UNIVERSIDADE DE BRASÍLIA
INSTITUTO DE RELAÇÕES INTERNACIONAIS

JÚLIA CAVALCANTE E SILVA

Between the biomedical model and deinstitutionalization: the "Comprehensive Mental Health Action Plan 2013-2030"

BRASÍLIA

2023

JÚLIA CAVALCANTE E SILVA

Between the biomedical model and deinstitutionalization: the "Comprehensive Mental Health Action Plan 2013-2030"

Trabalho de conclusão do curso de graduação de Relações Internacionais da Universidade de Brasília.

Orientador: Prof. Dr. Rodrigo Pires de Campos

BRASÍLIA

2023

JÚLIA CAVALCANTE E SILVA

Between the biomedical model and deinstitutionalization: the "Comprehensive Mental Health Action Plan 2013-2030"

Trabalho de conclusão do curso de graduação de Relações Internacionais da Universidade de Brasília.

Orientador: Prof. Dr. Rodrigo Pires de Campos

Brasília, __ de _____ de _____.

BANCA EXAMINADORA

____

Prof. Dr. Rodrigo Pires de Campos

____

Profa. Dra. Ana Flávia Barros-Platiau

____

Prof. Dr. Jonas Lotufo Brant

RESUMO

Pessoas com doenças mentais sofrem abusos todos os dias. Muitas vezes, esses abusos estão atrelados à institucionalização. Existem muitos trabalhos sobre o tema em relação a países, mas não em relação a organismos internacionais. Esta monografia tem como objetivo discutir institucionalização dentro da Organização Mundial da Saúde. Para fazer isso, será feito uma análise crítica e histórica do "Comprehensive Mental Health Action Plan 2013-2030". O argumento principal é que o plano está de acordo com aspectos do modelo biomédico e aspectos da desinstitucionalização (uma alternativa à institucionalização), o que o torna incoerente em parte.

Palavras-chave: Institucionalização. Organização Mundial da Saúde.

ABSTRACT

People with mental illnesses suffer abuses every day. Oftentimes, they are linked to institutionalization. There are many works on the subject in relation to countries, but not in relation to international organizations. This study aims to discuss institutionalization within the World Health Organization. To do this, a critical and historical analysis will be made of the “Comprehensive Mental Health Action Plan 2013-2030”. The main argument is that the plan is in accordance with aspects of the biomedical model and aspects of deinstitutionalization (an alternative to institutionalization), which makes it partly incoherent.

Keywords: Institutionalization. World Health Organization.

SUMMARY

1 INTRODUCTION....7
1.1 Method....10
1.2 Hypothesis....11
1.3 Structure....11
2 THE BIOMEDICAL MODEL AND DEINSTITUTIONALIZATION: TWO CONTENDING APPROACHES IN GLOBAL HEALTH and THE UN....12
2.1 The biomedical model....12
2.1.1 Institutionalization....14
2.1.1.1 Violation of the right to health....15
2.1.1.2 Violences of gender, race, and sexuality....16
2.2 Deinstitutionalization....17
2.3 Mental health inside the UN....19
3 THE “COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013-2030”....25
3.1 Proposing and approving the action plan within the WHO....25
3.1.1 The 130th Session of the WHO’s Executive Board and the 65th World Health Assembly: proposing the plan....25
3.1.2 Worldwide consultations, the 132th Session of the WHO’s Executive Board, and the 66th World Health Assembly: writing and approving the plan....29
3.2 Analyzing the document....31
4 FINAL CONSIDERATIONS AND FUTURE STUDIES....37
REFERENCES....39

1 INTRODUCTION

The idea that a drill through the skull and a stick through the eye would cure "psychiatric disorders" is brutal. Nonetheless, lobotomy was a widespread medical practice in the 20th century. Its creator even got a Nobel Prize for it (Levinson, 2011). Those "procedures" frequently occurred in places called asylums, also known as psychiatric hospitals. Despite lobotomy being now mostly banned, the type of hospitals where they occurred still exist and human rights violations are still happening to the humans admitted to those places. According to the World Health Organization (WHO), only 45% of WHO Member States answered positively to a self-evaluation survey that asked if they had a dedicated authority or independent body inspecting their countries' mental health facilities for human rights violations complaints (WHO, 2021a). That means that violations such as torture could be happening inside those care facilities and no one would even known about them.

Some countries have established oversight measures to prevent that those institutions that used to perform such surgeries continue to carry out other forms of violences. For example, in Brazil, a national inspection on therapeutic communities [1] resulted in a final report (first of its kind there) released to the public in 2018. The document presented the findings from 28 of those facilities. It reported social isolation, punishment from "misbehavior", and signs of torture in some of them (Brasil, 2018).

At the same time, non-governmental organizations (NGOs) have performed investigations both on nations that already have those oversight measures in place and nations that do not. A 2020 report by the NGO Human Rights Watch (HRW) titled "Living in Chains: Shackling of People with Psychosocial Disabilities Worldwide" compiled evidence of the "shackling" (chaining, tying or locking in a confined space) of people with mental health disorders around the world (HRW, 2020). They found proof that this type of human right violation occurred in at least 60 countries in Asia, Africa, Europe, the Middle East, and the Americas. Those people were deprived of hygiene, food, freedom to walk, and were subjects to torture, including the use of physical and sexual assault (HRW, 2020).

---

1 An umbrella term more commonly associated to a type of transitory residential care for people with substance use disorders (Brasil, 2018).

Shackling is a human right violation that can happen both inside mental health care facilities and outside it. The HRW (2020) addressed how, especially in countries where mental health information and services are not widely available, families might feel like restraining relatives is their only option to "control" their unwanted behaviors. Shackling practices are also examples of institutionalization. According to Basaglia (1981 apud Amarante, 1994), institutionalization goes beyond the commitment (voluntary or not) of a "mentally ill" person to an institution (such as an asylum[2], where lobotomies used to be performed). It is also all the damage caused by the institution itself. And by that he means the actual physical place as well as all the "institutional forces" of institutionalization, including Psychiatry as a scholar discipline, the people that work in those places, and even the idea of what is a "mentally ill" person (Basaglia, 1981 apud Amarante, 1994).

When the families of people with mental disorders see them as dangerous because that is also how the rest of society see their closed ones, they might feel compelled to lock their relatives in a separate space. In that way, the damage of the idea of what means being mentally ill was the shackling. Shackling, therefore, is a form of institutionalization (Basaglia, 1981 apud Amarante, 1994; HRW, 2020).

Despite the topic of institutionalization (and its alternative, deinstitutionalization) being discussed when related to States, there is a lack of studies on its connection to international organizations (IOs), especially the United Nations (UN). For example, when searching the Virtual Health Library (VHL) database for studies relating to the United Nations, only 1 article was found in the matter. The chosen terms were "institutionalization", "deinstitutionalization", and "united nations". They were organized in two searches. The first one was organized as: *"deinstitutionalization" AND "united nations".* There were 8 articles found. The abstracts were read and only 1 indicated a type of research regarding deinstitutionalization and its connection to the UN. The second one was organized as: *"institutionalization" AND "united nations"*. There were 20 articles found. The follow criteria was used: full text available (7 articles left). The abstracts were read and only 1 indicated a type of research on the topic, it was the same one found with the first search.

2 Unless otherwise explicitly mentioned, mental hospitals, psychiatric hospitals, and asylums will be used as synonyms.

In comparison, researches regarding institutionalization and deinstitutionalization when it came to countries were more common. The chosen terms were: "institutionalization", "deinstitutionalization", "countr*", "nation*", "state*", "mental health", and "mental health care". They were organized like this: *("institutionalization" OR "deinstitutionalization") AND (countr* OR nation* OR state*) AND ("mental health" OR "mental health care")*. There were 1978 articles found. Further criteria were applied, in that order: full text available (703 articles left), primary subject "deinstitutionalization" (131 articles left).

Considering the human right violations to people with mental illness because of institutionalization and in order to fill this gap in research, **the main objective of this study is to discuss institutionalization inside an IO, in this case, the World Health Organization (WHO).**

To be able to do that, a mental health action plan approved by the World Health Assembly (WHA) was chosen to be critically analyzed. The plan is called the "Comprehensive Mental Health Action Plan 2013-2030". It[3] offers this study a way to approach different fronts of the subject in one specific IO, including a presentation of past relevant documents approved within the scope of the WHA, the WHO, and the UN-system[4] as well as an analysis of the action plan itself.

The original "Comprehensive Mental Health Action Plan 2013-2020" was approved during the 66th WHA (2013). It was the first time in history the Organization proposed a widespread plan for mental health specifically[5]. In 2019, the plan was extended to

3 Global plans and strategies are not uncommon. Two of the most important international agendas created were the United Nations Millennium Development Goals (MDGs) and the United Nations Sustainable Development Goals (SDGs). Plans like those are important since they create a framework for how countries should move forward on a set of common objectives. Dissecting and analyzing those kind of plans are important for many reasons. One of them being the possible need to create better follow-ups plans, like the MDGs and SDGs or, for the WHO, the "2008-2013 action plan for the global strategy for the prevention and control of noncommunicable diseases" and its follow-up, the "Global action plan for the prevention and control of noncommunicable diseases 2013-2020". On SDGs, the SDG number 3, "To ensure healthy lives and promote well-being for all at all ages", includes a target mentioning mental health specifically. Target 3.4 envisions to "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being". Although mental health is only directly mention on that plan this time, it is a step forward in the right direction.

4 The WHA is the body of the WHO that makes decisions regarding its policies (WHO, 2020). The WHO, in turn, is part of the United Nations system. The UN-system is encompassed of UN "funds, programmes and specialized agencies" (UN, 2023).

5 In the past, the WHA has endorsed action plans in different areas of health, such as the "2008-2013 action plan for the global strategy for the prevention and control of noncommunicable diseases" and the "Global Plan of Action on Workers' Health for 2008-2017" (WHO, 2009; WHO, 2013a).

2030 and became the “Comprehensive Mental Health Action Plan 2013-2030” (WHO, 2023a).

Since its first release, the plan has received modifications. In 2021, a new version was endorsed by the 74th WHA. It gained revised indicators and options of implementation, while maintaining the same objectives as the original: (1) to strengthen effective leadership and governance for mental health; (2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; (3) to implement strategies for promotion and prevention in mental health; and (4) to strengthen information systems, evidence and research for mental health (WHO, 2021b).

Overall, the action plan is an important step in establishing mental health in the global health agenda. Not only because it is the first of its kind, but also because it was a combined effort from the UN, the WHO Member States, the civil society, and international partners (WHO, 2021b).

Even with the feeling of cooperation, the action plan is set in a context where the relevant actors might have different optimal goals. The UN (including its many agencies), the countries, the civil society, the international partners, all could have cooperated and still have visions that largely differ from one another. Because of it, the plan is bound to show those differences as well. And, with the “Comprehensive Mental Health Action Plan 2013-2030” specifically, two different visions seemed to be battling each other: the biomedical model (one of the models that tries to explain the relationship of health-disease) and deinstitutionalization (an alternative to institutionalization). The question “does the plan show influence from both the biomedical model and deinstitutionalization?” will guide this study in order to discuss institutionalization inside the WHO.

1.1 Method

In order to have this discussion of institutionalization inside the WHO, this study will critically and historically analyze the “Comprehensive Mental Health Action Plan 2013-2030”. It will use both primary sources, like UN resolutions, summary records from meetings, UN agencies reports, and State’s official documents as well as secondary sources, such as

books and articles on mental health. The texts, including the action plan, were read and analyzed using content analysis with focus on co-occurrences of themes, when two or more elements appear together. This is done in order to investigate relations between elements of the text. A computer software was not used but the method can still be called a content analysis. Minayo (2006, p. 304) mentions that content analysis “oscillated between an alleged objectivity of numbers and fecundity of subjectivity”. Also, Minayo (2006) points that mathematical models are forms to validate knowledge but intuition and look for meaning can never be overlooked. Her compilation of actions based on hermeneutics and dialectics are in line with this study. For example, the researcher must search historical documents but also use “empathy”, paying attention to culture and situation. Or, they must pretend to share the world being studied, asking “in what conditions?”.

1.2 Hypothesis

The main argument presented is that the “Comprehensive Mental Health Action Plan 2013-2030”, despite agreeing with major aspects of deinstitutionalization, is still embedded in the biomedical model.

1.3 Structure

This work is divided in four sections. The first section is the Introduction. The second one reviews current discussions on the biomedical model, deinstitutionalization, and the debate inside the UN. The third one discusses the processes of proposing and approving the plan as well as critically analyzes it. Last, final considerations are presented.

2 THE BIOMEDICAL MODEL AND DEINSTITUTIONALIZATION: TWO CONTENDING APPROACHES IN GLOBAL HEALTH AND THE UN

Stela do Patrocínio (1941-1992) was a Brazilian poet. She was a black domestic worker and, when she was 21, Stela was committed to an asylum. The place was called “Núcleo Psiquiátrico da Colônia Juliano Moreira” and was located in Rio de Janeiro (not so coincidentally, the asylum was build in a space that used to be a sugarcane farm, where slavery was the norm). According to the few registries left from her history, she supposedly had schizophrenia and a “psychopathic personality”. Having spent over 30 years institutionalized, she died of generalized infection after the amputation of her leg (MBR, 2023; Patrocínio, 2001; Zacharias, 2020).

Stories like the one above were common before the 21st century, and even now they still exist. Throughout history, society have came up with countless ways to strip people of their humanity. A lot of times, they did it with widespread support from the public, and even the law. One of the methods of this dehumanization that is particular relevant to the discussion posed in this study is the one discussed in the paragraph above: the institutionalization of people.

As mentioned in the Introduction section, institutionalization means more than just the act of committing a person to a specific facility (like an asylum). It is the damage caused within it, by it, and because of it (Amarante, 1994; Basaglia, 1981 apud Amarante, 1994; HRW, 2020). Institutionalization is closely related to the biomedical model and deinstitutionalization offers itself as a rupture to both of them.

This section aims to discuss the biomedical model as well as deinstitutionalization as contending approaches in global health, specifically in the UN. It is divided in three parts. The first one addresses the biomedical model. The second one presents an alternative to that way of thinking, discussing deinstitutionalization. The last one introduces how those ideas are visible within the UN-system.

2.1 The biomedical model

The biomedical model is a model of health-disease. Barros (2002) says that this model utilizes a mechanistic way of thinking (parts of a machine, organs of a human body), constant looks for a specific cause of a disease, and has a close connection to the logic of the market. It thrived with the Industrial Revolution, the rise of pharmaceutical companies, and their need for profits. One of the consequences of this model is the "medicalization" of conditions, that is, a lot of processes that could be socially explained started to need an immediate "cure" in the form of pills, which benefits the companies that sell them (Barros, 2002).

Moreover, this model is closely related to one of the many definitions of health: health as the absence of disease or, simply, non-disease[6]. According to Batistella (2007), this definition is perhaps the most dominant concept of health. The "explanatory power" (the easiness to explain) of it and its use by doctors, students, and medical researches are some of the reasons given by the author of why the idea of non-disease is so appealing (Batistella, 2007).

He explains that, centuries ago, disease went from being an element of the nature and sorted out in a classification system to being approached in a statics-manner, where the symptoms gained the spotlight. Alongside the progress of Anatomy as a scholar discipline, disease became the synonym of pathology and health, consequently, became the opposite of disease. In that way, health became the non-disease (Batistella, 2007).

Barros (2002) addresses that the idea of health as non-disease integrated well with the biomedical model because it matched the need of the biomedical model to find a specific cause to a disease.

Both the biomedical model and health as the absence of disease are concepts that receive a lot of criticisms. One of the main ones being how it offers little support to explain mental illness. The chronic aspect of those disorders, its subjectiveness, and multiple causes are some of the arguments presented (Barros, 2002; De Leonardis; Mauri; Rotelli, 1986).

6 On that matter, it does not go without notice that papers written in English prefer the term "disease-free" over "non-disease". This could go back to one of the first attempts to create a theory for health: the Boorse's negative concept of health. The use of the term "disease-free" might have be an attempt by new theories to distance themselves from Boorse's "negative" concept without actually giving up on the biomedical model. This study does not intend to go further into it but the reflection is worth pointing out.

Despite the difficulties to explain mental disorders with those models, there are attempts to do it in the hopes that it will reduce stigma surrounding the topic. By characterizing those disorders as “deficiency or excess of neurotransmitters”, or “chemical imbalances”, or “hormonal imbalances” affecting the brain (a biomedical approach), the problem became much closer to a “physical health disease” and there would be less stigma. However, there are researches that show that might not be the case[7] (Thachuk, 2011; UNHRC, 2017).

Similar arguments also propelled procedures like lobotomy. The very idea that the mental illness was caused by something in the brain showed a mechanistic way of thinking, a constant look for a specific cause of a disease as well as a unidimensional “chemical imbalance” argument (Levinson, 2011; Thachuk, 2011). Those are all features of the biomedical model (Barros, 2002).

However, lobotomy did not happen solely because of the biomedical model. There were different social questions that allowed for that brutality to happen. One of them being institutionalization, a central concept to this study that will be further discussed now.

2.1.1 Institutionalization

Basaglia (1981 apud Amarante, 1994) expressed his definition of institutionalization as not only the act of commitment (voluntary or not) of a “mentally ill” person to an institution (a psychiatric hospital), but also the damage caused by that same institution, when it is ruled by power disparity and coercion. From that, Amarante (1994) described institutionalization power, in the context of Basaglia’s work, as being the institutional forces in place that allowed the coerced reclusion of a “mentally ill” individual from the public space. For example, those forces can be the social imaginary of what constitutes madness. They can be Psychiatry itself as an academic discipline. They can be practitioners and their clinical work (Amarante, 1994; Basaglia, 1981 apud Amarante, 1994; HRW, 2020). In regards to those damages, also present in the form of human rights violations as well as violences in general, two will be commented further bellow.

7 For more on that, I recommend the article “Stigma and the politics of biomedical models of mental illness” by Thachuk (2011).

2.1.1.1 Violation of the right to health

As the widespread use of lobotomy in the 20th century, the report by the HRW on "shackling" practices in at least 60 countries worldwide, or the life of Stela do Patrocínio in an asylum demonstrate, violations of human rights to people with mental disorders were (and still are) carried everywhere.

It is worth taking a moment to discuss what is right to health. The WHO Constitution declares that the "highest attainable standard of health" is a fundamental human right. This is consistent with multiple international instruments on human rights, including Article 25 of the Universal Declaration of Human Rights, Article 11 of the American Declaration of the Rights and Duties of Man, and Article 16 of the African Charter on Human and Peoples' Rights.

Despite the right to health being reiterated in multiple declarations, such as the ones mentioned above, it was Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) that offered the international community a clearer understanding of what right to health entails as it provides examples of how to achieve it. The ICESCR was approved in 1966 and came into force in 1976. An even more in-depth description of right to health came 24 years later (in the year 2000) when the body that oversees the implementation of the ICESCR, the Committee on Economic, Social and Cultural Rights (CESCR) released the document "General Comment No. 14" on the right to the "highest attainable standard of health" (Backman et al., 2008; CESCR, 2000; OHCHR, 2023a).

In the document "General Comment No. 14", the CESCR (2000) discusses more in-depth the Article 12 of the ICESCR. They agree that, as result of socioeconomic factors, it might not be possible for the State party to ensure the "highest attainable standard of health". However, there are minimum core obligations such as:

> (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone; (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; (e) To ensure equitable distribution of all health facilities, goods and services; (f)

> To adopt and implement a national public health strategy and plan of action (CESCR, 2000, p. 13).

The comment also gives emphasis on social determinants of health[8] as well as the need to promote people's agency and autonomy (Backman et al., 2008; CESCR, 2000).

As discussed in the Introduction section, shackling is an example of institutionalization. When the family is a part of a society that sees mentally ill people as being dangerous, they might feel compelled to lock their relatives in a separate space. That is the social imaginary, the "institutional force" of institutionalization (Amarante, 1994; Basaglia, 1981 apud Amarante, 1994; HRW, 2020).

In a situation like the one presented above, it is possible that the person suffering from shackling will have to use the bathroom in the same place they sleep (core obligation "c" of Comment 14 unmet). In a country where information on the topic is not shared and the health system is unavailable, this could be common (core obligation "a" and "e" of Comment 14 unmet). Moreover, as the Brazilian 2017 Inspection shows, places such as therapeutic communities often have a punishment system that confiscates one of their patients' meals if they misbehave (core obligation "b" of Comment 14 unmet) (Brasil, 2018; CESCR, 2000; HRW, 2020).

2.1.1.2 Violences of gender, race, and sexuality

Another type of violence can also be perpetuated with institutionalization. Reflecting back to lobotomy, the social imaginary of what constitutes madness also plays a role in it. Even before the procedure, the person had to be labeled as "being mad", or having a "condition", or having a "mental disorder" in order to enter the system that would allow them to be "cured". A system that would allow the lobotomy to be performed (Amarante, 1994; Basaglia, 1981 apud Amarante, 1994).

Notice that the labeling was not social neutral, as there seemed to be a pattern. On that, Passos (2020), while calling the asylum "one of the most perverse forms of control and extermination existing in society" (p. 125, translation by the author), adds:

---

8 According to the WHO (2023b), social determinants of health "are the non-medical factors that influence health outcomes [...] include economic policies and systems, development agendas, social norms, social policies and political systems."

> In the name of order, moral, good manners [as in morality], social cleansing, patriarchy, racism, etc., multiple women, children, teenagers, and men that were considered deviants, anormal, sick, and insane by psychiatry […] were institutionalized (Passos, 2020, p. 125, translation by the author).

Passos (2020) mentions the works of Frantz Fanon, a black psychiatrist born in Martinique, a department of the French West Indies, and post-colonial scholar. He lead a mental hospital in Blida, Algeria, but resigned exposing the place as an instrument of the colonialism, where control and dehumanization were the norm. She also addresses the investigations by Daniela Arbex, a Brazilian journalist, that showed that the dead bodies of the ones institutionalized in an asylum known for committing gays, women, and homeless people in Brazil were sold to colleges of medicine for research (Arbex, 2013; Faustino, 2018; Passos, 2020). It is possible to see that institutionalization has a gender, race, and sexuality aspect attached to it.

The need to have a "normal" allowed places like asylums to exist, despite the violences happening there. When Amarante (1994) comments on one of the definitions of mental illness, he adds:

> the institutional aspect of mental illness, constructed from the denial of subjectivity, of identities, of the extreme objectification of a person. All this denial and objectification are constructed from the notions of dangerousness, irrecoverability and incomprehensibility of mental illness. In other words: different people, with different histories, cultures, sufferings, enter the psychiatric institution straight into a homologation process (Amarante, 1994, p. 67-68).

2.2 Deinstitutionalization

An alternative to institutionalization is deinstitutionalization. It implies more than just the dehospitalization of the "mentally ill" but also the rupture of the systems, including the institutional forces mentioned before, that supported the hospitalization in the first place (Rotelli, 2001). With regards to this, the political apparatus must be highlighted because, as mentioned previously, since the creation of mental hospitals, they have been used as a place to confine the poor, the women, the black, and the gay. Those hospitals served as tool by the politicians to hide the deviant and control the "dangerous outcasts" (Passos, 2020).

The Italian experience is also important in this context. De Leonardis, Mauri, and Rotelli (1986) provide a deeper understanding on how the Italian reform worked and what

deinstitutionalization meant there, while also addressing the differences between the reforms in Italy and other parts of the world (the rest of Europe and the United States specifically). According to them, the use of the word "deinstitutionalization" served different actors in different ways. In some places, deinstitutionalization became synonym to dehospitalization. Mainly, a way of cutting expenses that, under the name of a social reform, benefited the neoliberal and conservatives of the last half of the 20th century. Additionally, the authors mentioned that a bigger movement of "radicals" used the word to present their project of abolishment of all institutions that controlled society (De Leonardis; Mauri; Rotelli, 1986).

Leonardis, Mauri, and Rotelli (1986) explained that, in Italy, deinstitutionalization became the confrontation of the paradigm that was Psychiatry and its object, mental illness. According to them, Psychiatry treated its therapies similarly to how Medicine treated medication: there was a problem (illness or mental illness) and a clear solution (therapies). The result was a healthy individual, a 'normal" one. However, as the authors explained, given the chronic aspect of mental illness and, at the time, its undetermined causes, this model (based on the biomedical model) did not work. Since mental hospitals were a representation of Psychiatry, the failed model was there as well. De Leonardis, Mauri, and Rotelli (1986) suggested that the Italian deinstitutionalization took form in this reflection. For it to work, Psychiatry would need to abandon the idea of the perfect result (in the case of a mentally ill person, it meant a "normal" person); and concede that, in order to modify the sufferings of the individuals inside the mental hospital, they would need to modify the place itself (De Leonardis; Mauri; Rotelli, 1986).

The ideas of deinstitutionalization were also present in the psychiatry reform in Brazil. The Brazilian experience began around the 1960s and 1970s with a movement by mental health care workers against the prevalence of hospital-based approaches as well as "bad working conditions and treatment" (Borges; Baptista, 2008). According to Amarante and Nunes (2018), in 1987, with influence from the works of the Italians Franco Basaglia, Franca Basaglia, and Franco Rotelli, the movement transformed into a deinstitutionalization one. Amarante and Nunes (2018) emphasized the criticism of the biomedical model, the strong presence of the organized civil society and the cultural aspect of the movement. They said that, since deinstitutionalization also encompassed letting go of the cultural idea of what madness is, the movement also needed to be a cultural one (Amarante; Nunes, 2018).

Moreover, Amarante and Nunes (2018) discussed that the psychiatry reform in Brazil was happening in the context of an overall sanitary reform. According to them, the creation of a universal health system in the country gave the foundations for experiences on community-based approaches for mental health in some cities in Brazil. It was created public centres for psychosocial care that served as an alternative to hospital-only approaches. They were able to provide intensive care for people with mental illness without the need for in-patient care. It served as a way of deinstitutionalization in the country, going beyond dehospitalization since it was part of a bigger social movement. The positive response of the centres pushed for even more initiatives from the government, including a system of evaluation of hospital care in order to prevent human rights violations in those places from happening. A law project that defined the progressive end of psychiatric hospitals was proposed in 1989. In the end, the law was approved with modifications that did not establish this progressive end but put in place protections to mentally ill people in regards to the topic (Amarante; Nunes, 2018; Brasil, 2001).

2.3 Mental health inside the UN

The discussions presented in 2.1 and 2.2 are also occurring within the UN, especially in the WHO and the United Nations Human Rights Council (UNHRC). This subsection is dedicated to addressing that.

The WHO Constitution's definition of health is present in various documents, sometimes explicitly, sometimes implicitly. It could be useful to think of a person and their set of beliefs. Even when the beliefs are not the main topic of a debate, they come up in the logic behind the arguments of the person. The next phrase expresses it better: "Defining general terms is not an abstract exercise but a way of shaping the world metaphysically and structuring the world politically" (Callahan, 1973, p. 78).

According to the WHO Constitution, "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2020, p. 1). This definition has gained criticisms over the decades. Saracci (1997) pondered that the definition was too close to the definition of happiness (if that even can be attained) and lacked practicality. His solution, though, was to combine the idea of absence of disease and one that explicit health as a fundamental human right (Saracci, 1997).

Callahan (1973) also delved into the topic. According to him, there are some "evils" that come with trying to define health the way the WHO did. One of them being the consequences: the idea that all social problems could be seen as health problems, and, therefore, the responsibility of medical professions and political professions could become entangled. He goes on to mention the historical context of the WHO's definition and how it reverts back to the creation of the WHO itself, when there was a notion that health was a condition to peace (Callahan, 1973).

Additionally, the author addressed an important progress made by the WHO Constitution's definition: it tried to attach mental health to the idea of health. He mentions a speech made by Dr. Brock Chisholm, the first director-general of the WHO, during one of the preparatory meetings to the creation of the organism (Callahan, 1973). The transcript bellow of that same speech was copied from a book by John Farley (2008) called "Brock Chisholm, the World Health Organization, and the Cold War":

> The world was sick, and the ills from which it was suffering were mainly due to the perversion of man, his inability to live with himself. The microbe was no longer the main enemy; science was sufficiently advanced to be able to cope admirably with it, if it were not [for] such barriers as superstition, ignorance, religious intolerance, misery, and poverty. It was in man himself, therefore, that the cause of present evils should be sought; and these psychological evils must be understood in order that a remedy might be prescribed (Farley, 2008, p. 17).

Despite the fact that, for Callahan (1973), this speech summarized what came to be the notion that health could mean almost anything, it also represented a connection between health and mental health, through mental illness (showing that the non-disease definition of health also applied to mental health). When evoking the "prescription" of remedies for the "perversions of men" and "psychological evils", Dr. Chisholm was talking about mental illness. The medicalization aspect of the biomedical model is seem when Chisholm mentions a cure in those "remedies".

In any way, even if, in the final document, the WHO Constitution's definition of health might have added the "not merely the absence of disease or infirmity", the idea of non-disease and medicalization was still there, from the records of the creation of the organization (Barros, 2002; Callahan, 1973). It shows how influential the biomedical model was to the foundations of the organization.

Still on the topic of mental health, according to Callahan (1973), it was also during the time leading up to the 1946 Technical Preparatory Committee[9] that the Great Britain released a memorandum saying that “it should be clear that health includes mental health” (Callahan, 1973, p. 79). It is an interesting wording, since the slogan “there is no health without mental health” would be extensively used decades later when the WHO started to consistently release documents regarding the mental health of the world population.

Notwithstanding the WHO Constitution’s definition of health and the creation of the organization itself having been influenced by the biomedical model, it is worth mentioning that the UN’s position is far from being unidimensional. There are many voices inside the IO and their agencies.

In 1991, the United Nations General Assembly (UNGA) adopted Resolution 46/119 on the protection of persons with mental illness and the improvement of mental health care. The document endorsed the principles in which this protection and improvement should happen. In general lines, it establishes that a person with mental illness has the right to all fundamental freedoms and rights, including civil and political. Also, it suggested (the UNGA resolutions are not legally binding to the State Parties) that the mentally ill person should not be treated without consent except in extraordinary circumstances addressed in the document (UNGA, 1991).

In 1996, the WHO, the World Bank, and the Harvard School of Public Health published a study in a series of books titled “The Global Burden of Disease and Injury Series”. The main goal of it was to provide an assessment on disability and mortality of diseases in the world in 1990, alongside projections for 2020 (Murray; Lopez, 1996; UNHRC, 2017). In it, “burden of disease” was conceptualized as a way to measure the health status of a population and its effects. It combined the impact of premature death and disability. Disability was then set as a value based on the “years lived with a disability”. The idea of “burden” is there because it was thought that, in a population affected with a “high burden”, the economy of their country would be affected. The idea showed up frequently in later UN documents (Murray; Lopez, 1996; UNHRC, 2017).

9 The 1946 Technical Preparatory Committee created proposals for the WHO Constitution and submitted them to the 1946 International Health Conference, where they were considered, until a final version was adopted (WHO, 2023c).

Five years later, the widespread launch of mental health in the health agenda occurred during the 54th World Health Assembly in Geneva. There, ministerial round tables on the theme were held on May 15th, 2001. The connection of mental health to health and their relation to development was addressed during the meeting. Professor Ahyi from Benin emphasized a notion that was being constantly repeated during the round tables: there is no development without health and no health without mental health. Additionally, the idea of "burden of disease" was present, with one of the background documents (A54/DIV/4) discussing numbers for the burden of mental disorders in 1999 and projections to 2020, alongside the economic impact of those disorders. Last, the Report by the Secretariat on the round tables (A54/DIV/8) highlighted from the meetings the need to shift from specialized care to community-based care, indicating the importance to integrate mental health services to primary health care (WHA, 2001a; WHA 2001b; WHA, 2001c; WHA, 2001d).

On that same year (2001), the theme of the World Health Report, titled "New Understanding, New Hope", was mental health. The document discussed "[...] the current and future burden of all these disorders […] the effectiveness of prevention [...] the availability of [...] treatment [...] service provision and service planning. And […] policies" (WHO, 2001, p. x). The report constantly mentioned the burden of disease caused by mental disorders, also addressing the economic costs to society of those disorders.

In 2001, the World Health Day was focused on reducing stigma on mental health and mental health disorders (WHO EMRO, 2023a). With the round tables in the WHA, the World Health Report and the World Health Day all surrounding the theme of mental health, it is clear that the beginning of the 21st century marked the launch of the topic in the global health agenda.

In 2006, the Convention on the Rights of Persons with Disabilities was adopted by the General Assembly. The resolution emphasized the need to ensure human rights and freedoms to persons with disabilities, that is, "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" (UNGA, 2006, p. 4). It includes the principles of non-discrimination, respect, full participation in society, and

accessibility. The Convention also stipulates that persons with disabilities should not be subjected to involuntary treatment and torture (UNGA, 2006).

The WHO launched the Mental health gap action programme (mhGAP) in 2008. It focused on “scaling up services for mental, neurological and substance use disorders for countries especially with low- and middle-income” (WHO, 2023d). The gap referred in the name is the gap between the need for treatment and the resources available. The mhGAP has created manuals and guides, for example the “mhGAP humanitarian intervention guide (2015)” in partnership with the United Nations Office of the High Commissioner for Refugees (UNHCR), also known as the UN Refugee Agency (WHO EMRO, 2023b; WHO, 2023d).

Despite those resolutions and initiatives, the WHO only formally considered an action plan on the topic of mental health in 2012. It culminated in the “Comprehensive Mental Health Action Plan 2013-2020”. It will be discussed in-depth in a separate section.

One of the most prominent voices on the topic of institutionalization inside the UN is Dainius Pūras, who served as the Special Rapporteur (SR) on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health from 2014 to 2020. A Special Rapporteur is part of the special procedures of the UNHRC. They are independent human rights experts that “advise on human rights from a thematic or country-specific perspective” (OHCHR, 2023b). The annual reports during his mandate are very critical of the biomedical model and its implication on human rights.

In the 2017’s Report of the SR on the right to mental health (A/HRC/35/21), presented during the 35th session of the UNHRC, the SR proposed a series of recommendations for stakeholders regarding a human-rights based approach to mental health systems. The SR also discussed the obstacles for it. Some of them are in line to this current study and will be reviewed bellow (UNHRC, 2017).

First, the SR criticizes the use of the term “burden of diseases” in multiple UN documents and global studies. As previously mentioned, it is usually associated to the idea that a country with a “high burden of disease” would suffer economically (Murray; Lopez, 1996; UNHRC, 2017).

Secondly, the SR arguments that the "burden of disease" is a perspective that comes from the predominance of the biomedical model. He calls for a paradigm shift and proposes that, instead of focusing on the "burden of disease", the stakeholders should be focusing on the "global burden of obstacles", an idea he discussed further in the document. Those obstacles are the ones preventing the health systems from changing into a more rights-based system and away from the biomedical model (UNHRC, 2017).

Last, the SR explains those three obstacles. Here, discussing the first one is sufficient. The first obstacle to establishing a more human rights-based mental health system being the dominance of the biomedical model itself. The SR mentions that, in the hope to eliminate stigma, mental health begun to be explained more closely to health. However, the concept of health used was health as the absence of disease (based on the biomedical model). For mental health, that meant the lack of some sort of "chemical imbalance" that caused a mental disease. A healthy person would not have that imbalance. As mentioned before, De Leonardis, Mauri, and Rotelli (1986) also delved into the matter and argued that the chronic aspect of mental illness invalidated the use of this model when talking about mental health or mental illness. Additionally, the SR noted that the mental health field is extremely over-medicalized and powerful actors, such as the pharmaceutical industry, dominates it (De Leonardis; Mauri; Rotelli, 1986; UNHRC, 2017).

This section provided an introduction to the topics of the biomedical model, institutionalization, right to health, deinstitutionalization as well UN perspectives on mental health in general. Many ideas regarding those concepts, alongside some of the documents mentioned here, will me addressed in the analysis of the "Comprehensive Mental Health Action Plan 2013-2030".

3 THE "COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013-2030"

3.1 Proposing and approving the action plan within the WHO

Before talking about the "Comprehensive Mental Health Action Plan 2013-2030", it is worth mentioning the meetings and documents that directly preceded the approval of the plan. An action plan like the one this study focuses on does not come together overnight. More than just those prior documents themselves, there are a multitude of actors, contexts, and ideas involved in the past, present, and future of the plan. In this section, some of those past events preceding the action plan will be presented.

3.1.1 The 130th Session of the WHO's Executive Board and the 65th World Health Assembly: proposing the plan

During the 130th Session of the WHO's Executive Board, in January 2012, a draft resolution sponsored by India and cosponsored by Switzerland and the United States of America was considered. The document addressed the "Global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at the country level" (WHO, 2012a).

The main focus of the draft resolution is to request to the WHO Director-General the creation of a comprehensive mental health action plan. The future plan should: include a human rights perspective; address that mental health care needs to exist at all levels of health care[10]; as well as empower and take into consideration the participation of people with mental disorders. In correlation with past reports by the WHO, the draft resolution placed huge emphasis on the burden of mental disorders and the economic cost of that burden (WHO, 2012b).

The draft resolution was then discussed during the second, fourth, and eighth meeting of the 130th Executive Board session. During the third meeting, multiple countries (for example, Somalia, Mexico, and Brazil) spoke positively in regards to the human rights perspective addressed in the draft resolution. It was the position most of the countries agreed (WHO, 2012a).

10 As in primary care, seconday care, and terciary care.

Norway expressed that the social determinants of health should be included in the draft resolution. Moreover, the representative of the country voiced that pharmacological treatments for mental disorders should be done in conjunction with other type of treatments, such as the ones focusing on creating coping skills and resilience (WHO, 2012a).

Chile and Canada discussed the need to include different sectors when creating strategies for mental health, such as different public sectors. Additionally, Seychelles (speaking on behalf of the Member States of the African Region) brought attention to the exclusion of mental disorders from the global health agenda (WHO, 2012a).

Some countries, like Seychelles/Member States of the African Region, Mexico, Brazil, Thailand, and Indonesia conveyed the importance of community-based approaches to mental health. The International Council of Nurses and the World Federation for Mental Health, both invited by the Chairman of the meeting to speak, reinforced this need to address mental health in community settings, including primary health care (WHO, 2012a).

The United States of America requested that mental, neurological, and substance use disorders were grouped together in future reports by the Secretariat. That point in particular was brought up again at the end of the third meeting, when the Executive Board were discussing the scope of the future plan. It was decided that the scope should directly address mental disorders. Nevertheless, a mention to neurological and substance use disorders was maintained in the approved Executive Board resolution EB130.R8 (WHO, 2012a; WHO, 2012b).

In March 2012, a report by the Secretariat on the "Global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at the country level" (A65/10) was presented as part of the documents to be examined during the 65th World Health Assembly, to be held in Geneva from the 21st to the 26th of May, 2012. The report included some background context on the topic of mental health and one action to be considered by the WHA: approve the Executive Board resolution EB130.R8 (WHA, 2012a).

Some takeaways from the 65/10 report are: (i) how humanitarian emergencies could pose as a risk factor for mental health problems; (ii) the emphasis in the lost economic output of the burden of mental health conditions; and (iii) the differences between civil society movements related to mental health in low, middle, and high income countries (WHA, 2012a).

Additionally, the report refers to the "WHO's Mental Health Atlas 2011" and addresses that, according to data up to the time of writing the Atlas, 67% of the countries' financial resources allocated for mental health go to mental hospitals "despite their being associated with poor health outcomes and human rights violations" (WHO, 2012, p. 2). It also proposes community-centered care as an alternative (WHO, 2011; WHA, 2012a).

The report also addresses human rights violations to people with mental health conditions by saying that:

> In addition to restrictions on the right to work and to education, they may also be subject to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, and harmful and degrading treatment practices in health facilities. They are often denied civil and political rights (such as the right to marry and found a family), rights of citizenship, and the right to vote and to participate effectively and fully in public life (WHA, 2012a, p. 2).

Furthermore, the report presents activities made by the WHO Secretariat on the topic of mental health. They include its role in "strengthen mental health-care systems in Member States" (WHA, 2012a, p. 6). In the topic of institutionalization, it said the Secretariat works with Member States in order to deinstitutionalize their mental health care (WHA, 2012a).

During the third meeting of Committee A (May, 22nd) of the 65th WHA, the A65/10 report was discussed. Once again, a lot speeches made by representatives of countries gave focus to the "burden" aspect of mental disorders. India (sponsor of the resolution), USA (cosponsor), China, and the Russian Federation were some of the States that emphasized this perspective (WHA, 2012b).

Meanwhile, Argentina spoke about their approach to mental health as being based on social determinants of health, echoing a position made by Norway during the Executive Board meetings that preceded the 65th WHA.

Countries such as Ethiopia and Denmark (speaking on behalf of the Member States of the European Union, Croatia, North Macedonia, Montenegro, Iceland, Serbia, Bosnia and Herzegovina, Albania and Armenia) placed focus on community-based approaches to mental health and the need to treatments to be carried in the "least restrictive environment possible". Ethiopia specifically mentioned the integration of mental health in primary care, a position that was endorsed by a representative from the International Council of Nurses. The International Council of Nurses' position was similar to the one they took during the 130th Session of WHO's Executive Board (WHA, 2012b).

After the discussions, the draft resolution was transmitted from the committee meetings to the plenary meetings in the form of the "First report of Committee A". During the Health Assembly's tenth plenary meeting, the report was approved and the draft resolution became resolution WHA65.4.

During the proposal of the plan, it is possible to notice that the most agreeable principle is that of the guarantee of fundamental human rights to the person with a mental disorder. This aligns the future plan with the WHO's Constitution, the International Covenant on Economic, Social and Cultural Rights, the Universal Declaration of Human Rights, and the Convention on the Rights of Persons with Disabilities.

The idea that there is a "burden" of mental disorders is also apparent. It is worth adding that the main report discussed and the draft resolution are both named after that "burden" (India, Switzerland and the United States being the sponsors) so it could be a reason to why the expression (as mentioned in 2.3, it gained force after a study made by the WHO, the World Bank, and the Harvard School of Public Health) became such a repeated discourse during the meetings. Nonetheless, an approach to health that values the logic of the market is, as seem in 2.1, consistent to the biomedical model. And that model is dominant so the constant mention to the "burden" could be due to that as well.

Moreover, it is also noticeable that many countries value the integration of mental heath in primary healthcare as well as community-based approaches to healthcare (one of the principles of primary care) (Brasil, 2023). That, along with saying that treatment should be

carried in the "least restrictive environment possible", are ways in which a deinstitutionalization perspective is seem in some speeches.

3.1.2 Worldwide consultations, the 132th Session of the WHO's Executive Board, and the 66th World Health Assembly: writing and approving the plan

Now that resolution WHA65.4 is approved, the remaining of 2012 and the beginning of 2013 were used to write a draft of the action plan and carry multiple consultations on it. According to the document EB132/8, presented in the 132nd Session of the WHO's Executive Board (held in Geneva through the 21st to the 29th of January 2013), consultations were held in five regional meetings, through the web, during the Global Forum on Mental Health, as well as informal consultation with WHO Member States. The EB132/8 summarized that "Feedback was received from 134 Member States, 60 WHO collaborating centres and academic centres, 76 nongovernmental organizations, as well as 13 other organizations and individual experts" (WHO, 2013b, p.1).

After the consultations, the draft of the action plan was considered by the Executive Board during its 132nd session. Throughout the third meeting of the session, representatives expressed their countries vision on it, adding suggestions. Once again, there were multiple mentions of the burden of mental disorders and its "economic consequences". Countries such as Qatar and China reaffirmed the "principle" of "no health without mental health" (WHO, 2013c).

Many speeches addressed the need to integrate mental health care in community-based settings and primary care. Cuba, Senegal (speaking on behalf of the Member States of the African Region), Iran, Lithuania (speaking on behalf of the European Union, Croatia, North Macedonia, Montenegro, Iceland, Serbia, Bosnia and Herzegovina, Armenia, Georgia, and Norway), Timor-Leste, and Croatia were some of the countries that agreed with that perspective. The later, specifically, mentioned "the need to shift mental health care from large specialized institutions to community-based public health institutions" (WHO, 2013c, p. 32).

Additionally, Senegal (speaking on behalf of the Member States of the African Region) "asked why there were no objectives in the draft action plan specific to health-system

strengthening, a prerequisite for many of the proposed actions" (WHO, 2013c, p. 29). Other countries did not react in their speeches in regards specific to that question. However, the Assistant Director-General Dr. Chestnov assured that the final draft would take that factor into consideration. It is worth sharing that Senegal/the Member States of the African Region addressed the importance of the empowerment of people with mental disorders and their families (WHO, 2013c).

Moreover, the multisectoral approach was praised by many representatives, such as the ones from Ecuador, Senegal (speaking on behalf of the Member States of the African Region), Lithuania (speaking on behalf of the European Union, Croatia, North Macedonia, Montenegro, Iceland, Serbia, Bosnia and Herzegovina, Armenia, Georgia, and Norway), Oman, and Morocco. Lebanon and Mongolia mentioned the educational sector and school-based mental programmes, respectively (WHO, 2013c)

The United States of America, alongside Mexico, Canada, and Australia showed concerns regarding the indicators and targets of the plan. USA proposed web technical consultation on that matter, which was approved by the Board and carried during February of 2013 (WHA, 2013a).

From the 20th to the 27th of May, 2013, the 66th World Health Assembly was held in Geneva. Committee A of the Assembly was responsible for discussing the draft action plan along with a report on it (A66/10 Rev.1) and transmitting it to the consideration of the Health Assembly. The exchanges of the Committee on the topic happened during the fourth and eighth meeting (WHA, 2013a).

The commentaries made by the participants of Committee A were similar to the ones presented during the 132nd Session of the WHO's Executive Board. Topics about the integration of mental health in primary care, the empowerment of people with mental disorders, and the multisectoral approach to the plan were common (WHA, 2013a).

On the topic of primary care, the representative of Indonesia pointed out that "Countries also needed to strengthen community-based mental health services before reducing the number of hospital beds available" (WHA, 2013a, p. 52). Additionally, Brazil affirmed that it has "A political commitment to primary health care, support for community

and family networks, and respect for human rights, produced much better results than the traditional psychiatric approach used in institutions" (WHA, 2013a, p. 56).

After the discussions, the "Comprehensive Mental Health Action Plan 2013-2020" was submitted to the Health Assembly and approved as resolution WHA66.10. Its most updated version, the "Comprehensive Mental Health Action Plan 2013-2030" will be analyzed next.

3.2 Analyzing the document

The most recent edition of the "Comprehensive Mental Health Action Plan 2013-2030" was released in 2021, endorsed by the 74th WHA. It is divided in seven parts: (a) Foreword; (b) Setting the scene; (c) Overview of the global situation; (d) Structure of the Comprehensive Mental Health Action Plan 2013–2030; (e) Proposed actions for Member States and international and national partners and actions for the Secretariat; (f) Annex 1: Indicators for measuring progress towards defined targets of the Comprehensive Mental Health Action Plan 2013–2030; (g) Annex 2: Options for the implementation of the Comprehensive Mental Health (WHO, 2021b; WHO, 2023a).

It has four objectives, the same ones as the original: (1) to strengthen effective leadership and governance for mental health; (2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; (3) to implement strategies for promotion and prevention in mental health; (4) to strengthen information systems, evidence and research for mental health. The objectives are followed by global targets. Annex 1 addresses indicators for each target and Annex 2 offers various options for implementation of the actions. In relation to the "2013-2020" version, the 2021 update proposed new indicators and options of implementation (WHO, 2021b; WHO, 2023a).

Additionally, the document presents as its principles the following: (a) universal health coverage; (b) human rights; (c) evidence-based practice; (d) life-course approach; (e) multisectoral approach; (f) empowerment of persons with mental disorders and psychosocial disabilities. They are cross-cutting throughout the plan.

One of the concepts presented in the plan is the definition of mental health. Its is "conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2021b, p.1). Moreover, the Action Plan mentions the "the globally accepted principle that there is 'no health without mental health'" (WHO, 2021b, p.1). The concept of "burden of disease" is also present throughout the text. For instance, when addressing the lost economic output to the countries because of mental disorders (WHO, 2021b).

Most importantly, the "Comprehensive Mental Health Action Plan 2013-2030" balances itself on two ideas: deinstitutionalization and the biomedical model. It agrees with some aspects of deinstitutionalization but it still is embedded in the biomedical model. This can be seem explicitly in the text and throughout the process of approving and writing the action plan.

The objectives and principles are mainly taken from the resolutions and meetings that preceded the adoption of the plan. For example, the Objective 2 of the action plan, "to provide comprehensive, integrated and responsive mental health and social care services in community-based settings", echoes multiple comments during the 130th Session of the WHO's Executive Board, the 65th World Health Assembly, the 132nd Session of the WHO's Executive Board, and the 66th World Health Assembly. Some of the countries that discussed the integration of mental health care in community settings during the Assemblies and Sessions were: Seychelles and Senegal (speaking on behalf of the Member States of the African Region), Mexico, Brazil, Thailand, Indonesia, Cuba, Iran, Ethiopia, Denmark and Lithuania (speaking on behalf of the European Union), Croatia, North Macedonia, Montenegro, Iceland, Serbia, Bosnia and Herzegovina, Albania, Armenia, Georgia, Norway, and Timor-Leste. It is worth mentioning that bringing healthcare to community-settings is one of the backbones of primary healthcare (Brasil, 2023). As mentioned in 3.1, some countries, during the meetings, even mention primary care specifically when speaking about the community aspect.

Moreover, the Objective 3, "to implement strategies for promotion and prevention in mental health", also relates to community-based settings. Promotion and prevention are some of the most important strategies of primary care, and this type of care is heavily based on the community (Brasil, 2023). Additionally, both Objectives 2 and 3 are recommendations similar

to the propositions made by the SR in the A/HRC/35/21 report, published in 2017 and discussed in 2.3.

As the Brazilian experience with deinstitutionalization shows (see section 2.2), community-based approaches to mental health care can be one of the forms of deinstitutionalization. The idea to bring the person with mental illness to the community, away from asylums. Since the plan, especially in Objective 2 and 3, shows this preference, a link between deinstitutionalization and the plan is observable.

Another reason for Objective 2 and 3 to be in the Action Plan is the A65/10 report by the Secretariat, discussed during the 65th WHA. It addressed that the majority of the financial resources related to mental health goes to mental hospitals "despite their being associated with poor health outcomes and human rights violations" (WHA, 2012a, p. 2). That report referred to the WHO's Mental health atlas 2011 (WHO, 2011). A more updated version of that dcoument, the WHO's Mental Health Atlas 2020, said that 41% of countries that responded to the related question allocated more than 60% of their mental health expenditure to mental health hospitals, which excludes community-based psychiatric inpatient units, facilities treating only people with alcohol and substance abuse or only people with intellectual disability, psychiatric units in general hospitals, and mental health community residential facilities (WHO, 2021a). This expresses how this form of institutionalization is very common.

The Action Plan itself also explicitly addresses deinstitutionalization by advising the Secretariat to "Provide guidance and evidence-based for deinstitutionalization and service reorganization" (WHO, 2021b, p. 11). This goes in hand to the same A65/10 report discussed above. As mentioned in section 3.1.1, the report spoke on the help to Member States the Secretariat did in "deinstitutionalizing their mental health care" (WHA, 2012a, p. 6). This is the only mention of the word "deinstitutionalize" (in this case, in the form of "deinstitutionalization") on the plan.

Regarding the six-cross cutting principles, the human rights principle was the most prominent during the meetings and resolutions before the approval of the plan (see 3.1.1 and 3.1.2) and is very present on the action plan. For instance, proposed actions for Member States for Objective 1 include the development and strengthening of policies as well as law on

mental health that are in accordance to international and regional human rights instruments (WHO, 2021b).

Moreover, the empowerment of people with mental disorders and psychosocial disabilities is a principle that has appeared during the meetings. It is also one of the three initial propositions of the plan, when it was first introduced to the 130th Session of the WHO's Executive Board by India, Switzerland, and the USA. The other two being the need to include mental health care in all levels of healthcare and a human rights perspective.

The principles of "human rights" and "empowerment of persons with mental disorders and psychosocial disabilities" are in line with deinstitutionalization. As seem in section 2, bringing a mentally ill person away from psychiatric hospitals and to the community, away from human rights violations to an environment that supports their decisions and agency are central to deinstitutionalization. The plan shows supports to deinstitutionalization when it adheres to those principles.

Additionally, the multisectoral approach was constantly mentioned during the speeches made by representatives of the countries during the meetings and it is seem in the plan. The very structure of how the plan is organized show it. It presents an objective and follows-up with proposed action for States, international and national partners, as well as the Secretariat. In that way, the objectives are broken down by activities that could be done by different sectors of the society. During the meetings, it was mentioned how school-based programmes for mental health were positive and that is also seem on the plan in its annex on options for implementation of the objectives. Deinstitutionalization shows how important is to connect the topic of mental disorders with the society, since it should be a cultural and social rupture as well (see 2.2). The multisectoral approach can allow it to happen.

However, the process of proposing and approving the plan, alongside some repeated slogans on the writing of the action plan itself shows how it still is influenced by the biomedical model. As seen in 3.1.1 and 3.1.2, the idea of "burden of disease" was mentioned in writing on the plan as well as in the speeches of a lot of countries during the meetings that discussed the plan. The resolution that requested the plan to be created was called "Global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at the country level" (EB130.R8). From that start, the idea of burden

of disease was repeatedly emphasized. As mentioned in 2.3, “burden of disease” is associated with the economic loss a country endure because of a person that has a mental illness. The plan says: “The economic consequences of these health losses are equally large: a recent study estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16.3 trillion between 2011 and 2030” (WHO, 2021b, p.3). The need for profits is an idea from the biomedical model (Barros, 2002). The plan is attached to the concept of burden of disease and, in that way, related to the biomedical model.

Moreover, the repeated slogan of “no health without mental health” or, as the plan calls, “the globally accepted principle that there is ‘no health without mental health’” (WHO, 2021b, p.1) is linked to the biomedical model as well. It is a slogan that tries to equal “physical health” and “mental health” but comes from a context (see 2.3), the creation of WHO, that was trying to find medication, a “cure”, for both (Callahan, 1973). That echoes the characteristics of the biomedical model (Barros, 2002).

There is an incoherence there. The action plan appears to navigate a battle between a model, the biomedical one, that sees health as a commodity, and an idea, deinsitutionalization, that sees health as influenced by social factors. One model that is the backbone of Medicine and an idea that tries rupturing one of the many specializations of Medicine, Psychiatry.

Finally, it is worth addressing the principle of “universal health coverage” present in the plan. It is explained as being:

> Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health (WHO, 2021b, p. 5).

It is interesting that this principle was not directly discussed during the meetings that preceded the plan. The closest it got was when, in the 132nd Session of the WHO’s Executive Board, a representative of Senegal (speaking on behalf of the Member States of the African Region) voiced the question: “why there were no objectives in the draft action plan specific to health-system strengthening, a prerequisite for many of the proposed actions” (WHO, 2013c, p. 29). The other countries did not respond but the Assistant Director-General Dr. Chestnov assured that the strengthening of healthcare systems would appear in some way in the plan.

In the end, Objective 1, “to strengthen effective leadership and governance for mental health”, and Objective 4, “to strengthen information systems, evidence and research for mental health”, do touch on some points pertaining the strengthening of healthcare systems.

For example, the plan mentions actions for the Secretariat such as compiling best practices on policies and offering technical support for Member States. However, those are not directly linked to a global target. When it comes to proposed actions for the Member States, the focus is developing policies on mental health and law that secure human rights to people with mental illness. Those are directly linked to targets.

There is an interesting proposed action for countries on Objective 4: “Integrate mental health into the routine health information system”. This one is the most practical way of strengthening healthcare systems mentioned in the plan that is actually reflected on the global targets of the plan (Global target 4.1: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems, by 2030) (WHO, 2021b).

A good addition to the plan could have been on proposed actions for Member State’s aid support on mental health for other countries. For example, training healthcare force on evidence-based treatments.

In any way, going back to “universal health coverage”, this principle seems to be a standalone in the plan. It is there. It carries a lot of meaning because it shows WHO’s position of support of that type of system in the past years[11]. The plan having it as principle is an extension of that. This study does not set itself to go in-depth on healthcare systems and a reflection on the presence of this principle in the plan could even be its own work. However, the debate surrounding health systems is one of the most prominent discussions in global health (see Almeida; Campos, 2020; Campos; Kawai, 2023; Horton, 2023; Fukuda-Parr; Buss; Ely Yamin, 2021 for more) and simply ignoring it would not do justice to its importance.

11 For more on that, I recommend the article “Universal health coverage: how to mix concepts, confuse objectives, and abandon principles” by Noronha (2013).

4 FINAL CONSIDERATIONS AND FUTURE STUDIES

Getting a Nobel Prize because you drilled the skull and pierced the eye with a stick of a breathing human being seems bizarre. Unfortunately, lobotomy was common and that prize is still valid. The places where those procedures occurred still exist. People with mental illness are still denied fundamental human rights and freedoms both inside as well as outside their healthcare systems.

There have been many national movements towards deinstitutionalization but, when you think of it only as dehospitalization, you get the fact that shackling (chaining, tying or locking in a confined space) a person with mental illness is common in many countries worldwide. Those human beings sometimes are locked inside a kennel in the backyard of a family house. Alone. Abandoned.

The rupture to institutionalization, or deinstitutionalization, has been discussed inside international organizations. The "Comprehensive Mental Health Action Plan 2013-2030", approved by the World Health Assembly, is an example of that. However, the plan presents some incoherences. Agreeing with some aspects of deinstitutionalization, the plan is still embedded in the biomedical model. While supporting community-based approaches to mental health, it repeats slogans and concepts based on the biomedical model. Those slogans were present from the first document that proposed the action plan.

The plan might have been created in a cooperation field but it still represents many forces with different interests. Even within the UN, as seem in 2.3, the agencies have presented different views. The incoherences are a portrayal of that. The question "does the plan show influence from both the biomedical model and deinstitutionalization?" guided this study and the answer was clear: the plan has aspects of the biomedical model and deinstitutionalization. Throughout the text, it was also possible to discuss institutionalization inside the WHO.

A reflection from this study is the much larger geopolitical context of the global health debate. Especially when it comes to health systems. It was not the focus of this work but, through the course of the readings, it is clear that the study would benefited from discussing health systems. It is possible that the arguments could have showed a much greater

force towards the plan having a bigger influence from the biomedical model. That would be because the WHO has voiced its preference for the universal health coverage, it is even one of the principles of the plan (WHO, 2021b). Analyzing how the biomedical model is related to that type of system and how both of them are related to institutionalization could be an interesting follow up to this study. Diving into the discussions surrounding healthcare systems (which one prevail inside the WHO, the actors that pull the strings on that debate) might provide a new perspective to why the plan is incoherent.

There were many limitations for this work. Regarding section 2, specifically, it is worth mentioning that many of Franco Basaglia's original writings are not available in either Portuguese or English. Even in its original language, Italian, a lot of his published work were compilations by a third-party, Franca Basaglia. Nonetheless, his reflections were too important to not have been mentioned. Moreover, in section 3, the meetings presented were addressed using summary records as sources not complete transcriptions and nuances could have been lost because of that.

REFERENCES

ALMEIDA, C.; CAMPOS, R. P. Multilateralismo, ordem mundial e Covid-19: questões atuais e desafios futuros para a OMS. **Saúde em Debate**, Rio de Janeiro, v. 44, n. 4, p. 13–39, 2020.

AMARANTE, P. Uma aventura no manicômio: a trajetória de Franco Basaglia. **Manguinhos**, Rio de Janeiro v. 1, n. 1, p. 61–77, 1994.

AMARANTE, P.; NUNES, M. D. O. A reforma psiquiátrica no SUS e a luta por uma sociedade sem manicômios. **Cien Saude Colet**, Rio de Janeiro, v. 23, n. 6, p. 2067–2074, 2018.

ARBEX, D. **Holocausto Brasileiro**. São Paulo: Geração Editorial, 2013.

BACKMAN, G. et al. Health systems and the right to health: an assessment of 194 countries. **The Lancet**, London, v. 372, n. 9655, p. 2047–2085, 2008.

BARROS, J. A. C. Pensando o processo saúde doença: a que responde o modelo biomédico? **Saúde Soc.**, São Paulo, v. 11, n. 1, p. 67–84, 2002.

BATISTELLA, C. Abordagens Contemporâneas do Conceito de Saúde. In: FONSECA, A.; CORBO, A. (Eds.). **O Território e o Processo Saúde-Doença**. 1. ed. Rio de Janeiro: EPSJV/Fiocruz, 2007. p. 51–86.

BORGES, C. F.; BAPTISTA, T. W. D. F. O modelo assistencial em saúde mental no Brasil: a trajetória da construção política de 1990 a 2004. **Cad Saúde Pública**, Rio de Janeiro, v. 24, n. 2, p. 456–468, 2008.

BRASIL. Conselho Federal de Psicologia; Mecanismo Nacional de Prevenção e Combate à Tortura; Procuradoria Federal Dos Direitos do Cidadão/ Ministério Público Federal. **Relatório da Inspeção Nacional em Comunidades Terapêuticas**. Brasília, DF: Conselho Federal de Psicologia. 2018.

BRASIL. Lei No 10.216, de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. **Diário Oficial da União**: seção 1, Brasília, DF, ano 139, n. 69, p. 2, 9 abr. 2023.

BRASIL. Ministério da Saúde. **O que é Atenção Primária?**. Brasília, DF: Brasil, c2023. Disponível em: https://www.gov.br/saude/pt-br/composicao/saps/o-que-e-atencao-primaria. Acesso em: 30 nov. 2023.

CALLAHAN, D. The WHO Definition of “Health”. **Hastings Cent Rep**, New York, v. 1, n. 3, p. 77–87, 1973.

CESCR – Committee on Economic, Social and Cultural Rights. **E/C.12/2000/4**. General Comment No. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). Geneva: CESCR, 2000. Disponível em: https://digitallibrary.un.org/record/425041. Acesso em: 3 out. 2023.

DE LEONARDIS, O.; MAURI, D.; ROTELLI, F. Deinstitutionalization, another way: The Italian mental health reform. **Health Promot Int**, Oxford, v. 1, n. 2, p. 151–165, 1986.

FARLEY, J. **Brock Chisholm, the World Health Organization, and the Cold War**. Vancouver: UBC Press, 2008.

FAUSTINO, D. M. **Frantz Fanon**: um revolucionário, particularmente negro. São Paulo: Ciclo Contínuo Editorial, 2018.

FUKUDA-PARR, S.; BUSS, P.; ELY YAMIN, A. Pandemic treaty needs to start with rethinking the paradigm of global health security. **BMJ Glob Health**, London, v. 6, n. 6, p. e006392, 2021.

HORTON, R. Offline: The case for global health. **The Lancet**, London, v. 401, n. 10389, p. 1639, 2023.

HRW – Human Rights Watch. **Living in Chains**: Shackling of People with Psychosocial Disabilities Worldwide. USA, 2020. Disponível em: https://www.hrw.org/news/2020/10/06/people-mental-health-conditions-living-chains. Acesso em: 23 out. 2023.

LEVINSON, H. **The strange and curious history of lobotomy**. London: BBC News, 2011. Disponível em: https://www.bbc.com/news/magazine-15629160. Acesso em: 30 nov. 2023.

MBR – Museu Bispo do Rosário. **Colônia Juliano Moreira**. Rio de Janeiro: Museu Bispo do Rosário, c2023. Disponível em: https://museubispodorosario.com/colonia-juliano-moreira/. Acesso em: 28 nov. 2023.

MINAYO, M. C. S. **O desafio do conhecimento**: Pesquisa qualitativa em saúde. 9. ed. São Paulo: Hucitec Editora, 2006.

MURRAY, C. J. L.; LOPEZ, A. D. (Eds.). **The global burden of disease**: summary; a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Geneve: World Health Organization, 1996.

NORONHA, J. C. Universal health coverage: how to mix concepts, confuse objectives, and abandon principles. **Cad Saúde Pública**, Rio de Janeiro, v. 29, n. 5, p. 847–849, 2013.

OHCHR – Office of the High Commissioner for Human Rights. **Committee on Economic, Social and Cultural Rights**. Geneva: OHCHR, c2023a. Disponível em: https://www.ohchr.org/en/treaty-bodies/cescr. Acesso em: 28 nov. 2023.

OHCHR – Office of the High Commissioner for Human Rights. **Special Procedures of the Human Rights Council**. Geneva: OHCHR, c2023b. Disponível em: https://www.ohchr.org/en/special-procedures-human-rights-council. Acesso em: 9 out. 2023.

PASSOS, R. G. Mulheres negras, sofrimento e cuidado colonial. **Revista Em Pauta**, Rio de Janeiro, v. 18, n. 45, 6 jan. 2020.

PATROCÍNIO, S. D. **Reino dos bichos e dos animais é o meu nome**. Rio de Janeiro: Azougue Editorial, 2001.

CAMPOS, R. P.; KAWAI, S. Japan's ODA to Developing Countries in the Health Sector: Overall Trend and Future Prospects. In: HAMAGUCHI, N.; RAMOS, D. (Eds.). **Brazil—Japan Cooperation: From Complementarity to Shared Value**. Singapore: Springer Nature Singapore, 2023. p. 43–83.

ROTELLI, F. A instituição inventada. In: ROTELLI, F.; DE LEONARDIS, O.; MAURI, D. (Eds.). **Desinstitucionalização**. 2. ed. São Paulo: Editora HUCITEC, 2001. p. 89–100.

SARACCI, R. The World Health Organisation needs to reconsider its definition of health. **BMJ**, London, v. 314, n. 7091, p. 1409–1410, 1997.

THACHUK, A. Stigma and the politics of biomedical models of mental illness. **Int J Fem Approaches Bioeth**, Toronto, v. 4, n. 1, p. 140–163, 2011.

UN – United Nations. **UN System**. New York: UN, c2023. Disponível em: https://www.un.org/en/about-us/un-system. Acesso em: 28 nov. 2023.

UNGA – United Nations General Assembly. **A/RES/46/119**. The protection of persons with mental illness and the improvement of mental health care. New York: UNGA, 1991. Disponível em: https://digitallibrary.un.org/record/135851. Acesso em: 28 nov. 2023.

UNGA – United Nations General Assembly. **Convention on the Rights of Persons with Disabilities**. New York: UNGA, 2006. Disponível em: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities. Acesso em: 28 nov. 2023.

UNHRC – United Nations Human Rights Council. **A/HRC/35/21**. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Geneva: UNHRC, 2017. Disponível em: https://ap.ohchr.org/documents/dpage_e.aspx?si=a/hrc/35/21. Acesso em: 28 nov. 2023.

WHA – World Health Assembly. **A54/DIV/4**. Ministerial round tables: Mental health. Geneva: WHA, 2001b. Disponível em: https://apps.who.int/gb/archive/e/e_wha54.html. Acesso em: 28 nov. 2023.

WHA – World Health Assembly. **A54/DIV/8**. Round tables: mental health: Report by the Secretariat. Geneva: WHA, 2001c. Disponível em: https://apps.who.int/gb/archive/e/e_wha54.html. Acesso em: 28 nov. 2023.

WHA – World Health Assembly. **A65/10**. Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level Geneva: WHA, 2012a. Disponível em: https://apps.who.int/gb/e/e_wha65.html. Acesso em: 28 nov. 2023.

WHA – World Health Assembly. **Mental Health**: A Call for Action by World Health Ministers. Geneva: WHA, 2001d. Disponível em: https://www.mhinnovation.net/resources/mental-health-call-action-world-health-ministers. Acesso em: 23 out. 2023.

WHA – World Health Assembly. **WHA54/2001/REC/3**. Summary Records of Committees and Ministerial Round Tables. Reports of Committees. Geneva: WHA, 2001a. Disponível em: https://iris.who.int/handle/10665/329504. Acesso em: 1 dez. 2023.

WHA – World Health Assembly. **WHA65/2012/REC/3**. Summary Records of Committees. Reports of Committees. List of Participants. Geneva: WHA, 2012b. Disponível em: https://apps.who.int/gb/or/e/e_wha65r3.html. Acesso em: 28 nov. 2023.

WHA – World Health Assembly. **WHA66/2013/REC/3**. Summary Records of Committees. Reports of Committees. List of Participants. Geneva: WHA, 2013a. Disponível em: https://apps.who.int/gb/or/e/e_wha66r3.html. Acesso em: 28 nov. 2023.

WHO - World Health Organization. **Comprehensive Mental Health Action Plan 2013-2030**. Geneva: WHO, c2023a. Disponível: https://www.who.int/publications/i/item/9789240031029. Acesso em: 1 dez. 2023.

WHO - World Health Organization. **History of WHO**. Geneva: WHO, c2023c. Disponível: https://www.who.int/about/history. Acesso em: 28 nov. 2023.

WHO - World Health Organization. **Mental Health Gap Action Programme (mhGAP)**. Geneva: WHO, c2023d. Disponível: https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme. Acesso em: 28 nov. 2023.

WHO – World Health Organization. **2008-2013 action plan for the global strategy for the prevention and control of noncommunicable disease**s: prevent and control cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Geneva: WHO, 2009. Disponível em: https://www.who.int/publications/i/item/9789241597418. Acesso em: 28 nov. 2023.

WHO – World Health Organization. **Basic documents**: forty-ninth edition 2020. Geneva: WHO, 2020. Disponível em: https://iris.who.int/handle/10665/339554. Acesso em: 23 out. 2023.

WHO – World Health Organization. **Comprehensive Mental Health Action Plan 2013-2030**. Geneva: WHO, 2021b. Disponível em: https://www.who.int/publications/i/item/9789240031029. Acesso em: 1 dez. 2023.

WHO – World Health Organization. **EB130/2012/REC/1**. Resolutions and Decisions. Annexes Geneva: WHO, 2012b. Disponível em: https://apps.who.int/gb/e/e_eb130.html. Acesso em: 28 nov. 2023.

WHO – World Health Organization. **EB130/2012/REC/2**. Summary Records. Geneva: WHO, 2012a. Disponível em: https://apps.who.int/gb/or/e/e_130r2.html. Acesso em: 28 nov. 2023.

WHO – World Health Organization. **EB132/2013/REC/2**. Summary Records. List of Participants. Geneva: WHO, 2013c. Disponível em: https://apps.who.int/gb/or/e/e_132r2.html. Acesso em: 28 nov. 2023.

WHO – World Health Organization. **EB132/8**. Draft comprehensive mental health action plan 2013–2020. Geneva: WHO, 2013b. Disponível em: https://apps.who.int/gb/e/e_eb132.html. Acesso em: 28 nov. 2023.

WHO – World Health Organization. **Mental Health Atlas 2011**. Geneva: WHO, 2011. Disponível em: https://iris.who.int/handle/10665/44697 Acesso em: 23 out. 2023.

WHO – World Health Organization. **Mental Health Atlas 2020**. Geneva: WHO, 2021a. Disponível em: https://iris.who.int/handle/10665/345946. Acesso em: 23 out. 2023.

WHO – World Health Organization. **Social determinants of health**. Geneva: WHO, c2023b. Disponível em: https://www.who.int/health-topics/social-determinants-of-health. Acesso em: 30 nov. 2023.

WHO – World Health Organization. **The World Health Report 2001**: Mental Health: New Understanding, New Hope. Geneva: WHO, 2001. Disponível em: https://iris.who.int/handle/10665/42390. Acesso em 23 out. 2023.

WHO – World Health Organization. **WHO Global Plan of Action on Workers' Health (2008-2017)**: baseline for implementation: global country survey 2008/2009: executive summary and survey findings. Geneva: WHO, 2013a. Disponível em: https://www.who.int/publications/i/item/WHO-FWC-PHE-2013-01. Acesso em: 28 nov. 2023.

WHO EMRO – World Health Organization Regional Office for the Eastern Mediterranean. **Mental health gap action programme (mhGAP)**. Cairo: WHO EMRO, c2023b. Disponível: https://www.emro.who.int/mnh/mental-health-gap-action-programme/index.html. Acesso em: 28 nov. 2023.

WHO EMRO - World Health Organization Regional Office for the Eastern Mediterranean. **World Health Day 2001**. Cairo: WHO EMRO, c2023a. Disponível: https://www.emro.who.int/world-health-days/2001/. Acesso em: 28 nov. 2023.

ZACHARIAS, A. **Stella do Patrocínio, ou o retorno de quem sempre esteve aqui**. São Paulo: Revista Cult, 2020. Disponível em: https://revistacult.uol.com.br/home/stella-do-patrocinio-retorno-sempre-esteve-aqui/. Acesso em: 28 nov. 2023.