

Report on the

# **Regional workshop on health and human rights**

Cairo, Egypt  
21–23 September 2010

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## 1. INTRODUCTION

A regional workshop on health and human rights was held by the World Health Organization (WHO) Regional Office for the Eastern Mediterranean in Cairo, Egypt, on 21–23 September 2010. It was attended by international, regional and national experts in the field. The objectives of the workshop were to:

- introduce the concepts of health and human rights as stipulated by WHO's Constitution and the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD);
- establish a regional network for furthering the application of health and human rights treaties in the Eastern Mediterranean Region, including reporting on ratification and integration of human rights perspectives into national health policies;
- discuss mechanisms for increasing the implementation of the CRPD at regional level;
- identify needs at country level; and
- discuss how WHO can enhance capacities in the Member States of the Region.

The workshop was opened by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, who outlined the three key strategic areas for the workshop: the rights of persons with disabilities and mental health problems; new opportunities for the health sector in the health and human rights arena; and how to move forward to effectively position health as a human right at the regional level. He noted that, a little over sixty years ago, WHO's Constitution had asserted the enjoyment of the highest standard of health as a basic right of every human being. Since then, the Region had been working on advancing the right to health, and all health-related rights, enshrined in both regional and international conventions. However, the commitments have not been translated into action, particularly when addressing the right to health. This had resulted in limited achievement of the integration of health as a human right into national health policies and plans of action.

The Regional Office was holding this workshop to catalyse action and enhance understanding of this area of work at the national level as well as at the organizational level within WHO itself. He noted that WHO's work on health and human rights is following a twin tracked approach: 1) enhancing political commitment for action on the right to health; and 2) supporting Member States in fulfilling their commitments under international human rights treaties. He observed that countries of the Region were among the first to ratify human rights treaties protecting the right to health, starting with the International Covenant on Economic Social and Cultural Rights (ICESCR), through to the CRPD; the latest treaty related to health.

Dr Gezairy said that particular attention would be given within the workshop to reviewing mental health laws and policies in light of the provisions of the CRPD. He noted that eight countries in the Region had developed national mental health legislation, three within the past ten years, and that the workshop would provide a forum for sharing best practices to improve the quality of care provided to persons with mental health problems. The Regional Director expressed his hope that the workshop would be a significant step towards promoting observance of the human rights of persons with mental disorders through improved awareness and the participation of all concerned parties.

Dr Fatimah El Awa, Regional Adviser, Tobacco-Free Initiative and Regional Focal Point for Health and Human Rights, welcomed participants and observed that human rights as we know it today were a result of decades of struggle and deliberation. While the roots of human rights could be found in many different cultures, religions and traditions, the contemporary understanding of human rights developed out of the Magna Carta, the United States Declaration of Independence, the French revolutionary Declaration of the Rights of Man, the post World War II settlement, the fight against imperialism and the evolution of the strength and power of the nation state, she said. These all had led to the Universal Declaration of Human Rights (UDHR) in 1948 and the subsequent International Covenant on Civil and Political Rights (ICCPR) and the ICESCR, both in 1966. Together these formed the international bill of human rights.

Human rights were universal, interrelated and indivisible, she noted. Health was a human right and WHO's role was to support the mainstreaming of the right to health by supporting Member States to comply with right to health requirements in international treaties and conventions, and to pave the way for a better understanding of the right to health through partnerships, publications and other activities at regional and national level.

The workshop would address both health and human rights in general and the CRPD in particular, she explained. The expected outcomes of the workshop were therefore: the identification of ways forward for strengthening the nexus between health and human rights; the fostering of partnerships in order to prioritize health and human rights; the integration of health and human rights into health policies; the identification of areas where WHO could support countries; and the identification of resources to support health and human rights at national and regional levels.

Dr Khalid Saeed, Regional Adviser, Mental Health and Substance Abuse, welcomed the participants and noted that only eight countries in the Region had mental health legislation, and only three were passed in the last decade. This was coupled with a very limited purview of review bodies provided for in the existing legislation. Legislation and services were largely inadequate. In addition, only 28% of Member States in the Region had service user associations and 36% had family associations, he said.

However, the CRPD had now been in force for two years and several countries in the Region were keen to develop or update legislation, he noted. The workshop was therefore an opportunity to initiate the process of the review of mental health legislation in the light of the provisions made in international instruments, especially the CRPD, and to identify the gaps, and develop the strategies and mechanisms needed to bring legislation into conformity with international legislation. He outlined that the expected outcomes of the workshop would include the review of existing national mental health legislation and the initiation within 2010 of the process of amending it, including the drafting of legislation in Member States that did not have a separate mental health law.

The Chairpersons elected for the three working days were Dr Mariam Al Jalahma (Bahrain), Ms Basima Joudeh (Palestine) and Dr Nasser Loza (Egypt). The programme and list of participants are included as Annexes 1 and 2, respectively.

## 2. TECHNICAL PRESENTATIONS

### 2.1 WHO approach to health and human rights

*Dr Helena Nygren-Krug, WHO/HQ*

The WHO Constitution states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. In addition, the Vienna Declaration and Programme of Action (1993), from the World Conference on Human Rights, states:

All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.

WHO's human rights mandate resides in: nearly 50 World Health Assembly resolutions that mention human rights in relation to specific health challenges; in the 11th General Programme of Work for 2006–2015, which identifies promoting health-related human rights as one of the seven priority areas under the Global Health Agenda and states that in its relations with the UN, WHO will place particular emphasis on cross-cutting issues including human rights; and in Strategic Objective 7 of the Medium Term Strategic Plan for 2008–2013 to address the underlying social and economic determinates of health through policies and programmes that enhance human rights-based approaches.

In the World Summit Outcome, General Assembly Resolution 60/1, 2005, Member States called upon all parts of the United Nations to promote human rights and fundamental freedoms in accordance with their mandates, and resolved to integrate the promotion and protection of human rights into national policies and to support the further mainstreaming of human rights throughout the United Nations system.

The right to health relies on the availability, accessibility, acceptability and quality (AAAQ) of both health-care services and the underlying determinants of health (water, sanitation, food, nutrition, health occupational and environmental conditions, education, information, etc.). The principle of progressive realization of human rights entails an obligation to take steps using the maximum available resources with a view to progressively achieving the full realization of the rights; these should be deliberate, concrete and targeted steps. It is important to distinguish government incapacity from unwillingness. The use of indicators (structural, process and outcome) and benchmarks is also important.

The right to health can support ministries of health because human rights are a priority of government that are enshrined in international and national laws. Their monitoring mechanisms can enhance accountability. The obligation rests on government as a whole, including ministries of trade, finance and planning. The state also has an obligation to protect human rights, and must regulate

non-state actors. A human rights-based approach means that all programmes should further the realization of human rights, and that human rights standards and principles should guide all programming in all sectors. The outcome should be that the capacities of “duty-bearers” to meet their obligations and/or of “rights-holders” to claim their rights are developed.

### *Discussion*

It was noted that there is a need for guidance from WHO on health and human rights. The Organization has a mandate from its Member States to ensure the integration of human rights into its work. WHO’s role is primarily to support governments and to be a catalyst for action, acting as an “honest broker”. Many other actors have a role to play including the UN Special Rapporteur and nongovernmental organizations (local and international) working on the right to health.

A focus on the social determinants of health, such as access to food/nutrition and clean water, was felt to be needed. The need for multisectoral responses was also stressed. It was noted that gender-based discrimination in family law, forced and early marriages, and violence against women, all impact on women’s health, including maternal health. Maternal mortality is the Millennium Development Goal least progress has been made on. The issue goes beyond health to culturally-sensitive issues such as women’s status in societies.

The need to develop tools that can address these issues was identified, and it was noted that pilot projects are being carried out, such as in Yemen, looking at developing national health sector strategies that are consistent with human rights. WHO has human rights officers in some country offices, such as the occupied Palestinian territory. The issues are context dependent and vary from country to country depending on the needs and the actors; for example, in Uganda, a patients’ charter has been developed.

## **2.2 Health as a human right in human rights treaties: the implications for the EasternMediterranean Region**

*Dr Fatimah El-Awa, WHO/EMRO*

The legal and political sources of international human rights are the treaties, conventions, covenants and protocols that are legally binding on those states that are parties to the specific instrument. It also includes customary international law that is non-written and legally binding rules. Other sources include declarations, such as the Universal Declaration of Human Rights (UDHR), which are non-binding instruments, and non-legally binding policy documents, such as the Alma-Ata declaration of 1978 and the Cairo Declaration on Population and Development of 1994.

Other human rights instruments include: the Convention on the Elimination of all Forms of Racial Discrimination (CERD), 1966; the International Covenant on Civil and Political Rights (ICCPR), 1966; the ICESCR, 1966; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979; the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 1984; the Convention on the Rights of the Child (CRC), 1989; and the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICMW), 1990.

However, there are not only international instruments, but also Regional instruments, in particular the African Charter on Human and Peoples' Rights (1981) and the Arab Charter on Human Rights (2004). There is also national legislation such as mental health legislation and legislation protecting children, and rights that are enshrined in constitutions.

International human rights bodies also exist that include UN Charter-based bodies such as the Human Rights Council (HRC), and treaty-based bodies, such as the Human Rights Committee for the ICCPR and committees for the other UN Conventions. The HRC issues reports by the Special Rapporteur on country situations and thematic issues, has a complaints procedure, conducts studies and deals with complaints by civil society and by individuals.

The treaty-based bodies receive reports from the States Parties on their implementation of the specific convention and issue "recommendations" or "observations" in response. They also issue "general comments" or "recommendations" on the substantive interpretation on the convention's provisions. If a complaints mechanism exists they will issue "views" or "opinions" in response.

Health and human rights are enshrined in the WHO Constitution that came into force on 7 April 1948 and states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition, and that health is a state of complete physical, mental and social (*spiritual*) well-being and not merely the absence of disease or infirmity.

The ICESCR states, in Article 12, the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and stipulates in particular that steps should be taken for to achieve: the reduction of the stillbirth-rate and of infant mortality, and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and access for all to medical services and medical attention in the event of sickness.

Examples of other "health articles" are: CEDAW's Article 10(h) on access to specific health educational information, Article 12(1) on elimination of discrimination against women in health care and Article 14(b) on ensuring access to adequate health care facilities; CERD's Article 5 on the elimination of all forms of racial discrimination in the enjoyment of the right to public health and medical care; and CRC's Article 24(1) on the right of the child to the enjoyment of the highest attainable standard of health, including access to health care services.

The right to health is an inclusive right that contains freedoms and entitlements. Health services, goods and facilities must be provided to all without any discrimination, and all services, goods and facilities must be available, accessible, acceptable and of good quality. However, the right to health is not the same as the right to be healthy.

All human rights instruments agree that the role of the state includes "progressive realization", which entails taking steps to realize the right to health, as well as core minimum obligations, including the obligations to respect, to protect and to fulfil. Responsibility lies primarily with the state, but also with UN agencies and the private sector.

In the Eastern Mediterranean Region there is a need for a comprehensive vision of the right to health at national level and a need to address misconceptions such as the belief that human rights are part of a political agenda of Western supremacy or that human rights are only about preventing and addressing torture. There is a danger that the focus on political rights hinders a focus on social rights. In addition, there are limited human and financial capacities related to the right to health, and there is a need to clarify the role of civil society in relation to the state.

To progress it will be important to link the concept of health as a human right to the Region's heritage and traditions and to regional and national needs and priorities. It is also vital to involve official institutions and medical associations in activities, work with medical education institutions, and integrate health rights into the agenda of civil society. In addition, the reach of publications that explain health as a human right can be expanded by making them available in the different languages of the Region.

### **2.3 A human rights-based approach to health**

*Ms Mitra Motlagh, UNDP*

Human rights safeguard the most precious right: the right to be human. They safeguard both human dignity and human identity (individual and collective) and thus bring purpose and worth to existence. Human rights also provide a means of empowering people to make decisions about their own lives rather than being the passive objects of choices made on their behalf. A human rights-based approach to development programming addresses inequalities, supports sustainable development outcomes and is linked to state obligations. For the UN, it comes out of the UN programme of reform (1997), the 2005 World Summit and the Accra agenda for action (2008).

The human rights-based approach is a conceptual framework that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It aims to create the conditions under which people can live in dignity and peace and can develop their full potential. It tackles both development outputs and process. A human rights-based approach also ensures an increased focus on accountability, which in turn holds the key to improved effectiveness and transparency of action. The systematic application of human rights principles and standards to all programmes will lead to better analyzed and more focused strategic interventions.

The core components of the human rights-based approach are: human rights values (dignity and worth of the human person); human rights standards (core UN human rights conventions, regional instruments, constitutions etc.); and human rights principles, which are key in influencing attitudes and actions, and should guide us in developing strategies and designing programmes to achieve stated goals. A human rights-based approach situation analysis looks at what is happening, where and who is most affected, why the problems are occurring, who has the obligation to do something about them and what capacities are needed to take action.

The UN Common Understanding on the human rights-based approach is that all programmes of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the UDHR and other international human rights instruments. Human rights standards contained in, and principles derived from, the UDHR and other international human

rights instruments, should guide all development cooperation and programming in all sectors and all phases of the programming process and development cooperation. Programmes of development cooperation should contribute to the development of the capacities of duty-bearers to meet their obligations and of rights-holders to claim their rights.

### *Discussion*

A human rights-based approach to health was seen as an opportunity to bring different actors from different sectors together and to advance the health agenda in other sectors. The Universal Periodic Review (UPR) was seen, in particular, as a good opportunity for WHO to work with Member States on the right to health and for ministries of health to reposition themselves as a priority within governments and to bring different sectors together around the right to health. The UPR is a new process in which every Member State is reviewed every four years on its human rights record, under the auspices of the Human Rights Council. It is a peer review by other Member States with high media attention and is therefore being taken very seriously at a high level.

The challenge of ensuring the right to health in practice was discussed. While Conventions may be ratified, not all Protocols are and implementation does not always occur. Implementation is hindered by many obstacles, including financial constraints, bureaucratic rules, restrictions on nongovernmental organizations, conflicts, the low priority placed on health in government agendas, and a lack of awareness amongst the population and health staff.

The need for advocacy and monitoring tools was expressed. Some tools are available online at the WHO's website, including checklists, but it was noted that WHO does not have its own health and human rights monitoring mechanism, although there is a monitoring tool for human rights in mental health. There are UN commissions related to human rights conventions, such as CEDAW, that monitor government performance through periodic reporting. They cannot sanction but engage in constructive dialogue. Civil society can also provide "shadow reports" on government progress. There are two regional monitoring bodies linked to the African and Arab Charters on human rights, but the peer review process of the UPR was seen as the most effective tool. It was noted that health is a platform around which everyone can converge and should be seen as an opportunity to start a discussion with new partners, including national human rights commissions.

The difference between the right to health, which is the responsibility of governments, and the right to be healthy, which is the responsibility of the individual, was discussed. It was observed that it was an obligation of governments to create an enabling environment for individuals to be healthy. Concerns were expressed over the role of the private sector in health care provision and WHO is working with countries in this area.

The need for WHO to work with Member States on patients' rights and to raise awareness about them among the population was noted. Patients' charters and complaints mechanisms are tools that can help patients exercise their rights and ministries of health to improve their services. However, WHO's role is to provide technical advice and support to governments, and to use "quiet diplomacy" rather than public criticism, which could jeopardize relations. It was felt that there are different roles to be played by the different actors involved.

The challenge of addressing the perception that human rights are a “Western” concept, sometimes seen to be in opposition to Islam, was discussed. It was felt important to link human rights to the Region’s heritage. It was pointed out that human rights include the right to culture and the protection of cultural diversity, including the cultures of indigenous peoples. However, the need for translation and cultural adaptation of tools and strategies was acknowledged. Country training can be provided by WHO, as has happened in Bahrain and Yemen, for example.

#### **2.4 UN Convention on the Rights of Persons with Disabilities**

*Dr Soumitra Pathere, WHO Temporary Adviser*

The CRPD does not contain new rights, it re-emphasizes existing rights. It was needed because there are 650 million people with disabilities worldwide, 80% living in developing countries, and the existing human rights law and mechanisms were inadequate. It signals a paradigm shift in the treatment of people with disabilities, from being objects of charity to holders of rights, and has an inclusive social definition of persons with disabilities that includes ‘those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’ (Article 1).

The CRPD was adopted by the UN General Assembly on 13 December 2006, and came into force after on 3 May 2008. As of September 2010, there have been 146 signatories and 91 ratifications to the Convention, and 89 signatories and 51 ratifications to the Optional Protocol. The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity (Article 1). The principles it enshrines (in Article 3) are: respect for dignity and autonomy; non-discrimination; full and effective participation and inclusion in society; equality of opportunity; accessibility; equality between men and women; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; and respect for the evolving capacities of children with disabilities and for their right to preserve their identities. The last two aspects are innovative and differentiate the CRPD from other UN Conventions. The CRPD contains two types of obligation on States Parties: those of conduct (immediately binding, such as non-discrimination) and of result (through “progressive realisation”).

Monitoring implementation of the CRPD at the international level is done by the Conference of States Parties and the Committee on the Rights of Persons with Disabilities. Innovative features of the Convention include national monitoring mechanisms (government focal points and independent monitoring bodies) and the participation by persons with disabilities in monitoring. The Optional Protocol includes a mechanism of complaint to the Committee for individual cases and the ability for the Committee to conduct inquiries.

Another unusual feature of the Convention is its stipulation that international development programmes should be inclusive of, and accessible to, persons with disabilities. The focus should be on mainstreaming disability into all development activities, including through disability-specific measures to accelerate or achieve *de facto* equality. In the view of the UN Commission for Social Development, the Millennium Development Goals will not be achieved if persons with disabilities are not included.

## **2.5 Provisions of the UN Convention on the Rights of Persons with Disabilities: implications for mental health services**

*Dr Khalid Saeed, WHO/EMRO*

The CRPD brings together existing rights making it easier to focus. The key rights within the international human rights system that are relevant to people with mental disabilities are: the freedom from discrimination; the freedom from inhuman and degrading treatment; the right to liberty and security of person; and the right to the enjoyment of the highest attainable standard of physical and mental health. The latter right involves having full access to appropriate and professional services which are economically affordable, culturally and socially acceptable, and provided in the least restrictive environment. The CRPD also requires that State Parties provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons. The inclusion of this provision is very important since it mandates the creation of mental health services, where these are deficient.

A fundamental human right is the protection against discrimination. The concept of non-discrimination is closely linked with the concept of equality. Freedom from discrimination is a right that is effective immediately and not subject to progressive realisation. The protection against discrimination is, first and foremost, a promise that all people, including people with mental disabilities will enjoy the same legal rights as all other individuals without discrimination. This includes “positive rights” for example to access health services without discrimination. It also includes a “negative right” i.e. protection against discrimination in the right to marriage and to found a family, forced sterilization and exclusion from employment, etc.

Respect for autonomy is a general principle of the CRPD. Article 26 of the CRPD obligates State Parties to take measures to enable persons with disabilities to attain and maintain their maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. Habilitation and rehabilitation services must begin at the earliest possible stage, be voluntary, and be available to persons with disabilities as close as possible to their own communities, including in rural areas. This principle is profoundly important: throughout the world, people are placed in custodial facilities which essentially give up on the hope that a person has any potential to develop his or her skills or return to the community. By recognizing the right of every person to treatment that preserves or enhances skills and develops maximum potential, the CRPD raises expectations to a level that cannot be met by custodial care alone.

The CRPD emphasizes the right to community-based services and the systems necessary to promote and maintain this right. Article 19 recognizes the right of all persons with disabilities to live in the community, requires State Parties to facilitate disabled individuals’ full inclusion and participation in the community, and recognizes the right of all disabled individuals to chose their place of residence and to have access to ‘in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community’. Community services and facilities for the general population must be available on an equal basis to persons with disabilities. Very often admission to psychiatric institutions is necessitated not so much by the clinical condition of the patient but by the absence of any other alternative. Once in the institution, the lack of community

alternatives serves to retain patients in the institution long after their psychiatric condition has stabilized and they could function in the community if adequate services and supports were available. The principle of the least restrictive environment requires governments to create alternatives in the community.

The CRPD, in Article 12, stipulates that all persons are equal before and under the law, and that persons with disabilities have the right to recognition as legal persons and enjoy legal capacity on an equal basis with others in all aspects of life. The CRPD has brought about a paradigm shift away from the assumption that people with mental disabilities are incapable of making decisions into the presumption that they are capable – a response to guardianship laws and provisions that strip people of their right to make decisions and choices about their lives and strips them of many rights such as right to vote, to manage property, treatment decisions, the right to marry and found a family and so on. This can be seen as an affirmation of support for supported decision-making, rather than substitute decision-making.

In Article 14 of the CRPD it states that ‘the existence of a disability shall in no case justify a deprivation of liberty’. This can be understood to mean that the existence of a mental disability on its own will never provide adequate grounds for detention. Article 15.1 of the CRPD states that ‘no one shall be subjected without his or her free consent to medical or scientific experimentation’. This provision is of great significance to people with mental disabilities since it would require that a clinical determination must be made by a qualified professional that the patient is competent to consent and does in fact provide consent based on a full disclosure of the risks and benefits before a patient is enrolled in a scientific study.

Many people with mental disabilities are treated against their will, as issues concerning consent for treatment are ignored, and independent assessments of incapacity to consent are not always undertaken. Current controversy exists regarding the CRPD’s protection against involuntary treatment in relation to legal capacity and informed consent – does forced psychiatric treatment violate the prohibition against torture? In reality, forced psychiatric treatment and involuntary admissions are occurring and will continue to occur, and this needs to be addressed. In many countries, the use of compulsory treatment is authorized where mental illness is considered to have rendered a person at risk to themselves or others. Do governments have a duty to protect citizens from themselves or the larger community? It is hoped that the CRPD monitoring committee will provide guidance and clarification on this area in the near future.

The seclusion and restraint of people in psychiatric facilities are practices that cause degradation and suffering. In addition to the protection offered by the prohibition against torture, Article 16 of the CRPD requires State Parties to take measures to protect disabled people from ‘all forms of exploitation, violence and abuse’ which may occur within or outside of the home. Article 17 of the CRPD ensures that every ‘person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others’.

One of the most pervasive violations of human rights in institutional facilities is the violation of the right to privacy. People may live for years in dormitory-like wards where they may have no secure place in which to place their personal possessions or their clothing. Meetings with friends,

family, or even a spouse may be restricted. CRPD Article 22 provides strong protection for the right to privacy of people with mental disabilities, stating that ‘[n]o person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation’. The Article further states that persons with disabilities have the right to the protection of the law against such interferences. State Parties have the positive obligation to protect the privacy of personal, health and rehabilitation information of persons with disabilities. The right to privacy is also protected as a right in and of itself under Article 12 of the UDHR and Article 17 of the ICCPR. Furthermore, CRPD provides for equalization of opportunities for persons with mental disabilities to exercise their civil rights at par with rest of the population.

### *Discussion*

The definition of disability was discussed. It was noted that nongovernmental organizations representing persons with disabilities were involved in the drafting of the CRPD. The definition of disability it employs recognizes the social aspects of disability and is an inclusive one, however there is need for guidance on whether it encompasses short-term acute and often self-limiting mental disorders. While the social concept of disability it uses can be difficult for some medical professionals to accept, inclusive definitions of health and disability, such as that contained in the International Classification of Functioning, Disability and Health (ICF), already view health as a state of well-being and embrace the social aspects of disability.

The issue of ensuring implementation of the CRPD was also discussed. Different Member States have made different ministries responsible for its implementation, but there is scope for having more than one focal point and for developing a multisectoral approach. Apart from five-year reporting by countries, there is no monitoring mechanism contained in the Convention. It was noted that there is a need for guidance on monitoring and implementation strategies. It was also observed that there are no sanctions for non-compliance; these are for Member States who have signed/ratified the Convention to decide upon for themselves.

## **2.6 Linkages between health and human rights, the social determinants of health and community-based initiatives**

*Dr Mohammed Assai, WHO/EMRO*

Health is a fundamental human right that must be recognized as central to the broader development and poverty reduction agenda. Health is also a multisectoral issue: the poor need a package of services, including those related to access to water and sanitation, food and nutrition, housing, work and security, roads, literacy and information. There are three key actors in health: the community; health providers; and other sectors (e.g. local government, parliaments, the media, and ministries of transport, education and agriculture). All actions should be people-oriented and responsive to the needs of the poor.

Since 1978, countries have improved many health indicators but disparities still exist between rural and urban areas, poor and rich, men and women, marginalized and advantaged groups of the community. Services do not reach the poor and there is a lack of community participation in

promoting health. Barriers that prevent the access of the poor to services include: geographical barriers; financial barriers (including lack of insurance systems); socio-cultural attitudes, such as those related to gender or ethnicity; illiteracy, and lack of knowledge and awareness; and the poor quality and lack of responsiveness of health systems.

Within the countries of the Eastern Mediterranean Region inequities in health outcomes exist between income groups and between richer and poorer countries. For instance, studies of a poor community in Cairo, internally displaced people (IDPs) in Khartoum and health inequity in Rawalpindi, found populations that had limited access to basic services, clean water, sanitation, health facilities and schools and suffered from low incomes (absolute poverty), poor accommodation and high rates of illiteracy and unemployment. As a result these communities suffer from a higher prevalence of health problems, such as diarrhoea and malnutrition.

Strategies to reduce health inequity include prioritizing underserved areas, and poor and disadvantaged groups, investing in primary health care and redistributing health services and personnel equitably. Reducing the out-of-pocket costs of seeking health care for the poor, improving information and communication to stimulate health service demand, and improving the responsiveness of health systems are also important. Undertaking health equity-focused research and collecting disaggregated data by socioeconomic position, sex, age, ethnicity/race, geographical location or other relevant indicators of social exclusion, is also needed, as is finding community-based solutions.

The community-based initiatives (CBI) programme is a research-based response that tackles the social determinants of health and health inequity through community organization and participation. The six key practices it employs to achieve better health outcomes are: community organization; community needs assessment; community-based capacity building and planning; community-based management and ownership; community-resource mobilization and partnership; and institutionalization. Community involvement ensures the sustainability of initiatives, while government ownership results in increased coverage through the expansion of models nationally. The key issue is involving the community. The approach has worked in countries with different income levels, including Egypt, the Islamic Republic of Iran and Somalia, leading to improved health indicators, such as higher measles immunization rates and greater access to safe drinking water, and supporting progress on the Millennium Development Goals.

### *Discussion*

The obstacles to implementing the CBI approach were discussed. These include limited health budgets and vertical health systems. Multisectoral strategies, health needs assessment surveys and involving civil society, were all seen as important in promoting CBI. The interconnection of different but complimentary programmes addressing human rights and health, the social determinants of health and CBI, was observed and it was felt that there is a need to view them as a whole. The need to address cultural barriers to community involvement, such as the exclusion of women, and to build on the Region's high levels of social capital, was also noted.

Political support was viewed as being essential for the success of community-based approaches, as has been seen in countries such as Jordan, the Islamic Republic of Iran and Morocco. Politicians and policy-makers must be engaged through advocacy and evidence-building. A regional workshop for parliamentarians was suggested. It was felt that CBI needs to link in to national programmes and that health managers need to be familiarized with community-involvement. Intersectoral collaboration is essential and can often happen more easily at local rather than ministry level. It was noted that the sustainability of community-based initiatives depends on community ownership. The need to document and share experiences was also observed, building on the two publications on success stories in CBI in the Region that have been produced by WHO.

## **2.7 The role of nongovernmental organizations in promoting the right to health**

*Dr Amani Massoud, Egyptian Initiative for Personal Rights*

The Egyptian Initiative for Personal Rights (EIPR) is an independent, non-profit, human rights organization that was established in 2002 to promote and defend the personal rights and freedoms of individuals. EIPR was established to complement the work of Egyptian human rights groups by adopting as its mandate, and focus of concern, a group of rights and freedoms that are closest to the human-being: his/her body, privacy and home. These rights are often ignored or overlooked. The organization uses research, advocacy and strategic litigation to defend the rights to privacy, health, freedom of religion and belief, and bodily integrity.

Nongovernmental organizations are those that exist outside the public governmental and private market sectors, within what is referred to as the third, voluntary, or non-profit sector. Article 71 of the UN Charter states that the Economic and Social Council must make suitable arrangements for consultations with nongovernmental organizations concerned with matters within its competence. Nongovernmental organizations have been involved in all areas of human rights and their strategies include the empowerment and mobilization of members of society, information and knowledge production, advocacy, campaigning and lobbying, health litigation and human rights education. They provide citizens with a sense of solidarity and empowerment. By gathering and associating, citizens are mobilized to participate and be active.

Gathering information includes activities such as monitoring States that have agreed to be bound by the terms of international treaties through shadow reports on government actions. Research is another activity, including the desegregation and human rights analysis of data to highlight inequities and gaps (e.g. in health expenditure or access medicines), impact assessments and budget allocation monitoring. Epidemiological tools are also used to explore the underlying causes of ill health. This information is then provided to governments, civil society, international organizations, politicians and the media.

The documentation of human rights violations, for instance by Physicians for Human Rights, often using individual testimonies that put a face to the victims, gives publicity to violations of international norms. Advocacy, campaigning and lobbying to bring about a policy change or legal reform is another important role for nongovernmental organizations, such as campaigns to ban landmines or to reform mental health legislation in Egypt that led, in 2009, to a new law upholding and promoting the rights of persons with mental illnesses and mental disabilities reflecting human

rights principles. Human rights education of health professionals to create a human rights culture in the health sector, such as through publications on the right to health, is another strategy employed.

Health litigation is a strategy to advance the right to health by holding governments accountable to human rights norms in areas such as access to health services and medication, discriminatory labour practices, public health policies and the basic determinants of health (food, water, shelter, a healthy environment, etc.). In Egypt, in September 2008, a favourable court decision obtained by a number of human rights defenders, including EIPR, halted government efforts to establish a health care holding company and transfer all Health Insurance Organization hospitals and facilities into affiliate entities of a new for-profit company. Also, a new drug-pricing policy, which tied drug prices in Egypt with global prices, was suspended by a lawsuit which EIPR filed in 2009, with the court citing the Constitution and Egypt's obligations under international law.

Challenges for nongovernmental organizations include the competition for scarce resources, difficulties in working with the media and difficulties in measuring the impact of their work. In addition, there exists a lack of accountability and a "right to health" culture in many countries, and human rights and nongovernmental organizations may sometimes have negative connotations. However, ways forward include enhancing the recognition of health as a fundamental human right, identifying good practices for the operationalization of the right to health at national and international levels, multisectoral collaboration and enhancing the role of the medical community in promoting the right to health.

### *Discussion*

The need for more nongovernmental organizations to work on the right to health was noted, particularly in areas that WHO cannot work in, such as individual cases and monitoring of government actions. Partnerships between nongovernmental organizations were seen as being important at both local and international levels; to this end, a regional consultation was felt to be needed. The importance of building visibility and credibility was also stressed. It was also felt to be essential to increase awareness of human rights among populations through human rights education and the media, including the new social media.

## **2.8 Institutional practices for health and human rights historically**

*Dr Haytham Al Khayat, WHO/EMRO*

The right to life, from the Islamic perspective, is the second most important human right, after the right to freedom. However, the right to life is not assured unless people are able to enjoy good health and live in a healthy environment. Human rights in Islam are both a privilege and an obligation. To relinquish one's rights is to relinquish a part of one's humanity.

The body has rights in Islam. These predate the international declaration of human rights by fourteen centuries. Indeed, the rights of the body have still not yet been fully acknowledged. We must feed it when it is hungry, rest it when it is tired, clean it when it gets dirty, protect it against harm and illness, treat it when it has disease and not overburden it. Health is a right that must never

be overlooked or neglected in preference to other rights. Health is an essential requirement for life and is therefore necessary for the fulfilment of God's commandments.

The right to health, from an Islamic standpoint, involves great responsibility both to our bodies and to society and our world. It places duties on us towards each other, such as those between parents and children (to ensure adequate nutrition and health care, such as vaccinations), husbands and wives and within families. We must also ensure a balanced and healthy environment. This includes keeping it clean, safeguarding it and ensuring environmental resources are not depleted or exhausted. It also includes the promotion of agriculture, protection of trees and kindness to animals. Society has a responsibility for health protection, including the prevention of harm to oneself and others.

Human rights are broad from the standpoint of Islam and we have a responsibility to defend these rights in relation to ourselves and others, society and the environment. This is not a new approach but is deeply rooted in Muslim tradition and culture. We must return to these precepts for the uplift of humanity as a whole.

### *Discussion*

The need to combat the notion that human rights are a Western concept was discussed. Locating human rights within the religious traditions of the Region was viewed as important in this, as was raising the awareness of the population and engaging religious and civil leaders. Religious leaders could become partners and their support mobilized for health as a human right, as had been done successfully when developing the new mental health law in Egypt and the new family law in Morocco. Integrating human rights into the educational curriculum, and using the media and Friday sermons, were all mentioned as key strategies for increasing awareness and support for health and human rights in the Region. It was suggested that the promotion of a progressive approach to religious thinking on health and human rights could be assisted by WHO-supported regional meetings of religious leaders. The publication and dissemination of materials addressing the issues, including the Regional Office's *Health education through religion* series, was also mentioned as being important.

## **3. COUNTRY PRESENTATIONS**

### **3.1 Health as a fundamental human right: the Iraqi example**

*Dr Khalid Awad Khalifa, Ministry of Health, Iraq*

Iraq is one of the few countries in the Region which has a dedicated ministry for human rights and another for women's affairs. A national independent commission on human rights is currently being established. Articles 30 and 31 of the Iraqi Constitution, clearly state the right to health for all Iraqis.

Article 30 states that the State shall guarantee to the individual and the family, especially children and women, social and health security, the basic requirements for living a free and decent life, and a suitable income and appropriate housing. It also stipulates that the State shall guarantee

social and health security to Iraqis in cases of old age, sickness, disability, homelessness, orphanhood or unemployment, shall work to protect them from ignorance, fear and poverty, and shall provide them with housing and special programmes of care and rehabilitation, and that this shall be regulated by law.

Article 31 states that every citizen has the right to health care and that the State shall maintain public health and provide the means of prevention and treatment by building different types of hospitals and health institutions. It also states that individuals and entities have the right to build hospitals, clinics, or private health care centres under the supervision of the State, and that this shall be regulated by law.

Iraq has ratified a number of international human rights treaties, including the ICESCR and ICCPR, and acceded to the ICERD, CEDAW and the CRC, and is also party to the Arab Charter on Human Rights. Iraq is one of the few countries to provide free health care. All health policies and strategic plans are based on human rights with a focus on the most vulnerable populations. Special projects and programmes exist for displaced populations, prisoners and victims of violence.

Iraq's first mental health act was established in 2005, defining the mechanism to enable people with mental health disabilities to live in the community without discrimination. Currently, the Ministry of Health is working to revise the act so that people with mental health disabilities have the right to enjoy the highest standard of physical and mental health, live independently and be included in the community with an adequate standard of living and social protection, and be free from torture, degrading treatment, violence and abuse. Other initiatives include one for controlling mental health disability and the integration of mental health within primary health care.

However, ensuring the right to health in Iraq faces many challenges, including military occupation, conflict, lack of security, massive internal and external population displacement, rapid turnover and shortages of medical staff, and power supply shortages. These are accompanied by a process of decentralization taking place, poor communication within the levels of the health system, poor monitoring and supervision, and poor community participation. Support from WHO and UN agencies is therefore required to build capacity in human rights and health policy, planning and programmes.

### **3.2 The right to health in the occupied Palestinian territory**

*Mr Patrick Zoll, WHO West Bank and Gaza*

Key barriers to the realization of the right to health in the occupied Palestinian territory include the lack of territorial continuity that exists between Gaza and the West Bank, the Israeli blockade of Gaza since June 2007, the roadblocks and checkpoints that exist throughout the West Bank, and the West Bank Barrier. The latter is 707 km long, with 85% inside the West Bank; 7800 Palestinians live between the Barrier and the Green line. The Barrier also cuts off East Jerusalem from the West Bank, which is a major problem because of the importance of Jerusalem as the heart of the West Bank's health system. The city contains key specialist hospitals providing treatment and care not available elsewhere. This results in restricted access for patients, emergency services and medical students of the Al Quds Medical School. For example, West Bank patients requiring

treatment in Jerusalem require permits that can be hard to obtain and are often for shorter periods than required. Passing through the crowded checkpoints takes several hours and is on foot, while transfer between ambulances is required as West Bank ambulances are forbidden access to the city; this occurs without privacy in open air parking lots. In addition, some medical students have not had their permits renewed during their studies, preventing completion. The restricted access of medical students to the city's training institutions will have a negative impact on the quality of health care in the occupied Palestinian territory in the long term.

The WHO Constitution and the ICESCR recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The four main elements of the right to health have been defined as availability, accessibility, acceptability and quality. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. This has four overlapping dimensions: non-discrimination, physical access, economic access (affordability) and access to information. Israel is a Member of the WHO and a State Party to the ICESCR which applies to the occupied Palestinian territory. In addition, international humanitarian law, such as the Geneva Convention, which requires protection for health workers and facilities, is applicable in situations of occupation.

Advocacy by the WHO on the right to health in the occupied Palestinian territory includes behind the scenes negotiations (to secure access for medical staff and patients), briefings for the diplomatic community, input to UN mechanisms and delegations, research and data collection, public reports and media relations. A right to health framework is consistently used in these activities. For example, "access to health portraits" focusing on individual cases and a report on the Barrier and health have been produced. However, more data, a greater focus on the social determinants of health and the development of rights-based programming are still needed.

### **3.3 Yemen**

*Dr Mohammed Al-Khulaidi*

Yemen has signed many conventions on human rights and is currently developing and harmonizing its national laws to be in compliance with them. This includes Law 47/2008 concerning persons with disabilities and the ratification of the CRPD and its Protocol. It is trying to increase the awareness of the population regarding human rights. This has included the integration of human rights concepts into the educational curriculum.

The right to health can be impacted in many ways, whether through human rights abuses, discrimination in access to services, the lack of capacity of health care providers or by lack of access to the social determinants of health (water, etc.). It is important to monitor such issues. The government is trying to address the challenges created by the very high increase in population in Yemen and the unequal distribution of resources, but more remains to be done. Health services need to be expanded. However, there have been some successes such as a decrease in infant and maternal mortality rates.

*Discussion*

It was felt that advocacy documents need better dissemination to ensure higher visibility of the health and human rights issues, including beyond the health sector. WHO can play a role in ensuring this and Member States can be mobilized to raise issues, such as the situation in the occupied Palestinian territory, in international forums. Nongovernmental organizations were also seen as having an important role to play, including taking up individual cases. Activating Israeli and international nongovernmental organizations, such as Physicians for Human Rights, was also noted as important. Other challenges in the Region were identified, including the need to address hierarchical cultural attitudes, to develop school curricula to incorporate health and human rights, to encourage community participation and for governments to become more transparent.

**4. GROUP WORK**

Participants were divided into six working groups. Three groups were asked on day 1 to identify gaps in mainstreaming health and human rights at the national level, including gaps in information, statutory/regulatory gaps, implementation capacity and resource gaps, and the partnerships necessary to bridge these gaps. On day 2, the groups were asked to repeat the task in order to identify the gaps at the regional level.

The other three groups were asked on day 1 to identify gaps in implementing the CRPD within a mental health framework at the national level, including information, statutory/regulatory, implementation capacity, resource and partnership gaps. On day 2, these groups were asked to repeat the task to identify gaps at the regional level.

On day 3, participants were gathered into country-groups and asked to review the identified gaps and formulate action plans (the “way forward”) at the national level for mainstreaming health and human rights, implementing the CRPD within a mental health framework and strengthening partnerships towards integrating health and human rights.

Gaps in mainstreaming health and human rights at the national level include a need for more and better information and greater transparency regarding the current situation; needs assessments and mapping exercises are required. It was acknowledged that different situations exist in the different countries. There is a need for some Member States to ratify some human rights conventions and to harmonize national legislation with the various conventions. The weak implementation of legislation was also noted. There is a lack of financial resources and trained human resources in many countries, and unequal service coverage and resource allocation within countries, especially in rural areas. Guidelines and protocols for implementation are also lacking. There needs to be greater coordination and collaboration between stakeholders, and a greater involvement of civil society. Furthermore, few independent monitoring bodies exist.

Some contextual factors were identified. There is low awareness in countries of health and human rights, including of the various declarations and conventions, and of the relationship between health and human rights. There is also a denial of problems and a lack of political will to address them. In part this reflects the low priority given to health, and inadequate human resources capacity

and financial allocations. The lack of stability in many countries due to conflict, insecurity and political changes, further contributes to this. However, the perceived conflict between local cultures and human rights is another factor, as are the transfer of inappropriate models from developed countries and a limited conception of the role of health in development. Potential partners include ministries of health, finance, education, the interior, social welfare, justice and human rights, and civil society, religious leaders, trade unions, the private sector, government human rights organizations and international agencies.

Gaps in implementing the CRPD within a mental health framework at the national level include the CRPD not being signed in some countries and not ratified in others. In addition, national mental health legislation is lacking or needs updating in some countries, and is not in full compliance with the Convention. Gaps in legislation include a failure to protect the autonomy of patients and to protect against discrimination.

A lack of responsible bodies for the implementation and monitoring of the CRPD and mental health legislation was noted. There is also a lack of financial resources and trained human resources for mental health in many countries. The lack of adequate information systems and service infrastructure, including community support services, and the insufficient quality of services where they do exist, were other identified gaps. The resistance of health professionals to empowering patients was another concern. A lack of awareness of the CRPD among decision-makers, health care providers, service users, communities and families was also identified. Policy-makers sometimes lack commitment, and are more concerned with other priorities. Furthermore, there is a lack of monitoring and evaluation mechanisms. Potential partners include ministries of health, finance, education, the interior, social welfare, justice and human rights, and international agencies, nongovernmental organizations and religious leaders. However, there is a lack of coordination and unclear roles and responsibilities.

Gaps identified at the regional level included the need for a comprehensive country profile and situation analysis/needs assessment for health and human rights and the creation of a regional database. Technical support is required for national surveys and improving national registries, and for the development of a strategic plan on health and human rights. The establishment of regional/subregional networks for health and human rights, and the establishment of a high-level committee on integrating human rights into the health agenda, are also needed. Regarding the CRPD, the provision of technical support for the drafting of mental health acts consistent with the Convention and an advocacy campaign for CRPD ratification and implementation were identified.

Advocacy workshops for decision-makers on health and human rights and an advocacy campaign using mass media and information, education and communication (IEC) materials to raise awareness and change attitudes on health and human rights are also needed. Regional capacity-building is required in health and human rights through both short and long-term training, including for decision-makers and health managers, as well as training for health and human rights focal points. In addition, there is a need for the development of a monitoring and evaluation framework to follow-up on the integration of health and human rights and CRPD implementation, and the activation of a regional health and human rights monitoring body. Finally, a regional conference for health and human rights stakeholders is needed.

Ways forward identified for individual countries included: the revision of mental health and other legislation in line with the CRPD and other international conventions regarding health and human rights; the development of national strategies for health and human rights and CRPD/mental health legislation implementation; the designation of focal points for health and human rights and for persons with disabilities/mental health; the conduct of situation analyses and the development of information systems and databases for physical/mental disabilities and health and human rights; training and capacity-building on health and human rights/disabilities for policy-makers, health care providers, medical students and civil society; coordination with civil society and different ministries; awareness-raising and advocacy campaigns on health and human rights and the CRPD among policy-makers, service providers, service users, civil society and the general population; the development of national networking on health and human rights and mental health for service providers, service users and their families; and the establishment of national bodies to review and monitor the right to health.

## **5. RECOMMENDATIONS**

Over sixty years ago, the WHO's Constitution asserted the enjoyment of the highest attainable standard of health as a fundamental right of every human being. Since then, the Organization has been working towards this goal through strategies based on the best available evidence. The challenges of globalization have reinforced the need to ensure that health remains central to the development and poverty reduction agendas at the national and international levels. Identifying health as a human right can serve as an entry point for placing health as a priority on these agendas.

Every country in the Eastern Mediterranean Region is now party to at least one human rights treaty that recognizes the right to health. This commitment can help to reposition health higher on the political agendas of Member States.

The right to health is negatively impacted in situations of conflict and complex emergency including in countries such as Afghanistan, Iraq and the occupied Palestinian territory. These circumstances render the population as whole, and groups such as women, children, and persons with physical and mental disabilities, in particular, vulnerable to human right's abuses.

The CRPD is recognized as providing explicit provision for ensuring that the rights of persons with physical and mental disabilities are protected, even during situations of conflict and complex emergency. This entails recognition of the need for cooperation and dialogue between states on how to tackle health and humans rights issues.

The rich traditions of the Region, the cradle of the three great monotheistic religions, are recognized as providing the bedrock for the principles that are enshrined in current human rights treaties.

In light of the above, the workshop recommended that the following steps and strategies should be undertaken to strengthen the right to health at national and regional levels. These will contribute to ensuring that every person in the Region can enjoy the highest attainable standard of

health in accordance to Constitution of the WHO and the right to health as stipulated in the international treaties that are binding on the Member States in the Region.

*Recommendations for Member States*

1. The health sector should provide the leadership in advocacy for the mainstreaming of the right to health. However, a multisectoral approach based on the principles of equity, inclusion, participation and affirmative action is needed in order to ensure the realization of this aim.
2. Advocacy and awareness-raising activities on the rights of persons with physical and mental disabilities should be undertaken as an important step towards achieving national development goals and the Millennium Development Goals. Public support for this should be generated through the participation of national human rights institutions, community and civil society.
3. Comprehensive national public health legislation, with a special focus on vulnerable groups such as women, children, refugees/internally displaced people, and persons with physical and mental disabilities, should be developed and supported with well-formulated compliance and enforcement mechanisms.
4. Standing forums for health and human rights at the regional level should be established to ensure political and community support for health and human rights.
5. Governments should provide leadership in areas such as appropriate regulations and interventions for the accessibility, availability, acceptability and quality of services, to ensure that the right to health is not jeopardized under any circumstances including during situations of conflict and complex emergency.
6. Collaboration, partnership and coordination should take place between governments, civil society and other stakeholders to ensure coordinated and integrated action on the right to health.
7. Professional, consumer and family associations should be supported to play a role in advocacy for patients' rights and changes in social practices that impact on the right to health.
8. Particular attention should be given to national commitments and obligations under international treaties when designing health legislation and policies. In particular, mental health and disability legislation and policies should be consistent with the provisions of the CRPD.
9. Mechanisms to ensure transparency and accountability should be put in place to help build trust and ensure that the right to health is enshrined and provided for in all development and health policies of Member States.
10. A rights-based approach, consistent with the principles of non-discrimination and the inherent dignity of human beings, should be at the core of all national and international policies and decisions. This is essential for ensuring the inclusiveness, effectiveness and sustainability of policies and programmes.

*Recommendations for the WHO Regional Office for the Eastern Mediterranean*

11. A comprehensive country profile and situation analysis/needs assessment should be undertaken for health and human rights and a regional database created.
12. Technical support should be provided for national surveys and improving national registries.

13. Technical support should be provided for the development of a strategic plan on health and human rights.
14. Regional/subregional networks for health and human rights should be established.
15. A high-level committee on integrating human rights into the health agenda should be established.
16. Technical support should be provided for the drafting of mental health acts consistent with the CRPD.
17. An advocacy campaign for CRPD ratification and implementation should be undertaken.
18. Advocacy workshops should be provided for decision-makers on health and human rights.
19. An advocacy campaign should be undertaken using mass media and IEC materials to raise awareness and change attitudes on health and human rights.
20. Regional capacity in health and human rights should be built through both short and long-term training, including for decision-makers and health managers.
21. Training of trainers should be provided for health and human rights focal points.
22. A monitoring and evaluation framework should be developed to follow-up on the integration of health and human rights and CRPD implementation.
23. A regional health and human rights monitoring body should be activated.
24. A regional conference for health and human rights stakeholders should be held.
25. Advocacy should be undertaken for the adoption of a rights-based approach in regional programming.
26. Advocacy should be undertaken for the accession and ratification of international human rights covenants.
27. A regional awareness-raising meeting should be held for religious leaders on the right to health with the aim of activating the role of religious authorities in mainstreaming the right to health.

**Annex 1****PROGRAMME****Tuesday, 21 September 2010**

- 8:30–9:00 Registration
- 9:00–9:30 Opening ceremony  
Address by Dr Hussein A. Gezairy, Regional Director  
Background on the meeting, rationale, objectives and expected outcome/Dr Fatimah El Awa and Dr Khalid Saeed, WHO/EMRO
- 10:00–11:00 Discussion on expectations of the meeting (countries)
- 11:00–11:30 WHO approach to health and human rights/Dr Helena Nygren-Krug, WHO/HQ
- 11:30–12:00 Health and human rights in the Eastern Mediterranean Region and relevance to international conventions/Dr Fatimah El Awa, WHO/EMRO
- 12:30–13:00 Rights-based approach to health, by Ms Mitra Motlagh, UNDP
- 13:00–14:00 Background and history of CRPD/Dr Soumitra Pathare, Temporary Adviser
- 14:00–14:30 CRPD's provision and implications for mental health services development and delivery Dr Khalid Saeed, WHO/EMRO
- 14:30–16:30 Group work

**Wednesday, 22 September 2010**

- 9:00–11:00 Linkages between health and human rights, social determinants of health and CBI/Dr Mohammad Assai, WHO/EMRO
- 11:00–11:30 Brainstorming exercise (surgeon's dilemma)
- 11:30–12:00 Health is a fundamental human right (country examples): Iraq, occupied Palestinian territory, Yemen
- 12:30–13:45 Role of nongovernmental organizations in promoting the right to health/Dr Amani Massoud, Egyptian Initiative for Personal Rights
- 13:45–14:15 Energizing exercise (human rights in photos)
- 14:15–16:15 Group work: Mainstreaming health and human rights at national level/CRPD: support to mental health at national level

**Thursday, 23 September 2010**

- 9:00–9:30 Brainstorming exercise (human rights checklist)
- 9:30–11:00 Institutional practices for health and human rights historically/Dr Haytham Al Khayat, WHO/EMRO
- 11:00–11:30 Concluding exercise
- 11:30–12:00 Way forward for health and human rights in the Eastern Mediterranean Region/Dr Fatimah El Awa, WHO/EMRO
- 12:00–12:30 Way forward for implementation of CRPD in the context of mental health/Dr Khalid Saeed, WHO/EMRO
- 12:30–13:00 Recommendations and conclusions

**Annex 2**

**LIST OF PARTICIPANTS**

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