World Health Organization
Regional Office for South-East Asia

WORLD HEALTH DAY 2001

Mental Health

Better Understanding -
Appropriate Care
in Mental Health

Fact Sheet N°166

Revised February 2001

EPILEPSY: SOCIAL CONSEQUENCES AND ECONOMIC ASPECTS

SOCIAL IMPLICATIONS

Fear, misunderstanding and the resulting social stigma and discrimination surrounding epilepsy often force people with this disorder "into the shadows". The social effects may vary from country to country and culture to culture, but it is clear that all over the world the social consequences of epilepsy are often more difficult to overcome than the seizures themselves.

Significant problems are often experienced by people with epilepsy in the areas of personal relationships and, sometimes, legislation. These problems may in turn undermine the treatment of epilepsy.

Misunderstanding and Social Stigma

Some examples of misunderstandings about epilepsy from around the world:

- In Cameroon it is believed that people with epilepsy are inhabited by the devil. This does not mean that they are seen as evil, but that evil invades them and causes them to convulse from time to time.
- In China, epilepsy diminishes the prospect of marriage, especially for women. A survey of public awareness in 1992 revealed that 72% of parents objected to their children marrying someone with epilepsy.
- In some rural areas of India, attempts are made to exorcise evil spirits from people with epilepsy by tying them to trees, beating them, cutting a portion of hair from their head, squeezing lemon and other juices onto their head and starving them.
- In Indonesia, epilepsy is often considered as a punishment from unknown dark forces.

- In Liberia, as in other African countries, the cause of epilepsy is perceived as related to witchcraft or evil spirits.
- In Nepal, epilepsy is associated with weakness, possession by an evil spirit or the reflection of a red colour. Bystanders who witness a seizure will often spray water on the forehead of the person experiencing the seizure of make him or her smell a leather shoe.
- In the Netherlands in 1996, a person was whipped and put into isolation because her seizures were thought to result from magic.
- In Swaziland, many traditional healers mention sorcery as the cause of epilepsy.
- In Uganda, as in many other countries, epilepsy is thought to be contagious and so people with epilepsy are not allowed to join the communal foodpot for fear of others contracting epilepsy through that person's saliva.

Legislation

In many countries legislation affecting people with epilepsy has reflected centuries of suspicion and misunderstanding about epilepsy. For example, people with epilepsy are often prevented from marrying or having children:

- In both China and India, epilepsy is commonly viewed as a reason for prohibiting or annulling marriages.
- In the United Kingdom, a law forbidding people with epilepsy to marry was repealed only in 1970.
- In the United States of America (USA), many individual States prohibited people with epilepsy from marrying. The last State to repeal this law did so in 1980.
- In the In the United States of America (USA), 18 States provided eugenic sterilisation of people with epilepsy until 1956. Until the 1970s, it was also legal to deny people with seizures access to restaurants, theatres, recreational centres and other public buildings.

Employment

Unemployment and underemployment exist worldwide, but more so with people with epilepsy. The misunderstandings and stigma

mentioned previously are usually to blame for this. For instance:

- A survey in China showed that 31% of respondents believed that people with epilepsy should not be employed.
- Data from Germany, Italy and USA indicate that people with epilepsy of working age, 40%-60% are employed (although these jobs are often below their potential), 15%-20% are unemployed and about 20% retire early.
- In rural areas of India, people with epilepsy are generally looked after by their families and they usually help with their family's trade, although this will be with fewer responsibilities and less strenuous roles than "normal" people.
- In a recent research survey, nearly a quarter of Nepalese people with epilepsy took the view that they were unable to work. As in many countries, these people with epilepsy had been culturally conditioned to underrate themselves.

Treatment

Misunderstandings about epilepsy, combined with the economic and financial barriers to availability of treatment in developing countries, play an important role in preventing treatment becoming available to millions of people in developing countries. For example, culturally informed health-seeking strategies often lead the majority of people with epilepsy in developing countries to turn to traditional healers for treatment.

Economic Aspects

- In 1990, WHO, identified that, on average, the cost of the anti-epileptic drug phenobarbitone (which alone could be used to control seizures in a substantial proportion of those with epilepsy and which is on the WHO list of essential drugs) could be as low as US$ 5 per person per annum.
- The World Bank report "Investing in Health" (1993) states that, in 1990 epilepsy accounted for nearly 1% of the world's disease burden. Epilepsy commonly affects young people in the most productive years of their lives, often leading to avoidable unemployment.

KEY POINTS

- The cost and burden of epilepsy varies between countries.
- The anti-epileptic drug *phenobarbitone* can cost as little as US

$5/person/annum and can be used to treat many people with epilepsy.

- People with epilepsy continually face social stigma and exclusion. A fundamental part of ridding the world of this stigma is to raise public and professional awareness.

- Legislation which reinforces fear and discrimination must also be changed.

For further information, please contact the Office of the Spokesperson, WHO, Geneva. Tel: (+41 22) 791 2599. Fax: (+41 22) 791 4858. E-mail: inf@who.int. All WHO Press Releases, Fact Sheets and Features as well as other information on this subject can be obtained on Internet on the WHO home page http://www.who.int/

Fact Sheet N° 217
April 1999

THE 'NEWLY DEFINED' BURDEN OF MENTAL PROBLEMS

Mental and neurological problems are among the most significant contributors to the global burden of disease

- Increasingly sophisticated methods to measure health and its burden, in particular the DALY (Disability Adjusted Life Year), have helped to provide a more balanced conception of the needs and priorities in the area of health for both developing and developed countries.

What the DALY does is to quantify not only the number of deaths but also the impact of premature death and disability on a population. It combines them into a single unit of measurement of the overall burden of disease.

One DALY is one lost year of healthy life. As the table below shows, mental problems accounted for approximately 10% of all DALYs lost in 1990. They are as relevant in developing countries as in industrialized societies.

Health problems	% DALYS lost (1990)
Infectious and parasitic diseases	22.9
Unintentional injuries	11.0
Mental problems*	10.5
Cardiovascular diseases	9.7
Respiratory infections	8.5
Perinatal conditions	6.7
Malignant neoplasms	5.1

*Mental problems include unipolar and bipolar affective disorders, psychosis, epilepsy, dementia, Parkinson's disease, multiple sclerosis, drug and alcohol dependence, post-traumatic stress disorder, obsessive compulsive disorder, panic disorder, other neuropsychiatric disorders.

- It is also of great significance that 5 of the 10 leading causes of disability worldwide (major depression, schizophrenia, bipolar disorders, alcohol use, obsessive compulsive disorders) are mental problems. They are as relevant in developing countries as they are in industrialised societies

While there have been dramatic improvements in physical health in most countries, particularly unprecedented improvements in mortality rates, the mental component of health has not improved over the past 100 years. In fact, in many instances it has deteriorated significantly.

- Average life expectancy in low income countries such as Democratic

Republic of Congo, Egypt and India have risen from 40 to 66 years, infant mortality rates have plummeted, smallpox has been eradicated and many other infectious diseases brought under stricter control.

- In sharp contrast, mental, behavioural and social health problems, involving hundreds of millions of individuals, have become much bigger contributors to the global health burden. That emerges clearly from the table below:

Mental problems and neurological disorders	Number of cases (millions)
Major depressive disorders	340
Alcohol related problems	288
Mental retardation	60
Epilepsy	40
Dementia (including Alzheimer's disease)	29
Schizophrenia	45
Attempted suicides	10-20
Completed suicides	1

Mental problems tend to proliferate as a result of complex, multiple biological, psychological and social factors such as war, poverty and limited access to resources.

Mental problems are experienced by those suffering from serious and/or chronic 'physical' diseases and from war and trauma. They exist even when the above conditions are not present.

- In most cases, a complex interaction process between biological, psychological, and social factors contributes substantially to the development of mental health and neurological problems.
- Strong links have been made between mental health problems with a biological base, such as depression and changes in social behaviour, interpersonal support, personal coping, and adverse social conditions, such as high unemployment, limited education, gender discrimination, human rights violations, and poverty.

The future will bring an expotential increase in mental health problems

- The burden of mental and neurological problems is likely to become even heavier in the coming decades and will raise serious social and economic obstacles to global development unless substantive action is taken.
- Given the ageing of the population, exacerbating social problems and unrest, the burden of mental problems will grow substantially.

Specific reasons include: (1) increased life-expectancy of those with mental disorders; (2) a larger number of people reaching young adulthood, leading to a greater number of people developing schizophrenia; (3) a larger number of people surviving into old age, adding to the greater number of people suffering from dementia.

The incidence of depressive illness increases with age, and it is predicted that depression will be the second leading cause of disease burden in 2020. This is a sobering thought.

The rapidly rising numbers of persons affected by violent conflicts, civil wars and disasters, and the growing number of displaced persons will contribute to psycho-social problems and interpersonal violence within communities. Such populations have been systematically shown to have increased rates of mental disorders, including post-traumatic stress, depression and alcoholism. It is, therefore, urgent to deal with mental problems.

There are groups at special risk of developing mental problems

- Beyond the striking statistics related to suffering from defined mental disorders, there are many categories of people who, because of extremely difficult circumstances, are at special risk of being affected by mental problems. Amongst them are persons living in extreme poverty, such as slum-dwellers; children and adolescents experiencing disrupted nurturing, abused women, abandoned elderly people, others traumatised by violence, such as the victims of armed conflicts, migrants, including refugees, and many indigenous persons.

Mental health and well-being now constitute important challenges for mankind

Since physical illness and disease, wars, violence and poverty in the world are unlikely to disappear, and biological predispositions to mental problems will continue to affect a great many people. Mental problems need to be addressed now and in the future.

Mental health problems will only be addressed when there is sufficient awareness, commitment and resource allocation

Mental health and well-being have nearly always had a lower priority than communicable diseases and other 'physical' maladies, despite their significant impact on mortality and morbidity. But we are now in a position to make use of the wealth of knowledge and technology that allows us to effectively manage, treat and prevent a wide range of mental health, neurological and substance use problems.

- It is time to review priorities and commitments and to recognize that substantial benefits will accrue through investing in mental health. Many communicable diseases are now under control, but only as a result of public awareness and a commitment to address the problem.

Key mental health issues for all countries of Europe

- What is the level of responsibility of the public sector in addressing mental health issues and maintaining the highest possible standards for mental health in the midst of economic recession and an associated decline in resources?
- How do we find the appropriate balance between mental health promotion, which seeks to improve the mental health and well being of entire populations, and mental health service delivery, whose aim is to improve the mental health and living conditions of individuals suffering from mental problems and of their families?

For further information, journalists can contact :
WHO Press Spokesperson and Coordinator, Spokesperson's Office,
WHO HQ, Geneva, Switzerland / Tel +41 22 791 4458/2599 / Fax +41 22 791 4858 / e-Mail: inf@who int

Fact Sheet N° 218
April 1999

THE 'UNDEFINED AND HIDDEN' BURDEN OF MENTAL HEALTH PROBLEMS

The **Undefined Burden** of mental problems refers to the economic and social burden for families, communities and countries. Although obviously substantial, this burden has not been efficiently measured. This is because of the lack of quantitative data and difficulties in measuring and evaluating.

The Hidden Burden refers to the burden associated with stigma and violations of human rights and freedoms. Again, this burden is difficult to quantify. This is a major problem throughout the world, as many cases remain concealed and unreported.

Undefined Burden

Mental illnesses affect the functioning and thinking processes of the individual, greatly diminishing his or her social role and productivity in the community. In addition, because mental illnesses are disabling and last for many years, they take a tremendous toll on the emotional and socio-economic capabilities of relatives who care for the patient, especially when the health system is unable to offer treatment and support at an early stage. Some of the specific economic and social costs include:

- lost production from premature deaths caused by suicide (generally equivalent to, and in some countries greater, than deaths from road traffic accidents);
- lost production from people with mental illness who are unable to work, in the short, medium or long term;
- lost productivity from family members caring for the mentally-ill person;
- reduced productivity from people being ill while at work;
- cost of accidents by people who are psychologically disturbed, especially dangerous in people like train drivers, airline pilots, factory workers;
- supporting dependents of the mentally ill person;
- direct and indirect financial costs for families caring for the mentally-ill person;
- unemployment, alienation, and crime in young people whose childhood problems, e.g., depression, behaviour disorder, were not sufficiently well addressed for them to benefit fully from the education available;
- poor cognitive development in the children of mentally ill parents, and the
- emotional burden and diminished quality of life for family members.

The Hidden Burden

Stigma can be defined as a mark of shame, disgrace or disapproval which results in an individual being shunned or rejected by others. The stigma associated with all forms of mental illness is strong but generally increases the more an individual's behaviour differs from that of the 'norm'.

Because of stigma, persons suffering from a mental illness are:

- often rejected by friends, relatives, neighbours and employers leading to aggravated feelings of rejection, loneliness and depression;
- often denied equal participation in family life, normal social networks, and productive employment;
- Stigma has a detrimental effect on a mentally ill person's recovery, ability to find access to services, the type of treatment and level of support received and acceptance in the community;
- Rejection of people with mental illness also affects the family and caretakers of the mentally ill person and leads to isolation and humiliation; and
- A major cause of stigma associated with mental illness are the myths, misconceptions and negative stereotypes about mental illness held by many people in the community.

The stigma can be reduced by:

- openly talking about mental illness in the community;
- providing accurate information on the causes, prevalence, course and effects of mental illness;
- countering the negative stereotypes and misconceptions surrounding mental illness;
- providing support and treatment services that enable persons suffering from a mental illness to participate fully in all aspects of community life;
- ensuring the existence of legislation to reduce discrimination in the workplace, in access to health and social community services.

Human rights violations

Persons experiencing mental problems are more vulnerable than others in their social dealings and, as a result, are at a relatively higher risk to have their human rights and freedoms violated. These include:

- the right not to be discriminated against (e.g., in access to health care, social services or employment);
- the right to liberty (e.g., not to have restrictions automatically imposed on freedom of movement through measures such as detention);
- the right to integrity of the person (e.g., not to be unduly subjected to mental or physical harm. Typical violations include treatment that ignores the requirement to obtain either the patient's informed consent or a surrogate decision-maker's, and sexual abuse);
- The right to control one's own resources (e.g., one should not be automatically removed on the mere grounds of status as a mental patient, but should be judged on his or her actual ability to manage resources).

Mental health legislation – a necessary requirement

General principles for mental health legislation to protect the rights of the mentally ill include:

- **Respect for individuals and their social, cultural, ethnic, religious and philosophical values.**
- **Individuals' needs taken fully into account**. Individual's need for health and social care must be assessed thoroughly. In particular, it is important to ensure that the views of an individual (and his or her carers) are considered. For this to happen, there must be close liaison between health, housing and social care services.
- **Care and treatment provided in the least restrictive environment**. In order to uphold this principle, legislation should be framed so that involuntary (formal) hospital admission is a last resort. This can be achieved through: clearly defined grounds for detention; procedural safeguards when the power to detain is used; an obligation to discharge when grounds for detention are no longer met; an independent review of the decision to detain.
- **Provision of care and treatment aimed at promoting each individual's self- determination and personal responsibility**. It is vital that individuals are given the opportunity to exercise choice and make decisions about their own care and treatment. Legislation should aim to ensure that: treatment can be imposed only in strictly limited and clearly defined circumstances and must be the least restrictive alternative; where individuals are unable to make decisions for themselves, steps are taken to find out their wishes and feelings; clear information on treatment and detention is readily available; appropriate provisions for confidentiality are in force.
- **Provision of care and treatment aimed at achieving the individual's own highest attainable level of health and well-being**. In addition, to issues of quality and continuity of care, this principle addresses the question of a "right" to treatment. It can also cover more general issues such as the requirement that the individual should be cared for properly in a safe environment and subject only to restrictions for reasons of his or her health or safety, or the safety of others. In this regard: there should be no restrictions on an individual's contact with friends and family, except in rare and clearly defined circumstances; stringent safeguards from abuse, exploitation and neglect should be in place.

For further information, journalists can contact :
WHO Press Spokesperson and Coordinator, Spokesperson's Office,
WHO HQ, Geneva, Switzerland / Tel +41 22 791 4458/2599 / Fax +41 22 791 4858 / e-Mail: inf@who.int

Fact Sheet N° 219
April 1999

STRENGTHENING COMMUNITY MENTAL HEALTH SERVICES AND PRIMARY CARE

Community mental health services and primary care

During the past 20 years there have been radical changes in psychiatric care in Europe as a result of "deinstitutionalisation" of psychiatric patients. That is to say, those previously kept in large public mental hospitals were now discharged and reintegrated into the community where they received treatment and care. It had become clear that these institutions caused long-term damage to individuals' health and ability to function in society.

Deinstitutionalisation means (1) avoiding mental hospital admissions through the provision of community treatment alternatives, (2) the release into the community of all institutionalised patients who have been given adequate preparation for such a change, and (3) the establishment and maintenance of community support systems for non-institutionalised people.

Whilst the deinstitutionalisation process is much more advanced in Western Europe than in Eastern Europe, the issue of strengthening community mental health services is relevant for all European countries.

There is broad scientific support for the belief that an approach to treatment and care based on deinstitutionalisation and its replacement by community treatment and care leads to better results in respect to (1) global symptoms of mental illness, (2) psycho-social adjustment, (3) admission and readmission rates to mental hospitals, (4) length of hospital stay, (5) employment and (6) reduced burden for the family.

Clinical trials have shown that the important elements of an effective response to mental health and neurological problems are psychological and social intervention (independent living skills, training in social skills, vocational training, social support networks, family intervention) and pharmacotherapy (neuroleptics, lithium, antidepressants and anxiolytics).

For most disorders it is essential that pharmacotherapy be used in combination with other specific psychological and social interventions.

The efficacy of these treatments will be reduced substantially if they are not delivered within the context of a comprehensive and coordinated delivery service.

Requirements of a comprehensive community mental health service include:

- crisis intervention
- beds for acute episodes of severe and acute illness in general hospitals
- long-stay accommodation with a 24-hour staff in home-like units, for people

with enduring mental illness who need regular supervision of medication and daily monitoring of their mental state but who do not require the continuous presence of medical staff

- day care programmes
- concerted outreach efforts
- supported housing
- home services
- occupational rehabilitation programmes
- patient and family support services
- multidisciplinary health care teams.

Requirements of primary health care are (1) an adequately trained staff to assess, diagnose and manage mental problems, (2) availability of essential drugs for the treatment of mental disorders, (3) establishment of effective links with more specialist care, including well developed criteria for referral, methods of shared care, adequate information systems and communication, and (4) creation of appropriate links with other community and social services.

WHO is supporting the creation of a number of demonstration projects in 14 countries to strengthen community mental health services and primary health care. The major themes include (1) increasing the awareness of the community and educating it about mental health, (2) deinstitutionalisation, (3) reorganisation of mental health services, (4) creation of community mental health services and outreach programs, (5) training of primary care providers, (6) training of psychiatrists, and (7) psycho-social rehabilitation.

For further information, journalists can contact :
WHO Press Spokesperson and Coordinator, Spokesperson's Office,
WHO HQ, Geneva, Switzerland / Tel +41 22 791 4458/2599 / Fax +41 22 791 4858 / e-Mail: inf@who.int

Fact Sheet N° 220
April 1999

STRENGTHENING MENTAL HEALTH PROMOTION
Mental health is not just the absence of mental disorder

- The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." WHO's 191 member states have endorsed this sweeping statement.

How does one define mental health?

- It is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
- Mental health promotion is an umbrella term that covers a variety of strategies, all aimed at having a positive effect on mental health. The encouragement of individual resources and skills and improvements in the socio-economic environment are among them.
- Most health care resources are spent on the specialised treatment and care of the mentally ill, and to a lesser extent on community treatment and rehabilitation services. Even less funding is available for promoting mental health.
- Mental health promotion requires multi-sectoral action, involving a number of government sectors such as health, employment/industry, education, environment, transport and social and community services as well as non-governmental or community-based organisations such as health support groups, churches, clubs and other bodies.

Enhancing the value and visibility of mental health

- National mental health policies should not be solely concerned with mental illness but recognise and address the broader issues affecting the mental health of all sectors of society. These would include the social integration of severely marginalized groups, such as refugees, disaster victims, the socially alienated, the mentally disabled, the very old and infirm, abused children and women, and the poor.

Mental health promotion for children and adolescents

- Psychosocial and cognitive development of babies and infants depends upon their interaction with their parents. Programmes that enhance the quality of these relations can improve substantially the emotional, social, cognitive and

physical development of children. These activities are particularly meaningful for mothers living in conditions of stress and social adversity. WHO has developed an international programme to stimulate mother-infant interaction that has been widely adopted.

- It is clear that schools remain a crucial social institution for the education of children in preparation for life. But they need to be more involved in a broader educational role fostering healthy social and emotional development of pupils.
- WHO has developed a 'life skills' educational curriculum, which teaches a wide range of skills to school age children to improve their psychosocial competency. The skills include problem-solving, critical thinking, communication, interpersonal skills, empathy, and methods to cope with emotions. These skills enable children and adolescents to develop sound and positive mental health.
- "Child-friendly schools" are another WHO mental health initiative to promote a sound psychosocial environment in the school to complement the life skills curriculum. A child-friendly school encourages tolerance and equality between boys and girls and different ethnic, religious and social groups. It promotes active involvement and cooperation, avoids the use of physical punishment, and does not tolerate bullying. It is also a supportive and nurturing environment; providing education which responds to the reality of the children's lives. Finally, it helps to establish connections between school and family life, encourages creativity as well as academic abilities, and promotes the self-esteem and self-confidence of children.

Working life and employment

- Special emphasis should be given to those aspects of work places and the work process itself which promote mental health. Eight areas of action have been identified: increasing an employer's awareness of mental health issues; identifying common goals and positive aspects of the work process; creating a balance between job demands and occupational skills; training in social skills; developing the psycho-social climate of the workplace; provision of counselling; enhancement of working capacity, and early rehabilitation strategies.
- Another significant issue is unemployment, in particular, youth unemployment. In this area, mental health promotion strategies seek to improve employment opportunities, for example, through programmes to create jobs, provide vocational training, and social and job seeking skills.

Mental health promotion and the ageing population

- Ageing of the population is a highly desirable and natural aim of any society. By 2025 there will be 1.2 billion older people in the world, close to three-quarters of them in the developing world. But if ageing is to be a positive experience it must be accompanied by improvements in the quality of life of those who have reached - or are reaching - old age.
- WHO is responding to the challenge by launching a "global movement on active ageing". This is a new network for all those interested in policies and practices concerning active ageing. In this respect active ageing encompasses all dimensions, physical, mental and social. WHO considers that only by promoting older persons' citizen rights and aspirations will they

be able to live their lives to their full potential. A healthy, active older person is a resource for the family, the community and the economy. The "global movement on active ageing" takes in all of civil society and will be symbolically launched on 2 October 1999, the International Day of Older Persons, as part of the International Year of the same name.

Measuring and promoting quality of life

- WHO has developed a tool to assess quality of life as an additional measurement, along with the traditional morbidity and mortality data. A primary goal of mental health promotion is to help member states improve the quality of life of their people and to place mental health firmly on the national agenda.

For further information, journalists can contact :
WHO Press Spokesperson and Coordinator, Spokesperson's Office,
WHO HQ, Geneva, Switzerland / Tel +41 22 791 4458/2599 / Fax +41 22 791 4858 / e-Mail: inf@who.int

Fact Sheet No 248
June 2000

WOMEN AND MENTAL HEALTH

Background

In many under-served populations, women have considerable mental health needs. However, until recent years, the conception of women's mental health has been limited as have attempts to protect and promote it. When women's health issues have been addressed in these populations, activities have tended to focus on issues associated with reproduction - such as family planning and child-bearing - while women's mental health has been relatively neglected (WHO, 1993; WHO, 1995).

Women are integral to all aspects of society. However, the multiple roles that they fulfill in society render them at greater risk of experiencing mental problems than others in the community. Women bear the burden of responsibility associated with being wives, mothers and carers of others. Increasingly, women are becoming an essential part of the labour force and in one-quarter to one-third of households they are the prime source of income (WHO, 1995).

In addition to the many pressures placed on women, they must contend with significant gender discrimination and the associated factors of poverty, hunger, malnutrition and overwork. An extreme but common expression of gender inequality is sexual and domestic violence perpetrated against women. These forms of socio-cultural violence contribute to the high prevalence of mental problems experienced by women.

Significant mental disorders and problems experienced by women

In investigating common mental, behavioural and social problems in the community we find that women are more likely than men to be adversely affected by specific mental disorders, the most common being: anxiety related disorders and depression; the effects of domestic violence; the effects of sexual violence; and escalating rates of substance use.

Mental disorders

Prevalence rates of depression and anxiety disorders as well as psychological distress are higher for women than for men. These findings are consistent across a range of studies undertaken in different countries and settings (Desjarlais et al, 1995). In addition to the higher rates of depression and anxiety, women are much more likely to receive a diagnosis of obsessive compulsive disorder, somatization disorder and panic disorder (Russo, 1990). In contrast men are more likely to receive a diagnosis of antisocial personality disorder and alcohol abuse/dependency. The gender differences associated with mental disorders are brought out most clearly in the case of depression (Russo, 1990). Data from the

World Bank study revealed that depressive disorders accounted for close to 30% of the disability from neuropsychiatric disorders amongst women in developing countries but only 12.6% of that among men. The disparity in rates between men and women tend to be even more pronounced in underserved populations (World Bank, 1993).

Gender differences in mental disorders

Explanations for the gender differences in mental disorders have been discussed in relation to different help-seeking behaviours of the sexes, biological differences, social causes and the different ways in which women and men acknowledge and deal with distress (Paykel, 1991). Blue et al, (1995) argue that while all these factors may contribute to higher rates of depression or psychological problems among women, social causes seem to be the most significant explanation. Women living in poor social and environmental circumstances with associated low education, low income and difficult family and marital relationships, are much more likely than other women to suffer from mental disorders. They conclude that the combined impact of gender and low socio-economic status are critical determinants of mental ill-health (Blue et al, 1995).

Promoting women's mental health

It is essential to recognise how the socio-cultural, economic, legal, infrastructural and environmental factors that affect women's mental health are configured in each country or community setting. A gender-based, social model of health needs to be adopted to investigate critical determinants of women's mental health with the overall objective of contributing to improved, more effective promotion of women's mental health. Risk factors for mental disorder as well as for good mental health need to be addressed and where possible, a clear distinction should be made between the opportunities that exist for individual action and individual behaviour change and those that are dependent on factors outside the control of the individual woman.

To help clarify the meaning women themselves ascribe to mental health and various forms of psychological distress, findings from qualitative research need to augment those from quantitative research. Descriptions of life situations, case studies and direct quotes from women themselves can vivify the contexts in which emotional distress, depression, anxiety and other psychological disorders occur. Such first hand accounts of the experiences of poverty, inequality and violence will assist in developing a more accurate understanding of the structural barriers women face in attempting to exercise control over the determinants of their mental health and in effecting behavioural change. Both are needed to better inform the promotion of women's mental health.

Women's views and the meanings they attach to their experiences have to be heeded by researchers, health care providers and policy makers. Without them, research and the evidence it gathers, service delivery and policy formation, will be hampered in responding to women's identified health priorities, problems and needs. Moreover, all three will be ignorant of the nature and magnitude of unmet needs and unaware of the factors influencing women's utilisation of health care.

The identification and modification of the social factors that influence women's

mental health holds out the possibility of primary prevention of certain mental disorders.

Further Reading

1. Women's mental health: An evidence based review. WHO, March 2000.

For further information, journalists can contact :
WHO Press Spokesperson and Coordinator, Spokesperson's Office.
WHO HQ, Geneva, Switzerland / Tel +41 22 791 4458/2599 / Fax +41 22 791 4858 / e-Mail: inf@who.int

Stop Exclusion
Dare to Care

Message from the Regional Director

Populations of Member Countries of the World Health Organization's South-East Asia Region have suffered for ages from many communicable diseases. While some of these have been successfully controlled, others continue as serious public health problems. However, recently, it has become increasingly clear that noncommunicable diseases, including mental and neurological disorders, are important causes of suffering and death in the Region. An estimated 400 million people world-wide suffer from mental and neurological disorders or from psychosocial problems such as those related to alcohol and drug abuse. Our Region accounts for a substantial proportion of such people. Thus, the Region faces the double burden of diseases – both communicable and noncommunicable. Moreover, with the population increasing in number and age, Member Countries will be burdened with an ever-growing number of patients with mental and neurological disorders.

As Dr Gro Harlem Brundtland, the Director-General of the World Health Organization says, "Many of them suffer silently, and beyond the suffering and beyond the absence of care lie the frontiers of stigma, shame, exclusion and, more often than we care to know, death".

While stigma and discrimination continue to be the biggest obstacles facing mentally ill people today, inexpensive drugs are not reaching many people with mental and neurological illnesses. Although successful methods of involving the family and the community to help in recovery and reduce suffering and accompanying disabilities have been identified, these are yet to be used extensively. Thus, many population groups still remain deprived of the benefits of advancement in medical sciences. Dr Brundtland has said, "By accident or design, we are all responsible for this situation today."

The World Health Organization recently developed a new global policy and strategy for work in the area of mental health. Launched by the Director-General in Beijing in November 1999, the policy emphasises three priority areas of work: (1) Advocacy to raise the profile of mental health and fight discrimination; (2) Policy to integrate mental health into the general health sector, and (3) Effective interventions for treatment and prevention and their dissemination. The South-East Asia Regional Office of the World Health Organization is committed to promoting this policy.

Mental health care, unlike many other areas of health, does not generally demand costly technology. Rather, it requires the sensitive deployment of personnel who have been properly trained in the use of relatively inexpensive drugs and psychological support skills on an outpatient basis. What is needed, above all, is for all concerned to work closely together to address the multi-faceted challenges of mental health.

Dr Uton Muchtar Rafei
Regional Director, WHO South-East Asia Region

Agenda for the Mental Health Programme in the South-East Asia Region

Mental health can be measured in terms of a person's well-being where he/she is able to maintain "an inner sense of comfort" in as many life situations as possible. Mental health can also be seen in terms of how good individuals feel about themselves, feel comfortable with other people and cope with the demands and stresses of everyday life.

Historically, disease burden has been based on mortality statistics, which do not take into account non-fatal conditions such as neuropsychiatric illnesses. When disease burden measurements include an element of the time lived with disability, neuropsychiatric conditions emerge as major contributors to the suffering of populations. According to the World Health Report 1999, an estimated 10% of the burden from noncommunicable diseases measured in disability-adjusted life years in 1998 was accounted for by neuropsychiatric conditions in low and middle income countries. Neuropsychiatric conditions were responsible for the loss of one out of ten disability-adjusted life years in these countries. Population-based data on the magnitude of these conditions in Member Countries of the WHO South East Asia Region (SEAR) are now being compiled.

In SEAR Member Countries, mental health programmes have generally concentrated on hospital-based psychiatry. However, there is increasing awareness in these countries of the need to shift the emphasis to community-based mental health programmes. The WHO Regional Office for South-East Asia is concentrating on supporting Member Countries on the development of community-based mental health programmes and also programmes for prevention of harm from alcohol and substances of abuse. The programmes will be culturally and gender appropriate and reach out to all segments of the population, including marginalized groups.

There are many barriers to the implementation of community mental health projects and programmes. While some countries have developed mental health policies, there has not been adequate implementation. Governments urgently need to be sensitized on the importance of mental health and to clearly define the goals and objectives for community-based mental health programmes. Mental health services should be integrated into the overall primary health care system. At the same time, innovative community-based programmes need to be developed and research into relevant issues and traditional practices promoted. Communities have to be educated and informed about mental and neurological illnesses to remove the numerous myths and misconceptions about these conditions. But most important, the stigma and the discrimination associated with mental illness must be removed.

The Regional Office is developing strategies for community-based programmes based on five 'A's: **A**vailability, **A**cceptability, **A**ccessibility, **A**ffordable medications and **A**ssessment.

Availability: Services which will address at least the minimum needs of populations in mental and neurological 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 the countries continue to perpetuate superstitions and false beliefs about mental and neurological 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 neuropsychiatric 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 pricing and the role of the pharmaceutical industry in distribution and pricing become critical.

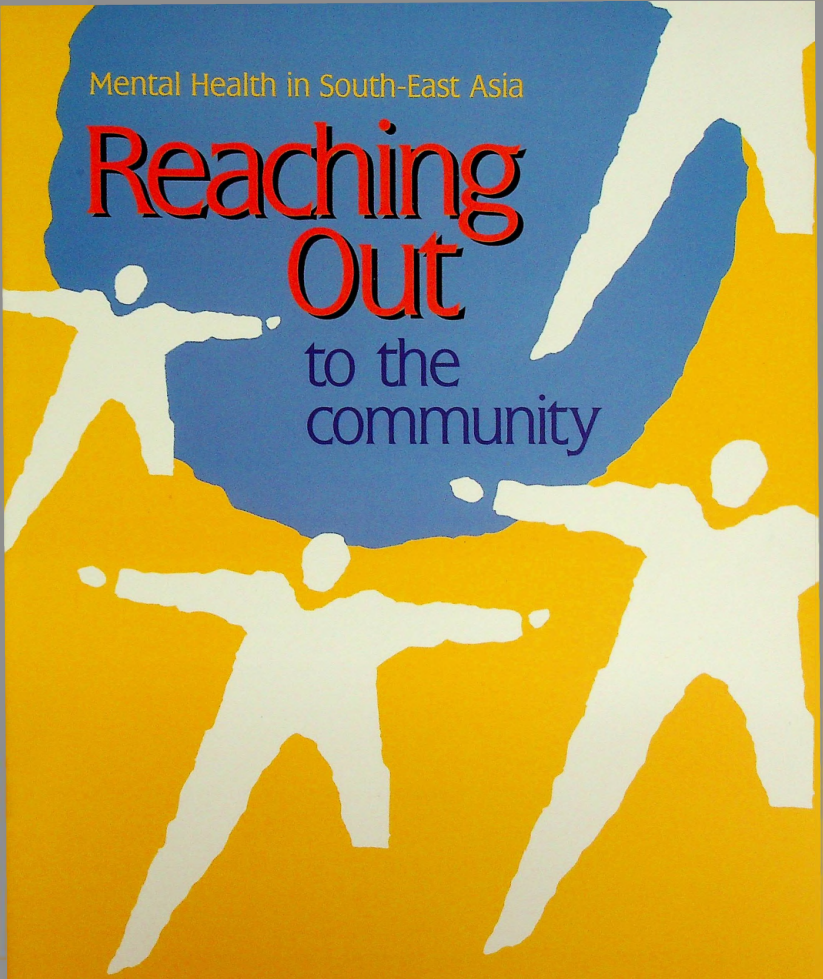
Assessment: Being new, these programmes need to be continuously assessed to ensure appropriateness and cost-effectiveness. Changes in the ongoing programmes based on impartial evaluations are essential.

Lucretius, the great Roman philosopher and poet who lived from 96 BC to 55 BC wrote: "The mind, like a sick body, can be healed and changed by medicine." Two thousand years later, we must accept and implement what Lucretius said. To this, we must add social and psychological support which should be extended to those suffering from mental and neurological illnesses to ensure that they get optimum treatment, care, love and affection to enjoy life with dignity.

Dr Vijay Chandra
Regional Adviser, Health & Behaviour,
WHO/SEARO, New Delhi

Mental Health in South-East Asia

Reaching Out to the community



World Health Day, 7April 2001
Dedicated to Mental Health

World Health Organization
Regional Office for South-East Asia

Mental Health in South-East Asia:

Reaching Out to the community

WHO defines health as, "A state of complete physical, mental and social wellbeing and **not** merely the absence of disease or infirmity". Thus mental health should be an integral part of all health programmes. Mental illness includes mental disorders, neurological and psychosocial problems such as those related to alcohol and drug abuse.

What are mental disorders?

Mental disorders are characterized by psychological and behavioural symptoms, resulting from changes in one's thinking, attention, concentration, memory and judgement. Changes in these mental functions, lasting for a prolonged duration cause abnormalities in speech and behaviour that may differ from socially and culturally accepted norms. Such changes in mental functions can also cause varying degrees of distress to the individuals, their families, and at times, the community. Psychological and behavioural symptoms may also result in impairments in personal, social and occupational functioning.

It is important to view behavioural changes in the context of the prevailing social and cultural milieu. What is considered normal in one culture may be unacceptable in another setting.

There are various types of mental and neurological disorders and psychosocial problems such as psychotic disorders (e.g. schizophrenia), mood disorders (e.g. depressive disorders), neurotic, stress-related and adjustment disorders (e.g. obsessive compulsive disorder, anxiety disorder), neurological disorders (e.g. Alzheimer's disease, epilepsy and mental retardation); childhood mental disorders (e.g. attention deficit hyperactivity disorder), and substance abuse-related disorders (e.g. alcoholism, drug abuse).

What causes mental disorders?

A complex interaction process between various genetic, biological, psychological and sociocultural factors causes mental disorders. Links have been established between the occurrence of certain types of mental disorders and adverse social conditions such as poverty, high rates of unemployment, homelessness, illiteracy, and gender discrimination. Severe malnutrition can result in cognitive impairment, impaired childhood development, stress and demoralization.

There are several groups of people who have a higher risk for developing mental disorders. These include people, socially isolated, abandoned elderly people, abused women, people belonging to ethnic minority groups, children and adolescents experiencing disturbed nurturing. Others are displaced persons, migrants, refugees, adults from broken families, people with other family members affected by psychiatric illness and people who are traumatized by violence, and populations affected by disasters. While these are some possible risk factors for neuropsychiatric illnesses in general, there may be specific risk factors for individual diseases.

Public health significance of mental disorders

Mental disorders are known to be widely prevalent. Today, about 400 million people are estimated to be suffering globally from various types of mental and neurological disorders including disorders caused by alcohol and drug abuse. One out of every four persons seeking primary care service suffers from such disorders. About one million suicides are reported every year. A majority of those committing suicide are known to have suffered from depressive disorder. Using Disability Adjusted Life Years (the DALY, expresses years of life lost to premature death and years lived with a disability of specified severity and duration. One DALY is thus one lost year of healthy life) as a basis for measurement, mental disorders have been found to be amongst the significant contributors to the Global Burden of Disease (GBD). According to the World Health Report 1999, an estimated 10% of the burden from noncommunicable diseases in 1998 was accounted for by neuropsychiatric conditions in low and middle-income countries. Five of the ten leading causes of disability worldwide are already mental disorders (unipolar depression, schizophrenia, bipolar affective disorders or manic depressive disorder, alcoholism and obsessive-compulsive disorder.). This situation will soon apply to developing countries including SEAR Member Countries.

Estimates of the prevalence of major mental and neurological disorders in the South-East Asia Region are as follows:

Schizophrenia: It affects about seven adults per thousand in the population, mostly in the age group 15-35 years. Dr R.D. Laing, a British psychiatrist wrote: "Schizophrenia cannot be understood without understanding despair." This was written in the early twentieth century, but still remains true for a majority of sufferers despite the availability of effective medications.

In SEAR: Developing countries have been consistently shown to have a lower number and better outcome of cases of schizophrenia than developed countries. One of the reasons for this could be the availability of better social support systems in these countries.

Depression: Establishing a diagnosis of depression versus a normal fluctuation in mood is a crucial issue in estimating the true prevalence of depression in the community. It is estimated that 5-10% of the population in the community at any given time suffers from identifiable depression needing psychiatric or psychosocial intervention. The lifetime risk of developing depression is 15-17 per 100 in females and slightly less in males.

In SEAR: In the last fifty years, treatment of depression has made rapid strides. Newer drugs are being discovered with better efficacy, less side-effects and better tolerance, and are being used for short-term and long-term treatment. Besides drugs, nonpharmacological therapies like psychotherapy and cognitive therapy have been found beneficial. Unfortunately, despite the seriousness of depression and all the associated consequences which can be effectively treated at any level of care, only 30% of cases all over the world with these disorders are properly diagnosed or treated. The situation about the lack of adequate diagnostic and treatment services may be worse in SEAR Member Countries.

Anxiety disorders: Anxiety is a common experience in daily life and must be differentiated from anxiety disorder which causes substantial suffering in the general population. Generalized anxiety disorder, panic disorder, phobia and obsessional disorder are also now considered in the group of anxiety disorders. Considering all the anxiety disorders together, data from western countries report the prevalence estimates as high as 10 to 15% of the population.

In SEAR: Although there are no definitive data on the prevalence of anxiety disorders in SEAR, indirect evidence suggest, that the prevalence of these conditions is as high as in western countries and perhaps increasing due to the changing social and cultural environment. Moreover, the easy availability of tranquilizers used widely by the common man as a remedy for anxiety, is a cause of concern.

Suicide: Suicide rates vary from 8-50 per 100 000 population in countries of the South-East Asia Region. India and Sri Lanka record the highest number of suicide rates (11 and 37 per 100 000 population respectively) and occupy the 45th and 7th positions globally. Nearly 2 548 persons in Bangladesh, 4 840 in the Democratic People's Republic of Korea, 104 000 persons in India, 5 616 in Sri Lanka and 5 095 in Thailand committed suicide during 1997-98 as per official reports.

In SEAR: SEAR Member Countries are witnessing rapid changes in population growth, socioeconomic development and health profiles. Suicide is now being recognized as a major public health problem in the complex scenario of development and lifestyle changes. In the socioculturally diverse communities of SEAR, suicide is a very important issue cutting across diverse disciplines and sectors such as health, religion, spirituality, law and welfare.

Epilepsy: Epilepsy affects 2-10 per 1000 population. Studies from different parts of India reveal that the problem varies from 9 per 1000 in Bangalore, 5 per 1000 in Mumbai, 4 per 1000 in New Delhi and 3 per 1000 in Calcutta area. In a survey conducted in the Kandy district of Sri Lanka, it was observed that 9 out of 1000 people had epilepsy. Though there are no national statistics from Bangladesh, it is estimated that there are at least 1.5-2.0 million people with epilepsy.

In SEAR: The World Health Organization, in partnership with the International League against Epilepsy, and the International Bureau for Epilepsy, has launched a worldwide public awareness programme, "Out of the Shadows". The programme, also being implemented in some SEAR countries, should help to create awareness, remove myths and misconceptions and make available appropriate care and treatment to people with epilepsy.

Mental retardation: Generally, mental retardation affects 2% of the population of all ages. Mild mental retardation is much more common, accounting for 65 to 75% of all cases of mental retardation. Looked at another way, in a population of 1 000 people, of the 20 who will have mental retardation, about 15 will have mild mental retardation and about five will have more severe forms of mental retardation.

In SEAR: Mental retardation is a common problem in SEAR Member Countries, affecting not only the individuals who have this problem but also their families and society as a whole. Several positive advances in the scientific and social understanding of this problem have opened up a variety of avenues and opportunities to reduce this problem and limit the extent of disability. One such successful programme is the control of mental retardation due to iodine deficiency which has largely been brought under control by iodination of salt. Combined and coordinated action by the families, governments and nongovernmental organizations is urgently needed.

Alzheimer's disease: It is estimated that there are currently about 18 million people worldwide with Alzheimer's disease. This figure is projected to nearly double by 2025 to 34 million. Much of this increase will be in developing countries, and will be due to the aging population. Currently, more than 50% of people with Alzheimer's disease live in developing countries and by 2025, there will be over 70% of such people.

Studies on Alzheimer's disease in South India, Mumbai and the northern state of Haryana in India have reported very low rates of occurrence of Alzheimer's disease in those 65 years or older, ranging from about 1% in rural north-India (the lowest reported from anywhere in the world where Alzheimer's disease has been studied systematically) to 2.7% in urban Chennai. Studies from China and Taiwan have also shown a lower risk of Alzheimer's disease in these countries as compared to western countries. Thus, from existing evidence, it would appear that the number of cases of Alzheimer's disease in Asia, and particularly in India and Africa, is lower than those reported from studies in developed countries. The reasons for these differences are a topic of intense research.

Epilepsy: Epilepsy affects 2-10 per 1000 population. Studies from different parts of India reveal that the problem varies from 9 per 1000 in Bangalore, 5 per 1000 in Mumbai, 4 per 1000 in New Delhi and 3 per 1000 in Calcutta area. In a survey conducted in the Kandy district of Sri Lanka, it was observed that 9 out of 1000 people had epilepsy. Though there are no national statistics from Bangladesh, it is estimated that there are at least 1.5-2.0 million people with epilepsy.

In SEAR: The World Health Organization, in partnership with the International League against Epilepsy, and the International Bureau for Epilepsy, has launched a worldwide public awareness programme, "Out of the Shadows". The programme, also being implemented in some SEAR countries, should help to create awareness, remove myths and misconceptions and make available appropriate care and treatment to people with epilepsy.

Mental retardation: Generally, mental retardation affects 2% of the population of all ages. Mild mental retardation is much more common, accounting for 65 to 75% of all cases of mental retardation. Looked at another way, in a population of 1 000 people, of the 20 who will have mental retardation, about 15 will have mild mental retardation and about five will have more severe forms of mental retardation.

In SEAR: Mental retardation is a common problem in SEAR Member Countries, affecting not only the individuals who have this problem but also their families and society as a whole. Several positive advances in the scientific and social understanding of this problem have opened up a variety of avenues and opportunities to reduce this problem and limit the extent of disability. One such successful programme is the control of mental retardation due to iodine deficiency which has largely been brought under control by iodination of salt. Combined and coordinated action by the families, governments and nongovernmental organizations is urgently needed.

Alzheimer's disease: It is estimated that there are currently about 18 million people worldwide with Alzheimer's disease. This figure is projected to nearly double by 2025 to 34 million. Much of this increase will be in developing countries, and will be due to the aging population. Currently, more than 50% of people with Alzheimer's disease live in developing countries and by 2025, there will be over 70% of such people.

Studies on Alzheimer's disease in South India, Mumbai and the northern state of Haryana in India have reported very low rates of occurrence of Alzheimer's disease in those 65 years or older, ranging from about 1% in rural north-India (the lowest reported from anywhere in the world where Alzheimer's disease has been studied systematically) to 2.7% in urban Chennai. Studies from China and Taiwan have also shown a lower risk of Alzheimer's disease in these countries as compared to western countries. Thus, from existing evidence, it would appear that the number of cases of Alzheimer's disease in Asia, and particularly in India and Africa, is lower than those reported from studies in developed countries. The reasons for these differences are a topic of intense research.

In SEAR: With an aging population, conditions such as Alzheimer's disease will be a cause for concern in the near future. If it can be verified that the risk of Alzheimer's disease is indeed lower in the eastern part of the world and the reasons for this protection of the population determined, the developing countries could perpetuate these factors and the developed countries could adopt them.

Alcohol abuse: 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 the other negative consequences such as accidents due to drunken driving, domestic violence and reduced productivity. Methanol poisoning due to adulterated alcoholic beverages too is a problem in the Region.

Alcohol abuse in poor and deprived communities is particularly deleterious as scarce financial resources of the family are diverted to alcohol rather than to food, health care and education. Another phenomenon which is commonly seen is "pay-day binge drinking". Some wage earners spend their entire month's earnings on alcohol. Frequently, vendors wait outside places of employment on pay day to entice workers to buy alcohol as they leave their place of work.

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 percent of all home and farm accidents were estimated to be related to alcohol regularly.

In Sri Lanka, the adult per capita alcohol consumption increased from 3.79 to 5.11 litres between 1990 to 1997. A survey in the mid-1990s revealed that 43% of urban shanty dwellers and 60% of estate workers consumed alcohol.

A 1991 survey in Thailand revealed that 31.4% of those over 14 years of age consumed alcohol (54% of males and 10% 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% 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.

Systematic research aimed at estimating and understanding the nature and extent of public health problems related to alcohol use in the Region is required. Meanwhile, there is a need to implement effective strategies for prevention of harm from 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.

Other substance abuse : Since times immemorial, in most countries of the South-East 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-East Asia Region is particularly affected by the problem of substance dependence. The notorious "Golden Triangle" (Myanmar, Laos, Thailand) is part of the Region. India has become a major transhipment point for hard drugs from Pakistan to the West. Injecting illicit drugs has been fuelling the AIDS epidemic in many countries of South-East Asia Region. The sharing of contaminated equipment to inject drugs has been a key factor in spreading HIV/AIDS and other infections among drug users.

Unfortunately, what we are witnessing today, on a global scale, is a virtual epidemic of drug dependence. A disturbing trend is that more and more young people are being drawn to this devastating addiction.

Social impact of mental disorders

The stigma associated with mental disorders leads to various negative consequences not only for the sick person but also for his family members. These include rejection, denial of equal opportunities and participation in various aspects of life, humiliation and isolation. Persons with mental disorders are at high risk of human rights violations. Despite the significant public health impact of mental disorders on morbidity, disability and mortality, policy-makers and health care administrators worldwide accord low priority to the development of mental health services. A large proportion of persons with mental disorders do not receive any meaningful care and have to feel undue suffering and disability.

What is community mental health

Community mental health (CMH) refers primarily to treatment and intervention programmes initiated and implemented outside institutions such as mental hospitals. In a narrow sense, CMH deals with the care of mentally ill persons in the community. However, over the years, CMH has broadened its concern to address all mental health problems of the population. Not only does CMH deal with different levels of mental morbidity in a population but it is also concerned with the perceived psychological welfare and wellbeing of society. CMH attempts to use methods and techniques of behavioural sciences and public health to prevent mental disorders, promote mental health and improve the general quality of life. CMH also includes service delivery strategies for identification, management as well as rehabilitation of persons with various mental disorders. The practice of CMH requires coordinated and multisectoral action involving a number of government sectors as well as nongovernmental and community-based organizations.

Successful community-based programmes:

In Bangladesh

Many NGOs are actively working for the welfare of persons with mental retardation in Bangladesh. One such organization is the Bangladesh Protibandhi Foundation (BPF). Started in 1984 as a parent – professional partnership, BPF has been playing a key role in the area of mental retardation. BPF has been able to initiate and sustain a variety of activities and programmes, which include health care and psychological services, other professional services such as physiotherapy and speech therapy, early stimulation programmes, a special school, and sheltered workshop.

In India

Under the aegis of the National Mental Health Programme, the District Mental Health Programme was started in 1982 in Bellary district of Karnataka, India. A series of activities beginning with training of primary health centre workers, evaluation of trained workers, and training of trainers formed the foundation of the Programme.

The essential components were:
(a) training of health functionaries; (b) continuous and uninterrupted provision of essential drugs; (c) a simple recording and reporting system;
(d) continuous support and supervision by technical experts, and (e) community participation and establishment of district units.

This model is able to deliver mental health services at the district level and is gradually being expanded by the Government of India.

In Nepal

Programmes of orientation and sensitization of traditional healers on mental disorders and epilepsy have been successfully conducted. This is of significance as large number of patients and their family members have great faith in traditional healers.

In Sri Lanka

'Sahanaya', a community mental health centre was established in 1983 by the National Council for Mental Health in Colombo. The organization provides a range of community-based mental health services by professionals and volunteers. Initial and follow up assessments are done in detail with special reference to psychiatric, psychological, social and other needs before deciding on a plan of action. A range of skills for daily living and personal care including shopping and cleaning, is offered to those suffering from disabilities associated with schizophrenia. Social, occupational, recreational and vocational activities including gardening, dancing, art, music and envelope making are also conducted.

In Thailand

An intervention programme in Thailand enlisted the support of village-level health workers in preventing suicide. These people were trained in detecting individuals with depression and those at risk of suicides, using basic helping skills

acquired from community work. After six months, suicides in the area declined significantly and this programme is being replicated in other areas in the country.

Thailand has developed the programme of "school counsellors" in public schools. The programme will be strengthened in future. A school-based general mental health programme is also being implemented. These programmes address the increasing mental health problems encountered amongst adolescents.

Conclusion

The Regional Director of WHO's South-East Asia Region, Dr Uton Muchtar Rafei, has very appropriately summarized the need for mental health in the Region:

> *"Mental health care, unlike many other areas of health, does not generally demand costly technology. Rather, it requires the sensitive development of personnel who have been properly trained in the use of relatively inexpensive drugs and psychological support skills on an outpatient basis. What is needed, above all, is for all concerned to work closely together to address the multi-faceted challenges of mental health".*

Prepared by:

Dr Nimesh G. Desai
Professor and Head,
Department of Psychiatry,
and Medical Superintendent,
Institute of Human Behaviour
and Allied Sciences,
New Delhi, India

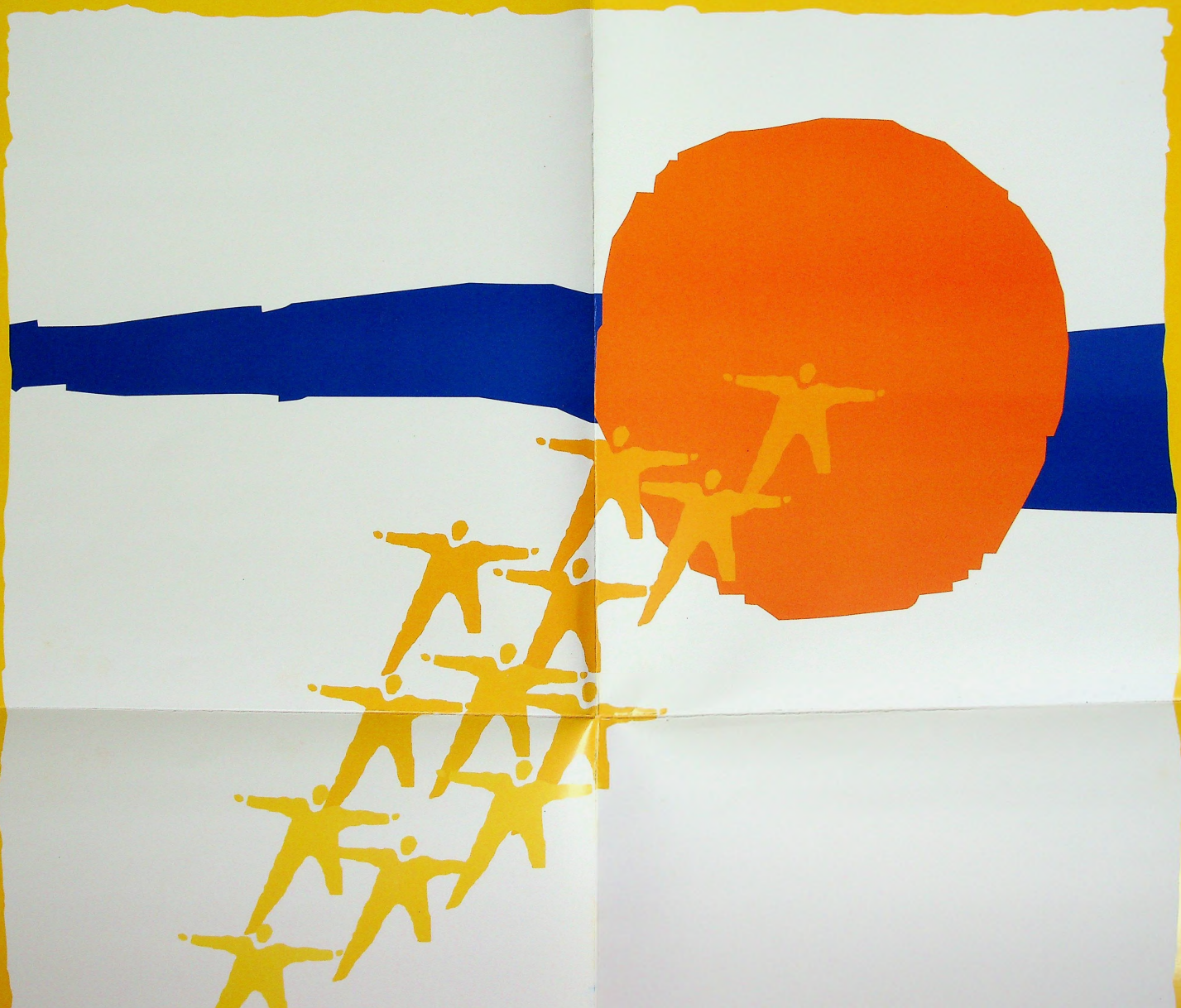
Dr Mohan Isaac
Professor of Psychiatry,
National Institute of Mental Health
& Neuro Sciences, Bangalore, India

World Health Organization

Regional Office for South-East Asia

World Health House, Indraprastha Estate
New Delhi - 110 002 INDIA
Tel: (+91 11) 331 7804 - 23 Fax: (+91 11) 331 8412
e-mail: chandrav@whosea.org
website: www.whosea.org/whd2001

WORLD HEALTH DAY • 7 APRIL 2001



Better Understanding – Appropriate Care in Mental Health

World Health Organization
Regional Office for South-East Asia

World Health Organization

Regional Office for South-East Asia

World Health House, Indraprastha Estate
New Delhi - 110 002 INDIA
Tel: (+91 11) 331 7804 - 23 Fax: (+91 11) 331 8412
e-mail: chandrav@whosea.org
website: www.whosea.org/whd2001