EXPLORING THE MENTAL HEALTH LANDSCAPE OF SCHOOL-GOING CHILDREN IN REMOTE AREAS OF BANGLADESH

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Abstract

Present study is an attempt to investigate the primary mental health challenges faced by school-going children residing in remote areas of Bandarban district of Bangladesh in relation to two demographic factors as gender and family type of them. Researchers adopted cross-sectional study design with the purposive sampling technique. The participants for this study were carefully selected from the Chakma and Marma school-going children in the Bandarban district. Sample included a total sum of 236 students, encompassing children enrolled in three schools namely, Matamohury girls High School, Alikadom; Bandarban Govt.Boys High School, Bandarban and Sangu High School, Hafezghuna, Bandarban. The specific inclusion criteria were limited to individuals aged 11 to 17 who were actively attending school. Survey was conducted with the help of Bengali version of Strength and Difficulty Questionnaire, originally developed by R. Goodman in 1997. Findings yielded that female student appeared with greater prevalence of mental health problems than their other counterparts and the difference was statistically not significant. Again, female students revealed that they have greater prevalence of emotional problems, hyperactivity problems and pro-social problems than male students. Considering family type, students from joint family background appeared with greater prevalence of mental health problems than students belong to nuclear families and the difference was statistically significant. Moreover, students belong to joint families revealed that they have greater prevalence of mental health problems including all the dimensions of it than students belong to nuclear families.

Keywords: Mental Health, Mental health Problems, Students from remote localities, Wellbeing.

Introduction

Mental health holds significance as a fundamental element of holistic wellness, comprising emotional, psychological, and social dimensions. It shapes cognition, emotions, behaviors, and plays a pivotal role in managing stress, interpersonal relationships, and decision-making processes. Mental well-being is a crucial consideration across all developmental phases, spanning from early childhood and adolescence to adulthood. Various factors contribute to the dynamics of mental health and overall well-being, encompassing biological aspects such as

genetic predispositions and neurochemical balances (Nemeroff & Vale, 2005), as well as life events such as traumatic experiences (Heim et al., 1997) or instances of abuse, alongside the presence of mental health concerns within family histories (Seedat et al., 2001). Despite the widespread availability of improved care and the prevalence of severe mental illnesses, a substantial proportion, more than two-thirds of individuals globally do not pursue treatment. This reluctance stems from the significant impediments posed by mental illnesses themselves, acting as formidable barriers to accessing mental health services. The World Health Organization's "Mental Health Action Plan 2013-2030" delineates a thorough strategy aimed at enhancing service provision on a global scale. This plan underscores the necessity for government intervention and the formulation of supportive policies conducive to mental health. (WHO, 2013).

The mental health landscape in Bangladesh faces significant challenges, including high prevalence rates of mental disorders, limited accessibility to mental health services, and pervasive stigma. A review of the current state of mental health care in Bangladesh identifies key areas for improvement, such as the need for large-scale epidemiological studies, the integration of mental health care at the primary care level, and the development of new human resources in the mental health field (Hasan et al., 2021). The inaugural national survey of mental health in Bangladesh, conducted from 2003 to 2005, unveiled a substantial mental health burden within the nation, revealing that approximately 16.1% of adults grappled with at least one form of mental illness (Hossain et al., 2014). Subsequently, another nationwide survey was conducted in 2019, revealing a slightly elevated prevalence rate of 18.7% (Karim & Shaikh, 2021). Recent research findings and survey data highlight an alarming mental health landscape in Bangladesh, as evidenced by reports from the World Health Organization (WHO) ranking the country among the top 10 globally in terms of the prevalence of mental health disorders. It is estimated that approximately 30% of the population grapples with mental health issues and approximately 8.4 million individuals in Bangladesh are grappling with mental health issues, constituting roughly 7% of the country's population of 120 million (Banglapedia, 2006). Additionally, research indicates that around one-fourth of children in Bangladesh are affected by various forms of mental health problems (Rabbani et al., 2009). Comparative studies suggest that between 9.5% to 29% of children across different nations experience diverse mental health challenges (The Daily Star, 15 June, 2011). Moreover, research conducted by Firoz et al. (2007) revealed that 16.1% of Bangladesh's adult population is afflicted with some form of mental health disorder. During childhood, both boys and girls

encounter numerous challenges. Parents often refer to this phase as the troublesome age, educators categorize it as elementary school, and psychologists recognize it as the gang age (Hurlock, 2000).

Overcoming these challenges demands a multifaceted strategy encompassing various components, including raising public awareness regarding mental health, mitigating stigma, bolstering training programs for healthcare practitioners, and embedding mental health services within primary care frameworks. Furthermore, legal and policy reforms, exemplified by the enactment of the Mental Health Act 2018, aspire to foster a more conducive environment for individuals grappling with mental health issues, safeguarding their rights and well-being.

Review of related literature

Mental health issues among the world's 370 million indigenous people are a pressing concern, yet research in this area remains sparse, particularly in comparison to studies on non-indigenous populations. While there is some international awareness regarding mental health in indigenous communities, such as among Aboriginal people in Australia (Brown et al., 2012) and in Canada (Bellamy & Hardy, 2015), comprehensive research remains limited (King et al., 2009). It is imperative to address mental health challenges among indigenous peoples to enable the development and delivery of appropriate services. Without essential epidemiological data on unmet treatment needs, the situation remains unresolved (Kisely et al., 2017), impeding effective planning and delivery of services. Research findings to date indicate that indigenous populations experience disproportionately high rates of mental health issues and bear a significant burden of mental illness (Nelson & Wilson, 2017). For instance, studies have shown that Canadian Aboriginal men and women, whether living on or off-reserve, experience elevated rates of depression compared to the general population (Brown et al., 2012; Boksa et al., 2015; Bellamy & Hardy, 2015). Faruk et al. (2021) examined anxiety and depression among two indigenous communities in Bangladesh. Their findings revealed that excessive anxiety and worry can impede young people's engagement in school and daily life, leading to negative behaviors and depression. Indigenous youth in Bangladesh face elevated suicide rates compared to the national average. The study also highlighted ethical and practical challenges in conducting research on mental health and anxiety (Adermann & Campbell, 2007).

Bangladesh is home to several indigenous communities, though estimating their exact number and population size is challenging due to definitional issues and limited demographic statistics. However, it is generally believed that these communities constitute less than 1% to 2% of the total population. The health and social conditions of indigenous peoples globally are alarming,

with around 300 million individuals living in 70 countries facing lower life expectancy, higher rates of diseases, accidents, and violence. Preventable diseases are the leading causes of death, with most indigenous populations comprising children or young adults. Indigenous health issues are influenced by cultural values and vulnerability, with non-indigenous policies and programs often proving ineffective and even harmful. Addressing indigenous health necessitates expanding the definition of health to encompass overall well-being, respecting traditional beliefs, and integrating science and technology into indigenous communities. Indigenous peoples prioritize inclusivity, community diversity, and environmental preservation in their health decision-making processes. However, urbanization and economic development pose significant challenges, including environmental degradation, pollution, and disease spread, underscoring the importance of public awareness and research on health concerns in indigenous communities. Access to healthcare is a major issue, with 40% of 100 million indigenous people lacking regular care due to marginalization, poverty, low wages, unemployment, illiteracy, and seasonal migration exacerbating these challenges. In Bangladesh, particularly in Bandarban, knowledge about the mental health of indigenous communities is limited. Therefore, there is a need for studies investigating the presence of mental health difficulties among school-going children in Chakma and Marma communities.

Rationale of the Study

Current study primarily focused on the mental health challenges among school-going children in remote area of Bangladesh as Bandarban. Children residing in remote localities frequently inhabit in remote localities, rendering them isolated from critical services, including mental health care. Such isolation can compound mental health issues, prolonging the process of diagnosis and treatment. Geographical obstacles pose a substantial challenge to the accessibility of mental health services, hindering children's access to necessary care (Gupta & Sagar, 2018). Hill regions are often inhabited by indigenous or minority groups characterized by unique cultures and social norms. Grasping these contextual nuances is imperative for crafting culturally sensitive mental health interventions. Research in the realm of mental health can provide insights into how cultural beliefs and practices shape the understanding, expression, and treatment of mental health issues among children within these communities (Kirmayer et al., 2009). Again, children residing in hill regions encounter distinctive environmental stressors, including heightened occurrences of natural disasters such as landslides and floods. These stressors wield considerable psychological ramifications, precipitating conditions like anxiety, post-traumatic stress disorder (PTSD), and other mental

health concerns. Investigations conducted in these locales serve to pinpoint the precise environmental elements influencing children's mental well-being, facilitating the formulation of tailored interventions (Norris et al., 2002). While the National Mental Health Survey of Bangladesh (2019) provides prevalence data for depressive and anxiety disorders at a national level (6.7% and 4.5% respectively), the current study, focusing on the Chakma and Marma ethnic groups, marks the first attempt to gauge the prevalence of depressive and anxiety symptoms exclusively within indigenous communities in the country. Bangladesh officially recognizes at least 11 indigenous ethnic groups, primarily concentrated in the hill tract areas in the southeast. The two largest indigenous groups in the nation are the Chakma and Marma tribes collectively. Exact population figures for these groups are challenging to ascertain, but estimates suggest figures upwards of 400,000 for the Chakma tribe and 200,000 for the Marma tribe. These tribes constitute the majority of the indigenous population in the region.

The Chattogram (Chittagong) Hill Tracts (CHT) comprise three mountainous districts bordering Myanmar to the south and east, and Indian states like Tripura and Mizoram to the north and east. Indigenous peoples in the CHT possess distinct customs and ways of life compared to those in the plains, including unique ceremonies for birth, death, and marriage. Both the Chakma and Marma communities traditionally engage in Jhum cultivation, a form of rotational shifting farming primarily cleared by burning, although they have recently transitioned to plough cultivation of rice. Other livelihoods in these communities include fishing, hunting, and the harvesting of forest products. Research on indigenous communities in Bangladesh has predominantly focused on political, legal, economic, and historical perspectives, rather than psychological aspects. National campaigns highlighting the marginalization of indigenous peoples have presented the issue from their standpoint. Due to its geographical location and political tensions arising from ethnic clashes between Bangalee settlers and indigenous populations, the region has largely neglected health coverage, particularly mental health services. Additionally, indigenous peoples may be hesitant to utilize available mental health services due to a lack of consideration for their unique cultural characteristics, such as language and values. The study highlights a significant gap in research on mental health of the school going children in remote areas, particularly in Bangladesh. The limited existing literature underscores the need for more comprehensive investigations into the mental well-being of these schools. In search of answers to the knowledge gaps, the researcher has identified the following research questions that he believes should guide the current study:

1. Do the school going children in remote areas in Bangladesh face any mental health problem?

2. How different demographic factors such as gender and family type cause in variation on mental health problems?

On finding answers to the above identified research questions researcher has been framed the problem as – ***"Exploring the Mental Health Landscape of School-Going Children in Remote Areas of Bangladesh"***

Delimitations

Further the researcher has delimited the study in following areas:

1. Among the remote areas of Bangladesh only Bandarban district has been considered as the population area.

2. Only three (3) school at Bandarban district in Bangladesh were survey.

3. Demographic factors were delimited to only gender and family types of school going children.

4. School-going children aged between 11-17 years were surveyed.

Objectives of the Study

Keeping in mind the aforementioned research questions and delimitations, the researcher has identified the following major objectives as:

1. To recognize the primary mental health challenges faced by school-going children residing in remote areas of Bandarban district.

2. To assess the prevalence rate of mental health problems among school-going children residing in remote areas of Bandarban district.

3. To investigate how mental health challenges of students' differs with gender and family type of them.

Hypotheses

On the basis of the purpose of the study, following hypotheses were formulated and stated as:

H_01: There is no significant difference in the rate of prevalence of Mental Health problems with respect to gender and family type of the children.

H_02: There is no significant difference in the rate of prevalence of Emotional problem with respect to gender and family type of the children.

H_03: There is no significant difference in the rate of prevalence of Conduct problem with respect to gender and family type of the children.

H₀4: There is no significant difference in the rate of prevalence of Hyperactive problem with respect to gender and family type of the children.

H₀5: There is no significant difference in the rate of prevalence of Peer problem with respect to gender and family type of the children.

H₀6: There is no significant difference in the rate of prevalence of Pro-social problem with respect to gender and family type of the children.

Methods and Materials

Study design

Current study adopted a cross-sectional study design with the purposive sampling technique. The participants for this study were carefully selected from the Chakma and Marma school-going children in the Bandarban District.

Sample

The study's sample included a total of 236 students, encompassing both Marma and Chakma children enrolled in three schools namely, Matamohury girls High School, Alikadom; Bandarban Govt.Boys High School, Bandarban and Sangu High School, Hafezghuna, Bandarban. The specific inclusion criteria were limited to individuals aged 11 to 17 who were actively attending school, ensuring a target.

Variables

Mental health problems of school-going children including five (5) different dimensions were taken as the dependent factor, whereas gender and family type of students were considered as the independent variables in present study.

Measuring Instrument

To assess the mental health problems, the Strengths and Difficulties Questionnaire (SDQ) for children aged 4 to 17 years was utilized. Originally developed by R. Goodman in 1997, the Bangla version of the questionnaire was translated by Mullick and Goodman in 2001. The SDQ comprises 25 items, categorized into five dimensions: Conduct Problems (five items), Emotional Problems (five items), Hyperactivity (five items), Peer Problems (five items), and Pro-social Behavior (five items). Each item is accompanied by three response options: "not true," "somewhat true," and "certainly true." A score of 2 points is assigned for "certainly true," 1 point for "somewhat true," and 0 points for "not true." The test-retest reliability of the SDQ ranges from 0.70 to 0.85, and its internal consistency ranges from 0.51 to 0.76. Again, a pilot study was conducted by the present researchers and the newly found Cronbach's alpha value was found to be 0.78.

Descriptive Statistics

MENTAL HEALTH STATUS OF SCHOOL-GOING CHILDREN IN REMOTE AREAS OF BANDARBAN DISTRICT

Table 1: Gender Wise Mental Health Status of School-Going Children of Bandarban

Problem	Gender	Abnormal N	Abnormal %	Borderline N	Borderline %	Normal N	Normal %	Total N	Total %	M	SD	df	t
Emotional Problem	Female	17	58.62	36	59.02	74	50.68	127	53.81	3.94	2.352		
	Male	12	41.38	25	40.98	72	49.32	109	46.19	3.38	2.360	233	1.818
	Total	29	100%	61	100%	146	100%	236	100%				
Conduct Problem	Female	13	41.94	09	39.13	105	57.69	127	53.81	2.64	1.905		
	Male	18	58.06	14	60.87	77	42.31	109	46.19	3.06	2.237	234	-1.582
	Total	31	100%	23	100%	182	100%	236	100%				
Hyperactivity	Female	00	00	02	66.67	125	53.88	127	53.81	3.21	2.014		
	Male	01	100	01	33.33	107	46.12	109	46.19	2.96	1.895	234	0.974
	Total	01	100%	03	100%	232	100%	236	100%				
Peer Problem	Female	27	45	18	54.55	82	57.34	127	53.81	2.98	2.033		
	Male	33	55	15	45.45	61	42.66	109	46.19	3.39	2.219	234	-1.477
	Total	60	100%	33	100%	143	100%	236	100%				
Pro-social Problem	Female	20	37.74	16	47.06	91	61.07	127	53.81	7.41	1.849		
	Male	33	62.26	18	52.94	58	38.93	109	46.19	6.73	2.391	234	2.445
	Total	53	100%	34	100%	149	100%	236	100%				
Total Difficulties	Female	73	59.84	18	39.13	36	52.94	127	53.81	20.21	5.536		
	Male	49	40.16	28	60.87	32	47.06	109	46.19	19.52	5.716	234	0.940
	Total	122	100%	46	100%	68	100%	236	100%				

Table 1 showed the prevalence of mental health issues among school-going children, categorized by severity levels and disaggregated by gender. In the domain of Emotional Problems, it was observed that out of 236 respondents, 29 were identified as abnormal, with 41.38% being boys and 58.62% being girls. Additionally, 61 respondents were categorized as

borderline, with 40.98% being boys and 59.02% being girls. The remaining 146 respondents showed no emotional problems. The t-score between boys (N=109, M=3.38, SD=2.360) and girls (N=127, M=3.94, SD=2.352) was 1.818 for emotional problems.

Regarding Conduct Problems, out of 236 respondents, 31 were identified as abnormal and 23 were borderline, with 60.87% being boys and 39.13% being girls. The remaining 182 respondents showed no conduct problems. The t-score between boys (N=109, M=3.06, SD=2.237) and girls (N=127, M=2.64, SD=1.905) was -1.582 for conduct problems.

In Hyperactive Problems, only one respondent was identified as abnormal, who was a boy, while three were borderline, with 33.33% being boys and 66.67% being girls. The remaining 232 respondents showed no hyperactivity problems. The t-score between boys (N=109, M=2.96, SD=1.895) and girls (N=127, M=3.21, SD=2.014) was 0.974 for hyperactivity problems.

Regarding Peer Problems, out of 236 respondents, 60 were identified as abnormal and 33 as borderline, with 45.45% being boys and 54.55% being girls. The remaining 143 respondents showed no peer problems. The t-score between boys (N=109, M=3.39, SD=2.219) and girls (N=127, M=2.98, SD=2.033) was -1.477 for peer problems.

In Pro-social Problems, 53 respondents were identified as abnormal, with 62.26% being boys and 37.74% being girls. Additionally, 34 were borderline, with 52.94% being boys and 47.06% being girls. The remaining 149 respondents showed no pro-social problems. The t-score between boys (N=109, M=6.73, SD=2.391) and girls (N=127, M=7.41, SD=1.849) was 2.445 for pro-social problems.

Lastly, in Total Difficulties, 122 respondents were identified as abnormal, with 40.16% being boys and 59.84% being girls. Additionally, 46 were borderline, with 60.87% being boys and 39.13% being girls. The remaining 68 respondents showed no total difficulties. The t-score between boys (N=109, M=19.52, SD=5.716) and girls (N=127, M=20.21, SD=5.536) was 0.940 for total difficulties.

Table 2: Family Type Wise Mental Health Status of School-Going Children of Bandarban

		Mental Health Status											
Problem	Family Type	Abnormal		Borderline		Normal		Total		M	SD	df	t
		N	%	N	%	N	%	N	%				
Emotional Problem	Nuclear	17	58.62	36	59.02	97	66.44	150	63.56	3.63	2.373	233	

		N	%	N	%	N	%	N	%	Mean	SD	N	t
	Joint	12	41.38	25	40.98	49	33.56	86	36.44	3.76	2.369		-0.429
	Total	29	100%	61	100%	146	100%	236	100%				
Conduct Problem	Nuclear	18	58.06	12	52.17	120	65.93	150	63.56	2.66	2.052	234	-1.718
	Joint	13	41.94	11	47.83	62	34.07	86	36.44	3.14	2.081		
	Total	31	100%	23	100%	182	100%		100%				
Hyperactivity	Nuclear	01	100	02	66.67	147	63.36	150	63.56	3.03	1.988	234	-0.663
	Joint	00	00	01	33.33	85	36.64	86	36.44	3.21	1.917		
	Total	01	100%	03	100%	232	100%	236	100%				
Peer Problem	Nuclear	34	56.67	18	54.55	98	68.53	150	63.56	2.96	2.130	234	-1.970
	Joint	26	43.33	15	45.45	45	31.47	86	36.44	3.52	2.085		
	Total	60	100%	33	100%	143	100%	236	100%				
Pro-social Problem	Nuclear	35	66.04	26	76.47	89	59.73	150	63.56	7.02	2.246	234	-0.671
	Joint	18	33.96	08	23.53	58	38.93	60	36.44	7.22	1.943		
	Total	53	100%	34	100%	149	100%	236	100%				
Total Difficulties	Nuclear	74	60.66	29	63.04	47	69.12	150	63.56	19.31	5.439	234	-2.143
	Joint	48	39.34	17	36.96	21	30.88	86	36.44	20.93	5.812		
	Total	122	100%	46	100%	68	100%	236	100%				

Table 2 showed the prevalence of mental health issues among school-going children, categorized by severity levels and disaggregated by family type. In terms of emotional problem, out of 236 respondents, 29 were identified as having abnormal levels, with 41.38% belonging to joint families and 58.62% to nuclear families. Additionally, 61 respondents were classified as borderline, while the remaining 146 showed no emotional problems. The t-score for emotional problems between joint and nuclear families was -0.429.

Regarding conduct problems, out of 236 respondents, 31 were categorized as abnormal, with 41.94% from joint families and 58.06% from nuclear families. Similarly, 23 were classified as borderline, with 47.33% from joint families and 52.17% from nuclear families. The t-score for conduct problems between joint and nuclear families was -1.718.

In hyperactivity problems, only one respondent from a nuclear family was identified as abnormal, while three were categorized as borderline. The majority, 232 out of 236, showed

no hyperactivity problems. The t-score for hyperactivity problems between joint and nuclear families was -0.663.

Peer problems exhibited by the respondents indicated that out of 236, 60 were abnormal and 26 were borderline, with 43.33% from joint families and 56.67% from nuclear families. The t-score for peer problems between joint and nuclear families was -1.970.

Regarding pro-social problems, 53 respondents were identified as abnormal, with 33.96% from joint families and 66.04% from nuclear families. Additionally, 34 were borderline, with 23.53% from joint families and 76.47% from nuclear families. The t-score for pro-social problems between joint and nuclear families was -1.0671.

Lastly, in total difficulties, 122 respondents were abnormal and 46 were borderline, with 39.34% from joint families and 60.66% from nuclear families. The t-score for total difficulties between joint and nuclear families was -2.143.

Hypothesis Testing

H_0 Number	*Statement of Hypothesis*	*Status of Hypothesis*
1.	There is no significant difference in the rate of prevalence of Mental Health problems with respect to gender and family type of the children.	Null Hypothesis with relation to gender is **Failed to Rejected.** Null Hypothesis with relation to Family Type is **Rejected.**
2.	There is no significant difference in the rate of prevalence of Emotional problem with respect to gender and family type of the children.	Null Hypothesis with relation to gender and family type is **Failed to Rejected.**
3.	There is no significant difference in the rate of prevalence of Conduct problem with respect to gender and family type of the children.	Null Hypothesis with relation to gender and family type is **Failed to Rejected.**
4.	There is no significant difference in the rate of prevalence of Hyperactive problem with respect to gender and family type of the children.	Null Hypothesis with relation to gender and family type is **Failed to Rejected.**
5.	There is no significant difference in the rate of prevalence of Peer problem with respect to gender and family type of the children.	Null Hypothesis with relation to gender and family type is **Failed to Rejected.**
6.	There is no significant difference in the rate of prevalence of Pro-social problem with respect to gender and family type of the children.	Null Hypothesis with relation to gender is **Rejected.** Null Hypothesis with relation to Family Type is **Failed to Rejected.**

Major Findings

Considering mental health problems, out of all respondents 122 were identified as abnormal, with 40.16% being boys and 59.84% being girls. Additionally, 46 were borderline, with 60.87% being boys and 39.13% being girls. The remaining 68 respondents showed no total

difficulties. Female students appeared with greater prevalence of mental health problems than their other counterparts and the difference was statistically not significant. Again, female students revealed that they have greater prevalence of emotional problems, hyperactivity problems and pro-social problems than male students.

Regarding mental health problems in relation to family type, it was found that 122 respondents were abnormal and 46 were borderline, with 39.34% from joint families and 60.66% from nuclear families. The t-score for total difficulties between joint and nuclear families was -2.143. Students from joint family background appeared with greater prevalence of mental health problems than students belong to nuclear families and the difference was statistically significant. Moreover, students belong to joint families revealed that they have greater prevalence of mental health problems including all the dimensions of it than students belong to nuclear families.

Recommendations

The findings underscore the urgency of addressing the mental well-being of indigenous school children, shedding light on the need for targeted interventions and support systems to alleviate the burden of anxiety and depression within these marginalized communities. This research not only advances our understanding of the mental health landscape among indigenous populations but also emphasizes the significance of culturally sensitive approaches in promoting the overall well-being of these vulnerable groups. The study recommended that evidence-based strategies for interventions should customized and be provided to the vulnerable children of remote areas in Bangladesh, aiming to effectively address mental health issues. National and local authorities should focus and offer policy recommendations for enhancing mental health support systems for children, based on identified needs and best practices. It is necessary to engage community leaders and local non-governmental organizations (NGOs) in fostering awareness and backing mental health initiatives, leveraging local resources and knowledge.

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