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MENTAL RETARDATION

Report by the Director-General

This report describes the steps taken by the Director-General to implement resolution WHA28.57 on mental retardation.

Psychosocial factors determine to a considerable extent the degree of disability that results from mental retardation. With a supportive family environment and appropriate education many mentally retarded individuals are able to have productive and enjoyable lives. In providing care there is a need for close coordination between health, education and social welfare services.

WHO has been involved in work on mental retardation, in collaboration with the United Nations, its specialized agencies, and nongovernmental organizations, for many years. Since the adoption of the resolution, new directions are being followed. Priority is being given to action within existing services and to interventions concerned with children. Simple methods of detection and care which can be used by public health nurses, auxiliary health workers and parents are being stressed. Improved antenatal and natal care, the control of infectious diseases and adequate nutrition in early childhood, combined with health education of parents, are seen as the most effective preventive measures.

Activities undertaken since the resolution was adopted include: (i) WHO meetings which have produced valuable guidelines; (ii) projects to test the feasibility of providing care at primary health care level in developing countries; (iii) an international survey of legislation; (iv) development of methods for the control of associated conditions such as epilepsy; (v) training for public health administrators; (vi) the identification and strengthening of potential training centres; (vii) development of mechanisms of coordination.

Certain constraints exist to responding fully to the resolution and future progress will depend mainly on the priority accorded by governments to work on mental retardation.

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1. INTRODUCTION

In resolution WHA28.57, taking into account the worldwide problem of mental retardation, the World Health Assembly requested the Director-General, in collaboration with the United Nations and its specialized agencies:

(1) to assist in the development of community care for the mentally retarded as part of a comprehensive disability prevention and rehabilitation programme through training programmes, provision of fellowships and encouragement of international exchange of personnel working in this field;

(2) to encourage the preparation of international guidelines for the training of persons concerned with the care and development of the mentally retarded and for the organization of relevant services; and

(3) to report on progress in these activities to the Thirtieth World Health Assembly.

This report describes the action taken to implement the above resolution, reviews previous work concerning mental retardation, and outlines the new direction and emphasis indicated by the resolution. Three other recent Health Assembly resolutions (resolutions WHA28.84 on promotion of mental health, WHA29.68 on disability prevention and rehabilitation, and WHA29.21 on psychosocial factors and health) have an important direct bearing on the approach to be taken by WHO in implementing resolution WHA28.57, and their implications are also discussed. In addition, the overall policy reorientation brought about by resolution WHA29.48 on programme budget policy has strongly influenced action and priorities for work on mental retardation.

2. BACKGROUND

Mentally retarded people constitute a sizeable minority in all communities and, in many instances, they remain underprivileged, deprived of their full rights, and unable to develop their potential for productive and enjoyable lives. This was recognized by the United Nations General Assembly in its Declaration on the Rights of Mentally Retarded Persons[1] and Declaration on the Rights of Disabled Persons.[2] Resolution WHA28.57 states that "mental retardation can affect up to 3% of a population". The great majority of these would be affected by a mild degree of retardation.[3] Individuals in this group who receive appropriate education, which can often be provided in ordinary schools, can readily become independent and responsible members of society. Difficulties are likely to arise when there are associated medical or social problems which interfere with normal psychosocial development and education. It is for this reason that the concept of "normalization" has gained wide acceptance in recent years and has become an important guiding principle in providing community care for the mentally retarded. Between 10% and 15% of the mentally retarded have more serious degrees of retardation (moderate or severe) and require more intensive care and specially designed education. Individuals in this group are also more likely to have other health problems, such as motor or sensory impairments due to cerebral palsy.

Of overriding importance in mental retardation work is the need for close coordination between different disciplines and public sectors. "No single discipline has the knowledge or competence to undertake alone the responsibility for meeting the needs of the mentally retarded" was one of the basic premises adopted in its report[4] by the WHO Expert Committee on Mental Health on organization of services for the mentally retarded, which urged a coordinated approach to the

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[1] United Nations General Assembly resolution 2856 (XXVI).

[2] United Nations General Assembly resolution 3447 (XXX).

[3] This term is that used in the International Classification of Diseases, 9th Revision. Detailed descriptions of this and other terms can be found in the Glossary of mental disorders and guide to their classification, Geneva, World Health Organization, 1974.

[4] WHO Technical Report Series, No. 392, 1968.

problem (see section 3). At an international level, close collaboration between the United Nations and its specialized agencies is essential and this should lead to a clear statement of responsibilities and linked plans of action.

Mental retardation cannot be regarded simply as a medical condition, with a direct relationship between impaired brain function and disability. In the majority of mentally retarded individuals no clear-cut anatomical, biochemical or physiological abnormality can be demonstrated, although in the more severely retarded such abnormalities are commoner. A number of intervening variables, particularly social and environmental factors, determine the degree of disability which occurs in children with developmental delays or intellectual impairment. Specific developmental delays (e.g., in language) if inappropriately managed may lead to lasting disability. There is therefore great scope for preventing or reducing disability in individuals with intellectual impairments, providing interventions are made at an early stage.

Under conditions of rapid technological development and social change in which the complexity of life tasks increases, the problems of mental retardation are likely to become more serious. Affected individuals will be relatively more disadvantaged in such transitional situations and, in addition, family support to less able members may decrease. The high rate of "educational failure" is causing concern in many countries, and mental retardation may be a contributing factor. In some cases it may be that the educational system itself is inappropriate to the child's social and cultural background and that this is the underlying cause of failure. In other cases, mild degrees of retardation may be associated with an emotional disorder or minor degrees of unrecognized sensory impairment (myopia or deafness) and appropriate intervention would allow the child to remain in school.

The request to the Director-General in resolution WHA28.57 was concerned primarily with the provision of care for the mentally retarded and the training of personnel. This report therefore deals mainly with these matters. However, many WHO activities are of great importance in the prevention of mental retardation. Improvement of antenatal, natal and early infant care will decrease the risks of brain damage associated with hypoxia and birth injury. Low birth weight is strongly associated with developmental delays in childhood and any action leading to a reduction in the rates of low birth weight will decrease the risk of subsequent mental retardation. Improved nutriton during the period of rapid brain development is also of great importance, and the clinical triad of subnutrition, understimulation and recurrent infectious illnesses is now recognized as being strongly associated with developmental delays. Recently, fresh impetus has been given by WHO's Expanded Programme on Immunization and Special Programme for Research and Training in Tropical Diseases to the control of infectious diseases, which also contributes to reducing problems of mental retardation. In the Organization's mental health programme, work on the control of neurological disorders is also relevant to prevention of mental retardation, and collaborative studies are being carried out on the physiopathology of mental retardation and on brain development and nutrition, which will contribute to a better understanding of the pathogenesis.

3. PREVIOUS WHO WORK

In 1953, a Joint Expert Committee convened by WHO with the participation of the United Nations, ILO and UNESCO formulated the following general principles: (a) wherever possible existing services for the mentally retarded should be expanded; (b) the family should be the unit receiving care; (c) parents should not be penalized economically and socially by keeping their child at home; and (d) social costs should form the basis of efficient planning.[1] The WHO Expert Committee (mentioned in section 2 above) endorsed the earlier recommendations and gave additional attention to problems relating to the management and rehabilitation of the severely retarded, the community adjustment of the adult retarded, and the role of

[1] WHO Technical Report Series, No. 75, 1954.

socioeconomic conditions as causal factors in mild retardation. The Committee emphasized that definitions and classification of the mentally retarded need to be related to the culture in which they are applied. At a WHO seminar (Washington, 1969) on the diagnosis and classification of mental retardation, a multi-axial classification was recommended including four types of information: degree of mental retardation, etiological factors, associated psychiatric disorder, and psychosocial factors.

A number of seminars have been organized, for example in Norway (Oslo) in 1957, Italy (Milan) in 1959 and Colombia in 1973, bringing together specialists from various fields such as psychiatrists, public health administrators, paediatricians, psychologists, nurses and social workers. At a WHO European Conference on the Care of the Mentally Retarded in the Community held in 1974 in Spain, participants from 19 European countries reviewed the health, social and educational services available to mentally retarded people in the Region and the role of voluntary organizations. Discussions were based on the results of a survey in nine pilot study areas in the European Region. As more emphasis is being placed on community care, responsibilities are being increasingly shared between psychiatric, educational and social services, and clearer definitions of their functions are necessary to ensure the optimum use of community resources.

WHO has provided some consultant assistance in mental retardation at the request of countries: these include Iraq (1954), Ceylon (1955), Denmark (1960), Switzerland (1963), Poland and Spain (1969), Saudi Arabia (1970), and Argentina (1974). However, a much larger number of consultants have visited Member States at the request of governments to assist in the development of mental health programmes in general and have included in their reports recommendations on the development of services for the mentally retarded. Very few countries have requested WHO fellowships specifically for study related to mental retardation.

Research projects carried out with the cooperation of WHO include a programme in the United Republic of Tanzania on the effects of malnutrition on mental development, one aimed at evaluation of the effectiveness of iodized oil in the prevention of endemic goitre in Ecuador, and comparative studies on the care of the severely retarded in Denmark, the USSR, and the United Kingdom.

4. DIRECTION OF WORK AND PRIORITIES

Taken together, resolutions WHA28.57, 28.84 and 29.68 provide clear guidelines for the direction of future work on mental retardation and the priorities to be adopted. Resolution WHA28.57 indicates that care for the mentally retarded should be "part of a comprehensive disability prevention and rehabilitation programme". Furthermore, resolution WHA29.68 recommends that WHO policy on disability prevention and rehabilitation be oriented towards "integrating disability prevention and rehabilitation into health programmes at all levels". It follows that work on mental retardation should be an integral part of several programmes, particularly mental health, disability prevention and rehabilitation, maternal and child health, and health education.

Resolution WHA29.48 on programme budget policy has also provided clear guidance. At a time when the Organization is reorienting its work in response to this resolution, a newly created, separate programme at WHO headquarters would be inappropriate. Instead, efforts are being directed towards increasing the capability of existing programmes to respond to countries' needs in the field of mental retardation and stimulating cooperation between countries by working with nongovernmental organizations.

A nonspecialized approach will therefore be taken, with emphasis on care in the community, on integration of health services for the mentally retarded within general health services, on strengthening collaboration between the health sector and other sectors, including education and social welfare services, and on developing and evaluating innovative methods of providing care. Priority will be given to action as an integral part of technical cooperation relevant to the needs of developing countries.

Most effective interventions in mental retardation work are based on human interactions which can take place in simple surroundings such as the home, schools, dispensaries or health centres. If these places become the foci for services, effective care for the mentally retarded can be made available to all communities. In training programmes, the emphasis will therefore be on simple methods with the aim of enabling community members and auxiliary personnel to carry out many of the tasks involved. Efforts will also be made to increase the amount of relevant training in mental retardation for public health administrators and child health specialists, in basic medical education, and in the training of nurses.

Mentally retarded individuals can be found in all age-groups and all need appropriate care. In the first instance, however, priority in WHO activities will be given to action concerned with children. This is because it is in childhood that health-related interventions are of greatest importance. In adults, social welfare and vocational guidance become relatively more important. Furthermore, actions early in life are more likely to prevent the development of severe disability and social isolation of the mentally retarded.

5. CURRENT AND PLANNED ACTIVITIES

5.1 Development of community care

The goals of community care for the mentally retarded are: (i) to ensure early detection of affected children; (ii) to provide effective treatment for associated medical conditions; (iii) to provide clear, consistent and continuous advice and support for the families of such children; (iv) to coordinate efforts with local education and social welfare services; (v) to ensure appropriate vocational training and provision of work for mentally retarded individuals; (vi) to protect and enhance the rights of mentally retarded individuals.

The diagnosis and assessment of mental retardation is hampered in many parts of the world by the lack of appropriate diagnostic methods and tests, as was recognized in a resolution of the Educational, Scientific, Cultural and Health Commission of the Organization of African Unity,[1] which stated that "tests at present used in our countries are ill adapted and do not respond to our culture, our environment and our development". Furthermore, simple methods of training for the detection of mental retardation in infant welfare clinics and peripheral health services are at present lacking. Clear guidelines for such work were provided by a WHO Expert Committee on Child Mental Health and Psychosocial Development, which met in Geneva in November 1976.[2] The Committee laid down three general principles for the provision of services:

(1) make use of existing services that are readily accessible to the community;

(2) enhance cooperation between different workers responsible for services to the child;

(3) involve families in treatment and seek to increase parental skills and confidence.

For these reasons, work has been started on projects concerned with development and testing of methods of care for mentally retarded children appropriate for the developing countries.

One such project is the WHO collaborative study on strategies for extending mental health care. This is being carried out in defined areas with populations of approximately 50 000 each in five developing countries (Brazil, Colombia, India, Senegal and Sudan). In

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[1] Resolution on psychotechnical tests, adopted at the Commission's first ordinary session, Addis Ababa, 30 June - 4 July 1969.

[2] The Expert Committee's report will be published in the WHO Technical Report Series. A summary of the salient points appeared in the WHO Chronicle, 31, 18-22 (1977).

these study areas there is at present no mental health care available. The aim is to test the feasibility of introducing care for a limited number of priority conditions such as psychiatric emergencies and chronic psychotic illnesses into basic health services and evaluating the effectiveness of such care. Mental retardation has been selected as a priority condition for which interventions will be introduced and evaluated in three of these areas. Simple methods of screening for mental retardation have been developed. Baseline data on the prevalence of mental retardation among children and adults coming to existing peripheral health services have already been obtained and an assessment of community attitudes to mental disorder, including mental retardation, has been made. The interventions will consist of brief training periods for health staff in the areas, regular supervision and support by mental health professionals, and the stimulation of appropriate community responses through education. Clear-cut data on the cost and the effectiveness of these interventions will be available and should allow health planners to decide whether such an approach is desirable and practicable. In this project, it should be stressed that work on mental retardation has been included with other mental disorders as an integral aspect of general health care.

Another project with similar aims but concerned with the whole range of disability prevention and rehabilitation has recently been started in Indonesia. In this the first step is to identify all disabled individuals in a sample population of 20 000-50 000. Mental retardation is one of the conditions included in the survey protocol. An analysis of each identified case will be made to ascertain (a) whether the disability could have been prevented and (b) whether simple techniques of rehabilitation which could be applied now in such areas are available. Appropriate preventive measures and techniques of rehabilitation will then be introduced in these areas and evaluated.

The latter project is part of the WHO programme on disability prevention and rehabilitation. Valuable guidelines for community based care and rehabilitation were provided in a policy statement for this programme submitted to the Twenty-ninth Health Assembly in 1976[1] in which many references to mental retardation were made. An analysis was made of the deficiencies in the conventional approach to rehabilitation and ways of improving the effectiveness and coverage of rehabilitation services were described.

A review of the present state of services for the mentally retarded and possibilities for immediate action in the Eastern Mediterranean Region was carried out at a group meeting held in Cairo in June 1976. In the report of this meeting[2] the role of social factors such as disintegration of the extended family, rapid urbanization and consequent need for learning more complex skills in making previously covert retardation more obvious was stressed. Recommendations were made for a coordinating mechanism at national level (see section 5.4). In planning services, it was stated that:

(1) early detection in infant welfare clinics together with straightforward advice and counselling for parents is required;

(2) family care of mentally retarded children should be encouraged and necessary support and advice made available for families;

(3) as far as possible, a normal life style and pattern of relationships should be sought for the retarded;

(4) rehabilitation should be more realistic than at present, with training in agriculture, simple occupations and workshops where the skills involved are more relevant to the prevalent social and economic situation.

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[1] Reports on specific technical matters: Disability prevention and rehabilitation (document A29/INF.DOC/1).

[2] Report of the Group Meeting on Mental Health and Mental Legislation, Cairo, 12-17 June 1976, Alexandria, 1976 (document EM/MENT/82).

In developing community care for the mentally retarded, the treatment of associated medical conditions is receiving attention. Epilepsy is of particular importance since mentally retarded individuals have epilepsy more frequently than the general population. Furthermore, uncontrolled grand mal epilepsy may lead to brain damage and consequent mental retardation. Several activities are being undertaken to develop cheap and effective methods for the control of epilepsy. At a consultation held in 1975,[1] a limited range of drugs required for treating epilepsy was put forward. This issue was further discussed by the WHO Study Group on the Application of Advances in Neurosciences for the Control of Neurological Disorders at its meeting in Abidjan from 28 March to 1 April 1977. Motor impairments are also important contributors to overall disability in some mentally retarded people, particularly those with cerebral palsy, and work on the problems of the multiply handicapped is being carried out within the WHO disability prevention and rehabilitation programme.

5.2 Legislation

Legislation is an important factor in the planning and delivery of care for the mentally retarded. In 1976 an international survey of mental health legislation was carried out by WHO. It was found that in the 42 countries surveyed, only 6 had separate legislation covering the needs and rights of mentally retarded people. In a further 26 there is specific reference to the mentally retarded either in mental health legislation or in public health legislation. In 10 countries no legal provisions of either kind exist. The results will be published in 1977 together with guidelines which will help countries to assess their legislation and enact new laws when necessary. An early draft of these guidelines was reviewed by a working group of leading mental health professionals, public health administrators, lawyers and sociologists at a meeting in Cairo in June 1976. There was also discussion by the larger group meeting (mentioned in section 5.1 above) held at the same time, and comments and suggestions were summarized in its report.

In this work, special emphasis is placed on the preservation of human rights, for which a basis is provided by the United Nations Declaration on the Rights of Mentally Retarded Persons. The survey and guidelines to be published by WHO will describe different options available in drafting laws appropriate for varying social cultural backgrounds and will suggest how the law can be used as a rallying point for public opinion and to promote relevant mental health programmes including care for the mentally retarded.

5.3 Education and training

A number of steps have been taken to develop guidelines for the training of persons concerned with the care of the mentally retarded. As indicated above, priority has been given to training of those at peripheral level and for those responsible for general health services.

5.3.1 The WHO Expert Committee on Child Mental Health and Psychosocial Development

The report and recommendations of this Expert Committee have already been mentioned in the section on community care (section 5.1 above). The Committee also gave considerable attention to the questions of manpower development and public education. Ways in which public health nurses and health auxiliaries in infant welfare clinics could be trained to cope with psychosocial as well as physical aspects of the development of young children were outlined. The need for relevant training of general physicians, paediatricians, medical assistants and those working in school health services was also stressed. Four principles in such training were put forward.

(1) A basic understanding of psychosocial development is needed by all workers concerned with the growth, health, education and socialization of children.

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[1] Report of a Consultation on Drug Treatment for Neuropsychiatric Disorders in Developing Countries, Geneva, 1976 (document OMH/76.2).

(2) Training should be directed towards defined circumscribed tasks necessary to deal with priority problems.

(3) New roles of existing workers should be encouraged: for example, the nurse as a teacher of mothers, the teacher as a behavioural therapist and counsellor.

(4) Innovative training methods using participatory techniques should be introduced and evaluated.

5.3.2 The primary health worker

In The primary health worker, published by WHO as a working guide,[1] is included a brief section on children who have difficulty in learning, with specific advice on finding children with serious developmental delays, identifying associated medical and social conditions, and providing support for mothers. The working guide as a whole is meant to be adapted to local conditions. The brief section concerned with mental retardation is a first step in developing and testing further teaching materials for health workers in peripheral health services. This work will be an integral part of the WHO collaborative study on strategies for extending mental health care described in section 5.1 above and will be pursued in collaboration with primary health care programmes. Only simple and circumscribed tasks can be carried out by primary health workers, and close links with local teachers are needed.

5.3.3 Public health administrators

In public health courses, little attention is generally given to mental retardation. As a result, those responsible for planning and administering health services frequently lack relevant knowledge and skills. This lack may be linked with negative and fatalistic attitudes towards mental disorders as a whole and mental retardation in particular. In developing brief mental health components for postgraduate courses in public health, close attention has therefore been given to mental retardation. A brief and concentrated course, in English, was given at the London School of Hygiene and Tropical Medicine in May 1976 and will be repeated in 1977. A second course, in French, is being held at the School of Public Health in Brussels during April 1977. In both cases the majority of students have been from developing countries. The courses are being carefully evaluated to provide a basis for improvement of further courses of this kind.

5.3.4 Physicians and professional nurses

In many medical schools there is no training on mental retardation. Even when present, such training is often limited in scope and based on institutions with an emphasis on severe retardation and no exposure to community care. The same is true of most basic training for professional nurses. There is an urgent need, therefore, to improve training in this field. As a preliminary step, WHO in collaboration with the Association of Psychiatrists in Africa carried out a survey on mental health training in Africa[2] in 1975 in which information from 23 countries was gathered, including data on training in mental retardation. The question will be further discussed at the next meeting of Deans of Medical Schools in the African Region to be held in 1977.

5.3.5 Parents

Parents of mentally retarded children are obviously key figures in their care. They need not only general encouragement, support and accurate information, but also specific skills to allow them to train their retarded child in such basic tasks as dressing, eating and

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[1] The primary health worker: a working guide, Geneva, 1976 (document HMD/74.5, Rev. 1976).

[2] Results will be published in English and French in the African Journal of Psychiatry.

washing. A number of practically oriented books have been written to fulfil this need.[1] They are mainly relevant to parents living in industrialized countries. WHO has developed a project proposal which would allow methods and materials to be developed and tested for use in developing countries, drawing on the techniques of behavioural psychology and sensorimotor exercises. Extrabudgetary funds are being sought for this project.

5.3.6 WHO fellowships

Resolution WHA28.57 makes specific reference to the provision of fellowships as a means of assisting in the development of community care for the mentally retarded. Selection of candidates and subjects of study is largely in the hands of governments and the number of fellowships awarded specifically in the field of mental retardation remains low.

At the first session of the Coordinating Group for the WHO Mental Health Programme,[2] there was strong support for a proposal that mental retardation should be included as a component in the training of fellows in child health, family health and other relevant areas. It was agreed that WHO should assist in the development of centres that could provide such training. Steps have already been taken to establish and strengthen such centres in two developing countries (Colombia and India) and to identify centres in developed countries that can provide suitable training.

5.3.7 WHO Collaborating Centre on Psychosocial Development of the Child, Bucharest

This collaborating centre is based at the Institute of Hygiene and Public Health, Bucharest. Steps have been taken recently to strengthen links between the Bucharest centre and other leading centres in the area of psychosocial development. The work of the centre on obtaining reliable indices of psychosocial development under conditions of rapid socioeconomic change is of direct relevance to the training of workers in infant welfare clinics. The centre provides an excellent opportunity for broadly based training.

5.4 Coordination

For some years, coordination at an international level has been achieved mainly through ad hoc interagency meetings on rehabilitation of the disabled. The first meeting on the general topic of rehabilitation of the disabled was in 1961, and since 1971 annual meetings have been held. These meetings are regularly attended by representatives of the United Nations, UNICEF, UNDP, the Office of the United Nations High Commissioner for Refugees, ILO and WHO. A number of nongovernmental organizations, including those specially concerned with the mentally retarded, are jointly represented by the Council of World Organizations interested in the Handicapped. These regular meetings have proved an effective means of exchanging information and coordinating efforts.

It was, in fact, an earlier resolution of the World Health Assembly (resolution WHA19.37) which led to a wider recognition of "the need for developing rehabilitation services not only for injuries and diseases affecting locomotive organs but also disabling diseases, particularly mental and cardiovascular diseases . . ." at these meetings. In direct response to this resolution, WHO initiated the first discussion of rehabilitation of the mentally retarded at the interagency meeting in 1968 and the topic has been regularly considered since then.

More recently, WHO has again taken the initiative at the interagency meetings in pressing for a "new concerted approach to rehabilitation" following the policy laid down by resolution WHA29.68. The Administrative Committee on Coordination has authorized the holding

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[1] For example, Marià Egg's Ein Kind ist Anders (Spiegel Verlag, Zurich, 1960), which has been translated into Arabic, English, French and Spanish.

[2] Report of the first meeting of the Coordinating Group for the WHO Mental Health Programme, Geneva, 17-23 February 1976 (document OMH/76.4).

of up to three interagency consultations a year so that these new approaches can be translated into concrete joint programmes of action. As a result, there is more regular interagency consultation and an agreement on overall policy and approaches to be adopted. This provides an excellent background for further interagency collaboration in the field of mental retardation.

In 1976 WHO worked closely with ILO and the nongovernmental organizations on definitions of terms used in mental retardation, to be published by ILO in a glossary.

The principal nongovernmental organization in official relations with WHO concerned with mental retardation is the Joint Commission on International Aspects of Mental Retardation through which two separate bodies are represented: The International League of Societies for the Mentally Handicapped and the International Association for the Scientific Study of Mental Deficiency. Both are extremely active and close links are maintained by WHO through informal consultations, attendance at meetings and congresses organized by the organizations, and invitations to appropriate WHO meetings. The nongovernmental organizations provide an extensive network of various kinds of professional expertise throughout the world and their cooperation has been sought in identifying well qualified consultants for work in the field of mental retardation.

At the regional level, coordination is achieved through the regional coordinating mechanisms established within the WHO mental health programme. In the Region of the Americas, the Organization collaborated in 1975 with the Government of Panama and the Inter-American Children's Institute in the second Pan American Congress on Mental Retardation and in 1976 in the first Latin American Conference on Mental Retardation. An International Seminar on Early Stimulation is being held in Santiago, Chile, in May 1977. Proposals have also been made for WHO to sponsor a workshop jointly with the Asian Federation for the Mentally Retarded covering the South-East Asia and the Western Pacific Regions. In the European Region, working groups will be held in 1979 on staffing of services for the mentally retarded, in 1981 on methods of rehabilitation for the mentally retarded, and in 1983 on reintegration of the mentally retarded in the community.

A specific recommendation concerning coordination at the national level was made at the Group Meeting on Mental Health and Mental Legislation held in Cairo in June 1976 (see section 5.1 above): ". . . governments should develop an interministerial body involving the departments of health, social work, education and justice, to ensure better coordination between the activities of agencies and between the government and voluntary agencies interested in mental retardation. The responsibility for care of the various groups of mentally retarded will have to be shared by the departments and ministries".

6. POSSIBILITIES AND CONSTRAINTS FOR THE FUTURE

The steps taken in response to resolution WHA28.57 have been outlined. There has been a reconsideration of priorities and a reorientation in activities. Concrete results have already been achieved. Techniques exist that can be applied now in developing countries, and work will be carried out to improve these techniques and further develop appropriate methods of training. It should be clearly recognized, however, that these activities remain somewhat limited in scope and the reasons for this should be stated.

Resources available to WHO for work on mental retardation are necessarily limited and the United Nations and its other specialized agencies also have only limited resources. Thus, although close coordination of efforts can be established and maintained, the volume of work at country level remains limited.

Efforts have been made to secure some extrabudgetary support for activities in this field. The survey of mental health legislation described in section 5.1 above was carried out with such support. It has not yet been possible to secure support for specific projects on mental retardation, but efforts will continue.

Resolution WHA29.48 has led to a major shift in resource allocation, with the emphasis being placed on direct technical cooperation with countries. Much could be done to alleviate the situation of the mentally retarded but significant progress will only be achieved when governments themselves decide to accord this work adequate priority in their health policies and development plans.

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