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The 2030 sustainable development goal for health

Must balance bold aspiration with technical feasibility

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In the year 2000, 193 countries adopted the millennium development goals (MDGs), a milestone in global development. The eight goals were simple to grasp, measurable, and time bound, ending in 2015. Goals 4, 5, and 6 focused on reducing child, maternal, and infectious disease mortality, respectively, raising health to the top of the global agenda and mobilising new health financing.[1] Although the three health related goals are unlikely to be met, there has been substantial progress towards their achievement, particularly for infectious diseases.[2]

As the MDGs come to an end, a new set of sustainable development goals (SDGs) will be debated during the UN General Assembly that starts on 24 September 2014. These goals will have a 2030 end date. They could catalyse further transformations in global health.

An intergovernmental open working group is writing the new goals and has just published its first draft.[3] Whereas the MDGs were "'top-down goals' formulated by policy elites,"[4] the working group deserves credit for drafting the new goals using a bottom-up approach, based on wide ranging consultations. There is much to like in the draft: a strong focus on women, climate change, and the importance of technological innovation for human development. But in trying to please everyone, it reads as a long wish list. Fortunately, the first draft is not the last word and will be revised over the next year. We urge the working group to address important weaknesses.

Focus, focus, focus

Firstly, the draft tries to do too much. It has 17 goals and 164 targets; the single health goal (SDG3), to "ensure healthy lives and promote well-being for all at all ages," has 13 targets. Though we favour ambition, this first draft is overly expansive and lacks focus, making the overarching purpose of the goals unclear. They should be winnowed down to no more than 10 goals.

Furthermore, several targets are aspirational, unachievable, or inappropriate. Take target 3.2, to "end preventable deaths of newborns and under-five children," or target 3.3, to "end the epidemics of AIDS, tuberculosis, malaria." We know of no research showing that we can "end" these health crises within just 15 years. And for malaria, the WHO's focus for 2015-2030 will be on reducing deaths and cases and eliminating the disease from an additional 30 countries, not on ending malaria epidemics.[5]

Instead of setting unattainable zero targets, a more valid approach is to model the trajectory of mortality to 2030 under different degrees of health sector investment. For example, the Commission on Investing in Health modelled the effect of aggressively scaling-up existing and new tools for HIV, tuberculosis, malaria, maternal and child health, and neglected tropical diseases on mortality.[6] It found that scale-up could lead to a "grand convergence" by 2030—death rates from these conditions in poor countries could fall to rates seen today in high performing middle income countries.


Needs to transform from utopian fairy tales

Early prioritisation of family planning, antiretroviral therapy, and vaccination would bring particularly large pay-offs. Yet even with these enhanced investments, by 2030 child mortality would still be about 27/1000 live births in low income countries. And though the mortality burden of AIDS, tuberculosis, and malaria would be greatly reduced, it would not be zero.

A third problem is that too many of the goals and targets are vague and unmeasurable. Consider SDG3—how will we measure progress towards "wellbeing for all"? We are strong supporters of publicly financed universal coverage of medical and surgical services in all countries, but target 3.8—"achieve universal health coverage"—is meaningless unless the package of services and the metric for measuring its coverage are clearly articulated.[7] Another concern is that health plays second fiddle to other development goals, relegated to a single goal with no links to the other sixteen goals. Health is integral to sustainable development—better health boosts educational and economic outcomes[6]—and should be more explicitly linked with economic and social development.

Finally, substantial new financing will be needed to finish the "unfinished health MDGs agenda" and curb non-communicable diseases and injuries, yet the draft says little on where the money will come from. As low income countries become middle income, they will increasingly be able to fund health programmes themselves through economic growth. But they will still have large populations living in poverty: 70% of the world's poor are in middle income countries.[8] They will need to find new domestic sources of health financing, such as taxing tobacco and diverting fossil fuel subsidies to the health sector,[9 10] and may require transitional donor support to target their subnational "pockets" of poverty.

Other countries, especially fragile states, will remain low income and reliant on aid through to 2030. Innovations in mobilising aid, such as "solidarity taxes" on airline tickets,[11] will be required to overcome the aid stagnation that has occurred since the global financial crisis.[12]

Could the SDGs be as influential as the MDGs? Yes—if the first draft can be transformed from utopian "fairy tales"[13] into a prioritised list of measurable goals, targets, and interim milestones that all countries can achieve, with a central role for health and new approaches to development finance.

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These authors' invaluable contribution is the previously unsuspected fact that detailed family histories should be taken to stratify women at special risk for postpartum haemorrhage

Genetic contribution to postpartum haemorrhage

Taking a family history from all pregnant women could save lives

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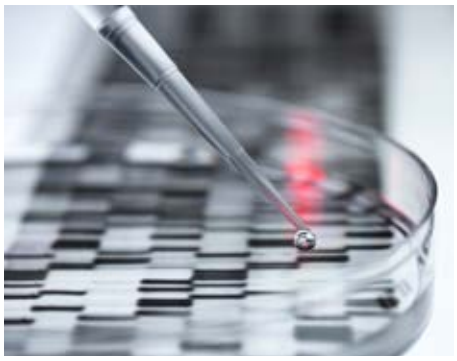
Women are still dying in childbirth at alarming rates in areas where resources are scarce and births are unattended by skilled health workers.[2] Not every birth can be attended by a health worker or take place in a maternity unit, even in developed countries. The best we can do is to suggest that women at particular risk for postpartum haemorrhage, the leading cause of maternal mortality worldwide,[2] should be managed in settings where interventions for excessive bleeding during childbirth are available and judiciously used. There is good evidence that use of oxytocin at delivery prevents primary postpartum haemorrhage[3] and that various medical and surgical interventions, including timely blood transfusion, can prevent death from postpartum haemorrhage.[4]

In a linked article, Oberg and colleagues give us some valuable new insights on how to identify women who are more likely to require these interventions.[5] Currently, we do not know how to reliably stratify women at risk for postpartum haemorrhage.[4] We know that previous postpartum haemorrhage is a risk factor along with antepartum haemorrhage, pre-eclampsia, fetal macrosomia, multiple gestation, polyhydramnios, grand multiparity, maternal obesity, coagulation disorders, and certain ethnicities.[4-6] Other common risk factors such as prolonged or augmented labours, prolonged third stage, and operative deliveries emerge only after labour has started, making pre-emptive transfer to a health facility difficult or impractical.

Oberg and colleagues studied 466 686 births in Sweden and found a higher rate of postpartum haemorrhage within some families than in the general population.[5] This is in contrast with other recent results showing no increased risk in the daughters and granddaughters of women who had a history of postpartum haemorrhage.[7] Oberg's findings suggest that susceptibility to postpartum haemorrhage has a maternal component. When the cases of postpartum haemorrhage were further separated into uterine atony and retained placenta subclasses, the familial clustering and maternal effects remained and were especially strong for retained placenta. The authors estimate that as much as 41% of the occurrence of postpartum haemorrhage can be explained by familial factors, with 18% explained by maternal genetics, 11% by fetal genetics, and 10% by maternal environment and 2% attributed to the couple.



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Maternal and fetal genetics both contribute to risk

Take detailed family histories to stratify risk

Although the authors found that about 29% of the predisposition to postpartum haemorrhage is genetic, they have not attempted to identify any particular genetic variant that might contribute, and therefore no additional genetic screening can be immediately put in place. These authors' invaluable contribution is the previously unsuspected fact that detailed family histories should be taken to stratify women at special risk for postpartum haemorrhage. Women with sisters and brother's wives and, probably, mothers who have experienced postpartum haemorrhage should be stratified as high risk. The authors have paved the way for future genetic screening for one of the world's leading maternal killers.

Excessive bleeding in the first 24 hours after vaginal birth occurs most commonly because of uterine atony and delayed delivery of the placenta.[4 6] Abnormal placentation, bleeding disorders, or trauma to the birth canal are other causes. Some of these causes could be genetically determined. The authors' findings that familial clustering and maternal effects were especially strong for retained placenta and that 11% is explained by fetal genetics suggest that placentation could be a genetic link to postpartum haemorrhage. Researchers should examine variations in placental development and their association with postpartum haemorrhage more closely in future studies.[8]

Meanwhile, the authors' findings make it imperative for carers of women to take a targeted family history, along with details of the other risk factors for postpartum haemorrhage, to help to stratify their risk for excessive bleeding. Studies should be conducted to validate the familial clustering of risk for postpartum haemorrhage in other populations and to determine the sensitivity and specificity of family history as a risk indicator. Women should be encouraged to let their relatives know if they experience excessive bleeding in childbirth. In developing countries, women noted to be at risk for postpartum haemorrhage should be transferred early to facilities with skilled birth attendants and the resources to deal with excessive bleeding. In developed countries, women at risk for postpartum haemorrhage should be advised to avail themselves of measures to prevent postpartum haemorrhage, including the avoidance of home births unless attended by trained health workers.

In some settings in developed countries, however, a tendency to "over medicalise" childbirth, with routine insertion of intravenous lines and other invasive procedures even in low risk pregnancies, has led to an increasing number of women opting for home births to escape these perceived unnecessary medical interventions.[9 10] Emerging evidence that a more physiological approach to childbirth is actually associated with lower rates of postpartum haemorrhage in low risk women[11 12] might make it difficult to entice women back to a medical setting, unless a personalisation of risk can be determined. Addition of family history to the current list of risk factors to check for in a childbearing woman might be a small step forward, but it is certainly easy, economical, and could yet save many lives.

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History suggests that governments and international agencies should approach change with caution

Which way for drug legalisation?

International drug control treaties need to allow for policy experiments

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The failure of the "war on drugs" is a standard presumption in most discussions of drug law reform. It has recently received impressive endorsement by high profile advocates, including retired senior statesmen (for example, George Schultz) and leading financiers and business people such as George Soros and Richard Branson.[1] However, reports of prohibition's failure—like those of Mark Twain's death—may be exaggerated.

Recent changes in the laws on cannabis in Uruguay and the states of Colorado and Washington have garnered mass headlines globally. Are these harbingers of global defection from current international treaties that require UN member states to prohibit the use of drugs such as cannabis, cocaine, heroin, and methamphetamine?

An impressive thinktank report from the London School of Economics has echoed recent calls for a radical overhaul of international drug treaties.[1] However, the report is more nuanced than a simple call for their repeal. As some contributors make clear, drug legalisation is not a master stroke in dealing with complex, global drug markets. Legalisation does not tackle the social inequity that surrounds drug use and drug markets in many countries or the fact that policies in developed countries such as the United States often shift the burden onto so called producer countries such as Mexico.

The mantra that current drug policy has failed is taken as given when discussing drug violence in Mexico, drug supply in Afghanistan and Pakistan, and rates of incarceration for drug use in the United States. And the prospect of a drug-free world is looking ever more remote: the criminalisation of the drugs trade has created increasingly profitable, organised crime that is challenging the government and stability of many states.

Action at a global level is hampered by the absence of consensus among governments on the best way to address the challenges of drug control. Many governments, including those of China, Russia, Sweden, and the US, are strongly in favour of tougher law enforcement.

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Time for a radical overhaul of drug treaties?

What constitutes "drug law reform" varies widely in different parts of the world. The discussion of what sort of drug control strategy should replace the existing framework is still in a rudimentary stage of development. Recent work indicates that the UN conventions on illicit drugs may not be as set in stone as is believed; there may be room for incremental change.[2]

Edgy

History suggests that governments and international agencies should approach change with caution. Liberalisation can produce political backlash and shift popular sentiment towards more punitive policies. In his essay in the LSE report, Jonathon Caulkins asserts that "in legalisation, as in software development, it may be prudent to distinguish between aspiring to be on the cutting edge [and] the bleeding edge of reform."[3]

The report suggests that governments that manage to reduce the violence surrounding illicit drug economies may not be able to rid their countries of organised crime. They can, however, lessen its grip on society, increasing citizens' confidence in government, encouraging more citizen cooperation with law enforcement, and reducing a national security threat to a more manageable public safety problem. This can be accomplished—as many countries have done—without drug legalisation.

Globally, tackling crime requires inclusion of marginalised populations, which often depend on illicit activities to survive, such as poppy farmers in Afghanistan. We need to provide the means for such communities to exist and survive within a social and economic environment that effectively contains crime and where the law and economy is perceived by the community to protect its key interests and is supported by the majority of the population.

The critical question is how to move beyond the tired old debate on drug legalisation, which means very different things to different stakeholders, and to develop a new framework that enables social experiments to better inform future decisions. If rigorously evaluated, the effects of the changes in cannabis laws in Colorado and Washington State can provide important information on how best to manage the cannabis market in a modern economy.

Over two thirds of drug policy expenditure is on enforcement and supply reduction, and despite debate and exhortation there has been little change in this over the past three decades. From a public health perspective, whatever resources are available need to be distributed more equitably between prevention, treatment, and harm reduction. Resources need to be used cost effectively, and one part of that is to lock up fewer people for drug related offences. This probably means that less money should be spent on law enforcement efforts to reduce drug supply. We need answers to questions such as: What safety controls and regulations are required for legal production and distribution? How much taxation will be raised in this process? How will legal drug markets in one country affect illicit markets in neighbouring states? What will happen to the incidence and prevalence of drug use and drug related harm?

The objective should be to change international drug control treaties in ways that enable policy experiments to be implemented and evaluated in a piecemeal way, avoiding the Herculean stalemate between supporters of the status quo and proponents of more radical change.

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Access to prepublication histories will encourage readers and other interested parties to participate in the self correction processes that are vital to the credibility of medical research

Prepublication histories and open peer review at *The BMJ*

We will publish peer reviews and authors' responses for all research articles

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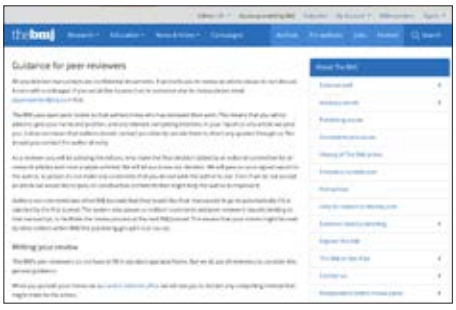
Over the past 15 years peer reviewers for *The BMJ* have shown, by signing their reviews and declaring to authors and editors any relevant competing interests, that they are unafraid of transparent scientific discourse. Now we are opening up our process to make our reviewers' role as authors' critical friends visible to all.

From this autumn on thebmj.com all research articles, and certain scholarly articles in *The BMJ*'s Analysis section, will have an article tab marked "Reviews." Clicking on this will open the article's prepublication history, comprising all signed reviews (including those by statisticians and patient peer reviewers), previous versions of the article, the study protocol for any clinical trial, the report from *The BMJ*'s manuscript committee meeting, and the authors' responses to the editors' and reviewers' comments. As now, reviewers will not be able to make private comments to editors, except in the rare case when a reviewer wants to express concerns about the scientific integrity of the work (www.bmj.com/about-bmj/resources-reviewers/guidance-peer-reviewers).

Such open peer review should increase the accountability of reviewers and editors, at least to some extent. Importantly, it will also give due credit and prominence to the vital work of peer reviewers. At present, peer review activities are under-recognised in the academic community. We hope that reviewers will find this increased visibility helpful when demonstrating the extent and impact of their academic work and that they and others will cite and share their reviews as a learning resource.

Greater accountability and transparency are clearly laudable goals.[1-3] But is there a downside to open peer review? Does it, for instance, provide "more scope for power relationships to favour 'the great and the good,'" as Karim Khan, editor of the *British Journal of Sports Medicine*, feared?[4] Or might it produce a flurry of spurious criticism motivated by commercial interest, academic jealousy, or pettiness? Such problems may occur, but we think the good consequences of more open editorial and peer review practices will outweigh any harms. One beneficial result may be that access to prepublication histories will encourage readers and other interested parties to participate in the self correction processes that are vital to the credibility of medical research.



Look for the "reviews" tab to read the full story

Randomised controlled trials conducted at *The BMJ* since the turn of the millennium found that removing anonymity improved the tone and constructiveness of reviews without detriment to scientific and editorial value. One of the trials also found that telling reviewers that prepublication histories might be posted online did not affect the quality of peer review.[5 6] These positive outcomes may reflect *The BMJ*'s position as a general medical journal that is relatively free from academic turf wars and the fact that editors, not reviewers, decide whether to accept or reject submissions. However, in the trial, reviewers who were asked to look at a paper that was randomised to online prepublication history were moderately more likely to decline the assignment or not to reply.[6] We will keep a close eye out for such a trend and will act quickly to solicit further reviews when needed.

A recent study investigated the potential of open peer review to improve the reporting of randomised trials.[7] The authors looked at changes in reporting of items on the CONSORT (Consolidated Standards of Reporting Trials) checklist between the original and final versions of 93 randomised controlled trials in BioMed Central's series of open access journals in medicine (www.biomedcentral.com/authors/bmcseries), which have been posting prepublication histories since 2000. They also looked at changes requested by peer reviewers and at authors' subsequent responses. Most changes had a positive effect on reporting of the trials' methods and results and on toning down of conclusions. Reviewers missed some important deficiencies in the articles, however, and in 15 of the 93 articles their advice actively worsened the reporting.

This study's authors did not know the extent to which these findings might be generalisable to other journals with different editorial and peer review processes. We hope that the open review processes at *The BMJ* and *BMJ Open* (which has successfully implemented prepublication histories of well over 2500 articles so far (http://bmjopen.bmj.com)) will provide equally fertile ground for study.

This action follows other important steps that *The BMJ* has taken to ensure the integrity of the research we publish. These include prospective registration of clinical trials, the routine use of research reporting guidelines and checklists, open (that is, signed) peer review, campaigning for data sharing and linking to datasets in the Dryad digital repository, and endorsement of the RIAT (Restoring Invisible and Abandoned Trials) initiative to publish or correct abandoned or misreported clinical trials.[8] Posting prepublication histories is another part—but not the conclusion—of a process aimed at restoring trust in the clinical research enterprise. We will closely monitor the effects of our new, more open review and editorial processes and refine or modify them as needed. We invite comments and suggestions from our readers.

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