

Health in the Post-2015 Development Agenda

Online comments received on draft Report of the Global Thematic Consultation on Health 1 - 19 February 2013

Rishita Nandagiri

Wed, February 20, 2013 at 05.25 am

Echo and support this comment by Neha Sood and the Sexuality Policy Watch; and strongly recommend that the aspect of sexual rights not be overlooked in the report, especially as it pertains to the empowerment and participation of women, young peoples, and other marginalised/vulnerable populations.

[on behalf of the Women's Global Network for Reproductive Rights]

Kate Riordan

Wed, February 20, 2013, at 00.25 pm

Family for Every Child is an global alliance of national civil society organizations working to enable significantly more children to grow up in secure families and access temporary, quality alternative care when needed.
(www.familyforeverychild.org).

In examining how health systems should be considered in the new development framework, we urge decisions makers to recognize that equitable health care systems must aim to meet the needs of all sections of the population, young and old; rich and poor, rural and urban. This should include health care for girls and boys without adequate care and protection who often have an even greater need than children in the general population, due to factors such as exposure to hazardous work, early sexual activity and substance abuse, and the trauma associated with parental separation.

Poverty and economic inequality have been shown to be closely linked to inadequate care and protection, and this poverty is also associated with inadequate access to health care, creating spirals of disadvantage. Unfortunately, there is much evidence to suggest that highly vulnerable children without adequate care and protection are not

receiving sufficient or appropriate health care and support.

Family for Every Child urges that the post-2015 agenda and associated goals reflect the strong inter-dependence between goals on health and child survival and the protection and care of children. Child survival is essential for the achievement of all child rights, including rights to protection and care, and maternal health and HIV have a major impact on child protection outcomes. Neglect, the quality of children's care, early marriage and sexual abuse have all been demonstrated to impact on the achievement of current MDG health targets. In addition, eliminating hazardous child labour and childhood neglect has benefits for the survival and well-being of older children, with impacts lasting long into adulthood.

To ensure maximum synergies between efforts to address health and child protection, it is imperative for a future health and survival goal to include a target reflecting the following:

- An increase in equity in access to health care, including access for the poorest and most vulnerable groups and children without adequate care and protection.

Both for the well-being and safety of children, and for ensuring that child survival and health targets can be met, it is also essential that the post-MDG framework includes a goal and indicators on child protection and care. For example:

- By 2030 we will ensure all children live a life free from all forms of violence, exploitation, abuse and neglect, and thrive in a safe family environment.

It is our hope that the addition of such a goal will help ensure well-resourced national child protection systems, with mutual benefits for those striving to improve children's protection and care, and those working to enhance rights to health and survival.

To read more, access the interagency paper, Protect My Future: The Links Between Child Protection and Health and Survival, available at:

<http://www.familyforeverychild.org/sites/default/files/resources/Child%20...>

Arne von Delft

Tue, February 19, 2013 at 09.29 pm

Dear WHO Post-2015 Team

Thank you for this important opportunity to contribute!

TB remains a major cause of death worldwide, aggravated by an alarming increase in drug resistant cases globally:

It is thought that tuberculosis (TB) has killed more people than any other disease in the history of human kind. Today, TB remains one of the top 10 causes of death in the world and it is second only to HIV/AIDS as the biggest killer amongst all infectious diseases worldwide. Before the end of today nearly 4,000 people will die of TB!

Despite these horrific numbers TB remains a largely neglected (and even forgotten) disease in many well developed parts of the world. This disparity is set to change with the increase of ever more resistant strains of tuberculosis which are eluding efforts at control and spreading globally. Extensively drug resistant cases of tuberculosis (XDR-TB) have already been documented in every country where such infections have been looked for.

Even more alarming: totally drug resistant strains (TDR-TB or XDR+) have also been described recently, particularly in countries with high numbers of XDR-TB treatment failures, such as South Africa (where we work). The true extent of this rapidly growing problem remains very difficult to quantify, due to inadequate diagnostic facilities in many of the hardest hit areas, but in South Africa MDR-TB rates are thought to be between 5-10% and rising. This in a country where approximately 1% of the population will be diagnosed with new TB every year!

Both drug sensitive and drug resistant TB programs in developing countries are failing on a global scale, largely due to continued inadequate resource allocation and a lack of innovative treatment advances, allowing the seemingly unchecked increase and spread of crippling drug resistance. To reverse this trend the global community needs to increase funding and support for current control programs as well as increase investment dramatically in Research and Development (R&D) similar to the impressive effort seen with the advent of the HIV/AIDS pandemic.

Only by intensifying our focus and efforts can we strive towards elimination of all forms of tuberculosis, both drug sensitive and drug resistant. The alternative scenario is one in which tuberculosis continues to elude faltering control strategies until it once again becomes the untreatable truly global scourge it was early in the 20th century .

There can be no doubt about which situation we should aim for post-2015!

Yours in safer, more effective and more equitable protection against TB for all!

Arne von Delft, Dalene von Delft, Bart Willems, Pat Bond, Heena Narotam, Koot Kotze, Helene-Mari van der Westhuizen and Angela Dramowski

TB Proof

Michelle Williams-Sherlock

Tue, February 19, 2013 at 09.00 pm

The Office of the U.S. Global AIDS Coordinator would like to thank you for the comprehensive synthesis report of the diverse papers submitted to the online health consultation. We appreciate your efforts to present a balanced picture of the discussions and issues, given the divergent opinions on the full spectrum of health topics.

While we appreciate that the HIV discussion was well summarized in the report, we

feel it should also be appropriately represented in the final recommendations made by the task force. For this reason we suggest the below revision, and ask that they be included into the UHC recommendation.

Universal health coverage

The objective should be to ensure that people have as equal as possible access to the best possible health services and financial protection. UHC could be measured with three sets of indicators focusing on coverage and protection.

1. Increased coverage of essential services: build on the present MDGs (immunization coverage, HIV/AIDS prevention, treatment, and care, reproductive health services, insecticide-treated bed nets, essential medicines, etc.) plus NCDs and preventive services.
2. Increased equity and financial protection: reduced gap between the first and fifth quintiles, reduced levels of out-of-pocket expenditure, increase domestic health expenditures, etc.
3. Strengthening health systems: indicators on workforce, management and leadership capacity, procurement, supply chain, finance, data and information systems, governance, infrastructure, and quality.

iERG Secretariat

Tue, February 19, 2013 at 06.35 pm

The comment by the independent Expert Review Group (iERG) was sent to the UN team by e-mail. It is available on:

http://www.who.int/woman_child_accountability/news/ierg_comment_health_p...

Daniel Eduardo Henao Nieto

Tue, February 19, 2013 at 06.35 pm

Some Latin American reflections on the draft report 'Health in the post-2015 development agenda'

Daniel E. Henao, Emerging Voice 2012 from a Latin-American middle income country (Colombia)

It is nice to be part of discussions about the destiny of humanity, so it was with great interest that I read the draft report "Health in the post-2015 development agenda". The task all of us face is one of extraordinary importance and responsibility when one of the possible destinies of mankind is extinction. Nobody can deny that our understanding of development (and the actions based upon it) has led to incredible achievements over the last few centuries. However, it is also becoming increasingly clear for more and more people that our economic system jeopardizes the

sustainability of our planet. Interestingly, the draft report of the Global Thematic Consultation on Health does not discuss –or eventually propose– the need to reformulate the ideological principles that have caused the current (dire) state of the world. The draft report hints at them, at various places in the text, and obviously supports sustainable development as the new paradigm for the post-2015 world. Yet, real criticism of the ideological underpinnings of our economic system remains limited and mostly under the radar; also, the text is not very explicit on how the world should move towards a more sustainable economic system. This is a pity. Lack of political will to challenge the ideological foundations of our world economy limited the capacity of the health-related MDGs to achieve effective transformation and structural change. In the post-2015 world, this urgently needs to change, if mankind is to have a future. Capitalism and especially its most harmful exponent, neoliberalism, need to be thoroughly questioned. Clear pathways towards sustainable development should be offered, and editors/compiler of the report should not refrain from ideology. Although our world is more complex and interdependent than ever, ideology still matters. In fact, maybe it has never mattered more than now. I know the draft was just meant to be a preliminary technical report, but I feel it's important to frame the enormous challenge we're facing in this way, especially with a view on the final report which will be presented to the High-Level Panel in a month. That report should not mince words.

True, achieving Universal Health Coverage (UHC) and maximizing healthy life expectancy are comprehensive goals that can impact hundreds of millions of lives and that certainly integrate the health-related goals with others related to economic development – starting from the premise that health is a cause and consequence of well-being. Nonetheless, if we focus on UHC for example, it is important to keep the people in mind who should greatly benefit from the current UHC momentum. It should not be taken for granted that common citizens, including the most vulnerable ones, will automatically benefit. In Colombia, for example, a structural reform – 20 years ago– of the national health system aimed to achieve UHC, at least nominally. Yet, it has disproportionately favored private health insurance companies and negatively impacted the accountability of the health system. Brazil, on the other hand, has demonstrated that a Unified Health System – centrally administered by the State – is an effective way to guarantee the right to health. This, however, required a clear and sustained political commitment. Community participation, empowerment and effective mechanisms to influence policies were also important to keep up the pressure on politicians. In both cases, respectively a MIC and a BRICs country, the proclaimed goal was UHC, but the outcome was very different. Political will to ensure the right to health through UHC is thus indispensable. The report could perhaps suggest ways to monitor and boost this vital political commitment & leadership and offer some 'checks and balances' to make sure politicians embarking on health care reform remain focused on the public good rather than on certain vested interests.

The draft report is very committed to the idea of equity. That is a big improvement over the MDG agenda. It is however disturbing that the strategies to promote equity (e.g. empowering of communities, social policies to mitigate the impact of markets) are most probably insufficient. It is well-known – and by now almost an axiom – that the current model of economic growth and development inherently produces (and worsens) inequity. Hence, if there are no (explicit and global) political commitments in the draft to promote structural change of the development model, I'm afraid we cannot expect a real impact on equity. Let's not be naïve.

According to the draft, modifying social determinants is a key strategy to increase healthy life expectancy. The Social Medicine Movement from Latin America has insisted that only structural change – which includes modifying the economic and power relationships – can really impact the social determinants and the health situation of communities. It is thus very important how social determinants are defined – they should definitely include the political variables & power dynamics. As a Latin-American citizen, I've seen enough evidence over the last decades of the importance of politics, both for the better and for the worse.

The ongoing globalization is steered by many forces, both deliberate and implicit ones. Although the geopolitical environment is now finally changing, till recently it has been driven a lot by asymmetrical relationships between the North and the South. In many countries of the world, I'm sorry to say this is still the case. In the Latin-American region, for example, the main dilemma countries face now is between deepening neoliberal reforms to integrate their economies in the world (Colombia, Mexico, Chile are obvious examples) or going for a drastically different model, boosting the role of the state in providing goods and services (Venezuela, Ecuador, Uruguay). In this trade-off between more neoliberalism and a structural alternative with a bigger role for the state, equity is a key concern. From my point of view, the first group has not yet given a convincing answer to the question how they're going to ensure equity while deepening neoliberal reforms. Needless to say, most international organisations (IMF, WB ...) support the former group and there's relentless pressure on the second group to give in too. Only some big countries like Brazil can afford to follow their own agenda, at least to some extent.

If we aim to effectively achieve UHC and increase healthy life expectancy across the world we should thus aim to remedy this fundamental imbalance between North and South, update global governance mechanisms and make them more equitable. In the short term, we should compensate the Northern dominance by implementing financing mechanisms that go beyond charity. As many states in the North suffer from their own crisis, it's obvious the financial sector and multinationals will have to cough up the bulk of the money. The recent G20 summit of Ministers of Finance was encouraging in this respect; at last, the international community seems to realize that international taxing has been very unfair in recent decades.

Zooming in a bit more on the Latin-American situation, I hope the final report will offer some suggestions to deal with continent-specific health problems, or at least allow for enough flexibility to let regional and national policy makers focus on very specific problems in their own environment. In Latin America, urban violence and narcotics are key issues. It's not clear to me how the current draft proposal intends to tackle them.

We may be facing a unique opportunity to build a better world. In fact, it might be our last chance. If we want to accomplish the ambitious goals as proposed in the draft, we need besides lofty goals and technocratic targets also a strong political commitment and ideological stamina.

Alberto Colorado

Tue, February 19, 2013 at 05.56 pm

Hi again,

The targets for the world we want post 2015 is: Zero new TB infections, Zero TB deaths, Zero TB suffering and Zero TB stigma and discrimination.

Alberto Colorado.

Zoe Gray

Tue, February 19, 2013 at 05.07 pm

Draft Report of the Global Thematic Consultation on health: Response from Vision Alliance

The draft report addresses many of the important themes on health and disability, with some key areas that must be improved. It covers the needed emphases on tackling structural issues, health systems strengthening, putting people at the centre of post 2015, and improving health data and monitoring. Further Vision Alliance supports the view that a major emphasis of the new framework be on equality, and reaching vulnerable and hard to reach groups, in particular those at risk of disability and living with a disability (such as visual impairment).

However, eye health and vision are not mentioned. In spite of the fact, that around the world about 285 million people are visually impaired and 39 million of these people are blind (with higher proportions of women or elderly visually impaired), and that visual impairment can have a major impact on other rights such the right to education, housing and work. Further with aging populations and the rise of NCDs more people are at risk of blindness.

Vision Alliance supports the following issues raised in the text:

- The emphasis on universal health care stressing coverage with needed health services (prevention, promotion, treatment and rehabilitation), and the safety net of coverage with financial protection. The latter is very important for disabled persons and their families, given the high costs of living with disability.
- ‘That all people should have access to quality health care services that include public health, health promotion, behaviour change, disease prevention, diagnostic and curative care’, with the need to address ‘face on’ the rights of disabled persons (in keeping with the UNCRPD).
- The importance given to healthy life expectancy, and recognition of the need to address the determinants and causes of ill-health and disability.
- Acknowledgement of the links between aging and NCDs and disability.
- The importance of participation of disabled persons in the Post 2015 processes, throughout planning, monitoring and evaluation.

Proposed amendments to the text:

- Eye health and visual impairment needs to be accounted for within the recommendations for the framework - including the prevention of avoidable visual impairment (about 80% of vision loss is treatable or avoidable), promotion, treatment and rehabilitation.
- As part of this Neglected Tropical Diseases must be tackled, including through development of effective and inclusive WASH services.
- In the box regarding the links between health and the other post-2015 themes (p.13), disability should be mentioned, particularly in the paragraph on inequalities where a number of other vulnerable groups are listed.
- The report mentions the importance of having targets and indicators to show effective and equitable implementation of interventions (p.25). It is important to be clear here: to realise universal health care targeted interventions are essential to ensure

persons with disability including the visually impaired are reached.

- Special efforts will need to be made to address social, transport and communication barriers in health care and in other programming (across non-health goals, such as education and employment) faced by disabled persons and other vulnerable groups, with related information in accessible formats.
- To achieve equality it is essential that disability is tackled across health and non-health goals. In the section ‘General comments on indicators in the post-2015 framework’, persons with disabilities must be added to the list of groups.

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Countdown 2015 Europe

Tue, February 19, 2013 at 04.55 pm

Countdown 2015 Europe, a consortium of 17 leading European non-governmental organizations working to ensure sexual and reproductive health and rights in developing countries, would like to thank you for the opportunity to contribute to this consultation. Our comments have been emailed to the Task Team and they can also be found on our website

(http://www.countdown2015europe.org/2013/02/19/countdown2015europe_on_the...).

Best regards.

Reproductive Health Matters

Tue, February 19, 2013 at 03.42 pm

Thank you for the opportunity to provide comments on the draft report. Reproductive Health Matters would like to make the following suggestions:

1. Sexual and reproductive health and rights as an essential part of the health goal: tackling inequities and disparities

Health cannot be ensured without ensuring sexual and reproductive health and rights (SRHR). We therefore support the inputs into this report that propose that SRHR should be at the centre of any health goal in the post-2015 development framework. It is time to reflect on and act upon the lessons learned from the MDGs, which

overlooked the broad SRHR agenda established at the 1994 International Conference on Population and Development to focus primarily on HIV and reducing maternal and child mortality. Crucial issues, seen by some to be “sensitive”, were ignored, and as a result have been sidelined in programming, policy and funding. This new development framework must support and galvanize efforts to achieve universal and equitable access to comprehensive sexual and reproductive health services and, especially, to increase reproductive autonomy and human rights, including in relation to sexuality.

The report calls for a “hierarchy of goals [...] to capture the increasing complexity of priority health challenges” (p.32). We recommend that any hierarchy must not be used to exclude priority health issues that have been neglected or inadequately addressed because they were left out of the MDGs. These include many other serious health problems that are subject to inequities and disparities affecting millions of people worldwide, which are central to achieving the right to health.

While we agree that the post-2015 development agenda should be relevant for all people in all countries (p.32), we suggest that the reduction of health inequities should be a primary focus of the development agenda. Furthermore, the needs of the poor, marginalized and those whom the efforts based on the MDGs have not reached should also be prioritised throughout.

In response to the paragraph “Universal access to sexual and reproductive health...” on p.24, it is important to emphasise that neither maternal health nor family planning, while extremely important, should be seen as the only important components of SRHR nor as separate services for attention. This would perpetuate the undermining of a holistic notion of SRHR that occurred as a result of MDG 5.

2. Universal health coverage

We question the assertion that UHC is considered to be one of the three goals that “appear to have the most support” (p.21), and we disagree that “universal health coverage”, as currently defined and outlined by WHO, (http://www.who.int/features/qa/universal_health_coverage/en/index.html) is acceptable as the basis of a health goal for the future. Health services alone are not enough, and the financing issues are fraught with controversies and difficulties that must be debated further before they are set in stone. We have shown in SRHR that the right to health, equity, universal access, reduction of disparities, and the external determinants of health are all undermined by private ownership of health services, private financing and private control (RHM journal 2009-2012). It is crucial to address where financing should come from, who has responsibility for health systems, and public vs. private ownership, control and provision of health care. We support the strengthening of public health systems above all and would argue that the increase in private medicine has not helped public systems to become stronger, to the detriment of the poorest socioeconomic quintiles, rural populations, women and young people above all.

3. Health and human rights

The right to the highest attainable standard of health, as enshrined in international law

and the WHO constitution, and other human rights that are inextricably linked to health, must be at the core of any health goal. This goes further than the “strong relationship” between health and human rights cited in the report (p.14). Specific components of this right, as elaborated by UN and regional human rights bodies, must be captured and reflected throughout the goals, targets and indicators of the new development framework. These components – based on legal norms binding on States that have ratified the relevant treaties(*) – must serve as the bottom line for actions expected of States. Measurement of a health goal requires a public health and human rights approach. Understanding of the relevance of legal norms to technical approaches and ways of capturing human rights considerations through measurement tools has been developed considerably since the MDGs were conceived, and must directly inform this agenda.

4. Using indicators to monitor progress in line with commitments

The document focuses on the need for indicators to measure impact, coverage and health systems (p.32). It is essential that the indicators are designed to capture health inequities. Putting inequities at the heart of the global development agenda can only be achieved if the measurement tools used are designed with this specific purpose.

In relation to the indicators for monitoring progress listed in the paragraph “Universal access to sexual and reproductive health...”(p.24), we would like to emphasise that any indicators on SRHR must be carefully designed to implement key components of the rights to sexual and reproductive health, and framed in such a way that they do not promote or encourage vertical approaches to programming.

5. Accountability

The report cites the example of the UN Commission on Information and Accountability for Women’s and Children’s Health in accelerating progress towards MDGs 4 and 5 (p.30) and setting a long-term foundation for accountability for health as being of “significant benefit for the post-2015 development framework”. Yet it has been acknowledged that MDG5 has been one of the least achieved goals to date, especially “universal access to reproductive health”. In order to ensure full accountability for a progressive development agenda, the scope and mandate of all accountability mechanisms must be expansive enough to address all issues that are relevant to achieving the new goals, be designed to ensure accountability at different levels (international, national and local) and cooperate with the range of existing accountability mechanisms in operation under UN and regional human rights frameworks.

(*)Including the International Covenant on Economic Social and Cultural Rights, International Convention on the Elimination of All Forms of Racial Discrimination, Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Rights of the Child, International Convention on the Rights of Persons with Disabilities, African Charter on Human and Peoples’ Rights, Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (“Protocol of San Salvador”), and European Social Charter.

SRINIVASA MURTHY

Tue, February 19, 2013 at 03.17 pm

In the post 2015 period, the health agenda will be dominated by two issues, namely, (i) the increase role of the lifestyle related health matters and (ii) the need for the individual level initiatives for personal health and social health.

The past approaches to health care have depended and focussed on the health providers as the source of knowledge and dispensers of services.

However, in the new era, knowledge will be available to all and the health of individuals will depend on the actions of individuals, families and communities, and less by that of the medical professionals.

The biggest challenge, of this shift, is the need to rethink the way knowledge would be made available to people. To a large extent all medical knowledge is currently organised to transfer the same to 'professionals' and 'paraprofessionals' over long period of professional training periods. When the shift occurs to individuals, the knowledge has to focussed, simplified and made relevant to the individual with limited theoretical knowledge of the body and mind.

The success of the post 2015 health initiatives will depend on empowering of the individuals.

There is need for a totally new way of thinking of transfer of knowledge and skills.

One positive tool to assist in this is the information technology, internet and the mobile phones, which overcomes limitations of reaching the unreached and bridge the barriers to actions.

R.Srinivasa Murthy, Professor of Psychiatry(retd)Bangalore, India

Jaymie Henry

Tue, February 19, 2013 at 03.23 pm

Response from the International Collaboration for Essential Surgery (ICES), a group of surgeons who are members and leaders of the International Surgical Society (ISS), International Federation of Surgical Colleges (IFSC), International Federation of Rural Surgery (IFRS), Association of Surgeons of Great Britain and Ireland (ASGBI), and Royal College of Surgeons (RCS), among others.

We welcome the opportunity to review and comment on this draft. We have two major comments:

1.) The 'emerging health priorities' mentioned on p.18 aptly describes the epidemiological shift in disease pattern 'from communicable, maternal, neonatal and nutritional causes, towards NCDs, mental illness, and injuries.' Indeed, in 2010, 5 million people died from injuries alone and almost 8 million people died from cancer compared with 3.8 million from HIV, TB and malaria combined. Millions more suffer from disability and impairment as a result of NCDs and injuries.

While we support a global effort to prevent and control NCDs and injury, we firmly believe that investments in health systems are integral to preventing premature death and severe, crippling disability from conditions requiring surgical care, especially injuries and emergencies. This was rightly pointed out on p.19, with mention of the “need for action to strengthen the building blocks of national health systems, including...infrastructure (including surgical capacity).” Many lives can be saved with simple, timely and cost-effective surgical interventions. It is estimated that approximately 2 million lives could be saved if services and systems for care of the injured are strengthened. These lives lost are usually the most economically-productive individuals in society and hence, places a severe economic burden on developing countries.

However, surgical care continues to receive little attention, funding and priority among public health professionals, governments, funding agencies, and ministries of health. Basic, essential, and life-saving surgical care does not exist in many parts of the world. Moreover, the surgical health workforce is scarce and often ill-equipped to provide even the most basic surgical care in many parts of the world. Unless the conversation changes in terms of public health priorities, there is little reason to believe that surgical health systems will really be strengthened.

2.) We applaud the goal of Universal Health Coverage (UHC) and agree that “access to quality health services is a vital component of efforts to improve healthy life expectancy.” On p.23, it was mentioned that “Access to needed services (primary, secondary, and tertiary including surgical care) improves or maintains health, allowing people to earn incomes and children to learn, thus providing them with a means to escape from poverty.”

We would like to stress that surgical care is not merely a ‘tertiary’ service; rather, certain surgical procedures are ‘primary’ in that they are, as defined in the declaration of Alma-Ata, “essential health care that are practical and cost-effective and should be made universally accessible to every individual in the community.”

Simple surgery must be seen as a primary health need, as trauma is a disease of epidemic proportions affecting mainly the young and healthy in the prime of life. Examples of necessary primary health care include emergency surgical services, especially immediate care of the injured to prevent premature death and unwanted crippling disability. Health care cannot be considered universal if mothers continue to die from lack of cesarean section when faced with obstructed labor or lack of surgical means to control severe hemorrhage from childbirth, or when injured patients cannot return to a full healthy state because of lack of simple wound or fracture care, or when children cannot be given opportunities to thrive because of an unmanipulated clubfoot.

We argue that building surgical capacity in health systems is the most holistic strategy to strengthen it. The crosscutting nature of surgery allows simultaneous service for maternal and child health, injury, NCDs, HIV prevention, treatment for certain infectious disease sequelae, and blindness. Furthermore, the provision of safe surgical care, whose results are immediately seen, builds the profound trust of the community in the health system.

ICES would therefore like to propose and support:

1. High-level attention and priority on building surgical capacity as a primary care component in national health systems not only on infrastructure, but more importantly in training the health workforce to provide the most basic, essential, life-saving and disability-preventing surgical care.
2. A focus on strengthening human resources for health by strengthening training in primary surgical services for health care providers (including non-surgeons) at health posts and district-level facilities, including modular training in basic essential surgical procedures.
3. A call to government agencies to create policies to provide incentive for trained surgical healthcare professionals to cooperate in strengthening surgical capacity in underserved areas by mentoring health workers to provide basic essential surgical care and to create a framework for career development for health workers, thus increasing retention.
4. Global advocacy for surgical care with public-private partnerships to leverage private sector resources as part of the recipe for targeted improvements in health care.

The World We Want post-2015 is a society moving towards strong, robust and integrated health systems that utilizes current medical and surgical knowledge to provide appropriate and safe care, where citizens who have fallen from accidents or who stand on the brink of death or disability from untoward incidents may also be given a real chance to gain their life and health back so they may live, grow and be productive.

Kathleen Casey

Tue, February 19, 2013 at 08.36 pm

I applaud the ongoing efforts of this next phase of the Millennium Development Goals and appreciate the opportunity to comment on the work to date.

I'd like to echo and reinforce the comments of the above post by Jaymie Henry on behalf of the International Collaboration for Essential Surgery.

In addition, I would like to refer to a commentary on this subject I was asked to contribute to Archives of Surgery in May 2012, "Putting the 'Global' back in Global Health: <http://archsurg.jamanetwork.com/article.aspx?articleid=1151065>.

As stated in that piece, " Greater provision of quality surgical care averts lifelong disability, prevents death, and ameliorates the conditions of poverty. Investment in surgical programs in conjunction with preventative and public health strategies is paramount on 2 fronts: advancing progress on existing MDGs and strengthening medical systems to ensure availability of necessary care on a comprehensive, truly "global" scope and scale."

Thank you.

Laura Kirch Kirkegaard

Tue, February 19, 2013 at 02.40 pm

Thank you Task Team for a nicely written report which reflects very well the richness and diversity of the debate. I do find however that key populations - or the most marginalized/criminalized populations - need to have more focus in a new framework, and that this is missing from the report. Reaching LGBTI, sex workers, migrants, convicts, people who use drugs, homeless people - those who are at the margins of society - with health services, information, prevention is not only a moral obligation but also key to combating diseases.

Another thing which deserves more attention is the pivotal moment at which we stand right now with regards to ending the three killer infectious diseases of MDG6. The scientific advances of the last decade have given us powerful new tools to combat them, and we need to fully apply them to not miss this window of opportunity - because if we let up, resistant, more virulent forms of the diseases will prevail. The potential to end HIV/AIDS, TB and Malaria has never been greater, but it will only happen if we stay committed AND invest in the development of diagnostics, treatments and new preventive technologies such as vaccines and microbicides. Targets for investment in research and development of new medicines and prevention tools aimed at the world's poorest were missing from the MDGs and should be incorporated in the new development framework if we don't want to be formulating another set of targets for combating HIV, Malaria and TB in 15 years' time!

Adrianus Ton Vlugman

Tue, February 19, 2013 at 02.18 pm

The indicators to MDG 7 target 3 do measure access to improved drinking water source, which is not necessarily "safe" drinking water. Several countries extract river water and pump it untreated to taps in the home. Such water supply is improved, but not safe.

It is therefore misleading to report achievements for this MDG sector as improvement in access to safe drinking water.

Post 2015 targets for drinking water should include water quality parameters as indicator for safe water.

Such targets should also be met at specific settings such as schools and workspaces which should have 100% access to SAFE drinking water and improved or adequate sanitation.

How can one do Health Promotion at schools if school don't have safe drinking water and good sanitary facilities. Also without adequate sanitary facilities school attendance by girls is much lower.

Discussions should be held on the definition of “Safe” drinking water, e.g. res chlorine >0.2 mg/l, or 0 E-cocci or E-coli in at least #% of samples.

Adrianus Ton Vlugman

Ruth Foley

Tue, February 19, 2013 at 12.40 pm

Draft Report on the Post-2015 Health Consultation: Comments by the Ecumenical Advocacy Alliance

The Ecumenical Advocacy Alliance (EAA) (www.e-alliance.ch) wishes to thank the WHO for the draft report on the Global Thematic Consultation on Health. The paper summarizes the many and varied consultation responses received in a succinct and clear way.

In particular, we are pleased that chapters 3 to 7 reflect many of the key points raised by our initial consultation response, such as the importance of ensuring a human rights-based and equity approach to health, and facilitating better collaboration and linkages between health and other development focuses (<http://www.e-alliance.ch/en/s/hiv/aid/eaa-and-the-post-2015-agenda/>). However, we would like to see the final recommendations, especially those included in chapter 8, sharpened to strengthen the argument that the post-2015 agenda must include clear and ambitious health goals that also address the unfinished business of the current health MDGs. Indeed, as chapter 8 will form the basis of recommendations to the High-Level Panel and the UN Secretary-General, it is vital that this chapter does not overlook key points raised in the consultation process, particularly those that are already well-summarized in the previous chapters of this draft report such as the importance of ensuring ongoing momentum behind a strong and effective response to HIV.

Some specific suggestions for strengthening chapter 8 are as follows:

1. There needs to be much stronger language about how it is vital that several overall health goals are included in the post-2015 development agenda. Indeed, chapter 8 should argue that, due to the dependency of almost all other development priorities on health outcomes, there is little hope of these other goals being achieved if health goals are not a key priority of the post-2015 agenda. While there may be discussion about how the actual health goals should be articulated (as demonstrated somewhat by our subsequent suggestions), there cannot be any doubt that the overwhelming consensus from this consultation is that health should feature prominently in any future global agenda for development.
2. We welcome the guiding principles for the new development framework outlined in chapter 6 (p.20) and feel that they should be reiterated in chapter 8. If these guiding principles are taken seriously by the High-Level Panel and UN Member States, then a strong and sure foundation for the subsequent health goals, and, indeed, for all other

goals, will have been built.

3. We are not convinced that the recommendation to include universal health coverage (UHC) as one of only two health goals is truly reflective of the consultation process, although, within our own constituency, there is support for a goal to maximize health life expectancy. As suggested in our consultation response, there is a danger that a primary focus on UHC would not provide a basis for addressing the determinants of health. Even when universal health care coverage is claimed, there may remain marginalized and vulnerable populations that cannot access these services due to other social, legal and economic barriers. We would therefore propose that UHC be included in the recommendations in chapter 8 as a key target under several more ambitious health goals aiming to realize the right to health for all.

4. We would also like to see a more developed proposal in chapter 8 for reaching the unmet health MDGs, including those relating to the HIV response, and to maternal and child health. While reference to these discussions is included in chapter 6, they are not reflected in chapter 8. For example, at the very least, recommendations relating to specific diseases, including non-communicable diseases, should be pitched at the level of targets rather than indicators alone. Preferably, we would like to recommend a specific goal on Universal Access to HIV, TB and Malaria services.

Gunilla Källenius

Tue, February 19, 2013 at 12.38 pm

Please add the the insertions (within citation marks) to the text on MDG 6, page 8, first paragraph: There were an estimated 8.7 million new cases of tuberculosis in 2011, of which about 13% involved people with HIV. Globally mortality due to tuberculosis has fallen 41% since 1990 and should reach 50%, "except in Africa", by 2015. Treatment success rates have been sustained at high levels, at or above the target of 85%, for the past four years. "However the incidence is falling very slowly, and the trend may be reversed due to the spread of multidrug-resistant and extensively drug-resistant TB strains."

Rhyddhi Chakraborty

Tue, February 19, 2013 at 11.45 am

Hello,

I just want to mention few things.

1. There are repeated mentions of "other infectious diseases" in this draft without any further specification. TB, HIV/AIDS are given maximum priority over other infectious diseases but seasonal influenza, influenza pandemic which has given a mild blow at this century, which has the history of being a recurrent event, and which can shatter the whole of global health by a single blow, has been overlooked in the draft. Though its reference can be found in the WHO discussion paper on Positioning Health in the

post-2015 Development Agenda

(http://www.who.int/topics/millennium_development_goals/post2015/WHODiscu...)

2. Use of too many values can be found in the draft. For example, equity, sustainability, transparency, etc. Values reflect the vision and mission of a project. With no mention of the particular set of values, there remains a scope of lack of clarity in grasping the ethical awareness and objective of the proposed project.

3. It has defined right to health by means of creating the conditions only but creating the opportunity is one of the determinants of health, which is not acknowledged in this proposed project.

4. The draft mentions about creating hierarchy of goals and increase of Life Expectancy (LE) but does not hint what are the goals that are to be there in the hierarchy, how the hierarchy can be established when there is simultaneous need of Universal Health Coverage, decrease of morbidity, mortality etc. Also it does not state how exactly, that is, upto which level or point, the LE can be increased.

5. The focus of Health Management Information System (HMIS) is solely on Reproductive Health in many countries such as India. There should be an extension HMIS to manage other diseases also, so that we can have proper data reporting and management.

Thanks,

Rhyddhi Chakraborty

Alberto Colorado

Tue, February 19, 2013 at 10.06 am

Dear amigos from the Health in the Post-2015 Development Agenda.

Thank you for sharing the report. It is bad that is not translated to Spanish, because I wanted to share it in Latin America to my community who do not read or write English. They feel left out of the process and I know that we are missing their good insights.

Regarding the health priorities for beyond 2015:

I support the principle of health as part of human rights, equality and social justice for all. My work involves Migration, Health and Human Rights and specifically those communities affected by Tuberculosis (TB), AIDS and other neglected diseases like the hidden problem of Chagas disease.

Every Migrant and mobile population has the right to the highest attainable standard of health. Migration crosses all the pillars of development and population trends: rapid population growth, population ageing, and urbanization.

I think on the recent wave of new development goals, it is the turn to the world to focus on TUBERCULOSIS (TB) elimination. It is an unfinished business from the MDGs where TB was sent to "other" diseases in the MDGs 6. but also it needs to be involved in the new development agenda.

TB is an indicator of health and social development of any country.

TB kills nearly three people every minute. In 2011, 8.7 million people fell sick of TB and 1.4 million died of this disease.

TB costs the global economy \$13 billion a year thru lost of productivity.

TB is among the top three causes of death for women aged 15 to 44 – the most economically productive years of a person's life.

TB is a leading cause of illness and death among children under the age of five. While the World Health Organization² (WHO) believes at least 70,000 die from TB every year and 500,000 children suffer TB-related illness, but the true burden of this disease is under reported due to the systematic failure to monitor and measure the TB burden in children. But, TB doesn't just sicken and kill children; it also robs them of their families and parents, creating an estimated 10 million orphans and terrible psycho-social and economic injustice.

According to the World Bank interventions to prevent and control TB are among the most cost effective health interventions today and can have a direct effect on poverty and sustainable development.

Alberto Colorado

Patient Advocate

International Public Health Consultant

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Neha Sood

Tue, February 19, 2013 at 03.48 am

On page 24, the report discusses ‘universal access to sexual and reproductive health and protection of reproductive rights’. This neglects the related but distinctly critical aspect of sexual rights. These are human rights related to sexuality, including the rights to comprehensive sexuality education; to access sexual and reproductive health care, information, and services; to express one’s sexuality free from discrimination and violence; to sexual pleasure without fear of any harm; to freedom from sexual violence; to choose if, when, how and with whom to be sexually active; and to enter relationships, including marriage, with full and free consent and without coercion. Sexual rights are essential to the empowerment of women, girls, adolescents and marginalized populations, and to everyone’s enjoyment of the right to health.

This report must recommend that States respect, protect and fulfil the sexual and reproductive rights of all, especially women and adolescents, and ensure access to comprehensive sexuality education and comprehensive and integrated sexual and reproductive health services.

The report recognizes that punitive legal environments cause poor health (page 10). This includes laws criminalizing abortion, conduct during pregnancy, sex work, same-sex sexual activity, sex outside marriage and unintentional HIV transmission. Additionally, laws and policies that restrict access to sexual and reproductive health services such as contraception, abortion, HIV testing and counselling lead to poor health outcomes. The report must recommend that States reform such punitive and restrictive laws as this is essential to the exercise of the right to health.

The report must also unequivocally call for a strong focus on meeting the health needs of marginalized groups, including those unjustly penalized for their sexual and/or reproductive behaviour. For example, adolescents, ethnic, linguistic and racial minorities, indigenous women, persons with disabilities, sex workers, persons living with HIV, transgender persons, men who have sex with men, women who have sex with women, migrant and displaced persons and rural women.

The report shares that several contributions called for the formulation of the Post-2015 agenda and its implementation to involve community participation, and especially the participation of women, young people and marginalized populations. This must be reflected in the recommendations emerging from the report.

[On behalf of the Sexual Rights Initiative, a collaborative project of six partner organizations – Action Canada for Population and Development, Akahatá – Equipo de Trabajo en Sexualidades y Géneros, the Coalition of African Lesbians, Creating Resources for Empowerment in Action (CREA, India), the Egyptian Initiative for Personal Rights, and the Federation for Women and Family Planning (Poland) – that aims to advance human rights related to sexuality, i.e., sexual rights within global policy processes.]

Paul Stark

Mon, February 18, 2013 at 08.42 pm

The first draft of the Report of the Global Thematic Consultation on Health offers important recommendations for the post-2015 development agenda. Among the goals highlighted are “end[ing] preventable child and maternal deaths” and “build[ing] on the vital unmet commitments to improving maternal, newborn, and child health” (p. 23). The post-2015 agenda should emphasize the importance of adequate nutrition and maternal health care during the first 1,000 days of life—from a baby’s conception to her second birthday. This period is essential to the health of both children and their mothers.

The draft Report notes that many contributors to the consultation proposed “universal access to sexual and reproductive health and protection of reproductive rights.” They argued that this should include “access to legal and safe abortion on demand” (p. 24). Such a recommendation would be a mistake.

Abortion on demand is not required by a commitment to health. Clear evidence shows that the incidence of maternal mortality is determined by the quality of maternal health care (and related factors), not by the legal status or availability of elective abortion. Legalized abortion is simply not necessary to improve maternal health and save women’s lives. Moreover, abortion, regardless of its legal status, can be detrimental to the health of women. Studies have linked abortion to an increased risk of mental health problems, for example, and also to an increased risk that future pregnancies will end in premature birth, which directly impacts the lives and health of children. The inherent dangers of abortion should not be ignored by the international community.

Abortion on demand is not required by any “right.” International law includes no right to abortion or legal obligation that nations provide access to abortion. On the contrary, international instruments—such as the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights—support recognition of the equal dignity and rights of all members of the human family. This should apply to human beings at all stages of biological development. The Convention on the Rights of the Child states that children need “appropriate legal protection, before as well as after birth.”

The post-2015 development agenda should renew, enhance and expand efforts to improve maternal health while respecting the decision of many countries to protect unborn children by law. Every human being matters—irrespective of not only gender, ethnicity and social status, but also age, size, ability and stage of life. Human beings are at the center of all sustainable development.

Minnesota Citizens Concerned for Life Global Outreach

Ross Bailey

Mon, February 18, 2013 at 06.31 pm

Response from WaterAid to the draft Health consultation report

WaterAid welcomes the focus on equity, human rights and sustainability, as well as the discussion on the determinants of health in the draft report. The discussion on the advantages and shortcomings of the health MDGs is frank and insightful. We welcome the inclusion of guiding principles that reflect the focus on rights, equity and universality, as well as on facilitation of action between and across sectors.

The following is a suggestion for additions that we believe will help improve the report.

Context:

1. Box 1: Progress on MDGs: description on MDG 7 is lacking and misleading. Whilst globally the water target has been met, this masks inequalities between and within countries. 31 of the 50 sub-Saharan African countries are still off track. Sanitation remains severely off-track, with 70% of the population of SSA without access to improved sanitation; 41% of the population of South Asia still practices open defecation. This has significant consequences for health and for the achievement of the health MDGs. The continued high burden of diarrhoea diseases and increase in outbreaks of cholera demonstrate the importance of making the links between WASH progress and health.
2. Box 2: the paper is correct in pointing out the links between health and water as a post-2015 development theme. The direction of the relationship – i.e. lack of access to safe drinking water, sanitation and hygiene leading to ill-health – suggests the need for WASH-related targets and/or indicators under health-related goals and targets in the post-2015 framework. These could be framed as part of broader set of social and environmental determinants of health.
3. Box 3: The “unfinished business” of the health MDGs: MDG4: the statement that diarrhoeal diseases are preventable by vaccines is untrue and misleading; although some diarrhoeal vaccines have been developed, most notably vaccine for rotavirus, mortality and morbidity from all-cause diarrhoea remains high and requires the implementation of a full package of preventive and curative interventions, clearly set out by WHO and UNICEF under the 7-Point Plan and more recently under the Global Action Plan on Pneumonia and Diarrhoea. This package crucially includes preventive interventions such as safe drinking water, sanitation and hygiene practices. Interventions for pneumonia also require a broader set of interventions, such as hand washing and reduction of indoor air pollution. Despite their importance, vaccines should not be seen as a ‘silver bullet’ for child health improvement.

Goals, indicators and targets:

Goal on Universal Health Coverage: more discussion is needed on what this term means and whether, as the paper says, it necessarily excludes a focus on health determinants – as some of these, in particular environmental determinants such as

WASH – can and should be addressed by the health system, especially aspects such as demand creation for sanitation and hygiene promotion. This should go beyond access to healthcare services to address the full range of prevention, treatment, care and support interventions. Any goal on UHC must include: a) Prevention – responding to the national burden of disease, with health systems playing a stronger stewardship role for public health beyond the remit of healthcare facilities and addressing the social and environmental determinants of health; and b) Attention to barriers to access – individual health-seeking behaviours and the ability to turn demand into action face numerous barriers, related to gender, income level, rural or urban geographies, governance, or access to decision making, among many other factors.

Indicators:

- Health goals should be accompanied by time-bound targets that address the challenges that contribute to the achievement of the goal in question. Therefore the lack of inclusion of indicators on the underlying determinants of health undermines the effectiveness of the goal. This measure will help ensure a move away from the vertical approaches that characterized many programmes under the MDG structure, and incentivize a cross-sector, holistic approach to disease prevention. Although this has been recognized in a later section of the report (8. Framing the future agenda for health), it should be clearly articulated in this section as a guiding principle.
- Few interventions would have a greater impact on the lives of the world's poorest and most marginalised people, particularly women and girls, than reducing the time spent collecting water and addressing the health problems caused by poor sanitation and hygiene which remain the second leading cause of death among children under 5.
- Indicators relating to drinking water and sanitation access across populations are relevant to achieving key health outcomes such as reducing child mortality and stunting, and can be measured and compared across countries, as demonstrated by the work of the WHO and UNICEF Joint Monitoring Programme on Drinking Water and Sanitation, which has been monitoring the implementation of the water and sanitation target under MDG 7.
- Further, targets on availability of water and sanitation as well as safe hygiene practices within healthcare facilities are relevant to aspects of health services quality and use, and should therefore be included under goals for Universal Health Coverage.
- The work undertaken by Joint Monitoring Programme expert working groups on Post-2015 should be taken into consideration during the Health Thematic Consultation. The working groups have defined a vision of universal access to safe drinking water, sanitation and hygiene in our time, with the following priorities:
 - No one should practice open defecation
 - Everyone should have safe water, sanitation and hygiene at home
 - All schools and health centers should have water, sanitation and hygiene
 - Water, sanitation and hygiene should be equitable and sustainable

Implementation – Cooperation and coordination:

We agree that to create effective working relations in global health and development, the principles of the Paris Declaration should be adhered to. Meeting ambitious goals for improvements in global health will require an integrated, holistic approach to health programming, but the way in which health aid is delivered can often act as a disincentive to integration. Successful adoption and scale up of integrated approaches

require a clear signal from high-level decision makers that such approaches are desirable, and preferable to disease-specific initiatives. This also requires a change in aid policy, to enable countries to initiate and roll out programmes that respond to countries' specific context and burden of disease, rather than donor-driven priorities.

- Health aid should be more flexible in terms of channels and time frames, to respond to country priorities and fund multi-sectoral approaches.

- This flexibility should extend to the nature of the integrated programmes – allowing for an approach that goes beyond tangible service delivery inputs to include elements such as behaviour change and creation of demand for health services as well as household inputs such as sanitation.

Lucica Ditiu

Mon, February 18, 2013 at 06.41 pm

As the Executive Secretary of the Stop TB Partnership, a public-private partnership of over 1400 partner organizations worldwide - including technical and international organizations, government programs, corporates, research and funding agencies, civil society and community groups – all united in a vision of realizing a world free of tuberculosis (TB), I am pleased to submit some brief comments on the draft report: health in the post-2015 development agenda.

Despite the enormous public health, economic and societal burden related to TB, the draft report seems to pay little attention to this disease. TB is a major public health threat and killer: more than 2 billion people are infected with TB today, and there were 8.7 million new TB patients and 1.4 million deaths in 2011 – making TB the second biggest infectious killer after HIV/AIDS. TB is the oldest disease of humankind, but thanks to its inclusion in MDG 6, significant progress has been made and we are closer than ever to actually making it a disease of the past.

However, our fight is not over and, if anything, it has to be accelerated.

I strongly advocate to global leaders and all those active in the post 2015 development agenda discussion to not neglect TB but rather to develop and promote solutions that build on the momentum of the MDGs to save millions more lives beyond 2015.

The draft report outlines two main options for a new development goal on health: universal health coverage and life expectancy. I strongly support both concepts, but advocate for a strong link with the current MDGs around concrete and ambitious indicators. We need ambitious and tangible indicators if we want to achieve and illustrate results. This is the key to a successful development agenda and in TB we are setting out an ambitious agenda towards eliminating the disease.

I also advocate for more synergies between the different diseases. For example, TB is the biggest killer of people living with HIV, and more must be done to ensure that no more HIV patient unnecessarily die of TB – a disease, which costs less than US\$ 30 to treat.

Finally, we must consider the alternative. If accelerated action – driven by a global TB target – is not taken it is likely that between 2016 and 2025 16 million people will die of TB including almost 5 million people co-infected with HIV.

We are at a place in time where we can make a real difference in the fight against this curable but airborne disease that puts us all at risk and ultimately limits economic growth and global development.

I urge all of us to not lose sight of the task we have at hand: to build a better and brighter future for our children and grandchildren.

Concrete and measurable targets, synergies between the different health programs and ambition – these are my suggestion for the post-2015 development agenda on health!

For more on why TB matters in the post-2015 development agenda please visit:
<http://www.worldwewant2015.org/node/309550>

Luis Tejedor López

Mon, February 18, 2013 at 05.21 pm

Firstly I would like to say, as a future Doctor, that there are more important health issues to be covered in developing countries than reproductive health issues. They are important, but they are not, and therefore should not be considered as, the key for health policies regarding this countries.

Secondly. The approach to maternal mortality is scientifically doubtful. As recent studies show, free abortion does not reduce maternal mortality. For instance, this recent article published in Plos One, showing the case of Chile
<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0036613>

Showed that that

"During the 50-year study period, the MMR decreased from 293.7 to 18.2/100,000 live births, a decrease of 93.8%. Women's education level modulated the effects of TFR, birth order, delivery by skilled attendants, clean water, and sanitary sewer access. In the fully adjusted model, for every additional year of maternal education there was a corresponding decrease in the MMR of 29.3/100,000 live births. A rapid phase of decline between 1965 and 1981 (–13.29/100,000 live births each year) and a slow phase between 1981 and 2007 (–1.59/100,000 live births each year) were identified. After abortion was prohibited, the MMR decreased from 41.3 to 12.7 per 100,000 live births (–69.2%). The slope of the MMR did not appear to be altered by the change in abortion law."

And the conclusions were clear "Increasing education level appears to favourably impact the downward trend in the MMR, modulating other key factors such as access and utilization of maternal health facilities, changes in women's reproductive behaviour and improvements of the sanitary system. Consequently, different MDGs can act synergistically to improve maternal health. The reduction in the MMR is not

related to the legal status of abortion.

According to the World Health Organization, the African country with the lowest maternal mortality rate is Mauritius, a country with one of most restrictive abortion laws. Meanwhile, the South African case has become paradigmatic. Maternal mortality has increased 20 percent in the period 2005-2007 in South Africa, which since 1996 has had one of the most permissive abortion laws in Africa.

Thirdly I would like to call attention to the the rights of the women who want to have more kids. If we follow the statements issued on this report their rights will be narrowed, not broadened.

I do not believe that the world we want for 2015 is a world in which there is less poor people... because they have not been born.

In stead of forcing (it is politically-correct forcing what this report proposes) women to have less children (even by castration), should not the states, the WHO and NGO's help them to be able to have all the children they want? Should not be granted the access to an appropriate health care to everyone?

It seems that lowering the number of poor people is the solution that the statement is giving for improving health and economy in developing countries. It is not an ethical or even humanitarian approach to the problem. It is just the easy and cheap solution. We can not support that.

Chhanda Chakraborti

Mon, February 18, 2013 at 05.07 pm

Hi,

Two observations: (a) Make some country reporting mechanism available which will help us to look beyond the national average health outcome to see how the health equity issues are actually dealt with in a given country. May be some subparameters for a country to check its progress on some obvious target groups, e.g. girls and women, the urban poor, the uninsured.

(b) In addition to the already known problem of no link between the isolated, vertical programs (e.g. Maternal health, TB), a holistic approach is desirable in post-2015 also to address the existing oversights and the systemic social determinants of health.

Consider for example, poverty and the DOTS regimen for TB patients for six months. DOTS program at present does not include any food or meal guarantee scheme for the patient. However, from field workers we got to hear that for the impoverished daily or casual workers in the DOTS program, a guaranteed meal can make a difference. For, The DOTS medicine dose is strong enough, and after taking it many patients are allegedly not in a position the next day to go out for work. For a daily wage laborer, this means no pay, and therefore almost always no meal. Post-2015 we do not want the DOTS participant to go hungry.

Fadekemi Akinfaderin

Mon, February 18, 2013 at 03.28 pm

Women's and adolescent health and human rights must be a priority in the Post-2015 health framework, particularly their sexual and reproductive health, which is a critical component of primary health care.

The next framework that focuses on health must include goals, targets and indicators that are thought of from the perspective of the poorest and most marginalized (equity): who they are, where they live, and what services they need. In order to deliver on women's and young people's health and human rights, it is necessary to create goals and targets that encompass accountability for:

- Universal access to quality, comprehensive, integrated sexual and reproductive health services, counselling, and information for young women and adolescent girls, with respect for their human rights, and with an emphasis on equality and equity and respect for diversity.
- Programs that empower women, particularly adolescent girls and young women, to know their bodies and to exercise their rights, especially through comprehensive sexuality education.
- Respect for adolescent girls and young women's sexual and reproductive rights.
- Young women's leadership at all levels and in all types of decision-making programs and policies that affect them.

Thomas Schwarz

Mon, February 18, 2013 at 11.09 am

The comment by the Medicus Mundi International Network was sent to the UN team by e-mail. It is available on:

<http://getinvolvedinglobalhealth.blogspot.ch/2013/02/comment-by-medicus-...>

Michal Bogacki

Sun, February 17, 2013 at 03.56 pm

Hello!

I would like to add my opinion about some issues pointed in the report.

First of all, I realized, that it's not about health problems, but about money problems connected with health.

It is clearly pointed in the beginning of chapter 4:

"(...)and therefore any governance agenda must address the issue of value for money in health spending."

The rest of the report just confirms that.

The report concentrates on „holistic point of view” - in my opinion, it does not. Basically, because almost two thirds of that document is circulating about „development”, „income”, „growth”, working-efficiency and so on. It is covered by „life expectancy” definition, which is: „summative indicator of progress across multiple sectors”.

So how is that connected with reality of most people on our planet which basic needs in health care are still the same since a long time ago?

If it was „holistic point of view” it would look for healthcare financing problems elsewhere, especially, when more and more people pay more and more taxes.

Some people's life expectancy is to have many children – and they are exercising that right! Meanwhile, the report says:

(...)Providing women with contraceptive choices is therefore crucial."

or

"(...) Education of girls and women is a crucial building block for improving women's and children's health and choices of family size."

It may sound pretty, but it just covers offensive of contraceptive propaganda.

These "reproductive rights" - what do author mean by that? I thought that everybody has a right to choose whether they have a sexual intercourse or not [except criminal cases, such as rapes], Thus speaking of reproductive rights in the context of narrowing these rights only to reduce number of children is just a manipulation.

And yet, there is another try to cover that:

„Guiding principles for the new development framework:

1. The principles of the Millennium Declaration — human dignity, equality, and equity at the global level — should be re-endorsed and made more explicit.”

By wildly introducing propaganda about benefits of being chemically - sterilized?

Well, that's definitely "healthy" - especially, when that kind of propaganda is introduced to poor societies - that is "equality"!

„2. The approach should be rights-based”

That is right! So how could it be, that you insist on sterilizing women and insinuating, that it is their right they should exercise? I thought they have right to choose what is good for them.

Right to be healthy is one of the basic rights of human, however right to be alive is even more important and is regulated by many countries' constitution – for those, who has problems with knowing right from wrong.

The bottom line is, that in my opinion, this report represents only financial interests of rich minority, and provides concept for aggressive propaganda, and also points measuring methods to control their realization progress.

Of course there are some real health issues [HIV, lack of fresh water etc.], but from The „Report of the Global Thematic Consultation on Health” i expected much more professionalism.

Published draft report looks like what I would expect from first semester sociology student created to please his teacher.

Luis Tejedor López

Mon, February 18, 2013 at 05.02 pm

I support this comment by 100%

Laurie Mazur

Tue, February 12, 2013 at 08.19 pm

The consultation report wisely recognizes the centrality of sexual and reproductive health and rights in the post-2015 development agenda:

"People's, and especially women's, right to decide the number of children they wish to have (and are able to afford) is a basic human right. Countries that have fully supported this right tend to have a lower total fertility rate. Smaller families benefit women's and children's health and make it easier for health systems in low resource contexts to serve their populations. Among other things, having fewer children empowers women to participate in society, complete their education, and access formal employment, giving them an independent income. It also contributes to human development by reducing household poverty. Smaller families slow population growth, which in turn reduces demand for water, food, and energy; alleviate pressures on education and the environment; diminish social conflict and state fragility; and reduce climate change and mitigate its impact."

At the same time, the report acknowledges the pressing need for greater equity in health and development. The report observes that the MDGs sometimes served to mask—or even deepen—inequities, by focusing on national averages that can obscure regional and socioeconomic disparities.

In reproductive health and rights, those inequities are stark. In Chad, a woman faces a 1 in 15 chance of dying in childbirth; for a Greek woman, the risk is just 1 in 25,500. Some 222 million women in low-income countries lack meaningful access to family planning and reproductive health services. And, even in affluent countries, the poor and marginalized face steep barriers to access.

The consultation report is right to acknowledge the importance of reproductive health and rights. The key challenge for post-2015 development efforts will be to eliminate disparities in access and outcomes, and ensure that all people have, in the words of the Cairo Programme of Action, the means and the power “to decide freely and responsibly the number, spacing and timing of their children.”

Lal Manavado

Tue, February 12, 2013 at 02.09 pm

In conclusion-

As this consultation draws to a close, one wonders whether those who determine the shape of the final plan would be bold enough to formulate a two-dimensional one, where similar national priorities are subsumed under generic goals, whose achievement becomes a joint endeavour among governments and other relevant institutions with reference to appropriate norms.

This approach would impart rationality to a global health plan, for it allows each country to set its health priorities with reference to its own health needs, and NOT with reference to irrelevant global incidence of a particular disease, nor yet to its distribution among social groups. The first could benefit most of those who actually need health care in a country, while the latter may benefit a very variable number of them.

Once such generic goals have been determined, one may discover that in certain areas provision of simple primary health care would benefit more people than say a HIV/AIDS programme, and could actually help in prevention of the latter. It is vital to note here that the reverse implication does not obtain.

Moreover, in some other areas, priority may be justifiably accorded to the treatment and prevention of a parasitic disease such as Malaria, but here again, primary health care and other sectors can play an important role in its amelioration.

Hence, the second dimension of the plan sketched here is concerned with describing what organised national and international bodies may help a state to resolve its health problems, and what means would be most appropriate with reference to its own cultural sensibilities and available resources.

Everything needed to build a steam engine was there long before James Watt was born. Many learned papers had been written about those things by venerable scholars ere Watt could read and write. He did not read those impressive works, yet he assembled them into a primitive engine that could do useful work. Likewise, we have the means, but do we have the creative will to assemble those disparate means into a holistic tool of global utility?

Manavado.

RESURJ

Tue, February 12, 2013 at 05.16 am

The draft report could be strengthened in its content on "people", and who this new framework will try to reach. Women's and adolescent health and human rights must be a priority in the Post-2015 health framework, particularly those who are poorest and most marginalized. Thus, this framework must include goals, targets and indicators that can measure equity in access to services: who accessed them (data disaggregated by geographical distribution; age; sex; gender; marital status; migrant

status; health status) quality of the services provided (informed choice, non-coercion, discrimination and stigma in the provision of care) type of services provided (prevention or treatment and of what condition).

In order to deliver on women's and young people's health and human rights, it is necessary to create goals and targets that measure the availability, accessibility, affordability, and quality of:

- Comprehensive and integrated sexual and reproductive health services, counseling, and information for young women and adolescent girls with respect for their privacy, confidentiality and human rights
- Comprehensive Sexuality Education Programs that empower women, particularly adolescent girls and young women, to know their bodies and to exercise their rights, in and out of schools
- Respect for adolescent girls and young women's sexual and reproductive rights, including by removing all legal, policy and social barriers in their access to health services
- Young women's leadership at all levels and in all types of decision-making programs and policies that affect them in order to ensure adequate program design, monitoring and evaluation, and accountability of health service provision to these populations

M de Bruyn

Mon, February 11, 2013 at 06.13 pm

The opportunity to review the draft report summarizing the consultation on health is welcome.

It is important that the final version of the report includes a recommendation on the importance of highlighting sexual and reproductive health as an essential component of any overarching health goal.

On page 15 of the report, an example is given of the multiple benefits that universal access to reproductive health services and protection of reproductive rights would bring. This should be reflected in the report's recommendations on the content of a health goal and how it would relate to other goals. Indicators should be proposed to monitor improvements achieved in data collection systems regarding access to reproductive health services, such as contraceptive use, skilled birth attendance, post-abortion care and safe abortion, disaggregated by age, residence and socioeconomic status.

On page 14, it is stated that: "Contentious health issues need to be faced head-on, including the rights of people living with disability, sexual and reproductive health rights, the rights of people living with and affected by HIV and AIDS and other diseases, and the rights of people whose access to health is obstructed by unjust laws and policies. The elimination of financial exclusion and of gender discrimination are priorities." This should be reflected strongly in recommendations regarding the human rights aspects of a health goal and indicators related to health rights should be

proposed.

For example, one indicator could address the implementation of laws and fulfillment of obligations assumed with the ratification of international treaties that promote access to all evidence-based reproductive health services (e.g., in UPR and Treaty Monitoring Committee periodic reports). A second indicator could be the revision of laws that criminalize issues such as substance use, same sex sexuality and sex work and laws that criminalize or impede access to comprehensive sexuality education, modern contraceptives including emergency contraception, and safe abortion care.

On page 28, the report references the “Guiding Principles on Human Rights and Extreme Poverty” and the “Commission on Social Determinants of Health”. At least one submission also referenced the “Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality” (A/HRC/21/22; 2 July 2012. Geneva: OHCHR; http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf), which contains principles that can easily be applied to multiple areas of health.

On page 33, a “maximizing healthy life expectancy” goal is proposed, for which one indicator would be reduced burden of disease, building on MDGs 4, 5 & 6. It would be important here to include maternal morbidity (e.g., infertility when women suffer irreparable uterine damage as a result of unsafe abortions, fistulas resulting from lack of skilled birth attendance and too early pregnancies).

On page 35, in addition to stressing the need for governments to continue addressing the MDGs in the next two years, the report should also advocate for incorporation of the ICPD beyond 2014 process outcome into the post-2015 development framework.

Finally, the report can make a much stronger case for integrating the SDG and post-2015 processes, a move which could also facilitate civil society participation which has been touted as so important to the UN processes.

Sarah Fisher

Fri, February 15, 2013 at 10.46 am

I agree with this comment, and others supporting the focus on sexual and reproductive health and rights in the report and calling for this focus to be strengthened, including through the report’s recommendations.

Sexual and reproductive health and rights are essential human rights, and enabling factors for sustainable development. Achievement of universal access to reproductive health, including access family planning programmes that respect and protect human rights, has the potential to drive progress towards a wide range of development priorities, including poverty alleviation , equity, health, education, gender equality food and water security. This makes sexual and reproductive health not only critical in its own right, but also for the overall achievement of sustainable development.

IFMSA-SKN

Mon, February 11, 2013 at 04.09 pm

In spite of the numerous mention of a need for education, research, and innovation in this draft, there has been absolutely no reference made to ethics, ethical guidelines, or ethical progress. The key to social progress will always hinge on society's adherence to sound ethical principles. To give meaning to the progress we have made in our world and eschew potential dangers and pitfalls that we may witness in the future the world community needs to be proactively engaged in introspective discussions surrounding ethical principles that may be undermined or eroded with social progress. Reaching a certain hunger eradication target may be a laudable goal indeed. However, without proper understanding of ethics, such attainment would be meaningless, or perhaps even dangerous.

Jose Luis Alfaro

Mon, February 11, 2013 at 03.36 pm

Cualquier política debería incluir financiamiento sustantivo destinado a prioridades como el VIH y el aseguramiento público
Asimismo debería establecer procesos claros de rendiciones de cuentas en todos los niveles y participación sustantiva de los beneficiarios. en todos los procesos.

El desarrollo de los pueblos y personas debería estar perfectamente ligado a procesos sociales de salud, educación y economía.

Todos los emprendimientos deberían incorporar procesos de responsabilidad social por parte de la empresa privada.

Rob Yates

Mon, February 11, 2013 at 05.56 am

Include UHC because it is popular - worldwide.

A strong reason for including Universal Health Coverage (UHC) as an overarching goal is that it is extremely popular. People like UHC and understand the simple idea that everyone should access the health services they need without suffering financial hardship. As a result, political leaders across the globe have been launching popular and effective UHC reforms. These reforms have delivered considerable health benefits to their populations and political benefits for their governments.

Recently, political pressure to deliver UHC has been evident at all income levels and in differing political systems including: US, China, India, Brazil, Mexico, Thailand, Indonesia, Turkey and South Africa. In addition, extending health coverage is proving very popular in LICs, noticeably in post-conflict countries where leaders want to deliver quick-win peace dividends to their populations.

The popularity of UHC as an overall health goal is also evident from the high volume of support this goal has attracted from civil society organisations across the world.

Therefore if the post-2015 development agenda is to be true to its stated principle that “people are the priority in global health” (page 19) then UHC should be included as an overall goal, because it is what the people want.

Dr. Mark Brennan-Ing

Fri, February 8, 2013 at 09.53 pm

MDG 6: combating HIV/AIDS, malaria and other diseases makes no specific reference to the growing population of older adults with HIV/AIDS. Largely as a result of widespread and effective treatment, the Centers for Disease Control and Prevention predict that half of all Americans with HIV will be older than 50 by 2015. In both developed and developing nations where there is access and adherence to ART we can expect much the same: individuals living with HIV into their 50s, 60s and beyond.

Data from developing countries is limited, but estimates suggest that currently there are more than 3 million people aged 50 and older with HIV in Africa alone. Projections suggest this figure could triple to just over 9 million by 2040 dramatically changing the age composition of the HIV epidemic in sub-Saharan Africa. Data from several developed nations show that 10-20 per cent of newly-detected HIV infections occur in those aged 50 and older. Similar data is rarely presented for developing countries but the data we do have shows a similar trend (25 per cent of new diagnoses in Antigua and Barbuda, 18 per cent in St. Lucia and 10 per cent in Malaysia). Recognizing the aging of the epidemic, countries such as Brazil and South Africa have added those over 50 to their list of key populations in need of HIV services. Unfortunately, the 2012 UNAIDS Report does not mention the ageing of HIV. At the least, it might have celebrated the fact that for millions of people around the globe HIV is no longer synonymous with early death and people with HIV can now expect to live nearly as long as their HIV-negative peers. As a result of the omission of data on those aged 50 and older, the report is inaccurate and misleading. We fear the report’s failure to include aging with HIV tacitly fuels several stigmatizing myths about older adults: that they don’t have sex or engage in other risky behaviors; that HIV only occurs among young people below age 49; and that their challenges in living with and treating HIV, among other health problems, are no different than those of younger adults.

The Report also ignores a significant research challenge: the unknown interactions of HIV and aging processes. The extraordinary success of ART is often complicated by the fact that older adults with HIV develop a combination of chronic, non-

communicable diseases, usually associated with aging but also appearing earlier in those living with HIV. With ever-increasing access to ART, and greater access to a wide array of prevention technologies, the age composition of the epidemic will continue to shift away from the young. Effective care and treatment of an aging population with HIV will necessitate moving beyond a narrow focus on viral loads and CD4 counts toward a more holistic, multimorbidity management approach and people's holistic health needs.

The neglect of older adults in the report also masks other notable challenges, including the particular vulnerabilities faced by older adults, particularly older women, who are playing a critical role in their families and communities, providing economic support and caring for family members, especially children who have been orphaned as a result of AIDS.

Many of us have spent over a decade working to ensure a greater understanding of the fact that the HIV epidemic affects people of every age. HIV does not discriminate on the grounds of age, even if the response to the epidemic appears to. Our efforts are supported by the available data and research, much of which is aimed at giving a voice to those aging with HIV who are too often invisible. We urge the Global Thematic Consultation on Health, UNAIDS, and all those working to end this epidemic, to address the entire epidemic, and include the ever-increasing number who are growing older with HIV. UNAIDS own commitment to the 'know your epidemic, know your response' approach demands this. More than 30 years into the epidemic and with millions receiving treatment, we are literally ignoring our successes when we fail to report on those aged 50 and older with and at-risk for HIV.

Without adequate data, we lack the evidence base to successfully address the burgeoning challenges of growing older with HIV. Thus, we strongly urge the following steps:

1. Include comprehensive data and guidance on aging and HIV in future UNAIDS reports
2. Eliminate age limits in guidance for reporting data on the epidemic and ensure data presented in country progress reports is reflected in the global report
3. Encourage service providers to expand their coverage to include older adults
4. Include research data showing changes in the health status of older adults with HIV including the onset of age-associated comorbid non-communicable diseases
5. Fund research efforts that assess the sexual and risk behaviors of older adults to better inform prevention efforts.

Lal Manavado

Mon, February 11, 2013 at 09.55 am

There is a general agreement on the importance of HIV/AIDS, but it hardly constitutes the target of a world health plan of the greatest possible applicability. Vide my comment on February 8th. - Manavado.

Chandra Mohan

Fri, February 8, 2013 at 02.38 pm

The MDG is a good step in enhancing the living conditions of all people in the world. Health is a very important factor that has to be appropriately addressed to improve the quality of life of all human beings. The best methods have to be evolved and reach to involve all those who could contribute positively in this endeavour.

Lal Manavado

Fri, February 8, 2013 at 10.25 am

A chance to set up a flexible, inclusive and holistic plan to enhance world health?

There is no doubt about the value of the suggestions the draft contains, and the correctness of the information, on which they are based. However, they seem to represent a reductive approach to the general problem of world health.

As a consequence, a post-2015 world health plan may emerge that may concentrate on certain diseases, health problems of some group, or indeed even the putative cause of some set of diseases. This would inevitably result in an exclusive world health enhancement plan owing to its fragmented and partisan character.

However, if at this crucial juncture, decision makers are able and willing to resort to a top-down approach in resolving the problem, it would be still possible to arrive at a holistic world health enhancement plan that would include all the participating nations, where problems of unique importance to them could receive due attention.

Some of those problems like Malaria, Tuberculosis and HIV/AIDS display a graded shared importance, but this does not warrant according to them a universal priority in a plan to improve world health. Nor yet would the somewhat vague notion of 'universal health care' has a universal applicability. The difficulty here then, is to design a general world health plan that could subsume what is important for individual nations with reference to their actual health needs.

A possible solution to this problem would have two logically inseparable, but distinct components. The first would represent a flexible strategy upon which the participants could agree without reservations. Its general character and flexibility should ensure consensus among them.

Its tactical component would empower each nation to determine the health problems to which it should accord priority with reference to sound epidemiological data, and determine the means of overcoming them with reference to the best practice its own peculiar circumstances would allow.

While the strategy would describe the agencies each nation may use to resolve its problems, it would also recommend and require global, regional and local pooling of resources in a manner that does not infringe state sovereignty.

Of course, the strategy would encompass the ways and means of ensuring the unity of

purpose among the participants of a national tactical plan, highest possible technical competence, availability of the appropriate resources, and the lowest possible level of corruption.

Although the views expressed here may not reflect those of the majority involved in the field, I hope they would be of some interest albeit as those of a defender of the faith, but better known as 'devil's advocate'.

Thank you.

Lal Manavado.

Vieng Akhone

Fri, February 8, 2013 at 03.30 am

Increased investment, Coverage of and quality of key affected population services

Vieng Akhone

Fri, February 8, 2013 at 03.28 am

Just Increased the Investment, Coverage and Quality of Key affected population services

Anastasia

Thu, February 7, 2013 at 01.28 pm

I would urge you to include more explicitly mention of marginalized pops, in particular migrants, in monitoring health and health care responses. This seems to be somewhat absent from the current draft.

Sono Aibe

Sun, February 17, 2013 at 07.43 pm

I agree with Anastasia's comment and in particular, addressing the sexual and reproductive health of these migrants who are often young people of reproductive age.

Edwina Pereira

Wed, February 6, 2013 at 05.23 am

Hi

An exhaustive report that just touches the surface of an important yet critical componet that needs to be added: (page 24) Child rprotection and care. Unless this is further spelled out, child protection against the growing abuse and exploitation will undermine the sustainability of efforts in every other health sphere that the Post 2015 is prioritising. The accountability of the governments to ensure child protection and care, the inclusion of children in this dialogue, is missing int he draft report.

Edwina Pereira
Program Director-training
INSA-India
www.theinsaind.org

Steven van de Vijver

Tue, February 5, 2013 at 07.13 am

Thanks for sharing this important report. Here are my two points I would like to share:

- regarding action points UHC, page 23, I think it is very important that we should strive to cover M-Health by providing health information/promotion and personal health data through digital channels (also to release the pressure on clinical workforce). Although this subject is discussed earlier in the document (page 16) it is not coming back in the action points.
- regarding More MDG goals, page 23, I think there should be a specific goal on

awareness of hypertension. As hypertension is the leading risk factor in the global burden of disease (7% of all DALY's) and the majority of the population at risk in most global settings is not aware of this and has never been screened, there should be a specific action point. I completely agree that screening of blood pressure should not be an extra vertical activity, but it should actively addressed and integrated in other public health activities and this could improve the overall health system. You could save a lot of lives if you would aim that 50% of the population/hypertension patients is aware of their risk factor.

I hope these small contribution will stimulate the discussion and improve the final document. All the best!

Samir Kumar Das

Mon, February 4, 2013 at 01.13 pm

HIV/AIDS are the present day problem in Indian states and with its rapid growing scenario anomalies the Health situation. Specially researchers and expert physicians on the line are always thinking to apply new and improved method of control and its application. Even after using different medicines and treatment the diseases could not be compartmentalized. In this connection my personal view is to teach the patients through public awareness campaign by using different methods by T.V., Cinema slides, through projection by showing door to door campaign, By public add showing different of banners, festoons, Leaflets, training camp, and finally it should be in the educational courses. Beside these there are several other diseases which affects our public life. Regarding other Health problem I shall write next time.

Samir Kumar Das

Chairman

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