Meeting of Regional Experts on Promotion of Mental Well-Being

Report of the Meeting
Jakarta 11–13 June 2009

World Health Organization

Regional Office for South-East Asia

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Annexes

1.   Opening session

The meeting was opened by Dr Eka Viora, Directorate of Mental Health, Ministry of Health, Indonesia. Dr Palitha Abeykoon, Acting Director, Noncommunicable Diseases and Mental Health of WHO Regional Office for South-East Asia (SEARO), welcomed the delegates on behalf of WHO and thanked them for participating in this new but important initiative of the Regional Office.

2.   Election of chair, co-chair and facilitators

Prof. Diyanath Samarasinghe was elected as Chairperson and Professor Radha Sharma as the Co-chairperson. Dr Avdesh Sharma was nominated as the facilitator for the session on promotion of mental well-being for individuals; Professor Radha Sharma for the session on promotion of mental well-being for groups; Dr Amporn Benjaponpitak for the session on promotion of mental well-being in the community and Dr Than Sein for the session on public policy for promotion of mental well-being. These facilitators served as rapporteurs for the respective sessions.

3.   Introduction and objectives of meeting

Dr Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse WHO/SEARO explained the background and objectives of the meeting. He stated that since its inception WHO had focused on important causes of morbidity and mortality. WHO also focused on health promotion and prevention of diseases. These programmes had made excellent progress, and now WHO/SEARO was advocating a fresh approach to promote the well-being of individuals. Policies and programmes aimed at improving well-being were few and far between. It was a new and challenging subject and this meeting was therefore extremely important to suggest the way forward.

The objectives of this meeting were to:

(1) Describe the concepts of mental well-being.

(2) Discuss promotion of mental well-being as a public health strategy.

(3) Share experiences among experts on programmes promoting mental well-being at individual, group and community level.

(4) Discuss incorporating mental well-being in national, state and local policies.

(5) Prepare the agenda for the inter-country, inter-sectoral meeting on promoting mental well-being in October 2009.

3.1   Background to the programme for the promotion of mental well-being

In his presentation, Dr Vijay Chandra said that WHO defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition was developed in 1946 and remains valid. The definition clearly emphasizes mental well-being. Since its establishment, WHO has focused on addressing the major causes of morbidity and mortality. It also emphasized health promotion and prevention of disease. However, the concept of well-being (including mental well-being), even though included in the original definition of health, has not been implemented as a public health strategy.

In programmes on promotion of mental well-being, the concept of "primordial prevention" should be used. In 1978, Strasser coined the term "primordial prevention" to mean activities that prevented the penetration of risk factors into populations. The basic idea is to intervene in order to stop the appearance of risk factors in the population. For example, stress management at the workplace may be considered as a strategy for primary prevention of executive burn-out, but programmes to prevent stress from occurring would be considered primordial prevention of executive burn-out.

There is no generally accepted "definition" of mental well-being. However, the concept of mental well-being is generally accepted and was described by WHO as a state in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

3.2 Concepts of promotion of mental well-being

In his presentation, Dr Sajeeva Ranaweera explained that there are many concepts relating to mental well-being described by diverse individuals and groups including WHO. Some examples are quality of life, salutogenic approach to health and the concept of social capital. Social, physical, economic, structural and other determinants of mental well-being have also been described. Some examples are social practices, access to social developmental resources such as education and health, employment status and housing. The levels at which mental well-being could be addressed can be the individual, family, group, community and national / supranational.

The global partnerships and initiatives that can be harnessed to improve mental well-being include the recommendations of the WHO Commission on Social Determinants of Health, the Ottawa and Bangkok Charters for Health Promotion and the objectives of the Millennium Development Goals. Population-level measures of well-being such as the Gross National Happiness Index of Bhutan and individual level instruments such as the Rhyffs Scales are two examples applied at national and individual levels. The methods of assessment and the levels and types of evidence required to operationalize programmes on mental well-being are different from traditional "trial" and "research" models. At programme level the evaluations should depend more on qualitative indicators. Current initiatives for improving mental well-being include programmes to improve social capital, early childhood interventions, addressing violence, addressing harm from drug and alcohol use and programmes to improve economic empowerment.

The contents of this presentation are further elaborated in the background paper entitled "Concepts of Mental Well-Being" given in Annex E.

3.3 Convergence of body, brain and mind in promotion of mental well-being

Dr Vijay Chandra said that the concept of mental well-being is usually ascribed to the "mind". Although the anatomy and physiology of the mind is still unknown, emotions such as anxiety, sadness and happiness are believed to be mediated through the mind. These emotions manifest as

various bodily functions such as headaches, increase in blood pressure and even increase in coronary artery disease. Thus, in programmes dealing with the promotion of mental well-being, the totality of a human being in terms of body, brain and mind should be considered. The three components are closely linked.

4. Interventions for promoting mental well-being: individual approaches

4.1 Traditional concept of mental well-being in South-East Asia

Prof. G.D. Sumanapala said that the mind plays an important role in moulding human behaviour. But it is closely connected with the sense-faculties of the physical body viz. the eye, ear, nose, tongue, and skin. Data gathered through the senses are processed by mental activities and they are transformed into sensations and perceptions. Perceptions or memories become dispositions as a result of repeated reflection over them. The totality of senses, sensations, reflections and dispositions represents the notions of self, personality (I-ness) and all other concepts of identification of oneself. This psychological evolution is based on three kinds of impulses: craving which takes experiences as "mine" (my-ness), conceit which takes experiences as "I" (I-ness) and view, which takes experiences as "soul".

Any kind of meditational practice should be reflected in the above psychological process. In order to maintain mental well-being, the following aspects of human personality should be balanced properly: sense faculties (through moral training), sensations and perceptions through psychological training (concentration) and dispositions and consciousness through cognitive processes.

The world is in action. There are no eternal or static functions in the human personality or in the external world. Attachment and hate are two reactions of people towards the actions of the world. If people achieve their purpose through their reactions conceit originates in their minds. If they fail the result is the origin of disillusionment. Thus, there are four mental states through the reactions of people: greed, hate, conceit, and disillusionment.

When these mental states are not excessive, mental balance can be maintained. Balance can be achieved through meditation on foulness (addressing greed), compassion meditation (addressing hate), meditation on impermanence (addressing conceit) and through development of mindfulness by following practices such as in-and-out breathing (addressing disillusionment).

The concepts of "good" or "bad" are useful instruments to guide the behaviour of people. At the initial stage we have to agree with their concepts and should change, replace or eliminate them gradually. Mental well-being and imbalance of people mostly depends on the agreement or disagreement among the concepts. Concepts manifest in human activities: verbal, physical and mental. And they are mostly reflected in rites, rituals and ceremonies related to cultural and religious traditions.

Concepts can be changed to maintain mental well-being by following various methods. Methods should be planned and determined with reference to the various cultural, religious and environmental factors of different countries.

One of the most successful methods of establishing mental well-being is the theory of assimilation. According to the theory we can utilize various religious and cultural beliefs, rites, ceremonies and practices on a psychological basis.

4.2   Spirituality and mental well-being

Dr Avdesh Sharma in his presentation explained that the concept of spirituality has individual and cultural perspectives. Traditional spiritual methods of improving mental well-being such as postures, breath control and meditation are being practiced in this Region. Psycho-spiritual techniques of improving mental well-being include mindfulness, yoga, tai-chi and Sufism. There is now increasing 'scientifically validated' evidence of various levels from case studies to randomized double blind placebo controlled trials for some techniques. The largest body of evidence mostly from western countries, specially the United States of America, but also from India has been on types of meditation including mindfulness. Yoga and Tai Chi has also been studied quite extensively.

Individual strategies can be applied at group or societal level specially with the advancements in technology. These must be started at an early stage of life including in schools and practiced as a way of life. Efforts can be made for acceptance by advocacy through policy makers, health professionals, utilizing agencies, media and religious / spiritual organizations without religious connotations. Cost effective, culturally acceptable, and easily available methods can be utilized with built in systems of evaluations.

4.3 Promotion of mental wellbeing through meditation

Dr Than Sein

Meditation as a method of promotion of mental well-being is extensively practiced in the South-East Asia Region. There are many types of meditation, all of which focus on the mind. Concentration meditation focuses the mind to a single object until special states of consciousness are realized and relieves the mind from the effects of the defilements. Insight meditation is mindfullness to any object arisen to the attention of the mind and is an observation on a reality of mind and matter. Current programmes for promotion of mental well-being in Myanmar include early childhood interventions, mental health promotion in schools and universities, support to women and old aged population and community development programmes to support for social and economic amenities

4.4 Transcendental meditation

Dr I.N. Gunadi explained that transcendental meditation is the most popular type of meditation practiced in Bali, Indonesia. It is a systematic technique that allows mental activity to reach a silent state of awareness - pure consciousness where the mind is calm, collected, yet fully expanded, and fully awake. It is a simple, natural, easy, effortless and effective technique which can be practiced by sitting comfortably in a chair for 20 minutes, twice daily, morning and evening. During the practice the mind and body gain deep rest, reducing stress and improving health and mental well-being. It is validated and verified both by the Vedic scriptures and science.

Beneficial changes in blood pressure, metabolic rates, heart rate and biochemical changes have been reported following this type of meditation.

Research has shown that the twice-daily experience of pure consciousness during transcendental meditation makes the mind more alert, creative and eliminates the build-up of stress. A transcendental meditation programme which was being conducted in Bali was described.

4.5 Prevention of illness through yoga

Prof. Subhash C. Manchanda said that yoga is a way of life, consisting of physical, mental, emotional and spiritual components. It is not just a series of exercises as commonly believed. Several studies suggest that yoga is beneficial in controlling risk factors for coronary artery disease such as hypertension, obesity, dyslipidemia, mental stress and diabetes mellitus. According to scientific studies, yoga may retard the progression of atherosclerotic cardiovascular disease or even regress it. Yoga has no side effects and is cost effective. Therefore, it is recommended to project yoga as a healthy and holistic technique for promoting physical and mental well being and prevention of heart disease and other lifestyle related diseases. Different schools of yoga should be involved throughout the world to impart training to the community especially in educational institutions and to executives for stress management and incorporate this mind-body technique in heart prevention programmes.

4.6 Beneficial outcomes for promotion of mental well-being through individual approaches

All presentations on meditation and yoga showed that these practices resulted in substantial benefits to individuals as assessed by reduced levels of stress, improved inter-personal relationships, family harmony, and prevention of physical illness. These benefits to individuals extend to other social settings such as schools and workplaces.

4.7 MHS unit observation: Implications for the programme on promotion of mental well-being

These practices have been an integral part of the culture of many communities of the Region for centuries. People identify with them and there is both scientific and traditional evidence of their benefits. Thus, little

effort will be required to advocate these strategies to communities. As individual experiences benefiting each participant can extend to the family and community at large, these strategies can be used to benefit entire communities.

However, the benefits of these strategies accrue only for those who accept and carry out the practice. Also, sustainability of the benefit is dependent on continuation of the practices. These practices also have to be learnt from skilled teachers and require time commitment on a regular basis. The availability of technical capacity to teach the practices is limited considering that this needs to be practiced in small groups. Despite these limitations, ways of making meditation and yoga a public health strategy to improve mental well-being should be further explored.

5. Interventions for promoting mental well-being: group approaches

5.1 Promotion of mental well-being at the workplace through enhancement of emotional intelligence

Prof. Radha Sharma explained that emotional intelligence is the ability of an individual to appropriately and successfully respond to a vast variety of emotional stimuli being elicited from the inner self and the immediate environment. It constitutes psychological dimensions such as emotional competency, emotional maturity and emotional sensitivity. The concept of "emotional intelligence" has been used to protect business executives from burnout. An empirically developed model highlighting the role of emotional intelligence in enhancing coping ability for stress and preventing executive burnout was described. Research has revealed that emotional intelligence is a differentiator between mentally healthy executives and cases of executives suffering from burnout. Also, empirical evidence suggests that a high level of emotional intelligence enhances an executive's personal effectiveness and improves resilience for workplace demands. Improving emotional intelligence is used by industry and other organizations to promote personal effectiveness, resilience and workplace adjustment. Therefore, it is expected to promote mental well-being too.

Beneficial outcomes for promotion of mental well-being

Emotional intelligence has been shown to enhance personal effectiveness and coping skills thus making a person resilient and improves his workplace adjustment and protects his mental health. But whether it contributes to promotion of mental well-being in workplaces has not been explored in the Region.

MHS Unit observation: Implications for the programme on promotion of mental well-being

Though there is little information on the role of enhancing emotional intelligence in the promotion of mental well-being at the workplace in the context of this Region, theoretically it is possible to extrapolate the benefits observed to reduce executive burnout to promotion of mental well-being. This needs to be explored further.

5.2   Promotion of mental well-being in the school setting

Prof. Diyanath Samarasinghe said that the objective of this project was to use schools as a setting for implementing activities to improve mental well-being. This intervention was carried out in 124 schools in the north-western province of Sri Lanka. The methodology consisted of creating forums for groups of teachers and students to discuss issues related to their mental well-being and generating dialogue and sharing ideas on what people mean by mental well-being and factors that influence it (i.e. determinants). This was followed by creating an interest in addressing these determinants and measuring the resulting changes. Efforts were made to enable teachers and students to use the information from assessments of progress to guide the process further and to spread success to the wider community through the families of students.

The processes of change took some time to initiate, but once they began they ran mostly on their own initiative, with little external inputs required to sustain the programme. Initially there was apathy but with continued discussion people began to take an interest in the idea that they could influence the school milieu to improve well-being of all its members. A guiding theme was to change the school in a direction that would it make it a happier setting for all. Changes noticed at the beginning of the programme included an increase in interest and enthusiasm among some teachers and students and a spread of this to the large majority in the course of time.

'Technical' improvements in the content of their discussion included greater ability to recognize determinants and measure changes in these parameters. Important determinants included the 'student culture' and 'culture among the staff'. Students learned to recognize who mostly controlled opinion among them and began to influence them to change the culture towards a 'better' setting (e.g., discouraging bullying, reducing victimization and labeling etc.). Similar changes were initiated by teachers to influence their milieu.

The use of subjective indicators demonstrated clear improvements in reported well-being by the vast majority of students and teachers. Associated changes noticed included reductions in absenteeism, improved punctuality, better academic performance, higher enrolment, less disciplinary problems and a dramatic reduction in punishments. In a few instances, there was an improvement in reported well-being amongst families of students too.

Some of the lessons learnt were as follows. Starting with a 'well-being improvement' entry led to spin-off benefits in reduced 'problems'. Improvement of well-being improvement was achieved by people without a prior definition of well-being being provided. The concept was clarified and refined through the process itself. Much of the progress was achieved by addressing negative influences by a previously dominant minority.

Beneficial outcomes for promotion of mental well-being

An improvement in overall academic performance in students was observed. Absenteeism, disciplinary problems, bullying and labeling (addressing using derogatory terms for each other) decreased. Subjective improvements in well-being (e.g., 'students are happier than before') was reported by staff and students and some family members of students. The process of improving their own well-being has been taken over by the staff and students and is continuing.

MHS unit observation: Implications for the programme for promotion on mental well-being

The model begins with identification of the specific needs of each school. Thus, the school takes full ownership of the project. Being a continuous iterative process of feedback and adaptation, it can be modified in the course of the programme based on actual experience in the school.

Therefore, this model permits substantial flexibility to meet the needs of any school setting, and can be adapted to other schools. Since this model advocates integration into existing curricula, there is no additional load in an already overburdened curriculum. This integration will contribute to long-term sustainability.

6. Interventions for promoting mental well-being: community approaches

6.1 Strengthening families to improve community mental well-being

Mrs Subhawadee Harnmethee and Mr Sandusit Deebugkam in their presentation explained that this approach improves community well-being through the family. Eastern culture encourages family values and stresses the importance of the family. Families and communities are closely connected to each other. Therefore, programmes addressing family and community cannot be developed separately from each other.

This approach uses "insiders" of families and communities as the change agents. "Outsiders" are used as catalysts and supporters. The basis of the approach is learning. Learning is the most effective way of improving one's quality of life, building resilience and improving mental well-being. Participatory learning is one of the most powerful ways of learning, starting from sharing experiences, analyzing one's own situation, moving to synthesis and conceptualization, finally leading to defining solutions by the family itself. It encourages people to understand their own problems and seek solutions. It is made to be an easy and a happy experience. Learning is encouraged through community forums, community research, cultural, religious and other issues, meditation and the media. This learning experience is aimed at self realization, empathy for other people, developing resilience and improving mental well-being.

The concepts that are included are the circumstances that affect families, family values, virtue, principles and relations, life development at every stage - children, teenagers, the elderly and the ways communities support families. The process of change is considered to be more than just end-points.

There were many beneficial outcomes of this approach in the programme implemented in the Lampang province. At the individual level, outcomes such as reduction in smoking, alcohol use, stress, violence, more care and understanding for the elderly were seen. At the family level, spending more time with families, diminishing of conflicts and happier relationships were seen. At the community level, some of the outcomes were reduced sale of alcohol, increased unity, improved safety and improved child friendliness. At the policy level, local administration organizations became involved and budgets were made available to work on quality of life. Several case studies were presented and discussed.

Beneficial outcomes for promotion of mental well-being

The beneficial outcomes related to families' improved family cohesion and relationships, decreased conflicts, violence, smoking and alcohol use. At the community level, improved safety and improved child well-being was observed. Another important outcome was the interest in this approach shown by the government's local administration which agreed to provide funds for activities related to promoting mental well-being.

MHS unit observation: Implications for the programme on promotion of mental well-being

The issues related to community ownership, adaptation and expansion remain the same as for the schools' intervention programme described earlier. Sustainability is ensured through community participation and ownership and partnership with local government. Technical capacity is available within the Region to implement the project.

6.2 Promoting mental well-being through building community resilience

Dr (Ms) Amporn Benjaponpitak said that resilience refers to the capacity of an individual or community to cope with stress, overcome adversity or adapt positively to change.

Processes and key success factors required for building community resilience in order to develop effective and appropriate techniques in Thailand were described. The first step is a context analysis where a

situation review is done and mental health experts group discuss factors related to development of resilience at the individual, group and community level. The next step is the identification of ways of approaching the targets where understanding on the issue is developed among the people in the community and the needs of each group at every level. The final step is development of methods through information and experience sharing among health experts, community leaders and other stakeholders for building community resilience.

It was found that the resilience building techniques needed by community-based workers are self-assessment questionnaires and self-learning material for individuals, counseling manuals on resilience-building for care providers, resilience-building information for students, workplaces, and community leaders.

The following methods were identified: discussions; conversations in daily life; campaigns; local radio programmes; house visits; activities on special occasions such as cultural ceremonies or religious days in order to provide health education; and integrating concepts into community meetings and establishment of health centres.

Beneficial outcomes for promotion of mental well-being

The community felt empowered as the material to be used was developed jointly by them and the technical experts. Therefore, they closely identified with the programme, and during the process, realized the importance of building resilience within their communities using their own initiatives.

MHS unit observation: Implications for the programme for promotion of mental well-being

This project could be used as a model for collaboration between community-level government networks and the community itself to address specific needs of the community. Community participation from the stage of planning to implementation will ensure ownership, appropriateness of interventions and government partnership will ensure sustainability.

6.3   Psychosocial support to the community after disasters in Myanmar

Daw Moe Moe Khine in her presentation said that cyclone Nargis hit the lower part of Myanmar on 2nd and 3rd of May 2008, causing unprecedented destruction with great loss of natural, social, economic and human resources. It had a significant impact on 37 townships in Ayeyarwaddy and Yangon Divisions. Out of 7.35 million people residing in these areas, 2.4 million were severely affected. The psychological impact of the cyclone was significant with a large number of people exposed to severely traumatic experiences. While 7% of households reported at least one deceased family member, 23% reported witnessing signs of psychosocial distress.

Government departments, UN agencies, international and local nongovernmental organizations, community-based organizations, religious organizations, community volunteers and business firms were involved in supporting those affected.

Volunteers were trained by a team of trainers to provide support. Labutta township was one of the worst affected areas. One volunteer from each village (total 38 villages) from the middle island of Labutta was given training for psychological support. All volunteers were cyclone survivors and had experienced severe psychosocial problems. Physical reactions such as fatigue and exhaustion, emotional reactions such as depression, anxiety, fear and hopelessness, cognitive reactions such as confusion and disorientation and behavioural reactions such as social withdrawal were seen in the survivors. In addition there were requirements for food, shelter, clothing and money. The training activities conducted were described. Following the training, the trainees were expected to identify those who were in psychological distress, provide technical support depending on their needs and provide appropriate referral where needed.

An evaluation six months after the training showed no attrition of trainees, enthusiastic and efficient performance of activities, appropriate referral to services and obtaining the services of networks such as midwives where needed.

The strong social cohesion of rural communities was evident during and after the cyclone and it remains a major source of support for vulnerable groups. The survivors shared shelter and food among themselves

and continue do so for orphans and lonely elders. The aftermath of the cyclone also demonstrated the resilience of the affected villagers and their capacity to help themselves and organize and implement relief and recovery activities. At the village level, the traditional social support systems including voluntary associations for youth, women, and other support groups for livelihood, cultural, and faith-based structures for various religions played a major role. New self-help groups were also formed spontaneously by the survivors themselves.

Beneficial outcomes

The social and psychological needs of the victims were met, and improved social cohesion was seen.

MHS unit observation: Implications for the programme on promotion of mental well-being

Psychosocial initiatives to disaster-affected communities have been shown to improve mental well-being in, as seem after the tsunami, the Nargis and Sidr cyclones. Substantial technical material and expertise is available in SEARO and the Region.

6.4   Community mobilization to improve mental well-being

Dr Neil Fernando said that the community is an important and vital setting for programmes on mental well-being to be implemented. A community basically comprises of three components: consumers of services, carers (family members) and community level workers (volunteers). With appropriate mobilization it is possible to change a community from being a passive recipient to an active provider in relation to health care services. Communities have the right and duty to participate individually and collectively in the planning, implementation and evaluation of health care programmes. This project was implemented in the southern province in Sri Lanka through Basic Needs, an international NGO.

The Basic Needs programme starts with a group discussion with the community to identify the needs, prioritize the needs and develop a plan. Thereafter, a village mental well-being committee is formed. Next, activities such as developing animation skills and training on sustainable livelihoods,

and income generation are conducted. In addition, the community is encouraged to identify those having mental illnesses and provide necessary help.

Participatory learning is the basis on which all activities take place. Participatory action research methodology is used to develop indicators, measure outcome and to monitor and share the progress. The results are used to change the programme as and when needed.

Beneficial outcomes for promotion of mental well-being

This model has shown that a community, once properly organized, is able to address needs relating to mental well-being. In addition to initiating the process of improving well-being, other determinants of well-being such as income generation were also addressed in the programme through community participation. Overall, community mental well-being improved.

MHS unit observation: Implications for the programme for promotion of mental well-being

This initiative shows how a community's needs could be integrated into an existing government health care system. Government programmes are usually centralized, and may not be totally relevant to the needs of the community at the local level.

This programme, which commences with a focus group discussion between the community and the service providers, results in a programme which is culturally appropriate and meets the needs of the community in a mutually acceptable manner. This "bottom up" approach will ensure community participation and ownership. As discussed earlier, linking with the existing government health care system will ensure its long-term sustainability to a great extent. This approach can be implemented in any community to implement required programmes for promoting mental well-being through a holistic approach. Being a community-level social approach, training community workers does not require intense, high level and costly training.

6.5   Improving mental well-being in deprived communities

Dr Sajeeva Ranaweera explained that interventions to improve community well-being have been undertaken in several locations in Sri Lanka. Through these interventions it has been seen that cost-effective approaches to improve mental well-being of communities are feasible and practicable. They were carried out in two different settings: in urban slum areas in the western province and in selected rural communities in the southern province. These interventions were based on a participatory, outcome-based approach. The community members were involved in deciding what they wanted their community to be, or the "ideal" state, in their opinion. Following agreement with the community, the factors hindering achieving this state were identified. Thereafter, the community itself discussed and deliberated what should be done to address these determinants. Most of the determinants were identified related to the following technical areas: well-being of children; violence including domestic violence; empowerment of women; harm relating to drugs and alcohol; media literacy; and mental health literacy.

The outcomes and impacts reported by the communities following the interventions included reduced fighting during festive periods, improved participation in community activities, women feeling safer and more comfortable, children becoming happier, confident and more outgoing, decreasing intra-family conflicts and decreased use of tobacco, and other drugs.

Entry into communities was mainly through child-centered activities. The activities relating to the intervention included preparation of a social map, discussions with key persons, formation of linkages with other government and nongovernmental agencies working in these locations, informal discussions with community members and groups and house visits. Participatory evaluation was used to assess the processes, outcomes and impacts.

The approach taken to improve media literacy was outlined as an example to describe how the community moved from passive observers of media to critical analysts and then moving into action to address portrayals which were detrimental to the well-being of individuals, families and communities. Possible approaches to upscale and institutionalize initiatives such as these at regional and national levels were outlined.

Beneficial outcomes for promotion of mental well-being

Social cohesion was enhanced as assessed by increased participation and interest in community activities. Other beneficial outcomes included reduced fighting during festive periods, reduced inter- and intra-family conflicts and violence, improved feeling of safety especially by women, reduced use of drugs and alcohol and improvement of overall well-being of children. These outcomes in tandem contributed to the overall improvement in mental well-being of the communities.

MHS unit observation: Implications for the programme for promotion of mental well-being

The observations relating to community ownership, sustainability, adaptation and scalability are the same as those for the school's intervention and improving community well-being through families, described previously. Technical capacity to promote mental well-being of entire communities though available is limited. Being a socially oriented approach the training required is not highly technical, intensive and expensive and therefore training a core of trainers is feasible in the context of this Region

7. Interventions for promoting mental well-being: healthy public policy

7.1 Gross National Happiness

Mr Karma Tshiteem in his presentation said that the Gross National Happiness (GNH) Commission, which was the former Planning Commission of Bhutan, has wide-ranging powers to allocate resources to sectors. Therefore, the concept of GNH is being operationalized at the highest levels of government. Currently, the Commission is involved in finalizing the measurement of GNH, carrying out measurements and feeding the findings into the policy making process.

Gross National Happiness has many parameters. These include psychological well-being, community vitality, ecology, time use, cultural diversity, good governance, standards of living, education and health. There

are currently 82 indicators. A method of obtaining a single composite national GNH score will be developed, taking into account all these indicators.

For example, the psychological well-being index has many measurements to cover emotional balance and spiritual well-being. These include stress, compassion, calmness, jealousy and frequency of meditation and prayer. Cultural indicators include the ability to speak the first language and knowledge of folktales. Time use indicators measure time spent with friends and time free from labour. The government performance indicators measure creation of jobs, reducing income gaps, provision of electricity and improvement of health services in addition to measuring the perceived levels of corruption of government agencies.

The community vitality indicators measure the closeness and cohesiveness of communities and family relationships. Living standard measures include incomes, house ownership and food security. Ecological indicators measure pollution, planting of trees and methods of waste disposal.

In addition, a policy screening instrument that will measure the impact any proposed policy will have on GNH, has been developed. As an example, the process of assessing the impact of Bhutan joining the World Trade Organization (WTO) on GNH was described. The perceived impact of such an action on aspects such as free time available and individual and community well-being was measured, in addition to the perceived economic benefits. When findings related to all the indicators were pooled, this survey showed that joining WTO will have a negative impact on GNH.

Once the composite GNH is finalized, the government will make it public and carry out national level measurements every two years.

MHS unit observation: Implications for the programme on promotion of mental well-being

The policy of GNH being implemented by the Royal Government of Bhutan will have a far reaching impact on promotion of mental well-being of the citizens of Bhutan. Being backed by government rules, regulations and resources, its long-term sustainability is assured. In addition, the

government proposes to continuously monitor the policy, modify it as necessary, to further enhance the well-being of the population.

Bhutan is the only country in the Region which is implementing such a policy. It can be studied by governments of other Member States for adaptation and implementation.

8. Conclusions

Following the presentations and discussion, the experts concluded the following:

➢ There are several approaches for promotion of mental well-being which can be implemented in the Region through individual, family, group and community approaches, supported by healthy public policies.

➢ Each of the approaches have been operationalized in the Region and shown to be beneficial.

➢ The need for inter-sectoral partnerships to promote mental well-being in the community was recognized.

9. Recommendations and next steps for promoting mental well-being in countries

9.1 Policy at country level

(1) Promote and advocate policies and practices which contribute to mental well-being.

(2) Assess the current policies and practices in countries on mental well-being for their efficacy and feasibility.

9.2 Programmes at country level

(1) See how interventions can be further modeled /reinforced – for individuals, family, workplace, schools, community.

(2)   Undertake pilot projects (commissioned by WHO or country-initiated) on feasibility and concept focusing on assessments of outcomes and impact using current experiences.

(3)   Determine what can be up-scaled and expanded to national and regional levels.

(4)   Mobilize resources.

9.3   Actions for WHO

(1)   Coordination between MHS and other programmes in SEARO (healthy settings, primary health care, health promotion etc.)

(2)   Include some activities on mental well-being in the WHO regular programme budget in 2010-2011.

(3)   Develop a regional network of institutions, expert or advisory group on this subject.

(4)   Organize some initial advocacy work in the countries.

(5)   Build capacity of stake-holders and Community-Based Organizations

(6)   Consider adopting a resolution at next year's Regional Committee.

9.4   Preparation for the inter-sectoral meeting on promotion of mental well-being (October 2009)

The following draft agenda was recommended for the inter-country, inter-sectoral meeting on mental well-being in October 2009.

(1)   Introductory session:

–   Background to the programme on promotion of mental well-being

–   Current concept of promotion of mental well-being

–   Historical and traditional concept of promotion of mental well-being

–   Convergence of body, brain, mind and spirit

(2)   Key note addresses (one address each during three morning sessions).

(3)   Technical presentations on promotion of mental well-being: individual approach, family approach, group approach (school and workplace), community approach and healthy public policy.

(4)   Group work and presentations on the contribution of different sectors for promotion of mental well-being. The following sectors relevant for promoting mental well-being were recommended: planning ministry, education (teachers, directors), media, industry, NGOs / social workers, health practitioners, musicians, promoters / practitioners of mental well-being, and professionals in anthropology, sociology and psychology.

(5)   Practice of traditional methods of promotion of mental well-being (three sessions, one each from Sri Lanka, Thailand and India)

(6)   Practical session on participatory learning for building community resilience (two hour session led by Thai group)

(7)   Suggestions for adaptation and scaling-up of strategies for promotion of mental well-being

(8)   Recommendations and next steps.

(9)   Adoption of 'Call for Action' on Promotion of Mental Well-Being.

Annex A

Concept of promotion of mental well-being

Prepared by Dr Sajeeva Ranaweera for WHO / SEARO

Introduction

Although there are varied concepts of health most of them include a component of mental well-being. However, there is no single definition of mental well-being which is accepted universally. This is probably because mental well-being may have different connotations for different individuals, groups and cultures. For some, it may be the notion of happiness or contentment. For others it may be absence of disease. For some it may be economic prosperity. It could be based on the goals and challenges placed on an individual or a culture. It also may mean the absence of negative determinants in the life of an individual or a community. Mental well-being includes cognitive, emotional and behavioural responses at a personal level. Some may also interpret mental well-being as determined by external stimulants and factors, sometimes beyond the control of individuals, such as housing and jobs. Thus mental well-being should be interpreted in the socio-cultural context of the individual. It should be considered as a continuum and as operating within a spectrum, rather than a state that is present or absent. An individual, group or community can be at any given point within this spectrum.

Concepts related to mental well-being

The World Health Organization describes mental well-being as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community[1]. This description asserts that mental well-being is more than an absence of mental illness. There are relative and subjective dements in this description which is necessary in trying to encapsulate mental well-being.

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[1] Mental health: strengthening mental health promotion fact sheet 220 World Health Organization 2007. http://www.who.int/mediacentre/factsheets/fs220/en/ accessed 1 June 2009

There are other concepts in the literature which are related to mental well-being.

Resilience: Resilience is described as the capacity to cope with adversity and to avoid break down when confronted with stressors. Many internal and external factors have been found to increase personal resilience. For example, resilience in children is strengthened through good relations with parents. Resilience also depends on a person's cognitive make up – a sense of self esteem – which could change along a spectrum depending on diverse factors.

Positive psychology: The term "positive psychology" is based on the idea that if people are taught to be resilient and optimistic they will be less likely to suffer from depression and will lead happier and more productive lives. Building on human strengths can be described as building psychological "potency" before problems occur.

Salutogenic perspective of mental health: Antonovsky's salutogenic perspective of mental health also contains concepts related to mental well-being[2]. Factors promoting health, not disease is considered. Here, health is considered a relative state, is projected as a continuum in the presence of life's stress, chaos etc. In this concept individuals use resources to resist negative determinants of health. Some examples of these resources are money, knowledge, experience, social support, culture, intelligence, traditions and ideologies. Added to this is the concept of sense of coherence which encapsulates factors that enable a person to use these resources optimally.

Social capital: The concept of "social capital" that came into being during the past decade has been known and experienced in many communities in the South-East Asia Region. This concept states that "social capital" consists of social life such as institutions, networks, norms, reciprocity and social trust that shape the quality and quantity of social interactions and facilitate collective action, coordination and mutual benefit[3]. It asserts that such social cohesion is critical for societies to prosper economically and their development to be sustainable. Aspects of social

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[2] Lindstorm B. Eriksson M. The Salutogenic Perspective of Mental Health. In: Promoting Mental Health: Concepts, Emerging Evidence, Practice. World Health Organization 2005.

[3] Whiteford H, Cullen M, Baingana F. Social Capital and Mental Health. In Promoting Mental Health: Concepts, Emerging Evidence, Practice. World Health Organization 2005.

capital such as trust, social support and social networks are also considered important determinants of mental health and well-being of individuals. Therefore it consists of both structural and cognitive aspects. Such support, networks, trust and reciprocity and protective norms have always been embedded in cultures of the Region. They have perhaps played an unrecognized role in maintaining well-being of societies of this Region despite severe financial and other constraints. Some believe that such factors are being eroded by the western concepts of materialism and "development" that is becoming more widely apparent in countries of this Region.

Quality of life: A wide ranging and inclusive description relevant to mental well-being is the concept of "Quality of life" expounded by the WHO Quality of Life Group. This description was developed following work in several culturally diverse centres over a period of time. It conceptualizes a the quality of life is an individual's perception of his or her position in life in the context of the culture and value systems in which he or she lives, in relation to his or her goals, expectations, standards and concerns[4]. This reflects a broad view of mental well-being encompassing social indicators, happiness and health status. It also captures positive aspects of coping, resilience, satisfaction and autonomy, among others issues.

Mental well-being in public policy, community, group and individual levels

Population-wide application of measures to improve mental well-being can be viewed at four levels. The first is policy level. The second is the community level, the third being group level and the fourth is individual level.

Healthy public policy

Policies and legislations are important aspects of improving population level mental well-being, as they pave the way for the creation of supportive environments necessary for sustained action and maintenance of impact of various initiatives.

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[4] The World Health Organization Quality of Life assessment (WHOQOL): position paper from the World Health Organization. <u>Social Science and Medicine.</u> 1995 Nov;41(10):1403-9

In practice, improvement of mental well-being cuts across several sectors. Therefore, elements of mental well-being should be built into policies of different sectors. Policies improving mental well-being have been developed for many sectors at different levels. Employee well-being policies and child well-being policies are examples. Some determinants of mental well-being are already being addressed in various legislations and regulations in some countries. Measures to address harm from alcohol use, domestic violence and child abuse are some such examples. It should be noted however that the objective of these legislations and regulations may not have been entirely the improvement of mental well-being.

At a lower level, components of policies too have a positive impact on mental well-being of individuals and specific groups. For example, implementation policies and measures to improve vision and hearing through a health policy will have a significant impact on the mental well-being of elderly populations. Proponents of mental well-being are in a position to advocate for a holistic view of well-being at national levels incorporating elements of mental well-being.

The best example of incorporating well-being into public policy comes from Bhutan where the National Planning Commission has been renamed the Gross National Happiness Commission, and has incorporated well-being into the national planning process[5]. Thailand too has recently instituted a Gross Domestic Happiness Index. There are also efforts to incorporate national level measures of well-being in several other countries outside this Region, but none of them have made any substantial progress so far.

Community level

Community level represents the real world. Living beings who work and spend time in their natural physical and social environment need more pragmatic and practical approaches. Families, schools and workplaces exist in communities. Cultures, norms, biases, social practices etc. survive in communities. Individual programmes such as ones preventing drug use alone cannot address overall well-being of communities although such programmes contribute to improving well-being. As discussed later, multi-

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[5] Royal Government of Bhutan. Gross National Happiness Commission. http://www.pc.gov.bt/. Accessed 1 June 2009

pronged intersectoral approaches addressing several determinants of mental well-being can significantly improve the mental well-being in communities.

The Ottawa[6] and Bangkok[7] Charters provides principles for implementation of effective and sustainable initiatives in communities.

Group level

Usually, groups are separately addressed in different settings such as schools and workplaces. As groups consist of individuals who in turn exist in communities, the factors that need to be addressed are often overlapping. It is difficult to remove a group from a community. Norms and practices in the wider community almost always filters into these settings. But there are also specific group norms or practices that will have a bearing on well-being as a whole. For example, if young people in a community enjoy making females uncomfortable, this should be addressed. In practice, groups in different settings are addressed through vertical programmes E.g. drug use prevention programmes in schools or stress reduction programmes in workplaces.

Individual level

At the individual level, traditional approaches to improve personal strengths such as development of social competence, problem solving skills and autonomy have been used. Addressing only individuals in behviour change interventions has not been very successful. This is because individuals think and behave within the norms, contexts and cultures of groups and communities[8]. When such factors are addressed in wider groups or communities, individual behaviour begins to change. Therefore any effort to improve mental well-being of populations should not solely address individuals.

When operationalizing the concept of mental well-being, it should be noted that there is a difference between individual mental well-being and

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[6] Ottawa Charter for Health Promotion First International Conference on Health Promotion 1986 PE/HPR/95.1. World Health Organization. www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf. Accessed 1 June 2009

[7] Bangkok Charter for Health Promotion 2005 World Health Organization http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/ Accessed 31 May 2009

[8] Bandura, A. (1977). Social learning theory. Englewood Cliffs, NJ.

group or community mental well-being. Therefore, different working definitions, approaches and indicators are required for addressing them at each level.

It may be argued that in some situations, what is good for individuals may not be so for the community and vice - versa. For example, if a person has learned that being violent, loud and abusive is effective in maintaining control over a group or a family, and that control gives that person a sense of acceptance and contentment, it is manifestly counter-productive to the family or the community. To give another example, a person may be used to loud music as a means of relaxation, but this may disturb for those living around him. If processions or positions produce a sense of mental well-being to a given individual, the method acquiring the same should not be counter-productive to the family, group (work place) or the community at large. These examples may not be common, but they are used to illustrate the point. The reality may be more subtle.

Intersectoral partnership to promote mental well-being

In developing programmes for promotion of mental well-being, a first step would be to be to understand the determinants of mental well-being in communities or groups where interventions are planned. Taking the community setting as an example, the concept of mental well-being in different communities may vary substantially, and so will the determinants that need to be addressed. Thus the requirements to improve well-being of a community may be diverse – for example addressing the issue of domestic violence, child friendliness, drugs and alcohol use etc. Currently, many such interventions are being carried out by different agencies as individual interventions. Community mental well-being programmes should contain aspects of all these programmes to have an impact on the overall mental well-being of its population. Taking into account the limited number of initiatives available in this Region, the most important aspect of such programmes should be its comprehensiveness.

Some examples of interventions that contribute to the improvement of mental well-being are listed below[9].

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[9] Patel V, Swarta L, Cohen A. Evidence for Mental Health Promotion in Developing Countries. In Promoting Mental Health: Concepts, Emerging Evidence, Practice. World Health Organization 2005.

> ➢ Improving community cohesion and social capital

> ➢ Early childhood development interventions, school interventions

> ➢ Workplace programmes for mental health promotion

> ➢ Improving well-being of the elderly – vision, hearing, exercise, networking

> ➢ Spiritual enhancement

> ➢ Raising mental health literacy

> ➢ Reducing harm of addictive substances including alcohol

> ➢ Prevention of domestic violence, child-abuse

> ➢ Prevention of violence, suicides

> ➢ Adolescent mental health promotion

> ➢ Economic empowerment

> ➢ Media literacy

For example, depending on the context, a programme incorporating aspects of social cohesion, child friendliness, preventing domestic violence, addressing drug and alcohol use, preventing suicidal behaviour, media and mental health literacy and - if relevant – economic empowerment will address many determinants of well-being relevant to communities of the Region.

Global initiatives for partnerships

The recommendations of the Commission on Social Determinants and Health which contain recommendations to improve daily living conditions and to tackle inequitable distribution of power, money and resources addresses many underlying determinants of mental well-being[10]. It calls for healthy and safe behaviours to be promoted equitably, which includes reducing violence and crime and addressing issues related to alcohol use. This is in addition to its call for establishing and strengthening universal comprehensive social protection policies. Many issues that have direct

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[10] Commission of Social Determinants of Health, Final Report. Closing the gap in a generation: Health equity through action on the social determinants of health, 2008

bearing on mental well-being such as housing, physical environment, employment, rural development and access to health care is also dealt with in this report

The Millennium Development Goals (MDG) [11], aim to respond to the world's main development challenges and address issues such as poverty, hunger, education, empowerment and environment that have a direct bearing on mental well-being of individuals and populations. These factors are considered to be contributors to mental well-being at many levels. Encouraging progress has been made in several fronts related to the above in many parts of the world.

Assessment of mental well-being

Indexes have been developed to measure mental well-being of populations.. These are similar to quality of life indicators used at macro levels, and take into account health, economic and social indicators. The interest in measuring and improving well-being of populations is becoming widespread as economically richer countries begin to realize that economic measurements as the Gross Domestic Product (GDP) and the GDP Per capita do not reflect actual mental well-being of their populations, where stress-related problems and mental disorders such as depression seem be increasing at the same time that they are becoming economically richer. Other alternatives such as the Genuine Progress Index (GPI) and the concept of Gross National Happiness (GNH) have been proposed.

There are also many instruments to measure personal mental well-being and happiness which have been proposed and used in many parts of the world. One example is the Ryffs Scales of psychological well-being

Evaluation of programmes

The level and the quality of evidence required to accept, implement and measure intervenes for mental well-being is different to the evidence required in a controlled clinical trial. A common mistake made is the attempting to evaluate and report behviour change interventions using stringent epidemiological and statistical criteria. Such approaches are

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[11] The Millennium Development Goals Report 2008, United Nations 2008

unsuitable in this context because behaviour changes are difficult to quantify and move spectra with time.

It is also well established that community or population level behaviour change requires long periods of interventions, often years. Therefore indicators used should be able to detect subtle changes that occur over time that will measure the direction of changes that are occurring. Standardized, validated questionnaires and standard techniques of gathering data may be inappropriate to detect subtle early changes.

The process and theory of evaluating such interventions have been debated and published extensively. Although there are many reports and publications related to community level behaviour change interventions on health and other matters, there is no agreed "gold standard" for evaluation. In practical terms, the nearest to a gold standard will the qualitative measurement of by individuals and the community itself, although this is subjective and may not be comparable.

Qualitative techniques based on observations and interviews with key persons should be the cornerstones in evaluation. Evaluation should be an ongoing process and the key will be to look for changes over time rather than absolute measures.

Types of evidence for programmes

A few select strategies that are sufficiently effective, which is applicable to a large number of people will have a greater impact than application of strategies thought to be very effective, but could be only applied to individuals or select groups.

The following typology has been suggested for evidence in promotion of mental well-being practice[12]:

➢ Type A: What works is known, how it works is known and repeatability is universal.

➢ Type B: What works is known, how it works is known but repeatability is limited.

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[12] Tang KC, Eshani J, McQueen D. Evidence-based health promotion: recollections, reflections and reconsiderations. Journal of Epidemiology and Community Health 57(11):841-843, 2003.

➢ Type C: What works is known, how it works is not known but repeatability is universal.

➢ Type D: What works is known, how it works is not known and repeatability is also limited.

Although type A evidence is the most desirable, Type B and C evidence will be the more practical target. Scouting for universally applicable programmes for promotion of mental well-being could be a fruitless exercise due to variety of cultural, legal and social differences among countries and even within countries. Therefore, type B programmes, modified according to the settings will be the best approach. In developing and implementing interventions relevant to the Region, such programmes should be given priority.

Indicators for programmes

During planning and implementation of mental well-being interventions appropriate emphasis should be placed on ways of ascertaining changes occurring, early in the intervention. As behaviour changes take time to become established, measures of early changes in the proposed behaviour to be assessed should be identified and measured, to ensure that the interventions achieve the desired final outcomes.

Process indicators: This term has been used in behaviour change interventions to mean the "process" of change, along a continuum, as well as for indicators measuring programme implementation. In the context of this paper, we will consider process indicators as measures of the delivery of the programme[13]. They measure the management process, which is the progamme delivery Examples are numbers of trainings carried out, numbers of brochures distributed etc.

Impact indicators: The outcomes are changes that the programme brings[14]. The impact will be the net outcome[15]. Simplistically stated, impact

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[13] Baker J.L. Evaluating the Impact of Development Projects on Poverty: A Handbook for Practitioners World Bank, 2000

[14] Evaluating Outcomes of HIV Prevention Programs, Centres for Disease Control, Department of Health and Human Services, USA 2007. http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/outcome-eval.htm. Accessed 2 June 2009

assessment measures if the interventions are successful in achieving the stated objectives.

In community projects to improve mental well-being, detecting early changes are best carried out by members of the community themselves using less formal methods. The community should be encouraged to develop their own indicators to measure change - this helps them in planning interventions and obtaining ownership of the interventions too. Many innovative direct and indirect indicators could be used to assess progress.

For example, in a tobacco demand reduction project the number of people smoking in a public place e.g. a bus stop, over a period of time can be a proxy indicator of smoking. In an alcohol use demand reduction intervention, the number of eggs sold in the community was used as a proxy indicator of increased savings by families. In this community, the number of eggs sold increased with the decline in alcohol consumption as people had more money to spend on food rather than alcohol. It should be noted that such indicators should not be considered in isolation, but taken with other similar and more formal indicators suggesting the direction in which the community is heading.

In behaviour change interventions, especially those targeted at groups and communities, qualitative and (sometimes subjective) indicators will provide an accurate picture of progress at ground level. Some examples of indicators that can be used to assess the initial changes in a community in relation to mental well-being are: can the community identify the determinants of mental well-being (e.g. violence)? Are they talking about them openly? Are they starting to do things to address these determinants? What type of progammes are most often watched on television?

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[15] What is impact Evaluation? Impact Evaluation. World Bank.
http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTISPMA/0,,contentMDK:20188174~menuPK:384336~pagePK:148956~piPK:216618~theSitePK:384329~isCURL:Y,00.html.
Accessed 2 June 2009

Annex B

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Annex C

Agenda

- ➤ Concept of mental well-being
    - Primordial prevention for mental health
    - **Speaker**: Dr Vijay Chandra
- ➤ Promotion of mental well-being as a public health strategy
    - **Speakers**: Drs Abeykoon and Ranaweera
- ➤ Programmes for promotion of mental well-being
    - Individual level
        - Traditional methods focusing on body and mind (yoga, meditation, vipasana)
        - Spirituality and religiosity
        - Promotion of healthy life styles
        - Developing skills for every day living (livelihood, inter-personal relationships, etc)
        - Addressing individual risk factors (alcohol abuse, drug abuse, depression)
        - Other programmes in Member States (experts to identify)
    - **Speakers**: Dr Manchanda (yoga for reversal of heart disease)
      Dr Awdesh Sharma (spirituality and mental health)
      Dr Than Sein (meditation in social settings)
    - Group level
        - Family cohesiveness
        - Happy schools
        - Workplace culture
    - **Speakers**: Professor Radha Sharma (healthy workplace)
      Dr Diyanath Samarasinghe (happy schools programme)
    - Community action
        - Building community resilience

- Urban slums programme in Sri Lanka

- Programmes of NGO "Basic Needs"

- **Speakers**: Daw Moe Moe Khine (building community resilience in disaster settings)
  Dr Sajeeva Ranaweera (urban slums programme)
  Dr Neil Fernando (Basic Needs programme for improving community well-being)
  Thailand experience in building community resilience

- Policy: Healthy public policy

  - Inter-sectoral collaboration (trade unions, employers

  - Inter-ministerial collaboration (trade, industry, finance vs health)

  - Gross happiness index (Bhutan)

- **Speakers**: Mr Karma Tshiteem (Bhutan's gross national happiness programme)
  Dr Palitha Abeykoon (intersectoral collaboration)

- Other programmes in Member States

  - Developing working papers for inter-country meeting (October 2009)

  - Setting the agenda for the inter-country, inter-sectoral meeting in October 2009

Annex D

Programme

Day 1: 11 June 2009, Thursday

0800 - 0900	Registration
0900 - 0930	Opening Session: Welcome by Ag NMH Welcome by Senior Official of MoH, Indonesia
0930 - 1015	Introduction of participants - *Dr V. Chandra* Appointment of Office Bearers Objectives and scope of the meeting - *Dr V. Chandra*
1045 - 1200	Background to programmes on promotion of mental well-being: *Dr Chandra* Convergence of body, brain and mind in promotion of mental well-being: *Dr Chandra* Concept of promotion of mental well-being: *Dr Ranaweera*
1200 - 1300	Programmes for promotion of mental well-being: Individual level
1400 - 1700	Programmes for promotion of mental well-being: Individual level (contd)
1900 onwards	Welcome reception with talk by *Professor Sumanapala*

Day 2: 12 June 2009, Friday

0900 - 1200	Programmes for promotion of mental well-being: Group level
1200 - 1300	Programmes for promotion of mental well-being: Community action
1300 - 1400	Lunch
1400 - 1600	Programmes for promotion of mental well-being: Community action (contd)
1600 - 1800	Healthy public policy for promotion of mental well-being

Day 3: 13 June 2009, Saturday

0900 - 1100	Finalization of working papers and country projects (in 4 groups)
1100 - 1200	Review of working papers prepared by other groups
1200 - 1300	Presentation and discussion of working papers and country projects
1300 - 1400	Lunch
1400 - 1600	Presentation and discussion of working papers and country projects (contd)
1600 - 1700	Setting the agenda for the October meeting and conclusion

WHO defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The definition clearly emphasizes mental well-being. Since its establishment, WHO has focused on addressing the major causes of morbidity and mortality, and has emphasized health promotion and prevention of disease. However, the concept of well-being (including mental well-being), even though included in the original definition of health, has not been implemented as a public health strategy.

There is no generally accepted "definition" of mental well-being. However, the concept is generally recognized and was described by WHO as a state in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
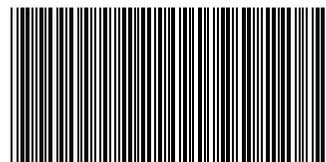
This expert meeting concluded that there are several approaches for promotion of mental well-being which can be implemented in the Region through individual, family, group and community approaches, supported by healthy public policies. Each of the approaches has been operationalized in the Region and shown to be beneficial. The need for intersectoral partnerships to promote mental well-being in the community was recognized.

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