



## Health Rights and Realization

### Comment on “Rights Language in the Sustainable Development Agenda: Has Right to Health Discourse and Norms Shaped Health Goals?”

Simon Rushton\*

#### Abstract

In their hypothesis published in *IJHPM*, Lisa Forman and colleagues examined the prominence of the right to health and sexual and reproductive health rights (as well as related language) in four of the key reports that fed into the process of negotiating the Sustainable Development Goals (SDGs). Now that the SDGs have been formally adopted, this comment builds on some of the insights of Forman and colleagues to examine the extent to which those rights have been incorporated in SDGs 3 and 5. I argue that sexual and reproductive health rights are relatively well-covered within the SDGs. In terms of the right to health, however, the picture is much less clear. Some of the elements that make up that right are present and correct, but the SDGs have delivered no coherent vision of how a ‘right to health’ might actually be realized. An important task facing global health and human rights advocates is to continue pushing human rights framings so that progress is made both on meeting the SDGs and on realizing the right to health.

**Keywords:** Right to Health, Sexual and Reproductive Health Rights, Sustainable Development Goals (SDGs), Global Health Policy

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#### \*Correspondence to:

Simon Rushton

Email: [simon.rushton@sheffield.ac.uk](mailto:simon.rushton@sheffield.ac.uk)

In their hypothesis published in *IJHPM* in December 2015,<sup>1</sup> Lisa Forman and colleagues examined the prominence of the right to health and sexual and reproductive health rights (as well as related language) in four of the key reports that fed into the process of negotiating the Sustainable Development Goals (SDGs). That process culminated in September 2015 with the United Nations (UN) General Assembly’s adoption of the SDGs which include, in Goal 3, a commitment to ‘Ensure healthy lives and promote well-being for all at all ages’ and, in Goal 5 (‘Achieve gender equality and empower all women and girls’), “universal access to sexual and reproductive health and reproductive rights.”

The formal adoption of the SDGs took place after Forman and colleagues wrote their hypothesis, and there is no intention in this response of using the benefit of hindsight to ‘judge’ their findings against what actually happened. Instead, I am interested in the reverse: using their arguments about the normative importance of rights language to ‘judge’ the value of the final text of the SDGs. If Forman and colleagues were right in arguing that the framing of health as a human right is a step towards more equitable global health policy and the realization of those rights, how far do the SDGs take us?

The first thing to note is that ‘Transforming our world: the 2030 Agenda for Sustainable Development’ – the resolution adopted by the UN General Assembly that set out the SDGs<sup>2</sup> – contained a good deal of rights language. Indeed the Preamble noted that one of the key purposes of the SDGs was to “realize the human rights of all.” International human rights instruments including the Universal Declaration of Human Rights were invoked (paras 10, 19) and the ‘right to development’ was specifically mentioned (paras 10, 35).

However, the health goal (Goal 3) included no explicit rights language at all (other than in relation to Intellectual Property Rights in 3b). In that respect SDG3 stands in contrast to some of the other goals, including those on education (Goal 4) and gender equality (Goal 5), where explicit human rights language *was* included.

Forman et al<sup>1</sup> rightly pointed out in their hypothesis that “an explicit human rights and right to health focus would sharply contrast with how human rights were dealt with in the Millennium Development Goals (MDGs).” Unfortunately for advocates of rights-based approaches to global health, this hope was not entirely fulfilled in the SDGs. As Carmel Williams and Alison Blaiklock noted:

*“Although human rights are acknowledged in the Agenda, there is no consistent rights-based approach to the goals and targets. The right to health, for example, is not in the text, nor within any of the targets. The SDGs offered opportunities to reinforce international legal human rights obligations in, for example, development aid, climate action or even trade agreements—unfortunately these were not taken.”*<sup>3</sup>

In fact what the General Assembly adopted as Goal 3 of the SDGs was almost word-for-word the text recommended by the Open Working Group (OWG) in its report of August 2014.<sup>4</sup> Other than a small (but significant) addition to the OWG’s proposal for Goal 3.2, indeed, the two texts are identical<sup>[1]</sup>. The OWG report was one of the four examined by Forman and colleagues, and they found that it was the one with the lowest ‘prevalence’ of rights-relevant terminology<sup>[2]</sup>, including “no *explicit* reference to the right to health or to sexual and reproductive health rights.” On the latter point, they erred in that reproductive rights were included in the OWG’s draft of

Goal 5 (the OWG and SDG texts of 5.6, indeed, are identical), but their wider point about the relative paucity of health rights language in the OWG proposal applies equally to the final SDGs, as adopted by the General Assembly.

The question that arises is whether this absence of an explicit reference to the right to health is likely to have a negative impact on global health policy during the SDG period. Is it enough that the Goal eventually adopted is “largely consistent with right to health imperatives”?

Forman and colleagues adopted a social constructivist-inspired approach, arguing that “express use of right to health language may subtly guide actors in the direction of realizing this right.” Social constructivists believe that language, and the way we use it to describe social phenomena (the way we ‘frame’ those phenomena), are important. Whilst agreeing with this stance, it is perhaps worth briefly rehearsing some of the mechanisms through which such uses of language might subtly, but palpably, affect ‘real world’ policy outcomes. In framing health as a human right, we do at least two things. First, we connect health with the realm of human rights more broadly (implying notions of entitlement and universality) - and with the history of international human rights instruments to which Forman and colleagues refer. This, we would hope, helps ‘anchor’ health within a framework that has acquired a good deal of international legitimacy over time; helps bolster claims for the imperatives of universality and equality; and draws attention to the connections between health and other fundamental rights. Conversely, constructivists would warn, failing to frame health as a human right could over time lead to the right itself falling into disrepair and, ultimately, to it becoming moribund<sup>[3]</sup>.

Second, framing health as a human right – and reiterating the existence of that right within high profile international documents such as the SDG declaration – might make it more difficult for governments to justify denying that right to their citizens. In practice, there are a variety of routes through which this can play out, including ‘shaming’ on the international stage and challenges through the domestic courts. These are of course imperfect vehicles for the realization of rights, but there are numerous examples both within and beyond health of these types of strategies being effective in some cases. The progress made by advocates for the right to access HIV treatment serves as an example, using both legal challenges and international campaigning to establish the principle (even if this is not yet realized) of access for all.

### Sexual and Reproductive Health Rights

A downside of certain framings, however, can be to embroil an issue in pre-existing controversies, making it subject to political, cultural or religious sensitivities. This is perhaps less of a risk with the ‘right to health.’ Such a right has been widely acknowledged in a series of international statements and agreements over the past 70 years. Sexual and reproductive health rights, by contrast, have long been a lightning rod for international disagreement. In some ways, it would not have been a surprise, therefore, if the OWG had fought shy of including reproductive health rights language for fear of creating division and reducing the chances of the universal international agreement necessary for the SDGs to succeed. In fact, what we find in the OWG proposal (and in the SDGs)

is not one but two relatively progressive targets, one of which specifically refers to rights and one of which does not:

“3.7 By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.”

“5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.”

This is a very different outcome to the MDGs 15 years earlier. In that case, whilst sexual and reproductive health rights had been extensively discussed in the run-up to the agreement of the Goals,

“By 2000, when the General Assembly adopted with much fanfare the Millennium Declaration and, a year later, the Millennium Development Goals, a roadmap for world development by 2015, an explicit commitment to the reproductive rights of women was nowhere to be found, only a vaguer promise of gender equality was there. When specific indicators for judging how the world could measure its progress toward those goals [were published], explicit sexual rights were again missing.”<sup>5</sup>

The huge progress that seems to have been made in legitimizing the principle of universal access to sexual and reproductive health services over those 15 years may well be evidence of the power of the rights discourse in this area. Advocates have consistently made the case for sexual and reproductive health rights *qua* rights – despite attempts by opponents of some elements of that agenda to put forward alternative framings.<sup>6</sup> Their inclusion in the SDGs has been seen as “a huge win for the women’s rights and sexual and reproductive health rights (SRHR) communities.”<sup>7</sup>

A global declaration on universal access to sexual and reproductive health rights, of course, is one thing; translating that into real services that real women can access is quite another. It is too early to know whether the inclusion of rights language will ultimately lead to progress towards realization. Already there are concerns being raised about what was not specified in the SDGs, as Rebecca Brown of the Center for Reproductive Rights noted:

“The targets fail to integrate language on the need to ensure people have sufficient choice around, and access to, quality and affordable commodities and services, or to reform restrictive laws, or enact new legislation, or ensure healthcare providers are properly trained to provide sexual and reproductive health care. Perhaps most importantly, the targets for the SDGs do not include the need for comprehensive sexuality education—a key component in ensuring all individuals are empowered to make informed decisions about their lives and their bodies.”<sup>7</sup>

Brown goes on to note that these omissions – and the fact that “States are doing their best to weaken any type of global accountability structure” – point to the need for advocates to be vocal in holding states to account. It is too early to know whether goals 3.7 (which applies to all) and 5.6 (which applies to women and girls) will give them the necessary leverage to be successful – but it seems clear that the SDGs at least

provide a far better foundation for such advocacy efforts than the MDGs did.

### The Right to Health and Universal Health Coverage

Whilst sexual and reproductive health rights are relatively well-captured in the SDGs, the same cannot be said of the broader concept of the ‘right to health.’ Forman and colleagues make a case that “the goals of UHC [universal health coverage] and maximizing or ensuring healthy lives share a common aspiration that could reasonably be translated into ‘healthcare for all’ and ‘health for all,’” which they in turn link with the right to health. They (with colleagues) have also written elsewhere that the concept of UHC represents a significant improvement on the MDGs.<sup>8,9</sup> But – as they acknowledge – there may be an element of danger in drawing too close parallels between what is in the SDGs and what we might wish had been there in terms of the right to health.

‘Ensuring healthy lives,’ the overall title of Goal 3, does indeed sound very like ‘health for all.’ But it remains a somewhat vague and aspirational title. What does it mean to have a ‘healthy life’? And who bears the responsibility for ensuring that individuals are able to enjoy such a thing? In not grappling with these questions, the phraseology risks repeating precisely what has fallen short in terms of the right to health: specifying what that right entails, and who is responsible for realizing it. UHC (Target 3.8) is a much more specific and (to some extent at least) quantifiable target than ‘ensuring healthy lives.’ But if UHC equates with a right, it is with the right to access healthcare services – an important aim in itself, but one which is only a part of the wider right to health. There has been a long-standing tendency in global health to focus upon service delivery, but the right to health must implicate not only health services but also the social and economic determinants of health status. As Ooms and colleagues have argued:

*“For the right to health to become a reality, policy-makers must strive for a healthy physical and social environment (eg, safe drinking water and good sanitation, adequate nutrition and housing, safe and healthy occupational and environmental conditions and gender equality).”*<sup>9</sup>

Whilst some of these determinants (including poverty, food security, gender equality and water and sanitation) are addressed elsewhere in the SDGs – and as components of the right to health in other documents, including CESCR General Comment 14<sup>10</sup> – there is a danger that in the context of Goal 3 the right to health and the right to access health services become blurred into the same thing, gradually narrowing the scope of how we understand the right to health in the process.

### Conclusion

As many anticipated, in adopting the SDGs the UN General Assembly created a framework of vague and aspirational goals underpinned by much narrower and more specific targets. Those targets do not – and could never hope to – include everything that matters for sustainable development. Indeed even as they are, many have argued that the SDGs are trying to cover too much ground.

In terms of the health-related rights that Forman and colleagues examined, sexual and reproductive health rights are relatively well-covered within the SDGs, even if troubling omissions remain. In terms of the right to health, however, the

picture is much less clear. Some of the elements that make up that right are present and correct, but the SDGs have delivered no coherent vision of how a ‘right to health’ might actually be realized. Perhaps they could never have been expected to; perhaps defining the right to health, let alone realizing it, will always remain tantalizingly out of reach.

Now that the SDGs have been finalized and adopted, it falls to advocates for global health and human rights to monitor the process of implementation, and to hold to account. Tracking the use of rights language using the types of methods deployed by Forman and colleagues should be a part of this process: ensuring that there is not ‘back peddling’ in subsequent documents and statements on sexual and reproductive health rights; that participatory accountability mechanisms are developed that allow individuals to claim their rights; and that the notion of a right to health in the broadest sense cuts across the 17 goals and 169 targets of the SDGs rather than being confined to SDG3. If Forman and colleagues are correct in believing that framing health in terms of human rights may guide policy actors, even if subtly, it is essential to continue pushing such framings so that progress is made both on meeting the SDGs and on realizing the right to health.

### Ethical issues

Not applicable.

### Competing interests

Author declares that he has no competing interests.

### Author’s contribution

SR is the single author of the paper.

### Endnotes

[1] The OWG proposed “3.2 By 2030, end preventable deaths of newborns and children under 5 years of age.” The final goal reads: “3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.”

[2] Forman et al rightly pointed out that, when adjusted for the varying length of the reports, the difference in prevalence of rights language was less striking. Nevertheless, they did find that “the OWG Report is on the lower end of this trend.”

[3] This is because norms are made and remade through social interactions on an ongoing basis. In fact, it is not unheard of for rights to ‘fall by the wayside.’ Indeed in some cases, as with the right to own slaves, we might celebrate the fact that they do.

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