


Report by the secretariat


This section contains a synthesis of the main issues raised by the Ministers during the four round tables.

World health ministers call for action



Ministers unanimously agreed that it is time to feature mental health on the world health agenda and to consider the huge burden of mental health problems as priorities for national action. The fact that countries have to face other health problems and that their health budgets are limited can no longer be deterrents to action. Mental health problems are significant contributors to the global disease burden, have huge economic and social costs, and cause human suffering. New developments persuasively indicate that cost-effective solutions are possible in all contexts. Many strategies, approaches and interventions have been identified and are being used in numerous small projects around the world. These need to be evaluated and the results disseminated widely to include them in national mental health programmes. The Ministers expressed their commitment to addressing the pressing mental health needs of their populations and called for international support and action.

The current social context of mental health




Ministers expressed the importance of contextualizing mental health since it is determined by a variety of challenges faced by their countries. Much of the world is facing rapid economic reforms and social change, including economic transitions that are linked to alarming rates of unemployment, family breakdown, personal insecurity and income inequality. Poverty remains a reality for much of the world, with women constituting a majority of those affected. Many countries experience political instability, social unrest and war. There are large populations of traumatized refugees and internally displaced persons who must be resettled, often in countries with limited resources to do so. The spread of HIV and AIDS has had a major social and economic impact on many countries, leaving large numbers of survivors in need of care and support. Women face great pressures with a range of gender-based

disadvantages and huge numbers experience physical and sexual violence resulting in high rates of depression and anxiety disorders. Young people, particularly street children and those exposed to violence, are at high risk for substance misuse including alcohol. Indigenous people and other groups are undergoing social upheaval that is accompanied by climbing suicide rates. In many parts of the world, mental health systems are poorly funded and organized.

Taken together the above concerns cast a broad framework for discussing mental health problems since they are squarely placed at the heart of the social changes of our era. Ministers also brought up some of the more positive effects of change which include a steady increase in awareness, weakening of stigma, and the development of global approaches to mental health problems and prevention. They referred to the enthusiastic engagement of governments and communities alike in the celebrations of World Health Day 2001 dedicated to mental health.

Overcoming stigma and human rights violations




The ministers repeatedly made urgent calls for action to further reduce stigma, discrimination and the violations of rights of persons with mental illness since these affect the whole continuum of care. It was noted that the discrimination between coverage of mental and physical illness by health insurance schemas is fed by stigma. There is need to address the institutionalized stigmatization of persons with mental illness, a process exacerbated by the placement of psychiatric hospitals in far out places away from public scrutiny. Shifting mental health services to general hospitals and community clinics has helped in mainstreaming mental health problems; this must be pursued. Efficiency can be gained by recycling the infrastructure of mental hospitals to serve general health care purposes. Enforcing minimum standards in infrastructure, and in the provision of high quality care, coupled by the support of updated legislation, is a critical step in protecting the rights of persons with mental illness. Most importantly, addressing stigma amongst all health professions, including mental health workers, was considered necessary.

Since much of the stigma related to people with mental illness results from lack of information on the causes, the frequency and treatment possibilities, accurate information and education should be provided to politicians, decision makers, service providers, the general public and the media as a primary means to reduce stigma. The media can either reinforce or reduce stigma powerfully. It needs to be involved in campaigns designed to eradicate negative stereotypes and promote attitudinal change. The role of consumers, families and their organizations as well as visible role models in stigma reduction efforts was considered pivotal. Educational campaigns must be accompanied by the development and upgrading of services.

Sensitization on mental health issues, removing ignorance, superstitions and false traditional beliefs, requires multisectoral approaches and should include, among others, schools, criminal and judiciary systems, employment agencies, and housing and welfare systems.

Improving mental health policies and services

Shifting to community-based care and integrating mental health within Primary Health Care

 Ministers discussed strategies to advance mental health care beyond the recognition that there must be parity between care for physical and mental disorders. There was agreement that mental health care should be intimately integrated into the general health care system. It was repeatedly noted that Primary Health Care (PHC) has a significant role to play in mental health services delivery, including in countries with highly specialised care. Integration into PHC is in line with the global movement in which many nations are engaged in the provision of mental health care shifting it from psychiatric hospitals to the community. For this shift to occur, budgets must be maintained or even increased; mental health teams, with multidisciplinary representation, must be developed; the needs of especially vulnerable groups must be met through supervised care; communities must have access to crisis centres for the management of acute conditions; and broad public support for community care must be

secured. Shifting the location of care also facilitates collaboration with non-governmental organizations, social services, and other community agents, many of which are motivated to fill some of the service gaps.

Treatment costs

Mental health treatments should be affordable for all those in need. Given that poverty is a risk factor for mental disorders, the principle of equitable treatment for the poor must be preserved. Concern was expressed that access to basic psychotropic drugs, especially in rural areas, was a crosscutting problem and that strategies to reduce costs should be considered by regions and by groups of countries, amongst them the bulk purchase of essential psychotropic drugs.

Financing of care

Financing community-based mental health care is a challenge for all nations, especially the provision of comprehensive care to all those in need. Since mental health problems have intersectoral ramifications, it was suggested that financing of services should be intersectoral as well; ways to overcome the barriers in this regard ought to be devised.

Human resources

Many ministers noted that the human resource base for mental health care is limited partly due to the brain drain. Therefore, attention has to be given to sustainable training programmes in mental health care at various levels of service provision. However, there are unsolved issues in this regard such as who should be trained and what should be the content of that training. Identifying categories of health workers who can be trained in the delivery of psychotropic drugs and psychosocial interventions with reasonable quality of care standards, is critical. Protecting mental health professionals working under adverse conditions was considered important to prevent the high rates of staff burnout. Special mention was made of the need to build capacity in research training in developing countries.

Traditional and faith healers

The reality in many countries is that traditional and faith healers provide much of the mental health care in communities because of traditional beliefs and because these practitioners outnumber those within formal health systems. There is a lack of adequate information on the practices of faith and traditional healers, and few programmes that articulate collaborative linkages between traditional and modern medicine systems. Research into these aspects is urgently needed along with inquiry into the effectiveness of traditional practices. In the meantime there is need to inform traditional healers and co-ordinate them with the general health care system through some form of regulation for consumer protection.

Consumer and family involvement

To help families in their role as primary care givers, they must have full access to systems of support including education and training. Consumers/users and their organizations can be most valuable in providing patient education, peer support and policy input.

Services for the special needs of women

All agreed that gender issues are pertinent in mental health care. Service provision has to take into account women's health and mental health needs resulting from widespread discrimination. In particular, the mental health needs of victims of domestic and sexual violence requires special interventions. To properly address this problem, special training must be provided to health workers. The reduction of two frequent factors, alcohol and drugs, that facilitate violent behaviour among men, demands preventive interventions.

Country strategies

Ministers reported recent developments and approaches in mental health care in their countries. These included:

Decentralization of mental health services:

- Downsizing of mental hospitals and establishment of community mental health services including beds in general hospitals.
- Establishing proper funding for community services.

Integration of mental health care in primary health care:

- Training health care professionals and paraprofessional workers.
- Training traditional healers in mental health care.

Improvement of mental health services:

- Incorporating a gender approach in mental health policies.
- Using mobile mental health units to serve remote and rural areas.
- Integrating a mental health component in essential packages of care.
- Using telepsychiatry to train and consult with mental health workers in rural areas and where populations are dispersed.
- Monitoring quality of care and human rights violations.

Legal provisions for mental health care:


- Revising legal provisions for care of persons with mental illness.
- Decreasing stigma around persons with mental illness.
- Involving the mass media.
- Encouraging self-help, consumer/family groups, and NGOs in mental health advocacy.
- Replacing stigma-generating labels with stigma-free denominations.

Implementation of multisectoral approaches for mental health:

- Collaborating with education, employment, social welfare, and other sectors.
- Building partnership with private enterprises and labour unions.

- Creating employment opportunities for women to empower them economically and reduce stress levels.
- Integrating mental health programmes with violence prevention initiatives.

Meeting the needs of special groups

 The following population groups were especially mentioned by many ministers since they require immediate mental health action in their countries:

Rural, remote and dispersed populations

The unmet needs and difficulties in providing adequate health services to rural and dispersed populations were noted.

Services for children and adolescents


A focus on the needs of children emerged. Attention to maternal nutrition, and the pre and post natal multiple needs of mothers and their infants is vital for the normal health and mental health development of children. School aged children constitute a group that is readily accessible for mental health services. School-based mental health activities serve to promote mental health, channel preventive interventions, and educate on the understanding of mental disorders and those affected by them. Bringing health care workers into schools also provides an opportunity for early detection and treatment of childhood and adolescent psychiatric disturbances that often remain undiagnosed. Additionally, children and adolescents are at high risk for substance misuse and suicidal behaviour for which sustained prevention and education are needed. Addressing the special needs of street children and those orphaned by AIDS was considered critical.

Refugees, displaced, indigenous and disaster-stricken populations

Wars, disasters and displacement have left huge population groups with serious mental health problems which countries are unable to address because of limited resources and untrained staff.

Social and economic change is having destructive impact on the mental health of indigenous populations which countries acknowledge but are unable to fully address.

Areas for WHO support and collaboration

 Ministers identified ways in which WHO could provide technical support to countries at global/regional and country levels.

At the global level, WHO should:

- Continue global awareness-raising and advocacy campaigns.
- Provide gender disaggregated estimates of incidence and prevalence rates, and on the burden of mental disorders.
- Carry out studies on the determinants of mental health problems and the factors that influence mental health outcomes, including spiritual support systems.
- Promote and support programme evaluation.
- Produce information (particularly for politicians and decision makers) on the burden, determinants and solutions to mental health problems.
- Document effectiveness of interventions with special reference to prevention, treatment and patient satisfaction.
- Update guidelines and materials for prevention, treatment and care of mental disorders.
- Include more psychotropic drugs in the essential drug list and devise strategies to ensure the continuous supply of these essential drugs at affordable prices.
- Establish regional and global networks.
- Mobilize funding support for mental health programmes.

At the national level, WHO should:

- Support the development of national databases on mental disorders that can inform policy and service development.
- Provide materials and guidelines for community education, awareness raising, and anti-stigma campaigns.

- Collaborate with countries in the implementation of programmes to repair the psychological damage of war and conflict.
- Provide technical expertise for capacity building in research and evaluation.
- Assist in the formulation of mental health policy and plans, and training of different cadres of health professionals in mental health care.
- Ensure supply of essential psychotropic drugs.
- Assist in addressing harmful traditional practices.
- Assist in mobilizing resources for national programmes.

Speech to the plenary

A new beginning

Senator the Hon. Phillip C. Goddard

Minister of Health
Barbados



Mr. President, Director-General, colleague Ministers, ladies and gentlemen, I have the honour and pleasure to share with you the salient points of the Ministerial Round Tables on Mental Health that were held on Tuesday, May 15th.

First let me say that Ministers spoke with great unanimity on the importance of mental health to health and human development and the relative under investment in this area of health services. In the words of one of our peers, “for too long we hid this subject”. Another said “our concern for infectious diseases should not deter us from dealing with mental health problems”. Yet another stated, “we must find a share for mental health out of our limited budgets”.

Given this response, it is not surprising that all Ministers expressed appreciation to the World Health Organization for placing this subject on the world health agenda. The overriding theme that emerged from the discussions was that mental health affected all spheres of human endeavour and that there is no health without mental health.

Ministers agreed that raising the level of awareness was the first priority. Policy makers in government and civil society need to be sensitized about the huge and complex nature of the economic burden of mental illness and the need for more resources to treat mental illness. To quote another Minister, we must “dispel the unjustified pessimism about the treatment of mental disorders”. Indeed, it was recognized that new technologies were available that are based on scientific evidence. Many of these are within the affordable range of most countries today.

We must also recognize the reinforcing loop between poverty and mental disorders. While poverty is often a powerful determinant of mental disorders, it is equally true that mental disorders could deepen poverty. Many families without support could fall into the abyss of poverty from which it would be difficult or impossible to extricate themselves.

Ministers agreed that the stigma associated with mental illness was a severe stumbling block because, among many other reasons, it prevented people from seeking help. Health professionals are not immune from the impact of stigma, which they

need to overcome to effectively manage the care of their patients. Stigma can also have an insidious effect on health policy, such as health insurers denying parity for the care of mental disorders. An understanding of mental health has to start early in life, and one Minister commented on the need for mental health to be placed in the schools’ curricula to help change attitudes.

Ministers discussed the need to move mental health care from outdated centralized institutions to community-based alternatives. “For too long, mental health institutions were placed in remote locations, out of site and out of mind” said one Minister, “they need to be brought back into population centres”. Furthermore, he noted “services located in general hospitals and clinics do not bear the stigma of the old mental hospitals”.

Of course this transference of care into the community requires new structures and the appropriate training of mental health care providers. It was recognized that evidence-based interventions in the community require proper knowledge and new skills. This massive effort, that entails the engagement of primary health workers to deliver mental health care, poses a challenge for which Ministers would like to have the support of the World Health Organization, particularly in training rural health care providers.

There was general agreement that the steady supply of psychotropic drugs was of fundamental importance if proper care is to be provided. Many ideas were floated in this regard; one of them was joint purchase of drugs by regional entities to reduce the cost to individual countries. It was also recognized that in many countries, faith and traditional healers outnumbered mental health workers, and treated large segments of the population. Not much was known about their effectiveness, however, and particularly so where traditional and modern methods of treatment coexist. The World Health Organization was asked to devise methodologies to study these phenomena and to assist in conducting the necessary research. Another area mentioned in this context were studies to provide national epidemiological data and evaluation of services including customer satisfaction.

Ministers from war torn countries and regions raised the need to involve the World Health Organization in restoring the mental health of

traumatized populations. Strategies and techniques to deal with large numbers of displaced victims of violence are needed along with the assistance to implement the appropriate remedial actions.

Sadly, violence afflicts those countries at peace as well. It was recognized that there was an alarming increase in violence against women in many countries. Ministers often mentioned that domestic violence should be considered an epidemic that ought to be eradicated. In addition to the physical damage and injury caused by domestic violence, there was also a significant impact on mental health that was often more damaging and long-lasting than the physical injuries. This was evident in the high rate of depression and anxiety disorders among women. Ministers wanted to better understand the gender-based mental health issues. They were all agreed that there was a need for short-term and long-term strategies to curtail violence against women, their families, the fabric of the communities and ultimately their nations.

The Round Table discussions were at times lively and informative. They generated much interest. A complete report of the issues highlighted during the course of the discussions is contained in the report which I invite you to take back with you.

Finally, I conclude by saying that Ministers share the universal concern of listening to people, and commit to strengthening the pivotal role the patients and families play in the treatment of mental illness. I would further remind you of the powerful presentation in the opening Plenary session made by a mother who related her real life experience of living with her son as she struggled to cope with the effects of his schizophrenia. We walked with her as she described his trauma and his slow recovery. We rejoiced with her as together they began the process of recovery and the joy of his first job.

Madame, I am sure that I can now say on behalf of us, your message has been heard.

Regional statements

**Renewing commitment
to mental health**

Regional Office for Africa

Dr Ebrahim M. Samba

Regional Director

Dr Custodia Mandlhate

Regional Adviser for Mental Health



The mental health situation in Africa is a very serious one indeed. It is recognized that poverty, civil strife, armed conflict, alcohol and drug abuse, among others, stand out as the main causes of mental problems which are a major concern of a number of countries in our Region. Needless to say, the HIV/AIDS pandemic is worsening the situation, adding considerably to the already existing psychosocial problems and creating unprecedented need for support, counselling and care for those affected.

In Africa, political turmoil deserves special mention as a causative factor of mental problems. As we observe World Health Day today, more than 20 of the 46 countries in our Region are experiencing one form of civil disturbance or other. This has created at least 10 million refugees and more than 30 million internally displaced persons. All these people, especially women, children and the elderly among them, are invariably severely stressed physically, psychologically and emotionally.

Also in Africa, as elsewhere, mental problems remain a hidden burden. Consider some of the economic and social costs: lost production from premature deaths (e.g. suicide); lost productivity of the mentally ill who are unemployed, underemployed or unemployable; lost productivity of family members providing care; the cost of accidents by people who are psychologically disturbed; direct and indirect costs for families caring for the mentally ill. If we add to these the incalculable emotional burden and the diminished quality of life for family members of people with mental illness, the magnitude of the problem becomes easier to appreciate.

In most countries of the African Region, mental health programmes are limited to curative health care of poor quality, usually provided in decrepit hospitals located far away from residential areas. These conditions create a serious problem of access to and acceptability of the treatment.

Hence, dropout rates are very high, and follow-up treatment as an outpatient is seriously hampered. In those countries where some services are provided, these are mainly for adults with major psychiatric disorders, the needs of children not being catered for.

Also, the pervasive effect of social exclusion resulting from stigma and discrimination prevents people from acknowledging their mental health problems, disclosing them to others and seeking treatment.

This situation is not helped by weak or total absence of policies, programmes and legislation to deal with the problem in many of our countries.

For example, a recent survey in the 46 countries of our Region indicates that only half of them have mental health and substance abuse policies.

Although 74% and 71% respectively of the countries have mental health programmes and legislations, these were developed relatively recently – only in the last five years. Some of the most distressing statistics emerging from the survey relate to financing: 84% of the countries spend less than 1% of their total health budget (usually 10% or less of the national budget) on mental health.

However, on the positive side, the report indicates the existence of drug policies and updated lists of essential drugs in 93 % of the countries; 64% of the countries also have included drugs for the treatment of conditions like epilepsy, depression and major disorders like psychosis. Unfortunately, most people who need these drugs cannot afford them because the costs are prohibitive. The situation is particularly serious in rural Africa where antidepressants, anticonvulsants and antipsychotic drugs are rarely available. In relation to the issue of access, it is pertinent for countries to make overall treatment for mental illness available to the general population. Therefore, mental health needs to be integrated into general health, especially primary health care.

All these show very clearly that our countries need to rank mental health higher on their scale of health priorities by providing the necessary funding as well as appropriate policy and legal frameworks to deal with the problem.

We therefore appeal to individuals, families, communities and Governments to use this year to

rededicate themselves to raising the profile of mental health, and to creating a solid basis for changing the present scenario regarding mental health in our Region.

A real beginning was made in Windhoek in 1999 when our Health Ministers adopted the Regional Strategy for Mental Health.

This Strategy serves as a tool to be used by Member States to identify priorities and develop and implement programmes at various levels of the health system, with particular emphasis on action at the district and community levels.

The aim of the strategy for mental health and the prevention and control of substance abuse is to help prevent and control mental, neurological and psychosocial disorders, thus contributing to the improvement of the quality of life of the populations. This can be achieved through the formulation and strengthening of national mental health policies and the development and implementation of programmes in all the Member States in the African Region.

While adopting and implementing the regional strategy, all Member States should integrate mental health and the prevention of substance abuse into their national health services. This will lead to:

- a reduction in the incidence and prevalence of specific mental and neurological disorders (epilepsy, depression, mental retardation and psychosocial disorders due to man-made disasters) and other prevalent conditions;
- equitable access to cost-effective mental, neurological and psychosocial care;
- progress in the adoption of healthy lifestyles; and
- improvement in the quality of life.

Today, thanks to advances in science and medicine, mental disorders can be correctly diagnosed and treated with medications or short-term therapy or a combination of approaches.

It is therefore the collective responsibility of all, particularly Governments, to take appropriate measures to increase access to care; to improve public awareness of effective treatments; to popularize the use of effective community-based services; to ensure the existence of conducive socio-economic environments for our people to live in, and

to factor mental health into general health programmes.

We, at WHO, pledge to continue to respond to these challenges by assisting Member States to develop evidence-based policies and effective strategies that will help our populations achieve the highest possible state of health.

Stop exclusion. Dare to care.

This is the ultimate challenge!

Regional Office for the Americas

Dr George Alleyne
Regional Director

Dr Caldas de Almeida
Coordinator, Program on Mental Health



The Pan American Health Organization, WHO's Regional Office for the Americas (PAHO/WHO) and the countries of the Americas have been working together for decades to promote mental health and improve mental health care in the Region.

These efforts have led to significant advances, particularly following the 1990 Caracas Declaration. These advances include the establishment of national mental health policies, plans, and legislation in several countries; the development of innovative experiences of community mental health services; and the promotion of specific programs for the treatment of the most prevalent disorders.

Although these advances represent important milestones, we recognize that much more must be done in order for mental health to recover from the historical neglect to which it has been subjected worldwide, and to meet the mental health needs of all populations in the Americas. Many problems remain.

For example, in the last few years spectacular progress has been made toward understanding mental health problems, as well as toward the development of new and more effective treatments. Yet, despite the availability of effective treatments for most mental disorders, millions of people suffering from depression, schizophrenia, epilepsy, and other disorders with devastating con-

sequences still do not have access to these treatments.

Similarly, although comprehensive community services have proven more cost effective than the older centralized models, and are preferred by patients and families, in most places mental health care continues to be centered in old institutions separated from the general health system and the community.

The recognition of these realities, together with recent data showing the true magnitude of the impact of mental disorders, has led to an increased awareness of the need to mobilize all of civil society, including policy makers, professionals, users, families, and NGOs, to change the situation.

WHO initiatives and events dedicated to mental health in 2001 have begun this urgently needed process of mobilization at the global level and have already elevated mental health on the global political agenda.

PAHO/WHO, and the countries of the Americas, have collaborated enthusiastically in these initiatives and, taking advantage of the unique opportunity created in 2001 by the World Health Day, the World Health Assembly, and the World Health Report, are strongly committed to reinforcing technical cooperation in mental health.

Based on an evaluation of the current situation, the following objectives have been defined for priority attention in the Region:

- implementing national mental health policies and plans ensuring: (a) the restructuring of mental health services, leading to the development of comprehensive community-based services and integrating all necessary facilities and programs to meet the different needs of the populations; (b) the provision of essential treatments for the most prevalent mental disorders, in particular depression; c) the development of preventive and health promotion interventions;
- creating/revising mental health legislation integrating the key elements of mental health policy, and providing basic guidance to protect the rights of people with mental health problems;
- raising awareness and fighting stigma related to mental disorders;
- reducing inequity and addressing issues of parity to ensure that: (a) disadvantaged populations, refugees, and victims of disasters have access to services that meet their specific needs; b) parity of mental health services with other types of services is achieved;
- promoting mental health training for health professionals;
- improving monitoring and evaluation of the implementation of mental health plans; and
- increasing the participation of users and families in mental health care.

To attain these objectives, the following actions are specifically being emphasized in technical cooperation with countries:

- collection and dissemination of information on mental health;
- development of country capacities to plan, manage and evaluate mental health services; and,
- dissemination of guidelines on cost-effective interventions and development of innovative experiences.

The establishment of partnerships in the areas of training, research and policy development is also a key element of the defined strategy. The conference "Mental Health in the Americas: Partnering for Progress", planned for November 2001, will seek to promote these partnerships, taking advantage of the momentum created by WHO initiatives.

Regional Office for the Eastern Mediterranean

Dr Hussein A. Gezairy

Regional Director

Dr Ahmad Mohit

Regional Adviser for Mental Health



The selection of mental health as the theme of the year 2001 is a reflection and recognition of the increasing importance of the role mental health plays in the everyday life of human beings. We would like to take this opportunity to dispel a common misconception that mental health is restricted to the treatment of mentally ill persons. Mental health is concerned with all aspects of our daily life, be they emotional, intellectual or behavioural. The quality of relationships we develop and maintain with fellow human beings, our familial bonds, the nurturing milieu we provide for our children to develop their potential, societies where individual members are respected and cared for, civil societies tolerant of dissent, are all dependent on mental health. Mental health thus encompasses, and interacts with, cultural life, traditions, religious aspirations and spiritual life of a population.

The countries of the Eastern Mediterranean Region of WHO are blessed with the existence of strong family ties, cohesive social institutions and the presence of spiritual and religious beliefs having the potential to positively affect the mental health of the population. However, the Region also faces a number of issues which can adversely affect mental health. Our population is very young and is faced with uncertainties about its future. Young people receive many conflicting cultural messages requiring reconciliation of traditions with the new trends, causing insurmountable stress in many instances. Waves of migration and unplanned urbanization, bringing in their wake poverty and loss of social capital, are placing heavy stress not only on the infrastructure but on the coping abilities of individuals as well. A number of countries of the Region face war, occupation, sanctions and internal conflicts, and millions of refugees in different parts of the Region are straining the social fabric of the societies they live in as well as facing the burden of nonassimilation in an alien culture.

There are also existing and emerging issues of the elderly, women and children, who are “doubly vulnerable” to develop mental health problems.

As far as diseases are concerned, the Region is particularly faced with issues of depression, epilepsy, management of the chronically ill and suicide, the incidence of which is on the rise in many parts of the Region. Substance abuse is a major mental health and development problem in the Region with grave public health consequences such as increasing the risk of HIV and other blood-borne infections.

In the past 15 years, the countries of the Eastern Mediterranean Region have adopted national programmes of mental health as a method of meeting the needs of the population. The main strategic approach of all these programmes is integration of mental health within the existing health systems, including primary health care. Accordingly, the objective of the almost all of the national programmes of mental health that are developed in collaboration between WHO and Member States is to develop proper systems for the realization of such integration. Such programmes that have specifically been put to experience in the countries of the Eastern Mediterranean Region of WHO during the last decade have been blessed by a number of opportunities and struggled with a number of constraints. Thus, the future success and/or failure of such programmes would depend on the correct understanding of these opportunities and constraints and on finding ways to deal with them.

In some countries, such as Bahrain, Cyprus, Islamic Republic of Iran, Pakistan, Saudi Arabia and Tunisia, mental health needs are addressed through integration of mental health into existing general health systems in more than one area of the country or on a nationwide basis. Other countries, such as Egypt, Jordan and the Republic of Yemen, have well sustained projects of integration of mental health in some areas. There are good examples of school mental health programmes in Egypt, Islamic Republic of Iran, Pakistan and Tunisia. Pakistan and Tunisia have also modernized their legislation. Sudan has worked on both modernizing the mental health programme and utilizing the traditional healers. Cyprus, Lebanon and Morocco are examples of effective use of NGOs. In Afghanistan a three-month diploma course was coordinated by

WHO/EMRO in collaboration with the two neighbouring countries of Islamic Republic of Iran and Pakistan. This model has been recently used to train a new group, this time using the trainers trained, in a move towards self sufficiency. The experience of Afghanistan can be utilized for countries with similar conditions.

At the regional level, the Region held a major advocacy event for mental health connected with the Region's ministers of health or their representatives, and signed a declaration in support of mental health during the Regional Committee of 1997 in Teheran, Islamic Republic of Iran. As a follow-up to this event, a 10-item programme for development of mental health was proposed and Member States asked to choose from among a number of activities and start implementation in their respective countries.

As we enter the new millennium, developing countries face a number of burning issues and challenges that affect all aspects of health, including mental health. Population explosion, unplanned urbanization, scarcity of human resources, reliable data and systematic approach to health delivery and referral and a number of cultural issues are among these. On the other hand, it is fair to say that since the middle of this century the general attitude towards mental health has been changing in both developing and developed countries. Reasons for this change include the coincidence of many factors like scientific and technological advancements and socioeconomic changes. The introduction of a more accurate and holistic definition of mental health, new scientific discoveries regarding the etiology and treatment of mental illnesses and their treatment, and the possibility of returning a considerable number of patients to their homes and the community are among these factors. One of the major by-products of these developments is the introduction of much better coordination between the general and mental health services. Integration of mental health within primary health care systems is a major product of this coordination.

Let us conclude by pledging to continue to develop mental health in the Region and collaborate with Member States to provide the minimum necessary mental health care for all. Let us also note that at this stage of the development we need to realisti-

cally assess our programmes and determine what challenges we face, what assets and opportunities we have and what constraints are ahead of us. Only through such a comprehensive approach and true understanding of the real needs and specifications of each country and community can we develop the capacity to provide an acceptable level of mental health for our people.

Regional Office for Europe

Dr Marc Danzon
Regional Director

Dr Wolfgang Rutz
Regional Adviser for Mental Health

A case for action



Depression and depression-related morbidity and mortality are an important focus of the Mental Health Programme of the European office of the World Health Organization. The distribution of these conditions is not homogeneous throughout the region. Some countries have recorded decreasing suicide and depression prevalence rates while others show increasing depression rates but stable or decreasing suicides. In yet others, both depression and suicide rates are on the increase. Among the reasons accounting for this unevenness are differences in access to mental health services as well as differences in quality of services for diagnosis, treatment and monitoring of depressive disorders.

In a number of countries affected by rapid social transitions, mortality rates are on the increase. These rates can be related to social stress, helplessness and loss of identity brought about by sudden, disruptive and severe changes in income, employment, living conditions and belief systems of large numbers of people who are powerless to resist them. Such changes can pose overwhelming threats to mental health through increases in alcohol abuse, depression, suicide, violence, accidents as well as cardio- and cerebrovascular diseases. Family violence is a widespread problem in countries undergoing rapid transition and armed conflict.

And so is sexual violence which affects women and girls disproportionately.

Studies have shown that in Western Europe one in four persons needs psychiatric treatment during their life-time, in some countries, this figure is one in three. Among adolescents, about 15-20% have mental problems. However, mental problems are not necessarily accurately reflected in the number of health service contacts since most of those requiring mental health care do not use the services.

As in other WHO regions, many European countries spend less than 3% of their health budgets on mental health care, although mental ill health can easily amount to one third to a half of all health care costs.

Mental health services development and obstacles for implementation

More than 50% of all patients in some Eastern European countries continue to be treated in large mental hospitals. Stigma and discrimination with regard to mental illness makes early intervention extremely difficult, especially in rural areas. However, there is consensus among most Member States on the need to shift from psychiatric hospitals to community-based services and on the involvement of personnel in mental health care.

Obstacles in Europe are often found in outdated legislation concerning the rights of doctors and patients and in the lack of or limited insurance coverage for outpatient care. Also, the transfer of inpatient services to outpatient settings has proved to be complex especially from the stand point of financing.

Sizable minorities in European countries are affected by poverty and deprivation creating large numbers of people with increased vulnerabilities to mental and behavioural disorders. Since it is not only the degree of poverty but the increasing gap between the richest and poorest in society which act as powerful determinants, many people are at risk of mental problems in the unequal societies in Europe. Overcoming poverty might contribute to improve mental health but it will not be enough; a more equitable distribution of wealth remains a challenge for all countries.

Stigmatization and human rights violations

In some countries positive changes have been made over the years to reduce stigmatization and human rights' violations of people with mental illness including legislative reforms. Such reforms take into account the right to freedom and autonomy as well as the right to health and treatment. These efforts have been potentiated by the extensive celebrations of World Health Day 2001 throughout Europe. Mass media initiatives aimed at raising awareness and improving the quality and quantity of information on mental health issues have intensified everywhere and it is expected that the momentum generated will be sustained over the next years.

WHO/EURO response

In order to address the finding that about 40% of European Member States have no government-sanctioned national mental health plan, WHO/EURO is assisting many of its Member States to establish or strengthen their national mental health plans. The regional office is actively pursuing technical collaboration activities with member states to reduce premature mortality in countries undergoing rapid transitions and those facing conflicts, address and eradicate stigma and human rights violations, control the rise in depression and suicides, and, buffer the effect of gender disparities in mental health. An area of special focus is to assist countries in pursuing psychiatric reforms through the establishment of community-based mental health services and the utilization of the primary care system with the active involvement of consumers and families.

Mechanisms for collecting reliable country information, promoting and carrying out research and establishing programmatic guidelines on various aspects of mental health have included the setting up specific Task Forces such as the ones on Premature Mortality, National Assessments and Mental Health Audits and Destigmatization. The work of these Task Forces will help to assess the situation in countries, identify the key determinants of mental problems in various population groups and assess their impact, analyse the obstacles to service improvement, design appropriate interventions and strategies and monitor the implement-

tation and follow-up of national programmes on mental health. Another objective of the Task Forces is to evaluate different models of interventions for promotion, prevention and care and to disseminate evidence-based information on successful strategies and approaches to Member States.

An example is provided by the heavy toll of mental health problems associated with violence, alcohol addiction and suicide in men. WHO/EURO is documenting this trend and designing appropriate intervention strategies based on different models. Also being investigated are the factors that protect females in times of change and transition and which lead to better coping by women. The ability of women to engage in social networking to keep a sense of control of their lives and to ask for help in time of need may provide a useful resource model for men.

Similarly, research generated in Western European countries is being used to assist East European countries to understand the complex socio-psychological processes currently being experienced by their populations. Promoting the practices of maintaining strong family ties, cohesive networks of families and friends, and spiritual and religious beliefs will hopefully protect some of the socially distressed societies from major mental health problems. EURO will continue to promote bilateral and multilateral collaboration including exchange of experience between Eastern and Western European countries in a mutually respectful way.

A European Ministerial meeting will be convened in the near future to provide further direction and guidance to EURO's mental health programme and to reach consensus on its broad strategic directions.

Regional Office for South-East Asia

Dr Uton Muchtar Rafei

Regional Director

Dr Vijay Chandra

Regional Adviser for Mental Health



Populations of Member Countries of the World Health Organization's South-East Asia Region have suffered for ages from many communicable diseases. Some have been successfully controlled, while others continue to be serious public health problems. However, it is now increasingly clear that noncommunicable diseases, including mental and neurological disorders, also cause untold suffering and death in the Region.

Worldwide, an estimated 450 million people suffer from mental and neurological disorders or from psychosocial problems related to alcohol and drug abuse. Our Region accounts for a substantial proportion of such people. Thus, the Region faces the double burden of disease – both communicable and noncommunicable. Moreover, with the population increasing in number and age, Member Countries will be burdened with an ever-growing number of patients with mental and neurological disorders. As stated by Dr Gro Harlem Brundtland, the Director-General of WHO, "Many of them suffer silently, and beyond the suffering and beyond the absence of care lie the frontiers of stigma, shame, exclusion and, more often than we care to know, death."

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

There are many barriers to the implementation of community mental health projects and pro-

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

The Regional Office is developing strategies for community-based programmes based on five "A"s: *Availability, Acceptability, Accessibility, Affordable medications and Assessment.*

Availability

Services to address at least the minimum needs of populations in mental and neurological disorders should be available to everyone regardless of where they live. The key questions are: what are the minimum services needed and who will deliver them?

Acceptability

Large segments of populations in the countries continue to perpetuate superstitions and false beliefs about mental and neurological illnesses. Many believe that these illnesses are due to "evil spirits". Thus, even if appropriate medical services are made available, they would rather go to sorcerers and faith-healers. Populations need to be informed and educated about the nature of neuropsychiatric illnesses.

Accessibility

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

Affordable medications

Frequently, medications are beyond the reach of the poor. Every effort should be made to ensure an uninterrupted provision of essential medications, at a reasonable cost. Thus, government policies in terms of pricing and the role of the pharmaceutical industry in distribution and pricing become critical.

Assessment

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

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

Regional Office for the Western Pacific

Dr Shigeru Omi
Regional Director

Dr Helen Hermann
Regional Adviser (a.i.) for Mental Health

Mental health is the foundation of all health. Scientific evidence and research today underscore the inseparable links between mental and physical health. But while physical health has improved in the Western Pacific Region, mental health has declined over the last 50 years.

Social and economic factors have had a significant negative effect on the level of mental health. Mental and neurological disorders include common disorders such as depression, anxiety, and substance abuse and dependence; less common but disabling conditions such as schizophrenia; epilepsy and dementia; and intellectual disability. Suicide is an important problem closely linked to mental health.

According to some estimates, the burden of mental disorders is higher in the Western Pacific Region than in some other parts of the world. In the relatively affluent countries of the Region, mental disorders accounted for 27% of the disease burden in 1999, and in the other countries the figure was 15%.

The obstacles to improving mental health range from poverty, family disruption, uncontrolled urbanization, disasters and armed conflict, and problems resulting from the situation of refugees and displaced persons, to community attitudes and knowledge, insufficient attention to healthy policies, low priority for services, and outmoded and inadequate service provision aggravated by weak links to community resources.

In the Western Pacific Region, two key strategic directions are proposed to improve mental health. First, the *application of the public health approach to mental health promotion and the prevention and treatment of illness*. This includes intersectoral approaches to mental health promotion (including legislation, policy and workforce training), gathering and disseminating the evidence of the effect on mental health of decisions in these areas, more specifically, prevention of disorders among groups at high risk (such as those with harmful use of alcohol and new mothers

with a history of depression), and organization of acceptable, accessible and effective health services.

Second, *the integration of mental health services into general health services and the wider community*.

Integrated services of a good standard will provide for (a) early recognition and treatment of mental health problems and mental disorders, and (b) continuity of care close to home, family and employment for those with persisting disabilities.

Providing quality service will require improving community awareness and reducing the stigma and discrimination affecting those with mental disorders and their families; easy and quick access to treatment and care; improved provision and organization of mental health services; appropriate legal protection; workforce training in mental health skills; service standards and accreditation; inclusion of support for consumers and families, self-help and advocacy associations in treatment and planning; a culture of service and programme research and evaluation; and attention to the psychosocial aspects of health care.

It is recognized that to improve mental health and address the challenges posed by mental disorders, WHO/WPRO and its partners will need to take concerted action. Action is needed at several levels – awareness, policy and intervention – and in developed and developing countries alike. WPRO will, therefore, work with countries and other partners to:

- analyse the situation and develop policies and programmes that reflect emerging perspectives in mental health;
- develop the technology needed for prevention, treatment and rehabilitation programmes;
- integrate mental health care into general health care;
- reorient services from hospital-based to community mental health care;
- develop a culture of research and evaluation; and
- include mental health in health promotion programmes.

WHO/WPRO is committed to using the framework of an agreed mental health strategy to work with Member States and other partners to translate these elements into action.

Epilogue

WHO's response to the Ministers call for action

Benedetto Saraceno

Director

Department of Mental Health and Substance Dependence

World Health Organization

Geneva



It is with a deep sense of satisfaction that we are witnessing the emergence of a phenomenal movement for improving mental health at international and national levels. This movement is the result of a series of events that unfolded progressively throughout 2001 in WHO and countries around the world. Never before did Mental Health receive such central focus during a single year, nor was there ever before a stronger sense of solidarity and mobilization of people around this critical health concern. Non-governmental organizations, private sector entities, academics, professional groups, and the media have expressed eagerness to team up with governments and civil society to increase access and means of addressing the mental health needs of all people.

Key amongst the recent events that have led to this global response for mental health is undoubtedly the consensus reached by more than one hundred Ministers of Health on the need to prioritize the mental health needs of their populations since this was threatening the wellbeing of large segments of their populations and compromising the socio-economic development of their nations. They made clear their beliefs by stating that the round tables on the theme of mental health were “*long over due*” and “*historic*” because “*for too long we hid the subject*”, and that “*our concern for infectious diseases should not deter us from dealing with mental health problems. . . . we must find a share for mental health out of our limited budgets*”. This new political commitment provides an important platform for scaling up action in mental health.

The reasons that have propelled WHO to bring mental health into the limelight are multiple and well described in the different sections of this book. On the one hand there is the alarming epidemiological burden and projected increases in incidence and prevalence of mental, neurological and behavioural disorders, the vast treatment gap and, the epidemic stigmatization and human rights violations of people with mental problems. On the other hand, there is the solid scientific evidence that provides us with strong basis for action. Psychotropic drugs with less adverse side effects are now available to treat different crippling disorders, such as schizophrenia and depression. The mechanisms of their action are better known and indications for their proper use have been systematized and made available for specialized and non

specialized medical personnel. Psychological interventions for depression have been researched and their success rates documented. The effect of modifying the family environment to reduce negative outcomes in some disorders such as schizophrenia, have been carefully tested. We have also made huge advances in identifying the best channels for delivering these treatments to people in the context of the primary health care and as close as possible to communities where people live.

Indeed, evidence is replacing ideology or tradition and all this new information is persuading many that the practice of mental health care can now have a scientific anchor. But progress in actually making the shift from knowledge to action is slow and uneven in countries. Recent surveys carried out by WHO Department of Mental Health show that no more than one third of persons with schizophrenia receive any treatment. It is likely the treatment gap is much higher since the basis for the calculations world-wide were studies carried out in countries where mental health care was more readily available. The case of epilepsy also illustrates well the treatment gap. Between 60 to 90% of treatable patients with epilepsy receive no care, 5% or less of people who have depressive disorders have access to treatment in resource poor countries. Moreover, even when treatments are accessible, people do not seek care for long periods of time because of the fear of being stigmatized by health workers, community and society at large. And, the prevalence rate of mental disorders cannot be reduced without reduction in the treatment lag.

These facts beg an appropriate response by governments. The reorientation of services, the use of available technologies and the promotion of healthy public policies can make a difference. It was time therefore for WHO to stimulate and catalyse a collective response for mental health action by taking the evidence to the international community, governments and the public. This is what we tried to achieve through the messages of the *World Health Day* (7th April) which reached all sectors of society.

This is also what we tried to achieve through the Ministerial Round Tables in the *World Health Assembly* this year by arousing the interest and motivation of health ministers to place mental health

squarely on the health and development agendas of their countries. The results of the Assembly Round Tables have been very encouraging. 132 Ministers of Health from all parts of the world came together and collectively expressed their political commitment for addressing people's needs in this area. They highlighted their strengths as well as their shortfalls in so doing during their discussions. They also made a strong call for international support specifying WHO's intensified technical support in priority areas. Based on these requests, we are proposing a global mental health strategy to ensure that WHO at headquarters, regional and country levels can assist countries effectively in achieving their national mental health goals.

The strategy consists of the four following pillars:

- generating information and disseminating it widely;
- supporting countries in developing their policies; programmes and services;
- promoting research and building national research capacity;
- strengthening advocacy and protection of human rights.

The *first pillar* addresses two essential elements: one which aims at increasing significantly the quantity and quality of information available to policy-makers and service providers on the science and programme experience related to mental health care, promotion and prevention. We believe that even if a small fraction of what is known can be made available to those who plan and provide services, it will have a large impact. The second arm addresses the existence of tremendous gaps in knowledge about the state of mental health in countries as well as lack of information on countries' capacity to address the factors affecting mental health. Intensified support to countries will need to be provided for building national information systems for the collection of reliable data relating to mental health systems and their monitoring, the evaluation of service delivery, and the collection of basic epidemiological information. Particular attention will be given to ensure these efforts are compatible with and linked to broader health sector information systems.

The *second pillar* of the strategy will redress the current situation in which more than 40% of coun-

tries have no mental health policy and over 30% have no mental health programme. Even countries that do have mental health policies often disappointingly neglect some of the more vulnerable populations. For example, over 90% of countries have no mental health policy that includes children and adolescents. Providing a comprehensive package of support to countries to develop capacity for policy and service development in prevention, treatment and surveillance of mental disorders is therefore a much-needed activity. The development of the package would be accompanied by technical assistance to countries, upon their request, for planning and financing of comprehensive mental health systems. Essential elements will include legislation, service planning especially the integration of mental health into the larger public health system, human resource development, services for especially vulnerable populations such as women, children, elders, refugees, adolescents and those with chronic physical illnesses and/or disabilities, and quality of care.

The *third pillar* of the strategy addresses research and country support for building research capacity. The impetus for considering research one of the four pillars of our strategy is driven by the understanding that there is currently very limited research capacity in most countries and a serious lack of trained researchers, especially in low and middle income countries. Yet this is a critical and essential element of health system development. Most current research on mental health is conducted in a few wealthy countries and we know that the relevance and transferability of findings from wealthy countries to poorer countries remains questionable. This is a serious contributing factor to the lack of locally relevant and evidence based mental health policies and practices based on operational research findings. Encouraging and supporting countries to build the necessary infrastructure to sustain research capability, in particular applied research, is essential for improved efficiency and effectiveness of services as well as for extending knowledge about the causes, preventive measures, and the possibilities of treatments.

The *fourth pillar*, pertains to the critical role of sustaining advocacy for mental health at the international, regional and national levels. Through the use of partnership relationships with governments, NGOs and community groups, countries will be

supported in developing their important advocacy sector in order to position mental health on the public agenda, to promote a greater understanding and acceptance of those affected by mental illness, to promote legislation for the protection of the human rights of people with mental illness, to reduce the pervasive effects of social exclusion resulting from stigma and discrimination and the out-dated nature of many mental institutions. Less exclusion, less discrimination will help those afflicted and their families to lead better and more productive lives and encourage those in need to seek treatment.

The systematic process of awareness raising and advocacy launched through the World Health Day campaign “Stop exclusion. Dare to care”, will continue to provide the platform for generating enthusiasm, inspiring people to represent the needs of families and consumers in policy, legislation and service delivery; and ensuring that the response of the mental health system matches the real needs of people with mental illness.

While beneficial results of this strategy are already evident, we expect much more substantial impact within the next three to five years. In order to better assess the impact of these activities, a systematic and in-built mechanism of evaluation is being put in place. We believe that we can optimally target our limited resources only through a continuous evaluation of the results of what we do, whether the area is research, policy/programme/service development or advocacy. The same applies for countries.

In conclusion, WHO wishes to pay tribute to the Ministers of Health who iterated a strong call for mental health action during the World Health Assembly of 2001. In aligning our strategic directions with their expressed concerns and priorities, we want to ensure that our vision and goals are collective and that they follow pathways that are realistic as well as achievable. We appeal to all who share this vision to join us in improving access and quality of mental health care for all those who have waited far too long.

Annex

List of participants of the round tables

ROUND TABLE – Room VII	
Chair	Mr Phillip Goddard (Barbados)
Facilitators	Professor Jill Astbury (Australia) Professor Arthur Kleinman (United States of America)
Belgium	Mrs Magda Aelvoet
Burkina Faso	Mr Pierre Tapsoba
Cameroon	Mr U. Olanguena Awono
Chile	Dr Carmen López
Denmark	Mr Arne Rolighed
Dominica	Dr John Toussaint
Ecuador	Dr Patricio Jandriska
Ethiopia	Dr Menilik Desta
Fiji	Mr Pita K. Nacuva
Germany	Mrs U. Schmidt
Hungary	Mr Gyula Pulay
Lesotho	Mr T. Mabote
Mexico	Dr Julio Frenk Mora
Mongolia	Professor P. Nymadawa
Morocco	Mr Thami El Khyari
Namibia	Dr Libertina Amathila
Nepal	Mr Ram Krishna Tamrakar
Oman	Dr Ali Bin Mohammed Bin Moosa
Pakistan	Dr A.M. Kasi
Paraguay	Dr Martin Chiola
Poland	Professor Grzegorz Opala
Qatar	Dr H.A.H. Al-Bin-ali
Republic of Korea	Dr Kyeong Ho Lee
Saint Kitts and Nevis	Mr Earl Martin
San Marino	Mr Romeo Morri
Senegal	Mr Abdoul Aziz Diop
Singapore	Professor Ee Heok Kua
Slovenia	Mr Dorjan Marušič
South Africa	Dr M.E. Tshabalala-Msimang
Turkey	Professor Orhan Canbolat
Zambia	Dr L. Mumba

ROUND TABLE - Room XII	
Chair	Mr Lyonpo Sangay Ngedup (Bhutan)
Facilitators	Dr J. López-Ibor (Spain) Dr Sylvia Kaaya (United Republic of Tanzania)
Angola	Dr Albertina Hamukwaya
Belarus	Dr Igor Zelenkevich
Bosnia and Herzegovina	Dr Zeljko Mišanović
Botswana	Ms Joy Phumaphi
Brazil	Dr João Yunes
Brunei Darussalam	Mr Ahmad Matnor
Democratic Republic of the Congo	Professor Mashako Mamba
Gabon	Mr Faustin Boukoubi
Greece	Professor Christina Spyraiki
Grenada	Dr Clarice Modeste-Curwen
Guatemala	Mr Mario Bolaños Duarte
Haiti	Dr Henri-Claude Voltaire
Israel	Dr A. Leventhal
Jordan	Dr S. Kharabseh
Lao People's Democratic Republic	Dr Bounghong Bouphe
Liberia	Dr Peter S. Coleman
Madagascar	Professor Henriette Ratsimbazafimahefa
Maldives	Mr Ahmed Abdullah
Nicaragua	Dra Mariángeles Argüello
Norway	Mr Tore Tønne
Peru	Sr Dr Eduardo Pretell Zárata
Rwanda	Dr Ezéchias Rwabuhiri
Samoa	Mr M. Siafausa Vui
Sierra Leone	Dr I.I. Tejan Jalloh
Slovakia	Mr Svätopluk Hlavačka
Sri Lanka	Mr W.D.J. Seneviratne
Switzerland	Ms Ruth Dreifuss
Uganda	Dr C. Kiyonga
United Arab Emirates	Mr Hamad Abdul Rahman Al-Madfaa
United States of America	Mr Tommy Thompson
Yemen	Dr Abdul Nasser Ali Al-Munibari

ROUND TABLE - Room XVII	
Chair	Mrs Annette King (New Zealand)
Facilitators	Professor Julian Leff (United Kingdom of Great Britain and Northern Ireland) Dr Lourdes Ignacio (Philippines)
Algeria	Dr M. Abdelmoumène
Bahamas	Dr Ronald Knowles
Bangladesh	Mr Sheikh Fazlul Karim Selim
Canada	Mr A. Rock
China	Dr Peng Yu
Côte d'Ivoire	Professor Raymond Abouo N'Dori
Cuba	Dr Carlos Dotres Martínez
Cyprus	Mr Frixos Savvides
Egypt	Professor Ismail Sallam
France	Dr Bernard Kouchner
Gambia	Mr Y. Kassama
Georgia	Dr A. Gamkrelidze
India	Dr C.P. Thakur
Iran (Islamic Republic of)	Dr Mohammad Farhadi
Japan	Mr Jungoro Kondo
Mali	Dr Fatoumata Traoré Nafo
Mozambique	Dr Francisco Ferreira Songane
Myanmar	Mr Ket Sein
Netherlands	Dr E. Borst-Eilers
Niger	Mr Assoumane Adamou
Nigeria	Professor A.B.C. Nwosu
Panama	Dr Fernando Gracia García
Papua New Guinea	Mr Ludger Mond
Portugal	Mr José Manuel Boquinhas
Russian Federation	Professor V.N. Krasnov
Saudi Arabia	Dr Mohamed Abdullah Al Shawoosh
The former Yugoslav Republic of Macedonia	Dr Muarem Nedzipi
Tunisia	Dr H. Abdessalem
United Kingdom of Great Britain and Northern Ireland	Ms Jane Hutt
Uruguay	Dr E. Touyá
Viet Nam	Professor Pham Manh Hung
Zimbabwe	Dr Timothy J. Stamps

ROUND TABLE – Room XVIII	
Chair	Professor M. Eyad Chatty (Syrian Arab Republic)
Facilitators	Dr Vikram Patel (India) Ms Paula Mogne (Mozambique)
Argentina	Dr Hector Lombardo
Australia	Professor John Mathews
Austria	Professor Reinhart Waneck
Bahrain	Dr Faisal Radhi Al-Mousawi
Benin	Professor G. Ahyi
Bolivia	Dr Guillermo Cuentas-Yáñez
Chad	Mme Fatimé Kimto
Colombia	Sra Sara Ordoñez Noriega
Croatia	Dr A. Gilić
Czech Republic	Professor Bohumil Fiše
Democratic People's Republic of Korea	Mr Ri Si Hong
Dominican Republic	Sra Angela Caba
Finland	Dr Jarkko Eskola
Ghana	Dr Richard W. Anane
Guinea	Dr Mamadou Saliou Diallo
Guinea-Bissau	Dr Francisco Dias
Honduras	Dr Plutarco Castellanos
Iceland	Mr David Gunnarsson
Indonesia	Dr Achmad Sujudi
Iraq	Dr Omid Midhat Mubarak
Italy	Dr F. Oleari
Jamaica	Mr John Junor
Malaysia	Mr Chua Jui Meng
Mauritius	Mr Ashok Kumar Jugnauth
Romania	Dr Daniela Bartos
Saint Lucia	Mrs Sarah Flood Beaubrun
Sudan	Dr Ahmed Bilal Osman
Sweden	Mr Lars Engqvist
Thailand	Dr Winai Wiriyakitjar
Tonga	Dr V.T. Tangi
Trinidad and Tobago	Dr Rampersad Parasram
United Republic of Tanzania	Ms Anna M. Abdallah
Venezuela	Dra María Lourdes Urbaneja Durant
Yugoslavia	Dr M. Kovac

Mental health is the capacity
of the individual, the group and the environment
to interact with one another in ways that
promote subjective well-being,
the optimal development and use of mental abilities,
the achievement of individual and collective goals
consistent with justice and
the attainment and preservation
of conditions of fundamental equality.



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