

Noncommunicable Diseases and Human Rights: A Promising Synergy

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Noncommunicable diseases (NCDs) have finally emerged onto the global health and development agenda. Despite the increasingly important role human rights play in other areas of global health, their contribution to NCD prevention and control remains nascent.

The recently adopted Global Action Plan for the Prevention and Control of NCDs 2013–2020 is an important step forward, but the lack of concrete attention to human rights is a missed opportunity.

With practical implications for policy development, priority setting, and strategic design, human rights offer a logical, robust set of norms and standards; define the legal obligations of governments; and provide accountability mechanisms that can be used to enhance current approaches to NCD prevention and control. Harnessing the power of human rights can strengthen action for NCDs at the local, national, and global levels. (*Am J Public Health*. 2014;104:773–775. doi:10.2105/AJPH.2013.301849)

NONCOMMUNICABLE DISEASES (NCDs), responsible for more than two thirds of all deaths each year and mostly occurring in low- and middle-income countries, are finally on the global health and development agenda.¹ Despite the inclusion of human rights in the guiding principles of the recently adopted World Health Organization (WHO) Global Action Plan for the Prevention and Control of NCDs 2013–2020, the objectives, targets, and indicators of the NCD Global Monitoring Framework attached to this plan, do not take human rights into account.¹ Human rights play an increasingly important role in other parts of the global health agenda, but their contribution to NCD prevention and control has yet to be fully recognized.

Public health and human rights share a common concern for ensuring the conditions in which people can live healthy lives. Human rights offer a logical, robust set of norms and standards; define the legal obligations of governments; and add accountability mechanisms to traditional public health strategies. These government commitments impose minimum standards on all sectors of development, including health, with practical implications for policy development, priority setting, and strategic design.

Public health policies and actions often integrate aspects of human rights in their strategies and practices such as avoidance of cruel, inhuman, or degrading treatment and respect for privacy, although they are often cast in ethical terms. Evidence from mental health,² HIV/AIDS,³

maternal and child health,⁴ reproductive health,⁵ and public health efforts more generally⁶ have shown that sustained attention to human rights can improve service delivery, focus attention on marginalized populations, mobilize resources, improve laws and policies, and enhance equality, equity, inclusiveness, and accountability.

By encouraging participation in health programs and targeting barriers to public health such as discrimination and inequality, incorporation of human rights in public health strategies favorably impacts health awareness, health-seeking behaviors, and health outcomes. Policies that respect human rights help governments fulfill their duties, help medical and public health professionals achieve their goals, and help people realize their rights and live healthier lives.

Clarifying how human rights could be included in the NCD response can help guide implementation of WHO's Global Action Plan. There are 4 areas in which the congruence of public health and human rights can enhance the response to NCDs. First, policies, laws, strategies, and practices in such realms as the environment; the food, tobacco, and pharmaceutical industries; and the educational sector can promote healthy diets and lifestyles by imposing stringent, evidence-based standards. Examples include the US Food and Drug Administration's regulations on salt content in foods,⁷ the European Charter on Counteracting Obesity,⁸ and the adoption and implementation of the

Framework Convention on Tobacco Control.⁹

The causes of ill health, along with their determinants and outcomes, can be framed around human rights principles, norms, and standards emphasizing equality, nondiscrimination, a focus on the most vulnerable populations, participation of affected groups, and access to technologies. Such linkages have been made in public reports and documents on diabetes in Canada,¹⁰ exposure to carcinogenic products in the workplace in the United Kingdom,¹¹ and prevention of cervical cancer in the United States.¹² At the global level, a useful resource for promoting attention to NCDs in human rights reporting mechanisms can be seen in the explicit reference made to NCDs by the Committee on the Rights of the Child, which provides guidance to incorporate children's right to health into NCD program planning, implementation, monitoring, and evaluation.¹³

Second, as evidenced in a number of areas such as the response to HIV¹⁴ and campaigns aimed at reducing NCD morbidity and mortality among aboriginal communities,¹⁵ facilities, goods, and services are required at every stage of risk factor and disease management for there to be a meaningful, culturally sensitive response to NCDs that complies with human rights principles. This includes appropriate technologies and essential medicines and vaccines that are available, accessible, acceptable, and of optimal quality.¹⁶ Protection of human rights in the identification of predictors of vulnerability to

NCDs as well as in their detection and treatment requires focused attention on and support for marginalized populations directly affected by NCDs, including children, people with disabilities, indigenous populations, elderly individuals, and groups that are socially, culturally, or economically excluded from mainstream society.

Third, although WHO's NCD Global Monitoring Framework includes monitoring of national policies relating to, for example, the food industry, it would benefit from equal attention to the degree to which such policies are implemented and whether accountability mechanisms exist to monitor and review progress and, if necessary, ensure remedial action in relation to all relevant actors.¹⁷

Finally, accountability at the subnational, national, and international levels can be advanced through use of the mechanisms being established specifically to address NCDs but will also benefit from more robust use of the existing United Nations (UN) human rights machinery (e.g., universal periodic reporting to the UN Human Rights Council and UN human rights treaty bodies). The UN's Committee on Economic, Social and Cultural Rights, for example, requests that countries report on measures taken

to prevent the abuse of alcohol and tobacco [and] to ensure affordable access to essential drugs, as defined by the WHO, including . . . medicines for chronic diseases.¹⁸

The committee then helps ensure accountability in terms of what a country does and does not do to fulfill its human rights obligations in this regard. For example, the committee has requested that a diverse range of countries, including Cameroon, Estonia, and

Mauritius, evaluate their strategies to combat NCDs, especially tobacco use, obesity, and diabetes, and subsequently report to the committee on their progress.

Other components of the human rights system should be encouraged to focus more explicit attention on NCDs. The special rapporteur on the right to the highest attainable standard of physical and mental health, for example, should produce a report on NCDs, and the UN Human Rights Council should place NCDs on its agenda. A subset of core indicators for the purpose of monitoring the public health and human rights response to NCDs should be developed for common use by these mechanisms. These indicators could include tracking of progress in the fulfillment of human rights objectives among affected populations, for example progress in equality, equity, and nondiscrimination in access to needed goods and services and participation among people living with or affected by NCDs in policies and actions intended for their benefit.

If human rights policies are to truly strengthen NCD prevention and control, there must be conscious attention to rights from the grassroots level up to the highest levels of leadership. Furthermore, attention to rights is required across all sectors of program design, monitoring, and evaluation with respect to service delivery, underlying NCD risk factors, and the social, economic, or environmental determinants that may influence risk behaviors.

Finally, as has been learned in efforts focusing on HIV and sexual and reproductive health, attention to the aforementioned issues is necessary but not sufficient. Also critical are an enabling legal and policy environment, political will,

donor support, and a dynamic and active civil society capable of playing an advocacy role, providing services, and serving a “watchdog” function. Harnessing the power of human rights to prevent and control NCDs can galvanize action toward meaningful change, broaden the number of actors and beneficiaries, and help strengthen the foundations for public health in the future. ■

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Geography Should Not Be Destiny: Focusing HIV/AIDS Implementation Research and Programs on Microepidemics in US Neighborhoods

African Americans and Hispanics are disproportionately affected by the HIV/AIDS epidemic. Within the most heavily affected cities, a few neighborhoods account for a large share of new HIV infections.

Addressing racial and economic disparities in HIV infection requires an implementation program and research agenda that assess the impact of HIV prevention interventions focused on increasing HIV testing, treatment, and retention in care in the most heavily affected neighborhoods in urban areas of the United States.

Neighborhood-based implementation research should evaluate programs that focus on community mobilization, media campaigns, routine testing, linkage to and retention in care, and block-by-block outreach strategies. (*Am J Public Health*. 2014; 104:775–780. doi:10.2105/AJPH.2013.301864)

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ALTHOUGH HIV INCIDENCE IN the United States has remained relatively stable since the mid-1990s, rates among African Americans and Hispanics are 8 and 3 times those among Whites, respectively.¹ Approximately 65% of new HIV infections in the United States occur in non-White populations. Individual behavioral risk factors, including unprotected sex and substance use, do not fully explain racial disparities in HIV infection; minority populations do not engage in higher rates of HIV risk behaviors than individuals of other races.²

GEOGRAPHIC AND RACIAL DISPARITIES IN HIV INFECTION

New research underscores the pivotal role that sexual networks, structural factors, and geography play in potentiating HIV risks; a recent study published in *Morbidity and Mortality Weekly Report* revealed strong associations between HIV and poverty, low socioeconomic status (SES), unemployment, and lower educational attainment in 24 US cities.³ A subsequent article published in the same journal showed that AIDS prevalence was 2.3% overall in urban census tracts

with high poverty rates.⁴ Similarly, new mapping tools (for examples, see www.aidsvu.org) help visualize associations between low SES, race, and geographic clustering of HIV infections in these same heavily affected communities. HIV prevalence rates in certain urban neighborhoods rival those of some sub-Saharan African countries. Within the most highly affected US cities, a discrete number of specific neighborhoods account for a large share of HIV infections and AIDS-related mortality.

For example, in Washington, DC, 2.7% of the general population is infected with HIV, but the epidemic is most heavily concentrated in wards 5, 6, 7, and 8, where residents are predominantly African American and of low SES, and where the HIV prevalence rate is as high as 3.1%. This is a stark contrast with ward 3, where residents are predominantly White and of higher SES, and the HIV prevalence rate is 0.4%.⁵

Similarly, although New York City has an overall HIV prevalence rate of 1.4%, the predominantly African American and Hispanic neighborhoods of East Harlem, Central Harlem, High-Bridge Morrisania, and Hunts

Point–Mott Haven, as well as predominantly White Chelsea, have rates ranging from 2.4% to 4.5% (Figure 1). However, AIDS-related mortality rates in the predominantly White neighborhood of Chelsea, which has a large gay population, are far lower than those in other predominantly African American and Hispanic neighborhoods with high infection rates.

Finally, Philadelphia's HIV infection rate of 114 per 100 000 is five times the national average. Although HIV prevalence in Philadelphia is high among residents of Center City, an affluent, predominantly White neighborhood with a large gay community, AIDS-related mortality in Center City is far lower than that in predominantly African American neighborhoods with high rates of infection (Figure 2).⁶ These higher rates of HIV infection and AIDS-related mortality in inner-city communities exemplify many of the public health challenges our nation faces in addressing domestic HIV/AIDS microepidemics.

The National HIV/AIDS Strategy (NHAS) calls for reducing HIV incidence, increasing access to care, reducing HIV-related health disparities, and distributing resources to the most heavily