G7 health commitments: greater specificity for greater accountability

The Lancet (June 20, p 2433) is right to praise the G7 for the impressive range of health commitments in its Schloss Elmau Summit declaration. Yet, if statements of intent are to translate into action and improved health outcomes, the strength of its rhetoric must be matched by an ability to be held to account.

Criteria to measure the robustness of declaration commitments include the specificity of targets and means, their future orientation, level of ambition, time-boundedness, the bindingness of the obligation and whether commitments apply to those issuing the declaration or other parties, among others.

“Welcoming” an initiative proposed by Ghana and Norway does not constitute a robust G7 commitment, nor does being “mindful” of the health needs of migrants and refugees, “acknowledging” the work of WHO, “encouraging” the G20 to advance the Pandemic Emergency Facility agenda—however welcome these statements are. Similarly, it is encouraging to see promises to “invest” in neglected tropical diseases (NTD) and “stimulate” NTD-related research, but over what timeframe and at what level? While weak, these commitments may be better than the failure to acknowledge non-communicable diseases, which arguably constitute the most pressing global health concern.

An accountability review of G8 and African Union commitments to AIDS, tuberculosis, and malaria in Africa was not only positive but possible due to quantitative and time-bound targets set in the past decade. The G7’s continued “strong commitment” to global health is timely, yet when the G7 Health Ministers meet in October, the litmus test of their leadership will lie in the specificity of more binding pledges to support the implementation of the health sustainable development goal.

I declare no competing interests.

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Gender disparities in water, sanitation, and global health

Celebrating World Water Day, The Lancet Editors highlighted the gains made towards Millennium Development Goal (MDG) 7c, “to halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation”; and noted UN-Water’s call for sustainable water management in view of future increases in demand and shortfalls in supply. As the primary water collectors worldwide, women are disproportionately affected by the scarcity of adequate resources; however, global estimates of improvements in water access do not reflect gender-disaggregated benefits and burdens.

While water fetching, women have increased risks of infection from facely transmitted diseases, such as ascariasis, trichuriasis, diarrhoea, and trachoma. Chronic or persistent infection, in addition to the physical effort of carrying water, causes fatigue that is not only harmful to women’s wellbeing, but also affects productivity and reduces energy and time for economic opportunities. Navigation of uneven terrain with substantial water loads can cause injury, especially if women are pregnant, carrying babies, or have recently given birth.

Additionally, water fetching, bathing, and defecation in the open expose women and girls to sexual harassment. Adolescent girls are especially vulnerable—as sadly experienced in May, 2014, by two girls who were raped and hung in rural India. Women might respond to insufficient water resources by limitation of water intake and personal hygiene behaviours, resulting in psychosocial distress. Women’s hygiene linked to their menstrual cycle is often ignored in design and delivery of water and sanitation, increasing their susceptibility to urogenital infections. Children accompanying their mothers in these unsafe environments might likewise have increased risks of gastrointestinal infection and injury.

With a 40% water shortfall estimated by 2030, women will face even greater challenges securing water. However, “global commitments made in the areas of water and sanitation (including the MDG goals) do not specifically address equitable division of power, work, access to, and control of, resources between women and men.” Imbalance between women’s water burden and denied agency in decision making underscores that post-2015 development targets alone will not reduce water access inequalities or enable future sustainability. Tackling women’s global infectious disease burden and assaults to their physical, mental, and social wellbeing should go beyond improvement of household water access to address underlying causes of gender inequality.

I declare no competing interests.
First, a gender-based goal for water and sanitation is necessary in order to understand how compromised water resources and poor sanitation and hygiene affect women and humanity as a whole. Second, to monitor this goal, generation of sex-disaggregated data and sex-specific indicators needs to be a priority to assess whether water improvements truly affect women. Third, new research should seek to understand how women experience their water and sanitation environments and the resulting health risks of women due to linked burdens. Finally, and most importantly, the voices of women and girls must be central in water development frameworks to operationalise this human right. Water and sanitation services should be available in an acceptable, adequate, affordable, and safe manner to all.

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1 The Lancet. Water: sustaining the reservoir. The University of Iowa, Iowa City, IA, USA (KKB)
2 Schmidlin T, Hurlimann E, Silue KD, et al. The Lancet. Water: sustaining the reservoir. The University of Iowa, Iowa City, IA, USA (KKB)

Rhesus disease: a major public health problem

We admire The Lancet’s Clinical Campaigns focusing the expertise of researchers and scientists to effect changes in management of diseases.1 The focus has been on major disorders that affect millions of people in high-income, low-income, and middle-income regions of the world. We believe minor issues that are immediately solvable but that need engagement with policy makers and other advocates for change likewise need attention.

Rhesus disease of newborns is an example of such a problem. The disease has been almost eliminated in high-income countries, but is a scourge in low-income and middle-income countries, where more than 100 000 newborn babies die of the disease and more than 25 000 have permanent brain damage as a result of the disease annually.2 We have formed a consortium with the goal of global elimination of rhesus disease. We include industry and academic institutions, and are recognised by the International Pediatric Association and the International Federation of Gynecology and Obstetrics. Involvement of policy makers who recognise the importance of the disease and who have the determination to eliminate it is needed.

We believe that a Lancet Clinical Campaign could bring rhesus disease to the attention of professionals and policy makers so that rhesus disease could be eliminated not only in high-income countries, but in all countries worldwide.

We declare no competing interests.

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Latanoprost for glaucoma: primum non nocere

With great concern, I have read the study by David Garway-Heath and colleagues (April 4, p 1295)3 on latanoprost for open-angle glaucoma. The World Medical Association Declaration of Helsinki (paragraph 33)4 states that “...the patients who receive any intervention less effective than the best proven one, placebo, or no intervention will not be subject to additional risks of serious or irreversible harm as a result of not receiving the best proven intervention”.

At the time that this study3 was designed the results of the Early Manifest Glaucoma Trial,5 the Collaborative Normal-Tension Glaucoma Study,6 and a meta-analysis7 of randomised controlled trials for treatment of open angle glaucoma were well known.

The fact that deprivation of treatment to patients with glaucoma—either open angle or normal tension—causes a substantially higher proportion of patients with irreversible visual field defect than when treatment is given was established in those studies. In both studies3,4 treatment was compared with a sham group of patients.

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