Non-communicable diseases, injuries and mental health

Chronic, non-communicable diseases (NCDs), mental health disorders, and injuries and violence are major problems, accounting for over 40 per cent of the disease burden in high mortality developing countries, and over 75 per cent in lower mortality developing countries. NCDs, such as cardiovascular disease, diabetes, chronic respiratory disease and major cancers, are often considered to be “diseases of affluence”. However, the majority of their disease burden occurs in developing countries, and at rates, particularly in urban areas, that are often substantially higher than in developed countries. As the populations of developing countries age, and with rapid urbanisation and globalisation driving increases in the risk factors for chronic NCDs, their burden is increasing rapidly.

Of the estimated 400 million persons affected by mental disorders, most live in developing countries which command only a fraction of global mental health resources. Mental disorders account for 5-10 per cent of the burden of disease in these countries. Vulnerable populations, such as the poor and those affected by disasters, are at greater risk. Mental disorders can be effectively and affordably treated at the local level. However, most of those in need do not receive any treatment. Injuries, including those caused by violence, are also a major public health concern, leading to over five million deaths worldwide each year. They include motor vehicle crashes, homicide, suicide, falls, poisoning, drowning, fires and burns. On the whole, injuries do not occur at random: they are largely predictable and, therefore, preventable.

In total, NCDs, mental health disorders and injuries and violence place a substantial economic burden on families and communities, and are a hindrance to social and economic development. However, their prevention and control currently receive trivial funding from the global assistance community.

The online version of this guide, with links to the latest resources on non-communicable diseases, injuries and mental health, is available at:

www.eldis.org/health/noncommunicablediseases.htm

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Feature: Globalization of risks for chronic diseases demands global solutions

Globalisation contributes to worldwide epidemic of chronic disease

Published by the Oxford Health Alliance, this chapter is taken from the journal Perspectives on Global Development and Technology. The authors argue that chronic non-communicable diseases (NCDs), including cardiovascular disease, cancer, chronic respiratory diseases and diabetes, have been widely neglected by policymakers. Yet, they now constitute the bulk of the world’s disease burden and their prevalence is increasing in almost all populations, most notably in the developing world. The chapter provides updated information on the key macro-determinants of NCDs: urbanisation, globalisation and ageing. It also highlights the emergence of related risk factors including obesity, tobacco and alcohol use, and reduced consumption of fruit and vegetables accompanied by a shift towards diets high in sugar and saturated fat. Global promotion of alcohol, tobacco, and sugary drinks is cited as a major cause.

The authors argue that globalisation drives the risk of chronic disease, indirectly through increases in household and national income, and directly through global forces in trade and marketing. They conclude that investment in chronic disease prevention and control has not kept pace with the growing burden of NCDs, and call on governments and international bodies involved in health policy and funding to give greater priority to these diseases and their risk factors.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18899
Chronic non-communicable diseases

Chronic non-communicable diseases (NCDs) account for 60 per cent of all deaths worldwide, 70 per cent of which occur in developing countries. Most share a small number of risk factors, including unhealthy diet, physical inactivity and smoking. Rates of premature mortality and morbidity from NCDs are greater among adults in urban centres in developing countries, including Africa, than in developed countries. NCDs place a substantial burden on already inadequate health services and are an impoverishing drain on families and communities. With further urbanisation and globalisation driving changes in behaviour, this burden is likely to increase, hindering economic and social development. Despite this, less than 0.1 per cent of all health funding from the international assistance community is directed towards chronic NCDs.

For information on prevention of NCDs, see [www.eldis.org/health/healthpromotion.htm](http://www.eldis.org/health/healthpromotion.htm)

For readings on NCDs and health systems, see the HRC/Eldis Health Systems Resource Guide: [http://www.eldis.org/healthsystems/diseases/index.htm#ncds](http://www.eldis.org/healthsystems/diseases/index.htm#ncds)

Feature: Rethinking the "diseases of affluence" paradigm: global patterns of nutritional risks in relation to economic development

Global risk of cardiovascular disease is shifting to poorer countries


This paper, published in the Public Library of Science Medicine, examines the global health effects of economic development, focusing on cardiovascular diseases and their nutritional risk factors, including overweight and obesity, elevated blood pressure, and cholesterol. The paper highlights findings from a study which used data from over 100 countries to examine the relationship between mean (average) blood pressure, cholesterol, and body mass index (BMI) and the following factors: national income, average share of household expenditure spent on food, and the proportion of the population living in urban areas. Results showed that BMI/cholesterol both increased in relation to national incomes, most rapidly up to an income of 5,000 US dollars (adjusted for inflation and for differences between countries in purchasing power). Higher BMI and cholesterol levels were also associated with lower household spending on food, and with urbanisation.

The authors argue that cardiovascular disease can no longer be classified as a disease of the rich. Cardiovascular disease risks can be expected to systematically shift to low- and middle-income countries and, together with the persistent burden of infectious diseases, further increase global health inequalities. The paper recommends that preventing obesity should be a priority from early stages of economic development, accompanied by population-level and personal interventions for blood pressure and cholesterol.

Available online at: [www.eldis.org/cf/rdr/rdr.cfm?doc=DOC11751](http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC11751)
Recommended readings on chronic NCDs

A race against time: the challenge of cardiovascular disease in developing economies

Heart disease in developing countries: can we prevent a crisis?

This report from the Earth Institute at Columbia University in the United States warns of a major global health crisis that is about to happen due to rising levels of cardiovascular disease (CVD) in developing countries. As it will affect the working population most severely, this health crisis will also have serious economic consequences.

CVD includes a range of diseases, including heart attack, stroke and kidney failure. It is set to become the leading cause of death and disability in the world by 2020. The report examines the current social and economic impact of CVD in five middle and low income countries (Russia, Brazil, China, South Africa and India) and the projected impact up to 2040.

Findings include the following:

• Heart disease and stroke kill 17 million people every year, compared to 3 million due to HIV and AIDS. 80 per cent of these deaths occur in low and middle income countries.

• Even if the risk factors for CVD remained as they are now, there will be a major increase in levels of CVD in developing countries in the next 30 years due to the rising populations in these countries. However, the risk factors will also increase substantially over this time due to increased levels of urbanisation and industrialisation.

• The group which will be most affected will be those aged between 34 and 65. Experience from developed countries show that the rise in the prevalence of CVD in developing countries will affect the poor disproportionately.

• The extent to which women are affected by CVD is often ignored in favour of a focus on reproductive health. In Brazil, twice as many women aged between 15 and 34 die due to CVD than due to pregnancy-related causes.

• The economic consequences of CVD include the loss of workers due to disability and death, the loss of experience and skills since those most affected are those in mid-life, the direct health costs, the cost of disability payments, and the loss of workers, especially women, who have to leave the workforce to take care of sick relatives.

• The problem of CVD in developing countries receives very little international attention, particularly in comparison to communicable diseases. This is partly because it affects older adults rather than children and because it is mistakenly thought of as a disease of affluence.

The causes of CVD include those which cannot be prevented (age, gender and genetic predisposition) and those which are social and environmental (smoking, diet, exercise, stress) and therefore can be modified. The interventions which are needed to help prevent CVD are all currently available and have been very successful in developed countries. The report warns that there is a very limited opportunity available to implement these interventions in developing countries if the predicted crisis is to be avoided. Key recommendations include:
Putting CVD in the developing world on the international health and development agenda

Further work of the type done for this report to accumulate more extensive and detailed data on the prevalence of CVD in developing countries and its projected economic costs

Advocacy and partnership work with governments of developing countries to ensure that CVD becomes a priority in health and related areas of policy

Providing specialist training in prevention and treatment of CVD to health professionals in developing countries

Undertaking trial treatment and prevention interventions

Long-term research to monitor the effectiveness of CVD prevention interventions and other health system changes.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18078

Innovative care for chronic conditions: building blocks for action

New challenges need new models: why health systems must adapt to treating chronic disease


Chronic illnesses are those which affect a patient on an ongoing basis over an extended period of time and require a level of health management. This includes conditions like diabetes, heart disease and now, in the era of antiretrovirals, HIV.

This report from the World Health Organization (WHO) states that health systems around the world must reorganise how they deliver healthcare if they are to respond effectively to the rising levels of chronic disease. It goes on to outline why the levels of these conditions are increasing and why health systems are structurally unable to deal with this.

Findings include the following:

- Chronic diseases will be the major cause of disability globally by 2020, and the most expensive cost facing health systems.

- The success of public health initiatives and in the treatment of communicable diseases has led to a rising population and extended life expectancy. As people live longer, they become more susceptible to chronic conditions and are living with them for longer periods.

- Rising levels of industrialisation and urbanisation in developing countries, the associated adoption of unhealthy lifestyles by greater numbers of people, and the global marketing of health risks such as tobacco smoking, are also important factors.

- Chronic diseases are strongly linked with poverty. They also bring an added burden and greater complexity to the health systems of those developing countries still tackling infectious and communicable diseases.

- Health systems have evolved around the treatment of acute infectious diseases and dealing with patients’ urgent concerns. This means that they are currently unable to effectively deliver the type of ongoing health management required in the treatment of chronic conditions. This is particularly the case in primary care where the majority of patients in developing countries seek treatment.
• While the acute care model dominates in health systems, the increasing levels of chronic conditions will lead to escalating expenditure on healthcare but without delivering any major improvements in people’s health.

Recommendations include the following:

• Promote political consensus for creating change in health policy by including all stakeholders – political leaders, community leaders, representatives of patients and families – in the process

• Ensure that policy in other areas, such as education, employment and housing, is aligned with health policy

• Create a health system where the different elements of care, and of administration, are effectively integrated

• Use healthcare personnel more efficiently, for instance by training healthcare workers to deliver the non-medical aspects of managing chronic illness such as counselling

• Ensure that healthcare is focused on the patient, their family and their community. This is important because it is the patient themselves, with the support of their family and community, who is the key individual in managing their own illness

• Prioritise public health initiatives aimed at preventing chronic disease.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18585

Globalisation and the prevention and control of non-communicable disease: the neglected chronic diseases of adults

Chronic illness reaching crisis levels in developing countries: the health consequences of globalisation?

This article from The Lancet outlines the relationship between globalisation and the expanding levels of non-communicable diseases (NCDs) in developing countries. It warns of a worrying gap between the rate at which the levels of these diseases are growing and the low priority given to the issue by international and national health policymakers.

Sixty per cent of deaths globally are due to non-communicable chronic diseases, mainly diseases of the heart and lungs. These diseases are the leading cause of death in both developed and developing countries, outside of Africa. The risk factors are more complex than for infectious diseases, but they are well known and can be successfully modified. They include diet, exercise levels and alcohol and tobacco consumption. The article explains the effect that globalisation has had on these increasing levels of chronic disease.

Findings include the following:

• In most developing countries, the level of risk factors for NCDs has increased in the past decade, which will lead to increased rates of these diseases in the next two decades.

• Globalisation has contributed to the increasing levels of non-communicable disease in two ways: directly, by increasing the levels of risk factors through changing patterns of work and consumption; and indirectly, through the impact on national economies and health systems.
There is a strong link between free trade, tobacco-related foreign direct investment and increased tobacco consumption. Trans-national companies are aggressively exploiting the potential for growth in tobacco sales in developing countries, particularly focusing on young people and women.

The European Union and the United States continue to provide large subsidies to their tobacco producers.

Replacement of a traditional diet rich in fruit and vegetables by a diet rich in calories provided by animal fat is happening in all but the poorest countries. Global marketing of salty, sugary and fatty foods now reaches most parts of most countries. The effects of this change in diet, combined with less physical activity, has been most marked in Asia, particularly in China where the prevalence of obesity among children grew from 1.5 per cent in 1987 to 12.6 per cent in 1997.

The issue of non-communicable diseases in developing countries has received little attention from policymakers, donors and academics and the actions taken at national and global levels have been inadequate. The agenda of most international donors is dominated by the belief that communicable diseases should be eradicated before non-communicable diseases receive attention, in part due to the misconception that such diseases mainly affect wealthy countries and populations. In addition, producers of unhealthy products, such as the tobacco industry, can exert influence on health policy. The article outlines a number of areas where action needs to be taken. These include the following:

- Strong and broad alliances of health professionals, consumer groups, industries and academics to effectively advocate and promote the adoption of prevention policies
- Partnership between health organisations and industry to improve the quality of food, and increase access to healthy food and opportunities for physical exercise
- The need to develop global norms, both legally binding and non-binding, across a range of spheres to balance the power of industry and global marketing. The proposed Framework Convention on Tobacco Control (FCTC) is an example of this
- National capacity for non-communicable disease prevention and control is weak and there needs to be substantial investment to build up health systems
- Health systems have to be re-orientated to take account of the rising levels of NCDs and to provide the types of risk reduction and care required to prevent and manage these diseases.

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Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18910
More readings on Chronic NCDs

The global distribution of risk factors by poverty level

Double burden of disease threatens the world’s poorest people

This article from the Bulletin of the World Health Organization highlights the association between poverty and major risk factors for ill-health. Research was focused on people in low and middle income countries within each of the World Health Organization (WHO) sub-regions. Findings showed that in each sub-region, poverty was strongly associated with increased malnutrition among children, having access only to unsafe water and poor sanitation, and exposure to indoor air pollution. However, associations between poverty and obesity, alcohol use and tobacco use varied across the sub-regions.

The authors suggest that halving the number of people who live on less than a dollar a day would still fail to reduce the prevalence of these health risks by the 50 per cent needed to meet the Millennium Development Goal (MDG) targets. They also warn of a “double burden of disease”, whereby chronic non-communicable diseases caused by tobacco use, excessive alcohol consumption and obesity become more prevalent in the poorest socio-economic groups as countries industrialise, while “traditional” communicable and nutritional diseases persist among the same populations. They conclude that economic development alone is not enough to achieve the MDGs, and stress the need for public health programmes to be implemented alongside poverty reduction strategies.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC17919

Combating cardiovascular diseases through nutrition in the Caribbean

Designing effective educational programmes and material to prevent cardiovascular disease in the Caribbean

Cardiovascular disease (CVD) has become the leading cause of death across the Caribbean in the last decade. However, it is recognised that nutrition and physical activity can play a great role in the prevention and management of cardiovascular disease. This study investigates the specific needs for physical activity and dietary education in the prevention and treatment of cardiovascular disease in the Caribbean.

Based on a qualitative research conducted in four Caribbean countries (Bahamas, Grenada, Jamaica, Trinidad and Tobago) and using group discussions, the research focuses on four broad areas:

- understanding the term "cardiovascular diseases"
- foods and their relationship to cardiovascular diseases
- obesity, physical activity and relationship to CVD
- sources and preferences of health information.

The main findings that emerge from the responses in the four countries indicate that:
participant's knowledge about the pertinent issues is superficial and not deep enough to empower them to take action

- there is a good understanding of the term "cardiovascular diseases", but a less clear understanding of the conditions that make up the disease

- there is ambiguity about the role of exercise and diet

- there is a good understanding of foods and food products which are protective of CVD

- the public has information as to how to prevent obesity but has problems putting this knowledge into practice

- the main sources of health information are health professionals and the print and electronic media.

Based on the previous results, the study recommends the following issues to be taken into consideration when developing education materials on physical activity and diet for the prevention and management of cardiovascular diseases in the Caribbean:

- clearly explaining medical terms when targeting the general public

- providing information on health conditions, risk factors and symptoms

- removing the negative perceptions surrounding some foods

- providing guidance on how to prepare healthy and tasty meals

- developing efficacy skills to enable individuals to move from the knowledge level to behavior

- offering practical advice on how to increase physical activity at the individual level

- providing user-friendly, easy to read and illustrative education materials and offering visual and interactive educational programmes.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19955

Improving the quality of health care for chronic conditions

Linking patient, community and health facility: a new model for managing chronic conditions


This article, published by the British Medical Journal, argues that chronic conditions – non-communicable diseases, mental disorders and latterly HIV and AIDS – are increasingly the concern of healthcare systems all over the world. It outlines the Chronic Care Model (CCM) devised in the US, which is based on the principle of integrated, organised systems of care for patients with chronic conditions, including self-management support and regular follow-up. The World Health Organization and the MacCall Institute for Healthcare Innovation have jointly adapted the CCM for use in developing countries. The resulting model, the Innovative Care for Chronic Conditions (ICCC) framework, outlines a comprehensive approach to managing chronic disease and emphasises community and policy aspects of improving care.
The paper presents international experiences with both the CCM and the ICCC framework, highlighting examples from Canada, Mexico, Morocco, the Russian Federation, Rwanda and the United Kingdom. The authors conclude that both tools are essential for generating health improvements in health and delivery of healthcare throughout the world. In the case of the ICCC framework, a positive policy environment supports community efforts that are formally linked to healthcare organisations. These in turn support patients, families, community partners and care teams in providing an effective "continuum of care". [adapted from author]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19378

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**Lancet Chronic Diseases 2: preventing chronic diseases: taking stepwise action**

**New framework for preventing chronic disease: learning from Indonesia, Philippines, Tonga and Vietnam**

This article, the second in the Lancet series on chronic non- communicable diseases (NCDs), presents a planning framework for preventing chronic diseases, divided into key steps or stages, which can be used in settings with limited resources. This "stepwise" framework, which is based on a public health approach, is designed to help ministries of health implement evidence-based prevention programmes, including tobacco control and promotion of healthy diet and physical activity. The authors highlight experiences from Indonesia, the Philippines, Tonga and Vietnam, where the stepwise approach has been applied. Key factors associated with successful implementation include: a high-level political mandate to develop a national policy framework; the involvement of a committed group of advocates; support from international collaborators; wide policy consultation; and a clear and compelling communication strategy at all stages of the process.

The authors conclude that many chronic disease interventions are effective and suitable for resource-constrained settings and that the stepwise approach is flexible enough to be applied in diverse contexts. They assert that with comprehensive and integrated action at country level, led by governments, it will be possible to achieve a 2 per cent yearly reduction in chronic disease by 2015, saving 28 million lives in low and middle income countries.

Please note: To read this article, you will first need to register with The Lancet. This process and access to the article is free of charge.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC20007

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**Can we prevent cardiovascular diseases in low- and middle-income countries?**

**Affordable steps to prevent and treat cardiovascular disease in developing countries**
Lenfant, C. / World Health Organization (WHO) (2001)

This paper, published by the World Health Organization (WHO), looks at trends in ischaemic heart disease (disease caused by decreased blood flow to the heart), risk factors, and possible interventions to reduce the rate of such diseases in developing countries. Ischaemic heart disease is the largest cause of death worldwide, and is rapidly becoming a major threat in low- and middle-income countries. Reasons for the rise in heart disease in developing...
countries include reductions in deaths due to other causes and increased longevity, and greater exposure to risk factors resulting from the adoption of a Western lifestyle.

Experience in a variety of populations has demonstrated that lowering certain risk factors, such as hypertension (high blood pressure) and hypercholesterolaemia (excessive cholesterol in the blood), reduces illness and deaths from cardiovascular illnesses. The paper recommends a dual approach: screening and intervening in cases of relatively high risk, while fostering population-wide preventive activities. Many of the steps involved in this approach have low costs, particularly those involving public education and lifestyle changes. The paper concludes that such efforts should be made now, before the cardiovascular disease epidemic becomes too great and puts impossible strains on the limited budgets of these countries. [adapted from author]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18312

**Obesity and inequities in health in the developing world**

**At what point does obesity become a disease of the poor?**  

This article from the International Journal of Obesity reports on a study which used data from national surveys in 37 developing countries to examine the social distribution of obesity among women of reproductive age. Findings showed that, although belonging to the poorest groups offers strong protection against obesity in low income countries, it becomes a risk factor for the disease in upper-middle income countries. The study revealed that obesity starts to fuel inequities in health once a certain level of economic development is attained (approximately when gross national product exceeds a value of $2500 per capita).

Suggested reasons for this shift in obesity to the poorest groups include lower levels of education and health-related knowledge among the poor, combined with greater difficulties accessing fruit, vegetables and whole-grain cereals, less leisure time, and fewer opportunities for physical exercise. Obesity among the poor adds to existing health inequities, while also substantially increasing the risk of non-communicable diseases, including cardiovascular diseases, diabetes and cancer, as well as mental health problems. The authors call for public education campaigns on the causes and effects of obesity, combined with social, economic and environmental changes to make healthier choices concerning diet and physical activity feasible for all socio-economic groups.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC17475

**The nutrition transition: worldwide obesity dynamics and their determinants**

**Global shift in obesity is most marked in low-income countries**  

Published in the International Journal of Obesity, this article explores the major changes in diet and physical activity patterns around the world, focusing on shifts in obesity (the condition of being extremely overweight). Key findings include evidence of rapid increases in demand and consumption of edible oils, sugars and other caloric sweeteners, and animal-source foods in low-income developing countries. Related changes in physical activity include a shift away from high-energy expenditure activities such as farming, mining and
forestry towards the service sector; and changes in modes of transportation and in leisure activities. Data on obesity patterns and trends shows that levels of overweight and obesity are increasing faster in the developing world than in higher-income countries. There is a particularly high obesity prevalence in adolescents, which has been shown to persist into adulthood.

The authors suggest that modern societies seem to be converging on a diet high in saturated fats, sugar, and refined foods but low in fibre (the typical “Western” diet) and lifestyles characterised by low physical activity. They conclude that rapid dietary and activity pattern shifts, particularly in the developing world, are resulting in major shifts in obesity on a global basis, with a likely increase in morbidity from related non-communicable diseases. [adapted from author]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18900

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**Effective screening programmes for cervical cancer in low- and middle-income countries**

**What are the preconditions for effective cervical cancer screening in developing countries?**

Sankaranarayanan, R.; Budukh, A.M.; Rajkumar, R. / World Health Organization (WHO) (2001)

This paper, published by the World Health Organization, reviews the costs and impacts of cervical cancer screening and research initiatives in developing countries. There are substantial costs involved in providing both organised and opportunistic screening programmes for cervical cancer. Owing to their limited health care resources, developing countries cannot afford the models of frequently repeated screening of women over a wide age range that are used in developed countries. Many low-income developing countries, including most in sub-Saharan Africa, have neither the resources nor the capacity for their health services to organise and sustain any kind of screening programme.

The paper recommends that middle-income developing countries, which currently provide inefficient screening, should reorganise their programmes in the light of experiences from other countries and lessons from their own past failures. New screening programmes should initially be tried in a limited geographical area. Programmes should target high-risk women once or twice in their lifetime using a highly sensitive test, and should try to cover at least 80 per cent of the targeted population. The paper also emphasises the need for adequate financial resources, infrastructure, manpower, and surveillance mechanisms for screening, investigating, treating, and following up the targeted women.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18741

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**Lancet Chronic Diseases 1: Preventing chronic diseases: how many lives can we save?**

**Global health goal needed to address growing number of deaths from chronic disease**


This article from the Lancet is the first in a series highlighting the growing global burden of chronic, non-communicable diseases (NCDs), including heart disease, stroke and cancer. Findings show that in 2005, 35 million people worldwide will die from these diseases, 80 per cent of them in low- and middle-income countries. Death rates are higher in poorer
countries, especially among adults aged 30 to 69. The authors argue that chronic NCDs are set to become an even greater problem in these countries, where people do not have the means to pursue healthy lifestyles or access treatments. Despite this, chronic diseases remain neglected by the international health community, and bypassed by donors, due in large part to the prevailing myth that they affect only rich and ageing populations.

The authors propose a new global health goal: to reduce chronic disease death rates by an additional 2 per cent each year, thereby saving 36 million deaths by 2015. They recommend using individual, population-based and macro-economic approaches to manage and prevent chronic diseases. They stress that chronic disease risks, including unhealthy diet and physical inactivity, arise from broad socio-economic changes, notably rapid urbanisation. They therefore advocate involving business, labour and other organisations outside the health sector in global prevention efforts.

Please note: To read this article, you will first need to register with The Lancet. This process and access to the article is free of charge.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19914

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**Non-communicable diseases in sub-Saharan Africa: where do they feature in the health research agenda?**

**Averting a public health crisis: call for more research on noncommunicable diseases in sub-Saharan Africa**


This paper, published by the World Health Organization (WHO), explores the issue of how much priority should be given to noncommunicable diseases in sub-Saharan Africa. It argues that, although communicable diseases will remain the predominant health problem for the region for the next ten to twenty years, noncommunicable diseases also present a substantial burden. Rates of non-communicable diseases within each age group are currently higher for adults in sub-Saharan Africa than for those in established market economies. The prevalence of diseases such as diabetes and hypertension is increasing rapidly, particularly in urban areas, placing significant demands on health services.

The paper argues that ignoring noncommunicable diseases will lead to an increase in their burden – their treatment and prevention would be left to local and global commercial interests, rather than health services being provided in accordance with issues of clinical and cost effectiveness. Improved surveillance of all diseases within sub-Saharan Africa is needed in order to place noncommunicable diseases properly within the context of the overall burden of disease. The paper recommends more research on how to improve clinical and cost effectiveness of resources directed at the care of patients with noncommunicable diseases, and to guide and evaluate preventive measures. [adapted from authors]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18743
Preventing chronic diseases: a vital investment

Chronic neglect: failure to prevent heart disease, stroke and cancer is killing the poor
WHO / World Health Organization (WHO) (2005)

In this report, the World Health Organization (WHO) presents data which shows that 80 per cent of the 35 million premature deaths from chronic diseases (including heart disease, stroke and cancer) during 2005 will occur in low and middle income countries. Projected figures also suggest that the number of deaths from chronic disease is growing, with men and women equally affected. In China, India and the Russian Federation, the cost of treating chronic disease is estimated at ten billion dollars over the next decade, likely to significantly hinder economic development in those countries. As the number of people with chronic disease increases, more families and communities are becoming impoverished as a result – the situation is made worse by the fact that chronic disease typically affects those in their most economically productive years. Despite this, it remains unrecognised as a cause of poverty.

The report presents information about chronic diseases and their risk factors, dispelling some of the myths which contribute to their global neglect, alongside regional and country specific data. It emphasises that effective, low-cost interventions to prevent chronic disease already exist and can be implemented in a step-wise manner even in the poorest settings. What is needed is the political will to ensure a comprehensive, integrated approach to this growing crisis.

Available online at: [www.eldis.org/cf/rdr/rdr.cfm?doc=DOC20062](http://www.eldis.org/cf/rdr/rdr.cfm?doc=DOC20062)

Diet, nutrition and the prevention of chronic diseases: report of a joint WHO/FAO expert consultation

You are what you eat: diet-related health risks and how to avoid them

Diet and nutrition have a key role in disease prevention activities. Chronic diseases linked to diet include obesity, diabetes, cardio-vascular diseases, cancer, osteoporosis and dental diseases. This document is a report of a joint World Health Organization (WHO) and FAO expert consultation that took place in 2002 to review scientific progress in preventing chronic disease, including the identification of risk factors and effective interventions to reduce risks.

The report describes the current context of diet-related diseases and gives an account of the global and regional patterns and trends in the availability and consumption of different food types. It places diet, nutrition and disease in the context of different stages of life and of the wider social, political and economic environment, before setting out specific goals for nutritional intake to prevent specific diet-related diseases. It then sets out the strategic directions and recommendations for policy and research, and concludes with a call to action.

Significant findings reported include the following:

- Economic development normally brings improvement in a country’s food supply and changes in the quality of food production. Not all such changes are positive: adverse changes include a shift towards a higher energy diet, with greater consumption of fats and sugars and reduced intake of complex carbohydrates, dietary fibre, fruit and vegetables;
There is evidence that chronic disease risks begin in the womb and continue into old age. Adult chronic disease reflects cumulative exposures to damaging physical and social environments over one’s lifetime;

Small changes in risk factors in large populations can significantly reduce disease levels and healthcare costs.

The report sets out a number of strategic actions for promoting healthy diets and physical activity. Such actions may be more or less appropriate in different local and national contexts. It also outlines the following policy principles for countries to address the epidemic of diet-related disease:

- All sectors of the food chain “from ‘farm to table” must be involved if the food system is to address the challenge of dietary change needed to cope with the epidemic of non-communicable disease;
- National strategies must be comprehensive, addressing all diet and physical activity risks for chronic disease together. They should draw on existing international standards, where the role of the WHO and FAO is crucial;
- Each country must select the optimal mix of actions in accordance with the national context. Governments and health ministries have a crucial steering and coordinating role and must work with the private sector, health professionals, academics and civil society;
- Risk factors must be addressed throughout the life course, starting with maternal and child health and continuing through school and workplace to community-based care for the elderly. Such strategies must focus on the needs of the poorest and be gender sensitive;
- Prerequisites for success include effective leadership and communication, functioning alliances and networks, and an enabling economic and policy environment where healthy lifestyle choices are easier to make.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18420

The global burden of chronic diseases: overcoming impediments to prevention and control

High levels of chronic disease in developing countries: but still a low priority for decision makers


This article from the Journal of the American Medical Association (JAMA) highlights the growing prevalence of major chronic diseases, including cardiovascular disease, cancer, chronic lung disease, and diabetes. The majority occur in developing countries, where cardiovascular disease is already the leading cause of mortality. The authors highlight the lack of financial support for prevention, treatment and research into chronic diseases in developing countries. They suggest that a key reason for this inaction is that up-to-date evidence on the burden of chronic diseases is not in the hands of decision-makers. Other factors include a persistent belief that chronic diseases affect only the rich and the elderly, that they arise from freely acquired risks, that the control of chronic disease is too expensive or ineffective, and that infectious diseases should take priority.

The authors stress the need to elevate chronic diseases onto the health agenda of policymakers. Key recommendations include: providing them with better evidence of how to
control risk factors (such as poor diet, physical inactivity, tobacco use and alcohol consumption); and persuading them of the need for changes to the health system. The authors call for a co-ordinated strategic and multi-sectoral approach, based on sound research, to meet the growing challenge of chronic disease worldwide. [adapted from author]

*Please note: to access this article, you will first be asked to register. This process and access to the journal is free of charge.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18898
Injury and violence

Injury, including that caused by violence, is a serious public health problem, leading to over five million deaths worldwide each year. Injury causes disability and places a heavy burden on health care systems, particularly in developing countries. It is the leading cause of death and disability among children and young adults; the poor are the worst hit. Injuries that cause death include motor vehicle crashes and other road traffic accidents, homicide, suicide, falls, poisoning, drowning, fires and burns. On the whole, injuries do not occur at random: they are largely predictable and, therefore, preventable. However, in order to develop effective prevention strategies, countries require better information, especially on the circumstances that lead to injuries, and the number and types of these injuries.

See also the HRC/Eldis HIV and AIDS Key Issues guide on The links between violence against women, HIV and AIDS: www.eldis.org/hivaids/vaw_consequences.htm

Feature: Violence and disasters

Dealing with increased violence following a natural disaster
WHO / Department of Injuries and Violence Prevention (VIP), WHO (2005)

This fact sheet, published by the World Health Organization, presents information on violence in communities affected by natural disasters. Anecdotal evidence and a small number of systematic studies indicate that intimate partner violence, child abuse and sexual violence are highly prevalent after disasters. Additional evidence suggests that the long-term effects of a disaster can lead to increased levels of crime and community violence. Elder abuse, youth violence and violence related to the distribution of emergency aid have not been studied systematically but are likely to affect communities after a disaster.

The fact sheet recommends that in the acute phase of the disaster, interventions should focus on caring for victims of violence and on taking measures to prevent abuse and exploitation. Health service delivery should include care for survivors of rape; health workers should be trained to identify victims of violence and to offer appropriate care; displaced children should be registered; and women’s access to resources and assistance should be ensured. The fact sheet also identifies steps to help ensure the safety of a community and to help preserve its ability to prevent and respond to violence during recovery from a disaster. These include community education and awareness campaigns and revitalising community networks. [adapted from author]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18638
Recommended readings on injury and violence

World report on violence and health

Is global violence a public health problem?

This report from the World Health Organization (WHO) outlines a public health approach to understanding and responding to the problem of violence worldwide. The report is aimed at national policymakers in the area of public health, and health professionals working at community level.

There has been a gradual move in recent decades from viewing violence as primarily an issue for law enforcement agencies, with health professionals dealing only with the consequences, to seeing public health policy as having a key part to play in addressing the root causes of violence and in violence prevention. This culminated in the adoption of a resolution declaring violence a leading worldwide health problem by the World Health Assembly in 1996. The report brings together data on the levels of violence worldwide and provides a model for a public health approach to tackling it.

Findings include the following:

- An estimated 1.6 million people lost their lives due to violence in 2000. About half of these deaths were suicides, one third murders and one fifth casualties of armed conflict.

- The rate of violence-related death in low and middle-income countries was more than twice that in high income countries.

- It is important to have a broad definition of violence to take account of cultural differences, the range of contexts and the range of perpetrators and subjective experiences of victims. The report outlines an ecological model for understanding violence which places the factors which cause it on four levels: society, community, relationship and individual.

- Violence can be self-directed, interpersonal or collective. It can take different forms: physical, sexual, psychological, and deprivation and neglect.

- Over 800,000 people killed themselves worldwide in 2000, making suicide the thirteenth highest cause of death worldwide.

- Approximately 520,000 people were killed in acts of interpersonal violence in 2000, and this included 57,000 children. Other widespread forms of interpersonal violence include sexual and physical abuse of children, abuse of the elderly, and violence against intimate partners. Surveys from around the world show that between 10 and 69 per cent of women report being physically or sexually abused by a male partner.

- Along with the very large numbers who die in collective violence and conflict, other health problems which result include: high levels of mortality and illness among refugees and vulnerable groups; increased levels of depression, alcoholism and post-traumatic stress; destruction of medical infrastructure; and loss of services.

The report makes a number of recommendations for how a public health approach to the prevention of violence can be taken forward. These include:

- Creating and implementing a national plan for the prevention of violence
Improving capacity for collecting data and supporting research on the causes, consequences, costs and prevention of violence

Promoting prevention interventions at local level and building resources for supporting the victims of violence

Integration of violence prevention into social and education policies and promoting gender and social equality

Promoting and monitoring adherence to human rights law and working towards finding effective international responses to the global trade in arms and illegal drugs

Increased collaboration and exchange of information on violence prevention.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18661

A profile of fatal injuries in South Africa: a platform for safety promotion

Unnatural deaths: public health is key to addressing injury and violence in South Africa

Matzopoulos, R.; Seedat, M.; Marais, S.; van Niekerk, A. / Medical Research Council (MRC), South Africa (2004)

Murders accounted for half of all deaths due to injury in South Africa in 2002, according to this report from the Medical Research Council of South Africa. The prevention of deaths due to injury is a major public health challenge in the country.

The statistics on the causes of death due to injury are compiled according to cause of death, age profile and gender. The system for compiling these statistics, the National Injury Mortality Surveillance System (NIMSS), was established in 1999. It uses data collected through the existing systems used in mortuaries. The figures for 2002 were collected at 34 mortuaries across 6 provinces. However, the majority of institutions taking part are in urban areas so the figures are more representative of urban rather than rural areas.

The findings include the following:

- Of the 25,494 deaths due to non-natural (external) causes, 50 per cent were homicides, of which over half involved firearms.

- Accidents, including transport accidents, were the cause of 37 per cent of deaths, and suicide was the cause in 10 per cent of cases.

- Eighty-one per cent of these deaths were male. The leading cause of death among men was homicide, accounting for half. Among women the leading cause of death, accounting for one third, was traffic accidents.

- The majority (56 per cent) of those killed in traffic accidents were pedestrians. The majority of both pedestrians and drivers killed in road accidents had blood alcohol levels in excess of the legal limit. This was also the case for the majority of homicide victims where sharp or blunt objects were involved.

- While the majority of homicide victims were men, a significant proportion of women died due to strangulation, injury by blunt objects and killing by burning where the perpetrator was male. This is consistent with other data showing high levels of violence against women in South Africa.
Most deaths were among young adults, with 37 per cent aged between 15 and 29, and 36 per cent aged between 30 and 44. However, the data also indicates a relatively high level of child homicide victims.

The evidence from developed countries shows that public health interventions can make a significant contribution to lowering the levels of deaths due to homicide, traffic accidents and other non-natural causes of death. The report calls for the mobilisation of a wide range of government and civil society actors in South Africa to create effective prevention strategies. The recommendations include the following:

- Co-ordinated national, provincial and city or regional programmes to provide effective treatment and prevention of injuries. This should be primarily the responsibility of health departments but should also involve strong collaboration across departments and sectors
- A comprehensive registration system for all incidents of both fatal and non-fatal injuries
- Stronger prevention interventions at both primary and secondary level
- Setting priorities for research on the causes, consequences, costs and prevention of deaths due to injury, and setting priorities for action
- Integration of prevention strategies into social and educational policies.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18660

The economic dimensions of interpersonal violence

What is the cost of violence in developing countries?


Interpersonal violence is violence between family members and intimates, and between acquaintances or strangers where no political or collective object is being pursued. This report from the World Health Organization (WH0) assesses the economic costs of interpersonal violence worldwide. It shows that the economic effects of such violence are felt most severely in low income countries.

The report divides interpersonal violence into different types, including child abuse, intimate partner violence, sexual violence, workplace violence, youth violence and violence related to guns, drugs and gangs. It provides an ecological model for analysing the economic cost of violence which looks at risk factors at an individual, relationship, community and societal level. Drawing on 119 studies, it provides figures for the economic cost of each of these in different countries and makes a number of recommendations for further research.

Findings include the following:

- Globally the cost of violence and crime in 2001 was estimated at 5 per cent of gross domestic product (GDP) in developed countries and 14 per cent of GDP in developing countries.
- Low and middle income countries are disproportionately affected. It is estimated that 90 per cent of violence-related deaths occurred in these countries.
In 1997 the cost of violence in Columbia and El Salvador was close to 25 per cent of GDP.

Public finances bear the main burden of the direct costs of violence, particularly the cost of medical care for victims.

The cost benefits of interventions to prevent violence are difficult to gauge and there has been very little analysis of this. All of the available evidence shows that behavioural, legal and regulatory interventions cost substantially less than the money which they save.

Comparisons of the economic costs of violence in different countries are difficult to make because of the different approaches used in calculating these costs and because there are fewer studies of the costs of violence in developing countries. Moreover, economic losses due to loss of employment and productivity tend to be undervalued for lower income countries since the costs are based on foregone wages and incomes.

The recommendations of the report include:

- Extensive and systematic further research on the economic costs of violence globally
- The development of rigorous methodological guidelines for such research which would standardise how direct and indirect costs are calculated, and allow for comparisons across countries and settings
- Prioritising research which specifically documents the economic cost of violence in developing countries
- More research on the economic costs of certain understudied types of violence, in particular abuse of elderly people which the 2002 World Report on Violence and Health has shown is widespread in all countries
- Further research on the links between the level of violence and socio-economic factors such as economic inequality, poverty and income levels
- Cost benefit analysis of public health and other interventions aimed at preventing and reducing violence.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18546
More readings on injury and violence

Women, violence and health

Violence against women is a human rights violation as well as a major public health issue
Amnesty International / Amnesty International (AI) (2005)

This report discusses violence against women and girls as a major human rights scandal and a public health crisis. The authors contend that globally women are regularly beaten and sexually abused by intimate partners, family members, neighbours, and by people not known to them. They also suffer gender-based violence during and after conflicts and wars. The impact on women’s health goes far beyond bruises, broken bones or even death. As well as causing physical suffering to women, such violence has a profound impact on women’s psychological well-being, on their sexual and reproductive health and on the well-being and security of their families and communities. The cost in human terms is huge and also has an economic dimension.

This paper examines the how gender based violence in perpetrated, in physical and social forms, in families, in communities, and during and after conflict, and looks specifically at the health consequences of gender based violence.

The paper closes with conclusions and recommendations for governments and professional associations, including, but not limited to:

- governments must recognise that violence against women is a major public health issue as well as a human rights crisis
- governments must reform law to eliminate any laws that challenge women's sexual autonomy, or facilitate impunity for anyone impinging on women's right to chose her own partner, or which promote impunity for rape
- governments must improve protection for institutionalised women
- governments must ensure adequate resources to address the health needs of women who are victims of violence, as well as encouraging local groups to support these women
- governments should ensure gender-sensitisation training for health personnel, custodial personnel, and those working in institutions
- governments should also ratify and implement the UN Convention on the Elimination of all Forms of Discrimination against Women and its Optional Protocol, without reservations; ratify and implement relevant regional standards which protect women’s rights; ratify the Rome Statute of the International Criminal Court (ICC) and adopt implementing national legislation so that the ICC can be a potential means to end impunity for violence against women in situations where it has jurisdiction; and agree on an international Arms Trade Treaty to stop the proliferation of weapons used to commit violence against women

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19500
The global road safety partnership and lessons in multisectoral collaboration

Forging partnerships in road safety, economic growth and public health
Bekefi, T. / John F. Kennedy School of Government (KSG), Harvard University (2005)

This policy brief focuses on road safety and the Global Road Safety Partnership (GRSP), it examines the relevance of this issue to economic growth and public health in a developing country context. The author considers some of the challenges of increased mobility and vehicle penetration, why this is important to business and, in turn, what the private sector is doing, or could do, to address the growing economic and health burden of road injuries and fatalities.

The brief examines the Global Road Safety Partnership, its structure, function and activities, as well as the key organisations involved in the initiative. It raises questions over whether a multi-sectoral partnership is a useful framework for addressing the road safety issue and the challenges and lessons have presented themselves so far.

The brief lists a number of policy recommendations including:

- a need to understand the impact that poor road conditions, injury and death have on a wide variety of sectors in addition to health
- identifying ways of addressing road safety in a cost effective manner, such as education and road repairs
- work with multilateral agencies for lessons learned in other country contexts. Become part of regional road safety initiatives

The author concludes that a lack of clarity remains over whether a multi-stakeholder partnership approach is the most effective and efficient way to address road safety.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19880

Preventing violence: a guide to implementing the recommendations of the World report on violence and health

Multi-sectoral involvement and clear leadership are needed for countries to tackle violence

This guide, prepared by the World Health Organization Department of Injuries and Violence Prevention, provides conceptual, policy and practical advice on how to implement the country-level activities described in the 2002 World report on violence and health. It is aimed mainly at health sector policymakers and programme planners at national, state, provincial or municipal levels. The guide outlines the six activities recommended in the 2002 report: increasing the capacity for collecting data on violence; researching violence; promoting the primary prevention of violence; promoting gender and social equality and equity to prevent violence; strengthening care and support services for victims; and developing a national plan of action. It also gives concrete suggestions for how countries can follow these recommendations.

The central message of the guide is that both multi-sectoral involvement and clear leadership are essential to the success of national, municipal and community-based efforts to prevent
violence. The health ministry, because it bears the major burden of caring for victims of violence and is chiefly responsible for the prevention of disease and health promotion, is strongly recommended as the lead agency. To enable inter-ministerial and multi-sectoral involvement, the establishment of formal mechanisms that clearly specify the roles and functions of the participants is also recommended. [adapted from authors]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18600

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**Taking chances: the lifestyles and leisure risk of young people**

**Increasing safety without limiting mobility for young people in the UK**

This report, published by the Child Accident Prevention Trust (CAPT), UK, describes the results of a two-year study examining how young people aged 11-14 are exposed to the risk of unintentional injury during their leisure time. It finds that over 60 per cent of young people asked said that they had been injured or had an accident at least once in the previous four weeks. Children who played truant from school were significantly more likely to get injured. Forty per cent said they thought they spent their leisure time in dangerous places and about half said they took risks and dares when out with their friends.

The report concludes that getting the balance right between risk and safety is a key challenge. Young people should be realistically informed of the potential danger of their own activities so that they can make decisions, and should be given the opportunity to learn by taking calculated, unsupervised risks. The study identifies a small proportion of young people as being highly at risk of accident and injury in their leisure time, and the report recommends that efforts to improve safety should be focussed on this group. Finally, the report emphasises that young people should be consulted in determining policy.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18595

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**Children and accidents factsheet**

**How can unnecessary child accidents be prevented?**

This fact sheet, published by the Child Accident Prevention Trust, UK, provides brief information about the causes of child accidents and how they can be prevented. Accidents are the main cause of death for children and young people in the UK, and are also a major cause of long-term disability and ill health. Boys are approximately twice as likely as girls to have accidents. Children in the manual social classes are estimated to be one and a half times more likely to die in accidents as other children. High-rise flats with balconies or communal stairs, unsecured windows, cars parked in side streets, and lack of public playgrounds can all increase the likelihood of accidents happening.

The fact sheet argues that children should not be prevented from learning and developing naturally but they need to grow up in a safe environment protected from unnecessary harm. This requires a combined approach through education and training for adults who are involved in caring for children, safe product design and modifications to the environment. Products and changes to the environment that are effective in increasing safety include traffic calming measures to reduce speed in residential areas, child restraints in cars, cycle helmets, window locks, smoke alarms, child resistant tops on containers, and stairgates.

[adapted from authors]
Injury surveillance guidelines

How to collect data on injuries for health system planning

This manual, published by the World Health Organization in conjunction with the US Centres for Disease Control and Prevention, aims to provide practical advice for researchers and practitioners on developing information systems for the collection of systematic data on injuries. It particularly focuses on circumstances where there may be constraints on the capacity to keep records or to assemble information, such as in low-income countries. It introduces the terms, analytical tools, and methods used by injury surveillance specialists, including ways of analysing the epidemiology of injuries. It also provides a twelve-step guide for designing and building an injury surveillance system, and a series of forms for recording information which readers can use or adapt.

The manual argues that injury surveillance can play a role in health care system planning, both by identifying injuries and their causes, and by monitoring the results of interventions. It also explains how surveillance can help agencies to argue for more resources and to identify ways of cooperating with each other. It advocates that all agencies should collect "core" data – the basic information considered necessary for local, national and international planning – but that individual agencies can also collect more detailed "optional" data suited to their particular circumstances.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18572

Persecution, intimidation, and failure of assistance in Darfur

Overview of the health situation of civilians in Darfur
Medecins sans Frontieres / Médecins Sans Frontières (MSF) (2004)

In the context of the civil war being waged in Darfur, Sudan, this paper seeks to convey what has happened to the health of people in Darfur based on data emerging from MSF clinics and surveys. The objective of the report is to create some understanding of the magnitude and depth of the suffering and the failure to address these problems. The authors combine technical health statistics with a human perspective gathered from the conversations and laments of the thousands who came to MSF clinics for assistance but who themselves were unable to remain silent about the atrocities committed against them and their families.

This report is based on a series of cross-sectional nutrition and mortality surveys carried out in conjunction with Epicentre in 6 locations of Darfur - as well as face-to-face encounters with displaced people and patients, reported by the teams working in West, South, and North Darfur since the beginning of the year 2004.

The paper traces various stages in the experience of refugees, from fleeing their homes, to the search for refuge, to going home again, all with a health perspective. This includes examination of access to food, water and sanitation, shelter, rape and violence.

The authors ultimately conclude that aid has been delayed and inadequate. Whilst the increased numbers of actors and volumes of aid now present in Darfur have stabilized the public health crisis in the major camps and around the main towns, many gaps remain in shelter, water and sanitation, nutrition and health. Assistance programming is not effectively meeting the needs of those in camps, let alone being rolled out to these many pockets of
victims, host and displaced alike, suffering deprivation. And conditions of life are still so treacherous that even daily tasks like gathering wood and water still mean serious threats of violence. The climate of fear that still exists in Darfur is all-pervasive. Camps of refuge are anything but; displaced Darfurians tell MSF that they are living under the guard of some of the same armed men that burned their villages and killed their families. The situation in Darfur perverts the very idea of refuge.

MSF concludes with three recommendations to begin redressing the situation of civilians in Darfur:

• expand assistance in terms of quality and quantity
• deliver aid wherever civilians have chosen to seek refuge
• strive to freed individuals from the threat of violence, the fundamental cause of this crisis

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC17814

Blueprints for violence prevention

What makes juvenile violence prevention programmes effective in the US?

This report, produced by the Center for the Study and Prevention of Violence at the University of Colorado and published by the US Office of Juvenile Justice and Delinquency Prevention, describes an initiative to identify programmes that have proven effective in preventing juvenile violence and delinquency. The report explains the criteria used by the initiative to identify effective programmes, and describes the programmes themselves. It stresses the importance of “implementation fidelity” – programmes remaining true to their original intent and design – and provides a review of empirical studies on this topic. It looks at ways of assessing site readiness before a programme starts and lists the critical components of successful implementation.

The report recommends that organisations and agencies implementing violence prevention programmes should do careful research before choosing a programme and try to enhance the readiness of the site to support the new programme. Steps that organisations can take to improve the quality of implementation include ensuring that the programme has a “champion” who is responsible for directing or coordinating it, and providing training and technical assistance. Recommendations for programme funders are that they should support research-based programmes; support implementation research; support capacity building among programme designers; and require accountability.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18597

A place to start: a resource kit for preventing sexual violence

Preventing sexual violence: key resources

This resource kit, published by the Minnesota Department of Health, aims to provide information, strategies, and tools for the prevention of sexual violence. Defining sexual violence as the use of sexual actions and words that are unwanted by and/or harmful to another person, it attempts to answer the following questions: Who are the victims of sexual...
violence? Who are the perpetrators? How are people’s lives affected by sexual violence? How big a problem is sexual violence? How much does sexual violence cost? It also considers why sexual violence happens, outlining both “protective” factors that help to avoid sexual violence and risk factors that make it more likely, and looks at how the laws deal with sexual violence.

The kit then presents some ideas for how different sections of the population can work to prevent sexual violence, including various community groups, health care and other service providers, workers in the criminal justice system, elected officials, the media, and employers. The kit also contains a number of information sheets on topics including ways of behaving, community assessment, health statistics on sexual violence, family violence, the role of criminal justice personnel, and signs and symptoms of child sexual abuse.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18593

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**Injury: a leading cause of the burden of disease**

**Too little attention is still paid to preventing injuries**


This document, published by the WHO, updates its 1999 publication of the same title with more recent data. The aim of the document is to inform policymakers, health officials, researchers and the general public about the magnitude and ranking of injuries. It reports that injury is a leading cause of death and disability for all age groups except persons 60 years of age or older; road traffic and self-inflicted injuries are the leading causes of injury-related deaths worldwide. A number of changes occurred between 1998 and 2002, some encouraging and some disappointing. War as a leading cause of death dropped in almost all regions and age groups; road traffic injuries have risen to become the ninth leading cause of death worldwide; and injury as a cause of death has increased among children in many regions.

The report concludes that, while some progress has been made since the first version of this publication, the data clearly show that injuries continue to be a significant public health problem. The authors hope that the document can be used to inform decision-makers and policymakers about the nature of the injury problem and, in turn, to argue for greater attention and the allocation of more resources for prevention efforts. [adapted from authors]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18568

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**Guidelines for conducting community surveys on injuries and violence**

**How to gather data on injuries and violence from community surveys**


This manual, published by the World Health Organization (WHO), aims to provide a standardised methodology for conducting community-based injury surveys that can be adapted for use in different settings, depending on local need and resource availability. It explains that the main advantage of community-based over hospital-based surveillance methods is that they capture injuries that fail to reach hospitals. These include injury deaths occurring in the community, injuries treated outside the formal health sector, and minor injuries that do not necessarily require hospital attention.

The manual consists of eleven chapters. It explains the public health benefits of community surveys, introduces key terms, and outlines how to plan and organise a community survey. It
then describes sampling methodologies, lists what data should be collected, and explains the
preparation needed before collecting data. Later chapters detail how to conduct the survey,
covering ethical issues, data entry and analysis of raw data, and discussing the importance
of reporting and disseminating results. The manual emphasises that the guidelines
presented are not meant to be prescriptive. The exact form of the survey methods used and
precisely what data are collected will vary according to the local context, priorities and
resources. [adapted from authors]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18640

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**Violence Prevention Alliance: building global commitment for violence prevention**

**How can the health sector get involved in violence prevention?**

*Violence Prevention Alliance / World Health Organization (WHO) (2005)*

This brochure, published by the World Health Organization (WHO), promotes the Violence
Prevention Alliance (VPA), a global network for organisations working to prevent violence.
The brochure lists the VPA’s aims as: increasing capacity for information-gathering on the
epidemiology of violence; improving knowledge about what works in violence prevention and
programming; and encouraging widespread implementation of policies and programmes
known to be effective. The VPA advocates a public health approach to the prevention of
violence, based on an “ecological framework”. This framework – which the brochure argues
can help describe the complexity of the causes of violence and identify strategies to prevent
it – characterises violence as the outcome of interactions between factors at four levels:
individuals, close relationships, communities and society.

The brochure argues that the health sector should take responsibility for contributing to the
prevention of violence, complementing responses from the criminal justice and other sectors.
In particular, it identifies data collection, service delivery, primary prevention programmes,
policy-making and advocacy, as areas in which the health sector could be involved. The
brochure also suggests that improved coordination and sharing of strategies by different
agencies will ensure that their independent efforts will reinforce each other, and provide a
unified voice to influence policy.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18602

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**TEACH-VIP: training, educating, and advancing collaboration in health on
violence and injury prevention**

**Training curriculum on injury prevention and control for public health workers**

*WHO / Department of Injuries and Violence Prevention (VIP), WHO (2005)*

This document, published by the World Health Organization (WHO), outlines WHO’s modular
training curriculum on injury prevention and control, TEACH-VIP. This course aims to identify
the basic principles of injury prevention, control and safety promotion; differentiate basic
methods for studying injury problems in the community; and diagnose problems from a
multidisciplinary perspective. Participants will be shown how to design, implement and
evaluate injury prevention and safety promotion interventions; compare effective injury
prevention and control interventions; identify relevant sources of information and critically
appraise them; advocate for injury prevention in communities; and practice injury prevention
control and safety promotion based on universally accepted ethical principles.
The main goal of TEACH-VIP is to train students, professionals and practitioners in the field of public health to better apply key injury prevention and control principles, to contribute to the development of preventive programmes and policies, design effective surveillance systems, evaluate intervention programmes and policies, and collect and assess injury data. While the curriculum has been developed primarily for public health, it is also expected that it can be used for allied medical and nursing students, injury prevention and response practitioners, health professionals, staff within government agencies and other relevant and interested parties. [adapted from authors]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18641

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**World report on road traffic injury prevention**

**Global strategies for prevention of road traffic injuries**


This report, jointly produced by the World Health Organization (WHO) and the World Bank, examines the growing problem of road traffic injuries from a health perspective. It argues that road traffic injuries are a major but neglected health challenge that requires concerted efforts for effective and sustainable prevention. Worldwide, an estimated 1.2 million people are killed in road crashes and as many as 50 million are injured. Projections indicate that these figures will increase by about 65 per cent over the next twenty years unless there is new commitment to prevention.

The report’s key recommendations for public health include that road safety should be included in health education campaigns and disease prevention programmes. Health-related data on road crashes and their consequences should be collected systematically. Research on risk factors and on the development and implementation of effective care programmes should be given increased support. Science-based information should be used to develop policy and practice that protects people on the roads. Pre-hospital and hospital care, including trauma care skills in medical staff at primary, district and tertiary health care levels, should be improved, as should rehabilitation services for trauma victims. Finally, the report argues for the integration of health and safety issues into transport policies. [adapted from authors]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC14662
Mental health

Of the estimated 400 million persons affected by mental disorders, most live in developing countries which command only a fraction of global mental health resources. Mental disorders account for 5-10 per cent of the burden of disease in these countries. However, budgetary allocations in national health budgets rarely exceed 1 per cent. Vulnerable populations, such as the poor and those affected by disasters, are at greater risk. Mental disorders can be effectively and affordably treated at local or community level. However, most of those in need do not receive any treatment. Mental health remains a low priority on the global public health agenda, in part due to the stigma associated with mental disorders.

For information on mental health in populations affected by disasters, see Health in emergencies and natural disasters: www.eldis.org/health/emergencies.htm

Feature: Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization world mental health surveys

World mental health surveys reveal chronic lack of treatment for serious disorders


This article from the Journal of the American Medical Association reports on findings from the World Health Organization mental health surveys, conducted in 14 countries worldwide, eight classified as developed and six as undeveloped. Results showed that overall prevalence of mental disorders varied widely from 4.3 per cent in Shanghai, China to 26.4 per cent in the United States. Mild or moderate anxiety disorders were the most common mental disorder. However, more serious disorders were linked to substantial impairment or disability. The surveys revealed a correlation between the severity of the disorder and the likelihood of treatment in almost all countries. However, up to 50 per cent of serious cases in developed countries and up to 85 per cent in less-developed countries received no treatment in the 12 months before the interview.

The authors conclude that, due to their higher prevalence, the number of mild and moderate cases receiving treatment greatly exceeds the number of untreated serious cases in every country. Acknowledging that structural barriers exist, they recommend the reallocation of resources to the treatment of serious disorders. However, they stress that value should still be given to the treatment of mild cases, especially those at risk of progressing to more serious disorders. [adapted from author]

Available online at: www.eldis.org/cfrdrerdr.cfm?doc=DOC18705
Recommended readings on mental health


Out of the institution into the community: treating mental health in developing countries

WHO / World Health Organization (WHO) (2001)

This report from the World Health Organization (WHO) recommends that the focus of mental health treatment policy in developing countries should shift from the current institution-based form of care to community-based care.

The report analyses the significant changes that have occurred in our understanding of mental health. It provides an overview of the level of mental health services and needs worldwide, and assesses the policy changes that are needed to bridge the gap between them.

Findings include the following:

- Mental health problems affect between 20 and 25 per cent of people. They are universal, affecting people in all countries and of all ages. The social and economic costs of mental health disorders are very high. There is also a strong link between mental health and other health issues; for instance, depression is linked to heart disease.

- The relationship between poverty and mental health problems is very strong, and the poor have a higher incidence of mental health disorders and substance abuse.

- There is a wide gap between the current level of need for mental health treatment and the level of treatment provision. This gap affects the poor most severely. In many developing countries, mental health care has a very low priority and treatment is restricted to a small number of poorly resourced and overcrowded institutions.

- The high incidence of suicide, particularly among young people, and the need for suicide prevention measures, are a significant public health issue in many countries.

- The emphasis on the treatment of mental health problems has shifted during the twentieth century from confining people in institutions to providing treatment in community settings. This was the result of developments in drug therapy and psychosocial interventions as well as increased awareness of human rights.

- Community-based care provides significant advantages as an approach to providing mental health treatment. However, governments of developing countries must be very careful in managing the move to this form of care, in particular ensuring that institutions are not prematurely closed down before sufficient community-based services are in place.

The report makes a number of recommendations for policymakers and health professionals. It also outlines three different approaches to implementing these recommendations, according to the level of resources available to each country. Key recommendations include the following:

- Develop a national policy and programmes for the prevention and treatment of mental health problems and ensure that adequate monitoring procedures are in place to measure their effectiveness.
• Involve communities and patients in the development of policies and programmes

• Invest in increased and improved training for mental health professionals and ensure that mental health services are effectively linked to other areas, such as education, employment and welfare

• Provide treatment for mental health problems at the level of primary care and move the main focus of treatment from institutions to community settings

• Ensure that essential drugs for treating mental health disorders are available to those who need them

• Educate people and raise awareness about mental health problems to reduce the levels of stigma and discrimination against those affected.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18419

Mental health policy, plans and programmes

What makes an effective mental health policy?


This document from the World Health Organization (WHO) gives evidence-based guidance on developing and implementing mental health policies, plans and programmes. It is designed to be applicable in different types of health systems and in countries with different levels of resources. The publication is aimed at policymakers and public health professionals working at national and regional level.

According to WHO, 40.5 per cent of countries do not have a mental health policy and 30.3 per cent do not have a mental health programme. These guidelines provide a step-by-step introduction to designing a mental health policy. Mental health policy has to be seen in the context of the other areas of policy – including health, welfare, employment, housing and general social policy – in which it operates. To maximise the effectiveness of a mental health policy, it is necessary to take account of the social and physical environment in which people live and to promote collaboration between different sectors. Designing a mental health policy includes the following steps:

• Gathering information and data on current mental health needs in the population and using this to establish priorities

• Identifying strategies that have been effective elsewhere and sharing experiences with other countries

• Consulting and negotiating with the key stakeholders

• Setting out the vision, values, principles and objectives on which the policy is based

• Defining the key areas for action. These can include financing, organisation of services, human resources and training, drug procurement and health promotion

• Identifying the major roles and responsibilities of the different sectors in mental health service provision. This will include government departments, general and mental health workers, professional associations, academic institutions and non-governmental organisations (NGOs).
It is important to have a national plan to set priorities and to avoid unnecessary duplication at local level. There is a difference between a plan, which covers the overall provision of services, and programmes, which are aimed at specific areas of mental health such as violence against women or epilepsy. Key stages in creating and implementing a national mental health plan include the following:

- Identifying the most effective strategy for each area of action, co-ordinating between these different strategies and setting measurable indicators and a timeframe for each one
- Deciding on the detailed actions that have to be taken in each area, and when and by whom these actions are to be carried out
- Establishing the costs and the available resources for implementation, and setting a budget
- Disseminating the policy, generating public support and funding for it and setting up an organisation which will be responsible for managing its implementation
- Setting up pilot projects in demonstration areas. The knowledge gained from these pilot projects will be vital in implementing the plan nationally and in providing training to health workers
- Empowering mental health service-providers and promoting collaboration among the key stakeholders and across different sectors.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC17725

**Insights Health, issue 6: no health without mental health**

**Why mental health is a development issue**

id21 insights health / id21 Development Research Reporting Service (2005)

Mental health services are under-resourced and neglected in many developing countries, according to a recent issue of the id21 Insights health bulletin. This is at a time when the demand for such services is growing rapidly.

Of the 450 million people worldwide with mental health problems, most live in developing countries. Although treatment is not expensive, most people do not receive the treatments they need and governments on average allocate less than one per cent of their health expenditure to mental health. The articles in this bulletin assess the current state of mental health services in developing countries and outline what policy changes are required.

Findings include the following:

- There is a common myth that depression is a disease of affluence. In fact, there is a strong link between marginalisation and mental health problems, and those living in poverty are more likely to suffer from depression.

- Families bear the main burden of caring for people with mental health problems. When people do seek treatment it is usually from primary medical care where their underlying mental health problems often go undetected. There is very little provision of treatment dealing with the psychological or social aspects of health.

- People with severe mental health problems such as psychotic disorders are often still incarcerated in old-style mental hospitals built during the colonial era. This type of
treatment stigmatises mental health problems, violates human rights and institutionalises people.

- There is a strong link between HIV/AIDS and mental health problems. Those affected by AIDS can suffer from depression, cognitive impairment and dementia. In the later stages of AIDS, a condition known as “AIDS mania”, a mood disorder characterised by inappropriate excitement, occurs in 1.4 per cent of cases.

- There is also a strong link between maternal mental health and infant health. In South Asia, depression during pregnancy and after childbirth is strongly associated with low birth weight, poor growth and development and a higher risk of physical health problems in babies.

- Mental health problems have a knock-on effect on other areas of healthcare. Depression can lead to increased likelihood of strokes and heart attacks, and alcohol and substance misuse can lead to a range of health problems and to violence.

- The rapid social change caused by the processes of globalisation has led to increased levels of mental health problems. Migration on a massive scale has disrupted family and community ties and increased unemployment among small-scale farmers and entrepreneurs. This has led to rising rates of suicide and premature death due to alcoholism and substance misuse.

The bulletin argues that mental health issues must be included in programmes directed at promoting poor people’s health and improving economic conditions in developing countries. Recommendations include the following:

- Treatments which originated in developed countries can also be used effectively in developing countries. For instance, group therapy has been used successfully in rural Uganda where it was delivered at low-cost by health workers with no previous mental health training.

- Depression, schizophrenia and substance misuse can be treated successfully and cost-effectively at local level. Community and primary treatment programmes are not costly to implement and should be supported by donor agencies.

- Local communities usually have mechanisms for promoting resilience and healing; social policies on healthcare and health promotion should incorporate culturally appropriate strategies.

- There should be more collaboration between health professionals working in mental health and those working in other areas of healthcare and health promotion.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18291
More readings on mental health

HIV/AIDS and mental health

Why mental health matters in HIV and AIDS interventions

This World Bank discussion paper examines the relationship between HIV and AIDS and mental health. It finds that cognitive disorders, personality disorders, and substance abuse can influence behaviour in ways that lead to greater risk of HIV infection. HIV and AIDS can also lead to mental disorders, due both to circumstances surrounding the disease and to HIV-related changes to the brain and nervous system. These disorders can adversely affect the progression of the disease, and increase the likelihood both of high-risk behaviours among people living with HIV and AIDS (PLWHA), and of non-compliance with prescribed medical treatment. Despite this, mental health is often overlooked in AIDS programming.

Key recommendations include: incorporating referral to mental health services in voluntary counselling and testing for HIV; addressing the psychosocial and mental well-being of orphans and other children made vulnerable by HIV; providing support and counselling for HIV-positive mothers; addressing the double stigma of HIV and mental health; and expanding access to antiretrovirals which have been shown to reduce dementia from 20 to 2 per cent. The authors conclude that organisations must incorporate mental health in their intervention agendas in order to meet the needs of PLWHA, reduce the spread of HIV and AIDS, and prevent the emergence of new strains of the virus.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19848

Group interpersonal therapy for depression in rural Uganda

Morale support: group psychotherapy proves effective against depression in rural Uganda

This article, published in the Journal of the American Medical Association, reports on a controlled clinical trial of group interpersonal psychotherapy (IPT) for the treatment of depression in rural Uganda. Thirty villages were randomly selected; of these, 15 were assigned for studying men and 15 for women. In each village, participants were selected from among adults who had been diagnosed with depression or depression-like illness. Half of the villages received group IPT in weekly 90-minute sessions over 16 weeks, with the remaining villages as control groups. Results showed that after completion of the IPT, the prevalence of major depression was significantly higher among the control groups, while there was a substantial decline in severity of depression symptoms and associated dysfunction (problems performing tasks) among the intervention groups.

The authors conclude that group interpersonal therapy was both feasible and effective in treating depression-like illness, depression symptoms and associated dysfunction among the individuals in the study sample. They note that this was the first time that IPT training of local people had been carried out, and suggest that increased local experience of this approach is likely to achieve a significant impact.

* To access this paper, you will first be asked to register with the Journal of the American Medical Association. This process and access to the paper is free of charge.
Evaluation of a community based rehabilitation model for chronic schizophrenia in a rural region of India

Positive proof: involving local communities is beneficial for schizophrenia patients in rural India

Published in the British Journal of Psychiatry, this paper describes how a model for community-based rehabilitation (CBR) for people with schizophrenia was evaluated in a resource-poor region of rural India. The study compared outcomes for the CBR model with standard outpatient care which used only clinical services. The CBR model used a three-tiered service delivery system: outpatient care was at the top, while the second tier employed mental health workers drawn from the local community, and the third tier consisted of family and members of local village health groups. Results showed that compliance with treatment was significantly better in the CBR group. Clinical and disability outcomes were also better for the CBR group.

The authors conclude that the CBR method was more efficient in reaching and retaining patients and their families in the programme, reflected in the results for compliance, and represents a feasible option for resource-poor settings. Key strengths are that it involves active local community participation and low levels of technical expertise to deliver services. The authors recommend that mental health professionals initiate services that draw upon resources from the local community, with an emphasis on compliance. They also call for randomised controlled trials of the cost-effectiveness of the CBR model.

Please note: This document is not freely available online. Photocopies can be obtained from the British Library of Development Studies. Click here to order a copy. There is a charge for this service.

Social factors associated with child mental health problems in Brazil: cross sectional survey

Study from Brazil shows link between social adversity and child mental health problems

This article from the British Medical Journal reports on a survey in Brazil which examined the association between child mental health problems and social factors, including poverty, family violence and parental mental illness. The survey was conducted in three contrasting neighbourhoods: a favela (shanty town) without sanitation and built on illegally occupied land; a stable urban community; and a rural village. Children in the survey were aged 7-14. Findings showed that poverty, maternal mental illness, and family violence were all strongly associated with higher rates of probable psychiatric disorder among the children studied.

The authors note the higher rate of behavioural problems in the favela. They question whether this was caused by social adversities, arguing that the children’s problems may be linked to maternal depression or harsh discipline. They also suggest that the social adversities and behavioural problems may both have arisen from unmeasured factors. They call for further research into the possible role of social capital and social networks in
mitigating the impact of social adversities on child mental health. Overall, they conclude that their findings helped to identify marginalised groups of “at risk” children and recommend that these groups be targeted for preventive or curative services. [adapted from author]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18456

Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria

Need for educational programmes to reduce stigma against mental illness in Nigeria

This article, published in BMC International Health and Human Rights, reports on a study of knowledge, attitudes and beliefs about mental illness among adults in a rural community in northern Nigeria. The study found that the most commonly perceived symptoms of mental illness were aggression, destructiveness, being excessively talkative or behaving eccentrically. Other causes identified by the respondents included drug and alcohol misuse, divine punishment, sorcery or spirit possession. Approximately 46 per cent advocated orthodox medical care for the mentally ill, while 34 per cent preferred spiritual healing. Findings also showed that almost half the respondents had negative feelings towards the mentally ill. However, literate respondents were seven times more likely than non-literate subjects to view the mentally ill in a positive way.

The authors conclude that a better understanding of mental illness among the public is needed to address common fears and misconceptions, and reduce the stigma against mentally ill members of the community. They recommend educational programmes aimed at demystifying mental illness. They also suggest their findings may be useful to health policy-makers designing community mental health education programmes and services in existing primary health centres in Nigeria. [adapted from author]

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC15725

Social capital and mental health

Strong community bonds don’t always mean better mental health

This article from the British Journal of Psychiatry focuses on social capital – broadly defined as the "glue" that holds societies together and enables group co-operation— and its effects on psychological health. A review of existing research on social capital and mental health indicates a link between lack of social cohesion and higher incidence of psychosis. However, one UK researcher showed that people with psychoses who lived in areas with high perceived community safety (a measure of social capital) were more likely to be readmitted to hospital, suggesting low community tolerance of "deviant" behaviour.

The authors find that research on social capital and health to date has largely focused on the "horizontal" links or bonds that exist within a community. However, they argue that societies with high levels of social capital according to traditional measures may also be intolerant of minority groups and score less well on other measures of integration. They suggest that future research should address the vertical dimensions of social capital, such as social structure, organisation and institutions, rather than focusing on the collective attributes of
Achieving the millennium development goals: does mental health play a role?

No health without mental health: so why is it missing from the millennium development goals?

This paper from the journal PloS Medicine notes that mental health is absent from the Millennium Development Goals (MDGs). However, it cites evidence which indicates that mental health-related conditions, including depressive and anxiety disorders, alcohol and drug abuse, and schizophrenia, contribute significantly both to the number of years lived with disability and lost due to disability in developing countries. It highlights further research which shows that poor mental health is closely linked to social determinants, notably poverty and disadvantage, as well as to HIV and AIDS and poor maternal and child health.

The paper emphasises that mental health has an integral role to play in achieving the MDGs, and further argues that mental disorders can be effectively and affordably treated at local level. It calls for a broader approach to national health targets, with the focus on strengthening health care systems. It also suggests indicators, including rates of depression and suicide, which could be used to monitor the mental health of target populations. It calls for more research and more opportunity for local voices from developing countries to acknowledge their own mental health needs, and urges global mental health advocates to reinforce the message that there is no health without mental health.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC19849

Mental health in complex emergencies

A mental health action plan for complex emergencies: cultural sensitivity is key

This review from The Lancet presents an action plan for providing mental health care in complex emergencies. Its recommendations include immediate, centralised coordination of all mental health activities, followed by a needs assessment to identify vulnerable groups, highlight risk factors, and find out what mental health resources are already available. The focus should then be on supporting public health activities aimed at reducing mortality and morbidity, while offering basic psychological care and helping communities build resilience and adapt to changing circumstances. The next step is to build the capacity of the existing mental health system of primary care providers, traditional healers, and relief workers, through provision of finance and training. The plan also recommends a self-care programme for all providers to prevent ‘burn out’ and other negative mental health outcomes.

Throughout, the authors stress the importance of using the cultural worldview of the population being served, and basing activities on scientific evidence. The need to involve the local community in active participation is also emphasised. The authors recommend public discussion of the results for the benefit of future interventions, and call on donors and relief organisations to make research and assessment in mental health a funding priority in complex emergencies.
Poverty and common mental health disorders in developing countries

Lack of education is the main risk factor for mental illness in developing countries

This article from the Bulletin of the World Health Organization reviews community-based studies which looked at the association between poverty and common mental disorders in low- and middle-income countries. Most studies showed an association between poverty and common mental disorders. The most consistent risk factor for common mental disorders was illiteracy or poor education. Many studies also showed a relationship with indicators of poverty such as financial insecurity; shame and social stigma linked to poverty; rapid and unpredictable social change; gender, with women more at risk than men; and poor physical health.

The authors argue that common mental disorders must be placed alongside other diseases associated with poverty. They call on the global mental health movement to play a larger role in public health activities, and for mental health professionals to confront global poverty. They recommend more research to establish causal links between common mental disorders and poverty, focusing both on specific risk factors, and on factors which reduce risk in persons facing economic or social adversity. They conclude by stressing the need for primary prevention, via microcredit schemes; and secondary prevention, by improving the treatment of common mental disorders in primary health care, and training staff in appropriate techniques.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18453

Where there is no psychiatrist (chapter 1): an introduction to mental illness

Practical guide to mental health problems for settings without a qualified psychiatrist
Patel, V.; Gaskell Publications / The Royal College of Psychiatrists (2003)

This chapter is from the book “Where there is no psychiatrist”, produced by the Royal College of Psychiatrists. It provides an overview of key issues in mental health and mental illness for developing countries, intended for the general or community health worker in settings without a qualified psychiatrist. The author explains the link between physical and mental health, before outlining symptoms and key features of a range of mental health problems, from the more common such as depression and anxiety, sexual problems and addiction, drug and alcohol misuse, to severe mental disorders (psychoses) including mania and schizophrenia.

The chapter also covers mental health problems affecting particular groups, including learning disability; dementia in the elderly; and mental illness in children, with a section on behavioural disorders. Key causes of mental illness are identified. These include stressful life events such as bereavement and trauma; violence or emotional neglect in childhood; brain diseases; heredity; and medical problems. The chapter concludes with a section on mental illness and culture, looking at different definitions of mental illness, language used to
describe emotional distress, and traditional and religious beliefs about mental disorders. Guidance is accompanied by case studies and pen-and-ink illustrations. The chapter is freely available online.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18536

**Effect of maternal mental health on infant growth in low income countries: new evidence from South Asia**

**Evidence from South Asia shows link between poor infant growth and maternal depression**


This article from the British Medical Journal considers new evidence for the impact of postnatal depression (a mental disorder affecting some mothers during the period after giving birth) on poor infant growth in South Asia. Findings show that postnatal depression is a common cause of disability among mothers in the region. Key risk factors include: mental health problems during pregnancy; economic difficulties; lack of education; marital disharmony; and giving birth to a girl (due to the cultural preference for sons). Research in both India and Pakistan also shows a clear association between infant undernutrition and high levels of maternal mental distress.

The authors conclude that failure to thrive is more common in infants whose mothers have postnatal depression. This may be because depressed mood during pregnancy leads to poor attendance at antenatal clinics, increasing the risk of low birth weight and early delivery. Alternatively, maternal depression may affect the emotional quality of parenting, and may be linked to negative life events and adverse social and psychological circumstances, which in turn affect development. The authors recommend combining child-focused interventions aiming to provide supplementary nutrition, with mother-focused interventions targeted at improving mental health both before and after birth. This in turn may also help to improve infant growth outcomes.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18581

**Mental and social health during and after acute emergencies: emerging consensus?**

**Is controversy crippling mental health programmes in emergency settings?**


This article from the Bulletin of the World Health Organization acknowledges that there is no agreement on the public health value of the post-traumatic stress disorder concept, or the appropriateness of vertical (separate) trauma-focused services during and after acute emergencies. It also highlights the separation of psychosocial care (focusing on non-medical intervention) from the mental health care field. It suggests that this has actually drawn practitioners skilled in non-biological interventions away from formal mental health services.

Strategies on which there is emerging consensus are identified. These include the need for contingency planning before an acute emergency, assessment before intervention, use of a long-term development perspective, collaboration with other agencies, training and supervision, and universal treatment in primary health care settings. In the acute emergency phase (the period where mortality rate increases due to lack of food, shelter, physical
security, water and sanitation, as well as from communicable diseases), the authors stress the need for access to clear, valid information, delivered sensitively. Overall, they advocate the integration of social interventions and trauma-focused care into general mental health care. They call for clear guidelines for programme planners so they are not forced to choose between specialised, trauma-focused care or ignoring mental health altogether.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC17250

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**Investing in mental health**

**What is the cost of mental illness worldwide?**

WHO / World Health Organization (WHO) (2001)

This paper from the World Health Organization outlines the scale and burden of mental disorders worldwide, and provides guidance on mental health promotion, suicide prevention, and effective treatments and interventions. Key findings include the following: approximately 450 million people suffer from a mental or behavioural disorder; nearly 1 million people commit suicide each year; mental disorders account for four out of every six years lived with disability; and one in four of all families have at least one member with a mental disorder.

Those suffering from mental illnesses may also suffer human rights violations, stigma and discrimination.

The paper notes the gap between the treatment needs of mentally ill persons and available resources; in developing countries, nearly 90 per cent do not receive treatment. A key initiative to bridge this gap is the WHO Mental Health Global Action Programme (mhGAP). The paper also examines the economic burden of mental disorders, which affect personal income, the ability of ill persons and their carers to work, and overall workplace productivity. It recommends combining well-targeted treatment and prevention programmes in the field of mental health as part of a public strategy to prevent suicide, reduce stigma and increase social capital, while promoting a country’s economic development.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18472

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**Child and adolescent mental health policies and plans**

**How to design effective mental health services for children and adolescents**

WHO / World Health Organization (WHO) (2005)

This guide is one module of the World Health Organization mental health policy and guidance package for countries. It outlines the social and economic context, and provides guidance on developing and implementing a child and adolescent mental health policy and plan. The module can be used individually or as part of the whole package, and can serve as a training aid, framework for technical consultancy, or advocacy tool. Its target audience includes policymakers; public health professionals in ministries of health, or local, regional and national health departments; mental health professionals working with children and young people; and policy and advocacy organisations including consumer groups, caregiver groups, and professional organisations.

Recommendations for effective implementation include: ensuring the policy reaches children, adolescents, and their families in a range of locations, such as schools, places of worship, streets, rural areas and workplaces; identifying allies in other parts of government or in the community or country to generate political support and funding; involving individuals with a wide range of expertise, while providing support to those with training or experience more
applicable to adults; setting up pilot projects in demonstration areas; and empowering providers through intersectoral collaboration and participation.

Available online at: www.eldis.org/cf/rdr/rdr.cfm?doc=DOC18451