GLOBAL HEALTH SECURITY IN CHINA, JAPAN, AND INDIA

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Introduction
Framing Global Health Security in China, Japan, and India Using the Sustainable Development Goals

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National health security focuses on the ability of individual countries to prevent, detect, and rapidly respond to public health emergencies such as pandemics, as well as to meet the primary health care needs of their citizens. These challenges have increasingly become multinational as fewer public health emergencies are contained by national borders and important segments of primary health care delivery, especially pertaining to pharmaceuticals, have become integrated into the global economy. The corresponding feeling is that when it comes to health security, we are all in this together: an undeniable lesson during the COVID-19 pandemic. The concept of global health security is at its core the idea that national health security today requires countries to coordinate and cooperate with one another to address pressing public health threats such as COVID-19 and to meet many domestic health care needs.[1] State membership in and engagement with United Nations (UN) organizations such as the World Health Organization (WHO), International Health Regulations (IHR), and Codex Alimentarius Commission (CAC) have recently increased in part because these organizations can facilitate such coordination and cooperation. The expanding reach of these organizations reflects a broad consensus among nations that the key to achieving global health security is the establishment of a set of international health standards and norms that can engage and guide domestic governments in the design and use of their systems for public health and primary health care delivery.[2]

This book focuses on how global health security is evolving in three major Asian countries – China, India, and Japan – that have committed to complying with international health standards and norms established by the United Nations Sustainable Development Goals (SDG). The citizens of these three countries constitute almost 40 percent of the world's total population. If challenges to global health security are genuinely something that we all must face together, a better understanding of health security in these major Asian countries is fundamental.

Rights-Based Global Health Standards

Over the past three decades, the United Nations has gradually established a set of global health standards based on the right to health in international human rights law, culminating in the Sustainable Development Goals adopted by 193 UN member states in 2015. The 1946 constitution of the World Health Organization (WHO) states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO 1946). Twenty years later, the UN International Covenant on Economic, Social and Cultural Rights (ICESCR)[3] similarly recognized the right to the highest attainable standard of physical and mental health (UNGA 1966).

The UN Committee on Economic, Social and Cultural Rights, which is responsible for monitoring the ICESCR, observed in 2000 that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health" (UNCESCR 2000a, para. 9). The committee's framing of the right to health, which is today dominant in international human rights circles, includes not only medical services but also public health and safety measures that address issues such as vaccinations, maternal health, safe drinking water and food, workplace safety, obesity, tobacco control, and alcohol consumption. In other words, the principal focus of the right to health is on health security, understood in terms of concerns about public health emergencies and primary health care services. International human rights instruments pertaining to health have long been accepted in Asia. Both China and India became founding member states of the WHO in 1948. (Japan was not invited to join the United Nations until 1956.) India and Japan ratified the ICESCR in 1979; China ratified it in 2001. All three were among the first countries in the world to adopt the UN Sustainable Development Goals.

The SDGs establish a robust set of global health standards and norms to measure progress toward global health security that underlie the discussion of health security in China, India, and Japan throughout this book. There are seventeen SDGs and 169 targets (United Nations 2015). The SDGs are broad objectives, whereas the targets are specific and in some cases numerical. Many of the targets set global health standards in areas of medical services or public health and safety. For example, SDG 3 sets the goal: "Ensure healthy lives and promote well-being for all at all ages," whereas its thirteen associated targets include, for example, doing the following by 2030: "reduce the global maternal mortality ratio to less than 70 per 100,000 live births"; "reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being"; and "support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries" (ibid.). SDG targets are used to identify specific global health standards in each of the chapters below.

Although the SDG agenda is in part an exercise in setting standards applicable to global health security, that agenda provides each country with immense flexibility in the selection and realization of specific targets. The SDGs are designed to be global in nature and universally applicable, but nonetheless allow for different national realities, capacities, levels of development, institutions, and policy-making. Likewise, the associated targets are defined as aspirational and global, with each government setting its own national targets guided by the global level of ambition but taking into account national circumstances. Each government also decides how these aspirational and global targets should be incorporated in national planning processes, policies, and strategies (United Nations 2015, para. 55).

In this book, we explore three challenging areas embedded in the UN Sustainable Development Goals – strengthening access to primary health care, protecting and promoting public health, and integrating global economic markets into health care provision – that have contemporary relevance for global health security. As noted above, the right to health is today framed around the importance of medical services and public health, which mirror the first two areas we have selected for the focus of this book. The theme of global economic markets for health care provision reflects perhaps the most important emerging issue in Asia for health security. As China, India, and Japan have all committed in the past twenty-five years to trade liberalization through multilateral trade agreements – ranging from the World Trade Organization (WTO) to the Comprehensive and Progressive

Agreement for Trans-Pacific Partnership (CPTPP)[4] to separate trade agreements with the European Union – global economic markets have increased their reach into all three countries, with significant effects on medical services, supplies of pharmaceuticals, and public health. The SDG agenda shares this commitment to engaging, and to a certain extent embracing, trade liberalization and the global economy.

Three chapters are devoted to each of these three areas. The individual chapters are designed to show the different ways in which China, Japan, and India have each contributed to global health security in light of the global health standards set by the SDG agenda. The common framework for these discussions is that in all three countries, domestic decisions about how to best meet global health standards balance considerations of health care programs, delivery, and infrastructure against issues of cost and affordability; the demands of stakeholders that deliver health care, such as hospitals and physicians; political ideology; and the pressures of global economic markets. The chapters highlight the barriers as well as the success factors of the various approaches taken by governments in the provision of public health and primary care as well as by for-profit firms engaged in the health care sector.

Part 1: Strengthening Access to Health Care Services

The three chapters in Part 1 focus on the first of the three areas of concern outlined above: strengthening access to primary health care services in China, Japan, and India, respectively. The 2015 SDGs can provide a good sense of the global health standards and norms concerning access to health care services. Targets set for all countries under SDG 3 include "ensur[ing] 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" (SDG 3.7), and "achiev[ing] 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" (SDG 3.8).[5]

In China, as Wenqin Liang and Ilan Vertinsky explore in Chapter 1, the challenge remains to fulfill the basic SDG 3 obligation to create a health care system that provides sustainable, high-quality essential medical services. China has invested heavily in its public health care system and there is clearly progress on improving access to essential services. Liang and Vertinsky observe, however, that despite the impressive strides China has

made in the past decade toward increasing health care coverage for its population, public insurance covers only a fraction of the cost of medicines and services. Focusing on measures taken by the Chinese government in the past decade, they identify the barriers to realizing universal access and strengthening its primary health care provision, many of them a direct reflection of China's transition to a market economy. They draw out how price controls on generic drugs, designed to maintain affordability for patients, are in tension with basic principles of market pricing mechanisms and have, in a market economy, created drug shortages in many parts of the country. At the same time, in order to encourage direct foreign investment in its pharmaceutical industry, China has facilitated an increase in the cost of non-generic drugs and the prescribing of non-generic drugs, drugs that are affordable only for wealthier patients and their families. Moreover, the salary structure for physicians has created perverse incentives for those physicians to prescribe treatment – often pharmaceuticals – that is neither effective nor high-quality to achieve national health care goals, especially with respect to the provision of essential medicines. The authors conclude with some recommendations for measures that the Chinese government can take to overcome these barriers to realizing access to health care for all in China.

In Chapter 2, Yoshitaka Wada examines how Japan is struggling with the issue of who pays for new or experimental services and drugs not yet covered by the Japanese universal health insurance scheme. At present, patients in Japan bear the full costs of these new services and drugs, with no contribution from the public insurer. This contrasts with most other countries with a universal health care system, including Canada, which allow for a mixed billing process where the patient pays a portion and the public insurer pays the rest. The upshot is that many Japanese patients do not have access to the latest, most innovative health care, raising the question of how well Japan is fulfilling its international rights-based obligations to provide universal health care for all, as required by SDG 3.8. Wada provides a careful, nuanced account of Japan's twenty-year journey toward adopting some sort of mixed billing process – it now has a limited scope of mixed billing for some new and innovative health care services and products. His chapter illustrates how even in advanced industrial countries with established health care systems providing universal access, there are ongoing challenges in extending and improving the system to meet evolving global health standards.

India's health care system is far less developed than either China's or Japan's, although it has made very significant improvements in the past decade on some important measures, such as infant mortality and the incidences of certain infectious diseases. Tiffany Chua, Marc McCrum, and Ilan Vertinsky illustrate in Chapter 3 how India's health care system has been built in the context of an immense, diverse country with a complex form of constitutional federalism where responsibilities for health care are shared between the central and the state governments. Like China's, India's health care system suffers in part from very significant underfunding by the central government. Major access initiatives appear inadequately funded. Unlike in China, however, where many of the barriers to access to health care are directly linked to the transition to a market society, the difficulties for health care measures initiated by the central government in India are often traceable to design flaws, tensions with market pricing mechanisms, or corruption. These barriers for the central government in India are so immense that it is hard to see a policy pathway for it to lead efforts to fulfill the obligation to provide universal access to affordable, high-quality medical services for all, which is the global health standard set by the target of SDG 3.8. In contrast to both China and Japan, where the central government is the leader in innovative health care policy, in India very promising innovation is occurring selectively at the state level as the country's federal system of government facilitates immense diversification and experimentation in health policy among state governments. Ultimately, the authors conclude that a commitment by the central and state governments in India to radical innovation in the delivery of health promotion and care, including the adoption of non-traditional methods of delivery and the deployment of new types (less expensive) of health and allied professional services, is required for significant progress to be made toward the universal access to essential health care services required by SDG 3.

Part 2: Protecting and Promoting Public Health

The three chapters in Part 2 focus on specific measures to safeguard public health in China, Japan, and India, respectively. The US Centers for Disease Control and Prevention (CDC) explains that "public health is the science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing and responding to infectious diseases. Overall, public health is concerned with protecting the health of

entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world."[6] The point is that public health refers to the measures, such as hygiene, vaccinations, food and drug safety, and maternal health, that are designed to benefit everyone, as opposed to the medical procedures, such as surgery, that benefit principally individual patients. Since public health includes the prevention and detection of and response to health emergencies such as COVID-19, it is an integral part of global health security. Apart from global pandemics, countries differ on what are the most pressing public health issues for their national health security. China is especially challenged by emerging infectious diseases, tobacco control, and drug addiction. Food and water safety is an especially important issue in India. Japan is struggling with vaccination programs and institutional long-term care for an aging population. These country-specific public health issues are the subject of Chapters 4 to 6.

Many of the global health standards for public health pertaining to these different issues are expressed as targets for SDG 2 and SDG 3.[7] The relevant targets for 2030 include "achiev[ing] ... access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (SDG 3.8); "end[ing] the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat[ting] hepatitis, water-borne diseases and other communicable diseases" (SDG 3.3); "strengthen[ing] the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate" (3.a); "strengthen[ing] the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol" (SDG 3.5); and "ensur[ing] access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round" (SDG 2.1).

In Chapter 4, Lesley Jacobs focuses on linking SDG targets on infectious diseases, tobacco control, and drug addiction to China's broader human rights performance. China has been a model in the Global South for developing a responsive public health system that has progressively realized the right to health by improving the health status of its people, without embracing other human rights centred on individual freedoms and liberties. Jacobs puts pressure on the idea that China can successfully realize progressively the right to public health without attending in tandem to issues of freedom. The right to health in international human rights law is now formulated as having two components – entitlements and freedoms – and

respecting, protecting, and fulfilling the right to health requires attention to both of these components. China's decades-old position that right to health performance requires attention only to entitlements and guarantees of health services and a public health infrastructure is simply inconsistent with the SDG approach to global health standards that now also encompasses freedoms. Jacobs shows that on measures to deal with tobacco control and emerging infectious diseases, including SARS and COVID-19, China has been effective at securing public health entitlements, but in areas such as the administrative detention of drug users it has disregarded the protections that must be afforded to basic freedoms. The upshot is that for compliance with health standards set by SDG 3.3 and 3.5 targets, the performance record in China is clearly stronger on entitlements but weaker on freedoms.

In Chapter 5, Toshimi Nakanishi shifts the focus to public health measures in Japan. Vaccinations and immunizations for disease prevention have long been among the most important public health measures a particular country can undertake to advance health security. The global health standard for vaccines in SDG 3.9 is for access to affordable, quality vaccines for everyone. In the wake of the COVID-19 pandemic, the importance of access to vaccines for all to deal with emerging infectious diseases is readily visible. Nakanishi examines the surprising vaccination gap that exists in Japan, where many vaccinations widely used in other countries are either not available or are underutilized. The vaccination gap in Japan refers to the vaccine strains that are recommended by the WHO but are not being implemented. In this sense, Japan is not meeting global health standards and is under pressure to fulfill its obligations in accordance with international health and human rights law. Nakanishi traces the gap to two factors that operate in tandem: 1) a drug approval system that is especially sensitive to Japanese societal norms and concerns about product safety, and 2) a preoccupation with medical malpractice avoidance. The second factor is a reflection of how lawsuits in Japan over harm caused to individuals by compulsory vaccinations have transformed much of the country's vaccination regime into one predicated on patient choice, insulating physicians, the government, and pharmaceutical companies from financial liability. Nakanishi builds his analysis with an eye ultimately to map out how vaccination policy in Japan can move toward the global health standard expressed in SDG 3.9, something that is especially relevant in helping the country deal with COVID-19.

Food security in India is the focus of Mariela de Amstalden's discussion in Chapter 6. SDG 2.1 identifies food security as a fundamental public health

issue. India has been a pioneer in the innovative use of international trade law provisions to advance its domestic health security. The government has, for example, successfully invoked provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement)[8] in the World Trade Organization to defend the unlicensed manufacture of patented pharmaceuticals by its generic drug companies from claims that they have violated international intellectual property law (Drache and Jacobs 2014). Amstalden focuses on India's import prohibition, beginning in 2007, against certain agricultural products, including poultry meats, eggs, and feathers from countries reporting avian influenza based on the WTO Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement).[9] The SPS Agreement was designed to create domestic policy space for countries like India to limit trade in certain circumstances out of a concern for public health, in this case food safety. The global health standard of food security expressed in SDG 2.1 supports this policy decision by the Indian government. Since ultimately India's position rested on a risk assessment about public health, and not prescribed scientific evidence, Amstalden draws out how well these health security assessments fit with India's other international obligations.

Part 3: Engaging Global Markets in Primary Health Care and Public Health

The expanding scope of international trade and the global economy over the past thirty years, including the adoption of global business strategies by local profit-oriented firms, has resulted in the introduction of market pricing mechanisms and for-profit provision into the delivery of primary health care and public health in China, Japan, and India. This pertains especially to the provision of medicines and other pharmaceuticals. All three countries are major players in the global economy and prominent voices in international economic law venues such as the World Trade Organization, which was founded in 1995. International trade and economic law is, at its core, about a complex body of law that sets out the legal rights and obligations of non-state actors (individuals, multinational firms, international organizations) and state actors (governments, state agencies, and so on) in the context of the global economy to support trade liberalization and enable private markets in goods and services, including in health care, to thrive. Trade and investment agreements are the most familiar legal instruments of this body of law. Becoming members of major international trade law bodies such as the World Trade Organization also requires a commitment for those countries to become market societies (Drache and Jacobs 2018). In market

societies, the state and for-profit market function in a complementary fashion (Polanyi [1994] 2001). The state has certain spheres in which it can operate through law and regulations and other spheres in which it has no role, and provision of goods and services is instead provided in large part through private markets. The economy in these societies is a configuration of the overlap of these different spheres. Japan and India have a long history of commitment to being market societies dating to the post–Second World War period. In China, that commitment emerged in the 1980s.

Although the SDGs are often associated with priorities of the Global South, such as poverty reduction and gender-sensitive economic development, the SDG agenda is distinctive because it also includes the integration of trade liberalization, market pricing mechanisms, private for-profit provision, and other levers of the global economy as instruments for the realization of the SDGs and correlated targets. The SDG agenda seeks to "respect each country's policy space and leadership ... domestic public resources, domestic and international private business and finance, international development cooperation, international trade as an engine for development, debt and debt sustainability" (United Nations 2015). The implementation of the 2015 SDGs "will facilitate an intensive global engagement ... bringing together Governments, civil society, the private sector, the United Nations system and other actors and mobilizing all available resources" (ibid.).

Underlying the SDG agenda is the embrace of the belief that global private markets and trade liberalization can advance global health security. This is reflected in the targets of SDG 8, 9, and 10. SDG 8, which aspires to "promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all," includes targets such as "achiev[ing] higher levels of economic productivity through diversification, technological upgrading and innovation" (SDG 8.2); "promot[ing] development-oriented policies that support productive activities, decent job creation, entrepreneurship, creativity and innovation, and encourage the formalization and growth of micro-, small- and medium-sized enterprises" (SDG 8.3); and "increase[ing] Aid for Trade support for developing countries" (SDG 8.a).[10] SDG 9 includes the target of "develop[ing] quality, reliable, sustainable and resilient infrastructure, including regional and transborder infrastructure, to support economic development and human well-being" (SDG 9.1).[11] SDG 10 includes the targets of "improv[ing] the regulation and monitoring of global financial markets and institutions" (SDG 10.5) and "implement[ing] the principle of special and differential treatment for developing countries ... in accordance with World Trade

Organization agreements" (SDG 10.a).[12] The three chapters in Part 3 draw out tensions between strengthening health security in China, Japan, and India and their engagement with international trade law and the global economy.

In Chapter 7, Jennifer Fang, Kelley Lee, and Nidhi Sejpal Pouranik explore whether the China National Tobacco Corporation (CNTC), a state-owned Chinese monopoly, poses a threat to global public health. CNTC is the dominant supplier of cigarettes in China and an important source of tax revenue for the national government and many provincial governments. However, tobacco use globally as well as within China is the single biggest cause of chronic disease, particularly cancer, heart disease, and stroke. The tobacco epidemic causes more than 8 million deaths annually across the world, and those numbers are continuing to rise.[13] The tobacco industry has flourished in the global economy, with cigarette manufacturing and sales concentrated in six giant for-profit transnational companies that have operations around the world – so-called Big Tobacco (Jacobs 2014). The World Health Organization adopted the Framework Convention on Tobacco Control (FCTC) in 2005 as a response to the tobacco epidemic, with the stated purpose of curtailing the global spread of the tobacco industry. An important target of SDG 3 is to "strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate" (SDG 3.a).[14] CNTC is the largest tobacco company in the world, producing one-third of the world's cigarettes. Over the past sixty years, it has focused on supplying a huge domestic market in China. However, as the domestic Chinese market has become increasingly saturated and potential foreign competition looms, the company has turned to expansion abroad. This is entirely consistent with the support for global economic liberalization in the SDGs but clearly contrary to the goal of tobacco control. The chapter discussion focuses on the global business strategy of the CNTC as a global public health threat. Using Chinese- and English-language sources, Fang, Lee, and Pouranik describe the globalization ambitions of the CNTC, and its global business strategy focused on internal restructuring, brand development, and expansion of overseas operations in selected markets. They conclude that the company has undergone substantial change over the past two decades and is consequently poised to become a new global player among Big Tobacco, one that has the potential to weaken the FCTC, not strengthen it as required by SDG 3.

In Chapter 8, Neil Munro and Ziying He turn the discussion to hospital services in China. For-profit, competitive markets for medical services

among hospitals in urban settings are now widespread in that country. Focusing on the economic incentive structures for Chinese physicians and hospitals to mis-prescribe some treatments, especially involving pharmaceuticals, Munro and He ask how in this competitive market patients can act strategically to deal with this incentive structure. This focus aligns with SDG target 16.6, which requires countries to "develop effective, accountable and transparent institutions at all levels."[15] Using Albert Hirschmann's well-known framework of exit, voice, and loyalty to identify types of responses to failing firms by employees and customers, Munro and He distinguish between "voice," where the patient speaks up in an effort to improve the behaviour of the physician or hospital, and "exit," where the patient moves to a different hospital. Using results from a survey of 3,680 Chinese citizens about their strategies and responses to hospital or physician behaviours, Munro and He found that patients in urban areas are in fact much more likely to exercise their voice or exit when they faced mis-prescribed treatments, suggesting that their choices are impacted by the existence of a competitive market in cities that is far rarer in rural China. This chapter provides guidance in how the SDG agenda and global health security can be advanced with private markets in primary health care provision in China.

In Chapter 9, Hiroyuki Kojin reports on his study of two Japanese companies that are now successfully selling Japanese medical services and technology to other Asian countries, including India, at prices set in the global marketplace. In Japan, an important part of the government's strategy to strengthen the economy is to support companies exporting Japanese-style health care services and medical instruments overseas for profit. This is entirely consistent with UN framing of the SDGs, which acknowledges "the role of the diverse private sector, ranging from micro-enterprises to cooperatives to multinationals, and that of civil society organizations and philanthropic organizations in the implementation of the new Agenda" (United Nations 2015). One of the targets for SDG 3 is to "substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries (SDG 3.c)."[16] The two Japanese companies are expanding their international service delivery in the context of trade liberalization in the Asia-Pacific region, where the export of health care has become much easier for Japan. One of these firms, based in Singapore, employs Japanese physicians and nurses and sells services to Japanese citizens living there. The other firm is based in India, and all the physicians and nurses are Indian; moreover, the patients are mainly

poor, local residents. Kojin emphasizes that both of these medical companies face significant obstacles and challenges because there are restrictions or prohibitions on employing Japanese physicians and nurses, reflecting limitations on the licensing of health care professionals with foreign credentials. The underlying point is that although there is growing liberalization of the for-profit market for health care services in Asia, there is not yet a corresponding liberalization of professional health care licences and similar forms of collaboration among different countries, which are also required for global health security.

This book is designed to sharpen discussion of three key areas of health security – primary health care, public health, and market provision – in major Asian countries by linking those areas to targets embedded in the UN Sustainable Development Goals. Those targets can be viewed as setting global health standards for China, Japan, and India. The underlying point is that since global health security requires countries to coordinate and cooperate with one another to address pressing public health threats such as COVID-19 and meet many domestic health care needs, the SDGs provide a framework for assessing global health security in these three Asian countries. Each chapter in this book offers an assessment of global health security within this framework. Ultimately, however, since using the SDGs to assess global health security is still in its infancy, especially in Asia, these assessments are intended to ignite a conversation that will continue long into the future.

NOTES

1 See, for example, the Global Health Security Index: https://www.ghsindex.org/.
2 https://www.cdc.gov/globalhealth/strategy/default.htm.
3 https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx.
4 https://www.mfat.govt.nz/vn/trade/free-trade-agreements/free-trade-agreements-in-force/comprehensive-and-progressive-agreement-for-trans-pacific-partnership-cptpp/comprehensive-and-progressive-agreement-for-trans-pacific-partnership-text-and-resources/.
5 https://sdgs.un.org/goals/goal3.
6 https://www.cdcfoundation.org/what-public-health.
7 https://sdgs.un.org/goals/goal2; https://sdgs.un.org/goals/goal3.
8 https://www.wto.org/english/docs_e/legal_e/27-trips_01_e.htm.
9 https://www.wto.org/english/tratop_e/sps_e/spsagr_e.htm.
10 https://sdgs.un.org/goals/goal8.

11 https://sdgs.un.org/goals/goal9.
12 https://sdgs.un.org/goals/goal10.
13 https://www.who.int/news-room/fact-sheets/detail/tobacco.
14 https://sdgs.un.org/goals/goal3.
15 https://sdgs.un.org/goals/goal16.
16 https://sdgs.un.org/goals/goal3.

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