with 200 beds in each divisional headquarter to ensure treatment facilities for men, women and children.

Mental health and suicidality

Suicidality among adolescents is a major public health concern because it is the second highest cause of death among young people globally (28). Self-harm in adolescents is also a major concern, which often eventually leads to suicidal attempts. Although worldwide variations exist, 10% of adolescents from community-based studies (irrespective of their sociodemographic profile) have reported self-harm (29). In Bangladesh, more than 10 000 people are estimated to be dying by suicide (30). Suicide or self-harm itself, accounts for an estimated 6% of all deaths among the 15–29-year-old population and is the second leading cause of death in this age group after road-traffic injuries. Among students aged 13-17 years, 4.4% boys and 5.8% girls consider attempting suicide (31). Although the overall estimated average rate of suicide in Bangladesh is 6 per 100 000 population per year, like other mental health issues, suicide is stigmatized; therefore, suicide deaths are often hidden by the family (32,33). Nevertheless, in rural areas, adolescent females were found to be most vulnerable to commit suicide (33).

Although suicide is criminalized in Bangladesh, there is no systematic suicide surveillance system and a nationwide survey on suicidal risk factors is yet to be conducted.

One of the core objectives in the finalized mental health policy of Bangladesh is to reduce the risk and incidence of suicide and attempted suicide. Suicide is largely preventable through significant evidence-based strategies. However, more research is required to analyse the magnitude and nature of current suicidal behaviours and at-risk populations in Bangladesh.

Mental health due to dementia

Dementia affected 47 million people worldwide (or roughly 5% of the world's older population) in 2015, and is projected to increase to 75 million by 2030 and to 132 million by 2050. Recent reviews estimate that globally nearly 9.9 million people develop dementia each year, i.e. one new case every three seconds. Nearly 60% of people with dementia currently live in low- and middle-income countries and most new cases (71%) are expected to occur in those countries (34). Dementia is one of the major causes of disability and dependency among older people worldwide. Approximately, 115 million people in 2050 who will suffer from dementia would mostly be from less developed countries in the WHO South-East Asia, Africa and Western Pacific regions as well as Latin America (35).

There are currently no published reports of dementia prevalence or factors associated with dementia occurrence in Bangladesh. The prevalence of questionable dementia and definite dementia in Bangladesh was 11.5% and 3.6%, respectively (36). Dementia prevalence increased with increasing age (adjusted OR d: 1.04; 95% CI = 1.002-1.1) and decreased with more years of education (adjusted OR: 0.8; 95% CI = 0.6-0.99). Being malnourished increased the odds of dementia by almost six-fold (adjusted OR: 5.9; 95% CI = 1.3-26.3), while frequent participation in social activities was associated with decreased risk of dementia (adjusted OR: 0.5; 95% CI = 0.2-0.9). In Bangladesh, there has been a betterment of socioeconomic and health indicators that could increase life expectancy over time, likely causing a greater burden of dementia in Bangladesh in the near future

SECTION 2

Situation analysis of mental health services in Bangladesh

2.1 Country context

Bangladesh is a densely populated country in South Asia, bordering Bhutan, India, Myanmar and Nepal. The estimated population of Bangladesh in 2019 was 163.04 million (37). Impressive economic growth with a gross domestic product per capita of US$ 1827, led to a steady drop in poverty rate in Bangladesh, from 31.5% living below the poverty line in 2010 to 24.3% in 2016 (38,39). Amidst commendable progress in heath service delivery, almost 14% people spent more than 10% of their total household expenditure on health care (30). Nonetheless, over the past few decades, the country has witnessed major strides in reducing maternal and child mortality, as well as deaths due to other communicable diseases. Child mortality had reduced to 32.4 per 1000 live births in 2017, and maternal mortality ratio had significantly reduced to 176 per 100 000 live births in 2015 (40,41). However, the total fertility rate stagnated at 2.3 in 2014 with significant geographical disparity (13). Bangladesh's health system still faces chronic health workforce crisis with a health workforce density of 8.3 in 2017 (42).

The magnitude of the threat posed by NCDs and mental health conditions is a matter of great concern. Recent epidemiological transition calls for the need for a policy and legislative shift to meet the challenges of increasing rates of NCDs. It is for this reason that world leaders, governments and stakeholders across all sectors of society have viewed the Third United Nations General Assembly High-level Meeting on the prevention and control of NCDs as a turning point in the global fight against NCDs and promotion of mental health and well-being (43).

WHO defines health as both the physical and mental state of well-being of all people. Untreated mental health conditions have been identified as one of the major causes for premature death, poor health outcomes, and a significant loss of economic activity at the global level. According to objectives of the SDGs, every member country of the United Nations is required to ensure that health, both mental and physical, is a priority area and inclusive of all. Improving mental health, well-being and mental health services is an integral part of achieving the SDGs, particularly Target 3.4 of SDG 3, which states: "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (44).

Furthermore, improving mental health, ensuring inclusion of persons with mental health conditions in society, and protecting the human rights of those with mental health conditions will enable social and economic development as reflected in several other SDGs, including SDGs 8 and 10, and their respective targets. In May 2013, the Sixty sixth World Health Assembly formally accepted the first ever Mental Health Action Plan of the WHO. The Plan has recognized the essential role of mental health in achieving health for all. The four major objectives defined in the WHO Mental Health Action Plan 2013–2020 includes: (i) Strengthening effective leadership and governance for mental health; (ii) Providing comprehensive, integrated and responsive mental health and social care services in community-based settings; (iii) Implementing strategies for promotion and prevention in mental health; and (iv) Strengthening information systems, evidence and research for mental health.

In line with the above objectives, Target 3.1 of the Mental Health Action Plan 2013–2020 indicates that: "80% of countries will have at least two functioning national, multisectoral promotion and prevention programmes in mental

health (by the year 2020)" (45).

Mental health disorders, despite causing enormous social burden, continue to be neglected due to stigma, prejudice, fear of disclosing an affliction because of anxiety of losing a job and/or social standing; or because health and social support services at the community level are not available or are out of reach for individuals and their families (46). Countries are not prepared to deal with this 'invisible' and often-ignored challenge. Mental disorders are associated with high levels of mortality, such as through suicide or due to comorbid medical conditions. In 2010 about 13 million excess deaths occurred in people with mental disorders. Strong associations have been reported between mental disorders and other global health priorities (such as childhood undernutrition and cognitive development) (3).

The 7th Five-year plan 2016-2020 and Vision 2021 of GoB recognized that health also includes mental health and social well-being. It also emphasized that proper health is essential not only for physical well-being but also for economic livelihood. The 7th Five-year plan envisions a country where all citizens enjoy a quality of life assured with basic health care and adequate nutrition. These goals have been reflected in subsequent policy initiatives, such as National Health Policy 2011, Population Policy 2012 and Nutrition Policy 2014.

To realize the vision of the 7th Five-year plan, the Ministry of Health and Family Welfare (MoHFW), GoB is implementing its 4th Health, Population and Nutrition Sector Programme (4th HPNSP) from January 2017 to June 2022. The 4th HPNSP's objectives include strengthening governance, institutional efficiency, expanding access and improving quality within the universal health care system. To achieve the SDG targets, the MoHFW has committed to ensuring that mental health is a priority in this 4th HPNSP. However, due to unavailability of a national costed mental health strategic plan, only a few ad hoc activities in mental health have been included in the operation plan for the Non Communicable Diseases Control (NCDC) Unit of the Directorate General of Health Services (DGHS), which are not sufficient to meet the increasing demands for mental health services by the huge population in need. This calls for the development of a comprehensive and costed mental health strategic plan to design mental health programmes and leverage necessary resources to ensure access to and utilization of quality mental health services.

Evolution of mental health services in Bangladesh

Bangladesh is among the first few countries in WHO SEAR to place mental health as one of its top 10 priority health conditions. Mental health programming in Bangladesh has undergone several phases of evolution. Diagnosis and management of priority mental health conditions with inpatient care for acute cases are provided at both district hospitals and medical college hospitals (National Institute of Mental Health and Hospital (NIMH)/Pabna Mental Hospital). At every government medical college and district hospital a child development centre or Shishu Bikash Kendro (SBK) has been established. These colleges and SBKs also provide training to primary health care providers (such as community health care providers (CHCPs), health assistants, nurses, subassistant community medical officers (SACMOs), and medical officers) on screening, identification and counselling for priority mental health conditions including developmental disabilities, early interventions, parent skills development and Psychological First Aid.

Legal framework and policy for mental health in Bangladesh

National Mental Health Act 2018. The GoB replaced the outdated 105-year-old Lunacy Act, 1912 (see Annex 10) in an effort to protect the dignity of citizens with mental health conditions, provide them with health care, ensure their right to property and rehabilitate them. The Act has 31 sections and will oversee the direction, development, expansion, regulation and coordination of mental health related issues and duties entrusted to the government.

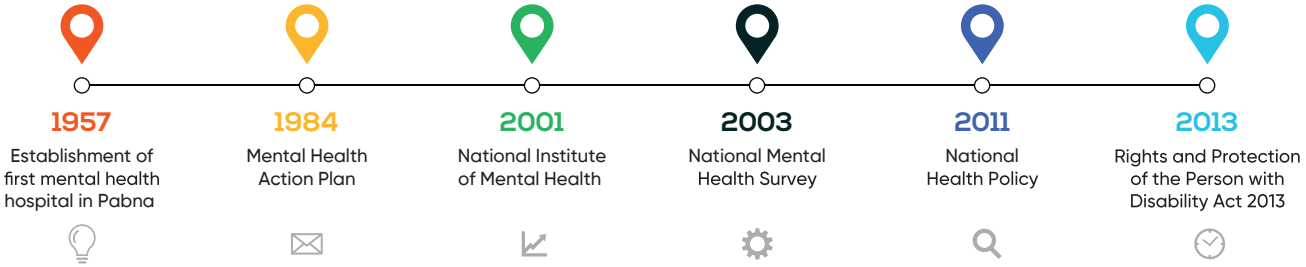
National Health Policy 2011 mentions that policy decisions for mental health uses a life course approach to health and equity. It addresses the rights of women in health along with mental health. It also calls for rights of marginalized people and those suffering from mental health conditions. The policy also includes a strategy to arrange special health services for those with mental and physical disabilities, as well as the elderly and marginalized populations (47).

National Social Protection Strategy of Bangladesh 2014 highlights the interaction between the poverty profile of specific groups (point 2.3 pages 25) and psychosocial well-being. This strategy addresses disability, socially excluded persons, support for people with mental health conditions, and its objectives to work towards integration of these people into mainstream society (48).

Poverty Reduction Strategy considers mental health and indicates that necessary steps will be taken to formulate, implement, review and periodically update comprehensive mental health services (38).

SIGNIFICANT

COUNTRY MILESTONES



National Rural Development Policy 2001 mentions health, physical disability and poverty alleviation. Poverty alleviation relates to discrimination and social barriers which are linked to mental health. Education for rural areas calls for social awareness, importance of self-reliance, as well as promotion of self-strength and self-confidence. Rural health services and nutrition development will ensure access to physical and mental health services (49).

National Mental Health Policy 2019 finalized by the MoHFW provides an overarching direction by establishing a broad framework for action and coordination, through common vision and values for programming and mental health service delivery. The Policy document acknowledges the significance and importance of relevant and useful local knowledge and practices and adheres to global and regional thinking, in Bangladesh's context. The Policy positions mental health as an integral part of the social and economic development of Bangladesh, and social determinants of mental health, such as poverty, environmental issues and education, have been given due diligence. Notably, the United Nations Convention on the Rights of Persons with Disabilities has been at the core of the policy. In addition, the mental health condition of caregivers of children and adults having neurodevelopmental disorders (NDDs) and other complicated syndromes are also acknowledged as a critical issue in the Policy.

The Policy was formulated based on the mental health needs of the population, available services, pilot projects, as well as experiences of other countries and rigorous consultations with representatives from the government, international organizations, professionals' associations, universities, nongovernmental organizations (NGOs) and persons with mental health conditions and their families. The Policy document is a part of the GoB's assurance and reflects its political commitment to mental health issues and recommends the development of a national mental health strategic plan to implement various policy actions.

National Strategy for Adolescent Health 2017-2030. Bangladesh has an adolescent population of approximately 36 million with more than one-fifth of its total population between the ages of 10 and 19 years. There is evidence that investments in adolescent health can triple immediate dividends, and reap benefits for future adult life as well as for the next generation of children. The Strategy was developed to address the overall health needs of adolescents and has identified four priority thematic areas for intervention: adolescent sexual and reproductive health, violence against adolescents, adolescent nutrition and mental health of adolescents. The Strategy envisions that by 2030, all adolescents in Bangladesh attain a healthy and productive life in a socially secure and supportive environment. This Strategy is guided by human rights principles and clearly states that all adolescents, irrespective of their gender, age, class, caste, ethnicity, religion, disability, civil status, sexual orientation, geographic divide or human immunodeficiency virus status, have the right to attain the highest standard of health (50).

Multisectoral Action Plan for Control of Noncommunicable Diseases 2018-2025. GoB's priority is to take all necessary steps to ensure and maintain good health of the population; one of the fundamental rights of the people. To implement this goal, the initiative to formulate the multisectoral action plan for prevention and control of NCDs is a timely step (51).

This action plan is a priority blueprint for key stakeholders and includes an operational plan from 2018 to 2021 in alignment with the 7th Five-year plan and the 4th Health, Nutrition and Population Strategic Investment Plan (HNPSIP) of the GoB. The aim is to advocate "health in all" policies and a "whole-of-government, whole-of-society" approach. There are four broad components of the multisectoral action plan:

i. Advocacy, leadership and partnership
ii. Health promotion and risk reduction
iii. Health system strengthening
iv. Surveillance research and monitoring

National- and subnational-level steering committees have already been formed and announced in the official 2019 gazette, along with the establishment of a National Multisectoral Noncommunicable Disease (control) Coordination Committee (NMNCC) secretariat. In addition, biennial national-level meetings were conducted involving 42 stakeholders from various ministries, divisions, academia, religious organizations, journalists, international NGOs, research organizations, civil society among others.

2.2 Factors associated with mental health

Bangladesh is progressing gradually in championing mental health in comparison with neighbouring countries, with the exception of Sri Lanka. The country has included mental health as one of the top 10 health priorities and has shown a strong political commitment for issues related to autism and NDDs. Bangladesh enacted the Bangladesh Mental Health Act 2018 by replacing the over 100-year-old Indian Lunacy Act. Furthermore, Bangladesh enacted the Rehabilitation Council and Disability Act 2018, developed the National Strategic Plan for Neurodevelopmental Disorders 2016-2021 and finalized the National Mental Health Policy 2019 which is under approval process.

Epidemiological and health system data related to mental disorders are scarce and not readily available in Bangladesh although a few published articles provide some estimates of the various mental disorders. Mental disorders are generally not perceived as a health problem and are not a priority in the Bangladesh's health care delivery system. This means that the extent of the problem remains poorly defined and thereby it becomes difficult to identify specific areas for prioritization (52). The results from the literature review as well as meeting with experts identified the following predominantly researched areas.

Overall prevalence of mental health disorders: According to the recent National Mental Health Survey 2019, about 17% of the adult population suffers from mental illness. This reflects a marginal increase compared to 16% prevalence of mental illness reported in the first National Mental Health Survey 2003-2005. The 2019 survey also reported that mental disorders among the adult population are higher among women (18.9%) than men (15%). The rural population (17.4%) suffers more from mental illnesses compared to their urban counterparts (16.7%). Among the confirmed cases, 3.2% had general anxiety disorder, followed by 2.1% with unspecific somatic symptoms and related disorders; 1.9% had major depressive disorder and 0.9% had insomnia. Apart from insomnia, data also indicated that women suffer more from different types of mental health disorders.

The first national survey on mental health conducted between 2003 and 2005 reported that 16.1% of the adult population had mental disorders with prevalence being higher among women than men (19% vs 12.9%) (52). A systematic review in 2014 revealed that the prevalence of mental health conditions in Bangladesh varied from 6.5% to 31.0% among adults and from 13.4% to 22.9% among children (38). There is an alarmingly high treatment gap of 91.9% in accessing treatment for mental illness across the country and among both males and females. However, among the confirmed cases of mental illness, over 4% had previous history of mental illness.

Another study reported an overall prevalence of mental disorders among 12.2% respondents; with more females than males being affected (13.9% vs 10.2%) (53). A rural community-based study showed the overall prevalence of psychiatric disorders as 16.5%; notably, half of the sufferers had depressive disorders (8%) and a third had anxiety disorders (5%) (54). On the other hand, another study on females in a rural setting reported that 16.4% had mental disorders, with depression (8.9%) being the single-most common disorder (55).

Physical comorbidities with mental illness: In Bangladesh, there are limited large scale studies on comorbidities. An unpublished survey conducted in 2018 by the NCDC Unit, revealed 30% prevalence of at least one chronic physical comorbidity among mentally ill patients (95% CI = 28%-32%); men 28% (95% CI= 26%–31%) and women 33% (95% CI= 30%–36%). Overall, the most prevalent age group with at least one chronic physical comorbidity among the respondents was the 18–29 years age group (22%; CI: 19%–26%) followed by the 40–49 years age group (21%; CI: 18%–25%). The most prevalent comorbidity among men was reported in the 18–29 years age group (24%; CI: 20%-29%), and the second most was among the 40–49 years age group (21%; CI: 17%-26%). For women, the most prevalent comorbidity was reported among the 30–39 years age group (23%; CI: 18%-28%) followed by the 40–49 years age group (21%; CI: 17%-26%). Studies revealed that overall, patients with schizophrenia spectrum disorder had the highest prevalence of at least one chronic physical comorbidity (28%; CI: 24%-31%), while those with bipolar disorder reported second highest prevalence of comorbidity (23%; CI: 20%-27%). In terms of number of comorbidities overall, 17% had a single chronic physical comorbidity, 5% had two and 2% had three or more chronic physical comorbidities. Among all age groups, occurrence of a single comorbidity was higher than two, three or more comorbidities together. In almost all mental disorders, the highest prevalence was a single comorbidity except for alcohol related disorders, where at least two or more comorbidities were present.

Another study which was a part of a larger longitudinal epidemiological study on diabetes in rural Bangladesh, found that 15.3% of the participants were living with depression (56). An urban facility-based study reported the presence of depression in one out of three patients with diabetes (57). Therefore, it is important to understand and comprehensively address the various mental health problems and its social determinants which burden Bangladeshi society.

Epilepsy and treatment gap: Given the lack of nationally representative survey data on epilepsy, a national-level household survey was conducted in 2017 to estimate the prevalence and type of epilepsy, proportion of active epilepsy, treatment gap and treatment pattern, commonly used antiepileptic drugs, and perceptions of epilepsy. The overall country prevalence of epilepsy per 1000 was 8.6 (95% CI 6.8-10.5). In urban areas, the prevalence was 7.9 per 1000 (95% CI 5.4-10.4) and in rural areas, 9.3 per 1000 (95% CI 6.6-12.0). The prevalence among males was 9.7 per 1000 (95% CI 6.9-12.5) compared to 7.6 per 1000 among females (95% CI 5.2-10.0). The survey revealed a very high treatment gap among those with active epilepsy with 94.6% not receiving appropriate anti-epileptic treatment.

Service availability and stigma around mental illness: A Service Availability and Readiness Assessment (SARA) of Health Facilities in Providing Mental Health Related Services survey (unpublished) was conducted by the Centre for Injury Prevention, Health Development and Research, Bangladesh and DGHS in 2018 to acquire more insight on mental health service availability. Data were collected from all tiers of health systems, including tertiary hospitals (79 medical college hospitals and two specialized hospitals), 54 district hospitals, 129 Upazila heath complexes (UHCs) and 76 private hospitals or clinics. This national survey also captured valuable information regarding stigma and care-seeking behaviours on mental illness from caregivers or patient attendants from eight medical college hospitals and two specialized hospitals.

This unpublished 2018 SARA survey reported the availability of mental health services in 89% of tertiary hospitals, 50% of the sampled district hospitals, 43.4% of UHCs and 42% of private health facilities. This survey confirmed the chronic shortage of mental health workforce at all levels. There is a severe lack of mental health professionals in both district hospitals and UHCs – only about 15% district hospitals and 2% UHCs had a psychiatrist, and none of these facilities had a clinical psychologist. Almost 69% of the tertiary hospitals had psychiatrists, but only 15% of them had clinical psychologists, followed by 8% psychiatric and mental health nurses, 10% psychotherapists and 5.6% certified mental health professionals. 62.5% of private hospitals had psychiatrists, while 6.3% had clinical psychologists. Although 11% of district hospitals and 12.5% UHCs had mental health nurses, only 3.1% of private facilities had deployed such cadre. Although a modest 18.2% of district hospitals and 9.4% of private hospitals had psychotherapists, none of the UHCs had these types of service providers. Availability of mental health workforce was very negligible in district hospitals, UHCs and private hospitals.

Research indicates that tertiary hospitals had the highest inpatient bed allocation (40.3%) followed by 15.6% in private facilities. However, there was no bed allocation either in the district hospitals or UHCs (58). Scarcity of psychotic drugs in district hospitals and UHCs pose great challenges in offering quality mental health services. In the UHCs, there is no supply of the two most commonly used drugs to treat clinical depression – amitriptyline and fluoxetine. Similarly, in district hospitals, only 2% and 1% had supply of amitriptyline and fluoxetine, respectively. However, the availability of psychotic drugs was modest in tertiary hospitals – ranging from 21% to 56%. Private facilities had the least amount of supplies, varying from as low as 5% to as high as 15%.

It is important to note that very few facilities providing mental health services followed national guidelines, reflecting varying quality and standards of service delivery. Only 36% of tertiary level facilities followed national guidelines on mental health, which was just over 14% for both district hospitals and UHCs. Impressively, 34% of sampled private facilities followed national guidelines on mental health. In terms of availability of service providers trained in mental health, UHCs were leading with about 43% trained staff, followed by tertiary hospitals with 39%, private facilities with 34% and district hospitals with 26%.

However, as per the provisional fact sheet of the National Mental Health Survey 2019, overall stigma towards mental illness was 4.5 (SD –0.7). There was no significant difference between males (4.6) and females (4.4), and stigma towards mental illness was the same among urban and rural communities (4.5).

Prioritizing mental health disorders: Due to the limited number of studies, it is difficult to categorize priority mental health disorders and conditions in Bangladesh. In 2017–2018, a national survey conducted in Bangladesh by the NIMH under its NCD control programme, found 3.3% prevalence of substance use among persons aged 18 years and above. A community-based rural study reported 3.6% psychiatric disorders, and 2.9% both psychiatric and physical disorders, with depression and anxiety being the most common condition (59) in the participants. A later urban community-based study reported psychiatric disorders among 28% of the participants as diagnosed by a psychiatrist (60).

Most of these aforementioned studies identified depression as a priority mental health disorder followed by anxiety. Several focus group discussions (FGDs) were conducted with various mental health professional groups including but not limited to the Bangladesh Association of Psychiatrists (BAP), Bangladesh Clinical Psychology Society (BCPS) and Bangladesh Education and Counselling Psychology Society (BECPS) to learn their experiences on the most prevalent mental health disorders and conditions (see Annex 7 for a summary of focus group discussions and workshops with

mental health stakeholders). A generic tool for FGDs was developed following WHO guidelines in consultation with the DGHS and mental health experts. The FGD tool covered concepts of mental health and psychosocial well-being, perception, stigma around mental health, current services and academic programmes by these professional societies, as well as challenges and recommendations to upscale mental health interventions. This generic tool was customized while conducting an actual FGD with these professional societies and other ministries and attached departments such as the Department of Narcotics Control (DNC) under the Ministry of Home Affairs (MoHA), Ministry of Education (MoE), Ministry of Primary and Mass Education (MoPME), Ministry of Social Welfare (MoSW) and Ministry of Women and Child Affairs (MoWCA). Members of these professional societies, officials from different ministries and departments as well as relevant NGO partners, attended these FGDs and provided their valuable inputs. Findings from these FGDs were used in different sections of this strategic plan, especially to identify priority mental health conditions which are appended in the following paragraphs. In addition, these recommendations also informed the identification of strategic priorities and actions which are included in Section 3 of this document.

It is noteworthy to mention that findings from these qualitative studies are commensurate with various study findings narrated in the aforementioned paragraphs. FGDs with BAP members identified depression, substance abuse, obsessive compulsive disorder and other anxiety disorders, schizophrenia and other psychotic disorders, convulsion disorder/hysteria, somatic syndrome disorder (noncardiac chest pain, headache, unexplained physical symptoms) and dementia among older people as major mental health disorders. BAP members also identified NDDs such as intellectual disability, autism spectrum disorder, attention deficit hyperactivity disorder, and conduct disorders as major disorders among children and adolescents, and conversion disorder or hysteria as a major mental health disorder among adolescents. BAP has categorized the conditions as anxiety disorders, mood disorders (including both bipolar and depression), schizophrenia and other psychotic disorders, substance abuse and NDDs.

However, FGDs with BCPS members identified the top mental health disorders and conditions among adults to be: anxiety, depression, panic disorder, conversion (prevalent mainly among females), relationship problems, personality disorders and substance abuse. BCPS also identified conduct disorders, attention deficit hyperactivity disorder and intellectual disorders as main conditions among children. They also mentioned device dependency or process addiction (Internet addiction) as an emerging mental health issue.

Additionally, FGDs with BECPS members identified depression as the most common disorder including postmenopausal depression, which was followed by relationship problems (married and unmarried) among men and women. They also stated relationship problems, particularly extramarital relations as a leading cause of depression. Members identified higher rates of obsessive convulsive disorders and cases of conversion disorder that ensued due to family conflicts. Members also stated school and examination phobia, relationship problems, attention seeking behaviour, concentration problems in school, drug addiction, suicide and Internet addiction, as other mental health problems among adolescents. Depression and weak performance among academics were also reported to lead to suicidal attempts and suicide. Members also mentioned that anxiety and anger issues were prevalent among adolescents who had family disharmony.

Mental health illnesses are underpinned by several interdependent factors and conditions including but not limited to physical health conditions, poverty, malnutrition, gender and postpartum mental health, violence and trauma during childhood and adolescence, and disability.

Mental health programming in Bangladesh has evolved in several phases. Mental health programming in Bangladesh has evolved in several phases. It is imperative to mention that in 1972, Bangabandhu Sheikh Mujibur Rahman had

inaugurated the first ever mental health programme titled `Organizational training on mental health'. Up until 1984, mental health was not appropriately prioritized, which led to the development of the 1984 Mental Health Action Plan, which was followed by the development of the 2006-2015 strategy and work plan for community mental health services. In 2011, mental health was integrated into primary health care efforts. Some mental health activities – WHO Mental Health Gap Action Programme (mhGAP) training, development and dissemination of mental health social and behaviour change communication (SBCC) material and television advertisement spots, awareness activities on substance use and harmful use of alcohol – were included in the 3rd HPNSP 2011-2016 and in the ongoing 4th HPNSP 2017-2022. While finalizing the mental health policy during 2016-2018, the MoHFW developed and initiated the implementation of a National Strategic Plan for Neurodevelopmental Disorders 2016-2021.

2.3 Mental health within the health care system

2.3.1 Leadership and governance

Mental health is a vital part for the socioeconomic development of Bangladesh and has been integrated in the following key policy documents: the Bangladesh Health Policy 2011, National Rural Development Policy 2001, National Social Protection Strategy of Bangladesh 2014, Poverty Reduction Strategy Papers 2011 and Millennium Development Goals, Persons with Disabilities Rights and Protection Act 2013, Neuro-Developmental Disability Protection Trust Act 2013, and the 2017-2030 Action for Adolescent Health Strategy. Mental health is also part of the SDGs adopted by member countries of the United Nations in 2015. Therefore, to achieve its SDGs, the MoHFW, in its 4th five-year HPNSP, committed to ensuring that "mental health and psychosocial well-being" is a priority area within the existing health care system.

In October 2018, the National Parliament enacted the Mental Health Act 2018 which replaced the over 100-year-old Indian Lunacy Act. This was a huge milestone for mental health services in Bangladesh as the new Act would ensure the protection of the rights of persons with mental health conditions and enable their access to quality mental services and information. The GoB also finalized the National Mental Health Policy 2019, which has been submitted to MoHFW for attaining final approval from the cabinet division. This Policy marks an important milestone in establishing the foundation for addressing mental health in Bangladesh. The Policy provides the overall direction for mental health by instituting a common vision, values, objectives and a broad framework for action, which in turn helps to establish benchmarks for the prevention, treatment and rehabilitation of persons with mental health conditions, as well as the promotion of mental health. The principal guideline of the national mental health action plan, programmes and service-related activities would be based on the policy document. Bangladesh is also a signatory to various human rights conventions and treaties, which could potentially be mobilized to ensure the protection of the rights of the people with mental disorders and psychosocial disabilities.

Mental health is managed by the NCDC Unit under the DGHS. The Line Director (NCDC) oversees all NCDC programmes, including mental health; while a programme manager and two deputy programme managers, are responsible for the national mental health programme in addition to other NCD activities. Also, an Autism & NDD Cell has been established in the Health Service Division under the MoHFW, led by a Director General who is an Additional Secretary. This Cell has been assigned to coordinate autism and NDD activities as well as disability and mental health,

as these areas require the cooperation and collaboration of multiple ministries. In 2016, the Cell commissioned international and national expert bodies to develop a national strategic plan on autism and NDD. This life-course based intersectoral strategic plan is to be the guideline for issues on disability and mental health (which have traditionally not been a part of health sector operations) and will act as the framework for all programmes to be formulated.

There is an urgent need to deploy a dedicated leadership and programme management structure for mental health programmes. The National Mental Health Policy 2019 recommends a formal organogram and a dedicated mental health position (equivalent to Director) within the DGHS to coordinate and monitor services and programmes for mental health conditions/services, based on well-planned guidelines and terms of references (ToRs). Such an individual should have demonstrable academic and practical knowledge on mental health.

2.3.2 Organization of health services

The health care network in Bangladesh is under the leadership of the MoHFW and comprises implementing authorities, regulatory bodies and health care facilities from the national to the community level. In addition, many services are also provided through NGOs and private institutions either working alone or in partnership with public health departments of the GoB. Given the dearth of services and the huge population size, Bangladesh has many specialized and community-based service centres designated (and even funded) as service providers in lieu of establishing a government service centre.

The MoHFW handles national-level policy, planning and decision-making, while the various implementing authorities and health care delivery systems are responsible for implementing national-level policies, plans and decisions in the provision of health care and education. The health care services provided by NGOs and the private sector are also controlled indirectly by the MoHFW and its relevant regulatory bodies.

In March 2017, a new administrative structure of the MoHFW was created. The GoB has divided MoHFW into two divisions: (i) Health Services Division, and (ii) Medical Education and Family Welfare Division. The Health Services Division has many roles, such as making policy regarding health-related matters, management and maintenance of nursing care, and health financing. On the other hand, the Medical Education and Family Welfare Division makes policy regarding family planning matters, medical education, matters relating to medical colleges and medical universities, registration of birth and death, among others.

The DGHS is the largest implementing authority under the MoHFW with more than 100000 personnel. The DGHS provides technical assistance to the MoHFW when new programmes and interventions are needed to improve existing ones. Under the DGHS, the management structure and health facilities are very sound. There are six tiers of health care infrastructure under the DGHS: national, divisional, district, Upazila (subdistrict), union and ward. At the national level, there are institutions both for public health services as well as for postgraduate medical education/training and specialized treatment to patients. A divisional director monitors the activity of each division, assisted by deputy directors and assistant directors. There is one infectious diseases hospital and one or more medical college(s) with its own hospital at each divisional headquarter. As the district health manager, the civil surgeon is responsible for delivering secondary and primary care services. Each district has a district hospital and most of these hospitals have superintendents for hospital management. In other districts, civil surgeons take on the additional role of a superintendent and oversee the district hospitals. Some of the district headquarters have medical colleges with attached hospitals, medical assistants' training schools, and nursing training institutes (61).

Domiciliary health services in rural Bangladesh: There are domiciliary workers – one for every 5000/6000 people at the ward or village level. Under the DGHS, there are 26538 sanctioned posts for domiciliary workers, of which 20908 are for health assistants, 4220 for assistant health inspectors, and 1410 for health inspectors; 78.54% of these posts are occupied. The Directorate General of Family Planning (DGFP) also has domiciliary workers at the ward or village level. These staff members are called family planning inspectors and family welfare assistants. Recently the DGHS, MoHFW took the initiative to recruit multipurpose health volunteers (MHVs) with support from donors and NGOs. MHVs, who receive an honorarium and incentives, will support community engagement and work towards strengthening the community health system which would expedite the achievement of SDG targets. MHVs should have passed the Staff Selection Commission examination and females are given preference while selecting MHVs (the female to male ratio will be 2:1). Each MHV will cover 200-250 households under a community clinic. MHVs will be appointed for one year.

Community clinics: About 14000 community clinics for every 6000 population in Bangladesh are bringing health care to the doorstep. CHCPs serve six days a week in the community clinics while health assistants and family welfare assistants serve every three alternate days. People can avail primary health care including family planning and nutrition services under one roof and within half-an-hour walking distance from their homes, even in remote areas (62,63). Community clinics have contributed significantly to the overall improvement of antenatal and postnatal care in Bangladesh. The clinics provide counselling on reproductive health and consequences of early marriage, and also supply contraceptives and provide care for pregnant women. Treatment is also provided for diarrhoea, pneumonia and other childhood infections. Local community members actively participate in the management and are an important element of community clinics. Currently each community clinic has one community group and three community support groups.

Union Health and Family Welfare Centre: The DGFP of the MoHFW has established approximately 3900 Union Health and Family Welfare Centres (UHFWCs) in rural areas providing: family planning; menstrual regulation; vaccinations; and general, reproductive, and maternal health services six days a week (64). The SACMO provides services to children and for general health check-ups. About 1500 UHFWCs have been upgraded with the necessary staff and equipment to provide normal delivery services round-the-clock in rural areas. There are 1399 union subcentres and UHFWCs established by the DGHS. One SACMO and one pharmacist in those facilities provide primary health care to the rural community.

Upazila Health Complexes: The 421 UHCs in Bangladesh (297 have 50 beds; 112 have 31 beds; 11 have 10 beds) play an important role in providing primary health care as well as secondary health care as they have a specialist doctor. The UHCs have a considerable number of sanctioned posts for professional doctors and nurses, house 31 to 50 beds (depending on the size of the Upazila), and are also equipped with sufficient medical equipment. Patients visiting the UHFWCs are also referred to the UHCs for primary and secondary health care services. These factors make UHCs the health care hub at the Upazila level. According to the Health Bulletin of DGHS 2015, the largest share (38% of total admissions in all three types of hospitals) of patients seeking primary care services at public health facilities in Bangladesh visit the UHCs. UHC also provides outpatient care, primary health care, family planning services and other preventive health care services. However, the UHC does not have assigned human resources to provide mental health services. The DGHS in partnership with WHO SEARO, has launched a programme to train selected doctors and nurses from the UHCs to provide basic mental health care services.

Health care at the secondary- and tertiary-level facilities: Secondary- and tertiary-level health care facilities provide more advanced or specialty care than the primary health care facilities at the ward, union and Upazila levels. District hospitals are usually termed secondary hospitals as these have fewer facilities for specialty care compared to many

in the medical college hospitals. Although medical colleges have psychiatry units, most of the posts are not filled up. District hospitals do not have assigned human resources to provide mental health services. The DGHS in partnership with WHO SEARO, has launched a programme to train selected doctors and nurses from district hospitals to provide basic mental health care services.

There are also various types of specialty-care centres, such as infectious diseases hospitals, tuberculosis hospitals, leprosy hospitals, which fall under the health facilities of secondary care. Medical college hospitals are located at the regional level, one for a few districts and provide specialty care in many disciplines. These hospitals are called tertiary-level hospitals. Also, specialty hospitals like NIMH, Bangabandhu Sheikh Mujib Medical University (BSMMU), Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders (BIRDEM) and others at the national level provide high-end medical services in a specific field and thus are considered tertiary care hospitals.

2.3.3 Multisectoral planning for mental health service delivery

Mental health services through the health system

WHO estimates that neuropsychiatric disorders in Bangladesh contribute to 11.2% of the total disease burden (65). Bangladesh's national health budget was US$ 2.3 billion, of which only 0.44% was allocated for mental health (66). According to the latest Bangladesh National Health Accounts, Bangladesh spends US$ 2.3 billion on health or US$ 16.20 per person per year, of which 64% is from out-of-pocket payments. In Bangladesh, mental health conditions are not covered by social insurance (65).

Institutional care: Bangladesh has one mental health institute – the NIMH – with a 200-bed specialized hospital attached to it. In addition, there is a 500-bed mental hospital (Pabna Mental Hospital, located 162 km west of Dhaka), 31 community-based psychiatric inpatient units (0.58 beds per 100000 population; on average patients spend 29 days in the facility), 15 beds in forensic inpatients units, 3900 beds in residential facilities (such as homes for the destitute, inpatient detoxification centres and homes for people with mental disability), and 50 outpatient mental health facilities (67). The Combined Military Hospitals and Armed Forces Medical Colleges of Bangladesh also have well organized mental health services with 0.43 mental health inpatient beds per 100000 population (52).

Of the 69 outpatient mental health facilities and 72 residential care facilities in Bangladesh, there is no follow-up care in the community and day-treatment mental health facilities. There are 20 outpatient facilities (including services for NDDs), and only two inpatient facilities specifically for children and adolescents (68). Most of these mental health facilities are clustered in urban areas, particularly in metropolitan cities. The density of psychiatric beds in or around the capital Dhaka is five times higher than that in the entire country, even though 70% of the Bangladeshi population lives in rural areas (52).

Unlike the European Union (EU) countries, there appears to be hardly any substantial mental health care available at primary or secondary health facilities in Bangladesh (52). Of all psychiatric beds available in community psychiatric units and mental hospitals, Bangladesh had only one psychiatric bed for every 100000 persons which is significantly lower than 52/100000 in EU countries (69). There were 0.13 psychiatrists per 100000 population in Bangladesh compared to 12.9/100000 in EU countries (52). The number of government employed psychiatrists were only 250, the total number of beds for psychiatric patients were only 840 (53). This critical shortage of trained health care providers in Bangladesh has resulted in a widespread increase in informal unregulated providers (largely untrained providers of western, homeopathic and traditional medicines) as alternative sources of care. Although not regulated by

government authorities, they are the principal health care providers for poor Bangladeshi populations, especially in remote rural and hard-to-reach areas (70). Not only is access to mental health care inequitable and insufficient, but pervasive stigma and misconceptions pose a significant barrier to adequate care for those in need of mental health services (68). Primary health care personnel lack the skills to detect and treat mental health patients, and referrals of patients with mental health problems to psychiatric providers by general practitioners or other health care providers is almost nonexistent. Hence, the choice of the provider depends on various factors including the knowledge and belief system of patients and their families, as well as the availability of care providers (52).

Mental health piloting through primary health care: Sonargaon Upazila (subdistrict), where mental health activities were implemented for one year in 2008, demonstrated a feasible mechanism for service delivery at the primary health care level, through strengthening of the existing system. Recommendations were made for future activities to achieve the goals of the programme, including training, supervision, support and availability of psychotropic drugs. From 2007, with the technical support of WHO and DGHS, about 10 030 general physicians, 4500 nurses and subassistant community medical officers were trained in mental health by the NIMH. The three to seven days of training included screening, diagnosis and management of common mental health conditions.*

Shishu Bikash Kendro or child development centre: SBK (established in 1992) – a first of its kind centre – is situated within the acute care Dhaka Shishu Hospital. It provides services for developmental disabilities and neurological impairments both in the oupatient department and for children being discharged from neonatal and inpatient units. The SBK, run by the Neurology, Child Development & Child Psychology Unit, provides services including outpatient neurodevelopmental screening and care of acute neurological cases and follow-up. A multidisciplinary team of professionals comprising physicians, psychologists, developmental therapists, neurophysiologists provide key services to the children and their families.

The MoHFW is scaling up the SBK by focusing on comprehensive care for autism and NDDs including a facility for diagnosis and management of epilepsy as envisaged in the National Strategic Plan for NDDs (NSPNDD) 2016-2021 (71). Currently, SBKs have been established in 14 medical college hospitals and in one district hospital. The Hospital Services Management (HSM) department under the DGHS provides overall financial and monitoring support to these SBKs under the ongoing 4th HPNSP. There is a plan to upscale SBKs in all district hospitals and 28 government medical college hospitals by 2022. Staff who work in SBKs are under temporary contract as project staff.

National Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases, MoHFW

The priority of the GoB is to take all necessary steps to maintain good health in a timely manner, as a fundamental right of the people. To implement this goal, the "National Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases, 2018-2025" has been formulated to address the rising epidemic of NCDs. This national action plan is a priority blueprint for key stakeholders, and includes an operational plan for 2018–2021, which is aligned with the 7th Five-year plan and the 4th HNPSIP of the GoB. The aim is to advocate "health-in-all policies" and a "whole-of-government, whole-of-society approach" through four broad components: (i) advocacy, leadership and partnership health promotion and risk reduction, (iii) health system strengthening, and (iv) surveillance research and monitoring.

In 2019, national- and subnational-level steering committees were formed and a NMNCC secretariat established to ensure oversight. Biennial national level meetings are held involving 42 stakeholders from various ministries, divisions, academic institutions, religious organizations, media organizations, international NGOs, research organizations, civil society and others. The National Mental Health Strategic Plan (NMHSP) will be annexed as part of the multisectoral plan and will be implemented by the NMNCC in an integrated way.

Mental health services through the Ministry of Women and Child Affairs: A multisectoral programme called Violence Against Women (a joint initiative of the Bangladesh and Denmark governments under the MoWCA) has encompassed important initiatives to provide psychosocial support to women survivors of violence such as the One Stop Crisis Centre/Cell (OCC) and National Trauma Counselling Centre (NTCC).

The objective of setting up OCC's in medical college hospitals was to provide all required services for female survivors of violence and trauma in one location. The OCC provides health care, police assistance, DNA test, social services, legal assistance, psychological counselling and shelter. To extend support for survivors of violence (women and children) around the country, 67 OCCs were established, including 47 in District Sadar Hospitals and 20 in UHCs. Substantial training of staff and professionals working in these centres include orientation on OCC, DNA laboratory activities, and psychological counselling on an ongoing basis to existing staff and others to be employed at these new centres. Training modules for combating violence against women will be developed for OCC staff, teachers, students, health assistants, family planning officers and other professions.

The NTCC at the Department of Women Affairs Building, provides mental health support to women and children who have survived violence. It also offers both individual and family counselling along with other services, such as skills training to develop a pool of skilled counsellors. The MoWCA has recently established Regional Trauma Counselling Centres (RTCCs) in the eight divisional medical college hospitals.

Mental health services through the Ministry of Social Welfare: The MoSW has established child development centres (formerly known as juvenile jails) to provide training and social inclusion of adolescents who come into contact with the legal system by committing minor offences. These centres also provide rehabilitation and training specifically to girls with disabilities and those who are socially marginalized; they also serve as a safe home for children, adolescents and women. Although psychosocial service provision has been included in their plan of activities, the 95 MoSW-supported institutions are unable to provide it due to lack of trained professionals.

Rehabilitation services for those recovering from chronic mental health conditions are severely lacking, although a few NGOs have attempted to provide it. Through the Neuro-Developmental Disability Protection Trust at the MoSW, Social Safety Net programmes are being developed through connected networks such as the Bangladesh Business Development Network with support from the International Labour Organization. The Trust is also trying to develop shelters for destitute persons with NDD and has prepared a development project proposal. The chairperson of the Trust also serves as the secretary for the national steering and advisory committees for autism and NDDs, which ensures collaboration with 16 relevant ministries such as MoHFW, MoE (primary, secondary and higher, madrasa board), MoWCA, Ministry of Youth and Sports (MoYS), Ministry of Local Government, Rural Development and Co-operatives (MoLGRDC) and others.

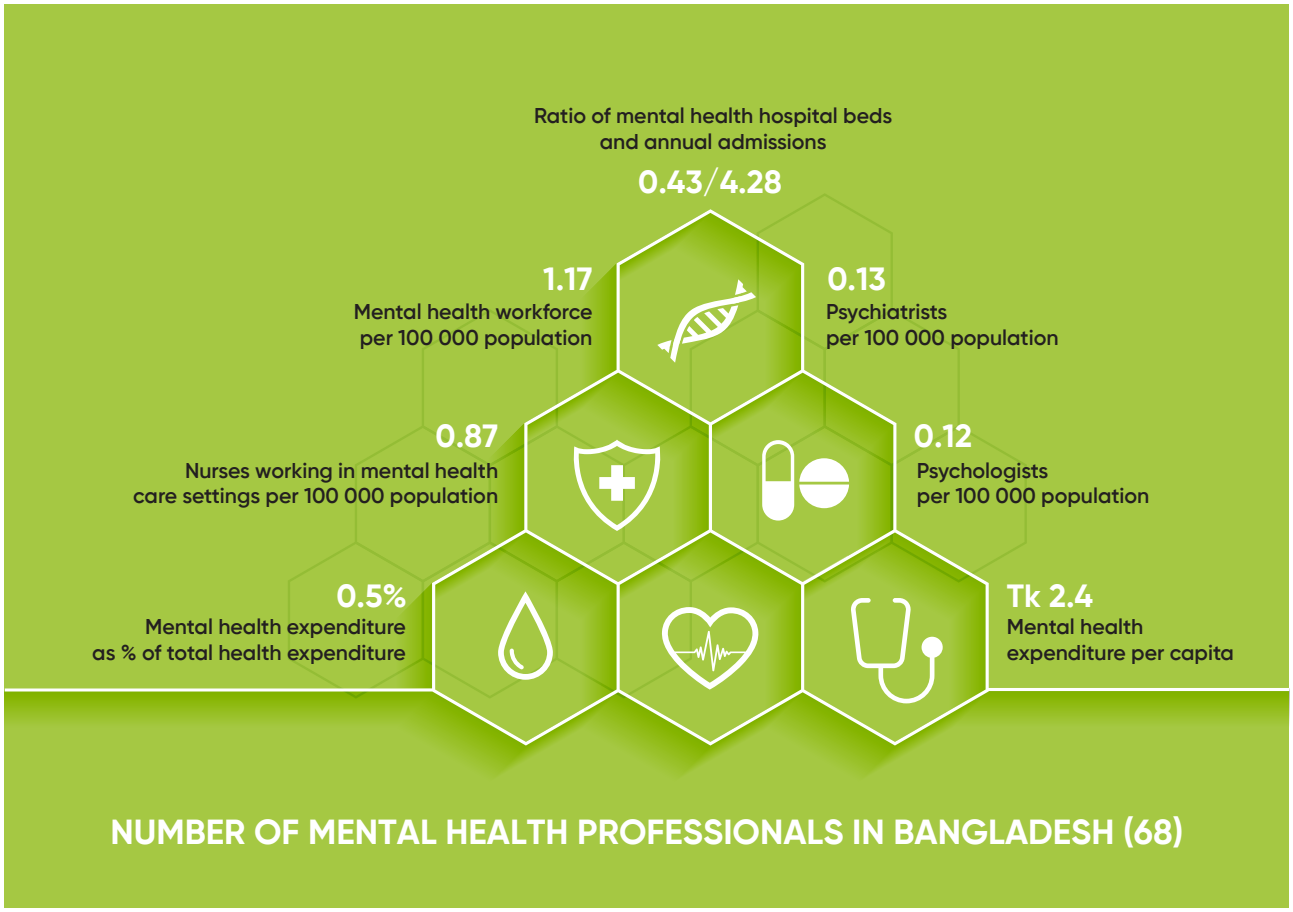
Mental health services through the Ministry of Disaster Management and Relief (MoDMR). Bangladesh has a well-organized crisis preparedness, management and rehabilitation system in place to address its frequent natural and manmade disasters. In 2017, the Crisis Preparedness and Management for Mental Health (CPMMH) training manual was developed to reduce mitigating future trauma and post-traumatic stress disorder symptoms, and enable laypersons in the community to become proficient in psychological well-being. The training manual on CPM is designed to equip the participant with information and skills necessary to assist survivors of critical incidents in coordination with other health and relief services. Currently, seven master trainers have graduated and the programme is ongoing with support from local and international partners.

Mental health services through the Ministry of Education: Education has the potential to influence other SDGs that have a bearing on mental health, such as through improved employment and reductions in income and gender inequality. Individual cognitive and ecological social capital have also been associated with reduced prevalence of common mental disorders (72). Ensuring mental health support through the education system has been a long-standing service in many countries. Unfortunately, for most low- and middle-income countries, the focus until very recently was on enrollment, passing standardized tests and graduation rates. Often, teachers are mentors and positive role models but at times, they can also be the source of trauma. Bullying by peers and teachers is not a new concept and has been experienced by many. Ensuring that students develop strong resiliency and the capacity to address such experiences in a manner that does not leave them permanently emotionally scarred is an extremely urgent and important issue that needs to be addressed without delay. Many countries have bullying prevention programmes implemented nationally, but Bangladesh is not one of them. In fact, in secondary schools and colleges, bullying is actually part of the culture and a part of the initiation process which predicates a 'big brother', that is part and parcel of daily life and follows into adulthood. This challenge, which has strong life-long debilitating effects on psychological and social well-being and the potential to particularly impact those with underlying mental health issues or those that have experienced trauma, needs to be addressed without delay.

Although recognized as an area of urgent need, due to the rise in suicide rates among children below 16 years of age, mental health support programmes do not exist within the education system. Compounded with that fact is the need for high achievement from students and high expectations from parents and teachers, and the frequent use of physical punishment and the practice of public reprimand as a behaviour management technique. Until recently, Bangladesh was focused on ensuring the enrollment of all students within the standardized education system and a lot of resources (providing free books, stipends to mothers, school meals and adequate toilets) were mobilized to achieve it. But with the advent of the SDGs and the creation of the education policy of the GoB, more focus is now being placed on ensuring that children learn and thrive. To ensure that teachers are adequately prepared, the MoE is reviewing various mechanisms that will enable teachers to receive training on learning and behaviour strategies, which will help to create an inclusive learning environment for all students including those with disabilities. The Policy also states that school psychologists are available at every school, but a severe shortage of such professionals has been a significant hindrance to achieving that goal. Currently, Bangladesh has only one academic programme to train educational/counselling psychologists. Psychosocial support programmes will be implemented in Bangladesh across educational settings through a phase-wise programme and thorough review of training of teachers, administrators and support staff.

2.3.4 Human resource structure for mental health

The magnitude of mental health conditions is high compared to available mental health specialists. As of 2016, there were 1.17 mental health workers per 100000 population, most of whom worked at a tertiary care setup situated in large cities (53). The breakdown according to profession was: 0.13 psychiatrists, 0.01 other specialist doctors, 0.87 nurses trained to work with mental health issues (there are no psychiatric nurses), and 0.12 psychologists and other paid mental health workers (psychotherapists and mental health counsellors). While NIMH provides postgraduate training, the BSMMU, as well as government and private medical colleges have training facilities along with inpatient/outpatient services. The number of trained mental health professionals is insufficient and most of the services are confined to large cities such as Dhaka, Chattogram, Sylhet and Rajshahi.



2.3.5 Infrastructure and service delivery

The limited availability of mental health facilities constrained access to and utilization of quality mental health services in Bangladesh. Equipments for the diagnosis and treatment for mental illness are also not readily available in hospitals, especially in district hospitals and UHCs. WHO has recently supplied four psychotropic medicines as part of the NCD kit box to Cox's Bazar district hospital and UHC, and in other districts that still lack access to essential psychotropic drugs. The DGHS has planned to procure some psychotropic drugs that are yet to be included in the National Essential Drug List.

There are two specialized mental hospitals in Bangladesh: (i) a 500-bed Pabna Mental Hospital; and (ii) a 200-bed NIMH. There are 31 community-based psychiatric inpatient units (for a total of 0.58 beds per 100 000 population and on average patients spend 29 days in the facility), 15 beds in forensic inpatients units, 3900 beds in residential facilities (such as homes for the destitute, inpatient detoxification centres and homes for people living with chronic mental health conditions and neurological disabilities) and 50 outpatient mental health facilities in the country (68). None of these outpatient facilities provide follow-up care in the community. Although day-treatment mental health facilities are yet to be established, 72 residential facilities are in operation in the country (69).

2.3.6 Information system and research

In Bangladesh, health service providers and the health-care delivery system are supposed to report routine data to administrative levels on a monthly basis (70). The reported data reaches the MoHFW through various levels of the administrative hierarchy, and is disseminated through health bulletins, newsletters, yearbook on health, digital health guideline and Voice of Management Information Systems (MIS)-Health (70). Unfortunately, a large number of private and nongovernmental health facilities are not yet under the umbrella of the formal MIS of the MoHFW (70). The MoHFW has recently established a web-based data collection system named District Health Information System version 2 (DHIS2), to collect routine health data from public health facilities (70). In DHIS2, data can be entered at the source and summary tables, charts and geographic information system maps can be prepared for all levels of hierarchy (73).

Variables of mental health illnesses including classification of disorders following International Classification of Diseases, Tenth Revision (ICD-10) have not been included in the DHIS2. Therefore, routine data on mental health is not available from government facilities (i.e. UHCs and district hospitals), which creates a huge gap in identifying real-time data on mental health service delivery by the various health facilities providing mental health services.

Findings from a recent NIMH study indicated that the current poor quality of NIMH data is due to limitations in accuracy, validity, reliability, completeness, timeliness and access. The study recommended improvement in data analysis aspects (70).

A recent national mental health survey was conducted during 2018-2019, nearly a decade after the last survey during 2003–2005. The GoB needs to institutionalize the national mental health survey and conduct it after every five years at least. There are two regular national level surveys to measure national estimates on health indexes – BDHS and Multiple Indicator Cluster Survey (MICS). Unfortunately, none of these surveys include any indicators on mental health.

2.3.7 Financing

Public expenditure on mental health is very low in low-and middle-income countries (less than US$ 2 per capita). A large proportion of available funds go towards inpatient care, especially in mental hospitals. Globally, the median number of mental health workers is 9 per 100000 population, but there are extreme variations (from below 1 per 100000 population in low-income countries to over 72 per 100000 population in high-income countries). Nearly 63% of WHO Member States have at least two functioning mental health promotion and prevention programmes. Of the 350 reported programmes, 40% were aimed at improving mental health literacy or combating stigma. Among the 11 WHO SEAR Member States, 9 have a standalone mental health policy/plan and eight have updated their policy/plan in the past five years (since 2013).

Bangladesh 5th National Health Accounts estimates total health expenditure at 3% of gross domestic product (US$ 451 889 million) and a relatively low per capita total health expenditure of Tk 2882 (US$ 37). The household out-of-pocket expenditure makes up to 67% of the total health expenditure, while government financing accounts for 23% of the total health expenditure (74). The percentage of out-of-pocket health expenditure of the total health expenditure is equally high in urban (68%) and rural (61%) areas (75). The budget allocation for mental health is negligible with only 0.50% of the total health budget assigned to mental health services, of which a major share (35.59%) is spent through mental hospitals (27). There is an urgent need to increase the allocation for mental health to ensure the scaling up of evidence based on mental health interventions throughout the country, especially at the primary health care and community levels.

2.4 Strategy development process

The NMHSP development process included a series of reviews of programme evaluation reports; literature search; evidence; strategy and policy documents by consultants; focus group discussions with relevant professional societies, ministries and divisions; semi-structured interviews with experts; technical group meetings; field visits; and stakeholder consultative workshops, for consensus building on critical issues and finalization.

In summary, while considerable progress has been made in the global mental health agenda in the past decade, much more needs to be achieved in all countries, especially in resource-poor settings. The sustainable development framework provides an opportunity to reframe mental health and make it a fundamental component of the broader global development agenda. Although mental health is explicitly recognized in SDG 3, all other SDGs have been conceptualized to be integrated and indivisible – progress on each SDG supports all others. Hence, the target of reducing the burden of mental disorders is supported by progress made on other goals and targets and vice versa. This two-way interaction is an important conceptual shift because mental health had always been isolated from mainstream efforts in health and development (6).

Mental health being an inevitable part of health systems makes public health programmes comprehensive and inclusive. If left untreated, mental disorders have serious social, psychological and physical health consequences, leading to widespread disabilities, economic hardships for the family and increased costs to the government. Mental disorders affect individuals and families in all societies. It is evident that when mental disorders go unattended, they can lead to significant morbidity and disability within the community. Increased incidence of suicide, reduced productivity, increased poverty and unemployment, increased academic failure, increased incidence of substance abuse and tobacco use, increased proportion of elderly population, domestic violence, child sexual abuse, family disruption, and increased aggression and violence are some of the broader social issues that can affect the mental health and well-being of individuals. Furthermore, people with mental disorders are often met with significant stigma and discrimination which can lead to the denial of basic human rights such as health, education, employment, housing, welfare services, and other civil rights. There is mounting global recognition on the burden of mental disorders in both developing and developed countries. The WHO increasingly encourages Member States to develop national mental health policies and plans as reflected in the WHO Mental Health Action Plan 2013-2020.

Global mental health has much to gain by supporting sectors engaged in human development to incorporate evidence-based interventions that can prevent mental disorders and enhance the mental health and well-being of populations. Therefore, an expanded agenda for mental health is required that ranges from promotion and prevention (which overlaps considerably, especially in terms of primary prevention) to treatment and rehabilitation, mapping the dimensions from good to poor mental health as well as from risk factors to the presence of mental disorders and disabilities.

SECTION 3

National Mental Health Strategic Plan 2020–2030

3.1 Rationale

Mental health has been less prioritized in health service delivery and health service planning in Bangladesh since a long time. Due to many limitations (such as inadequate local expertise, knowledge and practice, lack of advocacy at policy level, absence of policy-guided strategy), Bangladesh has been taking some initiatives to strengthen mental health services at the community level. However, these previous initiatives did not translate into improvements in availability of and accessibility to mental health care, and did not have adequate funds allocated.

In 2018, Bangladesh passed the new Mental Health Act, which replaced the outdated 105-year-old Lunacy Act, 1912. The final draft of the National Mental Health Policy 2019 is under approval by the cabinet division which has directed the development of the current NMHSP 2020-2030 for achieving the objectives identified in the Policy. This NMHSP would allow the incorporation of required priorities of the government within the broader framework of the Policy including appropriate resource allocation. The NMHSP will identify cost-effective interventions and comprehensive strategies for mental health prevention, mental health promotion, treatment of mental disorders and rehabilitation by developing adequate and appropriate human resources to deliver mental health care services throughout the country.

3.2 Vision, mission, core principles

Vision: To ensure the mental health and psychosocial well-being of all people of Bangladesh.

Mission: To establish a sustainable, rights based, holistic, inclusive, multisectoral guidance to ensure provision of information and quality mental health services for promoting mental health and psychosocial well-being, prevention, treatment and rehabilitation of mental illness throughout the life course of the people of Bangladesh. The NMHSP will focus on a human rights based approach with a community based mental health model to ensure that services are most easily available and accessible where people reside. The model would require strengthening of the existing government system in health and other sectors; equity; gender equality; self-empowerment; community and family support; enhancement and use of existing resources; and participation of individuals with mental illness and their caregivers in the planning process. This will pave the pathway to reach the target of universal health coverage and achieving SDGs.

3.3 Core principles

The core values and principles of the NMHSP are guided by the National Mental Health Policy 2019, Mental Health Act 2018 and several global plans and charters including the WHO Mental Health Action Plan 2013-2020, United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care which have been ratified by Bangladesh.

- Universal health coverage: Mental health promotion and mental health services are considered essential to achieving universal health coverage. Quality mental health services should be accessible, available and affordable, and all efforts will be made to ensure parity between physical and mental health.

- Equity and justice: All efforts will be made to prevent discrimination of persons with mental health conditions and ensure equal opportunities for health, education, employment and housing services. Gender equity as well as cultural diversities will be ensured. There would be an equitable share of the national health budget, consistent with the burden of mental health issues. The poorest and vulnerable populations will get priority assistance.

- Rights based approach: Human rights and dignity of persons with mental health conditions will be respected, protected and promoted according to the Mental Health Act 2018 and National Mental Health Policy 2019. This NMHSP complies with the National Policy for Persons with Disabilities, the UN Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments to protect the rights, worth and dignity of people with mental health conditions and psychosocial disabilities.

- Evidence-based practice: Services and approach of delivery will be based on findings from research, evidence-based practices, best practices, as well as feedback from service providers and service users; care will be cost-effective and adapted to the cultural norms, values, and practices of Bangladesh.

- Life course needs: Services and information for mental health and psychosocial well-being will take into account the needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and old age.

- Multisectoral collaboration: The "whole-of-government, whole-of-society" approach will be the motto of the NMHSP and partnerships with other ministries, government departments, agencies both government and nongovernmental will be assured. Although the NMHSP will be led by the MoHFW and the Department of Noncommunicable Diseases, a coordinated approach that incorporates all sectors (education, employment, legal, housing, urban and rural planning, social safety nets, government planning, religion, child and women affairs, information and communications technology, sports, youth and cultural), as well as private and NGO sectors will be implemented.

- Empowerment and community participation: All resources and evidence-based interventions will be provided on a nonhospitalized, outpatient basis to ensure that those living with mental health conditions are living in their community and participating in all activities to their maximum potential in a safe and secure manner. All opportunities would be provided to those living with mental health conditions to enable access to awareness and advocacy efforts; retain their legal rights to parenting and property; and participate in national and local decision making as well as activities that affect their well-being.

- Integrated inter-sectorial care: Mental health support services will be provided through existing health care system platforms (primary to tertiary) and integrated into existing programmes, social safety net programmes as well as the education, socioeconomic and cultural services currently provided in the country for all citizens.

- Quality assurance: Mental health services will meet evidence-based quality standards with regular monitoring of checks and balances, and will be made accessible and available to all.

- Community based care: The primary focus will always prioritize ensuring that care is provided closest to the community in which the individual resides, with adequate support systems within community health and social safety net programmes.

3.4 Objective

The NMHSP aims to establish a comprehensive, inter-sectorial, integrated and responsive system to ensure access to and utilization of quality mental health and psychosocial well-being services and information. To this effect, four general objectives derived from the 'WHO Comprehensive Mental Health Action Plan 2013–2020' have been envisioned in the NMHSP. Notably, all 15 objectives embodied in the Bangladesh National Mental Health Policy 2019 are commensurate as seen in Table 2.

i. To strengthen effective leadership and governance for mental health.
ii. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
iii. To implement strategies for promotion and prevention in mental health.
iv. To strengthen information systems, evidence and research for mental health.

Table 2: Alignment between objectives of the WHO' Comprehensive mental health action plan 2013–2020 and Bangladesh National Mental Health Policy 2019

Objectives of the WHO Comprehensive mental health action plan 2013–2020*	Objectives of Bangladesh National Mental Health Policy 2019
i. To strengthen effective leadership and governance for mental health and well-being	i) Strengthen effective leadership and governance for mental health issues ix) Ensure the rights and protection of persons with mental health conditions xi) Ensure representation from various stakeholders xv) Establish a regulatory body for mental health professionals and services xvi) Address mental health in all policies to create environment of mental well being
i. To provide sustainable, comprehensive, integrated and responsive mental health and social care services in community-based setting	ii) Provide mental health care at all levels of the health care system (primary, secondary, tertiary) and facilitate access to and utilization of comprehensive mental health services by persons with mental health conditions, and increase access to mental health services for vulnerable groups based on the principles of universal health coverage iv) Support the recovery process of people suffering from mental health conditions through rehabilitation' v) Provide mental health and psychosocial support to survivors of disaster, trauma and humanitarian emergencies xvii) Ensure that adequate treatment options (medical and non-medical) are available in the health care service centres vi) Give special attention to children and adolescents with mental health conditions and neurodevelopmental disabilities vii) Enhance availability and equitable distribution of skilled human resources for better mental health x) Update the academic curriculum on mental health and substance abuse xii) Address substance abuse and addictive disorders xiv) Provide support services for caregivers of persons with mental health conditions through a multisectoral approach
i. To implement strategies for mental health promotion and risk reduction for mental health conditions	iii) Promote mental health, prevent mental health conditions and enhance awareness by reducing the stigma associated with mental health conditions xiii) Reduce risk and incidence of suicide and attempted suicide xviii) Promote socioemotional, communication and student centred learning development from early childhood
i. To strengthen information systems, monitoring and implementation research for mental health	viii) Promote evidence generation and research

The NMHSP envisions to achieve the 15 identified objectives of the National Mental Health Policy 2019 that are well aligned with the four broader objectives of the WHO Mental Health Action Plan 2013-2020 (refer to page 10, Mental Health Action Plan, 2013-2020). The detailed action plans to achieve these objectives as well as universal access to, and utilization of comprehensive and integrated quality mental health services across different levels of the health sector and other government and nongovernment sectors are presented below.

Bangladesh has endorsed the "National Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases 2018-2025". For successful implementation of the NMHSP, the NMNCC and subnational level committees were endorsed with gazette notification along with specific ToRs. This NMHSP will either be a part of the NCD multisectoral action plan and implemented by the NMNCC or implemented by a separate high-level steering committee with the health minister as the chair of the committee. It is noteworthy to mention that the MoHFW has developed and has been implementing the 'National Strategic Plan for Neurodevelopmental Disorders 2016-2021' to address objective six of the Mental Health Policy, i.e. "to give special attention to children and adolescents with mental health conditions and neurodevelopmental disabilities" (71).

The following section includes an action plan for the remaining 14 objectives. It starts with the mention of each general objective of WHO's Mental Health Action Plan 2013-2020 along with a table exhibiting global and Bangladesh-specific indicators and targets. Furthermore, the corresponding specific objectives under each of the general objectives are appended along with the action plan for each of the specific objectives, which encompasses columns on core responsibility, collaborative partners, advised activity, resources, output indicators and funding allocation. It is important to note that the concerned ministries/departments/stakeholders will be responsible for indicating the timeframe and funding allocation to perform these activities against each of the specific objectives of the NMHSP

GENERAL OBJECTIVE 1: TO STRENGTHEN EFFECTIVE LEADERSHIP AND GOVERNANCE FOR MENTAL HEALTH AND WELL-BEING

Effective leadership and governance for mental health will be ensured through a formal organogram and deployment of a dedicated Directorate of Mental Health within the DGHS to implement, coordinate and monitor services and programmes on mental health. Director, Mental Health and programme managers should have demonstrable academic qualifications and public health experience on mental health programming and management. As per Mental Health Act 2018, a District Mental Health Review and Monitoring Committee will be formed in every district. Monitoring of mental health activities will be strengthened at the division, district and Upazila levels as mentioned in the NMHSP.

Global and corresponding national targets for General Objective 1.

Global Target	Bangladesh Target
Global target 1.1: 80% of countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments (by the year 2020)	**National target 1.1:** National Mental Health Policy 2019 is currently under progress of approval by 2019, National Mental Health Strategic Plan will be developed and endorsed by the MoHFW by 2020

Global Target	Bangladesh Target
Global target 1.2: 50% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments (by the year 2020)	**National target 1.2:** Bangladesh has passed the new Mental Health Act 2018 which replaced the Indian Lunacy Act 1905. Regulatory rules development following the Mental Health Act 2018 is under progress. Neuro-Developmental Disability Protection Trust Act 2013 was also passed in the Parliament during 2013. In 2018, the Parliament adopted the National Rehabilitation Council Act.

There are five specific objectives under this general objective:

i) Strengthen effective leadership and governance for mental health and well-being
ii) Ensure the rights and protection of persons with mental health conditions
iii) Ensure representation from various stakeholders and coordination with NMNCC at all levels
iv) Establish a regulatory body for mental health professionals and services
v) Address mental health in all policies to create a mental health promoting environment

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
i) Strengthen effective leadership and governance for mental health and well-being	MoHFW	MoE MoSW MoWCA MoDMR MoHA Ministry of Public Administration (MoPA) Ministry of Finance (MoF) Programme management office	Establishment of a National Multisectoral Mental Health Coordination Committee (NMMHCC) for implementation and monitoring of the National Mental Health Strategic Plan 2020-2030, which will be formed from and be a part of the NMNCC		NMMHCC formed and gazette notification published Resolutions will be endorsed in NMNCC meetings	
	MoHFW	MoE MoSW MoWCA MoDRM MoHA MoF Programme management office	Sensitize national policy makers to mental health and human rights issues through the preparation of policy briefs and scientific publications, and the provision of leadership courses in mental health	Required	Preparation and publication of policy briefs; dissemination of relevant scientific publications; availability of leadership courses in mental health	GoB

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	Ministry of Planning (MoP)	MoHFW	Integrate actions and programmes for mental health and psychosocial support services in all government five-year plans	NA	Mental health aspects incorporated in 5th Five-year plan of GoB	NA
	MoHFW	WHO	A mental health secretariat established with defined organogram and ToR	Required	Functioning secretariat in place	GoB
	Secretary, Health Service Division, MoHFW	MoHFW	Create a position for Director, Mental Health and strengthen the capacity of the programme management office	NA	New position for Director, Mental Health under DGHS created and resumed office	NA
	DGHS, MoHFW		Develop organogram and ToR for the programme management team under Director, Mental Health. • Two deputy directors (DDs) DD1: Administrative and procurement DD2: Field operation and service delivery • Four additional directors (ADs) AD1 (Admin) General mental health services (adult mental health services): Multisectoral coordination, advocacy, governance, partnership and community mental health services AD2 (Research and training): Training, capacity building,	Required	New position created for two DDs, four ADs, eight medical officers, one epidemiologist and one statistician; eight support staff resumed office	GoB

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			monitoring, survey and research, mental health information system, digital platform for service, training, documentation and reporting AD3 (Communication and awareness building): SBCC, information, education and communication (IEC), communication, operation and logistics and procurement, Help-line, media including social media and content development AD4 (Special mental health issues and mental health in emergency): Adolescent mental health, school children mental health, elderly mental conditions, workplace/ occupational mental health, suicide prevention, substance use, early childhood development (ECD), autism, NDD and mental health in emergency • Line Director, Mental Health and ECD • Two programme managers (PMs) PM-1: One for logistics and procurement PM2: One for field operations and administration • Eight deputy programme managers (DPMs) (four under each PM, one of the		New line director, PM, DPM, medical officer, epidemiologist, statistician and support staffs for Mental Health secretariat under DGHS created and resumed office	GoB/Reimbursable Project Aid (RPA)/ Direct Project Aid (DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			eight DPM's will be assigned for mental health in emergency • Sixteen medical officers/two mental health officers with each DPM to facilitate specific activities assigned for the DPMs • Two senior psychologists • Four junior psychologists • Two psychiatric social workers • One epidemiologist • One statistician • One occupational therapist • Eight monitoring officers • Two psychiatric nurses • Two information technology officers • Twelve support staff • One AD for rehabilitation			
	DGHS, MoHFW	MoPA MoF	Strengthen supervision and monitoring of the mental health programme from the Office of the Divisional Director through assigning: One DD for mental health One AD for mental health	Required	i) DD and AD for mental health posts created and in place ii) ToR for DD and AD mental health approved and in place iii) Quarterly report from DD's office	GoB

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
					following prespecified checklist iv) Monitoring, incorporation and quality control of mental health data (conditions, gender, age and service accessed) in DHIS2 v) Regular reflection in divisional monthly meetings	
	MoHFW	MoF MoPA	Strengthen monitoring and supervision of the mental health programme from the civil surgeon's office by creating new post of one deputy civil surgeon for mental health	Required	New post of deputy civil surgeon for mental health created; and has resumed office	GoB/ RPA/ DPA
	DGHS, MoHFW		Create posts for two medical officers trained on mental health conditions Issue government orders to assign two medical officers at UHCs for mental health services* ** 85 days training on mental health by NIMH, NCDC, WHO* Training and capacity building of community health personnel, including nurses, health workers, teachers, social welfare workers, MoWCA officers, Upazila information officers, local	NA	i) Monthly monitoring report on availability and quality of mental health services including availability of psychotropic drugs ii) Uploaded mental health data in DHIS2, including types of intervention and referral iii) Mental health agenda in Upazila monthly meeting report	NA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	DGHS, MoHFW		government officer/representatives , religious leaders, NGO representatives, persons with lived experience (i.e. mental health condition) and their caregivers Formation of a Community Mental Health Team consisting of trained physicians, psychologists, including nurses, health workers, teachers, social welfare workers, MoWCA officers, Upazila information officers, local government officer/representatives , religious leaders, NGO representatives, persons with lived experience and their caregivers Ensure early childhood development monitoring; specifically, in the social, cognitive and language domains by the community health service delivery system (e.g. family welfare assistants/health assistants/CHCPs)	Required	iv) Creation of two posts for medical officers	GoB
ii) Ensure the rights and protection of persons with mental health conditions	MoHFW MoSW	Deputy Commissioner, NMNCC Civil surgeon Neuro-Developmental Disability Protection Trust Act, Ministry of Law, Justice and Parliamentary Affairs	Establish and ensure functionality of District 'Mental Health Review and Monitoring Committee (MHRMC)' which will be a part of the NMNCC and will report to divisional and district MNCCs in eight divisions and 64 districts as per composition and ToR mentioned in the	NA	District MHRMC formed in 64 districts (government order issued and published in gazette)	NA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
		(MoLJPA) Autism & NDD Cell Security and armed forces, and legislative bodies of the government	Mental Health Act 2018 and National Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases 2018-25 and Coordinator (NCD, Mental Health and Disability)			
			Conduct quarterly meetings (as per need) of MHRMC	Required	Minutes of quarterly MHMRC meeting	Gob/ RPA/ DPA
			Conduct quarterly monitoring visits to observe mental health service delivery at district level and below	Required (to be ear marked by relevant ministry)	MHRMC members are oriented annually	Gob/ RPA/ DPA
	MoLJPA and legislative bodies of the government	NIMH Civil society organizations Academia	Training on human rights, United Nations Convention on the Rights of Persons with Disabilities and national laws and policies related to disabilities including but not limited to persons with autism, NDDs, disabilities and mental health conditions; suicide prevention; substance use		Manual developed No. of batches trained	
	MoHFW	NMNCC NIMH	Encourage and support the formation of independent national and local organizations of people with mental disorders and psychosocial disabilities and their active involvement in the development and implementation of mental health policies, laws and services	NA	Involvement of national and local organizations of persons with mental health disorders in national level policy planning and implementation	

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	MoHFW	NMNCC NIMH	Involve people with mental health disorders and psychosocial disabilities in the inspection and monitoring of mental health services	Required	No. of persons with mental health disorders and psychosocial disabilities involved in the inspection and monitoring of mental health services	
	MoHFW	NMNCC NIMH	Include people with mental health disorders and psychosocial disabilities in the training of health workers delivering mental health care	Required	No. of persons with mental health disorders and psychosocial disabilities involved in the training of health workers delivering mental health care	NA
iii) Ensure representatio n from various stakeholders and coordination with NMNCC at all levels	MoHFW NMNCC		Incorporate strategic interventions on mental health from NMHSP 2020-2030 within the National Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases 2018–2025	NA	Mental health interventions of the NMHSP are included in the National Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases 2018-2025 including incorporation of mental health roles and responsibilities within national and subnational MNCC ToRs	NA
			Continuous follow up with divisional, district and Upazila levels by Mental Health Director's office in DGHS in collaboration with the NMNCC secretariat to ensure formation of a committee as per	NA	Functioning MNCCs at national, divisional, district and Upazila levels NMNCC meeting minutes and reports (monthly, three-monthly,	

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			approved ToR and government gazette		quarterly) including detailed mental health agendas	
			Organize MNCC at the divisional, district and Upazila levels as per approved ToR and ensure to include mental health as one of the priority agendas	Required	No. of mental health topics discussed in multisectoral committee meetings No. of agencies attending multisectoral meetings have work/action plan on mental health and or related activities	GoB/RPA /DPA
			Upload signed minutes of MNCC meeting in DHIS2/NCDC-DGHS website		No. of mental health agenda items in signed minutes of MNCC meeting	NA
	MoHFW	WHO United Nations Children's Fund (UNICEF)	4Ws (Who is Where, When, doing What) mapping of mental health and psychosocial support (MHPSS) service providers at all levels		National database of MHPSS service providers throughout the country	
iv) Establish a regulatory body for mental health professionals and services	BSMMU Bangladesh Medical and Dental Council (BMDC) Hospital and clinics, DGHS DNC, MoHA (Rehabilitation centre) BMDC Bangladesh Rehabilitation Council	Bangladesh Association of Psychiatrists (BAP) NIMH academic institutions	Criteria set by already existing regulatory bodies for mental health professionals, and services to be reviewed and updated Update school curriculum by including basic knowledge on mental health and key messages (modify/add a section on mental health and well-being in a chapter of school science books with age appropriate content)		Independent regulatory body/bodies for mental health professionals and services established and made functional for credentialing, registering and licensing	NA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	MoE MoPME MoDMR		Ensure proper mental health knowledge and skills among MBBS doctors by incorporating one board on psychiatry in the final professional examination Review the MBBS curriculum to incorporate more knowledge and skills among doctors about psychiatry and psychotherapy, including mental health Establish a separate discipline of psychiatry in the MBBS curriculum Establish regulatory body/bodies for mental health professionals and services (individual and institutions), sets standards for credentialing, registering and licensing As Bangladesh Rehabilitation Council Act 2018 has already defined some mental health professionals, ensure that the existing act does not contradict with this or be reviewed and updated accordinglyUpdate the disaster management protocol by including basic information on mental health, key messages and basic mental health interventions			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	MoHFW MoSW MoWCA MoPA MoF		Create posts and deploy registered mental health professionals including allied mental health professionals (speech, language, physical and occupational therapists as well as psychiatric nurses and social workers) at different levels of health and other sector ministries, such as MoE, MoWCA, MoSW, MoHA, MoDMR	Required	No. of posts created No. of professionals deployed	GoB/ RPA/ DPA
ii) Address mental health in all policies to create mental health promoting environment	MoHFW	Relevant ministry (NMNCC members)	Issue government orders from the Cabinet division/Prime Minister's Office to scrutinize all sectoral policies/strategies to include mental health	NA	Policy reviewed and mental health issues duly incorporated (if needed)	NA
	MoHFW	Relevant ministry (NMNCC members)	NMMHCC to form a subcommittee to scrutinize all sectoral policies/strategies to include mental health and psychosocial support	Required	A functional subcommittee is formed under the NMMHCC consisting of members from multiple ministries/divisions /agencies that scrutinized all sectoral policies/ strategies to include mental health disability	GoB/ RPA/ DPA

GENERAL OBJECTIVE 2: TO PROVIDE SUSTAINABLE, COMPREHENSIVE, INTEGRATED AND RESPONSIVE MENTAL HEALTH AND SOCIAL CARE SERVICES AT ALL LEVELS

Sustainable, comprehensive, integrated and responsive mental health/social care services would be provided. This would be ensured through a network of linked community-based mental health services that include increasing the coverage of evidence-based interventions that are responsive to the diverse needs of the Bangladeshi population,

short- and long-stay inpatient and outpatient care (in selected tertiary care hospitals, all public and private medical college hospitals, district hospitals, UHCs, primary health care settings including UHFWCs and community clinics), to support people with mental disorders living with their families. Both pharmacological and psychosocial interventions will be provided from GoB's health and other sectors as well as through the private sector.

Global and corresponding national targets for General Objective 2

Global Target	Bangladesh Target
Service coverage for severe mental disorders will have increased by 20% (by the year 2020)	Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-to-severe depression) who are using services increased by 25% by 2025 Proportion of district hospitals offering quality mental health services increased by 20% by 2025 Proportion of UHCs offering quality mental health services increased by 15% by 2025 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders increased by 20% by 2025*

*DNC, MoHA/DGHS, MoHFW/MoSW

There are ten specific objectives under this general objective:

i) Provide mental health care at all levels of the health care system (community, primary, secondary, tertiary) and facilitate access to and utilization of comprehensive mental health services by persons with mental health conditions, and increase access to mental health services for vulnerable groups according to universal health coverage.

ii) Support the recovery process of people suffering from mental health conditions through familial, social and institutional rehabilitation

iii) Provide mental health and psychosocial support to survivors of disaster, trauma and humanitarian emergencies

iv) Ensure availability of psychotropic drugs in the health care service centres

v) Give special attention to social-emotional and communication development in the early years, early childhood development [cognitive, language, student centred learning] to children and adolescents with mental health conditions and neurodevelopmental disabilities

vi) Enhance availability and equitable distribution of skilled human resources for quality mental health services

vii) Update the academic curriculum on mental health and substance abuse

viii) Address suicide, substance abuse and addictive disorders and their prevention, treatment and rehabilitation process

ix) Provide support services for caregivers of persons with mental health conditions through a multisectoral approach

x) Ensure comprehensive and integrated mental health services and psychosocial well-being at the workplace.

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
i) Provide mental health care at all levels of the health care system (community, primary, secondary, tertiary) and facilitate access to and utilization of comprehensive mental health services by persons with mental health conditions, and increase access to mental health services for vulnerable groups according to universal health coverage	MoHFW	MoF MoPA BCPS Dhaka University (DU) Local Government Engineering Department (LGED) MoYS	**Specialized hospitals/tertiary care hospitals** **Upgrade Pabna Mental Hospital as Pabna Mental Hospital and Training Institute** Establish residential training facilities for different short- and long-term training on mental health and psychosocial support services for mental health and allied service providers Renovate Pabna Mental Hospital into a long-stay and short-stay academic hospital and training centre with accommodation facilities for trainers and trainees Create posts of different specialties and subspecialties in psychiatry and psychology Manpower required: • One executive director in the rank of professor of psychiatry • Two joint directors in the rank of associate professor of psychiatry o Joint director hospital and community services o Joint director training, monitoring and research	Required	Posts created and human resources deployed in place No. of trainings conducted No. of patients admitted (mental health condition, age and gender based) No. of patients receiving outpatient services No. and type of cases referred to specialists or specialized centres	GoB

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Training: • Two training coordinators in the rank of associate professor of psychiatry • Four assistant training coordinators in the rank of assistant professor of psychiatry/psychology* • Eight MHPSS trainers specialized in psychiatry and or psychology • Two senior epidemiologists in the rank of assistant professor epidemiology • Two content specialists Pabna Mental Hospital service posts • Four senior consultants • Eight junior consultants • Four registrars • Eight assistant registrars • 16 medical officers • 16 psychiatric nurses or nurses trained in psychiatry** • Six psychologists • Speech and language therapists, occupational therapists, psychiatric/clinical social workers • Two epidemiologists			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			• Two statisticians • One information technology specialist/software specialist • Twenty-four support staff **Upgrade NIMH, Dhaka into a research and training institute** • Two training coordinators in the rank of associate professor of psychiatry • Four assistant training coordinators in the rank of assistant professor of psychiatry/psychology *** • Eight MHPSS trainers specialized in psychiatry and or psychology • Two senior epidemiologists in the rank of assistant professor epidemiology • Two epidemiologists • Two content development specialists • Two statisticians • One information technology specialist • One software developer for e-training modules and research application development			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			• Rapid response team with:**** o Six specialist psychiatrists and/or psychologists o Six mental health medical officers o Six psychiatric/clinical social workers o Six psychiatric nurses/nurses trained in psychiatry (training should include psychological first aid o Three counsellors/ communication specialists (ToR will define their education, skill, accreditation and job aid) o Nine support staff including driver Ensure provision of Day Hospital Unit for at least 10 patients **This team will provide emergency mental health and psychosocial services for different hospitals and service centres/prison/child-care settings and respond to different national emergency and disaster situations* *** For the emergency mental health and psychosocial services, all the team members need special training, such as in Psychological First Aid* **** Annual mental health bulletin* ***** Mental health journal and indexing*			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	DGHS, MoHFW	NIMH BAP Bangladesh Association for Child and Adolescent Mental Health (BACAMH) BCPS BECPS	**At medical college hospitals:** Establish full-fledged inpatient and outpatient mental health and psychosocial services through department of psychiatry composed of: o One professor of psychiatry o Two associate professors of psychiatry o One professor of child and adolescent psychiatry o One associate professor of child and adolescent psychiatry o One assistant professor of child and adolescent psychiatry o Three assistant professors of psychiatry o One registrar, o Two assistant registrars o Four indoor medical officers o Four outdoor medical officers o Four clinical psychologists o Four assistant psychologists/counsellors		No. of posts created Bed occupancy rate No. of patients treated Quality of service assessment through standard tools	GoB

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			o Two speech and language therapists o Two occupational therapists o Six trained mental health nurses/psychiatric nurses, Eight support staff Allocate beds for indoor mental health services at medical college hospitals: o Medical college hospital, indoor facilities in the psychiatry department o 12 beds for a 500-bedded hospital o 20 beds for a 1000-bedded hospital o 24 beds in the inpatient department for above 1000-bedded hospital Allocate five beds for outdoor (day-care services) mental health services at medical college hospitals: o Five beds for day hospital care, and counselling Establish settings, including technology and logistics, for group therapy and intervention			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	DGHS, MoHFW	NIMH BAP BACAMH BCPS BECPS	**At district hospitals:** Establish mental health unit in the inpatient and outpatient departments with: o One senior consultant in psychiatry o Two junior consultants in psychiatry o Two indoor medical officers in mental health o Two outdoor medical officers in mental health o Six psychologists/ counsellors o Six trained mental health nurses; three for inpatient and three for outpatient departments Establish an inpatient department comprising five beds Integrate treatment with incarceration of substance users and distributors for a comprehensive drug addiction plan in collaboration with the MoHA Establish a seclusion room for aggressive and delirious patients, medical officers, mental health clinical psychologists, counselling psychologists and trained mental health care nurses	NA	Posts created and personnel deployed No. of patients admitted Bed occupancy rate Assessment through service availability and readiness assessment tool and standard monitoring checklist	NA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	Ministry of Planning (MoP)	MoHFW	Each district hospital will have a mental health expert team consisting of mental health experts, rehabilitation experts, crisis interventionists, coordinators with community health workers (CHWs), and a mechanism to coordinate with other associated departments at the district hospital	NA	Mental health aspects incorporated in 5th Five-year plan of GoB	NA
			At the civil surgeon's office: o One deputy civil surgeon (for mental health) o One medical officer in mental health as mental health coordinator		Posts created and reporting on district level mental health activity begun	
			At Upazila level hospitals: o Two medical officers for mental health o Two psychologists/counsellors o Two nurses trained in mental health Provide training in mental health and psychosocial services for junior consultants in medicine, pediatrics, gynecology and obstetrics, as well as surgery		No. of posts created and personnel deployed No. of personnel trained	

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			At union level health facilities: o SACMOs/family welfare assistants trained in MHPSS o Two community mental health service organizers (psychology/social science based) trained in MHPSS and Psychological First Aid Train Girls Guides and Boy Scouts in MHPSS Promote mental health, preventive activity, awareness creation, screening, identification, referral and reporting through ECD monitoring, parenting skill training programme, geriatric mental health care, and collaboration with schools in community mental health activities and suicide prevention			
		NIMH	**At community and field level:** o Orient and train CHCPs, health assistants, health inspectors, family welfare assistants, and MHVs in mental health o Promote mental health, SBCC, preventive activity, awareness creation, screening, identification, referral and reporting through ECD monitoring, care			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			of children with NDDs, parenting skill training programme, geriatric mental health care, collaboration with schools and community mental health activities, documentation and reporting			
	DGHS, MoHFW	NIMH BAP BACAMH BCPS BECPS Bangladesh Pediatric Association (BPA) Expert organizations with proven experience	Develop standard operating procedures (SOPs) for mental health service delivery for different types of mental health service providers including pharmacological and nonpharmacological interventions from medical college hospitals and district hospitals, following internationally recognized research-based criteria (such as ICD and Diagnostic and Statistical Manual of Mental Disorders (DSM-5)	Required	SOPs for mental health developed on pharmacological and nonpharmacological interventions to be delivered from medical college hospitals and district hospitals	GoB/RPA /DPA
	DGHS, MoHFW	NIMH BAP BACAMH BCPS BECPS Access to Information (a2i) programme Expert organizations with proven experience	Develop/update training modules for different types of mental health service providers E-training with multi-modal methods using the digital platform and development of e-learning modules on geriatric mental health, substance use disorder, child and adolescent mental health, mental health of women, perinatal mental health	Required	Comprehensive mental health training modules both printed and e-versions developed or updated for different types of mental health service providers at medical college hospitals and district hospitals Digital/online training platforms with competency assessment for	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			care, suicide prevention, ECD		skill based mental health training developed or updated for different types of mental health service providers at medical college hospitals and district hospitals	
			Update existing training materials Develop guidelines and SOPs (covering a one-year period) for all levels of mental health services			
	DGHS, MoHFW	NIMH BAP BACAMH BCPS	Establish inpatient, outpatient and community-based services through psychiatry and clinical psychology departments in all private medical college hospitals with necessary human resources, beds and equipment as per guidelines and SOPs		No. of private hospitals and clinics with outpatient and community based and psychiatry and clinical psychology unit as per SOPs (50% by 2025)	GoB/RPA /DPA **GoB will incentivize the private sector and funds allocated will be monitored and evaluated for transparency*
		NCDC HSM, DGHS Expert organizations with proven experience BAP BACAMH BCPS BECPS	Undertake independent evaluation of SBK using standard validated tools (service availability and readiness assessment) to re-design the programme as per the findings/situation analysis	Required	Evaluation of SBK programme executed, report disseminated and SBK programme redesigned	GoB/RPA /DPA
			Develop SOPs for SBK or recommendation to integrate the services in the proposed mental health service model (as proposed in the NMHSP)	Required	SOPs for SBK developed, approved and disseminated	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Ensure physical set up of SBK by HSM, DGHS and coordination and integration of SBK services to mental health services and services provided by MoSW and or MoWCA	Yes	HSM, DGHS ensured physical set up of all SBKs	GoB/RPA /DPA
			Monitor programmatic aspect of SBK by NCDC/mental health programme of DGHS	Required	Reports on quarterly monitoring visits of SBKs by PM/DPM of NCDC/mental health programme of DGHS	GoB/RPA /DPA
			Undertake necessary administrative process to ensure funding for SBKs from review budget including salary and benefits for staff	Required	SBK programme (human resources, commodities, infrastructure) funded from review budget and reflected in NCDC operational plan, HPNSP	GoB/RPA
			Undertake nationwide mapping for SBKs to establish them in all strategic locations of the country (district hospitals, public and private medical college hospitals) as per national guidelines/SOPs	Required	Mapping exercise on SBKs conducted as recommended nationwide with equitable coverage of SBK	GoB/RPA /DPA
			Establish SBKs in all district hospitals/ medical college hospitals/other facility as per mapping and SOPs Incorporate all SBKs into planned mental health services in collaboration with Maternal, Neonatal and Child Health (MNCH) and absorb existing human resources within the new system	Required	SBKs set up in the entire country as per mapping and SOPs	GoB

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
Community Based Mental Health Care	DGHS	DGHS NIMH Community Based Health Care (CBHC) NIMH WHO BAP BACAMH BCPS BECPS Expert organizations with proven experience	Develop SOPs for community-/primary health care-based mental health services from UHC, UHFWC, community centres and the community	Required	SOPs on community-/primary health care-based mental health services developed and endorsed	GoB
			Update/develop/ harmonize competency-based training modules (both printed and e-versions) Develop digital/ web-based learning platform for the same content for community-/primary health care-based mental health services (pharmacological and nonpharmacological) for UHCs, UHFWCs, community centres and the community	Required	No. of training modules for community-/primary health care-based mental health services for UHC, UHFWC, community centres and home Applications/digital/web-based learning platforms with pre-specified competency check for community/primary health care compliant mental health services (pharmacological and nonpharmacological) for UHCs, UHFWCs, community centres and the community	GoB
			Provide training for medical officers, senior staff nurses, SACMOs, family welfare visitors, CHCPs, health assistants and family welfare assistants, MHVs, NGO-CHWs	Required	No. of frontline staff trained on mental health and passed the competency test	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	DGHS	NIMH HSM/BAP WHO a2i Ministry of Information (MoI) Expert organizations with proven experience	Develop an electronic register to create, record and report mental health profiles of the population Develop standard identification, treatment and counselling protocols for common mental conditions Develop referral and back-referral guidelines, and establish referral systems between primary, secondary and tertiary health care levels	Required	Electronic database established Availability of identification and management guidelines on mental health Availability of referral guidelines on mental health	GoB/RPA /DPA
	DGHS	NIMH NCDC a2i Shuchona BAP BACAMH CBHC DGHS BCPS BECPS	Develop orientation modules (print, e-version, app-based) for CHWs and MHVs to carry out domiciliary follow-up service of people with mental health conditions	Required	Availability of Orientation module (print, e-version, apps based) for CHWs and MHVs to carry out domiciliary follow up of people with mental health conditions	GoB/RPA /DPA
			Orient CHWs and MHVs to carry out domiciliary follow up service for mental health conditions	Required	No. of CHWs and MHVs to carry out domiciliary follow up of people with mental health conditions	GoB/RPA /DPA
			Domiciliary follow up service of people with medical health conditions, CHWs and MHVs	Required	No. of persons having mental illness visited by CHWs/MHVs	GoB/RPA /DPA
	DGHS	NMNCC members Department of Primary and	Establish interdisciplinary community mental health teams (health, education, women	Required	Guidelines and tools developed Guidelines and tools implemented	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
		Mass Education MoE LGED	affairs, social welfare, LGED) deploying members from MNCC at district and Upazila levels to provide tailored mental health and social support for people with mental disorders and their families/caregivers in the community by developing guidelines, collaborative mechanisms, assessment tools and reporting tools for managing cases To collaborate with MoWCA for the mental health and psychosocial support for gender-based violence. Mental health fair held once a year for mental health promotion and prevention			
	Service delivery through other sectors (MoE, MoPME, MoWCA, MoSW)					
	MoE		o One education/school psychologist/school counsellor at each Upazila o Two teachers (preferably one male and one female) trained on MHPSS at each school; the number of teachers trained should be based on the number of students **Administrative accountability at each Upazila:** The psychologist/ school counsellor will			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			work in collaboration with the Upazila Education Office At city corporation and divisional headquarters and district headquarters, the psychologist/ school counsellor will be deployed according to the requirements of schools Identify technical supervisors (i.e., with relevant expertise; this can be done by academic institutes) for psychologists in schools Establish school mental health/ psychosocial services with the help of education officers, psychologists/school counsellors (the job aid and training needs will be defined) Establish mental health services in tertiary education (such as at university, college) Ensure referral to MoHFW and also training and report sharing **Administrative accountability to MoE/MoPME officers:** Emphasize psychosocial/mental well-being for nonformal education, marginalized children, orphanages, NGO-run schools, religious			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			institutes, shelter homes Develop guidelines for mental health care in those settings and deploy psychologists			
			Ensure mental health and behavioural services coordination and governance at division and district level schools			
	MoSW MoWCA	DGHS BCPS BAP	Strengthen and maintain RTCC at medical college hospitals to provide quality psychotherapy to those in need, children and adolescents; gradually expand services to the adult population	Required	Record of gender, ages and kind of issues, diagnosis received, interventions provided including follow-up and management plan	Developme nt/revenue budget of MoWCA, MoSW
			Ensure that posts of one trained psychologist and one psychosocial counsellor in eight medical college hospitals are funded from revenue budget for sustainability	Required	16 clinical psychologists and counsellor posts are funded from revenue budget	Revenue budget of MoWCA, MoSW
		DGHS	Conduct regular liaison for service coordination between the psychiatry department of the medical college hospital and RTCC of MoWCA	Required	Service coordination between the psychiatry department of the medical college hospital and RTCC of MoWCA discussed in NMNCC	NA
		DGHS BCPS BECPS	Standardize training for the operators to improve the quality of initial crisis support to	Required	No. of call operators trained in online counselling/	Developme nt/revenue budget of MoWCA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			mentally vulnerable people through the "RTCC Call Centre"of MoWCA		Psychological First Aid and referral	
	MoWCA	DGHS NGOs CBOs WHO	Develop modules, guidelines and SOPs for an organized mental health/psychosocial support team through public–private partnership Form an organized mental health psychosocial support team through public–private partnership	Required	Modules, guidelines and SOPs for the organized mental health psychosocial support team through public–private partnership developed and in operation Record of those who have received services	From respective governmen t and nongovern ment agencies
	MoSW	DGHS BECPS BCPS WHO	Conduct 4Ws service mapping and undertake independent reviews of the current situation of psychosocial support/counselling in all MoSW-supported institutions	Required	Four W service mapping in place and continuous updating Review report	Developme nt / revenue budget of MoSW
			Recruit psychologists/ counsellors (male and female) in all (now 95) MoSW-supported institutions with well-defined job descriptions, as per recommendations from the assessment • Update and scale up child/adolescent development centres (former juvenile jail) as child/adolescent development support and training centres • Update and scale up training and rehabilitation centres	Required	Psychologist/coun sellor (male and female) posts created and recruitments done for all MoSW-supported institutions	Developme nt / revenue budget of MoSW

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			for mentally disabled children • Fix standard criteria and strengthen all Shishu Paribars			
			Provide training and refresher courses to psychologists to render quality psychotherapy to various categories of children/adolescents		No. of staff being trained on psychotherapy/ supportive counselling Fix standard criteria for service settings of and service delivery at Shishu Paribars	Developme nt / revenue budget of MoSW
			Provide quality psychotherapy or counselling to children/adolescents who reside in MoSW-supported institutions	Required	No. receiving counselling/ psychotherapy (by gender, type of therapy and consistency in treatment participation) *Care needs to be taken so that recurring care receivers are not counted as new clients but recurring clients*	Developme nt / revenue budget of MoSW
	Design and implement e-mental health services in a primary health care setting through direct web-based consultation/video conference					
	DGHS	NIMH BAP BACAMH BCPS MIS WHO	Integrate mental health in the MoHFW/WHO digital health strategy Strengthen existing tele-counselling/ tele-medicine/emotio nal support helplines/suicide prevention helplines in collaboration with the government	Required	Mental health addressed and incorporated in the WHO digital health strategy	GoB/ RPA/DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Design an innovative e-mental health services model through public–private partnership (integrate mental health/ Psychological First Aid with existing health services)		e-mental health services model developed	
			Provide quality e-mental health services via e-learning platforms for capacity building		No. receiving online counselling/ psychotherapy/ Psychological First Aid	
ii) Support the recovery process of people suffering from mental health conditions through familial, social and institutional rehabilitation	DGHS NMNCC	Relevant government organizations and NGO entities (such as Centre for the Rehabilitation of the Paralysed (CRP))	Strengthen and expand rehabilitation services through government (i.e. social welfare, home affairs) and private sectors (i.e. CRP) and establish linkages with social protection schemes	Required		Relevant ministries
	DGHS NMNCC	Focal points from relevant ministries under NMNCC	Review existing social protection schemes to support rehabilitation and advocate with relevant ministries to include people with mental illnesses as beneficiaries in social protection schemes to support rehabilitation	Required	No. of people with mental health conditions receiving support from social protection schemes to support rehabilitation	GoB/ RPA/ DPA
	Neuro-Developmental Disability Protection Trust, MoSW	MoHFW NMNCC	Strengthen the Neuro-Developmental Disability Protection Trust initiative to create job opportunities for people with mental illnesses in collaboration with International Labour Organization and private sectors	Required	No. of jobs created for people with NDDs	Neuro-Developmental Disability Protection Trust, MoSW revenue/ development budget

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	MoHFW	Expert organizations with proven expertise Community based organizations Narcotics/ Alcohol Anonymous	Conduct parental training and establish self-help groups Develop modules/ guidelines/ SOPs for parental training and self-help groups Conduct awareness building programmes Raise awareness on the benefits of reintegration into the workplace	Required	No. of trainings organized for parents No. of self-help groups established	GoB/RPA/ PA
	MoHFW	NMNCC members MoYS IOM	Promote mental health promotion and risk reduction as well as protective activities (such as entertainment/ hobby/job/ sports) through relevant sectors to prevent relapse of mental health conditions	Required	No. of initiatives by other sectors to promote mental health and prevent relapse of mental health conditions established	GoB/RPA/ PA
iii) Provide mental health and psychosocial support to survivors of disaster, trauma and humanitarian emergencies	MoDM	MoHFW WHO United Nations Refugee Agency (UNHCR) Expert organizations with proven experience IOM	Institutionalize MHPSS and Psychological First Aid in all emergencies and national disaster management and planning during preparedness, response and recovery phases	NA	MHPSS institutionalized in all emergencies and national disaster management and planning	NA
			Incorporation of MHPSS in its disaster management policy, plans and programmes by the national disaster management authority in collaboration with MoHFW	NA	MHPSS incorporated in disaster management policy, plans and programmes	NA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Build capacity of crisis responders through the CPMMH training (training-of-trainers, master training, advanced training, foundation training) as per approved training module Specify criteria for selecting a trainee	Required	No. of persons receiving training for crisis responders, foundation training, advanced training and master training on CPMMH	Revenue/ developme nt budget of MoDM
			Maintain database of crisis responders, team leaders and crisis management as per agreed template of MoDMR	NA	Database of crisis responders, team leaders and crisis management developed and updated	NA
iv) Ensure availability of psychotropic drugs in the health care service centres	DGHS	Directorate General of Drug Administration MoHFW WHO NIMH BAP	Prepare a list of essential psychotropic drugs/name of generic psychotropic drugs in accordance with international guidelines (WHO model list of essential medicines and WHO mhGAP Intervention Guide)	Required	List of essential psychotropic drugs prepared	GoB/RPA/ DPA
			Include essential psychotropic drugs in the essential medicines list	Required	Reports on psychotropic medicine availability in DHIS2	GoB/RPA/ DPA
			Forecast/project regular procurement and supply of psychotropic drugs, for targeted facilities Ensure supply of psychotropic drugs at primary, secondary and tertiary level of health care services	Required	Medicine audit report including that of psychotropic drugs prepared	GoB/RPA/ DPA
			Document and report to the Logistics Management	Required		GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Information System of the DGHS on availability (and shortages) of necessary medicines for mental disorders			
v) Give special attention to social-emotional and communication development in the early years, early childhood development [cognitive, language student centred learning] to children and adolescents with mental health conditions and neurodevelop mental disabilities	DGHS	MoE MoPME Shuchona BACAMH BCPS BECPS	To address autism and other NDDs: Refer to the National Strategic Plan for NDDs (NSPNDD) 2016-2021 for a detailed action plan.	Required	NA	GoB/RPA/DPA from MoHFW and relevant ministries as per NSPNDD 2016-2021
			Develop, endorse, implement and monitor strategic plan on childhood and adolescent nonNDD mental health issues including process addiction, behavioural addiction, mental health in school, self-harm/suicide prevention, and responsible use of the Internet	Required	Strategic plan developed and endorsed on nonNDD mental health issues including process addiction, behavioural addiction, mental health in school, self-harm/suicide prevention, and responsible use of the Internet	GoB/RPA/DPA
vi) Enhance availability and equitable distribution of skilled human resources for quality mental health services	MoHFW	MoWCA MoSW MoE MoPME MoPA MoF	Estimate mental health care workforce needs and implement a strategy for developing and retaining human resources Build capacity to deliver mental health and psychological services in community clinics, UHFWCs, UHCs, district hospitals and tertiary hospitals	Required	Projection for mental health workforce needs undertaken Strategy/SOPs for deployment, retention and capacity building for mental health service delivery within the health sector workforce developed and implemented	GoB/DPA/RPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	MoHFW	MoWCA MoSW MoE MoPME	Develop and implement a strategy for projection of mental health care workforce, building and retaining human resource capacity to deliver mental health and psychological services through nonhealth sectors (such as MoE,MoWCA, MoHA, MoSW)	Required	Strategy for capacity building, deployment and retention of mental health workforce through nonhealth sectors (such as MoE, MoPME, MoWCA, MoSW) developed and implemented	GoB/RPA/ DPA of MoHFW and relevant ministries
			Develop clear job descriptions for all workforce categories providing psychosocial well-being services including clear guidance on authorities of scopes of practice (such as screening, diagnosis, treatment, prescribing)	Required	Job description for all mental health workforce categories including regular competency checks available	GoB/RPA/ DPA
			Develop human resource development plan, with clear guidance on recruitment, hiring and deployment processes and career development opportunities for psychiatrists and other mental health workforce	Required	Guideline on recruitment, hiring and deployment processes and career development opportunities for psychiatrists and other mental health workforce in place	GoB/RPA/ DPA of MoHFW and relevant ministries
	MoHFW	MoPA MoF	Recruit and deploy newly created positions One psychiatrist each at district hospitals Psychologists, social-workers at medical college hospitals and district hospitals	Required	One psychiatrist at each district hospital; psychologists and social workers at medical college hospitals and district hospitals; occupational therapist at medical college hospitals;	GoB/RPA/ DPA of MoHFW and relevant ministries

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Occupational therapists at medical college hospitals Counselling psychologists/social workers at UHCs as per the human resources strategy Design and implement courses for occupational therapy		counselling psychologists/social workers at UHCs are recruited and deployed as per the human resources strategy on mental health	
	MoHFW	BAP BCPS BECPS BSMMU University of Dhaka (DU) Medical college hospital Public universities	Develop/update training modules/ materials for training of nonspecialist health workers, and nonhealth workers (such as social workers, teachers, families, community members) including for nongovernment service providers to meet the expected standards and comply with regulations	Required	Training modules/ materials for training of nonspecialist health workers, and nonhealth workers (such as social workers, teachers, families, community members) including for nongovernment service providers developed	GoB/RPA/ DPA
			Develop or update the training module to train primary health care workers, general physicians, nurses, subassistant community medical officers, community health care providers	Required	Training module to train primary health care workers, general physicians, nurses, subassistant community medical officers, community health care providers developed	GoB/RPA/ DPA
			Strengthen the capacity of NIMH and BSMMU and DU as centres of excellence (for human resources, budget, logistics and supplies)	Required	NIMH, BSMMU and DU strengthened as centres of excellence as per WHO and global standards	GoB/RPA/ DPA
			Establish regional resource hubs in eight divisional medical	Required	Regional resource hubs established in eight divisional	GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			college hospitals and public universities to decentralize capacity building on mental health		medical college hospitals and public universities to decentralize capacity building on mental health	
			Emphasize on professional ethics and required supervision through continuous professional development Develop an accreditation board for academic and clinical programmes: • Licensure from accredited institutions • Programme and course evaluations • Integration of existing academic associations • Grandfathering Prepare guidelines for supervision of private practitioners and NGO workers who are providing mental health services			
vii) Update the academic curriculum on mental health and substance abuse	MoHFW MoHFW MoE	BMDC BCPS NIMH CME (Center for Medical Education) BMDC BSMMU DNC	Address, reinforce and update mental health content of undergraduate medical curriculum (MBBS, nursing), including substance dependence issues as a major subject of medicine in the undergraduate medical curriculum and increase clinical placement for students and intern doctors		Specialized curriculum on mental health, substance dependence and addiction in psychiatry programmes incorporated in undergraduate medical curriculum (MBBS)	

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
		BCPS BPA BECPS DU Other public universities	Review the undergraduate medical curriculum with special emphasis on mental health and behavioural sciences Ensure one mandatory board on psychiatry and behavioural science in final professional examination			
			Review, update and standardize postgraduate curriculum on fellowship (MD, FCPS) along with increasing the number of postgraduate training institutions	Required	MD and FCPS curriculum reviewed, updated and standardized as per WHO standard Record and registration of institutions providing postgraduation (MD/FCPS) increased	GoB/RPA/ DPA
			Design and implement diploma course on psychiatry including substance use and an academic course on psychiatric nursing along with increasing the number of postgraduate institutions	Required	One-year diploma course on substance dependence treatment specialization for mental health experts in place Academic courses for nurses on mental health designed and implemented	GoB/RPA/ DPA
			Review, update and standardize the curriculum and ensure that it is inclusive of mental health and psychosocial support for clinical, education and counselling psychology,	Required	Curriculum of psychology, clinical, education and counselling psychology, industrial and organizational psychology as well	GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			as well as clinical social work and increase the number of faculties to meet the target of mental health workforce for Bangladesh Designated ministries should suggest a competency framework		as clinical social work reviewed and standardized	
viii) Address substance abuse and addictive disorders and their prevention, treatment and rehabilitation process	NDC, MoHA	DGHS	Establish/revitalize the Steering Committee with MoHFW, MoHA, MoSW, MoWCA, MoE, MoHA to coordinate multisectoral activities on harm reduction, demand reduction and supply reduction of substance	Required	Bi-annual meeting of the Steering Committee held with relevant ministries to coordinate multisectoral activities on harm reduction, demand reduction and supply reduction of substance	GoB/ RPA/DPA of NDC, MoHA
	NDC, MoHA	DGHS BAP BACAMH BCPS NIMH BSMMU NGOs	Include psychiatrists and psychologists in the Narcotic Control Board Review of Narcotics Control Act 2018 and rules by various professional societies to ensure standard assessment, re-assessment, detoxification, drug addiction treatment and rehabilitation centre, therapeutic community and proper licensing of private facilities	Required	Narcotics Control Act 2018 reviewed and rules revised and updated by different professional societies to ensure standard assessment, treatment and rehabilitation	GoB/ RPA/DPA of NDC, MoHA
	DGHS	NDC, MoHA BAP BCPS	Develop national SOPs for drug addiction treatment/ rehabilitation centre (ratio of human	Required	National SOPs developed for drug addiction treatment/ rehabilitation	GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
	DGHS, MoHFW	BECPS NGOs	resources - psychologists, psychiatrists; and number of beds) and national training module for both public and private facilities		centre (ratio of human resources - psychologists, psychiatrists; and number of beds) and national training module for both public and private facilities	
			Develop national treatment guidelines on drug addiction, including referral protocol Ensure that it aligns with the mhGAP Intervention Guide – Bangladesh version (substance abuse)	Required	National treatment guidelines on drug addiction including referral protocol developed and disseminated	GoB/RPA/ DPA
			Training of service providers/counsellors/ psychologists of all public and private treatment and rehabilitation centres			
	NDC, MoHA	DGHS, MoHFW	Strengthen and expand treatment and rehabilitation centres at national and subnational levels for drug addicts following SOPs in collaboration with MoHA and MoHFW	Required	Treatment and rehabilitation centres at national and subnational levels for drug addicts following SOPs strengthened and expanded	GoB/RPA/ DPA
	NDC, MoHA	DGHS	Conduct regular supervision and monitoring from health authority to ensure compliance to SOPs (human resources, bed, treatment protocol) Emphasize monitoring for humane treatment of rehabilitation centre	Required	Joint supervision and monitoring of DGHS and NDC conducted to ensure compliance to SOPs (human resources, bed, treatment protocol)	GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			patients and establish a mechanism for reporting of malpractice			
	NDC, MoHA	DGHS	Undertake regular research on substance use disorders in Bangladesh	Required	Record of research on types of substance dependence services being sought, by whom (age, gender and socioeconomic status) and by type of substance (including alcohol)	GoB/RPA/ DPA
	DGHS	NIMH BAP BACAMH	Establish and ensure outdoor and indoor services for substance users in all public and private medical college hospitals, district hospitals and outdoor services in all UHCs	Required	Record of individuals receiving services to reduce substance dependence services from medical college hospitals, district hospitals and UHCs (data disaggregated by type of facility, age, sex)	GoB/RPA/ DPA
ix) Provide support services for caregivers of persons with mental health conditions through a multisectoral approach	DGHS	BCPS BECPS Expert organizations with proven experience	Develop guidelines/ orientation modules for caregivers of persons with mental health conditions (Care Companion Program)	Required	Guideline and training module for caregivers of persons with mental health conditions (Care Companion Program) developed and disseminated to stakeholders	GoB/RPA/ DPA
	DGHS MoWCA	DGHS	Provide special services to (pharmacological and nonpharmacological/ counselling) caregivers of persons with mental	Required	Record of persons accessing mental health services (data disaggregated by age, gender and	GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			health conditions through health facilities and MoWCA		type of services recommended and accessed)	
	MoWCA MoSW	MoLG MoHFW	Provide financial support/free-of-cost medicines through social protection scheme of MoWCA, MoSW (Hospital Social Welfare) and other ministries	Required	No. of persons with mental health conditions who received social protection services	GoB/RPA/ DPA
Ensure comprehensive and integrated mental health services and psychosocial well-being at workplace			Incorporate industrial/ organizational psychology/workplace psychology into national mental health policies and mental health service plan Recruit industrial and organizational psychology workforce in government and public–private industries/workplaces Provide training and courses for strengthening mental health service for preventing mental health risk related to workplace environment Establish employee assistanceship programme for organizations through industrial/organization al psychologists Strengthen capacity of industrial/organization al psychologists on providing psychometric assessment to organizations Incorporate artificial intelligence and			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			behavioural insights to provide comprehensive mental health services Develop guidelines and training manuals for mental health services and well-being promotion at the workplace Develop guidelines for inclusive workplaces			

GENERAL OBJECTIVE 3: TO IMPLEMENT STRATEGIES FOR MENTAL HEALTH PROMOTION AND RISK REDUCTION FOR MENTAL HEALTH CONDITIONS

Mental health promotion and risk reduction can be ensured by leading and coordinating a multisectoral strategy that combines universal and targeted interventions for promoting psychosocial well-being and preventing mental health conditions as well as reducing discrimination and human rights violations, inclusive of specific vulnerable groups across the lifespan. In addition to the recommended strategic priorities to promote psychosocial health among the general population mentioned below, it aims to reduce stigma and raise awareness in enabling access to accurate information and quality mental health services. There is an urgent need to work with medical practitioners, the education sector as well in the workplace to eliminate stigma and create a supportive environment.

Global and corresponding national targets for General Objective 3:

Global Target	Bangladesh Target
80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).	Two functioning programmes of multisectoral mental health promotion and prevention launched by 2025
Reduce suicide mortality rate by 10% by 2030	Reduce suicide mortality rate by 5% by 2025

The four specific objectives under this general objective which are stated below:

i) Promote psychosocial well-being, prevent untreated mental health conditions, as well as enhance awareness among families and communities to increase health seeking behaviours and reduce stigma associated with mental health conditions.

ii) Reduce risk and incidence of suicides and attempted suicides by increasing community awareness and vigilance for help-seeking behaviour.

iii) Promote socio-emotional communication development during early childhood and positive parenting skills (reduce physical punishment in homes and schools).

iv) Reduce domestic violence, substance and nonsubstance use addictive behaviours (mobile, virtual and internet addiction).

Detailed actions to achieve each of the above specific objectives are presented below. Concerned ministries/departments/stakeholders will include the time-frame, funding allocation and target population and prepare a detailed micro plan to realize these activities against each of the specific objectives.

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
i) Promote psychosocial well-being, prevent untreated mental health conditions, as well as enhance awareness among families and communities to increase health seeking behaviours and reduce stigma associated with mental health conditions	DGHS, MoHFW	MoI NMNCC WHO UNICEF a2i BAP BACAMH BCPS BECPS BHE IEM Behaviour Change Communication Working Group MoWCA MoPME MoE BMDC Bangladesh Clinical Social Worker's Association (BCSWA) LGRD National Institute of Local Government MoHA MoSW	Develop specific guidelines to promote and prevent mental health in different sectors such as workplace, educational institute, prison, juvenile correctional institution Conduct issue-based research (baseline and impact analysis) Select target groups focusing on child, women, vulnerable groups, the elderly and persons with disabilities Develop appropriate materials on mental health, based on community needs, and implement in collaboration with trained professionals, the local government and stakeholders for community engagement Promote mental health in prisons and juvenile correction institutions by appointing appropriately trained mental health workers Identify and screen vulnerable populations (before they fall into the criminal system) who are prone to social violence (individual, group and community violence) and provide appropriate services for them	Required	Communication (SBCC) consultant/ communication agency hired Social and behavioural change campaign to promote psychosocial well-being designed, implemented and monitored on social media platforms, television spots, e-toolkit etc. in place and operational	GoB/ RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Adopt national strategies of preventing adverse childhood experiences Teachers' training at schools on mental health literacy Maternal Mental Health Literacy training for midwifery nurses and relevant personnel Hire communication (SBCC) consultant/communication agency and mental health expert to design the campaign in line with Comprehensive SBCC Strategy for Mental Health and Health sector (http://etoolkits.dghs.gov.bd/toolkits/bangladesh-program-managers/comprehensive-sbcc-strategy)			
			Collate and review existing SBCC materials, campaigns, programmes and materials (print, online, and electronic media, social media) on mental health and psychosocial well-being			
			Organize workshops with communication experts/agencies to identify mediums and messages (social media, podcast, e-toolkit, television spots, radio spots, jingles) as well as potential partners for sensitization and stigma reduction			

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Design, implement and monitor multisectoral social and behavioural change campaign to promote psychosocial well-being, create awareness and reduce stigma in the community	Required		
			Graphic design, printing or multiplication and distribution of IEC materials including job aids	Required	IEC materials, television/radio spots, soap operas, jingles and podcasts developed, distributed and broadcasted/posted in mass and social media	GoB/ RPA/ DPA
			Produce and broadcast mass media campaigns on social media	Required		GoB/ RPA/ DPA
			Monitor mass media campaigns and measure impact on stigma, knowledge and behaviours Design a national suicide prevention programme Advocate on gradual decriminalization of suicidal attempts by amendment of the Bangladesh Penal Code Make amendments to the Mental Health Act relating to: • violation of persons with mental health conditions in the workplace/school/ home • inclusion of promotion and prevention of mental health in the Act	Required		GoB/ RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			• ensuring nondisclosure rights for mental health professionals so that they can maintain patient confidentiality			
		BAP BACAMH BCPS BECPS	Develop orientation modules (print/e-book/apps/digital learning platforms) and video content to sensitize and build capacity of the health service providers (specialists, general practitioners, nurses, paramedics, CHWs) on mental health and psychosocial well-being, counselling, screening and referral	Required	Availability of orientation module (printed/e-book/apps/digital learning platform) for health service providers Record of number and frequency of health workers who receive the orientation	GoB/RPA /DPA
			Develop orientation modules (print/e-book/apps/digital learning platforms) and video content, to sensitize and build capacity of nonhealth service providers (such as teachers, social workers, journalists) on mental health and psychosocial well-being, counselling, communication, self-esteem, motivation, coping skills, social skills, parenting strategies for children with mental health conditions and disabilities, etc. Skill development of nonhealth service professionals (such as teachers, social workers, journalists, law enforcement personnel, religious leaders, faith healers, community	Required	Availability of orientation module (print/e-book/apps/digital learning platforms) for nonhealth service professionals and community workers Mental health and psychosocial skill integrated in education curriculum Trained teachers/counsellors/ social workers/ journalists/ psychologists on curriculum	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			volunteers, local government leaders, community leaders) on early identification of mental health concerns, service options, and referral to experts to ensure adequate treatment and care Offer training on improving provider–patient communication and empathy			
			Integrate mental health and psychosocial skills in education curriculum	Required		GoB/RPA /DPA
			Provide training and capacity building of teachers and counsellors/ psychologists	Required		GoB/RPA /DPA
			Create a conducive environment in the workplace through awareness raising on psychosocial well-being, and establish a support system for those receiving treatment for a mental health condition (paid leave, health insurance, task shifting) to reduce burn out and enhance productivity	Required	Module to be developed and disseminated to raise awareness to staff Regular awareness raising sessions conducted in workplaces	GoB/RPA /DPA
			Organize workshops on MHPSS including stress management, work-life balance, life skills and positive workplace environment	Required		GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Design staff welfare programmes to promote workplace happiness, work-life balance and psychosocial well-being	Required		GoB/RPA /DPA
			Promote advocacy to include coverage for treatment of mental health conditions in all health insurance schemes by the government and private sectors (medical and nonmedical evidence-based treatments)	Required	Health insurance policies (public and private) include coverage for mental health conditions Used data from insurance company payouts for services	GoB/RPA /DPA
ii) Reduce risk and incidence of suicides and attempted suicides by increasing community awareness and vigilance for help-seeking behaviour	DGHS, MoHFW	Other ministries (agriculture and others) Ministry of Industry and Ministry of Commerce through NMNCC Media BMRC	Conduct national research studies on suicide risk and incidence Develop a national referral system to address cases according to the level of severity Develop a national multisectoral strategy to reduce risk and incidence of substance use, suicide and attempted suicide Develop a national substance use and suicide prevention programme Establish additional support services for suicide prevention such as social protection and rescue services for those who attempt suicide	Required	Conducted baseline study on identifying the severity level of cases and provided appropriate mental health support National multisectoral strategy to reduce risk and incidence of suicide and attempted suicide developed, disseminated and to be operational by 2021	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Identify pesticides most commonly used in fatal self-poisoning and highly hazardous pesticides used for withdrawal	Required	No. of commonly used pesticides for fatal self-poisoning are enlisted for withdrawal	GoB/RPA /DPA
			Develop/update/adopt orientation modules, IEC, apps, posters, stickers, flyers and orient/inform farmers and other users through agriculture extension workers, CHWs, local government and mass media on proper use of pesticides, withdrawal of lethal pesticides, availability of low-risk alternatives and proper storage of pesticides Conduct sensitization sessions for relevant stakeholders on the decriminalization of suicide	Required	Orientation module, IEC, apps, posters, stickers, flyers developed and religious and community leaders oriented through field workers and mass media Record of farmers, community and religious leaders trained on the need for secure storage and limited access of pesticides to reduce risk of its usage as a means for suicide Flyers developed and distributed to the community	GoB/RPA /DPA
			Organize orientation session for farmers and the community on the proper usage of pesticides, withdrawal of lethal pesticides, availability of low-risk alternatives and proper storage of pesticides			
			Research on lethal pesticides to reduce potency; and invent organic or low-risk alternatives	Required	Research conducted and disseminated on lethal pesticides to reduce potency/invent organic or low-risk alternatives	GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Enact and enforce laws to restrict the use of harmful pesticides to reduce access to means of suicide Formation of a national suicide prevention programme, and gradual decriminalization of suicidal attempts by amendment of the Bangladesh Penal Code	Required	No. of cases filed to restrict the use of harmful pesticides	GoB/RPA /DPA
		BAP BACAMH NIMH BCPS BECPS NGOs MoWCA Civil Registration & Vital Statistics (CRVS)/ MoLGRDC MoHA a2i MoI	Adapt generic module to country experiences, and conduct training for gate keepers and general practitioners	Required	Generic module adapted to country experiences and training conducted for gate keepers and general practitioners	GoB/RPA /DPA
			Strengthen existing public helplines/call centres such as Shasthya Batayan, MoWCA National Emergency Number – 999 and private helplines/call centres on suicide prevention/mental health counselling, and disseminate the numbers to the public through mass and social media	Required	Record of frequency and types of calls received, by gender and age group of callers who received services on mental health/suicide prevention	GoB/RPA /DPA
			Develop/update national training modules (print and e-learning platforms), train call centre operators to help at-risk people having suicidal ideation/ thoughts	Required	National training module (print and e-learning platform) for mental health/suicide prevention call centre operators developed	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Facilitate support group/survivor groups Train teachers based on WHO guidelines		Record of cases that call centre operators receive by age, gender, as well as kind of concerns brought up that could be placed under broad categories and used for future training needs	
			Map existing services and develop an emergency response and crisis team, build their capacity and ensure 24/7 service through public–private partnership	Required	Crisis team members deployed (gender and function performed) Ongoing record of how many occasions crisis teams were deployed, and the types of crisis situations	GoB/RPA /DPA
			Establish a national suicide registry in collaboration with CRVS, local government (Union Parishads, municipalities) and home affairs Maintain a registry of deliberate self-harm and suicide; produce annual suicide statistics including data from MIS/DGHS	Required	National Suicide Registry established and operational	GoB/RPA /DPA
			Initiate active surveillance for suicide monitoring and log records disaggregated by facility, sex, age and other relevant variables, and collect data on human risk assessments	Required	Active surveillance system for suicide monitoring established and operational	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Adopt and translate WHO media guidelines (Bengali) for responsible reporting on suicide and disseminate to journalists and other stakeholders	Required	Bangla guideline developed for responsible reporting on suicide	GoB/RPA /DPA
iii) Promote socio - emotional communication development during early childhood and positive parenting skills (reduce physical punishment in homes and schools)	MoHFW	MoWCA MoE MoSW UNICEF MoLGRDC Institute For Peadiatric Neurodisorder and Autism Dhaka Shishu Hospital NIMH Dhaka university NGOs CBOs Parents groups/ associations	Harmonize and strengthen existing ECD programmes (social emotional communication, language, cognitive etc.) by different ministries, divisions and NGOs	Required	No. of harmonized ECD programmes implemented and monitored by different ministries, departments and NGOs	GoB/RPA/ DPA from different ministries and NGOs
			Build capacity of CHWs, teachers, opinion and religious leaders, adolescent peer leaders, as well as caregivers in health, education and other sectors, addressing: • Geriatric mental conditions • Woman mental health • Perinatal mental health care services • Prevention of child abuse and neglect	Required		GoB/RPA/ DPA
			Integrate, implement and upscale the comprehensive ECD programme through all sectors (public and private) Design and develop standard adaptable ECD protocol for health service providers and another child development programme	Required		GoB/RPA/ DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
iv) Reduce domestic violence, substance and non-substance use addictive behaviours (mobile, virtual and internet addiction)	DGHS MOHFW	MOWCA MOSW MOHA MOI MOYS	Conduct qualitative study in assessing the community needs to address violence Provide appropriately trained family therapists to address family crisis, mitigating in separation/divorce and ensuring appropriate referrals in case of severe cases (in collaboration with local government authorities) Develop national level opportunities to provide couples counseling in collaboration with the local government and expert service providers Provide training to the service providers who are working with the substance use group Development of appropriate tools and guidelines		Different dimensions of psychosocial violence are explored and interventions are formulated accordingly Identification of tools Selection of professionals	

GENERAL OBJECTIVE 4: TO STRENGTHEN INFORMATION SYSTEMS, MONITORING, IMPLEMENTATION AND RESEARCH FOR MENTAL HEALTH

It is essential to integrate data on mental health services accessed, into the routine health information system (i.e. DHIS2). Data should be disaggregated by gender, age, services accessed, specialists and diagnosis received, including attempted self-harm and suicide wherever indicated, and satisfaction of services from the end users. The focus of the data should be to: improve support provided by the MoHFW, gather evidence for better decision making, review mental health service delivery, and study the impact of promotion and prevention strategies implemented. Research on effectiveness and scalability of innovative models of care should also be conducted incrementally to optimize potential of mass scalability and sustainability. All research should be informative and help improve the services and programmes being supported by the government.

Global and corresponding national targets for General Objective 4:

Global Target	Bangladesh Target
80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020)	Core set of identified and agreed mental health indicators routinely collected and reported every two years from 2020 onwards

Core mental health indicators include those relating to specified targets of the NMHSP, together with other essential indicators of health and social system actions (such as training and human resource levels, availability of psychotropic medicines, admissions to hospitals). The data will be disaggregated by sex and age groups. National mental health surveys will be conducted to complement real-time data from routine information systems (i.e. DHIS2). There are three specific objectives under this general objective:

i) Strengthen routine information systems, monitoring and supervision for mental health

ii) Promote evidence generation and research

iii) Disseminate and utilize research data and findings.

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
i) Strengthen routine information systems, monitoring and supervision for mental health	DGHS, MoHFW NCDC MIS HSM CBHC DGFP	WHO BSMMU National Population Research and Training Institute (NIPORT)	Establish a central mental health research body that will coordinate and showcase research being conducted nationwide	Required	Core set of indicators on mental health identified	GoB/RPA /DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
		Bangladesh Bureau of Statistics (BBS) MoE NIMH MoWCA MoSW MoHA National Institute of Preventive and Social Medicine (NIPSOM) NIPORT Relevant academic institutes	Identify core set of mental health indicators (including well-being indicators) for routine MIS/DHIS2 Recommended criteria of well-being indicators: • Behaviour – in family, and with colleagues • Involvement in daily life (work/home) • Self-care • Social engagement/ participation • Sleep pattern • Eating pattern Coping skills 1. External support • Relationships • Friends • Spiritual leaders • Internal skills • Belief/religion • Attitude			
			Strengthen MIS for mental health including substance abuse and suicide, integrate key variables related to mental health conditions and mental health services (segregated by age and sex) in DHIS2 and feed into mental health dashboard, and national suicide registry	Required	Mental health conditions including suicide, substance abuse and related mental health service indicators (data segregated by age and sex) for mental health displayed in DHIS2 Mental Health DashBoard created in DHIS2	GoB/ RPA/DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Establish a national synchronized data keeping/tracking system among training institutions and service providers			
			Provide training on new mental health indicators related to DHIS2 (including MIS) and build capacity of health managers, statisticians, service providers and other relevant persons	Required	No. of orientation trainings conducted Key mental health indicators reported in DHIS2 from all levels of health and other sectors including private sector	GoB/ RPA/DPA
			Enter real-time data from primary, secondary and tertiary health facilities, as well as nonhealth sectors such as MoWCA and MoSW, and private sectors/practitioners	Required		GoB/ RPA/DPA
			Build capacity to institutionalize the system for regular quality data collection, data analysis, reporting/documentation and effective feedback mechanism to respective facilities and inform service planning at all service levels	Required	No. of health managers, service providers and relevant persons trained on data collection method, data analysis, reporting and feedback	GoB/ RPA/DPA
			Develop and utilize standardized validated tools for screening, assessment, diagnosis and evaluation of mental health conditions	Required	Standardized and validated tools for screening, assessment, diagnosis and evaluation of mental health conditions developed and operational at all levels in public and private sectors	GoB/ RPA/DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
					4/5 item checklist developed for neurosis/psychosis for primary health care workers	
			Conduct and strengthen regular monitoring and supervision activities	Required	No. of monitoring and supervision visits	GoB/ RPA/DPA
			Develop a comprehensive supervision and monitoring checklist on mental health for different levels of the health system for regular monitoring and supervision	Required	Comprehensive supervision and monitoring checklist on mental health developed and operational	GoB/ RPA/DPA
ii) Promote evidence generation and research	Health Service Division Autism & NDD Cell NCDC NIMH DGHS	BSMMU, Relevant academic and research institutes NIPSOM NIPORT BBS BMRC DGHS	Conduct national level surveys, as well as surveillance and operations research for priority mental health issues in consultation with all stakeholders Prioritize research that is focused on the basic components of the consolidated framework of implementation (prevalence and evidence generating research should be less prioritized) Publish and disseminate reports	Required	Priority national level research programmes on mental health enlisted in consultation with relevant stakeholders No. of reports published	GoB/ RPA/DPA
			Establish and strengthen an institutional ethical review committee on mental health research, survey and surveillance	Required	Independent ethical review committee on mental health research, survey and surveillance established and functional	GoB/ RPA/DPA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Provide skill building on mental health research	Required	No. of trainings conducted No. of persons trained	GoB/RPA/ PA
			Provide skill building on mental health research	Required	No. and quality of new research on mental health by NIMH, BSMMU and public university following training on conducting mental health research No. of collaborative activities conducted Progress on activities based on notes from meetings conducted Periodic surveys conducted to measure attitudes and behavioural changes regarding perception on mental health	GoB/RPA/ PA
			Strengthen collaboration between universities, institutes, teaching hospitals and health services in the field of mental health research	Required		GoB/RPA/ PA
			Conduct regular national mental health surveys (at least after every five years)	Required	National Mental Health Survey conducted in 2014 and 2029	GoB/RPA/ PA
			Ensure that advocacy includes key mental health indicators in national population-based surveys and estimates like Demographic and Health Survey, MICS, Sample Vital Registration Statistics and Utilization and Essential Service Delivery	Required	No. of workshops/ collaboration meetings conducted Core set of mental health indicators included and reported through national surveys and estimates	GoB/RPA/ PA

Specific objectives	Core Responsibility	Collaborative partner	Advised activity	Resources	Output indicators	Funding alocation
			Develop/adapt/scale innovative community-/family-based mental health service model, including but not limited to half-way homes, domiciliary services, day care system and services for children, adolescents, elderly and vulnerable population in selected sites; and measure the effectiveness, scalability, adaptability and compliance	Required	No. of innovative models implemented and results disseminated	GoB/RPA/PA
iii) Disseminate and utilize research data and findings	DGHS, MoHFW Institute of Epidemiology Disease Control and Research	BSMMU Relevant academic and research institutes NIPSOM NIPORT Central Drug Addiction Treatment Centre (CDATC)	Publish reports and disseminate results Strengthen and develop a national research repository (online and offline) accessible to all stakeholders Utilize research findings for developing, designing and adapting scale up of mental health and related services	Required	No. of articles published No. of seminars, symposia, workshops conducted A central website developed and established (with institutionalized input options)	GoB/RPA/DPA

SECTION 4

Human resources development plan

For mental health services to be implemented effectively, it is necessary that the NMHSP includes a detailed human resource development plan. Unfortunately, in Bangladesh not only is the availability of skilled mental health professionals low for its population size, it is also an area of specialization that is under-paid, under-appreciated and very stigmatized. In addition, existing academic programmes follow a traditional training model that is didactic and places greater emphasis on clinical interventions. Moreover, due to the lack of any regulatory or credentialing system, standardization of practitioners and their expertise is significantly lacking.

As of 2016, there were an estimated 1.17 mental health workers per 100 000 population, with most working in tertiary care settings in large cities (67). The DGHS health bulletin 2018 reported that there were no sanctioned posts for psychiatrists, psychologists, mental health counsellors/social workers or at district hospitals and UHCs. While 31 posts for clinical psychologists were created in specialized hospitals, institutes and medical college hospitals in 2015, there were no recruitments.

A needs assessment should be conducted on how many mental health service providers are required and at what levels of the health system. To ensure that mental health services are provided at all tiers of the health system, all health providers can be trained on psychosocial well-being, early support and referral to trained personnel. In addition, given the significant dearth of professionals, existing MHVs and other health services providers could be trained over time to provide services in the community for milder conditions, and to ensure that those with chronic conditions are adequately monitored to warrant continuity of care. Utilizing the existing digital infrastructure of Bangladesh, an e-health or m-health system could be set up where expert clinicians can play a supervisory role to community care providers to enable more mental health services to be provided at home and in community settings. This system can also be utilized to gather necessary data and ongoing training of personnel. To ensure this task shifting and task sharing model of care, standardization of training as well as a system for licensing and credentialing should be established in partnership with the MoE. In addition, adequate recruitments, salary structure, operational procedures, as well as ethical guidelines to ensure confidentiality and protection of end users also need to be defined prior to implementation. Moreover, to provide standardized effective care as well as collaboration and cooperation between the various agencies and departments, it is necessary that guidelines for functional working relationships be established to mitigate any future conflicts in roles and functions.

SECTION 5

Monitoring, evaluation and research

To ensure that this NMHSP is adequately implemented and to measure the effectiveness of the goals and activities, a monitoring and evaluation system needs to be a necessary central component. Research that can provide valuable information and guide future endeavours should be conducted both independently as well as in partnership with the MoHFW. All research supported by government funds should help inform policy and practice. Based on this premise, core indicators and targets have been identified in each section under every objective which are also commensurate with WHO's Global Mental Health Action Plan, SDG 3 and 4th HPNSP, 2017-2022.

Conclusion

The issue of mental health is a complex and challenging one, which encompasses both preventative psychosocial well-being as well as care methods that ensure human rights and empowerment. Superseding all other financial and resource constraints is the challenge of stigma and prejudice against those experiencing poor mental health, whether situationally or over a long period of time. Due to the pervasive misunderstanding of what negatively impacts mental well-being, along with individual and cultural biases against those seeking or providing treatment, mental health is going to require an innovative, cost-effective and cross-sectoral approach. Due to the recent attention to NCDs (where mental health is currently incorporated in the health agenda) and the many overlapping risk factors, risk factors for poor physical health are also considered as risk factors for poor mental health (75). The current geo-political climate is well suited to effectively address this complex challenge. For low and middle-income countries like Bangladesh, it makes financial sense to incorporate a system of care that ensures comprehensive strategies for promotion, prevention, treatment and recovery in a "whole-of-government, whole-of-society" approach. Thus, the current document was prepared with a brief situational assessment and a detailed comprehensive strategic plan to holistically address mental health to help promote well-being throughout the life of an individual, and enable them to live a productive and contented life with their family and in their community.

Bangladesh, selected as one of only six countries by the WHO to participate in its Triple Billion Initiative on Mental Health, has a responsibility to not just demonstrate success but also pave the way for its neighbours to focus on this important health and human rights issue. It is hoped that this NMHSP would serve as a guideline for other low-resource countries to address mental health in an effective manner and be part of how each country achieves its SDGs.

SECTION 6
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SECTION 7
Annexures

Annex 1: Government and nongovernment organizations providing mental health services including drug addiction

Of the 105 medical college hospitals in Bangladesh, the majority are private (63) and rest are public (42). Among the public hospitals, 13 have allocated 891 inpatient beds for psychiatric patients. The divisional medical college hospital in Rajshahi does not have any inpatient beds. Among the private medical college hospitals, only four of the total 38 inpatient beds are for psychiatric patients. There are 199 beds in four public "drug addiction treatment and rehabilitation centres". These are operated by the DNC, MoHA and are located in Chittagong, Dhaka, Khulna and Rajshahi. In addition, 323 private rehabilitation centres are registered by the DNC with 4093 beds for treating and rehabilitating patients with substance use disorders.

Sl #	Name of the health facilities	Location	Mental health outpatient	Mental health inpatient (#bed)	Remarks
Government tertiary and medical college hospitals (42)					
1	Pabna Mental Hospital	Pabna	Yes	Yes (500)	Oldest mental health facility in Bangladesh
2	National Institute of Mental Health and Hospital	Dhaka	Yes	Yes (200)	
3	Bangabandhu Sheikh Mujib Medical University	Dhaka	Yes	Yes (40)	
4	Dhaka Medical College Hospital	Dhaka	Yes	Yes (25)	
5	Chittagong Medical College Hospital	Chittagong	Yes	Yes (30)	
6	Sir Salimullah Medical College Hospital	Dhaka	Yes	Yes (12)	
7	Mymensingh Medical College Hospital	Mymensingh	Yes	Yes (12)	
8	Sylhet MAG Osmani Medical College Hospital	Sylhet	Yes	Yes (12)	
9	Sher-e-Bangla Medical College Hospital	Barisal	Yes	Yes (12)	
10	Rangpur Medical College Hospital	Rangpur	Yes	Yes (12)	
11	Shaheed Ziaur Rahman Medical College Hospital	Bogra	Yes	Yes (12)	
12	Khulna Medical College Hospital	Khulna	Yes	Yes (12)	
13	Faridpur Medical College Hospital	Faridpur	Yes	Yes (12)	

Sl #	Name of the health facilities	Location	Mental health outpatient	Mental health inpatient (#bed)	Remarks
14	Shaheed Suhrawardy Medical College Hospital	Dhaka	Yes	No	
15	Rajshahi Medical College Hospital	Rajshahi	Yes	No	
16	Cumilla Medical College Hospital	Cumilla	Yes	No	
17	Kurmitola General Hospital	Dhaka	Yes	No	
18	Mugda Medical College Hospital	Dhaka	Yes	No	
19	Abdul Malek Ukil Medical College Hospital	Noakhali	Yes	No	
20	M Abdur Rahim Medical College Hospital	Dinajpur	Yes	No	
21	Pabna Medical College Hospital	Pabna	Yes	No	
22	Cox's Bazar District Hospital	Cox's Bazar	Yes	Yes (5)	One psychiatrist is posted on special arrangement Usually, a psychiatrist is not posted at a district hospital
23	Cox's Bazar Medical College Hospital	Cox's Bazar	Yes	No	
24	Jessore Medical College	Jessore	Yes	No	
25	Satkhira Medical College	Satkhira	Yes	No	
26	Shahid Syed Nazrul Islam Medical College	Kisorganj	Yes	No	
27	Kushtia Medical College	Kushtia	Yes	No	
28	Sheikh Sayera Khatun Medical College	Gopalganj	Yes	No	
29	Shaheed Tajuddin Ahmad Medical College	Gazipur	Yes	No	
30	Sheikh Hasina Medical College	Tangail	Yes	No	
31	Sheikh Hasina Medical College	Jamalpur	Yes	No	
32	Colonel Malek Medical College	Manikganj	Yes	No	
33	Shaheed M. Monsur Ali Medical College	Sirajganj	Yes	No	
34	Patuakhali Medical College	Patuakh	Yes	No	
35	Rangamati Medical College	Rangamati	Yes	No	
36	Sheikh Hasina Medical College	Habiganj	Yes	No	

Sl #	Name of the health facilities	Location	Mental health outpatient	Mental health inpatient (#bed)	Remarks
37	Netrokona Medical College	Netrokona	Yes	No	
39	Nilphamari Medical College	Nilphamari	Yes	No	
40	Magura Medical College	Magura	Yes	No	
41	Naogaon Medical College	Naogaon	Yes	No	
42	Chandpur Medical College	Chandpur	Yes	No	
Private medical college hospitals (63)					
43	Enam Medical College and Hospital	Savar, Dhaka	Yes	Yes (17)	Associate professor - 1, assistant professor - 1, medical officer - 4, assistant registrar - 1
44	Z. H. Sikder Women's Medical College	Dhaka	Yes	Yes (10)	
45	Bangladesh Medical College	Dhaka	Yes	Yes (06)	
46	Uttara Adhunik Medical College and Hospital	Dhaka	Yes	Yes (05)	No separate wards, but five beds are allocated for psychiatric patients
47	Dhaka National Medical College	Dhaka	No	No	
48	Ibrahim Medical College	Dhaka	Yes	No	
49	Holy Family Red Crescent Medical College	Dhaka	Yes	No	
50	Uttara Adhunik Medical College	Dhaka	Yes	No	
51	Shaheed Monsur Ali Medical College, Uttara	Dhaka	Yes	No	
52	Ibn Sina Medical College	Dhaka	Yes	No	
53	Community Based Medical College	Mymensingh	Yes	No	
54	Shahabuddin Medical College	Dhaka	Yes	No	
55	Medical College for Women & Hospital	Dhaka	Yes	No	
56	Ad-din Women's Medical College	Dhaka	Yes	No	
57	Kumudini Women's Medical College Hospital	Tangail	Yes	No	
58	Tairunnessa Memorial Medical College	Gazipur	Yes	No	

Sl #	Name of the health facilities	Location	Mental health outpatient	Mental health inpatient (#bed)	Remarks
59	International Medical College	Gazipur	Yes	No	
60	Central Medical College	Cumilla	Yes	No	
61	B.G.C Trust Medical College	Chittagong	Yes	No	
62	Eastern Medical College	Cumilla	Yes	No	
63	Islami Bank Medical College	Rajshahi	Yes	No	
64	Khwaja Yunus Ali Medical College	Sirajganj	Yes	No	
65	Jalalabad Ragib-Rabeya Medical College	Sylhet	Yes	No	
66	East West Medical College	Savar	Yes	No	
67	Jahurul Islam Medical College	Bajitpur, Kisorganj	Yes	No	
68	North East Medical College	Sylhet	Yes	No	
69	Institute of Applied Health Sciences, USTC	Chittagong	Yes	No	
70	Gonoshasthaya Samaj Vittik Medical College	Savar	Yes	No	
71	Chattagram Maa-O-Shishu Hospital Medical College	Chittagong	Yes	No	
72	T.M.S.S. Medical College	Bogra	Yes	No	
73	Prime Medical College	Rangpur	Yes	No	
74	North Bengal Medical College	Sirajganj	Yes	No	
75	Rangpur Community Medical College	Rangpur	Yes	No	
76	Delta Medical College	Dhaka	Yes	No	
77	Southern Medical College	Chitagong	Yes	No	
78	Anwer Khan Modern Medical College	Dhaka	Yes	No	
79	Popular Medical College	Dhaka	Yes	No	
80	Green Life Medical College	Dhaka	Yes	No	
81	Dhaka Community Medical College	Dhaka	Yes	No	
82	Northern Private Medical College	Rangpur	Yes	No	

Sl #	Name of the health facilities	Location	Mental health outpatient	Mental health inpatient (#bed)	Remarks
83	Sylhet Women's Medical College	Sylhet	Yes	No	
84	Monno Medical College	Manikganj	Yes	No	
85	MH Samorita Medical College	Dhaka	Yes	No	
86	City Medical College	Gazipur	Yes	No	
87	Marks Medical College	Dhaka	Yes	No	
88	Diabetic Association Medical College	Faridpur	Yes	No	
89	Barind Medical College	Rajshahi	Yes	No	
90	Gazi Medical College	Khulna	Yes	No	
91	Northern International Medical College	Dhaka	Yes	No	
92	Dhaka Central International Medical College	Dhaka	Yes	No	
93	Dr Sirajul Islam Medical College	Dhaka	Yes	No	
94	Mainamoti Medical College	Cumilla	Yes	No	
95	CARe Medical College	Dhaka	Yes	No	
96	Bikrampur Bhuiyans Medical College	Munsiganj	Yes	No	
97	Universal Medical College	Dhaka	Yes	No	
98	Ashiyan Medical College	Dhaka	Yes	No	
99	US-Bangla Medical College	Dhaka	Yes	No	
100	President Abdul Hamid Medical College	Kisorganj	Yes	No	
101	Brahmanbaria Medical College	Brahmanbaria	Yes	No	
102	Parkview Medical College	Sylhet	Yes	No	
103	Ad-Din Sakina Medical College	Khulna	Yes	No	
104	Shah Mokhdum Medical College	Rajshahi	Yes	No	
105	Monowara Sikder Medical College	Shariatpur	Yes	No	

*Source: https://en.wikipedia.org/wiki/List_of_medical_colleges_in_Bangladesh#Public_medical_colleges

Sl #	Name of the health facilities	Location	Mental health outpatient	Mental health inpatient (#bed)	Remarks
List of drug addiction centres (public and private)*					
106	Central Drug Addiction Treatment and Rehabilitation Centre	Dhaka	Yes	Yes (124)	Under MoHA
107	Divisional Drug Addiction Treatment and Rehabilitation Centre	Rajshahi	Yes	Yes (25)	Under MoHA. Only 1 doctor and 3 nurses to run the facility
108	Divisional Drug Addiction Treatment and Rehabilitation Centre	Chittagong	Yes	Yes (25)	Under MoHA. Only 1 doctor and 3 nurses to run the facility
109	Divisional Drug Addiction Treatment and Rehabilitation Centre	Khulna	Yes	Yes (25)	Bed numbers vary across different facilities – 10 beds to 190 beds

*DNC, MoHA, http://www.dnc.gov.bd/site/page/efb131fc-a930-43b2-aaa5-41a1cd1817ca

Annex 2: Mental health workforce at facility and community level

The MoHFW has developed a Health Essential Service Package (ESP) for the 4th HPNSP, 2017-2022. The inclusion of mental health in ESP seeks the involvement of all levels of care for identifying signs of most common priority conditions (autism and NDDs, epilepsy, and common mental health disorders including depression, psychosis, anxiety and substance abuse) and their referral to union-level facilities who will also participate to support rehabilitation and fight against stigma. The following table denotes different components of the mental health ESP, level of health care provision and types of available providers.

Component	**Community (facility and providers)**			**Union (facility and providers)**	**Upazila (facility and providers)**	**District (facility and providers)**		**Urban (facility and providers)**	
	Domiciliary	Satellite/ outreach	Community clinics	UHFWC	UHC	District hospital	Maternal and Child Welfare Centre	Primary Health Care Centre	Comprehensive Reproductive Health Care Centre
Counselling on identification and support to mental health cases, including fighting stigma and others	Health assistants Family welfare assistants MHVs	Family welfare volunteers Health assistants Family welfare assistants	CHCPs Health assistants Family welfare assistants	SACMOs Family welfare assistants	Doctor Nurses Midwives SACMO	Consultant Doctor Nurses Midwives	Doctor Family welfare volunteers (only women)	Doctor Paramedics Counsellor	Doctor Paramedics Counsellor
Identification of signs of mental health conditions and referral			CHCPs Health assistants Family welfare assistants	SACMO Family welfare assistants	Doctor Nurses Midwives SACMO	Consultant, Doctor Nurses Midwives	Doctor Family welfare volunteers (only women)	Doctor Paramedics Counsellor	Doctor Paramedics Counsellor
Diagnosis of priority conditions: Autism NDDs Epilepsy Common disorders: Depression Psychosis Anxiety Substance abuse				SACMO Family welfare assistants	Doctor Nurses Midwives SACMO	Consultant, Doctor Nurses Midwives	Doctor Family welfare volunteers (only women)	Doctor Paramedics Counsellor	Doctor Paramedics Counsellor
Management of priority, common mental health conditions					Doctor Nurses Midwives SACMO	Consultant, Doctor Nurses Midwives		Doctor Paramedics Counsellor	Doctor Paramedics Counsellor
Inpatient care for acute, severe cases						Consultant Doctor Nurses (if trained providers are available)			

Component	Community (facility and providers)			Union (facility and providers)	Upazila (facility and providers)	District (facility and providers)		Urban (facility and providers)	
Support to rehabilitation of mental health patients	Health assistants Family welfare assistants MHV	Family welfare volunteers Health assistants Family welfare assistants	CHCPs Health assistants Family welfare assistants		Doctor Nurses Midwives SACMO	Consultant Doctor Nurses Midwives		Doctor Paramedics Counsellor	Doctor Paramedics Counsellor

Annex 3: Suggested national essential medicines list for common mental, neurological and substance use disorders for Bangladesh (adapted from mhGAP 2.0)

Mental, neurological and substance use disorders	Medication	Caution	Remarks
Depression	Fluoxetine		Can be given to adolescents
	Amitriptyline	Use only in adults Do not use in children or adolescents	
Psychoses			
Antipsychotic medications	Haloperidol		
	Risperidone		
	Chlorpromazine		
	Fluphenazine	Avoid giving to women who are pregnant or breast feeding Do not use in children or adolescents	
Anticholinergic medications	Biperiden		Avoid in women who are pregnant or breast feeding
	Trihexyphenidyl		
Mood stabilizers	Lithium	Use only in hospital settings having laboratory and inpatient monitoring facilities	
	Sodium valproate		
	Carbamazepine		
Epilepsy			
	Carbamazepine	Use with caution in women who are pregnant or breast feeding	
	Phenobarbital		
	Phenytoin	Avoid giving to women who are pregnant or breast feeding Use lower dose in older adults	
Dementia			
Dementia without behavioural or psychological symptoms	Cholinesterase inhibitors (Donepezil, Galantamine) or Memantine	Close monitoring required in those with Alzheimer's disease	
	Memantine	In those with vascular diseases	
Dementia with behavioural or psychological symptoms	Antipsychotic medication as stated above	Avoid i.v. Heloperidol or Diazepam	Avoid if it is a risk to the person or caregivers
Disorder due to substance use			
Alcohol withdrawal	Diazepum	Do not use in people who are sedated	
Opioid overdose	Naloxone		
Prevent/treat Wernicke's encephalopathy	Thiamine (vitamin B1)		
Opioid withdrawal	Methadone		
	Buprenorphine	Do not use in people who are sedated	
	Morphine sulphate		
	Clonidine		
	Lofexidine		

Mental, neurological and substance use disorders	Medication	Caution	Remarks
Prevent relapse in alcohol dependence	Acamprosate		
	Naltrexone		
	Disulfiram		

Annex 4: Monthly reporting tool for health facilities

Ministry of Health and Family Welfare
Directorate General of Health Services

Name of the health facility/Upazila:

District/Municipality/City Corporation:

Reporting Month/Year:

Sl#	Diagnosis	Age (1-19 years)				Age (20-59 years)				Age (60+ years)			
		New		Old		New		Old		New		Old	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1	Depressive disorders												
2	Anxiety disorders												
3	Somatic symptoms and related disorders												
4	Major mental disorders (schizophrenia spectrum disorders)												
5	Major mental disorders (bipolar and related disorders)												
6	Obsessive compulsive and related disorders												
7	Sleep–wake disorders												
8	Neurodevelopmental disorders												
9	Neurocognitive disorders												
10	Substance related and addictive disorders												
11	Personality disorders												
12	Sexual dysfunction												
13	Disruptive, impulse control and conduct disorders												
	Total												

Approved by: .....

Prepared by: .....

Annex 5: Mental health supervision and monitoring checklist: follow up after training

Name of facility: **Upazila:** **District:**

Name and designation of the facility administrator/manager:

Contact mobile number: **email:**

A. SERVICE AVAILABILITY

1. Human resource profile on mental health

Designation	Total number of posts	Number of trained providers	Received any training on mental health? (yes/no)	If yes, title of the training and month/year?	Provided mental health services? (yes/no)	If no, explain the reason
Psychiatrist						
Medical officer						
Senior staff nurse						
SACMO						
Psychologist						
Clinical psychologist						
Counsellor						
Others (specify)						
Total						

2. Has the hospital/facility administrator (civil surgeon/superintendent/Upazila health and family planning officer) received any orientation on mental health?
   i) Yes
   ii) No

3. Do you provide mental health services from your hospital/facility?
   i) Yes
   ii) No

   If no, why? (please explain the reasons)
   If yes, do you have any designated consultation room (or NCD Corner)?
   i) Yes
   ii) No

4. Who provides mental health services in the hospital?
   i) Name/designation
   ii) Name/designation
   iii) Name/designation

5. Do you have a mental health register and reporting template?
   i) Yes
   ii) No

   If yes, take a look in the register and ask the following questions:
   a. Do you keep records and clinical notes, and organize documents of interviews and assessments?

   b. Do you keep records and clinical notes confidential, and store in a secure place?

   c. Name the variables against which information is being recorded (age, sex, type of psychiatric problem, duration of condition, treatment so far, others)

6. Is the mhGAP master chart hung or stuck on the wall in the facility?
   i) Yes
   ii) No

7. Is mhGAP IG V2 available on the table?
   i) Yes
   ii) No

8. Is any other information, education and communication or behaviour change communication material available?
   i) Yes
   ii) No

9. Availability of psychotropic drugs (as per list)
   i) Yes
   ii) No
   a. If yes, what psychotropic drugs are available? Please mention the names of the medicines.
   b. If no, did you ever procure or receive these drugs?
   c. If you do not procure these drugs, how did the patient get the drugs?

10. Do you have assigned beds for mental health patients?
    i) Yes
    ii) No

    a. If yes, how many?

*** List Psychotropic Drugs as per NCDC.**

B. SERVICE ACCESSIBILITY

[Please check with the health manager for any health facility/service mapping for the catchment area. If possible, organize a FGD with the community or exit interview with clients with mental health issues.]

11. Did you organize any awareness raising activity in the community to inform the availability of mental health services in the hospital?
    i) Yes
    ii) No

12. Have you trained/oriented your field workers (health assistant/family welfare assistant/CHCP/MHV) about mental health services, and provided basic counselling/information to the family, and referred the patient to a facility?
    i) Yes
    ii) No

13. a. Have you oriented community groups/local government elected members/teachers/others on mental health issues?
    i) Yes
    ii) No

    b. How do you engage other departments/sectors, such as MoSW, MoWCA, MoE?

    c. Do you have any suggestions to improve awareness on and access to mental health services?

14. Are mental health services free in your hospital?
    i) Yes
    ii) No

    a) If no, please share the average/estimated cost of mental health services in your facility.

15. a. If required, where do you refer mental health patients?

    b. Are there any back referral services to the referring facility (such as informing the UHC, if any patient is referred from UHC to district hospital/medical college hospital?
    i) Yes
    ii) No

    c. Do you have any mechanisms in place at homes of patients for follow-up by front line health workers (health assistant/family welfare assistant/MHV)?

16. Is there any private facility or private provider for mental health in this area?
    i) Yes
    ii) No

    a. If yes, please provide names of providers or hospitals .....

C. SERVICE UTILIZATION

17. a. What is the average number of mental health patients per day/month?
    ...../day ...../month
    b. Is there an increasing trend in patients coming after receiving training on mental health?
    i) Yes
    ii) no
    c. Who are the common patients, in terms of
    age = child/adolescent/adult/elderly:
    sex = male/female:
    religion/ethnicity:

18. What are the commonly presenting mental health illnesses or disorders you usually see in your hospital?
    •
    •
    •
    •
    •

19. Do you know the reasons for these illnesses?
    i) Yes
    ii) No
    If yes, mention the reasons according to priority.
    •
    •
    •
    •
    •

20. What types of investigations/laboratory tests do you commonly advice for mental health patients?

21. Do you provide any advice on psychosocial support, food or rest or family support?
    i) Yes
    ii) No
    If yes, please elaborate:

22. In your opinion, what are the barriers to providing mental health services at community clinics/UHFWCs/UHCs/district hospitals?
    •
    •
    •
    •

23. How do you find the mental health treatment seeking behaviour in your community?
    •
    •
    •
    •
    •

24. What are the common stigmas and discriminations related to mental health in your community?
    •
    •
    •
    •
    •

D. EFFECTIVE COVERAGE/QUALITY OF SERVICES

(If possible, observe the consultation of a patient during the visit OR check the knowledge of the respective service provider as per the following table.)

Competency assessment (only use competencies which apply to the task)	Needs work	Archived	N/A
1. Shows respect and dignity in a culturally appropriate manner • Greetings • Expressions • Empathy • Maintains confidentiality			
2. Uses effective communication skills • Creates an environment for open communication • Uses verbal and nonverbal communication skills • Performs active listening • Responds to client's perception on interview and assessment			
3. Knows assessment principles and performs assessment • Performs history taking • Determines diagnosis, examines mental status			
4. Knows management principles and performs management • Uses psychosocial interventions • Uses pharmacological interventions (if needed)			
5. Plans and performs follow up • Plans for follow up • Performs a follow-up assessment • Determines management based on progress			
6. Manages documentation • Keeps records and organizes documents related to interviews and assessments			
7. Refers to a specialist and links with outside agencies • Knows when to refer at any stage of the assessment and management • Links with other services and outside agencies			
8. Skill retention a. How was the mhGAP training? Do you have any suggestions to improve the training in the future? b. Did you use mhGAP IG V2 during the interview of a patient when necessary? c. What support is needed to operationalize mhGAP training? d. How do you retain your skills after the mhGAP training? Is there a need for any refresher training, mentorship/coaching/or on-the-job training? e. Have you heard of/used mhGAP IOS App 2.0? f. If yes, is it useful to retain the skill?			
9) Others (if any) i) Are there any changes or improvements in your skills? If yes, please specify a. Behaviour b. Communication skill c. Time allocation d. Mental state examination skill e. Maintenance of confidentiality f. Psychosocial interventions g. Others ii) Is a refresher training necessary? iii) Is supervision necessary/helpful?			

E. What are the other challenges you face in practicing what you have learned from the mhGAP training?

F. Recommendations/follow-up actions *

Name and designation of the assessor/monitor:

Date:

---

* Please share the key recommendations/follow-up actions with the hospital managers and service providers and share a copy of the full trip report with them within two weeks of the visit.

Annex 6: National Mental Health Progress Card

Ministry of Health and Family Welfare
Directorate General of Health Services

National Mental Health Progress Card

Year:

Objectives of the national mental health programme

1. To strengthen effective leadership and governance for mental health.
2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
3. To implement strategies for promotion and prevention in mental health.
4. To strengthen information systems, evidence and research for mental health.

Key performance indicator (KPI)#	Impact indicators (Morbidity and mortality: Are health and development results being achieved?)	Progress							Annual Result		
	KPI	Baseline (year 2018–2019)			Quarterly progress				Annual target	Annual result	Remarks
		Result	*Year*	*Source of Data*	*Q1*	*Q2*	*Q3*	*Q4*			
1	Case fatality rate of mental health conditions										
2	Case fatality rate of epilepsy										
3	Case fatality rate of substance use disorders (SUDs)										
4	% of morbidity attributable to mental health (prevalence of mental health conditions)										
5	% of morbidity attributable to epilepsy (prevalence of epilepsy)										
6	% of morbidity attributable to SUD (prevalence of SUD)										
Output indicators (Health coverage: Is the population receiving the health care services they need?)		Progress							Annual Result		
KPI #	KPI	Baseline (year 2018–2019)			Quarterly progress				Annual target	Annual result	Remarks
		Result	*Year*	*Source of Data*	*Q1*	*Q2*	*Q3*	*Q4*			
7	% of population receiving treatment for mental health conditions (with an expected prevalence of x%)										
8	% of population receiving treatment for epilepsy (with an expected prevalence of x%)										
9	% of population receiving treatment for SUD (with an expected prevalence of x%)										
10	% of mental health patients that dropped out from treatment last year										
11	% of epilepsy patients that dropped out from treatment last year										

12	% of SUD patients that dropped out from treatment last year										
13	% of epilepsy patients who completed treatment										
14	% of mental health, epilepsy and SUD patients who received domiciliary visits from a health worker										
Output indicators (Health system result: Are mental health services available, accessible and utilized by people who need these services?)		**Progress**							**Annual Result**		
KPI #	**KPI**	**Baseline (year 2018–2019)**			**Quarterly progress**				**Annual target**	**Annual result**	**Remarks**
		Result	*Year*	*Source of Data*	*Q1*	*Q2*	*Q3*	*Q4*			
15	% of health facilities (UHCs and above) with mental health outpatient services										
16	% of health facilities (district hospitals and above) with mental health outpatient services										
17	Total number of outpatient cases with mental health conditions, epilepsy and SUD										
18	% of health facilities implementing protocol for mental, neurological and substance use disorders (as per national standards)										
19	Number of health facilities having required number of trained staff in mental health (as per national standards)										
20	% of health facilities that received a monitoring and supervision visit in the past 3 months										
21	Number of hospital beds for mental, neurological and substance use disorder patients										
Output indicators (Health system facilities receiving resources and implementing activities they need to produce quality outputs)		**Progress**							**Annual Result**		
KPI #	**KPI**	**Baseline (year 2018–2019)**			**Quarterly progress**				**Annual target**	**Annual result**	**Remarks**
		Result	*Year*	*Source of Data*	*Q1*	*Q2*	*Q3*	*Q4*			
22	% of psychiatrists available according to organizational requirements/standards										
23	% of mental health nurses available according to organizational requirements/standards										
24	% of psychologists available according to organizational requirements/standards (district hospitals and above)										
25	% of social workers/counsellors available according to organizational requirements/standards (UHCs and below)										

26	% of finance disbursed for the planned mental health programme										
27	% of facilities with stockout of essential medicines for mental health services										

Annex 7: Summary of focus group discussions and workshops with mental health stakeholders

1. Summary of focus group discussions with the Bangladesh Association of Psychiatrists

Held on 08.07.2019 at NIMH (participants: 26)

Concept of mental health and psychosocial well-being

Good mental health is when someone can productively contribute to society and is mentally and physically sound. According to American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, good mental health is having no impairments affecting one's life at any level. There are some well-defined criteria for good mental health (including how to cope with adversity, flexible/adjustable nature, functional effectiveness, among others), which is subjective as well as objective.

Suggestions to improve mental health

"Catch them young." To ensure good mental health, early upbringing needs to be all-encompassing. There is a need to ensure nutritional food and a happy environment. Schools can play a part in early detection of mental health and psychological problems. If it is not possible to have a school psychologist in each and every school, they can be area-based. Digital platforms, such as telemedicine, social media, mobile phones, can be used to reach persons in need. There is a need to sensitize schools on mental health and psychosocial well-being by involving school administrations, teachers and parents. Discussions should be held on whether it is good to involve teachers because of inhibitions that students may feel towards authority.

Top mental health disorders in Bangladesh

Disorders among children include: autism spectrum disorder, attention deficit hyperactivity disorder, NDD, substance use disorder, behavioural disorders, process addiction, convulsion disorder. Mental health disorders among adults include: schizophrenia and other psychotic disorders, mood disorders (bipolar, depression), substance abuse, convulsion disorder. Suicide could be a consequence of any of these disorders.

People's perception of mental illness

Some doctors think that mental health is as not as important as physical health. Trained Imams, however, changed their attitude and referred patients to psychiatrists. People think that the solution to mental health problems is sleeping pills, and that psychiatrists themselves have mental health problems. People who even go to psychiatrists try to avoid them in public. Although some of it is changing, stigma exists. As other doctors do not have adequate knowledge of psychiatry, mental health adds to the stigma.

Service delivery

The number of psychiatrists is very low in proportion to Bangladesh's population. There are no psychiatrists at district and subdistrict levels, however some pharmacological treatment exists. However, there is telemedicine (90 centres around the country) which is managed by the NIMH. Primary health care-level doctors who receive training from NIMH typically provide some pharmacological support. All medicine specialists give psychotropic drugs but do not disclose it to the patient. They typically diagnose the patients and treat it under hypertension and diabetes management. Psychiatrists are alleged to give sleeping pills, but this is more common among other specialists. Most mental health patients go to a doctor specializing in medicine or neurology. In BSMMU, although psychiatrists approach doctors from other departments, other doctors never come to the psychiatry department for training. Some medical colleges do not even have a post for psychiatrist. Psychosocial counselling is provided by the psychotherapy wing in the BSMMU, where there are psychiatrists, psychologists and social workers. Many trainees and psychologists visit the NIMH to provide psychological support. While psychiatrists and counsellors strive to maintain privacy and confidentiality strictly, one-to-one counselling is difficult to do. Pabna Mental Hospital has about 400 beds but has other constraints such as scarcity of specialists and general staff. District and subdistrict facilities do not have any set-up for counselling. The health sector does not focus on much required rehabilitation. The rehabilitation sector needs to be part of social welfare as well.

Capacity building

The BSMMU has a postgraduate programme for psychiatry and a MD degree is offered in NIMH, Social Marketing Company, BSMMU. There are no diploma courses offered. BCPS has FCPS and MCPS. In the armed forces, there is provision for training of paramedics (basic training for 1 year and advanced for 1 year). They also have a grading course after which they can practice as psychiatrists. BSMMU has a six-month training of psychologists to give them psychiatric orientation. There are formal academic trainings and

smaller trainings on mental health. A BSc Psychiatric Nurse course has been submitted and awaiting approval. Undergraduate curriculum needs to have psychiatry as a required course.

Media promoting mental health/psychosocial well-being

There is some media engagement as family guidebooks are distributed; there are online papers/magazines; and psychiatrists give interviews and go on talk shows. However, other sectors such as social welfare, education, MoWCA, MoHA, Local Government Engineering Department, Public Works Department, Programme management office, should be engaged as well.

Reporting

This is mainly hospital-based. The NIMH report goes to the government MIS. NIMH also publishes a yearly bulletin. BSMMU may/may not have a central record for the whole university. All records may not appear in the government system.

Challenges

Psychotropic drugs are not supplied by the government other than in Pabna Mental Hospital and NIMH. There is no psychiatrist in the NCDC programme of the DGHS.

Recommendations

- Develop an integrated referral system.
- Set up a psychiatry department in medical colleges, including private ones.
- Develop a team approach (psychiatrist, psychologist and psychiatric social worker) to address mental health.
- Create psychiatrist posts in district-level hospitals.

2. Summary of focus group discussions with the Bangladesh Education and Counselling Psychology Society

Held on 25.07.2019 at the Department of Education and Counselling Psychology, University of Dhaka (participants: 24)

What is mental health and psychosocial well-being?

Mental health and psychological well-being is when – 'everybody is at peace with themselves, with their family, with their work and their educational life'. The balance in behaviour, thinking and emotions in a person can help in achieving inner peace and peace within the society and community.

What should be done to ensure mental health and psychosocial well-being?

In every stage of life – in every development span – positive factors give a person courage and self-confidence. The most important aspects for well-being in a family are a healthy relationship with spouse and bonding within the family (for which a proper parenting programme is very important). Parents should be taught to respect the likes and dislikes of their child, although they will set rules for the child. If a parent wants to punish a child or does not want to fulfill the child's demand, they should explain the reason to the child, so that the child grows in a healthy atmosphere. Teachers have a greater role in nurturing a student's childhood and adolescent periods. To ensure mental health and well-being, cultural issues and gender issues in terms of the family background, have to be considered.

There are two important domains for every human being – one for nurturing, and another at the structural level. When a person feels secure and safe, it builds self-confidence. Structural level domain includes factors like policy change. At first stigma around mental health and psychological well-being need to be addressed. Teacher training is the main approach to address stigma as well as provide proper messages to all levels through television, drama, media, to bring changes among teachers. The message should reach and appeal to everyone, such as the Meena cartoon that has helped to get rid of different types of stigmas.

There should be one psychologist for a couple of schools at the Thana (Upazila) level. S/he can visit each school for psychosocial services on a weekly rotational basis as is the practice in London.

In the education sector, mental health has to be addressed at all levels – primary, secondary, university. In universities, such as DU, there is only one regular counsellor post while there no such posts in other colleges. Some private universities (such as Brac and North South) have counsellors. In public educational institutions (university, college or school) there is no system to recruit a counsellor, except some examples that emerged from personal initiatives. A recruitment system can be put in place if changes happen at the

policy level and are implemented throughout the whole country. There was a plan to recruit counsellors in 317 schools, which is yet to be realized. Presently a class of 30 minutes duration per week can be used to talk about necessary basic mental health issues by trained teachers as an awareness programme; these can be done using existing resources without the need for extra budget.

Since there are not enough psychologists, teachers have to be trained handle basic mental health issues at the initial level. They will be able to identify which student needs Psychological First Aid to do referrals. Teachers should not counsel, but change their attitude towards such children. Previously, if s/he may have shouted at the student, now being aware would refrain from it. The teacher now understands that the child's behaviour could further deteriorate if the child experiences more fear or depression.

Mental health should be comprehensively integrated in the curricula of the Primary Teacher Training Institute, BEd, MEd courses and also used to build the capacity of master trainers. Madrasas should get due importance and lessons from projects like the Generation Breakthrough project under the MoE can be used for mental health services.

There should be branding for mental health professionals as people are using the Internet even in hilly and remote areas. It should be iterated that if someone receives mental health/psychology or counselling services it is not only for ill people. Counselling is also required to develop the self. There should be posts of psychiatrist, clinical psychologist and counselling psychologist in public hospitals to provide mental health services. Clinical social workers, in organizations such as the Building Resources Across Communities can provide counselling services, where counsellor fee is reimbursed to the employee, like health insurance.

It is very important to establish community-based counselling in the context of Bangladesh. Counselling and normal talk are not same. General people, even senior doctors, have this wrong perception – someone cannot be cured with only talking. There are counsellors in many places, even mobile phone helplines like Robi, Grameen; but all are not appropriate for counselling. It is important to make sure that correct messages are provided.

A mosque is also an important place in Bangladesh and can be used to create awareness on mental health while breaking the taboo around mental health. A simple message (two lines on mental health promotion) for jummah prayer can be developed.

Priority mental health conditions

Among adults, depression and relationship problems (among married and unmarried) are common mental health issues. Mental health conditions among adolescents include conduct disorders, school and examination phobia, relationship problems, attention seeking behaviours, attention/concentration problems in school, drug addiction, suicidal thoughts, Internet addiction. Depression and weak performance in studies could lead to suicidal attempts/suicide, anxiety, anger issues (especially due to family issues), and Internet/device addiction.

Services and academic courses

The Society conducts Masters, MPhil and PhD in Education and Counselling Psychology. It also provides services to the community (including parents and children) by pre-appointment (one-to-one service). There are family clinics for couples, family interventions and community outreach programmes, such as in Viqarunnessa school, colleges, also with an organization in Charfassion that works with underprivileged orphaned children. The Society is mostly active through the departmental webpage, and a subscription mailing list. Clients are either referred to the Society by psychiatrists who know the programme, or they directly contact online; lately there have been many client-to-client referrals as well as from TV and radio programmes that advertise the Society's services.

In the Department of Educational & Counselling Psychology centre of DU, various types of psychotherapy as per need of different clients are used such as: transactional analysis, cognitive behavioural therapy, eye movement desensitization and reprocessing therapy, neuro-linguistic programming therapy, systematic family therapy and couple therapy.

Reporting, management information system, good practice

Reporting and management are happening only in NGOs, and there is no system to share data with the government. Only service information from the Teacher Service Commission is shared with university authorities.

Major challenges

The biggest challenges are 'accreditation' and 'licensing'. A gap in service delivery is fixing the service fee which varies across providers. There is lack of monitoring and supervision of professionals. There is no standard/or guideline, such as a degree that will

qualify someone as counsellor. There is lack of coordination, strengthening and networking among the various inter-disciplines of the mental health discipline (subjects/areas). Unlike in the western world where mental health is considered a multidisciplinary issue, in Bangladesh there is lack of awareness. When a client comes with a situational difficulty, he gets prescribed a psychotropic drug, while actually he may just need counselling, psychotherapy or meditation. This is a big challenge, and how to move forward with coordination and cooperation from everyone needs to be worked out.

3. Summary of focus group discussions with MoE and the MoPME

29.08.2019 Held at the Office of the Additional Secretary, MoHFW (participants: 6)

Concept of mental health and psychosocial well-being

Mental health is when in addition to good physical health, if somebody has a positive attitude, does not become angry or anxious, and has patience and stamina, s/he can face any situation positively with mental strength. The level of mental strength depends on both physical and mental health, patience, tolerance, decision making capacity, and not becoming silent or depressed due to someone's comments. Depression is very prevalent but is not shared. People easily seek treatment easily for physical illness, but not for mental illness due to the stigma that only mad people go to get treated for mental issues as well as lack of awareness. People also think that mental illness will be cured automatically.

Information about mental illness is not widely known or disseminated in Bangladesh. People do not know that there are many types mental health issues. There are limited options to seek services. There are more psychiatric doctors than psychosocial counsellers. For any mental illness people in Bangladesh seek doctors for clinical treatment.

The Rohingya population has mental illnesses because they were forcefully removed from their home, resulting in mental trauma. Even during the floods, they resided out of their homes for a long time as they were cheated at different levels until they reached CIC.

Major challenges and solutions

✧ Corporal punishment has been stopped in public primary schools but not in private schools like the Ideal School. There is a need to stop the fear among students that the teacher will beat or shout at them in the class room. Early child learning where each and every child requires to be addressed individually is important. Each child has a different development pathway. Inclusive education is a next step, meaning children having mild form of autism and NDD will study together with normal children.

✧ If the teacher is not aware of a child's mental health and development, then solutions are difficult to implement. Early child development course is included in Diploma in Primary Education, BEd and MEd courses to attune the teachers. But a specialized course called Bachelor in Special Education is provided from DU (JPF, special institute of special education) with support from MoSW. Another challenge is the need for a trained doctor. Autism and NDDs are not part of the undergraduate medical curriculum, however, there is a national academy for autism and NDD.

✧ In addition, in the teachers training colleges there are modules on autism and NDDs. However, the challenge in the module is that it has to be used to train 400 teachers as used in the old system. For the past one year, the Shuchona Foundation has been reviewing the module and it is almost final. NDDs and some mental health issues will be added in this module.

✧ Presently teachers from public schools are overburdened with multiple tasks and thus do not find time to address the issue of mental health. Also, as the number of students to teach is large (60 to 80 per class), a teacher cannot screen and identify every student who needs special assistance within the 40–45 minutes of class time and cannot provide special support. In addition to providing education, primary school students are taught different life skills, such as personal care. The negative knowledge dissemination in the Madrasas is being changed as they are gradually being brought under a system, but it requires time to change a pattern. Primary school teachers have basic training, which has changed their mentality. But similar training is not available for teachers in high schools or polytechniques.

✧ As the BEd course (1 year-long) is mandatory for assistant high school teachers, mental health components are being integrated in the BEd course curriculum. Special options can also be kept under the normal education system, wherein children having mild problems study with normal children. Special provision has been kept for evaluating answer scripts, and the duration of examination.

✧ There are training institutions for Madrasa teachers, where NDDs and disability are included in the curriculum. Teachers are also trained to treat children with love and discipline and avoid physical abuse. But the attitude among the old teachers may be different. Now with fewer number of children in families and both parent and teachers having high expectations for achieving good results poses unnecessary mental pressure on students.

✧ Parents are responsible for affecting the mental health of their children by imposing huge demands on their children, such as saying, "you must secure first place in the class". There is an obligatory play time for one hour in the afternoon, but parents do not follow the instruction and send their child to a private tutor.

✧ The education system has to be changed, especially the use of the examination process to judge a student. Questions have to be innovative but teachers do not have the capacity to think and comprehend this new system of questions. Some of them are even reluctant to learn the new system. There is also corruption in recruiting teachers. The rule is that it is mandatory to provide the Non-Government Teachers' Registration & Certification Authority code while recruiting new teachers for private schools, and that government school teachers (in secondary) must have a BEd degree (either before entering the job or enroll after joining the job).

✧ Private schools (both kindergarten and English medium) teachers do not need a BEd degree. Since English medium schools are costly, parents monitor the quality and so it is assumed that the quality of education should be good in these schools.

✧ There is no post of counsellor in schools. A teacher can be trained in psychology so that s/he can teach as well as perform counselling.

✧ There are 103 disabled assistance centres (with one psychotherapist each) under MoSW. (In reality, a sanctioned post of psychologist in most institutions is a maximum of 4 or 5 per institution). A teacher cannot act as a counsellor for the student. Global evidence does not support that. The government can recruit a psychologist for a cluster of schools, s/he may sit in an Upazila education office. The psychologist will visit schools as per set schedule, screen out and provide services. Teachers can assist in primary screening as they know all students very well.

✧ An Assistant Thana Education Officer could also be assigned for counselling and/or screening since the recruitment of a psychologist/counsellor is a long-term process, taking up to five years.

✧ A former education minister's plan to recruit about 300 plus counsellors/psychologists for schools has been on hold for some time. There is no ongoing process to recruit psychologists for individual schools, but it is possible to provide one for a cluster of schools.

✧ There have been recruitments of psychologist/counsellor in various academic institutions, such as Dhaka College through a personal initiative – which is not sustainable. Private schools may recruit a psychologist by collecting a nominal fee from students during admission; there will be a different line item (Tk 100 or Tk 500 per student) to recruit a full-time psychologist. DU has one counsellor per 50 000 students, seated in the Teacher service commission (though the majority of students do not know about this). The student–counsellor gap requires to be addressed urgently.

✧ There are counsellor positions in private universities, like Brac University and North South university.

✧ The Vicarun Nesa Noon school is yet to recruit a counsellor, despite the recent sad incidence of the suicide of a student. The school has the finances to recruit a counsellor, but as this is not in the government policy they do not feel obligated to recruit a psychologist. There is an urgent need of a counsellor/psychologist in every school/college. It can be even one psychologist for a cluster or 10 schools or whatever number that could be decided later on. The Department of Education and Counselling Psychology, DU can provide necessary technical guidance.

4. Summary of focus group discussion with Bangladesh College of Physicians and Surgeons

16.07.2019 Held at the Department of Clinical Psychology, University of Dhaka (participants:13)

Concept of mental health psychosocial well-being

Mental health requires a continuum of support. Health means well-being; but in mental health, the focus is always on illness. While the majority of clinical psychologists are also illness focused, some are well-being focused too. Every human being should be able to fulfill his/her potential. A person's physical and mental health should be ensured and such an environment created so that a human being attains his/her potential – which is the essence of being. Mental health has three categories – promoting well-being, productivity and preventing any mental health disorder – so that a person can lead a fully functional life

What should be done to ensure mental health and psychosocial well-being?

Good mental health requires availability of all necessary conditions to ensure someone's physical, mental and social development. A well-developed individual can keep him/herself and others well. This is good mental health and complete well-being. A good school environment, less pressure for study, scope for sports, opportunity to develop in school are important requirements for good mental health. Any deviation could result in serious mental illnesses, requiring psychotherapy. Thus, the emphasis should be on health promotion and prevention.

There is a need to fulfill age-appropriate demands, and not only physical needs. Age-specific stimulation and ensuring learning as per the individual's level of intelligence are necessary. This will develop self-esteem and result in social, emotional and moral maturity, so that s/he can be responsible to other members of the society. "Self" is very important, but teachers and parents often destroy the self-esteem of children by criticism and negativity. It is important to consider a developmental approach, that does not address pathology. This requires a resourceful environment – resourceful family, community and state environments. A child learns by seeing and can easily pick up bad behaviours by observing bad situations. If more attractive things are offered to children, like scope to play, it could eventually reduce the time spent on unwanted activities and risk of substance use. There is a need to be cognizant about the immediate micro environment (family), meso environment (school and community) and macro environment (broader country context). If the state does not provide enough funds for a school's playground, children could pick up substance use addictions.

Parenting is also very important. The government should have a big agenda on parenting. Life skills should be taught to students: such as how to control emotions, how to handle negative pressures. There is also the need for a resourceful – not an impoverished – environment. Poverty is not only in terms of wealth but also poverty of the mind. People also need space to express their emotions.

There are three types of mental illness prevention methods: primary, secondary and tertiary. There is a need to work on the lowest level – primary prevention. Secondary prevention is early detection and enrolling into treatment to prevent further consequences. Tertiary prevention is to work on those who have already developed diseases, and bring them to full well-being or full functioning capacity. For this strategic plan, the government needs to measure the current status of these three levels and what it would like to achieve in 30 to 40 years.

Reasons for mental illness

There are various causes for mental illness – biological, psychological, socioenvironmental, genetic, among others. Genetic factors, could affect a biological factor, such as diabetes. Psychological cause related to developmental factors. If development is strong, then there is less chance of being mental ill. Social factors, such as when one in the family dominates the entire family, his/her behaviour causes illnesses in others. Social stressors affect those who are morally unsound or lack self control.

A cultural shift is happening in Bangladesh. Resources previously available in the society, such as a cohesive and supportive network, are no longer available. In parallel, stress is increasing due to consumerism that focuses on what one does not have rather what one has, which creates disturbance. This starts from the parent and translates onto children, and also among colleagues.

Priority mental health conditions

The major mental health conditions that exist among adults include anxiety, depression, convulsions, relationship problems, personality disorders, substance abuse. Common conditions among children include conduct disorders, attention deficit hyperactive disorders, and intellectual disorders. Another emerging issue is device dependency (Internet addiction) resulting in inadequate self-development which leads to relationship difficulties.

Perception of general people about mental health/illness

Earlier people perceived mental disease as a matter of shame and did not want to disclose it and felt uncomfortable to talk about it. This type of false perception is less among the poorest class. Stigma and tendency to hide mental illness is very high among middle and upper classes; they do not want to even treat it. People from low socioeconomic status are more accepting about mental illness and easy to work with in clinical practice. Those who are educated, come at the last minute with a tendency to hide the illness. Even a clinical psychologist if affected (mental illness) is unwillingly to share. There is another notion that if someone with mental illness gets married, he will be cured (the belief is that if you can satisfy the sexual drive, the person will be cured). This is very common belief even for severe psychotic patients. However, if they marry, the marriage does not last, thus increasing the complexity of the mental health condition. The other belief is that the person is affected by black magic by someone who wants to harm him; an amulet (tabij) is given to ward off black magic. However, all doctors are not knowledgeable. Even some psychiatrists refer an adolescent patient to such cures after a couple of years; even though they only required psychological therapy because of anger issues due to relationship problems.

Academic courses and short training

BCPS offers masters, MPhil, PhD courses. Basic counselling training is conducted for three days for staff from different organizations who are recruited for counselling, but may not have any counselling skills or knowledge. Two-day long parenting training is also available. In addition, BCPS also organizes a two-day "continuous skill development training" for practicing- and nonpsychologists

(who are practicing psychology) at a minimal fee with the objective to develop a minimum standard. BCPS organizes training in four districts through Nosrullah Psychotherapy Unit and also provides outreach work at the community level. There is a need to standardize the various trainings offered by different organizations. A concerning issue is when the training is put into practice: it is not clear who is doing what and why? People are identifying a doctor as a psychologist, or vice versa as they (people) have no idea who a 'clinical psychologist' is. Clinical psychologists are providing different types of treatment which is creating confusion. To overcome this a common standard is needed so that everyone can be brought under one structure. The Rehabilitation Council Act has been passed but this has some provision of registration. Endorsement by law would ensure at least a minimum standard.

Reporting, management information system

There is a system for reporting to the government. Private reporting may be less, but reports from government services is good as the psychiatrist has a regular job under the system. BCPS has developed by documentation mechanism for its members to report on how many patients they consulted each year. Members often feel that this is a burden. If BCPS psychologists are included in the government system, then reporting (on psychology) would be regular and effective.

Rehabilitation – challenges and solutions

Shelter homes seemed to be worse than prisons; victims who already had trauma were experiencing subsequent trauma in shelter homes; and attempts to commit suicide are very high. Concept of mental health is grossly absent in shelter homes. There is a need to overhaul the structure of shelter homes. Psychiatric rehabilitation is nonexistent in Bangladesh. There is only one project in the Centre for the Rehabilitation of the Paralysed, Savar in a limited scale for 10–15 schizophrenia patients. Patients stay only during the day time. There is no multidisciplinary setup like in the United Kingdom to ensure psychiatric rehabilitation. One of the social integration steps can be proving medical support or other support for employees working in public and private companies, such as medical support for physical illness with protection of job.

5. Summary of focus group discussion with Department of Narcotics Control

07.08.2019, Held at the DNC Meeting Room (participants: 28)

Concept of substance use

Substance abuse refers to harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome – a cluster of behavioural, cognitive and physiological phenomena that develops after repeated substance use which typically includes a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state. Chemical-based products are substances (drugs) which provide different psychotropic actions, perversions etc. in our body. There should be a restrictive law to make pharmaceutical companies who produce such drugs accountable; i.e. if the drugs are ever been abused, the companies will face penalty. There are three groups of substance use: misuse, dependence and abuse. There is no control mechanism (for these different stages) in Bangladesh. Nonsubstance use like mobile addiction, gambling disorder, nicotine use, which is on the rise should also be considered.

Current situation of substance use

There are about 700 000 drug addicts in Bangladesh. Families of the drug addicts become codependent and they (families) also become mentally sick. Therefore, it is required to include both addicts and their families in this strategic plan. By not including the families, the patient will not get full treatment and his family will also suffer resulting in sleeplessness, divorce, unemployment. For this the strategic plan has to address drug addiction – DNC needs to have a big role. DNC has been ignored in 31 operational plans under the MoHFW. The 3.1 target of SDG states that effective interventions have to be taken to prevent and treat mental health disorders. Substance abuse including use of narcotic drug abuse is an emerging social problem particularly among youth. Details about the situation have yet to be determined. As per Bangladesh's Narcotics law, the Directorate is responsible for the treatment of a drug addict. With this authority Niramoy Kendro (Drug Addiction Treatment Centre) was established and license was provided to a drug addiction treatment centre (in the private sector). To build the capacity of the 312 Niramoy Kendros in Bangladesh in the treatment of drug addiction, skilled manpower is needed – not of a doctor but a counsellor – without which this cannot be successful.

Conventionally, drug issues or health issues fall under the jurisdiction of health, but no hospital under MoHFW/DGHS has provision for treatment of drug addicts. For the past five years, there have been requests to allocate 10 bed corners for drug addicts in district

hospitals and UHCs, but this is yet to be realized. DNC has registered 312 private and public treatment centres. If resources are used properly in these facilities by setting targets (such as detox x number of people, counsel x number of people, follow up x number of people, counsel x numbers of families), and allocating the budget after fixing these parameters, it would bring value for money.

In Bangladesh, the cause of mental illness is not being addressed, rather the focus is on the effect. To identify the cause, there is a need to analyse personal and family life, and why children are becoming drug addicts in the nuclear family (feeling lonely after being mentally disturbed, becoming depressed). Another aspect is the incidence of abuse in the work environment. Doctors are prescribing sleeping pills without properly thinking of its consequences. There is no social institution to provide support.

Drug addiction situation in Bangladesh is devastating. DNC has been trying risk reduction activities for a long time. The challenges are: lack of an expert in remote areas, no focal (referral) point to connect, medical officers lack training in identifying patients. The Directorate is working as a law enforcement agency; it needs to provide treatment and licenses to private centres. Considering the rate at which the drug addiction curve is rising, services are not being rolled out as fast. To date, treatment is focused on a medical model. Families often do not seek support for drug addiction due to lack of knowledge about availability of services and sometimes simply waiting it out. There is a need to raise awareness through mass media.

Ongoing programme/interventions by the government and NGOs

Training for counsellors on mental health in 312 centres is needed to improve the mental health status of drug addicts. There is a need to collaborate with the Youth Development Directorate to rehabilitate substance abusers who receive treatment. There is a rehabilitation programme, for low income and poor people. One of the big challenges is that the family thinks that after discontinuing drug/substance, the person would become normal and not develop mental disorder again. It is important to raise awareness among these families on different signs/symptoms of mental disorders after discontinuing drug/substance use. After treatment, 40% of substance abusers get cured but the remaining 60% are at risk of relapse. Rehabilitation for all drug addicts cannot be considered; they can only be given treatment and some counselling. Various government departments need to inform people on these issues and prioritize low-income and middle-income families. The CTC does a primary assessment which is confirmed by DNC by administering a primitive level dope test. There is a referral system by which the patient is referred to identify whether he has any mental disorder and then accordingly advised for admission or for continuing treatment from home. CTC also provides services for the guardians/parents in parallel.

At the public level, there are 20 official beds in Regional Drug Addiction Treatment Centres in Rajshahi, Sylhet, Khulna and Chottogram. In addition, Pabna Mental Hospital has 25 beds for detoxification. At DNC (in Dhaka) only detoxification is done, as there are not enough human resources or infrastructure for relapse prevention and rehabilitation.

In the private sector, the Bangladesh Rehabilitation and Assistance Center for Addicts started drug addiction treatment services in 1980. They used a therapeutic community model for detoxification; which later the Asokti Punorbason Nibash and subsequently the Ahsania Mission followed. Although not of a high standard, but in the Bangladesh context, they are providing good therapeutic community service. However, root level service, known as Assertive Outreach is required. NIMH has a 50-bed unit. The BSMMU has recently started a deaddiction clinic, where there is provision to treat nonsubstance disorders as well.

Short-, medium- and long-term strategic plans are required to address mental health issues. In the short term – identify what to do quickly as the numbers are very high. This will include a protocol for degradation, detox, as per a national guideline for Bangladesh. For the medium term – operationalize protocols and organize massive training for primary care physicians who work in UHCs, and for nurses, health managers, civil surgeons and others. For the long term – plans cannot be made as there is no cure for drug addiction.

For a strategic plan, there is a need to clarify that drug addiction is a condition like diabetes which cannot be cured. Miswording of "cure" in the Narcotics Control Act needs to be replaced with "treatment"

Human resources need to be reviewed. Even with enough budget, addiction specialists or psychiatrists cannot be produced within a year (it takes eight years to be one). Thus, a long-term plan to produce psychiatrists, clinical psychologists, counsellors, should be put in place. During the first year, university faculty can be appointed. For country-wide planning there is a need for 24 supervisors for each field (i.e. clinical psychology, psychiatry, rehabilitation). In addition, psychiatry social workers are also required. Thus, the long-term plan would span 10 years. After receiving training from overseas such personnel can be deployed in universities to train others as a way to get optimum number of workforce. BSMMU has recently started a drug deaddiction clinic that lays emphasis on chemical substances. However, there is a growing number of people with Internet addiction, game addiction (i.e. process addiction

or behavioural addiction). In collaboration with CTC, BSMMU could start an addiction psychiatry course. DNC is providing treatment for drug addiction, even for drug addicts in jail. DNC has registered 312 private centres. CTC and the four regional centres report every month. Treatment coverage by these facilities can be calculated based on the number of drug addicts (460 000–700 000) in the country. This year the target is to set up 500 private treatment centres as included in the government election manifesto and aligned with the programme. There is a short speech for the khutbah on drug addiction. There are also many television channels that could disseminate messages on narcotics, but that would require funds.

6. Summary of focus group discussion with Ministry of Social Welfare

29.08.2019 Held at the Room of the Additional Secretary, MoSW (participants: 4)

Ongoing programmes/interventions

Neuro-Developmental Disability Protection Trust, which started from 2014, works on four disorders – autism, intellectual disability, cerebral palsy and Down's syndrome. The Trust though still very new (previously under Jatiya Protibondhi Unnayan Sangstha), is providing financial support (one-time) for treating children with NDDs. The NDD Trust plans to establish eight shelter homes at the divisional level which would be integrated centres for treatment, rehabilitation and other support. As per the Social Welfare Department, there are more than 261 000 NDD cases and about 160 000 disabled cases in Bangladesh. The GoB wants to integrate treatment of NDD and disabled persons together. The Department of Social Welfare (DSW) supports hospital social welfare activities to help hospital admissions and treatment, prioritizing the poor and marginalized patients. These supports include purchasing drugs, equipment and artificial limbs. There is a social work office in each district level hospital and also in National Institute of Traumatology & Orthopaedic Rehabilitation, Dhaka Medical, Mohammadpur Fertility Centre. Patients with mental health conditions should get priority (with support from social work office) and should be mentioned in this NMHSP. DSW also provides Tk 50 000 as one-time lump sum support to patients having chronic diseases such as kidney failure, liver cirrhosis, congenital heart diseases, among others. Tk 50 000–200 000 is sanctioned to institutions under the DSW; Tk 50 000–200 000 is sanctioned to the Rogi Kollayan Somittee; Tk 1000 is provided to each individual after any sudden crisis or accident – as this may affect mental health. There is a need to provide capitation grant to orphans throughout the country.

Under the recently integrated education policy for the disabled, DSW supports 12 types of special schools, eight types for addiction and four for NDDs. These schools will be under the online application and payment process and teachers will receive salary/benefits. Disabled students will receive stipend. For treatment, the Neuro-Developmental Disability Protection Trust Fund is providing support to children with NDDs. Somaj Kollayan Parishad also provides similar support. Jatiya Protibondhi Unnaan Foundation also supports 103 institutions (Protibondi Seba and Service Centre) at district and Upazila levels. They provide therapy, procure medicines and deliver advice through mobile phone.

Only one institution of its kind, the Roufabad Training and Rehabilitation Centre for Mentally Disabled Children at Roufabad, Chittagong houses children with mental disability, and imparts them education and other skills for rehabilitation. The institution has grown from providing space to 75 children to 178 children. Due to this overload, per the direction of the Prime Minister, an additional seven centres (each with a capacity to accommodate 200 children) will be established in the remaining seven divisions through DPP; the project is awaiting approval from the Executive Committee of the National Economic Council.

The challenge is limitation of man power. Ideally, there should have one caregiver for each child as they need full-time supervision, because they tend to fight with each other, or sometimes defecate in the room. Of the only four posts for caregivers, two are on leave before retirement and two have been transferred to other institutions. Two positions are being recruited through outsourcing to run the institution.

Some students may not be good in studies and thus there should be a lot of classes on music, art, dance. However, as seen in the Chottogram centre there is only one Assistant Teacher for music.

In Bangladesh, the DSW is covering four NDDs as per the approved law but in overseas countries 12 NDDs are covered. Recently, the Prime Minister has advised for integration of these four NDDs and eight others, which is in process. DSW is working mainly on rehabilitation, and providing training and other skills. These may be not up to the expected standard but efforts are going on.

Two psychiatrists (psychologists) work in Gazipur Kisor Unnayan Kendra (child development centre). Disabled children in Choto Moni Nibash in Azimpur are being treated together with NDD children in line with Prime Minister's guidance to do integrated work.

The DSW also faces another challenge: it gets orders from the court to send a particular child to Shishu Paribar without understanding whether the child is normal or disabled. It is difficult to keep a disabled child with a normal child. There are 17 juvenile jails that keep both normal and disabled children together. There are three Sishu Unnayan Kendras (previously known as subjail) or child development centres (housing 700 children in Jessore, Tongi and Konabari (only for girls)) where children who face legal conflict/contact are brought. These are always overcrowded except for the one for girls. If any child below 18 years commits any crime (juvenile crime), they are sent to these centres (instead of jails) and are provided counselling, and means to continue their education. There is a psychosocial counsellor and psychologists supported by UNICEF and Save the Children. In addition to education, these children are trained in vocational skills, such as electric work, driving, computers, so that they do not return to a life of crime. The limited number of staff for counselling is a major challenge.

The DSW has only three child development centres but the process of getting the remaining 14 unused (abandoned) subjails in different parts of the country, is underway. There are 11 autism schools under Protibondhi Unnayan Foundation and three vocational training centres for disabled children. There is no provision for counselling in orphanages under social welfare where children are more vulnerable and feel insecure. Counsellors are needed to provide counselling in these centres.

Reporting, management information system, good practice

There are no follow up data: such as how many return to normal life after leaving the centres. Social welfare institutions also do not have information. The only information is how many of them got bail and were re-integrated with families.

7. Summary of focus group discussion with Ministry of Women and Children Affairs

24.09.2019 Held at Department of Women's Affairs (participants: 2)

Ongoing projects /interventions /service delivery

MoWCA had established a OCC in Dhaka Medical College Hospital in 2001 to support women survivors of violence (more than 90% of victims were suffering from different types of trauma). Then a National Trauma Counselling Centre was established in 2009 to provide psychosocial counselling. Initially, MoWCA had provided services to only women and children who were victims of violence, particularly who were visiting OCCs. Then the MoWCA realized that preventive service is also required. This meant a huge demand for professionals trained to operate shelters (safe homes), and work on violence against women. Bangladesh Rural Advancement Committee (BRAC) District Coordinators and some headquarter staff who worked in the field of violence against women and gender were trained. The Meyeder Jonnyo Nirapod Nagorikotto programme was started for teachers who were trained on these issues. Teachers have suggested that this training be given as a part of their foundation course at the Primary Teachers Training Institute and Higher Secondary Teachers' Training Institute

MoWCA has identified three vital areas for interventions.

(i) **Hospitals.** A huge number of people visit tertiary, secondary and primary level hospitals. In 2014, a DGHS study showed about 11 core people visiting hospitals each year. It is the most common place to interact with a majority of people as about 80% of the entire population visits hospitals. This is the rationale to choose a health facility-based programme. Every day approximately 2% hospital patients develop mental illness, of which only a small fraction requires psychiatric support. More than 80% of admitted hospital patients require counselling support; which is unavailable.

There was a proposal to recruit 31 clinical psychologists 4-5 years ago, which has not yet materialized. If these posts were filled, then there could be two different units in a hospital – psychiatry and psychology. In 2017, the MoWCA opened a counselling unit (the RTCC) in each of the eight medical college hospitals. Clinical psychologists were deployed in the RTCC. Due to shortage of clinical psychologists, some had only one clinical psychologist. RTCC is very effective, because if a psychologist thinks that a particular patient should see a psychiatrist, the patient is referred to a psychiatrist. If a doctor in the psychiatry department thinks a patient needs physiological support, he/she can refer the patient to the clinical psychologist at RTCC.

All RTCCs are located in divisional medical college hospitals like the OCC. RTCC is a separate unit for general patients who require psychological support (women and children only). If the RTCC is effective and popular, then MoWCA may expand and promote them for: hospital-based counselling (OCC, RTCC); school-based counselling; and community-based counselling.

ii) **Educational institutes**, starting from primary school is another major area for interventions. There is an urgent need for school-based counselling, up to university level, including colleges and Madrasas. For school-based counselling, the MoWCA has a memorandum of understanding with BRAC, which has been providing joint training to the teachers since 2013. Training has also been organized through MoWCA's support but could not be done on a larger scale due to lack of trainers and resources to bring the participants to Dhaka or organize it in peripheral locations.

MoWCA provides supportive five-day counselling training to teachers with the main focus to enable teachers to deal/handle students in a nonjudgmental way. There should be empathic listening and then finding a way out in a nonjudgmental way. There is also a government funded school-based programme in place through BRAC partnership.

(iii) **Community counselling**. Government officials at the district level, such as social welfare officers and health education officers (in civil surgeon's office) under the MoHFW, and youth development officers are trained in Psychological First Aid. Local national NGOs, journalists of local newspapers, participants from government cooperatives, ministries of education and youth are also included in the training. Training is based at Sador Upazilas of selected districts. Currently, there are pilots in 18 districts. A total of five teachers, four student representatives and also religious leaders like Imams and Madrasa teachers are included in the training. Two members of the school governing body and two Union Parishad ward members are also included. This training addresses the immediate crisis of mental health of an individual in the community.

Adolescent students (studying in class 6 to 12 or 14 (honor's level) are at risk to be delinquent due to high emotional crisis. Sometimes workshops with both teachers and students are organized to help in behaviour modification. This is a sort of awareness raising training that lasts for one or two days where emotional crisis during adolescence and how to manage stress are discussed. Since 2010, MoWCA provides school-based training (through government funding) in selected government boys and girls schools in 64 districts. One teacher from each school is provided with "supportive counselling training".

Annex 8: List of focus discussion group participants contributing to strategy development

(not as per order of precedence or seniority)

Name	Designation	Organization
Focus group discussion with the Bangladesh Association of Psychiatrists, 8 July 2019		
Professor Md Waziul Alam Chowdhury	President BAP	Consultant, Square Hospital
Professor Mohit Kamal	Director	NIMH
Dr Md Delwar Hossain	Associate Professor	NIMH
Professor Nilufar Akhter Jahan	Professor	NIMH
Dr Mohammad Tariqul Alam	General Secretary, BAP and Associate Professor	NIMH
Dr Sifat E Syed	Associate Professor	BSMMU
Dr Sohaila Ahmed	Junior Consultant	NIMH
Dr Sultana Algin	Associate Professor	BSMMU
Professor Khasru Parvez	Professor	NIMH
Dr Farzana Rahman	Associate Professor	NIMH
Dr Md Mahbub Hasan Bappi	Medical Officer	NIMH
Dr Ahsan Aziz	Assistant Professor	NIMH
Dr Rubina Hossain	Honorary Medical Officer	NIMH
Dr Zinat De Laila	Assistant Professor	NIMH
Dr Nayem Akhter Abbassi	Senor Occupational Therapist	NIMH
Dr Saifun Nahar	Assistant Professor	NIMH
Dr Mekhala Sarker	Associate Professor	NIMH
Dr Niaz Mohammad Khan	Associate Professor	NIMH
Dr Mohammad Sibli Sadiq	Assistant Register	NIMH
Md Jamal Hossain	Psychiatric Social Worker	NIMH
Dr AK Md Khalequzzaman	Assistant Register	NIMH
Professor MMA Shahidullah Qusor	Chairman, Psychiatry	BSMMU
Professor Md Faruque Alam	Former Director	NIMH
Dr Helal Uddin Ahmed	Associate Professor	NIMH
Professor Golam Rabbani	Chairperson	Neuro-Developmental Disability Protection Trust Board
Brigadier Prof Dr Md Azizul islam	Professor of Psychiatry	CMH
Focus group discussion with the Bangladesh Clinical Psychology Society, 16 July 2019		
Dr Mohammad Mahmudur Rahman	President BCPC	University of Dhaka (DU)
Tarun Kanti Gayen	EC Member	BCPC
Mosammat Nazma Khatun	Associate Professor and Chairperson	Department of Clinical Psychology, DU
D Farhah Deba	Associate Professor	Department of Clinical Psychology, DU
Zohara Parveen	EC Member, BCPS Office Head	North South University

Name	Designation	Organization
Jobeda Khatun	Assistant Professor	Department of Clinical Psychology, DU
Liza Akter	EC Member	BCPC
SM Abul Kalam Azad	Associate Professor	Department of Clinical Psychology, DU
Dr M Kamruzzaman Mojumdar	Associate Professor	Department of Clinical Psychology, DU
Md Taifur Rahman	MS Student	Department of Clinical Psychology, DU
Habiba Sultana Runty	MS Student	Department of Clinical Psychology, DU
Shahnur Hossain	Associate Professor	Department of Clinical Psychology, DU
Md Zahir Uddin	Assistant Professor, NIMH General Secretary, BCPS	NIMH
Focus group discussion with Bangladesh Society of Education and Counselling Psychology Society, 25 July 2019		
Professor Shamim F Karim	Honorary Professor	Department of Education and Counselling Psychology (DECS), DU
Sabrina Mahmud	Senior Demonstrator and Educational Psychologist	DECS, DU
Md Moqsud Malaque	Consultant	Department of Clinical Psychology, DU
Umme Kawsar	Assistant Professor	DECS, DU
Nuzhat E Rahman	Assistant Counselling Psychologist	North South University
Professor Dr Mehjabeen Haque	Professor and Chairperson	DECS, DU
Professor Shaheen Islam	Professor	DECS, DU
Arifun Nahar Soma	Supervisor Help Desk, GBT	Plan International
Ulfat Ara Khatun	Counsellor Help Desk, GBT	Plan International
Jahan Ara Begum Asma	Counsellor Help Desk, GBT	Plan International
Jakiya Sultana	Counsellor, GBT	Plan International
Nurunnahar Begum	Psychological Services	DECS, DU
Sadia Afrin	Educational Psychologist	Institute of Paediatric Neurodisorder and Autism, BSMMU
Zinnatul Borak	Assistant Professor	DECS, DU
Md Salim Chwdhury	Assistant Professor (Psychology)	PhD Research Fellow, DECS, DU
Farhana Ahmed	Psychosocial Counsellor	BIRDEM-2 Hospital
Safina Binte Enayet	Psychosocial Counsellor and Lecturer	Brac University
Abu Tareque	Assistant Psychologist	Dhaka Medical College and Hospital
Md. Ashiqur Rahman	Trainee Psychologist	DECS, DU
Sayma Akter Pata	Trainee Psychologist	DECS, DU
Md Shahin Howlader	Counsellor	Soft Call Associated with Plan International
Azhrul Islam	Assistant Professor	DECS, DU
Kazi Rumana Haque	Psychosocial Counsellor and Lecturer	Brac University
Focus group discussion with Department of Narcotics Control, 7th August 2019		
Dr AIM Masum	RABBAM	DNC- Headquarters
Md Nuruzzaman SHarif	Director	DNC- Headquarters
SM Zakir Hossain	Director	DNC- Headquarters

Name	Designation	Organization
Dr Syed Imamul Hossain	Chief Consultant	Central Drug Addiction Treatment Centre, DNC
Md Mosaddeq Hossain Reza	Additional Director, Detective Branch	DNC- Headquarters
Md Mehedi Hasan	Assistant Director (Board)	DNC- Headquarters
Dipjoy Khisa	Assistant Director	DNC- Headquarters
Dijen Chandra Goap	Assistant Programmer	DNC- Headquarters
Dr Md Rahenul Islam	Resident Physician	Central Drug Addiction Treatment Centre, DNC
Mohammad Khurshid Alam	Assistant Director	DNC-Dhaka Metro
Shafiqul Islam Shafique	Director	Promises Medical Ltd
Md A Wahid Akand	Ex-Line Director, DGHS	Ex-LD, DGHS
Md Fazlur Rahman	Additional Director	Divisional Office, Dhaka
Palash Rozario	Representative	Bangladesh Rehabilitation and Assistance Center for Addicts
Stephen Corraya	Representative	Asokti Punorbason Nibash
Rabiul Alam Chowdhury	Liaison Officer	Bangladesh Youth First Conscience
Md Shamim Khan	Representative	Asroy
Imamul Islam Rony	Director	Sober Life Madoka Shokti Niramoy Kendro
Rasiduzzaman Rony	Director	Asroy NIR Madoka Shokti Niramoy Kendro
Lutfor Rahman Manik	CEO	Safe Home Madoka Shokti Niramoy Kendro
Urmy Day	Additional Director	DNC- Headquarters
Sanjoy Kumar Chowdhury	Additional Director General	DNC- Headquarters
Md Lokaman Hossain	Additional Director (C/S)	DNC- Headquarters
Dr Md Delwar Hossain	Associate Professor	NIMH
Md Azizul Islam	Director (Admin.)	DNC- Headquarters
Dr Md Shamsul Ahsan	Associate Professor	BSMMU
Focus group discussion with Ministry of Social Welfare, 29th August 2019		
Mohammad Ismail	Additional Secretary	MoSW
Md Saiful Islam	Director (DS)	Neuro-Developmental Disability Protection Trust
Shabnam Mushtary Rikta	Deputy Secretary	MoSW
Md Abu Masud	Director	DSS-MoSW
Focus group discussion with Ministry of Primary and Mass Education and Ministry of Education, 29th August 2019		
Salma Jahan	Additional Secretary	Division of Secondary and Higher Secondary Education, MoE
Dr AM Parvez Rahim	Joint Secretary	Autism & NDD Cell, MoHFW
Nazma Sheikh	Deputy Secretary	MoPME
Md Abdur Rahman	Deputy Secretary	Technical and Madrasa Division, MoE `

Name	Designation	Organization
Huzur Ali	Senior Assistant Chief	DNC- Headquarters
Md Saidur Rahman	Additional Secretary	Director General - Autism & NDD Cell, MoHFW
Dr Abul Hossain	Deputy Secretary	MoWCA
Ismat Jahan	Clinical Psychologist	NTCC, Multi-Sectoral Programme on Violence Against Women, MoWCA

Dr Riad Mahmud (Public Health Specialist, Management Sciences for Health/UK Department for International Development Transactional Analysis Project to MoHFW) moderated all six focus group discussions

Annex 9: Organogram of the mental health programme

Designation	Number of posts	Organizational level/office	Academic background and experiences	Job responsibility
Director, Mental Health	1	DGHS	Degree in psychiatry with public health experience at field level	Mental health programme design, advocacy, coordination and resource mobilization Report to Additional Director General (Planning)
Programme manager (Coordination, Advocacy and Partnership)	1	DGHS	Degree in psychiatry with public health experience	Mental health programme management; liaise with partner and manage NMSPNCD Report to Director, Mental Health
Programme manager (Capacity Building and Research)	1	DGHS	Degree in psychiatry with public health and research experience	Capacity building of government organization and NGO staff on mental health; oversee research portfolio Report to Director, Mental Health
Programme manager (Logistics and Operations)	1	DGHS	Degree in public health	Oversee field implementation, procurement and financial management Report to Director, Mental Health
Programme manager (Autism, NDDs, Disaster Risk Reduction)	1	DGHS	Degree in psychiatry with public health experience	Oversee autism, NDDs and mental health in disaster risk reduction Report to Director, Mental Health
Deputy programme manager	8	DGHS	Degree in psychiatry with public health experience	Assist programme managers in programme design, implementation and monitoring 2 deputy programme managers under each programme manager
Medical officer/ mental health officer	8	DGHS	MBBS/public health; clinical psychology; educational psychology	1 under each deputy programme manager Medical officer/medical health officer having psychology training will work under the programme manager/deputy programme manager for autism and NDDs
Data manager	2	DGHS	Master's in IT/statistics	Design mental health-MIS, data entry and analysis of routine MIS and research Report to programme manager (Capacity Building and Research)
Mental health officer	2	Civil surgeon's office	MBBS with mental health training or clinical psychologist; educational psychology	Oversee capacity building, coordination, implementation, monitoring and reporting of the mental health programme at the district level and below Report to civil surgeon
Total	**87**			

Annex 10: National Mental Health Act, 2018

রেজিস্টার্ড নং ডি এ-১

বাংলাদেশ গেজেট

অতিরিক্ত সংখ্যা
কর্তৃপক্ষ কর্তৃক প্রকাশিত

বুধবার, নভেম্বর ১৪, ২০১৮

বাংলাদেশ জাতীয় সংসদ

ঢাকা, ৩০ কার্তিক, ১৪২৫/১৪ নভেম্বর, ২০১৮

সংসদ কর্তৃক গৃহীত নিম্নলিখিত আইনটি ৩০ কার্তিক, ১৪২৫ মোতাবেক ১৪ নভেম্বর, ২০১৮ তারিখে রাষ্ট্রপতির সম্মতিলাভ করিয়াছে এবং এতদ্বারা এই আইনটি সর্বসাধারণের অবগতির জন্য প্রকাশ করা যাইতেছে :—

২০১৮ সনের ৬০ নং আইন

শত বছরের পুরোনো আইনের প্রাসঙ্গিকতা ও সময়োপযোগিতা হ্রাস পাওয়ায় The Lunacy Act, 1912 রহিতক্রমে যুগোপযোগী করিয়া নূতনভাবে প্রণয়নকল্পে প্রণীত আইন

যেহেতু মানসিক স্বাস্থ্য সমস্যায় আক্রান্ত ব্যক্তির স্বাস্থ্য সেবা প্রদান, মর্যাদার সুরক্ষা, সম্পত্তির অধিকার ও পুনর্বাসন এবং সার্বিক কল্যাণ নিশ্চিত করিবার জন্য The Lunacy Act, 1912 (Act No. IV of 1912) রহিতক্রমে উহা যুগোপযোগী করিয়া নূতনভাবে একটি আইন প্রণয়ন সমীচীন ও প্রয়োজনীয়;

সেহেতু এতদ্দ্বারা নিম্নরূপ আইন করা হইল, যথা :—

১। **সংক্ষিপ্ত শিরোনাম এবং প্রবর্তন।**—(১) এই আইন মানসিক স্বাস্থ্য আইন, ২০১৮ নামে অভিহিত হইবে।

(২) ইহা অবিলম্বে কার্যকর হইবে।

(১৪৯৪৩)
মূল্য : টাকা ১৬.০০

২। **সংজ্ঞা।**—বিষয় বা প্রসঙ্গের পরিপন্থি কোনো কিছু না থাকিলে, এই আইনে—

(১) '**অপ্রতিবাদী রোগী (Nonprotesting patient)**' অর্থ মানসিক স্বাস্থ্যগত কারণে চিকিৎসা অথবা ভর্তিসংক্রান্ত মতামত প্রদানে অক্ষম কিন্তু মানসিক চিকিৎসা গ্রহণে বাধা প্রদান করেন নাই এইরূপ কোনো মানসিক রোগী অথবা মানসিক প্রতিবন্ধী;

(২) **'অভিভাবক'** অর্থ ধারা ২১ এ উল্লিখিত কোনো অভিভাবক;

(৩) '**আত্মীয়**' অর্থ অভিভাবকের অপারগতায় অথবা অনুপস্থিতিতে মানসিকভাবে অসুস্থ রোগীর তত্ত্বাবধানে নিয়োজিত রক্তসম্পর্কিয় অথবা বৈবাহিক সূত্রে অথবা আদালত অনুমোদিত কোনো আত্মীয়-স্বজন;

(৪) '**আদালত**' অর্থ জেলা জজ আদালত বা তৎকর্তৃক ক্ষমতাপ্রাপ্ত অন্য কোনো আদালত;

(৫) '**কোম্পানী**' অর্থ কোম্পানী আইন, ১৯৯৪ (১৯৯৪ সনের ১৮ নং আইন) এ বর্ণিত কোম্পানী;

(৬) **'চিকিৎসা'** অর্থ মানসিক রোগবিশেষজ্ঞের তত্ত্বাবধানে ঔষধ প্রয়োগ, পরামর্শ বা সেবা প্রদান অথবা সরকার অনুমোদিত বিজ্ঞানসম্মত বিকল্প চিকিৎসা;

(৭) '**চিকিৎসার সম্মতি (Consent for treatment)**' অর্থ চিকিৎসার পূর্বে রোগ নির্ণয়, চিকিৎসার উপকারিতা, ঝুঁকি, চিকিৎসা গ্রহণ না করিবার ক্ষতি, ইত্যাদি বিষয় অবহিত রাখিয়া চিকিৎসা প্রদানের বা উক্ত চিকিৎসার পরিবর্তে সরকার অনুমোদিত বিজ্ঞানসম্মত বিকল্প চিকিৎসা সম্পর্কে ভীতি অথবা প্ররোচনা ব্যতিরেকে উহা গ্রহণের জন্য রোগী বা তাহার অভিভাবকের নিকট হইতে অনুমতি গ্রহণ;

(৮) '**দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার**' অর্থ মানসিক হাসপাতালে নিযুক্ত মানসিক চিকিৎসায় প্রশিক্ষণপ্রাপ্ত কোনো মেডিক্যাল অফিসার বা মানসিক রোগবিশেষজ্ঞ;

(৯) '**নাবালক (Minor)**' অর্থ আঠারো বৎসর বয়সের নিম্নে কোনো ব্যক্তি;

(১০) **'প্রজাতন্ত্রের সরকারি হিসাব'** অর্থ গণপ্রজাতন্ত্রী বাংলাদেশের সংবিধানের অনুচ্ছেদ ৮৪ (২) এ বর্ণিত হিসাব;

(১১) **'ব্যবস্থাপক'** অর্থ মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির সম্পত্তি রক্ষণাবেক্ষণের জন্য আদালত কর্তৃক নিযুক্ত ব্যক্তি;

(১২) **'বিধি'** অর্থ আইনের অধীন প্রণীত বিধি;

(১৩) **'ম্যাজিস্ট্রেট'** অর্থ মেট্রোপলিটন এলাকার ক্ষেত্রে এখতিয়ার সম্পন্ন মেট্রোপলিটন ম্যাজিস্ট্রেট, এবং মেট্রোপলিটন এলাকা ব্যতীত অন্য এলাকার ক্ষেত্রে এখতিয়ার সম্পন্ন জুডিশিয়াল ম্যাজিস্ট্রেট ও এক্সিকিউটিভ ম্যাজিস্ট্রেট;

(১৪) **'মাদকাসক্তি'** অর্থ কোনো দ্রব্য নিয়মিত ব্যবহার বা গ্রহণ বা নিয়মিত গ্রহণ পরবর্তী অকস্মাৎ বন্ধের ফলে ব্যক্তির জন্য ক্ষতিকর শারীরিক এবং মানসিক পরিবর্তনের লক্ষণ;

(১৫) **'মানসিক অসুস্থতা (Mental illness)'** অর্থ দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার কর্তৃক নির্ণীত মাদকাসক্তি এবং মানসিক প্রতিবন্ধিতা ব্যতীত মানসিক রোগের একটি ধরন;

(১৬) **'মানসিক রোগ (Mental disorder)'** অর্থ মানসিক প্রতিবন্ধিতা এবং মাদকাসক্তিসহ ক্লিনিক্যালি স্বীকৃত এইরূপ কতিপয় লক্ষণ অথবা আচরণ যাহা বিভিন্ন প্রকার শারীরিক ও মানসিক অথবা উভয়ের সহিত সম্পর্কিত এবং যাহা ব্যক্তির স্বাভাবিক জীবন-যাপনকে বাধাগ্রস্ত করে;

(১৭) **'মানসিক রোগবিশেষজ্ঞ (Psychiatrist)'** অর্থ সরকার কর্তৃক স্বীকৃত প্রতিষ্ঠান হইতে মানসিক রোগ বিষয়ে স্নাতকোত্তর ডিগ্রিপ্রাপ্ত এবং বিএমডিসি কর্তৃক নিবন্ধনকৃত চিকিৎসক;

(১৮) **'মানসিক সুস্থতা'** অর্থ এমন এক স্বাভাবিক অবস্থা যখন প্রত্যেক ব্যক্তি নিজের সম্ভাবনাসমূহ অনুধাবন করিতে পারেন, জীবনের স্বাভাবিক চাপসমূহের সহিত সংগতি রাখিয়া জীবন যাপন করিতে পারেন, উৎপাদনমুখী ও ফলদায়ক কার্যে নিজেকে নিয়োজিত রাখিতে পারেন এবং নিজ এলাকার জনগোষ্ঠীর জন্য কোনোভাবে অবদান রাখিতে সক্ষম হন;

(১৯) **'মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি'** অর্থ আইনের ধারা ৫ অনুযায়ী গঠিত রিভিউ ও মনিটরিং কমিটি;

(২০) **'মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবী বা সাইকোলজিস্ট'** অর্থ স্বীকৃত বিশ্ববিদ্যালয় হইতে ডিগ্রিপ্রাপ্ত ক্লিনিক্যাল সাইকোলজিস্ট, এডুকেশনাল সাইকোলজিস্ট, কাউন্সেলিং সাইকোলজিস্ট এবং মানসিক স্বাস্থ্য বিষয়ে বিশেষজ্ঞ মনোবিজ্ঞানী, সাইকিয়াট্রি, ক্লিনিক্যাল সাইকোলজি, সাইকিয়াট্রিক সোশ্যাল ওয়ার্ক, অকুপেশনাল থেরাপি, এডুকেশনাল সাইকোলজি, কাউন্সেলিং, কাউন্সেলিং সাইকোলজি, সাইকোথেরাপি এবং সাইকিয়াট্রিক নার্সিং-এ নিয়োজিত স্বীকৃত বিশ্ববিদ্যালয় ও প্রতিষ্ঠান হইতে ডিগ্রি ও প্রশিক্ষণপ্রাপ্ত ব্যক্তি;

(২১) '**মানসিক হাসপাতাল**' অর্থ ধারা ৭ এর অধীন স্থাপিত বা ধারা ৮ অনুযায়ী লাইসেন্সপ্রাপ্ত কোনো মানসিক হাসপাতাল, মানসিক রোগ চিকিৎসা কেন্দ্র, মানসিক ক্লিনিক, মাদকাসক্তদের চিকিৎসা কেন্দ্র, পুনর্বাসন কেন্দ্র বা আশ্রয় কেন্দ্র, উহা যে নামেই অভিহিত হউক;

(২২) '**মেডিক্যাল সার্টিফিকেট (Medical certificate)**' অর্থ দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার কর্তৃক রোগী পরীক্ষান্তে প্রদত্ত সনদপত্র; এবং

(২৩) '**লাইসেন্স (Licence)**' অর্থ আইনের ধারা ৮ অনুযায়ী প্রদত্ত লাইসেন্স।

৩। **আইনের প্রাধান্য।**—আপাতত বলবৎ অন্য কোনো আইনে ভিন্নতর যাহা কিছুই থাকুক না কেন এই আইনের বিধানাবলি প্রাধান্য পাইবে।

৪। **মানসিক স্বাস্থ্য সেবা কার্যক্রম পরিচালনা।**—সরকার এই আইনের অধীন মানসিক স্বাস্থ্য সেবাসংক্রান্ত কার্যক্রম পরিচালনা, সম্প্রসারণ, উন্নয়ন, নিয়ন্ত্রণ এবং সমন্বয় করিবার দায়িত্ব পালন করিবে।

৫। **মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি গঠন।**—(১) এই আইনের উদ্দেশ্য পূরণকল্পে প্রত্যেক জেলায় 'মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি' নামে একটি কমিটি থাকিবে এবং উহা নিম্নবর্ণিত সদস্য সমন্বয়ে গঠিত হইবে, যাহাদের মধ্যে ন্যূনতম একজন নারী সদস্য থাকিবেন, যথা :—

(ক)	জেলা প্রশাসক	সভাপতি;
(খ)	উপ-পরিচালক, জেলা সমাজসেবা কার্যালয়	সদস্য;
(গ)	জেলা মহিলা বিষয়ক কর্মকর্তা	সদস্য;
(ঘ)	জেলা প্রশাসক কর্তৃক মনোনীত একজন মানসিক রোগ বিশেষজ্ঞ বা সাইকোলজিস্ট	সদস্য; এবং
(ঙ)	সিভিল সার্জন	সদস্য-সচিব।

(২) মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির অভিভাবক বা আত্মীয় রোগীর চিকিৎসা সংক্রান্ত বিষয়ে সংক্ষুব্ধ হইলে কমিটির নিকট প্রতিকারের জন্য আবেদন করিতে পারিবে।

(৩) উপ-ধারা (২) অনুযায়ী আবেদন প্রাপ্তির পর কমিটি ৩০ (ত্রিশ) দিবসের মধ্যে উহা নিষ্পত্তি করিবে।

(৪) মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটির আদেশের বিরূদ্ধে সংক্ষুব্ধ হইলে সরকারের নিকট আপিল দায়ের করা যাইবে।

(৫) মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি সংক্রান্ত সকল বিষয় বিধি দ্বারা নির্ধারিত হইবে।

৬। **মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির অধিকার**।—(১) মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির স্বাস্থ্য, সম্পত্তি, মর্যাদা, শিক্ষা ও অন্যন্য অধিকারের বিষয়াবলি নিশ্চিত করিতে হইবে।

(২) উপ-ধারা (১)-এ বর্ণিত মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির অধিকার সংক্রান্ত বিষয়াবলি বিধি দ্বারা নিয়ন্ত্রিত হইবে।

৭। **মানসিক হাসপাতাল স্থাপন**।—(১) সরকার, মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির চিকিৎসা ও সেবা প্রদানের উদ্দেশ্যে যে কোনো স্থানে মানসিক হাসপাতাল স্থাপন, বা মেডিক্যাল কলেজ হাসপাতাল বা জেলা হাসপাতালসমূহের পৃথক বিভাগ বা ইউনিট প্রতিষ্ঠা করিতে পারিবে :

তবে শর্ত থাকে যে, প্রতিটি মানসিক হাসপাতাল বা ইউনিটে মাদকাসক্ত ব্যক্তি এবং বিচারাধীন বা সাজাপ্রাপ্ত মানসিক রোগীর চিকিৎসার জন্য পৃথক ব্যবস্থা থাকিতে হইবে :

আরও শর্ত থাকে যে, প্রতিটি মানসিক হাসপাতাল বা ইউনিটে নাবালক মানসিক রোগীর চিকিৎসার জন্য পৃথক ব্যবস্থা থাকিতে হইবে।

(২) মানসিক হাসপাতালের মান নির্ধারণ ও তত্ত্বাবধান সংক্রান্ত বিষয়াবলি বিধি দ্বারা নির্ধারিত হইবে।

৮। **লাইসেন্স (Licence)**।—(১) উপ-ধারা (২) এর বিধান সাপেক্ষে, সরকারের নিকট হইতে লাইসেন্স গ্রহণ করিয়া বেসরকারি মানসিক হাসপাতাল স্থাপন ও পরিচালনা করা যাইবে।

(২) বেসরকারি মানসিক হাসপাতাল স্থাপনের লাইসেন্স প্রদান, নবায়ন, স্থগিতকরণ, বাতিল, ফি নির্ধারণ, উহার শ্রেণি ও মান এবং এতদসংক্রান্ত অন্যান্য বিষয় বিধি দ্বারা নির্ধারিত হইবে।

৯। **মানসিক হাসপাতাল পরিদর্শন, তল্লাশি ও জব্দ**।—(১) সরকার কোনো মানসিক হাসপাতালে যে কোনো সময়ে প্রবেশ, পরিদর্শন, রেজিস্টার ও চিকিৎসা সেবা সংক্রান্ত যন্ত্রপাতি, নমুনা, কাগজপত্র পরীক্ষা এবং জব্দ করিতে পারিবে :

তবে শর্ত থাকে যে, রেজিস্টার বা কাগজপত্র কোনো রোগীর রোগ সংক্রান্ত হইলে সংশ্লিষ্ট রোগী বা তাহার অভিভাবকের অনুমতি ব্যতীত উহা সংগ্রহ করা বা জনসমক্ষে প্রকাশ করা যাইবে না।

(২) উপ-ধারা (১) এ বর্ণিত পরিদর্শনে এই আইন ও তদধীন প্রণীত বিধি লঙ্ঘিত হইয়াছে মর্মে প্রতীয়মান হইলে, সরকার—

(ক) নির্ধারিত সময়ের মধ্যে প্রয়োজনীয় শর্ত পূরণের বা প্রতিপালনের জন্য আদেশ প্রদান করিতে পারিবে এবং উক্ত মানসিক হাসপাতাল পরিচালনার দায়িত্বে নিয়োজিত ব্যক্তি বা দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার উহা পালনে বাধ্য থাকিবেন;

(খ) বেসরকারি মানসিক হাসপাতালে প্রদত্ত সেবা জনস্বাস্থ্যের জন্য ক্ষতিকারক বা মানসম্মত না হইলে এবং এই আইন, বিধি অথবা তদধীন প্রদত্ত নির্দেশ বা লাইসেন্সের শর্তাবলী ভঙ্গের প্রকৃতি যদি এইরূপ হয় যে, উক্ত বেসরকারি মানসিক হাসপাতালকে কারণ দর্শানোর সুযোগ প্রদান করা সমীচীন নহে, তাহা হইলে জনস্বার্থে উক্ত প্রতিষ্ঠানের লাইসেন্স স্থগিতপূর্বক তাৎক্ষণিকভাবে উহা বন্ধ করিতে পারিবে; এবং

(গ) কোনো বেসরকারি মানসিক হাসপাতাল বন্ধ করা হইলে চিকিৎসাধীন রোগীকে অনতিবিলম্বে উপযুক্ত চিকিৎসা সেবা সম্বলিত অন্য কোনো হাসপাতালে নিজ দায়িত্বে স্থানান্তরের জন্য বেসরকারি হাসপাতাল পরিচালনাকারী কর্তৃপক্ষকে নির্দেশ প্রদান করিতে পারিবে।

(৩) উপ-ধারা (১) এবং (২)-এর অধীন পরিদর্শন, তল্লাশি ও জব্দ সংক্রান্ত অন্যান্য বিষয় বিধি দ্বারা নির্ধারিত হইবে।

১০। জরিমানা আরোপের ক্ষমতা।—(১) কোনো ব্যক্তি এই আইন ও তদধীন প্রণীত বিধির কোনো বিধান লঙ্ঘন করিয়া লাইসেন্সবিহীনভাবে মানসিক হাসপাতাল পরিচালনা করিলে সরকার তাহাকে শুনানির যুক্তিসংগত সুযোগ প্রদান করিয়া, অনধিক ৫(পাঁচ) লক্ষ টাকা, এবং একই ব্যত্যয়ের পুনরাবৃত্তিতে অনধিক ২০ (বিশ) লক্ষ টাকা জরিমানা আরোপ করিতে পারিবে।

(২) উপ-ধারা (১) এর অধীন জরিমানা আরোপের অতিরিক্ত হিসাবে সরকার সংশ্লিষ্ট মানসিক হাসপাতালের সকল কার্যক্রম অনতিবিলম্বে বন্ধ করিবার নির্দেশ প্রদান এবং মালামাল জব্দ করিতে পারিবে।

(৩) মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবী জ্ঞাতসারে কোনো লাইসেন্সবিহীন মানসিক হাসপাতালে মানসিক স্বাস্থ্য সেবায় নিয়োজিত থাকিলে সরকার তাহাকে অনধিক ১(এক) লক্ষ টাকা জরিমানা করিতে পারিবে।

(৪) এই ধারার অধীন আরোপিত জরিমানা সরকারি কোষাগারে জমা করিতে হইবে।

(৫) এই ধারার অধীন সরকার কর্তৃক জরিমানা আরোপ ও আপিল করার পদ্ধতি বিধি দ্বারা নির্ধারিত হইবে।

১১। **মানসিক রোগে আক্রান্ত ব্যক্তির চিকিৎসার্থে ভর্তি।**—(১) মানসিক রোগে আক্রান্ত ব্যক্তির চিকিৎসা প্রদানের ক্ষেত্রে স্বেচ্ছায় ভর্তি, অপ্রতিবাদী রোগী ভর্তি এবং অনিচ্ছাকৃত রোগী ভর্তির বিধান প্রযোজ্য হইবে।

তবে শর্ত থাকে যে, নাবালক রোগী ভর্তির ক্ষেত্রে অভিভাবক বা আত্মীয়ের নিকট হইতে চিকিৎসার সম্মতি গ্রহণ করিতে হইবে।

(২) ভর্তির লক্ষ্যে আগত রোগীকে ধারা ১২ এবং ১৩-এ বর্ণিত সময়সীমা বা আদালত কর্তৃক নির্ধারিত সময়সীমার মধ্যে পরীক্ষার পর দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার বা মানসিক রোগ বিশেষজ্ঞ বিধিতে উল্লিখিত নির্ধারিত ফরম পূরণপূর্বক মেডিক্যাল সার্টিফিকেট প্রদান করিতে পারিবে।

(৩) উপ-ধারা (১) এর অধীন রোগী ভর্তি সংক্রান্ত অন্যান্য বিষয় বিধি দ্বারা নির্ধারিত হইবে।

১২। **স্বেচ্ছায় ভর্তির প্রক্রিয়া।**—(১) পূর্ণবয়স্ক রোগীর ক্ষেত্রে তৎসম্মতিতে ভর্তি করা যাইবে।

(২) উপ-ধারা (১) এর অধীন আবেদন প্রাপ্তির ২৪ (চব্বিশ) ঘণ্টার মধ্যে দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার ভর্তিচ্ছু ব্যক্তির মানসিক স্বাস্থ্য পরীক্ষা করিয়া বিধিতে উল্লিখিত নির্ধারিত ফরম পূরণপূর্বক সিদ্ধান্ত প্রদান করিবে।

(৩) স্বেচ্ছায় ভর্তিকৃত রোগী ছাড়পত্র গ্রহণের অথবা চিকিৎসা প্রত্যাখ্যান করিবার ইচ্ছা প্রকাশ করিতে পারিবে।

তবে শর্ত থাকে যে, ভর্তিকৃত ব্যক্তি দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার কর্তৃক অনিচ্ছাকৃত ভর্তির আওতাভুক্ত ঘোষিত হইলে উক্ত আবেদন বিবেচ্য হইবে না।

(৪) স্বেচ্ছায় ভর্তিকৃত রোগীকে দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার তাহার ভর্তির মর্যাদা (admission status) পরিবর্তন অথবা স্বেচ্ছায় ছাড়পত্র গ্রহণ অথবা চিকিৎসা প্রত্যাখ্যান করিবার অধিকার ক্ষুন্ন হইতে পারে মর্মে অবহিত করিবে।

(৫) মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি রোগী ভর্তির ও মেয়াদের যৌক্তিকতা প্রতি পনের দিবস এবং নাবালকের ক্ষেত্রে প্রতি সাত দিবস অন্তর অন্তর পুনর্বিবেচনা করিবে।

১৩। **অপ্রতিবাদী রোগী ভর্তির প্রক্রিয়া।**—(১) অভিভাবক অথবা আত্মীয়ের আবেদন বা চিকিৎসার সম্মতিক্রমে অপ্রতিবাদী রোগী ভর্তি করা যাইবে।

(২) উপ-ধারা (১) এর অধীন আবেদন বা সম্মতি প্রাপ্তির ২৪ (চব্বিশ) ঘণ্টার মধ্যে রোগীর মানসিক স্বাস্থ্য পরীক্ষা করিয়া দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার বিধিতে উল্লিখিত নির্ধারিত ফরম পূরণপূর্বক সিদ্ধান্ত প্রদান করিবে।

(৩) অপ্রতিবাদী রোগী ভর্তির ও মেয়াদের যৌক্তিকতা মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি ২৮ (আটাশ) দিবস অন্তর অন্তর পুনর্বিবেচনা করিবে।

(৪) অপ্রতিবাদী রোগী বা অভিভাবককে দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার তাহার ভর্তির মর্যাদা (Admission Status) পরিবর্তন অথবা স্বেচ্ছায় ছাড়পত্র গ্রহণ অথবা চিকিৎসা প্রত্যাখ্যান করিবার অধিকার ক্ষুণ্ন হইতে পারে মর্মে অবহিত করিবে।

১৪। **অনিচ্ছুক রোগীর ভর্তি প্রক্রিয়া**।—(১) উপ-ধারা (৪) এর বিধান সাপেক্ষে মানসিক রোগে আক্রান্ত ব্যক্তির অভিভাবক বা আত্মীয় বা স্থানীয় অধিক্ষেত্রে কর্মরত পুলিশ অফিসার বা দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসারের আবেদন বা চিকিৎসার সম্মতির পরিপ্রেক্ষিতে বিধিতে উল্লিখিত নির্ধারিত ফরম পূরণপূর্বক অনিচ্ছুক রোগীর ভর্তির কার্যক্রম গ্রহণ করা যাইবে।

(২) উপ-ধারা (১) এ বর্ণিত ভর্তির মেয়াদ হইবে নিম্নরূপ, যথা :—

(ক) দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসারের সুপারিশের ভিত্তিতে ৭২ (বাহাত্তর) ঘণ্টা পর্যন্ত জরুরি ভর্তি ;

(খ) একজন মানসিক রোগবিশেষজ্ঞের সুপারিশ অনুসারে ২৮ (আটাশ) দিবস পর্যন্ত চিকিৎসা অথবা অ্যাসেসমেন্টের (Assessment) জন্য ভর্তি ;

(গ) মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি অথবা মানসিক রোগবিশেষজ্ঞের পুনর্বিবেচনা অনুসারে ৬০ (ষাট) দিবস পর্যন্ত চিকিৎসা অথবা অ্যাসেসমেন্টের (Assessment) জন্য ভর্তি ;

(ঘ) মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটির পুনর্বিবেচনা অনুসারে দ্বিতীয়বার ১২০ (একশত বিশ) দিবস পর্যন্ত এবং প্রয়োজনে পরবর্তীকালে প্রতি ১৮০ (একশত আশি) দিবস পর্যন্ত চিকিৎসার জন্য ভর্তি; এবং

(ঙ) দফা (ঘ) এ নির্ধারিত সময়সীমা উত্তীর্ণ হইবার পর মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি রোগীর চিকিৎসার গুরুত্ব বিবেচনাক্রমে ভর্তির মেয়াদ বৃদ্ধি করিতে পারিবে।

(৩) অনিচ্ছুক রোগীর অভিভাবক বা আত্মীয়কে দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার তাহার ভর্তির মর্যাদা (Admission Status) পরিবর্তন অথবা স্বেচ্ছায় ছাড়পত্র গ্রহণ অথবা চিকিৎসা প্রত্যাখ্যান করিবার অধিকার ক্ষুণ্ন হইতে পারে মর্মে অবহিত করিবে।

(৪) তাৎক্ষণিক ও দীর্ঘায়িত চিকিৎসার জন্য অনিচ্ছুক রোগীর ভর্তির পূর্বে দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার বা মানসিক রোগবিশেষজ্ঞ বা মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটি রোগীর অসুস্থতার প্রকৃতি ও মাত্রা, আক্রমণের ঘটনা ও প্রবণতা, ঔষধ গ্রহণে অনিচ্ছা, আত্মহত্যার প্রবণতা, রাস্তায় ভবঘুরে থাকিবার প্রবণতা এবং রোগী ভর্তি না করা হইলে তাহার স্বাস্থ্য ও নিরাপত্তা এবং জনগণের নিরাপত্তা মারাত্মকভাবে বিঘ্নিত হইবার আশঙ্কা বিবেচনা করিবে।

ব্যাখ্যা।—এই ধারায় "অনিচ্ছুক রোগীর" বলিতে এমন মানসিক রোগীকে বুঝাইবে, যাহার মানসিক হাসপাতালে চিকিৎসা গ্রহণ, মানসিক রোগ বিশেষজ্ঞের বিবেচনায় জরুরি হওয়া সত্ত্বেও উক্ত রোগী চিকিৎসা গ্রহণে অনাগ্রহী।

১৫। ফৌজদারি অপরাধে অভিযুক্ত মানসিক রোগী ভর্তি প্রক্রিয়া।—(১) ফৌজদারি অপরাধে অভিযুক্ত মানসিক রোগী রিসেপশন অর্ডারের ভিত্তিতে ভর্তি থাকিবে।

(২) উপ-ধারা (১)-এর অধীন রিসেপশন অর্ডার গ্রহণ ও অন্যান্য বিষয় বিধি দ্বারা নির্ধারিত হইবে।

ব্যাখ্যা: এ ধারায় 'রিসেপশন অর্ডার (Reception order)' বলিতে ফৌজদারি অপরাধে অভিযুক্ত বা দণ্ডপ্রাপ্ত ব্যক্তিকে মানসিক হাসপাতালে ভর্তি এবং আবদ্ধ করিয়া রাখিবার উদ্দেশ্যে ম্যাজিস্ট্রেট প্রদত্ত আদেশকে বুঝাইবে।

১৬। ভর্তিকৃত রোগীর ছাড়পত্র প্রদান প্রক্রিয়া।—(১) স্বেচ্ছায়, অপ্রতিবাদী এবং অনিচ্ছুক ভর্তি মানসিক রোগীকে সুস্থ হইবার পর দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসারের অনুমতিক্রমে ছাড়পত্র প্রদান করা যাইবে।

(২) স্বেচ্ছায়, অপ্রতিবাদী এবং অনিচ্ছুক ভর্তি রোগীর ছাড়পত্র প্রদান সংক্রান্ত বিষয় বিধি দ্বারা নির্ধারিত হইবে।

১৭। **মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির চিকিৎসার অধিকার।**—(১) অভিভাবক বা আত্মীয়বিহীন বা ঠিকানাবিহীন মানসিক অসুস্থতায় আক্রান্ত ব্যক্তিকে সংশ্লিষ্ট এলাকার এখতিয়ার-সম্পন্ন স্থানীয় সরকার প্রতিষ্ঠানের প্রতিনিধি নিকটতম সরকারি মানসিক হাসপাতাল প্রধানের নিকট হস্তান্তর করিবে।

(২) কোনো ব্যক্তি মানসিক অসুস্থতায় আক্রান্ত বলিয়া ধারণা করিবার কারণ থাকিলে এবং মানসিক অসুস্থতার কারণে উক্ত ব্যক্তিকে বিপজ্জনক বলিয়া মনে করিবার কারণ থাকিলে স্থানীয় অধিক্ষেত্রের পুলিশ অফিসার তাহাকে স্বীয় জিম্মায় গ্রহণ করিয়া নিকটতম মানসিক হাসপাতালে প্রেরণ করিবে।

(৩) উপ-ধারা (১) এবং (২) অনুযায়ী হস্তান্তরিত মানসিক অসুস্থতায় আক্রান্ত ব্যক্তিকে সংশ্লিষ্ট মানসিক হাসপাতাল অনতিবিলম্বে উপযুক্ত চিকিৎসা প্রদানপূর্বক প্রমাণক কাগজপত্রের অনুলিপি সংশ্লিষ্ট স্থানীয় সরকার প্রতিষ্ঠান এবং স্থানীয় অধিক্ষেত্রের থানাকে সরবরাহ করিবে।

১৮। মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির পুনর্বাসন।—(১) অভিভাবক বা আত্মীয়বিহীন বা ঠিকানাবিহীন মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির সুস্থতার পর সংশ্লিষ্ট মানসিক হাসপাতাল তাহার সুস্থতার ছাড়পত্রসহ উক্ত ব্যক্তিকে সংশ্লিষ্ট জেলার অথবা নিকটতম সমাজসেবা প্রতিষ্ঠানে অথবা পুনর্বাসন কেন্দ্রে স্থানান্তর করিবে।

(২) উপ-ধারা (১) এ বর্ণিত ব্যক্তির সুস্থতা পরবর্তী চিকিৎসা সেবা (Follow-up treatment) সংশ্লিষ্ট মানসিক হাসপাতাল প্রদান করিবে।

(৩) উপ-ধারা (১) এ বর্ণিত প্রতিষ্ঠান বা কেন্দ্র পরিচালনার দায়িত্বপ্রাপ্ত ব্যক্তি রোগীর চিকিৎসা সংক্রান্ত বিষয়ে সংক্ষুব্ধ হইলে মানসিক স্বাস্থ্য রিভিউ ও মনিটরিং কমিটির নিকট প্রতিকারের জন্য আবেদন করিতে পারিবে।

১৯। **মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির পুনর্বাসন সংক্রান্ত কেন্দ্র স্থাপন ও পরিচালনা**।—(১) আপাতত বলবৎ অন্য কোনো আইনে যাহা কিছুই থাকুক না কেন, মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির পুনর্বাসনের অধিকার নিশ্চিতকরণে সরকারের পূর্বানুমতি সাপেক্ষে পুনর্বাসন কেন্দ্র স্থাপন ও পরিচালনা করা যাইবে।

(২) উপ-ধারা (১) এ বর্ণিত পুনর্বাসন কেন্দ্র স্থাপন ও পরিচালনা সংক্রান্ত বিষয়াদি বিধি দ্বারা নিয়ন্ত্রিত হইবে।

২০। **মানসিক অবস্থার বিচারিক অনুসন্ধান**।—(১) মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির কোনো অভিভাবক বা আত্মীয় উক্ত ব্যক্তির মানসিক অবস্থা নিরূপণের জন্য আদালতে আবেদন করিতে পারিবে।

(২) উপ-ধারা (১) এর অধীন আবেদন প্রাপ্তির পর আদালত কোনো দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসারকে সময়সীমা নির্ধারণপূর্বক মানসিক অসুস্থতায় আক্রান্ত হিসাবে অভিযুক্ত ব্যক্তির মানসিক অক্ষমতা চিহ্নিত ও যাচাই করিয়া প্রতিবেদন দাখিলের জন্য আদেশ প্রদান করিতে পারিবে।

(৩) উপ-ধারা (২) এর অধীন আদেশ প্রাপ্তির পর দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার অভিযুক্ত ব্যক্তিকে নির্ধারিত সময় ও স্থানে হাজির করিবার জন্য আবেদনকারীসহ সংশ্লিষ্টকে নোটিশ প্রদান করিবে :

তবে শর্ত থাকে যে, অভিযুক্ত ব্যক্তি মহিলা হইলে এবং ধর্ম বা প্রথানুযায়ী জনসম্মুখে উপস্থিত হইবার বাধা থাকিলে, আদালত সুবিধাজনক স্থানে তাহাকে পরীক্ষার ব্যবস্থা করিবে।

(৪) অনুসন্ধান সমাপ্তির পর দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার প্রতিবেদন দাখিল করিলে আদালত অভিযুক্ত ব্যক্তির মানসিক সুস্থতা এবং সম্পত্তি রক্ষণাবেক্ষণের সক্ষমতার বিষয়ে আদেশ প্রদান করিবে।

(৫) উপ-ধারা (৪) এর অধীন প্রদত্ত আদেশের বিরুদ্ধে সংক্ষুব্ধ হইলে উচ্চতর আদালতে আপিল দায়ের করা যাইবে।

ব্যাখ্যা: এই ধারায় '**মানসিক অক্ষমতা (Mental disability)**' বলিতে কোনো ঘটনা প্রবাহ সম্পর্কে কোনো ব্যক্তির ধারণা লাভের অসমর্থতাকে বুঝাইবে।

২১। **মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির অভিভাবকত্ব**।—(১) আপাতত বলবৎ অন্য কোনো আইনে যাহা কিছুই থাকুক না কেন, এই আইনের উদ্দেশ্য পূরণকল্পে, মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির শরীর ও সম্পত্তির অভিভাবক হইবে তাহার পিতা বা মাতা।

(২) মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির পিতা ও মাতার অবর্তমানে তাহার বা তাহার আত্মীয়ের আবেদনের পরিপ্রেক্ষিতে আদালত উপযুক্ত ব্যক্তিকে অভিভাবক নিযুক্ত করিবে :

তবে শর্ত থাকে যে, মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির জন্য যৌক্তিক কারণে কল্যাণকর বিবেচিত না হইলে কোনো আত্মীয়কে অভিভাবক নিযুক্ত করা যাইবে না।

(৩) অভিভাবকের দায়িত্ব ও কর্তব্য সংক্রান্ত বিষয়াবলি বিধি দ্বারা নির্ধারিত হইবে।

(৪) অভিভাবক উপ-ধারা (৩) এ বর্ণিত দায়িত্ব পালনে অবহেলা করিলে বা অবহেলার প্ররোচনার সহিত জড়িত মর্মে প্রাথমিকভাবে প্রতীয়মান হইলে, স্থানীয় অধিক্ষেত্রের পুলিশ অফিসার বা স্থানীয় জনপ্রতিনিধি ম্যাজিস্ট্রেটকে লিখিতভাবে অবহিত করিবে।

২২। **মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির সম্পত্তি রক্ষণাবেক্ষণ**।—(১) যেই ক্ষেত্রে মানসিক হাসপাতালে ভর্তির পর কোনো মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির মানসিক অক্ষমতার কারণে অথবা অন্য কোনো কারণে তাহার সম্পত্তি রক্ষণাবেক্ষণে সক্ষম না হন, সেইক্ষেত্রে দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার তাহার অভিভাবক বা আত্মীয়কে সম্পত্তির ক্ষতির সম্ভাবনা সম্পর্কে অবহিত করিবে।

(২) উপ-ধারা (১) অনুযায়ী অবগত হইবার পর মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির অভিভাবক বা আত্মীয় কোনো ব্যবস্থা গ্রহণে অনীহা প্রকাশ করিলে দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসার আদালতের নিকট উক্ত সম্পত্তি রক্ষণাবেক্ষণের জন্য ব্যবস্থাপক নিয়োগের আবেদন করিবার ব্যবস্থা করিবে।

(৩) দায়িত্বপ্রাপ্ত মেডিক্যাল অফিসারের আবেদনের প্রেক্ষিতে আদালতের নিকট যদি প্রতীয়মান হয় যে, মানসিক অসুস্থতায় আক্রান্ত ব্যক্তি তাহার সম্পত্তি রক্ষণাবেক্ষণে অক্ষম, এবং তাহার পিতা বা মাতা জীবিত নাই, তাহা হইলে আদালত একজন উপযুক্ত ব্যক্তিকে অনধিক ৩ (তিন) বৎসর মেয়াদে ব্যবস্থাপক নিযুক্ত করিবে।

(৪) ব্যবস্থাপক দায়িত্ব গ্রহণের ৬ (ছয়) মাসের মধ্যে মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির স্থাবর ও অস্থাবর সম্পত্তির হিসাব ও তালিকা আদালতে পেশ করিবে।

(৫) ব্যবস্থাপক মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির পক্ষে তাহার সম্পত্তি গ্রহণ, ব্যবস্থাপনা, নিয়ন্ত্রণ, ব্যবসা-বাণিজ্য পরিচালনা, অংশীদারি কারবার অবসান এবং এতদসংক্রান্ত আইনগত ব্যবস্থা গ্রহণ করিবে :

তবে শর্ত থাকে যে, ব্যবস্থাপক আদালতের অনুমতি ব্যতীত মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির কোনো স্থাবর সম্পত্তি বন্ধক, হস্তান্তর, বিক্রয়, ভাড়া, উপহার, বিনিময় করিতে অথবা ৫ (পাঁচ) বৎসরের ঊর্ধ্বে উক্ত সম্পত্তি লিজ প্রদান করিতে পারিবে না।

(৬) ব্যবস্থাপক প্রত্যেক আর্থিক বৎসর সমাপ্তির ৩ (তিন) মাসের মধ্যে তাহার দায়িত্বে থাকা সম্পত্তি ও সম্পদ, গৃহীত অর্থ এবং উক্ত ব্যক্তির মানসিক অসুস্থতার চিকিৎসায় ব্যয়কৃত অর্থের পরিমাণ এবং স্থিতির হিসাব সংশ্লিষ্ট আদালতের নিকট পেশ করিবে।

(৭) মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির কোনো অভিভাবক বা আত্মীয় ব্যবস্থাপকের নিকট হইতে অথবা তাহার অপসারণের পর দায়িত্বপ্রাপ্ত কোনো ব্যক্তির নিকট হইতে অথবা তাহার মৃত্যুর পর বৈধ প্রতিনিধির নিকট হইতে তাহার অধীনে থাকা অথবা তৎকর্তৃক গৃহীত কোনো সম্পত্তির হিসাব প্রাপ্তির জন্য আদালতে আবেদন করিতে পারিবে।

(৮) ব্যবস্থাপক মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির চিকিৎসার চলতি ব্যয় এবং তাহার সম্পত্তি বা সম্পদ তত্ত্বাবধানের জন্য প্রয়োজনীয় আনুমানিক ব্যয় ব্যতীত অবশিষ্ট অর্থ প্রজাতন্ত্রের সরকারি হিসাবে জমা প্রদান করিবে এবং সংশ্লিষ্ট ব্যক্তি মানসিক অসুস্থতা হইতে আরোগ্য লাভ করিলে তিনি উক্ত জমাকৃত অর্থ ফেরৎ পাওয়ার অধিকারী হইবেন।

(৯) ব্যবস্থাপক আদালতের নির্দেশে সংশ্লিষ্ট মানসিক অসুস্থতায় আক্রান্ত ব্যক্তি এবং তাহার আইনগত উত্তরাধিকারগণের স্বার্থে উক্ত অর্থ অন্য কোনোরূপে বিনিয়োগপূর্বক সকল লেনদেনের হিসাব উপ-ধারা (৪) অনুযায়ী পেশ করিবে।

(১০) যেই ক্ষেত্রে আদালতের নিকট প্রতীয়মান হয় যে, সংশ্লিষ্ট ব্যক্তি মানসিক অসুস্থতা হইতে আরোগ্য লাভ করিয়াছেন, সেইক্ষেত্রে আদালত উক্ত ব্যক্তির মানসিক সুস্থতা সম্পর্কে প্রতিবেদন প্রদানের জন্য একজন মানসিক রোগবিশেষজ্ঞ সমন্বয়ে অন্যূন ৩ (তিন) সদস্যবিশিষ্ট কমিটি গঠনপূর্বক অনুসন্ধানের নির্দেশ প্রদান করিতে পারিবে।

(১১) মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির অভিভাবক এবং তাহার সম্পত্তির ব্যবস্থাপক উভয়ই আদালত কর্তৃক নির্ধারিত হারে পারিশ্রমিক প্রাপ্য হইবে।

(১২) আদালত কর্তৃক উপযুক্ত বিবেচিত হইলে ব্যবস্থাপক বা অভিভাবক অপসারণ বা মেয়াদ বৃদ্ধি বা পুনঃনিয়োগের কার্যক্রম গৃহীত হইবে।

(১৩) মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির স্থাবর ও অস্থাবর সম্পত্তি আদালত কর্তৃক পরিত্যক্ত মর্মে বিবেচিত হইলে উহা সরকারি ব্যবস্থাপনায় হস্তান্তরের আদেশ প্রদান করিতে পারিবে।

২৩। **অপরাধ ও দণ্ড।**—(১) মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবী হিসাবে কোনো ব্যক্তি মানসিক অসুস্থতা সম্পর্কিত বিষয়ে উদ্দেশ্য প্রণোদিতভাবে মিথ্যা সার্টিফিকেট প্রদান করিলে অনধিক ৩ (তিন) লক্ষ টাকা অর্থদণ্ডে বা ১ (এক) বৎসর সশ্রম কারাদণ্ডে বা উভয় দণ্ডে দণ্ডিত হইবে।

(২) অভিভাবক বা ব্যবস্থাপক মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির চিকিৎসা বা সম্পত্তির তালিকা প্রণয়ন বা ব্যবস্থাপনার দায়িত্বে অবহেলা বা আদালতের কোনো নির্দেশ বাস্তবায়ন না করিলে অনধিক ৫ (পাঁচ) লক্ষ টাকা অর্থদণ্ডে বা ৩ (তিন) বৎসর সশ্রম কারাদণ্ডে বা উভয় দণ্ডে দণ্ডিত হইবে।

(৩) কোনো ব্যক্তি এই আইনের অন্য কোনো বিধান বা উহার অধীন প্রণীত কোনো বিধি লঙ্ঘন বা লঙ্ঘনে সহযোগিতা বা প্ররোচনা বা আইনে প্রতিপালনযোগ্য বিষয়াদি বা সরকারের কোনো আদেশ বা নির্দেশ প্রতিপালন না করা বা প্রতিপালন না করায় সহযোগিতা বা বাধা প্রদান করিলে উক্ত ব্যক্তি অনধিক ১ (এক) লক্ষ টাকা অর্থদণ্ডে বা ৬ (ছয়) মাস কারাদণ্ডে বা উভয় দণ্ডে দণ্ডিত হইবে।

২৪। **অপরাধ আমলে গ্রহণ, বিচার, ইত্যাদি।**—(১) ধারা ২৩ এর অধীন অপরাধসমূহ ম্যাজিস্ট্রেট কর্তৃক বিচার্য হইবে।

(২) ফৌজদারি কার্যবিধিতে ভিন্নতর যাহা কিছুই থাকুক না কেন, সরকার বা তৎকর্তৃক ক্ষমতাপ্রাপ্ত কোনো কর্মকর্তার লিখিত প্রতিবেদন ব্যতীত উপ-ধারা (১) এ উল্লিখিত কোনো ম্যাজিস্ট্রেট এই আইনের ধারা ২৩ এর অধীন কোনো অপরাধ আমলে গ্রহণ করিবে না।

(৩) এই আইনের অন্যান্য বিধানাবলী সাপেক্ষে, ধারা ২৩ এর অধীন অপরাধ সংক্রান্ত মামলা দায়ের, অপরাধের তদন্ত, বিচার ও অন্যান্য কার্যক্রম ফৌজদারি কার্যবিধির অধীন পরিচালিত হইবে, এবং উক্ত অপরাধসমূহ অ-আমলযোগ্য (Non-Cognizable), আপোসযোগ্য (compoundable) এবং জামিনযোগ্য (Bailable) হইবে।

(৪) ফৌজদারি কার্যবিধিতে ভিন্নতর যাহা কিছুই থাকুক না কেন, উপ-ধারা (১) এ উল্লিখিত ম্যাজিস্ট্রেট ধারা ২৩ এ উল্লিখিত অর্থদণ্ড আরোপ করিতে পারিবে।

ব্যাখ্যা: এই ধারায় **'ফৌজদারি কার্যবিধি'** বলিতে Code of Criminal Procedure, 1898 (Act No. V of 1898) কে বুঝাইবে।

Annex 11: Bangladesh Rehabilitation Council Act 2018

রেজিস্টার্ড নং ডি এ-১

বাংলাদেশ গেজেট

অতিরিক্ত সংখ্যা

কর্তৃপক্ষ কর্তৃক প্রকাশিত

বুধবার, নভেম্বর ১৪, ২০১৮

বাংলাদেশ জাতীয় সংসদ

ঢাকা, ৩০ কার্তিক, ১৪২৫/১৪ নভেম্বর, ২০১৮

সংসদ কর্তৃক গৃহীত নিম্নলিখিত আইনটি ৩০ কার্তিক, ১৪২৫ মোতাবেক ১৪ নভেম্বর, ২০১৮ তারিখে রাষ্ট্রপতির সম্মতিলাভ করিয়াছে এবং এতদ্বারা এই আইনটি সর্বসাধারণের অবগতির জন্য প্রকাশ করা যাইতেছে :—

২০১৮ সনের ৭১ নং আইন

রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান ও শিক্ষা কার্যক্রম বা পাঠ্যক্রমের স্বীকৃতি, রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান বা ইউনিট অনুমোদন, রিহ্যাবিলিটেশন পেশাজীবীর নিবন্ধন, এবং উহাদের যোগ্যতা ও সেবার মান নির্ধারণ ও নিশ্চিতকরণের উদ্দেশ্যে কাউন্সিল গঠন এবং এতৎসংশ্লিষ্ট বিধান প্রণয়নকল্পে প্রণীত আইন

যেহেতু রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান, শিক্ষা কার্যক্রম বা পাঠ্যক্রমের স্বীকৃতি, রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান বা ইউনিট অনুমোদন, রিহ্যাবিলিটেশন পেশাজীবীর নিবন্ধন, এবং উহাদের যোগ্যতা ও সেবার মান নির্ধারণ ও নিশ্চিতকরণের উদ্দেশ্যে কাউন্সিল গঠন এবং এতৎসংশ্লিষ্ট বিধান প্রণয়ন করা সমীচীন ও প্রয়োজনীয়;

সেহেতু এতদ্দ্বারা নিম্নরূপ আইন করা হইল, যথা:—

১। **সংক্ষিপ্ত শিরোনাম ও প্রবর্তন।**—(১) এই আইন বাংলাদেশ রিহ্যাবিলিটেশন কাউন্সিল আইন, ২০১৮ নামে অভিহিত হইবে।

(২) ইহা অবিলম্বে কার্যকর হইবে।

(১৫১৫৫)

মূল্য : টাকা ২৪.০০

২। **সংজ্ঞা।**—বিষয় বা প্রসঙ্গের পরিপন্থি কোনো কিছু না থাকিলে, এই আইনে,—

(১) "কাউন্সিল" অর্থ ধারা ৩ এর অধীন প্রতিষ্ঠিত বাংলাদেশ রিহ্যাবিলিটেশন কাউন্সিল;

(২) "তপশিল" অর্থ এই আইনের সহিত সংযুক্ত কোনো তপশিল;

(৩) "নির্বাহী কমিটি" অর্থ ধারা ১০ এর অধীন গঠিত নির্বাহী কমিটি;

(৪) "প্রতিবন্ধী ব্যক্তি" অর্থ প্রতিবন্ধী ব্যক্তির অধিকার ও সুরক্ষা আইন, ২০১৩ এর ধারা ৩ এ বর্ণিত প্রতিবন্ধী ব্যক্তি;

(৫) "প্রবিধান" অর্থ এই আইনের অধীন প্রণীত কোনো প্রবিধান;

(৬) "ফৌজদারী কার্যবিধি'' অর্থ Code of Criminal Procedure, 1898 (Act V of 1898);

(৭) "বিধি'' অর্থ এই আইনের অধীন প্রণীত কোনো বিধি;

(৮) "রিহ্যাবিলিটেশন" অর্থ কতিপয় স্বীকৃত পদ্ধতি অথবা ব্যবস্থার সমষ্টি, যাহা প্রতিবন্ধী ব্যক্তি অথবা প্রতিবন্ধিতার ঝুঁকিতে রহিয়াছে এইরূপ কোনো ব্যক্তির প্রাত্যহিক অথবা ব্যবহারিক জীবনমানের প্রত্যাশিত উন্নয়ন ঘটাইবার মাধ্যমে জীবনের সকলক্ষেত্রে পারিপার্শ্বিক পরিবেশের সহিত স্বাভাবিক ও অর্থপূর্ণ অংশগ্রহণ নিশ্চিত করে;

(৯) "রিহ্যাবিলিটেশন টেকনিশিয়ান" অর্থ কাউন্সিল কর্তৃক এই আইনের অধীন নিবন্ধিত এমন কোনো টেকনিশিয়ান, যাহার তৃতীয় তপশিলে উল্লিখিত যোগ্যতা রহিয়াছে, এবং যিনি রিহ্যাবিলিটেশন প্রাকটিশনারের তত্ত্বাবধানে সেবা প্রদান করেন;

(১০) "রিহ্যাবিলিটেশন টেকনোলজিস্ট" অর্থ কাউন্সিল কর্তৃক এই আইনের অধীন নিবন্ধিত এমন কোনো টেকনোলজিস্ট, যাহার দ্বিতীয় তপশিলে উল্লিখিত যোগ্যতা রহিয়াছে, এবং যিনি রিহ্যাবিলিটেশন প্রাকটিশনারের তত্ত্বাবধানে সেবা প্রদান করেন;

(১১) "রিহ্যাবিলিটেশন পেশাজীবী" অর্থ কাউন্সিল কর্তৃক এই আইনের অধীন নিবন্ধিত এমন কোনো পেশাজীবী যাহার প্রথম, দ্বিতীয় ও তৃতীয় তপশিলে উল্লিখিত যোগ্যতা রহিয়াছে;

(১২) "রিহ্যাবিলিটেশন প্রাকটিশনার" অর্থ কাউন্সিল কর্তৃক এই আইনের অধীন লাইসেন্স প্রাপ্ত কোনো রিহ্যাবিলিটেশন প্রাকটিশনার, যাহার প্রথম তপশিলে উল্লিখিত যোগ্যতা রহিয়াছে;

(১৩) "রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান" অর্থ চতুর্থ, পঞ্চম ও ষষ্ঠ তপশিলে উল্লিখিত রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান;

(১৪) "রিহ্যাবিলিটেশন সেবা ইউনিট" অর্থ কাউন্সিল কর্তৃক এই আইনের অধীন অনুমোদিত কোনো সরকারি বা বেসরকারি হাসপাতালের অধীন রিহ্যাবিলিটেশন সেবা প্রদানের নিমিত্ত সৃষ্ট সেন্টার, বিভাগ বা ইউনিট;

(১৫) "রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান" অর্থ কাউন্সিল কর্তৃক এই আইনের অধীন অনুমোদিত কোনো রিহ্যাবিলিটেশন সেবা প্রদানকারী প্রতিষ্ঠান;

(১৬) "রেজিস্ট্রার" অর্থ ধারা ৮ এর অধীন নিয়োগকৃত কাউন্সিলের রেজিস্ট্রার; এবং

(১৭) "স্বীকৃত প্রতিষ্ঠান" অর্থ পাবলিক বিশ্ববিদ্যালয় অথবা মেডিক্যাল বিশ্ববিদ্যালয় অথবা বিশ্ববিদ্যালয় মঞ্জুরি কমিশন অথবা ক্ষেত্রবিশেষে রাষ্ট্রীয় চিকিৎসা অনুষদ (State Medical Faculty) কর্তৃক অনুমোদিত প্রতিষ্ঠান।

৩। **কাউন্সিল প্রতিষ্ঠা।**—(১) এই আইন কার্যকর হইবার পর যথাশীঘ্র সম্ভব সরকার, সরকারি গেজেটে প্রজ্ঞাপন দ্বারা, বাংলাদেশ রিহ্যাবিলিটেশন কাউন্সিল নামে একটি কাউন্সিল প্রতিষ্ঠা করিবে।

(২) কাউন্সিল একটি সংবিধিবদ্ধ সংস্থা হইবে এবং ইহার স্থায়ী ধারাবাহিকতা ও একটি সাধারণ সিলমোহর থাকিবে, এবং এই আইনের বিধানাবলি সাপেক্ষে, ইহার স্থাবর ও অস্থাবর উভয় প্রকার সম্পত্তি অর্জন করিবার, অধিকারে রাখিবার, হস্তান্তর করিবার এবং চুক্তি সম্পাদন করিবার ক্ষমতা থাকিবে এবং ইহা স্বীয় নামে মামলা দায়ের করিতে পারিবে এবং ইহার বিরুদ্ধেও মামলা দায়ের করা যাইবে।

৪। **কাউন্সিলের কার্যালয়।**—(১) কাউন্সিলের প্রধান কার্যালয় ঢাকায় অবস্থিত হইবে।

(২) সরকার, প্রয়োজনবোধে, দেশের যে কোনো স্থানে কাউন্সিলের অধঃস্তন বা শাখা কার্যালয় স্থাপন করিতে পারিবে।

৫। **কাউন্সিলের গঠন।**—(১) কাউন্সিল নিম্নবর্ণিত সদস্য সমন্বয়ে গঠিত হইবে, যথা:—

(ক) সচিব, সমাজকল্যাণ মন্ত্রণালয়, যিনি কাউন্সিলের সভাপতিও হইবেন;

(খ) স্বাস্থ্য সেবা বিভাগ কর্তৃক মনোনীত একজন অতিরিক্ত সচিব;

(গ) চেয়ারপার্সন, নিউরো ডেভেলপমেন্টাল প্রতিবন্ধী সুরক্ষা ট্রাস্টি বোর্ড;

(ঘ) মহাপরিচালক, সমাজসেবা অধিদপ্তর;

(ঙ) মহাপরিচালক, স্বাস্থ্য অধিদপ্তর;

(চ) ব্যবস্থাপনা পরিচালক, জাতীয় প্রতিবন্ধী উন্নয়ন ফাউন্ডেশন;

(ছ) স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(জ) গৃহায়ণ ও গণপূর্ত মন্ত্রণালয় কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(ঝ) শ্রম ও কর্মসংস্থান মন্ত্রণালয় কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(ঞ) লেজিসলেটিভ ও সংসদ বিষয়ক বিভাগ কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(ট) মাধ্যমিক ও উচ্চ শিক্ষা বিভাগ কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(ঠ) কারিগরি ও মাদ্রাসা শিক্ষা বিভাগ কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(ড) মহিলা ও শিশু বিষয়ক মন্ত্রণালয় কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(ঢ) প্রাথমিক ও গণশিক্ষা মন্ত্রণালয় কর্তৃক মনোনীত একজন অন্যূন যুগ্মসচিব;

(ণ) সরকার কর্তৃক মনোনীত পাবলিক বিশ্ববিদ্যালয়সমূহের সংশ্লিষ্ট অনুষদের ডিনগণ হইতে অনধিক ০৩ (তিন) জন ডিন;

(ত) বিশ্ববিদ্যালয় মঞ্জুরি কমিশনের চেয়ারম্যান কর্তৃক মনোনীত একজন সদস্য;

(থ) ন্যাশনাল ইনস্টিটিউট অব ট্রমাটোলজি অ্যান্ড অর্থোপেডিক রিহ্যাবিলিটেশন (National Institute of Traumatology and Orthopaedic Rehabilitation) এর পরিচালক বা তদকর্তৃক মনোনীত একজন প্রতিনিধি;

(দ) পরিচালক, বাংলাদেশ মেডিক্যাল রিসার্চ কাউন্সিল;

(ধ) সরকার কর্তৃক মনোনীত (অধ্যাপক পদমর্যাদার) একজন বিশেষজ্ঞ চিকিৎসক, যিনি রিহ্যাবিলিটেশন সেবা সংশ্লিষ্ট কর্মকাণ্ডে ন্যূনতম ১৫ (পনেরো) বৎসর যাবৎ সম্পৃক্ত;

(ন) বাংলাদেশ ফিজিক্যাল মেডিসিন ও রিহ্যাবিলিটেশন সংস্থা (Bangladesh Association of Physical Medicine and Rehabilitation) কর্তৃক মনোনীত একজন সদস্য;

(প) ট্রাস্ট ফর রিহ্যাবিলিটেশন অব দি প্যারালাইজড কর্তৃক মনোনীত একজন সদস্য;

(ফ) সভাপতি, বাংলাদেশ মেডিক্যাল ও ডেন্টাল কাউন্সিল অথবা তৎকর্তৃক মনোনীত উক্ত কাউন্সিলের একজন অন্যূন ডেপুটি নিবন্ধক;

(ব) সরকার কর্তৃক মনোনীত প্রতিবন্ধী ব্যক্তির রিহ্যাবিলিটেশনে সক্রিয়ভাবে কর্মরত একজন ব্যক্তি;

(ভ) বাংলাদেশ মেডিক্যাল অ্যাসোসিয়েশন কর্তৃক মনোনীত একজন প্রতিনিধি;

(ম) সরকার কর্তৃক মনোনীত প্রথম তপশিলের (১) আবশ্যিকভাবে, (২) ও (৩) সংশ্লিষ্ট পেশাজীবী সংগঠনসমূহের প্রতিটি হইতে ন্যূনতম ০১ (এক) জন প্রতিনিধিসহ সর্বমোট ০৫ (পাঁচ) জন প্রতিনিধি;

(য) সরকার কর্তৃক মনোনীত সেবা গ্রহণকারীদের মধ্য হইতে একজন প্রতিনিধি; এবং

(র) কাউন্সিলের রেজিস্ট্রার, যিনি কাউন্সিলের সদস্য-সচিবও হইবেন।

(২) উপ-ধারা (২) এর দফা (ধ), (ন), (ফ), (ব), (ভ), (ম) ও (য) তে উল্লিখিত মনোনীত সদস্যগণ তাহাদের মনোনয়নের তারিখ হইতে ৩ (তিন) বৎসর মেয়াদে স্বীয় পদে বহাল থাকিবেন:

তবে শর্ত থাকে যে, উপ-ধারা (২) এ উল্লিখিত মেয়াদ শেষ হইবার পূর্বে মনোনয়ন প্রদানকারী কর্তৃপক্ষ উক্ত যে কোনো সদস্যকে তাহার দায়িত্ব হইতে যে কোনো সময় অব্যাহতি প্রদান করিতে পারিবে।

(৩) কাউন্সিলের কোনো সদস্য, সভাপতি বরাবরে স্বাক্ষরযুক্ত পত্রযোগে স্বীয় পদ ত্যাগ করিতে পারিবেন, তবে সভাপতি কর্তৃক গৃহীত না হওয়া পর্যন্ত উক্ত পদত্যাগ কার্যকর হইবে না।

(৪) কোনো ব্যক্তি একাধিক যোগ্যতায় কাউন্সিলের সদস্য হইতে বা থাকিতে পারিবে না।

ব্যাখ্যা।—এই ধারার উদ্দেশ্য পূরণকল্পে "পেশাজীবী সংগঠন" বলিতে প্রথম তপশিলে উল্লিখিত রিহ্যাবিলিটেশন প্র্যাকটিশনারের পেশা সংশ্লিষ্ট ও সরকারের যথাযথ নিবন্ধনকারী কর্তৃপক্ষ কর্তৃক পেশাজীবী সংগঠন হিসাবে নিবন্ধনপ্রাপ্ত সংগঠনকে বুঝাইবে।

৬। **কাউন্সিলের দায়িত্ব ও কার্যাবলি।**—কাউন্সিলের দায়িত্ব ও কার্যাবলি হইবে নিম্নরূপ, যথা:—

(ক) বাংলাদেশে স্বীকৃত প্রতিষ্ঠান বা রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান কর্তৃক রিহ্যাবিলিটেশন প্রাকটিশনার, রিহ্যাবিলিটেশন টেকনোলজিস্ট ও রিহ্যাবিলিটেশন টেকনিশিয়ানকে প্রদত্ত শিক্ষাগত যোগ্যতার স্বীকৃতি প্রদান;

(খ) বাংলাদেশের বাহিরে অবস্থিত রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান অথবা সমজাতীয় প্রতিষ্ঠান কর্তৃক প্রদত্ত রিহ্যাবিলিটেশন শিক্ষা যোগ্যতার স্বীকৃতি প্রদান;

(গ) অন্য কোনো দেশের রিহ্যাবিলিটেশন কাউন্সিল বা সংশ্লিষ্ট কর্তৃপক্ষের সহিত আলোচনার মাধ্যমে সেই দেশের রিহ্যাবিলিটেশন বিষয়ক শিক্ষাগত যোগ্যতার বিষয়ে পারস্পরিক সমঝোতার ভিত্তিতে স্বীকৃতি প্রদানসহ এতদসংক্রান্ত পরিকল্পনা গ্রহণ ও পরিচালনা;

(ঘ) রিহ্যাবিলিটেশন পেশাজীবীদের জন্য আবশ্যিক পেশাগত বা শিক্ষাগত যোগ্যতার ন্যূনতম ও অভিন্ন মান নির্ধারণ, পাঠ্যসূচি ও পাঠক্রমের মান ও মেয়াদ নির্ধারণ;

(ঙ) রিহ্যাবিলিটেশন পেশাজীবীদের জন্য আবশ্যিক পেশাগত বা শিক্ষাগত যোগ্যতার সকল পর্যায়ে ভর্তির যোগ্যতা, নীতিমালা ও শর্তাদি নির্ধারণ;

(চ) রিহ্যাবিলিটেশন পেশাজীবীদের জন্য পেশাগত বা শিক্ষাগত যোগ্যতা সংক্রান্ত পরীক্ষা গ্রহণ, পরীক্ষা গ্রহণ পদ্ধতি এবং অন্যান্য আনুষঙ্গিক বিষয়ের ন্যূনতম মান নির্ধারণ;

(ছ) রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠানে নিয়োগের লক্ষ্যে শিক্ষকগণের ন্যূনতম শিক্ষাগত, পেশাগত যোগ্যতা ও অভিজ্ঞতার মান নির্ধারণ;

(জ) রিহ্যাবিলিটেশন পেশাজীবীগণের নিবন্ধন ও রিহ্যাবিলিটেশন প্রাকটিশনারদের পরীক্ষা গ্রহণপূর্বক লাইসেন্স প্রদান;

(ঝ) রিহ্যাবিলিটেশন প্রাকটিশনারদের লাইসেন্স প্রদানের নিমিত্ত পরীক্ষা গ্রহণ, পরীক্ষা গ্রহণ পদ্ধতি, পরীক্ষা পরিচালনার লক্ষ্যে প্রয়োজনীয় বোর্ড গঠন এবং আনুষঙ্গিক বিষয়াদি নির্ধারণ;

(ঞ) তপশিল সংশোধনের নিমিত্ত সরকারের নিকট প্রস্তাব প্রেরণ;

(ট) রিহ্যাবিলিটেশন পেশাজীবীদের নিবন্ধন প্রদান, নিবন্ধন বহি (Register) প্রণয়ন, প্রকাশ, সংরক্ষণ ও প্রতিনিয়ত হালনাগাদকরণ;

(ঠ) রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান, রিহ্যাবিলিটেশন সেবা ইউনিট ও রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠানসমূহ যে-কোনো সময় পরিদর্শন করা, এবং এতদুদ্দেশ্যে প্রয়োজনীয় সংখ্যক বিশেষজ্ঞের মাধ্যমে পরিদর্শন কার্য সম্পাদন;

(ড) রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠানসমূহ স্বীকৃতি প্রদানের লক্ষ্যে সুপারিশ প্রদান;

(ঢ) রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান বা রিহ্যাবিলিটেশন সেবা ইউনিট অনুমোদন প্রদান;

(ণ) নিবন্ধন, পরীক্ষা গ্রহণ, পরিদর্শন ফি ও অন্যান্য ফি নির্ধারণ;

(ত) এই আইনের অধীন নিবন্ধিত নহে অথচ রিহ্যাবিলিটেশন পেশায় নিয়োজিত রহিয়াছে এইরূপ ব্যক্তির বিরুদ্ধে আইনানুগ ব্যবস্থা গ্রহণ;

(থ) রিহ্যাবিলিটেশন প্রাকটিশনার, রিহ্যাবিলিটেশন টেকনোলজিস্ট ও রিহ্যাবিলিটেশন টেকনিশয়ানদের ভুয়া পদবি, ডিগ্রি, প্রতারণামূলক প্রতিনিধিত্ব বা নিয়ন্ত্রণের বিরুদ্ধে ব্যবস্থা গ্রহণ;

(দ) রিহ্যাবিলিটেশন পেশাজীবীর পেশাগত কর্মকান্ডের পরিধি ও সীমা নির্ধারণ;

(ধ) রিহ্যাবিলিটেশন পেশাজীবীর পেশাগত অসদাচরণের ক্ষেত্রে শাস্তিমূলক ব্যবস্থা গ্রহণ;

(ন) কাউন্সিলের সকল স্থাবর-অস্থাবর সম্পত্তির ব্যবস্থাপনা ও রক্ষণাবেক্ষণ এবং উহার হিসাব নিরীক্ষা;

(প) রিহ্যাবিলিটেশন পেশাজীবীর জন্য অনুসরণীয় পেশাগত আচরণের মান নির্ধারণ ও অনুসরণের বিষয়টি নিশ্চিতকরণ;

(ফ) দেশি বা বিদেশি কোনো রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান কর্তৃক প্রদত্ত ডিগ্রি বা ডিপ্লোমা বা সার্টিফিকেটের মান নিয়মিত মূল্যায়ন এবং প্রযোজ্য ক্ষেত্রে তপশিল সংশোধনের উদ্যোগ গ্রহণ; এবং

(ব) এই আইনের উদ্দেশ্য পূরণকল্পে, প্রয়োজনীয় ও আনুষঙ্গিক অন্য যে কোনো কার্য সম্পাদন।

৭। **কাউন্সিলের সভা।**—(১) এই ধারার অন্যান্য বিধানাবলি সাপেক্ষে, কাউন্সিল উহার সভার কার্যপদ্ধতি নির্ধারণ করিতে পারিবে।

(২) সভাপতি কর্তৃক নির্ধারিত স্থান ও সময়ে কাউন্সিলের সভা অনুষ্ঠিত হইবে।

(৩) প্রতি ৬ (ছয়) মাসে কাউন্সিলের অন্যূন ১ (এক) টি সভা অনুষ্ঠিত হইবে এবং জরুরি প্রয়োজনে, যে কোনো সময়ে বিশেষ সভা আহ্বান করা যাইবে।

(৪) কাউন্সিলের সকল সভায় উহার সভাপতি সভাপতিত্ব করিবেন এবং তাহার অনুপস্থিতিতে তৎকর্তৃক মনোনীত কাউন্সিলের কোনো সদস্য সভাপতিত্ব করিবেন।

(৫) কাউন্সিলের মোট সদস্য সংখ্যার অন্যূন এক-তৃতীয়াংশ সদস্যের উপস্থিতিতে সভার কোরাম গঠিত হইবে, তবে মুলতবি সভার ক্ষেত্রে কোনো কোরামের প্রয়োজন হইবে না।

(৬) সভায় উপস্থিত সদস্যদের সংখ্যাগরিষ্ঠ ভোটে কাউন্সিলের সিদ্ধান্ত গৃহীত হইবে এবং ভোটের সমতার ক্ষেত্রে সভাপতিত্বকারী ব্যক্তির দ্বিতীয় অথবা নির্ণায়ক ভোট প্রদানের ক্ষমতা থাকিবে।

(৭) কেবল কাউন্সিলের কোনো সদস্যপদে শূন্যতা বা কাউন্সিল গঠনে ত্রুটি থাকিবার কারণে কাউন্সিলের কোনো কার্য অথবা কার্যধারা অবৈধ হইবে না, বা কোনো সিদ্ধান্ত বাতিল হইবে না এবং তৎসম্পর্কে কোনো প্রশ্নও উত্থাপন করা যাইবে না।

৮। **কাউন্সিলের রেজিস্ট্রার।**—(১) কাউন্সিলের একজন রেজিস্ট্রার থাকিবে।

(২) রেজিস্ট্রার রিহ্যাবিলিটেশন প্রাকটিশনারের মধ্য হইতে সরকার কর্তৃক নিযুক্ত হইবেন এবং তাহার চাকরির শর্তাদি সরকার কর্তৃক স্থিরীকৃত হইবে।

(৩) রেজিস্ট্রার কাউন্সিলের এবং নির্বাহী কমিটির সদস্য-সচিব হিসাবে দায়িত্ব পালন ও কার্য সম্পাদন করিবে।

(৪) রেজিস্ট্রার এর পদ শূন্য হইলে কিংবা অনুপস্থিতি, অসুস্থতা বা অন্য কোনো কারণে রেজিস্ট্রার তাঁহার দায়িত্ব পালনে অসমর্থ হইলে উক্ত শূন্য পদে নবনিযুক্ত রেজিস্ট্রার কার্যভার গ্রহণ না করা পর্যন্ত, অথবা রেজিস্ট্রার পুনরায় স্বীয় দায়িত্ব পালনে সমর্থ না হওয়া পর্যন্ত সরকার কর্তৃক মনোনীত কোনো ব্যক্তি রেজিস্ট্রার এর দায়িত্ব পালন করিবে।

৯। **কর্মচারী নিয়োগ।**—(১) কাউন্সিল, সরকার কর্তৃক অনুমোদিত সাংগঠনিক কাঠামো অনুসারে, প্রয়োজনীয় সংখ্যক কর্মচারী নিয়োগ প্রদান করিতে পারিবে।

(২) কাউন্সিলের কর্মচারীদের চাকরির শর্তাবলি প্রবিধান দ্বারা নির্ধারিত হইবে।

১০। **নির্বাহী কমিটি।**—(১) কাউন্সিলের একটি নির্বাহী কমিটি থাকিবে।

(২) কাউন্সিলের সভাপতি, রেজিস্ট্রার এবং সদস্যগণের মধ্য হইতে সরকার কর্তৃক, এই ধারার অন্যান্য বিধানাবলি সাপেক্ষে, অনধিক ০৫ (পাঁচ) জন সদস্য সমন্বয়ে নির্বাহী কমিটি গঠিত হইবে।

(৩) কাউন্সিলের সভাপতি নির্বাহী কমিটির চেয়ারপার্সনও হইবেন।

(৪) কাউন্সিলের রেজিস্ট্রার নির্বাহী কমিটির সদস্য-সচিবও হইবেন।

(৫) কাউন্সিলের পরিচালনা ও প্রশাসন নির্বাহী কমিটির উপর ন্যস্ত থাকিবে এবং কাউন্সিল যে সকল ক্ষমতা প্রয়োগ ও কার্য সম্পাদন করিতে পারিবে নির্বাহী কমিটিও সেই সকল ক্ষমতা প্রয়োগ ও কার্য সম্পাদন করিতে পারিবে।

(৬) নির্বাহী কমিটি উহার ক্ষমতা প্রয়োগ, কার্যাবলি সম্পাদন ও সিদ্ধান্ত বাস্তবায়নের জন্য কাউন্সিলের নিকট দায়ী থাকিবে এবং কাউন্সিল কর্তৃক, সময়ে সময়ে, প্রদত্ত নির্দেশনা, আদেশ ও নির্দেশ অনুসরণ করিবে।

১১। **কমিটি।**—কাউন্সিল উহার কার্যাবলি সুষ্ঠুভাবে সম্পাদনের জন্য, প্রয়োজনবোধে, এক বা একাধিক কমিটি গঠন করিতে পারিবে এবং উক্ত কমিটির দায়িত্ব ও কর্তব্য নির্ধারণ করিতে পারিবে।

১২। **কাউন্সিলের তহবিল।**—(১) বাংলাদেশ রিহ্যাবিলিটেশন কাউন্সিল তহবিল নামে কাউন্সিলের একটি তহবিল থাকিবে এবং নিম্নবর্ণিত উৎস হইতে প্রাপ্ত অর্থ দ্বারা উক্ত তহবিল গঠিত হইবে, যথা:—

(ক) সরকার কর্তৃক প্রদত্ত অনুদান;

(খ) সরকারের পূর্বানুমোদনক্রমে, কোনো বিদেশি সরকার, সংস্থা, দেশিয় বা আন্তর্জাতিক সংস্থা ও ব্যক্তি হইতে প্রাপ্ত দান, অনুদান ও সহায়তা;

(গ) কোনো স্থানীয় কর্তৃপক্ষ বা ব্যক্তি কর্তৃক প্রদত্ত দান, অনুদান ও সহায়তা;

(ঘ) এই আইনের অধীন আদায়কৃত নিবন্ধন ফি ও পরিদর্শন ফি;

(ঙ) কাউন্সিলের নিজস্ব সম্পত্তি হইতে প্রাপ্ত আয় এবং নিজস্ব বিনিয়োগ হইতে প্রাপ্ত মুনাফা; এবং

(চ) অন্য কোনো বৈধ উৎস হইতে প্রাপ্ত অর্থ।

(২) উপ-ধারা (১) এর অধীন গঠিত তহবিল কাউন্সিল কর্তৃক অনুমোদিত কোনো তপশিলি ব্যাংকে জমা রাখা হইবে এবং বিধি দ্বারা নির্ধারিত পদ্ধতিতে, তবে বিধি প্রণীত না হওয়া পর্যন্ত সরকারি বিধি-বিধান অনুযায়ী, তহবিল পরিচালনা করা যাইবে।

(৩) কাউন্সিলের তহবিল হইতে কাউন্সিলের প্রয়োজনীয় ব্যয় নির্বাহ করা হইবে।

ব্যাখ্যা।—এই ধারার উদ্দেশ্য পূরণকল্পে, 'তপশিলি ব্যাংক' বলিতে Bangladesh Bank Order, 1972 (President's Order No. 127 of 1972) এর Article 2(j) তে সংজ্ঞায়িত 'Scheduled Bank' কে বুঝাইবে।

১৩। **রিহ্যাবিলিটেশন শিক্ষা কার্যক্রম ও রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠানের স্বীকৃতি।**—(১) বিদ্যমান অন্য কোনো আইনের অধীন কোনো কর্তৃপক্ষ হইতে কোনোরূপ অনুমোদন বা স্বীকৃতি প্রাপ্ত হওয়া সত্ত্বেও, এই আইনের উদ্দেশ্য পূরণকল্পে রিহ্যাবিলিটেশন শিক্ষা কার্যক্রম পরিচালনাকারী সকল রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান বা স্বীকৃত প্রতিষ্ঠানকে কাউন্সিলের নিকট হইতে স্বীকৃতি গ্রহণ করিতে হইবে।

(২) উপ-ধারা (১) অনুযায়ী কাউন্সিল কর্তৃক স্বীকৃতি গ্রহণের জন্য রিহ্যাবিলিটেশন শিক্ষা কার্যক্রম পরিচালনাকারী সকল রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান বা স্বীকৃত প্রতিষ্ঠানকে এই আইন বলবৎ হইবার ১৮০ (একশত আশি) দিনের মধ্যে বিধি দ্বারা নির্ধারিত পদ্ধতিতে কাউন্সিলের নিকট আবেদন করিতে হইবে।

(৩) কাউন্সিল বিধি দ্বারা নির্ধারিত পদ্ধতি ও শর্তপূরণ সাপেক্ষে প্রত্যেক রিহ্যাবিলিটেশন শিক্ষাপ্রতিষ্ঠান বা স্বীকৃত প্রতিষ্ঠান কর্তৃক পরিচালিত রিহ্যাবিলিটেশন শিক্ষা কার্যক্রমকে স্বীকৃতি প্রদান করিতে পারিবে।

(৪) উপ-ধারা (১) এর বিধান লঙ্ঘন করিয়া কোনো ব্যক্তি রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান বা স্বীকৃত প্রতিষ্ঠান কোনো কোর্স বা প্রশিক্ষণ বা শিক্ষা কার্যক্রম পরিচালনা করিলে অথবা সনদ প্রদান করিলে উহা হইবে এই আইনের অধীন একটি অপরাধ এবং উক্ত অপরাধে জড়িত ব্যক্তি ০২ (দুই) বৎসর পর্যন্ত কারাদণ্ড অথবা অন্যূন ০১ (এক) লক্ষ টাকা হইতে অনূর্ধ্ব ০২ (দুই) লক্ষ টাকা অর্থদণ্ড অথবা উভয় দণ্ডে দণ্ডিত হইবে।

১৪। **রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান অথবা রিহ্যাবিলিটেশন সেবা ইউনিট, ইত্যাদির অনুমোদন।**—(১) বিদ্যমান অন্য কোনো আইনের অধীন কোনো কর্তৃপক্ষ হইতে কোনোরূপ অনুমোদন বা স্বীকৃতি প্রাপ্ত হওয়া সত্ত্বেও, রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান অথবা সেবা ইউনিটের সপ্তম তপশিলে অন্তর্ভুক্ত না থাকিলে উক্ত প্রতিষ্ঠান বা ইউনিটকে এই আইনের উদ্দেশ্য পূরণকল্পে কাউন্সিলের নিকট হইতে অনুমোদন গ্রহণ করিতে হইবে।

(২) উপ-ধারা (১) অনুযায়ী কাউন্সিল কর্তৃক অনুমোদন লাভের জন্য বিদ্যমান সকল রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান বা সেবা ইউনিটকে এই আইন বলবৎ হইবার ১৮০ (একশত আশি) দিনের মধ্যে বিধি দ্বারা নির্ধারিত পদ্ধতিতে কাউন্সিলের নিকট আবেদন করিতে হইবে।

(৩) কাউন্সিল বিধি দ্বারা নির্ধারিত পদ্ধতি ও শর্তপূরণ সাপেক্ষে প্রত্যেক রিহ্যাবিলিটেশন সেবাপ্রতিষ্ঠান বা রিহ্যাবিলিটেশন সেবা ইউনিটকে অনুমোদন প্রদান করিতে পারিবে।

(৪) উপ-ধারা (১) এর বিধান লঙ্ঘন করিয়া কোনো ব্যক্তি কোনো রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান অথবা রিহ্যাবিলিটেশন সেবা ইউনিট পরিচালনা করিলে উহা হইবে এই আইনের অধীন একটি অপরাধ এবং তৎজ্জন্য তিনি অন্যূন ২ (দুই) বৎসর পর্যন্ত কারাদণ্ড অথবা অন্যূন ০১ (এক) লক্ষ টাকা হইতে অনূর্ধ্ব ০২ (দুই) লক্ষ টাকা পর্যন্ত অর্থদণ্ড অথবা উভয় দণ্ডে দন্ডিত হইবেন।

১৫। **রিহ্যাবিলিটেশন পেশাজীবীর নিবন্ধন এবং রিহ্যাবিলিটেশন প্রাকটিশনারকে লাইসেন্স প্রদান।**—(১) বিদ্যমান অন্য কোনো আইনের অধীন কোনো কর্তৃপক্ষ হইতে কোনোরূপ নিবন্ধন ও লাইসেন্স প্রাপ্ত হওয়া সত্ত্বেও, রিহ্যাবিলিটেশন পেশাজীবীগণকে এবং রিহ্যাবিলিটেশন প্রাকটিশনারগণকে এই আইনের উদ্দেশ্য পূরণকল্পে বিধি দ্বারা নির্ধারিত পদ্ধতিতে কাউন্সিলের নিকট হইতে যথাক্রমে নিবন্ধন ও লাইসেন্স গ্রহণ করিতে হইবে।

(২) উপ-ধারা (১) অনুযায়ী কাউন্সিল কর্তৃক নিবন্ধন বা, ক্ষেত্রমত, লাইসেন্স প্রাপ্তির জন্য রিহ্যাবিলিটেশন পেশাজীবী বা রিহ্যাবিলিটেশন প্রাকটিশনারকে এই আইন বলবৎ হইবার ১৮০ (একশত আশি) দিনের মধ্যে কাউন্সিলের নিকট আবেদন করিতে হইবে।

(৩) কাউন্সিল বিধি দ্বারা নির্ধারিত পদ্ধতি ও শর্তপূরণ সাপেক্ষে প্রত্যেক রিহ্যাবিলিটেশন পেশাজীবী বা রিহ্যাবিলিটেশন প্রাকটিশনারকে যথাক্রমে নিবন্ধন ও লাইসেন্স প্রদান করিতে পারিবে।

(৪) উপ-ধারা (১) এর বিধান প্রতিপালন না করিয়া কোনো ব্যক্তি রিহ্যাবিলিটেশন পেশাজীবী অথবা রিহ্যাবিলিটেশন প্রাকটিশনার হিসাবে পেশা অথবা কার্য পরিচালনা করিলে তিনি অন্যূন ০২ (দুই) বৎসর পর্যন্ত কারাদণ্ড অথবা অন্যূন ০১ (এক) লক্ষ টাকা হইতে অনূর্ধ্ব ০২ (দুই) লক্ষ টাকা পর্যন্ত অর্থদণ্ড অথবা উভয় দণ্ডে দন্ডিত হইবেন।

১৬। **বাংলাদেশের বাহিরের প্রতিষ্ঠান কর্তৃক প্রদত্ত রিহ্যাবিলিটেশন শিক্ষাসংক্রান্ত যোগ্যতার স্বীকৃতি।**—(১) বিদেশি কোনো শিক্ষা প্রতিষ্ঠান হইতে ডিগ্রি, প্রশিক্ষণ অথবা সনদপ্রাপ্ত কোনো ব্যক্তি উক্ত ডিগ্রি, প্রশিক্ষণ অথবা সনদমূলে বাংলাদেশে রিহ্যাবিলিটেশন পেশাজীবী অথবা রিহ্যাবিলিটেশন প্রাকটিশনার হিসাবে পেশা বা কার্য পরিচালনা করিতে আগ্রহী হইলে বা বাংলাদেশে উক্ত ডিগ্রি অথবা সনদ ব্যবহারে আগ্রহী হইলে উক্ত ব্যক্তিকে বিধি দ্বারা নির্ধারিত পদ্ধতিতে কাউন্সিলের নিকট আবেদন করিতে হইবে।

(২) কাউন্সিল বিধি দ্বারা নির্ধারিত পদ্ধতিতে ও শর্ত পূরণসাপেক্ষে উপযুক্ত বিবেচনা করিলে আবেদনকারীকে নিবন্ধন ও, ক্ষেত্রমতে, লাইসেন্স প্রদান করিতে পারিবে।

(৩) উপ-ধারা (১) এর বিধান প্রতিপালন না করিয়া কোনো ব্যক্তি রিহ্যাবিলিটেশন পেশাজীবী অথবা রিহ্যাবিলিটেশন প্রাকটিশনার হিসাবে পেশা অথবা কার্য পরিচালনা করিলে উহা হইবে একটি অপরাধ এবং তজ্জন্য তিনি অন্যূন ০২ (দুই) বৎসর পর্যন্ত কারাদণ্ড অথবা অন্যূন ০১ (এক) লক্ষ টাকা হইতে অনূর্ধ্ব ০২ (দুই) লক্ষ টাকা পর্যন্ত অর্থদণ্ড অথবা উভয় দণ্ডে দন্ডিত হইবেন।

১৭। **স্বীকৃতি প্রত্যাহার।**—(১) কাউন্সিল কর্তৃক গঠিত বিশেষজ্ঞ কমিটির পরিদর্শন প্রতিবেদনের ভিত্তিতে যদি কাউন্সিলের নিকট প্রতীয়মান হয় যে—

(ক) রিহ্যাবিলিটেশন শিক্ষাসংক্রান্ত স্নাতক অথবা স্নাতকোত্তর যোগ্যতার কোনো ডিগ্রি, ডিপ্লোমা অথবা সনদ প্রদানের জন্য বাংলাদেশের কোনো রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান কর্তৃক প্রণীত পাঠ্যসূচি অনুযায়ী পরিচালিত পরীক্ষা মানসম্মত হইতেছে না; অথবা

(খ) উক্ত ডিগ্রী ডিপ্লোমা বা সনদ প্রদানের জন্য গৃহীত পরীক্ষায় অংশগ্রহণকারীদের কাঙ্ক্ষিত ব্যুৎপত্তির মান, নির্ধারিত মানদণ্ড ও নীতিমালার আলোকে সংশ্লিষ্ট যোগ্যতাধারীর জন্য আবশ্যিক জ্ঞান ও দক্ষতা নিশ্চিত হইতেছে না; অথবা

(গ) সরকার প্রদত্ত আদেশ, নির্দেশ, সার্কুলার অথবা নীতিমালা যথাযথভাবে অনুসৃত হইতেছে না;

তাহা হইলে কাউন্সিল যেরূপ যুক্তিসংগত হয় সেইরূপ মন্তব্যসহ উক্ত প্রতিবেদনে উল্লিখিত বিষয়ে তৎকর্তৃক নির্ধারিত সময়ের মধ্যে জবাব পেশ করিবার জন্য সংশ্লিষ্ট প্রতিষ্ঠানের নিকট প্রতিবেদনটি প্রেরণ করিবে।

(২) উপ-ধারা (১) অনুযায়ী প্রয়োজনীয় ব্যবস্থা গ্রহণের পর কাউন্সিল উহার বিবেচনায় প্রয়োজনীয় অনুসন্ধান সাপেক্ষে সংশ্লিষ্ট রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠানের স্বীকৃতি বা স্থগিত বা প্রত্যাহার করিতে পারিবে।

১৮। **কাউন্সিল কর্তৃক রিহ্যাবিলিটেশন পেশাজীবীদের নিবন্ধনবহি সংরক্ষণ, ইত্যাদি।**—(১) কাউন্সিল রিহ্যাবিলিটেশন পেশাজীবীদের নিবন্ধন করত প্রবিধান দ্বারা নির্ধারিত পদ্ধতিতে সংশ্লিষ্ট নিবন্ধন বহিতে (Register) অন্তর্ভুক্ত করিবে এবং উক্ত নিবন্ধনসমূহ তৎকর্তৃক নির্ধারিত পদ্ধতিতে যথাযথভাবে প্রকাশ এবং স্থায়ীভাবে সংরক্ষণ ও প্রতিনিয়ত হালনাগাদ করিবে।

(২) রিহ্যাবিলিটেশন পেশাজীবীদের নিবন্ধনের শর্ত, নিবন্ধনের প্রক্রিয়া, কোনো বাধ্যতামূলক প্রশিক্ষণ, ইন্টার্নশিপ অথবা এতৎসংক্রান্ত বিষয়াদি কাউন্সিল কর্তৃক নির্ধারিত হইবে।

১৯। **রিহ্যাবিলিটেশন পেশাজীবীগণ কর্তৃক ব্যবহার্য পদবি, ডিগ্রি, চিহ্ন, ইত্যাদি।**—রিহ্যাবিলিটেশন পেশাজীবী নামের পূর্বে অথবা পরে কী রূপ পদবি, চিহ্ন, ডিগ্রি, বর্ণনা ব্যবহার করিবে তাহা কাউন্সিল কর্তৃক নির্ধারিত হইবে।

২০। **মিথ্যা উপাধি, ডিগ্রি, চিহ্ন অথবা বর্ণনা ব্যবহার নিষিদ্ধ এবং উহার দণ্ড।**—(১) বাংলাদেশের অভ্যন্তরের অথবা বাহিরের কোনো আইনানুগ কর্তৃপক্ষ কর্তৃক অনুমোদিত না হওয়া সত্ত্বেও কোনো নিবন্ধিত রিহ্যাবিলিটেশন পেশাজীবী কাউন্সিল কর্তৃক নির্ধারিত নহে এইরূপ কোনো নাম, উপাধি, বর্ণনা অথবা চিহ্ন ব্যবহার অথবা প্রকাশ করিতে পারিবে না যাহাতে কোনো ব্যক্তির এইরূপ ধারণা জন্মে যে তিনি অতিরিক্ত অথবা অন্যবিধ কোনো পেশাগত যোগ্যতার অধিকারী।

(২) উপ-ধারা (১) এর বিধান প্রতিপালন না করিয়া কোনো ব্যক্তি যদি কোনো নাম, উপাধি, বর্ণনা অথবা চিহ্ন ব্যবহার অথবা প্রকাশ করেন তাহা হইলে উহা হইবে একটি অপরাধ এবং তজ্জন্য তিনি অন্যূন ০২ (দুই) বৎসর পর্যন্ত কারাদণ্ড অথবা অন্যূন ০১ (এক) লক্ষ টাকা হইতে অনূর্ধ্ব ০২ (দুই) লক্ষ টাকা পর্যন্ত অর্থদণ্ড অথবা উভয় দণ্ডে দণ্ডিত হইবে, এবং তাহার নিবন্ধন ও লাইসেন্স বাতিল হইবেন।

২১। **নিবন্ধন ব্যতীত মিথ্যা অথবা নকল ডিগ্রি ব্যবহার নিষিদ্ধ এবং উহার দণ্ড।**—কোনো ব্যক্তি এই আইনের অধীন নিবন্ধিত না হইয়া অথবা স্বীকৃত যোগ্যতা অর্জন না করিয়া যদি রিহ্যাবিলিটেশন পেশাজীবী হিসাবে ভুয়া সনদ ব্যবহার করেন অথবা পেশা বা কার্য পরিচালনা করেন অথবা মিথ্যা বা নকল ডিগ্রি অথবা সনদ ব্যবহার করেন, তাহা হইলে উহা হইবে একটি অপরাধ এবং তজ্জন্য তিনি অন্যূন ০৭ (সাত) বৎসর পর্যন্ত কারাদণ্ড অথবা অন্যূন ০১ (এক) লক্ষ টাকা হইতে অনূর্ধ্ব ০২ (দুই) লক্ষ টাকা পর্যন্ত অর্থদণ্ড অথবা উভয় দণ্ডে দণ্ডিত হইবেন।

২২। **নিবন্ধন বহি (Register) হইতে নাম কর্তন অথবা নিবন্ধন বাতিল।**—(১) যদি কাউন্সিলের নিকট প্রতীয়মান হয় যে—

(ক) কোনো নিবন্ধিত রিহ্যাবিলিটেশন পেশাজীবী কর্তৃক দাখিলকৃত সনদ মিথ্যা বা নকল বা ভুয়া; অথবা

(খ) রিহ্যাবিলিটেশন পেশাজীবী চারিত্রিক স্খলনজনিত কোনো অপরাধে সাজা প্রাপ্ত; অথবা

(গ) অনুসরণীয় আচরণ নীতিমালা লঙ্ঘনের জন্য কাউন্সিল কর্তৃক সাজা প্রাপ্ত; অথবা

(ঘ) শারীরিক অথবা মানসিক অসুস্থতা অথবা অন্যবিধ কারণে পেশাগত কার্য পরিচালনায় অনুপযুক্ত;

তাহা হইলে কাউন্সিল তাহাকে প্রযোজ্য ক্ষেত্রে শুনানির সুযোগ প্রদান করিয়া নিবন্ধন বহি হইতে তাহার নিবন্ধন সাময়িক অথবা স্থায়ীভাবে বাতিল করিতে পারিবে, এবং কোনো রিহ্যাবিলিটেশন পেশাজীবীর নিবন্ধন বাতিল করা হইলে রিহ্যাবিলিটেশন প্র্যাকটিশনার হিসাবে তাহার লাইসেন্সটিও স্বয়ংক্রিয়ভাবে বাতিল হইবে।

(২) উপ-ধারা (১) এর অধীন কোনো ব্যক্তির স্থায়ীভাবে অথবা সাময়িকভাবে বাতিলকৃত নিবন্ধন কাউন্সিল তাহার আবেদনের পরিপ্রেক্ষিতে যথোপযুক্ত বিবেচনা করিলে পরবর্তীকালে পুনর্বহাল করিতে পারিবে।

(৩) কোনো রিহ্যাবিলিটেশন পেশাজীবী স্থায়ী বা সাময়িকভাবে নিবন্ধন বাতিলের জন্য আবেদন করিলে, কাউন্সিল উপযুক্ত বিবেচনা করিলে প্রয়োজনীয় ব্যবস্থা গ্রহণ করিতে পারিবে।

২৩। **আপিল।**—(১) এই আইনের অধীন কাউন্সিল কর্তৃক গৃহীত কোনো সিদ্ধান্ত বা আদেশে কোনো ব্যক্তি বা প্রতিষ্ঠান সংক্ষুব্ধ হইলে বিধি দ্বারা নির্ধারিত পদ্ধতিতে সরকারের নিকট আপিল করিতে পারিবে।

(২) উপ-ধারা (১) এর অধীন আপিল আবেদনের বিষয়ে সরকার বিধি দ্বারা নির্ধারিত পদ্ধতিতে সিদ্ধান্ত প্রদান করিবে এবং এই বিষয়ে সরকারের সিদ্ধান্ত চূড়ান্ত বলিয়া গণ্য হইবে।

২৪। **রিহ্যাবিলিটেশন পেশাজীবীর মৃত্যুসংক্রান্ত তথ্যাদি অবহিতকরণ।**—কোনো রিহ্যাবিলিটেশন পেশাজীবী মৃত্যুবরণ করিলে মৃত্যু নিবন্ধনের দায়িত্বপ্রাপ্ত প্রত্যেক ব্যক্তি সংশ্লিষ্ট রিহ্যাবিলিটেশন পেশাজীবীর মৃত্যুর তারিখ ও স্থানসহ বিস্তারিত বিবরণী সংবলিত এবং স্বাক্ষরিত একটি মৃত্যু সনদ অবিলম্বে ডাকযোগে, ই-মেইল অথবা অন্য কোনো ইলেকট্রনিক মাধ্যমে কাউন্সিলের রেজিস্ট্রারের নিকট প্রেরণ করিবে, এবং তৎভিত্তিতে মৃত ব্যক্তির নাম রেজিস্টার হইতে কর্তন করা যাইবে।

২৫। **রেজিস্টারসমূহ সরকারি দলিল।**—কাউন্সিল কর্তৃক প্রণীত ও সংরক্ষিত রেজিস্টারসমূহ Evidence Act, 1872 (Act 1 of 1872) এর অধীন সরকারি দলিল বলিয়া গণ্য হইবে।

২৬। **বাজেট।**—(১) কাউন্সিল প্রতি বৎসর, ৩০ জুনের পূর্বে পরবর্তী অর্থ বৎসরের বাৎসরিক বাজেট বিবরণী প্রস্তুত করিবে এবং উহাতে উক্ত অর্থ বৎসরের সম্ভাব্য আয় ও ব্যয়সহ পরিকল্পনা গ্রহণ সংক্রান্ত তথ্যাদি উল্লেখ থাকিবে।

(২) উপ-ধারা (১) এর অধীন প্রস্তুতকৃত বাজেট কাউন্সিলের সভায় অনুমোদিত হইবার পর উহা সরকারের নিকট পেশ করিতে হইবে।

২৭। **হিসাবরক্ষণ ও নিরীক্ষা।**—(১) কাউন্সিল যথাযথভাবে উহার হিসাব রক্ষণ করিবে এবং হিসাবের বার্ষিক বিবরণী প্রস্তুত করিবে।

(২) বাংলাদেশের মহা হিসাব-নিরীক্ষক ও নিয়ন্ত্রক, অতঃপর মহা হিসাব-নিরীক্ষক ও নিয়ন্ত্রক বলিয়া অভিহিত, প্রতি বৎসর কাউন্সিলের হিসাব নিরীক্ষা করিবেন এবং নিরীক্ষা প্রতিবেদনের একটি করিয়া কপি সরকার ও কাউন্সিলের নিকট পেশ করিবেন।

(৩) উপ-ধারা (২) এর অধীন হিসাব নিরীক্ষার উদ্দেশ্যে মহা হিসাব-নিরীক্ষক ও নিয়ন্ত্রক কাউন্সিলের সকল রেকর্ড, দলিল ও কাগজপত্র, নগদ বা ব্যাংকে গচ্ছিত অর্থ, জামানত, ভান্ডার এবং অন্যবিধ সম্পত্তি পরীক্ষা করিয়া দেখিতে পারিবেন এবং রেজিস্ট্রার ও উহার যে কোনো সদস্য বা কর্মচারীকে জিজ্ঞাসাবাদ করিতে পারিবেন।

২৮। **প্রতিবেদন।**—(১) কাউন্সিল, প্রতি বৎসর, তৎকর্তৃক সম্পাদিত কার্যাবলির বিবরণ সংবলিত একটি প্রতিবেদন পরবর্তী বৎসরের ৩০ জুনের মধ্যে সরকারের নিকট পেশ করিবে।

(২) সরকার, যে কোনো সময়, কাউন্সিলের নিকট উহার যে কোনো বিষয়ের উপর প্রতিবেদন বা বিবরণী তলব করিতে পারিবে এবং কাউন্সিল উহা সরকারের নিকট সরবরাহ করিতে বাধ্য থাকিবে।

২৯। **অপরাধ বিচারার্থ গ্রহণ ও বিচার।**—(১) অন্য কোনো আইনে যাহা কিছুই থাকুক না কেন, এই আইনের অধীন অপরাধ সংঘটনের বিষয়ে সরকার অথবা কাউন্সিল কর্তৃক এতদুদ্দেশ্যে ক্ষমতাপ্রাপ্ত ব্যক্তির এবং প্রযোজ্য ক্ষেত্রে সংক্ষুব্ধ ব্যক্তির লিখিত অভিযোগ ব্যতীত কোনো আদালত এই আইনের অধীন কোনো অপরাধ বিচারার্থ গ্রহণ করিবে না।

(২) এই আইনের অধীন অপরাধসমূহ জুডিসিয়াল ম্যাজিস্ট্রেট বা, ক্ষেত্রমত, মেট্রোপলিটন ম্যাজিস্ট্রেট কর্তৃক বিচার্য হইবে।

(৩) এই আইনের অধীন কোনো অপরাধের অভিযোগ দায়ের, তদন্ত, বিচার, আপিল ও সংশ্লিষ্ট অন্যান্য বিষয়ে ফৌজদারি কার্যবিধির বিধানাবলি প্রযোজ্য হইবে।

৩০। **অর্থদণ্ড সংক্রান্ত বিশেষ বিধান।**—ফৌজদারি কার্যবিধিতে ভিন্নতর যাহা কিছুই থাকুক না কেন, কোনো ব্যক্তির উপর এই আইনের অধীন অর্থদণ্ড আরোপের ক্ষেত্রে জুডিসিয়াল ম্যাজিস্ট্রেট বা, ক্ষেত্রমত, মেট্রোপলিটন ম্যাজিস্ট্রেট এই আইনে উল্লিখিত অর্থদণ্ড আরোপ করিতে পারিবে।

৩১। **মোবাইল কোর্ট আইন, ২০০৯ এর প্রয়োগ।**—আপাতত বলবৎ অন্য কোনো আইনে যাহা কিছুই থাকুক না কেন, এই আইনের অধীন সংঘটিত অপরাধের ক্ষেত্রে, মোবাইল কোর্ট আইন, ২০০৯ (২০০৯ সালের ৫৯ নং আইন) এর তপশিলভুক্ত হওয়া সাপেক্ষে, মোবাইল কোর্ট দণ্ড আরোপ করিতে পারিবে।

৩২। **বিধি প্রণয়নের ক্ষমতা।**—এই আইনের উদ্দেশ্য পূরণকল্পে, সরকার, সরকারি গেজেট প্রজ্ঞাপন দ্বারা, বিধি প্রণয়ন করিতে পারিবে।

৩৩। **প্রবিধান প্রণয়নের ক্ষমতা।**—(১) এই আইনের উদ্দেশ্য পূরণকল্পে, কাউন্সিল, সরকারের পূর্বানুমোদনক্রমে, সরকারি গেজেটে প্রজ্ঞাপন দ্বারা, এই আইন বা বিধির সহিত অসংগতিপূর্ণ নহে এইরূপ প্রবিধান প্রণয়ন করিতে পারিবে।

(২) উপ-ধারা (১) এ প্রদত্ত ক্ষমতার সামগ্রিকতাকে ক্ষুণ্ন না করিয়া, নিম্নবর্ণিত সকল বা যে কোনো বিষয়ে প্রবিধান প্রণয়ন করা যাইবে, যথা:—

(ক) স্নাতক ও স্নাতকোত্তর পর্যায়ের রিহ্যাবিলিটেশন বিষয়ক শিক্ষাগত যোগ্যতার কোর্স, কারিকুলাম এবং অভিন্ন ন্যূনতম মান ও মেয়াদ নির্ধারণ;

(খ) রিহ্যাবিলিটেশন শিক্ষা বিষয়ক ডিপ্লোমা, অন্যান্য কোর্স ও প্রশিক্ষণসমূহের কোর্স, কারিকুলাম এবং অভিন্ন ন্যূনতম মান ও মেয়াদ নির্ধারণ;

(গ) রিহ্যাবিলিটেশন শিক্ষা বিষয়ক সকল পর্যায়ের কোর্সসমূহের ভর্তির যোগ্যতা ও শর্তাদি নির্ধারণ;

(ঘ) রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠানসমূহে শিক্ষক নিয়োগের ন্যূনতম যোগ্যতা, অভিজ্ঞতা ও শর্তাদি নির্ধারণ;

(ঙ) রিহ্যাবিলিটেশন শিক্ষা বিষয়ক ও প্রাকটিশনারের লাইসেন্স প্রাপ্তির সকল পরীক্ষা পরিচালনার পদ্ধতি ও মান নির্ধারণ;

(চ) রিহ্যাবিলিটেশন শিক্ষা বিষয়ক পেশাগত সকল পরীক্ষার পরীক্ষকগণের যোগ্যতা ও শর্তাদি নির্ধারণ;

(ছ) রিহ্যাবিলিটেশন পেশাজীবী প্রত্যেকের জন্য পৃথক ব্যক্তিগত নথি ও ইলেক্ট্রনিক নিবন্ধন বহি (Registers) প্রণয়ন, সংকলন, রক্ষণাবেক্ষণ ও হালনাগাদকরণ এবং নিবন্ধনসমূহ (Registers) প্রকাশ, সংরক্ষণ এবং হালনাগাদকরণের পদ্ধতি;

(জ) সকল রিহ্যাবিলিটেশন পেশাজীবীর নিবন্ধন এবং লাইসেন্সযোগ্য রিহ্যাবিলিটেশন প্রাকটিশনারকে পরীক্ষা গ্রহণপূর্বক লাইসেন্স প্রদান সংক্রান্ত প্রক্রিয়া, পদ্ধতি, যোগ্যতা, শর্তাদি, ফি ও নবায়ন এবং এই সংক্রান্ত সামগ্রিক বিষয়াদি;

(ঝ) সকল রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠানের নিবন্ধন ও স্বীকৃতি প্রদান সংক্রান্ত প্রক্রিয়া, পদ্ধতি, শর্তাদি, ফি ও নবায়ন সংক্রান্ত বিষয়াদি এবং এতৎসংক্রান্ত তালিকা সংরক্ষণ সংক্রান্ত বিষয়াদি;

(ঞ) সকল রিহ্যাবিলিটেশন পেশাজীবী, রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান অথবা রিহ্যাবিলিটেশন সেবা ইউনিটের নিবন্ধন ও অনুমোদন প্রক্রিয়া, পদ্ধতি, শর্তাদি, ফি ও নবায়ন সংক্রান্ত বিষয়াদি এবং এতৎসংক্রান্ত তালিকা সংরক্ষণ সংক্রান্ত বিষয়াদি;

(ট) কাউন্সিলের সম্পদ ব্যবস্থাপনা, উহার হিসাব রক্ষণাবেক্ষণ এবং নিরীক্ষা ব্যবস্থাপনা;

(ঠ) কাউন্সিলের সভা অনুষ্ঠান ও আহ্বান, সভা অনুষ্ঠানের স্থান ও সময়, সভার কার্যাবলি পরিচালনা সংক্রান্ত বিষয়াদি;

(ড) কমিটি গঠন, নির্বাহী কমিটি ও অন্যান্য কমিটির সভা আহ্বান, অনুষ্ঠান, কার্য পরিচালনা, কোরাম নির্ধারণ সংক্রান্ত বিষয়াদি;

(ঢ) কাউন্সিলের কর্মচারীর ক্ষমতা, দায়িত্ব, কর্তব্য ও মেয়াদ সংক্রান্ত বিষয়াদি;

(ণ) কোনো রিহ্যাবিলিটেশন শিক্ষা প্রতিষ্ঠান ও রিহ্যাবিলিটেশন সেবা প্রতিষ্ঠান অথবা রিহ্যাবিলিটেশন সেবা ইউনিট যে-কোনো সময় পরিদর্শনে পরিদর্শকগণের মনোনয়ন, ক্ষমতা, দায়িত্ব ও নিয়োগ পদ্ধতি;

(ত) এই আইনের অধীন সংঘটিত সকল ধরনের অপরাধ, অনিয়ম, ব্যত্যয়সমূহের অনুসন্ধান, এবং অন্যান্য আইনানুগ কার্যক্রম গ্রহণ সংক্রান্ত বিষয়াদি;

(থ) সকল রিহ্যাবিলিটেশন পেশাজীবীর জন্য অনুসরণীয় আচরণ নীতিমালা প্রণয়ন;

(দ) পেশাজীবীদের মধ্যে কোনো ধরনের রিহ্যাবিলিটেশন টেকনোলজিস্ট অথবা রিহ্যাবিলিটেশন টেকনিশিয়ান কোনো ধরনের রিহ্যাবিলিটেশন প্রাকটিশনারের তত্ত্বাবধানে পেশা অথবা কার্য পরিচালনা করিবেন তাহা নির্ধারণ;

(ধ) সকল রিহ্যাবিলিটেশন পেশাজীবীর জন্য পরামর্শ অথবা সেবা প্রদানের ফি এর হার নির্ধারণ;

(ন) কাউন্সিলের কর্মচারীদের চাকরি প্রবিধান প্রণয়ন;

(প) রিহ্যাবিলিটেশন পেশাজীবীদের পদবি নির্ধারণ; এবং

(ফ) প্রবিধান দ্বারা নির্ধারণযোগ্য অন্যান্য বিষয়।

৩৪। **তফশিল সংশোধন।**—সরকার, সময়ে সময়ে, সরকারি গেজেটে প্রজ্ঞাপন দ্বারা, তপশিল সংশোধন করিতে পারিবে।

৩৫। **অস্পষ্টতা দূরীকরণ।**—এই আইনের কোনো বিধান কার্যকর করিবার ক্ষেত্রে কোনো অস্পষ্টতার উদ্ভব হইলে, সরকার, সরকারি গেজেটে প্রজ্ঞাপন দ্বারা, এই আইনের বিধানাবলির সহিত সংগতিপূর্ণ হওয়া সাপেক্ষে উক্ত অস্পষ্টতা দূর করিতে পারিবে।

৩৬। **ক্ষমতা অর্পণ।**—কাউন্সিল, এই আইনের অধীন উহার উপর অর্পিত যে কোনো ক্ষমতা বা দায়িত্ব, প্রয়োজনবোধে, তদকর্তৃক নির্ধারিত শর্তসাপেক্ষে, লিখিতভাবে সাধারণ বা বিশেষ আদেশ দ্বারা, কাউন্সিলের সদস্য, নির্বাহী কমিটির সদস্য বা কাউন্সিলের যে কোনো কর্মচারীকে অর্পণ করিতে পারিবে।

৩৭। **ইংরেজিতে অনূদিত পাঠ প্রকাশ।**—(১) এই আইন প্রবর্তনের পর সরকার, সরকারি গেজেটে প্রজ্ঞাপন দ্বারা, এই আইনের ইংরেজিতে অনূদিত একটি নির্ভরযোগ্য পাঠ (Authentic English Text) প্রকাশ করিবে।

(২) বাংলা ও ইংরেজি পাঠের মধ্যে বিরোধের ক্ষেত্রে বাংলা পাঠ প্রাধান্য পাইবে।

প্রথম তপশিল
[ধারা ২(৩) দ্রষ্টব্য]

শিক্ষাগত যোগ্যতার মান (রিহ্যাবিলিটেশন প্রাকটিশনার)

ধরনভিত্তিক প্রাকটিশনারের নাম		ন্যূনতম যোগ্যতা	স্বীকৃত ডিগ্রি	মন্তব্য
(১)		(২)	(৩)	(৪)
(১)	(ক) ফিজিওথেরাপিস্ট (খ) অকুপেশনাল থেরাপিস্ট (গ) স্পীচ থেরাপিস্ট/স্পীচ ও ল্যাঙ্গুয়েজ থেরাপিস্ট	৪র্থ তপশিলে অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে সংশ্লিষ্ট বিষয়ে স্নাতক ডিগ্রিসহ ১(এক) বৎসর ইন্টার্নশিপ	ব্যাচেলর অব সাইন্স ইন (ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/স্পীচ ও ল্যাংগুয়েজ থেরাপি)	
(২)	(ক) এ্যাসিস্ট্যান্ট সাইকোলজিস্ট (ক্লিনিক্যাল/ কাউন্সেলিং/ এডুকেশনাল/ ডেভেলপমেন্টাল/ স্কুল)	৪র্থ তপশিলে অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে সংশ্লিষ্ট বিষয়ে স্নাতকোত্তর ডিগ্রিসহ ন্যূনতম ৩ মাসের ইন্টার্নশীপ এবং ন্যূনতম ২০০ ঘণ্টার সুপারভাইসড প্রশিক্ষণ	মাস্টার অব সাইন্স/মাস্টার ইন(ক্লিনিক্যাল/কাউন্সেলিং/ এডুকেশনাল/ ডেভেলপমেন্টাল/ স্কুল) সাইকোলজি।	
	(খ) সাইকোলজিস্ট (ক্লিনিক্যাল/ কাউন্সেলিং/ এডুকেশনাল/ ডেভেলপমেন্টাল/স্কুল)	৪র্থ তপশিলে অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে স্নাতকোত্তর ডিগ্রিসহ সংশ্লিষ্ট বিষয়ে এম.ফিল. অথবা সমমানের উচ্চতর ডিগ্রি, ন্যূনতম **৫০০** ঘণ্টার সুপারভাইসড প্রশিক্ষণ ও ন্যূনতম ০১ বৎসরের বাস্তব অভিজ্ঞতা	মাস্টার অব সাইন্স / মাস্টার ইন (ক্লিনিক্যাল/ কাউন্সেলিং/ এডুকেশনাল/ ডেভেলপমেন্টাল/ স্কুল) সাইকোলজি	
(৩)	(ক) পুষ্টিবিদ/নিউট্রিশনিস্ট	৪র্থ তপশিলে অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে ন্যূনতম ৩(তিন) মাসের ইন্টার্নশিপসহ স্নাতকোত্তর ডিগ্রি	মাস্টার অব সাইন্স ইন ফুড এন্ড নিউট্রিশন	
	(খ) স্পেশাল এডুকেটর	৪র্থ তপশিল-এ অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে সংশ্লিষ্ট বিষয়ে ন্যূনতম ৩ মাসের ইন্টার্নশিপসহ স্নাতকোত্তর ডিগ্রি	মাস্টার অব স্পেশাল এডুকেশন	
	(গ) ক্লিনিক্যাল সোশাল ওয়ার্কার	৪র্থ তপশিল-এ অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে সংশ্লিষ্ট বিষয়ে ন্যূনতম ৩(তিন)মাসের ইন্টার্নশিপসহ স্নাতকোত্তর ডিগ্রি	মাস্টার অব সোশ্যাল সাইন্স ইন ক্লিনিক্যাল সোশাল ওয়ার্ক	

দ্বিতীয় তপশিল

[ধারা ২(৩) দ্রষ্টব্য]

শিক্ষাগত যোগ্যতার মান (টেকনোলজিস্ট)

ধরনভিত্তিক টেকনোলজিস্ট এর নাম	ন্যূনতম যোগ্যতা	স্বীকৃত ডিগ্রি	মন্তব্য
(১)	(২)	(৩)	(৪)
টেকনোলজিস্ট (ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/ প্রস্থেটিকস ও অর্থোটিক্স)	৫ম তপশিলে অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে সংশ্লিষ্ট বিষয়ে ন্যূনতম ৩ বৎসর মেয়াদি ডিপ্লোমা ইন মেডিক্যাল টেকনোলজি	ডিপ্লোমা ইন মেডিক্যাল টেকনোলজি (ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/ প্রস্থেটিকস ও অর্থোটিক্স)	

তৃতীয় তপশিল

[ধারা ২(৩) দ্রষ্টব্য]

শিক্ষাগত যোগ্যতার মান (টেকনিশিয়ান)

ধরনভিত্তিক টেকনিশিয়ান এর নাম	ন্যূনতম যোগ্যতা	স্বীকৃত সনদ	মন্তব্য
(১)	(২)	(৩)	(৪)
টেকনিশিয়ান (ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/ কমিউনিটি রিহ্যাবিলিটেশন)	৬ষ্ঠ তপশিলে অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে সংশ্লিষ্ট বিষয়ে ন্যূনতম ১৮ (আঠার) মাস মেয়াদি সার্টিফিকেট কোর্স	সার্টিফিকেট	
টেকনিশিয়ান (কমিউনিটি হেলথ ওয়ার্কারস/ এমএলওপি অপথালমিক এসিসট্যান্ট/ এমএলওপি অপথালমিক রিফ্র্যাকশনিস্ট (*এমএলওপি: মিড লেভেল অপথালমিক পারসোনাল)	৬ষ্ঠ তপশিলে অন্তর্ভুক্ত স্বীকৃত প্রতিষ্ঠান হইতে সংশ্লিষ্ট বিষয়ে ন্যূনতম ১২ (বার) মাস মেয়াদি সার্টিফিকেট কোর্স	সার্টিফিকেট	

চতুর্থ তপশিল
[ধারা ২(৩) দ্রষ্টব্য]

ডিগ্রি প্রদানকারী শিক্ষা প্রতিষ্ঠানের নাম

বিশ্ববিদ্যালয়/ শিক্ষা প্রতিষ্ঠানের নাম	কোর্সের নাম ও মেয়াদ	প্রদত্ত ডিগ্রি	মন্তব্য
(১)	(২)	(৩)	(৪)
ঢাকা বিশ্ববিদ্যালয়	• এম এস ইন (ক্লিনিক্যাল / কাউন্সেলিং/ এডুকেশনাল/ ডেভেলপমেন্টাল/ স্কুল) **সাইকোলজি** • মাস্টার অব ফুড এন্ড নিউট্রিশন • মাস্টার অব স্পেশাল এডুকেশন • মাস্টার অব সোশ্যাল সাইন্স ইন ক্লিনিক্যাল সোশাল ওয়ার্ক (এক/ দেড় বৎসরের স্নাতকোত্তর কোর্স)	এম এস (মাস্টার অব সাইন্স)	
বাংলাদেশ হেলথ প্রফেশনাল ইনস্টিটিউট (বিএইচপিআই))	ব্যাচেলর অব সাইন্স ইন ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/ স্পীচ ও ল্যাংগুয়েজ থেরাপি (তিন/ চার বৎসরের স্নাতকসহ এক বৎসরের ইন্টার্নশীপ)	ব্যাচেলর অব সাইন্স ইন ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/ স্পীচ ও ল্যাংগুয়েজ থেরাপি	
ন্যাশনাল ইনস্টিটিউট অব ট্রমাটোলজি এন্ড অর্থোপেডিক রিহ্যাবিলিটেশন (নিটোর)	ব্যাচেলর অব সাইন্স ইন ফিজিওথেরাপি (চার বৎসরের স্নাতকসহ এক বৎসরের ইন্টার্নশীপ)	ব্যাচেলর অব সাইন্স ইন ফিজিওথেরাপি	

পঞ্চম তপশিল

[ধারা ২(৩) দ্রষ্টব্য]

ডিপ্লোমা প্রদানকারী শিক্ষা প্রতিষ্ঠানের নাম

শিক্ষা প্রতিষ্ঠানের নাম	কোর্সের নাম ও মেয়াদ	প্রদত্ত ডিগ্রি	মন্তব্য
(১)	(২)	(৩)	(৪)
বাংলাদেশ হেলথ প্রফেশনাল ইনস্টিটিউট	ডিপ্লোমা ইন মেডিক্যাল টেকনোলজি (ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/ প্রস্থেটিক্স এন্ড অর্থোটিক্স) ৩ বছর	ডিপ্লোমা ইন মেডিকেল টেকনোলজি (ফিজিওথেরাপি/ অকুপেশনাল থেরাপি/ প্রস্থেটিক্স এন্ড অর্থোটিক্স)	
আর্মড ফোর্সেস ইন্সটিটিউট অব হেলথ টেকনোলজি, ঢাকা	ডিপ্লোমা ইন মেডিক্যাল টেকনোলজি (ফিজিওথেরাপি) ৩ বছর	ডিপ্লোমা ইন মেডিকেল টেকনোলজি (ফিজিওথেরাপি)	
ইন্সটিটিউট অব হেলথ টেকনোলজি (আই এইচ টি) ঢাকা			
আই এইচ টি, রাজশাহী			
আই এইচ টি, রংপুর			
আই এইচ টি, বগুড়া			
আই এইচ টি, চট্টগ্রাম			
আই এইচ টি. বরিশাল			
আই এইচ টি, ঝিনাইদহ			
আই এইচ টি, সিলেট			

ষষ্ঠ তপশিল

[ধারা ২(৩) দ্রষ্টব্য]

সার্টিফিকেট কোর্স পরিচালনাকারী শিক্ষা প্রতিষ্ঠানের নাম

শিক্ষা প্রতিষ্ঠানের নাম	কোর্সের নাম ও মেয়াদ	প্রদত্ত সনদ	মন্তব্য
(১)	(২)	(৩)	(৪)
বাংলাদেশ হেলথ প্রফেশনাল ইনস্টিটিউট	সার্টিফিকেট কোর্স ইন (ফিজিওথেরাপি/অকুপেশনাল থেরাপি/ কমিউনিটি রিহ্যাবিলিটেশন) ন্যূনতম ১৮ মাস	সার্টিফিকেট ইন (ফিজিওথেরাপি/অকুপেশনাল থেরাপি/ কমিউনিটি রিহ্যাবিলিটেশন)	
বাংলাদেশ ইনস্টিটিউট অব কমিউনিটি অপথ্যালমোলজী (বিকো) ও চক্ষু হাসপাতাল, কুমিল্লা।	সিটিফিকেট কোর্স ইন এমএলওপি	সার্টিফিকেট	
ইসলামীয়া চক্ষু হাসপাতাল এবং এম এ ইস্পাহানী ইনস্টিটিউট অব অপথ্যালমোলজি, ফার্মগেট, ঢাকা			
স্টেট কমিউনিটি হেলথ ট্রেনিং একাডেমি, কালীগঞ্জ, ঝিনাইদহ	সার্টিফিকেট কোর্স ইন কমিউনিটি হেলথ ওয়ার্কার্স ১বৎসর	সার্টিফিকেট ইন কমিউনিটি হেলথওয়ার্কার্স	

সপ্তম তপশিল

[ধারা ২(৩) দ্রষ্টব্য]

(ক) রিহ্যাবিলিটেশন সেবা ইউনিটের নাম

সেবা ইউনিটের নাম	সেবা ইউনিটের ঠিকানা	প্রদত্ত সেবাসমূহ	মন্তব্য
(১)	(২)	(৩)	(৪)
ফিজিক্যাল মেডিসিন এন্ড নিউরো রিহ্যাবিলিটেশন	ন্যাশনাল ইন্সটিটিউট অব নিউরোসাইন্স এন্ড হাসপাতাল, শেরেবাংলা নগর, আগারগাও, ঢাকা- ১২০৭	• রিহ্যাবিলিটেশন সেবা (যথা: ফিজিওথেরাপি, অকুপেশনাল থেরাপি **এবং** স্পীচ ও ল্যাংগুয়েজ থেরাপি ইত্যাদি)	

(খ) রিহ্যাবিলিটেশন সেবা সেন্টারের নাম

(৫০ শয্যাবিশিষ্ট বা ততোধিক শয্যাবিশিষ্ট)

সেবা প্রতিষ্ঠানের নাম	সেবা প্রতিষ্ঠানের ঠিকানা	প্রদত্ত সেবাসমূহ	**মন্তব্য**
(১)	(২)	(৩)	(৪)
সেন্টার ফর দি রিহ্যাবিলিটেশন অব দি প্যারালাইজড (সিআরপি), সাভার	সেন্টার ফর দি রিহ্যাবিলিটেশন অব দি প্যারালাইজড (সিআরপি), চাপাইন, সাভার, ঢাকা-১৩৪৩	• অন্তঃবিভাগ ও বহির্বিভাগ চিকিৎসা ও রিহ্যাবিলিটেশন সেবা • প্যাথলজি ও ইমেজিং সুবিধা • বিভিন্ন থেরাপি সুবিধা • কাউন্সেলিং সেবা • ভোকেশনাল ট্রেনিং • কমিউনিটি রিহ্যাবিলিটেশন কার্যক্রম • চাহিদাভিত্তিক সহায়ক উপকরণ উৎপাদন ও বিতরণ	

ড. মোঃ আবদুর রব হাওলাদার
সিনিয়র সচিব।

মোঃ লাল হোসেন, উপপরিচালক, বাংলাদেশ সরকারী মুদ্রণালয়, তেজগাঁও, ঢাকা কর্তৃক মুদ্রিত।
মোঃ আব্দুল মালেক, উপপরিচালক, বাংলাদেশ ফরম ও প্রকাশনা অফিস তেজগাঁও, ঢাকা কর্তৃক প্রকাশিত। website: www.bgpress.gov.bd

Annex 12: Composition of National Mental Health Strategic Plan Working Group

Chief Adviser:
Ms Saima Wazed, Chairperson, National Advisory Committee on autism and NDDs and Shuchona Foundation

Coordinator:
Director General, Autism & NDD Cell, Health Services division, Ministry of Health and Family welfare

Chairperson:
Director General, Directorate General of Health Services, Mohakhali, Dhaka

Members:

1. Chairperson, NDD Protection Trust
2. Director General, Directorate General of Family Planning
3. Director General, Directorate General of Nursing and Midwifery
4. Director General, National Institute of Population Research and Training (NIPOT)
5. Director General, Department of Narcotics Control, Security Services Division, Ministry of Home Affairs
6. Representative, Medical Education and Family welfare Division (not below the rank of Joint Secretary)
7. Representative, Ministry of Social Welfare (not below the rank of Joint Secretary)
8. Representative, Ministry of Women and Children affairs (not below the rank of Joint Secretary)
9. Representative, Secondary & Higher of Education Division
10. Representative, Ministry of Primary and Mass Education (not below the rank of Joint Secretary)
11. Representative, Ministry of Information (not below the rank of Joint Secretary)
12. Representative, Ministry of Youth and Sports (not below the rank of Joint Secretary)
13. Ministry of Disaster Management and Relief (not below the rank of Joint Secretary)
14. Representative, Ministry of Cultural Affairs (not below the rank of Joint Secretary)
15. Representative, Local Government Division, Ministry of Local Government, Rural Development and Cooperatives (not below the rank of Joint Secretary
16. Representative, Autism & NDD Cell, Health Services Division, Ministry of Health and Family Welfare
17. Joint Chief, Health Services Division, Ministry of Health and Family Welfare
18. Professor Kamruzzaman Rahat, Chairman, Department of Clinical Psychology, Dhaka University
19. Professor Mohammad S I Mollick, Professor of psychiatry, Bangabandhu Sheikh Mujib Medical University
20. Director, Institute of Pediatric Neurology and Autism (IPNA), Bangabandhu Sheikh Mujib Medical University (BSSMU), Dhaka

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GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

NATIONAL MENTAL HEALTH STRATEGIC PLAN

2020-2030

Approved in May 2022

Members:

21. Line Director, Non-Communicable Diseases Control (NCDC)
22. Line Director, Hospital Service Management (HSM)
23. Line Director, Maternal, Neonatal, Child & Adolescent (MNCAH), DGHS
24. Line Director, Community Based Health Care (CBHC)
25. Ms Mahjabeen Haque, Associate Professor and Chair, Department of Education and Counseling Psychology, University of Dhaka
26. Secretary, Psychiatric Society of Bangladesh
27. Two Representatives, Shuchona Foundation
28. Two Representatives, NIMH (not below the rank of Associate Professor)
29. Program Manager-2, NCDC, DGHS
30. Deputy Program Manager-3, NCDC, DGHS
31. Dr. Tara Kessaram, Medical Officer, Non-Communicable Diseases, WHO Bangladesh
32. Ms Hasina Momotaz, National Consultant-Mental Health, WHO Bangladesh
33. Ms Olga Rebolledo, MHPSS Project Officer, IOM
34. Representative, UNICEF
35. Representative, UNHCR
36. Executive Director, Centre for Disability & Development (CDD), Savar, Dhaka
37. Executive Director, Centre for Injury Prevention and research Bangladesh (CIPRB), Mohakhali, Dhaka
38. Representative, Media
39. Self-Advocate (Mental Health)
40. Representative, Care Givers of persons with mental health problems
41. Representative, Rehabilitation Council of Bangladesh

Member-Secretary:
Director, National Institute of Mental Health and Hospital (NIMH)

Annex 13: Composition of Technical Task Team for National Mental Health Strategic Plan (Not according to seniority)

Convenor:
Professor Dr. Golam Rabbani, Chairman, NDD Protection Trust

Member:

1. Representative, Secondary & Higher Education Division, Ministry of Education
2. Representative, Ministry of Women and Children Affairs
3. Representative, Ministry of Social Welfare
4. Representative, Ministry of Disaster Management and Relief
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7. Professor Dr. Kamruzzaman Mozumder, Chairman, Department of Clinical Psychology, University of Dhaka
8. Ms Mahjabeen Haque, Associate Professor and Chair, Department of Education and Counseling Psychology, University of Dhaka
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10. Dr. Tara Kessaram, Medical Officer, NCD WHO
11. Hasina Momotaz, National Consultant-Mental Health, WHO
12. Malka Shamrose, COO, Shuchona Foundation
13. Nazish Arman, Lead Coordinator, Content Development, Shuchona Foundation
14. Ms Olga Rebolledo, MHPSS Project Officer, IOM
15. Professor Saidur Rahman Mashreky, Director, Centre For Injury Prevention and Research Bangladesh (CIPRB)

Member-Secretary:
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Coordinator:
Dr. Md. Rizwanul Karim, Associate Professor (Epid) PM-2, NCDC, DGHS

Rapporteur:
Dr Maruf Ahmed Khan, DPM-3, NCDC, DGHS

Acknowledgement

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Director General, Directorate General of Medical Education

Md. Tahmidul Islam
Additional Secretary and DG, Autism and NDD cell, HSD, Ministry of Health and Family Welfare

Dr. A M Pervez Rahim
Joint Secretary and Chief Coordinator, Autism and NDD Cell, HSD, Ministry of Health and Family Welfare

Professor Dr. Nasima Sultana
Additional Director General (Admin), Directorate General of Health Services

Professor Dr. Meerjady Sabrina Flora
Additional Director General (Planning & Development), Directorate General of Health Services

Professor Dr. Mohammad Robed Amin
Line Director, Non Communicable Disease Control Program, Directorate General of Health Services

This Strategic Plan was approved by the Health Services Division, Ministry of Health and Family Welfare in May 2022


NCDC
Non-Communicable Disease Control
DGHS MOHFW


আপনার স্বাস্থ্য আমাদের অঙ্গীকার
HPNSDP
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়


National Institute of Mental Health & Hospital
NIMHH


World Health
Organization
Bangladesh


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