

## **FOURTH MEETING**

**Wednesday, 22 May 2013, at 09:40**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

**later:** Dr L.G. ROSS (Solomon Islands)

**later:** Dr W.T. GWENIGALE (Liberia)

### **1. FIRST REPORT OF COMMITTEE A (Document A66/63 (Draft))**

Dr ARMSTRONG (Secretary) read out the draft first report of Committee A.

**The report was adopted.<sup>1</sup>**

### **2. NONCOMMUNICABLE DISEASES: Item 13 of the Agenda (continued)**

**Draft comprehensive mental health action plan 2013–2020:** Item 13.3 of the Agenda (Documents A66/10 Rev. 1 and A66/10 Rev. 1 Add. 1)

Dr ROZITA HALINA TUN HUSSEIN (Malaysia) welcomed the draft comprehensive mental health action plan 2013–2020 and endorsed its six cross-cutting principles, as well as the proposed actions for reducing the global burden of mental disorders. The plan's global targets were acceptable, with the exception of global target 3.2 (10% reduction of suicide rates by 2020) because accurate surveillance data might be difficult to obtain and, depending on past trends, the target might not be achievable in all countries. In developing a surveillance framework, account should be taken of the mental health issues common to all Member States. Furthermore, interagency cooperation and standardized data collection methods were necessary to enable data to be compared across countries.

Professor SHIRALIYEV (Azerbaijan) said that mental disorders placed a significant burden on health systems and socioeconomic development. His country had made considerable progress in reducing that burden: for example, it was currently drawing up a comprehensive plan for the prevention and treatment of mental health disorders; it had adopted a national strategy pursuant to the Mental Health Declaration for Europe, adopted in 2005; and it had enacted legislation to protect the rights of people with mental disorders. Psychiatrists, psychologists and social workers at the country's first national mental health centre, which had opened its doors in 2012, worked in cooperation with family doctors in the areas of prevention, early warning and rehabilitation. The draft comprehensive action plan would be instrumental in consolidating efforts to provide greater assistance in the area of mental health.

Dr KOH (United States of America) welcomed the fact that the draft comprehensive action plan proposed to build the knowledge and skills of both general and specialized health workers and that it called for reducing disparities in access to services and decreasing stigmatization. Global target 3.2, which aimed for a 10% reduction in suicide rates by 2020, was more realistic than the earlier target of

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<sup>1</sup> See page 309.

20% and was consistent with his country's goal of saving 20 000 lives in five years. He suggested that, in Appendix 1 of document A66/10 Rev.1, under global target 3.2, the words "number of completed suicides per year" should be replaced by "number of suicide deaths per year" in order to avoid any implication that death by suicide was a "success". Overall, he supported the objectives, targets and actions set out in the draft plan.

Professor PRASAD (India) welcomed the draft comprehensive action plan, which represented the culmination of the work initiated by his country with the support of Switzerland and the United States of America.

Professor DATTA (Bangladesh) welcomed the draft comprehensive action plan. According to *The Lancet* series on the Global Burden of Disease Study 2010, mental, neurological and substance use disorders together accounted for 13% of the total global disease burden, a greater percentage than heart disease, stroke and cancer. It was recognized that autism spectrum disorder placed a growing burden on all nations. Because it was mentioned only once in the draft comprehensive action plan, autism might not receive the attention it deserved when implementation began. He therefore proposed that the words "in accordance with the definition mentioned in paragraph 5" should be inserted after the words "with mental disorders" in the last line of paragraph 21 of the draft comprehensive action plan (document A66/10 Rev.1, Annex).

Dr MARTINEZ DE CUELLAR (Paraguay) said that Paraguay had its own mental health policy for the period 2011–2013 that reflected some of the main elements in the draft comprehensive action plan, which her country fully endorsed and was committed to implementing. Special attention should be paid in the draft comprehensive action plan to the traditional role of women as informal carers, particularly in low-income countries, and the need to provide them with holistic health care in order to prevent the onset of mental disorders. With regard to the draft resolution contained in document A66/10 Rev.1, she proposed that the words "ensuring that sufficient domestic resources are available, especially in developing countries, to enable the actions described in the draft comprehensive mental health action plan 2013–2020 to be put into practice" should be inserted at the end of paragraph 2.

Dr KABANGE NUMBI MUKWAMPA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, welcomed the collaborative approach that had been used to draw up the draft comprehensive action plan and urged Member States to adopt it. The action plan represented a global response to the burden of morbidity caused by mental illness. However, financial resources remained inadequate and there was a dearth of suitable strategies, trained mental health workers, medicines for treating mental disorders and relevant statistical data. Reform of health leadership and a stronger commitment by decision-makers nationally and internationally were also needed in order to ensure that effective mental health policy and legislation were in place. Furthermore, the impact of the draft comprehensive action plan could be heightened by: linking it to the draft action plan for the prevention and control of noncommunicable diseases 2013–2020, thereby increasing the pool of financial resources; using a multisectoral approach involving the health, education, employment, housing and legal sectors; and incorporating a mental health dimension into the prevention and treatment of drug and alcohol abuse.

Dr ISHIKAWA (Japan), endorsing the draft comprehensive action plan and the draft resolution contained in document A66/10 Rev.1, said that, traditionally, insufficient attention had been paid to mental health, but the growing interest in noncommunicable diseases should lead to greater awareness of the impact of mental disorders. Implementation of the action plan would require more work, in particular with regard to monitoring of indicators, an area in which WHO should take the lead. The number of health facilities and human resources with the necessary skills must be increased and a comprehensive approach adopted if the needs of people with mental disorders were to be properly met.

Professor BAGGOLEY (Australia) commended the collaboration in the preparation of the draft comprehensive action plan and endorsed its objectives. Global target 2, a 20% increase in service coverage for severe mental disorders (the definition of which should be set out clearly), was particularly worthy of support but should not detract from the broader objective of ensuring that people with mild and moderate mental disorders had access to the right level, mix and quality of services. In general, he supported global target 3.2, a 10% reduction in suicide rates, but was concerned that suicide reduction targets that were made public might discourage accurate reporting of suicide, and that more efficient data collection might lead to short-term increases in reported suicide rates. Furthermore, in view of the complexity of suicide determinants, suicide rates were not a suitable measure of mental health system performance.

Ms GRØNVOLD (Norway), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, welcomed the increased interest in mental health and endorsed the draft comprehensive action plan, the implementation of which must be cost-effective and synergistic. The draft action plan should place greater emphasis on the promotion of mental health, the principal determinants of which were a sense of identity and meaning in life, feelings of competence, a sense of security, affiliation and belonging, and adequate social support, and which was undermined by poverty, conflict and the breakdown of family and society. Health inequalities and the social determinants of health merited attention, for which greater intersectoral cooperation was needed, and better understanding of trans-generational and life-course perspectives should be sought. Indicators to assess mental health in populations should include positive as well as negative measures in order to produce a comprehensive picture of mental health status, and the prevalence and incidence of mental disorders should be monitored. Action plans concerning various health issues should be considered in conjunction with one another.

Ms PRETTY MULTIHARTINA (Indonesia) endorsed the draft comprehensive action plan in general, but some of the targets would need to be adjusted at country level to match existing capacities. Countries with limited resources should use their existing budgets as efficiently as possible to set up mental health programmes, while continuing to seek new funding. Many developing countries lacked accurate mental health data, including on treatment gaps and suicide rates, and most needed support in carrying out the relevant research. Reliable data were a powerful tool for implementing mental health programmes and identifying service needs, as well as for tailoring policies to local needs and strengthening existing initiatives. Objective 2, which called for the provision of comprehensive mental health and social care services in community-based settings, was a worthy goal but should be adjusted to reflect national capacities and priorities, in particular in developing countries. Countries also needed to strengthen community-based mental health services before reducing the number of hospital beds available.

Ms BELL (Canada) endorsed the draft comprehensive action plan, in particular its overall aims, which were to draw attention to mental health issues, reduce stigmatization and discrimination and improve mental health outcomes, and its emphasis on a multisectoral approach to mental health. Setting global targets was an important first step in bringing about measurable change. Nevertheless, it should be recognized that Member States' capacities varied and that some targets, particularly global target 3.2 on reducing suicide rates, the proposed amendment to which she endorsed, might be difficult to meet. Canada would do its utmost to achieve the global targets by 2020 and was willing to cooperate with WHO on the development of a core set of indicators to measure progress towards them.

Dr LEI Zhenglong (China) expressed broad support for the draft comprehensive action plan but requested that greater emphasis be placed on several aspects: sharing information on legal systems and outcome assessments in connection with mental health; fostering academic and technical cooperation; increasing support for mental health professionals in developing countries, particularly through

training programmes; and pursuing advocacy and awareness-raising projects, in order to encourage countries to provide assistance to impoverished mental health patients and to adopt a multisectoral approach. China was currently drafting its own mental health action plan covering the period 2013–2020 and would be willing to work more closely with WHO in that area.

Dr ESCARTIN (Philippines) endorsed the draft comprehensive action plan because it provided a wide range of strategies to guide Member States in promoting mental health and preventing mental disorders, which included protecting the human rights of persons with mental disorders and empowering families, communities and health care providers.

Mrs HARDING-ROUSE (Trinidad and Tobago), endorsing the draft comprehensive action plan, said that mental health and wellness was one of her country's strategic priorities. To that end, it was drafting a national mental health policy and plan, taking steps to integrate mental health into primary care and strengthening its mental health data collection system. Mental health legislation was being updated to ensure that the human rights of persons with mental disorders were protected, in accordance with the United Nations Convention on the Rights of Persons with Disabilities.

The mental health of all citizens must be protected. She therefore proposed that the words "and protected" should be inserted after "promoted" in paragraph 20 of the draft comprehensive action plan. The plan should also cover mental health literacy and create linkages between health ministries and authorities responsible for medical education. Under objective 3, suicide prevention measures should be extended to include all age groups since the suicide rate was highest among the elderly. Under global target 3.1, the word "national" should be replaced by "large-scale", in order to enable low- and middle-income countries with limited budgets to implement large-scale rather than national programmes. The plan should also include objectives that established a link between mental health and noncommunicable diseases, especially since mental disorders were not specifically targeted by the Millennium Development Goals.

Dr SOUMOUK (Central African Republic) endorsed the draft comprehensive action plan. Of particular importance was the sixth cross-cutting principle, which concerned the empowerment of persons with mental disorders and psychosocial disabilities. Although not explicitly stated in the action plan, one of the key dimensions of empowerment was social reintegration, given that victims of mental disorders suffered various social consequences, ranging from stigmatization to abandonment by family and society. Special attention should therefore be accorded to that dimension.

Mr PARK Chang-kyu (Republic of Korea) welcomed the draft comprehensive action plan, particularly since the incidence of suicide and mental vulnerability was high in his country. The Government had established mental health as a priority and was shifting its focus, not only in that area but for noncommunicable diseases in general, from treatment to prevention. It had established a comprehensive mental health plan the previous year and was working on revising its legislation in that field.

Dr AL-TAAE (Iraq) said that primary health care should cover all aspects of health care, including mental health. His Government was committed to tackling the problem of mental disorders through an integrated approach that included family planning and reproductive health services, and noncommunicable disease control initiatives. Its aim was to achieve the objectives set out in the draft comprehensive action plan, as well as the Millennium Development Goals. In view of the significant economic and social impact of mental illness, there was a need to link health services and social services in order to ensure the involvement of various sectors in the promotion of mental health.

Dr PAVIC SIMETIN (Croatia) strongly supported the draft comprehensive action plan, in particular its emphasis on the fundamental principles of universal access and equity, respect for human rights, evidence-based initiatives and best practices. The plan's multisectoral approach, its aim of

providing protection from mental disorder at all stages of the life cycle, and the empowerment of persons with mental disorders were equally welcome. She appreciated the fact that the actions proposed under the plan were clearly defined and partnerships at international, regional and national levels were encouraged.

Dr SEAKGOSING (Botswana) endorsed the draft comprehensive action plan. His Government would cooperate with WHO on its implementation. Mental disorders accounted for a significant proportion of all disabilities, and many people with severe mental disorders in low- and middle-income countries did not receive treatment. Recognizing the magnitude of the burden placed by mental illness on individuals, families and communities, his country had made strides in the areas of prevention and control, but more work was needed in order to enable people with mental disorders to lead productive lives. He supported the proposal by the delegate of Bangladesh to include the subject of autism in the draft plan and endorsed the idea of linking it with the draft action plan for the prevention and control of noncommunicable diseases.

Dr PITAKPOL BOONYAMALIK (Thailand), endorsing the draft comprehensive action plan, commended the cooperative efforts that had gone into its development. He particularly appreciated the plan's multisectoral approach, the clear guidance it provided in respect of the role to be played by the major partners involved, and the challenging targets it set for monitoring and evaluation. Nevertheless, the lack of a problem-oriented perspective within the action plan might result in misalignment between its objectives and indicators. Mental health problems must be prioritized, and activities involving promotion, prevention, health services and information systems should be coordinated during the planning phase, at all levels. The growing problem of childhood mental disorders called for separate plans and indicators devised specifically for children; in that connection, he welcomed the suggestion to place autism on the provisional agenda of the Executive Board at its 133rd session.

Ms TOELUPE (Samoa) welcomed the clear objectives and cross-cutting principles and approaches set out in the draft comprehensive action plan, which she endorsed as a whole. However, Member States would need support in carrying out the actions proposed in the plan and in achieving its objectives and targets.

Dr HO (Brunei Darussalam) supported the draft action plan, in particular the emphasis placed on policy and law, resource planning, stakeholder collaboration and empowerment. Her Government had been working to improve and expand its mental health services, in particular community-based services, with a view to providing integrated, multisectoral care with special sensitivity to cultural contexts. To that end it had drafted a national mental health plan and would shortly be implementing legislation related to education and training. She supported the call for increased mental health resources, which should be allocated to promotion and prevention, and welcomed the Secretariat's pledge to support Member States in developing information systems. Special mental health programmes should be designed not only for children and adolescents, as had been suggested by the delegate of Thailand, but also for pregnant women, mothers of young children and high-risk groups in the prison population.

Mr ÁLVAREZ LUCAS (Mexico), endorsing the draft comprehensive action plan, said that the main thrusts of the plan, and in particular its focus on human rights and the disabilities affecting mental health, were reflected in his country's national mental health policy, which accorded particular attention to promotion, prevention, treatment and rehabilitation, and access to community-based services. The draft action plan should include a psychosocial rehabilitation component specifically aimed at long-term psychiatric hospital patients who were especially vulnerable owing to physical or mental problems, abandonment by their family or inadequate access to social assistance.

Dr ALIMOV (Uzbekistan) welcomed the draft comprehensive action plan and said that his country would take the necessary steps to implement it. He endorsed the proposed draft resolution contained in document A66/10 Rev.1.

Dr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the Secretariat's decision to hold broad consultations prior to drawing up the draft comprehensive action plan, which he fully endorsed. The promotion and protection of mental health were a vital social concern, as mental health was fundamental to leading a productive and enjoyable life. Specific concerns in the Region with regard to mental health included the stigmatization attached to mental disorders, political crises and their impact on the most vulnerable groups, the disturbingly high gap in low- and middle-income countries between treatment needs and the care available to people with severe mental disorders, and the high rate of suicide in people from 15 to 45 years of age. In that connection, he welcomed the fact that both the draft comprehensive action plan and the WHO Mental Health Gap Action Programme made reference to childhood mental disorders, including autism spectrum disorder.

Mr PETTERSON (Sweden) proposed that, in paragraph 2 of the draft resolution contained in document A66/10 Rev.1, the words "as adapted to national priorities and specific national circumstances" should be inserted after "2013–2020", and that, in the first line of that same paragraph, the words "proposed actions" should be replaced by "a menu of options". That would make the draft resolution more consistent with the draft action plan for the prevention and control of noncommunicable diseases 2013–2020.

Dr MBUGUA (Kenya) said that Kenya had participated in the preparation of the draft comprehensive action plan and was convinced that its targets and indicators would adequately address mental health issues. Her Government had implemented a comprehensive and integrated mental health policy and was drafting legislation in that area, but faced difficulties in providing adequate services owing to a scarcity of health facilities with mental health services, mental health workers, and adequate and affordable medicines. She called for the mobilization of additional resources to be allocated to mental health.

Mrs CHARLES-STIJNBERG (Suriname) said that suicide was a public health problem in many countries, including her own. Responsible reporting by the media, listed in the draft action plan as a suicide prevention measure, was difficult to put into practice. Despite briefings and information sessions, including distribution of WHO press kits, the media still tended to treat suicide sensationally, which only encouraged copycat behaviour, and she called on the Organization to identify innovative ways of fostering responsible reporting. Furthermore, it was important to limit access to highly toxic pesticides, and to use locally trained professionals to identify and manage suicidal behaviour in its early stages, as was being done in Suriname on a trial basis. Countries should exchange best practices in prevention, under the auspices of the Organization. Without technical support from WHO, the member countries of the Caribbean Community would not be able to meet by 2020 the targets set out in the draft action plan.

Dr RODRIGUEZ (El Salvador), endorsing the draft comprehensive action plan, said that despite numerous initiatives, including in the Region of the Americas, little progress had been made in integrating mental health into overall health care services. It was time to reverse that trend. Following a reform of its health care system, El Salvador accorded the same importance to mental health as it did to physical health with regard to promotion, prevention, treatment and rehabilitation, and those services were provided with the compassion to which all patients were entitled. It had also made efforts to ensure that mental health care was available at all levels: all specialized community health centres had a psychologist and almost all hospitals had mental health units. International cooperation had also played a crucial role in strengthening the national health service network.

Dr RAMOKGOPA (South Africa) welcomed the draft comprehensive action plan and expressed her gratitude to the Organization for providing technical support to her country in revising its national mental health policy and plan. She particularly appreciated the emphasis in the draft plan on collaboration and community-based mental health services. Reducing gender-based violence and abuse of women and children would play a major role in improving access to mental health services and in reducing comorbidity with many communicable and noncommunicable diseases, as well as injury and trauma. The targets set out in the draft plan were ambitious and many countries would need technical support in order to achieve them by 2020.

Dr SIMENDA (Zambia) said that the draft comprehensive action plan, which he endorsed, provided a consistent and coordinated approach to the treatment of mental disorders, and one that Member States would be able to implement. Its objectives and global targets were realistic and could be achieved by 2020. He called on stakeholders to assist grass-roots organizations in building their capacities, help them to fight the stigmatization and discrimination associated with mental disorders, and provide training in the production of evidence-based data.

Mr NEVES (Brazil) said that the draft comprehensive action plan, which would help to reinforce and guide national action, represented an important achievement by virtue of its emphasis on a coordinated multisectoral approach, vital for dealing with mental health issues. His country was moving towards using social integration and community care as ways of improving treatment and quality of life for individuals with mental disorders and, in that regard, he underlined the importance of incorporating social determinants of health and access to appropriate medications into national mental health policies. A political commitment to primary health care, support for community and family networks, and respect for human rights, produced much better results than the traditional psychiatric approach used in institutions.

Dr HONG SON CUNG (Viet Nam) welcomed the draft comprehensive action plan, which would guide his country in the preparation and adoption of its mental health legislation. He proposed that, after the fifth subparagraph under paragraph 23 of the draft action plan contained in the annex to document A66/10 Rev.1, the words “Integrated and community-based approach: Mental health and social care services need to be integrated into primary health care services and based on communities” should be inserted as a new subparagraph. He asked whether the terms “mental disorders” and “psychosocial disabilities” in paragraph 38 referred to different conditions. If that were the case, both terms should be defined in paragraph 5. He also asked whether specialized mental health hospitals were to be included in the service reorganization referred to in paragraph 56.

Dr ABDULRAHIM (Bahrain) supported adoption of the draft comprehensive action plan, which commendably took into account the views expressed by Member States at regional meetings or via the Internet. The Director-General was requested to provide support to Member States for national capacity-building, in the interest of putting in place the policies and measures necessary to ensure implementation of the plan at the regional level, improve research capabilities and develop monitoring systems for data collection.

Dr AFZAL (Pakistan), endorsing the draft comprehensive action plan, said that she welcomed the open dialogue that had taken place during its preparation. The increasing prevalence and incidence of mental disorders were contributing significantly to the disease burden, yet such disorders had failed to receive the attention they deserved. The draft action plan would help Member States to meet the challenges of tackling mental health issues, including setting up mechanisms to promote mental health, developing reliable data collection systems and implementing a multisectoral approach.

Dr COITINÑO (Uruguay) endorsed the vision, goals and principles of the draft comprehensive action plan. Uruguay had been working since 2011 to provide universal access to psychosocial

services and to psychotherapy in all its forms, both of which were regarded as fundamental to the prevention of mental disorders and suicide. Such services would also help to modify mental, physical and social behaviour and would benefit not only patients, but also their families and society in general. The implementation of the draft action plan, which had been inspired in part by national strategies, would be a significant step forward for mental health in the Region of the Americas.

Professor DELAFOSSE (Côte d'Ivoire) said that anthropological studies had demonstrated that, particularly in rural areas, attitudes towards death were shaped by the culture and suicide was not always acknowledged because it was regarded as shameful. In urban areas, it was important to recognize that adolescents engaged in suicidal behaviour, which was most often motivated by an identity crisis, as a way of defying death, rather than actually seeking it.

Mr SAMO (Federated States of Micronesia), associating himself with the statement made by the delegate of Samoa, endorsed the draft comprehensive action plan but was concerned that some of its proposed indicators might be too ambitious. He agreed with the emphasis in the action plan on preventive mental health services, treatment and access to essential psychotropic drugs.

Dr COOMBS (Jamaica), speaking on behalf of the member countries of the Caribbean Community, endorsed the draft comprehensive action plan and said that the countries of the Caribbean Community were in the process of drafting mental health legislation and developing mental health programmes in line with the plan. He was concerned, however, that the absence of baseline data and a scarcity of resources would make it difficult for many countries to achieve the global targets set out in the plan. The importance of a life-course approach could not be overstated: recognizing that many mental health problems began in early childhood and that mental health problems were prevalent among adolescents, the countries of the Caribbean Community were convinced that regional and global strategies aimed at strengthening parenting skills and meeting the needs of adolescents were required. Greater emphasis should therefore be placed on parenting under objective 3 of the draft plan.

Dr GOMEZ (Bahamas), welcoming the draft comprehensive action plan and the Organization's heightened focus on mental health, acknowledged the rise in the number of suicides worldwide, some of which had been assisted by technology. It was therefore important to monitor and manage websites that encouraged suicide and provided instructions on how to carry it out successfully. Agreeing with previous speakers that it would be difficult for the countries of the Caribbean Community to achieve the action plan targets, he suggested that a mid-term review of the targets should be included under the plan.

Mr RAHMONOV (Tajikistan) supported the draft comprehensive action plan and welcomed the important role played by WHO. His country, which had gone through a civil war, had made mental health a priority. It had put in place a national mental health strategy 2012–2016, as called for in the draft action plan, and was currently reviewing legislation on psychiatric services. As had been pointed out by the delegate of Canada, every country was at a different stage, and that fact should be taken into consideration when looking at indicators relating to national strategies and monitoring.

Mr DEANE (Barbados) welcomed the draft comprehensive action plan, and in particular its focus on universal health coverage and human rights and the shift towards community care, which should mitigate the loss of valuable human resources resulting from institutionalization. Society must change its perception of persons with mental disorders if they were to rejoin their community. In that regard, the failure of the draft action plan to focus on sustainable mental health education and promotion programmes was a source of concern, and funding should be allocated for that purpose. In addition, he suggested that an indicator for measuring the reduction in hospital beds should be included in the plan.



Ms CHUN-YING HUANG (Chinese Taipei) said that Chinese Taipei had promulgated a mental health act and had launched various mental health programmes. It had also increased significantly the number of psychiatric hospitals and community psychiatric services, the latter of which provided patient tracking and care, case management, medical assistance and referrals to other community resources. Under the mental health service network, each county had a community mental health centre that offered education and training, transition services, and suicide and substance abuse prevention. The year 2010 had marked the first time in 14 years that suicide was not among the top 10 causes of death in Chinese Taipei, and the suicide rate had continued to decline.

Ms FENU (CBM), speaking at the invitation of the CHAIRMAN, welcomed the focus on mental health by the current Health Assembly. The participatory approach used in preparing the draft comprehensive action plan, which had included a wide range of stakeholders, reflected the reality at country level where international and local nongovernmental organizations played a vital role in the provision of health care and social services. Their involvement with the Organization helped to ensure that its plans and programmes were “fit for purpose” and more likely to have a significant impact. She encouraged those affected by the activities under the action plan to participate actively in its implementation and monitoring.

Mr KARAMI-RUIZ (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, commended the Secretariat’s vision and leadership in addressing the issue of mental health. Mental and neurological disorders often went unacknowledged yet placed a heavy burden on individuals, society and the economy, which must be reduced. Key tasks in that regard included overcoming external stigma and self-stigma, strengthening primary care services, and engaging government and other stakeholders in a multisectoral approach. The pharmaceutical industry was actively involved in the field of mental health: it was testing new compounds as well as helping patients on the ground. The International Federation itself had just launched a campaign to demonstrate the role that every stakeholder could play in mental health promotion. Innovative partnerships and new therapies were also needed, as was a renewed emphasis on brain research, to keep pace with the increasing disease burden of mental and neurological disorders.

Professor COPELAND (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN and endorsing the draft comprehensive action plan, said that the plan closely reflected the views of civil society worldwide, and called on the Health Assembly to adopt and implement it. The recently published People’s Charter for Mental Health, drafted by the World Federation, was a civil society manifesto: it called on the United Nations to convene a special session of the General Assembly on mental health and to appoint a special envoy for mental health; urged that mental health be regarded as one of the top five noncommunicable diseases; and encouraged all countries to implement the WHO draft action plan.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that, given WHO’s emphasis on integrating social services and mental health care into community care, Member States should include the pharmacy workforce in their human resources development policies in order to achieve the draft comprehensive action plan’s global target of increasing service coverage for severe mental disorders by 20%. The pharmaceutical industry had a proven track record in providing community-based mental health services, and his own organization was in the process of analysing the contribution of pharmacists to mental health and would produce a report on the subject in due course.

Dr LUCHESI (World Vision International), speaking at the invitation of the CHAIRMAN, said that mental disorders were a global health concern and could no longer be ignored. People with mental disorders experienced higher rates of disability and mortality, while suicide was the second most

common cause of death among young people worldwide. Mental, neurological and substance use disorders were on the rise. Mental disorders were linked to poverty, human rights abuses, social exclusion, and in some countries went untreated. The draft comprehensive action plan was ambitious and sought to ensure high quality, culturally appropriate health and social care. It offered civil society an opportunity to cooperate with countries in reaching a common goal.

Dr CORRALES DÍAZ (Costa Rica) proposed a series of amendments to the draft comprehensive action plan contained in the annex to document A66/10 Rev.1. In paragraph 28, Member States should be urged to strengthen inclusive social development processes. In paragraph 43, Member States should be encouraged to collaborate on national policy development with other sectors that had a direct impact on the country's economy, thereby ensuring that those social actors participated in the development of inclusive job definitions and inclusive job placement strategies. In paragraph 61, the Director-General should be asked to make Member States aware of the need to modify the traditional mental health care model and to inform them about the added value of decentralizing human and financial resources in order to strengthen primary health care services. Under global target 3.2, Member States should be encouraged to focus attention on suicide centres, with a view to measuring programme impact and determining the success rate of the activities undertaken.

Her country had only limited financial and human resources to allocate to implementation of the draft action plan. She therefore requested the Director-General to consider mobilizing resources for joint epidemiological research aimed at establishing baselines for mental and emotional disorders within populations, as well as to strengthen the leadership role played by health ministries.

Dr CHESTNOV (Assistant Director-General) commended Member States' willingness to lead the combat against mental disorders and welcomed their positive evaluation of the draft comprehensive action plan.

The burden of mental health disorders was increasing and Member States were taking adequate measures to reduce it. The draft plan was the first comprehensive mental health action plan to spell out the actions to be taken by Member States, stakeholders and the Secretariat; it was also the first plan to introduce a set of global targets for the promotion of mental well-being and the prevention and treatment of mental disorders. Adoption of the draft would be a landmark event, separating "before" from "after". Ignorance and complacency would thus be transformed into awareness and guided action.

Questions had been raised concerning the cost of the draft plan. The total cost for the eight-year period from 2013 to 2020 had been estimated at US\$ 97 million, of which US\$ 37 million was allocated to pay for staff and US\$ 60 million for activities. Additional funding from Member States, multilateral organizations and foundations would be needed to meet those costs, which would be discussed at the financing dialogues to be held in June and November 2013. He urged all countries to consider donating to that initiative.

Dr SAXENA (Mental Health and Substance Abuse) welcomed the strong support that had been expressed for the draft comprehensive action plan. As stated in paragraph 3 of the plan, it would be implemented together with other global and regional action plans, including the action plan of the global strategy for the prevention and control of noncommunicable diseases.

Autism and autism spectrum disorders merited attention and were definitely included in the draft action plan. Further guidance in that regard would be provided by the Executive Board at its 133rd session.

Responding to delegates' comments regarding the difficulty of attaining the proposed targets, he referred them to paragraphs 22 and 24 of the draft action plan, which specified the global nature of the targets. Member States could strive to reach those targets to the extent that was appropriate and feasible within specific national circumstances.

Dr ARMSTRONG (Secretary) indicated that the proposed amendments to the draft resolution contained in paragraph 6 of document A66/10 Rev.1 and to the draft action plan contained in the annex to that same document, would be reflected in a new document, which would be distributed as a conference paper.

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee agreed.

**It was so agreed.**

(For continuation of the discussion and approval of the draft resolution, see the summary record of the eighth meeting, section 3.)

**Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019:** Item 13.4 of the Agenda (Documents A66/11, A66/11 Add.1 and EB132/2013/REC/1, resolution EB132.R1)

Dr ST. JOHN (Barbados, representative of the Executive Board) recalled that the Executive Board, at its 132nd session in January 2013, had considered a report by the Secretariat containing the draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019. Fourteen members had taken the floor to comment on and support the draft action plan. Some had suggested specific actions that could be taken to strengthen the plan; others had requested the inclusion of indicators to measure eye care quality, and of references to trachoma and onchocerciasis elimination, as well as a greater focus on childhood blindness and rehabilitation. One had called for country- and region-specific targets and strategies to facilitate implementation. The Health Assembly was invited to adopt the draft resolution recommended by the Executive Board in resolution EB132.R1.

H.R.H. Prince ALSAUD (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the draft action plan, which drew on research and built on the previous action plan. WHO had made major strides in the previous two decades: according to the most recent data, the number of persons with blindness had fallen from 45 million to 39 million. The draft action plan would serve as an incentive to provide support for programmes aimed at preventing blindness. However, the plan would have to be amended to take account of the current average age for blindness. Some countries in the Region had begun to draw up national plans in line with the proposed plan, for which he expressed support. He called on other States to adopt and implement the plan.

Dr HONG SON CUNG (Viet Nam) welcomed the draft action plan. His country was seeking to reduce its blindness rate in keeping with the global target of a 25% reduction by 2019. In Viet Nam, the prevalence of avoidable blindness in people over the age of 50 years had been determined by rapid assessment as being 3.1%, and the cataract surgery rate was 1900 per million population, which fell short of the minimum target of 2500 per million population. That rate was due to shortages in funding, equipment and surgeons in several remote provinces, and he called on WHO and other international agencies to provide the needed support. He endorsed the draft action plan's focus on cataracts and uncorrected refractive error, which were two of the principal causes of avoidable visual impairment, and on the global effort to eliminate trachoma. The incidence of trachoma had decreased significantly in certain areas of his country, but the nationwide trachoma survey was incomplete and the incidence of entropion remained a challenge.

Professor ELIRA-DOKEKIAS (Congo), speaking on behalf of the Member States of the African Region, endorsed the draft action plan. It was estimated that 27 million people in the Region were visually impaired, 6.8 million of whom were blind. Those figures were especially worrying in view of the emergence of noncommunicable diseases and the persistence of onchocerciasis in some

parts of the Region. A series of preventive and treatment measures had been suggested for the Region, but implementing them would be a major challenge. Such measures would minimize the risk of congenital ocular anomalies resulting from rubella, enable early detection of the principal risk factors for vascular damage and blindness, and ensure better treatment for patients. Particular attention should be paid to the prevention and treatment of cataracts, an avoidable cause of blindness; operation rates would be a good indicator for evaluating results in that area.

The Member States in the Region were committed to achieving the global target of reducing avoidable blindness and visual impairment by 25% by 2019. To do so, they had to reach various intermediate goals. First, some countries were in need of technical support with the proper use of national indicators. Secondly, medical staff capacities needed to be built and health systems and health care improved. Thirdly, universal access to preventive treatments must be ensured for all high-risk populations and access to treatment guaranteed for all those who were ill; and fourthly, national programmes must be implemented effectively. Combating blindness should be a joint effort on the part of governments and international organizations.

**Dr Ross took the Chair.**

Dr KENYON (United States of America), endorsed the draft action plan. He welcomed the efforts of the Secretariat and international partners to implement the current action plan for the prevention of avoidable blindness and visual impairment covering the period 2009–2013, and in particular, the activities to improve data collection and surveillance, expand research initiatives globally, advance multisectoral action and set global targets and national indicators. The draft action plan for 2014–2019 appeared on the Health Assembly's agenda under the category of noncommunicable diseases, since complications of such diseases could lead to blindness. At the same time, there was a critical link between avoidable blindness and communicable diseases, in particular neglected tropical diseases and cytomegalovirus retinitis. WHO must continue to encourage the provision of eye care that reflected the disease burdens of individual Member States and was fully integrated into health care systems.

Mr FERDINAN TARIGAN (Indonesia) supported the measures that had been taken to eliminate trachoma and welcomed the attention that had been paid to the problem by the international community. Indonesia had updated its national plan for the prevention of avoidable blindness and visual impairment in 2000, and had been conducting a national eye health survey. It had reduced the prevalence of blindness by at least 40% owing mainly to an annual increase in the number of cataract surgeries performed. However, the needs of the country's ageing population were giving rise to a backlog in cataract surgeries. Indonesia was pursuing its efforts to combat avoidable blindness and visual impairment and needed technical assistance and programme development support, in particular for programmes to provide affordable eye glasses to school-age children and the elderly with visual impairments.

Dr MULENGA (Zambia) fully supported the principles, objectives and measures set out in the draft action plan. The plan covered all the critical areas of eye health service delivery; it was also practical and realistic and amenable to implementation. Ownership of the draft action plan should be decentralized to the national, provincial, district and community levels, and it should be integrated into health systems by means of regional and national agreements. Governments and other stakeholders must provide more resources for research so that data on disease burdens, obstacles to eye health, and service provision and costs could be obtained. Greater emphasis should be placed on human resource development in the area of eye health.

Dr AMUNUGAMA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, said that the Region accounted for 28% of the global burden of avoidable blindness, caused mainly by cataract in adulthood and childhood visual impairment. Measures taken in the Region under the current action plan had focused on an integrated approach to blindness prevention at the primary health care level aimed at achieving sustainable eye care services. Many national initiatives to combat preventable blindness had been carried out, but it remained an important public health issue. He welcomed the draft action plan, which would serve as a guide for strengthening regional and country-level plans. To pursue its work on avoidable blindness, the Region would need technical and financial support from WHO and other donor agencies, in particular for the development of infrastructure, human resources, national and regional indicators, and monitoring systems.

Dr SINGH (India) endorsed the draft action plan and said that her country was already implementing activities relating to the three objectives set out in the plan, and would continue to do so. With regard to objective 1, it planned to conduct another rapid assessment survey for avoidable blindness; under objective 2, its national blindness control programme had been incorporated into the national rural health mission; and in respect of objective 3, the national Government was fostering partnerships among multiple stakeholders. India had sufficient resources to use the draft plan's three indicators for measuring progress at the national level.

Dr SADRIZADEH (Islamic Republic of Iran) endorsed the draft action plan and the proposed draft resolution. He emphasized the need to provide affordable cataract surgery to all those who were in need of it, and the importance of developing national strategies for the prevention of traumatic blindness due to car accidents, with an emphasis on the use of seatbelts and other appropriate measures. Such strategies should be integrated into comprehensive eye care services to ensure their affordability and cost-effectiveness.

Dr KAMALIAH MOHAMAD NOH (Malaysia), endorsing the draft action plan and the proposed draft resolution, said that avoidable blindness and visual impairment must remain a priority on the global public health agenda since they were expected to increase in parallel with socioeconomic development, which brought with it a longer life expectancy and a rise in noncommunicable diseases. The plan's three objectives covered all the elements needed to reduce the burden of avoidable visual impairment. She endorsed the global target of reducing the prevalence of avoidable visual impairment by 25% by 2019 as well as the three indicators set out in the draft plan, and her Government would be asking WHO for technical support in strengthening its surveillance systems in order to measure progress.

Dr AL-TAAE (Iraq) said that, in order to be successful, implementation of the joint global initiative VISION 2020 should be paralleled by the integration of primary eye care into primary health care. Primary eye care services should also be included under the Millennium Development Goals in general, and in the strategies for poverty alleviation and the control of communicable and noncommunicable diseases in particular. They should likewise be integrated into reproductive health services owing to the problem of child blindness, which accounted for 10% of all cases of blindness. Iraq had made significant progress on that score through early detection of congenital defects and by tackling nutrient deficiencies, notably of vitamin A. It had also worked to integrate eye care facilities into school health services and activities aimed at promoting health and building a healthy lifestyle. Indicators to measure implementation should be established, especially for cases of cataract, refractive errors and diabetic retinopathy, based on the system of family medicine and family health practices, in order to reduce the disease burden.

Dr AHMED (Bangladesh) said that his country had been implementing the VISION 2020 initiative and the action plan for the period 2009–2013, with the cooperation of the relevant stakeholders. The proposed draft action plan, which he endorsed, would enable Member States to finish any tasks left over from the previous plan in addition to taking on new ones and, in that regard, he recommended that priority be given to emerging causes of blindness, including age-related macular degeneration, diabetic and premature retinopathy, ocular trauma and refractive error. He supported the draft resolution.

Dr CHOMPOONUT THAICHINDA (Thailand) endorsed the draft action plan but found it inadequate on several fronts. First, universal eye care applied not only to coverage but also to access. The indicators to measure progress in that regard should therefore include disaggregated data to assess progress in reducing unequal access to basic services. Secondly, the number of eye care personnel did not necessarily indicate a higher level of care; a more relevant indicator would be the quality of eye care personnel. Unbalanced distribution of the workforce, as well as its capacity and performance, was also a concern. Allied ophthalmic personnel, including those working in primary health care, should be trained to work effectively in specialized areas in settings that were appropriate to the local context. Thirdly, new technologies and techniques had greatly increased the cost of eye health care, while many countries did not have the resources to make evidence-based decisions about what equipment was needed. The Secretariat could play an important role in strengthening Member States' capacity to assess technology, and reference to that role should be included in the draft action plan. Fourthly, in view of the life-long consequences of childhood blindness and low vision, the draft action plan should focus on early detection and treatment of reversible causes of blindness and visual impairment.

Dr CICOGLA (Italy) said that, despite recent progress in the control and prevention of avoidable blindness and visual impairment, poor and vulnerable populations still suffered inordinately from those disabilities. His country had implemented many WHO resolutions in the area of blindness and visual impairment; for example, it had set up a national committee, prepared national guidelines, and produced an inventory of its development cooperation activities in that field. In addition, his country's National Centre for the Prevention of Blindness had recently been designated as a WHO collaborating centre. He supported the draft action plan, welcoming in particular its emphasis on visual impairment and rehabilitation, and wished Italy to join the list of sponsors of the draft resolution.

Mr COTTERELL (Australia) said that avoidable visual impairment was an issue of great importance not only for health and social progress, but also for economic growth. His country favoured the adoption and implementation of the draft action plan and the associated draft resolution, in accordance with national priorities. Australia had recently allocated 40 million Australian dollars over four years to help developing countries in the Asia-Pacific region to meet the challenge of avoidable blindness. He endorsed the global target and three indicators set out in the draft action plan, but pointed out that cataract surgery coverage might be difficult to measure.

Mrs CARTER TAYLOR (Barbados), endorsing the draft action plan and the draft resolution, said that the elimination of avoidable blindness would greatly enhance the quality of life for millions of people worldwide. She applauded the emphasis in the plan on evidence-based planning and on universal access and equity, and she welcomed the targets and indicators that it had identified. Barbados had established a national task force whose terms of reference were to develop a national policy and strategy that was consistent with the draft action plan, which was regarded as critical to shaping her country's eye health policy.

Mr KOBAYASHI (Japan) said that avoidable blindness and visual impairment were not fatal but had a significant negative impact on quality of life. The draft action plan had an important role to play in mitigating the disease burden imposed by those conditions, and the strategic actions that it recommended should be developed further to ensure the feasibility of the plan. Blindness and visual impairment had multiple causes, which must be taken into account in formulating public health prevention and treatment strategies. The current rise in noncommunicable diseases could be expected to increase the incidence of cataracts and diabetic retinopathy. Prevention and treatment of those conditions, including advocacy and awareness-raising, should be an integral part of eye health strategies, with a close link to noncommunicable disease programmes. He endorsed the draft action plan and the draft resolution associated with it.

**Dr Gwenigale resumed the Chair.**

Dr ALZAYANI (Bahrain) said that Bahrain fully supported the draft plan and would endeavour to implement it.

**The meeting rose at 12:30.**