

Expanding the Definition of the Right to Mental Health: Attending to Victims of Political Violence and Armed Conflict in Their Communities of Origin

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Abstract

The right to mental health waits to gain universal recognition. States have ignored it, following the general trend of relegating economic, social and cultural rights secondary to civil and political rights. The article examines how in the last decade several movements have brought this right to the foreground, in particular efforts to protect the rights of the mentally disabled, refugees and displaced persons. It discusses how, as a result, institutions of the United Nations (UN), including the General Assembly, Committee on Economic, Social, and Cultural Rights, the UN Commission of Human Rights and the World Health Organization have become more active in addressing the right to physical and mental health, for example appointing Paul Hunt as Special Rapporteur on Health. The authors argue that these inroads on the right to mental health limit the definition and vision of mental health. In particular, in countries undergoing post-conflict recovery there is the need to attend to the mental health of victims of serious human rights violations. However, until now there has been no clear international policy or plan of action on how to address this problem. Calling for more international discussion on this topic, the authors hope to contribute to the movement by exploring different dimensions of mental health and by identifying three possible origins of a violation of the right to mental health. The authors present scenarios where a State fails to *prevent* the violation of the right to mental health and its related issues, as well as the state's corresponding obligation to provide mental health reparations. They call for an expansion of the concept of the right to mental health on the international agenda, and offer suggestions on how this effort may begin. Having conducted a study on the right to mental health for victims of Peru's internal armed conflict, the authors will use examples from Peru to illustrate different observations and conclusions.

1. Introduction

The right to mental health, although protected by major international human rights instruments, waits to gain universal recognition. Traditionally States have neglected the right to mental health, following the general trend of relegating economic, social and cultural

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rights secondary to civil and political rights.¹ In the last decade, however, several movements have brought these rights - in particular those related to the mentally disabled, refugees and displaced persons - to the foreground.

While without doubt important, these inroads into the international agenda on the right to mental health keep the definition and vision of mental health limited. Instead, the concept of the right to mental health needs to expand to include victims of political violence and internal armed conflict who still reside in their communities of origin. This call responds to the growing international recognition of the urgent need to attend to this population, especially as more nations discover that post-conflict transition and recovery may depend on it.

However, until now minimal attention has been paid to the need for sustained, culturally appropriate mental health programmes in post-conflict settings. This situation arises in part from a historical neglect of the issue of mental health at both the national and international level, but also from a lack of coordination between various national and international players. As a result, there is inconsistent and reluctant international cooperation and minimal financial and technical support for these much needed mental health interventions. In addition, nations feel no external pressure to address the mental health needs of victims of violations of the right to mental health, and thus fail to protect them.

A new global awareness brought on by the international transitional justice movement offers an opportunity to reverse this trend. Truth commissions have created forums for victims to reveal the adverse and serious psychosocial effects of internal armed conflicts and political violence that prevent personal recuperation and reintegration into family, community and civic life. These revelations motivate new inquiries into how the right to mental health is best protected, or remedied when violated, thus raising complex issues related to definitions and approaches to mental health in post-conflict settings. This article presents a preliminary exploration of these complexities, using the experience of Peru as an example when relevant.

In conclusion, we recommend that the international community prioritizes this issue, and adopts new advocacy strategies and policies. This task will require the clarification of the complex definitions of mental health for victims of political violence and armed conflict and the seeking of consensus on the most appropriate approach to promoting and protecting it. This information will guide States in determining their corresponding obligations and ultimately help shape policy and practice. Although challenging, this invitation could contribute to the expansion of the definition of the right to mental health, and at the same time give it the same recognition as other universal fundamental rights.

2. International Legal Basis for the Right to Mental Health

While attention to the right to mental health has only increased in the last decade, its existence as a fundamental right dates back to the formation of the international human rights system. Previous academic works sufficiently explain the legal basis for the right to

¹ Center for Economic and Social Rights. 'Economic, Social and Cultural Rights A Guide to the Legal Framework' (2000), available at: <http://cesr.org/low/node/view/162>.

physical and mental health in international legal instruments and customary law.² However, we provide a brief overview of these legal sources, highlighting recognition of the right to mental health, to facilitate our discussion.

2.1 The Indisputable Legal Basis of the Right to Mental Health

The right to physical and mental health dates back to 1946 when the World Health Organization (WHO) adopted its Constitution, recognizing 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’,³ defining health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.⁴ This latter definition presents an integral vision of health, including body and mind, that, as will be discussed below, has only now come to assume greater importance.

In 1948 the Universal Declaration of Human Rights (UDHR) established the legal framework for enforcing the right to health through Article 25, which became a model for other legally binding international and regional human rights treaties that codify the right to health, often explicitly referring to mental health.⁵

For instance, Article 12(l) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes ‘the right of everyone to the enjoyment of the highest attainable standard of physical and *mental health*’.⁶ According to UN Special Rapporteur on Health Paul Hunt, Article 12(l) provides the cornerstone protection of the right to health in international law: ‘The Covenant introduces legally binding provisions that apply to all individuals in the 146 ratifying States’.⁷ Regionally in the Americas, Article 10(1) of the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) provides: ‘Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, *mental and social well-being*’.⁸

Various resolutions and principles produced by different organs of the UN reinforce the right to mental health. For instance, in 2000 the Committee on Economic, Social, and Cultural Rights (CESCR) issued its ‘General Comment No. 14: The right to the highest

² See for example, Jonathan M. Mann et al. (eds.), *Health and Human Rights: A Reader* (New York: Routledge, 1999).

³ World Health Organization, Constitution, in *Basic Documents*, 36th ed. (Geneva, 1986).

⁴ *Ibid.*

⁵ See Art. 16 of the African Charter on Human and Peoples’ Rights (1981), 21 *International Legal Materials (ILM)* 59; Art. 14 of the African Charter on the Rights and Welfare of the Child (1981), 21 *ILM* 59; and Art. 11 of the European Social Charter (1961), 529 *UNTS* 89 (note revision in 1996); Art. 24 of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women (1979), 1249 *UNTS* 13; and Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (1966) 660 *UNTS* 195, 3 *ILM* 164.

⁶ International Covenant on Economic, Social and Cultural Rights, 16 Jan. 1966, 993 *UNTS* 3, entered into force 3 Jan. 1976 (*italics added*).

⁷ Report to the UN Commission on Human Rights, Economic and Social Council, ‘The right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, UN Doc. E/CN.4/2003/58, para. 11 [hereinafter Hunt Report 2003].

⁸ Protocol of San Salvador (1988), 28 *ILM* 16 (*italics added*).

attainable standard of health', which interprets Article 12 of the ICESCR to specifically include 'appropriate mental health treatment and care'.⁹ Although not binding, this General Comment is nonetheless authoritative on the right to physical and mental health.

Similarly, in 2002 the UN Commission of Human Rights (CHR) affirmed the right to health through resolutions on 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.¹⁰ Demonstration of this new commitment came when the Economic and Social Council took note of the CHR's resolution 2002/31 and endorsed the appointment of Paul Hunt for three years as Special Rapporteur on Health. His mandate focuses on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.¹¹

Thus far, the Special Rapporteur has made four reports in accordance with the three primary objectives of his mandate: 'To promote – and encourage others to promote – the right to health as a fundamental human right; to clarify the contours and content of the right to health; and to identify good practices for the operationalization of the right to health at the community, national and international levels'.¹² He has also conducted mission trips to Peru, Mozambique and Romania, planning presentation of his final reports on these investigations at the 61st session of the CHR. Significantly, he has chosen mental health as one of the six illustrative issues to be given particular attention.¹³

Importantly, the UN General Assembly recently affirmed the various international treaties, the Constitution of the WHO, as well as the CHR's resolutions on the right to physical and mental health in December 2003, by adopting its own resolution, reaffirming: 'That the right of everyone to the enjoyment of the highest attainable standard of physical and mental health is a human right, and that such right derives from the inherent dignity of the human person'.¹⁴

This increasing recognition of the right to mental health runs against historic neglect of mental health due to longstanding stigmas and the feeling that mental health was 'only for the crazy',¹⁵ or a luxury for the wealthy, developed countries.¹⁶ Physical health, with its external manifestations, has taken the spotlight, overlooking the interconnection between

⁹ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: 'On the right to the highest attainable standard of health', adopted at its 22nd session in April/May 2000, UN Doc. E/C.12/2000/4, para. 17 [hereinafter, General Comment No. 14].

¹⁰ See for example, UN Commission of Human Rights resolutions, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', UN Docs. E/CN.4/RES/2002/31, E/CN.4/RES/2003/28 [hereinafter CHR 2003], and E/CN.4/RES/2004/27.

¹¹ UN Economic and Social Council, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. UN Doc. E/DEC/2002/259.

¹² Ibid., para 1.

¹³ Hunt, n. 7 above, para. 90-94.

¹⁴ UN General Assembly, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', UN Doc. A/RES/58/173.

¹⁵ In the course of the authors' study in Peru, this was the frequent response to the question as to why the survivors of the conflict did not seek psychological counselling.

¹⁶ The World Bank Group, *Fighting Poverty With Peace of Mind: Why tackling mental health issues can make development more effective* (26 July 2004), available at: <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20230090~menuPK:34463~pagePK:64003015~piPK:64003012~theSitePK:4607,00.html>.

mental and physical ailments.¹⁷ According to Dr Nila Kapor-Stanulović, the first psychosocial officer for the United Nations Children's Fund (UNICEF) dealing with children affected by armed conflicts, the UN has been 'primarily concerned with physical survival, which is indeed a priority. Nevertheless, psychosocial welfare has assumed too much a secondary position'.¹⁸

Recent trends have helped to encourage a new look at mental health, viewing it as not only a prerequisite for sustainable development,¹⁹ but also as facilitating post-conflict reconstruction, reconciliation, peace and democracy.²⁰ Building the infrastructure for the rule of law and democracy promises to be an empty endeavour if citizens are not mentally and physically prepared to exercise their rights. In fact, General Comment No. 14 recognizes that 'health is a fundamental human right indispensable for the exercise of other human rights'.²¹ The inextricable link between a state of physical and mental well-being and the ability to enjoy and exercise other fundamental rights, including civil and political rights, has recently been recognized after years of persuasive arguments made by experts in the field of health and human rights.²²

Utilitarian arguments aside, the evolution of prioritizing mental health comes more readily when framed as a fundamental human right, implying entitlement by individuals, and not left to the discretion of the State.²³ Promotion and protection of mental health becomes an obligation of the State, not just as an important social and public good, but rather as part of the inherent dignity of people. Using the rights approach to mental health also rescues it from being viewed as a shameful problem of the mentally ill, and instead puts it as top priority on national and international agendas.

2.2 National Neglect of the Right to Mental Health

Although international law indisputably protects the right to mental health, this has been long neglected, despite the direction of General Comment No. 14 establishing that the obligation to *fulfil* 'requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative

¹⁷ World Health Organization. *2001 World Health Report Mental Health: New Understanding, New Hope*, at 3. Available at: <http://www.who.int/whr/2001/en/> [hereinafter, 2001 WHO Health Report].

¹⁸ Biko Nagara, 'Psychological First Aid: Education Is Essential in Post-conflict Situations' (2003) 4 *The Chronicle*, available at: <http://www.un.org/Pubs/chronicle/2003/issue4/0403p53.asp>.

¹⁹ See Michelle Cullen and Harvey Whiteford, *The Interrelations of Social Capital with Health and Mental Health* (June 2001) Available at: <http://www.mentalhealth.gov.au/pdf/inter.pdf>.

²⁰ The World Bank, 'Mental Health and Conflict' (2003) 13 *Social Development Notes: Conflict Prevention and Reconstruction*. Available at: [http://lnweb18.worldbank.org/ESSD/sdvext.nsf/67ByDocName/MentalHealthandConflictCPRNote13/\\$FILE/CPR13legal.pdf](http://lnweb18.worldbank.org/ESSD/sdvext.nsf/67ByDocName/MentalHealthandConflictCPRNote13/$FILE/CPR13legal.pdf).

²¹ General Comment No. 14, n. 9 above, para 1.

²² J. Mann, L. Gostin, S. Gruskin et al., 'Health and Human Rights' (1994) 1 *Health and Human Rights* 6-23. Available at: <http://www.hsph.harvard.edu/xfbcenter/V1N1.htm>.

²² J. Mann, L. Gostin, S. Gruskin et al., 'Health and human rights' (1994) 1 *Health And Human Rights* 6-23. Available at: <http://www.hsph.harvard.edu/xfbcenter/V1N1.htm>. [Hereinafter, Mann, Health and human rights].

²³ Virginia A. Leary, 'The Right To Health In International Human Rights Law' (1994) 1 *Health and Human Rights* 24-56. Available at: <http://www.hsph.harvard.edu/xfbcenter/V1N1.htm>.

implementation, and to adopt a national health policy with a detailed plan for realizing the right to health'.²⁴

In response, in 1990 the Pan American Health Organization (PAHO) brought together mental health organizations, associations, professionals and jurists to the Regional Conference on Restructuring Psychiatric Care in Latin America, held in Caracas, Venezuela. Delegates of the Conference formulated frames of reference for restructuring the conventional psychiatric care in Latin America, resulting in the creation of the Declaration of Caracas. This event gave great impetus for numerous Latin American countries to revise their legislation on mental health and to address the protection of persons with mental disabilities.²⁵

Despite this impetus, however, mental health still holds low priority on national agendas in Latin America, and in other developing countries. According to the WHO 2001 Health Report:

Mental and behavioural disorders are estimated to account for 12% of the global burden of disease, yet the mental health budgets of the majority of countries constitute less than 1% of their total health expenditures ... more than 40% of countries have no mental health policy and over 30% have no mental health programme. Over 90% of countries have no mental health policy that includes children and adolescents.²⁶

For instance, during his mission to Peru, Special Rapporteur Hunt observed that although the Peruvian Constitution protects the right to health and the Minister of Health is committed to its realization, in recent years the central government has decreased its national budget for health, investing only 4 per cent of its Gross Domestic Product to support health programmes; and of that, only 3 per cent is dedicated to mental health, primarily to psychiatric hospitals, making recent progressive policies on mental health impossible to implement.²⁷ Peru's example shows that it is not just the failure to integrate the right to mental health into the national legal and political framework that violates international law, but also the lack of financial commitment to its realization. The economic constraints posed by the realities faced by poor countries make affirmative rights, such as health, more difficult to guarantee. However, sometimes it is a matter of political will, as we discovered during an interview with a representative of the Peruvian Ministry of Economy, who agreed mental health is a right, but added that 'it is not a priority'.

2.3 Recent International Trends Prioritize Mental Health

Against this backdrop of national neglect of the protection of the right to mental health, a growing preoccupation has brought new attention to the issue. The WHO chose the theme of mental health for its 2001 annual health report, 'Mental health: new understanding, new hope' (hereinafter 'WHO Report'). The then General Director, Dr Gro Harlem Brundtland, was of the opinion that the WHO was 'making a simple statement: mental health – neglected

²⁴ General Comment No. 14, n. 9 above, at para. 36.

²⁵ For summary see, 'The Development of Mental Health and Psychiatric Care Legislation in Latin America', Available at: <http://165.158.1.110/english/hdp/hdd-l001.htm>.

²⁶ 2001 WHO Health Report, n. 17 above, at 3.

²⁷ Rapator Especial de los Naciones Unidas Paul Hunt, 'Misión al Perú (7 – 15 junio 2004): Resumen de recomendaciones provisionales', para. 18 (on file with authors).

for far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light’.²⁸

The WHO report put into perspective the great personal, social and economic costs of mental health problems, stating that approximately 450 million people suffer from mental or neurological disorders, or from psychosocial problems such as those related to alcohol and drug abuse. Alcohol dependence, a disease in itself as well as often a symptom of other underlying mental health issues, affects seventy million people. Moreover, a million people commit suicide every year, and between ten and twenty million people attempt it. The WHO report concludes that major depression ‘is now the leading cause of disability globally and ranks fourth in the ten leading causes of the global burden of disease. If projections are correct, within the next 20 years, depression will have the dubious distinction of becoming the second cause of the global disease burden’.²⁹

2.3.1 *Limiting the Focus to the Mentally Disabled, Refugees and Displaced Populations*

While a significant milestone in bringing international recognition of the importance of mental health, the WHO Report approaches the issue of mental health in terms of mental and psychological disorders, recommending policies and practices to improve the treatment of this particular group of patients. Traditionally the mentally disabled have been defined by diagnosable mental diseases such as depression, substance abuse, schizophrenia, epilepsy, Alzheimer’s disease, suicide, mental retardation, among other mental disorders.³⁰

This focus reflects one of the most marked inroads into the issue of mental health that began in the 1970s with the Declaration on the Rights of Disabled Persons (1975).³¹ The movement for protecting the rights of the mentally disabled, especially against discrimination, has become stronger over the years, as reflected by the subsequent development of UN Principles, Standard Rules and Comments.³² In fact, in December 2001 the UN General Assembly initiated a formal process for drafting a specialized convention on the rights of people with disabilities.³³ In the WHO Report Dr. Harlem Brundtland notes that ‘our call has been joined by the UN General Assembly, which this year marks the 10th anniversary of the rights of *the mentally ill* to protection and care. I believe *The World Health Report 2001* gives renewed emphasis to the UN principles laid down a decade ago’.³⁴ In fact, many of the follow-up advocacy and policy guides published by WHO adopt this same focus, while also leaving out mention of mental health in post-conflict settings.³⁵

²⁸ 2001 WHO Health Report, n. 17 above, at ix.

²⁹ *Ibid.*, at x.

³⁰ *Ibid.*, at 29-36.

³¹ GA Res 3447 (XXX), 30 UN GAOR Supp (No. 34) at 88, UN Doc A/10034 (1975).

³² See for example, ‘Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’, GA Res 119, UN GAOR, 46th Sess., Supp. No. 49, Annex at 188, UN Doc. A/46/49 (1992) and Committee on Economic, Social, and Cultural Rights, General Comment No. 5: ‘Persons with Disabilities’ (Eleventh session, 1994).

³³ Comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities, Resolution 56/168, GA Res 168, UN GAOR, 56th Sess, Agenda Item 119(b), UN. Doc. A/RES/56/168 (2001).

³⁴ 2001 WHO Health Report, n. 17, above, at ix (*italics added*).

³⁵ See generally, http://www.who.int/mental_health/policy/en/.

In general, the focus on mental disorders has greatly influenced the direction of the international discussion on the right to mental health. For instance, in its General Comment No. 14, the CESCR places great emphasis on the rights of persons with mental disabilities, linking the majority of its comments and recommendations to protecting this population, even affirming General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health.³⁶

Nevertheless, both the WHO and the CESCR have recognized a broader definition of the problems of mental health, acknowledging that it does not always amount to diagnosable mental illnesses. The 2001 WHO Report provides that:

Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively.³⁷

It further acknowledges that the definition of mental health is 'broader than a lack of mental disorders'³⁸ and that 'not all human distress is mental disorder. Individuals may be distressed because of personal or social circumstances; unless all the essential criteria for a particular disorder are satisfied, such distress is not a mental disorder'.³⁹

Nevertheless, the paradigm of mental disorders confines the WHO Report, leaving out the complexities of the effects of economic and social conditions, political violence, armed conflict and human rights violations that may not necessarily amount to a diagnosable mental disorder but nevertheless negatively impact the mental health of victims. Although the WHO Report dedicates a small section to the link between mental problems and conflicts, including wars and civil strife, it does so to explain one of the many causes of individual mental disorders, overlooking the more subtle nuances of the mental health of communities and societies affected by political violence and armed conflict.⁴⁰

Moreover, in its brief discussion of the effects of armed conflict, the WHO Report refers to the other significant inroad into the international focus on mental health, specifically that related to the trauma of refugees and internally displaced persons, who are estimated to amount to 50 million people globally.⁴¹ While, again, the attention paid to these victims is of immense importance, it still does not capture the full significance of the right to mental health for all victims of political violence and armed conflict, an estimated one billion persons.⁴²

For instance, psychological treatment has been a small part of short-term emergency or disaster relief, and there are no sustained programmes that incorporate psycho-socio-

³⁶ General Comment No. 14, n. 9 above, para. 26.

³⁷ 2001 WHO Health Report, n. 17 above, at 5.

³⁸ *Ibid.*

³⁹ *Ibid.*, at 21.

⁴⁰ *Ibid.*, at 43.

⁴¹ *Ibid.*

⁴² Richard F. Mollica and Laura McDonald. 'Project 1 Billion Health Ministers of Post-conflict Nations Act on Mental Health Recovery' (2003) *UN Chronicle Online Addition*. Available at: <http://www.un.org/Pubs/chronicle/2003/issue4/0403p56.asp#>.

economic dimensions.⁴³ The approach to refugees has also had strong emphasis on the diagnosis of trauma, often criticized as being a Western, biomedical concept that pathologises the patient, keeping him or her in a state of victim identity.⁴⁴ Most importantly, the discussion on refugees and displaced populations overlooks the unique needs of victims and their original communities, which often require integral, culturally sensitive approaches to rebuilding family and community support networks, often using traditional practices and healers.⁴⁵ In particular, there are hardly any comprehensive studies on psychosocial effects of victims still residing in their places of origin, resulting in minimal guidance for policy decisions.⁴⁶

In summary, the WHO Report reflects a common international approach to mental health issues that are often criticized for individualizing treatment as opposed to adopting a community-based approach. It also does not consider the politico-socio-economic factors that give rise to mental health problems and/or exacerbate mental distress and suffering, which are not always treatable through therapy or medicine, but rather through alternative projects that emphasize human rights and empowerment.⁴⁷

3. Expanding the Definition of Mental Health

Lobbying on the rights of the disabled and refugees has helped include mental health issues on the global agenda. However, the focus must be expanded to include victims of political violence and armed conflict residing in their communities of origin. To facilitate this dialogue, we consider the ways in which the right to mental health can be violated, and the corresponding remedy to this violation, as a way to provide a framework for understanding and defining the right to mental health. While acknowledging that States have an affirmative duty to *respect, protect* and *fulfil* the right to mental health,⁴⁸ we present an examination of possible scenarios of when a State fails to *prevent* the violation of the right to mental health either through an act or omission.

Notwithstanding other possibilities, we have identified three possible origins of a violation of the right to mental health, moving from the simple ones to the more complex. Space does not allow a comprehensive examination of these issues, but we hope that our brief discussion encourages a more sustained conversation on the topic.

⁴³ Derek Summerfield, 'A critique of seven assumptions behind psychological trauma programmes in war-affected areas' (1999) 48 *Social Science & Medicine* 1449-1462.

⁴⁴ Vanessa Pupavac, 'Pathologising Populations and Colonising Minds: International Psychosocial Programmes in Kosovo.' Paper for the 51st Political Studies Association. Manchester, United Kingdom (10-12 April 2001), available at: <http://www.psa.ac.uk/cps/2001/Pupavac%20Vanessa4.pdf>. See also 2001 WHO Health Report, n. 17 above, at 44.

⁴⁵ Duncan Pedersen, 'Political violence, ethnic conflict and contemporary wars: broad implications for health and social well-being' (2002) 55 *Social Science & Medicine* 175-190, at 182.

⁴⁶ *Ibid.*

⁴⁷ Bertha Lucía Castaño, Luis Eduardo Jaramillo and Derek Summerfield, *Violencia Política y Trabajo Psicosocial (Political Violence And Psychosocial Work)*. (Bogotá, Colombia, 1998).

⁴⁸ General Comment No. 14, n. 9 above, para. 33.

3.1 First Dimension to the Violation of Mental Health: Denial of Access to Quality Mental Health Services

In its General Comment No. 14, the CESCR established the traditional approach to examining the right to health based on the *availability, accessibility, acceptability* and *quality* of health-care facilities, goods, services and programmes,⁴⁹ an approach later endorsed by Special Rapporteur Hunt.⁵⁰ This ‘non-exhaustive catalogue’ of ‘interrelated and essential elements’ is meant to guide States to take action to protect the right to physical and mental health. According to these standards, health care in general must be available to all, especially the most vulnerable or marginalized sections of the population, without discrimination; and they must be appropriate in terms of being respectful of medical ethics and culture, while also being scientifically and medically appropriate and of good quality.⁵¹ This criterion is meant to illustrate the content of the right to health.⁵²

Thus, denial of healthcare services, goods and programmes results in a violation of the right to physical and mental health, and the remedy is the correction of this denial of access or improvement in supply of the services and goods. This criterion limits the definition of the right to physical and mental health to the more narrow definition of treatment of people with diagnosable mental disorders through conventional health care services in clinics and hospitals. For instance, the CESCR calls on States to fulfil their obligation through ‘the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country’.⁵³ This approach excludes situations in which mental health problems, such as those that arise out of political violence and armed conflict, require an integral, community based approach to treatment and not mental health clinics or services.

In fact, in our study of mental health in post-conflict Peru, we have observed that the mental health *sequelae* experienced by victims of political violence and armed conflict, such as strong distrust of government institutions and institutionalized care, discourages their use of public healthcare services. Moreover, we have encountered an absence of medical professionals trained to work with the specific problems presented by this population of victims. Finally, we found that victims may also have different priorities in their mental recuperation, such as finding a job or working with a community healer.

Interestingly, General Comment No. 14 recognizes that ‘the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health,’⁵⁴ should be ‘culturally appropriate’, especially for indigenous populations.⁵⁵ Moreover, the CESCR suggests that ‘acceptability’ requires identifying ‘elements that would help to define indigenous peoples’ right to health’, such as through

⁴⁹ Ibid., para. 12.

⁵⁰ Report of the Special Rapporteur Paul Hunt to the Commission of Human Rights, Addendum: Mission to the World Trade Organization E/CN.4/2004/49/Add.1, at 41.

⁵¹ General Comment No. 14, n. 9 above, para. 12.

⁵² Ibid., para. 13.

⁵³ Ibid., para. 36.

⁵⁴ Ibid., para. 8.

⁵⁵ Ibid., para. 12(c).

traditional preventive care, healing practices and medicines.⁵⁶ They also acknowledge that among these populations, ‘health of the individual is often linked to the health of the society as a whole and has a collective dimension’.⁵⁷

Despite these suggested deviations from the mainstream concept of mental health care, the international community generally viewed the right to mental health in terms of *access to services*, as reflected in many subsequent UN documents, including Special Rapporteur Hunt’s preliminary introduction to the theme of mental health, which narrowly focuses on the mentally disabled.⁵⁸ The gravitation towards this focus could be due in part to the fact that it provides a simpler route to denouncement, advocacy and reform; that is, making health care accessible and acceptable, and assuring non-discrimination of the mentally disabled. Other concepts of mental health, to be discussed below, present great challenges in conceptualization and implementation.

3.2 Second Dimension of the Violation of the Right to Mental Health: Mental Suffering and Harm as the Result of Other Human Rights Violations

While discussing the normative character of Article 12 of the ICESCR, General Comment No. 14 clarifies that the right to health includes both freedoms and entitlements, including the right to be free from interference, such as torture, and presumably other categories of human rights violations that have historically occupied the international community’s attention.⁵⁹

These same violations arise out of tactics used during political violence and armed conflict, especially within as opposed to between nations, and have come to define contemporary war. In fact, in the last fifty years there have been some 200 internal armed conflicts in countries as diverse as Northern Ireland, Bosnia, South Africa, Mozambique, Sudan, Angola, Sierra Leone, Guatemala, Colombia, Afghanistan, East Timor and the Philippines,⁶⁰ and during these some 191 million people lost their lives directly or indirectly in the twentieth century.⁶¹ These modern wars, typically between authoritarian States and insurgents, as in Peru, often use psychological techniques such as terror, torture, rape, arbitrary imprisonment, disappearances, extrajudicial killings, and other grave human rights violations in their struggle for power, with 90 per cent of the casualties being innocent people, typically ethnic minorities and the poor, thus representing the most marginalized members of society.⁶²

Despite this worldwide phenomenon, there is a noticeable lag in the development of an articulated international policy regarding the mental health impacts of massive human rights violations, and thus no clear guidance on the most appropriate standard for guaranteeing an appropriate response to this problem. Only in 2003 did the Commission on

⁵⁶ Ibid., para. 27.

⁵⁷ Ibid.

⁵⁸ Hunt Report 2003, n. 7 above, at 93.

⁵⁹ General Comment No. 14, n. 9 above, para 8.

⁶⁰ Derek Summerfield, ‘Childhood, War, Refugeedom and Trauma: Three Core Questions for Mental Health Professionals’ (2000) 37 *Transcultural Psychiatry* 417–433, at 417.

⁶¹ *World Report on Violence and Health* (WHO, 2002), at 218. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/ [hereinafter, WHO Report on Violence].

⁶² Pederson, n. 45 above, at 176-7.

Human Rights issue a resolution to prioritize a discussion on violence and the need for its prevention, recognizing that it causes ‘physical and mental injury that constitutes a human rights violation’, and that there is a need to reduce ‘its possible negative impact on the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as well as on the enjoyment of other human rights’.⁶³ It even recommended that the UN General Assembly should declare the year 2007 as the UN Year for Violence Prevention.

Responding to the UN Commission’s call for contributions on the topic of violence prevention, Special Rapporteur Hunt affirmed that violence has a direct impact on the enjoyment of the right to health, since it results in ‘significant physical, psychological and emotional harm to individual victims and contributes to social problems for individuals, families and communities’ and concerns both human rights and public health.⁶⁴ Yet the Special Rapporteur promises to follow the issue of domestic violence, with no mention to political violence or armed conflict.

Similarly, the WHO has also begun to measure the impact of violence on health outcomes around the world, publishing its ‘World Report on Violence and Health’ in 2002, defining violence as ‘the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation’.⁶⁵

The report dedicates a chapter to collective violence, and touches upon the mental health impact of violence and how ‘local community structures and activities may be seriously disrupted’,⁶⁶ but acknowledges the overall lack of documentation, research and dissemination of information relating both to the impact of collective violence and to the best approach to responding to it.⁶⁷ Interestingly, the report mentions that ‘recovery from psychological trauma resulting from violent conflict is associated with the reconstruction of social and economic networks and cultural institutions’.⁶⁸ However, most follow-up work to the report has centred on interpersonal violence, such as domestic abuse, and not collective violence.⁶⁹

If political violence and armed conflict do not figure in the general examination of how violence negatively impacts on mental health, they will be largely omitted from policy considerations, narrowing the chance for coordinated national and international response and action.

⁶³ ‘The right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, Commission on Human Rights resolution, 59th Session, UN Doc. E/CN.4/RES/2003/28, at para. 7.

⁶⁴ Report of the Special Rapporteur Paul Hunt to the Commission on Human Rights, ‘The right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, E/CN.4/2004/49 (16 Feb. 2004), para. 84 [hereinafter Hunt Report 2004].

⁶⁵ WHO Report on Violence, n. 61 above, at 5.

⁶⁶ *Ibid.*, at 231.

⁶⁷ *Ibid.*, at 232.

⁶⁸ *Ibid.*, at 224.

⁶⁹ See for example, *Preventing violence: a guide to implementing the recommendations of the World Report on Violence and Health* (WHO, 2004). Available at: <http://whqlibdoc.who.int/publications/2004/9241592079.pdf>.

3.2.1 *Transitional Justice Initiatives Present Mental Health Reparation Programmes for Victims of Political Violence and Armed Conflict*

The recent increase in the number of countries devastated by internal armed conflicts and political violence, in transition towards peace and democracy, and opting for transitional justice mechanisms, has helped to expand the dialogue on mental health. In particular, the formation of truth commissions by transitional governments, as in South Africa, Chile, El Salvador, Guatemala and most recently Peru, has provided a forum for victims to tell their truth about human rights violations and their devastating effects. Viewed together, these findings provide the unavoidable conclusion that democratic transition and recovery from devastating political violence requires attention to the mental health of the thousands of victims, often in the form of reparations.⁷⁰

In fact, mental health programmes for victims of human rights violations have traditionally been framed in terms of reparations, which is a right in and of itself. Since its early reparation decisions, the Inter-American Court of Human Rights has followed the assumption that serious human rights violations such as extrajudicial killings, torture, disappearance and arbitrary detention cause mental suffering and moral harm. In the landmark *Loayza Tamayo* case, the Court writes: '[I]t is obvious to the Court that the victim suffered moral damages, for it is characteristic of human nature that anyone subjected to the kind of aggression and abuse proven in the instant case will experience moral suffering. No evidence is required to arrive at this finding'.⁷¹ Although not explicitly referring to mental health, the term 'moral damages' is construed to mean the psychological impact of the human rights violation, which amounts to mental suffering and harm.⁷² The court also assumes that this damage affects more than the victims, extending to the family, requiring no evidence of proof.⁷³

However, harm to mental health due to other grave violations of human rights has yet to be presented as a *per se* violation of the right to mental health, and rather is a factor considered when calculating reparations. It is thus possible to view reparations for mental suffering for violation of civil and political rights as also repairing violations of the right to mental health. For this reason, reparations in mental health are important not only to raise awareness on this issue, but also as a backdoor way of reinforcing the right to mental health.

3.2.2 *Expanding the Definition of Mental Health: Peru's Integral Reparations Programme*

In 2001, following the flight of authoritarian president Alberto Fujimori, Peru established its Truth and Reconciliation Commission (TRC), to investigate and clarify the causes and responsibility for grave human rights violations that arose out of the twenty year internal armed conflict between the State and terrorist groups, from 1980 to 2000.⁷⁴ Publishing its

⁷⁰ For general discussion see Priscilla B. Hayner, *Unspeakable Truths: Confronting State Terror And Atrocity* (New York: Routledge, 2001).

⁷¹ *Loayza Tamayo v. Peru*, Judgment on Reparation of 27 November 1998. Inter-American Court of Human Rights, Series C/ No. 42, para. 138.

⁷² *Velasquez Rodriguez v. Honduras*, Judgment on Compensatory Damages of 21 July 1989. Inter-American Court of Human Rights, Series C/No. 7, para 50.

⁷³ *Bulacio v. Argentina*, Judgment on the Merits of 18 September 2003. Inter-American Court of Human Rights, Series C, No. 100, para. 98 (citations omitted).

⁷⁴ See the Final Report of the Peruvian Truth and Reconciliation Commission, available at: www.cverdad.org.pe [hereinafter, Final Report TRC].

final conclusions in August 2003, the TRC dedicated an entire chapter to the psychosocial *sequelae* of the internal armed conflict, giving a comprehensive analysis of the effects of this conflict. Significantly, almost fifty per cent of the little more than 16,000 people who gave private and public testimonies reported some form of mental suffering.⁷⁵ Given that the TRC estimated that almost 70,000 people were killed or disappeared during the war, it is assumed that many more survivors share this suffering. As a consequence, the TRC included attention to the psychosocial needs of victims as one of its main features of its 'Plan of Integral Reparations' (PIR).⁷⁶

In addressing the physical and mental health needs of victims, PIR contemplates an integral model of attention that includes not only simple access to public healthcare, but also the training of health professionals in the special problems associated with political violence and armed conflict, and clinical and communitarian intervention, adopting an expansive objective of contributing:

to the recuperation of mental and physical health of populations affected by the internal armed conflict, so that they may reconstruct the networks of social support and strengthen their capacity for personal and social development. This will favour the development of the necessary autonomous development of the victims to reconstruct their individual and collective life plan ('proyecto de vida') that was cut off by the conflict.⁷⁷

The TRC's vision of mental health, along with its other recommendations, moves beyond the narrow focus on access to public health services, towards viewing physical and mental recuperation as requiring long-term intervention with both psychological and socioeconomic assistance.

3.2.3 *Calling for a Clear Policy on Attention to the Mental Health Needs of Victims of Political Violence and Armed Conflict*

Although the international community has finally begun to acknowledge the serious mental health consequences of political violence and armed conflict, there is no clear 'mental health recovery approach' in post-conflict reconstruction projects, and consequently programming and funding fall short of the great need to attend to this pressing problem.⁷⁸ Vocal critic Dr Richard Mollica, of the Harvard Program in Refugee Trauma (HPRT), writes: 'Within most post-conflict countries, mental health policy is essentially non-existent. Moreover, there is no global and collaborative approach to the mental health and physical healing of traumatized groups'.⁷⁹

Part of this problem is due to the lack of consensus on the most appropriate approach to addressing the mental health needs of affected communities, with an international debate consumed by disagreement on issues of cultural perceptions and definitions of mental health.⁸⁰ There is also little systemized knowledge on best practices for

⁷⁵ Authors' conversation with ex-psychologist of the TRC, Miryam Rivera (Lima, Peru, 2 Nov. 2004).

⁷⁶ 'Programa Integral de Reparaciones' in Final Report TRC, n. 74 above, Tomo IX/sec. 2.2.

⁷⁷ Hatun Willakuy: *Versión Abreviada del Informe Final de la Comisión de la Verdad y Reconciliación*. (Lima, Peru 2004), at 419 (translated by authors).

⁷⁸ Mollica, Project 1 Billion, n. 42 above.

⁷⁹ Ibid.

⁸⁰ Kimberly Theidon. *Entre Projimos: El Conflicto Armado Interno y La Política De La Reconciliación en El Peru* (Lima, Peru: IEP, 2004), at 40-41.

sustained, culturally sensitive post-conflict mental health community based programmes,⁸¹ and few programmes to train human resources for this particular work.⁸² This absence of articulation and coordination results in reluctant support from international donors. Specifically:

Ministers of health, who have been responsible for healing the suffering of their traumatized citizens, have been unable to provide adequate mental health care for their societies due to a lack of knowledge of effective skills and practices, and the reluctance of international donors and Governments to invest in, approaches without demonstrable outcomes and cost-effectiveness.⁸³

The Peruvian post-conflict experience may offer important insights into these challenges in Peru's own efforts to attend to the mental health needs of the thousands of victims identified by the Peruvian TRC.

3.2.4 *Peru's Minister of Health Develops a Plan of Reparations in Mental Health*

The Peruvian Ministry of Health (MINSA) is taking a leading role in implementing the TRC's recommendations. In October 2004 the Minister of Health, Dr Pilar Mazzetti Soler, presented the Inter-American Commission for Human Rights in Washington, D.C. with 'Actions of the Minister of Health: Advances in Health Reparations 2004'.⁸⁴ Referring to the psychosocial diagnosis of the TRC, the Minister highlighted the mental health damage to victims, such as their fear and mistrust, as well as maladaptive conduct such as inter-family violence, alcoholism, juvenile gangs and suicide, and pointed towards the general disintegration of family and community ties.

MINSA's lines of action include not only basic access to existing healthcare but also training of professionals to deal with the special needs of this population. One important initiative involves the support of the Japanese Agency of International Cooperation and the public University of San Marcos, Lima, Peru in training health professionals to attend to the mental health needs of victims of political violence in five regions of the country most seriously impacted by the internal armed conflict.⁸⁵

Importantly MINSA's plan presents an integral approach through both individualized clinical attention and communitarian intervention. Dr Mazzetti presented the general objective of this plan of reparations as:

Contributing to the elevation of the quality of life of populations affected by the armed conflict through integral attention to mental health, with emphasis on a psychosocial approach, with focus on inter-cultural

⁸¹ See also, Leslie Snider et al., 'Psychosocial Assessment for Victims of Violence in Peru: The Importance of Local Participation' (2004) 36 *Journal of Biosocial Science* 389-400.

⁸² Fausto Garmendia, 'Formación y Capacitación de Recursos Humanos en Salud para la Atención Integral de Víctimas de la Violencia y Violación de Derechos Humanos', *Violencia en Latinoamérica Actas del Seminario-Taller Latinoamericano: Formación y Capacitación de Recursos Humanos en Salud para la Atención Integral de Víctimas de la Violencia y Violación de Derechos Humanos* (Lima, Peru: 2004), at 99.

⁸³ Ibid.

⁸⁴ MINSA Press Alert, 'Ministra De Salud Participará De Audiencia De Recomendaciones De Comisión De La Verdad' 25 Oct. 2004. Available at: http://www.minsa.gob.pe/ocom/prensa/notadeprensa.asp?np_codigo=1806&mes=10&anio=2004. Peruvian Minister of Health. 'Acciones Del Ministerio de Salud: Avances En Reparaciones en Salud 2004'. Available at: http://www.minsa.gob.pe/portalminsa/destacados/destacado.asp?dest_codigo=29.

⁸⁵ MINSA Press Alert, 'Minsa Elabora Proyecto De Atención Para Víctimas De Violencia Y Violación De DDHH' 28 Oct. 2004. Available at: http://www.minsa.gob.pe/ocom/prensa/notadeprensa.asp?np_codigo=1814&mes=10&anio=2004.

and gender issues, that will be produced through the collaborative and committed work of the health sector, both institutions and the community.⁸⁶

In choosing not to frame attention to mental health only in terms of access to mental healthcare and services, but rather to achieve a holistic, integral intervention, the Peruvian Minister of Health opted for the more challenging approach to fulfilling her duty to repair the mental health damage to this population. The implementation of this programme presents an important opportunity to learn from the challenges and successes of such an approach. For instance, as mentioned, this programme falls short of its ambitious vision because of the great financial restraint.

3.2.5 State Practice Reinforces the Right to Mental Health

MINSA's mental health reparation programme runs parallel to its general national strategy to promote mental health through its 'Strategies for Action in Mental Health',⁸⁷ which define mental health as:

An expression of a group of protective factors, conditions, determinants, precipitants and of sustenance, of an integral nature that manifests in the subjective well being of the person. The disequilibrium of these factors results in a mental maladjustment. Mental health is an inseparable dimension of integral health, and is the nucleus of balanced development throughout life, that has an important function in interpersonal relations, family life and social integration. It is a key factor in the social inclusion and full participation in the community.⁸⁸

If viewed in accordance with the CESCR's guidance on the duty to fulfil the right to mental health by undertaking 'actions that create, maintain and restore the health of the population',⁸⁹ Peru is setting an important national precedent in expanding the definition of the general duty under international law to protect the right to mental health, with emphasis on the affirmative duty of States to provide integral measures at both the individual and collective level. As MINSA presents its plan of reparations within its general initiative to promote mental health as a human right, it reinforces the principle that mental health is a right of every person that must be protected and promoted by the State.⁹⁰

3.3 Third Dimension of the Violation of the Right to Mental Health: Mental Health Suffering due to Economic, Political, Legal and Social Structures

Some argue that understanding political violence, armed conflict and its consequent human rights violations requires an examination of the oppressive structural conditions that caused these epidemics.⁹¹ This presents the most challenging inquiry into the origins of the violation of the right to mental health, since the means of protecting it and remedying it are comprised of systemic reform. Special Rapporteur Hunt in his recent report recognizes that:

A lack of respect for human rights is often the root cause of violence, while specific acts of violence may themselves amount to a violation of human rights. Introducing a human rights approach to violence prevention brings to bear States' international obligations concerning risk factors for violence such as

⁸⁶ Ibid. (translation by authors).

⁸⁷ 'Lineamientos de Salud Mental del Ministerio de Salud', approved through Ministerial Resolution N° 075-2004/MINSA on 28 Jan. 2004. Available at: <http://www.minsa.gob.pe/publicaciones/descarga.htm> [hereinafter, MINSA Lineamientos].

⁸⁸ Ibid.

⁸⁹ General Comment No. 14, n. 9 above, para 37.

⁹⁰ MINSA Lineamientos, n. 87 above.

⁹¹ WHO Report on Violence, n. 61 above, at 220.

poverty, gender discrimination, lack of equal access to education, and other social and economic inequalities.⁹²

In this approach, physical and mental health are viewed as inextricably linked to the economic, political and social structures of society, expanding the definition of physical and mental health beyond mental disorders to consider general living conditions, such as poverty, environmental hazards like pollution and contaminated water, racism and discrimination, that cause physical and mental suffering. While this expansive definition of health can be found in earlier UN documents, the true implications of this interpretation have only begun to be explored.

Paul Farmer, medical doctor and long time health activist in countries like Haiti, Russia and Peru, argues that: ‘Right violations are ... symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm’.⁹³ Thus, in accordance with Farmer’s interpretation of the origins of violations of health and human rights, the remedy would be more than the provision of integral individual and communitarian attention and rather an overhaul of the entire social, economic and political conditions of a country in order to prevent future violations of the right to physical and mental health.

In fact, different investigators and commentators, including the Peruvian TRC, acknowledge that these conditions may very well be considered the catalyst to the political violence and internal armed conflict that generated serious and systematic human rights violations in Peru, and as we observe, the violations of the right to health and mental health.⁹⁴ Thus the means for protecting the right to physical and mental health include projects in institutional reform and development, such as poverty reduction, health programmes and education, among others.

Indeed, General Comment No. 14 clarifies that ‘the highest attainable standard of physical and mental health *is not confined to the right to health care*’, but rather embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.⁹⁵

Health and human rights pioneer Jonathan Mann reminded us that the WHO definition of physical and mental health moved beyond a limited, biomedical and pathology-based perspective to the more positive domain of ‘well-being’ with social dimensions.⁹⁶ In fact, the American Declaration of the Rights and Duties of Man, the inspiration to the general human rights movement, contains similar language in its Article XI which recognizes that the right to the preservation of health comes through sanitary and social measures relating to food, clothing, housing and medical care.⁹⁷

⁹² Hunt Report 2004, n. 64 above, para. 82.

⁹³ Paul Farmer, *Pathologies Of Power: Health, Human Rights, and the New War on the Poor* (California: University of California Press, 2003), at 7.

⁹⁴ Hatun Willakuy, n. 77 above, at 337 (translated by authors).

⁹⁵ General Comment No. 14, n. 9 above, at 4 (italics added).

⁹⁶ Mann, n. 22 above, at 6.

⁹⁷ Similarly, the important WHO and UNICEF Declaration of Alma-Ata, adopted at the International Conference on Primary Health Care in 1978, interpreted Article 12 of the ICESPR to encompass more than

Legal and political conditions are also considered as related to the right to physical and mental health. In particular General Comment No. 14 states:

The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.⁹⁸

Despite the original expansive view of health, articulated international policy has only begun to stress this broader vision of protecting the right to physical and mental health.

4. Expanding the Dialogue on the Right to Mental Health

As with other areas of human rights, the right to health is an ever-evolving concept that requires national and international players to constantly update and expand the interpretation of the contours of the right to physical and mental health. In fact, in its General Comment No. 14, the CESCR recognizes that:

Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. *A wider definition of health also takes into account such socially-related concerns as violence and armed conflict...*⁹⁹

The dynamic nature of this dialogue requires diverse participation, including the very victims intended to benefit, to assure the currency of mental health programmes.

The CESCR contemplates the inclusion of the community in 'all health-related decision-making at the community, national and international levels'.¹⁰⁰ Giving a voice to the direct beneficiaries of physical and mental health policy, as well as the conditions and factors that influence it, suggests a new shift in power relations and opens the door to a wider definition of physical and mental health not normally prioritized or included on the public agenda. In Peru, the Special Rapporteur suggested that civil society be involved in the development of national policy on mental health, including legislation, programmes and strategies.¹⁰¹

In post-conflict recovery, victims are key stakeholders in seeking justice and reparations and thus ensuring the political and legal recovery of nations. Yet they are often excluded from formulating policy that directly impacts their lives. As Dr Mollica points out:

Individuals from these communities have remained consistently absent from leadership positions in the international mental health movement, and therefore their expertise and views have been pushed to the

access and equitable distribution of health facilities, goods and services, but also called for the guarantee of minimum access to essential, nutritionally adequate food so as 'to guard against hunger, to ensure basic shelter, housing and sanitation, and an adequate supply of safe and potable water'. Available at: <http://www.paho.org/english/dd/pin/almaata25.htm>.

⁹⁸ General Comment No. 14, n. 9 above, para. 3.

⁹⁹ Ibid., para. 10 (italics added).

¹⁰⁰ Ibid., para 11.

¹⁰¹ Hunt, n. 27 above.

background of debates in which major participants are more likely representatives from international and non-governmental organizations (NGOs).¹⁰²

One paradox is that victims often need to be physically and mentally healthy to be active citizens in demanding their right to mental health, an observation the authors have made in Peru. The very *sequelae* of victims, if not treated appropriately, may undermine their political participation. Given that political violence, and the violation of human rights, aims to generate distrust and undermine the capacity of these individuals to exercise their rights, empowerment becomes a critical factor in the recuperation of victims, something only recently contemplated in mental health recovery programmes. Yet their increased participation will help shift power, as recommended by Dr Farmer, thus helping to eliminate cycles of violence and future human rights violations.

Most importantly, if engaged in this dialogue, survivors can better educate their governments, which in turn can help inform the international community of mental health effects of political violence and armed conflict. As one such project in Peru revealed: '[T]he participatory approach in design of the survey instrument recognized villagers as experts in their traumatic experiences and recovery'.¹⁰³ Following this example, reaching a consensus on best approaches to mental health for survivors of political violence and armed conflict is a more probable outcome. Hopefully, nations will then encounter more international financial and technical support for the arduous challenge of mental health programmes in post-conflict recovery.

5. Conclusion

In conclusion, the authors call upon the international and national communities to prioritize the issue of mental health among survivors in post-conflict recovery. This task may require more time and resources to study how political violence and armed conflict impact the right to physical and mental health and should not only consider the factors and conditions that lead to political violence and human rights violations in an effort to prevent their repetition, but also the most appropriate approaches to dealing with mental suffering in situations where prevention is not possible.

An immediate priority should be to educate policymakers on the unique needs of this particular population, perhaps through the opportunity recently presented by the UNCHR, which solicited suggestions and proposals for the enhancement of the international community's response to violence by strengthening prevention efforts at the national level and through international cooperation.¹⁰⁴ This call to action could be the first significant step towards widening the protection of the right to physical and mental health to include victims of political violence, armed conflict and human rights violations still residing in their communities of origin.

¹⁰² Mollica, n. 42 above.

¹⁰³ Snider, 81 above, at 397-8.

¹⁰⁴ CHR 2003, n. 10 above, para. 9-10.