Regional Health Forum

WHO South-East Asia Region

ISSN 1020 4237

Printed in India

Editorial

The main objective of the Regional Health Forum is the exchange of information, experience, ideas and opinions on all aspects of public health and health development. This publication is intended to serve as a platform from where people can express their views, observations and experiences rather than as an official medium of the World Health Organization's policy or as reference material.

As mentioned in the last issue, the focus of this issue is mental health, which was the theme of World Health Day 2001. We would like to receive your feedback on the first issue to be devoted almost exclusively to one subject.

We have tried to include articles on different aspects of mental health, which will be of interest to the readers. There are articles on mental health policies in developing countries, community-based model of mental health, a description of the mental health programme in the countries of South-East Asia Region, the mental health of women - an often neglected issue - and the link between depression and poverty. Besides this, we learn about partnerships in the health sector with financing institutions, specifically in Indonesia, and an essay on TRIPS and access to medicines which explain how international trade agreements have a bearing on the health sector.

Readers are invited to forward their contributions in the form of articles, essays, letters, or comments written in an informal, anecdotal style. Suggestions on improving the content are also welcome.

Contents

HEALTH SYSTEMS

TRADE AND HEALTH

COMMENT

Message from the Regional Director

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

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

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

The World Health Organization recently developed a new global policy and strategy for work in the area of mental health. Launched by the Director-General in Beijing in November 1999, the policy emphasizes three priority areas of work:

(1) Advocacy to raise the profile of mental health and fight discrimination; (2) Policy to integrate mental health into the general health sector, and (3) Effective interventions for treatment and prevention and their dissemination. The South-East Asia Regional Office of the World Health Organization is committed to promoting this policy.

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

Dr Uton Muchtar Rafei
Regional Director

Agenda for the Mental Health Programme in South-East Asia

*Dr Vijay Chandra**

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

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

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

There are many barriers to the implementation of community mental health projects and programmes. While some

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

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

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

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

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

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

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

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

Mental Health Policies in Developing Countries: A Radical Rethink

Vikram Patel, R Thara***

THE year 2001 marks an important milestone in the profile of mental health for governments and international health agencies. This year, mental health is the theme for the World Health Day (April 7) and the World Health Report. The World Health Assembly meeting in May discussed the policy implications of issues pertaining to mental health such as its socioeconomic determinants, gender influences and mental health services. It is fortunate that mental health will be in the global spotlight with such intensity over the coming months. In the past decade, a veritable mountain of research, literature and multilateral reports have demonstrated the rising tide of depression and other mental disorders across the world, and most importantly, in developing countries where the subject has always been the least prioritized in public health. The literature has demonstrated several key findings: mental disorders are common; they tend to occur more often in vulnerable groups such as the poor and traumatized; they are associated with considerable disability; the mentally ill suffer much stigma and discrimination; and while there is abundant evidence of efficacious and even cost-effective treatments for most mental disorders, the overwhelming majority of mentally ill persons do not have access to these treatments. Mental health care is yet to create a niche for itself in the health care delivery systems of many countries.

In the move to place mental health on the global public health agenda, however, there is the danger of overwhelming already stretched health systems and governments with the impression that vast new investments are required to implement effective mental health policies. In particular, the staggering prevalence rates of Common Mental Disorders (CMD) such as depression and substance abuse (particularly alcohol abuse) and the severe paucity of trained mental health manpower in most developing countries poses a serious question of cost-effective policies. On the other hand, the relatively rare Severe Mental Disorders (SMD) which include schizophrenia, bipolar disorder and dementias, are associated with profound disability and often require specialized multi-

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disciplinary care. There are serious concerns regarding the quality of care for persons with SMD with high levels of stigma and discrimination and human rights abuses, sometimes perpetrated in the very institutions created to care for them. It is imperative not to scare off already skeptical governments by demanding massive increases in mental health manpower or expensive infrastructural expenditure. Instead, the emphasis must lie on use of already existing services and manpower by allocating mental health issues into appropriate segments of the health sector. This is where a radical rethink is required in implementing mental health policies.

The key to cost-effective mental health policies lie in recognizing that the lumping together of CMD in the same basket of "mental disorders" as SMD cannot be sustained. There are several reasons for this. CMD, for example, are extremely common, typically occur in patients attending general or primary health care settings. Emotional and behavioural symptoms are rarely evident unless specifically inquired for; instead, somatic complaints are the typical clinical presentations. CMD are rarely conceptualized by patients or health care providers as being "mental" disorders. Thus, patients would be reluctant to consult mental health professionals (even if they were accessible). The aetiology of CMD is more likely to be found in the social and economic stressors faced by people. The remedies for CMD are relatively simple to deliver in primary health care settings; indeed, complex health problems such as tuberculosis are already being managed in primary health care. The clinical and social contexts of CMD place them well within existing public health priorities, such as maternal depression within maternal and child health. On the other hand, SMD are rare and have far more obvious behavioural and emotional symptoms. SMD are typically associated with "mental disorders" and are recognized as requiring specialist psychiatric care. Many patients will need multidisciplinary care over extended periods of time; some will require active rehabilitation inputs; some will require residential care in specialist mental health units or hospitals. While the etiology of SMD is more likely to lie in the sphere of neurodevelopmental and genetic factors, the explanatory models ascribed to them in many rural communities is still largely based on magic and religion, a fact influencing help seeking patterns. SMD are typically associated with considerable long-term disability, stigma and discrimination and impose a heavy burden on families who are often the principal care-givers. The quality of care in hospitals is highly variable; even today, many persons with SMD are treated with appalling lack of concern of their basic human rights.

It would be fair to conclude, then, that lumping together CMD and SMD in the same policy boat will not be acceptable or feasible in developing countries. Borrowing from other medical specialties, this would be as impractical as lumping together, for example, the common cold and lung cancer, or dyspepsia and ulcerative colitis. Thus, mental health policies in developing countries should work on a dichotomy such that CMD and substance abuse are integrated into general medicine and SMD become the focus of a mental health specific policy. Integration of mental health in primary health care, though often used as a cliche, has failed to a large extent because of the lumping together of CMD and SMD. Integration into general

health care should only be applied to CMD and substance abuse. This would entail that these topics being taught from undergraduate curricula for all grades of health workers as part of general medicine, for example, in the clinical approach to common symptoms such as sleep problems, tiredness and headache. The problem-solving approach used in clinical medicine is perfectly suited to such an integration. The emphasis must lie on CMD and substance abuse being considered a general health issue which can be confidently diagnosed and managed by general health workers. Providing social workers and antidepressants in general health care would provide potential interventions for the majority of patients. This would represent only a fractionally higher investment in exiting resources to meet the needs for persons with common mental disorders. The situation would be radically different for SMD where a defined mental health policy is required. The policy may consider the development of a network of skilled, multidisciplinary mental health teams covering large catchment area populations. Strict enforcement and monitoring of quality of care in mental hospitals and an active campaign to remove stigma and increase employment opportunities should be the hallmarks of mental health policy. Long term care of people with SMD would also require working with a "disability mindset" which alone would be able to address issues of rehabilitation and reintegration. A similar dichotomy could also be identified in the area of child mental health problems. Thus, rare disorders such as autism which require multidisciplinary and, on occasion, residential care, are arguably best managed by mental health specialists. Common problems such as learning disabilities and emotional disorder are best managed in mainstream settings such as general child health clinics or schools.

This year, governments around the world have been asked to take note of the burden of mental disorders on their populations and the need to implement policies aimed at unmet needs. It is our contention that this message will fail unless new policies emphasize the use of existing resources, and acknowledge the clinical and cultural realities which make lumping together of all types of mental disorders into the same programme unrealistic. Splitting off CMD from SMD provides the most cost-effective and, for patients and providers, acceptable model for implementing mental health policies in developing countries.

Mental Health in South-East Asia: Reaching out to the Community

Dr Nimesh G. Desai, Dr Mohan Isaac***

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

What are mental disorders?

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

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

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

What causes mental disorders?

A complex interaction process between various genetic, biological, psychological

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

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

Public health significance of mental disorders

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

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

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

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

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

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

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

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

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

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

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

statistics from Bangladesh, it is estimated that there are at least 1.5-2.0 million people with epilepsy.

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

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

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

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

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

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

Alcohol Abuse: There is clear evidence that alcohol-related morbidity and mortality is high in most countries of the Region. Impairment due to excess alcohol use also adds to the other negative consequences such as accidents due to drunken driving, domestic violence and reduced productivity. Methanol poisoning due to adulterated alcoholic beverages too is a problem in the Region.

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

In India, in the mid 1990s, the adult male per capita consumption was 5-6 litres and the prevalence of alcohol dependence syndrome was estimated to be 3.2 million. The total alcohol production more than doubled to 800 million litres between 1993 and 1996. Fifty percent of all home and farm accidents were estimated to be related to alcohol regularly.

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

A 1991 survey in Thailand revealed that 31.4% of those over 14 years of age consumed alcohol (54% of males and 10% of females). Thailand showed a 11-fold increase in beer production between 1970 and 1993.

In the Democratic People's Republic of Korea, the per capita consumption is reported to be three litres. In Myanmar, 10% of all admissions to the Yangon Psychiatry Hospital in 1994-96 were due to alcohol dependence. Cirrhosis of the liver, possibly related to excess alcohol consumption, has been reported as the third most common cause of death in Bhutan.

Systematic research aimed at estimating and understanding the nature and extent of public health problems related to alcohol use in the Region is required. Meanwhile, there is a need to implement effective strategies for prevention of harm from alcohol. These strategies, which are being developed and implemented include strategies for early identification and services for alcohol abuse and dependence, campaigns aimed at reducing specific problems like drunken driving and industrial accidents, and increasing public awareness about the harmful effects of alcohol abuse.

Other Substance Abuse: Since times immemorial, in most countries of the South-East Asia Region drugs have traditionally been used, in addition to alcohol, for ritual, religious, and recreational purposes. These drugs were mainly cannabis products and opium. The apparent social acceptance of the use of such substances stemmed largely from the fact that there was no abuse. Where there was, it was severely ostracized. Society had very clearly drawn the line and there was no question of condoning any abuse.

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

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

Social impact of mental disorders

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

What is community mental heath

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

Successful community-based programmes

In Bangladesh

Many NGOs are actively working for the welfare of persons with mental retardation in Bangladesh. One such organization is the Bangladesh Protibandhi Foundation (BPF). Started in 1984 as a parent – professional partnership, BPF has been playing a key role in the area of mental retardation. BPF has been able to initiate and sustain a variety of activities and programmes, which include

health care and psychological services, other professional services such as physiotherapy and speech therapy, early stimulation programmes, a special school, and sheltered workshop.

In India

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

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

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

In Nepal

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

In Sri Lanka

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

In Thailand

An intervention programme in Thailand enlisted the support of village-level health workers in preventing suicide. These people were trained in detecting individuals with depression and those at risk of suicides, using basic helping skills acquired from community work. After six months, suicides in the area declined significantly and this programme is being replicated in other areas in the country.

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

Conclusion

The Regional Director of WHO's South-East Asia Region, Dr Uton Muchtar Rafei, has very appropriately summarized the need for mental health in the Region: "*Mental health care, unlike many other areas of health, does not generally demand costly technology. Rather, it requires the sensitive development of personnel who have been properly trained in the use of relatively inexpensive drugs and psychological support skills on an outpatient basis. What is needed, above all, is for all concerned to work closely together to address the multi-faceted challenges of mental health*".

Is Depression a Disease of Poverty?

*Vikram Patel**

Abstract

Throughout much of Asia, diseases of poverty such as tuberculosis and other infectious diseases, have commanded the lion's share of the pie of health policy and funding. The relationship of a mental illness such as depression to poverty has rarely been questioned. This paper has used research evidence from across the Region to demonstrate that depressive and anxiety disorders are disabling and can prevent sufferers from carrying out their tasks at home and in employment and thus have adverse economic implications for the individual, their families and society. Irrespective of the average per capita income of a society, persons who are at the bottom end of the social hierarchy are at a greater risk of suffering from these disorders than those who are at the upper end. Thus overcoming poverty might contribute to improving mental health, but it is unlikely to be enough; a more equitable distribution of resources is necessary. Social and economic policies may impose an unacknowledged burden on society by influencing the prevalence of depressive disorders. Poverty reduction and full employment policies should have benefits in reducing the prevalence of depression. Provision of microcredit as a means of reducing dependence on informal moneylenders may also reduce financial strain. Investing in education and school completion should improve the individual's long-term opportunities and improve mental health, especially in the developing world. General practitioners and community health workers must be involved in mental health programmes. The emphasis in health policy must be to achieve adequate skills for the diagnosis and treatment of depressive and anxiety disorders in general health care settings. Treatment with antidepressant medication and inexpensive psychosocial interventions should be available everywhere. These programmes can be implemented at little additional cost, because they use existing human and infrastructural resources. Research is needed to strengthen the evidence base, particularly to identify the factors which protect persons living in severely deprived conditions from suffering from depression.

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Introduction

POVERTY was termed many years ago as 'the mother of all diseases'. Governments and donors such as the World Bank give priority in policy and funding to diseases associated with poverty. This is a prudent choice, for the poor are least able to access appropriate quality health care. Further, in most Asian countries, the majority of the population belong to the lower income group. In making choices for health funding, policy-makers are therefore guided by the epidemiological evidence which indicates the burden of disease on the population as a whole, and on the poor in particular. So far, policy on health and poverty has almost entirely skirted the issue of mental health. It has been assumed that mental illness is not a relevant health concern for the poor because they are faced with the considerable burden of 'physical' diseases. These attitudes are strengthened when one considers that the vast majority of mental health professionals are urban-based, and in many countries work in the private sector which caters to relatively wealthier sections of the population. Public health facilities and primary care centres report very low figures of mental illness, further reinforcing the stereotype that mental disorders are rare and mainly a problem identified in urban, middle or high income groups.

This paper focuses on depressive and anxiety disorders which are the commonest of all mental illnesses but are almost entirely seen in the general health care system as opposed to the specialist mental health care system. The paper presents evidence that these disorders pose a tremendous public health burden in all societies, irrespective of their overall level of economic development. Evidence is then presented demonstrating the relationship between these disorders with poverty and inequality. The paper concludes that depression is a disease of poverty and considers some of the public health strategies which can be implemented in Asian countries to reduce its burden on the poorest sections of the population.

Depression and Anxiety

The symptoms of depression and anxiety are common and reported in all populations of the world [1]. There is now professional consensus about the major symptoms of depression and anxiety. For example, depression is characterized by a number of symptoms, in addition to a lowering of mood. These are loss of interest, poor concentration and forgetfulness, lack of motivation, tiredness, irritability, poor sleep and changes in appetite. Anxiety is associated with a fearful feeling, worrying thoughts and physical symptoms such as palpitations, tingling sensations, headaches and chest pain. Depression and anxiety in the primary or general health care setting typically occur together. In this document, the term 'depression' is used to denote the clinical presentation of both depression and anxiety.

The evidence of high prevalence of depression has been building up over the past 20 odd years from a range of settings in Asia [2;2-5;5;6]. These studies reveal community prevalence figures that vary between different countries but can be up to 50% in some studies from Pakistan[6]. Prevalence estimates in attendees at primary health care centres, catering to the poorest members of societies, show levels that can be as high as 40% [2;7;8]. Depression often runs a chronic or recurrent course with nearly half of the patients in treatment settings remaining ill for 12 months or more [9].

There is now a large body of evidence demonstrating the considerable disabling effects of depression both in the community and primary health sector[10;11]. Depression and anxiety are exceptionally disabling conditions and the disability is often not widely acknowledged, in part because of the stigma associated with these illnesses. Depression is disabling for a variety of reasons. The symptoms of depression such as poor concentration and lack of motivation impair the ability to carry out everyday tasks. Irritability combined with these can affect the relationships with other family members and fellow workers. The "negative" attitudes of depression can impair judgement and reduce problem-solving abilities. It is perhaps this latter aspect of depression that is especially worrying in relation to socioeconomic inequalities. It is likely that depression impairs the ability of poor people to deal with the difficult circumstances they experience. Arguably, for the poorest people in the world, problem-solving abilities are essential in order to deal with their circumstances.

In addition to disability, there is evidence that depression can also lead to increased mortality. There is growing concern over the rising rates of suicide in many developing countries, particularly amongst adolescents and young adults in whom suicide is one of the three leading causes of death. In India, for example, the suicide rate increased by 6.2% per annum between 1980 and 1990, during which period the population growth rate was 2.1%; the highest growth in suicide rates was for young adults [12]. Deliberate self-harm (i.e. self-harm which does not lead to death) is far commoner than completed suicide and is fast becoming the commonest reason for emergency medical treatment in some developing countries such as Sri Lanka [13].

Primary care is regarded as the cornerstone of health care in both the developed and developing world. Most cases of depression are treated in primary health care settings rather than in specialist clinics. However, despite the considerable evidence of the effectiveness of drug and psychological treatments for depression, albeit largely from the developed world[14;15], the vast majority of patients in developing countries do not receive these treatments. Instead, they are prescribed a cocktail of medicines aimed at various symptoms, such as painkillers, vitamins and sleeping medicines [2;16].

The Global Burden of Disease study ranked depression as the fourth leading cause of burden among all disease, accounting for 4.1% of total burden[11]. By 2020 it will rise from the fourth to the second leading cause of DALYs. It will then be second only to ischaemic heart disease for DALYS among both sexes. Taking the example of ischaemic heart disease, risk factors such as smoking and high blood pressure have been identified, and public health interventions target those risk factors and try to reduce their frequency in the population. We need such public health-oriented research into depression that will then lead on to primary preventive programmes and to improved access to efficacious treatment for people with depression.

Socioeconomic Inequalities and Depression

There is now a substantial body of evidence, which demonstrates the relationship between poverty and socioeconomic inequalities with depression in developed countries [17;18]. Evidence is beginning to accumulate demonstrating a similar association between

economic disadvantage and the presence of depression in Asian countries too. For instance, a community study from Indonesia found strong associations between depression and the presence of household amenities such as electricity, and ownership of a television [19]. In this study, the rates of depression in the least developed villages were twice those in the most developed villages. A primary care study reported a strong association between indicators of poverty such as being in debt and being unable to buy food with CMD, even after adjustment for a range of sociodemographic variables [2]. Association of CMD with other indicators such as unemployment and low income and social class groups have been reported in other studies [3;6;8;20]. There is also evidence, from prospective longitudinal studies in less developed countries outside the Region, that economic deprivation is associated with incidence and persistence of depression [21]. Education, which is strongly correlated with poverty, emerges as a factor strongly associated with the prevalence of depression in many developing countries [22]. The mechanism through which education might protect persons from depression is unclear. However, it is plausible that education is an important determinant of present and future life opportunities which promote mental health in later life.

Causal Pathways Between Socioeconomic Factors and Depression

Do socioeconomic factors cause depression?

At present, there is little real understanding about the mechanisms or mediating factors between low socioeconomic status and depression. The following section gives some plausible ideas about the importance of various factors.

Loss of social supports

There is evidence that lack of social supports may increase the risk of depression. Low socioeconomic status might decrease a person's ability to engage in social activities. Unplanned urbanization has and is posing great strains on traditional social support systems across the developing world. The lack of social support and the breakdown of kinship structures is probably the key stressor for the millions of migrant labourers to the urban centres of Asia leaving behind millions of dependants in the rural areas whose only hope of survival are the remittances their relatives will send from distant cities. Brown and Harris, in their seminal work on the social origins of depression, identified factors such as having no one to confide in as one of the vulnerability factors for depression [23]. For young women who are married far from their parental homes and live for most of the year without their husbands, it is not hard to imagine why they may be more likely to be depressed.

Lack of control on resources

There are the obvious material stresses, which accompany poverty. The daily worries about paying essential bills and being able to afford food in the face of inflationary pressures and insecure employment could be expected to wear down even the strongest mind. The ability to deal with new difficulties is harder for those with less money. One of the most consistent predictors of mental disorder in developing country studies is lack of education. Education might provide a

means of escape from poverty or access to knowledge and other ways to resolve problems [22]. The lack of opportunity in a society where there is huge income inequality, high unemployment, and underemployment, and no social welfare provision can be expected to lead to feelings to hopelessness, anger and despair. There is the well-recognized association between poverty and a higher burden of physical ill health, particularly infectious diseases, and inadequate access to good, cheap health care. This may mean that many poor persons with mental health problems go untreated, and suffer for long periods as has been already described earlier.

Social comparison

The potential stresses imposed by absolute poverty may be considerably different from those of relative poverty. One proposed mechanism is that of "cognitive comparison", whereby people are made aware of the vast differences in socioeconomic status that prevail. The knowledge of how the richer "other half live" affects psychosocial wellbeing and thus, overall health status [24].

Does depression worsen poverty?

There is a reason to support this possibility with evidence for two major mechanisms. First, the evidence that mental disorders lead to disability which has been described earlier. For example, studies of primary health care users in India showed that subjects with depression spent more than twice the number of days in the previous month in bed or were unable to do their daily activities as compared to others [2]. Second, there is evidence that persons with depression receive more health care, especially in primary health care. Most people with depression consult for physical symptoms and in many health systems, both in developing and developed countries, this can lead to numerous costly consultations, investigations and polypharmacy [7;16]. Often governments are not capable or willing to finance treatment and the costs are then transferred to the sufferers who resort to the private sector. No matter who pays the bill, depression drains away precious resources.

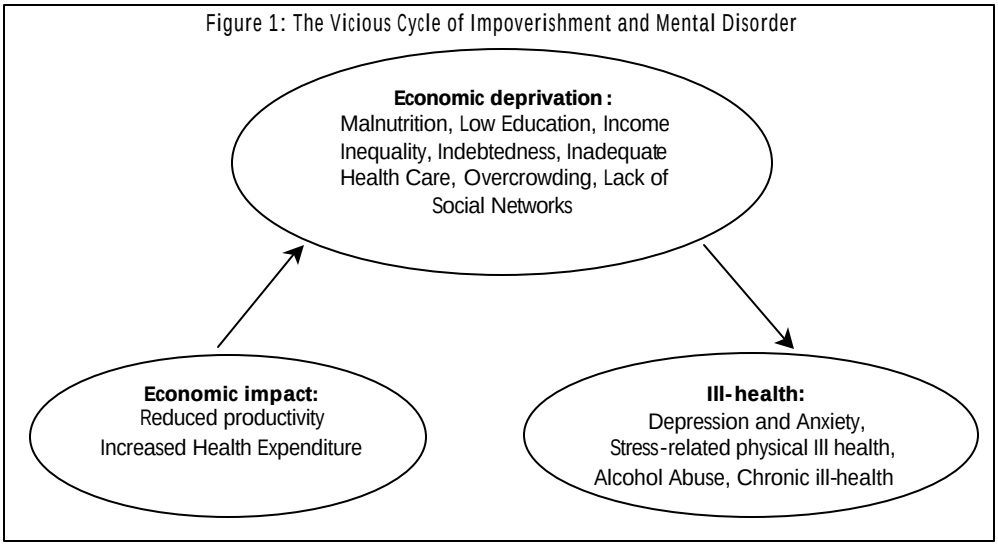
Cycle of impoverishment and mental disorder

Thus, the nature of the relationship between impoverishment and mental illness is complex, bi-directional and dynamic, leading to a vicious cycle of impoverishment and mental illness (Figure 1). An example of such a vicious cycle could be as follows: an episode of depression is triggered by material deprivation and domestic violence; depression in turn robs the woman of the necessary coping skills and energy to overcome her problems and leads her to spend money and time seeking relief from various health practitioners, often without any benefit.

Implications for Health Policies and Programmes

The implication of the evidence is that policies and programmes aimed at providing education and reducing poverty, and socioeconomic inequalities are highly likely to help bring down the prevalence of depression. From a public health perspective, the evidence on socioeconomic determinants and depression can be used to consider a number of primary and secondary preventive strategies.

Figure 1: The Vicious Cycle of Impoverishment and Mental Disorder



Primary prevention

Primary prevention is used to describe policies aimed at reducing the prevalence of depression. The evidence to support the efficacy of interventions in this field is weak, mainly because few, if any, interventions have been tried and/or evaluated in terms of their impact on depression. It is difficult to persuade governments or international agencies to invest in these programmes rather than primary prevention programmes for malnutrition or infectious diseases. Based on the earlier discussions, we now consider examples of primary preventive strategies:

Investing in education

The key factor may not be whether 100% of children are in primary school, but rather the proportion of children who fail to complete the minimum years needed to obtain a secondary school certificate [10-12 years in most countries]. Even though there are impressive gains in increasing school enrolment, there may need to be further emphasis on reducing school drop-out rates; in many Asian countries, less than half the children, particularly girls, who are in primary school go on to complete their 10 years of secondary education. Because education permits greater choices in life decisions and influences aspirations, self-image and opportunities [25], it is likely that investment in education will lead to improved mental health of the population.

Microcredit

In many Asian countries, indebtedness to loansharks is a consistent source of stress and worry. Indeed, it is not uncommon for the children of a family to spend their lives toiling to repay the interest of relatively small loans taken out by their parents. It is clear that here lies another potential preventive strategy in that local banks could step in and review their process of assessing credit-worthiness for persons who belong to the poorest segments of society. Radical

community banks and loan facilities such as those run by SEWA in India and the Grameen Bank in Bangladesh could be involved in setting up such loan facilities in areas where they do not exist.

Health promotion

Most public health campaigns such as WHO's 'Stop Exclusion: Dare to Care' campaign are generally aimed at increasing awareness of mental illness, and knowledge about the effectiveness of interventions available in health services. There is also the potential to use health promotion to publicize "stress reduction" techniques that could be used more widely. Similarly, changing the characteristics of the workplace and working practices could have a beneficial effect on mental health. At present, these ideas are necessarily speculative but deserve further development and evaluation.

Secondary prevention

The key to secondary prevention, reducing the disability consequent from the disorder, is to strengthen the treatment of depression in primary health care. There needs to be much greater cooperation and collaboration between mental health and primary care health workers.

Integration of mental health in primary health care

The integration of mental health into primary health care has been the mantra of WHO for over a decade. There needs to be greater emphasis on training general health practitioners to recognize and effectively treat depression. Just as clinicians must treat tuberculosis even if they cannot get rid of the overcrowding, so too we must challenge the mental despair of clinicians who argue that if their patients are poor, they must be depressed and there is little they can do about it. The best evidence that this belief is untrue is evidenced by the fact that the majority of the poor do not get depressed, they are merely at greater risk than the rich.

Medical pluralism in mental health care

Mental health manpower cannot meet the needs of all persons with depression, especially in developing countries. The population of India, now exceeding 1 billion people, has less than 4000 psychiatrists. The vast majority of psychiatrists in developing countries work in large mental hospitals or in private practice. Most persons suffering from depression are treated, if at all, by general health care providers, traditional and religious healers, nongovernmental and voluntary organizations and families. The private medical sector is a major provider of general health care in many developing countries[26]. Their involvement in implementation of mental health programmes would be imperative.

Integration of mental health into existing health promotion programmes

Depression typically occurs in situations of extreme stress. There are several examples of existing public health priorities in which depression is of great relevance such as maternal and child health, reproductive and sexual health, adolescent health and violence prevention. Piggybacking mental health interventions onto these programmes would imply using existing resources and manpower

and providing more comprehensive care, which reflects the broad concerns of health. Such integration can be implemented with minimal additional cost and would have the advantage of greater access to sufferers as a result of the lesser stigma than would be attached to seeking help from mental health services.

Intersectoral cooperation

In Pakistan, the Gujarkhan demonstration project involves community leaders, schoolteachers, and primary health care workers. Mass educational campaigns were launched and mental health issues introduced into the school curriculum as a means of reducing stigma as well as educating families on how best to protect their mental health [27]. These initiatives can help to increase the involvement of communities in deciding and implementing solutions for their own problems. Local participation is a fundamental requisite for the success of any such programmes.

Conclusions

This article has presented evidence, focusing on the Asian region, which demonstrates the public health importance of depressive and anxiety disorders. The evidence demonstrates a close association between socioeconomic adversity and depression, an association that is present in many societies, irrespective of the stage of economic development. Inasmuch as depression is caused by stressful life circumstances, and that the poor are more likely to face such circumstances and have less resources to adequately cope with them, depression is a disease of poverty. Furthermore, depression can impair economic productivity and drains precious resources due to untreated morbidity. Thus, the answer to the question posed in the title of this article is affirmative. Depression is, like most other diseases, a disease of poverty. Donors and governments concerned about improving the health of the poor must recognize that depression typically occurs along with other physical health problems which are already the focus of attention of programmes directed at the poor.

Despite the compelling evidence of an association between depression and economic deprivation, it is important to recognize that the majority of people living even in squalid poverty remain well, cope with the daily grind of existence and do not succumb to the stressors they face in their lives. Indeed, this is the real challenge for public health researchers; to identify the protective qualities in those who do not become depressed when faced with awful economic circumstances for therein lies a potential to help and prevent mental health problems. Could informal local community social networks protect some from depression? Could religious or spiritual involvement limit alcohol abuse in some men and help prevent suicide in women and teenagers? Could microcredit schemes which are challenging the existing notions on who knows how to handle money properly help prevent some from succumbing to despair? Could being close to one's family provide the necessary confidence and support? Could a caring local councillor's efforts to clean up a slum help reduce the suicide rate? These are the practical research questions arising from the relationship between poverty and mental illness.

References

1. Ustun TB, Sartorius N. The Background and Rationale of the WHO Collaborative Study on "Psychological Problems in General Health Care". In: Ustun TB, Sartorius N, editors. Mental Illness in General Health Care: an international study. Chichester: John Wiley & Sons; 1995. p. 1-18.

2. Patel, V., Pereira, J., Coutinho, L., Fernandes, R., Fernandes, J., and Mann, A. Poverty, Psychological Disorder & Disability in Primary Care Attenders in Goa, India. British Journal of Psychiatry 171, 533-536. 1998.

3. Mumford DB, Nazir M, Jilani F, Yar Baig I. Stress and Psychiatric Disorder in the Hindu Kush: A community survey of mountain villages in Chitral, Pakistan. Br.J.Psych. 1996;168:299-307.

4. Nikapota, A., Patrick, V., and Fernandes, L. Aspects of psychiatric morbidity in the out-patient population of a general hospital in Sri Lanka. Indian Journal of Psychiatry 23, 219-223. 1981.

5. Cheng TA. A community study of minor psychiatric morbidity in Taiwan. Psychol.Med. 1988;18:953-68.

6. Mumford DB, Saeed K, Ahmad I, Latif S, Mubbashar M. Stress and psychiatric disorder in rural Punjab. A community survey. Br.J.Psych. 1997;170:473-8.

7. Mental Illness in General Health Care: an international study. Chichester: John Wiley & Sons; 1995.

8. Kishore J, Reddaiah V, Kapoor V, Gill J. Characteristics of mental morbidity in a rural primary health centre of Haryana. Ind.J.Psych 1996;38:137-42.

9. Patel, V., Todd, C. H., Winston, M., Gwanzura, F., Simunyu, E., Acuda, S. W., and Mann, A. The outcome of common mental disorders in Harare, Zimbabwe. British Journal of Psychiatry 172, 53-57. 1998.

10. Ormel J, Von Korff M, Ustun TB, Pini S, Korten A, Oldehinkel T. Common Mental Disorders and Disability Across Cultures. JAMA 1994;272:1741-8.

11. Murray C, Lopez A. The Global Burden of Disease. Boston: Harvard School of Public Health, WHO and World Bank; 1996.

12. Shah G. Suicide Prevention in India. In: Ramsay RF&TBL, editor. Global Trends in Suicide Prevention: Toward the Development of National Strategies for Suicide Prevention. Mumbai: Tata Institute of Social Sciences; 1996. p. 233-52.

13. Eddleston, M., Rezvi Sheriff, M. H., and Hawton, K. Deliberate Self-Harm in Sri Lanka: an overlooked tragedy in the developing world. British Medical Journal 317, 133-135. 1998.

14. Patel, V. Why we need treatment evidence for common mental disorders in developing countries. Psychological Medicine 30, 743-746. 2000.

15. Sumathipala, A., Hewege, S., Hanwella, R., and Mann, H. Randomized controlled trial of cognitive behaviour therapy for repeated consultations for medically unexplained complaints: a feasibility study in Sri Lanka. Psychological Medicine 30, 747-757. 2000.

16. Linden, M., Lecrubier, Y., Bellantuono, C., Benkert, O., Kisely, S., and Simon, G. The prescribing of psychotropic drugs by primary care physicians: an international collaborative study. Journal of Clinical Psychopharmacology 19, 132-140. 1999.

17. Lewis, G., Bebbington, P., Brugha, T. S., Farrell, M., Gill, B., Jenkins, R., and Meltzer, H. Socioeconomic status, standard of living and neurotic disorder. Lancet 352, 605-609. 1998.

18. Bruce ML, Takeuchi DT, Leaf PJ. Poverty and psychiatric status. Longitudinal evidence from the New Haven Epidemiologic Catchment Area Study. Arch.Gen.Psych. 1991;48(May):470-4.

19. Bahar E, Henderson AS, Mackinnon AJ. An epidemiological study of mental health and socioeconomic conditions in Sumatra, Indonesia. Acta. Psych. Scand. 1992;85:257-63.

20. Amin, G., Shah, S., and Vankar, G. K. The prevalence and recognition of depression in primary care. Indian Journal of Psychiatry 40, 364-369. 1998.

21. Todd, C., Patel, V., Simunyu, E., Gwanzura, F., Acuda, W., Winston, M., and Mann, A. The onset of common mental disorders in primary care attenders in Harare, Zimbabwe. Psychological Medicine 29, 97-104. 1999.

22. Patel, V., Araya, R., Lima, M. S., Ludermir, A., and Todd, C. Women, Poverty and Common Mental Disorders in four restructuring societies. Social Science and Medicine 49, 1461-1471. 1999.

23. Brown E, Harris T. Social Origins of Depression. London: Tavistok; 1978.

24. Wilkinson, R. Health inequalities: relative or absolute material standards? British Medical Journal 314, 591-595. 1997.

25. Sinha D. Psychological Concomitants of Poverty and their implications for education. In: Atal Y, editor. Perspectives on Educating the Poor. New Delhi: Abhinav Publications; 1997. p. 57-118.

26. Brugha, R. and Zwi, A. Improving the Quality of Private Sector Delivery of Public health Services: Challenges and Strategies. Health Policy & Planning 13(2), 107-120. 1998.

27. Rahman, M., Mubbashar, M., Gater, R., and Goldberg, D. Randomised Trial Impact of School Mental-Health Programme in Rural Rawalpindi, Pakistan. Lancet 352, 1022-1026. 1998.

Women's Mental Health: A Public Health Concern

R.Thara and V.Patel***

Introduction

THE state of women's mental health is indeed in a state of flux. On the one hand, it has begun to figure, as never before, on the agenda of many national and international commissions and organizations. The World Health Report [1] says, "Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination. Today, the status and well-being of countless millions of women worldwide remain tragically low."

UNDP has developed two measures of the disparity between men and women. The Gender Empowerment Measure (GEM) measures gender inequality in two key areas of economic and political participation and decision-making. The other GDI (gender related development index) measures achievement in life expectancy, educational attainment and income. Based on all available data, UNDP [2] concludes that "no society treats its women as well as its men".

Databases generated by many sources include appalling statistics on women's health in general and mental health in particular. Notable among these has been the estimate of the Global Burden of Disease [3], which has named unipolar depression among women to be the second most important cause of disease burden by the year 2020. The excessive preoccupation of the health care system, its planners and administrators about mortality has shifted to morbidity, well-being and quality of life, all of which are profoundly influenced by mental health. The 1997 Human Development Report states: "No society treats its women as well as its men".

On the other hand, reports of violence against women are on the increase, violence of a nature that scars the psyche almost permanently and even affects the social position of women adversely. Childhood sexual abuse, female infanticide in some societies, battering of female children, the resulting homelessness and psychological trauma inflicted by dowry demands on newly

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married women in countries such as India are all sordid tales of the world's apathy, neglect and indifference to women's woes. The relative lack of education and authority make them extremely vulnerable to all kinds of abuse, all of which result in increasing emotional morbidity. This inextricable intertwining of the state of education, economy, autonomy and health makes it imperative that a multipronged strategy be deployed to systematically address women's mental health problems.

Global Burden of Disease

Burden of disease and DALYS (Disability Adjusted Life Years) which have now been extensively studied, show the importance of mental health of women in terms of role performance, productivity and health economics.

- For women, neuropsychiatric conditions were the second leading cause of disease burden worldwide, following infections and parasitic diseases.
- For women between the ages of 15-44 years of age, unipolar depression was the leading cause of disease burden in both developed and developing countries.
- Schizophrenia, bipolar disorder and obsessive-compulsive disorders also ranked in the top ten leading causes of burden for women aged 15-44 years.
- The impact of these disorders is also felt on DALYS.
- Projections to the year 2020 still foresee that the major impact of these six mental disorders will overwhelmingly affect women in this age group. The aging effect of this population will not change the profile of the impact of these disorders.

Projections

- DALYS associated with neuropsychiatric conditions will increase for women of all ages between 1990 and 2020.
- In 1990, the six major mental disorders accounted for 8.51% of all DALYS for women. This figure will increase to 14.32% in 2020.
- By 2020, unipolar major depression alone will account for 8.62 of all DALYS for women, particularly between the ages of 15 and 44.The bulk of the disease burden will therefore remain in the prime child-bearing, child-rearing, parenting and working years.

In many countries of the South-East Asia Region, the mental and social well-being of women is at a low rung largely because of socioeconomic factors. Women are second-rate citizens and are denied many rights. Access to health care is often denied to them. Poverty, illiteracy, big families, number of children all compound this problem. Domestic violence, abuse of women, attitudes towards the girl child and female infanticide are other aspects of the spectrum not auguring well for their well being.

This paper only attempts to provide the readers an overview of some of the mental health issues affecting women, especially in

this Region. Considering the vastness of the subject and the wide array of social and political factors impacting them, it is well nigh impossible to do total justice to this subject within the framework of this chapter.

Women and Common Mental Disorders

From the perspective of women and mental health, the key epidemiological finding is the much-replicated association of female gender and Common Mental Disorders (CMD) such as depression and anxiety. Both community-based studies and studies of treatment seekers indicate that women are, on average, two to three times, at greater risk to be affected by CMD [4,5]. The obvious question thrown up by these findings are the reasons for this apparent vulnerability, and its significance. There are a number of potential factors, which may make women more vulnerable to depression. Davar has reviewed this issue in detail in a recent book on the mental health of women in India [6]. Some of the implications of the greater vulnerability of women to suffer CMD are considered below:

- There is considerable evidence demonstrating that stressful life events are closely associated with depression and such events are more common in the lives of women [7,8]. Thus, women are far more likely to be victims of violence in their homes. The multiple roles played by women such as child-bearing and child-rearing, running the family home, caring for sick relatives and, in an increasing proportion of families, earning income, may lead to considerable stress.
- The reproductive roles of women, such as their expected role of bearing children, the consequences of infertility and the failure to produce a male child have been linked to wife-battering and female suicide [6,9].
- Women are far more likely to be denied educational and occupational opportunities and access to appropriate health care.
- Differences may also be partly accounted for by a gender bias in the way mental problems are diagnosed, since these are often influenced by cultural expectations and stereotypes of what is normal behaviour for men and women.
- The impact of mental health problems also shows a gender differential. For example, whereas women were required to be the primary carers if their husbands were mentally ill, it was their own families that were responsible for their care if they were to become ill.
- Women with mental health problems are less likely to receive appropriate health care when sick and when they do seek help, a gender bias ensures that symptoms are taken less seriously than they are for men [6,10].
- Furthermore, the negative effects of globalization and economic reform on public health are likely to hit women harder than men; for example, since the economic reforms and subsequent crisis in South-East Asia, there has been a rise in the incidence of reported domestic violence, rape and alcohol abuse [11].

- Indeed, "it is not surprising that the health of so many women is compromised from time to time. Rather, what is more surprising is that stress-related health problems do not affect more women". [9]

Chronic Mental Illness

Although the prevalence of chronic psychotic illnesses such as schizophrenia and bipolar disorders in women may be less than that of depression, anxiety and related conditions, they pose an immense problem in management and rehabilitation. Their propensity to be chronic, sometimes unresponsive to treatment, the resultant disability in various aspects of functioning, and above all, the stigma attached to these illnesses and the social sequelae make it a public health issue, notwithstanding the smaller numbers.

While men and women are equally affected by schizophrenia, there have been some differences in their manifestations and course and outcome. A consistent finding has been a higher mean age at onset and first hospitalization for women suffering from schizophrenia. Women have also been found to have more paranoid and affective symptoms, more atypical symptoms, and more frequently an insidious onset with passivity and social withdrawal.

The most robust research finding has probably been the better course and outcome of schizophrenia in women as reported by Thara & Rajkumar [12] and many others in the developing world. Various hypotheses including the protective effects of oestrogen have been put forward to explain this difference.

Social consequences such as homelessness, vulnerability to sexual abuse and exposure to HIV and other infections contribute to the difficulties of rehabilitation of women. The absence of any clear welfare policies in this part of the world for this group of women, and the social stigma further compound the problem. Stigma has been reported to be more towards ill women than men. Women caregivers also reported being the target of stigma [13].

Mentally Ill Women and Their Marriages

The Schizophrenia Research Foundation at Chennai, India carried out an ethnographic, qualitative study of 75 mentally ill women who were separated or divorced.[14] It was found that all but eight of these separated women lived in their parental homes with the onus of care being borne by the aging parents. Legal separation had occurred only in 16 cases, all of them being educated women. None of them remarried, while 34 of the husbands had done so. The fathers looked after only six of the 26 children. This study sharply brings into focus some issues, which confront women in many developing countries. They are:

- A lack of awareness of the illness and its disabilities resulting in a widespread belief that marriage is a panacea for all ills. This resulted in the parents of the ill women arranging their marriages, very often suppressing the fact of mental illness from the husband and his family.
- Absence of legal protection including maintenance for such women.

- The burden of care of these women goes back to the parents, many of whom are aging and themselves sick.
- Lack of any state managed programmes, which will offer some kind of physical, sexual and financial security for such women.
- Negative attitudes of the husband and his parents and sometimes even the extended family hastened the process of separation and sometimes desertion.

Suicide and Self Harm

Studies of suicide and deliberate self-harm have revealed a universally common trend of more female attempters and more male completers of suicide. A spate of studies from India in the 90s has reiterated this finding. Biswas et al [15] found girls from nuclear families and women married at a very young age to be at a higher risk for attempted suicide and self harm. Malone et al in Dublin [16] reported a 2:1 ratio of women and men in 100 cases of deliberate self- poisoning to such behaviours as a response to failures in life, and difficulties in interpersonal relationships. It may also be noted that terrorist groups train many women as human live bombs.

However the women in many of these studies were not referred to psychiatric services. This could be due to a variety of reasons such as the need to downplay such behaviours in an attempt not to reinforce them and because of the stigma attached to seeking psychiatric help.

Violence

Although violence against women has been documented even in ancient historical documents, it is only in the last half century that it has evoked the attention it deserves. The extent and nature of this problem have been brought to light by women activists and acknowledged by international agencies. A WHO report in 1998 called it a priority health issue. Violence against women is emerging as a pervasive global issue and contributes significantly to preventable morbidity and mortality for women across diverse cultures[17]. In some regions, violence has reached staggering levels; in a recent population-based study from India, nearly half the women reported physical violence[18]. There is now substantive evidence demonstrating that amongst the most disabling and long-lasting health effects of violence are mental health effects such as depression and Post Traumatic Stress Disorder.

The Fourth World Conference on women held at Beijing in 1995 defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape,

female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.

There are several and types of violence against women, all of which need not take the form of brutal assaults. Demands by society on widows, however young they be, to lead a rigidly austere life, social isolation and a total lack of access to men have all been condoned for ages as necessary measures to keep them from temptation and sin. The practice of "*sati*" in certain parts of India, by which the wife throws herself into the funeral pyre of her husband, has been documented to occur in the not too distant past. Such behaviours of self-denial, torture and even death are indeed sanctified and glorified and there are even temples erected for the goddess of *sati*.

Historically, culture, customs, traditions and beliefs have fostered in their own way various forms of violence against women.

A very poignant report of the effect of violence on women in El Salvador can be seen in the book "World Mental Health" [19]. "Women regularly encountered brutal evidence of war, ... "nerves" is the chief complaint of many of these women.... nearly all of these women had suffered one or more major depressive episodes within the past two years,.... many of them also report symptoms of PTSD including recurrent nightmares of traumatic violence... many of them suffer from illnesses related to domestic violence and abuse."

Reproductive Health and Mental Health

Reproductive health is a fundamental aspect of women's health and is widely considered one of the main public health priority areas in developing countries. The areas of intersection of reproductive and mental health are considerable in scope and include, for example, psychological issues related to childbirth, violence, rape, adverse maternal outcomes such as stillbirths and abortions, reproductive tract surgeries, sterilization, premarital pregnancies in adolescents, HIV/AIDS and the impact of caring, menopause and infertility. These are vast in range and cannot be covered within the scope of this article. Instead, the article will provide an overview of some key areas of intersection, focusing on CMD, the commonest mental disorders in women in developing countries.

- **Gynaecological Morbidity and Psychological Disorder:** Gynaecological symptoms, for example vaginal discharge, are among the most commonly cited health problems in women in developing countries. Although much earlier

research assumed this symptom to be indicative of reproductive tract infections, recent studies (particularly from South Asia) show considerable discordance between symptoms and actual disease[20]. Depression typically presents in the form of medically unexplained physical symptoms. Rates of depression are high in women attending gynaecological clinics and qualitative studies demonstrate a strong relationship between vaginal discharge, weakness, psychosomatic symptoms and psychosocial stress[21]. Part of the aetiology of 'medically unexplained' vaginal discharge may be that it is a somatic idiom for depression and psychosocial distress.

- **Childbirth and Mental Health:** Women are vulnerable to suffer depression during the period immediately following childbirth [22]. There is limited literature on Post-Natal Depression (PND) from Asian countries; this research demonstrates a wide range of prevalence of PND from 3-36% of mothers after childbirth[23,24]. The majority of PNDs are self-limiting though, if untreated, this process of resolution may take upto 6 to 12 months. There is a "compelling body of evidence implicating PND in a range of adverse child cognitive and emotional outcomes". The detection of PND is of great public health interest not only because of its profound impact on maternal and child health but also due to the abundant evidence that simple inexpensive interventions such as non-directive counselling are of significant benefit in terms of remission of PND.

- **Adolescent Sexuality & Mental Health:** The sexual health of adolescents is now a major issue in reproductive health research and programmes because of the obvious potential of HIV/AIDS prevention by empowering young people to take decisions regarding their sexual health. However, there is a risk that the agendas and priorities of reproductive health workers may miss out on the other real concerns of adolescents and their families, viz., stress arising from conflict within families and from pressures in the educational system and rising unemployment. There is now substantial evidence pointing to the rising rates of depression and suicide amongst young people; for example, suicide is the commonest cause of death and hospitalization in adolescents in Sri Lanka (25). Pressures of academic performance in many developing countries lead to considerable psychological stress and suicides and symptoms of weakness, lack of concentration, headaches and other functional symptoms.

- **HIV/AIDS and Women's Mental Health**: HIV/AIDS produces mental health problems such as depression for those who suffer from the disorder for a variety of reasons including the stigma and discrimination associated with the disorder, the obvious implications of diagnosis to long-term survival, the

impact of discovering an illness which may have already infected loved ones in the family, and the direct and indirect effects of HIV and secondary neoplastic and infectious diseases on the brain. The effect of caring for terminally ill persons on the mental health of carers is now recognized as an important cause of CMD. There are reports that women, who are often carers for persons with HIV/AIDS, suffer considerable mental and physical health problems as a result of care-giving and that depression, in particular, is common.

Health Care Utilization

The health system is not without its contribution. Women are known to use health services, especially mental health services, less frequently. The kind of treatment offered to them is also discriminatory. Behaviours such as sexual abuse of women patients, misconduct by mental health professionals towards women clients and the increasing use of certain discriminatory procedures having little or no justification are all examples of violence against women. Several researchers have drawn attention to the association between Caesarian sections and mental health morbidity in several countries. A similar association has been noted between infertility and childlessness and mental health, especially in societies which are quick to single out women as the lone cause for this. A barren woman is often looked down upon, especially if she is also illiterate and unable to contribute financially to the family. On the other hand, many women in Asia and Africa have to bear the physical and emotional burden of bearing and caring for a large number of children. Denied the right to decide on the use of contraceptives or other family planning measures or bereft of easy access to it, these women often feel deluged by the aftermath of repeated deliveries, often in quick succession, taking a heavy toll on their nutritional status, and emotional well-being. Refusal to have a child is still considered a kind of sacrilege in some societies.

Evaluations of services for women with long-term mental health problems have underscored the need to set right the unevenness in the access and utilization of mental health services among the genders. Services should be made attractive to women and agencies and facilities outside mainstream mental health services should be supported to accommodate women with long-term mental health problems.

Future Directions

Women's mental health is increasingly recognized as a major public health concern with impact on the well being of individuals, families and society. It is also recognized that this field is in its infancy, calling for more research and the development of policies and programmes consistent with the broader definitions of health.

The last two decades have witnessed a growth of self-help movements in women's groups, and some local groups have been outstanding in their efforts. Examples of this are the spearheading of anti-alcohol movement by women in the South Indian state of Andhra Pradesh and the activities of local women in Sumatra to operate a primary

health clinic. There is an urgent need to strongly reinforce such movements, since they are all measures which will strengthen self-esteem, enhance problem-solving abilities, and reinforce autonomy and assertiveness skills.

It is equally important for treating clinicians to be sensitive to the mental health impact that various disorders and their interventions can produce.

Policy planners also play a critical role since any comprehensive strategy to improve the mental health of women necessitates coordinated action. This involves improvement of policies and legislation, better access and availability of health care facilities, better health education, and determination of safety at the places where women live and work. An enhanced gender sensitivity in all walks of life will certainly augur a better future for the mental health of women.

References

1. The World Health Report. World Health Organization, Geneva, 1998.
2. United Nations Development Programme, Human Development Report. New York, Oxford University Press. 1997.
3. Murray JL & Lopez AD. The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Summary. Boston: Harvard School of Public Health, World Health Organization, 1996.
4. Patel, V., Araya, R., Lima, M. S., Ludermir, A., and Todd, C. Women, Poverty and Common Mental Disorders in four restructuring societies. Social Science and Medicine 49, 1461-1471. 1999.
5. Mumford DB, Saeed K, Ahmad I, Latif S, Mubbashar M. Stress and psychiatric disorder in rural Punjab. A community survey. British Journal of Psychiatry. 170:473-8, 1997
6. Davar B. The Mental Health of Indian Women: A Feminist Agenda. New Delhi: Sage (India); 1999.
7. Hussain, N., Creed, F., and Tomenson, B. Depression and Social Stress in Pakistan. Psychological Medicine 30, 395-402. 2000.
8. Listening to Women Talk about their Health: Issues & Evidence from India. New Delhi: Ford Foundation; 1994.
9. Dennerstein, L., Astbury, J., and Morse, C. Psychosocial and Mental Health Aspects of Women's Health. WHO/FHE/MNH/93.1. World Health Organization. 1993
10. Malik S. Women and Mental Health. Indian Journal of Psychiatry;35:3-10, 1993.
11. Subramaniam, V. The impact of globalization on women's reproductive health and rights: a regional perspective. Development 42, 145-149. 1999.
12. Thara R. and Rajkumar S. Gender Differences in Schizophrenia, Results of a follow-up study from India. Schizophrenia Research, 7 , 65-70 1992.
13. Thara R & Srinivasan TN . How stigmatizing is schizophrenia in India? The International Journal of Social Psychiatry. 46(2):135-41, Summer 2000.
14. SCARF publication. A Study of Mentally Disabled Women. 1998
15. Biswas S, Roy S, Debnath C & Sengupta SB. A study of attempted suicide in adolescents in west Bengal. Indian J. Of Psychiatry, 39, 54-55, 1997

16. Mallone K, Mc Cormack G & Malone JP. Non-fatal deliberate self-poisoning in Dublin's North Inner City- an overview. Irish Medical Journal, 85 (4): 132-135,1992

17. Fikree FF, Bhatti LI. Domestic Violence and Health of Pakistani Women. International Journal of Gynaecology and Obstetrics ,65(2):195-20,1999.

18. Jejeebhoy, S. Wife-Beating in rural India: a husband's right? Evidence from survey data. Economic and Political Weekly (April 11), 855-862. 1998.

19. Desjarlais R, Eisenberg L, Good B & Kleinman A. World Mental Health, Problems and Priorities in Low Income Countries. New York: Oxford University Press, 1995.

20. Patel, V. and Oomman, N. M. Mental Health Matters Too: Gynaecological Morbidity and Depression in South Asia. Reproductive Health Matters 7, 30-38. 1999.

21. Bang R, Bang A. Women's perceptions of White Vaginal Discharge: ethnographic data from rural Maharashtra. In: Gittelsohn J, Bentley ME, Pelto PJ, Nag M, Pachauri S, Harrison A et al., editors. Listening to Women Talk about their Health: Issues & Evidence from India. New Delhi: Ford Foundation; p. 79-94, 1996.

22. Kumar R. Postnatal Mental Illness: a transcultural perspective.. Social Psychiatry &.Psychiatric Epidemiology; 29:250-64, 1994.

23. Gautam S, Nijhawan M, Gehlot P. Postpartum psychiatric syndromes: an analysis of 100 cases. Indian Journal of Psychiatry, 24:383-6, 1982.

24. Kit, L. K., Janet, G., and Jegasothy, R. Incidence of postnatal depression in Malaysian women. Journal of Obstetric & Gynaecological Research 23, 85-89. 1997.

25. Eddleston, M., Rezvi Sheriff, M. H., and Hawton, K. Deliberate Self-Harm in Sri Lanka: an overlooked tragedy in the developing world. British Medical Journal 317, 133-135. 1998.

WHO, World Bank and Asian Development Bank Partnership at the Country Level: The Indonesian Example

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Introduction

THE World Health Organization (WHO), the World Bank (WB) and the Asian Development Bank (ADB) enjoy a strong partnership in Indonesia, which intensified during the economic crisis beginning in late 1997. The roles of these organizations are complementary and increasingly interdependent. WHO recognizes that national health development is closely related to economic development, especially regarding the elimination of poverty. The banks, in turn, recognize that investments in health are needed to promote national development. The major areas for collaboration include health policy formulation, identification of key programmes to support, local implementation of programmes, and institutional development. Mechanisms for collaboration include formal and informal general discussions on health-related issues, including challenges facing Indonesia and potential areas for WB and ADB support to the government; technical discussions on project and health sector loan preparation; and ongoing dialogue during project implementation.

General Discussions on Health-related Issues and Challenges

WB and ADB country staff involved in health-related matters, as well as WB and ADB headquarters staff visiting Indonesia, meet with the WHO Representative and other appropriate WHO staff to review the current health situation in the country, discuss ongoing WB and ADB technical assistance

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missions that may result in WB and ADB loans, consult on the implementation of existing WB and ADB loan-supported projects and their response to the changing health challenges, and brainstorm on potential new WB and ADB technical assistance and loan projects that could be developed for priority health problems. WHO plays an advocacy role with WB and ADB, as well as other potential donors in the health sector, to increase investments in health – especially for high priority areas, such as polio eradication, reduction of maternal mortality, control of tuberculosis, and supply of essential drugs.

WHO often chairs, co-chairs or assists the government in organizing donor and development partner meetings on the health sector in general, or on a specific health programme. For such meetings, WHO invites WB and ADB country staff, as well as any of their headquarters staff involved in health-related matters who may be in the country at the time, to attend these meetings. An example is the invitation to the quarterly meetings of donor and development partners with the Ministry of Health (MoH) on the Safe Motherhood and Reproductive Health initiative co-chaired by WHO and MoH. At these meetings, a specific area of concern is presented with background papers (topics have included the Safe Motherhood Management Information System, Social Mobilization and IEC for the Safe Motherhood Initiative, Resource Mobilization for the Safe Motherhood Initiative, STD and Safe Motherhood, and Intersectoral coordination on Safe Motherhood), followed by discussion on the topic, and concluded with the opportunity for the donor and development partners to share information about their current and proposed project areas. Such meetings help to exchange information and develop a "donor matrix" that facilitates identifying potential areas of donor "overlap" of projects and pinpointing "gaps" in funding or technical assistance that remain in high priority areas. WB and ADB staff have made valuable contributions during these meetings, including presenting topics such as "ADB III Project: Referral System Implementation Strategy." Another example was the convening of a donor and development partners meeting on malaria control, with WB and ADB participation, that has helped to stimulate an Indonesian response to the new WHO Roll Bank Malaria initiative.

The Current Economic Crisis and its Impact on Health

More recently, in the face of the economic crisis affecting Indonesia. WHO has chaired or co-chaired meetings between MoH and the development and donor partner community regarding the economic crisis and ways that MoH can be supported to minimize the impact of this crisis on health (copies of the notes for the record are available from WHO on request and are also available on the WHO Indonesia website: www.who.or.id). WB and ADB have been active participants at these meetings which have included, in addition to Indonesian Government representatives, other UN agencies, bilateral development assistance agencies, and nongovernmental organizations.

WB and ADB have also taken initiatives in areas involving health and have, on those occasions, invited WHO to participate. A notable example has been the donor meetings on Social Safety Net Issues in

Indonesia, convened by WB, during which WHO was invited to present an overview of the issues involving the health component of a social safety net. WB also convenes annual and special meetings of the Consultative Group on Indonesia (CGI) that have, on occasion, included health issues and in which WHO has sometimes participated.

WB, ADB and WHO are currently working together in WB and ADB's development and implementation, with the Government of Indonesia, of large multi-million dollar loans for supporting a "social safety net" that includes elements for the health sector, such as provisions for operations costs for health centres to ensure that access to primary health care for the most vulnerable segments of the population is maintained. A Social Monitoring and Early Response Unit (SMERU) was created, administered by WB, to monitor implementation of the social safety net programmes by empowering cooperation between civil society and the government.

Technical Discussions on Project Preparation

WB, ADB and WHO have had extensive technical discussions during technical assistance missions for project design and preparation. A recent example has been the ADB technical assistance leading up to the ADB loan for the Intensified Communicable Diseases Control (ICDC) Project focusing on Tuberculosis, Immunization, ARI, Malaria and Surveillance. Three WHO long-term medical officers in Indonesia (for Tuberculosis, for Integrated Management of Childhood Illness, and for the Expanded Programme on Immunization) and WHO national consultants worked side by side with ADB headquarters and country staff, ADB technical assistance consultants and MoH staff to design and refine the ICDC project. In addition, the WHO Regional Adviser on Malaria in the South-East Asia Regional Office (SEARO) provided technical comments on the Malaria portion of the Technical Assistance document. Other recent or ongoing ADB technical assistance missions, in addition to the social safety net project mentioned in the previous section, in which WHO and ADB are collaborating, include the technical assistance for Resource Mobilization and Budgeting for Decentralized Health Services, for Reproductive Health Care, and for Capacity Building of MoH for Strategic Development.

WB and WHO have also worked in partnership on project preparation. WB in Indonesia credits WHO for the strong advocacy efforts that influenced their lending and project supervision in reproductive health that was included in the Fifth Population Project (a project designed to strengthen collaboration between MoH and the National Family Planning Board) and a follow-on project in Safe Motherhood that is designed to build community demand for safe motherhood and improving training and career opportunities for village midwives (Bidan de Desa). WHO also worked closely and extensively with WB in preparing the Health Professionals (HP5) project which focuses on the development of health manpower, especially nurses and midwives. WHO provided country budget funds to support studies during the assessment period, sent an international consultant to ensure that WHO strategies were considered, and supported national consultants to assist full time in the project preparation. This shows

how the more limited resources of WHO can be effectively used to "leverage" a much bigger project than could ever have been funded by WHO alone. Recently, WHO professional staff – both international and national – have worked with WB by providing technical input into the "health link" of the multi-million dollar "Social Safety Net" loan.

Ongoing Dialogue During Project Implementation

After WB and ADB supported projects enter their implementation phase, WHO, WB and ADB continue their collaboration. A good example is the collaboration throughout the implementation of the Rural Health and Population Project. The ADB loan-supported project staff work closely with WHO staff, including the WHO Representative, the WHO Planning Officer, the WHO Reproductive Health Officer, the WHO District health Systems and Quality Assurance Officer, and the WHO Integrated Management of Childhood Illnesses Officer as well as the WHO national consultants for these programmes. The ADB loan-supported Rural Health and Population Project has been a partner with MoH and WHO in adapting and field-testing materials for the Integrated Management of Childhood Illnesses and the Safe Motherhood and Reproductive Health initiatives, as well as in developing models for district health referral systems and quality assurance. Lessons learned from field tests in ADB loan-supported project areas are used to further refine these materials and models.

Another example is the continuing WHO technical collaboration with the ICDC project in its implementation phase. In November 1998, a meeting of all WHO professional staff with ADB headquarters and country staff was held at the WHO office to discuss the ongoing partnership between the two agencies and the progress in this ADB-funded project as well as other ADB-funded projects and health sector loans. There is ongoing negotiation between ADB, WHO and MoH regarding the possibility for WHO to provide the 24 man-months of effort for malaria technical assistance identified in the project under a mechanism whereby loan funds from ADB provided to the government would be used by MoH to contract for this technical assistance from WHO. The advantage of this mechanism is that it helps ensure that the consultant is placed directly in MoH with counterparts, the WHO country office is available for logistics support, and the WHO Regional Office and headquarters are available for technical backstopping. The mechanism would be similar to that of the provision of WHO technical assistance for the WB Community Health and Nutrition (CHN3) project described below.

An example of the continuing partnership during project implementation between WB and WHO is the WB community health and Nutrition (CHN3) project. In this project, a WHO Technical Officer for district health system and quality assurance was recruited to provide technical assistance. The loan funds, with WB permission, were used by MoH to contract for two years of full time WHO technical assistance. This very close partnership between WB, MoH and WHO provided an opportunity for daily working contact in this project area and helped to focus WHO technical resources, not only from the country but also from the Regional Office and Headquarters as well, to this important subject area. As a result, MoH

placed a sufficiently high priority to this technical assistance that the post was retained using WHO country budget funds.

The expertise available from WHO collaborating centres have also been utilized in the activities of WB and ADB loan-supported projects. These centres of excellence (e.g., WHO collaborating Centre for New, Emerging and Re-Emerging Infectious Diseases in Jakarta) collaborate with WHO technical programmes and help extend the manpower and technical assistance available, in conformity with WHO policies and strategies, at the country level.

Lessons Learned

From the experience of WHO, ADB and WHO collaboration to date, a number of factors facilitating partnerships have emerged, including the following:

- Fostering an atmosphere of collaboration at the headquarters and Regional Office levels helps enable country offices of WHO, WB and ADB to collaborate, and vice versa. Examples of such efforts include the meetings to discuss mechanisms and modalities of collaboration held in WHO headquarters in 1994 between WB and WHO (with selected government officials and WHO headquarters, Regional Office and country staff),[1] in WHO/SEARO in 1995 between ADB and WHO (with all WHO SEAR Representatives present), and in WHO headquarters in 1998 between ADB and WHO (with selected WHO headquarters, Regional Office and Country staff).
- WHO expertise is appreciated by WB and ADB in technical assistance missions as it helps improve project design, ensures that the state-of-the-art policies and strategies are considered, and provides and additional "seal of approval" helpful to senior management at WB and ADB in their decisions on project funding and level of funding.
- WB and ADB support is appreciated by WHO as it helps disseminate and put into operation WHO policies and strategies (suitably adapted to local conditions by MoH at the country level) on a much wider scale than WHO's or the government's own limited resources would otherwise allow.
- personalities and working relationships that encourage cooperation rather than competition, including respect for the comparative advantage of each organization and the desire to synergize, also greatly facilitates collaboration. This is fostered by government policies that encourage donor and development partner collaboration.

In addition to those factors that facilitate partnerships, there are also factors that may operate as constraints at the country level, including the following:

- The assignment of donors to selected working areas in the provinces, usually not overlapping, does help to ensure that there is no duplication of effort in the same geographical area, but may also reduce the "cross fertilization" that would more easily occur if donors

worked together in the same areas. WHO is working with MoH and donors, including WB and ADB, to provide fora (e.g., quarterly meetings on Safe Motherhood and Reproductive Health) in which experiences and lessons learned are shared so that "re-inventing the wheel" phenomena can be minimized and effective strategies quickly disseminated.

- Institutional differences of opinion. Occasionally there arise institutional differences of opinion regarding policies or strategies. These may result from either local decisions or from global policy differences. Continued dialogue, in an amicable and partnership atmosphere, and sometimes with the benefit of coordinated policy decisions made at the headquarters' levels of both organizations, have been able to overcome such differences of opinions.

Conclusions

WB, ADB and WHO in Indonesia have enjoyed fruitful collaboration over many years that has recently intensified. There is a trend, especially within WB and WHO, to strengthen their country offices which will also help to place more decision-making authority at the country level. The World Bank, for example, has recently decentralized some of its operations, such as that the WB Resident Representative is now the WB Country Director. Current and future WB and ADB loan-supported projects for a Social Safety Net, including health, will provide additional opportunities for collaboration between WB, ADB and WHO in Indonesia. It is hoped that the examples and lessons learned from this collaboration, as outlined above, will provide a foundation for even further collaboration in Indonesia as well as in other countries.

Acknowledgement

The authors would like to acknowledge the collaborative efforts between staff (both professional and support staff) of MoH, WB, ADB and WHO at country, regional and headquarters levels that have helped to make Indonesia a good example of WB, ADB and WHO collaboration at the country level.

References

1. World Health Organization, "World health Organization/World Bank Partnership: Recommendations for Action for Health Development." WHO/World Bank Review Meeting. WHO/INA/95.1.

Role of Private Hospitals in Health Care

Dr Uton Muchtar Rafei and Dr U Than Sein***

Introduction

THE development of the practice of allopathic medicine has been commensurate with the increasing number of hospitals. These medical establishments have been classified into two basic categories: private facilities usually run by private-for-profit agencies or charitable organizations or public hospitals supported by public funds. These facilities were earlier established for the care of acute and chronic infectious and non-infectious diseases, maternal and child health and mental illness. Whether they are large or small in terms of bed strength, hospitals have traditionally been regarded by the layman as important and rather awe-inspiring institutions for the health care. With the advances in scientific and technological development, the number of hospitals, especially in the private sector, has increased tremendously during the last few decades. Private health care, especially in Asia, is also growing rapidly with its parallel economic growth. In some cases, the growth in the health sector is more than the national economy can handle. This over-investment has resulted in underutilization and financial loss, as seen in many countries that faced economic crises recently.

Historically, hospitals have accounted for the bulk of all health care spending in the development of health services. At the same time, the major proportion of hospitals in most countries of the Region is in the private sector. This paper reviews the role of private hospitals in health care with particular reference to India.

Health Situation

When the trend of development, using the human development index (HDI) in selected Asian countries (ASEAN and SAARC), is analyzed, there is a wide variation both in terms of total magnitude and the excess gained during the same period as shown in Figure 1.

The HDI is a composite measure of the quality of human life in terms of development in health (life expectancy), wealth (per capita income) and education (educational attainment). While Singapore and Brunei Darussalam have achieved high HDI values,

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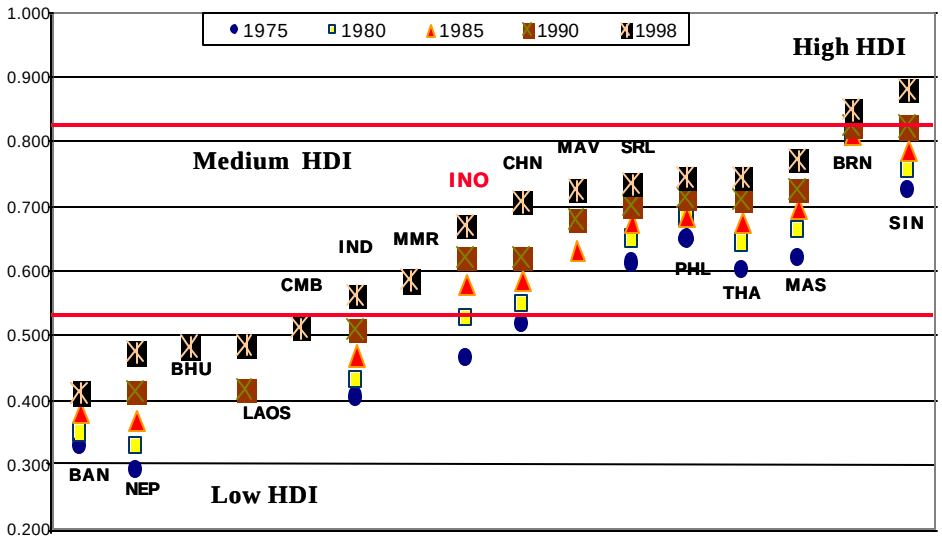
Figure 1: Trends of Human Development Index among WHO-SEAR Countries

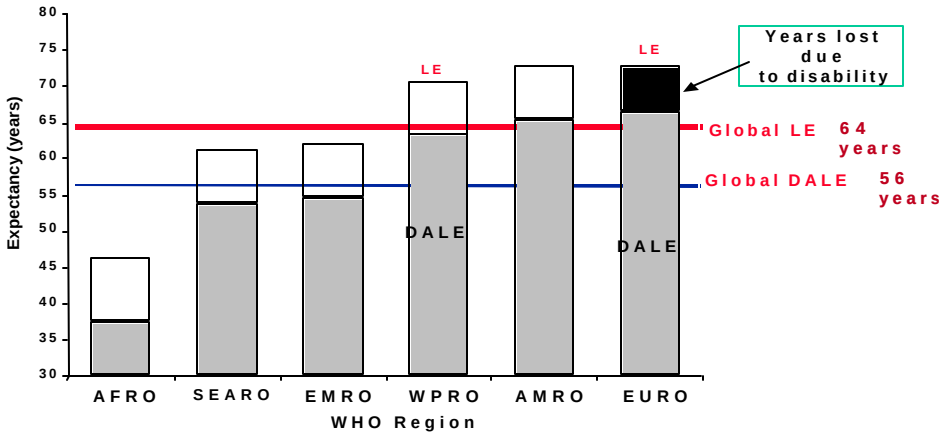


Source: UNDP Human Development Report 2000

other ASEAN countries, a few SAARC countries and China fall into the medium range. Cambodia and Laos (ASEAN), and Bhutan, Nepal and Bangladesh (SAARC) still fall in the low-HDI group. When comparing the values of each country over a period of more than 20 years (from 1975 to 1998), we find that Nepal has achieved higher growth in relation to Bangladesh and Laos. Similarly, Indonesia and China have performed well compared to Malaysia and Philippines. If the index is computed using available data for India, the national average is around 0.57. While the states of Kerala, Maharashtra, Punjab and Tamil Nadu are at the upper end, Uttar Pradesh, Madhya Pradesh and Orissa are below 0.5, with Bihar being the lowest. This clearly reflects the difference in achieving human development status, based upon the differences in policies, economies and other aspects of social development.

The main goal for any health system is to achieve the highest level of health for all people. Recently, many public health experts have been debating on summary indicators for measuring the health status. No measure is perfect for the purpose of summing up the health of a population. Life Expectancy at Birth (LEB) has been used for a century as a summary measure to compare the progress of health status between gender and population groups. A new summary measure of the health status recently introduced and being much debated is 'Disability-adjusted life expectancy-DALE'. DALE is also referred to as "Healthy life expectancy", as it deals with healthy survival. It is estimated from the life tables for each country and adjusted with estimates for disability and other non-fatal health outcomes.

Figure 2: Disability-adjusted life expectancy (DALE), years lost due to disability, and life expectancy (LE) at birth, for total populations, WHO Regions, 1999



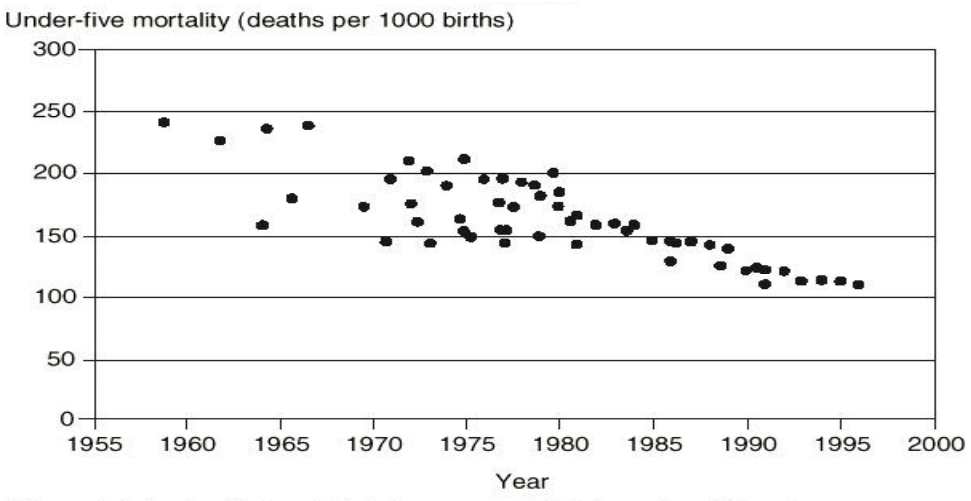
As reported in the World Health Report 2000 (Figure 2), the global average LEB is around 64 years and the global DALE average is around 56 years. Around 24 countries of the world, mostly in Europe and North America, Japan and Australia, have equal to or more than 70 years of DALE. The lowest-ranking 32 countries have DALE of less than 40 years. Except Afghanistan, all countries in this category are in the sub-Saharan Africa. The rest of the WHO Member Countries fall in-between. Sri Lanka, Thailand and Indonesia are in middle-rank with DALE around 60 years, while other SEAR countries have around 50 years of DALE. India's DALE at birth for both sexes is around 53 years.

A similar analysis using other health status indicators also shows many health gaps among countries. The major constraints contributing to these health gaps are the lack of strong political commitment to health for all and primary health care; weak inter-sectoral collaboration; inadequate allocation, and inequitable distribution of health resources, among others. The slow economic growth and the recent economic crises that affected some Asian countries have impeded the progress towards health for all.

Specific to India, the analysis of under-five mortality for the last 50 years shows that the rates have decreased by half. But not much progress has been made in recent years, despite heavy investment in maternal and child health programmes. (See Figure 3).

If the comparison between different states of India is made, as shown by trends of infant mortality rate (IMR) among major states in India during 1990-1998 (Figure 4), there is a lot of disparity. While some states have maintained a low level of mortality, a few still have unacceptably high levels. Moreover, the trend analysis between the rural and urban settings or between the sexes reveals that the gaps remain the same.

Figure 3: Trends in U-5 Mortality 1958-1996 India



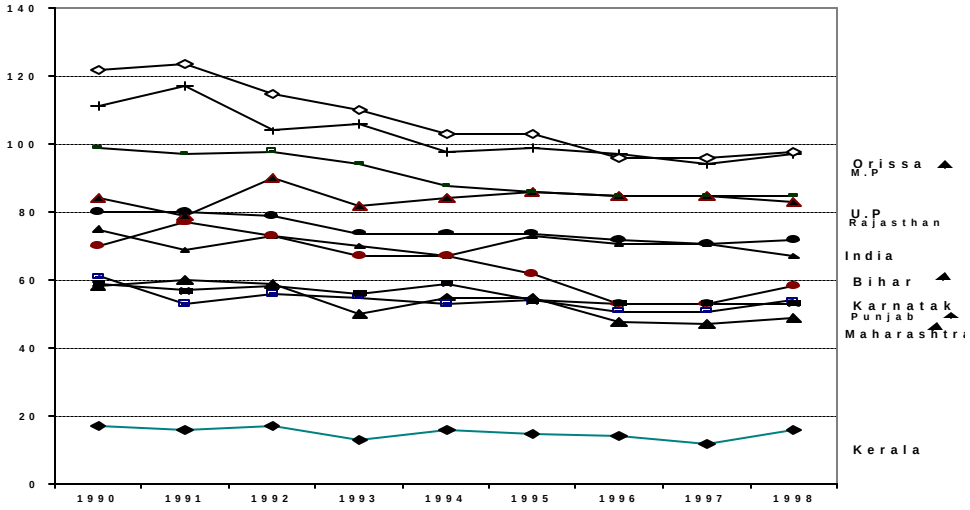
* Separate dots at particular points in time represent data drawn from different sources.

The WHO South-East Asia Region could be divided into two main groups of countries based on the epidemiological situation. One group, consisting of Indonesia, Thailand and Sri Lanka, has low child and adult mortality, while the other group, consisting of India and others in the Region, has high child and adult mortality. The people in the former group of countries have suffered more due to noncommunicable diseases such as cardiovascular diseases and accidents/ injuries. The major mortality in countries of the latter group is due to emerging and re-emerging communicable diseases, such as malaria, measles, tetanus, diarrhoea, tuberculosis, kala-azar, acute respiratory infections (ARI) and HIV/AIDS. India still accounts for around 20 per cent of the global disease burden, with communicable diseases accounting for about 50%, noncommunicable diseases 40% and injuries 9% as the national average. The disease burden estimates for India for the year 2020 indicate that the majority of the burden would be on account of noncommunicable diseases, including cardiovascular diseases and cancer, injuries and accidents.

Hospitals

Private hospitals in India constituted nearly 66 per cent of total hospitals in 1993. Government-owned hospitals accounted for around 31% and local bodies own the rest. When analyzed by hospital beds by ownership, there are more beds in government institutions-62%, while private hospital beds constitute 35% only. The majority of private hospitals have smaller bed capacity. About 85 per cent of hospitals in the private sector have a capacity of fewer than 25 beds. Most private health institutions have an average of 10 beds. About 36 per cent of private hospitals and 30 per cent of their beds

Figure 4: Trends in Infant Mortality Rates in Major States of India 1990-1998



* 1998 figures are provisional
Source: Registrar General of India, Sample Registration System

are in rural areas, as compared to 25% government hospitals and 10% of their beds.

Many studies on the utilization of health care in India show that people generally prefer private health care facilities. Cost analysis shows that the costs of hospital care in either public or private facilities, especially paying services, do not show any difference. (See the following Table)

User Costs and Duration of Stay

Particulars	Rural		Urban	
	Govt	Pvt	Govt	Pvt
Payment to hospitals (Rs per episode) All wards	320	735	385	1206
Total Expenditure (Rs)				
Free ward	582	975	630	666
Paying General Ward	1421	1393	1040	1031
Number of days stayed				
Free wards	17	16	17	11
Paying General Ward	17	10	19	12

Source: NSS, 1992 & VHAI 1997

Health Systems

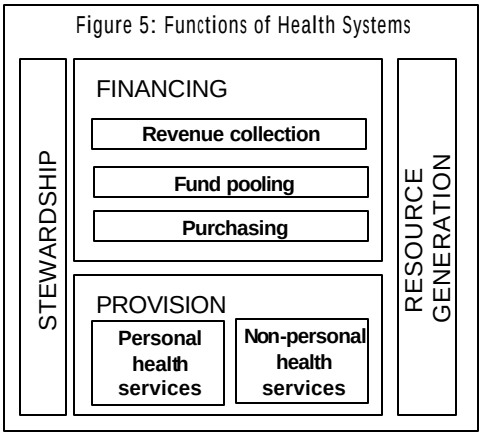
The structure of health systems can be described in different ways. Roemer in 1991 identified five major groups: resource production; organization; management; economic support, and delivery of health care. The OECD in 1992 categorized national health-systems by dividing them under voluntary or compulsory insurance coverage or public-financed. During the last few decades, different types of health systems have been classified to illustrate the differences in performance, as under:

- the dominant method of financing (public or private financing, universal, insurance, out-of-pocket payment, etc.)
- the level of economy and income (industrialized, transitional, least-developed or high, medium-or-low income)

- the underlying political philosophy (capitalist, socialist, welfare).

The World Health Report 2000 describes the comparative analysis of health systems based upon four major functions, namely: Financing (revenue collection, fund pooling, purchasing care); Provision of care (personal or non-personal); Stewardship, and Resource Generation (Figure 5).

Figure 5: Functions of Health Systems



The major determinant of health system performance is related to how the health system is being financed and/or how health care is being provided. In India, it is estimated that the total health care expenditure as a percentage of gross domestic product is about five per cent. Private health expenditure constitutes around 63 per cent of total health expenditure. Private expenditure includes mainly out-of-pocket costs incurred by households. About 4-6 per cent of the total expenditure is covered by different social health insurance schemes. Individuals have to purchase health care of their own choice, while it is the private providers who mainly control the health care market.

There is a disproportionately high allocation to the tertiary level of hospitals at the expense of first-referral facilities and preventive and promotive care. The annual allocations for the non-salary component of hospital budget, especially in public and private institutions, have shrunk. On top of this, these health care institutions are running low on efficiency, and are undermining the capacity for planning and management and the capability to cope with health emergencies. A broader hospital sectoral reform is envisaged.

Issues

What role is being played by private hospitals in health care in India?

- Do the private hospitals still function as health care facilities or are they jointly functioning as academic, research and training institutions? Most of the large private hospitals in India are not just providing hospital service, but are also acting as academic, research and training institutions. Most of them also provide services to the public to some extent, free of cost. With the rising cost of maintenance and investment, there is a need to review the existence and expansion of big private hospitals.
- Should the hospital sector be open to foreign investment? India has announced that foreign investment could be made in the hospital sector within the framework of a multilateral international trade agreement - General Agreement on Trade in Services (GATS). Services are normally thought to be intangible, non-transferable economic goods. Health care services also fall into this category of tradable goods and trading may be done either by providing services across borders; by consumption

abroad (getting health care in other countries); by foreign direct investment or by movement of personnel serving abroad. How do Indian hospitals, existing or planned, deal with this globalization? While many hospitals in India have received foreign nationals for providing care, especially special care services, many Indian nationals are also going abroad, seeking various health care services. During the last decade, foreign investment in the hospital sector has increased tremendously. Many feel that such investment enhances job opportunities, reduces the number of nationals going abroad for health care, and increases the competition for quality health care. It might also remove the burden on the public sector. Some feel that these foreign-invested private institutions attract the best human resources from the public sector and thus contribute to internal brain drain. Heavy reliance on foreign investment and foreign expertise might also lead to the squeezing of the domestic sector and thus, the smaller, less competitive health institutions would get edged out.

- Should the bed strength be kept small? The majority of private hospitals in India are small, with an average bed strength of less than 25 per establishment. With a smaller establishment, there is a tendency to practise quality assurance as well as economies of scale in managing hospital waste and deploying staff.
- Should private hospitals be regarded as nursing homes or general and specialized health care institutions? During the last few decades, private hospitals of different types have increased in number with a proportional increase in the number of beds as well. Many of them are registered as nursing homes, but in fact provide acute and chronic hospital care. A few cater to specific areas such as cardiac by-pass, kidney transplant, eye care or neurology. Medical and para-medical professionals, with the support of business entrepreneurs, are taking advantage of the rapid growth in the hospital sector. There is a tendency to expand the small and medium-scale superspeciality nursing homes as compared to large-sized, multi-speciality hospitals. A few hospitals also serve as general and speciality diagnostic centres.
- Do they want to change the management practice – ownership (public, private, for-profit, not-for-profit, different mix) or management by autonomy or corporate? As per available information, about 66 per cent of hospitals are owned by the private sector. The private, for-profit sector owns the majority of hospitals, while the rest are managed by the private, not-for-profit sector, including voluntary organizations, charitable institutions, religious missions and trusts. Attempts are also being made to change the management practices of public hospitals by providing autonomy in management. Hospitals are to be managed as hotels.
- What will be the financing arrangement? Investment in public hospitals is through general taxation. In many public establishments, different forms of user-fees have been introduced. Out-of-pocket expenditure for hospital care is high both for public and private health institutions. Comprehensive social

health insurance coverage is limited. A few employees, mainly government employees and workers in the formal private sector, are fully covered with different health insurance schemes. In some parts of the country, a few community health-financing schemes, including social insurance, have been initiated with limited coverage.

- What about quality assurance – medical audit, accreditation? India has recently adopted different regulations related to drugs, medical practice and facilities in the private health sector. There is a need to increase the awareness of such regulations for the general public as well as for professionals. The implementation and enforcement of these regulations varies from state to state. While India has many hospitals accredited with international ISO standards, concerns have been expressed on the quality of care in many instances.
- How could hospital sector policy and reform address the challenges and opportunities of globalization? Globalization is inevitable and desirable. There is a need to initiate dialogues between trade, commerce, health and legislators, in order to promote the hospital sector as an opportunity for international trade and economic growth, while public health interests are taken into account. Introducing competition and opening up of the hospital sector must be accountable for social justice and equity.

Conclusion

The success of reforms in hospitals depends upon the update of the national hospital policy within the framework of national health policy. There is a need to improve public information and education on the use of private hospitals. Some form of risk-pooling and sharing of costs should be promoted, to ensure a reduced burden on poor households. Private hospitals are also required to meet the health challenges of the coming decades. There is a need to encourage dialogue among professionals, trade unions, commerce and trade people and legislators, so that new and desirable strategies and policies are framed, addressing globalization in the hospital sector. The time for action is NOW.

References

1. Newbrander W. (ed.); Private Health Sector Growth in Asia-Issues and Implications, New York, John Wiley and Son; 1997
2. Srinivasan A.V. (ed.); Managing a Modern Hospital, Sage Publications, London; Sage Publications; 2000
3. Berman P. and Khan M.E. (ed.); Paying for India's Health Care, London; Sage Publications; 1993
4. Berman P. and Kutzin J.; Public Hospitals in Developing Countries – Resource use, Cost, Financing; Washington; World Bank; 1993
5. World Health Organization; World Health Report 2000-Health systems: Improving Performance, Geneva; 2000

TRIPS and Access to Medicines

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Introduction

THE creation of the **World Trade Organization (WTO)**[1] in January 1995 led to rapid expansion of international trade in goods and services. WTO is the legal and institutional foundation of the multilateral trading system, as a successor to the General Agreement on Trade and Tariffs (GATT). The latter was a unique international institution, established in 1947 by means of a treaty among 23 nations. GATT was, in fact, used as an international instrument, whose objective was to promote and regulate the liberalization of international trade through "rounds" of trade negotiations. The eighth round of multilateral trade negotiations held under the auspices of GATT in Uruguay from 1986 to 1994 led to the establishment of the World Trade Organization.

WTO is the only international organization dealing with rules of trade between nations. It is charged with setting the legal ground rules for international trade, and all matters related to international trade fall within its jurisdiction. WTO provides the principal contractual obligations determining how governments should frame and implement their trade policies, thereby helping them in as free flow of trade as possible. It is also the platform on which trade relations among countries evolve through collective debate, negotiation and adjudication.

WTO members have to undertake to abide by its rules or instruments. There are over 141 members with 33 observers as of May 2001. Seven countries of WHO South-East Asia (Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand) are full members of WTO, while Bhutan and Nepal have obtained Observer status. DPR Korea has not yet applied for membership.

The multilateral trade agreement managed by WTO contains 29 individual

[1] Detailed information is available in the booklet "Introduction to the WTO-Trading into the Future", published by WTO, Second Edition, July 1998. Information can be obtained by visiting the Website http://www.wto.org/ english/thewto_e / whatis_e/ tif-e/tif_e.htm.

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agreements, covering all matters from agriculture to textiles and clothing and from services to government procurement, rules of origin and intellectual property. Added to these are more than 25 additional ministerial declarations, decisions and understandings, which spell out further obligations and commitments for WTO members. The highest authority in WTO is the Ministerial Conference, which dominates the WTO structure and meets every two years. The General Council of WTO is the highest decision-making body, which meets regularly to carry out the functioning of WTO, and the day-to-day work of WTO falls upon Secretariat.

The World Health Organization (WHO), in collaboration with its Member Countries and other international agencies including those of the UN system, collected, analyzed and disseminated information on the health implications of the multilateral trade agreements of WTO. WHO and other international agencies, including nongovernmental organizations, have organized debates or involved themselves with the same subject at national, regional and international levels. The findings and outcomes of these exercises reveal that several of the WTO multilateral trade agreements do have direct implications on the health sector.

All WTO members must grant *patent* for any invention, whether product or process in all fields of technology, and patent rights will be enjoyable without discrimination as to the place of invention or origin of the product (imported or locally produced). *Patent* is a right granted by the public authorities, based on their national statutory laws, conferring a temporary monopoly for the exploitation of an invention upon the person who reveals it, furnishes a sufficiently clear and full description of it, and claim this monopoly. The right is enforceable for a specified period within the national territorial boundaries. There are two categories of patents, namely, product and process patents.

Many concerns and apprehensions on the implications of the TRIPS Agreement on the health sector were expressed at the 51st session of the WHO SEA Regional Committee in September 1998, and also at the Fourth Meeting of the Health Secretaries of the Region held in January 1999. Since then, a series of national case studies and research studies were undertaken and relevant expertise consolidated. These accumulated experiences resulted in a series of forums and meetings at both national and international levels. The WHO Regional Office for South-East Asia convened a regional consultation on WTO Multilateral Trade Agreements and their implications on health, including TRIPS, in August 1999 at Bangkok, Thailand. Based on the discussions at the ASEAN Health Ministers' Meeting, in collaboration with ASEAN, a workshop was organized on the TRIPS Agreement and its impact on pharmaceuticals, at Jakarta, in May 2000. WHO Headquarters also organized an interregional workshop on intellectual property rights in the context of traditional medicine in Bangkok, Thailand, in early December 2000. Later, in collaboration with WHO Headquarters an Intercountry Expert Group Meeting on globalization, trade and health: tools and training for national action was organized at New Delhi, India, in mid-December 2000.

For the last five years, the World Health Assembly debated the implications of the

TRIPS Agreement on the health sector in detail, while reviewing the implementation of the WHO Medicines Strategy. The Resolutions[2] of the Health Assembly charged WHO, in collaboration with Member States and other international agencies, ***to monitor and analyze the pharmaceutical and public health implications of these agreements.*** The findings will strengthen its Member States to effectively assess and subsequently develop appropriate medicines policy and related health policy and regulatory measures that address their concerns and priorities, and are able to maximize the positive, and mitigate the negative impact of the TRIPS Agreement.

The government sectoral ministries, which are primarily responsible for the negotiations and implementation of international trade agreements, are like foreign affairs, finance, trade and commerce, home affairs (legislation), science and technology, agriculture and forestry, transport, and industries. These ministries are the bodies directly concerned to deal with various technical areas of WTO. In some countries, there are national trade and commerce councils or parliamentary bodies, which are responsible for legislative and controlling authority.

In most instances, health policy-makers and health planners within the ministries of health were not involved in the formulation or implementation of multilateral trade agreements, including TRIPS, that might have major implications for health. The discussion on the issues relating to the TRIPS Agreement has become urgent, as more countries have started having experiences on implications in health. This paper is addressed to senior public health officials and other governmental officials who have to deal directly or indirectly with TRIPS and related matters with a view to providing them with summarized information on TRIPS and its potential implications for the health sector.

TRIPS

Agreement

Ideas and knowledge are increasingly becoming important parts of international trade. The development of new products and technology depends on invention, innovation, research, designing and testing. With the rapid advancement of science and technology, the development and transfer of technology have greatly contributed to an increase in international trade. There are still wide and varying degrees of national legislation and at the same time, proliferation of trade in counterfeit goods has become a growing source of tension in present day international trade. In the light of this, the Uruguay Round negotiated on the intellectual property issues and adopted a new and comprehensive international treaty, known as ***Agreement on Trade-related Aspects of Intellectual Property Rights* (TRIPS).**

The aim of TRIPS is to strengthen and harmonize certain aspects of the protection of intellectual property rights at the global level. The Agreement established a common set of standards for all countries, without differentiating on the basis of socioeconomic and technology development. It requires all WTO members to adopt in their laws minimum standards of protecting and enforcing nearly all forms of intellectual property rights, including those for pharmaceuticals.

[2] WHA52.19 and WHA54.11

The TRIPS Agreement covers both categories of intellectual property, viz., ***industrial property and literary and artistic property***. The first one deals with trademarks including service marks, patents, geographical indications, industrial designs, layout-designs (integrated circuits) and undisclosed information including trade secrets; and, the latter covers copyright and related rights.

The key message of the Agreement is that intellectual property rights are private rights, and they should be given effective and adequate protection to reduce "distortions and impediments" in international trade. It envisages a fair application of the principles governing the treatment of nations in general and most favoured nations in particular. Members are required to accept and implement all provisions of the Agreement unconditionally within the time frame provided.

- All WTO members must grant ***patent***[3] for any invention, whether product or process in all fields of technology, and patent rights will be enjoyable without discrimination as to the place of invention or origin of the product (imported or locally produced).
- Patent shall also be granted for microorganisms as well as non-biological and microbiological processes.
- Members may exclude from *patentability* certain invention if its commercial exploitation is prohibited for reasons of public order or morality or protection of human, animal or plant life or health. They are also permitted to exclude diagnostic, therapeutic and surgical methods, for the treatment of humans and animals. Plants and animals other than microorganisms are also excluded from patentability.
- The term of patent should be a ***minimum of 20 years*** from the filing date of patent application.
- There are provisions for the use of *patent without authorization of the patent holder*, with a number of conditions and limitations.
- In a dispute on the infringement of a process patent, the defendant could take responsibility for proving that the process is different from the patented one.
- Members are given a **transitional period** (with effect from 1 January 1995) during which they are required to bring their national legislation and practices into conformity with TRIPS provisions. The last dates for transitional arrangements were/are: the year 1996 for industrialized countries, the year 2000 for developing countries (as a general rule), the year 2005 for developing countries who had not introduced patent before joining WTO and the year 2006 for ***least developed countries***. There are provisions for further expansion of the transitional period by the least-

[3] Patent is a right granted by the public authorities, based on their national statutory laws, conferring a temporary monopoly for the exploitation of an invention upon the person who reveals it, furnishes a sufficiently clear and full description of it, and claims this monopoly. The right is enforceable for a specified period within the national territorial boundaries. There are two categories of patents, namely, product and process patents.

developed countries. However, members who introduced product patent system for pharmaceuticals only after TRIPS Agreement must provide exclusive marketing rights for five years to the applicant for the pharmaceutical and agricultural chemical product patents even before the expiry of the transitional period.

Relationship to Public Health and Medicines[4]

It is estimated that industrialized countries hold 97% of all patents, global multinational corporations 90% of all technology and product patents, while developing countries have few inventors, but only users. Except a few developing countries with middle-level income, most of other developing countries usually spend small resources for research and development, including those for pharmaceuticals. Before the TRIPS Agreement was in place, the major problems in intellectual property rights in all aspects, including production of pharmaceuticals, were the limited terms of the product and process patent, the short terms of protection, the broad scope for compulsory licensing and ineffective enforcement procedures in their national patent systems. However, after the TRIPS provisions are implemented within national legislation, keeping in view the obligatory nature of the Agreement, the situation might be totally reversed, especially in the developing countries.

The provisions in the TRIPS Agreement relating to the following areas are the concerns of the developing countries in general:

Patentability: The TRIPS Agreement requires WTO Members to grant patent protection for a minimum of 20 years for any inventions in any branch of technology. This provision is essentially aimed at pharmaceutical products and processes, which most developing countries and some developed countries have so far not covered in their national patent laws.

It is estimated that multinational companies have spent over US$ 100 billion on research and development of new chemical entities (medicines). Nobody could be expected to invest on such a scale without the guarantee that any resulting products will enjoy a strictly limited period of protection. However, because of the high prices of patented drugs and large amount of expenditure required for research and development (R&D) in the pharmaceutical field, some countries have chosen to relax their patent laws. Through the system of ***reverse engineering process***[5]**,** such countries meet their national requirements for drugs at a lower cost and develop their technology. Other countries with no pharmaceutical industry buy these drugs at competitive prices. This practice will be discontinued as soon as the TRIPS Agreement comes into force in such a country. If the national regulation on patent does not provide for this prohibition, or it is not respected, the Member in question may, pursuant to the

[4] Please see details in "Globalization and access to drugs, perspectives on the WTO/TRIPS agreement", WHO/DAP/98.9 Revised, WHO-Geneva, 1999.

[5] ***Reverse engineering process*** is a practice of discovering the manufacturing process of a product by working backwards from the finished product. This practice has often been used to copy original drugs in countries which do not grant patents for pharmaceutical products.

dispute settlement process, incur commercial sanctions by the WTO Dispute Settlement Body.

Members may exclude diagnostic, therapeutic and surgical methods for the treatment of humans and animals. The Agreement also authorizes certain exclusions from patentability for the protection of human, animal, or plant life. However, this will not be applicable to life-saving drugs to be sold in the market.

Patentability of the microorganism, microbiological and non-biological processes is also a very important issue, in view of its significant contribution to increasing the availability, for example, of therapeutic and human proteins through *in vitro* production, and of antibiotics and enzymes, and because of its particular impact on the introduction of new and improved vaccines. However, the nature of biotechnological inventions, which find their origin in organisms existing in nature, is still in dispute. Indeed, a patent can only be granted for an invention, which is new, has inventive and is capable of industrial application, and not for a "discovery".

The difference between the number of new drugs that are developed globally each year, and the number of patents awarded for new uses of a drug or process or dosage forms, formulations and different forms of the same molecule, including patent on genes and genome sequences, is enormous. Countries need to establish standards or criteria to set for "new" and "inventive". Promotion of "generic drugs" requires appropriate legislation and regulations, which fall beyond TRIPS provisions. The Agreement does not prevent Members from requiring generic labelling and allowing generic substitution.

Effects of extending the term of a patent for 20 years: Under the TRIPS Agreement, all Members should *provide patent protection for a minimum of 20 years*. In many countries, 20 years of patent protection will result in increased duration of patent owner's monopoly.

In the pharmaceutical field, the logical consequence of this provision is that drugs will be sold at a high price, as is the case for all monopoly products, over a longer period of time. The manufacturers of generic drugs will have to wait for a longer time before they can produce the drugs in question and sell them at a more accessible price. In some developed countries, patents for drugs are available for usage, dosage and for combinations. New patents can be established even when the product or process patent on the basic drug – the active ingredient - may have expired long back.

Compulsory licensing: The provision in the Agreement for *use of a patent without authorization* of the patent-holder could be understood as being a *compulsory licence* that countries use for public health interests or patent holder. In any case, the patent holder still retains intellectual property rights and shall be *paid adequate remuneration* according to the circumstances of the case (Article 31). However, there are differences between the traditional provision of compulsory licence and the TRIPS provision. Many considered that the former is intended to serve public interest more, while the purpose of the latter is to protect the interests of the right holders.

The scope of this authorization under the TRIPS Agreement is very limited and a number of conditions must be fulfilled before applying compulsory licensing. Some of them relate to adequate remuneration being paid for such use (as mentioned above), taking into account the economic value of the authorization, only when efforts have been made to obtain the licence on reasonable commercial terms, and taking into account the supply factor of the domestic market. A licence can be granted in case of an emergency, but it should be suspended if such circumstances cease to exist.

Local working conditions: Another important aspect in the Agreement is the invalidation of local working conditions. Previously, many countries applied non-local working conditions to one of the grounds for compulsory licences. If the patented invention did not work for more than three years in the country in which the patent was granted, it could be authorized for public use. However, a new provision in the Agreement provides that patent rights shall be available, whether the products are imported or locally produced. This implies that it will no longer be possible to use prolonged non-working conditions as a ground for granting a compulsory licence. This new provision may affect the transfer of technology and national capacity of drugs.

Exclusive marketing rights have to be provided to the pharmaceutical product, for which patent was applied for after 1995 in the "mail-box system", in a Member Country where it is yet to be protected by the law if certain conditions are met. This will enable the patent holder to enjoy monopoly rights even if proper patent protection may not be available before the patent is granted.

Parallel importation is the importation, without the consent of the patent-holder, of a patent product marketed in another country either by the patent-holder or with the patent-holder's consent. It promotes competition for the patented products by allowing importation of equivalent patented products marketed at lower prices in other countries. Article 6 of the TRIPS Agreement explicitly mentions that practices relating to parallel importation cannot be challenged under WTO dispute settlement system, provided that there is no discrimination on the basis of the nationality of the persons involved. It is generally understood that parallel importation is effectively a matter of national discretion.

The burden of proof: Under the new rule of the Agreement, Member Countries must provide for reversal of the burden of proof in their legislations in a manner that a judge may order the defendant in legal dispute, to prove that the process to obtain his identical product is different from its patented process. This will strengthen the position of the patent holder at the cost of those who try to obtain the same product through another technological route. This may hamper small pharmaceutical industries, which may not have affordable expenses for the high cost of court process.

2.3 Possible Impacts

Protection of intellectual property rights aims at promoting innovation by providing incentive and investment in research and development. The magnitude of the impact of the TRIPS Agreement on a particular country would depend on its national legislation related to intellectual property rights (IPRs), market structure and

commercial investment, the situation of its local pharmaceutical industry, its legal environment, trade and foreign investment, the national health policy and national drug policy and other factors. All of these really make every country a special case.

One of the main objectives of TRIPS is to provide protection and enforcement of IPRs to contribute to the transfer and dissemination of technology in a manner conducive to social and economic welfare and balance of rights and obligations, and hence the issue is how to provide this objective in the national legislation on patent to minimize any negative impacts on health. The principle of the Agreement also permits adoption of measures to protect public health and nutrition, as well as public interest in the sectors of vital importance to socioeconomic and technological development. Therefore, national legislation may provide provisions by ensuring public health and nutrition and liberal use of the strengthened role of domestic industries, which are vital sectors for health care.

The Agreement also permits taking measures to prevent the abuse of IPRs, and restrain trade and international transfer of technology. Member Countries in this respect may take measures to prevent abuse such as continuous imports, non-working of patents, restrictions on export and withholding of transfer of technology. In the light of the definition of patentability, discoveries, new dosage form, new usage, new off-patent formulations (including combinations) can be excluded from national legislation. The conditions for the use of patent without authorization of patent holder are being provided in the Agreement, such as: use by the government or authorized parties in a situation of unsuccessful attempt for licensing by enterprise on reasonable terms and conditions, and national emergencies or extreme urgency or public non-commercial use should be incorporated in an independent section on national patent legislation since these are extremely important for health.

Countries may also allow exceptions to use inventions provided in the Agreement for research, teaching purposes, experimental test of improvement, and experiments for seeking regulatory approval for early marketing after the expiry of the patent (Bolar exception system) and non-commercial purpose. In regard to the exhaustion of IPRs, appropriate provision should be made on parallel import in the national legislation for importing medicines at reasonable prices.

As of 1998, the situations on national patent laws in SEA Region vary extensively. Maldives has not yet enacted a patent law. Bangladesh and Myanmar are reviewing and updating the Patents and Designs Act that existed since the British colonial period. Indonesia, Sri Lanka and Thailand updated their patent laws in the early 1980s and made amendments in 1990s to bring them in line with the provisions of the TRIPS Agreement. India enacted the Patent Act in 1970 and several amendments have been attempted since then. The term of patent varies from country to country. A few countries still do not grant patents for pharmaceutical products. The production and distribution of pharmaceuticals and related products will have to be taken into consideration while drafting the national drug policy, which is a component of the national health policy.

The TRIPS Agreement also relates to traditional medicine and knowledge. Thailand, in addition to its Patent Act, has adopted two national acts, namely "Protection and Promotion of Thai Traditional Medicine Intelligence Act 1999" and "Plant and Plant Varieties Protection Act 1999". A Community Forest Act for preservation of traditional plants is also under development. These acts cover protection of traditional knowledge (individual and national formulation), accessibility, the role of community and stakeholders, conservation, risk of extinction and public funds. Thailand has the experience of one traditional plant "Plao Noy" being over-exported and nearing extinction now. There are also issues for IPRs in relation to some traditional practices such as "Thai Massage-Nuad Thai". WHO Interregional Workshop on Intellectual Property Rights in the context of Traditional Medicine, held in Bangkok, from 6-8 December 2000, noted that the IPRs system may not be applicable to traditional knowledge or medicines which are simple and known for centuries, since no new chemical entities are involved in that procedures, and therefore, no issue of patent process can be raised. Trade mark does not belong to individual healers or universities, and the issue of trade secret will also, therefore, not be applicable, and the costs of obtaining and maintaining patents will be prohibitive.

In the national context, there may be different objectives for obtaining patent protection, either to obtain monopoly rights or to stop others from monopolizing. There is a dilemma in this respect such as public interest vis-à-vis private interest (individual or company); publish and share vs. keep it secret, get patent protection; desire to share the benefits widely vs. benefit financially; and ensure access to affordable medicines vs. commercial interests. Within and between countries, there is an absence of mechanism for equitable benefit sharing. There is an issue of biopiracy at the international level and lack of sharing with the community at large. There are different interests between owners of traditional knowledge and research institutions (national/foreign), different R&D priorities between industrialized and developing countries - traditional practitioners vs. modern health care providers; individuals or small-scale traditional medicine industries vs. large (foreign) companies; and different needs of developing countries' populations vs. protection of the interests of large (foreign) companies.

There is also a gap between 'high tech' and 'low tech' countries. The gap is increasing, since developing countries fail to advance the development of their knowledge. The interests may result in the widening of the gap in many areas including cultural/conceptual/philosophical aspects. In industrialized countries, there is an "extravaganza", an alternative choice, but in developing countries, it is a need for affordable medicine and a part of lifestyle. Efforts to solve this problem are hampered by the non-existence of institutional mechanisms for collaboration between local/community and national levels (but also at the national level, by the lack of financial support) and national and international institutions and lack of a common definition for "invention", "discovery", etc. Also, different perceptions and approaches exist on traditional medicines - some see it as an opportunity, others as a threat.

Countries should, among others, develop and use all possible systems to protect traditional knowledge and develop national strategies to safeguard continued access and prevent misappropriation by third parties. A mechanism should be developed to protect their biological resources, ensure equitable benefit sharing and encourage technology transfer.

Different views still remain on the impact of the Agreement on the health sector.

Views against

- Many studies on the subject agreed that due to the strong globally harmonized patents system, as proposed in the TRIPS Agreement, the availability of pharmaceutical products at reasonable prices is going to be seriously affected in the least developed and other developing countries.
- Some studies already showed that prices of patented drugs and the amount of patent royalties would sometimes increase manifold.
- It could lead to a real concentration of drug production in industrialized countries rather than to transfer of technology or foreign investment directly in developing countries.
- The new WTO patent system will not increase research and development in developing countries. Replacement or adaptation of the existing infrastructure for producing drugs based on "reverse engineering" will entail considerable cost.
- There are concerns on potential conflicts between commercial interests of pharmaceutical companies and the public health needs of developing countries. These concerns were manifested in the lengthy debate over the revised medicines strategy, which took place at the World Health Assembly.
- There are a few who have a strong opinion that patents are all very well for developed countries, but that the provisions relating thereto, should not be expected to apply to developing countries.

Views for

- Some quarters argued that protection of pharmaceuticals will lead to an increase in the flow of technology transfer, which could lead to improving the dissemination of technological know-how at the global level.
- There would be an increase in the magnitude of foreign direct investment, which could benefit the developing countries.
- An increase in resources, devoted to research and development by local pharmaceutical companies in developing countries, could also lead to the development of new drugs suited to their own situations, as well as better quality drug products and to end the "brain-drain" in developing countries.
- The pricing of drugs in developing countries relates mostly to the comparatively high tariffs introduced in developing countries. There are other factors and constraints in the health care delivery system, in addition to the pricing factor that relate to the accessibility of drugs.

How can countries mitigate the potential adverse impact?

Members of WTO have an obligation to review and revise existing legislation or enact new legislation to give effect to the TRIPS Agreement. By 2005 at the latest, *all* developing countries will have to grant legal protection by patents to pharmaceutical products. *WTO Members should make the fullest use of the periods of transition being granted, to transcribe the provisions of the TRIPS Agreement into their domestic law.*

In many studies, it has been suggested that developing countries should take advantage of the flexibility provided in the Agreement to safeguard their development and national interests. In fact, the Agreement allows "limited exceptions to the exclusive rights" of the patent holder.

Members are also allowed, under the Agreement, to formulate or amend their national laws and legislation and to adopt measures necessary to protect public health and nutrition. They also need to promote public interest in sectors of vital importance to their socioeconomic and technical development, provided that such measures are consistent with the limitations provided in the Agreement.

It is also suggested that members should provide, in their national laws, for the provisions on compulsory licensing in a way to ensure the maximum use of flexibility permitted under the TRIPS Agreement. The Agreement refers to several types of licenses but does not state that these are only cases and ground permitted. The national health authorities need to be aware of the TRIPS Agreement and its possible impact on health to safeguard public health interests in the national reform process of the intellectual property system and in the future trade negotiations in the area.

Key Questions for monitoring the public health impact of TRIPS

- Are essential drugs and vaccines more expensive than they would have been if not under patent?
- Is the expenditure increasing or decreasing for importation of drugs by a country which has no local production capacity?
- Is there any transfer of technology or direct foreign investment in developing countries, to strengthen national capacity for production of drugs at affordable prices? Is it increasing or decreasing?
- Are more new drugs introduced in the market for priority diseases?

Role of WHO

The WHO Director-General, Dr Gro Harlem Brundtland said[6] that trade and health are interrelated and there is a need for health and trade people to have dialogues with each other. There are many roles that WHO could play as a lead agency specializing in international health. The role of WHO in international trade agreements is primarily in two areas: international health advocacy from public health interests and setting up of international norms and standards. WHO has entered into partnerships with WTO (as observer), to help ensure that health is taken into account when trade policies are framed, without prejudice to WTO's role of legal and institutional foundation of the multilateral trading system.

[6] Speech of the WHO Director-General, Dr Gro Harlem Brundtland, made at the Ad hoc Working Group Meeting on Revised Drugs Strategy, 1999.

The main mission of WHO is to formulate policies and set standards and norms with a view to promote and protect public health and provide access to health care for everybody universally.

WHO will continue providing appropriate information and advice to its Member Countries, especially on increasing accessibility of essential medicines and vaccines and other health technologies. While acknowledging patent protection has been an effective incentive for research and development for new drugs, vaccines and technologies, WHO has to ensure that adequate research and development are made for addressing priority diseases affecting larger proportion of population.

The affordability and accessibility of essential medicines is a public health priority. In addition to getting agreement or conformity to TRIPS provisions, there need to be other legal and regulatory provisions that ensure access to essential drugs. Essential medicines are not simply another tradable commodity, and patents must be managed in an impartial way, protecting the interest of patent holders, while safeguarding public health principles.

WHO will also ensure health concerns being weighed appropriately when trade and health interests clash. From time to time, WHO conducted studies on the health impact of TRIPS Agreement and provided appropriate guidelines to its Member Countries. Most WHO Member Countries are also Members of WTO, and they all have been encouraged to discuss areas of mutual interest in the WTO agreements with their countries' trade, commerce and industry sectors. Members need to develop informed approaches to health and trade. They should install mechanisms to secure better coordination between various ministries responsible for trade and health – seeing to it that public health concerns are duly taken into account. Creating institutions and resource centres, networks of expertise, which have special knowledge and understanding of intellectual property rights, international multilateral trade agreements, pharmaceutical industries, macroeconomics and public health are needed. An open dialogue and direct interaction among interested partners will promote better understanding and mutual agreement, leading to stronger partnerships.

Conclusion

The World Development Report in 1997 indicated that the expansion of markets and the increase in competitive pressure will leave some unprepared countries highly vulnerable to unforeseen shocks and policy mistakes. Although it is often asserted that trade liberalization and economic globalization are "inevitable and desirable", they present formidable challenges and uncertainties in the promotion of 'health' in many countries. Coordinated and determined advocacy by health workers at national, regional and global levels could and should play a much greater role in mobilizing public and political support in this respect.

Two immediate challenges lie ahead of them, (a) to deal with the national reform process now taking place at the country level to conform to WTO agreements, and to prepare for future WTO negotiations. In these two exercises, their objective should be the promotion of "essential public health functions" - a basic package of services that should be available to all sections of populations.

References

1. Correa CM, *Health and Intellectual property Rights*, Bulletin of the World Health Organization, 2001 79 (5) 381
2. Keayla BK. *TRIPS-Impact on health and pharmaceuticals*, Paper presented at Regional Consultation on *WTO Multilateral Trade Agreements and their Implications on Health-TRIPS*, held at Bangkok, Thailand, 16-18 August 1999, WHO South-East Asia Regional Office; 1999 (unpublished)
3. Siripen S. *et al. Impact of the World Trade Organization TRIPS Agreement on the pharmaceutical industry in Thailand*, Bulletin of the World Health Organization, 2001 79 (5) 461-470
4. World Bank. *World development report 1997: the state in a changing world*. Washington: The World Bank; 1998.
5. World Health Organization. *Globalization and access to drugs: perspectives on WTO/TRIPS Agreement, DAP series; No. 7* Geneva: WHO Action Programme on Essential Drugs; 1998. 58p. (WHO/DAP/98.9).
6. World Health Organization. *Intellectual Property Rights in the context of Traditional Medicine*, Report of the Inter-Regional Workshop, Bangkok, Thailand, 6-8 December 2000, Geneva: WHO Traditional Medicine; 2001 (WHO/EDM/TRM/2001.1).
7. World Health Organization. *International trade agreements and their implications on health* [working paper]. Regional Committee, 51st session, 7-11 September 1998. Provisional agenda item 10. New Delhi: WHO South-East Asia Regional Office; 1998. (SEA/RC51/Inf.5).
8. World Health Organization. *TRIPS and the health sector in the South-East Asia Region*. Fourth meeting of health secretaries of SEAR, SEARO, New Delhi, 15-17 February 1999. New Delhi: WHO South-East Asia Regional Office; 1999. (SEA/HSM/Meet.4/5).
9. World Health Organization. *WTO Multilateral Trade Agreements and their Implications on Health-TRIPS*. Report of a Regional Consultation, Bangkok, Thailand, 16-18 August 1999, WHO South-East Asia Regional Office; 1999. (SEA/HSD-232 (Rev.1)).
10. World Health Organization. *Globalization, Trade and Public Health: Tools and Training for National Action*. Report of an Intercountry Expert group Meeting, New Delhi, India, 12-14 December 2000, WHO South-East Asia Regional Office; 2000 (SEA/HSD-244)
11. World Health Organization. *TRIPS and Pharmaceuticals*. Report of an ASEAN Workshop on the TRIPS Agreement and its impact on Pharmaceuticals, Jakarta, 2-4 May 2000, WHO Jakarta and Ministry of Health, Jakarta 2000 (Limited publication)
12. World Health Organization. *Uruguay round and health: the agreement of the World Trade Organization - a review of its impact on health in countries of the South-East Asia Region, WHO*. New Delhi: WHO Regional Office for South-East Asia; 1996.
13. World Trade Organization. *Introduction to the WTO: trading into the future*,2nd edition. Geneva: WTO Information and Media Relations Division; 1998.

SEARO Notes and News

26th SEA/ACHR, Thimphu, Bhutan

The Twenty-sixth Session of the SEA/ACHR was held in Thimphu, Bhutan from 17-20 April 2001 under the chairmanship of Dr N.K. Ganguly, Director-General, Indian Council of Medical Research, New Delhi. In his inaugural address, H.E. Loyonpo Sangay Ngedup, Hon. Minister of Health & Education, Royal Government of Bhutan, commended WHO for supporting research capacity strengthening, in view of the heavy disease burden in the South-East Asia Region. He stressed the need for health research at the grassroots level and urged the ACHR members to research into ways of incorporating traditional knowledge and wisdom in treating mental illness.

The ACHR adopted regional health research strategies, shared information on the development of human genetics with particular reference to the human genome project and regional perspectives on the ethical, legal and social implications (ELSI) of human genetics. The Committee recommended that WHO should map the national centres of expertise in the area of human genetics and utilize them as a network of regional resource centres to provide information and technical support to the countries of the Region in responding to the ELSI issues. It also called for periodic monitoring and systematic evaluation of the joint collaborative activities of WHO Collaborative Centres.

Sixth Meeting of Health Secretaries, Yangon

H.E. Maj. Gen. Ket Sein, Minister of Health, Government of the Union of Myanmar inaugurated the Sixth Meeting of Health Secretaries of SEAR countries in Yangon, Myanmar on 19 February 2001. It was attended by the Vice Minister of Health, DPR Korea; Deputy Minister of Health, Myanmar; Health Secretaries of Bangladesh, Bhutan, India, Indonesia, Nepal, Sri Lanka and Thailand; and the Head of the Project Planning and Monitoring Section, Maldives.

Among other things, the meeting called for strengthening of partnerships, enhancement of disease surveillance and promotion of health systems research in Member Countries. The Health Secretaries also requested WHO assistance in developing a database for reasonable pricing of essential drugs; undertaking a large-scale study to assess feasibility of health insurance schemes, and in developing bulk purchasing arrangements for vaccines, medicine and raw materials for drug manufacture.

Meeting of Global Alliance for Elimination of Leprosy

The first meeting of the Global Alliance for the Elimination of Leprosy (GAEL) was

inaugurated by Dr C.P. Thakur, Minister of Health & Family Welfare, Government of India, in New Delhi on 30 January 2001. The Regional Director, Dr Uton Rafei and Dr David Heymann, Executive Director, WHO/HQ addressed the inaugural session. Participants of the two-day meeting consisted of WHO experts on leprosy and elimination of communicable diseases from WHO/HQ and the Regions, including Drs Samba and Gezairy, RDs of AFR and WPR Regions, Health Ministers from the twelve endemic countries, and the seven endemic states of India and other partners.

GAEL was created in November 1999 to make a coordinated effort to eliminate leprosy as a public health problem by 2005. The objectives of the first meeting are to review the global situation; decide on joint strategies for implementation; enhance political commitment for elimination, and support initiatives for additional resource mobilization.

In his message to the meeting, H.E. Mr Atal Behari Vajpayee, the Prime Minister of India, reaffirmed his commitment to accord the highest priority to leprosy elimination in India and called for a pledge to attain the target set by WHO in the next five years. The DG, Dr Brundtland, calling for the partners of GAEL to make the final push towards leprosy elimination, said: "No one should have to suffer the stigma, deformity and disability caused by this curable disease. We have four more years to consign leprosy to history. Let us do it."

The GAEL partners endorsed the Delhi Declaration, which recommends intensive collaboration among the partners to eliminate leprosy by the year 2005 and supports the final push strategy. It urges all concerned to ensure, among others, uninterrupted availability of free multi-drug therapy (MDT) at all health centres and improve community awareness of the availability of the treatment. As the Hon. Health Minister, Dr C.P. Thakur said in his inaugural address, "We cannot afford to miss the new 2005 deadline for leprosy elimination."

ILAE/IBE/WHO Global Campaign against Epilepsy

The second phase of the Global Campaign against Epilepsy was launched by the WHO Director-General, Dr Gro Harlem Brundtland in February 2001. Representatives from 13 missions of WHO Countries, 24 national member organisations IBE/ILAE, 4 NGOs in neuroscience/neurology and 17 private sector concerns attended this event, which was a huge success, both according to IBE and ILAE, and according to WHO, standards.

Speaking at the launch, Dr Brundtland said: "*……so we are facing the two challenges of reducing stigma and of building up capacity to correctly diagnose and treat epilepsy patients world-wide. It can be done……"*

As you know, the secret for the success of the Campaign lies in the partnership, the partnership between ILAE and IBE and with WHO. Dr Brundtland also remarked on this partnership by saying: "*……The collaboration between the International Bureau for Epilepsy, the International League against Epilepsy and the WHO has shown that when people with different backgrounds and roles*

come together with a shared purpose, creativity is released and expertise is used in innovative and constructive ways……"

The Director-General also released a WHO monograph entitled, "Epilepsy Out of the Shadows – From Prejudice to Hope" prepared by WHO/SEARO.

Workshop on Mental Health Legislation, Galle, Sri Lanka, 24-27 May 2001

A regional workshop on mental health legislation was organized by WHO/SEARO in collaboration with the Ministry of Health, Sri Lanka. The workshop provided a forum to bring into focus important issues of mental health within the South-East Asia Region. Eminent personalities of the medical and legal fields from within and outside the Region made presentations on the historical evolution of mental health legislation; recent advances in mental health care; overview of the regional mental health problem; barriers to development of mental health care; role of legislation in addressing mental health issues; international human rights instruments relating to mental health; applicability of international standards on mental health to domestic laws and scope and content of mental health legislation.

Representatives of each participant country surveyed the current status of the mental health problem, with special emphasis on any laws relevant thereto, in their respective contexts. The workshop culminated in the collective formulation of recommendations on a regional policy for mental health legislation.

Book Review

Design and Implementation of Health Information Systems

[ISBN 92 4 156199 8; Sw.fr.70.-/US$ 63.00]

This book responds to the urgent need to restructure systems and make them work, by being a resource for routine decisions and a powerful tool for improving health services. Information needs at all levels are considered in this comprehensive guide in which the authors provide a host of conceptual and technical options. Throughout the book, case studies and numerous practical examples are used to explore problems and illustrate solutions. The first part of the book explains the potential role of health information as a managerial tool, while the second and most extensive part provides a step-by-step guide to the restructuring of information systems to improve the quality and relevance of data. Resource needs and technical tools are addressed in part three and practical advice on restructuring a health information system is provided in the final part.

Obesity: Preventing and Managing the Global Epidemic

WHO Technical Report Series No.894 [ISBN 92 4 120894 5; Sw.fr.56.-/US$ 50.40]

This report calls for urgent action to combat the growing epidemic of obesity, which now affects both developed and developing countries. It aims to help policy-makers introduce strategies for prevention and management that have the greatest chance of success. Recommended lines of action reflecting the consensus of 25 leading authorities are based on a critical review of current scientific knowledge about the causes of obesity. Major attention is given to behavioural and societal changes that have increased the energy density of diets and reduced physical activity.

The report has eleven chapters presented in five parts. Part one assesses the magnitude of the problem and provides an overview of trends in all regions of the world. Part two evaluates the true costs of obesity in terms of physical and mental ill health, human and financial resources. Specific health consequences of obesity as well as the health benefits and risks of weight loss are assessed. Part three considers specific factors involved in the development of obesity and pays attention to the multitude of environmental and societal forces adversely affecting food intake. The fourth part maps out prevention and management strategies including dietary management, physical activity, behaviour modification and drug treatment. Separate chapters address the need to develop population-based strategies that tackle the environmental and societal factors implicated in the development of obesity and compare the effectiveness of options for managing overweight individuals. The final part sets out key conclusions and recommendations for responding to the global obesity epidemic and identifies priority areas requiring research.

Foodborne Disease: A Focus for Health Education

[ISBN 92 4 156196 3; Sw.fr.62.-/US$ 55.80]

This book provides a guide to the education of food handlers and consumers as an effective strategy for reducing the enormous illness and economic losses caused by foodborne diseases. The rising incidence of foodborne disease, including outbreaks caused by new or recognized pathogens has necessitated the presentation of facts, figures and practical examples to understand the links between food and disease. The book addresses policy-makers as well as food safety managers in the public and private sectors and presents numerous case studies to illustrate the costs of food contamination and the benefits of prevention. It pays particular attention to the use of the Hazard Analysis and Critical Control Point (HACCP) system as a rational and scientific method for food safety management.

There is a 46-page annex, which provides invaluable information in tabular form on 31 foodborne diseases caused by bacteria, viruses and parasites. It concludes with a guide to effective risk communication aimed at mitigating public concern about food safety issues.

WHO Expert Committee on Biological Standardization

[Technical Report Series, No. 897; ISBN 92 4 120897 X; Sw.fr.70.-/US$ 18.00]

This report presents the recommendations of a WHO expert committee commissioned to coordinate a range of research and other activities needed to assure the purity, potency, safety, and stability of biological products used in medicine. Work includes the development and adoption of detailed recommendations for the manufacturing, licensing, and control of vaccines and other biologicals.

The report has four parts. The first provides a brief discussion of general concerns being addressed by WHO in its efforts to ensure the safety and efficacy of biological medicines. The second part provides a brief review of the status of various international guidelines and recommendations relevant to the manufacture and quality control of biologicals, and identifies recommendations in need to revision. Part three summarizes activities relating to the status and development of biological reference materials for selected antibodies, antigens and related substances, blood products and related substances, cytokines, and other substances requiring international reference materials.

As guidance for national control authorities and manufacturers, the fourth and most extensive part issues detailed recommendations for the production and quality control of *Haemophilus influenzae* Type B conjugate vaccines, and provides and addendum to the 1990 requirements for oral poliomyelitis vaccine.

The report concludes with a 30-page inventory of WHO international biological reference preparations held and distributed by the WHO International Laboratories for Biological Standards.

International Classification of Diseases for Oncology

(ICD-O) [ISBN 92 4 154534 8; Sw.fr.60/US$ 54]

The ICD-O has been used for nearly 25 years as the standard tool for coding diagnoses of neoplasms in tumour and

cancer registries and in pathology laboratories. It is a dual classification with coding systems for both topography and morphology. While topography codes remain the same as in the previous edition, morphology codes have been thoroughly reviewed and revised where necessary, to increase their diagnostic precision and prognostic value.

The book has five main sections. The first provides general instructions for using the coding systems and gives rules for their implementation in tumour registries and pathology laboratories. Section two includes the numerical list of topography codes that remain unchanged from previous editions, while the next section provides the list of morphology codes. Section four contains the alphabetical index giving all the codes and includes selected tumour-like lesions and conditions. The final section provides a guide to differences in morphology codes between the second and third editions.

Biomedical Research Ethics: Updating International Guidelines

(edited by R.J. Levine and S. Gorovitiz with J. Gallagher) [ISBN 92 9036 073 9; Sw.fr.30.-/US$ 27.00]

This book records the papers and commentaries presented at an international consultation to guide the revision of the CIOMS International Ethical Guidelines for Biomedical Research involving Human Subjects. The Guidelines are being updated and expanded to address a number of new and challenging ethical issues, including collaborative trials of drugs in developing countries, the use of placebo controls in randomized clinical trails and human genetics, among others.

The first paper, on justice in international research deals with the question of whether proposals for research to be conducted in a developing country should provide for future access of the population involved to the interventions under investigations. Case studies of recent drug trials and their research protocols are discussed to illustrate the circumstances under which this is justified. The second paper considers ethical challenges of the randomized controlled trials including a paper on informed consent in international health research. Subsequent papers address issues in genetics research including the use of embryos in research. The final paper gives an overview of capacity building and the role of communities in international biomedical research.

The Use of Essential Drugs

(Ninth Report of the WHO Expert Committee including Revised Model List of Essential Drugs), WHO Technical Report Series No.895; [ISBN 92 4 120895 3; Sw.fr.14.-/US$ 12.60]

This report intends to guide the selection of drugs in countries where the need is great and resources are small, the list identifies a core group of prophylactic and therapeutic substances judged capable of meeting the vast majority of health needs. It also serves as an information and educational tool for health professionals and consumers. WHO model lists are regularly updated to ensure that recommendations are in line with the latest data on the comparative safety, efficacy and costs of specific drugs as well as their relevance to priority health problems.

The first part of the report provides updated information on several components of national drug policy necessary to ensure that essential drugs are available at all times in adequate amounts and proper dosage. In view of the increasingly high levels of resistance to standard anti-TB drugs, the report designates nine drugs and formulations as essential for the treatment of multidrug-resistant TB. The second part covers the eleventh WHO model list of essential drugs together with an explanation of changes made during revision. The list includes information on route of administration, dosage forms and strengths for each of 306 drugs.

Global Water Supply and Sanitation Assessment 2000 Report

[ISBN 92 4 156202 1; Sw.fr.35.-/US$ 31.50]

This report, prepared by the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, provides a global assessment of the water supply and sanitation sector in 2000. Using a new methodology that gives a more accurate estimate of access to water supply and a better understanding of factors influencing changes, it also compares current findings with data from 1990 and assesses the feasibility of reaching targets set for 2015.

The 2000 report uses consumer-based data drawn from household surveys, thereby creating a platform for tracking the local initiatives that are now recognized as central to the attainment of sustained improvements. It also uses technology type as an indicator of access to improved water and sanitation.

The report has eleven chapters. The first presents the main findings of the assessment, emphasizing issues that can aid decisions about the planning and management of services and the investment in priority needs. Chapter two shows the global and regional status of coverage for water supply and sanitation and discusses key trends within the context of rapid population growth. Chapter three on sector performance details planning and management in the WS&S sector including targets, constraints, investment, costs and tariffs and quality of services. Subsequent chapters consider how the world's largest cities are coping with heavy demands for service coverage. As data in the report show, strategies must be established that focus on results at the household level. In the second half of the report, data on coverage for all the continents are given. For each region, urban and rural figures are shown in tables and maps by country, area or territory for 1990 and 2000, illustrated by graphs.

Chemistry and Specifications of Pesticides: Sixteenth Report of the WHO Expert Committee on Vector Biology and Control

[ISBN 92 4 120899; Sw.fr.14.-/US$ 12.60]

This report identifies issues of safety or quality in the use of pesticides and proposes appropriate actions. Specifications for individual pesticides for use in quality control by purchasing and regulatory authorities are also recommended. The report is written in response to the changes in the use of pesticides, integration of vector control into basic health services, greater individual responsibility for personal protection and community responsibility for vector control.

The report has two parts, the first of which discusses several activities aimed at improving the safety and quality of pesticides used in vector and public health pest control. The WHO Pesticide Evaluation Scheme is also described in detail in Section one. Section two assesses regional trends in the use of pesticides, concentrating on public health initiatives that account for the greatest use of specific insecticides and larvicides. A section on analytical methods and quality control in developing countries addresses the major problem of substandard products and the need to make quality control capacity available in all countries lacking access to analytical facilities. The remaining sections address the need for guidance on safety issues relating to containers, packaging and the marking and storage of pesticides and issues recommendations for responding to the common problem of unusable pesticide stocks requiring disposal. The second part of the report issues changes to existing specifications for 20 pesticides, recommended specifications for two new pesticides and formulations and procedures for performing four new WHO test methods.

Guidelines for Contributors

THE Regional Health Forum seeks to inform and to act as a platform for debate by health personnel including policy-makers, health administrators, health educators and health communicators.

Contributions on current events, issues, theories and activities in all aspects of health development are welcome. Contributions should be original and contain something of interest to those engaged in health policy and practice, some lesson to be learned, some idea, something that worked, something that didn't work, in fact anything that needs to be communicated and discussed on a broader scale. Articles, essays, notes, news and views across the spectrum of health development will be published.

Papers for submission should be forwarded to the Editor, Regional Health Forum, World Health Organization, Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Road, New Delhi 110002, India (e.mail address: editor@whosea.org).

Contributions should:

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- not normally exceed 3000 words with an abstract (approx. 250 words) and a maximum of 30 references.

Letters to the editor should normally be between 500-1000 words with a maximum of six references.

Responsibility of the Authors

Authors are responsible for:

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- ensuring that all abbreviations (if used) are explained;
- giving their full names, the name and address of their institutions, and an exact description of their posts;
- declaring sources of funding for the work undertaken, and
- disclosing at the time of submission, information on financial conflict of interest that may influence the manuscript. They may also choose to declare other interests that could influence the results of the study or the conclusions of the manuscript. Such information will be held in confidence while the paper is under review, and if the article is accepted for publication the editors will usually discuss with the authors the manner in which such information is to be communicated to the reader.

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- All illustrations and tables should be numbered consecutively and should be lightly marked on the back with the figure number, and the author's name indicated.
- Graphs and figures should be clearly drawn and all data identified.
- Photographs should be on glossy paper, preferably in black and white.
- Each table should be submitted on a separate sheet of paper.

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