

## **Impact of Urbanisation on Mental Disorders in SAARC Countries**

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### **Abstract**

Mental disorder can be a determinant factor of a society's health as it affects the most vital resource available within it, which is people who are a part of the workforce, form relationships, and act in an operational capacity within industries. This study explores the impact of urbanisation on the mental health situation in the South Asian Association for Regional Cooperation (SAARC) countries. Quadratic polynomial regression was taken to quantify the impact in 08 countries between 1990 to 2019. The findings revealed that Sri Lanka shows a higher coefficient of 202.8%. It shows that when urbanisation increases by 1%, health expenditure is increased by 202.8%. The second largest coefficient is observed in Maldives, which is 0.3%. The result of this study contributes to the current knowledge in this area by assessing urbanisation's impact on mental disorders in the SAARC countries. Therefore, the findings of this study will be helpful for policymakers to create effective policies and programmes that support mental health care in unprivileged urban areas and re-consider their urban development policies to prevent the negative externalities of rapid urbanisation by prioritizing adequate health services and easy access to mental health care services.

**Keywords:** *Mental Disorder, SAARC Countries, Urbanisation*

## **1. Introduction and Research Problem**

Urbanisation is a process of migration of individuals from rural environments to more urban areas. The United Nations (2018), statistically demonstrated that compared to 1950, urbanisation has increased from 30% to 55%, which shows an over 20% increase in the urbanised populous worldwide. Moreover, the United Nations (2018) predicted that almost two-thirds of the world population will have shifted to urban areas by the mid-century. Moreover, between 2018-2050, the urban population will grow by 2.5 billion urban dwellers. The UN has also stated that the effect will be most visible in lower and lower-middle-income countries between the current year and 2050. However, the increase in population with a lower standard of life will threaten the mental health of the population. They have also indicated a visible relationship between an increase in urbanisation and mental health issues in low and middle-income countries.

The United Nations further states that mental health issues related to urbanisation arise due to lower levels of engagement in physical activities and high levels of social stressors, including violence, poverty, and social isolation. Moreover, another cause is the environmental conditions in urban areas, such as air and noise pollution and crowding. Thus, the impact of urbanisation on mental health is caused by economic, psychological, physiological, cultural, and genetic factors (United Nations, 2018). It states that 66% of the global population will be situated in urban areas by 2050, and the factors that cause mental health issues in the urban population need to be identified (Nawrath et al., 2022). The risk of a higher burden of mental illness will have adverse effects, including high costs, long-term incapacity, increased

mortality, and improved overall human suffering. As a result, according to the data on disease, 264 million people worldwide suffer from depression, while 20 million individuals worldwide have schizophrenia or another mental ailment (Akins, 2022).

Researchers have made different conclusions when perusing the literature on the impact of urbanisation on mental disorders. According to De Vries et al. (2018), in low-income countries mental disorders are higher in residential areas which are crowded due to lower living standards, unemployment, poverty, crime, pollution, cultural change, conflict, estrangement, and isolation. Turan and Besirli (2008) also conclude that the probability of developing a psychotic disorder caused by schizophrenia is amplified from being born or most of the childhood spent in urban areas. The same study by Turan and Besirli (2008) indicates that the rapid urbanisation rate increases the psychosis and depression rate for both men and women due to the social stress, environmental pollution, and noise arising from higher population densities reported within urban areas. Another study by Adli (2011) shows that the urban population has a 20% higher risk of developing an anxiety disorder and a 40% risk of developing a mood disorder.

According to studies by Kumar et al. (2005), mental health issues are prevalent in underprivileged urban areas, with factors such as limited access to mental healthcare, poverty and economic stress, violence and crime, substance abuse, inadequate housing and homelessness, social isolation, environmental stressors, limited educational opportunities, discrimination and stigma, and community and family support playing crucial roles in exacerbated mental

health problems. Therefore, this study mainly focuses on underprivileged urban areas and the associated mental disorders.

The literature in this area proves the impact of urbanisation on mental disorders in different countries in the world. Accordingly, it is opportune for the researchers to examine the effect of urbanisation on mental disorders, specifically focusing on SAARC countries. Therefore, the study examines urbanisation's effects on mental illnesses in SAARC countries (Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka) from 1990 to 2019. Furthermore, a special attention was given to the SAARC countries since South Asian nations show a high prevalence of mental disorders (Naveed et al., 2020). The polynomial regression model was utilised to examine the impact of urbanisation on mental disorders using time series data from 1991-2019.

The rest of the research paper is structured as follows. First, variables are introduced and the justification for adopting them in the study is discussed. Second, a summary of the primary literature used in the study is presented. Third, the study's methodology, results, and discussion are presented and the conclusion is given in the fifth section.

## **2. Research Problem**

As discussed in the previous section, the increasing global population increases urbanisation. In turn, increasing urbanisation leads to the emergence of mental issues compared with rural areas. Moreover, the literature provides

that mental disorders are more common in developing nations (Patel & Kleinman, 2003).

When looking at Asia, the Asian population is expected to grow from 1.4 billion to 2.6 billion between 2000-2030, making the Asian population figure double. As seen in the literature, such an increase in the Asian population may impact mental disorders caused by social stressors, air and noise pollution, etc. When looking at the levels of urbanisation and mental disorders in the SAARC region, it is explicit that the prevalence of mental disorders among South Asian nations is very high (Trivedi et al., 2008). As highlighted by David et al. (2017), services integrated within primary care must be established for mental health and psychosocial issues for the conflict-affected population in South Asian countries. Owoeye and all (2011) demonstrate the lack of studies that prioritise the relationship between mental illness and internal migration, specifically internal urban-to-rural migration in a contextual background of economic and political benefits. Therefore, considering the aforementioned problem area and filling an empirical research gap, this study aims to examine the impact of urbanisation on mental disorders in the SAARC countries.

### **3. Objective of the Study**

The objective of this study is to examine and analyse how urbanisation impacts mental disorders in the SAARC countries, with a particular emphasis on understanding the socio-demographic, economic, and environmental factors associated with mental health outcomes in rapidly urbanizing areas. In addition, it will provide evidence-based insights and recommendations for

policymakers, healthcare providers, and relevant stakeholders to address mental health needs in unprivileged urban areas.

#### **4. Scope and the Significance of the Study**

This study will examine the impact of urbanisation on mental health in the SAARC countries. It will cover a range of factors, including urban infrastructure, population density, socioeconomic disparities, cultural shifts, and access to mental health services. It will use quantitative analytical methods to analyse data.

The significance of this study lies in its potential to generate valuable insights into the impact of urbanisation on mental health in the SAARC countries. As urbanisation continues to accelerate in the region, understanding its effects on mental well-being is crucial for policymakers, urban planners, healthcare professionals, and communities. By identifying the specific challenges and opportunities associated with urbanisation, the study can inform evidence-based interventions and policies that prioritise mental health support in urban areas.

Also, the impact of urbanisation on mental disorders is a critical and underexplored area of research, especially in South Asian countries. This study fills this gap by conducting a comprehensive analysis of eight SAARC countries. By examining the impact of urbanisation on mental disorders across different countries, the study provides valuable insights for policymakers, researchers, and stakeholders seeking to enhance sustainable urbanisation, economic stability, and adequate health services. This research significantly

contributes to the existing literature and offers a solid foundation for evidence-based decision-making.

## **5. Review of Literature**

Global urbanisation is causing an increase in several health issues, including mental health. The literature review aims to investigate the relationship between urbanisation and mental disorders in the SAARC countries.

Mental disorders are highly prevalent in the SAARC countries with a high disease burden and limited access to mental health services. For example, according to a study undertaken in Nepal, the prevalence of mental disorders among adults was 15.5%, and within that figure, depression is the most common mental disorder (Thapa et al., 2018). On the other hand, anxiety is the most common type of mental disorder among adults in India, where the prevalence of mental disorders among adults is 10.6%. Similarly, anxiety was found to be the most common mental disorder in Pakistan, where the prevalence of mental disorders was estimated to be 16% (Afzal et al., 2014).

Numerous studies have shown that mental disorders are highly prevalent in urban areas compared to rural areas (Peen et al., 2007; Turan & Besirli, 2008; Ventriglio et al., 2021). According to Ventriglio et al. (2021), urbanisation affects mental health through social, environmental, and economic factors. Under these three main areas, issues of social disparities, social insecurity, poverty, pollution and minimal access to green spaces are the root causes for the high prevalence of common mental disorders in cities. Similarly, Sahadevan and Mathews (2023) observed that mental disorders such as

anxiety, depression, and schizophrenia have increased in urban areas compared to rural areas due to bad urban planning. According to the descriptive analysis of Trivedi et al. (2008), poverty and mental health have a multidimensional relationship due to the fringe population. This review is cognizant of the causes of urbanisation on mental disorders in urban areas.

A study by Hilario et al. (2014) highlights that most Southeast Asian youth face mental disorders with migrations, such as depression, due to a lack of social connectedness. According to its findings, the family connection appears to have the most substantial effect on emotional distress. Furthermore, studies show that people with high perceived insecurity report social isolation, face difficulties in making relationships, and report suffering from mental disorders (Dean, 2017; Earnshaw et al., 2016). Thereby, social disconnection and fewer social networks caused by urbanisation are the main social factors that cause mental disorders.

High rates of mental problems are caused by environmental variables in urban areas. Increasing levels of urbanisation increase the risk from environmental variables for more immigrants, such as increased levels of air pollution, lack of green space, and lack of social safety. As it has been demonstrated that not only physical and social settings have a substantial influence, the environmental factors may affect mental health and well-being (Qiu et al., 2019). According to studies on rapid urbanisation, Kathmandu is facing many environmental problems, such as air and noise pollution and less urban green space (Haack, 2009). In addition, most of the immigrant population lives in slums near Bagmati and Bishnumati rivers. The living conditions of slum



dwellers are poor, and do not have adequate services and facilities and mainly suffer from poor mental health (Nielsen & Khanal, 2021).

Several studies show limited accessibility, availability, and affordability of mental health services in urban areas. For example, a study by Karim et al. (2004) highlighted that the number of trained mental health professionals is deficient compared to the population size. Also, it was reported that mental health specialist services are almost nonexistent in Pakistan. Consequently, rapid urbanisation causes many challenges when providing sufficient mental health services to the urban population in the SAARC countries.

Consideration of how cultural factors could be associated with mental disorders with the rapid urbanisation process in the SAARC countries is vital. Cultural factors such as beliefs, norms, values, perceptions, expressions, and other behaviours are related to mental disorders. People showing variations in sexual orientations, religions, races, beliefs, etc., face discrimination and social marginalization through immigration (Ventriglio & Bhugra, 2015). A quantitative study by Williams et al. (2018) in Bangladesh demonstrated that cultural attitudes have affected women who live in urban slums. Moreover, they face emotional stress through violence and financial crises.

According to the literature analysis, urbanisation significantly affects mental disorders in the SAARC countries. Urbanisation, related psychosocial stressors, lack of access to mental health treatments, migration, and cultural variables all have a role in the increased prevalence of mental disorders in urban communities. However, further study is required to comprehend the

intricate relationship between urbanisation and mental health in the SAARC countries.

## **6. Research Methodology**

Study used the secondary data sources and the data file used for the study is presented in the S1 Appendix. The data analysis was done using polynomial regression, which included observations of eight SAARC countries. A secondary source of data on urbanisation and mental disorders were collected from the World Bank and the Institute for Health Metrics and Evaluation (IHME) from 1991 to 2019. The IHME and World Bank are well known in the field of public health research for their extensive and thoroughly collected health-related databases. As evidence that the use of IHME data is consistent with accepted methods within the research community, it can be shown that numerous studies in this field of study have used IHME and World Bank data to support the conclusions. This broad use of IHME and World Bank data highlights its validity and importance for our investigation.

The data was collected for the 08 SAARC countries, namely, Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. The independent variable considered in this study is 'Urbanisation' which is estimated from the urban population as a percentage of the total population. According to national statistical authorities, the term "urban population" refers to those who reside in urban regions. Urban ratios from the United Nations World Urbanisation Prospects and population projections from the World Bank are used to generate the indicator. The percentage of people who live in an area that is considered to be "urban" out of every 100 people. The dependent

variable of this study is mental disorders measured by the prevalence of mental disorders which is estimated as the number of people with mental disorders as a percentage of the total population.

The polynomial regression is used in this study to examine the impact of urbanisation on mental disorders as follows,

Equation 1:

$$MD_i = \beta_0 + \beta_1 URB + \beta_2 URB_i^2 + \varepsilon_i$$

This study focuses on the SAARC countries with considerable identification of mental disorders to get a deeper understanding of how urbanisation impacts mental disorders. Equation 01, a polynomial regression model, was used to investigate the impact of urbanisation on the mental disorders of 8 SAARC countries. Accordingly,  $MD_i$  represents the value of the dependent variable in the I country.  $URB_i$  represents the value of the independent variable of country i.  $\beta_0$  is the intercept of the regression equation.  $\beta_1$  is the coefficient for the linear variable of URB1 indicating how much the dependent variable changes for one-unit change in URB1.  $\beta_2$  is the coefficient for the squared term of URB1, indicating the impact of the quadratic (squared) relationship between URB1 and the dependent variable.

At the initial phase of the study, scatter plots were constructed using the data that were collected for the two variables of urban population as a percentage of the total population and number of people with a mental disorder as a percentage of the total population for the period of 1990-2019. From the constructed scatter plot lines, the best-fit line needed to be identified, which was suggested by the polynomial regression model. This was a clear choice

because the estimation taken from the linear relationship when compared to the estimation taken from the quadratic polynomial regression the R squared value was comparatively higher for the polynomial model. Thus it was utilised to illustrate all of the countries.

## 7. Results and Discussion

Table 1 and 2 provides descriptive statistics for the two variables (urbanisation and mental disorders) in SAARC countries. Table 2 shows the number of observations (Obs), mean, standard deviation (SD), minimum (min), and maximum (max) values of each variable in each SAARC country. From 1990 to 2019, there were 232 total observations with 30 observations corresponding to SAARC countries.

**Table 1: Descriptive Statistics of Urbanisation in SAARC Countries**

	Urbanisation							
	Countries							
	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
<b>Obs.</b>	30	30	30	30	30	30	30	30
<b>Mean</b>	22.9	27.32	29.50	29.405	32.315	14.7087	33.83	18.3608333
<b>SD</b>	1.407	5.50	7.9292	2.719	5.419	3.386	1.870	0.11234371
<b>Min</b>	21.17	19.81	16.388	25.547	25.58	8.854	30.576	18.196
<b>Max</b>	25.75	37.405	41.612	34.472	40.238	20.153	36.907	18.585

Note: obs, mean, SD, min and max represent observations, standard deviation, minimum and maximum values, respectively.

**Table 2: Descriptive Statistics of Mental Disorders in SAARC Countries**

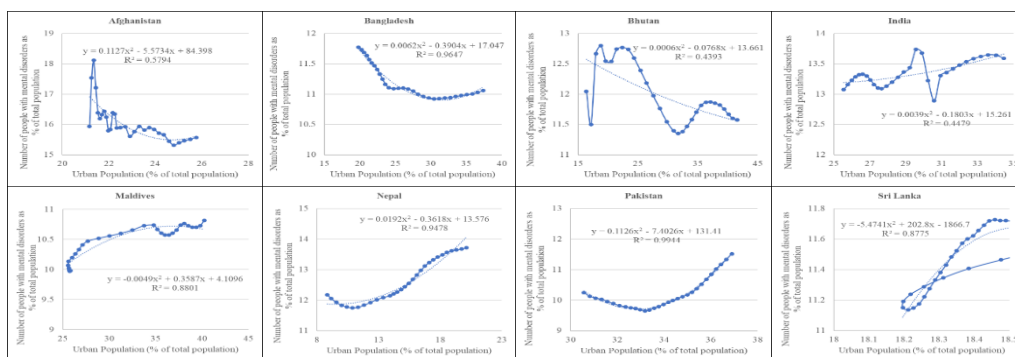
	Mental Disorders							
	Countries							
	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
<b>Obs.</b>	30	30	30	30	30	30	30	30
<b>Mean</b>	16.043	11.19036	11.98249	13.3457	12.38905	12.6100	10.19382	11.46382
<b>SD</b>	0.6300	0.274231	0.48337	0.211688	2.833233	0.6973	0.520662	0.212074
<b>Min</b>	15.31	10.92276	11.34904	12.89017	9.652664	11.7479	9.652664	11.13546
<b>Max</b>	18.11	11.77431	12.8022	13.73745	21.60837	13.7176	11.51938	11.72761

As shown in Table 2, Pakistan has the lowest mean number of people with mental disorders as a percentage of the total population at 10.19 and Afghanistan has the highest mean number of people with mental disorders as a percentage of the total population which is 16.04. Furthermore, Nepal has the lowest mean urban population as a percentage of the total population which is 14.70. The highest mean of urban population as a percentage of total population, which is 33.83 is observed in Pakistan. Considering the SD, it measures the variability or spread of data from the mean. If the SD shows a larger value, it indicates more variability. According to the results, SD varies across the countries and variables, mental disorder is generally low for all the SAARC countries. The analysed results give valuable insight into the variation

in health sectors across the SAARC countries. The third largest mean of urbanisation is shown in India and compared to that when considering the mean of mental disorders in India is at the second highest. Thereby, it can be concluded that with the highest urban population, the prevalence of mental disorders is higher in India which represents the second largest mean of mental disorders. Same as that Maldives depicts the same result when analyzing the means of urbanisation and mental disorders. Thereby, these insights will be useful for policymakers and researchers to make informed decisions to increase the concerns of mental health in developing regions.

Figure 1 shows each country's estimated polynomial regression models. Based on the results, the R2 value of the polynomial regression model is higher compared to the estimated simple linear regression model. Thereby, the best fitting model, which is the polynomial regression model was selected for the analysis of urbanisation's impact on mental disorders in the SAARC countries.

**Figure 1: Relationship Between Urban Population (% of Total Population) and Number of People With Mental Disorders (% of Total Population)**



**Table 3: Results of Polynomial Regression Model of the Study**

	Polynomial Regression Results of SAARC Countries							
	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Constant	84.398	17.0467	13.661	15.261	4.10959	13.57	131.41	-
	8	2	***	**	1	63	***	1865.98
	(32.431)	(.2579502)	(1.48396)	(4.603433)	(.9730982)	(0.7644)	(2.82213)	(505.3012)
URB	-	-.39038	-	-	.358703	-	-7.402	202.725
	5.5734	***	.07683	.180287	***	0.361	***	***
	68	0	3	8	***	8	***	***
	(2.72939)	(.0193083)	(.099483)	(.3102589)	(.061259)	(.1094)	(.165565)	(55.04341)
URB <sup>2</sup>	.11269	.006199	.00063	.003883	-.00486	0.019	.11256	-
	79	***	14	9	***	1	***	5.47189
	(.057267)	(.0003485)	(.001588)	(.0051596)	(.0009435)	(.0038)	(.002423)	(1.498956)
R <sup>2</sup>	0.5794	0.9647	0.4393	0.4479	0.8801	0.947	0.9944	0.8775
	8					8		

Note: The symbols \*, \*\*, and \*\*\* represents 10%, 5%, and 1% significance level, respectively. Parentheses represent the robust standard error.

The results of quadratic polynomial regression in Table 3 present the impact of urbanisation on mental disorders in the SAARC countries. The results show the period between 1990 to 2019 of both variables.

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According to the results of polynomial regression, Sri Lanka shows the highest coefficient of 202.72, which means when urbanisation increases by 1% the mental disorder will be increased by 202.72%. The lowest positive coefficient is shown in Maldives (0.35), which indicates when urbanisation increases by 1% mental disorders increase by 0.35%. This negative impact might be caused by stress, environmental pollution, and noise arising from higher population densities reported within urban areas, being born, or most of the childhood spent within urban areas (Turan & Besirli, 2008). Furthermore, as support to such a positive impact, Minas et al. (2017) indicate that, after the Tsunami and terrorist attack, mental disorders increased, and a focus was given to improving psychiatric hospitals and small inpatient units in rural Sri Lanka. Thereby, it shows during the terrorist attack the people must have gone through mental trauma and mental disorders. These can be the reason for getting the highest coefficient in Sri Lanka since the people have gone through mental instabilities and stressful lives due to natural disasters and terrorist attacks. Due to the non-linearity of the impact, there exists a point that the effect reaches its maximum in those countries, as shown in Figure 1. Later, the significant negative coefficient for  $URB^2$  implies that urbanisation's impact on mental disorders eventually decreases in Maldives and Sri Lanka. Such a decrease might be attributable to increased access to and availability of mental health care-related medical facilities.

India, Pakistan, Nepal, Bhutan, Afghanistan, and Bangladesh show a negative coefficient which shows that mental disorders decrease with a 1% increase in urbanisation. Pakistan has the highest negative coefficient of -7.4. It implies that when urban population increases by 1%, mental disorders decrease by 7.4%. The lowest negative coefficient is shown in India which shows when



urbanisation increases by 1% mental disorders decrease by 0.18%. This might be due to increased access to medical treatment for mental disorders and improved awareness of the mental disorders from which people tend to recover from such disorders. According to the trend line after a pivotal moment, mental disorders have shown a significant increase in Pakistan, Nepal, and Bangladesh. According to Khan et al. (2012) Pakistan's urban issues stem from policies focusing on the dichotomy between rural and urban areas, often neglecting the complex dynamics of rural-urban interactions and interdependencies. Policymakers must understand the complex nexus of urban-rural livelihoods, focusing on linkages across space and sectors. Policies should also consider the influence of globalization on social, economic, and ecological aspects of the urban-rural nexus, which has been often ignored in Pakistan.

Considering the legislation and mental health laws in South Asian countries, it lacks the emphasis on human rights and community-based approaches, and implementation flaws, leaving mentally ill individuals vulnerable to abuse and violation of rights. (Tripathi & Kumar, 2015). The region's policies focus on community mental health care, primary care integration, medication availability, user involvement, and equity of access. Countries like Bangladesh, Bhutan, Pakistan, India, and Sri Lanka have made progress in implementing these components. Nepal focuses on basic medication, protecting human rights, and raising awareness. The Maldives lacks a policy, legislation, or plan. Studies show a large number of untreated patients in the community, leading to seeking help from religious and traditional healing sites (Thara & Padmavati, 2013). Thereby, along with more trained labor, better resource allocation, and enhanced services, reform of the legal framework

governing mental health is crucial. It is crucial to conduct a community needs assessment to allocate resources and focus community-based efforts.

However, there is a significant negative relationship between urbanisation and mental disorders before a pivotal point in Nepal, Bangladesh, and Pakistan. After the pivotal moment, the impact of urbanisation on mental disorders is positively significant only in Nepal, Bangladesh, and Pakistan. The positive impact may be due to the rapid urbanisation rate increases the psychosis and depression rate for both men and women owing to social stress, environmental pollution, and noise which arise from higher population densities reported within urban areas or either being born or most of the childhood is spent within urban areas (Trivedi et al., 2008). As supporting the positive impact, a study found that residents in Dhaka mega city were living in inadequate housing areas with insufficient infrastructure and lack of proper drainage, sanitation, and garbage disposal services which led to a lack of self-reported mental disorders (Fahmida et al., 2009). In addition, Tabassum et al. (2000) study states that Pakistan's families face mental disorders due to cultural background and attitudes in the urban society. Thereby with the supporting literature the country faces high mental disorders due to economic, social, and environmental changes. The overcrowding effect makes people more stressed and their living standards get low. According to past studies, Bangladesh has inadequate services and the prevalence of mental disorders is very high. Therefore, living in a crowded, unhygienic environment with no access to essential services can exacerbate helplessness, anxiety, and depressive symptoms. Men and women in Pakistan may face distinct expectations and pressures due to traditional gender norms. The difficulties with gender-specific mental health may be influenced by these assumptions. Men may feel

pressure to be the main breadwinners, whilst women may experience stress connected to household duties.

## **8. Conclusions**

The SAARC countries are in the region that has the highest prevalence of mental disorders. Many research studies have been conducted to determine the impact of urbanisation in some specific regions and countries. However, the present study sheds light on urbanisation and mental disorders and their relationship. Therefore, this study focused on examining the impact of urbanisation on mental disorders in the SAARC countries. The study is analyzing the period from 1990 to 2019. The analytical technique utilised to investigate the impact of urbanisation on mental disorders polynomial regression. The findings infer that with a highest positive coefficient and 1% increase in urbanisation, Sri Lanka stands out as having a significantly higher rate of mental disorders. This outcome can be linked to a history of terrorism and natural calamities that have had a lasting effect on the population's mental health. The stress and trauma brought on by these occurrences undoubtedly have a significant role in the reported rise in mental diseases. In contrast, India, Pakistan, Nepal, Bhutan, Afghanistan, and Bangladesh exhibit negative coefficients, suggesting that the prevalence of mental diseases tends to decline as urbanisation rises. Pakistan has the most notable negative coefficient, which indicates that as urbanisation increases, mental problems have significantly decreased. This might be a result of increasing awareness and easier access to mental health care.

Addressing mental health challenges in SAARC countries requires a holistic approach that considers cultural, social, and economic factors while prioritizing accessibility, awareness, and quality of care. Policymakers should promote mental health awareness, increase access to mental health services, provide cultural competency training for mental health professionals, support community-based initiatives, develop gender-specific programmes, encourage family-centered care, implement workplace mental health programmes, and implement mental health legislation. Research and data collection should be invested to better understand the prevalence and determinants of mental health issues within different cultural and demographic groups in SAARC. International collaboration with international organizations and mental health experts can access best practices, technical assistance, and funding for mental health initiatives. Telehealth and e-mental health services should be explored to expand access to mental health care, particularly in remote and underserved areas. Monitoring and evaluation mechanisms should be implemented to assess the effectiveness of mental health programmes and policies. By working collaboratively with healthcare professionals, community leaders, and mental health advocates, policymakers can create a comprehensive, culturally sensitive, and accessible mental health support system that supports the mental well-being of the population.

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