Do more to prevent alcohol-related deaths and diseases

Did you know that in 2012 harmful use of alcohol caused 3.3 million deaths worldwide? That on average, 6.2 litres of pure alcohol are consumed for every person in the world aged 15 years or older every year? …

And since not all drink alcohol, the actual average statistic for consumption of pure alcohol for those who do (38.3%) is 17.2 litres annually? This is equivalent to 43 litres of whisky or vodka, or 140 litres of wine, or 380 litres of beer!

That while Europe is the region with the highest consumption of alcohol per capita, significant increases in alcohol consumption were observed in both the WHO South-East Asia and Western Pacific regions between 2005 and 2010?

These are just a few of the dire facts reported in the Global status report on alcohol and health 2014 launched by WHO on 12 May. The report provides country profiles for alcohol consumption in all countries, the data reflecting the impact of harmful use of alcohol on public health and policy responses at the global and regional levels.

Alcohol consumption can not only lead to dependence but also increases people’s risk of developing more than 200 diseases, including liver cirrhosis and some cancers. In addition, harmful drinking can lead to violence and injuries and make people more susceptible to infectious diseases such as tuberculosis and pneumonia.

The report highlights the need for more action by countries. These include:

- national leadership to develop policies to reduce harmful use of alcohol (66 countries had written national alcohol policies in 2012);
- national awareness-raising activities (nearly 140 countries reported at least one such activity in the past 3 years);
- health services to deliver prevention and treatment services, in particular increasing prevention, treatment and care for patients and their families, and supporting initiatives for screening and interventions for hazardous and harmful drinking.

"We found that worldwide about 16% of drinkers engage in heavy episodic drinking—often referred to as ‘binge-drinking’—which is the most harmful to health,” explains Dr Shekhar Saxena, Director, Department of Mental Health and Substance Abuse at WHO. “Lower-income groups are more affected by the social and health consequences of alcohol. They often lack quality health care and are less protected by functional family or community networks.”

Some countries are already strengthening measures to protect people. These include increasing taxes on alcohol, limiting the availability of alcohol by raising the age limit, and regulating the marketing of alcoholic beverages.

"The role of health professionals in reducing the harmful use of alcohol is not limited to provision of treatment interventions for clients with alcohol use disorders, but also includes prevention of hazardous and harmful drinking as well as advocacy for effective policy measures,” emphasizes Dr Vladimir Poznyak, Coordinator of Management of Substance Abuse at WHO.

However, policy-makers and health professionals are not the only ones who need to get involved in reducing the harmful use of alcohol: it is everyone's responsibility, and communities must therefore also engage.

Read more:
From virtual to practical: mhGAP in the Caribbean

Over a period of 7 months starting in 2013, 28 health professionals from 6 Caribbean countries received mhGAP training, just as health professionals had also received it in 14 other countries of the WHO Region of the Americas to date. However, mhGAP training in Caribbean countries was carried out differently: it was virtual.

Through PAHO’s Virtual Campus for Public Health and in collaboration with the Douglas Mental Health University Institute and McGill University WHO Collaborating Centre, participants attended 65 hours of online training over 20 weeks, with self-directed exercises and evaluations. The training also involved constant interaction with tutors. This was followed by a one-week in-person training before submitting the final assignment.

The virtual platform offered adaptability, flexibility and accessibility to mhGAP training. The spread over time enabled participants to consolidate their knowledge and skills and to make tangible changes in their practices, improving their communities’ access to mental health care. Participants became advocates for mental health and motivated other health colleagues to seek virtual mhGAP training in the future.

mhGAP implementation continues in the PAHO Region, encouraged by new findings. A region from a country that initiated mhGAP in 2012 recently reported an increase of over 300% of the number of people being treated for a mental health condition in Primary Health Care.

“I started out this course with a lot of skepticism. I thought that I would be presented with a lot of theory which would in no way apply to my reality. Boy, was I wrong! There is so much that I have learned that I have been able to apply, and it is so relevant in the community that I work in... I know that I have to keep using these skills that I have learnt, and that in time I will get better at it. I am actually sad that the course has ended.”

Quote from one of the trainees

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“Integrating NCDs and mental health in Primary Health Care is one of the priorities of this Department. The mhGAP is a practical tool that facilitates the integration of key mental health conditions into the daily practice of general practitioners, nurses and other health personnel. As Director of the Department, I’m pleased that initiatives such as the one described are being implemented in our Region.”

Anselm Hennis, Director of Department of Non-Communicable Diseases and Mental Health PAHO/WHO

On 10th of October 2014 WHO will celebrate World Mental Health Day; the theme of this year is “Living with schizophrenia”.

On 5th September 2014 the first WHO report on suicide “Preventing suicide: a global imperative” will be launched by Dr Margaret Chan, WHO Director-General, in Geneva in the presence of representatives of WHO Member States and a number of invited speakers. Watch out for it on the WHO website on the same day.

www.who.int/mental_health/mhgap/en/
Ethiopia commits to expanding mental health services

Hannah’s story (see above right) is not unique. In rural Ethiopia, people who suffer from mental, neurological and substance use disorders have very limited access to care as mental health services are mainly centralized around Amanuel Mental Specialized Hospital in Addis Ababa. However, things are changing slowly but surely.

mhGAP Ethiopia, supported financially by the European Commission and the Fondation d’Harcourt, has provided the platform for the Federal Ministry of Health to plan for the scale-up of services for people suffering from mental, neurological and substance use disorders.

The 1-year expansion plan involves all regions in Ethiopia and has been committed to through six memorandums of understanding signed between the Federal Ministry of Health, Regional Health Bureaus, Amanuel Mental Specialized Hospital and five regional universities. These partnerships will address the lack of human resources in mental health by providing essential training needed to ensure that enough mental health workers are available to support the planned scale-up. Moreover, close supervision will be provided to ensure the continual provision of quality services and enhancement of skills by service providers.

In 2014 alone, more than 150 clinics will be involved in the expansion process and above 300 health workers will be trained according to the mhGAP guidelines. This will enable more people like Hannah who live in rural Ethiopia to receive mental health care when they need it.

“I have always been happy and healthy in my life. Until something terrible happened: my only child died. After that dramatic episode, my life hasn’t been the same. I kept thinking about him, and couldn’t sleep at night. I would feel sad, I would be very nervous and my heart would beat very fast.

This made me so worried I thought something bad was going to happen to me as well. When I visited the clinic the nurse asked me many questions. Finally she explained that my feelings were due to what they call depression. She explained that many mothers who lose a child experience it. She listened to me. She told me that I do not need medications. With time, I felt much better and my sleep has become regular again.”

From Hannah’s story

Thanks to the successful implementation of the WHO Mental Health Gap Action Programme (mhGAP) in selected sites over the past three years, there is now an ongoing effort to develop mental health services that are “decentralized and integrated at the primary health care level” (National Mental Health Strategy 2012/13–2015/16).

“The scaling up of mental health services through integration into primary care demonstrates the political commitment of the government of Ethiopia. Ethiopia will continue to build on its successful community health extension program and emphasize the importance of community empowerment to bring about social mobilization and address stigma and discrimination against the mentally ill.” Dr Kesete-Birhan Admasu, Minister of Health, Ethiopia

Read more: http://www.who.int/mental_health/mhgap/euproject_mhgap/en/
Last year, Ma Nwet Nwet Yee’s life changed radically. Until then, frequent seizures, loss of memory and learning difficulties made for a life of isolation and stigma with little hope of anything changing for the better. The 18-year-old from Myanmar lost her parents when she was young, and she lives with her grandmother. She had been suffering from epilepsy since childhood but when she started daily anti-epileptic medication in 2013, her seizures decreased considerably. She now works in a Buddhist nunnery near the little village of Bo Daw Na Gone. – From Ma Nwet Nwet’s story

“Hope for epilepsy” launched in Myanmar

Myanmar’s “Hope for Epilepsy” project was launched on 25 March 2014. Government coverage of basic anti-epileptic drugs, as well as commitment to and planning for the scale-up of epilepsy treatment services in the country were at the heart of the successful launch.

Project launch attendees, including Myanmar’s Deputy Minister of Health, WHO officials, the funding partner UCB, health workers and community members, heard testimonies from people living with epilepsy and renewed their commitment to reducing the treatment gap in Myanmar.

“Hope for Epilepsy”–part of the WHO Programme on Reducing the Epilepsy Treatment Gap–is being implemented by the Myanmar Department of Health, Yangon General Hospital, WHO and other partners. It aims to:

- expand skills of primary-care, non-specialist health professionals at the community level to diagnose, treat and follow-up with people living with epilepsy;
- reduce the associated stigma; and
- mobilize nongovernmental organizations and community groups to better support people with epilepsy and their families.

In Myanmar, epilepsy is the third most common neurological disorder with approximately half a million estimated to be living with it. Currently, approximately 80% of them do not receive any treatment. Lack of continuous supply of anti-epileptic medication is a major challenge to reducing the epilepsy treatment gap and improving the quality of life of people with epilepsy.

Nwet Nwet Yee’s grandmother (see story in the text box), who raised her, also wishes that Myanmar’s health insurance would cover the cost of the medication for people like Ma Nwet Nwet. Though her health has improved considerably, it is a constant financial struggle to keep it that way.
Persons with autism spectrum disorders: sharing needs, concerns and hope

“(…) I don’t want to live in a big institution once I leave my parents’ home. It is my deepest wish that I can have the flexibility to go from my room at my parents’ house and my own place in a small set-up. Do you think this could happen ever?” [Nassim, aged 16]

Persons living with autism spectrum disorders and their families often face stigma and exclusion; they cannot always access health care; and living an independent life may not be an option. Questions like the one posed by Nassim were among those asked at an event to observe World Autism Awareness Day on 3 April 2014 at the World Health Organization headquarters in Geneva.

Organized jointly by WHO and Autisme Suisse Romande, an autism advocacy organization, the event was attended by persons with autism spectrum disorders (ASD), their family members and caregivers, as well as representatives of several advocacy and self-advocacy organizations. The meeting provided them with the opportunity to share concerns, needs, hopes and perspectives on the Resolution on autism spectrum disorders (ASD).

The Sixty-seventh World Health Assembly in May 2014 endorsed the resolution on ASD requesting WHO, governments and other partners to strengthen efforts to better meet the needs of persons living with the disorder. It demands advances in research and sharing of knowledge and technology for diagnosis and treatment of ASD. The resolution also addresses Nassim’s concerns by urging countries to implement plans for providing technical, financial and human support to families. It also asks for a more comprehensive management of ASD and a shift away from long-stay health facilities to community based services.

However, countries alone cannot ensure that the resolution is implemented: persons with ASD and their families, who have the most at stake from the resolution, have an essential role to play in ensuring that the needs of persons living with ASD are addressed.


Developmental disorders are a group of conditions with onset in infancy or childhood and characterized by impairment or delay in functions related to the central nervous system's maturation. They may affect a single area of development (e.g. specific developmental disorders of speech and language, of scholastic skills, and/or motor function) or several (e.g. pervasive developmental disorders and intellectual disability).

The umbrella term “autism spectrum disorders (ASDs)” covers conditions such as autism, childhood disintegrative disorder and Asperger syndrome. Core symptoms include a variable mixture of impaired capacity for reciprocal socio-communicative interaction and a restricted, stereotyped and repetitive repertoire of interests and activities.