Health in the post-2015 development agenda - response from STOP AIDS NOW!

Introduction

STOP AIDS NOW! is an independent organisation, based in The Netherlands, working towards a world without AIDS. The work involves integrating the response to HIV and AIDS into development cooperation. Aids Fonds, Hivos, ICCO, Cordaid and Oxfam Novib are all collaborating within STOP AIDS NOW! Annex 1 summarizes the specific input from five Southern partner organisations based in Bolivia, India, Malawi, Swaziland and Peru. This paper aims to engage with the post-2015 development agenda. It explores how global health needs should be addressed in a new development framework after 2015.

Lessons learnt from the health MDGs

MDG 6 has driven unprecedented progress in addressing HIV and AIDS. For the first time in history, optimism and momentum has been building around the real possibility that an AIDS-free generation is imminent. Enthusiasm is fuelled by news about the rapid scale-up of antiretroviral therapy, evidence that HIV treatment can prevent new infections, and expanded coverage of programmes to prevent mother-to-child transmission of HIV. Yet, the most recent estimates of HIV prevalence and incidence and of AIDS-related mortality released by UNAIDS\(^1\), together with data from the Global Burden of Disease Study 2010 in The Lancet\(^2\,\,3\), make clear that AIDS is not over.

Key achievements

In 2001, the United Nations General Assembly held its first health-related session on HIV and AIDS. As a result, the General Assembly endorsed the Declaration of Commitment on HIV/AIDS, providing political momentum to catalyse the HIV response at national, regional and global

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At national level, the MDGs have resulted in a strong sense of ownership and shared responsibility in many countries. According to the UNAIDS report ‘Together we will end AIDS’ (2012) 81 countries increased their domestic investments for HIV/AIDS by more than 50% between 2006 and 2011. In 2012, the African Union launched the ‘Roadmap for shared responsibility and global solidarity for AIDS, Tuberculosis and Malaria in Africa’ which charts a course for more diversified, balanced and sustainable financing for the HIV/AIDS response by 2015 and demonstrates Africa’s regional leadership in the global HIV/AIDS architecture. At global level, the Global Fund to fight AIDS, Tuberculosis and Malaria was established (2002), specifically to mobilise international financing for MDG 6. The Global Fund approved more than $22 billion in a decade and has saved more than 7.7 million lives to date.

1. What have been the shortcomings of the current MDGs?

The first shortcoming of the current MDGs is that many countries will not meet the health MDGs. And even for countries that have met them, the MDGs make it possible to mask huge inequity and inequalities in access to health care. The general indicators in the current framework are not detailed enough to give a realistic view of those inequalities.

Secondly, a human rights-based approach is missing in the MDGs.

Thirdly, the focus of the current MDGs is too strong on low income countries rather than on poor people. Increasing equity in terms of opportunity, access and outcome is more important now since three-fourths of the world’s poorest people live in middle income countries. This is a very important trend and it will have immense consequences. According to the report of the UN System Task Team, the issue is no longer confined to a debate about just development aid, but rather about social justice and its realisation in all countries.

Fourthly, southern governments and civil society organisations were not enough involved in the development of the MDGs and their implementation, which consequentially led to lack of ownership. The AIDS response however has demonstrated that meaningful engagement of civil society and communities in policy development, programming and funding processes is essential for ensuring that programmes are of high quality and tailored to the needs of specific populations.

A fifth issue which is considerably marginalized under the current MDG framework is protection of both adults and children. All people, children and adults, should be able to live their lives free from violence, exploitation, abuse and neglect, but ensuring this requires strong political commitment and adequate resources for social protection systems.

A sixth shortcoming is the lack of interlinkages. HIV indicators need to be included across all MDSs to meaningfully reflect their cross-cutting nature in addition to being a key development
issue in own right. The fact that the MDGs did not make those links is seen as a huge gap, a fact recognised by the UN System Task Team. Overall, it can be argued that the MDGs fail to recognise the interlinkages between the different MDGs, hindering progress on the goals overall. The health MDGs, which have been very much addressed in silo in the current framework, with often separate strategies and funding streams, are inseparable from each other. The achievement of one goal very much depends on the progress of the other goals. And the health MDGs are also interlinked with many of the other targets, including nutrition, gender equality, and education.

The last shortcoming is the exclusion of many aspects of sexual and reproductive health and rights from the current MDGs, which was a major obstacle to progress on all the goals.

2. Health priorities post 2015: What is the priority health agenda for the 15 years after 2015?

The health priorities post 2015 should be to continue strong efforts to meet the unmet MDGs, other global commitments such as universal access to HIV prevention, treatment, care and support, and ensure universal access to sexual and reproductive health.

The basis of the health agenda after 2015 should be health equity and the promotion of human rights. AIDS is unfortunately a metaphor for inequality, showing that the value of life is not the same across the world. 1.8 million people are dying of AIDS every year in the developing world, when in developed countries AIDS is becoming a chronic disease. 9 million people are still waiting for treatment, and their lives are hanging in the balance. In the North we are seeing a new generation born HIV-free, while each year, 370,000 babies are born with HIV in the South.

Tackling inequity should be realised through addressing inequalities among and within countries through mainstreaming equity across the new Framework and across all development policies and strategies in countries. HIV-related stigma and discrimination and marginalization as well as gender inequality and gender-based violence pose a major obstacle for many groups to have equitable access to HIV prevention, treatment, care and support. This should be addressed through sustainable efforts to promote legal reform and an enabling environment for these groups to access services and advocate for their rights. Vulnerable, marginalized and hard-to-reach groups, including people living with and affected by HIV, should be explicitly made the primary beneficiaries, as well as key shapers and implementers of the new Framework. Attention will need to be paid to children’s specific vulnerabilities, including age and their dependence on adults.

The UN System Task Team recognizes that a human rights based approach to health is essential, stating that 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. The Team states in its Thematic Think Piece on Health (2012) that the right to...
health underpins action and provides part of the rationale for including health in the post-2015 development agenda.

In order to make sustainable progress towards attaining the right to health, the key role of communities as health service providers alongside or in the absence of government services, in particular the role they play in reaching vulnerable and marginalized groups, should be strengthened and supported politically and financially.

3. Framing the future health goal: How does health fit in the post 2015 development agenda?

The next framework should firstly reflect the importance of health as a key determinant and expression of poverty and as a priority issue in its own right, while recognizing health is interlinked with all other development sectors and key to achieving equity and sustainable development.

Secondly, the post-2015 development agenda should consist of goals that enshrine equality for all, deliberately seek to improve the life chances of the poorest and most vulnerable people, including those communities most marginalised, such as men who have sex with men, sex workers, drug users, and women and children. In order to facilitate a more equitable approach to the pursuit of development goals, all targets and indicators should be disaggregated by income, wealth and other forms of group-based inequalities such as gender, region and ethnicity. Considering children’s access to income is also pivotal, as it can tell much about children’s opportunities and well-being.

Increasing equity and equality in terms of opportunity, access and outcome is even more important now that three-fourths of the world’s poorest people live in middle income countries. According to the report of the UN System Task Team, the issue is no longer confined to a debate about just development aid, but rather about social justice and its realization in all countries rich and poor.

The future health goal should commit to achieving improved health outcomes for all through the provision of universal health coverage, including universal access to HIV prevention, treatment, care and support and universal access to sexual and reproductive health services via a rights-based approach. As more countries reach middle income status and are expected to build self-sustaining national health services, it is crucial that the provision of affordable and quality health service is ensured and that social protection mechanisms and HIV services are part of the health care package. The availability of a significant share of public funding is key to help subsidizing equitable universal health coverage. In the 2010 World Health Report on health financing, Margaret Chan notes, “continued reliance on direct payments, including user fees, is by far the greatest obstacle to progress (to universal health coverage).” Thus, in order to advance universal access to health care, including universal access to HIV prevention, treatment, care and support, bilateral and multilateral donors must continue to support countries to set up tax systems based on solidarity. These tax systems should raise funds for
health, reduce reliance on out-of-pocket payments, especially through elimination of user fees, and promote risk pooling in the form of an increased proportion of public financing for health spent more effectively, efficiently and equitably. **The UNAIDS Investment Framework** provides a key model for investing in HIV at the country level, through identifying core programme interventions and critical enablers to ensure more targeted and more efficient interventions.

Thus, **any future health goal(s) should set targets for financing for health** (total health expenditure per capita and proportions of domestic government budget expenditure on health, such as the Abuja target). In addition, the new Framework should provide the political space for new innovative financing mechanisms, such as a Financial Transaction Tax, to help countries implement the new Framework and the new health goal(s). In addition, **clear accountability mechanisms of funding modalities should be set for both donors and governments**. More attention needs to be placed on the current and future trends in the use of resources, the mix of donor, public and private funding and the transition from donor funding to funding from domestic resources, a trend which can be seen in countries that reach middle income status. The effect of that transition on the scale up of effective approaches targeting specific populations needs to be taken into account, in particular in countries where certain groups of the populations are marginalized and stigmatized by their governments.

Finally, the social and economic determinants of health need to be more strongly addressed, both within the future health goal as well as across other goals. This is one of the most important ways equity of access and outcome can be realized.

4. Measurement of progress towards the health goals: What are the best indicators and targets for health?

First of all, “unfinished” health MDGs require sustained focus in the post 2015 framework and any new targets and progress indicators should not be weaker than in the current MDGs. Also, women’s and children’s health should be strongly embedded in the post 2015 framework. **The future health goal should expand the scope of coverage and not backtrack from existing commitments and targets such as universal access to HIV prevention, treatment, care and support.**

Secondly, health and HIV indicators need to be included in all new development goals to meaningfully reflect interlinkages and their cross-cutting nature in addition to being a key development in its own right.

Thirdly, the new health goal(s) should include more sector and programme-specific targets and indicators which also reflect existing commitments and the current (unmet) MDGs as well as

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targets which aspire to reach all people and have at least three major equity-related features. First, targets should explicitly require reductions in health inequities and should include both coverage of services and health outcomes indicators. Second, any health goal(s) should include a time-bound target for each country to define their hard-to-reach, vulnerable and marginalized groups and develop specific strategies for overcoming barriers to access to health services for these groups. Third, there is a need to include specific targets to end criminalizing and discriminatory laws such as laws against men who have sex with men, criminalization of sex workers, and violation of women’s rights, such as property rights and gender-based violence.

In addition, to get more accurate information about marginalized groups and their access to health services, and from a human rights perspective, there is a need to disaggregate data by gender, sexual orientation, age, ethnicity, income, and vulnerability. Some health issues demand disaggregation on particular grounds: for example, in the context of sexual and reproductive health, disaggregation on the basis of sex and age is crucial. The UNAIDS Guidelines on the Construction of Core Indicators state that without disaggregated data, monitoring of access, equity and change over time is very difficult. Disaggregated data should inform specific targets to uncover inequities and patterns of discrimination, and enable informed development of policies and strategies to ensure that vulnerable and marginalized groups receive the support and services they need.

Finally, the new framework should provide space for locally developed indicators, such as one related to the proportion of community health workers representing marginalized groups, as their services contribute to increased utilization by these groups and ensure quality of care. Indicators should also reflect differences across populations, identify populations where progress is lacking, and concentrate efforts on improving the health of these populations.

5. Ensuring a process and outcome that is relevant to the key stakeholders: How can country ownership, commitment, capacity and accountability for the goals, targets and indicators be enhanced.

Some countries have made important efforts to adapt the MDGs to their national and local needs. In some cases, new goals, targets, and related indicators have been added to address specific national policy priorities, and national development strategies explicitly oriented at achieving the MDGs were designed including disaggregated data across regions and vulnerable groups. In this way, greater national ownership of the goals and targets has been achieved.

The post-2015 framework should include formal guidance on policies and processes that countries should follow in order to form inclusive processes that include marginalized populations when adapting global targets and indicators to the country context and when developing strategies to achieve the goals and targets.

Country health systems must specifically target the problems, causes, and interventions required by the disease burden of the country as well as by the populations in which the
disease burden is the highest. There must be a clear rationale guiding the choice of program inputs, processes, actions and outputs based on their contribution to the ultimate health goal(s). Data and evidence should be the basis for decision making as much as possible.

Civil society at the local, national and global level, will need to be enabled to play a critical role in providing these data and evidence, as well as shaping the new agenda and acting as a watchdog in its implementation. Lessons learned from the HIV response in particular demonstrate that civil society and advocates have not only contributed significantly to the progress made in the recent decade but also in making sure that the voices of the poorest and most marginalized are heard and their specific needs put forward. Through their work at the community level and directly with beneficiaries of services, civil society and community-based organizations are well positioned to ensure that the health goal(s), targets and indicators are accountable and meet the needs of those most affected. Community mobilisation and community systems strengthening should therefore be at the core of the post-2015 Development Framework to ensure services reach the poorest and most marginalized groups and enhance true country ownership and accountability. The Community Systems Strengthening Framework of the Global Fund to Fight AIDS, Tuberculosis and Malaria provides an important model on how to support and strengthen effective community engagement in health and development efforts. 

Sustained political and financial commitment for MDG 6 is needed to capitalise on the momentum, as Michel Sidibé, Executive Director of UNAIDS in June 2011 said: “It is not a question of paying now or paying later. Either we pay now or we pay forever.”

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6 UN General Assembly High Level Meeting on AIDS, 11 June 2011, New York.
Annex 1: Country partner responses

STOP AIDS NOW! contacted a number of civil society and community-based partners of STOP AIDS NOW! and the International HIV/AIDS Alliance, working in the field of HIV, sexual and reproductive health and with marginalized populations, to learn about their needs at country-level. We sent them four key questions regarding health in the new post-2015 development framework. Please find below the responses of the following partner organisations:

- Family life Association of Swaziland
- MASUNA, Malawi
- International Services Association (INSA), India
- Via Libre, Peru
- Instituto para el Desarrollo Humano (IDH), Bolivia

1. What would your national government propose as health priorities?

**Swaziland**

In Swaziland, current health priorities are HIV prevention, in particular addressing the social determinants; universal access to health services, in particular for the marginalized and hard-to-reach; and TB & HIV co-infection.

**Malawi**

In Malawi, HIV/AIDS and other sexually transmitted diseases and Malaria are the major diseases that kill many people across the country. The country’s current health strategy is focused on having zero HIV infections, zero HIV deaths and zero people suffering from AIDS. According to MANUSA, in order to achieve universal health coverage, the government should in particular focus on reaching people in remote and rural areas. Mobile clinics, establishment of rural health centers, access to education and awareness about nutrition and HIV, as well as community mobilization are key issues which need to be taken into consideration to achieve universal health coverage in Malawi.

**India**

The Government of India is implementing an ambitious programme called the “National Rural Health Mission”, which is the overarching health programme for the rural population. The program has established “Accredited Social Health Activists (ASHA), who are female health workers assigned to each village of more than 1000 people in the country to support and provide various health services, in particular reproductive and child health. In line with the National Rural Health Mission, the Government of India is planning to implement a “National Urban Health Mission” as well for cities and towns with at least 100,000 people, primarily focused on inhabitants of slums and other urban poor.
Bolivia
The Government of Bolivia does not have an overarching development vision and national budget allocations to health cover only 6% of the overall budget. The Ministry of Health is mainly focused on clinical issues, spending over 80% of their budget on health commodities, and very little on prevention and education, which has resulted in a lack of qualified health care providers. The Ministry of Health functions in an inefficient way and data collection is insufficient, in particular HIV-related data. The role of community-based organisations and local NGOs is rarely acknowledged or supported by the Government of Bolivia. The government’s current health strategy is to support the country’s health by targeting the main diseases in the country (HIV, malaria, TB< diarrhea, acute respiratory infection.). However, policies are often not translated into action.

Peru
The Government of Peru does not have long term national health policy strategies. It is currently focusing on maternal and child health; maternal mortality; nutrition for infants between 0 – 5 years old; and cancer. Peru also seeks to promote universal health coverage, mainly through social inclusion and awareness raising programmes such as the “Programme Esperanza” for cancer.

2. What considerations would you want the UN and the international community to take regarding the new health goal and universal health coverage?

Swaziland
The UN should consider including health as a basic human right as well as strengthening linkages between different health issues, in particular HIV and sexual and reproductive health integration.

Malawi
The UN should prioritize strengthening, supporting and funding local NGOs and community-based organizations, in addition to supporting national governments. The UN and the International Community should also work with the Government of Malawi on tax reform and increasing tax revenues to implement development priorities in Malawi.

India
Access to better health services is a challenge in India. Public health facilities are often of poor quality and private clinics which better quality care are unaffordable for the majority of the population. In order to achieve universal health coverage, delivery of public health services need to be strengthened and their quality improved. The UN and the International Community can also play a key role in ensuring affordable health care technologies and medication, in particular through monitoring TRIPS and availability of generic drugs.
Bolivia
The UN should ensure there is a mechanism in place for shadow reports by local civil society in countries in which they can define their own priorities for the post-2015 Development Framework, in addition to the Government’s. It is essential that the needs of the population are taken into account in this process. The UN should make it easier for NGOs to engage with UN agencies at the country-level. The UN should also encourage the government to engage and consult with civil society.

Peru
To make universal health coverage an achievable reality, the UN should first and foremost look at what still needs to be achieved in terms of the current MDGs, for example achieving universal access to HIV prevention, treatment, care and support, rather than choosing new issues. What we see in a middle-income country like Peru is that there is still a large population living in poverty and extreme poverty and the country is dealing with enormous social inequalities. This has a direct impact on health and universal health coverage.

3. Coverage for all health needs and coverage for all people are key principles of universal health coverage. How would this affect HIV, sexual and reproductive health and human rights? How would this affect access to services for marginalized populations? What additional principles and/or monitoring indicators should be included to ensure that universal health coverage is truly “universal”?

Swaziland
It is important to include indicators in the new health goal(s) related to rights and the social and cultural determinants of health. In some regions in the country, the social environment and behaviors pose a barrier to universal health access. The UN should also take into account the specific contexts and environments of different countries, so the approach should be as targeted as possible.

Malawi
Universal health coverage will affect the various health components in many ways. Universal health coverage should respond to the challenges of HIV and to reducing the spread of HIV in Malawi. Some issues not properly covered in the current MDGs, such as awareness-raising on HIV and other HIV prevention strategies as well as sexual and reproductive health in particular for young girls, need to be included in any universal health care package.

India
Universal Health Coverage will definitely have a positive impact on HIV and reproductive and child health. The Government of India recently created a new mechanism called “ADHAAR” (Unique Identification Authority of India) which will focus on efficient delivery of welfare services. This mechanism could also be linked to health services and be used as a monitoring tool to ensure service delivery and its optimal utilization.
Currently, there is no national database, public sector nor private, of health service take up. There is no lifetime medical record for individuals due to lack of coordination between the different health facilities. If health service delivery would be linked to ADHAAR and there would be better data collection, patterns of health seeking behavior, morbidity and mortality could be generated resulting to stronger progress towards universal health coverage. This would also ensure that services reach all who need them, including the most marginalized.

**Bolivia**
Under current circumstances, the government of Bolivia could not afford universal coverage of HIV and AIDS services. There is a need for specific support to structure and strengthen Bolivia’s health system, with a strong focus on HIV and marginalized populations. It must be a transition process which could take years, depending on the capacities of the government and political will. In addition, marginalized populations and people most vulnerable to HIV are faced with stigma and discrimination in Bolivia and often have no access to health services. Universal access, in this situation, is a utopia. The new health goal should include indicators related to healthcare workers training, policy criteria, qualification of medical staff, and indicators related to laws, rules and norms fulfillment as well as State responsibility to implement laws.

**Peru**
While there has been a lot of progress on universal coverage for HIV services, an important percentage of the population, in particular the most vulnerable and affected populations (such as pregnant women and gay and transgender people), have no access to services. In addition, the lack of awareness and political and financial support to marginalized populations, combined with high levels of stigma, affect how health and financial priorities are defined. Marginalisation and exclusion result in increased vulnerability to the HIV epidemic and negatively impacts on the health status of these people. This is of great concern as 55% of new HIV infections in Peru are concentrated among gay and transgender people. With regard to pregnant women, 2 out of 1000 are tested HIV positive. A key principle to consider regarding universal health coverage is equity, with a three-fold approach: human rights, gender identity and sexual diversity. Indicators should be formulated taking the equity approach into account as well as the specific needs of marginalized populations.

4. **What considerations should the international community and national governments take regarding the financing and affordability of universal health coverage?**

**Swaziland**
Considering the important role of communities in achieving universal health coverage, the international community and the national government should significantly invest in community systems strengthening.
Malawi
Universal health coverage will require significant investments. The principle of universal health coverage is good, but for it to be truly universal and reach everybody across the entire country is a huge challenge.

India
The international community and the national government should ensure more affordable health technologies and services. Duplication of services should be avoided and there is a need for much better coordination and convergence between the various service providers. Low cost technologies should be used to reach out to the larger population. India has one of the largest mobile phone user base in the world and the market has grown considerably both in rural and urban India. This technology can be used for health promotion and awareness raising, as well as information on health service delivery points.

Bolivia
Universal health coverage is a fundamental right and the State must assume its costs. The government of Bolivia must increase the national budget for health, investing in infrastructure, equipment, and quality and capacity of health care providers, especially in prevention, care and health services management. In Bolivia there is a national health insurance system, financed by taxes, but it is badly administered by the government and the syndicates. Poor people should have access to free health services.

Peru
Universal health coverage requires a better understanding of cost-effectiveness by the Peruvian government through focusing on equity and social inclusion. The future health goal should be underpinned by the right to health principle, taking into account ethical, technical and political aspects.