WHO has continued to advocate extension of the concept of mental health care and psychiatry into the wider concept of public mental health. As a consequence, the need to develop new technologies has been obvious. The Schizophrenia Research Foundation (SCARF) in Chennai, India, has been designated as the WHO Collaborating Centre for Research and Training in Mental Health. This centre has developed an instrument, based on extensive ethnographic work, to quantify the perceived burden on home care-givers of chronic psychotic patients.

An innovative approach to reduce family violence due to inebriation has been developed in Sri Lanka by an NGO with support from WHO. Also, with WHO support, ethnographic work has been carried out in Indonesia to understand the motivational patterns in street-gang violence in Jakarta, leading to more effective rehabilitation techniques.

A training workshop on health behaviour research methodology was held in Yangon, Myanmar. The Regional Office prepared substantial reading and background material which can be used in similar training workshops in other countries of the Region.
The Indian Council of Medical Research, New Delhi, developed indicators for the quality of community life, based on the protocol developed earlier in a WHO intercountry workshop on Research for Mental Health Programmes. The result is an ethnography-based instrument to quantify feelings people have about their communities or neighbourhoods. This instrument can now be used in programmes which aim to increase community participation in an activity or in other community-based projects.

Advances have been made in some countries of the Region, especially India and Sri Lanka, in the development of community-based programmes of demand reduction of illicit drugs. In Sri Lanka, the National Dangerous Drugs Control Board compared the results of a community-oriented outreach research work with drug users with the results obtained from clinic-based detoxification efforts. The superiority of the former approach was so obvious that the Board decided to transform the three existing detoxification centres into centres for community activities. The second phase of the UNDCP-supported drug abuse control project in Sri Lanka ended in December 1995. The Regional Office assisted the national authorities in drafting a document for the third phase of the project.

Technical support was provided to a network of NGOs to effect the agreed standards of drug services, including harm minimization. These services included help in problems related to alcohol and opium use in rural areas as well as heroin use in urban areas.

Unlike alcohol control, anti-tobacco activities received increased attention in most countries of the Region where advocacy and public education on control measures took a positive turn. Focal points for tobacco control were appointed, and, in some countries, national committees were set up to study the relevant issues and other problems. National seminars and conferences on tobacco were organized in two countries providing a forum for review and replanning. Legislative acts and executive instructions banning tobacco smoking in public places were promulgated in Delhi, India, where the sale of cigarettes to people below 19 years of age is also prohibited. India, Indonesia and Thailand banned smoking on all
domestic and some international flights. Advertisements promoting smoking have been banned in Sri Lanka and in the National Capital Territory of Delhi. Maldives has declared two islands as tobacco-free.

The health education infrastructure has been decentralized in some countries to the community level, with health volunteers playing a critical role in information dissemination and community mobilization. Health education services have been extended to a large number of schools, communities, hospitals, and, in some cases, to workplaces. These services focus on areas such as maternal and child health, immunization, communicable diseases and noncommunicable diseases such as HIV/AIDS, cancer, cardiovascular diseases, hypertension and thalassemia. A series of in-service training programmes for various categories of health and health-related personnel such as primary health care workers, health devotees (as they are known in Myanmar) and doctors were organized at the community level.

Major strides were made towards the implementation of comprehensive school health education programmes. School curricular reviews in Indonesia, Maldives, Sri Lanka and Thailand gave adequate recognition to subjects such as drugs, alcohol, counselling, sex-related problems, thalassemia, tobacco and life-skills. Deworming and nutrition supplement programmes have taken centrestage in the efforts to improve the health status of the school-going child in India and Maldives.

Information on WHO collaborative activities was provided to a number of organizations, individual’s, health educators and other health personnel. The media was kept posted with WHO policies and strategies and specific activities. Production and dissemination of information materials were continued. The regional newsletter, HFA 2000, was issued regularly during the reporting period. A fact file on Dominant Communicable Diseases in South-East Asia, a video on Bridging the Gaps — WHO in the South-East Asia Region, and regional versions of the World Health Report were produced and
Rehabilitation

WHO continued to promote the concept of community-based rehabilitation (CBR) in the Region. A bi-regional training workshop on Management of Rehabilitation Programmes was organized jointly by WPRO and SEARO in October 1996 in Ciloto, Indonesia, which focused on strengthening the managerial skills in developing and implementing CBR programmes in the two regions.

A regional workshop on Strengthening CBR Programmes as an Integral Part of Primary Health Care was held in New Delhi in December 1996. It recommended some country and regional action points for sustainability and expansion of programme activities as well as for incorporation of rehabilitation components into existing health systems.

Support was provided to Bangladesh and Bhutan for translating the WHO manual on CBR into local languages. India and Myanmar took up re-translation and/or re-printing of the manual. In Bhutan, a national CBR programme was established as a priority programme of national health development.

Technical support was provided to Sri Lanka for reviewing the feasibility of local production of low-cost artificial limbs and holding
training programmes on CBR for health workers and volunteers. A training worksheet on CBR for provincial health personnel was produced in Indonesia, while seminars and conferences dealing with various aspects of disabilities were supported in India.

A study was conducted in Thailand on Alternatives for Community-based Rehabilitation Model, while the CBR programme was expanded in the country’s northern provinces.