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1. INTRODUCTION

There is a common misconception about the meaning of the term "mental health". A large number of people, including health professionals, often regard it as nothing more than a branch of medicine which deals with the treatment of the seriously mentally ill or, in popular terms, a speciality dealing only with "mad people". This unfortunate view of mental health is erroneous and limiting. In fact, a mental health programme deals with mental, psychological and behavioural factors affecting health and health services. It deals with serious mental and neurological illnesses as well as with many common problems of daily living, i.e. tensions, worries, stresses and their impact on health, but does not stop there: above all, it seeks to promote the value given to mental health and the life of the mind by individuals and societies*. It is in this spirit that WHO's Constitution conceived health, when it stated that "health is a state of complete physical, mental and social well-being".

Another common misconception about mental health, which is often expressed by health administrators, is that the many pressing health problems arising from malnutrition, infections and poor sanitation, make mental health a luxury for developing countries and therefore not deserving priority in health programmes. This assessment is neither correct nor fair. In fact, mental illness is as common in developing countries as in the more developed. It occurs frequently and causes severe socio-economic losses: according to WHO estimates at least 300 million people throughout the world are suffering from incapacitating mental disorders at any given time and the majority of them live in developing countries. There are few human conditions which cause more anguish to the individual and to the family than mental illness.

But the case for mental health does not rest only on prevalence of or disability caused by mental illness; there is a growing awareness that many health and social problems, for example those related to drug abuse, alcohol, violence and delinquency among youth, are a function of mental ill-health and thus are the concern of mental health programmes. Many of the most serious health problems and common causes of death in the world, e.g. heart diseases, cancer, accidents and infections, could be considerably reduced if human behaviour were modified. If people could be persuaded to adopt healthier life-styles, by reducing consumption of alcohol and tobacco, or by engaging in regular exercise, a large proportion of such illnesses could be prevented. It should also be noted that many failures in health care are not due to any lack of technological solutions but to an inability to apply technology, often resulting from an insufficient understanding of sociocultural factors and human behaviour. Schistosomiasis and diarrhoeal diseases could be prevented by changing people's behaviour so that they would not continue to spread these diseases. Similarly, we know the techniques of family planning, yet we lack the means of persuading people to use them. One could easily list

* This view is also reflected in WHO's Eighth General Programme of Work, where Programme 10, i.e. Protection and Promotion of Mental Health, has the following sub-areas:

1. Psychosocial and behavioural factors in the promotion of health and human development.
2. Prevention and control of alcohol- and drug-abuse.
3. Prevention and treatment of mental and neurological disorders.

many similar examples. They all show that, without paying adequate attention to psychosocial and behavioural factors, success in health fields is unlikely to be achieved. The current pandemic of acquired immunodeficiency syndrome (AIDS) is a glaring example of how inadequate our technological response can be when human behavioural factors are not taken sufficiently into account.

Yet another major misconception about mental health programmes is that they deal with very technical and complex matters requiring highly trained professionals and therefore that mental health cannot be included in primary health care. The contrary is the case: the essentials of mental health are simple principles, many of which have been taught by most religions all over the world. For instance, caring, showing concern, consoling and many other qualities are helpful in dealing with a human being in distress, or suffering from a disease, yet such basic mental health strategies are not given prominence in the training of health workers. Furthermore, modern medical technology has provided us with medicaments which can be used at the primary health care level for the treatment of serious mental illnesses such as psychosis, epilepsy or depression. In fact a number of countries in the Eastern Mediterranean Region have successfully introduced the treatment of such problems into primary health care.

In summary, mental health programmes are not limited to the treatment of serious mental illness in a mental hospital; they deal with the whole range of psychosocial and behavioural factors affecting both health and disease. A well-structured mental health component is vital for the success of all health programmes. A mental health programme must begin with mental health promotion and the prevention of mental and neurological illness. Mental health technology is simple and effective. It should be incorporated into primary health care. Even more than other health efforts, mental health programmes must develop in harmony with the local sociocultural traditions and conditions.

2. SCOPE AND ORGANIZATION OF THE PAPER

Resolution WHA39.25 requested regional committees to discuss possibilities for the prevention of mental, neurological and psychosocial problems including those related to the use of alcohol and other drugs. This paper presents background information which may be useful for this discussion. After a review of knowledge about psychosocial factors relevant to health and development programmes, a presentation is given of possibilities for the prevention and control of drug abuse, including the uses of tobacco and alcohol, and for the prevention of mental and neurological disorders. This is followed by a discussion of the framework of national mental health programmes, which also focuses on preventive activities. Then comes a summary of measures that can be undertaken by social service sectors other than the health sector. The paper ends with a brief summary and conclusion highlighting its most salient points.

A Summary of Recommendations is being presented together with this paper for consideration by the Regional Committee.

3. REVIEW OF THE CURRENT SITUATION AND POSSIBILITIES FOR ACTION

3.1. Psychosocial factors affecting health and development: possibilities for preventive action

Rapid social changes resulting from economic development, industrialization and urbanization, have profound effects on the structure of

communities, the functioning of families, and the psychological well-being of individuals. They can erode traditional psychosocial support systems and thus reduce the capacity of individuals, families and communities to cope with distress, disease and disability. The resulting social disorganization can exacerbate problems such as juvenile delinquency, violence and accidents, both at work and in traffic.

Mental health and psychosocial skills and knowledge which could assist individuals and communities, as well as governments, in understanding, anticipating and coping with emotional and other health consequences of social change are not used sufficiently nor in enough countries. Such skills and knowledge could also permit health workers to engage positive sociocultural and traditional resources - for example those residing in religion - in the promotion of health and welfare.

Psychosocial factors have been increasingly recognized as being of key importance in the success of broad-scale health and social actions (e.g. smoking cessation programmes). If these actions are to be effective in the prevention of diseases and in the promotion of health and well-being, they must be based on an understanding of the culture, traditions, beliefs and patterns of family interaction. This is at present only infrequently the case which often leads to failure of such interventions. The same holds true when health workers want to influence the behaviour or life-styles of clients/patients, their families and communities in the context of general, and in particular, primary health care. Most education for health workers introduces them to the techniques and language used for dealing with physical problems. Psychological and social problems are dismissed as "not real" and outside the competence of the health worker. Training of health workers (and the way in which health care is organized) should enable them to deal with psychosocial problems and to see their patients as people functioning in a specific way within their community. At present, such training is rarely provided and in general receives insufficient emphasis in most countries.

3.1.1. Psychosocial stress in the countries of the Eastern Mediterranean Region

Countries in the Eastern Mediterranean Region experience a multitude of major psychosocial stresses, ranging from the consequences of war to economic insecurity and poverty. Environmental catastrophes add their weight to the burden under which many communities must live and survive. These stresses have their most serious pathogenic effect in the absence of protective mechanisms that have evolved in human societies. Social networks, e.g. those provided by family and friends, and other features of community life which, until recently, have played an important protective role in many countries, are in danger of disappearing. Recent trends toward community disintegration and breakdown leave populations more vulnerable and make them a prey to health damage. In such cases, the health care system, and particularly primary health care workers, can become important agents of social change playing a vital nurturing and psychologically supportive role, especially for the socially and economically deprived. Alone, however, they are unable to succeed: they must mobilize other influential members of the community and provide specific content for joint activities promoting health, reinforcing social networks and preventing illness.

Homicide, suicide, accidents, child abuse and numerous other forms of violence - in the occurrence of which psychosocial factors play a major

TABLE 1. SOME EXAMPLES OF DESIRABLE BEHAVIOUR CHANGE REQUIRED FOR THE PREVENTION OF MAJOR HEALTH PROBLEMS IN THE EASTERN MEDITERRANEAN REGION

HEALTH PROBLEMS	BEHAVIOUR CHANGE REQUIRED
<p>1. <u>Communicable diseases</u></p> <p>1.1 Diarrhoeal diseases</p> <p>1.2 Malaria</p> <p>1.3 Hookworm</p> <p>1.4 Ascaris</p> <p>1.5 Schistosomiasis</p> <p>1.6 Leprosy</p>	<p>1.1 Promote breast-feeding, personal hygiene, domestic sanitation</p> <p>1.2 Eliminate water-collection locations</p> <p>1.3 Promote use of shoes, use of latrines and refuse disposal</p> <p>1.4 Eliminate use of human excreta as fertilizer; promote use of latrines</p> <p>1.5 Eliminate urination and defaecation in streams</p> <p>1.6 Eliminate spitting and indiscriminate discharge of nasal secretions</p>
<p>2. <u>Non-communicable diseases</u></p> <p>2.1 Cardiovascular diseases</p> <p>2.2 Cancer</p> <p>2.3 Traffic accidents</p> <p>2.4 Dental caries</p> <p>2.5 Emotional disorders</p> <p>2.6 Malnutrition</p>	<p>2.1 Reduce salt intake, fats in diets; reduce smoking and alcohol consumption; reduce stress; increase exercise</p> <p>2.2 Reduce smoking, alcohol consumption, promote consumption of vegetables and fruit, fibres</p> <p>2.3 Reduce alcohol use particularly while driving; educate parents and children</p> <p>2.4 Promote brushing teeth and dental hygiene</p> <p>2.5 Reduce stress; increase coping skills</p> <p>2.6 Promote proper nutrition through education of the public and health professionals</p>

role - are a leading cause of death in many countries. Violence can also lead to neuropsychiatric morbidity (e.g. brain injury) and to a variety of psychosocial consequences for individuals and communities, ranging from an increase in stress-related diseases to a decrease of community cohesion and involvement. Dealing with consequences of violence for the victims and the communities can be significantly facilitated if mental health skills are used by health workers.

In many countries in the Eastern Mediterranean Region, for example where fathers migrate in search of labour, but also for a variety of other reasons, there is an increasing tendency toward family breakdown which not only affects the upbringing of children but also weakens ties between generations and prepares the ground for other health problems. High-risk behaviour of young people (e.g. experimenting with drugs and alcohol, sexual activity without precautions against sexually transmitted diseases or pregnancy, driving at excessive speed) tends to become more frequent when family cohesion is weakened. Appropriate training of health workers can help them to identify families at risk of breakdown, and support them through periods of crisis.

3.1.2. The role of religion

Modern man in search of a soul has come to recognize the importance of spiritual values, not only for mental but also for physical health. Religion, if properly understood and used, can be a powerful force for health promotion. Islam in particular, the dominant religion in the Region, offers a total life-style rather than an isolated belief system.

Health services in countries of the Eastern Mediterranean Region could find particular support to their work on health care in the teachings of the religions dominant in the Region and in an alliance with religious leaders. In this respect, WHO EMRO has already taken important steps and organized meetings which should help to define appropriate strategies. A comprehensive report dealing with the promotion of behaviour and life-styles conducive to health on the basis of Islamic teaching is in preparation. It is likely to be followed by a similar report on Christian religious teachings for health.

Traditional healers have maintained their role in health care in many developed societies: this is even more so in the developing countries. In the countries of the Eastern Mediterranean Region, these healers often have a religious background and are willing to collaborate with health services in the care of people with specific problems. Such collaboration with religious healers has been successful in some countries (e.g. Sudan). Collaboration with religious institutions, e.g. mosques, proved to be a valuable strategy in health care development. Care for drug-dependent persons through mosques in Egypt is a good example of such cooperation.

3.1.3. Application of behavioural sciences in health services

A WHO consultation on the application of behavioural sciences in health services in developing countries was held in Alexandria in 1985. The consultation stressed that appropriate behavioural science knowledge and technology should be applied to health services. Table 1 from that report outlines some examples of behaviour change which could help in dealing with major health problems in the Region.

Information about teaching behavioural sciences in various institutions for health personnel in the Region is being collected so that curricular inserts can be designed. Also, during recent years, several WHO publications have been prepared, some dealing with results of general surveys of activities or studies conducted in the Eastern Mediterranean Region (e.g. on attitudes towards the mentally ill, on cultural determinants of female circumcision and on the role of attitudes in health programme development).

Lack of resources and trained manpower rendered development in this part of the programme slower than its importance for health promotion warrants. In future years it will be necessary to strengthen both WHO's and countries' activities in this area.

3.1.4. Mental health promotion through school health programmes

In the field of mental health promotion an interesting programme has recently been started in schools in the rural area of Rawalpindi Division in Pakistan. After imparting basic mental health education to teachers in a weekly series of lectures, the school authorities were persuaded to introduce a programme of mental health promotion for students in schools. Each teacher was asked to spend five minutes daily with his class to teach principles of mental health, concentrating only on the following three messages:

1. Smoking is injurious to health (and is also the starting point for future drug abuse).
2. Mental illnesses are, like physical illnesses, due to natural causes and are treatable. Mental illnesses are not due to a curse of God or evil spirits.
3. If you see a child with a physical or mental handicap, you should not laugh at him/her but you should try to help him/her.

The programme has become very popular and is being increasingly introduced in other schools. The principal of one school has had these slogans written on classroom walls and printed on the back of all school report cards for the parents to see. Recent reports indicated that the programme has already had very positive results. Children have identified mentally ill relatives and brought them for treatment to rural clinics, thus reducing family stress and increasing the efficiency of primary health care units; smoking among teachers has been reduced and handicapped children seem to be better accepted by their classmates and better looked after by their teachers.

3.2. Prevention of health problems related to the abuse of alcohol, tobacco and other drugs

Health problems caused by the use of narcotic and psychotropic drugs and by the consumption of alcoholic beverages have increased dramatically in recent years. This is true both globally and for many of the countries of the Eastern Mediterranean Region.

Besides their direct effects on health and life expectancy, alcohol- and drug-abuse are also associated with suicide, accidents, absenteeism, negative impact on family life and offspring, prostitution and delinquency. These adverse effects are experienced not only by individuals but by the whole community. Changes which occur in individuals as a result of alcohol- or

drug-abuse are linked to increasing neglect of their professional and personal affairs and of social responsibilities and to health-damaging life-styles. Although the social implications of this process are less well quantified and documented than the health consequences, they present an even more serious problem to communities and societies at large. Where psychoactive-substance-abuse is a frequent phenomenon in a given population, this may have a most serious impact on the overall development and on the economy of the community.

Although the strength of religious and cultural values has so far protected some of these countries from the worst excesses of alcohol abuse, there are signs that psychoactive substances are becoming increasingly available and that there is a clear rise in tobacco consumption. Unless effective and coordinated action is taken now, it is likely that the consequent health and social problems will pose an intolerable burden on these societies, and threaten the very values that have to date provided protection.

In his opening speech during the Technical Discussions at the Thirty-Fifth World Health Assembly, Dr Al-Awadi emphasized "the imperative need to seek effective means of tackling these problems in view of their serious consequences in a world suffering from lack of qualified manpower, from unemployment and from scarcity of financial resources - a world striving for construction and progress, not destruction and backwardness". That plea is as relevant today as it was in 1982; indeed it is even more urgent.

3.2.1. Problems associated with tobacco and other licit drugs

The use of tobacco is a major threat to the health of the world population. Socially induced, smoking is a behaviour pattern which is powerfully maintained by the development of dependence on nicotine. The health consequences of the habit are catastrophic. In the United States of America (for which sound data are available) smoking has been shown to cause one-third of all cases of cancer, at least 80% of all lung cancer, 75% of chronic bronchitis and 25% of myocardial infarctions. Between 1976 and 1980 tobacco consumption decreased at a yearly rate of 1.1% in the industrialized countries, but continued to rise at a yearly rate of 2.1% in the developing countries. Besides premature deaths, which have been estimated at over one million per annum, innumerable cases of debilitating diseases (such as chronic obstructive lung disease) are also due to smoking. The proportion of women of reproductive age who smoke regularly, already high in most industrialized countries, has been increasing rapidly in the developing world. There is now evidence of health risks from "passive smoking" i.e. inhalation by non-smokers of smoke produced by smokers in a confined environment at home or in the workplace*.

The Regional Committee for the Eastern Mediterranean recognized the gravity of health consequences of smoking and adopted a resolution (EM/RC34/R.7) urging Member States to take immediate action. The Regional Office undertook a variety of measures to support country efforts. Ministries of Information, Environment, Agriculture, Education and Youth were approached

* These trends and possible measures to counter them are described in detail in the Director-General's Report to the Seventy-seventh Session of the WHO Executive Board (Document EB 77/1986/REC/1 Annex 3).

with a view to enlisting their collaboration. Seminars and workshops were organized involving various categories of health workers. Books, pamphlets, videotapes and posters against smoking were published and distributed. Sets of slides were prepared for educational campaigns. Round-table discussions were organized to discuss ways of arresting the smoking pandemic.

At country level action was also resolute. Bahrain, Jordan and Somalia, for example, banned smoking in public places and offices. Iraq banned smoking in teaching institutions and on television programmes. Islamic Republic of Iran prohibited smoking on domestic flights. Country programmes aiming to enhance awareness of the dangers of smoking have been introduced (e.g. in Bahrain and Oman). Advertisements for tobacco have been prohibited in a number of countries including Jordan, Kuwait, Pakistan and Qatar. Prices of tobacco products have been raised. Other measures such as smoking cessation clinics and health awareness campaigns are under trial and on the way to being implemented in numerous countries of the Region.

Licit psychoactive drugs, whose correct use brings benefits to society, can also cause dependence and lead to a wide variety of health and social problems. Worldwide, there are approximately 2.5 million amphetamine abusers and at least 4 million abusers of barbiturates, sedatives and tranquillizers. Abuse of these substances is widespread and affects countries at all stages of development. In many countries, the ready availability of psychotropic substances without prescription, with insufficient information to the general public, and because of inappropriate prescribing practices by physicians (who often employ medication instead of counselling in response to the pressures of a busy practice or because of insufficient training) has led to abuse of psychotropic drugs (especially among women) and a variety of consequent public health problems. The best way to prevent these problems is to give appropriate training (and refresher training) to health workers responsible for the prescription and distribution of these medicaments and to combine this with health education of the general population about the benefits and risks of medicaments. This approach has the added advantage of permitting open dialogue with the public, which can also help in education about illicit drugs.

Another contribution to the prevention of problems related to the use of licit substances is the participation of countries in activities required under international treaties (to which many of the Eastern Mediterranean Region countries are parties). These treaties request WHO to assess the benefit/risk ratio of psychotropic drugs and to make recommendations for their control. Member States who are parties to the various conventions help in this assessment and subsequently undertake measures for control foreseen in the conventions in accordance with the decisions on control reached on the basis of WHO's advice to the UN Secretary General (see Annex III).

3.2.2. Problems associated with the use of illicit drugs and alcohol

Problems linked to the use of illicit drugs are more dramatic in the public eye. Although it is difficult to measure the health consequences of abuse of these drugs, educated guesses about the nature and magnitude of the problems are possible and can help in programme planning.

In 1983, there were an estimated 1.76 million opium abusers worldwide, concentrated mainly in the West and in South-East Asia. The number of people abusing heroin was estimated at about 750 000. These figures have to be

accepted with particular caution because of a variety of non-scientific reasons for their distortion. It is, however, certain that heroin abuse has greatly increased and affects both industrialized and developing countries. The number of coca-leaf chewers was put at 1.6 million and of those abusing cocaine at 4.3 million. Although coca-chewing has traditionally been confined to certain countries in Latin America, the abuse of cocaine is now of active concern in industrialized regions.

Cannabis use has been reported from 120 countries and involves 29 million individuals. Consumption of alcoholic beverages is even more widespread and has also been reported from countries where no tradition of alcohol use had previously existed. Although trends in alcohol consumption have begun to decline in some industrialized countries in Western Europe and North America, global figures for per capita alcohol consumption still reveal a steady increase, even invading countries where it is not socially acceptable. Reliable figures for the abuse of hallucinogens and inhalants/solvents are not currently available.

Health problems related to the use of alcohol have not seriously affected EMR countries although they seem to be on the increase. In preventing their occurrence the Region will have at its disposal experience from other countries, assembled by WHO, and more importantly the tremendous preventive potential of the Islamic religion and sociocultural traditions of the Region. These can and should be used by health workers who should also provide a model of behaviour in respect to the use of tobacco, alcohol and other drugs.

3.2.3. *Situation in EMR countries*

In the countries of the Eastern Mediterranean Region, religious influence has so far limited the occurrence of public health problems related to alcohol use. Until recent years, it also reduced the seriousness of drug abuse problems. The traditional use of opium and cannabis (hashish) in Western Asia and North Africa and the chewing of khat in countries bordering the southern part of the Red Sea were tolerated by society and not seen as a cause for serious public health concern. A survey among patients attending university hospitals at Cairo and Mansoura Universities in Egypt in 1973 and 1977 found only 0.2% diagnosed as "drug-dependent".

The last few years, however, have witnessed a dramatic change in the nature of drug abuse in the Region. New drugs such as heroin have spread in some Regional countries in an epidemic fashion. Psychotropic drugs (e.g. sedatives and stimulants) became widely prescribed or self-administered. Powerful criminal interests entered the picture. The social class of users changed - while in the past drugs were often used by middle-aged men in rural areas the new users are often young adults and women from urban areas, often with higher education and from affluent classes.

Reliable estimates of numbers of users of narcotic and psychotropic substances in the countries of the Eastern Mediterranean Region are difficult to obtain. Some idea of the size of the problem can be obtained from hospital statistics. Police seizures of drugs also provide useful information. In the Alexandria Psychiatric Hospital, for example, no case of heroin dependence was seen until 1982. During 1983, twenty-six cases were admitted for treatment. During 1984, the number grew to one hundred and sixteen. By 1987, the number of patients admitted because of heroin dependence was more than

six hundred. A similar increase has been reported from mental hospitals in Cairo, as well as from private psychiatric clinics in other big cities.

In Pakistan, the situation seems to be even more alarming. A Pakistan Narcotic Control Board Survey puts the figure for heroin addicts for 1986 at 657 000. In 1982, this figure was reported to be 30 000. In Karachi, one in nine male adults in the city is reported to be using this drug.

Reliable data on drug abuse are important for planning services and for evaluating the effects of measures which countries take. There is an urgent need, therefore, to evolve simple and reliable methods for collecting such information from countries of the Region.

The current situation in EMR countries regarding services for drug-related problems is unsatisfactory. This is largely because of the rapid increase and changing nature of drug-related problems, and the variety of legal problems involved in treatment and prevention activities. Also, most of the countries of the Eastern Mediterranean Region do not have special services for drug-dependent persons but offer services in existing mental hospitals and psychiatric clinics, mostly for detoxification.

The trend toward transferring the responsibility for health services for drug-dependent persons from health authorities to law enforcement agencies has also given rise to difficulties. Although collaboration between various sectors is essential for the success of a drug abuse programme, the responsibility for the management of health problems arising in the context of drug abuse must remain with the ministries of health and should be closely linked to rehabilitative, preventive and treatment services organized by the health authorities.

3.2.4. WHO activities in the field of drug-abuse control

WHO has been concerned, from its very inception, with health problems related to the abuse of psychoactive substances. Three facts constitute the main reasons for this:

- Firstly, drug abuse is among the most significant causes of illness and death in both developing and developed countries. Diseases of neglect, hepatitis, and brain damage are the better known among numerous illnesses caused by it. The significance of the public health burden created by drug abuse has recently been further highlighted by the lethal contribution of acquired immunodeficiency syndrome (AIDS) infecting and killing not only those injecting drugs but also spreading from them into a far wider population.

- Secondly, drug abuse strikes at youth, a most vulnerable section of the population. Young people are the world's investment in the future and the protection of their health is of highest priority in the effort to assure that the world in the year 2000 and beyond will be a world in which human beings can live a healthy and productive life.

- Thirdly, drug abuse is both a symptom and a cause of psychosocial deterioration. Commitment to improving the health of society depends on the common acceptance of a positive value system. Drug abuse undermines values and therefore also threatens the goal of Health for All.

WHO is concentrating its efforts in order to prevent the catastrophic health consequences of drug abuse on four strategic lines of action:

- Firstly, WHO promotes individual and social values which make health and well-being possible and enduring and drug abuse less likely.
- Secondly, WHO has an extensive programme of cooperation with countries to improve methods for treating those affected.
- Thirdly, WHO is promoting the proper and rational use of drugs. Psychoactive and other medicaments can be of enormous benefit to humankind. The WHO revised drug strategy, endorsed by Member States of the Organization at the World Health Assembly in 1986, is a demonstration of the will of the countries of the world to continue to make progress in the rational use of drugs.
- Fourthly, WHO seeks to build alliances among different social sectors, non-governmental organizations (NGOs) and the scientific community, who must work actively together if the spectre of drug abuse is to be controlled.

WHO has undertaken a number of activities to stem the growth of problems related to alcohol- and drug-abuse in the countries of the Eastern Mediterranean Region. These included country visits by consultants, organization of local training courses and workshops, upgrading local services and laboratory facilities, awarding fellowships for training, supply of special laboratory equipment, literature, etc. WHO has also collaborated with countries in the formulation of multisectoral policies and programmes to combat drug-related health problems. A recent project in which WHO EMRO was involved is summarized below to exemplify the work undertaken so far.

In Egypt, with the support of the UN Fund for Drug Abuse Control (UNFDAC) a project for the control of drug abuse was started in 1983 and successfully completed in 1986. During this project:

- treatment and laboratory facilities were upgraded in five cities (Alexandria, Helwan, Mahalla El Kobra, Assiut, and Fayoum);
- provincial workshops were held in five centres during 1985 (Alexandria, Cairo, Fayoum, El Gharbia, and Assiut) and in five centres during 1986 (Marsa Matrouh, Sohag, Ismailia, Kena and Menoufia);
- four training courses for physicians, two courses for social workers, nurses and psychologists, two courses for volunteers and religious workers, and five interprovincial training courses were organized, involving more than 300 professionals as follows:

Year	Physicians	Psychologists, social workers etc.	Volunteers	Technicians
1984	50	30	30	--
1985	50	30	30	20
1986	80	--	--	--

Four research projects were initiated and completed. Three national conferences on control of drug abuse were held (in 1984 in Alexandria, 1985 in Cairo, and 1986 in Luxor).

Measures undertaken to deal with health problems related to drug abuse are often overshadowed by measures which governments undertake to control the supply of drugs. A lack of balance between health measures and other actions to reduce demand (e.g. adolescent education, sports programmes etc.) on the one hand and action to control supply on the other seriously affects the credibility and chances of success of programmes. This need for a balanced approach was expressed clearly during the conference of Ministers of Health on Narcotic and Psychotropic Drug Misuse, in London, organized by WHO in collaboration with the Government of United Kingdom, 1986. The joint statement issued by the 32 countries which attended this meeting was in its turn a valuable input to the International Conference on Drug Abuse and Illicit Trafficking, held in Vienna in June 1987; WHO played a key role in the preparation and organization of this major international event. The role of the health sector is repeatedly emphasized in the targets for action at national and international levels, as set out in the Comprehensive Multidisciplinary Outline of Future Action, which was produced by the International Conference.

3.2.5. Future directions for work on the prevention of health problems related to drug abuse

In view of limitation of resources and trained manpower, the developing countries face special problems in the field of drug abuse control. From discussions held at various recent conferences, the following approaches appear particularly relevant for developing countries:

- Development of clear national policies and programmes linked with national health plans, combining both supply and demand aspects.
- Coordination of various sectors dealing with drug abuse problems, e.g. health education, social welfare, police, law and justice, religious groups, NGOs, etc.
- Laying stress on the promotion of healthy life-styles and the prevention of drug abuse, by health education.
- Reinforcing religious teachings which support healthy life-styles and reduce the demand for drugs.
- Including tobacco in drug abuse control programmes and using anti-smoking campaigns as indirect approaches to drug abuse in general.
- Developing drug-dependence treatment services integrated with mental health and general health services and not in institutions for drug dependence isolated from the general health care system.

3.3. Prevention of mental, neurological and psychosocial disorders

Conservative estimates indicate that in the Eastern Mediterranean Region there are at least 20 million people who suffer from mental and neurological disorders. At least one half of these people could have been free of such diseases or subsequent impairments had preventive measures, available today, been appropriately used. What is more, most of those who have mental and neurological disorders today could be significantly helped by modern treatment: and yet only a small proportion of those affected have access to such treatment.

There are no reliable epidemiological studies of mental and neurological disorders for most of the countries of the Region. The estimates given below are based on figures obtained in some Regional countries and in a variety of developing and developed countries, in other parts of the world.

3.3.1. *Mental retardation and cognitive deficit*

The prevalence of severe mental retardation below the age of 18 years (defined by an intelligence quotient or I.Q. of less than 50, and major disabilities in intellectual and social functions, usually associated with neurological abnormalities) is approximately 3 to 4 per thousand; the prevalence of mild to moderate mental retardation (defined by an I.Q. between 50 and 70 and by marginal performance at school in complex intellectual tasks) is approximately 20 to 30 per thousand. These figures are likely to be underestimates for many areas of the developing world because of the persistence of preventable mental retardation secondary to (a) inadequate antenatal care; (b) faulty delivery methods which lead to birth trauma and (c) bacterial and parasitic infections of the central nervous system. Of greatest importance from the standpoint of prevalence is the mild mental retardation and behavioural maladaptation that result from the interrelated problems of malnutrition, infectious disease and cognitive understimulation in infants reared in severely disadvantaged families.

There are numerous measures which can contribute to the prevention of mental retardation. They include:

1. Improvement of antenatal and perinatal care by education and training of:

(a) women of childbearing age (e.g. about genetic risks, spacing of pregnancies, ingestion of harmful substances such as tobacco, alcohol, and other drugs);

(b) pregnant women and mothers (e.g. about appropriate nutrition including correction of deficiencies such as of iodine, advantages of breast-feeding, and hygienic preparation of food);

(c) health workers (e.g. identifying high-risk pregnancies, skills for educating families for prevention and health care).

2. Improvement of infant and child care by providing services for:

(a) immunization against diseases that might affect the brain;

(b) early recognition of such diseases and appropriate treatment;

(c) early recognition of sensory handicaps, e.g. poor vision;

(d) family support and guidance;

(e) prevention of accidents in childhood;

(f) provision of nursery facilities for children of working mothers;

(g) avoidance of long-term institutional treatment (for any disease);

(h) teaching of parenting skills.

3.3.2. *Acquired lesions of the central nervous system*

Damage to brain tissue - resulting from trauma, bacterial and parasitic infections, alcohol abuse, malnutrition, hypertensive encephalopathy, pollutants (e.g. carbon monoxide, heavy metals, chemical fertilizers, and insecticides), lack of essential nutrients and other conditions - constitutes

a major source of mental and neurological impairment. It has been estimated that, world-wide, no less than 400 million people suffer from iodine deficiency, their children being at risk of mental and neurological disorders associated with foetal damage due to this deficiency. Debilitating effects of cerebrovascular accidents resulting from uncontrolled hypertension are a rapidly increasing problem in developing countries. Cerebrospinal meningitis, trypanosomiasis and cysticercosis are major sources of brain disorders in a number of countries. Persistent infections, even when the brain is not directly invaded, and prolonged use of psychoactive drugs, may impair cognitive efficiency.

The estimated prevalence of this type of affection will vary from country to country, but is likely to remain within a range of 5-10/1000 in most countries.

Preventive measures here can include prompt treatment of hypertension and infections of the central nervous system, accident prevention, control of epilepsy and protection against (industrial) pollutants and toxins at the workplace and elsewhere. Treatment of drug and alcohol dependence can also, in most cases, prevent serious brain damage resulting from prolonged use of these substances.

3.3.3. *Peripheral nervous system damage*

Inadequate and/or unbalanced diet (e.g. related to cassava), metabolic diseases (diabetes), infections (leprosy), trauma and toxins can cause incapacitating peripheral neuropathies which in turn can cause impairments and consequent social and psychological problems.

The prevalence of these disorders is difficult to estimate because it varies with the prevalence of other diseases (e.g. diabetes, leprosy), the predominant occupation of the population and other factors. Preventive measures will include measures directed against the underlying disease as well as health education which can prevent significant secondary impairments (e.g. amputations of the foot in diabetics with peripheral nerve damage).

3.3.4. *Psychotic disorders*

The prevalence of severe mental disorders such as schizophrenia and severe affective disorders is estimated conservatively at not less than 1%. The prevalence of schizophrenia according to several surveys is 2 to 4 per thousand. There are no demonstrable differences in these figures between developing and developed countries. The rate for depressive disorders is several times higher. Moreover, the incidence of depressive disorders has shown a striking increase in some countries. The amount and kind of treatment services, as well as family and community attitudes towards patients suffering from these disorders, are important determinants of their outcome.

Effective treatment of psychotic conditions can be provided by general health care staff at the peripheral health services after brief training, provided that there is a regular supply of a small number of essential psychotropic drugs and an appropriate referral and supervision chain. No primary prevention is as yet certain in most of the psychotic conditions: there is, however, good evidence that appropriate treatment can reduce impairment and significantly reduce the probability of relapse after a good remission has been achieved. Appropriate treatment can also significantly

reduce stress which families and communities of patients experience. The course outcome of schizophrenia and related disorders seems to be significantly better in developing countries and a major proportion of people with schizophrenia in these countries can be treated in out-patient services.

3.3.5. *Dementias*

Dementia is not part of normal ageing, but represents a disease, the cause of which should be sought and if possible treated: metabolic, toxic, infectious and circulatory diseases can all be the cause of impaired cognitive function. These disorders constitute an ever greater burden on health services as an increasing proportion of the population survives until older ages and becomes vulnerable to senile dementias of the Alzheimer type. The prevalence of senile dementias in individuals aged 70 years or older is estimated at about 100 to 200 per thousand in countries where surveys have been carried out. Isolated reports of lower incidence of dementia in certain developing countries in Africa merit special attention since they may provide important clues for the aetiology and prevention of the condition. These reports have not yet been confirmed by studies in other parts of the world.

No effective treatment has been discovered for dementia: there are however important preventive activities that need to be undertaken in connection with this disease. These include: (i) training of health staff in ways of diagnosing pseudodementia in the elderly - a dementia-like syndrome arising in the course of other diseases (e.g. depression, certain metabolic diseases) for which effective treatment exists; (ii) support to families taking care of dementia patients; (iii) improvement of facilities for part-time institutional treatment of the demented, reducing burdens on families, and (iv) prevention of iatrogenic damage (e.g. by inappropriate application of various medicaments in the treatment of physical illness of the elderly) which can lead to or worsen syndromes of dementia.

3.3.6. *Epilepsy*

The prevalence of epilepsy in the population ranges from 3 to 5 per thousand in the industrialized world to 10 or even 20 per thousand in some areas of the developing world. This six-fold difference in prevalence provides a measure of what could be accomplished by a comprehensive programme of prevention in the developing countries. The extent of social handicap resulting from epilepsy varies with its type, and also with the adequacy of medical management, and with community acceptance of or support for the patient with epilepsy. Unfortunately, in many developing countries, the majority of patients with epilepsy receive little or no treatment; in consequence, they suffer from avoidable physical injuries and social handicaps.

Treatment of epilepsy can be carried out in the framework of primary health care and can serve as a preventive measure against secondary brain damage, injury, rejection of the patient by those surrounding him and a host of family problems.

3.3.7. *Emotional and conduct disorders*

Such disorders (neurotic and personality disorders) are estimated to occur at a frequency of 5 to 15% in the general population. Not all require treatment, but some (e.g. severe anxiety disorders) can lead to major

impairment. Some conduct disorders, which are common among schoolchildren and interfere with learning in the classroom and with social adjustment, often respond well to simple treatments (e.g. behaviour therapy and parent counselling). Learning disorders, whether or not they are associated with other psychiatric symptoms, require special help in the classroom in order to avoid secondary emotional problems and occupational handicaps (e.g. those associated with failure to learn to read).

Treatment methods for a number of these disorders can be taught to general health service staff. Specific preventive methods are not well defined, although there are a number of techniques which can be used in coping with excessive stress, thus preventing the occurrence of its morbid consequences.

3.3.8. *Somatic symptoms of psychological origin*

Many patients who contact primary health care agents or health care facilities in general present somatic symptoms for which no organic cause can be found or complain of dysfunction disproportionate to physical findings.

Patients with such presentations form the largest diagnostic entity at primary health care level (15-25% in most countries). Unfortunately, the narrow biomedical approach, which dominates most physicians' education, does not prepare health workers to recognize and deal with psychosocial problems of this type. As a result, iatrogenic complications (due to unnecessary medical prescribing and even surgery) and dissatisfaction of patients with the service received are frequently observed in both developed and developing countries.

Appropriate training of general health workers and physicians can help them to deal with such psychosocial problems and bring about a positive doctor-patient relationship which is itself a major component of the benefit of health services.

4. PREVENTION AS PART OF COMPREHENSIVE NATIONAL MENTAL HEALTH PROGRAMMES AND POLICIES

4.1. Introduction

An effective prevention programme will be possible only if there is commitment to such a programme by the national government and provision of additional resources for this purpose. Such commitment must find its expression in a mental health policy and programme which will be an identifiable part of the national health programme.

The implementation of the programme will require intersectoral cooperation and the formulation of (at least) medium-term plans developed on a realistic basis. This task should be entrusted to a coordinating group on mental health with the authority to lead the activity and to assign specified tasks to the appropriate sectors. Useful experience with such groups has already been obtained and clearly shows that this mechanism can be of crucial importance in programme development and evaluation.

In the area of prevention, more so perhaps than in other health work, it is important to recall that government actions in spheres apparently remote from health may have implications for health that were not taken into account

in their formulation: for example, housing projects that worsen mental health because of inappropriate design; industrial development projects that destroy local culture and lead to family disruption, child neglect and abuse of psychoactive substances; or the widespread use of pesticides which, because of their neurotoxicity, can often lead to brain damage. This makes appropriate intersectoral cooperation, which can be supported by the intersectoral mental health coordinating group, all the more vital.

A national mental health policy must include, in addition to a component of prevention, other components dealing with the promotion of mental health, with the management of mental and neurological diseases and with psychosocial aspects of health and development programmes. Among these components, promotion of mental health is of the most fundamental importance. It means raising the value attached to mental life and mental health. If the value attached to mental health by individuals, by the community and by the government is high, the motivation to undertake measures to prevent or treat mental illness will be high; programmes dealing with psychological aspects of health and development can be launched; community participation in such programmes can be expected; and social support for appropriate programmes will be forthcoming.

The component of the policies and programmes dealing with the management, treatment and rehabilitation of the mentally and neurologically ill can rest on the well-established fact that appropriate treatment for a number of mental, neurological and psychosocial disorders can be provided at low cost within the framework of primary health care. The technology which can be used to prevent the occurrence of disability associated with mental and neurological disorders, drug- and alcohol-dependence, has also been developed. In many situations, treatment of these disorders and the prevention of disability that may result from them will be the central or starting point for a national mental health programme: by no means, however, should such a programme remain restricted to those two tasks alone.

The policy component dealing with psychosocial aspects of health and development includes provisions necessary to deal with the issues outlined in 3.1. above. It is often a complex task to define ways to implement relevant measures because they touch upon the activities and provinces of many social sectors. The importance of this policy component, however, is such that major effort is justified.

Over the past few years numerous Member States of the Eastern Mediterranean Region have undertaken to formulate national mental health policies and programmes. By the end of 1987, almost half the Regional countries had prepared their national mental health programmes, basing them on the primary health care approach. A number of countries, including Republic of Afghanistan, Democratic Yemen, Pakistan, Sudan and Yemen, had followed the formulation of proposals by multisectoral national workshops which discussed and adopted national mental health programmes as part of national health plans. These workshops were attended by representatives from various Ministries including those of Education, Social Welfare, Law, Justice Planning and Finance as well as experts from health and mental health. Following the formulation of national mental health programmes a number of countries have undertaken specific activities; their plans for the next biennium indicate a clear progression of work foreseen in national programmes.

In this chapter, a brief review of some national mental health programmes (4.2) is followed by comments on training of primary health care staff (4.3), on the role of other social sectors in preventive activities (4.4) and on research necessary to strengthen preventive action (4.5).

4.2. National Mental Health Programmes in the Eastern Mediterranean Region

A brief summary of national mental health programmes produced by Eastern Mediterranean countries may be useful to illustrate the various countries' achievements.

Republic of Afghanistan

Republic of Afghanistan adopted the National Programme of Mental Health at a specially convened multisectoral workshop in Kabul in August 1987. The workshop was attended by experts from various parts of the country and representing various disciplines. A high-power multisectoral national coordinating committee for mental health has been formed and a number of activities have been undertaken including:

- Formulation of a new Mental Health Act.
- A three-month training course for 50 doctors/health personnel from various districts.
- Short-term mental health training for 200 health workers.
- Extension of mental health services in a number of provincial centres through the newly trained staff.
- Establishment of a drug dependence treatment centre in Kabul.

Democratic Yemen

Democratic Yemen adopted the National Programme of Mental Health in December 1986 at a specially convened multisectoral national workshop held in Aden. Under the National Programme a number of activities have been undertaken which include:

- Extension of mental health services in a number of governorates e.g. Lahej and Hadramout.
- Mental health training for 50 PHC doctors and 200 multipurpose workers.
- Development of a manual (in Arabic) for training doctors/health personnel working in PHC.

Egypt

During the late 1970s, through a WHO-supported project, Egypt introduced mental health services at PHC level in the Governorate of Fayoum. Based on the experience gained there, a specially convened group of experts developed the National Programme of Mental Health for Egypt in 1986; it was submitted to the Government for approval and implementation. Under this programme, during 1987, more than 300 physicians and 200 other health personnel were trained in mental health, covering over twelve governorates.

A manual for training of general doctors has been prepared (in Arabic).

Pakistan

Pakistan has made significant progress in developing a comprehensive national programme of mental health. In December 1985, a group of mental health experts met and prepared a document outlining the objectives of the programme, the strategy to achieve them and the activities proposed for the next few years. This document was presented to a specially convened multi-sectoral national workshop in Islamabad in March 1986. The workshop was inaugurated by the President of the country and attended by representatives from the Ministries of Education, Social Welfare, Planning, Interior, and Finance, as well as experts from mental health and the general health fields. The resulting National Programme of Mental Health was presented to the Government of Pakistan which has adopted it.

During the last two years, a number of activities have been undertaken under this programme including:

- An extension of mental health services to the rural areas through primary health care centres in the Rawalpindi Division in Punjab Province and later in one district each in Sind, Baluchistan and North West Frontier Provinces.
- Mental health training of more than 500 doctors and health assistants working in primary health care facilities, and of more than 1000 multi-purpose workers in various districts.
- Provision of a limited number of essential neuropsychiatric drugs to PHC centres.
- Inclusion of mental health education in primary and secondary schools in the Rawalpindi Division.
- Involvement of community leaders in the rural mental health programme.

In 1987 the Department of Psychological Medicine, Rawalpindi, was designated a WHO Collaborating Centre for Research and Training in Mental Health; WHO has supported trainees from Pakistan and other countries in the Region who obtain training in community psychiatry at the Centre.

Sudan

In Africa, Sudan has been a pioneer in developing social and community psychiatry. Through a WHO-supported project in the late 1970s mental health services were extended to rural areas. A large number of health staff working at PHC level have been trained in mental health. Sudan has also been a pioneer in developing collaboration with traditional healers in dealing with mental illness. Modern psychiatric services have been organized on the premises of traditional religious healers where patients receive modern psychiatric treatment as well as spiritual support from the religious healers.

In December 1987, at a multisectoral national workshop in Khartoum the National Programme of Mental Health for the next five years was adopted.

Yemen

Yemen adopted a national programme of mental health at a specially convened multisectoral national workshop held in Sana'a in December 1986. It has been presented to the Government and is soon likely to be included in the

TABLE 2. NATIONAL PROGRAMMES OF MENTAL HEALTH IN EASTERN MEDITERRANEAN REGION
ACTIVITIES DURING 1986/1987*

Country	1 Formulated national mental health policy and programme	2 Intersectoral workshop to support programme	3 Special drug dependence programme	4 Mental health care in PHC	5 Mental health training for PHC staff	6 Organized programme of prevention of mental and neuro- logical diseases	7 Specific action to promote mental health	8 Action concerning psychosocial factors
Afghanistan, Republic of	+	+	+	+	+	-	-	-
Bahrain	-	-	+	+	+	-	-	-
Cyprus	-	-	-	+	+	-	-	-
Democratic Yemen	+	+	-	+	+	-	-	-
Djibouti	-	-	-	-	-	-	-	-
Egypt	+	-	+	+	+	-	-	-
Iran, Islamic Republic	+	-	-	-	-	-	-	-
Iraq	+	-	-	-	+	-	-	-
Jordan	-	-	-	-	-	-	-	-
Kuwait	-	-	+	-	-	-	-	-
Lebanon	+	-	-	-	-	-	-	-
Libyan Arab Jamahiriya	-	-	-	-	-	-	-	-
Morocco	-	-	-	-	-	-	-	-
Oman	-	-	-	-	-	-	-	-
Pakistan	+	+	+	+	+	-	+	-
Qatar	-	-	-	-	-	-	-	-
Saudi Arabia	-	-	+	-	-	-	-	-
Somalia	+	-	-	+	+	-	-	-
Sudan	+	+	-	+	+	-	-	-
Syrian Arab Republic	+	-	-	-	-	-	-	-
Tunisia	-	-	-	-	+	-	-	-
United Arab Emirates	-	-	-	-	-	-	-	-
Yemen	+	+	-	+	+	-	-	-

* Based on information available in EMRO

National Health Plan. Under this programme a number of activities have already been undertaken including:

- The introduction of mental health services into primary health care facilities in four governorates.
- Training of more than 150 doctors and 300 trainer/supervisors and midwives in mental health.
- Introduction of mental health services into general hospitals in the major cities.

A summary of National Mental Health Programmes in the Eastern Mediterranean Region countries

Even a cursory review of the above programmes shows the similarity of approach in many countries. Two elements of this approach have been present in almost all the programmes: (a) the early introduction of treatment of the mentally and neurologically ill contacting primary health care services and (b) the effort to train various categories of health staff in skills necessary to provide such treatment. Other components of national programmes have been developed less uniformly, depending on availability of well-trained professional leaders, the interest of decision-makers in the public health system, and a variety of other factors. It may, therefore, be useful to summarize the main features of the national mental health programmes undertaken in countries so far. (Table 2).

The table shows that ten EMR countries have formulated national mental health programmes and that in a number of countries in which such programmes have not yet been formulated, training activities as well as treatment of mental illness within primary health care were introduced. It is hoped that as the national programmes develop, more and more activities related to prevention of mental disorders and promotion of mental health will be added to the programmes: these components of national programmes have been neglected in country programmes so far.

4.3. Mental health training for PHC staff

The central strategy for mental health training for PHC staff in this Region has been the organization of short goal-oriented mental health training for doctors and other health personnel working in primary health care in rural and district centres. This strategy was chosen in view of the convincing demonstration in a number of countries during the last decade that, with appropriate training, health staff at PHC level can adequately look after a limited number of serious and common mental disorders, using two or three essential neuropsychiatric drugs. It has also been shown that providing general health care staff with psychosocial knowledge and skills can improve the quality of the general health services.

Ideally, such mental health training should be provided at the schools training medical doctors and other health workers. Unfortunately, this either does not happen at all or is done in such an unsatisfactory way that mental health and behavioural sciences appear to have no relevance to primary health care. An efficient way to correct this shortcoming is to organize short in-service training courses which are task-oriented and related to the day-to-day problems dealt with by health staff in PHC.

To provide countries with guidelines for work in this area, an intercountry workshop was held in Islamabad in March 1987. The objectives of

the workshop were to train the participants as future trainers and to assist them in formulating plans for training about mental health in primary health care in a manner relevant to local needs in their countries. The workshop proposed the following principles as important for such training programmes:

1. Training should be relevant to the daily work of the physician and health staff working at PHC level. Emphasis should be on acquisition of skills rather than only on acquiring knowledge.
2. Training should affect the attitude of the trainees. As a result of training, there ought to be increased awareness of the importance of psychosocial factors, both in health and disease.
3. Training should increase knowledge about mental illness and enhance correct management while avoiding unnecessary complexity or the use of technical jargon which bears no meaningful relationship to the everyday work of PHC workers.
4. The effects of training should be visible through its impact on existing services by decreasing the number of unnecessary secondary referrals, laboratory tests and hospitalizations.
5. The mental health training programme for auxiliaries should be made even simpler than that for physicians working at the level of first contact. Only a limited number of mental or neurological diseases should be discussed, e.g. epilepsy, psychosis, depression, drug dependence and mental retardation. Special emphasis should be laid on preventive and promotive aspects.
6. Psychosocial skills, such as the art of listening, assessing psychological or social stress, providing emotional support to the family in time of crisis, etc., should form an essential part of training.
7. Techniques of working with the family and community, for example in promoting mental health, should be included in training.
8. Linkage of mental health training with other preventive and curative tasks at PHC level must be emphasized.

The workshop recommended that, for the success of the national programmes, mental health training should be available to all categories of PHC staff as well as health administrators and community leaders. An essential step in the development of appropriate training is a clear listing of tasks that should be undertaken by various PHC agents. Such a list has now been developed; Annex I gives an outline of PHC mental health tasks for consideration of health administrators.

In recent years mental health training courses have been organized in many countries of the Eastern Mediterranean Region, including Republic of Afghanistan, Cyprus, Democratic Yemen, Egypt, Libyan Arab Jamahiriya, Iraq, Pakistan, Somalia, Sudan and Tunisia. Some countries have prepared training manuals in local languages. Two manuals for training about mental health have been published in Arabic (one in Democratic Yemen and one in Egypt) as well as one in Urdu in Pakistan. A catalogue of existing manuals for use in training about mental health in primary health care worldwide has been published and made available to countries.

4.4. Prevention of mental, neurological and psychosocial disorders by activities of other social sectors

Preventive activities which can be undertaken by the health system have been described above. What follows is an outline of some of the activities which other sectors can undertake to prevent mental and neurological disorders. The description given here is illustrative rather than comprehensive, because of the vast difference between countries in the way in which other social sectors interact with the health system and because of the differences in the definition of their mandate among countries.

(i) Better day care for children

Retarded mental development and behaviour disorders among children growing up in families that are unable to provide appropriate stimulation can be minimized by early psychosocial stimulation of infants and by day care programmes of good quality, particularly if such programmes involve parents as participants. However, adequate quality of the day care programme is essential: "child minding" in crowded quarters with insufficient numbers of adult care-takers, who are often inadequately trained, may retard children's development, not facilitate it. Among useful measures that countries could take are: surveys of existing day care facilities and an assessment of the need for them (particularly pressing in urban areas); establishment of quality standards and appropriate regulatory measures; setting of progressive targets for (a) ensuring quality and (b) training staff about psychosocial development and needs of children.

(ii) Better long-term care institutions

While the use of institutions for long-term care (e.g. hospitals, residential institutions, nursing homes) can be minimized by making alternatives available in the community, such institutions will remain a necessary part of a full range of services. Whether they care for the young or the old or for the physically or the mentally handicapped, the quality of the institutional environment is a major determinant of the way in which those who inhabit them function. Improvements in architectural design and the content of work programmes, and regular evaluations of the quality of long-term care institutions, present important opportunities for preventive interventions.

(iii) Self-help groups

In addition to their action in the community, self-help groups, organized by lay citizens, can play an important advocacy role and facilitate changes in legislation, better resource allocation, and satisfaction of other needs of groups of people with specific mental disorders.

(iv) Role of schools

The progressive extension of obligatory schooling in more countries provides new opportunities to broaden people's understanding of how they can protect their health. At the same time, it leads to the identification of child health problems not previously known to health authorities. Schools

also often provide possibilities for preventive measures. Two such measures are:

(a) Teaching of parenting skills

A variety of risks to mental health and psychosocial development can result from lack of parenting skills and from parents' insufficient knowledge of children's needs. Urbanization and other socio-economic changes (e.g. small families not offering children opportunities to exercise responsibility for younger siblings) may result in a growing number of young parents not having such skills. Therefore, education for parenthood may well have to become a responsibility of public education.

(b) Health education

Instruction and counselling about family life, human sexuality, child development, nutrition, accident prevention and abuse of certain substances are among the subjects that are most frequently recommended for inclusion in school curricula. Evidence of the effectiveness and usefulness of such instruction is still incomplete and evaluation of programmes should be incorporated into their design. A particularly promising area of work is the new strategy to prevent abuse of certain substances among young adolescents by equipping them, through group work, to resist the ubiquitous solicitations to smoke cigarettes and consume drugs and alcohol.

(v) Preventing accidents and poisoning

In view of the high mortality and morbidity (in particular injury to the central nervous system) resulting from accidents and poisoning, measures for their prevention must have a high public health priority. Measures to prevent injury and accidents have been reviewed by WHO on several occasions and some of the most effective are listed here by way of example.

Brain damage through exposure to toxic substances at work can be prevented by imposing strict limits; untoward effects of shift work can be avoided by using the principles of chronobiology; child-proof safety caps on medicine bottles and containers of household chemicals can reduce poison ingestion and consequent damage to the central nervous system; wearing crash helmets can help in preventing cerebral trauma; and lead poisoning in children can be prevented by prohibiting paints containing lead for household use and by decreasing the lead content of gasoline to reduce blood lead levels and lead encephalopathy in children living in urban environments. Many of these measures require cooperation with industry and relevant government authorities usually not participating in health efforts.

(vi) Role of the media

Radio, television, newspapers and comic strips have the potential to play a major role in public health education - for the better (e.g. by explaining why sanitation is essential for health) or for the worse (by advertising cigarettes or making smoking look glamorous because heroes and heroines in TV dramas smoke). Several well-documented studies directed toward: taking proper exercise, eliminating smoking and adopting healthy eating habits have shown that public education campaigns can make a difference to health behaviour and consequently to health status. The potential of the media for the enhancement of health and the prevention of

disease and health-damaging behaviour has, however, hardly begun to be exploited.

(vii) Collaboration with religious institutions

Cultural factors are among the principal determinants of human behaviour. Cultural and religious influences can help health workers in their efforts to change health-damaging life-styles (e.g. abuse of psycho-active substances). In addition to the role which religious institutions can play at the local level (see also 3.1.2 and Annex I), there is a major potential for preventive and health-promoting activities in religious teachings. To fully utilize this, consultation and joint study of relevant tasks by health workers and religious scholars may be a particularly fruitful way to proceed.

(viii) Collaboration with non-governmental organizations

A productive alliance with non-governmental organizations (e.g. local, national, and international organizations concerned with mental health) can help to educate the public and to supply care to the victims of disease. Non-governmental professional organizations can be an important factor in advocating preventive measures among their members and with governments.

(ix) Support services

Support services provided at the community level can enable families to care for members with chronic illnesses (e.g. schizophrenia, senile dementia) who would otherwise require more expensive and less satisfactory institutional care. An excellent example is the organization by the community, on the basis of voluntary efforts by retired workers, of "home beds" for chronically handicapped mental patients in China where neighbourhood volunteers take care of patients while the family members are away at work.

(x) Legislative review

A comprehensive review of legislation affecting the mental health aspects of family life, health services, drug control and schools could be an early step in national mental health programmes. Such a review could assist the national mental health coordinating group considerably in carrying out its work.

4.5. Research: needs and possibilities

At present, a limited amount of health research is in progress in the Region, most of it not linked to service needs. Efforts to conduct operational research are greatly hampered by the lack of adequate training of mental health professionals and lack of a research infrastructure. Coordination between universities and ministries of health in the conduct of research is poor in most countries.

In spite of this, a variety of studies have been undertaken and successfully completed in the countries of the Region. Useful experience in this respect has been obtained by centres in Egypt, Islamic Republic of Iran, Pakistan and Sudan which have taken part in WHO-sponsored collaborative studies.

In considering the development of mental health programmes in the countries, several research themes appear to be of particular relevance at this juncture. These include:

1. Examination of types of mental, neurological and psychological problems encountered in general health care services. This would include an estimation of the frequency of such problems, their current management, prognosis and outcome.
2. Development of indicators of mental health programme development. Here, research leading to the definition of indicators of change and impact of interventions may have particular priority.
3. Management of mental health and related problems in different settings; this requires research leading to the definition of the most effective treatment and rehabilitation regimens, of criteria for the assessment of institutions and services (e.g. day care facilities for children) and of the specific roles which health care staff and others concerned have to play in the care of the mentally ill.
4. Comparative research and multicentred investigations involving several countries; both of these approaches can be of immense practical value for the countries of the Region and elsewhere and require research leading to the standardization of assessment instruments, terminology and methods.
5. Research on psychosocial aspects of health and on mental health promotion; this is an area of major significance currently neglected. There is an urgent need for vigorous support to the development of research in these areas.

5. SUMMARY AND CONCLUSIONS

Mental health programmes have to deal with issues of major public health importance. These issues include: (i) control of mental, neurological and psychosocial disorders, including those related to the use of tobacco, alcohol and other drugs; (ii) promotion of mental health and (iii) psychosocial aspects of health and development programmes.

For a long time public health authorities did not act decisively, largely because they were unconvinced of the importance of the problems, unaware of effective methods of intervention and reluctant to embark on programmes which would further tax resources which were being used to deal with a variety of disease control programmes.

Recent years have brought about a significant change in this situation. Solid evidence of the enormous magnitude of mental, neurological and psychosocial problems and of the possibilities of effective interventions to reduce them by prevention and treatment became available. Psychosocial aspects of health and development programmes were recognized as being of decisive importance for their success. Evidence of the possibility of using knowledge about these factors in a constructive way was produced in a variety of countries. It was demonstrated that investment in mental health programmes in general can reduce the costs of handling other health programmes, as well as reduce the costs resulting from inaction in the face of mental disorder and resultant disability.

Treatment of mental and neurological disorders became part of national health programmes in a number of countries and mental health components found their place in the primary health care system, enriching it and making it more apt to respond to populations' needs. Prevention of mental, neurological and psychosocial disorders seemed, however, impossible and little action followed in this respect.

In 1986, the World Health Assembly examined this matter and, impressed by new findings of research and by the positive experience of countries, adopted a resolution urging countries to examine the possibilities of application of a series of proposed measures. It also requested regional committees to review the matter.

This paper presents possibilities for the prevention of mental, neurological and psychosocial disorders including those linked to the use of tobacco, alcohol and other drugs in the framework of experience and evidence from countries in the Eastern Mediterranean Region of WHO. It shows that there are numerous possibilities for useful action. The Summary of Recommendations which is presented together with this paper will, if accepted, provide the mandate for a strong involvement of the Organization in relevant programmes in the countries of the Region and elsewhere.

Annex I

MENTAL HEALTH TASKS AT PRIMARY HEALTH CARE LEVEL

Primary health care is characterized by the effort to improve health by the active involvement of people, their communities, and their families. Its backbone is made up of non-specialized, general health workers, collaborating with and leading personnel in other governmental and non-governmental sectors. These general health workers can perform their tasks if they are trained in the use of simple but effective techniques which will include: techniques useful in working with communities, skills of health education, and skills necessary for prevention and treatment of prevalent diseases and health problems. In defining these skills it is important to recall that the key components of primary health care are: decentralization; delegation of responsibility for the use of simple skills to general health care workers and to the people themselves; and a permeation of health knowledge and techniques into other sectors of the community.

The most challenging task for health administrations is the clear definition of roles that general health workers and other members of communities can play in a health programme. In the field of mental health, a tentative list of the important tasks is as follows:

(a) Community health worker

- Mobilizing the community for mental health activities;
- providing first aid in neuropsychiatric emergencies such as acute excitement and convulsive disorders;
- supervising maintenance treatment of patients with chronic mental disorders;
- giving advice and support to high-risk families (such as those with a mentally ill or a disabled member);
- referral, where necessary, of mentally ill patients to the nearest established health facility for diagnosis and treatment;
- education of family members about normal psychosocial development needs of children, needs of the aged, the sick and the disabled;
- giving support and education about self-care to the mentally ill;
- collaboration with, and engagement of, community leaders in activities aimed at the preservation of cultural values, of the beneficial features of the extended family and of other factors protecting and promoting mental health;
- establishing contact with traditional healers and, if possible, usefully collaborating with them in the field of mental health;
- collaborating with other agents in the community involved in health-related activities, e.g. members of voluntary organizations.

(b) The village leader

- Advising the health team about traditions and beliefs in the community;
- facilitating contact between the traditional healer and the health workers;
- facilitating the role of the community health worker, e.g. by organizing village meetings when necessary;
- identifying people in need of mental health care;

- assisting in the re-integration of the mentally ill into the community;
- collaborating with the community health worker in activities aiming to promote mental health and psychosocial development.

(c) Teacher

- Early detection of sensorial defects (difficulty in hearing or seeing), of mental retardation or of lack of coordination of body movements;
- early detection of emotional and behavioural disorders;
- adjustment of school environment and teaching programmes to the needs of the disabled child;
- understanding his/her role as a part-time substitute for the parents;
- contributing - through educational activities - to the promotion of positive attitudes towards the mentally ill;
- understanding and fostering cultural norms and traditions which are likely to enhance the value attached to mental health;
- emphasizing and promoting the value of mental health.

(d) The police or community (village) security agents

Police can play a useful role in improving health if trained to carry out their function in supporting health care appropriately. Mental health legislation can be helpful in this regard if it is formulated so as to protect the rights of the individual patient, his family and the community.

The functions of this agent at the community level may include:

- recognition of acute mental disorders and undertaking necessary action to protect the mentally ill, his family and his fellow citizens;
- responding appropriately to drug-related problems, to cases of juvenile delinquency, and to family disputes where there may be an important mental health element;
- helping in the identification of cases for whom care could be made available, as well as knowledge about possible sources of such help;
- providing first aid in specified problems (e.g. in epileptic fits, acute excitement, threatened suicide);
- prevention of violence and victimization through tactful handling of explosive situations.

(e) The family

- Providing care and support to the mentally ill member of the family;
- finding ways to cope with problems that may arise from the illness of one of its members;
- helping the community to understand the mentally ill and to promote the value of mental health in the community;
- transmitting cultural values promoting mental health.

(g) Youth organizations

- Providing peer support to those members who may have mental health problems, e.g. drug abuse;
- acting as a vehicle for the education of their own members and other members of the community;
- assisting in community-oriented action (e.g. in improving conditions of life in slums).

(h) Religious institutions at local level

- Helping with the treatment and care of the mentally ill;
- acting as a forum for the dissemination of messages or information promoting mental health;
- helping to maintain the cohesion of the community;
- counselling on mental health problems.

(i) Traditional healers

There are vast differences in the legal provisions concerning traditional medicine among countries. It is therefore difficult to make generally valid recommendations about the level and intensity of their integration into the health system. The following two general principles, however, could be related:

(a) There are numerous techniques, drugs and treatment styles which are used by traditional healers. These should be closely examined so as to incorporate the use of elements proven to be effective into the health care system (e.g. group psychotherapy through rituals).

(b) At the community level, health care personnel should adopt a flexible attitude towards traditional healers. This would make it possible to find ways of collaboration in the best interests of the patients and their families.

Annex II

LIST OF USEFUL PUBLICATIONS RELATED TO THE WHO MENTAL HEALTH PROGRAMME

1. DEVELOPMENT OF NATIONAL POLICIES AND PROGRAMMES OF MENTAL HEALTH

(a) EMRO publications

1. Report of the Intercountry meeting on national programmes of mental health, Damascus, November 1985, WHO/EM/MENT/113-E. WHO/EMRO, Alexandria 1986.
2. Report of the intercountry workshop on training in mental health in primary health care, Islamabad, March 1987. WHO/MENT/114-E. WHO/EMRO, Alexandria 1988.
3. Report of a consultative group meeting on application of behavioural sciences in health services in developing countries, Alexandria, September 1985. WHO-EM/MENT/111. WHO/EMRO, Alexandria 1985.
4. Country documents on national programmes of mental health. The following countries in the Eastern Mediterranean Region have produced documents on national programmes of mental health. These are available with the respective Ministries of Health or can be obtained from WHO EMRO Alexandria: Republic of Afghanistan, Democratic Yemen, Egypt, Islamic Republic of Iran, Iraq, Pakistan, Somalia, Sudan, Syrian Arab Republic, Yemen.

(b) Other publications

1. Prevention of mental, neurological and psychosocial disorders. Report by the Director-General. WHO/MNH/EVA/88.1. WHO Geneva 1988.
2. Social dimensions of mental health, World Health Organization, Geneva 1981.
3. Care of the mentally ill - Components of mental health policies governing the provision of psychiatric services. WHO/MNH/POL/87.10. Division of Mental Health, WHO Geneva and WHO Collaborating Centre for Mental Health, Montreal, Canada, 1987.
4. The introduction of a mental health component into primary health care. Division of Mental Health, WHO Geneva (in press).
5. Mental health care in developing countries: a critical appraisal of research findings. TRS.698. World Health Organization, Geneva 1984.
6. Problems of mental health in the African Region. Report of a round table, Brazzaville, 9-11 July 1986. WHO/AFRO/MNH/13.

2. TRAINING MANUALS FOR TRAINING OF HEALTH STAFF IN PHC

(a) In the Eastern Mediterranean Region

1. Manual of mental health training for multipurpose workers (in Urdu) by Dr M.H. Mubbashar. Published by the Department of Psychiatry, Rawalpindi Medical College, Rawalpindi, Pakistan, 1986.

2. Manual of primary mental health care for general physicians (in Arabic) by Dr Ahmed Nayar Kotry and Dr Taha Baasher. Published by the Ministry of Health, Cairo, Egypt, 1987.
3. Manual for training in psychology and psychiatry for general physicians (in Arabic) by Dr Abdullah Al Kathiri, assisted by Mr Mohamed Baharoun. Published by Ministry of Public Health, Aden, Democratic Yemen, 1988.

(b) From other regions

1. Manual of mental disorders for PHC physicians (in English) by N.N. Wig and R. Parhee. Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India, 1984.
2. Manual of mental health for multipurpose workers (in English). Edited by R. Srinivasa Murthy. National Institute of Mental Health and Neurosciences, Bangalore, India, 1985.

(c) General

1. Annotated directory of mental health training manuals. WHO/MNH/NAT/87.8, (in English). Division of Mental Health, WHO Geneva, 1987.

3. PUBLICATIONS RELATED TO THE CONTROL OF ALCOHOL- AND DRUG-ABUSE

1. Drug Abuse - Guidelines for national policy formulation, implementation and evaluation. By D.C. Jayasuriya, A.E. Arif, I. Khan and W. Gulbinat. WHO/MNH/PAD/87.7. WHO Geneva, Division of Mental Health, 1987.
2. Drug dependence and alcohol-related problems. A manual for community health workers with guidelines for trainers. WHO Geneva, 1986.
3. Final report of the WHO/UNFEDAC project in Egypt, AD/EGY/83/480. Activities during January 1984 - December 1986. Principal investigator, Dr A.N. Kotry. Available from the Ministry of Health, Cairo, or from WHO/EMRO, Alexandria.

Annex III

UNITED NATIONS DIVISION OF NARCOTIC DRUGS

LIST OF COUNTRIES SIGNATORY TO INTERNATIONAL DRUG CONTROL TREATIES

Status of treaty adherence as at 5 April 1988

LIST OF PARTIES TO:

1961 Single Convention on Narcotic Drugs: 1/ The following 117 States are Parties to this Convention:

Afghanistan, Republic of; Algeria; Argentina; Australia; Austria; Bahamas; Bangladesh; Barbados; Belgium; Benin; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burma; Byelorussian SSR; Cameroon; Canada; Chad; Chile; Colombia; Costa Rica; Côte d'Ivoire; Cuba; Cyprus; Czechoslovakia; Denmark; Dominican Republic; Ecuador; Egypt; Ethiopia; Fiji; Finland; France; Gabon; German Democratic Republic; Germany, Federal Republic of; Ghana; Greece; Guatemala; Guinea; Haiti; Holy See; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kenya; Kuwait; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Liechtenstein; Luxembourg; Madagascar; Malawi; Malaysia; Mali; Mauritius; Mexico; Monaco; Morocco; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Republic of Korea; Romania; Saudi Arabia; Senegal; Singapore; Solomon Islands; South Africa; Spain; Sri Lanka; Sudan; Sweden; Switzerland; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Ukrainian SSR; Union of Soviet Socialist Republics; United Kingdom; United States of America; Uruguay; Venezuela; Yugoslavia; Zaire; Zambia.

1972 Protocol: 2/ The following 80 States have become Parties:

Argentina; Australia; Austria; Bahamas; Bangladesh; Barbados; Belgium; Benin; Botswana; Brazil; Brunei Darussalam; Cameroon; Canada; Chile; Colombia; Costa Rica; Côte d'Ivoire; Cyprus; Denmark; Ecuador; Egypt; Fiji; Finland; France; Germany, Federal Republic of; Greece; Guatemala; Haiti; Holy See; Honduras; Hungary; Iceland; India; Indonesia; Iraq; Ireland; Israel; Italy; Japan; Jordan; Kenya; Kuwait; Lesotho; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Mexico; Monaco; Netherlands; Niger; Norway; Oman; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Portugal; Republic of Korea; Romania; Senegal; Singapore; South Africa; Spain; Sri Lanka; Sweden; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; United Kingdom; United States of America; Uruguay; Venezuela; Yugoslavia; Zaire.

1/ Entry into force: 13 December 1964

2/ Entry into force: 8 August 1975

1961 Convention as amended by 1972 Protocol: 3/ The following ten States have become Parties:

Bolivia; China; Gabon; Liberia; Nepal; Netherlands; Nigeria; Qatar; Rwanda; United Arab Emirates.

1971 Convention on Psychotropic Substances: 4/ The following 90 States have become Parties:

Afghanistan, Republic of; Algeria; Argentina; Australia; Bahamas; Barbados; Benin; Bolivia; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Byelorussian SSR; Cameroon; Canada; Chile; China; Colombia; Costa Rica; Côte d'Ivoire; Cuba; Cyprus; Denmark; Dominican Republic; Ecuador; Egypt; Ethiopia; Finland; France; Gabon; German Democratic Republic; Germany, Federal Republic of; Greece; Grenada; Guatemala; Guyana; Holy See; Hungary; Iceland; India; Iraq; Italy; Jordan; Kuwait; Lesotho; Libyan Arab Jamahiriya; Madagascar; Malawi; Malaysia; Mauritius; Mexico; Monaco; Morocco; Nicaragua; Nigeria; Norway; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Rwanda; Saudi Arabia; Senegal; Somalia; South Africa; Spain; Sweden; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Ukrainian SSR; Union of Soviet Socialist Republics; United Arab Emirates 5/; United Kingdom; United States of America; Uruguay; Venezuela; Yugoslavia; Zaire.

3/ Entry into force: 8 August 1975. Only those countries which adhered directly to the 1961 Convention as amended are listed.

4/ Entry into force: 16 August 1976.

5/ With effect from 17 May 1988.

Agenda item 9

RATIONAL USE OF DRUGS
SUMMARY OF RECOMMENDATIONS

It is recommended that:

- (1) Drug Regulatory Authorities in the Member States should take all possible measures to prevent dispensing of potent drugs, such as antibiotics, hormones, etc. without proper medical supervision.
- (2) WHO Regional Office may consider, in addition to the publication and distribution of EMRO Drugs Digest, the possibility of publishing and distributing suitable drug information leaflets to the public.
- (3) Academic Medical Institutions in all countries of the Region be encouraged to include in their under-graduate education, the concept of rational use of drugs and Essential Drugs List.