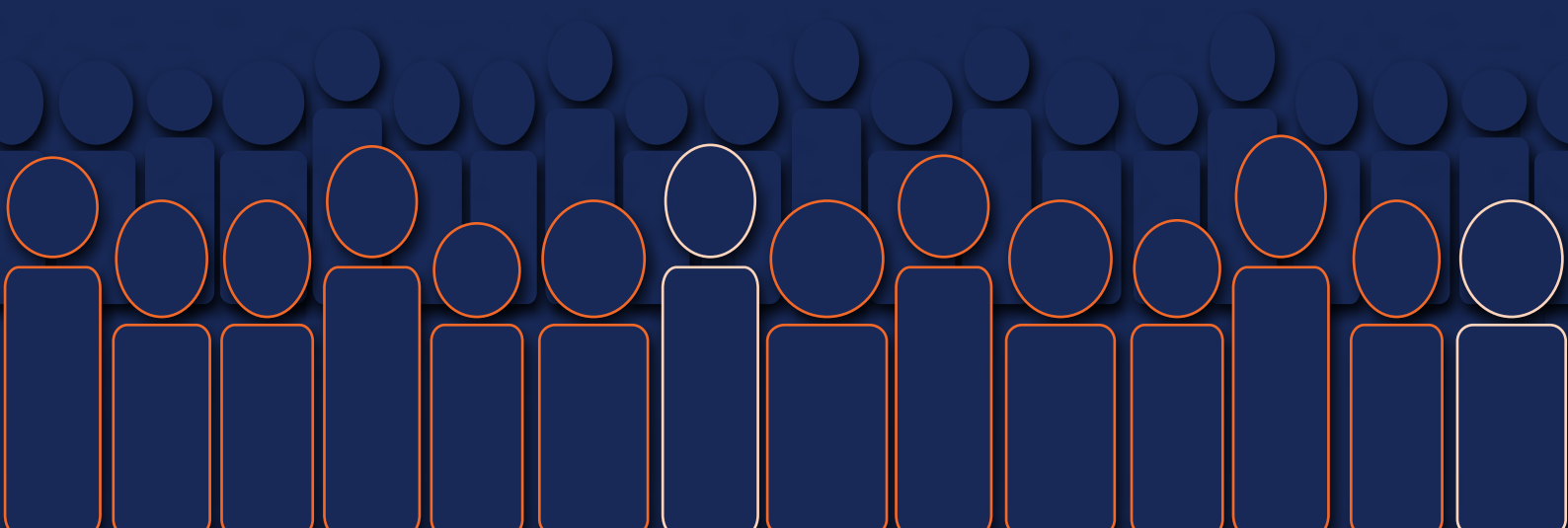
World Health Organization

REGIONAL OFFICE FOR South-East Asia

Mental health conditions

in the WHO South-East Asia Region



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This publication contains the report of the third meeting of the WHO Technical Advisory Group on Diabetes and does not necessarily represent the decisions or policies of WHO.

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Contents

Tables

Figures

Foreword

The World Health Organization (WHO) and its Member States in the WHO South-East Asia Region are committed to ensuring access for everyone, everywhere in the Region to quality mental health care and services, as highlighted by the "Paro Declaration on universal access to people-centred mental health care and services" that was unanimously adopted at the Seventy-fifth Session of the WHO Regional Committee for South-East Asia in 2022.

In the WHO South-East Asia Region, the estimated prevalence of mental health conditions is 13.2%, equivalent to 260 million people living with some form of mental health condition. Mental health conditions are the leading cause of years of healthy life lost to disability, with depression being the largest contributor, and schizophrenia the single most disabling condition. Suicide accounts for 1 in 100 deaths globally. People with severe mental disorders die at an age 10 to 20 years earlier than the average age of death for the general population.

Since 2014, preventing and controlling noncommunicable diseases – including mental health conditions – has been a Regional Flagship Priority Programme in South-East Asia, with significant progress to show, including a 33% reduction in suicide mortality. However, gaps and challenges persist, not least in financing, human resources, and programme delivery. While the Paro Declaration and Regional Mental Health Action Plan 2022–2030 address many of these gaps and challenges, this publication responds to an urgent and as-yet-unmet need: high-quality data.

To that end, this report provides a comprehensive overview of the burden of mental, neurological and substance use disorders and self-harm in the WHO South-East Asia Region. It synthesizes and analyses data on mental health published in the WHO Global Health Estimates (GHE) database, as well as the Global Burden of Diseases database of the Institute of Health Metrics and Evaluation of the University of Washington, United States of America.

It presents and compares the prevalence of different mental, neurological and substance use disorders, as well as self-harm, globally and in the Region, and also compares differences in the prevalence of these conditions between countries of the Region. The burden of specific mental health conditions is also analysed using key metrics – including years lived with disability (YLD) and disability-adjusted life years (DALYs) – across time and also by age groups. Human resources for mental health and financing for mental health in the Region are also compared with global estimates. A separate section presents the prevalence and evidence on the mental health burden by country.

I urge all stakeholders in the Region and beyond to utilize this information to better plan mental health interventions, and to mobilize adequate political and financial commitments, with the aim of ensuring that everyone, everywhere in the Region can access people-centred mental health care and services.

Dr Poonam Khetrapal Singh
Regional Director, WHO South-East Asia

Acknowledgements

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The conceptualization, technical inputs and development of the report and interpretation of key findings were carried out by Dr Andrea Bruni, Regional Advisor, Mental Health and a Substance Abuse and Dr Sajeeva Ranaweera, Consultant, Mental Health and Substance Abuse Unit. Ms Shabana Khan, Executive Assistant, Mental Health and Substance Abuse, provided secretariat support.

The data extraction, management, analysis, formulation of the graphs, figures, presentation of key findings and results was carried by Dr Amani Siyam, Regional Advisor, Health Information System, Ruchita Rajbandhari, Technical Officer, Delivery and Data Analytics, and Tarun Jain, Data Assistant, Health Situation and Trend Assessment Unit.

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Abbreviations and acronyms

DALY	disability-adjusted life year
GBD	Global Burden of Disease
GHE	Global Health Estimates
ICD	International Classification of Diseases
IHME	Institute for Health Metrics and Evaluation
MNSS	mental, neurological and substance use disorders and self-harm
WHO	World Health Organization
YLDs	years of healthy life lost to disability
YLLs	years of life lost from mortality

Executive summary

In the WHO South-East Asia Region, epidemiological knowledge of mental health conditions remains a relative unknown, given the sparsity of data and information on (a) the total burden associated with each disorder; (b) the degree of met and unmet needs for treatment and interventions; and (c) the patterns and costs of treatment. This is a common situation in other regions of the world, where the global descriptive epidemiology of the Global Burden of Disease (GBD) study is mainly used in association with the WHO Global Health Estimates (GHE) to quantify, at the very least, the total burden associated with mental health conditions.

In these inaugural analyses, the aim is to present key findings of comparative analyses of the burden of mental health conditions in the Region, using the latest GBD and GHE estimates, expressed in terms of summary measures, the prevalence of years of healthy life lost to disability (YLDs) and disability-adjusted life years (DALYs), and, where possible, using disaggregation of data by sex and gender. Key results pertain to mental, neurological and substance use and self-harm (MNSS).

The report also spotlights the burden of mental health conditions among children and provides a summary of human resources and financing requirements for mental health.

The key findings include data on:

- mental disorders
- neurological disorders
- substance use disorders
- self-harm and suicide
- the burden of mental, neurological and substance use among children
- the health system response in terms of financing and human resources for mental health.

1. Background and context

WHO defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community” *(1)*.

Greater attention is being paid to mental health globally and within the WHO South-East Asia Region, particularly following the COVID-19 pandemic. Mental health is intrinsic to health and social well-being and allows people to live up to their potential and connect meaningfully with others. Mental health is pivotal to the complete development of individuals and societies – there is no health without mental health.

The Mental health action plan for the WHO South-East Asia Region 2023–2030 highlights the main areas of action for the Region *(2)*. Globally, the prevalence of mental health disorders is estimated to be 13.0%; 970 million people suffer from mental health conditions. In the WHO South-East Asia Region, the estimated prevalence is 13.2%, which is equivalent to 260 million people living with some form of mental health condition *(3)*. Mental health conditions are the leading cause of years of healthy life lost to disability (YLDs), with depression being the largest contributor to YLDs from mental health conditions *(3)*. Suicide accounts for 1 in 100 deaths globally *(4)*. People with severe mental disorders die 10 to 20 years earlier than the average age of death for the general population *(5)*.

The four risk factors for noncommunicable diseases (NCDs) – tobacco use, alcohol use, unhealthy diet and physical inactivity – are all linked to mental health conditions *(6)*. Mental health conditions coexist in persons living with a range of physical ailments, including such noncommunicable diseases as cardiovascular diseases, diabetes, hypertension and cancer, and communicable diseases such as HIV/AIDS *(7)* and TB *(8)*. It is estimated that the loss of productivity across the life-course attributed to mental health conditions will cost the global economy US$ 6 trillion a year by 2030 *(9)*.

Apart from economic costs, there are social costs too. People with mental health conditions suffer stigma and discrimination, and are more likely to experience lack of access to educational and employment opportunities, impoverishment and social exclusion. The conventional systems of care for people with mental health conditions in specialized settings not only pose barriers to access but have also significantly contributed to stigma and isolation of people with such conditions. There is, thus, an urgent need to re-orient mental health care to compassionate, person-centred, timely, accessible and affordable forms of care.

Several factors that shape the social, cultural and economic environment also impact mental health at the population level. Poverty, socioeconomic and gender inequalities, discrimination and lack of services, or access to them, impact mental health negatively. At the individual level,

mental health is adversely impacted by factors such as poor education, alcohol and substance use, job loss or unemployment, exposure to different forms of violence and bullying, and pre-existing chronic diseases *(3)*.

Research on the links between climate change and mental health is a new but rapidly growing field. As is the case with most disasters and emergencies and their aftermath, children, young people, the elderly, women and the poor bear the major brunt of these adverse events, including the impact on their mental health. Climate change and consequent floods, famines, loss of homes and livelihoods *(10)*, disasters and humanitarian emergencies *(11)* and economic downturns *(12)* have been observed throughout the WHO South-East Asia Region.

The COVID-19 pandemic exposed the vulnerabilities, aggravated by the fact that little attention has been paid to mental health issues over the years. It also underscored the critical importance of mental health for healthy lives and well-being. An estimated 25% rise in depressive and anxiety disorders across the world was reported in the first year of the pandemic alone *(13)*. The long-term mental health effects of the economic fallout of the pandemic are yet to be witnessed or estimated *(14)*.

The Region carries a high burden of mental health conditions across all its Member States, as reported in recently published data. In Bangladesh, the prevalence of mental disorders among adults was estimated as 18.7% *(15)*. India reported an overall weighted prevalence of current mental morbidity at 10.6%, and at 13.7% across the life-course *(16)*. In Indonesia, the estimated prevalence of depression was 6.1% among adults, and 7 million households had at least one member living with psychosis *(17)*. In Nepal, the lifetime prevalence of mental disorders among adults was estimated to be 10% *(18)*.

Paucity of data constrains estimation of the full magnitude of the disease burden and the treatment gaps, both expected to be large in the Region, as exemplified in the national mental health surveys carried out in some countries. Bangladesh has reported a treatment gap of 91% across mental health conditions *(15)* and India a gap of 70%–95%. *(16)*. In Nepal, only 23% of adults with mental health conditions sought treatment *(18)*.

Most countries have tertiary care facilities for mental health services in urban centres. Crucially, there is an urgent need to extend mental health services closer to the community through the primary and secondary care systems. Bhutan, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand have prioritized providing primary health care-oriented mental health services through specific policies and programmes. Efforts are being made in Bangladesh and Nepal to strengthen mental health services through primary health care in pilot districts, supported by the WHO Special Initiative for Mental Health.

Deploying a cadre of well-trained human resources in adequate numbers for providing mental health services is a major challenge throughout the Region. As reported in the WHO *Mental health atlas 2020*, the number of psychiatrists per 100 000 population ranged from 0.2 to 0.6 in Bangladesh, Bhutan, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. Similarly, the number of psychiatric nurses ranged from 0.4 to 2.9 per 100 000 population and that of psychologists from 0 to 1.3 per 100 000 population in these countries *(19)*. There is a similar shortage of occupational therapists and mental health social workers.

Data collected for the WHO *Mental health atlas 2020* show that investment in mental health services remains very low across the Region and is below US$ 1 per capita in several countries *(19)*.

This report therefore attempts to present the latest prevalence and burden data available on mental health conditions in the Region, and aims to provide guidance on where countries can prioritize strategic actions for tackling mental health disease and lifelong related disabilities. The analysis presented in this report utilizes the latest Global Burden of Disease estimates and the WHO Global Health Estimates to quantify the scale and intensity of the mental health disease burden which, if left unaddressed, will result in a dramatic treatment gap.

To address the treatment gap and other challenges, the *Mental health action plan for WHO South-East Asia Region 2023–203*0 was published in 2023. This followed the ministers of health of all 11 Member States adopting the Paro Declaration on universal access to people-centred mental health care and services at the Seventy-fifth Session of the Regional Committee for South-East Asia, held in September 2022.

2. Methods

2.1 Data sources

The estimates used in this report are those of the Global Burden of Disease (GBD) study and the WHO Global Health Estimates (GHE). Led by the Institute for Health Metrics and Evaluation (IHME), the GBD study represents a systematic and scientific effort to quantify the magnitude of all major diseases, risk factors and intermediate clinical outcomes in a highly standardized way to allow for comparisons over time, across populations and between health conditions *(20)*. The IHME, which is the coordinating centre for the GBD, hosts an online data catalogue for all data sources used in the study, evaluated in each analysis, using surveys, censuses, cohort studies and administrative data for over 200 countries and territories. The GBD provides estimates in a revised time series, from 1990 to the present, for all outcomes.

Building on the GBD estimates, the GHE *(21)* presents comprehensive and comparable time series data from 2000 onwards for the health-related indicators, including life expectancy, healthy life expectancy, mortality and morbidity, as well as the burden of diseases at global, regional and country levels, disaggregated by age, sex and individual causes. These are produced using data from multiple consolidated sources, including national vital registration data, latest estimates from WHO technical programmes, interagency estimates for all-cause mortality and priority diseases and injuries, and other scientific studies.

A broad spectrum of robust and well-established scientific methods was applied for the processing, synthesis and analysis of the data. Estimates are made for 183 WHO Member States with populations greater than 90 000 in 2019, disaggregated by sex and age for the following age groups: neonatal (<28 days), 1–59 months, 5–14 years, 15–29 years, 30–49 years, 50–69 years, 70 years and older.

For this report, IHME GBD and WHO GHE data provide point prevalence within the three major categories of communicable diseases, noncommunicable diseases and injuries *(3)*.

The IHME GBD estimates were used to extract data on the prevalence of mental, neurological and substance use disorders and self-harm (MNSS) for all countries of the Region and in disaggregation by age, sex and individual causes.

The data related to the following MNSS conditions (Table 1) were analysed.

Table 1. Mental, neurological and substance use disorders and self-harm

Mental disorders		Neurological conditions	
1	Depressive disorders	1	Alzheimer disease and other dementias
2	Bipolar disorder	2	Parkinson disease
3	Schizophrenia	3	Epilepsy
4	Anxiety disorders	4	Multiple sclerosis
5	Eating disorders	5	Migraine
6	Autism and Asperger Syndrome	6	Non-migraine headache
7	Childhood behavioural disorders	7	Other neurological conditions
8	Idiopathic intellectual disability		
9	Other mental and behavioural disorders		
Substance use disorders		**Intentional Injuries**	
1	Alcohol use disorders	1	Self-harm (suicide and self-harm behaviour)
2	Drug use disorders		

2.2 Assessing the overall burden of mental health

The GBD estimates expanded the traditional focus of global health on death or premature mortality to also encompass outcomes related to morbidity and disability *(20)*. Two key summary measures were proposed and implemented: disability-adjusted life years (DALYs) and healthy life lost to disability or ill health (YLDs).

DALYs are calculated as the sum of years of life lost due to premature mortality plus years lived with disability. They combines the time lost through premature death and the time lived in states of less-than-optimal health, loosely referred to as “disability” *(22)*.

On the other hand, a YLD represents the equivalent of one full year of healthy life lost to disability or ill health. YLDs are calculated as the prevalence of each non-fatal condition multiplied by its disability weight *(23)*. Disability weights represent the magnitude of the health loss associated with a specific health outcome in each population. The weights are measured on a scale from 0 to 1, where 0 equals a state of full health and 1 equals death *(24)*. It is worth noting that the GHE estimates of YLDs draw on the GBD 2019 analyses, with selected revisions to disability weights and prevalence estimates, as noted below.

This report presents a comparative analysis, using estimates of prevalence and of DALYs and YLDs and, where possible, disaggregation by sex and age.

3. An overview of the disease burden in the WHO South-East Asia Region

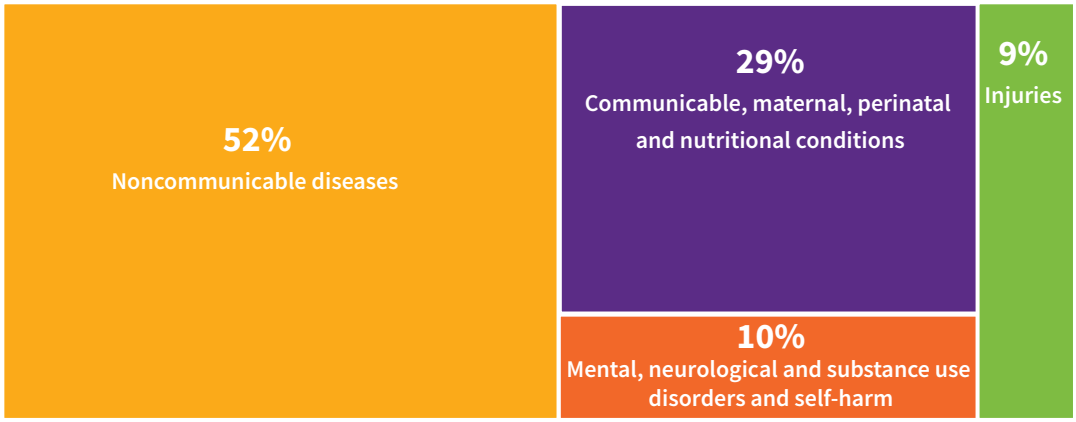
Mental, neurological and substance use disorders and self-harm (MNSS) conditions are responsible for 23% of the overall years of healthy life lost to disability (YLDs) in the WHO South-East Asia Region; their share is greater than that attributable to communicable diseases and maternal, perinatal and nutritional conditions (Fig. 1).

Fig. 1. The distribution of YLDs by major disease categories in the WHO South-East Asia Region (2019)

Source: WHO Global Health Estimates (GHE), 2019

On the other hand, when measured in disability-adjusted life years (DALYs), MNSS conditions constitute only 10% of the total in the WHO South-East Asia Region (Fig. 2), similar to the burden attributable to injuries (9%).

Fig. 2. The distribution of DALYs by major disease categories in the WHO South-East Asia Region (2019)

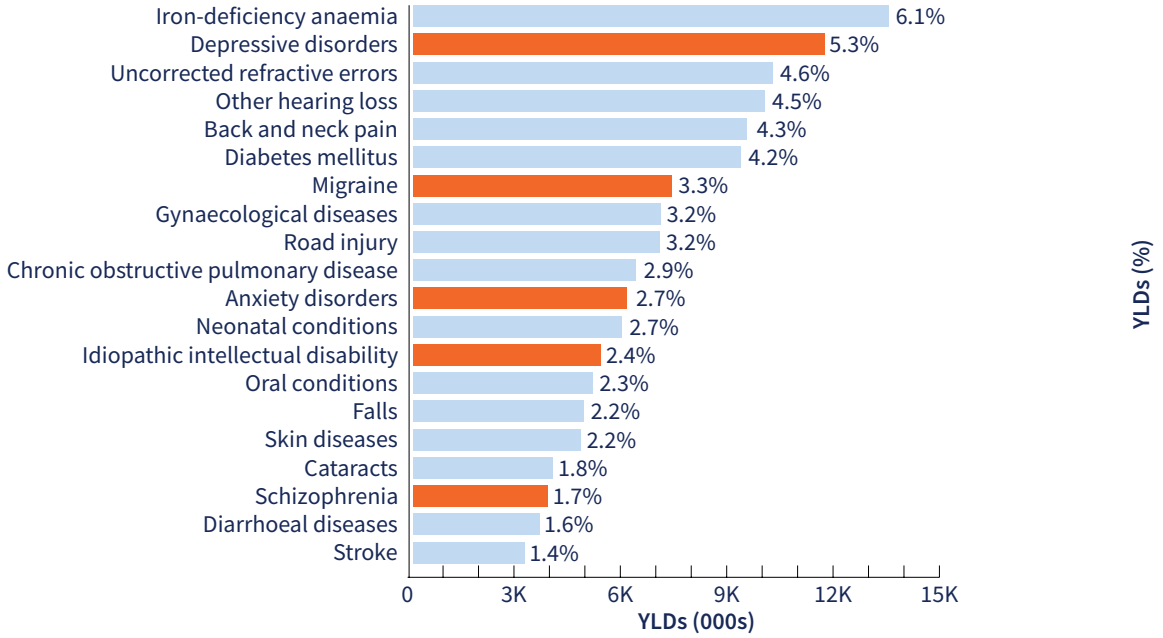


Source: WHO Global Health Estimates (GHE), 2019

3.1 Examining the top causes of disability in the Region

In 2019, the most common cause of YLDs in the Region was iron-deficiency anaemia (see Fig. 3), with depressive disorders as the second most common cause. Other significant mental disorders, such as anxiety and schizophrenia, along with migraine, also feature in the top 20 causes.

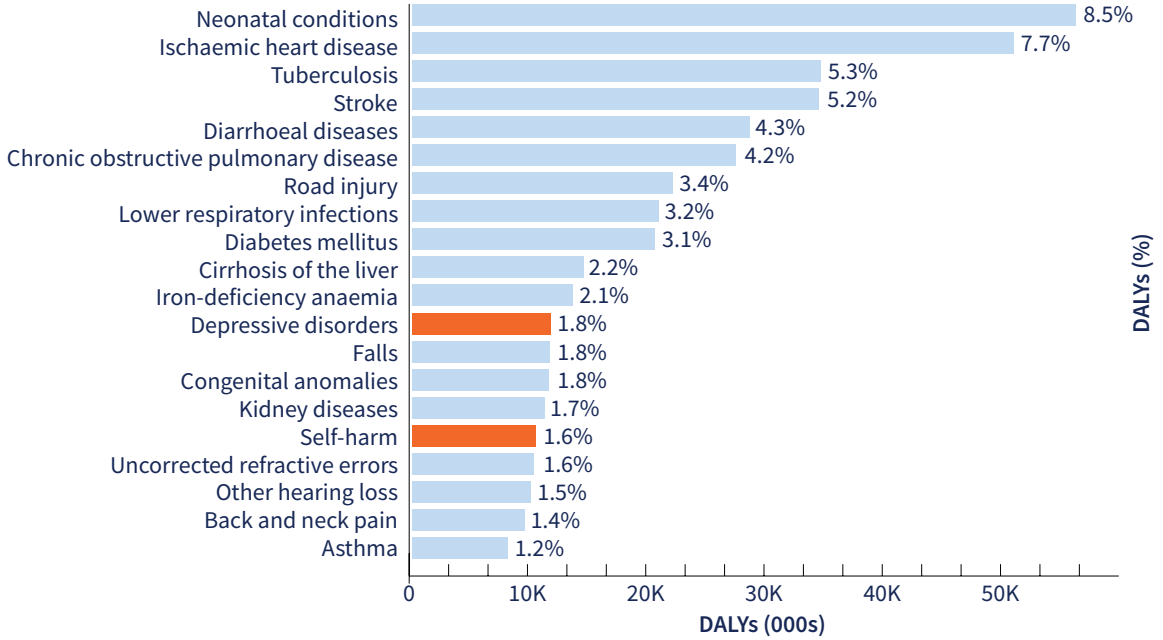
Fig. 3. Top 20 causes of YLDs in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

Depressive disorders and self-harm are among the top 20 causes of DALYs in the WHO South-East Asia Region (Fig. 4).

Fig. 4. Top 20 causes of DALYs in the WHO South-East Asia Region (2019)

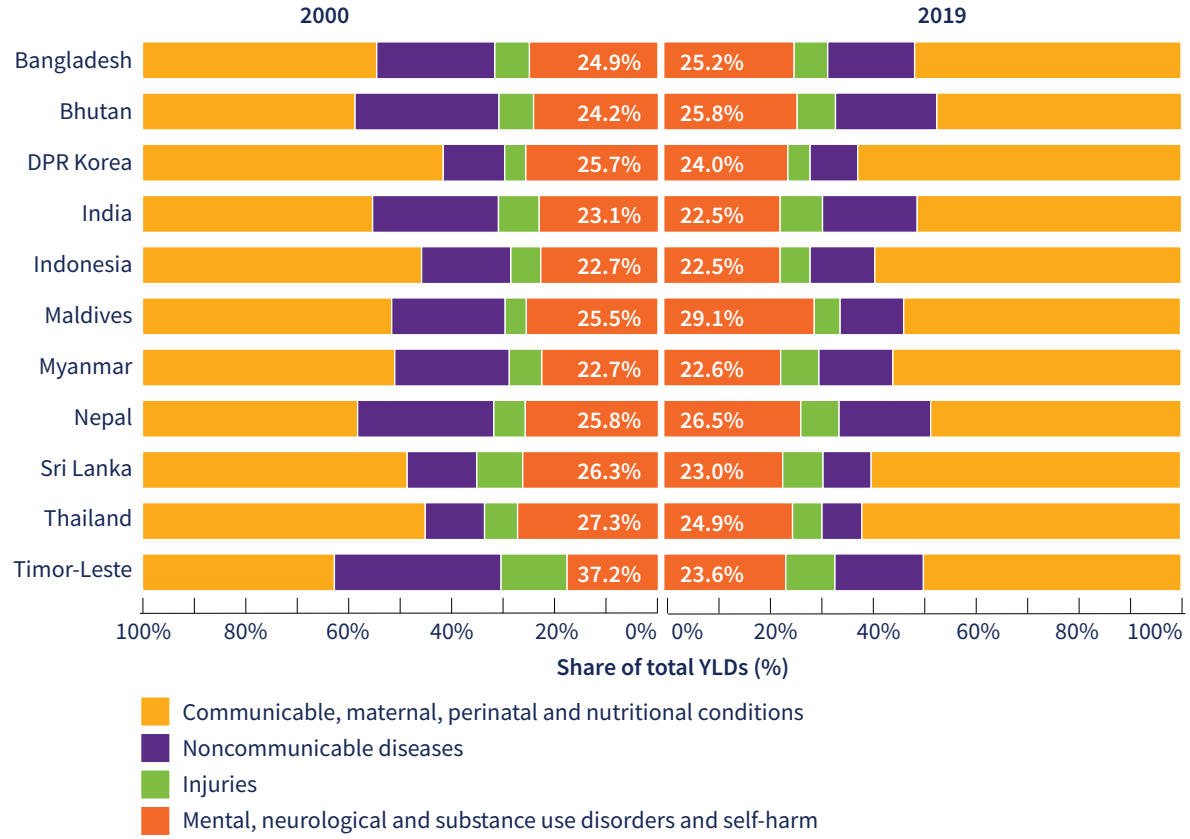


Source: WHO Global Health Estimates (GHE), 2019

3.2 The burden of mental health conditions compared with other conditions in the Region

The burden of mental health conditions remained high in the Region between 2000 and 2019. There were small changes in the burden within countries, except for Maldives and Timor-Leste, which experienced notable increases. The most important aspect of the data in Fig. 5 is that mental health conditions account for a significant percentage of the total non-fatal burden of disease in all Member States.

Fig. 5. YLDs due to major disease categories as a percentage of total YLDs, by country (2000 and 2019) in the WHO South-East Asia Region

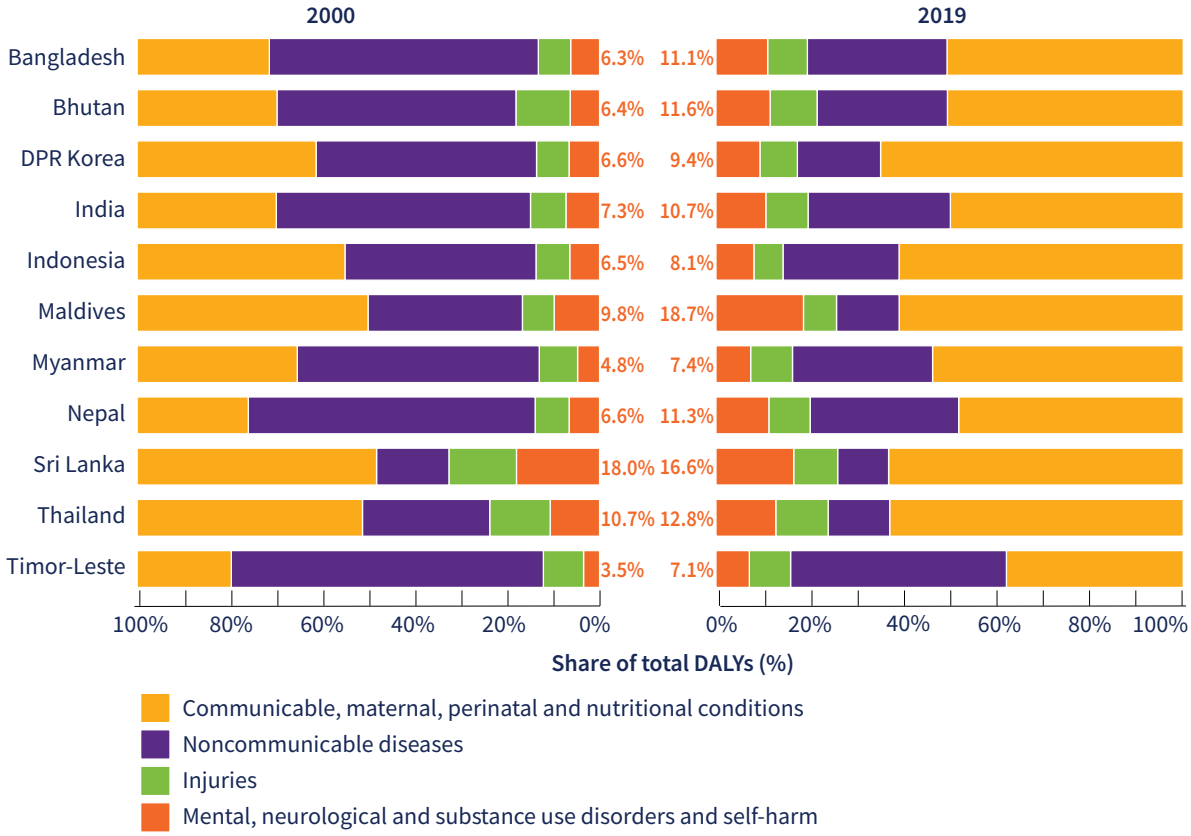


Source: WHO Global Health Estimates (GHE), 2019

Fig. 6 shows that the DALYs attributable to mental health conditions rose significantly in almost all Member States of the Region between 2000 and 2019. In some countries, DALYs increased by over 50%. Coupled with the lack of human resources and adequate funding (discussed in Section 10), this is likely to compound the situation in the future unless urgent actions are taken now.

Policy-makers, programme planners, government and other funders should therefore give priority attention to mental health conditions in all countries of the Region.

Fig. 6. DALYs due to major disease categories as a percentage of total DALYs, by country (2000 and 2019) in the WHO South-East Asia Region



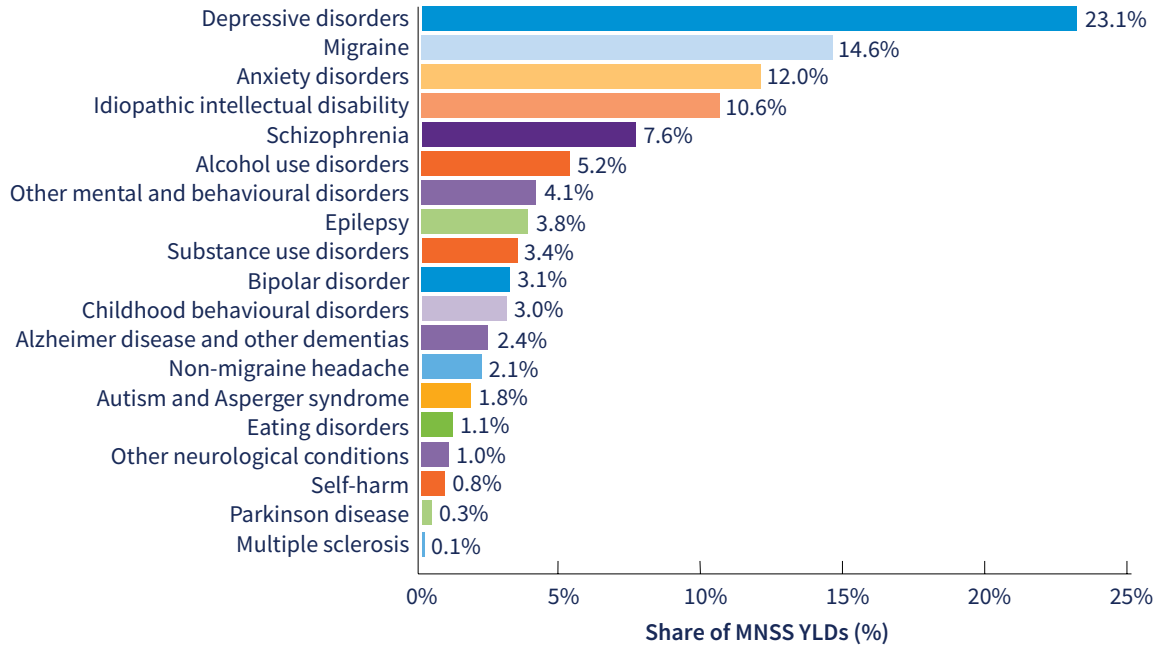
Source: WHO Global Health Estimates (GHE), 2019

3.3 Unpacking the burden of mental, neurological and substance use disorders and self-harm in the Region

Depressive disorders account for almost a quarter of the healthy years lost to disability resulting from MNSS in the WHO South-East Asia Region (Fig. 7). This is a significant disease burden because of the impact this condition has on families, communities and workplaces. There are also correlations between depression and other medical conditions, as well as links to self-harm and suicide. This is a major concern in the Region, where treatment gaps for depression are around 80% or more in countries for which data are available *(25)*.

Among the severe mental disorders, schizophrenia causes the highest burden. Migraine, anxiety disorders and intellectual disability are the other conditions leading to significant morbidity. These findings underscore the need not only for promotion and prevention strategies, but also for availability and access to a wide range of services for diverse mental health conditions.

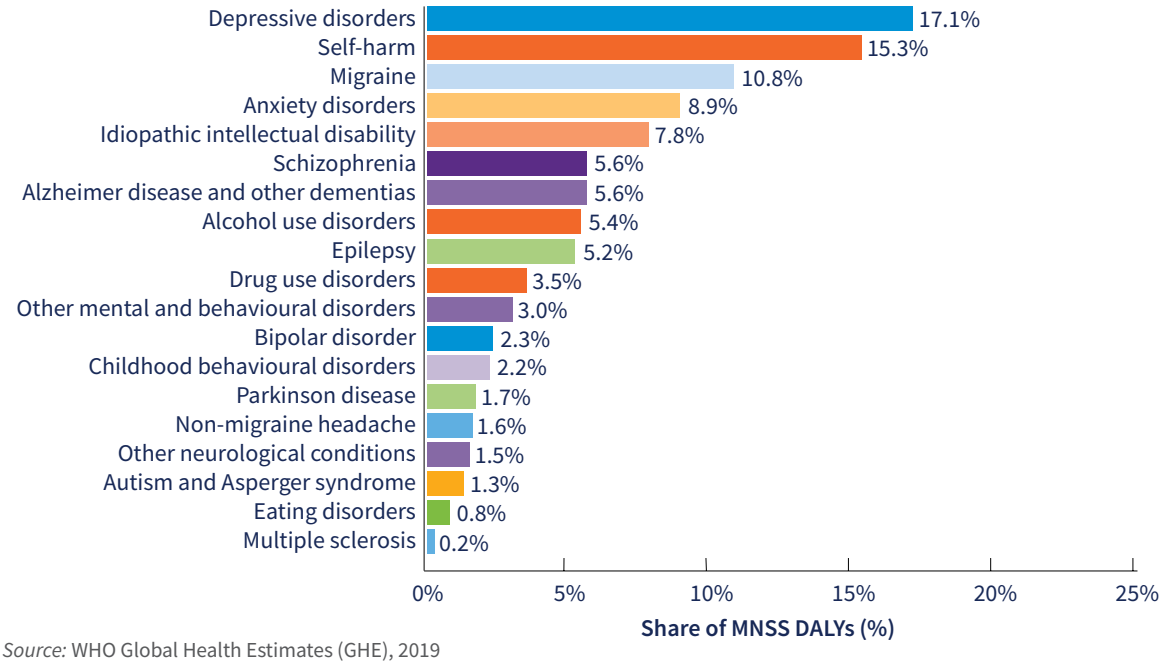
Fig. 7. Ranking of individual causes of MNSS YLDs as percentage of total MNSS YLDs in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

In Fig. 8, a comparative analysis using DALYs reveals a slightly different picture: that depressive disorders account for the highest burden of disease among the MNSS conditions, followed by self-harm, migraine and anxiety disorders. Those four conditions together account for more than half of the disease burden attributable to MNSS.

Fig. 8. Ranking of individual causes of MNSS DALYs as percentage of total MNSS DALYs in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

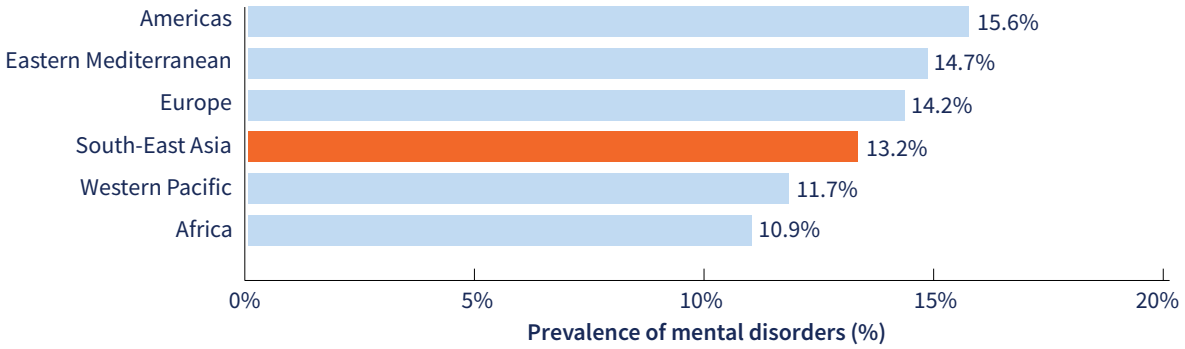
In the following sections, the report presents a detailed analysis of the burden of mental, neurological and substance use disorders and self-harm (MNSS).

4. Mental disorders

4.1 Estimated prevalence

It is estimated that, globally, 970 million people are living with mental disorders *(3)*. Fig. 9 depicts the estimated prevalence of mental disorders by WHO Region. It shows a prevalence of 13.2% for the WHO South-East Asia Region, which is lower than that for the WHO Region of the Americas, the WHO Eastern Mediterranean Region and the WHO European Region. However, in absolute numbers, the WHO South-East Asia Region has over a quarter of a billion people living with mental disorders (260 million out of 970 million). In other words, one in every four people living with mental disorders globally belongs to the WHO South-East Asia Region.

Fig. 9. Prevalence of mental disorders across WHO regions (2019)



Source: Global burden of disease (GBD) 2019

The estimated prevalence of mental disorders in the Region remained almost unchanged in the past two decades (13.2% in 2019, compared with 12.9% in 2000). By and large, the stagnant prevalence of mental disorders relates to the mental health treatment gap with regard to meeting the needs of countries of the WHO South-East Asia Region and/or lack of empirical data to improve the modelling estimations over time.

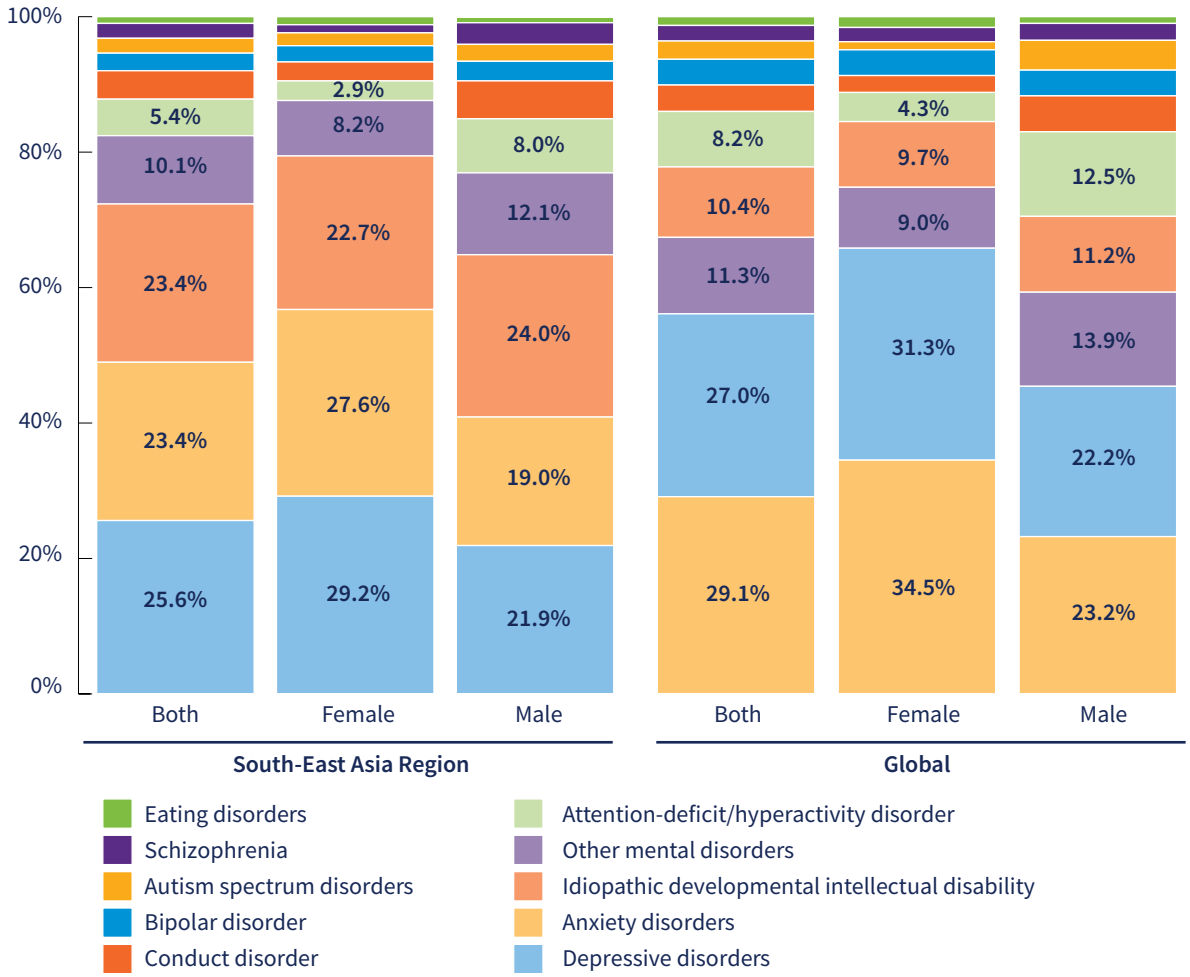
4.2 Distribution and disaggregation

Anxiety and depressive disorders were the commonest conditions among both men and women in 2019, accounting for about 50% of the prevalence of mental disorders in the Region (Fig. 10). Intellectual disability was the next largest contributor (Fig. 10). Those with severe mental disorders (schizophrenia and bipolar disorder) represented around 5% of both men and women.

The global picture was similar insofar as the ranking of disorders among mental conditions was concerned. But developmental and intellectual disability has a significantly higher prevalence in

the Region, where it constituted 23% of the mental disorders, compared with only 10% globally. This requires priority consideration and actions because it is more than double the global prevalence.

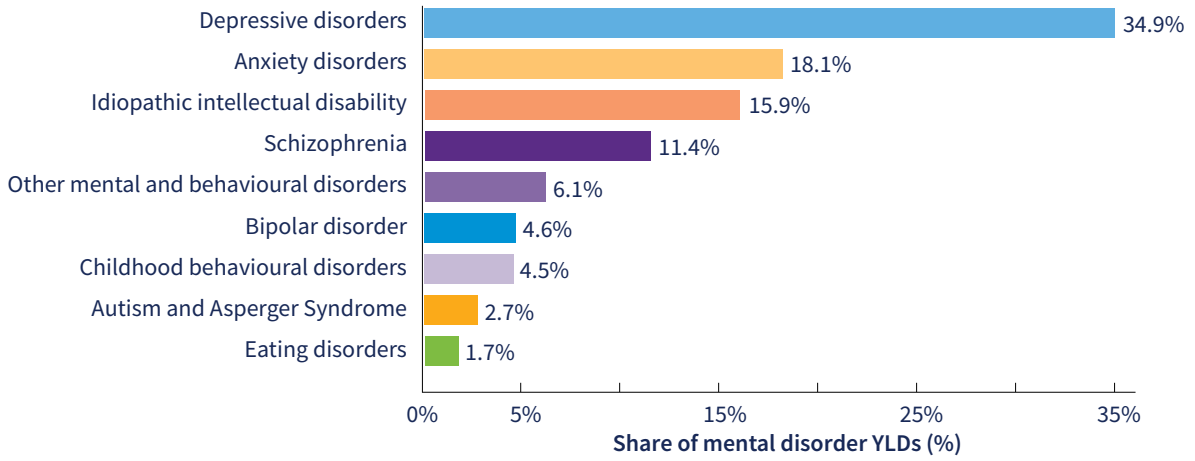
Fig. 10. Distribution of mental disorders in WHO South-East Asia Region and globally (2019)



Source: Global Burden of Disease (GBD), 2019

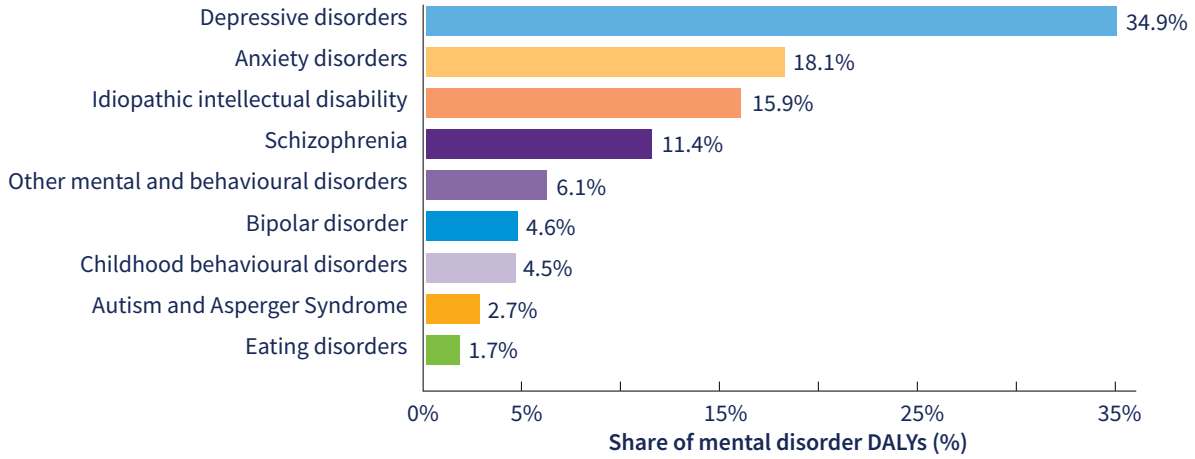
Depressive disorders cause more than a third of the YLDs due to mental disorders in the Region (Fig. 11). These are followed by anxiety disorder, which cause around a sixth of the YLDs. In Fig. 12, a very similar picture is depicted when measured in DALYs.

Fig. 11. Ranking of individual causes of mental disorder YLDs as percentage of total mental disorder YLDs in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

Fig. 12. Ranking of individual causes of mental disorder DALYs as percentage of total mental disorder DALYs in the WHO South-East Asia Region (2019)



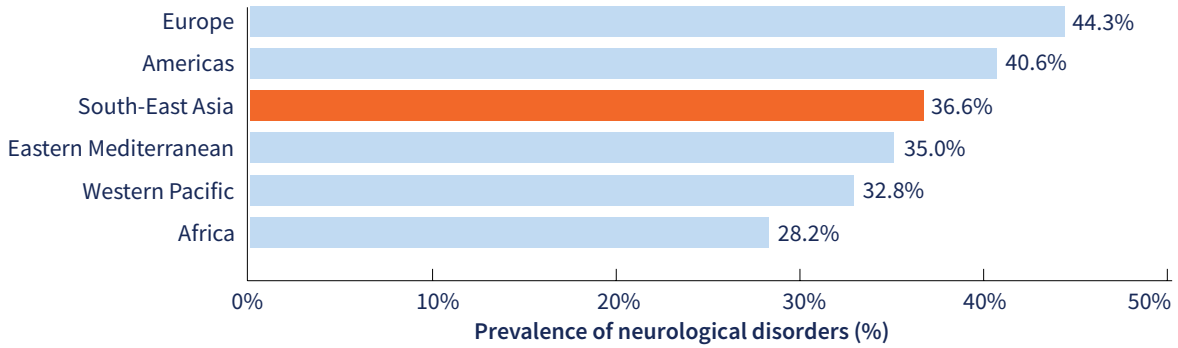
Source: WHO Global Health Estimates (GHE), 2019

5. Neurological disorders

5.1 Estimated prevalence

Globally, 2.7 billion people (one third of the world population in 2019) were living with neurological disorders in 2019. Fig. 13 depicts the estimated prevalence of neurological disorders by Region. The South-East Asia Region has the third-highest prevalence among WHO regions (36.6%). It is important to note that the following analysis does not include data on strokes.

Fig. 13. Prevalence of neurological disorders across WHO regions (2019)



Source: Global Burden of Disease (GBD) estimates, 2019

The overall prevalence of neurological disorders increased by over 9% in the WHO South-East Asia Region between 2000 and 2019. Around 27% of those living with these disorders globally live in this Region. At present, around 719 million people, or more than one in three persons in the Region, live with a neurological disorder.

5.2 Distribution and disaggregation

Fig. 14 shows that, globally, almost the entire neurological disease burden is caused by headache disorders (98.1% or 2.65 billion people). Of the remaining part of the burden, around 500 million people suffer from other neurological disorders (Alzheimer disease and other dementias, idiopathic epilepsy and Parkinson disease).

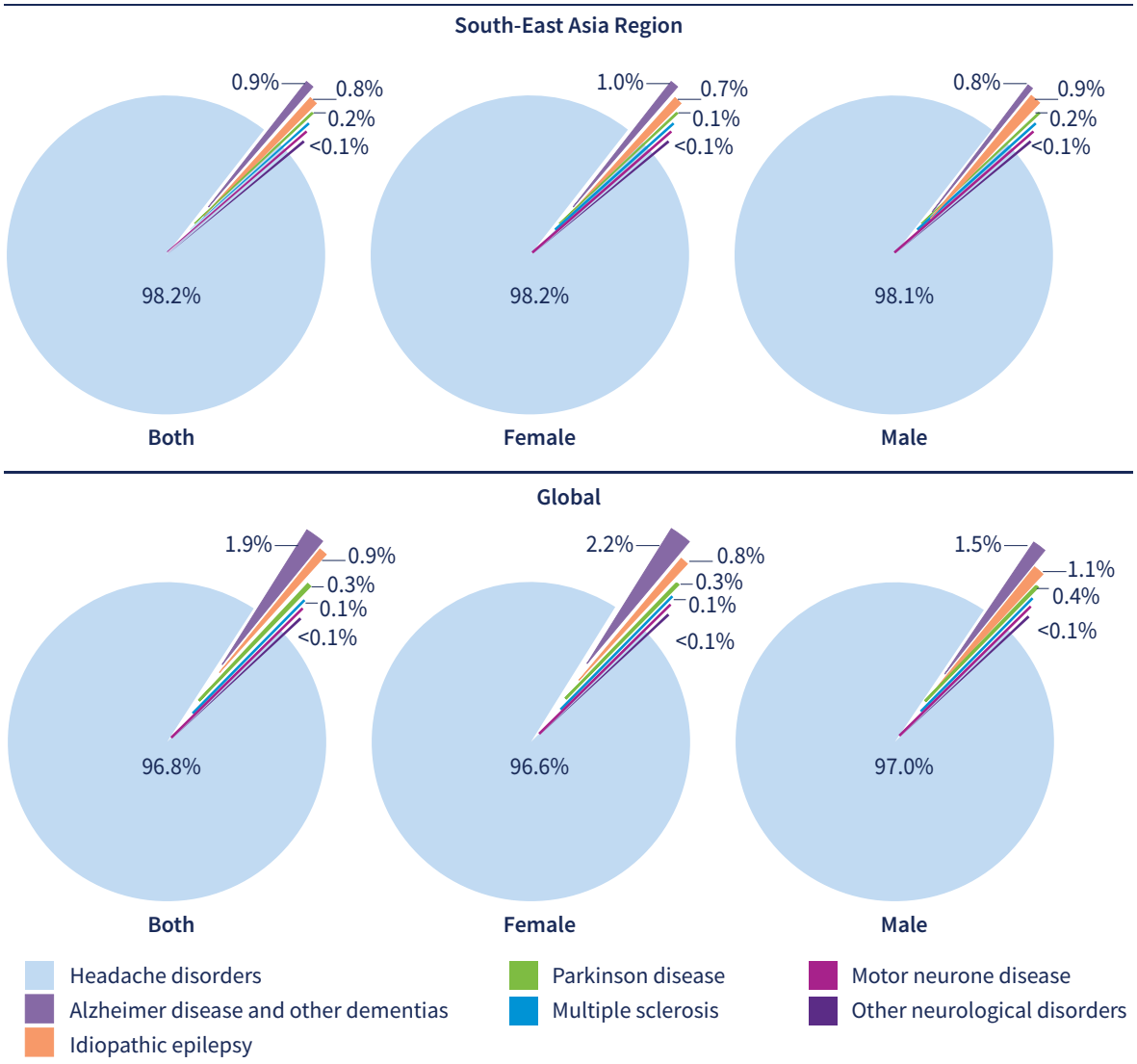
Similarly, in the WHO South-East Asia Region, headache disorder is the dominant condition, with almost no difference between men and women. Other neurological disorders constitute less than 2% of the burden of neurological disorders (Fig. 14) but this still equates to around 14 million people suffering from Alzheimer disease and other dementias, idiopathic epilepsy and Parkinson disease.

Given the overwhelming burden of neurological conditions because of headache disorders, migraine remains responsible for 60% of YLDs in the WHO South-East Asia Region (Fig. 15). Non-

migraine headaches are responsible for only 8.8% of YLDs. Epilepsy and Alzheimer disease and other dementias are the two other most important disorders (Fig. 15).

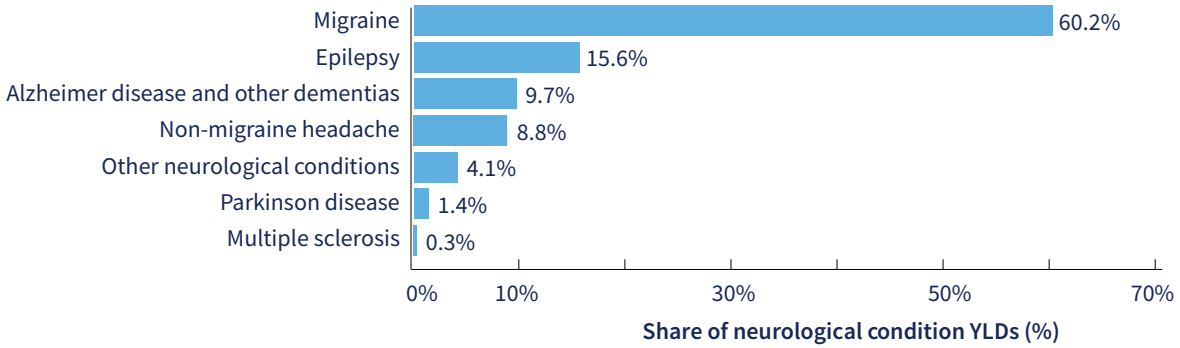
When DALYs are considered, Alzheimer disease (21.1%) moves up to be the second most important disorder after migraine (40.6%), followed by epilepsy (19.9%). The three disorders explain 80% of the DALYs attributed to neurological disorders in the Region (Fig. 16).

Fig. 14. Distribution of neurological disorders in 2019



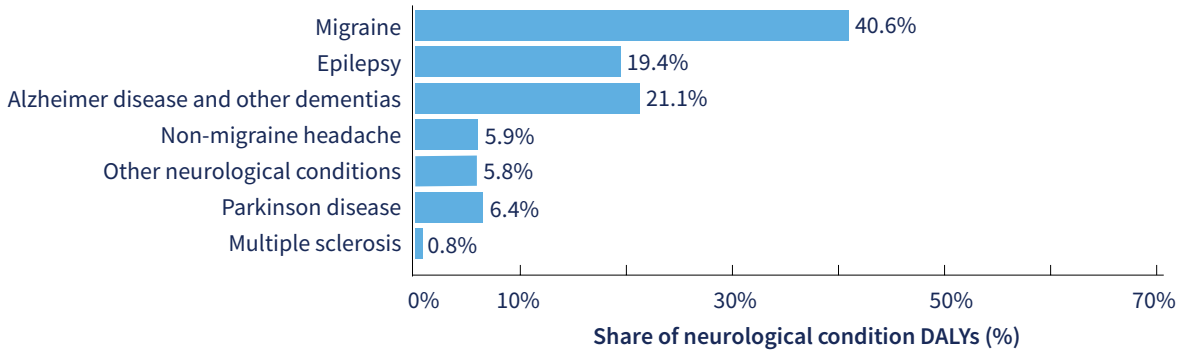
Source: WHO Global Health Estimates (GHE), 2019

Fig. 15. Ranking of individual causes of neurological disorder YLDs as a percentage of neurological disorder YLDs in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

Fig. 16. Ranking of individual causes of neurological disorder DALYs as a percentage of neurological disorder DALYs in the WHO South-East Asia Region (2019)



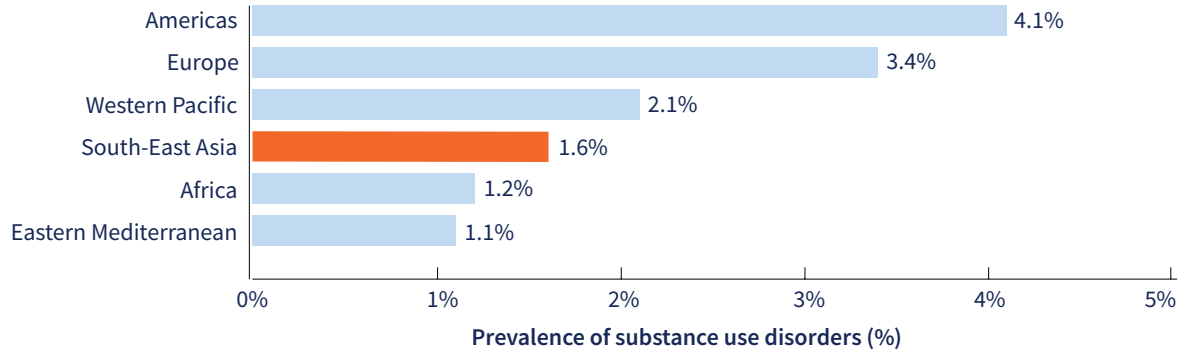
Source: WHO Global Health Estimates (GHE), 2019

6. Substance use

6.1 Estimated prevalence

Globally, 161 million people were living with substance use disorder in 2019, with alcohol use disorders predominating. Of those, 32 million people lived in the Region. The prevalence of substance use disorder has been stable in the WHO South-East Asia Region since 2000. Substance use impacts not only health, but also families and communities. The social harms of substance use are wide-ranging and include law and order issues. Although the overall prevalence is stable, prevention and treatment aspects of substance use disorder need to be strengthened. The estimated prevalence of substance use disorder in the Region was 1.6% in 2019 (Fig. 17).

Fig. 17. Prevalence of substance use disorder across WHO regions (2019)



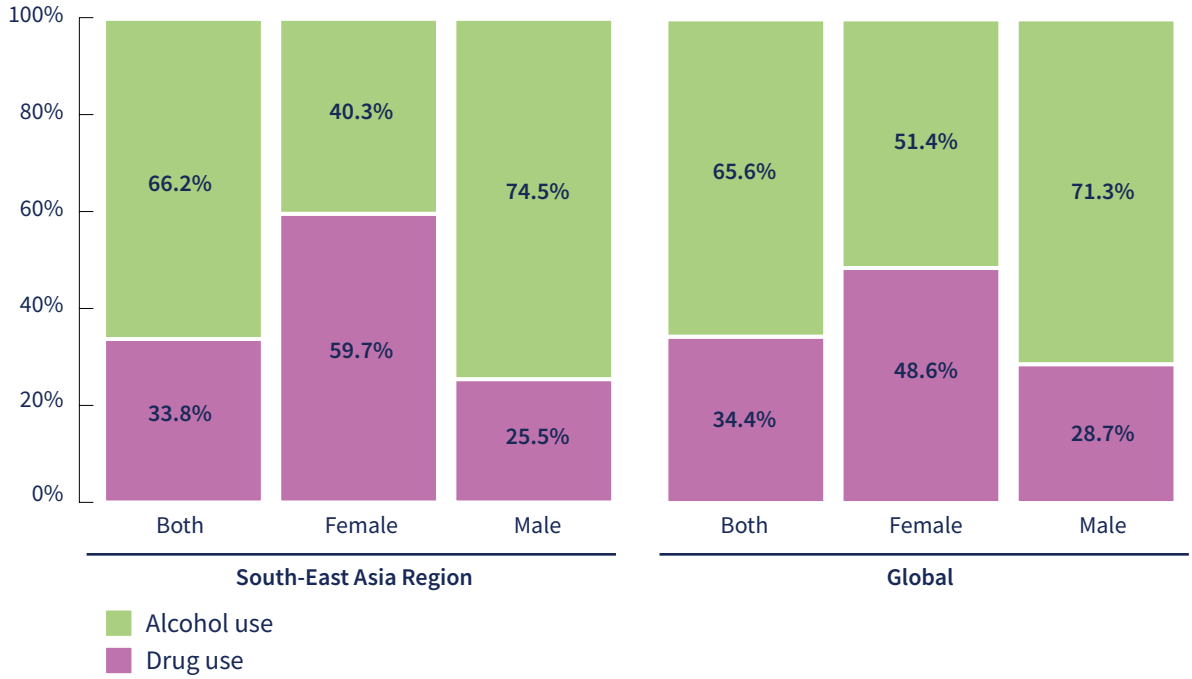
Source: Global Burden of Disease (GBD) estimates, 2019

6.2 Distribution and disaggregation

Fig. 18 shows the distribution of substance use disorder for each sex, comparing the situation in the WHO South-East Asia Region with that globally. Interestingly, while alcohol use disorder is predominant among men in the Region, drug use disorder is more prevalent among women in the Region. This deviates from the global finding wherein alcohol use disorder is shown to predominate over other forms of substance-use disorders among both men and women.

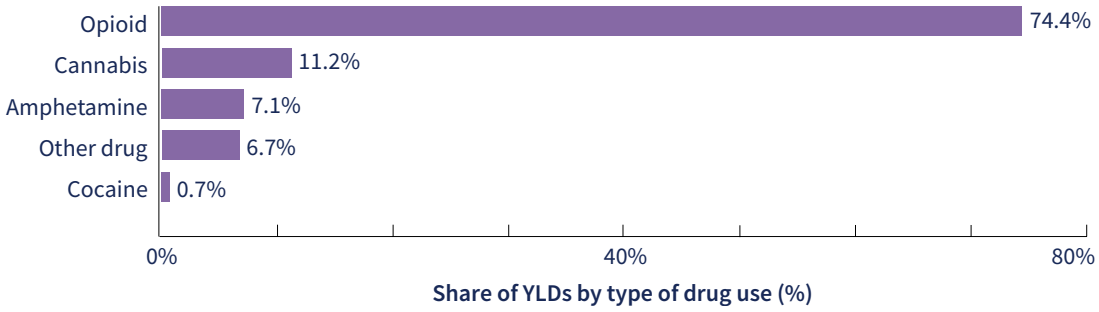
Alcohol use disorder was responsible for 60% of the YLDs as well as the DALYs caused by substance use disorder in the Region. A further disaggregation of the remaining 40% of the burden attributed to drug use disorder (Figs. 19 and 20) shows that nearly three quarters (74.1% of YLDs, 70.2% of DALYs) are caused by opioid use.

Fig. 18. Distribution of substance use disorder (2019)



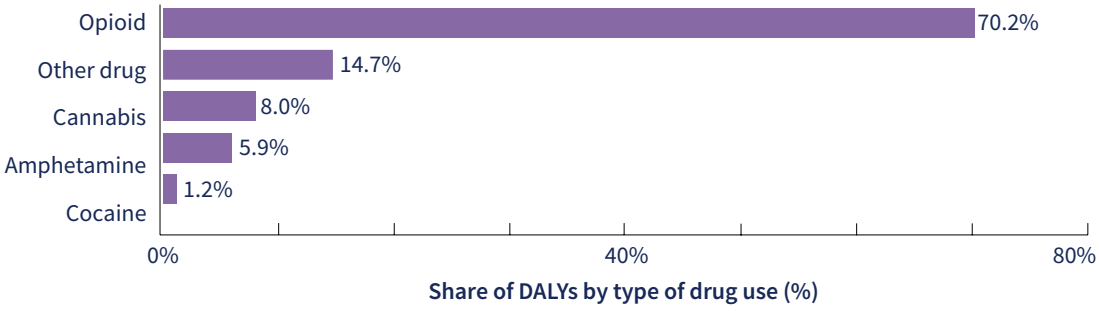
Source: Global Burden of Disease (GBD), 2019

Fig. 19. Ranking of individual types of drug use disorder YLDs as a percentage of total drug use YLDs in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

Fig. 20. Ranking of individual types of drug use disorder DALYs as a percentage of drug use DALYs in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

7. Self-harm and suicide

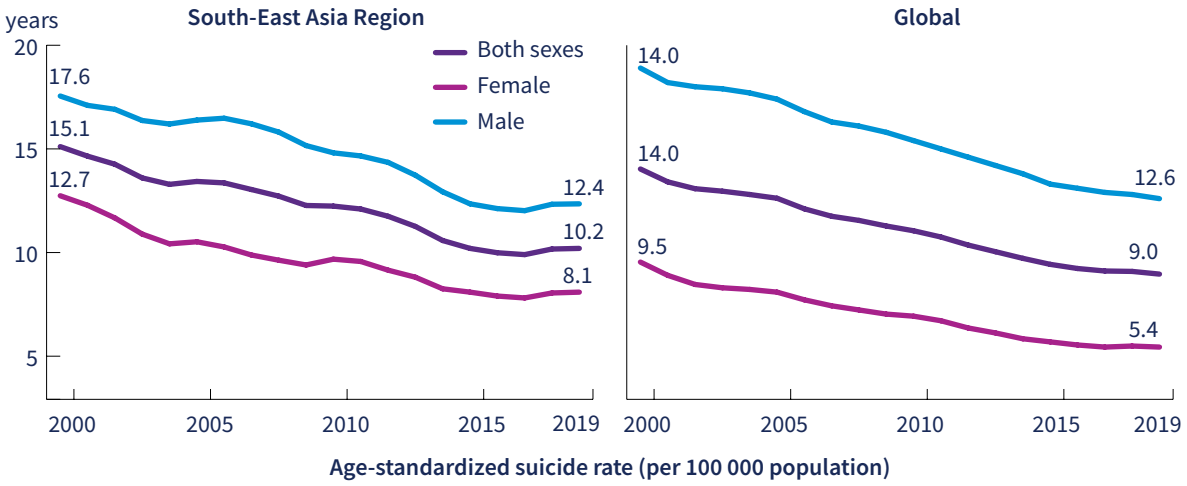
7.1 Estimated prevalence

In this comparison, the term, “self-harm” includes mortality due to suicide. In the WHO South-East Asia Region, it is estimated that 4.7 million people attempted self-harm in 2019. The prevalence of self-harm, however, remained stable between 2000 and 2020 despite multiple media reports on the increasing number of deaths from suicide in several countries.

Although the Region shows a slightly higher rate (10 per 100 000) of deaths from suicide, compared with the global average (9 per 100 000), there has been a significant reduction in deaths from suicide since 2000 (Fig. 21). Age-standardized suicide mortality declined by a third – from 15 per 100 000 to 10 per 100 000 population between 2000 and 2019 (Fig. 21). This can be termed a major public health achievement by the WHO South-East Asia Region Member States. The rate of deaths from suicide among men in the Region decreased by more than one third during this period, in line with the global trend.

The stable prevalence of self-harm, coupled with a significant reduction in suicide deaths, indicates that the reduction in suicide is due to better management of self-harm conditions, the use of less lethal means, or both. This situation should be given priority consideration for two reasons. First, the determinants of self-harm may not have changed since 2000, which requires further investigations and interventions. Secondly, the steps Member States have taken to reduce mortality due to self-harm, which may include discontinuing lethal pesticides and improving treatment for poisoning and other means of suicide, should be upscaled and further strengthened.

Fig. 21. Age-standardized suicide rate in the WHO South-East Asia Region and across the world (2000–2019)

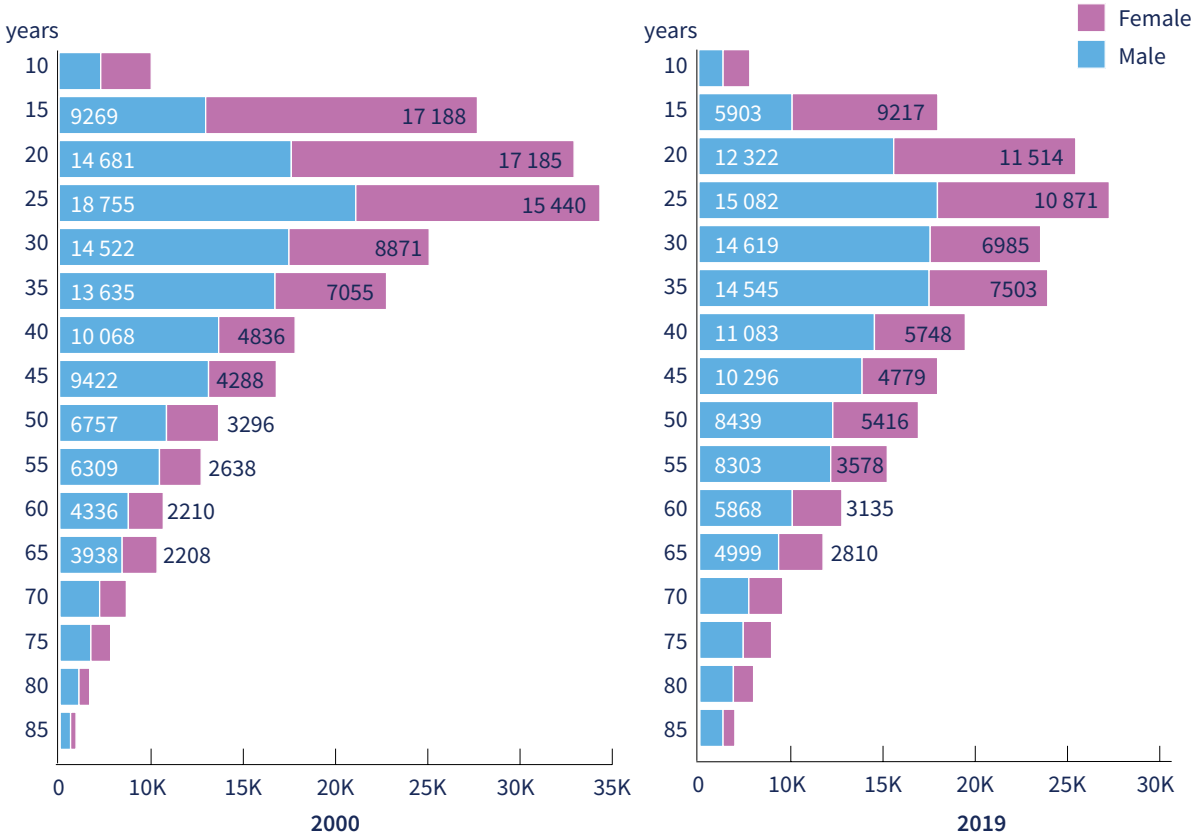


Source: WHO Global Health Estimates (GHE), 2000–2019

71%
of deaths from suicide occur before the age of 50

The age groups in which suicides occurred show similar patterns in 2000 and 2019. However, Fig. 22 shows that the number of deaths from suicide in the age group 35 years and above had increased by 2019, while the number of deaths from suicide in groups below this age reduced significantly. This is an important aspect that needs to be studied and any action taken by the Member countries in this regard needs to be strengthened.

Fig. 22. Estimated number of suicides by age and sex in the WHO South-East Asia Region (2000 and 2019)



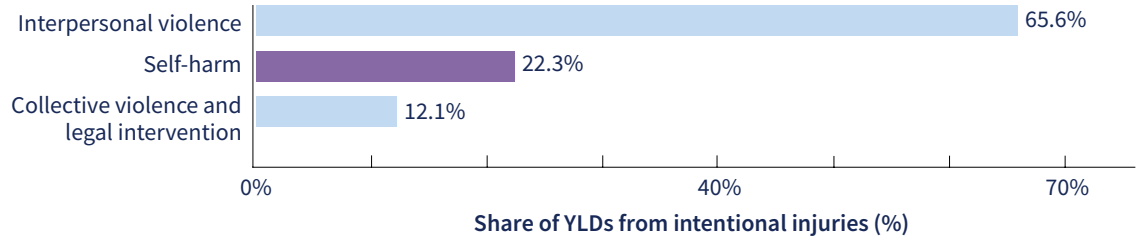
Source: WHO Global Health Estimates (GHE), 2000–2019

7.2 Distribution and disaggregation

Self-harm was shown in Fig. 8 to account for 15.3% of all DALYs due to MNSS conditions in the WHO South-East Asia Region. It caused almost a quarter of the YLDs (Fig. 23) and two thirds of the DALYs (Fig. 24) related to intentional injuries in the WHO South-East Asia Region Member States.

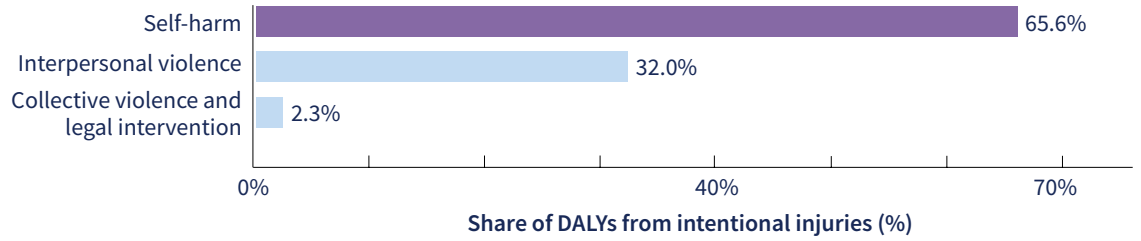
It is worth noting that the GHE does not provide a breakdown of the specific methods used for self-harm. Both global and regional data largely refers to self-harm through “other specified means” (Fig. 25). In the WHO South-East Asia Region, commonly used methods include use of pesticides, pharmaceuticals and toxic substances and hanging.

Fig. 23. Ranking of individual causes of intentional injuries YLDs as a percentage of the total in the WHO South-East Asia Region (2019)



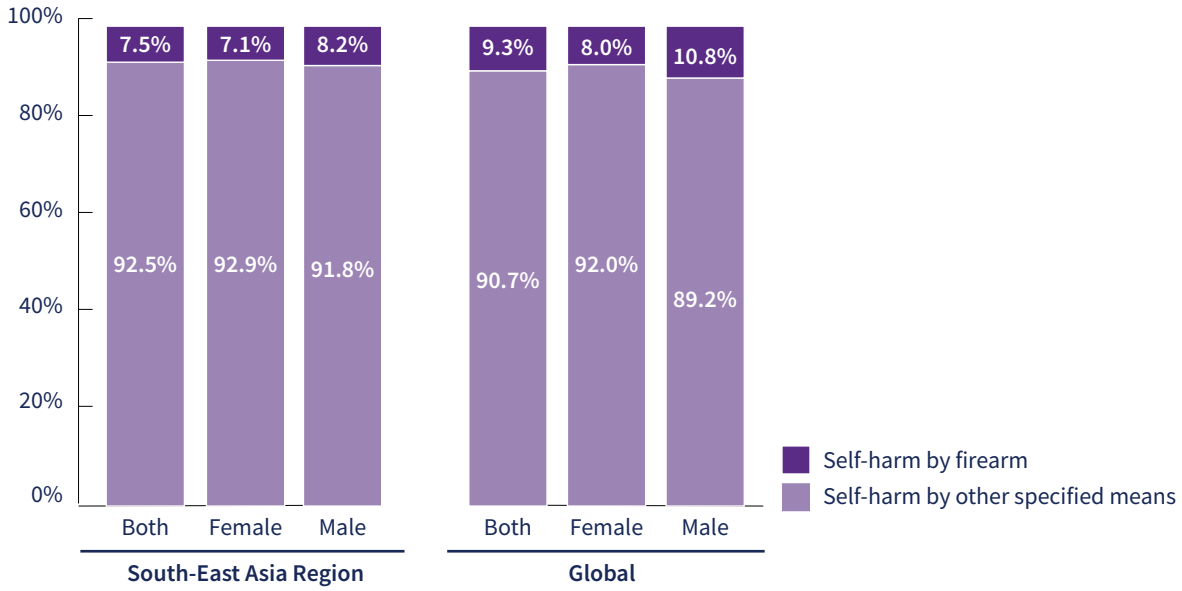
Source: WHO Global Health Estimates (GHE), 2019

Fig. 24. Ranking of the individual causes of intentional injuries DALYs as a percentage of the total in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

Fig. 25. Methods of self-harm in the WHO South-East Asia Region and globally (2019)



Source: Global Burden of Disease (GBD) 2019

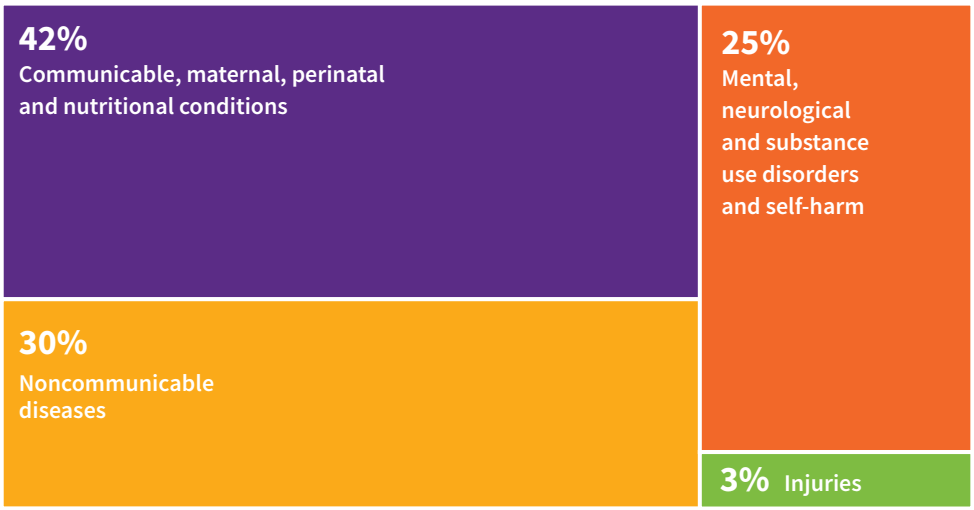
8. The burden of mental health conditions among children in the WHO South-East Asia Region

Globally, half of all mental health disorders manifesting in adulthood start by the age of 14, but most cases remain undetected and untreated. Early onset of substance use disorder is associated with higher risks of developing dependence and other problems during adult life. Younger ages are disproportionately affected by substance use disorder, compared with people belonging to older age groups. Depression is one of the leading causes of illness and disability among adolescents, while self-harm is the second leading cause of death among people aged 15–19 years. Mental health conditions account for 16% of the global burden of disease and injury among people aged 10–19 years *(26)*.

Across the world, more than a quarter of those aged 15–19 years, numbering 155 million, are current drinkers. The prevalence of heavy episodic drinking among adolescents (those aged 15–19 years), was 13.6% in 2016, with males most at risk. Cannabis is the most widely used psychoactive drug among young people, with about 4.7% of people aged 15–16 years using it at least once in 2018 *(26)*.

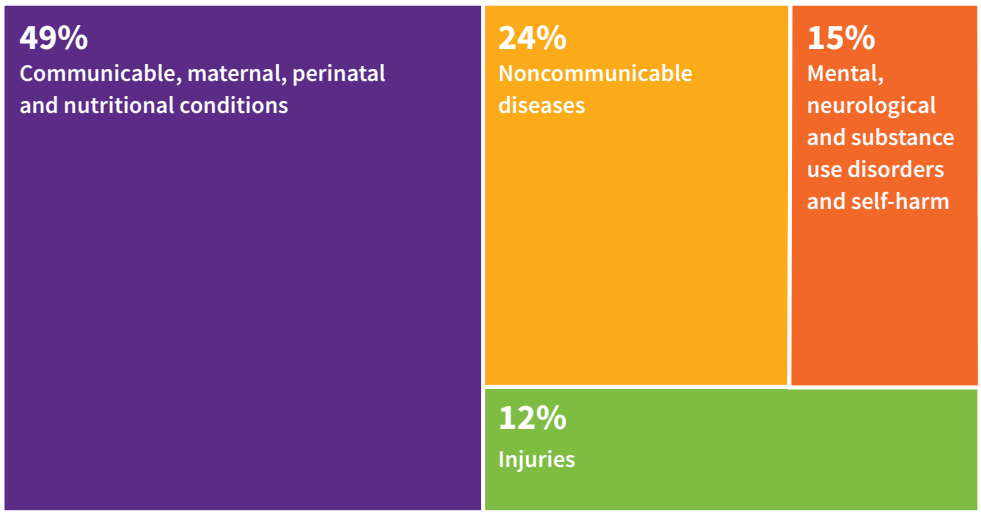
The burden of mental, neurological and substance use disorders and self-harm (MNSS) among children aged 5–14 years was significant, compared with that of other health conditions, measured by both YLDs (Fig. 26) and DALYs (Fig. 27). Mental health conditions accounted for 25% of all YLDs and 15% of all DALYs in the age group 5–14 years, underscoring the need for priority attention for this age group.

Fig. 26. Regional distribution of YLDs among children aged 5–14 years (%) in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019.

Fig. 27. Regional distribution of DALYs among children aged 5–14 years (%) in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2000–2019

8.1 The burden of specific MNSS conditions in children by age group

In the under-five age group, intellectual disability and epilepsy are responsible for more than 80% of the burden attributed to MNSS conditions (Figs. 28 and 29).

Fig. 28. Distribution of YLDs for MNSS among children aged 1–59 months in the WHO South-East Asia Region (2019)

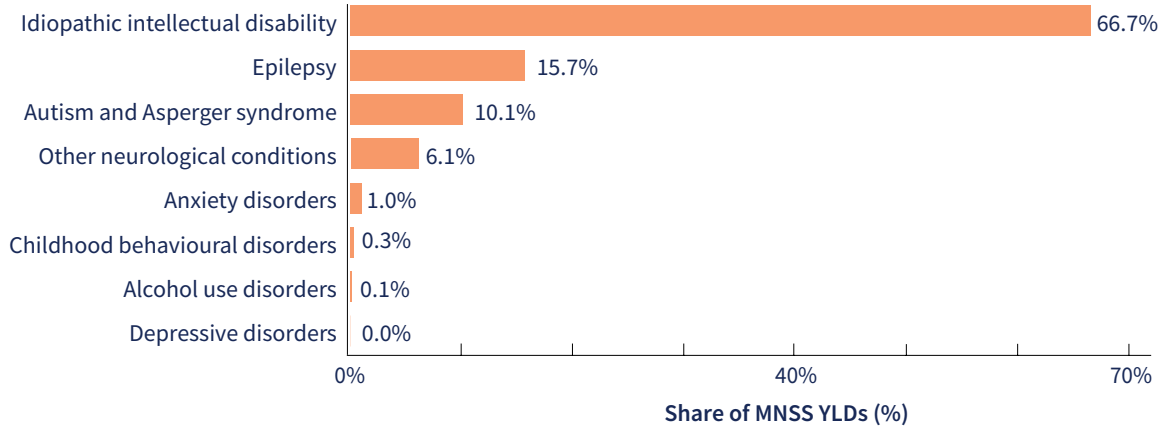
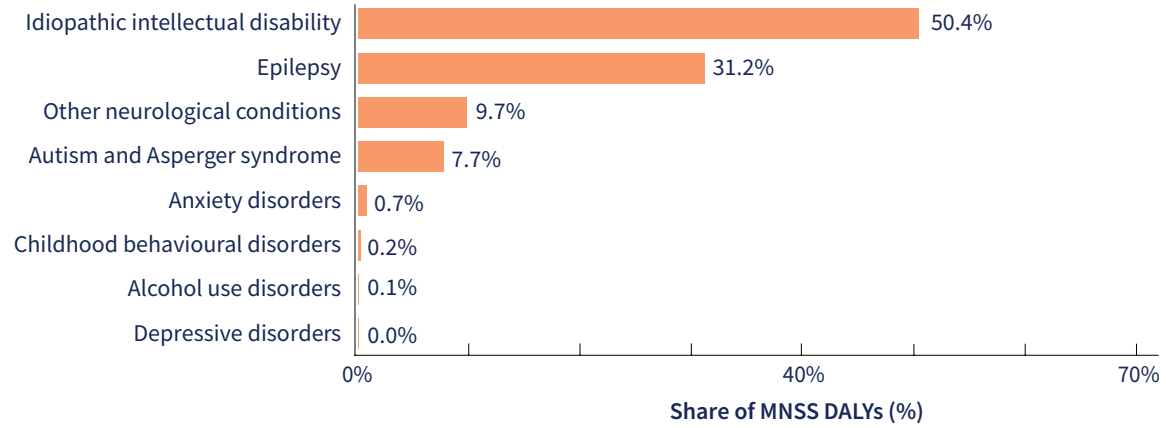


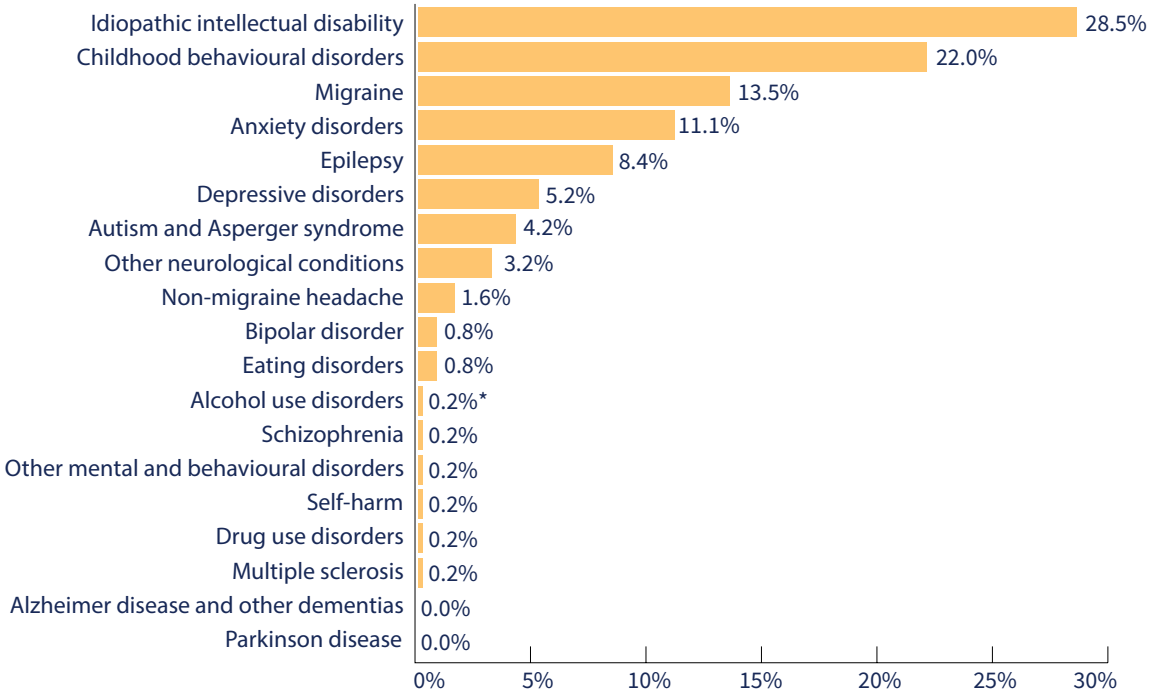
Fig. 29. Distribution of DALYs for MNSS among children aged 1–59 months in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates, 2019

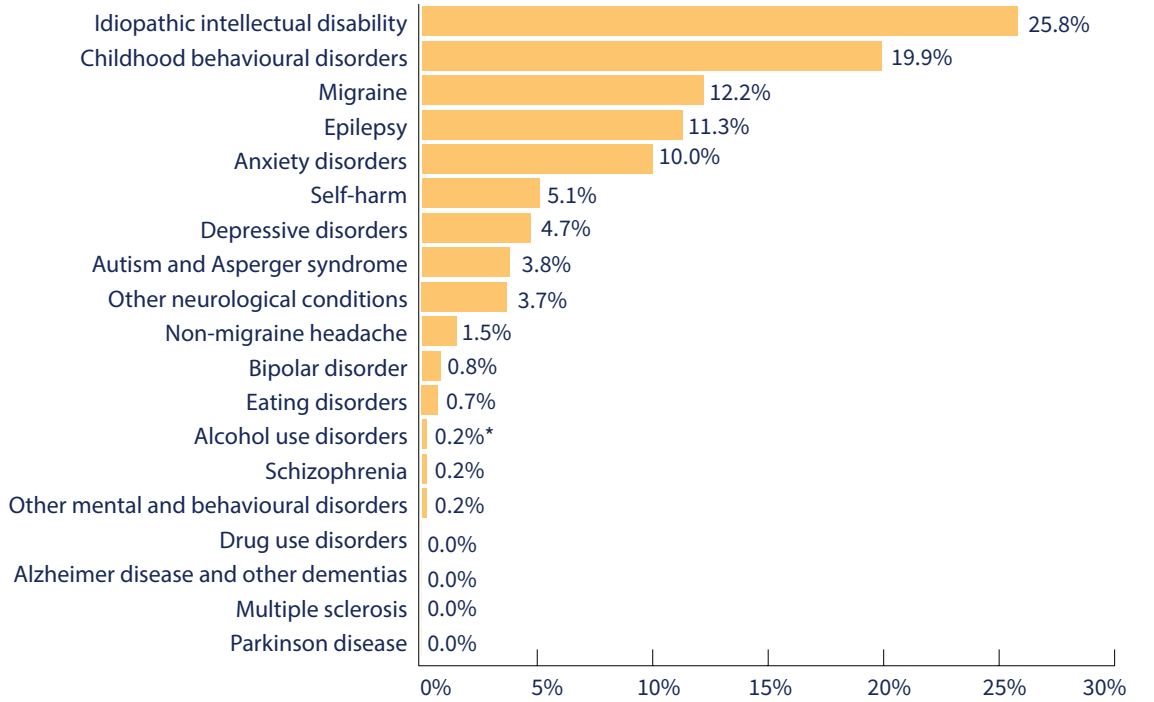
Intellectual disability accounted for the biggest MNSS burden among children aged 5–14 years in the Region. Childhood behaviour disorders, migraine, anxiety disorders and epilepsy constituted a significant share of the overall MNSS burden (Fig. 30 and Fig. 31). This pattern of MNSS burden underscores the need for different types and different ranges of services that are accessible and acceptable to this age group.

Fig. 30. Distribution of YLDs for MNSS among those aged 5–14 years in the WHO South-East Asia Region (2019)



Source: WHO Global Health Estimates (GHE), 2019

Fig. 31. Distribution of DALYs for MNSS among those aged 5–14 years in the WHO South-East Asia Region (2019)



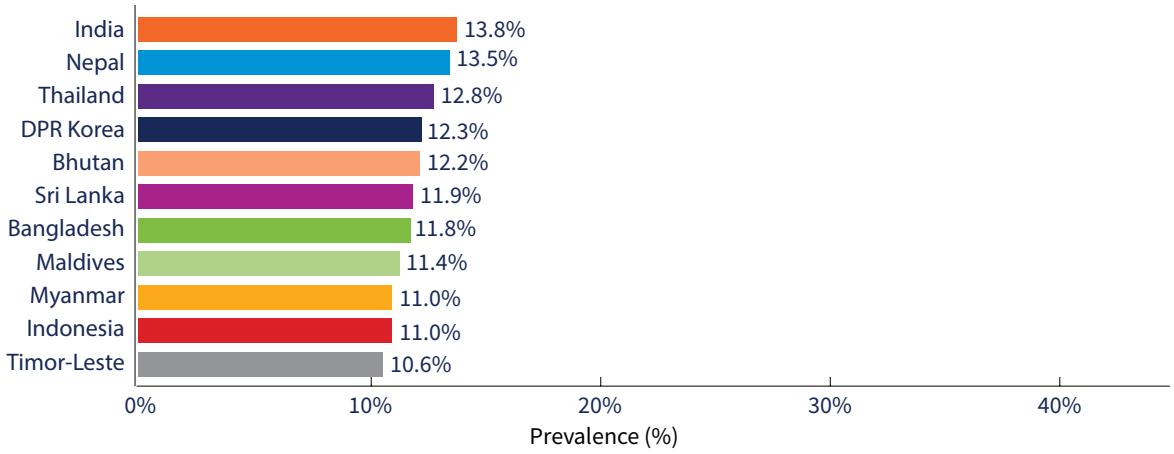
* Alcohol use disorders in this age group include foetal alcohol syndrome (FAS) under the ICD-10 code, Q86.0

Source: WHO Global Health Estimates, 2019

9. Country-focused comparisons

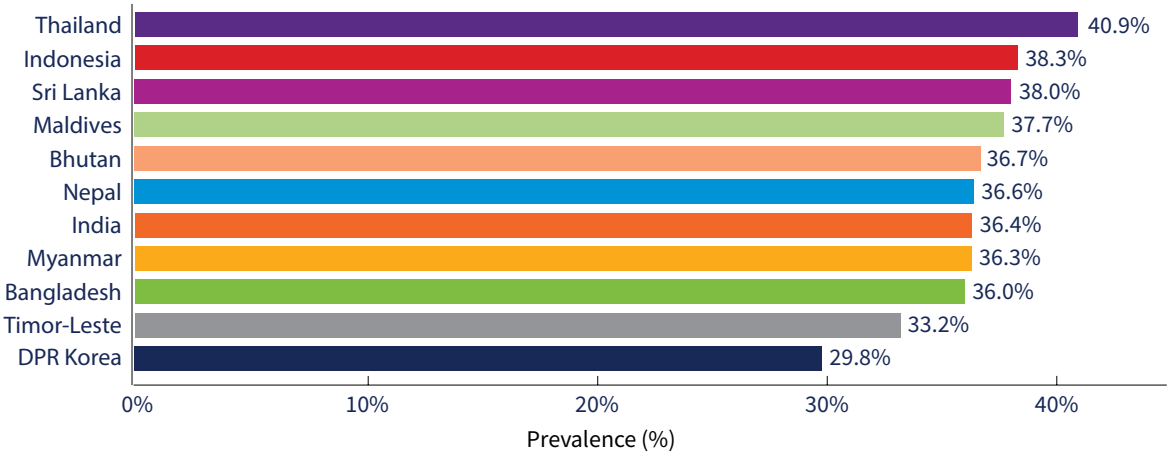
It is useful to compare the country-specific prevalence rates for mental, neurological and substance use disorders and self-harm with the regional averages. In terms of the prevalence of mental disorders (Fig. 32), all estimates for Member States in the Region lie close to the regional average of 13.2%, while in the case of neurological disorders (Fig. 33) results indicate that Thailand has a slightly higher prevalence (40.9%) compared to the regional average of 36.6%. In terms of the prevalence of substance abuse (Fig. 34), both Bhutan (2.9%) and Thailand (2.1%) has a slightly higher prevalence than the regional average of 1.6%. The regional prevalence of self-harm (Fig. 35) is 0.3%, while in the case of Sri Lanka it is slightly higher at 0.44%.

Fig. 32. Prevalence of mental disorders in the WHO South-East Asia Region by country (2019)



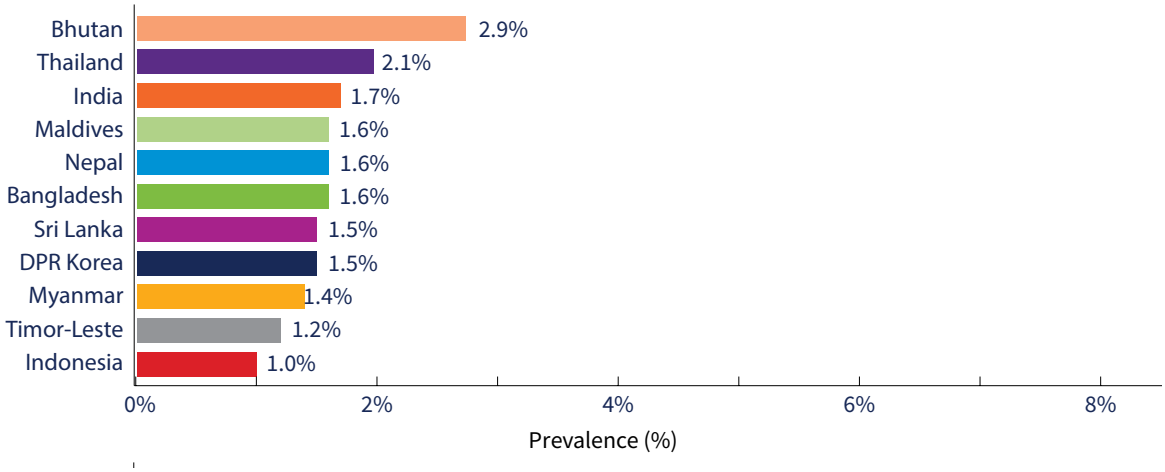
Source: WHO Global Health Estimates 2019

Fig. 33. Prevalence of neurological disorders in the WHO South-East Asia Region by country (2019)



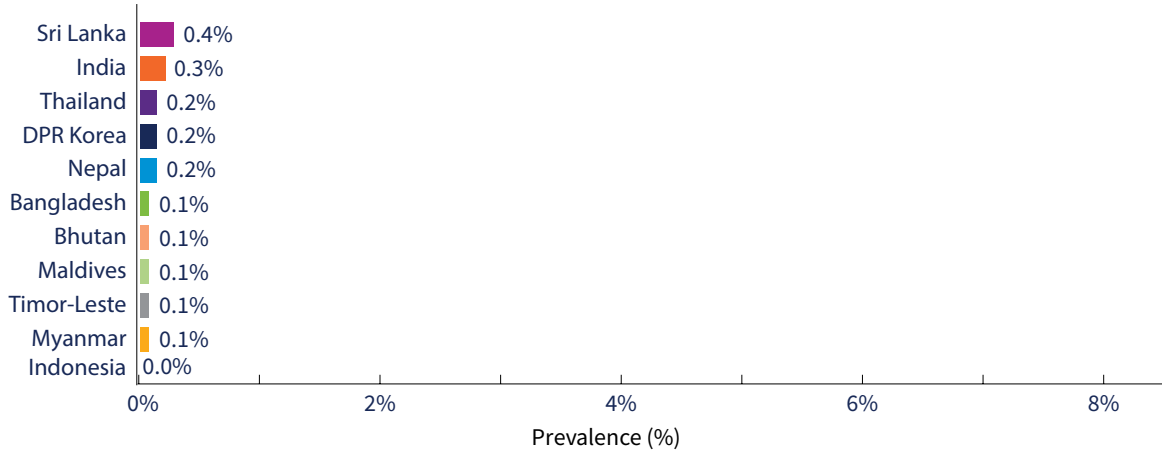
Source: WHO Global Health Estimates 2019

Fig. 34. Prevalence of substance use in the WHO South-East Asia Region by country (2019)



Source: WHO Global Health Estimates 2019

Fig. 35. Prevalence of self harm in the WHO South-East Asia Region by country (2019)



Source: WHO Global Health Estimates 2019

10. Health systems

10.1 Financing for mental health

In 2020, the WHO South-East Asia Region had the lowest estimated median government expenditure per capita on mental health, calculated using data from the reporting countries. It was 75 times less than the global average of US$ 7.49 (Table 2). Financing is a crucial barrier that needs to be addressed for the development of prevention and promotion programmes and expansion of services for mental health. Even the very limited investment is usually channelled to tertiary care settings. To address the significant treatment gaps seen, proper investment should be made to strengthen mental health services at primary care level and in community-based mental health services.

Table 2. Government expenditure on mental health per capita

	Median government expenditure on mental health per capita (US$)		Mental health expenditure as percentage of GGHE–D* per capita
	2017 (N=80)	2020 (N=67)	2020 (N=67)
Global	2.5	7.49	2.13%
WHO Region			
Africa	0.10 (n=10)	0.46 (n=8)	2.10%
Americas	11.80 (n=18)	7.81 (n=14)	1.80%
Eastern Mediterranean	2.00 (n =4)	12.08 (n=4)	1.30%
Europe	21.70 (n=31)	46.49 (n=22)	3.60%
South-East Asia	0.10 (n =5)	0.10 (n=7)	0.50%
Western Pacific	1.10 (n=12)	5.81 (n=12)	1.60%

* General government health expenditure – domestic

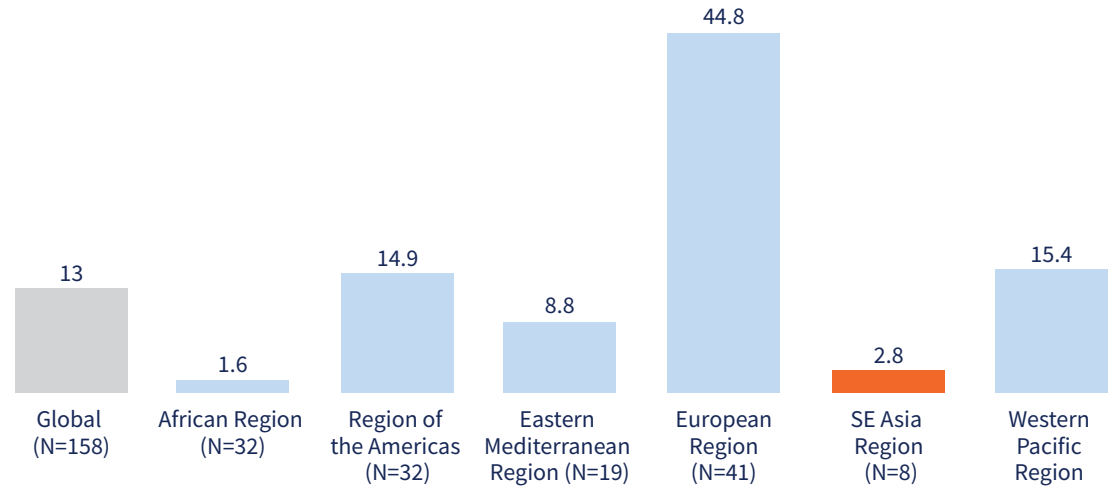
Source: WHO Mental Health Atlas, 2020

10.2 Human resources for mental health

Globally, the median number of mental health workers per 100 000 population (Fig. 30) increased from 9 per 100 000 to 13 per 100 000 between 2017 and 2020, respectively. This is a substantial increase of 40%. In contrast to the increase in the global ratio, the ratio in the Region increased by 0.3 per 100 000 population, from 2.5 per 100 000 to 2.8 per 100 000.

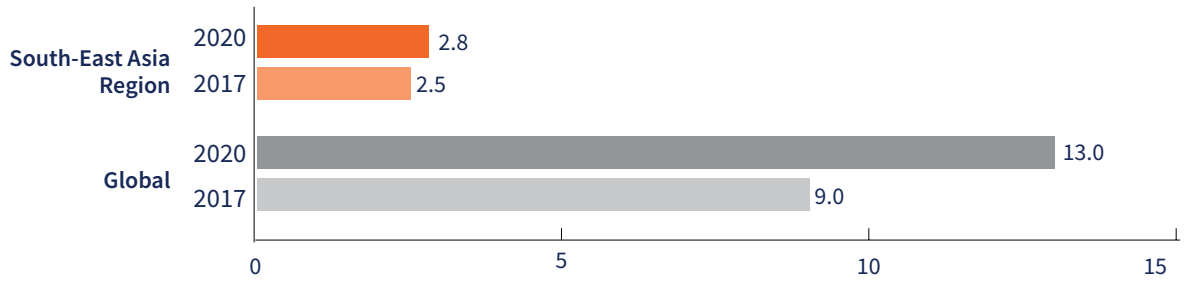
As a result, the WHO South-East Asia Region has the second lowest ratio of health workers per 100 000 population among the six WHO Regions – one fifth of the global figure (Fig. 36).

Fig. 36. Mental health workers (median number per 100 000 population) by WHO Region (2020)



Source: WHO Mental Health Atlas, 2020

Fig. 37. Estimated number of mental health workers (median number) per 100 000 population in the WHO South-East Asia Region (2017 and 2020)



Source: WHO Mental Health Atlas, 2020

11. Key findings

The overall burden of mental, neurological and substance use disorders and self-harm

- Mental, neurological and substance use disorders and self-harm (MNSS) accounts for a significant percentage of the total burden of disease in all Member States of the Region. The overall prevalence of years lived with disability (YLDs) ranged from 22.5% to 29.1% across all countries of the Region; five countries had a YLD prevalence of 25% or more.
- Depressive disorders constitute the biggest burden, followed by self-harm, migraine and anxiety. Together, these four conditions account for nearly half of the disability-adjusted life years (DALYs) attributable to MNSS conditions in the WHO South-East Asia Region.
- DALYs related to mental health conditions rose significantly in almost all Member States of the Region between 2000 and 2019; from a prevalence of below 10% in 2000 in all countries (except in Sri Lanka) to a range of 7.1% to 18.7% in 2019.
- Therefore, there is a high burden of mental health conditions in the Region, compared with that of other health conditions. Addressing this requires both promotion and prevention strategies as well as the strengthening of accessible and wide-ranging services for diverse mental health conditions.

Mental disorders

- One in every four people living with mental disorders globally lives in the WHO South-East Asia Region.
- Anxiety and depressive disorders were the commonest conditions among both men and women, contributing to almost 50% of the total number of people living with mental disorders in the WHO South-East Asia Region.
- Depressive disorders accounted for more than a third of the YLDs due to mental disorders in the Region. This was followed by anxiety disorders, which caused around a sixth of the YLDs.

Neurological disorders

- More than one in three people in the WHO South-East Asia Region, amounting to 719 million people, live with a neurological condition.
- Headache disorders are the predominant neurological condition, with migraine responsible for 60% of the YLDs attributed to neurological conditions in the Region. Of the non-headache conditions, Alzheimer disease and other dementias were the commonest cause, followed by epilepsy.

Substance use disorders

- Alcohol use disorders were responsible for 60% of the YLDs as well as the DALYs caused by substance use disorder in the WHO South-East Asia Region. Of the remaining 40% of the burden attributed to drug use, nearly three quarters (74.1% of YLDs, 70.2% of DALYs) involved opioid use.
- Alcohol use disorders are predominant among men in the Region. Contrary to the global pattern, other substance use disorders (excluding alcohol) were higher among women in the Region; this aspect needs priority consideration.

Self-harm and suicide

- In the WHO South-East Asia Region, it is estimated that 4.7 million people attempted self-harm in 2019. However, the prevalence of self-harm in the Region remained stable between 2000 and 2019.
- The age-standardized suicide mortality declined by a third from 15 per 100 000 population to 10 per 100 000 population between 2000 and 2019. This can be considered as a major public health achievement by the Member States. The rate of suicide among men has decreased by more than one third during this period.
- Despite the overall reduction, the estimated number of deaths from suicide among those aged over 35 years increased between 2000 and 2019.

The burden of mental health conditions among children

- Intellectual disability accounted for the biggest burden among children, aged 14 years and below. Childhood behaviour disorders, migraine, anxiety disorders and epilepsy also constituted significant burdens, underscoring the need for different types and different ranges of services that are accessible and acceptable to this age group.

The health system response: financing and human resources for mental health

- Among the WHO regions, the WHO South-East Asia Region shows the lowest estimated median government expenditure on mental health, calculated using data from reporting countries (seven out of 11 Member States). In 2020 it was 75 times less than the global average. This is a significant barrier to the development of prevention and promotion interventions and mental health services.
- Globally, the median number of mental health workers per 100 000 population has increased from 9 to 13 per 100 000 population between 2017 and 2020, respectively. This is a substantial increase of 40%. By contrast, the ratio in the Region has increased by 0.3 per 100 000 population, from 2.5 per 100 000 to 2.8 per 100 000 population; an increase of about 12%.

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