THE SUSTAINABLE DEVELOPMENT GOALS AS A VEHICLE FOR ACHIEVING GLOBAL HEALTH OBJECTIVES: AN ETHICAL CRITIQUE

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Declaration

I, Esther Murugi Muiruri, declare that this thesis is my own original work. All the relevant sources that I have used during the course of writing have been fully credited and acknowledged. It is being submitted for the degree of Doctor of Philosophy in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signature  ----------

Signed this 14th day of October, 2019

Dedication

To my Father and my parents

Abstract

This is an ethical critique of the Sustainable Development Goals (SDGs); and specifically, their potential for achieving healthy lives and well-being for all human beings.

Drawing from globalization as the context in which various interactions take place across the globe between persons, corporations, institutions, and states, an argument is made that the dominant narratives of globalization have focused on its macro environmental impact, but have under-explored globalization's effects on individual health and well-being.

The case is made that the negative effects of globalization which individuals experience emanate from exclusion, powerlessness, and physiological risks to health. A further claim is made that Agenda 2030 and the SDGs represent a global consensus that seeks to focus on individual health and well-being.

Using a broader conception of health and well-being that is grounded in diverse philosophical approaches, a link between the determinants of health and individual health and well-being is made, with Agenda 2030 and the SDGs as a central component of this undertaking. An ethical critique of reason, motive, and intention is also carried out; justified by an argument that they are crucial to the sustainability of actions under Agenda 2030. A detailed epidemiological and ethical analysis of SDG3 is also carried out, and the links between SDG3 and other goals explored.

Challenges identified by various authors as being impediments to progress towards the SDGs are analysed, and solutions proposed. A contribution to knowledge is made by proposing Herbert Simon's related concepts of satisficing and bounded rationality as being relevant to guiding the decisions that states will make towards progress in Agenda 2030.

The conclusion is reached that while the SDGs are unlikely to be achieved by 2030, they are congruent with several philosophical approaches and represent a robust impetus for action to improve health and well-being for all.

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I am blessed to have the unwavering love of my husband Donald, who has always believed in me, generously supported me, and seen to it that the family keeps going during my long absences away from home. I thank our children for always cheering me up and for their understanding when I have had to be away.

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To my father and mother – I am forever grateful for the impactful role you have played in my life; and for your abundant generosity in countless ways. Only God can truly reward you.

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INTRODUCTION

The interconnectedness of people and their activities, and the emergence of shared values and beliefs around the world, provide common ground on which to begin exploring the effects of globalization on individuals. Numerous conceptions and critiques that perceive globalization as involving a multiplicity of people, processes, outcomes, products, or complex combinations of these, have largely framed globalization in terms of its macro environmental impact, and have failed to acknowledge its significant impact on individual lives.

Using illustrations of the various interactions that take place across the globe between and amongst persons, corporations, institutions of government, and between and amongst nations, I show the interconnectedness between persons and their activities across the globe. I analyse some of the diverse discussions and conceptions of globalization and its historical origins that have been written by various authors, and in so doing, show the ways in which globalization is perceived to be shaping our world.

Looking at the literature on globalization reveals the startling finding that while some of its aspects such as its impact on economic and political systems appear to attract particular prominence, the effects of globalization on the individual have been under-explored, with most of the literature on globalization focusing on globalization's effect on the macro environment. Through an analysis of various writers' critiques of globalization, I make the case that little regard has been given in the literature on globalization to how it affects an individual's health and well-being.

I make a contribution to bridging this gap on individual health and well-being in the literature on globalization by demonstrating that the effects of globalization pervade through more immediate and personal areas of an individual's life. Using three specific manifestations of globalization, namely: the threat of terrorism, threats to cyber security, and globalization's effects on physiological health, I show the need for a perspective of globalization that focuses on the health and well-being of the individual, rather than on the prominent macro environmental narratives of globalization.

If persons are excluded from meaningful interaction in social and economic life, or experience a sense of powerlessness to make a positive change in their lives, and also experience risks to

their physiological health emanating from the activities of persons near and geographically distant, there is a likelihood that their health and well-being will be negatively affected. In order to arrive at this understanding of health and well-being, we must go beyond a narrow definition of health that perceives health only as the absence of disease. Health must be considered from a point of its moral significance as well.

In Chapter 1, I claim that the Sustainable Development Goals (SDGs) exemplify a global attempt to mitigate the negative effects of globalization on individual health and well-being. This can be seen in Agenda 2030's call to 'leave no one behind'; as well as the framing of the SDGs, which focus on meeting certain targets *for all* people by 2030. Agenda 2030 and the SDGs also call for action from states, individuals, non-state actors, and other entities in order to meet the goals. In this way, Agenda 2030 views individuals as persons who can play a role in positively influencing their own as well as others' health and well-being.

Chapter 2 broadens the understanding of what health and well-being from the perspective of the individual means.

Beyond a narrow, biomedical definition of health, I carry out a critique of the moral significance of health and the importance of well-being. It is not only risks to a person's body organs and systems that we ought to be concerned about, but also those factors that contribute to the conditions which deprive human beings of the means, or the ability, to realise and actually live lives of their own choosing. Extreme poverty, being subject to unfair discrimination on morally unjustifiable grounds such as race, and the lack of opportunities for gainful work or employment, for instance, are among the conditions that adversely affect health and well-being. The determinants of health are therefore an inextricable part of any endeavour that seeks to promote health and well-being.

I analyse well-being from diverse philosophical approaches that include Kant's deontology, the Capabilities Approach, utilitarianism, virtue ethics, cosmopolitanism, and Ubuntu. I justify this analysis of well-being from different philosophical approaches by arguing that an ethical critique of well-being from diverse perspectives is required in order to capture the variety of conceptions of well-being as might be understood and experienced by persons from different geographical, cultural, religious, educational, social, economic, and other contexts.

A more holistic view of health and well-being must link the state of an individual's health and well-being to that individual's interaction with the determinants of health, which determinants I argue must themselves incorporate considerations of social justice.

Using Rawls's justice as fairness, and a critique of justice as the restoring of equilibrium, I show that social justice considerations have been taken into account in the determinants of health in Agenda 2030 and the SDGs. I make a contribution to knowledge by showing that determinants of health which incorporate social justice considerations are the crucial link between the state of health of the individual, and the well-being of that individual when analysed broadly using diverse philosophical approaches.

Chapter 2 also incorporates an ethical critique of the intentions, motives, and reasons for carrying out particular actions. I argue that the sustainability of actions is informed by the motives and intentions that are prior to, or that lead to those particular actions. Thus, while there may be many reasons for carrying out particular actions (making a profit, or simply for altruistic purposes), I make the argument that the alignment of reasons, motives and intentions with actions has implications for individual health and well-being.

Chapter 3 contains a detailed analysis of the epidemiological and ethical aspects of SDG3, including its targets, indicators, and means of implementation.

I justify this analysis of SDG3 using four main reasons. Firstly, since Agenda 2030 and the SDGs are the outcome of a global consensus in 2015, it is important to analyse SDG3 which specifically mentions health and well-being, in order to determine what this global conception of health and well-being entails.

Secondly, the arguments that I make in Chapter 2 which draw from, amongst others, Venkatapuram (2007), and Daniels (2001), hold that health extends far beyond a narrow biomedical definition that is focused on alleviating disease and restoring normal human functioning. Analysing the broader implications of SDG3 beyond a narrow, biomedical definition of health is necessary in order to consider what effects these could have for well-being.

A third reason is the need to test whether Agenda 2030's claim that all the SDGs are integrated, interconnected and indivisible, holds true. In my analysis, I show that the impact

of SDG3 (and all other goals) must of necessity be examined contextually, with reference to the other goals. As I argued in Chapter 2, the determinants of health are the link between the broader conception of health, and the well-being of an individual. It is therefore also necessary to consider the ethical implications of SDG3 and its targets and indicators, to other goals. I carry out my analysis of SDG3 using various philosophical approaches such as cosmopolitanism, Ubuntu, utilitarianism, Kant's deontological approach and the Capabilities Approach.

The fourth and final reason for analysing the SDGs is in answer to Venkatapuram (2007) and Venkatapuram and Marmot's (2009) call for inter-disciplinary reasoning and engagement between the determinants of health as well as epidemiology. Besides taking up Venkatapuram and Marmot's challenge, my focused analysis of SDG3 which combines its epidemiological grounding with ethical analysis is a contribution to knowledge, given that a detailed analysis and ethical critique of SDG3 and its targets, indicators, and means of implementation has not previously been carried out. I make a further contribution to knowledge by incorporating multiple ethical approaches in my analysis of SDG3.

My analysis reveals that some of the targets and indicators under SDG3 would benefit from clarification and expansion, particularly in what they are intended to measure. Some of the indicators are also inadequate in terms of what they are supposed to measure. An example is one of the tracers for Indicator 3.8.1, which measures "Percentage of population in malaria-endemic areas who slept under an insecticide-treated net the previous night". This is an inadequate measure since evidence shows that mosquitoes do change their biting patterns in response to mosquito-treated nets, and can begin to bite at all times of the day.

Other issues which I identify include the exclusion of certain age-groups from the indicators, and the inclusion of unjustifiable and ethically problematic terms such as 'unintentional poisoning' in at least one indicator.

In Chapter 4, I explore the measures which states, non-state actors, institutions, and individuals can take in order to accelerate progress towards meeting the SDGs by 2030.

I analyze aspects of the 2018 Report of the Secretary-General of the United Nations to the High-level Political Forum on Sustainable Development, which indicated that progress

towards the SDGs is generally slow, and in some cases has shown a decline.There has been a mixed record of success with regard to progress on the SDGs thus far. For instance, there has been a rise in cases of hunger rather than a reversal; contrary to SDG2's aim to end hunger. SDG3 records some gains in terms of a general decrease in HIV incidence around the globe, but an increase in the cases of malaria. The number of deaths occurring as a result of suicide have remained largely the same.

I also explore some of the issues that have been identified as impediments to progress in the SDGs, as well as measures proposed by various authors to spur action by states, non-state actors, institutions and other entities to meet the SDGs by 2030. I offer ethical perspectives that link these proposals to the ethical critiques on individual health and well-being that I carried out earlier.

Some of the most pressing challenges that could impede the success of the goals include a lack of statistical capacity within countries, a lack of clarity as to how much in terms of financial resources would be required to meet the goals globally, and the absence of interlinkages, trade-offs and synergies in national policies and processes. I make a novel contribution to knowledge by arguing that Herbert Simon's related concepts of satisficing and bounded rationality are relevant to guiding the decisions that states will make towards progress in Agenda 2030. This is particularly so in cases where states face constraints such as incomplete indicators for the SDGs and a lack of data collection capacity. I argue that satisficing can help states to determine which targets and indicators they should focus on first in order to have the widest impact.

Chapter 5 concludes the ethical critique of the SDGs by summarising the previous chapters and making a few recommendations. One recommendation calls for certainty in financing the goals. Another one calls for the SDG indicators to be finalised. With 232 indicators as at March 2018, and progress on others still ongoing, it is likely that many countries will face a challenge in trying to meet the SDGs by 2030.

I. Rationale for the research

Owing to the impact of globalization on individual health and well-being, an approach that represents a global perspective on global health is called for. The SDGs represent the widest

consensus on the priorities to be tackled at a global level, having been unanimously ratified by the 193 members of the United Nations. They offer the best chance to begin building on the various determinants of health at a global level.

II. Research Aims and Objectives

Through an ethical critique grounded in various philosophical approaches, this research aims to show how the SDGs can spur action towards ethically justified global health objectives.

Objectives

1. To critically defend the claim that the impact of globalization in our world requires a global approach to health.
2. To ethically critique the Sustainable Development Goals, using a broad selection of approaches from, *inter alia,* Kant's deontological approach, utilitarianism, cosmopolitanism, African traditional philosophies such as Ubuntu and virtue ethics.
3. To normatively analyse specific measures that could accelerate progress towards the achievement of the SDGs.

III. Research Methodology

This is a purely normative study. It has been based primarily on desk-top and library-based research. No new data has been collected or analysed. The research has not involved any study participants. It is an ethical critique drawing from the literature relevant to the topic and employing philosophical approaches from a traditional Western, African as well as other diverse global perspectives.

One aim of normative bioethical research can be to argue in favour of, or against practical recommendations or policies. Ethical critique in this research has been undertaken by analysing SDG3 and its targets, indicators and means of implementation as against diverse ethical approaches. The ethical approaches used include virtue ethics, Kant's deontological approach, utilitarianism, cosmopolitanism, the Capabilities Approach and Ubuntu. Other SDGs which potentially have an impact on health and well-being are similarly analysed using diverse ethical approaches, and their contribution to health and well-being defended. The use of diverse ethical approaches to analyse the SDGs sets the foundation for examining the

suitability of SDG3's targets, indicators and means of implementation, analysing possible challenges to their success, and making recommendations for their improvement.

I have employed the typical research methods and standards applicable to philosophical research, primarily involving the interpretation and critical analysis of salient texts. My critical analysis of relevant texts involves the definition and clarification of concepts, the identification and criticism of assumptions, the analysis and evaluation of theoretical frameworks, the development and defence of arguments, the establishment of consistency between general principle and particular judgment and the articulation of the most plausible interpretation of significant concepts found in the sources.

Sources of literature have been drawn from, but have not been limited to, books and articles at the University of the Witwatersrand Library, electronic databases of online scientific journals and books including BioMedCentral, Wiley Online, PubMed, Taylor & Francis Online, and internet search engines such as Google Scholar. Examples of some of the keywords used in my online searches include ethics, justice, SDGs, global health, Ubuntu, cosmopolitanism, intention, motive, SDG indicators, and satisficing.

In my analysis of SDG3, I have examined each target as well as its indicators, in order to establish the basis for the indicators chosen. This examination necessitated making extensive use of the World Health Organization's Global Health Observatory Data Repository, as well as resources from various departments of the United Nations Secretariat. These include but are not limited to, the United Nations Department of Economic and Social Affairs, and the United Nations Statistics Division. These resources were chosen for their comprehensiveness as well as their wide scope of coverage in terms of the number of countries covered.

IV. Limitations of the research

Given that the SDGs were adopted in September 2015, there remain limitations in terms of the available literature discussing the goals post-adoption. Many of the resources available were written prior to the adoption of the goals. There exists another limitation in terms of the most current indicators that this research considers. As at March 2018, there were 232 indicators for the SDGs, which continue to be reviewed and developed by the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs). Given that the IAEG-SDGs continues to

hold meetings to review and update the indicators, they are likely to change further. The indicators discussed in this research are those that were in existence as at March 2018.

In view of the word limit for this thesis and the specific aims stated, a discussion of each and every SDG in depth is beyond the scope of this thesis. I have therefore focused on an analysis of SDG3 as the main basis for considering health in the SDGs overall. This is not because the other SDGs do not have a bearing on health – far from it. As will be evident from the general discussion of the SDGs, the goals are interconnected, and each goal focuses on an area of concern that is a determinant of health and well-being when objectively considered. I have attempted to mitigate this limitation by drawing on some of the other SDGs to buttress many of my arguments in my analysis of SDG3.

In terms of the philosophical approaches that I have employed in analysing the SDGs, I have largely drawn insights originating from a Western and African communitarian perspective, which over time have become well-known and widely-applied in various societies around the world. I have not discussed philosophical traditions from an Eastern perspective, however, owing to various factors including the length of the thesis, as well as the time constraints within which to undertake my PhD. Utilising Eastern philosophical traditions in relation to global health can potentially be an area of future research.

CHAPTER 1: THE INFLUENCE OF GLOBALIZATION

Setting the stage

"All the world's a stage,

And all the men and women merely players."

(Spoken by Jacques, in the play'*As You Like It*').

These lines, written by William Shakespeare in his play, 'As You Like It' (Folger Digital Texts, n.d.) remain as relevant today as when they were first written. Though Shakespeare's reference was to the seasons of a life, the interconnectedness of our world makes this statement apt. Interactions that take place between and amongst persons, services that are provided to citizens through institutions of government, the business operations of private corporations, and relations between and amongst nations often occur against the backdrop of globalization. The daily lives of most human beings have been affected or influenced by globalization in its various manifestations. In stating that '*all the men and women [are] merely players'* (Folger Digital Texts, n.d.), Shakespeare alludes to the co-operation of people – that whatever their geographical placement, their expression of purpose, and their different actions from day to day, they all act in fidelity to particular ends. Such ends include, for instance, exchanging goods and services for money or other compensation; formulating the rules of engagement with respect to matters like security, education, health, and infrastructure; and the engagement of countries in diplomatic relations.

A brief and concise definition of globalization is difficult to come by. Encompassing as it does so many elements and multi-dimensional strands, attempting to confine it to a simple sentence or two would not do it justice. As Warrier and Wunderlich (2009, p.1) put it, "Few terms have evoked the range of responses, or been quite so used, and abused, as the term

'globalization'. It has been variously described as a process, a period, a force and a condition. The resulting ascriptions and attributions are diverse and invariably invite confusion."

In Section I, I analyse some of these diverse discussions and conceptions of globalization and its historical origins, and by so doing, show the ways in which globalization is perceived to be shaping our world. While some aspects of globalization such as its impact on economic and political systems appear to attract particular prominence, the effects of globalization on the individual have been under-explored. Most of the literature has focused on globalization's effect on the macroenvironment, with little consideration given to how globalization affects an individual's health and well-being. Section II contributes to bridging this gap in the literature by demonstrating that the effects of globalization pervade through even more immediate and personal areas of an individual's life. I show this by analysing three specific manifestations of globalization: The threat of terrorism; threats to cyber security; and globalization's effects on physiological health. In Section III, I argue that while the influence of globalization can neither be ignored nor denied, the Sustainable Development Goals (SDGs) introduce an ethical face to globalization, and exemplify a global attempt to mitigate some of the negative effects of globalization. I make the case that the SDGs seek to reorient the place of the human person at the centre of globalization, rather than as a peripheral subject upon whom the effects of globalization must inevitably occur.

Section I: Basic definitions and historical origins of globalization

Etymologically, the word 'globalization' arises from 'globalize', which according to the Online Etymological Dictionary (2017), appears to have made its first entry in 1953. The Merriam-Webster Online Dictionary (2017) however places the first known use of globalization in 1930, with its broadest definition of globalization being "the development of an increasingly integrated global economy marked especially by free trade, free flow of capital, and the tapping of cheaper foreign labor markets". The economic aspects and characteristics of globalization are greatly emphasised in this view of globalization. While it is acknowledged that commerce plays an important role in global interactions, this narrow definition does not do justice to the multiplicity and richness of the possible expressions of globalization.

In the Oxford Living Dictionaries (2017), globalization is referred to as "the process by which businesses or other organizations develop international influence or start operating on an international scale". Though in concurrence with one of Warrier and Wunderlich's (2009) descriptions of globalization as a process, this definition is limiting in its attribution of globalization to legal persons such as corporations and organizations, seemingly to the exclusion of natural persons. 'Developing international influence' surely can be said of an individual human being – some arguably well-known examples being, for instance, Nelson Mandela, the physicist and Nobel Laureate Albert Einstein, football star striker Cristiano Ronaldo, singer and entertainer Beyoncé Knowles-Carter, and activist and Nobel Peace Prize Laureate Malala Yousafzai, to name but a few.

In terms of its historical origins, globalization occurred in several phases. Pfister (2012) and Taylor (2002) consider the long-distance trade involving goods such as silk, spices, tea and coffee from Asia to Europe, and silver from Europe to other parts of the world, as one of the earliest beginnings of globalization. Holton (2005) employs a classification of globalization he attributes to the work of Hopkins (2002) (Hopkins, 2002, as cited in Holton, 2005, p.41). Holton states that the first phase of globalization, 'archaic' globalization "[predated] industrialization and the nation-state", and its principal actors included "kings, warriors, priests and traders" such as Gengis Khan, Marco Polo and Saint Paul (Holton, 2005, p.40).

The second phase of globalization according to Holton was 'proto' globalization, which occurred between the 17th and 19th centuries "with state reconfiguration and commercial expansion". 'Modern' globalization which Holton describes as a "conventional, Western-centred phase, post-1800, associated with industrialization and the rise of the nation-state", was the third phase of globalization (2005, p.41). McKeown (2007, p.223) notes that the modern phase was characterised by institutions that "enforced customs laws in predictable ways, adhered to standardized means of diplomatic and commercial interaction, implemented international agreements, and provided predictable legal and commercial protections".

The fourth 'post-colonial' phase is one in which we find ourselves today. It began after 1950 in a largely decolonized world, with "new types of supra-territorial organization and regional integration" (Holton, 2005, p.41). The main actors in the post-colonial phase are "business and political elites, migrants and asylum seekers, global civil servants, radical social movements and virtual networks around the internet" (Holton, 2005, p.41).

Unlike Holton, who considers some phases of globalization as being driven largely by the West, Sen (2002a, p.2) asserts that the agents of globalization are "neither European nor exclusively Western, nor are they necessarily linked to Western dominance". Sen illustrates this point by referring to the development of scientific and technological innovations such as the printing press, the magnetic compass, and the cross-bow which was already in use in China by A.D. 1000. He also refers to the decimal system, which became established between the second and sixth centuries A.D. in India, and spread into other continents.

Historically, therefore, globalization's roots have been inter-regional and inter-continental. Inasmuch as the participation and influence of different actors may have increased or decreased over time, at one time dominant and at another subdued, globalization appears to be a fabric woven from the threads of cumulative, collective contributions from the people of various continents on the globe.

Capturing a broader understanding of globalization from the generalised dictionary definitions and its historical origins thus proves elusive. In endeavouring to bring clarity to globalization and its impact, the image of a pebble thrown into a pond comes to mind, with its resultant and ever-increasing concentric ripples moving from the centre outward. This picture also serves the dual-purpose of illustrating the effects of globalization as emanating from an action or the confluence of actions, and spreading across the world.

It is imperative to cast an eye further out and consider some analyses of the current characterisations of globalization in order to get a richer picture of its influence on lives in today's world.

Broadening the understanding of globalization

The State University of New York (SUNY) Levin Institute has described globalization as:

> a process of interaction and integration among the people, companies, and governments of different nations, a process driven by international trade and investment and aided by information technology. This process has effects on the environment, on culture, on political systems, on economic development and prosperity, and on human physical well-being in societies around the world (SUNY Levin Institute, 2016).

This description recognises globalization as involving natural and legal persons as well as nations. Rather than focus on the process alone, it also includes the effects of the process, or its characteristics – what Warrier and Wunderlich (2009, p.1) refer to as "symptoms" of globalization.

The Defense Science Board Task Force on Globalization and Security (1999, cited in Wells, 2001, p.1), also mentions the characteristics of globalization, describing it as the integration of activities of "geographically and/or nationally separated peoples", and describing the nature of these activities as political, cultural as well as economic. Even though people's activities are acknowledged as central to globalization, there is no recognition of the effects of these activities on the human person who tangibly and palpably experiences the negative or positive consequences of globalization.

Rastegar and Moradi (2014, p.163) consider globalization to be "the product of communication technologies as well as human development and consciousness", which in turn is the result of a process described as "natural and spontaneous". The extent to which globalization can be described as 'natural' is debatable. Rastegar and Moradi themselves acknowledge this in default, by describing a second view of globalization as the outcome of a plan or a process, and giving a third view of globalization as a hybrid of spontaneity as well as planning (2014, p.163). The word 'natural' in their first description of globalization is problematic because one of its definitions in both the Cambridge English Dictionary (2017) and the Oxford Living Dictionaries (2017), "as found in nature and not involving anything made or done by people", appears to exclude human intervention; yet Rastegar and Moradi in their first definition place human beings as an integral component of globalization. A second definition of 'natural' in the Cambridge English Dictionary as "normal or expected" still does not cure the breach. Expectation, surely, presupposes foreseeability, which in turn would arise from a discernible pattern which must have been observed, experienced or known by the conscious human mind through a deliberate process, rather than by happenstance.

One of the most cited conceptions of globalization comes from Anthony Giddens (1990). Giddens uses the term "time-space distanciation" to describe the intricate relationship that exists between "local and distant social forms and events" (1990, p.64). Noting the great expansion and networking of relations between the local and the distant, Giddens describes globalization as "the intensification of worldwide social relations which link distant localities

in such a way that local happenings are shaped by events occurring many miles away and vice versa" (1990, p.64). The networking of time and space therefore expands the influence of persons or other entities beyond their immediate geographical confines.

Goldin and Reinart (2010, p.5) view globalization as the expanding of worldwide connections in many spheres, as well as the "increasing interdependence of human activity" within these spheres, such as economic, social, and cultural activities. Illustrating the multi-faceted aspects of globalization, Goldin and Reinart use HIV/AIDS as exemplifying a biological sphere which interacts with social, economic, political and other aspects at a local as well as global level (2010, p.5).

Melluish (2014) observes the creation of a significantly greater global interdependence owing to the rapid flow of culture between people. He states that culture, like globalization, is dependent on external influences such as the economy and ideology, as well as the power of the people involved. Melluish's is a welcome perspective, since it considers globalization in terms of its psychological effect on the individual, and its ability to impact "how we think about ourselves in relation to our social environment" (2014, p.539). Steger (2009, p.19) describes globalization as involving "both the macro-structures of community and the micro-structures of personhood", thereby highlighting globalization's influence on both one's external environment as well as the internal perception of self in relation to the rest of the world.

Ritzer (2007) offers three types of globalization theories – economic, political, and cultural. Political globalization has as its main participants nation-states and the power relations among them. Economic globalization focuses largely on the capitalist world, as well as transnational corporations and practices. With regard to cultural globalization, Ritzer follows what he states to be Pieterse's (2004) approach to theorizing cultural facets of globalization: "whether cultures around the globe are eternally different, converging, or creating new "hybrid" forms out of the unique combination of global and local cultures" (Pieterse, 2004, cited in Ritzer (2007, p.10).

Ritzer's preferred view of globalization incorporates the integration of cultural convergence as well as hybridization. His approach sheds light on globalization's effects on some aspects of human living such as food, clothing, entertainment and language. Ritzer coins the term

"grobalization" to refer to "the growing worldwide ability of, especially, largely capitalistic organizations and modern states to increase their power and reach throughout the world" (2007, p.16). This increase in power is aimed at exerting greater influence (in the case of states) or the maximization of profits, hence the '*gro'* in 'grobalization' (2007, p.16). Grobalization in Ritzer's view is an extreme form and undesirable outcome of globalization.

Another term used to describe a different form of globalization is 'glocalization'. Blatter (2013) defines glocalization as "the simultaneous occurrence of both universalizing and particularizing tendencies in contemporary social, political, and economic systems". According to Blatter, the term is "a linguistic hybrid of *globalization* and *localization,* [and] was popularized by the sociologist Roland Robertson". Robertson in turn attributed it to "Japanese economists [who used it] to explain Japanese global marketing strategies".

Roland Robertson (2001) views glocalization as a useful concept for considering the question of whether global change involves "increasing homogeneity or increasing heterogeneity or a mixture of both" (2001, p.462). Using the example of commodification, Robertson discusses the interplay between economic and cultural factors. He sees commodification as "a central feature of the connection between culture and the economy ... particularly because transnational corporations have a vested interest in promoting sales in a variety of different cultural contexts in an age of consumerism" (2001, p.462). Robertson concludes that glocalization is a hybrid of homogenization and heterogenization.

Glocalization in Ritzer's view (2007, p.13) is "the interpenetration of the global and the local, resulting in unique outcomes in different geographic areas". This definition is in keeping with previous descriptions of glocalization that show streaks of differences within the fabric of sameness. Thus the utility of the term 'glocalization' lies in its ability to describe the simultaneous paradoxes of 'sameness' and 'difference' that globalization presents in its wake. Ritzer (2012) sees grobalization as a useful counterpart to glocalization, which he considers "a continuum from grobalization at one end to glocalization on the other".

One of the most well-known manifestations of glocalization is exemplified by McDonald's Corporation's adoption of local ingredients in its menus in different countries, and its offering of meal options favoured by particular markets. Crawford, Humphries and Geddy (2015, p.12) note McDonald's use of locally sourced cheeses such as "chevre, cantal, and blue" in France;

the introduction of 100% Angus Beef in its New Zealand menu; and the option of the "kao fan burger in Hong Kong, a fried chicken patty served in a bun made of rice".

King and McGrath (2002) approach their critique of globalization from a largely political perspective, classifying it into three groups. The first is the neo-liberal account, whose proponents such as Kenichi Ohmae tend to extol the benefits of globalization in terms of providing a higher quality of life as well as its prioritisation of the economic aspects. King and McGrath see this account as failing to recognise issues of power and inequality. The second is a 'critique from the Left' (King & McGrath, 2002, p.19); in which globalization is treated as being inevitable, imbued with power, and favouring the economically privileged. In this account, the imbalances caused by power are acknowledged and discussed, their main effect being an increase in inequality in states that do not wield as much economic influence as others. The third group King and McGrath cite is 'A Third Way' (2002, p.19), whose exponents such as Anthony Giddens and David Held are credited with going beyond globalization's common focus on economics and looking at transformations in social life.

Holton (2005, p.15) affirms this third way, seeing globalization as "an ongoing set of processes shaped by human agency, and far too complex to be encompassed within a single master process". It is worth noting that Holton's view again places the human being at the centre of shaping the movements and transformations that characterise globalization.

David Held (2005) discusses globalization as well as its merits, challenges, and opportunities for inclusivity for all human beings in a work that takes the form of a debate. Held describes a world in which "overlapping communities of fate" exist; one in which "the trajectories of all countries are deeply enmeshed with each other" (Held, p.1). These connections are not confined to economics alone, but to culture, law, beliefs and communication, amongst others. Within these connections too, is entwined power as well the lack of it; and human rights as well as institutional and environmental concerns. Held's essay covers a broad range of issues – the impact of agricultural and related subsidies, free movement of capital, security and law enforcement, and global warming, to name but a few. Held concludes by making the case for a 'social democratic consensus' which would help create a level playing-field in the world-wide economy and "reshape the economic system in a manner that is both free and fair" (2005, p.31). Held's wide scope of discussion, as well as the solutions he proposes, enables an appreciation of the reach, as well as the intricacies involved in a discourse on globalization.

Micklethwait and Wooldridge (2003) consider globalization as rooted in freedom, describing it as "the freer movement of goods, services, ideas and people around the world" (2003, p.xix). They emphasise the importance of people and culture to globalization, explicitly stating that globalization is a process that is driven by various forces such as the digitalization of information and the removal of trade barriers. The sense in which Micklethwait and Wooldridge use 'freedom' here is, arguably, that aspect meaning 'without restriction'; or with minimal or reduced restrictions, if any. There are, of course, other meanings of freedom. For instance, Priest (2007) in discussing Kant's concept of freedom, states that "Kant's most concise yet clearest definition of 'freedom' is the statement that freedom is 'self-activity'" (Priest, 2007, p.4). For Amartya Sen (2002b, p.10), freedom is to be valued for the "substantive opportunity it gives to the pursuit of our objectives and goals". The concept of freedom mentioned briefly here, and some of its meanings, will be discussed in subsequent chapters as part of the ethical critique of the SDGs.

Mullard (2004, p.22) sees globalization as a "social construct" defined by economic interests as well as political determinations, thereby alluding to its dynamic nature. Mullard's dominant examples and themes in his discussion of globalization are based on the nature of markets, politics, free trade, the financial community (including international financial institutions as well as large multinational corporations), labour markets, and the policy choices arising therefrom. He states that his central theme is to "make connections" between citizenship, democracy and globalization, and "to understand the processes that are influencing people's lived experiences" (2004, p.16). Mullard does succeed in making these connections through his detailed characterisations of citizens that he classifies variously into the public, the independent, the entitled, the communitarian, and the consumer citizen. Each classification discusses how the citizen would interpret or react to matters such as attachments to community, access to health and education, decision-making, liberty and individualism, political processes and social change. Mullard's work in this is important because it brings the effects of globalization down to the individual level – How do different people react to the wide-ranging effects of globalization? Mullard shows that the concept of citizenship is not static, but fluid – its character dependent on the ebb and flow of individuals' lives.

Srinivasan (2002) perceives globalization as "the process of the dismantling of state-created barriers to trade, and the economic, social, and political responses to such dismantling" (2002,

p.1). In his view, globalization is a positive process that creates growth. He attributes what critics see as the negative effects of globalization – such as people pushed into poverty – to an unconducive environment in those countries,which in turn arises from governance issues such as endemic corruption and a restrictive financial environment. Srinivasan however fails to consider the imbalances in power and influence that characterise some aspects of globalization; and that more often than not, the party with more financial resources is able to use those resources, and its more powerful position in relation to the ordinary citizen, to maintain the status quo which favours inequality. Sen (2002a, p.2) however views globalization as a "world heritage", rather than as an imposition of ideas from the West to the rest of the world. Sen's treatment of the poor is more sympathetic than Srinivasan's – he locates poverty in some countries as arising from injustices in the distribution of gains from globalization.

One description focusing on the globalization of culture comes from Manuel Castells (2009). Castells defines cultural globalization as "the emergence of a specific set of values and beliefs that are largely shared around the planet" (2009, p.116). Even though Castells' writing here is largely focused on communication power and networks, and how these impact on the social structure through flexibility, adaptability and expansion, he shows that globalization is amenable to a variety of influences and can encompass a remix and hybridization of diverse cultures.

Movius (2010), observes that cultural globalization can sometimes appear to be like a solvent, "dissolving cultural differences to create homogeneity across the globe" (2010, p.6). She however states that firstly, culture, for the most part, is not becoming homogeneous, citing audience reception studies carried out to gauge reactions to, and interpretations of mass media content. These studies revealed differences in how this content was perceived by audiences in 'western' and 'non-western' contexts. Secondly, media content is not a one-way information flow – recipients of content also generate and distribute their own, thus dispersing their culture abroad. Thirdly is the persistent strength of a national and regional identity over a cosmopolitan one, as indicated in surveys. The fourth reason standing against the idea of the cultural homogenisation of the world is an apparent audience preference for content in their own language and culture; and the popularity of such content as evidenced by market share and audience time. Movius's arguments point to a discriminating and independent media

audience, rather than a common characterization of audiences as passive consumers and absorbers of content. The phenomenon she describes regarding media content being both locally as well as globally inspired and created could arguably be more fittingly described as the 'glocalization' of the media.

Keohane and Nye (2000) describe globalization as implying the increase of something, hence resulting in more of it. They call this condition of increasing or decreasing "globalism", further defining it as "a state of the world involving networks of interdependence at multicontinental distances" (2000, p.105). These connections are carried out through flows of capital, goods, information and people, amongst others, and include environmental as well as biological factors such as pathogens.

Globalism can be 'thin' – when it involves interdependence between relatively small groups of people over a limited distance; or 'thick' – when it involves "many relationships that are intensive as well as extensive", affecting many people spread over large distances. Globalization is therefore "the process by which globalism becomes increasingly thick" (Keohane & Nye, 2000, p.108). Keohane and Nye's perspective differs from many others in their attempt to elucidate a description for nascent globalization – at its very beginning when it involved bi-continental trade, for instance, rather than the multi-continental connections that characterise it today. Their contribution gives a name to that process or state of linkages and interdependence of peoples which though not local in terms of geographical placement, could not accurately be described as global, given that it was still limited in its reach.

Some criticisms of globalization

Globalization as a process or a 'social construct' (per Mullard, 2004) has its critics, too, with most writers condemning in particular the inequalities caused by its economic aspects, as well as what they deem to be the erosion of some cultural values.

Arigbede (1999) describes globalization as a "new tyranny". He gives examples of globalization's negative effects on Nigeria, which include the impoverishment of local farmers, the imbalance of trade with richer countries, and the unrestricted entry of global corporations in Nigeria which have occasioned job losses locally. Arigbede calls on "ordinary

human beings, especially in the 'South', [to] ... see that it is not necessary to lie prostrate before this global terror and that it can be defeated".

Agustín and Pastén (2005, p.2) view grobalization, which they consider to be "the process by means of which the global overwhelms the local", as exerting an inexorable influence over the economies and cultures of poorer nations. Through an analysis of how Latin Americans maintain their national identities in the face of globalization, Agustín and Pastén caution against an uncritical acceptance of globalization thus: "Those who envision globalization as the equal exchange of goods and services and not yet another, fancier word for colonization and exploitation, heed these words!" (2005, p.15).

Holton (2005, p.16) takes the view that much of the condemnation ascribed to globalization stems from "the simplistic chain of reasoning in which globalization meant economic globalization, and economic globalization meant free trade, deregulated markets, multi-national companies and liberal ideology". Holton's contention is that once globalization is seen as a multi-faceted process, "the coherence of the moral confrontation between advocates and critics of 'globalization', so defined, becomes weakened if not fatally undermined" (Holton, 2005, p.16). A proper understanding of globalization according to Holton thus calls for the realisation that the visibility of one facet such as the economy does not preclude globalization in other areas such as culture, law and religion.

Matusitz (2014, p.1) sees grobalization as "a form of unbounded capitalism and cultural imperialism". He states that grobalization "tends to eliminate the local and impose the global" (2014, p.2), a position he illustrates through a discussion of the practices, growth and influence of Walmart Stores, Inc., particularly in Mexico and China. Matusitz considers, for instance, the easy access to credit cards and micro-lending by Walmart to be potentially exploitative and detrimental to the working poor in Mexico.

Summary

The above analysis of conceptions and critiques of globalization by various authors reveals that it has an impact on multiple aspects of human life. It influences the political systems adopted by various states, ranging from a neoliberal outlook extolling its economic benefits to a 'Leftist' approach that criticises its favouring of the economically privileged. The

networking of time and space first described by Giddens (1990) and aided by technological advances has enabled the instantaneous exchange of information between geographically distant persons, an increase in commercial transactions, the exchange and adoption of cultural influences among people through travel, and the local availability of goods manufactured in distant lands.

Most of the authors whose conceptions of globalization I have discussed, including Castells (2009), Giddens (1990), Keohane and Nye (2000), King and McGrath (2002), Ritzer (2007), and Robertson (2001), perceive it from a macro environment perspective, analysing globalization from its effects on the economy, political systems, corporations and institutions, and its wider effects on different cultures. The few such as Mullard (2004) and Steger (2009) who consider some of the effects of globalization on the person focus primarily on the impact globalization has on the person's perception of self in relation to the rest of the world.

In Section II below, I argue that inasmuch as globalization affects the national and international macro environment, its effects on the individual have been under-examined and have failed to give sufficient consideration to the impact of globalization on the individual in terms of health and well-being. Using three manifestations of globalization – the threat of terrorism, cyber security threats and globalization's effects on physiological health, I show how the interconnections and technological advances attributed to globalization can affect individual lives in hitherto unexpected ways. I argue that the effects of globalization ought to be considered holistically; both at the macro environment level and at the micro-level of the individual's health and well-being.

Section II: Globalization's effect on individual health and well-being:

i. The threat of terrorism

One of the most evident manifestations of the impact of globalization is found in disturbances to the security situation in many countries globally. The Oxford Living Dictionaries' (2017) definition of security is "The state of being free from danger or threat". This definition can include aspects such as food security, job security and security of land tenure. In this section, I will limit my discussion of security to the threats of danger, and actual harm, that has been

occasioned to persons and infrastructure in various countries following incidents attributed to terrorism.

September 11, 2001 marked a significant turning point in the way in which the world views security and terrorism. On this day, now widely referred to as "9/11" after the conventional way of referring to dates using the month-day-year format in the United States of America, the country came face-to-face with what has been described by Bergen (2017) as "the deadliest terrorist attacks on American soil in U.S. history". Nineteen militants affiliated with the Al-Qaeda terrorist group then headed by Osama bin Laden carried out attacks targeted at various buildings in the United States of America, using commercial airplanes as weapons. The World Trade Center's Twin Towers in New York City were hit by two aeroplanes which caused the collapse of the towers. Part of the Pentagon in Virginia was also destroyed after another hijacked aeroplane with 64 people on board crashed into the building, killing another 125 people in the Pentagon (Bigler, 2017). A fourth airplane, United Airlines Flight 93, crashed into an open field in Stonycreek Township, near Shanksville, Pennsylvania, after its passengers attempted to wrest control of the airplane from the hijackers. All 44 on board, who included 33 passengers, 7 crew and the 4 hijackers, were killed (National Park Service, 2017).

The 9/11 Commission Report prepared by the National Commission of Terrorist Attacks upon the United States of America, notes that 2,973 people were killed in the immediate aftermath of the attacks (National Commission of Terrorist Attacks upon the United States of America, 2004, p.311). This figure does not include the nineteen terrorists. At least an additional 1,000 people are known to have since died as a result of "illnesses related to their exposure to debris that spread from the wreckage of the World Trade Center towers in downtown Manhattan" (Walters, 2016). More than 37,000 people, members of the federal World Trade Center Health Programme that was established in 2011, have been "certified ... as suffering from serious respiratory or digestive illnesses, cancer, or a combination. Most of those registered are from New York City and 82% are male" (Walters, 2016). The World Trade Center (WTC) Health Program was established to provide "medical monitoring and treatment for responders at the WTC and related sites in New York City, Pentagon, and Shanksville, PA, and survivors who were in the New York City disaster area" (Centers for Disease Control and Prevention, 2017a). One forecast by Dr. Jim Melius indicates that by 2021, "we will be at the point where

more people have died from World Trade Center-related illnesses than died from the immediate impact of the attacks" (Walters, 2016).

Evidently, the toll on human health and well-being of this particular attack has been devastating. Apart from the millions of dollars that shall be spent on treating and/or managing the adverse physical effects of the illnesses arising from toxic exposure and other injuries, there is a great psychological cost as well. One example is seen in the death of Sandra "Sandy" Dahl in 2012. Sandy Dahl was the wife of United Airlines pilot Jason Dahl, the captain of the ill-fated United Airlines Flight 93 on September 11 2001 when it crashed into a field near Shanksville, Pennsylvania. She passed away in her sleep in May 2012, a death that an autopsy noted was "consistent with the combined impact of alcohol and multiple drug toxicity" (Ingold, 2012). The report also noted that Sandy Dahl had a heart condition that may have contributed to her death. Ingold notes that in a previous interview, Sandy Dahl had revealed that she had been diagnosed with Post-Traumatic Stress Disorder. The World Trade Center Health Program also covers treatment for various disorders classified under its "Mental Health Conditions". Among these are: Acute stress disorder, anxiety disorder, depression, Post-Traumatic Stress Disorder and substance abuse (Centers for Disease Control and Prevention, 2017b).

Bromet et al., (2016) document a 17.7% incidence of Post-Traumatic Stress Disorder in 3,231 responders in their study of Post-Traumatic Stress Disorder occurring 11-13 years after the World Trade Centre attacks; with 9.7% of participants reporting active Post-Traumatic Stress Disorder. The authors conclude that Post-Traumatic Stress Disorder shows "strong associations with physical health and psychosocial well-being, especially reduced satisfaction with life" (Bromet et al., p.780). Responders to the World Trade Center attacks and residents of New York City who were in the disaster area continue to have their physical and psychological well-being affected, more than a decade and a half after the attacks took place. Sandy Dahl's death is indicative of the high price that continues to be paid by those who lost loved ones in the attacks, even though they themselves were not physically present in the vicinity of the attacks. The acts or omissions of a person who is geographically distant can have an enduring effect on the well-being of persons who were present, and even those who are distant.

Future persons can also be affected by the current acts and omissions of others. The global nature of terrorism is amply illustrated by a look at the 9/1 terrorist hijackers, their victims as well as the consequences of the attacks.

Information from the Central Intelligence Agency (2002) shows that of the nineteen hijackers, fifteen were of Saudi nationality, two from the United Arab Emirates, and one each from Egypt and Lebanon. Ziad Jarrah, the Lebanese hijacker, piloted United Airlines Flight 93 after the hijacking, with Muhammad Atta of Egypt, Marwan al-Shehhi of the United Arab Emirates and Hani Salih Hassan Hanjur of Saudi Arabia piloting the other three airplanes. Three of the four hijacking pilots had found their way to Hamburg, Germany, to work or study (Public Broadcasting Service, 2014). It is in Hamburg that these pilots came into contact with each other as well as the other planners of the attacks, eventually forming a cell (British Broadcasting Corporation, 2005). Some of the masterminds as well as the executors of the terrorist hijackings also lived and studied in the United States of America. Khalid Sheikh Mohammed, known as "KSM", was one of these. He had studied mechanical engineering in North Carolina, and was described as the "principal architect of the 9/11 attacks" in the 9/11 Commission Report (National Commission of Terrorist Attacks upon the United States of America, 2004, p.146).

All four pilots had spent some time in various flight schools in the United States – three of them primarily in Florida, and the fourth, Hani Hanjur, in Arizona. According to the 9/11 Commission Report (National Commission of Terrorist Attacks upon the United States of America, 2004) all nineteen terrorists apparently managed to clear the screening checkpoints at the various airports from which they boarded the planes in the United States – Boston's Logan International Airport, Dulles International Airport in Washington, D.C., and Newark International Airport.

With their origins in the Middle East and North-East Africa, and having lived in Europe and North America, the terrorist hijackers and planners of the 9/11 attacks were able to take advantage of their global connections and knowledge to execute an attack that marked a significant watershed in the global state of security and interaction between various peoples. The terrorists apparently had on board knives, box-cutters and Mace, (National Commission of Terrorist Attacks upon the United States of America, 2004, p.8) as recounted by various passengers in telephone calls to their loved ones from the planes before they crashed. Soon

after these attacks, new laws such as the USA PATRIOT Act (Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act) were passed, resulting in increased collaboration and information-sharing between various law enforcement and intelligence agencies, as well as increased penalties for terrorist-related crimes, amongst other measures (United States Department of Justice, n.d.).

The Transport Security Administration (TSA) was also formed in the United States of America in November 2001, with a mandate including taking responsibility for airport screening, as well as requiring explosives detection screening for all baggage checked in (International Air Transport Association (IATA), 2011). Regulations resulting in enhanced security at airports and on board flights were subsequently adopted by IATA. Some of these include Table 2.3.A of the Dangerous Goods Regulations, which prohibit the carrying of certain items such as pepper spray, Mace and electro-shock weapons, and the placing of restrictions on the carrying on board of containers containing flammable liquids, particular aerosols, and certain types of batteries, amongst other goods (IATA, 2017). The International Civil Aviation Organization introduced additional structural changes to aircraft, such as hardened cockpit doors on international passenger flights carrying more than 60 passengers (IATA, 2011). Due to enhanced screening measures adopted by airlines and most airports, passengers are to this day required to report earlier at airports and spend more time going through various security checks.

September 11 2001 also brought to the fore the reality that detecting and preventing terrorism requires the co-operation of various countries in sharing information and intelligence on suspected terrorist activity, and in co-ordinating global standards that would enhance security for people worldwide. The intercontinental nature of terrorism is clear in the lives and movement of the 9/11 terrorists. The globalization of terrorism is seen in the various nationalities of the victims of 9/11. It is possible that many others died; unrecorded and nationalities unknown. Aguirre and Quarantelli (2008) discuss some of the factors that result in inaccuracies regarding the numbers of victims of disasters. They include social exclusion; structural factors; – as when disasters “wipe out not only persons, but also others who would report on their disappearance” (Aguirre & Quarantelli, 2008, p.21); and systemic factors – when the system that collects and records the numbers itself breaks down (Aguirre & Quarantelli, p.22). With regard to social exclusion, Aguirre and Quarantelli speak of

"invisibility", stating that, "to be counted, a victim must be noticed, often as a result of having access to membership in the community and to the instrumentalities of membership in it" (Aguirre & Quarantelli, 2008, p.20). Thus, new-comers, visitors, marginalized communities, as well as minorities bear the brunt of invisibility during disasters, as seen in Aguirre and Quarantelli's discussion (2008, pp. 20-21).

Globalization's pull also attracts immigrants from various nations, and many remain undocumented and therefore invisible in many facets of life, owing to laws and policies whose effect, as described by Gonzales and Raphael (2017, p.2), is to "narrowly circumscribe their worlds". In the United States of America, undocumented immigrants are currently estimated to be about 11.3 million; with New York being one of the six states that account for 60 percent of all undocumented immigrants (Gonzales & Raphael, 2017, p.2). It is therefore highly plausible that many more persons of various nationalities than are officially recorded could have lost their lives in the 9/11 attacks.

ii. Threats to Cyber Security

Besides the threat to human well-being that arises from terrorism, one manifestation of the interconnectedness brought about by globalization is evident in cyber security[1]. Carr (2016, pp.49-50) states that:

> Cyber security is used to refer to the integrity of our personal privacy online, to the security of our critical infrastructure, to electronic commerce, to military threats and to the protection of intellectual property. These areas range extremely widely, and are united only by the technology with which they engage.

Gordon et al., (2015, p.3) use cyber security "to mean the protection of information that is transmitted via the Internet or any other computer network". They use the term interchangeably with 'information security'. For Dunn Cavelty, cyber security "[i]n its basic form … signifies a multifaceted set of technologies, processes and practices designed to protect networks, computers, programs and data from attack, damage or unauthorized access"

[1]The presentation of the term 'cyber security' in the literature varies, with 'cybersecurity', 'cyber-security', and 'cyber security' all being used by various authors in the relevant literature. For the sake of consistency, I shall use 'cyber security' in this discussion.

(2014, p.702). Dunn Cavelty also extensively discusses the different representations of threats to security in cyber space via the framing and language of different political processes over time (Dunn Cavelty, 2013; 2014).

The scope of my focus on cyber security, however, shall be on actual breaches of information, data, and infiltration of privacy as a way to illustrate the reach of global networks and the effect of such threats on human well-being.

Gordon et al., (2015) note the need for consideration of the cost of 'externalities' in a cyber security breach, stating that these costs are not usually factored into the cost-benefit analysis firms make of their investment decisions in cyber security. Describing 'externalities' as the "spill-over costs to other firms, in both the private and public sectors, as well as to individuals" (2015, p.4), Gordon et al., make the argument that investing in cyber security is akin to a public good, as it "creates a positive externality by decreasing the likelihood of a cybersecurity breach to consumers and other firms (as well as to the investing firm)" (Gordon et al., 2015, p.5).

One example of the harm that can be caused by a cyber security breach is the 'ransomware' attack that disrupted the operations of the National Health Service (NHS) in the United Kingdom in May 2017. Gayle et al., (2017), state that the attack "resulted in operations being cancelled, ambulances being diverted and documents such as patient records made unavailable in England and Scotland". The NHS systems had been rendered vulnerable to just such an attack, with a report in December 2016 stating that "nearly all NHS trusts were using an obsolete version of Windows for which Microsoft had stopped providing security updates in April 2014" (Gayle et al., 2017). Government agencies and public bodies are therefore not averse to failing to take into account the cost of externalities in cyber security investment. Yet, the amount and nature of information and data that governments hold on their citizens and other residents can compromise national security if breached – for instance, if citizenship records are altered in favour of terrorists; or defence and intelligence systems are infiltrated.

The attack on the NHS was apparently carried out using software called WannaCrypt0r 2.0 or WannaCry, which "exploits a vulnerability in Windows" (Gayle et al., 2017). The disruption to health and well-being arising from the cancellation of operations and appointments, as well as the anxiety likely experienced by persons fearing the misuse of their information, calls for

greater investment in cyber security, the timely sharing of information on threats, as well as co-operation to build capacity between countries. The WannaCry ransomware affected more than 150 countries, with organizations affected including Spain's Telefónica, FedEx in the United States, Russia's Ministry of Health as well as its Interior Ministry, Brazil's social security administration and Ministry of Justice, and a local authority in Sweden, amongst others (Dwoskin & Adam, 2017).

Robinson et al., (2013, p.43) characterise the nature of cyber threats as emanating from "state-sponsored intelligence agencies, nation-states (as a supplementary activity or as part of hostile state-on-state conflict), serious and organised criminality and ideological threats". It is therefore likely that there would be difficulties, or reluctance to co-ordinate between countries, where the cyber security threat is state-sponsored or part of state conflict. This, however, does not negate the need to co-operate in combating threats of a criminal or ideological nature. A view of cyber security as a public good, as proposed by Gordon et al., (2015) would be helpful in resolving the tension often evident between the state's security interests as well as individual interests. Carr (2016) notes that while the individual's cyber security is important at a significant societal level, it "may have to be subsumed into broader collective state concerns". Arguably, however, for governments committed to respecting the privacy of their citizens, greater protection of individual liberties can result from greater investment in, and prioritisation of, cyber security. One option would be a combination of government subsidies towards the acquisition of up-to-date cyber security protection by various corporations, institutions, and individuals; as well as the formulation of policies and the enactment of laws to sanction errant entities. The rationale behind this would be akin to the concept of 'herd immunity' in healthcare that arises when sufficient members of the population are vaccinated against contagious diseases. Therefore, the risk of a cyber threat materialising from well-protected systems would be greatly reduced for each individual, not to mention for government interests as well.

Dunn Cavelty (2014, p.710) however notes that, "It has been suspected for a while and is now confirmed that the intelligence services of this world are making cyberspace more insecure *directly*; in order to be able to have more access to data, and in order to prepare for future conflict" (Emphasis in original). This presents a paradoxical challenge in which vulnerabilities in cyber security are surreptitiously created, or tolerated, ostensibly to protect

future security. There is speculation that WannaCry emanated from a vulnerability in Microsoft systems that had been deliberately 'stockpiled' by the United States of America's National Security Agency for future deployment into enemy systems, (although apparently not created by the agency). Therefore, system vulnerabilities can be exploited by government intelligence agencies as well as by criminals and hackers (Groll, 2017). The best defence against a cyber security attack, however, would be for governments to ensure that the integrity of their own as well as other institutional systems, is maintained, and to seek co-operation with other governments in preventing attacks of a criminal nature.

iii. Adverse effects of globalization on physiological health:

Cyber threats and breaches to healthcare infrastructure have a significant effect on human well-being. However, the impact of globalization on health, generally, extends much further. The principles of the World Health Organization (2006) describe health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". From this description, which shall be analysed further in Chapter 2, it is clear that 'health' encompasses several aspects of a human life. This section will however focus on threats to physiological health and well-being.

A brief trip to a different country can end up being the trigger that introduces diseases previously considered distant and 'locally confined' into the developed world, as has happened in recent times with Ebola in the United States of America (Botelho & Wilson, 2014). Food exports from one country to another can have far-reaching adverse effects. The recall in 2013 by a New Zealand milk exporter of milk powder suspected to have been contaminated by botulism affected seven countries (British Broadcasting Corporation News, 2013).

Other threats to human health from globalization stem from the existence and availability of counterfeit drugs. Blackstone, Fuhr, Jr. and Pociask (2014) discuss the harmful consequences that result from counterfeit drugs, which include various health hazards, wastage of consumer incomes, and a reduction in the incentive for researchers to engage in development and innovation. With regard to hazards to physiological health, in particular, Blackstone et al., (2014, p.217) give examples of counterfeit versions of bevacizumab (Avastin), a cancer-fighting medication, which did not contain the active ingredient of the drug. A 2008 incident

in the United States of counterfeit heparin, a blood thinner, was suspected to have caused 81 deaths; and necessitated a nationwide recall of heparin. Given that "nearly 40% of drugs are made overseas and approximately 80% of the active medicinal components of drugs are imported" into the United States (Blackstone, et al., 2014, p.217), it is clear that the challenge of preventing counterfeit drugs getting into markets is significant.

The World Health Organization, at its Seventieth World Health Assembly in 2017, resolved to use the term 'Substandard and Falsified (SF) medical products', to create a common understanding of the meaning of this term, as well as to refer to the public health implications of medical products of this type (World Health Organization, 2017a). SF medical products include medicines that are authorised by national regulatory authorities but fail to meet quality standards or specifications, as well as those which "deliberately or fraudulently misrepresent their identity, composition or source" (World Health Organization, 2017a). According to the World Health Organization, anti-malarials and antibiotics are some of the most commonly reported SF medical products. The use of such medicines has long-term implications, given that deaths and further health complications can arise from untreated malaria and infections.

Further risks to health and well-being can emanate from machines and other goods manufactured to ease various aspects of human life. The manufacturing process, which involves aspects of automation and sometimes human intervention, can result in errors that compromise the proper operation of these goods and machines and cause bodily harm. Defects in motor vehicles, for instance, have resulted in the recall of millions of cars. A recall in September 2016 of particular models of vehicles manufactured by General Motors Corporation was occasioned by a fault that could prevent airbags deploying during a crash (British Broadcasting Corporation News, 2016). Another significant recall in 2016 involved 2.9 million vehicles manufactured by the Toyota Motor Corporation, owing to concerns over possible cracks in the fuel emissions control unit (Davies, 2016). Of these motor vehicles, 713,000 were located in Europe, with "743,000 vehicles in Japan, 495,000 in North America, 9,000 in China and 46,000 in other regions" (Davies, 2016). The risks to health and safety posed by these defects include a higher likelihood of death in the event of a crash if airbags fail to deploy, and an increased risk of motor vehicles bursting into flames as a result of fuel leaks in the case of cracks in the fuel emissions control unit. Such defects in the manufacturing

process can therefore affect persons who are located in distant parts of the world should these risks manifest.

McMichael (2013, p.1335) discusses the influence of human-induced climatic changes on health, stating that these "often act in concert with environmental, demographic, and social stressors that variously influence regional food yields, nutrition, and health". He notes further that the current state of global interconnectedness means that the environmental impact of human activity has a wider global reach. McMichael refers to a study by Grace et al., (2012) on Kenya which established a relationship between regional changes in climate such as increasing temperatures and declining rainfall; and increased rates of childhood stunting, based on trends and data since 1975. In their findings, Grace et al., state the long-term effects of childhood stunting as including decreased chances of completing secondary education and obtaining wage-earning employment, as well as difficulties in giving birth by those mothers who themselves suffered from stunting as children. These mothers in turn are likely to deliver low-weight babies, which has implications for these new-born children's health and growth. The effects of climate change; the spread of cigarette marketing; a rise in the prevalence of obesity and non-communicable diseases; increasing disparities in wealth; and occupational health risks owing to decreased deregulation in the labour market; are some of the social and economic factors of globalization that negatively affect the health of populations (McMichael, (2013). Schrecker (2014, p.4) suggests a link between the rise in diet-related non-communicable diseases and "the ease with which supermarkets, manufacturers of high-fat, high-calorie processed foods, and fast food chains have expanded into new markets under liberalized trade and investment regimes".

Expounding on the impact that climate change has on global health, McMichael (2013, p.1338) notes an effect on "the integrity of natural and human-built protection against natural disasters (including forest cover, windbreaks, mangroves, vulnerable constructed seawalls, and urban water-drainage systems)". A depletion or scarcity of resources such as water and pasture in areas experiencing the negative effects of climate change necessitates the movement of persons and livestock in search of them, frequently resulting in what McMichael terms "the adverse health consequences of social disruption, displacement of communities, and conflict situations" (2013, p.1338). Adverse health consequences of social disruption can include risks of hypothermia in cold temperatures, risks of dehydration in hot temperatures, contracting

water-borne diseases such as amoebic dysentery and other diarrhoeal diseases from drinking contaminated water, exposure to schistosomiasis from contact with infested water, and the risks of injuries and death from predators both in water and on land.

The influence of climate change on health is also seen in evidence that changes in climatic conditions affect epidemic infections, as discussed by Patz et al., (2003). They note that, "the incubation time of a vector-borne infective agent within its vector organism is typically very sensitive to changes in temperature, usually displaying an exponential relationship. Other climatic sensitivities for the agent, vector and host include level of precipitation, sea level elevation, wind and duration of sunlight" (Patz et al., 2003, p.104). For some diseases such as malaria borne by mosquito vectors, "[t]emperature may modify the growth of disease carrying vectors by altering their biting rates … affect vector population dynamics and alter the rate at which they come into contact with humans" (Patz et al., 2003, p.108).

Another phenomenon arising from globalization which can affect health is the occurrence of teenage suicides triggered by online activity, ostensibly as a result of the teenagers' involvement in 'death groups'. Filipp Budeykin, described as a 'curator' of a social media game dubbed 'Blue Whale', was in July 2017 sentenced to 3 years and 4 months in jail after pleading guilty to inciting teenagers to commit suicide (Russia Today, 2017). The 'game' apparently involved the curator contacting vulnerable teenagers over the internet via some closed groups, and manipulating them into completing various tasks over 50 days. The final task was instructing the teenager to commit suicide. Reports in Russia indicate that "at least 130 teenagers in Russia were prompted to commit suicide by these kinds[s] of closed social media groups" (Russia Today, 2017).

It is not only in Russia that deaths arising from Blue Whale were reported, but also in other parts of the world including India (Sharmal 2017); Kenya (Cherono, 2017); and the United States (Timm-Garcia & Hartung, 2017). As medical practitioners interviewed for Sharmal's article noted, there is a high likelihood that these teenagers were suffering from depression, loneliness, and were experiencing challenges such as a lack of acceptance from their peers. However, the ease of access to this game, and its influence over vulnerable teenagers located in diverse geographical areas all over the world, show the reach of globalization and the need for collaboration amongst worldwide regulatory authorities in protecting children and other vulnerable persons from harm.

Two beneficial outcomes for health from globalization

The twenty-fold increase in access to anti-retroviral medicines between 2003 and 2011 for persons living with HIV/AIDS in Low- and Middle-Income Countries (Schrecker, 2014), counts as one of the successes of global co-operation. A second benefit of globalization to health is reverse innovation, where technology or innovations first utilised in developing countries are adapted to an industrialized setting (Busse et al., 2014). Busse et al., highlight reverse innovation as having been successfully applied by General Electric (GE) "in its design of lower-cost, portable ultrasound machines, initially designed for lower-resource settings" (Busse et al., 2014, p.2). Immelt, Govindarajan and Trimble (2009, p.3), the originators of the term 'reverse innovation' in the article referenced by Busse et al., locate reverse innovation as "the opposite of the *glocalization* approach that many industrial goods manufacturers based in rich countries have employed for decades", thereby showing its nexus with globalization.

Summary

Globalization is characterised by both beneficial as well as adverse impacts. I have illustrated some of its adverse effects with actual examples that show the far-reaching effects of distant actions on the lives of many who are not geographically proximate to the sources of these adverse actions. The two positive outcomes for health that have been highlighted draw attention to the effectiveness of global co-operation for health and well-being. States, corporations, non-state actors and individuals ought to consider not just the economic, political, cultural, and other effects of globalization, but also have regard to how the macro environment in which globalization operates impacts on individual lives in terms of health and well-being.

In the next Section III, I argue that the negative perceptions that many persons have with regard to globalization are linked to the lack of acknowledgment by states of globalization's effects on individual health and well-being. I analyse some of the criticisms of globalization emanating from different geographical regions. I use three common themes, namely: exclusion from meaningful participation in social and economic life; powerlessness to influence positive

change in one's own life when viewed against globalization; and physiological risks to health; in order to show how these themes are linked to globalization.

I claim that Agenda 2030 and the Sustainable Development Goals (SDGs) offer the much-needed starting point for engaging with the effects of globalization on individual health and well-being. I argue that the SDGs seek to reorient the place of the human person at the centre of globalization, rather than viewing the individual as a peripheral subject upon whom the effects of globalization must inevitably occur.

Section III: Linking individual health and well-being to global health

The interconnectedness of people and their activities, and the emergence of shared values and beliefs around the world, provide common ground on which to begin exploring the effects of globalization on individual health and well-being. The numerous conceptions and critiques that perceive globalization as involving a multiplicity of people, processes, outcomes, products, or complex combinations of these, have largely framed globalization in terms of its macro environmental impact, and have failed to acknowledge its significant impact on individual lives.

An examination of some of the criticisms of globalization carried out by Agustín and Pastén (2005); Arigbede (1999); Matusitz (2014); and others reveal common themes in the negative perceptions of globalization, even among people who are geographically distant from each other.

Firstly, people experience a sense of exclusion from meaningful participation in social and economic life. Agustín and Pastén (2005, p.7) argue that the age of globalization in Latin American cities has brought with it:

> Fear of the indigent, the unemployed, the drug addict, and the Other, punctuated by the ever more tenuous nature of social relations and the loss of spontaneous sociability. On the other [hand], we encounter the mall and the gated-community as locales of refuge from the insecurity of the streets evidenced by the

mushrooming of security systems and the increasing desire to live in apartments instead of homes.

Arigbede (1999), referring to the World Bank and the International Monetary Fund, wonders why the two institutions "can dictate to the rest of the world and make decisions for us all without our participation". He asks this and other questions from the perspective of his "ordinary friends, from both poor rural and deprived urban settings" in Nigeria.

A second negative perception that is discernible from criticisms of globalization is the powerlessness that many feel in the face of globalization. The negative effects of globalization appear to be inevitable. Arigbede (1999) asks, "Why, in spite of the fact that we work very hard, from dawn to nightfall, not spending anything on ourselves or our children, not having any luxuries, in fact, not eating enough at any time, why do we continue to be so poor?" Arigbede shows the sense of helplessness that some persons experience; given that their efforts do not produce the benefits that they anticipated.

Matusitz (2014, p.304) gives the example of Trust-Mart, a large retailer in China that was acquired by Wal-Mart in 2006. According to Matusitz, "the very simple fact is that Trust-Mart just could not compete with Wal-Mart", adding that many local stores located near a Wal-Mart usually decline or go out of business. The closure of businesses and the consequent loss of jobs leads to stress, anxiety, loss of income, and other negative effects on health and well-being.

A third negative perception of globalization involves the risks to physiological health from various factors which many persons and states cannot on their own control without the co-operation of others. Air pollution from factories, for instance, can affect many people spread over large distances. High-fat, high-sugar fast foods are aggressively advertised, widely available, and relatively cheap globally, despite the well-known contribution of these foods to increased risks of Non-Communicable Diseases (NCDs). Gostin (2014, p.147) notes that "Some 80% of the 35 million deaths attributed to NCDs each year are in low- and middle-income countries".

Myers (2017) highlights the emerging field of research known as planetary health, which has been necessitated by the recognition that the unsustainable use of the earth's resources has led

to an increasing global burden of disease. Areas impacted by human activity include disruptions in the global climate system, the pollution of air, water and soils, and scarcity and even extinction of resources. These consequences all have implications for the health not only of human beings, but also of plants and animals.

The loss of professional expertise in healthcare by low- and middle-income countries through the migration of professionals to wealthier countries is another factor that can negatively impact the physiological health of individuals. This is especially so if the migration of these professionals results in a shortfall of healthcare workers in the low- and middle-income countries. Arigbede (1999) decries the loss of highly-qualified professionals from Nigeria including medical doctors, to wealthier countries, despite these professionals' expertise being badly needed in their home country.

The same script is familiar to many low- and middle-income countries. Quoting the World Health Organisation, Mpofu, Gupta and Hays (2016) note that "It has ... been reported that the 11 per cent of the world's population in sub-Saharan Africa bears 24 per cent of the global disease burden but only has 3 per cent of the world's healthcare personnel". The reasons why healthcare workers migrate to high-income countries are varied, and include seeking greater economic, professional, and educational opportunities; as well as escape from instability and personal risk in their home countries (Kapur, 2017). The lack or absence of a stable environment, and/or opportunities for professional and economic advancement can have negative effects on the persons who were relying on such professionals for healthcare. The health and well-being of the healthcare workers themselves, however, could also suffer (even if in the short-term), as a result of having to leave a familiar social environment and family relationships in search of greater opportunities.

Summary

The experience of exclusion from meaningful participation in social and economic life; a sense of powerlessness against the inevitability of globalization; and risks to physiological health, are some of the adverse effects to health and well-being that many people experience in their daily lives. I have argued that these adverse effects on individuals are linked to

globalization, but that they have not been adequately considered in the literature on the conceptions and critiques of globalization.

A focus on globalization's impact on health and well-being at an individual level would be crucial in order to mitigate the negative effects that globalization can have on different lives. Without such a perspective, many persons' experience of globalization, and the adverse effects that they experience in the context of globalization, can easily get lost in the prevailing narratives that overwhelmingly analyse globalization from its macro environmental effects, but hardly consider the micro-environmental impact of these effects have on individual health and well-being.

In the following part of Section III, I introduce the Sustainable Development Goals (SDGs). I argue that the SDGs provide a starting point for considering the missing perspective of health and well-being that incorporates individual-level concerns. I make the claim that the SDGs exemplify a global attempt to mitigate some of the negative effects of globalization; and I show how the SDGs seek to reorient the human person as an active participant in shaping the state of the world, rather than as a peripheral subject upon whom the effects of globalization must inevitably occur.

Background to the Sustainable Development Goals (SDGs)

The SDGs are 17 goals which were unanimously adopted by the 193 members of the United Nations on 25th September 2015 (United Nations Development Programme, 2015). Each goal is supported by 'targets', which are the yardsticks by which progress towards each goal is assessed. The SDGs are time-bound until 2030, and are the successors to the Millennium Development Goals (MDGs).

In the Millennium Summit in September 2000, world leaders adopted the Millennium Declaration, the key document that emanated from that summit, and from which the MDGs were derived. There were 8 MDGs as follows:1) Eradicate extreme poverty and hunger; 2) Achieve universal primary education; 3) Promote gender equality and empower women; 4) Reduce child mortality; 5) Improve maternal health; 6) Combat HIV and AIDS, malaria and other diseases; 7) Ensure environmental sustainability; and 8) Develop a global partnership for development (United Nations, 2006).

There was a mixed record of success for the MDGs by the time their deadline for achievement elapsed towards the end of 2015. MDG2 on achieving universal primary education saw an increase in the net primary school enrolment rate from 83% in 2000 to 91% in 2015 (United Nations, 2015, p.4). Under MDG4, the global under-five mortality rate declined "by more than half, dropping from 90 to 43 deaths per 1,000 live births between 1990 and 2015" (United Nations, 2015, p. 5).

Various authors have criticised aspects of the MDGs, including their focus and implementation. Fukuda-Parr (2016, p.44) termed the MDGs a "North-South aid agenda"; with the goals mainly relevant for developing countries. She noted that the MDGs concentrated on alleviating poverty as their conception of development, rather than on enlarging productive capacities of economies to make improved living standards possible (Fukuda-Parr, 2016, p.45).

Hopper (2017, p.8) notes that the MDGs lacked inclusivity and consultation, with many developing countries not afforded the opportunity to contribute meaningfully to them. Further, the MDGs failed to place emphasis on human rights, with the resultant effect that some of the goals were undermined. As Hopper states, "it is difficult to improve maternal health (MDG 5) without addressing the issue of women's sexual and reproductive rights" (Hopper, 2017, p. 9).

According to Kharas and Zhang (2014), support for the MDGs was slow in coming; and despite the formal commitment made by leaders at the Millennium Summit, the goals and targets "were not codified until the following year ... it was only after 2005 that MDG momentum truly began to build".

The World Health Organization (2015, p.7) noted a focus of attention and resources on some MDGs at the expense of others. With regard to physical health goals, implementation of the MDGs was geared towards the ends (health outcomes), without offering major incentives to invest in the means – i.e. health systems. Further, the MDGs applied a one-size-fits-all approach that failed to take into account the reality that different countries were starting off from vastly different points – some from very poor circumstances. This view is borne out by Chandy (2015), who notes the depth of poverty in Africa compared to poverty elsewhere. He says:

> Poor people in Africa start further behind the poverty line. So even if their income is growing, it is rarely enough to push them over the $1.25 threshold. In 2011, the average person living in extreme poverty in Africa lived on 74 cents a day, whereas for the rest of the developing world, it was 98 cents".

The global poverty line was subsequently adjusted upwards to $1.90 as from October 2015 (World Bank Group, 2015).

i. Some lessons from the MDGs

At the Millennium Summit, leaders stated that "the central challenge of today is to ensure that globalization becomes a positive force for all, acknowledging that at present both its benefits and its costs are unequally shared" (United Nations General Assembly, 2000, para 5).

The highlighted shortcomings of the MDGs indicate, firstly, that the challenges facing many people across the globe require an inclusive, participatory, approach; rather than an imposition of measures that inadequately consider their unique circumstances. Criticism of the MDGs as an agenda imposed by the wealthier nations on countries in the global South only served to defeat the Millennium Declaration's stated aim to make globalization 'a positive force for all'. There was inadequate consultation and the participation of developing countries was not sought in the process of deciding on the MDGs. This is an illustration of the exclusion from participation in social and economic life that certain individuals experience with regard to globalization.

Secondly, the MDGs seemed to consider quite a narrow definition of 'health', with goals focused on combating HIV and AIDS, malaria, reducing child mortality, and improving maternal health. There was a cursory reference to combating 'other major diseases' which were neither specified, nor any details given as to how they were to be combated. All targets for MDG6 were focused only on HIV/AIDS and malaria; whose higher prevalence in the global South lends credence to the criticism that the MDGs were intended not as global goals, but as goals for developing countries.

The narrow definition of 'health' discernible in the goals also failed to take into account the World Health Organization's constitutional principles, which consider health to be "a state of complete physical, mental and social well-being and not merely the absence of disease or

infirmity" (World Health Organization, 2006). There was insufficient acknowledgment of the impact that social, economic, and other factors such as an individual's level of education also have on health.

If globalization is to be beneficial to all, health must be construed from a broader perspective than the absence of disease and infirmity. Such an approach will more effectively take into account the effects of the absence of health, or reduced health, on individual health and well-being. A broader discussion of health will be considered in Chapter 2.

Thirdly, the MDGs did not adequately take into account considerations of justice in how the goals would be achieved. Chandy (2015) noted the unequal position that many countries and individuals find themselves in with regard to their levels of poverty. Setting goals that are supposed to be met by all states within a uniform deadline, despite glaring disparities in levels of poverty, is one example where the *prima facie* existence of inequity must be considered.

While the Millennium Declaration had 'Shared Responsibility' as one of its fundamental values (United Nations General Assembly, 2000, Part I, para 6), such responsibility must itself be grounded in justice. Setting goals for developing countries without their meaningful participation is ethically problematic because it fosters the powerlessness earlier discussed, where some individuals perceive the negative effects of globalization as being inevitable.

Another issue of justice concerns the effect of peoples' actions on distant others, and on future persons. O'Neill makes an argument for shared obligations by basing it on "an account of justice that is relevant for a world in which state boundaries are increasingly porous to movements of goods, capital, ideas and people, and in which state sovereignty is increasingly circumscribed" (O'Neill, 2000, p.3).

O'Neill says:

> In our world, action and interaction at a distance are possible. Huge numbers of distant strangers may be benefitted or harmed, even sustained or destroyed, by our action, and especially by our institutionally embodied action, or inaction – as we may be by theirs. Perhaps we have obligations not only to nearby but to distant strangers, or rights against them (O'Neill, 2000, p.187).

If distant strangers can be harmed by our actions or inaction, then justice demands that we exercise the appropriate restraint in our actions, or alternatively, spur ourselves out of inaction, if we are to forestall looming danger. The harms to health that would arise from, amongst others, human-induced climate-change, air pollution, and the availability of unhealthy foods that increase risks of Non-Communicable Diseases (NCDs), attest to the need to have distant strangers, and even future persons in mind when considering our obligations to others.

Summary

Prior to the adoption of the SDGs, world leaders had endorsed the MDGs as a plan for action to ensure that "globalization becomes a positive force for all the world's people" (United Nations General Assembly, 2000, para 5). An analysis of the MDGs shows that while there was some success in achieving some of the MDGs, there was notable criticism of the MDGs'focus and implementation, as well as its narrow conception of development. Other aspects of the MDGs that were criticised included their lack of inclusivity and consultation, and the delay in codifying and implementing the goals despite the earlier commitments made by countries.

I have argued that the shortcomings in the MDGs are attributable not only to their failure to consider health and well-being from an individual perspective, but also to their narrow conception of health. I have also shown that the three themes I had earlier drawn out from various criticisms of globalization (exclusion from social and economic life; a sense of powerlessness to make a positive impact against the inevitability of globalization; and physiological harm to health from distant others) are present in the criticisms of the MDGs. The MDGs did not therefore succeed in their aim to make globalization a positive force for all, nor in ensuring that the benefits and costs of globalization were fairly shared.

In the next section, I analyse whether the SDGs, the successors to the MDGs, can, *prima facie,* overcome the shortcomings in the MDGs.

ii. The SDGs and global health

The 17 SDGs, also referred to as the 'Global Goals' (The Global Goals for Sustainable Development, 2018) are the product of intense negotiation, consultation and compromise by

the 193 countries that unanimously adopted them on 25th September 2015 at the United Nations General Assembly. Table 1 below shows the SDGs as adopted in 2015.

TABLE 1. A list of the Sustainable Development Goals as contained in the United Nations General Assembly's Resolution 70/1 of 2015: *Transforming Our World: the 2030 Agenda for Sustainable Development.* This table is on page 14 of Resolution 70/1.

Sustainable Development Goals	
Goal 1.	End poverty in all its forms everywhere
Goal 2.	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3.	Ensure healthy lives and promote well-being for all at all ages
Goal 4.	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5.	Achieve gender equality and empower all women and girls
Goal 6.	Ensure availability and sustainable management of water and sanitation for all
Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8.	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9.	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10.	Reduce inequality within and among countries
Goal 11.	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12.	Ensure sustainable consumption and production patterns
Goal 13.	Take urgent action to combat climate change and its impacts*
Goal 14.	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 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
Goal 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
Goal 17.	Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

* Acknowledging that the United Nations Framework Convention on Climate Change is the primary international, intergovernmental forum for negotiating the global response to climate change.

Resolution 70/1, more popularly known as *Transforming our world: the 2030 Agenda for Sustainable Development* (hereafter, 'Agenda 2030'), contains the principles, values and commitments behind the SDGs, as well as the SDGs themselves.

The selection and adoption of the SDGs was preceded by a more inclusive and participatory approach involving both developed and developing countries, as compared to the process leading up to the selection of the MDGs. Through the Open Working Group co-chaired by Csaba Kőrösi of Hungary and Macharia Kamau of Kenya, several developing countries participated in and contributed to the choice of SDGs. As Agenda 2030 acknowledges in Paragraph 6, "The Goals and targets are the result of over two years of intensive public consultation and engagement with civil society and other stakeholders around the world, which paid particular attention to the voices of the poorest and most vulnerable" (United Nations General Assembly, 2015, p.3).

In contrast, Paragraph 27 of the Millennium Declaration stated that, "We will support the consolidation of democracy in Africa and assist Africans in *their struggle* for lasting peace, poverty eradication and sustainable development, thereby bringing Africa into the mainstream of the world economy" (United Nations General Assembly, 2000) (emphasis mine). This wording appeared to frame the challenges faced by Africa and other developing countries as distant problems which do not affect the developed world; with the role of wealthier countries being one of superiority and of providing direction. The inference that the purpose of assistance was merely to 'bring' Africa into the mainstream of the world economy was rather condescending. It also failed to recognise that persons have other desires including a need for respect; to be treated with, and viewed as, possessing dignity; and to participate in the making of decisions that concern them and affect their welfare.

Agenda 2030 acknowledges the role of various actors in achieving the SDGs, thus fostering a sense of empowerment rather than the powerlessness that many individuals experience with regard to the negative effects of globalization. While the Millennium Declaration looked primarily to states and regional authorities to fulfil the commitments made within it, Agenda 2030 at Paragraph 39 widens the scope of actors tasked with the responsibility of achieving the SDGs. The success of the SDGs will require the participation not only of governments, but also of "the private sector, civil society, the United Nations system and other actors[2] and

[2]Arguably, 'other actors' includes individuals, since Paragraph 10 of the Addis Ababa Action Agenda, to which Agenda 2030 refers to at Paragraph 40, names "the private sector, civil society, the scientific community, academia, philanthropy and foundations, parliaments, local authorities, volunteers and other stakeholders" as important in sharing their knowledge, resources and expertise to meet the goals (United Nations Department of Economic and Social Affairs, 2015, p.5).

mobilizing all available resources" (United Nations General Assembly, 2015, para 39, p.10). Paragraph 51 of Agenda 2030 also makes specific reference to children, young women and men finding within the SDGs a platform to channel "their infinite capacities for activism"; thereby emphasising the need for action at an individual level (United Nations General Assembly, 2015, p.12).

The SDGs acknowledge the interplay of various factors such as the environment, education, peace and security, and poverty in affecting health outcomes. As McMichael (2013, p.1337) had suggested, "Future global health goals must be better integrated with the fundamental influences of poverty, inequity, illiteracy, climate change, land-use patterns, and food insecurity on health".

Dr. Margaret Chan, the then Director-General of the World Health Organization stated in 2015 that, "Fundamental to achieving the SDGs will be the recognition that eradicating poverty and inequality, creating inclusive economic growth, preserving the planet and improving population health are not just linked but interdependent" (World Health Organization, 2015, p. III).

Agenda 2030 frames the SDGs as being "integrated and indivisible". This phrase first appears in its Preamble, and is subsequently repeated in paragraphs 5, 18 and 71 (United Nations General Assembly, 2015). Being integrated and indivisible means that progress made in one goal is likely to have an impact on the success of the other goals. Conversely, failure to meet one goal will negatively affect the chances of other goals being met. Take the example of SDG1 to end poverty in all its forms everywhere. It is clear that without an accompanying effort to promote financial inclusion, and ensure that persons have the opportunity to earn a decent living as required by SDG 8, SDG1 will not be met. SDG 10 which aims to reduce inequality within and among countries will not succeed if SDG 5 fails to meet its objective of achieving gender equality and empowering women and girls.

At any one time, individuals will have different experiences of a combination of several factors that have an impact on health and well-being. Such factors include the environment in

which they live; the type of employment or gainful work in which they are engaged (if any); their levels of education; the availability and access to healthcare when needed; and whether they have sufficient food and access to potable water. It is the interaction of these and other factors that will determine whether an individual has a negative experience of health and well-being, or a positive one. Since the SDGs take an integrated and indivisible approach to the goals, they offer a good foundation for states to engage with the impact of these various factors – the determinants of health – on individual health and well-being.

Agenda 2030 also acknowledges that risks to physiological health can arise from the actions of distant others. Paragraph 14 states that:

> Global health threats, more frequent and intense natural disasters, spiralling conflict, violent extremism, terrorism and related humanitarian crises and forced displacement of people threaten to reverse much of the development progress made in recent decades ... The survival of many societies, and of the biological support systems of the planet, is at risk" (United Nations General Assembly, 2015).

As earlier shown by the analysis of actual events concerning terrorism, cyber security, and threats to physiological health, threats to health and well-being can emerge from geographically distant nations and persons. No state can claim to be completely insulated from threats originating from other states.

In terms of justice, Agenda 2030 acknowledges the special challenges that face small island developing states, African countries, least developed and land-locked developing countries; and that these states need assistance in mitigating these challenges. Paragraph 2 in Agenda 2030 identifies poverty eradication in all its forms and dimensions as "the greatest global challenge". Subsequent paragraphs emphasise the need for commitment in international co-operation, and global partnerships to meet the goals (United Nations General Assembly, 2015).

In terms of representation on the Open Working Group whose proposals gave rise to Agenda 2030, justice as fairness appears to have been exercised in terms of the allocation of seats in this group. Countries from Africa and the Asia-Pacific region had seven seats each, while

Latin American and Caribbean countries had six. European countries had ten seats, with efforts also made to factor in the levels of development of all countries (Bhattacharya, Khan & Salma, 2014, p.167).

The pledge in Agenda 2030 that "no one will be left behind", first stated in the Preamble, and reiterated in Paragraphs 4, 26 and 28, speaks to the need for justice; particularly the emphasis in Paragraph 4 where states "will endeavour to reach the furthest behind first" (United Nations General Assembly, 2015). Agenda 2030 thus acknowledges the different starting points from which countries are embarking on the SDGs in terms of wealth and resources.

Summary

The adoption of the SDGs was preceded by a considerable period of consultation and negotiation by various countries. Developed and developing countries had the chance to participate in the discussions through fair representation in the Open Working Group. The SDGs, and Agenda 2030 from which they emerged, represent a more inclusive engagement of countries with the both the process and substance of selecting the goals.

Unlike the MDGs, the SDGs explicitly call for the participation of states, non-state actors, and individuals in meeting the goals. As such, the sense of powerlessness that attends the interaction of many individuals with globalization is diminished; and individuals have the opportunity to play an active role in achieving the SDGs. Thus the participation of individuals in matters that affect their own lives from the social, economic, educational, and other perspectives could have positive implications for their health and well-being.

Agenda 2030 and the SDGs also acknowledge the interconnection between all the goals. Being integrated and indivisible, success in one goal will depend on the success of the others. By expressly linking the goals in this way, the SDGs offer a broader interpretation of health and well-being which incorporates the determinants of health – the social, economic, environmental and other factors that influence how well a life is lived. The SDGs also recognise the adverse effects that the actions of distant others, such as engaging in terrorism and conflict, have on global health.

Considerations of social justice are also much stronger in Agenda 2030 compared to the MDGs, given that the vulnerability and special challenges faced by African countries, small island developing states, land-locked developing countries, and least-developed states are acknowledged and commitments to support these countries made.

The SDGs represent an improvement over the MDGs in terms of the opportunities they offer to individuals to participate in matters that affect them socially, economically and politically. The SDGs call for individuals to take action to improve their environment, education, healthcare, and other aspects of their lives. They foster a sense of empowerment that can, *prima facie,* have a positive impact on the health and well-being of individuals. While the effects of globalization discussed in Section II can neither be ignored nor denied, Agenda 2030 and the SDGs seek to place an individual's health and well-being at the centre of globalization. They also provide impetus for individuals to take actions that can have a positive influence over the effects of globalization. The individual is therefore viewed as an active participant in shaping the state of the world, rather than as a peripheral subject upon whom the effects of globalization must inevitably occur.

CHAPTER 2: A BROADER CONCEPTION OF HEALTH AND WELL-BEING

Introduction

The principles of the World Health Organization's Constitution describe health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (2006, p.1). This definition has not been amended by the World Health Organization since 1948 when the constitution entered into force. Even though it links health to well-being, it has also been criticised over the years for, amongst other things, failing to recognise that chronic illnesses and disability can co-exist with health (Bradley, Goetz, & Viswanathan, 2018); having a narrow, biomedical focus on health that does not consider values such as a person's ability to adapt to an imperfect world; and being an unattainable ideal given that no person, according to its definition, is in a perfect state of well-being (Misselbrook, 2014).

In the first section of this chapter, I go beyond a narrow, biomedical definition of health to consider the broader moral significance of health. I also analyse well-being as viewed from diverse philosophical approaches that include Kant's deontological approach, the Capabilities Approach, utilitarianism, virtue ethics, cosmopolitanism, and Ubuntu. My analysis of well-being from different philosophical approaches is justified by the need to capture the variety of conceptions of well-being as might be understood and experienced by persons from different geographical, cultural, religious, educational, social, economic, and other contexts. I emphasise the need for a more holistic view of health and well-being by further linking the state of an individual's health and well-being to that individual's interaction with the determinants of health.

In Section II, I show how social justice considerations have been applied to the determinants of health in Agenda 2030. I argue that social justice is an integral consideration in any decision that concerns the availability and distribution of the determinants of health. I then make the novel claim that determinants of health which incorporate social justice considerations are the crucial link between the state of health of the individual, and the well-being of that individual analysed broadly using diverse philosophical approaches. I argue that in construing an ethically defensible view of health and well-being that takes into account

diverse ethical frameworks, the determinants of health are a pivotal consideration. It is however not enough for a state or any other entity simply to make available the determinants of health. Any decision as to what priority ought to be placed on these determinants of health in terms of selection, availability and distribution must be made in a manner that is fair and that takes cognisance of existing inequalities with a view to remedying them.

In Section III, I analyse whether the actions that states are supposed to take in Agenda 2030 in order to achieve the SDGs are generally coherent with the broader view of individual health and well-being analysed in Section I. I critically examine the influence of reason, motive, and intention on states' and agents' actions; arguing that these three philosophical concepts also should be analysed since they influence the sustainability of actions which ought to be taken towards the provision of the determinants of health. Their role in influencing actions thus has an impact on individual health and well-being.

Section I: The Moral Significance of Health

Physiological effects of disease and injury include pain, organ dysfunction, disability, and changes in breathing and internal body temperature, amongst others. Such effects are what a narrow, biomedical view of health seeks to alleviate. The prescription for relief from these symptoms and manifestations of disease and injury often involve the use of medication, undergoing surgery, physiotherapy, and the provision of assistive devices such as wheelchairs or crutches, for instance. In sum, the remedy for the physiological effects of disease and injury is often taken to be the provision of healthcare. While it is true that these adverse effects certainly have a negative impact on a person's physical body, Ruger (2012) states that diseases such as schizophrenia and Alzheimer's can have additional effects on a person's ability to make decisions, as well as to participate in physical activities.

An inability or a reduced capacity to make decisions affects a person's agency. This in turn might require that other people be called upon to make decisions on his behalf. In cases where a person would prefer to handle his or her own affairs – for instance, those of a financial or legal nature– this loss of one's sense of independence can lead to distress and frustration. Physical incapacities and ill health also tend to limit the kind of activities that one can

participate in. Take, for instance, a situation in which a construction worker employed on a daily-wage basis falls ill with typhoid. He cannot report to the construction site owing to the serious symptoms he is experiencing. As a consequence of his absence from work for three days, he does not earn the wages that would have enabled him to eat properly, or take care of his family's needs.

Ruger buttresses her case for the moral significance of health by making the argument that health inequalities and cross-border issues "are morally troubling and efforts to address these and prevent future global health problems are morally justified" (Ruger, 2012, p.35). She argues that global health problems give rise to positive duties that are necessary to create the ability for all humans to be healthy, as well as negative duties not to harm or impede the ability to be healthy. Ruger (2012, p.35) goes on to note that, "These duties in turn generate duties of cooperation and obligations on international and domestic actors", with such duties also including the reform and alignment of institutions to conform with the appropriate values for such an undertaking. Ruger sees the basis of these duties not as legal obligations, but as "voluntary commitments" (Ruger, 2012, p.35), which view is in keeping with the nature of obligations that arise in Agenda 2030.

Health is considered to be of moral significance in the Capabilities Approach. Martha Nussbaum (2011, p.20) considers health to be one of the most important capabilities, since it protects freedoms which make it possible for a person to live a life of dignity. She describes capabilities as "the answers to the question, 'What is this person able to do and to be?'" Nussbaum refers to capabilities as encompassing not just "characteristics of a person (personality traits, intellectual and emotional capacities, states of bodily fitness and health, internalized learning, skills of perception and movement)" (Nussbaum, 2011, p.21); but as "freedoms or opportunities created by a combination of personal abilities and the political, social and economic environment" (2011, p.20). In Nussbaum's list of ten 'Central Human Capabilities', 'Bodily Health' comes second; with Nussbaum defining it as "Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter" (Nussbaum, 2011, p.33). For Nussbaum, good health encompasses the determinants of health such as adequate housing and nutrition, and not just access to healthcare.

Other determinants of health include the opportunity to work and earn a decent income, and living a life of one's own choosing. A limitation or lack of these opportunities can contribute

to ill-health and a lack of well-being. Apart from the economic effects of job losses and unemployment, Brand (2015) notes other effects on a person, including the "[disruption of] individuals' status, time structure, demonstration of competence and skill, and structure of relations". It also "carries societal stigma ... presents a source of acute stress ... as well as chronic stress resulting from continuing economic, social, and psychological strain"; and "higher levels of depressive symptoms" (Brand, 2015, p.365). If the individual's health and well-being is of moral concern, then these 'other' factors that influence health ought to be under consideration in any account of health. As Marmot (2017, p.374) puts it, "What good does it do to treat people and send them back to the conditions that made them sick?"

A consideration of 'functionings' is also important in the Capabilities Approach. Sen (1999, p.7) describes a functioning as "an achievement of the person: what is this person able to do and to be?" This is a question which is very similar to that which Nussbaum asks with regard to capabilities. A functioning, however, is distinguishable from a capability in that a functioning considers what a person is *actually* able to do and be with the things that are available to her; while a capability looks at what a person *could potentially do,* with the things that are available to her and in the space that she finds herself in. The capability or set of capabilities available to the person must however be real and not conjectural; and the person can freely choose to take them up or not. Sen distinguishes between possessing a bicycle and bicycling, noting that having a bicycle does not say much about whether the person who owns it can actally use it. He states that "a bicycle is treated as having the characteristic of 'transportation', and this is the case whether or not the particular person happening to possess the bike is able-bodied or crippled" (Sen, 1999, p.6).

Having something – in the sense of possessing it – does not necessarily translate into that person having or enjoying the full spectrum of what that thing (Sen refers to such objects as 'commodities'), can do; or the pleasure it can bring someone when it is utilised. A person can have a bicycle which he considers solely as a means of getting from A to B. Another person with the same bicycle might use it for transportation as well, but also get immense fulfilment from bicycling as a hobby. Another may have a bicycle that he can no longer use – perhaps because of having had his legs amputated. The Capabilities Approach however values capabilities as being the real freedom or opportunity to achieve functionings. While being in good health is a valuable capability and is of intrinsic value, the functionings it produces for

each person will in many ways be dependent on personal characteristics, as well as social, environmental, and other determinants of health – what Sen (1999) refers to as conversion factors. States, institutions, and other agents seeking to understand health and well-being at the individual level must therefore have regard to the multi-dimensional aspects of the determinants of health and how they impact individual health and well-being. In the provision of housing, for instance, the consideration must not only be to provide shelter from the elements, but also to ensure the security of the occupants, to provide a space for privacy, and to provide a sense of community.

Venkatapuram (2007, p.10, para 15) conceives of health as "a capability to achieve a cluster of basic and inter-related capabilities and functionings", which he terms the "capability to be healthy". Venkatapuram rejects the notion of health as merely the absence of disease or statistically normal functioning; holding that an individual's capability to be healthy, or "bundles of health 'beings and doings'" are the outcome of

> the interaction between 1) an individual's biological needs or features, 2) her physical and mental abilities to convert her own endowments and external, extant material goods and social conditions into health functionings, and the extant 3) material goods and 4) social conditions in the environment (2007, p.14, para 21).

Shortcomings in a person's health can therefore be explained by their capability set being "either not comprehensive enough, being restricted, or both" (Venkatapuram, 2007, p.15, para 21). Venkatapuram argues that every person has a moral entitlement to the capability to be healthy because of its intrinsic value in terms of human dignity, as well as its instrumental value in enabling the pursuit of one's own life plans. The moral entitlement to a capability to be healthy in turn gives rise to obligations to states, institutions, other entities and individuals to remove the restrictions to this capability and expand its range; specifically in the aspects of social concern which are extrinsic to the individual. Nourishment, housing, environmental conditions, and economic opportunities – all of which are determinants of health – would fall under the third and fourth category of factors that interact to shape an individual's capability to be healthy.

Norman Daniels (2008) makes the argument that health is morally significant for its capacity to protect equality of opportunity. He argues for a broader population view of health, and for

the inclusion of the social determinants of health in any account that would consider whether health is of moral significance. In developing his argument, Daniels formulates the central question he seeks to answer thus: "As a matter of justice, what do we owe each other to promote and protect health in a population and to assist people when they are sick or disabled?" (Daniels, 2008, p.11). He calls this the 'Fundamental Question', and further breaks it down into three 'Focal Questions'. The first is whether health, and therefore healthcare and other factors that affect health, are of special moral importance; the second asks when health inequalities are unjust; and the third seeks an answer to how health needs can be fairly met under resource constraints. In discussing these questions, Daniels further develops his previous argument[3] in which he considered disease or illness to be a curtailment on normal species-typical functioning, and therefore a limitation on the opportunities that are available to individuals.

The Fundamental Question, and the first and second Focal Questions, point clearly to the importance of the determinants of health such as clean air and water and decent housing on the physiological well-being of an individual's body, for instance. A person's level of education is another factor that often has an impact on the kinds of employment opportunities that are available to her, and may influence her income and access to other goods. Daniels's position is therefore that if a person's state of health is determined in some part by factors outside or beyond medical treatments as well as one's access to healthcare, then the ill health of a person, and consequently the wider population, is not simply a matter of bad luck or the outcome of their bad choices. It is a matter of justice.

Being a matter of justice, it behoves us to actively engage with what Daniels terms the 'socially controllable factors' (2008, p.13); and what Venkatapuram includes in the 'social basis' of the capability to be healthy (Venkatapuram, 2007, p.18); in order to achieve a just distribution of health. Therefore, since 1) justice demands that the socially-controllable factors (determinants of health) that cause ill-health be addressed; and 2) given that access to medical care also contributes to normal species-typical functioning and hence impacts the opportunities available to individuals; then 3) health and healthcare are of special moral

[3]See, for instance, Daniels (1985) *Just Health Care.*

importance. This argument answers the first Focal Question in the affirmative – health and healthcare are of special moral importance.

Daniels observes that the determinants of health as well as access to healthcare are unevenly distributed within and among different social groups. He says, "As a society, we distribute important goods – such as education, housing, jobs, income, wealth, opportunity, political participation, and a sense of community – very unequally across subgroups that differ by race, ethnicity, gender or class" (Daniels, 2008, p.13). These inequalities in distribution in turn have a disproportionate impact on particular segments of the population, particularly when they persist across several generations. Such inequalities have the effect of diminishing the opportunities available to certain persons and groups, and unjustifiably so. Thus, Daniels' focus on the moral significance of health in terms of its centrality to determining the opportunities available to a person (or lack thereof), takes a view of the individual that finds consonance with the Capabilities Approach, which seeks to expand the range of a person's capabilities. Daniels' view of health as a question of justice broadly considered from a population view also utilizes Rawls's justice as fairness – any distribution of these determinants of health must be fairly carried out without unjustifiable inequalities. Ensuring fairness in the equality of opportunity is therefore just as applicable to one individual as it is to the wider population and to the various groups within it. Daniels thus extends Rawls's theory of justice to health, locating the moral significance of health in its capacity to protect opportunity.

From Kant's deontological approach, health is morally significant because it enhances the dignity of humanity as well as agency. As Kant (2013, p.496) puts it, "The human being and in general every rational being *exists* as an end in itself, *not merely as a means* to be used by this or that will at its discretion; instead he must in all his actions, whether directed to himself or also to other rational beings, always be regarded *at the same time as an end*" (emphasis in original).

Being in ill-health affects the dignity and agency of a person in certain ways. From a biomedical perspective, ill-health, accompanied as it often is by pain, lethargy, vulnerability, anxiety, and sometimes physical incapacity, diminishes a person's vigour and ability to pursue one's life plans. The availability of healthcare for persons in ill-health would be integral to maintaining their bodily and mental wholeness or integrity, as well as their

capacity to convert or to will their thoughts or ideas into action. The dignity of the person is maintained, and her agency enhanced, by her capacity to create ideas and to conceive and execute her own plans, or those of others, should she so wish. The instrumental value of health is evident in the opportunity to pursue those things that give her life meaning.

Good health generally increases happiness by enabling one to participate in those activities that he deems to bring pleasure or good, to him. On one utilitarian view, however, health is also of non-derivative value[4]. According to Mill (1990, p.16), "The principle of utility does not mean that any given pleasure, as music, for instance, or any given exemption from pain, as for example health, is to be looked upon as means to a collective something termed happiness, and to be desired on that account. They are desired and desirable in and for themselves; besides being means, they are a part of the end."

Rozier (2016) provides a virtue ethics perspective on the importance of health. Noting that virtue ethics is at its heart concerned with building character, Rozier connects the central questions of virtue ethics – which he states to be " 'Who am I?' 'Who ought I become?' and 'How ought I get there?'"; with an account of structures of virtue. Rozier notes that these three questions "recognize the dynamic between being and doing" (Rozier, 2016, p.38), a view notable for its linguistic similarity to the question of what a person is 'able to be and to do' in the Capabilities Approach.

The 'beings and doings' of the Capabilities Approach have more to do with the ability of the person to act within a given environment or set of circumstances; or her capacity to extract fulfilment or benefit from a given commodity or a particular kind of life. Virtue ethics, on the other hand, focuses first on the kind of character that a person develops, and then on the kind of actions which flow from this character. Both character and its accompanying actions are what ultimately lead to human flourishing and the good life. Human flourishing has been

[4]If something has non-derivative value, it is worth having for its own sake; and not because its value is attributable to the value of something else. Good health is often considered to have non-derivative value – It is valuable in and of itself, quite apart from whatever having good health can enable one to do or have. According to Zimmerman and Bradley (2019), non-derivative value differs from intrinsic value in that intrinsic value, as traditionally understood, appears to be some particular way of understanding a non-derivative good: While all things that are said to be intrinsically good are non-derivatively good, it does not follow that all things that are non-derivatively good are also intrinsically good. That good health has non-derivative value holds, even though different persons might assign varying degrees of value to a question as to *how much* intrinsic value good health has. See Zimmerman and Bradley (2019) for a discussion on non-derivative, intrinsic and extrinsic value.

described by VanderWeele (2017, p.8149) as "doing or being well in the following five broad domains of human life: (*i*) happiness and life satisfaction; (*ii*) health, both mental and physical; (*iii*) meaning and purpose; (*iv*) character and virtue; and (*v*) close social relationships". According to VanderWeele, the five domains are the minimum, but not the comprehensive content of well-being; which can also include other aspects that may be important to a specific person – for instance, religion.

The use of 'doing and being' by VanderWeele, as well as by Sen and Nussbaum in articulating the Capabilities Approach is an indicator that *both* the internal state of a person, as well as the actions that the person performs, are morally significant. It is not enough for a person just to be well or healthy in the five domains of life – it is also important that this person is also able to *do* well. It will often be the case that a person who is well in his being will often be in a better position to do (act) well. The actions carried out by a person (or their omissions) are often the only way that one can determine whether a fellow human being is doing well or not. We might wonder whether there is something wrong when a colleague suddenly begins reporting late and unkempt for work, is unable to finish tasks which he could comfortably handle previously, or regularly makes errors which are unusual for his previous standard of work. These actions and omissions speak to a state of mind that could be addicted, anxious, afraid, depressed, overwhelmed, not well-rested, or the beginnings of diseases such as Alzheimer's. 'Being' and 'doing' well go hand-in-hand; since the internal state of mind or body of the individual impacts his actions.

Human flourishing in turn has a symbiotic relationship with agency. As Ruger (2012, p.36) states, "Human agency is constitutive of human flourishing, as people flourish by making their own decisions and choices". Human flourishing therefore contributes to agency as well as to the outworking of that agency through one's actions.

The Importance of Well-being

Well-being has been a concern of many persons through the ages. Aristotle considered well-being part of the good life, and connected it with happiness (1962, *NE,1*.1098b 10-25, trans. Ostwald).

Ransome (2010) observes that well-being is often taken to mean "what is good for a person overall". He notes three traditional categories of well-being: Firstly, hedonistic theories, which have as their focus the intrinsic value "of certain psychological states"; secondly, desire-satisfaction theories, which are concerned with the satisfaction of a person's desires or preferences; and thirdly, "objective list theories", which consider well-being not as the satisfaction of desires, or the worth of internal states, but as being derived from certain deontological perspectives (Ransome, 2010, p.42).

Ransome considers Sen's Capabilities Approach as a fourth category in which to consider well-being, stating that the concept of functionings which it employs has its roots in Aristotle's *ergon,* or human function, which Aristotle considers necessary for *Eudaimonia,* or perfect well-being (Ransome, 2010, p.44). Some of the indicators of well-being in the Aristotelian sense include having external goods (these can be likened to Sen's commodities); as well as "goods of the body and goods of the soul" (Ransome, 2010, p.45).

Aristotle, according to Ransome (2010), considers courage, self-control, and practical wisdom as part of well-being and the good life. Sen's version of the Capabilities Approach includes freedom as part of one's valuable functionings. Freedom in Sen's view is not considered merely as a lack of constraining factors, but as the "*opportunity* to achieve those things that we value, and have reason to value" (Sen, 2002b, p.585; emphasis in original). It is therefore not sufficient for a state to simply provide healthcare services, for instance, and do no more. The state must also ensure that other determinants that have a positive impact on health are also provided, and are promoted. Therefore, the availability and accessibility of safe and adequate shelter, for instance, is important for well-being; as is the opportunity to earn a decent income through work either in employment or for oneself. As Sen (1993, p.33) puts it, "the freedom to lead different types of life is reflected in the person's capability set. The capability of a person depends on a variety of factors, including personal characteristics and social arrangements". It is not enough to have courage or temperance, for instance, without the accompanying social arrangements that would enable the meaningful exercise of these personal characteristics through action, thereby actualising the capabilities of the person from which we can then gauge well-being.

Dodge et al., (2012, p.230) define well-being as "the balance point between an individual's resource pool and the challenges faced". They represent this definition visually in the form of

a see-saw, with well-being at the fulcrum and 'resources' and 'challenges' at either side of it. Both 'resources' and 'challenges' are each comprised of psychological, social, and physical elements; and the balance of these on either side is what determines the well-being of a person – their lack or presence on either side determining how the well-being of the person can dip and rise. A lack of balance (say where an individual is overwhelmed by challenges such as a lack of food and housing yet has no resources) could cause his well-being to diminish significantly. A person with an abundance of resources but no challenges could also find her well-being diminished – for instance, in her struggle to find meaning and purpose in her existence. Meaning and purpose is one of VanderWeele's five broad domains of human life that contribute to human flourishing (2017, p.8149).

A person who lacks a source of income can be said to be lacking a physical resource and therefore experiences a deficiency in one aspect of well-being. However, a person who has abundant sources of income but no ideas as to how he can utilise this income is arguably also lacking on the 'challenge' side of well-being. The idea of 'challenge' and 'resources' is one which Dodge et al., borrow and adapt from Hendry and Kloep's lifespan model of development; which although "not directly linked to wellbeing", demonstrates "challenges that an individual faces and in terms of how wellbeing is a fluctuating state" (Dodge et al., 2012, p.229).

Dodge et al., thus provide an account of well-being that demonstrates the necessity not only of psychological resources to a person, but also of external resources and social arrangements. The resources that a person has ideally ought to be sufficient to meet the challenges he faces; thus providing the opportunity for the person to take up capabilities of his own choosing and therefore enhance his well-being. As earlier argued, meaningful activities and not just resources are supported from a virtue ethics perspective.

Veenhoven (2012, p.64) says, (albeit with regard to the development and acquisition of skills for living, which he calls "self-actualization"): "Since abilities do not develop alongside idleness, this quality of life is close to the 'activity' in Aristotle's concept of eudaimonia." Opportunities (as well as freedom to take up or leave those opportunities) are necessary to gauge what each person is able to do and be in the Capabilities Approach. Challenges are necessary for the good life in virtue ethics. It would, for instance, be difficult to develop courage without having had to exercise courage in particular circumstances. These

opportunities and challenges correspond in many ways to the determinants of health; which include the social and economic environment; the availability of clean water and decent housing; caring for the environment; as well as opportunities to do meaningful work and to earn an income (World Health Organization, 2018l). Promoting the well-being of persons therefore must include the furthering, fostering and developing of opportunities and activities for their meaningful participation in what they consider to be a good life.

A good life can be objectively as well as subjectively ascertained. Varelius (2003, p.364) distinguishes between subjective and objective well-being; stating that while subjective well-being is often dependent on the person's view of how well or badly she is faring, objective list theories of well-being look at "whether a thing or an activity satisfies human needs; realizes human nature"; or otherwise meets certain criteria that persons perceive as being necessary for the good life. Varelius notes that while in bioethics subjective well-being has traditionally been the perspective from which a person's quality of life is assessed – that is, her own views as to whether her life is going well or poorly – objective well-being is just as important; for it is from this perspective that another person can determine in what ways, or how, her life *could have* gone better (emphasis mine). It is therefore possible to look at a given set of circumstances and determine, quite apart from the person's own perspective, whether her life is objectively good. Varelius offers an alternative view of objective list theories, noting that the intersubjective agreement of agents can also plausibly be used to gauge objectivity (Varelius, 2003, p.367). Thus the argument here is that the coincidence, or constancy, of various agents' subjective views of the good can be taken to be an objective view of what the good entails.

In the following paragraphs, I discuss the views of various authors which are representative of diverse ethical approaches towards well-being. Each view indicates which ethical approach is under discussion. I also analyse areas of commonality between (and criticisms of) the different ethical approaches.

With regard to utilitarianism, Harsanyi (1997) states that early utilitarians considered a person's utility level to be a measure of her well-being. This in turn was largely identified with the measure of happiness in the person's life. Harsanyi notes that latter theories, particularly in economics, attribute persons' choices to their preferences, rather than to their utility function; arguing that the concept of utility is simply "a convenient mathematical

representation of people's preferences" (1997, p.131). Harsanyi notes that while happiness might be considered to be subjective, "we desire also some objective outcomes in the outside world as important ingredients of a good life, such as an acceptable level of economic well-being and of social standing, some success in our various endeavors, worthwhile accomplishments, as well as other people's love and respect" (Harsanyi, 1997, p.131).

Seeking one's own well-being is not incompatible with promoting the well-being of another. As Harsanyi states, "We desire not only our own happiness but also that of many other people we care about" (Harsanyi, 1997, p.131). It might very well be that one's well-being is influenced in a great way by the well-being of others that one cares about. It is quite plausible to imagine a situation where illness or the lack of employment of a loved one weighs heavily on one's mind, thereby causing worry and diminishing their sense of inner peace.

Anderson (1991) articulates a view of happiness which states that each individual will place different value on various activities. Anderson argues that, "An individual's conception of happiness governs her estimate of the relative worth and priority she is to give to different kinds of pleasure. It includes a conception of other values realized in a life – dignity, independence, nobility, beauty – as different kinds of pleasures" (1991, p.11). It may well be the case that for many persons and communities, happiness is found in participating in activities that they find worthwhile. With regard to the SDGs, for example, an individual might find great happiness simply by participating in activities that are geared towards advancing the goals, because she finds the goal worthwhile. Her happiness may not be reduced even if the goals were not met but progress was still being made. From a utilitarian perspective, however, there is bound to be *more* happiness if her participation in actions that are geared towards the SDGs culminates in the achievement of the goals.

If the human individual is worthy of moral concern, then it is not only the well-being of those one cares about that ought to matter, but the well-being of unknown or distant others, who are also persons worthy of moral concern. This argument was robustly made by Peter Singer in his seminal paper, *Famine, Affluence and Morality* (1972). Consider the example of a person who has a great abundance of wealth and physical resources, but is surrounded by a community that has serious poverty and deprivation. The wealthy person might be deprived of other aspects of well-being – for instance, having a social connection with his community or enjoying some of the simple pleasures of life such as taking a leisurely walk, if he fears being

robbed should he venture out of his fortress. Should the wealthy person advocate for, or participate in promoting the well-being of the community around him, it is arguable that these other-regarding considerations would still, in true utilitarian fashion, result in all persons being collectively better off, particularly if their own well-being – both subjective and objective – were taken into account. This would still hold if the wealthy person's sole concern in promoting the well-being of the community was his own self-interest.

Ashford (2000) analyses the oft-stated criticism of utilitarianism, which is that it requires obligations of agents that are too onerous. She notes that the situation in the world is such that so many persons are in such dire straits of poverty or want, that their situation can be considered an emergency that moral agents ought to attend to as a matter of urgency. The moral agent, who also has her personal projects to attend to, will often be compelled to choose between giving assistance in this urgent situation; and pursuing her personal projects. Given the consequences of failing to help persons in great need (which include death and morbidity) Ashford states that utilitarianism, in contrast to other theories, "makes this conflict explicit, by emphasizing the moral seriousness of omissions"; stating further that:

> In the current emergency situation, in which relatively affluent agents are continually in a position to save others' vital interests ... tragic trade-offs are constantly taking place between central aspects of persons' well-being. The irresolvable conflict between agents' personal and moral commitments is the result of these trade-offs (Ashford, 2000, p.435).

These tragic trade-offs imply that an affluent agent is constrained to give up the pursuit of her own projects in order to help other persons in need of help. To the extent that such trade-offs result in the vanishing of the relatively affluent agent's own capability to pursue her personal projects, they are to be avoided; for the well-being of one person ought not to be promoted at the expense of another. The situation I have in mind is one where the relatively affluent agent can no longer pursue any personal projects because all her time and resources – (at least to an extent that leaves just enough to meet her bare necessities) – are going towards attempting to meet the needs of other persons. Only a person who is "extraordinarily altruistic" as Ashford puts it, would choose to live this kind of life (Ashford, 2000, p.435). Since this kind of extraordinarily altruistic life is not one that everybody would prefer, Ashford states that, "The only solution to this conflict is the eradication of extreme poverty, which is the most urgent

goal of utilitarianism because of the extremity and scale of the suffering it causes" (Ashford, 2000, p.435).

For Bentham, an action conformed to the principle of utility to the extent that it increased the happiness of the community to a greater extent than it diminished it. Bentham considered the happiness of the community to be the sum total of the interests of its members (Bentham, 1990). Actions that serve to reduce the extent of poverty, rather than increase it, and enhance opportunities for education in a community, for instance, can be defended as having utility. There is therefore a congruence of utilitarianism with the SDGs to the extent that they seek to eradicate extreme poverty, encourage co-operative action among states and individuals, and promote the well-being of all at all ages.

Given the consensus amongst the 193 states that adopted the SDGs, the goals represent an opportunity to begin tackling health challenges collaboratively. As Jha et al., (2016) state, "SDGs have the potential to be a game changer in global health – a platform and mechanism to greatly improve the health and wellbeing of the world's population". Further, the importance of health for the achievement of sustainable development in its three dimensions of social, economic and environmental, was earlier acknowledged by the heads of state and government in the outcome document from the Rio +20 Conference in 2012; formally known as Resolution 66/288 and titled '*The Future We Want'*. Part of its paragraph 138 states as follows:

> We recognize that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development. We understand the goals of sustainable development can only be achieved in the absence of a high prevalence of debilitating communicable and non-communicable diseases, and where populations can reach a state of physical, mental and social well-being (United Nations General Assembly, 2012).

The leaders further urged "action on the social and environmental determinants of health", in order to "create inclusive, equitable, economically productive and healthy societies" (United Nations General Assembly, 2012). In this way, the connection is made between health and the other Agenda 2030 goals, which also serves to strengthen the interconnectedness of the goals.

Immanuel Kant (2013) also makes a case for showing concern about the well-being of others, and assisting them when in need. Kant argues that a law in which each person cared only about his own welfare but not about the welfare of others could not become a universalisable law, since one would not want the same sort of uncaring attitude to befall him in his hour of need. Whether a particular action can become a universalisable law or not involves the agent asking himself whether that action conforms to the principle that "I ought never to act except in such a way that I could also will that my maxim should become a universal law" (Kant, 2013, p.488). In other words, should my actions "hold as a universal law (for myself as well as for others)?" (Kant, 2013, p.489). As Kant states regarding a person who stood nonchalantly by as others suffered:

> It is still impossible to will that such a principle hold everywhere as a law of nature. For, a will that decided this would conflict with itself, since many cases could occur in which one would need the love and sympathy of others and in which, by such a law of nature arisen from his own will, he would rob himself of all hope of the assistance he wishes for himself (Kant, 2013, p.494).

Seeing to it that the well-being of others is fostered also buttresses Kant's position that a person must be treated as an end in himself and not merely as a means to an end. Kant states:

> Now, humanity might indeed subsist if no one contributed to the happiness of others but yet did not intentionally withdraw anything from it; but there is still only a negative and not a positive agreement with *humanity as an end in itself* unless everyone also tries, as far as he can, to further the ends of others. For, the ends of a subject who is an end in itself must as far as possible be also *my* ends, if that representation is to have its *full* effect in me (Kant, 2013, p.497) (Emphasis in original).

It is not enough, as Kant explains, to simply let the world be; to focus solely on one's own interests, and let the chips fall where they may. Each person has a duty to further the well-being of others.

Well-being is of great importance from the perspective of Ubuntu, a philosophy which has its roots in African communitarianism. The word 'ubuntu' is usually associated with the word for

humanness in southern African languages such as Zulu, Xhosa and Ndebele (Mabovula, 2011; Metz, 2016; Mnyaka & Motlhabi, 2005). However, as Eze (2008) notes, ubuntu is a word with variants amongst the Bantu-speaking people of sub-Saharan Africa. One example from Kenya is the word '*mtu'* – It is the Swahili word for person. It is expressed as '*mũndũ'* in the Kikuyu language and as *mundu* in the Tiriki language – just two of the Bantu languages spoken in Kenya. The Swahili saying "*Mtu ni watu"* roughly translates to "a person gains relevance through other persons". It corresponds fairly well to what in Ubuntu is considered an acknowledgment of the interconnectedness of one human being to the other – usually captured in the phrase "I am because of who we all are" (Mugumbate & Nyanguru, 2013, p. 83). The values espoused by Ubuntu are however not confined to Bantu language speakers, but also find expression in other communities of sub-Saharan Africa (Eze, 2008; Mdluli, 1987; Metz, 2016).

Among the values embraced by Ubuntu are "a deep allegiance to the collective identity"; as well as "sensitivity to the needs and wants of others, the understanding of others' frames of reference and man as a social being" (Mabovula, 2011, p.40). Metz (2016, p.138) notes that Ubuntu places emphasis on relationships of identity – in terms of "considering oneself part of the whole, being close, sharing a way of life, belonging and integrating with others", as well as relationships of solidarity, which he describes as "achieving the good of all, being sympathetic, acting for the common good, serving others and being concerned for others' welfare" (Metz, 2016, p.138).

For Kamwangamalu (1999, p.27), communalism, one of the core values of Ubuntu, holds that, "the good of all determines the good of each or, put differently, the welfare of each is dependent on the welfare of all". Eze states that, "Accordingly, a person's humanity is dependent on the appreciation, preservation and affirmation of other persons' humanity ... To be a person is to recognize therefore that my subjectivity is in part constituted by other persons with whom I share the social world" (2008, p.387).

Ubuntu therefore places great value on a person's participation in the life of the community, as well as his contribution to advancing the good of the community. Since the person's well-being is inextricably bound up with that of the community, the person enjoys a good life to the extent that his activities and relationships also advance the good of the community. From the perspective of Ubuntu, the pursuit of personal projects would therefore not be of value if

this pursuit resulted in the person shirking his responsibility to foster the good of the community. What is esteemed in the Ubuntu way of living is that the person carries out his *role* in the community. Such roles are sometimes formally assigned; may arise simply as a result of the needs of the community; or through one's social position within the structure of the community. Older persons, for instance, are called upon to give guidance and advice in times when clarity on an issue affecting the community is needed. Carrying out one's responsibilities in the manner expected of such a role-bearer in that community results in the well-being of the role-bearer as well as that of the community. The role-bearer finds meaning in fulfilling the responsibilities he has well; and also receives gratitude and respect from the community. The members of the community in turn have their well-being and their interests taken care of through the contribution of each one, as well as others, to the whole. As Eze puts it:

> In advancing the good of the community, the individual's good is concomitantly advanced precisely because the community's and individual's goods are not radically opposed but interwoven. The community is a guarantor of my subjectivity, whereas I guarantee the community's survival by advancing its constitutive goods, knowing that if the community hurts, it is the individual that hurts (2008, p.388).

From the perspective of Ubuntu, the well-being of one individual need not be achieved at the expense of others in the community, but in concert with them. The individual's own well-being then is the outcome of his or her actions that are aimed at meeting the well-being of others. The implication of the Ubuntu way of life is that it is through meeting the needs of others that the individual finds his own fulfilment.

In contrast to Ubuntu, from which a person derives significance through his interactions, roles, activities and relationships with other persons in the community, cosmopolitanism takes a broader, if more abstract perspective, since it considers even distant others as being of moral concern. This is not to say that Ubuntu does not consider strangers to be of moral concern. However, the locus from which a person demonstrates humanness in Ubuntu is more closely circumscribed, given its relational and collaborative nature. Cosmopolitanism, on the other hand, takes as its starting point the realities of globalization – the interaction and movement of people, goods, services and the like – and recognises that decisions made by a few can have

wide-ranging effects on others, regardless of geographical distance. As O'Neill (2000, p.187) puts it, "Some action and some moral relations can link millions of distant strangers ... If there is now no *general* reason to suppose that distance obstructs action, or that action must affect or respect only a few, there is no *general* reason to think that justice or other moral relations between vast numbers of distant strangers are impossible" (emphasis in original).

Eze (2017, p.86) describes the picture of the cosmopolitan that often comes to mind – a "global denizen with a sophisticated outlook about the world". Eze traces cosmopolitanism's origins to the Stoic ideal of a community of citizens bound by their shared humanity and rationality.

Pogge draws a distinction between legal and moral cosmopolitanism. He notes that legal cosmopolitanism focuses on a "political ideal of a global order under which all persons have equivalent rights and duties". Moral cosmopolitanism "holds that all persons stand in certain moral relations to one another ... every human being has a global stature as a unit of moral concern" (Pogge,1992, p.49). Since human beings interact with each other even at great distances, there is a need for coherence and a common understanding if cosmopolitanism is to live up to its ideals of ensuring that every human being is of equal moral concern. Pogge (2012) argues that one of the ways in which cosmopolitan ideals can be applied is through "the demand that social institutions ought to be designed so that they include all human beings as equals" (Pogge, 2012, p.313); and then "by directing social institutions as well as the conduct and character of human agents to one common goal" (2012, p.314).

With regard to Agenda 2030, individuals, states, and non-state actors all have a role to play in achieving the SDGs. The global focus of the SDGs also advances cosmopolitan ideals. Our respect for each person as being worthy of moral concern ought to inform how we express that moral concern. Since persons who are of equal moral concern are dispersed far and wide around the globe, efforts to give assistance where we are in a position to help, as well as to set standards for what we ought to do to actualise each person's well-being, are best carried out collaboratively with other states and institutions.

Parekh (2003, p.9) argues that:

> Pursuing goals that damage others' well-being and prevent them from leading minimally decent lives violates their equal rights to their well-being, and is inherently illegitimate. Furthermore, when others are prevented from pursuing their well-being by circumstances beyond their control, such as exiguous natural resources, poor technology, civil war, and a tyrannical form of government which they cannot easily dislodge, they need our help, and we have a duty to give it.

The primary concern in a cosmopolitan outlook is therefore the status of every human being as one who is worthy of moral concern, and taking such actions as would ensure that the well-being of each is realised.

Summary

The philosophical approaches analysed above offer a broader view of health and well-being from the perspective of the individual. I have justified analysing diverse philosophical approaches by arguing firstly, that various approaches are necessary in order to capture the broadest conception of individual health and well-being that is possible. Secondly, different individuals across the globe will identify with or experience health and well-being differently, as a result of each person's specific geographical, cultural, religious, educational, social, economic, and other contexts.

Kant's and Kantian deontological perspectives, the Capabilities Approach, virtue ethics, cosmopolitanism, Ubuntu and Daniels's extension of Rawls's justice as fairness are all supportive of viewing the effect of actions from the position of their possible impact on the health and well-being of the individual.

It is important to recognise the paradox that this view of health and well-being from the perspective of the individual is largely other-regarding; in the sense that an agent's or actor's actions fall to be considered against their effect on another's health and well-being. Put differently, the question as to what effect an agent's or actor's actions have on *another* person will often determine whether the health and well-being of the individual – the *other* – has been taken into account. This is not to say that self-regarding actions are of less importance.

As the virtue ethics perspective shows, for instance, it is the kind of character that an individual has built within himself that informs the kinds of actions that such an individual will take towards others. The actor or agent is himself not bereft of benefit on this view, since a person with a sense of empathy and who exhibits courage, for instance, is likely to better recognise and take action on injustices and barriers to health and well-being that affect him and others.

While the utilitarian approach often favours actions that will produce the greatest happiness for the greatest number of people, health and well-being are still considered to be of value and therefore are worth having since they add to the count for the greatest happiness for the greatest number. Further, utilitarianism clearly shows the need for collective action among a greater number of people if health and well-being for each person (and consequently for all persons) are to be achieved. Without such collective action, there would be a counter-productive diminishing of the health and well-being of those individuals who are taking on the disproportionate burden of striving to meet the needs of those in dire situations while abandoning their own personal projects in the process.

A broader perspective that considers health and well-being at the individual level therefore requires the collaborative efforts of different countries and agents around the world; not least because the experiences of globalization by individuals across the world may vary depending on their geographical location, cultural context, levels of education, economic resources, and other factors which include the determinants of health.

Section II: Social justice and the determinants of health in Agenda 2030

In this section, I show how Agenda 2030 has linked social justice considerations to the determinants of health. This is an improvement over the Millennium Declaration, which as discussed in Chapter 1, had a narrow focus on the economic aspect of poverty alleviation, and also failed to ensure the meaningful participation of countries in the global South when setting the goals to be followed. I argue that social justice concerns are crucial to any decisions taken by states and other agents concerning the availability and distribution of the determinants of health, since these have an impact on individual health and well-being. I then make the novel

claim that determinants of health that have incorporated social justice considerations are the crucial link between the wider view of an individual's health and also his well-being broadly conceived and as analysed from diverse philosophical approaches.

Reading through Agenda 2030 reveals several mentions of the words 'just' and 'justice' in various paragraphs. There are also paragraphs which frame issues in terms that are often associated with justice, such as 'equity' 'empowerment' and 'participation'. All the references in the following two paragraphs are to Agenda 2030 (United Nations General Assembly, 2015), unless otherwise indicated.

In the Preamble to Agenda 2030 under the sub-heading 'Peace', is a commitment to "foster peaceful, just and inclusive societies which are free from fear and violence" (p.2). Paragraph 3 resolves "to build peaceful, just and inclusive societies"; while paragraph 8 envisages "A just, equitable, tolerant, open and socially inclusive world in which the needs of the most vulnerable are met". Paragraph 35 "recognizes the need to build peaceful, just and inclusive societies that provide equal access to justice and that are based on respect for human rights (including the right to development)".

Other paragraphs which allude to considerations of justice although not explicitly using the word, include paragraph 7, which envisages "A world with equitable and universal access to quality education at all levels, to health care and social protection"; paragraph 23 which seeks to ensure that vulnerable people are empowered; paragraph 27 which promises to work towards the sharing of wealth and addressing income equality; and paragraph 44 on "broadening and strengthening the voice and participation of developing countries". The Preamble to Agenda 2030 pledges "to leave no one behind", and declares (under the sub-heading 'Prosperity'), that states are determined "to ensure that all human beings can enjoy prosperous and fulfilling lives".

The framing of various issues in the above paragraphs in terms of social justice shows just how widely applicable issues of social justice are to human life. Just from the paragraphs in Agenda 2030 extracted above, it is clear that social justice ought to be considered in the provision of education, healthcare, social protection, the distribution of income and wealth, participation in decision-making bodies, access to justice (in terms of the legal system), and opportunities for earning an income. However, the determinants of health discussed above in

the context of Agenda 2030 by no means constitute an exhaustive list of the determinants of health in which social justice is applicable. Other determinants are access to clean water and energy, decent housing, nutritious food, and many others which are also included in Agenda 2030 as part of the SDGs.

In the next section, I carry out an ethical analysis of the social justice considerations that are relevant to Agenda 2030, focusing in particular on Rawls's justice as fairness, and justice as restoring equilibrium. I show the importance of distributing social goods fairly, arguing that while the law can help to an extent in setting the rules for such a distribution, *how* such laws and/or rules come into being also matters. These laws and/or rules must have been arrived at in a manner that shows fairness to affected persons both in terms of *substance* (what is ultimately done) as well as in *procedure* (the process of arriving at what was to be done). Lack of fairness in either substance or procedure could be a pointer to a lack of fairness overall.

i. Justice as fairness:

John Rawls in his book, *A Theory of Justice*, describes principles from which a society might begin to consider certain rules of conduct in order to advance the good of persons in that society. The participants in this society must decide on how their various interests are to be met, and how conflicts will be resolved.

Of necessity, this will be a cooperative endeavour since, as Rawls puts it, "social cooperation makes possible a better life for all than any would have if each were to live solely by his own efforts" (Rawls, 1971, p.4). For Rawls, then, 'justice as fairness' consists in the principles that a society might formulate to determine how fundamental rights and duties, economic opportunities, assets, advantages and disadvantages – both natural and acquired – and other benefits and burdens, are to be distributed.

Rawls argues that there are two principles that the society would choose: Firstly, that "Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all" (Rawls, 1971, p.302). He refers to this as the 'Principle of Greatest Equal Liberty' (Rawls, 1971, p.124).

The second principle entails that, "Social and economic inequalities are to be arranged so that they are both a) to the greatest benefit of the least advantaged [the 'Difference Principle']; and b) attached to offices and positions open to all under conditions of fair equality of opportunity" (Rawls, 1971, p.83) ['the Principle of Fair Equality of Opportunity']. Rawls, despite his formulation, considers the Principle of Fair Equality of Opportunity as being prior to the Difference Principle (Rawls, 1971, p.303). Since the two principles are designed to ensure that distribution is fairly done, they focus on the rightness of the distribution and not on maximising good; although the maximising of the good could be a foreseeable result of the application of the principles.

Rawls states that his principles are applicable primarily to institutions of a democratic nature, and not particularly as a general moral conception (Rawls, 1985, pp.224-225). There have since been numerous critiques of Rawls's two principles, including from Hart (1973); Martin (2015); and Pogge (1994; 2004). Pogge, for instance, states that some of Rawls's ideas would have to be adapted to fit into a more interdependent world (1994, p.197). Pogge also highlights contradictions in Rawls's position that "endorses normative individualism domestically but rejects it internationally" – Normative individualism being "the view that, in settling moral questions, only the interests of individual human beings should count" (Pogge, 2004, p.1744). Pogge's criticism is supportive of my position argued earlier that health and well-being ought to be considered from the individual's perspective. What Pogge criticises is a stance that advocates concern for some human beings to the exclusion of others.

Rawls's two principles however still hold relevance for assessing actions taken by states, or by institutions on behalf of states, to the extent that they can demonstrate the fairness or lack thereof, of these actions. Thus, while Rawls considers his theory of justice not to apply internationally, I show, in the following discussion, how Rawls's theory can in fact be extended more broadly to apply to assessing fairness and equality of opportunity globally.

Justice as commonly understood, conveys "the quality of being fair and reasonable"; with synonyms such as 'validity', 'soundness', and 'legitimacy' (Oxford Living Dictionaries, 2018). An impartial observer looking at a specific action in relation to an agent ought to consider it sound and well-founded. The consequences of particular actions or decisions on agents, jointly and severally, should be proportionate and defensible if those actions and decisions are to be considered just. A government intending to compulsorily acquire land, for

instance, must ensure that the acquisition is necessary; that the process of acquisition is transparent and explicable; that the affected landowners are fairly compensated; and that the landowners are relocated humanely, or otherwise granted sufficient opportunity to relocate. A failure in any of the procedural or substantive aspects of compulsory acquisition will be likely to taint the validity and legitimacy of the state's actions in relation to the affected landowners, who are likely to conclude that justice has not been served.

SDG16 specifically calls for states to "provide access to justice for all and build effective, accountable and inclusive institutions at all levels" (United Nations General Assembly, 2015, p.25). Some of the targets for this goal include promoting the rule of law at national and international levels (Target 16.3); the development of "effective, accountable and transparent institutions at all levels" (Target 16.6); and ensuring "responsive, inclusive, participatory and representative decision-making at all levels" (Target 16.7). This goal and its targets is one example of *prima facie* conformity with Rawls's principles on equal liberty. SDG16 would also have application in a situation where it was necessary to determine whether actions or decisions taken by a state were fair.

Justice does not therefore simply consist in the decision ultimately rendered, but is the totality of antecedent actions as well as the outcome – particularly with regard to proceedings of a judicial nature. Justice considers both the result as well as the process leading up to it; the embodiment of which is most often captured and expressed in the concept of 'natural justice'. Natural justice in turn is characterised by two major principles: "The first, *audi alteram partem*, relates to the right to be heard; the second, *nemo debet esse judex in propria sua causa* or *nemo judex in re sua*, establishes the right to an unbiased tribunal" (Schauer, 1976, p.48). The right for parties involved to be given notice of a hearing, to be sufficiently informed of the case against them and to mount their own case are some of the procedures that characterise the practical outworking of the two natural justice principles (Schauer, 1976; Groves, 2013). These two principles certainly accord with Rawls's first principle of equality of opportunity.

With regard to national and international institutions, justice as fairness can be applied to determine whether there are governance structures that are exclusionary and are impeding the participation of certain individuals in decisions that affect them. Situations in which there are

actual or potential conflicts of interest involving persons in a decision-making role ought also to be analysed in terms of fairness.

Rawls's second principle of justice can plausibly also be extended to apply to situations requiring the global co-operation of states (Kuper, 2000). If we consider developing countries the least advantaged – at least in terms of economic power and influence – then the lack of fair representation on the boards of influential decision-making institutions excludes their contribution. These countries also do not have fair equality of opportunity when the rules for getting representation in institutions such as the World Bank favour particular developed countries in terms of procedure, as well as in numbers, as I will show in Section III.

Agenda 2030 does fall short in some crucial aspects of justice as fairness, particularly on issues touching on economic and financial measures that negatively affect developing countries. An example is Paragraph 30 of Agenda 2030:

> States are strongly urged to refrain from promulgating and applying any unilateral economic, financial or trade measures not in accordance with international law and the Charter of the United Nations that impede the full achievement of economic and social development, particularly in developing countries (United Nations General Assembly, 2015, p.8).

"Strongly urged to refrain" does not seem have the requisite force in terms of language that conveys the seriousness of impeding developing countries' growth and development in social and economic terms. It seems to allow room for such measures to be applied to developing countries (albeit perhaps as a last resort). Phrases such as "States resolve not to ..." or "States undertake not to ..." would have more robustly communicated the gravity of applying disadvantageous economic and financial measures to developing countries. Since Agenda 2030 is not legally enforceable, the language that is used in it ought to have the appropriate weight to convey the effects of particular actions.

Another indication that Agenda 2030 skirts the issue of economic and financial reform is in Target 16.8. Despite committing to "Broaden and strengthen the participation of developing countries in the institutions of global governance", there are no further details as to what

measures will be taken towards this end. This raises concerns as to the resolve of states towards the reform of these institutions.

ii. Justice as restoring equilibrium:

Giving priority to the worst off shows an attempt at the redress of inequalities which, for historical or other reasons, have made it more difficult for certain persons to have access to the determinants of health (and therefore to social justice). Rachels (1997) refers to 'special treatment', with the context in which he uses this phrase indicating that certain circumstances call for peculiar, or atypical treatment of the agents at whom such action is directed. As Rachels puts it, "If we were to stop thinking of people as deserving or undeserving of special treatments, our moral outlook would be unrecognizably different" (Rachels, 1997, p.2). This is certainly true. Inasmuch as justice conceives of treating persons in the same way as others, justice also supports dealing with other persons differently from what would ordinarily be expected.

Affirmative action in university admissions is one instance where states might attempt to restore equilibrium. Another example is the reservation of certain quotas in government tenders for specific groups, ostensibly because such groups have traditionally suffered discrimination in the award of these tenders. An example is a government policy in Kenya that reserves 30% of government contracts for women, youth and persons living with disabilities (Access to Government Procurement Opportunities, 2017).

In Agenda 2030, justice as restoring equilibrium is discernible in Paragraph 4, which pledges to leave no one behind, and to endeavour "to reach the furthest behind first" (United Nations General Assembly, 2015, p.3). Paragraph 20 pledges a significant increase in investments that will close the gender gap, strengthen gender equality, and "empower women at the global, regional and national levels" (United Nations General Assembly, 2015, p.6). SDG5 gives further details as to how the restoration of equilibrium is to be achieved through its targets, including Target 5.1 that calls for the ending of all forms of discrimination against women and girls, and Target 5.5 in which states should ensure the"full and effective" participation of women in leadership and decision-making at all levels of political, economic and public life (United Nations General Assembly, 2015, p.18).

This apparent paradox where justice treats persons differently can be explained in another way: that justice conceives of treating persons in the same way as others, *all things being equal*. Where all other things are *not* equal, the corollary to this statement then becomes that persons who have been treated disadvantageously by others, or suffered disproportionately negative consequences as a result of the acts or omissions of others, are entitled to recompense for their disadvantage. Those persons who have gained advantage, particularly at the expense of others, should be alive to the distorting effect of such acts and omissions, and the obligation, from a moral point of view, to try and find some equilibrium between the disadvantaged and the privileged. In this, Aristotle's description of the 'unjust man' comes to mind:

> An unjust man does not always choose the larger share. When the choice is between things which are without qualification bad, he chooses the smaller. However, since the lesser evil seems in a sense to be good, and since taking a larger share means taking a larger share of the good, he seems to be a self-aggrandizer. He is unfair, for "unfair" includes and is common to both (taking more than one's share of the good and taking less than one's share of the bad). (Aristotle, *NE,*5.1129b7-12, trans. Ostwald).

The broad proposition that there is a moral obligation to restore equilibrium between disadvantaged and privileged persons needs to be considered with an eye to future obligations as well; for the consequences of some kinds of unjust treatment, such as prolonged racial discrimination, have an impact over several generations, with such impact extending to communities and other societal groups. The apparent paradox of justice as the 'same treatment of persons' and justice as 'different treatment of persons', is then dissolved by cognizance of the fact that even where justice advocates as a starting point 'special treatment' for certain persons, the rationale, as well as the expected end point, is to ensure that in dealings with various persons, even over generations, equilibrium is maintained or restored.

Justice thus remains true to its ultimate goal of similar treatment for similar actions – with dissimilar treatment allowed only to the extent that it advances the restoration of equilibrium for and between persons, institutions and states.

iii. Linking the determinants of health to individual health and well-being:

Having established that social justice considerations are integral to the availability and distribution of the determinants of health, I now set out my case that determinants of health which incorporate social justice considerations are the pivotal link between the wider view of an individual's health, and his well-being, broadly conceived. This holds true even when health and well-being are analysed from diverse philosophical approaches, as I have already shown.

I have justified this analysis which incorporates diverse philosophical approaches by arguing that it captures a broad variety of conceptions of health and well-being that might be understood and experienced by different individuals across the globe, as a result of each person's specific geographical, cultural, religious, educational, social, economic, and other contexts.

Social justice considerations are evident in Rawls's justice as fairness, which seeks to determine how the various interests within a society shall be fairly met. The distribution of rights and duties, as well as benefits such as assets, economic, educational, political and other opportunities is considered, as is the distribution of burdens. Fairness in legal and administrative procedures, and in the decisions ultimately rendered therefrom, is also a part of justice as fairness. Consideration is given for the least advantaged persons, so that any distribution of benefits and burdens is to their benefit. In Agenda 2030, the principles of justice as fairness are evident in various provisions, and also in the SDGs which call for a just distribution of the determinants of health such as access to safe and adequate housing, clean and safe water, the protection of the environment, and also inclusive economic growth, education, and industrialization for all.

Justice as restoring equilibrium recognises the invidious effects of certain actions and policies on particular persons, who are then subjected to disadvantages such as discrimination, racism, poverty, and a lack of opportunities as a result of these actions. These disadvantages have a negative impact on the affected individual's health and well-being. Being denied a promotion at work because one is a woman, for instance, or not being considered for elective office solely because of one's race, can have adverse effects such as anxiety disorders, distress, loss of economic opportunities, and exclusion from social and political participation. Justice as

restoring equilibrium seeks to mitigate these disadvantages and their generational effects through policies such as affirmative action in employment or in educational opportunities. In Agenda 2030, justice as restoring equilibrium is clearly discernible in the call to 'leave no one behind'; in the emphasis on empowering vulnerable people; and in the commitment by states to give assistance in resolving the special challenges faced by African countries, least developed countries, landlocked countries and small island developing states. Such assistance includes strengthening such countries' statistical capacities as indicated in paragraph 48 of Agenda 2030, and developing their research capacity and marine technology under SDG14 (United Nations General Assembly, 2015).

The determinants of health – the social, economic, environmental, and other factors that influence how well a human life is lived – are what provide the inextricable link between individual health, and also well-being as viewed from various philosophical approaches. The availability and distribution of these determinants of health must however have considerations of social justice embedded in them, an argument which I have established using Agenda 2030. This is a novel contribution. While there have been arguments made which link the determinants of health to how well a human life is lived[5], there has been no explicit link made between Agenda 2030, the determinants of health, and their role in well-being as conceived from ethical approaches as diverse as the Capabilities Approach, cosmopolitanism, Kant's deontology, virtue ethics, utilitarianism, and Ubuntu.

Without incorporating justice as fairness, and a determination to restore equilibrium into the determinants of health, individuals' health will be negatively affected through, for instance, anxiety disorders, distress, loss of economic opportunities, and exclusion from social and political participation – all of which can have effects that persist across generations.

Summary

Social justice considerations are crucial to the selection, availability and distribution of the determinants of health. Given the diverse social, economic, educational, cultural, environmental and other contexts with which individuals interact daily, it is important for the

[5]See, for instance, Daniels (2008); Venkatapuram (2007); Venkatapuram & Marmot (2009).

determinants of health to be made available and distributed with these various contexts of human life in contemplation. Considerations of social justice which take into account fairness and restoring equilibrium ensure that decisions concerning the determinants of health are not only arrived at through a fair and justifiable process, but that ultimately, the determinants of health to which priority is given are made available and distributed in a manner that enhances individual health and well-being.

Agenda 2030 frames many of its provisions in a language that indicates that considerations of social justice and its related concepts such as equity, inclusivity, empowerment and participation have been taken into account. My application of the Rawlsian conception of justice as fairness, and my discussion of justice as restoring equilibrium indicates their usefulness for analysing the determinants of health, and for considering whether their availability and distribution takes into account the different life circumstances and contexts in which various individuals across the world find themselves. It is therefore crucial that a view of individual health and well-being incorporates not only a perspective from diverse ethical approaches, but also considers determinants of health within which social justice considerations have been embedded.

Section III: Sustainable actions and Agenda 2030

Agenda 2030 in paragraph 2 considers "eradicating poverty in all its forms and dimensions, including extreme poverty" to be "the greatest global challenge and an indispensable requirement for sustainable development" (United Nations General Assembly, 2015, p.3). Sustainable development in Agenda 2030 is viewed from three dimensions: economic, social and environmental, all of which ought to be achieved in a balanced and integrated manner (United Nations General Assembly, 2015, p.3). Eradicating poverty is again emphasised in paragraphs 13 and 24 of Agenda 2030. As argued in Chapter 1, the effects of globalization on the individual include exclusion from social and economic aspects of life, a sense of powerlessness in changing the negative effects of globalization, and physiological risks to health and well-being. It is therefore apt to examine whether Agenda 2030 can *prima facie* provide a remedy for such exclusion and powerlessness and mitigate risks to health.

If the greatest global challenge in Agenda 2030 is eradicating poverty, a look at the financing structures that are supposed to show solidarity with the poorest and with those in vulnerable situations will also be necessary. In paragraph 41 of Agenda 2030, states acknowledge that, "Public finance, both domestic and international, will play a vital role in providing essential services and public goods and in catalysing other sources of finance" (United Nations General Assembly, 2015, p.10). It is not sufficient to simply state that states 'are determined' to achieve the eradication of poverty, as is emphasised several times in the Preamble to Agenda 2030 (United Nations General Assembly, 2015, p.2), as well as in subsequent paragraphs such as paragraph 33. From a point of view of social justice, the existing financing structures which would have an impact on the eradication of poverty from a social, environmental, and economic perspective ought to be examined.

In addition to examining whether the prevailing financing structures accord with the stated objectives of Agenda 2030, I claim that a focus on the health and well-being of the individual must of necessity also involve an examination of the intentions, motives, and reasons for carrying out particular actions. I argue that the sustainability of actions is informed by the motives and intentions that are prior to, or that lead to those particular actions. Thus, while there may be many reasons for carrying out particular actions (making a profit, or simply for altruistic purposes), the sustainability of those actions that would have a positive impact on individual health and well-being will depend on the intentions and motives that inform them.

i. Examining the structures of international financial institutions

In paragraph 44 of Agenda 2030, countries "recommit to broadening and strengthening the voice and participation of developing countries – including African countries, least developed countries, landlocked developing countries, small island developing States and middle-income countries – in international economic decision-making, norm-setting and global economic governance" (United Nations General Assembly, 2015, p.11). The use of the word 'recommit' implies that efforts at inclusivity have been made before, but did not succeed. A look at the governance and institutional structure of some of the global financial institutions points to why this failure may have occurred.

Agenda 2030 envisages official development assistance (ODA) as well as debt financing, debt relief, and debt restructuring as being key ways of strengthening the capacity of developing

countries to meet their resource mobilization obligations (United Nations General Assembly, 2015, p.26). The criteria that international financial institutions use to assess whether a country qualifies for debt relief is that set by the World Bank, the International Monetary Fund and other multilateral, bilateral and commercial lenders under the Heavily Indebted Poor Country (HIPC) Initiative (World Bank Group, 2018b). The composition of the boards of these decision-making institutions raises plausible questions as to the fairness of representation for all member countries, and hence the fairness and inclusivity of the criteria used to decide on debt-cancellation or increased development assistance.

One example is the World Bank, which likens itself to "a cooperative" and is made up of 189 member countries which are represented by a Board of Governors described as "the ultimate policymakers" (World Bank Group, 2018d). The Board of Governors, generally comprising the "member countries' ministers of finance or ministers of development", meets annually at the meetings of the Boards of Governors of the World Bank and the International Monetary Fund (World Bank Group, 2018d). The Board of Governors of the World Bank in turn has delegated significant responsibilities to twenty-five Executive Directors, each of whom sits on four separate boards that make up the World Bank Group Boards of Directors. The four organisations represented by the twenty-five Executive Directors are the International Bank for Reconstruction and Development (IBRD), the International Development Agency (IDA), the International Finance Corporation (IFC) and the Multilateral Investment Guarantee Agency (MIGA) (World Bank Group, 2018a). A fifth organisation, the International Centre for Settlement of Investment Disputes (ICSID) has a separate governance structure consisting of an Administrative Council, established under the ICSID Convention. Each Member State has one representative on the Administrative Council (International Centre for Settlement of Investment Disputes, 2018).

It is worth noting that the World Bank states that of the twenty-five Executive Director positions, five are *appointed* by the largest shareholders, with the remaining positions taken up by directors *elected* by the rest of the member countries (World Bank Group, 2018d) (emphasis mine). However, a look at the current list of the boards of directors of the four organisations reveals six appointed positions – by France, Japan, the United Kingdom, the United States of America, China and Germany (World Bank Group Corporate Secretariat, 2018). It is rather unfair for twenty two countries in Africa to have a vote to elect only one

director, (as happened in the election of Andrew Bvumbe of Zimbabwe, for instance), while specific member states have a say in the appointment of one director per country. The voting powers of each country are based on a formula that incorporates votes allocated at the time of taking up membership, and subsequently, "for additional subscriptions to capital"; with some additional variations between the four organisations (World Bank Group, 2018e). Arguably, it is the richer countries which have a greater say in the policies of the World Bank, based on their initial allocations as well as their economic ability to increase their subscriptions to capital.

Representation on the Boards of the World Bank is also skewed in favour of certain countries. Following the nomination of candidates for President of the World Bank Group in 2012, for instance, Schneider (2012) stated that "under a gentleman's agreement that goes back 60 years, the U.S. government gets to name the World Bank chief", further noting that in the contest to head the World Bank, Jim Yong Kim, the United States' candidate, "starts with 15.74 percent of the votes in his pocket – the U.S. voting share on the Bank's board". In the event, Jim Yong Kim was selected to head the World Bank in 2012; and again for a second term effective 1 July 2017 (World Bank Group, 2018c).

Other than concerns over the fairness of the criteria used to determine debt-cancellation or increased development assistance, as well as the fairness of representation for member countries, there are possible conflicts of interest within the Articles of Agreement that the Executive Directors are expected to adhere to.

An example is Article I(ii) of the IBRD Articles of Agreement, which gives one of the purposes of the IBRD as being:

> To promote private foreign investment by means of guarantees or participations in loans and other investments made by private investors; and when private capital is not available on reasonable terms, to supplement private investment by providing, on suitable conditions, finance for productive purposes out of its own capital, funds raised by it and its other resources (World Bank Group, 2013b).

The conflict of interest arises in the fact that the primary purpose in this particular article is the promotion of *private foreign investment* by an entity which also participates in the World

Bank's business of "approval of loans and guarantees, new policies, the administrative budget, country assistance strategies and borrowing and financial decisions" for member countries in general (World Bank Group, 2018d). As private foreign investors are usually looking for a return on their investments, there could be a conflict of interest in the board that is considering, for example, whether to cancel a particular bilateral debt – especially if there is pressure from the private investor(s) regarding their returns, and even though the poorer country is doing the best it can to keep up with its repayments. In carrying out its purpose, the International Finance Corporation, too, in Article I (iii) of its Articles of Agreement states that it shall "seek to stimulate, and to help create conditions conducive to, the flow of private capital, domestic and foreign, into productive investment in member countries" (International Finance Corporation, 2017). It is worth questioning whether the goals of ending extreme poverty and promoting shared prosperity as stated by the World Bank as a whole (World Bank Group, 2013a) can credibly and ethically be achieved in tandem with the objectives to promote private foreign investment, given that it is the same Board of Directors that is tasked with making decisions to effect these incongruent mandates in each of the four organizations. As Provost and Kennard (2015) note:

> In its pursuit of profits, the IFC has at times partnered with controversial oligarchs and made investments that, while contributing to its balance sheet, are of questionable benefit to the people it is supposed to be lifting out of poverty ... the IFC has backed enterprises that include private health care companies that cater to the elite and multinational supermarket chains known for poor labor practices and displacing small, family-run businesses.

Provost and Kennard cite amongst other examples, the IFC's investment in Robert Kuok's Shangri-La chain of hotels and luxury residences around Asia, as well as its investment in MedLife in Romania.

Further inequalities within poor countries can also be masked by the apparent success of a wealthy minority in a poor country, which could lead to the invisibility of gnawing poverty in that country. Moreover, the corrupt misdeeds of a wealthy minority could plausibly result in the punishment of the many poor for the sins of the few through the denial of debt-relief or the withdrawal of development aid. On 9th May 2017, the United States Embassy in Kenya issued a statement suspending approximately $21 Million (Kenya Shillings 2.1 Billion) of

assistance to the Ministry of Health, owing to "ongoing concern about reports of corruption and weak accounting procedures at the Ministry" (U.S. Embassy in Kenya, 2017). Inasmuch as the statement also indicated that the amount suspended "represents only a small portion of the overall U.S. health investment in Kenya, which exceeds $650 million (65 billion KSH) annually", it is likely that persons who were not involved in corruption and who could have benefitted from that portion of suspended aid were adversely affected.

Countries ought to make efforts at fostering the fair inclusion of developing countries in the governance structures of financial institutions such as the World Bank. In view of Agenda 2030's claim of commitment to strengthening and broadening the voice and participation of developing countries, a reorganization of these structures to ensure that developing countries also have fair representation and an audible voice at the table is imperative. Since Agenda 2030 also makes it clear in paragraph 36 that its conception of 'shared responsibility' for achieving Agenda 2030 includes "[recognizing] that all cultures and civilizations can contribute to, and are crucial enablers of, sustainable development" (United Nations General Assembly, 2015, p.10), such acknowledgment must not be in words only, but backed up by the requisite actions. Failing to dismantle these exclusionary structures would be indicative of paying lip-service to remedying structural inequality and repeating the error of the Millennium Declaration, which, as indicated in Chapter 1, viewed development largely as the eradication of a narrow conception of poverty – specifically the economic dimension.

ii. Reasons, Intentions and Motives for actions

The sustainability of any action carried out with the aim of achieving a stated goal depends not only on the adoption of resolutions and the signatures of parties, but on the intentions, motives, and reasons of the parties making the commitment. In the section below, I defend this claim by arguing for the importance of interrogating reasons for acting, using development aid and migration as the main discussion point. I then consider intentions and motives for acting, and claim that these too ought to be examined since they have a bearing on the sustainability of any actions that states as well as individuals are expected to take to improve health and well-being.

Reasons for acting: Development Aid

Consider a situation where a particular developed country commits to granting development aid to a poor country. There could be several reasons why the developed country might decide to give aid – for instance altruism; or out of a sense of duty – say to fulfil a commitment made in a bilateral agreement, or a global resolution such as Agenda 2030. Paragraph 11 of Part III in the Millennium Declaration cited "[sparing] no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty" as one of the reasons for granting aid and fostering development (United Nations General Assembly, 2000).

Bermeo (2017) observes that there appears to have been a shift in how donor countries view development aid. Donor countries may not necessarily grant development aid to poorer countries in order to encourage development, but to advance the donor country's own interests. Put another way, the action of giving aid may be informed by reasons other than encouraging development and eradicating poverty, even though eradicating poverty is the reason stated. As Bermeo argues:

> In a connected world, policymakers in wealthier countries believe that transboundary problems such as terrorism, unwanted migration, spread of disease, regional instability, crime, gang violence, and trafficking in persons and illicit substances are exacerbated by underdevelopment. Donor states, unable to insulate themselves from negative spillovers emanating from developing countries, are altering aid policy in an attempt to mitigate problems in the source countries.

With self-interest as a rationale for development aid, an argument can be made that the donor country achieves its aim of 'containing' a problem such as unwanted migration at source, gains the praise of other nations (and perhaps its own people), for its generosity and development credentials, and assuages its collective conscience, so to speak, by lending a hand. The recipient country benefits, presumably, from having funding, and perhaps technical assistance, going towards its projects; which if utilised as they should be, ought to translate into lifting persons in the recipient country out of poverty; as well as enhancing knowledge

transfer and capacity-building – in short, the quintessential case of killing two birds with one stone.

The problems highlighted by Bermeo reflect the negative effects of globalization analysed in Chapter 1. The self-interested approach taken by some developed countries may not be a solution to these global challenges, but may instead for various reasons exacerbate the sense of exclusion, powerlessness and threats to physiological health that many individuals face.

Firstly, as argued in the preceding section, development aid does not necessarily herald a reduction of poverty for those who need it the most, or even to a degree that would be meaningful. The risks of development funding being wasted through misuse, misallocation and corruption remain real.

Secondly, it can be argued that self-interest has always been a defining characteristic of donor countries' aid initiatives. As Bermeo (2017) notes, "During the Cold War, aid was often used to project the donor's influence in far away countries; to help strategically important states regardless of development impact". After 2001, Bermeo notes a change by donor countries, such that "Aid in the post-9/11 period disproportionately flows to countries that send more migrants to and trade more with the donor". Therefore, while there might be a change in the amount of aid given to particular countries, and in the list of recipient countries themselves, there appears to be a consistency in the *quid pro quo* nature of aid given by donor countries – Self-interest, rather than pure altruism, is a major reason for giving aid. However, since poverty eradication in countries that have been recipients of aid has still not been achieved, it is worth considering whether there is a mismatch of interests as between donor countries and recipient countries. This mismatch would imply that once the donor country achieves its aim for giving aid (whatever it may be), it can then terminate the giving of further assistance despite the recipient country's need for it.

Despite the noble intentions of Agenda 2030 and the resolutions made therein, it is likely that the fulfilment of commitments made can be negatively impacted by the self-interested reasons of different countries. Seeking to meet others' needs is more likely (ultimately) to result in the actor having his/her/its own needs met. The distinction is that the fulfilment of one's needs is more likely to occur if all actors are other-regarding; rather than considering their own needs solely (or largely) in isolation of others' needs.

Thirdly, the actions of donor countries in sending more aid to those nations from which more migrants come – particularly if aimed at preventing migration – raises some doubts as to the commitment of these donor countries to some of the outcomes envisaged in Agenda 2030.

Inclusiveness is one of the commitments repeated several times in Agenda 2030. Paragraph 8 of Agenda 2030 contemplates "A just, equitable, tolerant, open and socially inclusive world in which the needs of the most vulnerable are met" (United Nations General Assembly, 2015, p.4). Paragraph 36 of Agenda 2030 acknowledges that all cultures are contributors to and enablers of sustainable development, and a pledge is made "to foster intercultural understanding, tolerance, mutual respect and an ethic of global citizenship and shared responsibility". In paragraphs 9, 21 and 27 of Agenda 2030, "inclusive and sustainable economic growth" is envisaged globally (United Nations General Assembly, 2015). The resolve to build "peaceful, just and inclusive societies" is also mentioned in paragraphs 3, 17 and 35 of Agenda 2030, and is given further prominence as the main focus of SDG16. Finally, paragraph 29 of Agenda 2030 specifically acknowledges "the positive contribution of migrants for inclusive growth and sustainable development"; and a commitment is made by states "to cooperate internationally to ensure safe, orderly and regular migration involving full respect for human rights and the humane treatment of migrants regardless of migration status, of refugees and of displaced persons" (United Nations General Assembly, 2015, p.8). This pledge is repeated as Target 10.7 of SDG10, albeit with the addition of 'responsible migration' to "safe, orderly and regular migration" (United Nations General Assembly, 2015, p.21) – perhaps as a concession to domestic political realities in many states where migration is unpopular with citizens.

Migration is a consequence of globalization – whether as a result of people fleeing wars, turmoil and persecution in their own countries, or perhaps for the purpose of seeking or taking up better opportunities for economic advancement in other countries. With the dispersal and settling of persons of different nationalities all over the world, it is important for all countries to ensure that they take seriously Target 10.7's call for the facilitation of "orderly, safe, regular and responsible migration" (United Nations General Assembly, 2015, p.21). Since this target falls under SDG10, which seeks to "Reduce inequality within and among countries", it would seem to imply that countries ought to consider orderly migration as part of the acceptable measures to reduce inequality within and among countries. There are many

negative narratives and attitudes towards migration that receive considerable coverage in the media – for instance, the perception that immigrants are responsible for disproportionate increases in crime rates (Editorial Board of the New York Times, 2018; Peel & Khan, 2017). Despite the adoption of Agenda 2030, migration remains an issue of contention. A June 2018 European Union summit resolved, amongst other things, "to tighten their external border and increase financing for Turkey, Morocco and other North African states to prevent migration to Europe" (Baczynska, Barkin & Lough, 2018). Many developed countries continue to give aid to others not as a way of rendering assistance for its own sake, but as a way of keeping these countries' nationals out of their territories.

In the following section, I carry out an ethical analysis of aid as a tool to stem migration. This analysis is helpful in order to show the impact of an approach that perceives persons purely as a means to one's ends, versus an approach that sees others as ends-in-themselves, as argued by Kant. The sorts of actions that flow from either perspective will differ; with the latter one that views persons as ends-in-themselves more likely to be in conformity with Agenda 2030 and the promotion of healthy lives and well-being. Migration in my view is one of the most illustrative issues on this point, given that it involves persons of different nationalities who come from different socio-economic, educational, cultural, and other backgrounds.

Ethical critique of aid as a tool to stem migration

Increasing or giving development aid to countries from which immigrants come, if done in order to keep migrants away from donor countries, could be indicative of fear or intolerance, and has the potential to diminish respect for the diversity of humanity if migrants are to be kept away from physical proximity to persons in the donor countries.

From Kant's perspective, each human being ought to be able to recognise in another the same humanity that resides within him, and to seek, as far as is possible, to assist the other in bringing his ends to fruition (2013). This view by Kant brings out part of what is morally troubling about the decisions by some countries to give aid to particular countries to stem migration – The persons receiving the aid are arguably being treated as a means to others' ends – one particular end being to stem migration. A cosmopolitan perspective would

consider aid that is tied to stopping migration as diminishing what ought to be the status of each person as one who is equally worthy of moral concern. Such aid suggests that there are persons who must be kept away from others, which seems to imply unequal moral status. It is not denied that countries need to have migration policies; and that they also need to plan adequately for their own citizens. What I oppose here is the manner of handling migration by espousing an attitude that appears to exclude any intercultural understanding and tolerance right at the outset, and is instead designed to keep persons well away. Self-interested reasons such as giving development aid in order to stem migration perpetuate the sense of exclusion that individuals experience in our globalized world, and have an impact on their health and well-being.

There can be no meaningful inclusion if persons will not engage with one another, and in particular with those who are different from them. The success of Agenda 2030 depends on the goodwill of leaders and persons in all countries, and on their willingness to truly engage with other persons on equal footing and not just as objects of moral concern. There would thus need to be a radical shift in some of the attitudes that hold presently which deem it acceptable to exclude particular persons without engaging with them.

In cases where leaders of particular countries frame migration issues and describe immigrants using pessimistic language, states as well as the United Nations system need to step up and defend orderly, safe, and regular migration as one of the SDG targets. António Guterres, Secretary-General of the United Nations, has been quoted as describing migration as a "positive global phenomenon"; stating that, "Authorities that erect major obstacles to migration – or place severe restrictions on migrants' work opportunities – inflict needless economic self-harm, as they impose barriers to having their labour needs met in an orderly and legal fashion" (Summers, 2018).

iii. Normative and motivating reasons for action

Apart from donor countries giving aid, Agenda 2030 envisages that states will also take other actions that can contribute towards meeting the SDGs. For instance, in order to make cities and human settlements inclusive, safe, resilient and sustainable (SDG11), states must ensure access to adequate, safe and affordable housing and basic services for all (United Nations General Assembly, 2015, p.21). SDG3 on ensuring good health and well-being for all at all

ages includes states taking actions such as ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases by 2030.

The reasons that Agenda 2030 gives for states taking action are normative reasons, which make claims about how things ought to be. However, it is also important to consider the motivating reasons of states *when* they act. Why should we concern ourselves with normative and motivating reasons in examining state action? It is because in certain cases, mismatches between the normative reasons and the motivating reasons for an action arguably have implications for the sustainability of those actions.

Consider, for instance, Alvarez's (2017) illustration inquiring whether a government has a reason to tax sugary drinks (a normative reason); and then asking what *actual* reasons the same government has, if it does in fact implement a tax on sugary drinks – the 'motivating reason' (emphasis mine). In Alvarez's example, the normative reason could be that such a tax can help reduce child obesity – and this may also be the motivating reason. However, the motivating reason could in fact be that certain members in government own shares in a company manufacturing low-sugar drinks – in which case the motivating reason here, per Alvarez, "is not, or not solely, the reason" for which the sugar tax is introduced.

In the event that the manufacture of low-sugar drinks becomes commercially unviable, it is possible that the policy of preventing childhood obesity could be abandoned by the government since the underlying motivating reason (profit) acted as an incentive for the introduction of the tax. This might in turn have negative implications for the health and well-being of children and other individuals consuming the sugary drinks.

iv. Intentions and motives for actions

There are several ways in which the word 'intention' can be understood. A plain reading of the word "intention" in the Oxford Living Dictionaries (2018) gives meanings such as "an aim or plan"; with its synonyms including "purpose, intent, objective, object, goal, target [and] end". This definition and its synonyms are unsatisfactory as they arguably conflate different concepts.

From a legal perspective, 'purpose' and 'intention' are distinct. The South African Institute of Chartered Accountants (2006), for instance, highlights several New Zealand cases in which

'purpose' and intention' have been shown to be different in tax legislation and court judgments. In one case, *Wairakei Court Ltd v CIR* (1999) 19 NZTC 15 202 (at 15 206), it was held that, "Purpose is a reference to the object that the taxpayer had in mind or in view. This is not synonymous with intention or motive. Moreover, care must be taken to avoid confusing the means by which the taxpayer achieves his purpose with the purpose itself" (South African Institute of Chartered Accountants, 2006).

If 'intention' is not synonymous with 'purpose', there must then be another way of disambiguating the kind of meaning that would convey the moral relevance of 'intention' and 'motive' to actions. In order to find this meaning, a further distinction must be made between 'intention' and 'motive'. Anscombe notes a distinction often made in philosophy between the two, illustrating the difference thus:

> If a man kills someone, he may be said to have done it out of love and pity, or to have done it out of hatred; these might indeed be cast in the forms 'to release him from this awful suffering', or 'to get rid of the swine'; but though these are forms of expression suggesting objectives, they are perhaps expressive of the spirit in which the man killed, rather than descriptive of the end to which the killing was a means – a future state of affairs to be produced by the killing ...We should say: popularly, 'motive for an action' has a rather wider and more diverse application than 'intention with which the action was done.' (Anscombe, 1956, pp. 325-326).

In Anscombe's example, therefore, the 'intention' is the future state of affairs to be produced by the action of killing. The motive for the killing is love, or hatred, or pity. Arguably, it is also possible for one to have more than one motive in contemplation when deciding which action would best actualise an intention, and for these different motives to be given different weighting by the moral agent(s) considering the decision, and prioritised accordingly.

In law, as in philosophy, 'intention' and 'motive' differ. Although the traditional doctrine in the criminal law has often been stated as implying that motive is not relevant to criminal liability (Kaufman, 2003), a further analysis reveals that motive does in fact play a part – particularly as a mitigating factor during sentencing. As Kaufman notes, "the criminal law does not depart from morality so as to ignore motive altogether. Motive is relevant at the prosecutorial and sentencing stages" (Kaufman, 2003, p.330).

A further example of the relevance of motive and intention is pithily illustrated by Kramer (2015, p.2), who gives a quote he attributes to William F. Buckley during the Cold War: "To say that the CIA and the KGB engage in similar practices is the equivalent of saying that the man who pushes an old lady into the path of a hurtling bus is not to be distinguished from the man who pushes an old lady out of the path of a hurtling bus on the grounds that, after all, in both cases someone is pushing old ladies around".

Definitions of motive are quite varied, and in many cases, employ words that from a philosophical point of view, might elicit different meanings. For instance, 'motive' in the Oxford Living Dictionaries (2018) is defined as "the reason for doing something"; with another definition being, "causing or being the reason for something". The words 'reason' and 'cause' are also used by Anscombe (1956, pp.321-322), albeit here in expounding on the discussion of 'intention'.

For Anscombe, 'reason' and 'cause' might influence action in different ways. Anscombe gives the example of someone who thinks she saw a face at the window, and it made her jump. This startling action is different from, for instance, a person explaining why she left someone out of her will. Both 'cause' and 'reason', however, are antecedent to an action.

Sverdlik (1996, p.335) gives several propositions concerning motives, as follows:

> 1) Motives are actual psychological states or events; 2) Motives are at least part of the cause of an action or of the decision to act. 3) While motives precede an action, they typically continue to be present or operative as the act takes place. 4) Mentioning the motive of an action is typically done in order to explain why the agent acted as she did. Motives thus count as one sort of explanatory reason for action. 5) However, from the agent's point of view, (and, perhaps, from others') her motives specify what is of value about her action. They thus can also count as justificatory reasons. 6) The two main types of motive seem to be emotion and desire.

Sverdlik then goes on to give examples of typical motives, including jealousy, spite, affection, sympathy, greed and a sense of duty. In Sverdlik's account therefore, the motive of an action

is intricately bound up with the action itself, even if it precedes it, given that it continues to influence, or be operative, in the performance of the action.

Ethical analysis of motives and intentions for actions

If the motive for an action is woven into the performance of that action, as Sverdlik argues, a perspective from Kant's deontology as well as virtue ethics would consider motives for an action to be just as crucial as the performance of the action itself.

Kant's universal law formulation of the Categorical Imperative calls on persons to act in accordance with a maxim that in their moral judgment can become a universal law. The kinds of actions that ought to be performed are therefore those an agent wills should become universalisable. Actions that are informed by motives which are contrary to the Categorical Imperative can have adverse effects on the health and well-being of the agent, as well as others affected by the agent's actions.

One real-life illustration of the negative effects to health and well-being that can arise from morally wrong actions informed by certain motives is evident in the Mid Staffordshire scandal which occurred in England. Motivated by the need to cut costs and to meet the then Labour Government's central targets to achieve a coveted "foundation status", managers in the Mid Staffordshire NHS [National Health Service] Foundation Trust which ran the Stafford Hospital, took several actions that seriously compromised the health and well-being of patients in hospital, and led to several deaths.

According to *The Telegraph* (2013):

> NHS managers staffed the hospital so thinly that there were never enough consultants to properly supervise junior doctors, who took many of their instructions from the senior nurses and matrons who enforced the targets.
>
> Orders were cascaded down the management hierarchy, from the executive board, to the operational managers, to the senior nurses and matrons; nurses and doctors who failed to meet them were threatened with the sack.

> It led to junior nurses and doctors abandoning seriously-ill patients to treat minor cases who were in danger of breaching the four-hour Accident & Emergency (A&E) waiting time limit.
>
> For the same reason, patients were often moved out of casualty covered in their own waste because the target – to admit or discharge patients within four hours – was under threat.

Motives do inform the sorts of actions that a person will take in order to bring about a certain intention. The Stafford Hospital's staff failed to consider the effects of their actions on the health and well-being of their patients (harm and death); and also failed to realise that these very actions would also negatively impact their own health and well-being. A work environment in which constant threats of sacking abound, and in which persons are asked to falsify records cannot be said to promote well-being. Abandoning patients was not in conformity with the Categorical Imperative.

With regard to virtue ethics, which is concerned with the internal state and character of an agent as well as the actions that flow from that internal character, the motive or motives for an agent's acts ought to be in congruence with the performance of those actions. An agent who acts in a manner that is contrary to her internal convictions is likely to struggle with the disintegration she will experience owing to the mismatch between her motives and her actions. It is however possible for a person to behave virtuously without necessarily having a virtuous character – the behaviour and actions perhaps being driven by external compulsion rather than a principled character.

In contrast, a view from consequentialism would hold that the rightness of an act depends only on its consequences, and not from the history preceding it. As Sverdlik puts it, "A completely forward-looking theory of rightness cannot allow that the antecedent of an action can affect its rightness" (Sverdlik, 1996, p.330).

A philosophical approach that excludes the consideration of motive and intention is, however in my view inadequate; given that it fails to have regard to an important factor that influences the justification for an action, and therefore also, the inclination or disinclination to perform it. For Stocker, ethical theories that fail to examine motives for action are defective in that they

cause persons to live their lives in disharmony. While we ought to be moved by what we value, disregarding motives results in psychological discomfort, and in lives that are "essentially fragmented and incoherent" (Stocker, 1976, p.456).

Ethical analysis of motives and intentions where promises are concerned

Agenda 2030 calls for developed countries "to implement fully" their commitments to provide official development assistance (ODA) to developing countries (United Nations General Assembly, 2015, p.26).

A report issued towards the end of the MDGs however showed a gap in the conversion of commitments made by states into action. For instance, while states resolved in paragraph 28 of the Millennium Declaration to take special measures to tackle challenges faced by Africa, "including debt cancellation, improved market access, enhanced Official Development Assistance and increased flows of Foreign Direct Investment, as well as transfers of technology" (United Nations General Assembly, 2000), many of these commitments had not been met by 2014. The MDG Gap Taskforce Report 2014 noted that, "After two years of declines, official development assistance hit a record high of $135 billion in 2013, but fell $180 billion short of commitments made and reaffirmed by UN Member States" (MDG Gap Taskforce Report 2014, p.1).

While this shortfall in financial assistance could perhaps be attributed to the economic challenges that the European Union was experiencing, there was still broad support from its citizens for assistance to be given to developing countries in order to reduce poverty. 83% considered it important to help people in developing countries; and 61% believed that aid to developing countries should be increased in line with commitments made; with 11% of these taking the view that aid should be increased beyond what was promised (European Union, 2013).

Economic difficulties can indeed disrupt commitments to act in a particular manner that an agent or a state had made earlier. Such commitments also raise starkly the precarious nature of promises that are not legally binding, which are liable to being the first casualties of any austerity measures that are subsequently adopted by these states.

In the case of the European Union, the support by its citizens for the position that commitments made ought to be kept despite economic challenges is arguably indicative of the view that honouring a promise is a price worth paying – a view also endorsed by the psalmist in the 15th Psalm when referring to a person who keeps his oath "even when it hurts" (Bible Hub, 2016).

From a Kantian perspective, it is important to honour commitments made; for in so doing, we treat other persons as ends in themselves by founding our actions "on principles that do not undermine but rather sustain and extend one another's capacities for autonomous action" (O'Neill, 2013, p.513). Since each person ought to be treated as an end in themselves, it behoves us to see to it that we support actions that enable the most vulnerable to exercise their capacities to bring their own plans and activities to fruition. Therefore, even if we do not treat persons as a means to an end, *per se*, but fail to treat them as ends in themselves, we still miss the mark from a Kantian perspective (O'Neill, 2013). Failing to honour commitments made also leaves those who were anticipating their fulfilment worse off – if not materially, at least psychologically, having had their hopes for assistance raised and subsequently dashed.

Is honouring promises universalisable under Kant's universal law formula of the Categorical Imperative, which calls on persons to act in accordance with a maxim that in their moral judgment can become a universal law? Bojanowski (2017, p.3), considers universalisability an unnecessary condition to maintaining the practice of promise-keeping, calling instead for a generalised obligation to keep promises.

For Posner, promises made by individuals should be broken if "[a] competing obligation ... defeats the obligation to keep the promise" (2003, p.1906). The case Posner has in mind is, for instance, a promise "to help out in a scheme that turns out to be harmful" (Posner, 2003, p.1906). On this view, then, the only reason for failing to keep a promise would be that keeping it would cause greater harm than fulfilling it.

If persons or states made promises that they then failed to keep, there would be a need for an evaluation of the harm that they would be seeking to avoid in failing to keep the promise, so as to determine whether it was greater than the obligation to keep the promise. Put another way, the competing obligation would, from a moral perspective, have to outweigh the earlier obligation to fulfil the promise.

Imagine, for instance, a fire department chief breaking a promise to speak at a long-awaited international conference in order to co-ordinate search and rescue efforts following a sudden disaster. In the case of states failing to keep promises for aid and other forms of assistance to developing countries, the harm to be avoided would perhaps need to be such that the citizens of the donor country would be left just as worse off, or just marginally better off than the persons in the developing countries that they would be seeking to help. If the cost of keeping the promise would be that citizens of the donor country are left *marginally* worse off than they otherwise would be, this is arguably not a sound reason to abandon their promises.

SDG Target 17.2 calls on developed countries to fully implement the commitments for Official Development Assistance (ODA) that they have made to developing countries, which assistance targets the attainment of "0.7% of gross national income for official development assistance (ODA/GNI) to developing countries; and 0.15 to 0.20 % of ODA/GNI to least developed countries" (United Nations General Assembly, 2015, p.26). From an objective point of view, these amounts are unlikely to be so onerous an obligation for developed countries as to override the good that the commitments were intended to achieve.

Making, and just as easily breaking promises without countervailing reasons, would not augur well for progress towards achieving any of the goals in Agenda 2030, which require the participation of various actors in activities geared towards meeting the goals. The level of commitment of both the promise makers and those whose expectations are unfulfilled would be significantly reduced if promises made were easily abandoned. Considering that the SDGs were the result of over two years' work "of intensive public consultation and engagement" (United Nations General Assembly, 2015, para 6, Page 3), it would be hoped that there was more than a passing level of consideration to determine how to meet the financial and resource demands of the goals. Promises made to assist vulnerable states ought not to be discarded lightly.

Further, countries which fail to keep their promises for development aid and other forms of assistance (particularly those in the European Union), would arguably be acting in contravention of the stated wishes of their citizens if they failed to honour the promises made. Where citizens of particular countries have expressed the view that commitments ought to be honoured, these states ought then to act to fulfil those obligations; having regard to the existing evidence of citizens' expressed wishes, on whose behalf they govern. This in turn

raises the question as to whether promises should be broken, if citizens perceive their fulfilment as being against their national interest. Posner (2003, p.1908) considers unproven the argument that keeping promises increases utility for citizens; especially where the state is characterised by a lack of "representative institutions, or if democratic institutions are controlled by interest groups or selfish elites". Posner notes further that if leaders keep promises because doing so stands them in good stead for the future, this "[makes] the state's obligation to keep promises a prudential decision, not a moral decision" (2003, p.1908). Therefore, in Posner's view, a state may have no obligation to keep any promises that adversely affect its national interests.

Posner's view is problematic to the extent that it then casts the issue of states keeping promises as wholly dependent on national interests and nothing else. It therefore becomes easy for a state to backtrack on any commitment, provided 'national interests' are trotted out as the justification for this action. In a globalized world, however, I contend that each state's national interests may be secured more strongly when the interests of other countries are also weighed in the balance; given that many issues that negatively affect national interests are global in nature – terrorism and trade conflicts being just two examples.

States ought to honour commitments given to other states, particularly if these commitments involve assistance that can improve the circumstances of the most vulnerable persons. From the point of view of distributive justice, keeping such promises of assistance goes a long way in ensuring that the interests of the most vulnerable persons are protected, and that they have the opportunity to participate meaningfully in realising their own conception of what constitutes the good.

Summary

In this chapter, I have analysed philosophical approaches which go beyond a narrow, biomedical definition of health in order to consider the moral significance of health and of well-being. I have argued that individual health and well-being must be considered holistically, and have shown how the determinants of health are the link between health and well-being.

In terms of social justice considerations in Agenda 2030, I have claimed that Agenda 2030 acknowledges that social justice is important in the provision of the determinants of health. Using an extension of Rawls's justice as fairness, and a conception of justice as restoring equilibrium, I have carried out an ethical analysis showing that Agenda 2030 and the SDGs incorporate considerations of social justice within them, but fall short in terms of economic, financial, and global institutional reform. In particular, save for 'recommitting' to broadening the voice and participation of developing countries, it does not give guidance as to how the current lack of fairness in terms of representation and voting rights in international financial institutions such as the World Bank shall be resolved. Without explicitly stating the specific measures to be taken under Agenda 2030, it is likely that there will be no meaningful structural and governance reforms, thereby exacerbating the exclusion from meaningful social and economic life that many individuals currently experience.

Agenda 2030 is an improvement on the Millennium Declaration that preceded it. This is especially so in terms of its having a broader conception of development; its much greater acknowledgment of considerations of social justice; its recognition that all the goals are integrated, indivisible and interdependent and therefore must be viewed as a whole rather than separately; and its appreciation of the determinants of health as crucial elements towards realising its overall plan of action for people, the planet and prosperity. I have also argued that Agenda 2030 does, *prima facie,* attempt to resolve the three negative effects of globalization identified in Chapter 1 – namely the exclusion from meaningful participation in social and economic life, powerlessness to change the negative effecs that arise in a globalized world, and risks to physiological health.

When analysed for coherence with philosophical approaches such as virtue ethics, Ubuntu, Kant's deontology, utilitarianism, cosmopolitanism, and the Capabilities Approach, which were discussed in the first section, Agenda 2030 accords with the general principles of these ethical approaches, thereby showing that it is worth considering as a foundation for analysing individual health and well-being. I have claimed that reasons, motives and intentions do play a part in the sorts of actions that states and other agents take in order to meet certain goals. I have argued that a mismatch between actions and the reasons, motives and intentions behind them can render those actions unsustainable, and also lead to harms to individual health and

well-being. Intentions, motives and reasons for acting ought therefore to cohere with the actions they inform.

In the next chapter, I narrow my focus to analysing SDG3, which seeks specifically to "Ensure healthy lives and promote well-being for all at all ages" (United Nations General Assembly, 2015, p.14).

CHAPTER 3: HEALTHY LIVES AND WELL-BEING IN SDG3: ANALYSIS AND ETHICAL CRITIQUE

Introduction

SDG3 in Agenda 2030 seeks to "ensure healthy lives and promote well-being for all at all ages" (United Nations General Assembly, 2015, p.16). I have argued in the previous chapters that there are three main negative effects which arise from globalization that individuals experience: Exclusion from meaningful participation in social and economic life; powerlessness to influence change against the negative effects of globalization; and physiological risks to health and well-being. I have argued further that these three negative effects can only be remedied by considering health and well-being from an individual perspective.

In this chapter, I carry out an analysis of the epidemiological and ethical aspects of SDG3 which is justified by four main reasons. Firstly, Agenda 2030 and the SDGs are the outcome of a global consensus in 2015. It is important to analyse SDG3 which specifically mentions health and well-being, in order to determine what this global conception of health and well-being entails.

Secondly, in carrying out this analysis, I am alive to the arguments I have made earlier drawing from, amongst others, Venkatapuram (2007), and Daniels (2001); which hold that health extends far beyond a narrow biomedical definition that is focused on alleviating disease and restoring normal human functioning. My analysis will consider the broader implications of SDG3 beyond a narrow, biomedical definition of health, and consider what effects these could have for well-being.

Thirdly, I also have regard for Agenda 2030's emphasis that all the SDGs are integrated, interconnected and indivisible. This implies that the impact of SDG3 (and all other goals) must of necessity be examined contextually, with reference to the other goals. As argued in Chapter 2, the determinants of health are the link between the broader conception of health, and the well-being of an individual. It is for these reasons that I also consider the ethical implications of SDG3 and its targets and indicators to other goals; and the impact of other goals on SDG3. This analysis of ethical implications will be carried out concurrently with my analysis of the epidemiological aspects of SDG3. I will also utilise perspectives from the

philosophical approaches such as cosmopolitanism, Ubuntu, Kant's deontology and the Capabilities Approach in my analysis.

Fourthly, Venkatapuram (2007) and Venkatapuram and Marmot (2009) state that both the social determinants of health as well as epidemiology require inter-disciplinary reasoning and engagement on both sides; given that each enriches and clarifies the other. My focused analysis of SDG3 which combines its epidemiological grounding with ethical analysis is a contribution to knowledge, given that a detailed analysis and ethical critique of SDG3 and its targets, indicators, and means of implementation has not previously been carried out. A further contribution to knowledge is made by the incorporation of multiple ethical approaches in my analysis of SDG3.

The basic structure of SDG3

SDG3, like the other goals in Agenda 2030, has a specific area of focus, which is in turn supported by a number of targets. 'Healthy lives and well-being' is the particular focus of SDG3; with 9 targets which are intended to give further details of the kind of actions that should be taken in order to achieve this goal by 2030. Achieving universal health coverage under Target 3.8, and strengthening the prevention and treatment of substance abuse in Target 3.6, are two of the actions that must be taken under SDG3 (United Nations General Assembly, 2015, p.16).

Each target in turn has indicators that are intended to help measure the progress being made towards achieving the goal. The indicators for all the goals are not contained in Agenda 2030, but are the outcome of ongoing deliberations of the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDG). As at March 2018, there were 232 different indicators for all the goals (United Nations Statistics Division, 2018c).

Other than targets and indicators, SDG3, like other goals, also has 'means of implementation'. The means of implementation are, as their name suggests, the foundational actions that are

necessary for the targets to be carried out.[6] They are distinguishable from targets in Agenda 2030 by their alpha-numeric listing. SDG3 has 4 means of implementation.

i. Ensuring healthy lives and promoting well-being in SDG3

Having analysed what a healthy life and well-being would entail in Chapter 2, it is worth examining what obligations are implied by the use of the word 'promote' in SDG3.

The word 'promote' connotes a positive obligation to do something, rather than simply maintaining, (or preventing the deterioration of) a particular situation or state of affairs. Its synonyms include 'further; advance; foster; nurture; boost; stimulate, and develop' (Oxford Living Dictionaries, 2018). The sorts of actions that would lead towards 'promotion' of well-being in SDG3 are, at a minimum, those listed in SDG3's targets, indicators, and means of implementation. They are the minimum actions to be carried out because Agenda 2030 emphasises the interconnectedness and indivisibility of the SDGs, which means that the targets and indicators of SDG3 must be considered contextually in the light of other determinants of health.

Myers (2017) gives some illustrations that show how the SDGs are indeed integrated and indivisible. Activities which might at first glance not appear to have a direct impact on health do affect health in very significant ways. Myers gives the example of a Belizean farmer whose use of fertilizer on his crops upstream causes a change in the type of vegetation which grows downstream as a result of run-off of nitrogen and phosphorus into waterways. Myers says, "This shift creates [a] habitat less conducive to *Anopheles albimanus* but ideal for *Anopheles vestipennis*, a mosquito that, because of its feeding preferences, is better suited to transmit malaria to human beings. The uplands farmer has, unwittingly, put his lowland compatriot at higher risk of malaria" (Myers, 2017, p.2863). Myers also notes a surprising correlation "between ground water salinity in coastal communities in Bangladesh and prevalence of pre-eclampsia and gestational hypertension in pregnant women"; noting further that "increased ground water salinity has also been shown to correlate directly with increased

[6]I use 'means of implementation' as used in Agenda 2030 (United Nations General Assembly, 2015, p.28) and also by Buse and Hawkes (2015, p.3); although Gostin and Friedman refer to them as 'broader targets' (2015, p.2621).

blood pressure in coastal dwellers" (Myers, 2017, p.2864). The salinity of the water in Bangladesh is as a result of the combination of, amongst others, rising sea levels, damming upriver and increasingly recurrent extreme storms. Myers' examples therefore demonstrate the importance of SDG13 that seeks to combat climate change and its impacts to SDG3. SDG12 which seeks to ensure sustainable consumption and production patterns is also crucial in finding alternatives to harmful fertilizers which negatively affect plants and soils.

The World Health Organization (2015, p.9) has provided a table of some of the targets and the means of implementation which are related to SDG3. Table 2 below is an extract of these targets:

TABLE 2. Other SDG targets and means of implementation related to SDG 3.

SDG TARGET	DESCRIPTION
1.3	Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable
2.2	By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons
4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education
4.a	Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all
5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
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
6.1	By 2030, achieve universal and equitable access to safe and affordable drinking water for all
6.2	By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations
6.3	By 2030, improve 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
10.4	Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality
11.5	By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations

16.1	Significantly reduce all forms of violence and related death rates everywhere
16.2	End abuse, exploitation, trafficking and all forms of violence against and torture of children
16.6	Develop effective, accountable and transparent institutions at all levels
16.9	By 2030, provide legal identity for all, including birth registration
17.18	By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

The above table is however in my view still not exhaustive of the targets which have a bearing on health. One example of a target that is missing in the above table is Target 11.1, which seeks to "ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums" (United Nations General Assembly, 2015). The materials used, design, access and location of houses that persons live in can affect individuals' physiological health, for instance, in many ways. In slum areas in Kenya, for instance, houses are often constructed from iron sheets and polythene papers, which do not provide protection from extreme cold, thereby contributing to respiratory illnesses. Ventilation in these houses is also poor in many instances, and there are no basic sanitation facilities. This can lead to the spread of water- and air-borne diseases. Since there is poor road access to these areas, and the houses are built very close together, the risk of a fire from one house burning down many others is extremely high – Fire engines in many cases cannot access these areas when a fire occurs, which also leads to loss of property and financial hardship (Ombati, 2018).

Target 8.7, which aims to "Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour" is also significant to health (United Nations General Assembly, 2015). This is because the conditions in which trafficked persons and persons subjected to slavery are exposed to are inhumane and are hazardous to their health.

In the remaining part of this chapter, I will analyse each SDG3 target, discussing its epidemiological basis and incorporating research from diverse sources. I also consider ethical implications of the targets, including the consequences of failing to meet them. These ethical perspectives will incorporate Kantian deontology, cosmopolitanism, the Capabilities Approach, Ubuntu and utilitarianism. I will also consider the relevant SDG3 indicators in my

discussion. The text quoting the specific targets discussed is extracted from pages 16-17 of Agenda 2030 (United Nations General Assembly, 2015).

Target 3.1:

Target 3.1 seeks to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. The World Health Organization's *World Health Statistics 2017* Report (2017, p.29) indicates that the global maternal mortality ratio (MMR) – the number of maternal deaths related to childbirth, pregnancy, or its management per 100,000 live births within a given time period – stood at 216 per 100,000 live births in 2015. The report notes that achieving Target 3.1 by 2030 "will require a global annual rate of reduction of at least 7.5% – which is more than triple the annual rate of reduction that was achieved between 1990 and 2015" (2017, p.29).

A significant challenge here is the inequalities that exist within and among countries; particularly in access to antenatal care and the availability of skilled health personnel during childbirth. These inequalities are particularly glaring as between rural and urban areas. In East Africa on average, for instance, a mother living in a rural area has a 40% chance of being attended to by a skilled birth attendant, compared to her counterpart in the urban areas whose chances of encountering a skilled birth attendant more than double at 81% (United Nations, 2015, p.40). Tanzania in East Africa, for instance, had "coverage of skilled attendance at birth at 55 percent in rural areas, compared to 87 percent in urban areas" (United Nations Children's Fund, 2017, p.5). Evidently greater is the gap between poor and rich households. It is noted that, "Among the poorest households, only 42 percent of deliveries were assisted by a skilled attendant, compared to 95 percent of deliveries in the richest households" (United Nations Children's Fund, 2017, p.5).

The disparities illustrated above certainly contribute to the dire MMR that Africa in particular labours under. For instance, Angola's MMR was 477 in 2015, while Austria's MMR was 4 in the same year. Burundi's 2015 MMR was 712, while South Africa's was 138 and Poland's was 3 (World Health Organization, 2016a). A regional comparison shows a similar pattern, with Africa far behind other regions of the world. The MMR for Africa in 2015 stood at 542 per 100,000 live births. Europe's MMR over the same period was 16. For the Americas, the MMR is 52, with South East Asia's at 164 (World Health Organization, 2016b).

If any meaningful progress is to be made in this target, it is crucial that there be concerted efforts to invest in the training and deployment of skilled health personnel; the building and proper equipping of health facilities even in the regions considered most remote within countries; and sustained and adequate financing as proposed in the 'social compact' of the Addis Ababa Action Agenda. Part of the social compact includes providing "fiscally sustainable and nationally appropriate social protection systems and measures for all ... quality investments in essential public services for all, including health, education, energy, water and sanitation", as well as a commitment "to strong international support for these efforts, [including a consideration of] ... coherent funding modalities to mobilize additional resources" (United Nations Department of Economic and Social Affairs, 2015, p.6).

Ethical implications in Target 3.1:

The disparities in the MMR between and within countries are of moral concern. A situation in which so many expectant mothers die during childbirth for reasons that could be avoided through appropriate investments in healthcare is morally wrong. The Kantian perspective that calls for supporting agency as exemplified in the giving of assistance to improve health, as well as healthcare, is violated by the needless deaths of these women, which are disproportionately high in certain regions of the world.

The World Health Organization's MMR figures indicate that a woman in a rural area in Africa and certain other parts of the world is likely to experience difficulties accessing antenatal healthcare. Access to information and advice that would enable her to choose nutritious foods to eat, for instance, or perhaps spot symptoms signalling the need for a visit to a hospital or clinic may also be difficult to come by. Should any life-threatening complications arise during childbirth, the mother's and baby's lives are at risk of significant morbidity and mortality. Whilst this disparity can also be framed in terms of justice, given the need to allocate scarce resources fairly between rural and urban areas and between regions, it is also an issue that concerns respect for persons.

Respect for persons, according to Behrens (2018) is the recognition that the choices that a person makes have an impact not only on her life but on the lives of others in the family and community. A failure of the state to provide well-equipped healthcare facilities and trained healthcare professionals not only denies the person the options from which to choose, but also

erodes her autonomy as a person entitled to self-determination. One cannot choose to exercise an option that she does not have.

These avoidable deaths are tragic in and of themselves, but there are yet wider consequences considering that children who survive the birth are left without the care and nurture of the mother and face increased risk of morbidity and mortality to their own lives. As Moucheraud et al., (2015) show, there is evidence that in Ethiopia, "Children who experienced a maternal death within 42 days of their birth faced 46 times greater risk of dying within one month when compared to babies whose mothers survived" (Moucheraud et al., 2015, p.1). The authors also note that the effects of maternal mortality on the child, families and communities include a lack of nutritional support for the infant from the absence of breastfeeding, which can result in malnutrition; as well as suffering and increased vulnerability of older children who are left without maternal care. For example, "among orphans, the risk of child labour, poor learning outcomes and lower educational attainment, and disrupted living arrangements can impose trauma that has detrimental impacts on health and well-being" (Moucheraud et al., 2015, p.2). Avoidable maternal mortality diminishes well-being and health for not only the newborn child who is left without a mother, but for older children and for spouses as well.

Target 3.2:

Target 3.2 in SDG3 aims to "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 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births".

As at 2015, the *World Health Statistics 2017 Report* indicated a global neonatal mortality rate of 19 per 1,000 births; and 43 per 1000 births for the under-five mortality rate (World Health Organization, 2017b, p.30). In the neo-natal and under-five mortality rates, Africa again bears the greatest burden of these deaths, many of which are preventable with adequate and timely care. As the report notes, "The WHO African Region also had the highest under-five mortality rate (81.3 per 1000 live births) that year – almost double the global rate" (World Health Organization, 2017b, p.30).

Data from the Global Health Observatory of the World Health Organization (2018d) shows that in 2016, there was a slight drop in the under-five mortality rate in Africa to 76.5 per 1,000

live births. However, in contrast to Europe's 9.6 per 1,000 over the same period, it is clear that the magnitude of the inequalities between Africa and the other regions is great.

Ethical implications in Target 3.2:

Healthy lives and well-being for all at all ages means that the lives of neonates and young children are of as equal moral value as the lives of older children, young adults and the elderly. A situation in which so many children from a particular region die at childbirth or at a very young age is indicative of a failure in our conception of which lives ought to matter; and what we ought to do in order to ensure that we demonstrate and uphold respect for these lives.

Respect for persons would entail that where we can, we should assist all persons in need of help in the manner that would uphold and advance their health or well-being. Such assistance can be rendered personally; or perhaps can be more effectively channelled through institutions and governments that we have mandated to act on our behalf. To any arguments that might be raised objecting to the personhood of neonates, my reply would be that such personhood can only be realised if those neonates have the opportunity to grow and develop into personhood; which occurs gradually and on a continuum in any event. Curtailing the development of such neonates through failure to provide adequate healthcare and suitable conditions within which they can grow and thrive, amounts to a failure of our moral obligation to show care and concern for those who are the most vulnerable.

The health and well-being of mothers who lose their children during childbirth is also negatively impacted, as is the well-being of families. As Kersting and Wagner (2012) note, the impact of perinatal loss, including neonatal death, has been associated with "post-traumatic stress, depression, anxiety, and sleeping disorders" (Kersting and Wagner, 2012, p.188). If the mother has other children, her ability to care for herself and for them following a neonatal death may also be compromised.

While Europe as a region has already surpassed SDG Target 3.2, countries in Africa and other regions where the target is still a long way off will need financial and other assistance in order to meet the target; bearing in mind that even if it is met, every avoidable neonatal death is still one death too many. Without the commitment of all countries to funding both maternal and neonatal care, and accountability mechanisms being followed through to gauge the progress of each country, such avoidable deaths are likely to continue.

Target 3.3:

This target to "end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases" by 2030 contains quite a broad spectrum of diseases for which action is required.

There has been considerable progress in combating HIV/AIDS, with a drop of 40% in new HIV infections between 2000 and 2013. There were 13.6 million people on Anti-Retroviral Therapy as at June 2014, up from just 800,000 in 2003 (United Nations, 2015, p.6). There have also been great strides made in fighting malaria, with "More than 900 million insecticide-treated mosquito nets ... delivered to malaria-endemic countries in sub-Saharan Africa between 2004 and 2014" (United Nations, 2015, p.6); a measure which seems to have had some impact given the "37% global decline in malaria incidence since 2000" (World Health Organization, 2018b).

Targeting an end to these diseases however, means that other than preventive care such as vaccinations where available, the provision of information and education must also be prioritised in order that persons are aware as to how to protect themselves from these diseases. Many of the diseases listed in Target 3.3 are greatly impacted by the determinants of health. The incidence of malaria can be greatly reduced by maintaining a clean and neat environment, and other measures such as sleeping under mosquito nets. Long grass, uncontrolled growth in bushes around homes, the presence of mounds of garbage, as well as stagnant pools of water often serve as potent breeding grounds for mosquitoes. Keeping grass and bushes trimmed, disposing of garbage properly, and providing for drainage, so that pools of still water do not accumulate, can help keep mosquitoes away from residential areas and thus reduce incidents of malaria. Simple and cost-effective measures such as these must not be abandoned but must be carried out alongside other measures including providing medicines.

According to the World Health Organization (2018k), neglected tropical diseases comprise 20 diseases which affect more than one billion people in 149 countries. Neglected tropical diseases include dengue and chikungunya (also transmitted by mosquitoes and which therefore can be mitigated by effecting the simple measures earlier discussed), leishmaniasis, schistosomiasis, onchocersiasis (river blindness), and rabies.

Cases of leishmaniasis demonstrate the link between determinants of health and good health and well-being. The World Health Organization (2018h) recognises this disease as one that is heavily influenced by socio-economic conditions, stating that, "Poverty increases the risk for leishmaniasis. Poor housing and domestic sanitary conditions (such as a lack of waste management or open sewerage) may increase sandfly breeding and resting sites, as well as their access to humans". Other factors that influence the spread of leishmaniasis include malnutrition, environmental changes such as human incursion into forest areas and climate change, which can alter the distribution patterns and population sizes of disease-carrying vectors.

In combating hepatitis, it is important to consider the possibility that Omar et al., (2017) raise that "Increased susceptibility to HBV [Hepatitis B Virus] infection may be caused by schistosomal infections" (2017, p.762). Further, Omar et al., observe that "The risk of exposure to HBV in CHC [chronic Hepatitis C] patients with schistosomiasis was two and a half times greater than that in CHC patients without schistosomiasis" (2017, p.763). Detecting and treating schistosomiasis infections would therefore also significantly impact the rates of detection of hepatitis infections and increase the chances of early treatment. As Omar et al., state, "We recommended that early detection and treatment of schistosomiasis ... can serve as an early indicator of occult hepatitis B and can prevent hepatic complications and liver damage" (2017, p.764). There is therefore a need for reliable research that makes linkages between various diseases and hence informs the actions that persons need to take in order to achieve the goals and targets.

Target 3.3 also requires that efforts be made to fight water-borne diseases and other communicable diseases. SDG6 that seeks to "ensure the availability and sustainable management of water and sanitation for all" (United Nations General Assembly, 2015, p.18) will be a crucial factor in the success of this target. Diseases such as cholera, typhoid and dysentery, which are transmitted through contaminated water or food, can be greatly reduced if clean and safe drinking water is made available to all. Currently, "Waterborne diarrhoeal diseases ... are responsible for 2 million deaths each year, with the majority occurring in children under 5" (World Health Organization, 2018e). The availability of potable water would therefore also have a positive effect on Target 3.2 on reducing neonatal and under-5 mortality. Other than making available safe water for drinking and other uses, information and

education at a national and global level on simple measures such as hand-washing and behavioural changes through which the incidence of water- and food-borne diseases can be prevented should be provided.

A communicable or infectious disease is defined as "an illness caused by a specific *infectious agent* or its toxic product that results from transmission of that agent or its products from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or inanimate environment" (Barreto, Teixeira & Carmo, 2006, pp.192-193); (emphasis in original). This definition therefore includes diseases such as malaria, HIV/AIDS, cholera and tuberculosis, which are already earlier mentioned in Target 3.3. Perhaps the distinction in naming some diseases specifically in this target is that malaria and HIV/AIDS, for instance, are to be eliminated by 2030, while the other diseases subsumed under 'water-borne and communicable diseases' are to be combated, but not necessarily eliminated, by 2030. There is no specific guidance as to what degree of success is to be expected by 2030 for water-borne and communicable diseases, since a look at the indicators for this target only require measurement of the incidence of HIV, tuberculosis, malaria, Hepatitis B and the "Number of people requiring interventions against neglected tropical diseases" per either 1,000 or 100,000 population (United Nations Statistics Division, 2018e).

While the indicators might inform, at a national level, the kind of action to be taken in order to reduce the incidence of these specific diseases, it is not clear what the fate of unmeasured water-borne and communicable diseases such as cholera and say, measles, would be. It is therefore the responsibility of various states which suffer a disproportionate burden of infectious and water-borne diseases to take the initiative to set their own measures and indicators in order to track progress towards achieving this target.

There is also a need to finance the various interventions that are necessary to fight neglected tropical diseases, communicable, and water-borne diseases. Countries could consider contributing to a fund modelled on some of the principles of The Global Fund to Fight AIDS, Tuberculosis and Malaria, which has since its inception in 2002 "[raised] and [invested] nearly US$4 billion a year to support programs run by local experts in countries and communities most in need" (The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2018b). Under the Global Fund partnership, countries retain ownership of the process and

have a vested interest in its outcomes since they are also expected to co-finance Global Fund programmes by increasing government spending on health generally and also increasing co-financing of programmes supported by the Global-Fund (The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2018a). A similar approach to neglected tropical diseases and other communicable diseases would not only increase financing for these diseases, but also demonstrate commitment by all countries to this target.

Ethical implications in Target 3.3:

Many of the diseases in Target 3.3 impact the health and well-being of the persons affected in many ways. River blindness will affect the functionings of a person who goes blind and can no longer participate in certain occupations which require sight, such as driving. Without opportunities for support, a previously sighted person who was driving a taxi, for instance, will experience a loss of freedom in many ways given that he will probably need to rely on other persons to do the things that he could previously do for himself. There is also likely to be a diminishing of his opportunities.

An argument from cosmopolitanism holds that distant others are still worthy of moral concern, and that where one is in a position to render assistance to others in need, one ought to give such assistance[7]. Kant's deontological perspective recognises that it is only through viewing others as persons who are ends in themselves, and consequently promoting their ends, that one can in turn find the full realisation of herself as a person with her own ends. The imperative for countries to ensure that resources are available to fight the diseases that are the subject of Target 3.3 is therefore clear and is also backed up by their commitments made in Agenda 2030.

[7]While obligations in the SDGs are directed primarily at states, on whose behalf leaders made commitments towards fulfilling Agenda 2030, non-state actors such as non-governmental organizations, charitable foundations, corporations, and individuals also have a role to play in advancing the SDGs as discussed in Chapter 2 of this thesis.

Target 3.4:

This target seeks, "By 2030, [to] reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing".

Neither non-communicable diseases (NCDs) nor mental health was mentioned in the Millennium Declaration, and this target therefore represents progress in the recognition of both as crucial to meeting SDG3.

It is estimated that out of a total number of 56 million deaths that occurred globally in 2015, 40 million of these were as a result of NCDs; with the major contributors to this number being cardiovascular disease, cancer, chronic respiratory disease and diabetes (World Health Organization, 2017b, p.31).

Prevention and treatment of NCDs requires the recognition of the role of determinants of health in their incidence and prevalence. Therefore, for instance, lower socio-economic status as well as lower levels of educational attainment are associated with a higher prevalence of smoking (European Union, 2014). Brown (2013, p.696) also states that "the further down the social hierarchy an individual is, the more likely she is to experience poorer health outcomes". Brown notes that "Evidence from health psychology suggests that individuals from deprived backgrounds are less likely to develop those self-regulatory skills needed for them to intervene with habitual, impulsive behaviour" (Brown, 2013, p.697). This means that it will be much harder for a person living in an environment characterised by poor socio-economic conditions to resist the temptation to eat high-fat, high-salt food, for instance, if others around him are eating the same; not to mention the fact that such foods might for them be the easiest and cheapest to obtain. Further evidence of the effects of socio-economic standing on health is provided by Cummins, McKay and MacIntyre (2005), who noted that one of the environmental determinants that contributed to a high incidence of obesity in deprived neighbourhoods in England and Scotland was the presence of an increased number of fast food outlets in deprived areas. Restricting their study to McDonald's outlets, Cummins et al., found that the more deprived an area was, the greater was the number of McDonald's outlets per 1,000 of the population.

Gostin (2014, p.147) proposes that global agencies "regulate industry to improve nutrition, [and] alter built environments to promote physical activity". Gostin states that such regulations can be modelled on the World Health Organization's Framework Convention on Tobacco Control, which would result in more effective action across the globe. Such measures can also be carried out by states in the absence of a formal global agreement. Gostin suggests, for instance, "industry-government collaborations"; giving the example of the United Kingdom, where a "salt-intake-reduction programme sets voluntary targets for 85 categories of processed foods". Gostin notes that, "This helped to reduce the population's sodium intake by 15% between 2003 and 2011" (2014, p.149). The World Health Organizations "Best Buys" represent cost-effective interventions that can be implemented in order to enhance the prevention and control of NCDs. These measures include tax increases for tobacco use, smoke-free indoor workplaces and public places, Hepatitis B immunizations to prevent liver cancer, and screening and treatment for cervical cancer (World Economic Forum, 2011, p.7).

Without an accompanying focus on the determinants of health that influence persons to engage in health-reducing behaviour, very little progress will be made on the aspect of prevention of NCDs.

The treatment of NCDs is also an aim of Target 3.4. It is stated that:

> Where intervention efforts remain static and rates of NCDs continue to increase as populations grow and age, cumulative economic losses to low- and middle-income countries (LMICs) from [cardiovascular disease, diabetes, cancer and chronic respiratory diseases] are estimated to surpass US$ 7 trillion over the period 2011-2025 (an average of nearly US$ 500 billion per year) (World Economic Forum, 2011, p.3).

The cost of treating or managing non-communicable diseases is generally high, and these costs are often prohibitive in low- and middle-income countries. For example, Siddharthan et al., (2013) note that, "The average monthly cost for a patient with diabetes and hypertension would be $33, roughly one-third of the average monthly income in Uganda". A study carried out in India noted that "Hospitalisation due to an NCD had a three times higher odds of incurring catastrophic spending than hospitalisation due to a communicable disease"; with the

greatest chance of incurring catastrophic expenditure being 12 times higher for hospital stays due to cancer as compared to hospitalisation for communicable diseases (Tripathy et al., 2016, pp.1021-1023).

Catastrophic expenditure has been defined by Su, Kouyaté and Flessa (2006, p.21), as "Any health expenditure that threatens a household's financial capacity to maintain its subsistence needs".

Following the World Health Organization's Global Conference on NCDs which took place in Montevideo, Uruguay, in 2017, a Roadmap to guide action by countries between 2012 and 2018 was produced. It proposed, amongst other measures, the emphasising of health as a political priority; the promotion of a health-in-all policies approach for governments; investing in health workers and health systems to ensure effective prevention and control of NCDs; and prioritizing NCDs in domestic budgetary allocations (World Health Organization, 2018j). Funding for NCDs is also an important part of the Roadmap, with the recognition that NCDs "require adequate, predictable and sustained financing, commensurate with the global health and socioeconomic burden they impose" (World Health Organization, 2018j, para 16). The measures proposed, if followed up with concrete action, can go a long way in focusing action on NCDs.

Promoting Mental Health and Well-being:

Target 3.4 also calls for the promotion of mental health and well-being. The World Health Organization defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization, 2018i).

This definition has been criticised by some as requiring far too unrealistic a standard. Galderisi et al., (2015, p.231) state that, "People in good mental health are often sad, unwell, angry or unhappy, and this is part of a fully lived life for a human being ... mental health has been often conceptualized as a purely positive affect, marked by feelings of happiness and sense of mastery over the environment". Arguably, the definition by the World Health Organization does not state that a person must *always* work fruitfully and productively, for

instance; nor does it suggest that a person must *at all times* make a contribution to the community. A reading of the definition rather implies that the characteristics stated are to be expected more often than not, and that the potential of each individual will be different.

It is estimated that "804,000 deaths due to suicide occurred worldwide in 2012"; and that "Nearly one in 10 people in the world suffer from a mental disorder" (World Health Organization, 2015, p.155). The presence of a mental disorder might also be a pointer to a much higher risk of mortality from other conditions, given that, "The level of premature mortality among people living with mental disorders is more than twice that of those without mental disorders" (World Health Organization, 2015, p.156). Other than premature mortality from suicide, these deaths can be explained by "unaddressed physical health conditions such as cardiovascular disease, aggravated by poor access to and quality of health-care services, lifestyle factors and other social determinants of health such as poverty" (World Health Organization, 2015, p.156).

The importance of dealing with the determinants of health rather than focusing solely on healthcare is again apparent here. Since a person does not exist in isolation but is instead influenced consciously or subliminally by his environment, it is important that the determinants of health such as socio-economic status, one's physical environment, level of education, as well as individual factors such as drug and alcohol use, be considered in promoting mental health and well-being.

Ethical implications in Target 3.4:

The combination of a person's lower socio-economic status, together with other factors such as low educational attainment, may serve to increase individual vulnerability and consequently, affect the person's agency. Straehle (2016, p.37), while noting the challenge that individual vulnerability causes to individual agency, considers that circumstantial vulnerability, which she considers to be caused by "the specific conditions that frame individual decisions about the protection of the interests in health", is an issue of concern from a social justice perspective.

Straehle observes that there exist "circumstances that make it difficult if not impossible to promote and protect one's agency and welfare interests, circumstances that make it difficult if not impossible to take health-enabling decisions about our lives" (Straehle, 2016, p.37).

Arguably, lower socio-economic status, the psychology of health behaviour – which shows a significant influence of habitual behaviour on actions taken – and other factors such as the concentration of fast-food outlets in deprived areas, are just the kind of situations that foster circumstantial vulnerability. Straehle argues that such situations of circumstantial vulnerability are morally troubling since they cause health, which is of fundamental value for all individuals, to be inaccessible or difficult to access for some, thereby putting into question "the promise of moral equality" (Straehle, 2016, p.38). The health and well-being of persons in circumstantial vulnerability is therefore diminished.

State actions that may help to remove circumstantial vulnerability include limiting fast food outlets in any given area, particularly residential areas, to a certain number; and encouraging investment by healthy food outlets in residential areas through tax breaks. This would increase access to healthy food options in particular areas, and offer people the opportunity to choose that they may not currently have if only fast foods are what is available.

NCDs cause significant morbidity, and can affect a person's capability set by reducing the number and range of things that a person can be and do. A person who has diabetes that progresses to an extent that say, amputation of a limb is necessary, will have their mobility affected; as will a person who has cancer which necessitates undergoing chemotherapy and which results in long periods of illness and inability to work. In countries where public health facilities are poorly equipped and lack sufficient healthcare personnel, persons who are unwell often have no option but to seek treatment in private health facilities. The cost of treatment for NCDs in a private facility can result in families falling into poverty, since they will have spent most of their financial resources, and even sold assets such as land, in order to afford treatment. Treating or managing NCDs therefore has a negative effect on the economic status and well-being not only of the patient, but of her family and the community, which is deprived of the contribution to social life of the person who is now unwell. Conditions whose effect is to diminish a person's flourishing ought to draw our moral concern, and states, non-state actors, as well as individuals have a moral responsibility to remove such health- and welfare-reducing factors.

In the World Health Organization's definition of mental health and well-being, 'realizing one's own potential' implies an *actual* possibility of such realization, rather than an abstract or conjectural possibility. Actual possibilities in turn call for the creation of the conditions

through which persons can then pursue their interests and enhance their well-being and that of others. From a capabilities perspective, realizing one's own potential means actually having the opportunities from which to choose those one wishes to take up. It also means having the freedom to settle on the ones one wishes to actualise and develop. Since, per Nussbaum (2011, p.20), capabilities consist not only in the "freedoms or opportunities created by a combination of personal abilities", but also "the political, social and economic environment", it is clear that the environment within which one chooses her capabilities and exercises her functionings must be such as to foster the development of one's own potential. From a virtue ethics perspective, realising one's potential is part of the good life; and through the congruence of one's psychological state with the external environment, a person has the opportunity to flourish.

The phrase 'can cope with the normal stresses of life', in the World Health Organization's definition of mental health can be said to be rather vague, given that persons have varying capacities for handling different levels of stress. Besides, one might enquire from whose viewpoint 'normal stresses of life' are to be understood. Is it from the perspective of the woman widowed after 60 years of marriage? Or from the perspective of the young student who has failed his university's final exams and is aware that his extremely poor family has been looking up to him to get a job that can help lift them out of poverty? Is it part of the 'normal stresses of life' if a father is left with three very young children to take care of after their mother walks out on the family? How would we perceive the situation that many persons find themselves in, living in areas of armed conflict and some having to flee from these war-ravaged regions? This is one aspect of the definition which may not be helpful in that it is open to claims of being unduly subjective. It might also arguably engender some level of shame where a person who is unable to cope with certain stressors experiences a sense of self-reproach and failure.

With regard to 'working productively and fruitfully', I contend that the opportunity to work must first exist. Situations in which there are neither job opportunities available in employment; nor the means, or even support, to begin and carry on one's own gainful business, are conditions of moral concern; precisely because they can have an effect on a person's psychological well-being through increased stress levels, depressive symptoms, and a consequent diminishing of the person's well-being. It is not clear exactly what 'fruitful'

here means. Perhaps it is intended to convey that a person ought to be able to make a living out of the work one does. It is certainly preferable not just to barely make a living, but to make a decent living – one that would afford the person the time and means to pursue the opportunities that one wishes to have. SDG8 that aims to "[p]romote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all" is therefore one of the key goals that would have an impact on this particular aspect of fostering mental health and well-being.

'Making a contribution to one's community', the final part of the World Health Organization's definition of mental health, is notable for its coherence with the Ubuntu philosophy, in which the person is fully rooted in the community; contributes to advancing the welfare of the community; and recognises that his well-being is bound up with that of the community. Making a contribution to one's community therefore acknowledges that in order for the person's mental health and well-being to flourish, he must positively participate in the affairs of the community. It is in seeking to advance the well-being of the community that his well-being is also thereby enhanced. This aspect also mitigates the sense of exclusion from social and economic life as well as the sense of powerlessness that many feel in our globalized world. Having regard to the determinants of health would also form part of the individual's contribution to the community – for instance through advocating for an increase of schools and teachers in the local area, holding local and national governments accountable for service delivery – such as in providing well-equipped healthcare facilities and decent housing, participating in community clean-up efforts and participating in mentoring activities, amongst others.

Target 3.5:

Strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol is the subject of Target 3.5. Unlike the previous targets discussed, there is no specific deadline allocated to this target. However, being part of the SDGs, it is presumed that this target ought to be achieved by 2030, in line with the other SDGs. In terms of measuring this target, 'strengthening' as a gauge for the success of prevention and treatment of alcohol and substance abuse is an unclear measure.

A look at the indicators tied to this target (United Nations Statistics Division, 2018e) shows that they are still a work in progress. There are currently two indicators for this target: 3.5.1, which seeks to measure "Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders"; and indicator 3.5.2, which has a vague and convoluted measurement stated as, "Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol" (United Nations Statistics Division, 2018e). 'Harmful use' ought not to be a subjective measure based on national contexts, but an objective and evidence-based measure applicable to all countries, and by which progress for this indicator can be tracked.

The age restriction of indicator 3.5.2 to '15 years and older' is also not justified. Adger, Jr. and Saha (2013, p.103) state (in the context of the United States of America) that, "By the 12th grade, close to three-quarters of adolescents in high school report ever having an alcoholic drink, and more than one-quarter report having their first drink before age 13 years". They note further that, "data show that 12% of 8th-graders, 22% of 10th-graders, and 29% of 12th-graders report engaging in heavy episodic drinking" (Adger, Jr. & Saha, 2013, p.103).

Given that 8th-graders in the United States of America are between the ages of 13 and 14, drinking patterns must be examined for all age groups without what is seemingly an unwarranted cut-off age. Adger Jr. and Saha further state that, "Studies find that drinking alcohol often starts at very young ages. Moreover, studies indicate that the younger children and adolescents are when they begin to drink, the more likely they are to engage in behaviors that can harm themselves and others" (2013, p.103). The harm occasioned by under-age drinking is therefore not captured solely by 'litres of pure alcohol consumed in a calendar year', but also by increased cases of vandalism caused by drunk teenagers, increased chances of morbidity and mortality as a result of drink-driving, and perhaps classes skipped, which would probably result in disruption and low attainment in education.

The scale of the problem of under-age drinking is evident in Adger, Jr. and Saha's stating that, "approximately 10% of 9- to 10-year-olds have already started drinking; nearly one third of youth begin drinking before age 13; and more than one in four 14-year-olds report drinking within the past year" (Adger, Jr. & Saha, 2013, p.104).

Kabiru et al., (2010, p.2) report that, "data from the 2003 Ugandan Global School-based Student Health Survey show that 14% and 12% of boys and girls aged 13-15 years, respectively, reported that they had ever drunk so much alcohol that they were really drunk". It is clear that capturing only persons who are 15 years and older will miss a significant portion of the population; and that any interventions designed to prevent alcohol abuse while excluding persons below 15 years of age may not have the desired effects. It is therefore necessary to consider all age groups in measuring harmful alcohol use. This is also in keeping with the overall SDG3 which seeks to enhance health and well-being for *all* at *all ages;* and not just a specific age-group.

Globally, the World Health Organization (2014, p.xiv) estimates that "In 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributable to alcohol consumption". This number represents the figure for mortality only. It does not include other health-reducing effects such as accidents arising from drink-driving, involvement in violence while drunk, or illnesses such as liver cirrhosis. As with perhaps all the SDG3 targets, the determinants of health play a critical role in determining how successful efforts at curbing harmful alcohol use will be.

It has been stated that, "Environmental factors such as economic development, culture, availability of alcohol, and the level and effectiveness of alcohol policies are relevant factors in explaining differences in vulnerability between societies, historical trends in alcohol consumption and alcohol-related harm" (World Health Organization, 2014, p.7). In societies where alcohol is sometimes locally brewed within homesteads, there may be a need for governments to regulate the manufacture of these brews; liaise with the local community to ensure that they understand the direct and indirect effects of alcohol abuse; seek the community's involvement in ensuring responsible consumption of alcohol and the prevention of under-age drinking; and institute some form of taxation for their manufacture. The availability of well-staffed and equipped rehabilitation facilities is also an important healthcare consideration, in addition to hospitals and clinics.

Ethical implications in Target 3.5:

The harmful use of alcohol can contribute to what Harris (1985) terms 'defects in autonomy'. Harris states that, "An individual's autonomy is apparently undermined and diminished by four different kinds of what we might call 'defects'" (1985, p.196). He names these defects as:

1) Defects in the individual's ability to control either her desires or her actions or both;
2) Defects in the individual's reasoning;
3) Defects in the information available to the individual, upon which she bases her choice; and
4) Defects in the stability of the individual's own desires (Harris, 1985, p.196).

With regard to defects in control, Harris states that there are, "circumstances in which an individual might find his behaviour controlled by desires which he does not wish to have" (1985, p.196). He describes a situation where a heroin addict "wishes no longer to take heroin say, but still passionately desires another fix". Harris argues that since the addicted person no longer wishes to take drugs but finds himself unable to stop, "there is a tension between the addict's first-order desire for drugs, and what might be described as a second-order desire not to be an addict" (Harris, 1985, p.196). Applying this argument to the situation of harmful alcohol use, a person who wishes to stop her excessive consumption of alcohol but finds herself unable to do so will have her autonomy diminished through the disintegration of her desire to stop and her actions in continuing to drink.

From a Kantian perspective, we have a moral obligation to assist persons achieve their ends, and to ensure that persons are able to exercise their will in the ways that they reason is appropriate. The congruence of mind and action is also important. A person's well-being can be negatively affected if her perception of her inner state does not align with her actions.

Through collaborations between states, non-state actors and individuals, the genuine exercising of a person's autonomy can be enhanced. The integration of persons' desires, will and actions can be fostered by ensuring that adequate regulatory controls are placed on the manufacture and sale of alcohol, and by the provision of sufficient rehabilitation and treatment facilities for persons addicted to alcohol or substance abuse.

It is also important to consider defects in information. Harris states that, "Where beliefs or choices are based on false or incomplete information, or depend on such information at any crucial point, they will to that extent be less autonomous" (Harris, 1985, p.198). Promoting the autonomy of a person who believes that it is not harmful to drink excessive amounts of alcohol will entail the provision of evidence-based information as well as education on the harms that can occur if alcohol and other substances are abused. Such information ought to include not only the ill effects on the health of the person abusing alcohol or drugs, but also the very real effects of such abuse on other persons.

Lander, Howsare and Byrne (2013, p.105) state that, "Each family and each family member is uniquely affected by the individual using substances including but not limited to having unmet developmental needs, impaired attachment, economic hardship, legal problems, emotional distress, and sometimes violence being perpetrated against him or her" (Lander, Howsare & Byrne, 2013, p.105). They also note a high likelihood of the children of persons with a substance use disorder developing such a disorder themselves[8]. If persons have no appreciation of the consequences of their harmful alcohol use and substance abuse, they are unlikely to be acting autonomously in abusing such substances. To the extent that they are not well-informed, they are engaging in actions that are harmful to them while under a deficit in information; a situation of moral concern that raises an obligation on persons, states and other institutions to provide the requisite information. In a situation where a person is aware of the harmful effects of alcohol abuse and other substances, but yet persists in such behaviour, it will still be important to ascertain whether they are truly acting autonomously; or are affected by another defect in autonomy. This will require eliminating the possibility that such persons are by now addicted, and therefore have no control as to whether they can stop the harmful use of alcohol and other substances.

One other defect relevant to the harmful use of alcohol and substance abuse is the defect in stability of desires. Harris notes that, "our character, and with it what we value and like to do, is very likely to change over time and to change considerably over long periods of time" (Harris, 1985, p.198-199). He notes that this change in our preferences is often cited as

[8] Some children may be at further risk of Foetal Alcohol Syndrome (FAS), which results from exposure to alcohol during the mother's pregnancy. Some of the effects of FAS include brain damage, growth problems, some physical defects and social and behavioural issues (Mayo Clinic, 2019).

justification for paternalism, and that it is often argued that "people must be prevented from doing things that they will come to regret" (Harris, 1985, p.199). Harris however contends that if persons were to be prevented from making any decisions now because they might regret them later, "then no decisions can be made until, at best, extreme old age" (Harris, 1985, p.199). Harris argues, following Mill, that the making of decisions, and self-determination, improves with both time and practice; and that one must be permitted to make decisions and learn from them without paternalistic intervention.

Harris does have a point; but only if the persons who are making these decisions are of the age of majority, have the competence to make these decisions, and are making them voluntarily. However, it is important to always bear in mind the possibility of other defects such as a defect in information being present. In such circumstances, states, non-state actors and individuals ought then to seek to remove these defects to ensure that the person is making an autonomous decision. Arguably, there is also a place for placing restrictions on who can make certain decisions. These restrictions may be justifiable on moral, legal, and/or scientific grounds.

Given the harms that can occur due to under-age drinking, for instance, governments are justified in enacting laws that prevent the selling of alcohol to persons under the age of majority, which in many countries is 18 years. From a scientific perspective, it has been established that the adolescent brain is particularly susceptible to vulnerability in response to drugs and alcohol; and that maturity of the brain proceeds at different rates in individuals. This in turn has a significant impact on behaviour (Court, 2013).

Court states:

> The amygdala is responsible for reaction to the environment with fear and anxiety as a protective response. In adolescence, there may be a weaker sensitivity in considering harmful behaviour. The hippocampus relates to memory functions and the prefrontal cortex to reward response and to susceptibility to drugs of addiction and mood, also placing the vulnerable adolescent at risk. The prefrontal cortex matures later [than] the other areas, affecting attention, reward evaluation and behaviour that is directed to specific goals (2013, p.884).

As Court notes, brain maturation extends into the mid-20s, a point supported by other research (Arain et al., 2013; Somerville, 2016; Squeglia & Gray, 2016; Yuan et al., 2015). For instance, Arain et al., note that, "Several investigators consider the age span 10–24 years as adolescence, which can be further divided into substages specific to physical, cognitive, and social-emotional development" (2013, p.452). It is therefore clear that in many countries, the age at which persons are held to be mature is actually too early, from a scientific and developmental point of view. It would be particularly helpful, in terms of mitigating any harms that could occur from alcohol consumption, if the age at which a person is legally allowed to drink alcohol or smoke cigarettes was to be raised from the 18 years many countries currently have. Pending any such change in the law, states must take their role of protecting persons seriously, and ensure that no alcohol is sold or provided to persons under the age of majority. States should also step up their efforts at surveillance and preventing the unauthorised sale and use of narcotic and other substances.

Part of showing moral concern for others is to enable them, as far as possible, to live lives of their own choosing. An argument can be made that we fail in our obligation to such persons by turning a blind eye to under-age persons drinking alcohol, smoking, or partaking of other harmful substances.

A 10-year longitudinal study established that heavy use of alcohol and marijuana in adolescence has an effect on neuropsychological functioning. Squeglia and Gray (2016) state that, "heavy substance-using youth in treatment were assessed at age 16 and followed until early adulthood (~age 25). Youth who were heavy substance users showed poorer verbal learning and memory, visuospatial functioning, and working memory and attention at the 10-year follow-up". They suggest that "heavy substance use during adolescence could have lasting effects into adulthood" (Squeglia & Gray, 2016, p.4).

Camchong, Lim and Kumra (2017) note the effects of cannabis on IQ, citing longitudinal data which "show that individuals with more persistent cannabis dependence have a pronounced intelligence quotient (IQ) decline, with significant impact on overall IQ (full-scale IQ) ... evidence suggests that overall IQ deficits do not fully recover after cessation of use (1 year), particularly in adolescent-onset cannabis users".

Poor verbal learning and memory can have deleterious effects on a person's educational attainment and job prospects, for instance, both of which are important for human flourishing, and which also contribute to one's well-being. States, non-state actors, as well as individuals therefore have an obligation to enable persons to live lives of their own choosing, and must act to ensure that an individual's spectrum of choices is protected and enhanced.

From the perspective of Ubuntu, it would be an abdication of our responsibility to persons in our communities, and particularly to young adolescents, to be at ease while they engage in harmful behaviour. Since our personhood is enhanced by the recognition and promotion of the personhood of others, the correct response in the case of such under-age substance and alcohol use would be to liaise with the community to help such adolescents (and also adults who need it), to avoid these harmful substances. Where they might already be addicted, our response ought to include assisting them to find ways to overcome their addiction through rehabilitation and community support. In this way, we affirm the person as a valued member of the community; and also demonstrate to them that they can still make a positive contribution to the community.

Target 3.6:

Halving by 2020 the number of global deaths and injuries from road traffic accidents is the aim of Target 3.6. This target is notable for its deadline which is supposed to be achieved 10 years earlier than the other targets under SDG3.

As with many of the SDGs, Africa suffers a disproportionate burden of the negative effects that the goals seek to prevent or eliminate. In terms of deaths from road traffic accidents, Africa's countries have on average a noticeably higher proportion per 100,000 of the population, compared to other regions of the world.

According to the World Health Organization (2017b, p.63), Malawi had, as at 2013, the highest recorded number of deaths from road traffic injuries in Africa at 35.0 per 100,000, followed closely by Liberia at 33.7, and the Democratic Republic of Congo at 33.2. The lowest rate of deaths in Africa per 100,000 occurred in the Seychelles at 8.6; followed by Mauritius at 12.2; and the third-lowest Nigeria at 20.5. In between these two extremes lie countries like South Africa, recording 25.1 deaths per 100,000 of the population. The number

of registered motor vehicles in South Africa as at 2013 was 9,909,923 (World Health Organization, 2016d). The United Republic of Tanzania, on the other hand, with 1,509,786 registered motor vehicles (World Health Organization, 2016d), recorded the fourth highest number of deaths in Africa, at 32.9 per 100,000 (World Health Organization, 2017, p.63).

There appears to be little, if any, correlation between the number of registered vehicles on the road and the number of deaths from road traffic accidents. Take, for instance, the United Kingdom, with 2.9 deaths per 100,000 in 2013; and with registered motor vehicles in 2013 at 35,582,650. Or Canada, with 6.0 deaths per 100,000; and registered motor vehicles in 2013 at 22,366,270. China, with 250,138,212 motor vehicles in 2013 (World Health Organization, 2016d), had 18.8 deaths per 100,000 (World Health Organization, 2017, p.63); which is proportionately lower than the majority of the countries in Africa with far fewer registered motor vehicles.

Since the statistics indicate that it is arguably not the case that a higher number of motor vehicles results in a higher number of deaths, it is worth considering what the causative factor for higher deaths arising from road traffic accidents is. There is only one indicator for this target: "Death rate due to road traffic injuries" (United Nations Statistics Division, 2018e). I contend that 'deaths due to road traffic injuries' is an inadequate measure for several reasons.

Firstly, it is not at all defined what a death due to road traffic injuries is. Take a case where a person is seriously injured in a road traffic accident, and rushed to hospital. At the hospital, it is discovered that the severity of the injuries is such that the person suffers quadriplegia. She is eventually discharged from hospital and into a facility where she can be cared for. One year later, this person suffers a breathing complication that is directly attributed to her quadriplegic condition and dies. Would we not be entitled to classify this death as a death 'due to a road traffic injury'? There is a clear connection between the injury suffered, and the subsequent death; albeit occurring much later in time. Yet, from the indicator, it appears that these later deaths are not captured.

Secondly, it is arguable that under this target, there ought to be at least some indicators measuring the injuries resulting from road traffic accidents, as well as the other external factors that might be contributing to a high incidence of road traffic accidents. There is no justification for measuring only deaths. As with the illustration given in the previous example,

injuries from road traffic accidents can be severely debilitating and negatively impact a person's health and well-being. A person who suffers head injuries and slips into a coma, for instance, only re-emerging after a few months but now with severe brain damage, needs to be captured in the data. The same would go for a person who has had to have limbs amputated following a road traffic accident.

The external factors that contribute to road accidents and which ought to be included in the measuring of this target can include, for instance, whether there are laws that deal with road traffic offences such as driving under the influence of drugs and/or alcohol, or laws dealing with the roadworthiness of motor vehicles. Other measures can include the robustness of such laws in terms of how and whether they are enforced; number of convictions arising out of road traffic offences; number of policemen on the roads enforcing the law; and other like measures. It seems to be a futile exercise to measure deaths alone and not include other crucial measures which can assist in the better design of programmes and subsequently greatly reduce road traffic accidents. A few examples in the following paragraphs will suffice to illustrate this.

Having data on the effectiveness of road traffic laws can help legislative bodies enact stiffer penalties for road traffic offences and thereby, for instance, get dangerous drivers off the roads either through their serving a custodial sentence, or through the suspension of their driving licences. Knowing the number of police officers assigned to road traffic duties can be used to measure the effectiveness of the police on the roads; and give rise to inquiries should there be numerous accidents caused by vehicles that are not roadworthy; or that are caused by drivers impaired by alcohol or drugs. Should there be too small a number of police officers on the roads for the number of motor vehicles and other road users, the respective states can then take action to increase the number of police officers on the roads – perhaps through opening up more places for training or other such measures. There can be a redesign of the driving curriculum that is used in many countries, particularly in this age where persons use Global Positioning Systems (GPS) a lot more than they might have been used in the last decade or so. This would enable drivers understand how to navigate roads with or without the use of GPS.

The use of mobile phones is another factor that has greatly contributed to the increase of road traffic accidents. According to Klauer et al., (2014), "Estimates based on cell-phone records indicate that cell-phone use among all drivers increases the risk of a crash by a factor of 4"

(Klauer et al., 2014, p.55). They note further that distracted driving, which they define as "diversion of attention away from activities critical for safe driving toward a competing activity" (Klauer et al., 2014, p.55), is a major contributor to road traffic accidents. With regard to cell-phone use, some of the behaviour they observed in their study included talking on a cell-phone, dialling, sending text messages and using the internet to read email or browse the web. Novice drivers engaging in any secondary activity, including the use of cell-phones, had "a significantly increased risk of a crash or near-crash" (Klauer et al., 2014, p.57). Experienced drivers, on the other hand, were not significantly affected by secondary tasks such as eating, adjusting the radio or looking at roadside objects. They did, however, have a significant increase in the risk of a crash when it came to dialling a cell-phone (Klauer et al., 2014, p.57). Governments can use such data to provide information and education to drivers and other road users on the effects of cell-phone use and other distracting tasks when driving, or crossing the road. For example, Stavrinos et al., (2018, p.123), who were examining the impact of mobile technology on young pedestrians, cyclists and drivers, have established that the use of mobile technology "impacts both visual and cognitive processes, thus reducing youth safety on the road"; noting that this result was applicable across the board to pedestrians, bicycling and driving (2018, p.123).

One other measure that can be included under this target is the number of road accidents (whether resulting in death or not), that occur on particular roads within a country. There is a peculiar phenomenon which occurs in some countries where there is an extremely high number of accidents on particular roads, or on sections of particular roads. In Kenya, such spots are often marked with a road sign designating the site a 'black spot', with drivers asked to exercise caution while driving along those roads (Kenya Police Service, 2018). Arguably, however, if the only action taken to reduce these accidents is marking such spots, it would fall far short of providing a solution to curbing these road accidents. While there may be many reasons as to why a statistically higher number of accidents occur in some spots, the greater likelihood is that such statistics point to either a structural or design problem with the road. The permanent solution for this would be to carry out a structural and design review of the existing road and redesign the road if necessary. From a moral point of view, it is an abdication of the obligations of the state to protect the lives and livelihoods of its people if the state undertakes ineffective measures, or measures that are bound to fail every so often, without at the same time considering lasting action to resolve such issues. States must

therefore ensure that they seek a permanent solution to such road accident 'black spots' and redesign such roads where necessary.

The United Nations Statistics Division metadata (2018a) gives as "related indicators" to this target 3.6 other indicators, namely '3.5 and 11.2'. This is likely to be an error, since there are no indicators 3.5 and 11.2; but instead there are *targets* 3.5 and 11.2.

Target 3.5 has to do with the prevention and treatment of substance abuse and harmful use of alcohol. It is well-known that driving under the influence of particular substances can cause delayed reaction time, erratic control of a motor vehicle, and also compromise a driver's ability to anticipate danger on the road. These factors contribute to an increased number of road traffic accidents. Target 11.2 seeks "By 2030, [to] provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons". There is therefore a connection between the two targets; although what is entailed in 'improving road safety' has not been explained in detail.

If there is to be any reduction in deaths arising from road traffic accidents by 2020, let alone a halving of these deaths, Target 3.6 needs to have the appropriate indicators. The current indicator, as argued, is insufficient to spur action to reduce such deaths. Other indicators to measure the relevant contributors to accidents are needed; as is a measure for injuries arising out of road traffic accidents in order for the appropriate interventions to be designed and carried out by states.

Ethical implications in Target 3.6:

It may very well be that there are persons under a defect of information, and perhaps even control, who do not appreciate the severe consequences that their secondary activities on the road while driving can have on themselves and on other road users. In such cases, there is an obligation to remove these defects in autonomy, and to assist such persons to be fully aware of the impact of their actions on themselves and on others.

From a utilitarian perspective, there is little happiness, if any, to be gained from increased injuries, deaths and maimed individuals (unless, of course, we consider the macabre prospect

of increased happiness to morally-maladjusted individuals who consider such injuries and deaths solely as an opportunity to make money rather than an opportunity to promote the health and well-being of these others). It is more likely to be, or ought to be the case, that such deaths and injuries should be of moral concern, given their impact on diminishing the health and well-being not only of the person injured, but also the well-being of the community, which is deprived of the participation and contribution of a member of the community. If the injured person dies, or suffers a disability that results in an inability to participate in his previously gainful employment or other income-generating activity, there is a risk of him and his family falling into poverty, as earlier seen in the case of catastrophic expenditure and NCDs. The same scenario of catastrophic expenditure driving families into poverty is applicable in instances of long hospitalisations and care arising from road traffic accidents[9].

Target 3.7:

Ensuring "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", is what Target 3.7 seeks to achieve by 2030.

The World Health Organization defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations Population Fund, 2004, p.45, para 7.2).

This definition of reproductive health emanated from the Programme of Action adopted at the International Conference on Population and Development in Cairo in 1994, which was adopted by 179 countries (United Nations Population Fund, 2004, p.iii). The definition has not been revised over the years and is still in use today. Since Agenda 2030 in paragraph 11 reaffirms the outcomes of all major United Nations conferences and summits, specifically

[9] In South Africa, the Road Accident Fund (RAF) established by statute provides cover "to all users of South African roads, citizens and foreigners, against injuries sustained or death arising from accidents involving motor vehicles within the borders of South Africa" (Road Accident Fund, 2019). Affected persons can claim, *inter alia* past and future loss of income and earnings, general damages for pain, suffering and disfigurement, past and future hospital and medical expenses and necessary funeral expenses (Road Accident Fund, 2019). The RAF is however not without its challenges, which include shortfalls in the funds required to settle claims as well as delays in settling claims (DSC Attorneys, 2019).

mentioning the 1994 Cairo Programme of Action, Target 3.7 is likely to adopt this definition of reproductive health as well.

Reproductive health is stated to be characterised by people "able to have a satisfying and safe sex life ... [who] ... have the capability to reproduce and the freedom to decide if, when and how often to do so". It is also stated to include "an implicit right" of men and women to be informed and have access to "safe, effective, affordable and acceptable methods of family planning of their choice" (United Nations Population Fund, 2004, p.45). While the introduction of this latter right suffers from the absence of clarification of what O'Neill terms *"who* has to do *what* for *whom"* (O'Neill, 2002, p.42; emphasis in original), it can be argued that in keeping with Agenda 2030, there is an obligation to provide such family planning access and choice. This obligation belongs first to the state; then to other non-state actors such as non-governmental organisations; and also to individuals, to the extent that they can meet it. The obligation however must justifiably rest first with the state, because it has the means to not only purchase sufficient quantities of contraceptives, but also to carry out tests on such contraceptives to ensure that they are fit for human use. Once the state has verified the safety and efficacy of such contraceptives, non-state actors and individuals can then join in distributing them, as well as in complementing state efforts to provide information and education on the correct use and effects of such contraceptives.

Reproductive health-care is then defined as "the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems" (United Nations Population Fund, 2004, p.45, para 7.2). Sexual health is stated to be included in reproductive healthcare; with the distinction being that the purpose of sexual health "is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (United Nations Population Fund, 2004, p.46, para 7.2). This enhancement of life and personal relations speaks to the acknowledgment of the person as one who has an interest in his own well-being, as well as an interest in the well-being of others, quite apart from the concern for his own health in seeking the prevention and treatment of disease.

A curious issue to note is the separation of sexual and reproductive healthcare services, and sexual and reproductive healthcare rights, into two different SDGs. The World Health

Organization notes that in the SDGs, "The sexual and reproductive rights are included in the gender goal" (World Health Organization, 2015, p.94).

SDG5, the gender goal referred to, has as its Target 5.6, "[Ensuring] 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" (United Nations General Assembly, 2015, p.18). The justification for separating sexual and reproductive healthcare services, and rights, is not at all apparent, and arguably could lead to unnecessary confusion and duplication of efforts. Splitting sexual and reproductive healthcare services and rights in two different goals lends credence to O'Neill's (2002) assertion on the lack of clarity when the language of rights is used without an accompanying allocation of responsibility.

Target 3.7 has two indicators: 3.7.1, which seeks to measure "Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods"; and 3.7.2, measuring "Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group" (United Nations Statistics Division, 2018e).

Target 5.6 also has two indicators. Indicator 5.6.1 seeks to measure "Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care". Indicator 5.6.2 measures "Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education". As at December 2017, there was no data available for this indicator (United Nations Statistics Division, 2018e). There is, however, a work plan explaining ongoing progress towards this indicator. The work plan states, amongst other things, that what is to be measured through self-reporting by governments is the number of legal barriers, in the form of restrictive laws and regulations as well as legal enablers – that is, positive laws and regulations.

Legal barriers seek to ascertain whether "restrictions by marital status, third party authorization and age are specially addressed" (United Nations Statistics Division, 2018g, p.2). The work plan further states that since this indicator only measures legal frameworks and barriers, "and does not measure implementation of such laws ... the data must be assessed

in complementarity with 5.6.1 and other indicators under Goal 3 (health) and 5" (United Nations Statistics Division, 2018g).

The question then persists as to what informed the separation of healthcare services and rights in two different goals, if they are after all to be considered together. A further question concerns what value is to be gained from measuring the existence of a right without also considering its enforcement. At first glance, the implication of this unnecessary separation of healthcare services and rights might seem to be that should a person fail to receive these services under SDG3, there will be some sort of distinct mechanism under SDG5 that will spring up to guarantee the performance of this obligation. This, however, is not so, and in fact could be counter-productive to enhancing access to sexual and reproductive healthcare services. I discuss the reasons for this position below.

Ethical implications in Target 3.7:

Firstly, the failure to perform an obligation can be challenged on moral grounds. It is this challenge that will often give rise to a right, and not the other way around. If this were not so, it would mean, for instance, that in countries in which there is no right to healthcare in the constitution or other statutes, there would not be any obligation whatsoever on the state to provide any sort of healthcare.

The United States of America is one country in which there is currently no universal right to healthcare (Bauchner, 2017; Jones & Kantarjian, 2015). However, the government of the United States still provides some level of healthcare to persons through Medicaid, a programme which covers "eligible low-income adults, children, pregnant women, elderly adults and people with disabilities" (Centers for Medicare and Medicaid Services, 2018). Some level of healthcare is also provided through Medicare, which covers persons 65 years and older, "certain younger people with disabilities, and people with End-Stage Renal Disease" (Centers for Medicare and Medicaid Services, n.d.). While Medicare and Medicaid have the backing of laws enacted during President Lyndon Johnson's time in office, their enactment is attributable to the realisation that costs of medical care for the vulnerable such as the elderly and disabled were prohibitive. There was therefore a need to shield these persons from having to pay for such costs (Berkowitz, 2005).

A moral obligation precedes the law. It is not the existence of a law, or a right, that creates a moral obligation. As Daniels puts it, "Rights are not moral fruits that spring up from bare earth, fully cultivated" (1985, p.5). There is often a tending of the earth, so to speak, through a deliberative process that persuades persons that such an obligation (for instance, the provision of health care by the state for all who need it) is an entitlement that belongs to all persons. Such deliberations may also entail a conclusion that the fulfilment of such an obligation ought also to have the backing of legislation. Therefore, primacy ought to be given to ensuring clarity in the moral obligation first.

Secondly, and as earlier indicated, failing to seek, or measure information on the implementation or enforcement of existing laws on sexual and reproductive health rights dilutes the efficacy of Indicator 5.6.2. Arguably, such an omission renders this indicator fruitless, since the existence of a law does not guarantee its enforcement. Whether the law is effective or not can only be measured by its interpretation in actual situations where the right has been declared to have been violated, and appropriate corrective action has been taken to ensure that the right is fulfilled. There should therefore be (under Target 3.7), at least two further indicators: one measuring the frequency with which claims for the infringement of such rights, where they exist, are brought into the judicial system; and another to measure the outcome of such legal challenges in terms of either affirming or denying the right.

Thirdly, "[guaranteeing] full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education" requires that these components (access to sexual and reproductive healthcare, as well as the provision of information and education), be measured. While Indicators 3.7.1 and 5.6.1 do partly fill in some gaps evident under Indicator 5.6.2, it is glaringly obvious that while there are some measures which relate to women's access and use of sexual and reproductive healthcare services, there are none whatsoever to measure access and use of these services for men, which could lead to claims of discrimination against men. This might be an oversight; or a pointer to the status of Indicator 5.6.2 as a work in progress, which would still give room for the addition of another indicator measuring men's access, use, information and education regarding sexual and reproductive healthcare.

Part of the uncertainty and duplication that concerns sexual and reproductive healthcare in the SDGs is arguably attributable to the wide range of issues encompassed under this head. This

is evident from the definition given earlier, as well as from the World Health Organization's observation that one of the challenges of managing this target [3.7] is that it, "covers a wide range of health issues, from contraception to FGM, which makes it difficult to agree on a manageable set of appropriate indicators for the target" (2015, p.94).

Looking at the 1994 Programme of Action, the health issues covered under 'Reproductive Rights and Reproductive Health' also include the welfare of children and adolescents; sex education and the prevention of sexually-transmitted diseases; supporting the elderly; the needs of indigenous persons; the needs of persons with disabilities; and human sexuality and gender relations (United Nations Population Fund, 2004). These are indeed a broad range of issues covering a diverse range of age-groups. The indicators accompanying Targets 3.7 and 5.6 do not however, appear to have adequately captured this diversity. For instance, there is no measure at all for those above 50 years of age, whether men or women; an omission which tends to convey the message that their sexual and reproductive healthcare concerns do not matter. Limiting the measurement of these indicators to persons aged 15-49 also seems to imply that our concern is only for those who are in their reproductive years, which is unjustifiable and discriminatory as against older people. SDG3 seeks to ensure healthy lives and well-being for all at all ages, and not just between 15 and 49 years of age. Another indicator for persons over 50 ought therefore to be added; as should another one for persons living with disabilities, since they face unique challenges.

Addlakha, Price and Heidari (2017, p.4) state that, "People with disabilities are infantilised and held to be asexual (or in some cases, hypersexual), incapable of reproduction and unfit sexual/marriage partners or parents". Nampewo (2017) notes that persons living with disabilities in Uganda face challenges in gaining physical access into many health facilities due to the design of these facilities. The absence of disability-friendly designs such as ramps and wide doorways hampers access to sexual and reproductive services. There are also challenges of communication in healthcare facilities since the number of healthcare personnel trained in sign language, for instance, is too small for the number of persons living with disabilities" (Nampewo, 2017). In order to ensure that persons living with disabilities have their sexual and reproductive healthcare needs met, states should ensure that not only are such persons able to get to the facilities where these services are provided, but that the state can also go to such persons in case of need. It should not be assumed that the absence of persons

with disabilities in healthcare or other facilities is attributable to their contentment with their current healthcare situation. It is more likely to be the case that they have difficulties in accessing these facilities and in getting the help that they require.

Adolescents may also face challenges in meeting their sexual and reproductive healthcare needs. Denno, Hoopes and Chandra-Mouli (2015) note that adolescents face health risks such as maternal deaths as well as unsafe abortions. Since Denno et al., deem adolescents to be aged between 10-19 years, we again encounter another gap in the indicators – The absence of any measurement for persons below the age of 15 years. It is likely that this omission is not inadvertent, but is due to differences in cultural and religious perceptions amongst various states as to the propriety of young people engaging in sex.

A look at the 'Oral statements and reservations on the Programme of Action', which are contained in the Report of the International Conference on Population and Development, records representatives of various countries putting forward their concerns regarding aspects of the Programme of Action that were in conflict with their religious, national or cultural values (United Nations, 1995).

Paragraph 8, for instance, records the representative for Brunei Darussalam stating that:

> According to our interpretation, one aspect of reproductive rights and reproductive health, referring specifically to paragraphs 7.3 and 7.47 and subparagraph 13.14 (c) of the Programme of Action, contradicts Islamic law and our national legislation, ethical values and cultural background. My country wishes to place on record its reservation on those paragraphs (United Nations, 1995, p.133).

Paragraph 7.3 in the Programme of Action discusses, amongst other things, the "right to attain the highest standard of sexual and reproductive health" (United Nations Population Fund, 2004, p.46). Paragraph 7.47 states that, "Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs". It further states that, "Sexually active adolescents will require special family-planning information, counselling and services" (United Nations, 1995, p.50).

The provision of sexual and reproductive healthcare services such as giving contraceptives to adolescents is considered in some interpretations of religions such as Christianity and Islam, to be inappropriate and against religious teachings. Further, in societies where cultural traditions are still practised and held in high esteem, the community has rites of passage for various age-groups. These are considered the proper forum for information on sexual and reproductive health and education; and only then at the age-appropriate time. It is therefore arguable that many countries perceive some of the provisions of the Programme of Action to be an intrusion into the stability of the community and an attempt to circumvent the proper order of transitioning from adolescence to adulthood within that cultural or religious community.

Given the importance of passing on community values from the older persons to the younger ones (an example being the importance attached to community and the respect of elders from an Ubuntu perspective), it is important for such viewpoints to be acknowledged and respected; while at the same time bearing in mind that some deeply-held values and traditions may also eventually have to adjust as the world changes.

Paragraph 9 in the oral statements and reservations also records concerns raised by the representative of El Salvador, part of which include the following:

> Life must be protected from the moment of conception. In addition, because our countries are mainly Christian, we consider that life is given by the Creator and cannot be taken unless there is a reason which justifies it being extinguished. For this reason, as far as Principle 1 of the Programme of Action is concerned, we associate ourselves with the reservation expressed by the delegation of Argentina: we consider that life must be protected from the moment of conception (United Nations, 1995, p.133).

Principle 1 contains the statement that "All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights" (United Nations Population Fund, 2004, p.8).

It would appear that the reservation made by Argentina, El Salvador, and other Latin American countries likely arose from that part of the Universal Declaration of Human Rights'

Article 1 which states that, "All human beings are *born* free and equal in dignity and rights" (United Nations, n.d.; emphasis mine). The implication here is that the rights in the Declaration are applicable only to those who are born, but not those who are in the womb. The reservation was therefore to register their countries' position that the rights of the human beings referred to in the Universal Declaration of Human Rights begin from as early as conception; and do not just spring up upon birth.

Adhering to particular religious beliefs is, for many persons, a significant part of their own conception of flourishing and well-being. Such beliefs are also part of their expression of what their ends ought to be, and an important part of exercising their agency. The state, as the representative of its people in global gatherings, has an obligation to ensure that the commitments it makes during these global meetings are broadly representative of the ends which its citizens would want to achieve. It can ascertain, generally, the citizens' preferences through regular surveys on pertinent issues, for instance; or even through referenda. It is therefore important for a state to ensure that it is, as far as is possible, broadly representing the views of its citizens in such forums, since the citizens will be bound by the commitments the state makes. In a global gathering, a position taken by a state that is not representative of the majority views of its citizens ought not to bind the citizens, who would be entitled to view it as being contrary to their interests and hence consider that they had no obligation to follow it.

Target 3.8:

Universal Health Coverage (UHC) is at the core of Target 3.8, which is to "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".

UHC is however not accepted by all. Some arguments from a liberal democratic tradition, particularly in the United States of America, view UHC as some form of 'socialized medicine'; a term used pejoratively to represent interference in individual choice and interests and undue government intrusion into matters that its opponents argue should be left to the operations of a free market.

St. Onge (2015, pp.350-351) describes the use of the term 'socialized medicine' as, "an argument grounded in cultural logic; [which] reflects an individualistic mythos that privileges freedom of business over equality in health care". It is morally troubling when a large number of people cannot get the healthcare that they need because of an inability to pay for it; or because they fall outside a circumscribed group such as persons with disabilities; or those over 65.

Dickman, Himmelstein and Woolhandler (2017) note that in 2014, 19% of "non-elderly adults" in the United States who received prescriptions were unable to pay for them; and that 39% of Americans with low incomes reported not seeing a doctor for a medical problem owing to cost" (Dickman, Himmelstein & Woolhandler, 2017, p.1432).

Prainsack and Buyx (2011) employ the concept of 'solidarity' to argue that "individuals are not seen as given and clearly bounded entities, but as people whose identities, interests and preferences emerge out of relations to others" (Prainsack & Buyx, 2011, p.xvi). They define solidarity in its simplest form as "shared practices reflecting a collective commitment to carry 'costs' (financial, social, emotional or otherwise) to assist others" (Prainsack & Buyx, 2011, p.xiv).

West-Oram and Buyx (2017) state that solidarity within and between groups is often required for the establishment and maintenance of important social infrastructure. They argue that, "Rather than deriving solidarity from universal, innate features of humanity ... we should understand solidarity as enacted practices that are based on concrete recognition of similarity in a given *specific* context" (West-Oram & Buyx, 2017, p.213) (emphasis in original). West-Oram and Buyx therefore consider global health threats such as anti-microbial resistance, as well as climate change, to be some of these specific contexts that can unify persons into a solidarity group. They argue that the realities of globalization, which include faster transmission of information and faster movement of persons, results in a greater awareness of these global threats; thereby helping to create a shared recognition and solidarity between richer and poorer countries. Further, shared vulnerabilities for both rich and poor arising out of these threats can spur action to "provide the basis of recognition of shared interests in cooperatively promoting health for all persons" (West-Oram & Buyx, 2017, p.216).

Arguably, the concept of solidarity can also apply to UHC. Prainsack and Buyx (2011, p.xvi) make the case that solidarity within a particular collective can exist in tandem with a focus on individual choice and liberal rights; especially where solidarity is already built in within existing relationships such as nuclear families. In other instances, they argue that it would be necessary "to convince individuals that there is a good reason to act in solidarity with others"; particularly if we conceive of the person as one who is "at least partly shaped by her social relations, including those that pertain to her in her capacity as a citizen" (Prainsack & Buyx, 2011, para 40).

One of the persuasive reasons that can be advanced to citizens to make contributions to the cost of UHC is the availability to them of quality, essential healthcare and medicines in their time of need. In a situation where some may at present need healthcare but cannot afford to pay for it, a case can be made that those who can afford to make such payments but do not presently need healthcare ought to contribute to funding UHC costs. They would then be assured of healthcare in their time of need, even when they could no longer make any contributions – perhaps after retirement, or if they themselves fell ill and were subsequently unable to work.

West-Oram and Buyx (2017, p.217) recognise the existence of "self-interested motivations" in acting co-operatively with distant others in order to prevent shared global threats. An argument for contributing to UHC also employs an element of self-interest, in that the primary motivation for contribution might be a person's realisation that illness, disease or catastrophic injury can strike at any time; and that one might later require healthcare that he could not, at the time of need, afford to pay for out-of-pocket.

UHC is deemed by states to be crucial for the success of SDG3. Agenda 2030 at Paragraph 26 states that, "To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind" (United Nations General Assembly, 2015, p.7).

UHC has been defined by the World Health Organization as meaning that, "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" (World Health Organization,

2018f). According to the World Health Organization, this definition encompasses three related objectives: Firstly, equity in access; such that all who need the health services can use them; secondly, the quality of services must be "good enough to improve the health of those receiving services"; and thirdly, that persons should be protected from the risk of financial harm as a result of using the services.

O'Connell, Rasanathan and Chopra (2014) note that the starting point for any definition of UHC ought to be a definition of each term – Universal; health; and coverage. With regard to 'universal', O'Connell et al., note that a commitment to universality does little to change the fact that, "many governments either deliberately or passively refuse to grant access to health services to some people living within their national borders. So-called stateless people, such as refugees, undocumented migrants, nomadic people, or those denied birth registration, are often seen by authorities as without legal entitlement to any rights to health care" (2014, p.277). Other grounds upon which persons are discriminated against include "sex, sexual orientation, religion, ethnic origin, or political affiliation" (2014, p.277).

The meaning of 'universal', whose dictionary definition as an adjective includes "applicable to all cases"; and as a noun, "a term or concept of general application" (Oxford Living Dictionaries, 2018); is thus in the case of healthcare selectively applied, which does render it a misnomer. The circumstances (if any) under which a person can be denied the healthcare that is accessible to others need to be robustly justified, and if such reasons are found wanting, they must immediately be removed so that healthcare is accessible to all and becomes an additional factor in the promotion of health and well-being. If the human person is the ultimate unit of moral concern, (and I here do not mean the *only* unit of moral concern), then one's humanness is what ought to guide the accessibility of healthcare when one is in need of it – rather than considerations like nationality, for instance. West-Oram and Buyx (2017, p.218) consider "common vulnerabilities to emerging threats" as providing a perhaps stronger reason for cooperative action based on solidarity; noting that who counts as worthy of moral concern in a public health context is often subject to national and regional interpretations that can render any responses insufficient. Arguably, however, at the core of solidarity is still the acknowledgment of another human being's moral worth, through the recognition of the commonalities between one human being and another. The realisation that one is just as vulnerable to the threats that affect another can be viewed as an implicit acknowledgment of

the commonalities that exist as between one human being and the other; inclusive of moral worth.

O'Connell et al., (2014) consider the definition of health given by the United Nations General Assembly's Resolution A/67/L36 as encompassing "a much broader definition of health than provision of basic or essential health services could achieve". This, they say, is because, "It calls for UHC and social health insurance to deliver equitable opportunities for the "highest attainable standard of physical and mental health", including "work on determinants of health" (O'Connell et al., 2014, p.277). Given the earlier arguments that the determinants of health are an inescapable component of any efforts at improving health and well-being, 'health' in UHC must encompass this broader view. A situation in which 'health' in the context of UHC is more narrowly circumscribed than 'health' in the SDGs would be untenable and unjustifiable. The view of health expounded in earlier chapters indicates that its achievement undoubtedly requires the collaboration of the other state programmes and global initiatives which deal with the determinants of health. These include housing, agriculture, education, industry, as well as the care and protection of the environment. Rather than being a weakness, this wide definition in fact shows the strength of health as a cross-cutting concern which therefore ought to be accorded a very high priority in the global agenda.

'Coverage' in UHC, as O'Connell et al., note, "must go past mere accessibility of services to incorporate an assessment of effective utilisation". They suggest that if coverage is to be considered effective, two aspects, "the appropriateness, and the quality of coverage" must be stated clearly (O'Connell et al., 2014, p.278). In terms of appropriateness, they note that "perverse provider incentives, underinvestment in promotive and preventive services, and insufficient attention to reduction of risk conditions or promotion of healthy lifestyles" all can "skew coverage towards curative and more fiscally lucrative interventions" (O'Connell et al., 2014, p.278).

Reducing risk conditions would include, for instance, ensuring that persons have sufficient nutritious food to eat, as this will greatly reduce incidents of malnutrition. Having clean and safe water to drink, and for domestic use, is an important safe-guard against water-borne diseases which can greatly reduce health and well-being. Here the importance of considering the determinants of health is again evident.

Perverse provider incentives in terms of coverage can be seen in Mindell et al.'s (2012) example of Reform; an organisation they describe as a "neoliberal think tank". They state that Reform, "which has actively propagated private sector involvement in the NHS [National Health Service], receives financial support from management consultancies benefiting from the NHS reforms ... All these organisations would benefit greatly if Reform's vision of an NHS based on private health insurers and providers were realised" (2012, p.2). Other perverse incentives include the advancing of the interests of the pharmaceutical industry "by the patient groups that it supports and by doctors willing to promote its products" (2012, p.2). In such cases, as Mindell et al., note, the role of government as protector of the public interest is subverted; with commercial interests, which have as their raison d'être the maximization of profits for shareholders, taking over instead.

The provision of UHC itself, rather than the appropriateness of coverage, can also be at risk from external factors. McKee et al., (2013, p.S41), note that such risks include "the existence of powerful vested interests, such as a medical profession dependent on informal payments or a private insurance industry that can call on vast resources to lobby politicians, [which] may be sufficient to block progress".

Depending on how UHC in a particular country is structured, private healthcare facilities can sometimes be the beneficiaries of the bulk of payments made by governments to reimburse costs of healthcare, leaving public healthcare facilities underfunded and ill-equipped. This then leads to a vicious cycle where persons needing healthcare will avoid going to the ill-equipped public health facilities. Since there will now be very few patients coming in through its doors, the public health facility cannot meet its operating expenses, and eventually lies deserted or has to close. Such closures have the effect of perpetuating disparities in health that instead ought to be reduced. For instance, an article by Jones and Exworthy (2015, p.201) noted opposition by the local population towards the planned closure of a maternity unit in a hospital in England. Some of their reasons against the closure were that there would not be another hospital within a reasonable distance, and also that the growing population needed locally accessible services. The closure plans were subsequently abandoned following sustained protests by locals. In cases where closures are actually effected, there is a possibility of placing an expectant mother and her unborn baby at a greater risk of an adverse outcome if

they have to travel a long distance during childbirth, than if they could access help much closer and faster.

In terms of quality of coverage, there ought to be, as O'Connell et al., argue, "specific and practical policy guidance about the quality needed to achieve effective coverage that reduces preventable death and illness" (O'Connell et al., 2014, p.278). Coverage under Target 3.8 is contained in Indicator 3.8.1. I carry out an analysis of this indicator in the section below:

Indicator 3.8.1:

Indicator 3.8.1 seeks to measure "Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)" (United Nations Statistics Division, 2018e).

A look at the metadata for this indicator shows that it covers a wide spectrum of health services – there are 14 tracer indicators in all – (United Nations Statistics Division, 2018b). There also appear to have been efforts made at articulating what kind of quality ought to be aimed at for some of the tracer indicators. For instance, the cluster of tracer indicators grouped under 'Infectious Diseases', has as the tracer for HIV/AIDS, "Percentage of people living with HIV currently receiving antiretroviral therapy". For tuberculosis, the tracer is, "Percentage of incident TB cases that are detected and successfully treated" (United Nations Statistics Division, 2018b, p.2).

Still, in the same cluster of infectious diseases is malaria, whose tracer is, "Percentage of population in malaria-endemic areas who slept under an insecticide-treated net the previous night [only for countries with high malaria burden]" (United Nations Statistics Division, 2018b, p.2). This tracer does not go nearly far enough in terms of prevention and treatment of malaria because mosquitoes can bite at all hours of the day, inasmuch as they have previously been believed to mostly bite at night. Sougoufara et al., (2014) for instance, noted a behavioural change in the biting activity of the *Anopheles funestus* mosquito, which began after the introduction of long-lasting insecticidal nets. These mosquitoes began adopting diurnal feeding patterns; with six times more mosquitoes captured during the day than at night; and eight times more the biting rate in broad daylight than that measured at night.

Measuring the effectiveness of this aspect of UHC by capturing only persons sleeping under insecticide-treated nets, and further, only *at night* is surely an ineffective exercise. This tracer should be revised to take into account scientific evidence that some mosquitoes bite throughout the day and also at night, which might in turn imply that other preventive means should be considered – for instance, the availability and effectiveness of insect-repellent creams.

With regard to the cluster named 'Reproductive, maternal, newborn and child health', one of the tracers is 'Child immunization'. It is described as, "Percentage of infants receiving three doses of diphtheria-tetanus-pertussis containing vaccine" (United Nations Statistics Division, 2018b, p.2). While this may be an effective measure against these three diseases, there is a need to consider other childhood vaccinations such as the BCG [Bacillus Calmette–Guérin], which is given at birth and prevents tuberculosis; or the Rotavirus vaccine, which can guard against diarrhoea.

Also under the Reproductive, maternal, newborn and child health cluster is the tracer for 'Pregnancy and delivery care'. This is measured as the "Percentage of women aged 15-49 years with a live birth in a given time period who received antenatal care four or more times" (United Nations Statistics Division, 2018b, p.2). While this is a good measure for antenatal care, it says nothing regarding the presence of skilled health personnel during delivery, which is critical. It also says nothing on the number of mothers who deliver in a healthcare facility.

A pregnancy can be uneventful all through, but the tide can quickly turn during delivery, when the skills of a person with healthcare training are crucial in raising the chances of saving mother and baby; or in knowing where and when to refer them for further care. It is therefore important to include the numbers of skilled health personnel as an additional tracer. Within countries, this number can also be further disaggregated into the numbers of skilled personnel within different regions of the country, so as to ensure that pregnant women can at least have access to skilled care without having to travel far or to wait for inordinately long periods for help. Both the numbers of skilled health personnel as well as their distribution, are crucial if we are to meaningfully speak of UHC. Both affect the quality of health services being rendered.

Without the appropriate measurements for these tracers, coverage may be wide in some aspects, but the quality of care will be low, given that some relevant aspects of the tracers are not even measured. The absence of these tracer indicators in turn means that the areas not covered are unlikely to be given priority. The appropriate measures ought to be incorporated for UHC, given that it is considered a necessity for the promotion of physical and mental well-being. As indicator 3.8.1 shows thus far, many persons are likely to be forgotten, contrary to the rallying call in paragraph 26 of Agenda 2030 that "no one must be left behind" (United Nations General Assembly, 2015, p.7).

The metadata for indicator 3.8.1 states that, "These tracer indicators are meant to be indicative of service coverage, not a complete or exhaustive list of health services and interventions that are required for universal health coverage" (United Nations Statistics Division, 2018b, p.2). It further states that, "The 14 tracer indicators were selected because they are well-established, with available data widely reported by countries (or expected to become widely available soon)" (United Nations Statistics Division, 2018b, p.2). This explanation is simply not satisfactory. It is not at all persuasive that the reason for selecting some of these indicators is that they are 'widely reported' by countries. Firstly, 'wide reporting' is not necessarily concomitant with appropriateness as a gauge for progress. The question instead ought to be this: Is what is being reported *useful* with regard to the target to be achieved?

As noted earlier, while it is good for a pregnant mother to attend several times for antenatal care, the desired outcome of these antenatal appointments is not simply just to register attendance, but to increase the chances of delivery of a healthy baby, and to have a healthy mother. It is a tragic situation for a mother and family to lose a baby at birth owing to a lack of skilled care. Therefore, the *ends* to which all these measures are being carried out must always be the priority, rather than measuring what is widely available. The ends for which these measures are being undertaken are the promotion of the health and well-being of all, at all ages. In terms of maternal and child health, therefore, our measures must reflect the end that is a healthy mother and a healthy baby. For malaria, the tracer must reflect not only persons sleeping under insecticide-treated nets at all times (not just at night), but also, for instance, how many are successfully treated for malaria. Is what is currently being measured sufficient to gauge *effective* coverage of UHC, even within the tracers indicated? The answer to this question is currently in the negative. Access to quality, essential healthcare, as well as

safe and effective, quality medicines and vaccines for all, must be measured in terms of suitability not only for the prevention and treatment of diseases, but also in terms of the promotion of health and well-being.

Another reason why the appropriate measurements matter, as mentioned earlier, is the increased likelihood of persons being left behind. Failing to have any tracer indicators for persons suffering from, say, mental illness, will mean that such persons become 'invisible' in terms of the allocation of funding and other resources towards UHC. They are therefore unlikely to receive the help that they require.

The broader implication of this invisibility is that the health and well-being of a section of the population will be diminished rather than promoted, contrary to SDG3's purpose. Target 3.5, under which the promotion of mental health and well-being falls, also contains no indicator whatsoever to measure the prevalence of mental illnesses; nor does it assess the availability and accessibility of mental healthcare interventions. It then becomes clear just how a section of the population with particular health needs can easily be forgotten. There is a need for concerted efforts by states to incorporate the appropriate tracer indicators, and also ensure that they are as inclusive as possible, given the 'universal' in UHC. Given the time-bound nature of the SDGs, we cannot afford to have crucial measures for UHC missing.

Indicator 3.8.2:

Indicator 3.8.2 is intended to measure the "Proportion of population with large household expenditures on health as a share of total household expenditure or income" (United Nations Statistics Division, 2018e). These expenditures on health are defined "in terms of two thresholds: 10% and 25% of total household expenditure or income". This definition was chosen following two years of consultation, to represent 'catastrophic expenditures' (World Health Organization, 2017, p.11).

As earlier defined, catastrophic expenditure is "Any health expenditure that threatens a household's financial capacity to maintain its subsistence needs" (Su et al., 2006, p.21). The 10% and 25% thresholds do give a fair indicator of such expenditure. For some families, however, any health spending is still significant. The extreme poverty that such households

experience mean that any illness that requires any amount of money disrupts the household budget.

A further definition related to indicator 3.8.2 concerns out-of-pocket (OOP) payments, stated to be, "payments made at the point of use to receive any type of treatment, from any type of provider, for any type of disease or health problem" (World Health Organization, 2017, p.11). These payments exclude "any reimbursement by a third party such as the government, a health insurance fund or a private insurance company" (World Health Organization, 2017, p.11). Médecins Sans Frontières (MSF) (2017, p.3) defines OOP payments as including both user fees, which are the direct payments made by patients to get medicines or medical services; and additional financial payments including "costs for transport and food, as well as the costs linked to patients' caretakers".

Many families do experience catastrophic expenditures, which mean that they miss out on getting other requirements in the family such as food, or education. Su et al., (2006, p.21) note that households headed "by an elderly or disabled person, families with a low income and those who have a member with chronic disease" are particularly at risk. However, in families which experience a high degree of poverty, the ability to make OOP payments can mean the difference between life and death. With regard to user fees, for instance, MSF notes that, "Patients with communicable and/or non-communicable diseases are not receiving or [are] dropping out of care because of the catastrophic costs linked to (life)long treatment".

There are also further implications for a robust public health response in case of an epidemic, as "outbreak monitoring and response frameworks are weakened, since patients unable to afford care die in the community and go unreported in health facilities" (2017, p.7). Giving an example of Guinea, MSF notes that in a malaria-endemic region called Kouroussa:

> Close to half (48%) of the deaths among the general population were caused by malaria, with 8 out of 10 cases of child mortality due to the disease. Among the deaths reported, up to 27% did not seek care for the illness and for 12% of those, a lack of money was the main obstacle. 42% of those who did seek care did not have the necessary funds, 38% had to go into debt or sell goods to raise the money needed, and only 16% received care free of charge (Médecins Sans Frontières, 2017, p.10).

These numbers paint a grim picture of the effects that a lack of financial protection can have on the health and well-being of persons. States need to reconsider the impact of user fees on persons who need healthcare, particularly the very poor. MSF proposes that a dedicated subsidy to fund free healthcare ought to be established by states. Such financial assistance would go a long way in cushioning access to healthcare for persons who cannot afford it, and would ensure that health facilities are utilised by as many as need them. MSF also proposes that support for UHC ought to be given, albeit with the doing away of user fees as a financing option for UHC. This is because of the detrimental impact such user fees have on the health and well-being of users. Such health-reducing effects include persons falling into debt, or further into poverty. The worsening of diseases from which persons are suffering is another consequence of user fees. This is because many cannot afford consultation fees, or afford to buy the full course of prescribed treatment; opting instead to take the quantity of medication that their money can purchase. Death is also a consequence of such incomplete or delayed treatment.

Other than ensuring financial risk protection for users of health services under Target 3.8, there is need to ensure that essential medicines and vaccines, as well as essential services, are offered in an equitable and non-discriminatory manner. Shayo et al., (2016) conducted a study in Mbarali District in Tanzania, in which they established that, "often public facilities lacked medicines, which when available were unfairly dispensed, as reported by respondents" (Shayo et al., 2016, p.417). Studies in other parts of Tanzania confirmed a similar trend, with poor services in public health facilities, long waiting times, and drug shortages. In some cases, persons who were seeking services at the health facilities and were entitled to waivers of payment were still asked to pay for the services (Shayo et al., 2016, p.418).

States must ensure that financial risk protection goes hand-in-hand with the training of health personnel, and institutional and regulatory oversight of both personnel and operational processes. This will ensure that services are provided in an ethical manner, with beneficence, non-maleficence, justice, and respect for persons as the guiding principles. These principles would also guide processes such as OOP payments and eligibility for waivers, the prescribing and dispensing of drugs, the scheduling of surgeries and other medical appointments, amongst others.

Ethical implications in Target 3.8:

It ought to be an issue of moral concern for states, non-state actors and individuals – in sum, all with obligations under the SDGs – if persons are losing their lives, and experiencing a severe diminishing of their health and well-being, owing to their lack of access to healthcare. When the lack of access can be attributed to the denial of services for want of money, the moral imperative to act is clear. From a Capabilities Approach, there is a diminishing of the capabilities that persons could have; and a reduction of their functionings. It is self-defeating, in terms of achieving the SDGs, to expect persons who are already struggling to make ends meet to pay for healthcare when they cannot even afford to be ill. For many persons, any day off work might mean that they receive no pay for that day. A far better proposition would be to ensure that such persons are able to access the healthcare that they need, when they need it; and are thus able to get back to work sooner, and in good health.

A healthy person is better able to exercise his functionings; and to have the inclination, and freedom, to consider which capabilities he can choose to take up. For example, a small-scale farmer can tend to his coffee crop, and also choose to attend meetings with his fellow farmers to discuss how they can form a co-operative to package, market and export their coffee to high-end retailers. If the same farmer was unwell, with no means of accessing healthcare for lack of money, his coffee crop would likely go untended; the quality of his berries would then deteriorate; and he would also have neither the strength (owing to illness); nor the inclination, (or even the high-quality coffee); to participate fully in the marketing initiative. While this might be considered a consequentialist argument, which views the rightness of an action in terms of its results, it also demonstrates the effect that ill-health can have in restricting a person's exercise of their functionings and capabilities, as well as their freedom.

From the perspective of Ubuntu, turning away persons in need of assistance, and especially for reasons that they cannot afford to pay for treatment, would be considered cruel. It would also signify a lamentable failure of the community in supporting one of their own. One person's suffering ought to spur the community to unite and find a solution to remove the cause of that suffering; and not to turn such a person away. While collectively raising funds for a person's treatment continues to be one of the methods most widely-used in Africa to ensure that a person can obtain treatment when needed, it is not always sustainable. The needs in healthcare often far outweigh what funds the community is able to mobilise. As such, the

obligation to remove health-reducing effects ought rightly then to fall to states, primarily, since they are better able to raise and distribute funds through taxation, via their more established structures. They also have a better chance of rallying action from the global stage.

Target 3.9:

Target 3.9 aims to "substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination" by 2030.

This target illustrates the need for collaboration between ministries and other state agencies concerned with healthcare, and ministries and agencies charged with setting policy and providing oversight for environmental protection, agriculture, water and industries. It also buttresses the importance of the determinants of health in the promotion of health and well-being, and the integrated and indivisible nature of the SDGs. For instance, SDG6 which seeks to ensure that clean and safe water is available for all will be crucial in meeting this target; as will SDG9 on promoting inclusive and sustainable industrialization. Other SDGs which will play a vital role in meeting Target 3.9 include SDG7 on reliable, affordable and clean energy; SDG11 on safe and sustainable cities and human settlements; and SDG12 which calls for sustainable consumption and production patterns.

The phrase 'substantially reduce' implies that there must already be in existence measures of the deaths and illnesses which have occurred as a result of exposure to, and use of, hazardous chemicals and water. If no such data currently exist for some countries, they must be put in place as a matter of priority since there would be no other way to ascertain whether there is a reduction in deaths and illnesses unless they are tracked.

Target 3.9 contains three indicators. Indicator 3.9.1 measures "Mortality rate attributed to household and ambient air pollution"; while indicator 3.9.2 tackles "Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene". Indicator 3.9.3 seeks to measure "mortality rate attributable to unintentional poisoning" (United Nations Statistics Division, 2018e).

Ambient air pollution arises as a result of fine particulate matter emitted by industries, households, cars and trucks (World Health Organization, 2018c). Such particulate matter contributes to "a broad spectrum of acute and chronic illness, such as lung cancer, chronic

obstructive pulmonary disease (COPD) and cardiovascular diseases"; and was responsible for 4.2 Million deaths worldwide in 2016 (World Health Organization, 2018c). Other diseases and conditions attributable to ambient air pollution include ischaemic heart disease and strokes. The type of household and cooking fuels used do have a contributory role in these diseases.

Choi et al., (2015) in a study carried out in Bangalore, India, note a higher likelihood of persons cooking with kerosene fuel having respiratory illnesses as compared to those using Liquefied Petroleum Gas (LPG). Children living in such households were also more likely to have bronchitis and phlegm.

In Malawi, Das, Jagger and Yeatts (2017) found that persons cooking with high-quality and low-quality firewood experienced symptoms such as chest tightness and palpitations; with persons using low-quality firewood having double the prevalence of shortness of breath while walking uphill (Das, Jagger &Yeatts, 2017, p.13).

The demand for charcoal for cooking can cause environmental degradation through deforestation. SDG15 which seeks to promote the sustainable management of forests, as well as to combat desertification, amongst others, must therefore also be monitored as part of Target 3.9. States, non-state actors, and other entities can make available and perhaps subsidise the purchase of alternative cooking fuels such as Liquified Petroleum Gas (LPG), as well as alternative means of heating in order to encourage a shift away from firewood and charcoal. Such measures can contribute to the success of SDG15; not to mention promote health and well-being through the reduction of respiratory illnesses. A reduction of mortality under Target 3.9 would also be a positive outcome, since carbon monoxide poisoning can result from charcoal stoves left burning in poorly ventilated spaces; often in a bid to provide warmth for households.

With regard to poor ventilation, states have a role to play in providing oversight, through the relevant agencies, in the design of houses and other types of buildings. Such oversight would ensure that minimum standards of decent housing are adhered to; including, for instance, provision for adequate flow of fresh air into and out of such dwellings, and the proper spacing between one building and another. SDG11 on inclusive, safe, sustainable and resilient cities and human settlements must also be tied to this target and its indicators.

Indicator 3.9.2 on the mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene must also be viewed in the context of SDG6 which deals with clean water and sanitation. As earlier discussed under Target 3.3 in the context of communicable diseases, the availability of clean and safe water for all can contribute immensely to the reduction of morbidity and mortality, and the promotion of health.

A notable omission under Target 3.9 is that while Indicator 3.9.2 measures the mortality rate arising from unsafe water and sanitation and lack of hygiene, there is no indicator which measures the morbidity rate attributable to these factors. Target 3.3 which includes combating water-borne diseases contains no such indicator either – whether to measure morbidity or mortality from contaminated water.

Other than the presence of pathogens in water, there are other forms of pollution which can cause illnesses and death. These include the release of toxic chemicals from industries into waterways, as well as run-off from the application of fertilizers and other chemicals on crops. Lu et al., (2015) also include the contamination of water from heavy metals as a result of mining and smelting, sewage irrigation, and the re-use of sludge from wastewater treatment. Apart from the effects of contaminated water on the safety of food produced, Lu et al., also note a rise in cancer cases in China, which in turn leads to the phenomenon known as "cancer villages", where "the morbidity rate of cancer is significantly higher than the average level, most probably caused by environmental pollution" (Lu et al., 2015). Owing to rapid urbanization in China, as well as industrialization and weak enforcement of environmental standards and controls, there has been an increase in water pollution, to the extent that, "nearly 38.6% of the length of the rivers could not be used as industrial or recreational water sources, with 17.7% of the length of the rivers not suitable for irrigation" (Lu et al., 2015).

Since there is a shortage of water for irrigation in grain-producing areas in China, most of the water used for irrigation is sewage water, which contains hazardous materials. Sewage water adds contaminants into the soils, which are then taken up by plants and subsequently consumed by human beings, thereby increasing their risk of ill-health from cancers. Other diseases that occur as a result of high concentrations of heavy metals such as cadmium, mercury, lead, nickel, and arsenic in water or food include renal impairment, cardiovascular diseases, diabetes, and neuron damage (Rehman et al., 2017).

High levels of arsenic can also cause arsenicosis, which in turn can cause psychological disturbances, thereby affecting a person's mental health. As Rehman et al., put it, with reference to Bangladesh, "people suffering from arsenicosis are isolated socially and suffer from social uncertainty ... Society considers such victims as a burden to their family" (Rehman et al., 2017, p.165). The health and well-being of such persons is therefore indubitably affected, and further magnified by their social exclusion.

Target 3.9 is also clearly interconnected with Target 6.3 of SDG6. Target 6.3, for instance, seeks to "improve 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" (United Nations General Assembly, 2015, p.18). It has two corresponding indicators: 6.3.1 seeks to measure "Proportion of wastewater safely treated"; while 6.3.2 measures "Proportion of bodies of water with good ambient water quality" (United Nations Statistics Division, 2018e).

A more helpful measure for indicator 6.3.1 would be the number of persons presenting with diseases suspected to arise from water contamination or poisoning. These numbers would then inform what specific actions would need to be taken in order to effectively treat their source of water, since the pollutants in different areas of a country might vary. Knowing the details of morbidity arising from polluted water would also enable closer regulatory monitoring of the source of the pollutants and also assist persons in getting the correct treatment.

The negative effects of contaminated air, water, and soils on human health emphasise the need for an integrated approach in considering SDG3. This integrated approach is also critical for all the other SDGs, since the success of one goal feeds into and supports the success of the others. It is an unjustifiable omission for indicators on morbidity arising from the use of unsafe water to be missing under Target 3.9 and also in SDG6, which is the main goal with a focus on the availability and sustainable management of water and sanitation for all.

Ethical implications in Target 3.9:

Indicator 3.9.3 seeks to establish the "mortality rate attributed to unintentional poisoning" (United Nations Statistics Division, 2018e). It has a connection with indicator 3.9.2 given that the effects of consuming contaminated water or food, absorbing toxic chemicals through the

skin, or inhaling harmful gases can result in the poisoning of one's normal physiological environment and even death.

This indicator however also raises interesting questions regarding 'intention', a philosophical concept which cannot be separated from Indicator 3.9.3 as currently framed; and the reason why I discuss it under the ethical implications.

As earlier discussed in Chapter 2, 'intention', following Anscombe (1956), is the end towards which a particular action is undertaken; the "future state of affairs" to be produced by the action (Anscombe, 1956, p.326). To speak of 'intentional poisoning' therefore, would mean that the agent who carried out the poisoning had as the aim either killing, or negatively impacting the health and well-being of the person affected. An 'unintentional' poisoning would imply that the end which materialises (poisoning) was not the end that was hoped for by the agent who carried it out.

Unintentional actions seem to suggest, at first instance, that only causal responsibility should accrue to the agent who carried out the action, but not necessarily moral responsibility. However, whether moral responsibility should be attributed to an agent for 'unintentional' actions arguably ought to depend on whether the outcome – the end result – was *foreseeable* or not. An unintended end is not synonymous with an unforeseeable end. Let us take an example where some factory workers discharge toxic effluent into a nearby river. Several homesteads are located some distance away from the banks of this river, but the river is the main source of water for domestic use for the occupants of these homesteads. Following the toxic discharge into the river, persons in these homesteads suddenly begin to fall seriously ill, and some die. It is eventually established by the government that their illness is as a result of consuming the now-poisoned water, or eating food cooked using this water. Would it be reasonable for the factory workers to state that their intention in discharging the effluent into the river was only to get rid of the effluent but not to poison the persons living nearby? My answer would be in the negative. Poisonous substances and toxic effluent should be disposed of carefully, with due regard for their hazardous effects on human and environmental health.

One way of looking at this poisoning situation is to say that the outcome – that is, the suffering and death of these persons – ought not to attract any moral responsibility on the part of the argents since it was 'unintentional'. The end that the factory workers sought to achieve

was to get rid of the effluent. I contend, however, that any such actions taken by an agent must always consider the consequences of those actions in the light of their potential to cause harm should any persons be affected. Put another way, the proper question to be answered should always be this: What harm *could* occur *if* a person happens to come into contact with, ingest, or inhale these poisonous substances? The answer to this question should then guide the actions of such agents and inform the sorts of actions that they ought to take to avoid, or mitigate, the occurrence of any such adverse outcomes. In other words, 'foreseeability', defined by Nolo's Plain-English Law Dictionary (2018) as, "The ability to reasonably anticipate the potential results of an action, such as the damage or injury that may happen if one is negligent or breaches a contract", must be a prime consideration in any actions taken by agents.

In our example, the factory workers disposed of poisonous effluent negligently, given that the disposal or discharge was carried out in an area not designated for such purposes; or else done without regard for the consequences of those actions. Whether the outcome that materialises – the poisoning – is intended or not, is immaterial to the moral responsibility of the agent who carries it out. If it is foreseeable that harm could occur to persons who come into contact with, or ingest the poisonous substance, then moral responsibility must attach to the agent. If we accept that foreseeability must always be part of the considerations antecedent to other-regarding actions, then 'unintentional poisoning' in the context of the SDGs ought really not to be considered separately; implying as it does that its consequences have a lesser effect on persons affected. Intention certainly would be relevant in determining the extent of the criminal culpability of the agent who carried out the poisoning action. However, the persons who suffer the ill-effects of the poisoning suffer equally – whether 'intentionally' or 'unintentionally' poisoned. Such a distinction is therefore unjustifiable.[10]

[10]This argument differs from the Doctrine of Double Effect in that the harmful effect in our disposal case is not brought about as a side-effect of some good end. The disposal of toxic waste in undesignated places is wrong *ab initio.* The action of dumping is neither morally good nor morally neutral; because such waste is harmful to the earth's ecosystem in general, besides being harmful to human beings. In terms of proportionality, there is also no good reason for engaging in such dumping; given that it is not an impossibility for there to be alternative disposal methods, and/or designated areas, that would avoid or mitigate the harm to both humans and the environment. On the Doctrine of Double Effect, see, for instance, Mangan, 1949; and McIntyre, 2014.

Given the abundant evidence of the negative effects of polluted water on human health and well-being, we need not wait for death to occur in order to measure the magnitude of the problem. Target 3.9 therefore ought to have additional indicators to measure morbidity and not just mortality, as earlier argued. The deleterious effects of cancers, neurodegenerative, cardiovascular, and other diseases on persons, their families, communities, and nations ought to cause us to take action to tackle these diseases and reduce or eliminate such suffering. States, non-state actors, institutions, and other entities cannot take the appropriate action if they wait until deaths occur in order to gauge the scale of the problem. Prior to the occurrence of these deaths is ongoing harm and suffering which ought also to be acknowledged by being included as a measurement towards progress.

ii. The Means of Implementation in SDG3

The 'means of implementation' in the SDGs, as earlier explained, are the foundational actions that are necessary in order for the targets to be carried out. They are distinguishable by their alpha-numeric listing immediately following the targets for each goal. SDG17, however, is slightly different from the other SDGs since it is a goal that purely comprises various means of implementation as its targets. Each means of implementation also has accompanying indicators.

There are 4 means of implementation under SDG3. Each contains some aspects of the SDG3 targets through which action can be taken so as to make progress towards the goal. The means of implementation collectively seek to create partnerships, as well as the appropriate enabling environment through which the goals can be achieved. These partnerships and resources include capacity-building, financial resources, and the adoption of appropriate policies and governance structures (United Nations, 2014).

The means of implementation under SDG3 broadly urge compliance with already-existing global treaties and agreements such as the Framework Convention on Tobacco Control (FCTC) and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS); as a means of giving impetus to the SDGs. In this section, I analyse the means of implementation for SDG3 as well as their indicators, and consider potential areas for improvement.

Progress on tobacco control – 3.a:

The first means of implementation, 3.a, concerns the strengthening of the World Health Organization's Framework Convention on Tobacco Control (FCTC) "in all countries, as appropriate" (United Nations General Assembly, 2015, p.16). Responses from 142 countries in a survey carried out in 2015 established that fewer than half the countries that are parties to the FCTC (which has 180 Parties), had implemented the provisions of Article 14 of the FCTC. Article 14 requires that Parties "promote tobacco cessation and implement effective measures to help tobacco users quit" (Nilan et al., 2017, p.2023). Such measures include, for instance, the availability of tobacco dependence treatment, the existence of a national tobacco treatment strategy, as well as the availability of information and advice on how to stop using tobacco (Nilan et al., 2017, p.2023).

The slow place of implementation of Article 14 of the FCTC by Parties does not augur well for the success of this measure by 2030, given that the FCTC guidelines were adopted in 2010. Further challenges are presented by the use of the word 'strengthening', which is not defined. The parameters within which 'strengthening' would be assessed are not given, either.

Inasmuch as various states have different smoking burdens, and also varying levels of resources which they can commit towards stopping the use of tobacco, there ought to be some minimum standards to which all Parties to the FCTC must adhere – for instance, progress in the reduction of numbers of people smoking or using tobacco can be measured by say a minimum of a 10% reduction in the number of users of tobacco per country, in the first year, and thereafter by a cumulative percentage increase in subsequent years. In this way, there is an acknowledgment of different countries' capacities; but there is also a more concrete level of accountability towards progress that is expected for each country.

The World Health Organization's Guidelines on Article 14 (2010) also recognise that Parties need funding for the national coordination of tobacco cessation, as well as treatment for dependency. However, the funding burden ought not to be left to individual countries alone, given that many already have funding shortfalls related to other healthcare needs. The Guidelines in Article 14 therefore propose that countries "consider placing the cost of cessation support on the tobacco industry and retailers". This can be done through measures such as designated tobacco taxes, tobacco product registration fees, tobacco selling licences

and other measures (World Health Organization, 2010, para 40). Money from such measures would certainly go a long way in funding tobacco dependency treatment and cessation initiatives, but only if the funds so generated were ring-fenced and applied strictly towards these tobacco cessation and treatment purposes.

With regard to indicator 3.a.1, which seeks to measure, "Age-standardized prevalence of current tobacco use among persons aged 15 years and older", it would be important to ascertain whether there might be persons under the age of fifteen who could be using tobacco in one form or another. This would ensure that they too are not left behind in the designing of initiatives to curb the use of tobacco.

On essential vaccines and medicines – 3.b:

The second means of implementation, 3.b, aims to support the research and development of medicines and vaccines for communicable and non-communicable diseases – particularly those which affect developing countries – and to provide access to essential medicines and vaccines. Such access is envisaged as being provided "in accordance with the Doha Declaration on the TRIPS Agreement and Public Health". Under the Doha Declaration on the TRIPS Agreement and Public Health, developing countries have a right to "use to the full" provisions in the TRIPS Agreement that would enable them to protect public health (United Nations General Assembly, 2015, p.17).

The Doha Declaration on the TRIPS Agreement and Public Health clarified that members of the World Trade Organization had some rights to grant compulsory licences to governments or third-parties in situations where states needed to take measures to protect public health. Other measures that countries can take to protect public health include a right to parallel importation as well as an extension in the period of transition for implementing TRIPS provisions for Least-Developed Countries (World Health Organization, 2018a).

In determining whether a compulsory licence to obtain essential medicines could be granted for reasons of national emergencies, or other circumstances of national urgency, certain requirements, such as the need to show prior attempts to obtain a voluntary licence from the patent-holder were waived in the Doha Declaration (World Health Organization, 2018a). This therefore means that a patent-holder refusing to grant a voluntary licence to countries in need

of such medicines and vaccines can have that refusal overridden by the granting of a compulsory licence to a government agency or other third-party of the country in need. The country facing the public health problem can then import the medicines needed without facing sanctions from the patent-holder.

The importance of the Doha Declaration on TRIPS and Public Health is that it demonstrates the existence of a moral obligation to help persons in need of assistance. At state level, it does indicate that the human being is a fundamental unit of moral concern; hence the effort to provide essential medicines and vaccines to the persons in those states who require them, without undue restrictions. At an individual level, it accords with Kant's argument that one can only fully realise his own humanity insofar as he seeks to recognise and support the humanity that is in others (Kant, 2013).

There are three indicators under 3.b. Indicator 3.b.1 measures the "Proportion of the target population covered by all vaccines included in their national programme" (United Nations Statistics Division, 2018e). This is a fairly robust measure, since it covers all vaccines within a particular country for the relevant age group. Care needs to be taken, however, to ensure that the required vaccines in each national programme include all those considered to be essential as measured against globally-agreed upon lists. There are likely to be some variations in these lists, given that the burden of disease in a region such as Africa differs markedly from say, that in Europe.

Indicator 3.b.2 seeks to assess the "Total net official development assistance to medical research and basic health sectors" (United Nations Statistics Division, 2018e). This is a good measure, since gaps in funding would probably be more apparent when quantified as against the needs of each country. Countries can ensure that they disaggregate the amount of official development assistance per disease, for instance, so that future assistance can be appropriately channelled to the most pressing need. Support for research and development ought also, according to 3.b, to be directed towards "communicable and non-communicable diseases that primarily affect developing countries" (United Nations Statistics Division, 2018e). The appropriate reference point for such support must therefore be the needs of the developing countries and not the preferences of any donors. A mismatch between country needs and donor preferences would be ineffective in promoting the health and well-being of persons in those countries. Properly directed support also demonstrates respect for the ends of persons in

these developing countries, in accordance with the Kantian imperative to treat persons as ends in themselves and not as a means to an end.

Indicator 3.b.3 is to measure the "Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis" (United Nations Statistics Division, 2018e). Of note is that this indicator is still a work in progress, and so falls to be considered under the Tier III Work Plans (United Nations Statistics Division, 2018f). This is an indicator that might present difficulties in measurement, since it seeks to assess three different dimensions – availability, affordability, and sustainability; all within the same parameter. A more manageable measure would perhaps have considered these three dimensions separately.

The 'core set' of relevant essential medicines referred to ideally should be viewed in terms of usage of the specific health facility (that is, in terms of numbers of persons who typically use that facility). This will in turn inform the quantity of medicines and vaccines that ought to be available in that particular facility at any given time.

It is important to note that the 'core set' of relevant essential medicines can vary from one facility to another. This is because it is possible to find different health needs within different regions of a country. For instance, in Kenya, as in other countries in the world, there are regions where snake-bites are more common than in others. In such areas, which are often also far from any major towns and health facilities, it is essential that there be sufficient quantities of snake-bite antivenom in the nearest health facility, whereas far lesser quantities may be required in other areas of the country. Habib and Brown (2018) however note that snake-bite antivenom is currently severely under-resourced; and that it is not produced in quantities that are sufficient to mitigate the effects of snake-bites around the world. They note that the World Health Organization's reclassification of snake-bites as a Neglected Tropical Disease in 2017 could present a good opportunity to shine a spotlight on this forgotten yet debilitating crisis, in which 95% of deaths occur in Asia and sub-Saharan Africa.

One notable omission in this indicator as stated is that there is no measurement for the quality of essential medicines and vaccines available within those health facilities. This leaves a gap in ascertaining whether any available medicines and vaccines are effective for the purpose for which they are procured. A look at the Work Plan for this indicator as at September 2017

however shows that there is an aspect of quality being considered once the indicators are finalised. It is still not clear, though, how sustainability, which is part of what is to be assessed in the indicator, is to be measured. The Work Plan seems to be considering substituting quality for sustainability in this indicator.

Health financing and the health workforce – 3.c:

This means of implementation is connected to Target 3.8 on UHC, but adds the important dimension of the health workforce, which was not specifically mentioned under Target 3.8. Indicator 3.c aims to "Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States" (United Nations General Assembly, 2015, p.17).

There are severe shortages of qualified health personnel in many countries, but this shortage is particularly acute in developing countries. Gabon in 2016 had 0.406 physicians per 1,000 of the population; while Senegal had 0.068; and Zambia had 0.091. In contrast, Austria in 2016 had 5.23 physicians per 1,000 of the population; France had 3.238; and Italy had 4.021. (World Health Organization, 2016c). The number of nurses, while more than the number of physicians per 1,000 of the population, follows a similar trend, with Gabon in 2016 having 2.898 nursing and midwifery personnel per 1,000 of the population while Italy had 5.718 (World Health Organization, 2016c).

Without sufficient numbers of health personnel in each country, it will be extremely difficult to meet the other targets under SDG3. For instance, Target 3.1 seeks to reduce the global maternal mortality ratio. With skilled health personnel present during childbirth, complications arising from the birth can be swiftly dealt with, and would reduce such incidents of mortality. This target also has a direct impact on Target 3.2, which seeks to end preventable deaths of newborns and children under five. Similarly, Targets 3.3 and 3.4 require sufficient health personnel to attend to persons suffering from communicable and non-communicable diseases, as well as provide care and treatment for those with mental illnesses.

A major problem faced by developing countries is the retention of their health workforce once trained. Many healthcare workers will, for various reasons including low pay within their own

countries, emigrate from their own countries seeking better economic, social, or educational opportunities in high-income countries. Mpofu, Gupta and Hays (2016) show the severity of the 'brain-drain' that particularly affects the retention of professionals in developing countries. Quoting the World Health Organisation, the authors note that,"11 per cent of the world's population in sub-Saharan Africa bears 24 per cent of the global disease burden but only has 3 per cent of the world's healthcare personnel". A major contributor to this state of affairs, according to the authors, is the migration of medical personnel from low- and middle- income countries (LMICs) to high-income countries (HICs).

Without the requisite health workforce, this means of implementation will be hard to fulfil. Mpofu, Gupta and Hays (2016, p.397) note that "the exacerbation of the disproportionate global distribution of the medical workforce by HICs reliance on such resources, reveals a potential injustice". In terms of the social contract, Rawls's "justice as fairness" in medical migration would, according to the authors, require that "global society should take an interventionist approach to this situation ... and that "that HICs need to acknowledge their dominant position and seek to remedy this imbalance" (Mpofu, Gupta, & Hays, 2016, pp.398-399).

From a virtue ethics perspective, a case could be made that the medical practitioners trained in LMICs ought to be motivated by compassion and integrity to practice medicine in the countries in which they received training – sometimes at a rate highly subsidised by their governments.

A perspective from Ubuntu would also make the case for the medical practitioners' acknowledgment of the interconnectedness of one human being to the other, usually captured in the phrase "I am because of who we all are"; and of the pressing need to offer their services for the good of their communities (Mugumbate & Nyanguru, 2013, p.83). Medical practitioners would express Ubuntu by acknowledging the social and financial investment in their education and upbringing, and therefore serve the members of the contributing community. While it can be argued that compassion, integrity and other virtues such as honesty are of value wherever exercised, and thus need not be 'proved' within, or confined by, geographical boundaries, there is a far greater need to be alleviated in LMICs than in HICs; given that LMICs generally have fewer financial and human resources dedicated to

healthcare than do HICs. This is a utilitarian argument, since it seeks to ensure the greatest happiness for the greatest number of people.

The ill-health, suffering, and diminished well-being that persons in these countries experience as a result of a considerable burden of disease, coupled with fewer resources to mitigate these adverse effects, is an issue of pressing moral concern. From the perspective of justice as fairness, it is arguable that it is an inequitable practice for developed countries which have more resources, to hire healthcare workers from poorer countries where the numbers of healthcare workers are already so few as to present severe challenges in the health systems of those countries.

There ought to be greater focus by both developed and developing countries on the training and retention aspect of this means of implementation, with resources being directed towards ensuring that sufficient numbers of persons are recruited, competently trained, and thereafter deployed within their countries in the areas of greatest need. There must also be sufficient planning and mobilisation of resources by states, which would ensure that persons working in the health sector are well-remunerated and work under decent and humane conditions.

From a capabilities perspective, decent working conditions enable the healthcare workers to have a range of capabilities within which they can exercise their functionings. These capabilities can include, for instance, being able to offer effective treatment, and being compassionate in their care of patients. Patients visiting the facilities have their capability sets expanded when they visit a well-equipped health facility in which they can get treatment or effective management of their health conditions. The removal of health-limiting conditions in turn enables them to have the freedom to pursue opportunities that may not otherwise have been open to them – For instance, a career in athletics after effective setting and healing of a broken leg.

Managing global health risks – 3.d:

Strengthening "the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks" is the final means of implementation under SDG3 (United Nations General Assembly, 2015, p.17).

This means of implementation is inextricably bound up with 3.c – without sufficient numbers of healthcare workers on the ground to detect and immediately raise an alert over say, the beginnings of an infectious disease such as ebola, early warning of such risks will be extremely difficult. Fully implementing 3.c, then, is a critical part of enhancing the capacity of developing countries to deal with global health risks.

The indicator for this means of implementation, 3.d.1, is the "International Health Regulations (IHR) capacity and health emergency preparedness" (United Nations Statistics Division, 2018e). This is a "Percentage of attributes of 13 core capacities that have been attained at a specific point in time"; and include surveillance; response; preparedness; risk communication; as well as national legislation, policy and financing (United Nations Statistics Division, 2018d).

One challenge with the IHR is that it is not clear whether any measures countries take to mitigate a public health emergency of international concern actually result in the strengthening of a country's deficiencies in any of the 13 core capacities. Put another way, does the collaboration and cooperation of countries endure beyond the public health emergency, and result in the strengthening of health systems within countries? The answer to this question is perhaps not to be found within this one target, but in the resolve by each country to strengthen its own health systems, and work with other countries to promote healthy lives and well-being for all at all ages.

Summary

In this chapter, I have carried out an analysis of the epidemiological and ethical aspects of SDG3. Given that SDG3 specifically seeks to ensure healthy lives and well-being for all at all ages, my analysis has utilised the broader view of health and of well-being that I had earlier established, in order to determine what SDG3's global consensus with regard to health and well-being entails. In my analysis, I have shown how the targets under SDG3 are interconnected and integrated with other SDGs and their targets. This interconnectedness indicates that the impact of SDG3 and the other goals must be examined contextually, with reference to the other goals, and not in isolation. The goals and targets together give an

expanded picture of the determinants of health, which I had earlier argued are the crucial link between the health and well-being of the individual.

I have analysed the epidemiological basis of SDG3 targets and whether they can achieve what they set out to do. In my analysis, I have incorporated indicators under SDG3 and indicators from related SDGs, with a view to determining their suitability for what they seek to measure.

Some of the targets and indicators under SDG3 can benefit from clarification and expansion, particularly in what they are intended to measure. Target 3.5, for instance, seeks to strengthen the prevention and treatment of substance abuse and harmful use of alcohol. The relevant indicator, however, does not take into account that persons below 15 years of age may already have begun drinking alcohol. Such persons would also need targeted interventions to enable them to stop drinking alcohol. If, however, they are not captured in the indicators, they may be left behind. Indicator 3.9.3, for instance, introduces a measure for mortality rate due to 'unintentional poisoning'. I have argued that this is an unjustifiable distinction and that what ought to be measured is the mortality rate from poisoning. Whether mortality occurs from intentional or unintentional poisoning should be immaterial from the point of view of the *effect* of the poisoning.

I have considered the ethical implications of SDG3 targets, indicators, and means of implementation. The ethical implications include the impact of failing to achieve the targets. By utilising diverse ethical approaches including Kant's deontological approach, the Capabilities Approach, Ubuntu and virtue ethics in my analysis, I have shown the impact that SDG3 targets can have on individual well-being. My focused analysis of SDG3 combining its epidemiological grounding with ethical critique is a contribution to knowledge, given that such a detailed analysis and ethical critique of SDG3 and its targets, indicators, and means of implementation has not previously been carried out. I have contributed to the literature by considering multiple ethical approaches in my analysis.

It is clear that what is entailed in healthy lives and well-being for all under SDG3 when viewed contextually, extends beyond a narrow, biomedical definition of health to incorporate the determinants of health. These determinants include the availability of clean and affordable energy, decent housing, water and sanitation facilities, education, and the creation of economic and other opportunities. The diverse ethical approaches of well-being that have

been used to analyse SDG3 bring out the importance of placing the individual at the centre of any actions designed to promote health and well-being. Without such a view of the centrality of the individual, many persons will be forgotten and will be left behind.

In Chapter 4, I discuss and analyse potential measures that can be employed to accelerate the achievement of the SDGs by 2030.

CHAPTER 4: MONITORING PROGRESS AND ACCELERATING THE ACHIEVEMENT OF THE SDGs

Introduction

With 17 goals and 169 targets to be met by 2030 [the number of targets comprising 126 targets and 43 means of implementation], it is clear that there is much to do if success in the SDGs is to be achieved. As at March 2018, there were 232 indicators (United Nations Statistics Division, 2018c); some of whose methodologies are yet to be finalised and therefore are not yet operationalised.

232 indicators certainly present a challenge in terms of data collection, particularly with regard to the resources (both human and technological) which will be required to collect and analyse this data. Collection and measurement of data is central to Agenda 2030 and the SDGs because of the way in which the goals are structured – each goal has targets whose progress and achievement is dependent on measuring certain indicators.

In June 2015, prior to the adoption of Agenda 2030, the Leadership Council of the Sustainable Development Solutions Network presented a report to the Secretary-General of the United Nations, stating that, "We believe 100 to be the maximum number of global indicators on which NSOs [National Statistical Offices] can report and communicate effectively in a harmonized manner" (Sustainable Development Solutions Network, 2015, p.2). It would appear that there is much more to be measured than was envisaged, given the expansion of this number to its current 232. It is thus not clear whether NSOs will be in a position to expand their capacities to take on the additional 132 indicators that are implied to be beyond their capacity to report effectively. The number of indicators for the SDGs is however still likely to change further, given ongoing work on the indicators.

The Leadership Council of the Sustainable Solutions Development Network had envisaged that approximately USD 1 Billion would be required to monitor the SDGs annually, and that, "At least half of this will need to be raised through domestic resource mobilization, but at least $100-200m will be required in incremental ODA [Official Development Assistance]" (Sustainable Development Solutions Network, 2015, p.4). An increase in the number of indicators is likely to see an increase in the amount of money required to monitor the SDGs.

Since countries are expected to collectively contribute to half of the amount required annually for monitoring the SDGs, (which as indicated is likely to have now increased), there will be challenges in financing the collection of this data. These challenges are likely to affect developing countries more severely.

As argued in Chapter 3, however, the appropriateness of some of the indicators in terms of what they are supposed to measure needs to be re-evaluated. The principles upon which the indicators ought to be based include: being "limited in number; simple, intuitive, and policy-relevant; consensus-based, in line with international standards; relevant to all countries and all people; and able to be disaggregated to track progress for all relevant groups" (Sustainable Development Solutions Network, 2015, p.3).

Other than the global indicators, which are applicable to all countries, each country can also adopt national indicators, which would provide some flexibility in what is tailored to each country's needs. Regional indicators allow for "knowledge-sharing, peer-review, and reciprocal learning across regions"; while thematic indicators are those specialist indicators which particular communities might wish to contribute to in terms of providing "novel ways of collecting, analysing, and presenting data" (Sustainable Development Solutions Network, 2015, p.3). Thematic indicators include, for instance, "health, education, [and] agriculture" (Sustainable Development Solutions Network, 2015, p.9). The acknowledgment that different countries and regions might require their own indicators speaks to the diverse experiences that individuals have of health and well-being within different contexts, such that additional indicators might be needed in countries and regions which face a unique burden of disease, for instance, or of severe climate impacts.

In Section I of this chapter, I analyse aspects of the 2018 Report of the Secretary-General of the United Nations to the High-level Political Forum on Sustainable Development. This was a report on the progress being made towards the SDGs. The report indicates that progress towards the SDGs is generally slow, and in some cases shows a decline – For instance, an increase of malaria cases in 2016 from the figures reported in 2010.

In Section II, I analyse some of the issues that have been identified as impediments to progress in the SDGs, as well as the measures proposed by various authors to spur action by states, non-state actors, institutions and other entities to meet the SDGs by 2030. Where

relevant, my analysis incorporates ethical perspectives that link these proposals to the ethical critiques earlier offered, in order to give a holistic picture of the proposals and their capacity to motivate action. A significant contribution of this chapter in Section III is the claim that Herbert Simon's related concepts of satisficing and bounded rationality are relevant to guiding the decisions that states will make towards progress in Agenda 2030. This is particularly so in cases where states face constraints such as incomplete indicators for the SDGs and a lack of data collection capacity. I argue that satisficing can help states to determine which targets and indicators they should focus on first in order to have the widest impact. The flexibility allowed to different states to set nationally appropriate targets under Agenda 2030 could also be a factor that states could use to choose to focus on the actions that they consider most appropriate within their national resources and capacities.

Section I: The present status of progress on the SDGs

In his report on progress towards the SDGs, the Secretary-General of the United Nations notes that while the proportion of persons living with their families on less than $1.90 per day has "declined significantly over the past two decades", in 2017 there were still 9.2% of persons globally who were living with their families on less than $1.90 per day (United Nations Economic and Social Council, 2018). It is important to note that this figure is 9.2% "of the world's workers" (United Nations Economic and Social Council, 2018, para 7, p.3). This seems to imply that it does not include persons without employment, or those without an income-generating activity. This percentage is therefore likely to be much higher. Only 22% of unemployed persons around the world receive unemployment cash benefits, which indicates that the rest have to find other means of support throughout the period of unemployment (United Nations Economic and Social Council, 2018, para 9, p.3).

With regard to health and well-being from an individual perspective, the lack of an income (whether from employment or other income-generating activity), further compounded by a lack of cash benefits during unemployment is an issue of moral concern. The impact of unemployment is felt not only by the unemployed person, but also by his or her family. In terms of health and well-being, the effect on the individual can include an increased risk of depression, lack of money to afford healthcare when needed, and the inability to participate

meaningfully in social interactions; particularly if the ability to bring in an income is perceived as conferring a particular status or respect.

In terms of progress towards SDG3, the Secretary-General states that, "The world is not on a trajectory towards ending malaria by 2030 – in fact, the trends are worrisome". He notes that, "In 2016, there were 216 million cases of malaria, compared with 210 million cases in 2013" (United Nations Economic and Social Council, 2018, para 28, p.5). This increase needs to be interrogated, and its causes identified and appropriately mitigated. As I argued in Chapter 3 when analysing Target 3.8, there are gaps in the indicators and tracers proposed to measure progress in ending malaria. The proposals I have suggested in my analysis, and the use of evidence-based research on mosquito behaviour, could present a solution to reverse this trend.

While there have been reductions reported in new cases of tuberculosis, HIV/AIDS, as well as Hepatitis B in infants, there remain challenges in tackling other infectious and non-communicable diseases. Out of 870,000 deaths which occurred as a result of unsafe drinking water, unsafe sanitation and a lack of hygiene, "329,000 deaths occurred in children under 5 years of age. Sub-Saharan Africa and South-Eastern Asia bear the highest disease burden" (United Nations Economic and Social Council, 2018, para 30, p.5).

If healthy lives and well-being for all at all ages are to become a reality, states must ensure that all persons have access to clean water and proper sanitation. It is also important for these states, in collaboration with non-state actors, to provide information and education on hygiene and ways of reducing the risk of contracting infectious diseases. Special attention must be paid to children under 5, who from the figures given appear to suffer the most adverse effects of unsafe water and a lack of hygiene. States, in collaboration with non-state actors, institutions, and other entities, ought therefore to provide information and education on hygienic practices to new mothers and their families.

The number of deaths from "cardiovascular disease, cancer, diabetes or chronic respiratory disease" stood at 32 million in 2016 (United Nations Economic and Social Council, 2018, para 31, p.5). This figure does not include persons who were suffering the effects of morbidity from these diseases– for instance, an inability to participate in sports, or reduced mobility from the amputation of a limb as a result of diabetes.

The reduction of an individual's capabilities and functionings is of moral concern. States need to make efforts to capture such persons in the data and take measures to remove impediments to their capabilities and functionings. This would have the effect of increasing their freedom and opportunities for living a life of their choosing.

The figure for suicides globally in 2016 remained unchanged from nearly 800,000 in 2015. This indicates a need, as argued in Chapter 3, for an indicator to measure the prevalence of mental illnesses, and the availability and accessibility of mental healthcare interventions. While mental illnesses may not be the only cause of suicides, they do contribute to the incidence of suicides, and thus need to be captured.

The health workforce in many countries is also overstretched and cannot adequately cover the population. As the Secretary-General's progress report noted, "close to 45 per cent of all countries and 90 per cent of the least developed countries have less than one physician per 1,000 people, and over 60 per cent have fewer than three nurses or midwives per 1,000 people" (United Nations Economic and Social Council, 2018, para 40, p.6). The shortage of health workers is a critical issue which needs solutions if SDG3 is to be met by 2030. As proposed in Chapter 3, countries must scale up the training of health professionals, as well as provide the means to retain them where they are most needed – an imperative that is particularly urgent in developing countries.

Other SDGs and their targets with a bearing on SDG3 include, for instance, SDG7 on ensuring access to affordable, reliable, sustainable and modern energy. 59% of persons globally had access to clean fuels and technology for cooking in 2016. There is still much to be done, however, since 3 billion people are still using "polluting fuels and stove combinations" for cooking (United Nations Economic and Social Council, 2018, para 68, p.9). Such polluting fuels have an adverse effect on health and well-being as they cause respiratory illnesses and other diseases such as lung cancer and stroke. Access to safe water under SDG6, as well as access to hand-washing facilities, is also important. Only 27% of the population in developing countries had access to basic hand-washing facilities in 2015 (United Nations Economic and Social Council, 2018, para 60, p.8).

Section II: Challenges and solutions to progress in the SDGs

Several writers have analysed the challenges that exist in the SDGs, their targets, and indicators which could pose a threat to the attainment of the goals. It is important to consider these challenges and seek to mitigate or remove them, if the SDGs are to be achieved by 2030.

A. Challenge: Gaps in data and sustainability indicators:

Chattopadhyay (2016) discusses three "blind-spots" that present challenges for the SDGs. The first is, "large data-gaps and paucity of publicly accessible data"; the second is "the missing notion of sustainability in the chosen metrics"; and the third, "the lack of data on the distributional aspect of the development agenda" (Chattopadhyay, 2016, p.3). With regard to the first challenge, Chattopadhyay states that since data provides "the *tools* for decision-making, the paucity of data hampers effective decision-making" (Chattopadhyay, 2016, p.4) (emphasis in original). Policy decisions made would therefore not be based on the actual situation on the ground, but perhaps on assumptions or the practices of other countries. This could plausibly result in a focus on the wrong aspect of a particular problem, and therefore a longer time to achieve the SDGs. This is because the policies would not effectively guide the necessary action.

In terms of the sustainability gap, Chattopadhyay notes that the indicators are unable to capture costs and benefits of future-oriented technologies – for instance, those that would help in mitigating climate change, or create new energy sources. Such indicators "based on existing or past experience are therefore inherently backward-looking" (Chattopadhyay, 2016, p.4). One example of a sustainability gap is seen in Indicator 3.b.3, as earlier argued in Chapter 3. It seeks to measure the availability, affordability, and sustainability of a core set of relevant essential medicines (United Nations Statistics Division, 2018e). There is, however, no indicator to measure sustainability.

Another challenge involves countries being tied to "policies and investments that might be prudent in the short-run but might be sub-optimal and, at times, even counterproductive in the long run" (Chattopadhyay, 2016, p.4). How to mitigate this challenge is not at present clear, although Chattopadhyay suggests "[incorporating] complementary qualitative data or

quantitative projection data that can factor in uncertain future possibilities with some sort of probability assessment" (Chattopadhyay, 2016, p.4). Arguably, such data would still be relying on measures that have a considerable level of uncertainty. Unless some way can be found to overcome this challenge, the present indicators, after making appropriate revisions that can be measured, would have to do.

The third issue discussed by Chattopadhyay, which raises the challenge of a lack of data on the distributional aspect of Agenda 2030, includes the unavailability of data at regular time intervals for particular regions – For instance, "the World Bank has no official (publicly available) income-inequality data for countries in the Middle East and North Africa region, and in some cases the most recent country statistics are from 2005" (Chattopadhyay, 2016, p.5). Countries will need to make efforts to collect up-to-date data at regular intervals. Disaggregating such data would go a long way in ensuring that the most marginalised sections of the population are adequately catered for in subsequent interventions.

Proposed solutions to gaps in data and sustainability indicators

States will need to gather data at regular intervals if that data is to be useful in informing action towards the SDGs. Thomas et al., (2016) give a view of gathering data in the specific context of SDG3. They note that in order to effectively measure what they refer to as 'health indicators', "low- and middle-income countries (LMICs) will have to build new, bigger, and better health information systems ... to capture, store, manage, and transmit information on the health of individuals and the activities of the institutional healthcare and health policy apparatus" (2016, p.1446). Thomas et al., also recognise that a system will only be as effective as those who will be required to gather and record the information that feeds into it, stating that there is a danger that healthcare providers can be overburdened by requirements to collect data. While Thomas et al., assert that healthcare providers "cannot compromise their duty to the clients they serve" (2016, p.1446), they do not provide solid proposals as to how the increased need for data should be handled within the healthcare system.

One of the possible options would be for governments to hire more staff in order to free healthcare providers to concentrate on caring for patients. Such staff would not necessarily be directly involved in clinical care, but would liaise with medical practitioners, for

instance, to seek consent from patients for data to be collected. Gathering data in this way would be likely to entail an increase in the budgetary allocations for healthcare, even though allocations for healthcare in many countries are already overstretched.

Should extra staff who are not necessarily health professionals ultimately be hired, governments and healthcare facilities would need to have regard to the implications of their presence in healthcare facilities, and the impact of their proximity and access to confidential information. Healthcare professionals are trained and required to maintain the ethical duties of privacy and confidentiality. Other persons may not have received such training; and further, may not be subject to oversight by a regulatory body. In these cases, governments would probably need to invest in training the persons collecting data on the importance of protecting privacy and confidentiality. This would not be the only training required – As Thomas et al., note, "Each system will need computer hardware and software and people trained to use and maintain them, following standard procedures" (2016, p.1446). These are just a few of the issues that would need to be considered with regard to the data required specifically for healthcare institutions.

With regard to Chattopadhyay's observation of the lack of sustainability indicators for future technologies, the only way forward is to work with the indicators that are available – It is not possible to know with certainty the effects of as yet undeveloped technologies. States, however, ought to have the leeway to adjust these indicators appropriately should new technologies prove to be more effective at achieving what older ones were designed to do. Agenda 2030, as it states in its Preamble, is "a plan of action for people, planet and prosperity"[11] (United Nations General Assembly, 2015, p.1) and therefore must be flexible enough to adjust to what is best for people, planet and prosperity. In this regard, Agenda 2030 must therefore be considered a 'living document' which must be updated as circumstances demand. As argued earlier, the overarching focus must be on a view of individual health and well-being that takes into account Agenda 2030's call to improve the lives of people and leave no one behind.

[11] In addition to being a plan of action "for people, planet and prosperity", the Preamble to Agenda 2030 also seeks to strengthen universal peace and calls for collaborative partnerships with all stakeholders (including individuals) to implement Agenda 2030 (United Nations General Assembly, 2015).

B. Challenge: Selectivity, simplification, and national adaptation of the SDGs:

Fukuda-Parr (2016, p.50) identifies three challenges that would impact success in the SDGs by highlighting a risk that "the most transformative goals and targets would be neglected in implementation through selectivity, simplification, and national adaptation".

On selectivity, Fukuda-Parr suggests that some of the SDGs, particularly those which tackle structural issues, could be neglected. She gives as an example the means of implementation 5a for SDG5, which requires countries to undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property (Fukuda-Parr, 2016, p.50). On the risk of simplification, Fukuda-Parr notes that the language of the SDGs in considering the issues of equitability and sustainability in development, is complex. She cautions against the simplification of this language, which risks reinterpreting the goals.

The third challenge raised by Fukuda-Parr is the national adaptation of the goals. Inasmuch as there is some flexibility that countries have as they work through the goals, "this reduces the political pressure on national governments to address the political causes of poverty and inequality. It can then be an invitation to water down the ambition of the SDGs" (Fukuda-Parr, 2016, p.50). This dilution of the goals would then lead to reduced accountability, and perhaps a lag in progress; which could result in many countries failing to meet the goals by 2030. The most affected persons in such a scenario would of course be the most vulnerable and marginalised; an outcome that would defeat the very raison d'être of Agenda 2030, which seeks to 'leave no one behind'.

Proposed solutions to selectivity, simplification, and national adaptation:

The SDGs do allow some scope for countries to adapt the goals to their most pressing needs. The risk that Fukuda-Parr raises concerning selectivity, national adaptation and slow progress in the goals would begin to be material if states altogether discarded any attempts at making progress in certain SDGs; or else only made feeble efforts at meeting certain goals.

While it is indeed true that each country will have different experiences in terms of its own policies and implementation, there is indeed a risk, as noted by Fukuda-Parr, that national

adaptation could be used by governments to water down the SDGs – particularly if political expediency favoured such an approach. There ought rather to be a fine balance between national needs and a consistent view of health and well-being from the perspective of the individual. This would require that national plans and strategies do not derogate from, but rather adapt accordingly to fulfil the SDGs.

In view of the fact that Agenda 2030 is based on the voluntary co-operation of states, the voluntary national and thematic reviews in Paragraphs 84 and 85 of Agenda 2030 must take on the character of not just a reporting forum, but also an accountability forum; where states' representatives actively participate in asking probing questions that are designed to draw out responses for which solutions can then be found. Reporting states can also be spurred on to rise to the occasion and do better particularly where it becomes apparent that it is a lack of commitment by the leadership to the SDGs, rather than resources, that is at issue.

C. Challenge: Actualising SDG interlinkages, trade-offs and synergies in national policies and processes:

Allen, Metternicht and Wiedmann (2018, p.8) note the limited progress that some countries are making in assessing "interlinkages, trade-offs and synergies" in the SDGs, as well as in "policy evaluation and design". Following an analysis of 26 countries which had submitted a Voluntary National Review to the High-Level Political Forum on Sustainable Development either in 2016 or 2017, Allen et al., found that none of the 26 countries had completed the assessment of their national plans and strategies as against the SDGs in terms of policy evaluation and design, or in terms of interlinkages that would better inform these plans and strategies. Without the deliberate incorporation of the relevant aspects of the SDGs into national planning, it is unlikely that the goals will be met, particularly if countries perceive them as an add-on rather than as integral to the design of those national strategies.

While Allen et al., state that this gap is perhaps likely to be explained by the "newness" of the SDGs, they also suggest that "other factors such as the complexity of the agenda, political dynamics and capacity gaps" could also account for these missing aspects (Allen

et al., 2018, p.9). Xue, Weng and Yu (2017, p.151), also point to capacity challenges as an impediment to meeting the goals.

Proposed solutions to facilitate SDG interlinkages, trade-offs and synergies in national policies and processes:

The SDGs, as I have shown earlier, are interconnected and indivisible. Each goal must be viewed in the context of its impact on the other goals. I have also argued that a holistic view of health and well-being must have regard to the determinants of health; which themselves must incorporate social justice considerations.

One example which shows the interlinkages between different SDGs, the determinants of health, and individual health and well-being is the existence of labour laws and policies within a country.

Lucci and Lally (2016, p.17) note that one of the ways in which the most marginalised can be reached is through "[improving] the quality of informal employment, in particular through labour standards and support for internal migrants". Such support can include the enactment of minimum wage laws, which would see an increase in the wage of such workers (2016, p.17). Whilst this is certainly a welcome move, the enactment of such laws must be followed by their enforcement; without which the benefit to be gained from such laws might be lost. In the absence of the enforcement of laws, vulnerable persons would be constrained to work for whatever wages the employing entity would be willing to pay them; given that the alternative to demanding a minimum wage might be cast as getting no wage at all.

Although there is some evidence that the setting of a minimum wage can result in an increase in unemployment (Brunt & Barilla, 2018; Meer & West, 2016), other studies show mixed results – some show an increase in unemployment, and others show no change (Bhorat et al., 2017). An analysis by Lundstrom (2017, p.42) of the effect of setting a minimum wage, raises the possibility that "the minimum wage increases the employment of low-skilled *poor* individuals relative to the employment of low-skilled *non-poor* individuals" (emphasis in original). Lundstrom however considers the minimum wage an 'imperfect tool' to address poverty (2017, p.42).

Arguably, on the other hand, receiving a wage that cannot afford a vulnerable person a sustainable existence, and which is further negatively impacted by the effects of inflation, also has a deleterious effect on health and well-being.

Spencer and Komro (2017, p.46) note that in the case of the United States of America, economic security policies (including setting a minimum wage), have an impact on the health and behaviours of persons and families. They state that such policies can influence the social determinants of health by reshaping "social conditions in ways that reduce disparities in exposures to toxic and health-compromising environments and increase protective environments". Further, they note that with regard to increases in the minimum wage in particular, these changes can also encourage healthy behaviours while reducing unhealthy ones. Spencer and Komro provide a summary of studies showing that an increase in the minimum wage is associated with a reduction in all-cause mortality rates; a decrease in premature deaths; as well as a decrease in low birth-weight.

Of the studies cited by Spencer and Komro with regard to increases in the minimum wage, only one by Hoke and Cotti (2016) shows a negative impact on health – specifically, that an increase in minimum wage is associated with an increase in binge-drinking among teenagers, especially males. This negative effect is postulated as being attributable to the increase in disposable income – a $1 increase in the minimum wage increased binge-drinking among 14-18 year olds by approximately 9% (Hoke & Cotti, p.365).

One way of mitigating the health-reducing effect of minimum-wage increases for teenagers and adolescents is through adopting the measures proposed in Chapter 3 as pertains to Target 3.5, which include tightening restrictions on the access to, and sale of alcohol to teenagers. The setting of a minimum wage in the United Kingdom has also been shown to have resulted in improved reported mental health in persons earning a low income, through reducing the financial strain that causes anxiety and depression (Reeves et al., 2017).

In Sub-Saharan Africa, the levels of non-compliance with minimum wage laws are high, and few countries have reliable data on wages (Bhorat et al., 2017). Overall, however, "introducing and raising the minimum wage has a small negative impact or no measurable negative impact" on employment (Bhorat et al., 2017), although there are some variations within countries around this finding.

For persons who are self-employed, there are improvements that can be made in terms of systems and processes that can assist them to register and begin running their own businesses. One improvement can involve the easing of processes that are required for small and medium sized businesses to be licensed. The reduction or elimination, where possible, of the many permits and various fees that are often required by governments before one can begin operating such businesses is another example.

According to the World Bank Group (2017), the Doing Business Ranking indicates that high- and upper-middle income countries have made it easier for persons to do business within their countries, while lower-income developing economies tend to rank much lower on this list. Developed countries dominate the top 40 places in this ranking, save for Georgia, a lower-middle income country which is ranked 9th on the list. Rwanda, a low-income country, is the top country from Africa, ranking at 41st on the list; with Morocco the next African country at number 69 (World Bank Group, 2017). In contrast, 30 countries in Africa make up the bottom 45 countries in this ranking, which shows the need for the causes of these imbalances to be examined and removed. Without such policies focused on the most vulnerable, SDG11 on sustained, inclusive and sustainable growth, and productive employment and decent work for all, will not be attained. Given the integrated and indivisible nature of the goals, a lack of sufficient income would also impact on other goals – For instance, it would certainly impact SDG10 on reducing inequalities within and among countries.

If the interlinkages, trade-offs and synergies within the SDGs are to be taken into account and factored into national plans and strategies, there must be active participation by the citizens of each state in contributing to these national plans and strategies. The most effective way in which persons can do this is by holding leaders to account as to the steps that they are taking to ensure that the SDGs are reflected in local, provincial and national plans. Without the active participation of citizens, there is the risk that considerations of political expediency might trump what is of moral concern for these citizens; and that the goals will ultimately not be considered a priority.

As entities tasked in Agenda 2030 with the obligation to ensure the success of the SDGs, states will also need to hold themselves accountable to their citizens; and each state ought to be accountable to others, to ensure that they are taking measures to make progress in the

goals. Individuals too, have the obligation to play their part in advancing the goals, and in pursuing accountability by the leadership.

D. Challenge: Complexity and vagueness in SDG targets and indicators:

As earlier discussed, Fukuda-Parr (2016) raises the risk that in seeking to simplify the SDGs, the various dimensions that are necessary for their fulfilment will be lost. She argues that the goals are complex, but that this complexity ought not to be lost.

Xue et al., (2017, p.151) consider the complexity of the goals to be problematic, describing the SDGs and their targets as an "implementation nightmare". They suggest that "finding the interlinkages among different goals could enhance the effectiveness of implementation and reduce the related costs". Other than the challenges attributable to the complexity of the goals and a lack of capacity within countries, there are difficulties presented by the large number of indicators, as well as the vagueness of terms such as 'sustainable,'; 'efficient'; and 'substantial'; which Xue et al., (2017, p.151) consider to be difficult to measure with any exactitude.

Proposed solutions to the complexity and vagueness of SDG targets, and indicators:

There are several aspects to tackling the complexity and vagueness of SDG targets and indicators. One of the ways in which to overcome the challenge of complexity might be by simplifying the language that is used in the targets and indictors so that a wider audience from diverse age-groups can better engage with them. The large number of indicators in the SDGs also contributes to their complexity, as does the presence of indicators that are unsuitable for what they are intended to measure. As earlier argued, different individuals across the globe will have varying experiences of health and well-being that are influenced by their social, economic, cultural, environmental, educational, religious and other contexts. There would therefore need to be some level of flexibility afforded to each state to adapt some of the goals to their local circumstances. I discuss some of the solutions for the complexity and vagueness of SDG targets and indicators in the following paragraphs.

Adaptive governance:

Xue et al., (2017) suggest an "adaptive governance" approach to implementing the SDGs, rather than a reliance on the traditional mechanisms which involve "intergovernmental negotiation and rigid implementation" (Xue et al., 2017, p.152). Describing 'adaptive governance' as that which can recognise the complexity of policy design; "emphasizes alignment between high-level goals and local arrangements"; "recognizes the importance of local contexts and experiences"; and is subject to continual evolvement by "facilitating continual renegotiation to achieve ultimate goals", Xue et al., propose this approach as suitable for the SDGs since they consider the different contexts of various countries.

It is however not immediately apparent that an adaptive governance approach also takes into account individual health and well-being. It may turn out to be the case that an adaptive governance approach glosses over the health and well-being needs of many persons using the reason that particular needs are not a national priority at that time. The risk that adverse effects on individual health and well-being could be ignored is real.

Communicating the message of the SDGs:

With regard to the complexity of the SDGs, I argue that the message of the SDGs can be effectively communicated without losing their meaning.

Various organisations have undertaken initiatives that try and simplify the meaning of the SDGs – two examples are the International Disability and Development Consortium (IDDC) (2013) and the United Nations Regional Information Centre for Western Europe (UNRIC) (2017). Their efforts at simplifying the goals are commendable. If persons at least have an awareness and understanding of the basic meaning of the goals, there can be ongoing supplementary efforts at education by states, non-state actors, and other institutions to expound further on what the goals entail.

In the Easy Read version of the SDGs created by the IDDC and other partners, for instance, SDG1 is stated as, "Stop poverty around the world. Poverty doesn't just mean being poor, it can mean not having other things you need to live a good life" (IDDC, 2013, p.3). SDG3 is stated as, "Make sure people are in good health and know how to make decisions to stay healthy all through their lives" (IDDC, 2013, p.3). These are good

statements as a beginning, since they necessarily would give rise to the question, 'How?' and thereby trigger a conversation as to how these goals can be achieved.

UNRIC has approached the SDGs by focusing on teaching children aged 8-10 about the goals using a board game. Described as "a do it yourself kit", the UNRIC website states that, "all you need are a printer, a pair of scissors, some tape or glue, and you can start playing". As at the end of 2017, the game was due to be made available in Dutch, Chinese and Italian languages, in addition to English (2017). This kind of approach ensures that the children targeted are aware of the goals early enough. It also presents an opportunity for them to begin playing a role in working towards the goals. By the time they have reached adulthood, they are likely to be aware of what needs to be done differently to accelerate progress towards the goals; or to come up with other goals beyond 2030.

Every state and global region can take the initiative to find creative ways to communicate the message behind the goals in ways that can be easily understood by young and old alike. This is an endeavour in which individuals and non-state actors can also participate. Therefore, for instance, while children in Western Europe and other developed countries might have ready access to a printer, children in many parts of developing countries might not. The board game could therefore, for instance, be translated into some of the main languages spoken within Africa and made available for children via community gatherings and other local events. The game could also be adapted, so that it is not only available as a board game, but perhaps in other forms such as a singing game, or adapted to oral narratives. Adolescents and older children can also learn about the games in ways that are appropriate for their level of development, as can young adults. Competitions can perhaps be arranged where young adults showcase creative ways to solve the challenges posed by the SDGs, with the added incentive of seeing their ideas implemented nationally. Complexity in the goals and targets can be overcome.

Some ethical perspectives on simplifying the SDGs:

Efforts at simplifying the SDGs demonstrate a recognition of the importance of inclusiveness for all, and the acknowledgment that each person has the capacity to influence his or her environment through deliberate actions. The opportunity for persons to contribute to their own, and others' well-being, fulfils the Kantian imperative of treating

persons as ends in themselves – not simply as bystanders on whose behalf decisions are made, but as persons who can make a valuable contribution to the state of the world.

From a virtue ethics perspective, participation by persons in causes such as eradicating poverty (SDG1); ensuring good health and well-being for all (SDG3); and protecting, restoring and promoting the sustainable use of ecosystems (SDG15); amongst others, fosters virtues such as empathy, compassion, responsibility, tolerance and generosity.

Regarding responsibility, for instance, Williams (2008) says that, "responsibility represents the readiness to respond to a plurality of normative demands" (2008, p.459). He states that there are two distinctive features of human agency applicable to adult human agency (not to children or animals); and to "certain forms of collective agency" – These he states are, "first, the capacity to move between different frames of reference; [and] second, to respond for past actions and plan future interventions" (Williams, 2008, p.460). He explains further that, "When we praise an agent as responsible we are describing a readiness to exercise judgment and initiative with regard to the (changing, variable, never entirely foreseeable) demands she encounters over time" (Williams, 2008, p.460). With regard to the SDGs, therefore, a willingness to participate in actions that would potentially advance the goals is indicative of personal as well as institutional or collective responsibility when exercised – Williams' use of the word 'agent' refers "to both individual persons and collective bodies" (Williams, 2008, p.457). It certainly would be a great achievement were all the goals to be met by all countries by 2030. However, there is value (and virtue) simply in the attempt; and personal growth and development to be gained just by participating in actions that are geared towards advancing the goals. In short, whether or not the goals are met by 2030, participating and contributing to efforts to meet the goals is worthwhile.

With regard to practical judgment, which would be required as a result of competing normative demands, Williams says:

> The most consequential form of irresponsibility consists in simplifying matters by ignoring some normative demands ... Judgment and initiative, imagination and commitment are our resources for discerning and extending what is possible and appropriate by way of response – not just in terms of individual

acts, but also courses of action or institutional policies (Williams, 2008, pp.460-461).

State plans and strategies too, ought to reflect carefully considered and justifiable decisions which conform to social justice considerations. They should therefore incorporate wide consultation with the citizenry, for instance, who would be the persons affected by any actions taken or not taken.

The SDGs have been further explained through targets, which represent a global consensus on what were considered the most pressing issues that require action. Targets in turn have indicators to track progress. As earlier demonstrated, it is clear that data will be crucial to the fulfilment of the SDGs.

Hák, Janoušková and Moldan (2016, p.567) support the evaluation of the quality of sustainable development indicators by certain criteria: "Credibility, relevance and legitimacy (so-called CRELE)". Hák et al., note that "despite complementarities and trade-offs between these criteria, the indicator framework should secure their appropriate level". Thus, legitimacy in the indicators will be seen if the criteria are "respectful of stakeholders' divergent values and beliefs, unbiased, and fair in [their] treatment of opposing views and interests" (2016, p.567).

'Appropriate levels' would imply that there ought not to arise a situation where decisions by a state are taken in complete disregard for people's values and beliefs. While not all interests can be satisfied, all persons must be offered the opportunity to be heard. It is a delicate balancing act to ensure that credibility, relevance and legitimacy are met with regard to the SDGs. SDG16 that seeks to "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels" will be relevant here, together with its accompanying targets such as 16.7: "Ensure responsive, inclusive, participatory and representative decision-making at all levels" (United Nations General Assembly, 2015, p.25).

E. Challenge: Lack of statistical capacity within countries:

Several writers have pointed out the need for data in order to track progress in the SDGs (AbouZahr et al., 2017; Chattopadhyay, 2016; Marmot & Bell, 2018; Sankoh & Byass, 2017; Schmidt-Traub et al., 2017; Xue et al., 2017). A key challenge for many countries, but particularly for developing countries, is the absence of data. Other challenges include a lack of up-to-date data; data gathering that is driven by donor needs rather than country requirements; and a lack of statistical and data-collection capacity (AbouZahr et al., 2017; Xue et al., 2017; Marmot & Bell, 2018).

Schmidt-Traub et al., raise another challenge regarding data, stating that, "More and better data are needed, but it will take years to build the necessary statistical systems even if adequate resources were mobilized, which is currently not the case" (2017, p.547). With the deadline for the SDGs set at 2030, any delay in obtaining the necessary data is likely to result in many countries failing to meet the goals by then, since they would be unable to track their progress effectively and take corrective action early enough to meet the goals.

Proposed solutions to a lack of statistical capacity within countries:

The lack of statistical capacity within countries is a long-term project which will require the training of people within countries that have such gaps. This will be necessary in order to build up the required capacity for each country to take on the data collection and analysis that is necessary for the SDGs and perhaps for future goals.

In the interim, where countries have an abundance of expertise in terms of personnel, or in setting up statistical and data-collection systems, or financial resources that can be dedicated to strengthening statistical capacity, they can offer assistance and collaboration to countries which have such shortfalls.

F. Challenge: The influence of neoliberal mechanisms:

Scheyvens, Banks and Hughes (2016, p.376) note that while the private sector as a whole is one of the actors in Agenda 2030 with an obligation to advance the SDGs, there is often the critique that there exists an insufficient challenge to "the neoliberal mechanisms that have created many inequalities and poor development results in the first place". Scheyvens

et al., note that having been instrumental in the creation of inequalities, these neoliberal mechanisms ought not to be relied on to solve the very same inequalities they brought about. They argue that self-interest is a key factor in the involvement of business in the sustainable agenda, with a business focus towards voluntary change rather than regulation, for instance. Further, they note that the structural causes of poverty have also not been addressed; and propose that changes need to be made in the global institutional order, which is currently dominated by powerful corporations and other elites. As argued in Chapter 2, the balance of influence is also unfairly skewed in favour of developed countries, which command a disproportionately larger share of the voting and financial power within global institutions. This power ensures that they also set the agenda to be followed globally. If the needs of developing countries are also considered to be important, there ought to be a corresponding effort at ensuring that they have sufficient and effective representation prior to, and during the point at which decisions in these global institutions are made. This will necessitate reconsidering the mandates of these global institutions, as well as their restructuring to better accommodate developing countries. As Pogge and Sengupta (2015, p.574) argue, "Official and non-governmental development assistance can indeed substantially improve the trends in global poverty and income inequality, but they cannot fully neutralize the centrifugal tendencies produced by the ordinary operation of the world economy as presently structured".

Proposed solutions to the influence of neoliberal mechanisms:

By adopting Agenda 2030, leaders of the 193 countries have made a voluntary commitment to take the steps necessary to meet the goals by 2030. The SDGs, including ending poverty, ending hunger, ensuring healthy lives and well-being, and ensuring sustainable consumption and production patterns cannot be achieved in the absence of a radical shift in the structural and economic environment in which global trade occurs. As argued by Pogge and Sengupta (2015); Scheyvens et al., (2016); and earlier in Chapter 2 of this thesis, the success of the SDGs requires that institutional reforms be undertaken in order to begin dismantling the inequalities in trade and the unjust advantages that developed countries have by virtue of their dominance of representation in global decision-making bodies. The result of this dominance is significant influence in shaping how the global economy operates, since there is a tendency not only to ascribe more weight to the

health, well-being and voices of particular individuals, institutions, corporations and countries (especially from developed countries), but also to entrench these ascriptions institutionally.

Without fairness in the representation of both developed and developing countries in global institutions, the voices of developing countries (and hence what would improve the health and well-being of individuals in those countries) are not likely to be considered. The policies of a global institution such as the World Bank Group, for instance, which has set goals to end extreme poverty as well as promote shared prosperity (World Bank Group, 2013a) are therefore unlikely to achieve these stated goals since the voices that inform these policies are not representative *ab initio*.

As I have argued in previous chapters, states would need to consider health and well-being from the individual's perspective in order to appreciate how the adverse impacts of globalization affect these individuals. This in turn would give clarity to the content and scope of the state's obligations towards these persons, and hence inform the sorts of actions that states would need to take in order to protect health and well-being.

G. Challenge: Financing the goals:

As Schmidt-Traub et al. (2017) indicate, one of the major challenges in the SDGs is the financing of the goals.

Lucci and Lally (2016) note that critical areas for financing in order to reach the most vulnerable include education, health, and social protection. With regard to health, they note that despite African Union signatories to the 2001 Abuja Declaration pledging to commit 15% of annual budgets towards health, only 8 out of 49 countries had met this target "during 2009-13; and only 21 out of 49 allocated at least 10%" (Lucci & Lally, 2016, p.19). These are dismal numbers. In view of the fact that the analysis was carried out 12 years after the commitment to the 2001 Abuja Declaration was made, they could be a pointer to the kind of challenge that will be faced in seeking adequate financing for the SDGs.

There have been various estimates regarding the cost of financing the SDGs ranging from between USD 5-7 Trillion (Niculescu, 2017); to USD 30 Trillion by 2030 (Rao, 2017). The

uncertainty as to how much it will cost to implement the SDGs is a cause for concern, particularly if countries allocate, and commit to funding far less, than would be required for the goals.

Part of the uncertainty may be caused by the ongoing work on the indicators, and the revisions and additions emanating therefrom. However, this does not quite account for such a broad variation in terms of anticipated costs; and may be indicative of the worrying possibility that countries have not actually properly considered what it would take to implement the goals fully. If this is indeed the case, there are turbulent times ahead for the implementation of the SDGs, particularly when the actual costs of implementation become clear and many countries find that they cannot then commit to funding them adequately.

Proposed solutions to financing the goals:

With regard to financing the costs for the SDGs, the first and obvious challenge is that there is as yet no agreement as to how much it will cost to implement the goals. There have been extremely wide variations in the estimates proposed thus far.

As a first step, the United Nation's High-level Political Forum (HLPF) on Sustainable Development – which is the main platform for the follow-up and review of the SDGs – must make efforts to engage a group of independent experts from around the globe to look into and report on the anticipated costs for implementing the SDGs. This group must contain expertise from a broad range of disciplines; so as to give as accurate a picture of the costs as would be possible using the information available. The experts would be required to issue their joint report to the HLPF within a reasonable deadline, with this report subsequently forming the official estimates of the costs of implementing the SDGs.

As Agenda 2030 is based on the voluntary commitments of states, citizens, as well as other non-state actors and institutions, they would have an important role to play in holding the leadership of each state accountable for the allocation of budgetary resources for implementing the SDGs. In this age of globalization and technology, citizens of various countries around the world can mobilize each other and create an influential movement that can keep the SDGs at the forefront of states' plans and strategies. This same influence would be crucial in ensuring that states honour the commitments that they have made to

developing countries for Official Development Assistance (ODA). SDG Target 17.2 calls on developed countries to fully implement the commitments for ODA that they have made to developing countries, thereby providing further impetus for citizen activism. Individuals in both developed and developing countries can use various platforms such as social media, door-to-door visits and public gatherings to campaign for the keeping of commitments made by their countries towards meeting the SDGs – not just for ODA, but those geared towards meeting the other SDGs.

H. Challenge: Lack of interim time targets in the SDGs:

Another area in which some writers such as Sachs (2012) and Madeley (2015) recognise that the SDGs might fall short, is in the lack of 'interim time targets'.

Many of the current targets, especially those to do with health, have 2030 as the goal, which is the life-span of the current SDGs. As such, waiting until 2030 would be too late to make adjustments in case countries are falling behind. There is need for an approach that can help to set what Sachs calls 'intermediate milestones', which would help to gauge progress in meeting the goals. A defined, time-bound, interim deadline can be set for the achievement of particular targets of the SDGs – for instance, what milestones ought to be achieved within, say, the first five years of a particular SDG. Once this 5-year target is met, another 'good enough' 5-year target which would build on the first one can be set; and so on, until 2030. This approach would require that the indicators relevant to the selected goals are in place, which is currently not the case for all the goals. It would therefore mean that apart from other considerations such as national plans and strategies, the initial targets would have to be those for which indicators that are broadly agreed upon are already available.

Proposed solutions to the lack of interim time targets within the SDGs:

The lack of interim time targets for the SDGs, a concern raised by Madeley (2015) and Sachs (2012) is an important issue to consider.

Pogge and Sengupta's (2016) approach on the issue of timelines for action on the SDGs takes the view that there is a tension between "presenting moral ambitions in the language of (human) rights and presenting them in the language of (development) goals" (Pogge &

Sengupta, 2016, p.84). They hold that rather than focus on 'progressive realisation' of the goals – an approach encouraged by the development language of the goals – the levels of deprivation and suffering demand that "deprivations must be ended right away ... When severe deprivations constitute unfulfilled human rights – and, given their social origins, even human rights violations – then they categorically require immediate and top-priority remedial attention" (Pogge & Sengupta, 2016, p.84).

One of the ways in which persons can hold states to account is through the exercise of their human rights. Whether human rights are conceived of as entitlements possessed simply by being human; as political values chosen through social agreement; or as claims made by or on behalf of those subject to injustice (Dembour, 2010), they are often the means through which individuals can hold states to account, and also call for concerted action on various issues including health and well-being. The protection and enhancement of human rights is an essential component of any state, and indeed any global effort, at gauging the progress of initiatives geared towards well-being, particularly if also embodied in law.

Pogge and Sengupta consider it unacceptable to delay the removal of deprivations such as poverty. They criticise the language of development which, they say, "suggests, falsely, that present severe deprivations can somehow be rendered morally acceptable, or more acceptable, by the fact that like deprivations had been even more widespread and severe in the past" (Pogge & Sengupta, 2016, p.86). Pogge and Sengupta make a persuasive argument. It is indeed inexplicable for governments to delay or postpone the removal of deprivations for which they have the resources to eliminate forthwith.

The issue, however, I argue, is not necessarily the language of development, but rather, the collective will of the people, and states, to act with urgency on the morally right actions that are required in these circumstances of deprivation. There is, after all, no prohibition in the SDGs against the immediate elimination of circumstances that lead to poverty, or hunger, for instance.

A state could conceivably choose to immediately ensure that no persons within its boundaries suffer hunger. It could find ways to provide social protection for all who need it, such that nobody is deprived of shelter, food, or warmth – and this without having to wait for the year 2030 to arrive. Not all states, however, can meet all the competing and

valid demands all at once – perhaps due to financial or human resource capacity constraints. There are constant demands to be met, and prior commitments to be kept. It is here that Williams' (2008) characterisation of the meaning of responsibility for an agent becomes explicit. As Williams says, responsibility in an agent implies not only "the readiness to respond to a plurality of normative demands", but also one who (or one 'which', for a collective body) exercises judgment and initiative; "discerning and extending what is possible and appropriate by way of response – not just in terms of individual acts, but also courses of action or institutional policies" (Williams, 2008, pp.460-461).

There is an urgent imperative for states to do their best to end poverty, end hunger, and ensure good health and well-being for their people. However, it is not the language of human rights that gives urgency to this imperative, but rather, the moral concern that is due to every human being; together with our recognition of the diminishing effects that such deprivations have on a person's agency, dignity and well-being.

O'Neill (2002, p.42) provides an interesting perspective on the issue of rights, stating that in order to establish "intellectually robust norms for health policies" in particular, it is better to begin "from a systematic account of obligations rather than of rights". O'Neill notes that while rights require the clarification of *"who* has to do *what* for *whom",* obligations make for easier assessment since they state clearly the requirements for action (O'Neill, 2002, p.42) (emphasis in original). This is arguably true, since the duty-bearer of the obligation is often explicitly indicated at the outset. In Agenda 2030, for instance, states (as the parties which adopted Agenda 2030) have a primary obligation to meet the SDGs. However, the obligation to work towards the SDGs does not belong solely to them. Non-state actors, corporations, institutions, other entities, and individuals also have an obligation to participate in activities that would help meet the SDGs.

It is certainly important for states to have in place properly articulated rights that expressly state "who has to do what for whom*"*. However, as earlier argued, the omission or failure by a state to expressly include certain rights within its constitution or in other statutes does not negate the existence of its obligation to act in a manner that protects and promotes life, health and dignity. Neither does it excuse states from facilitating the creation of conditions through which persons can thrive; particularly if we consider rights as entitlements that one

already has simply on account of being human. The moral worth of each person ought to provide the impetus for actions that acknowledge moral concern for him.

States and other institutions have a facilitative role to play in order to ensure that as far as possible, the health and well-being of the individual is protected and enhanced. States ought therefore to ensure that each individual has the opportunity to meaningfully participate in any decisions which affect him, for instance, and to have options from which he can choose those that will best meet his desired aims. We cannot genuinely talk of a person exercising choice when there is only a single option provided – more so if that single option does not satisfy the need it is supposed to. I have in mind, for instance, hospitals and other healthcare facilities which are poorly equipped, lack drugs, and also lack the healthcare professionals who can provide care to persons seeking healthcare in those hospitals.

The language of development is perhaps an acknowledgment that the structures and mechanisms which have created the present inequalities will take some time to dismantle; having themselves had considerable time to take root. This is not to say that it will take as much time to dismantle them as it has taken to create them – it is simply the recognition that the factors which have influenced the present state of inequalities themselves require not only financial resources, but also time, to overcome. The declaration by a state of an immediate right to nutritious and sufficient food, for all persons in the state, for instance, will be of no meaningful effect after all, if there is no actual availability or access to such food; owing perhaps to the state's financial or logistical constraints.

Time is also a necessity and an unavoidable constraint for some aspects of the SDGs and their targets and means of implementation. An example is the means of implementation for SDG3 (3.c), which requires "the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States" (United Nations General Assembly, 2015, p.17). The requirements for this means of implementation clearly shows that it cannot be achieved at once – specifically, the training and development aspect. Should states keep hiring an already-trained health workforce from other countries, it could result in more harm than good to the states whose trained workforce is the source of these workers – specifically where the emigration of these workers in turn results in a shortage of health workers in

their own countries. The ethically dubious aspect of such a practice is particularly evident where the hiring of health workers from other countries is perceived not as an opportunity to foster the training of the local workforce while also promoting knowledge-transfer, but as *the* solution to health workforce shortages in the particular state that is hiring. Adequate training and development requires sufficient time; and this time cannot be circumvented if proper training, development and retention of health workers are to be achieved.

Section III: Satisficing and Bounded Rationality

With the majority of the SDG targets having 2030 as the deadline for achievement, there is a need for focused action that will enable progress to be made towards achieving the goals. Having interim time targets can also act as an early warning to inform a change of pace or focus where the goals are not on course for achievement by 2030.

One of the ways in which to spur action is by employing the concept of satisficing; an approach which could provide the impetus to move the SDGs from aspiration to realisation. Often attributed to Herbert A. Simon, satisficing is ostensibly a combination of two words, 'satisfactory' and 'sufficing' (Stüttgen, Boatwright and Monroe, 2012, p.881). As Stüttgen et al., note, "Satisficing is a simple choice rule in which the first alternative that is good enough according to some criterion is chosen" (Stüttgen et al., 2012, p.879). Simon says, "The Scottish word "satisficing" (=satisfying) has been revived to denote problem solving and decision making that sets up an aspiration level criterion, and selects that alternative" (Simon, 1972, p.168).

A satisficing approach applied towards the SDGs is worth contemplating for several reasons. Firstly, given that the 17 goals and 169 targets have been deemed to be rather complex by some writers (Fukuda-Parr, 2016; Xue et al., 2017), it is important for states to find some way of successfully navigating through all the goals and begin the important work that is required to achieve them by 2030.

Secondly, is the challenge presented to states by the SDG indicators. The present situation is one where some indicators are yet to be finalised; others are not appropriate for what they

seek to measure; and others, as argued by Chattopadhyay (2016), cannot be properly formulated at present in that they cannot anticipate the costs and benefits of future-oriented technologies.

The incompleteness of the information that is required for the measurement of SDG indicators can thus only result in decisions being taken on the basis of partially complete information. Under Indicator 3.b.3, for instance, countries are supposed to measure the "Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis" (United Nations Statistics Division, 2018e). Should a state not have the capacity to collect data from every health facility, a decision can be made to focus its efforts at gathering data from a few selected provincial hospitals, for instance, even though by so doing, it would be omitting several district hospitals and smaller health facilities such as dispensaries. Countries will have to fill in gaps in SDG indicators by taking action based on measures and thresholds that they have set for themselves. Such decisions would have been made from a point of bounded rationality, described by Simon thus:

> Bounded rationality, a rationality that is consistent with our knowledge of actual human choice behavior, assumes that the decision maker must search for alternatives, has egregiously incomplete and inaccurate knowledge about the consequences of actions, and chooses actions that are expected to be satisfactory (attain targets while satisfying constraints) (Simon, 1997b, p.17).

In my illustration where a decision has been taken to focus attention on the availability and affordability of core essential medicines in a few selected provincial health facilities, the operative constraint is the lack of data-collection capacity, and the choice is thus made that provincial hospitals can be taken to be broadly representative of the state of smaller local hospitals and dispensaries (this may not actually be the case, but a choice has to be made).

Decisions made from a position of bounded rationality result in satisficing – The selecting of options that are good enough, given the agent's constraints.

Barros (2010, p.461) states:

> According to this hypothesis, decision makers, instead of trying to maximize values in a given choice, aim at *satisficing*: they search for alternatives that are

> good enough according to some pre-established criteria. The decision maker *optimizes* if he or she chooses an alternative that is *the best* one, as judged by a criterion that allows comparing all alternatives between themselves. The decision maker *satisfices* if he or she chooses an alternative that *attends or exceeds* a set of minimal acceptability criteria, if he or she chooses a satisfactory alternative, but one that is not necessarily the unique, nor the best (Emphasis in original).

Simon has suggested some factors that tend to impinge upon an agent's rationality. They include risk and uncertainty, incomplete information about alternatives, and complexity that would prevent the agent from calculating the best course of action (1972, p.168). The agent's rationality is thus 'bounded'; and the agent tends to use satisficing as a way to make decisions given his existing limitations. Additional limitations identified by Johnson (2015, p.227) in human information behaviour are interpersonal communication, accessibility, inertia (relying on the old, tried and true sources even when that information is bad), and individual preferences.

With incomplete indicators, shortages in data colletion capacity, as well as the uncertainty concerning which indicators present the best alternatives, decisions with regard to the SDGs will of necessity involve satisficing. The flexibility allowed to different states to set nationally appropriate targets is also going to be a factor that will see states choose the option that they consider appropriate within their national resources and capacities.

The question then arises as to who these decision-makers are. Simon (1972, p.161) briefly describes rationality as "a style of behavior that is appropriate to the achievement of given goals, within the limits imposed by any given conditions and constraints". In considering a theory of rational behaviour, Simon presupposes a human agent, or an organization making decisions. He states that the significant difference between individual rationality and organizational rationality is first, the assumptions that they make about particular goals and conditions; and second, whether these conditions and constraints are externally situated – that is, in the surrounding environment; or internally situated – within the agent's own cognitive limitations as a processor of information. Simon says that, "theories that incorporate constraints on the information-processing capacities of the actor may be called *theories of bounded rationality"* (Simon, 1972, p.162) (emphasis in original).

From the above explanation, it is arguable that the theory of bounded rationality can be extended, and is applicable to decisions made by states, for a number of reasons.

Firstly, is the reality that decisions taken on behalf of states are made by human beings on behalf of those states. Human beings are also tasked with the responsibility of making decisions on behalf of institutions and organizations. Agenda 2030 was adopted by the leaders of 193 countries on behalf of these countries. The responsibility for coming up with the SDG indicators is currently being undertaken by the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs); a group of persons who present regular updates on progress to the United Nations Statistical Commission (United Nations Statistics Division, 2018c). A decision made by a state, an institution, or a corporate organization is therefore a decision made by a human agent, or several human agents, *on behalf of* that state or organization.

Secondly, external constraints are applicable to both human agents as well as states and other organizations. Take the example of a state which must decide which SDG targets it must focus on within the first five years of the SDGs; given its current human resource and financial capacities. It may be an organization which is seeking to come up with a particular product and must then seek regulatory approval for this product. Perhaps it is a person who would like to attend an international conference, and must consider, amongst other things, how and whether he can obtain a visa in time; and also whether he can afford the airline ticket and accommodation. These are external considerations – occurring or influenced by factors outside of the agent.

There may be formal or informal guidelines or rules applicable to the corporation or state, which give direction as to how human agents tasked with making decisions on behalf of these entities can navigate these external factors and arrive at a decision. These rules may provide effective guidance for decision-making. However, they may also be such as cannot anticipate particular external factors; or else can only provide guidance up to a particular stage of a problem, after which the human agent must fill in the rest of the gaps.

In such a case where guidelines may be incomplete or do not provide a clear advantage of one option over another in an array of choices, the human agent representing the state or corporation will arguably resort to his own internal capacities; and therefore be subject to his internal constraints. This will in turn influence the decisions which the state or organization

will take. Such a situation could plausibly arise when a government is considering what kind of policies to pursue, for instance, in order to ensure sufficient availability and funding of healthcare facilities. If the options available indicate advantages for both publicly-financed and privately-financed facilities, the cabinet within that government could opt to have both publicly-funded and privately-funded facilities; with the proportions of each to be decided following discussion and consultations. In some cases, the final decision will be left to the president or prime minister.

Bounded rationality can therefore influence human agents who are making decisions on their own behalf, as well as on behalf of corporations, institutions, and states.

Satisficing and interim time-targets for the SDGs

Considering the complexity of the SDGs and their targets; the incomplete information on their indicators; and the 2030 deadline for their achievement, it is likely that countries will need to make decisions regarding which SDG targets to focus on first. If we accept that bounded rationality can have an impact on states as well as on individuals; then we can propose that countries can begin to make headway on the SDGs by taking a satisficing approach. I argue that this is particularly so in cases where states face constraints such as incomplete indicators for the SDGs, a lack of interim time targets, and a lack of data-collection capacity. A satisficing approach can help states to determine which targets and indicators they should focus on first in order to have the widest impact. The flexibility allowed to different states to set nationally appropriate targets under Agenda 2030 could also be a factor that states could use in order to select the actions that they consider most appropriate within their national resources and capacities. As Simon notes, satisficing involves a process of decision in which alternatives considered appropriate for reaching desired ends are selected (1997a, p.73).

Where there are inadequate or incomplete indicators to measure progress, each state can set its own threshold to gauge progress. The threshold set would be justified by the existing constraints that the state faces. States can also set reasonable timelines to gauge their own progress in the SDGs, which they can regularly review much earlier than 2030. An example is an interim time-target with a deadline that is set to expire after three years. In order to ensure accountability to its citizens for progress, there might in turn need to be sub-targets requiring that progress reports to citizens be made in various forums by the institutions and ministries

with governmental responsibility for those particular targets – this could be done annually. Citizen activism can also spur accountability where progress reports by states are delayed or withheld. In this way, each state would be alive to the need for ongoing progress towards the goals; and aware of the necessity to take action using the information and resources available to it.

Summary

The 17 SDGs, 169 targets and currently 232 indicators present a challenge for countries in terms of seeking ways to work towards their achievement by 2030. The United Nations Secretary General's 2018 report on progress towards the SDGs shows that there is a lot of work to be done to make progress on the goals. While there has been some improvement in some aspects such as a reduction in the proportion of people living on less than $1.90 globally, the number of persons living in poverty overall is still unacceptably high. SDG3 on health has experienced mixed results – a decline in the number of new cases reported for tuberculosis, HIV/AIDS, as well as Hepatitis B in infants; but an increase in cases of malaria to 216 million in 2016, up from 210 million cases in 2013. The need for a concerted and urgent effort by states, non-state actors and individuals in order to meet the SDGs by 2030 is evident.

Several challenges to the implementation of the SDGs have been identified. These include the persistence of neoliberal mechanisms which have themselves perpetuated some of the most glaring inequalities that the SDGs are now attempting to reverse. I have argued that in order for these neoliberal mechanisms to be dismantled, there will have to be structural changes to global institutions, as well as ideological changes in the way states perceive their roles in promoting the health and well-being of individuals. Other challenges include gaps in data, a lack of statistical capacity within countries, the risk of states selecting which targets to focus on based on political expediency, and the absence of interlinkages between national plans, strategies and the SDGs. States with sufficient data-collection and training capacity can collaborate to assist other states in need of such capacity so that all have reliable and timely data that would be useful for planning and determining areas for improvement.

Financing for the goals remains a major challenge – not least because there appears to be at present no clear estimate as to how much it will cost overall to implement the SDGs. This is an anomaly which makes it difficult for proper planning for the goals to be undertaken. The United Nation's High-level Political Forum (HLPF) on Sustainable Development ought to engage independent experts from around the globe to look into and report on the anticipated costs for implementing the SDGs. Developed countries ought also to uphold their commitments for Official Development Assistance and perhaps increase this assistance. Non-state actors can also play a role in mobilising funds for the financing of the goals. Large multinational corporations and other private enterprises can also be encouraged to incorporate the SDGs in their policies and strategies.

With a deadline of 2030 to achieve the SDGs, time is of the essence; and states must hold each other accountable for progress, particularly during the voluntary national reviews which must not merely be a reporting forum, but also a session to interrogate reasons for slow progress or inaction. Citizens of various states also have a role to play in holding their leaders to account. Both states and citizens have a responsibility, as Williams (2008) argues, to engage with and respond to the plurality of normative demands and to exercise judgment and initiative as to what actions need to be taken in response to those demands. Pogge and Sengupta (2016) also challenge the language of the goals; deeming it as tending to encourage delays in the removal of deprivation. As I have argued, however, it is not necessarily the language of the goals at issue, but the collective will of states and citizens to remove the existing deprivations within the shortest time possible.

Finally, I argued in favour of the novel suggestion that Herbert Simon's concept of satisficing can be used by states to set a threshold for measuring progress in the SDGs. I have argued that where states must make decisions but yet without the benefit of complete information, or where states must act within the context of certain constraints such as a lack of data-collecting capacity, then each state can set its own threshold to measure progress in the SDGs. The threshold set would be justified by making reference to its existing constraints. States can also set their own interim time targets – say at three year intervals – in order to gauge the progress they are making towards achieving the SDGs.

The state can ensure accountability for progress to its citizens by holding regular forums where the state reports on the progress it has made. Each state would thus be alive to the need for making continuous progress towards the goals.

In Chapter 5, I provide a summary of my previous chapters, and also highlight the recommendations that I have made.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

This thesis sets out the case that Agenda 2030 and the SDGs can provide the impetus needed to spur action towards achieving global health objectives.

Chapter 1 began with a contextual view of the current state of the world against the backdrop of globalization. Using illustrations of the various interactions that take place across the globe between and amongst persons, corporations, institutions of government, and relations between and amongst nations, I showed the interconnectedness between persons and their activities across the globe. I analysed some of the diverse discussions and conceptions of globalization and its historical origins by various authors, and by so doing, showed the ways in which globalization is perceived to be shaping our world.

I argued that while some aspects of globalization such as its impact on economic and political systems appear to attract particular prominence, the effects of globalization on the individual have been under-explored, with most of the literature on globalization focusing on globalization's effect on the macro environment. I made the case that little regard has been given in the literature as to how globalization affects an individual's health and well-being.

I made a contribution to bridging this gap on individual health and well-being in the literature on globalization by demonstrating that the effects of globalization pervade through more immediate and personal areas of an individual's life. I used three specific manifestations of globalization, namely: the threat of terrorism, threats to cyber security, and globalization's effects on physiological health, to show the need for a perspective of globalization that focuses on the health and well-being of the individual, rather than the prominent macro environmental narratives of globalization.

I made the argument that the negative perceptions that many persons have with regard to globalization are linked to the lack of acknowledgment by states of globalization's effects on individual health and well-being. I buttressed this claim by using three common themes, namely: exclusion from meaningful participation in social and economic life; powerlessness to influence positive change in one's own life when viewed against globalization; and physiological risks to health, in order to show how these themes are linked to globalization.

I then made the claim that the Sustainable Development Goals (SDGs) exemplify a global attempt to mitigate the negative effects of globalization on individual health and well-being. I made the case that the SDGs seek to reorient the place of the human person at the centre of globalization since they consider health and well-being from the perspective of individuals; rather than considering individuals to be peripheral subjects upon whom the effects of globalization must inevitably occur.

Chapter 2 broadened the understanding of what health and well-being means from the perspective of the individual.

Beyond a narrow, biomedical definition of health, I carried out an ethical critique of the broader moral significance of health. I analysed well-being from diverse philosophical approaches that include Kant's deontological approach, the Capabilities Approach, utilitarianism, virtue ethics, cosmopolitanism, and Ubuntu. I justified this analysis of well-being from different philosophical approaches by making the case that an ethical critique of well-being from diverse perspectives is required in order to capture the variety of conceptions of well-being as might be understood and experienced by persons from different geographical, cultural, religious, educational, social, economic, and other contexts.

I emphasised the need for a more holistic view of health and well-being by further linking the state of an individual's health and well-being to that individual's interaction with the determinants of health, which I argued must themselves have incorporated considerations of social justice.

Using Rawls's justice as fairness, and a critique of justice as the restoring of equilibrium, I demonstrated that social justice considerations have been taken into account in the determinants of health in Agenda 2030. I provided a novel contribution to the literature by showing that determinants of health which incorporate social justice considerations are the crucial link between the state of health of the individual, and the well-being of that individual analysed broadly using diverse philosophical approaches.

I carried out a further analysis that explored whether the actions that states are supposed to take in Agenda 2030 in order to achieve the SDGs are generally coherent with the broader

view of individual health and well-being, and arrived at the conclusion that Agenda 2030 generally coheres with ethical analyses of individual health and well-being.

I critically examined the influence of reason, motive, and intention on states' and agents' actions, justifying this examination with the argument that these three philosophical concepts have an influence on the sustainability of actions which ought to be taken by states and other agents towards the provision of the determinants of health. I defended my claim that a mismatch between actions and the reasons, motives and intentions behind them could render those actions unsustainable, and also lead to harms to individual health and well-being.

Chapter 3 contains a detailed analysis of the epidemiological and ethical aspects of SDG3, including its targets, indicators, and means of implementation.

I justified this analysis of SDG3 using four main reasons. Firstly, since Agenda 2030 and the SDGs are the outcome of a global consensus in 2015, it was important to analyse SDG3 which specifically mentions health and well-being, in order to determine what this global conception of health and well-being entails.

Secondly, the arguments that I made earlier drawing from, amongst others, Venkatapuram (2007), and Daniels (2001), hold that health extends far beyond a narrow biomedical definition that is focused on alleviating disease and restoring normal human functioning. Analysing the broader implications of SDG3 beyond a narrow, biomedical definition of health was necessary in order to consider what effects these could have for well-being.

Thirdly, was the need to test whether Agenda 2030's claim that all the SDGs are integrated, interconnected and indivisible, holds true. My analysis has proved this claim by showing that the impact of SDG3 (and all other goals) must of necessity be examined contextually, with reference to the other goals. As I had earlier argued in Chapter 2, the determinants of health are the link between the broader conception of health, and the well-being of an individual. It was therefore also necessary to consider the ethical implications of SDG3, its targets and indicators to other goals. My analysis of SDG3 utilised perspectives from philosophical approaches such as cosmopolitanism, Ubuntu, Kant's deontological approach and the Capabilities Approach.

The fourth justification for an epidemiological and ethical analysis of SDG3 is my answer to Venkatapuram and Marmot's call for inter-disciplinary reasoning and engagement between the determinants of health as well as epidemiology. My focused analysis of SDG3, which combined its epidemiological grounding with ethical analysis, is a contribution to knowledge, given that a detailed analysis and ethical critique of SDG3 and its targets, indicators, and means of implementation has not previously been carried out. I made a further contribution to knowledge by incorporating multiple ethical approaches in my analysis of SDG3.

My analysis revealed that some of the targets and indicators under SDG3 would benefit from clarification and expansion, particularly in what they are intended to measure. Some of the indicators are also not suitable for what they are intended to measure. Other issues which I identified include the exclusion of certain age-groups from the indicators, and the inclusion of unjustifiable and ethically problematic terms such as 'unintentional poisoning' in at least one indicator.

In Chapter 4, I explored the measures which states, non-state actors, institutions, and individuals can take in order to accelerate progress towards meeting the SDGs by 2030.

I analysed aspects of the 2018 Report of the Secretary-General of the United Nations to the High-level Political Forum on Sustainable Development, which indicated that progress towards the SDGs is generally slow, and in some cases has shown a decline.

I also explored some of the issues that have been identified as impediments to progress in the SDGs, as well as measures proposed by various authors to spur action by states, non-state actors, institutions and other entities to meet the SDGs by 2030. I offered ethical perspectives that link these proposals to the ethical critiques on individual health and well-being that I had carried out earlier.

I defended the novel suggestion that Herbert Simon's related concepts of satisficing and bounded rationality are relevant to guiding the decisions that states will make towards progress in Agenda 2030. I argued that these concepts would be particularly relevant in cases where states face constraints such as incomplete indicators for the SDGs and a lack of data collection capacity. I made the case that satisficing can help states to determine which targets and indicators they should focus on first in order to have the widest impact. I also proposed

that the flexibility allowed to different states to set nationally appropriate targets under Agenda 2030 could be a factor that states could use to choose to focus on the actions that they consider most appropriate within their national resources and capacities.

Recommendations:

In this final section, I summarise the three key recommendations of this report, namely: the need to finalise SDG indicators as soon as possible; the necessity for certainty as to how much it will cost to finance Agenda 2030; and the importance of having a long-term view of Agenda 2030 that goes beyond 2030.

i. The need to finalise the indicators:

With the increase in SDG indicators from the initially-proposed 100 in 2015, to the current 232 as at March 2018, there will certainly be a challenge in tracking progress due to this large number. Compounding the difficulty even further is that the indicators are yet to be finalised by the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs), as indicated in Chapter 4. In view of the 2030 deadline for the SDGs, it is recommended that there should be a halt to the consideration of any additional indicators. Instead, there could be a reduction of some indicators; or a substitution of those which are deemed not to be suitable for what they seek to measure as discussed in Chapter 3. While this is an exercise which might take the IAEG-SDGs some time, states can still proceed with the work needed to meet those goals for which indicators are available; with whatever resources they have available.

ii. The need for certainty in financing:

As indicated in Chapter 4, there is as yet no agreement as to how much it will cost globally to finance the goals. The estimates for financing the goals which have been indicated, including USD 5-7 Trillion (Niculescu, 2017) and USD 30 Trillion by 2030 (Rao, 2017), are so far

apart as to suggest that no serious global effort whatsoever has gone into considering this aspect of the SDGs. This is a glaring anomaly which is likely to hamper efforts at achieving the goals. It is regrettable that such a fundamental aspect, without which very little progress can be made, is as yet uncertain. Clearly, this will have an impact not only on SDG3 on health and well-being, but on all the other goals. UHC and financial risk protection in Target 3.8 are absolute non-starters without the necessary financing; as is Target 3.9, which seeks to reduce the number of deaths and illnesses from hazardous air, water and soils. There will be need for water treatment plants and chemicals, for instance; and the provision of alternative fuel and cooking methods; as well as the retrofitting of all existing polluting factories and industries – if not their shutting down. These would then have to be replaced with other clean-energy alternatives; and the re-training of workers carried out.

If there is no clarity with regard to the global cost of financing the goals, states will have an even greater challenge estimating their costs. This is especially so, in view of the fact that many states – particularly those in developing countries – are already grappling with data collection and capacity challenges. As suggested in Chapter 4, the High-Level Political Forum must take action to immediately constitute an independent and multi-disciplinary group of experts to come up with a well-considered estimate as to the cost of financing the SDGs. Countries which have made pledges for ODA to developing countries ought also to honour their pledges. As argued in Chapter 3, the amounts pledged, which are cumulatively below 1% of each pledging country's gross national income, are not so onerous as to justify the avoidance of this promise.

iii. Agenda 2030 beyond 2030:

The SDGs are far broader in scope than the MDGs were. The SDGs also require the collection and analysis of vast amounts of data. A look at the scope of the SDGs seems to indicate that they will require significant financial and human resources. At the time of writing, there is as yet no complete list of the indicators that are integral to the measurement of SDG targets.

All these factors point to the deadline of 2030 being far too soon for the achievement of the SDGs. This view does not imply that there is now no need for states and other actors to

attempt to achieve the goals by 2030 – Progress must begin as soon as possible, and must be continual and sustained, if any improvement is to be made in the lives and well-being of people all around the globe. We cannot afford to wait any longer, given the deprivations that people suffer, which have been so eloquently pointed out by Pogge and Sengupta (2016). The determinants of health, a critical component in the success of SDG3, must be central to the national plans and policies of states; and their link to health and well-being ought to be acknowledged through the adoption of a "Health in All Policies" (HiAP) approach. The HiAP approach has been described by the World Health Organization as:

> An approach on health-related rights and obligations. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health, and well-being. It also contributes to sustainable development (World Health Organization, 2018g).

Without a focus on the determinants of health, and the realisation of the importance of a HiAP approach, it will be well-nigh impossible to make any progress on the SDGs. There must therefore also be a continuing obligation on persons to hold leaders accountable for progress in the SDGs, and for states to hold each other accountable during SDG-related forums such as the voluntary national reviews as discussed in Chapter 4. Even though the SDGs are likely to extend beyond 2030, the effort that will have been put in, and the progress that will have been made by 2030, makes Agenda 2030 a worthwhile pursuit, and a moral imperative worth advocating for.

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