Ten-year incidence and time trends of psychiatric disorders in Scutari from 2005 to 2015

Msc. Kilda GUSHA
Regional Directory of Public Health, Scutari, Albania

Prof. Asoc. Dr. Voltisa LAMA
European University of Tirana, Faculty of Social Sciences,
Department of Education, Tirana, Albania

Abstract

Aim: *One in four people in the world will be affected by mental or neurological disorders at some point in their lives. Mental disorders are among the leading causes of ill-health and disability worldwide. There is no data on mental health incidence in our country. Scutari is the most important city in north region of Albania, which provides hospital and day care mental health services for people living in this area. This retrospective study aimed to estimate the ten-year incidence and time trends of mental health cases, diagnosed in Scutari from 2005 to 2015.* ***Method:*** *All new cases diagnosed in Scutari during 2005-2015 were included in the study. The data were collected from statistic office registry of mental health Institutions in Scutari. We considered demographic and socioeconomic data, age, diagnosis, timing of first diagnose and the service which provided the care for each case. It was estimated the incidence per 100.000 inhabitants and it was analysed the time trends over a decade.* ***Results:*** *There were 7620 cases diagnosed in total during ten years. Among them about 83 % (n =6287) were hospital inpatients, while community mental health centres provided inpatient and day care for 17% of cases (n=1333). The incidence ranged from 244 to 378 per 100.000 inhabitants, still there was not much change in*

the incidence rates over a decade. Community mental health services were established in Scutari in 2010 reflecting the new public health policy. Since 2010 community mental health centres had a rapid increase in figures each year, taking over some of the patients flow from state psychiatric hospital of Scutari which was the only service up to 2010. About 60% of diagnosed psychiatric patients were males versus 40% females; 57% lived in rural areas versus 43% in urban areas. The most prevalent diagnoses according ICD-10 were psychotic disorders (F20-29), followed by mood disorders (F 30-F39). ***Conclusion*** *Mental disorders were more frequent in this study with predominance of Schizophrenia. Those problems were more common in male, in patients that live in rural area and unemployed persons. Young people and active age people were also more likely to have mental disorders that indicating an early age of onset for mood, anxiety and alcohol disorders.*

Keywords: *mental health services; Scutari; psychiatric disorders; incidence; time trend; decade*

Introduction

WHO defines mental health as "*a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community* (WHO, 2004). The mentally ill is vulnerable and should be recognized as such and strongly considered whenever we are talking of universal coverage (Obayi et. al, 2017). So nowadays the adopted slogan "No health without mental health" is the true one (Prince et. al, 2007).

Based to the WHO report, one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide. (WHO, 2001).

The problem of mental disorders and mental disorders continues to grow with a significant impact on health and social, human and economic rights in all countries of the world (Demyttenaere et al., 2004). For this reason, the fact that mental health is a foundation for the well-being and efficient functioning of the individual and the community as a whole, and the World Health Organization and other international organizations identify the improvement of mental health as a preoccupation primary for both low and middle income and wealthy countries (WHO, 2005).

Mental disorders include: depression, bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities and developmental disorders including autism.

In our country, there is no national survey about mental problems and their prevalence in the population. In Albania the data about epidemiology and incidence of mental disorders are few (Kruja et. al, 2012). Scutari is the most important city in north region of Albania, which provides hospital and day care mental health services for people living in this area. This retrospective study aimed to estimate the ten-year incidence and time trends of mental health cases, diagnosed in Scutari from 2005 to 2015.

Method

All new cases diagnosed in Scutari during 2005-2015 were included in the study. The data were collected from statistic office registry of mental health Institutions in Scutari. We considered demographic and socioeconomic data, age, diagnosis, timing of first diagnose and the service which provided the care for each case. It was estimated the incidence per 100.000 inhabitants and it was analysed the time trends over a decade. Classification of the mental disorders was based on diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders DSM-5. 5th ed (DSM_V) (APA, 2013) and also the International Classification of Diseases and Injuries 10th Revision (ICD_10) (WHO, 1992). For analyze of epidemiological statistical data we were used the software SPSS version 19.

Results

There were 7620 cases diagnosed in total during ten years. Among them about 83 % (n =6287) were hospital inpatients, while community mental health centres provided inpatient and day care for 17% of cases (n=1333). The incidence ranged from 244 to 378 per 100.000 inhabitants, still there was not much change *in* the *incidence* rates over a decade. Community mental health services were established in Scutari in 2010 reflecting the new public health policy. Since 2010 community mental health centres had a rapid increase in figures each year, taking over some of the patients flow from state psychiatric hospital of Scutari which was the only service up to 2010. About 60% of diagnosed psychiatric patients were males versus 40% females; 57% lived in rural areas versus 43% in urban areas. The most prevalent diagnoses according ICD-10 were psychotic disorders (F20-29), followed by mood disorders (F 30-F39).

Table 1 represent the overall demographic data of patients surveyed from 2005 -2015 for SHSHMSH and 2010-2015 for QKSHM.

TABLE 1 The general demographic data of the population

The general demographic data of the population	Number of cases	Percentage of cases
Total number of cases 7620		
Number of cases dealt with at QKSHM	1,333	17.5%
Number of cases dealt with at QKSHM	6,287	82.5%
Settlement (225549 inhabitants according to CENSUS 2011)		
Scutari	6,139	80.57%
Puka	86	10.7%
Great mountain	566	7.43%
Other	99	1.30%
Residential area		
rural	4,327	56.8%
urban	3,293	43.2%
gender		
Females	3,085	40.5%
Male	4,535	59.5%
Age group		
Average age 43 ± 4		
0-14 age	68	0.90%
15-24 age	417	5.48%
25-44 age	3,3341	43.85%
45-64 age	3,385	44.43%
+65 age	409	5.37%
Ethnicity		
Albanian	7,415	97.3%
Egjyptiane	55	0.73%
Malazeze	26	0.35%
Not declared	124	1.63%
Religious Sessions		
Catholic	4,070	53.42%
Myslyman and Bektashis	3,394	44.54%
Christian is a Catholic	34	0.45%
Atheist	15	0.20%
A believer without proper definition	38	0.50%
Data is missing	69	0.91%

Table 2 present other demographic data of the population related to the educational level, monthly family income, employment and family heritage.

Familiar familiarity with many studies carried out (mentioned in the theoretical part) is very related to the emergence of PSHMs to successors. It is worth pointing out that each data is contained in each patient's card.

TABEL 5.2 Other population data

Other general population data	Number of cases	Percentage of cases
Educational level		
Without education	91	1.19 %
Primary Education	157	2.06 %
8-9 Year Old Education	492	6.45 %
Secondary education	5,181	68 %
High education	1,699	22.3 %
Monthly income		
No income	34	0.44 %
Social help	267	3.5 %
100 to 200 thousand for month	2,349	30.8 %
200-400 thousand for month	2,612	34.29 %
400-600 thousand for month	1,583	20.77 %
> 600 thousand for month	775	10.2 %
employment		
Employed	3,423	44.9 %
Without job	2,670	35.04 %
retiree	970	12.73 %
Gardens and schools	557	7.3 %
Familiar familiarity		
Previous family history	2,699	35.42 %
No family history	4,921	64.58 %

For years now, the clinical diagnosis of cases is based on the determination of mental health problems according to DSM-IV and DMS-V classification. In recent years, especially after 2010, the classification of DSM V coded by ICD 10 is being used.

The table below presents the prevalence of morbidity based on classification of DSM V but coded according to ICD 10.

TABLE 3 Prevalence of morbidity according to ICD 10

1Diagnosis by ICD 10	No. of cases	Prevalence0
F10-F19	245	3.2%
F20-F29	3534	46.4%
F30-F39	2001	26.3%
F40-F48	771	10.1%
F60-G69	256	3.3%
ETC	813	10.7%
Total	7620	100%

Since classification of mental health problems was introduced long afterwards by the existence of the psychiatric hospital in Shkodra district, the detection, classification and treatment of cases with disorders were based on DMS-IV and DMS-V. For this reason, the cases dealt with by the SHSHMSH are presented with the classification according to DSM - V as the cases taken in the study are from 2005.

TABEL 5.20 Demographic factors and mental problems. Logistic regression

Demographic data	Demographic Factors and Mental Health Problems Odds Ratio (95% CI) p value <0.05[1]					
	F10-19	F20-29	F30-39	F40-48	F60-69	Tjetër
Separation by sex						
Female	1[2] (reference)	1.18 1.08-1.27 p=0.0003	1.01 0.9-1.12 p=0.79	2.60 2.23-3.04 p<0.0001	1.08 0.87-1.35 p=0.44	1.03 0.90-1.17 p=0.65
Man	28.12 (11.56-68.39) p<0.0001	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Residence						
Urban	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Rural	1.08 0.84-1.39 p=0.60	1.24 1.14-1.34 p<0.0001	1.18 1.08-1.3 P=0.0013	1.36 1.17-1.54 P=0.0001	1.73 1.36-2.23 p<0.0001	1.06 0.91-1.22 p=0.51
Age groups						
0-14 age	-[3] N/A	-[3] N/A	10.0 (2.24-40.0) p=0.0022	-[3] N/A	-[3] N/A	94.33 (22.70-391.84) P<0.0001

15-24 age	1.89 (0.99-3.59) p=0.05	1.35 (1.02-1.8) p=0.032	2.18 (1.5-3.23) p=0.0001	1.54 (0.98-2.40) p=0.057	1.09 (0.57-2.09) p=0.82	1.22 (0.960-1.7) p=0.22
25-44 age	1.24 (0.71-2.13) p=0.47	1.71 (1.38-2.12 p<0.0001	1.29 (1.01-1.66) p=0.037	1.25 (0. 87-1.8) p=0.2	1.3 (0.80-2.13) p=0.3	4.17 3.23-5.56 p<0.0001
45-64 age	1.25 (0.72-2.18) p=0.44	1.72 (1.39-2.14) p<0.0001	1.41 (1.10-1.8) p=0.0058	1.07 (0.75-1.54) p=0.68	1.93 (1.17-3.23) p=0.011	3.85 2.95-5.0 p<0.0001
+65 age	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)

1. All p values values that resulted in <0.05 are called statistically significant for 95% CI.

2. Since the habit of drinking alcohol or drugs is most commonly encountered in males compared to women, in this table for illnesses caused by ethylitis or female drugs are taken as a reference. This is to see the impact that this consumption may have on males.

3. Can not be calculated due to lack of value. For diseases classified in F10-19, F20-29, F40-48 there are no diagnosed cases for the age group 0-14 years.

TABEL 5.22 Demographic factors and mental problems. Logistic Regression (continued)

Demo-graphic data	Demographic Factors and Mental Health Problems Odds Ratio (95% CI) p value <0.05[1]					
	F10 - 19	F20 - 29	F30 - 39	F40 - 48	F60 – 69	ECT
Educational level						
Without education	7.4 (4.08 – 13.47) p<0.0001	6.37 (3.43 – 11.85) p<0.0001	10.30 (5.9 – 17.94) p<0.0001	5.38 (2.8 – 10.31) p<0.0001	6.37 (3.43 – 11.85) p<0.0001	6.37 (3.43 – 11.85) p<0.0001
Primary Education	9.27 (5.8 – 14.8) p<0.0001	7.32 (4.48 – 11.95) p<0.0001	11.8 (7.52 – 18.5) p<0.0001	4.98 (2.9 – 8.5) p<0.0001	4.18 (2.37 – 7.3) p<0.0001	2.67 (1.4 – 5.12) p = 0.0031
8-9 year education	2.17 (1.37 – 3.43) p = 0.0009	9.85 (6.95 – 13.96) p < 0.0001	11.57 (8.15 – 16.44) p < 0.0001	7.03 (4.9 – 10.10) p < 0.0001	3.98 (2.67 – 5.92) p < 0.0001	2.32 (1.48– 3.64) p = 0.0002
Secondary education	0.70 (0.50 – 0.99) p = 0.043	30.29 (22.8 – 40.24) p < 0.0001	12.41 (9.33 – 16.51) p < 0.0001	2.73 (2.03 – 3.67) p < 0.0001	0.51 (0.36 – 0.73) p = 0.0002	4.55 (3.4 – 6.09) p < 0.0001

High education	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Monthly income						
No income	3.08 (1.13 – 8.38) p = 0.027	4.64 (1.9 – 11.28) p = 0.0007	3.83 (1.5 – 9.78) p = 0.0049	5.5084 (2.34 – 12.92) p = 0.0001	1.73 (0.5 – 5.9) p = 0.37	3.08 (1.13 – 8.38) p = 0.02
Social help	1.52 (0.88– 2.63) p = 0.12	10.38 (6.9 – 15.5) p < 0.0001	5.76 (3.78 – 8.77) p < 0.0001	1.21 (0.67 – 2.18) p = 0.508	1.21 (0.67 – 2.18) p = 0.508	2.7 (1.68 – 4.34) p < 0.0001
100-200 thousand	5 (3 – 7) p = 0.0001	18.04 (13.03 – 24.96) p < 0.0001	4.9 (3.5 – 6.8) p < 0.0001	1.91 (1.3 – 2.69) P = 0.0002	0.38 (0.24 – 0.58) p < 0.0001	3.20 (2.29 – 4.48) p < 0.0001
200-400 thousand	0.5 (0.37 – 0.81) P = 0.0025	19.96 (14.43 – 27.59) p < 0.0001	6.70 (4.84 – 9.29) p < 0.0001	0.97 (0.68 – 1.39) p = 0.89	0.55 (0.37 – 0.82) p = 0.0031	1.73 (1.23 – 2.44) p = 0.0016
400-600 thousand	0.80 (0.54 – 1.19) p = 0.28	9.96 (7.15 – 13.87) p < 0.0001	7.58 (5.4 – 10.57) p < 0.0001	3.64 (2.59 – 5.13) p < 0.0001	0.60 (0.4 – 0.92) p = 0.019	1.98 (1.39 – 2.83) p = 0.0002
> 600 thousand	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Employment						
Employed	1.34 (0.71 – 2.52) p = 0.36	65.39 (35.8 – 119.24) p<0.0001	17.46 (9.6 – 31.8) p<0.0001	3.97 (2.16 – 7.32) p<0.0001	1.05 (0.55 – 1.99) p = 0.87	2.61 (1.4– 4.83) p = 0.0023
Without job	2.13 (1.13 – 3.99) p = 0.017	44.95 (24.63– 82.06) p<0.0001	22.98 (12.5 – 41.97) p<0.0001	5.08 (2.75 – 9.36) p<0.0001	2 (1 – 3) p= 0.58	3.03 (1.63 – 5.64) p<0.0004
retiree	1.0 (0.9 – 3.58) p = 0.0931	18.56 (10.05 – 34.27) p<0.0001	11.0025 (5.9 – 20.42) p<0.0001	8.79 (4.7 – 16.38) p<0.0001	6.61 (3.52 – 12.38) p<0.0001	15.95 (8.6 – 29.5) p<0.0001
Gardens and schools	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Familiar familiarity						
Previously familiar history	1.31 (1.01 – 1.69) p = 0.039	3 (2 – 4.69) p < 0.0001	1.13 (1.02 – 1.26) p = 0.016	2.88 (2.47 – 3.35) p<0.0001	2.95 (2.29 – 3.81) p<0.0001	1.113 (0.95 – 1.29) p = 0.16
No family history	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)	1 (reference)

Based on the logistic regression of variables with morbidity, it is worth pointing out that a strong signal correlation exists for most of the variables taken in the study for CI 95% p values have resulted to be less than 0.05

Discussion

A state that respects and protects the basic civil, political, economic, social and cultural rights of its people has as its core issue the promotion of mental health. Without the security and freedom offered by these rights, it is very difficult to maintain a high level of mental health (Gost, 2001). Dr. Gro Harlem Brundtland, Director-General of WHO, on releasing the World Health Report has said; "Mental illness is not a personal failure. In fact, if there is failure, it is to be found in the way we have responded to people with mental and brain disorders" (WHO, 2001).

In this study, 7620 individuals have received special treatment at the Mental Health Service [6,287 (82.5%)] and the Community Mental Health Service [1,333 (17.5%)]. This is a descriptive retrospective epidemiological study, which is based on the research of individuals' files that have been diagnosed with at least one mental health problem during their lifetime in the Shkodra district for a period of 10 years from 2005 to 2015. The analysis of the data on the incidence of PSHM problems in Shkodra district is based on the number of population according to 2011 CENSUS (Census, 2011).

The number of inhabitants of Shkodra region according to CENSUS is 225,549, out of which 166,050 inhabitants belong only to Shkodra district.

In total, the PES incidence over 2005-2015 resulted in 3378.42 persons with PSHM for a number of 100,000 inhabitants, which is a relatively high figure compared to some of the countries close to Albania. In a 2010 study on mental health problems in Serbia, Kosovo, Malta, Croatia and Bosnia and Herzegovina), the prevalence of mental illness resulted in figures of 44.8%. However, the prevalence of having a mental disorder ranges between the Balkan countries, for example, the Republic of Macedonia has the lowest prevalence of 21.5%, followed by Croatia with 39.9%, Bosnia and Herzegovina with 48.2%, Serbia with 54% and Kosovo with 62.2% of the population analyzed. Issues related to anxiety disorders ranged from 15.6% to 41.8%, behavioral disorders from 12.1% to 47.6%. Disorders due to Etilization, Somatization and Psychotics were less frequent. The most commonly encountered individual problems in this study were Post-Traumatic Stress Disorder with an interval of 10.6% -35.4% and Major Depression with 4.1% -35.4% (Priebe et al., 2010).

Table 1 and 2 presented the general demographic data of patients surveyed from 2005 -2015 to the AHSH and from 2010-2015 to QKSHM. With regard to the

prevalence of morbidity we can say that we have a prevalence of cases who suffer from diseases that according to the classification of ICD 10 are included in F20-29. This group includes diseases such as schizophrenia that takes the lead, delusional disorders, and reactive psychiatry. These diseases occupy a 46.4% prevalence of the total morbidity encountered in this paper.

We think that this large number comes as most of the cases analyzed belong to the SHSHMSH, where the patients treated there are serious complications with PSHMs such as Schizophrenia.

Second, we classify Depressive Disorders and Affective Disorders with 765 and 739 cases, respectively. Then rank those with mental retardation, neuritis disorders, personality, anxiety, reactive, and so on. If we were to be based on the ICD-10 classification, the highest prevalence is shown for the categories of diseases that are included in F 20 - 29 with 46.4%, in the second place those with F 30-39 with 26.3%, with F 40-48 and the other category with 10% respectively, while those in category F 10 - 19 and F 60 - 69 with over 3%.

The number of men cases treated near the two centers resulted to be higher by 4,535 (59.6%) compared to female cases 3,085 (40.5%). The incidence appeared higher again for male gender compared to women 2011.98 and 1367.8 respectively. Even with regard to the classification according to the classification of diseases, again there is a prevalence of male cases against women. This is most evident in cases of diseases caused by ethylisation or drugs. This is also in line with the literature cited as men in this category have the highest percentage of cases in men: 5.6%, women 1.3% (WHO, 2014).

In urban-rural segregation, rural households account for 56.8% of urban areas compared to urban areas 43.2%. Even with regard to the incidence, there is still a high incidence in rural areas of 1918.34 cases per 100,000 inhabitants versus 1460 cases per 100,000 inhabitants in urban areas. The largest number of cases analyzed belonged to age groups 35-44 years and 45 to 54 years with 1726 and 1861 cases respectively. The age groups 55-65 and over 65 already represent the same number of cases with 1067 cases altogether. The 25-34 age group represents 1018 cases altogether. The smallest number of cases is noted for age groups 0 to 24 years.

Regarding the level of education, those who have declared a secondary education level have a very high prevalence of 68%, secondly those with higher education 22.3%. those with 8-9 years of education and primary education rate of the cases is small by 6.45% and 2.06%.

The highest proportion of cases with PSHM represent individuals who have declared income from 2004-400 thousand lek per month and 100-200 thousand lek per month with 34.29% and 30.8% respectively. Then rank them with 400-600 thousand lek per month with 20.7% and over 600 thousand lek per month with 10.2%. Individuals who have had a previous family history with mental health

problems appear with 35.42% of cases while those without family history with 64.58% of cases.

It is worth pointing out that this paper revealed a strong correlation for all the risk factors that we have taken in the study. Significant strong links were noted for gender, place of residence, age groups, educational level, monthly income, employment and familial heritage. For all these cases we have had significant links of $p < 0.05$ and CI 95%.

Conclusion

The prevalence of mental disorders in Albania is higher if we compared with other countries. This difference may be explained by population or/and genetic structure and environmental factors. Mental disorders were more frequent in this study with predominance of Schizophrenia. Those problems were more common in male, in patients that live in rural area and unemployed persons. Young people and active age people were also more likely to have mental disorders that indicating an early age of onset for mood, anxiety and alcohol disorders.

Reference

1. American Psychiatric Association. (2013). DSM-5 diagnostic classification. In: Diagnostic and Statistical Manual of Mental Disorders DSM-5. 5th ed. Arlington, Va.: http://www.psychiatryonline.org. 2015.
2. Census. (2011). *"Population and Housing Census Shkoder 2011". (PDF).*
3. Controf of Diagnostic Centre. (2011). Workshop on US data to evaluate changes in the prevalence of autism spectrum disorders. Atlanta, Georgia, U.S: Feb 1, 2011. Available from http://www.cdc.gov/NCBDDD/autism/documents/EvaluatingChanges_WorkshopSummary.pdf
4. Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, Kovess V, et al. (2004) Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. JAMA 291: 2581-2590.
5. Gostin L (2001). Beyond moral claims. A human rights approach to mental health. Special section: keeping human rights on the bioethics agenda. *Cambridge Quarterly of Healthcare Ethics*, 10:264–274.
6. J. Kruja; E. Beghi; D. Zerbi; D. Dobi; A. Kuqo; I. Zekja; S. Mijo; M. Kapisyzi; P. Messina. *High Prevalence of Major Neurological Disorders in Two Albanian Communities: Results of a Door-to-Door Survey*". Available from: March 2012. Neuroepidemiology 38(3):138-47. DOI: 10.1159/000336348
7. Obayi N. Okwudili K; Asogwa Festus; Ugwunna Nwachukwu. Universal Health Coverage and Healthy Living in South-east Nigeria: How Far with Mental Health? Open Journal of Psychiatry, 2017, 7, 199212. DOI: 10.4236/ojpsych.2017.73018.
8. Priebe Stefa, Bogic Marija, Ajdukovic Dean, Franciskovic Tanja et. al, 2010. Mental Disorders

Following War in the Balcans. A study in 5 Countries. ARCH GEN PSYCHIATRY. Vol 67 (No. %). 2010. American Medical Association.
9. Prince M, Patel V, Saxena S, et.al. No health without mental health. Lancet. (2007) Sep 8;370 (9590): 859-77.
10. WHO, 2001. The world health report 2001 - Mental Health: New Understanding, New Hope.
11. WHO. (2005). Promoting Mental Health: Concepts, Emerging evidence, Practice: A report of the World Health Organization, Departmentof Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: WHO.
12. WHO. (2014). Përllogaritjet Globale të Shëndetit (2014). Tabelat Përmbledhëse: DALY sipas shkakut, moshës dhe gjinisë, nga Rajoni i OBSH-së, 2000-2012.
13. World Health Organization (WHO). The ICD-10 Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization; 1992.
14. World Health Organization. Promoting mental health: concepts, emerging evidence, practice (Summary Report) Geneva: World Health Organization; 2004.