Non-communicable diseases and mental health: the importance of human rights

QUESTIONS AND ANSWERS

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UN INTERAGENCY TASK FORCE ON NCDs
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UNITED NATIONS HUMAN RIGHTS
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I. INTRODUCTION

1. Who would find this document helpful?

As States have the primary responsibility for ensuring the realisation of human rights for all, these key questions are intended to raise greater awareness among States and other relevant stakeholders of the relevance and the impact of a human rights-based approach to non-communicable diseases (NCDs) and mental health.

2. What are NCDs and mental health conditions?

Also known as chronic diseases, NCDs tend to be of long duration and are the result of a combination of behavioural, environmental, genetic and physiological risk factors. They include cardiovascular diseases, diabetes, cancers and chronic respiratory diseases.[1] Although NCDs are often associated with older age groups, every two seconds, one person under the age of 70 dies of an NCD (a total of 17 million premature deaths per year), with 86 per cent of those deaths occurring in low and middle-income countries.[2] NCDs are collectively responsible for an estimated 41 million deaths annually, equivalent to 74% of all deaths globally, making them the leading cause of global mortality and disability.[3]

These diseases are driven by phenomena and trends that include rapid unplanned urbanisation, globalisation of unhealthy lifestyles, and population ageing. Individuals across all stages of life are exposed to the major risk factors contributing to NCDs: consumption of tobacco and exposure to tobacco smoke, insufficient physical activity, alcohol consumption, air pollution and unhealthy diets. An important way to control NCDs is to focus on reducing these risk factors and to invest in improving the management of NCDs, including through prevention, detection, screening and treatment.[4]

Mental health conditions are states associated with significant distress, impairment in functioning, or risk of self-harm. They are highly prevalent in all countries, with around one in eight people in the world living with a mental health condition. They are the leading cause of years lived with disability (YLDs), accounting for one in every six YLDs globally. Persons with severe mental health conditions die on average 10 to 20 years earlier than the general population, often of preventable physical diseases.[5]

[1] WHO. NCD factsheet. 2022 (accessed 12 March 2023).
[2] Noncommunicable diseases now 'top killers globally' – UN health agency report. United Nations News. 2022.
[3] WHO. Noncommunicable Diseases – overview (accessed 12 March 2023).
[4] Noncommunicable diseases: a compendium. Eds: Nick Banatvala, Pascal Bovet.2023. Routledge, Oxford UK.
[5] World mental health report: transforming mental health for all. WHO. 2022.

3. How has the UN system responded to NCDs and mental health?

The Economic and Social Council established the Ad Hoc Interagency Task Force on Tobacco Control in 1999 to develop a joint United Nations response to NCDs and to strengthen global support for tobacco control. The entry into force of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) followed in February 2005. One of the most widely ratified treaties, the WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest attainable standard of physical and mental health (the right to health). The treaty aims to "protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties."[6] In 2013, the UN Secretary-General established the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases by expanding the mandate of the Ad Hoc Interagency Task Force on Tobacco Control. This is the body which coordinates the work of the United Nations on NCDs.

The same year, following the commitments made in the United Nations Political Declaration on the Prevention and Control of NCDs,[7] the World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs, 2013-2030.[8] The Global Action Plan provides Member States with a road map and policy options to achieve nine global NCD targets and identifies a human rights-based approach as one of its overarching principles.[9] For its part, the WHO Comprehensive Mental Health Action Plan, 2013-2030 emphasises the need for services, policies, legislation, plans, strategies and programmes to align with international human right standards.[10] Through the Political declaration of the third high-level meeting of the UN General Assembly on the prevention and control of non-communicable diseases, UN Member States affirmed the need to uphold human rights in addressing NCDs and mental health.[11]

NCD and mental health responses contribute to achieving Sustainable Development Goal (SDG) 3 (ensure healthy lives and promote well-being for all at all ages) as well as other SDGs, including: SDG 1 (no poverty), SDG 2 (zero hunger) and its target 2.2 (end all forms of malnutrition), SDG 4 (quality education), SDG 5 (gender equality), SDG 10 (reduced inequalities) and SDG 13 (climate action). In addition to target 3.4 (by 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being), many other targets under SDG 3 have a direct bearing on NCDs and mental health: target 3.a aims to strengthen the implementation of the WHO FCTC in all countries; target 3.5 calls for strengthening the prevention and treatment of substance abuse, including the harmful use of alcohol; target 3.8 aims to achieve universal health coverage; and target 3.9 is concerned with the substantial reduction, by 2030, of the number of deaths and illnesses from hazardous chemicals, pollution and contamination, including from air pollution.

[6] WHO Framework Convention on Tobacco Control. Article 3. 2003.
[7] Political declaration of the high-level meeting of the general assembly on the prevention and control of non-communicable diseases. United Nations General Assembly, A/66/L.1, 2011.
[8] Global action plan for the prevention and control of NCDs 2013-2030. WHO. 2013.
[9] Ibid, page 3.
[10] Comprehensive mental health action plan 2013–2030. WHO. 2013.
[11] Political declaration of the third high-level meeting of the general assembly on the prevention and control of non-communicable diseases. Time to deliver: accelerating our response to address non-communicable diseases for the health and well-being of present and future generations. United Nations General Assembly, A/RES/73/2, 2018 (paras. 11, 28 and 37).

II. NORMATIVE FRAMEWORK

1. What are human rights?

Human rights are rights we have simply because we exist as human beings - they are not granted by any State. These inalienable, universal rights are **inherent** to us all, regardless of nationality, sex, national or ethnic origin, race, sexual orientation, gender identity, religion, language, or any other status. They range from basic – the right to life – to those that make life worth living, such as the rights to food, education, work, health, liberty and access to basic services.[12]

The human rights framework is an ecosystem of interrelated, indivisible rights, each depending on the realisation of others for its full exercise. In the case of the right to health, the enjoyment of the rights to social protection and work, for instance, has a bearing on the affordability of health services, including for NCDs and mental health. Realising the right to adequate food, which includes adequate nutrition, is vital for health and wellbeing. Freedom of association and assembly enable people to organise and advocate for better health policies and services, while the right to information empowers people to make informed decisions about their health and lifestyles.

A range of human rights instruments articulate, affirm and guarantee these rights. These include (among many others, both international and regional) the Universal Declaration of Human Rights, the International Covenant on Economic Social and Cultural Rights, and the International Covenant on Civil and Political Rights, all adopted by the UN General Assembly. Together these three instruments have come to be known as the International Bill of Human Rights.

2. Why are human rights necessary for the prevention and control of NCDs and in the context of mental health?

(a) The human rights framework is indispensable to how we respond to health challenges such as NCDs and mental health because:

- human rights are legal standards that States are bound by and must, therefore, apply.
- human rights emphasise that certain values, such as equality, non-discrimination and the protection of those in situations of marginalisation, are non-negotiable.
- it incorporates agreed interpretations of the content of specific rights, which have emerged from years of reflection, discussion and adjudication, allowing substantive, human rights-based policies to be developed.
- it identifies principles that should guide decision-making processes, such as participation, transparency, and accountability.
- the language of rights recognises the dignity and agency of all individuals (regardless of race, gender, social status, sex, age, disability, sexual orientation or any other distinguishing factor) and is intentionally empowering.[13]

[12] OHCHR. What are human rights? (accessed 12 March 2023).
[13] A/70/274. Report of the Special Rapporteur on extreme poverty and human rights. 4 August 2015.

(b) The five major risk factors for NCDs are closely connected with social, economic and environmental conditions, such as inequality, discrimination, poor access to education (particularly health literacy), inadequate housing, poor nutrition, poor air quality and poverty. Risk factors for mental ill-health include adverse childhood experiences, social isolation, stigma, discrimination, violence, poverty and job and housing insecurity. Most of these are consequences of the denial or violation of human rights, making it imperative to incorporate a human rights-based approach (outlined below) into how NCDs and mental health are addressed.

(c) The protection of marginalised people in society is a distinguishing preoccupation of human rights. Its message is one of equality and non-discrimination, inclusion and participation, and dignity and justice. People who are most often excluded from access to health services tend to belong to populations living in situations of marginalisation or experiencing systemic discrimination. These populations will also tend to be disproportionately exposed to the major risk factors for NCDs and to be at greater risk of experiencing mental health conditions. Incorporating human rights principles and norms into how governments respond to NCDs and mental health is critical for unlocking non-discriminatory access to better quality health services and to effectively reducing exposure to risk factors. Human rights also have the objective of redressing power dynamics which perpetuate inequality and marginalisation.

3. Where do the norms most relevant for NCDs and mental health come from?

The right to health is protected under various international human rights instruments adopted at both regional and global levels. These include, in addition to the International Bill of Human Rights, the Convention on the Rights of the Child (art. 24(1)), the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of Persons with Disabilities. The right to health is also affirmed in the Constitution of WHO and in the WHO FCTC.[14] Most recently, on 28 July 2022, the UN General Assembly recognised the right to a clean, healthy and sustainable environment as a human right, one that is important for the enjoyment of human rights.[15]

4. Is the right to health a right to be healthy?

No, the right to health is a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.[16] It may be described as an inclusive right that calls for access to timely and appropriate health care, as well as attention to the "underlying determinants of health".[17] These determinants are the conditions which influence our ability to live in the best health possible and include the risk factors and conditions mentioned above in relation to NCDs and mental health.

Tackling NCD and mental health risk factors means, for instance, taking into account how socio-economic status, sex, age, gender, sexual orientation, race, ethnicity, disability and other factors affect exposure for different populations, including in the way they may intersect, create societal barriers and reinforce marginalisation. It also means addressing the root causes of these differential experiences. NCDs and mental health conditions are more prevalent among

[14] Regional instruments recognising the right to health include: (i) European Social Charter; (ii) African Charter on Human and Peoples' Rights, 1981; (iii) Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, 1988.
[15] Res. 76/300 (para 1). See also A/HRC/RES/48/13.
[16] United Nations Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), (para 8 and 9). Office of the High Commissioner for Human Rights 2000.
[17] CESCR. General Comment No. 14, para 11.

socially and economically disadvantaged communities such as people living in poverty or those with relatively little education. Dealing with inequalities and discrimination, including intersectional discrimination, is a key right to health intervention for NCDs and mental health.

5. What is a human rights-based approach to health?

The human rights-based approach to health derives from the human rights norms and standards contained in relevant human rights instruments, as interpreted by treaty monitoring bodies such as the Committee on Economic, Social and Cultural Rights (CESCR), the Committee on the Rights of the Child and the Committee on the Elimination of Discrimination Against Women.[18] These interpretations elaborate on the normative content of the concerned rights as well as the duties which attach to them, and are widely accepted as authoritative.[19]

For example, under the International Covenant on Economic Social and Cultural Rights, ratified by 171 countries,[20] a human rights-based approach to health places a duty on States Parties to ensure that health goods, facilities and services are available in sufficient quantity, and are physically accessible and affordable to everyone without discrimination. Health facilities, goods and services must be gender-sensitive, culturally appropriate and respectful of medical ethics (acceptable), as well as scientifically and medically appropriate and of good quality. The cross-cutting human rights principles of equality and non-discrimination require that States address all forms of discrimination and take steps to ensure substantive equality.[21]

The right of everyone to participate in decisions which concern them is also part of integrating human rights into health. States should develop the capacity of rights holders to participate in the design, implementation and monitoring of health policies, as well as in planning and budgetary processes related to health, including mental health and NCDs. Transparent, gender-responsive and accessible mechanisms should be established to enable stakeholders' meaningful participation and to facilitate regular communication between rights holders and authorities at the community, subnational and national levels. Particular attention should be paid to those who are usually excluded and most at risk of being left behind, such as racial, ethnic and other minorities, older persons, persons with disabilities, children, youth, women, and LGBTIQ+ people.

Finally, accountability is a fundamental element of the human rights-based approach; any person who has experienced the violation of their right to health is entitled to have access to effective judicial or other appropriate remedies, such as reparations and guarantees of non-repetition.[22]

6. How might a human rights-based approach apply to NCDs and mental health?

The following are examples of measures to give effect to the right to health by ensuring access to good quality services, removing barriers and addressing the underlying determinants of health.[23]

[18] United Nations treaty monitoring bodies officially adopt interpretations of the content of the rights in the treaties concerned by way of "general comments" or "general recommendations".
[19] A comprehensive statement of the content of the right to health, incorporating all the elements of what is referred to as the human rights-based approach, may be found in CESCR. General Comment No. 14, especially paras 12, 17, 55 and 59.
[20] United Nations. International Covenant on Economic, Social and Cultural rights. 1967.
[21] E/C.12/GC/20. UN Committee on Economic, Social and Cultural Rights. General Comment No. 20, Non-discrimination in economic, social and cultural rights. 2009.
[22] CESCR. General Comment No. 14, para 14.
[23] Many of the examples in this section come from: WHO. Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. 2017.

(a) Availability

- Put in place a national health infrastructure with equitable coverage of rural, urban and peri-urban areas, providing comprehensive mental health services and services for the prevention, diagnosis and treatment of NCDs.
- Develop and implement a national multisectoral policy and plan for the prevention and control of NCDs through multi-stakeholder engagement and participation.
- Improve the availability of cost-effective basic technologies and essential medicines required to provide treatment, care and support for major NCDs, in both public and private facilities.
- Orient health systems to address mental health, NCDs and their associated risk factors through people-centred health care, social support and universal health coverage.
- Integrate rights based, cost-effective NCD and mental health interventions into the basic primary health care package with referral systems to all levels of care.
- Develop and implement a palliative care policy, together with appropriate training for health workers.
- Include essential nutrition interventions in the public health care system.
- Adopt measures that reduce the negative impacts of current food systems on public health.

(b) Accessibility

- Ensure non-discriminatory access to a nationally determined set of rights-based NCD and mental health-related services, such as essential medicines, health information and mental health services which respect dignity, autonomy and legal capacity.
- Prioritise accessibility of rights-based NCD and mental health services for service users from marginalised populations and groups such as children living in poverty, persons with disabilities and older persons.
- Promote informed decisions among consumers concerning diet and lifestyle by raising public and political awareness and understanding of impacts, risks and good practice for mental health and the management and prevention of NCDs.
- Explore viable health financing mechanisms and innovative economic tools, ensuring that due diligence is exercised in order to prevent and address conflicts of interests, protect public health objectives, and fulfil human rights goals.[24]

(c) Acceptability

- Ensuring mental health and NCD services that are free from stigma, discrimination and coercive practices.
- Providing community-based mental health services.

(d) Good quality

- Develop and implement a national research agenda for NCDs and mental health, and prioritise budgetary allocations accordingly.

[24] For example, 'recent acquisitions by tobacco transnational corporations of pharmaceutical companies that could complicate and hinder tobacco control implementation'. FCTC/COP9(10). Declaration on WHO FCTC and recovery from the COVID-19 pandemic. WHO Framework Convention on Tobacco Control Conference of the Parties, 2021.

- Implement health workforce training, especially at the primary care level, on the protection of human rights in health settings, particularly addressing stigma, discrimination, respect and dignity, including in the context of mental health.
- Ensure health systems are equipped for early detection, treatment and care in the case of children and adolescents living with NCDs, as well as effective referral systems for children suffering from (acute) malnutrition.
- Ensure that mental health services and support systems are adapted for children, including integrating the principles of applying the best interests of the child in all actions concerning them and taking their views seriously into account, in line with their age and maturity.[25]

(e) Addressing underlying determinants of health

- Raise public and political awareness and understanding about the impacts, risks and measures needed for the prevention and control of NCDs and the protection of the rights of persons with mental health conditions.
- Develop and implement rights-based national multisectoral policies and plans for mental health and for the prevention and control of NCDs through multisectoral engagement.
- Develop and implement measures to address tobacco use, alcohol consumption, unhealthy diets, insufficient physical activity and air pollution, utilising international and domestic legal and policy frameworks and mechanisms.
- Ensure that measures take a multi-stakeholder, participatory and whole-of-government approach, align with evidence and global best practice and contribute to the fulfilment of applicable human rights (such as to health, food, information).
- Develop and implement a national research agenda to understand and address the determinants of health as they apply to mental health and NCD prevention and control, and prioritise budgetary allocations accordingly.

(f) Participation

- Ensure non-discriminatory access to health education, particularly related to NCDs and mental health, as well as information technology and infrastructure and legal literacy.
- Promote equality of digital literacy, paying particular attention to women, girls and marginalised populations and groups.
- Strengthen the capacities of civil society and community-based organisations and promote their engagement and participation in health-decision making processes.
- Establish transparent social dialogue and multi-stakeholder mechanisms at community, sub-national, and national levels, promoting meaningful participation of persons with lived experience of NCDs and mental health conditions in these dialogues.
- Ensure that participation outcomes inform sub-national, national and global policies and programmes related to NCDs and mental health.

(g) Accountability

- Establish a legal and policy environment equipped to develop, implement, enforce and monitor robust measures to address NCD risk factors, such as the regulation of commercial sector activity, particularly with a view to reducing alcohol consumption,

[25] United Nations Committee on the Rights of the Child. General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art 24), paras. 12 and 19.

preventing and reducing the use of tobacco and exposure to tobacco smoke, and promoting healthy diets and physical activity.

- Establish accountability mechanisms both within and outside the health sector, and across all branches of government, to enable violations to be remedied and gaps to be addressed (examples include professional standards associations and national ombudspersons).
- Promote and encourage breastfeeding in line with the International Code of Marketing of Breast-milk Substitutes and the cultural context as locally relevant.26

In addition to the examples above, the WHO's Innov8 tool provides a practical, comprehensive approach to identifying the factors which facilitate or hinder access to health programmes and services related to NCDs and mental health. It integrates a human rights-based analysis to recognise these factors as they affect priority subpopulation(s) at each key stage of the programme, including gender-related barriers.[27] The WHO QualityRights initiative provides comprehensive guidance and tools to implement a rights-based approach to mental health.[28]

[26] WHO. International code of marketing of breast-milk substitutes. 1981.
[27] WHO. The Innov8 approach for reviewing national programmes to leave no one behind. technical handbook. 2016.
[28] WHO. QualityRights. Act, unite and empower for mental health. 2023.

III. WHICH HUMAN RIGHTS-BASED ACTIONS CAN STRENGTHEN THE PREVENTION AND CONTROL OF NCDS AND IMPROVE MENTAL HEALTH RESPONSES?

1. Giving effect to the right to a clean, healthy and sustainable environment

Air pollution is a leading cause of death from NCDs. Globally, household and ambient air pollution causes 7 million premature deaths each year, including more than 5 million due to NCDs.[30] Energy sources that currently drive transport, electricity generation, industry and food production systems are largely responsible for air pollution, with a clear link having been established between the sources of local air pollution and the emissions responsible for climate change.[31] Effective action in this area requires committed leadership at global, national, subnational and community levels to develop and implement the policies needed to address air pollution, using human rights-based, multi-disciplinary, multi-stakeholder approaches. Policy making should be participatory and inclusive, ensuring that no groups or populations are excluded from contributing and having their views meaningfully integrated. Specific actions include investing in renewable energy, phasing out polluting energy systems, regulating and implementing industrial emissions controls, ensuring access to clean fuels and technologies for all cooking, lighting and heating, and developing healthy and efficient transport options.

2. Human rights-based approach to data collection

Evidence-based planning, policy design, monitoring and accountability depend on the availability of comprehensive, good quality and gender-sensitive data. Disaggregation of data according to the grounds of discrimination prohibited under human rights law (race, age, sexual orientation, gender, disability, sex, socio-economic status, etc.), and the use of human rights indicators, are concrete ways of integrating human rights norms into a classical public health intervention – data collection. A human rights-based approach to data collection requires the participation of stakeholders (particularly affected communities and individuals with lived experience of NCDs and mental health conditions) during all stages of data collection, analysis and dissemination.[32] This approach is vital for NCD and mental health responses as the spread of risk factors can then be assessed across any marginalised groups identified by the data, and appropriate policies designed.

[29] This section contains a small selection of examples, which is not intended to be exhaustive.
[30] WHO Regional Office for Europe. Noncommunicable diseases and air pollution. WHO European high-level conference on noncommunicable diseases. 2019.
[31] Campbell-Lendrum D, Prüss-Ustün A. Climate change, air pollution and noncommunicable diseases. Bull World Health Organ. 2019 Feb 1;97(2):160-161.
[32] OHCHR. A human rights-based approach to data: leaving no one behind in the 2030 agenda for sustainable development. 2018.

3. Eliminating discrimination and stigma

Everyone is entitled to access health services on an equal basis with others. People living with NCDs or mental health conditions often experience stigma and discrimination, which can negatively impact their health, management of their disease or condition and quality of life. Discrimination and stigma, whether related to an NCD, mental health condition, or other status, may discourage people from seeking health care.[33] Ensuring appropriate, acceptable health services that respect human rights and uphold dignity should be a priority for health policy makers and those involved in delivering services, including for people seeking services for the management of NCDs or mental health conditions.

4. Protecting, respecting and fulfilling women's right to health

According to one study, two thirds of women across the globe who die each year succumb to an NCD.[34] Often coinciding with women's most productive years, NCDs tend, in low- and middle-income countries, to contribute to a constellation of health challenges resulting from reproductive and maternal health conditions, as well as communicable diseases. The risk of developing NCDs is elevated, for instance, for women living with HIV/AIDS, while maternal health conditions are an early determinant of risk. Hypertension and diabetes can cause life-threatening complications during pregnancy and increase the risk of children developing an NCD later in life.[35] Healthy maternal nutrition, exclusive breastfeeding, and optimal infant and young child nutrition are critical for appropriate growth and development, as well as reducing the risk of developing NCDs, for both mothers and children.[36]

Depression and anxiety are about 50 per cent more common among women than men throughout the life-course.[37] Around 13 percent of women worldwide experience postpartum depression, and this figure rises to 19.8 percent in developing countries.[38] Women who have experienced intimate partner violence or sexual violence are at particularly high risk of developing a mental health condition.[39]

The realisation of women's right to health requires NCD and mental health policies that are gender-sensitive, taking into account how discriminatory norms and practices, along with other intersecting factors such as race, ethnicity, sexual orientation and disability impact the ability of women to benefit from services for mental health and NCD prevention and treatment. It also means paying due attention to the different risks and needs of women, and ensuring that investments, including in risk factor management, respond to their specific needs. One important intervention to protect women's right to health relates, for example, to the tobacco industry's gender-based marketing designed to promote smoking as representing empowerment and positive sexuality, and as being beneficial for various reasons.[40]

[33] Doty MM et al. How discrimination in health care affects older Americans, and what health systems and provide. The Commonwealth Fund. 2022.
[34] NCD Alliance. Women and NCDs (accessed 12 March 2023).
[35] NCD Alliance. A call to action. Women and non-communciable diseases. 2016.
[36] WHO Europe. The best start in life. Breastfeeding for the prevention of noncommunicable diseases and the achievement of the Sustainable Development Goals in the WHO European Region. 2020.
[37] Mayo Clinic. Depression in women: understanding the gender gap.
[38] Denning S. Postpartum depression in developing countries. The Borgen Project. 2017.
[39] World mental health report: transforming mental health for all. WHO. 2022.
[40] WHO FCTC. Gender-responsive tobacco control: evidence and options for policies and programmes. 2018.

5. Universal health coverage and universal social protection

Each year, 100 million people are pushed into poverty because of medical expenses, while 800 million people spend at least 10 per cent of their household income on health care.[41] In order to facilitate both income security in the event of illness, and access to health services, States should take legal, policy and other measures to achieve universal health coverage and universal social protection. A participatory, inclusive and comprehensive approach to universal health coverage, for example, would contribute significantly to "the creation of conditions which would assure to all medical service and medical attention in the event of sickness".[42] For its part, universal social protection would help to address the multiple dimensions of deprivation and hardship linked to illness, such as accessibility of medical care, related non-medical expenses and loss of income or time due to absence from work, both for those living with NCDs and mental health conditions and unpaid family carers. Investing adequately in the rights to social protection and health is part of the duty of States Parties to the International Covenant on Economic Social and Cultural Rights to use their maximum available resources for the progressive realisation of economic, social and cultural rights.[43]

6. Integrating human rights protection into mental health services and interventions

Mental health conditions attract stigma and discrimination in unique ways across many areas of life including interpersonal relationships, community life, education and work. From a policy perspective, mental health is marginalised in many countries, resulting in persons with mental health conditions receiving inferior care. Major challenges include the under-resourcing of quality community based mental health services (while investing disproportionately in psychiatric hospitals and institutions), the inadequate training of mental health personnel, and human rights violations experienced by many service users. Discrimination, non-consensual and coercive treatment practices, violence and the denial of legal capacity are examples of some of these violations.

A human rights-based approach to mental health includes preventing, addressing and remedying violations, training health personnel in human rights and working to eliminate stigma and discrimination in health settings and in broader society. It also involves investing in person-centred, human rights-oriented community mental health services and following evidence-based good practices such as a recovery-based approach. Similarly, involving users of mental health services in the design, implementation and monitoring of mental health policies, laws and services and promoting their full inclusion in community life, employment and education are crucial areas for action. With the proportion of the world's population over 60 years set to almost double between 2015 and 2050, holistic health promotion policies, emphasising both physical and mental wellbeing, are necessary to protect the rights of older persons with mental health conditions and psychosocial disabilities.[44]

7. Access to health information

The right to access information, particularly health information, is an essential part of making health goods, facilities and services accessible and allowing people to make healthier choices, for example by choosing healthier foods, where available and affordable, and avoiding or

[41] ILO. Towards universal health coverage: social health protection principles. Social protection spotlight. January 2020.
[42] ICESCR, art. 12(2)(d).
[43] ICESCR, Art. 2(1).
[44] WHO. Mental health of older adults – key facts. 2017.

ceasing tobacco use.[45] It involves the right to seek, receive and impart information and ideas concerning health issues, including on access to health care and prevention.[46] One of the "core obligations" of States under right to health norms is the provision of education and access to information concerning the main health problems in the community.[47] A relevant example is "the duty to educate, communicate with and train people to ensure a high level of public awareness of tobacco control, the harms of tobacco production, consumption and exposure to tobacco smoke, and the strategies and practices of the tobacco industry to undermine tobacco control efforts…"[48]

Strengthening the uptake of health measures and ensuring informed decision-making requires access to accurate, appropriate health-related information for all. States should ensure awareness among the general population of the major NCD risk factors and their impact on health, and of the services available for prevention, health promotion and treatment.[49] They should also provide information on the rights of persons with mental health conditions, and the services and support available. Information should be gender-sensitive, available in all languages used in the country, culturally appropriate and accessible for migrants, including undocumented migrants, refugees, asylum seekers, and internally displaced persons. It should be adapted for persons with specific needs, such as children, the hearing impaired or persons with limited reading ability.

8. Widening civic space

The participation of civil society in health-related decision making processes is necessary for sustainable action to address NCDs and protect the rights of users of mental health services. It enhances the legitimacy of governments' decisions and their ownership by all members of society.[50] The principle of participation rests squarely on the realisation of civil and political rights and is instrumental for the enjoyment of other human rights, including the right to health.

According to the Committee on Economic, Social and Cultural Rights: "The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. […] Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States."[51] To this end, action should be aimed at building the capacities of civil society and community-based organisations to engage in the development and implementation of NCD and mental health-related policies, programmes and strategies, including through legal literacy and legal empowerment programmes. Measures should also seek to create effective, transparent and non-discriminatory mechanisms to foster participation and enhance accountability.

[45] CESCR. General Comment No. 14, para 12.
[46] CESCR. General Comment No. 14, para 12(b)(4).
[47] CESCR. General Comment No. 14, para 44(d).
[48] WHO Framework Convention on Tobacco Control. Guidelines for implementation of Article 12. 2013.
[49] 'The duty to educate, communicate with and train people to ensure a high level of public awareness of tobacco control, the harms of tobacco production, consumption and exposure to tobacco smoke, and the strategies and practices of the tobacco industry to undermine tobacco control efforts (as embodied in Article 12), derives from the Convention and reflects fundamental human rights and freedoms. These include, but are not limited to the right to life, the right to the highest attainable standard of health and the right to education.' WHO Framework Convention on Tobacco Control. Guidelines for implementation of Article 12. 2013.
[50] Guidelines on the right to participate in public affairs. Office of the United Nations High Commissioner for Human Rights. 2018.
[51] CESCR. General Comment No. 14, para 54.

9. Effective regulation

States have obligations to take legislative, policy, judicial and other measures to give effect to human rights, and this includes the duty to prevent third parties from interfering with their exercise.[52] For instance, States parties to the Convention on the Rights of the Child are obliged to integrate and apply the principle that the best interests of the child are a primary consideration in all actions concerning children. One way of upholding this principle is the development of legislation and policies that regulate business activities and operations with a direct or indirect impact on children.[53]

Harmful commercial practices which cause or contribute to NCDs and have an impact on mental health (such as the sale of harmful products, marketing practices which are harmful to children, and activities by industry representatives to weaken, delay or undermine public health policies), require effective regulation as a crucial tool in addressing NCD risk factors.[54] Regulation should be:

- in line with applicable human rights norms and standards, including the UN Guiding Principles on Business and Human Rights,55 and with obligations under treaties to which a State is party.
- developed through a human rights-based approach, on a transparent, participatory basis and implemented comprehensively through multisectoral action.
- evidence-based.
- aligned with global guidance and best practice, including the Best Buys and Recommendations under the WHO Global Action Plan to Prevent and Control NCDs.
- compliant with the WHO FCTC and its guidelines for implementation in relation to tobacco use.

The human rights framework can assist in enacting and enforcing robust regulation against harmful practices, as in the examples below:

- Legal instruments restricting harmful marketing practices, including marketing of unhealthy food or alcohol across multiple types of media, can include objectives based on the protection of children's rights as well as rights to privacy and health. Such instruments could, among other things, target marketing (including advertising and sponsorship of events) to which children, young people and women are exposed.
- Advocacy in support of the rights to life and health, focusing on the duty of governments to protect public health, can reinforce legal frameworks for tobacco control, including all measures recommended under the WHO FCTC such as comprehensive bans on tobacco advertising, promotion and sponsorship, creation of smoke-free public spaces, fiscal measures, graphic health warnings, tobacco plain packaging and cessation support.
- Rights to life, health and food can underpin legal measures to promote healthy diets, including those designed to reduce levels of sugars, trans fatty acids, saturated fats and sugars in food or to discourage the consumption of foods that are high in those nutrients, ultra-processed or unhealthy.
- In addition to the rights mentioned above, consumer rights and rights to information can also support mandatory nutrition labelling, including front of pack labelling, and health warnings on food, alcohol and tobacco products.

[52] CESCR. General Comment No. 14, para 35.
[53] CRC/C/GC/16. Committee on the Rights of the Child. General Comment No. 16 (2013) on State obligations regarding the impact of the business sector on children's rights. UN Convention on the Rights of the Child, General Comment No. 16. 2013, para15.
[54] Kickbusch I, Allan L, Franz C. The commercial determinants of health. *Lancet Glob Health.* 2016;4:e895-e896.
[55] OHCHR. Guiding principles on business and human rights: implementing the United Nations 'protect, respect and remedy' framework. OHCHR and United Nations. 2011.

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