Health in the Post – 2015 Development Agenda

Identifying goals, indicators and targets: key questions
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BACKGROUND

The Millennium Development Goals (MDGs) have had a profound influence on the way the world understands and grapples with development issues. Initially formulated as a means of monitoring progress towards the goals and targets of a series of UN conferences, the MDGs, and their associated targets and indicators have morphed into interventions in their own right, shaping the meaning of development and influencing resource transfers within and between nations and institutions.1

The approach of the 2015 deadline has stimulated reflection on the usefulness and effectiveness of the MDGs and deliberations on what should succeed them.2 What can be learnt from the experience of the MDGs at global and country levels?3 4 5 Looking beyond 2015, would a simple revision of the current targets and timelines be sufficient or is it necessary to introduce new dimensions? Should the post 2015 goals emphasize issues that are missing in the MDG framework, such as inequality, empowerment, climate change, and sustainability. Should they address failing states, absence of democracy, or trade rules? Should they focus on ends alone or also address the means whereby the ends can be achieved? Should they continue to target the challenges of poverty and under development or should they be reformulated to be relevant to all countries? Is it even possible, given the vastly increased complexity of development issues today, to design a set of post-2015 goals and targets that simultaneously engage policy makers and the public while setting out a development agenda that is both ambitious and feasible? And where does health fit within this emerging agenda? The answers matter because global goal-setting influences investments and behaviours at both country and global levels.6

A consensus is emerging that merely extending the MDGs time frame and making minor adjustments to the framework of goals and targets is not an acceptable option. At the same time, it is important to avoid undermining current achievements by rejecting the MDG framework in its entirety. Instead, what is needed is agreement around better ways of defining development, setting priorities, identifying actions and measuring progress.

This paper examines these issues from the perspective of health. While better health is an aspiration with which people can readily identify and for which efforts and resources can be mobilised, aspirational statements are of little value without metrics that enable the formulation and monitoring of targets. The purpose of this paper is to support the process of defining health goals in the post-2015 agenda and offer guidance on the range of potential targets and indicators that could be used for monitoring health progress. The paper starts with a brief overview of the background and history of the health-related MDGs, highlighting key lessons learnt through MDG reporting processes at global and country levels. It goes on to discuss the positioning of health within the broader post-2015 development agenda. Finally it proposes a framework for the selection of health-related goals, targets and indicators. The paper also describes basic principles and criteria for the identification of health-related indicators and the implications in terms of data collection, analysis and dissemination. The underlying premise is that health will continue to occupy a central position within emerging development frameworks, as a beneficiary of development, as a contributor to development, and as a key indicator of what development seeks to achieve.
WHAT HAVE WE LEARNT FROM THE HEALTH-RELATED MDGS?

The health MDGs have gained traction for a number of reasons. First, they encapsulate some of the most serious challenges to population health of the 20th century – child and maternal mortality, infectious diseases including HIV/AIDS, malaria and tuberculosis. Second, the health MDGs were built upon earlier decades of development effort expressed through global and regional conferences, including the Alma Ata Declaration of 1978, the 1987 Safe Motherhood Conference, the 1990 World Summit for Children, the decennial conferences on population and development, and the global HIV/AIDS conferences. Third, the simple format of a nested set of concise, goals, targets, and indicators with defined time lines is intuitively attractive and readily understandable.

The health-related MDGs have been instrumental in mobilising senior decision makers in countries and within agencies and development partners around a common framework for health development. This framework is centred on the health needs of the large proportion of people in the world who are deprived and poor. Through its statement of intent and commitment, the MDG framework fostered enhanced cooperation between development partners and donors and with the recipients of aid. By setting time-bounds goals and targets, the MDG framework provides a mechanism to enhance accountability for results by promoting regular monitoring of progress.

A FLAWED PROCESS

However, with the benefits of hindsight, a number of weaknesses in the MDGs framework have become apparent. These limitations relate to both the process of selection of goals and the outcomes of that process in terms of the targets and indicators. The process was flawed for a number of reasons, including:

- A top down, technocratic approach to the selection of goals, targets and indicators;
- Absence of a comprehensive organizing framework for health development;
- Lack of clarity in definitions and limited attention to the feasibility of measurement.

The selection of the goals, targets and indicators, including the health-related ones, was through a top-down, technocratic, donor-centric approach, led mainly by UN experts, and characterised by a development paradigm that prioritised the diseases of poverty and sought solutions in aid flows and concessional lending. The requirements of simplicity, brevity and a focus on outcomes and results, made it difficult to bring into the framework complex issues such as the social and economic determinants of health, inequalities in health outcomes and access to care, empowerment, and human rights.

The origins of the MDGs in the global conferences of the 1990s, was particularly problematic from the perspective of health because there had been no global health conference since Alma Ata in 1978. Health entered the MDGs indirectly by way of conferences on child survival, population control, and HIV/AIDS. Thus, there was no coherent organizing framework for health development to guide the prioritisation of health-related MDGs which are presented in the framework as separate objectives rather than aspects of a broader common aspiration of better health for all. The imperative to deal with the health challenges associated with underdevelopment was not counterbalanced by attention to threats to health such as poorly managed urbanisation, environmental degradation, unhealthy lifestyles, violence, conflicts, etc. Of particular concern is the lack in the framework of any reference to the health systems needed to deliver the health-related interventions.

ABSENCE OF CONSISTENCY AND COHERENCE

The drive to come up with a short list of MDGs led to a simplistic and reductionist approach and loss of coherence between the goals, targets and indicators. The health-related MDGs were selected from longer lists developed for the UN global conferences by disease-specific programmes. This resulted in inconsistencies in the way the goals were defined. The three major health goals (Goals 4, 5 and 6) are formulated at different levels of action: Goal 4, is expressed in terms of a reduction in mortality; Goal 5 in terms of improvements in health; and Goal 6 in terms of combating disease.
TROUBLE WITH TARGETS

There is also variability in the formulation and precision of the targets. Some are set out in proportional terms: reducing child mortality rates by two-thirds; reducing maternal mortality rates by three-fourths; or reducing the proportion of people without access to safe drinking water and basic sanitation facilities by one-half. Others are set out in terms of completion: universal access to reproductive health; universal access to treatment for HIV/AIDS.

Goal 4 has a single target expressed in the same terms as the Goal (reduction of child mortality), whereas there are two targets for Goal 5 – reduction of maternal mortality and increased access to family planning – both of which are assumed to be proxies for improved maternal health. Goal 6, which is itself vaguely worded, has three targets, two of which refer to halting and reversing the spread of HIV or malaria, the third referring to access to treatment for HIV/AIDS.

The numerical targets for Goals 4 and 5 were derived from the global conferences and based on the assumption that reductions in child and maternal mortality would continue at a similar pace as had been observed in the past. This explains why the targets call for different numerical targets which were assumed to be feasible at the global level. Other health-related targets were not based on historical experience, but designed to be aspirational in nature. Thus Target 5B calls for the achievement “by 2015, [of] universal access to reproductive health”, something that, even if it could be properly defined, has never been empirically observed. Target 6B, manages to be both aspirational and outdated, as it calls for the achievement “by 2010, [of] universal access to treatment for HIV/AIDS for all those who need it.”

INCONSISTENT INDICATORS

There are also differences in the way indicators were defined for tracking progress towards the targets. Goal 4 has the merit of consistency, with the same metrics – child mortality – used for the goal, target and indicator. An additional indicator on measles immunization was added alongside mortality because immunization coverage is more responsive to short term changes than mortality. There is a role for such proxy indicators in health monitoring if they are closely correlated to health outcome but it is overly simplistic to limit proxies to a single indicator –immunization against measles is only one component of the reduction of child mortality. Similar considerations apply to the use of an indicator on births attended by skilled health personnel as a proxy for maternal mortality. Moreover, proxy measures tend to gradually evolve into the main indicator of interest, distracting attention from the original objective of a policy or programme.

The identification of indicators for Goal 6 was particularly difficult given the vague wording of both the goal and targets across the different diseases. At first, because of the difficulty of estimating incidence, a proxy indicator of HIV prevalence in young people was used. More recently, however, improved statistical modelled have enabled reporting of estimated incident cases. Other indicators relate to condom use at high risk sex and to knowledge about HIV/AIDS among young people. All the proxy indicators focus on the sexual transmission of HIV infection and none address other drivers of HIV/AIDS, such as the use of contaminated drug injecting equipment.

Failure to clearly define indicators, data sources and metadata from the start resulted in lack of precision in the description of several indicators. For example, the malaria indicator “proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs” is unclear because not all children with fever will actually have malaria. Several of the targets and indicators refer to “access” – universal access to reproductive health, access to antiretroviral drugs, access to safe drinking water and basic sanitation, and access to affordable essential drugs. Access is a complex construct that covers multiple elements such as service availability, affordability, and acceptability. Because these components are difficult to combine in a single indicator, what is actually measured is service use, often referred to as coverage. This is easier to measure insofar as questions on service use can be included in household surveys. However, the quality of care cannot be measured in this way. Thus, indicators on skilled attendant at birth or antenatal care monitor the quantity of care provided rather than its quality. Similarly, monitoring progress on water and sanitation indicators uses a proxy indicator, use of an improved water source.
However, “improved” refers to the type of technology a household reported as primary source rather than to the quality of the drinking water.

A further weakness in some indicators is that it is not self-evident where the ultimate desired value lies. Indicators for which the desired values are clear are described as monotonic. Mortality indicators are monotonic because lower levels are always desirable. Coverage of care indicators are monotonic because high coverage – preferably 100% – is the ultimate aim. However, there is no preferred value for the adolescent birth rate or contraceptive prevalence rate (which explains why there is also an indicator on unmet need for contraception which is monotonic).

**REMEDIAL REPORTING**

In global MDG reporting the lack of clarity in indicator definitions has been dealt with by redefining the indicators in a way that is more amenable to measurement. For example, reporting on the access to drugs indicator focuses on the availability of key essential medicines in public and private facilities and on their relative price differences. Global MDG reporting has taken a very flexible approach, reporting indicators that are measureable even if they are not included in the MDG list and adding additional indicators to complete the picture. Both the United Nations annual MDG report and the WHO reporting to the annual World Health Assembly use multiple indicators in order to provide a comprehensive picture of progress towards the overall goals. The reports also make explicit connections across the MDG goals and targets, in acknowledgement of the multiple determinants of health outcomes. The WHO annual reports also make good use of the “other diseases” element of Goal 6 to include noncommunicable diseases, neglected tropical diseases and other health issues as part of its MDG reporting.

**FROM GLOBAL TO NATIONAL: A DIFFICULT TRANSLATION**

Thus far we have discussed problems with the MDGs process and products from a global perspective. However, the MDGs quickly became identified with national goals, targets and monitoring strategies. This had not been the original intention of the UN agencies that came up with the MDGs. The global targets were set for the world as a whole and should not have been confused with national targets. Earlier global conferences had always made a distinction between global and national targets. For example, the World Summit for Children of 1990 noted that the global goals should be “adapted to the specific realities of each country”. 9

The wholesale downloading of the global targets to national level meant that national targets were defined that had no basis in the initial starting conditions in countries. Indeed, very often there was no sound data on the baseline level from which the target would be monitored. In practice, what a country can achieve in a given time horizon depends at least, in part, on where it starts out from. The failure to acknowledge the importance of the process of change, or the transition path, meant that the MDGs could easily be dismissed as inappropriate to national priorities. Added to this, because the MDGs were described in terms of national aggregates or averages, with no reference to distributional outcomes, they did not generate the engagement of local communities or disadvantaged populations.

Furthermore, the challenges of monitoring progress at country level were not sufficiently taken into account, the assumption being that the existing data sources would be sufficient to the task. In practice however, despite the development of innovative methods for measuring child mortality, fertility, and HIV, the ability of countries to effectively monitor progress for their populations as a whole remains constrained.

The weakness of country reporting has greatly affected global reporting. Many if not most of the indicators are in fact estimates developed by global agencies on the basis of incomplete country data. Inevitably, this has led to divergences between official national indicator values and those reported by the agencies, further compounding the lack of country ownership of the MDG framework.
LEARNING THE LESSONS: POSITIONING HEALTH IN THE POST 2015 AGENDA

Given the prominence of health within the MDGs, its positioning in the post-2015 agenda requires careful consideration, both of health vis-à-vis other development areas, and of the various elements within the health agenda. Ensuring people’s rights to health, including through universal access to quality health services, will remain critical elements of the post-2015 vision. However, it is now clear that the new framework must address the limitations of the MDGs. It must adopt a broader paradigm of inclusive, equitable and sustainable growth and development, reversing ecological destruction while providing decent work, sufficient nutritious food, life-long learning opportunities, adequate housing, justice and personal security and health care. Within this broad agenda, health will need to jostle for space. This makes it essential to start from a coherent overall health framework that addresses health comprehensively and avoids the risk of a narrowing in the scope and reach of the health goals and targets.

AN INCLUSIVE, PARTICIPATORY PROCESS

A missed opportunity of the MDGs process was the failure to engage countries directly in decision-making about goals, targets and indicators. Country involvement came only at the end of a process which was managed by the UN agencies. This mistake should be avoided for the post 2015 agenda; the process of country adaptation is key to country ownership and essential for eventual success.

Although discussions on the post-2015 agenda have been under way in the UN system for many months, involvement of countries, partners, NGOs, and civil society has been limited to their participation in meetings and conferences, such as, for example, the Rio Summit which addresses the range of development issues across multiple sectors. However, advances in communications technologies provide many more opportunities for such engagement this time around. Providing space for commentary and discussion through electronic media would enable a much broader range of interested stakeholders to contribute and greatly enrich the scope and quality of debate.

A COMPREHENSIVE FRAMEWORK FOR HEALTH

A comprehensive framework for health is needed that take into account the important changes that are underway that have a bearing on how priorities for health development are defined and measured.

- **Changing disease patterns**: Epidemiological and demographic transitions impose a complex burden of infectious diseases alongside noncommunicable diseases, mental health, injuries and the consequences of violence. Emerging infectious disease outbreaks and epidemics constitute a universal threat to the global economy.

- **Universal health challenges**: Whereas the current set of health-related MDGs focus on the problems of poverty and priorities for developing countries, the rapid spread of risk factors, such as tobacco use and physical inactivity, along with ageing populations and unplanned urbanization, have a profound influence on health and wellbeing in all countries.

- **Health systems under threat**: Health systems around the world face complex challenges in responding to population needs. In many settings, health systems are characterized by inadequate levels of unpredictable funding, limited access to life-saving technologies, lack of financial coverage and a continuing daily toll of unnecessary death and disability from preventable causes. Elsewhere, increasing costs of technology, ageing populations and rising public expectations threaten the financial sustainability of health systems.

These developments imply that the new health framework must comprise three major elements. First, the framework must expand the focus beyond selected diseases and conditions to ensuring universal access to comprehensive services, using innovation to foster efficiency, preventing exclusion (particularly of poor women and girls) and protecting people against catastrophic expenditure when they fall ill through extending universal health coverage.
Second, the framework must move beyond a preoccupation with aggregate achievement and take into account the multidimensional aspects of increasing equity (in terms of opportunity, access and outcome). With about three-fourths of the world’s poorest people now living in middle income countries, the issue is no longer confined to a debate about development aid (although aid will remain important for some countries). Rather it is about social justice and its realization in all countries rich and poor.

A third element of is the need to address the social, economic and environmental determinants of health, not just the proximal causes of illness and disease. Clearly, all these elements are linked. Addressing social determinants has been shown to be an effective way of increasing equity of access and outcome. Similarly, tackling the burden on noncommunicable diseases requires action in multiple sectors.

It is not just content issues that need to be reflected in the new global health agenda, it is also how health issues can be addressed more effectively. In this regard, a human rights-based approach to health is essential. The right of everyone to enjoy the highest attainable standard of physical and mental health is recognized in numerous global, regional and national treaties and constitutions. It underpins action and provides part of the rationale for including health in the post-2015 development agenda. The realization of civil, cultural, political, economic and social rights is a prerequisite for sustainable growth and human development. Irrespective of where one lives, gender, age or socio-economic status being healthy and having access to quality and effective health care services is of fundamental importance for all people, while at the same time healthy populations are essential for the advancement of human development, well-being and economic growth.

For health to retain its rightful place at the apex of development there is a need for a single high-level goal. In this way, improved health becomes one of a set of indicators that together track progress across economic, social and environmental domains. An equity dimension needs to be an integral part of such an indicator. Below this overarching health goal, a hierarchy of more sector- and programme-specific goals, targets and indicators can reflect existing agreements (including the current MDGs) and incorporate elements of the new health agenda. This approach could help rationalize target setting and help develop a limited set of numeric targets that are adaptable at country level and relevant globally. This could involve a shift from relative reduction targets to absolute thresholds for child mortality, maternal mortality, HIV, TB, malaria, child stunting/underweight, safe water and sanitation. It could also involve setting completion targets in terms of annual average improvements rather than as binary achievements. Discussion is also needed on the rationale and benefits of setting elimination and eradication targets.

**Clarity in Definitions and Feasibility of Measurement**

Goals, targets and indicators should be both measurable and motivational, to continue to galvanize public support for development. Metrics must be sophisticated - not too crude, but also not too technocratic. Serious limitations in data exist and should be acknowledged and strategies developed to address them.

Health in the post 2015 development agenda should be positioned as a positive, inclusive concept that comprises positive outcomes such as good health and well-being for all persons, not only freedom from disease and avoidance of premature mortality. Health goals, targets and indicators will need to be identified that cover three broad areas:

- **Health status** (outcome or impact) indicators that measure health status (good health, well-being) and health outcomes (illness, disability, death, injury). Health status indicators are the most important indicators in a national population health indicator set, as they provide baseline information (or denominators) about the state of a population’s health. These baselines allow for the examination of the impact of all economic, health system and social changes on health.

- **Performance indicators** that measure aspects of the performance of health services or public health programmes such as universal coverage, service utilisation/accessibility, costs and availability/quality of health infrastructure and care. These kinds of indicators are more often used in programme monitoring. They are generally more sensitive to programme inputs than outcome/impact indicators which may be affected by many external factors apart from health-related programme interventions.
• **Health risks and determinants** that measure the effect on health status of a range of determinants and risk factors (genetic, nutritional, behavioural, lifestyle, socio-economic, educational, occupational, environmental, etc.). In most countries, there are various programmes across sectors that try to improve all these factors. Thus, improved health status a also key indicator for tracking programme performance across non-health sectors.

Health-related indicators should be presented as a pyramid (Figure 1), with the high level health status indicators at the apex and programme level indicators (in health and non-health sectors, at the base). The high level summative goals reflect progress across multiple domains; they do not ‘belong’ to any particular sector or agency. Achieving improved health and reducing mortality and disease requires action on many fronts, not only – or even primarily – in the health sector. For example, reductions in child mortality reflect increased food security and nutrition, access to safe drinking water and sanitation, female education, employment and financial resources, social protection, reduction in environmental threats, as well as improved access to preventive and curative health care. Indicators for monitoring progress would be chosen from each level according to their country relevance and priorities. But countries would have a degree of freedom to tackle the issues most pertinent to them.

Health status indicators should start with positive measures of health and wellbeing, including functioning. At the next level, indicators should cover health status measures that cover negative outcomes such as premature mortality, stunting, disability, and incidence/prevalence of disease. These would include child and maternal mortality, mortality due to infectious diseases (such as AIDS, TB and malaria) and premature mortality due to noncommunicable diseases (such as cardiovascular disease, cancer, diabetes, or chronic respiratory disease).

At the next level, indicators of health system performance should be included, such as distribution of health infrastructure and human resources; health system financing, policy, and information systems; universal coverage; coverage of major health interventions such as MCH; safety of interventions; efficiency; and responsiveness of the health system to people’s expectations and aspirations.

Indicators of risk factors and determinants are key to understanding the persistence of poor health outcomes despite programme interventions. These determinants include genetic, nutritional, socio-economic and environmental factors as well as the adverse health impact of wars, conflict and natural disasters.

Countries should adopt and adapt global goals, targets and indicators and develop national data sets that are relevant to their own challenges and needs. The process of doing so is summarised in Annex I. The identification of goals, setting targets and defining indicators should be guided by agreed criteria and best practices. Some criteria for indicator selection are summarised in Annex II.

The MDGs process paid insufficient attention to the data sources required to generate the various indicators. It will be essential to provide specific guidance not only on which indicators to include but also how they can be measured most effectively and efficiently. Each essential indicator identified should be linked with one or more suitable data sources. A budget should be developed for this period and the data-collection plan should indicate likely financing sources and levels.
CONCLUSION

Within the MDG framework, the goals were clear, concise, measurable, and resonated with decision-makers and the general public. But health is a complex field and a reductionist approach focused on a limited set of indicators cannot capture important trends. Indicators selected for setting targets and monitoring progress towards the post 2015 development agenda should:

- Express the multiple dimensions of health and wellbeing yet include a limited number of targets;
- Reflect the complexity of development yet retain the characteristics of simplicity and understandability;
- Be sensitive to principles of human rights, inclusiveness and equity but amenable to quantitative measurement;
- Reflect global priorities and universal standards yet be tailored to the domestic situation and local challenges;
- Reflect both overall goals as well as interim objectives;
- Combine universality with country-specificity.

Key to understanding the direction and degree of progress in health is an in-depth, analytical effort that brings together – in a readily comprehensible format or dashboard – multiple quantitative indicators with summary information on context, determinants, and policy and institutional coherence. Such an analytical process can also be the basis for ‘health impact assessments’ that evaluate the effects on health of policies in different sectors and offer a mechanism for accountability and actions to accelerate progress and redress deficiencies.
Annex I – Developing a national indicator data set

When designing a national indicator set, the first step is to define priority health areas and government objectives. Successful indicators tap into issues that are important across society and address problems that can potentially be changed through government policies and operational initiatives. Health indicators should reflect important issues of social concern and should be grounded in areas that are the subject of policy and operational initiatives. Once priorities have been set, existing health status indicators can be selected. The selection of indicators from existing data sources is desirable because of the difficulties in establishing new indicators. Indicators should be selected on the basis of their ability to measure the problem adequately, their ability to be understood clearly by users and policy makers, and their ability to describe disparities in population health. In relation to population disparities, indicators should have enough data categories to describe different populations and should provide information at various population levels (national, state, local, community). If data deficiencies exist, new collections can be established using the same criteria as those for selecting existing sources.

- **Health status**
  - Life expectancy at birth
  - Life expectancy at age 50 years
  - Healthy life expectancy
  - Healthy life expectancy at age 50 years
  - Functioning/wellbeing
  - Infant mortality rate
  - Neonatal mortality rate
  - Child mortality rate
  - Adult mortality rate 15q45
  - Maternal mortality ratio
  - Mortality due to:
    - Cardiovascular disease, cancer, chronic respiratory disease, diabetes
    - HIV, TB, malaria
    - Maternal and child mortality, including VPD
    - Epidemics, disasters and shared health threats

- **Health system performance**
  - Universal access for key health interventions
  - Universal financial protection
  - etc

Further indicators are to be developed based on existing guidance.
Annex II - Desirable characteristics of health-related indicators for the post 2015 agenda

Indicators should be seen as useful for mobilizing activity and enabling comparisons but not as ends in themselves. Indicators should illuminate without distorting reality or driving programmes. Three main criteria should guide the selection of indicators for the post 2015 agenda. They should be:

- Theoretically sound and linked to public health objectives
- Meshed with publicly understood concepts so they can be readily introduced to the public and policy makers, and
- Technically useful.

To be theoretically sound, indicators must: reflect important national health topics that are seen as having some social value; be underpinned by government health objectives; and address problems that could be changed through public policy and operational initiatives.

To be commonly understood, indicators must: be in a form the general public, opinion leaders, and the health and medical communities can easily interpret and understand; have a dissemination plan.

To be technically useful, indicators must:

- be reliable measures;
- be available from established sources on a regular (at least biennial) basis;
- be able to be disaggregated at multiple levels (national, state, local, and community) and for diverse select populations;
- address primary, secondary, and tertiary prevention issues as well as the environmental and socioeconomic determinants of health;
- must have involved a range of stakeholders in their development so they have credibility.
Figure 1. Hierarchy of health goals

**Health status:**
Health, functioning, wellbeing

**Health status:**
Mortality by age group & cause; disability; incidence/prevalence of disease

**Health system performance:**
Inputs & processes:
Policy, finance, human resources, information

**Health system performance:**
Outputs & outcomes:
Coverage of health interventions; Effectiveness & safety; Efficiency; Responsiveness

**Risk factors and determinants:**
Nutrition, socio-economic status, education, occupation, environment, natural and man made catastrophe
2. UN System Task Team to support the preparation of the Post-2015 UN Development Agenda. Realizing the Future we Want for All Report to the Secretary General. Draft for Final Comments, 22 May 2012
10. Three health-focused goals (MDGs 4, 5 and 6), none health-related targets, (MDGs 1, 4, 5, 6, 7, 8) and 23 health-related indicators