Post-2015 Health Consultation: Response from the Ecumenical Advocacy Alliance

Background

The Ecumenical Advocacy Alliance (EAA) is a global network of churches and related organizations covering the full spectrum of church families – Roman Catholic, Orthodox, Protestant and Evangelical – committed to collaborating in advocacy for social justice and human dignity and rights. The EAA focuses its collective efforts, campaigning on two key issues per four-year cycle (currently HIV and AIDS, and Food), with a cross-cutting human rights based approach to the issues it is working on.

Many EAA members[i] are responsible for the delivery of a wide range of key community, health and humanitarian services. For example, EAA members include large international NGOs such as World Vision International, Caritas Internationalis, the Lutheran World Federation, and the World YWCA, as well as large and small national service delivery organizations such as the Churches Health Association in Zambia, the Christian Community Health Care Foundation (Cameroon) and the Madras Christian Council of Social Services. Over a quarter of EAA members are based in Africa or Asia, with many others having offices and/or partners and programs worldwide.

This written response to the health thematic of the post-2015 consultation process draws on EAA members' and partners' extensive expertise within the field of HIV and AIDS in particular. However, EAA has also been part of the drafting team for the Beyond 2015 response to the health consultation and thus commends this paper which is more overarching in terms of health in general.

Lessons learnt from the health-related Millennium Development Goals (MDGs)

Much can be learnt from the MDGs. Progress has certainly been made and we must now ensure that this is safe-guarded and built upon. Yet the experiences of the past 12 years have revealed some crucial shortcomings that we now have the opportunity to address in the post-2015 period.

Undoubtedly, the greatest strength of the MDGs has been the simple and clear focus that they have provided for both political and public attention which, in turn, has greatly influenced international funding priorities and thus created momentum behind the MDGs. This is not least demonstrated by the gains made on the HIV-related targets encompassed in MDG 6. New multilateral and bilateral institutions like the Global Fund and PEPFAR, as well as increased domestic spending, have greatly contributed to successes in the HIV response. For example, the number of people newly acquiring HIV continues to decline globally – from 3.2 million in 2001 to 2.5 million in 2011, and the number of people receiving treatment globally is now more that 8 million. This is, in turn, leading to fewer deaths from AIDS-related causes and fewer babies being born with HIV.

These advancements in the HIV response have had an impact that is far wider than simply galvanizing progress towards the attainment of MDG 6. For example, a focus on improving HIV prevention and treatment services has not only strengthened health and community systems but also shines a light on what needs further strengthening. What's more, the HIV response has shown that promoting and acting on the linkages between HIV and other issues such as human rights, gender, sexual and reproductive health, maternal and child health, TB and hunger/nutrition, have overall benefits for all three of the sustainable

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development pillars: economic, social and environmental, as well as for the attainment of the other seven MDGs and other health outcomes.

Acting on these linkages is crucial for a comprehensive response to HIV, and will be crucial for extending HIV treatment to the other 8 million people who still need it but do not yet have it. Indeed, it is this reality that points to a fundamental weakness in the design of the MDGs: They do not articulate the synergies between the individual goals and thereby there were missed opportunities for coordination and efficiency. For example, MDG 3 is key for achieving the HIV targets of MDG 6, yet the gender response within HIV initiatives remains inadequate. Even within MDG 6 itself, efforts to address tuberculosis are seldom linked closely enough with HIV responses, despite intrinsic linkages between these two diseases. And, in terms of the other two health-related MDGs (4 and 5) as well as MDG 6, cross-cutting issues integral to their achievement, such as sexual and reproductive health, the elimination of gender-based violence, and human dignity and rights for all, are not included in the MDG framework at all.

As a result, advances towards achieving the MDGs have not fostered equal progress and have actually resulted in increased inequality both within and between countries. Again, the HIV response provides a telling picture in this respect: Access to treatment for children lags far behind that of adults, and equal access to treatment for other key populations, such as sex workers, people who inject drugs and men who have sex with men, also remains an unmet challenge of the global HIV response.

It is vital, therefore, that the synergies between various global goals are better articulated in the post-2015 period so that collaboration and efficiencies between various development focuses are harnessed and placed within an overall framework that promotes human dignity, rights and health for all.

Framing health in the post 2015 agenda

Based on the lessons learned, the careful framing of health in the post 2015 agenda is crucial in order to ensure that the centrality of health to advances in other sectors is adequately reflected at the same time as seeing the right to health as a goal in its own right. Therefore, echoing the Beyond 2015 submission, we suggest that health is framed in two ways:

1. At least one overall health goal with disease-specific targets

Such a goal should promote access to affordable and quality health services for all, and thus the realization of the right to health. Universal health care coverage, including universal access to HIV prevention, treatment, care and support, should be a key part of this goal as long it does not focus solely on health care systems but also addresses social and structural barriers such as stigma and discrimination which often prevent the most marginalized and vulnerable populations from accessing health care services.

In order to ensure that gains made in the 2000-2015 period are not lost but built upon, clear disease-specific targets, including for HIV and AIDS, must also be encompassed in the overall health goal, and these targets must facilitate scale-up to responses thus far. For example, the post-2015 period should provide a framework within which concerted financial and political commitments to achieving an AIDS-free generation are leveraged, as this could indeed become a triumph of the post-MDG era.

Other illnesses that need to be included among the disease-specific targets are tuberculosis, malaria, and non-communicable chronic diseases, particularly cancer, cardio-vascular disease and respiratory disease.

2. Explicit health-related targets and indicators integrated into other global goals

In order to systematize and strengthen the links between HIV and other relevant sectors, such as trade, education, gender, sexual and reproductive health, food/nutrition, water

and social protection, health and HIV targets and indicators should be included across all post-2015 goals.

Measurement of progress towards the health goals

It is vital that the post-2015 goals have clear targets that are time-bound, measurable and achievable. As demonstrated by the MDGs, this helps galvanize support from state and non-state actors, mobilizes public support and facilitates accountability among world leaders.

While the framework articulated for the post-2015 era should hold all countries to account for the achievement of the global goals, it may also be advisable to include contextualized national targets for the less economically developed countries. In addition, it will be vital that middle-income countries are an essential component of the post-2015 framework, in order to ensure that poor and marginalized groups in these countries are reached.

To further address concerns about inequality, the new framework should include specific indicators to measure equity and process made in reaching vulnerable and marginalized populations. For such purposes, disaggregated data is crucial. In addition, it will also be important to find ways to incorporate qualitative measurements as well as quantitative data.

Ensuring a process and outcome that is relevant to the key stakeholders

It is also essential that the new framework calls for a multi-sectoral response, whereby the responsibility to improve health and increase access to affordable and quality health care and services is shared by all. Notably, donors and national governments must work hand in hand to share the financial and political commitment for achieving the right to health for all, and the private sector and other non-state organizations must also be mobilized to support the aims of the framework.

However, in conclusion, the HIV response has shown that health and HIV cannot be addressed without putting the communities most affected by the epidemic at the centre of the response. Therefore, it is vital that the HIV and broader global health communities are at the centre of the post-2015 decision making processes. In particular, more global south voices are needed since, as yet, they are not sufficiently apparent in the discussions around the health thematic.

[i] A full list of EAA members is available at http://www.e-alliance.ch/en/s/about-us/members/.