

SDG 3: GOOD HEALTH AND WELL-BEING



A LEGAL GUIDE



This Legal Guide to the Sustainable Development Goals (SDGs) was first published by Advocates for International Development (A4ID).

Disclaimer

The information contained within this guide is correct at the date of publication.

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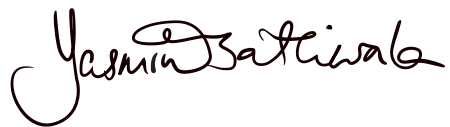
About A4ID

Advocates for International Development (A4ID) was founded in 2006 to see the law and the skills of lawyers used effectively to fight global poverty. Today, A4ID is the leading, international charity that channels legal expertise globally toward the achievement of the UN SDGs. Through us, the world's top lawyers offer high-quality, free, legal support to NGOs, social enterprises, community-based organisations and developing country governments working to advance human dignity, equality and justice. A4ID also operates as a knowledge and resource hub, exploring how the law can be better used to achieve the SDGs through a range of courses, publications and events.



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Foreword

A handwritten signature in black ink, reading "Yasmin Batliwala". The signature is fluid and cursive, with the first name "Yasmin" and last name "Batliwala" clearly distinguishable.

Yasmin Batliwala

Chief Executive

Advocates for International Development



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Key terms



Panelists during the first Global Disability Summit co-hosted by the UK Government, the International Disability Alliance and the Government of Kenya, July 2018

SDG 3: Ensure healthy lives and promote well-being for all at all ages

In the context of Goal 3 and health, the key terms are defined as follows:

‘Health’: ‘A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ and ‘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.’¹

‘Well-being’: A multi-factorial concept that is based on the satisfaction of material, physical, affective and psychological needs. While well-being extends beyond physical and mental health, physical and mental health is clearly the key to the notion of well-being. Well-being is the antithesis of illness.

‘For all at all ages’: The World Health Organisation (WHO) promotes a life course approach to health (LCAH). LCAH emphasises health from a temporal and social perspective, looking retrospectively across an individual’s or a social group’s life experiences or across generations for indications of current patterns of health and disease, whilst recognising that both historical and contemporary experiences are shaped by the broader social, economic and cultural context.

The concept of **universal health coverage** is also key here and is defined as ‘all communities and all people receiving the services they need and being protected from health threats, whilst also ensuring that they are protected from financial hardship.’²

1 Constitution of the World Health Organisation, World Health Organisation (WHO), p. 1 (2006), available at: http://www.who.int/governance/eb/who_constitution_en.pdf.

2 Health in the 2030 Agenda for Sustainable Development, World Health Organisation, EB138/14, p. 24 (11 December 2015), available at: http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_14-en.pdf.

Overview of the targets



SDG 3 is much more than the promotion, development and protection of health. This goal on health and well-being is very much intertwined with all other goals, meaning the achievement of SDG 3 will have a huge influence on the fulfilling of other targets and vice-versa. The protection of health was already at the heart of the development agenda under the Millennium Development Goals (MDGs), with several goals concerned with health, including MDG 4: reduce child mortality; MDG 5: improve maternal health; and MDG 6: combat HIV/AIDS, malaria and other diseases.

According to the WHO Secretariat's 2015 report on health and sustainable development, as well as the report monitoring the

achievement of the health-related Millennium Development Goals, the MDGs have been successful in mobilising money and political attention towards health-related issues.³ In the same direction, the MDG Report 2015 describes several achievements in relation to health, which are discussed further below in relation to the targets under SDG 3 to which they are connected. However, as pointed out by WHO, 'many of the mechanisms established over the last 15 years have contributed to creating a competitive institutional landscape globally, with fragmented delivery systems at country level. The result is that competition for funds for one target over another and for the limelight of public attention, too often outweigh collaboration on improving health as a whole.'⁴

3 Monitoring the achievement of the health-related Millennium Development Goals, World Health Organisation (WHO) (2013), available at: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_13-en.pdf

4 The SDGs: Reflections on the Implications and Challenges for Health, World Health Organisation (WHO), p. 197 (2015), available at: http://www.who.int/gho/publications/mdgs-sdgs/MDGs-SDGs2015_chapter9.pdf.

The MDG Report also acknowledges that ensuring healthy lives and well-being for all at all ages remains a challenge worldwide.

Several of the SDGs health-focused targets follow on from the unfinished agenda of the MDGs, whilst others derive from World Health Assembly resolutions and related action plans. While the MDGs focused on the fight against specific diseases or the improvement of selected health indicators, the SDGs adopt a more comprehensive approach aiming at the strengthening of health systems, as witnessed by target 3.8 concerning universal health care.

Access and use of quality healthcare services is only one factor affecting the health of individuals and communities. Whether people are healthy or not is determined by the conditions in which they are born, grow, work, live and age. These conditions are known as ‘social determinants of health’. The Sustainable Development Goals address many of these underlying determinants in the targets of SDG 3 itself, such

as road safety, alcohol and tobacco use, and environmental pollution, as well as in other goals and targets, including on poverty reduction (SDG 1), nutrition (SDG 2), education (SDG 4), gender equality (SDG 5), clean water and sanitation (SDG 6), access to energy (SDG 7), decent work (SDG 8), reducing inequalities (SDG 10), climate change (SDG 13) and peace, justice and strong institutions (SDG 16).

The WHO’s Thirteenth General Programme of Work 2019-2023 covers all the main priorities of SDG 3.⁵ There is therefore hope that the implementation of the SDGs will result in overcoming the fragmented character of the MDGs in relation to health.

For more details on global and regional progress made by States towards achieving SDG 3 and other health-related SDGs and targets, you can consult the report by the WHO Director-General on Implementation of the 2030 Agenda for Sustainable Development (2019).⁶



By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

Maternal mortality refers to deaths due to complications from pregnancy or childbirth.

The maternal mortality ratio declined by 44% globally between 1990 and 2015 from 385 deaths to 216 deaths

per 100,000 live births.⁷ However, in 2017, nearly 300,000 women died from complications relating to pregnancy and childbirth. Over 90 per cent of them lived in low- and middle-income countries.⁸ Achieving the SDG target 3.1. of less than 70 maternal deaths per 100,000 live births by 2030 requires increased investment and attention to reduce the number of deaths at an annual rate of 7.5 per cent. This could save more than one million lives over the course of a decade.⁹

5 Thirteenth General Programme of Work, 2019-2023, World Health Organisation A71/4 (5 April 2018), available at: http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1.

6 Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_11Rev1-en.pdf.

7 Maternal deaths fell 44% since 1990 – UN, World Health Organisation (WHO) (12 November 2015), available at: <http://www.who.int/news-room/detail/12-11-2015-maternal-deaths-fell-44-since-1990-un>.

8 The United National Department of Economic and Social Affairs. 2019. The Sustainable Development Goals Report 2019. Available at: <https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf>

9 Ibid.

TARGET 3-2

By 2030, end preventable deaths of new-borns and children under 5 years of age, 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

The global under-five mortality rate has dropped from 77 to 39 deaths per 1,000 live births between 2000 and 2017 according to the SDG 2019 Report.¹⁰ To reduce child deaths even further, greater attention must be focused on the first 28 days of life (the neonatal period), where achievements have not been as rapid. The global neonatal mortality rate in 2017 was reduced by 41% in comparison with 2000, to 18

deaths per 1,000 live births. To diminish neonatal mortality to less than 12 per 1,000 births, reductions need to accelerate.¹¹

More than half the number of deaths in early childhood are preventable.

More than half of early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions, and most of these deaths are concentrated in Sub-Saharan Africa.¹² This target thus requires much action in the poorest parts of the world, as this is vital to the reduction of global child mortality rates.

TARGET 3-3

By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

There has been important progress on increasing access to clean water and sanitation and reducing communicable diseases such as malaria, tuberculosis and the spread of HIV/AIDS. According to reports published by WHO, the global malaria mortality rate decreased by 47% between 2000 and 2013¹³ and the global tuberculosis mortality rate fell by 21%

between 2000 and 2017.¹⁴ However, after more than a decade of steady gains against malaria, progress has stalled. No significant advances were made in reducing the number of malaria cases worldwide from 2015 to 2017.¹⁵

According to the SDG 2019 Report, the global incidence of HIV among adults declined by 22 per cent from 2010 to 2017, well short of the progress required to meet the 2030 target.¹⁶

¹⁰ The United National Department of Economic and Social Affairs. 2019. The Sustainable Development Goals Report 2019. Available at: <https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf>

¹¹ The Sustainable Development Goals Report 2017, United Nations, p. 20 (2017), available at: <https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf>.

¹² Children: Reducing Mortality, World Health Organisation (WHO), Factsheet 31 October 2017, available at: <http://www.who.int/mediacentre/factsheets/fs178/en/>.

¹³ World Malaria Report 2014, World Health Organisation (WHO), p. 1 (2014), available at: http://www.who.int/malaria/publications/world_malaria_report_2014/report/en/.

¹⁴ The United National Department of Economic and Social Affairs. 2019. The Sustainable Development Goals Report 2019. Available at: <https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf>

¹⁵ Ibid.

¹⁶ Ibid.

TARGET 3-4

By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

In 2015, the risk of dying between the ages of 30 and 70 from one of the four main non-communicable diseases (NCDs) – cardiovascular disease, cancer, diabetes or chronic respiratory disease – fell from 23% in 2000 to 19%, a rate too slow to meet the target in 2030.¹⁷

Non-communicable diseases have increased in low and middle-income countries, threatening to 'overwhelm fragile health systems unless rapid investments are made in disease prevention and health promotion'.¹⁸ Internationally, the fight

against NCDs has not been funded on the same level as AIDS or pandemics.

Promoting mental health was also introduced in the SDGs, marking the global recognition of the importance of mental health and well-being. People with mental disorders face disproportionately higher risk of disability and premature mortality. In total, mental, neurological, and substance use disorders accounted for 13% of the total global burden of disease in 2004. Mental health is also highly related to other aspects of well-being, for example, mental disorder frequently leads individuals and families into poverty.¹⁹ Suicide is the second leading cause of death for 15-29 year-olds globally, and 79% of suicides happen in low- and middle-income countries.²⁰

TARGET 3-5

Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

The harmful use of alcohol resulted in 3.3 million deaths worldwide in 2012. In contrast to other health related issues under the SDGs and Goal 3, this target refers to current health issues largely facing developed countries, as alcohol is consumed more heavily in wealthy countries.²¹ In 2010, narcotic drugs had been used at least once by about 230 million people or 5% of the world's adult population, while

problem drug users number at around 27 million. Since then, illicit drug use appears to have been generally stable, though it has continued rising in several developing countries meaning it is becoming much more of a global issue.²²

17 The Sustainable Development Goals Report 2017, United Nations, p. 6 (2017), available at: <https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf>.

18 Health in the 2030 Agenda for Sustainable Development, World Health Organisation (WHO), EB138/14, p. 7 (11 December 2015), available at: http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_14-en.pdf.

19 Mental Health Action Plan 2013-2020, World Health Organisation (WHO), ISBN 978 92 4 150602 1, p. 7, available at: http://www.who.int/mental_health/action_plan_2013/en/

20 Suicide, World Health Organisation, available at: <http://www.who.int/en/news-room/fact-sheets/detail/suicide>

21 Management of Substance Abuse: Alcohol, World Health Organisation (WHO), available at: http://www.who.int/substance_abuse/facts/alcohol/en/.

22 World Drug Report, United Nations Office on Drugs and Crime, Preface (2012), available at: https://www.unodc.org/documents/data-and-analysis/WDR2012/WDR_2012_web_small.pdf.

TARGET 3-6**By 2020, halve the number of global deaths and injuries from road traffic accidents**

In 2013, approximately 1.25 million people died as a result of road traffic accidents, an

increase of 13% since 2000. Approximately, from 20 to 50 million more people suffer non-fatal injuries, which has led to disability in many cases. According to the WHO, it was predicted that road traffic accidents would rise to become the 7th leading cause of death by 2030, if no action is taken.²³

TARGET 3-7**By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.**

In developing countries, about 19% of pregnancies occur before the age of 18, and about 3% of pregnancies occur before the age of 15.²⁴ These figures can be reduced significantly through better access to modern contraception, which is currently not available in Sub-Saharan Africa and

Central and Southeast Asia to more than 60% of adolescents who wish to avoid pregnancy.²⁵ In 2017, 78% of girls and women of reproductive age worldwide who are married or in union have their need for family planning satisfied but this global average masks wide regional disparities: an estimated half of women in sub-Saharan Africa do not have access to modern contraceptive methods.²⁶ In most countries, comprehensive sexual education (CSE) programmes are unavailable even though they have been proved to delay sexual activity, reduce the number of sexual partners, increase condom or contraceptive use, and reduce sexual risk-taking.²⁷

TARGET 3-8**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.**

According to WHO, at the end of the year 2015, 400 million people globally lacked access to one or more essential health services, 100 million per year were pushed into poverty and 150 million people suffered financial catastrophe because of out-of-pocket expenditure on health services.²⁸

Access to health technology remains a major challenge, with

23 Road Traffic Injuries Factsheet, World Health Organisation (WHO) (2015), available at: <http://www.who.int/mediacentre/factsheets/fs358/en/>.

24 Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda, United Nations Foundation, Universal Access Project, available at: <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>.

25 Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda, United Nations Foundation, Universal Access Project, available at: <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>.

26 The Sustainable Development Goals Report 2017, United Nations, p. 21 (2017), available at: <https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf>.

27 Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda, United Nations Foundation, Universal Access Project, p. 5, available at: <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>.

28 Universal Health Coverage (UHC) Factsheet, World Health Organisation (WHO) (31 December 2017), available at: <http://www.who.int/mediacentre/factsheets/fs395/en/>.

new drugs being researched and produced but many still unable to gain access to these. In a 2016 report, the United Nations Secretary-General's High-Level Panel on Access to Medicines noted that some of the barriers to accessing medicine and healthcare include under-funded healthcare systems, a lack of investment in developing qualified and skilled healthcare workers, deep inequalities within as well as between countries, discrimination, exclusion, stigma, and exclusive marketing rights to different medicines.²⁹

Two indicators have been chosen to measure the progress

towards universal health coverage:

- i. the average coverage of essential health services
- ii. the proportion of people covered by health insurance or a public health system.

It is estimated that 18 million additional health workers will be needed by 2030 to attain effective coverage of the broad range of health services necessary to ensure healthy lives for all.³⁰ In addition, every 5 years, 1 billion more people will need to be covered by health insurance.³¹



By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

According to the MDG Report, in 2015, 91% of the global population were using improved drinking water sources, compared to 76% in 1990. Since 1990, 2.1 billion people have gained access to improved sanitation.³² But the numbers of deaths related to pollution remain alarming: globally, in 2016, an estimated 4 million deaths were caused by household air pollution from cooking with unclean fuels and inefficient technologies; another 4.2 million deaths were attributed to ambient air pollution from traffic, industrial sources, waste burning and residential fuel combustion.³³

Reaching target 3.9 will require complex environmental negotiations.

These environmental issues are addressed under SDGs 13, 14 and 15 on tackling climate change, protecting life under water and life on land. Reaching this target represents a huge challenge, as it depends on complex environmental negotiations and often non-binding agreements.

29 Report of the United Nations Secretary-General's High Level Panel on Access to Medicines, Promoting Innovation and Access to Health Technologies, High Level Panel on Access to Medicines, p. 15 (2016), available at: <http://static1.squarespace.com/static/562094dee4b0d00c1a3ef761/t/57d9c6ebf5e231b2f02cd3d4/1473890031320/UNSG+HLP+Report+FINAL+12+Sept+2016.pdf>.

30 The Sustainable Development Goals Report 2017, United Nations, p. 23 (2017), available at: <https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf>.

31 Draft Thirteenth General Programme of Work, 2019-2023, Promote Health, keep the World Safe, Serve the Vulnerable, World Health Organisation, A71/4, p. 7 (2018), available at: http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1.

32 The Millennium Development Goal Report 2015, United Nations, p. 7 (2015), available at: [http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf).

33 The United National Department of Economic and Social Affairs. 2019. The Sustainable Development Goals Report 2019. Available at: <https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf>

Top 10 actions you can take



Strengthen your understanding of universal health care, policy and programmatic efforts at national and international levels



Re-align your firm's policies and practices to enhance positive impact on mental wellbeing in the workplace



Think about standards of professional responsibility and broader questions of ethics



Participate in the legislative process, including building legal health frameworks to facilitate national implementation of SDG 3



Feed into public consultations on health policy using your knowledge of the domestic legal system



Share previous experience from any health related or pharmaceutical cases you have worked on



Use litigation to bring justice to those have had their right to health violated



Provide pro bono services to individuals who cannot afford legal costs to pursue health related rights violations



Raise awareness and strengthen legal literacy on the Right to Health and on SDG 3



Partner with A4ID to provide pro bono services to NGOs dedicated to improving health and well-being and patients' associations which advocate for the rights and interests of patients

Elements of the international legal framework

The Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) are the backbone of the right to health in international treaties. Alongside these two treaties, there are

several other influential international instruments concerning health and well-being, some of which specifically address vulnerable groups.



Universal Declaration of Human Rights

Adopted by the UN General Assembly: 10 December 1948

The Universal Declaration on Human Rights (UDHR) is a landmark in the articulation and advancement of fundamental human rights and freedoms. In thirty articles, the UDHR sets forth a series of civil, political, economic, social and cultural rights. Although it was not intended to create legally binding obligations, the UDHR presents a common standard of achievement that is widely regarded as customary

international law. Moreover, many of its provisions were later adopted in binding international human rights instruments.

Article 25 of the UDHR refers to health as part of the right to an adequate standard of living, showing both how important and how closely related health is to other rights. Other articles are relevant to health because they enshrine rights related to social determinants of health, such as social security (Article 22), work conditions (Article 23), and education (Article 26).

The Constitution of the World Health Organisation

Adopted by the International Health Conference: 22 July 1946

Entered into force: 7 April 1948

Status of ratification (as of August 2018): 194 Parties

mental and social well-being and not merely the absence of disease or infirmity' and it further provides 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.'³⁴

“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.”

The WHO Constitution first articulated the right to health as the right to the enjoyment of the highest attainable standard of physical and mental health. The preamble of the WHO Constitution defines health as 'a state of complete physical,



³⁴ Constitution of the World Health Organisation, World Health Organisation (WHO), p. 1 (2006), available at: http://www.who.int/governance/eb/who_constitution_en.pdf.

International Covenant on Economic, Social and Cultural Rights

Adopted by the UN General Assembly: 16 December 1966

Entered into force: 3 January 1976

Status of ratification (as of August 2018): 168 Parties

The International Covenant on Economic, Social and Cultural Rights (ICESCR), drawing on the UDHR, affirms a series of human rights and encourages social progress. Legally binding on a large number of States, it indicates a wide consensus on economic, social and cultural human rights. However, a number of States have signed but not ratified the ICESCR, notably Cuba, Malaysia, Saudi Arabia, and the United States.

Article 2 of the ICESCR reflects a 'progressive realisation principle' imposing a duty on parties to 'take steps (...) to the

maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means'.³⁵

Article 12 of the ICESCR provides that 'the States parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. It further provides that States must take the necessary steps with respect to child mortality and development; environmental and industrial hygiene; disease prevention and control; and medical services. Article 12 is to be understood based on the General Comments of the Committee on Economic, Social and Cultural Rights (CESCR), particularly General Comment 14 (2000) which focuses on Article 12 of the ICESCR (see below).³⁶

Convention on the Rights of the Child

Adopted by the UN General Assembly: 20 November 1989

Entered into force: 2 September 1990

Status of ratification (as of August 2018): 196 Parties

The United Nations Convention on the Rights of the Child (CRC) is a human rights treaty which sets out the civil, political, economic, social, health and cultural rights of children. It defines a child as any human being under the age of eighteen, unless the age of majority is attained earlier under national legislation. Compliance is monitored by the UN Committee

on the Rights of the Child. The CRC is the most widely ratified international human rights treaty. Notably, the United States is the only country in the world that has signed but not ratified this convention.

Article 24 recognises the right of every child to the enjoyment of the highest attainable standard of health. State parties shall submit regular reports on how the rights are being implemented, including the legislative, judicial, administrative or other measures they have adopted.³⁷

35 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, Office of the High Commissioner for Human Rights, p. 15 (11 August 2000), available at: <http://www.refworld.org/pdfid/4538838d0.pdf>.

36 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, Office of the High Commissioner for Human Rights, p. 15 (11 August 2000), available at: <http://www.refworld.org/pdfid/4538838d0.pdf>.

37 Reports submitted by State Parties, United Nations Human Rights Office of the High Commissioner (OHCHR), available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=5&TreatyID=10&TreatyID=11&DocTypeID=29&DocTypeCategoryID=4.

WHO Framework Convention on Tobacco Control

Adopted by the World Health Assembly: 21 May 2003

Entered into force: 27 February 2005

Status of ratification (as of October 2018): 181 Parties

The Framework Convention on Tobacco Control (FCTC) is an evidence-based treaty developed in response to the globalisation of the tobacco epidemic. The core demand-reduction provisions are contained in Articles 6-14, including price, tax and non-price measures to reduce the demand for tobacco. The core supply-reductions are contained in Articles 15-17, including illicit trade in tobacco products, sales to and

by minors, and provision of support for economically viable alternative activities.

States are required to submit regular reports on implementation, including the legislative, judicial, administrative or other measures they have adopted.³⁸ According to the 2014 Global Progress Report on Implementation of the FCTC, '80% of the Parties have strengthened their existing or adopted new tobacco control legislation after ratifying the Convention, but one third of the Parties have still not put in place legislative measures in line with the requirements of the Convention.'³⁹

The International Health Regulations

Adopted by the World Health Assembly: 23 May 2005

Entered into force: 15 June 2007

Status of ratification (as of August 2018): 196 Parties

The International Health Regulations (IHR) are legally binding regulations designed to help protect States from the international spread of disease. Through the IHR, States have agreed to build their capacities to detect, assess and report public health issues on the basis of defined criteria indicating that the issue may constitute a public health emergency of international concern.⁴⁰ The WHO plays a coordinating role

in implementation of the IHR and, together with its partners, helps countries to build such capacities. To support countries in meeting their obligations, the WHO Secretariat developed guidance on implementation of the IHR in national legislation.⁴¹

38 Global Progress Report on the Implementation of the WHO Framework Convention on Tobacco Control, FCTC, p. 13 (2014), available at: <http://www.who.int/fctc/reporting/2014globalprogressreport.pdf?ua=1>.

39 Global Progress Report on the Implementation of the WHO Framework Convention on Tobacco Control, FCTC, p. vii (2014), available at: <http://www.who.int/fctc/reporting/2014globalprogressreport.pdf?ua=1>.

40 States Parties Reports to the International Health Regulations, United Nations Human Rights Office of the High Commissioner (OHCHR), available at: http://www.who.int/ihr/legal_issues/states_parties/en/.

41 International Health Regulations (2005): Guidance on implementation in national legislation, World Health Organisation (WHO), available at: http://www.who.int/ihr/legal_issues/legislation/en/.

Convention on the Rights of Persons with Disabilities

Adopted by the UN General Assembly: 13 December 2006

Entered into force: 3 May 2008

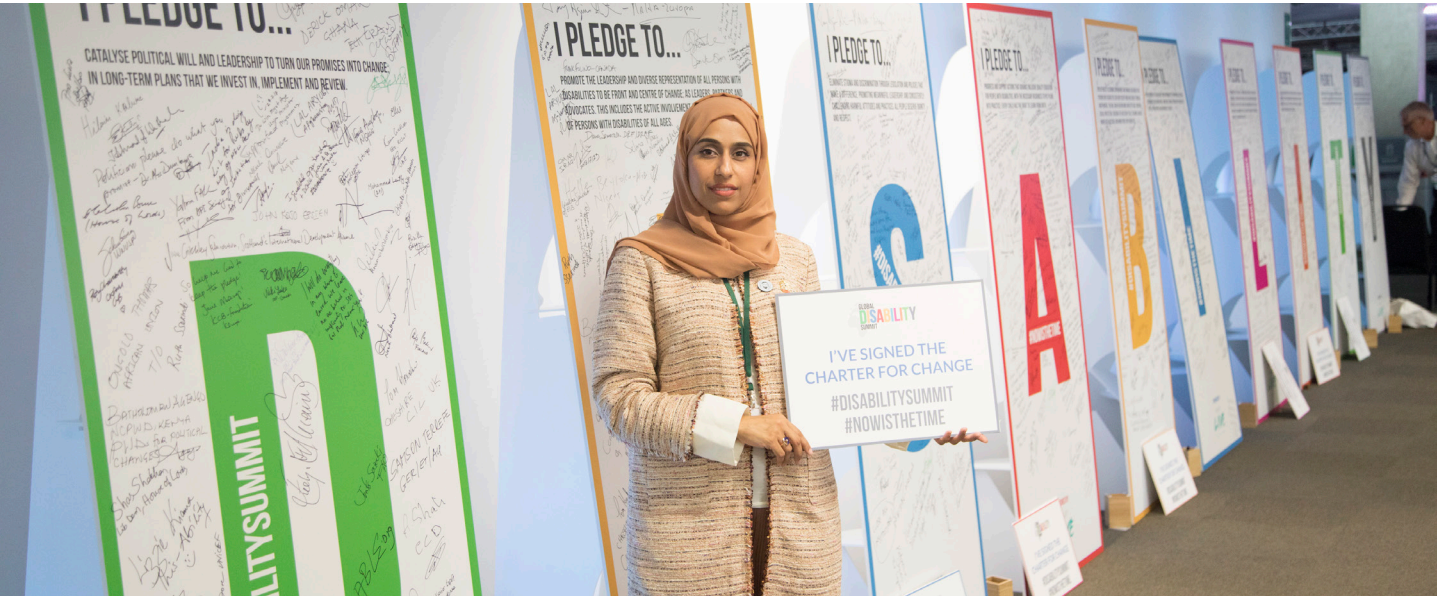
Status of ratification (as of August 2018): 177 Parties

The Convention on the Rights of Persons with Disabilities (CRPD) is a UN treaty intended to promote and protect the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities. Article 25 of the CRPD provides that:

‘States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination

on the basis of disability. States shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.’

States are required to submit regular reports on how rights are being implemented, including the legislative, judicial, administrative or other measures they have adopted.⁴² According to a survey conducted by the WHO, between 35% and 50% of people with serious mental disorders in developed countries, and between 76% and 85% in developing countries, received no treatment in 2015.⁴³ These statistics demonstrate that much still needs to be done to implement the Convention.



42 Reports submitted by State Parties, United Nations Human Rights Office of the High Commissioner (OHCHR), available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29.
43 Disability and Health Factsheet, World Health Organisation (WHO) (16 January 2018), available at: <http://www.who.int/mediacentre/factsheets/fs352/en/>.

Soft law and declarations

Declaration of Alma-Ata on Primary Healthcare (1978)

Adopted at the International Conference on Primary Health Care, the Alma-Ata Declaration of 1978 identified primary health care as the key to health for all and is still considered as a major milestone in the field of public health. The

declaration affirms that, as the first level of contact with the national health system, primary healthcare should be the 'central function and main focus'⁴⁴ of national health policies.

CESCR General Comment No.14: The Right to the Highest Attainable Standard of Health (Art. 12) (2000)

Adopted by the Committee on Economic, Social and Cultural Rights in 2000, the General Comment No.14 interprets Article 12 of the International Covenant on Economic, Social and Cultural Rights. The Comment identifies the legal foundations of the right to health, recognises the close relation of the right to health with other human rights, and adopts an extensive definition of the right to health taking into account the importance of the social determinants of health. This is followed by details of the State Parties' obligations to guarantee the effectiveness of the rights to health in terms

of availability, accessibility, acceptability and quality of health facilities, goods and services (para. 12). The Committee then elaborates on cross-cutting issues, such as non-discrimination and gender mainstreaming, and on the rights of specific vulnerable groups (women, children and adolescents, older persons, persons with disabilities, indigenous peoples). Since it clarifies the normative content of States' obligations to respect, protect and fulfil the right to health, the General Comment appears to be a useful interpretive tool in legal proceedings.

Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS (2011)

This UN General Assembly Declaration notes the contributing factors to the spread of the HIV/AIDS epidemic, reaffirms a human rights approach to tackling HIV/AIDS and declares a commitment to take action. The 2011 Declaration follows on from the Political Declaration on HIV/AIDS adopted by the

General Assembly in June 2006⁴⁵ and renews the Declaration on HIV/AIDS of June 2001, in which countries committed to provide universal access to HIV prevention, treatment, care and support services to all those in need by 2010.

Countries also committed to adopting anti-discrimination

⁴⁴ Declaration of Alma-Ata, International Conference on Primary Healthcare (6-13 September 1978), available at: http://www.who.int/publications/almaata_declaration_en.pdf.

⁴⁵ Political Declaration on HIV/AIDS, UN A/RES/60/262 (15 June 2016) available at: http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf.

laws to further protect those with HIV. According to the 2011 Report of the UN Secretary-General 'Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths', the number of countries reporting anti-discrimination laws against people with HIV

increased from 56% in 2006 to 71% in 2010.⁴⁶ The latest Declaration on HIV and AIDS sets forth new targets and calls for UN Member States to redouble efforts to achieve universal access to treatment by 2015.

ILO Recommendation 202 on Social Protection Floors (2012)

The International Labour Organisation (ILO) Recommendation 202 provides guidance to Member States in extending social security coverage by prioritising the establishment of national floors of social protection accessible to all in need.⁴⁷ The Recommendation aims at the rapid implementation of basic social security guarantees that ensure universal access

to essential health care and income security at a nationally defined minimum level. These guarantees should ensure at a minimum that, over the life cycle, all in need have access to essential health care and basic income security, which is in line with SDG 3, and especially SDG target 3.8.



46 Uniting for Universal Access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths, UN, Report of the Secretary-General (28 March 2011), available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2011/20110331_SG_report_en.pdf.

47 Recommendation 202 concerning National Floors of Social Protection, 101st ILC Session, Geneva (2012), available at: https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_183326.pdf.

Regional legal and policy frameworks

African Union

Africa confronts the world's worst public health crisis. Despite marked improvements in health over the past decade, the life expectancy at birth for Africans is still fourteen years

shorter than the mean global life expectancy.⁴⁸ This section summarises regional treaties of relevance to SDG 3 on health in Africa.

African Charter on Human and Peoples' Rights (1981)

The Organisation of African Unity, now replaced by the African Union adopted the Charter on Human and Peoples' Rights in 1981 which formally entered into force on 21st October 1986. The Charter encompasses civil, political, economic, social and cultural rights.⁴⁹

Article 16 recognises individuals' right to enjoy the best attainable state of physical and mental health. States are required to take the necessary measures to protect the health of their people and to ensure that they receive medical

attention when they are sick. The African Commission on Human and People's Rights, stressing the intertwined characters of human rights, has considered that the violation of other rights could amount to a breach of the right to health. In the case *Social and Economic Action Rights Centre (SERAC) v. Nigeria (2002)*, the Commission held that the environmental degradation caused to the Ogoni community, which led directly to human health problems, was a violation of Article 16 of the Charter.⁵⁰

The African Charter on the Rights and Welfare of the Child (1999)

The African Charter on the Rights and Welfare of the Child came into force on 29 November 1999. Like the UN Convention on the Rights of the Child, the African Charter is a comprehensive instrument that sets out rights and defines principles and norms relating to the wellbeing of the child.

Article 14 specifically addresses children's right to health. Full implementation of this right requires measures to reduce the infant and child mortality rate, ensure the necessary medical assistance and health care of all children, as well as the provision of nutrition and safe drinking water.

48 The African Regional Health Report 2014: The Health of the People, World Health Organisation (WHO), Regional Office for Africa, available at: <http://apps.who.int/iris/bitstream/handle/10665/137377/9789290232612.pdf?sequence=4>.

49 African Charter on Human and Peoples' Rights, Health and Human Rights Regional Office for the Eastern Mediterranean, available at: http://www.who.int/hhr/Human_and_Peoples_rights.pdf.

50 *Social and Economic Action Rights Centre (SERAC) v. Nigeria*, African Commission on Human and Peoples' Rights, 27th October 2001, available at: <http://www.achpr.org/communications/decision/155.96/>.

States are required to submit periodic reports on their domestic implementation, including national legislation reformed or adopted for the purpose of implementing the right to health. According to the 2013 African Report on Child

Wellbeing, a total of 35 countries have consolidated their laws on children. However, lack of access to healthcare services is still a significant contributing factor for persistent high levels of child mortality in Africa.⁵¹

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003)

The African Protocol on Women's Rights, also known as the Maputo Protocol, came into force on 25 November 2005. Women's health is addressed under Article 14 which provides that the right to health of women, including sexual and reproductive health, shall be protected by States and which entails the obligation to take appropriate measures to provide adequate, affordable and accessible health services to all women. The Protocol has been signed and ratified by

36 countries, while an additional 15 have only signed it.⁵² The Protocol on Women's Rights has received significant religious and cultural opposition since its adoption, focused on articles granting reproductive health access and condemning female genital mutilation.⁵³ Legislative and other measures undertaken for the full realisation of women's rights are included in the periodic reports submitted by States pursuant to the African Charter.



51 Towards Greater Accountability to Africa's Children, The African Child Policy Forum (18 November 2013), available at: <http://www.awepa.org/wp-content/uploads/2013/12/ARCW2013-English.pdf>.

52 Ratification Table: Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, African Commission on Human and People's Rights, available at: <http://www.achpr.org/instruments/women-protocol/ratification/>.

53 The Fight Against the Maputo Protocol, Catholic and African Opposition, The Maputo Protocol, available at: <http://www.maputoprotocol.com/the-fight-against-the-maputo-protocol>.

Examples of relevant national legislation

At least 115 constitutions around the world have entrenched the right to health or health care,⁵⁴ whether as justiciable

claim-rights, aspirational guarantees, or a combination of the two.⁵⁵



54 The Right to Health: Fact Sheet No. 31, Office of the United Nations High Commissioner for Human Rights and World Health Organisation (WHO), p.10(2008), <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>.

55 The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa, K.G. Young and J. Lemaitre, Harvard Human Rights Journal, Vol. 26, p. 179, available at: <http://harvardhrj.com/wp-content/uploads/2013/05/V26-Young-Lemaitre.pdf>.

India

The Constitution of India imposes a duty on the State to raise the level of nutrition and the standard of living and to improve public health under Article 47. In 2018, the Indian government announced an ambitious health insurance

programme that would provide up to 500,000 rupees (US\$ 7,800) per family to 100 million poor families and give half a billion citizens free health insurance.⁵⁶

Philippines

In the Philippines, the right to health is protected under the Constitution. Article I Section 15 of the Constitution, provides that ‘the State shall protect and promote the right to health of the people and instil health consciousness among them.’⁵⁷

Article I Section 16 of the Philippines Constitution further provides that ‘the State shall protect and advance the right of the people to a balanced and healthful ecology in accord with the rhythm and harmony of nature.’

Chile

Named after the journalist Ricarte Soto, who led a movement calling for effective healthcare coverage with a focus on high cost diseases, the Law 20850, adopted in 2015, creates a financial protection system for low-incidence and high cost diagnostics and treatments.⁵⁸ It includes a set of explicit guarantees for patients diagnosed and treated for a rare disease.

Decisions to provide financial coverage of diagnosis, medicines, therapies and treatments involve health professionals, patients, and the Ministries for Health and Finance, based on elements of cost and clinical effectiveness as well as epidemiological data.

56 India just announced a vast new health insurance program. But can it afford it?, V. Doshi, Washington Post (1 February 2018), available at: https://www.washingtonpost.com/world/asia_pacific/india-just-announced-a-vast-new-health-insurance-program-but-can-it-afford-it/2018/02/01/805efb46-0757-11e8-ae28-e370b74ea9a7_story.html?noredirect=on&utm_term=.6993b4077e58.

57 The 1987 Constitution of the Republic of the Philippines, State Policies, Section 15, available at: <http://hrlibrary.umn.edu/research/Philippines/PHILIPPINE%20CONSTITUTION.pdf>

58 Ley 20850 Crea un Sistema de Protección Financiera para Diagnósticos y Tratamientos de Alto Costo y Rinde Homenaje Póstumo a Don Luis Ricarte Soto Gallegos (2015), Chile, Ministerio de Salud, available (in Spanish) at: <https://www.leychile.cl/Navegar?idNorma=1078148>

Insights for the legal profession

a) Examples of relevant cases and legal proceedings

Health-related litigation is now commonly pursued in domestic courts on the ground on negligence or medical malpractice, failure to provide adequate healthcare and failure to make basic health care affordable for the most

vulnerable, and refusal to provide emergency medical assistance. However, there are vast differences between States as to how enforcement through litigation is promoted.



Argentina

In Argentina the number of health litigation cases is low, and the enforcement impact of such litigation is fairly weak. In *Menores Comunidad Paynemil/ accion de amparo Expte. 311-CA-1997*, an Appeal Court held that the right to health of the indigenous community, as protected by the Argentinean Constitution, had been violated by the States neglect in remedying a situation of high-level pollution of the

community's drinking water source caused by a private oil corporation working nearby. The Court explained its ruling as follows, 'even though the Government has performed some activities as to the pollution situation, in fact there has been a failure in adopting timely measures in accordance with the gravity of the problem.'⁵⁹

Colombia

In contrast, in Colombia, huge numbers of individual cases have been initiated, seeking remedies for claimed breaches of national laws protecting rights of access to health care. In these cases, the courts have strengthened the right to health in several respects: the State's obligation to provide access to health care for children, found in Article 44 of the Constitution, encompasses free vaccination programmes for children in the poorest areas; health providers, both private and public, may be compelled to cover the costs of specialised overseas medical treatment of children under several conditions; as well as requiring both public and private care institutions to make available free retroviral medications to adult HIV/AIDS patients who cannot afford them, even though the relevant medicines are not included on the free compulsory health plan. This range of cases led to systematic changes within the Colombian healthcare system and the Constitutional Court developed a special monitoring chamber to oversee the implementation of these

judgments.⁶⁰ This case law, however, has largely favoured relatively wealthy claimants rather than the poorest.



59 *Menores Comunidad Paynemil, Accion de amparo, Expte. 311-CA-1997*, Cámara de Apelaciones en lo Civil de Neuquén, Sala II, available (in English) at : <https://www.esccr-net.org/caselaw/2006/menores-comunidad-paynemil-saccion-amparo-eng>

60 *How Do Courts Set Health Policy? The Case of the Colombian Constitutional Court*, PLoS Medicine, Volume 6 Issue 2 (February 2009), available at: <https://pdfs.semanticscholar.org/a451/af7e1e0a287a039c4d2ae657eb08ee15ba94.pdf>.

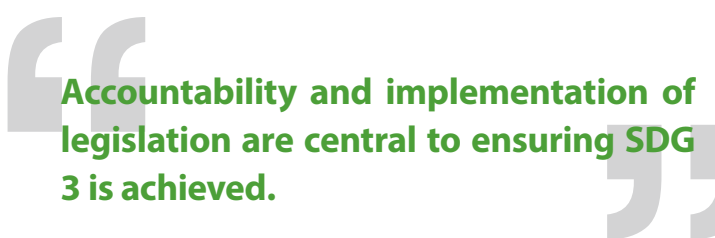
b) Legal context and challenges

The SDGs are integrated and indivisible: progress in one area is dependent on progress in many others. Health, understood as a state of complete physical, mental and social well-being, can only be achieved through a strengthening of health systems (SDG 3) as well as an improvement of all social determinants of health. Some synergies are well known, such as those that exist between health and education (SDG 4), gender equality (SDG 5), nutrition (SDG 2) and social protection (SDG 8); other links may seem less direct but are not less important, for example the inverse relationship between health and inequalities (SDG 10) or the effects of climate change on communicable diseases (SDG 13). Transferring this vision into practical action is a key challenge for the Agenda 2030.

Domestic laws need to be reformed or adopted, as the right to health is an inclusive right containing various underlying determinants and because it is dependent on other human rights. Apart from recognising the right to health in national Constitutions, a large number of specific laws addressing health care and other elements of the right need to be reformed or passed as well. This requires governments to devote financial and other necessary resources. Moreover, healthcare systems are complex and typically involve many public and private stakeholders, making legislative reform processes long and complicated, whilst public health issues can be in need of quick changes.

The justiciability of Economic, Social and Cultural rights, as

opposed to Civil and Political rights, has been controversial but, today, it is generally accepted that all human rights are indivisible, interdependent, and interrelated.⁶¹ This is reflected through the entry into force of complaints procedures for the ICESCR.⁶²



Accountability and implementation of legislation are central to ensuring SDG 3 is achieved.

While the right to health is recognised by numerous international instruments, it is subject to progressive realisation, which means that States have an obligation to ‘move expeditiously and as effectively as possible, through concrete and targeted steps’ towards the full realisation of the right.⁶³ International treaties often do not set out detailed implementation measures. In the absence of such provisions, States are free to determine the way they implement their international obligations, and legal incorporation is usually considered the most effective way. Adopted by the Committee on Economic, Social and Cultural Rights in 2000, the General Comment n°14 on the right to health provides a highly authoritative interpretation of the States’ obligations to guarantee the effectiveness of the rights to health.

Integrating the right to health into domestic legislation, however, does not necessarily guarantee such a right.

61 Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in Vienna on 25 June 1993, United Nations Human Rights Office of the High Commissioner (OHCHR), available at: <https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx>.

62 Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (ICESCR), General Assembly adopted resolution A/RES/63/117 (10 December 2008), available at: https://www.ohchr.org/Documents/HRBodies/CESCR/OPProtocol_en.pdf.

63 Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, United Nations Human Rights Office of the High Commissioner (OHCHR), available at: <https://www.ohchr.org/en/issues/health/pages/srrihealthindex.aspx>.

In some cases, government passes general provisions without reference to enforcement, monitoring, resourcing and the wider measures needed to deliver results. One suggestion is that specific institutions should be identified for implementing particular laws in order to promote efficiency in responsibility and accountability. On the other hand, more effort should be put on impact assessment of legislations, rather than emphasising legislative initiative.

The MDGs were created in a global climate of optimism: the increased spending in development assistance seemed

fruitful, and results were indeed reached. The global context surrounding the SDGs is very different: with economic austerity and rising inequalities in many developed countries, international development is no longer on top of the political agenda and public hostility towards aid increases.⁶⁴

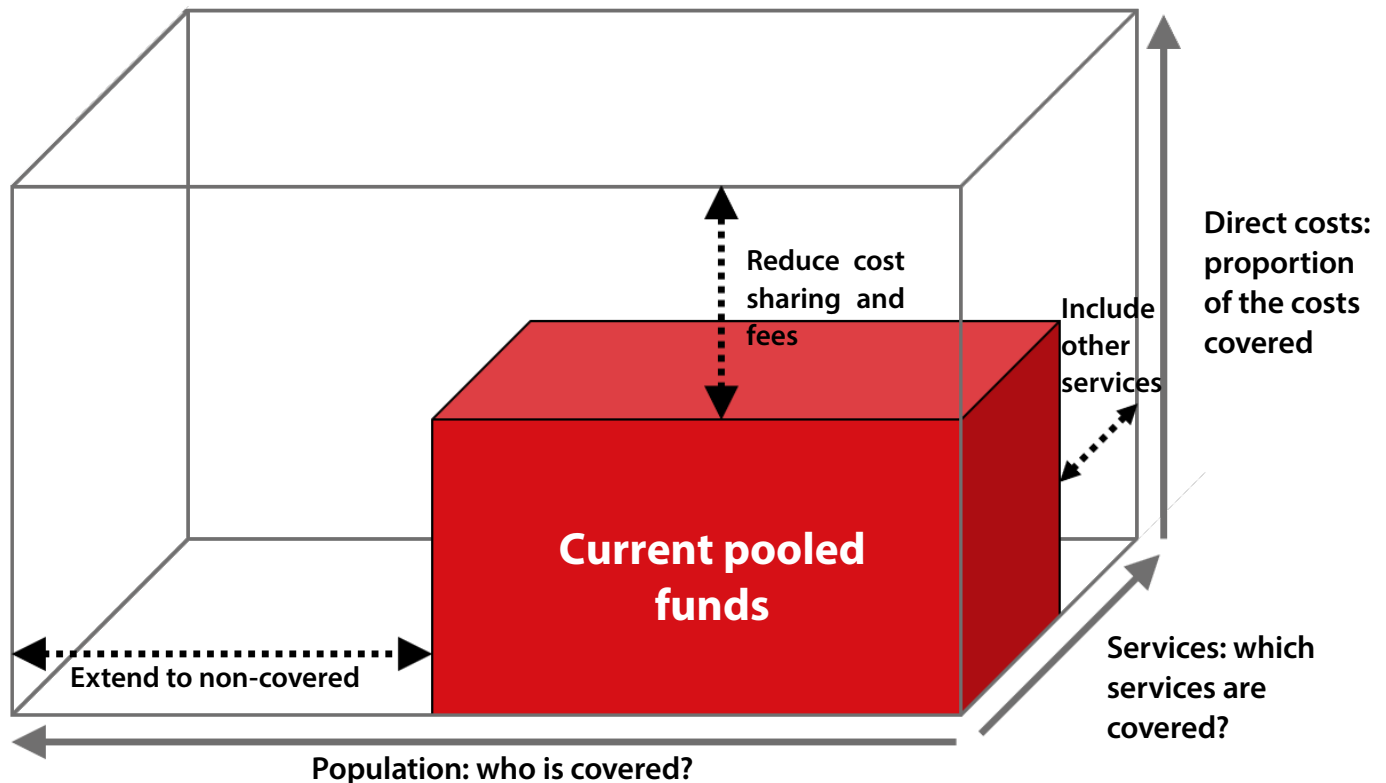
An unresolved question is how to better integrate short-term humanitarian aid and development assistance, as local health systems can be weakened by ill-defined emergency assistance.⁶⁵



64 Addis: A Good First Step, but a Terrible Last Word for 2015, O. Barder, Center for Global Development (2015), available at: <http://www.cgdev.org/blog/addis-good-first-step-terrible-last-word-2015>.

65 Health in the 2030 Agenda for Sustainable Development, EB138/14, p. 7, para. 32 (11 December 2015), available at: http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_14-en.pdf.

Three dimensions to consider when moving towards universal coverage



Another challenge to the realisation of universal health coverage (UHC) is the need to dispel the many misinterpretations that exist surrounding it. These include concerns that providing universal health care to citizens would be too expensive, that such a system would end up depriving citizens of medical services through, for example, a shortage of doctors; and the idea that the private sector is better suited to providing efficient health care. In dispelling the myths of universal health coverage, the WHO has to some degree sign-posted lawyers as to what kind of further

disputes may arise in issues other than that of clinical practice and care:

- UHC is not just health financing, it should cover all components of the health system to be successful: health service delivery systems, health workforce, health facilities or communications networks, health technologies, information systems, quality assurance mechanisms, governance and legislation.

- UHC is not only about assuring a minimum package of health services, but also about assuring a progressive expansion of coverage of health services and financial risk protection as more resources become available.
- UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.
- UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, social inclusion and cohesion.⁶⁶

Advocacy efforts are currently ongoing to encourage adoption of a WHO Framework Convention on Global Health.⁶⁷ Grounded in the right to health, this legally-binding instrument would establish a global health governance framework with clear obligations for States, robust standards, monitoring and enforcement. It is hoped that the treaty would help overcome challenges in global public health such as underfunding, fragmented policies, and lack of enforceability of the right to health.



66 Universal Health Coverage (UHC) Factsheet, World Health Organisation (WHO) (31 December 2017), available at: <http://www.who.int/mediacentre/factsheets/fs395/en/>.

67 Towards a framework convention on global health, Gostin L. and others, Bulletin of the World Health Organisation, 2013, 91:790-793, available at: <https://www.who.int/bulletin/volumes/91/10/12-114447/en/>.

c) So, what can lawyers do?

Law firms and individual lawyers can contribute to the implementation of Goal 3 in various ways, including participating in the legislative process, providing relevant

pro bono advice, and getting involved in awareness-raising activities.

Learn and educate

Lawyers can enhance their understanding of universal health care along with the policy and programmatic efforts to promote it at national and international levels. Substantial research and analysis is available, including with a special focus on SDG 3. Important sources include international development agencies, especially the World Health

Organisation. The WHO portal 'Health Laws and Universal Health Coverage' provides essential information on how to create an enabling national legal environment for universal health coverage.⁶⁸ Of particular interest for lawyers, are also the reports of the Special Rapporteur on the right to health.⁶⁹

Integrate

The adoption of the UN Sustainable Development Agenda provides impetus for law firms, corporate legal departments, and other law-related organisations to examine and re-align their own policies and practices. In the case of SDG 3, lawyers specialised in the healthcare and pharmaceuticals sectors can seek to reduce potentially negative impacts and enhance positive outcomes. This may include aspects of client advisory services, potential impact of transactions and investments, and implementation of good practices. Attention can also be given to standards of professional responsibility and broader questions of ethics. Law firms as employers can provide healthy working environments and lead by example.



68 Health Laws and Universal Health Coverage, World Health Organisation (WHO), available at: <http://www.who.int/health-laws/en/>.

69 Annual reports of the Special Rapporteur on the right to health, United Nations Human Rights Office of the High Commissioner (OHCHR), available at: <https://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx>.



Act

The SDGs also present a compelling opportunity for law firms, corporate legal departments and other lawyers to expand their pro bono legal activities domestically and abroad. This can be provided in several ways:

- Lawyers can actively participate in the legislative process to facilitate national implementation of SDG 3. Laws and regulations are a key lever for governments to affect the quantity, quality, safety and distribution of services
- in health systems. Health legal frameworks can help countries to attain important health goals, including universal health coverage, implement health policies, and apply international health regulations.
- In some legal systems, the legislative process requires public consultation during which draft bills are open to public comments for a specific period of time. Individual lawyers as citizens can provide their input based on their

expertise of the domestic legal system. Lawyers with experience representing clients in health care related cases might have more to contribute as they have gained a better understanding of practical obstacles that have prevented individuals from enjoying their right to health.

- Law firms and individual lawyers can also contribute to the implementation of SDG 3 by providing pro bono legal services to non-governmental organisations dedicated to improving healthy lives and human well-being, or to certain individuals who cannot afford the legal costs to pursue their health-related rights where they have been violated.
- Law firms and lawyers can also provide legal support to patients' associations, which advocate for the rights and interests of patients.
- Discriminatory laws and practices can have a direct impact on the well-being of vulnerable groups. Pro bono legal services may help marginalised communities to secure access to health care or to seek remedy for violations of their right to health. For example, poor people are often excluded from access to health services because they lack an official legal identity.⁷⁰ At the national level, and increasingly at the regional and global levels, judicial and quasi-judicial reviews are playing a role in supporting accountability for the right to health. Litigation can play a transformative role where the right to health has been violated. For example, in Africa, lawyers as individuals and law firms as organisations can make submissions to the African Commission on Human and People's Rights on

behalf of individuals who have had their right to health violated by a State Party to the African Charter.⁷¹ In order for such submissions to be accepted by the Commission, a *prima facie* violation of the right guaranteed under the African Charter must be alleged. Lawyers can use their legal analysis and drafting skills when preparing such communications.

- Law firms and individual lawyers can get involved in activities to raise awareness on the right to health and the ways to get it implemented, such as publishing research papers or giving presentations on relevant topics. Strengthening legal literacy can also be instrumental in relation to the underlying determinants of health, such as obtaining social housing (Goal 1 and target 11.1); protecting or establishing land rights (Goals 1, 5 and 11); establishing identity and citizenship (target 16.9) or preventing gender-based discrimination (Goals 5 and 16).⁷²

70 Report of the Special Rapporteur on the right to health and Agenda 2030, United Nations Human Rights Office of the High Commissioner, A/71/304 (2016), available at: <https://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx>.

71 See Communications Procedure, available at: <http://www.achpr.org/communications/procedure/>.

72 Report of the Special Rapporteur on the right to health and Agenda 2030, United Nations Human Rights Office of the High Commissioner, A/71/304 (2016), available at: <https://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx>.



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