

# The discussions

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Summary records of  
statements by Ministers



This section contains summaries of the statements made by the Ministers of Health participating in the round table discussions. The statements appear in alphabetical order according to country and regroup the participants of all four round tables.

## Angola

**Dr Hamukwaya** described how the mental health situation in her country had been aggravated by internal conflict and its consequences. Political, social and economic stability and prosperity were essential to bring about improvements. She emphasized the importance of promoting healthy lifestyles and adopting psychosocial rehabilitation measures as part of a national policy to improve the mental and physical health of the Angolan people. She also reaffirmed her country's intention to fight marginalization and social exclusion by associating its efforts with initiatives taken by WHO to promote mental health.

## Argentina

**Dr Lombardo** traced the history of mental health care in his country from its origins in the 19th century, including the establishment in 1957 of the National Mental Health Institute, which had endorsed the approach of treating mental health disorders as health problems and not diseases. Nevertheless, developments in lifestyles, including the emergence of "modern" problems such as stress had led to the increased incidence of serious mental disorders. The treatment of such disorders had developed in parallel on an interdisciplinary and intersectoral basis, with recognition of the fundamental importance of community participation in health matters. Argentina currently had a high number of mental health specialists, comparable to the numbers in the most developed countries. Progress had also been made in the treatment of mental disorders with the emergence of new drugs in the second half of the twentieth century, while the development of new outpatient services had helped persons with mental disorders to avoid social marginalization and stigmatization. In that respect, he emphasized that the isolation of many adults in modern society was a basic reason for the development of mental health disorders.

Legislation placing emphasis on promotion and prevention was currently being adopted at various levels in Argentina. A National Primary Mental Health Care Act, the principal focus of which was on prevention, had recently been adopted and had been accompanied by legislation covering the treatment of various conditions related to mental health disorders. Similar legislative measures were also being adopted by the provinces. The mental health policy had been incorporated into the national health policy emphasizing the promotion of healthy lifestyles and including the prevention of substance abuse, and the development of a national programme to prevent depression and detect possible cases of suicide at an early date. The basic elements of the treatment of mental health disorders were: the elimination of stigmatization; the organization of multidisciplinary health services covering prevention, health promotion, care and rehabilitation; and the social reintegration of patients. Gender was another fundamental aspect of mental health problems, since more women than men suffered from mental health disorders. Attention therefore needed to be paid to problems of gender discrimination in modern societies. Finally, it was necessary to identify the socioeconomic elements that led to the development of mental disorders, including poverty and marginalization. Mental health patients needed immediate reintegration and assistance to promote their participation in the life of the community. He welcomed the initiative taken by WHO on one of the major health problems of the coming years.

## Australia

**Professor Mathews** said that the rapid pace of social change, economic pressures, war and population movements and other factors had contributed to difficulties in recognizing and providing adequate support for mental health problems. That social change had also been accompanied by the loss of traditional family support in many countries. Transitional societies, such as indigenous Australians, were having difficulty with social adjustment, and they and other vulnerable groups were likely to suffer from drug and alcohol problems, and problems related to violence and suicide, which Australia, like other countries, was taking very seriously.

Stigmatization was still a problem, and new approaches to the philosophy of care and treatment were needed. The Australian National Mental Health Strategy sought to promote the mental health of the Australian community and to prevent the development of mental health problems and mental disorders; to reduce the impact upon individuals, the family, and the community; and to protect the rights of people with mental illness.

Particular emphasis had been placed on reducing stigmatization through programmes targeted at schools to increase awareness and understanding of mental health problems, engaging with the media to promote community understanding, and working with community groups, as well as the professional health sector, to promote acceptance. Australia had underpinned its work with legislative protection of the rights of people with mental illness and had developed community plans for mental health support involving specialist care and an interdisciplinary focus. Australia's commitment to promotion and prevention had engaged the Commonwealth and state Governments and community organizations, as well as stakeholder groups, patient groups, and also the private sector. Australia fully supported the WHO mental health initiative and was committed to an interdisciplinary focus with a view to reducing stigmatization and recognizing co-morbidities, emphasizing mental health promotion and prevention and rehabilitation.

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## Austria

**Professor Waneck** said that WHO had successfully drawn public attention to mental health problems, which were often underestimated and misunderstood. Great progress had recently been made in the field of psychiatry and yet psychiatric disorders in the industrialized countries were increasing. A new consciousness had emerged, evidenced by the burgeoning number of self-help groups, as a result of which most people with mental illnesses were living within the community, able to make their own life choices. At the global level, however, much remained to be done. The Austrian health authorities vigorously pursued the WHO-advocated policy aimed at ending the exclusion of the mentally ill, particularly in the field of hospital psychiatric services, which had been decentralized

and integrated, thus representing an important step forward in destigmatizing psychiatric disorders and those suffering from them. Self-help groups also played an instrumental role in the efforts to destigmatize psychiatric illness, as they provided vital back-up to the policy already in place.

To strengthen the Austrian mental health policy, a countrywide survey of mental health provision had been commissioned, bringing together, for the first time, data on psychiatric and psychosocial care for the benefit of the mentally ill, their families and those professionally concerned. Projects would be analysed and additional measures adopted in the light of the data produced by the survey, the second part of which was due at the end of 2001. Other important future objectives included the satisfaction of needs, the integration of basic care, quality assurance and the participation of patients and their relatives, care professionals, administrators and politicians. In conclusion, he hoped that the national and international efforts undertaken would improve the information available in the field of psychiatric care and that the stigma attached to psychiatric illness would diminish to the point where such health problems could be openly discussed without taboo.

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## Bahamas

**Dr Knowles** said that he had taken comfort from the realization that most countries had problems similar to those in his own country but was sad to hear that solutions were hard to come by, regardless of the size of a country's gross domestic product.

The Bahamas, was a country of scattered populations, which hindered service delivery. In addition to the country's usual array of mental health problems, it had suffered from being directly situated between the major cocaine-producing Latin American countries and the United States of America. The crack and cocaine epidemic of the 1980s had been closely followed by the AIDS epidemic and an upsurge in violent crime.

The Bahamas had recently reviewed its mental health services and was revising its mental health plan correspondingly. His country would welcome direction in its efforts to provide sufficient num-

bers of mental health workers, especially psychiatrists. That was not seen as a glamorous profession, nor did graduate nurses want to specialize in psychiatric care. He also asked for advice on the care of mentally ill patients in prisons, where the necessary psychiatric services were not available, and on the multidisciplinary care of mentally ill adolescents.

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## Belarus

**Dr Zelenkevich** said that it was time to bring the problem of mental illness out into the open. One of the principal challenges was how to ensure that such illness was allocated its proper share of the scarce resources available, and to that end, it was important to include mental health in all health plans and policies and to involve general practitioners. The change-over from institutionalized forms of care to care in the community, as well as the increase in the number of specialists in mental health being trained in medical schools, would contribute to a more efficient use of resources. Greater efficiencies could also be achieved by mobilizing other sectors to assist the health sector and by pooling resources. Nongovernmental organizations also had an important contribution to make.

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## Belgium

**Mrs Aelvoet** said that in her country, as in others, there had been an increasing demand for mental health treatment, despite a substantial economic upsurge, which indicated that wealth per se was no solution. Furthermore, stigmatization was still widespread; people with mental disorders were treated differently from those with physical illnesses and tended to be regarded as abnormal. During the past 25 years, there had been a trend towards encouraging patients to stay in their home environment, thereby enabling them to continue to work and function as usual. That had been achieved by the development of first-level care, home support services and home visits by doctors, in addition to outpatient and institutional care.

In 2001, a 10% increase in the health budget had been agreed, constituting the largest increase for any government department. The concept had

been accepted that chronically ill patients, including those with mental disorders, should receive financial and institutional support. A system had also been developed to place a ceiling on the amount each patient should pay in any one year, anything over and above that amount being covered by a reimbursement system, taking into account personal socioeconomic circumstances.

In connection with gender specificity, it had been established that women were more dependent on legal drugs, whereas men tended to be dependent on alcohol. For issues of national importance, it had been stipulated that at least one-third of the members of all national committees should be women, including those concerning health.

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## Benin

**Professor Ahyi** observed that his country, like many others, had been slow in responding to mental illnesses, in part because of the belief, common in Africa, that they could be treated by traditional medicine. The recognition that many conditions did not respond to such treatment had forced a new approach and helped to raise mental health to one of the six top health priorities for Benin. With support from WHO the country had begun cooperation with Ghana and Mozambique on issues of health promotion, but that concept had rapidly led to issues of well-being and quality of life. A small national coordinating team had soon discovered that "health problems" were viewed in a prejudicial light, there being a major general confusion about illness and health: as soon as one talked about health promotion, that raised images of illness. Similarly, health centres and dispensaries were seen as focused on disease rather than on health. A conclusion was that, in Benin, the training of health care workers needed to be revised to correct those misperceptions. In the past two years there had been a move to educate the public at community level, for example by encouraging communication between generations. For instance, in one village a bench had been placed by a communal path, enabling older people to come out of their homes and be more integrated into community life. People stopped and talked, and perceptions and attitudes soon changed.

With regard to medicines, even generic drugs were rare in Benin. Moreover, those psychotropic drugs that featured on the essential drugs list were not ordered because the population was poor and the demand for such drugs was considered to be small. Further, the Bamako Initiative encouraged cost recovery. After the introduction of the health promotion policy, there had been a reduction in the number of patients and the rate of cost recovery had also declined. A contradiction became apparent: people preferred to have more patients so that there would be sufficient funds to maintain the existing system of health rather than reducing the number of patients. Health promotion had meant social mobilization in order to reduce costs. A further important point was the culture of health, not disease – and mental health was a case in point. The conclusion reached was that there was no development without health and no health without mental health. Mental health was the portal of entry for the development of developing countries. With democratization came decentralization, but that had posed various problems. For example, social mobilization had resulted in the multiplication of demands for the expansion of services based on the successes of pilot projects with the incorporation of mental health into primary health care.

## Bolivia

**Dr Cuentas-Yáñez** observed that mental health programmes, whether against familial violence or alcoholism or for the administration of psychiatric hospitals, were based on a predominantly clinical vision. He advocated a more cultural approach to mental health, and recalled that Bolivia had been part of the Inca empire. At that time, some 400 years ago, itinerant “doctors” (cayaguayos) had dispensed basic mental health care. He argued that every mental health programme should take cognizance of the cultural heritage as well as of the epidemiological profile and the impact of poverty. The prevalence and incidence of mental illnesses were known to be associated with social groups; alcoholism was closely linked with intrafamilial violence, both of which were synonymous with the mechanisms of desperation during economic difficulties. Culture differentiated mental health from other health programmes, and people’s perceptions

and cultural background needed to be accommodated.

## Bosnia and Herzegovina

**Mr Mišanović** said that stigmatization was an important issue in Bosnia and Herzegovina. The stigma arose from the subconscious fear that anyone could fall victim, permanently or temporarily, to mental ill-health. Bosnia and Herzegovina was a post-traumatic society in transition. Half the population suffered from war or stress-related psychiatric disorders; the other half had dealt with the problem by referring to the sufferers as “broken” people, partly out of fear that psychological trauma could be passed on to the next generation. It was difficult to fight stigmatization in post-traumatic societies because stigma was used to deny people’s rights. Bosnia and Herzegovina needed a very different procedure for eradicating the problem of stigmatization. It needed extremely clear recommendations not only on how to eliminate stigma, but also on how to promote mental health and prevent mental disorders.

## Botswana

**Ms Phumaphi** said that steps similar to those described by other speakers had been taken by Botswana in relation to patient integration, the setting up of community hospitals, and campaigns to reduce the stigma associated with mental illness. Two issues were of particular importance. First, it was essential to recognize that mental illness was a human problem as well as a medical problem, and to develop programmes aimed at particular social and economic groups. The power of peer groups could be harnessed to promote mental well-being. Secondly, her country attached importance to early intervention, which was a critical element in implementing mental health policies. She agreed that there was a need for research into mental illness and into the links between mental and physical health.

In Botswana, stigmatization corresponded to fear of those with mental illnesses. That was perhaps because their loss of control of their lives was associated in the minds of others with disruption to their lives. The response to the four questions

raised by their Chairman could be summed up in three words: information, education, communication. Botswana had medical-aid societies that did not provide adequate care for the mentally ill because of stigma; there was a high unemployment rate among the mentally ill because employers did not want to hire them; and insurance payments had been denied to the families of mentally ill patients who had committed suicide.

Consideration also had to be given to the plight of those who already had special needs in addition to suffering from the stigma of mental ill-health, for example, children in difficult circumstances, women, refugees and migrants, the elderly, conflict survivors, prisoners, and young people engaged in substance abuse. Those groups' needs should be accommodated in appropriate legislation. It was also vital that patients be properly managed; to do so entailed removing stigma among health care workers. Consideration should be given to ways of countering the results of stigmatization by legislative means, such as regulations governing patient management that would help to eliminate stigmatization among health care workers.

## Brazil

**Dr Yunes** said that mental health was one of his Government's main priorities. Historically, it had been given a low priority despite the fact that mental disorders represented a heavy burden on the quality of life of patients and their families, as well as on the economy. In Brazil, as in many other countries, hospital-based care was still predominant, swallowing up most of the financial, technical and human resources available and limiting access to treatment. There was a need for strategies to enhance primary and community-based care.

A reform had been launched in the early 1990s aiming to decentralize the mental health care system and to redistribute resources from hospitals to community-based services; to disseminate information on the effectiveness of new models of treatment on patient rights and on the importance of combating stigma and discrimination; and to design and implement broad-based programmes for the social reintegration of long-term patients. The obstacles to the implementation of community-based mental health services in Brazil were the

lack of trained health professionals, including general practitioners who could act as psychiatrists in remote areas, and the insufficient availability of drugs. His Government had introduced a programme to finance basic kits of psychiatric drugs for distribution, free of charge, at outpatient clinics, but since outpatient services were still insufficient the drugs were not yet reaching all those who needed them.

It had also addressed stigmatization and human rights problems by conducting regular inspections of psychiatric hospitals. Legislation had been adopted to protect the rights of mental patients and to promote their social integration, and services had been introduced to support women living in violent domestic environments.

## Brunei Darussalam

**Mr Matnor** noted that WHO had not paid mental health the same attention as it had to other issues, and therefore needed to organize activities to promote awareness. In many countries, developments in the approach to mental health were guided by the outcome of discussions on the issue at international and regional forums. In his country, closed mental clinics within hospitals had been replaced in 1982 by a single specialist hospital providing outpatient care and counselling, and steps had been taken to decentralize primary health care so that it could be provided at community level. Brunei was able to provide free medical care and drugs because of its small population and land area.

One of the country's approaches to the problem of stigmatization of mental illness had been to change certain names. For example, the term "ward 5" commonly associated with mental problems, and hence "bad" people, had been replaced by "psychiatric ward", and the new hospital had comfortable rooms instead of the cages and bars formerly used to hold mentally ill patients. The Lunatic Law had been renamed the Psychiatric Act. The word "mental" was no longer used; the terms "stress" or "light depression" were more acceptable to young people and made them more willing to come forward for treatment. Because those identified as having mental problems often lost their jobs, the Government provided allowances to encourage them to undergo treatment. Brunei's main problem was how to

encourage the formation of a nongovernmental organization to care for the mentally ill. The stigma attached to mental disease was apparently still too high for that to come about.

## Burkina Faso

Mr Tapsoba described the evolution of mental health care in his country, which included decentralizing the health system and incorporating mental health care into the responsibilities of district level structures. Lack of coordination had resulted in a lack of adequate supervision, insufficient epidemiological data, lack of enough properly trained staff, insufficient financial and material resources for mental health services, and inequitable access to medicines owing to the slow introduction of cheaper generic psychotropic drugs. A national mental health programme had been formulated to meet the main areas of concern and would be implemented, despite financing problems, as part of the national development plan which extended to 2010.

In regard to gender issues, he drew attention to a particular problem in Burkina Faso, that of a category of woman known as the “devourer of souls”. These women, because they lived alone, were widows or had no resources, were often driven out of their villages although healthy in mind and body because they were alleged to be the cause of mysterious deaths. Eventually they either committed suicide, disappeared into the bush or suffered mental health problems. Only women – never men – were so accused. The public authorities and religious associations were aware of the problem but did not have enough resources to provide adequate support. He appealed for help from WHO.

## Canada

Mr Rock, welcoming the exchange of views on common problems, said that his country’s experience was similar to that described by previous speakers. The Canadian Government had recognized the importance of integrating mental health into primary health care systems and had recently funded a pilot project to make mental health services available within the community. As almost 20% of primary health care patients presented

with mental health problems, it had been considered important to ensure that the training of health professionals included the identification, recognition and treatment of such problems. The importance of early intervention in children to prevent more complex difficulties later on could not be overemphasized. Disease prevention was given high priority in Canada, and the development of a national approach towards early childhood development was encouraged. Thus, a “children’s agenda” had been created, covering prenatal nutrition for young mothers, programmes focusing on the crucial years of brain development between birth and the age of three years, early identification of signs of emotional maladjustment, and emphasis on the prevention of foetal alcohol syndrome and defects that limited personal development and led to social cost and disruption in later life.

Many of Canada’s communities, especially those of indigenous peoples, were rural and remote and experienced harsh winter weather. Increasing and successful use had been made there of modern information and communication techniques, such as telemedicine, teleradiology and telepsychiatry. Rather than being a barrier to the personal relationship between therapist and patient, the televised connection appeared to facilitate full participation in the consultation.

A new approach to the organization, coordination and financing of health research, including mental health, had been adopted with the creation of virtual mental health research institutes consisting of networks of researchers. One such institute was devoted to mental health and involved researchers in clinical and biomedical fields, the provision of services, and population health and health determinants. By bringing those four perspectives together and substantially increasing the level of financing, Canada’s research enterprise was more effective and better use was made of its research funds. Investment in mental health was being increased to reflect more appropriately the importance attached to that area in the health system. Canada would be hosting the World Assembly for Mental Health in July 2001, bringing together people from around the world with valuable perspectives and insights into the ways in which national health systems could better organize, coordinate and deliver services for mental health, and he encouraged the involvement of all Ministers present.

## Chad

**Mrs Kimto** recalled that her country had suffered many years of civil war. Added to that was a difficult economic situation and the fact that health coverage reached only 11% of the population. The need for mental health care was enormous, for instance, for children, people with HIV/AIDS, war widows, alcoholics, prisoners and refugees. Furthermore, mental disorders were traditionally considered as deriving from evil spirits or curses. At the time of independence in 1970 the country had one asylum in the capital, where patients were shut away and made the objects of curiosity and mockery. The building had been destroyed in the civil war. Currently the psychiatric unit of the main national hospital acted as a referral centre and provided an open service with care and treatment. The Government accorded mental health a top priority. The national programme of mental health had organized a consensus workshop in 1999 which had helped to identify the current situation, priority areas, strategies, interventions, funding and the main actors. To achieve social mobilization in favour of mental health issues, the Ministry of Public Health had involved traditional and religious authorities in the programme. The number of associations concerned with mental health had grown and were linked in a network. Every year a mental health day was celebrated on 10 October in order to mobilize public opinion and to raise awareness of the need to prioritize mental health, particularly as Chad was in a post-war situation. WHO's World Health Day offered a good opportunity to undertake additional activities, for instance in communities and schools, including the use of mass media. A community, multidisciplinary approach was considered to be the most logical. Within the ministry an intersectoral, interministerial committee for mental health had been created, charged with the task of creating a coordinated mental health programme covering care, social reinsertion, awareness and information, and advocacy at the highest levels. The major role of traditional medicine in Chad justified cooperation with relevant structures and bodies.

Legislation enacted on mental health had been effective, but practical difficulties remained. Qualified staff, psychotropic drugs, infrastructure and funds were all lacking. The Government aimed

to strengthen the national programmes for the promotion of mental health, to formulate a national plan for the distribution of drugs and to create referral centres. A new centre was being built in N'Djamena. The Government was also integrating mental health into the health activities of district health authorities.

## Chile

**Dr López** stressed that close alliances between all those involved in treating and caring for people with mental illness, including their families, were needed in order to raise the profile of mental health and attract more resources. For the past 10 years, Chile had therefore been promoting the establishment of such groups at national and regional levels. The initiative had been accompanied by efforts to raise general awareness of the public health implications of mental health disorders and to improve the ability of local health services to respond to the problem. Chile had benefited from access to national and international epidemiological research studies that had enabled the scientific community and health professionals to develop better treatment and prevention strategies. As a result of its greater visibility, mental health was now regarded as an important component in Chile's health reform programme.

The public sector had an important role to play in ensuring that psychiatric treatment was made available at the primary health care level to people with few resources. Indeed, the population should have access to the specialized services they required regardless of their ability to pay.

In addition to the type of mental health disorders prevalent in developing countries, Chile also had to contend with those associated with more developed countries, such as schizophrenia and bipolar disorders. Treating them was proving to be a considerable challenge and had led to the establishment of outpatient clinics and specialist units in general hospitals.

Depression was a major cause for concern, particularly among women. A programme designed to detect and treat depression was being developed at the primary health care level and 40% of general medical practices currently provided access to a psychologist. In addition, the new generation of

safer antidepressants was being made more widely available. Alcohol and drug dependence constituted another serious mental health problem which Chile was confronting through the development of a system to provide treatment to those in need with support from non-profit organizations. Other major areas of concern, about which more information was urgently required, included the mental health of schoolchildren and indigenous people, and work-related mental health problems.

In 2000, Chile had launched a national mental health plan, and additional resources had been made available that would increase the proportion of the total health budget allocated to mental health by between 1% and 1.4% in the first year.

## China

**Dr Peng Yu** described how the transition to a market economy in China had been accompanied by an upsurge in mental health problems; for instance, mental disorders were the single most important factor in university student drop-out rates. While recognizing the need to adapt its policies and activities to reflect the new health situation, the Government had insufficient numbers of health professionals with adequate training in the diagnosis and treatment of mental disease. Although China had sufficient supplies of domestic and imported psychotropic medicines, limited funds in remote areas restricted the access of farmers and agricultural workers to the drugs they needed. The Government was focusing its efforts on providing basic and community-based training, delivered, in the case of remote areas, through the use of telecommunications.

In the 1990s, China had launched a programme aimed at assuring the rehabilitation of some 200 million persons and providing training in mental health for primary health care physicians. Its current goal was to reach as many as 400 million people nationwide, drawing on the help of WHO, among others, in order to launch pilot projects and honour its commitment to promoting mental health.

## Croatia

**Dr Gilić** recalled that, more than 50 years previously, his countryman Dr Andrija Tampar, one of the founders of WHO, had proposed the inclusion of mental health among other components in the definition of health for the WHO Constitution.

Socioeconomic conditions were a prerequisite for mental health and welfare, as the example of Croatia illustrated. One in six of Croatia's population had been displaced during the recent war. War damage had also had a dramatic effect upon productivity and unemployment, and had caused poverty and related mental health disorders. Although the new Government was addressing the ongoing effects of the war, in 1999, three out of every five cases of illness were associated with mental disorders, such as schizophrenia, alcoholism, and reaction to stress. The Croatian health authorities were giving effect to WHO recommendations such as the transfer of patients suffering mental disorders from hospitals to primary health care, the focus on community-based mental health care, emphasis upon training of mental health care workers, and seeking to prevent stigmatization and discrimination against mental health patients, so as to enable them to participate to the fullest possible extent in the life of the community.

In conclusion, with improving social and economic conditions in Croatia, a reduction in mental disorders was to be expected in the near future.

## Cuba

**Dr Dotres Martínez** stressed the importance of providing adequate care to all patients with mental disorders and of considering mental health from the point of view of both health services and such social factors as poverty, inequity, violence and other risk factors.

In Cuba, where health care was universally provided free of charge, priority was given to mental health. The trends since 1995 had been towards community-based care mediated through training and education of families to enable them to live with sufferers. Thus, 137 municipalities had established community mental health centres. Work was under way to restructure psychiatric hospitals and

redefine their mission and functions both from the viewpoint of increasing primary health care coverage and of focusing attention on mental health.

Improvements had been made in information systems and in the identification of indicators to evaluate the impact of mental health measures. The identification of risk factors played a fundamental role in community-based care of patients with mental disorders and should be addressed as part of a preventive strategy that included family members and the community. In Cuba, the shift towards mental health had been carried out by training doctors, nurses and specialists at all levels. The country had a large number of psychiatrists providing care to adults and children, while mental health concepts had been incorporated into training of primary health care physicians and family health specialists.

The participation of communities and of community organizations in providing services and rehabilitation to patients was vital for the management of risk factors, and ensuring that the goals set could be achieved in a sustainable manner.

Legislation was important: public health law, the family code and even the criminal code should include provisions to protect psychiatric patients and all disabled persons. Those persons should be guaranteed social benefits, opportunities to participate in society and to gain access to employment and education, and thus to avail themselves of an integrated system of care. In that regard, one of Cuba's greatest difficulties was that the economic embargo imposed on it by the United States of America restricted access by patients to the psychotropic drugs they needed. In spite of the difficulties, Cuba remained committed to community participation and health education as the best means of reducing the incidence of mental disorders.

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## Cyprus

**Mr Savvides** said that since the 1980s Cyprus had shifted the emphasis of its national policy away from outmoded mental asylums, characterized by stigmatization of the disease and violation of patients' human rights, to community-based services and the integration of mental health care into primary health care. Most patients were now

released into half-way houses or hostels and to their families, and only the oldest and most institutionalized of patients remained in the old-style institutions.

Among the measures introduced in the context of care in the community were the retraining of psychiatric nurses and establishment of community psychiatric services; the deployment of multidisciplinary teams at the community level; and collaboration with nongovernmental organizations and local authorities in setting up various centres, clinics, and types of accommodation. Although much had been achieved, significant problems remained, including a shortage of trained personnel, poor coordination with social services, inadequate coverage in rural areas, inadequate training of primary health care workers and poor information and communication systems.

Among the most important actions taken by Cyprus to counter stigmatization and human rights violations was the enactment of a law in 1997 for the provision of psychiatric treatment, which incorporated the 10 principles recommended by WHO. The media had been enlisted to draw attention to mental health issues, making patients more visible, emphasizing the availability of successful treatment and providing information and education to professionals and the public at large. The fact that World Health Day 2001 had been devoted to mental health had offered an opportunity to intensify efforts in that domain.

Since knowledge of the extent of mental illness and neurological problems in Cyprus was poor, an epidemiological study would be conducted in 2002 and the results would be used to direct policy. Future measures would include more training of professionals, greater multisectoral cooperation, public education, research and the removal of all barriers that prevented the full reintegration of patients into society.

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## Czech Republic

**Professor Fiše** welcomed the round-table discussion, particularly since psychological and psychiatric disorders were increasing in importance in his country. The highest prevalence rates were for neurotic disorders, affective disorders and schizophrenia. The number of suicides of men in the Czech

Republic was also increasing, while the suicide rate of women was decreasing. Although higher than the average in the European Union, the suicide rate of 15.5 per 100 000 population in his country was significantly lower than, for example, the countries of the former Soviet Union.

One of the most serious problems faced by his country in the field of mental health was the shortage of specialists in psychiatry; more were being trained in psychiatry, psychology and psychotherapy, although problems persisted in financing that training, and that of general practitioners and nurses in modern aspects of psychology and psychotherapy. Psychiatric patients were traditionally located in specialized institutions, which were very frequently isolated and oriented towards the long-term, and sometimes lifelong hospitalization of patients, thus underlining the segregation of the mentally ill and contributing to discrimination against both the discipline of psychiatry and against the patients themselves. In recent years, the number of places in institutions for the mentally ill had been increased by one-third. It was planned to organize psychiatry departments as sections of large hospitals, with modern equipment, designed for short stays with intensive diagnostics and treatment, to be followed by outpatient care. It would also be necessary to organize a system of care for chronic alcoholics and persons affected by other kinds of addiction. However, the necessary measures would require substantial funding.

Finally, he welcomed the possibility of cooperating, through his country's Research Institute of Psychiatry and the Society of Psychiatry, with WHO and its office for Europe in the field of mental health.

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### **Democratic Republic of the Congo**

**Professor Mashako Mamba** said that mental health problems in his country had been neglected because of the prevalence of major factors affecting physical health, notably infectious and parasitic diseases. Such neglect also stemmed from the African belief that more emphasis should be given to concrete than to abstract health problems. The war that his country was experiencing, which had displaced and killed many people and split up fami-

lies, had resulted in various kinds of depression and stress caused by psychological trauma. Another major problem was the abuse of psychoactive substances, particularly cannabis.

Faced with a lack of mental health institutions and specialized human resources, his Government had decided to integrate mental health into primary health care, although such integration raised the problem of adequate training. The community-based health care system reduced the risk of patient rejection or stigmatization, but treatment often required the prescription of psychotropic drugs, whose high cost placed them beyond the reach of most patients. In that respect, he appealed for a North-South partnership so that his country's requirements for such drugs could be met.

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### **Denmark**

**Mr Rolighed** said that, in his country, all persons had free and equitable access to the health system irrespective of sex, age, social status and the problem from which they suffered. It was important to ensure that mentally ill patients were given appropriate treatment, and to that end the Danish medical authorities worked closely with research, education and quality assurance programmes.

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### **Dominican Republic**

**Mrs Caba** described how the traditional barriers to improving mental health in her country, such as attitudes of health workers and managers towards people with mental disorders, remained unchanged. The formulation of mental health services was thus restricted, particularly in general hospitals. Integration of mental health into primary health care needed money and time, the high cost of drugs forming part of the problem. As part of health sector reform, the Government was working on a subsystem of mental health care with community and nongovernmental organizations in order to strengthen the provision of services at different levels.

The theme of World Health Day 2001 had provided a unique opportunity to enlist allies in the process of improving mental health care. A campaign had been launched to strengthen the human rights of people with mental disorders, and to try

to improve the way they were treated. Its targets included people in the business sector and the workplace, where issues such as alcohol abuse and stress needed to be addressed. In addition her country was working to improve its present inadequate system of monitoring and record-keeping. Coverage of primary mental health care needed to be improved, too. Although for some 22 years there had been good results with community-based mental health care, the network was concentrated in the capital. Crisis care centres were urgently needed in hospitals, but that development had been thwarted by the resistance of health care personnel, often hospital administrators. The lack of a crisis intervention unit for children and young people presented a serious gap in the system. Rehabilitation and social reinsertion programmes were also needed.

With regard to gender issues, progress had been made through work with nongovernmental organizations, other ministries such as those for women's affairs, the judiciary, and in particular the police. Campaigns had been run on prevention of and dealing with violence in the family, and "solidarity networks" for women had been established throughout the capital and in some other cities. The Government was trying to re-educate health personnel to have a more positive attitude to mental health care. In the education sector, considerable support in the early detection of the effects of domestic violence came from teachers. The current focus was on violence against women, children and young people, together with ensuring routine screening for risk factors of domestic violence. Refuges for the victims of such violence were planned.

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## Ecuador

**Dr Jandriska** drew attention to four issues associated with mental health problems in his country: the fact that Ecuador was located in a high-risk disaster area; the number of persons displaced as a result of the "Plan Colombia" strategy; the high levels of migration away from families in order to find work; and the level of political instability. It was important to analyse mental health in relation to society. To that end, his Ministry had set up a series of mobile units in poor areas from which wage earners were often forced to migrate and a

psychologist had been attached to each unit to analyse the resulting community problems.

Since 1994, there had been greater awareness of mental health in Ecuador, and it was hoped that the draft legislation developed in that regard would enter into force as soon as possible. Ecuador faced a wide range of mental health disorders with prevalence of alcohol misuse particularly high in young people. A multifaceted approach was needed to ascertain the causes of substance misuse and violence, in particular violence directed at women. Ecuador and a neighbouring country planned to develop joint legislation on psychotropic substances.

Affirming the need to pay attention to indigenous populations, he said that his Government was taking steps to provide those in Ecuador with health care services of good quality based on local needs.

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## Egypt

**Professor Sallam** emphasized the importance of differentiating between mental health and addiction and between mental illness in children and criminals. Prevention of mental illness and rehabilitation were not high priorities in developing countries. Egypt had undertaken a major reform in that regard, and a Presidential Decree had been issued to the effect that, while psychiatric hospitals were still needed, the system should be reformed. Many speakers had advocated incorporating mental health care into primary health care; could WHO establish an agenda for that, according to the different countries' needs?

There was an urgent need in developing countries to act promptly against early addiction. Ways should be sought of "immunizing" children against addiction with a service set up for people at high risk and for first-time users. Countries like his would greatly benefit from assistance from international donors for prevention of addiction and rehabilitation. Therapeutic measures such as music and agriculture could be helpful in transforming psychiatric hospitals into rehabilitation centres. Similar treatments could be applied to violent behaviours. That problem, linked to psychological depression, was affecting the entire world. He would welcome the introduction of a social component into mental health strategies. As things

stood, sufferers were often ignored by their relatives and friends; a change in attitude was the first step towards improvement.

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## Fiji

**Mr Nacuva** noted the need to consider mental health problems in the specific context of each particular country, taking into account changes such as the moves from colonial status to independence and from traditional societies to cash economies. In Fiji, the health budget was small and it was difficult to find the funds for mental health services.

However, the sense of responsibility for caring for others was strong and it had therefore been possible to build on community involvement. The Ministry of Health had opted for a multisectoral approach involving all aspects of civil society in the promotion of mental health and the prevention of mental disorders. Fiji had one specialized psychiatric hospital. The emphasis on community-based services and vigorous clinical management had led to a dramatic decrease in the bed occupancy rate and length of stay despite an increase in the number of new cases. Relevant legislation was also being reviewed. It was vital to change social attitudes to mental health care and Fiji was addressing the problem in its own particular context and in spite of budgetary constraints.

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## Finland

**Dr Eskola** noted that WHO had been active in the mental health area since the 1970s. Although mental health had received a lower priority in the 1980s, it was a cause for satisfaction that greater emphasis was now being placed on it. As the Finnish approach to mental health was very similar to that described for Sweden, he focused on the reduction of the specific problems of suicide and depression in his country, areas in which considerable success had been achieved.

The rates of suicide in Finland had increased rapidly from the 1950s through the 1980s, rising from 26.5 to 41 per 100 000 for men, with a figure double that for women. A 10-year, nationwide suicide prevention strategy had been launched in the 1980s and had achieved a reduction of suicide rates of nearly 20% in relation to the peak period. An

evaluation of the project had shown that the stigmatization of mental health disorders had been greatly reduced and on that basis a programme to address the problem of depression had been launched.

During its presidency of the European Union two years previously, Finland had identified mental health as the number one health problem. From that experience, his Government had concluded that clear changes were needed in mental health policies. First, mental health should be brought out of its political isolation into the broader sphere of public health. Second, instead of concentrating on mental health at the individual level, there was a need to strengthen the approach to mental health for the population as a whole, in particular as a means of promoting the integration of mental health into public health policies, strategies, and programmes. Third, emphasis must be shifted from the negative concept of mental disorders to a more positive mental health model. The key importance of mental health was encapsulated in Finland's slogan: "There is no health without mental health."

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## France

**Dr Kouchner** said that mental health was a concept with wider social ramifications than traditional psychiatry. Although the drugs developed over the past 20-30 years had allowed some progress in the treatment of mental disorders, they had also camouflaged the difficulties. People with mental health problems were always stigmatized. Furthermore, psychiatrists, psychologists and social workers did not agree on their practices or general objectives. The general medical community and psychiatrists disagreed about the extent of the mental health sector. Was social work a marginal component of the sector or was it fully integrated? Psychiatrists were unwilling to become involved in what they considered to be social problems, such as depression and suicides among young people. There was poor follow-up on the part of hospital emergency services and society in general of young people who attempted suicide. It was known that one in two succeeded on a second attempt and that half of those who had committed suicide had consulted a general practitioner the week previously. General practitioners did not have the training to deal with such problems.

There was insufficient communication between psychiatrists and social workers in developed countries. In France, the problem of drug addiction had initially been viewed as a psychiatric illness, whereas it was now considered a social problem. It appeared that 30% of prisoners suffered from mental illness, and 20% had been imprisoned for that reason. Was their mental health dealt with adequately? Were domestic violence and alcohol abuse psychiatric problems? Those problems remained unsolved because of a lack of understanding between social workers, general practitioners and psychiatrists.

Efforts had been made to close down psychiatric hospitals and provide care in small community structures in general hospitals, close to the patients' families and to patients' associations. However, some psychiatrists complained that they were swamped by social problems and that closure of the large psychiatric hospitals meant that no beds were available for patients with severe psychiatric conditions such as schizophrenia or manic depression.

## Georgia

**Dr Gamkrelidze** said that the significant social, political and economic changes that had occurred in Georgia at the beginning of the 1990s had had a negative effect on the country's medical care system and particularly on psychiatric care. Owing to major shortages of psychotropic medicines and a drastic deterioration of the conditions in hospitals, patients had left, and the mortality rate in the institutions had increased. In March 1995, the Georgian Parliament had passed a law on psychiatric care which had become the legal basis for the State programme. Hospital and outpatient care was provided by a network of hospitals, regional clinics, psycho-neurological clinics and consulting units. The State covered the treatment costs of about 30 000 patients registered as suffering from schizophrenia, affective disorders, organic and symptomatic psychoses, post-traumatic psychoses and other psychiatric disorders. However, more than 70 000 patients registered in psychiatric institutions outside the public programme required professional psychiatric care. The budget of the programme was greatly in deficit. In order to func-

tion optimally, it would require US\$ 4.5 million, whereas the actual allocation was about US\$ 1.5 million.

Nevertheless, the Government had managed to extend its programme. Regional psychiatric clinics had been opened, and a programme of psychosocial rehabilitation for children and young people had begun functioning in 2000. A service for urgent psychiatric care was planned for 2002. In 2000, a national health policy had been developed in the Ministry of Health, in cooperation with the European Regional Office of WHO and the Georgian Society of Psychiatrists, with a strategic plan for implementation during the coming decade. The main strategic goals for development and reform of the psychiatric care system were:

- extension of the public programme of psychiatric care and a gradual increase in free medical care;
- creation of a system of social rehabilitation and social assistance to patients with mental disorders;
- creation of a system of psychiatric care for children and young people;
- a reduction of the suicide rate in the general population; and
- reduction of the incidence of psychiatric diseases due to social stress.

The plan envisaged the creation of five centres for the psychosocial rehabilitation of patients by the year 2009, in addition to the centre functioning in the capital; nine psychosocial assistance units had been opened in various regions of the country. The prolonged economic crisis did not permit full, regular financing of the state mental health care programme and made it difficult to ensure optimal functioning of the system of psychiatric care in his country.

## Ghana

**Dr Anane** welcomed the choice of mental health as the theme for World Health Day 2001. In Ghana mental ill-health was typically regarded as aggressive or strange behaviour; general society did not consider the milder but distressing forms such as depression and anxiety as mental disorders. Mental health programmes had begun in 1888, with the enactment of the Lunatic Asylum Ordinance. That

Act had been improved in 1972 with a mental health decree, followed by upgrading of facilities, strengthening of personnel and an expansion of institutional care, with a decentralization policy leading to the setting up of mental health units in general hospitals. However, progress in that area had slowed sharply with the economic decline in recent years. Owing to financial constraints, institutions were not giving the required attention to the subject, professional development programmes were constrained and many trained staff were lured abroad to better paid jobs – the proportion had reached 30% of mental health care providers, nurses in particular, in the previous year. Currently, the country had one psychiatrist for 1.5 million population. Low pay and the stigmatization associated with mental illness did not encourage recruitment. Although the Ministry of Health had implemented a motivational programme for all health professionals, that step had been limited by financial constraints and offset by the increasing incidence of mental illness, especially depression, which might underlie the fatalism engendered by spreading poverty. Ghana therefore supported the view that coordinated global efforts to mitigate the ravages of poverty would be a major step to counter mental illness.

Ghana had set its priorities. The Government's mental health policies stressed decentralization of mental health services, not only through the establishment of units in tertiary and regional hospitals but also through the integration of mental health into primary health care. Also, even with the current meager resources, model programmes for training of both medical and non-medical staff in prevention, identification and treatment of mental disorders had been drawn up. Major focuses were attitudinal change, particularly for senior health workers and policy-makers, and the need to ensure that all health professionals were knowledgeable about mental health. Finally, the focus should be on a biophysical model for mental health care, which recognized the biological, psychological and social roots of mental disorders. A purely medical approach would be bound to fail; a sector-wide approach including communities was needed for effective care. Prevention must be seen to be as important for mental health as for general health. Effective communication, including parenting skills, crisis management and the use of non-pro-

fessionals in the community would be vital for prevention of mental health problems. Since 1978 Ghana had had a three-monthly training programme for community psychiatric nurses, who were subsequently placed in all districts.

He noted that gender issues might often be seen as mental health problems. Societal attitudes about expected gender roles, including the childbearing role of women, often caused intense stress: female infertility was an instance. As in other countries, more women reported depression than men.

In order to achieve success, mental health workers were needed to take the lead, but they were in short supply. He urged support for disadvantaged countries in training and retaining personnel.

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## Greece

**Professor Spyraiki** said that the mental health system in Greece had significantly changed in the past two decades, including the introduction of a modernizing legislative framework. With assistance from WHO and with financial support from the European Union, Greece had reformed its system of mental health care, thereby gradually bringing about significant qualitative and quantitative changes. Legislation passed in 1999 had given priority to primary care, outpatient care, de-institutionalization, psychosocial rehabilitation, community care and the provision of information to the community; mental health services were to be decentralized and divided into sectors; social enterprises were being set up for persons with mental health disorders, and a committee had been established for the protection of their rights.

Within the framework of psychiatric reform, an action programme to develop mental health services throughout the country had been launched in 1997, which was reviewed and updated every five years. The recent creation of a large number of permanent government posts related to the programme, at a time of relative economic austerity, had been a measure of the priority assigned to the mental health care system by the Government. In the current year, a committee of persons working in the media had been set up for the purpose of increasing awareness of mental health issues through television, radio and other means.

## Greece

**Professor Spyraiki** said that fighting stigmatization was important not only to overcome mental illness but also to improve society. In response to the Chairman's first question, about the measures put in place to fight stigma, he said that Greece had offered services for the mentally ill in psychiatric units in general hospitals and mental health centres; that had changed perceptions for both the patient and the relatives. Secondly, campaigns were important to teach children tolerance at an early age. Children had to realize that while mental illness had biological and genetic determinants, social disparities were also crucial factors. Everyone should ask themselves to what extent they were responsible for the mental illness of others and what they could do to help.

## Grenada

**Dr Modeste-Curwen** said that her country had tried to fight stigmatization by shifting the emphasis from institutionalization of patients to the start of treatment in the community. However, because many of the mentally ill had never had a job or were unable to hold one, they returned to the institution shortly after being sent out to the community. Grenada had therefore started on a policy of industrial therapy to develop or teach skills, essentially in agriculture. She had recently toured an agricultural area in the presence of media representatives so that they would show mental health patients as productive rather than nonproductive or destructive persons. A multisectoral organization (involving health sector representatives and the community) was helping those with mental disorders by organizing activities such as sports meetings in which healthy members of the community participated alongside the patients. Recently, a long-term institutionalized patient had been helped to launch a book of poetry. The media had been extremely supportive throughout in promoting understanding of the productivity of the mentally ill.

## Guinea

**Dr Saliou Diallo** said that his country had earlier introduced a mental health policy and programme with a strategy of decentralizing all the health structures that would facilitate referrals. That meant the integration of mental health into the basic minimum package of health activities, particularly in primary health care. That required changes in attitude and culture with regard to mental disorders by decision-makers, health care personnel and the general population, with promotion of healthy lifestyles. Unfortunately many obstacles were being met, such as the great gap between supply and demand, the paucity of trained staff, the high cost of drugs, the civil disturbances in Liberia and Sierra Leone with the resulting influx of refugees and incursion of rebels, all on top of poverty and exclusion. With a calming of tensions and the implementation of decentralization, Guinea looked forward to an improved situation.

## Honduras

**Dr Castellanos** said that the prevalence of hurricanes on the Caribbean and Atlantic coasts and the Pacific Rim Fault, which gave rise to frequent earthquakes, were special factors affecting mental health in his country. They precipitated both economic difficulties for the country and mental disorders among the people. The most frequently diagnosed problems in Honduras included violence (30%), depressive illnesses (27%), epilepsy (11%), psychological disorders (6%), and behavioural problems beginning in childhood (5%). In 1975, the Ministry of Health had established a mental health department to deal specifically with such problems. Intensive work throughout the country had formed the basis for the mental health programme.

In 1998 Hurricane Mitch had killed three thousand people and wreaked extensive infrastructural and agricultural damage with lingering effects on the population. Following a detailed analysis of the general health situation, a poverty-reduction strategy had been devised that included a major primary mental health care component. Working directly with the victims of Hurricane Mitch, spe-

cific attempts had been made to enhance community participation through decentralization. A strong response had been received from both the people of Honduras and from such organizations as PAHO, WHO, and other friendly institutions and governments which had provided support. Currently under development was a strategy on mental health in disaster situations.

Gender issues figured largely in the efforts being made to bring about change in the country. Many women had been participating, particularly young single mothers from rural areas who were suffering mental disorders. In that connection, much had been done to enact laws against family violence and a special national institute for women's issues had been established. The Ministry of Health had devised a national sexual and reproductive health programme, and work was proceeding on a special law on HIV/AIDS. Destructive as it had been, Hurricane Mitch had strengthened the unity of the people of Honduras and had provided an incentive to confront mental health problems.

## Hungary

**Mr Pulay** said that awareness-raising campaigns had targeted various groups, the first being decision-makers, including the Minister of Health. With a view to a better allocation of resources, it was important to convince ministers of finance of the significance of mental health problems. For example, in Hungary, it had been decided that new antidepressant drugs should be made available at affordable prices, since the chronically mentally ill were among the poorest members of society. Hence national insurance now covered 90% of the costs for such drugs. A second target group consisted of the patients themselves. Although they were insured, lack of objective information and fear of stigmatization prevented them from coming forward for treatment. Other targets had included primary health care workers, who were crucial in combating gender discrimination, and detecting violence and mental illness in the family and schools. As the Director-General had stated in her address to the current Health Assembly, it was essential to act now to create a better future for the children of the world.

## Iceland

**Mr Gunnarsson**, noting that mental health was vitally important to the well-being of nations and to human, social and economic status, said that it had been included as one of seven target areas in Iceland's new health plan. In that connection, the specific objectives of his Government included the reduction, within the next 10 years, of suicides by 25% and of mental disorders by 10%. The action planned to attain those objectives included: better registration of mental disorders; better training for health care personnel; provision of better information to the public, in particular by enlisting the cooperation of the media; improvement of access to mental health care; the offering of more treatment options; and improvement of coordination between schools and the mental health services. The focus was on children, young people and the elderly, especially those in rural areas. It was hoped that the health plan would help to reduce the stigmatization of those suffering from mental health disorders and discrimination against them and their families.

Studies had shown that those suffering from mental disorders tended to be from the less well-off sectors of society and, despite the fact that Iceland had a strong social welfare infrastructure, steps were being taken to strengthen the system still further. Efforts were also being made to reduce gender disparity: the longevity of women as compared to men, together with other factors such as their greater exposure to stress, made it necessary to distinguish between the health needs of women and those of men and to take such factors into account when planning mental health care. In conclusion, he recalled that most mental illness could be treated and that many mental illnesses were preventable.

## India

**Dr Thakur** said that mental health disorders had been treated in India by yoga since ancient times. India had launched a mental health programme in 1982. The integration of mental health in the public health programme had aroused criticism at first, but was currently recognized as having been correct. Efforts were being made to improve services

in mental hospitals in order to make them more patient-friendly. While he agreed with Professor Ladrigo-Ignacio that problems such as natural disasters and wars caused mental disorders, there were also area-specific problems. For instance, men from Kerala often worked in neighbouring countries, and their absence led to family problems, even suicide, while in poorer states such as Bihar the suicide rate was much lower.

With the development of genomic research, it would be possible to investigate whether some mental disorders were of genetic origin. The round table might identify the need for such a study, as gene therapy could then be used in treatment.

Mental disorders should not be considered as diseases but as part of life. It was his day-to-day experience in medical practice that many persons suffered from slight depression. Addressing their mental health would help them to function better. Efforts should be made to combat the stigma attached to mental deterioration.

## Indonesia

**Dr Sujudi** said that, as a result of legislation passed in 1960, Indonesia had adopted a social approach towards mental health care offering more open and comprehensive facilities and services. In 1974, mental health care had been integrated into selected district hospitals and health centres. Inadequate results in the identification and care of patients had led to the introduction in 1993 of training in the diagnosis and treatment of psychiatric patients for substantial numbers of personnel in such hospitals and health centres. Subsequently, the detection of mental health disorders among outpatients had increased from 0.47% to 2.15%. Community mental health activities had been promoted on a nationwide scale; they would support the development of relevant policies and strategies for improvements at provincial and district levels. Much remained to be done, as indicated by the unsafe environmental conditions and unhealthy behaviour which prevailed, but Indonesia was seeking to adopt strategies that emphasized welfare-oriented and community-based mental health care, as well as the inpatient services, and promotion and prevention, activities which were important to enhancing the overall development of health.

## Iran, Islamic Republic of

**Dr Farhadi** observed that the problem of the increasing gap between physical and mental health services was particularly acute in developing countries, owing largely to lack of awareness, low political commitment, an acute shortage of trained professionals, weak intersectoral collaboration and the absence of community services. All too often, mental health services were neither affordable nor accessible. The only way forward was to integrate mental health services into general and primary health care systems, thus ensuring the provision of the most basic level of services for the seriously ill.

Iran had taken that initiative following a pilot project in 1987, aimed at promoting awareness of mental health issues and making essential mental health care available to all. Following wide-ranging training programmes for medical personnel and community workers and the establishment of a large number of rural and urban mental health centres, mental health care was now available to 6% of the rural population and 12% of the urban population. In addition, innovative programmes had been developed, such as an urban mental health programme, the integration of a preventive programme for substance abuse disorders, within the primary health care system, a school programme and integration of mental health into the "Healthy Cities" project.

With a view to expanding mental health services in 2001 and beyond, Iran's national mental health programme was being revised, a new mental health act was in preparation, and efforts were being made to increase inpatient and outpatient mental health facilities and counselling services.

## Iraq

**Dr Mubarak** recalled that his country was experiencing a difficult situation in view of the sanctions imposed and almost daily bombardments. Cases of mental ill-health had increased, caused by the fear of air raids and the constant trauma of bombing attacks, which particularly affected children, women and the elderly. Those difficulties were well known; the lengthy duration of such problems was another source of trauma. The current situation meant that it was very difficult to measure the

social consequences of mental health problems, as it was impossible to obtain research data. Despite the signature of a memorandum of understanding, the measures taken under the pretext of protecting human rights, and particularly the positions taken by certain representatives on the United Nations Security Council Committee established by Resolution 661, made it difficult to achieve any progress in the health situation in Iraq. Close cooperation was required with WHO to develop better approaches to mental health disorders, particularly through hospital treatment.

It was difficult to persuade trained practitioners to work in the field of mental health. His Government did not have the capacity to provide them with scholarships to study abroad, and it was difficult to bring in qualified personnel to train health practitioners in Iraq. Measures adopted to encourage newly graduated health professionals to work in the field of mental health included the creation of training programmes and rotation systems for new graduates, including incentives for them to spend two years working in mental health. The sanctions meant that the drugs required to treat mental disorders were classified as non-urgent and were in very short supply.

Iraq's situation was having a severe impact on society, and particularly on women. Frustration was coming to the surface and confrontations were developing between family members. Children experienced frustration when they saw toys advertised to which their access was restricted or prohibited, and women, confined to their houses, were experiencing depression. To relieve the situation, legislation had been adopted and other measures devised, including soft loans, to enable women to work from home. The Government was cooperating with nongovernmental and other organizations in civil society to deal with mental health disorders. Heavy penalties were imposed on institutions and enterprises discriminating against persons with mental disorders.

The treatment of mental health should be a subject of close cooperation between countries at regional and international levels and should not be treated as a political issue. Although there could not be one standard approach to mental health which would fit all countries, WHO should lead in developing action in that field.

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## Israel

**Dr Leventhal** said that the future of mental health lay not in hospitals, but in the community; it was the concern of society as a whole, not just of mental health professionals.

Israel had taken the opportunity provided by World Health Day 2001 to extend the event to a week of awareness-raising on mental health. He thanked WHO for providing excellent supporting material.

Mental health affected the whole community since virtually everyone experienced some form of mental health disorder at some point in their lives, although mostly to a very minor degree. The problems associated with mental ill-health were part of living in a modern society. Prevention of those problems and mental health promotion were important at all levels. He regretted the shortage of material available for preventive activities and asked WHO to provide leadership in that field; such material would have the added advantage of ensuring that the public was well informed.

In conclusion, he commended the admission of a former prime minister of Norway that he too had suffered from depression, thus highlighting the fact that such issues affected privileged as well as disadvantaged members of society.

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## Israel

**Dr Leventhal** considered that the present round table and the World Health Day campaign were part of the fight against stigmatization. Society could only fight stigmatization if the health sector played a leading role. The health sector should be reoriented to incorporate consideration of mental health issues in physical health. It had to set a good example. However, the fight against stigmatization concerned not just the health system but also the education and welfare systems. All should contribute to the fight against stigmatization.

In answer to the Chairman's fourth question, violence had in the past been associated with mental illness because mental health institutions had once been considered prisons. To avoid that, patients should now be given access to health services before their illness reached the point where they required institutionalization. In Israel's experience,

only the courts could strike the balance between respect for human rights and enforced admission to a mental health institution. Since Israel had adopted the policy of using the courts, more people were reflecting on the question. Health professionals were in effect asking society as a whole to share in taking such decisions, which resulted in a better balance.

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## Italy

**Dr Oleari** said that the Italian experience in the area of mental health dated from the 1978 law to reform psychiatric services and specifically to eliminate institutionalization. However, institutionalization could continue as a problem, even in the absence of psychiatric hospitals, just as stigmatization and marginalization could still occur, unless the patient was treated as a full citizen. What was needed was a network that included health, social and community services.

Many problems had been encountered after the adoption of the 1978 law, in particular in connection with specific mental health programmes involving the participation of associations of the families of psychiatric patients, which was considered to be essential. Treatment necessarily involved inpatient mental health centres, care for acute patients in general hospitals, and residential structures that were conducive to the reintegration of the patient into society.

Many national health services had encountered the problem of how to finance social and health services. Such economic difficulties had not yet been fully surmounted in Italy also. Mental health funding was not related to expected outcomes, and an effort was being made to weight the per capita contributions through which health services were funded, by taking into account such sex-related factors as neonatal mortality and infant mortality, rather than purely socioeconomic criteria. Much more remained to be done along those lines. In Italy, 5% of the health service budget was currently allocated to mental health.

All psychiatric hospitals had been closed, and general hospitals had been given responsibility for treating acute patients. He considered that the Italian approach was both positive and in line with the experience of other countries, and expected

future efforts to place emphasis on the rights of mental health patients as citizens and on the prevention of mental health problems.

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## Japan

**Mr Kondo** said that the competition inherent in a free-market economy had resulted in rising incidences of stress, distress and mental disorders in his country, underlining the importance of placing mental health high on the agenda. He welcomed the decision to devote World Health Day 2001 to that problem.

Until recently, Japan had placed considerable emphasis on the hospitalization of psychiatric patients. The results were too many long-term patients, and the raising of several human rights concerns. Currently, efforts were being made to ensure that patients acquired greater autonomy as part of their reintegration into society. The Ministry of Health, Labour and Welfare now focused on community-based care, and adequate support mechanisms were being set up, including employment opportunities for patients with mental disorders. Suicide was a significant social problem in Japan, often caused by financial difficulties. Adequate services to improve the social environment should be provided at the regional and workplace levels to prevent such difficulties. It would also be important to conduct research into the causes of depression.

As in other countries, stigmatization of patients with mental disorders was a major problem. Measures were being taken to eliminate prejudice and achieve social integration of sufferers through education and information campaigns, such as those carried out by and through WHO.

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## Jordan

**Dr Kharabseh** explained that his country faced two obstacles to the improvement of mental health care provision: lack of resources and a shortage of specialized workers in the mental health sector. Those two barriers were the result of war, human rights violations and other injustices.

He emphasized the importance of integrating mental health and general health programmes, and of making treatment affordable in order to care for the poor properly.

## Lao People's Democratic Republic

**Dr Boupha** congratulated WHO for highlighting mental health and bringing that important topic to the attention of Member States.

Among its strategies for addressing mental health, her country had promoted a series of activities using video productions and school contests within a community-based approach, as part of a deliberate strategy to tackle mental health issues.

She stressed that mental health factors relating to women had generally been overlooked. There were some 75 million unwanted pregnancies in the world each year. Unwanted pregnancies could have tragic consequences for the women, their families and society as a whole. The issue was one of empowerment: women should be allowed to decide when and whether they wished to become pregnant. A great deal of distress and depression could thus be avoided. She urged WHO and the authorities in each country responsible for mental health programmes to take into consideration the problems related to women's health.

## Lesotho

**Mr Mabote** said that, historically, mental health services in Lesotho had been marginalized, as was reflected in both legislation and budget allocations, with stigmatization and discrimination rife. Mental ill-health accounted for a significant proportion of DALYs lost, with the largest proportion of the burden due to epilepsy and depression, the latter being more common in women than in men. Substance abuse, especially of alcohol, was rising and his country recognized the need for vigilance in that area. For many years, mental health services had failed to pay sufficient attention to emerging gender-related issues and violence. The Government was now giving serious attention to gender-sensitive policies and a specific ministry was dealing with the question. Moreover, an association of women lawyers was playing a leading

role in raising private and public awareness of gender issues in many areas. Mental health policy was being revised to incorporate contemporary gender-related issues, such as the effects of unemployment, and to encourage disclosures concerning violence and emotional abuse. In addition, public awareness campaigns, seminars and workshops were providing a strong foundation for policy formulation concerning effective prevention of gender-related mental health problems. Preventive measures included poverty-reduction strategies involving income-generation projects. Training was needed to sensitize health care workers and others, such as the police, to the mental health consequences of gender-related violence, and to the need to provide tactful counselling and support.

## Madagascar

**Professor Ratsimbazafimahefa** observed that mental health was an integral part of WHO's definition of health, although it had long been overlooked in the developing countries because of the priority given to control of communicable diseases. At Madagascar's present stage of epidemiological transition, the number of mental disorders and disabilities, the legal battles concerning people with mental problems, the increasing number of suicides and of patients who remained hidden away, unable to face the difficulties of adapting to life in society, all served to highlight mental health as a top priority.

The celebration of World Health Day 2001 had further widened the country's understanding of the issue by seeking to redefine mental health and its implications for quality of life. It had also underlined that mental health was a means and an indicator of economic, social and cultural development so that failings in mental health led to poverty at every level. Thus her country had attached particular importance to the management of mental illness, which was handled chiefly by the public health system. Severe cases could be referred to provincial psychiatric centres, but otherwise mental health was part of primary health care. However, deficiencies both in number and quality of personnel had led to the appointment of a mental health coordinator to review the national mental health policy. That policy would include prevention and treatment of mental illness with social

reintegration, and would especially emphasize the development of human resources with training for mental health nurses and psychiatrists. Doctors working in primary health care had training guides to teach them about mental health. The lack of international solidarity on mental health issues was to be deplored. She asked WHO to seek ways of developing partnerships to give fresh impetus to that new world priority.

## Malaysia

**Mr Chua Jui Meng** recounted a visit to a mental institution that had a clock tower with no clock; that had brought to his mind the thought that, on entering the place, there was no time, no reality and, for many inmates, no hope – they had been marginalized and stigmatized by society and, worst of all, by their own families. For the whole of the previous year, the Government had run a healthy lifestyle campaign in the mass media on the theme of mental health, including prevention. He echoed the description by the delegate of Trinidad and Tobago of the mass media as allies; every year, Malaysia, had given awards to journalists for the best writing on HIV/AIDS, as well as to the newspapers they worked for. As poor or unbalanced reporting about mental health issues could spark fear and discrimination, he proposed that similar awards be given to the journalists and the mass media which projected a more positive picture of what mental illness meant; that would be a start.

## Maldives

**Mr Abdullah** welcomed WHO's initiative to place mental health actively on the global agenda. Awareness-raising on behalf of the complex and forgotten issue of mental illness could be just as successful as that on behalf of HIV/AIDS. WHO should vigorously persuade Member States to dedicate a significant part of their national health budgets to improving treatment and facilities for the mentally ill, thereby enabling a large number of people to return as productive contributors to the mainstream of society. He called upon his fellow ministers to attach greater importance to mental health and to step up their contributions to it.

## Maldives

**Mr Abdullah** said that the biggest stumbling block in the fight against mental ill-health was the stigma attached to it. He endorsed the view that information, education and communication provided a way forward. He was gravely concerned by the breakdown of family values and strongly believed that spending more time with family and children would help to solve the problems. Research had proved that time spent with one's family removed fear and prevented the development of mental afflictions. People were being killed by the hectic lives they led, which gave rise to social problems for their families, including mental illness. The health sector could not tackle the growing problems on its own. An integrated approach was required, involving the education sector, the community and nongovernmental organizations.

## Mauritius

**Mr Jugnauth**, speaking as a lawyer rather than as a medical doctor, asked why it had taken so long for governments and international organizations to recognize the issue of mental health. What were the problems, and the related solutions, in the field of mental health? In response to those questions, he said that the key words were: recognition, identification, and treatment. Because those suffering from mental illness often attempted to hide their problem, such illness was both denied by the affected person and unrecognized as a real illness by their families. Accordingly, those who needed help were excluded from treatment.

Barriers to implementation of mental health services included public attitudes, resulting in a fear among individuals which prevented them from coming forward with their problems. A centrally-based institution in Mauritius had been constructed in a remote area as a high-security hospital for disruptive psychiatric and acute psychiatric patients, with different rules and regulations from those applied to general hospitals. Those admitted to that institution could not receive relatives or close friends.

The main barrier had been the failure to recognize mental illness, which was essential if the necessary treatment were to be provided. To achieve such

goals and overcome such barriers, he suggested that countries might follow the example of Mauritius in adopting a mental health act that clearly identified the fundamental freedoms and basic rights of those affected by mental illness, and provided for the protection of minors suffering from mental illness, life in the community and their rehabilitation in society. Other provisions of the act included the determination of mental illness, medical examination, confidentiality, the role of the community and culture, standards of care and treatment on a basis of equality with other patients, conditions in mental health facilities, resources for those facilities, admission principles, review bodies, procedural safeguards, access to information and equal treatment of criminal offenders.

Decentralization of mental treatment had been moving forward but with acute patients remaining in the psychiatric hospital. Wards for psychiatric patients in the regional hospitals were situated so as not to affect the rest of the patients.

Although Mauritius had eradicated malaria, poliomyelitis and tuberculosis, about 30% of the population still suffered from some kind of mental illness. Decentralization had been essential to reach those people and to make mental health services more available; to assure cost-effectiveness of services; to promote greater awareness in the community; and to suppress stigmatization of mental and psychiatric problems.

The main problems were societal, but there were also financial constraints, particularly in African and other developing countries, which made it difficult to decentralize. Another problem involved shortages of medical personnel, owing particularly to the emigration of trained medical personnel.

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## Mexico

**Dr Frenk Mora** underlined the double burden of disease that was afflicting developing countries. They faced mental health problems linked to backwardness and poor hygiene, such as epilepsy and mental retardation, as well as new types of mental disorder more commonly associated with developed countries, such as depression and psychosis. Moreover, current epidemiological and demographic trends, such as population ageing, indicat-

ed that the burden of mental disease was set to increase in the future in all countries.

Mental health problems served to magnify existing deficiencies in the overall health care system in respect of quality of treatment and care, respect for the human rights of people with mental health disorders, and fairness in financing, including the lack of health insurance cover for the mentally ill. Consequently, mental health should be treated as a priority in efforts to reform health systems. An important first step in increasing awareness of the problems associated with mental disorders was to document the scope of the problem. In that respect, Mexico had carried out several surveys which, in conjunction with WHO's ATLAS project, should provide scientific evidence for treating mental health as a priority area.

The public sector had a vital, proactive governance role to play in articulating the importance of mental health, protecting the human rights of those suffering from mental disorders and combating the stigma attached to mental illness. In Mexico, priority had been given to devising new mental health programmes, in particular to tackle alcohol and drug dependence, depression, schizophrenia, dementia, psychological disorders in children, and epilepsy. New pilot projects were under way to introduce innovative approaches that included the integration of prevention and treatment of mental health disorders in general health care systems; early detection of learning disabilities and social rehabilitation of patients in half-way houses, sheltered workshops and residential accommodation to facilitate their gradual reintegration into the community.

He agreed with Dr López on the need to focus special attention on the mental health of indigenous people, taking into account their particular cultural circumstances.

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## Mongolia

**Professor Nymadawa** observed that, while mental disorders were increasing in all Member States, they were a particular problem for countries in transition. In the previous 10 years, Mongolia had undergone drastic socioeconomic changes in its efforts to build up a multiparty democracy and a market economy. That difficult task had rendered

social problems more acute, resulting in increased prevalence of depression, alcoholism, accidents, suicide and crime, especially among the poor. According to a recent study, 51% of the adult population used alcohol and the suicide rate had risen five-fold between 1989 and 2000. The Government had introduced several measures to promote stabilization and provide social protection. Since 1990, cost-sharing mechanisms had been introduced into the previously universally free health service and a social health insurance scheme had been set up in 1994. However, the costs of treatment for chronic mental health conditions continued to be met by the State in the same way as some other priority health services such as immunization programmes and pregnancy and childbirth care.

He expressed appreciation for WHO's support in coping with the mental health problems arising from economic transition. Mongolia faced a severe challenge from increasing mental health disorders, especially alcoholism and depression, and hoped to learn from the experience of other countries with different conditions and structures.

## Morocco

Mr El Khyari observed that lack of knowledge was hampering efforts to tackle mental health problems, many of which were influenced by complex social factors. Moreover, the financial and human resource costs of long-term treatment and support for those with mental disorders were beyond the reach of many developing countries. Many were experiencing economic transition and its consequences, such as the splitting of families and decreasing belief in traditional medicine, at the same time as undergoing as severe resource constraints. Mental health disorders required the involvement of several different ministries and many different aspects of civil society; they called for solutions that went beyond the conventional health care framework. He therefore welcomed the interest being shown by the international community through WHO.

## Mozambique

Dr Ferreira Songane described the development of his country's mental health programme in 1990, based on prevention, training and partnership, in a multisectoral approach. Although Mozambique's psychiatric hospitals had largely become redundant, it lacked the resources to eliminate the stigmatization of the mentally ill. In practice, many sufferers were simply left on the streets to die.

Since it had insufficient specialists and wanted to decentralize services, Mozambique was providing psychiatry training for doctors at the middle level of the system, including a significant public and social health component. The physicians worked closely with traditional practitioners who also had expertise in the use of drugs, and who thus could help overcome social resistance to seeking treatment.

The streets of Mozambique revealed children as young as five years of age who were forced out to work or to seek food and were deprived of the education and care they needed to enjoy mental health in later years. His Government hoped that, with the help of WHO and through its highly effective Regional Office for Africa, such phenomena could be effectively eradicated.

## Myanmar

Mr Ket Sein described how the launch of his Government's mental health programme in 1998 had started to break down the misconceptions previously attached to mental health disorders. Awareness had been enhanced by the activities of health education teams and projects. Community participation in activities designed to provide moral support for sufferers had also been important in improving acceptance by the community and in encouraging community-based care. The engagement of well-known artists and cartoonists to open and promote exhibitions of paintings and drawings by people with mental disorders had contributed greatly to the change in people's perception of mental illness and to minimizing discrimination.

The community-based approach to mental disorders covered the training of basic health care workers. New care guidelines had been issued, and the supply of basic psychotropic drugs had improved.

Nongovernmental organizations were encouraged to promote mental health activities, including the prevention of substance abuse among young people. Health education activities had been introduced in schools and in the community. A maternal and child welfare association had started to promote health and well-being, including programmes for education and income generation. National committees for women's affairs had sponsored the establishment of counselling centres for victims of violence.

At the national level, a concerted effort was being made as a result of the mental health theme for World Health Day 2001 to secure adequate supplies of affordable, good quality psychotropic drugs. Meditation, which was already part of Myanmar's culture, continued to be encouraged for the harmonious mental state that it promoted.

## Namibia

**Dr Amathila**, noting that the stigma of mental illness had been eclipsed in Namibia by that associated with HIV/AIDS, said that gender disparities had been actively addressed in her country, and that no health service excluded women. As far as mental health was concerned, women in Namibia appeared to be stronger than men; however, the level of violence against women was increasing. The health authorities had set up centres for women and children who had been abused, and in the previous year, an organization entitled "Men against violence against women" had been set up by men to provide counselling to abusive men.

Unemployment, poverty, alcoholism and HIV/AIDS were important factors in the rise in mental instability in Namibia, especially among young people. The refugees from neighbouring war-torn Angola also experienced mental health problems. It would therefore be important to create employment opportunities where possible, and to improve the country's economy. HIV/AIDS had resulted in an increased incidence of depression and suicides; counselling services were not always accessible to the young, and immediate, confidential support, which should also cover mental health issues, should be provided. Traditional healers were now based at rural clinics to deal primarily with mental illness. Pensions for persons aged 60 years

and over had helped to reduce depression among the elderly. However, the elderly were having to take care of an increasing number of AIDS orphans, and additional steps should be taken to support them in that regard.

Namibia currently had only one psychiatrist, and there was a clear need for additional investment in human resources and training to improve care for those with mental illness. Some 15% of the gross domestic product was devoted to health services, and it was important to ensure that due attention was given to mental health.

## Nepal

**Mr Tamrakar** observed that further study was needed in order to determine whether certain behaviours and lifestyles might be conducive to mental illness, and to investigate the mitigating influence of spiritual aspects of individuals' lives, such as meditation. His country had adopted a national mental health policy. In the past, the size of the problem had not been recognized, owing to the stigma attached to mental disease, as well as to the shortage of trained personnel. A community-based pilot project was gradually being introduced, involving traditional healers and civil society as a whole in an awareness-raising campaign. However, it was difficult to allocate adequate resources in that area, and Nepal would welcome support from WHO to find funding for mental health projects and to provide drugs for a limited period.

## Netherlands

**Dr Borst-Eilers** said that her country had also seen a growing demand over the past 10 years for help for mental disorders, due to the increasing incidence of such problems and to the fact that help was being sought at an earlier stage, largely as a result of de-stigmatization. The change had undoubtedly been promoted by well-known personalities who had openly admitted to suffering from certain disorders. The availability of effective treatment for mental health problems such as anxiety and depression in primary health care centres, by family doctors, psychiatric nurses, social workers or primary care psychologists, was also responsible for the growing demand.

Like France, the Netherlands had also begun to shift from institutional to community care, where patients received support and various kinds of ambulatory treatment. In order for the shift to be successful, budget cuts were inadvisable, as community care was not necessarily cheaper than institutional care in view of the personal support required. It was also important not to push the concept further than the community could tolerate. Some vulnerable patients with chronic psychotic conditions and those who posed a threat to others needed the protected environment of an institution and should not be exposed to life in a community. One of the most important aspects of community care was the building up of broad public support by making it clear to the local community that professional help was readily available in the event of a disturbance. Community care had been introduced into a number of cities in the Netherlands with great success.

## Niger

**Mr Adamou** said that, since the independence of his country, mental health care had been provided at the national hospital in the capital and at three hospitals that had psychiatric units; however, with waning funds and resources, their performance had deteriorated. On the occasion of World Health Day 2001, WHO had provided certain psychotropic drugs, which had enabled the country to resume its activities in that field. Clearly, in a country as vast as Niger, three hospitals were insufficient to cover all mental health care needs. The mentally ill, whether hospitalized or not, were rejected by their families and were looked after by the State. In his country, traditional medicine existed side-by-side with modern medicine. The traditional healers were not witch doctors and did cure some mentally ill people. The intention of the authorities was to promote primary health care for mental disorders and to decentralize that care through personnel training and the provision of sufficient drugs. Niger's mental health programme was new, and there was need still to formulate policy, coordinate the activities of all those involved in mental health care and to raise awareness. All that was needed was financing. He had found the round table useful and would make good use of some of the suggestions that had been made.

## Nigeria

**Professor Nwosu** commented that in Nigeria mental health care had initially been the responsibility of families and communities, and had then been transferred to hospitals before being restored to the community. The disintegration of the extended family system in Africa had placed an enormous burden on the community for the management of mental health care. In that regard, poverty alleviation was a crucial instrument for integrating mentally ill patients into society and giving them adequate care. While traditional healers played a major role in treatment, the community also needed education and awareness programmes so that traditional care would be effectively integrated into the orthodox health care system.

She asked that WHO devise a special programme on postpartum psychosis, a neglected area of mental illness.

## Norway

**Mr Tønne** said that as a result of a study conducted a few years earlier, which had led to some shocking conclusions about the state of the mental health care system in Norway, his Government was working on a long-term plan to bring the system up to acceptable standards. In reply to the third question put by the Chairman, he said that openness and inclusion were two of the key issues being addressed. The history of mental health care in Norway, as in many other countries, had been one of non-information, lack of openness, closed institutions, stigmatization, exclusion, shame and fear. The reform of that situation had been a long process which had required changes in culture, attitude and behaviour amounting to a complete re-education of society. The second key issue, inclusion of those afflicted and affected, was closely connected to the first, because it could not be attained without the active participation of patients and their families. That implied participation in the development of the mental health care system and treatment offered, participation in the design and performance of information and education programmes, and, perhaps most importantly, individual participation in self-help and self-treatment.

Research in Norway indicated that 20% of the population suffered from mental illness at least once during their lifetime, and that mental illness was a growing factor in causing school drop-outs, unemployment and absenteeism. In the debate on mental health some difficult and controversial questions had arisen, for example the question of whether a general recognition of mental health problems as illness might not entail the risk of lowering the threshold of illnesses requiring treatment, thereby reducing the capacity of individuals to cope with their own problems.

## Norway

**Mr Tønne** said that the broad answer to the Chairman's four questions was that information, in the sense of education of society as a whole, was the best remedy. All efforts to fight stigma had actively to involve everyone who suffered from mental health problems and stigmatization.

With regard to the comments made by the delegate of Israel, it was important to distinguish between mental illness and the mental problems that arose in normal society. Care had to be taken that efforts to promote mental health did not produce stigma by turning normal problems into illnesses and disorders. Thresholds should not be lowered; rather, work should continue on education and information.

## Pakistan

**Dr Kasi** said that the debate had shown that the prevalence of mental ill-health was high in all societies, particularly among women. Governments were obviously keen to adopt preventive as well as curative measures to eradicate mental health problems, to reduce stigmatization of people with mental disorders, and promote their social rehabilitation. However, efforts in developing countries were hindered by lack of financial resources and technical capacity. He urged WHO and the developed countries to assist the developing countries in that regard. It was also essential to determine the scale of the problem and how it affected countries' societies and economies. The current discussion would contribute to that process and Pakistan looked to the international community

for further support, while following a consistent policy.

An area not so far discussed was the collection of data on mental health problems in areas of conflict and occupation by foreign forces, in particular among refugee populations, as for example in Kashmir and Palestine. There was a danger that their concerns might be marginalized in the general debate.

## Pakistan

**Dr Kasi** related that recent studies carried out in rural areas and urban slums in Pakistan had shown a high prevalence of neuropsychiatric disorders. Mental health had also been identified as a main priority area in the national health policy. The Lunacy Act of 1902 had recently been replaced by the National Mental Health Ordinance 2001 which provided a balanced framework for protecting the human rights of mentally ill people and their families. The national mental health programme had established pilot projects at local level to provide mental health care as a component of primary health care. The media and nongovernmental organizations were supporting efforts to promote public awareness and understanding of mental illness by tackling traditional myths and superstitions. Other public sectors, in particular the Department of Education, were actively involved in the mental health programme, and mental health education was being introduced in private and state-run medical schools. Psychiatric nursing courses were also being offered by nursing schools. Mentally ill people and their families were eligible to receive grants, as well as social and disability pensions. Most health care services for the mentally ill were provided by the public sector, although the private sector was rapidly emerging as a new player in that area. As yet, no policy existed to regulate private sector providers and health insurance was not available, although the Government had recently submitted an ordinance on the regulation of private hospitals, including mental health institutions.

## Panama

**Dr Gracia García** said that he had found the round table highly instructive. It would be important to determine to what extent mental health systems had been affected by the economic and social policies and crises imposed by the current development model. Panama resembled other Latin American countries in experiencing increased poverty, greater unemployment and a resultant rise in disease in general and in mental illness in particular. One immediate effect of an unstable economy was decreased spending on health and education.

In 2000, Panama had made mental health a priority and had implemented four programmes. The first had focused on obtaining accurate epidemiological data on the real impact of mental illness on society. The second had ensured early diagnosis and treatment of mental illness in a national care system through promotion campaigns and education programmes for patients, their families and general practitioners. Joint public-private sector support groups for patients and their relatives had been established to eradicate stigmatization of mentally ill patients by their families and society, so that the patients could be reintegrated into society as rapidly as possible. A community pharmacy programme had been established that gave patients access to high-quality drugs at reasonable prices. The possibility of State subsidies for drugs in the event of economic necessity was being studied.

## Papua New Guinea

**Mr Mond** described his country's 10-year action plan for social change and mental health. The main challenges were: the need to increase public awareness and involvement; the limited financial resources; poor service coverage; inadequate training of staff, community, and home care providers; a lack of psychiatrists and psychiatric nurses; a neglect of forensic psychiatry; poor intersectoral collaboration; and, finally, insufficiently developed data and evaluation indicators. To respond to those problems, month-long awareness campaigns and training seminars were held for skills development, and a community-based psychosocial health care centre had been established. Pocket-sized standard treatment manuals were being prepared for gener-

al practitioners, nurses and other health care professionals, to help them deal with mentally ill patients in the hospital setting.

The Government's mental health policies were linked to social change, and included free psychiatric care and rehabilitation as an integral part of the public hospital system and the establishment and support of community-based treatment and psychosocial rehabilitation, carried out in collaboration with nongovernmental organizations and other such groups.

## Peru

**Dr Pretell Zarate** said that developing countries, with their many priorities and scant resources, needed more information on mental health in order to raise awareness of the problem. The first step should be to carry out national epidemiological studies. He appealed to WHO to support countries in carrying out surveys on mental health at country level, in order to provide more accurate data on the prevalence and epidemiological profile of mental disease. Such surveys would permit an assessment of requirements in terms of human, professional, and family resources, and of mental health care provision. They would also support the development of appropriate models for developing countries to deal with mental health problems. He applauded the pragmatic efforts of many countries in providing psychiatric training for health care workers, but he wondered what results had been obtained from such training in terms of quality of care, prevention, diagnosis and referral to other levels. Secondly, he enquired what experience had been gained in mobilizing families and communities, particularly in rural areas, to avoid isolation, discrimination and stigmatization in respect of the mentally ill. Lack of resources and failure to prioritize mental health were problems shared by all developing countries, and it was therefore of vital importance to conduct a global survey on mental health.

## Peru

**Dr Pretell Zarate** said that a significant cause of stigmatization and segregation was the pessimistic view of mental health patients as lost causes or as a

source of great expense to the State. It would therefore be very useful to wage a major educational campaign showing the scientific progress made with regard to the causes of many of those problems and the existence of new and more effective methods of treatment and rehabilitation. For example, the World Summit for Children's global campaign to iodize salt was an effective, cheap and easy means of preventing damage to the brain and mental disease.

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## Poland

**Professor Opala** said that the Polish Ministry of Health and Social Welfare had approved a new mental health programme in 1994 with the aim of ensuring improved access to appropriate health care and support for those with mental disorders. The implementation of the programme and the mental health of the population were being monitored. A recent study of mental health had revealed that the number of people with a positive assessment of their lives had increased but feelings of happiness and satisfaction had declined. Higher mental well-being was associated with broader social support, increased income, participation in religious practices and marriage, whereas a lower sense of mental well-being affected in particular the elderly, the unemployed, those with a lower income and those suffering from loneliness. The highest risk for mental disorder was found in persons over 65 years old, 51% of whom (88% in women) admitted to feeling sad and depressed. The Council for Mental Health Promotion had drawn attention to some of the risk factors for mental disorder and measures had been introduced to monitor and promote mental health, including the identification of risk groups, the introduction of educational programmes for families, the implementation of school curricula to develop skills in problem-solving and coping and the establishment of various forms of psychological counselling and intervention for people in emotional crisis. Such measures would be included in the national mental health programme.

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## Portugal

**Mr Boquinhas** said that his Government had approved a national mental health plan in 1996 and

in the last five years had ratified a new mental health act and organized new mental health services around hospital and community care. Intersectoral cooperation was being promoted.

Other legislation, concerning collaboration between the health sector, social services and non-governmental organizations in the development of psychosocial rehabilitation programmes had also been approved. For example, the national council for mental health and a number of regional councils had been established, and a hospital referral network put in place. The integration of mental health services into the national health service ensured their greater accessibility and adequacy. In-patient treatment was now provided in general hospitals. Local services had been developed to replace psychiatric hospitals, and new psychiatric services were being funded at the community level, including services for children. Drugs for the treatment of severe mental illness were partly subsidized.

There was nevertheless a marked lack of progress in some areas. Stigmatization persisted, little attention was paid to preventive programmes and there was a lack of community-based facilities to bridge the gap between hospital and home care. There was also a lack of epidemiological data on psychiatric morbidity and mortality and use of the available facilities. There was a particular need for monitoring and assessment of the national mental health policy, its implementation and the quality of care. Efforts were being made to promote mental health by investing in community-based facilities for long-term patients, developing a national plan to create other facilities such as day care and continuity of care on medium-term and long-term bases. Epidemiological and economic studies were being planned at the local and national levels, and an ongoing monitoring and assessment programme had been established to ensure quality of service.

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## Republic of Korea

**Dr Lee** said that, until the mid-1990s, his Government's policy had been geared to long-term hospitalization of mentally ill patients. However, with the enactment of the Mental Health Act in 1995, there had been a trend towards a community-oriented approach, concentrating on early

detection, early treatment, rehabilitation and integration in the community. Considerable improvements had been achieved. About one million persons were currently receiving treatment, representing 2.7% of the total population. A large-scale epidemiological study on mental illness was under way. Measures had been put in place to provide support for families, appropriate jobs for those able to work, and entitlements to disablement benefits. The Government was committed to combating social stigma related to mental illness through public campaigns and community-based projects. Mental Health Day 2001 had been celebrated with the design of a special emblem to draw attention to the importance of mental health and the organization of academic seminars and rallies for mentally ill patients.

## Romania

**Dr Bartos** explained how she had learned early in her medical career the true importance of adequate mental health services. The lack of such services allowed many persons with mental disorders to hide behind real or virtual barriers, some of which were presented by prejudice and intolerance. In her country, despite the important social changes that had occurred, violence, unemployment and a rapid deterioration in economic conditions and living standards were all affecting the mental health of the population. The Government believed that health care was a collective social good to which everyone should have free and equitable access. Better health in Romania would be achieved through a strategy of correcting the excessive orientation towards hospital services which was detrimental to outpatient and community care.

The Ministry of Health and the Family had submitted a bill to promote mental health and the protection of persons with psychological disorders, to ensure that they were treated in a manner that fully respected their dignity, without discrimination and, in so far as possible, in the community. WHO had supported the preparation of that bill and had also contributed to the evaluation of mental health at the national level. Romania needed a national mental health plan based on: the determination and evaluation of the real dimension of the problem; the reform and

effectiveness of the system of mental health services; and integrated, interdisciplinary and intersectoral programmes to promote mental health. Family doctors needed to be involved to a greater extent as “gatekeepers” and special assistance would have to be provided to vulnerable and high-risk groups. The Ministry was also coordinating a project financed by the World Bank for the establishment of a mental health centre. She welcomed the support provided by WHO and its initiatives to raise awareness of mental health problems, which had prompted several new activities, which she hoped, would reduce certain obstacles to mental health service reform, including traditional attitudes and inertia. In transition countries, such as her own, one of the most difficult reforms had concerned hospitals, in which most mental health services were located and the call for emphasis to be given to outpatient and community services. Such a course of action was hard, given the lack of information on the real dimension of the problem. She therefore welcomed the round table which, even if it did not knock down existing barriers, would nevertheless weaken them.

## Russian Federation

**Professor Krasnov** stressed that the rise and spread of mental health problems were characteristic of all societies, rich, poor, or in transition. It was wrongly assumed that poverty eradication was the prerequisite to the reduction of prevalence of mental health problems; however, those problems were themselves factors of social and economic development.

Any long-term strategy of care and prevention required greater integration of psychiatric services into the general health system, with families and even former patients contributing their unique experience, skills and advice on how to overcome certain problems. The task could not be left to specialists alone; it required the participation of all members of society, and of primary health care workers in the first instance. Although his country had limited experience in that domain, it had organized local polyclinics facilitating early intervention through offering access to services that communities would otherwise shun if provided by large institutions.

He suggested that a global appraisal be made of experience in mental health care in different countries in order to develop effective health care models. WHO was uniquely positioned for such a task.

Many participants had described community-based mental health care policies, but there were as many interpretations of the term “community” as there were regions, countries or towns. Whereas most villagers knew one another, in large urban apartment blocks people rarely knew their neighbours. Effective community-based care should be predicated by a definition of “community”.

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## Rwanda

**Dr Rwabuhiri** noticed that the date for World Health Day, devoted to mental health, had been 7 April. However, that day was one of mourning in Rwanda to commemorate the tragedy of 1994, where in the space of only 100 days one million Rwandans had been killed by other Rwandans. The significance of that date would prevent Rwanda from celebrating World Health Day for many years to come. Mental health programmes in Rwanda were being decentralized in order to help to cope with the healing of an entire society. It was not a question of healing a few groups on the margins but of instituting a mental health programme for the whole population. The need was more readily understood when set against the backdrop of the more-than 120 000 persons still in prison on suspicion of having participated in the massacre of their compatriots. One survey of 3000 children in 12 provinces had revealed that over 90% had been in danger of being killed and more than 95% believed that they were dead, even though they were living. Those factors gave an indication of the enormity of the task being faced with very few resources. Rwanda had chosen a participatory form of justice in which people who had witnessed the massacres for three months would be able to tell the truth about what had happened. That was the reason to ask everyone to participate, including the traditional health systems, the district hospitals and the health centres, in order to seek the truth and assist in the healing process. The traditional healers were needed because there was a desperate shortage of so-called modern medical personnel. There were fewer than 200 doctors in Rwanda as compared with more than 10 000 traditional healers. He

thanked all those who had helped Rwanda, especially in training. He expressed his particular appreciation to Switzerland for its cooperation in training doctors and mental health specialists.

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## Rwanda

**Dr Rwabuhiri** said that mental health institutions should not remain in isolation but should be located in city centres. Rwanda had recently opened a centre for psychological and social consultations in the middle of town, next to the main bus station, and had been surprised to find how many people it had attracted. It might help to make that approach more widespread.

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## San Marino

**Mr Morri** said that mental disorders should receive greater attention. Since 1955, patients in San Marino had enjoyed free, direct access to medical care, including care for mental and neurological disorders. As San Marino had no psychiatric hospitals, patients requiring admission were referred to institutions in other countries. In addition, relevant legislation was being reviewed to respond to new needs, including support to care providers.

San Marino had always attached importance to caring for patients with mental disorders through social and community-based services, and strategies had been improved to enhance quality of life. Rehabilitation was individually tailored, and included access to half-way houses for reintegration into the community, occupational rehabilitation workshops and special training contracts. Private companies could enjoy reductions in their social contributions if they employed certified disabled persons and were required by law to employ one disabled person for every 20 employees. Those and other administrative and social measures were effective in preventing the stigmatization of persons with mental disorders.

Voluntary assistance contributed significantly to the services provided by the State, and some voluntary associations were actively promoting information on mental disorders, supporting rehabilitation, and encouraging the involvement of the mentally and physically disabled in sport.

Current commitments would need to be sustained, through, inter alia, investment in human resources and the implementation of preventive programmes targeted at all social groups, and the provision of effective and individually tailored care. It would also be essential to improve understanding between patients with mental disorders and doctors.

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## Senegal

**Mr Diop**, describing the experiences in his country, said that particular stress was being laid on raising public awareness of mental health matters. Through the national health education system, mental health experts were promoting a programme in the mass media, using all the Senegalese languages. In 2001, particular emphasis was being given to epilepsy, prevalence of which was 8% to 11%. An information programme was being developed to induce traditional practitioners to refer patients with mental disorders to specialized care services. So far, participation by the State in care for patients with mental diseases was still very low, although the Ministry of Health was currently developing a national programme in that regard. The strategies were aimed at reducing stigmatization and exclusion and encouraging family participation in caring for patients with mental health problems. Some patients were cared for in psychiatric villages, staffed by carers from the same region. Elsewhere specialized teams were being set up to visit patients in their own environment. An attempt was being made to integrate mental health care into the basic health care programme, which involved training health workers at all levels and improving prevention, screening and treatment. Traditional practitioners were also becoming increasingly involved in mental health care alongside professional health workers.

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## Sierra Leone

**Dr Jalloh** welcomed the decision to focus on mental health for World Health Day 2001 and to include the subject on the agenda of the current Health Assembly.

The Ministers of Health of Uganda and the Democratic Republic of the Congo had raised the

issue of civil strife as a factor in mental health problems. It was important for countries that had undergone war to share their experience of the relationship between war and mental health. On 6 January 1999, rebels had invaded his country's capital, Freetown, and had carried out widespread and barbaric attacks on the civilian population, including arbitrary executions, abductions, single and gang rapes, amputations, arson and looting. At least 10 000 people were alleged to have died and at present some 150 000 were displaced from their homes.

While most medical personnel acknowledged that gross atrocities had been committed, they knew little or nothing about post-traumatic stress disorder, which was difficult to define both conceptually and operationally. It was a unique diagnosis, in that an exposure or criterion stressor was an integral part of the disease. The criterion stressor required that a person had experienced an event that was outside the range of usual human experience. Although specific criterion stressors might be difficult to define, participation in war was generally deemed to be such an experience.

The concept of post-traumatic stress disorder should be considered with care, as not all disorders arising after traumatic events fell into that category. To overcome mass traumatization, as in the case of Sierra Leone, the healing capacity of family community systems should support people in coping with severe stress and with more severe mental health problems. The number of traumatic experiences and their duration were important risk factors in the development of post-traumatic stress disorder. Sufferers from traumatic stress often had physical complaints, the so-called psychosomatic stress symptoms, although they were often misdiagnosed by medical practitioners who were not psychiatrists. It was important to consider not only conventional forms of depression and schizophrenia, but also the stress disorders that arose as a result of war.

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## Singapore

**Professor Ee Heok Kua** said that it was important to convey a positive message indicating that many people did recover from mental health problems. To that end, Singapore's health authorities worked closely with nongovernmental organizations, held

public forums every two months on common mental illnesses including depression and anxiety, and collaborated with the mass media to destigmatize mental illness and to ensure that correct information was provided.

It was important for governments to ascertain the extent of mental health illnesses in order to plan service. Following a national survey in Singapore, action had been taken in three areas: teachers and counsellors had been trained to recognize and manage mental health problems in schoolchildren; personnel and managerial staff had also been taught to recognize the common signs of mental illnesses in the workforce, as well as counselling techniques; and retired professionals had been trained to provide counselling support to the elderly. In all cases, if a problem could not be managed, the individual concerned was referred to a specialist.

He hoped that mental health would remain a focus of attention for WHO, and that, in the future, the Organization would coordinate programmes and make sure of their effectiveness.

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## Slovakia

Mr Hlavačka said that because mental health care was dominated by medical specialists the related strategies did not involve other professionals, such as social carers, patients and families. The role of the family was crucial, not only in terms of diagnosis (as the family was often the first to identify the problem), but also in enhancing access. The family could bring the patient for treatment and assist in reintegration. Thought should be given to a social environment that optimized the ability of the family to care for the patient. Often, the problem was not one of education or understanding, but of the economic ability to care.

Like other countries, Slovakia had formulated a mental health strategy. The difficulties lay in monitoring implementation and in establishing indicators of performance. Evaluation of treatments tended to be based on costs, the number of drugs used and the number of treatment centres available. However, there were few indicators to measure responsiveness of care. The views of the care givers, the families and the individual patients should be sought on how to improve the service.

There was also a place for the type of benchmarking that WHO was carrying out. Finally, as to the role of WHO and other international organizations, the causes of mental illness, such as poverty and stress, must also be tackled.

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## Slovenia

Mr Marušič said that alcohol consumption and suicide each accounted for 30 deaths per year per 100 000 population. The current national health programme contained little on the subject of mental health, so a national mental health programme and national legislation on alcohol and tobacco consumption were currently in preparation. Primary prevention had already been introduced into the work of general practitioners, who were required to put questions to their patients concerning their mental well-being. Those with the highest risk factors were then involved in group therapy. A programme to encourage healthy schools and workplaces had also been launched. In order to reduce stigmatization, a patient advocacy act that stressed the need to protect the human rights of those with mental disorders was under discussion. The third and final reading of that act was to take place in the near future.

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## South Africa

Dr Tshabalala-Msimang said that one of her Government's objectives was to promote an integrated approach to health care. Health care was not regarded as being the responsibility of the Department of Health alone and it had been possible to achieve an increase in social spending in recent years. A mental health bill, to be submitted to Parliament in the near future, would provide a framework for the delivery of care at all levels of the health system and would promote rights for those disabled by mental illness. South Africa was also finalizing a special training instrument to improve the skills of staff. An important challenge was the provision of appropriate services for people emotionally traumatized as a result of, for instance, rape, child abuse and family break-up. Prevention of mental disorders was crucial and often involved intersectoral collaboration. South Africa had initiated a programme aimed at the prevention of violence in schools and projects

along the lines of the WHO parent-child bonding programme. The next step was to improve primary mental health care. One-stop centres had been established for abused women, and health workers were being trained to deal with basic problems, to counsel on victim empowerment, and to recognize the need for referral. Future activities should include expansion of the network of referral centres and attention to the needs of health workers who took care of people with mental disorders.

Recent research had indicated that high blood alcohol levels were associated with well over half of all non-natural deaths including homicides and traffic accidents. Greater emphasis should be given to reduction of demand and supply of alcohol; prevention work in that area would have many human and financial advantages. The spread of HIV/AIDS among psychiatric patients was also a serious concern. A project aimed at developing comprehensive life skills in schools, which covered HIV/AIDS and substance abuse prevention, had been introduced under the WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. Lastly, she drew attention to the need to develop appropriate community services and to shift budget resources accordingly.

## Sri Lanka

Mr Seneviratne said that, although his country had achieved high levels of health with a relatively small financial investment, developments in mental health had lagged behind other aspects. Sri Lanka was facing high suicide rates and psychosocial disabilities related to stress, in connection with the socioeconomic effects of the war in the northern and eastern areas of the country. Lack of awareness of mental disorders, social stigma and the low priority attached to mental health continued to obstruct the development of mental health services. A series of measures had been taken in recent years to develop mental health services and to decentralize mental health care. The greatest problems faced by Sri Lanka were the lack of qualified psychiatrists, which he hoped would be alleviated by the training of medical officers; and the high rate of suicide among the young, which he hoped could be addressed through research conducted in cooperation with other countries.

## Sweden

Mr Engqvist said that, in 1995, Sweden had challenged the traditional views of mental health services, shifting from large-scale institutional psychiatric care towards municipality-based rehabilitation and integration programmes. The aim was to ensure that people with mental health problems were closer to the main stream of health services. Despite major investment and a positive response to the structural changes introduced, however, the professional and other available resources had not met the required high standards of care. A national centre had therefore been established to provide support for individuals suffering mental or functional impairment and to ensure maintenance of their dignity and respect, in which connection personnel training was important. Moreover, a national action plan presented in 2000 would substantially increase health care funding and focus efforts on improving primary health care and care for the elderly and the mentally ill. The important role and the responsibilities of general practitioners in prevention and early intervention were equally underlined. Under Swedish legislation (compliance with which was annually monitored) patients had the right of access to information, as well as the right to a second opinion and a voice in their care and treatment. Special attention was devoted to patient empowerment and the valuable assistance of patient organizations was recognized, both in the development of legislation and guidelines and in the evaluation of reform and other changes.

Although mental health conditions had generally improved in Sweden, mental ill-health had increased at an alarming rate, particularly among teenagers and young women. Special measures would therefore be taken. Mental illness was strongly connected to poverty and substance abuse. Notwithstanding the significance of genetic factors in many conditions, social support systems were crucial in diminishing the consequences of mental illness, in which context he highlighted the advantage of multiprofessional approaches and the importance of cooperation between the different actors, including nongovernmental organizations.

Together with a well-developed preventive health system, a proper education system was the key to

providing the basic conditions needed to ensure that young people developed self-esteem and adopted healthy lifestyles. In that context, encouraging progress had been recorded in Sweden's efforts to tackle domestic violence, including the development of a new training programme for professionals in the fields of health, social services and law enforcement. Sweden had also investigated gender differences in the provision of health care and was endeavouring to eliminate conditions attributable to gender discrimination.

## Switzerland

**Ms Dreifuss**, responding to the Chairman's second and third questions, suggested that the prime responsibility of the public sector was to ensure that everyone had access to care. In Switzerland, that meant that mental health was covered by health insurance on an equal footing with physical health. However, access to mental health care was hampered by the public's poor level of knowledge of mental disorders. A second responsibility of the public sector was therefore to promote understanding of how mental disorders evolved in order to allow early intervention. Whereas certain issues such as drug dependence, because of their effect on public order, were well known and tackled, such disorders as depression quietly took hold before treatment could be delivered and before the community or the family became aware of their existence.

It was also the State's responsibility to develop and to ensure good quality mental health care, to conduct epidemiological studies, research and training, and to safeguard the human rights of patients with mental illnesses as persons fully integrated into society.

The approach to mental health problems should target different segments of society. Young people's problems, as manifested in drug abuse, suicides and depression, differed from the problems of the very old, characterized by serious depressions, and the problems of work-related stress and the workplace in general. Those approaches needed to be adjusted to take account of differences between men and women. Switzerland had had to develop specific responses to the problems of migrants and displacement. Caring for refugees and the particu-

lar traumas they brought with them required a different perspective on diagnosis. In summary, she stressed the need for widespread information, but also a targeted approach according to population groups, in order to promote understanding of mental health.

## Thailand

**Dr Winai Wiriyakitjar** remarked that his country had experienced two major crises in the past decade: HIV/AIDS and the economic recession. There was an increasing number of mental health problems, including suicide: the annual rate had increased from 7.2 to 8.6 per 100 000 population over the past five years. The Government had tried not to cut health expenditure but to use the economic crisis as an opportunity to review its health strategies.

The World Health Day theme and related activities showed that discrimination and access to mental health care were major concerns in most countries. Thailand's experience with psychotropic drugs was that side-effects increased stigmatization and reduced compliance. Newer drugs had fewer side-effects but were more expensive. For that reason he proposed that access to such drugs should be given high priority in the WHO revised medicine strategy. Also, he wanted WHO to consider recommending that Member States ensure that such drugs were appropriately represented on essential drug lists. He concluded by expressing the hope that the output of the round tables would be more than a report; he expected a concrete result that would improve mental health and alleviate the suffering of those with mental disorders.

## The former Yugoslav Republic of Macedonia

**Dr Nedzipi** said that mental health care in his country was inadequate, and lack of resources for hospital and community care deprived many mentally ill persons of their basic human rights. With WHO's support, however, the Ministry of Health had elaborated a master plan to improve human resources and had proposed new legislation to enhance patients' rights and combat stigmatization.

Community mental health services had been set up in three pilot areas in partnership with three European municipalities. Day-care centres, protected homes, social enterprises and social clubs were supported by the public service and by nongovernmental organizations, in a multisectoral approach. Mechanisms were in place to ensure the sustainability of the community-based approach, and initiatives had been taken to increase the resources of the project and replicate it in other pilot areas.

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## Trinidad and Tobago

**Dr Parasram** said that, after a long period of neglect, mental health had become an integral part of his country's health sector reform programme. The new mental health plan currently being implemented took into account the relationship between mental health, social pathology and other exacerbating conditions and sought to provide a range of integrated services, with the emphasis on primary care of the individual within the community. It also comprised activities such as a legislative review, restructuring, an assessment of health needs and human resources, training, health promotion and the development of regional plans in association with provider agencies. Approval had been given for the establishment of a suicide-prevention task force; the current system of drug procurement and distribution was under review; and new generations of drugs were available at public mental health care institutions. Such policies and reviews, however, were insufficient in themselves to reverse the stigma of mental illness and related problems, a process which demanded continuous efforts. In his country, fruitful forums had been held with the media. That group could serve as an important ally in overcoming the challenges entailed in moving the mental health care agenda forward. On that score, he looked forward to the continuation of national, regional and international action aimed at improving the quality of mental health for the world's citizens.

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## Tunisia

**Dr Abdessalem** said that mental health had long been neglected for a number of reasons. Once independent, Tunisia had immediately tackled such scourges as infant mortality and had embarked on a

countrywide immunization campaign. Since 1990, it had included mental health in its general health strategy, with emphasis on legislation, organization and human resources.

The first major component of that strategy had been the integration of the mental health programme into existing structures dispersed throughout the country, to take those services closer to the users. The second component, still being finalized, was the establishment of the structures necessary for the various categories of mental health care. Counselling units had been set up in secondary schools, higher education establishments, and in some small hospitals. A decision had yet to be taken with regard to voluntary and involuntary hospitalization. A third important measure was to attack the myriad risk factors for mental disorders through education, affording all children the opportunity to continue their studies and the fight against poverty with the creation of jobs for young people. Action was being taken to protect vulnerable groups, particularly children and the elderly, especially with respect to violence against women and children. The authorities were also endeavouring to ensure that persons who were or had been mentally ill were reintegrated into the country's social and economic systems.

He endorsed the view expressed by many speakers that legislation on its own did not provide effective mental health care. A change of mentality was required among all persons involved in mental health care, including psychiatrists, who were sometimes unwilling to share their power and knowledge. It was equally important to train social workers, specialized nurses, psychologists and psychiatrists, and to provide psychiatric training for general practitioners. In short, Tunisia's strategy focused on prevention and reduction of risk and affording its citizens better access to proper care in decentralized clinics, sponsored by university faculties of medicine and psychiatry.

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## Uganda

**Dr Kiyonga** had seen evidence in his country that stigmatization could be overcome. When he had been a medical student in the late 1970s, no student would have dared to admit to being near a mental hospital, yet when a psychiatric clinic had

recently been closed in town and mental health patients had been asked on radio to go to an out-of-town hospital for treatment, the reaction had been good. Furthermore, people were now contacting physicians about mental illness. In two further major developments, former sufferers from schizophrenia had formed an advocacy group to eliminate stigmatization of the disease, and the parents of epileptic children had created an association to seek care for their children and to promote the message that epilepsy was a manageable condition. In order to give people confidence, the health sector had to demonstrate that treatment worked and that people got better. Sufficient confidence had to be generated in the population that people could be treated before legislation was adopted. Such legislation should be timed to coincide with an improvement in care and not be rushed through.

Lastly, was there any evidence that the extended family structure prevailing in most African States offered an advantage in mental health care? Could it be shown, all other things being equal, that countries with an extended family structure stood a better chance of dealing with mental illness than developed countries that did not have such a structure?

## Uganda

**Dr Kiyonga**, noting the trust placed in traditional healers by the general population in his country, expressed interest in views on the role that traditional medicine could play in mental health care. His country gave a high priority to the treatment of mental illness as the HIV/AIDS pandemic and protracted civil strife had increased the incidence of such illnesses. Uganda, in common with other sub-Saharan countries, suffered from high rates of unemployment and poverty. The public sector was therefore seen as the key to tackling mental health problems and to raising public awareness so as to reduce stigmatization and to encourage the mentally ill to seek help. A loan recently granted by the African Development Bank would be used to reform national institutions responsible for health care delivery and to integrate the delivery of mental health and general health care. The training of health workers was currently being reviewed, in order to facilitate recognition at primary health care level of conditions likely to affect mental health and to avoid over-specialization.

## United Arab Emirates

**Mr Al-Madfaa**, concurred with previous speakers on the importance of eliminating discrimination and stigmatization in regard to the mentally ill. His country took account of the psychiatric causes of certain illnesses, and was making efforts to raise awareness of mental health issues among students in universities and training institutes. The need for interaction between various ministries was recognized, and the ministries of health and education in his country were working together to combat psychological disorders among schoolchildren. He emphasized the importance of awareness-building, of the role of the family, of research, and of the use of the media in order to target areas for mental health action more successfully.

## United Kingdom of Great Britain and Northern Ireland

**Ms Hutt** said that the National Assembly for Wales was aware that all the policy areas for which it was responsible, namely health and social services, housing, environment, economic development and education, were relevant to the improvement of health and well-being and to tackling mental health problems. It had also become clear to that Assembly in the two years of its existence that a national strategy for mental health was essential, with priority funding. Such a strategy would provide for local delivery and local management of services through primary care and community health development.

Every effort was being made in Wales to ensure that people who had used mental health services or were suffering from mental health problems were involved in policy development, both in their local communities and in the National Assembly.

In developing community services, it was essential to have plans and funds in place before closing existing institutions. It was equally important, with one in four people likely to experience mental distress at some time, either in their families or in their communities, to ensure that the community was able to address their needs.

## United Republic of Tanzania

**Ms Abdallah** observed that some 85% of the population of her country lived in rural areas where there were practically no mental health services apart from traditional healers. In most cases mental illness was associated with curses or supernatural causes. Her Government had developed a mental health policy, but traditional practices still needed to be integrated into modern medicine. She requested assistance from WHO in that area.

Specific causes of mental disorders in her country included the rapid breakdown of traditional psychological support systems and social norms, poverty and rural-urban migration in the absence of social skills and strategies to adapt. A second cause was the long-term presence of refugees, whose settlements were breeding grounds for mental disorders. In surrounding areas there had been increases in crime, resulting in insecurity among the indigenous population. Mental health services thus needed to serve local populations as well as refugees.

## United States of America

**Mr Thompson**, responding to the second question put by the Chairman, said that it was the responsibility of governments to disseminate information on mental health as widely as possible in order to combat the suspicion and scepticism that surrounded the subject. In the United States, one seventh of gross national product was spent on mental and physical health combined, and in all countries mental illness was among the five leading factors contributing to low productivity, absenteeism and suicide. The United States was spending more than US\$ 1 000 million on research into mental health, as a result of which great progress was being made.

Two of the most difficult problems in the field were suicides among young people and discrimination against women. More needed to be done to reach out to young people and to try, through the education system, to reduce the number of suicides and eventually to prevent them. There was no doubt that certain mental illnesses were more prevalent among women than men, a difference that should be reflected in research and in expenditure on services. His Government intended to give mental ill-

ness a higher priority than in the past, and to ensure that it was treated on a par with physical illness.

## Uruguay

**Dr Touyá** said that a process of de-institutionalization of mental health care had begun in 1986, with much of the responsibility passing to the community. That had resulted in fewer and shorter hospital stays, thereby improving patients' quality of life in their family environment. Psychiatric care could not fail to improve with increasing knowledge about brain function. Nevertheless, the risks for mental disorders were increased in a civilization that pushed people increasingly towards self-destruction. The most positive approaches were prevention and protection, to which end WHO should firmly support countries that set examples of strong family bonds, which were known to reduce poverty and violence. The media should be used to raise awareness.

## Venezuela

**Dr Urbaneja Durant** reported her country's experience in carrying out extensive political and institutional changes that had enabled progress by ensuring that universal rights such as the right to health were met. That right must include the right to mental health, and health must be seen as an integral part of well-being and development. Obstacles to those goals were often related to poverty and inequality. Venezuela had worked out three strategies to try to overcome those obstacles: incorporating guarantees for rights in the country's constitution; ensuring application of the constitutional provisions through governmental policies; and health system reform.

Venezuela's constitution enshrined health as a basic right, without any discrimination on grounds such as mental ability or gender. It included respect for diversity and differences between individuals, which demanded a major change in attitudes.

Promoting health was essential for guaranteeing overall rights. That meant intersectoral approaches, improved access to more effective and appropriate services, tackling discrimination, and provision of

decent living conditions for health. Gender differences were recognized, for instance in access to health services, discrimination and quality of life. The National Women's Institute had designed specific policies and strategies together with national plans in that regard. A council for the protection of children and young people had been established to ensure shelter, proper nutrition and feeding, and access to education, especially for street children. For disabled people there was a national committee for disabled persons and legislation for improved protection was being enacted. Steps were being taken to improve the living conditions for indigenous people whose rights were guaranteed in the constitution. Laws were in place to guarantee individual rights in times of emergency and disasters.

Her country had changed its model of health care, emphasizing health, rather than disease, as the starting point. Prevention and health promotion formed critical strategic elements for health care workers; they needed to understand that in integrated health care, health must be promoted in places regularly frequented by people, such as schools, sports venues, and outpatient clinics. In parallel, the profile of a health worker was being changed in favour of that integrated health care approach. That would help to remove the stigmas that blocked access to the mental health care which people needed; otherwise mental health problems and stigmatization would be exacerbated.

Specifically with regard to psychiatric care, she was convinced of the need to care for both acute and chronic cases, with involvement not only of patients but also of their families and communities. That would ensure proper treatment, both in hospitals and in communities, with rapid reintegration into society.

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## Viet Nam

**Professor Pham Manh Hung** informed the meeting that, like many developing countries, Viet Nam had seen an increase in the incidence of mental and brain disorders. The Government was dedicated to poverty reduction and had made considerable progress in the past five years. Priority had been given to programmes with a strong commitment to the provision of equitable health care services

for the poor, including priority allocation of expenditure for health in poor areas. Health workers in the mental health field were encouraged by additional allowances equivalent to 20% of their salaries, a seven-hour working day and early retirement.

Improvements had also been made in hospital care, and the number of mental health departments in cities and provinces had been increased, as had the number of psychiatrists. More recently, mental health care had been integrated into the general health service, with emphasis on community-based services. Most districts currently had a mental health consultancy, responsible for the care and follow-up of patients.

Community awareness of mental health problems had increased. Nevertheless, and despite the considerable progress made in providing mental health care, poor people continued to suffer. Limited government expenditure on health and the lack of well-trained psychiatrists on the one hand, and poverty, social discrimination and prejudice, a lack of information and superstition on the other, were major obstacles to the provision of mental health care and information on preventive treatment.

To counteract that situation, the Government had approved a five-year plan for development of the health sector with the aims, inter alia, of expanding health care centres to a further 50 communes, expanding community-based mental health services to other provinces, providing community-based management and improving cure and rehabilitation rates. A notable result was that 50% of the country's community health centres now had at least one medical doctor.

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## Yemen

**Dr Al-Munibari** agreed with earlier speakers that warfare and violence were among the major causes of mental illness. He also pointed out that smoking had a deleterious effect on mental health, and emphasized the importance of sporting activities in overcoming mental health problems. It was essential that the subject of mental health should remain on the agenda of future round tables.

## Yugoslavia

**Dr Kovac** said that in the past 10 years the population of his country had experienced the traumas of war, sanctions, and consequent impoverishment. That had occurred at both family and community levels, and materially as well as spiritually, through the collapse of traditional social and cultural values, and the loss of hope. Mental health was impaired as never before. The incidence of classical mental disorders had increased, as had conditions such as post-traumatic stress syndrome, anxiety, neurosis, substance misuse and marked depressions with psychosomatic symptoms. Those were reactive pathologies to which people were not susceptible in normal conditions. The consequences were increased social pathologies, evidenced as greater delinquency, crime and violence. The presence of large numbers of refugees, with associated mental disorders, posed an additional problem. Children, many orphaned or living in collective centres, constituted the most vulnerable population. Some had experienced traumas at an early age.

The past 12 months had seen considerable improvement in mental health. The Ministry of Health and Social Policy was finalizing a multidisciplinary project to reduce and eliminate suffering and to facilitate treatment. The support of WHO in those efforts would be welcomed.

## Zambia

**Mr Mumba** observed that mental health problems continued to have a considerable negative impact on his country's health status. While Zambia had done a great deal to upgrade the quality of mental health care in recent years, there had been a significant erosion of the human resource base, in particular, front-line mental health workers. Health infrastructures and equipment were in a deplorable state, and essential psychotropic drugs were only intermittently available. Zambia had established a post of mental health specialist, and some progress had been made. A mental health situation analysis had been undertaken; a draft bill had been submitted to the Ministry of Legal Affairs; mental health had been integrated into the essential health care package at community level, with the possibility of

referrals; and mental health had been accorded its place among public health priorities.

Zambia's participation in international forums and projects had led to the establishment of key links with a broad spectrum of mental health experts. As a member of the International Consortium for Mental Health Policy and Services of the Global Forum for Health Research, Zambia was pursuing ways of securing WHO support, and was participating in the WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. At the local level, partnerships had been established with communities, giving them a central role in realizing improvements in mental health care. His Government was committed to developing a mental health policy, providing human resources for mental health, reviewing relevant legislation and upgrading health infrastructure and equipment. New international networks would also be developed that would benefit the local mental health programme. Zambia viewed the stigmatization and marginalization of people with mental health problems as an inappropriate legacy from the past. Mental health services were a crucial component of primary health care that would enable people to work productively and fruitfully. The inclusion of mental health in WHO's public health agenda underscored the commitment of governments to the development and improvement of national mental health services in line with relevant resolutions adopted by the World Health Assembly, the WHO Regional Committee for Africa, the United Nations General Assembly and UNDCP.

## Zimbabwe

**Dr Stamps** said that, after achieving independence, his country had totally recast its Mental Health Act, so that it was currently dedicated to the needs of the patient rather than to the needs of society for protection. The Government had formulated its policy on mental illness, on the basis that psychiatric events were never due to a deliberate act on the part of the patient, so that all treatment, including the provision of drugs, was free. There was, however, a severe staffing problem. Nurses were being trained but, on qualifying, often went to more attractive posts abroad. The lack of trained staff meant that passive disorders were diagnosed a long time after the first symptoms appeared.

He drew attention to the increasing use of drugs in treating mental disorders, including the administration of stimulants and sedatives to children aged between two and four years.

The use of psychedelic substances to ensnare youth, for the purpose of commercial gain, was a matter of great concern. Although the worst problem was that of alcohol, dangerous drugs were readily available to young patrons of night clubs. The involvement of community leaders had been very effective in confronting such trends. He appealed to all to work together to bring about a more spiritual approach to living, in order to reduce temporary or permanent mental disability.

