Mental Health and Injury Prevention

Mental health

Strategic issues

An estimated 100 million people in the Western Pacific Region suffer from mental and neurological disorders. At least 2% of the population suffers from the most severe disorders, including schizophrenia, bipolar disorder, severe mental retardation and the consequences of brain injuries. Less severe but still disabling conditions—such as depressive disorders, anxiety and obsessive–compulsive disorder—affect another 3%–4% of the population. With the populations ageing in many countries, the number of people living with dementia in the Region is expected to hit 66 million by 2030.

Despite the significant burden associated with mental disorders, the majority of low- and middle-income countries spend less than 2% of health budgets on mental health. In many parts of the Region, hundreds of thousands with mental health disorders remain untreated. Families struggle without much-needed support and resources, and communities suffer losses that could be avoided.

Action and results

Since its launch in 2007, the WHO Pacific Islands Mental Health Network (PIMHnet) has been a vehicle for the delivery of support across the Pacific on a range of issues, from mental health policies and legislation to workforce capacity and delivery of quality services. Human resource development plans have been developed in all PIMHnet countries. At the Ninth Meeting of Ministers of Health for the Pacific Island Countries in June 2011, ministers called on Member States to strengthen and increase the scope of PIMHnet.

At the same meeting, the ministers encouraged Member States to identify and integrate mental health into existing public health frameworks and workplans, to ensure proper integration of mental health into health systems, to enhance the mental health information base for better decision-making, and to include mental health in costed national health and development plans. The ministers also called for early interventions and increased efforts to build resilience in young people.

The Sixty-fifth World Health Assembly, in adopting resolution WHA65.4, called on WHO to develop a comprehensive mental health action plan covering services, policies, legislation, plans, strategies and programmes for the treatment and promotion of mental health. Closing the gap between the demand for treatment services and the ability to deliver them remains a top priority for the Region. Continuous efforts were made to strengthen mental health education and training for medical and nursing students, health professionals in general practice, and programme managers at national and local levels. An approach that combines domestic and international fellowships, short-term training courses, and development of a...
psychiatric resident programme to build capacity for mental health was supported in a number of countries including China, the Lao People’s Democratic Republic, Mongolia, Solomon Islands and Vanuatu.

The WHO-supported Yongin Mental Health Fellowship programme, in collaboration with Yongin Mental Hospital, Republic of Korea, has provided one-month training for 44 mental health professionals from 10 countries since 2006. The programme consists of various psychosocial rehabilitation teaching activities and community site visits intended to educate, update and reorient mental health professionals and primary health-care workers in order to develop the attitudes, skills and knowledge needed for modern mental health care.

The WHO Suicide Trends in At-Risk Territories (START) study is an international initiative that aims to stimulate suicide research and promote suicide prevention across the Region and globally. A central component of the study was the development of registration systems to collect data on fatal and non-fatal suicidal behaviours. An analysis of pooled data demonstrated an enormous variation in suicidal behaviours. The baseline data will be used to develop suicide prevention initiatives that are sensitive to the variations across different locations.

**Future directions**

WHO will continue its efforts to monitor, analyse and disseminate information on regional mental health trends, as well as consequences and risk factors, particularly for suicidal behaviour. Pilot projects are planned to promote evidence-based, cost-effective interventions for high-priority conditions with a focus on depression. Greater effort is needed to strengthen partnerships for advocacy and support to increase public awareness, as well as political, financial and technical commitment to develop multidisciplinary and multisectoral programmes to improve mental health. In terms of the START study, there is a need for further research to assess the reliability of the established data-recording systems for suicidal behaviours.

**Alcohol-related harm**

**Strategic issues**

Reducing the health burden caused by the harmful use of alcohol, thereby reducing disease and preventing injuries, is an important public health objective for WHO. The harmful use of alcohol is a major contributing factor to death, disease and injury. It impacts the drinker’s health through alcohol dependence, liver cirrhosis, cancer and injuries, and it impacts others through the dangerous actions of intoxicated people such as drink-driving and violence. Furthermore, drinking during pregnancy can have a harmful effect on fetal and child development.

The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011 noted that alcohol is one of the core risk factors for noncommunicable diseases (NCDs). As a result, WHO is committed to increasing the awareness of
Presidential Teetotalism

If Genghis Khan were alive today in what is now Mongolia, perhaps he would take the President’s advice and opt for milk—instead of vodka—to settle the dust in his throat after a hard day of conquest.

Alcohol consumption in Mongolia remains among the highest in the Western Pacific Region. STEPS surveys on noncommunicable diseases (NCDs) in 2005 and 2009 found that the prevalence of alcohol consumption among those aged 15 to 64 was approximately 40%.

The high level of alcohol consumption is reflected in high morbidity and mortality from traffic accidents and domestic violence, as well as NCDs such as heart disease, hypertension, stroke and liver cancer.

WHO has supported the Ministry of Health and other stakeholders over the years to develop appropriate policies, strategies and plans based on the Organization’s Regional Strategy to Reduce Alcohol-Related Harm (2006).

To support the Government’s efforts in the prevention and control of alcohol-related harm, President Tsakhia Elbegdorj has now initiated a cross-cutting, multisectoral campaign with the theme: Alcohol-Free Mongolia.

The President has called upon the Government and other agencies to abstain from serving alcohol at any official ceremonies or functions. Instead, he recommends milk.

He has also invited all sectors, including nongovernmental organizations, to join the campaign. Meanwhile, the President is also leading a movement to change the legal environment for manufacturing, sale and distribution of alcohol throughout the nation in public health context towards prevention and control from alcohol-related harm.

alcohol-related harm and to including alcohol in the development of health indicators and monitoring frameworks.

Action and results

To promote the development of effective national action plans and policies on alcohol, WHO convened a meeting in Fiji for Pacific island countries and areas and another in Hong Kong (China) for other Member States. The meetings recommended country-specific actions to reduce harm from alcohol and helped strengthened links between NCD prevention and tobacco control.
WHO co-hosted the Global Alcohol Policy Conference in Bangkok in February 2012, and a regional meeting was held during the conference to discuss developments in the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol.

In the Pacific, WHO collaborated with the Pacific Drug and Alcohol Research Network (PDARN) and supported community action training for Fiji. A training programme on alcohol as a NCD risk factor was also developed.

WHO supported activities in Cambodia, the Lao People’s Democratic Republic and Mongolia, including the drafting of new alcohol legislation and the establishment of a multisectoral government working group on alcohol and research training for the International Alcohol Control Study.

In the area of data collection and monitoring, WHO has been coordinating the 2012 survey on alcohol and health and finalized the country profiles on alcohol and drug services as part of the WHO Project ATLAS.

A technical guidance document on alcohol taxation was developed.

**Future directions**

Increased awareness and stronger action are urgently needed to address the harmful use of alcohol as a major risk factor for NCDs and injuries. WHO will intensify efforts to support Member States in implementing the Global Strategy to Reduce the Harmful Use of Alcohol, while recognizing the need to develop appropriate domestic action plans in consultation with local stakeholders.

WHO also will support the development of specific policies and programmes, taking into account the full range of options as identified in the global strategy, and help raise awareness of the problems caused by the harmful use of alcohol, particularly among young people. The approach will emphasize multisectoral interventions using policies, legislation, regulation and fiscal measures.

Reducing risk factors is the cornerstone of NCD prevention. But to reduce risk factors we need to address their determinants, which often lie beyond the health sector and involve education, finance and planning, food and agriculture, transport, trade, labour and social welfare. Action requires whole-of-government and whole-of-society approaches.

**Disability and rehabilitation**

**Strategic issues**

The definition of disability is complex, but best understood as a dynamic interaction between health conditions and contextual factors—both personal and environmental. The World Report on Disability in 2011 estimated that 15% of the population has a disability, and this percentage is on the rise due to population ageing and an increase in chronic health conditions.

Many low- and middle-income countries in the Western Pacific Region lack adequate disability policies and legislative frameworks, as well as rehabilitation programmes and services. The rehabilitation workforce capacity is limited, with small numbers of rehabilitation-trained doctors, nurses and allied health professionals. Services are focused largely in urban areas and are therefore limited at the community level or in rural areas.

The Region has inadequate data regarding disabilities, with disability prevalence rates not yet available in all countries. In most countries, multiple stakeholders are engaged in disability and rehabilitation issues with limited coordination between them. Responsibility for disability service provision often sits outside of health ministries, and...
frequently, nongovernmental organizations are closely involved. Disabilities are increasingly understood and guided by human rights concepts, framed by the *Convention on the Rights of Persons with Disabilities* adopted in 2006.

**Action and results**

WHO continued to create opportunities for policy dialogue regarding disability and rehabilitation. One specific opportunity was the national launch events of the *World Report on Disability*, which WHO supported in China, Mongolia and the Philippines. WHO also recommended strategic approaches to the development of national rehabilitation programmes and supported the development of a national rehabilitation strategy in Mongolia.

Strengthening national rehabilitation services requires initiatives from tertiary to community levels. WHO supported these efforts through technical support and capacity-building in Member States. Building a stronger continuum of rehabilitation care with improved coordination was also a priority, and WHO supported initiatives on this front in Papua New Guinea and Solomon Islands.

Significant increases in amputation and stroke paralysis as a result of noncommunicable diseases were identified in some Pacific island countries. In response, WHO identified initiatives aimed at Member States to strengthen rehabilitation services and to provide assistive devices. Assistive devices are necessary to increase independent functioning and mobility, but obtaining wheelchairs, prostheses and appropriate orthotic services remains a challenge in this Region. WHO continues to address this challenge through technical support and capacity-building, which it provided in Fiji and Solomon Islands.

Community-based rehabilitation (CBR) is a multisectoral approach used to achieve human rights for people with disabilities. WHO supported the Second Asia Pacific CBR Congress in November 2011 hosted by the Philippines, and the first Pacific Islands Community Based Rehabilitation Forum in Fiji in June 2012. WHO also supported country-specific capacity-building and CBR-strengthening initiatives.

People with disabilities have the right to equitable access to health services. To meet this demand, WHO began building its capacity to deliver disability-inclusive health programmes with a targeted approach. One of the initial
focus programmes—reproductive health—raised awareness and strengthened capacity to meet the needs of women with disabilities.

**Future directions**
Recent increases in financial support from the Australian Agency for International Development (AusAID) has allowed WHO to step up its overall engagement in disability and rehabilitation in the Region. Future directions include strengthening WHO’s engagement in disability policy and the development of national rehabilitation systems and services. Specific focus areas will include strategic approaches to rehabilitation workforce capacity-building and data collection.

**Injury and violence prevention**

**Strategic issues**
Injuries and violence account for 9% of global deaths, with road traffic accidents responsible for about 1.2 million deaths a year. With increasing urbanization and motorization, the number of traffic-related deaths is certain to rise unless substantial investments in prevention are made.

The Western Pacific Region has an estimated 278,000 road traffic deaths annually, accounting for 22% of the global total. Road traffic injuries are one of the leading causes of death for people aged five to 44 in the Region. Meanwhile, drowning is the leading cause of death among children aged five to 14 in the Region.

The *Regional Framework for Action on Injury and Violence Prevention (2008–2013)* was developed in consultation with Member States. This guidance document for key stakeholders covers objectives, priorities, timetables and mechanisms for evaluation. In order to effectively prevent injuries and violence, the health sector has to partner with other sectors including transport, law enforcement, legislation, education, welfare, labour and finance.

**Action and results**
In 2011, 17 Member States organized activities for the launch of the Decade of Action.
for Road Safety. In addition, data collection took place in many countries for the second Global Status Report on Road Safety, which will be published in 2012. With support from Bloomberg Philanthropies, WHO supported Cambodia, China and Viet Nam in the implementation of multisectoral community-based interventions for road safety, in particular legislation on motorcycle helmets, seatbelts and drink-driving. These efforts resulted in better capacity for the enforcement of traffic laws and for data collection.

WHO supported meetings for road safety stakeholders in Cook Islands, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines, Samoa and Tonga to discuss data issues, agree on intersectoral collaboration and develop plans for interventions. With WHO guidance, the island of Guimaras became the first province in the Philippines to promulgate a law on drink-driving.

WHO supported pilot activities in Cambodia and the Philippines that aimed to prevent child drowning, including building barriers to bodies of water near homes, encouraging the use of playpens for children, setting up nurseries for the supervision of children, and training community workers and swimming lifeguards in resuscitation techniques. In Malaysia, a review of road safety interventions for children was carried out with WHO guidance.

In Mongolia, WHO provided support to obtain data on childhood burns and initiate pilot interventions to build barriers around stoves in gers, traditional Mongolian homes. Guidance was provided to Cambodia and Mongolia to review their pre-hospital trauma care systems, with a view to build capacity in service delivery to victims of trauma.

Capacity-building for injury and violence prevention is a priority for WHO. Support was provided to Cambodia, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines and Viet Nam for training professionals in the areas of trauma care, child safety, and injury and violence prevention.

**Future directions**

Given current trends, road traffic and other injuries are expected to increase unless Member States commit to appropriate interventions.

WHO will continue to support the health sector as it engages and collaborates with other sectors to promote injury and violence prevention. Priority areas will include improved surveillance systems, implementation of multisectoral interventions, better care for victims and community-based rehabilitation.

WHO will continue to work to incorporate injury and violence prevention interventions into the development of national plans and healthy communities.