South Asia is the southern region of the Asian continent comprising of sub-Himalayan countries on the west and the east. It is surrounded by Western Asia, Central Asia, Eastern Asia and South-east Asia. Following countries comprise of South Asia:
(i) Bangladesh
(ii) Bhutan
(iii) India
(iv) Maldives
(v) Nepal
(vi) Pakistan
(vii) Sri Lanka

South Asia

These countries are also currently members of a regional co-operation group, the South Asia Association for Regional Co-operation (SAARC) jointly formed by these countries. Some authorities also include the following countries in South Asia:
(i) Afghanistan
(ii) Myanmar
(iii) Tibet

Geographically, the term Indian sub-continent is used to describe those regions which lie on the Indian plate, bordering on the north by the Eurasian plate. However, a good proportion of Pakistan land mass is not on Indian plate, but on the fringes of Iranian plateau. As in the case of Hindukush mountains, everything to the south-east of the Iranian plateau is considered south Asia. But, geographically, the southern Asia subsumes the Indian subcontinent and includes both, the territories found internal to the Indian plate and those in proximity to it. Afghanistan, for instance, is sometimes grouped in this region due to socio-political, historical and ethnic ties to neighbouring Pakistan.

Historically, the Indian subcontinent has been likened to be a deep net into which various races and people have drifted and been caught and their diverse origin has dictated variety. Geographical conditions forced these varied people to stay together in a multiple society imposing on them what has been described by historians as “unity in diversity.” Most of the societies in the region are predominantly patriarchal with women’s role confined to house-hold. For the predominantly agricultural econo-mies of South Asia currently, rural development is the core issue of development. South Asia has the world’s largest concentration of people living below the poverty line. Per capita income averaged $430 in 1998, and ranged from $1,171 (Maldives) to $210 (Nepal). By the year
2000, the world population stood at 6100 million, of which 1354 million (22%) people lived. In South Asia with Bangladesh, India, and Pakistan account for the bulk of the region’s population.

Currently, the whole world is in a flux of transformations in social structures, cultural values and behavioral patterns due to modernization process. People move around the world, migrate and return, live abroad and raise children abroad. They are bound to live together with other ethnic and cultural groups, the process of modernization has its impacts everywhere and South Asia region is no exception. Cowgill\textsuperscript{3} has defined modernization as follows:

“Modernization is the transformation of a total society from a relatively rural way of life based on animate power, limited technology, relatively undifferentiated institutions, parochial and traditional outlook and values, toward a predominantly urban way of life based on inanimate sources of power, highly developed scientific technology, highly differentiated institutions matched by segmented individual roles, and a cosmopolitan outlook which emphasizes efficiency and progress.”

**Impact of Modernization on Family**

The family is the basic unit of a society to attribute with biological functions such as reproduction, social functions pertaining to nurturing and socialization of children, caring and support for older persons, the sick, and those with disabilities. It is the institution responsible for maintaining and building relationships among family members as well as with the community.

A family may be defined as a group of persons related to a specific degree, through blood, adoption, or marriage. Household is defined by location, community or living arrangements. A person or a group of persons that usually live and eat together constitute a household. It is important to distinguish between a family, where members are related either by blood or by marriage, and a household, which involves the sharing of a housing unit, facilities and food.

There have been certain modernization related determinants which have impact on the structure and function of families. These determinants have been described below.

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| 1. Population changes                     |
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| 1. Population changes                     |
| (i) Fertility change                      |

Due to reduced fertility levels the reduction in average annual rate of population growth is a global phenomenon. Family size is reducing due to declining fertility rates and increasing age at first birth in most of the countries. The total fertility rate (TFR) of Bhutan, Maldives and Pakistan was well over five live births per woman, during the period of 1995-2000. India reports a TFR of over three children. Sri Lanka has reached the replacement level fertility with a TFR of 2.1.\textsuperscript{4} A main emerging feature in the modern family system is the changing attitude towards the value of children. In traditional societies, where human labour was a source of strength, more children were preferred to fewer. But as the economic contribution from the children in a family decreased, because of a move away from agriculture, the need for large numbers of children decreased. Improvements in health care and child survival also contributed. The emphasis as on the quality of life rather than the quantity of children, a new concept added to family values. Achievement of low fertility levels is a result of delayed marriage and increased age single-hood, both linked to the rising status of women.
(ii) **Change in age at marriage and age at first birth**

A substantial increase of the proportion of people not married, among both males and females, at young ages, has been noted. In Bangladesh, the proportion of females never married in the age group 20-24 was 4.6 percent in 1970 and it increased to 18.5 percent in 2000. People not married in Sri Lanka remain at a significantly high level of 61-63 per cent in 2000. The highest increase in average age at marriage of females during the period 1970 to 1990 was observed in India. A higher median age at first birth is an indicator of lower fertility. Postponement of marriage among females resulted in postponement of childbearing. The age at which women start childbearing is an important demographic determinant of fertility. The median age at first birth in South Asian countries increased slightly in recent years. Median age at first birth in Bangladesh was 16.9 years for women who are currently age 45-49 years, while the corresponding figure is 18.4 years for women who are in the age group of 20-24 years. Sri Lanka reports the highest median age for mothers at first birth, where young women (25-29) report their age at first birth as 26.3 years.

(iii) **Change in mortality**

With decline in fertility, there is decline in mortality particularly infant mortality. Improved survival rates of children mean that when women reached the age of 30 they increasingly had achieved the completed family size they desired. Earlier, much larger numbers of births were required to achieve the desired family size. The countries in South Asia that have achieved a low level of fertility also have a low level of infant mortality. During the period 1970-1975 in all the South Asian countries except Sri Lanka, the infant mortality rates exceeded 100 infant deaths per every 1000 live births. In the last three decades infant mortality has declined significantly in every country and this trend led to fertility decline. Sri Lanka reached an infant mortality rate of 23 by 1995-2000. Diverse situations can be seen in infant mortality at present among the South Asian countries, where Sri Lanka reported an IMR of only 23 compared to 165 in Afghanistan.

(iv) **Change in size and structure of the households**

A comparison of average household size over the period of 1970s/1980s to 1990s for South Asian countries in general indicates a declining trend. India has a marginal decline in average household size from 5.5 to 5.4 persons during the 1980s and 1990s. Over the past three decades Sri Lanka has a clear decline in the household size and reported the lowest figure for the region. Due to many demographic, socio-economic and political reasons family members may disperse. Consequently, the size of the household could be reduced but not the size of the family. In Asian countries, most young people after their marriage live jointly with their parents and later move to another place whenever custom imposes or economic conditions permit the new couple to do so. Young and older adults, spouses, and other relatives who might otherwise have shared a home are now more likely to live apart. Families with a large number of persons are still the norm in south Asian countries. In the 1990s Pakistan reported the highest percentage of households (74.2 per cent) with 5 or more members. Bangladesh, India and Nepal all indicate a marginal and Sri Lanka strongest decline in prevalence of large households. The reduction of the family size could be attributed partly to economic difficulties, low levels of income, the high cost of living, the costs of education of children and the desire to maintain a better standard of living, which is best within the more affordable smaller size family. A few decades ago in south Asian countries single person households were virtually not existent. As a result of population ageing, migration, and other social and economic changes, there is an emerging trend of single person households. Over the last few years in Nepal the proportion of single person households increased from 3.2 to 4.0%.

(v) **Female headed households**

In many Asian societies, the oldest male is the head of household regardless of whether he is the primary source of economic support, the authority figure, or fulfills other tasks purportedly performed by household heads. Gradually, female headed households have become a growing phenomenon due to various reasons including widowhood, migration, non-marital fertility and marital instability. In recent decades an increasing number
of women, particularly rural women, have become heads of households because men, the traditional heads of households, had left for work or other reasons. Moreover due to civil unrest, and displacement, a refugee situation exists in a number of countries in the region, often resulting in females taking over the task of running the household. The highest proportion of female-headed households in south Asia can be observed in Sri Lanka where the figure increased from 19 per cent in the 1990s to 20 percent in 2000. In Sri Lanka the increase is mainly due to the existing political unrest.

A noteworthy feature of female headed households is that the majority is widowed women, and the average size of their households is comparatively small. In demographic survey of Sri Lanka in 1994, 56 per cent of the female heads were widowed while only 37 per cent were married. In contrast a mere 2 per cent of the male heads were widowed while 95 per cent were currently married. In Nepal and India, the female headed households are increasing. These households are smaller than male headed households. The 1993 national household survey of Sri Lanka, show that 66 per cent of households in the country comprised of 1-4 members, while male headed are estimated to be 44 per cent only.

(vi) Marriage dissolution

Many marriages are disrupted suddenly for reasons such as desertion, separation or divorce. Divorce is recognized across the countries in the Asian region due to two broad reasons of cruelty and desertion. The law has not only initiated legal changes to enhance the status of women and their children within the family, but also it contributes largely to dissolution of unsatisfactory marriages. Separation or divorce may stigmatize a woman in Asian countries, reducing her social status and shrinking her support network, causing sometimes community members or her ex-partner’s kin to reject her. In the last decade, Bangladesh, India and Sri Lanka reported an increase in the proportion of divorced women in the age group 45-49. In south Asian culture, childlessness exerts a strong effect on the divorce rate. However it is believed that in the last couple of years even in most of the Asian cultures a growing proportion of divorces involve couples with young children. Widowhood is most likely to strike older persons and therefore worsen the economic problems of ageing. Death of a spouse can result in single parenthood for women for two main reasons: first is that women have longer life expectancy and second is that at the time of marriage of almost all couples, the husband is significantly older than his wife. Since marital fertility continues even in advanced ages of reproductive span, widows are often left with dependent children to support. Bangladesh reported the highest proportion of widowed women in the age group 45-49 in the 1990s and has shown further increases. At present approximately one out of every five women in that age group is already widowed. The lowest proportion is reported in Nepal. Bangladesh and India indicate an increase in the incidence of widowhood, while in Nepal and Sri Lanka the opposite is true. Presumably in Sri Lanka the decline in widowhood is expected with the decrease in age difference between husband and wife. For instance the difference between male and female age at marriage in Sri Lanka in 1963 was about 6 years, while by 1981 the figure has dropped to 3.5 years. This trend would have made a reduction in the percentage of women widowed in the age 45-49.

(vii) Women’s economic participation

The economics of the family and the gender division of labour within the family are determined by opportunities in the labour market. The economic system has facilitated the freeing of women from household chores and their entrance to the labour market. The market has invented new labour-saving methods for women to supply their labour in the market; consequently women’s share of the labour force has increased in almost all the countries. Furthermore, deregulation of labour markets has resulted in weakening income and employment securing and the ‘feminization’ of many jobs traditionally held by men. The growing need for cash for family maintenance has resulted in an increasing number of female members (particularly the wife) in the family engaging in economic activities. The highest female share of the labour force in 1970 was noted in Bangladesh while the lowest one was in Pakistan. In almost all the countries in the region an increase in the women’s share in the labour force is shown in 1995.
2 Migration

(i) International migration

Internally displaced persons and refugees

Urbanization and effect on family

During the last two to three decades population movements beyond country boundaries have increased. Major causes of such a trend are, increasing globalization, economic interdependence, rapid population growth, ecological deterioration, civil war, ethnic and religious conflicts and increased poverty.

(i) International migration

Since late 1960s, professionally and technically qualified persons migrate in search of employment overseas, particularly to the United Kingdom, North America and Australia. In recent decades labour migrants, refugees and asylum seekers have also migrated from this region. Since 1995 Canada, Australia and New Zealand have opened new avenues for all types of migrants and paved the way for thousands of professionally and technically qualified persons to migrate.

Economic development in the Middle East countries since the 1970’s, which paved the way for a massive technological development and an expanded construction industry, opened up new employment opportunities in overseas employment for skilled, semiskilled and unskilled labour from south asia. Contract migration, where migration was defined to be for a short period only, mostly one to two years, with a facility for renewal was a popular form by which migration was organized. The impetus of contract migration for families in the region was large and varied. An economic impact was seen at the family, community and village level of the out-migrants and a socio-cultural impact was experienced at the point of destination and also among return migrants at the point of origin. Contract labour migration involves most countries of South Asia, particularly Bangladesh, India, Pakistan and Sri Lanka

Among half a million Pakistani migrants during 1984-1989 only a couple of hundred were women, mostly nurses and domestic workers. The number of women originating in Bangladesh has probably been higher but still insignificant compared to the number of male migrants from that country. Women predominate among labour migrants from Sri Lanka during the 1990s.

The impact of international migration on the family

Contract migration requires a temporary separation from the family, and living in a culturally, ethnically and religiously different environment in the host country. Temporary migration impacts on the families of migrants. Within Sri Lanka, in the last quarter of 1995 during three months, forty-nine migration-related adverse incidents had been reported, including thirteen suicides and deaths of migrants or members of the family. Others, such as clandestine love affairs (migrant or spouse) and instances of abandoning the family, were observed. Evidence of stress and strain is becoming increasingly manifest in marital and family relationships. Investigations have demonstrated that the price paid by families was in the form of disruption of family life and disorientation of matrimonial and social relationships. Incidents of family break-up due to migration, bigamy or polygamy as a result of separation of married couples are increasing. In Sri Lanka the divorce rate is higher among migrant families and wasteful consumption, increased alcoholism and gambling, devaluation of the moral values of migrant women - particularly the unmarried - and the problem of social reintegration upon return, are among negative effects highlighted. Emergence of female dominated household planning has emerged as a significant feature among some of the migrant families. In recent years, because of their contribution of foreign remittances, a new socio-economic scenario has been created which significantly increased the accounted and recognized economic role of women in the community and family structure. The workers long absences from their households - especially in the case of married persons with young children - make it necessary for them to seek the assistance of parents or other siblings to attend to the needs of the young children and to assist the spouse left behind. When an immediate family member is not available, the assistance of distant relatives is sought. A parallel development is the more active participation of the male spouse in multiple family roles hitherto performed by females only, particularly in families where married women have migrated (child care, marketing). As the circumstances require, a relocation of a part of the chores performed by the migrant member of the
family among other members within the family, to an elder child or to a close family relative (e.g. Grandparent, aunt) is observed. In some instances, such redistribution of family responsibilities within the family had a negative effect. The elder child may be discouraged from schooling to look after the younger siblings left behind or to attend to other household chores. The extended family system, which was virtually collapsing due to lifestyle changes brought in by various urbanization and westernization processes, has risen again. Where available, members of the extended family step in to fill the family role void left by the migrant member, activating a positive reaction. There are psychological and behavioral problems of children and deterioration of parent child relationships. Problems of readjustment/reintegration of the returnee migrant to the family and community have visible manifestations, because of prolonged exposure to work and living away from the family. A higher incidence of divorce is reported among migrants. The incidence of divorce and separation was found to be higher in the first year after return. One conclusion can be that migration has a negative effect on marital stability. Another adverse social consequence of overseas migration, particularly, among poorer migrants, is the impact of the sometimes incompatible socio-cultural experience of the returnee migrant member on the traditional family life. The long absence from home, and exposure to a totally different economic and social situation and cultural milieu - have contributed to upsetting traditional family relationships. The importance of the family as a component part of the migratory process has not received the policy attention it deserves. Migration of family members can have favorable or adverse effects depending on the circumstances.

(ii) Internally displaced persons and refugees

Nearly all the south Asian countries are afflicted by refugee problems. The refugee issues may affect more than the two directly involved countries. Bhutanese refugees, for instance, are an issue both in India and Nepal. Afghanistan is the major refugee producing country in the region.

Rural to urban migration enhances the process of urbanization and is linked to the process of economic development. Apart from economic reasons, the flow of people from rural to urban areas occurs for better educational or health services available in urban areas. Social and economic disparities and lack of job opportunities in rural areas have resulted in increased rural to urban migration in many south Asian countries. The process of urbanization may be described as irreversible. Emergence of “the big city” phenomenon in Asian countries is linked to large scale rural to urban migration. Such a migration pattern occurs within the framework of high population growth in which the agriculture sector is unable to absorb the additional labour supply of the growing rural population. It is noted “population mobility whether between or within the rural and urban sectors, is related to sustainable development. People who moved out of unsustainable systems in rural areas to rapidly growing urban centers often move into urban poverty. Another major internal migration process is rural to rural migration. The predominance of the agriculture sector and the opening up of new agricultural land have been the major reasons for rural to rural migration. This is especially true of south Asian countries where population mobility is still dominated by rural to rural migration. In absolute numbers an increase in the rural to rural type of mobility can be observed in Bangladesh, India, Nepal, Pakistan Sri Lanka and Afghanistan.

The impact of internal migration on family

Internal migration also affects the structure and the functions of the family like the international migration. For married women the chances to break out from a confined role appear to be greater in urban than in rural areas. They can more easily evade the direct control of their family, causing traditional family structures to collapse and paving the way for development of new ones. Such outcomes are particularly important in patrilineal and patrilocal societies, when migration results in living away from the woman’s in-laws which in turn encourages the development of more intimate and egalitarian relationships between the husband and wife. Thus a study of urban neighborhoods in a city in northern India found that the trend towards the incorporation of married women into their husband’s kin network was weak; nevertheless stronger ties were observed between the women...
concerned and the family of origin than was typical in traditional rural India. “it is the reorganization of the household with its emphasis on the nuclear family and the geographic distances separating the extended family as well as the disparity between access to information and control over its use that challenges the traditional ordering of family authority”. Married women migrating from rural to urban areas of south Asian countries often experience not only a transition from an extended to a nuclear family but also an important change in the nature of their economic activity. From being unpaid family workers, they become wage earners. Such change is likely to enhance the independence of women and to strengthen their role in decision making within the family. In general the higher a women’s income as a proportion of total family income is, the more power she holds in the family

(iii) Urbanization and the effects on family

Urbanization processes stabilize the nucleation of the family system because urban congestion and housing patterns, particularly of the low income groups, discourage large households. The demographic transition occurring in some of the south Asian countries reached a stage of low mortality and low fertility (tending towards replacement level fertility) which also enhances the process of family nucleation. A gradual collapse of the extended family system creates new problems of family support for the young dependents and older persons in the family. Time series data showing the age structure of urban areas of south Asian countries indicate that the proportion of older persons increased and the proportion of working age population and the proportion of working parents is high. Moreover, consequent to rural to urban migration and rapid urbanization processes, a small average household size is observed for urban areas, compared to rural, in most of the south and central Asian countries. Adoption of urban life style tend to influence health profiles in the family. Changes in the quality of food consumed, including adoption of a “fast food culture” for convenience, and increased preferences for such food types particularly among the younger generations, are beginning to show negative results. Stress caused by conflict between work and family life also has negative effects. The result is a change in the epidemiological profile of the urban population in the region by increasing the mortality and morbidity due to diseases originating from life style changes. Living with congestion and pollution has more or less become a way of life for families living in slum and shanty dwellings. Unplanned industrial development in urban areas and the resultant over urbanization seen in most of the major cities and other urban centres of south Asia have caused massive environmental degradation and pollution problems. Provision of necessary services, safe water supply, sewerage and other services and facilities for families living in urban areas, has become major problems for urban planners.

3. Demographic aging and retirement
   (i) Demography of aging
   (ii) Impact of aging on family
   (iii) Impact of aging on health care

(i) Demography of ageing

Demographic ageing is defined as an increase in the share of the aged population in relation to other segments in the age structure of a population. The changing demographic scenario in the south Asian countries has led to a significant increase in the proportion of older persons. In combination with economic development and social change, increases in the average lifetime of the individual allow for greater time spent in family roles. (UN, 1994) the demographic ageing process and the resultant issues are an outcome of irreversible changes. Among the observed effects of mortality decline are changes that occurred in fertility. In addition to the impact of social change, which reduced the desirability of large families, the success of family planning programmes contributed to a decline in fertility. Lower fertility meant that the proportion of older persons to the total population began to rise. International migration of younger persons further aggravated the situation. The age selectivity of migration skewing towards younger ages contributed to the ageing of societies (UN, 1999). The highest proportion of older persons (age 60 years and more) is reported in Sri Lanka. The medium variant projection shows that this proportion would increase to 18 per cent by 2025. The projected female life expectancy at birth of Sri Lanka, for the period 2000-05, is 75.9 years, while
for Afghanistan the projected level is 43.5 years. In Maldives, Nepal and Pakistan the life expectancy at birth of males is higher than that of females. By 2025-30 it is projected that in all countries of south Asia females will enjoy longer life spans than males. More significant is the progressive upward trend in the growth rate of older persons and declining trends in national growth rates. Increasingly large proportions of older persons will be dependent on a gradually declining proportion of people of working age (those who are 15 to 59 years). Associated with these trends affecting the economy are implications related to family support of older persons (UN, 1999). Support ratios, which measure the number of persons in the working ages per every older person, have declined in most countries in south Asia. The support ratio will decline significantly in the next two decades. Older persons in south Asian countries face many problems such as insolvency, loss of authority, social insecurity, inadequate health care services, insufficient recreational facilities, lack of overall physical and mental care problems associated with living arrangements. Ultimately these problems affect the family.

(ii) Impact of ageing on family

The traditional obligations towards parents and the duty, to provide them with the love and care that they deserve, are now becoming difficult to fulfill as the search for employment opportunities takes their sons and daughters more to locations away from their homes and to distant lands (UN, 1999). The process of ageing ultimately leads to loss of formal occupation and loss of income causing economic hardship resulting in loss of self sufficiency and economic independence and decline in overall standards of living. The bulk of employment in south Asian countries is in the agricultural sector. In south Asian countries, there has been a long tradition of supporting the older members of the family, a feature which is still prevalent, and provides economic security for the majority of older persons, particularly in the rural areas. Nevertheless, changing family patterns and size, have weakened this security system of older persons. Past experience in Pakistan shows that older persons provided monetary assistance to the family budget from their savings. In such instances, the economic status of older persons is positively associated with their ability to be self-sufficient in basic needs.

Ageing has caused changes in the structure of the population in the region. In this respect the age pyramid of population provides a visual insight to the relative sizes of older and younger cohorts. The dramatic shift in the age pyramid of a population towards more mature age groups occurs with population ageing and could also be understood as a shift in the relationships within a family between the younger and the older generations. With high fertility, the middle segment of the population pyramid who constitute, the “productive” generation had to accept the responsibility of supporting many young dependents and few old dependants. With a low fertility regime, at least after the passage of few generations, the size of older and young cohorts becomes more similar. A large majority of older Sri Lankans are cared for by their families, in most cases by co-residing children. More than 80 per cent of older persons live with their children and two thirds live in households with at least four other people. In traditional peasant agrarian societies, production tends to be family-based and unspecialized. With modernization production shifts to more specialized processes, modern market economies are dependent on an inherent division of labour. Increasing individualism in the labour market eventually diffuses in to other areas of life, including the legal system, family relations and social values. Parental authority of elderly parents over adult children weakens, and generally loses most of its economic and legal basis. This is particularly the case in the event of rapid urbanization, where the members of the extended family living in rural areas are left behind in rural areas, as children move to the cities. This is an important process affecting the family structure. Increased schooling may break down traditional values and norms, including family values, which entails a specific obligation for the children to support and care for their elderly parents.

(iii) Impact of ageing on health care costs

Population ageing leads to increased health care costs. These have an impact on both government health expenditures and household expenditures after the age of 65 years or so, the probability of
disability or of impairment in general functioning increases dramatically. While people are increasingly living beyond seventy years of age, the increased life expectancy is not necessarily additional years of life free of disability. As the number of disabled older persons increases, these individuals will need additional support in order to maintain themselves. With increasing numbers of older persons, the number of persons with disabilities is likely to grow (UN, 1996). This poses a major economic hardship for many south Asian families. Within the domain of extended family relationships, the concern expressed and help given by the family members to older persons during sickness or disability is usually more conspicuous. The traditional solidarity between generations helps to ensure a sufficient level of social security. Such mutual help has not only been prevalent for the sustenance of family social and economic ties but has also extended beyond the domains of the family to the community level. Because of greater longevity among women in most countries in Asia, and the tendency for men to marry women younger than themselves, women are more likely than men to end their lives as widows. The implication of this is a serious gender asymmetry in the support and care of older persons. The economic and social problems for older women are in many cases worse than for men. Older women are often economically dependent on others, especially in populations where female economic activity in general is low. The prolonged care of such women (because of longer life span) necessitate that those on whom they depend for livelihood, should have sufficient financial resources (UN, 1996).

4. Impact of the HIV/AIDS pandemic on the family
   (i) HIV/AIDS infection in south Asia
   (ii) Impact on the family

(ii) HIV/AIDS infection in south Asia

Few HIV infections and aids cases were detected in Asia before the mid 1980’s. Since then, the number of HIV infection has continued to rise markedly in several Asian countries. During the year 2000, 5.3 million persons were newly infected with HIV. More than 700,000 of these new infections are in south and south east Asia. More than 173,000 aids cases have been reported from many countries of this region. The most rapid growth of HIV/AIDS infections in south Asia was occurring in India and there is a serious threat of a major generalized epidemic. In 2001, India had a population of 1,025,096,000 and out of this population 3,800,000 adults were infected with HIV/AIDS. The number cases had increased by 300,000, from 1999 to 2001. In India approximately 9 per cent of people infected by HIV died in 1999 (UNAIDS and WHO, 2001). The Indian epidemic is fueled by both married and unmarried men visiting sex workers (AIDSCAP, Harvard School of Public Health and UNAIDS, 1996). The spread of the disease in other countries of the sub continent is slower. In 1999, only 73 thousand were infected with HIV/AIDS in Pakistan, 33 thousand in Nepal, thirteen thousand in Bangladesh, and 7 thousand in Sri Lanka.

(ii) Impact on the family

Of AIDS strips the family of assets and income earners. The costs for a family of a prolonged illness include additional expenditures particularly on health, lost income, and re-allocation of work and domestic responsibilities. The illness or deaths of parents because of HIV can deplete family structures. Children don’t get parental love, protection and care. Often children are sent to relatives for upbringing (WHO, 2001 and UNAIDS, 2002) or grandparents have to stand in as parents for their grandchildren. Family incomes usually decline because sickness makes adults unable to work. Children often have to take on adult roles in the family and they have to take on responsibilities, including earning money, for the survival of the family in the absence of capable adults caretakers HIV/AIDS increases the number of orphans in the world. An estimated 14 million children have lost one or both parents due to AIDS. In south and Southeast Asia there were estimated to be 1,800,000 orphans. As the number of adults dying of AIDS rises over the next decade increasing number of orphans will grow up without parental love and be deprived of their basic rights to house foods health and education (UNAIDS, 2002). AIDS patients are cared for by their families with most of the burden borne by women including wives, mothers, sisters, daughters, aunts and grandmothers. Especially because of the very different roles played by women and men death is a gendered experience. The death
of women will also impact home and family, as fathers have to accept the mother’s role in the home.

5. **Globalization**

   (i) **Impacts on South Asian family**

   (ii) **Struggle for survival and implications**

   (iii) **Implications of income generation on family**

   (iv) **Phase of transition towards nuclear concept**

The globalization is defined as a mass process in which various, geographical regions, economies and states and the people belonging to different cultures of the globe are linked together in an efficient and meaningful way. It is a combination of various administrative, economic and political processes paving the way for increased global inter-dependence. According to the 1997 report of the Asia Pacific Commission, globalization is a process in which capital, goods and services, technology, information, and various cultural items flow freely beyond national boundaries. Substantial changes in consumption and investment sphere have occurred due to huge increases in foreign direct investments and the large amounts of international bank lending. In the sphere of work and pleasure the effect of globalization is shown by the increasing numbers of migrant workers and tourists. The changes in communications are reflected in the rapid increase of telephone and internet usage. Globalization of the privatization process is reflected in the massive growth of the number of multinational companies. There are about 53000 multinationals and 450000 affiliates in the world now. There are differing views on the impact of globalization some view it as an engine of development others see it as a new version of neo-colonialism operating at the expenses of poor countries.

(i) **Impacts on South Asian family**

Globalization has caused most of the governments of the region to restrict and curtail the welfare policies that they implemented for a long period in the past. Budgetary cuts in health and education sectors have the greatest impact on the family domain and its functioning. Most of the population in the region are poor and are highly dependent upon the welfare provisions of the government. In Sri Lanka during the 1981-1985 period allocation of resources for health amounted to one per cent of GDP and constituted 4.1 per cent of the total government expenditure. This allocation increased marginally to 1.6 per cent of the GDP during the second half of 1980s. But in the previous 1978-82 period, the allocation amounted to an average of 19 per cent total government expenditure. Such recurrent expenditure reductions have resulted in substantial declines in the use of diagnostic equipment, over crowding in hospitals, inefficiencies in provision of health care services and overall decline in the quality of the services rendered. These changes in welfare policies will directly affect the health and the nutrition level of the new born members of the family. Most families, especially urban families are influenced by the socio-cultural agents of globalization such as television, movies, and radios which drive them in the direction of consumerism. The new trend is marked by the emergence of a new urban middle class (NUMC), stimulated by the trends in globalization and information technology. The new middle class families live in modern houses and apartments; own luxury vehicles and other status symbols; engage in overseas traveling; educate their children in international colleges; shop at modern supermarkets with credit cards; seek private hospitals and services for maintaining health care. At first, the new life style had been restricted to NUMC only, but with the expansion of liberalized media technologies NUMC consumerism patterns seems to be invading rather rural families and wider social strata rapidly. The impact of television on intra family relations had been quite considerable, irrespective of the class position of the respondents. This situation could be generalized for the countries of the region to a greater or lesser extent.

(ii) **Struggle for survival and implications**

Alternative ways and means have been found by families to balance increasing

Expenses due to welfare reductions and ever growing high inflation levels are increasing. The newly embraced global life styles require more and more income. The dual forces of globalization, namely economic and socio-cultural, have not only put pressure on the families living in this region but also have introduced almost new, alternative, methods of income generation for the house hold
units for their benefit. Foreign employment opportunities, free trade zones and huge expansion of tourism are some of the areas offering employment due to globalization, a process that has intensified in recent decades. There has been an increased demand for female labor. The employment patterns in garment factories and assembly industries are largely labour intensive with a high demand for unskilled cheap labour. Countries like Sri Lanka and India have facilitated foreign investment through economic policy, legislation and provision of infrastructure and establishments such as free trade zones with attractive incentives for the investors. Most of the south Asian countries currently gain a major part of their foreign earnings through the overseas labor force, a majority of whom are women. The tourism industry has become a major income generator, and one of the most influential agents of change in the process of socio-cultural globalization.

On the other hand working daughters in families are no longer dependents in those family units but they actively participate in fulfilling the material needs of that unit. Most of their income is essential for the unit as a means for getting better care for the sick members, educating younger members and getting access to the material items such as television and hi-fi sets.

(iii) Implications of income generation on family

To adjust to the globalization process, a related set of problems in family roles, structure and norms is encountered. Defects that have emerged in the smooth functioning of the family-based socialization process are: the problems of nutritional status of children and disorders in adult and child sexual behavior and degradation of overall intra family relationships. These are now becoming more and more common in countries of South Asia. It is pointed out that, the children of working class families with working mothers show a low level of achievement in their educational performance, relative to their middle class mates. It is further pointed out that the issue of child nutrition is highly correlated with the mother’s employment status. Two contrary outcomes are seen affecting the family socialization process. Mothers’ income from employment supports the family to maintain sufficient nutritional levels for the children. Yet malnutrition problems persist among children of working mothers, due to the quantity and the quality of food that they consume. Among mothers who are working away from home, breast feeding of infants is ignored, and incorrect timing of feedings prevail, due to tight working conditions and routines enforced by the work ethics. Thus there is positive and negative inter-action on the quality of life of the children of employed mothers. The tourist industry provides direct and indirect employment to a substantial number of families who subsequently experience various disruptions in family life. Most of the families in tourist areas adopt new social values and life styles. Over 30,000 child prostitutes are located in tourist areas of Sri Lanka. The number of drug addicts, including heroin and marijuana addicts is ever increasing. In some families, the husbands motivate their own spouses to provide sexual services for the foreigners. This lead to complex types of family disorders and life style changes in the region as globalization takes place.

(iv) Phase of transition towards nuclear concept

Globalization has tended to promote the nucleation of family units. Difficulties of child bearing and rearing due to formal sector employment, lack of government incentives, global cultural influences, and rural to urban migration have diminished the importance of the extended family. The nuclear family has a high capacity for mobility. This capability is advantageous as families move from one place to another within short periods of time due to the instability and working routines involved with new kinds of jobs. Another adaptive method of coping with new trends is for families to consume services they no longer provide directly to their members. Moving towards substitutes for familial functions and services is marked by a growing number of day care centers, super markets and take-away restaurants, homes for the aged, and paid hospitals for health care.

6. Effects of major trends on social functions of families
   (i) Poverty
   (ii) Modernization, industrialization and westernization
   (iii) The institution of family and effects of globalization
Families the world over have undergone rapid changes in their structure, functions and responsibilities during the last two decades and this is no less true in South Asia, where predominately traditional value systems with patriarchal customs and beliefs prevailed. Poverty, privatization, promotion of open market economies, advances in technology and science, effects of advances in health and epidemiological transition, changes caused by demographic transition, modernization and industrialization, urbanization, globalization, are common trends affecting families. Internal and international migration, armed conflicts, and the global pandemic of HIV/AIDS have contributed to changes in value systems affecting families in South Asia.

(i) Poverty

Poverty is common in south Asian countries. It is a dehumanizing condition which leads to marginalization and alienation of families, making family members vulnerable to social ills. Poverty has, in a way, determined the family structure. Many poor families are large in size. One explanation for the perseverance of high fertility in Bangladesh is that economic insecurity leads parents to desire a large number of children, who are considered assets in the patriarchal production structure and an insurance against old age destitution and poverty. The conceptualization is that when parents become aged, the children will look after them in Sri Lanka an affluent family has only one or two children; the tendency in the middle class is generally to have a smaller family. In a poor family usually, 4 – 8 children are found, especially in the dry zone areas. Agricultural communities need more labour and in that context, a large family is a resource base and acts as insurance for old age support. In the long run large families create problems especially about inheritance of land and property. In an agricultural society this is very crucial as fragmentation of land occurs with every generation. In Bangladesh some parents prefer sons to daughters because they have higher earning potential and are expected to assist in times of crisis or when parents are aged and no longer able to support themselves. Poverty can cause people to take part in antisocial activities such as the production and sale of illicit liquor, drugs, theft, robberies and prostitution. Drinking, drug abuse and gambling have a high prevalence in poor families compared to well to do families. Most of them are unskilled casual laborers, vendors or serving in the informal sector. They are unable to fulfill the familial roles and functions satisfactorily. This causes future generations to be uneducated, and inadequately socialized. Therefore, any poverty related policy should be a comprehensive social policy, which would address various aspects of poverty and its impact on the family. One such intervention is the in-home service and out-of-home services provided by the state through social welfare programmes. In-home services are those provided to a family in order to help it live together more safely, more comfortably or more harmoniously in its own home. The family's ability to live together in its own home is enhanced by giving support. In-home services for south Asian countries could be financial aid, protective services for children, daycare for children, older people and persons with disabilities and counseling (marriage counseling, family counseling and budget counseling). Out-of-home services are mainly for children and would be provided through adoption, foster care institutional care and intervention by the judicial system.

(iii) The institution of family and effects of globalization

Globalization accelerates the free flow of labour across continents, decreases the bargaining power of labour and creates opportunities for migration. Globalization and open economies have created opportunities for migration and this has influenced the family to change its structure. Population ageing in South Asian countries is a common feature which increases the dependency ratio and puts pressure on families. The traditional values that prevailed in the extended family system ensured economic and social support for aged parents, to be supplied by the children. The emergence of the nuclear family in place of the extended family, and international migration has made older persons more prone to destitution.

Impact of modernization on mental health

All the seven SAARC countries belong to the low income group. South Asia region accounts for around one fourth of the world population and one
fifth of psychiatrically ill patients in the world. The prevalence and problems of mental disorders in all these countries are similar. In south asia region, there are many myths and beliefs which are a barrier to the treatment of the mentally ill. Psychotic illnesses are considered a “curse from gods” or manifestations of evil spirits or punishment for sins in the past life. Many times patients are ignored, isolated or taken to sorcerers and faith healers and treated with rituals rather than with appropriate medications.

In South Asian countries where predominantly a traditional society existed for generations especially with an extended family system, a vacuum is created between the traditional society and the modern society, when modernization take place. This leads to adjustment problems and feelings of insecurity and alienation from traditional land and family. Extended family system is getting eroded due to physical, social and economic reasons, particularly in the urban settings, leading to problems of caring for children, older persons and the mentally sick who were well tolerated in the extended family. Other social problems such as housing and sanitation are prominent. Drug addiction and crime are on the increase. Family disruptions take place specifically due to adjustment problems and there is collapse of family values. Links have been found between mental disorders and adverse social conditions such as poverty, unemployment, illiteracy, homelessness, gender discrimination, migration, globalization, industrialization and modernization. Problem of substance abuse is unique unlike any experienced before.

There are very few population-based studies of mental health morbidity in member countries of the region. Mental disorders, such as dementia, depression and schizophrenia, generally affect the elderly. The proportion of elderly people - 60 years and above – is expected to increase from 5.3 per cent in 1980 to 12.4 per cent in 2025 for the whole region. In some member countries, the number of elderly is huge, e.g. In india it is estimated that there will be approximately 142 million elderly, defined as those over 60 years, by 2025.

The mental health situation in the south Asian region

Research on the relationship between urban living and schizophrenia has yielded culturally intriguing findings. The international pilot study for schizophrenia compared 1200 patients in nine countries. The investigators found that patients with schizophrenia in developing countries tended to have a less severe course and better outcomes than those in developed countries and those outcomes may be more favorable in rural settings. Favorable outcome was associated with vertical mobility, extended families, psychiatric services that included active family participation, and absence of specific community stereotypes of mentally ill persons. These findings point to the importance of cultural expectations, support systems, and stigma. High tolerance for mental illness appears to have a significantly positive impact on patients with schizophrenia in developing countries. Similarly, in the outcome of severe mental disorders study in patients with schizophrenia all measured indices had better outcomes in developing countries than in developed ones. A particularly striking finding was that 41.6% of the sample from the developed-countries cohort had impaired social functioning throughout the follow-up period, compared with 15.7% of the sample from developing countries. How much of this large difference can be accounted for by the local cultural expectations for functioning remains an unanswered question that awaits further inquiry. Chronic difficulties such as poor, overcrowded physical environments, high levels of violence and accidents, insecure tenure, and poor housing have all been shown to be associated with depression. In developing countries, major depression is projected to be the leading cause of disease burden.

National mental health policies exist in only four countries: India, Pakistan, Nepal and Bhutan. With the exception of India (policy in 1982), all of them have been developed during the late 1990s. The policies still lack comprehensiveness, and countries like India do not have policies in the area of drug and substance control and prevention of abuse. Though mental health legislations are present in some countries, they are old and need amendments. Most countries have national mental health programmes. Some of them have integrated mental health with the general health delivery system, while some have separate mental health programmes. Some countries have a separate budget
for mental health activities.

The mental health manpower is grossly inadequate. The number of psychiatrists for one million population ranges from 0.4 in India to 3 in Maldives, and the number of psychiatric nurses from 0.4 in India to 18 in Sri Lanka. The total psychiatric beds per 10,000 population range from 0.065 in Bangladesh to 1.8 in Sri Lanka.

The centralization of mental health delivery system has received a major setback in recent years and the focus has now shifted to community care rather than creating new mental hospitals. Many reasons have been identified for the failure of mental hospitals in the south Asian region, including ill-treatment of patients, geographical and professional isolation, poor reporting and accounting, bad management, poorly targeted financial resources, lack of staff training and inadequate quality assurance procedures. The concept of community care has brought the focus to individual based care and treatment, wider range of services, coordinated treatment programmes, services closer to home, ambulatory care, and partnership with caregivers.

The mental health issues can be tackled and delivery can be improved through better cooperation among the regional countries. Partnership is needed in areas like research, organizing community care, health education, public awareness through media, publication of data, training programmes, exchanges of faculty/postgraduate trainees, integration with general health care, training primary care physicians, national mental health programmes, teaching psychiatry to undergraduate medical students, general hospital psychiatry, and enlisting cooperation of private sector.

Mental health priorities in the south Asian region

The government expenditure on mental health in the majority of the SAARC countries is less than 1% of the total national health budget. Most of the people needing treatment have to spend from their own pocket, and most are not covered by insurance schemes. Hence, the majority of poor people do not get adequate treatment, or they prefer alternative forms of treatment which are cheap and affordable, but not effective.

The United Nations secretary general asked in 2001 all the governments to make mental health a priority, to allocate the resources, develop the policies and implement the reforms needed to address this urgent problem. Similarly, the director general of the world health organization addressed all the member states on the same issue. However, we are yet to see significant changes in this area.

The following mental health priorities have been recommended for this region: including mental health as one of the priorities in the national health system; allocating a separate mental health budget; integrating mental health at all levels of health delivery system; developing district mental health programmes with targets; increasing the number of psychiatrists and other mental health professionals; promoting mental health legislation; ensuring availability of psychotropic and antiepileptic drugs free of cost; supporting families and communities to take care of the mental patients and retain them within the communities for rehabilitation; arranging for social welfare and disability funds for chronically ill mental patients; performing a regular evaluation of the district mental health programmes.

The magnitude of mental health problems is huge, with limited financial and other resources, paucity of skilled mental health professionals and more emphasis on treating communicable diseases. Thus, a cost-effective strategy is necessary for better health care delivery.

This strategy may include the following elements: conceptualization, definition, demarcation and scope of “mental health” and “mental disorder”; proper positioning and marketing of “mental health” and “mental disorder”; exploitation of existing resources; establishment of workable partnerships and collaboration for shared care between various governmental departments, governmental organizations and NGOs, public and private sectors; integration of aspects of basic mental health care into all existing health, education and social welfare programmes of governments and NGOs; in-service training, support and supervision for different categories of personnel; enhancement of “mental health literacy” of general population; development of measurable “goals” and “indicators” for monitoring progress; promotion of innovative programmes of mental health service delivery, training and research.

Women and mental health

Women are particularly vulnerable and they
often disproportionately bear the burden of changes associated with modernization. In the rural setup, they would work mostly at homes but the predominantly nuclear setup of the cities and sheer economics is forcing women to venture out. Domestic violence is also highly prevalent in urban areas. In both developed and developing countries, women living in urban settings are at greatest risk to be assaulted by intimates. A meta-analysis of 13 epidemiological studies in different regions of India revealed an overall prevalence rate of mental disorders in women of 64.8 per 1000. Women had significantly higher prevalence rates for neuroses, affective disorders, and organic psychoses than men. A survey carried out in Nepal demonstrated that women had a higher psychiatric morbidity than men, with a sex ratio of 2.8:1 in the health post, and 1.1:1 in the district hospital. A study in Bangladesh showed that the sex ratio for mental disorders was 2:1 and that for suicide was 3:1.

In South Asian countries, women bear the burden of responsibilities of being wives, mothers, and care givers; at the same time a part of labor force. In 25-33% households, they are the prime source of income. Significant gender discrimination, malnutrition, overwork, domestic, and sexual violence add up to the problems. Social support and the presence of close relationships (more commonly observed in rural society) appear to be protective against violence. The rate of mental distress has been reported to be high also in working women in South-east Asian countries and cultural factors are among the contributing variables. This mental distress usually remains unacknowledged.

Old age and Mental health

Modernization alters the dynamics of society at large and family in particular. Rapid urbanization has created a huge population of older men and women left to fend for themselves in the rural areas while the young make their living in the cities. This also means less availability of caregivers when older people fall ill.

Among the psychiatric conditions, dementia and major depression are the two leading contributors, accounting, respectively, for one-quarter and one-sixth of all disability adjusted life years (DALYs) in this group. Most people with dementia live in developing countries: 60% in 2001, rising to 71% by 2040. Rates of increase are not uniform: numbers are forecast to increase by 100% in developed countries between 2001 and 2040, but by more than 300% in India, China, and their South Asian and western pacific neighbors.

Developing country health services are generally ill-equipped to meet the needs of older persons. Health care, even at the primary care level, is clinic-based: the older person must attend the clinic, often involving a long journey and waiting time in the clinic, to receive care. Even if they can get to the clinic, the assessment and treatment that they receive is orientated toward acute rather than chronic conditions. The perception is that the former may be treatable, the latter intractable and not within the realm of responsibility of health services. In developed countries, with their comprehensive health and social care systems, the vital caring role of families, and their need for support, is often overlooked. Conversely, in developing countries, the reliability and universality of the family care system is often overestimated; older people are among the most vulnerable groups, in part because of the continuing myths that surround their place in.

Mental health care of children and adolescents

Due to modernization and migration people get in touch with different cultural orientations and values. “Cultural invasions”, cultural pluralism and clashes between cultures are inevitable consequences. Children are especially vulnerable to interpersonal violence in urban areas, especially in developing countries, where cities are populated by a large percentage of children and adolescents. By 2025, 6 of 10 children will live in cities. As a result of rural-urban migration it is estimated that about 50% of the urban population in developing countries is younger than 25 years. Children and adolescents in socio-economically deprived urban areas are often drawn to antisocial behavior. In the inner city areas where degradation, poverty, drug use, and unemployment are common, it results in an explosive blend favoring violent solutions.

More than 50% of the countries in the world lack any formal child psychiatric service, and only a few countries have established a successful service system. In order to start a child mental health service program in any country, it is essential to secure
qualified child psychiatrists who will be the pioneers for the development of child psychiatry. Training people abroad, e.g. in the USA or the UK, is very consuming in time and money. It is also limited in terms of the number of trainees and the contents of training, which may not be culturally appropriate. Therefore, I would like to propose that regional training centers for child psychiatry/child mental health be established in all regions of the world (e.g., one or two centers in Asia, Africa, South America). International societies, such as the international association for child and adolescent psychiatry and allied professions, could help the regional centers by providing lecturers and faculties.

The leading international organizations like the world health organization, the international association for child and adolescent psychiatry and allied professions and the world psychiatric association should continue their efforts and take necessary actions to assist the establishment of child psychiatry/child mental health services in developing and underdeveloped countries, and that international scientific meetings should allocate time to discuss the issues involved in establishing child psychiatry services and the clinical problems of developing countries which do not have adequate child mental health/child psychiatry services.

Substance and alcohol abuse

Substance abuse

Since time immemorial, in most countries of the South Asia region, drugs have traditionally been used, in addition to alcohol, for ritual, religious and recreational purposes. These drugs were mainly cannabis products and opium. The apparent social acceptance of the use of such substances stemmed largely from the fact that there was no abuse. Where there was, it was severely ostracized. Society had very clearly drawn the line and there was no question of condoning any abuse. The South Asia region is particularly affected by the problem of substance dependence. India has become a major transshipment point for hard drugs from Pakistan to the west. Injecting illicit drugs has been fuelling the AIDS epidemic in many countries of the region. The sharing of contaminated equipment to inject drugs has been a key factor in the spread of HIV/AIDS and other infections among drug users. Seven member countries already have substance abuse policies.

Unfortunately, there seems to be a virtual epidemic of drug dependence on a global scale. A disturbing trend is that more and more young people are being drawn to this devastating addiction. WHO's strategy to address the situation for substance abuse will concentrate on demand reduction and prevention of harm to the user from the substances of abuse.

Alcohol consumption

There is clear evidence that alcohol-related morbidity and mortality is high in most countries of the region. Impairment due to excess alcohol use also adds to other negative consequences such as accidents due to drunken driving, domestic violence and reduced productivity. Methanol poisoning due to adulterated alcoholic beverages is also a problem in the region. Some wage earners spend their entire month's earnings on alcohol. According to a who study, alcohol is responsible for 3.5 per cent of the global burden of disease. Alcohol use is currently the leading cause of disability among men in the developed countries and the fourth leading cause of disability in developing countries. The situation is likely to become worse as multinational alcohol manufacturers are now aggressively targeting the developing countries, particularly in South Asia. In India, in the mid-1990s, the adult male per capita consumption was 5-6 litres and the prevalence of alcohol dependence syndrome was estimated to be 3.2 million. The total alcohol production more than doubled to 800 million litres between 1993 and 1996. Fifty per cent of all home and farm accidents were estimated to be related to regular alcohol consumption. In Sri Lanka, the adult per capita alcohol consumption increased from 3.79 to 5.11 litres between 1990 and 1997. A survey in the mid-1990s showed that 43 per cent of urban shanty dwellers and 60 per cent of estate workers consumed alcohol. A 1991 survey in Thailand revealed that 31.4 per cent of those over 14 years of age consumed alcohol (54 per cent of males and 10 per cent of females). Thailand showed an 11-fold increase in beer production between 1970 and 1993. In the democratic people's republic of Korea, the per capita consumption is reported to be 3 litres. In Myanmar, 10 per cent of all admissions to the Yangon Psychiatry Hospital in 1994-96 were due to alcohol dependence. Cirrhosis of the liver,
possibly related to excess alcohol consumption, has been reported as the third most common cause of death in Bhutan. Meanwhile, there is a need to implement effective strategies for prevention of harm from alcohol to users of alcohol. These strategies, which are being developed and implemented, include strategies for early identification and services for alcohol abuse and dependence, campaigns aimed at reducing specific problems like drunken driving and industrial accidents, and increasing public awareness about the harmful effects of alcohol abuse.

**Cigarette consumption**

In 1999, South Asia region accounted for 3.4% of the world’s cigarette consumption. 54% of this amount was consumed in India alone. Pakistan showed the highest per capita consumption of 30 packets of cigarettes amongst South Asian countries. Average per capita consumption of all South Asian countries was 10 packets.

**Strategies for control of mental disorders and substance abuse**

The regional office is developing strategies for community-based programmes on the basis of five ‘A’s: availability, acceptability, accessibility, affordable medications and assessment.

**Availability**: services which will address at least the minimum needs of

- Populations in mental disorders should be available to
  - Everyone regardless of where they live. The key questions are: what are the
    - Minimum services needed and who will deliver them?

**Acceptability**: large segments of populations in member countries continue to perpetuate superstitions and false beliefs about mental illnesses. Many believe that these illnesses are due to “evil spirits”. Thus, even if appropriate medical services are made available, they would rather go to sorcerers and faith healers. Populations need to be informed and educated about the nature of psychiatric illnesses.

**Accessibility**: services should be available to the community, in the community, and at convenient times. If a worker has to give up his daily wages and travel a substantial distance to see a medical professional who is only available for a few hours a day, he/she is unlikely to seek these services.

**Affordable medications**: frequently, medications are beyond the reach of the poor. Every effort should be made to provide essential medications uninterruptedly and at a reasonable cost. Thus, government policies in terms of taxes on medications and the role of the pharmaceutical industry in distribution and pricing become critical.

**Assessment**: being new, these programmes need to be continuously assessed to ensure appropriateness and cost-effectiveness. Changes in the ongoing programmes based on impartial evaluations are essential. The regional office has initiated some projects to assist member countries in controlling certain priority mental disorders.

**Development of mental health legislation**

During the last few decades, there have been significant developments in the field of mental health, mental health care and organization of mental health services. Similarly, considerable developments have taken place in the field of human rights and social expectations in relation to the care of the mentally ill. People with mental illness have benefited significantly from these developments.

In 1991, the UN General Assembly adopted resolution 46/119 entitled “principles for the protection of persons with mental illness and the improvement of mental health care”. However, in many countries of the region, mental health legislation does not reflect these developments. It is therefore essential to review the existing legislation and incorporate new developments with a view to improving the quality of mental health care. Mental health policies are important because they coordinate, through a common vision and plan,
all programmes and services related to mental health. In the absence of such policies, mental disorders are likely to be treated in an inefficient and fragmented manner.

The mental health policy and service development unit of the department of mental health and substance dependence at who headquarters has launched an initiative entitled mental health policy project. The goal of this project is to bring together the latest information on mental health policy and planning, compile it into a guidance package, distribute it to member countries, and assist with its implementation. The project will help countries to create policies and then put them into practice, which, in turn, should lead to improved mental health care, treatment and promotion. Some member countries (Bangladesh, India, Indonesia, Sri Lanka) have already initiated steps to develop mental health legislation based on current thinking. Workshops have been held and drafts prepared. Member countries could benefit from the experience of other member countries in the finalization of these drafts.

Community-based rehabilitation of those with mental illness

Rehabilitation and community integration of persons with mental illness and associated disabilities (particularly those in the early years of life) is effectively done at home or in a community setting, such as the school. This not only minimizes cost of rehabilitation, but also permits service provision in a familiar and caring environment. A major problem with the community-based approach in the past has been that the knowledge about rehabilitation was often thought to be the exclusive preserve of professionals who were senior and available only in hospitals. Families and community bodies responsible for the care of persons with disabilities often feel the need for guidance from trained personnel to implement even the existing programmes. A major difficulty faced by most member countries in the region appears to be the lack of trained personnel. Training community workers for basic disability work in an attempt to expand services and improve the quality of life for persons with mental illness and associated disabilities requires urgent consideration. There is a need to develop and implement a course for holistic training in the community for people with mental disabilities by adapting to local situations, changing needs over the course of time, make the content user-specific and more relevant to the ‘trainer and the trained’ for the community.

Promotion of mental health among adolescents

Adolescence is a sensitive and impressionable period in the life-cycle of a person. Healthy habits (eating a balanced diet, exercise, abstinence from alcohol and tobacco), formed at this stage, can protect from many lifestyle-related diseases later in life. Similarly, promotion of positive mental health during this period can afford protection from mental and neurological disorders later in life.

Strategies for the promotion of mental health include life skill development in coping with stress, self-esteem enhancement, problem-solving, development of interpersonal relationships and conflict resolutions. Practical and easy-to-implement modules for these strategies should be developed for implementation in the community.

Community-based strategies for prevention of harm from alcohol

Though the production and consumption of alcohol has increased alarmingly in the region, alcohol-related data are scarce and there have been few scientific studies on prevention of harm from abuse of alcohol. Beside licit alcohol, there is the serious problem of illicit alcohol, which is extremely toxic and harmful for health. Unfortunately, alcohol is considered a major source of revenue for governments. To plan community-based intervention strategies, the first step is to assess the magnitude of the problem in relation to the production, marketing and consumption patterns in the community. Based on this, countries can plan culturally appropriate strategies for prevention of harm from alcohol.

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