THE SUSTAINABLE DEVELOPMENT GOALS (SDGS) AND THE RIGHT TO HEALTH: IS THERE A NEXUS?

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Abstract

The indispensability of health to life and human wellbeing is not subject of any serious controversy. Similarly, the link between health and poverty is firmly established in the literature—the simple reason being that poverty is both a cause and consequence of ill health. Recognition of this relationship explains the inclusion of health as a component of the most important contemporary poverty centered global policy framework, namely, the 2030 Agenda for Sustainable Development, which established the Sustainable Development Goals (SDGs) in 2015. Nonetheless, although there seems to be a general consensus that at the core of the SDGs is poverty eradication (SDG 1) and that all the SDGs are intertwined and intimately linked with this core, no such link has been established between health (SDG 3) and the rest of the SDGs. Yet, this is a very important question that cannot be glossed over. Specifically, the question is whether there is a nexus between each and every SDG, on one hand, and health or the right thereto, on the other? The importance of this question derives from the idea that the linkages, should they be found to exist, would have a monumental impact on global health, in terms of contributing to the capacity of States to fulfil the obligation they assumed under international law to respect, protect, and fulfil the right to health. Probing the question is the task of this Article.

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INTRODUCTION

One of the outcome documents released at the end of the Third International Conference on Financing for Development, which was held in Addis Ababa, Ethiopia, on 13–16 July 2015, and which was attended by all 193 Member States of the United Nations (U.N.), attributed this statement to the U.N. Secretary-General Ban Ki-moon:

> This is the People's Agenda, a plan of action for ending poverty in all its dimensions, irreversibly, everywhere, and leaving no one behind. It seeks to ensure peace and prosperity, and forge partnerships with people and planet at the core. The integrated, interlinked and indivisible 17 Sustainable Development Goals are the people's goals and demonstrate the scale, universality and ambition of this new Agenda.[1]

Discernible from the statement of the global chief scribe was not only the overarching purpose of the Sustainable Development Goals (SDGs), namely, eradication of poverty and integration of solidarity in the process but an emphasis on the interlinkages and indivisibility of the SDGs—meaning that successful implementation of any of the SDGs will inevitably lead to the attainment of others and vice versa. In other words, the SDGs and targets cannot be disassociated from each other and must be implemented in an integrated and comprehensive manner. The intention of the global community was to chart a course that would holistically address all dimensions of human well-being, to build on the "success of the Millennium Development Goals [MDGs]," which was instrumental to freeing "more than 700 million people [from the clutches of] poverty."[2]

The need to operationalize that intention prompted the Sustainable Development Summit, which was held on September 25, 2015 in New York City, and at which Heads of States and Governments of the 193 U.N. Member States unanimously voted to adopt a new global Agenda entitled, "Transforming Our World: 2030

1. *Consensus Reached on New Sustainable Development Agenda to be adopted by World Leaders in September*, U.N. THIRD INT'L CONF. FIN. FOR DEV., http://www.un.org/esa/ffd/ffd3/press-release/consensus-reached-on-new-sustainable-development-agenda.html [https://perma.cc/25PS-A69G] (last visited Mar. 8, 2021) [hereinafter *Consensus Reached*].

2. *Id.*

Agenda for Sustainable Development."[3] The 2030 Agenda comprises 17 SDGs and 169 targets, with the year 2030 as the deadline for achieving most of them.[4] The Heads of State and Representatives present were adamantly categorical as to what is expected for the strategy to succeed, emphasizing that for "the goals to be reached, everyone needs to do their part: governments, the private sector, civil society and people like you."[5] Although the Agenda is underpinned by the same ideals as the MDGs, the former is more cosmopolitan and ambitious in scope, intended to have universal application—unlike the MDGs which was specifically intended for action on developing countries.

A distinguishing feature of the SDGs is that its reach is broader than the MDGs, an ambitious agenda aimed at "addressing the root causes of poverty and the universal need for development that works for all people."[6] Whilst the MDGs targeted poverty reduction as its goal, the Agenda seeks total elimination of poverty and incorporates more demanding targets on health, education and gender equality as well as issues that were not addressed by the MDGs such as climate change, sustainable consumption, innovation, the importance of peace and justice for all and so forth.[7] In addition, the global policy framework addresses the three interconnected dimensions of sustainable development, namely, social inclusion, economic growth and environmental protection[8]—all of which have relevance to health as does each of the SDGs. Demonstrating this relevance or nexus is the task of this Article.

This Article consists of four sections. Following this introductory section, Part II theorizes on the possible relationships between the right to health and each of the SDGs. Having established that the right to health has dual dimensions, the section argues that the two facets of the right—access to medicine as well as underlying or social determinants of health—provide binary paths of interface between the right to health and

3. Kathy Zhang, *World Leaders Adopt Sustainable Development Goals (SDGs)*, U.N. SUSTAINABLE DEV. SOLS. NETWORK (Sept. 27, 2015), https://www.unsdsn.org/news/2015/09/27/world-leaders-adopt-sustainable-development-goals-sdgs071edd29 [https://perma.cc/P62V-AKNZ].

4. *Id.*

5. *Sustainable Development Goals*, U.N., https://www.un.org/sustainabledevelopment/sustainable-development-goals-retired-link/ [https://perma.cc/ARW9-U97C] (last visited Mar. 8, 2021).

6. *Consensus Reached*, *supra* note 1.

7. *World Leaders adopt Sustainable Development Goals*, U.N. DEV. PROGRAMME (Sept. 25, 2015), http://www.undp.org/content/undp/en/home/presscenter/pressreleases/2015/09/24/undp-welcomes-adoption-of-sustainable-development-goals-by-world-leaders.html [https://perma.cc/WN65-F2LD].

8. G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development, Prmbl., ¶ 3 (Sept. 25, 2015), https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E [https://perma.cc/XL84-BEZR] [hereinafter 2030 SDG Agenda].

the SDGs. In other words, each of the SDGs shares affinity with the right to health, by either contributing to the production or accessibility of drugs, equipment or related consumables, or by making possible the availability or accessibility of social health determinants. The precise nature of the linkages; that is, the specific particulars of each of the SDGs and how these particulars relate to health or the right to health is the subject of Part III. The conclusion affirms the obvious (deducible from the analyses of the preceding sections of this Article), that there is in fact a nexus between each of the SDGs and the right to health.

I. RIGHT TO HEALTH: THE DUAL DIMENSIONS OF THE LINKAGES WITH THE SUSTAINABLE DEVELOPMENT GOALS

An apt starting point of discussing how the right to health is interlinked with the 2030 Agenda is to conceptualize the Agenda as a human rights initiative. The U.N. General Assembly Resolution, which established the initiative, was clear and stated that the 17 SDGs and 169 Targets not only "seek to build on the Millennium Development Goals and complete what they did not achieve," but also "seek to realize the human rights of all" persons worldwide.[9] The Agenda "is guided by the purposes and principles of the Charter of the United Nations, including full respect for international law" and "is grounded in the Universal Declaration of Human Rights, international human rights treaties, the Millennium Declaration and the 2005 World Summit Outcome."[10] In other words, the Agenda itself as well as the SDGs are human rights centered. Thus, the question which necessarily arises, since the task of this section is to define the precise interface between the SDGs and one of those human rights, namely, the right to health, is, what does the term "right to health" mean?

The first contemporary instrument to respond to the question was the Constitution of the World Health Organization (WHO).[11] Having

9. *Id.*

10. *Id.* ¶ 10.

11. Constitution of the World Health Organization (WHO), July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185 (entered into force Apr. 7, 1948), https://www.who.int/governance/eb/who_constitution_en.pdf [https://perma.cc/V2G8-JNHQ]. The first footnote of the Constitution of the WHO summarizes the amendments since it was entered into force in 1948, and reads as follows:

> The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org.*, 2, 100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23) came into force on 3 February 1977, 20

identified "the attainment by all peoples of the highest possible level of health,"[12] as the sole objective of WHO, the Constitution asserts quite unequivocally that 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."[13] This pronouncement was subsequently immortalized by the Third Committee of the U.N. General Assembly when it adopted the position enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which is generally accepted as the standard definition of the right to health, *to wit*, "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[14] Strikingly, the Third Committee affirms that the right to health should be expansively interpreted, not to be understood merely as the right to health care but as encapsulating also a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and extends to the underlying or social determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment.[15]

The importance of this two-pronged interpretation of the right to health lies on its implication, what it mandates or the obligation it imposes upon States Parties to the ICESCR—to provide not only health care but also to attend to underlying determinants of health. In other words, what the interpretation projects as a *sine qua non* to the realization of the right to health is not only access to medicine but also social health determinants.[16] This distinction, the dualization or bifurcation of the avenues through which acceptable standard of health is attainable, is germane to the subject of this Article because it shows the various ways in which each of the SDGs could meaningfully contribute to realizing the right to health; that is, either by facilitating the attainment of the first prong (production, manufacturing or accessibility of drugs and related

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January 1984, 11 July 1994 and 15 September 2005 respectively and are incorporated in the present text.

Id. at 1.

12. *Id.* art. 1.

13. *Id.* pmbl. ¶ 3.

14. G.A. Res. 2200A (XXI), Int'l Covenant on Econ., Soc., and Cultural Rights (ICESCR), art. 12 (Dec. 16, 1966) (entered into force Jan. 3, 1976), https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_2200A(XXI)_economic.pdf [https://perma.cc/R4EK-TTWA] [hereinafter ICESCR].

15. U.N., Comm. on Econ., Soc. and Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), ¶ 4, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), https://www.refworld.org/pdfid/4538838d0.pdf [https://perma.cc/ST9D-XDW7] [hereinafter General Comment No. 14].

16. *Id.* ¶¶ 4, 10, 11, 12(a)-(b), 16, 18, 36.

consumables) or attending to the availability and accessibility of social health determinants.

II. THE INTERSECTION OF THE SUSTAINABLE DEVELOPMENT GOALS AND THE RIGHT TO HEALTH

In a 2016 commentary titled "Health in the Sustainable Development Goals," WHO Director-General Margaret Chan sums up a misconception that is common in the literature on the interface between health and the SDGs:

> I sometimes see articles arguing that health has been short-changed in the SDG agenda, [having been] given less prominence than it deserves. After all, three of the eight Millennium Development Goals were directly focused on health and two others, on nutrition and water supply and sanitation, addressed major determinants of health. In the new agenda, health is only one in a crowd of 17 goals. As some have argued, such small space undermines the significance of health as an issue that matters profoundly to every person on this planet. I disagree.[17]

The Director-General notes that the reason for this disagreement is that whilst scholars are correct in asserting that health was allotted a prominent status in the MDGs, they seem to have misunderstood the underlying considerations which fueled the crafting of the SDGs.[18] Each of the SDGs testifies to a recognition that is impossible for health challenges to be addressed by the health industry alone and that other sectors and activities have very important roles to play in ensuring health. In other words, despite not having multiple SDGs explicitly addressing health issues, as did the MDGs, health enjoys a privileged positioning in the 2030 Agenda through the multisectoral or multidimensional approach adopted by its drafters:

> In my view, health occupies a privileged place in the [20130 Agenda] for several reasons. First, health is an end-point that reflects the success of multiple other goals. Because the social, economic, and environmental determinants of health are so broad, progress in improving health is a reliable indicator of progress in implementing the overall agenda. In the final analysis, the ultimate objective of all development activities—whether aimed at improving food and water supplies or making cities safe—is to sustain human lives in

17. Margaret Chen, Commentary, *Health in the Sustainable Development Goals*, WORLD HEALTH ORG. (WHO) (Nov. 17, 2016), http://www.who.int/mediacentre/commentaries/2016/health-sustainable-goals/en/ [https://perma.cc/2MZM-SJNS].

18. *Id.*

> good health. Second, all health targets can be reliably measured using sophisticated scientific methods. Disease burdens and their causes can be measured, the impact of specific interventions can be assessed, and changes over time can be tracked. Finally, the inclusion of a target for reaching universal health coverage, including financial risk protection, gives health the power to build fair, stable, and cohesive societies while also furthering the overarching objective of ending poverty. Ensuring that all people receive essential health care without risking financial hardship can have a significant impact on poverty.[19]

In other words, lack of dedication of multiple SDGs to health does not betray the central status of health in the overall scheme of the 2030 Agenda. This contention derives from the fact that despite explicit mention of health in each of the SDGs, concern for health (health care specifically or one or more health determinants) is embedded in all of them. In defense of this position, the rest of this section is devoted to explicating the precise link between health and other SDGs—a link that is crucial to respecting, protecting and fulfilling the right to health as mandated by international law.

A. *SDG 1: End Poverty in All its Forms Everywhere*

The nexus between poverty and health is patently obvious. The same set of factors which are responsible for poverty, namely, socioeconomic and political injustices, underly poor health—a major reason the two are said to be inextricably intertwined.[20] It is important to emphasize that socioeconomic and political injustices—described in peace studies as "structural violence"[21] or "institutionalized violence"[22] by liberation theology scholars—are responsible for disparities in most dimensions of wellbeing, health and income differentials inclusive. Quite distinct from the use of weapons such as guns, knives and so forth, this is violence of a different genre, defined with the word "violence" to emphasize its peculiar features, as the "violence of the rich against the poor, institutionalized in structures, systems, values, and worldviews" of society.[23] The injustice generated by this violence is responsible for

19. *Id.*

20. Sorsha Roberts, *Key Facts: Poverty and Poor Health*, HEALTH POVERTY ACTION (Jan. 10, 2018), https://www.healthpovertyaction.org/info-and-resources/the-cycle-of-poverty-and-poor-health/key-facts/ [https://perma.cc/JT3M-GX9J].

21. Johan Galtung, *Violence, Peace, and Peace Research*, 6 J. PEACE RSCH. 167, 171 (1969), https://www.jstor.org/stable/422690?seq=19#metadata_info_tab_contents [https://perma.cc/Y2ZZ-XE4E].

22. REBECCA S. CHOPP, THE PRAXIS OF SUFFERING: AN INTERPRETATION OF LIBERATION AND POLITICAL THEOLOGIES 15 (1986).

23. *Id.*

widening income disparities both within and across nations. Accentuating this dimension of poverty (as imbedded in structural violence) is critical for it directs policy makers to strategies that really works as well as the proper subjects and objects upon which attention should be focused. Successful eradication initiatives must be anchored on the understanding that "[p]overty is an evil . . . scandalous condition," as philosopher and theologian Gustavo Gutiérrez explicates;[24] that "[it] is not caused by fate; [rather] it is caused by the actions of [others] . . . There are poor because some people are victims of others."[25] It is this distortion of equilibrium in human ecology that is the target of policy initiatives such as SDG 1 and such targeting has critical ramifications not only on poverty but health as well.

Poverty is not only a cause of poor health. It is also a consequence of poor health. In other words, the two are mutually reinforcing. It is estimated that of all global deaths, one third—18 million people annually or 50,000 daily—are due to poverty-related causes.[26] In 2011, the U.N. General Assembly affirmed that risk factors of noncommunicable diseases (NCDs) worsen poverty, whilst poverty, on the other hand, contributes to rising rates of NCDs.[27] The result is a strangulating cycle of inescapable misery and extreme hardship on victims. NCDs and their risk factors result in increased burdens on households and individuals, including impoverishment due to the high cost of treatment, making NCDs a contributing factor to poverty.[28] This is buttressed by a 2013 report from the African Union which shows that the extremely high costs associated with NCDs are forcing 100 million people in Africa into poverty annually.[29] But this (health cost triggered poverty) is not unique to Africa. In the United States, for instance, health care cost is the principal reason people declare bankruptcy.[30] And throughout the world,

24. GUSTAVO GUTIÉRREZ, A THEOLOGY OF LIBERATION: HISTORY, POLITICS AND SALVATION 171 (Sister Caridad Inda ed., & John Eagleson trans., 15th ed. 1988).

25. *Id.* at 166.

26. César Chelala, *The Critical Link Between Poverty and Health*, COUNTERPUNCH (Aug. 5, 2016), https://www.counterpunch.org/2016/08/05/the-critical-link-between-poverty-and-health/ [https://perma.cc/JXK3-UBHS].

27. *NCDs, Poverty and Development*, WORLD HEALTH ORG. (WHO) https://www.who.int/global-coordination-mechanism/ncd-themes/poverty-development/en/ [https://perma.cc/5N6T-WHX4] (last visited Sept. 28, 2020).

28. *Id.*

29. *Id.*

30. *See* David U. Himmelstein, et. al, *Illness and Injury as Contributors to Bankruptcy,* 24 HEALTH AFF. W5-63 (2005); David U. Himmelstein, et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741–42 (2009); Christiana Lamontagne, *NerdWallet Health Study: Medical Debt Crisis Worsening Despite Policy Advances*, NERDWALLET HEALTH (Oct. 8, 2014), https://content.money.com/wp-content/uploads/2015/04/nerdwallet-health-study-medical-debt-crisis-worsening-despite-health-care-policy-advances.pdf

catastrophic health care expenditure is a major force driving people into poverty. Catastrophic health spending refers to paying over 40 percent of household income directly on health care following the satisfaction of basic needs[31]—a problem affecting about 150 million people globally, out of which 100 million are pushed into poverty.[32]

Obviously, nobody is immune from diseases and illnesses; yet, the chances of exposure to these conditions are increased by poverty, due principally to deprivations suffered in the realm of lifestyle, preventive care, as well as underlying determinants of health such as safe and potable drinking water and adequate sanitation facilities, shelter, safe and healthy working conditions, healthy environment and so forth. These deprivations, where they occur, are unavoidable consequences of poverty and are devastating to health as documented in a 1990 study which found that life expectancy of young black men in Harlem (an impoverished black neighborhood in New York City) is less than men in Bangladesh, one of the poorest countries in the world.[33] The reason was that almost half of the population in Harlem live below the poverty line (41 percent)—and with this burden, a disproportionately higher rate of diseases and deaths compared to the general population.[34] Similarly, a more recent study found that the life expectancy of poorest males in Glasgow, Scotland, is 54 years, compared to 82 years for affluent males living in the same city, despite equal access to health care provided by the National Health Services (NHS) of the United Kingdom.[35]

Bearing in mind the depiction in a previous paragraph of poverty as "structural violence," and as undergirding both disparities in income as well as health, a relevant question becomes whether the measures specified in SDG 1 respond adequately to the full labyrinth of poverty, its full dimension? To eradicate poverty (SDG 1), States are required to, *inter alia,* implement nationally appropriate social protection systems and measures for all, and, by 2030, achieve substantial coverage of the poor and the vulnerable;[36] ensure, by 2030, that all men and women, in

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[https://perma.cc/54UC-CPHF]. More than 50 percent of personal bankruptcies in the United States in 2001 resulted from medical bills. *See* WORLD HEALTH ORG. (WHO), HEALTH SYSTEMS FINANCING: THE PATH TO UNIVERSAL COVERAGE 9 (2010), https://www.who.int/whr/2010/10_chap01_en.pdf?ua=1 [https://perma.cc/T379-DJLA] [hereinafter WHO, HEALTH SYSTEMS].

31. WHO, HEALTH SYSTEMS*, supra* note 30, at 5.

32. *Id.* at 5, 9.

33. Colin McCord & Harold P. Freeman, *Excess Mortality on Harlem*, 322 NEW ENGLAND J. MED. 173, 173 (1990) (finding, as causes of the excess mortality, high prevalence of cardiovascular disease, cirrhosis, homicide, and neoplasms).

34. *Id.*

35. Michael Reid, *Behind the "Glasgow Effect*,*"* 89 BULL. OF THE WORLD HEALTH ORG. 701 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3209974/pdf/BLT.11.021011.pdf [https://perma.cc/EF8E-RS8U].

36. 2030 SDG Agenda, *supra* note 8, SDG 1, Target 1.3, at 15.

particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance;[37] ensure significant mobilization of resources from a variety of sources, including through enhanced development cooperation, in order to provide adequate and predictable means for developing countries, in particular least developed countries, to implement programs and policies to end poverty in all its dimensions[38] and so forth.

These measures, at least in principle, seem robust enough to eventuate in substantial reduction, if not the eradication, of poverty. Meeting these targets will, no doubt, liberate the have-not(s) from the clutches of poverty—meaning economic freedom and capacity to access both health care as well as health determinants. That is the nexus between poverty and right to health.

B. *SDG 2: End Hunger, Achieve Food Security and Improved Nutrition and Promote Sustainable Agriculture*

Each of the various components of SDG 2 targets a single objective, namely, the elimination of hunger or food insecurity. Defined as "inadequate or insecure access to food due to financial constraints," food insecurity is a serious challenge which, in addition to negatively impacting physical, mental, and social health, also imposes a huge cost burden on the health care system.[39] The New York McSilver Institute for Poverty Policy and Research describes the relationship between food insecurity and health (including physical, mental, and behavioral health) as bidirectional; meaning, a two-way traffic in which one feeds into the other and vice versa.[40] Just as food insecurity leads to poor health, so too does poor health result in food insecurity, as an unhealthy man or woman is unlikely to be able to optimally engage in productive activities. Inability to work means lack of resources with which to attend to basic needs—a recipe for hunger or food insecurity. And that is the link between right to health and SDG 2.

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37. *Id.* SDG 1, Target 1.4, at 15.

38. *Id.* SDG 1, Target 1.a, at 15.

39. *The Impact of Food Insecurity on Health*, PROOF FOOD INSECURITY POLICY RESEARCH, http://proof.utoronto.ca/wp-content/uploads/2016/06/health-impact-factsheet.pdf [https://perma.cc/UM5N-GH2V] (last visited Mar. 8, 2021) [hereinafter PROOF].

40. *Bidirectional Relationship of Health and Hunger*, NEW YORK UNIVERSITY SILVER SCHOOL OF SOCIAL WORK, MCSILVER INSTITUTE FOR POVERTY POLICY AND RESEARCH, https://ctacny.org/sites/default/files/trainings-pdf/Bidirectional%20Relationship%20of%20Health%20and%20Hunger%20%282%29.pdf [https://perma.cc/4BWH-CKNF] (last visited Mar. 8, 2021).

Poor health amongst food-insecure individuals are explicable on several grounds; the most critical, for our purposes, is that deprivation of necessary nutrients in the body (as a consequence of inadequate/proper food intake) results in greater susceptibility to a wide array of diseases and illnesses. Compared to the general population, food-insecure adults are more likely to suffer chronic health conditions, including stomach or intestinal ulcers, mood/anxiety disorder, migraines, hypertension, heart disease, diabetes, bowel disorders, back problems, arthritis, and asthma.[41] It is significant to note that the risk of vulnerability to these conditions increases with the severity of food insecurity.[42] The same is true regarding children, and may even be worse considering lower immunity amongst that demographic vis-à-vis adults. Children who are exposed to food insecurity have poorer health status and are more vulnerable to health challenges requiring hospitalization,[43] and are at greater risk of suffering a variety of conditions like asthma, depression, and suicidal ideation as they mature into adulthood.[44]

C. *SDG 3: Ensure Healthy Lives and Promote Well-Being for All at All Ages*

SDG 3 is a restatement of one of the principles of the Alma-Ata Declaration, *to wit,* health is "a fundamental human right" and "a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."[45] Significantly, aside from recognizing that "responsibility for the health of [the] people . . . can be fulfilled only by the provision of adequate health and social measures" by the government,[46] the Declaration set the year 2000 as the deadline for the attainment of everyone "of a level of health that will permit [everyone] to lead a socially and economically productive life."[47] In other words, a deadline was established for global realization of the right to health. Apparently, this target was not met, resulting in renewed international efforts toward turning the tide, one of which is SDG 3.

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41. PROOF, *supra* note 39.

42. *Id.*

43. John T. Cook et al., *Child Food Insecurity Increases Risks Posed by Household Food Insecurity to Young Children's Health*, 136 J. NUTR. 1073 (2006).

44. PROOF, *supra* note 39.

45. Int'l Conf. on Primary Health Care, *Declaration of Alma-Ata*, WORLD HEALTH ORG. (WHO), ¶ I (Sept. 12, 1978), https://www.who.int/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2 [https://perma.cc/NV6B-6ASX] [hereinafter *Declaration of Alma-Ata*].

46. *Id.* ¶ V.

47. *Id.*

Specific means of realizing the objective of SDG 3 include to reduce, by 2030, the global maternal mortality ratio to less than 70 per 100,000 live births;[48] end preventable deaths of newborns and children under 5 years of age, by 2030, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births;[49] by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases;[50] achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all,[51] and so forth. The precise link these targets have to the right to health is quite obvious and, therefore, needs no further elaboration.

D. *SDG 4: Ensure Inclusive and Equitable Quality Education and Promote Lifelong Learning Opportunities for All*

The interface between health and education is premised on the idea that education is a major predictor of health outcomes in that, all things being equal, an educated person is more likely to have better health outcomes compared to the general population and, importantly, this gradient improves with the level of educational attainment. This is explicable on a number of grounds. Adults with higher levels of education are less prone to risky behaviors such as alcohol consumption and smoking, and are more likely to adopt healthy lifestyle such as diet and exercise.[52] Data from the United States Centers for Disease Control and Prevention (CDC), for instance, indicate that whilst smoking prevalence rate amongst adults with a graduate degree was 4.5% in 2016, for those with an undergraduate degree, the rate was 7.7% whilst a whopping 40.6% was the figure for those with a graduate education degree certificate (GED)—a high school equivalent.[53] Since it is known that smoking is associated with a number of serious diseases such as cancer, cardiovascular diseases, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis, it follows that the largest number of those that will be

48. 2030 SDG Agenda, *supra* note 8, SDG 3, Target 3.1, at 16.

49. *Id.* SDG 3, Target 3.2, at 16.

50. *Id.* SDG 3, Target 3.3, at 16.

51. *Id.* SDG 3, Target 3.8, at 16.

52. EMILY B. ZIMMERMAN ET AL., *Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives*, *in* POPULATION HEALTH: BEHAV. AND SOC. SCI. INSIGHTS 354 (Robert M. Kaplan, Michael L. Spittel & Daryn H. David eds., 2015).

53. Ahmed Jamal et al., *Current Cigarette Smoking among Adults—United States 2016*, 67 MORBIDITY AND MORTALITY WEEKLY REPORT 53, 55–56 (2018), https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6702a1-H.pdf [https://perma.cc/MX9U-FP6X].

exposed to these diseases are the least educated. This is the reason lack of education features prominently amongst factors responsible for health disparities throughout the world.

Aside from being less likely to engage in risky behaviors, the educated class is more likely to have easier access to underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, better paying jobs and more money, and a healthy environment—all of which contribute to better health. In addition, except for incurable genetic conditions, maintenance of good health or restoration thereof is a function of awareness and access to preventive and curative care, both of which are more readily available to people who are educated. Education is empowering in the sense that it imbues one, not only with the knowledge necessary to shield oneself from exposure to conditions that would impair health by making lifestyle choices and adopting personal behaviors that are conducive to good health, but also equips one with the tools necessary to navigate the health care system when prevention fails. This was confirmed by a recent study in the United States which found that disparities in health outcomes have widened over the past four decades between Americans with high level of education vis-à-vis those not similarly situated.[54] Life expectancy, for instance, amongst white Americans without a high school diploma, has decreased since 1990 whilst it has increased for others.[55] Whereas death rates are declining amongst the most educated people in that country, death rates have remained steady or increased amongst the least educated.[56] In 2011, the diabetes prevalence rate for American college graduates was 7% compared to 15% for adults without high school education.[57]

The challenge that lack of education or illiteracy presents to health may be illustrated with maternal health. Illiterate women constitute a danger not only to themselves but also to their children.[58] Many of these women do not appreciate the importance of prenatal care during pregnancy, postnatal care, or the benefit of timely interface with physicians once illness strikes, which is one reason why children of uneducated mothers have about a 2.5 times higher risk of death than those

54. ZIMMERMAN ET AL., *supra* note 52, at 348.

55. *Id.*

56. *Id.*

57. Jeannine S. Schiller, Jacqueline W. Lucas & Jennifer A. Peregoy, *Summary Health Statistics for U.S. Adults*: *National Health Interview Survey 2011*, 10 VITAL HEALTH STATISTICS 6 (2012), https://www.cdc.gov/nchs/data/series/sr_10/sr10_256.pdf [https://perma.cc/VMJ9-Q7YR].

58. Obiajulu Nnamuchi, *Millennium Development Goal 5 and Maternal Health in Africa: Possibilities, Constraints and Future Prospects*, 23 ANNALS OF HEALTH L. 92, 110–11 (2014), https://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1411&context=annals [https://perma.cc/LLX5-LG7M].

whose mothers have secondary school or higher education.[59] In urban India, the mortality rate amongst children of educated women is approximately one-half that of children of uneducated women.[60] These benefits underscore the need for speedy implementation of the targets of SDG 4, particularly the obligation to ensure that by 2030, all girls and boys complete free, equitable, and quality primary and secondary education[61] as well as equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university.[62]

E. *SDG 5: Achieve Gender Equality and Empower All Women and Girls*

SDG 5 is intertwined with the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), which condemns discrimination against women and imposes an obligation upon States Parties to embody the principle of equality of men and women in their legal frameworks and to ensure, through law and other appropriate means, the practical realization of this principle.[63] In addition, CEDAW requires States Parties to take ". . . all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."[64] This is important, for as the U.N. General Assembly affirms:

> Realizing gender equality and the empowerment of women and girls will make a crucial contribution to progress across all the Goals and targets [of the 2030 Global Agenda]. The achievement of full human potential and of sustainable development is not possible if one half of humanity continues to be denied its full human rights and opportunities. Women and girls must enjoy equal access to quality education, economic resources and political participation as well as equal opportunities with men and boys for employment, leadership and decision-making at all

59. WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2005 - MAKE EVERY MOTHER AND CHILD COUNT 26 (2005), https://www.who.int/whr/2005/whr2005_en.pdf?ua=1 [https://perma.cc/9G72-CHMY] (reporting, specifically on Nigeria, although there is no reason the result would be any different in countries similarly placed; that is, in terms of comparable level of socioeconomic development).

60. Chelala, *supra* note 26.

61. 2030 SDG Agenda, *supra* note 8, SDG 4, Target 4.1, at 17.

62. *Id.* SDG 4, Target 4.3, at 17.

63. Convention on the Elimination of all Forms of Discrimination against Women, art. 2, Dec. 18, 1979, 1249 U.N.T.S. 13, https://treaties.un.org/doc/Publication/UNTS/Volume%201249/volume-1249-I-20378-English.pdf [https://perma.cc/RAT8-ZS75].

64. *Id.* art. 3.

> levels. . . . The systematic mainstreaming of a gender perspective in the implementation of the Agenda is crucial.[65]

So, how does the foregoing discussion relate to health? The idea behind projecting gender equality as a goal worth pursuing is that inequality leads to disempowerment in most dimensions of human wellbeing, including health, and disempowerment leads to poor health outcomes for the disempowered person or group of persons. Early marriage provides a striking illustration. Quite often in this type of marriage, the husband is much older than the wife and has had more time to acquire resources, which could be used as a form of control or disempowerment. The husband might prevent his wife from holding a job, thereby creating a dependency relationship which forces the woman to rely on him, even for basic needs such as health care and access to social health determinants—all of which could be denied, thereby fostering poor health outcomes. Such is the link between health and gender equality/empowerment (SDG 5)—a disempowered woman is more likely to suffer deprivations in the realm of health care and social health determinants (and, consequently, poor health outcomes) than women who are empowered.

On a more cosmopolitan level, empowerment means allowing women full participation in the socio-economic and political affairs of the community. This places women in a position to address gender-specific needs in several areas, including health. Elsewhere, this author argues, regarding assigning leadership positions to women:

> The maxim "who feels it knows it" powerfully validates the idea that as the primarily affected party—in this case, women—they know best what the problems are and the right mix of approaches and strategies to be blended and distilled into a sustainable formula for success. The benefit of integrating such interests into policy decisions, particularly in the realm of health and health care, is self-evident. It is empowering.[66]

It is also this kind of empowerment that was contemplated by SDG 5 as vital to routing challenges negatively impacting women, including harmful practices, such as child, early and forced marriage and female genital cutting;[67] denial of equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance, and natural resources;[68] and lack of sound policies and enforceable legislation for the promotion of gender equality

65. 2030 SDG Agenda, *supra* note 8, ¶ 20, at 6.
66. Nnamuchi, *supra* note 58, at 131–32.
67. 2030 SDG Agenda, *supra* note 8, SDG 5, Target 5.3, at 18.
68. *Id.* SDG 5, Target 5.a, at 18.

and the empowerment of all women and girls at all levels.[69] Responding to these concerns have a bearing on access to health care as well as social determinants of health.

F. *SDG 6: Ensure Availability and Sustainable Management of Water and Sanitation for All*

This assertion in a James Madison University publication—that the "interconnectedness and the impacts that unsafe water and inadequate sanitation have on human health and general well-being makes it absolutely necessary to deal with all these issues or concerns together"[70]—brings to the fore the reason for conjoining water and sanitation as the subject of SDG 6. The link between water and sanitation is straightforwardly simple as is the relationship between the two and health. Poor sanitation leads to contamination of water sources which, in turn, creates conditions that could trigger disease outbreak and illness. Cases of water contamination throughout the world are typically the end-product of improper disposal of sewage and human waste, and the result could be catastrophic as this experience in Zimbabwe demonstrates. Massive seepage of sewage into the Limpopo River (a major source of drinking water) in 2008 triggered a cholera outbreak in that country, resulting in 3,000 deaths and 60,000 cases of infection.[71] The high casualty is explicable by the fact that many Zimbabweans lack access to safe drinking water sources, particularly the poor and residents of rural communities, and must depend on unsafe water sources for sustenance.[72]

In Zambia, although approximately 68% of the households have access to improved water supply, only 40% have improved sanitation,[73] making that country prone to the cholera epidemic. Between 1990 and 2017, the cholera outbreak accounted for the deaths of 4,731 people in that country.[74] Diseases transmissible through contaminated water and poor sanitation include diarrhea, dysentery, hepatitis A, typhoid, and

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69. *Id.* SDG 5, Target 5.c, at 18.

70. *The Relationship between Water and Health*, JAMES MADISON UNIVERSITY, https://canvas.jmu.edu/courses/1484140/pages/the-relationship-between-water-and-health [https://perma.cc/3EPF-E5U5] (last visited Sept. 28, 2020).

71. *See* Chris Bateman, *Cholera—Getting the Basics Right*, 99(3) S. AFR. MED. J. 138, 138 (2009); *See also Cholera in Zimbabwe*, WORLD HEALTH ORG. (WHO) (Dec. 2, 2008), http://www.who.int/csr/don/2008_12_02/en/ [https://perma.cc/824E-PQJU].

72. BRIGIT TOEBES ET AL., THE RIGHT TO HEALTH: A MULTI-COUNTRY STUDY OF LAW, POLICY AND PRACTICE 32 (2014).

73. Miljan Sladoje & Anand Rajaram, *Cholera in Zambia: Treating the Causes, not the Symptoms*, INT'L GROWTH CTR. (Mar. 9, 2018), https://www.theigc.org/blog/cholera-zambia-treating-causes-not-symptoms/ [https://perma.cc/YGL6-7MHN].

74. *Id.*

polio.[75] Globally, contaminated drinking water is responsible for about 485,000 diarrheal deaths each year whilst schistosomiasis, an acute and chronic disease caused by parasitic worms contracted through exposure to infested water, affects 220 million people annually.[76]

SDG 6 recognizes these linkages and circumstances, especially the disproportionate impact of health risks associated with exposure to contaminated water sources on the poor and the need to shield them from such risks. This is evident in the stipulations of its targets such as achieving, by 2030, universal and equitable access to safe and affordable drinking water for everyone, regardless of socioeconomic circumstances;[77] access to adequate and equitable sanitation and hygiene for all persons and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations;[78] and improving water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally,[79] and so forth.

Aside from poor health resulting from contaminated water sources, water is important to health in another significantly fundamental way. Water is indispensable to life. Without water, human life, as we know it, would cease to exist since human beings can only survive for a few days without water.[80] Yet, globally, approximately 785 million people lack a basic drinking water service, and that number includes the 144 million people who are dependent on surface water.[81] Even more alarming, it is predicted that by 2025, half of the world's population will be living in water-stressed areas.[82] This creates a need which SDG 6 seeks to address by setting 2030 as the deadline for States to substantially increase water-use efficiency across all sectors and ensure sustainable withdrawals and supply of freshwater to address water scarcity;[83] expand international cooperation and capacity-building support to developing countries in water- and sanitation-related activities and programs, including water harvesting, desalination, water efficiency, wastewater treatment,

75. *Drinking-water: Key Facts*, WORLD HEALTH ORG. (WHO) (June 14, 2019), https://www.who.int/news-room/fact-sheets/detail/drinking-water [https://perma.cc/9DJM-KMTN] [hereinafter WHO, *Drinking-water*].

76. *Id.*

77. 2030 SDG Agenda, *supra* note 8, SDG 6, Target 6.1, at 18.

78. *Id.* SDG 6, Target 6.2, at 18.

79. *Id.* SDG 6, Target 6.3, at 18.

80. WORLD HEALTH ORG. (WHO), THE RIGHT TO WATER (2003), http://www.who.int/water_sanitation_health/en/righttowater.pdf [https://perma.cc/N434-UATT].

81. WHO, *Drinking-water*, *supra* note 75.

82. *Id.*

83. 2030 SDG Agenda, *supra* note 8, SDG 6, Target 6.4, at 18.

recycling and reuse technologies;[84] and, by 2020, protect and restore water-related ecosystems, including mountains, forests, wetlands, rivers, aquifers, and lakes.[85] The stipulations are aimed at ensuring access to clean water for sustenance and reduction of exposure to diseases from usage of contaminated water sources, thereby aiding countries in fulfilling its obligation regarding the right to health.

G. *SDG 7: Ensure Access to Affordable, Reliable, Sustainable and Modern Energy for All*

There are two dimensions to the relationship between access to energy and health—direct and indirect. Direct relationship describes the interface between lack of reliable power sources in health facilities and its impact on health outcomes. Lack of power means no light to perform even rudimentary medical procedures. In addition, medicines, blood, vaccines and other biologicals cannot be refrigerated; equipment cannot be sterilized and those dependent on power such as scanners, cannot be used; and, telehealth and mobile applications cannot also be used. These deprivations have a direct bearing on health care delivery and poor health outcomes. Indirect relationship between health and energy refers to poor health outcomes that arise outside health care delivery system. The most critical is indoor air pollution, which is a major health hazard, particularly in developing countries. Using traditional fossil-fuels such as kerosene, diesel and charcoal produce harmful smoke/air pollutants which are injurious to health and could result to many diseases including stroke, ischemic heart disease, chronic obstructive pulmonary disease (COPD), pneumonia and lung cancer.

SDG 7 addresses these challenges by mandating States to, *inter alia*, ensure that by 2030, there will be universal access to affordable, reliable and modern energy services;[86] the global rate of improvement in energy efficiency will be doubled;[87] the share of renewable energy in the global energy mix will be substantially increased;[88] and, infrastructure and technology support for supplying modern and sustainable energy services in all in developing countries, in particular least developed countries, small island developing States and landlocked developing countries.[89]

84. *Id.* SDG 6, Target 6.a, at 19.
85. *Id.* SDG 6, Target 6.6, at 18.
86. *Id.* SDG 7, Target 7.1, at 19.
87. *Id.* SDG 7, Target 7.3, at 19.
88. *Id.* SDG 7, Target 7.2, at 19.
89. 2030 SDG Agenda, *supra* note 8, SDG 7, Target 7.b, at 19.

H. *SDG 8: Promote Sustained, Inclusive and Sustainable Economic Growth, Full and Productive Employment and Decent Work for All*

General Comment No.14, which is the most authoritative document on the interpretation of the right to health, was quite explicit that the reference in Art. 12(1) of the ICESCR to "the highest attainable standard of physical and mental health" is not be understood as being confined to the right to health care but also as inclusive of underlying or social determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[90] Deducible from this pronouncement, as previously emphasized, is that attaining good health is a product of two factors, namely, access to health care services as well as social health determinants.

Health care is a product of availability of resources, with which to pay for services rendered—just like one cannot have access to the enumerated social determinants of health in absence of funds. The reason Africa and other resource-deficit parts of the world perennially record poor health outcomes boils down to poverty, lack of funds with which to secure either of the two components of health, which, in turn, is the result of bleak economic circumstances in virtually all those places. It is this deficit that SDG 8 is poised to vanquish by requiring States to sustain per capita economic growth in accordance with national circumstances and, in particular, at least 7 per cent gross domestic product growth per annum in the least developed countries;[91] achieve higher levels of economic productivity through diversification, technological upgrading and innovation, including through a focus on high-value added and labor-intensive sectors;[92] achieve, by 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value,[93] and so forth.

Global success in implementation these obligations would result in rapid and sustainable economic growth and increased employment opportunities, which translates to availability of income with which to pay for health care and social health determinants. Failure, on the hand, would attract the opposite repercussion and therein lies the link between health and SDG 8.

90. General Comment No. 14, *supra* note 15, ¶ 4.
91. 2030 SDG Agenda, *supra* note 8, SDG 8, Target 8.1, at 19.
92. *Id.* SDG 8, Target 8.2, at 19.
93. *Id.* SDG 8, Target 8.5, at 19.

I. *SDG 9: Build Resilient Infrastructure, Promote Inclusive and Sustainable Industrialization and Foster Innovation*

Underlying SDG 9—building of resilient infrastructure and promotion of industrialization and innovation—is development, both individually and collectively (at country level). Understood as progress or exodus from an unacceptable/underperforming position or situation, the aim of development is to promote growth and human wellbeing. The U.N. Declaration on the Right to Development projects development as a "comprehensive economic, social, cultural and political process, which aims at the *constant improvement of the well-being of the entire population and of all individuals* on the basis of their active, free and meaningful participation in development and in the fair distribution of benefits resulting therefrom."[94] The aim of that "constant improvement" is to place the individual in a position where deprivations are not constant fixtures of existence, where constraints to human flourishing is consigned to the abyss of history. In this new position, the individual, now emancipated or liberated from strangulating life circumstances, would be able to meet at least his basic needs, including in the sphere of health, and be able to receive support from the nation, recently transformed to a thriving economy. The relationship between development and health is captured by the Alma-Ata Declaration, *to wit*, "[t]he promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life . . ."[95] The reverse is equally true.

To further locate the significance of SDG 9 to health, one needs to consider some of its Targets such as to develop quality, reliable, sustainable and resilient infrastructure, including regional and transborder infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all;[96] promote inclusive and sustainable industrialization and, by 2030, significantly raise industry's share of employment and gross domestic product, in line with national circumstances, and double its share in least developed countries;[97] facilitate sustainable and resilient infrastructure development in developing countries through enhanced financial, technological and technical support to African countries, least developed countries, landlocked developing countries and small island developing States;[98] and so forth. Each of these obligations, when fulfilled, is a necessary component of attaining SDG 9 and, in so far as

94. G.A. Res. 41/128, annex, Declaration on the Right to Dev. (1986), https://undocs.org/en/A/RES/41/128 [https://perma.cc/R4SQ-CV79].

95. *Declaration of Alma-Ata*, *supra* note 45, ¶ III.

96. 2030 SDG Agenda, *supra* note 8, SDG 9, Target 9.1, at 20.

97. *Id.* SDG 9, Target 9.2, at 20.

98. *Id.* SDG 9, Target 9.a, at 20.

the effect is economic liberation, leads to attainment of better health outcomes.

J. *SDG 10: Reduce Inequality Within and Among Countries*

The converse of inequality is equality, which is a human right, and since all human rights are equal, interrelated, interdependent and indivisible,[99] and health is a human right,[100] it follows that the link between health and SDG 10 is automatic, self-evident. The focus of SDG 10 is consistent with eradicating the major obstacle to achieving "health for all," namely, inequality. The concept of "health for all the people of the world by the year 2000," which was first articulated by the Alma-Ata Declaration in 1978,[101] has remained elusive nearly 40 years post-declaration, despite being recognized as a "main social target of governments, international organizations and the whole world community,"[102] precisely because of inequality within and among countries—the challenge targeted for evisceration by SDG 10. This is consistent with an earlier pronouncement that the "existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries."[103]

Examples of the impact of inequality on health abound. Universal Health Coverage (UHC) (another name for "health for all") has been attained in some countries but not others specifically on account of inequality of resources amongst countries. Even in countries that have succeeded in attaining UHC, there is no uniformity of health status throughout the countries, due to differences or inequality in access to social health determinants. The same holds true in countries that are yet to attain UHC—inequality in resources determines who gets what, in

99. *See* U.N., Econ. & Soc. Council, Comm. On Econ. Soc. And Cultural Rts, The Maastricht Guidelines on Violations of Economic, Social & Cultural Rights, ¶ 4 at 17, U.N. Doc. E/C.12/2000/13 (2000), *reprinted* in 20 HUM. RTS. Q. 691, ¶ 4 at 692 (1998), https://undocs.org/en/e/c.12/2000/13 [https://perma.cc/9MXS-WXRR]; U.N., Econ. & Soc. Council, Comm. On Econ. Soc. And Cultural Rts., Limburg Principles on the Implementation of the Int'l Covenant on Econ., Soc., and Cultural Rights, ¶ 3 at 3, U.N. Doc. E/C.12/2000/13 (2000), *reprinted* in 9 HUM. RTS. Q. 122, ¶ 3 at 123 (1987); World Conference on Human Rights, *Vienna Declaration and Programme of Action*, ¶ 5, U.N. Doc. A/CONF.157/23 (June 25, 1993), https://undocs.org/en/A/CONF.157/23 [https://perma.cc/4S9E-5TM3]; U.N., Convention on the Rts. of the Child, Comm. on the Rts. of the Child, General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, art. 24, ¶ 7, U.N. Doc. CRC/C/GC/15 (2013), https://undocs.org/CRC/C/GC/15 [https://perma.cc/6HDU-JQR7].

100. ICESCR, *supra* note 14; G.A. Res. 217 (III) A, art. 25, Universal Declaration of Human Rights (Dec. 10, 1948), https://undocs.org/en/A/RES/217(III) [https://perma.cc/S76W-TZRV].

101. *Declaration of Alma-Ata*, *supra* note 45, ¶¶ V, X.

102. *Id.* ¶ V.

103. *Id.* ¶ II.

this case both health care and social health determinants. Income differential is the principal factor responsible for health disparities, a reason affluent households in poor countries enjoy similar standard of living and health outcomes as those in wealthy countries since they have the resources to meet their needs from within and outside their countries of residence.

Reversing the status quo involves fundamental restructuring of the society, and this accounts for the imposition by SDG 10 of far-reaching obligations upon states, including, by 2030, to progressively achieve and sustain income growth of the bottom 40% of the population at a rate higher than the national average;[104] by 2030, to empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status;[105] to ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard;[106] and so forth. These stipulations affirm a key provision of the Alma-Ata Declaration and the connection between SDG 10 and the right to health, namely, that "[e]conomic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries."[107]

K. *SDG 11: Make Cities and Human Settlements Inclusive, Safe, Resilient and Sustainable*

Making human settlement inclusive, safe, resilient and sustainable, as intended by SDG 11, addresses a core social health determinant, namely, shelter or housing as well as the cities and towns in which people live and work.[108] Underlying or social determinants of health consist of the "structural determinants and conditions of daily life"—that is, "the conditions in which people are born, grow, live, work, and age,"[109] which obviously is inclusive of "cities and human settlements"—the focus of SDG 11. Adequate attention to these conditions is very important, for health status is not entirely a product of availability or access to healthcare services. More than anything else—including access to medicine and hospital services—as the Commission on Social Determinants of Health (CSDH) notes, the conditions under which people live and work, including the cities and towns in which they live,

104. 2030 SDG Agenda, *supra* note 8, SDG 10, Target 10.1, at 21.
105. *Id.* SDG 10, Target 10.2, at 21.
106. *Id.* SDG 10, Target 10.3, at 21.
107. *Declaration of Alma-Ata*, *supra* note 45, ¶ III.
108. General Comment No. 14, *supra* note 15, ¶ 11.
109. WHO, *supra* note 15, at 1.

are far more significant contributors to health, for it is these conditions that largely determine morbidities and mortalities or absence thereof amongst the population.[110]

SDG 11 seeks to make cities and human settlements inclusive, safe, resilient and sustainable through a number of tasks imposed upon states, including, by 2030, to ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums;[111] provide access to safe, affordable, accessible and sustainable transport systems for all, and improve road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations;[112] enhance inclusive and sustainable urbanization and capacity for participatory, integrated, and sustainable human settlement planning and management in all countries;[113] reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management,[114] and so forth. Commitment to these obligations is a *sine qua non* to attaining good health and, therefore, demonstrative of the link between SDG 11 and the right to health.

L. *SDG 12: Ensure Sustainable Consumption and Production Patterns*

Although the goal of ensuring sustainable consumption and production patterns is meant to regulate the use of all products needed for human survival and wellbeing, it does have special relevance to health as evident in the recognition by the Alma-Ata Declaration that "an acceptable level of health for all the people of the world . . . can be attained through a fuller and better use of the world's resources."[115]

The reason is simple. Raw materials needed for pharmaceutical production are not inexhaustible, particularly those that are freely available in nature such as trees, herbs and minerals. The same is true of the products needed to attend to underlying determinants of health such as crops (food) and timber (shelter). In absence of global commitment to sustainable consumption and production patterns regarding these items, as championed by SDG 12, their availability and accessibility will come to a grinding halt, with disastrous consequences not only for global health but also every other aspect of human wellbeing—all of which have a

110. For a comprehensive account of the value and impact of underlying health determinants on health, *see* WHO, *id.*

111. 2030 SDG Agenda, *supra* note 8, SDG 11, Target 11.1, at 21.

112. *Id.* SDG 11, Target 11.2, at 21.

113. *Id.* SDG 11, Target 11.3, at 21.

114. *Id.* SDG 11, Target 11.6, at 22.

115. *Declaration of Alma-Ata*, *supra* note 45, ¶ X.

bearing on health. This is the nexus between SDG 12 and the right to health.

Means of operationalizing SDG 12 include, amongst others, implementing the 10-Year Framework of Programmes on Sustainable Consumption and Production Patterns, all countries taking action, with developed countries taking the lead, taking into account the development and capabilities of developing countries;[116] achieving, by 2030, the sustainable management and efficient use of natural resources;[117] halving, by 2030, per capita global food waste at the retail and consumer levels and reducing food losses along production and supply chains, including post-harvest losses;[118] and achieving, by 2020, the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimize their adverse impacts on human health and the environment.[119] Regarding the last means of operationalizing SDG 12, it is interesting to note that although from 2010 to 2019, global e-waste generation grew continuously, from 5.3 kg per capita to 7.3 kg per capita, the environmentally sound recycling of e-waste increased at a slower pace, from 0.8 kg per capita to 1.3 kg per capita. The alarming deficit between e-waste generation and its recycling means that more effort is needed on the part of the global community to reverse the situation.[120]

M. *SDG 13: Take Urgent Action to Combat Climate Change and its Impacts*

The U.N. Framework Convention on Climate Change (UNFCCC) defines climate change as "a change of climate which is attributed directly or indirectly to human activity that alters the composition of the global atmosphere and which is in addition to natural climate variability observed over comparable time periods."[121] The stated objective of the treaty, as stipulated in Article 2, is the "stabilization of greenhouse gas concentrations in the atmosphere at a level that would prevent dangerous anthropogenic interference with the climate system."[122] The goal is to reach that level "within a time frame sufficient to allow ecosystems to

116. 2030 SDG Agenda, *supra* note 8, SDG 12, Target 12.1, at 22.

117. *Id.* SDG 12, Target 12.2, at 22.

118. *Id.* SDG 12, Target 12.3, at 22.

119. *Id.* SDG 12, Target 12.4, at 22.

120. U.N. Econ. and Soc. Council, *Progress towards the Sustainable Development Goals*, Report of the Secretary-General, ¶ 110, U.N. Doc. E/2020/57 (Apr. 28, 2020), https://undocs.org/en/E/2020/57 [https://perma.cc/8TF7-KUBT].

121. U. N. Framework Convention on Climate Change art. 1(2), *adopted* May 9, 1991, 1771 U.N.T.S. 107 (entered into force Mar. 21, 1994).

122. *Id.* art. 2.

adapt naturally to climate change, to ensure that food production is not threatened and to enable economic development to proceed in a sustainable manner."[123] As to the means of attaining this objective, State Parties to the UNFCCC undertake to combat climate change and the adverse effects, in accordance with their common but differentiated responsibilities and respective capabilities, with developed countries taking the lead.[124] These provisions of the UNFCCC are important because of their interface with SDG 13, namely, to take urgent action to combat climate change and its impact. In fact, the latter could be construed as a policy restatement of the former—which is important since it provides additional avenue or weapon for solving the same problem.

Climate change regime is about extreme weather conditions (mostly warmer weather) and its impact, as the UNFCCC affirms, on food production and economic development, and for States Parties to take measures to enable both to proceed in a sustainable manner.[125] This recognition is illustrative of the relationship between health and SDG 13, for any interruption in food production and economic development will adversely impact health given the importance of food (a social health determinant) and economic development (necessary for availability of medicines and underlying determinants of health) to the health of the population. An editorial in *Lancet* powerfully sums up this relationship:

> The effects of climate change are inextricably entwined with health: ranging from the WHO estimate of 7 million deaths from breathing polluted air indoors and outdoors; through the impact of weather-related natural disasters; negative effects on crop yields and food security; and changing patterns of vector-borne diseases; to the shaping of social and environmental determinants of health.[126]

Regarding the nature of the action necessary to combat climate change, SDG 13 imposes the following obligations, amongst others, on States, namely, to strengthen resilience and the increase the capacity to adapt to climate-related hazards and natural disasters in all countries;[127] integrate climate change measures into national policies, strategies and planning;[128] improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact

123. *Id.*

124. *Id.* art. 3(1).

125. *Id.* art. 2.

126. Editorial, *Turning Climate Change Legislation into Public Health Policy*, 391 THE LANCET 1865, 1865 (2018), https://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2931004-3 [https://perma.cc/9CNG-NTLA].

127. 2030 SDG Agenda, *supra* note 8, SDG 13, Target 13.1, at 23.

128. *Id.* SDG 13, Target 13.2, at 23.

reduction and early warning,[129] and so forth—all of which are relevant to health and the right thereto.

N. *SDG 14: Conserve and Sustainably use the Oceans, Seas and Marine Resources for Sustainable Development*

The question that needs to be asked regarding the nexus between health and conservation/sustainable use of oceans, seas and marine resources is whether resources obtainable from these sources are useful to health? Before responding to the question, however, we need to determine what these resources are. One of earth's most valuable natural resources, the ocean, is a major source of food such as fish, octopus, oyster, lobster, clam, crab, crocodile, mollusk, otter, sea snail, seal, squid and so forth. The ocean is home to many biomedical organisms, used in fighting diseases, such as algae, bryozoans, corals, echinoderms, fishes, nudibranchs, prawns, sea slugs, shells and sponges.[130] Important minerals (such as cobalt, copper, gypsum, iron, limestone, magnesium, manganese, nickel, phosphorites, and salt) which have economic and medicinal value are obtained from the ocean.

Some of the obligations imposed upon States in pursuit of the realization of the objectives of SDG 14 include to prevent and significantly reduce marine pollution of all kinds by 2025—in particular from land-based activities, including marine debris and nutrient pollution.[131] They also include sustainably managing and protecting marine and coastal ecosystems to avoid significant adverse impacts, including by strengthening their resilience and taking action for their restoration in order to achieve healthy and productive oceans, with 2020 as the deadline.[132] By 2020, the obligations are to effectively regulate harvesting and end overfishing, illegal, unreported and unregulated fishing and destructive fishing practices and implement science-based management plans, in order to restore fish stocks in the shortest time feasible,[133] and so forth.

Although attempts by the global community to sustainably manage and protect marine and coastal ecosystems have intensified, it is not clear whether the goal of achieving healthy and productive oceans, whose deadline was set at 2020 has been met. Remarkably, despite the continuing decline of the sustainability of global fishery resources, the latest data indicates that the rate of decline is reducing, with the proportion of fish stocks within biologically sustainable levels at nearly

129. *Id.* SDG 13, Target 13.3, at 23.

130. Harshad Malve, *Exploring the Ocean for New Drug Developments: Marine Pharmacology*, 8(2) J. PHARM. BIOALLIED SCI. 84 (2016).

131. 2030 SDG Agenda, *supra* note 8, SDG 14, Target 14.1, at 23.

132. *Id.* SDG 14, Target 14.2, at 23.

133. *Id.* SDG 14, Target 14.4, at 24.

66% in 2017—down from 90% in 1974 and 0.8 percentage point lower than 2015 levels.[134] Since the adoption of the Agreement on Port State Measures [APSM]—the first binding international agreement that is designed to prevent illegal, unreported and unregulated fishing—the number of States Parties has been on the rise, increasing to 66 (including the European Union) in 2020, from 58 in the previous year.[135] Significantly, of the countries reporting on the implementation of the Agreement, nearly 70% indicated high level of compliance thereof.[136]

O. *SDG 15: Protect, Restore and Promote Sustainable Use of Terrestrial Ecosystems, Sustainably Manage Forests, Combat Desertification, and Halt and Reverse Land Degradation and Halt Biodiversity Loss*

A relevant question to ask in the context of the nexus between heath and SDG 15 is whether failure to protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, halt and reverse land degradation, and halt biodiversity loss would have any effect on health. If the answer is affirmative, as this Article seeks to show, then, a linkage is established. The inevitable result of desertification, land degradation, biodiversity depletion, and an inaction regarding the protection of ecosystems and forests will be the extinction of plants and animals, loss of arable land as well as scarcity of necessary minerals and organisms. Untamed deforestation reduces availability of timber for housing construction as well as trees whose extracts are used in drug manufacturing. Desertification and land degradation lead to reduction in arable land, adversely impacting food production and availability. Inadequate protection of the ecosystem including air, water, and mineral soil contributes to air pollution, reduced availability of clean and potable water as well as drugs and other biomedical products derived from mineral soil. Similarly, since biodiversity (species of life on earth and their biological diversity) is a reservoir of resources to be used for food, medicine, industrial products and so forth,[137] its depletion or destruction leads to the loss of these benefits.

There is no gainsaying that each of the losses that would result from inaction regarding the ecosystem, forests, desertification, land degradation and biodiversity will have deleterious impact on health. Vigorous pursuit, on the other hand, of the obligation imposed upon

134. U.N. Econ. and Soc. Council, *supra* note 120.

135. *Id.* ¶ 121.

136. *Id.*

137. Anup Shah, *Why is Biodiversity Important? Who Cares?,* GLOB. ISSUES (Jan. 19, 2014), https://www.globalissues.org/article/170/why-is-biodiversity-important-who-cares [https://perma.cc/8CLB-ZW4Y].

States would attract positive health consequences. To this extent, the nexus between health and SDG 15 seems to have been established. Some of the obligations assumed under SDG 15 include, to ensure, by 2020, the conservation, restoration and sustainable use of terrestrial and inland freshwater ecosystems and their services, in particular forests, wetlands, mountains and drylands, in line with obligations under international agreements;[138] to promote, by 2020, the implementation of sustainable management of all types of forests, halt deforestation, restore degraded forests and substantially increase afforestation and reforestation globally;[139] ensuring, by 2030, the conservation of mountain ecosystems, including their biodiversity, in order to enhance their capacity to provide benefits that are essential for sustainable development,[140] and so forth.

P. *SDG 16: Promote Peaceful and Inclusive Societies for Sustainable Development, Provide Access to Justice for All and Build Effective, Accountable and Inclusive Institutions at All Levels*

Does SDG 16 share any relationship with health? The answer is imbedded in some of the Targets of the Goal. The first and second Targets, namely, to significantly reduce all forms of violence and related death rates everywhere;[141] and, end abuse, exploitation, trafficking and all forms of violence against and torture of children,[142] directly speak to critical health concerns. The ultimate result of significant reduction of violence and related deaths is containment of human suffering, pain, disability and mortality associated with violence—meaning improvement in health status and other dimensions of wellbeing. Promoting the rule of law at the national and international levels and ensuring equal access to justice for all—Target 3—is critical to health. Where rule of law reigns supreme, there will be no discrimination in access to health as well as social health determinants on any of the prohibited grounds, such as those stipulated in Art. 2 of the ICESCR, *to wit*, race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[143]

The second component of SDG 16, ensuring equal access to justice, is equally relevant to health in the sense of distributive justice—"fair, equitable and appropriate distribution determined by justified norms that structure the terms of social cooperation,"[144] meaning that even the poor

138. 2030 SDG Agenda, *supra* note 8, SDG 15, Target 15.1, at 24.
139. *Id.* SDG 15, Target 15.2, at 24.
140. *Id.* SDG 15, Target 15.4, at 25.
141. *Id.* SDG 16, Target 16.1, at 25.
142. *Id.* SDG 16, Target 16.2, at 25.
143. ICESCR, *supra* note 14, art. 2.
144. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 226 (Oxford Univ. Press ed., 5th ed. 2001).

would have access to health care regardless of socioeconomic circumstances. Where anyone suffers any deprivation, for instance, discrimination in access to health care, the person would be entitled to legal remedy, even if unable to afford legal representation.

Target 16.4, namely, to significantly reduce, by 2030, illicit financial and arms flows, strengthen the recovery and return of stolen assets and combat all forms of organized crime,[145] is particularly relevant to third world countries. The fragile and underperforming state of health systems in these countries is the direct result of inadequate investment in the health sector, which, in turn, is a product of deficit of resources. Reducing illicit financial and arms flows, and strengthening the recovery and return of stolen assets, means more cash for investment in the economy, including the health sector. Apart from these, corruption and bribery are two critical challenges of underperforming health systems which Target 16.5 is designed to tackle. Even in countries operating social health insurance systems, with payment exemptions for the poor, these people are often denied services on account of inability to make unofficial payments to corrupt health workers.[146] Medicine and hospital equipment is often sold by health care workers with proceeds paid into private bank accounts.[147] Addressing these twin evils will undoubtedly lead to improvement in population health.

Target 16.6 requires States to develop effective, accountable and transparent institutions at all levels.[148] This stipulation is relevant to health in the sense that many of the morbidities and mortalities are the result of lack of accountability, the kind that ensures maximization and efficient use of available services and resources. Institutions that are deficient in effective accountability mechanisms are often afflicted with resource embezzlement, wastage and diversion, thereby entrenching systemic underperformance. Health institutions are not immune from this challenge and stand to benefit from a reversal thereof, which is attainable by sticking to the prescription of Target 16.6.

The prescription of Target 16.7 is particularly relevant to health, namely, ensuring responsive, inclusive, participatory and representative decision-making at all levels.[149] Participation in the decision-making process pertaining to things that will impact one is an inherent human right, premised on the principle of autonomy or individual sovereignty. This has particular resonance to health. The Alma-Atta Declaration is

145. 2030 SDG Agenda, *supra* note 8, SDG 16, Target 16.4, at 25.

146. OBINNA ONWUJEKWE, ET AL., CORRUPTION IN ANGLOPHONE WEST AFRICA HEALTH SYSTEMS: A SYSTEMATIC REVIEW OF ITS DIFFERENT VARIANTS AND THE FACTORS THAT SUSTAIN THEM, 34 HEALTH POLICY AND PLANNING 533–39 (2019).

147. *Id.* at 539.

148. *Id.* SDG 16, Target 16.6, at 25.

149. *Id.* SDG 16, Target 16.7, at 25.

quite categorical, affirming that the "people have the right and duty to participate individually and collectively in the planning and implementation of their health care."[150] It is a requirement of human rights law that:

> The formulation and implementation of national health strategies and plans of action should respect, *inter alia*, the principles of . . . 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.[151]

The application of this principle is not limited to adults and collectivities. Even non-adults must be given "the opportunity to participate in decisions affecting their health."[152]

Q. *SDG 17: Strengthen the Means of Implementation and Revitalize the Global Partnership for Sustainable Development*

Is SDG 17 related to human health? As tempting as it is to immediately respond to this question, we will tarry a little while in order to first explore the content of the last of the SDGs. The Goal has been described as calling for the global partnership for sustainable development to be revitalized, which is a recognition that achieving the targets and benchmarks of the SDGs depends on the willingness of various actors and entities, both in the private as well as public sectors, to forge partnerships.[153] This is critical because situating the success of the entire 2030 Global Agenda on international cooperation or partnerships evokes an important concept in human rights, namely, multisectoralism, meaning that attaining to human rights requires the cooperation of multiple actors, ranging from those in education, industry, agriculture, labor and so forth as well as private and public sector collaborations—an idea that is premised on the interdependent nature of human rights. This is not surprising given that the Agenda has been proclaimed to be a human rights enterprise, being "grounded in the Universal Declaration of Human Rights, international human rights treaties, the Millennium Declaration and the 2005 World Summit

150. *Declaration of Alma-Ata*, *supra* note 45, ¶ IV.

151. General Comment No. 14, *supra* note 15, ¶ 54.

152. *Id.* ¶ 23.

153. *Revitalizing the Global Partnership for Sustainable Development*, JUSTMEANS (Apr. 6, 2016, 8:30 AM), http://www.justmeans.com/article/revitalizing-the-global-partnership-for-sustainable-development [https://perma.cc/3YLD-SHNV].

Outcome" and "informed by other instruments such as the Declaration on the Right to Development."[154]

If we accept, as the U.N. General Assembly affirms, that the SDGs are centered on human rights,[155] then, we must also acknowledge that the means of implementation, namely global partnership (the central objective of SDG 17) has an indelible link with the right to health. The reason is quite obvious. Without a robust implementation mechanism, like the kind enshrined in SDG 17, health will be detrimentally impacted as there would be no availability or access to health care and underlying determinants of health. Indeed, it is not inappropriate to argue that "the final goal, SDG 17, is more fundamental than the others, because if we fail to achieve it, we won't be able to achieve any of the others,"[156] a failure that would be catastrophic to health and other dimensions of wellbeing. Stated differently, the last of the SDGs "is in many ways the most important. . . . The challenges laid out in the other goals can never be achieved if business, government and civil society organizations fail to work together."[157] Translation, addressing the challenges enumerated in the rest of the SDGs, which this Article has argued is linked to health, are predicated on successful implementation of SDG 17—a success, which if attained, would positively affect health.

The global partnership envisaged by SDG 17 is designed to cover five areas, namely, finance, technology transfer and cooperation, capacity-building, fair and competitive trade, and systemic issues. Under finance, States are required to, amongst others, strengthen domestic resource mobilization, including through international support to developing countries, to improve domestic capacity for tax and other revenue collection;[158] for developed countries, implement fully their official development assistance (ODA) commitments, including the commitment by many developed countries to achieve the target of 0.7% of gross national income (GNI) for ODA to developing countries and 0.15 to 0.20% of ODA/GNI to lesser developed countries;[159] mobilize additional financial resources for developing countries from multiple sources;[160] and, assist developing countries in attaining long-term debt sustainability through coordinated policies aimed at fostering debt financing, debt relief and debt restructuring, as appropriate, and address the external debt of highly indebted poor countries to reduce debt distress.[161]

154. 2030 SDG Agenda, *supra* note 8, ¶ 10.
155. *Id.*
156. JUSTMEANS, *supra* note 152.
157. *Id.*
158. 2030 SDG Agenda, *supra* note 8, SDG 17, Target 17.1, at 26.
159. *Id.* SDG 17, Target 17.2, at 26.
160. *Id.* SDG 17. Target 17.3, at 26.
161. *Id.* SDG 17, Target 17.4, at 26.

Technology partnership involves enhancement of North-South, South-South and triangular regional and international cooperation on and access to science, technology and innovation and enhanced knowledge sharing on mutually agreed terms;[162] promotion of the development, transfer, dissemination and diffusion of environmentally sound technologies to developing countries on favorable terms,[163] and so forth.

The third rubric, capacity-building, centers on enhancing international support for implementing effective and targeted capacity-building in developing countries to support national plans to implement all the SDGs, including through North-South, South-South and triangular cooperation.[164]

On trade, States are required to promote a universal, rules-based, open, non-discriminatory and equitable multilateral trading system under the World Trade Organization;[165] significantly increase the exports of developing countries, in particular with a view to doubling the least developed countries' share of global exports by 2020,[166] and so forth.

The final component of the implementing mechanism of SDG, systemic issues, requires striving to achieve policy and institutional coherence in terms of global macroeconomic stability, policy coherence for sustainable development;[167] multi-stakeholder partnerships (public/private sector actors) involving mobilization and sharing of knowledge, expertise, technology and financial resources to support the achievement of the SDGs, particularly in developing countries;[168] and, data, monitoring and accountability.[169]

CONCLUSION

The overarching purpose of this Article was quite straightforward, and that was to determine whether a nexus could be established between each of the SDGs and the right to health. As made apparent in the introductory section, the task was achievable by situating the SDGs within the two dimensions of the right, namely, access to health care and social determinants of health. Relying on the provisions of the 2030 Agenda and key human rights instruments as explicatory of the SDGs as well as the prescriptions and proscriptions of international law relating to human rights, this Article has endeavored to show that these dual dimensions of the right to health are, to varying degrees, imbedded in all the SDGs. In

162. *Id.* SDG 17, Target 17.6, at 26.
163. 2030 SDG Agenda, *supra* note 8, SDG 17, Target 17.7, at 26.
164. *Id.* SDG 17, Target 17.9, at 27.
165. *Id.* SDG 17, Target 17.10, at 27.
166. *Id.* SDG 17, Target 17.11, at 27.
167. *Id.* SDG 17, Targets 17.13–15, at 27.
168. *Id.* SDG 17, Targets 17.16–17, at 27.
169. *Id.* SDG 17, Targets 17.18–19, at 27.

other words, the argument advanced in some quarters that health is shortchanged in the SDGs is fatally flawed. What is urgently needed from countries, the international community and civil society is to strengthen efforts in the direction of turning the health-related imperatives of the SDGs to concrete reality in the lives of individuals, particularly those languishing in misery and extreme hardship on account of asphyxiating life circumstances, most of them in the developing world.

Concretizing the health-related imperatives of the SDGs in people's lives raises a very important concern; and that is, whether progress is being made toward achieving the targets of the 17 SDGs. An authoritative response is the Report of the Secretary General of the U.N., which was published in April 2020:

> Through the end of 2019, progress continued to be made in some areas: global poverty continued to decline, albeit at a slower pace; maternal and child mortality rates were reduced; more people gained access to electricity; and countries were developing national policies to support sustainable development and signing international environmental protection agreements. In other areas, however, progress had either stalled or been reversed: the number of persons suffering from hunger was on the rise, climate change was occurring much more quickly than anticipated and inequality continued to increase within and among countries.[170]

Related to the progress, or lack thereof, being made toward the SDGs is the impact of the coronavirus (COVID-19) pandemic on the SDGs. The U.N. General Secretary's Report paints a grim picture. Prior to the pandemic, poverty (SDG 1) was declining but not anymore,[171] hunger and food insecurity (SDG 2) are on the rise.[172] Not only are health systems (SDG 3) devasted, health outcomes that have already been achieved are being threatened.[173]

The picture is indeed gloomy. Nonetheless, there is hope, in the sense of major breakthrough, on the horizon. Like every other pandemic, COVID-19 will not be a permanent fixture in global affairs. Massive production and distribution of vaccines, which have proven to be effective against the virus in various parts of the world, signal quite strongly that the end is near.[174] Once the spread of the virus is contained,

170. U.N. Econ. and Soc. Council, *supra* note 120 ¶ 2.

171. *Id.* ¶ 10.

172. *Id.* ¶ 14.

173. *Id.* ¶ 20.

174. Eric Bellman, *U.S. Taps Indian Covid-19 Vaccine Production Prowess to Inoculate Indo-Pacific*, WALL ST. J., Mar. 14, 2021, *available at* https://www.wsj.com/articles/u-s-taps-

the hitherto stalled march toward the realization of the targets of the SDGs will be a thing of the past, resulting in greater availability of the resources and attainment of the values imbedded in the SDGs. The net effect, ultimately, will be more resources for the fulfilment of the two faces of the right to health, namely, medicine and social health determinants, thereby bolstering the thesis of this Article, *to wit*, there is a nexus between the SDGs and the Right to Health.

indian-covid-19-vaccine-production-prowess-to-inoculate-indo-pacific-11615719604 [https://perma.cc/9M8X-YL64] (last visited Mar. 14, 2021).