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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Algeria

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, on his visit to Algeria from 27 April to 10 May 2016. Algeria has made considerable progress with regard to the realization of the right to health, particularly improving basic health-related indicators and aligning most of the normative framework with its international human rights obligations. In the report, the Special Rapporteur encourages the Government to address a number of serious challenges that remain connected to the normative and policy framework and its implementation as well as to the prevalence of inequalities and discrimination against certain population groups, particularly women, adolescents and youth, people living with HIV/AIDS and drug users. The Special Rapporteur also addresses challenges affecting the national health system and the mental health framework and makes a number of recommendations.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Algeria*

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* Circulated in the language of submission and French only.

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, visited Algeria from 27 April to 10 May 2016 at the invitation of the Government. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health.

2. During his visit, the Special Rapporteur met with high-ranking government officials from the Ministries of Employment and Social Security; Foreign Affairs; the Interior; Health, Population and Hospital Reform; National Education; National Solidarity, Family and Women; and Youth and Sports. He also met with members of the National Assembly Commission on Health, Labour and Social Welfare, the Health Commission of the Senate and the National Council, and held meetings with representatives of civil society, international organizations and United Nations funds and agencies.

3. The Special Rapporteur visited different health facilities, primary and secondary schools, drug dependency centres and one health-care facility for detainees, in different areas, including Algiers, Blida, Djelfa, Sétif and Oran.

4. The Special Rapporteur is grateful to the Government of Algeria for its invitation and full cooperation during his visit. He appreciates the significant support provided by the United Nations country team, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO).

II. Right to health framework

A. Background

5. Since Algeria gained independence in 1962, it has made considerable achievements in improving the health status of its population through sustained investment in public health. Revenues from hydrocarbon exports have enabled macroeconomic stability, economic growth and development over the past decades. This, together with an explicit commitment by the authorities, has paved the way for some achievements in the realization of the right to health.

6. The national health system was established on the predominance of the public sector and free access to preventive and curative services, so as to guarantee equity.[1] Health-related indicators have improved significantly since independence, including the life expectancy of most segments of the population, maternal and child mortality rates and successful vaccination campaigns. The country has also embarked on important social reforms, including universal free access to health care and education.

7. The health sector in Algeria has developed with a strong focus on primary care and universal free access for its population. Since independence, significant investments have been made to develop health infrastructure, make services available and accessible, and address the underlying determinants of health, including poverty, education, food and nutrition, and housing.

8. Although the effects of global financial crises have been felt since 2008, social expenditure focusing on disadvantaged groups represents about 12 per cent of the gross domestic product.[2] Despite the current financial crisis linked to the crash of international oil prices since mid-2014, the country has maintained its expenditure towards improving the health of its population. Concerted efforts are being made to address the challenges of the

[1] Algeria, *2ème Rapport National sur les Objectives du Millénaire pour le Development*, September 2010, p. 73.

[2] Ibid., p. 17.

ongoing demographic and epidemiological transitions in a country where almost 55 per cent of the population is below the age of 30 and non-communicable diseases have become a primary issue of concern.

9. Algeria still has high maternal and neonatal mortality and morbidity rates and significant disparities between urban and rural areas remain. The lack and insufficient quality of relevant health-related data and analytical studies are important deficiencies and challenges that seriously compromise public policy efforts in the health and health-related sectors.

10. The next two decades represent a critical juncture for the country to achieve two key and interrelated objectives: the Sustainable Development Goals by 2030 and the effective realization of the right to health of its population. Efforts made in these directions will be reinforced by the effective implementation of the WHO *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* and the technical guidance on the application of a human rights-based approach to reducing and eliminating preventable maternal and under-five mortality and morbidity (A/HRC/21/22 and A/HRC/27/31).

B. Normative and institutional framework

11. Algeria has ratified almost all of the international human rights treaties, except for the International Convention for the Protection of All Persons from Enforced Disappearance and some Optional Protocols — mainly those relating to individual complaints procedures.[3]

12. Algeria has introduced interpretative declarations and reservations with regard to provisions in the two International Covenants on Human Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. This, together with the lack of ratification of the Optional Protocols on individual complaints procedures, undermines the nature and scope of its obligations under these treaties, including access to remedies and accountability with regard to the right to health.

13. Although the Government has accepted visits by a number of special procedure mandate holders of the Human Rights Council, it has yet to issue a standing invitation to all special procedure mandate holders. Algeria was evaluated under the universal periodic review in 2008 and 2012; its next review is scheduled for January 2017.

14. At the regional level, Algeria ratified the African Charter on Human and Peoples' Rights and has taken important health-related initiatives, in particular with regard to the eradication of malaria and the fight against HIV/AIDS.

15. The constitutional and normative framework recognizes the right to health and other related rights as well as the right to freedom from violence and discrimination. Pursuant to article 54 of the Constitution of 1989 (reinstated in 1996), "all citizens have the right to protection of their health" and the State "shall ensure the prevention and the fight against epidemics and endemic illnesses". Ordinance No. 73-65 of 28 December 1973 made the provision of both prevention and curative care free of charge. Health services are predominantly financed by the State, with limited but increasing private participation.[4]

[3] Algeria has not yet acceded to the Optional Protocols to the following treaties: the International Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of the Child, on a communications procedure; the Convention on the Elimination of All Forms of Discrimination against Women; the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

[4] African Commission on Human and Peoples' Rights, "Algeria: fifth and sixth periodic reports on the implementation of the African Charter on Human and Peoples' Rights" (December 2014), p. 44; and World Bank, "Algeria — Strengthening health system governance: Towards more effective regulatory environment for improved efficiency and quality of care", Concept note for technical assistance (December 2006), p. 3.

16. The most important law governing the right to health is the Health Protection and Promotion Act No. 85-05.[5] It sets out the basic principles and provisions regarding, inter alia, public health and epidemiology, mental health, the health workforce, and health financing. A new version of the Health Act is being developed in consultation with various stakeholders. The Special Rapporteur trusts that the new law will soon be adopted so as to guarantee equality, non-discrimination, effective participation and accountability in the enjoyment of the right to health.

17. The National Advisory Commission for the Promotion and Protection of Human Rights (*Commission nationale consultative de promotion et de protection des droits de l'homme*) was established in 2001. While it is in charge of monitoring, early warning and evaluating the realization of human rights, it is not authorized to receive complaints or conduct investigations.[6] In 2009, the Commission was accredited with "B" status for failure to implement the recommendations to bring it into conformity with the Principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles), lack of a transparent and participatory appointment process and unsatisfactory interaction with the international human rights system.[7]

18. Several public policies, programmes and initiatives stem from this normative and institutional framework, including efforts to address the ongoing demographic and epidemiological transitions. The Special Rapporteur commends the efforts made to address inequities in accessing health in different parts of the country, such as twinning programmes (*jumelage*s), the use of telemedicine and the establishment of mobile health units.

C. National health-care system

19. The Ministry of Health, Population and Hospital Reform manages the hospitals and the public health sector. There are five health regions across the country, with five regional health councils, five regional health observatories and 48 health and population directorates (one in each *wilaya*). The country is divided into 185 health districts.[8]

20. The health-care system has posted impressive results in making care available and accessible, with strengthened infrastructure, equipment and workforce. The population has financial coverage for most of the basic health services, which has contributed to a significant improvement in health indicators over the past decades.

21. Public investment in the national health system is among the highest in the region. In 2014, per capita health expenditure amounted to US$ 932; total health expenditure was 7.2 per cent of gross domestic product compared to 5.6 per cent in Egypt, 5.9 per cent in Morocco and 7.0 per cent in Tunisia. General public expenditure on health in 2014 was 9.9 per cent of total public expenditure. Out-of-pocket expenditure represented about 26.5 per cent of total expenditure on health in 2014.[9]

Priorities for strengthening the health-care system

22. Considerable challenges regarding equitable access to care, especially in the south, were identified in 2006, including allocative and technical inefficiencies under the hospital-centred delivery model, a poorly functioning primary-care network and dysfunctional hierarchy across health-care levels. The dissatisfaction of the population with the technical

[5] Algeria, Loi relative à la protection et à la promotion de la santé (Law on the protection and promotion of health). Available from www.mindbank.info/item/984.

[6] See Algeria, Presidential Decree No. 01-71 of 25 March 2001; and Ordinance No. 09-04 of 5 August 2009.

[7] See International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights, reports of the Subcommittee on Accreditation (April 2008 and March 2009).

[8] Algeria, National Advisory Commission for the Promotion and Protection of Human Rights, *Rapport annuel 2014*, p. 170.

[9] See WHO Global Health Observatory, Algeria. Available from http://apps.who.int/gho/data/node.main.75?lang=en.

quality of care provided in public facilities was also underlined, with those who can afford to pay out of pocket increasingly seeking care in the growing private sector.[10]

23. In 2007, Algeria launched the reform of its health system with the aim of improving the quality of services, ensuring efficiency of health-care establishments and the national health system in general, and minimizing disparities and inequalities among regions.

24. The health-care system was reorganized to bring health-care structures closer to the people: 195 public hospitals, 271 community health centres and 26 new mother-and-child hospitals were established. Specialized hospitals (*établissements hospitaliers spécialisés*) have independent status and funding and are dedicated to providing care to the target population.[11]

25. In an attempt to ensure equitable access to highly specialized health care, the 2014 Health Sector Development Framework envisaged the establishment of regional specialized centres and national referral centres to address the burden of morbidity linked to emerging pathologies, including cardiovascular diseases and different forms of cancer.

26. The Special Rapporteur visited various health-care structures in different parts of the country and found them to be in relatively good condition. However, he was made aware of deficiencies in infrastructure and equipment, and the lack of qualified health staff, especially in remote areas.[12]

27. The Committee on Economic, Social and Cultural Rights expressed concern about the availability of medicines, the insufficient quality of health care, in terms of standards of the upkeep of buildings, hygiene and reception of patients, as well as the poor conditions of work of health-care professionals in Algeria (see E/C.12/DZA/CO/4, para. 20).

Primary care as the path to universal coverage

28. There is a strong focus on primary (proximity) care and specialized services in Algeria, which is a good basis for reaching full coverage. However, significant challenges remain regarding equitable access to and the quality of services throughout the country and excessive emphasis on hospital care and specialized medicine.

29. The Special Rapporteur observed a disproportionate reliance on hospital care compared with attention paid to primary care, outpatient specialized care and health promotion and prevention. Between 2010 and 2015, the number of primary-care establishments remained the same (271 establishments), while the number of specialized centres increased from 64 to 75 and the number of medium-sized establishments also increased.[13]

30. Health-care systems function more effectively and rationally if general practitioners and their teams manage the majority of cases in primary-care structures. This allows resources to be accumulated for the expensive treatment of severe or complicated medical cases. In Algeria, there seems to be a lack of good governance and incentives to manage the different levels of health care in order to encourage the use of primary care.

31. The Government should invest in strengthening the role of general practitioners by building their capacities and competencies, as well as those of nurses, social workers and medical assistants, through continuous learning programmes. It should also consider establishing innovative incentives to consolidate the position of general practitioners as "gatekeepers" of the system, including with regard to children's health, mental health and the management of oncological and other non-communicable diseases.

[10] World Bank, "Algeria — Strengthening health system governance" (December 2006), p. 3.

[11] See Executive Decrees No. 07-140 of 19 May 2007 and No. 07-204 of 30 June 2007.

[12] Algeria, National Advisory Commission for the Promotion and Protection of Human Rights, *Rapport annuel 2014*, pp. 142-144 and 168-173; also *Rapport sur la visite des établissements hospitaliers (2008/2009)*, pp. 31-43.

[13] Figures provided by the Ministry of Health.

32. More efforts should be made to assess the performance of the national health-care system by establishing independent mechanisms and using indicators to measure the cost-effectiveness of investments in specialized health care, including the use of expensive diagnostic and therapeutic biomedical technologies.

33. Moreover, the Government should ensure that people in situations of poverty have the same access as others to specialized health-care centres, such as cancer treatment centres, and that they are not discriminated against when there are waiting lists.

34. The Special Rapporteur observed that, owing to the quality of care provided in the public sector and the dissatisfaction of service users, the private sector was growing fast and in an unregulated manner. This was leading to a dual system that offered better quality care for those who could afford to pay out of pocket or travel abroad to be treated, thereby increasing inequalities in access to health care.

Regional inequities in access to health care

35. Algeria has a population of over 39 million. Approximately 90 per cent of the population is concentrated on about 10 per cent of the territory in the north of the country, where most of the economic activity takes place.[14] One of the main challenges of the health-care system is linked to the significant regional disparities in socioeconomic indicators and infrastructure, in particular affecting those living in the southern and High Plateau regions.

36. Access to health care has improved over the past decades by the extension of health coverage in terms of infrastructure, staff and financing, and a deliberate policy by the Government. In 2006, geographic access to health facilities was measured at 98 per cent of the population.[15] However, concern was expressed about the difficulties faced by people living in rural areas in accessing health care, owing to an unequal geographic distribution of care facilities and medical practitioners (see E/C.12/DZA/CO/4, para. 20).

37. The Special Rapporteur visited the High Plateau region (Djelfa and Sétif) and noted some of the initiatives taken by the Government to address these inequities, in particular regarding access to specialized care. One such initiative is the twinning programme (*jumelage*) launched in 2014 and sanctioned by Executive Decree No. 16-197 of 4 July 2016.

38. The twinning programme is intended to encourage a partnership, whereby university hospitals in the north of the country would provide technical assistance and capacity-building to hospitals in the southern and High Plateau regions, which lack specialized personnel. In 2015, 207 missions, over 20,000 consultations and over 3,500 surgical interventions were carried out within this framework. A total of 53 public health centres, university hospitals and secondary-care centres have been included in the programme.[16]

39. The Special Rapporteur commends these efforts and encourages the Government to continue to improve access to health care and build the capacity of health structures in remote regions of the country. He reiterates the key role played by primary health structures and general practitioners and their teams.

Health workforce, transparency, accountability and participation

40. The health sector in Algeria is the second largest public service employer with 18 per cent of all female public officials. Training for the basic medical degree, doctor of medicine (MD) lasts six or seven years. The licence to practise medicine is granted by the Ministry of Health. There are South-South cooperation programmes aimed at reinforcing capacities in the health sector, including in specialized fields such as ophthalmology.

[14] Algeria, National Advisory Commission for the Promotion and Protection of Human Rights, *Rapport annuel 2014*, pp. 130-133.

[15] World Bank, "Algeria: Strengthening health system governance" (December 2006), p. 4.

[16] Data provided by the Ministry of Health.

41. Health-care workers in the public sector are generally underpaid, which places the workforce in a precarious situation that is often aggravated by the prevalence of temporary contracts without maternity or sick leave entitlements (see E/C.12/DZA/CO/4, para. 10). As such, many health-care workers opt to leave the country.

42. In order to prevent the brain drain, investing in human resources is crucial, including decent salaries for health-care workers and improved working conditions, as well as strengthening the independence and building the capacities of health professionals. They should enjoy ownership of their professional activities and have self-regulation capacity with regard to setting professional standards relating to clinical and ethical issues.

43. While the country is taking important steps to strengthen data collection and statistical systems to meet international standards, there is a need to improve the availability of high-quality data to better inform public policies and action. Effective health information systems, civil registration systems and disaggregated data should be in place for adequate situation analysis, identification of gaps and proper monitoring, review and oversight of performance. More efforts are needed to ensure proper accountability in the health-care sector, including through nationally led evaluations and the establishment of independent monitoring mechanisms of health policies and programmes.

44. Algeria should reinforce investment to enhance transparency and the meaningful participation of all stakeholders, including users and providers of health services, independent civil society and local authorities. Consultations organized in June 2014 in the context of the revision of the Health Act were a positive sign in this direction.

III. Right to health of key populations and groups

45. Significant inequalities persist in the enjoyment of the right to health, expressed in the form of barriers hindering access to and affecting the quality of essential services, in particular in rural and remote areas of the country. This disproportionally affects groups in situations of poverty and those living in the south and High Plateau regions.

46. In addition, certain population groups face discrimination and specific challenges in realizing their right to health, including women, adolescents and youth, persons with disabilities, drug users and people living with HIV/AIDS. The Special Rapporteur also looked at the mental health framework in the country.

A. Women

47. Women have enjoyed an overall improvement in health indicators since independence, including increased life expectancy, decreased maternal mortality rates and the fight against infectious and, more recently, non-communicable diseases. The Special Rapporteur commends the Government for the efforts made over the past few years to address the prevention and treatment of cancer, including breast and cervical cancers.

48. While women have access to the education system at all levels, are represented at various levels of national and local government and form a large part of the health-care workforce, including as medical professionals, the ongoing demographic transition has implied a significant decrease in fertility rates.

49. In addition, serious challenges remain when it comes to the full realization of women's right to health, including barriers to the enjoyment of sexual and reproductive health rights and the effective implementation of a normative framework on violence against women.

50. The health-care sector is one of the best placed public sectors to ensure that women are adequately supported, protected and empowered through equitable access to quality services and evidence-based information. However, women's full realization of the right to health requires more than service provision. Attention should be paid to the underlying social determinants such as violence, poverty and discrimination, which are often

reinforced by patriarchal gender norms and stereotypes as well as restrictive interpretations of cultural and religious norms and practices.

Maternal and child mortality and morbidity

51. Algeria ranks below the global average on maternal mortality and morbidity, but slightly above the regional average for the Middle East and North Africa.[17] Despite notable progress made over the past decades in reducing the maternal and neonatal mortality ratio, from 230 maternal deaths per 100,000 live births in 1989 to 63.6 in 2014, the country fell short of meeting the Millennium Development Goal 5 target on reducing maternal mortality, which was 57 per 100,000 live births (see DP/FPA/CPD/DZA/6, para. 6).

52. In 2012, the Committee on the Rights of the Child expressed concern about the high levels of maternal, neonatal and under-five mortality rates (see CRC/C/DZA/CO/3-4, para. 57). The health of mothers and young children has become a national priority in health care and social services in Algeria.

53. The legislative basis for the maternal and child mortality and morbidity policy is the Health Act, which addresses family planning with the aim of promoting a harmonious family balance and preserving the lives and health of mothers and young children. In addition, chapter V (arts. 67-75) of the Health Act sets out measures for the protection of mothers and young children. The National Perinatal Care Programme 2006-2009 was launched in 2005 and aimed at a 30-per cent reduction in perinatal mortality and a 50-per cent reduction in maternal mortality.[18]

54. The majority of maternal deaths are preventable and there is a higher rate of such deaths in remote rural regions. The situation underscores persistent inequalities in access to health care, as well as in the enjoyment of the underlying and social determinants of women's health, with some regions being noticeably worse off than others. Rural regions and the south are most affected by poverty and social exclusion and rank higher in relation to the absence of monitoring during pregnancy and unaccompanied births.[19]

55. Over the past decade, the monitoring of mothers-to-be and specialized support and care have improved, with the proportion of births attended by skilled personnel increasing from 76 per cent in 1990 to 96.6 per cent in 2013. This is crucial for reducing perinatal, neonatal and maternal deaths. Furthermore, over the past decade, antenatal care coverage has increased significantly.

56. The under-five mortality rate (deaths per 1,000 live births) was reduced by 45.5 per cent from 46.8 in 1990 to 25.6 in 2015. Similarly, the infant mortality rate was reduced by 44.8 per cent from 39.7 in 1990 to 21.9 in 2015. The neonatal mortality rate (deaths per 100,000 live births) was estimated to be 15.5 in 2015. While child mortality rates have reduced significantly, Algeria did not meet the Millennium Development Goal target to reduce child mortality by two thirds in 2015, mainly owing to the prevalence of high neonatal mortality rates.

57. The main causes of death in children under 5 years of age include premature birth (20 per cent); congenital anomalies (18 per cent); birth asphyxia (13 per cent); and acute respiratory infections (13 per cent). Nonetheless, the proportion of infants (under 1 year of age) immunized against measles increased from 83 per cent in 1990 to 95 per cent in 2015 and the prevalence of underweight children under 5 years of age was reduced from 9.2 per cent in 1992 to 3 per cent in 2012/2013.[20]

58. The National Plan for the Reduction of Maternal Mortality (2014) of the Ministry of Health, in partnership with UNICEF, addressed maternal mortality and inequities through five strategic interventions: improving governance; reaching every woman to reduce

[17] See World Bank, MDG Progress Status, Algeria. Available from http://data.worldbank.org/mdgs/compare-trends-and-targets-of-each-mdg-indicator.

[18] Also Executive Decree No. 05-435 (2005).

[19] UNICEF Annual Report 2014: Algeria, p. 18.

[20] See WHO Global Health Observatory. Available from https:// apps.who.int/gho/data/node.home.

inequalities; strengthening family planning; raising the quality of prenatal and postnatal care; and promoting women's and caregivers' participation. The plan also envisaged the launch of a maternal death audit system and a reference guide on obstetric care standards.[21]

59. The Special Rapporteur acknowledges the achievements made in reducing maternal and child mortality rates, as well as the important work currently being carried out by the Government, with the support of United Nations agencies, to reduce maternal and neonatal mortality. He commends the reinforcement and expansion of the hospital and care network to offer maternal and neonatal care services throughout the country. Emergency obstetric care is a core obligation and a crucial maternal health intervention. In this sense, the maternal death audit system established in 2014 and the reference guide on obstetric care standards developed in 2016 are key tools for operationalizing obligations and commitments, and should be effectively implemented.

60. However, commitments at the highest level of government need to be accompanied by comprehensive measures to ensure substantive equality for women throughout the country. This implies simultaneous attention to short-term life-saving interventions and long-term socioeconomic and political transformations to address broader patterns of discrimination and violence against women and children which affect maternal, neonatal and under-five mortality and morbidity (see A/HRC/21/22, para. 65).

61. Addressing the underlying and social determinants of maternal and neonatal mortality and morbidity is essential. Poverty, low education levels, insufficient access to health services, gender discrimination and lack of empowerment are barriers hindering women from making the best informed choices about their sexual and reproductive health and the health of their children, which results in poorer health outcomes and higher risks (A/HRC/27/31, para. 74).

62. Sexual and reproductive health rights are an integral part of the right to health.[22] The sexual and reproductive health services most needed by women, in particular young women, include access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion, and prevention and treatment of sexually transmitted infections and HIV/AIDS (see E/CN.9/2014/4, paras. 68-77).

63. Therapeutic interruption of pregnancies is allowed in Algeria, with a few exceptions. The Penal Code of 8 June 1966 prohibits abortion unless it is performed as an indispensable measure to save the life of the mother (arts. 304-313) and, under the Health Act, abortions may be performed as an essential measure to save the woman's life if in danger or to preserve her mental equilibrium if it is seriously threatened (art. 72).

64. However, interruption of pregnancy in cases of rape and incest is not allowed under the current legal framework. A woman inducing or agreeing to the inducement of her own abortion is subject to imprisonment for a period of 6 to 24 months and a fine. The person who performs the abortion is subject to imprisonment of one to five years and a fine. If that person is a medical practitioner, he or she may also be suspended from practising his or her profession.[23]

65. The criminalization of abortion forces many women to seek unsafe clandestine abortions, which are extremely dangerous for their health and lives. It also exposes women to additional dangers, violence and stigma which are additional barriers to the full enjoyment of their right to health. The Government should review the normative framework with a view to decriminalizing abortion and guaranteeing access to services for the therapeutic interruption of pregnancy, at the least when the pregnancy is the result of rape or incest, in cases of grave and severe fetal impairment and when the life and health of the

[21] UNICEF Annual Report 2014: Algeria, p. 19.

[22] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 1.

[23] See Algeria, Penal Code, arts. 304-309.

woman is in danger. The necessary information and training should be provided to the relevant health professionals.[24]

Violence against women and girls

66. The prevalence of violence against women, including domestic violence, poses serious human rights concerns and is a serious public health issue that should be addressed without delay. In 2006, a national survey on violence against women revealed that 9.4 per cent of Algerian women between the ages of 19 and 64 years had encountered physical violence often or daily within the family and that 31.4 per cent had been regularly subjected to threats of physical or psychological violence. The survey also found that marital rape and other forms of sexual abuse existed, with 10.9 per cent of women admitting that they had been subjected to forced sexual relations on more than one occasion by their intimate partners.[25]

67. Following her visit to the country in 2010, the Special Rapporteur on violence against women, its causes and consequences acknowledged notable progress made at the legislative and institutional levels, but highlighted several issues which remained of particular concern, including violence against women in the family, sexual harassment at work and in educational and training institutions and stigmatization of and hostility towards unmarried single women and women living on their own. She stated that women's vulnerability to violence was heightened by patriarchal mentalities, challenges in the interpretation and implementation of the law and the absence of verifiable statistics on the prevalence of violence (see A/HRC/17/26/Add.3, paras. 12-23).

68. Violence against women is a severely underreported phenomenon worldwide because the women affected fear that disclosure will lead to stigmatization, and both victims and witnesses fear that they would not receive adequate protection, particularly in criminal cases. It is estimated that the figures reported represent only the tip of the iceberg.

69. The National Strategy for Combating Violence against Women provides for women victims to have access to medical and psychological care, legal support and professional training, with a view to their social and economic reintegration. In addition, the National Security Directorate has implemented several preventive security measures aimed at combating violence against women, such as the establishment of counselling services at city police stations. However, concern was expressed about the lack of a policy for medical personnel to monitor and report cases of domestic violence against women (see CEDAW/C/DZA/CO/3-4, para. 40).

70. To break the vicious cycle of violence, there must be a clear and strong political will to ensure that the normative and policy framework protects and empowers women and to address gender-based stereotypes, assumptions and expectations that place women in a subordinate role in society. In this connection, the Special Rapporteur points to gaps in the normative framework that should be addressed.

71. Certain provisions of the Penal Code remain problematic with regard to different forms of gender-based violence. Article 336 criminalizes rape, but does not provide a definition of the offence as a violation of an individual's physical and mental integrity, and marital rape is not recognized as a criminal offence. Article 326 makes abduction or corruption of or the attempt to abduct or corrupt a minor under 18 years, without violence, threats or deception an offence punishable by imprisonment of one to five years. However, if the perpetrator marries the minor, he is not liable to prosecution or conviction until the marriage is annulled.

72. The Penal Code does not define other forms of sexual violence, such as sexual assault, but such acts may be prosecuted under articles 334 and 335 covering indecent assaults (*attentat à la pudeur*). However, these provisions have limited scope as they do not

[24] See WHO, *Safe abortion: technical and policy guidance for health systems*, 2nd ed. (2012).

[25] See Algeria, Ministry responsible for the Family and the Status of Women, *Violence à l'égard des femmes en Algérie : enquête nationale de prévalence* (2006).

cover non-violent acts against adults or minors who, owing to early marriage, are treated as adults.

73. The Penal Code criminalizes adultery (art. 339) and homosexuality (art. 338). However, it has been reported that victims of sexual violence are deterred from filing a complaint for fear of finding themselves prosecuted under these provisions. The introduction in 2004 of sexual harassment as a criminal offence was limited to instances of sexual harassment by a person abusing his position of authority in the workplace (art. 341 bis).

74. The Special Rapporteur welcomes the draft law on comprehensive protection for women against all forms of violence, which was passed at first reading in Parliament in December 2015. He trusts that it will be adopted and implemented without delay.

75. In February 2016, amendments to the Penal Code introducing penalties for domestic violence and violence against women, including sexual harassment, were passed. These amendments had been blocked by the Senate for eight months amid resistance from conservative groups that viewed them as interference in family affairs. The Special Rapporteur commends these amendments and urges the authorities to address without delay the remaining gaps in legislation and in practice regarding gender-based violence so as to uphold women's right to health and related rights.

B. Adolescents and youth

76. In 2012, about 16.6 per cent of the population of Algeria was aged 10 to 19 years.[26] In 2016, adolescents and youth aged 10 to 24 years represented about one quarter of the population. Given the ongoing demographic transition over the past decades, with lower fertility rates (about 3 children per woman in 2014) and increased life expectancy, adolescents and youth comprise a very important segment of the population and offer a unique opportunity for the country to reap the demographic dividend. This group can play a decisive role in effectively achieving the health-related Sustainable Development Goals.

77. Algeria acceded to the Convention on the Rights of the Child in 1990 but has made interpretative declarations to certain provisions (arts. 14 (1) and (2), 13, 16 and 17), which place national legislation before international law and amount to reservations. To date, Algeria has not ratified the Optional Protocol to the Convention on a communications procedure, which would allow individuals effective access to justice and redress for violations of their rights.

78. A national strategy for combating violence against children was launched in 2005, jointly with UNICEF. The strategy emphasizes the prevention of violence, intervention by relevant agents, child protection and the social reintegration of victims. According to the strategy, key public officials, including teachers, social workers and educational social workers, have a duty to report allegations of violence at school or within the family (see CRC/C/DZA/3-4, para. 101 (c)).

79. In 2008, the Government adopted the National Plan of Action for the Protection and Welfare of Children, entitled "An Algeria fit for children", for the period 2008 to 2015. The Plan covered four main areas: rights of the child, promoting a healthy and better life; quality of education; and child protection (see CRC/C/DZA/3-4, para. 46). The Special Rapporteur was not able to ascertain whether the plan had been reviewed in 2010, as was foreseen, and whether its impact had been assessed after 2015. On 15 July 2015, Algeria adopted Law No. 15-12 on the protection of children.

80. The Committee on the Rights of the Child raised some important issues relating to the right to health of children and adolescents but many of them do not seem to have been adequately addressed as yet. For example, sexual and reproductive health services for

[26] See UNICEF, statistics on Algeria. Available from www.unicef.org/infobycountry/algeria_statistics.html#123.

adolescents remain inadequate and comprehensive age-sensitive sexual education and information is generally unavailable.

81. The Special Rapporteur observed a lack of effective implementation and impact assessment of policy measures addressing children, owing to limited political will and insufficient financial and technical resources, including reliable disaggregated data and indicators. To date, an independent national institution for the promotion and protection of children's rights has not been established.

82. An intersectoral public policy on sexual and reproductive health rights aimed at adolescents within and outside the educational system should be designed and implemented. This policy should take into account sexual and reproductive health rights, healthy sexuality, prevention of unplanned pregnancies and sexually transmitted diseases, including HIV/AIDS, and use of all types of contraceptives.

83. Adolescents and youth should be seen as rights holders and should be meaningfully involved in all matters and decisions affecting them. Services need to be adolescent- and youth-friendly, so that they are trusted and not avoided. This is especially important with regard to their mental health and emotional well-being, in particular to prevent suicide and ensure early identification of mental health conditions, and crucial when it comes to drug use. Adolescents and youth should be empowered to exercise their right to health according to their evolving capacities so that they are responsible and fully able to control their health and lives when they reach adulthood.

Right to health in schools

84. The Special Rapporteur visited several primary and secondary schools in different areas and commends the efforts aimed at ensuring access to basic health services in primary and secondary schools. Health in schools is considered a key pillar of the public health system and a range of preventive, curative and educational services are provided to children and adolescents.

85. Since 2005, the Programme for the Promotion and Protection of Health in the School Environment has been implemented by the Ministries of Health and National Education. It has a multidisciplinary and multisectoral approach with the participation of students and parent associations. Its main objectives are to guarantee optimal coverage through vaccinations, health screenings and educational campaigns and to ensure adequate conditions regarding hygiene, food and infrastructure in schools.

86. Under the programme, screening and follow-up units (*unités de dépistage et de suivi*) composed of multidisciplinary teams of doctors, dentists, psychologists and paramedical personnel have been established in schools. The teams are part of the daily life in schools and integrate their health-related programmes in coordination with the educational teams.

87. In 2016, there were a total of 1,831 such units, of which 1,343 (1,159 full-time; 184 part-time) were located in schools throughout the country and employed over 2,000 doctors, dentists and paramedical personnel and over 1,500 psychologists.

88. The Special Rapporteur visited several of these units and commends the efforts. Schools offer excellent opportunities to promote the health and well-being of children, including through the implementation of comprehensive programmes and the provision of health-related education and evidence-based information to address patterns of discrimination and other barriers to the enjoyment of the right to health of the children, adolescents and youth.

89. Algeria has established a good model to prevent discrimination and exclusion of children in relation to accessing basic health services linked to the enjoyment of the highest attainable standard of physical health. However, inadequate screening for emotional and behavioural health conditions and identification of developmental disabilities or emotional difficulties in children have led to children being excluded from mainstream schools. The Special Rapporteur recommends that a better balance be struck to address both physical health and mental health in the school setting.

90. There are unique health challenges facing adolescents and youth (see A/HRC/32/32), but investing in the health and health rights of adolescents and youth, including their education and participation, can galvanize a vast human potential in the context of the 2030 Agenda for Sustainable Development, in particular in countries like Algeria, where a demographic transition is taking place.[27]

C. People living with HIV/AIDS

91. Algeria has a low prevalence rate of HIV/AIDS, estimated at below 0.1 per cent of the population. The rate is considerably higher for men who have sex with men (3.7 per cent) and sex workers (4.7 per cent). Prevalence in people who inject drugs is approximately 2.9 per cent.[28]

92. In 2015, it was estimated that 8,800 people of all ages were living with AIDS in Algeria. Reportedly, about 90 per cent of persons living with HIV (7,915) received antiretroviral therapy; around 500 women living with HIV were in need of antiretrovirals to prevent mother-to-child transmission; and about 112 pregnant women (about 25 per cent) actually received antiretrovirals in 2015.[29]

93. Available data indicate that fewer than 17 per cent of women in Algeria know where to go to be tested for HIV; only 2 per cent benefit from HIV counselling and testing when receiving maternal care; and only 1 per cent of pregnant women has been tested for HIV/AIDS.[30] Regarding comprehensive knowledge of HIV among young girls and women (ages 15-24), data show low levels of awareness and stark differences between those in urban and rural areas.[31]

94. The institutional framework for HIV care was significantly strengthened during the 1990s with the establishment of the National Blood Agency in charge of blood transfusion safety; compulsory screening for blood donations and other blood-related activities throughout the national territory; the establishment of 15 referral centres for HIV/AIDS; and the supply of free antiretroviral drugs in those centres.[32] The National Committee for Combating and Preventing HIV/AIDS and Sexually Transmitted Diseases acts as the national coordinating body.[33]

95. The Government has put in place policies and programmes to fight the spread of and ensure access to treatment for those living with HIV/AIDS, including through testing centres and the National Strategy on the Elimination of Mother-to-Child Transmission of HIV/AIDS 2013-2015.

96. In 2011, there were 59 testing and counselling facilities in Algeria,[34] and 61 screening centres have been opened in *wilayas* across the country providing confidential and free services. In 2012, UNAIDS and the Ministry of Health announced the establishment of a dedicated HIV/AIDS research centre in Tamanrasset in southern Algeria, which has yet to materialize. Prevention activities target youth in particular and are conducted through school and university health programmes and multisectoral mechanisms,

[27] WHO, *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*, p. 11.
[28] See http://aidsinfo.unaids.org/.
[29] See http://aidsinfo.unaids.org/.
[30] UNICEF Annual Report 2014: Algeria, pp. 18-19.
[31] See UNICEF statistics on Algeria. Available from www.unicef.org/infobycountry/algeria_statistics.html.
[32] See African Commission on Human and Peoples' Rights, "Algeria: fifth and sixth periodic reports" (December 2014), para. 65.
[33] See UNAIDS Country Progress Report 2014. Available from www.unaids.org/sites/default/files/country/documents/DZA_narrative_report_2015.pdf.
[34] See WHO Global Health Observatory. Available from http://apps.who.int/gho/data/node.main.625TC?lang=en.

in particular the partnership between UNAIDS and the National Office for the Fight against Drug Use and Drug Addiction.[35]

97. The National Strategic Plan 2016-2020 aims to achieve the UNAIDS 90-90-90 goal: by 2020, 90 per cent of all people living with HIV will know their HIV status; 90 per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90 per cent of all people receiving antiretroviral therapy will have viral suppression.

98. However, during his visit, the Special Rapporteur noted that the key populations faced serious barriers, in law and in practice, to the enjoyment of the right to health. HIV/AIDS remains a taboo in Algerian society. People living with HIV/AIDS face different forms of discrimination and stigma in accessing health care and treatment, and tend to avoid using health services.

99. Algeria does not have legislation specifically prohibiting non-discrimination of persons living with HIV/AIDS. General provisions on the prohibition of discrimination are contained in, inter alia, the Constitution (art. 29) and the Code of Medical Ethics (art. 7). In 2005, the Family Code was amended (by Ordinance No. 05-02 of 27 February 2005) to introduce an obligatory prenuptial medical examination as part of the marriage procedure, which may include HIV testing. Although the test results do not prevent couples from getting married, this requirement is incompatible with obligations under the right to health as it infringes upon the rights to privacy, autonomy and refusal of non-consensual treatment.

100. The Penal Code criminalizes homosexuality and sex work (arts. 338, 343 and 347), which is not only discriminatory, but can have dramatic public health effects. While the adoption of health-related policies and programmes targeting key affected populations is commendable, it does not offset the impact of criminalization, which is a serious barrier to the enjoyment of the right to health of those at risk, driving them away from the services they need and increasing health-related risks for them and society as a whole.

101. Algeria is a major transit hub for irregular mixed population movements. Over the past few years, the number of migrants in the country has increased, including migrant workers and undocumented migrants. Overall, migrants, including those in irregular situations, have access to health-care services free of charge. However, there is a lack of reliable disaggregated data to assess and monitor their situation from a right-to-health perspective. This is of concern since mobility is a determining factor for the HIV/AIDS epidemic and other communicable diseases.

102. More efforts are needed to actively reach out to those populations both as a preventive measure but also to ensure effective access to health services. The Special Rapporteur strongly recommends that the Government decriminalize homosexuality and sex work and implement awareness-raising campaigns to combat discrimination against persons living with HVI/AIDS, in particular in health-care services. In addition, age-appropriate evidence-based educational modules on HIV/AIDS transmission and prevention should be included in the school curriculum.

103. The Sustainable Development Goals aim to eliminate HIV/AIDS by 2030. Algeria has made considerable progress in this direction and could achieve this goal and lead efforts in the region. However, this cannot be accomplished without the normative and societal changes necessary to achieve zero discrimination, in particular in health-care services.

D. People who use drugs

104. Owing to its geographical location between two sensitive cannabis production and consumption areas, Algeria continues to be classified as a transit country for drug trafficking.[36] While drug addiction has been a public health issue for decades in many

[35] See African Commission on Human and Peoples' Rights, "Algeria: fifth and sixth periodic reports" (December 2014), para. 63.

[36] Pompidou Group of the Council of Europe, "Drug situation and policy in Algeria" (2014), p. 9.

countries, according to official sources, the phenomenon of drug use and addiction is relatively recent in Algeria.[37] Nowadays, both domestic production and consumption are on the rise and drugs are more easily accessible in all sectors of society.

105. Drug use was, until recently, taboo in Algerian society and considerable progress has been made in addressing the issue over the past decades. A national epidemiological survey carried out in 2010 showed that the most frequently consumed drugs in Algeria were cannabis and psychotropic substances. The number of consumers of psychoactive substances is estimated to be around 300,000, aged 12 and above, that is, 1.15 per cent of the population, with a clear predominance among persons between 20 and 39 years of age.[38] The situation of people who inject drugs in Algeria is undocumented and harm-reduction services are generally unavailable.

106. Shortly after independence, Algeria acceded to and ratified the 1961 Single Convention on Narcotic Drugs (by Decree No. 63-343 of 11 September 1963) and subsequently ratified the 1971 Convention on Psychotropic Substances (by Decree No. 77-177 of 7 December 1977) and the 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (by Decree No. 95-41 of 28 February 1995). However, some years elapsed before legislation on drug use was adopted. Order No. 75-9 of 17 February 1975 on penalties for trafficking in and the illicit use of poisonous substances and narcotics merely laid down penalties for drug-related offences.

107. The Health Act provides that, in the future, the production, transport, import, export, possession, supply, transfer, acquisition or use of narcotic or non-narcotic poisonous substances or plants, and the cultivation of such plants, will be governed by a regulation (sect. 190); and contains criminal-law provisions concerning drug-related offences (sects. 242-259).

108. Law No. 04-18 of 25 December 2004 on the Prevention and Repression of Illicit Use and Trafficking of Narcotics and Psychotropic Substances is regarded as the most important piece of drug legislation in Algeria. The law makes a distinction between victims and criminals and provides for the possible waiving of court proceedings against those who agree to undergo medical treatment or rehabilitation (arts. 6-12). Under these provisions, drug users may avoid criminal prosecution if, as per a court order, they agree to undergo curative and detoxification treatment at specialized establishments under the supervision of health personnel.

109. The Special Rapporteur acknowledges the efforts made to address drug use through non-custodial measures. However, he considers that granting the criminal courts jurisdiction over a public health issue by issuing drug "treatment and testing orders" as an alternative to imprisonment could be considered as a form of coerced treatment, which does not necessarily ensure the protection of drug users' rights and is not an effective public health measure.

110. Drug use does not always equate to drug addiction and certain users do not require rehabilitation or medical treatment. Adequate safeguards should be in place to guarantee the promotion and protection of the rights of drug users to access evidence-based information about substance use and addiction. Adequate health services should be put in place based on informed consent and the right to refuse treatment, a key element of the dignity and autonomy of those individuals affected. Drug use should not be a criminal offence and restorative measures should be put in place to address such behaviours outside the criminal justice system, particularly with regard to adolescents and youth.

Available from www.coe.int/T/DG3/Pompidou/Source/Images/country%20profiles%20flags/profiles/CP%20Algeria%20English%2044s-X3.pdf.

[37] See, for example, Algeria, Ministry of Health, Population and Hospital Reform, "Programme de lutte contre la toxicomanie", p. 1. Available from www.mindbank.info/item/5323.

[38] Algeria, Ministry of Justice, "Enquête épidémiologique nationale et globale sur la prévalence de la drogue en Algérie" (September 2010), p. 13. Available from www.plateforme-elsa.org/files/Enquete_Nationale_Algerie_UD_2010.pdf.

111. Over the years, a number of institutions have been established to address drug use and addiction in Algeria. Since 2002, the National Office for the Fight against Drug Use and Drug Addiction has been the main body dealing with such issues.

112. Currently, there are two centres for the prevention and treatment of drug addiction, in Blida (since 1996) and in Sidi Chami, Oran (since 1997). There are three intermediary centres for treating drug addiction in Annaba, Sétif and Bab El Oued (Algiers). The 2007-2009 National Action Plan on Drug Use and Drug Addiction created 15 drug treatment centres and 53 intermediary centres throughout the country. Each *wilaya* is supposed to have at least one intermediary centre (see CRC/C/DZA/3-4, paras. 179-180). In 2013, it was reported that 25 intermediary centres had been established and were operational. In the same year, existing treatment centres and intermediary centres reported 14,936 consultations and 1,477 hospitalizations, including 96 for court-ordered treatment.[39]

113. The Special Rapporteur visited the treatment centres in Oran and Blida, which have specific programmes and services for drug users, and had the opportunity to speak to health providers and service users. Although the structures and programmes seem to have a good approach, they should be accompanied by appropriate harm-reduction services at the community level and by education and information campaigns and programmes, particularly for reaching out to adolescents and youth.

114. The health and related sectors and authorities, including the ministries responsible for education and youth, should be more active in promoting participatory and evidence-based prevention services and treatment for people who use drugs. The Government of Algeria should make sure that its normative framework does not criminalize drug use and minor drug-related offences, and should continue to promote non-punitive and non-custodial public health measures that ensure respect for the dignity and autonomy of those concerned.

IV. Mental health framework

115. Mental health conditions account for 6 per cent of the causes of disabilities in Algeria. For the population as a whole, the incidence of mental health conditions has been estimated at 0.5 per cent for both sexes (see E/C.12/DZA/4, para. 296). [40] An epidemiological study carried out by the Ministry of Health in 2004 showed that chronic mental disorders were diagnosed in 0.7 per cent to 1.9 per cent of subjects in different age groups. Those below 40 years of age and women were particularly affected.[41]

116. In 2011, public expenditure on mental health accounted for 7.3 per cent of the total health budget, of which expenditure on inpatient hospitalization represented 81.44 per cent of the total mental health budget. Algeria has an urgent need for qualified human resources in the mental health sector. For a number of years now, different programmes have been set up to strengthen the training of mental health professionals (psychiatrists, nurses, psychologists) and increase the number of mental-health positions.[42]

117. Violence in the country during the 1990s, known as the "Black Decade", including sexual violence, has had a detrimental impact on the enjoyment of the right to physical and mental health of the population. It is estimated that up to 92 per cent of the Algerian population witnessed acts of violence during this time, with the consequent negative impact on their mental health. Several treaty bodies have expressed concern about the failure of the Government to provide adequate psychological support to victims of violence, including

[39] Pompidou Group of the Council of Europe, "Drug situation and policy in Algeria" (2014), p. 28.

[40] Also Pan Arab Project on Family Health, *Enquête Algérienne sur la santé de la famille* (2002), p. 39. Available from www.sante.gov.dz/images/population/RAPPORT%20FINAL%20PAPFAM.pdf.

[41] WHO Mental Health Atlas 2005, p. 54. Available from www.who.int/mental_health/evidence/atlas/profiles_countries_a_b.pdf?ua=1.

[42] See WHO Mental Health Atlas 2011, Algeria. Available from www.who.int/mental_health/evidence/atlas/profiles/dza_mh_profile.pdf.

those who experienced sexual violence during the 1990s (see CAT/C/DZA/CO/3 and E/C.12/DZA/CO/4).

118. Law No. 98-09 of 1998 is the most recent legislation relating to mental health. Mental health provisions are also included in the Health Act (arts. 103-149). In the context of the review of this law, the section on mental health will be substantially enhanced to reinforce the prevention of mental health conditions and guarantee patients' rights.[43] The Government ratified the Convention on the Rights of Persons with Disabilities in 2009 and submitted its initial report to the Committee in 2015.

119. The updated Mental Health Policy 2016-2020 covers prevention, treatment and rehabilitation with an intersectoral and a life course approach, in line with WHO *Mental Health Action Plan* (*2013-2020*).[44] Previous mental health policies reportedly faced challenges in their implementation.[45]

120. The National Programme on Mental Health (2010-2013) considered the provision of mental health care with a focus on decentralized primary health care, a community-based approach and the greater availability of medications; the update of mental health legislation; the development of programmes to prevent mental conditions; psychological and social rehabilitation programmes for victims of violence; and information campaigns to educate professionals and the general public as well as communities and families (see E/C.12/DZA/4, para. 297). Objectives included the strengthening of curative and preventive care through the inclusion of the private sector (160 private psychiatric practices) and the promotion of partnerships and cooperation with other sectors concerned (see CEDAW/C/DZA/3-4, pp. 88-89).

121. The Algerian authorities have underlined their commitment to maintaining public spending on mental health to ensure access to free services without discrimination. The first steps to develop general mental health services for children and adults should be commended; however, such initiatives still remain pilot projects and need to be further developed and replicated. It is a good sign that psychologists are working in the health and education sectors and that psychiatrists are working in proximity health centres. But this is not enough for modern human rights-based mental health policies and services to be in place.

122. The mental health sector in Algeria is excessively reliant on psychiatric hospitals and inpatient care. Instead of building new psychiatric hospitals, each general hospital should have an inpatient psychiatric unit to make mental health care more accessible to all and avoid stigmatization. Although the availability of mental health services in primary-care centres has increased in recent years, with 129 centres providing such services, additional steps should be taken to reinforce outpatient services within general hospitals and reduce dependency on hospital care. There should be a shift in mental health services and public investments in the community, with initiatives grounded in human rights and modern principles of mental health policy and based on quality services and the empowerment of users.

123. Moreover, Algeria should move towards the implementation of the Convention on the Rights of Persons with Disabilities, which implies, first, moving away from a medical model with excessive emphasis on medical diagnosis and abandoning old-fashion practices leading to violations of people's rights based on diagnosis, treatment and medical necessity, as well as to stigmatization and discrimination.

124. For example, after they have been evaluated by medical doctors and psychologists, children with moderate and severe levels of developmental disabilities are referred to care centres which are under the jurisdiction of the Ministry of National Solidarity, Family and Women. The fact that the education of those children is not within the realm of the Ministry of National Education could be considered as a violation of their right to education. All children, including children with disabilities, should be enrolled in the mainstream school

[43] Ibid.

[44] See www.who.int/mental_health/publications/action_plan/en/.

[45] WHO Mental Health Atlas 2005, p. 54.

system and individual educational plans should be developed to appropriately address the level of development of each child.

V. Conclusions and recommendations

125. **Significant progress has been made over the past decades in Algeria with respect to the enjoyment of the right to health and there are good opportunities for its progressive realization. However, the authorities need to step up their efforts to address certain normative, structural and systemic issues to make sure that no one is left behind.**

126. **The right to health should be promoted and protected through access to health services, supplies and facilities, which should be available, affordable, appropriate and of good quality. The right to health can only be fully realized through the enjoyment of the underlying and social determinants of health, which requires the design and implementation of cross-sectoral policies and programmes that focus not only on life-saving biomedical interventions but also on broader socioeconomic, cultural and environmental factors.**

127. **Health policies or programmes should be guided by a human rights-based approach with strong emphasis on the principles of equality and non-discrimination, transparency, participation and accountability. Issues relating to the right to health would be better addressed through intersectoral policies with horizontal approaches that promote the effective use of primary care and incorporate the concerted efforts of all stakeholders.**

128. **The Special Rapporteur recommends that the Government of Algeria:**

(a) **Consider withdrawing all declarations and reservations to international human rights treaties; ratify the Optional Protocols on individual complaints procedures; and extend a standing invitation to the special procedures of the Human Rights Council;**

(b) **Strengthen the health-care system and guarantee adequate, equitable and sustainable financing by maintaining or increasing national budget allocations for health; and continue improving access to and the capacity of health structures in remote regions, with particular focus on primary care and the role of general practitioners;**

(c) **Ensure that a solid health information system is in place to generate quality national data and statistics to analyse gaps and design, implement, review and assess policies;**

(d) **Invest in nationally led evaluations of health policies and programmes; and establish independent mechanisms to monitor the performance of the health system;**

(e) **Address maternal and neonatal mortality and morbidity, including by launching a maternal death audit system and a reference guide on obstetric care and referring to the technical guidance on the application of a human rights-based approach to reducing and eliminating preventable maternal and under-five mortality and morbidity (A/HRC/21/22 and A/HRC/27/31);**

(f) **Respect, protect and realize the right to health of women and girls by removing barriers to their sexual and reproductive rights; ending the criminalization of abortion and ensuring access to abortion services; and providing sexual and reproductive health information, services and goods, in particular comprehensive, age-sensitive and inclusive sexual education in secondary schools;**

(g) **Ensure comprehensive protection for women against all forms of violence by addressing, without delay, the remaining gaps in legislation and in practice in order to ensure substantive equality and uphold their right to health and related rights;**

(h) **Protect children, adolescents and youth from all forms of violence and promote their health, well-being and autonomy by creating conducive environments and services and ensuring their meaningful participation in all decisions affecting them, particularly in the areas of mental health, sexual and reproductive health rights, and drug and substance use;**

(i) **Establish an independent national institution for the promotion and protection of children's rights with the mandate and resources necessary to enable it to perform its functions in consultation with key stakeholders;**

(j) **Remove the legal provisions criminalizing and stigmatizing people living with HIV/AIDS, including provisions in the Penal Code, and remove the requirement of a prenuptial medical certificate;**

(k) **Guarantee non-discrimination against people living with HIV/AIDS in the health-care sector by ensuring that health services, goods and information are available, accessible, acceptable and of good quality for all key populations and that the health workforce is properly trained and equipped;**

(l) **Promote a non-punitive approach to drug use policies and programmes outside the criminal justice system and expand pilot services for people who use drugs, based on scientific evidence and with full respect for their dignity and rights;**

(m) **Follow the guidance of the Committee on the Rights of Persons with Disabilities with regard to children and adults with psychosocial and intellectual disabilities;**

(n) **Adopt modern mental health policies and services with a view to mainstreaming them in the general health system and community support services, and ensure the availability of psychotropic medication as well as psychosocial intervention for children and adults in need;**

(o) **Launch a gradual comprehensive reform of the mental health-care system to optimize investments and move away from excessive reliance on hospitals and inpatient care to community-oriented services based on the principles of non-discrimination, participation and respect for the dignity and rights of the users of such services.**