

Chapter 9

Operationalizing the Right to Development: Health and Well-Being in the 2030 Agenda for Sustainable Development

Obijiofor Aginam*

Learning Objectives:

- To understand the scope and content of the right to the highest attainable standard of health using the right to development framework.
- To analyze the Goals and Targets in the 2030 Agenda related to health and well-being.
-
- To understand how operationalizing the right to development can help in better implementation of the Goals and Targets in the 2030 Agenda related to health and well-being.

This Chapter is part of the E-Learning Module on “Operationalizing the Right to Development in Implementing the Sustainable Development Goals” conceived, developed, and supported by the Right to Development Section of the Office of the United Nations High Commissioner for Human Rights (OHCHR) in collaboration with the University for Peace (UPEACE). The Module is offered by OHCHR in partnership with UPEACE and the United Nations University – International Institute for Global Health (UNU-IIGH). All Chapters in the module are co-edited by Dr. Mihir Kanade (Director, UPEACE Human Rights Centre) and Dr. Shyami Puvimanasinghe (Human Rights Officer, Right to Development Section, OHCHR).

The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized.

UN Declaration on the Right to Development (DRTD) ¹

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Constitution of the World Health Organization ²

Context

The celebration, in 2016, of the 30th anniversary of the United Nations Declaration on the Right to Development (DRTD)³ by epistemic and policy communities, international organizations, and civil society across the world provided an opportunity to reflect on the challenges of operationalizing the right to development (RtD) in human rights discourse. The DRTD adopted on December 4, 1986 was catalyzed by decades of sustained agitation by “Third World” states for a New International Economic Order (NIEO)⁴ which led to the adoption of two key resolutions by the United Nations in 1974: Resolution on the Establishment of a New International Economic Order,⁵ and Resolution on the Economic Charter of Rights and Duties of States.⁶ Within the larger NIEO discourse, the credit for the pioneer articulation of the right to development is often given to Senegalese jurist, Keba M’Baye.⁷ In the years immediately following M’baye’s treatise, the RtD discourse became the subject of insightful but often polarized and acrimonious debate in international human rights law.⁸ As Mickelson observed “scholarly debate on the existence and

* Director Ad-Interim & Head of Governance for Global Health, United Nations University-International Institute for Global Health (UNU-IIGH), Kuala Lumpur.

¹ A/RES/70/1, Article 1(1).

² *Constitution of the World Health Organization*, signed on 22 July 1946, and entered into force on 7 April 1948, Preamble.

³ A/RES/41/128.

⁴ Mohammed Bedjaoui, *Towards a New International Economic Order* (Paris: UNESCO, 1979); Oswaldo de Rivero, *New Economic Order and International Development Law* (Oxford: Pergamon Press, 1980); Karin Mickelson, “Rhetoric and Rage: Third World Voices in International Legal Discourse”, *Wisconsin International Law Journal*, vol.16, no.2 (1998), pp. 353–419; Bhupinder Chimni, “Third World Approaches to International Law: A Manifesto”, *International Community Law Review*, vol.8 (2006), pp. 3–27; Anthony Anghie, Bhupinder Chimni, Karin Mickelson, and Obiora Okafor (eds), *The Third World and International Order: Law, Politics and Globalization*, (Leiden/Boston: Martinus Nijhoff, 2003).

⁵ A/RES/S-6/3201

⁶ A/RES/29/3281

⁷ Karin Mickelson, “Rhetoric and Rage”, citing Keba M’Baye, “Le Droit au Development Comme un Droit de L’Homme”, *Revue Des Droits de L’Homme*, vol. 5 (1972), p. 505.

⁸ Stephen Marks, “Emerging Human Rights: A New Generation for the 1980s”, *Rutgers Law Review*, vol.33 (1981), pp. 435–452; Philip Alston, “A Third Generation of Solidarity Rights: Progressive Developments of Obfuscation of International Human Rights Law”, *Netherlands International Law Review*, vol. 29, no. 3

scope of a right to development as a human right continued in the late 1970s and into the 1980s; during that time, it was frequently identified as part of a ‘third generation’ of human rights, referred to as collective or solidarity rights”.⁹

The raging controversies of the RtD debates in the 1980s that centred around its individual/collective attributes, and the uncertainties of the scope and identities of the duty-bearers led Donnelly to characterize RtD as a delusion “not merely...of well-meaning optimists, but a dangerous delusion that feeds of, distorts, and is likely to detract from the urgent need to bring together the struggle for human rights and development”.¹⁰ Despite the RtD controversies, Marks defined its individual component as the “right to benefit from development policy based on the satisfaction of material and nonmaterial human needs and to participate in the development process [...]”.¹¹

The DRTD recognized RtD as an “inalienable human right” that serves as the anchor and the pillars of the parameters for the enjoyment of economic, social, cultural and political development for the full realization of all human rights and fundamental freedoms. If development is a process that improves the economic and social circumstances of every human being, then the proclamation of the DRTD is in tandem with the socially and economically holistic definition of health offered by the Constitution of the World Health Organization (WHO) as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.¹²

Operationalizing the RtD and the Right to Health: Some Extant Provisions of International Treaties and Declarations

The adoption of the WHO Constitution by the International Health Conference held in New York from 19 June to 22 July 1946 (entered into force on 7 April 1948), and the Universal Declaration of Human Rights (UDHR)¹³ by the UN General Assembly on 10 December 1948 were important milestones in the evolution of human rights approaches to health and wellbeing. Since 1948, some examples of international human rights treaties and declarations that recognize the right to health are set out below.

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition – *Preamble of the WHO Constitution*.¹⁴
- Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary

(1982), pp. 307–322; Philip Alston, “Conjuring up New Human Rights: A Proposal for Quality Control”, *The American Journal of International Law*, vol. 78, no. 3 (1984), pp. 607–621; Jack Donnelly, “In Search of the Unicorn. The Jurisprudence and Politics of the Right to Development”, *California Western International Law Journal*, vol. 15 (1985), pp. 473–509.

⁹ Karin Mickelson, “Rhetoric and Rage”, p. 376.

¹⁰ Jack Donnelly, “In Search of the Unicorn”, p.478.

¹¹ Stephen Marks, “Emerging Human Rights”, p.445.

¹² *Constitution of the World Health Organization*, Preamble.

¹³ A/RES/3/217 A

¹⁴ *Constitution of the World Health Organization*, Preamble.

social services, and the right to security in the event of [...] sickness, disability, [...] old age or other lack of livelihood [...].- *Article 25, UDHR*.¹⁵

- States should undertake, at the national level, all necessary measures for the realization of the right to development and shall ensure, inter alia, equality of opportunity for all in their access to basic resources, education, health services, food, housing, employment and the fair distribution of income. Effective measures should be undertaken to ensure that women have an active role in the development process. Appropriate economic and social reforms should be carried out with a view to eradicating all social injustices - *Article 8, DRTD*.¹⁶
- (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness - *Article 12, International Covenant on Economic, Social and Cultural Rights (ICESCR)*.¹⁷
- States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services - *Article 24, Convention on the Rights of the Child*.¹⁸
- States Parties undertake to prohibit and eliminate racial discrimination in the enjoyment of the “right to public health, medical care, social security and social services” - *Article 5(e)(iv), Convention on the Elimination of all Forms of Racial Discrimination*.¹⁹
- States Parties shall take all appropriate measures to eliminate discrimination against women in the enjoyment of the “right to protection of health”, and “in the field of healthcare in order to ensure on a basis of equality of men and women, access to healthcare services, including those related to family planning” - *Articles 11(1)(f) and 12(1), Convention on the Elimination of All Forms of Discrimination against Women*.²⁰

¹⁵ A/RES/3/217 A, Article 25.

¹⁶ A/RES/41/128, Article 8.

¹⁷ United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations Treaty Series, vol. 993, pp. 3–12, Article 12.

¹⁸ United Nations, *Convention on the Rights of the Child*, 20 November 1989, United Nations Treaty Series, vol. 1577, pp. 44–61, Article 24.

¹⁹ United Nations, *International Convention on the Elimination of All Forms of Racial Discrimination*, 7 March 1966, United Nations Treaty Series, vol. 660, pp. 212–38, Article 5e(iv).

²⁰ United Nations, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations Treaty Series, vol. 1249, pp. 14–23, Articles 11(1)(f) and 12(1).

- Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources - *Article XI, The American Declaration on the Rights and Duties of Man*.²¹
- (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health (2) States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick - *Article 16, African Charter on Human and Peoples' Rights*.²²
- (1) Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being (2) In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right: (a) primary health care, that is, essential health care made available to all individuals and families in the community (b) extension of the benefits of health services to all individuals subject to the State's jurisdiction (c) universal immunization against the principal infectious diseases (d) prevention and treatment of endemic, occupational and other disease (e) education of the population on the prevention and treatment of health problems, and (f) satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable - *Article 10, Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador")*.²³
- Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable. The Contracting Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed among others to: (1) remove as far as possible the causes of ill health (2) provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health (3) prevent as far as possible epidemic, endemic and other diseases - *Article 11 European Social Charter*.²⁴

Notwithstanding these normative and declaratory provisions on the right to health, there remains a systemic dichotomy between civil and political rights, and economic, social and cultural rights in human rights scholarship. Because of this dichotomy, civil and political rights are often classified as “first generation rights” while economic, social and cultural rights are treated as “second generation rights”. Despite the persuasive argument that all human rights are interdependent, interrelated, indivisible and of equal importance, Western states and NGOs have

²¹ Inter-American Commission on Human Rights (IACHR), *American Declaration of the Rights and Duties of Man*, 2 May 1948, available at: <http://www.refworld.org/docid/3ae6b3710.html>, accessed on 27 July 2017, Article XI.

²² Organization of African Unity, *African Charter on Human and Peoples' Rights*, 27 June 1981, CAB/LEG/67/3 rev. 5, *International Legal Materials*, vol. 21, no. 1 (1982), pp. 58–68, Article 16.

²³ Organization of American States (OAS), *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador")*, 16 November 1999, A-52, available at: <http://www.refworld.org/docid/3ae6b3b90.html>, accessed on 27 July 2017.

²⁴ Council of Europe, *European Social Charter*, 18 October 1961, ETS 35, available at <http://www.refworld.org/docid/3ae6b3784.html>, accessed on 27 July 2017.

historically treated economic, social and cultural rights as if they were less important than civil and political rights.²⁵ One implication of this dichotomy is that civil and political rights – the “first generation” rights - are “justiciable” because their violation by the State or agencies of the State as duty bearers is redressed through a court, tribunal or other quasi-judicial and administrative procedures and institutions such as National Human Rights Commissions. Despite the dichotomy between the “first generation” and “second generation rights”, interdependence of all rights based on human dignity remain the starting point for holistic human rights approaches to health and wellbeing.²⁶ Likewise, such interdependence and indivisibility are the foundational premises of the RtD which places the human person as the “central subject of development” and simultaneously as the active participant and beneficiary of the RtD.²⁷ Article 9(1) of the DRTD provides that “all the aspects of the right to development set forth in the present Declaration are indivisible and interdependent and each of them should be considered in the context of the whole”.²⁸

Right to Health in National Constitutions

The controversies surrounding what constitutes “health” tend to obscure human rights approaches to health. There is no consensus among legal scholars, practitioners, and the policy community on the meaning of the terms: health, health care, health services, medicare, medical services, public health, and how human rights norms can advance them.²⁹ Some scholars argue that “right to health” is a utopian absurdity because it implies a guarantee of “perfect health”; they rather prefer “right to health care” which encompasses eco-social and developmental factors: protective environmental services, prevention, health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare.³⁰ This has been critiqued as too extensive and contrary to the common understanding of the phrase “right to health care”.³¹ Some scholars argue for the phrase “right to health protection” comprised of two components: a right to health care and a right to health conditions.³² Navigating these controversies and using a set of defined criteria Kinney and Clark found that “67.5% of the constitutions of the

²⁵ Brigit Toebes, “Towards an Improved Understanding of the International Human Right to Health”, *Human Rights Quarterly*, vol.21, no.3 (1999), pp. 661–679; Virginia Leary, “The Right to Health in International Human Rights Law”, *Health and Human Rights: An International Quarterly*, vol.1, no.1(1994): pp. 24–56.

²⁶ Virginia Leary, “The Right to Health in International Human Rights Law”; Virginia Leary, “Justiciability and Beyond: Complaint Procedures and the Right to Health”, *Review of the International Commission of Jurists*, vol.55 (1995), pp. 105–122.

²⁷ A/RES/41/128, Article 2(1).

²⁸ *Ibid*, Article 9(1).

²⁹ Brigit Toebes, “Towards an Improved Understanding of the International Human Right to Health”; Charles Ngwena and Rebecca Cook, “Rights Concerning Health”, in Danie Brand and Christof Heyns (eds), *Socio-Economic Rights in South Africa* (Pretoria: Pretoria University Press, 2005), pp. 107–151.

³⁰ Ruth Roemer, “The Right to Health Care”, in H.L. Fuenzalida-Puelma and S.S Connor (eds), *The Right to Health in the Americas: A Comparative Constitutional Study* (Washington, DC: Pan American Health Organization, 1989), pp. 17–23, at p. 17.

³¹ Virginia Leary, “The Right to Health in International Human Rights Law”, p. 31.

³² H.L. Fuenzalida-Puelma, and S.S. Connor, *The Right to Health in the Americas: A Comparative Constitutional Study* (Washington, DC: Pan American Health Organization, 1989), p. 600.

world have a provision addressing health or healthcare. In almost all of these constitutions, the provisions regarding health and healthcare are universal, rather than limited to particular groups”.³³

One of the widely-cited examples of a codified constitutionally-protected right to health is Section 27 of the Constitution of the Republic of South Africa 1996.³⁴ It provides as follows:

1. Everyone has the right to have access to -
 - (a) health care services, including reproductive health care;
 - (b) sufficient food and water; and
 - (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

3. No one may be refused emergency medical treatment.

Apart from South Africa, Ngwena and Cook observed that there is a variety of 109 jurisdictions,³⁵ “such as Brazil, Chile and Venezuela, to have embraced the idea of providing for a right concerning health in a substantive and justiciable form”³⁶.

Right to Health and RtD: Circumventing the Myth of Justiciability

The entrenched dichotomy between the *largely justiciable* civil and political rights, and the *largely non-justiciable* economic, social and cultural rights impedes the realization of the right to health including the health-related aspects of the RtD. In worst case scenarios in the judicial *fora*, socio-economic rights are treated as “juridical orphans who had no ties of consanguinity with the pantheon of liberty-oriented rights”.³⁷ Even in South Africa with one of the most progressive provisions of a constitutionally-guaranteed right to health, justiciability remains significantly impeded by lack of resources, and a legacy of gross inequalities between groups and races,³⁸ characterized by a “bureaucratic entanglement of racially and ethnically fragmented services; wasteful, inefficient and neglectful of the health of more than two-thirds of the population”.³⁹ In recent years, a good number of scholars have explored pragmatic ways to circumvent the

³³ Eleanor Kinney and Brian Alexander Clark, “Provisions for Health and Health Care in the Constitutions of the Countries of the World”, *Cornell International Law Journal*, vol.37 (2004), pp. 284-355, at p. 291.

³⁴ See: Eleanor Kinney, “The International Human Right to Health: What Does This Mean for Our Nation and World”, *Indiana Law Review*, vol.34, no.4 (2001), pp. 1457-75; Danie Brand and Christof Heyns, *Socio-Economic Rights in South Africa* (Pretoria: Pretoria University Press, 2005); Charles Ngwena and Rebecca Cook, “Rights Concerning Health”.

³⁵ Charles Ngwena and Rebecca Cook, “Rights Concerning Health”, p.126.

³⁶ Eleanor Kinney, “The International Human Right to Health”.

³⁷ Chima Nweze, “Justifiability or Judicialization: Circumventing Armageddon Through the Enforcement of Socio-Economic Rights”, *African Yearbook of International Law*, vol. 15 (2007), pp. 107–127.

³⁸ See: Adila Hassim, Mark Heywood and Jonathan Berger (eds.), *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa* (Cape Town: Siber Ink, 2007).

³⁹ Medical Research Council, *Changing Health in South Africa: Towards New Perspectives in Research* (Menlo Park: California: Henry J. Kaiser Family Foundation, 1991).

impediments to justiciability of economic, social and cultural rights, especially in Africa.⁴⁰ There are three identifiable pathways in the struggle for realization of economic, social and cultural rights in human rights discourse and activism.⁴¹ The first tacitly characterizes economic, social and cultural rights (including aspects of the right to health and RtD) as *non-justiciable*. The second pathway, in principle, does not simply over-glorify the *justiciability* of civil and political rights over and above economic, social and cultural rights. In essence, while this dichotomy exists, a pragmatic interpretation of civil and political rights, especially the right to life, creates the necessary linkages between life and its essential necessities – health, food and water, housing and shelter, education, and the environment. In this endeavor, a holistic, indivisible and inter-dependent human rights paradigm emerges since life is almost meaningless without food, good health, housing and other indices of development. Although this trend has gained traction recently across Africa because of a robust civil society activism and the emergent jurisprudence of the African Charter on Human and Peoples’ Rights,⁴² the Indian Supreme Court championed this mode of judicial activism in interpreting non-justiciable rights in the Indian Constitution. The third pathway is anchored on an express codification of economic, social and cultural rights (including the right to health including aspects of RtD) as legally *justiciable* rights. The South African Constitution, for example, provides for health, housing, and environment as legally-justiciable rights.⁴³ Circumventing the impediments to justiciability of the right to health in most countries would generally oscillate between these three dominant modes depending on the constitutional or other legislative provisions of the particular country. In the South African case of *S v Makwanyane*, Chief Justice Chaskalson (then of the Constitutional Court) stated that;

Public international law would include non-binding as well as binding law. They may both be used under the section as tools of interpretation. International agreements and customary international law accordingly provide a framework within which [the Bill of Rights] can be evaluated and understood, and for that purpose, decisions of tribunals dealing with comparable instruments, such as the United Nations Committee on Human Rights, and the European Court of Human Rights, the European Commission on Human Rights, the Inter-American Court of Human Rights, and, in appropriate cases, reports of specialised agencies such as the International Labour Organisation, may provide guidance as to the correct interpretation of the provisions of [the Bill of Rights].⁴⁴

Circumventing the justiciability impediments to right to health and health-related aspects of RtD in international human rights treaties is much more complicated. With the exception of the few

⁴⁰ Danie Brand and Christof Heyns, *Socio-Economic Rights in South Africa*; African Foundation for International Law, *African Yearbook of International Law, Realizing Economic and Social Rights in Africa: Innovations, Challenges, and Prospects*, Vol. 15 (Leiden/Boston: Martinus Nijhoff, 2007).

⁴¹ Obijiofor Aginam, ‘The Rights to ‘The Highest Attainable Standard of Health’: Trade Agreements and the Rights to Health in Africa’, *African Yearbook of International Law*, vol.15 (2007), pp. 233–235.

⁴² Obiora Okafor, *Legitimizing Human Rights NGOs: Lessons from Nigeria* (Trenton, New Jersey: Africa World Press, 2006); Obiora Okafor, *The African Human Rights System, Activist Forces and International Institutions* (Cambridge University Press, 2007).

⁴³ *Constitution of the Republic of South Africa*, Act No. 108 of 1996, Articles 24, 26, 27, 28.

⁴⁴ *S v Makwanyane*, 1995 (3) SA 391 (CC), paragraph 35. See also the South African Constitutional Court decision in *Minister of Health v. Treatment Action Campaign and Others*, 2002 (10) BCLR 1033 (CC).

regional human rights systems with judicial or quasi-judicial institutions for the enforcement or realization of the right to health enshrined in regional treaties and charters, most efforts are concentrated on the “progressive realization” of economic, social and cultural rights. Since the adoption of the ICESCR in 1966, the meaning, scope and operational dynamics of the right to health enshrined in Articles 2(1) and 12 thereof have raised complicated questions. Given the economic disparities between countries, does the financial, technical or economic handicap of the developing and least developed countries impede the progressive realization of the right to health? If so, do the rich and industrialized countries owe any duty or obligation under international (human rights) law to commit financial and economic resources towards the promotion of health in developing countries? Does Article 2 of the ICESCR imply that countries do have any obligation(s) to promote health abroad? Given the realities of State sovereignty in the contemporary international system, many would argue that these obligation(s) (if any) are moral rather than legal. On the other hand, the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights, 2011, adopted under the aegis of the International Commission of Jurists interprets the ICESCR as imposing clear extraterritorial obligations to respect, protect as well as fulfill economic, social and cultural rights on States.⁴⁵ Article 2(1) of ICESCR has also been criticized as vague and imprecise, especially the obligation on a State party to “take steps...to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant.” According to Robertson, “maximum of its available resources”, is “a difficult phrase of two warring adjectives describing an undefined noun. ‘Maximum’ stands for idealism and ‘available’ is the wiggle room for the state”.⁴⁶ In the spirit of mutual interdependence of States, the duty towards international cooperation is unambiguous in Article 3(3) and 4(1) of the DRTD. This is reaffirmed by the 2030 Agenda with SDG 17 focusing on strengthening the means of implementation and revitalizing the global partnership for sustainable development.

Beyond the narrow confines of justiciability, efforts at the progressive realization of the right to health in Article 12 of the ICESCR have focused on developing other core paradigms, especially the articulation of core state obligations. Examples of these include “The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, 1986”,⁴⁷ “The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 1997”,⁴⁸ and “The Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights, 2011”,⁴⁹ and the successive General Comments developed

⁴⁵ International Commission of Jurists, *The Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights, 2011*, 28 September 2011, available at <http://www.icj.org/wp-content/uploads/2012/12/HRQMaastricht-Maastricht-Principles-on-ETO.pdf>, accessed on 27 July 2017.

⁴⁶ Robert Robertson, “Measuring State Compliance with the Obligation to Devote the Maximum Available Resources to Realizing Economic, Social and Cultural Rights”, *Human Rights Quarterly*, vol.16 (1994), pp. 693–714, at p. 693.

⁴⁷ UN Commission on Human Rights, *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN doc. E/CN.4/1987/17, Annex, 8 January 1987.

⁴⁸ International Commission of Jurists (ICJ), *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 26 January 1997, available at: <http://www.refworld.org/docid/48abd5730.html>, accessed on 27 July 2017.

⁴⁹ International Commission of Jurists, *The Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights, 2011*.

by the UN Committee on Economic, Social and Cultural Rights, especially General Comment No 3 “The Nature of States Parties’ Obligations” (1990),⁵⁰ and General Comment No 14, “The Right to the Highest Attainable Standard of Health” (2000).⁵¹ General Comment No 14 (2000) calls for co-ordinated efforts towards the realization of the right to health to enhance interaction among all relevant actors including various components of civil society. Relevant international organisations – WHO, International Labour Organization (ILO), UNDP, United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), the World Bank, regional development banks, International Monetary Fund (IMF), World Trade Organization (WTO), and other bodies within the United Nations system – should co-operate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level. The international financial institutions, notably the World Bank and IMF, should pay greater attention to the protection of the right to health in their lending policies, credit agreements, and structural adjustment programmes. General Comment No. 14 developed the major planks of obligations of state parties under Article 12 of ICESCR including the obligations to “respect”, “protect”, and “fulfil” the rights conferred therein. Both General Comments 3 and 14 confirm that “States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care”.⁵² In this respect, General Comment No 14 treats the following core obligations as non-derogable:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.⁵³

In general, most of these indicators and benchmarks that have been developed by the WHO and other relevant UN agencies have formed an integral part of state reporting under relevant international treaty bodies that provide for the right to health.

⁵⁰ UN Committee on Economic, Social and Cultural Rights, *The Nature of State Parties’ Obligations*, General Comment No. 3, E/1991/23. 14 December 1990.

⁵¹ UN Committee on Economic, Social and Cultural Rights, *Right to the Highest Attainable Standard of Health*, General Comment 14, E/C.12/2000/4. 11 August 2000.

⁵² E/C.12/2000/4, paragraph 43.

⁵³ *Ibidem*.

Unpacking Health and Wellbeing in the SDGs: Right to Health and RtD

In September 2015, world leaders adopted an ambitious set of 17 Sustainable Development Goals (SDGs) and 169 targets after a long and tortuous consultative process led by the United Nations. The SDGs, which replaced the Millennium Development Goals, would guide the global development agenda until 2030. Influenced by the Report of the High-Level Panel established by the UN Secretary-General, the SDGs are driven by five big transformative concepts: leave no one behind; put sustainable development at the core; transform economies for jobs and inclusive growth; build peace and effective, open and accountable institutions for all; and forge a new global partnership.

Health is primarily anchored in SDG 3: “Ensure healthy lives and promote well-being for all at all ages”.⁵⁴ This goal has 13 ambitious and specific targets that includes: reducing maternal mortality and preventable deaths of newborns; ending epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases; strengthening the prevention and treatment of substance abuse; ensuring access to sexual and reproductive health services; and achieving universal health coverage. Other targets include strengthening the implementation of WHO Framework Convention on Tobacco Control⁵⁵; reducing premature deaths from non-communicable diseases; supporting the research and development of vaccines and medicines for communicable and non-communicable diseases; providing access to affordable essential medicines and vaccines in accordance with the Doha Declaration on TRIPS and Public Health;⁵⁶ increasing health financing, and strengthening the capacity of all countries for management of national and global health risks.

To achieve these health-related targets, States have a duty, individually and collectively, nationally and internationally. Adopting the approach in Articles 3 and 4 of the DRTD will significantly boost the needed mutual interdependence and cooperation of all States to achieve the targets of SDG 3. Related to the duty of States to cooperate internationally to implement the SDGs is the need to create policy space for developing and least-developed countries to pursue their development priorities within an international system that promotes the right to development of everyone. Operationalizing the RtD means that States are required to take relevant actions towards achieving the SDGs and the targets while living up to their normative obligations as members of inter-governmental institutions like the WHO or the WTO. This is why, for instance, the “means of implementation” targets of SDG 3 include strengthening the implementation of WHO Framework Convention on Tobacco Control, and providing access to affordable essential medicines and vaccines in accordance with the Doha Declaration on the TRIPS and Public Health, two normative frameworks within the mandates of the WHO and the WTO. The 2001 Doha Declaration on the TRIPS Agreement and Public Health was a major victory for developing countries at the World Trade Organization. The Declaration was unanimously adopted by the WTO member states (Ministerial Conference) after years of sustained agitation by developing countries supported by

⁵⁴ A/RES/70/1, SDG 3.

⁵⁵ World Health Organization, *WHO Framework Convention on Tobacco Control*, 21 May 2003, United Nations Treaty Series, vol. 2302, p. 166.

⁵⁶ World Trade Organization, *Doha Declaration on the TRIPS Agreement and Public Health*, WT/MIN(01)/DEC/2, 20 November 2001. Note: TRIPS is the acronym for the Agreement on the Trade-Related Aspects of Intellectual Property Rights enforced by the WTO.

leading civil society organizations that patents were impeding access to essential medicines (right to health/life) in most developing countries. The Declaration, among others, affirmed that TRIPS should be interpreted and implemented in a manner supportive of WTO Members' right and duty to protect public health, and in particular, to promote access to medicines for all.⁵⁷ Complex interlinked trade-health-development-human rights issues like TRIPS and public health and many others within the WTO catalysed the launch of The Doha Round of trade negotiations among the WTO member-states in 2001. Known semi-officially as The Doha Development Agenda (DDA),⁵⁸ it aims to achieve major reform of the international trading system with a fundamental objective to improve the trading prospects of developing countries. What is urgently needed for the DDA to make progress is recognition of the stark disparities and inequalities between countries (now explicitly recognized with a commitment to reducing inequalities in SDG 10, followed by policy space and incentives to enable countries at different stages of development to strengthen their institutional capacities in line with the "special and differential treatment" provisions codified in many trade agreements enforced by the WTO.⁵⁹

The five transformative shifts that underpin the 17 SDGs, and some of the targets of SDG 3 and a number of the other 16 Goals are in tandem with State obligations on the RtD. Article 8(1) of the DRTD states that:

States should undertake, at the national level, all necessary measures for the realization of the right to development and shall ensure, inter alia, equality of opportunity for all in their access to basic resources, education, health services, food, housing, employment and the fair distribution of income. Effective measures should be undertaken to ensure that women have an active role in the development process. Appropriate economic and social reforms should be carried out with a view to eradicating all social injustices.⁶⁰

Successful implementation of the SDGs in 2030 would largely depend on whether states adopt and pragmatically operationalize the RtD by encouraging popular participation in their development agendas, and in full realization of all (indivisible and interdependent) human rights. Operationalizing the RtD on health and well-being requires an RtD impact assessment of the 13 health targets of SDG 3 as well as other SDGs focusing on the opportunities and impediments of both their national and international implementation. Unless the permissive environments necessary for implementing the health-related goals are created at both national and international levels following a holistic operationalization of the RtD, it would be difficult to achieve much success in implementing the health-related SDGs. The 2030 Agenda therefore needs to build the required synergies with existing human rights obligations, norms, and soft-law mechanisms notably the ICESCR, the DRTD, relevant General Comments of UN Special Rapporteurs, and Comments by the relevant committees of UN Human Rights treaty bodies.

⁵⁷ *Ibidem*

⁵⁸ World Trade Organization, *Doha Ministerial Declaration*, WT/MIN(01)/DEC/1, 20 November 2001.

⁵⁹ For an overview of the Special and Differential Treatment provisions in WTO agreements, see: World Trade Organization, *Special and Differential Treatment Provisions*, available at https://www.wto.org/english/tratop_e/devel_e/dev_special_differential_provisions_e.htm, accessed on 27 July 2017.

⁶⁰ A/RES/41/128, Article 8(1).

Paradoxically, the SDGs have been critiqued as being “unremittingly utopian”⁶¹, and praised as the “blueprint for a better future”⁶². Very few commentators and scholars have scrutinized SDG 3 or all the SDGs in search of pragmatic right to health and the RtD language. In a recent study, Forman, Ooms and Brolan observed that since universal health coverage (UHC) is central to the right to health, and a major step towards equity and health financing, the reference to UHC in the SDG 3, Target 8, is of utmost significance for the right to health in the SDGs. This approach has been critiqued as too narrow.⁶³ Without diminishing the importance of UHC, Hawkes and Buse observed that “the significance of the SDGs lies in their ability to move beyond a biomedical approach to health and healthcare, and instead to seize the opportunity for the realization of the right to health in its fullest, widest, most fundamental sense: the right to a health-promoting and health protecting environment for each and every one of us”.⁶⁴ The authors are right to argue that “realizing the right to health with the SDG framework will mean utilizing the full range of commitments, conventions and covenants already in existence that promote, protect and ultimately realize rights in relation to the determinants of health”⁶⁵. There is a litany of such covenants, conventions and declarations including the RtD. Using the ICESCR as an example, Hawkes and Buse point to the codification of the rights to fair wages within a safe and healthy working environment, education, safe portable water, adequate sanitation, adequate and safe nutrition, and non-discrimination as indispensable to health.⁶⁶ The fact that the SDGs are presented as an “interlinked and integrated” package is in tandem with the concept that “all human rights are universal, indivisible and interdependent and interrelated”⁶⁷. The RtD also follows this approach of indivisibility and interdependence. Ultimately, the SDGs are 17 integrated and interdependent goals. SDG 3 (health) is meaningless without SDG 2 (ending hunger and achieving food security). Neither will SDG 4 (ensuring inclusive and equitable quality education) make much sense if children are too sick or hungry to attend school.⁶⁸

The legacy of the SDGs for the right to health “lies in the possibility that the ambition of the global goals reaches far beyond rolling out of UHC to one that gives impetus to action on the range of social determinants of health”.⁶⁹ This proposal, albeit unassailable, is not radically new. Going

⁶¹ Richard Horton, “Offline: 13/11—The flames of war”, *Lancet*, vol. 10008 (2015), p. 2041, available at <http://www.thelancet.com/pb/assets/raw/Lancet/pdfs/S0140673615009939.pdf>, accessed on 27 July 2017.

⁶² Ban Ki-Moon, *UN adopts new Global Goals, charting sustainable development for people and planet by 2030*, 25 September 2015, available at http://www.un.org/apps/news/story.asp?NewsID=51968#.V_Yi3c18qg4, accessed on 27 July 2017.

⁶³ Lisa Forman, Gorik Ooms, and Claire E. Brolan, “Rights Language in the Sustainable Development Agenda: Has Right to Health Discourse and Norms Shaped Health Goals?”, *International Journal of Health Policy and Management*, vol.4, no.12 (2015), pp. 799–804.

⁶⁴ Sarah Hawkes and Kent Buse, “Searching for the Right to Health in the Sustainable Development Agenda”, *International Journal of Health Policy and Management*, vol.5, no.5 (2016), pp.337–339, at p.338.

⁶⁵ *Ibidem*.

⁶⁶ *Ibidem*.

⁶⁷ United Nations, *Vienna Declaration and Programme of Action*, 25 June 1993, A/CONF.157/2, paragraph 5; Virginia Leary, “The Right to Health in International Law”.

⁶⁸ Obijiofor Aginam, *Getting Past the Pathological: Governing Global Health*, 2015, available at <https://unu.edu/publications/articles/getting-past-pathological.html>, accessed on 27 July 2017.

⁶⁹ Sarah Hawkes and Kent Buse, “Searching for the Right to Health in the Sustainable Development Agenda”, p. 338.

back to the socially ambitious definition of health in the WHO Constitution 1946, the WHO-UNICEF Declaration of Alma-Ata on Primary Health Care 1978,⁷⁰ Ottawa Charter for Health Promotion (1986),⁷¹ Reports of two important commissions by WHO: Commission on Social Determinants of Health (2008),⁷² and Commission on Macroeconomics and Health (2001),⁷³ health (and by extension the right to health) has never been confined to the biomedical sphere. In the context of the 2030 Agenda, it is important to place health and wellbeing at the centre of sustainable human development. This expansive and holistic approach promotes a right to health framework which includes two things: healthcare and the underlying social and economic determinants of health. This approach is in full synergy with the holistic nature of the RtD,⁷⁴ as well as the “interlinked and integrated” nature of all the SDGs in the 2030 Agenda. In other words, operationalizing the RtD in the implementation of SDG 3 means not only focusing on health care, but also on the underlying determinants of health.

A pragmatic realization of the right to the highest attainable standard of health in the 2030 Agenda requires two things: (i) effective accountability mechanisms for the review of the social determinants of health taking into consideration the benchmarks that are already working in some existing human rights treaty obligations,⁷⁵ and (ii) sustained use of workable human rights impact assessment practices in the development sector⁷⁶. If meticulously developed and applied, policies developed under these two pragmatic pathways will connect with existing international human rights instruments and have measurable impacts on most of the SDG 3 targets: maternal and child mortality, epidemics of AIDS, tuberculosis and malaria, substance abuse, UCH, road traffic accidents, tobacco control, prevention and control of non-communicable diseases, training and retention of health workforce in developing countries, risk reduction and management of national and global health risks.

It is noteworthy that some of the targets like tobacco control, and prevention and control of non-communicable diseases would require states to regulate the operations and activities of the private sector (non-state actors). As a perennial problem in international human rights law, the challenges of implementing the SDGs will open a new vista to develop effective and innovative accountability mechanisms targeting non-state actors in national, regional, and international governance

⁷⁰ International Conference on Primary Health Care, *Declaration of Alma-Ata*, 6–12 September 1978.

⁷¹ International Conference on Health Promotion, *Ottawa Charter for Health Promotion*, Ottawa, November 1986.

⁷² Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva: World Health Organization, 2008).

⁷³ Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: World Health Organization, 2001).

⁷⁴ A/RES/41/128, Articles 1(1) and 6(2).

⁷⁵ Paul Hunt, “SDGs and the importance of Formal Independent Review: An Opportunity for Health to Lead the Way”, *Health and Human Rights Journal*, 2 September 2015, available at <https://www.hhrjournal.org/2015/09/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way/>, accessed on 27 July 2017.

⁷⁶ Lawrence Gostin and Jonathan Mann, “Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies”, *Health and Human Rights*, vol.1, no.1 (1994), pp. 58–80; Paul Hunt and Gillian MacNaughton, *Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health* (Paris: UNESCO, 2006).

frameworks for health and wellbeing in the 2030 Agenda.⁷⁷ This innovative thinking is required where, for instance, pharmaceutical patents held by multinational corporations keep the prices of essential medicines artificially high for poor and vulnerable, groups and peoples who are in most need of the drugs. In their struggles to roll out generic anti-retroviral drugs, the experiences of some developing countries including Brazil, South Africa, Kenya,⁷⁸ and others in the post-TRIPS era have shown that invoking the human rights (right to health and the RtD) argument can be a long, tortuous and complicated journey because of the corporate lobby.

⁷⁷ Andrew Clapham, *Human Rights Obligations of Non-State Actors*, (Oxford: Oxford University Press, 2006); Andrew Clapham (ed), *Human Rights and Non-State Actors*, (Cheltenham, UK: Edward Elgar, 2013).

⁷⁸ Ellen t'Heon, "TRIPS, Pharmaceutical Patents and Access to Essential Medicines: A Long Way from Seattle to Doha", *Chicago Journal of International Law*, vol.3, no.1 (2003), pp. 27–46; Naomi A. Bass, "Implications of the TRIPS Agreement for Developing Countries: Pharmaceutical Patent Laws in Brazil and South Africa in the 21st Century", *George Washington International Law Review*, vol.34, no.1 (2002), pp.191–222; John Harrington, "Access to Essential Medicines in Kenya: Intellectual Property, Anti-Counterfeiting, and the Right to Health", in Michael Freeman FBA, Sarah Hawkes, and Belinda Bennett (eds), *Law and Global Health: Current Legal Issues Volume 16* (Oxford: Oxford University Press, 2014).